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Tobacco Control in South Africa: Next Steps

Minister of Health Dr. Nkosazana Zuma provided crucial early leadership for tobacco control legislation in South Africa. Her efforts included excise taxes increases, development of local research capacity, and amendments to strengthen the Tobacco Products Control Act of 1993. Supported by local NGOs, research groups, and the South African Ministries of Health and Finance, this multi-pronged approach led to further decreases in smoking prevalence in South Africa and gained recognition for South Africa as a global leader in tobacco control. Zuma's success also laid the groundwork for continued progress in tobacco control beyond her tenure as Minister of Health.

Expanding Research Capacity

Research produced by Dr. Derek Yach and colleagues at the South African Medical Research Council (MRC) had been instrumental in gaining political support for tobacco control in the early 1990s. Building on their previous research success, in 1996 the MRC and the University of Cape Town partnered to form the Economics of Tobacco Control project (ETC). The project was funded largely by the Research for International Tobacco Control (RITC), a Canadian organization focused on building research capacity in developing countries.¹

The ETC produced several important findings that supported the tobacco control movement. The group modeled the lost government revenue during the 1970s and 1980s when cigarette taxes were low. It demonstrated that government revenues were higher with the increased excise tax (see **Exhibit 1** for graph showing real cigarette excise taxes compared to real government revenue)^{2,3} and that additional increases in excise tax would continue to increase state earnings even with reduced consumption. As Dr. Olalekan Ayo-Yusuf, a South African tobacco control researcher, stated:

Making a case for tax increases was imperative for tobacco control to move forward, especially for a government that needed money for social development. So making a case that you could get more money for your social development agenda by taxing tobacco, which is something that's not going to hurt anyone but the smokers if at all, and you can create better health for all, so it made sense. The two agendas met, melted into

Asaf Bitton, Laura Taranto, Julie Rosenberg, and Einat Kadar prepared this case for the purposes of classroom discussion rather than to illustrate either effective or ineffective health care delivery practice.

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one thing... Tobacco control is one ideal situation; it is a health-related legislation with interests that cut across government departments, so building an argument of economics was imperative to get buy-in across departments.

The ETC's work provided substantive evidence discrediting the tobacco industry's assertion that high taxes would decrease consumption, thereby decreasing government tax revenues, and lead to cigarette smuggling.

The ETC also showed that decreased tobacco consumption would enable consumers to spend their money in other areas, creating jobs in those industries that would make up for jobs lost in the tobacco sector.⁴ In 1995 smokers spent approximately USD 507 million on tobacco products; the ETC estimated that between 9,000 and 50,000 new jobs would have been created if smokers spent their money elsewhere.⁵ The ETC publicized its findings widely in South Africa and beyond, offering an important counterweight to tobacco industry arguments against Zuma's initiatives.^{1,4} Connections with local policy makers in the Departments of Health and Finance enabled the research to have a direct effect on policy.

As the ETC was generating local data, the World Bank was doing similar research on a global scale. It published research showing that tobacco control would not have negative economic effects in *Curbing the Epidemic*,⁶ a landmark report based in part on South Africa's pioneering tobacco control research and experience.⁶ The ETC and the World Bank partnered to disseminate their research at an international conference held in Cape Town, *The Economics of Tobacco Control: Towards an Optimal Policy Mix*, in 1998. Their work ameliorated widespread fears among governments that tobacco control would cause economic loss.⁶

Excise Tax Increase

After years of advocacy by Zuma and the South African tobacco control movement, the Ministry of Finance arrived at an important milestone in 1997: tobacco taxes reached 50% of the retail price of cigarettes, a goal Zuma had set as early as 1994.¹ Though not as aggressively as the Ministry of Health wanted, the Ministry of Finance continued to make tax increases through 2008 to keep pace with inflation and maintain the 50% tax rate (see **Exhibit 2** for graph showing relationship between taxes and consumption).¹ Tax changes did not require legislative approval, so pro- and anti-tobacco groups fought intensely on an annual basis for influence over the tax rates.

As tax rates rose, tobacco companies increased the price of cigarettes to recoup lost earnings; they hoped this move would make the tax increase seem more onerous so and stimulate backlash against the government's policies.¹ Between 1993 and 1999, the real price of cigarettes increased by 85% due to excise taxes and cigarette price increases.¹ This increase spurred continued decreases in tobacco consumption among the price-conscious public.

However, despite successful and hard won tax increases, tax as a percentage of the price of cigarettes in South Africa was still low in comparison with many developed nations.³

National Legislation

After reaching their tax rate goal, the Ministry of Health and its tobacco control allies worked hard to pass the Tobacco Products Control Amendment Act of 1999, a more comprehensive legislation to strengthen and close loopholes in the Tobacco Products Control Act of 1993.² Ayo-Yusuf explained the significance of the legislation:

We needed to set an environment that is conducive for all other tobacco control initiatives to work and that's why tobacco control [advocates] stayed with legislation.... If we do not have an environment that's conducive,

your school programs would not work, your cessation programs would not work, the government won't put any money into it.... Debates around legislation actually also create lots of awareness across government departments and in the public.

Key components of the 1999 Act included:

- ◆ A ban on free tobacco product distribution, including gifts and prizes
- ◆ Authority for the Minister of Health to set maximum tar and nicotine levels in tobacco products
- ◆ Stricter regulations on advertising, outlawing any visual, written, or audible messages promoting smoking including tobacco brand names and logos
- ◆ Expansion of clean indoor air provisions to include workplaces
- ◆ Increased fines for violations of tobacco regulations

The tobacco industry adamantly opposed the bill. With its passage the industry could no longer advertise at or sponsor sporting events. Tobacco companies had exploited this large advertising loophole under the previous law.⁴ Additionally, the clean indoor air stipulations represented a major shift in the rights paradigm: smokers would no longer have the right to smoke in public; instead, non-smokers would have the right to clean air.¹

The public hearings for the bill were well attended by representatives from both sides; over 80 groups applied to give testimony.⁴ The cabinet of President Mandela unanimously supported the bill. The prevailing arguments in favor of it were: (1) tobacco was a major cause of preventable illness and death, (2) public places should be smoke-free, and (3) advertising glamorized smoking and did not provide accurate information.

Zuma pushed the bill through the legislative process, earning herself the nickname, "The Zuma Bulldozer."⁴ In response to the hospitality industry's strong lobbying efforts, the government conceded to allow 25% of restaurant floor spaces, representing the 25% of South Africans who were smokers, to be smoking areas, provided that these spaces were well ventilated and separated by a partition. In 1999 the bill passed successfully, and regulations were promulgated in 2000 to go into effect in 2001 (see **Exhibit 3** for tobacco control timeline in South Africa).²

Tobacco Control 1999 – 2009

In June of 1999, Zuma transitioned into a new position as Minister of Foreign Affairs, and Dr. Manto Tshabalala-Msimang succeeded her. Zuma ended her tenure as Minister of Health on a high note, receiving the World Health Organization's (WHO) Tobacco Free World Award in May of 1999. WHO Director-General Dr. Gro Harlem Brundtland noted that South Africa was a global role model for tobacco control⁷ and presented Zuma with her award saying, "We congratulate you on your work—you have strengthened our hands and given hope to many countries."⁸

Tobacco control's momentum changed with the end of Zuma's tenure. Ayo-Yusuf explained, "The public health agenda changed to HIV/AIDS ... [Tobacco] was always there, but there was a greater focus on HIV/AIDS... [O]f course, the tobacco industry sees the opportunity and says, 'We've got more serious problems than tobacco.'.... MDR-TB became a problem in South Africa and then XDR-TB, but no one said, 'Tobacco control has to be part of the holistic response.'"

South Africa's experiences with tobacco control had international influence. After his pioneering work in South Africa, Yach brought his expertise to WHO where Director General Brundtland had made tobacco a top priority. In 1999 with Yach's help, WHO member states began composing the WHO Framework Convention on Tobacco Control (FCTC), the world's first public health treaty designed to address the global tobacco epidemic. Despite significant opposition from tobacco companies and an arduous, multi-year process of formulating the guidelines, the World Health Assembly adopted the FCTC in 2003. It went into effect in 2005; 165 out of 192 Member States, including South Africa, ratified the treaty over the next four years.⁹

The FCTC treaty gave governments a framework for quickly passing and implementing evidence-based tobacco control laws, many of which were based on the South African experience. It called for sharp tax increases; meaningful protection from secondhand smoke exposure; large, graphic health warnings on tobacco product labels; a complete ban on all tobacco advertising and promotion; treatment to help users quit; and, comprehensive public health campaigns to inform the public of tobacco-related health risks and prevent smoking.⁹ The FCTC enabled strong tobacco control internationally, especially in low- and middle-income countries, and created a forum for collaboration. WHO later expanded the reach of the FCTC guidelines further with the MPOWER strategy (see **Exhibit 4** for strategy).

Though South Africa ratified the treaty, updating its policy to align with the FCTC recommendations proved to be a struggle in the absence of Zuma's leadership. A 2006 bill to conform the South African Tobacco Control Act to the FCTC regulations was tabled due to strong tobacco industry opposition. The main controversial points included a change in the definition of "tobacco products" to include tobacco paraphernalia (pipes, rolling papers, etc.); an expansion of clean indoor air provisions to prohibit smoking near windows, ventilation systems, or entryways; and a substantial increase in fines for breaking regulations.¹⁰

Eventually, with support from the Ministry of Health and persistent lobbying by effective civil society groups such as the National Council Against Smoking, the legislature passed the Tobacco Products Control Amendment Act of 2008 to bring current policy into alignment with the FCTC guidelines. The amendments included:

- ◆ Mandating content disclosure and regulating tobacco products manufacturing standards
- ◆ Stronger restriction of tobacco sponsorship and promotion, including a product placement ban at points of sale
- ◆ Outlawing misleading messages on tobacco product packaging
- ◆ Increased legal age for purchasing tobacco products from 16 to 18
- ◆ More extensive health warnings to be displayed at points of sale

Even though tobacco control policy during the 2000s had not progressed as dramatically under Tshabalala-Msimang as in the 1990s, South Africa was still seen as a leader in tobacco control, especially in the developing world.

Results

Under Zuma's leadership, smoking prevalence among adults fell from 32% in 1993 to 27% in 2000 (see **Exhibit 5** for prevalence by year).¹ The decreased consumption during this time period occurred primarily within specific groups: youths (24% to 19%), low-income earners (31% to 25%), Blacks (28% to 23%), and males (51% to 44%) (see **Exhibit 6** for prevalence by race, age, and gender).¹¹ In 2000 prevalence rates for

Whites and high income earners were 36% and 32%, respectively, and had not changed significantly since 1993.³ The rate for females remained constant at around 12%.¹ After Zuma's tenure, smoking prevalence continued to fall despite the lack of significant policy changes until 2008; in 2005 prevalence among adults was 18.4%; 27.5% for males and 9.1% for females.¹² There was optimism that the 2008 Tobacco Products Control Amendment would spur further decreases.

The consensus among most tobacco control researchers and advocates was that South Africa's tax increases had been the single most effective tobacco control measure: every 10% increase in the price of cigarettes resulted in a 5% to 7% decrease in cigarette consumption.³ The tobacco industry argued that the regressive nature of the taxes was placing an unfair burden on the poor. While this was an area of concern for the government, decreased consumption and eventual cessation among low-income earners lowered their overall tax burden.¹

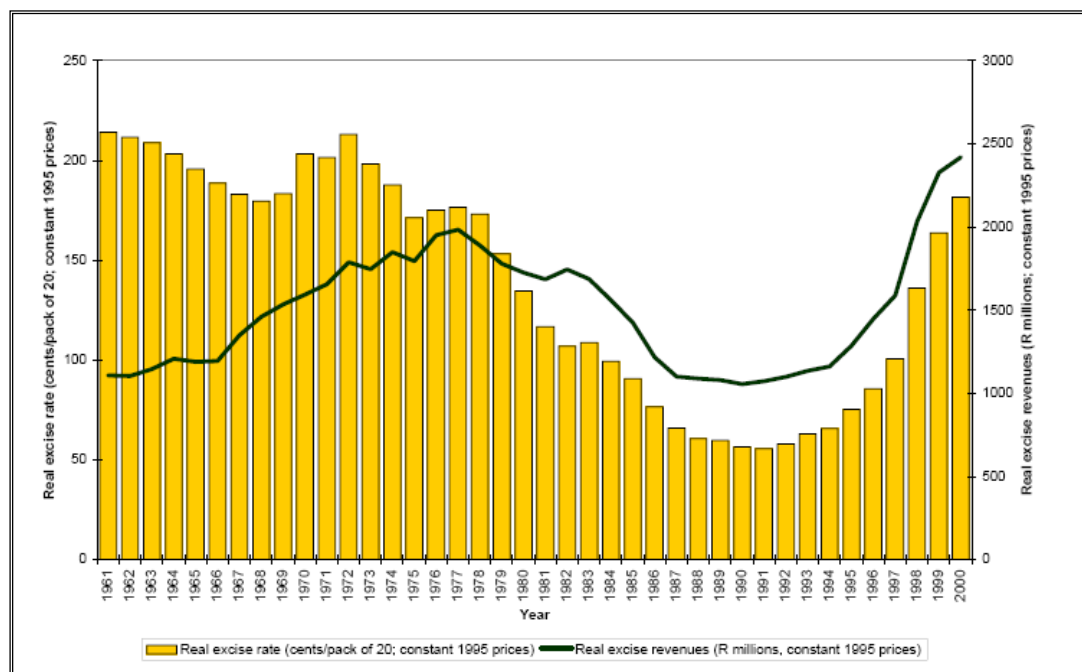
The media coverage of both the 1993 and the 1999 legislation and the public information campaigns were thought to have had a positive impact on tobacco control, highlighting the health concerns associated with smoking and giving tobacco control a public spotlight.¹³ The clean indoor air provisions in the Tobacco Products Control Amendment Act of 1999 increased the percent of restaurants with smoke-free spaces from 53% to 89%.¹⁴ Surveys in 2007 showed that most restaurant owners supported the clean indoor air laws and did not lose revenue after their passage.¹⁴ Research from the early 2000s showed the lack of efficacy that separate smoking areas had for reducing secondhand smoke exposure, which was a cause for concern that had not yet been addressed by the South African tobacco control policy.¹⁵

Despite successes, tobacco remained a significant cause of preventable death in South Africa. In 2000 cigarette consumption caused 8% of deaths.¹⁶ The main causes of tobacco-attributable death in order of prevalence were cardiovascular disease, chronic pulmonary disease, lung cancer, and pulmonary tuberculosis (see **Exhibit 7** for graph of tobacco attributable deaths by disease and gender).¹⁷ Colored men suffered disproportionately from tobacco-attributable death (see **Exhibit 8** for tobacco-attributable mortality by race and gender).¹⁷ In the 1990s the MRC estimated that the costs of medical care and reduced productivity caused by tobacco use amounted to twice as much as the taxes paid by the tobacco industry, though up-to-date research on the exact costs of smoking-attributable illness did not exist.⁵ Ayo-Yusuf explained that 25% of TB deaths could be prevented if smoking were eliminated. He said:

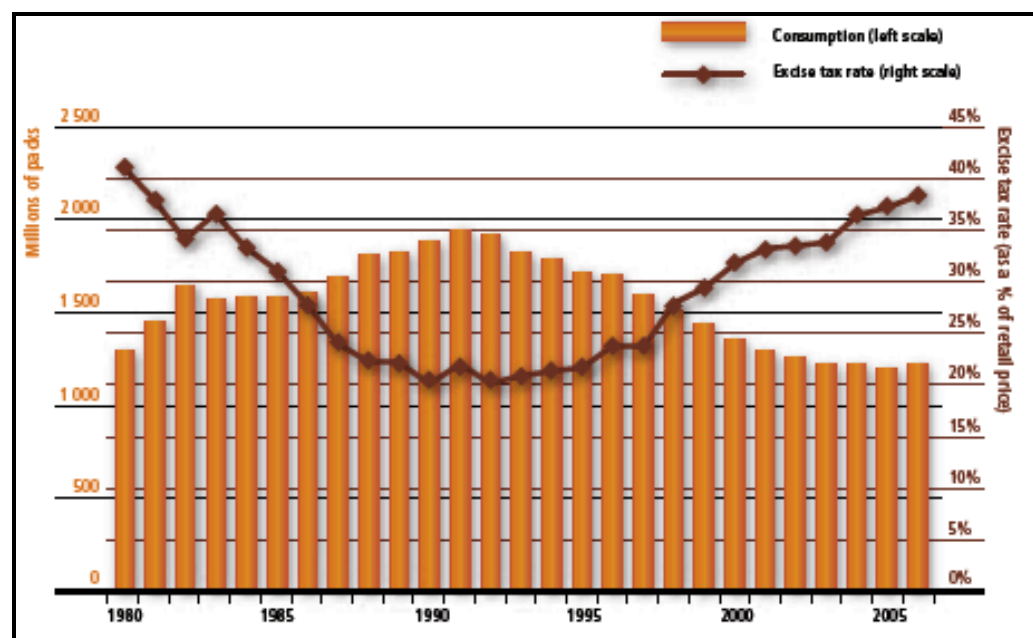
TB is what the government understands as a big problem, which obviously goes together with HIV. So looking forward, if we don't control smoking, we would have big problems with our HIV and TB control.... Evidence has also shown that smoking increases HIV infection, but the state has not been able to connect all of this together and give smoking the priority it deserves within the public health priorities of HIV and TB control.

Nonetheless, Zuma, Tshabalala-Msimang, the Ministries of Health and Finance, civil society, and research organizations' commitment to tobacco control empowered South Africa to take a strong stand against the tobacco industry. The next challenge that the nation faced was keeping momentum for tobacco control and creating new ways to combat a strong industry. Ayo-Yusuf highlighted this and expanded in saying:

The tobacco industry is very big. People always underestimate their influence. It's so subtle, and they're very clever and crafty people. In retrospect, it's clear that the industry always knows in advance what's coming next but advocates usually know industry's strategies only after the event. ...We need to start doing some scenario-building, trying to anticipate what next step they will take, instead of reacting...The lesson in tobacco control, is that it's not yet finished. It's not like the work is done. It's a continuous work. Because the industry never stops reinventing itself or its strategies.

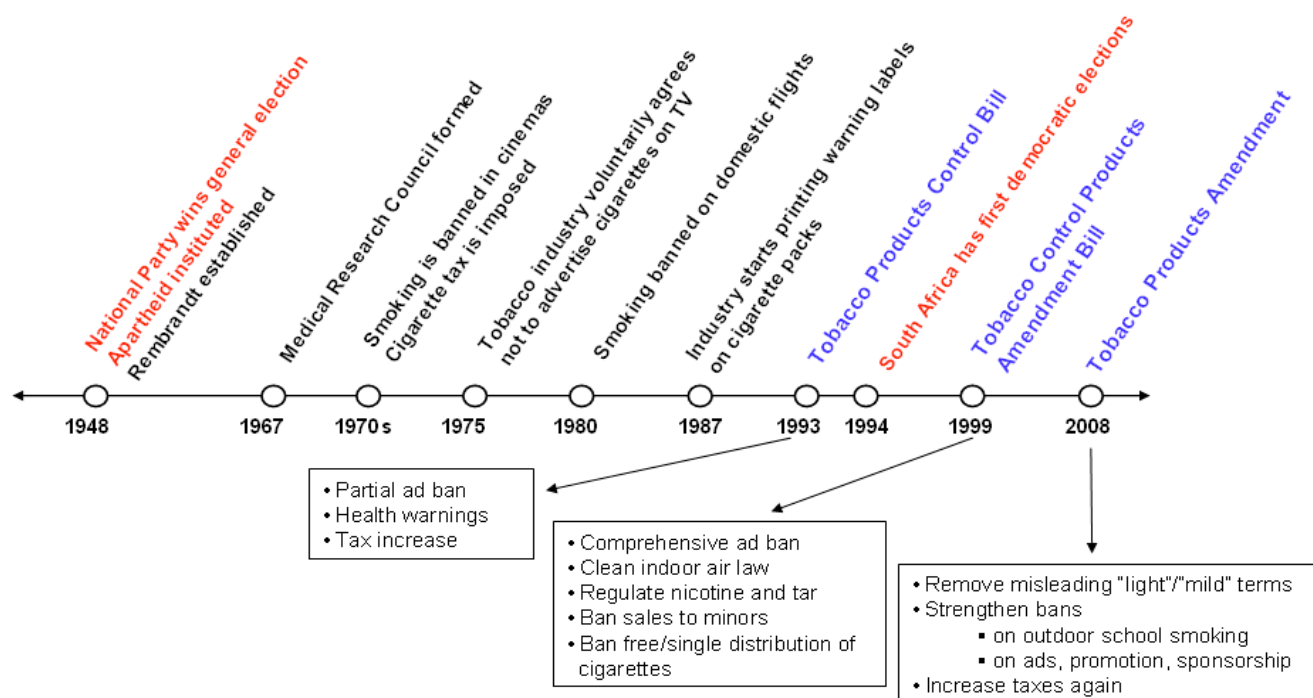
Exhibit 1 *Real Cigarette Excise Taxes and Real Government Revenue*

Source: van Walbeek C. *Political Will Required: Tobacco Control in South Africa*: IDRC Seminar; 2001.

Exhibit 2 *Relationship between Excise Tax Rate and Cigarette Consumption in South Africa*

Source: van Walbeek C, WHO. *Tobacco Excise Taxation in South Africa*.

Exhibit 3 Tobacco Control Timeline: South Africa 1948-2008

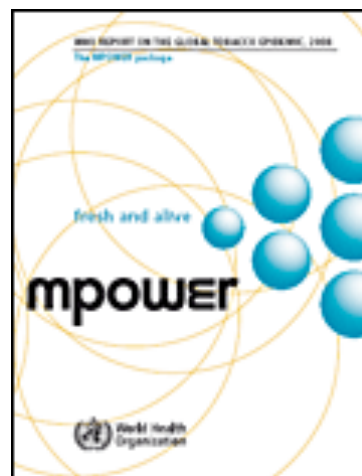


Source: compiled by case writers.

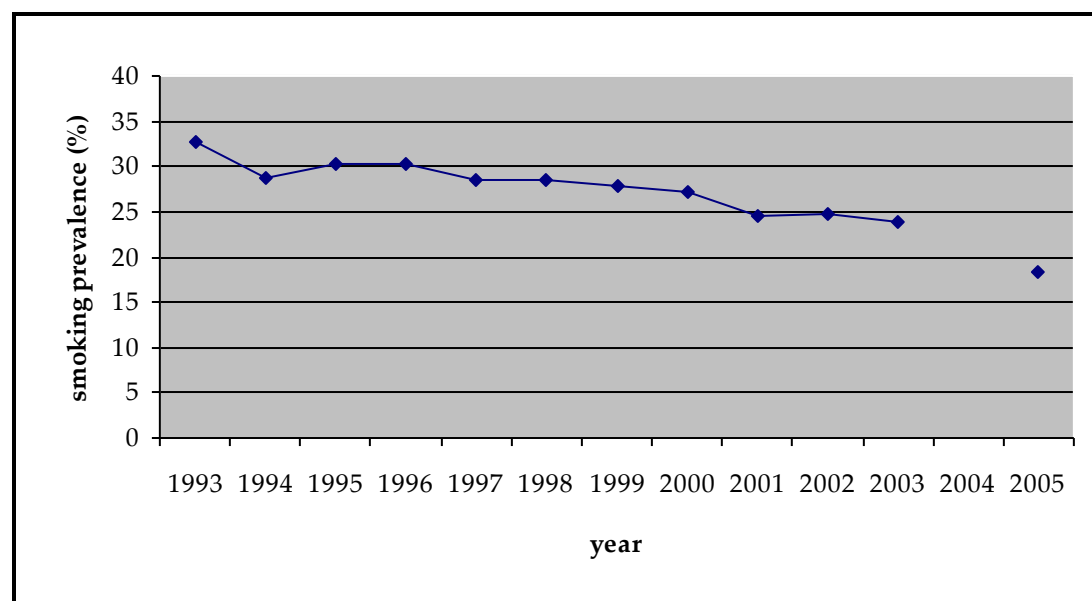
Exhibit 4 WHO MPOWER Package of Tobacco Control Interventions

MPOWER

- M** Monitor tobacco use and prevention
- P** Protect people from tobacco smoke
- O** Offer help to quit tobacco
- W** Warn about the dangers of tobacco
- E** Enforce bans on advertising
- R** Raise taxes on tobacco



Source: MPOWER: WHO Report on the Global Tobacco Epidemic. 2008.

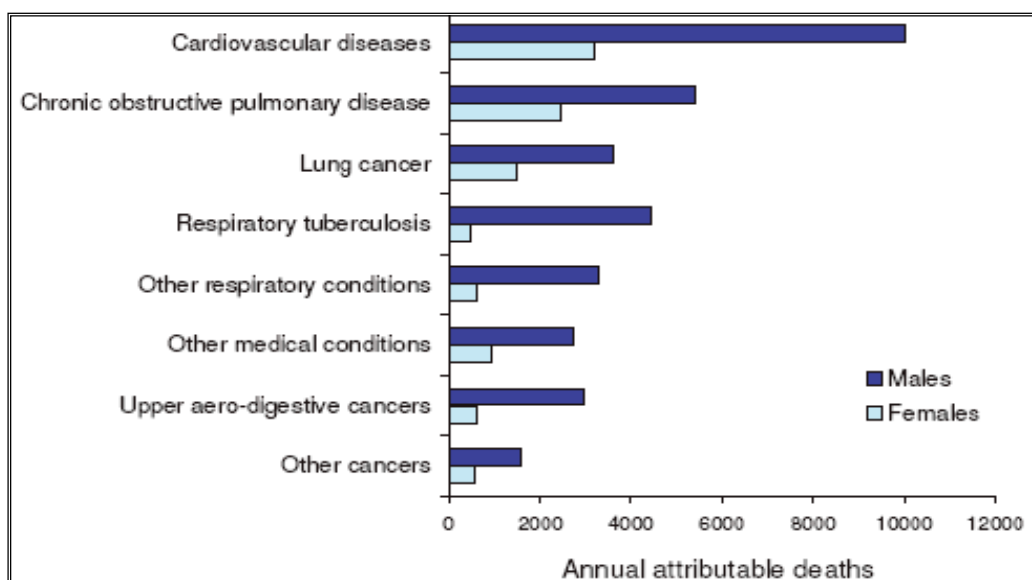
Exhibit 5 *Smoking Prevalence among Adults in South Africa over Time*

Source: van Walbeek C. *The Economics of Tobacco Control in South Africa*. Cape Town: Economics, University of Cape Town; 2005.

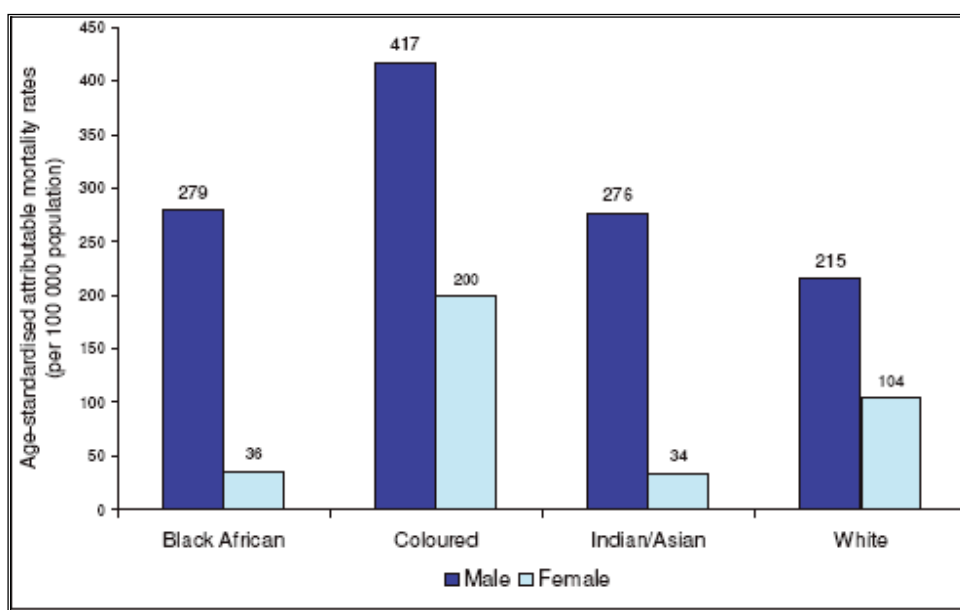
Exhibit 6 *Smoking Prevalence 1993-2000 by Gender, Race, and Age*

Description	% of Population	1993 Prevalence	2000 Prevalence
Sex			
Male	48.0%	51.4%	43.8%
Female	52.0%	12.9%	11.7%
Race			
White	15.7%	35.6%	36.6%
Black	73.2%	28.1%	22.7%
Coloured	8.5%	49.3%	48.7%
Indian	2.6%	32.3%	28.1%
Age Group			
16-24	28.0%	24.0%	18.7%
25-34	25.7%	38.7%	31.9%
35-49	25.5%	38.5%	35.2%
50+	20.8%	23.4%	22.5%

Source: van Walbeek C. *Recent Trends in Smoking Prevalence in South Africa: Some evidence from AMPS data*: Economics of Tobacco Control Project and University of Cape Town; 2001.

Exhibit 7 *Tobacco-Attributable Deaths by Disease and Gender, 2000*

Source: Groenewald P. et. al. Estimating the burden of disease attributable to smoking in South Africa in 2000. *South African Medical Journal*. 2007; 97(8):674-681

Exhibit 8 *Age-Standardized Tobacco-Attributable Mortality by Gender and Race, 2000*

Source: Groenewald P. et. al. Estimating the burden of disease attributable to smoking in South Africa in 2000. *South African Medical Journal*. 2007; 97(8):674-681

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