Legislative Action to Combat the World Smoking Epidemic

R. Roemer

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LEGISLATIVE ACTION TO COMBAT THE WORLD SMOKING EPIDEMIC

by

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With a Foreword by Sir George Godber

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The present study was conducted by Professor Ruth Roemer at the request of the World Health Organization, in view of the considerable interest expressed in smoking-control legislation by numerous Member States, particularly at the World Health Assembly. It represents the first WHO publication concerning the regulatory control of smoking that has been issued since the establishment, in May 1980, of WHO's Programme on Smoking and Health.

The opinions expressed in this study are those of the author and do not necessarily reflect the views of the World Health Organization.

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FOREWORD

Thirty years have passed since publication of the first firm evidence that smoking is the main cause of the epidemic of lung cancer in the industrialized world. In that time the epidemic has reached its height in those countries where smoking has been widespread longest, and we now know that lung cancer accounts for only some 40% of the lethal consequences of smoking. Early coronary thrombosis, chronic obstructive respiratory disease, and various less common complaints account for the remaining 60% of deaths, and cause even more cases of disability. In 1970 the World Health Assembly adopted by consensus its first anti-smoking resolution, sponsored by Uganda, the United Kingdom, and Uruguay, calling upon governments to act against what is the largest single avoidable cause of death in many industrialized countries and a threat to health in any country in which smoking becomes established.

The 30 years since the danger was first identified can be divided into three phases of almost equal length. In the first phase, the facts were widely published, but few people — and no governments — took serious action to limit smoking. At the same time the tobacco industry began to intensify tobacco promotion. The number of deaths from smoking-related disease in the United Kingdom (one of the most seriously affected countries) almost doubled in 10 years; only those physicians who knew and had heeded the facts had at this stage taken steps to reduce the harmful effects upon themselves. In the second phase, the 1960s, some governments began to give the problem serious attention, largely as a result of authoritative reports in various countries (notably by the Royal College of Physicians of London in 1962 and the United States Surgeon General in 1964) and the First World Conference on Smoking and Health held in New York in 1967. The higher socioeconomic groups in some industrialized countries were by now following the example set by physicians. However, the main effort was still being made through public education, supported by very little regulatory action. The rate of increase in cigarette consumption was briefly checked after each major health campaign, but the industry was quick to develop new means of promotion and could spend far more on these than was available to present the opposite view. Quite simply, the industry was ready to use any trick of promotion and salesmanship to maintain and increase its volume of sales, and would never acknowledge — at least publicly — the harm its products were doing to the health of the people.

Virtually all the serious statutory and regulatory measures to reduce exposure to tobacco smoke have been taken in the last decade. This report by Professor Roemer, opportunely commissioned by the World Health Organization, reviews the strategies of the different countries which have introduced legislation to curb promotion of tobacco products and to restrict smoking in public places. Professor Roemer also describes some of the

attempts to obtain voluntary restraint. Although the different laws and regulations are listed, the report is much more than a catalogue, for it examines in depth the methods used and their effectiveness. It has become obvious — and the report clearly shows this — that the tobacco industry will not merely resist smoking control measures but will use every available means, and in particular enormous financial resources, to counteract or neutralize any health-promotion activity which threatens its sales. Moreover, it has no compunction about opening up new markets for its products, especially in developing countries, which as a result are already beginning to experience the adverse consequences of smoking.

Professor Roemer's examination of how some countries — notably Bulgaria, Finland, France, Norway, and Sweden — have introduced systematic legal controls will be of great help to others which, in the fourth decade we have now entered, must surely follow suit and introduce their own controls. Successive World Health Assemblies, two WHO Expert Committees, and four World Conferences on Smoking and Health have stressed that such action is urgently necessary. Let one gross example suffice to justify this urgency. The United Kingdom has made increasing efforts over the years to obtain voluntary restriction by the industry and action by the public. Yet this effort has been so effectively frustrated by sales promotion that some three-quarters of a million people in the United Kingdom have died of smoking-related diseases since 1970, nearly 300 000 of them before normal retiring age. About 30% of all cancer deaths — almost one-third of a million — have been due to lung cancer, and at least 90% of those cases were caused by smoking. Governments therefore have a duty to restrict the promotion of tobacco products, to limit smoking in public, to protect the non-smoker from nuisance and harmful exposure, to educate the public — especially children — about the risks of smoking, and to see that exported national tobacco products are no more dangerous than those sold at home and are accompanied by equivalent warnings.

This report helps to fulfil part of WHO's duty to assist governments in formulating their own programme by reporting what others have found useful. It also shows the urgent need for cooperation between WHO and other agencies within the United Nations system in order to assist tobacco-producing countries in developing other uses for their land without damaging rural economies. It is imperative that national action should be mutually supportive and that WHO should use all its influence to secure an international programme such as that proposed some years ago by the Nordic Council for its Member States. This report will certainly be an important instrument to this end, and we are all in Professor Roemer's debt for the exhaustive study she has made.

Sir George Godber
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PREFACE

This study has been undertaken in an effort to assist governments and health officials, alarmed by the health and economic consequences of smoking in their countries, to develop effective legislation as part of a campaign to reduce morbidity and mortality from smoking-related diseases and, in general, to combat what has been described as the "smoking epidemic". More specifically, the study is designed:

— to update the first worldwide survey of anti-smoking legislation published by WHO in 1976;
— to communicate the experience of various countries with different types of anti-smoking legislation to other countries contemplating the introduction of such legislation;
— to present the reasons why certain types of smoking control measures were chosen;
— to comment on and evaluate, as far as possible, different legislative approaches; and
— to relate legislative activity to other strategies for combating the smoking epidemic and its consequences.

The study is based primarily on an examination of the legislative texts relating to smoking control in various countries throughout the world. In addition, the extensive literature that reports on research findings and describes smoking control programmes has been reviewed as far as possible.

The study is presented in three parts. Firstly, the background to legislation in this field is reviewed. Secondly, the legislation enacted is summarized according to 10 kinds of objective. Finally, the challenge to developing countries is outlined, and conclusions are drawn concerning experience with attempts to control smoking by means of legislation.

Because the focus of the study is on legislation, other components of comprehensive smoking control programmes are discussed only inasmuch as they relate to legislation. It is beyond the scope of this study to undertake an analysis of the full range of comprehensive smoking control programmes.

As part of the effort to communicate the experience of different countries with various legislative strategies, evaluations of legislation have been included where they are available. Much more information is needed, however, on which types of legislation are more effective, and which are less effective, in particular national settings.

1. BACKGROUND

Chapter I. The smoking epidemic and action by the World Health Organization

Nations of the world have set as their main social target the attainment of health for all the world's peoples by the year 2000... The International Conference on Primary Health Care, at Alma-Ata, USSR, declared that all governments should launch national strategies and plans of action to achieve this target... Governments have it within their power, today, to reduce drastically what is probably one of the largest preventable causes of death and ill-health. Action against smoking, involving as it does individual decision-making, supported by government action, can show the way for the reform of our health system from one based upon medical consumerism to one that fosters individual and collective responsibility for health protection.

— Dr H. Mahler, Director-General, WHO, at the Fourth World Conference on Smoking and Health, Stockholm, 1979

Recognizing that tobacco smoking is one of the serious health hazards of modern times and — what is even more tragic — an avoidable and unnecessary one, the World Health Organization has joined forces with national governments and voluntary organizations to alert the world to the health consequences of the smoking epidemic and to develop strategies to combat it.[1] The harmful effects of smoking are no longer questioned, except by the tobacco industry. Smoking increases the incidence of lung cancer and other cancers, cardiovascular diseases, bronchitis, emphysema, and asthma, and has other adverse effects on health.

National findings

The Royal College of Physicians of London has set forth in successive reports the overwhelming evidence on the harmful consequences of smoking.[2] It has calculated that the average loss of life for a person smoking 20 cigarettes a day is about five years. (Among British physicians 35 years of age and older, studied over a long period of time, more than twice as many smokers as non-smokers died before reaching age 65.) However, if a smoker stops smoking, the extra risk of death declines in about 10–15 years, so that his life expectancy becomes on a par with that of a non-smoker. Strong evidence led the Royal College of Physicians to state that "cigarette smoking is still as important a cause of death as were the epidemic diseases of the past".[3] Smoking is, in fact, an epidemic disease of the modern world.

The grim findings of the Royal College of Physicians are confirmed by the 1979 Report of the United States Surgeon General on Smoking and Health.[4] On the basis of an exhaustive review of worldwide scientific evidence, the report reaches the conclusion that overall mortality for all cigarette smokers is about 70% higher than for non-smokers. Life expectancy for a 30-year-old, two-pack-a-day smoker is eight years less than for a non-smoker of the same age. Mortality rates are higher among those who have smoked for longer periods, those who started smoking at a younger age, and those who smoke cigarettes with a higher tar and nicotine content. Ex-smokers, however, experience a decline in mortality rates, as noted above. There is recent evidence of adverse effects of smoking by pregnant women on the fetus and the newborn baby and of increased risk of ill-health for very young children in smoking families. The synergistic effect of cigarette smoking and exposure to toxic industrial agents is well documented. Literature has also appeared on the effects of involuntary or "passive" smoking (inhalation by non-smokers of sidestream smoke from the lighted tip of a cigarette between puffs as well as of exhaled mainstream smoke). In the words of Mr Joseph Califano, the then Secretary of Health, Education, and Welfare, the 1979 report "reveals, with dramatic clarity, that cigarette smoking is even more dangerous — indeed, far more dangerous — than was supposed in 1964",[5] when the first Surgeon General's Report on Smoking and Health was released.

Publication of the first report by the Royal College of Physicians of London in 1962 prompted a group of Swedish scientists to petition their Government to take action to control smoking. This petition led in 1963 to the first, and still probably the most comprehensive, smoking control programme in any country.

Epidemiological findings in other countries have turned attention to smoking and health. Finland's infant mortality rate is known to be one of the lowest in the world, but its high adult male mortality rate — the highest in Europe and strikingly different from those in other Nordic countries — has caused Finland to examine the reasons.[6] Finding that much of the excess mortality was due to smoking-related diseases, Finland in 1976 enacted comprehensive anti-smoking legislation and launched a vigorous campaign to tackle this preventable source of mortality.

Similarly, in France it has been calculated that as many as 60 000 deaths a year — including 18 500 cancer deaths, or 15% of all cancer deaths — are related to smoking.[7] Since France has approximately 500 000 deaths per year, this means that 11–12% of all deaths are linked to smoking — a finding that has triggered energetic control measures.

A particularly pressing cause for concern is the increase in tobacco production and consumption in the developing countries. According to FAO, tobacco production in the developing countries rose by 28% between 1969–71 and 1977, while in the developed countries it rose by only 15%.[8] World consumption of tobacco rose by about 3–4% annually during the decade 1965–1975; in 1975 and 1976 consumption slowed down in the developed countries, but continued to rise in the developing countries by about 5% per annum.[9]

Reports of the long-term health effects of tobacco use in developing countries, previously few and far between, are now beginning to appear more regularly.[10] A growing body of research conducted in India, Jamaica, Pakistan, Papua New Guinea, and Singapore has linked smoking to cancer of the lung, oral cavity, oesophagus, and to bronchitis and peptic ulcers, and points to it as a risk factor in cardiovascular diseases.[11] Even before this evidence was readily available, however, the writing on the wall was sufficiently clear to cause the WHO Expert Committee on Smoking Control to issue a warning in 1979 to the effect that if forceful government action was not taken promptly in developing countries, the smoking epidemic would spread there within the following decade, affecting their populations with the numerous smoking-related diseases before communicable diseases and malnutrition had been brought under adequate control.[12]

Action by WHO

Among the strategies devised for combating the smoking epidemic, with its tremendous toll in human suffering as well as its economic costs,[13] is regulatory action by governments to control and discourage smoking. In 1970, 1971, and 1976, the World Health Assembly adopted resolutions which laid the groundwork for the development of WHO's anti-smoking policy.[14] In 1974, WHO convened an Expert Committee which called for legislative action as a useful component of an overall anti-smoking campaign.[15] In 1976, a World Health Assembly resolution reiterated this call for legislative measures[16] and, in the same year, WHO published its pioneering survey of existing anti-smoking legislation.[17] In 1978, the Thirty-first World Health Assembly adopted a strong resolution on the health hazards of tobacco and ways to limit its use.[18] This resolution calls for the adoption of comprehensive measures to control tobacco smoking by, among other things, providing for increased taxation on the sale of cigarettes, restricting as far as possible all forms of publicity in favour of smoking, and protecting the right of non-smokers to breathe an atmosphere unpolluted by tobacco smoke. In 1979, the WHO Expert Committee on Smoking Control issued its landmark report, *Controlling the Smoking Epidemic.* When the Fourth World Conference on Smoking and Health met in Stockholm in 1979, the Director-General of WHO, Dr H. Mahler, called on every nation to meet the world challenge of stopping the smoking epidemic.[19] In 1980, the World Health Assembly adopted its strongest resolution to date on smoking control (reproduced in Annex 2); it was this resolution that led to the establishment of WHO's Programme on Smoking and Health.

Chapter II. The role and evolution of legislation to control smoking

... the solution to many of today's medical problems will not be found in the research laboratories of our hospitals, but in our Parliaments. For the prospective patient, the answer may not be cure by incision at the operating table, but prevention by decision at the Cabinet table.

— Sir George Young, Parliamentary Under Secretary of State for Health, Department of Health and Social Security, London, at the Fourth World Conference on Smoking and Health, Stockholm, 1979

The general purpose of anti-smoking legislation, as with all strategies in this field, is to prevent and reduce the burden of illness and early mortality, and the resulting enormous human suffering, that are due to smoking. A WHO Expert Committee divides restrictive action into primary prevention (protecting young people against the dangers of smoking and encouraging "symptom-free" smokers to stop), secondary prevention (encouraging high-risk smokers or smokers who are beginning to show disease symptoms to stop, and protecting non-smokers), and tertiary prevention (stopping smoking among persons already suffering from smoking-related diseases).[20]

It should be emphasized at the outset of this analysis that the enactment of legislation is a necessary but not a sufficient prerequisite for any campaign to combat smoking and smoking-related diseases to be effective. Legislation is essential as a means of establishing and promulgating public policy, enlisting the resources of all government departments (not merely of the health department), strengthening the activities of voluntary organizations, and contributing to the development of a non-smoking environment; but it is only one component in a comprehensive attack on the smoking epidemic, which includes preventive action, public education, assistance with smoking cessation, special activities for high-risk groups, and research on the biological and behavioural aspects of smoking. For these important components of an anti-smoking campaign, however, legislation can serve as a useful underpinning.

Specific purposes

More specifically, the purposes of anti-smoking legislation are:

— to reduce smoking by dissuading young people from beginning to smoke;

— to reduce smoking by encouraging all smokers to stop smoking, particularly the following high-priority groups: pregnant women,

parents of very young children, persons with medical problems (especially those with asthma, allergies, emphysema, bronchitis, and cardiac problems), workers exposed to industrial hazards, and individuals such as airline pilots and other public transport workers in whom the risk of sudden cardiac arrest as a result of smoking would present a danger to others;
— to protect the right of non-smokers to breathe clean air;
— to hasten the development of a public attitude that smoking is dangerous, unhealthy, and socially unacceptable, thus assisting the community to create an anti-smoking environment; and
— to provide the impetus for a comprehensive anti-smoking campaign.

The issue of law and liberty

Restrictive legislation inevitably raises the question of liberty, and one of the responses from the tobacco industry to legislation designed to control smoking is that it is an infringement of freedom of speech, freedom of the press, and freedom of choice (to smoke or not to smoke, or to choose another brand). This specious argument ignores the fundamental interest of governments in protecting public health. In all countries, the government has the power to intervene to protect the health of children, to preserve the quality of the environment, to regulate trade and commerce, and to promote public safety and welfare. To protect public health, governments traditionally have power, for example, to require chlorination of public water supplies or to regulate the production of drugs, even though these actions may infringe some individual rights. In the case of tobacco smoking, the evidence of much higher rates of lung cancer and other serious diseases in smokers than in non-smokers places an obligation upon governments to act to protect the public. The health of the population has to take precedence over the freedom of the tobacco industry to promote sales of what are known to be harmful products.

In the United States, enactment by Congress of the Federal Cigarette Labeling and Advertising Act of 1965 and the Public Health Cigarette Smoking Act of 1969 (requiring a warning to appear on cigarette packages and banning cigarette advertising on television and radio) is grounded in the Federal Government's power to regulate interstate (as distinguished from intrastate) commerce. The various "Clean Indoor Air Acts" passed by State legislatures in the United States, even though they entail some limitation of the freedom of the cigarette industry and of individuals who smoke,[21] are intended to keep the air clean for people to breathe and, if reasonably related to this purpose, represent a constitutionally valid exercise of the State's police power.[22]

Finland confronted this question of law and liberty directly. In enacting its comprehensive legislation (banning advertising and sales promotion of tobacco, controlling tar, nicotine, and carbon monoxide levels, requiring a health warning, prohibiting sales to persons under 16, limiting sales from vending machines, and prohibiting smoking in public places and public

transport facilities), the National Board of Health cogently explained the views of the Finnish Government on the issue of freedom as follows:

> The philosophy in our approach has been one of "rule-switching": instead of allowing smoking unless specifically forbidden the general rule now is that smoking in all public places is *prohibited unless specifically allowed* — and then it must be in separate areas provided for it. "No smoking" now prevails in nurseries, schools, hospitals and other health facilities, cinemas and theatres, and conference halls, and also in waiting rooms of such premises to which the public has free access.
>
> The provisions for no-smoking areas have been overwhelmingly welcomed even though they restrict individual liberty. The question of principle is, of course, whether individuals are free to cause harm or nuisance to other individuals, and the unequivocal answer in our country was "no". But these questions were never even raised in the Cabinet or in Parliament. This suggests that the time was long overdue for introducing such measures. There was, in fact, a profound debate in Parliament on the issues of freedom and constitutional liberties but on a quite separate issue, that of advertising and sales promotion. The Parliament's Select Committee on Constitution decided, after a thorough examination of the matter, that the constitutional liberties of free speech, freedom of the press, and freedom of expression are not jeopardized by restrictions on sales promotion or advertising, and that the restrictions can be looked on as normal legal regulation of business and trade, not requiring the complicated procedure of constitutional legislation. The original purpose of these constitutional liberties was to guarantee free criticism of the Government and authorities and not of the sales promotion of life-endangering substances.[23]

The reasoning of the Finnish Government may well serve as a precedent for other governments concerned with the protection of the health of their people. While no one proposes seriously that use of tobacco should be banned outright, restrictive measures to limit its use, to minimize the number of young people who take up smoking, to reduce its harmful components, and to protect the non-smoker are vital. In the view of the WHO Expert Committee on Smoking Control: "'Freedom' should be seen not as the freedom of the manufacturer to promote a known health hazard but rather as the freedom and ability of society to implement public health measures".[24]

Forms of governmental action

The vast majority of countries with smoking control programmes have found legislation to be crucial in establishing official policy. As of 1981, at least 57 countries have enacted some form of smoking control legislation. In at least some countries with a federal structure, such as Australia, Canada, and the USA, federal, State (or provincial), and local governments all have some jurisdiction over smoking control and even in some non-federated countries, where national legislation is the principal form of regulation, municipal authorities may pass by-laws, ordinances, etc. to control smoking.

Experience has shown that legislation places the authority of the government and all its departments behind the smoking control programme. It gives impetus to all the components of the programme and enhances the impact of other measures, such as school health education programmes.[25] Authorities on smoking control point out that legislation has four phases of