Anti-smoking legislation — an international perspective applied to South Africa

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Summary
Legislation is an essential component of any effective anti-smoking programme, and is being used increasingly in many countries. Legislative measures may control or ban tobacco advertising, require that cigarette packets carry a health warning and contents statement, limit the tar and nicotine content of cigarettes, restrict sales, impose taxes on tobacco products, restrict smoking in public places and workplaces, make health education mandatory or provide for the establishment of a national anti-smoking agency. A major objective is to establish non-smoking as the norm. We recommend that the government of South Africa introduces a comprehensive anti-smoking programme that will include the following steps: (i) putting extra taxes on cigarettes to fund health education, (ii) prohibiting the sale of cigarettes to minors, (iii) making health warnings and contents labelling on both cigarette packets and advertisements prominent, and (iv) encouraging public and private sector involvement in protecting non-smokers' rights and helping smokers to stop smoking.

The scientific evidence indicating the dangers of both active and passive smoking is incontrovertible. Health experts have stated that smoking-related diseases are the single most preventable cause of death and disease in the world. There are many reasons why millions around the world continue to smoke, in spite of all the disadvantages of doing so. Many people (especially in developing countries) are unaware of the health risks, others choose not to believe the evidence because smoking fulfills psychological or social needs for them, others would desperately like to give up smoking but cannot do so because it is a physiologically addictive habit. An important factor contributing to continued smoking is the tremendous amount of money that the tobacco industry puts into promoting it, thus encouraging those who do not smoke to begin doing so.

The World Health organisation launched a campaign against tobacco in 1970 and since that time it has adopted successively stronger resolutions urging all countries to adopt anti-smoking measures. The experience of different countries has shown that for maximal effectiveness, anti-smoking programmes should have all of the following components: legislation (at national and lower levels), information and education (including 'stop-smoking' assistance), and economic intervention. Aspects of these three components are often inextricably linked.

Purposes of legislation
Legislation is clearly one of the measures required for fighting smoking and the use of tobacco, in order to protect the public health and welfare. The chief aims of anti-tobacco legislation are: (i) to establish governmental policy on the production, promotion and use of tobacco; (ii) to encourage smokers to stop smoking and to dissuade others from starting; (iii) to protect non-smokers' rights to breathe clean air; (iv) to reduce the harmful substances in cigarettes; and (v) to allocate official resources for promoting the anti-smoking message.

Types of anti-tobacco legislation
Table 1 summarises existing anti-tobacco legislation around the world, and in RSA. The various types of legislation are discussed below.

Control of advertising and sales promotion
Advertising is a powerful and pervasive means of promoting smoking, and the tobacco industry spends vast amounts of money on it — more than US $2,1 billion in the USA alone in 1984. Advertising strikes a blow at the public's health in several ways: it conveys the message that smoking is associated with success, pleasure, wealth, and attractiveness, it stops the flow of full information about the risks of smoking because many magazines and newspapers do not wish to offend the tobacco advertisers, and it undermines the credibility of health education campaigns against smoking.

Internationally legislation restricting cigarette advertising is becoming one of the most powerful weapons for halting the growth of the smoking habit. By mid-1968, 21 countries had already adopted total bans on advertising. Thirteen countries had strong partial bans on advertising. These, for example, limit the content of the advertisement to factual information, or restrict the places where tobacco advertising is permitted. Moderate partial bans existed in 21 countries by 1986. These include a requirement for rotating health warnings on cigarette packages, certain time and content restrictions for TV or radio advertisements, or measures to restrict promotional activities directed at young people. Total bans on advertising are more readily enforced than partial bans, which can sometimes be evaded.

In the RSA the SABC and the tobacco industry have agreed that cigarettes will not be advertised on television, but indirect
TABLE I. TYPES OF ANTI-TOBACCO LEGISLATION

<table>
<thead>
<tr>
<th>Nature of legislation</th>
<th>Countries applying it as of 1986</th>
<th>Situation in the RSA</th>
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<tbody>
<tr>
<td>1. Control of advertising:</td>
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<tr>
<td>(a) Total ban</td>
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<tr>
<td>21 countries, including Mozambique, Algeria, Sudan, the Gambia</td>
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<td>(b) Strong partial ban</td>
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<td>13 countries, including Argentina and Bolivia</td>
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<tr>
<td>(c) Moderate partial ban</td>
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<tr>
<td>21 countries</td>
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<td>2. Requirement that packets be labelled with:</td>
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<tr>
<td>(a) A health warning</td>
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<tr>
<td>43 countries, including Algeria, Kenya, Senegal</td>
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<tr>
<td>(b) Statement of tar and nicotine contents</td>
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<tr>
<td>21 countries</td>
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<tr>
<td>3. Limits on tar and nicotine content</td>
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<tr>
<td>A few</td>
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<td>4. Restrictions on where or to what age people tobacco products can be sold</td>
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<tr>
<td>A few, including Australia, Uruguay, and Rio Grande do Sul (Brazil)</td>
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<tr>
<td>5. Imposing of extra taxes/levies on tobacco products</td>
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<tr>
<td>Many. In some countries, e.g. France, Finland, part of this tax funds health or anti-smoking activities</td>
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<tr>
<td>6. Tax incentives and/or subsidies for replacing tobacco with other crops</td>
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<td></td>
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<tr>
<td>None</td>
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<td></td>
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<tr>
<td>7. Restrictions on smoking in public places</td>
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<tr>
<td>In many countries bans exist at national or more localised levels</td>
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<td>8. Restrictions on smoking in the workplace</td>
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<tr>
<td>In many countries bans exist at national or more localised (provincial, municipal, private employer) levels. Occupational safety laws may also be applicable</td>
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<tr>
<td>9. Making health education mandatory</td>
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<tr>
<td>Several e.g. Finland</td>
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<tr>
<td>10. Establishing a national agency to co-ordinate anti-smoking activities</td>
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<td>Several, e.g. Venezuela</td>
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advertising occurs in sports programmes that cover events such as the Rothman’s July or Gunston 500 Surfing. This indirect advertising through sports events clearly has great potential to influence young people.

With the exception of Reader’s Digest, all the major South African magazines and newspapers carry cigarette advertisements. These include women’s and family-orientated magazines that have a considerable teenage readership. The English and Afrikaans radio services of the SABC do not carry cigarette advertisements (apparently by voluntary agreement), but the regional and black radio services do. The RSA’s developing populations are thus subjected to advertisements on the radio, in their magazines and newspapers, on billboards at railway and bus stations, and at sponsored sports or cultural events, all implying that smoking is a desirable and sophisticated activity.

Requirements for health warnings and statement of tar and nicotine contents

By mid-1986 43 countries required health warnings on cigarette packets, and 21 required a statement of tar and nicotine content. Several countries have realised the effectiveness of rotating health warnings, so that smokers do not become too used to a
single warning. For example, in Australia all tobacco packages and advertisements must carry one of four warnings: smoking causes lung cancer and heart disease; smoking damages your lungs; smoking is addictive; smoking kills.

Labelling the packet with the tar and nicotine content of cigarettes should be mandatory so that those smokers who wish to switch to brands with lower values have the information available. (The tar or condensate value refers to the amount of particulate matter in the smoke. Cigarettes with lower tar and nicotine values may cause less health damage provided that smokers do not compensate by smoking more of them.) Both health warnings and statements of harmful contents should be required elements on cigarette advertisements as well as packages.

In the RSA a voluntary agreement exists between the tobacco companies and the government whereby a short health warning is required on cigarette packets. As yet, a small warning appears only in English and in Afrikaans and is usually coloured to blend in with the package colouring. The nicotine and condensate content of the cigarettes are also stated on the packet. Neither this information nor the warning appear on any advertisement.

**Control of harmful substances**

Only a few countries have enacted legislation to set maximum levels of noxious substances. Such legislation, however, is feasible and enforceable. Laws can be drafted to set progressively lower maximum levels of harmful substances. In the RSA the nicotine and tar yields of cigarettes are checked by the SABS but maximum levels are not laid down. The average sales-weighted tar yield for South African cigarettes in 1982 fell in the medium range (17 - 22 mg/cigarette) when compared with that in 45 other countries.

**Restrictions on sales**

Restricting the places where cigarettes may be sold is effective because it has a strong educational impact. It implies that cigarettes should not be freely available, and contributes to the creation of a non-smoking environment. A few countries have legislation forbidding the sale of cigarettes in health institutions and government buildings.

Various countries — for example, Australia and Uruguay, also have legislation to outlaw the sale of tobacco to minors. In RSA there is no national legislation preventing minors from buying cigarettes, nor are there any municipal by-laws prohibiting this, as far as we are aware.

**Taxation and price policy**

Effective legislation and education can achieve some reduction in smoking, but to achieve the goal of a non-smoking society the price of cigarettes must rise substantially and repeatedly in real terms. Such price rises can be brought about by levying an ever-increasing excise tax on cigarettes. Tobacco taxes are easily administered and are more acceptable than many other forms of taxation. The most important effect of high cigarette prices is in discouraging young people from starting the habit. Taxes can also be an acceptable way of getting smokers to pay for at least part of the additional health care costs associated with smoking-related diseases. Finland, Iceland, and French Polynesia all lay down by law that a certain percentage of tobacco tax revenue must be used for anti-smoking activities.

Higher taxes for high-tar cigarettes can also discourage their consumption. For example, within 3 months of the introduction of an extra tax on high tar cigarettes in the UK in 1987, their market share fell from 15% to 3%.

In the RSA cigarettes are taxed, but this income does not accrue directly to health or anti-smoking activities.

**Economic incentives to substitute other crops for tobacco**

Tobacco is a cash crop that gives a high return on investment. It provides employment in rural areas and foreign exchange for exporting countries. Because the short-term rewards are obvious and substantial, governments have generally not moved strongly to try and substitute tobacco with other crops. It may prove difficult to develop substitute crops for tobacco, and studies to do so are urgently needed. In the interim farmers should be encouraged by tax incentives or subsidies, or both, to replace tobacco with more healthy products. Such legislation does not currently exist anywhere.

**Restrictions on smoking in public places**

The evidence on the dangers of passive smoking is mounting. Banning smoking in public places is therefore justified on health as well as aesthetic grounds. Many countries have adopted legislation to ban smoking in certain public places, and in even more countries such bans are imposed at a local (for example, provincial, municipal) level. It is particularly important for hospitals and official health agencies to set an example by banning smoking.

In Finland all smoking in public places is prohibited unless specifically stated otherwise. In Sweden the regulations for public places and workplaces are designed to accommodate both smokers and non-smokers as far as possible, although priority has to be given to the rights of the non-smokers. In South Africa the sale of tobacco to minors is regulated by proclamation in the Government Gazette, the smoking or advertising of tobacco products in certain public places.

The Bill was not passed. According to Mr Widman, 'The Government's official standpoint on smoking is that they are not prepared to introduce legislation as they feel they have an agreement with the Tobacco Board who, according to them, were cooperating. However, they are prepared to promote the non-smoking cause amongst children and at schools.' (A. Widman — personal communication.)

Telephone enquiries revealed that officials in the Provincial Administrations or Regional Service Councils are themselves not aware of exactly what provincial ordinances exist. People contacted in the Cape, Natal, and the Orange Free State all thought that there are laws in these provinces banning smoking in public places, including hospitals, cinemas, and on public transport. No prosecutions under these laws had taken place, however, as far as they knew, even though these bans are not always observed.

Many local authorities (such as municipalities) have their own by-laws concerning smoking. In Cape Town there are, for example, by-laws banning smoking in lifts, public assembly areas such as cinemas, on public transport, and in areas where food is handled (but not where it is consumed). No-smoking signs must be displayed in these areas. The onus to enforce the ban is on the person in charge of the area who may call in the police for assistance if necessary (although this is awkward to
do in practice). At the time of writing the Cape Town City Council is also considering various measures such as compulsory non-smoking sections in restaurants and the banning of cigarette advertisements from Council property.\textsuperscript{10}

Johannesburg, Pretoria, and Durban have by-laws similar to those already existing in Cape Town. A telephone survey found that the by-laws of several other large cities in all the provinces seem to cover fewer public places, if such by-laws exist at all. The importance of such by-laws is that they help to create a non-smoking environment as the norm. As public awareness of this norm increases, smokers will be more ready to observe the bans, and there will also be greater pressure from non-smokers for them to do so.

**Restrictions on smoking in the workplace**

Legislation banning smoking in certain public places such as schools and hospitals will obviously restrict smoking by workers in these places. Many countries, however, have additional legislation — either at a national or local level — to protect non-smokers in the workplace. Under USA common law the employee has a right to a safe working environment and the employer a duty to provide it. Many state and local laws exist that oblige employers to establish a policy that tries to accommodate the needs and preferences of smokers and non-smokers. Where this is impossible the preferences of non-smokers must prevail.\textsuperscript{11} In general, smoking in the workplace in the USA has been controlled with great success by means of these local ordinances.

British employers also have a duty under common law to protect the health of their employees. Provisions of the Public Health Act of 1936, which oblige employers to keep the atmosphere ‘free from noxious effluvia prejudicial to health’, would seem to apply to fumes from tobacco.\textsuperscript{12} A recent report recommends that employing organisations should draw up a formal written smoking policy in consultation with their employees.\textsuperscript{11} The ideal is obviously for smokers to stop smoking at work voluntarily as a result of health education, peer influence, and consideration of non-smokers. Courtesy is not, however, a satisfactory way of regulating smoking in general — the report points out that we do not rely on goodwill or ‘voluntary regulations’ to avoid traffic accidents or industrial pollution of the environment.

The Canadian Government introduced a smoking policy for all civil service offices in 1987, which will lead to a complete smoking ban in 1989. The Australian Public Service Board aims to achieve smoke-free workplaces in all government offices by March 1988.\textsuperscript{11}

In the RSA, the Machinery and Occupational Safety Act No. 6, 1983, requires employers to provide a safe environment for their employees. This applies to all employees, not just factory workers, and ‘safe’ is defined as ‘free from any threat which may cause bodily injury, illness or death’. A court could conceivably rule that tobacco smoke is such a threat.

There have been several reports from the USA of cases in which smokers or ex-smokers who claimed to have suffered severely harmful effects to their health as a result of their own smoking, unsuccessfully sued tobacco companies. These claims were generally refused on the basis of the defence of voluntary assumption of risk. Any similar claim brought in the RSA would probably also be unsuccessful. ‘Passive’ smokers are not necessarily consenting parties, but it would probably be impossible for a ‘passive’ smoker to prove a causal connection between his ill-health and the fact that a particular manufacturer markets tobacco. A sensitive non-smoker could conceivably obtain an interdict against someone who constantly smokes in a situation where the applicant cannot, because of his occupational duties, ‘escape’ the smoking (Professor S. A. Strauss — personal communication).

**Making health education mandatory**

One way of achieving education is to make specific legislative provision for it. The personnel and financing necessary for such programmes are then more likely to be available. Several countries have such legislation, often aimed particularly at children and young people. As already mentioned, some countries use a proportion of tobacco tax revenue to fund health education programmes.

The RSA does not have any anti-smoking health education programme that is governed by legislation. The Department of National Health and Population Development does, however, attempt to prevent schoolchildren from taking up smoking. Anti-smoking literature and posters are made available to schools together with other health education literature (Dr H. Steele — personal communication). Other activities are also undertaken from time to time, for example the holding of ‘smokeless days’.\textsuperscript{12}

**Establishing a national organisation for policy development and coordination**

A national agency on smoking and health is important in order to facilitate cooperation of governmental and voluntary agencies, and to provide continuity and official recognition and support for an anti-smoking effort.

Several countries have legislation establishing such a central body; South Africa is not among them. In RSA a Joint Action Group has recently been established by the National Cancer Association, the Heart Foundation, and the National Council on Smoking and Health of Southern Africa, which are all voluntary organisations.

**Effectiveness of anti-smoking legislation and health education**

It is difficult to define the effectiveness of any one measure against smoking because so many factors are involved in the use of tobacco, but the evidence from countries with legislation is that legislative restrictions generally do cause a decline in, or at least halt the growth of, smoking generally or among young people.

The Swedish Government has made use of both legislation and education, and the percentage of daily smokers dropped from 43% of the population in 1976, to 31% in 1986. The Swedes noticed a ‘snowball effect’ in that more and more people find themselves surrounded by friends and companions who have stopped smoking.\textsuperscript{4}

The acceptance of the non-smoking environment as the norm is obviously a desirable development, and one which requires extensive health education in order to bring it about. Though it is helpful for a country’s government to be directly involved in such education, it is unreasonable to expect it to carry the whole responsibility, because there are always so many other health needs requiring attention. This is where other bodies of both a scientific (for example, medical associations) and a lay nature (for example, civic groups, employers) can play a vital role.

The support of the media is also important. It is heartening that several South African magazines have carried articles on the dangers of smoking even though these magazines accept cigarette advertising because of economic considerations. Television is a particularly powerful medium for putting across health education, as shown in a recent survey.\textsuperscript{2} The fact that the SATV Advertising Services have stated that they will not object to editorial material focussing on the controversy surrounding the use of tobacco products, or publicity for non-smoking events, is therefore good news (D. M. Baird, personal communication).
communication). The SABC will also accept ‘advocacy’ advertising (that is, advocating non-smoking) on its radio stations, provided that this is paid for at the prevailing rate. (In the USA anti-smoking advertisements on TV were most effective.)

Need for legislation in South Africa

The international trend is for more countries to introduce anti-smoking laws, and for those that have measures to strengthen them progressively. This applies not only to the developed world but also to many countries in Asia and South America, and some African countries. In the RSA the need for such legislation is particularly great because a large section of our population is relatively unsophisticated and therefore more likely to be taken in by the allure of tobacco advertising and to be unaware of the adverse health consequences of smoking.

One argument for failing to pass legislation is that the economic gains to the country from the tobacco industry are greater than the losses. This is a short-term and incorrect view, as shown by an analysis of economic factors in the RSA published in 1982 and a re-analysis completed in 1987 (Dr S. Taylor, personal communication). While tobacco is a money-earning crop for the country, we are in the fortunate position (unlike many third world countries) of having many other commodities to export as well as the technology and infrastructure to investigate which crops can most lucratively and healthfully be substituted for tobacco. Tobacco is one of Brazil’s top three export products and yet Brazil has introduced fairly comprehensive anti-smoking measures.

A second argument is that the voluntary code with the tobacco industry works well enough. Experience around the world, however, has shown that voluntary advertising codes simply do not work. For example, in the UK, which has voluntary agreements, the death rate from lung cancer for males aged 60-90 is more than three times that of Norway, which has strong legislation.

Legislative measures should be acceptable to most of the population they are aimed at, or they will not work; laws that are perceived as too restrictive are likely to be disregarded. It is therefore interesting that surveys have shown that even smokers are in favour of some restrictions on smoking. A recent survey in Ontario for example, of current and former smokers and those who have never smoked drawn from a wide socio-demographic range showed that all three groups favoured some restrictions on smoking, differing only in the degree or extent advocated. Among current smokers, 98.7% were in favour of smoking restrictions in certain public settings, 33% supported a prohibition of tobacco advertising, and 44% thought restrictions might help smokers to stop. (For the other two groups these percentages were all higher.) In 1983 a British government survey found that 79% of 2667 smokers agreed that ‘people who don’t smoke should have the right to work in air free of tobacco smoke.’

In the RSA there is certainly some degree of awareness of the dangers of smoking, as evidenced by the existence of the measures mentioned earlier. Some of the credit for these measures belongs to organisations and individuals who have campaigned for them, for example the South African Medical Research Council, the National Cancer Association, the National Council on Smoking and Health of Southern Africa, and the Heart Foundation.

Recommendations

South Africa needs a comprehensive anti-smoking programme that will aim to prevent young people from starting to smoke, to protect the rights of non-smokers, and to help those who want to stop to do so. Legislation is an essential component of such programmes. As a start, the programme should include at least the following measures:

1. Cigarettes should be taxed by an extra 10%, with the additional revenue going to a National Health and Fitness Fund. This Fund could promote health and health education — for example, by paying for advertisements advocating non-smoking.

2. The sale of cigarettes to minors should be prohibited.

3. Prominent health warnings and contents labelling should appear on both cigarette packets and advertisements. Several different warnings should be used in rotation.

4. The rights of non-smokers should be protected and smokers who want to give up should be helped to do so. Here both the public and private sectors can play a valuable role — for example, employers can formulate non-smoking policies for the workplace, and medical aid schemes can cover the costs of smoking cessation programmes.

The WHO has declared 7 April 1988 as World No-Smoking Day, so 1988 would be an ideal time for such a programme to be launched. The Department of National Health and Population Development could ideally take the lead, with measures being introduced and implemented by local authorities around the country, and with private bodies and individuals promoting health education and non-smoking policies.

We thank Mrs J. Aalbers for helpful suggestions.

REFERENCES


