

Tobacco control in India: A case for the Health-in-All Policy approach

UPENDRA BHOJANI, WERNER SOORS

INTRODUCTION

Nearly one in two men and one in five women in India consume tobacco in one form or another.¹ Directly or indirectly, tobacco kills one million adult Indians every year.²⁻⁴ At the family level, expenditure on tobacco crowds out spending on education and essential items such as food.⁵ At the societal level, we are yet to come to terms with the ecological impact, through deforestation and environmental degradation, of large-scale tobacco farming and manufacturing processes. In the past decade, the Government of India started making attempts to intervene to reduce the consumption of tobacco.⁶ In 2003, the Cigarettes and Other Tobacco Products (prohibition of advertisement and regulation of trade and commerce, production, supply and distribution) Act (COTPA) was passed by Parliament. India ratified the World Health Organization's Framework Convention on Tobacco Control (FCTC) in 2004. The Union Ministry of Health and Family Welfare (MoHFW), the nodal agency for these legal commitments, launched the National Programme for Tobacco Control in 2007. In late 2013, the then Prime Minister of India stated that a combination of multisectoral policies and public awareness was required for the achievement of tobacco control.⁷ On World No Tobacco Day 2014, the then Health Minister mentioned the need for a strong social movement against tobacco, and the need to engage all sections of people.⁸

In this commentary, we expand and extend the notion of multisectoral action for tobacco control. The policies are already rooted in various government sectors, but they are still sub-optimal and at times, conflicting. We argue that the Indian health sector can and should assume a stronger stewardship role to improve the health of the population and achieve health equity. For this, it is necessary to systematically scrutinize the impact of tobacco policies on health across different sectors and seek synergies which result in the most favourable impacts. This would be a welcome application of what is known as the Health-in-All Policy (HiAP) approach.⁹

Far from being new, HiAP is based on the long-standing accumulation of evidence for the social, political and economic root causes of ill health and inequity.^{10,11} It takes the recommendations of the Commission on Social Determinants of Health¹² to the policy level. Based on the notion of multisectoral action for health and equity, it relies on mobilization through a proactive health sector.^{10,13,14} The advocates of HiAP argue that tobacco control is a natural candidate for this approach. Unlike most health issues, the tobacco epidemic already permeates the agenda of a range of government and non-government sectors, and tobacco control has proved to be most successful when based on national coordination involving the widespread participation of stakeholders.¹⁵ We briefly discuss four components of tobacco control in India today, describing the achievements and limitations, and outline three challenges that the

health sector has to overcome to make effective tobacco control possible within a HiAP framework.

COMPONENTS OF TOBACCO CONTROL IN INDIA

Prohibition on tobacco smoking in public places

In India, it was not the health but the transport sector that was the first to deal with smoking in public places. The Motor Vehicles Act, 1939 enabled state governments to make rules to regulate the conduct of passengers in motorized vehicles. The rules included prohibition on smoking in such vehicles. Half a century later, the Railways Act, 1989 prohibited people from smoking in trains when other passengers objected, and eventually expanded this to an outright ban on smoking in trains. In response to a public interest litigation (PIL), the Kerala High Court in 1999 prohibited tobacco smoking in public places in the state, considering it a violation of individuals' right to life, which is guaranteed under Article 26 of the Indian Constitution.¹⁶ The court drew upon the 1981 Air (Prevention and Control of Pollution) Act and the 1960 Indian Penal Code to deem smoking in public places as a form of air pollution and public nuisance, respectively. In response to another PIL, the Supreme Court in 2001 prohibited tobacco smoking in eight categories of public places across India.¹⁷

It was only in 2003 that the Union Government, facilitated by the MoHFW, enacted COTPA, section 4 of which prohibited smoking in public places. The detailed rules for this section and its enforcement came into force in October 2008.

Ban on chewable tobacco products

The chewing of tobacco in different forms has a long history in South Asia. It has become more common over the past three decades, with large commercial units manufacturing tobacco products that are chewed, such as *gutka* and *pan masala*. These products were widely available in cheap plastic sachets and their use was inconspicuous compared to that of tobacco products which are smoked. Hence, they became popular among children and the youth, often serving as a starter product for tobacco addiction.

In response to this trend, in 2001, the food authorities in Tamil Nadu and Andhra Pradesh banned the manufacturing, storage and sale of tobacco products that are chewed, variously known as *gutka*, *pan masala* (with tobacco), *zarada*, *khaini*, etc. under the 1954 Prevention of Food Adulteration Act. Three more states followed suit: Maharashtra in 2002, and Goa and Bihar in 2003. However, *gutka* manufacturers challenged the ban in the Supreme Court, which directed the states to lift the ban in 2004. The Court held that the Prevention of Food Adulteration Act conferred the power to impose such a ban only on the Union Government. Meanwhile, a PIL was filed in the Rajasthan High Court, demanding that tobacco manufacturers be restrained from using plastic in the packaging of tobacco products that are chewed. The petitioners demanded that the court invoke the 'polluter pays principle', which holds the polluter liable for damages to the natural environment. In 2007, the court ordered tobacco manufacturers not to use plastics in the sachets.¹⁸ The manufacturers challenged this order in the Supreme Court, which upheld the High Court order.¹⁹

In 2011, new regulations were framed under the 2006 Food Safety and Standards Act, according to which tobacco and nicotine

Institute of Public Health, 250, 2C Main, 2C Cross, Girinagar 1st Phase, Bengaluru 560085, Karnataka, India

UPENDRA BHOJANI

Institute of Tropical Medicine, Antwerp, Belgium
WERNER SOORS Department of Public Health

Correspondence to UPENDRA BHOJANI; upendra@iphindia.org

© The National Medical Journal of India 2015

shall not be used as ingredients of any food product. State governments can now take action in cases in which these ingredients are found in any food product. Madhya Pradesh was the first to take such action, and banned *gutka* and similar products. This set off a chain reaction: within a short period, 26 states and 7 Union Territories passed similar ban orders.

Tobacco production and taxation

All tobacco-growing countries find that their efforts to control tobacco products are challenged by the tobacco industry.¹⁵ India, the third largest producer of tobacco in the world, is no exception.⁴ National policies in the commerce, finance and agriculture sectors are often at odds with those pursued by the health sector. The Tobacco Board of India, which was established under the Union Ministry of Commerce and Industry and has its headquarters in Guntur, Andhra Pradesh, with several branches in Karnataka and Andhra Pradesh, provides financial, material and technical inputs to tobacco farmers to promote tobacco farming and trade. The Central Tobacco Research Institute, which was established under the Union Ministry of Agriculture and has several branches, strives to enhance the quality and yield of the tobacco crop in India. In fact, tobacco production has been on the rise; the production of tobacco leaves increased from over 500 000 tonnes in 2000 to nearly 600 000 tonnes in 2009.⁴

Given this scenario, the implementation of the FCTC's core recommendation of increasing taxation to reduce demand is not an easy task. In fact, between 2001 and 2007, all major forms of tobacco (*bidis*, tobacco products that are chewed and cigarettes) actually became more affordable.²⁰ The possible gains of increased taxation would nevertheless be considerable; for example, raising the tax on the retail price of *bidis* from 9% to 40% and on that of cigarettes from 38% to 78% is estimated to reduce the number of smokers by 23 and 4.7 million, respectively. This would help save many lives and increase government revenue.²⁰ India does not even come close to using taxes on tobacco to finance the health system (while reducing tobacco consumption), as advocated by both the WHO²¹ and Planning Commission of India.²² Besides, the taxation structure for tobacco products is very complex, with the Central and state governments using different types of tax assessment, collection and exemption structures. There are no uniform taxes across the major forms of tobacco products. This complexity easily diverts attention from the fact that tobacco is highly under-taxed in India. Small manufacturers of *bidis* are even exempted from taxes. Only cigarettes, while still under-taxed, generate government revenue to a moderate extent.²⁰ This is in contrast to the consumption pattern of tobacco in India, where of 34.6% of all the current tobacco users, only 5.7% are cigarette smokers.¹

Recently, some states have started increasing the value added tax (VAT) on tobacco. Rajasthan increased VAT on all tobacco products from 20% in 2008–09 to 65% in 2013–14. However, Rajasthan remains an exception. The rate of VAT imposed on tobacco products is variable across the states, with at least five states levying zero VAT on *bidis*. In 2014, the Health Minister recommended to the Ministry of Finance that the tax on the retail price of cigarettes be raised from 45% to 60% in the Union budget.²³ Subsequently, in 2014, the excise duty on cigarettes was increased by 11%–72% depending on the type of cigarettes.²⁴

Tobacco promotion and advertisements

The 1975 Cigarette Act failed to address the promotion and advertisement of tobacco. It was not until 2003, under a particular

provision of the COTPA, that all forms of tobacco advertisements were prohibited. A decade earlier, the media and broadcasting sector—highly influential with the younger section of the population—had already taken action. In 1991, the Union Ministry of Information and Broadcasting notified guiding principles for the Central Film Certification Board. One of these was that it should be ensured that films do not contain scenes which tend to encourage, justify or glamorize the use of tobacco or smoking. As for television, the 1995 Cable Television Networks (Regulation) Act eventually led to self-regulation in 2008. The portrayal of tobacco use and smoking was restricted to content that is certified for adult viewing, and then too, the justification or promotion of tobacco use was not allowed. The rules initially framed under section 5 of COTPA prohibited the depiction of tobacco use in films and television. However, a film director challenged these rules and in 2009, the Delhi High Court struck them down as they were beyond the ambit of the authority of COTPA and impinged on the freedom of artistic expression guaranteed in the Indian Constitution.²⁵ In 2011, the COTPA rules were reframed. The rules made health spots, scrolls, disclaimers and health warnings mandatory; prohibited the promotion of tobacco and tobacco product placements; and mandated masking of the brand names and logos of tobacco products in films and television.

With film and television protected from tobacco promotion to some extent, the tobacco industry has increasingly been using so-called socially responsible activities to promote its image, and indirectly, that of tobacco consumption.² In this respect, the government has not followed the FCTC's recommendation to de-normalize the tobacco industry's corporate social responsibility (CSR) activities. The amendment to the Companies Act (2013), facilitated by the Union Ministry of Corporate Affairs, is particularly problematic. The amendment requires every company with a net worth of ₹500 crore (5 billion) or more and/or a net profit of ₹5 crore (50 million) or more during any financial year to spend at least 2% of its average net profits from the preceding three financial years on CSR activities. This reform legitimizes CSR activities by tobacco companies, which will ultimately divert public opinion from the lethal nature of tobacco. For example, in 2013, ITC Ltd.—India's major cigarette manufacturer—collaborated with the municipal corporation of Bengaluru to help source recyclable plastic waste and create sustainable livelihoods for ragpickers and those who collect municipal waste. This was part of a CSR initiative called 'Wealth Out of Waste'.²⁶ Such initiatives enhance the public image of the tobacco company and provide easy access to government authorities.

India's tobacco control policies did not originate in the health sector and were multisectoral from the start. This makes it difficult to overcome an equally multisectoral counteraction and has resulted in a lack of synergy to do so. It can reasonably be argued that the health sector—through the MoHFW, which has been given charge of tobacco control under the COTPA—should play the key role in bringing about the needed synergy.¹⁴ The examples of the interventions made by the MoHFW with the Ministry of Finance, as well as the Ministry of Information and Broadcasting, in the areas of taxation and depiction of the use of tobacco in films, illustrate that the MoHFW has the potential to promote a HiAP approach for tobacco control. The question then is whether the Indian health sector has the capacity to catalyse actions from across various sectors. Without this capacity, no HiAP can be successful, be it in the case of tobacco control or any other health issue. To build this capacity, three major challenges need to be overcome.

CHALLENGES

Overcome the neglect of social determinants of health

The dominance of a biomedical paradigm and of curative and personal health services within the health system too often results in the neglect of action needed to address the social determinants of health. Health workers and their institutions are less inclined to work on the non-curative and non-personal aspects of population health. Engagement with policies in other sectors is, therefore, not seen as part of their 'business'. This is unfortunate because the social status of health workers, and their intimacy with patients who suffer visible harms from tobacco, could work in their favour and help them to be heard and respected by policy-makers. The Voice of Tobacco Victims, a movement facilitated by cancer surgeons of people who survived tobacco-related cancers, is a good example of how health workers and patients can gain access to influential policy-makers and have their important policy-related demands heard.

Build skills for advocacy and mediation

Health workers may also lack the skills for effective engagement with other sectors. These skills include, but are not limited to, interaction with the media, knowledge of and advocacy for policies and familiarity with processes in other sectors, and mediation between different and often conflicting interests. The discourse surrounding tobacco control is full of intensely conflicting interests, e.g. raising taxes on tobacco versus banning tobacco products that are chewed and the potential impact on the livelihoods of tobacco and areca nut farmers. Effective mediation by health advocates is required to deal with the conflicting interests of different sectors. Such mediation should lead to *negotiated policy outcomes* that prioritize health concerns to a reasonable extent. The health advocates involved in the mediation must have expertise in diverse disciplines, such as economics, politics, journalism, human rights and law.

Mainstream health impact assessments

Last but not the least, India has no structural requirement for policies and programme development processes in sectors other than health to consider the potential impact of these policies and programmes on individual and population health. Ahuja,²⁷ in an earlier issue of this *Journal*, elaborates on how health impact assessments could be carried out in India by drawing lessons from the currently mandated environmental impact assessments. Caussy and colleagues²⁸ have made a similar case for Southeast Asia, as have Collins and Koplan²⁹ for the USA. For all member countries, the WHO advocates the assessment of 'health impacts of policies either through a stand-alone assessment or as a part of an integrated assessment to inform the engagement process. Examples of tools include health impact assessment, health and health equity lens analysis, environmental impact assessment, policy audits, and budgetary reviews'.¹⁴ Without mandatory health impact assessments, the health sector will never have enough bargaining power to influence policies in other sectors, and HiAP will remain a distant dream. Without a HiAP, we feel, tobacco control in India will remain sub-optimal.

ACKNOWLEDGEMENTS

We would like to thank Prashanth NS, Pragati Hebbur, Neethi Rao, Vishal Rao and anonymous reviewers for their useful comments on the manuscript. We did not receive any funding for this work. Our respective institutes supported us by allowing us the time to write this paper.

REFERENCES

- 1 Ministry of Health and Family Welfare. *Global adult tobacco survey: GATS India 2009–2010*. New Delhi:Ministry of Health and Family Welfare, Government of India; 2010.
- 2 Reddy KS, Gupta PC (eds). *Report on tobacco control in India*. New Delhi:Ministry of Health and Family Welfare, Government of India; Centers for Disease Control and Prevention, USA; World Health Organization; 2004.
- 3 Jha P, Jacob B, Gajalakshmi V, Gupta PC, Dhingra N, Kumar R, et al.; RGI-CGHR Investigators: A nationally representative case-control study of smoking and death in India. *N Engl J Med* 2008;**358**:1137–47.
- 4 Eriksen M, Mackay J, Ross H. *The tobacco atlas*. 4th ed. Atlanta, GA:American Cancer Society; 2012.
- 5 John RM. Crowding out effect of tobacco expenditure and its implications on household resource allocation in India. *Soc Sci Med* 2008;**66**:1356–67.
- 6 Kaur J, Jain DC. Tobacco control policies in India: Implementation and challenges. *Indian J Public Health* 2011;**55**:220–7.
- 7 Ministry of Health and Family Welfare. Shri Ghulam Nabi Azad inaugurates 'International Conference on Public Health Priorities in the 21st Century: The Endgame for Tobacco'. New Delhi:Press Information Bureau, Government of India; 2013. Available at <http://pib.nic.in/newsite/erelease.aspx?relid=99265> (accessed on 27 Jul 2014).
- 8 Ministry of Health and Family Welfare. Health Minister Dr Harsh Vardhan: Strong social movement needed to tackle the menace of tobacco. New Delhi:Press Information Bureau, Government of India; 2014. Available at <http://pib.nic.in/newsite/PrintRelease.aspx?relid=105269> (accessed on 27 Jul 2014).
- 9 Ollila E, Baum F, Peña S. Introduction to Health in All Policies and the analytical framework of the book. In: Leppo K, Ollila E, Peña S, Wismar M, Cook S (eds). *Health in All Policies: Seizing opportunities, implementing policies*. Helsinki:Ministry of Social Affairs and Health; 2013:3–23.
- 10 Baum FE, Bégin M, Houweling TA, Taylor S. Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *Am J Public Health* 2009;**99**:1967–74.
- 11 Baum F, Ollila E, Peña S. History of HiAP. In: Leppo K, Ollila E, Peña S, Wismar M, Cook S (eds). *Health in All Policies: Seizing opportunities, implementing policies*. Helsinki:Ministry of Social Affairs and Health; 2013:25–42.
- 12 Commission on Social Determinants of Health. *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva:WHO; 2008.
- 13 Leppo K, Tangcharoensathien V. The health sector's role in HiAP. In: Leppo K, Ollila E, Peña S, Wismar M, Cook S (eds). *Health in All Policies: Seizing opportunities, implementing policies*. Helsinki:Ministry of Social Affairs and Health; 2013:309–24.
- 14 World Health Organization. *Health in All Policies (HiAP) framework for country action*. Geneva:WHO; 2014.
- 15 Bettcher D, Luiza Costa e Silva V. Tobacco or health. In: Leppo K, Ollila E, Peña S, Wismar M, Cook S (eds). *Health in All Policies: Seizing opportunities, implementing policies*. Helsinki:Ministry of Social Affairs and Health; 2013:203–24.
- 16 Kerala High Court. K. Ramakrishnan and Anr. vs State of Kerala and Ors on 12 July 1999; AIR 1999 Ker 385. Bench: A Lakshmanan, K N Kurup. Available at <http://indiankanoon.org/doc/1480636/> (accessed on 27 Jul 2014).
- 17 Supreme Court of India. Murli S. Deora vs Union of India and Ors on 2 November 2001; Bench: M.B. Shah, R.P. Sethi. Case No. Writ Petition (civil) 316 of 1999 Bench: M.B. Shah, R.P. SETHI. Available at <http://indiankanoon.org/doc/1495522/> (accessed on 27 Jul 2014).
- 18 The Rajasthan High Court. In the High Court of Judicature for Rajasthan at Jaipur Bench Judgment 1. Indian Asthama Care Society & another vs. State of Rajasthan & Others (D.B. Civil Writ Petition No.1966/2003); 2. Mam Raj Singh Choudhary Vs. State of Rajasthan (D.B. Civil Letter Petition No.3708/2003 PIL); 3. Suhas Singh Bhadoria Vs. State of Rajasthan (D.B. Civil Letter Petition No.7590/2002 PIL) D. B. Civil writ Petitions under Article 226 of the Constitution of India. Date of Judgment: August 29, 2007. Available at http://www.tobaccocontrollaws.org/files/live/litigation/243/IN_Indian%20Asthama%20Care%20Society%20%26%20.pdf (accessed on 27 Jul 2014).
- 19 The Supreme Court of India. Ankur Gutkha Vs. Indian Asthama Care Society & Ors; SLP(C) No. 16308/2007, 7 December 2010. Available at <http://www.tobaccocontrollaws.org/litigation/decisions/in-20101207-ankur-gutkha-v.-indian-asthama> (accessed on 27 Jul 2014).
- 20 John RM, Rao R, Rao M, Moore J, Deshpande R, Sengupta J, et al. *The economics of tobacco and tobacco taxation in India*. Paris:International Union Against Tuberculosis and Lung Disease; 2010.
- 21 World Health Organization. *Mpower: A policy package to reverse the tobacco epidemic*. Geneva:WHO; 2008.
- 22 Planning Commission of India. *High Level Expert Group report on universal health coverage for India*. New Delhi:Planning Commission of India; 2011.
- 23 Budget 2014: High tax on tobacco will safeguard citizens, say health groups. *The Economic Times*; 2014. Available at <http://economictimes.indiatimes.com/news/economy/policy/budget-2014-high-tax-on-tobacco-will-safeguard-citizens-say-health-groups/articleshow/37649882.cms> (accessed on 27 Jul 2014).
- 24 Live Budget 2014–15: Excise duty hike on tobacco & cigarettes ranging 11–72% 10 July 2014. Available at <http://www.moneycontrol.com/news/budget-news/live->

- budget-2014-15-excise-duty-hiketobaccocigarettes-ranging-11-72_1123661.html* (accessed on 27 Jul 2014).
- 25 Delhi High Court. Mahesh Bhatt vs Union Of India & Anr. on 23 January, 2009. WP (C) No.18761 of 2005 & WP (C) No.23716 of 2005.
- 26 Urs A. *ITC to set up waste processing units in Bangalore.*. Bangalore: ITC News; 2013. Available at http://www.itcspd.com/ITC_to_set_up_waste_processing_units_in_Bangalore_239.aspx?NEWS (accessed on 27 Jul 2014).
- 27 Ahuja A. Health impact assessment in project and policy formulation. *Eco Pol Wkly* 2007;**42**:3581–7.
- 28 Caussy D, Kumar P, Than Sein U. Health impact assessment needs in south-east Asian countries. *Bull World Health Organ* 2003;**81**:439–43.
- 29 Collins J, Koplan JP. Health impact assessment: A step toward health in all policies. *JAMA* 2009;**302**:315–17.

Attention Subscribers

The subscriptions for *The National Medical Journal of India* are being serviced from the following address:

The Subscription Department
The National Medical Journal of India
 All India Institute of Medical Sciences
 Ansari Nagar
 New Delhi 110029

The subscription rates of the journal are as follows:

	One year	Two years	Three years	Five years
Indian	₹600	₹1100	₹1600	₹2600
Overseas	US\$ 85	US\$ 150	US\$ 220	US\$ 365

Personal subscriptions paid from personal funds are available at 50% discounted rates.

Please send all requests for renewals and new subscriptions along with the payment to the above address. Cheques/demand drafts should be made payable to **The National Medical Journal of India**. Please add ₹75 for outstation cheques.

If you wish to receive the Journal by registered post, please add ₹90 per annum to the total payment and make the request at the time of subscribing.