Community Research

Tobacco control legislation in India: Past and present

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Abstract

Beginning with the Cigarettes Act, 1975, a number of legislative strategies and programs to curb tobacco use have been implemented in India, with limited success. Currently, the Cigarettes and Other Tobacco Products Act, 2003, is designed to curb the use of tobacco in order to protect and promote public health. This review presents a critical appraisal of the current situation in its historical context.

Key words: Government, legislation, program, tobacco control

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Introduction

Of the 1.1 billion people who smoke worldwide, 182 million (16.6%) live in India. In 2004, in an estimated population of 1065 million, 800,000–900,000 Indians die annually from diseases associated with tobacco use—some 2500 a day.[1] By 2020, it is predicted that tobacco will account for 13% of all deaths in India.[2]

These numbers will be dwarfed if present trends in tobacco use continue. India needs to adopt a more holistic and coercive approach to fight the problems of tobacco.

Tobacco control legislation in India dates back to 1975, when the Cigarettes (Regulation of Production, Supply, and Distribution) Act, 1975[3] required the display of statutory health warnings on advertisements, cartons, and cigarette packages. The Act also contained specific restrictions for trading and commercialization practices regarding the production, supply, and distribution of tobacco. The Act set penalties, including the confiscation of tobacco in the event of its provisions being breached. However, the Act had major limitations as it did not include noncigarette tobacco products, such as beedis, gutka, cigars, and cheroots. The language, style, and type of lettering, and the manner of presentation of the warning were meticulously described. Legislated by the Government of India, under the aegis of the Ministry of Commerce, the Act empowered the Central Government to intervene in marketing, monitoring, and development of the tobacco industry. However, the Act supported and favored tobacco production and trade because tobacco was considered a major source of public revenue.

The Act had provisions to contain the liberal use of tobacco. The Act made mandatory the registration of growers of Virginia tobacco.

The Cigarettes and Other Tobacco Products (prohibition of advertisement and regulation of trade and commerce, production, supply, and distribution) Bill, 2003, was a more comprehensive description for the control of tobacco as stated: "A bill to prohibit the advertisement of, and to provide for the regulation of trade and commerce in, and production, supply and distribution of, cigarettes and other tobacco products and for matters connected therewith or incidental thereto." This new legislation was explicitly intended to reduce tobacco consumption, in contrast to the Tobacco Board Act, which had favored tobacco production.

Pressure for stronger action and comprehensive legislation

India is the world's third largest producer of tobacco. In India, tobacco is believed to provide livelihood to over 6 million farmers and 20 million industry workers and contributes over 70 billion rupees (£1bn; $1.5bn)

to government earnings. The Indian Council of Medical Research (ICMR) argued, however, that the health care costs of tobacco use to India far outweighed the economic benefits. In the year 2000, the Council estimated that the annual cost of diseases associated with the use of tobacco was 270 billion rupees. This clearly states that the income is only 25.9% of the expenditure on health care due to tobacco use. The council further predicts that the health costs of tobacco to India will increase unless any further rise in tobacco consumption is stopped.

The ICMR conducted a study, choosing samples from 2 Indian locations—195 patients in Delhi and 500 patients in Chandigarh, which provided a conservative estimate of the cost of treatment of 3 major tobacco-related diseases (cancer, heart disease, and chronic obstructive pulmonary disease).[4] Data were collected on treatment expenditures (medical and nonmedical), institutional expenditures, and loss of wages during treatment for 1990–1992, or until death or recovery. Using consumer price Index, the Council estimated that in 1999 alone, the total annual direct and indirect cost of cancers, heart disease, and chronic obstructive lung disease associated with the use of tobacco would be 277.6 billion rupees (US$6.0bn). During the same year, the nationwide sales revenue from all tobacco products would amount to 44 billion rupees. The gap between revenue from sales and expenditure for treating tobacco-related diseases was particularly high because only a small fraction of earnings from the net sales was going to the government. The results strongly supported the argument that tobacco was of no real economic benefit to the nation, while being a major health hazard.[5-7] Similarly, another estimate of costs for 2002–2003 for the 3 major tobacco-related diseases amounts to 308.33 billion rupees (US$ 6.6bn.).[1]

In 2003, the central and state governments acted on a number of areas of concern to strengthen the legislative provisions for tobacco control. This included better quantification of health risks posed by tobacco, increasing knowledge of diseases linked to tobacco use, increased global awareness regarding the harmful effects of tobacco, and increased scientific evidence of tobacco as a cause of mortality.

Background to the Indian tobacco control legislation of 2003

In 1993, the Central Cabinet expressed plans to introduce a comprehensive legislation that would cover all regulations for tobacco products and the activities related to their utilization and trade.

A parliamentary committee was set up to examine the provisions of the Cigarettes Act, 1975. As a result, in December 1995, the 22nd Report of the Parliamentary Committee on Subordinate Legislation of the 10th Lok Sabha presented a series of recommendations for achieving better tobacco control. The Committee proposed that the statutory health warnings on cigarette packages should use strongly worded language and be made more effective by the use of pictorial images. The warnings were to be extended to include beedis, cigars, gutka, snuff, or any other products of tobacco, whether produced in India or imported. In addition, the warnings were to be displayed at outlets selling tobacco in any form. The Committee recommended a total ban on any form of advertisements, sponsorships, smoking in public places and transport systems, and sale of tobacco to individuals younger than 18 years. The government was called on to implement strict penalties for contravening the regulations. Due emphasis was given to the requirement for research into developing alternative crops and to allocating resources for the retraining of workers engaged in tobacco industry for employment in other sectors, by opening avenues for alternative employment.[8]

In 1995, the Central Government formed a Coordination Committee with representatives from the Central Ministries of Commerce, Agriculture, Labor, Information and Broadcasting, the Indian Council of Medical Research, and the National Council of Educational Research and Training. All the representatives, with the exception of the Ministry of Labor, supported the proposition that the economic consequences of exercising tobacco control could be effectively managed.

Following this, later in 1995, the Central Ministry of Health appointed an Expert Committee to study the Economics of Tobacco Use. The Committee investigated the economic status and the consequences of tobacco use and trade. In February 2002, it presented its findings, which concluded that the use of tobacco had many short- and long-term consequences and that the economic burden of diseases associated with tobacco use clearly outweighed the indirect macroeconomic benefits of tobacco use and trade. It identified tobacco as a demerit commodity.[9] The losses were enormous when factors, such as the use of expensive tertiary-level medical facilities involving even imported equipment for the treatment of tobacco-related diseases, losses due to fire hazards, ecological damage due to deforestation, and disposal of tobacco-related waste are compared against factors, such as tax revenue, foreign exchange, employment, and consumer expenditure due to use of tobacco.

Meanwhile, accepting the suggestions of the 1995 Parliamentary Committee on Subordinate Legislation, the Ministry of Health and Family Welfare introduced the Tobacco Control Bill in the Rajya Sabha in 2001 (Bill No. XXIX-F of 2001).[10]

"A Bill to prohibit the advertisement of, and to provide for the regulation of trade and commerce in, and production, supply and distribution of, cigarettes and other tobacco products and for matters connected therewith or incidental thereto."

The Bill declared that the tobacco industry be controlled by the Center stating,

"It is hereby declared that it is expedient in the public interest that the Union should take under its control the tobacco industry."

The Committee declared that the Parliament could legislate on tobacco products other than cigarettes and that the Bill should apply to the whole of India. It made pictorial depictions of health warnings mandatory and required nicotine and tar contents and their maximum permissible limits to be printed on cartons and packages of all tobacco products. Sale of tobacco products must be banned within 500 yards (457.2 m) of educational institutions. The Committee also recommended that special smoking areas be provided in hotels, restaurants and airports and that penalties for noncompliant producers, dealers, and sellers of tobacco products be standardized across the country[11,12] The Central Cabinet further proposed a ban on tobacco products within 100 yards (not 500 yards) (91.44 m) of educational institutions. It was proposed that the bill may be supported to evolve into an Act as follows:—"This Act may be called the Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003."

The proposed Bill eventually became an Act of Parliament on May 18, 2003.

The National Human Rights Commission of India (NHRC) in collaboration with the Government of India and the WHO had in the meantime convened a South-East Asia Regional Consultation on "Public Health and Human Rights" at New Delhi in 2001. In addition to the right to health and the right to clean air, it recognized the rights of citizens to programs/facilities to encourage tobacco control. The Commission recommended that the right of the people to access accurate information about the effects of tobacco consumption must be promoted through programs of information, education and communication. It called upon the medical, scientific and legal sectors to collaboratively form a national level nodal agency for the comprehensive control of tobacco.[13] There have been several instances of the tobacco industry opposing basic consumer rights—the right to information, the right to safe products, and the right to compensation and redressal for losses from the use of its products.

The industry has been focusing attention on loss of personal freedom, excessive governmental power, use of social coercion, or the rights of smokers. This has led to resistance to tobacco limitation efforts and has confused tobacco control supporters.[14] In addition, the industry has tried to project the efforts of tobacco control being made by the government as a threat to its marketing freedom.[15] The industry has utilized the process of liberalization in removing government restrictions on cross border commerce through trade agreements. This has supported the growth of the industry. It is thus good to have increased national level activity to control tobacco use, rather than actively encouraging restrictions on trade.[16] The tobacco industry has expanded its efforts to oppose tobacco control media campaigns through litigation strategies. Although litigation is a part of tobacco industry business, it imposes a financial burden and is an impediment to media campaigns' productivity. Tobacco control professionals need to anticipate these challenges and be prepared to defend against them.[17]

In November 2001, the Supreme Court of India delivered a judgment that prohibited smoking in public places throughout the country, thereby protecting the rights and health of those exposed to the risk of becoming passive smokers.[18]

Regulatory actions of the Indian government

The Central Government amended existing legislation to enforce stronger controls on the use of tobacco. For example, the Prevention of Food Adulteration Act, 1955, treated chewable forms of tobacco, such as zarda as a food item.[19] The act states that "tobacco whether an article of food—in order to be 'food' for the purpose of the Act, an article need not be fit for human consumption since tobacco is used for human consumption, it will be food keeping this test in view."

Changes were implemented to ensure that a mandatory health warning was given with these products. The act clearly stated that

"Every package of chewing tobacco shall bear the following label, namely,

'Chewing of tobacco is injurious to health.'"

In 1990, the Central Government issued an Executive Order prohibiting smoking in select enclosed public places where large numbers of people could be expected to be present over long periods of time. These places included educational institutions, conference halls, planes, trains, and buses, and each location was required to display bill boards indicating that smoking was strictly prohibited. No ashtrays were allowed in these places and the sale of cigarettes was banned here.[20]

In December 1991, the Central Government amended the Cinematograph Act, 1952, to ban scenes that endorse or promote the consumption of tobacco in any form.[21]

In 1992, the Central Government amended the Drugs and Cosmetics Act, 1940, and thereby banned the manufacture and use of toothpastes and toothpowders containing tobacco.[22]

In September 2000, amendments to the Cable Television Networks (Regulation) Act, 1994, banned any direct or indirect advertisements related to the use or trade of tobacco on cable television, and introduced penalties of imprisonment or fines for offenders.[23]

On World No Tobacco Day 2005, the Ministry of Health announced that the depiction of any form of tobacco use in films and television serials would be banned. The notification also stated that Indian films made before that date, along with foreign films exhibited in India, would have to incorporate scrolled health warnings in scenes where tobacco use was shown. The ban was due to be brought into effect from August 1, 2005; however, opposition from the media and film industries led to consultation with the Ministry of Information and Broadcasting and delayed implementation until October 2, 2005.[24]

In addition, any advertisements related to tobacco were prohibited on national television and on All India Radio. Also, the sale of tobacco was banned around educational institutions.

On October 2, 2008, to commemorate Mahatma Gandhi's birthday, the government imposed a ban on smoking in public places, offices, restaurants, bars, and open streets. This was a gesture to protect the rights of the nonsmokers and safeguard them from passive smoking. A fine of 200 rupees (US$4.50) was imposed for contravening this regulation.

This was clearly stated as follows:

"For the first few days, smokers caught flouting the ban will be given a warning; thereafter they will be fined 200 rupees (approximately US$4.5), more than the average person's daily wage."

This law needs quick and strict implementation.[25-28] It should be strictly implemented with due care that it is not flouted and every citizen should be motivated to participate and help others participate in the implementation. Such practices have been adopted in Chandigarh, which was declared the first city to be smoke free in 2007.

Legislative and regulatory actions of the states

Any legislative steps taken to intervene in practices of tobacco use are bound to trigger protests. A recent example is the ruling of Delhi High Court (January 23, 2009) quashing the government's notification to ban smoking in films on grounds that it violates the fundamental rights of freedom of speech and expression of filmmakers. This was a reaction to the ban imposed by the Union Ministry of Health and Family welfare in May 2005, which was subsequently challenged by the film industry in September 2005. The High Court order has since been challenged in the Supreme Court in April 2009. Forming and reforming of legislative judgments should be always focused on a common goal.

In India, health legislation has been historically and practically enacted at the state level. National legislation has been reserved for major issues requiring country-wide uniformity.[29] Tobacco control is a comprehensive program relying on the collaborative efforts of both the Central Government and the states. The implementation of the National Tobacco Control Law, 2003, at state level is the responsibility of the State Governments. Some states have formulated independent legislations to address specific components of tobacco control strategy, as outlined below.

The Delhi government was the first to impose a ban on smoking in public places, with the Delhi Prohibition of Smoking and Nonsmokers Health Protection Act, 1996.[30] In addition to prohibiting the sale of cigarettes to minors and prohibiting sale 100 m from a school building, this law allowed for enforcement in public places and public transport by police and medical professionals. A first time offender is fined 100 rupees (US$2.40) on the spot and briefed by the police or medical officer about the law and the negative health consequences of tobacco use. As expected, it has been difficult to enforce this ambitious program, and it has probably had little real impact—the key problem being lack of manpower to enforce the law.[31,32]

Other states have enacted bans on public smoking. For example, in 1999 the Kerala High Court's judgment, The Kerala Prohibition of Smoking and Protection of NonSmokers Health Bill, 2002, prohibited smoking in public places, including parks and highways.[33,34]

The states of Tamil Nadu, Andhra Pradesh, Maharashtra, Goa, and Bihar have banned the use of smokeless forms of tobacco, such as gutka and pan masala.

The state of Tamil Nadu has undertaken notable anti-tobacco activities. In 2001, even before the Cigarettes and Other Tobacco Products Act was passed, it banned the sale of all forms of chewable tobacco. Following this, the Tamil Nadu Prohibition of Smoking and Spitting Act, 2003, was introduced.[35] The Act has provisions for display of warnings as stated:

"Every person in charge of a place of Public work or use shall display and exhibit a board at a conspicuous place in or outside the place prominently stating that the place is a 'No Smoking and No Spitting place' and that 'Smoking or Spitting is an Offence' which shall be both in Tamil and English and the version in English shall be in the second place below the Tamil Version."

Further, the Act has provisions for inspections and subsequent actions as stated below:
"Any authorized officer may enter and inspect at any time if he has reason to believe that any person is in possession of Cigarettes, Beedis, Cigars, Supari with tobacco, Zarda, Snuff or any other smoking or chewing substance or substances for sale or distribution in any premises, which is within an area of 100m around any College, School or any other educational institutions and may search and seize the articles or other substances under a seizure list as specified in Form A."

The state has shown great concern for the welfare and well-being of such workers by making provisions for the social security, health insurance, and other schemes. The same has been supported by the Central Government through the Ministry of Labour and Employment in the "The Beedi Workers Welfare Fund Act (1976)." The Government has also introduced a number of housing schemes for beedi workers.

The Goa Prohibition of Smoking and Spitting Bill Act, 1997, is one of its kind in the country. The Act bans smoking or chewing tobacco, and also bans public spitting, which means "voluntary ejection of saliva from the mouth after chewing or without chewing and ejection of mucus from the nose after inhaling snuff or without inhaling."

The Act has been described as "A bill to provide for prohibiting smoking and spitting in places of public work or use and in public service vehicles in the State of Goa and to make provision for other matters connected therewith."

The bill clearly prohibits smoking and spitting in places of public work or use as stated:
"No person shall smoke or spit in any place of public work or use."

The Goan Act also bans tobacco advertising in the form of writing instruments, stickers, symbols, colors, logos, trademarks, and prohibits display on T-shirts, shoes, sportswear, caps, carry bags, and telephone booths.[36]

A ruling of the Delhi High Court in January 2009 lifted the ban on smoking scenes in movies on the grounds that such a ban contravened rights of expression. This move sends a loud and clear message that a blanket ban does not remove tobacco from people's awareness.

Legislative reforms at state level refine the methodology for addressing the problem of tobacco use.[36]

Legislation forms the core of any tobacco control activity. It helps integrate the disparate actions taken for tobacco control and subjugate any the challenges faced for the same. Legislation serves specific social objectives. It helps to raise, recognize, reinforce, reassess, reach, and reconcile the solemn societal values. Secondly, the enactment and implementation practices help raise public awareness by serving as a presage of the hazards associated with tobacco.

Two and a half thousand Indians die every day from smoking-related diseases—one every 40 s. Each cigarette is said to decrease the life span of the average smoker by 5.5 min. This highlights the need for prompt and dynamic interventional strategies. As the only country where single cigarettes can be bought, India needs to adopt a more holistic and coercive approach to fight the problems of tobacco. Not only the government, but all responsible citizens will need to support the fight against this global epidemic.

In the future it is imperative to impose a ban on oral tobacco products, strengthen enforcement of existing regulations, establish coordinating mechanisms at the levels of center and state and mobilize people to combat the problem. Taxes on tobacco products should be raised and the generated revenue could be spent for the strengthening of the tobacco control program.

Multipronged approaches should be undertaken for the cessation of use of tobacco.

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