THIRD ACTION PLAN FOR A TOBACCO-FREE EUROPE 1997–2001

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

TARGET 17

TOBACCO, ALCOHOL AND PSYCHOACTIVE DRUGS

By the year 2000, the health-damaging consumption of dependence-producing substances such as alcohol, tobacco and psychoactive drugs should have been significantly reduced in all Member States.

ABSTRACT

Keywords

SMOKING – prevention and control
TOBACCO
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PROGRAM EVALUATION
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SUMMARY

Tobacco products are responsible for 1.2 million deaths (14% of all deaths) each year in WHO's European Region. It is predicted that, unless stricter measures are implemented, tobacco products will be responsible for 2 million deaths (20% of all deaths) each year by 2020. Tobacco products cause a net economic loss to the world of at least US $200 billion a year. A reduction in tobacco use is the single most important public health action that countries can take for both health and economic gain.

Determined and unprecedented action is required to protect public health from the activities of the tobacco industry. Given the long and widespread availability of tobacco products, it is not at present feasible to prohibit their use. However, it is realistic and desirable to call for a significant and sustained reduction in daily smoking prevalence from the current level of over 30% of adults in the European Region of WHO. In particular, targeted action is needed to prevent a catastrophic escalation in smoking and the harm done by tobacco use among women and young people.

It is proposed that within each Member State intersectoral coordinating committees for tobacco control are appointed by competent authorities no later than 1998, with the respective ministries of health acting as secretariat. These coordinating committees should have responsibility for drawing up comprehensive action plans on tobacco, based on policies and programmes that have been demonstrated to be effective, taking into account gender perspectives. The coordinating committees should be answerable for theimplementation of the action plans.

The action plans should have clear timetables for implementation and specific age and gender-based targets for reductions in tobacco use. If the targets for reductions in tobacco use are not met, additional measures should be considered. Tobacco taxes or a special levy on tobacco products can be used to finance the implementation of the action plans.

To achieve more effective action than has been realized to date, it is proposed to set up a Committee for a Tobacco-free Europe, with effect from 1 January 1999, to support the development and implementation of country-based action plans on tobacco.

The Committee for a Tobacco-free Europe should, in addition, advise on international aspects of tobacco control policy as they affect the Region, particularly the development and implementation of the proposed international framework convention for tobacco control. The Committee should also have responsibility for regular reporting on the implementation of country-based action plans, gender-based action and international action against tobacco.

The Regional Office offers to act as secretariat to the Committee for a Tobacco-free Europe and to support the Committee's work through its international networks, its information database and its research and science base for effective policy.

The Regional Office will also support the development and implementation of country-based action plans through its networks and tobacco policy missions, particularly to countries in the eastern part of the Region.

THE NEED FOR ACTION IN EUROPE

Tobacco use in Europe

Manufactured tobacco products deliver regulated doses of the addictive drug nicotine. Tobacco products are the most readily used drug in WHO's European Region. Over 30% of adults are regular daily smokers. Smoking prevalence rates are considerably higher among men in the eastern part of the Region, than in the western part. In the north-western part of the Region, smoking prevalence rates are similar for men and women, whereas in the southern and eastern parts of the Region, smoking prevalence rates are considerably lower for women than for men.

Cigarette use is increasing in two fifths of countries, predominantly in the central and eastern part of the Region and particularly among women, decreasing in another two fifths, predominantly in the western part of the Region, and stable in one fifth. In two thirds of countries, cigarette use is increasing among young people who, along with women, are a target group of the tobacco industries.

Tobacco and harm in Europe

Tobacco products are the most dangerous commonly used drug in the European Region. One half of all people who regularly smoke will die from cigarettes, half in middle age and half in old age. Cigarettes are responsible for about 30% of all cancer deaths, 20% of deaths from coronary heart disease and stroke and 80% of cases of chronic obstructive lung disease. There are benefits at all ages for stopping smoking, but cessation before middle age reduces almost all of the excess risk.

Exposure to environmental tobacco smoke (enforced smoking), which is widespread, increases the risk of lung cancer, coronary heart disease, respiratory illness and, among infants, sudden infant death syndrome. Maternal smoking during pregnancy is associated with a higher risk of lower birth weight babies.

Cigarettes were responsible for an estimated 1.2 million deaths (14% of all deaths) in the European Region in 1995. Middle-aged men in the eastern part of the Region are twice as likely to die from a tobacco-related death than middle-aged men in the western part of the Region. Tobacco products are responsible for 25% of the social class gradient of mortality from coronary heart disease that occurs in the western part of the Region. If current trends in smoking prevalence continue, tobacco-related deaths in women will increase dramatically during the first part of the 21st century. It is predicted that, unless stricter measures are implemented, tobacco products will be responsible for 2 million deaths (20% of all deaths) each year by 2020.

The economic burden of tobacco

Tobacco is a significant economic burden to individuals, families and society through medical costs, lost productivity from increased morbidity, costs from fire and damage to property and foregone income due to early mortality.

The World Bank estimates that tobacco products cause an economic loss to the world of at least US $200 billion a year. They are responsible for environmental degradation and cause untold suffering to individual smokers, their families and friends.

There are also significant economic losses through failure to collect taxes on smuggled tobacco products, which are particularly prevalent in the eastern part of the Region, an area with scarce governmental financial resources.

POLICY RESPONSE IN EUROPE TO DATE

Annex 1 contains an evaluation of the first and second Action Plans for a Tobacco-free Europe.

Country-based action

Although the vast majority of countries in the European Region have some element of tobacco policy, there remains a lack of commitment and failure to implement effective gender-based policy.

In general, the Nordic countries and some western European countries have the most comprehensive legislative frameworks. Some countries in the eastern part of the Region have also recently established comprehensive legislative frameworks.

Article 129 of the Maastricht Treaty on European Union states that health considerations should be taken into account in all EU policies. Through its directives, the EU has set minimum standards for tobacco control policy, but to date there has been a failure in the EU to agree a phasing out of agricultural subsidies for tobacco. In July 1998, the European Union agreed proposals to introduce a ban on tobacco advertising and sponsorship.

Health policy for Europe

Target 17 of the 1991 health policy for Europe calls on Member States to increase the number of nonsmokers to at least 80% of the population and to protect nonsmokers from involuntary exposure to tobacco smoke by the year 2000.

In 1988, the Madrid European Conference on Tobacco Policy adopted the Charter against Tobacco. Action on tobacco in Europe has been supported by 16 resolutions of the World Health Assembly and two Action Plans for a Tobacco-free Europe, spanning the period 1987–1996.

Although the Regional Office for Europe (EURO) has analysed the problem, documented effective policy and advocated for policy implementation, no country is likely to achieve target 17, since there has been a failure to counteract the marketing strategies of the tobacco industry.

Obstacles to smoke-free policies

While the Region provides several examples of a comprehensive approach to smoke-free policies, there are also many examples of piecemeal measures and failure to implement legislation. So far, very few countries have taken into account the need to prevent the increase in women's smoking in their national programmes, almost none of which are gender-based. Transnational television and press advertising are problems for a large number of countries, as is the enforcement of legislation banning sales of tobacco products to young people.

Countries in the eastern part of the Region have been paid particular attention by the transnational tobacco companies, not just in terms of advertising and promotion but also in the form of considerable investment in their tobacco-manufacturing sectors. This development has taken place in a situation where new tobacco legislation has not yet been implemented. Compounding the problem for many of these countries has been a failure to regulate smuggling and collect taxes on all tobacco products.

The push by multinational companies into new markets has been greatly assisted by the philosophy of free trade. For commodities which potentially threaten public health or order, international agreements exist under which nations control exports and support each other's market controls. This is notably the case for psychoactive drugs under international control, but not, so far, for tobacco. In 1996, however, the World Health Assembly by resolution WHA49.17 called for the development of an international framework convention for tobacco control. The Assembly proposed cooperation in achieving broadly stated goals, with the possibility that parties to the convention conclude separate protocols containing

specific measures designed to attain these goals. A framework convention would be technically binding but contain no explicit obligations.

EFFECTIVE ACTION FOR A TOBACCO-FREE EUROPE

Research and successful examples in Europe and throughout the world demonstrate that significant reductions in tobacco use leading to significant health and economic gain can be achieved through flexible, differentiated and novel implementation of strategies which are known to be effective.

Since tobacco products are manufactured to deliver regulated doses of the addictive drug nicotine, and in view of the severe health consequences of tobacco to users and the substantial increased risk to health through exposure to environmental tobacco smoke, consideration should be given to regulation of tobacco through appropriate drug regulation agencies, as is the case with the Food and Drug Administration in the United States.

Regulation of the market

Price

Raising taxes on tobacco products increases government revenue, corrects for externalities and decreases tobacco consumption. In general, a 10% increase in the price of cigarettes leads to a decrease in the quantity smoked by the total population of about 5% and by young people of 10–15%.

Establishing minimum allowable prices for tobacco products will keep price-sensitive consumers (particularly young people) out of the market and may prevent many of them from ever starting to smoke. All tobacco products should be taxed to the extent that substitution of one tobacco product by another does not occur. Tobacco prices should not be part of the consumer price index; this will avoid any inflationary impact on the cost of living index.

Tobacco taxes could be used to fund all tobacco control activities, including health education, research on tobacco control and support to health services. Tobacco tax revenue can also be used to fund sports and artistic events formerly sponsored by the tobacco industry.

By the year 2001, all countries of the European Region should have implemented taxation policy for tobacco products to reduce tobacco use, with the real price of tobacco being increased by more than the average inflation rate thereafter.

Availability

Restricting access to tobacco products for people under 18 years of age is effective in reducing the number of adolescents and young people who become daily smokers.

One way of implementing restrictions on sale is to ensure that tobacco products are sold only in a direct face-to-face exchange between a licensed retailer and the consumer. Further, it should be the legal responsibility of retailers to verify that people who intend to purchase tobacco products are legally entitled to do so. Thus, self-service displays, mail-order sales, vending machines and other impersonal modes of sale would need to be eliminated.

Making the minimum package size for cigarettes a closed packet of 20 would preclude the ready availability to younger people of smaller and cheaper packet sizes and single cigarettes. Manufacturers, distributors and retailers should be prohibited from distributing free samples of tobacco products.

By the year 2001, all countries of the European Region should have implemented legislation to restrict access to tobacco products for people under 18 years of age, eliminating all impersonal modes of sale.

Advertising

There is a causal relationship between advertising and youth smoking behaviour, and a positive effect of stringent advertising measures on smoking rates and on youth smoking. Specific marketing campaigns directed at young people encourage them to start smoking, sustain their smoking habit and increase consumption. Campaigns targeted at women and their changing roles in society are particularly effective in recruiting young women smokers.

If tobacco consumption – and particularly that of women and young people – is to be reduced significantly and quickly, it is essential to have total bans on advertising, on all sponsored events being identified with a tobacco product brand name or characteristic, and on the sale or distribution of all non-tobacco items that are identified with a tobacco product brand name or characteristic. In addition, because of the importance of imagery, the use of a non-tobacco product's trade or brand name as the trade or brand name for a tobacco product should not be allowed.

By the year 2001, all countries of the European Region should have implemented a total ban on advertising of tobacco products.

Control of smuggling

Substantial smuggling occurs in a number of situations, including those where market controls are weak and where there is a need to establish market dominance. Within the European Union, smuggling tends to occur from countries with high-cost cigarettes to those with low-cost cigarettes. Reduction in price is not an effective control strategy. Although a reduction in price may lead to a temporary and small reduction in smuggling, the net effect is an overall increase in tobacco use. An effective strategy utilizes duty-paid stamps on cigarette packets, with a responsibility on retailers to sell only products with duty-paid stamps.

By the year 2001, effective tools to combat the smuggling of tobacco products should be implemented in all countries of the European Region.

Product control, identification and information

Each tobacco product and advertisement, where these have not yet been prohibited, should state the product's established name, describe its intended use and give a brief statement regarding relevant warnings, precautions, side-effects and contraindications. There should be requirements for strong health warnings occupying at least 20% of the front and 20% of the back of tobacco packages and 20% of any advertisements in countries where these have not yet been prohibited. Legislation should set maximum levels of tar at 12 mg and of nicotine at 1 mg per cigarette.

By the year 2001, legislation should be enacted in all countries of the European Region to ensure that health warnings occupy at least 20% of the front and 20% of the back of tobacco packages and that maximum levels of tar are set at 12 mg and of nicotine at 1 mg per cigarette by the year 2005.

Litigation and product liability

Judicial action against the tobacco industry is being made through court cases in Europe and North America. Lawsuits on grounds of product liability are seeking compensation from cigarette manufacturers for ill smokers (and people ill from exposure to environmental tobacco smoke) or their surviving relatives and for authorities providing health care costs. These lawsuits allege that tobacco products are unreasonably dangerous in that their risks exceed any possible benefits, or that the manufacturers have failed to give full disclosure of additives, have failed to give full undiluted warnings

and have failed to pursue safer product designs. As a consequence of litigation in the United States, a settlement was proposed between the States and the tobacco industry. There seems little doubt that in the immediate future, lawyers' organizations and advocacy organizations will expand judicial action against the tobacco industry throughout the European Region.

Smoke-free environments

Legislation to control smoking in public places minimizes and eventually eliminates the risks of involuntary exposure to tobacco smoke and protects the right of nonsmokers to a smoke-free environment. Legislation also deters young people from smoking, by conveying the idea that smoking is socially unacceptable, and it provides support to the large numbers of smokers who want to quit. Furthermore, legislation improves public safety by reducing the risk of fire and damage to structures and furnishings. Legal restrictions need to be supplemented by educational work and advocacy among both the general public and policy-makers about the advantages of creating smoke-free common environments.

By the year 2001, legislation should be enacted in all countries of the European Region to ensure that involuntary exposure to tobacco smoke is eliminated in all workplaces, all public buildings and all forms of public transport.

Support for smoking cessation

A number of surveys show that some two thirds of current smokers report that they would like to stop smoking completely. Unselective brief interventions in primary health care settings are both effective and cost-effective in supporting smoking cessation, with one-year quit rates of 5% to 10%. These cessation rates can be doubled using nicotine replacement therapy. Interventions which are more selective and of longer duration provide greater motivation for change, and their follow-up sessions produce higher success rates of between 20% and 40%. Primary health care providers who have received skills-based training are more likely to be involved in smoking cessation activities and have higher success rates than those who do not receive training. Gender-based cessation programmes need to be widely implemented. Further, targeted activities for pregnant women can lead to significant health gain for neonates and infants.

Training programmes need to be widely implemented for primary health care providers, including nurses, physicians, pharmacists and dentists, and incentives offered for giving brief interventions in primary health care.

By the year 2001, all countries of the European Region should have introduced training programmes in smoking cessation techniques, according to agreed standards, for primary health care physicians, nurses, pharmacists and dentists, together with mechanisms for monitoring their impact.

Education, public information and public opinion

Intensive education and counter-advertising media campaigns are effective in reducing smoking use. While reviews of school-based education show that its influence on attitudes and behaviour is uncertain, some elements (particularly peer-led sessions and skill-based learning) have been demonstrated to have an impact on smoking behaviour and should receive greater emphasis.

It is important to mobilize popular movements to take action against tobacco and create a climate of opinion which is more supportive of reduced tobacco use. Civil society should receive open information about the tobacco industry's structures, funding activities, knowledge base and potential for political influence and decision-making.

Popular movements, the response by civil society and policy initiatives can all be supported by a media advocacy process. Media advocacy has been described as the strategic use of the mass media for

advancing social or public policy initiatives. The mass media are effective in setting the public agenda and stimulating public discussion.

In community action, the emphasis should be on mobilization and organization rather than on intervention. Comprehensive gender-based community programmes can reduce tobacco use and improve the health of the population. More sharply focused community interventions, while leading to change, have a smaller impact.

By the year 2001, coordinated and sustainable gender-based media campaigns should be mounted in all countries of the European Region to promote public support for tobacco control policy, and effective school gender-based education about tobacco should be implemented in all schools in all countries of the European Region.

ROLE OF MEMBER STATES

Country-based coordinating committees

If effective action is to be taken, it is necessary for each country to establish and maintain adequately funded coordinating committees on tobacco, with ministries of health acting as secretariats.

These coordinating committees should be intersectoral in composition and consist of representatives of relevant government departments (including the finance and justice department), other levels of government, the media, nongovernmental organizations (including those dealing with cancer), and medical, nursing, pharmaceutical and other professional associations, as well as lawyers, educators and religious leaders.

The coordinating committees should have responsibility for developing and implementing country-based action plans on tobacco, taking into account gender perspectives with specific targets and timetables for implementation.

By the year 1998, adequately funded committees for coordinating action against tobacco should be operational in all Member States.

Country-based action plans

Country-based action plans should be comprehensive and gender-based, and include policy and programme elements of proven effectiveness.

The action plans should have a clear timetable for implementation, and gender-based targets for reduced use of tobacco products. If the targets for reduction in tobacco use are not met, additional measures should be considered.

If effective action is to be taken, comprehensive tobacco control measures need to be adequately funded. A proportion of tobacco taxes or a special levy on tobacco products can be used to fund activities under country-based action plans such as the implementation and monitoring of tobacco control measures, education about the hazards of tobacco and other initiatives for health purposes, including the implementation of effective programmes for smoking cessation by primary health care providers and meeting the costs of relevant sponsorship of arts and sporting events.

By the year 1999, adequately funded country-based plans of action against tobacco should be drawn up in all Member States, taking into account the need for gender and age specificity at all levels of action.

Monitoring and evaluation

Successful implementation of tobacco control activities requires effective monitoring and evaluation of tobacco use, tobacco-related harms and tobacco control policy responses. Monitoring and evaluation should cover action at the international, country and local levels, be intersectoral and address both governmental and nongovernmental action. Effective monitoring should include information on the enforcement of legislation, on smoke-free environments, on public opinion and on the structures, finances and actions of the tobacco industry. Ongoing research into effective policy development and implementation should be undertaken and documented.

Starting in 1998, and every two years thereafter, each country in the European Region should prepare and publish a comprehensive report on the use of tobacco products, tobacco-related harm and the implementation of tobacco control policy.

COMMITTEE FOR A TOBACCO-FREE EUROPE

To achieve more effective action, it is proposed to set up a Committee for a Tobacco-free Europe (CTE), to support the development and implementation of country-based plans of action on tobacco throughout the European Region. The CTE should become operational with effect from 1 January 1999, with WHO offering to act as the principal technical instrument and secretariat. The CTE should comprise up to four representatives designated by the WHO Regional Committee for Europe and – subject to the agreement of the respective institutions to being members of the CTE – representatives designated by the United Nations Economic Commission for Europe, the European Commission, the Council of Europe, the World Bank and possibly other intergovernmental and nongovernmental organizations.

The CTE should advise on and actively support international aspects of tobacco control policy as they affect the Region, including the regional response to the forthcoming international framework convention for tobacco control.

The CTE should also have responsibility for regularly reporting on the implementation of country-based action plans and international action against tobacco. In its membership, the CTE needs to recognize the increasing harm done by tobacco use to women.

INTERNATIONAL PARTNERS FOR ACTION

Integrational and intergovernmental organizations

Within the European Region, integrational and intergovernmental bodies provide the platform for multilateral action on tobacco; WHO's proposed role in this area is set out in the next section. Article 129 of the Maastricht Treaty has created opportunities to view tobacco as a health issue, rather than as an economic issue, in the European Union (EU). The EU member states can take forward effective implementation of internationally-based policy against tobacco, which would have a significant impact on policies in other parts of the Region. Building on existing policy, implementation of the Action Plan for a Tobacco-free Europe can be enhanced through a Europe-wide total ban on the advertising of tobacco products and a phasing out of agricultural subsidies for tobacco. Regulations on package warning labels and limits on tar and nicotine content can all be strengthened. Through the activities of the European Commission, opportunities exist for supporting competence-building at all levels of society and research into effective policy implementation in the Member States not only of EU but also of the whole of WHO's European Region.

The Council of Europe can support the regional Action Plan through its various programmes and resolutions addressing the parliaments and governments of its member states, with particular emphasis on

ethical considerations linked to issues such as exposure to environmental tobacco smoke and smoke-free environments.

Nongovernmental organizations

Throughout the Region, an extensive array of nongovernmental organizations and networks have experience and competence in advocating for tobacco control policy at the international and country levels. These organizations and networks include those which have a specific tobacco control advocacy function, cancer organizations with responsibility for tobacco control activities, health care professional associations, and representatives of civil society and consumer organizations which have included action against tobacco within their remit. Nongovernmental organizations and networks have a specific role to play in informing and mobilizing civil society with respect to the harm done by tobacco use and the need for effective tobacco control policy. Representation by women's groups are of particular importance in policy development. Nongovernmental organizations also have a clear mandate to report on existing government policy and action and to lobby for policy change and effective policy implementation at the governmental level. Nongovernmental organizations and networks are active in exposing the actions of the tobacco industry.

Health care professions

Through their public health expertise and experience, health care professions have a special responsibility to mobilize their members and lobby for effective action against tobacco. At the regional level there are European fora of national medical, nursing and pharmaceutical associations in formal collaboration with WHO, as well as of dental associations in informal collaboration. Members of these associations, and in particular women, make up a considerable workforce throughout the Region which needs to be mobilized to set its own example of nonsmoking behaviour, to provide support for smoking cessation and to act as advocates for tobacco control policy at local, country and international levels. In this respect, the European Forum of Medical Associations and WHO (EFMA) and the European Forum of Pharmaceutical Associations and WHO (EuroPharm Forum) have taken decisive steps to support nonsmoking and smoking cessation action, both for their own members and for the general public.

ROLE OF THE WHO REGIONAL OFFICE FOR EUROPE

Support for country-based action plans and country-based networks

Through demonstration projects, the eastern part of the Region has been given priority attention in a global project to strengthen tobacco control. EURO will continue to support the development and implementation of country-based action plans and will continue its series of policy missions, particularly to countries of eastern Europe, to advise on and strengthen the implementation of effective tobacco control policy.

EURO will support country-based action plans through its networks, including those of medical, nursing and pharmaceutical associations, the countrywide integrated noncommunicable disease intervention (CINDI) programme, the Regions for Health network, the Healthy Cities project, the Health Promoting Schools project and the Health-Promoting Hospitals project.

EURO will advise on and give an assessment of the effectiveness of country-based action plans, taking into account gender perspectives.

Committee for a Tobacco-free Europe and mobilizing partners

EURO will offer to act as secretariat and principal technical instrument to the CTE as well as taking the lead in international coordination of work to implement the third Action Plan, in line with its mandate to reduce tobacco use. In so doing, it will be supported by its collaborating centres and will maintain its international partnerships, including those with other relevant specialized agencies of the United Nations

system, the World Bank, the European Commission's Europe against Cancer programme, the Council of Europe, the Nordic Council, the International Union for Health Promotion, the International Network of Women Against Tobacco, the European Network for Smoking Prevention, the European Network of Young People and Tobacco, the International Union against Cancer and the European fora of medical, nursing, pharmaceutical and dental associations.

The Office will continue to update its information database on tobacco use, tobacco-related harm and Member States' policy responses, through its database and questionnaire surveys to Member States, and will report to the CTE each year.

The Office will continue to develop a research and science base for effective policy through meetings and publications and will actively disseminate information, in printed and electronic forms, throughout its networks of policy-makers and those responsible for implementing policy at international, national and local levels.

Media advocacy

Through its media and communication activities, EURO will ensure that civil society receives open information about the tobacco industry's structures, funding activities, knowledge base and potential for political influence and decision-making.

Popular movements, the response by civil society and policy initiatives will be supported through a process of media advocacy and joint work with the European Health Communication Network.

Actions aimed at the women and youth market will be developed with the media to counteract the activities of the tobacco industry and to foster the important process of cultural change for reduced tobacco use.

CONCLUSION

Tobacco is one of the greatest public health challenges facing the European Region of WHO. Solutions to this challenge are well known. What is needed now is to exercise political will, mobilize civil society and carry out systematic programmes in every Member State to implement the effective strategies outlined above. Ministries and government departments responsible for finance and taxation need to be persuaded that regular increases in tobacco tax raise revenue, correct for externalities such as health costs and deter tobacco consumption. Ministries and government departments responsible for customs need to be persuaded that failure to control tobacco smuggling is leading to lost revenue and lost lives. Government ministries and departments need to be persuaded that effective action requires a total ban on tobacco advertising and prohibition of sponsorship associated with a tobacco brand name or product, and that restricting access to tobacco products by people under 18 years of age is an effective way of reducing the number of young people who become daily smokers.

The Action Plan for a Tobacco-free Europe creates a European movement to reduce tobacco use, promote health and economic gain, and protect the public from the activities of the tobacco industry.

Annex 1

TOBACCO IN EUROPE 1988–1996: EVALUATION OF THE FIRST AND SECOND ACTION PLANS FOR A TOBACCO-FREE EUROPE

1. THE HARM DONE BY TOBACCO USE

One half of all people who regularly smoke will die from cigarettes, half in middle age and half in old age. Exposure to environmental tobacco smoke, which is widespread, increases the risk of lung cancer and, among infants, of sudden infant death. The World Bank estimates that tobacco products cost the world at least US $200 billion a year, are responsible for environmental degradation and cause untold suffering to individuals, families and friends.

The public health community and indeed the tobacco industry have known of the harm done by tobacco use since the 1960s. What has become clearer in recent years has been the severity of harm, the importance of exposure to environmental tobacco smoke and the extensive economic costs to individuals and societies resulting from tobacco use. It has become clear that tobacco is not only a health issue but also an economic issue, leading to significant and widespread economic loss. It has also been made public that the tobacco industry has known of the harm done by tobacco use for a long time, although the industry has consistently concealed and denied this knowledge.

2. COUNTERACTING THE HARM DONE BY TOBACCO USE

The effective policy responses to reduce the harm done by tobacco use have been known for many years. They include legislative measures to increase the price of tobacco products and restrict their marketing and availability, educational measures to inform the public of the harm done by tobacco use, and measures to promote cultural changes to reduce tobacco use.

What has become clearer in recent years is the need for comprehensive policy approaches supported by intersectoral and international action. Recognition of the harm done by environmental tobacco smoke and the creation of smoke-free public places have promoted a cultural change towards reduced tobacco use and increased support for tobacco control measures. The use of litigation and the recognition of product liability, even by the tobacco industries, have become powerful public health tools to limit the marketing and availability of tobacco products. In the United States of America, tobacco has been recognized as a drug, with the US Food and Drug Administration asserting jurisdiction over cigarettes. It has also been made public that the tobacco industry has known of the addictive properties of nicotine and of the impact of targeted advertising and marketing to recruit new young smokers, although it has concealed this knowledge and denied this practice.

3. THE POLICY RESPONSE

With the knowledge of the harm done by tobacco use and the availability of effective policy responses, how have countries, the European Region and the global community responded?

Response at the global level

Since 1970, the World Health Assembly has adopted 16 resolutions on tobacco or health issues calling for comprehensive, multisectoral, long-term tobacco control strategies. Unlike the situation with regard to illegal drugs, where international agreements exist by which countries control exports and support each other's market controls, to date there have been no international agreements on tobacco. However, in 1996, World Health Assembly resolution WHA49.17 requested the Director-General to initiate the development of a framework convention for tobacco control in accordance with Article 19 of the WHO Constitution.

Response in the European Region

The Regional Committee for Europe has adopted two resolutions supporting the Action Plans for a Tobacco-free Europe. The first Action Plan ran from 1987 to 1991 and called for the formulation of national programmes, greater cooperation between organizations and sectors, wider availability of public information and the establishment of a European monitoring and evaluation system. In 1988, the Madrid European Conference on Tobacco Policy adopted the Charter against Tobacco, listing six ethical principles and ten strategies for a tobacco-free Europe.

In 1991, Member States reconfirmed their commitment to the health policy for Europe, target 17 of which calls for an increase in the number of nonsmokers to at least 80% of the population by the year 2000 and the protection of nonsmokers from involuntary exposure to tobacco smoke.

The second Action Plan put forward 37 action proposals in six areas: alliance-building, multisectoral tobacco policies, smoke-free environments, smoking prevention among young people, support to smokers for quitting, and strengthening the capacity for implementation of policy.

Through its resolutions, the Madrid Charter against Tobacco and the Action Plans for a Tobacco-free Europe, WHO has provided the strategic framework for effective action to reduce tobacco use and tobacco-related harm. This framework for action has been supported by policy missions and conferences to at least ten countries in the eastern part of the Region, which have resulted in significant policy development and the implementation of effective legislation.

The Regional Office for Europe (EURO) has built up an extensive network to support the implementation of tobacco policy. The network includes counterparts nominated by all Member States, five WHO collaborating centres, and partnerships with integrational, intergovernmental and nongovernmental organizations, including the European Commission's Europe against Cancer programme, the World Bank, the Council of Europe, the Nordic Council, the International Union for Health Promotion, the European Network for Smoking Prevention, the International Union against Cancer and European fora of medical and pharmaceutical associations.

EURO has compiled an extensive information base on tobacco use, tobacco-related harms and tobacco policy in all Member States; this information is documented in tobacco profiles for Europe and has been summarized in *Smoking, drinking and drug taking in the European Region*.[1] The information base is being updated during 1997.

At country level, tobacco policy and programmes are also being implemented throughout EURO's networks. The multi-city action plan on tobacco develops models of good practice with regard to municipal legislation and programmes for tobacco control and disseminates the experience gained throughout the Healthy Cities project network. Based on the Health Promoting Schools project, young people are being mobilized to take action in countries of eastern Europe, thereby strengthening the role of the health-promoting school as an agent for community change and action. The Regions for Health network is developing and implementing a series of action plans for tobacco-free regions.

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[1] Harkin, A.-M. et al. *Smoking, drinking and drug taking in the European Region*. Copenhagen, WHO Regional Office for Europe, 1997.

Programmes have been drawn up and put into practice in English and Russian to train the trainers of primary health care providers in the skills required to motivate people to make lifestyle changes, thereby supporting smokers who wish to quit. The EuroPharm Forum's Pharmacists' Charter against Smoking is being actively disseminated. The CINDI programme is supporting activity in primary health care and, through the "Quit and Win" campaign, public information and smoking cessation programmes.

Although the Action Plans have created effective networks, supported nongovernmental action and been an important stimulus for tobacco control activities, there remains a need for more focused and coordinated activity at the country level.

Response in the European Union

Within one part of the European Region, the EU, under article 129 of the Maastricht Treaty, has started to regard tobacco as a health rather than an economic issue. The EU has issued directives, which are binding on member states, on some aspects of tobacco control policy, including a ban on television advertising, regulations on labelling packages, limits on tar content and the approximation of tobacco taxation. The EU has issued opinions (which are non-binding) on other aspects, including banning smoking in places open to the public. Through its directives, the EU has set minimum standards for tobacco control policy, but to date there has been a failure to agree on a total ban on advertising and a phasing out of agricultural subsidies on tobacco. EU policies have a significant impact on the development of tobacco policy in non-EU countries.

Response in countries

The vast majority of countries in the European Region have some elements of a tobacco policy in place, but there is considerable variation in its extent and comprehensiveness. In general, the Nordic countries and some western European countries have the most comprehensive legislative frameworks. However, some countries in the eastern part of the Region have also established or are establishing comprehensive legislative frameworks. While legislative control is overwhelmingly the approach most in evidence in the Region, some countries favour voluntary agreements with the tobacco industry.

Countries are beginning to exercise political will, to obtain public support for action and to implement effective comprehensive tobacco control programmes and legislation. However, there remain problems in many countries in securing interministerial and intersectoral support for tobacco policy and ensuring the lasting and effective implementation of legislation.

4. WHAT HAS BEEN THE IMPACT?

Using the indicators of smoking prevalence and tobacco-related mortality, the impact of policies and action have, in recent years, been poor throughout the Region as a whole. Although in a number of countries the prevalence of cigarette smoking has declined from the high levels of the 1960s and 1970s, as of the mid-1990s, over 30% of adults within the Region remained regular daily smokers (Fig. 1).

Cigarette use among adults varies from over 40% in the Russian Federation to around 25% or less in Belgium, Finland and Sweden. Smoking rates among men are particularly high in Armenia, Estonia, Latvia, Lithuania, Poland, the Republic of Moldova, the Russian Federation, Turkey and Ukraine, and lower in Ireland, Sweden and the United Kingdom.

The highest rates among women are to be found in Denmark, Hungary and Norway. Less than 10% of women smoke in Albania, Armenia and Uzbekistan.

Fig. 1. Prevalence of smoking in adults in countries of the WHO European Region, early to mid-1990s (%)

Source: WHO tobacco or health database 1996. Figures for Bosnia and Herzegovina are from a survey of health professionals. Figures for the Russian Federation are estimates by the Ministry of Health and Medical Industry.

Of the 36 countries for which data are available, cigarette use is increasing in 15 countries (predominantly in the central and eastern part of the Region), decreasing in another 14 (predominantly in western Europe and the Nordic countries), and stable in 7. Prevalence among women, while generally lower than that among men, is increasing in 15 countries.

Of the 33 countries for which there is information on trends in smoking among young people, cigarette use is increasing in 21 countries, declining in 7 and stable in 5.

Cigarettes were responsible for about 1.2 million deaths in the Region in 1995, of which almost three quarters of a million occurred in middle age (35–69 years). The percentage of all deaths among men aged 35–69 attributable to smoking ranges from 11% to 46%, with the highest proportions in the eastern part of the Region (Fig. 2). Among women the percentage of all deaths in those aged 35–69 attributable to smoking ranges from less than 1% to 31%, with the highest proportions in the western part of the Region.

In western European countries, smoking-related deaths are decreasing among men but increasing among women. In eastern European countries, smoking-related deaths are increasing among both men and women. It is predicted that, unless stricter measures are implemented, tobacco products will be responsible for 2 million deaths in the Region (20% of all deaths) in the year 2020.

5. WHY HAS THE OUTCOME BEEN SO POOR?

There are a number of reasons for the poor outcome in recent years.

It can be argued that the public health sector has lagged some 20 to 30 years behind the transnational tobacco companies. Its failure to act in the 1960s and 1970s has made effective action in the 1990s very difficult. Market forces have gained power at the expense of health. Free markets have produced strong vested interests and strong lobbying forces, vigorously opposed to any attempts to reduce the use of tobacco. Too little has been done to counteract the marketing actions of the tobacco industry, whose main aim is to collect even more profits at the direct expense of health.

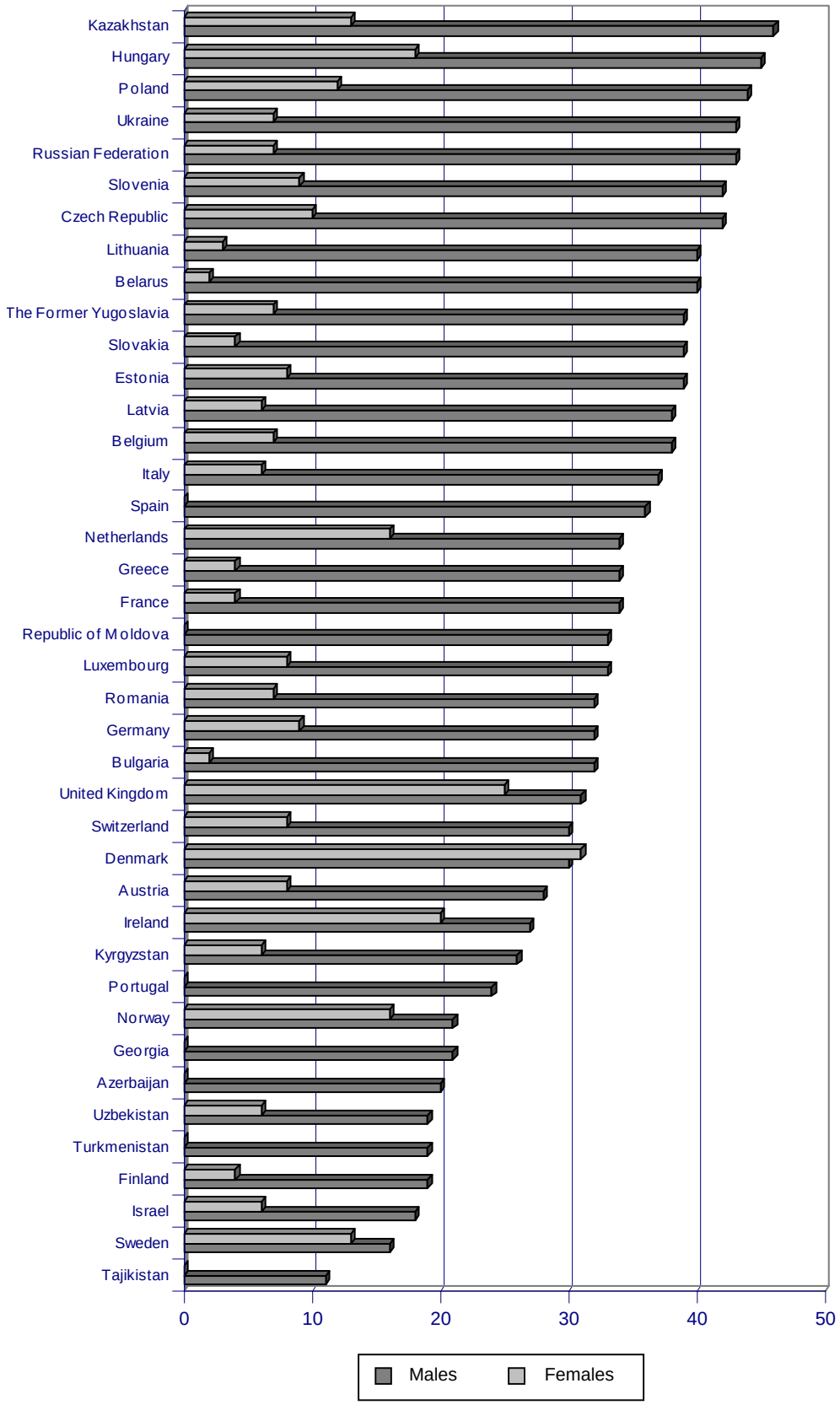
Throughout the Region as a whole, there has been a lack of interministerial and intersectoral political will to implement extensive and comprehensive tobacco control policy. However, where there have been exceptions, positive results have been achieved in terms of reductions in tobacco use and exposure to environmental tobacco smoke.

For example, the Loi Evin (which was introduced in 1991 in France) prohibited the advertising of tobacco, removed tobacco from the consumer price index and introduced smoke-free public places. After 15 years of increasing consumption, cigarette consumption had declined by 9% by 1995. The law received widespread public support. Indeed, three quarters of all people in the EU favour a ban on cigarette advertising.

The 1994 amendment to the 1977 Finnish anti-tobacco law prohibited smoking at all indoor worksites, tobacco advertising and the sale of tobacco to persons under 18 years of age. In the year following the amendment, the proportion of people exposed to environmental tobacco smoke at work decreased sharply, particularly among smokers. Nearly all nonsmokers and three quarters of smokers supported the regulations at the workplace.

The United Kingdom has committed itself to using the rate of tobacco taxation as one instrument for reducing tobacco consumption, by raising tax rates on cigarettes in real terms by at least 3% per annum in future budgets. About one half of the 23% reduction in smoking that occurred in the United Kingdom during 1976–1988 was achieved by an overall rise in cigarette prices.

Fig. 2. Projected percentage of deaths attributable to smoking in males and females aged 35–69 years in countries of the WHO European Region, 1995 (ranked according to percentage of deaths in males)



Source: Peto, R. et al. *Mortality from smoking in developed countries 1950–2000*. Oxford University Press, 1994. (No separate data are available for Albania, Armenia, Iceland, Malta, Monaco, San Marino or Turkey. Data for the countries of the former Yugoslavia are only available in aggregate form.)

Countries in the eastern part of the Region have since the early 1990s come under particular attention from the transnational tobacco companies, not just in terms of advertising and promotion but also in terms of considerable investment in their tobacco-manufacturing sectors. This development has taken place in a situation where the old legal frameworks surrounding tobacco were often no longer commanding support, and where new legislation had not yet been implemented. Sometimes aspects of the old legislation (such as bans on advertising or requirements for health warnings) were applicable only to domestically produced cigarettes, with no such controls on foreign cigarettes which came on the market following economic liberalization. Compounding the problem for many of these countries have been weak transitional border controls, which have resulted in widespread and systematic smuggling.

Many countries in the eastern part of the Region are also those with the highest prevalence of smoking among men and the highest level of tobacco-related mortality. The low rates of smoking among women are a particular target of the transnational tobacco companies. Putting comprehensive control frameworks in place and securing public support for regulating the marketing of tobacco are particularly urgent tasks in countries in the eastern part of the Region. It is encouraging to see that, as some countries with quite comprehensive measures in the western part of the Region move to strengthen them and close loopholes, other countries in the eastern part of the Region are succeeding in enacting comprehensive controls.

Annex 2

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE
COPENHAGEN

REGIONAL COMMITTEE FOR EUROPE
Forty-seventh session, Istanbul, 15 – 19 September 1997

RESOLUTION

EUR/RC47/R8
18 September 1997
12377
ORIGINAL: ENGLISH

THIRD ACTION PLAN FOR A TOBACCO-FREE EUROPE 1997–2001

The Regional Committee,

Recalling resolutions WHA39.14 and WHA43.16, which call for the implementation of comprehensive tobacco control policies, and WHA49.17 which requests the Director-General to initiate the development of a framework convention for tobacco control in accordance with Article 19 of the WHO Constitution;

Concerned by the continued threat to public health from tobacco consumption;

Having considered document EUR/RC47/12, which evaluates the outcome of the first and second Action Plans for a Tobacco-free Europe and contains proposals for a third Action Plan;

1. RECOGNIZES the third Action Plan for a Tobacco-free Europe as a set of basic principles for European Member States to follow, and notes the need for further exploring innovative solutions for its implementation;

2. DECIDES that:

(a) the WHO Regional Office for Europe shall examine the possibilities of setting up, in collaboration with the United Nations Economic Commission for Europe, the European Commission, the Council of Europe, the World Bank and possibly other intergovernmental and nongovernmental organizations, a Committee for a Tobacco-Free Europe to be in effect from 1 January 1999, initially for a period of five years;

(b) the functions of the Committee for a Tobacco-Free Europe shall be discussed with the collaborating partners on the basis of proposals set out in the third Action Plan for a Tobacco-free Europe;

(c) the WHO Regional Office for Europe shall offer to participants to act as the principal technical instrument for providing support to the Committee and as its secretariat;

3. URGES Member States to establish or make use of existing intersectoral mechanisms with responsibility for drawing up action plans on tobacco as part of their general prevention policies, also taking into account the gender perspective;

4. URGES European integrational, intergovernmental and nongovernmental organizations to join forces with the Committee for a Tobacco-Free Europe in joint action, maximizing their contribution to a Europe-wide effort to prevent and reduce tobacco consumption;

5. REQUESTS the Regional Director:

(a) to give high priority in terms of resource allocation to enable the Regional Office to examine the possibilities of setting up a Committee for a Tobacco-free Europe;

(b) to intensify efforts to raise voluntary contributions in order to fulfil WHO's international mandate in this field;

(c) to take into account the proposals and comments made by the Regional Committee in concluding the third Action Plan for a tobacco-free Europe;

(d) to report to the Regional Committee at its forty-eighth session on negotiations with the other integrational, intergovernmental and nongovernmental partners regarding their participation and the jointly agreed functions of the Committee for a Tobacco-free Europe, for approval by the Regional Committee.