

Tobacco excise tax and children

To the Editor: While the recently promulgated Tobacco Products Control Act of 1993 has made it an offence to sell or give cigarettes to children under the age of 16 years, several studies in South Africa have indicated that children who begin to smoke do so between the ages of 10 and 12 years.¹ In the UK, policy makers have recommended that part of the excise tax collected from children who smoke should be used to develop health promotion programmes, particularly programmes aimed at reducing smoking among teenagers.²

To estimate the amount of excise tax received by the government from children who smoke in South Africa, published studies carried out since 1988 were used to estimate smoking rates among children aged 11 - 15 years. The excise tax rates being applied in 1991 were used. It was assumed that children who reported smoking more than 1 cigarette a day on average smoked 2 a day, and that smoking rates among rural populations were 50% of those reported in urban studies.

On this basis it was calculated that R10 million per year is obtained by the Commissioner in the form of excise tax on cigarettes sold to smokers among South Africa's approximately 4½ million 11 - 15-year-olds.

Current investment in health programmes targeting tobacco control in children constitutes less than 10% of that amount. The case for earmarking excise tax for health promotion initiatives was made in a previous publication,³ and I emphasise it here. An increase in excise tax would substantially reduce the likelihood that children would start smoking and, further, reduce the amount that they smoke. These funds could ensure rapid development of comprehensive school-based education programmes and enable children to make healthful choices, not only with regard to tobacco use but in all spheres of their lives.

The recent decision of government to increase excise tax by only 25% represents a major blow to public health. A valuable opportunity for prevention has been missed. It is to be hoped that future budgets will favour public health over short-term profits for the tobacco industry.

Derek Yach

Medical Research Council
Pretoria

1. Yach D, McIntyre D, Saloojee Y. Smoking in South Africa: the health and economic impact. *Tobacco Control* 1992; 1: 272-280.
2. Parliament and Government. *ASH Bulletin* 1994; Issue No. 5.
3. Yach D. The case for an increased tobacco tax in South Africa. *S Afr Med J* 1993; 83: 161-163.

Proposed Cochrane Collaboration for tuberculosis treatment

To the Editor: During a meeting of interested persons held at the International Centre for Health Care Research of the Karolinska Institute, Stockholm, on 24 and 25 May of this year a decision was taken to initiate a Cochrane Collaboration in the field of tuberculosis. This voluntary collaboration between individuals interested in a particular field aims to undertake systematic comprehensive reviews of all published and unpublished randomised controlled

trials of different aspects of tuberculosis therapy. For such a collaboration to succeed, participants speaking different languages and with access between them to a wide range of (often) seldom-read journals is essential. Interested persons are asked to write to Dr Vinod K. Diwan, Karolinska Institutet, Department of International Health and Social Medicine, S-171 77 Stockholm, Sweden, stating clearly their particular field of interest.

P. R. Donald

Department of Paediatrics and Child Health
University of Stellenbosch
Parow, W. Cape

Treating tuberculosis with one combination drug

To the Editor: We wish to correct certain misconceptions which could have arisen from the 'Editor's Choice' commentary' on our recent publication.²

1. We compared Rifater (a combined preparation of isoniazid, rifampicin and pyrazinamide) not simply with the

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same three drugs in separate preparations but with *four* drugs (the same three plus ethambutol). It was therefore not inconceivable that there could have been different clinical outcomes in the two treatment groups.

2. Criteria for adequate compliance were very strictly applied. Technically a single dose of treatment could separate 'compliant' and 'non-compliant' subjects. Nevertheless, while inadequate compliance was the biggest single reason for dropping subjects from the study, this group only constituted 22% of the original 319 admitted to the study. A further 45% were eliminated for a variety of other reasons.

3. The population studied was a relatively settled community in the Cape Town municipal area. None had had previous treatment for tuberculosis. The drug resistance rate of 4,84% therefore applies to this population only. In certain high-risk groups drug resistance, including multiple resistance, is a serious and increasing problem in the western Cape.

M. F. Macnab

City Health Department
Cape Town

J. R. Seager

National Urbanisation and Health Research Programme
Medical Research Council
Parowvallei, W. Cape