

TOBACCO CONTROL
FACT SHEET

Croatia

Health impact of tobacco control policies
in line with the WHO Framework Convention
on Tobacco Control (WHO FCTC)

➔ Based on the current level of adult smoking in Croatia (1), premature deaths attributable to smoking are projected to be as high as 636 000 of the almost 1.3 million smokers alive today (Table 1) and may increase in the absence of stronger policies.

TABLE 1.
Initial smoking prevalence and projected premature deaths

Smoking prevalence (%)			Smokers (n)			Projected premature deaths of current smokers (n)					
Male	Female	Total	Male ^a	Female ^a	Total ^a	Male ^b	Female ^b	Total ^b	Male ^b	Female ^b	Total ^b
40.9	34.0	1 272 033	338 857	297 160	636 017	220 257	193 154	413 411			

^a Premature deaths are based on relative risks from large-scale studies of high-income countries.

^b Premature deaths are based on relative risks from large-scale studies of low- and middle-income countries.

Source: Glavak Tkalić et al (1).

Key findings

Within 15 years, the effects of individual tobacco control policies when fully implemented in line with the WHO FCTC (2) are projected to reduce smoking prevalence by:

- 21.6% by increasing excise cigarette taxes from its current level of 55% to 75% and prevent much youth smoking;
- 7.5% with more comprehensive smoke-free laws and stronger enforcement;
- 6.3% by increasing from a low-level to a high-level mass media campaign;
- 4.5% by increasing from minimal provision to a well-publicized and comprehensive tobacco cessation policy;
- 4.5% by requiring strong, graphic health warnings added to tobacco products; and
- 2.6% by banning most forms of direct and indirect advertising to have a comprehensive ban on advertising, promotion and sponsorship that includes enforcement.

With this stronger set of policies and consistent with the WHO FCTC (2), smoking prevalence can be reduced by 30% within 5 years, by 40% within 15 years and by 48% within 40 years. Almost 304 000 deaths could be averted in the long term (Table 2). The SimSmoke tobacco control model (3) incorporates synergies in implementing multiple policies (e.g., strong media campaign with smoke-free laws and tobacco cessation policies).

TABLE 2.

Effect of tobacco control policies (individual and combined) on initial smoking prevalence and smoking-attributable deaths

Tobacco control policy	Relative change in smoking prevalence (%)		Reduction in smokers in 40 years (n)	Reduction in smoking-attributable deaths in 40 years (n)					
	5 years	40 years	Total	Male ^a	Female ^a	Total ^a	Male ^b	Female ^b	Total ^b
Protect through smoke-free laws	-6.5	-8.1	103 119	27 470	24 090	51 560	17 856	15 659	33 515
Offer tobacco cessation services	-2.6	-6.5	82 438	21 961	19 258	41 219	14 274	12 518	26 792
Mass media campaigns	-5.5	-6.6	83 954	22 365	19 613	41 978	14 537	12 748	27 285
Warnings on cigarette packages	-3.0	-6.0	76 322	20 331	17 830	38 161	13 215	11 590	24 805
Enforce marketing restrictions	-2.2	-2.8	35 553	9 471	8 306	17 777	6 156	5 399	11 555
Raise cigarette taxes	-14.4	-28.8	365 958	97 487	85 492	182 979	63 367	55 569	118 936
Combined policies	-30.0	-47.8	607 506	161 833	141 920	303 753	105 191	92 248	197 439

^a Smoking-attributable deaths are based on relative risks from large-scale studies of high-income countries.

^b Smoking-attributable deaths are based on relative risks from large-scale studies of low- and middle-income countries.

→ Monitor tobacco use

The prevalence of current adult smokers (15–64 years old) was 37.4% in 2011 (men: 40.9%; women: 34.0%) (1).

→ Protect people from tobacco smoke

Health care facilities and education facilities including universities in Croatia are completely smoke free (Table 3). In government facilities, restaurants and public transport, designated smoking rooms with strict technical requirements are allowed under the current legislation. Smoking violations consist of fines on the establishment and the patron. Funds are dedicated for enforcement; however, no system is in place for citizen complaints and further investigations (4).

TABLE 3.

Complete smoke-free indoor public places

Health care facilities	Education facilities except universities	Universities	Government facilities	Indoor offices & workplaces	Restaurants	Cafés, pubs & bars	Public transport	All other indoor public places
✓	✓	✓	✗	✗	✗	✗	✗	✗

Source: WHO (4).

✓ = completely smoke-free; ✗ = not completely smoke-free.

→ Offer help to quit tobacco use

Smoking cessation services are available of which some are cost-covered, but Croatia only provides cessation support in some health clinics or other primary care facilities. Nicotine replacement therapy can be purchased over the counter in a pharmacy but is not cost-covered, and no toll-free quit line is available (4).

→ Warn about the dangers of tobacco

Health warnings are legally mandated to cover 30% of the front and 40% of the rear of the principal display area, whereby 16 health warnings are approved by law. They describe the harmful effects of tobacco use on health, rotate on packages and are written in the principal language(s) of the country. The law also mandates font style, font size and colour for package warnings. However, the health warnings do not include a photograph or graphics and are not mandated to appear on each package and any outside packaging and labelling used in the retail sale (4).

Total tobacco control expenditures, which may include mass media campaign expenditures, amount to US\$ 48 429 in Croatia, which is less than US\$ 0.05 per capita and is, therefore, classified as a low level of funding (4).

→ Enforce bans on tobacco advertising, promotion and sponsorship

Croatia has a ban, through a law adopted in 2008 and amended in 2009 and 2013 (5), on most forms of direct and indirect advertising (Table 4). The law requires fines for violations of these direct and indirect advertising bans (4).

TABLE 4.

Bans on direct and indirect advertising

Direct advertising		Indirect advertising	
National television and radio	✓	Free distribution in mail or through other means	✓
International television and radio	✓	Promotional discounts	✓
Local magazines and newspapers	✓	Non-tobacco products identified with tobacco brand names	✓
International magazines and newspapers	✓	Appearance of tobacco brands in television and/or films (product placement)	✓
Billboards and outdoor advertising	✓	Appearance of tobacco products in television and/or films	✓
Advertising at point of sale	✓	Sponsored events	✓
Advertising on internet	✓	Tobacco products display at point of sale	✓

Source: WHO (4).

✓ = banned.

Croatia does not have:

- bans on tobacco companies/tobacco industry publicizing their activities;
- bans on entities other than tobacco companies/tobacco industry publicizing their activities;
- bans on tobacco companies funding or making contributions (including in-kind contributions) to smoking prevention media campaigns including those directed at youth; and
- a requirement to present prescribed anti-tobacco advertisements before, during or after the broadcasting or showing of any visual entertainment (4).

→ Raise taxes on tobacco

In Croatia, a pack of cigarettes costs 23.00 HRK¹ (US\$ 4.04), of which 75.26% is tax (20.00% is value added and 55.26% is excise taxes) (4).

¹ The currency code is according to International Organization for Standardization, ISO 4217 currency names and code elements.

About the SimSmoke model

The abridged version of the SimSmoke tobacco control model, developed by David Levy of Georgetown University, United States of America, projects the reduction in smoking prevalence and smoking-attributable deaths as a result of implementing tobacco control policies (individually and in combination) (3). Specifically, the model projects the effects from:

- protecting from secondhand smoke through stronger smoke-free air laws
- offering greater access to smoking cessation services
- placing warnings on tobacco packages and other media/educational programmes
- enforcing bans on advertising, promotion and sponsorship
- raising cigarette prices through higher cigarette taxes (6).

For the SimSmoke model, data on smoking prevalence among adults were taken from the most recent nationally representative survey that covered a wide age range, and data on tobacco control policies were taken from the *WHO report on the global tobacco epidemic, 2015* (4).

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References²

1. Glavak Tkalić R, Miletić G-M, Sakoman S. Prevalence of substance use among the general population: situation in Croatia and comparison with other European countries. *Druš. Istraž.* 2013;22(4):557–78.
2. WHO Framework Convention on Tobacco Control [website]. Geneva: Convention Secretariat and World Health Organization; 2016 (<http://www.who.int/fctc/en/>).
3. Levy DT, Fouad H, Levy J, Dragomir AD, El Awa F. Application of the Abridged SimSmoke model to four Eastern Mediterranean countries. *Tob Control.* 2015. doi:10.1136/tobaccocontrol-2015-052334 [Epub ahead of print].
4. WHO report on the global tobacco epidemic, 2015: raising taxes on tobacco. Geneva: World Health Organization; 2015 (http://www.who.int/tobacco/global_report/2015/en/).
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6. Tobacco Free Initiative MPOWER [website]. Geneva: World Health Organization; 2016 (<http://www.who.int/tobacco/mpower/en/>).

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² Websites accessed on 19 February 2016.