

Strengthening the Enforcement of Tobacco Control Initiatives under Republic Act 9211

Republic Act (RA) 9211, otherwise known as the Tobacco Regulation Act, was passed by the Philippine Congress in 2003. The law aims to: 1) Promote a healthful environment by prohibiting smoking in public places, and designating smoking and non-smoking areas where applicable; 2) Inform the public of the health risks associated with cigarette smoking and tobacco use; 3) Regulate and subsequently ban all tobacco advertisements and sponsorships; 4) Regulate the labeling of tobacco products; and 5) Protect the youth from being initiated into cigarette smoking and tobacco use by prohibiting the sale of tobacco products to minors. Various provisions of the law serve as benchmarks in implementing tobacco control initiatives in the country.

In addition, the Philippines is a signatory to the WHO Framework Convention on Tobacco Control (FCTC), the treaty that seeks the total eradication of tobacco use worldwide. The country also adopted the United Nations Millennium Development Goals (MDGs), thus making a commitment to eradicate poverty and provide health services to the people. Tobacco use is a major contributor to ill health, and its reduction and eradication could contribute towards ending poverty and towards achieving the MDG targets.

Global and National Burden as a Result of Tobacco Use

About 5 million people die from tobacco-related illnesses around the world each year. Unless urgent action is taken, the annual death toll from tobacco-related illnesses could rise to more than 8 million by 2030, (*Source: MPOWER*). It is estimated that 70% of all tobacco-related deaths will occur in developing countries like the Philippines. (*Source: Tobacco and Poverty in the Philippines, WHO, 2008*)

In the Philippines, 34% of adults are current smokers. More than half (56%) of adult males smoke (*Source: National Nutrition and Health Survey, FNRI, 2003*) while 21% of adolescents use tobacco. (*Source: GYTS 2007*). Thus, the tobacco epidemic doesn't spare young people as one in every five students aged 13-15 currently smoke (*Source: GYTS*).

Smoking prevalence was highest among the poor (1st and 2nd quintile of total annual income). Among poor households, tobacco spending accounts for 2.6% of monthly family expenditure -- higher than the expenditure on education (1.6%) and health (1.3%), and equal to the expenditure for clothing (2.6%). Among the poorest households, tobacco gets 2.5% of their total monthly expenditure and has bigger share than clothing (2.3%), education (1.4%) and health (0.9%). (*Source: Tobacco and Poverty in the Philippines, WHO, 2008*)

Smoking attributable mortality estimates for four smoking-related diseases (lung cancer, cerebrovascular diseases, coronary artery diseases, COPD) showed that these four account for around 6-8% of deaths from all causes. Majority of deaths attributable to smoking are COPD and cerebrovascular diseases. The total economic cost as a result of the four smoking-related diseases studied reached between US\$3-6 B. (*Source: Tobacco and Poverty Study, 2006*)

The economic consequences of tobacco use are devastating. The burden of illness for developing countries is proportionally greater in terms of productivity loss due to the impact of the disease (*Source: WHO, 2008*). Tobacco use is a major drain in the world's financial resources, with at least half of the losses occurring in developing countries that can least afford them.

National Initiatives on Tobacco Control

Cost-effective measures can be used to reduce tobacco consumption. Studies show that health promotion (including assistance with smoking cessation), education and advocacy, legislative and financial measures (including taxation and price policies), capability building and tobacco control monitoring and surveillance are among the many effective strategies for tobacco control.

In 2007, the Department of Health established the National Tobacco Prevention and Control Program which aims to: 1) Strengthen national, regional, and local infrastructure and capacity; 2) Develop an integrated and multi-sectoral based program; 3) Advocate for the implementation and monitoring of laws and policies; and 4) Strengthen social mobilization and community participation, and initiate and strengthen collaboration and partnership among stakeholders, external development agencies and civil societies. The WHO-FCTC and RA 9211 serve as tools in the implementation of tobacco control activities. (*Source: DOH Administrative Order 2007-0004*).

Issues and Challenges in Tobacco Control

Formula One serves as the policy framework for health programs, including tobacco control, of the DOH. The following challenges and issues on tobacco control are discussed in line with the four pillars of Formula One, namely: 1) Service Delivery; 2) Good Governance; 3) Regulations; and 4) Financing.

I. SERVICE DELIVERY

One of the strategic thrusts of the DOH for 2005-2010 is to establish smoking cessation clinics (SCC) in public and private facilities nationwide. By 2010, the DOH has targeted to establish tobacco cessation clinics in 72 DOH-retained hospitals, 60% of provincial hospitals, 60% of city health and municipal health offices, and 50 % private hospitals. (Source: *National Objectives for Health 2006-2010*).

DOH Administrative Order No. 122 s 2003 contains specific guidelines in implementing the National Smoking Cessation Program (NSCP). The order covers all DOH offices, attached agencies, retained DOH hospitals and health facilities, permanent or temporary (such as field hospital or clinic tents) and fixed or mobile units (ambulances, vehicles, etc.). Local Government Units (LGUs) and other institutions with health facilities such as schools, industrial establishments, and other government or private agencies or establishments were encouraged to participate. (Source: *Helping Smokers Quit: A Training manual for Health Workers, Bonito and Dones, 2007*)

In 2004, the National Center for Disease Prevention and Control (NCDPC) conducted an evaluation study in 69 pilot areas in Luzon. In the study, only ten areas were able to sustain smoking cessation clinics. It was also observed that since no Standardized Clinical Practice Guidelines were provided, implementing units decided on the operation of the SCC in accordance with their own capabilities and available resources. (Source: *Helping Smokers Quit: A Training Manual for Health Workers, Bonito and Dones, 2007*)

Factors that facilitated SCC implementation included discussion with the Local Health Board and integration of tobacco use screening in the Risk Assessment Form of Healthy Lifestyle. The clinics often provided 3 to 10 minutes of counseling to smokers, but no pharmacotherapy. (Source: *Helping Smokers Quit: A Training manual for Health Workers, Bonito and Dones, 2007*)

Restraining factors include: insufficient willingness of the smokers; difficulty in conceptualizing SCC operation because there was no Standard Operating Procedures (SOP); unavailability of a clinic space, and factors on human resources particularly inadequate role modeling; and lack of commitment skills, time and awareness by health personnel. (Source: *Helping Smokers Quit: A Training manual for Health Workers, Bonito and Dones, 2007*).

To date, there is a lack of access to and/or absence of smoking cessation clinics in most areas of the country. Often, smokers want to quit but do not know where, when and who to approach for assistance. (Source: *DOH Report by Dr. Ismael Pastor of the Degenerative Diseases Office*)

II. REGULATION

RA 9211 has been in place since 2003 but its effective implementation remains a challenge to date. Majority of its provisions are poorly implemented by most local government units and other enforcement agencies and institutions.

As of July 2008, prohibition of all forms of tobacco advertising in mass media, except tobacco advertisements placed inside the premises of point-of-sale advertisements should have been already in effect. To date, outdoor tobacco advertisements are still widespread. Tobacco ads in the form of movable banners are openly displayed outside the Seven-Eleven convenience stores up to present. (Source: *Article by Ronnel Domingo for the Philippine Daily Inquirer*)

Tobacco advertising often links smoking with athletic prowess, sexual attractiveness, success, adult sophistication, adventure and self-fulfillment. In Asia, tobacco companies are among the top 10 advertisers particularly in Cambodia, Indonesia, Malaysia, Myanmar and the Philippines. (WHO, 2002) Tobacco companies are also known to invest more on promotional materials, allowances and premiums such as T-shirts for young people or lighters and key rings. Article 13 of the FCTC addresses tobacco advertising and recognizes that “a comprehensive ban on advertising, promotion and sponsorship would reduce the consumption of tobacco products.”

Another issue is the indirect authorization of the Bureau of Food and Drugs for tobacco industries to promote its products through the issuance of permits indicated on every leaflet or brochure of tobacco packs.

Figure 1. Permit issued by DOH-BFAD placed on a cigarette flyer



RA 9211 requires rotational text health warnings to occupy not less than 30% of the front panel of tobacco packages. Although this is in compliance with the minimum requirement stated in Article 11 of FCTC, there is proof that the law is not serving its purpose of curbing smoking as evidenced by the increasing prevalence of smoking among the youth (*Source:GYTS, 2007*).

Efforts from tobacco control advocates are currently being undertaken. These include legislating a measure that will require having graphic health warnings placed on tobacco packs apart from text warnings in order to more effectively increase smokers' awareness of their risks. Studies have shown that the use of pictures with graphic depictions of disease and other negative images has greater impact than words alone, and is critical in reaching the large number of people worldwide who cannot read. Pictures are also effective in conveying messages to children – especially the children of tobacco users, who are most likely to start using tobacco themselves (*Source: WHO, 2008*). A comparative study by Hammond et al., found out that smokers in countries where a warning depicts a particular health hazard of smoking are much more likely to realize the hazard and smokers who reported noticing warnings were 1.5 to 3 times more likely to believe in each health hazard. The graphic health warning bill, however, is pending in Congress.

Countries such as Canada, Brazil and Australia have advocated for graphic health warnings to be placed on tobacco products.

- In 2001, about 91% of Canadian smokers surveyed reported having read the warning labels and demonstrated a thorough knowledge of their content after large pictorial warnings were introduced.
- In Brazil, after the introduction of new picture warnings, 73% of smokers approved of them, 54% had changed their opinion on the health consequences of smoking and 67% said the new warnings made them want to quit.
- The introduction of stronger warning labels in Australia resulted in a 29% increase in the percentage of people reporting that they always noticed the warning.

RA 9211 primarily bans smoking in public places like hospitals, clinics and enclosed public places. However, the law has included a provision that requires the setting aside of an open space or a separate area with proper ventilation as designated smoking area. The WHO Guidelines on Article 8: Protection from Exposure to Tobacco Smoke clearly state that approaches other than 100% smoke free environments including ventilation, air filtration and the use of designated smoking areas, whether with separate ventilation systems or not, have repeatedly shown to be ineffective and there is conclusive evidence, scientific and otherwise, that engineering approaches do not protect against exposure to tobacco smoke. Tobacco use in indoor offices, restaurants, pubs and bars and other indoor workplaces is high in the Philippines.

III. GOVERNANCE

The health sector needs to play a more active role in tobacco control. The DOH is currently vice-chair of the Inter-Agency Committee on Tobacco (IACT) which is tasked to administer and implement the provisions of RA 9211. The inter-agency body is chaired by the Secretary of the Department of Trade and Industry and includes representation from the tobacco industry.

The DOH and NGO partners lead the way in advocating for the effective implementation of the national law. It is the mandate of the local government units to see to it that the law is enforced within their areas of jurisdiction.

Surveillance systems provide valuable inputs for tobacco control. Currently, the Global Tobacco Surveillance System of the WHO and United States Center for Disease Control (CDC) is in place in the country to monitor implementation of various provisions of the FCTC and the national law and evaluate effectiveness of tobacco control program interventions. Data utilization for policy and program enhancement should be encouraged. The FCTC Reporting Instrument and the Global Tobacco Control Report of the WHO are surveillance and monitoring tools utilized in the Philippines.

IV. FINANCING

One of the major challenges in the effective campaign against tobacco use is the tax structure imposed on tobacco products.

Tobacco taxes can take several forms. Specific tobacco taxes, added as a fixed amount to the price of cigarettes, present the greatest flexibility and allow governments to raise the tax with less risk that the industry will respond with actions that keep low the real amount charged. Ad valorem taxes, such as value-added taxes or sales taxes, are a percentage of the base price and are imposed by virtually all countries—often on top of the specific excise tax. Ad valorem taxes may be imposed at the point of sale or on the wholesale price. Taxes may vary according to the place of manufacture or the type of product; for example, some governments impose higher taxes on cigarettes produced abroad than on domestically produced ones, or on high-tar cigarettes compared with low tar.

Raising the price of tobacco and tobacco products through tax increases is the most effective way to reduce smoking. Higher cigarette prices reduce the number of smokers and induce those who continue to smoke to consume fewer cigarettes per day. Due to inelastic demand and the slow share in the total taxes in retail prices, raising tobacco prices increases a country's tax revenues, at least in the short- and medium- term, even if reduced consumption is taken into consideration. Indeed, some countries have imposed tobacco rates in excess of 75% of the retail price.

It is estimated that for each 10% increase in retail prices, consumption is reduced by about 4% in high-income countries and by about 8% in low- and middle-income countries. Smoking prevalence is reduced by about half those rates, with variations associated with income, age and demographic factors. Higher tobacco taxes are particularly effective in preventing or reducing tobacco use among teenagers and the poor. Young people and low-income smokers are two to three times more likely to quit or smoke less than other smokers after the price increases because these groups are the most economically sensitive to higher cigarette prices. (Source: *Tobacco and Poverty in the Philippines, WHO, 2008*)

The Philippines currently has a complicated excise tax system for tobacco products under the four-tier system (low, medium, high, and premium) with no regular adjustments for inflation resulting in a 640% tax differential between low-priced and premium-priced brands. (Source: *Quimbo, S, et al, 6-Country Economics of Tobacco and Tobacco Taxation, PHL 2008*)

Under Republic Act 9334, all tobacco taxes included in the current policy are imposed per unit of goods. For cigars, there is an ad valorem tax of 10% for packs with a net retail of P500 and below. It provides for an increase in taxes every two years by about 10-11% for cigarettes packed by hand and those packed by machine with a price below P5 per pack, and 4-6% for cigarettes packed by machines with a price of P5 or above per pack, beginning in 2005 until 2011. The rate would be adjusted every two years with the adjustment set at 3.6% of the existing rate plus 16 centavos. (Source: *Quimbo, S, et al, 6-Country Economics of Tobacco and Tobacco Taxation, PHL 2008*)

An International Monetary Fund (IMF) study showed that a move to adopt a single rate of cigarette tax would enable the country to yield anywhere between P31.8 billion and P33.8 billion in additional revenues in the first year of implementation. According to World Bank (WB), the government could raise an additional P86.5 billion by maintaining uniform rates on all kinds of cigarettes. It noted that every peso increase in excise tax rates will generate some P2 billion in extra revenues for the government.

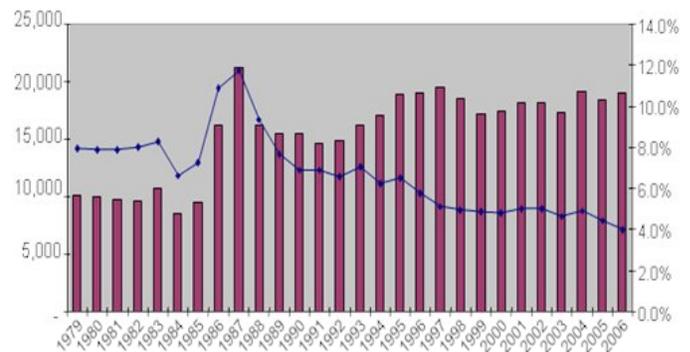


Figure 2. Real Excise Tax Collections from Tobacco Products and Percentage Share of Tobacco Taxes to Total Taxes (2000 = 100)

Source: *Quimbo, S, et al, 6-Country Economics of Tobacco and Tobacco Taxation, PHL 2008*

A growing number of countries now earmark taxes raised on tobacco for anti-smoking activities or other specific health-related activities. For example, one of China's largest cities, Chongqing, and several U.S. states earmark part of the revenue from tobacco taxes for education about tobacco's effects, counter-advertising, and other control activities. Other countries use earmarked tobacco taxes to support health services

RECOMMENDATIONS:

The proposed roadmap for the tobacco control program should provide effective strategies to curb the epidemic.

The Department of Health can lead the way through the following initiatives:

- **Institutionalizing surveillance system to monitor concerns regarding the prevalence, policies, and other factors affecting tobacco use.** Surveillance tools currently in place in the country include the following: FCTC reporting instrument, Global Tobacco Control Report., and the Global Tobacco Surveillance System which includes the Global Youth Tobacco Survey (GYTS) and the Global Adult Tobacco Survey (GATS) starting in 2008. The tools help monitor the implementation of significant provisions of RA 9221 and to a lesser extent, RA 9334 (Sin Tax Law). Statistics on tobacco use can be a powerful instrument for getting the attention of policymakers and the public regarding the state of health of the nation. Effective translation of surveillance results into relevant actions should be pursued.
- **Intensifying health promotion and increasing the awareness of the dangers of tobacco use and second hand smoke.** The passage of a national legislation requiring graphic health warning on tobacco packages will support efforts on this regard. The DOH and partner institutions should come up with an intensified media campaign which will highlight the ill-effects of tobacco use and second hand smoke and also strategize on how to implement and operationalize a total ban of tobacco promotion through BFAD despite RA 9211 allowing promotions as long as they cater to adults.
- **Creating more smoke-free environments.** Local government units should be encouraged to pass ordinances to support local implementation of RA 9211 since this is within their mandate as stipulated in the Local Government Code, to develop ordinances which are stricter than the national law geared towards phasing out of designated smoking areas in enclosed places. The DOH should strive for 100% smoke-free as the norm and should develop and institutionalize a system that would give recognition to LGUs striving towards this norm.
- **Enhancing access to smoking cessation services and products.** The DOH and its partners can establish smoking cessation clinics in primary health facilities and selected institutions such as retained DOH hospitals, which in turn can serve as referral centers for highly-structured treatment to address withdrawals, cope cravings and avoid relapse in tobacco use. Brief cessation counseling should be integrated into the primary health care and human resource development on this area should be continually pursued. A smoking cessation package especially for minors should be developed by PhilHealth in accordance with section 33 of RA 9211.
- **Increasing tobacco taxes.** Current tobacco tax rates under RA 9334 are deemed low and are not considered effective in curbing smoking. Restructuring the four-tiered tax structure for tobacco products and eventually coming up with a unified single tax rate indexed to inflation to increase the tax will make this an effective public health intervention that should be strongly advocated for. Studies have shown that increases in tobacco tax rates would not only raise government revenues but would primarily reduce cigarette consumption and prevent initiation of smoking behavior.
- **The Department of Health must have continued access to the earmarked proceeds of the revenues collected from RA 9334.** These revenues include the 2.5% incremental revenues for sustaining the goal of universal coverage of the National Health Insurance Program and the 2.5% for the disease prevention program to be able to allocate needed funds for tobacco control. Since the earmarking provisions of RA 9334 only cover the period 2005-2010, the health sector should lobby for the creation of the Health Promotion Foundation under the auspices of the DOH, either as a separate office or as an attached agency.
- **Creating a Sector-Wide Anti-Tobacco Council.** Given the enormous challenge posed by the tobacco industry, the DOH needs to establish a national coordinating mechanism for comprehensive tobacco control. This proposed council will be tasked to oversee the implementation of the country commitments to the Framework Convention on Tobacco Control by concerned government agencies in partnership with civil society. Cooperation and collaboration with concerned stakeholders for policy and regulation, enforcement, training, cessation services, communication, advocacy, education and surveillance of tobacco control policies could be strengthened and sustained through this mechanism.

The Philippines is also a signatory to three human rights treaties: the International Covenant on Economic, Social and Cultural Rights, the Convention to Eliminate Discrimination Against Women and the Convention on the Rights of the Child. The country implementation of these human rights treaties are being monitored by the Committee on Economic, Social and Cultural Rights, Committee on the Elimination of Discrimination Against Women and the Committee on the Rights of the Child, respectively. The DOH with its constitutional mandate of protecting the health of the people could explore correlating issues on second-hand smoke, targeted marketing, child labor, green tobacco sickness, and diverting family income needed for food and education into satisfying an addiction for nicotine with human rights violations of children and women, and consider initiating reports of these violations with these committees under the Office of the United Nations High Commissioner for Human Rights.

References:

Baquilod, MM et. al. *Tobacco and Poverty in the Philippines*. Geneva, Switzerland: WHO.

____ (2008). *WHO Report on the Global Tobacco Epidemic: The MPOWER package*. Geneva, Switzerland: WHO.

[NSCB] National Statistical Coordination Board. *The Philippines Millennium Development Goals*. Available at: <http://www.nscb.gov.ph/stats/mdg/> (last accessed October 28, 2008).

____ (2005) *National Objectives for Health*. Manila, Philippines: DOH

____ (2000) *Tobacco Warning Labels and Packages*. Available at: <http://www.tobaccofreekids.org/campaign/global/docs/warning.pdf>. (last accessed October 30, 2008)

____ (2008). *WB backs plan for single tax rate on all cigarette brands*. Available at: <http://www.gmanews.tv/story/83625/WB-backs-plan-for-single-tax-rate-on-all-cigarette-brands>. (last accessed October 25, 2008)

____ (2005). *Service Delivery*. Available at: <http://doh.gov.ph/F1/SD.htm>. (Last accessed November 7, 2008)

Domingo, Ronnel (2008). *Tobacco control group hits 7-11, cigarette firm*. Available at: <http://business.inquirer.net/money/breakingnews/view/20080418-131136/Tobacco-control-group-hits-7-11-cigarette-firm>. (last accessed October 30, 2008)

Esson, Katharine M. and Stephen R. Leeder. (2005). *The Millennium Development Goals and tobacco control: an opportunity for global partnership [electronic resource]*. Available at: www.who.int/tobacco/publications/mdg_final_for_web.pdf. (last accessed October 30, 2008).

Panti, Llanesca T. (2008). *Studies show smoking drives people deeper in poverty*. Available at: www.manilatimes.net/national/2008/oct/08/yehey/top_stories/20081008top8.html. (last accessed October 30, 2008)

Pastor, Ismael MD. (2003). *The Smoking Cessation Program*. Available at: [doh.gov.ph/tobacco/The%20SCP%20\(Dr.%20I.%20Pastor\).ppt](http://doh.gov.ph/tobacco/The%20SCP%20(Dr.%20I.%20Pastor).ppt). (last accessed October 30, 2008)

Vingno, Alah Baby (2006). *Assessment of Smoking cessation Clinic Status among Pilot Areas: A program Process Evaluation Report*. Manila, Philippines: DOH-NEC