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Taxation (including Smuggling Control)

# Tobacco Excise Taxation in South Africa

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## Introduction

The past ten years have witnessed a major turnabout in government policy on tobacco control in South Africa. Within a relatively short time, government policy has changed from complete apathy to one where the tobacco control measures are regarded as some of the most progressive in the world.

South Africa's tobacco control policy rests on two important pillars: legislation and excise tax increases. In 1999 the government passed legislation that banned tobacco advertising and sponsorship, prohibited smoking in all public places (including workplaces), and banned the sale of tobacco to minors. This legislation was an amendment to an act passed in 1993 that prohibited smoking on public transport and introduced health warnings for the first time.

As well as increasing the implicit costs of smoking, the legislation prohibiting smoking in public and work places represents a clear transfer of property rights from smokers to non-smokers. Whereas previously smokers enjoyed the right to pollute the air, the legislation unambiguously assigns non-smokers the right to unpolluted air. Although the direct impact of the legislation on tobacco consumption is still unclear, the legislation has continued the trend of deglamorising smoking in South Africa. As a result, smoking is no longer regarded as socially acceptable by large sections of the population.

In the past decade the government has substantially increased the excise tax on tobacco products for health reasons. Since 1994 the nominal tax on cigarettes has increased by nearly 25 per cent each year. Econometric evidence indicates that the resulting price increases have had a significant impact on cigarette consumption. The aim of this paper is to investigate tax increases in some detail.

## Description of the Intervention

During the 1970s and 1980s tobacco control was not on the public agenda. The tobacco industry used its cordial relations with the government to prevent any measures that would harm the industry. On tobacco issues, the government regularly consulted the industry. For example, before the budget was presented to Parliament the tobacco industry was consulted about possible tax increases. Not surprisingly, the tax increases were generally very modest. In fact, between 1970 and the early 1990s the real (i.e. inflation adjusted) excise tax on cigarettes decreased by 70 per cent. This rapid decrease occurred despite calls by the medical community and the Ministry of Health to increase the excise tax.

In 1994 the African National Congress became the dominant party in the Government of National Unity after the first democratic elections. In the early 1990s the outgoing government had started introducing some tobacco control measures, in the form of legislation mandating health warnings, and increases in the excise tax. In 1993 the ANC announced that it would accelerate the tobacco control measures if it came to power.

The new government made its intentions clear at the reading of the Budget in June 1994, when the Minister of Finance announced that the government would increase the tax on tobacco products to 50 per cent of the retail price.[1] At that point, excise taxes amounted to 21 per cent of the retail price and the total tax burden (i.e. including sales tax) was 32 per cent of the retail price. However, after being pressurised by the industry, the government opted for a slower phasing in of the adjustment. While the phasing in approach was a temporary setback for the tobacco control lobby, the government kept to its promise, increasing the excise tax by substantially more than the inflation rate at subsequent readings of the Budget. In 1997 the Minister of Finance announced that the 50 per cent target had been achieved. Subsequent tax increases were aimed at keeping the tax percentage at that level.

Some trends regarding tobacco taxation in South Africa are shown in Table 1. Column (f) illustrates the rapid decrease in real excise tax between 1970 and the early 1990s, followed by a sharp increase subsequently. A recent study has shown that, in the past decade, South Africa has had the third highest percentage change in tobacco taxes (after Korea and France) amongst 90 countries. It is interesting that, despite the industry's protes-

[1] In South Africa, as in many countries, the excise tax is levied as a specific tax, i.e. a certain amount per pack of cigarettes. Unless the tax is adjusted regularly, inflation will erode the tax. This is exactly what happened in South Africa during the 1970s and 1980s.

However, even though the excise tax is technically a specific tax, the government's policy of setting the tax at 50 per cent of the retail price has turned it into a *de facto ad valorem* tax.

## Table 1

**Trends in cigarette prices, taxes and consumption**[a]

| Year | Cons, millions of packs | Price, Nominal, Cents per pack | Price, Real, 1995 base, Cents per pack | Excise tax, Nominal, Cents per pack | Excise tax, Real, 1995 base, Cents per pack | Excise tax as % of price | Total tax as % of price | Industry price, Real, 1995 base, Cents per pack | Excise revenue, Real, 1995 base, R millions |
|---|---|---|---|---|---|---|---|---|---|
| (a) | (b) | (c) | (d) | (e) | (f) | (g) | (h) | (i) | (j) |
| **1961** | 517 | 19.1 | 449 | 9.1 | 214 | 47.6% | 47.6% | 235 | 1106 |
| **1965** | 608 | 19.4 | 417 | 9.1 | 196 | 46.9% | 46.9% | 222 | 1189 |
| **1970** | 783 | 22.1 | 405 | 11.1 | 203 | 50.2% | 50.2% | 202 | 1593 |
| **1975** | 1048 | 31.8 | 373 | 14.6 | 171 | 45.9% | 45.9% | 202 | 1795 |
| **1980** | 1283 | 49 | 328 | 20.1 | 134 | 41.0% | 44.9% | 181 | 1725 |
| **1981** | 1443 | 53 | 308 | 20.1 | 117 | 37.9% | 41.8% | 179 | 1684 |
| **1982** | 1632 | 62 | 314 | 21.1 | 107 | 34.0% | 39.1% | 191 | 1745 |
| **1983** | 1551 | 66 | 298 | 24.1 | 109 | 36.5% | 42.2% | 172 | 1686 |
| **1984** | 1570 | 74 | 299 | 24.6 | 99 | 33.2% | 41.0% | 176 | 1560 |
| **1985** | 1571 | 84 | 292 | 26.1 | 91 | 31.1% | 41.4% | 171 | 1425 |
| **1986** | 1591 | 94 | 276 | 26.1 | 77 | 27.8% | 38.5% | 170 | 1217 |
| **1987** | 1671 | 109 | 275 | 26.1 | 66 | 23.9% | 34.7% | 180 | 1101 |
| **1988** | 1795 | 122 | 273 | 27.1 | 61 | 22.2% | 32.9% | 183 | 1089 |
| **1989** | 1809 | 138 | 269 | 30.6 | 60 | 22.2% | 33.5% | 179 | 1079 |
| **1990** | 1868 | 165 | 281 | 33.1 | 56 | 20.1% | 31.6% | 193 | 1055 |
| **1991** | 1927 | 171 | 253 | 37.6 | 56 | 22.0% | 32.9% | 170 | 1072 |
| **1992** | 1900 | 222 | 288 | 44.6 | 58 | 20.1% | 29.2% | 204 | 1100 |
| **1993** | 1802 | 255 | 302 | 53.2 | 63 | 20.9% | 31.3% | 204 | 1135 |
| **1994** | 1769 | 284 | 309 | 60.5 | 66 | 21.3% | 33.6% | 205 | 1162 |
| **1995** | 1708 | 348 | 348 | 75.3 | 75 | 21.6% | 33.9% | 230 | 1287 |
| **1996** | 1690 | 387 | 360 | 92.0 | 86 | 23.8% | 36.1% | 230 | 1447 |
| **1997** | 1577 | 497 | 426 | 117.5 | 101 | 23.6% | 35.9% | 273 | 1588 |
| **1998** | 1495 | 608 | 487 | 169.5 | 136 | 27.9% | 40.2% | 292 | 2032 |
| **1999** | 1422 | 730 | 558 | 214.3 | 164 | 29.3% | 41.6% | 325 | 2332 |
| **2000** | 1333 | 803 | 582 | 254.5 | 184 | 31.7% | 44.0% | 326 | 2453 |
| **2001**[b] | 1272 | 889 | 608 | 291.5 | 199 | 32.8% | 45.1% | 334 | 2540 |

[a] Sources: Auditor-General, Statistics South Africa (previously Central Statistical Services and Department of Statistics), Budget Review, Tobacco Board

[b] Preliminary figures.

Table 2

**Nominal percentage changes in the excise tax on various tobacco products**[a]

| Financial year | Cigarettes | Cigarette tobacco | Pipe tobacco | Cigars | Inflation rate |
|---|---|---|---|---|---|
| **1990/1** | 11 | 11 | 10 | 13 | 12.0 |
| **1991/2** | 14 | 14 | 11 | 14 | 11.4 |
| **1992/3** | 8 | 8 | 4 | 5 | 8.3 |
| **1993/4** | 9 | 19 | 2 | 2 | 9.7 |
| **1994/5** | 25 | 29 | 25 | 30 | 9.0 |
| **1995/6** | 24 | 27 | 25 | 28 | 8.7 |
| **1996/7** | 18 | 20 | 18 | 19 | 7.4 |
| **1997/8** | 52 | 56 | 52 | 53 | 8.6 |
| **1998/9** | 29 | 31 | 29 | 29 | 6.9 |
| **1999/00** | 20 | 85 | 166 | 3669 | 5.2 |
| **2000/1** | 16 | 40 | 56 | 74 | 5.4 |
| **2001/2** | 12 | 12 | 20 | 17 | 5.7 |
| **Average 1990/1 – 1993/4** | 11 | 13 | 7 | 9 | 10.4 |
| **Average 1994/5 – 2001/2** | 25 | 38 | 49 | 490 | 7.1 |
| **Average 1990/1 – 2001/2** | 20 | 29 | 35 | 330 | 8.2 |

[a] Source: Budget Review

[2] However, during the 1960s cigarettes, like all goods, were not subject to sales tax. The imposition of sales tax, since the late 1970s has increased the effective tax burden above the level of the 1960s.

[3] Since 1997 the Ministry of Finance has claimed that it has achieved the 50 per cent tax target. This is more illusionary than real. When the Ministry calculates the tax incidence percentage, the denominator they use is the retail price before the tax increase. This is unrealistic. The tax increase causes the retail price to increase, with the result that the denominator increases. So, ex post, the total tax percentage is much lower than the claimed 50 per cent, as is illustrated by column (h) of Table 1.

tations about the "unreasonableness" of the excise tax increases, the real excise tax in 2001 is no higher than the level of the 1960s.[2] Total tax as a percentage of the retail price follows a similar trend, as indicated in column (h). The tax proportion decreased from 50 per cent in 1970 to 30 per cent in 1992, after which it rose to 45 per cent in 2001.[3] Despite the excise tax increases, the tax proportion of South African cigarettes, compared to many Western countries, is still low.

The real retail price of cigarettes has more than doubled over the past decade, as is shown in column (d). This means that cigarettes, in comparison to a basket of other goods and services, have become very expensive. In fact, of all commodities surveyed by the South African statistical

authorities, cigarettes have been subject to the largest price increases over this period. This was a dramatic reversal of the previous 20 years' trend, since between 1970 and the early 1990s the real price of cigarettes had fallen by a third. At purchasing power parity, the price of South African cigarettes is currently comparable to those of many European countries and Japan.

In South Africa cigarettes represent more than 90 per cent of tobacco sales. Some of the poorer sections of society buy pipe and cigarette tobacco and roll their own cigarettes. However, despite the large increases in the real price of cigarettes, the non-cigarette tobacco segment has remained small.

In order to be effective, tobacco excise tax increases should not create incentives for people to shift their tobacco consumption from one form to another. The tax increases should thus be similar for the various tobacco products. In Table 2 the percentage changes in the excise tax for the four excisable tobacco products are shown. In most years the tax increases on potential substitutes to cigarettes (i.e. pipe and cigarette tobacco) have been similar to that of cigarettes, but in some years, notably 1999 and 2000, the tax increases have been substantially greater. This suggests that the government was aware of the possible substitutability of tobacco products, and did not want to create an incentive for consumers to switch to substitutes.

An important omission is snuff, which is not taxed at all. According to the National Council Against Smoking, in South Africa, almost as many women use snuff as smoke cigarettes. Despite tobacco control groups lobbying for a tax on snuff, no tax has been imposed to date.

In South Africa the excise tax on cigars has traditionally been very low. However, this changed dramatically in 1999 when the excise tax was increased nearly forty-fold. This was followed by another 74 per cent increase in the excise tax in 2000. The Minister of Finance claims that the large increases in the tax on cigars were necessary to bring them into line with the tax on cigarettes. However, the fact that few people in South Africa smoke cigars on a regular basis, and that they are regarded as luxury and "special events" items, suggests that the primary aim of increasing the tax on cigars was to increase government revenue.

## Implementation

In contrast to tobacco control legislation, which has to go through a lengthy parliamentary process, it is very easy to increase the excise tax on tobacco products. Even before 1994, the Minister of Finance announced increases in the tobacco excise tax at the annual reading of the Budget. However, as pointed out, the increases were small and usually less than the inflation rate.

In South Africa a vocal tobacco control lobby, led by the Medical Research Council (MRC) and the National Council Against Smoking (NCAS), had been arguing for significant tax increases since the 1970s. They appealed for a comprehensive tobacco control strategy resting on three basic pillars: (1) an advertising ban, (2) restrictions on smoking in public places, and (3) rapidly increasing tobacco taxes. They pointed out that international evidence had shown that increasing the excise tax on tobacco is the most effective tobacco control measure. Despite the fact that tobacco is addictive, numerous studies, performed in a variety of countries, have shown that excise-induced increases in tobacco prices causes tobacco consumption to decrease. They also pointed out that international experience had clearly shown that increasing tobacco excise taxes also increases government revenue.

The tobacco control lobby wanted the government to earmark a proportion of the tobacco excise taxes for general health promotion strategies. However, the lobby groups were unsuccessful with these requests, even after the changes of the 1990s were implemented. As a rule, the South African government does not earmark revenues.[4] It is argued that earmarking distorts the prioritization of government policies, and could lead to economic inefficiency in the spending of these funds.

The MRC and NCAS regularly pointed out that the real excise tax rate had been decreasing during the 1970s and, even faster, during the 1980s. Even though this point was well taken in the Department of Health, the Ministry of Finance did not increase the tax. The government explained its inaction as follows: (1) increasing the tax would stimulate smuggling, and (2) an increase in the tax might, in fact, decrease government revenue, because the

[4] Exceptions to the rule are the Unemployment Insurance Fund, the Skills Levy, and levies to fund regulatory bodies of specific industries

tax-induced price increase would cause a sharp reduction in demand. In providing these explanations, the Ministry of Finance apparently did not question their empirical foundations; they were generally taken as an article of faith from the tobacco industry.

In the early 1990s, after the ban on the ANC had been rescinded,[5] and negotiations for a democratic transition were taking place, the tobacco control groups started lobbying the ANC for stricter tobacco control measures, including rapid tax increases.[6] The tobacco control lobbyists found an ally in Dr Nkozasana Zuma, the later Minister of Health. She was passionately against smoking and, in this regard, had the full support of the president-to-be, Nelson Mandela.

In June 1994, less than two months after the democratic transition, the Minister of Finance announced that the government would increase the tax on tobacco products to 50 per cent of the retail price. The Ministry of Health and tobacco control lobby groups had been lobbying the Ministry of Finance for a doubling of the excise tax that year. Because of pressure exerted by the tobacco industry, the Minister of Finance increased the tax by only 25 per cent in 1994. Although this was a temporary setback for the health community, the tax was increased by substantially greater percentages in subsequent years. The guiding principle for each of the subsequent tax increases was the "50 per cent goal" announced in 1994.

The industry was naturally furious about the excise tax increases. The Tobacco Institute of South Africa was particularly vocal about the "discriminatory" tax increases. They argued that tobacco was already the most highly taxed consumer product, and that such large tax increases would encourage smuggling. Furthermore, they argued that the tax would decrease tobacco consumption, which would cause large numbers of workers to be retrenched. The chairman of the Rembrandt Group, the country's largest cigarette manufacturer, wrote an open letter to the Minister of Health in 1996 in which he argued that smuggling was out of control, and that the government was losing revenue as a result. He quoted the example of Canada where smuggling had reached epidemic proportions, which was reduced significantly after the taxes were reduced.[7]

In 1996 the tobacco control lobby was strengthened when the Economics of Tobacco Control (ETC) Project was established at the University of Cape Town. Among other things, the Project quantified how much revenue the government had lost during the 1970s and 1980s by allowing the real excise tax to fall so sharply. This effectively destroyed the industry's argument that the government might lose revenue by increasing the tax, because of the reduction in consumption that it would cause. The tobacco control lobby used these and other research results of the ETC Project to counter the industry's claims that tobacco benefits the economy as a whole.[8]

The tobacco control lobby was heavily dependent on information and news in order to retain the attention of the public and the policymakers. Research results and tobacco related news from developed countries certainly maintained public awareness, but locally produced research results generally received more media attention. The tobacco control lobby in South Africa used locally generated research outputs to influence policymakers. This is important because policymakers want to know what the impact of certain interventions is likely to be on the South African situation. They are generally not very interested in, or persuaded by, research that has been performed in a different country, possibly under very different circumstances.

[5] The African National Congress is a political party which was founded in 1912. It was banned for 30 years under the apartheid regime, from 1960 to 1990.

[6] It must be noted that the National Party government passed the country's first tobacco control legislation in 1993. This was the result of persistent lobbying with the then Minister of Health. The legislation was mild, even by 1993 standards, but it nevertheless represented a schism between the NP government and the tobacco industry. This legislation did not make any provisions for tax increases. However, the more comprehensive legislation of 1999 did not include such provisions either.

[7] However, subsequently it was found that the tobacco industry was involved in the smuggling network. Litigation is currently being brought against Brown & Williamson regarding their role in the smuggling.

[8] The ETC Project was not the first to investigate the economic impact of smoking, but it was the most comprehensive. So, for example, a cost benefit analysis performed by the University of Cape Town's Health Economics Unit in 1988 indicated that, for every R1 received in tobacco taxes, the economy incurred medical costs and lost productivity of R4.

The public's reaction to the tax increases has been mixed. In the "letters" section of newspapers people have expressed both support for and disappointment in the tax increases. Surveys indicate that most people, mainly non-smokers, but also a sizeable proportion of smokers, generally support strategies aimed at reducing smoking.

## Success of the Intervention

Internationally, tobacco control advocates generally propose a comprehensive strategy in the fight against tobacco. Such a strategy would typically consist of an advertising ban, clean indoor air policies, restrictions on sales to minors, an effective education programme, and tax increases. The international literature indicates that, of all these interventions, increases in tobacco taxes are the most effective in reducing tobacco use.

The South African experience confirms these findings. Econometric studies have shown that the average price elasticity of cigarettes in South Africa is between 0.5 and 0.7. This means that, all other factors (e.g. income) remaining constant, the consumption of cigarettes decreases by between 5 and 7 per cent for every 10 per cent increase in the real price of cigarettes.

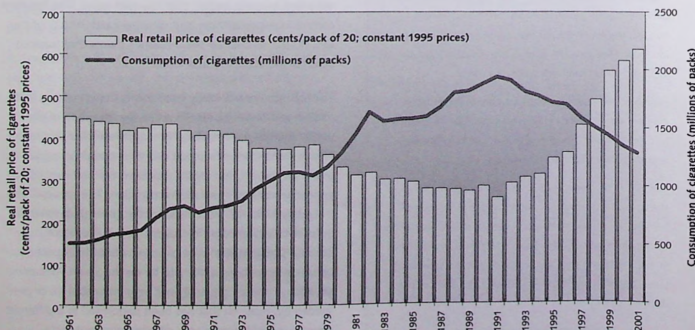
In Figure 1 the relationship between cigarette consumption and the real price of cigarettes is shown for the past four decades. The figure clearly illustrates the inverse relationship between these two variables. The increase in excise taxes explains about half of the real price increase since 1991; the other half is attributed to the industry's pricing strategy (discussed in section 5). Since 1991 total cigarette consumption has decreased by a third; in per capita terms it has decreased by more than 40 per cent.

It was found that approximately 40 per cent of the decrease in cigarette consumption was to be ascribed to people giving up smoking. This is reflected in the fact that the smoking prevalence percentage among adults decreased from 33 per cent in the early 1990s to 27 per cent in 2001. The other 60 per cent of the decrease in cigarette consumption is explained by the fact that smokers are smoking less. In fact, average cigarette consumption per smoker has decreased by approximately 20 per cent in the past decade.

An analysis of smoking prevalence in South Africa reveals that young people, low-income earners, black South Africans and males have experienced the largest reductions in cigarette smoking. Smoking prevalence among young people decreased from 23 per cent in 1993 to 19 per cent in 2000; among low-income earners from 31 per cent to 25 per cent; among black South Africans from 28 per cent to 23 per cent, and among males from 51 per cent to 44 per cent. Surprisingly, smoking prevalence among black South Africans has decreased despite a heavy tobacco advertising campaign, specifically focused on emerging

**Figure 1**

**Cigarette consumption and real prices of cigarettes in South Africa, 1961 to 2001**



middle-class black South Africans in the second half of the 1990s. The demographic groups that have not experienced significant decreases in smoking prevalence include females (although, admittedly, their smoking prevalence level, at 13 per cent, is relatively low), high-income earners (32 per cent), and white South Africans (36 per cent).

Studies performed in other countries indicate that young people and the poor are more responsive to cigarette price changes than older and more affluent people. The reason is straightforward: an increase in the price of cigarettes makes the product too expensive to those groups, with the result that they either reduce their consumption or quit altogether. The evidence from South Africa supports the hypothesis that young people and the poor tend to reduce their cigarette consumption by a greater percentage than other groups in reaction to a price increase.

A related issue concerns the regressivity of an excise tax on cigarettes. Some people are against using excise tax increases as a tobacco control tool because it could have a detrimental impact on the poor. Since the poor, vis-à-vis the rich, generally spend a larger portion of their income on tobacco products, they pay proportionally more tax. This implies that the tax is regressive, which is regarded as socially inequitable.

However, it has been shown that, in South Africa, an increase in the tax on cigarettes causes a larger reduction in cigarette consumption among the poor than among the rich. This means that, while the absolute burden of the tax is likely to increase for all income groups, the burden on the poor, relative to that of the rich, is reduced. Thus, even though excise taxes are regressive, increases in excise tax reduce the regressivity of excise tax.

## Other Effects of the Intervention

While the primary aim of a tobacco control strategy is to reduce tobacco consumption, an agreeable by-product of increasing the excise tax on tobacco is that it increases government revenue. Column (j) of Table 1 shows that, despite a 33 per cent reduction in tobacco consumption over the past decade, real government revenue has more than doubled. Since 1994, for every 10 per cent increase in real excise tax, real excise revenues have increased by approximately 6 per cent.

The tobacco industry has been ferocious in its opposition to any tobacco control measures, including excise tax increases. Under the present government, the policy on tobacco and tobacco control is unlikely to change. The industry has had to drastically change its marketing strategy under these difficult external conditions.

Whereas the pricing strategy of the cigarette manufacturing industry before the 1990s was focused primarily on the growth in cigarette quantities, there is currently a much stronger focus on the growth in price. Column (i) in Table 1 shows that the real industry price (i.e. the retail price less all taxes) did not change much between the 1960s and the early 1990s. If anything, the real industry price decreased over this period. However, there has been a very rapid increase in the real industry price since 1991 and especially since 1996. In 2001 the real industry price of cigarettes had increased by more than 60 per cent compared to the early 1990s. An analysis of the industry's major cost factors indicates that this increase is not the result of an increase in the real costs of producing cigarettes.

There is only one explanation: the industry is maintaining its overall profitability by increasing the profit per cigarette, despite the fact that quantities are falling. The external environment has turned against the industry to the extent that future growth in cigarette quantities seems unlikely. Since the merger between Rothmans (of the Rembrandt Group) and British American Tobacco (BAT) in 1999, one company has controlled 95 per cent of the South African cigarette market. This gives the newly created BAT the necessary monopoly power to raise cigarette

[9] The Department of Customs and Excise has recently commissioned a study aimed at quantifying the number of smuggled cigarettes. However, to the author's knowledge, the results of this research are not yet known. An analysis by the Economics of Tobacco Control Project, based on rather cursory data, suggests that between 5 and 7 per cent of cigarettes consumed in South Africa are not taxed by the authorities. This percentage compares well with most European countries.

[10] In a recent newspaper article, BAT claims that 148 million cigarettes were confiscated by the Department of Customs and Excise in 2001. This is about 0.6 per cent of total cigarette consumption in South Africa. However, the proportion of smuggled cigarettes impounded by the authorities is unknown. On the other hand, the smuggling and trade in hard drugs (especially heroin and cocaine) is a serious problem in South Africa, and attracts much media attention.

prices above competitive levels. The industry can disguise the retail price increases behind the well-publicised tax increases.

A simulation analysis has indicated that this strategy has been very beneficial to the cigarette manufacturing industry. The strategy has increased total sales revenue for the industry, with the result that the profitability of the industry has been enhanced. Also, the strategy has reduced the government's ability to increase its excise tax revenue. By increasing the real industry price the industry siphoned off the extra revenue to itself, at the expense of the government. The downside, from the industry's perspective, is that its pricing strategy has further reduced cigarette consumption. The actions of the industry suggest that they are in an end-game scenario, looking to milk the cow for all it is worth before it finally dies.

From a tobacco control perspective the industry's pricing strategy has been beneficial, because it has reduced cigarette consumption by a much greater percentage than what the excise increases would have achieved in isolation. It is ironic that the industry itself, in its attempt to further its own short-term interests, followed a strategy that benefited both the industry and the tobacco control lobby.

An issue of considerable importance in many countries is that of cigarette smuggling. In South Africa, whenever the excise tax on tobacco products is increased, the industry claims that this will increase smuggling activities. Unfortunately, given the dishonest character of cigarette smuggling, accurate data do not exist.[9] Over the past decade there have been very few reports of smuggled or counterfeit cigarettes being impounded by the South African police or customs authorities.[10] While this is not meant to imply that cigarette smuggling is not a problem, it can be said with confidence that South Africa does not experience the cigarette smuggling problems currently experienced by the UK and, in previous years, by Canada. Also, considering the official consumption statistics (as shown in column (b) of Table 1), the decrease in cigarette consumption in the past decade seems reasonable in view of the very sharp increase in the real price of cigarettes.

An interesting characteristic of the South African cigarette market is the absence of the Marlboro brand. In fact, Philip Morris has no presence in South Africa. In a court case in 1998 Rembrandt accused Philip Morris of smuggling cigarettes into South Africa via neighbouring countries. Tobacco industry documents clearly reveal that cigarette smuggling is used to gain market entry and/or share and to undermine tax policies. If smuggling, especially of Marlboro, into South Africa becomes uncontrolled, this could enable Philip Morris to formally enter the market. For this reason it is in the interest of the dominant incumbent (first Rembrandt, and now BAT) to contain smuggling.

Apart from keeping Philip Morris out, the industry has obvious motives for emphasizing the smuggling problem in South Africa. If cigarettes were smuggled on a large scale, the logical step, according to the industry, would be to reduce the tax on cigarettes. This is exactly what happened in Canada in the early 1990s.[11] While some informal bootlegging and some more organized smuggling definitely occur, cigarette smuggling is not a serious threat to the government's excise tax policy.

## Conclusion

South Africa has been able to significantly reduce its tobacco consumption in a decade. While strong tobacco control legislation and changing social norms have created an environment where smoking is increasingly regarded as socially unacceptable, the instrument with the biggest impact has been excise taxation.

In South Africa, as in most countries, it is administratively easy to change the excise tax on tobacco. What is required is the political will to challenge the vested interests of the tobacco industry. In South Africa the Minister of Health and nongovernmental organizations played a pivotal role in implementing a comprehensive tobacco control strategy, of which large increases in the excise tax are a key part.

The effects of an increase in the excise tax on cigarettes are soon felt: cigarette consumption decreases and government revenue increases. In South Africa the impact of the excise tax increases was enhanced by the industry when it increased the real retail price by more than the increase in the real excise tax.

An important proviso concerns cigarette smuggling. While South Africa's experience can, in principle, be easily duplicated in other countries, the success of such a strategy will depend crucially on whether the country can contain

[11] However, the logic is flawed. Evidence from several countries shows that tax reductions do not, in themselves, reduce smuggling.

cigarette smuggling within reasonable limits. In South Africa cigarette smuggling certainly did not undermine the strategy, despite the industry's claims to the contrary. Although individual countries may differ, international experience shows that, despite smuggling, higher tobacco tax decreases tobacco consumption and increases government revenue. Smuggling erodes but does not completely destroy the benefits of higher taxes.

Regarding cigarette smuggling, the industry has its own reasons for exaggerating the threat. In countries where smuggling could be a problem, the authorities should impose strong control mechanisms, including stiff penalties, cooperative efforts with customs and law enforcement officials in other countries, and laws to make exporters responsible for their exports all the way to a final legal and taxed destination, thus discouraging potential smugglers.

**Tools for Advancing Tobacco Control in XXI$^{st}$ century:**
Success stories and lessons learned

**Outils pour poursuivre la lutte antitabac au XXI$^{e}$ siècle:**
Expériences concluantes et nouveaux enseignements

# Advertising and Promotion Bans

WHO/NMH/TFI/FTC/03.2

PH-152

## Norway: Ban on Advertising and Promotion

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# Norway: Ban on Advertising and Promotion

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## Background

### Introduction

Norway constitutes the western part of the Scandinavian peninsula with a population of 4.5 million. The country does not grow tobacco, but has a tobacco industry with a long tradition.

The standard of living is high; unemployment is low representing, in April-June 2002, about 4.0% of the labour force. Price levels and wages are relatively high.

The population's health is fairly good, with life expectancy figures being one of the highest in the world. The health service and social security system are well developed.

A democratic form of government and a separate judicial system ensure everyone freedom of expression, the right to vote, and protection under law. The welfare state is based on ideals of equality and justice, which are clearly stated in its legislation: everyone has the right to employment, an education, social security and health service.

### Tobacco advertising in Norway

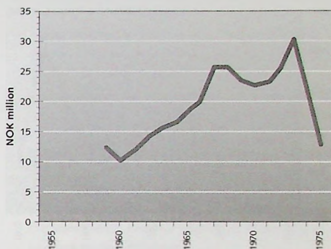
Before World War II, Norwegian broadcasting ran programmes with radio advertisements that included tobacco. After the war, radio advertisements for *all* products were abolished and were not allowed again until the 1990s; the same applied to TV advertisements. Tobacco advertising, however, was prohibited (see later).

Tobacco advertisements began appearing in Norwegian print media in the latter half of the 19th century, first in newspapers and magazines.

The degree of tobacco advertising can be measured *by expenditures*. In the figure below (figure 1), the trend of advertising activity is presented as annual total sales of tobacco advertisements by Norwegian advertising agencies, 1959 to 1975. Sales are given in Norwegian crowns (NOK) for 1979 prices, VAT not included[1]. During the entire period, the sales tripled. From 1960 to 1970 sales increased by 125% for *all* media. For *magazines*, however, the increase was 600% *(1)*.

### Figure 1

**Total sales of tobacco advertisements by Norwegian advertising agencies, 1959-75**




Source: A/S Norsk Reklamestatistik

**The tobacco-advertising ban was enforced on 1st July 1975; the obvious reason for the low 1975 figure. The relatively low figure for 1974 may be due to a slowing down of the industry's marketing activities as the time for ban enforcement approached; it is not explained by a general lowered advertising activity, cf."Counter attack".**

The extent of tobacco promotion in Norway measured by expenditures was moderate, however, compared with, for example, the United Kingdom and the United States of America *(2)*. For 1974, expenditures per inhabitant on newspaper and magazine advertisements, movies, trade papers and outdoor posters were the equivalent of US$ 0.69 for Norway, US$ 1.00 for the United Kingdom and US$ 1.14 for the United States (all figures given in 1974 values). It should also be remembered that large sums were used in the United Kingdom and the United States for other promotional activities, which did not exist in Norway (gift coupons, sport sponsorship, etc.).

The amount of advertising in printed media can also be measured *by area*. The total quantity per year of tobacco advertising in two popular weekly family magazines, each with a circulation of more than 300000 copies per week, was presented in a paper published recently; (see figure 2) *(3)*. As magazines attract female readers in particular, it is interesting to note that the total area of tobacco advertisement increased 12 times in the ten-year period from 1964

[1] In 2003, 1 US$ = NOK 6.85

**Figure 2**

**Area (dm2) of tobacco advertisements published in two Norwegian magazines, 1955-75**

Source: Karl Erik Lund

to 1973; an increase much higher than for the total extent of tobacco advertising (figure1). The share featuring women in the advertisements in the two magazines went up from 33% between 1955 and 1964 to 62% between 1965 and 1975, when 51% of the advertisements showed women smoking, against 31% men. Pre-1964 advertisements primarily contained information to smokers on price, type of tobacco, packaging and country of origin; after 1964 the advertisements developed a more universal appeal, associating smoking with various social situations marked by style, well being and comfort. It is obvious that the industry's advertising activities focused increasingly on a female market.

### Early recognition of the tobacco and health problem

In Norway, nongovernmental organizations (NGOs) play a vital role as pioneers of tobacco control. In the late 1950s, the Norwegian Cancer Society started disseminating information on the harmful effects of tobacco in the schools, and a small but active group, the Norwegian Tobacco and Health Association, started to lobby for an advertising ban, by sending its periodical to the parliamentarians and by visiting key politicians and lobbying for a ban.

At an early stage, prominent medical authorities became concerned with the health consequences of tobacco. Among them was the prominent pathologist Professor Leiv Kreyberg, who published several papers on smoking and lung cancer *(4)*.

In January 1964, the Director General of Health Services released a report on "Cigarette Smoking and Health" *(5)*, i.e. in the same months as the United States Surgeon General's Committee issued its famous report "Smoking and Health". Both reports were covered in the Norwegian press.

## The Committee for research in smoking habits

### Appointment of the committee

As early as February 1964, shortly after the release of the reports by the American and Norwegian health authorities (cf. "Early recognition of the tobacco and health problems"), the tobacco control issue was thoroughly debated in the Norwegian Parliament. A unanimous resolution was passed in which it was stated that:

> ... the Parliament requests the Government to set up a broadly based committee whose main task should be to plan the campaigns against harmful cigarette smoking.

In February 1965, at the initiative of the Director-General of Health Services, such a committee was set up (the Chair was the chief physician Kjell Bjartveit). The interdisciplinary Committee was given the following terms of reference:

> ... to submit a report, based on a comprehensive scientific analysis, on what measures can be implemented to counteract the adoption of smoking habits and to encourage the discontinuance of smoking or reduction of tobacco consumption.

### The Committee's report

In September 1967, the Committee's unanimous report of 245 pages, *"Influencing Smoking Behaviour"*, was released *(6)*.[2]

The Committee recommended that tobacco control strategy should be based on a combination of information, restrictive measures and cessation activities. Lack of bal-

[2] In 1969, the International Union Against Cancer (UICC) published a shortened English version of the report, cf. ref. no 6.

[3] In 1971, the National Council on Tobacco and Health was established by Royal Decree.

ance between these three components would decrease the effectiveness of such a triple programme.

The restrictive measures included a total ban on tobacco advertising, compulsory health warning on packages, an active price policy, maximum levels of emissions of specific harmful substances, restrictions on smoking in public transportation and indoor public spaces, and prohibition of sales to minors.

The Committee recommended that a permanent multidisciplinary council with a secretariat be established to supervise and coordinate the Government's smoking control work.[3]

Since this report concentrates on the advertising ban, it should be strongly emphasized that this measure is only a part of the total programme.

The Committee's report was covered extensively by the media, which focused almost entirely on the proposal for an advertising ban.

### The Committee's motives for an advertising ban

Although the entire Committee was responsible for its report, the chapter on an ad ban was written by one of its members, Professor Leif Holbæk-Hanssen, Professor of Distribution and Marketing Economics at the Norwegian School of Economics and Business Administration, and the country's leading expert in this field. The Committee concluded:

> ... that the volume of tobacco advertising should be restricted as far as possible in the direction of a total ban of advertising as is practically enforceable. Even if advertising may perhaps not strongly affect present consumption, it must be considered that the fact that advertising is permitted may, on a long-term basis, be interpreted as indicating that the harmful effects of smoking have not been proved. The lack of advertising restrictions implies that those authorities that might introduce such restrictive measures do not use their powers. The implicit effect could be that the public consciously or unconsciously believes that smoking cannot be so dangerous, since "responsible" authorities still permit tobacco advertising.

In light of the above, the Committee is of the opinion that the main effect of a prohibition of the advertising of tobacco products is a clear signal of the seriousness with which the authorities regard the situation.

The Committee's opinion is that the total effect of a prohibition against advertising would be:

- A possible direct and immediate effect on the development of total consumption, essentially by slowing down an expected increase.
- An effect beyond this through changes in *attitudes* of the public resulted from the well-defined position thus taken by the authorities in the relationship between tobacco smoking and harmful effects. The Committee is of the opinion that this will have an immediate and strongly smoking-negative effect. This immediate effect will decrease over time, but will still be present in a permanently negative labelling of all attempts of smoking-positive influence.
- A certain weakening of the competitive situation of Norwegian manufacturers versus foreign producers.
- A reduction in the advertising income of the press, estimated to be NOK 6-7 mill per year.

The term used by the Committee, "*... restricted as far in the direction of a total ban on advertising that is practically enforceable*", was later applied by political bodies that discussed the subject.

Retrospectively, it may be said that the Committee was fairly correct in its predictions of the effect upon consumption (cf. "Effect upon consumption and smoking rates").

## Follow up on the committee's report

### The 1969 political party conventions

Between 1968 and 1969 political parties were engaged in drawing up their party's public policy declaration[4] to be adopted by the party conventions before the General Election for the Parliamentary period 1969 to 1973 *(7)*. In Norway, all nominees throughout the country are committed to their declaration, unless they have publicly reserved the right to their own opinion on a particular issue.

[4] A party's public policy declaration before an election is a booklet that describes the party's intentions in all sectors of public life during the forthcoming years. It is binding for the party and its MPs; the party would loose credibility in the electorate if it goes against its own declaration.

Traditionally, public health issues appeal to the electorate; when there is a threat to health, people demand action. This may be why four out of the five parties represented in the Parliament from 1969 to 1973, quite independently included an advertising ban in their public policy declaration. There is reason to believe that the 1967 report from the Committee for Research in Smoking Habits, and the publicity around it, had an influence upon this decision.

Of the five parties, the Conservatives did not include an advertising ban in their public policy declaration; most probably it was never considered. The three medium-sized parties in the centre (the Centre Party, the Christian Democratic Party and the Liberal Party) did so, which was not surprising, considering their ideological basis. Of particular importance, however, was that the same decision was made at the convention of the Labour Party. Here, the proposal came from the party's women's organization, and, in fact, was carried through by one dedicated woman, Mrs. Merle Sivertsen, in particular.

This meant that the MPs of the four parties were committed. Since together they formed a majority on the issue, the battle was, to a large extent, already won. In the author's opinion, those few months prior to the General Election in 1969, were the most important period in the history of the Norwegian tobacco advertising ban.

One may ask where the opponent was, where was the tobacco industry when the political parties were drafting their manifestos? At that time the industry remained fairly silent on the issue. Perhaps the industry failed to see the writing on the wall and the upcoming political conventions. Or perhaps its communication with the international industry was inadequate, so that the threat was not apparent. It also is possible that Norway was looked upon as a remote market of minor importance, so that the snowball-effect on other countries was disregarded. In any case, the industry's low profile in 1969 is surprising, at least compared with the international industry's strong attempts today to present the Norwegian law as a failure. And as we shall see in section "Counter attack", the Norwegian industry's concern changed markedly shortly after 1969.

## The 1969 White paper

In 1969, the Government included the Committee's report in a White Paper to the Parliament, and in April 1970, the newly elected Parliament discussed it. The Parliament's Standing Committee on Social Affairs endorsed the White Paper unanimously on all main points, thus marking a milestone. Since 1970 Norway has had an active government tobacco control programme.

Specifically, the Parliamentary Committee recommended working out a draft for an act that would impose as complete a ban on advertising that is possible to enforce in practice.

## The legal drafting committee

In July 1970, the Government appointed a Committee to draft the Act proposed by the Parliament (the Chairs: Professor Anders Bratholm and Dr Juris) *(8)*.

The Committee defined advertising as the *'paid mass communication of information and ideas with the object of publishing the available offers and of creating definite attitudes in the consumers in such a way as to facilitate sale'*. To start with, the Committee tried to list all forms of advertising that should be included in the ban. However, the Committee found it impossible to produce a list that would cover the future rapid pace of developments in the field of mass communication and advertising technique. Therefore, the Committee found that the purpose was best served by laying down a general principle in the text of the Act, that the *advertising of tobacco products is prohibited*. Branding all such activity illegal would give a clear signal that all the various stages in the communication-chain would be compelled to respect.

The Committee recommended that the Act empower the Ministry of Health and Social Affairs to grant dispensation from the fundamental principle in special cases, for example, if at some future date tobacco products can be produced that are not associated with health risks, and in the case of particular forms of advertising which, in practice, are difficult or impossible to control.

The general ban was also to cover tobacco products shown in advertisement of other goods or services. Although it may be held that, strictly speaking, such cases are not advertising of tobacco, the Committee thought that there was no reason to allow this form of advertising. First, it may have considerable smoking-positive influence, especially when it combines smoking with the use of typical status symbols. Second, certain tobacco manufacturers might try to make use of this kind of "sneak-advertising" to circumvent the general ban of tobacco advertising.

In April 1971, after nine months' work, the Legal Drafting Committee presented its recommendations.

**No more advertising of tobacco as from 1st July. No more bad examples to follow.**

As from 1st July there will be no more advertising of tobacco in Norway …

The Parliament's view is as follows: It hopes that the ban on the advertising of tobacco will imply that fewer young people than at present will start smoking. It is also hoped that more people than at present who smoke will stop doing so, or will reduce their consumption.

Tobacco smoking endangers health – no doubt about it. This has been established by research. Nobody believes that a ban on advertising will solve the problem. But it may perhaps *contribute* to a change in our smoking habits. Efforts to inform the public about smoking will be initiated at the same time as spreading information about the new Act.

We believe that all these elements *combined* will contribute towards improvement of our smoking habits, and thus to avoidance of serious disease. And that is the whole point.

## The proceedings in Parliament

In June 1972, the Bill on the Tobacco Act was introduced by the Government, after gathering comments and opinions from all bodies concerned. To all intents and purposes the Bill was in accordance with the draft prepared by the Legal Drafting Committee.

In 1973, the Bill was debated in Parliament, which now was divided. The minority, the Conservative members, presented alternative proposals, which were much weaker than the Bill. The majority, the other four parties, supported the Bill, and even strengthened it. On 9 March 1973 the Act was sanctioned by the Royal Assent of the King in Council *(9)*.

The two first sections of the Act adopted in 1973 read as follows:

— **Section 1:** The object of the Act is to limit the damage to health caused by the use of tobacco.

- **Section 2:** Advertising of tobacco products is prohibited. Cigarette paper, cigarette rollers and pipes are regarded as tobacco products.
- **Tobacco products must not be included in the advertising of other goods and services.**
- **The King may issue regulations concerning exceptions to the first and second paragraph.**

### Enforcement of the Act

In October 1974, the Ministry of Health and Social Affairs laid down regulations concerning the implementation of the Act, and on 1 July 1975, the Act entered into force. Outdoor advertising signs had to be removed before 1 January 1976.

The regulations defined 'tobacco products' to include cigarettes, cigars, smoking tobacco, chewing tobacco, snuff, cigarette paper, cigarette rollers and pipes. The term 'advertising' should be understood to include mass media advertising for market promotion purposes, hereunder pictorial representation, advertising signs and similar devices, exhibitions and the like, as well as the distribution to consumers of printed matter and samples etc. The regulations specifically pointed out the following forms of mass media advertising 'as known today': Ordinary written material in print, radio and television, film, outdoor advertising, special printed matter and samples, entertainment and gatherings (for example in connection with public performances and concerts), retail outlets and objects (for example, the use of named tobacco brands, pictorial representation and the like on objects such as playing cards, match-boxes, ashtrays, cloakroom tickets etc. intended for public use) *(9)*.

The Act was strongly supported by the public. In 1973 a survey of the population aged 16 to 74 showed that 81% were in favour of the ad ban and the compulsory health labelling *(2)*.

Nonetheless, the Government found it necessary to introduce the Act to the public through large advertisements in all Norwegian newspapers and in selected magazines, picturing, for example, a small boy in cowboy outfit, staring admiringly at a giant photo of his cowboy hero, a John Wayne-like figure with a cigarette in his mouth, see figure above. The text in English of the advertisements is given in the frame. It shows that the authorities' expectations as to the effects of the ban were realistic and modest. And again, it was emphasized that the ad ban was only one part of a comprehensive programme.

### Procedure in cases of infringements of the Act – the 1970s and 1980s

In general, the introductory phase went smoothly. The tobacco industry and retailers were mainly loyal to the Act. Nevertheless, some attempts were made to exploit uncertainty, to balance on the edge of the law or actually break it.

*Staff members of the Ministry and the Council kept an eye on possible infringements in newspapers and other printed material. Also, people's reaction to such attempts occurred quickly. The health* authorities were informed immediately about clear violations of the Act and about borderline cases open to doubt. Most obvious was a case where a traditional cigarette advertisement was printed by pure accident in a small magazine. Telephones began ringing – from the general public and the mass media.

In cases of reported infringements, or doubtful incidents, the following practice was established by the National Council on Tobacco and Health: All cases were sent to one of the Council's legal members, whose professional reputation has been of the highest standard. Their evaluations were discussed by the Council, and then forwarded to the Directorate of Health for final decision. With rare exceptions, the Directorate agreed with the conclusions of the legal members and the Council. In cases of infringement, the Directorate approached the persons responsible. Its warnings carried various degrees of seriousness; the most significant being that a new offence would be reported to the police.

With very few exceptions in the 1970s and 1980s, this procedure was enough to stop further violation in the particular case

Professor Asbjørn Kjønstad, Dr Juris, one of the Council's legal members, and previous Dean of the Faculty of Law at the University of Oslo, published a review of the cases he evaluated during the first eight years, when an average of one case a month was dealt with in the way described *(10)*. His conclusion is:

> So far the Tobacco Act and those who enforced it have been victorious as regards the industry's advertising drive.
>
> And he gives three explanations for his view:
>
> ... First, there is a total ban on tobacco advertising in Norway, and it is therefore virtually impossible for the industry to find any loopholes in the law.

Second, most of the dubious issues have been thoroughly discussed in pre-legislative works. Problems arising in connection with enforcement can nearly always be solved by referring to pre-legislative work.

Third, Norwegian opinion and the National Council on Tobacco and Health have been keeping a watchful eye on the marketing practice of the tobacco industry. The authorities have cracked down on illegal advertising, thus preventing slip-ups.

### Procedure in cases of infringements of the Act – recent years

The tobacco industry, however, did not give in. Confronted with the decline in sales since the Act took effect in 1975, (cf. "Effect upon consumption and smoking rates), the tobacco industry tried to circumvent the ban in a variety of ways. Great inventiveness was shown in order to bypass the ban.

In this context it is noteworthy that the tobacco industry's new attitude occurred at a time when the industry organized a world symposium in Amsterdam in May 1986. One of the main themes of this symposium was *"Successful Marketing in a Colder Climate"*, and the programme preview said:

> Discussions will centre on different ways of combating anti-smoking groups and will include presentations on successful marketing strategies in countries where severe restrictions operate.

In 1992, the National Council on Tobacco or Health published a report about the increasing use of indirect advertising. Brand names that were known as a brand for tobacco products were increasingly used to promote other goods and services. The report outlined the extent of these campaigns, the most widespread being advertising for the clothing brand *Marlboro Classics*, as well as *Camel Boots* and the *Barclay Racing Experience*. This led to a watering down of the total advertising ban that was intended by the existing legislation. Unless a very clear ban on indirect tobacco advertising was adopted, it was feared that in time, the advertising ban would be undermined.

Therefore, the Council proposed amendments of the Act that would make the law even clearer on this point. Not surprisingly, the tobacco industry expressed no need for further amendments. The Government, however, introduced a bill including a new section 2 of the Act, which against a small minority was passed by the Parliament. The amendments went into force on 1 January 1996. Among other things, the word *"all"* was added in the first sentence of this section of the Act, in order to make it clear that the ban on tobacco advertising was a total one. An additional provision pertaining to indirect advertising was also included. The Act now explicitly forbids this kind of indirect advertising.

The wording of the Act's Section 2, cf. "The proceedings in Parliement", is now as follows:

> All forms of advertising of tobacco products are prohibited. The same applies to pipes, cigarette paper and cigarette rollers.
>
> Tobacco products must not be included in the advertising of other goods or services.

A brand name or trademark that is mainly familiar as a brand or mark for tobacco products may not be used in the advertising of other goods or services so long as the name or mark in question is used in connection with a tobacco product.

Tobacco products may not be launched with the aid of brand names or trade marks which are familiar as, or used as, brands or marks for other goods or services.

All forms of free distribution of tobacco products are prohibited.

The King may issue regulations concerning exceptions to the provisions in this section.

In order to strengthen the monitoring of the Act, the Council employed a full time legal adviser on its staff in the mid 1990s to review, among other things, the cases concerning the advertising ban.[5] Most of the cases concern minor infringements of the law, but the authorities still review various campaigns initiated by the tobacco industry. It is estimated that the total number of cases is approximately 20 per annum. Since 1990 only two cases have been prosecuted by the police; they were, however, dismissed on the grounds of insufficient evidence, and no cases have so far been brought to court.

[5] Since 2002 the Council's staff has formed a special department for tobacco under the Norwegian Directorate for Health and Social Services.

In addition, the Government has found it instrumental to introduce another enforcement of the Act, stating that those who break the law will be liable to pay enforcement damages to the authorities. In 2002, a Bill on this amendment was introduced to the Parliament, which is expected to be debated in 2003.

## The Parliamentarians' motives in 1973

Why did the Norwegian parliamentarians jump in with these restrictive measures? What were their motives and arguments?

> *It is noteworthy that the politicians reached their decision without any advance proof of an effect of an advertising ban.* And yet the MPs still voted for it.

Most probably they accepted the reasoning for an ad ban that had been given by the Committee for Research in Smoking Habits (cf. "The Committee's motives for an advertising ban"). In addition, they noted that the Act was supported by the health authorities and health institutions, and by the nongovernmental health organizations.

In the debate in Parliament, the Minister of Health and Social Affairs, Mrs. Bergfrid Fjose, stressed that a conflict exists between the health authorities and those who produce and sell tobacco. If less tobacco is used, the result will be less tobacco produced and sold. In this matter the authorities responsible for health have to announce clearly on what side it stands. The opposition's leading spokeswoman, Mrs. Sonja Ludvigsen, emphasized that voluntary arrangements would not provide for effective limitation of the advertising efforts. She had hoped that that the tobacco industry, for humanitarian reasons, at least, would refrain loyally from contributing actively to increased consumption. But, on the contrary, the industry had met every information effort and every report with increased and expanded advertising, aimed particularly at young people, most of all at young girls, whom the industry saw as an unexploited market.[6]

The author of this report followed the procedure in the Parliament closely, and was left with the impression that the parliamentarians' decision was taken on one or more of the following grounds *(11)*.

— a common sense judgement that the extensive, increasing, suggestive and technically advanced advertisements undoubtedly *did* have a substantial effect on young people in particular, recruiting them as new smokers;

— a recognition that to support massive campaigns *against* a dangerous product, and at the same time allow massive sales promotion campaigns *for* the same product could be looked upon as a double standard, an accusation that would be made by young people in particular;

— a desire to give a clear signal of the problem's severity, and thereby strengthen the effect of campaign work. On the other hand, if they did not put an end to tobacco advertising, this could be interpreted as a signal that there is still some doubt about the danger, and this would weaken the effect of information campaign;

— the realization that the tobacco industry's voluntary rules had not led to arresting the alarming increase in tobacco consumption, and that voluntary agreements would be regarded as compromises and half-measures without the clear signal effect that would be achieved by legislative ban;

— and maybe *in addition* to the arguments above: a pragmatic view that important values would not be lost by a ban and could by no means outweigh the value of positive health effects.

In other words: the ban was considered *a matter of ethics*. When dealing with an epidemic of such enormous dimensions, *it would have been unethical to permit sales promotion for these deadly products to continue* regardless of whether the ban would prove to have a substantial effect.

## The counter-attacks

Resistance to the advertising ban came from organizations in the tobacco trade and in the advertising sector, and from parts of the press. In particular, the tobacco industry appeared strongly in the arena and gave comprehensive statements to the reports from the Committee for Research in Smoking Habits and the Legal Drafting Committee, where they argued vigorously against the ban.

In this work, the Norwegian tobacco industry established close contact with the international tobacco industry. This has been revealed in the so-called "Tobacco Documents"

[6] Chapter "Tobacco advertising in Norway" (author's remark).

that includes letters from the Norwegian tobacco industry (J.L. Tiedemanns Tobaksfabrik) to The Tobacco Institute in Washington D.C. *(12):*

**Letter of 15 January 1973:**

> We have tried to make a last-minute effort to moderate or postpone the law, but under the present political circumstances this is very difficult. With a Prime Minister and the Minister for Social affairs from the Christian Democratic Party the anti-tobacco forces would unfortunately have a very strong backing in the Government.

**Letter of 28 February 1973:**

> For your information, a Tobacco Advertising Ban has again been discussed by the Nordic Council. A working group will be set up with the purpose of establishing similar laws in the Nordic countries. An attempt from our side to postpone a law in Norway until the Nordic alternative had been discussed got unfortunately no response among the politicians.

**Letter of 29 August 1973 concerning the regulations to the Act:**

> As expected, the present Government has followed a very restrictive line in their present draft.
>
> The Tobacco Manufacturers Association of 1901 has set down a working committee to prepare the comments which are asked for in the enclosed letter dated August 16th from the Ministry. As you will see, any remarks should be sent to the Ministry by October 15th 1973. The writer is a member of this working committee and any comments you might have will be highly appreciated.
>
> Needless to say, the Norwegian tobacco manufacturers will do their utmost to moderate the regulations, but under the present Government this will be a very difficult task. It is doubtful whether the Government will survive the Parliament elections in September, but even with a new labour Government we can hardly expect any major amendments in the regulations".

What were the opponents' arguments? The preamble to the Bill summarizes the counter-arguments, and the main points are repeated below, together with some comments on subsequent developments to the specific argument (this overview has been published previously together with graphs or tables which substantiate the conclusions) *(1, 11, 13).*

The opponents claimed that an ad ban would:

1. **weaken the competitive situation of the Norwegian advertising industry**

   Subsequent experience:

   There has been a continuous increase in the annual turnover of the advertising agencies, and in the two eight-year periods before and after introduction of the ban, the average increase was 3.6% before, and 4.3% after; it means a *higher* increase after the ban.

2. **weaken the competitive situation of Norwegian manufacturers versus foreign producers.**

   Subsequent experience:

   The cigarettes most commonly smoked in Norway are *hand rolled*. Before the ban, Norwegian brands accounted for about 95% of smoking tobacco used for hand rolled cigarettes. This fraction has been fairly constant over the years since the ban. The market share of Norwegian brands of *manufactured cigarettes* has declined *at the same rate* throughout the whole period; it dropped by about two-thirds from 1965 to 75, and by about two-thirds from 1975 to 1985, the ten-year periods *before* and *after* enforcement of the ban.

3. **cause reduced employment in Norwegian industry.**

   Subsequent experience:

   The number of employees *in the tobacco industry* dropped continuously before and after introduction of the ban. The mean annual change was about the same in the two ten-year periods before and after enforcement, with a 2.7% reduction *before* and 2.6% reduction *after*. There is no evidence that the ban has had any influence upon the general employment situation in Norway.

4. **worsen the economic situation of the press.**

   Subsequent experience:

   From 1967 to 1975, eight years *before* the ban, sales of advertisements, of all kinds, to Norwegian newspapers increased annually by a mean of 3.9%, as against a 5.6%, annual increase in the eight-year period *after* enforcement; that is to say a *higher* increase *after the ban*.

**5. preclude the steering of consumption over to less hazardous products.**

Subsequent experience:

Denmark and Norway differ as regards restrictions on advertising; Denmark has never had a ban. In the years following the ban, the average tar content per cigarette sold has decreased as rapidly in Norway as in Denmark, and proportions of cigarettes with tar yields up to 15 milligram increased at least as fast in Norway as in Denmark. Another example: In 1984, one company introduced a new cigarette, claiming that tar delivery was as low as one milligram. This was reported in the press, but there were no advertisements. Nevertheless, within one year the market share of this particular brand increased from 0 to 6%. So, the ad ban has *not* obstructed a shift to low tar cigarettes.

**6. be contradictory to the Constitution's provision concerning freedom of expression.**

Subsequent experience:

A legal expert, Professor Torkel Opsahl, Dr Juris, who was *employed by the tobacco industry* to evaluate this question, concluded in his report:

In the main I must agree with the Legal Drafting Committee that the protection of the freedom of expression will not be legally affected by the provisions which it proposes.

This conclusion must have come as a disappointment to the tobacco industry, and is not referred to at all in its comments. The Ministry of Justice received Professor Opsahl's report and the industry's statement, and said that the Ministry

... agrees with the conclusion reached by Professor Opsahl, namely that the proposal cannot be assumed to violate the Constitution's protection of the freedom of expression.

After enforcement of the ban, the legal opinion of Professor Opsahl and the Ministry of Justice has been generally accepted in Norway.

**7. be extremely difficult to implement and would lead to extensive problems for the prosecuting authorities in their enforcement of the Act.**

It suffices to refer to the section: "Procedure in cases of infringements of the Act" above, which shows that implementation of the Act, in general, went smoothly. New problems have been dealt with appropriately in order to fulfil the aims of the Act.

**8. little effect upon total consumption of tobacco.**

This question is discussed in the next chapter of this report. In this context, however, it is remarkable to see that parts of the industry, at the least, have a more nuanced view now upon this problem, which has been disclosed in the Minnesota documents *(12)*. On 27 February 1986 a letter was sent from Philip Morris to the chairman of the Norwegian tobacco manufacturers' association (NMA). The letter comments upon a draft prepared by the NMA to the Norwegian health authorities:

In the final sentence of the NMA's conclusion, we suggest that it is misleading to state that the government's ban on advertising in Norway and other measures introduced by the National Council on Smoking and Health have had <u>no</u> particular influence on smoking habits.

Philip Morris maintains that any objective analysis of research on cigarette consumption is highly complex, that a number of factors impact consumption and that it is very difficult to make generalized statements on the data.

This view may perhaps be based upon a report which at the end of the 1980s was prepared by a Norwegian researcher at the University of Oslo, Professor Jon Hovi. Philip Morris had hired him to carry out an econometric study of the effect of the Norwegian advertising ban. Obviously, Hovi's results differed from what Philip Morris expected. The report was retained from publicity, and the researcher was bound to secrecy. Nevertheless, Philip Morris sent a statistician from abroad to see Professor Hovi, and this statistician put forward some suggestions concerning methods and control variables. Hovi's results, however, remained the same *(14, 15)*.

## Effect upon consumption and smoking rates

This question has been discussed in details in a special report *(1)*, that is also available on Internet[7]. Some of the essential points will be summarized below. Problems in measuring the effect of an advertising ban have been taken up elsewhere*(14, 16)*.

[7] See: *www.kreft.no*.

## Per capita consumption of tobacco

The figure below shows *registered sales of manufactured cigarettes plus smoking tobacco per adult aged 15 and above*. Sales per capita rose considerably during the 1950s and 1960s, and reached a peak in the mid-1970s. Since then they have dropped, and are now below the 1950 figures. The actual peak year was 1975, the year when the Act was enforced.

When interpreting the Norwegian sales figures, one must take into account the widespread habit in Norway of "roll-your-owns", which come out much cheaper than manufactured cigarettes. In 1975, when the advertising ban was introduced, about two-thirds of all cigarettes smoked in Norway were hand rolled. Since then, however, the fraction of hand-rolled cigarettes has decreased substantially, probably due to the population's greater prosperity.

In order to gain a true picture of the Norwegian scene, one has to *calculate Norwegian sales figures in grams*, assuming the weight of one manufactured cigarette to be 1 gram (which results, however, in an overestimate of the total consumption for recent years, since the weight of one manufactured cigarette has decreased from about 1 gram in 1975 to about 0.75 gram from the mid-1980s onwards) *(1)*. This gives the following picture of sales trends, calculated as *registered sales of grams of tobacco per adult 15+:*

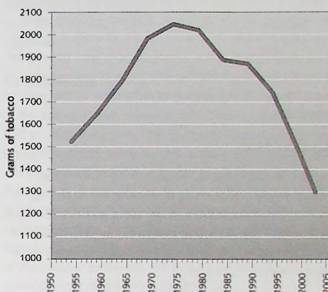
| | 1974/1975 | 2001/2002 |
|---|---|---|
| Manufactured cigarettes | 561 | 716 |
| Smoking tobacco | 1 539 | 550 |
| Total | 2 100 | 1 266 |

This positive development may be expected to accelerate in the future, when a lower consumption in the younger generations (see figure 4) will have an increasing impact on total consumption.

Today, lung cancer mortality in Norway is only half that already experienced in countries with a history of longer and heavier smoking like the United Kingdom and Canada *(2, 13)*. Given the new trend of consumption in Norway since 1975, the country will never reach these countries' high level of mortality. An essential health benefit has been achieved already. As a matter of fact, lung cancer mortality in males culminated between 1985-1990 *(17)*.

### Figure 3

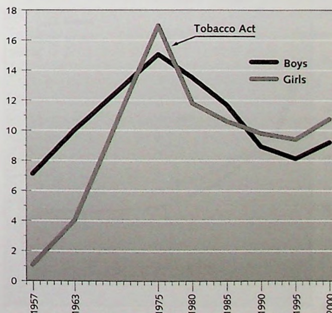
**Registered annual sales of cigarettes + smoking tobacco per adult 15+, Norway. Five year means 1950/'51-1999/2000 + mean 2000/'01-'01/'02**




Source: Directorate of Customs and Excise, Norway

### Figure 4

**Per cent daily smokers age 13-15, by sex, Norway. Nationwide surveys 1957, 1963 and every fifth year 1975-2000**




Source: Norwegian Cancer Society/ National Council on Tobacco and Health

## Smoking rates in young people

There are reasons to believe that young people are more susceptible to advertising than are adults, hence, an ad ban is presumed to affect smoking incidence rates in the younger age groups more than it affects smoking cessation rates in adults *(1)*. Therefore, it is of interest to compare smoking prevalence among persons who grew up in a climate free of advertising with those of persons who went through their adolescence before the ad ban was introduced.

### Schoolchildren

As early as 1957, the Norwegian Cancer Society conducted a nation-wide study of smoking habits among Norwegian school children in the upper grades of compulsory school. The study was carried out in a representative sample of Norwegian schools. The Cancer Society repeated the study in 1963 *(1)*.

From 1975 onwards, the National Council on Tobacco and Health has carried out surveys every fifth year among *all* schoolchildren in the upper grades of the compulsory school throughout the country, with attendance rates of more than 90%. From this universe (results for more than 150000 students), a representative sample has been drawn and sent to the Council for statistical analysis *(1)*.

The results from these surveys are presented in the figure above. Two features are striking. First, up to the mid-1970s, smoking rates rose considerably in both sexes, particularly among girls, whose smoking rates increased from 1% in 1957 to 17% in 1975. During these years, the tobacco industry ran extensive advertising campaigns aimed especially at a female market, cf. "Tobacco advertising in Norway". It may be objected that it is not known what happened between 1963 and 1975, and therefore, that the peak year does not necessarily coincide with the enforcement of the advertising ban. However, another series of surveys, carried out annually in the age group 15 to 21 in the cities of Oslo and Bergen, show that the peak was reached in the mid-1970s *(18, 19)*. The highest percentage of daily smokers was found in Oslo in 1974 and in Bergen in 1975.

The second feature from this figure is that in 1975, the Tobacco Act was enforced. By 1980, smoking rates among young people were declining for both sexes, and continued to do so for 20 years. A small increase in the year 2000 gives reason for concern (cf. "Could the results have been better?").

### Young adults

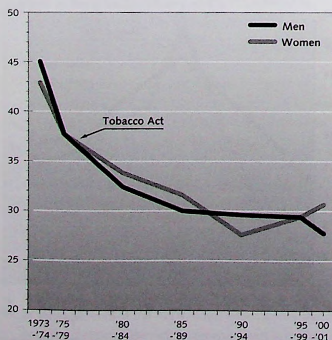
This age group may also have been increasingly influenced by the ad ban.

Since 1973, Statistics Norway has carried out annual surveys of smoking habits in representative samples of the adult Norwegian population aged 16 to 74.

The figure above shows the percentage of daily smokers by age and sex in young adults aged 16 to 24. As a whole, in the years following the enforcement of the advertising ban, there were clear downward trends in both sexes. Since the late 1980s, however, these trends have levelled off.

**Figure 5**

**Per cent daily smokers age 16-24, by sex, Norway Mean 1973-74 + five year means 1975-1999 + mean 2000-01**




Source: Statistics Norway/ National Council on Tobacco and Health

## Smoking rates in the total population

In the series of surveys carried out by Statistics Norway, the figures for the *total adult population aged 16 to 74* show, as a whole, a downward trend for men and a fairly stable trend for women. In 2001 the percentages of daily smokers were 30.3 for men and 29.3 for women; for the first time the female rate came under 30%. Mean cigarette consumption in daily smokers was 14.0 per day for men and 11.2 cigarettes per day for women.

However, crude rates for a total population may disguise important developments in different age groups. Broken down by age and sex, smoking rates in males aged 45 to 64 have dropped about 35% since 1973. For females, only small changes are seen, except in the youngest age group, 16 to 24 years. In women aged 55 and over the trend is upward.

When interpreting the data for middle-aged and elderly women, it is necessary to take into account a marked cohort effect, as described elsewhere *(1, 20, 21)*. In previous years, smoking was uncommon in these age groups. After World War II, there was a dramatic increase in smoking among younger women, who maintained their smoking as they grew older. In the individual female birth cohorts, however, there is a distinct drop in smoking prevalence.

#### The decrease in smoking – other explanations?

As shown, tobacco consumption and young people's smoking rates have decreased considerably since the mid-1970s. One may ask what the cause is of this marked break in trends. Something *new* must have happened in the 1970s that had not been experienced before. No data substantiate that this change was due to huge price increases or to restrictions on smoking in public places and at work. The only reasonable explanation is that the ad ban has played an important role in this new trend *(1)*.

A study employing econometric techniques has suggested that the Norwegian Act enforced in 1975 brought about a long-term reduction in tobacco consumption of 9% to 16% *(22)*. It is not possible to quantify exactly how much of this reduction can be attributed to the advertising ban itself, but, in the view of the minor nature of the other provisions of the Act, the ad ban is likely to have accounted for the major part.

### Could the results have been better?

The ad ban was intended to be one element of a comprehensive package, which should include the full range of anti-tobacco measures (cf. "The Committee's report").

Regrettably, from the mid-1980s this did not turn out as well as hoped for; and thus, the advantage of the ad ban was not fully exploited. Price mechanisms were used to only a minor degree, and the resources for information and education were relatively small. This may explain why the trends regarding young people's smoking rates have been less favourable in recent years than previously.

From the late 1990s, however, there developed a marked increase in government funding for tobacco control purposes, and new initiatives have been taken in terms of health warnings on packages, on smoke-free indoor environments and on cessation. In light of these latest signals from the authorities, some of the lost ground may be recovered.

## Conclusions

In the author's view, sooner or later Norway would have had an advertising ban. That it was achieved so soon, was brought about by many sectors, among them people from various professions who, with great skill and drive, took the cause from one step to the next. NGOs lobbied actively for the ban. Not the least the 1969 political party conventions played a crucial role. Determined politicians were willing to put the interests of public health before those of the tobacco enterprise, although they did not have any advance proof of the effect of an ad ban.

As a whole, the implementation of the ban has been successful, in spite of heavy resistance from the tobacco industry. The Government has responded by new steps to counteract the industry's attempts to circumvent the ban.

The industry's arguments were the same as we run into today in many other countries. Today Norway has 27 years experience with the Act, and all the pessimistic and tragic events the opponents of the Act predicted have not occurred. All difficulties were highly exaggerated. No one has suffered, no values have been lost, and there has been no serious recommendation to return to tobacco advertisements.

A cautious conclusion would also be that the advertising ban, with the concomitant publicity throughout the legislative process, *has* had an impact on consumption and young people's smoking, and in combination with the continued educational efforts was a causal factor in the new trend.

This view is also shared in letters from political authorities *(1)*. In June 1997 the former Health Minister, Professor Gudmund Hernes, PhD, made the following statement:

> ...there is no doubt that the Norwegian advertising ban has had a clear and substantial influence on total consumption in general, and smoking rates among school children in particular. In my view the reduction brought about by the advertising ban will have a positive and marked impact on the future

incidence of smoking-related diseases, and consequent mortality.

In May 1998 the present Health Minister Mr. Dagfinn Høybråten stated:

> I share the view that the ban on advertising of tobacco products has had a marked and beneficial influence upon tobacco consumption and young people's smoking rates in Norway. In my opinion, however, the effect of legislation could have been even better if the ban had been accompanied by a much more active and offensive use of other smoking control measures, in particular, health information and education. Shortly after I took office, I presented a proposal to increase substantially the grant for such activities. My intention is to maintain a considerably higher involvement in a comprehensive smoking control programme, including legislative measures.

In 1993 the 3rd International Conference on Preventive Cardiology was held in Oslo. In an address to Conference, the Norwegian Prime Minister Dr Gro Harlem Brundtland brought the advertising ban to a global perspective *(23)*:

> Most outrageous is the fact that the tobacco industry, to serve its own interests in developing countries, is taking on the role of a benefactor which encourages the growth of tobacco crops, but at the same time advertises a Western lifestyle with cigarettes as the major symbol...
>
> We can and should put an end to all sales promotion of tobacco. It should not be too much to ask governments to abolish such marketing activities altogether.

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Success stories and lessons learned

**Outils pour poursuivre la lutte antitabac au XXIe siècle:**

Expériences concluantes et nouveaux enseignements

# Labelling and Packaging (including Health Warnings)

WHO/NMH/TFI/FTC/03.5

PH-153

## Canada's Tobacco Package Label or Warning System: "Telling the Truth" about Tobacco Product Risks

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# Canada's Tobacco Package Label or Warning System: "Telling the Truth" about Tobacco Product Risks

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## The Need for an Effective Package-Based Label System

The World Health Organization's draft Framework Convention on Tobacco Control (FCTC) will be presented to the World Health Assembly in May 2003. Its call for dramatically improved tobacco warnings worldwide reflects growing interest in tobacco package labelling or warning systems *(1)*. This interest is augmented by greatly improved warnings now appearing on the shelves of retail outlets throughout the European Union, and by the announcements of other countries, such as Malaysia, of the planned introduction of reforms modelled on the Canadian or Brazilian warnings.

This heightened interest created by the FCTC process, and the encouragement it provides to parties to the Convention to implement more effective warnings, raises significant questions. Why are bigger and bolder warnings better? What messages are most effective? What tactics might be expected from an industry determined to undermine any measure that might cut its sales?

Canada has been one of the pioneering countries in developing and implementing innovative labelling requirements for tobacco products. This Country Report on warnings has been prepared in the hope that it will make a timely contribution to the development of similar reforms in other countries. Though some aspects of Canadian warnings are now well known, particularly the use of images, the debate and analysis that led Canada to move ahead in this area are less well understood. The gradual move towards large, explicit and graphic health messages came about because of a deepening understanding of the misinformation and deception that underlie the tobacco epidemic.

### The right to be warned

The tobacco epidemic has rightly been described as a global catastrophe of unparalleled proportions: unless extraordinary public health interventions occur, tobacco products will kill 500 million people *among those alive at present. (2)* In other words, a single product category will kill about ten times the number of civilian and military casualties from the Second World War, even if future generations reject tobacco industry products.[1]

In the Canadian context, about 45 000 smokers die annually from the tobacco epidemic.*(3)* In fact, Health Canada, which is the federal health department, estimates that the products of tobacco manufacturers will cause the premature death of 3 million Canadians from among this country's 32 million population.*(4)* Such predictions of enhanced mortality of this magnitude necessitate extraordinary public health interventions.

In the case of major epidemics caused by viruses or bacteria, governments have a duty to provide clear, full information to their citizens on the seriousness of the diseases and how to avoid them; this general duty applies equally to tobacco. However, tobacco is unique among major epidemics in possessing its own public relations department, the tobacco industry, which has a vested interest in ensuring that consumers know as little as possible about the disastrous health effects of addiction to tobacco products.

Though the details of consumer protection law vary widely from country to country, there is widespread agreement on general principles, as exemplified by the *United Nations' Guidelines for Consumer Protection* These guidelines recognize the right of consumers (a) to be protected from health and safety hazards in the marketplace and (b) to be given "adequate information to enable them to make informed choices" – including choices about risk.*(5)*

Historically, the marketing of tobacco products has grossly violated both of these principles. Consumers have been exposed to extremely large risks: mortality rates of 50 per cent for long-term users of tobacco.*(6)* They have not been provided with accurate information.

In Canada, tobacco manufacturers have had a longstanding duty at common law to warn their customers of the risks associated with their products. This duty requires tobacco companies to warn of both the nature of the risks (e.g. over 20 debilitating or terminal diseases alone *(7)*) and the magnitude of the danger (e.g. about 85 per cent of the time, lung cancer causes death, usually within two years *(8)*). The Ontario Court of Appeal, described the duty of all manufacturers to warn as follows:

Once a duty to warn is recognized, it is manifest that the warning must be adequate. It should be communicated clearly and understandably in a manner calculated to inform the user of the nature of the risk and the extent of the danger; it should be in terms commensurate with the

[1] World War II. Encyclopaedia Britannica 2003. Encyclopaedia Britannica Premium Service, Accessed 23 April 2003. *http://www.britannica.com/eb/article?eu=118868*

gravity of the potential hazard, and it should not be neutralized or negated by collateral efforts on the part of the manufacturer. *(9)*

Warnings of the nature and magnitude of risks are two clear responsibilities in Canada's consumer law. A third important principle of consumer protection is that the duty to warn may take different forms depending on the buyers (or prospective buyers). For example, in the case of a product designed for use by blind people, a manufacturer would have difficulty escaping liability for product hazards by pointing to a written warning included on the product.

More generally, consumer protection law makes special efforts to protect various types of *vulnerable groups*. Children are particularly vulnerable to deception or exaggerated advertising claims and usually cannot legally enter into major contracts, because they are deemed unable to judge reliably what is in their best interests. As well, people who are afflicted with terminal diseases are particularly vulnerable to advertising for "miracle cures".

Tobacco marketing is largely directed towards two such vulnerable groups: children/teenagers (who must be enticed to take up smoking if the industry is to replace customers who die or quit), and addicted adults. In the case of teenagers, the vulnerability is obvious: with good reason, society does not expect them to be able to make an informed choice between the promise of immediate if symbolic rewards (i.e. social acceptance and identity) and the prospect of dire consequences in a few decades' time (i.e. death in middle age). Nor is it realistic to expect dry, scientific information to compete with the emotional impact of well-crafted imagery.

In the case of addicted smokers, the vulnerability to misinformation comes from the phenomenon of cognitive dissonance: it is very difficult to go on believing one thing while doing the opposite. Specifically, for a smoker who is physiologically unable to refrain from smoking his or her next cigarette, there is a strong tendency to discount information about health risks – and to fall for pseudo-arguments typically provided by the tobacco industry. ("It hasn't been proven that smoking causes cancer" and "Tobacco is addictive in the sense that drinking soda pop is addictive", etc.).

The need to cut through cognitive dissonance, and to communicate effectively with children and teenagers, helps explain why Canadian tobacco-control policy has moved from occasional education campaigns, via print-only information on packages, to the present system of large, graphic-based warnings. Further, to help reduce cognitive dissonance, the new health information system includes help for smokers wanting to quit: clearly, it is easier to absorb health information if there is some hope that you can do something about your addiction.

The debate over warnings goes back almost three decades in Canada. The fact that the industry negotiated a weak, on the face of it absurd voluntary warning which was in effect from 1975 to 1988 ("The Department of National Health and Welfare advises that danger to health increases with amount smoked. Avoid inhaling") does not negate the industry's tort or civil law obligations during this period. Clearly, a voluntary agreement does not cancel the longstanding obligations that the industry has to its customers in civil law. Nor does Canada's new warning system give the industry complete sanctuary if current Canadian warnings are found to be inadequate. Section 16 of Canada's *Tobacco Act* [2] under which current warnings are mandated says:

> This part does not affect any obligation of a manufacturer or retailer at [civil] law or under an Act of Parliament or of a provincial legislature to warn consumers of the health hazards and health effects arising from the use of tobacco products or from their emissions.

This section of Canada's tobacco statute preserves the civil law duty to warn, which could be more onerous than the duty spelled out in the new warning regulations. This section was in part a reaction to the tobacco industry's often successful use of federal labelling legislation in the United States of America as an argument to escape liability in that country's courts ("The Congressional Shield"). The United States courts have ruled that American warnings legislated by Congress protect the manufacturers from the responsibility of providing more meaningful warnings than those presently in use. It has been successfully argued that if Congress had wanted stronger warnings, Congress would have mandated stronger warnings.

Thus, regardless of the perceived strength of the Canadian warnings now, tobacco manufacturers long had a civil law duty to warn – which they ignored. Judge André Denis decided in 2002 to throw out the tobacco

[2] Available on-line at *http://laws.justice.gc.ca/en/T-11.5/index.html* .

industry's constitutional challenge to the *Tobacco Act* and Canada's landmark tobacco package warning system. Using remarkably strong language rebuking the manufacturers, he observed:

> The duty [to warn effectively] must be imposed because the tobacco companies have continuously failed to fulfil their obligations in this respect [in civil law], despite their knowledge of tobacco dangers...The industry knew this [tobacco's harms], but said nothing."*(10)*

So it was, in the face of this decades-long failure to warn adequately, that the government forced the industry to implement Canada's first generation of world precedent-setting tobacco warnings in 1994.

## Increasing Information about Tobacco Risks and the Elimination of Deception

Tobacco products are extraordinary in a number of respects. One of them is the unique nature of the product in terms of risk. Tobacco is addictive to children and has no safe level of use. Tobacco products kill on an extraordinary scale, causing the death of nearly one out of two of their long-term users.*(11)* Despite this, governments have allowed such products to be marketed in some of the most sophisticated and alluring packaging or trade dress ever developed. The message to users and to potential child and adolescent starters sent via the design and graphics of the package has been that the product inside is normal, legitimate and safe.

An effective package-based label and warning system can do much to counter the implicit reassurance provided by alluring packaging. In fact, because of the perfect targeting for these labels, the immense size of the target audience (in Canada, 5 million smokers, and their families) and the low cost of the measure, such a warning system has the potential to become the most cost-effective public health education campaign the country has ever seen.

There are at least two purposes of warning labels. First, as stated above, any warning system must inform potential and actual users of both the nature of tobacco risks and the magnitude of those harms, including the prognosis should a given tobacco-related disease strike.

The second purpose is less well understood than the first. Any effective warning system or package reform generally should also remove any deception that is part of the package, including the deception related to the marketing of the family of low tar cigarettes, the 'light' and 'mild' consumer fraud. *(12, 13)* However, to the extent that any remaining colour and design on Canadian tobacco packaging suggests that the product is safer than it is or undermines the warnings of risk, that deception should also be removed. This objective will probably move health policy inexorably towards plain packaging (see text below).

### Ancillary benefit to an effective warning system

Although some governments have taken steps to reduce tobacco advertising and promotion, most have ignored the lynch-pin of tobacco marketing, the package itself. All tobacco advertising, sponsorship and point-of-purchase promotion relates ultimately to the colour and graphics or trade dress of the package, like spokes are connected to the hub of a wheel. However important the packaging has been to the industry to date, as advertising bans increasingly take effect, the manufacturers will focus even greater attention on the package itself.*(14)*

In Canada, there are 2 thousand million packs sold annually, each one a miniature ad display. Each time a package is pulled from a pocket or purse, about 20 times a day for the average smoker, it creates an advertising impression. Tobacco packages place about 40 billion ad impressions into the Canadian market every year, a total that undoubtedly dwarfs the value of other tobacco promotions and advertisements. It is a legitimate health goal for governments to use large warnings to draw attention to the messages and to increase knowledge of risks. If the size of such messages coincidentally reduces the industry's ability to use the remainder of the package for the deception that is implicit in the alluring packaging, public health will benefit again. Even if governments, for any reason, feel they cannot use large warnings solely to diminish the promotional power of tobacco trademarks or package trade dress, they should be aware that, at a minimum, the reduction of this power is an ancillary health benefit.

The value of reducing the trademark's promotional power was acknowledged by the Quebec Court in its decision. Judge Denis wrote:

> Warnings are effective and undermine tobacco companies' efforts to use cigarette packages as badges associated with a lifestyle [i.e. an adolescent badge suggesting entry into adulthood].*(15)*

## Levels of Awareness of Tobacco Risks

Despite recent claims by tobacco manufacturers that their industry is now climbing to new heights of social responsibility, much offensive behaviour continues as before. For example, in the Rothmans *2002 Annual Report* [3], Rothmans Benson and Hedges says:

> RBH acknowledges the health risks which have been *associated with* smoking. The *choice* to smoke is made with *full awareness of these risks* which have been widely known for decades. (emphasis added)

By claiming that its products are only "associated with" disease, the manufacturer maintains the fiction that it has not been proven that the tobacco/disease relationship is a causal one. In fact, research reveals precisely the opposite of what this passage asserts.

The literature shows that many smokers, including child and adolescent starters, are generally aware that tobacco industry products are "bad for you". But scratch below this superficial level of awareness and you will find a knowledge level that is clearly inadequate for such a lethal product.*(16)*

The World Bank addresses the level-of-awareness issue:

> An overview of the research literature recently concluded that smokers in high-income countries are generally aware of their increased risks of disease, but that they judge the size of these risks to be smaller and less well-established than do non-smokers. Moreover, even where individuals have a reasonably accurate perception of the health risks faced by smokers *as a group*, they minimize the personal relevance of this information, believing other smokers' risks to be greater than their own. Finally, there is evidence from various countries that some smokers may have a distorted perception of the health risks of smoking compared with other health risks." (emphasis in original)*(17)*

It was in the absence of acceptable levels of awareness among starters and users that Canada implemented serious tobacco warnings reform in 1994.

## The Context for Warnings

In the early 1980s, Canada had the highest rate of per capita tobacco consumption in the world.*(18)* However, in the decade following 1983, the country experienced rapid decline in per capita consumption, including a 34 per cent drop in the seven years to 1990.[4] The fall in teen smoking rates was particularly dramatic, with prevalence rates virtually halved between 1981 and 1992.*(19)*

A number of factors contributed to this reduction, including the national debates over and enactment of two landmark tobacco control bills, the *Tobacco Products Control Act (TPCA)* and the *Non-smokers' Health Act (NsHA)* in 1988, and the passage of municipal by-laws to regulate smoking in public areas and workplaces. The *TPCA* banned tobacco advertising and sponsorship. (Unfortunately, a loophole in the law gave the manufacturers an opportunity to continue sponsorships to date. The loophole is set to expire in October 2003.) The *NsHA* effectively banned smoking in federally-regulated workplaces (about 9 per cent of all workplaces), including federal buildings, banks, air and rail transportation and Crown corporations.

These valuable legal reforms were preceded by aggressive tobacco control advocacy. Undoubtedly, both the public debate and the law reform that followed reduced consumption. However, the single most important factor in the declines in consumption was likely the equally steep increase in tobacco taxation at the national, provincial and territorial levels from 1983 to 1991. *(20)*

Unfortunately, much of the momentum and some of the health gains during this 10-year period were lost in 1994 when the federal government and several of the provinces made substantial cuts in tobacco taxes to combat smuggling promoted by the tobacco industry.[5] *(21, 22)*

The "half-price cigarettes" that resulted in much of Canada were the first of two major setbacks that slowed the remarkable momentum in tobacco control which had been building. The second was the loss in 1995 of the *TPCA* when the Supreme Court of Canada ruled, 5

[3] Available on-line at *http://www.rothmansinc.ca/English/2002/Annual_Report/RINC.02.Colour.Eng.pdf.*

[4] NSRA calculation from Statistics Canada data on domestic sales of cigarettes and roll-your-own tobacco, and on population 18 years and over.

[5] Joy de Beyer, World Bank, presentation to the International Conference on Illicit Trade, New York, July/August 2002.

votes to 4, that this legislation was unconstitutional. The *Tobacco Act* which replaced the *TPCA* in 1997 is the cornerstone of the federal government's legislative response to the tobacco epidemic. This statute bans most advertising and gives the government extensive power to regulate the tobacco industry, including the labelling of tobacco products.

In late 2000, as the latest generation of Canada's landmark labels or warnings started to appear in the market, 24 per cent of Canadians aged 15 years or more reported smoking, and 20 per cent were daily smokers. Smoking prevalence was higher among men than women: 26 per cent as compared to 23 per cent. Smoking among teenagers aged 15–19 was 25 per cent.*(23)*

A series of tobacco tax increases in 2001 and 2002 has made it difficult to tease out the specific impact of warnings on consumption. Per capita tobacco consumption in 2002 was down a whopping 8.1 per cent on 2001. It would defy common sense to conclude that the new warnings had no role in such a remarkable decline.[6]

## Canadian Warnings: 1994 Generation

With the passage of the *TPCA* in June 1988, Health Canada planned strong tobacco warnings including a world precedent-setting warning of tobacco addiction. But in a secret meeting with senior bureaucrats, tobacco lobbyists negotiated away the addiction warning and other reforms that would have revolutionized tobacco warnings.*(24)* The result was a warning system which incoming health minister Perrin Beatty said was so artfully hidden in the package colours that the tobacco industry could have taught the Canadian military lessons in "camouflage." *(25)*

In an appropriate response, Mr Beatty announced the first generation of Canada's landmark warnings in 1990. Almost immediately, this reform stalled. The delay was caused by a risk-averse approach to implementation related to the tobacco industry's constitutional challenge of the *TPCA*. The Non-Smokers' Rights Association (NSRA), Canadian Cancer Society (CCS) and the Heart and Stroke Foundation of Canada then led a three-year campaign for enactment including a letter mailed to one million households in the constituencies of federal cabinet ministers.

The black and white, text-based warning system finally appeared on cigarette packages in 1994. The new warnings undoubtedly blunted, to some degree, the extremely negative effects of the almost half-price cigarettes available in much of Canada following the tobacco tax reductions. Unfortunately, the appearance of the new warnings made it more difficult to measure the negative impact of the tax cuts independently of the positive gains from the improved warnings.

By world standards, the labels produced in 1994 were indeed impressive, setting global precedents for tobacco warning systems.*(26)* The warnings, excluding borders, were the largest in the world (25 per cent of principal display areas) and the first to appear on both major faces of the package: English text on one face and French on the reverse. The warnings *plus* borders occupied as much as 40 per cent of each major face of the package one entire side panel. Of considerable importance, these warnings were placed at the top of the major faces, the premier location on the package.

The tobacco industry was also forced by these warnings into a black-and-white format, which prevented the manufacturers from camouflaging the warnings in the package colours. Half of the time, the warnings were printed with black lettering on a white background with a 3 mm black border. For the other half, the law required the opposite: white lettering on a black background with a white border, the graphic format that the industry found the most distasteful.

There were other breakthroughs in the 1994 warning system. For the first time, a causal relationship between the product and disease was recognized in a tobacco warning ("Cigarettes cause cancer"). These warnings were the first to transfer the responsibility for the epidemic from individual behaviour (smoking) to the industry's products ("Cigarettes cause cancer"), the first to the warn of addiction ("Cigarettes are addictive"), the first to establish environmental tobacco smoke as the cause of terminal disease ("Tobacco smoke causes fatal lung disease in non-smokers"). Given the noteable departure from the largely invisible warnings that preceded them, these dramatic warnings shocked the country when they first appeared.

The focus on tobacco packages did not end with these changes. When tobacco taxes were cut in 1994 in order to price smugglers out of business, the House of Commons health committee was asked to review the sale of tobacco

[6] Comparing 2002 (Jan–Dec) with 2001, per capita consumption of cigarettes plus roll-your-own (assuming 0.7g of ryo = 1 cig) was down 8.1%.

in plain packages. (Plain packaging is defined as packaging on which the surface graphics currently used to differentiate brands have been standardized.*(27)* Plain packs incorporate a standard package base colour and are stripped of any trademark colour, graphics and language.) Early in 1995, the committee recommended plain packaging *(28)* but tobacco lobbyists worked hard to stall this reform. A focused advocacy campaign would be required to force the implementation of this recommendation.

## Canadian Warnings: 2000 Generation

### Enactment and implementation

The latest iteration of Canada's warnings was implemented by the then health minister Allan Rock under Section 15 of the *Tobacco Act* and implemented by way of regulation in June 2000. The law required that about 50 per cent of tobacco packages had to have the new warnings in place within 6 months from enactment. Any remaining packaging had to comply within 1 year. This gave the industry some flexibility related to problems of production and clearance of inventory. The regulation dictated the labelling of tobacco products sold in individual packages, cartons and tubs, and applies to products produced domestically and imported.

### Two distinct warning systems

Canadian cigarette packages consist of three types. The most common package in Canada – though it is virtually unknown elsewhere – is the shell and slide design which accounts for over 85 per cent of the Canadian market. The slide surrounding the cigarettes moves up and down inside the outer shell on which most of a company's trade dress is printed. The package with about 10 per cent of the market is a flip-top box, common in other markets. Soft packs, the third type of pack used, account for less than 1 per cent of sales.

There are two distinct warning systems in the new Canadian labels for manufactured cigarettes: (a) an exterior system printed on the shell of the most common package and on the outside of the flip-top box or soft pack; (b) an interior system printed on the slide or on a leaflet which is inserted inside the flip-top package. As explained below, some tobacco products that occupy a small segment of the market face less stringent requirements. For example, a loophole given to manufacturers exempts soft packs from the leafletting requirement imposed on flip-top boxes. This could encourage manufacturers to shift production to soft packs to avoid carrying the interior warning/cessation system.

### Exterior warnings

The regulation requires 16 warning labels in rotation which use full colour, pictures and graphics[7]. These labels occupy the upper 50 per cent of both of the "principal display surfaces" of each package: English on one side, French on the other (Canada's two official languages). These are the warnings that have captured international attention.

Considerable focus-group testing and polling went into determining both the size and the format of the exterior warnings. Smokers consistently reported that warnings with images were far more likely to influence their behaviour, and that of youths who might be tempted to start smoking. They also reported that larger warnings would be more effective in encouraging them to quit. Initially, the government announced warnings that would occupy 60 per cent of both major faces. Subsequent research suggested that warnings of 80 per cent would be even more effective.*(29)* Despite this, in the trade-off that normally accompanies political decisions of this kind, the health minister settled for warnings occupying the upper 50 per cent of both major faces. These measures set global precedents in both size and content.

### Interior warnings

Health Canada made only a modest effort to realize the potential of the interior system. It consists of 16 messages in rotation printed on either the slide of the dominant package type, or on a removable insert for the flip-top box. When the interior system was originally recommended to Health Canada by health groups, it was suggested that any messages rotated on the inside should be a "surprise" to the smoker, which would only be revealed after the purchase was made. Because of this feature, the impact of the interior messages would only be limited by the obvious requirement of scientific and legal validity and the skills of the advertising creative team.

Considering Health Canada was breaking new ground with these warnings, and that the *Tobacco Act* under which the warnings were being implemented was under

[7] See "Images of Canadian Health Warnings," at *http://www.nsra-adnf.ca/news_info.php?cPath=22&news_id=78*

attack in the courts, the development of the interior system proceeded with some timidity. These restraining influences caused the interior messages to be limited to highlighted text without full colour, pictures or graphics.

Whatever the limitations of the interior system in this generation of warnings, the government did establish the precedent of using the inside of the pack. This gave Health Canada the potential to develop this system more fully in the future.

### Messaging

Tobacco industry documents reveal concern about effective warnings. One Bitish American Tobacoo (BAT) document says, "There should be no specific mention of smoking related disease" in warnings. *(30)* Another says, "Reference to specific diseases on health warnings should be resisted strongly."*(31)* Industry objections not withstanding, the exterior warnings speak to specific risks: addiction, lung cancer (two messages), heart disease, emphysema, mouth disease, stroke, second-hand smoke (three messages), maternal smoking during pregnancy (two messages), effect of parents' smoking on the risk of uptake among children, a warning of hydrogen cyanide, and a "proportionality" message (deaths from tobacco compared with other causes of preventable death).

The 16 interior messages include the following: nine positive messages to encourage cessation (beginning "You CAN quit smoking!") and seven more detailed messages to complement the exterior warnings introduced by questions such as:

— "If I get lung cancer, what are my chances of surviving?"

— "Can second-hand smoke harm my family?"

— "Can tobacco cause brain injury?"

To ensure print quality control, the regulation specifies that the "warnings and health information" must be obtained from electronic images obtained from Health Canada and that the quality must be "as close as possible to the colour" set out in Health Canada's source document.

### The toxic constituent panel

In addition to the package faces occupied by the warning systems described above, one side panel of each package carries information about machine-measured yields of various smoke constituents. In the warnings introduced in 1994, yields of three toxins were listed: tar, carbon monoxide and nicotine, as measured by machine using International Organization for Standardization (ISO) testing parameters.

It was by then well established that ISO numbers do not provide meaningful information on quantities of toxins absorbed by smokers – a 'light' cigarette can easily give the same amount of tar as a 'regular' one, as smokers adjust puff volume and other characteristics to achieve their habitual nicotine dose. The government had developed a new set of testing parameters, designed to approximate yields under realistic conditions of smoker compensation.

The decision was made that the new 2000 format would include a range that would show the yields of both the ISO and "realistic" parameters. While this approach makes it less easy to tie misleading marketing devices, such as the 'lights' moniker, to officially sanctioned tar yield numbers, it is still far from satisfactory.

The range between the results from the two test methods is considerable, particularly in the case of highly ventilated cigarettes[8]. To the extent that smokers optimistically believe their personal exposure level to be near the lower end of the range, they may assume a health benefit to brand-switching where actually none exists.[9]

Canadian health organizations recommended that the ISO numbers be dropped altogether. However, Health Canada was reluctant to abandon the ISO system completely, which the government had embraced for many years. Nevertheless, health groups expect changes in the next generation of warnings. In the meantime, Health Canada has added three new toxins in tobacco smoke that the

[8] See "Toxic constituents information" at *http://www.nsra-adnf.ca/news_info.php?cPath=22&news_id=187* .

[9] For example, in the popular brand family Player's, Player's Filter (i.e. regular) has a tar rating of 15-33 mg. Player's Extra Light has a rating of 11-29 mg. The newly introduced Player's Silver has a range of 8-27 mg. Somebody switching from regular to Silver would quite naturally assume that in the process they reduced their exposure substantially, possible by as much as 50% (from 15 to 8 mg, say). In fact, they are likely at the lower end of the range when they smoke the regular and at the higher end when they smoke the Silver, e.g., 20 mg in either case.

industry must now report in the toxic constituent panel: benzene, hydrogen cyanide and formaldehyde.

Health Minister Rock published a *Notice of Intent to Regulate* in 2001 to signal the intent to ban 'light' and 'mild' descriptors. However, to date, with a change in ministers, this reform seems stalled.

### Pipe tobacco and cigars

These tobacco products occupy a very minor part of the Canadian market and have less stringent warning requirements to meet. Manufacturers must rotate four bilingual warnings with pictures, colour and graphics. Bidis, chewing tobacco, oral snuff and nasal snuff carry four text-only messages in rotation.

### Cartons and kits

Each carton must carry one of 16 warnings in rotation which occupy 50 per cent of the surface area of every face. This requires each carton to have three warnings in English and three in French chosen from among the 16 exterior warnings required on individual packages. Because every face of the package has a warning, the manufacturers and retailers are prevented from stacking cartons in such a way as to create a large, warnings-free cigarette display at point-of-purchase.

### Marker words

A typical feature of warning labels and signs is the use of marker words such as "CAUTION", "WARNING", or "DANGER". Almost all of Health Canada's messages utilize "WARNING" or "AVERTISSEMENT". The marker word "CAUTION" is not strong enough for a product that kills and has no safe level of use. "DANGER" suggests that the hazard or risk is immediate or imminent; this marker was therefore thought to be inappropriate. Markers are often highlighted in some way. Graphically, it was thought that "WARNING" or "AVERTISSEMENT" in red or yellow was most effective depending upon the background colour. For example, red markers disappear on black backgrounds in some Canadian warnings. Yellow should have been used.

### Attribution and extraneous messaging

Health Canada rejected the language encouraged by the industry, whereby the authority to which the warning is attributed leads the message; for example, "Surgeon General's Warning: Smoking causes..." or "The Department of National Health and Welfare advises...".

This ordering of the language forms a word block and allows the dissonant smoker to ignore the rest of the warning. Therefore, the attribution to "Health Canada" in small typeface was wisely placed below the warning.

To Health Canada's credit, it also rejected an attempt by the tobacco industry to slip in the following message "Underage sale prohibited." The government recognized that industry attempts to position its products as "for adults only" encourages youth to attempt to use cigarettes as a "badge" signifying entry to adulthood.

### Wear-out

Warning labels become stale with the passage of time. To address problems related to obsolescence or "wear-out", at the time of enactment of the 2000 generation of warnings, the government committed to changing and refreshing the warnings within three years.

## Success of the Intervention

The purpose of the intervention was to provide current and potential smokers with accurate information, compellingly presented, with respect to the nature and magnitude of the risks of tobacco products. In the face of the continuing tobacco epidemic, the government sought to address at least partially the manufacturers' ongoing failure to provide full and accurate risk information. Clearly, it will take many years before the effects of decades of omission and misrepresentation are overcome; but access to proper warnings is a public benefit in itself.

The short-term impact of the warnings on consumption or smoking rates is impossible to quantify, because of a number of other tobacco control measures, such as tax increases, workplace smoking bans and mass media campaigns that were implemented virtually simultaneously. However, smokers and recent ex-smokers are surprisingly numerous in reporting that the new warnings were "a factor" or "a major factor" motivating a recent quit attempt.[10]

[10] A total of 38%, according to a survey conducted in October 2001. See Environics Research Group, Evaluation of new warnings on cigarette packages (Research prepared for the Canadian Cancer Society). Available on-line at *http://www.cancer.ca/vgn/images/portal/cit_776/35/20/41720738niw_labelstudy.pdf*

### What the research shows

In general terms, smokers are saying, "Give us the truth, however uncomfortable, anything that will help us get off cigarettes." *(32)* Quantitative and qualitative research completed both before and after enactment of Canada's new warnings shows that:

- smokers and potential starters have an imperfect understanding of the nature and magnitude of the risks of tobacco use *(33)*;
- large warnings with pictures and graphics in colour are seen as crucial, first, in attracting attention to messages *(34)* and, second, in increasing the desire to quit smoking *(35)*;
- emotive messages are often more effective than statistics *(36)*;
- personalized messages are more effective than impersonal ones *(37)*;
- messages about risks which have a component involving personal appearance have a greater impact (e.g. Canada's warning about mouth disease) *(38)*;
- positive messages related to cessation assistance in conjunction with strong risk messages are more effective *(39)*. Not unexpectedly, if anxiety about risk is raised, suggestions that offer hope of avoiding the risk are warmly received;
- after a few months on the market, package warnings had high visibility and were rated a "top-of-mind" source for health information. *(40)*

The Quebec Superior Court reviewed the evidence about the efficacy of the warnings and concluded the "warnings are effective." Judge Denis said:

> A study commissioned by Rothmans, Benson & Hedges Ltd. (R.B.H.) in the year 2000 (Project Jagger, June 23, 2000) mentioned in Dr. Pollay's report shows that the warnings with photos recently mandated by the federal government are having a *major impact on consumers*." (emphasis added) *(41)*

## Attempts to Block Labelling Reform

Opposition to the labelling reform came from three principal sources: the three major Canadian manufacturers, the Canadian Tobacco Manufacturers' Council, and tobacco package printers who were either incited or frightened by their manufacturer clients. This followed a plan outlined in a secret presentation given to directors and advisors of the Canadian Tobacco Manufacturers' Council in 1999. One goal of the plan was "to stall and, ultimately, significantly amend government's proposed regulations on packaging and point-of-sale." The document makes clear the need to organize unions in opposition and to "coordinate anti-packaging campaign with key suppliers." *(42)*

A variety of arguments were employed. It is worth underlining that the content of the warnings was not at issue. The manufacturers said they would not contest the language, presumably because they could not win such a protest. Attempts to block the reform focused on:

- the constitutionality of taking 50 per cent of the package's trade dress, an alleged infringement of the industry's commercial freedom of speech,
- the claimed inability of the printers, using a rotogravure printing process, to meet the requirements of Health Canada to produce both full colour warnings and the sophisticated printing demands related to industry trademarks, and
- the threatened loss of jobs when printing contracts moved to the United States.

However, unlike in the plain package debate, alleged violations of international trade laws and of intellectual property rules did not feature prominently in the political fight over the warnings.

Pressuring the government to proceed and countering the various industry blocks was a coalition of over a 100 national and regional health and human service organizations led by the NSRA and the CCS.

Threats related to constitutional issues were countered by lawyers acting for the federal Attorney General and the CCS. To counter the block created by the printers and their clients, the health organizations enlisted the aid of printing experts. Health Canada showed leadership by manufacturing cigarette packages which proved that the warnings could be produced while protecting the manufacturers' trademark colours.

Curiously, as soon as the warnings were approved by parliament, the issue of job losses disappeared into the ether. The manufacturers did follow through with their legal assault on the warnings. This argument was rolled into the constitutional challenge of Canada's *Tobacco Act* then underway. In December, Judge Denis said the rights of the industry under the Charter "cannot be given the same

legitimacy as the government's duty to protect public health" and rejected all of the industry's challenges.*(43)*

## Factors Leading to Enactment in 2000

In the real world of tobacco control, many factors influence the formation of policy and the final form of interventions. In an observation attributed to Bismarck, it is said that there are two things one might not wish to see in production: sausages and laws. Several factors impacted on the development of the Canadian warnings and not all of them were health based. Prior to the announcement of health minister Rock's plans for new warnings, his government had been severely criticized for concessions given on tobacco sponsorship to international motor-racing. Although the minister had little to do with the concessions, he was an activist minister and wanted to make a positive contribution to the development of the tobacco file. After receiving a thorough briefing on the importance of tobacco warnings and the role of the package in tobacco marketing by a non-governmental health agency, he decided in 1999 to proceed with improvements to the package warning system.

The NSRA, CCS and Physicians for a Smoke-Free Canada led non-governmental organization (NGO) advocacy for the 2000 warnings reform. In particular, the NSRA manufactured a prototype warning system *(44)* and the CCS contributed valuable research on a variety of issues related to the new warnings. Health Canada conducted its own research including research on recommendations originating with the NGO community.

Because the changes being planned were substantial, time constraints soon became a factor. In the rush to completion, the final product was influenced by legislative time constraints, lack of optimal time for research and testing, risk averseness related to litigation, and uncertainty with respect to how intrusive the warnings could be. For example, the failure to commit to a complete interior warning system earlier in the process affected the quality of that system.

Despite these problems, the product that emerged in late 2000 was a precedent-setting system, a system that went further than any other tobacco labelling system in any country at the time. This success may in large part be attributed to factors not always acknowledged in the development of public policy and we stress their importance. There were three key influencers in the system working cooperatively and with commitment towards the development of an outstanding system. First, we had a unified health community pressing for the initiative, developing a prototype of a breakthrough system, *(45)* conducting research *(46)* and generating counter pressure to the opposition from the tobacco industry. Second, there was a health minister and a key ministerial aide who were committed to the reform and who provided the political leadership so very essential for enactment. Third, there was a team within Health Canada charged with the responsibility to see this project to completion which worked hard and with commitment to move the warnings to completion. In the absence of leadership from any of these three interests, the new warnings may not have come to fruition.

## Recommendations

Our experience with the warnings reform process suggests the following recommendations:

1. Select warnings that cover the nature of the risks and the magnitude of the danger. Warnings should provide information about specific diseases and the prognosis if a tobacco disease strikes.
2. Cessation information that offers hope works well when it follows anxiety-raising warnings. But cessation information should not overwhelm the purpose of the warning system expressed in point 1 above.
3. Risks of disease should be attributed to the product (e.g. cigarettes), not to individual behaviour (i.e. smoking). Cessation messages can focus on individual responsibility.
4. Non-smokers should not be overlooked as targets of any warning system. Second-hand smoke warnings are of great interest to them. Spouses, children and friends of non-smokers read the warnings and encourage smokers to quit.
5. Warnings should be large and utilize blunt language, pictures, colour and graphics.
6. Warnings should be introduced by an appropriate marker, such as WARNING.
7. Personalized messages work best, for example, "Cigarettes can kill you!".
8. Weasel words such as "is related to", "is linked to" or "is associated with" should be rejected to the extent that science permits. Identifying causation is important, for example, "Cigarettes can cause lung cancer, in you!".

9. Blocks in warnings created by difficult or wordy language should be avoided.
10. Position of warnings counts. The top of major package faces is the premier space on a package. This position sells cigarettes. Government should occupy it in the interests of public health.
11. Second-hand smoke (especially death from second-hand smoke diseases) and addiction are two warnings themes that cause the tobacco industry special discomfort.
12. In text-only warnings, white lettering on black background, is more dramatic than the reverse, especially if it is framed with a white border. Attempts to camouflage the text of messages in the colours of the package should be rejected.
13. Deception undermines warning systems. Deceptive claims or graphics should be banned (e.g. the 'light' and 'mild' family of descriptors).
14. Just as creativity with trademarks on packages is being used by the industry, creativity should also be utilized with warning systems (e.g. surprise messages inside the pack).
15. Warnings should be rotated frequently. Wear-out of messages should be prevented by scheduling regular changes to the warning system.

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Smokefree Policies

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# Report on Smokefree Policies in Australia

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# Report on Smoke-Free Policies in Australia

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## Introduction

Tobacco use is the leading cause of death and disease in Australia. Each year nearly 20 000 Australians die and more than 150 000 are hospitalized due to tobacco-related illnesses *(1)*. The economic and social costs of tobacco use in Australia are estimated at $AU 12,736.2 million per annum *(2)*.

In 2001, approximately 22% of Australian adults were smokers *(3)*. Australian males (24.3%) are more likely to smoke than Australian females (19.9%), with adult smoking rates peaking in the 20–29-year age group *(4)*. Young Australians are still taking up smoking at a disconcerting rate, with 260 000 students aged 12–17 estimated to be smokers *(5)*. Around one-third of 17-year-old students smoke.

Smoking rates are significantly higher in some disadvantaged groups in the Australian community. People from lower socioeconomic brackets, people with mental illnesses and some ethnic communities such as Greek, Vietnamese and Eastern Mediterranean, all have substantially higher smoking rates than the general population *(6,7,8)*. Of particular concern is the smoking rate among indigenous Australians, which is over double the rate of the overall Australian population: 53% of indigenous males and 43.6% of indigenous females are smokers *(9)*. While smoking prevalence in the general Australian population is declining, there have not been corresponding decreases in smoking prevalence in these high-risk groups.

## Smoke-free policies in Australia

### Self regulation

As evidence has grown of the harmful impact of exposure to environmental tobacco smoke (ETS), smoke-free environments have become increasingly common in Australia. Prior to introducing smoke-free legislation throughout Australia's six states and two territories, self regulation was the predominant means of regulating ETS exposure in workplaces and public places, with employers and venue operators voluntarily implementing smoking restrictions at premises within their control. In some areas, self-regulation has been highly successful. For example, a smoke-free work environment policy was adopted throughout the Australian Public Service in 1988. This ban was the first of its type in Australia and similar policies were subsequently introduced in public services across the country. The smoking ban in government buildings enjoys a high compliance rate, and a smoke-free work environment is now an expected condition of employment with the Government and, indeed, in many other professional settings.

However, smoking restrictions imposed by individual employers and venue operators have failed to protect staff and patrons in many enclosed environments, such as restaurants, pubs and casinos. A study conducted seven years prior to the introduction of smoke-free dining laws in New South Wales found that not only did restaurateurs underestimate patron demand for smoke-free areas, even those who did perceive the need to provide smoke-free areas offered few such areas *(10)*.

### Smoke-free legislation

The responsibility for tobacco control in Australia rests primarily with state and territory governments. However, the federal Government has played a leadership role, taking the country's first legislative step in this area by banning smoking on domestic airline flights in 1987. This was followed by smoking bans in other federally controlled areas, such as on interstate buses and coaches (1988), on domestic sectors of international flights (1990) and on all Australian airlines flights anywhere in the world and on all international airlines flights within Australia (1996).

As evidence mounted of the significant economic and social costs of tobacco use in Australia, tobacco use was identified as a major public health issue, requiring a coordinated national response. In 1994, the development of a National Tobacco Strategy was endorsed by the nation's peak ministerial drug policy group, comprising federal, state and territory health and law enforcement ministers. The goal of the National Tobacco Strategy 1999–2003 is to improve "the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms."[2] Reducing exposure to ETS is a critical part of the National Tobacco Strategy. The strategy is informed by a set of guiding principles to assist states and territories in implementing best practice smoke-free legislation. Principal components of the guidelines are:

[2] Commonwealth Department of Health and Aged Care. *National Tobacco Strategy 1999 to 2002-2003 A Framework for Action*. 1999, Canberra. Note that the operation of the National Tobacco Strategy has been extended by 12 months to 2003–2004.

- non-smoking environments should be regarded as normal practice in enclosed public places and workplaces;
- there is no "right to smoke" in an enclosed public place or workplace;
- smoking restrictions should apply equally to all premises within any particular industry;
- any exempted premises must meet health-based criteria for ETS; and
- compliance mechanisms should be based on education and community support *(11)*.

While no Australian jurisdiction has implemented smoking bans as comprehensive as those recommended by the guidelines, all states and territories have taken some legislative steps to reduce ETS exposure in public places and workplaces. South Australia and Victoria have adopted a piecemeal approach, legislating to provide limited smoke-free environments, such as restaurants, parts of licensed premises and, in Victoria, shopping centres and gaming and bingo venues.

Comprehensive legislation concerning smoke-free enclosed public places has been enacted in the Australian Capital Territory (ACT) (1994), Western Australia (1999), New South Wales (2000), Tasmania (2001), Queensland (2002) and the Northern Territory (2003). A public place is defined in similar terms in these jurisdictions. For example, in the ACT it is defined as: "a place which the public, or a section of the public, is entitled to use or which is open to, or is being used by, the public or a section of the public (whether on payment of money, by virtue of membership of a body, or otherwise)."[3] Places captured by this definition include enclosed restaurants, shopping centres, sporting facilities, libraries, universities and public transport. However, since many workplaces, such as factories are not open to the general public, and employees are not considered to be 'a section of the public', legislative bans on smoking in enclosed public places do not prohibit smoking in all workplaces.

The Queensland legislation prohibits smoking in 'enclosed places' and therefore covers workplaces as well as public places. Private places like residential premises, private vehicles and non-common areas of multi-unit residential accommodation are specifically excluded from the ban. Legislation in Tasmania (2001) and the Northern Territory (2003) creates 'smoke-free areas' that are defined in both jurisdictions to include enclosed public places and enclosed workplaces. However, regulations in the Northern Territory permit employers to designate smoking areas.

In the remaining jurisdictions, smoking in the workplace is dealt with mainly under occupational health and safety legislation. In Western Australia, occupational health and safety regulations prohibit smoking in the workplace, although there are many exemptions, such as the allowance of designated smoking areas. In the ACT, a Code of Practice for Smoke-free Workplaces, which falls under occupational health and safety legislation, recommends implementing full smoking bans in workplaces. Failure to comply with the Code of Practice may be used as evidence in proceedings under the Territory's occupational health and safety legislation, but does not of itself constitute a breach of the legislation. In the remaining states, employee protection from ETS relies on general obligations in occupational health and safety legislation that require employers to provide a "working environment that is safe and without risks to health."[4] Attempts to use these general obligations to ensure smoke-free workplaces, particularly by workers and unions in the hospitality sector, have proven largely unsuccessful. The National Occupational Health and Safety Commission recently recommended that ETS exposure be excluded, without exception, in all Australian workplaces. However, state and territory Workplace Relations Ministers have not acted on this issue, intimating that workplace exposure to ETS should be dealt with by Health Ministers through smoke-free legislation.

With smoke-free workplace legislation in place in only three Australian jurisdictions, and even this legislation failing to cover all workplaces, many Australian workers remain at risk of ETS exposure. In the majority of workplaces, smoke-free policies are implemented at the discretion of employers. A study of Victorian workplaces found that around a quarter of workers had only partial or no smoking restrictions in their workplaces and that 9% of indoor workers in that state are potentially exposed to tobacco smoke in their immediate work area *(12)*. Blue-collar workers and employees in the hospitality sector are at highest risk of ETS exposure in the workplace *(13, 14)*. Imposing full smoking bans in all enclosed workplaces is an initiative that is relatively inexpensive for governments, while having significant public health benefits *(15)*.

[3] Section 2, *Smoke-free Areas (Enclosed Public Places) Act* 1994 ACT.

[4] For example, section 21 of the *Occupational Health and Safety Act* 1985 (Victoria).

### Exemptions from smoke-free laws

Despite the existence of comprehensive smoke-free public places legislation in the majority of Australian jurisdictions, smoking is still generally permitted in licensed venues (that is, hotels, pubs, bars and clubs), casinos and gaming areas, with these venues either wholly or partially exempted from smoking bans. The application of smoking restrictions to licensed premises differs in each jurisdiction, and is invariably complex. Exemptions from smoking bans apply, for example, to single-room premises (Victoria), to bar areas (New South Wales, Tasmania and Queensland), to entertainment areas (South Australia), to places with adequate ventilation (Western Australia and ACT) and to places with ministerial exemptions (ACT and South Australia).

The Tasmanian legislation provides that a 'reasonable area' of a bar area must be smoke-free and stipulates that the smoke-free area must not be of 'inferior amenity' to the smoking area. The legislation does not define 'reasonable area' or 'inferior amenity' and a current review of that legislation has identified this as a significant area of confusion for both patrons and venue operators *(16)*. In the Northern Territory, occupiers of licensed venues may designate smoking areas, as long as a smoke-free area of 'equal amenity' is maintained. An attempt is being made to define 'equal amenity' through an industry code that is currently being drafted by the Australian Hotels Association (AHA) in consultation with the territory government *(17)*.

While best-practice smoke-free legislation would cover all public places, including licensed premises, casinos and gaming venues, to date no Australian jurisdiction has committed to making these venues totally smoke-free. Hospitality industry groups, many of which have close ties to the tobacco industry, have played a significant role in ensuring the continuing exemption of licensed premises, gaming areas and casinos from smoke-free legislation across the country. For example, both Philip Morris and British American Tobacco Australiasia provided funding to the Tasmanian branch of the AHA to assist in preparing materials to lobby Parliamentarians prior to introducing smoke-free laws in that state.[5]

[5] Edwards C. *Hansard*, Parliament of Tasmania. 29 March 2001.

Hospitality industry groups have actively opposed implementing smoke-free laws on the basis of their negative economic impact on hospitality businesses, an argument that is contrary to both Australian and international research findings *(18)*. The AHA has been particularly active in advocating an accommodation model using ventilation and segregation of smokers and non-smokers as an alternative to legislative bans. The AHA's draft accommodation code is modelled on the United Kingdom's AIR Initiative, which receives funding from the Tobacco Manufacturers Association *(19)*. Also of concern is the claim by unions in New South Wales that the extension of smoking bans in that state has been slowed by political donations by members of the hospitality industry *(20)*.

In jurisdictions where there is no comprehensive smoke-free legislation, or where gaps in the law exist, smoking policies voluntarily adopted by venues or organizations continue to play an important role. Often such policies are motivated by the threat of litigation as well as patron and staff demand. For example, while Western Australia's Burswood Casino is specifically exempted from the smoke-free regulations in that state, intense lobbying and union pressure led to the venue introducing a smoke-free policy. In New South Wales, a draft agreement between Government, publicans, the casino and workers provides that all licensed premises will be 'predominantly smoke-free' by 2005 *(21)*. What this means and how it will be achieved is still being negotiated.

## Implementation model: the introduction of smoke-free dining in Victoria

The effective implementation of smoke-free policies relies on a number of key elements such as consultation and education. The policy development and implementation process is discussed below in relation to introducing smoke-free dining laws in Victoria from 1 July 2001. Similar implementation models have been used when introducing smoke-free laws in other jurisdictions such as Queensland (2002) and the Northern Territory (2003).

In the late 1990s Victoria was lagging behind other Australian jurisdictions in providing smoke-free environments. In 1999, a new state government came to office with the expressed policy commitment of protecting the Victorian community from the harms of ETS exposure. In developing its smoke-free dining laws, the Victorian Department of Human Services undertook extensive

consultations with stakeholders, including other relevant government departments (for example, the Treasury and small business), regulatory authorities (for example, Liquor Licensing Victoria), industry groups, key employers, unions and health bodies. The input of these groups helped to inform policy development, in particular how the smoking bans would apply to licensed premises with a dining component, such as pubs.

Restaurateurs voiced concerns about the potential negative impact of smoke-free dining and were particularly critical of the fact that the bans singled out the restaurant industry, with smoking still permitted in other venues such as bars and gaming venues, a distinction that is not justifiable on health grounds *(22,23,24)*. As has been the experience in other jurisdictions, the tobacco industry was active in rallying restaurant industry opposition to the ban. Tobacco industry documents show that Philip Morris was heavily involved in a lengthy campaign run by 50 of the state's top restaurants to win community support for an accommodation model, rather than a legislated smoking ban *(25)*. However, as will be discussed in more detail later in this report, several other Australian jurisdictions had already introduced smoke-free dining without negative consequences for business and surveys showed that the Victorian public was highly supportive of the proposed new laws *(26)*. This, coupled with strong support from key health and union groups, ensured the successful passage of smoke-free dining legislation through the Victorian Parliament in 1999 with bipartisan support.

The Victorian state government conducted an AU$ 500,000 communications campaign to inform both industry members and the community about the new laws *(27)*. A key component of the laws' successful implementation was the input and support of industry groups and members. An advisory committee comprising key employers, industry groups, health bodies, unions, enforcement officers and other key government departments was established to advise on the communication needs of stakeholders. As well as providing advice on the advertising campaign and signage, the members of this group also played an important role in disseminating information on the laws through industry seminars and newsletters. One vital function of this group was to provide feedback on potential implementation issues, enabling these to be addressed at an early stage.

Other key communications campaign elements included:

— the publication of a comprehensive booklet explaining the laws and how to comply with them *(28)*. The booklet and free signage was mailed to Victoria's 16 400 eating establishments. It was printed in seven community languages to meet the diverse language needs of Victoria's multicultural community.

— education seminars for restaurateurs conducted throughout the state, including in rural areas. A total of 650 people attended 18 seminars held at 9 different locations.

— community and industry radio and press advertising campaign (in both mainstream and multicultural media).

— workshops to educate enforcement officers about the new laws. A total of 245 enforcement officers from the state's 78 local councils attended these workshops. The government of Victoria provided $AU 1.3 million to councils to undertake education visits to eating establishments to ensure awareness and compliance with the new laws.

— telephone information line and web site *(29)*. Both the web site and phone line were well utilized. There were 1 475 hits to the web site in June 2001, the month prior to the introduction of smoke-free dining, and 2 075 hits in July 2001. Nearly 1 000 calls were made to the phone line in both June and July 2001.

The success of the communications campaign was demonstrated by pre- and post campaign surveys, which were conducted to assess awareness of smoke-free dining among eating establishment proprietors *(30,31)*. Of the eating establishment proprietors surveyed three weeks after the introduction of smoke-free dining, 100% were aware of the laws, compared with 80% of those in the pre-campaign survey. The relatively high rate of pre-campaign awareness can be attributed to heavy media coverage of the smoke-free dining laws and the active role played by industry groups in providing information on the laws to members. Importantly, the communications campaign was shown to have been significant in increasing proprietors' understanding of the details of the law, such as the requirements to display signage and not to provide ashtrays as well as the offences under the legislation. Awareness of such details increased by an average of 87% among restaurant proprietors and 77% among hotel and club proprietors between the pre- and post campaign surveys. Over three-quarters of proprietors surveyed rated

the mailed government information as helpful or very helpful in assisting them to implement smoke-free dining.

It should be noted that while the major costs of implementing smoke-free laws are associated with the initial public awareness campaign, there are some ongoing costs to the Government, including the maintenance of a web site and telephone information line, provision of signs as well as continuing education and possible low-level funding of enforcement officers.

## Measuring the success of Australia's smoke-free policies

The success of smoke-free laws across Australia is demonstrated by widespread compliance, high levels of community support and a decrease in tobacco consumption.

### Compliance

The experience in all Australian jurisdictions has been that smoke-free laws are generally self-enforcing, with smokers refraining from smoking in smoke-free areas once they become aware of the laws. Following the introduction of smoke-free dining in South Australia, venue owners and managers were surveyed in relation to customer compliance with the laws *(32)*. Five months after the commencement of the laws, 93.8% reported observing either no or few customer breaches of the smoking ban. This reported compliance rate increased to 95.5% after 18 months. Where a breach of the legislation was observed, most proprietors reported asking the smoker to cease smoking, with only 4.4% of customers refusing to comply with this request. These findings are consistent with a survey of diners in that State in which only 1.8% of smokers reported smoking in a non-smoking dining area *(33)*. Similar high-customer compliance rates have been reported in other jurisdictions *(34)*.

A compliance inspection of South Australian eating establishments found that venue compliance with the legislation was between 88.2% and 92.3% five months after the introduction of smoke-free dining and between 95.7% and 99.6% after 18 months *(35)*. While only 1% of premises were found to be breaching the laws by allowing smoking indoors, one-third of premises were not displaying the prescribed signage.

Reviews of smoke-free legislation currently underway in Tasmania and Western Australia, both identify proprietor confusion as a barrier to compliance with smoking restrictions *(36, 37)*. Both reviews note that proprietors and, in some cases, enforcement officers, have had difficulty in applying smoking restrictions, which are based on subjective criteria such as the 'predominant activity of an area', whether meals (as opposed 'snacks') are being served and whether an area is 'substantially enclosed'. The experience in these states demonstrates the importance of well-drafted, easy-to-apply legislation. It also highlights the necessity of providing ongoing assistance to proprietors, such as education visits by enforcement officers and the maintenance of a telephone information line.

As compliance with the smoke-free laws is high, enforcement officers primarily respond to complaints rather than conducting active compliance monitoring. Enforcement is undertaken by a range of personnel across the country, including local council officers (e.g. in Victoria), area health staff (e.g. in New South Wales), police (Northern Territory), licensing officers (Northern Territory) and volunteers (Tasmania). Some jurisdictions, such as the Northern Territory and Queensland, have on-the-spot fines (infringement notices) while in the majority of jurisdictions, enforcement is by way of prosecution. In all jurisdictions there are penalties for occupiers who fail to display prescribed signage ($AU 75–100 infringement notice or $AU 500–5,000 fine) or who allow smoking in a smoke-free area ($AU 100–150 infringement notice or $AU 500–11,000 fine). Occupiers are defined in similar terms in most jurisdictions as the person managing, controlling or in charge of an enclosed place or part of an enclosed place. Individuals who smoke in a smoke-free areas may also receive a $AU 75–150 infringement notice or a $AU 500–2,200 fine. In practice, however, most complaints result in the provision of education and the clarification of the law rather than any punitive enforcement action.

### Community support

Smoke-free environments have been well received by the Australian community. A survey of community attitudes towards South Australia's smoke-free dining laws found that support for the laws was high, increasing from 81% four months after the laws' implementation, to 85% after 18 months *(38)*. Smokers were less likely than non-smokers to support the laws, but smoker support also increased from 54.8% after four months to 61% after 18 months. Patrons reported increased enjoyment of dining out and were also found to be slightly more likely to dine out following the introduction of the smoke-free dining laws. Of the smokers, 80.7% reported that smoke-free dining laws had not affected their dining habits. These findings of high community

e Australian Bureau of Statistics' Retail Trade
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## on

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Success stories and lessons learned

# Outils pour poursuivre la lutte antitabac au XXI$^{e}$ siècle:

Expériences concluantes
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# Effective Access to Tobacco Dependence Treatment

WHO/NMH/TFI/FTC/03.3

PH-15.5

## Tobacco Dependence Treatment in England

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# Tobacco Dependence Treatment in England

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## Introduction

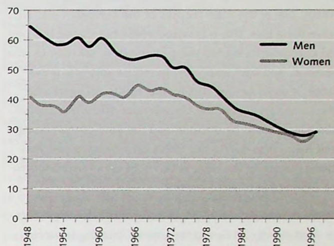
In England[1] (as in the United Kingdom of Great Britain and Northern Ireland as a whole) smoking prevalence in adults (aged 16 and over) has been falling in both men and women since the 1970s *(1)*. During the 1990s, however, this decline levelled off, as the diagram below illustrates. Currently, in England 27% of adults smoke – 28% of men and 26% of women. Over the last 20 years there has been a similar trend in 11–15-year-olds, in whom prevalence has fallen only very slightly. In 1982, 11% of 11–15-year-olds were regular smokers (defined as at least one cigarette a week on average), 11% of boys and 11% of girls. In 1999, the figures were 9%–8% of boys and 10% of girls *(1)*.

There are currently about 13 million smokers in Britain *(2)* and a large socioeconomic gradient: 15% of professionals smoke compared with 39% of unskilled manual workers *(1)*. This gradient has become steeper as more professionals have stopped smoking. There is also evidence of higher dependence within the more deprived smokers *(3)*. Most smokers (82%) start as teenagers and most – about 70% in Britain (see footnote) – say they want to stop *(1)*. Even among those who want to stop, the unaided cessation rate measured at one year is less than 5% *(4)*.

In the United Kingdom of Great Britain and Northern Ireland more than 120000 people a year are killed as a result of smoking, mainly through lung cancer, chronic obstructive pulmonary disease and coronary heart disease. This represents one in five of all deaths (1.2). Half of all lifelong smokers are killed by their smoking in middle age (35 to 69 years), and the average loss of life is 15 to 20

**Figure 1**

**Adult smoking prevalence in England (per 100)**




years *(5)*. The total annual cost of smoking-related disease to the national health service (NHS) in England is from about £1,500 to £1,700 million a year (about US$ 2,250 to US$ 2,550 million; all dollar conversions at £1 = $US 1.5) *(6)*.

## The historical context: development of policy on tobacco control and on treatment within it

The development of a policy to treat dependent smokers in the United Kingdom should be seen in the context of the development of tobacco control as a whole, which was a lengthy process. Doll & Hill's first report, in 1950, linking the increase in lung cancer to smoking *(7)*, planted the seed. Their work led to the establishment of the British doctors' study, a long-term cohort study that is still yielding data now on smoking death rates. In 1962, Charles Fletcher persuaded the Royal College of Physicians (RCP) to publish their first report on smoking and health *(8)*, and this was really the beginning of the tobacco control campaign in Britain. Disappointed by the lack of political action following the report's publication, the college published a second report in 1971 *(9)* and, perhaps more significantly, created the organization Action on Smoking and Health (ASH), which appointed its first campaigning director in 1973. The Government set up the Health Education Council (later called the Health Education Authority (HEA), then the Health Development Agency) in 1967, so that by the mid-1970s, a decade after the first RCP report, there were governmental and nongovernmental bodies campaigning on smoking and health. However, progress

[1] The data and events described in this paper are from England unless otherwise stated. Government policy on smoking, and its 1998 White Paper *(2)* apply to the whole of the United Kingdom of Great Britain and Northern Ireland (England, Scotland and Wales and Northern Ireland) have implemented a broadly similar policy on treatment for smokers. However, the countries have slightly different healthcare systems and the authors' main experience and involvement has been in England, so this article has focused on the situation in there. This is also why over the years survey data have not consistently been available for one country and so have sometimes been drawn from England, and sometimes from Britain and the United Kingdom.

was slow. In 1984 the British Medical Association (BMA), which represents about 90% of all British doctors, added its influential voice to the campaign *(10)*. During the 1980s, one of the main focuses of the campaign was an advertising ban. This was unsuccessful but during this period governments started using increases in taxation to raise revenue, and later (explicitly) to reduce smoking prevalence. It could be said that by the 1990s, 30 years after the campaign began, the Government officially accepted the harm caused by smoking and the goal of minimizing this harm. Also during the 1990s an increasing role was being played by the HEA, which built up and contributed to expertise in tobacco control.

While extremely important, none of these developments in itself directly advanced the case of treating tobacco dependence. Tobacco dependence was not widely recognized as an addiction until the 1990s (the United States Surgeon General's report on nicotine addiction was published in 1988 *(11)*). Some in the health education field in Britain felt it was more important to concentrate resources on mass population approaches to persuading smokers to stop, rather than on a minority of nicotine addicts who needed help. In effect, smoking was seen as an educational issue, the key task being to persuade smokers that they should try to stop. Such mass population approaches are important. Because of their wide reach they can trigger quit attempts, and cessation, on a massive scale. They are also an important precursor to helping smokers stop since they create the demand for this help, by increasing motivation to stop. Treatment services are unlikely to be feasible in a country that does not have a broader tobacco control campaign, since there may not be enough smokers motivated to stop. By the same token, once there is greater motivation to stop smoking in a population, it then becomes clear that many smokers are addicted to nicotine and need help in stopping. The statistics quoted above remind us of this: about 70% of smokers in England want to stop, and the unaided cessation rate is less than 5%.

It was during the 1990s in Britain that treatment of dependent smokers finally became accepted as an important activity in its own right. One occurrence that influenced this was the parallel development of research on tobacco addiction, the best-known national centre in Britain being the Addiction Research Unit in London, part of London University, which during the 1970s and 1980s was supported by large programme grants from the Medical Research Council. The relatively long duration of the funding was important, because it allowed the progress over several decades of a team of researchers, which resulted in pioneering research on nicotine addiction, the role of the general practitioner *(12)*, behavioural treatment and groups, and nicotine replacement therapy *(13)*, *inter alia*. Furthermore, many of the group, led by Michael Russell, remained in the field after leaving the Addiction Research Unit and contributed to the continuing evolution of treatment policy and research, from universities, the health service, and a national governmental organization.

Thus, by the mid-1990s, in Britain there was a strong tobacco control coalition. It was led (informally) by the campaigning organization ASH, supported by expertise from the HEA (that funded supporting projects and research), which included medical and other health professionals, and university-based treatment specialists and researchers developing the evidence foundation. The ground was fertile. All these strands were brought together following the election in 1997 of a new Government, which promised concerted action against tobacco, including an advertising ban and a tobacco "White Paper" – a formal Government policy paper *(2)*.

During 1997, while the Government was writing the White Paper, the HEA commissioned the first English smoking-cessation guidelines. These guidelines played a large part in shaping Government policy as a result of the interaction among the cessation researchers writing them, the HEA director who managed the project and a key official in the Department of Health. New treatment services were written into the White Paper.

Three key concepts were also vital in persuading the Government of the importance and value of treatment to help dependent smokers stop: that smoking is an addiction *(4)*, *(11)*, *(14)*,*( 15)*, that treatment is effective *(16)*, *(17)*, and that treatment is cost effective *(6)*. It was important to emphasize that many smokers are nicotine addicts who need and deserve help from the health care system. This fact is underscored by the classification of nicotine addiction/tobacco dependence as a disease by the World Health Organization's ICD classification *(14)* and by the American Psychiatric Association's DSM-IV classification *(15)*. Within Britain, the Royal College of Physicians report *Nicotine Addiction in Britain (4)* was significant, again illustrating how influential medical professional bodies can be.

The effectiveness and cost-effectiveness evidence were also important in demonstrating that money spent by the health care system helping smokers stop is extremely well

spent. When the national cessation guidelines were first published, guidance on cost effectiveness was published with them. This guidance showed smoking cessation to be one of the most cost-effective interventions in the health care system. It produces one extra life year at a cost of less than £1,000, compared with an average cost of £17,000 from a review of 310 medical interventions *(6)*. These data and arguments compelled key people, including those inside Government, to support a treatment policy. Since the treatment services were established, a new Government body, the National Institute of Clinical Excellence (NICE), has published its own assessment of the effectiveness and cost effectiveness of NRT and bupropion, which has added strong and authoritative support to the services *(18)*.

The provision of new funding (see next section) – for educational measures *and* separately for treatment services – was fundamental in advancing the case of treatment. It had been argued in the past that scarce health education resources should not be 'diverted' from population approaches to treatment, which would not affect population prevalence. The new funding meant that educational approaches could continue, and that treatment could be offered by the appropriate sector – the healthcare system (as opposed to the health education sector).

Thus, after years of failing to recognize the needs of addicted smokers, a policy on treatment emerged within a wider tobacco control policy drawn up officially by the Government. The Government White Paper also crucially proposed a tobacco advertising ban, action on tobacco taxation, smoking in public places, under-aged smoking, smoking and pregnancy, and action against cigarette smuggling.

## Chronology and implementation of new English treatment policy

The Government's White Paper *Smoking Kills* was published in December 1998 *(2)*. English national smoking cessation guidelines (16), along with guidance on cost effectiveness (6), were also published by the HEA, for the first time ever, in December 1998 and launched by the Public Health Minister in 1999. These guidelines were evidence based and formally endorsed by more than 20 professional organizations, including medical and nursing bodies. The Minister announced that approximately £110 million (about US$ 165 million) would be made available for tobacco control in England, roughly half of this for new treatment services. The new treatment services were to be developed over three years starting in April 1999. In the first year, £10 million (US$ 15 million) would be spent in 26 selected "pilot" areas; areas especially chosen for their levels of social and economic deprivation. In April 2000 the services were extended to the rest of England, with a budget of up to £20 million (US$ 30 million) for the first year, and up to £30 million (US$ 45 million) for the second year. At the time it was not stated by the Government what would happen to the services when the funding ran out in March 2002. Services were advised to target priority groups, in particular socially disadvantaged smokers. In addition, in each year targets were set for the numbers of smokers who had received specialist support though the services and reported having stopped four weeks after their quit date. Because these targets were exceeded in years one and two, they were increased for the third year of services, and again for the (subsequently funded) fourth year.

Implementation of the new policy developed as more detailed guidance was provided by the Government and as problems were encountered. One problem that had negative consequences throughout the project was the short-term nature of the funding. Originally, the Government said that money for year two would depend on evidence of success from year one *(2)* – an unrealistically short time scale in the real world. In the third year of the project a lobbying campaign was launched to try to persuade the Government to announce further funding to continue the services, in order to prevent staff losses caused by short-term contracts *(19)*. This campaign included a document written by experts and supported by professional bodies, the Department of Health, and the pharmaceutical companies, setting out the cost-effectiveness argument for treating smokers *(20)*. This document illustrated the savings that could be made on other aspects of the health care system, such as statins (cholesterol-lowering drugs that reduce the risk of heart disease) expenditure, if smoking cessation interventions were a routine part of health care. It was produced with the support of the World Health Organization (WHO) Europe Partnership Project *(21)*. At the end of 2002 one year's extra funding – the fourth year – was announced, thus extending the project to March 2003.

Despite the formidable challenge of setting up a brand new treatment service nation-wide, progress was rapid. By the end of 1999, just 9 months after the official start of the new services, 137 new staff (mainly cessation

counsellors but also managers – many of whom were also cessation counsellors) in England were already in post. This was a remarkable achievement in such a short time, considering the need to move the money to the health service, advertise for new staff, appoint them, and train them. At the time of this writing (late 2002) the services have some 500 paid staff, with many more primary care professionals who have been trained to give smokers support as part of their wider work.

The Government spent £53 million ($US 80 million) on the new services in their first three years (this does not include expenditure on pharmaceuticals) and up to £20 million ($US 30 million) more in the fourth year, which is still in progress at the time of this writing *(22)*.

A crucial part of the smoking cessation services was the offer of effective pharmacotherapies. The evidence shows that in any setting pharmaceutical treatment (nicotine replacement therapy and/or bupropion) approximately doubles success rates *(16), (17)*. The chronology of policies on these medications is outlined below.

## Smoking cessation pharmacotherapies

Nicotine replacement therapies (NRTs) had been licensed in England since 1982, when nicotine gum was introduced as a prescription-only medicine. Unfortunately, the Advisory Committee on Borderline Substances at the time decided that the gum was a "borderline substance" (not a truly medicinal product with clinical or therapeutic value), which meant that the gum should not be available on reimbursable NHS prescriptions. Only private prescriptions were therefore allowed (in which the patient pays the full price apart from Value Added Tax). When 'blacklisting' (when the Government blacklists a medicine it specifically excludes it from being prescribed on the NHS) was introduced, the nicotine gum was automatically added to it. In 1991, the gum became available in pharmacies over-the-counter (OTC). As the newer NRT products were introduced to the market they continued to be 'blacklisted' and although the criteria changed slightly, they were still not considered a priority for the use of limited NHS resources *(23)*. Researchers and practitioners advocated strongly that NRT should be available on the NHS; indeed, this had been advocated for almost 20 years *(24)*. Most of the other NRT products also became available through pharmacies.

The White Paper acknowledged the effectiveness of NRT but only allowed one week's supply of NRT to be given free to those smokers least able to afford it, who were attending the services. This was done through a voucher scheme, which was criticized because of the time and resources needed to implement it, but also because while it was a modest step forward, it was less than justified on clinical and cost-effectiveness grounds. It ignored the fact that most smokers do not use enough NRT and for long enough when they attempt to quit. Lobbying for proper reimbursement therefore intensified, led by ASH *(23)*.

Bupropion is an anti-depressant that has been on the market in the United States of America for over ten years, and was discovered serendipitously to increase cessation in smokers. Thus, it is an entirely different class of drug from NRT. When it was introduced in the United Kingdom in June 2000, it was made available on NHS prescription, creating a disparity between the way two effective smoking cessation pharmacotherapies were treated. This had a disruptive effect on the treatment services. Finally, in April 2001, almost 20 years after it was first licensed for use in England, NRT was also made available on reimbursable NHS prescriptions. This is crucial for poorer smokers. Although there is a prescription charge for those who can afford it (about £6 or $US 9.00) almost 80% of all prescriptions are free to users, usually because of their economic status. This means that, in effect, making NRT and bupropion available on NHS prescription makes it free to smokers who would otherwise have difficulty affording it.

In 1999, the 2-milligram gum was given a general sale license, meaning it also became available in non-pharmacy outlets like shops, supermarkets and petrol stations. This had been advocated by many health organizations *(4)*, to enable cost-effective treatments to be as accessible and available as cigarettes. In May 2001, other NRT products were added to the general sale list.

In summary, in the United Kingdom there are currently two types of pharmaceutical smoking cessation treatments (and seven products) available: nicotine gum, the nicotine patch, the nicotine inhalator, nicotine nasal spray, nicotine lozenge, nicotine sub-lingual tablet, and bupropion. Some are available through three routes (NHS prescription, from a pharmacist (OTC), general sale, e.g. supermarket) but bupropion is prescription only:

- All of them are now available through the NHS on prescription.
- All NRTs are available in pharmacies, where they can be bought under the supervision of a pharmacist (OTC).

— Some NRTs are also available on general sale, which means any shop can sell them: 2-milligram and 4-milligram gum, all the patches, and the 1-milligram lozenge.

Thus since 1998 and the launch of the Government's smoking cessation services, there have been several significant policy changes regarding smoking cessation medications. While these were warmly welcomed from the tobacco control community, the piecemeal nature of their introduction created difficulties for those running the services.

## Description of treatment services in England

At the time of this writing, in late 2002, every health authority in the country offers treatment to dependent smokers who want help in stopping through the National Health Service. This means that the treatment is free to all users (although partial payment can be required for the pharmacotherapies as described above). Each local service has a coordinator, whose role is that of service manager, although many of them also do some cessation counselling. Under them the coordinator has counsellors trained and paid to help smokers stop, and most services have also trained primary care nurses (and others like pharmacists) to include counselling of smokers within their wider work.

Exact service models vary according to local conditions, especially depending on population spread. However, in its official guidance on how to set up the services, the Government urged the services to base themselves on the evidence base which, *inter alia*, meant they should not offer treatments that do not work. One model, found more in cities, has a core central clinic where specialist counsellors run groups that offer behavioural support plus pharmaceutical aids, with satellite clinics also offering groups run in the community. This central service trains and supports community counsellors, often nurses, who offer smokers support usually in primary care settings. Other services offer both group support and individual (one-to-one) counselling in a variety of settings throughout their communities. A third service model offers all smokers individual counselling, by trained nurses, in their own primary care centre/general practice. This latter model is typically found in rural settings. Almost all services offer group and individual support backed up by pharmaceutical treatment – NRT and/or bupropion. Smokers are encouraged to take advantage of the behavioural support offered. This maximizes cessation rates and means higher success rates than would be achieved if they only used pharmaceutical products. Thus, at the heart of the system is behavioural support, in groups or individual, which typically consists of support, teaching coping strategies and providing encouragement and help in the use of smoking cessation pharmacotherapies.

One of the original rationales for treatment guidelines and for the services proposed by them, was to engage the entire health care system in treating addicted smokers, by ensuring that when general practitioners raise the issue and advise smokers to stop, they can refer them to specialist treatment. In effect, the idea was to make tobacco dependence treatment like the treatment of any other condition in the NHS: primary care acts as initial point of contact and advice (it has been called the gatekeeper role) and then refers to specialist treatment when necessary. In Britain this had been true for many years for those addicted to illicit drugs and to alcohol, but nicotine addicts were excluded from such help.

A key role of the smoking cessation coordinator was therefore to promote the services to primary care staff (particularly general practitioners) and to offer training and support to these healthcare professionals. Involving general practitioners and other primary care staff in the treatment of nicotine dependence is important for two reasons. First, this advice triggers quit attempts in smokers, and although only a small percentage will stop as a result, this is an important effect since general practitioners can reach so many more smokers than could be reached through intensive support alone *(25), (26), (27)*. Secondly, although smokers can self-refer to the services, a greater throughput will be achieved if general practitioners and other primary care staff also refer or recommend smokers to the services.

This model of care is now beginning to be achieved but a few cautionary statements are in order. First, when NRT and bupropion could be prescribed, it became easier to encourage general practitioners and other primary care staff who can prescribe, to play a greater role in intervening with smokers. Secondly, most attention focused initially on specialist support. This was because recruiting and training the specialist staff had to take precedence, but also because of the way the monitoring and evaluation were set up, such that only those smokers who set a quit date and received specialist support counted towards the

targets. Thus, there still remains work to be done in fully engaging general practitioners and their staff.

Finally, tobacco dependence treatment has not yet been truly "normalized" within the system. This is because the system of funding the NHS is being changed, with control being devolved to a more local level – to primary care groups (serving a population of around 200 000). This means that from April 2003 onwards, primary care groups will take over the funding and running of these services, and the Government's mechanism for encouraging them to do so is the setting of targets – cessation targets for example. It remains to be seen, therefore, how fully, or in what form these services survive. The Government initiative has certainly raised the profile of tobacco dependence treatment hugely, but not in itself normalized it.

## Success of the treatment services

The Government insisted on the services monitoring their throughput and outcome from the beginning and has published bulletins periodically. From April 2001 to March 2002, the third year of the services, 220000 smokers came to the services and set a date for stopping smoking (the base for all outcome statistics). Of these 120000 said they had stopped smoking four weeks later, an increase from 65000 the previous year *(22)*. During the second year of the services going nation-wide there were around 500 new staff. Using conservative assumptions, the cost effectiveness of the new services was estimated at just over 600 per life year gained for treated smokers aged 35 44 years and 750 for those aged 45 54 years (28). These figures are consistent with estimates published with the original national guidelines (6). In addition to the collection and publication of official statistics, the Government also commissioned a research team to conduct a detailed evaluation of the services. This project is ongoing and will publish a series of papers reporting the impact of the services, including how well they are reaching smokers, especially low-income and pregnant smokers. Although the data are not yet available the Government intends that they will be published in full, in a scientific journal, and presented at the 12th World Conference on Tobacco or Health, in Helsinki, in August 2003.

## Discussion

To what extent can this English/United Kingdom experience be reproduced in other countries? It grew within a tradition of relatively well-funded addictions research and health education. It also had the active support of the campaigning organization ASH and the medical professions over more than 30 years. Successive Governments accepted, at least in principle, the desirability of combating tobacco (and of raising revenue from it by increasing taxes, which has been shown to increase demand for the treatment products *(29)*). In addition, it benefited from the existence of a national health service, with a relatively well-developed infrastructure. And of course this story took place in a wealthy country. Can any aspects of this experience be exported?

From an historical perspective the role of the medical profession was critical. The Royal College of Physicians (RCP) (which created ASH) and later the British Medical Association campaigned vigorously over decades and provided crucial health and scientific information. The series of RCP reports was extremely influential. The national treatment guidelines published by the HEA in 1998 were not only evidence based, but were also formally endorsed by more than 20 professional organizations, especially medical and nursing bodies. Getting this endorsement took time and money but almost certainly enhanced the authority and influence of the resulting document.

The United Kingdom story also depended on the fusion of several strands at a crucial time (a new Government promising action against tobacco) and on some of the personalities involved. Obviously, the personalities cannot be reproduced, nor can the Government, but at a crucial time there were key people outside and inside the Government who were knowledgeable about tobacco addiction, who were committed to taking things forward, and who learned to work together. It seems unlikely that things can move forward without enough committed individuals – one of their key roles being to present the case to Government.

The effectiveness and cost effectiveness evidence was critical and influenced the Government to act. This can be reproduced elsewhere if committed individuals and organizations persist in making the case, backed up by good data. Treating dependent smokers is one of the most cost-effective interventions that a health service can deliver, which means that if health care systems offer such services, they will eventually release resources (no longer needed to treat lung cancer for example) for other uses. In spite of this, when the United Kingdom Government was developing plans for the treatment services, their Finance Ministry insisted on careful estimates of how much the services would cost. So another key point is that tobacco

dependence treatment services are relatively cheap (they do not, for example, require enormously expensive high-tech equipment).

Although not all countries will be able to afford all the elements described here, the research does not need doing again everywhere, and much of the expertise is exportable. There are several countries now implementing treatment for tobacco dependence, and thus there are more and more people capable of helping (including with training).

## Lessons learned

— *Present the evidence and arguments until they are accepted*. The English experience suggests this can be done. Since funding will always be an issue, the effectiveness and cost-effectiveness evidence and arguments are crucial. In England, smoking costs the health service about £1,500 million each year. The smoking treatment services are costing approximately £25 million a year. Funding smoking cessation interventions will have a knock-on effect and reduce other healthcare expenditure. The anomalous position of nicotine addiction compared with the provision of treatment for other addictions might also be highlighted.

— *Obtain necessary government commitment to develop a treatment system nationally*. In England this took many years. However, it need not take so long in other countries since much of the evidence and arguments are available from other countries' experience. For example, WHO's Europe Partnership Project in partnership with the British Government, *The case for commissioning smoking cessation services (18)* , could be adapted by other countries.

— *Work with doctors at as high a level as possible and benefit from their influence*. The voice and involvement of the medical profession was crucial in Britain, so the lesson to smoking cessation specialists and campaigners is work with doctors at as high a level as possible and benefit from their influence. If they first need educating then do that first.

— *Work together and share the load*. This includes researchers, campaigners, health professionals and government officials. This may sound obvious but it doesn't always happen. No one organization or group can do everything. In England a number of mistakes were made that could have been avoided with more sharing of expertise and foresight.

— *Learn from experience and do it even better*. In England a number of problems that could have been avoided slowed progress:

- Set standards for and plan training, increasing capacity if necessary. There were no national standards governing training and no control over its quality or quantity, yet a huge training capacity was a predictable requirement of the project.
- Standardize the provision of pharmaceutical treatments and make them as widely available/accessible as possible. This also means make them affordable. When the project started, neither NRT nor bupropion was available on NHS prescriptions. Their introduction on prescription, as well as being made more widely available over the counter and through general sale, was done in a piecemeal way; again the need for widely available pharmaceutical aids was totally predictable.
- Give the new services time to become well established. An enterprise as huge as this takes time to develop, but the short-term funding promised caused recruitment difficulties and staff losses. We suggest that whatever initiative or level of funding a country proposes to develop treatment for tobacco dependence it should have at least five years guaranteed development to promote stability and commitment from its staff.
- Whereas targets for numbers of smokers quitting through the smoking cessation services can be helpful, care needs to be taken that this does not create a tension between throughput and reaching priority groups. In England, the key priority group was the more deprived smoker who may be more dependent and therefore more in need of help.

— *Make appropriate investments*. Up to £50 million was announced by the Government for educational programmes and up to £60 million for treatment systems. There has been some debate as to whether this balance of investment is the right one. It is important that a significant investment be made in developing smoking cessation services, but it is vitally important to maintain the wider tobacco control strategy with appropriate investment made in other areas, such as mass media campaigns. Certainly countries that do not yet have population approaches to motivating smokers to stop will probably not want to start by developing treatment services.

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# Tools for Advancing Tobacco Control in XXIst century:

Success stories and lessons learned

# Outils pour poursuivre la lutte antitabac au XXIe siècle:

Expériences concluantes et nouveaux enseignements

WHO/NMH/TFI/FTC/03.6

PH-15.6

# Taxation (including Smuggling Control

## Report on Smuggling Control in Spain

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# Report on Smuggling Control in Spain

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## Introduction

Tobacco smuggling has become a critical public health issue because it brings tobacco on to markets cheaply, making cigarettes more affordable and thus stimulates consumption. The result is an increase in the burden of ill health caused by its use. According to the tobacco trade report *World Tobacco 2002* a major feature of the world cigarette market is the continued growth in smuggling and counterfeit trade, which accounts for a minimum of 8% of the world cigarette consumption at around 400 thousand million pieces.*(1)*

Smuggled tobacco products represent both a threat to public health and to government treasuries, which are losing thousands of millions of dollars or euro in revenue.

Smuggled cigarettes became a major concern for governments and international organizations such as the World Health Organization, the World Customs Organization, the World Bank, the International Monetary Fund and the International Criminal Police Organization (Interpol). At a conservatively estimated average tax of US$ 1.0025 to US$ 1.50 per cigarette pack (this is much higher in most developing countries) cigarette smuggling (20 thousand million packs) accounts for US$ 25 to US$ 30 thousand million being lost by governments every year.

The tobacco industry has argued that tobacco smuggling is caused by market forces—by the price differences between countries, which create an incentive to smuggle cigarettes from "cheaper" countries to "more expensive" ones. The industry has urged governments to solve the problem by reducing taxes, which will also, it says, restore revenue. The facts contradict all these assertions. Smuggling is more prevalent in "cheaper" countries and, where taxes have been reduced, such as in Canada, consumption has risen and revenue fallen. There are, however, countries that have solved the problem by better control, Spain being the most impressive example to date. There are two main reasons why the example of Spain in terms of combating smuggling is impressive:

- The country had a huge smuggling problem, despite low prices.
- It effectively reduced smuggling without reducing prices

### A huge smuggling problem, despite low prices

Joossens and Raw (1998, 2000, 2002) showed that tobacco smuggling defies apparent economic logic. Common sense might suggest that cigarettes would be smuggled from countries where they are cheap (southern Europe, for example) to expensive countries (such as northern Europe) and that this is due simply to price differences between these countries, as the tobacco industry claims. Although this does happen, it is not the largest type of smuggling, and in Europe there is far more smuggling from north to south rather than the reverse.*(2)*

Using 1995–1997 data on nine countries from the European Confederation of Cigarette Retailers and other sources, Joossens and Raw classified the 15 European Union (EU) countries and Norway as follows: *high-smuggling countries*, with a contraband market share of 10% or more (Spain 15%, Austria 15%, Italy 11.5%, Germany 10%), *medium-smuggling countries*, with a contraband market share between 5% and 10% (Netherlands 5-10%, Belgium 7%, Greece 8%, and probably Luxembourg and Portugal, but no studies are available), and *low-smuggling countries*, with a contraband market share of less than 5% (France 2%, the United Kingdom 1.5%, Ireland 4%, Sweden 2%, Norway 2%, and probably Denmark and Finland, but no studies are available).*(2)* The results can be seen in Table 1. (Note that the situation has changed in a number of the countries since the study was done.)

Table 1

**Prices of cigarettes (in US$, June 1997) and level of smuggling (1995) into countries of the European Union**

| Country | Price | Level of smuggling |
|---|---|---|
| Spain | 1.20 | high |
| Portugal | 1.75 | medium* |
| Greece | 2.06 | medium |
| Italy | 2.07 | high |
| Luxembourg | 2.12 | medium* |
| Netherlands | 2.43 | medium |
| Austria | 2.69 | high |
| Belgium | 2.95 | medium |
| Germany | 3.02 | high |
| France | 3.38 | low |
| Finland | 4.26 | low* |
| Ireland | 4.27 | low |
| United Kingdom | 4.35 | low |
| Denmark | 4.55 | low* |
| Sweden | 4.97 | low |
| Norway | 6.27 | low |

**Notes:** The table shows the price (in US$ at 1 June 1997) of 20 cigarettes from the most popular price category. Sources for prices are the Commission of the European Communities and the Norwegian Council on Tobacco and Health.

* Probably details of how this index was constructed are given in the text

The correlation between high prices and high levels of smuggling claimed by the tobacco industry simply does not exist. In fact, countries with very expensive cigarettes do not have a large smuggling problem. Table 1 shows high levels of cigarette smuggling in the south of Europe rather than the north. Other factors than price levels that make cigarette smuggling more likely include corruption, public tolerance, informal distribution networks, widespread street-selling, and the presence of organized crime.

## Effective reduction of smuggling without reducing prices

Spain is one of the few countries in the world to have tackled smuggling successfully. It did not do so by reducing tobacco tax. Despite Spanish cigarettes being among the cheapest in the European Union, smuggled cigarettes had an estimated market share of 15% in 1995.*(3)*

According to the EU lawsuit against Philip Morris, RJ Reynolds and Japan Tobacco, filed on 3 November 2000 in New York under the United States Racketeering Influenced and Corrupt Organization Act (RICO), Spain has been a primary destination for smuggled *Winston* cigarettes for so long that the smugglers are sometimes known as "Winstoneiros". According to the EU lawsuit, because of the way RJR mark and label their cigarettes, the company could identify which smuggled RJR cigarettes in the marketplace had been originally supplied by RJR USA, and which were smuggled into the country by persons without authorization of RJR.

As the demand for *Winston* in Spain rose through the 1990s increased numbers of "lower quality" *Winston* from other sources were being smuggled into Spain, interfering with the smuggling authorized by RJR. According to the EU complaint, RJR took steps to prevent the unauthorized smuggling. They developed a particular presentation of Winston cigarettes known to the Spanish consumer as *patanegra*. The *patanegra* presentation could be distinguished from the other "lower-quality" Winstons by distinctive markings and because they did not have the blue sticker found on most Winston cigarettes.

It was alleged that RJR produced the *patanegra* presentation specifically for their best smuggling customers, to insure that they could maintain their competitive advantage over other smugglers and so that RJR could increase their market share (because if you can guarantee good quality you will sell more and increase market share). The *patanegra* presentation was developed specifically for the Spanish market and sold only in Spain. According to the EU lawsuit, it was one of the examples that showed how RJR maintained and exercised control of the smuggling operations in Spain.*(4)*

Another source of smuggled cigarettes in Spain and the EU was Andorra. In a 1992 BAT internal tobacco industry document, the illegal cigarette trade in Andorra was described in the following way:

"Smuggling is a traditional and highly lucrative trade in Andorra. The growth has increased rapidly in recent years as Andorran supply has replaced that which used to enter Spain by sea and has been subjected to increased controls because of the links with the drugs trade." *(5)*

Between 1997–1998 there was concerted action at national and European levels to reduce the supply of contraband cigarettes. Close collaboration among the authorities in Andorra, Britain, France, Ireland, Spain and the European Anti-Fraud Office (OLAF) reduced the supply of smuggled cigarettes from Andorra. Actions included sealing the Andorran border, and having civil guard brigades patrol valleys and hills to make smuggling more difficult. The European Anti Fraud Unit led a first mission to Andorra in March 1998, accompanied by representatives from the neighbouring countries (France and Spain) and from cigarette exporting countries (Ireland and the United Kingdom). The enquiries revealed a lack of appropriate legislative instruments in Andorra to prevent and combat fraud. In November 1998 a EU Commission mission visited the Andorran Government and found that attitudes had changed fundamentally. The laws on customs fraud and the control of sensitive goods and the law amending the criminal code and making smuggling a crime were published respectively in the Andorran Official Journal on 4 March 1999 and 7 July 1999.*(6)*

As a result, contraband cigarettes which had accounted for an estimated 12% of the Spanish market in early 1997, held only 5% by mid-1999[1] and only an estimated 2% in 2001. Sales of legal cigarettes increased from 78 thousand million in 1997 to 87 thousand million in 1998 (see Table 3), and tax revenue increased by 25% in the same year (see Table 2). According to the Spanish customs authorities, their success was not due to controlling distribution at street level, which is almost impossible, but to reducing the supply into the country at "container level" through intelligence, customs activity and cooperation, and technology[2].

**Table 2**

**Excise revenue from cigarette sales in Spain, 1996-2000 (billion Pesetas)**

| | |
|---|---|
| 1996 | 443 |
| 1997 | 516 |
| 1998 | 646 |
| 1999 | 667 |
| 2000 | 742 |

Source: Spanish Customs and Excise

**Table 3**

**Cigarette sales in Spain (thousand million pieces)**

| | |
|---|---|
| 1996 | 72 |
| 1997 | 78 |
| 1998 | 87 |
| 1999 | 86 |
| 2000 | 88 |
| 2001 | 90 |

Source: Comisionado del Mercado de Tabaco

Andorra is important because it illustrates the role of the tobacco industry. Andorra was not only supplying illegal cigarettes to the Spanish market but also to the United Kingdom. Exports from the United Kingdom to Andorra (which has a population of only 63 000) increased from 13 million cigarettes in 1993 to 1 520 million in 1997. Since few of these cigarettes were legally re-exported and Andorran smokers do not generally smoke British brands, then either each Andorran (including children and non-smokers) was smoking 60 British cigarettes a day in 1997 or these cigarettes were being smuggled out of Andorra. It seems obvious that the companies would know what was happening to their cigarettes. In a television interview on the BBC's *Money Programme* of 8 November 1998, a spokesperson for the tobacco company (Gallaher) said: "We will sell cigarettes legally to our distributors in various countries. If people, if those distributors subsequently sell those products on to other people who are going to illegally bring them back into this country, that is something outside of our control." *(7)*

## Discussion

The tobacco industry has often claimed that smuggling is more prominent in high-tax countries and that the best way to tackle cigarette smuggling is by reducing the demand and by lowering taxes. In fact, cigarette smuggling

[1] (Ignacio Garcia, Customs and Excise, Madrid, personal communication)

[2] (Ignacio Garcia, Customs and Excise, Madrid, personal communication)

occurs in all parts of the world, even in countries where prices are low. Spain had the lowest cigarette prices in the EU and still had a huge smuggling problem. Cigarette smuggling in Spain was not caused by the demand of smokers in search of cheaper cigarettes, but by the illegal supply of international cigarette brands on the Spanish market.

Fortunately, the Spanish experience shows also that coordinated action to stop the illegal cigarette supply can solve the smuggling problem. The proportion of smuggled cigarettes in the Spanish market was reduced dramatically and revenue was increased, without lowering taxes, whereas tax reductions produced disastrous results – lower revenues and a sharp increase in consumption, especially among young people – in Canada. *(3)* Governments need to acknowledge that smuggling is, to large extent, a supply-driven process and that manufacturers exercise a large degree of control over their end markets, both legal and illegal, as testified to by many documents from the Guildford archives.*(8)* What follow logically from this, is the need to cut off the supply of cigarettes to the smugglers.

Economic analysis of the effect of cigarette prices in Spain and the analysis of smoking histories from the national health survey 1993-1995-1997 has shown that the price increase of black cigarettes had a significant effect on prevalence, but the price increase of blond cigarettes did not.*(9)* Smuggling may be an explanation for this difference between the effect of price increases of blond and dark cigarettes as smuggling of cigarettes in Spain occurred mainly with blond (Winston) cigarettes, which were promoted on the illegal market as "high-quality cigarettes" (the so called *Patanegra* Winstons). The ready availability of lower-price smuggled blond cigarettes undermined the effect that price increases of legitimately sold cigarettes should have had.

While the success of the fight against smuggling in Spain was evident, the impact of the reduction of smuggling on smoking prevalence is unclear. Smoking prevalence among women remained stable at 27% in 1995 and 2000-2001, but decreased among men from 47% in 1995 to 42% in 2000-2001.*(10)* It is unclear whether the decline of smoking among men is linked to the reduction of cigarette smuggling, but it might be, since the action against smuggling greatly reduced the ready supply of cheap Winstons available to consumers.

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**Tools for Advancing Tobacco Control in XXIst century:**

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# The Surveillance and Monitoring of Tobacco Control in South Africa

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# The Surveillance and Monitoring of Tobacco Control in South Africa

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## Introduction

South Africa is situated at the southernmost tip of Africa and is divided into nine provinces: Western Cape, Eastern Cape, Northern Cape, KwaZulu-Natal, Free State, Gauteng, Mpumalanga, Limpopo Province and North West Province. It has a population of approximately 43 million, half of whom are under 19 years of age.*(1)* South Africa is considered a middle-income, developing country and has extremes of wealth and poverty due to 350 years of colonialism and apartheid[1]. Almost 78% of the population are "Black/African" *(1)* and they represent the majority of those living in poverty.*(2)* About 72% of the poor live in rural areas. *(2)* There are 11 official languages in South Africa.

The history of tobacco control in SA dates back to the 1970s when tobacco use was banned in cinemas, followed by a ban on smoking on domestic flights.*(3)* In 1993 the first Tobacco Products Control Act *(4)* was passed and was implemented in 1995. It regulated smoking in public places, prohibited tobacco sales to minors under the age of 16 and regulated some aspects of advertising of tobacco products such as labelling. It was not a comprehensive act in that it had the following shortcomings: radio advertising was still allowed; smoking in public places was not banned completely; the definition of a public place was not specified, and no enforcement mechanism was built into the act. In 1995, health warnings were introduced for all tobacco packaging and tobacco advertising on billboards. Due to the shortfalls of the 1993 Act, the Tobacco Products Control Amendment Act was passed in 1999.*(5)* It primarily bans all advertising and promotion of tobacco products, including sponsorship and free distribution of tobacco products; it restricts smoking in public places, including the workplace and public transport; it stipulates penalties for transgressors of the law, and specifies the maximum permissible levels of tar and nicotine. The regulations were implemented in 2001.*(6)*

During the 1990s, there was a concerted effort by the research community to alleviate the risks associated with tobacco-use by collecting data on the extent of its use. Reddy and associates *(7)*, in a study carried out in February 1995, reported that 34% of adult South Africans, or a total of seven million adults, smoked.

A household survey in 1996 showed that the overall smoking prevalence among adults remained at 34%. However, there had been an increase in the prevalence of smoking among adults in five provinces when compared to the prevalence rates of the February 1995 survey.*(8)* The smoking prevalence analysed by "race" and gender showed that the rate had increased for "Coloured", "Indian" and "White" males; and for "Black/African" "Indian" and "White" females. From February 1995 to October 1996, smoking prevalence in the 18-24 age group increased from 31% to 36%.

By 1998, Meyer-Weitz *et. al (9)* reported that the smoking prevalence rate for adults had dropped to 25%. This is consistent with the smoking rate of 24.6% obtained from the South African Demographic and Health Survey (SADHS).*(10, 11)* According to the All Media and Product Survey (AMPS), smoking prevalence decreased from 32.6% in 1993 to 27.1% in 2000.*(12)* The dramatic decrease in smoking prevalence from 34% in 1996 to 24.6% in 1998 registered by SADHS could possibly be attributed to the introduction of health warnings on cigarette packages and all tobacco advertisements, together with the extensive media coverage that the impending tobacco control legislation received during that period. Media coverage in particular revolved around debates concerning the pros and cons of the intended legislation. Strong arguments were put forward by government, NGOs, and researchers via the media as to the health, economic and social benefits of comprehensive tobacco control legislation. In addition, the consistent increase in tobacco excise tax may also have had an impact on the prevalence of smoking.

In 1999, the Global Youth Tobacco Survey *(13)*, the first nationally representative study on tobacco use among adolescents was conducted in SA. About 23% of the sample reported being current smokers (smoked cigarettes at least one day in the 30 days preceding the survey). Some 18.5% of students reported first smoking cigarettes before the age of 10. Almost a fifth of the sample (18.2%) had

[1] During the apartheid years, all South Africans were classified in accordance with the Population Registration Act of 1950 into "racial groups" namely "Black/African"(people mainly of African descent), "Coloured" (people of mixed descent), "White" (people mainly of European descent) or "Indian" (people mainly of Indian descent). The provision of services occurred along these "racially" segregated lines. The disproportionate provision of services to different "race groups" led to inequities. Information is still collected along these "racial" divisions in order to redress these inequities. In no way do the authors subscribe to this classification.

used tobacco products other than cigarettes such as chewing tobacco and snuff.

Tobacco-related morbidity and mortality is monitored by using the data from the National Cancer Registry. Data collected for 1993-1995 showed that lung cancer among "White" women was not in the top five types of cancer before 1992 but, by 1995, it was fourth. *(14)* With regard to "Black" women, lung cancer featured fifth in 1995 but previously had not been one of the major forms of cancer among them. *(14)* Lung cancer among "Coloured" women was ranked second, and fifth among "Indian" women.*(14)* Between 1993 and 1995, lung cancer was the third most common cancer in "Black" males and the second most common in "Coloured" males.*(14)* It was the fourth most common in "White" males and the third most common in "Indian" males.*(14)* However, by 2000, trends showed a stabilisation of tobacco-related cancers.*(15)*

Tobacco-related mortality is also monitored by the new death notification system. This new system was implemented in 1998 and records the smoking history of the deceased. A 5% sample of 13000 forms was used to conduct a case control study.*(16)* It showed significantly increased relative risk of death due to lung (RR=3.3), oesophageal (RR=4.1), stomach (RR=2.2) and digestive diseases (RR=1.6), tuberculosis (RR=2.5) and other lung diseases (RR=1.6) among the deceased who had smoked 5 years prior to their death.*(16)*

## Surveillance of Tobacco in South Africa

South Africa has a short history with regard to the establishment of surveillance systems and mechanisms for monitoring tobacco use. Even though policy development in South Africa preceded the establishment of surveillance systems, continuous monitoring and evaluation systems must be in place so that scientific data can be used to justify amendments to the policy and programmes. However, in the absence of these systems, tobacco was included as part of other surveillance mechanisms. In this way trends in tobacco use and tobacco-related morbidity and mortality were measured over time.

### The Cancer Registry

The National Cancer Registry, which was established in 1986, is a co-operative venture of the Department of Health, the Medical Research Council, the Cancer Association of South Africa, the National Health Laboratory Services and the University of Witwatersrand; it is also funded by these institutions.*(14)* The National Cancer Registry was set up in the absence of a Population Based Cancer Registry. It collects information from approximately 70 private and public histology, haematology and cytology laboratories. The information is based on histologically verified cancers including those caused by tobacco use. This information is sent on a voluntary basis and thus at irregular intervals.*(17)* The data are extracted from the pathology report. This report is not standardized and varies from laboratory to laboratory. Data collection covers cases from all age groups. The essential items of information collected are: name, date of birth, age, date of diagnosis, method of diagnosis, primary site of cancer, morphology, extent, gender and ethnic/population group, and usual home address.

### The Household Surveys

The inclusion of tobacco-related questions in the Household Survey dates back to 1994. These questions were included to gather information on tobacco use among South African adults between 1994 and 1998. The questionnaire was put by the interviewer to adults aged 18 and older at the respondents' home. The survey was conducted twice a year, in February and October. Smokers were defined as those who smoked one or more cigarettes, pipes or cigars per day; ex-smokers were defined as those who had smoked at least once a day and stopped for a period of six months and non-smokers were defined as those who never smoked or smoked less than one cigarette a day. In the February 1996 survey, the definition of smoking status used was worded slightly differently but it also categorised participants as smokers, ex-smokers and non-smokers.*(9)* This survey has been discontinued.

### All Media and Product Survey (AMPS)

The All Media and Product Survey (AMPS) is conducted by the South African Advertising Research Foundation in order to generate data about consumer trends in advertising and the mass media as well as in product usage.*(18)* The AMPS survey is carried out in the adult population of South Africa aged 16 and over. The questionnaire is administered by interviewers in the participants' home. The study is conducted at least once a year using the same questions. Those are limited to tobacco usage (they do not investigate attitudes towards tobacco use), to tobacco control policies, smoking initiation and exposure to second hand smoke. Smokers are defined as those individuals who spend money on cigarettes.*(19)* The tobacco-related

questions are not standardized but are repeated without changes each year. The study is funded by the South African Research Foundation, which receives an annual endowment from the Marketing Industry Trust (MIT). MIT is in turn financed through an industry levy on advertising expenditure that is collected by media owners.*(18)*

### Death Notification

As part of the Vital Registration Infrastructure Initiative, a new death notification form was approved by the government in July 1998 and adopted in September 1998.*(20)* A question on the smoking status of the deceased, "Was the deceased a smoker five years ago?", was included in the form. This question was added in order to collect information on tobacco-related mortality. The tobacco-related information was evaluated in a case-control study that involved a 5% sample of death notification forms.*(16)* A 15% sample of death notification forms will be analysed in 2003.*(17)* It is envisaged that the data collected will be analysed on a 2-3 year cycle.*(17)*

### South African Demographic and Health Survey (SADHS)

The first nationally representative South African Demographic and Health Survey was conducted in 1998 to provide accurate baseline data on a range of demographic and health indicators including chronic health conditions and lifestyles that affects health status.*(10)* The study was primarily funded by the National Department of Health, with contributions from Macro-International and USAID. It is envisaged that this survey with interviewer-administered household questionnaire will be repeated in South Africa every five years.*(21, 22)* The tobacco-related questions were derived from the 1998 WHO Guidelines for controlling and monitoring the tobacco epidemic.*(10, 23)* The questions covered adult smoking patterns, their opinions on the health effects of tobacco use and their exposure to environmental tobacco smoke in the home and at the workplace.*(10, 11)* Participants were also asked about their exposure to smoke, dust, fumes or strong smells at their workplace. Data on tobacco-related morbidity was also collected: the symptomatology of chronic bronchitis, which was based on four standardized questions on chronic productive coughing; airflow limitation (asthma) was measured using four standardized questions on wheezing and chest tightness, and peak expiratory flow rate was also measured for each participant. Questions were asked on other tobacco-related illnesses, including tuberculosis, emphysema and cancers. The questionnaire was administered to adult household members aged 15-49.

The following definitions of smoker categories were used:

- regular smokers: adults who smoked daily or occasionally;
- daily smokers: adults who smoked daily at the time of the interview;
- light smokers: daily smokers who smoked 1-14 tobacco equivalents per day (one tobacco equivalent was calculated as one manufactured cigarette (1g), one handrolled cigarette (1g), one pipe smoked (1g: conservative estimate of the amount of tobacco smoked in pipes), one cigar, cheroot or cigarillo;
- heavy smokers: daily smokers who smoke 15 or more tobacco equivalents per day;
- ex-smokers or quitters: adults who reported previously smoking daily but did not smoke at all at the time of the survey;
- non-smokers: adults who had never smoked tobacco but who may have used smokeless tobacco products

Due to the large sample size of the study, it was possible to identify socio-economic and socio-demographic characteristics that are related to tobacco-use. This makes it possible to prioritize the provision of programmes to target groups in the population.

The findings of the SADHS were disseminated in the following ways:

- preliminary research report
- final report
- press releases
- journal articles
- dissemination workshops at various levels within the Department of Health.

In 2003, the SADHS will include a more robust questionnaire on tobacco use as it was developed for the Non-communicable Disease Risk Factor Surveillance (STEPS programme) by WHO.*(21)* This is necessary because of problems experienced with the ordering of questions and with low levels of literacy and numeracy. *(21)*

### Global Youth Tobacco Survey (GYTS)

The Global Youth Tobacco Survey *(13)* is a multi-country study that forms the second phase of a 3 phased project initiated by the World Health Organization's Tobacco Free

Initiative to "create a generation of tobacco free children and youth". The National Departments of Health and Education, in collaboration with the Medical Research Council, deemed it necessary to join this initiative due to a lack of nationally representative data on tobacco use among adolescents. South Africa was one of the first 13 countries to conduct this study. The 1999 study was funded by the National Department of Health, UNICEF and MRC. The research instrument was designed at a workshop convened by WHO and the CDC. It consists of a "core" set of questions to be used by all countries. The core questions included an investigation of the prevalence of tobacco use, including cigarette smoking, and current use of smokeless tobacco, cigars or pipes. The questionnaire was also meant to assess students' attitudes, knowledge and behavior related to tobacco use and its health impact, including cessation, environmental tobacco smoke (ETS), media and advertising, minors' access, and school curriculum. In addition, the questionnaire was designed to be flexible enough to include specific issues and individual needs of each of the participating countries (i.e. optional questions could be added). The GYTS is a school-based, self-administered tobacco specific survey which focuses on adolescents aged 13-15 (Grades 8-10). The study was repeated 3 years later in 2002 and was funded by WHO and MRC. The main definitions of smokers used were:

— ever smokers: those who had smoked a cigarette, even one or two puffs;

— current smokers: those who had smoked cigarettes on at least one day in the 30 days preceding the survey.

The results of the GYTS 1999 were disseminated in the following ways:

— report of research findings;

— fact sheet with summary of national and provincial results;

— posters at the national launch;

— poster presentation at the eleventh World Conference on Tobacco or Health;

— national launch held at one of the participating schools;

— press release;

— presentations to provincial and national Ministers of Health and Education;

— presentation to the National Department of Health, Occupational Health, Health Promotion and Environmental Health Cluster.

The findings of the GYTS were presented to the national and provincial Ministers of Education. This resulted in the National Department of Education declaring nicotine an addictive drug and including tobacco use in its drug policy for schools.

The purpose of repeating the GYTS in 2002 was to monitor changes in smoking prevalence within and between gender and "race" groups as well as to monitor provincial and regional trends. Monitoring the trends in underage sales of tobacco products, tobacco advertising and promotion, and exposure to second hand smoke in public places between 1999 and 2002 is particularly pertinent to South Africa. During this period, a new tobacco law that re-emphasises the ban on underage sales, prohibits all tobacco advertising and promotion, and limits smoking in public places, was enacted.

The 1999 GYTS showed a high smoking prevalence among adolescents, high percentages of smokers wanting to quit, and high relapse rates. As a result, the Medical Research Council of South Africa and Emory University, Atlanta, USA made a successful application to the National Institute of Health to fund a study that will test two school-based tobacco prevention and cessation programmes.

### Measuring compliance levels with the smoke free policy of the Tobacco Products Control Amendment Act of 1999.

This study was initiated in 2002 as a means to measure compliance levels with the newly implemented Tobacco Products Control Amendment Act of 1999 and its regulations of 2001, namely the restriction on smoking in public places in both formal and informal restaurants and pubs, and in other places of entertainment.*(24,25)* The study will be conducted in three of the nine provinces. Information will be collected by means of one-to-one interviews and telephone interviews for both the qualitative and quantitative phases of the study. The research instruments have not been standardized against any guidelines. The findings of the study will be used to develop guidelines for the monitoring and enforcement of the smoke free policy as well as to compare compliance levels between provinces.*(25)* It is intended that the study be repeated nationally on a three year cycle and that its scope will be expanded to include all public places.*(25)* The study will be conducted among smoking and non-smoking patrons as well as among owners of establishments. The questions will assess the level of compliance, reasons related to the levels

of compliance, and patrons' and owners' attitudes to and perceptions of the tobacco legislation. The tobacco control legislation and regulations in South Africa will be amended during 2003. The follow-up study will also evaluate the implementation of these amendments and compare compliance levels with the 2002 study. The South African government, through the National Department of Health, is funding the study.

### Youth Risk Behaviour Survey

The YRBS is a multi-risk behaviour study that has been conducted over the past 10 years by the CDC in the USA. Due to a lack of nationally representative data on multi-risk behaviour among young people attending schools, the National Department of Health in SA awarded the MRC a grant to conduct the first YRBS in SA during 2002.*(26)* The GYTS and the YRBS were conducted in the same schools but with different classes in the course of 2002. The self-administered questionnaire was completed by grades 8-11 (13-16 years) students. The seven tobacco questions were common to both the GYTS and YRBS questionnaires and were based on the questions developed at the global planning meeting to expand the multi-risk behaviour survey to other countries that was convened by WHO and the CDC in December 2001. Questions were asked on current use of cigarettes and tobacco products other than cigarettes, current use of smokeless tobacco, age of initiation of cigarette use, attempts to quit cigarette use during the past year, exposure to second-hand smoke during the past week, and the smoking status of parents and guardians. The study is intended to be repeated every three years. Current smokers were defined as those students who smoked cigarettes on one or more days in the 30 days preceding the survey. The findings of the study will be disseminated in the following ways:

- research report;
- fact sheets with national and provincial results;
- posters at the national and provincial launches;
- national launch of the findings;
- provincial workshops;
- press releases;
- journal articles;
- conference presentations.

### Surveillance of tar and nicotine content of cigarettes.

The Minister of Health has, in terms of section 3A of the Tobacco Products Control Act of 1993, specified the amount of tar and nicotine that is permissible in tobacco products. According to the Tobacco Products Control Amendment Act of 1999, the tar yield of cigarettes marketed in the Republic of South Africa must not be greater than 15 mg per cigarette, and the nicotine yield not greater than 1.5 mg per cigarette, as from 1 December 2001. As from 1 June 2006, the tar yield of cigarettes must not be greater than 12 mg per cigarette, and the nicotine yield not greater than 1.2 mg per cigarette. The legislation also stipulates that the tar and nicotine content of cigarettes be measured to check that they are within the values prescribed by legislation and that they comply with the values on the pack imprints.*(27)* Test House, a company affiliated to the South African Bureau of Standards (SABS), conducts the tests.*(28)* The cigarette laboratory is part of the Chromatographic Services business unit and consists of 2 staff members. Tests are conducted on all cigarettes that are legally sold on the South African market. Determination of the tar and nicotine content of cigarette smoke is conducted according to ISO 4387 [2]: determination in cigarettes of total and nicotine-free dry particulate matter is carried out using a Filtrona, linear type smoking machine, 300 series. There are currently 77 cigarette brands that are sampled every two months by SABS representatives. These test results are reported to the

[2] WHO has made recommendations (see reference 29) regarding the validity of the ISO standard as follows:

[a] Tar, nicotine, and CO numerical ratings based upon current ISO/FTC methods and presented on cigarette packages and in advertising as single numerical values are misleading and should not be displayed.

[b] All misleading health and exposure claims should be banned.

[c] The ban should apply to packaging, brand names, advertising and other promotional activities

[d] Banned terms should include light, ultra-light, mild and low tar, and may be extended to other misleading terms. The ban should include not only misleading terms and claims but also, names, trademarks, imagery and other means conveying the impression that the product provides a health benefit.

Department of Health. The cigarette laboratory is SANAS (South Africa National Accreditation System) accredited.

## Conclusions

Even though South Africa has a short history of tobacco control with few dedicated tobacco control researchers and limited resources, several mechanisms have been set up to monitor and evaluate tobacco prevalence as well as tobacco-related morbidity and mortality.

Considering that South Africa is a developing country with limited resources to allocate to tobacco-specific surveillance, the Demographic and Health Survey can fulfil this role adequately. Even though a standardized WHO questionnaire was used to measure tobacco use in this study, problems of literacy and numeracy limited the usefulness of the questions on tobacco. It is therefore recommended that questionnaires be adapted, tested and validated for the local context. The SADHS makes it possible to see the relationship between tobacco use and tobacco related morbidity as well as between co-risk factors such as exposure and occupational hazards such as dust and fumes.

An innovative and cost-effective method was employed in conducting the GYTS and YRBS in the same schools but with different classes. This decreases the amount of time required in the school and is a methodology that suits the needs of both the school community and survey administrators. The tobacco questions were standardized across both studies. This allows for comparison between the studies increasing the sample size from 15000 in each study to 30000 across both studies. If both these studies are repeated on a 3 year cycle, then South Africa will have an effective system in place to monitor trends in adolescent behaviour.

The National Department of Health should be applauded for using research as a basis to monitor and evaluate the implementation of the smoke-free policy in formal and informal restaurants and pubs. Other aspects of the legislation that could be monitored include compliance with smoke-free policies in the work place and underage sales of tobacco.

It is unfortunate that the biannual Household Survey that included tobacco-related questions was discontinued as this was an inexpensive surveillance tool to monitor trends in tobacco use on a yearly basis. This survey could have complemented the SADHS by monitoring tobacco use over a shorter period than the 5 year intervals at which the SADHS is conducted. It is recommended that the tobacco-related questions be included in other studies that are conducted nationally on an annual basis.

One of the strengths of surveillance in SA is the active participation of the government from the inception of the research project. This ensures ownership of the research process and the findings of the study. The SADHS and GYTS provide good examples of the dissemination of research findings to government and other agencies in a user-friendly manner. Both these studies are being used by the government (as a partner and funder in the research process), and by the researchers themselves, to translate the research findings into programmes and policies. However greater emphasis, and perhaps skills as well as resources, are needed to disseminate the research findings to a wider audience and to develop effective programmes. It must be noted that there usually is lack of continuity in the research process after the dissemination stage, as the researchers are not necessarily responsible, capable or funded to develop programmes.

The Cancer Registry has a formidable infrastructure for collecting tobacco-related morbidity information. In order to streamline the process, information needs to be collected on a standardized form that is shaped by international initiatives, at prescribed intervals; it should include data from many more public and private laboratories.

Including a tobacco question on the Death Notification form is an innovative and cost-effective way of measuring tobacco-related mortality. Tapping into existing surveillance structures is particularly useful in countries where financial resources are limited. However, the question needs to be piloted so that it yields useful information. The Cancer Registry and Death Notification System could maximize their usefulness by identifying deaths caused by histologically verified tobacco-induced cancers.

Standardization of questions, including definitions used, is of paramount importance for local and international comparability of studies, particularly when these show shifts in trends of tobacco use.

In South Africa, the tobacco control policy was developed and partially implemented before tobacco-specific research was conducted. Countries lacking tobacco research or research capacity could also follow this route. Ideally, local research findings should be the motivation for policy development. Once the policy is in place, research should continue in order to monitor and evaluate the implementation of the policy and guide amendments to the policy and programmes.

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# New Zealand: Effective Access to Tobacco Dependence Treatment

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## Introduction

At the beginning of 1998 New Zealand lacked tobacco dependence treatments. Only a small amount of Government funding was committed to smoking cessation programmes and it was difficult for many people to find help in quitting. Most of the cessation programmes available were offered by the private sector. These programmes were few in number, often expensive and tended to target white, middle-class smokers. There was little help available for Maori – New Zealand's indigenous population – 50% of whom smoke.

In addition, broader tobacco control measures that would indirectly support smoking cessation were lacking. Health warnings were weak, smoke-free environments largely confined to offices and public transport, and there had not been a significant increase in tobacco excise since 1991.

For several years the tobacco control community in New Zealand lobbied for a smoking cessation media campaign and the provision of help for individuals. The Government listened. In 2003, New Zealand has one of the most advanced mixes of population-level smoking cessation initiatives in the world. In five years it has gone from almost zero Government funding of smoking cessation programmes, to funding of around NZ$ 13 million per annum. This is nearly 50% of the total New Zealand tobacco control budget.[1] The initiatives include a national Quitline, subsidized nicotine replacement therapy (NRT), Maori-focused quit services including quit support and NRT for Maori women and their whanau (families), and a hospital-based quit service for inpatients and their families.

Broader measures supporting smoking cessation are also in place or planned, including stronger health warnings, a ban on point-of-sale advertising, legislation that proposes to ban or severely restrict smoking in workplaces, and significant excise increases in 1998 and 2000.

## Description of the policy interventions

New Zealand's smoking cessation landscape is made up of a number of varied initiatives, targeting different groups. It includes Government-funded organizations such as The Quit Group and private-sector services that receive no Government funding. Other services may be partially Government funded.

## The Quit Group

The Quit Group is contracted to provide Government-funded whole-population smoking cessation services in New Zealand. Programmes it manages include the Quitline, the Quit Campaign (which includes the *Every cigarette is doing you damage*, and *It's about whanau* multimedia campaigns), the Health Provider NRT Exchange Card Programme, and the *Quit for our kids* programme.

## The Quit Campaign

The Quit Campaign is a mass communications campaign and a national telephone Quitline. The Quitline was first piloted in the Waikato/Bay of Plenty region between September 1998 and April 1999 by a partnership of three organizations: the Health Sponsorship Council, Cancer Society of New Zealand and Te Hotu Manawa Maori. The region chosen for the pilot had a smoker population base of around 100000, approximately 30% of whom were Maori. 'Threat appeal' television commercials adapted from the Australian National Tobacco Campaign were screened. These commercials showed the consequences of smoking in graphic detail – images of fatty aortas and rotting lungs, for example. Smokers were given the freephone Quitline number and urged to call for help and advice. Nine thousand calls were received during the six-month pilot.

In 1999, Government funding was secured for the Quitline, and it was launched nationally in May that year. A multimedia campaign promoting the service was launched two months later. The Australian television campaign *Every cigarette is doing you damage* was continued, and an empathetic Quitline advertisement was also shown.

The campaign was particularly designed to be effective for New Zealand's Maori population. A number of Maori quit advisers were employed, and culturally appropriate Quitline services and quit materials were developed.

The Quitline and the multimedia campaigns now receive around NZ$ 3 million annually.

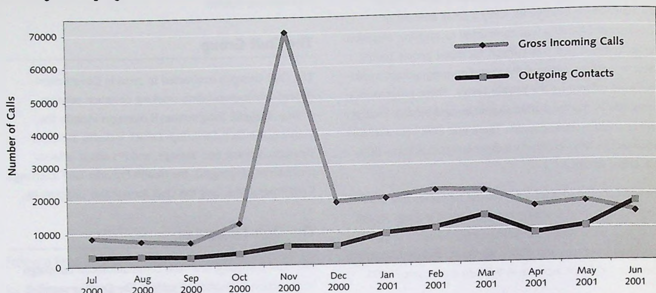
## Subsidized NRT

In November 2000, the cessation landscape in New Zealand changed significantly with the introduction

1 Personal communication, Candace Bagnall (Ministry of Health, Public Health Portfolio Manager, Auckland Locality), August 2002.

Figure 1

**Incoming and Outgoing Quitline Calls – July 2000 to June 2001**




of Government-subsidized nicotine patches and gum. Government funding of NZ$ 6.18 million per annum had been allocated to this project earlier in the year. This meant that the price of nicotine patches or gum for smokers could be greatly reduced – from a maximum of around NZ$ 136 to NZ$ 10 for a four-week supply. Since then, the price of subsidized patches and gum has been further reduced to NZ$ 5 for the first month and NZ$ 10 for the second month.

When callers contact the Quitline they are connected to a call centre. An operator offers the caller a choice of receiving a pack of quit information or being put through to a quit adviser. Callers who meet specific criteria are issued with a nicotine patches or gum 'exchange card' which they can redeem at participating pharmacies (see below). Research shows that heavier smokers are more responsive to NRT, and therefore as a general rule only those who smoke more than 10 cigarettes a day are eligible for the subsidized patches and gum. Pregnant or breastfeeding smokers, and those who have angina, palpitations or who have suffered a heart attack are asked to talk to their general practitioner (GP) about their suitability for nicotine patches and gum *(1)*.

Around 55 000 people a year have registered with the Quitline since subsidized NRT was made available in 2000.[2] This represents 7% of the smoker population in New Zealand registering each year.

Initially public demand was overwhelming, peaking at 70000 calls to the Quitline in the first month.[3] A number of major changes to the Quitline were required to cater for the huge numbers. These included moving to bigger premises, increasing staff numbers, and greatly reducing advertising and public relations activity over several months until call levels dropped. Quitline advisers also make outgoing calls (known as call-backs) offering ongoing support and advice to people undertaking a quit attempt. Call-backs had to be reduced for a time after the introduction of the subsidized patches and gum owing to the volume of incoming calls.

## Health Provider Exchange Card Programme

Another initiative, the NRT Health Provider Exchange Card Programme, allows individuals and groups with an interest in smoking cessation to distribute exchange cards directly to their clients. Exchange card recipients can then redeem the cards at participating pharmacies and receive subsidized

2 Personal communication, the Quit group, August 2002.

3 This figure includes 'hang-ups' and also those people calling more than once while the Quitline initially struggled to cope with the number of people calling.

4 Personal communication, Steeve Cook, Coordinator of the Health Provider Exchange Card Programme, the Quitline, August 2002.

| Type of NRT | Distribution | Price, subsidized (on presentation of Exchange Card)[a] | Approximate price unsubsidized |
|---|---|---|---|
| Patches | General sales medicine (can be obtained from any outlet) | NZ$ 5 for four-week supply (5 mg, 10 mg and 15 mg) | NZ$ 71.20 for four-week supply (10 mg) |
| Gum | General sales medicine | NZ$ 5 for four-week supply (2 mg and 4 mg) | NZ$ 136.80 for four-week supply (4 mg) |
| Nasal spray | Prescription medicine (can only be obtained on a doctor's prescription) | Not subsidized | NZ$ 43.71 (10 mg/ml) for one- to two-week supply |
| Nicotine inhaler | Pharmacist-only medicine (can only be obtained from a pharmacist, but a prescription is not needed) | Not subsidized | NZ$ 43.37 (10 mg starter pack and refills) for two- to four-day supply |

[a] Source: National Health Committee *(5)*.

nicotine patches and gum. All providers who wish to be part of this programme must be registered with The Quit Group, which oversees the programme. As of August 2002, around 250 health providers were registered with the service.[4] They included independent practitioner associations representing several hundred GPs, individual GPs, mainstream cessation providers (serving the general population rather than a specific population or ethnic group), and Maori health providers. more Than 40000 exchange cards have now been issued through the programme.

To guide the programme, The Quit Group has established an advisory committee consisting of professionals from relevant fields, to assist with policy decisions.

## It's about whanau

A media initiative designed by Maori to appeal to Maori smokers, the *It's about whanau* campaign was launched in August 2001. The campaign aims to motivate Maori smokers to see the benefits of quitting, not only for themselves but also for their family and friends. Maori are the priority group for the campaign because of the disproportionately high number who smoke and their high rates of smoking-related disease.

The campaign uses Maori role models to give a positive message about the benefits of quitting. It includes national television commercials and magazine and radio advertising, supported by public relations activities.

## Quit for our kids programme

*Quit for our kids* is a national programme for hospital patients, established in 2000. It aims to help parents and caregivers of children who are having hospital treatment to quit smoking. The programme operates in nine hospitals in New Zealand, with a focus on areas with a high need for smoking cessation services. The quit coaches working in each hospital provide advice, support and NRT to those parents and caregivers who want to quit. Quit coaches are also able to distribute nicotine patches and gum as part of the treatment plan. The programme will be promoted in five new hospitals in 2002. The Quit Group coordinates this programme, provides training and manages the programme evaluation.

## Aukati Kai Paipa

Aukati Kai Paipa is currently delivered by over 30 Maori health providers. The programme offers Maori women and their whanau free cessation services. Those referred are assessed for their readiness to quit *(2)*. Participants initially undertake an intensive eight-week programme using NRT and motivational counselling delivered through a minimum of seven follow-up visits. After the initial eight-week period, participants receive further follow-up visits at intervals of three, six and 12 months.

The programme has a focus on holistic health. Te Hotu Manawa Maori coordinates, trains, assists and advises the network of Aukati Kai Paipa services.

## Guidelines for smoking cessation

The Government-funded *Guidelines for smoking cessation* document was developed by a team of smoking cessation experts in 1999 and updated in 2002. The guidelines are designed for smoking cessation providers in assisting clients with smoking cessation. The document is based on comprehensive literature reviews and background information on smoking cessation.

Training in smoking cessation, following the steps set out in the guidelines, is available from several nongovernmental organizations (NGOs).

## NRT reclassified as general sales medicine

Nicotine patches and gum were reclassified as general sales medicine (able to be sold 'over the counter') in August 2000. Previously only pharmacies or smoking cessation clinics run by a health professional could sell the products *(3)*.

Nicotine nasal sprays remain a prescription medicine, while nicotine inhalers are a pharmacist-only medicine *(4)*. Nasal sprays and nicotine inhalers were not made available over the counter as it was felt that these products had a greater potential for abuse than patches and gum. It was also felt that sprays and inhalers were better suited to those who were more severely addicted and would benefit from a greater input from a medical professional.

## Quit & Win

A *Quit & Win* smoking cessation competition was piloted in 2001, and extended to five health regions in 2002. The Government-funded competition requires entrants to stop smoking for the month of May to be eligible for local, national and international prizes.

*Quit and Win* is coordinated by the Health Sponsorship Council, a Government agency. Nearly 1800 people entered the 2002 competition, representing 1.8% of the *Quit & Win* region's smoking population. This result was well in excess of the 1.25% international participation rate. The competition is currently being evaluated to determine quit rates.[5]

## Smoking cessation services for pregnant women

Specific cessation services are available to pregnant women. These services are often associated with maternity hospitals, and can be accessed through maternity carers, for example GPs, midwives etc. Smoking cessation training for health professionals working with pregnant women is also available. New Zealand's smoking cessation guidelines *(6)* advise that NRT should be considered when a pregnant/lactating woman is unable to quit, and when the likelihood of quitting, with its potential benefits, outweighs the risks of NRT and potential continued smoking.

## Smoking cessation services offered by GPs and GP groups

An increasing number of GPs offer smoking cessation services to their patients, often in conjunction with subsidized nicotine patches and gum.

## Other smoking cessation programmes

Smoking cessation services are also offered by a number of other individuals and groups. Cessation help can be provided in a number of ways – from group-support sessions, counselling and the provision of nicotine replacement therapy, to hypnotherapy and acupuncture. Many of these services are offered by the private sector, although some may be partially Government funded. In addition, some of these services deliver subsidized NRT through the Health Provider Exchange Card Programme administered by The Quit Group.

## Bupropion (Zyban) and nortriptyline

Bupropion and nortriptyline are available on a doctor's prescription. Following the recording of over 200 adverse reactions to bupropion in New Zealand, the Medicines' Adverse Reactions Committee advised in September 2001 that it be prescribed only after a person has unsuccessfully tried other stop smoking treatments *(7)*. Bupropion is not publicly subsidized and a seven-week course will cost around NZ$ 300 *(8)*.

[5] Personal communication, Jeremy Lambert, Health Sponsorship Council, July 2002. Also in Health Sponsorship Council Chat Sheet, March 2002.

Nortriptyline is not registered in New Zealand for use as a smoking cessation aid, but can be prescribed for this purpose. It is fully subsidized and as such the New Zealand Smoking cessation guidelines recommend that it be considered after a person has unsuccessfully tried other treatments, in particular for people who cannot afford bupropion.

## Other tobacco control initiatives undertaken during this period

The period 1998–2002 was a busy one for tobacco control in New Zealand. Smoking cessation initiatives included:

## Steps of implementation

In 1997 New Zealand's inaugural National Smokefree Conference was held, bringing together for the first time a large number of tobacco control workers. The conference endorsed a strong call to Government for the provision of smoking cessation services. In the same year a national Auahi Kore (smoke-free) conference was held for Maori tobacco control workers. Maori advocacy group Apaarangi Tautoko Auahi Kore (ATAK) was established as a result of the conference. Maori had a coordinated voice, and were calling for funding to help their people stop smoking.

| | |
|---|---|
| Ongoing | Promotion of smoke-free environments in a variety of settings by the Government agency, the Health Sponsorship Council. |
| Ongoing | Enforcement of the Smoke-free Environments Act 1990, and promotion of smoke-free messages by Government-funded public health services. |
| May 1998 | Tobacco excise increase of 50 cents plus tax on a pack of 20 cigarettes, and equivalent for other tobacco products. |
| June 1998 | Cessation of the requirement for replacement sponsorship by the government of previously tobacco-industry sponsored events. |
| June 1998 | National conference: *Smokefree Towards 2000*. |
| December 1998 | Tobacco advertising at point of sale ceases. |
| July 1999 | Smoke-free Environments (Enhanced Protection) Amendment Bill introduced to Parliament. Proposals include a ban on smoking in educational institutions except tertiary, further restrictions on the display of tobacco products, further restrictions on smoking in workplaces, and strengthening of penalties for retailers convicted of selling tobacco to minors. |
| September 1999 | Auahi Kore conference. |
| January 2000 | Stronger health warnings and constituent information on tobacco packets. |
| April 2000 | National Smokefree Conference. |
| May 2000 | Tobacco tax increases of NZ$ 1 on pack of 20 cigarettes, and equivalent for other tobacco products. |
| May 2001 | World Smokefree Day focus is *Let's Clear the Air*. Television commercials promoting smoke-free homes and bars are aired. |
| June 2001 | Supplementary Order Paper to the Smoke-free Environments (Enhanced Protection) Amendment Bill introduced to Parliament. Proposals include further restrictions on smoking in restaurants, clubs and casinos, and restrictions on smoking in bars, a ban on the supply of tobacco products to minors, and a ban on self-service vending machines. Health groups push for total ban on smoking in restaurants, bars, clubs and casinos. |
| October 2001 | Auahi Kore conference. |
| June 2001 | Consultation on the draft Tobacco Control Research Strategy initiated. |
| May 2002 | New Zealand's World Smokefree Day focus Is again *Let's Clear the Air*. |
| June 2002 | Invercargill woman Janice Pou initiates legal action against British American Tobacco and W D & H O Wills claiming that they continued to manufacture, supply and advertise cigarettes that were addictive and gave her cancer. |
| August 2002 | *Let's Clear the Air* television campaign re-launched by The Quit Group. |
| September 2002 | National Smoke-free Conference. |

for those aged 15 years and over was 26% in 1998 and 25% in 2001 *(10)*.

Maori smoking prevalence has remained static over this time, hovering at 49–51%. This is unacceptably high when compared with a non-Maori smoking rate of 21%. The lack of change may be because Maori-focused tobacco control programmes have only been delivered over the past few years, while mainstream programmes (although not necessarily quit programmes) have been available for decades. Maori smoking rates over the next five years will be a telling indication of whether the new, targeted cessation initiatives are having an effect.

Tobacco consumption decreased from 1377 cigarettes per adult in 1998 to 1139 cigarettes per adult in 2001. Over the past 10 years, the average number of cigarettes consumed per adult has decreased by more than one-third *(11)*. The accelerated rate of decline in consumption in 2000–2001 is likely to be mainly attributable to the tobacco excise increase of NZ$ 1 in May 2000.

A comparison with other OECD countries suggests that the New Zealand adult smoking rate is in the medium to low category *(12)*, while New Zealand has one of the lowest tobacco product consumption rates of any OECD country *(13)*.

Many of New Zealand's cessation initiatives began relatively recently and are still being evaluated. Some interim results are available from the subsidized NRT and Aukati Kai Paipa programmes.

| | |
|---|---|
| Subsidized NRT | Quit rate after three months: around 44%[6] |
| Aukati Kai Paipa | Quit rate appears to be significantly higher at 12 months (23%)[7] than the rate for those not on the programme (12.5%) |

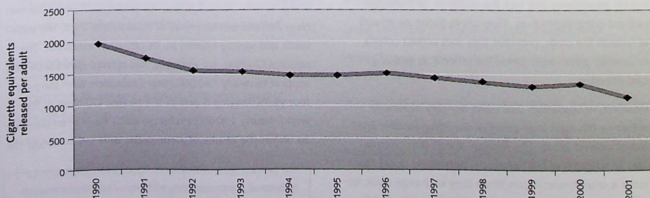
Biological correlates of self-reported quit rates have not been undertaken in the subsidized NRT and Aukati Kai Paipa programmes. A literature review into the value of validation of self-reported smoking status was carried out recently by The Quit Group. Many of the papers reviewed found that self-response of smoking status is a good indicator of actual smoking status. Where underreporting does occur, there is no statistically significant difference between self-reported and validated smoking status, meaning that the overall conclusions of the studies are not affected *(14)*.

[6] This is a conservative measure. A simpler measure of 'Quit = not smoked for two days but may have had occasional puffs', would give a point prevalence quit rate of 58% after three months.

[7] This is also a conservative measure. The simpler measure of 'Quit = not smoked for two days but may have had occasional puffs', would give a point prevalence quit rate of 30% after 12 months.

**Figure 2**

**Tobacco Products Released for Consumption**



## Youth smoking rates

Smoking among New Zealand fourth-form students (14 and 15 year-olds) rose steeply from 1992, but began to level off in the late 1990s. In 2001, smoking rates for both males and females had returned to levels comparable with 1992. In 2001, 16.3% of males and 22% of females 14 to 15 years of age smoked at least weekly *(15)*.

## Other impacts of the intervention

### Budget pressure

The NZS 6.18 million allocated to subsidized nicotine patches and gum initially appeared to be in danger of being exceeded, because of huge demand. However, this did not turn out to be the case, and the budget appears to match demand well.

### Rise in cessation advertising

Advertising of cessation services and products has increased over the past three years. Some providers of smoking cessation services promoted subsidized NRT, while others used the increased profile of NRT to promote non-subsidized and in some cases non-nicotine-based products. The various cessation initiatives resulted in tobacco dependence treatment becoming a much more prominent health issue than previously.

### Impact on pharmacies

The subsidized NRT initiative has had a significant effect on pharmacies, as they are the point of redemption for exchange cards. Despite initial plans to consider other outlets, such as supermarkets and service stations, as possible redemption points, pharmacies remain the only type of outlet involved.

Initially pharmacies also had the ability to be exchange card providers themselves. They could distribute as well as redeem the cards, provided they met certain criteria. Around 80 pharmacies joined the scheme as exchange card providers.

However, in September 2001, the Ministry of Health withdrew this right from pharmacies, citing possible conflict of interest issues. The Ministry stated that pharmacies, as suppliers of NRT products, potentially stood "to make a small financial gain when they exchange cards for the product" *(16)*. Many pharmacists were critical of the ministry's decision, believing that the system was working well. Pharmacies are now involved in the programme as dispensers of NRT only.

### Impact on pharmaceutical companies

It was no surprise that the subsidized NRT programme significantly altered market forces with respect to the sale of stop smoking products. Sales of the subsidized products rose, while sales of non-subsidized products fell. An exception occurred soon after the introduction of the subsidized Government programme, when the Quitline was having difficulty coping with demand. Sales of some non-subsidized stop smoking products were relatively high, as people motivated to quit by the publicity around the subsidized programme purchased full-price products. A general increase in awareness of smoking cessation issues also contributed.

Volumes of all NRT products dispensed – subsidized and unsubsidized – peaked in May 2001, and have since declined. Unsubsidized stop smoking products are still selling, but at lower levels. Interestingly, most impact has been on sales of nicotine patches – nicotine gum sales have not been affected to the same extent.[8]

## Conclusion

Several key factors contributed to New Zealand's transformation from a country that offered little in the way of smoking cessation help to one that has a comprehensive mix of initiatives. Central to the change was strong and persistent advocacy from the tobacco control community. Other key factors were proactive policy analysts and a supportive government. Tax increases also played a part in motivating smokers to call for cessation help. Their message to the Government was that it was unfair to increase the price of tobacco products without providing cessation help. This message was picked up and amplified by health groups.

New Zealand can be proud of its activities. First, the wide reach and variety offered by its cessation initiatives. The national Quitline, for example, has offered quit advice and support to nearly 140000 New Zealanders over the past four years, making it one of the busiest Quitlines in the world. Nearly 190000 exchange cards have been distributed. While the results of a comprehensive evaluation of the

[8] Personal communications with New Zealand pharmaceutical companies, August 2002.

Quitline and subsidized NRT are not yet available, early figures are promising. For those who prefer an individual or small-group approach, subsidized nicotine patches and gum, along with quit support and advice, can be obtained from health providers spread throughout the country.

Second, New Zealand's cessation initiatives are targeted at groups with higher smoking rates, particularly Maori. The Aukati Kai Paipa, and *It's about whanau* initiatives, for example, have been developed by Maori for Maori. Even the mainstream initiatives, such as the Quitline, have Maori as a primary audience.

These cessation initiatives have been complemented by New Zealand's other tobacco control programmes. Tobacco tax increases, smoke-free environments, and health promotion initiatives have all created a demand for stop smoking services.

One lesson learnt was the unanticipated demand for subsidized NRT. The Quitline was overwhelmed, and delivery of exchange cards was slow for several months. More time to establish this initiative would have enabled demand to be better gauged and catered for. The demand, however, proves that many smokers are motivated to quit, and the availability of reduced-cost NRT can act as a catalyst.

There is no apparent reason why New Zealand's programme could not be adapted to other countries if sufficient funding was available. Strong advocacy is needed to put pressure on governments to provide this funding. Once the funding is available, care should be taken to target initiatives at those with the highest smoking rates. Services and resources should be developed with the input of those in the target audience, to ensure that they are appropriate for that group. Initiatives should also be carefully evaluated to ensure that they are reaching objectives and represent value for money. Positive results from carefully researched, developed, tested and evaluated cessation initiatives in one country enable tobacco control advocates internationally to argue for similar programmes.

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# Advertising and Promotion Bans

PH-159

## Thailand Country Report on Tobacco Advertising and Promotion Bans.

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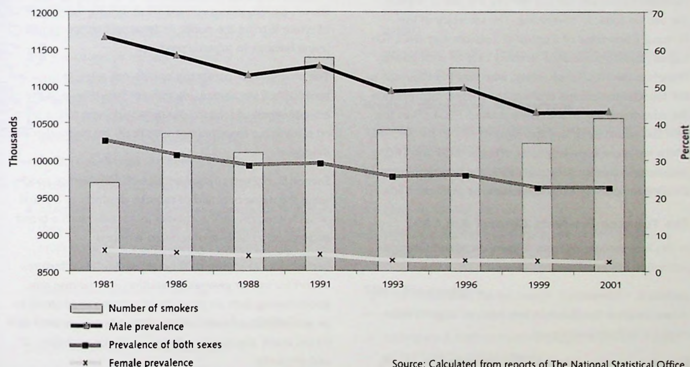
## Introduction

Countrywide household surveys by the National Statistical Office have been the main source of information support for tobacco control in Thailand. The first, second and third surveys were carried out in 1976, 1981 and 1986 (five year intervals). Thereafter the surveys were carried out every two years.

For the past two decades, the total number of smokers has risen, presumably as a result of the rise in population, from 9 676 700 in 1981 to 10 551 300 in 2001. Smoking prevalence declined from 35.2% in 1981 to 22.5% in 2001. Male and female smoking rates fell in this period from 63.19% to 42.92%, and from 5.39% to 2.36% respectively. Annual adult per capita cigarette consumption has also been decreasing, from 1087 in 1995 to 798 in 2000.

**Figure 1**

**Number of Smokers and Smoking Prevalence of Population. Both Sexes, 15 Years and Over, 1981–2001**




Source: Calculated from reports of The National Statistical Office

## Development of policy: Chronology

**26 April 1988** – *The Cabinet approved tobacco control measures, including a ban on advertising, proposed by the Ministry of Public Health (MOPH). This resolution was forwarded to all ministries to be put into practice.*

**20 December 1988** – *the Thailand Tobacco Monopoly (TTM) complained to the Ministry of Finance, its supervisor, that after the April cabinet resolution the TTM had ceased its promotional activities, while foreign cigarettes, though not allowed to be sold legally, continued to advertise in the printed media and on outdoor billboards. The cabinet therefore ordered the Consumer Protection Board (CPB) to pass a regulation prohibiting tobacco advertising.*

**10 February 1989** – *The Advertising Committee of the CPB made an announcement, published in the Royal Gazette, that cigarettes are under labelling control, thus cannot be advertised, pursuant to the Consumers Protection Act 1979.*

**4 August 1992** – *The Tobacco Product Control Act (TPCA) 1992 became effective.*

Information about tobacco-related morbidity and mortality has been fragmented owing to the lack of relevant studies and surveys. Among cancers of various organs, lung cancer was the second most common during 1988–1991. The age-standardized incidence rate of lung cancer among women in the Northern region is 37.4 per 100000 – considered to be a high world indicator.

The advertising ban under the Consumers Protection Act 1979, which became effective on 10 February 1989, was enforced by the office of the CPB which has a wide responsibility in the area of consumer protection. Officials of the CPB were not knowledgeable about tobacco promotional tactics and did not enforce the law as regards the ban on tobacco advertising. The secretary of the National Committee of Control of Tobacco Use (NCCTU) had to request prosecution in every case of wrongdoing. Therefore the NCCTU secretary, who was the chairman of the tobacco control law drafting committee, incorporated the advertising ban in the newly drafted TPCA. Thus the new law would be under the responsibility of the MOPH, which has more knowledgeable officials. After the TPCA became effective on 4 August 1992, the announcement of the CPB Advertising Committee became nullified.

### The Tobacco Products Control Act 1992

In this Act, sections relevant to bans on advertising and promotion are as follows:

**Section 3:** "Advertising" means an act undertaken by any means to allow the public to see, hear, or know a statement for commercial interest;

**Section 4:** No person shall be allowed to dispose of, sell, exchange or give tobacco products to a person when it is known to the former that the buyer or receiver has not attained eighteen full years of age;

**Section 5:** No person shall be allowed to sell tobacco products through vending machines;

**Section 6:** No person shall be allowed to do any of the following:

— to sell goods or render services with the distribution, addition or gift of tobacco products, or in exchange for tobacco products, as the case may be;

— to sell tobacco products with the distribution, addition, gift of, or in exchange for, other goods or services;

— to give or offer the right to attend games, shows, services or any other benefit as a consideration to the buyer of tobacco products or a person bringing the packaging of tobacco products for exchange or redemption therefor;

**Section 7:** No person shall be allowed to distribute tobacco products as a sample of tobacco products so as to proliferate such tobacco products or to persuade the public to consume such tobacco products except for a customary gift;

**Section 8:** No person shall be allowed to advertise tobacco products or expose the name or brand of tobacco products in the printed media, via radio broadcast, television or anywhere else which may be used for advertising purposes, or to use the name or brand of tobacco products in shows, games, services or any other activity the objective of which is to let the public understand that the name or brand belongs to tobacco products.

The provisions of paragraph one do not apply to live broadcasts from abroad, via radio or television, and the advertisement of tobacco products in printed media printed outside the Kingdom not specifically for disposal in the Kingdom;

**Section 9**: No person shall be allowed to advertise goods using the name or brand of tobacco products as a brand of such goods in such a manner as to make such a brand understood to be that of tobacco products;

**Section 10**: No person shall be allowed to manufacture, import for sale or general distribution, or advertise any goods having such an appearance as to be understood to be an imitation of such tobacco products as cigarettes or cigars, under the law on tobacco, or of the packaging of said products;

**Section 17**: Any person violating Section 4 or Section 5 shall be subject to an imprisonment not exceeding one month or a fine not exceeding 2000 Baht or both;

**Section 18**: Any person violating Section 6, Section 7, Section 9 or Section 10 shall be subject to a fine not exceeding 20000 Baht;

**Section 19**: Any person violating Section 8 paragraph one shall be subject to a fine not exceeding 200000 Baht;

**Section 24**: In case the violation of Section 4, Section 5, Section 6, Section 8 paragraph one, Section 9, Section 10 or Section 13 is by manufacturer or importer, the violator shall be subject to the penalty twice that provided for such offences.

The Tobacco Products Control Act 1992 contains a very comprehensive ban on advertising and promotion. It can be summarized as follows:

**The ban covers all media (Sections 3 and 8).**

— The ban is almost complete, and includes sponsorship. Although there is no such term as "sponsorship" the definition of "advertising" (Section 3) means that showing, mentioning, or referring to cigarette logos or products is illegal. Therefore sponsorship, which must show cigarette logos or product names is considered an illegal act (Section 8).

— The only exceptions are live radio or television broadcasts from abroad, and advertisements in printed media published outside Thailand (Section 8).

— The ban covers all indirect advertising:

- point-of-sale (POS) advertising is not allowed. Although the law does not specify POS, it is covered by the phrase, "or anywhere else which may be used for advertising purposes", in Section 8;
- product placement (Sections 3 and 8);
- trademark diversification (TMD) (Section 9);
- advertising goods that have an appearance such that they are understood to be in imitation of tobacco products or of the packaging of said products (Section 10); and
- sponsorship (Sections 3 and 8).

**The ban covers several promotional activities:**

— prohibition of sale to minors (Section 4);

— prohibition of sale through vending machines (Section 5); and

— prohibition of exchanges, free premiums, redemption, giveaways, etc. (Sections 6 and 7).

## Steps of Implementation

### 10 February 1989–3 August 1992: Prohibition under the Consumers Protection Act 1979

Because the CPB was not knowledgeable about tobacco industry tactics, the secretary of the NCCTU monitored violations and notified the CPB, which then prosecuted cases accordingly. Violations included the following:

**Direct advertising, for example:**

— installing large outdoor billboards advertising the cigarette brands Winston, Kent and Salem; billboards were also placed in the international airport and its tax-free shops;

— painting the logo "Mild Seven" on the bodies of cigarette delivery vans;

— launching new cigarette brands, such as Waves of Japan Tobacco Inc., with giveaways, exchanges, etc.

**POS advertising, for example:**

— placing numerous empty cartons in front of shops;

— placing large dispensers displaying logos, at sales points;

— suspending mobiles (imitating cigarette packaging) in such places.

**Product placement, for example:**

— wearing a t-shirt exhibiting the "Lucky Strike" logo in a television drama;

— publishing pictures with cigarette logos in magazines and calendars, advertising other products in newspapers, yearbooks etc.;

— printing cigarette brand names on clothes and postcards.

**TMD, for example:**

— advertising a "Marlboro Country Tour" on television;

— setting up a billboard with the logo "Winston – Style of the USA" across a street;

— advertising in newspapers "Kent Leisure Holidays", "555 The Statesman Collection" and "Camel Boots".

**Sport sponsorship, for example:**

— football: telecast of the "555 Football Special";

— snooker: telecast of the "555 Asian Snooker Open" and the "555 World Series Challenge";

— golf: a small billboard with the logo "Salem" at the venue of the "Singha Beer Pro-Am Tournament";

— cricket: a small billboard at the venue of the "Benson & Hedges Cricket International";

— motorcycling: a "Lucky Strike–Suzuki" team competed in a race.

All of these violations were discovered by the NCCTU secretary and were sent to the CPB for prosecution. Some

cases were investigated and fines resulted, and in some cases the final result was not known. The fines were up to 40 000 Baht, according to the stipulations of the Consumer Protection Act. The billboards were ordered to be removed by the CPB.

After promulgation of the CPB advertising ban, violations of the law by the transnational tobacco companies (TTCs) continued the wrongdoing that had existed previously. Violations and circumventions that occurred long after the enactment of the advertising ban were either through the TTCs pretending to be naïve, or because they wanted to test the effectiveness of law enforcement.

### 4 August 1992–present: Prohibition under the Tobacco Products Control Act 1992

The Minister of Public Health appointed officials of the MOPH, the Ministry of Interior, Municipalities, the Excise Department, and the Customs Department, to be responsible for the enforcement of this law. Approximately 3000–4000 officials were appointed on 25 August 1992 and on 9 June 1993. There was only one meeting, held shortly after the TPCA enactment, for the appointed officials to clarify the law. The supposed law enforcers are from various government agencies with wide-ranging responsibilities. Their superiors are not interested in tobacco control. Most of the appointed MOPH officials have several identity cards for enforcing several laws and never utilize them. This is a major flaw of the Thai bureaucratic system of law enforcement.

Appointed officials from the Institute of Tobacco Consumption Control (ITCC) of the Department of Medical Services (DMS) are supposed to form the core of law enforcement in this area. There has been no official report of violations recorded by the ITCC. The president of the Thailand Health Promotion Institute (THPI) is at the same time the drafter of the laws, the establisher of the Office of Tobacco Consumption Control (later the ITCC), and the former boss of the ITCC director. He used this informal relationship to push the ITCC director to take action in several cases of violation of the law, but very few results were achieved. The THPI is a nongovernmental organization and the THPI president is a retired government official. Both have no authority in law enforcement.

The THPI has been the only organization that has compiled lists of practices violating the law. They included:

— Direct advertising, for example:

— cigarettes advertised in Thai Airways' duty-free price list. In the May–June 1994 issue there were full-page advertisements for Marlboro, Dunhill and 555. There were several cigarette advertisements in the Thai Airways in-flight magazine "Swasdee". In the January 1994 issue, on one page there were advertisements for Marlboro, Mild Seven, Dunhill and 555; there was advertising for the "555 Subaru World Rally Team" in the June and August 1994 issues.

**POS. In retail outlets selling foreign cigarettes there were:**

— colour pictures of cowboys, the camel logo, and the logo "get lucky" installed on cigarette cabinets;

— large signs showing prices and price reductions for certain brands.

**Product placement included:**

— wearing clothes with cigarette logos on television shows;

— smoking by principal characters, especially the heroes and heroines, in television shows;

— displaying tobacco brand names in calendars, e.g. a Honda car calendar depicting several Marlboro logos;

— advertisements for other products in newspapers, e.g. an advertisement for Shell Oil included a picture of a Formula One car displaying both Shell and Marlboro logos;

— pictures in magazines and on the sports pages of newspapers showing cigarette logos on cars, athlete's clothes, etc.

**TMD included:**

— advertising "Winston House" and "Camel Trophy Adventure Wear" in newspapers;

— advertising "Camel Trophy Adventure Wear" and "Marlboro Classics" on posters installed in shopping outlets and in other media on different occasions.

**Sport sponsorship included:**

— participation by the "555 Subaru" team in the Asia-Pacific Rally, 3–6 December 1993;

— publicity for a visit by Mild Seven-sponsored Formula One driver Michael Schumacher, dressed in his racing suit. This was followed by the "95 Formula-1 Festival" at a department store on 14–30 October 1994;

— THPI research found that in one year (1998–1999) a cable television station aired 1343 hours of tobacco-sponsored sports events, consisting of 99 live legal telecasts and 1698 repeats. According to the law only live telecasts are permitted (see Section 8 of TPCA 1992). Therefore the repeats are considered illegal.

**Other promotions, for example:**

— in December 1992, the tax-free shops at the Bangkok International Airport ran a promotional programme: people buying goods worth 1000 Baht would be entitled to a reduction of 100 Baht for other goods, including cigarettes.

## Success of the Intervention

During the first period (10 February 1989–3 August 1992) when the advertising ban was under the Consumer Protection Act 1979, the intervention was reasonably successful. Almost all cases notified to the CPB by the NCCTU Secretary were investigated and led to fines.

After 4 August 1992, the MOPH became responsible for the newly enacted Tobacco Products Control Act 1992 and law enforcement has become very weak. The THPI has been the main monitoring force and provided numerous notifications to the ITCC. Most of these were not dealt with efficiently. In a few cases, however, suppression of the tobacco industry's promotional activities was successful owing to the THPI's vigilance and strong media advocacy.

### Success Story 1

**Defeat of the Olympic Committee of Thailand's attempt to adopt tobacco sponsorship**

In October 1990, the secretary of the Olympic Committee of Thailand (OCT) gave a press interview stating that the OCT would consider accepting TTC sponsorship of sport, and that the OCT would push for amendment of the law banning cigarette advertising.

On 21 October, the secretary of NCCTU gave a press interview opposing the proposal. This was followed by streams of news items, columns, and articles supporting and opposing the planned sponsorship. From October 1990 to March 1991, there were 20 news stories and 24 articles in favour of sponsorship; 18 news stories and 15 articles opposed it; and there were 9 news stories, 7 articles and 1 cartoon expressing a neutral stance. The pro-sponsorship group included the Secretary and Treasurer of the OCT, a former Deputy Public Health Minister, and a large number of sport columnists. The opposition consisted of the Secretary of the NCCTU, the Secretary of the No-Smoking Campaign Project, the Public Health Minister, the Privy Councillor, and some journalists.

After the continuous 5-month debate, the pro-sponsorship group gave up.

## Success Story 2

### Thailand was the only country in which the "Subaru-555" logo could not be displayed in the Asia-Pacific Rally

1993 was the first year of the Asia-Pacific Rally, which was held in six countries: Australia, Hong Kong (now Hong Kong Special Administrative Region of China)–Beijing (China), Indonesia, Malaysia, New Zealand and Thailand. After the race, the THPI and its grass-roots allies gave a press conference stating that exhibiting the "Subaru-555" logo was illegal. The MOPH followed up with a letter of protest to the organizers of the rally. The planned domestic rallies – four in 1993 – were scrapped.

From 1994 on, the "Subaru 555" logo was changed to "Subaru ///" when the rallies were held in Thailand.

## Success Story 3

### Thailand is the only country on the Asian golf circuit in which Davidoff logos are not displayed

The Asian Professional Golf Association (Asian PGA) had the watch company, Omega, as its main regional sponsor until 1999, when Davidoff took over. The Asian PGA's "Davidoff Tour" tournaments were held 20 times in 11 countries.

In Thailand there were 2 tournaments – The Lexus International on 14–17 October 1999, and The Thailand Open on 1–4 December. Both times, local organizers were told by the THPI president that displaying Davidoff logos was illegal. The Lexus tournament did not heed the warning and the THPI president initiated an arrest by the ITCC staff. The tournament organizer was prosecuted.

Since then, all Davidoff Asian PGA tours held in Thailand have not dared to exhibit the Davidoff logo. Thailand is the only country on the tour to have "Davidoff-free" competitions.

### Success Story 4

#### British American Tobacco's (BAT) first nicophilantrophy was thwarted – a rare occurrence in BAT's history

Bangkok was once known as the "Venice of the East" because of the many canals that crisscrossed the metropolis. One of the canals – Saen Saeb – was dug 166 years ago by royal order of the third king of the present Chakri Dynasty, and in former times was a center for marine commerce. People used the 72-kilometre canal to travel to many districts situated along its course, which went all the way to Chacoengsao Province in the east of the country. The pleasant way of life has changed. Now the canal is filled with the sounds of insects and mosquitoes buzzing around. Travel along the canal is no longer leisurely; boats emphasize speed to get through the polluted waters as quickly as possible.

Two daily newspapers of the Nation Multimedia conglomerate – The Thai language "Krungthep Turakit" and the English-language "The Nation" – published half-page black and white advertisements for the project called "Clean Saen Saeb Canal", on 4, 8, 9, 14, 19, 21, 26, September and 3 October 2001. The main sponsor was British American Tobacco (BAT) (Thailand) Inc. The captions read as follows: *"Returning Life to Saen Saeb Canal is Returning Life to the People"*, *"Saen Saeb: Venice of the East Once More"*, etc. Publicity was also carried out through a television channel and a radio station owned by the Nation Group. Billboards were installed along the banks of the canal. On 22 September a colourful festival was organized and the Governor of Bangkok ceremoniously received a donation from BAT's country manager. This was the first act of nicophilantropy by the company since its recent establishment as BAT's subsidiary in Thailand.

An NGO, funded by the Thai Health Promotion Foundation, compiled a list of the types of misconduct carried out by BAT from its own internal documents, and published a booklet, *Facts about BAT*. This was sent to the chairman of the Nation Group along with a letter requesting him to abandon BAT's sponsorship.

From 3 October on, publicity for the project ended. The NGO's grass-roots allies wrote to the Nation chairman thanking him for his conscientious decision.

There have been failures as well, including the following:

- Philip Morris has been sponsoring an Association of South East Asian Nations (ASEAN) Arts Award since 1994. In the first year of the award, the THPI president used press interviews to oppose the activity, supported by the MOPH, the No-Smoking Campaign Project, the Medical Council, and some newspaper columnists. In spite of this activity, Philip Morris has continued to hold the yearly contest until today. Sponsorship shows only the Philip Morris company logo. Since the cigarette brand name is not displayed, the act cannot be considered as illegal.
- POS promotional activities at tens of thousands of retail shops all over the country, which are illegal, have not been dealt with.
- Product placement on television is still rampant, even increasing, especially in foreign films televised by cable companies across the country – even though there is a law prohibiting such activity. The law controls radio and television broadcasting and the responsible agency is the public relations department of the Prime Minister's office.
- TMD in the form of "Camel Trophy" stickers are pasted onto cars roaming all over the country.
- Cigarette logos can be seen in numerous tobacco-sponsored sport telecasts on cable television.

## Conclusion

Thailand has a very good and strong law with an exceptionally comprehensive ban on advertising, promotion and sponsorship. However, law enforcement has been very weak and circumventions and violations are still common. To prevent an increase in people's tobacco consumption, enforcement of the advertising ban must be comprehensively planned and efficiently implemented.

# Tools for Advancing Tobacco Control in XXIst century:

Success stories and lessons learned

# Outils pour poursuivre la lutte antitabac au XXIe siècle:

Expériences concluantes
et nouveaux enseignements

# Taxation (including Smuggling Control)

WHO/NMH/TFI/FTC/03.10

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## Report on Tobacco Taxation in the United Kingdom

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# Report on Tobacco Taxation in the United Kingdom

**Excise Social Policy Group**

**HM Customs and Excise**

**World Health Organization**

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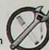


## Introduction[1]

### Taxation levels

The United Kingdom has among the highest levels of tobacco tax in the world[1]. Table 1 shows the current duty rates for tobacco products while Table 2 presents taxation levels. The latter is based on a typical pack of each product and on the most popular price category for cigarettes.

Table 1

**Current United Kingdom tobacco duty rates**

| Product | Duty rate |
|---|---|
| Cigarettes | 22% *ad valorem* and £94.24 (130.24 Euro) per 1 000 |
| Cigars | £137.26 (189.69 Euro) per kilogram |
| Hand-rolling tobacco | £98.66 (136.35 Euro) per kilogram |
| Other tobacco (e.g. pipe tobacco) | £60.34 (83.39 Euro) per kilogram |

Source: HM Customs and Excise (HMCE)

Note: VAT at 17.5% is also charged on the total cost of tobacco products, that is, their value plus the duty charged on them.

Table 2

**Comparison of selling price and tobacco tax**

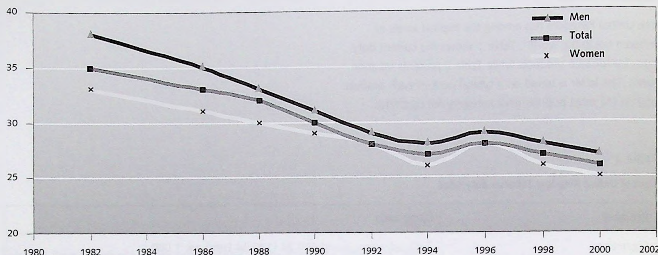
| Product | Typical selling price | Total tax (Excise duty and value added tax) | Total tax as a % of selling price |
|---|---|---|---|
| Cigarettes (pack of 20) | £4.51 | £3.55 | 78.7% |
| Small cigars (pack of 5) | £3.05 | £1.37 | 45.0% |
| Hand-rolling tobacco (25g) | £4.60 | £3.15 | 68.5% |
| Pipe tobacco (25g) | £3.55 | £2.04 | 57.5% |

Source: HM Customs and Excise

1 *Tobacco Journal International Yearbook*, Fact Sheet Number 18, 2002.

Figure 1

**Smoking prevalence (percentage of adult population who smoke cigarettes and hand-rolling tobacco in the United Kingdom)**




Source: Office of National Statistics, General Household Survey, 2000-2001

### Smoking prevalence

Smoking prevalence (the proportion of the adult population over 16 who admits to smoking) in the United Kingdom declined steadily throughout the 1970s and 1980s. Since then the rate of decline has slowed but it remains on an overall slight downward trend[2].

### Product trends

The majority of smokers in the United Kingdom smoke cigarettes[3]. Since 1997 there has been a trend for smoking cheaper brand cigarettes[4] and also for increased use of hand-rolling tobacco[5]. Although the percentage of the population who smoke has been decreasing since 1996–1997, the percentage smoking hand-rolling tobacco has been increasing slightly since then.[6]

Prevalence of cigar smoking has declined substantially since 1974[7]. Although cigars are smoked mostly by men, use by women is increasing slightly due to their consumption of miniature cigars.[8] Prevalence of pipe tobacco smoking is now very low. Nearly all pipe smokers are men.[9]

### Health

Smoking is the greatest single cause of premature death and avoidable mortality in the United Kingdom, killing some 120 000 people in the United Kingdom every year. It is responsible for one death out of every five and causes 84% of deaths from lung cancer as well as 83% of deaths from chronic obstructive lung disease, including bronchitis. Treating smoking-related illnesses costs the National Health Service in excess of £1.5 thousand million a year.

## Taxation and tobacco policy

### Brief historical facts about tobacco taxes

The United Kingdom has a very long history of taxing tobacco. Excise duty on tobacco was first introduced in 1660. The present structure of specific and *ad valorem*

[2] Office of National Statistics, General Household Survey 2000-2001

[3] Office of National Statistics, General Household Survey 2000-2001

[4] HM Customs and Excise

[5] Office of National Statistics, General Household Survey 2000-2001

[6] Office of National Statistics, General Household Survey 2000-2001

[7] Office of National Statistics – General Household Survey 2000-2001

[8] Gallaher Group, Gallaher Tobacco Category Review, 2002

[9] Office of National Statistics – General Household Survey 2000–2001.

Table 3

**United Kingdom tobacco duty rates 1992 to date***

| | Cigarettes | | Cigars | Hand-rolling tobacco | Other tobacco |
|---|---|---|---|---|---|
| **Date of Change** | **Ad valorem %** | **Specific £ per 1000** | **£ per kg** | **£ per kg** | **£ per kg** |
| 10.03.92 | 21 | 44.32 | 67.89 | 71.63 | 29.98 |
| 16.03.93 | 20 | 48.75 | 72.30 | 76.29 | 31.93 |
| 30.11.93 | 20 | 52.33 | 77.58 | 81.86 | 34.26 |
| 29.11.94 | 20 | 55.58 | 82.56 | 85.94 | 36.30 |
| 01.01.95 | 20 | 57.64 | 85.61 | 85.94 | 37.64 |
| 28.11.95 | 20 | 62.52 | 91.52 | 85.94 | 40.24 |
| 26.11.96 | 21 | 65.97 | 98.02 | 87.74 | 43.10 |
| 01.12.97 | 21 | 72.06 | 105.86 | 87.74 | 46.55 |
| 01.12.98 | 22 | 77.09 | 114.79 | 87.74 | 50.47 |
| 09.03.99 | 22 | 82.59 | 122.06 | 87.74 | 53.66 |
| 21.03.00 | 22 | 90.43 | 132.33 | 95.12 | 58.17 |
| 07.03.01 | 22 | 92.25 | 134.69 | 96.81 | 59.21 |
| 17.04.02 | 22 | 94.24 | 137.26 | 98.66 | 60.34 |

* nominal terms

Source: HM Customs and Excise

excise duty on cigarettes was introduced in 1976 to ease tax harmonization within the European Economic Community (EEC).

## United Kingdom tobacco duty rates

Since evidence shows that price increases have a major effect on reducing both smoking prevalence and consumption,[10] raising the price of tobacco products through duty increases has been a vital element in the strategy of successive United Kingdom Governments to reduce smoking. Cigarettes, which form the majority of the tobacco market in the United Kingdom, are now sold at historically high prices. Table 3 shows the current duty rates for tobacco products.

[10] Research includes: *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Washington, D.C., The World Bank, 1999. At web site: *www.worldbank.org/tobacco*; and Jha P, de Beyer J and Heller PS. Death and Taxes, Economics of Tobacco Control. Washington, D.C. International Monetary Fund, December 1999.

### Tax rises from 1992

From November 1993 to November 1999 there was a commitment to increase tobacco duties in real terms annually, initially by at least 3% on average and from July 1997 by at least 5% on average.

In November 1999 the commitment to real increases was replaced by Budget-by-Budget decisions on the level of tobacco duty, although the Government made it clear that there was still a strong ongoing health case for real increases.

In 2000 tobacco duty was raised by 5% in real terms and in 2001 and 2002 it was increased in line with inflation to maintain the high price of cigarettes in real terms. Table 3 shows the tax rates on all tobacco products from March 1992 to date and Table 4 shows the percentage increase in both real and nominal terms in tobacco duty over that period. Figure 2 shows the duty (in nominal terms) on the various tobacco products from March 1992 to the latest increase in April 2002. It is based on a typical pack of each product, i.e. 20 premium-price category cigarettes (the most popular price category), 5 small cigars and a 25-gram pack of hand-rolling tobacco or other tobacco.

### Use of tobacco taxes

Tobacco taxation brings in over £9 thousand million a year in duty and VAT.[11] This is an essential source of government funding for investment in public services such as schools and hospitals. Furthermore, in 1999 the Government of the United Kingdom announced that any additional revenue raised from future real increases in tobacco duty would be spent on improved health care. Proceeds from the 5% real terms increase in 2000 contributed to additional funding for the United Kingdom National Health Service (NHS).

### Health initiatives

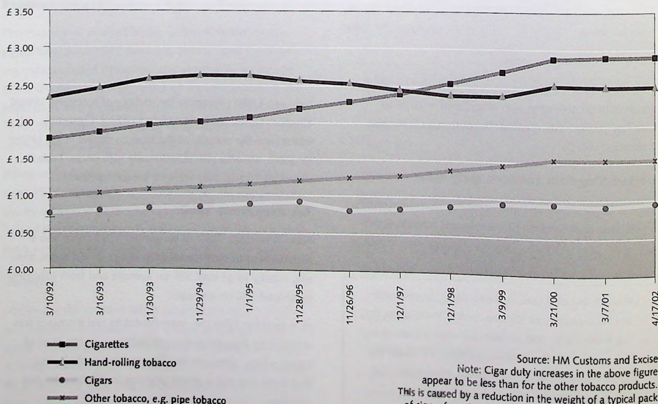
In 1998 the Government of the United Kingdom published a White Paper *Smoking Kills*, which sets out a comprehensive strategy designed to reduce smoking. It includes measures specifically targeted at those in lower income groups. The initiatives include:

- a comprehensive ban on advertising, which begins to come into effect in early 2003;
- a £76 million smoking cessation initiative from 1999–2000 to 2002–2003, including a targeted programme to address smoking during pregnancy, with a further £138 million made available for 2003–2004 to 2005–2006;
- a large-scale health education campaign designed to persuade smokers to quit and non-smokers not to start; and

[11] VAT on tobacco products is estimated from the Office for National Statistics figures for household consumption of tobacco.

Figure 2

**Duty on tobacco products (in real terms at November 2002 prices) since March 1992**




Source: HM Customs and Excise
Note: Cigar duty increases in the above figure appear to be less than for the other tobacco products. This is caused by a reduction in the weight of a typical pack of cigars from 8.55 grams to 6.7 grams during this period.

Table 4

**Percentage increase* in tobacco duty per product from 1992** to date**

| Product | Nominal % increase | Real % increase |
|---|---|---|
| Cigarettes | 113.1% | 84.2% |
| Cigars | 102.2% | 73.3% |
| Hand-rolling tobacco | 37.7% | 8.8% |
| Other tobacco (e.g. pipe tobacco) | 101.5% | 72.6% |

* Based on duty on a pack of 20 premium priced cigarettes and duty per kilogram for the other products

** From 11/3/92 Budget

Source: HMCE

Note. Duty on hand-rolling tobacco was frozen on several occasions due to concerns about the effect of smuggling on its small domestic market.

— making smoking cessation aids available on NHS prescription: Zyban (Bupropion) since 2000 and Nicotine Replacement Therapy since 2001.

The Government of the United Kingdom[12] believes that the United Kingdom now has one of the most comprehensive smoking cessation services in the world.

In November 2002 details of a further accelerated drive to combat smoking were announced. This includes an increase in hard-hitting public awareness campaigns and new health warnings of significantly increased size on the front and back of cigarette packs. A partnership is being developed between the Government and the pharmaceutical industry to assess how they can work better together to reduce smoking. The Government of the United Kingdom's Department of Health is seeking to develop a rebate system whereby pharmaceutical companies compensate the National Health Service (NHS) part of the additional money they receive from seeing cessation grow and prescriptions rise.

## Policy implementation

### Sequence of tax changes

In 1992 targets to reduce adult smoking by 40% by 2000 were published.[13] These targets, related to consumption of cigarettes, were set against a background of steadily decreasing prevalence, a trend that stalled in the mid-1990s when there was an increase in tobacco smuggling. The Conservative Government committed to "at least maintain the real level of taxation on tobacco" and in 1992 increased tobacco taxes by 5% above the inflation rate.

In March 1993 tobacco taxes were again raised by more than inflation. In the autumn of 1993 a joint pre-Budget submission by several health organizations called for unique treatment for tobacco because of its health consequences. This included a request for a real increase in the forthcoming Budget and a commitment to real increases in future. The Health Minister asked the Finance Minister to establish "future real increases". The 'tobacco escalator' was introduced, which promised rises in tobacco duty of at least 3% in real terms in future Budgets. The reasons given for this were:

— to raise revenue;

— to encourage further reductions in the levels of smoking; and

— to demonstrate the Government's commitment to the *Saving Lives: Our Healthier Nation* White Paper.

In 1994 tax on cigarettes was raised by 4.2% above inflation while tax on hand-rolling tobacco was raised by 3% above inflation. A second increase in tax was announced in December 1994 that added an extra 3.7% tax to cigarettes from January 1995.

[12] Department of Health

[13] *Saving Lives: Our* Healthier Nation White Paper. Presented to Parliament by the Secretary of State for Health, the Stationery Office, July 1999.

By 1995 tobacco smuggling had begun to take root, in particular hand-rolling tobacco smuggling. Tax on cigarettes was raised by 4.6% above inflation, but tax on hand-rolling tobacco was frozen because of concerns about the impact of smuggling on its small domestic market.

Although cigarette smuggling was being contained in 1996, there was concern that it was switching from amateur gangs to organized crime. Customs were allocated additional staff to deal with smuggling. Tax on cigarettes was raised by 5% above inflation while tax on hand-rolling tobacco was raised in line with inflation.

In 1997 the new Labour Government announced an increase in the 'tobacco escalator' from 3% to 5% because of its concern about the rates of death and disease attributable to active and passive smoking. The increased escalator was one of the measures intended to reduce tobacco consumption and dissuade young people from taking up the habit. Tax on cigarettes was increased by 5% above inflation while tax on hand-rolling tobacco was frozen again because of the impact of smuggling on its small domestic market.

In 1998 and 1999 tax increases were the same as in 1997. Tobacco smuggling continued to grow, and in 1999 the Government commissioned an independent review by a senior businessman of tobacco smuggling. In 2000 the Government, acting on recommendations made in this review, announced their strategy *Tackling Tobacco Smuggling* to address the growing tobacco smuggling problem. This included a new Government investment of £209 million over three years to reduce smuggling. The strategy provided additional customs staff and a network of x-ray scanners, funded a major publicity campaign, introduced fiscal marking of cigarettes and hand-rolling tobacco along with related new criminal offences, and introduced a tough vehicle seizure policy.

In November 1999, the Government announced that it was abandoning the 'tobacco escalator' in favour of Budget-by-Budget decisions. It also said that future real increases in tobacco taxes would be spent on improved health care. Taxes were increased by 5% above inflation in 2000 and with inflation in 2001 and 2002 to maintain the real cost of cigarettes. At the same time the Government sought to increase the average price of cigarettes for the consumer by clamping down on the supply of cheap smuggled products through the successful *Tackling Tobacco Smuggling* strategy.

### Lobby for and against policy

As already mention in paragraph 3.2, several health organizations submitted a joint paper in 1993 calling for unique treatment of tobacco because of its health consequences. They considered that the general affordability of tobacco products had been unaffected by the previous tax rises and they noted that the market was changing with the introduction of cheaper cigarette brands. They also considered that the introduction of tax stamps and law enforcement were the appropriate way to tackle smuggling and that it should not be addressed by a reduction in duty rates.

Health and anti-smoking groups have been supportive of tobacco policy, including *Tackling Tobacco Smuggling*, since that time. Prior to the 2002 Budget these groups said they believed that "greater emphasis should now be placed on raising prices through addressing the trends that tend to drive prices down rather than on increasing headline tax rates for cigarettes." The trends include the supply of cheap, unregulated tobacco through the smuggling market.

Tobacco manufacturers, retailers and tobacco workers groups have continually blamed the tobacco smuggling situation on the level of tobacco taxation in the United Kingdom and have called for significant reductions in duty to tackle smuggling. However over the last year manufacturers have publicly acknowledged an increase in legitimate trade due to the success of the *Tackling Tobacco Smuggling* strategy. Despite this, both manufacturers and retail trade groups lobby at every opportunity for a decrease in tax levels to reduce the differential between the tax level in the United Kingdom and in other nearby European Union (EU) countries.

## Effect of the taxation policy

### Tobacco prices

Cigarette prices in the United Kingdom are now at historically high levels. Although high tax levels are the major factor in these high prices, manufacturers' pre-tax prices are also significantly higher in the United Kingdom than elsewhere in the world for the same product. For example, in 2001 the pre-tax price of 20 Benson & Hedges Special Filter cigarettes was 93p in the United Kingdom, 48p in France and 39p in Greece.[14]

[14] Gallaher, Ltd.

Table 5

**Prevalence of cigarette smoking by sex and socioeconomic group**

| Socioeconomic group | Men | Women |
|---|---|---|
| Professional | 15% | 13% |
| Employers & managers | 22% | 21% |
| Intermediate & junior non-manual | 26% | 25% |
| Skilled manual & own account non-professional | 34% | 27% |
| Semi-skilled manual and personal service | 36% | 34% |
| Unskilled manual | 39% | 34% |
| Total non-manual | 23% | 22% |
| Total manual | 35% | 30% |
| All aged 16 and over | 29% | 25% |

Source: Office of National Statistics, General Household Survey 2000-2001

### Smoking prevalence

Smoking prevalence (the proportion of the adult population who admit to smoking) has been declining but at a slow rate recently. In 1992 it was 29% and in 2000 it was 27%.[15] Figure 1 shows the decline in a longer time scale.

Although taxation plays an important role in reducing smoking, it is not possible to isolate the effect of taxation. Smoking is affected by an entire range of measures such as health campaigns and targeted cessation programmes. It is also affected by social trends, e.g. the acceptability of smoking or peer pressure for young people.

### Social groups

Table 5 illustrates that smoking prevalence increases down the socioeconomic groups. Manual workers are also likely to consume more cigarettes than those in non-manual professions. Households with children are more likely to have smokers and smoking is increasingly linked with poverty. Tobacco duties are regressive: lower-income households are more affected by duty increases than richer ones.[16] This is why the Government balances high tobacco taxes with real support for people to quit (see "Health initiatives").

## Impact of tobacco taxation policy

### Revenue

From 1992 to approximately 1997 revenue from tobacco taxes was increasing. There followed a period of decreasing revenue until early 2000 due to the revenue loss caused by tobacco smuggling. Since then tobacco duty revenue has started to increase again because of the success of the United Kingdom *Tackling Tobacco Smuggling* strategy. The latest estimate of tobacco revenue being evaded or avoided is £4.3 thousand million for 2001–2002. However, this includes about £1 thousand million from legitimate cross-border shopping (duty-free and EU duty-paid goods). Table 6 shows tobacco duty revenue

[15] Office of National Statistics – General Household Survey 2000-2001

[16] Even if tobacco duties are regressive this does not mean that increases in tobacco duties are. A paper by Townsend et al., Cigarette smoking by socioeconomic group, sex, and age: effects of price, income, and health publicity, *British Medical Journal* 1994, 309:923-927, shows that when the price of cigarettes increases, lower-income groups decrease their consumption more than do higher-income groups.

from 1992–1993 to 2001–2002, although the latter is a provisional figure.

Table 6

**United Kingdom tobacco duty revenue in £million (in real terms at November 2002 prices)**

| Year | Revenue £million |
|---|---|
| 1992–1993 | 7,551.3 |
| 1993–1994 | 8,007.2 |
| 1994–1995 | 8,837.6 |
| 1995–1996 | 8,448.0 |
| 1996–1997 | 9,093.7 |
| 1997–1998 | 9,152.4 |
| 1998–1999 | 8,712.4 |
| 1999–2000 | 5,939.0 |
| 2000–2001 | 7,764.5 |
| 2001–2002* | 7,754.5 |

* Provisional

Source: HM Customs and Excise

## Tobacco manufacturers

We cannot provide detailed information on the United Kingdom tobacco manufacturers' profits, but Imperial Tobacco, the United Kingdom's largest manufacturer, recently announced a 27% increase in operating profit. Despite the high levels of tobacco taxation and smuggling, tobacco manufacturers continue to make large profits. As already mentioned in paragraph 4.1, pre-tax prices in the United Kingdom are much higher than in other countries. During 2002–2003 manufacturers publicly acknowledged the success of the *Tackling Tobacco Smuggling* strategy, which has increased legitimate sales and begun to restore a more orderly market.

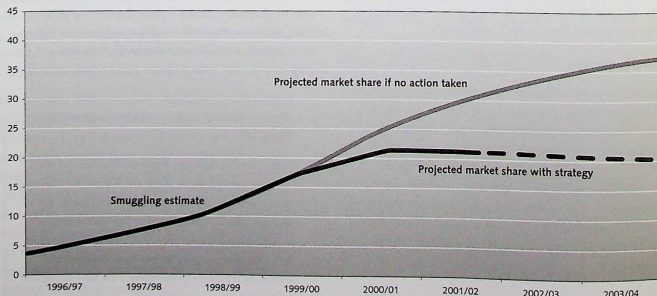
## Tobacco smuggling

The introduction of the single market in 1993 and ease of travel to neighbouring EU countries where tobacco products were priced lower that those in the United Kingdom both led to increased tobacco cross-border shopping and smuggling as United Kingdom prices rose. Initially the smuggling was confined to cross-Channel smuggling of hand-rolling tobacco but it soon increased to both cross-Channel and freight smuggling of cigarettes.

By 1999 the revenue lost through tobacco smuggling was an estimated £2.5 thousand million, which was about 25% of all tobacco revenue; smuggling was on a strong upward trend. Customs estimated in 2000 that without

Figure 3

**Percent market share of smuggled cigarettes**




Source: Tackling Tobacco Smuggling. HM Customs and Excise, HM Treasury, March 2000.

intervention the smuggled share of the cigarette market would have reached over a third by 2002–2003. Figure 3 shows the trend in cigarette smuggling and the projected trend with and without the *Tackling Tobacco Smuggling* strategy.

In March 2000 the Government announced its strategy to tackle the tobacco smuggling problem, investing £209 million over three years toward this end. The *Tackling Tobacco Smuggling* strategy provided additional resources and technology (x-ray scanners) for customs, funded a publicity campaign and led to the introduction of fiscal marks on tobacco and hand-rolling tobacco in 2001, with new criminal offences related to their use. The strategy set challenging targets for customs to slow, stabilize and reverse the growth in tobacco smuggling by the end of 2002–2003.

Customs achieved its first year target and held the illicit share of the cigarette market to 21% in 2000–2001. In 2001–2002 customs continued to restrict the illicit share to 21% (when its key target was 22%) thereby stopping the growth in tobacco smuggling for the first time in a decade.[17]

In the first two years of the *Tackling Tobacco Smuggling* strategy customs:

— broke up 103 gangs involved in large-scale cigarette smuggling; and

— seized in excess of 5 thousand million illicit cigarettes.

In 2001–2002 the network of x-ray scanners detected 13 tonnes of hand-rolling tobacco and 325 million cigarettes. Revenue lost from tobacco smuggling is now estimated to be some £3.3 thousand million, a slight decrease from the previous year.

The strategy has also had a significant impact on cross-Channel smuggling of hand-rolling tobacco. The estimated revenue lost from this is now £95 million compared to approximately £785 million two years ago.

### Cross-Channel shopping

The introduction of the single market in 1993 led to an increase in cross-border shopping as well as smuggling.

As a result of the success of the *Tackling Tobacco Smuggling* strategy, cross-Channel smugglers have increasingly sought to pose as honest shoppers in an attempt to evade customs controls. In October 2002 the Government announced a new package of measures designed to be fair to honest shoppers, tough on criminal smugglers and clear about the distinction between the two. This package includes an increase in the guidelines, which are an indicator that a traveller has brought a significant quantity of tobacco goods into the United Kingdom, to about six months' use for an average smoker.

## Conclusion

Smoking is the single greatest cause of preventable illness and premature death in the United Kingdom, killing over 120 000 people a year. Research shows that the demand for cigarettes is affected by price[18] so high tax levels have played a significant role in reducing overall consumption. In particular, high tobacco prices are a valuable deterrent to children who are tempted to take up smoking. Various other benefits occur for individuals, society and the economy through a reduction in smoking:

— non-smokers enjoy healthier and longer lives than smokers and smokers who quit can eventually achieve almost the same levels of health as those who have never smoked;

— there is an economic benefit particularly for low-income families for whom money spent on tobacco can be a large proportion of income;

— the risk of fire is reduced;

— industry benefits from reducing lost time due to smoking breaks at work and the higher absence rates of smokers[19]; and

— there are savings to the NHS.[20]

[17] The methodology for calculating the illicit market share was published in *Measuring Indirect Tax Fraud as part of the Pre-Budget Report*, November 2001 (available on the United Kingdom Government web site: www.hmce.gov.uk)

[18] Research includes *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, The World Bank, 1999 and Jha P, de Beyer J and Heller PS. Death and Taxes, Economics of Tobacco Control, International Monetary Fund, 1999.

[19] See for example: Parrot et al. Costs of employee smoking in the workplace in Scotland. *Tobacco Control*, 2000, 9 pp.187-192.

[20] Department of Health

Over the last ten years tax on tobacco products in the United Kingdom has risen significantly, mostly well in excess of inflation.

Unfortunately, the effect of these increases has been undermined by tobacco smuggling, which increases the availability of cheap smuggled products. Not only does this make cigarettes more affordable, it also decreases revenue required for investment in public services such as health and education.

The Government of the United Kingdom believes that the way to tackle tobacco smuggling is through enforcement and it will not allow criminal activity to dictate its policies to improve the nation's health. Health and anti-smoking groups have supported that approach. The successful *Tackling Tobacco Smuggling* strategy is currently addressing this problem and restricting the illicit share of the total cigarette market.

Tobacco manufacturers frequently call for the United Kingdom duty rates to be reduced to rates that are closer to those of the neighbouring EU countries. However at the same time those same manufacturers contribute to the current historically high cigarette prices in the United Kingdom by setting their pre-tax prices in the country at levels significantly above those for the same product in other countries, including those belonging to the EU.

The United Kingdom believes that focusing on differentials between the United Kingdom and EU countries is misleading and misses the key issue, which is that the vast majority of illicit goods have borne no tax in any country. Cutting duty levels to those prevalent in countries from which smuggling occurs would cost thousands of millions of pounds in revenue. The shortfall in revenue would either mean less investment in essential public services or increases in other forms of taxation to fund them. Lower cigarette prices would increase consumption, lead to more premature deaths and smoking-related illnesses and incur further costs for the National Health Service.

The United Kingdom has therefore tackled tobacco use by a multi-pronged approach. It has used a package of health measures along with taxation to bring about a reduction in smoking. Where this has been undermined by tobacco smuggling, the United Kingdom is tackling this criminal activity and has sought to increase the effective price of cigarettes by reducing the supply of cheap smuggled products and so raising the share of the market taken by more expensive legitimate products.

**Tools for Advancing Tobacco Control in XXI$^{st}$ century:**
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**Outils pour poursuivre la lutte antitabac au XXI$^{e}$ siècle:**
Expériences concluantes et nouveaux enseignements

# Taxation (including Smuggling Control)

WHO/NMH/TFI/FTC/03.11

PH-1511

## Earmarked Tobacco Taxes and the Role of the Western Australian Health Promotion Foundation (Healthway)

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# Best Practices in Tobacco Control Earmarked Tobacco Taxes and the Role of the Western Australian Health Promotion Foundation (Healthway)

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## Introduction

The concept of creating health promotion foundations, funded by a portion of the tobacco excise revenue was developed in Australia. These foundations provide sponsorship to sports, arts and racing organizations and replace tobacco industry sponsorship and outdoor advertising. The Victorian Health Promotion Foundation VicHealth, founded in 1987, was the first of its kind. This report will describe the implementation and evaluation of the Western Australian Health Promotion Foundation Healthway, which was established under the Western Australian Tobacco Control Act of 1990. With a population of 1.9 million, Western Australia (WA) has about one-tenth of the total Australian population, and is the largest Australian state in geographical terms.

### Current situation and recent trends in tobacco use

The 2001 National Drug Strategy Household Survey of almost 27 000 Australians aged 14 years and above found that the proportion of respondents who smoked daily declined by just over 2% between 1998 and 2001, from 21.8% to 19.5%. Overall, the prevalence of smoking has been falling since 1945 among males and since 1976 in females, although the downward trend has slowed somewhat in recent years. Based on the survey, it is estimated that in 2001 approximately 3.6 million Australians aged 14 years and over were smokers and just under 3.1 million smoked daily *(1)*.

While the state-specific figures for the 2001 survey were not yet available at the time of writing, some West Australian figures from the 1998 survey are notable. Among 20 to 29 year-olds, WA had the lowest regular smoking rate in Australia, with 29.1% of this group reporting daily or near-daily smoking (Australian average: 31.6%). WA also had the lowest regular smoking rate among 14 to 19 year-olds, at just 9.9% (Australian average 16.1%). Among regular West Australian smokers, the typical quantity of cigarettes consumed in 1998 was 11 to 20 cigarettes per day *(2)*.

In 1999, a survey on drug use was conducted among 3 458 12 to 17 year-old WA school students. The results indicated that 21% of students had smoked at least once in the last four weeks, 17% had smoked at least once in the last week and 4% had smoked daily. Overall, 52% of students had smoked at least a few puffs of a cigarette in their lifetime. These figures appear to be consistent with those described above. Compared with a similar survey undertaken in 1996, the largest reduction in smoking prevalence occurred in females aged 16 to 17 years, with the proportion smoking in the preceding week falling from 29% to 20%% *(3)*.

### Disease and death toll of tobacco

Between 1985 and 1996, about 19% of all deaths in WA were due to addictive substances and, of these, 79% were due to tobacco smoking with an average of 1 502 deaths each year *(4)*. Nationally, there were approximately 19 000 deaths and about 140 000 episodes of hospitalization attributable to tobacco smoking in 1998. The annual cost of these hospitalizations was about $AUD 390 million. The most frequently occurring tobacco-related conditions were cancers, ischaemic heart disease and chronic airflow limitation (5).

During the 1998–1999 financial year, the Commonwealth Government received over $AUD 8 thousand million in revenue from the importation and sale of tobacco products in Australia. However, data from customs and excise suggest a slight fall in the demand for tobacco products over the five years up to 1999–2000 and there was a decrease in per capita consumption of cigarettes in Australia from 8th in the world in 1991 to 17th in 1996 *(5)*.

## Description of the policy intervention

### WA Tobacco Control Act 1990

The WA Tobacco Control Act 1990 was passed in December 1990 and came into effect in February 1991. The purposes of the Act were to actively discourage tobacco smoking and to promote good health and prevent illness by encouraging non-smokers, particularly young people, not to start smoking; by limiting the exposure of children and young people to persuasive messages about smoking; and by encouraging and assisting current smokers to quit.

### Healthway

The Act outlined the creation of the Western Australian Health Promotion Foundation (Healthway) and prohibited tobacco advertising, tobacco sponsorships, competitions run by tobacco companies and distribution of free tobacco samples, though the Minister of Health was permitted to grant exemptions under certain circumstances.

The objectives of Healthway, as stated in the legislation, are:

— to fund activities related to the promotion of good health, with particular emphasis on young people;
— to offer an alternative source of funds for sporting and arts activities currently supported by manufacturers or wholesalers of tobacco products;
— to support sporting and arts activities that encourage healthy lifestyles and advance health promotion programmes;
— to provide funds to replace tobacco advertising with health promotion advertising;
— to provide grants to organizations engaged in health promotion programmes;
— to fund research relevant to health promotion;
— to raise funds by soliciting donations and grants to support its work; and
— to evaluate and report on the effectiveness of its performance in achieving health promotion activities.

Established on 8 February 1991, Healthway remains governed by a Board representing arts, sports, health, youth and country interests. Originally reporting to the Board were five advisory committees: arts, health, racing, sports and tobacco replacement. Currently, there are six committees: sports, arts, racing, health, research and finance. These committees, comprising members appointed for their relevant expertise, have a direct role in reviewing sponsorship and grant applications and in making funding recommendations to the Board.

## Phasing out of tobacco sponsorship and outdoor advertising

By 8 February 1992, all tobacco sponsorship in WA had been replaced, unless specifically exempted by the Minister of Health. Outdoor tobacco advertisements were removed gradually, with approximately 50% by July 1992, a further 25% by July 1993 and the remaining 25% by July 1994. Health promotion messages replaced about 25% of the total outdoor advertising space formerly held by tobacco companies and non-tobacco advertisers used the remainder. For a period of five years following the passage of the legislation, the Act required Healthway to give priority to organizations and individuals disadvantaged by the banning of tobacco sponsorship and advertising, by replacing tobacco activities with health sponsorship and advertising *(6)*.

## Healthway funding: earmarked tobacco taxes

In the early years, Healthway received $AUD 12.9 million each financial year for its activities. More recently, a 2.5% funding increase per annum has been granted to keep in line with inflation. Accordingly, Healthway's annual budget stands at about $AUD 16 million. For this, Healthway must endeavour to ensure that, in each financial year, at least 30% is disbursed to sporting organizations; at least 15% is distributed to arts organizations; and not more than 50% is earmarked for any single group, be it sports, arts, health, community, youth, research or racing organizations.

Until 1997, Healthway was funded by earmarked tobacco taxes, namely, a portion of the state tobacco franchise fee. This fee was introduced under the WA Business Franchise (Tobacco) Act 1975 as a wholesale tax or licence fee, which was paid in regular instalments by wholesale tobacco merchants. The rate was based on the wholesale value of tobacco sales in the preceding period and rose incrementally from 10% in 1976 to 100% in November 1993 (Table 1) *(7)*.

In August 1997, Healthway's source of funding changed when the High Court of Australia ruled that it was unconstitutional for states to charge state-based tobacco taxes. Since then, the Federal Government has collected state tobacco franchise fees on behalf of the states, which it then returns as part of the state's funding. As a result, health promotion foundations in Australia are now funded by direct allocation from consolidated revenue *(8)*.

The establishment of Healthway in February 1991 was not directly linked to an increase in the state tobacco franchise fee. A rise had occurred in January 1990, when the fee was raised from 35% to 50%, and a further rise occurred in November 1993, when the fee was raised from 50% to 100% *(7)*. This may have assisted the passage of the legislation, as opposition from the tobacco companies would likely have been greater had an attempt been made to raise the state tobacco franchise fee in conjunction with the ban on tobacco industry sponsorship and outdoor advertising.

In the 1992–1993 financial year, WA had the lowest state franchise fee (50%) in Australia and reports of an illegal cross border trade from WA to higher taxed states developed. The rise in the tobacco franchise fee to 100% in late 1993 resolved the issue and the average cost of a packet of 30 cigarettes in WA rose by $AUD 1.76, from $AUD 4.23 to $AUD 5.99 *(7)*.

Table 1

**The history of smoking control in Western Australia (WA)**

| Year | Smoking control activity |
|---|---|
| 1911 | WA statute prohibited smoking in cinemas and theatres |
| 1917 | Sale or supply of cigarettes to children under 18 years made illegal |
| 1950 | Association between smoking and lung cancer reported in *British Medical Journal (11)* |
| 1967 | Australian Council on Smoking and Health (ACOSH) established |
| 1972 | Health warnings on cigarette packets became mandatory Australia-wide |
| 1976 | Federal legislation banned direct cigarette advertising on radio and television |
| | WA Tobacco Franchise Fee introduced (10%), January |
| 1982 | WA Smoking and Tobacco Products Advertisements Bill to ban tobacco advertising defeated |
| | WA Tobacco Franchise Fee raised (12.5%), March |
| 1983 | WA Tobacco (Promotion and Sales) Bill, 2nd unsuccessful attempt to ban tobacco advertising |
| | The Smoking and Health Programme of the WA Department of Health established |
| | Federal Tobacco excise increased and linked to consumer price index (CPI), November |
| | WA Tobacco Franchise Fee raised (35%), December |
| 1984 | First Quit Campaign in WA |
| 1987 | Federal legislation banned smoking on all domestic airline flights and instituted revised health warnings on cigarette packets |
| 1988 | In the Australian state of Victoria, the first health promotion foundation VicHealth, is established under state legislation |
| 1990 | Federal ban on cigarette advertising on radio and television extended to all tobacco products |
| | WA Tobacco Franchise Fee raised (50%), January |
| | WA Tobacco Control Act passed, December |
| 1991 | Federal ban on tobacco advertisements in the print media, December |
| 1992 | Western Australian Health Promotion Foundation Healthway formally established 8 February |
| 1993 | All tobacco sponsorship in WA ended 8 February, unless specifically exempted by Health Minister |
| | Healthway's programme of replacing outdoor tobacco advertising commenced |
| | Federal Government legislates to ban tobacco sponsorship Australia-wide |
| 1994 | Federal tobacco excise increased above CPI |
| | WA Tobacco Franchise Fee raised (100%), November |
| 1995 | Federal tobacco excise increased above CPI |
| | Phasing out of all outdoor tobacco advertisements in WA completed, July |
| | WA "Smarter than Smoking" youth campaign launched, partly funded by Healthway |
| | Federal customs duty on imported tobacco and excise duty on domestic product harmonized |
| 1999 | Federal tobacco excise increased above CPI |
| 2000 | Tobacco sponsorship banned in Australia from 31 December |
| | WA Health (Smoking in Public Places) Regulations banned smoking in enclosed public places, including restaurants. (Exemptions: bars and some gaming areas) |
| | "Per stick" rather than weight-based tobacco excise system introduced by Federal Government increases cigarette prices |
| | Further price rise after Goods and Services Tax introduced in July |

Table 2

**Key stakeholders for and against a ban on tobacco sponsorship and advertising**

| **Pro-legislation** |
|---|
| Asthma Foundation of Western Australia |
| Australian Council on Smoking and Health |
| Australian Medical Association (Western Australian branch) |
| Cancer Foundation of Western Australia |
| Department of Health, Western Australia |
| Health Education Council of Western Australia |
| National Heart Foundation (Western Australian division) |
| Public Health Association of Australia |
| Royal Australasian College of General Practitioners (Western Australian faculty) |
| Royal Australasian College of Pathologists (Western Australian committee) |
| Royal Australasian College of Physicians |
| Royal Australasian College of Surgeons |
| Thoracic Society of Australia (Western Australian branch) |
| Tuberculosis and Chest Association of Western Australia |
| **Anti-legislation** |
| Advertising Federation of Australia |
| Australian Association of National Advertisers |
| Australian Cinema Advertising Council |
| Australian Publishers Bureau |
| Australian Retail Tobacconist |
| Confederation of Australian Motor Sport (WA branch) |
| Ethnic Press Association of Australia |
| Federated Tobacco Workers' Union of Australia |
| Newspaper Advertising Bureau of Australia |
| Outdoor Advertising Association of Australia |
| Tobacco Institute of Australia |
| Tobacco companies |
| WA Cricket Association & Indoor Cricket Super League |
| WA Dart Council |
| WA Football League, Rugby League & Rugby Union |
| WA Golf Association |
| WA Greyhound Racing Association |
| WA Motion Pictures Exhibitors' Association |
| WA Sporting Car Club |
| WA Trotting Association |

Source: Musk AW, Shean R, Woodward S. Legislation for smoking control in Western Australia. British Medical Journal, 1985, 290:1562-1565.

Castleden VM, Nourish DJ, Woodward S. Changes in tobacco advertising in Western Australian newspapers in response to proposed government legislation. *Medical Journal Australia*, 1985,142:305-308

## Steps of implementation

The passage of the WA Tobacco Control Act 1990 was not without difficulty. Two previous attempts to ban tobacco sponsorship and advertising in WA in 1982 and 1983 had failed. The history of tobacco control in WA is one of setbacks and gains. Table 1 outlines progress to date.

Following the Federal Government's ban on cigarette advertising on television and radio in 1976, the tobacco industry sought to exploit an exemption of the legislation, which allowed cigarette advertising in the electronic media if it occurred incidentally or accidentally. As a result, sponsorship of televised sporting events carrying arena advertising for tobacco products increased. The volume of advertising matter in the print media also rose *(9)*.

### WA Smoking and Tobacco Products Advertisements Bill, 1982

In 1982, in an attempt to ban tobacco industry sponsorship and outdoor advertising, the Smoking and Tobacco Products Advertisements Bill was introduced into the West Australian parliament. The bill was defeated following a massive lobbying campaign by the Tobacco Institute of Australia, the Australian Publishers Bureau, by organizations with a well-defined interest in continued tobacco promotion and by sports organizations sponsored by tobacco companies. Full-page advertisements and newspaper editorials claimed that the legislation was an infringement of civil liberties and would have a detrimental effect on sport and employment *(9)*.

### WA Tobacco (Promotion and Sales) Bill, 1983

A second attempt to introduce a ban was undertaken in 1983, with the WA Tobacco (Promotion and Sales) Bill. Again, the volume of tobacco industry advertising increased markedly *(10)* and the bill was defeated, despite the state government's campaign to "Give kids a chance". That year, the WA tobacco franchise fee was raised from 12.5% to 35% and $AUD 2 million was appropriated for smoking education (9). Table 2 lists a number of the key stakeholders for and against the ban on tobacco industry sponsorship and outdoor advertising at that time.

### WA Tobacco Control Act, 1990

A third attempt was made in 1990. On this occasion, the ban was linked to the establishment of a health promotion foundation, funded by the WA tobacco franchise fee, which would buy out tobacco sponsorship and replace outdoor advertising of tobacco products. With concerns about revenue loss by potential opponents of the legislation allayed and with the successful passage of an Australia-wide ban on tobacco advertising in newspapers and magazines, the WA Tobacco Control Act 1990 was passed, banning tobacco industry sponsorship and outdoor advertising in WA.

## The intervention's success

### Healthway programmes and priority areas

Healthway runs a number of programmes: a Health Promotion Projects Programme, a Health Promotion Research Programme, a Sponsorship Programme and a Tobacco Replacement Programme *(6)*. In addition to its sponsorship and advertising activities, Healthway offers annual grants for health promotion projects and research. A number of research priority areas have been identified, with the prevention and control of tobacco smoking receiving the highest funding allocation (Table 3).

Table 3

**Healthway's programme and research priority areas**

| |
|---|
| Alcohol and other drug misuse |
| Asthma prevention and control |
| Cardiovascular disease prevention, including hypertension control |
| Cancer prevention, in particular, skin cancer prevention |
| Determinants of healthy behaviour |
| Diabetes prevention |
| Good nutrition |
| Healthy environments |
| Indigenous health |
| Injury prevention |
| Mental health promotion |
| Physical activity promotion |
| Sexual health (includes HIV/STI prevention) |
| Tobacco smoking prevention and control |

### Health promotion in recreational settings

Healthway's health promotion objectives are based on the principles of the Ottawa Charter. In particular, Healthway seeks to create supportive environments and healthy public policy, strengthen community action and work collaboratively across sectors. Before the establishment of health promotion foundations, recreational settings had a minor role in health promotion. Yet since Healthway's inception, research has indicated that the average West Australian attends a foundation-sponsored event on four occasions per year and that Healthway is particularly effective in reaching the most disadvantaged 10% of young people. Many participants also have elevated risk factor profiles compared with the general population *(12)*. Thus, recreational settings present an opportunity to deliver health messages to broad sections of the community, including those traditionally considered hard to reach.

### Health sponsorship in recreational settings

Health sponsorship dollars can be used to negotiate benefits such as naming rights, signage, player endorsement of a health product and structural reforms such as smoke-free areas and health catering *(8)*. When Healthway provides sponsorship funds for larger grants, it simultaneously awards support funds to an independent health agency to promote an audience-appropriate health message at the event. For small grants, Healthway provides a health promotion support kit *(6)*.

Examples of agencies that have received Healthway funds include the National Heart Foundation, Diabetes Association, Cancer Foundation, Asthma Foundation, Australian Sports Medicine Federation, Kidsafe, Australian Council on Smoking and Health, and the Alcohol Advisory Council. Healthway also provides support to smaller community-based organizations. This helps to achieve a more equitable distribution of health-promoting resources within the community *(6)*.

### Achieving structural reforms: Smoke-free policies

Structural reforms to create healthier environments have been introduced into sports, art and racing venues by Healthway. These reforms include smoke-free areas, healthy catering, sun protection measures, safe alcohol practices, safe exercise practices and improved access for disadvantaged groups *(6)*.

The introduction of smoke-free policy was an incremental process. Initially, as part of the sponsorship agreement, Healthway requested the creation of smoke-free areas. Later, as contracts were renegotiated, Healthway required venues and events to become entirely smoke-free *(8)*.

Prior to the implementation of smoke-free policies, a survey was conducted at major sporting venues to assess public support for this activity and the majority favoured at least some restrictions *(13)*. After introduction, the support among spectators actually increased further, particularly among non-smokers *(14)*. Furthermore, Pikora et al. *(15)*. found that the level of compliance with the policy at two major sporting venues in WA was high, indicating that the measure was effective in protecting non-smokers from environmental tobacco smoke. The successful introduction of smoke-free sports venues helps to create social norms that strengthen support for smoke-free areas in public places.

### Healthway evaluation

The Health Promotion and Evaluation Unit of the School of Population Health at The University of Western Australia evaluates Healthway programmes. In the early years, the University's Graduate School of Management was also involved. Evaluation is necessary to ensure that Healthway is meeting its health objectives. For projects attracting funds valued at over $AUD 25,000, post-event surveys are undertaken to assess cognitive and attitudinal measures such as awareness, comprehension and acceptance of the event's health message, using a standardized questionnaire. Encouragingly, past surveys (n=5 710) have indicated that 67% of respondents could recall the health message; of those, 82% had understood it; of those, 88% had accepted it; and of those, 9% (or 4% of the total number of respondents) intended to act on it *(6)*. Evaluation data from 2001 report a further improvement with 9% of the total sample intending to act on the health message *(16)*.

### Tobacco replacement

Tobacco replacement venues refer to those settings previously sponsored by the tobacco industry. Such venues offer opportunities for structural reforms, promotion of anti-smoking messages and targeting of at-risk groups. On evaluation of Healthway's tobacco replacement programme, replacement projects achieved a level of direct population reach for a given amount of funding that was four times higher than other sponsorship projects.

Table 4

**Achievements of the 1990 legislation**

**Achievements of the WA Tobacco Control Act 1990**

1) The WA Health Promotion Foundation (Healthway) established
2) Tobacco sponsorship prohibited and replaced with Healthway sponsorship
3) Tobacco advertising restricted to point of sale only from July 1994
4) Distribution of free tobacco samples and competitions involving tobacco products banned
5) Penalties for the sale of tobacco to minors raised
6) Facilitated the passage of a national ban on tobacco advertising, effective as of end of 1995

**Achievements of the WA Health Promotion Foundation (Healthway)**

1) Promotion of health messages at sports, arts and racing venues
2) Replacement sponsorship to organizations previously sponsored by tobacco industry by 8 February 1992
3) Sponsorship for other sports and arts organizations
4) Replacement of all outdoor tobacco advertising by 1 July 1994, 25% replaced directly by health promotion messages
5) Implementation of structural changes at venues e.g. smoke-free areas, healthy catering
6) Collaboration with sectors outside of health including recreational and cultural sectors
7) New source of Government funding for health promotion research and community projects
8) Facilitated the introduction of the WA Health (Smoking in Public Places) Regulations, which banned smoking in enclosed places, including restaurants in 1999

Source: Holman CD, Donovan RJ, Corti B. Report of the evaluation of the Western Australian Health Promotion Foundation. Health Promotion Development and Evaluation Programme, The University of Western Australia, 1994.

Musk AW, et al. Progress on smoking control in Western Australia. *British Medical Journal*, 1994, 308:395-398.

Structural change towards a smoke-free environment was also obtained more often. However, surveys have revealed a higher resistance to health messages at these sites *(17)*.

### Effects of programme on smoking prevalence

The overall trend in the prevalence of smoking in WA has been downward. While there are numerous reasons behind reductions, which cannot be attributed to any single tobacco control measure, it is likely that the ban on tobacco sponsorship and outdoor advertising and the work of Healthway have contributed to the fall in prevalence.

In 1998, the prevalence of smoking among young West Australians was the lowest in the country. This may in part be due to the Smarter Than Smoking campaign, which began in 1995, with the aim of discouraging smoking among young people. This initiative receives funding from Healthway.

### Achievements

The achievements of the WA Tobacco Control Act 1990 and Healthway are summarized in table 4.

## Other impacts of the intervention

### Effect on government finances and tobacco company revenue

The establishment of Healthway was not directly linked to an increase in the state franchise fee. However, by 1995, almost two-thirds of the retail price of a packet of cigarettes in WA was accounted for by the federal excise duty and state franchise fee *(7)*. With respect to the tobacco companies, during the early 1990s, increased taxation, limitations on advertising opportunities, negative publicity about tobacco products and an economic recession affected industry profitability. Locally, the WA Tobacco Control

Act 1990 contributed to this. Competitive price discounting ensued and by August 1994, these subsidies were costing the tobacco companies some $AUD 8 million per week. The companies recognize that the Australian market is declining and are turning to more profitable ventures in the Asia-Pacific region (19).

### Banning tobacco-funded research

Healthway has successfully banned tobacco-funded research at WA's four major universities by making it a condition of funding that organizations do not accept financial support from the tobacco industry. At the time, these universities were among only 13 of the 45 universities across Australia reported to have even discussed the issue *(8)*.

### Paving the way for further anti-tobacco legislation

By creating smoke-free venues with community support, Healthway paved the way for further tobacco control measures. In 1999, the WA Health (Smoking in Public Places) Regulations banned smoking in enclosed public places, including restaurants, with a limited number of exemptions for bars and some gaming areas. WA was the first state in Australia to implement such legislation.

## Conclusion

The health promotion foundation model was developed primarily to replace tobacco sponsorship and outdoor advertising, using a portion of the revenue raised from government tobacco taxes, with health-promoting alternatives including anti-smoking messages and structural reforms. Secondary benefits include the creation of new opportunities for health sponsorship and the availability of an additional funding source for health promotion programmes and research. Healthway, a model that has been used in a number of Australian states and in California is one example of what a health promotion foundation can achieve.

It is this author's opinion that health promotion foundations are an effective tobacco control measure and could be used more widely, in both developed and developing countries. However, strong leadership, a stable govern-

**Table 5**

**Achieving change: lessons for tobacco control advocates and policy-makers**

| |
|---|
| 1) Identify realistic objectives and priorities |
| 2) Adopt an incremental approach to change |
| 3) Coordinate professional networks |
| 4) Develop a strategic plan |
| 5) Educate decision-makers |
| 6) Secure an ongoing funding arrangement, preferably using tobacco taxes |
| 7) Collaborate with a variety of sectors and organizations |
| 8) Foster cooperative relationships with sponsored organizations |
| 9) Recruit community support and involvement |
| 10) Select audience-appropriate health messages |
| 11) Develop opportunities for structural reforms |
| 12) Renegotiate contracts on a regular basis |
| 13) Evaluate programmes, including reach, impact and outcomes |
| 14) Communicate progress to stakeholders and the community |

*Source:* Musk AW et al. Progress on smoking control in Western Australia. British Medical Journal 1994;308:395-398.

Corti B et al. Warning attending a sport, racing or arts venue may be beneficial for your health. *Australian and New Zealand Journal of Public Health* 1997, 21:371-376

ment and a commitment to health are required to achieve this type of change and some important lessons are listed in Table 5. Undoubtedly, there will be strong opposition from the tobacco companies and extensive consultation with current recipients of tobacco company largesse will be required to allay fears of revenue loss as a result of the proposed changes. Several iterations may be required before legislation is passed. On the other hand, since this measure is not reliant on an increase in tobacco taxes *per se*, it may be easier to introduce this strategy in between tobacco tax increases, as occurred in Western Australia.

Finally, any comprehensive national or state-based tobacco control programme relies on a number of strategies, including legislation, taxation, education, and environmental and organizational change. Establishing a health-promotion foundation using earmarked tobacco taxes to replace tobacco advertising and sponsorship is one innovative and effective component that can be added to the armamentarium.

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**Tools for Advancing Tobacco Control in XXI$^{st}$ century:**
Success stories and lessons learned

**Outils pour poursuivre la lutte antitabac au XXI$^{e}$ siècle:**
Expériences concluantes et nouveaux enseignements

# Labelling and Packaging (including Health Warnings)

WHO/NMH/TFI/FTC/03.12

p11-15.12—

## Thailand Country Report on Labelling and Packaging

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Tobacco Free Initiative Headquarters would like to thank the Regional Offices for their contribution to this project.

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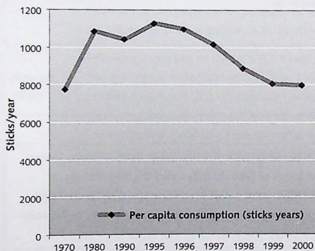
## Introduction

From 1981 to 2001 there were dramatic changes in tobacco consumption in Thailand. The total number of smokers rose from 9.7 million in 1981 to 10.6 million two decades later. Smoking prevalence declined from 35.2% to 22.5% during the same period. The male smoking rate decreased from 63.2% to 42.9%, while female prevalence fell from 5.4% to 2.4.%. Per capita consumption rose from about 774 in 1970 to 1 087 in 1980. Since that time, it has decreased progressively to 798 in 2000.

### Figure 1

**Per capita consumption estimates 1970-2000**




Source: Developed by THPI from: Guidon GE, Boisclair D. Past, Current and Future Trends in Tobacco Use. HNP Discussion Paper. Economics of Tobacco Control, Paper N° 6, February 2003.

There have been no systematic studies of morbidity and mortality of tobacco-related diseases. Table 1 shows that the estimated number of deaths from various diseases in South East Asia for 2001 (within the low child and low adult mortality stratum to which Thailand belongs).

### Table 1

**Estimated number of deaths from diseases in South East Asia, 2001**

| Diseases | Deaths |
|---|---|
| Cancer of trachea, lung, and bronchus | 35 000 |
| Cancer of mouth and oropharynx | 16 000 |
| Respiratory diseases | 130 000 |
| Ischaemic heart diseases | 232 000 |

Source: World Health Report, 2002. Geneva, World Health Organization, 2002.

In terms of cancer of the various organs, lung cancer was the second most common cancer between 1988 and 1991 in Thailand. Women in the northern region of the country, who have the highest smoking prevalence among the various regions, have lung cancer at an age-standardized incidence rate of 37.4 per 100 000 (1).

## Policy intervention

Policy intervention on labelling and packaging, including health warnings, only involves manufactured cigarettes. This applies equally to both domestic and imported cigarettes. Other tobacco products, e.g. cigars and pipe tobacco, are not included because there are too many varieties of packages and it is difficult to carry out regulatory procedures. In addition, the consumption level of these products is low and small gains in health are not worth the regulatory effort.

In Thailand, policy is based on legislative action. Initially, the Medical Association of Thailand pressed for regulatory action and such issues were later taken up by the Announcement of Labelling Committee of the Consumers Protection Board (CPB) pursuant to the Consumers Protection Act 1979. This announcement became effective on 20 September 1990. Finally, labelling was mandated by successive Ministerial Announcements pursuant to the Tobacco Products Control Act (TPCA) 1992. After this Act became effective on 3 August 1992, the CPB's Announcement of Labelling Committee was disbanded. These efforts are outlined chronologically in table 2.

## Steps toward implementation

Before 1989 there was no established national policy to control tobacco consumption. In late 1988, the Deputy Director-General of the Department of Medical Services (DMS), proposed and received approval from the then-Minister of Public Health (later a two-time Prime Minister of Thailand) to establish an inter-agency policy committee for tobacco control called the National Committee for Control of Tobacco Use (NCCTU).

In the proposal the committee appointed the Public Health Minister as the chairman. The members comprised chairpersons of the standing committee on health of both the Senate and the House of Representatives. They were the following: permanent secretaries[1] of the Ministries of Public Health, Education, Agriculture, Interior, Finance, and Prime Minister's office; Deputy Permanent Secretary for Health of the Bangkok Metropolitan Administration; Director-Generals of Departments of Health, Medical Services, Excise, Public Relations; President of the Reporters Association of Thailand, Secretary-General of the Medical Council, and five experts. The Deputy-Director-General was the NCCTU's first secretary.

The Ministry of Public Health (MOPH) proposed the formation of the NCCTU. The proposal received approval from the Cabinet and the Committee was formally established on 14 March 1989. This interagency body is now responsible for formulating the country's policy on tobacco control. To this end it has initiated several tobacco control policies, one of which was a regulation mandating health warnings.

Table 2

**Chronology of regulation on labelling and packaging**

| **The first health warning** | |
|---|---|
| **1967** | A secretary-general of the Medical Association of Thailand under Royal Patronage, who was also a chest physician with post-graduate training in the United States of America, requested that the Ministry of Finance require the Thailand Tobacco Monopoly (TTM) to print a health warning on cigarette packages they produced. (The Ministry supervises the TTM, which was the only cigarette manufacturer in the country at that time). |
| **1974** | After a long delay, the TTM began printing the small health warning 'Smoking may be harmful to health' on the side of cigarette packages. |
| **The second set of health warnings** | |
| **25 April 1989** | At its first meeting the NCCTU secretary proposed that there had been only one small health warning placed on cigarette packets and six new rotating health warnings should be mandated. The NCCTU approved the new set, which comprised the following messages: 'smoking causes lung cancer and emphysema', 'smoking causes ischaemic heart disease', 'smoking harms babies in the womb', 'respect other people's rights by not smoking in public places', 'giving up smoking reduces serious illness' and 'for the sake of your children please give up smoking'. |
| **11 July 1989** | The cabinet endorsed the MOPH proposal mandating health warnings on cigarette packages and ordered the CPB to take further action. |
| **18 May 1990** | The CPB's Labelling Committee mandated a seventh health warning on cigarette packages, namely, 'smoking may be harmful to health' (this warning had been in place since 1974), as well as the six warnings approved by the cabinet. These had to be placed in the front of the package, the size of the letters had to be at least 1 mm wide and at least 2 mm high. The warning had to be evenly distributed among the produced packages. This announcement became effective on 20 September 1990.<br>The procedures for enacting a law or a regulation pursuant to a certain section of a law must follow these consecutive steps: |

| | |
|---|---|
| | — a law is passed by the National Assembly;<br>— the Prime Minister proposes the law to His Majesty the King of Thailand;<br>— the King signs on to the law and returns it to the Prime Minister, who counter signs; and<br>— a regulation or ministerial announcement is sent to the Government printing house to be published in the Royal Gazette. The announcement is publicized by the person responsible for that law, and includes a statement on how many days following its publication the law will become effective. |
| **The third set of health warnings** | |
| **3 August 1992** | The TPCA 1992 was enacted and became effective as of 3 August 1992. Section 12 of this Act stated that 'the manufacturer or importer of the tobacco products must place the labels on the packages of tobacco products before they leave the manufacturing site or before importation into the Kingdom[2] as the case may be.<br><br>The criteria, procedures and conditions of displaying these labels and the statements therein shall be in accordance with those published in the Government Gazette by the Minister.[3] |
| **25 August 1992** | Following a meeting of the NCCTU, it was decided that a new set of health warnings would be mandated. The Ministerial Announcement, pursuant to Section 12 of the TPCA 1992, was issued mandating ten rotating health warnings on cigarette packages. They were the following: 'smoking causes lung cancer', 'smoking causes heart disease", 'smoking causes lung emphysema', 'smoking causes obstructive or haemorrhagic stroke', 'smoking kills', 'smoking is addictive', 'smoking is harmful to people around you', 'smoking is harmful to babies in the womb", 'quitting smoking reduces the risk of serious illness' and 'giving up smoking leads to a healthy body'.<br><br>The warnings had to occupy no less than 25% of the front and back of the main surfaces of cigarette packages or cartons. The lines bordering the warnings had to be white and letters black. The size of the font 'Si Phya' had to be 16 points for packages that have 37 cm² of the main surfaces, 21 points for 37–85 cm², 33 points for 85 cm² and 36 points for the cartons. |
| **24 Sept. 1992** | The announcement was published in the Royal Gazette and the regulation became effective one year later. |
| | This set of warnings represented a significant strengthening of tobacco control laws compared to previous ones. This was largely due to the fact that MOPH had just passed its own law (the TPCA 1992), which was a means of putting its regulations into effect. In addition, the Ministry had just established the first national governmental agency for tobacco control – the Office of Tobacco Consumption Control, which acts as a full-time secretariat for the NCCTU. The first and second set of health warnings were initiated by other mechanisms outside the full control of the MOPH, that is, by the Medical Association of Thailand under Royal Patronage and by the NCCTU via the Consumers Protection Act, which fell under the responsibility of the CPB of the Prime Minister's Office. The third version was achieved by the NCCTU secretariat. |

1 A permanent secretary is the highest ranking permanent official of a ministry.

2 "Kingdom" is the legal term for the Kingdom of Thailand

3 "Ministers" means the Minister of Public Health who is responsible for this Act.

| **The fourth set of health warnings** | |
|---|---|
| **15 October 1997** | The NCCTU decided to mandate a new version of health warnings. The new Ministerial Announcement was issued replacing the former one, mandating ten health warnings on cigarette packages: 'smoking causes lung cancer', 'smoking causes heart failure', 'smoking causes emphysema', smoking causes brain haemorrhages, smoking causes leads to other addictions, 'smoking causes impotence', 'smoking causes premature aging', 'smoking can kill you', 'smoke harms people near you', and 'smoke harms babies in the womb'. The warnings had to follow the requirements described below:<br>— The warnings, including bordering lines, must occupy no less than one-third of the principal surfaces of the cigarette packages or cartons.<br>— The border must be white and 2 millimetres thick.<br>— The background must be black and the letters white.<br>— The letter font must be 'Si Phya' and the size must be 20 points for packages with an area of 37 cm2 front and back, 25 points for an area of 37–80 cm2, 38 points for 80+ cm2 areas and 75 points for cigarette cartons. |
| **4 Nov. 1997** | The announcement was published in the Royal Gazette and became effective one year later. |
| **The fifth set of health warnings – the pictograms** | |
| **Feb. 2000** | The president of the Thailand Health Promotion Institute (THPI), who was a DMS adviser, suggested to the then-Director-General of the DMS that Thailand mandate pictorial health warnings. The Director-General agreed and ordered the DMS's Institute of Tobacco Consumption Control (ITCC) to proceed. |
| **23 March 2000** | The MOPH approved the DMS proposal and set up a committee to consider graphic health warnings on cigarette packages. The DMS Director-General was the chairman and THPI president was the vice-chairman. |
| **5 April 2000** | At the first meeting TTM representatives opposed the printing of graphic health warnings on cigarette packages. The THPI president, who was the meeting chairman, asked the TTM to submit an official letter explaining its reasoning. In its letter the TTM stated that they only had a printer that could produce three-colour pictures. For four-colour pictures a new machine would have to be imported, and in addition to costing 12 million Baht, it would take two to three years to acquire.<br>The THPI president asked the ITCC to ignore the TTM's complaint and proceed to acquire three-colour pictures for the health warnings.<br>The protracted delay in implementation could have been due to either the ITCC's bureaucracy or the tobacco industry's underground lobbying. In Thailand the transnational tobacco companies never act publicly because every time they do they are heavily challenged by the country's strong tobacco control advocates. |
| **28 Feb. 2002** | During the NCCTU meeting the THPI president complained that the process of acquiring pictorial health warnings was dragging and the NCCTU ordered further action without delay. New subcommittees were established, one for implementation of the TPCA. |
| **26 April 2002** | At the subcommittee meeting chaired by the THPI president it was decided that 12 pictorial health warnings would be put in the Ministerial Announcement. The themes of the 12 pictures included the 10 previous warnings and 2 new ones 'smoking causes oral cancer' and 'smoking causes foul odours and blackened teeth'. |

| | |
|---|---|
| **3 May 2002** | After several contacts with the ITCC to determine the progress of preparing pictures and ministerial announcements, the THPI president found that there were certain obstacles in the process, namely, the major difficulties in acquiring pictures through bureaucratic means. The THPI then decided to use media advocacy to push for the policy's achievement by releasing a press message reporting that Philip Morris had sent a letter dated 27 February to the Public Health Minister threatening to take legal action if the MOPH ordered the printing of pictorial health warnings on cigarette packages. |
| **4 May –17 June 2002** | The press release culminated in a continuous stream of news, letters, and articles in the media and in international news agencies as well as numerous radio and television interviews, including CNN. |
| **11 May 2002** | An entire week after news broke out of the Philip Morris threat the Public Health Minister stated in a press interview that the MOPH did not believe that the decision mandating pictorial health warnings was contradictory to the Constitution and TRIPS (Trade-related aspects of intellectual property rights), and that the MOPH would go ahead with the plan. |
| **17–21 June 2002** | The THPI president asked for and received a green light from the DMS to produce the pictures. It was decided that five pictures, which depicted diseased organs, would be acquired from hospital slide libraries, that is, lung cancer, heart disease, emphysema, stroke, and oral cancer, and the other seven pictures would be acquired by conducting a country-wide contest so that the public could participate. The Photography Association of Thailand under Royal Patronage was invited to collaborate and the Thai Health Promotion Foundation was asked to fund the contest. |
| **3 July 2002** | Nongovernmental organizations (NGOs) organized the award ceremony for the contest winners. The Minister of Public Health was invited to chair the events. |
| **6 Sept. 2002** | The THPI sent the complete set of pictorial health warnings to the DMS Director-General to draw up the ministerial announcement and proposal for the Minister of Public Health to sign. |
| **1 Oct. 2002** | The newly organized MOPH proposed that tobacco control work be a part of the new Department of Disease Control (DDC). |
| **1 Nov. 2002** | The THPI president sent a letter to the DDC Director-General urging him to expedite the long-delayed process. |
| **20 Jan. 2003** | The DDC Director-General called a meeting to consider pictorial health warnings. THPI president and Action on Smoking and Health (ASH) Secretary-General were invited. The Director-General asserted that the 12 pictures acquired did not seem to communicate very well to the viewers. The meeting decided to have a pre-test for these pictures. |
| | After acquiring satisfactory pictures there are still a few steps to be taken: drawing up the Ministerial Announcement, sending a proposal to the MOPH Minister for signature; and publication in the Royal Gazette. This regulation would become effective six months following its publication. The long interval would provide ample time for the cigarette producers to clear their stock and produce the new labelling. |

### Opponents counter the intervention

The tobacco industry does not want graphic health warnings and would go to any lengths to obstruct this effort. There are two main reasons:

— The pictograms were found to be very effective. An evaluation in Canada showed that 44% of smokers said the pictorial health warnings increased their motivation to quit, 58% thought more about the health effects of cigarettes, 27% were motivated to smoke less inside their home, and 62% thought the pictograms make the packages look less attractive.

— Thailand would be the third country in the world to mandate graphic health warnings if the regulation passes and it would be an exemplary regulation that other countries would follow.

The Philip Morris letter of 27 February 2002 was sent to the Public Health Minister, though no one knew her response or that of her secretariat. The THPI president knew of the Philip Morris action from a DMS official and asked a DMS Deputy-Director-General to fax the Philip Morris letter. The THPI then used the letter for advocacy in the media to reinforce the policy of educating smokers through pictorial health warnings.

The Philip Morris letter propagated four myths.

— **Myth 1:** "It would impose an undue burden on the Company in that Ministerial Regulation (No.6). B.E. 2543 already requisitions 33.3% of the total area of a cigarette pack for the prescribed textual health warnings."

— **Reality:** What type and how big is the 'undue burden'?

— **Myth 2:** "The Regulation would impair the use of the Company's valuable trademarks by obscuring the marks on the pack face, thereby undermining the trademarks' functions of brand identification and communication with the Company's customers. Packaging is more important for cigarettes than other products since all forms of advertising are banned by the Tobacco Products Control Act."

— **Reality:** The trademarks are still there and not obscured.

— **Myth 3:** "The Company has the right to communicate with its customers through its display of trademarks and logos. Any attempt to limit this right must be necessary to achieve a legitimate public purpose. The imposition of the graphic health warnings would limit this right unnecessarily because existing health warnings already cover one-third of the pack."

— **Reality:** The Government also has the right to clearly inform the people about the health hazards of smoking.

— **Myth 4:** "Trademarks are valuable Company property and are protected by the Trademark Act B.E. (Buddhist Era) 2534, the Penal Code, as well as by TRIPS, of which Thailand is a member. TRIPS provides that the use of a trademark shall not be unjustifiably encumbered by special arrangements, such as use in a special form or manner detrimental to its capacity to distinguish the goods or service of one undertaking from those of other undertakings. The Regulation would violate this principle."

— **Reality:** The Trademark Act B.E.2534 prohibits destruction or imitation of trademarks. The pictograms would do neither.

TRIPS provides public health exception in Article 8.2, which states that the "Member may, in formulation or amending their national laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in the sectors of socioeconomic and technological development, provided that such measures are consistent with the provisions of this agreement." Therefore, the regulation on pictograms does not violate TRIPS.

The Philip Morris letter sent to the Public Health Minister was meant only to bluff those who were unfamiliar with Thailand's copyright law, its constitution and TRIPS. By citing the risks involved in their taking legal action, the tobacco multinationals had hoped that the MOPH bureaucrats would stop the implementation process.

## The intervention's success

Regulation on packaging and labelling has been quite successful. To date, the first four different sets of health warnings have been mandated. The number of rotating warnings has increased from one to twelve. The warning area size on cigarette packages and cartons has been enlarged from small letters on the sides of cigarette packages to one-third of the principal surfaces of packages, including cartons. The last set of pictorial health warnings, occupying half of the front and back, is being prepared and it is hoped that it will be enacted in 2003.

In Thailand, there has been no scientific study of the impact of cigarette package textual health warnings on tobacco use.

## Other impacts of the intervention

The graphic health warnings have created immense public interest. There is widespread support from the media and all sectors of society.

Media advocacy about pictorial health warnings has been enormous as the following figures demonstrate:

- After the THPI press release, from 4 May to 17 June 2002, the subject was mentioned 16 times in the newspapers and 6 of those articles were published on front pages; 4 letters and 5 newspaper articles devoted to the subject; at least 4 news releases by international news agencies, including CNN, and innumerable radio and television interviews.
- Before and after the picture contest described in Table 2, from 17 June to 4 July 2002, pictorial health warnings were mentioned 23 times in newspapers; there were 4 newspaper articles on the subject, 1 public opinion poll, and numerous radio and television interviews.

## Conclusion

Package labelling is a vital measure in controlling tobacco. It should be mandated with minimum cost, changed at appropriate intervals, and improved consistently. Thailand's legal system enables it to be easily implemented because packaging and labelling is a section of the law and regulation can be passed pursuant to the legislation. Textual health warnings can be changed and upgraded into pictorial ones that have, according to the Canadian experience, better impact upon smokers.

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# Labelling and Packaging (including Health Warnings)

WHO/NMH/TFI/FTC/03.13

PH-1513

## Labelling and Packaging in Brazil

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# Labelling and Packaging in Brazil

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## Introduction

Brazil is the largest country in South America, with an area of 8 547 403.5 square kilometres and a population of 169 799 170 (IBGE, 2000). Its geopolitical structure comprises 26 states and one Federal District, the capital of Brazil, Brasilia. Each state is divided into municipalities, of which there are a total of 5 507.

The primary causes of death in Brazil are cardiovascular diseases and cancer and their major risk factor is tobacco use. Lung cancer is the leading cause of death by cancer among men and the second cause among women. In 1999, there were 14 127 deaths due to lung cancer. Among women the mortality rate of lung cancer is increasing faster than among men. An analysis of a temporal series of cancer mortality from 1979 to 2000 showed that the lung cancer mortality rate among men rose from 7.73 per 100 000 to 12.13 per 100 000, representing a 57% increase. Among women it rose from 2.33 per 100 000 to 5.33 per 100 000, which represented a 134% increase (Ministerio da Saúde do Brasil/Instituto Nacional de Câncer, 2003).

In 1989, a national survey on health and nutrition showed that smokers comprised 32.6% of the population over 15 years of age (IBGE, 1989). There were nearly 28 million smokers in the group over 15 years old. Among them, 16.7 million were males and 11.2 million were females (Ministério da Saúde, 1998). The Ministry of Health is developing a new, nation-wide survey in 26 states and in the Federal District, *The national domicile survey on risk behaviour and referred morbidity related to non-communicable diseases*. It will include 53 987 people in 18 794 households and provide a new tobacco-use profile in Brazil.

The monitoring of per-capita cigarette consumption shows a reduction of over 32% when comparing the annual per-capita consumption in 1989 and in 2001 (including consumption estimates of the black market). In 1989 annual per-capita cigarette consumption was 1 772 whereas in 2001 it was 1 194.

In 2001, a survey among 2 479 people living in Rio de Janeiro city (Ministério da Saúde/ Instituto Nacional de Câncer, 2002b) showed that smoking prevalence had decreased from 30% in 1989 to 21% in 2001.

At the same time, Brazil is the world's third-largest tobacco producer, after China and India. It is also the world's leading exporter of non-manufactured tobacco (Ministério da Saúde, 2000; ILO, 2003).

## The National Tobacco Control Programs

The National Cancer Institute of Brazil (INCA) is the Ministry of Health body that coordinates the National Cancer Control Policy and the National Tobacco Control Programme.

INCA has coordinated the National Tobacco Control Programme for the last 14 years. This programme encompasses four main strategy groups: prevention of smoking initiation, protection of the population from environmental tobacco smoke exposure, promotion and support for smoking cessation and tobacco product regulation.

To this end, the programme was structured to systematize different kinds of educational activities and to mobilize legislative and economic action with a view to creating a favourable social context that would:

- reduce social acceptance of smoking;
- reduce the social stimulus to smoking initiation by youth;
- reduce the social stimulus that makes it difficult for smokers to quit;
- protect the population from the hazards of passive smoking;
- reduce access to tobacco products by minors; and
- increase availability and accessibility to smoking cessation support.

In addition to these actions, it was necessary to develop a strategy that would ensure that these efforts had a nationwide reach. Therefore, the process of building a network with State and municipal health offices was begun. With the support of this network, a national action plan for tobacco control has been carried out throughout the country. To prepare human resources from state and municipal health offices to manage the programme at the local level, INCA launched a capacity-building process in 1996 for programme management. Today the programme management is shared among all 26 States, the Federal District and over 3 500 municipalities.

Considering that one of the most important components of tobacco control action is socialization of scientific knowledge on the hazards of tobacco, the programme has sought to develop different kinds of efforts towards this goal. It has been disseminating information through

campaigns and the mass media as well as engaging in continuous educational interventions directed at opinion leaders, such as teachers and health professionals, using school-, health unit- and workplace-based programmes. Within this context, one of the most important strategies employed to reach the smoker is the dissemination of information through tobacco product packs.

## Why tobacco product packs are used to inform consumers about tobacco risks

According to data presented by the World Bank (1999), people's knowledge about the health risks of smoking appears to be partial, especially in low- and middle-income countries, where information about these hazards is limited. Today, 80% of the global consumption of tobacco is concentrated in low- and middle-income countries. In China, where 25% of world's smokers live, 61% of adult smokers surveyed in 1996 believed that cigarettes did them "little or no harm" (World Bank, 1999).

For over a century, cigarette smoking has been advertised and promoted through different strategies to target different people in their different aspiration of happiness and fitness. This reality has enabled the creation of a positive representation of smoking and a favourable social context for the growth of smoking. As part of these strategies, cigarette packs have been used as an important way of promoting and marketing to attract the smoker, through colours, shapes and brand names. Cigarette packs were also used to send subliminal messages to tranquillize the smoker as the scientific knowledge about smoking risks began to increase in the last 50 years (Kozlowski & Pilliteri 2001; Pollay & Dewhirst, 2001; Shiffman, et al., 2001).

One clear example is the fact that the tobacco industry has tried for decades to introduce new brands as safer choices, using the tactic of pack colours and product imagery to communicate the idea of "lightness".

The tobacco industry's own words tell how this works:

> Red packs connote strong flavour, green packs connote coolness or menthol and white packs suggest that a cigarette is low tar. White means sanitary and safe. And if you put a low-tar cigarette in a red pack, people say it tastes stronger than the same cigarette pack in white (Pollay & Dewhirst, 2001).

Considering the pack influences over the smoker's choices, Brown and Williamson tested 33 packs before choosing the blue, gold and red pack design for the brand Viceroy Rich Light. Phillip Morris's successful brand *Merit* connotes a "flamboyant, young-in spirit- image (to offset low tar's dull image) with big, yellow, brown, and orange racing stripes" (Pollay & Dewhirst, 2001).

Tobacco companies also recognize certain elements as key to the product's acceptance. One of them is psychological and another is the product's ability to deliver the physiological stimulus of nicotine.

As tobacco industry documents acknowledge, the marketing strategies are enhanced by nicotine dependence and create a very strong relationship between the smoker and the packs of his or her preferred brand. Cigarette packs are present at every moment of a smoker's life, in situations of pleasure and satisfaction as well as in moments of sadness and conflict. Many times the smoker lights his or her cigarette as a reflex, and several social cues, such as drinking coffee, reading, creating intellectual works, driving, and others, function as triggers to this act. (Henningfield et al., 1993; Balfour & Fagerström, 1996).

Within this context, obtaining knowledge about smoking risks and their dimensions is one of the first steps of the cognitive behaviour approach for smoking cessation. Other components can develop strategies to break the automatic behaviour of smoking by creating obstacles. This can be achieved by making access to tobacco packs and to smoking difficult or creating other kinds of internal barriers, such as thinking about the negative aspects of smoking. In order to deal with cravings and to maintain abstinence, many former smokers report using a strategy of creating a mental image of a harmed lung or other organ, or the image of a loved one suffering from severe tobacco-related illness, such as cancer.

Considering this context, it is clear that tobacco products packages could function as an important vehicle for risk communication. Besides reinforcing the knowledge and the dimension of the hazards of smoking, strong health warnings on packs, mainly when illustrated by photo images, could also undermine the attraction and the cues that make a smoker light a cigarette automatically in various situations during the day.

In addition to breaking the automatic habit of lighting up, the health warning with photo illustrations could also destroy the positive aura that was created around cigarette packs for many years. Likewise, it could have an important influence in changing cultural beliefs about smoking, mainly in low- and middle-income countries, where information

about hazards is limited. Towards this goal, the larger the space the warnings occupy on the packs, the greater will be their communication power. Therefore, it is vital that the strength of the warning messages be proportional to the magnitude of the risks.

On the other hand, it is also possible that many smokers will refuse to look at these images, mainly those smokers who do not want to quit as well as those who even wanting to, have trouble remaining abstinent. Some of them will ignore the images. But even so, this measure will have achieved its function. The pack will not exert the same attraction as it did before. The smoker will be conflicted, ambivalent, and in general, this is the first feeling that leads the smoker toward the process of quitting smoking.

## The evolution of health warning messages on tobacco packs in Brazil

In Brazil, the process of tobacco control began in 1985, when the Government, pressured by nongovernmental organizations (NGOs) and medical associations, officially assumed the role of coordinating tobacco control actions, and created the Health Ministry Advisory Board for Tobacco Control (Mirra & Rosemberg, 2001). Three years later, and inspired by the example of the United States of America, where the health warning insertion on tobacco products had been approved by the United States Congress, it was possible to publish the first regulation on this issue in Brazil. Hence, in August 1988, the Ministry of Health Ruling no 490[1] was published. This ruling recommended restricting smoking in indoor public spaces, regulating tobacco advertising and requiring tobacco companies to include the health warning "The Health Ministry advises: Smoking is harmful to health" on all tobacco product packs (cigarettes, cigars and pipe tobacco) as well as advertisements. The ruling also required that the letters be clear, legible, and written in contrasting colours. The responsibility for ensuring that tobacco companies complied with this ruling was given to the Health Ministry's Health Surveillance department and to regional health offices.

[1] This is a type of executive act that can be put into force by any public authority and that can involve guidelines regarding existing laws, rules, recommendations of general character, rules for the carrying out of services or any other act within its competence. It does not have the power of a Federal law.

In 1989, INCA, under the auspices of the Ministry of Health, assumed the responsibility of coordinating the National Tobacco Control Programme. On that occasion, following once again the example of other countries such as the United State of America and Canada, INCA started seeking to upgraded the regulation on the health warning. In 1990, a new Ruling of the Ministry of Health no 731 increased the size of the warning on packs and in ads, prohibited smoking in health units and banned the free distribution of cigarettes. The idea was to amplify the power of the warning, making it more explicit about the risks of tobacco use, since previous warnings were vague. Later, in 1995, the Inter-ministerial Ruling 477 (a ruling signed by more than one Government ministry) replaced the previous regulation and the former warning was replaced by a varied and more specific series of health warnings.

It is important to note that this new regulation was signed by the Health Ministry, the Communication Ministry and the Justice Ministry. It was also a result of a negotiation process that led to an agreement among these three ministries as well as trade associations representing the media and the tobacco industry. The presence of the tobacco industry representative in the negotiation process was probably the result of the tobacco lobby and trade associations.

During the negotiation process, INCA, as the Ministry of Health technical advisory board for tobacco control, presented various proposals for the new health warning messages, including one about nicotine dependence and pictograms to illustrate the warnings. At that time, despite all the accumulated scientific knowledge on the power of nicotine to create physical dependence, the tobacco industry, as usual, strongly denied the addictive nature of tobacco, and refused to agree to including the warning on the addictive properties of tobacco. On that occasion, the tobacco industry also exploited the uncertainty of the epidemiological risk argument to avoid the use of more direct statements for the warning messages. It was a tough negotiation, and neither the pictograms nor the message about nicotine dependence passed as a result of the tobacco industry's resistance. In addition to this, the expression "can cause" was introduced in all messages emphasizing the uncertainty of risks.

Therefore, this ruling was a result of an agreement and had attached to it a commitment letter signed by the three represented government agencies and by the representatives of tobacco companies and media trade associations.

Formerly secret, internal documents of tobacco companies such as Philip Morris and British American Tobacco make clear that industry executives were strongly prepared to resist any attempt to advance health warnings. The following quote illustrates how the tobacco industry had been preparing their executives to deal with health warning issues, which they considered as a threat to their business.

> We should resist the introduction of warning clauses on packs or advertisements on the grounds set out in Position Papers. Additional arguments that could be put forward in negotiations with authorities are that in countries where warning clauses are in force there is no evidence that they have been effective in reducing cigarette consumption... If faced with a warning clause, the wording of which implies or states that cigarettes cause named disease, we should resist it with all means at our disposal and never make this concession. If such wording becomes inevitable, we should do our utmost to ensure that all warning clauses, irrespective of wording, are attributed to Government or some other official body (British American Tobacco Public Affairs, 1992)

The new ruling defined certain graphic specifications for the warnings such as type, size and the duration of the warning's sequential replacement. But it did not define the responsibility for surveillance and applying penalties for non-compliance with the ruling. This enabled the tobacco industry to interpret and apply it as the industry saw fit. Thus, the warnings were inserted on packs in a very discrete way, compromising their visibility, which achieved another tactic that today is confirmed among millions of pages of secret tobacco industry documents.

This strategy is confirmed in another quote found in a British American Tobacco (BAT) analysis of the Marlboro brand and distributed to its affiliated companies (including Souza Cruz in Brazil). This analysis illustrates how deliberately the tobacco industry had been working to reduce the health warnings' visibility on packs. Among the analyses of the characteristics of several packs of Marlboros, such as design, consistency across the market – and over time, the colour red, the way in which health warnings were inserted was analysed:

> ...clever positioning and use of colour (discrete gold) have ensured minimum impact on the overall design and minimum legibility to the smoker. (British American Tobacco Competitor Activity Report, 1994).

Figure 1

**Prior health warning in Brazilian cigarette packs before the new warnings with pictures.**

The Ministry of Health advises: children begin to smoke when they see adults smokiing

### Previous health warnings on Brazilian cigarette packs before the introduction of new warnings with photo illustrations

Though it had not been possible to achieve all INCA proposals due to tobacco industry tactics, there were some gains. For example, it was possible to replace the previous health warnings with different and more specific health warnings in a rotating fashion. In addition, spoken warning messages were introduced following all tobacco ads on radio and TV. Considering that the previous regulation only permitted its transmission in written form and that there was a significant level of illiteracy among the low-income population, such changes in warning messages represented one more advance within this difficult process. The new warnings introduced are outlined below.

The Ministry of Health advises:

- Smoking can cause heart disease and stroke;
- Smoking can cause lung cancer, chronic bronchitis, and emphysema;
- Smoking during pregnancy can cause harm to the baby;
- People who smoke get stomach ulcers more frequently;
- Avoid smoking in the presence of children; and
- Smoking cause severe harm to your health.

Later, in 1996, Federal law[2] no. 9.294/96 was published, regulating different aspects of tobacco consumption, such as smoking in public places, tobacco product advertising and promotion and inclusion of health warnings on the package labels of tobacco products. Consequently, this measure became stronger, as the former executive measure (a ministerial ruling based on an agreement) was replaced with a Federal law. The warnings defined in the prior ruling were retained. But the definition of the characteristics of the lettering remained vague since it only required that the warning message be placed on one of the lateral sides of packs in a legible and highlighted form. There were not any other details specified, such as size and colours of letters and background. There was also no definition of responsibilities for surveillance and applying penalties in the event of non-compliance with the law.

In 1999, thanks to the personal commitment of the Ministry of Health, this measure was strengthened. Federal law no. 9.294/96 was modified by Provisional Measure[3] no. 1814, which gave the Ministry of Health the power to determine the health warnings. It is important to remember that until that time, the language of the messages was that of the previous message in 1995, which grew out an agreement with tobacco industry and trade associations representing the media. Hence, Provisional Measure no. 1814 followed by publication of the Ministry of Health Ruling no. 695 in June 1999 enabled the Health Ministry to render the language of the health warning messages much stronger, and more direct and effective by removing the term "can cause" from the messages. In addition to this improvement, two new and stronger messages were introduced: "Nicotine is a drug that causes dependence" and "Smoking cause sexual impotence". At this point there was no negotiation and the new messages were as outlined below.

The Ministry of Health advises:

— Smoking causes lung cancer;

— Smoking causes heart infarction;

— Nicotine is a drug that causes dependence;

— Smoking causes sexual impotence; and

— Children start smoking by seeing adults smoking.

However, the law still lacked force when it came to the warning's graphic specifications, namely, the size and space it should occupy on packs and the colours. Nor was responsibility assigned for inspection and punishment. The strength of the language was not matched by the quality of the warning's graphics. Exploiting these loopholes, the tobacco industry continued to add the warning messages in muted colours and small letters.

In other words, for the consumers, the visibility of the health warnings on the packs continued to be poor. The way in which the health warning messages were presented suggested that the message was of little import.

## The new health warnings with photo in Brazil

### Key steps

Other important new advances were possible after the National Tobacco Control Programme gained an important ally in the field of tobacco product regulation. Through Federal law no. 9.782 enforced in January 1999, the National Health Surveillance Agency, Agência Nacional de Vigilância Sanitária (ANVISA), was created and within its authority, fell the control, inspection, advertising and promotion of tobacco products.

[2] Before becoming a federal law any legislative initiative has to be submitted for the approval of the National Congress (House of Deputies and Senate). The Constitution of Brazil allows an initiative of a complementary or ordinary law to originate from any member of the National Congress, President of Republic, Federal Supreme Tribunal, Superior Tribunals, the General Procurator of Republic and from any Brazilian citizen. This law came from a Bill originated by a federal deputy supportive of tobacco control in Brazil. When a legislative initiative comes from the executive branch, the National Congress can either approve or not approve it. But depending on the matter of the bill, the non-approval does not prevent the executive branch from converting it into a legislative decree.

[3] For reasons of relevancy and urgency, the President of the Republic can adopt a provisional Measure, that is, a legislative instrument with the power of law. Each provisional measure is valid only for 30 days. After its publication it can be valid for more than 30 days, and after 45 days it is automatically sent to be voted on by the National Congress and Senate, when it can be converted into a federal law or dismissed.

Also in 1999, the National Commission on Tobacco Control[4] in Brazil was formed by Presidential Decree no. 3136[5] (13 August 1999). The commission's objective was to serve as adviser to the Brazilian Government during the negotiation process of the Framework Convention on Tobacco Control (FCTC).

This new commission enabled the measures that were proposed during the negotiation of the FCTC process and the health warnings with illustrations that Canada adopted to be recommended by the National Commission on Tobacco Control in August 2000 to the President of Brazil.

Hence, recognizing the importance of this measure for public health, in May 2001, the President of Brazil published Provisional Measure no. 2.134-30. This regulation complemented the above-mentioned legislative background on tobacco control, determining that the health warnings on tobacco products packs would be illustrated by photo images. At the same time, the publication of ANVISA resolution no. 104 defined the kind of warnings and images that would illustrate them, as well as their graphic specifications, such as colour and size patterns, the placement and the space that they had to occupy on tobacco product packs. It also provided the tobacco industry with models of images and warnings, through the Internet: www.anvisa.gov.br (Figure 2).

The ANVISA Resolution added four more warnings to the five previous ones. The new warnings were related to smoking risks during pregnancy, smoking risks for babies whose mothers smoked during pregnancy, smoking risks for oral diseases, including cancer and risks to breathing impairment that smoking causes. It also prohibited the use of any kind of external wrapping or devices that could impair or make it difficult to see the warnings.

Regarding the size of the health warning messages with photo illustrations, ANVISA Resolution determined that they had to occupy 100% of one of the largest sides of cigarette packs. This decision was due to the small size of cigarette packs in Brazil when compared to Canadian ones. The trials had shown that the model Canada adopted, in which the images occupy 50% of both larger sides of packs, would not fit well on packs in Brazil. This is because they are smaller than Canadian ones, and the images' visibility could be compromised. In addition, in Brazil the only language spoken is Portuguese. Hence, there was no need to put the messages in different languages.

In March 2001, before publishing the health warnings with the photo illustration measure, ANVISA had also published another important measure regarding package labelling, ANVISA Resolution no. 46. It established that the maximum yields for tar, nicotine and carbon monoxide on mainstream smoke for commercialized cigarettes in the country had to be ten milligrams per cigarette, one milligram per cigarette and ten milligrams per cigarette respectively. It also prohibited the use of descriptors such as *light, soft, low yields,* and other terms that could give the consumer a false sense of security about the products. This measure also required tobacco companies to insert information on packs about these yields, and an additional and non-rotating health warning "There is no safe level for consuming these substances". This non-rotating warning had to occupy 100% of one of the lateral pack sides.

It must be underscored that ANVISA's role in surveillance and applying penalties over non-compliance enhanced this measure's power. The penalty for non-compliance includes admonition, product seizure and a fine that can range from 1 410 000 reais (US$ 470.00) to 7 250 000 reais (US$ 2 416 000). In cases of recurring non-compliance, companies can be charged two, three and four times these amounts, depending on the number of relapses.

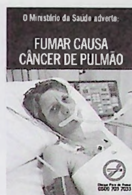
[4] The National Commission on Tobacco Control was created in August 1999 by Presidential Decree no. 3136. Its function was to provide support for the President of Brazil on the Brazilian position during the negotiations of the Framework Convention on Tobacco Control. This Commission has representatives from the Health Ministry, Finance Ministry, Industry and Trade Ministry, Agriculture Ministry, Agrarian Development Ministry, Justice Ministry, Foreign Relations Ministry, Labour and Employment Ministry and Education Ministry. The Ministry of Health is the president of the Commission, and the National Cancer Institute is its executive secretariat.

[5] The term 'legislative d'ecree is used to designate executive measures that have the power of law without being submitted to the approval of the Congress. The Brazilian constitution allows the President of the Republic to publish legislative decrees on specific matters, such as those related to public finances and social security

## Figure 2

**The labeling regulation – on Brazilian tobacco products. Health warning with images illustrating them and information about cigarette emission followed by the message "There is no safe level for this substance consumption:"**

"Smoking causes bad breath, teeth loss and mouth cancer"




"Smoking causes lung cancer"

"Smoking causes heart attacks"

"Children begin to smoke when they see adults smoking"

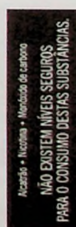
"Smokers are short of breath"

"Smoking during pregnancy harms your baby"

"Nicotine is a drug and causes dependency"

"Smoking causes sexual impotence"

"Cigarette smoking by pregnant women causes premature births, underweight babies and babies liable to have asthma"




One side of packs

"There is no safe level for these substances consumption"

### Tobacco product packs – vehicles to stimulate and give support for smoking cessation

Since INCA had created a hot line to lend support for smoking cessation, the ANVISA Resolution also required the insertion of the hotline phone number in tobacco product packs. This hotline for smoking cessation, *Disque Pare de Fumar,* (Call to quit smoking) complements the stimulus for smoking cessation generated by the health warning on packs.

Through this communication channel, people can receive advice on smoking cessation, and also messages supporting and enhancing the client's self sufficiency in quitting smoking. Since the National Tobacco Control Programme is building a national network of services for supporting smoking cessation in the public health system, the hotline service maps these service locations to show smokers where they can receive a more intensive approach to quitting smoking within the health system.

### Tobacco industry reaction

The tobacco industry was taken aback by the Government's adoption of this measure on health warnings with photo illustrations in 2001, since there was no previous negotiation. However, soon after the measure's announcement, tobacco companies approached the Government to negotiate the three-month timeframe that was first established for enforcing the measures. During the negotiation process, the tobacco industry also tried to downgrade the quality of the warning graphic specifications required by the ANVISA resolution. Using the argument that they lacked the graphic capabilities to produce the quality of graphics the measure required on such short notice, representatives of major tobacco companies in Brazil asked to use only two colours for the warning image printing. They also requested a two-year timeframe to revamp their graphics production to comply with the new regulation's graphic requirements.

Another argument used by the tobacco industry was that the costs of the new warnings would have to be passed on as product price increases, thus increasing the possibility of smuggling and counterfeiting, and lost revenues for the Government.

Following negotiation, February 2002 was targeted as the deadline for the enforcement of both ANVISA measures. So, despite being published in 2001, both measures came into force only in February 2002.

As tobacco companies received more time to comply with the new rules, they exploited this time lag to develop tactics to circumvent the prohibition of the use of brand descriptors like 'light', 'mild', 'low yields'. During the period between the publication of ANVISA's resolution (March to May, 2001) and their enforcement (February 2002), the

**Figure 3**

**Example of brand marketing strategies used in order to create a link between brand descriptors and the color packs variations in a same brand family.**

Soon your Derby is going to change the name of its versions King Size, Suave (Mild) and Lights. Now besides the different yields, the traditional colors are going to mark the difference among them:

Red for those that prefer a more intense taste

Blue for those who want mildness

Silver light taste, the lighter of the family

The names have changed, but Derby is still the same, with the same quality, leadership and taste that conquered Brazil.

**Figure 4**

**Example of advertising cards inserted into cigarette packs by tobacco companies after the new health warning with photos began to circulate in Brazilian market**

FREE MUDOU DE ROUPA

FREE MUDOU DE ROUPA

FREE

CADA UM NA SUA

NICOTINA É DROGA E CAUSA DEPENDÊNCIA

**FREE has changed its clothes**

biggest tobacco companies developed brand marketing strategies to create a link between brand descriptors and pack colours.

At first, they invested heavily in diversification of the colour packs to represent variations within the same brand family. For example, for the Hollywood brand, one of the most popular in Brazil, they created the blue and green menthol variants, in addition to the regular red colour packs. Besides creating different pack colours for each brand family, during the same period they circulated pamphlets with messages to consumers within the packs of these brand variants, introducing them as the new version of the light variation of the brand (Figure 3). The idea was to prepare the consumers to link the colours of the packs with the notion of light, mild or low yields. One of the managers of the companies sent a letter to INCA informing it of the strategy's aim:

> ...Due to the prohibition of the descriptors use, the company will be using different colours for the different versions of a same brand family, as, for example, the Hollywood family, that has the RED, BLUE and GREEN MENTHOL versions, to allow the consumer to identify his preferred brand. The yields of each version are printed on the lateral side of the packs... (Gava JP, unpublished data, 2001)

Tobacco companies also adopted another strategy to circumvent the new health warnings with photo illustrations, after the new packs began to circulate in February 2002. Some companies began to put ad inserts into packs with the same shape and size of the photo warnings, in order to allow the smokers to use them to cover the warning images

During 2002, tobacco companies did not completely comply with the graphic specifications established by ANVISA. Despite the fact that the ANVISA resolution required the messages to be written in white letters on a black background, the packs began to circulate with different background colours. For example, for red packs there was a red background, for blue packs, a blue background, for gold packs, a gold background and so one.

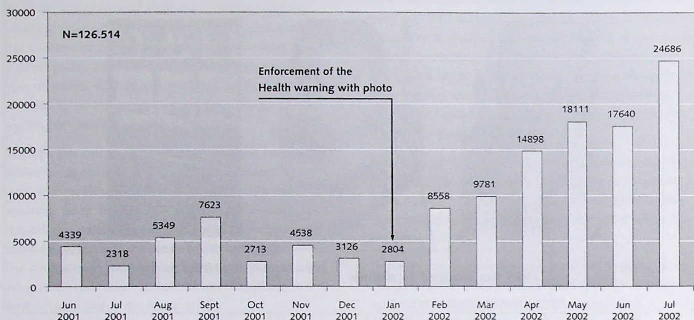
### Government counter reaction

As ANVISA began to apply penalties, the tobacco industry looked to ANVISA to renegotiate the timeframe for adopting the colour quality required by the measure. The argument used was that they still were not prepared to have the quality colours required by the regulation and that they could not reproduce the black colour required as background to the white letters of the warnings.

Therefore, ANVISA renegotiated the timeframe and published another resolution in January 2003. With this new resolution, ANVISA also modified its prior resolution, no. 46 and passed it to require tobacco companies to insert non-rotating warnings on one of the lateral sides of tobac-

**Figure 5**

**Number of calls to the Hot line - Call to quit smoking - before and after the insertion of the hot line number in packs as part of the measure of health warning with photos. Statistics from June 2001 to June 2002**




co products. They were: "This product contains more than 4 700 toxic substances and nicotine that causes physical and psychological dependence. There is no safe level for consuming these substances". It also prohibited the use of messages such as "only for adults" and "product for 18 years older or more" and similar messages that tobacco companies used to place "voluntarily" on the other lateral sides of tobacco packs. Realizing that the message "for adults only" clearly has a strong appeal for adolescents, and reinforces the identification of cigarette packs with the adult world, this new resolution required tobacco companies to replace this 'voluntary and ambiguous' message with a new one targeting tobacco sellers. The new message read: "Sale prohibited to minors of 18 years old, Law 8.069/1990 PENALTY: 6 months to 2 years in jail and fine". This regulation will enter into force in January 2004, when tobacco companies must be prepared to fulfil all of the health warning regulation's graphic requirements.

## Public reaction

The announcement of the health warning with the photo illustration measure galvanized public opinion. There was heavy media coverage and considerable public discussion on this subject.

With the media's intense coverage during the measure's enforcement, many cigarette sellers interviewed by the media reported that there were three images that smokers rejected most during sales. Most rejected was an image of a baby with tubes, showing the harm induced by smoking during pregnancy. The second most rejected was the image of a women in an intensive care centre for lung cancer, and the third most rejected was the image of a couple in relation to sexual impotence. Of course these perceptions need to be further confirmed by a survey that is being prepared by the Health Ministry.

Conversely, an independent poll conducted in April 2002 by the *Instituto Datafolha* showed positive results. The poll involved 2 216 people over 18 years old in 126 municipalities. It showed that 76% of those interviewed approved of the measure. Of the smokers, 73% approved of the measure and 67% said the images increased their desire to quit smoking. Within the low-income smokers group, 73% said the new warnings increased their desire to quit smoking, and within the group from 18 to 24 years of age 83% approved of the measure[3]. Other evidence of a positive impact could be seen in the statistics of the hotline Call to Quit Smoking. After printing the number in the packs, the number of calls increased progressively (Figure 5).

In addition to this measure, after the legislation's enforcement, an interview with 32 664 people who called the hotline showed that 92.62 % knew about the hotline

[6] See web site: http://www1.folha.uol.com.br/folha/datafolha/po/campanha_fumo_22042002a.shtml.

number through the cigarette packs. A poll conducted two months after the enforcement of this measure among people who called the hot line showed that 67% of smokers became willing to stop smoking when they saw the new warning with the photos.

On the other hand there were some polemics around the warning images, such as certain people and some associations claiming that such a measure amounted to an invasion of smoker privacy. A black people's rights association decided to sue the Health Ministry because one of the health warnings used an image of a black man to illustrate the dependence on nicotine. Their argument was that this was a racial prejudice because it stimulated the association of black people with drug use and criminality.

Conversely, the Health Ministry has been receiving considerable support and feedback from Brazilian citizens through the Internet and hotline. Some people suffering from tobacco-related diseases have even offered their images to illustrate the health warnings.

## Conclusion

In Brazil, tobacco control legislation has advanced over the years and has seemed to follow an increasing level of maturity within the Brazilian population concerning smoking risks. The National Tobacco Control Programme played a vital role in constructing an educational base through campaigns, continuous efforts to educate opinion leaders like teachers, health professionals, legislators and media, and developing a partnership network. This network, which included government organizations and NGOs, seemed to have been pivotal in raising national consciousness on tobacco's harm and in mobilizing a change in the social representation of smoking. Educational measures and legislation have been mutually supportive. At the same time, educational measures have been creating an advocacy network that supports and stimulates implementing legislation for tobacco control. The Brazilian legislative environment has been enhancing and reinforcing the educational measures developed by the programme.

Within this context the Brazilian legislative process began inserting warning messages on tobacco packs in 1988 through executive measures (Health Ministry rulings). As scientific knowledge of the harm done by tobacco gained broad exposure through public campaigns and the activity of scientific bodies, it was possible to make additional advances. Incrementally, and despite tobacco industry opposition, advances like rotating different warnings, and spoken warnings on the dangers of tobacco use following smoking ads on the radio and TV were possible .

Later in this process, a sequence of key legislative steps culminated with the recent advance of stronger warnings accompanied by photos. One of these steps was the conversion of the executive ruling on health warnings into a federal law in 1996. This was the result of the special engagement of the Health Ministry and a deputy that presented a bill of law that was approved by the Congress as Federal Law no. 9.294. The second and third steps took place in 1999. A provisional measure gave Health Ministry the power to define the health warnings and a federal law created the National Health Surveillance Agency (ANVISA), and included the control and inspection of tobacco products along with their advertising and promotion among its responsibilities. These historical key steps helped to create a positive context for stronger tobacco product regulation including, its labelling.

In addition to these measures, the Framework Convention on Tobacco Control (FCTC) negotiation process and the Brazilian Government's involvement in this process strengthened the political will to regulate tobacco products.

Within this process, the National Cancer Institute (INCA), the Health Ministry body and coordinator of the National Tobacco Control Programme, and later the executive secretariat of the National Commission on Tobacco Control, played a vital role in articulating, lobbying and lending technical support to executive and legislative measures.

At the same time, taking account of the measures that were presented for FCTC negotiation process, and the positive experience of Canada in adopting health warnings with photo illustrations, the National Commission on Tobacco Control of Brazil recommended to the President of Brazil the adoption of a similar measure.

Its important to recognize that the FCTC language and the whole process of its negotiation created a climate of legitimacy for some advances that were much harder to achieve before the FCTC's existence.

What is more, access to millions of tobacco company internal documents proving their real intentions and strategies, has contributed to gaining advances for tobacco control more easily than in years past. Today, tobacco control advocates can be better prepared to face tobacco industry arguments and strategies to counteract tobacco control actions. They can also better understand the arguments and strategies the tobacco industry uses to circumvent

any attempts to implement tobacco control measures, as well as their strategies to create positive relationships with government authorities and legislators to convince them to not adopt tobacco control measures.

The effort to control tobacco has not been an easy task. One very important step is to build a supportive context of public opinion. In spite of all the tobacco industry lobbying, today in Brazil, a bill of law is much more likely to be approved than it was 15 years ago. Today, Brazilians not only support measures for tobacco control, they charge the Government with adopting stricter measures.

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# Jordan: Mass Media Campaign Combating Smoking Requires Serious Commitment and Not Just Words

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## Introduction

Tobacco use is a growing problem in Jordan, a developing country with a population of 5.3 million *(1)*. Each year, cardiovascular diseases are responsible for about 42% of all deaths in Jordan and cancer is responsible for 13% *(2)*. Smoking has been found to be the main factor contributing to these health problems.

In 2000, Jordan's National Cancer Registry recorded an average of 3 360 new cancer cases. Lung cancer was the most prevalent type, with 223 cases. Of these cases, 185 lung cancer patients were smokers.

Smoking is highly prevalent among adolescents. Jordan's Global Youth Tobacco Survey (GYTS) conducted in 1999 showed that 19.3 % of students between the ages of 13 and 15 (25% of male students and 14.5 % of female students) are smokers. This is primarily due to their imitating adults, peer pressure and easy access to cigarettes. This is a high percentage in a country where half of the population is under the age of 18 *(1)*.

Another study on morbidity, conducted in 1996, revealed that the prevalence of smoking among Jordanian adults over 25 years was 26.9% *(4)*. Almost 48% of males and 10.2% of females smoked daily . However, only 9.7% of the adult population was able to quit.

National figures reveal that smokers in the Kingdom spend an estimated JD 250 million[1] *(2)* annually on tobacco products, or some 4% of the country's national gross domestic product. Smoking the water pipe or Argileh is also becoming a very popular practice in tobacco use.

## Policy intervention

In November 2001, the Ministry of Health (MOH), through its tobacco control programme, started a three-month media campaign to fight tobacco use in the country. The campaign sought to counter the influence of pro-tobacco marketing and advertising by promoting health awareness of the hazards of smoking, exposure to second-hand smoke and the existing tobacco-related legislation. In fact, Jordan was one of the first countries in the region to introduce an anti-smoking regulation in 1977 by slapping a ban on smoking in public places and on public transport as well as prohibiting tobacco advertising. But enforcement was lax over the years.

The campaign was carried out through paid television ads, radio, official newspapers, billboards and publications. The target group was the adult population. The first of November was designated as a 'Jordanian No-Tobacco Day', as part of a smoke-free Arab week, an idea developed by the Arab League. This theme was highlighted in State radio and TV. Both radio and TV hosted experts for an entire week, promoting cessation. Talk shows and discussions made reference to the health consequences arising from consuming different types of tobacco in cigarettes, the hisheh, the pipe and the 'hubbly bubbly,' known as 'argileh'. Addressing the problem of disease caused by second hand smoke, Jordan TV repeatedly aired an ad showing a healthy young woman turning into a sickly person with decaying teeth.

Part of the counter-marketing efforts included leasing 60 billboards that were set up in different parts of the capital for three months. They highlighted the 1977 anti-smoking regulation that restricts smoking in public places and on public transport. Counter-advertising in print included free-of-charge ads, which continuously appeared in official newspapers emphasizing the antismoking regulation via 'No smoking' signs or text.

Another part of the media campaign comprised posters and brochures illustrating the health risks of tobacco use. They were distributed to university students, sports clubs, maternity and child health-care centres as well as women's societies. Posters focused on presenting toxic and carcinogenic effects of tobacco use. One such poster detailed over 400 poisonous substances contained in a cigarette. Another poster sought to promote a smoke-free culture, urging smokers to "Break Free" by choosing to breathe.

Despite these efforts, no studies were conducted on the ratio of pro- to counter-advertising to assess whether the media campaign promoted cessation and decreased the likelihood of initiation. However, data available in the global youth tobacco survey (GYTS) included a survey on pro-cigarette advertising in 1999.

The GYTS found that 81% of 7th to 9th graders were exposed to indirect pro-cigarette marketing and advertising. Of the 3 912 students surveyed, 61% of them saw pro-cigarette ads in newspapers and magazines, 59% saw pro-cigarette commercials during sport shows, 33% possessed an object with a cigarette brand logo and 27% were offered cigarettes by a tobacco company representative.

**[1] The Jordan dinar is equivalent to about $US 1.42.**

Other tobacco control measures included imposing restrictions on tobacco sale for minors as part of a Juvenile Monitoring Legislation, effective as of 1 November 2001. Penalties for minors include a JD 20 fine for a first-time violation, which would double if the offence were to be repeated. The vendor would face a JD 100 fine and a jail sentence of up to one year. The legislation was announced on radio and TV and published in Official Gazette one month before it became official.

At the grassroots level, a school-based pilot project that involved peer education on tobacco control was applied in 28 schools during the scholastic year 2002–2003. Seventh to ninth graders were provided with anti-smoking educational kits comprising thought-provoking exercises, puzzles and an evaluation form to assess their comprehension.

The project, dubbed "Rising Generation without Smoking" was first introduced by the United Nations Children's Fund (UNICEF) and the Jordanian Anti Smoking Society (JASS) in cooperation with Ministry of Education. It was implemented in 17 schools throughout 2002–2003. As a result of its popularity, the Health Ministry and UNICEF ran a parallel project adopting the theme "Smoke Free Schools" using the same educational material and covered 11 schools. Plans are under way to expand the school programme to include an additional 50 schools for the scholastic year 2003–2004.

In addition, an anti smoking clinic was set up in late 2001 to promote cessation among smokers, which is supervised by the tobacco control programme. The clinic offers free-of-charge counselling and nicotine inhalers for those who wish to kick the habit. It will include a hotline as part of its future services. Until last year, the clinic offered counselling for 70 adult patients, 10% of whom quit smoking without resorting to any anti-smoking drugs. There are plans to set up clinics in the country's 12 governments, once funding is available.

A series of tobacco-related awareness workshops were conducted to educate the media as well as personnel from both the Ministries of Health and Justice about tobacco-related legislation. An annual contest for volunteer workers adopted the negative effects of smoking as its theme in 2002 in an attempt to educate people about the risks of tobacco use.

## Steps toward implementation

Fighting tobacco use in the country was intensified in 2001, the year Jordan began taking part in negotiations for the recently adopted Framework Convention on Tobacco Control (FCTC).

As a first step, the Health Ministry in cooperation with UNICEF and the World Health Organization (WHO) established a multisectoral steering committee, known as the National Committee for Anti-smoking. Its members were drawn from the Ministry of Health and the Ministry of Religious Affairs, UNICEF, JASS, United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and the Jordan Medical Association, and included a lawyer. The Committee was in charge of supervising tobacco control activities.

Later, the Health Ministry adopted a tobacco control programme and appointed personnel to run it during the second half of 2001. The programme acted as a coordinator between Government ministries and funding organizations to implement anti-tobacco activities. The tobacco control programme then launched a three-month media campaign on 1 November 2001, which was designated as a Jordanian No Tobacco Day.

Subsequently, the steering committee drafted a five-year tobacco control strategy, with eight goals and a plan of action. On 31 May 2002, World No Tobacco Day, the Health Minister endorsed the strategy and it was put into action. The main objectives of the tobacco control strategy were based on elements of the FCTC, which Jordan adopted on 21 May 2003. The strategy was comprehensive and provides for a general ban on tobacco advertising, a raising of public awareness on the hazards of tobacco use, enforcement of legislation, and encouragement of smoking cessation, among others.

Establishing the tobacco control programme and the endorsement of the five-year tobacco control strategy were crucial steps toward reaching the final stage of the intervention policy. This is the first time ever that Jordan has adopted a tobacco control programme that is responsible for overseeing the implementation of the tobacco control strategy.

In addition, securing funds from UNICEF and WHO contributed to the intervention process. A tobacco control programme requires funding, and currently the MOH does not have adequate funds to support the programme.

## Key actors in the process

Fighting tobacco use in Jordan required partnership between the Health Ministry through the tobacco control programme, UNICEF, WHO, the steering committee and JASS. The Health Ministry's tobacco control programme played a key role in the intervention policy. Planning activities, training of employees, research and follow-up were among its main responsibilities.

UNICEF and WHO provided technical and financial assistance for the tobacco control programme and helped to establish an anti-smoking clinic. During 2001 and 2002, WHO contributed approximately US$ 40,000 for anti-smoking activities at the national and international level. This included seminars, research and educational material as well as training of staff, and participation in the intergovernmental negotiating body for the FCTC.

UNICEF contributed financial assistance of well over US$ 200,000 over the past two years. It sponsored the media campaign and seminars, and helped the Education Ministry integrate a school-based educational programme in 27 schools. It strengthened the infrastructure of JASS as well as sought to increase awareness of the existing anti-smoking regulation.

However, the intervention policy is facing an uphill challenge from tobacco companies because of their strong financial resources and marketing capabilities. Although tobacco advertising is banned, tobacco is still marketed attractively in tobacco-outlet stores, through offers of cash prizes and a variety of gifts such as T-shirts, watches and sports bags that appeal to adolescents. Female representatives also display different-coloured cigarette packages and encourage shoppers to try cigarettes free-of-charge.

Eye-catching posters are placed on shop fronts, where smoking is seen as a glamorous act. The amount of fines imposed on such violations is low and they do not exceed JD 500. Penalties are also not strictly imposed. As such, tobacco companies are not deterred from attempting to promote tobacco use.

Cross-border advertisements promoting tobacco use on the Internet and on privately owned Arab satellite stations also target a wide range of viewers. Lax law enforcement of the anti-smoking regulation also constitutes another stumbling block in the country's efforts to fight tobacco use.

Jordan's anti smoking regulation was part of a public health law issued in 1971. Those who violate the public health law are subject to a jail sentence that does not exceed four months, or a fine ranging from JD 25 to JD 500 or both penalties. The public health law does not include any direct article that deals with violating the anti-tobacco regulation. In other words, there are no clearly defined penalties for those who smoke in public places and on public transport and advertise tobacco use.

Effectively, and from a technical point of view this renders the punishment unconstitutional unless a direct article addresses the issue of penalties related to the anti-tobacco regulation. Ministries in charge are also not enforcing the law, because a mechanism of enforcement requires coordination between various government institutions. Failure to enforce the legislation was not limited to this law and regulation, but in fact many regulations in Jordan were abandoned by the executive authorities for no clear reasons.

The anti-smoking legislation, like many other laws in Jordan, was not put into effect due to financial and budgetary restrictions. In this respect, the Government should issue clear regulations and instructions to specify the process of enforcement. The implementation process is bound by a budget drawn up by the Minister of Finance. As such the Health Ministry cannot enforce the law on its own, and it does not have an annual budget earmarked for tobacco control policy. It relies heavily on external funding from WHO and UNICEF. In addition to these limitations, there is no serious commitment on the part of policy-makers to enforce existing laws, especially those concerning smokers.

## The intervention's success

At this stage, it is too early to determine whether the intervention has had any positive impact on tobacco use. Such policies enforced in developed countries have taken years to bear fruit. In addition, there are no studies available on the knowledge, attitudes and practice of tobacco use. Yet, raising awareness about the anti-smoking legislation through the billboard campaign raised public inquiries.

According to the tobacco control programme, adults over 20 years of age wanted to learn more about the anti-smoking legislation. But it was not known how many calls the programme received during the three-month campaign that started in November 2001. Since the billboards were concentrated in Amman only as a result of limited funds, the message failed to reach the desired target groups, namely the adult population.

Meanwhile, radio listeners and TV viewers who witnessed the campaign learned about the existing anti-smoking regulation, the dangers of passive smoking and the risks inflicted on those consuming the various types of tobacco products. This campaign was also limited to one week due to funding constraints, so that the message did not reach the general public, as it was initially planned.

The intervention's outcome, although undocumented, was modestly successful in a number of ways that are worth mentioning. Two tribally dominated governorates have announced to their communities that cigarettes are no longer part of a traditional offering at weddings and funerals as well as other social gatherings. A number of private companies, and government institutions declared themselves smoke-free and reserved a special room for smokers. The Ministry of Education has prohibited teachers from smoking in schools. As a result, private schools have restricted smoking during working hours. Public schools, where teachers once shared cigarettes with students, are becoming tough on the practice.

Many supermarkets have placed signs displaying the juvenile law that restricts minors' access to tobacco. According to the tobacco control programme, shopkeepers often ask buyers whom they suspect are minors for identification before selling them tobacco products.

Yet despite these positive signs, success may have been very limited. School students smoke outside school campus, security personnel and law enforcement officers smoke in public places, including the airport, and despite no-smoking signs, minors can purchase cigarettes from street peddlers *(5)*.

## Conclusion

The introduction of legislation restricting tobacco sales to minors and the anti-tobacco peer education project are key steps in the country's intervention policy. Smoking among minors is a growing problem in Jordan, especially since minors comprise half of the population. These are two primary areas that require the Government's serious attention.

Enforcement of the law restricting minors' access to tobacco through random check-ups on retail tobacco outlet shops and on street vendors from whom minors attempt to purchase cigarettes as well as the imposition of penalties on retailers is needed to help implement the law.

The peer education school programme, which targets 13- to 15-year-olds, the typical age when students start smoking, was a successful pilot project. Feedback from JASS and the tobacco control programme suggested that parents, students and teachers perceived it as positive intervention.

Adequate resources should be provided for anti-smoking educational programmes to ensure that this project becomes accessible in all the schools in Jordan. School-based tobacco prevention programmes should be introduced in late elementary grades to prevent the onset of smoking. This project should also be incorporated in school curricula.

The media campaign in newspapers, radio and TV, with their broad spectrum, could have played a major role in offsetting tobacco publicity. Adolescents are more likely to be influenced by advertising since they are the present target group for tobacco companies. However, Jordan cannot limit cross-border marketing on the Internet and privately owned Arabic satellite station.

In this regard, counter-marketing efforts through media advocacy with sufficient reach, frequency and duration are needed to raise public awareness about the risks of tobacco use, and to promote cessation.

Adequate funds and resources, including experienced people are required to ensure that the campaign educates adolescents and adults on the hazards of smoking. In addition, other counter-marketing efforts through a variety of appealing techniques are called for instead of communicating redundant themes.

An annual budget earmarked for a tobacco control programme to carry out its activities is necessary. Jordan needs to double its efforts and show serious commitment to enforcing laws to fight tobacco use. Unfortunately, until now, the mechanism of implementing the anti-smoking legislation is at the legislative bureau and introducing legislation without enforcement is not enough to fight smoking. When such issues are addressed, then it will be possible to generalize the country's experience.

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# Advertising and Promotion Bans

WHO/NMH/TFI/FTC/03.15

PH-15.15

## A Report on Smoking Advertising and Promotion Bans in the Islamic Republic of Iran

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# A Report on Smoking Advertising and Promotion Bans in The Islamic Republic of Iran


## Ministry of Health and Medical Education Deputy of Health

**Occupational and Environmental Health Management Centre**

**Secretariat of the National Tobacco Control Committee Islamic Republic of Iran**

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Tobacco Free Initiative Headquarters would like to thank the Regional Offices for their contribution to this project.

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## Introduction

The Islamic Republic of Iran is a country of 1 648 000 square kilometres, with a population of some 70 000 000. Before the Islamic revolution in 1979, the country had a national State-owned tobacco monopoly which was responsible for producing tobacco products for domestic consumption as well as importing different tobacco brands into the country. There are no data available on tobacco product smuggling before the revolution. While the tobacco monopoly continued following the revolution, the importation of tobacco products ceased.

Although there was no tobacco advertising on radio or television before the revolution, advertising and promotion of various cigarette brands was displayed on billboards throughout the country, in the streets and on highways, in public spaces, public transport vehicles and in movies as a sign of prestige.

Smoking was not prohibited in public areas; public transport vehicles and work places and smokers smoked freely in all such areas. There was no legislation on the various aspects of smoking, including production, distribution, retail and advertising. After the revolution, a group of experts, among them physicians, pharmacists, religious leaders, traders and other social groups, came together from a religious and social health standpoint to combat smoking and cigarette companies. They understood that smoking was highly dangerous to people's health.

These actors began lobbying the country's leaders to persuade them to restrict tobacco production and smoking in public places as well as ban tobacco advertising and promotion. Their activities resulted in the proposal *How to gradually decrease and eliminate tobacco smoking,* which was introduced to parliament and passed by the parliamentary delegates in 1992 and became law. However, the Guardian council, which is responsible for reviewing laws passed by the parliament to ensure that they do not violate the Islamic Republic of Iran's constitution and religious laws, rejected it on the grounds that it violated the country's constitution because certain parts of the law imposed a financial burden on the Government.

## Description of the intervention policy

While the 1992 Guardian Council proposal was rejected, in line with the Government of the Islamic Republic of Iran's policy to prohibit any kind of tobacco product advertising and promotion, the Council of Ministries approved a number of regulations, which are mentioned below:

### Approval by the Council of Ministries

**A: A plan for how to decrease smoking (Date: 3 September 1994)**

**Article 4:** Any activity and propaganda that results in people being encouraged or motivated to smoke is prohibited at all the ministries, Government organizations and institutes, Islamic revolutionary institutions, municipalities, and departments to which the application of the law involves mentioning the names, and at the office buildings affiliated with them.

**Article 6:** The Ministry of Health and the Ministry of Industries will be responsible for supervising the proper implementation of these regulations and for codifying appropriate circulars within the limits of the laws.

**B: Regulations relating to "The ban on smoking and supply of cigarettes and other tobacco products in public places" (Date: 4 January 1997)**

**Article 2:** To prevent youth from becoming addicted and to elucidate smoking's damage to health as well as the financial and social harm done by smoking, the Ministry of Health, the Ministry of Culture and Islamic Guidance, the Islamic Republic of Iran Broadcasting, along with cultural departments and municipalities will be required to prevent any act and propaganda that results in people being encouraged or motivated to smoke or further consume tobacco. They will be required to embark on preparing regular, coordinated and appropriate cultural and propaganda programmes for the public, especially youth, that show disapproval of smoking and elucidate the harm done by it. These agencies are to take necessary measures to ensure that this law is properly implemented.

**Note 2.** Any propaganda and activity that will result in the public being encouraged to smoke, will be prohibited.

**Article 3:** The Islamic Republic of Iran Broadcasting, the Ministry of Cultural and Islamic Guidance, municipalities and the mass media must take necessary measures to ensure that smoking is not directly or indirectly encouraged in their work, publications, films and serials, which includes ensuring that the leading characters in their films do not smoke.

Advertising bans cover both direct and indirect activities, which promote and encourage smoking among people. Other policies such as prohibition of smoking in public

## Table 1

**Smoking prevalence by sex and age in the Islamic Republic of Iran 1991**

| Age (year) | 15-24 | | | | 25-39 | | | | 40-69 | | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex | Male | | Female | | Male | | Female | | Male | | Female | | Male | | Female | |
| Smoking | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Non-smoker | 3568 | 89.9 | 4982 | 99.3 | 2792 | 63.3 | 4839 | 97.5 | 2754 | 66.2 | 3802 | 92.3 | 9114 | 72.8 | 13623 | 96.6 |
| 1-9 cig/day | 207 | 5.2 | 26 | 0.5 | 622 | 14.2 | 87 | 1.8 | 356 | 8.6 | 164 | 4 | 1185 | 9.5 | 277 | 2 |
| 10-19 cig/day | 94 | 2.4 | 3 | 0.1 | 376 | 8.6 | 27 | 0.5 | 287 | 6.9 | 71 | 1.7 | 757 | 6 | 101 | 0.7 |
| >20 cig/day | 99 | 2.5 | 5 | 0.1 | 600 | 13.7 | 11 | 0.2 | 766 | 18.4 | 80 | 1.9 | 1465 | 11.7 | 96 | 0.7 |
| Total | 3968 | 100 | 5016 | 100 | 4390 | 100 | 4964 | 100 | 4163 | 100 | 4117 | 100 | 12521 | 100 | 14097 | 100 |

## Table 2

**Smoking prevalence by sex and age in the Islamic Republic of Iran 1999**

| Age (Year | 15-24 | | | | 25-39 | | | | 40-69 | | | | >70 | | | | Total | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex | Male | | Female | | Male | | Female | | Male | | Female | | Male | | Female | | Male | | Female | |
| Smoking | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| Non-smoker | 4922 | 92.9 | 6749 | 99.8 | 3663 | 67.2 | 6481 | 99.1 | 3377 | 67.7 | 5379 | 96.3 | 755 | 77.2 | 843 | 94.3 | 12717 | 76.1 | 19452 | 98.3 |
| 1-9 Cig/day | 206 | 3.9 | 4 | 0.1 | 741 | 13.6 | 41 | 0.6 | 435 | 8.7 | 125 | 2.2 | 87 | 8.9 | 25 | 2.8 | 1469 | 8.8 | 195 | 1 |
| 10-19 Cig/day | 94 | 1.8 | 5 | 0.1 | 448 | 8.2 | 7 | 0.1 | 396 | 7.9 | 39 | 0.7 | 48 | 4.9 | 11 | 1.2 | 986 | 5.9 | 62 | 0.3 |
| > 20 cig/day | 77 | 1.5 | 3 | 0 | 598 | 11 | 12 | 0.2 | 779 | 15.6 | 45 | 0.8 | 88 | 9 | 15 | 1.7 | 1542 | 9.2 | 75 | 0.4 |
| Total | 5299 | 100 | 6761 | 100 | 5450 | 100 | 6541 | 100 | 4987 | 100 | 5588 | 100 | 978 | 100 | 894 | 100 | 16714 | 100 | 19784 | 100 |

places and prohibition of purchase of tobacco products by youth under 18 years of age are enforced at the same time. In addition, smoking cessation clinics will offer their consultative services to help smokers quit.

### Steps toward implementation

Following the approval of "A plan for how to decrease smoking" (Date: 3 September 1994) and "A ban on smoking cigarettes and other tobacco products in public places" (Date: 4 January 1997), these regulations had to be implemented by the different ministries and organizations, such as the Islamic Republic of Iran Broadcasting, the Ministry of Cultural and Islamic Guidance, municipalities and the mass media. The Anti-smoking National Committee of the Ministry of Health assumed the role of observing and following up on the proper implementation of these regulations at the national level. There was no opposition to these regulations in the country since the Government had a monopoly on the tobacco industry.

## The intervention's success

The prohibition of smoking advertising has been a very successful policy and was well received by the communities. Indeed, there is no direct or indirect advertising and promotion of tobacco products and there is no tobacco sponsorship of sports or cultural programmes throughout the country.

Since the Islamic revolution, transnational tobacco-producing companies have had no economic support for their products in the Islamic Republic of Iran. The national tobacco industry is not allowed to engage in any promotional or advertising activities within the country.

Based on statistics published by the Ministry of Health and Medical Education in 1991, 14.6% of the Islamic Republic of Iran's population were smokers and in 1999 this rate decreased to 11.7%. Tables 1 and 2 show smoking prevalence by age and sex in the Islamic Republic of Iran between 1991 and 1999. As these tables demonstrate, smoking prevalence has decreased among males from 27.2% in 1991 to 24% in 1999 and from 3.4% to 1.5% among females in the same period.

## Conclusion

As mentioned earlier, since the Islamic revolution no foreign industries have been permitted activities within the tobacco industry and national media has not been permitted to promote and advertise tobacco products. Therefore, it is not possible to estimate the financial loss incurred by the media and other enterprises.

A comprehensive ban on tobacco product advertising was a successful policy thanks to the collaboration of all the organizations involved in the implementation of the Council of Ministries' decision.

Indeed, there was no opposition to this policy because international corporations do not have any activities within the country and the tobacco industry is entirely run by the Government of the Islamic Republic of Iran. The result of all these policies has been a decline in smoking prevalence from 1991 to 1999. In the end, the Ministry of Health strongly opposed privatization of the tobacco industry because it facilitates the entrance of transnational companies into the country. These companies would begin opposing the restrictions on advertisement of their products, which would eventually increase tobacco use in the Islamic Republic of Iran.

# Labelling and Packaging (including Health Warnings)

WHO/NMH/TFI/FTC/04.03

PH-13.

## European Community Directive on Packaging and Labelling of Tobacco Products

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# European Community Directive on packaging and labelling of tobacco products

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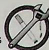

Directive 2001/37/EC of 5 June 2001 concerning the manufacture, presentation and sale of tobacco products was published in the Official Journal of the European Communities on 18 July 2001. It was introduced in the national legislation of the 15 European Union (EU) Member States on 30 September 2002. The Directive contains provisions on maximum yields, warning labels, reporting requirements, misleading descriptors, traceability, monitoring and review. This paper discusses the provisions on packaging and labelling and assesses their impact.

## History of the packaging and labelling of tobacco products in the European Union

The Treaty of Rome, which established the Community in 1957, did not contain a specific article that gave the community competence in public health. In 1985, two political leaders—President Mitterrand of France and Prime Minister Craxi of Italy—felt strongly that the Community should become more involved in public health. At their bi-annual meeting in Milan in 1985, the heads of state and of Governments of the Member States of the European Community called on the Commission to launch a European Programme against Cancer[1]. A high-level cancer-expert committee was established to advise the European Commission. At its meeting in February 1986 a comprehensive set of measures to combat cancer was formulated. An action plan was elaborated upon with the aim of reducing the number of deaths by 15% in 2000. Fourteen of the proposed actions of the "Europe against Cancer" programme were related to tobacco control. One of proposed measures was to introduce European tobacco labelling legislation.

The European Community legislative process is long and complex and cannot be described in detail in this paper. The lobbying activities around these directives were described by Michel Richonnier, who was in charge of the Programme "Europe against Cancer" during the period 1996–2001[2]. The tobacco industry was strongly opposed to new legislative measures and was omnipresent at every level of European decision-making. The tobacco industry put heavy pressure on governments to oppose the directive.

At the Council of Ministers on 16 May 1989, the British Minister of Health voted against the directive since the Government of the United Kingdom felt that the Community had no health competence to introduce such legislation. The German Government was another target in the tobacco industry's strategy. Ridiculing the health consequences was one of their tactics. Another was to advance the argument that the proposed Directive would be violating the German constitution. The tobacco industry's strategy failed into the short term since the German Government supported the first Labelling Directive (89/622) in 1989[2]. In the long term, however, the tobacco industry strategy was successful because the German Government would eventually become the industry's strongest ally in Europe.

The European labelling legislation finally resulted in two legislative measures: Directive 89/622 of 13 November 1989 and Directive 92/41 of 15 May 1992. This legislation pushed Member States, many of whom had had little or no legislation on labelling, to adopt a system of warnings and product information that is relatively satisfactory from a public health point of view, in particular, the introduction of rotating warnings. However, despite the amendments adopted in 1992, which reinforced, in particular, the labelling of tobacco products other than cigarettes, the European legislation had several weaknesses that needed to be addressed. The two weak points of the Directives' labelling requirements were the warnings' small size and lack of visibility.

### The small size of the warnings

According to the Directive 89/622, the general warning and the specific warnings must cover at least 4% of each of the large surfaces of the cigarette pack, excluding the indication of the authority that is author of the warnings. Warnings should ideally be printed in sufficiently large characters so as to be easily read by the consumer. This means that a large area of the pack needs to be reserved for this purpose. In this context, the 4% of the pack planned in the Directive seemed derisory. This was confirmed by research inside and outside the EU. The following two findings demonstrate this point:

- Qualitative research and quantitative research among 2 000 adults in the United Kingdom in November 1990 to test the new EU health warnings concluded that:
  *the impact of the new pack warnings is likely to be marginal whatever the nature of the message, because of their comparatively small size. At 4% of the pack face, they are difficult for many to read, and comparatively easy to ignore. There is a tendency to interpret the smallness of the warnings as evidence of government complicity. More worryingly, there seems to be a tendency to equate the size of the warning with the magnitude of the risk* [3].

- Despite the fact that EU legislation on labelling came into force on 1 January 1992 and contained an obligation to have warnings on the front and the back of the packs, research in 1997 among 1 000 people in the United Kingdom showed that:
  *only 29% of the smokers, 28% of the ex-smokers and 30% of the non-smokers were able to say that the warning was printed on the front of the pack* [(4)].

**The lack of visibility**

Another vulnerable point of the Directive was the requirement that warnings be printed on a contrasting background. In the Oxford English dictionary "contrasting" is defined as "a juxtaposition or comparison showing striking differences". According to a report undertaken by the European Bureau for Action on Smoking Prevention (BASP) at the request of the Commission of the European Communities, the contrasting background was a major problem. In August 1993, a survey of the top five cigarette brands in the EU countries, which covered some 60% of the European cigarette market, indicated that the colour gold was used for the lettering of the warnings on 68% of the packs. The use of gold lettering was considered by the authors to be against the spirit of the EU Directive because as a reflective colour it offered only a minimal contrast. A number of other colour combinations were also felt to have been chosen deliberately with a view to minimizing the warning's visibility (grey on white, blue on darker blue, etc.) In certain cases, the choice of colour was felt to so severely undermine the intention of EU legislation as to be contravening the Directive [(5)].

**The new labelling provisions of the Directive 2001/37/EC**

The main criticism of the previous legislation on labelling was the warning's lack of visibility as a result of its small size and the colour of the lettering, which failed to adequately contrast with the background colour of the pack. New EU legislation (Directive 2001/37/EC) would increase the size of warnings (from 4% to 30% and 40%) and stipulate in very precise terms in which colours the warnings should be printed (black on white, surrounded by a black border).

The main provisions on packaging and labelling in the Directive 2001/37/EC are the following:

- The tar, nicotine and carbon monoxide yields of cigarettes shall be printed on one side of the cigarette packet in the official language or languages of the Member State where the product is placed on the market, so that at least 10% of the corresponding surface is covered (12% for two official languages and to 15% for three official languages).
- Warning labels should cover 30% of the front of the pack (32% for two languages and 35% for three languages) and 40% of the back of the pack (45% for two languages and 50% for three languages).
- Warning texts should contain a general warning on the front—either "Smoking kills" (or "can kill", depending upon transposition) or "Smoking seriously harms you and those around you" to be rotated on a regular basis; additional warnings on the back—a list of about 12 different texts, also to be alternated on a regular basis.
- The text of warnings and yield indications shall be printed in black Helvetica bold type on a white background; in lower case type, except for the first letter of the message and where required by grammar usage; centred in the area in which the text is required to be printed, parallel to the top edge of the packet; surrounded by a black border not less than 3 mm and not more than 4 mm in width, which in no way interferes with the text of the warning or information given; in the official language or languages of the Member State where the product is placed on the market.

The Commission prepared rules for the use of colour photos (e.g. as recently introduced in Canada), graphics, etc. on 5 September 2003. Member States that wish to authorize the use of pictures, etc. would then still be entitled to do so, but only within the context of the agreed rules. The implementation of the use of colour photographs or other illustrations as health warnings shall apply as of 1 October 2004 at the earliest (Commission Decision of 5 September 2003).

- Mechanisms were introduced to ensure that the implementation of the Directive is properly monitored and that the provisions of the Directive are kept up-to-date in terms of scientific developments. The Commission shall be assisted by a committee of representatives of the Member States to adapt to scientific and technical progress: the maximum yield measurement methods and the definitions relating thereto; the health warnings and the frequency of rotation of the health warning and the marking for identification and tracing purposes of tobacco products.

– No later than 31 December 2004, the Commission shall submit a report on the application of this Directive and shall pay special attention, among other things, to:

- improvements in health warnings, in terms of size, position and wording,
- new scientific and technical information regarding labelling and the printing on cigarette packets of photographs or other illustrations to depict and explain the health consequences of smoking,
- methodologies for more realistically assessing and regulating toxic exposure and harm,
- development of standardised testing methods to measure the yields of constituents in cigarette smoke other than tar, nicotine and carbon monoxide.

**Implementation of the Directive 2001/37/EC**

Directive 2001/37/EC of 5 June 2001 concerning the manufacture, presentation and sale of tobacco products had to be introduced in the national legislation of the 15 EU Member States by 30 September 2002. Products that did not comply with the warning provisions of the Directive could continue to be marketed until 30 September 2003. The ten European accession countries, which will join the European Union in May 2004, also have to introduce the Directive into their legislation according to a time table agreed upon with the EU.

The impact of labeling regulation cannot yet be measured since the new warnings have not been available in most EU countries until recently. Cigarette packs with the new, bigger health warnings have only been on sale in the Netherlands since 1 May 2002 (Decree of 21 January 2002).

The Directive was challenged in the European Court of Justice by British American Tobacco, Imperial Tobacco and Japan Tobacco International. The Advocate General of the European Court of Justice published its Opinion on 10 September 2002 on the legal challenges to the Tobacco Products Directive. He believes that the Directive is valid, and recommends that the Court should rule accordingly. On 10 December 2002, the Court decided to uphold the validity of the Directive. (Case 491/01). This decision can be considered as a major setback for the tobacco industry.

There has been discussion as to whether the three-millimetre black border surrounding the warnings should be additional to the health warning area or part of it. In Sweden, the National Institute of Public Health decided that the black border should be additional to the warning, which resulted in a legal challenge by Philip Morris on the interpretation of this article of the Directive in Sweden. The tobacco industry lost this case. On 10 October 2002, the Swedish Cabinet of Government Ministers decided on the case and rejected the arguments of Philip Morris. The black border interpretation has not led to legal challenges in other countries. In Belgium, for instance, provisions regarding the black border are laid down in Article 3 of the Royal Decree of 29 May 2002. In the comments to this new Article, it is clearly laid down that the texts in question shall be surrounded—*in addition*—by a black border. It is also being stated that the EU Commission officially has confirmed that the Directive thereby has been correctly implemented in Belgian legislation. Moreover, the Belgian constitutional court (Conseil d'Etat, legal advice of 19 February 2002) agreed with this interpretation, acknowledging that only the European Court Justice will have a final say on this interpretation. Considering that Belgium has three official languages, which increases the size of warnings from 30% to 35% and from 40% to 50%, adding the black border in addition to the warnings, means that in that country the size of the warnings will be 46% of the front and 62% of the back of the cigarette packs.

The new EU warnings have been warmly welcomed by health organizations. The only major criticism of the new legislation is the printing of the tar, nicotine and carbon monoxide yields of cigarettes on the packs, since the tar and nicotine yields are based on ISO measurements and do not provide meaningful information for consumers. One of the recommendations of the WHO conference *Advancing knowledge on regulating tobacco products*, was to remove these yields from the packs [6]. During the discussions on the directive, some representatives of health ministries felt that it would be wrong not to provide the consumers with any information on the yields on the packs.

**Impact of the labeling provisions**

In most EU countries the new health warnings have not been visible until recently on cigarette packs. Products that do not comply with the warning provisions of the Directive could continue to be marketed until 30 September 2003. The exception is the Netherlands, where tobacco products with the new warnings have been on the market since May 2002. On 26 November 2002, the Dutch organization *Defacto* presented the results of two Dutch studies on the effects of the new health warnings on the cigarette

packages. One study was conducted among a representative sample of 7 387 adults, the other among 299 youngsters. Nine per cent of the adult smokers, who had seen the new warnings said they smoked less and 16% were more motivated to quit. The effect of the warnings was even stronger on adolescents (13–18-year-olds) Twenty-eight per cent of youngsters said they smoked less because of the new health warnings. Moreover, the results showed that very few youngsters thought the new warnings were "cool". Only 5% of the youngsters, who knew about the new health warnings, tried to collect all 14 warnings (7).

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WHO/NMH/TFI/FTC/04.06

PH-13.

# Smoke-free Policies

# Report on National Policies on Tobacco Smoke-free Environments in Chile

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# Report on national policies on tobacco smoke-free environments in Chile

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## Introduction

### Prevalence of smoking in Chile

The findings of the surveys carried out by the National Drug Control Council (CONACE), which have been conducted every two years from 1994 to 2000, are the most reliable source of data on drug consumption in Chile.

Table 1 shows levels of prevalence in the years in which the survey was conducted.

**Table 1. Prevalence of smoking (last month) among Chile's general population**

| Year | Men | Women | Total |
|---|---|---|---|
| 1994 | 45.4 | 36.3 | 40.5 |
| 1996 | 45.3 | 36.2 | 40.4 |
| 1998 | 47.2 | 35.5 | 40.9 |
| 2000 | 47.7 | 39.5 | 43.2 |

These data show the rising trend in tobacco use between 1994 and 2000, with a higher increase among women; this is even more striking if we compare these data with those from the survey carried out by Joly in 1971, which found prevalence among women to be approximately 20%. Prevalence has thus doubled in 30 years, and the gap between men and women has narrowed.

As for prevalence in the last month, broken down by socioeconomic status, it is noteworthy that people of lower socioeconomic status smoke most; prevalence among them is 44.1%, while among people belonging to the higher strata it is 41.7%.

The first National *Quality of Life Survey* (2000)* yielded results that are consistent with those of CONACE. Prevalence in the last month was 40%, and was higher among men (44.1%) than among women (36.6%) and among urban dwellers (40.9%) than among the rural population (32.6%). Significantly, 32.5% of smokers said they intended to give up smoking the following month, evidence of willingness to change behaviour. A total of 90.6% of those who had given up smoking had done so six months or more ago.

* National Quality of Life Survey 2000. Dept. of Epidemiology and Dept. of Health Promotion. Ministry of Health, Chile.

As regards exposure to environmental tobacco smoke at the workplace, smoking was completely prohibited in more than one-third of workplaces and restricted in the other two-thirds, although the figures reported by men and women differed. Smoking in the home was restricted by family agreement in 48.5% of homes (Table 2).

**Table 2. Perception of smoking prohibition indoors, by sex. Quality of life survey 2000**

| | Men (%) | Women (%) | Total |
|---|---|---|---|
| Workplace | 29.1 | 43.8 | 34.8 |
| Home | 46.5 | 50.1 | 48.5 |

Data obtained by CONACE in association with the Ministry of Education and the Ministry of Health, which carried out surveys in 1995, 1997, 1999 and 2001 among 12- to 18-year-old schoolchildren found that on average the age at which they smoked their first cigarette was 13, with a trend towards smoking the first cigarette at an increasingly low age.

The 2001 survey showed that annual prevalence (tobacco consumption in the year prior to the survey) had risen by two points, a rise attributable to the 4.4 point increase in smoking among adolescent girls. However, last-month consumption declined between 1999 and 2001, as is shown in Table 3.

**Table 3. Last-year and last-month tobacco consumption: 12- to 18-year-old schoolchildren in Chile**

| | Boys | | Girls | | Total | |
|---|---|---|---|---|---|---|
| | Last year | Last month | Last year | Last month | Last year | Last month |
| 1995 | 54.3 | 33.3 | 58.3 | 36.3 | 56.3 | 34.8 |
| 1997 | 53.5 | 44.4 | 59.7 | 48.2 | 56.6 | 46.4 |
| 1999 | 51.4 | 41.1 | 55.8 | 44.7 | 53.7 | 43.6 |
| 2001 | 51.2 | 38.7 | 60.2 | 45.0 | 55.7 | 41.8 |

### Mortality from tobacco in Chile

The Ministry of Health's Department of Epidemiology has indicated that according to mortality statistics for 1999, 16.9% of total mortality in that year was attributable to tobacco (13 888 deaths); 8888 (64%) were from cardio-vascular disease, 2917 (21%) from various forms of cancer and 2083 (15%) from respiratory illness.

## Description of the policy of action

One of the priorities of the National Health Promotion Plan for the six-year period 2000–2006 is to «check the surge in risk factors for health». One of the most important of these is smoking, on account of its numerous harmful effects on health.

The shift in the approach to smoking as a social phenomenon is one of the strategies to have proved most effective in controlling this global epidemic. The strategy's aim is to portray smoking as socially unacceptable behaviour, which is a private rather than a public habit.

As part of this strategy, in early 2001 the Ministry of Health (MINSAL) introduced its «Tobacco-smoke-free environments» programme (TSFEP) as a means of encouraging this change in social behaviour. The programme was first implemented in the health sector and efforts are under way to introduce it into the education sector and other areas, both public and private, and especially those participating in the National Health Promotion Council Vida Chile.

The legal basis for the programme is Act N° 19 419 of 9 October 1995, which relates to smoking issues. Significantly, article 7 of the Act lays down absolute or partial prohibitions on smoking in different premises in the following terms:

#### Places in which smoking is completely banned

Smoking is never permissible in:

- public or collective means of transport;
- school classrooms;
- lifts;
- place in which explosives, inflammable materials, medicaments or food are manufactured, processed, stored or handled.

#### Places in which smoking is partially banned

Smoking is not permissible, except in specially designated areas:

- hospitals, clinics, surgeries and health posts;
- theatres and cinemas.

#### Government offices, including municipal offices

Two categories are distinguished:

- premises on which services are provided to the public: smoking is completely prohibited;
- premises on which services are not provided to the public: smoking is neither prohibited nor restricted;

#### Restaurants, bars, hotels and other establishments

It is left to the establishment to set aside smoking and non-smoking areas. Any such divisions must be sign-posted.

Despite the law, tobacco control has not improved since its adoption, hence the need for programmes to encourage and make possible its implementation and to complement it. The Tobacco-smoke-free environments programme contributes to this objective through participation, dialogue and agreement among all the members of a given institution, both smokers and non-smokers.

#### Objectives and strategies

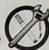
The aim of TSFEP is to initiate a process leading to the restriction of smoking on the premises of a firm, organization or institution, whether in the public or private sector. This is achieved by reaching a consensus among all the institution's members. At the same time, the population is encouraged to agree not to smoke in the home.

The programme has the following objectives:

- To help improve the overall quality of life of the population, of workers and civil servants working indoors by protecting them from environmental tobacco smoke and by protecting non-smokers.
- To encourage changes in the image of smoking in society, so that from being an acceptable habit it becomes an unacceptable one.

#### Strategies

The strategies required to achieve these objectives are described below.

*1. Publicity*
A range of information, publicity and social communication actions will be used to inform and educate the population about the programme and the reasons for it.

*2. Education*
The programme undertakes educational activities targeting different population groups (schoolchildren, health-service users, workers, families, social organizations and citizens). At the same time, human resources educational and training activities are carried out.

*3. Social involvement*
The decision to establish a tobacco-smoke-free environment requires the active agreement of the members of the organization concerned. At the same time, mechanisms for ensuring effective social control of the measures adopted need to be set up.

*4. Research*
Research is carried out to identify the prevalence of and attitudes towards smoking among civil servants, workers and members of the institutions or firms taking part in the programme.

*5. Accreditation and certification of tobacco-smoke-free environments*
Those institutions and firms that successfully establish tobacco-smoke-free environments will receive accreditation and certification from the Ministry of Health. The Ministry will draw up and periodically issue a directory of firms, organizations or institutions certified as providing tobacco-smoke-free environments.

*6. Internal regulations*
The following proposals are made, although each institution is free to adapt them to its own circumstances:

- No form of tobacco consumption is permitted within the building, the surrounding area and its entrances and exits at any time of day.
- Signs will be put up to inform people that they are in a tobacco-smoke-free environment and that smoking is prohibited.
- The decision as to whether to establish a smoking area will be taken at the local level. The area shall be located on premises on which no one is required to remain or to pass through for their work.
- All academic, social, commemorative or other events held on the premises of the establishment shall be declared «Tobacco-smoke-free events»; this shall be specified on the invitations and on the premises on which the event is held. It is suggested that relevant documents and advertising mention this policy.

In parallel to the introduction of TSFEP, the Ministry of Health has encouraged other tobacco-control activities in Chile, of which the following are noteworthy:

- A number of Chilean primary health care services have begun to provide counselling on giving up smoking.
- Communication campaigns:
  - targeting health workers, in conjunction with the implementation of TSFEP
  - targeting children in the 5th and 6th grades of basic education in all Chile's State-subsidized schools, in association with the Ministry of Education (MINEDUC).
  - The Quit and Win competition, an international initiative that Chile joined in 1998, and that has also been held in 2000 and 2002. The competition has proven very popular with the population, and in the three years in which it has been held, it attracted 12 000, 14 000 and 17 000 participants respectively.

## III Phases of implementation

- Forming the task force

The first assignment undertaken by the Ministry of Health, in December 2000, was to form a task force of professionals with broad experience in tobacco control. The task force set about formulating TSFEP and carrying out a situation analysis in health facilities that were already free of tobacco smoke.

This work resulted in a document setting out the technical guidelines needed by health teams to implement and develop the programme. In 2002, on the basis of these technical guidelines, TSFEP was approved as an official MINSAL programme.

- Management commitments

In January 2001, the programme was included among the management commitments made by health services to the Ministry of Health; this gave strong encouragement to its implementation as it is included in the health services annual grading exercise. In 2002, TSFEP targets were also included as management commitments.

- Training

A two-day national training workshop was held in April 2001 for managers of health teams in health services throughout Chile who are responsible for implementing and running TSFEP in all Chile's regions.

The existence of a network of experienced health promoters made it possible to incorporate rapidly the management of TSFEP into the health services at the regional and local levels.

A summary is given below of the technical guidelines of TSFEP for application at the local level, together with its methodology and accreditation system.

**1. TSFEP methodology at the local level**

The methodology breaks down into seven basic stages, which may be implemented gradually or in accordance with the plans adopted by the local teams.

The stages in the establishment of a tobacco-smoke-free environment are as follows:

Stage 1. Formation of the team, formulation of the plan and awareness-raising

Stage 2. Survey application and analysis

Stage 3. Education and communication

Stage 4. Changes to the physical environment

Stage 5. Official declaration

Stage 6. Communication and publicity among the community

Stage 7. Keeping the goal in sight

It is estimated that it may take approximately five months to establish a tobacco-smoke-free environment in a particular workplace.

**2. Accreditation and certification**

Accreditation by the health authorities of premises as offering a tobacco-smoke-free environment is part of the regulatory role of the Ministry of Health.

Accreditation is awarded after the competent authorities have ascertained that the suggested activities have been carried out and after verifying the information provided to and the impact on users and the community.

Accreditation is the responsibility of SEREMIS (Regional Ministerial Secretariats) and of Chile's health services; the health services are responsible for health facilities and SEREMIS for other sectors.

The basic criteria for accreditation are:

- performance of specific activities: smoking surveys, designation of the smoking area and signposting;
- presentation of formal documents: a record making the policy official;
- public information activities: registers of press releases, internal memos, etc.

Once an institution, establishment or firm has received accreditation, it will be certified by the Ministry of Health, which will officially issue it with a certificate.

Accreditation is valid for two years, and may be renewed by the health authority once it has ascertained that the criteria are satisfied.

A directory listing all the institutions that have been accredited and certified as TSFE is available for distribution; the directory will be widely distributed and will encourage more participants to join the Programme.

## Results

**Quantitative achievements**

By 30 August 2002, a total of 502 establishments had been accredited as TSFE; 425 of them were in the health sector, 57 in the education sector, 11 in the local government sector and 9 in the private sector.

As of this year, an effort is being made in the education sector through the Schools that Promote Health strategy. The management commitment made to the health sector is to declare 30% of schools as tobacco-smoke-free areas. The target for the current year is over 200 schools; we are confident that this goal will be more than achieved.

A major effort has also been begun with several institutions belonging to the VIDA CHILE network (National Health Promotion Council).

- Carabineros de Chile: the institution's hospital submitted itself to the process and was accredited as a TSFE; it was certified as such in June 2002, in the presence of the leading authorities of the institution and of MINSAL.
- The National School Assistance and Grants Board (JUNAEB), the National Sports Institute, the National Customs Administration, the University of Chile's Institute of Nutrition and Food Technology (INTA)

and the Catholic University of Chile, through its healthy university strategy, have begun the TSFE accreditation process and are each at a different stage in the process. We are confident that they will receive accreditation and official certification this year.

#### Degree of acceptance of the policy's impact

The policy has been well received. This was shown by the diagnostic survey in which people were asked their opinion about smoking restrictions in the workplace; out of a total of 20 848 persons surveyed countrywide, the level of approval was 89.5%. According to those responsible for promoting the policy in Chile, subsequent acceptance has been quite satisfactory.

#### Impact on non-smokers

Those who benefit most from this kind of policy are undoubtedly non-smokers; tobacco smoke is eliminated from the workplace and they are able to breathe better-quality air. In addition, the working environment is improved thanks to the existence of a consensus among all the workplace's employees, which makes it possible to resolve conflicts between smokers and non-smokers.

#### Documentation on the policy

For the moment, we have the data from the baseline survey carried out when the policy was introduced in the health sector. The study, which was carried out among 20 848 health workers throughout Chile, has provided the programme with a firm foundation by enabling us to determine the prevalence of smoking in each establishment, together with attitudes towards smoking, both in the home and in the workplace. It is worth mentioning that 89.5% of those interviewed supported the restriction on smoking. It is intended to repeat the survey in each establishment two years after the introduction of TSFE in order to obtain objective information on developments in premises on which the policy has been introduced.

## Other results of the programme

The cost to employers of implementing the programme has been very low. The only expense they have had to bear has been to adapt some premises as smoking areas for those who wish to smoke.

The other costs, both for the advertising campaign and educational material for employees, were met by the central Ministry of Health. Training for health teams was also provided by the TSFE programme's central team through a national workshop held in early 2001, and through subsequent support in the form of supervisory visits and direct communication via e-mail or the phone.

For the health sector, the direct per-capita cost of the TSFE programme was approximately 800 pesos (US$ 1.1).

## Conclusions

#### Lessons for decision-makers

In our opinion, the following factors contributed to the satisfactory implementation of the TSFE programme:

- the reliance of TSFE on a national health promotion policy, with a country plan and goals, which had already been under way for four years;
- the programme's design and features (technical, political and strategic) were adapted to the Chilean situation and relied on participative and decentralized management suited to the national cultural context;
- its association with an incentives system; management commitments subject to evaluation and grading by the health services. Certification by Chile's supreme health authority (the Ministry of Health) served the same purpose;
- a competent and recognized management team with technical and political support;
- the existence of real goals attainable within the time frame;
- the availability of sufficient funds to implement the programme.

#### The key moments in the intervention

At the national level, the crucial phase was the implementation of the programme, together with planning and drafting of documents.

At the local or establishment level, the diagnostic survey and awareness raising among employees, on which the future development of the programme depended, were crucial.

At every level, support from the relevant authorities has proven vital for the programme.

### Strengths

The incentives: the management commitments and certification, which represented a meaningful ritual for institutions or establishments;

### Resources that might have improved the intervention, had they been available

So far, the programme has made do with one full-time and two part-time employees. Fresh and increased human resources would make it possible simultaneously to address other spheres of work, such as other workplaces, especially in the private sector, public spaces such as airports, road and sea transport terminals and restaurants, and to extend coverage in important areas such as municipalities.

### Requirements in order to generalize the experience

We believe that it is perfectly possible to generalize the experience, provided it is adapted to local circumstances. It is an easily adaptable model, as the basic tools are simple and may be used after basic training.

It involves little expense and a cost-effectiveness evaluation is easily carried out.

WHO/NMH/TFI/FTC/04.05

PH-13.

# Advertising and Promotion Bans

Country Report on Tobacco Advertising and Promotion Bans-Croatia

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# Country report on advertising and promotion bans – Croatia


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## Introduction

For centuries tobacco has been grown and consumed in Croatia. In the last century the habit of cigarette smoking was highly prevalent and socially accepted. People smoked not only at home, individually or at family gatherings and celebrations but also in pubs and restaurants, at work, meetings, and on social occasions or at media events. Smoking was considered a sign of adulthood, as illustrated by the popular saying, «I am older, so I can send you to get me a pack of cigarettes».

The results of the first major survey on smoking prevalence in Croatia at the beginning of the 1970s, covering a representative sample of households, showed that 57.6% of the males and 9.9% of the females between the ages of 20 and 64 were smokers (1). According to the basic indicators for the Health Promotion subproject within the First Croatian Health Project in 1997, 34.1% of Croatia's males and 26.6% of females between the ages of 18 and 65 were daily smokers. The males were «heavier» smokers than females. Of the male smokers 40% reported smoking more than 20 cigarettes a day, outnumbering the 12.5 % of female smokers who had the same habit (2). The respondents claimed they started smoking between the ages of 16 and 20, in contrast with the results of the international study European School Survey Project on Alcohol and Other Drugs (ESPAD), showing the current shift towards younger age groups in starting the habit (Table 1).

Table 1. Prevalence of daily smokers in Croatia

| Year of study | Age (years) study population | % smokers among men | % smokers among women |
|---|---|---|---|
| 1970 | 20-64 | 57.6 | 9.9 |
| 1997 | 18-65 | 34.1 | 26.6 |
| 1995 | 16 | 25 | 19 |
| 1999 | 16 | 30 | 25 |

The ESPAD study, conducted in Croatia in 1995, was done again in 1999, with data collected between March and April of that year. The sample consisted of randomly selected school classes with the highest proportion of students born in 1983. The results showed that 70% of boys and 69% of girls in Croatia in 1999 had experimented with cigarettes at least once, compared with 71% of boys and 67% of girls four years earlier. In 1995, 25% of boys and 19% of girls admitted they were daily smokers, while in 1999 the corresponding percentage for boys was 30% and for girls 25%. Whereas 45% of male and 34% of female respondents said they had begun experimenting with cigarettes before their 13th birthday, 14% of male and 8% of female respondents said that by the age of 13 they had begun smoking on a daily basis (3).

With regards to the health consequences of smoking, it should be underscored that the two leading causes of death in Croatia are closely related to smoking. Cardiovascular diseases, with a 53.6% share in Croatia's mortality total in 2001, ranked first. Next in rank was neoplasms, with 23.8%, while diseases of the respiratory system, with 4.1%, were fifth (4). Using R Peto's methodology presented in the World Health Organization's 1997 publication Tobacco or Health: A Global Status Report, Croatia's smoking-related deaths for 2001 were estimated at 8400 (17% of all deaths), i.e. 25% of all male and 9% of all female deaths (Table 2). In the WHO Regional Office for Europe, Health for All database , the standardized mortality rate (SDR) for selected smoking-related causes of death for Croatia in 2001 was 390.2/100 000.

## Description of policy interventions

Until 1999 there were three pieces of legislation governing the control of tobacco:

- the Tobacco Act, which regulated the planting of tobacco and the manufacture of tobacco products;
- individual articles of the Work Safety Act, which forbid smoking in any room within the workplace or closed area where meetings and gatherings take place, but allowing firms or organizations, through internal regulations, to permit smoking in certain designated smoking rooms as long as this did not infringe upon the right of non-smokers or pose a fire hazard ;
- individual articles of the Food and Object of Common Use Health Safety Regulation Act, which banned direct advertising of tobacco and alcohol beverages in public places, and the display of advertisements for these products in public places, on buildings and in the media. It also prohibited advertising tobacco and alcoholic beverages in books, reviews or similar publications or exhibiting stickers, posters and leaflets separately from the cigarette packaging itself. This provision did not apply to technical publications intended for manufacturers and sales people or to consumer information about the properties of tobacco manufacture in the facilities where such products are sold. The same act regulated the requirement of having health warnings on cigarette packages.

Following these regulations, the Croatian tobacco industry simply changed its advertising strategy, switching from direct to indirect advertising. Cigarettes were advertised in different media (e.g. newspapers, billboards and television commercials) by simply avoiding direct mention of smoking, cigarettes, brand names, etc. Additionally, the implementation of the advertising ban was poorly supervised and penalties were decidedly low for firms that were caught and fined for violating regulations.

Realizing that tobacco is the major avoidable health risk and cognisant of weaknesses in the existing regulations, the Ministry of Health initiated the drafting of a new law. In November 1999, the Croatian Parliament passed a Tobacco Product Use Restriction Act, which contains the sections: (i) General Provisions; (ii) Noxious Cigarette Ingredients and Mandatory Health Warnings on Tobacco Products; (iii) Restriction Measures for Tobacco Product Use; (iv) Smoking Prevention Measures; (v) Surveillance; (vi) Penal Provisions; and (vii) Transitional and Concluding Provisions.

In the third section, Articles 9 and 10 refer to advertising. Article 9 states:

> There is a ban on advertising tobacco products through the following means:
>
> - mass media; and
> - any type of advertising in public areas, transportation facilities, means of transport; in books, reviews, calendars, on clothing articles, stickers, posters and in leaflets, if these stickers, posters and leaflets have been separated from the original packaging of tobacco and tobacco products.
>
> Considered as advertising in the sense of Paragraph 1 of this Article are all types of either direct or indirect advertising, including by show of logotypes and other marks to signify tobacco and tobacco products and placed on objects that are not defined as tobacco products by this Act. Tobacco and tobacco product handouts for advertising purposes also belong to this category.
>
> Also prohibited is the advertising of products which, according to this Act, are not tobacco products but which directly stimulate the consumption of tobacco and tobacco products by their appearance and designed use.
>
> The provision of Paragraph 1 of this Article does not relate to technical books, reviews and other professional publications describing the properties of tobacco and tobacco products, provided that these publications are intended exclusively either for manufacturers or sellers of these products.
>
> The provision of Paragraph 1 of this Article does not refer to informing the consumers about the properties of tobacco, respectively tobacco products, within the facilities in which these are marketed. [Note: This exception was made under pressure from the tobacco industry, which claimed they have the right to give information to consumers on the quality of their products, e.g. lower nicotine and tar levels.]
>
> The Croatian Government may decree one-time exceptions to this ban on tobacco and tobacco product advertising, and this solely for sporting events of international importance. [Note: The Government only issued such a decree several times for international motor-bike-crosses and auto rallies so that Croatia was not left out of these international sports events.]

Article 10 stipulates:

> No smoking of tobacco products is allowed during live television shows. The press may not publish any photographs or drawings of people smoking for advertising purposes.

Therefore, the law has placed a complete ban on direct and indirect advertising of smoking in practically all media, barring special cases related to international sporting events (international motor-bike-crosses and auto-rallies).

The only unspecified media left is the electronic media, the share of whose use three years ago was significantly smaller than now. Moreover, the past practice did not point to these media being a problem.

According to this Act, sanitary inspection assumed oversight of adherence to the advertising regulations in Articles 9 and 10. When the Act passed in Parliament, sanitary inspectors began overseeing the implementation of the Articles' regulations. Because the fines were high, tobacco advertisements disappeared from the media within a few months.

## The implementation's steps

With the aim of promoting the population's health and alleviating the health impact of smoking, and prompted by the World Health Organization (WHO) as well as the success of other countries in the area of tobacco control, Croatia's Ministry of Health has initiated the drafting of the Tobacco Product Use Restriction Act.

During the law-making procedure, the Minister of Health, the various professionals who drew up the Act, and disease-prevention-oriented health specialists explained the Act's intentions in medical journals, at professional and public gatherings and in the mass media, etc.. They also warned of the health consequences of smoking and made use of other countries' best practices in tobacco control.

This Act was relatively long in the making, because tobacco growers and the tobacco industry kept reminding the public that tobacco constitutes an important sector of agriculture and industry, one which contributes heavily to the national budget. (For example, in 2001 the value of non-manufactured tobacco was Kn 136 189 000 or 2.9% of the total purchased and sold agricultural, forestry and fishing products) (5) .

The tobacco growers and tobacco industry further argued that introducing new regulations could lead to a reduction in the state's tax revenue and threaten the livelihood of people who make their living from tobacco growing and the manufacture and sales of tobacco products.

In these activities they were joined by some journalists, whose articles questioned just how harmful to health smoking was, especially considering the pollution people lived with. They also questioned the truthfulness of study results concerning the impact of smoking on health, saying that those who initiated this Act did not consider people who made their living growing, manufacturing or selling tobacco, or whose salaries partly depended on tobacco revenue. Some press articles suggested that advertising was a way for the tobacco industry to inform customers about their products' quality and business results, etc.

Furthermore, writing in one of the major Zagreb daily newspapers, one of the more well-known journalists directly attacked the professionals who had prepared the Act for disregarding journalists' income, arguing that if journals and magazines are paid to advertise tobacco, it will raise their income and journalists' salaries as well.

## The intervention's success

It should be emphasized that from the outset of the Act being drawn up (the procedure taking over a year) the tobacco industry intensified its advertising activities and ran a campaign called «What are we silent about?» During the campaign, they availed themselves of every means to advertise smoking indirectly, in practically every media, something not prohibited by previous legal provisions. Use was made of likeable characters calling for silence either onomatopoeically or through mime, showing, in addition, how enjoyable they found it to smoke.

The passing of the Tobacco Use Restriction Act was promptly followed by the disappearance of the 'What-are-we-silent-about?' campaign's likeable characters, who had advertised smoking, and, step by step, of other smoking-related advertisements. This is understandable in view of the stiff fines for breaking the law. Specifically, a legal person contravening the complete ban on tobacco product advertising can be fined between Kn 200 000 and Kn 500 000 (the approximate equivalent of between Euro 26 000 and Euro 66 000) and responsible individuals within the legal person with 10 000 to 20 000 HRK (between Euro 1300 and 2600).

Nonetheless, the tobacco industry's efforts to advertise its products do not seem to have slackened. Last summer, a "Greeting from Rovinj" message appeared for a while in different media. It is a picture of Rovinj, a colourful tourist resort on the Adriatic coast (which has a large tobacco factory as well). This raises the issue of whether a

new attempt at sending ads, this time by hiding behind a tourist advertisement, is involved. The suspicion was supported by the as-yet-unchecked information that the two grey lines have appeared in patches on this message that could also be found on the paper inside of some cigarette packs from the Rovinj Tobacco Factory. Should this happen again, the Ministry of Health-appointed Commission for Smoking Control plans to inform the sanitary inspection, who is responsible for the implementation of Article 9, and to undertake the penal provisions against the Rovinj factory if they are breaking the law.

## Other impacts of the intervention

It must be emphasized that formerly Croatia also had certain legal provisions aimed at enabling tobacco control, including the direct tobacco advertising ban. The influence of tobacco advertising and promotion bans is impossible to consider in isolation from other measures. The current Tobacco Product Use Restriction Act, which came into force in November 1999, banned direct and indirect advertising as well as laid down noxious ingredient allowances in tobacco products, imposed the obligation for tobacco products to carry health warnings specifying the content of messages, instituted restrictions on the use of tobacco products, including a ban on smoking in all health and educational institutions and prescribed preventive measures against smoking that include health education.

It should be borne in mind that, according to information available, the proportion of revenue from a special tax on tobacco products (99.9% of which relates to cigarettes) has demonstrated the following trends during the period 1995-2001.

Table 2. Trends in revenue from tobacco product tax

| Year | % from special tax on tobacco products out of total special taxes |
|---|---|
| 1995 | 35.5 |
| 1996 | 37.8 |
| 1997 | 37.0 |
| 1998 | 33.6 |
| 1999 | 32.0 |
| 2000 | 27.0 |
| 2001 | 27.4 |

The special tax on tobacco products was introduced in July 1994. From 1996 until 2000, the proportion of this tax out of the total of collected special taxes declined. For the most part this has been ascribed to a fall in sales due to increased retail prices, but it could also be the result of an increase in the sale of illicit tobacco products.

In 2001, the special tax on tobacco products amounted to Kn 2 094 696 000 or 27.4 of the total of collected special taxes. Unfortunately, it was not possible to obtain the data on the tobacco industry's advertising expenditures as well as the impact of the Act on the media's advertising revenues.

## Conclusions

Croatia's experience has demonstrated that gaining the support and advocacy of leading professionals, decision-makers and public figures is critical to passing laws that ban direct and indirect tobacco advertising and promotion, as well as limit the use of tobacco products.

The provisions banning tobacco product advertising and promotion have proven efficient, largely owing to the fact that they are accompanied by adequate penal provisions (stiff fines) and actually implemented. Unfortunately, electronic media is the loophole in this Act. Another problem is the sale of foreign reviews, which come from countries with no ban on cigarette advertising. The same is true for foreign TV programmes and for international sports and other events sponsored by the tobacco industry. A portion of these take place in Croatia or are broadcasted on TV. The Ministry of Health-appointed Commission for Smoking Control plans to prepare the amendments to the existing Act to close these legislative loopholes. It is definitely expected that the WHO Framework Convention on Tobacco Control (WHO FCTC) will be supportive to these amendments.

Table 3. Estimated percentage of deaths caused by smoking in Croatia, 2002, by sex and major cause of death groups

| Sex | All causes | | All cancer | | Lung cancer | | Upper aero-digestive cancer | | Other cancer | | Chronic obstructiv pulmonary disease | | Other respiratory diseases | | Vascular diseases | | Other causes | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N |
| M | 25 | 6433 | 43 | 3044 | 92 | 1924 | 66 | 481 | 15 | 645 | 75 | 428 | 14 | 93 | 21 | 2516 | 18 | 973 |
| F | 9 | 2235 | 13 | 650 | 72 | 356 | 36 | 34 | 2 | 89 | 53 | 161 | 7 | 40 | 6 | 883 | 7 | 294 |
| Total | 17 | 8597 | 30 | 3623 | 87 | 2250 | 60 | 494 | 8 | 693 | 66 | 577 | 10 | 123 | 13 | 3471 | 12 | 1162 |

'*Cancers of the mouth, oesophagus, pharynx, and larynx.*

*Source: Tobacco or Health: A Global Status Report, WHO, 1997.*

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# Taxation (including Smuggling Control)

WHO/NMH/TFI/FTC/04.02

PH-13.

## Tobacco Taxation and Smuggling Control: New Zealand

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# Tobacco taxation and smuggling control: New Zealand

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## Introduction

For over 100 years taxation has been a common method of revenue collection in New Zealand and the major policy instrument for reducing tobacco use since the comprehensive tobacco control programme began in 1985[1]. Tobacco tax rates have been raised once or twice a year since that time[2]. A comparison of cigarette prices in relation to income in the year 2000 showed that in New Zealand cigarettes were more costly than in 22 Organisation for Economic Co-operation and Development (OECD) countries, except for the United Kingdom[3]. During the 1986–1992 recession, the Government increased the tobacco tax to raise revenue.

**Table 1. Smoking trends in New Zealand, 1976–1996**

| Years in which Census asked smoking question | All males<br>% who smoke | All females<br>% who smoke | Maori males,<br>% who smoke | Maori females<br>% who smoke | Cigarette consumption per smoker per day | Tobacco product consumption per adult<br>cigarettes or grams per year | Estimated deaths from cigarette smoking (as % of all deaths) |
|---|---|---|---|---|---|---|---|
| **1976** | 40 | 36 | 56 | 59 | 24 | 3154 | 4114 (16%) |
| **1981** | 33 | 27 | 54 | 58 | 25 | 2905 | 4559 (18%) |
| **1996** | 25 | 23 | 40 | 47 | 16 | 1512 | 4679 (16%) |
| **% change 1976-1996** | -38 | -36 | -29 | -20 | -33 | -52 | 14 |

*Sources: Prevalence: New Zealand Census. Consumption per adult age 15 years and over: Statistics NZ.*

Attributable deaths: Peto et al. 1994; and thereafter by Laugesen M.

Note: Maori, the indigenous people of New Zealand, comprised 15% of the total population in 2001.

The lung cancer death rates fell from 1975 onwards for men, and from 1992 for women under 70.

The estimated number of cigarette deaths was still increasing in 1996, due to the ageing population, but the cigarette death rate continues to fall in line with the lung cancer death rate. (See Surveillance and monitoring).

From 1985 to 1998, consumption of tobacco products fell more rapidly in New Zealand than in other OECD countries as a result of reliance on taxation to increase revenue[1]. However, compared to some countries, prevalence did not fall as rapidly; before 1999 there was little support to help smokers quit (e.g. there was no quit advertising and no toll-free quit line).

### The intervention—various types of tobacco taxation increases and policies

#### Tobacco excise contributed 1.9% of the Government's income in 2001.[4]

**Periodic tax increases above the level of inflation (1800s to the present day).** Since the 1800s the Government has levied increases in tobacco tax when it needed revenue. In 1958, the Government increased cigarette prices 42% and also increased alcohol taxes heavily. Consumption fell by 13%; this was before health warnings were placed

[1] Laugesen M, Swinburn B. New Zealand's tobacco-control programme 1985-1998. Tobacco Control 2000, 9: 155-162. *www.tobaccocontrol.com*

[2] Laugesen M. Tobacco Statistics 2000. Cancer Society of New Zealand. *www.cancernz.org.nz*

[3] Health New Zealand international tobacco control database, 1960-2000. *www.healthnz.co.nz*

[4] Budget revenue tables year to June 2001. *www.treasury.govt.nz*

on cigarette packets. Such a low decrease in consumption response was good for revenue, but not so effective for health. The Government was defeated in the next election and forced to decrease cigarette prices slightly. By 1960 consumption was rising again, thanks to cigarette advertising, lack of health warnings, competition between transnational tobacco companies and the new filter cigarettes.

**1960–1983**. Without regular cigarette price increases, cigarettes became cheap relative to the price of other goods.

**1984–1989**. As inflation became more severe, keeping the real price from slipping became even more important. Large catch-up increases were needed.

**1990–2002**. Finance Minister Caygill had obtained changes to the Customs Act to require automatic regular annual increases in tobacco tax to adjust for inflation from 1990 onwards. The cigarette companies supported this reform. This added up to a 20% increase in tax over the decade 1990–2000, which health groups did not have to particularly ask for, releasing parliamentary time, and enabling health lobbyists to focus instead on periodic price increases over and above the level of inflation.

**Annual or six-monthly adjustments of the tobacco tax rate for inflation (1990)**. These adjustments, which are almost always increases, maintain the real tax rate and price of tobacco products rather than increase these above the level of inflation.

**A uniform tax rate across all tobacco products, according to tobacco content (1995)**. Before tobacco tax reform in 1989, tax was a mixture of ad *valorem* and specific tax rates. Finance Minister Caygill reformed this to a simple specific rate of tax, based on tobacco weight of the product. Thus the price remains high whether the smoker shifts to a lower-priced brand or to hand-rolled cigarettes. Today there are no extra levies in the form of import duty, and no farm subsidies: tobacco is no longer grown in New Zealand.

The uniform rate of tobacco tax when raised in December 2002 was NZ$ 324.50 (approximately US$ 175.00) per kilogram of tobacco, applied whether the tobacco is in cigars, pipes or cigarette tobacco. For manufactured cigarettes, which contain just under 0.8g of tobacco, the same rate also applies, as the tax rate per 1000 cigarettes is calculated as 80% of the tobacco tax rate per kilogram. In 2002, each cigarette was taxed currently at 26 cents per cigarette, which amounts to 60% of the current retail price of 43 cents for the Holiday brand, the most popular manufactured cigarette. In addition, a goods and services tax is applied to all goods and services, at the rate of 12.5% of the final retail price.

Hand-rolled cigarettes made up 26% of all tobacco used in 2001. Pipes and cigars accounted for 1% of tobacco used, and oral tobacco is banned. But without the uniform rate of tobacco tax by tobacco weight in place, shifting to hand-rolled cigarettes would provide a way to avoid quitting, in the face of a tax or price increase on manufactured cigarettes.

A refinement of this method is to review the taxed weight of tobacco in manufactured cigarettes, and if it were, for example, to fall to about 0.6g tobacco as in Swedish or Finnish cigarettes, to decrease the rate of tax to 60%—not 80%—of the per kilogram rate.

**The goods and services tax includes tobacco**. It makes up one-ninth of the final retail price. As this tax is aimed at all goods and services, it does not increase the price of tobacco compared with other goods. However, any increase in tobacco tax causes follow-on increases in the goods and services tax—a tax on a tax.

**Tied-tobacco tax**. Until 2002 there was no direct cents-in-the-dollar levy that was written into law in New Zealand for allocating tobacco taxation revenue to tobacco control or the treatment of smokers' diseases. The Treasury has traditionally opposed tied tax, though such levies are in place for alcohol and gambling.

**Correction for increased affordability**. There is no automatic upward correction of the tobacco tax rate for increased wages, which often tend to push up demand. However, raising tax periodically above the level of inflation should take care of income growth and increased affordability effects on demand.

**Hazardous substances or toxicity taxes**. Though not a policy in use in New Zealand, a "pollution tax" or toxicity tax, on hazardous chemicals in smoke could provide a financial incentive that could be rapidly applied, as an alternative to regulatory control over (independently tested) levels of leading hazardous substances in mainstream smoke. An example of this would be hydrogen cyanide gas, arsenic,

5 Fowles J, Barker M, Noiton D. The chemical constituents in cigarettes and cigarette smoke: Priorities for Harm Reduction. A report to the Ministry of Health, March 2000. Porirua: ESR. www.ndp.govt.nz

and the carcinogen 1:3 butadiene[5]. Taxing actual tar or nicotine yields is not helpful, but taxing the ratio of the hazardous substance to nicotine yield makes more sense, since smokers smoke up mainly to get more nicotine.

## The key steps

Budget planning begins six months beforehand. The Treasury decides with the Minister of Finance whether the country's finances require extra revenue from tobacco. Specialist anti-smoking groups such as Action on Smoking and Health, the Smoke-Free Coalition and Heart, Cancer and Asthma charities, in their lobbying emphasize the premature death toll from tobacco, and urge the Minister of Health to support an increase in tobacco tax. In fact, the Minister of Finance is usually the prime mover, and the Minister of Health sometimes wins a share of the increased revenue for tobacco control programmes.

The tobacco companies, without publicity, also lobby the Minister of Finance to not increase the tobacco tax rate, emphasizing their huge current contribution of tobacco excise and corporate income tax to the Government coffers. Companies also have made contributions to political parties, though no New Zealand evidence has come to light that undue influence was obtained in this way.

## The effect of the intervention

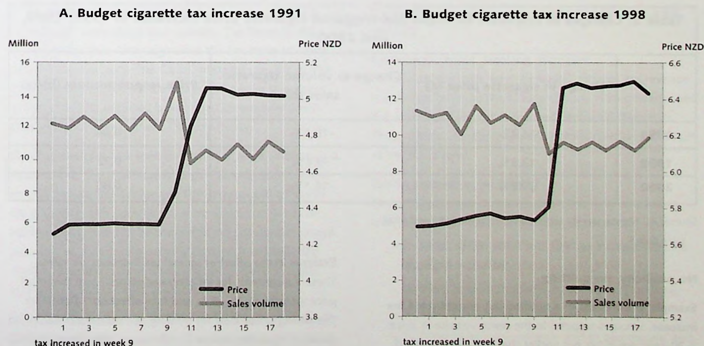
### The effect of taxes on cigarette prices

In New Zealand after past tax increases, the tobacco trade (comprising manufacturers, wholesalers and retailers), traditionally raised its share of the cigarette price by as much as or almost as much as the tax increase. As tax made up over half of the retail price, a tax increase of 23% in 2000 resulted in a packet price increase of 20%. The cigarette companies increased their prices within a few days, and sales fell within a week of the tax increase (Figure 1).

### The effect of taxation on consumption

As Figure 1 shows, in 1991, 1998, and in 2001, when the price rose by a dollar or more per packet, the number of cigarettes sold fell immediately after the price increased by approximately 2 million cigarettes a week. Cigarette prices in the years between these graphs increased in line with inflation, due to annual automatic adjustments of tobacco tax. This allowed for increases in the all-items consumer price index, which increased by 13.5% between graphs A and B, and by a further 1.2% between graphs B and C.

**Figure 1. Weekly manufactured cigarette sales before and after tax-triggered price increases in 1991, 1998 and 2001, New Zealand**



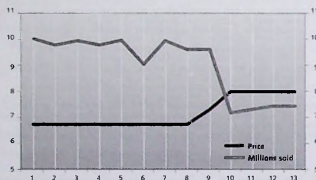

Source: Table 2, and AC Nielsen weekly supermarket national sales and retail price for 20 cigarettes in current dollars.[2]

Figure 1 shows that:

- the consumption falls dramatically after a well-publicized major price increase;
- the decrease is seen within a week of the price increase; and
- the smoking public's responsiveness to the price rise has increased over time.

When alcohol and socializing was at a holiday high, quitting was less likely. Health groups are not in the habit of emphasizing unpopular price-increase news to smokers. Governments do not wish to publicize their tax increases. Weekly sales data showed no decrease at all. Yet similar-sized increases in tax in 1988 at government budget time or soon after had resulted in decreased consumption—probably because of publicity surrounding the annual government budget.

**C. Pre-Budget cigarette tax increase 2000**




As price increased in response to the tax and price rise, the number of cigarettes sold decreased.

Each of the tax increases in 1991, 1998 and 2000 was followed within a week or so by a similar increase in price by the tobacco trade.

The volumes of cigarettes sold fell to a new level within one week.

As shown in Table 2, price rose 20%, and sales fell 16%. 16/20 = 80% price responsiveness.

Source: Table 2, and AC Nielsen weekly supermarket national sales and retail price for 20 cigarettes in current dollars.[2]

**Table 2. Changes in response to major tax-triggered cigarette price increases in 1991, 1998, and 2000**

| | Change in cigarette price (a) | Change in volume cigarette sales (b) | Price responsiveness (b)/(a) |
|---|---|---|---|
| **1991** | 16.3% | -10.5% | 0.64 |
| **1998** | 13.3% | -9.6% | 0.72 |
| **2000** | 20.2% | -16.1% | 0.80 |

Source: AC Nielsen weekly supermarket national sales and retail price data.[2]

**No publicity, no quitting**

**Example 1: the effect of a notified but unpublicized tax increase.** Smokers respond to the perceived rise in price. A 20-cent rise in tax per packet that had been notified by the Finance Minister six months before went unnoticed on 1 January 1989, during annual summer holidays.

**Example 2: the effect of annual tax increases on sales.** These adjustments for inflation sometimes equal to a retail price increase of 2%–3%, and take effect on 1 December. The timing is not ideal for quitting as: retailers are starting to discount cigarettes before Christmas and New Year; smokers are pre-occupied with preparation for Christmas and vacations; and quit line advertising support tends to be less, due to higher television advertising costs during this season.

**Example 3: trade-induced price increases.** The consumer price index increased by 2.65% in the year to September 2002. As required by law, the tobacco tax rate was increased by 2.65% on 1 December. Within a week, the price of cigarettes increased not by 2.65%, but by 30–40 cents per pack, or to 3.6% to 3.9% above the previous price, as the manufacturers set a new recommended retail price to retain their percentage share of the packet price. The price increase occurred without publicity, and though some callers to the quit line mentioned price as a reason for calling, the number of calls to the quit line in the first week of the new price did not increase. We conclude that even if smokers noticed the unpublicized price increase at the beginning of the year-end busy holiday-shopping season, they were just too busy to think about quitting at this time.

### The effect of tobacco taxation on smoking prevalence

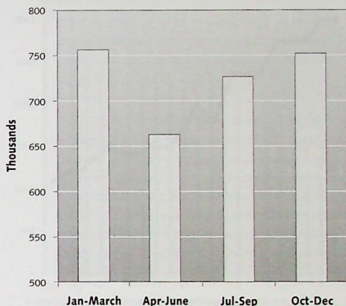
**Example 4: the effect of a sudden but well-publicized price increase (Figure 2).**
On 12 May 2000, a sudden cigarette tax without prior warning triggered a cigarette price increase of 20%. The surprise timing was deliberate, to maximize revenue. Publicity was intense because of the size of the increase—approximately NZ$ 1.40 for a packet of 20 cigarettes. Smokers were angry and unprepared to quit. Cigarette sales fell 16%. Prevalence fell three percentage points. An estimated 80 000 (one in eight) smokers quit smoking in the second quarter of 2000, but prevalence returned to "normal" after about four months. The Treasury did not warn the Quit Campaign since the tax increase came under budget secrecy. The Quit Campaign was not targeted to, or able to prevent the relapse of this large number of smokers. This occurred before the Government subsidized Nicotine Replacement Therapy (NRT).

Quitting even for four months by one in eight smokers is a major event. The challenge is to plan to help these smokers stay smoke-free for longer. The private pain of smokers grappling with addiction and the economic stress of smoking, may need to be converted into an annual staged planned-for community event with mass media and the media-promoted support of family and work colleagues, and with subsidized NRT available.

**Effect of tobacco tax on revenue to the Government and the tobacco trade**
From 1990 to 2001, measured in constant dollars, government tobacco tax revenues increased an estimated 15%, while the gross revenue of the tobacco trade (retailers, wholesalers and manufacturers combined) decreased 18%.

**Figure 2**

**Smoking population, any cigarette, New Zealand 2000, quarterly data**




Source: AC Nielsen and Roy Morgan Research data combined.
Comment: From April to June the smoking population was significantly less than in the other quarters. ($p<0.001$). In quarters 2 and 3 taken together, the smoking population was significantly less than for quarters 1 and 4 combined. ($p<0.001$)

During this time, sales volumes (consumption) per adult fell 42%.

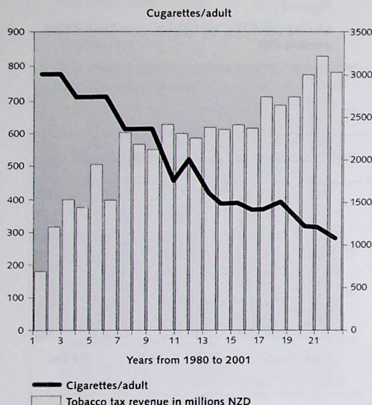
**Revenue increases, smoking decreases**
As tobacco tax rates were increased, tobacco tax revenue rose in real terms in New Zealand from 1980 onwards, and the number of cigarettes smoked decreased (Figure 3). Thus, tobacco taxation helped improve revenue and health at the same time.

**Tax for revenue or for health?**
Major tobacco tax increases above the level of inflation were introduced for a combination of reasons:

- in 1986, 1988, 1989 and 1991 to increase revenue during a recession;
- in 1995 as part of policies to curb youth smoking;
- in 1998 to increase revenue; and
- in 2000 to increase revenue and to accompany, and possibly pay for, new expenditure on Maori quit-smoking programmes.

**Figure 3**

**Tobacco products revenue and consumption, 1980-2002**




Source: Treasury, letter of 5 July 2002, and *Tobacco Facts www.ndp.govt.nz*. Calendar year data with the exception being that 2002 data are for the 12 months to June. Excise revenue as well as customs revenue (an extra 5%) is included since 1995. Revenue was deflated to 1995 prices using the all-items consumer price index.

Decisions to use the increased revenue from any increase in the tobacco tax, to fund tobacco control programmes, as in 1995 and 2000, were made at the cabinet table, but not written into statute as a percentage of the increase in tobacco tax.

**Effect on youth smoking**

One of the main justifications for tobacco tax increases has been to discourage young people from smoking. At age 14 to 15, students are price sensitive; those receiving more pocket money were more likely to be smokers[6]. The price of cigarettes may affect those youth smokers who feel the need to buy a packet of cigarettes every day or so, and an increase in price may delay these smokers' progression to adult consumption levels.

But from ages 15–24, despite low affordability for many in this age group, smoking rates are reaching their highest levels[7].

**Recent and planned policies for tobacco taxation**

**1 Making the policy more palatable to smokers**

As cigarette prices rose in the 1980s and 1990s, further taxes became less attractive politically, as many people felt smokers were being taxed but not being helped to overcome their addiction. However, in 1999 the Government funded a Quit campaign and quit line and in 2000 subsidized nicotine patches and gum. These moves demonstrated to smokers that the Government and the national tobacco control programme were willing to assist smokers, and not just to regard tobacco tax as the best way to meet revenue needs.

In 2000, smokers phoned the quit line, angry because the price had risen. However, by later in the year 2000 they were offered a much cheaper way of accessing nicotine (gum or patches) for several weeks while they quit, thus hopefully avoiding the tax altogether in future. In 2000, 7% of all smokers called the quit line for advice on quitting.

**2 Making the policy more health-effective: planned linkage of tax and quitting**

- From 1970 when health was first mentioned by the Finance Minister as a reason to tax tobacco, to 1995 when the Health Minister actually introduced the tobacco tax bill into Parliament to help pay for youth smoking programmes, tobacco tax was increasingly regarded as a health issue. But more often than not, the primary purpose was revenue collection, and the health aim often used to justify taxing smokers to make up a revenue shortfall. Health groups did not object, because they knew that a higher price for tobacco was necessary to discourage adolescent smoking.
- Once the price has been raised to deter adolescents, and the Government aims to make the first goal of tobacco taxation smoking cessation and the second goal revenue, then a planned approach is necessary so that quitting services can be strengthened for

[6] Scragg R. Cigarette-smoking, pocket money and socioeconomic status: results from a national survey of 4th form students in 2000. New Zealand Medical Journal, 26 July 2002; 115 (1158) *www.nzma.org.nz* under Journal.

[7] Laugesen M, Sheerin J. Tobacco Statistics, 1991. Wellington: Department of Statistics, Department of Health.

when the cigarette tax is raised. In addition, assuming a media campaign is established to persuade smokers to quit and stay quit and a well-publicized, toll-free quit line is in place, will this increase or decrease tobacco tax revenue?

- Figure 2 shows how a price increase induced a fall in prevalence for four months, after which the mass quitting led to mass relapse. With open planning for a notified future tax increase, more quitting support can be planned, to make every tax increase day into a mass quit day—for example, annually, on World No Tobacco Day. The United Kingdom has an annual No-Smoking day, but tobacco tax increases have never coincided with it.

**3 Making the tax and quit policy more attractive to the Minister of Finance.**

Periodic "Big bang" tobacco tax increases do lower consumption dramatically, at least for a while, as they attract media publicity. But smaller, more regular tax increases are also effective in proportionately lowering consumption – and in gaining revenue, with less political cost to the Government from smoker voters. Repeated smaller-tax increases give smokers more opportunities to quit, and quit line support is more likely to be able to cope.

A minister of finance who seeks increased revenue from tobacco tax can expect smokers to be angry when the price rises by a dollar a pack, as happened in 2000. This is the price of gaining the revenue, since all taxes are unpopular. Health groups and officials in other years sought more regular increases but by a smaller percentage, say 5% per year. Provided the tax rate is already adjusted for inflation, and the increase in publicized consumption will decrease, and if smokers are also provided assistance to quit, the political cost of taxing tobacco will be greatly lessened.

The World Health Organization (WHO) recently called for a 5%–10% annual increase in tobacco taxes. A 5% annual increase in price would double the price in 13 years.

**The price responsiveness of tobacco consumption**

- The price sensitivity of cigarette sales to increases in tobacco tax (sales percentage decrease divided by the price percentage increase) rose from 30% in 1958 (no warnings, no advertising restrictions, few health posters) to 80% in 2000 (Table 2). This change is usually attributed to price, but now smokers face cigarette packet warnings, the example of doctors not smoking, health advertising combined with no tobacco advertising[8], and social pressures and government assistance through the quit line, to quit.
- Price increases are an essential part of an effective tobacco control programme. The huge peaks in quitting following a price increase suggest that unless there is already constant encouragement from mass media to quit, many smokers will wait for a price increase before quitting.
- A strong, comprehensive tobacco control programme is likely to increase the health effects of a given price increase, maximizing quitting and decreasing cigarette consumption, which translates into cleaner air to breathe at home and more money freed up for food. Thus, governments wishing to soften the harsh effects of raising the cigarette tax on poor smokers, assist most by strengthening other tobacco control measures.

**Increased price responsiveness means more health gain, less revenue gain**

From a revenue-gathering perspective, increased price responsiveness of smokers means that the tax level per cigarette has to be increased more than previously to collect the same revenue, since the new prices shrink the smoking tax base for raising the revenue.

Eventually, governments may have to rethink the purposes of tobacco tax, put less emphasis on revenue, and give more weight to the health gains, which continue to improve as the price increases.

Higher tobacco taxation levels have not yet decreased revenue in any jurisdiction.

**Conclusion**

New Zealand has had a long history of frequent tobacco tax increases. The following refinements have been put in place or have been proposed for consideration:

- Automatic adjustment of the tobacco tax rate for inflation is a feature of tobacco taxation in New Zealand and some other countries. If the inflation rate in the preceding year was 2%, the tax rate rises by that amount.
- A uniform tax per gram of tobacco, from 1995 across all tobacco products, represented another important improvement in tobacco tax policy, in decreasing smokers' tendency, when cigarette prices

[8] Smoke-free Environments Act 1990. *www.ndp.govt.nz*

rise, to shift to cheaper cigarette brands or to hand-rolled tobacco, instead of quitting.

- The reliance on a specific rate of taxation (dollars per 1000 or per kilogram) introduced around 1989 makes for decreased price differences between brands, thus discouraging brand-switching as a substitute for quitting.
- The provision of full quitting support to help smokers who face regular, planned tax increases and quit days, for example, every World No Tobacco Day, seems a logical and feasible next step, if tobacco tax is to be valued for its health-gain advantages, rather than for the revenue gain.

## Smuggling—inbound and outbound

### Compliance with revenue collection and smuggling of exports

With only two tobacco factories and few ports as well as a simple system involving a specific rate of tax, achieving compliance in collecting tax is not difficult. There is no provision at present to tax cigarettes intended for export and refund the tax once excise tax is paid in the country of final destination. The Canadian Finance Ministry has promoted such a scheme to discourage "disappearance" of exported cigarettes into illegal smuggling channels worldwide. New Zealand exports are small scale and mainly to the South Pacific.

### Smuggling of imported cigarettes

New Zealand, separated by 2000 kilometres of ocean from other landmasses, seized over 2 million cigarettes in 2001–2002[9], out of total sales of over 3388 million cigarette equivalents in 2001. As tobacco is no longer grown commercially, evasion of duty from local cultivation is easily detected, and of small scale.

[9] Customs foils cigarette smuggling. News release, 6 June 2002, at web site: *http://www.customs.govt.nz*

# Advertising and Promotion Bans

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PH-13.

## Country Report on Tobacco Advertising and Promotion Ban-Botswana

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# Country report on tobacco advertising and promotion ban – Botswana

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Tobacco Free Initiative Headquarters would like to thank the Regional Offices for their contribution to this project.

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## 1. Overview of tobacco control activities in Botswana

The Government of Botswana has long recognized and accepted the need to sensitize its population to the harmful effects of tobacco. The Primary Health Care approach, adopted in the 1970s in Botswana after the 1978 Alma Ata Declaration emphasized this requirement. However, the theme "Tobacco or Health", launching the first World No Tobacco Day on 7 April 1988 in Botswana, marked the beginning of an intensive anti-tobacco campaign in the country. Since then, World No Tobacco Day has been held annually on 31 May. The commemoration of World No-Tobacco Days together with other educational programmes aimed at different sectors of the population and the general public, have contributed to sensitizing the general public about tobacco products' harmful effects on human health and fostered a positive political climate. This has led to the development of a comprehensive tobacco control programme in Botswana.

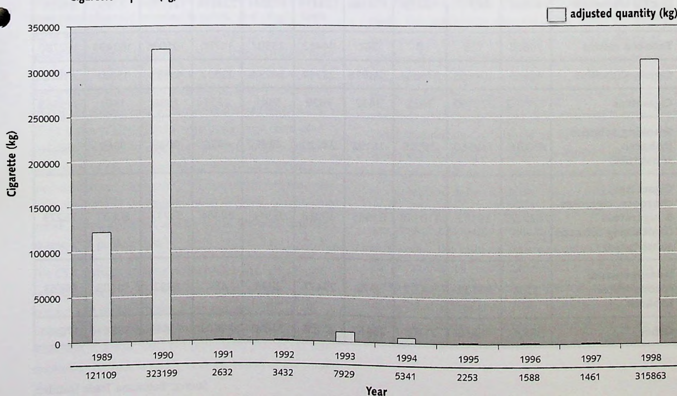
In December 1992, the Government of Botswana enacted its first law on tobacco and tobacco products—the Control of Smoking Act (CSA). The intention of this Act is to control smoking in enclosed public places, which include licensed premises, government and private offices, health institutions, public transportation and passenger lounges. The legislation also prohibits tobacco advertising and sales of tobacco products to persons under 16 years of age. To ensure the smooth implementation of its provisions, the Act also established a committee whose primary role has been to advise the Minister of Health on all matters relating to tobacco smoking.

Following the enactment of the law in 1992, several major developments took place. In 1993, a National Coordinating Committee (NCC) responsible for implementing the Act was established. The NCC's membership included government representatives from the Ministries of Home Affairs, Agriculture, Health, Transport, Trade and Industry and the private sector—the Botswana Federation of Trade Unions (BFTU) and the Botswana Confederation of Commerce, Industry and Manpower (BOCCIM). The activities of the Committee include sensitization of the different population groups on the health effects of tobacco and on the requirements of the CSA.

The national airline Air Botswana was the first to respond to the provisions of the Act by banning smoking on all its domestic flights in 1993. In 1995 the Airline expanded the ban to all flights within the Southern African Development Community (SADC) region.

**Figure 1**

**Cigarette imports (kg)**



As part of its sensitization activities, the NCC organized its first stakeholder workshop in 1994 aimed at familiarizing senior government officials, the private sector and community leaders with the Act's provisions and the actions required from them. Particularly important at this workshop were issues related to the Act's requirement that every employer prepare in writing, a workplace smoking policy in consultation with the employees. The primary objective of the workplace smoking policies is to ensure that employees who do not smoke or who do not wish to smoke in their workplace are protected from tobacco smoke. As a result of this workshop a positive response was received from both Government and the private sector. During the same year (1994) the Directorate of Public Service Management issued a Directive, which prohibited smoking in all government offices and government vehicles. Smoking was also banned on public transport in 1994. One of the major commercial banks, Barclays Bank of Botswana, also responded to the call by banning smoking in all its banking halls.

In 1997 a major campaign to create smoke-free workplaces was launched. It comprised training managers in workplaces on how to develop workplace smoking policies and sensitizing them to the importance of protecting non-smokers from the harmful effects of tobacco. The education campaign also linked smoking with productivity, enlightening managers on the effects of smoking on their organizations' performance. In 2001, a survey assessing the implementation of the CSA and, in particular, the establishment of workplace smoking policies was carried out. The survey showed that 91.0% of private companies had such policies, 77.0% of which were written. The majority of the written policies were done after 1997 (Figure 1).

## 2. Tobacco-growing and use in Botswana

Botswana is not a tobacco-producing country. However, different types of tobacco and its products are imported

**Table 1. Quantities (Kilograms) of various tobacco products imported into Botswana**

| Product | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Tobacco (not stemmed/ stripped)** | 70856 | 143886 | 24005 | 35934 | 88391 | 28689 | 8149 | 29502 | 432363 | 35396 |
| **Tobacco (partly stemmed/ wholly stripped** | 63559 | 44957 | 92739 | 174166 | 134478 | 193044 | 224634 | 127570 | 2795 | 33801 |
| **Tobacco refuse** | 74603 | 123 | 0 | 341 | 44412 | 23307 | 11750 | 101085 | 182494 | 162780 |
| **Cigars, Cigarillos** | 45940 | 104659 | 976258 | 773918 | 28214 | 34234 | 22512 | 45935 | 15521 | 61073 |
| **Cigarettes** | 121109 | 323199 | 2632 | 3432 | 7929 | 5341 | 2253 | 1588 | 1461 | 315863 |
| **Smoking tobacco (tobacco substitute)** | 630203 | 149560 | 28005 | 26192 | 24920 | 4985 | 6426 | 9086 | 8868 | 3851 |
| **Cigarettes, cheroots, cigarillos & cigarettes (containing tobacco substitutes)** | 66927 | 89132 | 110118· | 81985 | 80026 | 59916 | 62444 | 53717 | 80687 | 78229 |
| **Homogenized/ reconstituted tobacco** | 2508 | 33722 | 30052 | 3572 | 29477 | 2843 | 613 | 6252 | 54603 | 99653 |
| **Other** | 55420 | 26956 | 21705 | 25462 | 21206 | 22650 | 71670 | 90649 | 83841 | 176961 |

Source: Botswana Trade Statistics

from neighbouring countries such as South Africa. There are also a limited number of households that grow tobacco for their own consumption and sales to households without tobacco gardens on a restricted scale. Although there are no data on tobacco consumption in Botswana, there is evidence that most of the tobacco and tobacco products imported into Botswana are consumed domestically. Data from the Central Statistic Office (1993, 1996) have shown that over a five-year period (1992–1996) less than 2% of tobacco and tobacco products were legally exported (re-exports) to other countries. Table 1 shows quantities of various tobacco products imported to Botswana between 1989 and 1998. It is evident from the table that cigarette imports are significantly higher than other tobacco products. However, a major reduction in the imports was recorded between 1991 and 1997.

Although data are available in Botswana on tobacco expenditure, it is difficult to know the trends in consumption by age group, sex and population groups. However, available information shows that male-headed households (where the family considers the male as a head of the family) spend more on tobacco than female-headed households (i.e. where the family considers the female as a head of the family) (Ndegwa, 1998).

The prevalence of tobacco use among the youth has also increased over the years. Traditionally, it is taboo for young persons (school age) to be seen smoking in public, or at school. But over the years more and more young persons have been observed smoking in public, and caught smoking in school. While we do not have data on the reasons usually attached to the suspension of school children from school, cigarette smoking is more often reported as the culprit for the suspension. A recent study of 1 920 secondary school students in Botswana showed that 14.2% of the students aged 13–15 were using some form of tobacco, 6% smoked cigarettes and 11% used some other form of tobacco such as cigars, chewing tobacco, snuff and pipes (Botswana GYTS, June 2002). In the same study, four out of ten students lived in homes where adults smoke in their presence, and six out of ten were exposed to smoke in public places.

The CSA restricts smoking in enclosed public places such as restaurants and other licensed premises, passenger lounges and waiting rooms. It requires that 50% of an eating hall be reserved for non-smoking customers. The restriction, however, does not adequately protect the non-smokers since there is no physical separation of the smoking and non-smoking areas. This situation therefore justifies the high exposure (60%) of students to environmental tobacco smoke (ETS) in public places.

It is now well documented that the use of tobacco and its products increases a person's risk of contracting a number of diseases. There is a relationship between tobacco use and chronic diseases such as cancer. In a recent 18-month study by Nashi and his colleagues (2001) 605 out of 911 patients diagnosed and treated for cancer in 3 referral hospitals in Botswana were associated with tobacco use.

## Tobacco advertising and promotion in Botswana

Tobacco advertising and promotion activities appear both to stimulate adult consumption and to increase the risk of youth initiation. Research has shown that children buy the most heavily advertised brands (Centers for Disease Control, 1994), and are three times more affected by advertising than adults (Polay et al., 1996). Although there are no data specific to Botswana on the relationship of tobacco advertising to tobacco consumption, studies in the United States of America have shown that 34% of all youth experimentation with smoking in California between 1993 and 1996 could be attributed to tobacco promotional activities (Pierce et al., 1998).

The 1992 CSA prohibits tobacco promotion and advertising. This prohibition grew out of the high level of awareness at the political level of the harmful effects of tobacco and the fact that tobacco growing is not one of the country's major economic activities. The Act prohibits the publication by persons or arrangement for any other person to publish any tobacco advertisement in Botswana. Tobacco advertising, as defined by the Act, "means any words written, printed or spoken, or film or video recording or other medium of broadcast or telecast, or pictorial representation, design or device used to encourage the use of or notify the availability of, or promote the sale of any tobacco or tobacco products, or to promote smoking behaviour." The National Tobacco Control Committee and the Environmental Health Officers in Local Authorities and in the Ministry of Health currently administer all provisions of the tobacco legislation. These bodies together with the Police are also responsible for the enforcement of the ban on advertising and promotion.

Since 1992, direct and indirect advertising of tobacco products has not been permitted in Botswana. All tobacco billboards were removed and no advertising was allowed on the print media, radio or television. The current issue of concern is cross-border advertising, which cannot be addressed by national legislation alone. The tobacco industry is also finding ways of cutting into this prohibition by brand stretching. Some of their current activities include cigarette lighters made up as little dummy cigarette packets (Marlboro brand), clothing and household commodities such as ashtrays and menu holders in restaurants bearing brand logos (Marlboro in particular).

To address this problem, counter-marketing attempts were made to offset pro-tobacco influences and increase pro-health messages and influences throughout the country. Counter advertising activities were therefore used to promote smoking cessation and decrease the likelihood of initiation. The activities included media advocacy and other public relations activities such as press releases and national and local health promotion activities and events. While there are limited data to quantify the influence on public support for tobacco-free interventions, reports by members of the public on violations of the provisions of the Act, particularly smoking in public places are on the increase. In 2000, employees in 16 private companies in the capital city of Gaborone reported such violations, followed by 42 in 2001. There has also been an increase in the number of smokers and other tobacco users who want to be assisted to quit. While a total of 255 smokers needing help were registered in 2000, 449 were registered in 2002 nationally.

## Implementation of the ban on tobacco promotion and advertising

Although there are no tobacco industries in Botswana, there are several sales agents for different tobacco brands. Before the advertising ban policy was introduced, these agents were responsible for advertising the products in the entire country, including efforts to ensure that their products were advertised and displayed in an attractive and visible fashion in supermarkets and other retail outlets. As soon as the advertising ban came into force, all adverts and attractive displays of tobacco products were removed from supermarkets and other outlets.

Tobacco agents in Botswana have responded to this move by engaging in other marketing tactics such as giving free gifts in the form of pens, ashtrays and other promotional material with logos of the different tobacco brands printed on them. The companies also engaged in handing out free cigarettes in malls, night clubs and hotels to members of the public, including the youth.

Furthermore, in 1998, the tobacco agents intensified their efforts to use other forms of indirect advertising to recruit more smokers and encourage the use of other forms of tobacco products. Sponsorship or event marketing, being a form of promotion that is a key component of marketing strategies for tobacco industries began to surface in Botswana. Sponsorship of sports and cultural events, which are relatively cost-effective forms of advertising and promotion, became the tobacco industry's focus of attention. The industry approached a few organizations offering them money to carry out their activities. However, this was unsuccessful because of the public's high level of awareness of the CSA's advertising and promotion provisions. The tobacco agents are cognisant of the advantages of event marketing over traditional advertising in heightening tobacco brand-name visibility, shaping consumer attitudes and communicating commitment to a particular lifestyle. These events, which include sporting activities and music festivals, are often designed to appeal to the youth market, create good will for the tobacco industry through association with sports and the arts, and to link tobacco use with exciting, glamorous and fun events.

## Successes of the intervention

In the late 1990s, the intensification of the tobacco industry's campaign in Botswana threatened to defeat the Government's determined efforts to control the use of tobacco in the country. Tobacco imports, in particular cigarettes, immediately fell in 1991, a year before the enactment of the CSA. Over and above a ban on tobacco advertising, the Act restricts smoking in enclosed public places and prohibits the sale of tobacco products to persons who have not yet reached 16 years of age. Figure 1 shows a reduction in cigarette imports between 1991 and 1997. The intensified public education on tobacco and the harmful effect it causes to its consumers could have also contributed to this fall in cigarette imports. To date there have been no reports of any violations of the advertising ban.

This success cannot be attributed only to the introduction of legislation. It is also a result of the strong partnership between the Government and the private sector. Through

this partnership a high level of compliance achieved and weaknesses in the legislation were identified in a timely manner. The raised awareness of the legislation's requirements has empowered communities to report any anomalies they discovered, thereby making it difficult for the tobacco industry to defeat government efforts. For example, the organizer of the Miss Botswana Beauty Pageant sent a representative to approach the tobacco control activities office in 2001 to enquire whether a tobacco agent based in Botswana could sponsor the pageant. In 2002, another representative from the Botswana Volleyball Association also enquired about sponsorship by a tobacco agent. Both organizations were approached by tobacco companies proposing sponsorship. The organizations, being aware of the advertising provisions of the CSA, immediately sought advice from the Tobacco Control office. In response to these enquiries the two organizations were advised that the law does not allow any advertising and that it is common practice for any sponsoring organization to be acknowledged during the event by way of verbal or written communication. They were informed that it was not advisable to allow such sponsorship since the industry may want their products advertised, which might contravene the provisions of the law on advertising. There have also been reports of the tobacco industry offering sponsorship for music festivals in the country, but these never materialized. Although the tobacco industry offered sponsorship to various organizations, it is heartening to note that as a result of the general public's awareness of the tobacco legislation and, in particular, the provisions on advertising, the industry was denied the opportunity to advertise its products indirectly.

Through the involvement of organizations such as the Wholesalers Association of Botswana, compliance has been successfully monitored within the retailing community, ensuring that there were no tactics used by the tobacco agents in the country to promote tobacco use. Partnership with local authorities and the media were also some of the crucial aspects to compliance.

Despite the successes we have had, we still have shortcomings, which need to be addressed constantly and in a sustained manner. A sharp increase in cigarette imports was observed in 1998 and while it is fully acknowledged that the data may need to be studied further, there are a few factors that may be linked to this increase. The tobacco industry, being aware of the advertising ban in Botswana, has used other forms of indirect tobacco advertising not explicitly covered by the law, thereby increasing the demand for tobacco in the country. Second, the increase came at a time when South Africa, a neighbouring country, was tightening its tobacco control laws. Third, we have observed the establishment in Botswana of new tobacco agents to begin marketing their products. It is therefore probable that more tobacco products were imported to Botswana due to the increase in the number of tobacco agents that were otherwise based in South Africa. Lastly, even though this has not been confirmed, the increase could be due to imports from South Africa smuggled back into that country as a result of the tightened legislation. As indicated, the current data need further verification from its source.

## Limitations of the Control of Smoking Act (CSA) of 1992

While the CSA has played a major role in the control of smoking, particularly in restricting smoking in public places, reducing tobacco sales to persons under 16 and banning tobacco advertising, it has been limited in scope. There are difficulties in the language of the Act, such as the provision on smoke-free workplaces, which requires the employer to consult with staff inputting in place a no-smoking policythat allows protection of non-smokers while giving smokers a place to smoke. Even though most organizations have these policies, there are some practical difficulties. The great success of bans on smoking in workplaces may have therefore been more the result of the intensive anti-tobacco campaigns and government directives that followed immediately after the enactment of the legislation. The CSA of 1992 never intended to achieve this objective, and was limited to creating a partial ban on smoking in the workplace, with accommodation for smokers. While the advertising ban was successful, with advertising disappearing from the media, issues of cross-border advertising are not adequately addressed. The tobacco industry has found ways of cutting into this prohibition by brand stretching. Smoking in restaurants and the restrictions on sales to children under 16 years old were also some of the problematic areas of the 1992 CSA.

The CSA empowered employees to complain to their employers about violations of the Act in the workplace. But this proved to be difficult if it was the employer smoking. In practice, the Tobacco Control Office has been receiving complaints and attending to them as best as it can.

While the Act has an elaborate scheme of fines, not a single prosecution was ever brought by the police force. This is despite the mechanism for admission of guilt, which would have greatly facilitated enforcement of the Act. It would be relatively easy to do random inspections of say restaurants and issue spot fines to any establishment that does not comply with the 1992 CSA (the requirement of separate smoking and non-smoking areas with signage). Similar enforcement could be done for workplaces.

In 1999, the Government decided to revise the CSA to cover the above issues, including aspects of advertising such as sponsorship and other promotional activities not explicitly covered by the 1992 CSA. The proposed new act "The Tobacco Products Control Bill" is intended to repeal the 1992 CSA and to provide a comprehensive tobacco control regime. Some of the issues addressed in it that were not covered by the previous act include packaging and labelling prescriptions, comprehensive bans on advertising, prohibition of tobacco, promotion and sponsorships, anti-smuggling measures, taxation of tobacco products, licensing requirements and litigation-enabling provisions.

The Act is currently being revised with the help of the World Health Organization (WHO) and is nearing completion. The process of revision has entailed extensive consultations nationally in the form of meetings among different stakeholders involving government and nongovernmental organizations (NGOs). The Botswana Government actively participated in the negotiations of the WHO Framework Convention on Tobacco Control. Of major interest to Botswana were the provisions of the Convention on advertising, promotion and sponsorship. Botswana is one of the countries strongly advocating for a ban on tobacco advertising, including cross-border advertising. This has been particularly so since it was the first to ban advertising in the region but its efforts have been thwarted by cross-border advertising from neighbouring countries. The revision of the Act is a comprehensive one that covers all other tobacco products not included in the 1992 CSA and is in line with the provisions of the Convention.

## Conclusions

Comprehensive restrictions on tobacco advertising are necessary to prevent the proliferation of messages and images that attract people, especially youth to tobacco products. Such restrictions are aimed at reducing the appeal of tobacco products, pre-empting the tobacco industry's efforts to develop positive associations with tobacco products and thus help prevent their use and ensuing dependency (Joossens, 1997). A comprehensive prohibition is considered the most effective measure to achieve the policy objective. All forms of advertising contribute to making tobacco products socially acceptable and desirable as consumer goods and therefore represent an inducement to use tobacco products. Consequently, alternative measures, such as a partial ban, a ban on lifestyle advertising or a ban on advertising aimed at youth, would not appear to be as effective.

Although there is no comprehensive data on the trends in tobacco use and consumption in Botswana, there is evidence that a ban on tobacco advertising is an important component of comprehensive tobacco control. However, in addition to underscoring this importance, it is equally essential to recognize why a ban on tobacco advertising alone cannot work. The involvement of the communities for which the legislation/ policy is developed and a strong political commitment to tobacco control, are crucial for any intervention to work. To achieve the individual behaviour change that supports the non-use of tobacco, communities must be empowered to change the way tobacco is promoted, sold and used. Effective community programmes must involve families, work places, schools, places of worship and entertainment, civic organizations and other public arenas. The ban on advertising in Botswana has therefore succeeded due to the involvement of the communities for which it was intended.

In its effort to curb tobacco use, the Government of Botswana has continued to focus on the need for national and local action required to ensure the success of tobacco control interventions. The Government acknowledges the unique role played by the different sectors within and outside government in tobacco control efforts.

One of the major shortcomings of the tobacco control programme in Botswana, however, is the lack of surveillance to monitor the achievements of our primary goals. These include prevalence of tobacco use among the different community groups, per capita tobacco consumption and the prevalence of pro-tobacco influences, including advertising, promotions and events that glamorize tobacco

use. Specific evaluation surveys and data collection systems are also needed to evaluate our advertising ban. The lack of financial and technical resources has led to this vital component being left behind.

Enforcement of tobacco control policies enhances their efficacy both by deterring violators and by sending a message to the public that the leadership of the country believes the policies are important. Tobacco advertising, protection from environmental tobacco smoke and restrictions on minors' access to tobacco, are some of the important areas requiring enforcement strategies. While a ban on advertising has worked for Botswana, it has done so because of the recognition that individual tobacco control components must work together to produce the synergistic effects of a comprehensive programme. A ban on tobacco advertising, therefore, could not have achieved the expected results without the needed community education and empowerment strategies in place.

A major lesson learned is that, when making policies on tobacco control, regional cooperation and collaboration should be considered seriously. The issue now before Botswana is cross-border advertising, which has proved to be difficult for the country to tackle alone.

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# Taxation (including Smuggling Control)

WHO/NMH/TFI/FTC/04.01

PH-13.

## Taxation Reform as a Component of Tobacco Control Policy in Australia

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# Taxation reform as a component of tobacco control policy in Australia

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## Introduction

In 1998, the Australian Government announced a major reform of Australia's overall tax system. The previous system was characterized as out of date (it included a range of historically justified but now anachronistic taxes), unfair, discouraging of exports and investment, ineffective and complex. The proposed reforms included the introduction of a Goods and Services Tax (GST) and the abolition of a raft of state taxes and charges. The aim was to bring the service economy into the tax net, provide sustainable funding to the states and lower corporate and individual tax rates. Tobacco control advocates felt that it was essential to ensure that this did not adversely affect tobacco taxation levels.

Higher tobacco taxes significantly reduce cigarette smoking and other tobacco use. However, for a specific tax increase to have maximum effect on reducing consumption there are a number of criteria that must be considered. Firstly, it must be a real, sustained increase, that is, greater than the rate of inflation. Ad valorem taxes such as the GST will increase with actual prices. Secondly, the impact of the tobacco tax will depend on the magnitude of the price increase. Thirdly, it must be understood that smokers exhibit compensating behaviour, for example, substituting with higher tar and nicotine cigarettes. And finally, smuggling can reduce the effect on consumption of a tax increase (Chaloupka, 1998), as can other means of excise avoidance.

In Australia, a country without land borders, distant from other producers of the types of cigarettes that smokers want, smuggling is not believed to be a major issue. Of greater local concern, is the increased use of roughly chopped leaf, sold on the black market and sourced illegally from the small number of remaining tobacco-growing areas in the country. This product appears to be used mainly by the very poor.

In Australia, tobacco companies had dampened the effect of tax rises on smokers. Taxes were based on weight of tobacco, so by reducing the amount of tobacco per cigarette, without reducing yields, price could be contained. Furthermore, through packaging cigarettes (often the lighter sticks) in larger budget packs additional economies were made. This has meant that smokers have been able to avoid much of the price increases that extra taxes should have produced by moving to these budget cigarettes.

This report examines health groups' contribution to the argument that the tax reform campaign should be used to secure reform of tobacco taxes in Australia. Such taxes should achieve two objectives. They should limit the ability of companies to undermine the tax increases and restrict consumers' capacity to compensate when faced with increased prices. The report describes the reforms that were introduced and the effect these had on tobacco tax levels and prices. Data collected from mid-1997 for the purpose of evaluating Australia's National Tobacco Campaign were used to make a preliminary assessment of the likely contribution of price increases to recent declines in tobacco use in Australia and relate that to declines attributable to other factors.

Tobacco users in Australia mainly smoke factory-made cigarettes. Around 20% of smokers at least occasionally purchase pouches of manufactured tobacco to make "roll-your-own" (RYO) cigarettes. It is illegal to sell smokeless tobacco products, and only a small percentage of smokers regularly use pipe tobacco or cigars (Hill DJ et al., 1998).

Cigarettes and manufactured tobacco in Australia are sold, broadly speaking, in two market sectors. Firstly, they are sold from a large number of convenience shops, where smokers purchase cigarettes at close to or at the recommended retail price. Second, they are sold from supermarkets or specialist tobacconists, where prices are well below the recommended retail prices (Scollo et al., 2000).

Smoking prevalence in the Australian adult population decreased from about 36% in 1974 (Hill D and Gray, 1982) to 22% in 1998 (Wakefield et al., 1999), a decline of about 39%. Over that time tobacco consumption declined by 58%, from around 3287 grams per capita in 1974 to 1364 grams per capita in 1998. This decline was due both to reductions in the average number of cigarettes consumed and reductions in the amount of tobacco per cigarette (Winstanley et al., 1995). Most of the latter effect and some of the former has probably occurred without any real reduction in the level of exposure to tobacco-related toxins.

Australia has a federal system of government, consisting of the federal Government and each of six state governments and two territory governments. Federal taxes, in the form of excise or customs duty, had been levied on tobacco based on the weight of the product since 1901. State-based taxes, in the form of franchise fees—based on the wholesale value of a pack of cigarettes—were only introduced by the state of Victoria in 1974, originally calculated at 2.4% of the wholesale price. Over the following couple of years, each of the other five states and two territories introduced similar fees.

Over the 25-year period described above, there were two phases of marked increases in tobacco taxes. The first, beginning in the 1980s, involved a 12-year period of progressive leap-frogging of state-based tobacco licence fees. For several years after they were introduced in 1975, these fees remained at around 10% of the wholesale price of cigarettes in most Australian states. Between 1981 and 1993, in response to budgetary pressures and capitalizing on the support of nongovernment health groups, various state and territory governments at various times increased the fees in a series of steps to 75% (in most states). Between 1995 and 1997 there were also further increases in state tobacco licence fees—from 75% to 100% of the wholesale price. None of the additional revenue raised was invested in tobacco control programmes.

In 1997, state tobacco licence fees were deemed by the Australian High Court to be operating as an excise and as such in breach of the Australian constitution. A key factor in the Court's finding was the lack of a clear relationship between the level of the fees and the cost of regulating tobacco control. The federal Government stepped in to increase federal excise duty on tobacco products by an amount equivalent to the abolished state fees, and to return the resulting additional revenue to the states up until 2000. Figure 1 shows the value of franchise fees (or equivalent in 1998–1999) per average cigarette pack in the largest Australian state New South Wales (NSW), adjusted for inflation.

Federal taxes, by contrast, remained pegged to inflation between 1983 and 1993. A period of sharp excise increases commenced in 1993 (Figure 2). This included small increases in 1993 and 1994 a 10% increase in the 1995 budget. Major health groups had made submissions calling for both increases in excise duty and a change in the way that excise duty was raised. No changes in the manner of raising the excise were made at this time.

Beyond the bi-annual indexation, there were no further increases in Australian tobacco taxes between mid-1997 and late 1999.

Several countries such as Malaysia, Singapore and Sri Lanka tax tobacco products on the basis of weight, and most countries impose ad valorem fees. However, in the 25 years up to 1999, Australia was the only country in the world to both impose ad valorem fees and to tax cigarettes on the basis of weight rather than number of sticks (Scollo, 1996). The combination of the increasing ad valorem component of the overall tax structure combined with the weight-based excise system resulted in lighter-weight, bulk-packaged budget cigarettes rising in price substantially less than heavier, larger-diameter, premium brand cigarettes. Each time franchise fees rose, manufacturers developed a lighter cigarette variant packaged in an ever-greater pack size configuration (Figure 3). In this way, manufacturers were able to offset, at least partially, the impact of the steep increases in state fees. Australia became the only country in the world where cigarettes were commonly sold in packs of 30 or more—over 60% of smokers were purchasing cigarettes in packs of 30, 35, 40 or 50.

After the publication in 1990 of an Offices of Prices report which, for the first time, highlighted the problem of large pack sizes (Herington, 1990), health groups began advocating for the levying of excise per stick. Both adult and teenage smokers preferring large pack sizes smoked substantially more per week, in terms of both the number of cigarettes smoked per day (Hill DJ et al., 1998) and the

**Figure 1**

**State tax per pack of 25, NSW, 1976 to 1999, concerted to US$ 89-90**

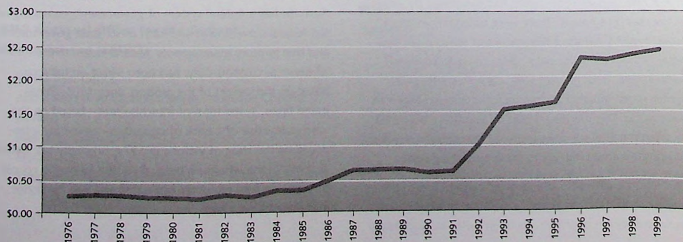
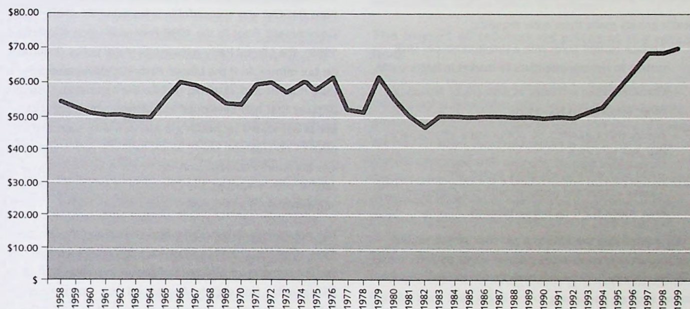


**Figure 2**

**Federal excise duty in Australia, Feb 1958 to 1999, converted to US$ 89-90**




overall weight of tobacco consumed (Scollo, 1996). Health groups believed that large packs were encouraging the development of more addictive patterns of smoking and were providing price-sensitive smokers with an alternative to quitting, thereby reducing the effectiveness of tobacco excise increases as a means of discouraging tobacco consumption in Australia (Scollo, 1996).

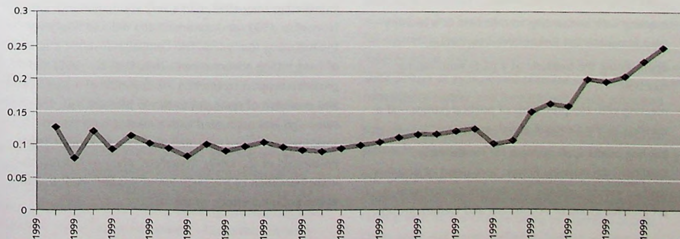
## The lobbying process

Between 1992 and May 1998, health groups had submitted to the Government written proposals making the case for increases and changes in the system of taxing tobacco products. While several increases in excise were included in annual budgets over that time, there was little interest in addressing problems with the system.

To capitalize on the 1998 national tax reform campaign announced by the then-Liberal Government, the Anti-Cancer Council of Victoria contracted a consultant to produce a more detailed and better-illustrated submission (Scollo, 1998). The consultant was also to present this to a consultative committee that had been established by the Government to hear submissions from community and business groups (Scollo, 1998). The National Heart Foundation and the Australian Cancer Society also support-

**Figure 3**

**Price per stick of top-selling cigarette brands in Australia, US$ 89-90**



ed the submission's author to accompany lobby group ASH Australia on several trips to the national capital in order to explain the proposal and build support for its adoption.

Health groups made three basic requests:

- Replace current taxes with a simple cents per stick system to remove incentives to market in larger packs;
- Consider excise increases as a means of financing other elements of tax reform;
- Ensure that cigarettes do not become affordable in the shift to a GST;
  - add GST without adjusting excise; and
  - index wages and pensions with the Consumer Price Index (CPI) excluding tobacco.

It was argued that the shift to a per stick system would lead to sharp increases in the price of larger pack formats and, in response, an immediate reduction in consumption among smokers continuing to use larger pack sizes. More importantly, it was predicted that, in the longer term, fewer people would regularly smoke large packs, and that this would also reduce the prevalence of very heavy smoking. Finally, it was hoped that the lower prevalence of heavy smoking would translate, eventually, to higher population quit rates.

Traditional lobbying included letters and personal visits to:

- cabinet and shadow cabinet ministers;
- party whips, key power-brokers;
- health and economic policy committees for both major parties; and
- treasurer and Prime Minister's advisers on tax reform.

Additional, less formal input was provided by:

- briefing key academic economists from whom the Government was seeking advice;
- meeting with and writing to members of a treasury (departmental) Tax Reform Working Group;
- approaching the treasurer at a party fund-raising function;
- meeting with the presidents of political parties – at a meeting at the Cancer Council; and
- briefing media spokespeople for the Business Coalition; the Business Forum, a coalition of business welfare groups; and the Tax Reform Commission, a progressive group of economists and welfare groups.

## Description of policy intervention

The submission of the nongovernmental organizations (NGOs) was successful in influencing the then-Government. Prior to the 1998 Federal election (Costello, 1998), the Liberal Party released its major policy document on tax reform. In it the Liberal PartyADDIN announced that, if re-elected, it would replace the anomalous system of taxes that had developed in Australia with a per stick tax as advocated by health groups, at a level such that the price of no cigarette brand would fall. The goods and services tax was to be added on top of the new excise level. After it was re-elected, the Government released plans for implementation of the policy (McCullough, 1999).

The new excise duty became operational on 1 November 1999 (Costello, 2000), and was set at a level such that the tax component and price of premium packs of 20 or 25 cigarettes rose slightly. As planned, the total tax payable on large budget packs rose by more than 20%. This resulted in marked increases in prices for budget brands, particularly those that used less tobacco, had lower diameter tubes or were sold in large packages (40s and 50s) or both. Smoking (RYO) tobacco, cigars and cigarettes weighing more than 0.8 grams remained taxed by weight.

Eight months later, a GST of 10% was introduced on all goods and services sold in Australia, and, as promised, the Government applied the GST on tobacco product sales without decreasing the excise. This resulted in price increases somewhat lower that the 10% tax as manufacturers were required to pass on savings from tax reforms that reduced cost in other parts of the production cycle.

Another major policy intervention was also operating in Australia prior to and during the introduction of these reforms in tobacco taxation. The National Tobacco Campaign (NTC), a major mass-media led campaign launched in May 1997, had a very strong presence until November 1997, and continued at a reduced level over the following four years. The Campaign featured a series of hard-hitting advertisements (Hill, D et al., 1998) and provided support to smokers via operation of a Quit line and provision of resources to health professionals. The campaign was associated with a marked reduction in smoking prevalence in its first phase (to November 1997) (Wakefield et al., 1999). Therefore, when considering the implementation of the tax reforms, it is important to look at the potential effects of the NTC.

## The impact of the intervention

This section provides preliminary information on the impact of tax changes on recommended and actual retail prices. It also documents changes in smoker consumption patterns over the period before and after the tax reforms were implemented.

As part of the overall strategy to evaluate the NTC (described above), extensive data were collected through an ongoing retail survey of cigarette prices (Scollo et al. 2000) and an annual population survey. The population survey assessed brand preferences, prices paid, and reported daily consumption and quitting attempts among 18- to 40-year-old smokers, the main target of the campaign (Wakefield et al. 1999). Data are presented from the first phase of the campaign, which lasted from May to November 1997 (Hill, D and Alcock 1999) and the third phase, which was completed when data were collected in November 2000 (Hill, D et al. 2000). A more detailed analysis can be found in Scollo et al., 2003 (Scollo et al. in press).

### The impact of reforms on the range of tobacco products sold in Australia

Prior to 1999, cigarette brands could be split into three reasonably clear segments: premium, value and budget (Nicholas and Oldham 1998). Premium brands include Marlboro, Benson and Hedges and other leading international brands. Value brands included Peter Jackson 30s and Escort 35s, which were launched in the 1970s in response to the steadily increasing ad valorem state franchise fees. The budget segment includes brands such as Holiday and Horizon, which were first introduced in 1990 in packs of 50. In 1997 the premium segment had 35% of the market, the value segment 35% and the budget section 25%, with the rest spread among rare brands and RYO.

Between November 1997 (before the excise changes) and November 2000 (a year after the excise change and four months after the imposition of the GST), there was a 37% increase in the number of pack variants, 84% of this in smaller pack sizes (20s and 25s). This was in contrast to a small decline in the total number of variants in the previous three years.

Following the introduction of the per stick system, all three tobacco companies reconfigured a number of the most popular cigarette brands, increasing the amount of tobacco in each cigarette and promoting the reconfigured brands as "better value for money". Given the tendency of smokers to determine the dose, we suspect that this resulted in little extra exposure to tobacco toxins per cigarette smoked, but we cannot be certain.

### The impact of reforms on prices at the retail level

As intended, the shift to a per-stick method of levying excise duty in November 1999 resulted in a significantly greater increase in the recommended retail price of budget brands compared to premium brands (18% for budget brands, compared with only 5% for premium brands). The differential between premium and budget brands (the percentage by which budget brands were cheaper than premium brands) consequently reduced from a high of 25% in November 1995 to 12% following the change to the per stick method. Further increases in cigarette prices across the board were evident following the introduction of the GST in June 2000.

Actual monitored retail prices were lower than recommended prices both before and after the reforms, and were substantially lower in discount outlets. Actual monitored retail prices increased in both the discount and convenience sector for all segments of the market over the period of the campaign. Recommended retail prices rose in parallel.

Between May 1997 and November 2000, average (unweighted) recommended retail cigarette prices increased by 34% and actual prices paid by smokers also increased by 34%. Actual prices paid in each market segment increased in line with recommended retail prices for each brand segment (28 % compared with 27.6% in the premium sector; 35% compared with 34% in the value segment, and 40.1% compared with 42% in the budget segment).

Reliable data are not available on the actual and reported prices paid on roll-your-own tobacco, however extensive data were collected in each NTC survey on what people reported paying for factory-made cigarettes. Prices paid for cigarettes increased in all brand segments and were roughly equal across socioeconomic status groups. The same pattern of increase was observed with the discount and convenience sectors, and for pack and carton purchasers.

### Smokers' attempts to offset the impact of price increases

The proportion of smokers favouring budget brands declined significantly between 1997 (17%) and 2000 (10%), with all the change being to premium brands. Once again this trend applied to both blue- and white-col-

lar groups, for carton as well as for pack purchasers, and for purchasers in both the discount and the convenience sector. Some of this occurred before the excise changes.

Following the shift to the per stick excise system in November 1999, there was a substantial reduction in the percentage of remaining smokers using 40s and 50s (down from 30% to 19%). There was also a corresponding increase in the proportion of remaining smokers using 20s and 25s (up from 48% to 58%).

The rise in prices may have increased supermarket sales at the expense of other places, but the effect is small. There was a continuing shift to RYO cigarettes, which may relate to greater use of illicit tobacco known as Chop-chop, which is grown and clandestinely distributed by farmers and wholesalers and sold without government intervention or taxation. There was no significant change in the proportion of remaining smokers buying cartons over the course of the campaign (Table 1).

Apart from the shift to RYO and a shift to discount outlets during Phase 1 of the campaign, it appears that remaining smokers have not been able to cushion themselves from the impact of cigarette price increases by shifting to cheaper brands, format and outlets. In fact, as intended by the November 1999 cigarette excise reforms, which differentially increased the price of light-weight cigarettes, there has been a large shift away from budget brands and large pack sizes.

The extent to which the decline in the percentage of smokers using budget brands results from differential rates of quitting among budget versus premium smokers or a real shift among remaining smokers to smaller pack sizes is unclear. However, the size of the effect suggests much is due to brand shifting.

Consistent with these observed trends, 52% of smokers reported in November 2000 that they found cigarettes "more difficult to afford compared with one year ago". Overall, around 11% of smokers reported changing to RYO (4%) or a cheaper brand (7%), and 13% reported that they smoked fewer cigarettes.

### Changes in cigarette consumption

Changes in consumption can be due to quitting or to reduced consumption among remaining smokers or both. Analysis of data from the NTC Evaluation respondent surveys indicates a significant drop in consumption among remaining smokers over the period of the campaign. This occurred both among blue- and white-collar groups. During the period of high advertising and small price changes there was little change in consumption per smoker (-.65%), while following the price rises the reduction was greater (-7.84%). This seems to have led to a reduction in the percentage of heavy smokers (25+ per day).

As anticipated, average consumption among remaining smokers using larger pack sizes appeared to reduce more significantly than consumption among smokers using smaller pack sizes (Table 2). The reduction in consumption due to the price increases remained significant ($p<.05$) after taking account of the change in cost/stick, and any sex, age, education, and socioeconomic status differences.

To assess the likely contribution to reduced tobacco use of cigarette price increases, it is first of all necessary to establish how much less affordable cigarettes were in November 2000 compared to November 1998 before the tax reforms, and May 1997 at the commencement of the NTC.

Average per stick prices paid by smokers were adjusted for each phase of the campaign to take account of overall

**Table 1. Summary of changes in prevalence of price-minimizing behaviours**

| At least weekly smokers | Benchmark May 1997 (n=921) | Follow-up 2 Nov 1998 (n=1239) | Follow-up 4 Nov 2000 (n=1155) | % change May 97 to Nov 1998 | % change Nov 98 to Nov 2000 |
|---|---|---|---|---|---|
| % using RYO | 13% | 17% | 22% | +31% | +29% |
| % using budget brands | 17% | 14% | 10% | -18% | -28% |
| % using 35s, 40s or 50s | 29% | 32% | 21% | +10% | -34% |
| % using discount outlets | 48% | 55% | 54% | +15% | -2% |
| % using cartons | 14% | 13% | 12% | -7% | -8% |

Source: NTC Evaluation respondent surveys

| Table 2. Reported cigarette consumption among current smokers, by pack size | | | |
|---|---|---|---|
| **At least weekly smokers** | **Benchmark, May 1997** | **Follow-up 2 – Nov 1998** | **Follow-up 4 – Nov 2000** |
| For daily and weekly smokers | n=1,075) | (n=1,496) | (n=1,480) |
| **Mean cigs/day (sd)** | **15.4 (10.4)** | **15.3 (10.3)** | **14.1 (9.4)** |
| Pack size 20 | 10.5(7.4) | 9.9(7.9) | 9.8 (7.6) |
| Pack size 25 | 13.2(10.0) | 12.8(8.3) | 13.1(9.8) |
| Pack size 30 | 15.0(9.2) | 15.5(10.4) | 15.1(9.1) |
| Pack size 35 | 17.8(10.5) | 18.0(10.7) | 14.2(5.8) |
| Pack size 40 | 18.1(9.8) | 20.2(9.6) | 17.4(8.7) |
| Pack size 50 | 22.3(11.4) | 19.2(10.3) | 18.4(9.3) |

Source: NTC Evaluation respondent surveys

increases in prices of common consumer goods and services since the previous phase (Table 3). This shows that the excise changes did lead to greater real changes.

International research suggests that the price sensitivity of demand for cigarettes in Western countries is probably around -0.4 (Centers for Disease Control and Prevention, 1998). That is, for every 10% increase in cigarette prices, cigarette consumption can be expected to fall by about 4%. There is also evidence from behavioural studies, however, that price sensitivity of demand may be higher where prices are higher. (Bickel et al., 1990). Australian cigarette prices are among the highest in the world (Scollo, 1996). Separate estimates were derived for the impact on smoking participation and consumption among remaining smokers. International research has indicated that around three-fifths of the drop in demand tends to be due to reduced smoking prevalence, and around two-fifths to reduced consumption by remaining smokers (Chaloupka, 1998).

How do these estimates compare with overall changes in smoking participation and prevalence over the period of the NTC? Data from NTC Evaluation surveys indicate that the proportion of the population aged 18 to 40 years who smoked fell by about 9.5% over the period of the NTC, with just over 4% of the reduction occurring in the last two years of the Campaign following tax changes. A roughly equal drop in participation occurred among blue- and white-collar groups, with most of the drop among blue-collar groups occurring in the third stage of the campaign

In short, if we assume a sensitivity of demand for both participation and consumption of 0.4 we would expect a reduction in participation of about 1% over the NTC period and 4.3% over the excise reform period. This can be compared with observed reductions of 5.4% and 4.3% respectively. Price cannot explain the drop in the first phase of the NTC, but it can explain the drop in the subsequent phase, which corresponded with the excise reforms. The drop in the first phase seems to be in part due to the strong advertising campaign. For consumption, the picture is somewhat different. We estimate reductions of 0.7% and 2.8% respectively and found reductions of 0.7% and 7.8%. Here price can account for the reduction in consumption in the NTC period, but underestimates consumption declines in the excise reform period. Sensitivity analysis for this is found in Table 4.

The higher-than-expected effects of the excise reforms on consumption could be due to the reduced opportunity to compensate. We also need to consider other potential contributions such as the role of nicotine replacement therapies, which became more widely promoted and more readily available in Australia over this time. This was also a period of rapid change in social norms with regard to the acceptability of smoking indoors, even in the home and this may have acted to drive down consumption as well.

## Other effects

Source: Industry data provided to Australian members of Parliament, updated with excise data from ABS

Industry reports suggest that production figures reduced significantly in response to price changes. Figure 4 shows that there was a decline in production leading up to the changes, and further declines thereafter. The figures for June 2000 suggest that the industry may have underestimated the likely effect and overproduced in the short term.

## Summary

Recent tobacco tax reforms do seem to have been effective both in increasing the availability of smaller pack size configurations for popular brands and in reducing the affordability of factory-made cigarettes, particularly the so-called budget brands.

Despite some evidence of a shift to roll-your-own tobacco, the reforms appear to have contributed to the recent decline in smoking participation in Australia, and in particular to a decline in heavy smoking and in reported consumption among remaining smokers, particularly those using budget cigarette brands. The decline in cigarette consumption and smoking participation appears to have occurred across all socioeconomic groups.

**Table 3. Summary of changes in affordability of cigarettes and expected total consumption changes over the period of the NTC**

| At least weekly smokers Benchmark | Benchmark May 1997 (n=921) | Follow-up 2 Nov 1998 (n=1239) | Follow-up 4 Nov 2000 (n=1155) | % change May 97 to Nov 2000 | % change Nov 98 to Nov 2000 |
|---|---|---|---|---|---|
| Average price paid per cigarette – cents per stick | (n=881) 22.60 | (n=1171) 23.90 | (n=1053) 30.30 | 5.8% | 26.8% |
| CPI for relevant quarters | 120.2 | 121.9 | 131.3 | 1.4% | 7.7% |
| Average price paid per cigarette in AUS$ May 1997 | **22.60** | **23.57** | **27.74** | **4.4%** | **17.7%** |

Source: NTC Evaluation respondent surveys; Australian Bureau of Statistics, Consumer Price Index (ABS 2001)

**Table 4. Expected compared to actual falls in smoking prevalence and consumption among respondent groups**

| **Period** | **May 1997 to Nov 1998** | | **Nov 1998 to Nov 2000** | |
|---|---|---|---|---|
| **Price increase** | **4.4%** | | **17.7%** | |
| **Expected fall @ price demand elasticity** | **Prevalence** | **Consumption** | **Prevalence** | **Consumption** |
| - 0.3 | - 0.65% | -0. 65% | -2.65% | -2.65% |
| - 0.5 | - 1.08% | - 1.08% | - 4.23% | - 4.23% |
| - 0.7 | -1.51% | -1.51% | -6.20% | -6.20% |
| **Actual falls** | **-5.42%** | **- 0.65%** | **- 4.30%** | **- 7.84%** |
| **Percent of reduction plausibly explained by price increases** | **Prevalence** | **Consumption** | **Prevalence** | **Consumption** |
| @ - 0.3 | 12% | 100% | 62% | 34% |
| @ - 0.5 | 20% | 166% | 98% | 54% |
| @ - 0.7 | 28% | 232% | 144% | 79% |

Source: NTC Evaluation respondent surveys; Australian Bureau of Statistics, Consumer Price Index [10]; Centres for Disease Control MMMW bulletins [11]

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# Labelling and Packaging (including Health Warnings)

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## Thailand Country Report on Labelling and Packaging

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# Thailand: Country Report on Labelling and Packaging

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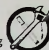
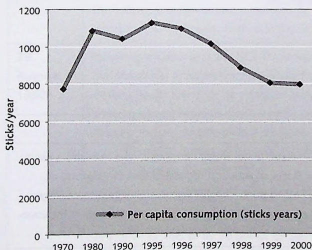


## Introduction

From 1981 to 2001 there were dramatic changes in tobacco consumption in Thailand. The total number of smokers rose from 9.7 million in 1981 to 10.6 million two decades later. Smoking prevalence declined from 35.2% to 22.5% during the same period. The male smoking rate decreased from 63.2% to 42.9%, while female prevalence fell from 5.4% to 2.4.%. Per capita consumption rose from about 774 in 1970 to 1 087 in 1980. Since that time, it has decreased progressively to 798 in 2000.

### Figure 1

**Per capita consumption estimates 1970-2000**




Source: Developed by THPI from: Guidon GE, Boisclair D. Past, Current and Future Trends in Tobacco Use. HNP Discussion Paper. Economics of Tobacco Control, Paper N° 6, February 2003.

There have been no systematic studies of morbidity and mortality of tobacco-related diseases. Table 1 shows that the estimated number of deaths from various diseases in South East Asia for 2001 (within the low child and low adult mortality stratum to which Thailand belongs).

### Table 1

**Estimated number of deaths from diseases in South East Asia, 2001**

| Diseases | Deaths |
|---|---|
| Cancer of trachea, lung, and bronchus | 35 000 |
| Cancer of mouth and oropharynx | 16 000 |
| Respiratory diseases | 130 000 |
| Ischaemic heart diseases | 232 000 |

Source: World Health Report, 2002. Geneva, World Health Organization, 2002.

In terms of cancer of the various organs, lung cancer was the second most common cancer between 1988 and 1991 in Thailand. Women in the northern region of the country, who have the highest smoking prevalence among the various regions, have lung cancer at an age-standardized incidence rate of 37.4 per 100 000 (1).

## Policy intervention

Policy intervention on labelling and packaging, including health warnings, only involves manufactured cigarettes. This applies equally to both domestic and imported cigarettes. Other tobacco products, e.g. cigars and pipe tobacco, are not included because there are too many varieties of packages and it is difficult to carry out regulatory procedures. In addition, the consumption level of these products is low and small gains in health are not worth the regulatory effort.

In Thailand, policy is based on legislative action. Initially, the Medical Association of Thailand pressed for regulatory action and such issues were later taken up by the Announcement of Labelling Committee of the Consumers Protection Board (CPB) pursuant to the Consumers Protection Act 1979. This announcement became effective on 20 September 1990. Finally, labelling was mandated by successive Ministerial Announcements pursuant to the Tobacco Products Control Act (TPCA) 1992. After this Act became effective on 3 August 1992, the CPB's Announcement of Labelling Committee was disbanded. These efforts are outlined chronologically in table 2.

## Steps toward implementation

Before 1989 there was no established national policy to control tobacco consumption. In late 1988, the Deputy Director-General of the Department of Medical Services (DMS), proposed and received approval from the then-Minister of Public Health (later a two-time Prime Minister of Thailand) to establish an inter-agency policy committee for tobacco control called the National Committee for Control of Tobacco Use (NCCTU).

In the proposal the committee appointed the Public Health Minister as the chairman. The members comprised chairpersons of the standing committee on health of both the Senate and the House of Representatives. They were the following: permanent secretaries[1] of the Ministries of Public Health, Education, Agriculture, Interior, Finance, and Prime Minister's office; Deputy Permanent Secretary for Health of the Bangkok Metropolitan Administration; Director-Generals of Departments of Health, Medical Services, Excise, Public Relations; President of the Reporters Association of Thailand, Secretary-General of the Medical Council, and five experts. The Deputy-Director-General was the NCCTU's first secretary.

The Ministry of Public Health (MOPH) proposed the formation of the NCCTU. The proposal received approval from the Cabinet and the Committee was formally established on 14 March 1989. This interagency body is now responsible for formulating the country's policy on tobacco control. To this end it has initiated several tobacco control policies, one of which was a regulation mandating health warnings.

Table 2

**Chronology of regulation on labelling and packaging**

| **The first health warning** | |
|---|---|
| **1967** | A secretary-general of the Medical Association of Thailand under Royal Patronage, who was also a chest physician with post-graduate training in the United States of America, requested that the Ministry of Finance require the Thailand Tobacco Monopoly (TTM) to print a health warning on cigarette packages they produced. (The Ministry supervises the TTM, which was the only cigarette manufacturer in the country at that time). |
| **1974** | After a long delay, the TTM began printing the small health warning 'Smoking may be harmful to health' on the side of cigarette packages. |
| **The second set of health warnings** | |
| **25 April 1989** | At its first meeting the NCCTU secretary proposed that there had been only one small health warning placed on cigarette packets and six new rotating health warnings should be mandated. The NCCTU approved the new set, which comprised the following messages: 'smoking causes lung cancer and emphysema', 'smoking causes ischaemic heart disease', 'smoking harms babies in the womb', 'respect other people's rights by not smoking in public places', 'giving up smoking reduces serious illness' and 'for the sake of your children please give up smoking'. |
| **11 July 1989** | The cabinet endorsed the MOPH proposal mandating health warnings on cigarette packages and ordered the CPB to take further action. |
| **18 May 1990** | The CPB's Labelling Committee mandated a seventh health warning on cigarette packages, namely, 'smoking may be harmful to health' (this warning had been in place since 1974), as well as the six warnings approved by the cabinet. These had to be placed in the front of the package, the size of the letters had to be at least 1 mm wide and at least 2 mm high. The warning had to be evenly distributed among the produced packages. This announcement became effective on 20 September 1990.<br>The procedures for enacting a law or a regulation pursuant to a certain section of a law must follow these consecutive steps: |

| | |
|---|---|
| | — a law is passed by the National Assembly;<br>— the Prime Minister proposes the law to His Majesty the King of Thailand;<br>— the King signs on to the law and returns it to the Prime Minister, who counter signs; and<br>— a regulation or ministerial announcement is sent to the Government printing house to be published in the Royal Gazette. The announcement is publicized by the person responsible for that law, and includes a statement on how many days following its publication the law will become effective. |
| **The third set of health warnings** | |
| **3 August 1992** | The TPCA 1992 was enacted and became effective as of 3 August 1992. Section 12 of this Act stated that 'the manufacturer or importer of the tobacco products must place the labels on the packages of tobacco products before they leave the manufacturing site or before importation into the Kingdom[2] as the case may be.<br>The criteria, procedures and conditions of displaying these labels and the statements therein shall be in accordance with those published in the Government Gazette by the Minister.[3] |
| **25 August 1992** | Following a meeting of the NCCTU, it was decided that a new set of health warnings would be mandated. The Ministerial Announcement, pursuant to Section 12 of the TPCA 1992, was issued mandating ten rotating health warnings on cigarette packages. They were the following: 'smoking causes lung cancer', 'smoking causes heart disease", 'smoking causes lung emphysema', 'smoking causes obstructive or haemorrhagic stroke', 'smoking kills', 'smoking is addictive', 'smoking is harmful to people around you', 'smoking is harmful to babies in the womb", 'quitting smoking reduces the risk of serious illness' and 'giving up smoking leads to a healthy body'.<br>The warnings had to occupy no less than 25% of the front and back of the main surfaces of cigarette packages or cartons. The lines bordering the warnings had to be white and letters black. The size of the font 'Si Phya' had to be 16 points for packages that have 37 $cm^2$ of the main surfaces, 21 points for 37–85 $cm^2$, 33 points for 85 $cm^2$ and 36 points for the cartons. |
| **24 Sept. 1992** | The announcement was published in the Royal Gazette and the regulation became effective one year later. |
| | This set of warnings represented a significant strengthening of tobacco control laws compared to previous ones. This was largely due to the fact that MOPH had just passed its own law (the TPCA 1992), which was a means of putting its regulations into effect. In addition, the Ministry had just established the first national governmental agency for tobacco control – the Office of Tobacco Consumption Control, which acts as a full-time secretariat for the NCCTU. The first and second set of health warnings were initiated by other mechanisms outside the full control of the MOPH, that is, by the Medical Association of Thailand under Royal Patronage and by the NCCTU via the Consumers Protection Act, which fell under the responsibility of the CPB of the Prime Minister's Office. The third version was achieved by the NCCTU secretariat. |

1 A permanent secretary is the highest ranking permanent official of a ministry.

2 "Kingdom" is the legal term for the Kingdom of Thailand

3 "Ministers" means the Minister of Public Health who is responsible for this Act.

| The fourth set of health warnings | |
|---|---|
| **15 October 1997** | The NCCTU decided to mandate a new version of health warnings. The new Ministerial Announcement was issued replacing the former one, mandating ten health warnings on cigarette packages: 'smoking causes lung cancer', 'smoking causes heart failure', 'smoking causes emphysema', smoking causes brain haemorrhages, smoking causes leads to other addictions, 'smoking causes impotence', 'smoking causes premature aging', 'smoking can kill you', 'smoke harms people near you', and 'smoke harms babies in the womb'. The warnings had to follow the requirements described below:<br>— The warnings, including bordering lines, must occupy no less than one-third of the principal surfaces of the cigarette packages or cartons.<br>— The border must be white and 2 millimetres thick.<br>— The background must be black and the letters white.<br>— The letter font must be 'Si Phya' and the size must be 20 points for packages with an area of 37 cm2 front and back, 25 points for an area of 37–80 cm2, 38 points for 80+ cm2 areas and 75 points for cigarette cartons. |
| **4 Nov. 1997** | The announcement was published in the Royal Gazette and became effective one year later. |
| **The fifth set of health warnings – the pictograms** | |
| **Feb. 2000** | The president of the Thailand Health Promotion Institute (THPI), who was a DMS adviser, suggested to the then-Director-General of the DMS that Thailand mandate pictorial health warnings. The Director-General agreed and ordered the DMS's Institute of Tobacco Consumption Control (ITCC) to proceed. |
| **23 March 2000** | The MOPH approved the DMS proposal and set up a committee to consider graphic health warnings on cigarette packages. The DMS Director-General was the chairman and THPI president was the vice-chairman. |
| **5 April 2000** | At the first meeting TTM representatives opposed the printing of graphic health warnings on cigarette packages. The THPI president, who was the meeting chairman, asked the TTM to submit an official letter explaining its reasoning. In its letter the TTM stated that they only had a printer that could produce three-colour pictures. For four-colour pictures a new machine would have to be imported, and in addition to costing 12 million Baht, it would take two to three years to acquire.<br>The THPI president asked the ITCC to ignore the TTM's complaint and proceed to acquire three-colour pictures for the health warnings.<br>The protracted delay in implementation could have been due to either the ITCC's bureaucracy or the tobacco industry's underground lobbying. In Thailand the transnational tobacco companies never act publicly because every time they do they are heavily challenged by the country's strong tobacco control advocates. |
| **28 Feb. 2002** | During the NCCTU meeting the THPI president complained that the process of acquiring pictorial health warnings was dragging and the NCCTU ordered further action without delay. New subcommittees were established, one for implementation of the TPCA. |
| **26 April 2002** | At the subcommittee meeting chaired by the THPI president it was decided that 12 pictorial health warnings would be put in the Ministerial Announcement. The themes of the 12 pictures included the 10 previous warnings and 2 new ones 'smoking causes oral cancer' and 'smoking causes foul odours and blackened teeth'. |

| | |
|---|---|
| **3 May 2002** | After several contacts with the ITCC to determine the progress of preparing pictures and ministerial announcements, the THPI president found that there were certain obstacles in the process, namely, the major difficulties in acquiring pictures through bureaucratic means. The THPI then decided to use media advocacy to push for the policy's achievement by releasing a press message reporting that Philip Morris had sent a letter dated 27 February to the Public Health Minister threatening to take legal action if the MOPH ordered the printing of pictorial health warnings on cigarette packages. |
| **4 May –17 June 2002** | The press release culminated in a continuous stream of news, letters, and articles in the media and in international news agencies as well as numerous radio and television interviews, including CNN. |
| **11 May 2002** | An entire week after news broke out of the Philip Morris threat the Public Health Minister stated in a press interview that the MOPH did not believe that the decision mandating pictorial health warnings was contradictory to the Constitution and TRIPS (Trade-related aspects of intellectual property rights), and that the MOPH would go ahead with the plan. |
| **17–21 June 2002** | The THPI president asked for and received a green light from the DMS to produce the pictures. It was decided that five pictures, which depicted diseased organs, would be acquired from hospital slide libraries, that is, lung cancer, heart disease, emphysema, stroke, and oral cancer, and the other seven pictures would be acquired by conducting a country-wide contest so that the public could participate. The Photography Association of Thailand under Royal Patronage was invited to collaborate and the Thai Health Promotion Foundation was asked to fund the contest. |
| **3 July 2002** | Nongovernmental organizations (NGOs) organized the award ceremony for the contest winners. The Minister of Public Health was invited to chair the events. |
| **6 Sept. 2002** | The THPI sent the complete set of pictorial health warnings to the DMS Director-General to draw up the ministerial announcement and proposal for the Minister of Public Health to sign. |
| **1 Oct. 2002** | The newly organized MOPH proposed that tobacco control work be a part of the new Department of Disease Control (DDC). |
| **1 Nov. 2002** | The THPI president sent a letter to the DDC Director-General urging him to expedite the long-delayed process. |
| **20 Jan. 2003** | The DDC Director-General called a meeting to consider pictorial health warnings. THPI president and Action on Smoking and Health (ASH) Secretary-General were invited. The Director-General asserted that the 12 pictures acquired did not seem to communicate very well to the viewers. The meeting decided to have a pre-test for these pictures. |
| | After acquiring satisfactory pictures there are still a few steps to be taken: drawing up the Ministerial Announcement, sending a proposal to the MOPH Minister for signature; and publication in the Royal Gazette. This regulation would become effective six months following its publication. The long interval would provide ample time for the cigarette producers to clear their stock and produce the new labelling. |

## Opponents counter the intervention

The tobacco industry does not want graphic health warnings and would go to any lengths to obstruct this effort. There are two main reasons:

— The pictograms were found to be very effective. An evaluation in Canada showed that 44% of smokers said the pictorial health warnings increased their motivation to quit, 58% thought more about the health effects of cigarettes, 27% were motivated to smoke less inside their home, and 62% thought the pictograms make the packages look less attractive.

— Thailand would be the third country in the world to mandate graphic health warnings if the regulation passes and it would be an exemplary regulation that other countries would follow.

The Philip Morris letter of 27 February 2002 was sent to the Public Health Minister, though no one knew her response or that of her secretariat. The THPI president knew of the Philip Morris action from a DMS official and asked a DMS Deputy-Director-General to fax the Philip Morris letter. The THPI then used the letter for advocacy in the media to reinforce the policy of educating smokers through pictorial health warnings.

The Philip Morris letter propagated four myths.

— **Myth 1:** "It would impose an undue burden on the Company in that Ministerial Regulation (No.6). B.E. 2543 already requisitions 33.3% of the total area of a cigarette pack for the prescribed textual health warnings."

— **Reality:** What type and how big is the 'undue burden'?

— **Myth 2:** "The Regulation would impair the use of the Company's valuable trademarks by obscuring the marks on the pack face, thereby undermining the trademarks' functions of brand identification and communication with the Company's customers. Packaging is more important for cigarettes than other products since all forms of advertising are banned by the Tobacco Products Control Act."

— **Reality:** The trademarks are still there and not obscured.

— **Myth 3:** "The Company has the right to communicate with its customers through its display of trademarks and logos. Any attempt to limit this right must be necessary to achieve a legitimate public purpose. The imposition of the graphic health warnings would limit this right unnecessarily because existing health warnings already cover one-third of the pack."

— **Reality:** The Government also has the right to clearly inform the people about the health hazards of smoking.

— **Myth 4:** "Trademarks are valuable Company property and are protected by the Trademark Act B.E. (Buddhist Era) 2534, the Penal Code, as well as by TRIPS, of which Thailand is a member. TRIPS provides that the use of a trademark shall not be unjustifiably encumbered by special arrangements, such as use in a special form or manner detrimental to its capacity to distinguish the goods or service of one undertaking from those of other undertakings. The Regulation would violate this principle."

— **Reality:** The Trademark Act B.E.2534 prohibits destruction or imitation of trademarks. The pictograms would do neither.

TRIPS provides public health exception in Article 8.2, which states that the "Member may, in formulation or amending their national laws and regulations, adopt measures necessary to protect public health and nutrition, and to promote the public interest in the sectors of socioeconomic and technological development, provided that such measures are consistent with the provisions of this agreement." Therefore, the regulation on pictograms does not violate TRIPS.

The Philip Morris letter sent to the Public Health Minister was meant only to bluff those who were unfamiliar with Thailand's copyright law, its constitution and TRIPS. By citing the risks involved in their taking legal action, the tobacco multinationals had hoped that the MOPH bureaucrats would stop the implementation process.

## The intervention's success

Regulation on packaging and labelling has been quite successful. To date, the first four different sets of health warnings have been mandated. The number of rotating warnings has increased from one to twelve. The warning area size on cigarette packages and cartons has been enlarged from small letters on the sides of cigarette packages to one-third of the principal surfaces of packages, including cartons. The last set of pictorial health warnings, occupying half of the front and back, is being prepared and it is hoped that it will be enacted in 2003.

In Thailand, there has been no scientific study of the impact of cigarette package textual health warnings on tobacco use.

## Other impacts of the intervention

The graphic health warnings have created immense public interest. There is widespread support from the media and all sectors of society.

Media advocacy about pictorial health warnings has been enormous as the following figures demonstrate:

— After the THPI press release, from 4 May to 17 June 2002, the subject was mentioned 16 times in the newspapers and 6 of those articles were published on front pages; 4 letters and 5 newspaper articles devoted to the subject; at least 4 news releases by international news agencies, including CNN, and innumerable radio and television interviews.

— Before and after the picture contest described in Table 2, from 17 June to 4 July 2002, pictorial health warnings were mentioned 23 times in newspapers; there were 4 newspaper articles on the subject, 1 public opinion poll, and numerous radio and television interviews.

## Conclusion

Package labelling is a vital measure in controlling tobacco. It should be mandated with minimum cost, changed at appropriate intervals, and improved consistently. Thailand's legal system enables it to be easily implemented because packaging and labelling is a section of the law and regulation can be passed pursuant to the legislation. Textual health warnings can be changed and upgraded into pictorial ones that have, according to the Canadian experience, better impact upon smokers.

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# Advertising and Promotion Bans

## Thailand Country Report on Tobacco Advertising and Promotion Bans.

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# Thailand Country Report on Tobacco Advertising and Promotion Bans

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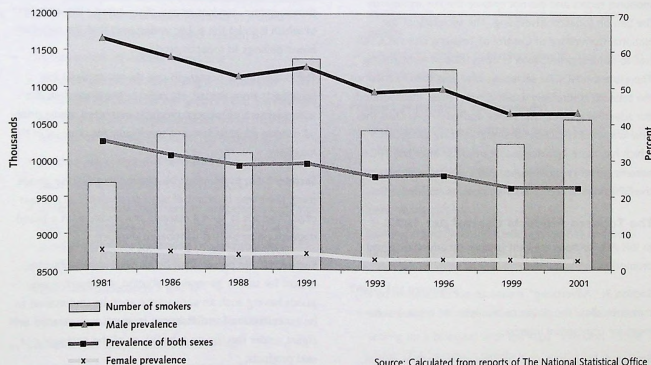
## Introduction

Countrywide household surveys by the National Statistical Office have been the main source of information support for tobacco control in Thailand. The first, second and third surveys were carried out in 1976, 1981 and 1986 (five year intervals). Thereafter the surveys were carried out every two years.

For the past two decades, the total number of smokers has risen, presumably as a result of the rise in population, from 9 676 700 in 1981 to 10 551 300 in 2001. Smoking prevalence declined from 35.2% in 1981 to 22.5% in 2001. Male and female smoking rates fell in this period from 63.19% to 42.92%, and from 5.39% to 2.36% respectively. Annual adult per capita cigarette consumption has also been decreasing, from 1087 in 1995 to 798 in 2000.

Figure 1

**Number of Smokers and Smoking Prevalence of Population. Both Sexes, 15 Years and Over, 1981–2001**




Source: Calculated from reports of The National Statistical Office

## Development of policy: Chronology

**26 April 1988** – *The Cabinet approved tobacco control measures, including a ban on advertising, proposed by the Ministry of Public Health (MOPH). This resolution was forwarded to all ministries to be put into practice.*

**20 December 1988** – *the Thailand Tobacco Monopoly (TTM) complained to the Ministry of Finance, its supervisor, that after the April cabinet resolution the TTM had ceased its promotional activities, while foreign cigarettes, though not allowed to be sold legally, continued to advertise in the printed media and on outdoor billboards. The cabinet therefore ordered the Consumer Protection Board (CPB) to pass a regulation prohibiting tobacco advertising.*

**10 February 1989** – *The Advertising Committee of the CPB made an announcement, published in the Royal Gazette, that cigarettes are under labelling control, thus cannot be advertised, pursuant to the Consumers Protection Act 1979.*

**4 August 1992** – *The Tobacco Product Control Act (TPCA) 1992 became effective.*

Information about tobacco-related morbidity and mortality has been fragmented owing to the lack of relevant studies and surveys. Among cancers of various organs, lung cancer was the second most common during 1988–1991. The age-standardized incidence rate of lung cancer among women in the Northern region is 37.4 per 100000 – considered to be a high world indicator.

The advertising ban under the Consumers Protection Act 1979, which became effective on 10 February 1989, was enforced by the office of the CPB which has a wide responsibility in the area of consumer protection. Officials of the CPB were not knowledgeable about tobacco promotional tactics and did not enforce the law as regards the ban on tobacco advertising. The secretary of the National Committee of Control of Tobacco Use (NCCTU) had to request prosecution in every case of wrongdoing. Therefore the NCCTU secretary, who was the chairman of the tobacco control law drafting committee, incorporated the advertising ban in the newly drafted TPCA. Thus the new law would be under the responsibility of the MOPH, which has more knowledgeable officials. After the TPCA became effective on 4 August 1992, the announcement of the CPB Advertising Committee became nullified.

### The Tobacco Products Control Act 1992

In this Act, sections relevant to bans on advertising and promotion are as follows:

**Section 3:** "Advertising" means an act undertaken by any means to allow the public to see, hear, or know a statement for commercial interest;

**Section 4:** No person shall be allowed to dispose of, sell, exchange or give tobacco products to a person when it is known to the former that the buyer or receiver has not attained eighteen full years of age;

**Section 5:** No person shall be allowed to sell tobacco products through vending machines;

**Section 6:** No person shall be allowed to do any of the following:

— to sell goods or render services with the distribution, addition or gift of tobacco products, or in exchange for tobacco products, as the case may be;

— to sell tobacco products with the distribution, addition, gift of, or in exchange for, other goods or services;

— to give or offer the right to attend games, shows, services or any other benefit as a consideration to the buyer of tobacco products or a person bringing the packaging of tobacco products for exchange or redemption therefor;

**Section 7:** No person shall be allowed to distribute tobacco products as a sample of tobacco products so as to proliferate such tobacco products or to persuade the public to consume such tobacco products except for a customary gift;

**Section 8:** No person shall be allowed to advertise tobacco products or expose the name or brand of tobacco products in the printed media, via radio broadcast, television or anywhere else which may be used for advertising purposes, or to use the name or brand of tobacco products in shows, games, services or any other activity the objective of which is to let the public understand that the name or brand belongs to tobacco products.

The provisions of paragraph one do not apply to live broadcasts from abroad, via radio or television, and the advertisement of tobacco products in printed media printed outside the Kingdom not specifically for disposal in the Kingdom;

**Section 9:** No person shall be allowed to advertise goods using the name or brand of tobacco products as a brand of such goods in such a manner as to make such a brand understood to be that of tobacco products;

**Section 10:** No person shall be allowed to manufacture, import for sale or general distribution, or advertise any goods having such an appearance as to be understood to be an imitation of such tobacco products as cigarettes or cigars, under the law on tobacco, or of the packaging of said products;

**Section 17:** Any person violating Section 4 or Section 5 shall be subject to an imprisonment not exceeding one month or a fine not exceeding 2000 Baht or both;

**Section 18:** Any person violating Section 6, Section 7, Section 9 or Section 10 shall be subject to a fine not exceeding 20000 Baht;

**Section 19:** Any person violating Section 8 paragraph one shall be subject to a fine not exceeding 200000 Baht;

**Section 24:** In case the violation of Section 4, Section 5, Section 6, Section 8 paragraph one, Section 9, Section 10 or Section 13 is by manufacturer or importer, the violator shall be subject to the penalty twice that provided for such offences.

The Tobacco Products Control Act 1992 contains a very comprehensive ban on advertising and promotion. It can be summarized as follows:

**The ban covers all media (Sections 3 and 8).**

- The ban is almost complete, and includes sponsorship. Although there is no such term as "sponsorship" the definition of "advertising" (Section 3) means that showing, mentioning, or referring to cigarette logos or products is illegal. Therefore sponsorship, which must show cigarette logos or product names is considered an illegal act (Section 8).
- The only exceptions are live radio or television broadcasts from abroad, and advertisements in printed media published outside Thailand (Section 8).
- The ban covers all indirect advertising:
  - point-of-sale (POS) advertising is not allowed. Although the law does not specify POS, it is covered by the phrase, "or anywhere else which may be used for advertising purposes", in Section 8;
  - product placement (Sections 3 and 8);
  - trademark diversification (TMD) (Section 9);
  - advertising goods that have an appearance such that they are understood to be in imitation of tobacco products or of the packaging of said products (Section 10); and
  - sponsorship (Sections 3 and 8).

**The ban covers several promotional activities:**

- prohibition of sale to minors (Section 4);
- prohibition of sale through vending machines (Section 5); and
- prohibition of exchanges, free premiums, redemption, giveaways, etc. (Sections 6 and 7).

## Steps of Implementation

### 10 February 1989–3 August 1992: Prohibition under the Consumers Protection Act 1979

Because the CPB was not knowledgeable about tobacco industry tactics, the secretary of the NCCTU monitored violations and notified the CPB, which then prosecuted cases accordingly. Violations included the following:

**Direct advertising, for example:**

- installing large outdoor billboards advertising the cigarette brands Winston, Kent and Salem; billboards were also placed in the international airport and its tax-free shops;
- painting the logo "Mild Seven" on the bodies of cigarette delivery vans;
- launching new cigarette brands, such as Waves of Japan Tobacco Inc., with giveaways, exchanges, etc.

**POS advertising, for example:**

- placing numerous empty cartons in front of shops;
- placing large dispensers displaying logos, at sales points;
- suspending mobiles (imitating cigarette packaging) in such places.

**Product placement, for example:**

- wearing a t-shirt exhibiting the "Lucky Strike" logo in a television drama;
- publishing pictures with cigarette logos in magazines and calendars, advertising other products in newspapers, yearbooks etc.;
- printing cigarette brand names on clothes and postcards.

**TMD, for example:**

- advertising a "Marlboro Country Tour" on television;
- setting up a billboard with the logo "Winston – Style of the USA" across a street;
- advertising in newspapers "Kent Leisure Holidays", "555 The Statesman Collection" and "Camel Boots".

**Sport sponsorship, for example:**

- football: telecast of the "555 Football Special";
- snooker: telecast of the "555 Asian Snooker Open" and the "555 World Series Challenge";
- golf: a small billboard with the logo "Salem" at the venue of the "Singha Beer Pro-Am Tournament";
- cricket: a small billboard at the venue of the "Benson & Hedges Cricket International";
- motorcycling: a "Lucky Strike–Suzuki" team competed in a race.

All of these violations were discovered by the NCCTU secretary and were sent to the CPB for prosecution. Some

cases were investigated and fines resulted, and in some cases the final result was not known. The fines were up to 40000 Baht, according to the stipulations of the Consumer Protection Act. The billboards were ordered to be removed by the CPB.

After promulgation of the CPB advertising ban, violations of the law by the transnational tobacco companies (TTCs) continued the wrongdoing that had existed previously. Violations and circumventions that occurred long after the enactment of the advertising ban were either through the TTCs pretending to be naïve, or because they wanted to test the effectiveness of law enforcement.

### 4 August 1992–present: Prohibition under the Tobacco Products Control Act 1992

The Minister of Public Health appointed officials of the MOPH, the Ministry of Interior, Municipalities, the Excise Department, and the Customs Department, to be responsible for the enforcement of this law. Approximately 3000–4000 officials were appointed on 25 August 1992 and on 9 June 1993. There was only one meeting, held shortly after the TPCA enactment, for the appointed officials to clarify the law. The supposed law enforcers are from various government agencies with wide-ranging responsibilities. Their superiors are not interested in tobacco control. Most of the appointed MOPH officials have several identity cards for enforcing several laws and never utilize them. This is a major flaw of the Thai bureaucratic system of law enforcement.

Appointed officials from the Institute of Tobacco Consumption Control (ITCC) of the Department of Medical Services (DMS) are supposed to form the core of law enforcement in this area. There has been no official report of violations recorded by the ITCC. The president of the Thailand Health Promotion Institute (THPI) is at the same time the drafter of the laws, the establisher of the Office of Tobacco Consumption Control (later the ITCC), and the former boss of the ITCC director. He used this informal relationship to push the ITCC director to take action in several cases of violation of the law, but very few results were achieved. The THPI is a nongovernmental organization and the THPI president is a retired government official. Both have no authority in law enforcement.

The THPI has been the only organization that has compiled lists of practices violating the law. They included:

— Direct advertising, for example:

— cigarettes advertised in Thai Airways' duty-free price list. In the May–June 1994 issue there were full-page advertisements for Marlboro, Dunhill and 555. There were several cigarette advertisements in the Thai Airways in-flight magazine "Swasdee". In the January 1994 issue, on one page there were advertisements for Marlboro, Mild Seven, Dunhill and 555; there was advertising for the "555 Subaru World Rally Team" in the June and August 1994 issues.

**POS. In retail outlets selling foreign cigarettes there were:**

— colour pictures of cowboys, the camel logo, and the logo "get lucky" installed on cigarette cabinets;

— large signs showing prices and price reductions for certain brands.

**Product placement included:**

— wearing clothes with cigarette logos on television shows;

— smoking by principal characters, especially the heroes and heroines, in television shows;

— displaying tobacco brand names in calendars, e.g. a Honda car calendar depicting several Marlboro logos;

— advertisements for other products in newspapers, e.g. an advertisement for Shell Oil included a picture of a Formula One car displaying both Shell and Marlboro logos;

— pictures in magazines and on the sports pages of newspapers showing cigarette logos on cars, athlete's clothes, etc.

**TMD included:**

— advertising "Winston House" and "Camel Trophy Adventure Wear" in newspapers;

— advertising "Camel Trophy Adventure Wear" and "Marlboro Classics" on posters installed in shopping outlets and in other media on different occasions.

**Sport sponsorship included:**

— participation by the "555 Subaru" team in the Asia-Pacific Rally, 3–6 December 1993;

— publicity for a visit by Mild Seven-sponsored Formula One driver Michael Schumacher, dressed in his racing suit. This was followed by the "95 Formula-1 Festival" at a department store on 14–30 October 1994;

— THPI research found that in one year (1998–1999) a cable television station aired 1343 hours of tobacco-sponsored sports events, consisting of 99 live legal telecasts and 1698 repeats. According to the law only live telecasts are permitted (see Section 8 of TPCA 1992). Therefore the repeats are considered illegal.

**Other promotions, for example:**

— in December 1992, the tax-free shops at the Bangkok International Airport ran a promotional programme: people buying goods worth 1000 Baht would be entitled to a reduction of 100 Baht for other goods, including cigarettes.

## Success of the Intervention

During the first period (10 February 1989–3 August 1992) when the advertising ban was under the Consumer Protection Act 1979, the intervention was reasonably successful. Almost all cases notified to the CPB by the NCCTU Secretary were investigated and led to fines.

After 4 August 1992, the MOPH became responsible for the newly enacted Tobacco Products Control Act 1992 and law enforcement has become very weak. The THPI has been the main monitoring force and provided numerous notifications to the ITCC. Most of these were not dealt with efficiently. In a few cases, however, suppression of the tobacco industry's promotional activities was successful owing to the THPI's vigilance and strong media advocacy.

### Success Story 1

**Defeat of the Olympic Committee of Thailand's attempt to adopt tobacco sponsorship**

In October 1990, the secretary of the Olympic Committee of Thailand (OCT) gave a press interview stating that the OCT would consider accepting TTC sponsorship of sport, and that the OCT would push for amendment of the law banning cigarette advertising.

On 21 October, the secretary of NCCTU gave a press interview opposing the proposal. This was followed by streams of news items, columns, and articles supporting and opposing the planned sponsorship. From October 1990 to March 1991, there were 20 news stories and 24 articles in favour of sponsorship; 18 news stories and 15 articles opposed it; and there were 9 news stories, 7 articles and 1 cartoon expressing a neutral stance. The pro-sponsorship group included the Secretary and Treasurer of the OCT, a former Deputy Public Health Minister, and a large number of sport columnists. The opposition consisted of the Secretary of the NCCTU, the Secretary of the No-Smoking Campaign Project, the Public Health Minister, the Privy Councillor, and some journalists.

After the continuous 5-month debate, the pro-sponsorship group gave up.

## Success Story 2

### Thailand was the only country in which the "Subaru-555" logo could not be displayed in the Asia-Pacific Rally

1993 was the first year of the Asia-Pacific Rally, which was held in six countries: Australia, Hong Kong (now Hong Kong Special Administrative Region of China)–Beijing (China), Indonesia, Malaysia, New Zealand and Thailand. After the race, the THPI and its grass-roots allies gave a press conference stating that exhibiting the "Subaru-555" logo was illegal. The MOPH followed up with a letter of protest to the organizers of the rally. The planned domestic rallies – four in 1993 – were scrapped.

From 1994 on, the "Subaru 555" logo was changed to "Subaru ///" when the rallies were held in Thailand.

## Success Story 3

### Thailand is the only country on the Asian golf circuit in which Davidoff logos are not displayed

The Asian Professional Golf Association (Asian PGA) had the watch company, Omega, as its main regional sponsor until 1999, when Davidoff took over. The Asian PGA's "Davidoff Tour" tournaments were held 20 times in 11 countries.

In Thailand there were 2 tournaments – The Lexus International on 14–17 October 1999, and The Thailand Open on 1–4 December. Both times, local organizers were told by the THPI president that displaying Davidoff logos was illegal. The Lexus tournament did not heed the warning and the THPI president initiated an arrest by the ITCC staff. The tournament organizer was prosecuted.

Since then, all Davidoff Asian PGA tours held in Thailand have not dared to exhibit the Davidoff logo. Thailand is the only country on the tour to have "Davidoff-free" competitions.

# Taxation (including Smuggling Control

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## Report on Smuggling Control in Spain

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# Report on Smuggling Control in Spain

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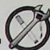

## Introduction

Tobacco smuggling has become a critical public health issue because it brings tobacco on to markets cheaply, making cigarettes more affordable and thus stimulates consumption. The result is an increase in the burden of ill health caused by its use. According to the tobacco trade report *World Tobacco 2002* a major feature of the world cigarette market is the continued growth in smuggling and counterfeit trade, which accounts for a minimum of 8% of the world cigarette consumption at around 400 thousand million pieces.*(1)*

Smuggled tobacco products represent both a threat to public health and to government treasuries, which are losing thousands of millions of dollars or euro in revenue.

Smuggled cigarettes became a major concern for governments and international organizations such as the World Health Organization, the World Customs Organization, the World Bank, the International Monetary Fund and the International Criminal Police Organization (Interpol). At a conservatively estimated average tax of US$ 1.0025 to US$ 1.50 per cigarette pack (this is much higher in most developing countries) cigarette smuggling (20 thousand million packs) accounts for US$ 25 to US$ 30 thousand million being lost by governments every year.

The tobacco industry has argued that tobacco smuggling is caused by market forces—by the price differences between countries, which create an incentive to smuggle cigarettes from "cheaper" countries to "more expensive" ones. The industry has urged governments to solve the problem by reducing taxes, which will also, it says, restore revenue. The facts contradict all these assertions. Smuggling is more prevalent in "cheaper" countries and, where taxes have been reduced, such as in Canada, consumption has risen and revenue fallen. There are, however, countries that have solved the problem by better control, Spain being the most impressive example to date. There are two main reasons why the example of Spain in terms of combating smuggling is impressive:

— The country had a huge smuggling problem, despite low prices.

— It effectively reduced smuggling without reducing prices

### A huge smuggling problem, despite low prices

Joossens and Raw (1998, 2000, 2002) showed that tobacco smuggling defies apparent economic logic. Common sense might suggest that cigarettes would be smuggled from countries where they are cheap (southern Europe, for example) to expensive countries (such as northern Europe) and that this is due simply to price differences between these countries, as the tobacco industry claims. Although this does happen, it is not the largest type of smuggling, and in Europe there is far more smuggling from north to south rather than the reverse.*(2)*

Using 1995–1997 data on nine countries from the European Confederation of Cigarette Retailers and other sources, Joossens and Raw classified the 15 European Union (EU) countries and Norway as follows: *high-smuggling countries*, with a contraband market share of 10% or more (Spain 15%, Austria 15%, Italy 11.5%, Germany 10%), *medium-smuggling countries*, with a contraband market share between 5% and 10% (Netherlands 5-10%, Belgium 7%, Greece 8%, and probably Luxembourg and Portugal, but no studies are available), and *low-smuggling countries*, with a contraband market share of less than 5% (France 2%, the United Kingdom 1.5%, Ireland 4%, Sweden 2%, Norway 2%, and probably Denmark and Finland, but no studies are available).*(2)* The results can be seen in Table 1. (Note that the situation has changed in a number of the countries since the study was done.)

Table 1

**Prices of cigarettes (in US$, June 1997) and level of smuggling (1995) into countries of the European Union**

| Country | Price | Level of smuggling |
|---|---|---|
| Spain | 1.20 | high |
| Portugal | 1.75 | medium* |
| Greece | 2.06 | medium |
| Italy | 2.07 | high |
| Luxembourg | 2.12 | medium* |
| Netherlands | 2.43 | medium |
| Austria | 2.69 | high |
| Belgium | 2.95 | medium |
| Germany | 3.02 | high |
| France | 3.38 | low |
| Finland | 4.26 | low* |
| Ireland | 4.27 | low |
| United Kingdom | 4.35 | low |
| Denmark | 4.55 | low* |
| Sweden | 4.97 | low |
| Norway | 6.27 | low |

**Notes:** The table shows the price (in US$ at 1 June 1997) of 20 cigarettes from the most popular price category. Sources for prices are the Commission of the European Communities and the Norwegian Council on Tobacco and Health.

* Probably details of how this index was constructed are given in the text

The correlation between high prices and high levels of smuggling claimed by the tobacco industry simply does not exist. In fact, countries with very expensive cigarettes do not have a large smuggling problem. Table 1 shows high levels of cigarette smuggling in the south of Europe rather than the north. Other factors than price levels that make cigarette smuggling more likely include corruption, public tolerance, informal distribution networks, widespread street-selling, and the presence of organized crime.

## Effective reduction of smuggling without reducing prices

Spain is one of the few countries in the world to have tackled smuggling successfully. It did not do so by reducing tobacco tax. Despite Spanish cigarettes being among the cheapest in the European Union, smuggled cigarettes had an estimated market share of 15% in 1995.*(3)*

According to the EU lawsuit against Philip Morris, RJ Reynolds and Japan Tobacco, filed on 3 November 2000 in New York under the United States Racketeering Influenced and Corrupt Organization Act (RICO), Spain has been a primary destination for smuggled *Winston* cigarettes for so long that the smugglers are sometimes known as "Winstoneiros". According to the EU lawsuit, because of the way RJR mark and label their cigarettes, the company could identify which smuggled RJR cigarettes in the marketplace had been originally supplied by RJR USA, and which were smuggled into the country by persons without authorization of RJR.

As the demand for *Winston* in Spain rose through the 1990s increased numbers of "lower quality" *Winston* from other sources were being smuggled into Spain, interfering with the smuggling authorized by RJR. According to the EU complaint, RJR took steps to prevent the unauthorized smuggling. They developed a particular presentation of Winston cigarettes known to the Spanish consumer as *patanegra*. The *patanegra* presentation could be distinguished from the other "lower-quality" Winstons by distinctive markings and because they did not have the blue sticker found on most Winston cigarettes.

It was alleged that RJR produced the *patanegra* presentation specifically for their best smuggling customers, to insure that they could maintain their competitive advantage over other smugglers and so that RJR could increase their market share (because if you can guarantee good quality you will sell more and increase market share). The *patanegra* presentation was developed specifically for the Spanish market and sold only in Spain. According to the EU lawsuit, it was one of the examples that showed how RJR maintained and exercised control of the smuggling operations in Spain.*(4)*

Another source of smuggled cigarettes in Spain and the EU was Andorra. In a 1992 BAT internal tobacco industry document, the illegal cigarette trade in Andorra was described in the following way:

"Smuggling is a traditional and highly lucrative trade in Andorra. The growth has increased rapidly in recent years as Andorran supply has replaced that which used to enter Spain by sea and has been subjected to increased controls because of the links with the drugs trade." *(5)*

Between 1997–1998 there was concerted action at national and European levels to reduce the supply of contraband cigarettes. Close collaboration among the authorities in Andorra, Britain, France, Ireland, Spain and the European Anti-Fraud Office (OLAF) reduced the supply of smuggled cigarettes from Andorra. Actions included sealing the Andorran border, and having civil guard brigades patrol valleys and hills to make smuggling more difficult. The European Anti Fraud Unit led a first mission to Andorra in March 1998, accompanied by representatives from the neighbouring countries (France and Spain) and from cigarette exporting countries (Ireland and the United Kingdom). The enquiries revealed a lack of appropriate legislative instruments in Andorra to prevent and combat fraud. In November 1998 a EU Commission mission visited the Andorran Government and found that attitudes had changed fundamentally. The laws on customs fraud and the control of sensitive goods and the law amending the criminal code and making smuggling a crime were published respectively in the Andorran Official Journal on 4 March 1999 and 7 July 1999.*(6)*

As a result, contraband cigarettes which had accounted for an estimated 12% of the Spanish market in early 1997, held only 5% by mid-1999[1] and only an estimated 2% in 2001. Sales of legal cigarettes increased from 78 thousand million in 1997 to 87 thousand million in 1998 (see Table 3), and tax revenue increased by 25% in the same year (see Table 2). According to the Spanish customs authorities, their success was not due to controlling distribution at street level, which is almost impossible, but to reducing the supply into the country at "container level" through intelligence, customs activity and cooperation, and technology[2].

**Table 2**

**Excise revenue from cigarette sales in Spain, 1996-2000 (billion Pesetas)**

| Year | Revenue |
|---|---|
| 1996 | 443 |
| 1997 | 516 |
| 1998 | 646 |
| 1999 | 667 |
| 2000 | 742 |

Source: Spanish Customs and Excise

**Table 3**

**Cigarette sales in Spain (thousand million pieces)**

| Year | Sales |
|---|---|
| 1996 | 72 |
| 1997 | 78 |
| 1998 | 87 |
| 1999 | 86 |
| 2000 | 88 |
| 2001 | 90 |

Source: Comisionado del Mercado de Tabaco

Andorra is important because it illustrates the role of the tobacco industry. Andorra was not only supplying illegal cigarettes to the Spanish market but also to the United Kingdom. Exports from the United Kingdom to Andorra (which has a population of only 63 000) increased from 13 million cigarettes in 1993 to 1 520 million in 1997. Since few of these cigarettes were legally re-exported and Andorran smokers do not generally smoke British brands, then either each Andorran (including children and non-smokers) was smoking 60 British cigarettes a day in 1997 or these cigarettes were being smuggled out of Andorra. It seems obvious that the companies would know what was happening to their cigarettes. In a television interview on the BBC's *Money Programme* of 8 November 1998, a spokesperson for the tobacco company (Gallaher) said: "We will sell cigarettes legally to our distributors in various countries. If people, if those distributors subsequently sell those products on to other people who are going to illegally bring them back into this country, that is something outside of our control." *(7)*

## Discussion

The tobacco industry has often claimed that smuggling is more prominent in high-tax countries and that the best way to tackle cigarette smuggling is by reducing the demand and by lowering taxes. In fact, cigarette smuggling

[1] (Ignacio Garcia, Customs and Excise, Madrid, personal communication)

[2] (Ignacio Garcia, Customs and Excise, Madrid, personal communication)

occurs in all parts of the world, even in countries where prices are low. Spain had the lowest cigarette prices in the EU and still had a huge smuggling problem. Cigarette smuggling in Spain was not caused by the demand of smokers in search of cheaper cigarettes, but by the illegal supply of international cigarette brands on the Spanish market.

Fortunately, the Spanish experience shows also that coordinated action to stop the illegal cigarette supply can solve the smuggling problem. The proportion of smuggled cigarettes in the Spanish market was reduced dramatically and revenue was increased, without lowering taxes, whereas tax reductions produced disastrous results – lower revenues and a sharp increase in consumption, especially among young people – in Canada. *(3)* Governments need to acknowledge that smuggling is, to large extent, a supply-driven process and that manufacturers exercise a large degree of control over their end markets, both legal and illegal, as testified to by many documents from the Guildford archives. *(8)* What follow logically from this, is the need to cut off the supply of cigarettes to the smugglers.

Economic analysis of the effect of cigarette prices in Spain and the analysis of smoking histories from the national health survey 1993-1995-1997 has shown that the price increase of black cigarettes had a significant effect on prevalence, but the price increase of blond cigarettes did not. *(9)* Smuggling may be an explanation for this difference between the effect of price increases of blond and dark cigarettes as smuggling of cigarettes in Spain occurred mainly with blond (Winston) cigarettes, which were promoted on the illegal market as "high-quality cigarettes" (the so called *Patanegra* Winstons). The ready availability of lower-price smuggled blond cigarettes undermined the effect that price increases of legitimately sold cigarettes should have had.

While the success of the fight against smuggling in Spain was evident, the impact of the reduction of smuggling on smoking prevalence is unclear. Smoking prevalence among women remained stable at 27% in 1995 and 2000-2001, but decreased among men from 47% in 1995 to 42% in 2000-2001. *(10)* It is unclear whether the decline of smoking among men is linked to the reduction of cigarette smuggling, but it might be, since the action against smuggling greatly reduced the ready supply of cheap Winstons available to consumers.

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# SACTob Recommendation

## on Nicotine and the Regulation in Tobacco and non-Tobacco Products

Scientific Advisory Committee on Tobacco Product Regulation (SACTob)

World Health Organization
Tobacco Free Initiative

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## Preface

The Scientific Advisory Committee on Tobacco Product Regulation (SACTob), established by the World Health Organization, held its first meeting in October 2000. The committee is composed of national and international scientific experts on product regulation, smoking cessation and laboratory analysis. SACTob advises WHO about scientifically sound recommendations to Member States addressing the most effective and evidence-based means to achieve a co-ordinated regulatory framework for tobacco products. The work of the committee is based on recent leading edge research on tobacco product issues and aims to fill the regulatory gaps in tobacco control.

The present recommendation was finalized by SACTob during its Fourth Meeting in 4-6 February 2002 held at Oslo, Norway.

# SACTob Position Statement on Nicotine and Its Regulation in Tobacco and Non-Tobacco Products.

## Background

Over the past two decades a wealth of research findings have pointed to nicotine as the key pharmacological factor underlying tobacco use. The 1988 report of the US Surgeon General identified cigarette smoking as nicotine addiction (1); the Royal College of Physicians similarly concluded that nicotine is an addictive drug on par with heroin and cocaine, and that the primary purpose of smoking tobacco is to deliver a dose of nicotine rapidly to the brain (2). The Diagnostic and Statistical Manual of Mental Disorders [D.S.M-IV] classifies nicotine-related disorders into the sub-categories of dependence [305.10] and withdrawal [292.0] which may develop with the use of all forms of tobacco (3). The effects of tobacco and nicotine to produce dependence and withdrawal are also identified by the International Statistical Classification of Diseases and Related Health Problems [I.C.D-10] as a disease in the category [T 65.2] 'Toxic effect of other and unspecified substances' (4).

While nicotine is acknowledged to be the primary reinforcer of smoking (5,6), and nicotine-free cigarettes have consistently failed in the marketplace (7), exposure to nicotine in itself is believed not to be responsible for more than a minor portion of tobacco related disease (8). Rather, harmful gases and particulates, which can be thought of as contaminants of the cigarette as a nicotine delivery device (9), cause the great majority of smoking related diseases and their specific role in the reinforcing effects of smoking is not well understood.

Despite their toxicity, tobacco products have enjoyed an unprecedented degree of freedom from the regulations that apply to food and drug products and to consumer products generally (10,11). Paradoxically, pure nicotine products designed to aid smokers trying to quit (12), are subject to stringent regulation and are required to meet the same standards of safety and product information as any other pharmaceutical preparation (13,14,15,16).

It is theoretically possible that changes in cigarette design could lower exposure of smokers to the harmful constituents in smoke, but efforts to do so through so called "low-yield" cigarettes have failed (2, 17). Smokers self-dose for nicotine, and they smoke more intensively or smoke more cigarettes per day to obtain the dose that will give them satisfaction (9, 15, 16, 17, 18). Most so called "low-yield" cigarettes are designed such that these changes in smoking behaviour return the delivery of nicotine and other smoke constituents to levels similar to those of so called "full flavour" or "high -yield" cigarettes (19). Dependence on nicotine is a biological force that drives such behaviour (1,2,20).

Proposals for more effective nicotine regulation have ranged from reducing nicotine availability from cigarettes to the point where they are no longer reinforcing (6,21) to restricting unwanted particulate and gas phase components while accepting a laissez faire approach to nicotine (7, 22, 23, 24). A common thread is the recognition of the need to level the regulatory playing field, as between consumer and pharmaceutical nicotine products (14, 25, 26), as well as the need to ensure that the future market for nicotine does not continue to be dominated by the most contaminated product, the cigarette (27).

**Based on the existing science, SACTob makes the following recommendations:**

1. The present situation in which the most toxic form of nicotine delivery is the least regulated, is unacceptable from a public health perspective.

2. Because nicotine appears to be responsible for a small proportion of tobacco-caused diseases relative to other tobacco constituents and emissions, there is considerable scope for developments that reduce the risks experienced by users of tobacco, but without undermining efforts to prevent initiation to tobacco use and promote cessation among established users.

3. In the absence of firm contrary data, those responsible for public policy decisions are justified in using the conservative assumptions that smokers' preferences for a nicotine dose are persistent over time and are not influenced by changes in the product used and that smokers will compensate for reductions in yield to maintain a relatively consistent dose of nicotine.

4. A broad and comprehensive regulatory framework is required to enable policy options for controlling nicotine to move forward in ways that minimise the risks.

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