WORLD HEALTH ORGANIZATION
EUROPE

# The current status of the tobacco epidemic in Poland


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## ABSTRACT

This report was prepared within the framework of the current biannual joint cooperation agreement between the World Health Organization and the Ministry of Health of Poland as an element in the implementation of the Bloomberg Global Tobacco Control Initiative. Poland was one of the countries that pioneered the tobacco control effort. In 1995 it passed the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products, amended multiple times since then. In 2006 Poland joined the Framework Convention for Tobacco Control. This report presents the current spread of tobacco-smoking in Poland, including the health and social aspects, epidemiological data and economic, legal and political issues. The report also seeks to define key areas in need of improvement and the consequential priorities of tobacco control policy in the medium term.



### Keywords

SMOKING – adverse effects – economics –prevention and control
TOBACCO – legislation
TOBACCO INDUSTRY – legislation
HEALTH POLICY
EPIDEMIOLOGIC STUDIES
POLAND

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The data in the report draw on the official national statistics maintained by the Central Statistical Office, official and legislative documents relating to tobacco control, analyses and monitoring conducted by the Ministry of Health, the State Sanitary Inspectorate and the Ministry of Finance, systematic epidemiological studies carried out by the Cancer Centre and Institute of Oncology in Warsaw and the Cancer Epidemiology and Prevention Department, and information provided by institutions such as the Ministry of Agriculture and Rural Development and the National Health Fund.

The report is an attempt to present the data, covering all aspects of the spread of tobacco-smoking, in the light of the changes that have occurred in this area in past years. Its authors have sought to describe the areas where improvements are needed and to formulate the priority tasks for medium-term tobacco control.

## Foreword

Tobacco-smoking is a serious threat to our civilization as a result of its prevalence and its detrimental impact on society and economic activity. In Poland, the nicotine dependence epidemic kills thousands of people of productive age every year and permanently disables or hampers the early development of a much larger number of individuals. The treatment of tobacco-related diseases accounts for a substantial proportion of expenditure on health. Nine to ten million regular tobacco-smokers define the footprint of the problem, while the powerful social, traditional and economic factors that determine its persistence also underpin its complexity. This is why the development of a health care strategy which checks exposure to tobacco smoke is one of the most important and urgent tasks and also one of the hardest because of the complexity of the issue.

We now possess extensive knowledge and understanding of the nature of this threat and its consequences. Over the past decade or so, we have amassed practical experience in the effective adoption of regulatory measures and implementation of systemic solutions which has contributed to a significant improvement in the situation and confirmed the relevance of our health policy directions and objectives. Now we need to intensify activities aimed at accelerating desirable changes in the general culture and the health-related behaviour of the population.

As we engage in the global movement to free the world's population from the grip of the nicotine dependence epidemic, we draw on the extensive intellectual achievement and practical experience available to us. With the support of the World Health Organization, the initiator and coordinator of the international cooperation in health, and of the Bloomberg Initiative to Reduce Tobacco Use, we can introduce elements of the strategy and enhance the effectiveness of our health policy.

Ewa Kopacz
Minister of Health

## Executive summary

Tobacco-smoking has been a persistent and serious social problem for years. This report presents the current status of the spread of tobacco dependence in Poland, with a discussion of the health, social, economic, legal and political aspects of the problem. It was prepared as part of the implementation of the Bloomberg Initiative within the framework of the Biennial Collaborative Agreement between the World Health Organization (WHO) Regional Office for Europe and the Ministry of Health of the Republic of Poland 2008–2009.

The WHO M-POWER report published in February 2008 *(1)* demonstrates that the tobacco-smoking epidemic kills 5.4 million people globally every year. Data from 2000 indicate that in Poland tobacco-smoking caused approximately 69 000 deaths, of which approximately 43 000 were premature deaths of individuals aged 35–69 years.

It is estimated that currently there are approximately nine million tobacco-smokers in Poland, representing 29% of the country's adult population. Results of a national survey conducted in 2007 indicate that 34% of men and 23% of women smoked on daily basis.

A gradual decline in tobacco-smoking has been observed over the past 30 years, although in recent years researchers have observed a slowdown in the rate of decline in smoking incidence among men and a halt in the declining trend among young adult women. The poorest people and those with the least formal education smoke much more frequently than more wealthy individuals with higher educational qualifications.

The data on tobacco-smoking incidence among children and young people are also highly alarming. The results of a 2003 survey indicate that 64% of boys and 53% of girls aged 13–15 years had already smoked, while 30% of boys and 21% of girls had tried their first cigarette before they were ten years old.

Passive smoking is another serious problem: at the workplace 19% of non-smoking individuals (24% of men and 14% of women) and at home 25% of non-smokers (29% of women and 20% of men) are exposed to involuntary inhalation of tobacco smoke. The scale of involuntary exposure to tobacco smoke among children is huge: every day approximately four million children involuntarily inhale tobacco smoke at home or in public places.

An important aspect of the fight against tobacco-smoking is the monitoring and study of this phenomenon. Carried out regularly, statistical studies and economic and health analyses can be solid and effective tools in systematically countering it.

The legal basis for the control of tobacco-smoking has been laid down by the Act on the Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products (as amended). This legislation covers the main areas of tobacco control policy, including bans on advertising and smoking in public places (with the exception of designated places in eating establishments) and the requirement to place warnings on the harmfulness of smoking on tobacco product packaging (30% of the larger pack surface).

Parliament is currently working on an amending bill incorporating some far-reaching tobacco control measures. These would provide for: the removal of all and any possibility of tobacco-smoking in designated facilities (smoking rooms) in schools and health care units; the introduction of a complete ban on tobacco-smoking in eating establishments, with an option of making available separate facilities for smoking purposes (smoking rooms); and the introduction of a complete ban on tobacco-smoking in all other public venues, e.g. at bus-stops. The legislative plans also provide for the more precise regulation of advertising and promotion of tobacco products, with the aim of preventing illicit marketing practices which abuse, for example, the imperfect definitions of the terms used in the law.

The Act on the Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products and the Act on Excise Duty Tax, with executive regulations promulgated by relevant ministers, complies with the provisions of the WHO Framework Convention for Tobacco Control, which Poland joined in 2006, and with the appropriate European Union (EU) directives.

A reduction in the spread of tobacco-smoking is included within operational objective 1, in the wider context of the risk factors and health promotion measures of the national health programme for 2007–2015. The abovementioned law and the basic premises of the national health programme formed the foundation for the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking, a policy paper complying with the provisions of the WHO Framework Convention. The central government officer engaged in coordinating the programme is the Chief Sanitary Inspector. The Prime Minister has established the Interministerial Coordinating Team, composed of representatives of the relevant ministries and other institutions engaged in improving the general health of the population and specifically in the prevention of tobacco-smoking. A great number of associations and other nongovernmental organizations are also involved in implementing tobacco control measures.

Health promotion programmes aimed at implementation of anti-tobacco measures should be funded from the state budget up to an amount equivalent to 0.5% of the revenue from cigarette excise duty. The funds transferred yearly for that purpose are, however, substantially lower.

Expenditure on health in Poland is 6.2% of gross domestic product (GDP), one of the lowest among the EU member states both as a percentage of GDP and in absolute terms. This is less than typical for developed economies.

Tobacco control activities in the health system related to prevention of tobacco-related diseases and dependence treatment are carried out under contract with the National Health Fund. However, at both primary and secondary, or specialist, levels of the health care system, implementation remains inadequate of programmes focusing on the prevention and treatment of tobacco-related diseases that involve anti-tobacco education and provision of support to individuals seeking to give up the habit.

Present tax policy provides for regular increases in the rates of excise duty levied on cigarettes above the rate of inflation. The rate of these increases is nonetheless too slow: Poland has yet to achieve the EU's minimum level of excise duty on cigarettes (€64 per

1000 pieces) as the expected cigarette price increases have not yet been reached. The mechanism for setting cigarette excise duty, which includes a relatively high percentage rate element (as opposed to the monetary value element), has resulted in tobacco companies being able to influence excise duty levels. Neither does the separate tax treatment of cigarettes and of loose tobacco help to curtail tobacco consumption: it leads only to changes in the relative share of the respective tobacco products on sale.

Overall, there are many areas of the tobacco control policy which continue to require effort. The effective legal regulations and systemic solutions do not ensure:

- adequate increases in excise duties and prices of cigarette and other tobacco products;
- complete smoking bans in public facilities;
- effective blockage of the possibility for advertising tobacco products under the guise of "non-public" forms of promotion, with attendant abuse of the trade information category.

Other shortcomings of the anti-tobacco policy include:

- the lack of warnings in the form of graphic signs on tobacco product packaging;
- inadequate provision in the health care system for anti-tobacco prophylaxis, the need for professional support for individuals wanting to stop smoking and for treatment of their dependence, and the inadequate involvement of the medical professions in combating tobacco-smoking; and
- the problem of access to cheaper cigarettes, roll-ups prepared from tobacco sold in loose form and smuggled tobacco products.

These shortcomings in the tobacco control policy define the priorities and tasks for the medium term.

# Introduction

Tobacco-smoking is one of the leading risk factors for cardiovascular diseases, diseases of the respiratory system and tumours. Chronic noncommunicable diseases, including those caused by tobacco-smoking or second-hand smoke, have for many years constituted the most significant health, social and economic problems in Poland. In response to the growing epidemic of chronic noncommunicable diseases, the last few years have seen the implementation of preventive programmes and early detection. In spite of the major successes achieved in recent years in this field, tobacco-smoking remains a massive health, social and economic problem. Although people are more aware of the harmful effects of the addiction, huge numbers of women and men persist in smoking cigarettes. Poland is not exceptional in this respect. The WHO M-POWER report published in February 2008 demonstrates that the tobacco-smoking epidemic is the cause of lung cancer and cardiovascular and other diseases, and that every year it kills 5.4 million people worldwide. By 2030 this number could increase to 8 million per annum *(1)*.

It is estimated that smokers now represent close to 29% of the adult population, or approximately nine million individuals. To fight this phenomenon effectively and comprehensively, monitoring and investigative mechanisms must be put into place in order to keep abreast of its characteristics and scale.

The list of the most serious issues related to tobacco-smoking includes: the fall in the age at which children begin to experiment with cigarette smoking, with some going on to become permanent smokers; the unabating number of young women, including pregnant women and young mothers, who smoke cigarettes; and the problem of exposure to passive smoking, particularly by children. The last-mentioned is particularly important in the light of data indicating that passive smoking is at least equally and at times even more hazardous to health than active smoking.

In addition to the undeniable threats to health of tobacco-smoking, the huge economic costs incurred through it by all of society are an important factor. These are not limited to financing the treatment of tobacco-related diseases, but also include the disease prevalence-related costs of work absences, lower work productivity and an increase in the number of disability pensions paid to individuals who develop a related disease.

This is why the establishment of adequate legislation aimed at curbing tobacco-smoking calls for the full and active involvement of the legislature and the executive authorities, in particular of the Ministers of Health and of Finance. It also requires the involvement of the greatest number of organizations and social groups to form a broad coalition of support for tobacco control activities.

The diversity and scale of the hazards ensuing from tobacco-smoking, for both individuals and entire societies, are such that continued efforts are needed to raise social awareness and to establish adequate legal regulations and economic mechanisms so that this dangerous phenomenon can be combated effectively.

# General

## Population

According to Central Statistical Office estimates, the population of Poland at the end of 2006 was 38 125 000 (preliminary estimates for the end of 2007 put the number at 38 115 000).

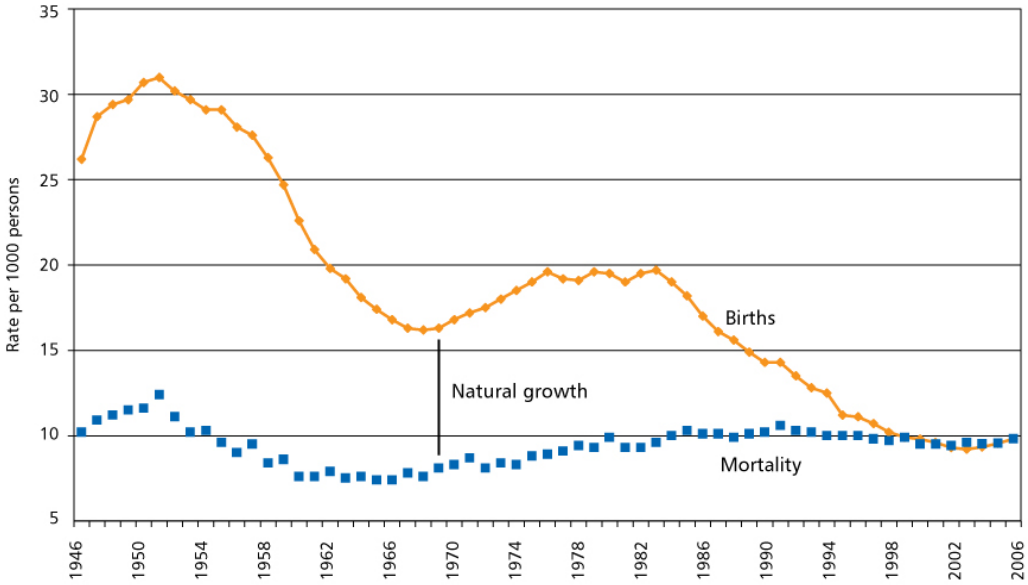
The population increased up to 1998 and then slowly began to fall. In 2006, for the first time since 2002, a positive population growth rate of nearly 5000 was registered (Fig. 1). Negative growth persists, however, driven by waves of emigration which have increased since 2006.

In terms of age structure, the population is still considered a relatively young one in the WHO European Region, although there is evidence of the population ageing (Fig. 2). Since 2000, the working-age population has increased slightly to reach nearly 25 million, representing 65% of the entire population.

Fig. 2 presents the gender structure of the population, showing that men are more numerous in the younger cohorts whereas women are substantially more numerous in the cohorts aged 45+ years. This is particularly true for individuals aged over 65 years: men make up only 38% of all senior citizens.

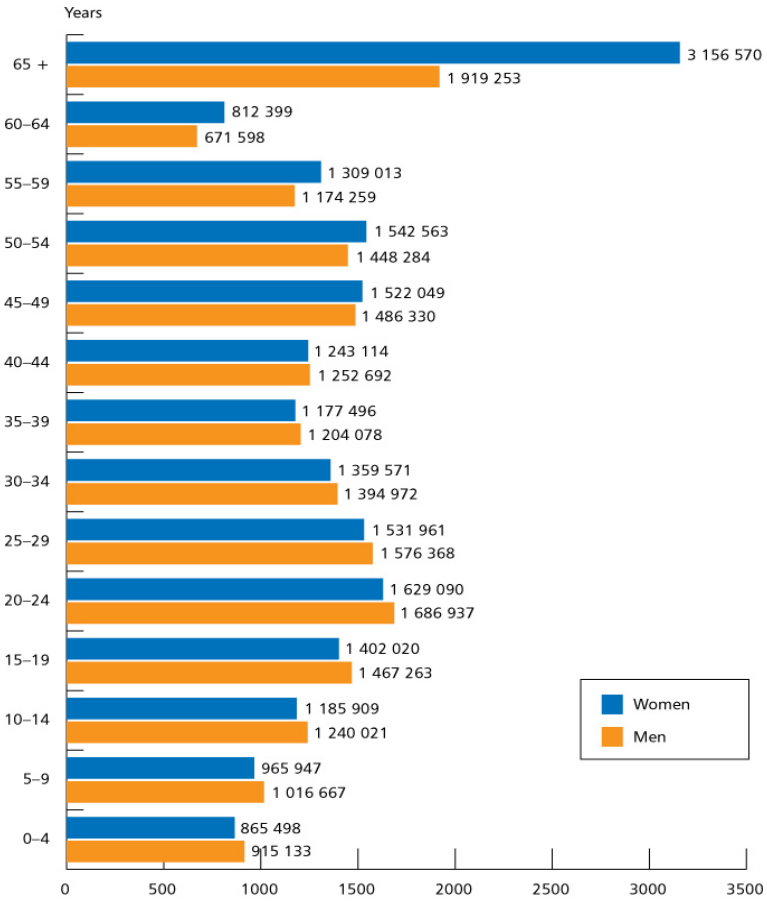
For many years there has been the urban population has been larger than the rural, with over 61% of the population living in urban areas. In recent years, however, a minimal decline in the urban population has been in evidence (Table 1). The urbanization ratio is lower than the entire European Region average (according to WHO's definition) and stands at 70.3%.

Fig. 1. Births, deaths and population growth rate, Poland, 1946–2006




*Source:* Central Statistical Office *(2)*.

Fig. 2. Population by age and gender, 2006




*Source:* Central Statistical Office *(2)*.

Table 1. Population of Poland, 2000–2006

| | 2000 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|
| Total population (as at 31 December) (millions) | 38.3 | 38.2 | 38.2 | 38.2 | 38.2 | 38.1 |
| Women | 19.7 | 19.7 | 19.7 | 19.7 | 19.7 | 19.7 |
| Urban (%) | 61.9 | 61.7 | 61.6 | 61.5 | 61.4 | 61.3 |
| Working age population (as at 31 December) (millions) | 23.3 | 23.8 | 24.8 | 24.2 | 24.4 | 24.5 |
| Cross-border population migrations for permanent residence purposes (thousands) | -22.7 | -17.9 | -13.8 | -9.4 | -12.9 | -36.1 |
| by immigration | 7.3 | 6.6 | 7.0 | 9.5 | 9.3 | 10.8 |
| by emigration | 27 | 24.5 | 20.8 | 18.9 | 22.2 | 46.9 |

*Source:* Central Statistical Office *(2)*.

Table 2 shows the distribution of the population across the 16 regions. The most heavily populated regions are Mazowieckie and Sląskie (14% and 12% of the population, respectively). Primarily urban regions include Sląskie (79% of the population living in urban areas) and Dolnośląskie (71%), while the primarily rural include Podkarpackie (41% living in urban areas) and Swiętokrzyskie (45%). The most densely populated regions are

Sląskie (379 individuals per $km^2$) and Małopolskie (215 per $km^2$), while the most sparsely populated is Warmińsko-mazurskie (59 per $km^2$).

Table 2. Population by region, 2006

| Region | Total (millions) | Percentage | Urban percentage | No. per $km^2$ of total area | No. of women per 100 men |
|---|---|---|---|---|---|
| **Total population** | **38 125.5** | **100.0** | **61.3** | **122** | **107** |
| Dolnośląskie | 2 882.3 | 7.6 | 70.9 | 145 | 108 |
| Kujawsko-pomorskie | 2 066.4 | 5.4 | 61.3 | 115 | 107 |
| Lubelskie | 2 172.8 | 5.7 | 46.6 | 86 | 106 |
| Lubuskie | 1 008.5 | 2.7 | 64.0 | 72 | 106 |
| Łódzkie | 2 566.2 | 6.7 | 64.6 | 141 | 110 |
| Małopolskie | 3 271.2 | 8.6 | 49.5 | 215 | 106 |
| Mazowieckie | 5 171.7 | 13.6 | 64.7 | 145 | 109 |
| Opolskie | 1 041.9 | 2.7 | 52.6 | 111 | 107 |
| Podkarpackie | 2 097.6 | 5.5 | 40.5 | 118 | 105 |
| Podlaskie | 1 196.1 | 3.1 | 59.5 | 59 | 105 |
| Pomorskie | 2 203.6 | 5.8 | 67.0 | 120 | 106 |
| Śląskie | 4 669.1 | 12.2 | 78.5 | 379 | 107 |
| Świętokrzyskie | 1 279.8 | 3.4 | 45.3 | 109 | 105 |
| Warmińsko-mazurskie | 1 426.9 | 3.7 | 60.0 | 59 | 105 |
| Wielkopolskie | 3 378.5 | 8.9 | 56.9 | 113 | 106 |
| Zachodniopomorskie | 1 692.8 | 4.4 | 69.0 | 74 | 106 |

*Source:* Central Statistical Office *(2)*.

## Administrative structure

The administrative structure has changed many times. Since the Second World War administrative reforms have taken place in 1946, 1950, 1957 and 1999.

At present, Poland is made up of 16 regions (*voivodships*) (Fig. 3), 379 second-tier local administrations (*poviats*) (65 municipal and 314 rural) and 2478 first-tier local administrations (*gminas*) (306 urban, 586 urban-rural and 1586 rural). Administrative authority at regional level is exercised by an official (*voivod*) representing central government and a marshal, who is an elected local government representative.

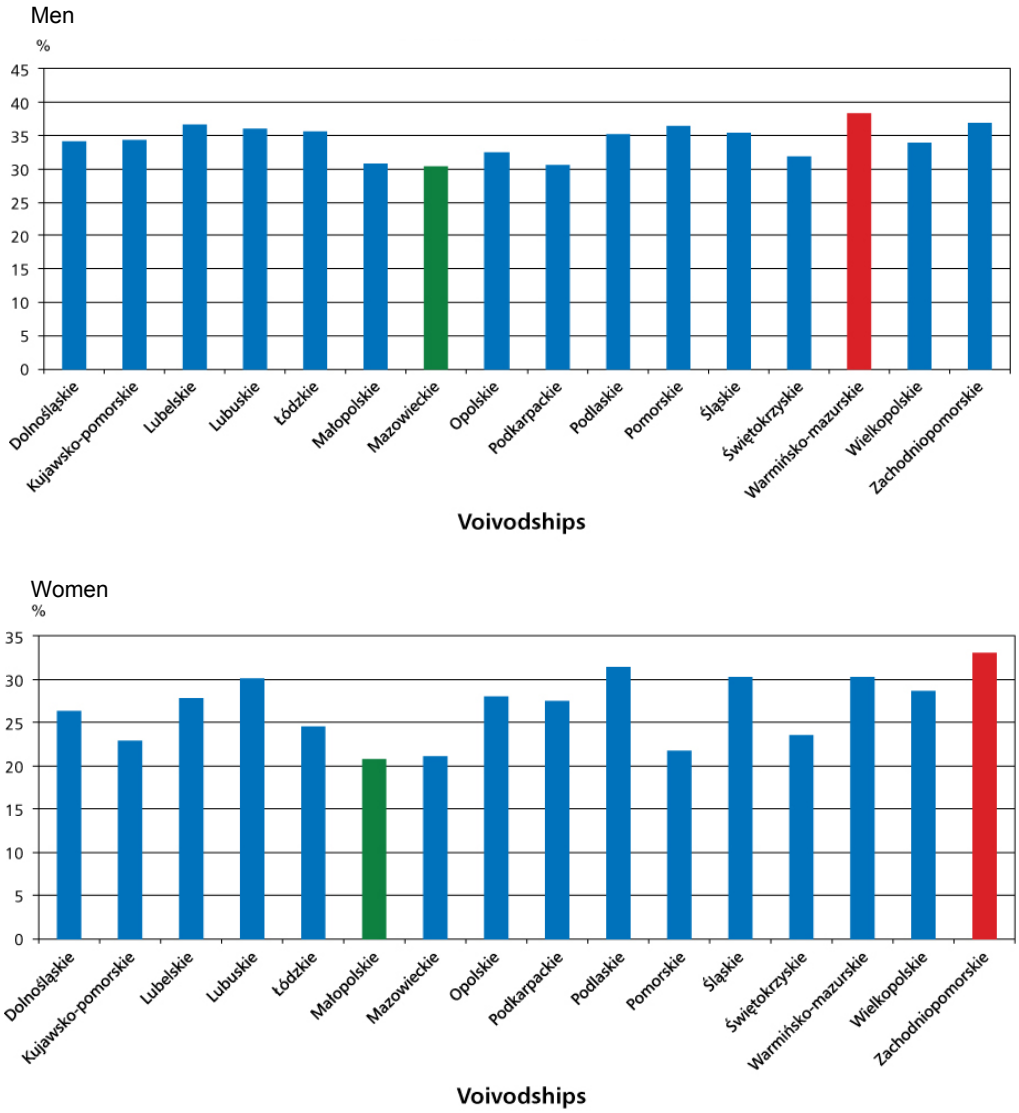
Fig. 3. Administrative division of Poland into 16 regions


*Source:* Central Statistical Office *(2)*.

Health promotion tasks in the regions are carried out by regional public health centres, which report to a *voivod* and regional sanitary and epidemiological stations operating as part of the National Sanitary Inspectorate. At the lower administrative levels, health care and health promotion are carried out by relevant units of the first- and second-tier local administrations.

The 2004 national population health study demonstrated clear inter-regional differences in tobacco-smoking between both men and women (Fig. 4). Smoking incidence is highest among men in Warmińsko-mazurskie (38.4%) and women in Podlaskie (32%), and lowest among women in Małopolskie (20.7%) and among men in Mazowieckie (30.4%).

Fig. 4. Daily smokers by region, 2004



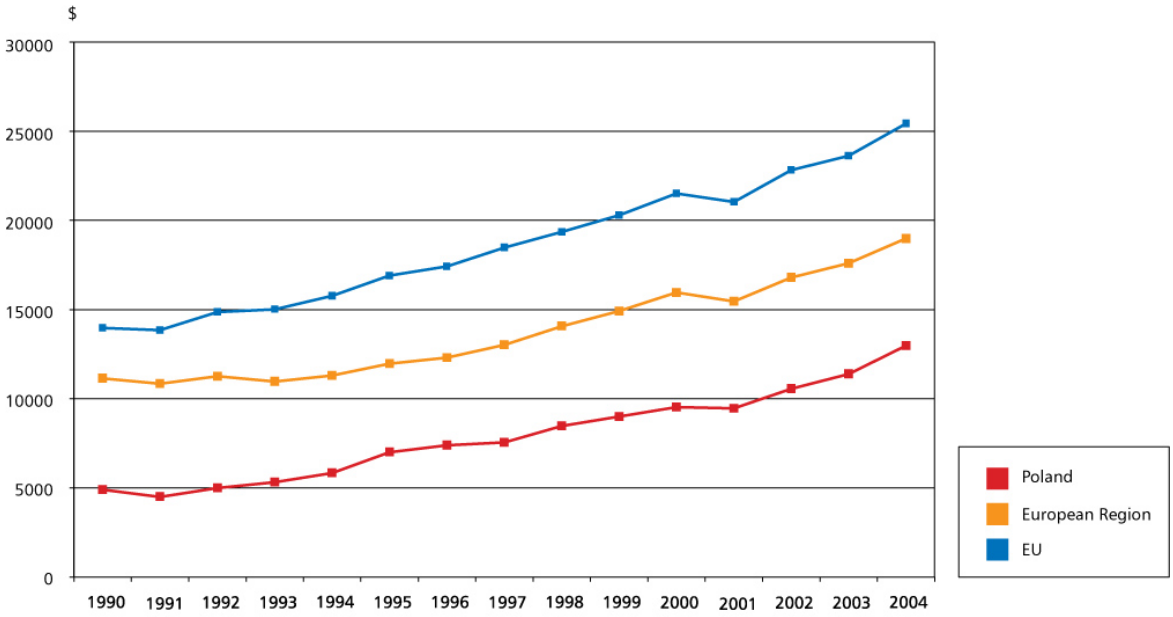

*Source:* Central Statistical Office *(3)*.

## Economic conditions

Poland is a middle-income European country, with GDP below one third of the European average and approximately 50% below the EU average. This less than beneficial situation is, however, improving systematically (Fig. 5).

GDP grew dynamically in the respective five-year periods (Table 3): in 1995–2000 it more than doubled while in 2000–2005 it increased by 30%. In 2006 it was 7%. Forecasts for the next few years point to a probable slowdown in annual growth rates. The rapid growth in GDP in the early 1990s (Fig. 5) was a result of high inflation during that period.

Fig. 5. GDP per capita of Poland and average for the WHO European Region and countries of the EU, 1990–2004, in relative purchasing power parity (PPP) terms




*Source:* WHO *(4)*.

Similarly dynamic growth has been occurring in GDP per capita; according to Central Statistical Office data, in 2006 it stood at nearly Zl 28 000. Taking into account the 2006 year-end average US dollar exchange rate, this represents US$ 9622. The value of GNP is lower than that of GDP (Table 3).

Table 3. Gross domestic product and gross national product, 1995–2006, in current prices

| | 1995 | 2000 | 2005 | 2006 |
|---|---|---|---|---|
| Total (Zl million)[a] | 337 222 | 744 378 | 983 302 | 1 057 855 |
| Gross domestic product per capita (Zl)[a] | 8 810 | 19 458 | 25 767 | 27 742 |
| Gross domestic product per capita (US$)[a] | 3 611 | 4 475 | 7 932 | – |
| Gross national product per capita (US$)[b] | 2 790 | 4 430 | 7 160 | – |

[a] *Source:* Central Statistical Office *(2)*.
[b] *Source:* WHO *(4)*.

## Health expenditure

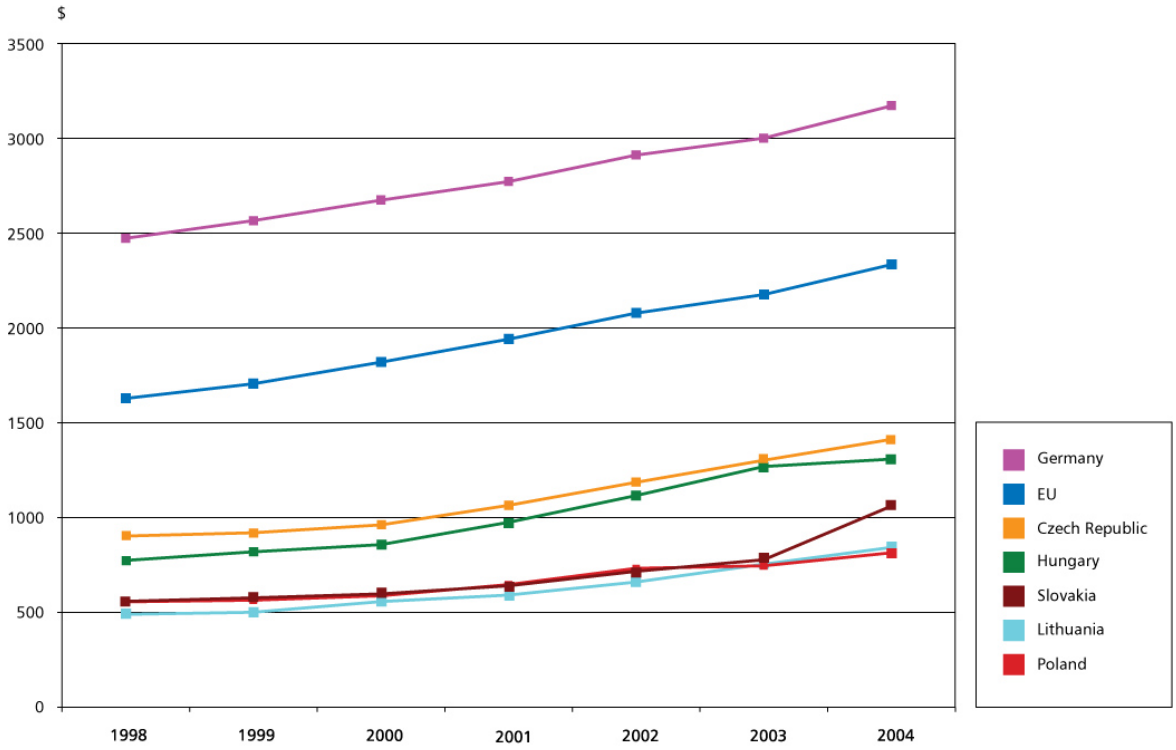
Table 4 shows Poland's health expenditure estimates, prepared by the Organisation for Economic Co operation and Development (OECD). The data indicate that health expenditure represents 6.2% of Poland's GDP, which is a lower percentage than is typical for developed economies. The disproportion increases if Poland's PPP$ 867 per capita health expenditure is compared with the comparable four-digit amounts (in PPP$) spent on health by some of the earlier 15 EU member states. Fig. 6 presents the historical medium-term health expenditure of all of the EU member states in relative purchasing power parity terms. The comparison demonstrates this expenditure increasing systematically in all the countries (with the exception of Luxembourg, where annual per capita health expenditure reached PPP US$ 5178). At the other end of the spectrum is Romania, with per capita health expenditure under half that of Poland (PPP US$ 433).

Table 4. Health expenditure in Poland and average for OECD countries, 2005

| | Poland | Average for OECD countries |
|---|---|---|
| Health expenditure as % of GDP | 6.2 | 9.0 |
| Health expenditure per capita, in PPP$ | 867.0 | 2759.0 |
| Public health expenditure as % of total health expenditure | 69.3 | 72.7 |
| Pharmaceutical spending as % of total health expenditure | 28.0 | 15.0 |

*Source:* Organisation for Economic Co-operation and Development *(5)*.

Fig. 6. WHO estimated health expenditure per capita in selected EU member states, in relative PPP US$ terms



*Source:* WHO *(4)*.

In 2005, pharmaceutical spending in Poland reached 28% of total public health expenditure, one of the highest percentages in the EU. In the same year pharmaceutical spending in Denmark was 9%, in the Netherlands and Switzerland it was 10%, and in Hungary and Slovakia it was higher than in Poland (29% and 32%, respectively).

**Box 1. Key points on Poland's general situation**

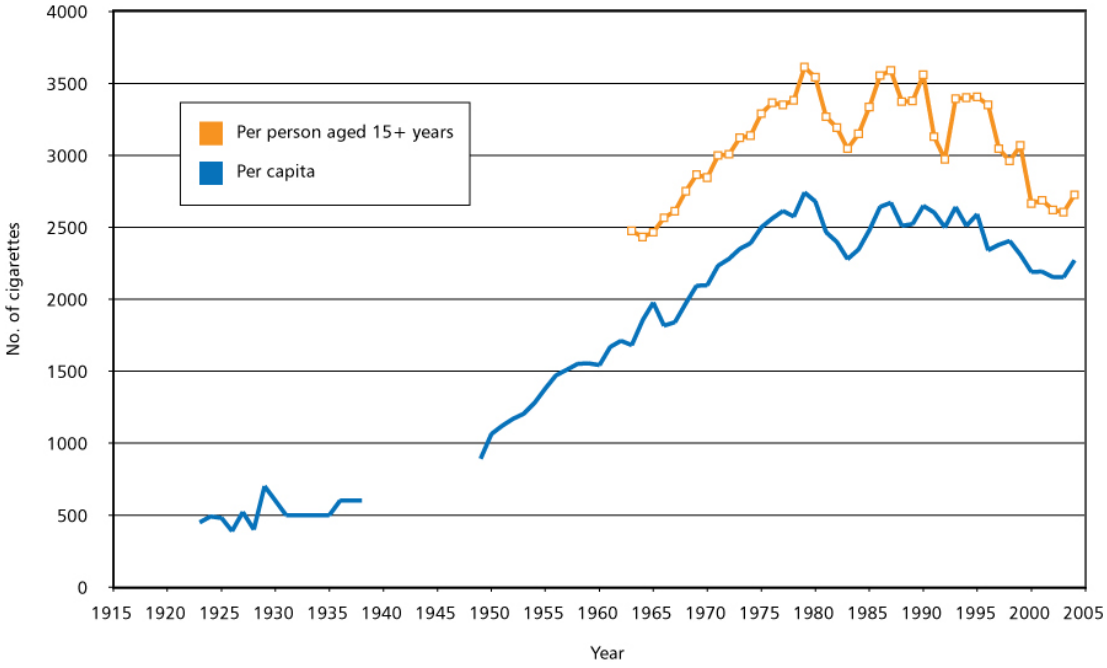
- The population has been declining slowly over the past decade, primarily as a result of outward migration. Even though the population is ageing, Poland is still one of Europe's relatively young societies.
- The population is not ethnically diversified: 96.7% declare Polish nationality.
- Poland is less urbanized than the average of European countries.
- GDP per capita is approximately 50% lower than the EU average.
- Health expenditure is one of the lowest in the EU, both as a percentage of GDP and in absolute terms. Pharmaceutical spending represents a high share of health expenditure.

# Tobacco-smoking and the health status of the population

## Cigarette sales and consumption

The sale and consumption of cigarettes soared after the Second World War to reach their peak in the late 1970s *(6)*. Between 1949 and the late 1970s, cigarettes sales and consumption rose dramatically (Fig. 7). A comparison with international data indicates that the consumption of cigarettes in the 1970s and 1980s was one of the highest in the world, reaching approximately 3600 cigarettes per adult.

Fig. 7. Cigarette consumption in Poland, 1923–2004




*Source:* Central Statistical Office *(7)*.

In the early 1980s, the previously observed growth trends in the sales and consumption of cigarettes halted. Throughout the 1980s and in the early 1990s, cigarette sales varied between 90 and 100 billion cigarettes a year while cigarette consumption, in spite of periodic fluctuations, stabilized at approximately 2500 pieces per capita (3500 pieces per adult).

Since the mid-1990s, the sale and consumption of cigarettes have declined. Between 1995 and 2004, cigarette sales fell from 97 to 72 billion pieces and cigarette consumption from 2591 to 2269 cigarettes per capita, with consumption per average adult falling from 3405 to 2724, respectively. Thus cigarette consumption in 2004 reached levels equivalent to those of the 1960s *(8)*. The most recent tobacco industry data on cigarette sales (70 billion pieces in 2007 and 61 billion forecast for 2008) indicate a continuation of the declining trend *(9)*. However, estimates of the sale and consumption of cigarettes need to be approached with caution and further developments in the market observed closely, as cigarette consumption statistics of the 1990s are incomplete, based primarily on domestic production (disregarding imports) and fail to take into account any data on cigarette-smuggling.

## Prevalence of smoking in the adult population

### *General population*

#### *Current status*

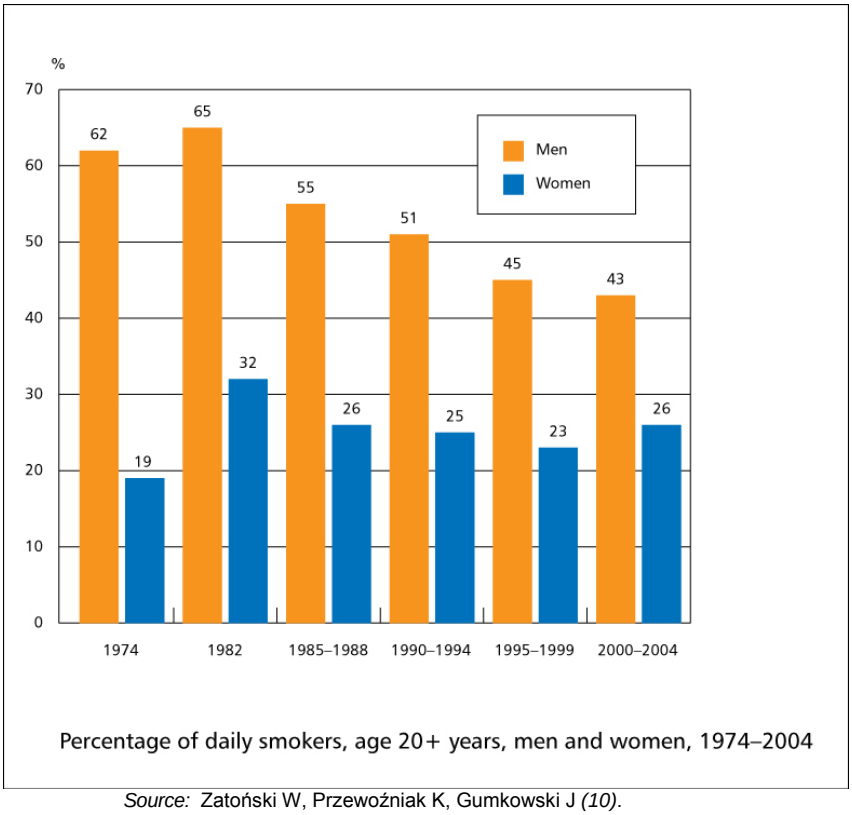
The results of a national survey conducted from 22 to 26 November 2007 by the Department of Cancer Epidemiology and Prevention of the Maria Sklodowska-Curie

Cancer Centre and the Institute of Oncology in Warsaw (the 2007 survey)[1] indicated that 34% of men smoked daily, 2% were occasional smokers, 19% were former smokers and 45% never smoked. In women, these percentages were, respectively, 23%, 3%, 10% and 64%. The social distribution of tobacco-smoking is a cause for concern. The poorest, uneducated people smoke much more frequently (e.g. about 70% of unemployed men) than more affluent individuals with a university education (about 30% of such men).

### *Trends in smoking*

The results of studies conducted between 1974 and 2004[2] on attitudes towards tobacco-smoking in the adult population indicate that some changes in smoking behaviour that began in the mid-1980s continued in subsequent years, while other changes slowed down and, in some sociodemographic groups, came to a standstill (Fig. 8–10) *(10)*.

Fig. 8. Percentage of daily smokers, age 20+ years, men and women, 1974–2004

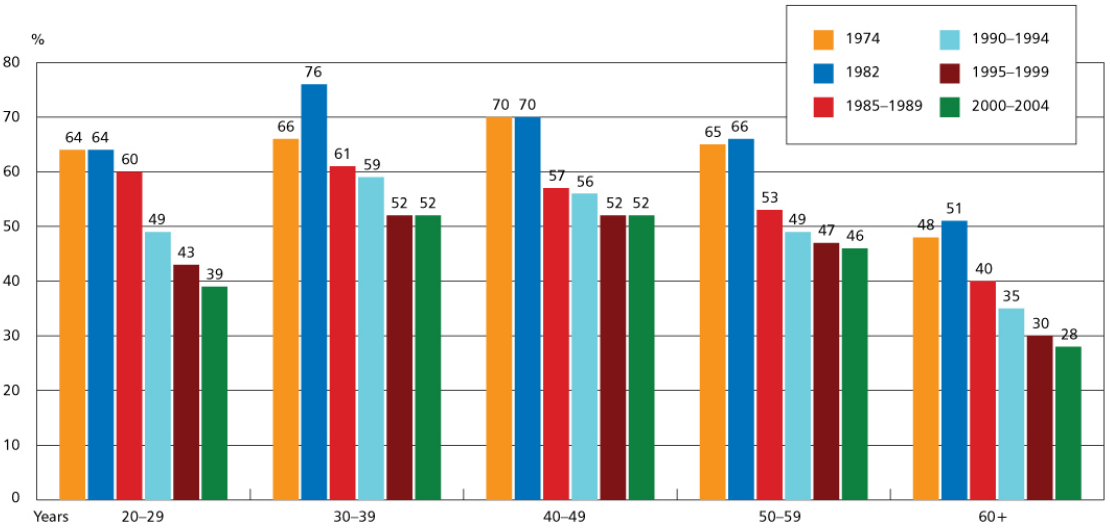



*Source:* Zatoński W, Przewoźniak K, Gumkowski J *(10)*.

[1] Survey conducted in collaboration with the public opinion polling centres TNS and OBOP within the National Cancer Prevention Programme and carried out as a face-to-face questionnaire survey in a nationwide representative sample (random-route) of 1004 individuals aged over 15 years.

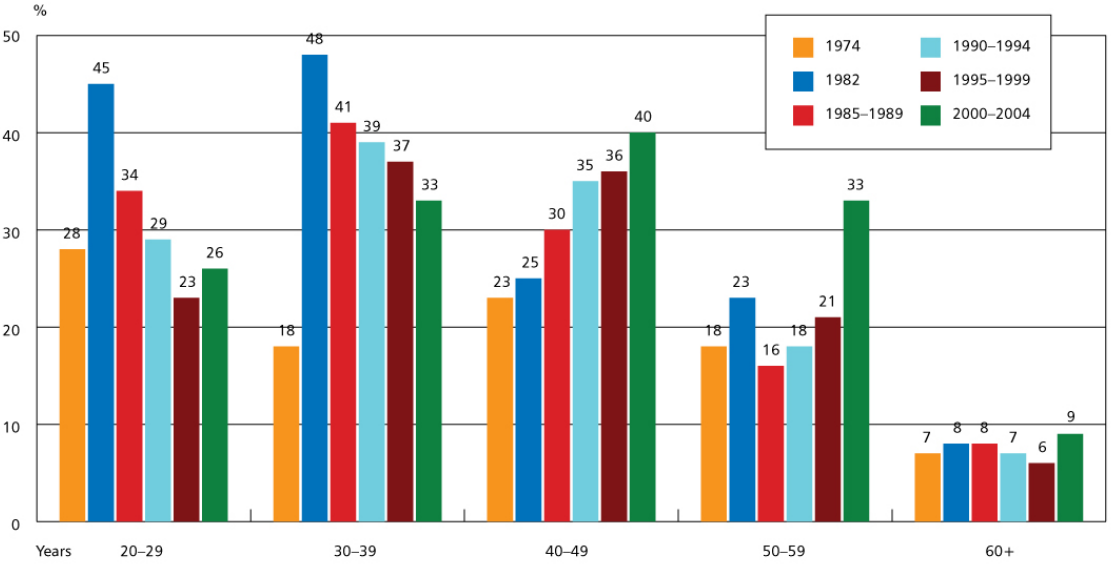
[2] The analysis of smoking trends is based on the results of studies conducted in 1974, 1980, 1985–1988 and 1990–2004. Since 1982, the study has been executed by the Cancer Centre and the Institute of Oncology in Warsaw in collaboration with public opinion polling centres (OBOP, CBOS, PENTOR, RUN). All the surveys were performed on representative random samples of the adult population. People over 15 years of age participated in most of the studies. The analysis was limited to people aged over 20 years, with a decision to aggregate and average out the data from 1985 to 2004. The numbers of respondents in the time series analysed were: 1974 (N=985), 1982 (N=796), 1985–1988 (N=4340), 1990–1994 (N=9725), 1995–1999 (N=14274), 2000–2004 (N=10549) *(10)*.

Fig. 9. Percentage of daily smokers, men by age group, 1974–2004




*Source:* Zatoński W, Przewoźniak K, Gumkowski J *(10)*.

Fig. 10. Percentage of daily smokers in Poland, women by age group, 1974–2004




*Source:* Zatoński W, Przewoźniak K, Gumkowski J *(10)*.

The initial studies indicated that 60% of adult men and 18% of adult women smoked daily in 1974 (Fig. 4) *(11)*. In the male population, smoking prevalence was not strongly dependent on sociodemographic factors (such as age or education), whereas the women who smoked most frequently included young and middle-aged and better-educated individuals.

In the early 1980s, the frequency of smoking increased, particularly among women (in 1982, 30% were daily smokers) driven, among other things, by the introduction of cigarette vouchers and the rationing of tobacco products. In 1982, the percentage of smokers was the highest in the country's history and one of the highest in Europe, including in central and eastern Europe *(12,13)*. Among young and middle-aged men that percentage reached 70%, and in similar-aged women 50% *(14)*. Polish smokers differed from those in the EU countries by the high average number of cigarettes smoked per day (circa 20 for men and 15 for women), the long duration of smoking (circa 20 years for men and 18 years for women) and the high percentage of individuals dependent on tobacco (approximately 15% according to the Fagerström's Test for Nicotine Dependence score) *(15,16)*.

In the late 1980s, and particularly in the 1990s, social acceptance of smoking noticeably lessened. Comparative international studies conducted in Poland and EU countries showed that in the late 1990s the social climate against smoking in Poland was the strongest in Europe *(17)*. The change in attitude towards smoking was stimulated by population-based public awareness campaigns and smoking cessation programmes *(18)*,[3] effective enforcement of comprehensive tobacco control legislation[4] and the launch of a government programme aimed at reducing smoking and its health consequences *(19)*.[5] The number of people who gave up smoking went into millions and a clear fall in smoking incidence among smokers of both sexes was observed *(11,20)*. Among men, the fall in percentage of daily smokers occurred in all age groups (from around 60% in 1982 to 40% in 2000–2004), reaching among all men approximately 1% annual rate of decline *(10)*. Among women the highest decline in incidence of daily smoking occurred in the youngest age group (20–29 years: from 50% to 25%).

Unfortunately, there is evidence in recent years of a slowdown in the rate of decline in smoking incidence among men and of a halt in the falling trend among young adult women *(10,20)*. This is a result of cutbacks in funding for implementation of the government programme, inordinately slow increases in the prices of tobacco products and mass advertising of cigarettes in the 1990s, which broadly targeted young women. The proportion of nicotine-dependent smokers in the entire smoking population has been rising *(10,20)*.

Currently, in contrast to the 1970s, daily smokers are predominantly found among poorer people and women with low educational status *(14)*. The percentage of women who smoke daily in rural areas has increased 2.5-fold over the past 30 years, and in major cities the smoking prevalence among women is equivalent to that among men.

[3] For example, the Great Polish Smoke-out campaign conducted every year since 1991 under the slogan "Together Let's Stop Smoking" *(18)*.

[4] The Law on Protection of Heath against the Consequences of the Use of Tobacco and Tobacco Products from 1995 and its amendments from 1999 and 2004; see the section on Human Resources Engaged in Tobacco Control Activities below.

[5] The National Tobacco Control Programme was enforced in Poland for the first time in 1997–2001 and again in 2002–2006.

### *Physicians*

Nationwide studies of attitudes towards tobacco-smoking among physicians conducted over the past 20 years (1983, 1986, 1995, 1999 and 2000) offer opportunities for assessing the scale of and trends in tobacco-smoking among physicians, as well as permitting analysis of the social and professional ramifications of the phenomenon. In 1983, 43% of male and 36% of female doctors smoked *(21)*. Among women doctors, the incidence of tobacco-smoking was higher than among all women who smoked (32%). The studies carried out in the 1980s suggested that one of the causes of this was that physicians' knowledge about the harmfulness of tobacco-smoking was superficial, not much deeper than that in the general population *(22)*. The ordinance of the Minister of Health and Social Welfare restricting smoking in health care units, which came into force in the mid-1970s, remained a dead letter.

It was only the introduction of the Law on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products, a process in which physicians took an active part,[6] that contributed to making smoking among physicians less the norm. A substantial impact on their attitudes also came with the imposition of a ban on smoking on all health care premises (except in special smoking zones) and from the subsequent involvement of physicians in implementing the government programme. Under the programme, thousands of physicians were trained in the treatment of tobacco dependence and prevention of tobacco-related diseases and, as a result, were encouraged to proceed with health education programmes and to introduce the latest achievements in dependence treatment into their medical practice.[7]

In subsequent years, the rate of smoking among physicians began to fall *(23,24)*. In 1995, the rate among male doctors in all medical specialties fell to 29%,[8] while among male primary care physicians the proportion in 2000 was 25% *(25)*.

A much greater decline in the percentage of smoking among physicians was seen in women: in 1999 it was down to 15%. The 1999 data show that smoking prevalence among women of some specialties (internists, paediatricians and gynaecologists) fell to levels generally accepted as world standard (5–10%, observed in Sweden, the United Kingdom or the United States) *(23)*. The results of studies conducted among family doctors in 2000 confirmed the same *(25)*. It seems that the decline in the proportion of smoking among female physicians was primarily related to the rapidly growing number of non-smokers in the younger generation of adult women, and reflected changes taking place at that time in the entire female population.[9]

### *Teachers*

The evidence of smoking among teachers was only fragmentary until the late 1990s. The only nationwide survey, carried out in 1999, showed that among primary school teachers, 34% of men and 25% of women smoked *(26)*. The older teachers and those with lower

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[6] For example, the Polish Medical Association, Polish Pneumonological Association and Polish Oncological Association.

[7] See also the section on Political Commitments and Priorities in Tobacco Control Policy.

[8] In 1999, the level of smoking among male physicians was a little higher (33%).

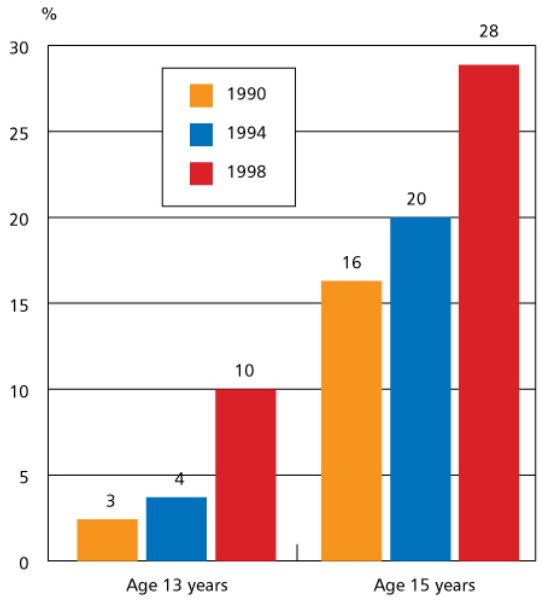
[9] In 1999, 2% of women physicians aged under 30 years smoked daily *(10,23)*.

social and economic status smoked almost as frequently as all men and women in the general population in the late 1990s. There is an urgent need for further studies to provide answers to such questions as to whether the smoking ban[10] introduced in 1995 in educational premises, including schools, has resulted in a fall in smoking prevalence among teachers.

## Tobacco-smoking among children

Studies conducted in the 1990s under the auspices of the WHO Health Behaviour of School-Aged Children (HBSC) project *(27)* pointed to a dramatic rise in smoking incidence among girls in Poland over that period *(28–30)*. Between 1990 and 1998, the percentage of girls smoking cigarettes increased among 13-year-olds from 3% to 10% and among 15-year-olds from 16% to 28% (Fig. 11). It seems that the phenomenon was at least partially related to the mass advertising of cigarettes aimed primarily at adolescent girls and young women. In the late 1990s, the tobacco industry spent 20 times more (approximately US$ 100 million) on cigarette advertising than in 1990 *(31)*. Subsequent surveys in 2002 and 2006, conducted after the enforcement of a complete ban on advertising, promotion and sponsorship of tobacco products, show that smoking prevalence among girls levelled off and subsequently began to fall *(28)*.

Fig. 11. Percentage of girls aged 13 and 15 years smoking tobacco, HBSC, 1990–1998




*Source:* Wojnarowska BJ *(30)*.

A precise description of attitudes towards tobacco-smoking among school-aged children in Poland was provided by a nationwide study carried out as part of the Global Youth

[10] With the exception of separate smoking zones (see article 5 of the Law on Protection of Heath against the Consequences of the Use of Tobacco and Tobacco Products).

Tobacco Survey (GYTS) *(31–34)*.[11] Study results from 2003 indicated that: 64% of boys and 53% of girls aged 13–15 years had attempted to smoke (32); 30% of boys and 21% of girls had tried their first cigarette before they were ten years old; 25% of boys and 21% of girls had smoked in the previous month; and 10% of boys and 5% of girls also used tobacco products other than cigarettes – far more than in the adult population. Approximately 80% of those who had smoked in the previous month admitted to having smoked tobacco on daily basis. Thus, for most, experimenting with smoking had also become the way to regular smoking or even tobacco dependence. Although the majority of the adolescents expressed a wish to give up smoking (53%), and had even attempted to do so (62%), 16% of the boys who smoked and 8% of the girls who did so, smoked cigarettes in the morning immediately on waking up, which is assumed to be a symptom of tobacco dependence.

## Passive smoking

### *Exposure of adults*

The 2007 survey shows that 25% of non-smoking adults smoke involuntarily at home (29% of women and 20% of men, respectively) while 19% of non-smoking adults (24% of men and 14% of women) are exposed to tobacco smoke in the workplace. Exposure to tobacco smoke at levels similar to that of the workplace are encountered in public places, although the situation here is much differentiated. Non-smokers are most frequently exposed to inhaling tobacco smoke in bars and pubs (32%), discothèques and music clubs (25%), cafés (22%) and restaurants (17%). In health care units and cultural venues (2%), shopping centres (5%) and schools (8%), this exposure is far lower.

As with active tobacco-smoking, passive exposure to tobacco-smoke, particularly in the home, has its social determinants, happening more frequently to those with limited educational qualifications and to the financially disadvantaged, e.g. unemployed adults.

In recent years, there has been a decline in the incidence of passive tobacco-smoking in public places and the workplace. The percentage of non-smokers exposed to involuntary inhalation of tobacco smoke at work has fallen among women from 37% in 1995 to 14% in 2007 and among men from 47% to 24%, respectively *(11)*. The scale of involuntary exposure to tobacco smoke in the home environment (29% of women and 20% of men in 2007) is also substantially lower than in the past (47% and 39%, respectively, in 1995). These changes are chiefly a result of a decline in the incidence of smoking in the adult population, primarily among men and young women. They are also correlated with the introduction of regulatory restrictions on tobacco-smoking at the workplace and in public places,[12] initiatives by local authorities and some employers, implementation of the government programme aimed at (among other things) the protection of non-smokers from

[11] The GYTS is a worldwide research project coordinated by the US Centers for Disease Control and Prevention and WHO. In Poland it has been conducted twice, in 1999 and 2003, both times by the Cancer Centre and Institute of Oncology in Warsaw, Cancer Epidemiology and Prevention Department, in collaboration with the polling organization TNS OBOP.

[12] Article 5 of the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products of 1995 introduced a ban on smoking in indoor facilities of all public venues and places of work except for in designated facilities (see the section on Human Resources Engaged in Tobacco Control Activities below).

tobacco smoke in different environments, and various public health campaigns conducted since the early 1990s (such as the World No Tobacco Day and the Great Polish Smoke-out) aiming to increase awareness of the harmfulness of passive smoking which have reduced the social acceptance of tobacco-smoking in the presence of non-smokers *(18)*.

### *Exposure of minors*

The scale of involuntary exposure to tobacco smoke among children is huge. Every day approximately four million children involuntarily inhale tobacco smoke at home or in public places *(35,36)*. In the 2007 survey, 48% of adults admitted to smoking or having smoked in the presence of their children, and 27% to smoking in the presence of pregnant women. The 1999 GYTS revealed that 65% of children aged 13–15 years faced the threat of passive smoking in schools and cinemas as well as in public places such as discothèques *(34)*. The majority of parents do not protect their children from involuntarily inhaling tobacco smoke at home: children passively smoke tobacco in as many as 67% of households *(34)*, a figure many times higher than in the Nordic countries (8% in Finland, 15% in Sweden).

Many more children are exposed to tobacco smoke in the home and in public places than non-smoking adults. This is indicated both by the results of the GYTS surveys discussed here and the nationwide study conducted among adults in 2007 as well as by the results of the international biochemical study carried out in Poland in 2005 showing the nicotine content of the hair of children exposed to tobacco smoke at home was higher than of the hair of their non-smoking mothers *(34,37)*.

## Tobacco-related diseases – incidence and mortality

### *Current status*

*Number and percentage of tobacco-related deaths*

Tobacco-smoking has for years represented the largest single yet preventable cause of death among the adult population. Epidemiological estimates show that in 2000, tobacco-smoking was the cause of approximately 69 000 deaths (57 000 among men and 12 000 among women), of which approximately 43 000 (37 000 among men and 6000 among women) were premature deaths (at age 35–69 years) *(38)*. Because of tobacco-smoking, middle-aged adults lost approximately 22 years of life and older individuals (aged 70 and above) around 9 years.

The proportion of premature deaths attributable to smoking was particularly high among men. In 2000, smoking-attributable deaths represented 38% of all deaths in the entire male population aged 35–69 years. In middle-aged men, tobacco-smoking caused 95% of all deaths from lung cancer and 55% from all cancers, 63% of deaths from all non-cancerous diseases of the respiratory system, 37% of deaths from all cardiovascular diseases and 21% of deaths from all other diseases *(38)*.

Because the tobacco-smoking epidemic in women occurred later and was less widespread than in men, the percentage of tobacco-related deaths continues to be substantially lower among women than among men. In 2000, premature deaths attributable to smoking among women aged 35–69 years reached 13% of all deaths *(38)*. The proportion was highest in

the case of lung cancer deaths (71%) and non-cancerous pulmonary diseases (33%). Exposure of women to tobacco smoke was also the cause of 15% of premature deaths due to cardiovascular diseases, 12% of deaths due to all types of cancer and 10% of deaths due to other diseases (Table 5).

Table 5. Number (thousands) and percentage of deaths attributed to smoking, by causes, 2000

| Cause of death | Men | | | Women | | | Total |
|---|---|---|---|---|---|---|---|
| | 35–69 years | 70+ years | 35+ years | 35–69 years | 70+ years | 35+ years | 35+ years |
| Lung cancer | 9.5 (95%) | 5.5 (93%) | 15 (94%) | 1.7 (71%) | 1 (59%) | 2.7 (67%) | 17.7 (89%) |
| All cancers | 15 (55%) | 8.2 (41%) | 23 (49%) | 2.2 (12%) | 1.4 (8%) | 3.6 (10%) | 26.6 (32%) |
| Cardiovascular diseases | 13 (37%) | 7.2 (15%) | 21 (25%) | 2.2 (15%) | 2.8 (4%) | 5 (5%) | 26 (15%) |
| Respiratory system diseases | 2.2 (63%) | 3.1 (46%) | 5.3 (51%) | 0.5 (33%) | 0.9 (14%) | 1.5 (19%) | 6.8 (38%) |
| Other diseases | 6.2 (21%) | 1.8 (12%) | 8 (18%) | 1 (10%) | 0.7 (3%) | 1.7 (5%) | 9.7 (12%) |
| All diseases | 37 (38%) | 20 (23%) | 57 (31%) | 5.9 (13%) | 5.8 (5%) | 12 (7%) | 69 (19%) |

*Source:* Adapted from Peto R et al *(38)*.

### *Lung cancer*

In 2004, 20 359 individuals in Poland were diagnosed with lung cancer and a further 21 206 died from the disease, which is almost exclusively related to inhaling tobacco smoke *(39)*.

Among men this cancer is the most prevalent cause of cancer incidence and mortality. In 2004, one in four new cancer cases (25.2%) and one in three cancer deaths (32.3%) were caused by lung cancer *(39)*. That cancer dominates among men of all adult age groups (20+ years) in terms of incidence and mortality. Among young men (aged 20–44 years), deaths from lung cancer represent 15.6% of all deaths due to cancer; among middle-aged men (aged 45–64 years) it is 36% and among men over 65 years it is 31%. In 2004, 15 741 men were diagnosed with lung cancer and 16 565 died from it. At the time, the standardized incidence rate for lung cancer stood at 60/100 000 while lung cancer mortality rate was 65.7/100 000.

Among women in 2004, lung cancer represented 7.8% of all cancer cases and 12% of all cancer deaths *(39)*. The highest percentage of lung cancer incidence (9%) and deaths (16%) among women was registered in women aged 45–64 years, whereas in the entire population of women, lung cancer is the second largest cause of death. Among women aged 65 years and over, lung cancer occurs frequently (8% of incidence, 11% of deaths) and ranks third in the structure of disease incidence and deaths. In 2004, a total of 4618 women were diagnosed with lung cancer and 4641 died of it. Lung cancer incidence and mortality among women stood at 13.9/100 000 and 13.4/100 000, respectively.

## *Mortality trends*

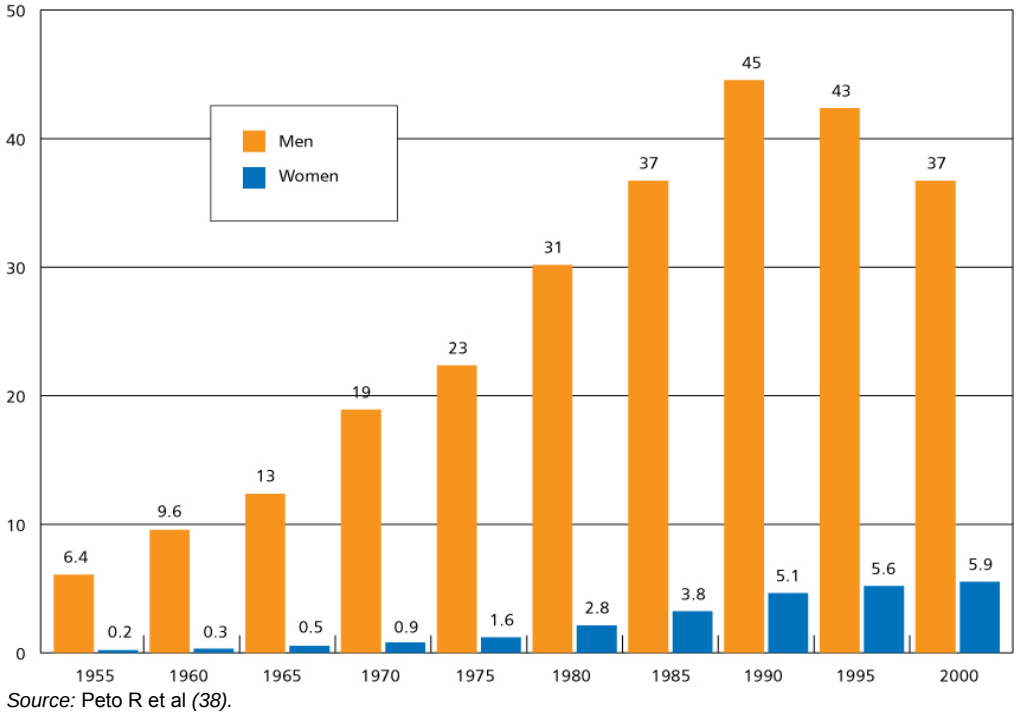
Owing to the availability of longer and more complete time series on mortality as opposed to disease incidence in Poland (particularly of cancer), trend analysis of tobacco-related diseases is here limited to an analysis of mortality rates.

*All tobacco-related deaths*

*Men.* After the mid-1950s, the number of tobacco-related deaths increased exponentially *(38)*. In the entire male population the number of smoking-related deaths increased from 7700 annually in 1955 to 61 000 annually in 1995. It was not until 2000 that a decline in the number of tobacco-related deaths among men was observed (57 000). Among men aged 35–69 years, the number of premature tobacco-related deaths rose from 6400 in 1955 to 45 000 in 1990, after which it began to fall (to 43 000 in 1995 and 37 000 in 2000) (38). The share of tobacco-related deaths out of all deaths in this group rose from 13% in 1955 to 42% in 1985, before subsiding (to 42% in 1990) and eventually beginning to fall (to 38% in 2000).

*Women.* Until the mid-1960s, there were few tobacco-related deaths among women, although the number rose steadily (from 300 in 1955 to 700 in 1965) *(38)*. In subsequent years until the end of the period under analysis there occurred a more rapid increase in the number of these deaths (to 12 000 in 2000). As among men, so also among women: the straight majority of tobacco-related deaths occurred among individuals aged 35–69 years. In 1955, only 200 women of that age died from smoking-attributable diseases but by 2000 the number had risen to 5900. The percentage of tobacco-related deaths increased linearly both among all women and among women aged 35–69 years. In the latter group, the proportion of tobacco-related deaths out of total deaths increased from 0.6% in 1955 to 13% in 2000. In contrast to men, no drop in the growth in number and percentage of tobacco-related deaths was observed among women until 2000 (Fig. 12).

Fig. 12. Number of premature deaths (in thousands)attributed to smoking, men and women aged 35–69 years, in years 1955–2000




*Source:* Peto R et al *(38)*.

*Lung cancer*

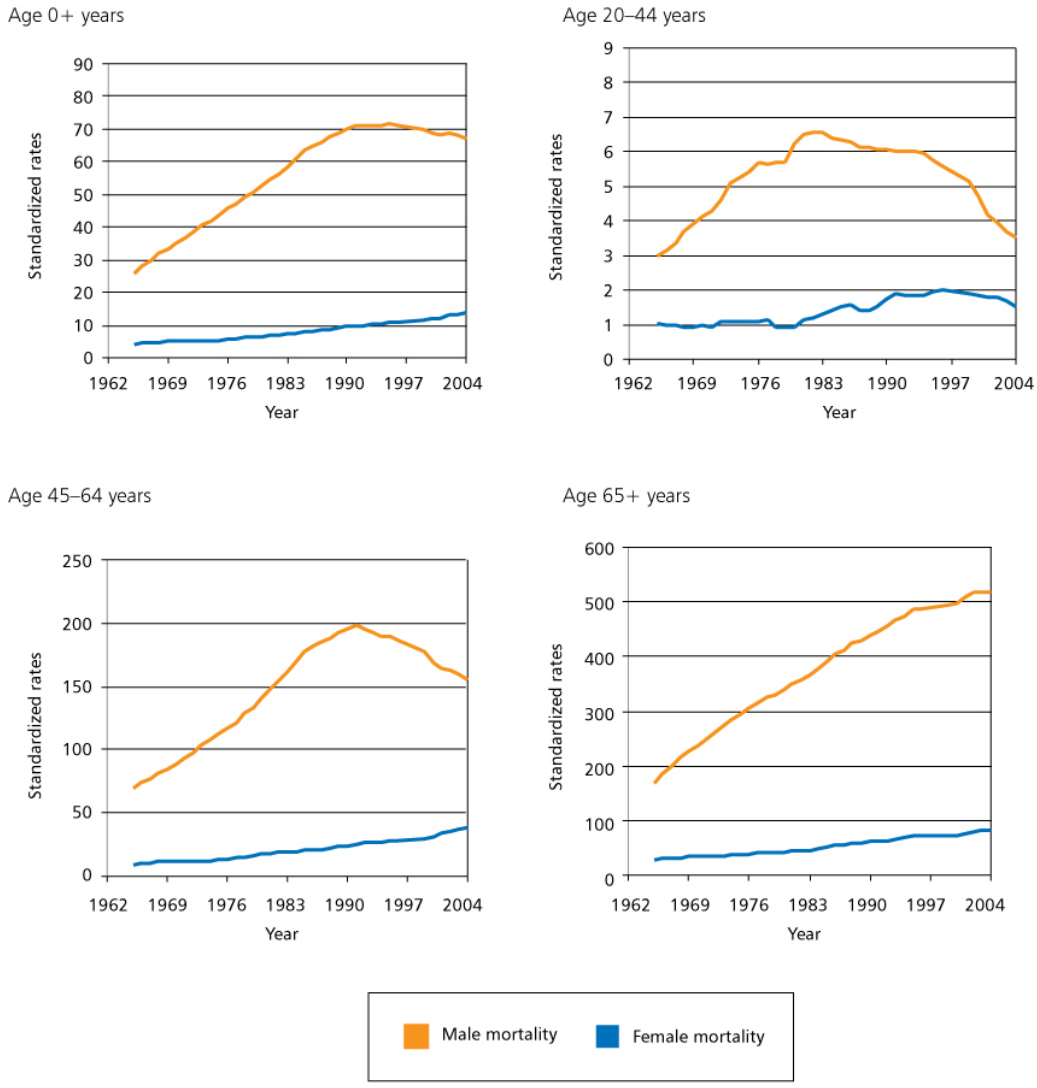
Epidemiological analysis of trends in lung cancer mortality is treated as the model for assessment of the tobacco epidemic at population level. Polish data show that over the last 20–25 years, lung cancer mortality has declined among men and in some age groups of women *(39)* (Fig. 13).

*Men.* The decline in prevalence of daily smoking in men and the growth in the percentage of men who have either never smoked or have given up smoking registered over the past two decades probably represents the main cause of decline in lung cancer mortality among young adult and middle-aged men *(39)*.

The fall in lung cancer mortality rates has been proportionately highest among men aged 20–44 years. A halt in the growth trend for lung cancer mortality in that group occurred in the early 1980s, at which time the percentage of non-smoking men in the population started to rise, albeit very slowly (18% in 1974, 26% in 1980), while a clear decline has developed in the mortality rate since the early 1990s (since 1993 there has been a decline in the annual mortality rate in the group aged 20–44 years of 5.47%).

A decline in lung cancer mortality rates among men aged 45–64 years has been evident since the early 1990s and is primarily related to the decline in incidence of daily smoking (65% in 1982, 51% in 1990–1994). The annual decline in lung cancer mortality rate in this group has levelled off at 2% since 1991.

Fig. 13. Lung cancer mortality trends by gender and age, 1965–2004




*Source:* Wojciechowska U et al *(39)*.

The decline in lung cancer mortality among young and middle-aged men evident since the early 1990s has led to a halt and subsequent slight fall in mortality related to that cancer among all men (0.3% annual rate of decline since 1988).

Unfortunately, lung cancer mortality is continuing to rise in the oldest group of men (aged 65 years and over), an unfavourable phenomenon since this mortality, which has remained high in that age group for years, is decisive to the number of lung cancer deaths among all men. It seems, however, that the annual rate of growth of this mortality in the past decade (1.21%) is currently not as high as in the past years.

*Women.* A rapid fall in daily smoking among young women in the 1980s (from 48% in 1982 to 28% in 1990–1994 in the group aged 20–29 years) is the main cause of the arrest, since the early 1990s, in the rise of lung cancer mortality among women aged 20–44 years.

Since 1991, the annual lung cancer mortality rate in women aged 20–44 years has declined at 0.9%.

Lung cancer mortality has, however, continued to rise in the remaining age groups of women (45–64 years and 65+ years) as well as among all women, and the rate of that growth has not changed substantially.

### *Forecast of tobacco-related disease mortality*

The results of the Health and Economic Consequences of Smoking (HECOS) model, developed in collaboration with WHO in the mid-1990s, estimated that if smoking rates observed in Poland in that period do not come down over the next 20 years, approximately 12% (1.2 million) of people who are currently smoking will die from tobacco-related diseases, primarily from chronic obstructive pulmonary disease, cardiovascular diseases, bronchial asthma, cerebral infarction and lung cancer.

The statistics in this report on the reduction of smoking prevalence and lung cancer mortality occurring primarily among men and young women indicate that the actual number of tobacco-related deaths can be reduced. This conclusion is confirmed by observations on the fall in the number of these deaths among men since the 1990s *(38)* as well as by the projection of lung cancer mortality, which takes into account modelled changes in attitudes towards smoking in Poland *(40)*. Such favourable changes in tobacco-related disease mortality will, however, only come about if the consumption of tobacco continues to fall. The decline in smoking prevalence among men (which has continued over recent years) also militates in favour of this optimistic scenario. Among women, however, it may fail to materialize, as among young women the early symptoms of an arrest in the dramatic decline in smoking incidence, which occurred in the 1980s and 1990s, can be observed *(10)*.

## Health consequences of passive smoking

### *Adults*

Epidemiological studies indicate that the inhalation of tobacco smoke by non-smokers (second-hand smoke or involuntary smoking) constitutes one of the main causes of premature mortality among adults in Poland *(41)*. Cautious estimates for 2002 show that, at that time, passive smoking caused the deaths of at least 1826 non-smoking people, of whom 933 died from ischaemic heart disease, 692 from cerebral infarction, 128 from lung cancer and 73 from chronic obstructive pulmonary disease. A straight majority of these deaths came from involuntary exposure to tobacco smoke in the home environment (1716), but not a few can be traced to exposure to tobacco smoke in the workplace and in public places (110 a year). Of deaths among non-smokers arising from tobacco smoke pollution of the home environment, 27% were premature (occurring before the age of 65 years).

### *Children*

Many clinical and epidemiological studies have been conducted in Poland to specify the health consequences of passive tobacco-smoking by children, which include, among other things, increased risk of lower body weight at birth, infections of respiratory pathways, lung dysfunction, chronic ear diseases, asthma attacks and sudden infant death syndrome

*(35,36)*. In recent years there have not been any population studies which have permitted the scale of the damage to children's health caused by passive exposure to tobacco smoke to be assessed. Taking into account the results of the 2007 survey cited above on the scale of exposure of children and pregnant women to involuntary inhalation of tobacco smoke, it is estimated that every year 75 000 newborns come into the world after nine months of exposure to tobacco smoke, frequently with symptoms of a tobacco dependence syndrome.

## Box 2. Cigarette sale and consumption

- Since the middle of the 1990s, there has been a substantial decrease in the sale and consumption of cigarettes, following a continuous increase from the end of the Second World War until the beginning of the 1980s, when they reached some of the highest levels in the world.

**Smoking behaviour and passive exposure to tobacco smoke**

- In adult men, a substantial and continuous decrease in smoking prevalence in all age groups has been observed since the beginning of the 1980s (among all men, from 65% in the 1980s to less than 40% currently), although the annual rate of decrease appears to have been lower in recent years than earlier.
- In adult women, three different patterns have been observed in time trends in smoking during the 1980s: (i) a substantial decrease in smoking prevalence (from around 50% to 25%) in young adult women (although this has tended to level off in recent years); (ii) a substantial increase (from around 20% to 35%) in smoking rates among middle-aged women (birth cohort effect); and (iii) no changes among the oldest women (where smoking rates remain at a three-fold lower level than in younger age groups).
- Despite some positive changes in smoking behaviour in recent decades, the prevalence of smoking among both men and women is the highest in Europe, especially among middle-aged women.
- The differences in smoking rates between social groups seem to have widened in recent years. Currently, about 70% of unemployed men smoke daily compared with about 30% among highly educated men.
- In the past 25 years, there has also been a rapid decrease in smoking rates among physicians, especially among the youngest female doctors whose level of smoking dropped from around 30% to the best world standard (5–10%).
- Smoking prevalence among schoolchildren is at a high European level, especially among girls where smoking rates have doubled in the 1990s (although this rapid increase has halted in recent years).
- Although the percentage of adult non-smokers exposed to tobacco smoke at home and at work is currently two-fold lower than in the mid-1990s, a big proportion of non-smokers, including more than 60% of children and about 30% of pregnant women, are still exposed to involuntary tobacco smoke in the home, public places and worksites.

**Smoking-attributable mortality**

- The decline in smoking prevalence in all age groups of adult men has influenced smoking-attributable mortality in this population: lung cancer mortality in men is tending to fall in young adult and middle-aged men.
- WHO estimates show that both the proportion and the number of premature deaths attributable to smoking in the male population have also diminished.
- In women, lung cancer mortality rates have only fallen slightly among the youngest adults, whereas the rates in middle-aged and old women are still tending to rise.
- There is also an increase in the number and proportion of premature deaths attributable to smoking among the female population.
- Current estimates indicate a large number of deaths in the non-smoking population caused by involuntary exposure to tobacco smoke, mainly at home but also at the worksite and in public places.

# The health protection and health care system and its role in tobacco control policy

## The health care system: stewardship in anti-tobacco politics

The health care system has been built on a number of legal, organizational and administrative bases that, combined, enable the monitoring of threats to the community's health related to the condition of the natural environment and of every day life, work, education and leisure. Tobacco smoke and the health damages consequent on inhaling tobacco smoke are some of the most serious health problems. The legal grounds for tobacco control have been laid down by the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products of 9 November 1995[13] which:

- provides protection to non-smokers against tobacco smoke through the curbing of tobacco-smoking in schools and other similar establishments, health care units and other workplaces, and public facilities;
- controls the availability of tobacco to children and young people;
- prohibits the advertising and promotion of tobacco products and sponsorship by tobacco companies;
- obliges the placing of health hazard warnings on the packaging of tobacco products, together with information on the content of harmful substances in tobacco smoke; and
- requires the government to adopt and implement a programme aimed at limiting the consumption of tobacco, and to identify the source of funding for that programme (state budget) and the volume of annual budgetary allocations towards the programme (0.5% of revenue from excise duty on tobacco products).

In September 1997, the Council of Ministers, in implementation of the Act, approved the first edition of the Programme for Limiting the Health-Threatening Consequences of Tobacco-Smoking for 1997–2000 followed, in July 2002, by the second edition spanning the period 2002–2006. The Programme provides for awareness-raising activities, restricts demand for tobacco products, and provides for the training of medical professionals and support to individuals with tobacco dependence, etc. The Programme is interdisciplinary and involves cooperation between many sectors of the national economy. The Minister of Health holds overall responsibility for implementation of the Programme and coordination of work across the administration.

The government makes an annual report on the implementation of the Programme to Parliament.

[13] As amended in 2003, the Act has implemented provisions in Directive 2001/37/EC of the European Parliament and Council on the Adjustment of Acts, Orders and Administrative Regulations of Member States, on Production, Presentation and Sale of Tobacco Products (*Official Journal*, 18 July 2001, L 194:0026–0035) and Directive 2003/33/EC of the European Parliament and Council of 26 May 2003 on the Rapprochement of Statutory, Executive and Administrative Regulations of Member States in Respect of Tobacco Products Advertising and Sponsoring (*Official Journal,* 20 June 2003, L 152:0016–0019).

Among the central administrative bodies, the State Sanitary Inspectorate has the key role of overseeing all of the above-mentioned areas. To deliver on its statutory duties, the State Sanitary Inspectorate has deployed 9709 professional supervisory staff organized in a network of 334 sanitary and epidemiological stations (16 in the *voivodships* and 318 in the *poviats*). Charged with the oversight of work safety and hygiene, hygiene in education and child care, and the health conditions of catering, the State Sanitary Inspectorate staff assess compliance with the tobacco control rules set out in the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products. In addition, the State Sanitary Inspectorate initiates, organizes, coordinates and supervises the educational activities of other government institutions, local government bodies and nongovernmental organizations striving to promote the desired attitudes and behaviour among the public, including those linked to tobacco-smoking. The Departments of Public Health and of Health Promotion, which specialize in education across social and professional backgrounds, play a major role in these respects. The Departments include 600 experienced personnel, well prepared to initiate and organize campaigns to stop smoking.

The Commercial Inspectorate also has a role in protecting health, as it screens against tobacco-related diseases by controlling the market for products and services (detecting and eliminating products that are illegal or have inadequate markings, eliminating advertisements for and promotion of tobacco products and blocking illegal selling schemes) *(42)*. In delivering on their statutory duties, the government supervision and monitoring services carry out assignments related, among other things, to tobacco products and their use, funded from the public purse.

## Medical professionals and their part in fighting tobacco-smoking

The health system provides preventive measures and treatment funded by public monies credited to the universal health insurance account, which is controlled by the National Health Fund as the payer *(43)*. Health care units provide primary and specialist medical services within many organization and ownership schemes, both public and private. Owing to the rules for contracting the services by the National Health Fund, the ownership form of a health care unit is irrelevant.

A significant proportion of the primary medical services includes early prevention of chronic noncommunicable diseases (such as chronic obstructive pulmonary disease, cardiovascular diseases and lung cancer). The linking of these conditions to tobacco-smoking as the central risk factor boosts the effectiveness of prophylaxis and treatment. More than 62 000 professionals working in primary health care units constitute a large group of potential partners with a well-grounded contact with their charges (Table 6).

Table 6. Primary health care staff

| Category of staff | Number |
|---|---|
| Doctors in various medical specialties | 20 937 |
| General practitioners | 5 684 |
| Paediatricians | 5 480 |
| Nurses | 25 231 |
| Midwives | 5 090 |

*Source:* Statistical bulletin, Ministry of Health, Health Care Information Systems Centre, Warsaw 2007.

Together with the primary care specialists, the numerous specialist staff in outpatient care facilities and hospital wards are a crucial human resource in anti-nicotine prophylaxis (Table 7).

Table 7. Numbers of specialist doctors in the specialisthealth care outlets (primary workplace only)

| Specialty | Number |
|---|---|
| Internal diseases | 9 879 |
| Paediatrics | 6 221 |
| Lung diseases | 1 475 |
| Midwifery and gynaecology | 5 015 |
| Laryngology | 1 902 |
| Cardiology | 1 335 |

*Source:* Statistical bulletin, Ministry of Health, Health Care Information Systems Centre, Warsaw 2007.

Public hospitals are fundamental to the inpatient health care system. The number of beds in private hospitals accounts for only 5.3% of all beds in the general care hospitals. In 2006, these facilities (except for the hospitals providing medical services for bodies reporting to the Ministry of Internal Affairs and Administration, the Ministry of Justice and the Ministry of Defence) treated nearly 7.2 million patients, who stayed an average of 6.4 days in the public hospitals and 5.4 days in the private hospitals (fluctuations in the length of stay varied across the regions from 5.5 to 7.7 days). Both the number of patients treated in hospitals and the average duration of their stays point to the potential for influencing patients who smoke and their family members (Table 8). In 2006 for instance, 371 756 children were born in gynaecological and midwifery wards. This points to the feasibility of taking the opportunity to reach many smoking women and their families. Approximately 25% of the group aged 20–29 years smoke daily, and an even larger group are exposed to tobacco smoke from other members of the household who smoke.

Table 8. Number of patients treated and average stay in selected general care wards, 2006

| Ward | Number of patients treated (per year) | Average time of stay (days) |
|---|---|---|
| Internal medicine | 1 204 691 | 6.8 |
| Cardiology | 413 903 | 5.2 |
| Rheumatology | 59 689 | 11.3 |
| Gastrology | 69 897 | 5.5 |
| Oncology | 210 346 | 5.6 |
| Pulmonology | 215 456 | 11.2 |
| Otolaryngology | 223 558 | 4.1 |
| Dependence treatment | 12 326 | 19.0 |
| Gynaecology and midwifery | 1 048 761 | 4.1 |
| Rehabilitation | 171 843 | 22.1 |
| Chronic diseases | 36 414 | 23.0 |
| Intensive care | 92 371 | 6.4 |

*Source:* Statistical bulletin, Ministry of Health, Health Care Information Systems Centre, Warsaw 2007.

The law allows for selected rooms in health care units to be turned into smoking areas. However, many health care units, including hospitals, have introduced regulations prohibiting tobacco-smoking anywhere on the premises. This approach creates specific situations for the patients and obligations on the medical staff, who are expected to help patients not to smoke. This frequently leads to patients who are about to complete their

treatment giving up smoking altogether. Experience shows that hospitalization is a powerful stimulant for patients and their families as far as tobacco-smoking is concerned.

The numbers of medical professionals quoted above, who are singled out owing to their potential contribution to changing attitudes towards cigarette-smoking, illustrate only the potential of the health care system. At present the syllabuses followed in training doctors, nurses, chemists and other medical professionals focus only on general information about the detrimental effects of smoking and miss out on the components supporting effective interventions vis-à-vis patients who smoke. To prepare them for this role is one of the tasks identified by the authors of the Programme for Limiting the Health-Threatening Consequences of Tobacco-Smoking, whereas educational and intervention measures targeting smokers, including treatment of tobacco dependence, have been listed among the services contracted by the National Health Fund.

Tobacco control activities in the health care system for prevention of tobacco-related diseases and treatment of dependencies are carried out under contract with the National Health Fund.

Prophylaxis programmes have been contracted since 2005, when the Mazowieckie Region implemented its pilot tobacco-related diseases prophylaxis programme: Smoking is Curable for 2005–2006. The basic phase of the programme, carried out mainly by primary health care physicians, included surveys of tobacco-smoking, education in the health consequences of exposure to tobacco smoke, motivation of health care providers to stop smoking and planning of therapy schemes. The specialist phases of the programme involved further diagnostics (psychological tests and studies) and tobacco dependence therapy.

In 2007, the programme was made available (on an elective basis) to all the other regional branches of the National Health Fund. At the same time, anti-nicotine education was also carried out in the framework of the Prophylaxis of Chronic Obstructive Pulmonary Disease Programme.

The rules for contracting preventive health programmes have been altered in 2008. The basic phases of the Prophylaxis of Tobacco-related Diseases and the Prophylaxis of Chronic Obstructive Pulmonary Disease programmes have been combined and allocated to primary health care physicians for implementation. Every provider that meets the mandatory criteria of the National Health Fund can carry out such a programme without needing to participate in any additional competitive tender. The specialist phases of the Prophylaxis of Tobacco-related Diseases Programme were combined in order to streamline contracting.

Over the years the contracting of services for the prevention of tobacco-related diseases has increased markedly at various levels. Expenditure on the basic phase in 2005 reached over Zl 9000 (€2250), rising to in excess of Zl 2 300 000 (€575 000) in 2006. The programmes provided care to over 6000 individuals in 2005 and over 58 000 individuals in 2006 (complete data in respect of 2007 are not available). Expenditure on the specialist phases in 2005 reached over Zl 230 000 (€57 500), in 2006 nearly Zl 600 000 (€150 000) and in 2007 over Zl 560 000 (€140 000).

The treatment of tobacco dependence services are funded by the National Health Fund within the framework of primary health care and tertiary health treatment. Tertiary (or specialist) care is offered in this respect in psychiatry and dependence treatment, in dependence treatment clinics and tobacco dependence treatment clinics. Total spending on the treatment provided by anti-nicotine clinics in 2005 amounted to over Zl 86 000 (€21 000), in 2006 nearly Zl 50 000 (€13 000) and in 2007 over Zl 50 000 (€13 500).

**Box 3. Key points on the health system related to tobacco control**

- The foundations for combating tobacco-smoking have been laid down in the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products.
- The Act constitutes the basis of the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking. The Programme is coordinated by the State Sanitary Inspectorate.
- Medical professionals employed within the primary health care system have unique opportunities for effective diagnosis and intervention vis-à-vis the entire population of those threatened with nicotine dependence and those who have developed it. Hospital stays create unique opportunities for motivating smokers and offering them effective help in stopping smoking.
- The anti-nicotine intervention should constitute an indispensable component of the primary medical services contracted by the National Health Fund.
- Medical professionals need to be adequately prepared for providing relevant anti-nicotine interventions.

# Economic information related to tobacco

## Tax policy

### *Regulation of excise duty rates*

The tax policy applied by the Finance Ministry complies with the recommendations of the Framework Convention for Tobacco Control (FCTC), and specifically with Article 6.2(a) of the Convention which concerns, among other things, the implementation of relevant tax policies aimed at reducing tobacco consumption.

Pursuant to this policy, the excise duty on tobacco products is being increased year by year. In keeping with the overall strategy pursued since 1999, the increases exceed the rate of inflation. A look at cigarette prices shows clearly the operation of the mechanism as excise has been raised systematically since the 1990s. The trend has been retained in recent years, with excise duty increases as follows:

2005 10.4% increase (inflation 2.1%);

2006 16% increase (inflation 1.0%);

2007 13% increase (annual inflation 2.2% assumed for 2007 in the annual budget).

Pursuant to the provisions of Article 2.l of Council Directive 92/79/EEC of 19 October 1992 on the approximation of taxes on cigarettes (as amended) *(44)*, an EU member state is required to apply excise duty at 57% of the retail selling price for cigarettes of the price category most in demand, and to achieve an excise duty amount of €64 per 1000 cigarettes (being the minimum taxation applicable throughout the EU). Poland was granted a derogation from this stipulation, which expires on 31 December 2008.

In 2006, the most popular price category included cigarettes at the retail price of Zl 5.85 per 20 pieces, or Zl 292.50 per 1000 pieces. Excise duty on these cigarettes was Zl 166 67 per l000 pieces, i.e. €42.54 per l000 pieces (at the then exchange rate), and was thus below the minimum taxation applicable in the EU.

The next increase in excise duty on cigarettes and smoking tobacco, planned for 2008, of 23.3% (based on an annual inflation rate of 2.3% assumed for 2008 in the annual budget) fulfils Poland's obligation to achieve the minimum taxation on cigarettes applicable in the EU, as it will have an impact on the pricing policies of the manufacturers of tobacco products and stimulate further increases in the prices of these goods.

### *Stimulation of the prices of tobacco products*

One measurable effect of the excise policies pursued by the Finance Ministry in respect of tobacco products (with particular consideration given to cigarettes) has been the rise in the retail price of these products. Table 9 presents the increases in excise duty chargeable to and average retail prices of cigarettes in 2005–2008 as well as the percentage share of tax in the average retail price of cigarettes.

Table 9. Increases in excise duty chargeable to and average retail price of cigarettes, 2005–2008 (in Zl)

| Cigarettes | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|
| Average retail price | | | | |
| per 20 pieces | 4.95 | 5.36 | 5.86[a] | 6.88[b] |
| per 1000 pieces | 247.50 | 268.00 | 293.00 | 344.00 |
| Total excise | | | | |
| per 20 pieces | 2.78 | 3.18 | 3.59 | 4.43 |
| per 1000 pieces | 138.84 | 159.00 | 179.61 | 221.44 |
| Percentage share of excise duty in retail price | 56% | 59% | 61% | 64% |

[a] Average retail price of cigarettes calculated on figures for the first nine months of 2007.
[b] Average retail price of cigarettes forecast for 2008 based on the excise duty rates planned for that year.

*Source:* Ministry of Finance, Excise and Ecological Tax Department (unpublished document).

In addition to the price development mechanism involving increases in the rate of excise duty, in December 2004 the Finance Ministry applied the minimum excise duty on cigarettes in order to counteract the manufacturers' trend towards keeping cigarette prices unchanged (or reducing them), as provided for in Article 16.5 of Council Directive 95/59/EC of 27 November 1995 on taxes other than turnover taxes which affect the consumption of manufactured tobacco (as amended) I.

The minimum excise duty for each year is set at 90% of the total duty charged on the price equivalent to the most popular price category of the preceding year. The minimum rate is applied to cheap cigarettes. This measure forces manufacturers to introduce additional price increases on these products, making them less accessible to poorer buyers such as young people. Raising the excise duties should lead to increases in the retail or sale prices of tobacco products and thus restrict their consumption. This can work in favour of achieving health objectives, in accordance with the recommendations of the FCTC.

This tax and prices policy on tobacco products is expected to contribute to a decline in tobacco consumption, particularly among those requiring the most protection from it: poorer people, children and young people. However, the actual contribution of changes in the excise duty (and consequently of prices) in controlling the consumption levels of tobacco products depends equally on average earnings, which in recent years have continued to rise.

## Smuggling and illegal trade in tobacco products

An assessment of smuggling and the illegal trade in tobacco products should focus on cigarettes. Smuggling of other such products (cigars, cigarillos and hand-rolling tobacco) is of marginal consequence. The share of illegally sourced cigarettes in the overall tobacco market is estimated (depending on the source of information) at between 8% and 15%. This does not seem to be threatening compared with the situation in other EU countries (for example, the share of illegally sourced cigarettes in the United Kingdom market is estimated at over 30%). Nevertheless, they create a real challenge to the national revenue interest and to public health.

For years now, the indicators reflecting the scale of smuggling have shown a rising trend: in 2004, the customs seized 400 million cigarettes; by early December 2007 this had risen to 500 million pieces.

Smuggling into Poland is primarily via the borders in the east with the countries of the Commonwealth of Independent States (CIS). These cigarettes originate mainly from manufacturing plants in the Russian Federation and Ukraine and, less frequently, from other former CIS countries such as Armenia or Kazakhstan. There have been isolated attempts to bring in between one and three container-loads of cigarettes smuggled from China, mainly through the ports of Gdynia or Szczecin, but these are incidental and have not had much impact on the domestic tobacco market.

Among the various methods of smuggling tobacco products dealt with by the law enforcement agencies, two distinctive categories stand out.

- Smuggling on a commercial scale, mainly associated with organized crime and undertaken via sea, rail and road transport. This type of smuggling most often uses means of transport suited for bulk quantities – lorries, rail cars, containers and the like.
- "Ant smuggling", which is to some extent a Polish speciality. This involves individuals and relatively small quantities of goods, which are moved in a variety of ways. It takes place primarily in the border areas, mainly in the east, i.e. regions with high jobless rates recognized as the most impoverished parts of the country. The scale depends on many factors, including the price differences between specific goods in the adjacent states, and can generally be assessed as significant. For example, in the Warmińsko-mazurskie region alone, which includes areas along Poland's border with the Kaliningrad region of the Russian Federation, the customs estimate that more than 10 000 individuals are involved in "ant smuggling".

The nature of this criminal activity has undergone some changes in recent years: illegal import for own use has shrunk in favour of activities with the telltale signs of organized crime. More and more frequently, individuals (the so-called "ants") are used as couriers to carry the goods over the border and deliver them to a designated place, usually an illegal warehouse, from where they are channelled to local markets and fairs for retail sale, recipients in other regions of the country, or to markets in the EU (in larger quantities), most frequently to Germany, the Netherlands, the Nordic Countries and the United Kingdom.

One new development in this illegal trade is smuggling in parcels sent by ordinary or courier post. This phenomenon, which poses a serious threat to markets in, for example, the United Kingdom, is currently under surveillance and analysis by the customs.

Traditionally, the fight against smuggling has been a priority mandate of the Customs Service. The mounting scale of the phenomenon as well as the appearance of other threats combining to increase the supply of tobacco products from illegal sources (e.g. an increase in illegal cigarette manufacturing facilities) have, however, led to greater involvement by other law enforcement agencies. In accordance with the government's strategy in this respect, the tasks assigned to the relevant services are as follows.

- The Customs Service and the Border Guard Service mainly concentrate on restricting smuggling (primarily on the external borders of the EU) and on the illegal trade in tobacco products within the country. To achieve these objectives, the Customs Service has formed special mobile control units – dynamic, professionally-equipped units which carry out inspections throughout the country, mainly on roads, at markets and trade fairs, in rail transport vehicles and on business premises and private land.
- The Police concentrate mainly on the detection and closing down of illegal manufacturing facilities and of storage places of cigarettes brought over in minor quantities by individuals crossing the border multiple times.

The operation of illegal cigarette manufacturing facilities is a relatively new phenomenon, observed in recent years in other EU member states as well as in Poland. The effectiveness of the Polish law enforcement agencies in combating the smuggling of finished tobacco products (primarily cigarettes) has substantially increased the risk of detection of illegal goods and thus of financial loss for the organizers. In these circumstances, criminal organizations have sought to move cigarette production as close as possible to the market in which the goods will be distributed. The mounting threat from these illegal practices is seen by the fact that the police closed down two illegal manufacturing facilities of cigarettes in 2005, one in 2006 and five in 2007.

A further decision at government level has resulted in the setting up of a special Interministerial Working Group for countering cigarette-smuggling. The Group brings together experts in all the services relevant to counteracting and combating the illegal trade in tobacco products, including the Police, the Customs Service, the Border Guard Service and the tax authorities, with the aim of streamlining operations primarily through the exchange of information and coordination of search and control operations.

The growing involvement of the administration and law enforcement agencies and the effectiveness of their measures to counter the illegal trade in tobacco products are illustrated in Table 10.

Table 10. The fight against the illegal trade in tobacco products, 2005–2007

| | 2005 | | 2006 | | 2007 | |
|---|---|---|---|---|---|---|
| | **No. of seizures** | **Cigarettes seized ('000)** | **No. of seizures** | **Cigarettes seized ('000)** | **No. of seizures** | **Cigarettes seized ('000)** |
| Customs Service | 114 635 | 425 068 | 140 963 | 472 014 | 121 984 | 565 366 |
| Border Guard Service | 3 610 | 55 263 | 4 202 | 69 011 | 5 719 | 111 472 |
| Police | 2 964 | 55 204 | 1 981 | 43 817 | 1 415 | 65 656 |
| **Total** | **121 209** | **535 535** | **147 146** | **584 842** | **129 118** | **742 494** |

*Source:* Ministry of Finance, Customs-Excise Control and Gambling Control Department (unpublished document).

On the one hand, these data possibly testify to the mounting flow into Poland of tobacco products from illegal sources, which may indicate an increasing supply of illegal goods and their increasing percentage share of the tobacco market. On the other hand, the growth in the number of detections and the quantities of cigarettes seized may also reflect the increasing operational effectiveness of the services responsible for countering smuggling. If the latter is true, it validates the strategy chosen by the authorities in the period leading up to Poland's accession to the EU (on 1 May 2004) and in anticipation of the country's

joining the Schengen zone, namely to strengthen the Customs Service and the Border Guard Service staff at crossings on the eastern border and to equip the mobile control units with modern smuggling detection equipment at border crossings. If this is correct, the percentage share of illegal goods in the domestic tobacco market can be expected to decline.

The results of a survey commissioned by one tobacco company in May 2007 bear out this premise. The study suggested that the share in the Polish tobacco market of illegally sourced cigarettes (traded without payment of duty, including both smuggled cigarettes and those brought in legally by travellers but destined for illegal sale) stands at 7.3% and exhibits a slight declining trend. In 2005, it was estimated (according to a study commissioned by an association of the largest tobacco manufacturers in Poland) to be 8.8%.

To round out the picture of tobacco products originating from illegal sources on the Polish tobacco market, it should be stressed that substantial numbers of the cigarettes brought into Poland are possibly intended for transfer to the western EU states, as seen from the facts that:

- the substantial quantities of cigarettes caught being smuggled out of Poland around crossings on the western and the southern borders: in 2006 these made up approximately 11% of all the seizures made by the customs, rising to approximately 14% in 2007;
- of the brands of cigarettes caught being smuggled into Poland, a substantial percentage (approximately 22% in the first half of 2007) are popular exclusively in the British market, such as Superkings, Regal or Dorchester, while others (L&M, Marlboro or West) are widely sold throughout the EU.

It seems that with the increase in excise duty on cigarettes in Poland (leading to a rise in retail prices), the market share of cigarettes from illegal sources can also go up: the profit on sales of cigarettes originating in the Russian Federation or Ukraine on the Polish market can be comparable to the profit on black market sales in Belgium or Germany, achieved at lower risk relating to shipment of goods over longer distances.

With the aim of further reducing the smuggling and illegal trade in tobacco products, Poland has entered into agreements concluded between the European Commission (represented by the European Anti-Fraud Office) and the major tobacco companies (Philip Morris International in 2005 and Japan Tobacco International in early 2008). Pursuant to the official position presented by the contracting parties in the preamble to the agreement with Japan Tobacco International, "…the Parties have a joint objective of eliminating illegal sales of cigarettes on the territory of the Community (both smuggled and/or counterfeit) and of assisting the law enforcement agencies in combating such illegal turnover…".

**Box 4. Key points on tobacco economics**

- For a number of years Poland has pursued a consistent tobacco control tax policy, with excise duty rates raised regularly each year at a rate exceeding inflation.
- The tax policy has translated into increases in the retail prices of tobacco products. The data disclosed by the Finance Ministry do not, however, take into account the relation between the increase in prices of tobacco products and the increase in average salaries in the national economy.
- Smuggling and illegal trade in tobacco products (primarily cigarettes) constitute a serious threat to the tobacco market in Poland and the EU, which is why they have been the target of determined activity by the government.
- Year by year the effectiveness of the law enforcement agencies in combating smuggling and the illegal trade in cigarettes has improved. This growing effectiveness expresses itself in the growing number of seizures and increasing quantities of cigarettes seized, and the declining percentage share of goods from illegal sources in the domestic tobacco market.

# Production and marketing of tobacco products

## Tobacco cultivation

Tobacco is traditionally grown in five regions, namely Lubelsko-podkarpackie, Świętokrzysko-małopolskie, Kujawsko-pomorskie, Mazurskie and Dolnośląskie (for the detailed lists of districts classified as tobacco-growing regions see the Ordinance of the Minister of Agriculture and Rural Development on the Tobacco Growing Regions of 10 November 2006 *(46)*.

Polish growers produce tobacco of four sub-species out of the eight groups popular in Europe, particularly the light Virginia and Burley sub-species. Local production of raw tobacco does not meet the industry's demands. A substantial proportion of the tobacco processed in cigarette factories is imported (Table 11).

Table 11. Production and use of raw tobacco, 2002–2006

| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Domestic production of raw tobacco (thousand tonnes) | 20.7 | 22.0 | 29.0 | 33.0 | 40.5 |
| Use in domestic industry: thousand tonnes | 15.8 | 15.5 | 22.2 | 20.5 | 28.9 |
| percentage | 76.3 | 70.4 | 76.5 | 62.1 | 70.1 |
| Exports of raw tobacco (thousand tonnes) | 4.9 | 6.5 | 6.8 | 12.5 | 11.6 |
| Imports of raw tobacco (thousand tonnes) | 52.5 | 19.7 | 43.1 | 58.3 | 64.3 |
| Percentage share of domestically grown raw tobacco in domestic industry | 23.1 | 44.0 | 33.9 | 26.0 | 31.0 |

*Source:* data from the Central Statistical Office, Foreign Trade Data Centre and Ministry of Finance.

At present, when there is no obligation on cigarette manufacturers to procure specified volumes of the domestic raw material, the percentage share of domestic raw material production in domestic production of tobacco products (as presented in Table 11) is equivalent to real demand driven by assortment-related needs and economic calculation. The reduction in consumption of tobacco products assumed by the state can lead to a reduction in the production of these goods and limited demand for raw tobacco, both imported and home-grown. It would, however, be difficult to estimate the consequences of such a curtailment for imports and domestic growers – whether it would be proportionate or whether one or the other would be preferred.

Tobacco is grown predominantly on small specialized farms. According to the Agricultural Market Agency, in 2006 over 14 000 growers entered into contracts to cultivate tobacco (Table 12).The average area under tobacco per farm is 1.19 ha, as a consequence of labour intensity and the low level of mechanization.

Table 12. Raw tobacco production, 2006

| | |
|---|---|
| Number of planters | 14 123 |
| Area cultivated with tobacco | 16.820 ha |
| Output | 40 500 tonnes |
| Average crop | 2.41 tonnes /ha |

*Source:* data from the Agricultural Market Agency.

If the demand for tobacco from domestic growers should fall, the opportunities for production of, for example, fruit and vegetables would be limited by the wide fragmentation of the areas under tobacco cultivation and the mainly manual labour (according to expert studies conducted by the Ministry of Agriculture and Rural Development), while achievement of equivalent levels of profitability would require subsidies at levels currently provided to tobacco production. Article 17 of the WHO FCTC requires adequate support to be provided for restructuring production on tobacco-growing farms, should there be a decline in demand for raw tobacco.

## Production and market share of tobacco products

Apart from one manufacturer, Zakłady Tytoniowe w Lublinie S.A. (a wholly-owned state Treasury company), tobacco products on the Polish market come from manufacturers capitalized by foreign companies, some of which are members of multinational tobacco companies (Philip Morris, British American Tobacco, Gallaher, Imperial Tobacco, Scandinavian Tobacco, Japan Tobacco and Altadis).

In 2006, the single most popular tobacco product in Poland was cigarettes: over 110 billion were produced by tobacco plants owned by the above companies. Some 74 billion were sold locally while the remainder were exported to the EU and beyond. In addition, tobacco in bulk equivalent to another 4.7 billion cigarettes was sold for roll-ups. Since the increases in excise tax on and prices of cigarettes, the sales of bulk tobacco used for roll-ups have been rising. This has been offsetting the regulating role of the tax which, instead of reducing demand for and consumption of tobacco to the expected extent, has led to a shift in demand towards cheaper tobacco products – a detrimental development, in that bulk tobacco is not subject to regulation of maximum content of tar, nicotine and carbon monoxide in cigarette smoke.

Other tobacco products, such as pipe tobacco, cigars and cigarillos attract only a fraction of consumers and are for the most part imported.

According to the manufacturers' declarations, their shares of the tobacco market remain essentially stable. Minor fluctuations in the competitive situation are the consequence of price wars, which have been possible because of the high share of the percentage element in the excise duty. One element of these price wars – undesirable from the perspective of the health policy – is the appearance of cheap tobacco products.

## Marketing strategies of the major tobacco companies

Any action aimed at reducing tobacco-smoking mobilizes the producers, who are interested in maintaining consumption, i.e. protecting their revenue. This does not, however, involve any contravention of the law, as the rules of legal production and sales are transparent and the system of supervision and audit is sufficiently effective. The leading producers, who are concerned for their company's image and brand positioning, will not risk any illegal practices; on the contrary, they seek to demonstrate their care for legality and even for the health of children and young people with campaigns such as the current one for "responsible vending", meaning compliance with the ban on the sale of tobacco products to minors.

The manufacturers of tobacco products have protected their interests chiefly by exploiting inconsistencies in government policy and/or legal loopholes. Given the wide differences in taxation on bulk tobacco and cigarettes, bulk tobacco is becoming increasingly available combined with a wide range of pre-cut cigarette paper and machines for hand-rolling cigarettes. Since 2005, "tobacco for manual making of cigarettes", which is taxed at Zl 65.62 (some €17) per kg plus 27.34% of the maximum retail price, has been replaced by "smoking tobacco", which is taxed at only 59% of the top retail price, with no tax component expressed in absolute value terms. Smoking tobacco differs in the length of the strips, but it is perfectly fit for making roll-ups. Table 13 shows the shares of the two types of bulk tobacco in the overall volume of bulk tobacco sold.

Table 13. Structure of tobacco supply for roll-ups and smoking, 2005–2006

| | 2005 (%) | 2006 (%) |
|---|---|---|
| Tobacco for rolling cigarettes | 80.9 | 25.2 |
| Smoking tobacco | 19.1 | 74.8 |

*Source:* data from the Rocky Mountain Center for Health Promotion and Education and AC Nielsen, 2007.

In structuring the market for tobacco products, most manufacturers abide by the law, but they use a broad variety of marketing strategies focused on circumventing the bans on advertising and promotion (Table 14). As an example, the ban on tobacco advertising has been bypassed through the use of legal information on tobacco products for advertising purposes, and publication of advertisements in "club" press and publications marked "for internal use only" that are nonetheless available at newsstands offering other press titles. The ban on the promotion and sponsorship of tobacco products is being circumvented by placing competition vouchers and coupons inside cigarette packs and mailing them "privately" to smokers.

Table 14. Marketing strategies of suppliers of tobacco products intended to protect their revenue

| Antismoking policy components | Suppliers' activities |
|---|---|
| Ban on advertising defined as "public dissemination" | Placing advertisements in so-called "club" publications and those marked "for internal use only" that are available at newsagents |
| Information on the products to be provided only in sales outlets | "Information" turns into advertisement as its content encourages purchase and use |
| Ban on promotion or sponsorship defined as public forms of encouraging purchase | Competition vouchers are placed inside cigarette packs or sent to smokers by post as "private" mailings |
| Publication of the health and social damage caused by tobacco-smoking | Promotion of the image of a community-friendly company (initiating "responsible vending" campaigns and debates on corporate social responsibility) |

*Source:* data from the Public Health Department.

**Box 5. Key points on tobacco marketing in Poland**

- Tobacco is grown predominantly on small specialist farms with an average of 1.19 ha under tobacco cultivation.
- Foreign manufacturers, including a number of tobacco multinationals, supply tobacco products to the Polish market.
- In addition to ready-made cigarettes, enough tobacco for some 4.7 billion cigarettes is sold in bulk for hand-rolling.
- The decline in consumption of manufactured cigarettes is compensated for by the consumption of cigarettes manually rolled from cheap bulk tobacco.
- Any action aimed at reducing the spread of tobacco products mobilizes the producers, who are interested in maintaining consumption, to intensified action involving the exploitation of weaknesses in the law and inconsistencies in the government's tobacco-smoking policy.

# Political commitments and priorities in tobacco control policy

## Current legal and tax regulation

Polish law regulates most conditions of manufacturing, market and consumption of tobacco products from the perspective of health care needs. Observations of the market and consumer behaviour reveal that there are well-aimed and effective solutions but also areas requiring thorough analysis and amendments to legislation (Table 15).

Table 15. Legal regulations in tobacco control and their implementation

| Regulation | Result |
|---|---|
| *1. 9 November 1995* ***Law on the Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products*** *(Journal of Laws, 1996, 10, item 55, as amended)* | |
| Obligation on the government to implement the Programme leading to reduction in tobacco consumption and to set a budget for this with reference to revenue from excise duties on tobacco goods. | Two phases of the Programme completed. Draft Programme for 2008–2012 in preparation.<br>Financing provided in arbitrary amounts far from satisfactory leading to slow-down in starts of Programme initiatives in recent years. |
| Limiting smoking in the workplace, institutions of learning and public use venues. | In spite of numerous cases of violation of statutory norms, substantial improvement in protection of non-smokers.<br>Solutions ineffectual in catering establishments. |
| Limiting accessibility of tobacco to minors. | Limitation generally effective (no sales from vending machines, by piece or in small packs).<br>Prohibition on sales to minors violated by some small retailers (irregular inspections, ineffectual fines). |
| Prohibitions on: introduction of smokeless forms of tobacco (except snuff), use of additives exacerbating dependence, placing of messages suggesting lower harmfulness of the goods on tobacco product packaging. | Prohibition generally respected. |
| Prohibition on advertising and sponsorship of tobacco products. | Official advertising and sponsorship effectively eliminated (in compliance with directive 2003/33/EC).<br>Attempts to apply narrower definitions regarding provisions covering illegal advertising and sponsorship of tobacco products and provision of information at points of sale. |
| Obligation on manufacturers and importers to inform Minister of Health of any additives used in the goods, their properties and the purpose of their use. | Implemented and complied with by manufacturers and importers. |
| Obligation to provide warning labels on packaging of tobacco products. | Implemented and complied with by manufacturers and importers. |
| *2. Ordinance of the Minister of Health of 24 February 2004 on* ***Testing for Certain Substances in Tobacco smoke and Information and Warnings Placed on Packaging of Tobacco Products*** *(Journal of Laws, 31, item 275)* | |
| Introduction of a norm on permissible levels of tar, nicotine and carbon monoxide in tobacco-smoke. | Cigarettes available comply with the norms.<br>No regulation applicable to: bulk tobacco for roll-ups, cigarillos, cigars, pipe tobacco. |

Table 15. Legal regulations in tobacco control and their implementation (cont'd)

| Regulation | Result |
|---|---|
| Establishment of a testing laboratory (laboratory of the regional Sanitary and Epidemiological Station in Łódź). | Lack of funds for assessing cigarettes available on the market. |
| Definition of textual content of warnings and information placed on packaging of tobacco products and description of their placement. | Warning labels on tobacco products compliant with EU regulations. |
| *3. Act of 23 January 2004 on **Excise Duty Tax** (Journal of Laws, 29, item 257)* | |
| Establishment of list and definitions of tobacco products subject to excise duty. | Length of tobacco roll specified in definition of a cigarette and differentiation of forms of loose tobacco available for sale open to manipulation of tobacco product prices by manufacturers. |
| Setting of excise duty structures and rates. | Rates, which are set high, substantially at variance with current market situation (cigarettes: Zl 120 per 1000 pieces + 50% of the maximum retail price) but adjusted every year by ordinance of Minister of Finance (see below). |
| | The substantial differences between rates applicable to cigarettes as opposed to loose tobacco – unjustified by differences in manufacturing costs – thwart intended objective of reducing tobacco consumption via taxes and prices.<br>Major share of rate in total excise duty gives manufacturers the power to influence excise duty levels. |
| *4. Ordinance of the Minister of Finance of 22 April 2004 on **Reduction of Excise Duty Rates** (Journal of Laws, 87, item 825 as amended)* | |
| Excise duty rates set for respective years – progressively increased and maintaining substantial differences between cigarettes and loose tobacco. | Decline in cigarettes sales compensated for by sales of loose tobacco, used for manual preparation of roll-ups. |
| *5. Ordinance of the Minister of Finance of 3 July 2007 on **Minimum Excise Duty Rate on Cigarettes** (Journal of Laws, 128, item 888)* | |
| Total excise duty rate on cigarettes expressed in absolute terms chargeable whenever excise duty, calculated from its absolute value and percentage rate, is lower than minimum rate. | Manner of setting minimum rate (90% of most popular price category) gives manufacturers the opportunity to reduce prices of cigarettes which fill the primary market segment (in spite of taxation policy assumptions and health policy aims). |
| *6. Act of 19 December 2003 on the **Organization of Fruit and Vegetable Markets, the Hops Market, the Tobacco Market and the Market for Dried Plant Material for Feed** (Journal of Laws, 2003, 223, item 2221)* | |
| Establishes subsidies for manufacturers of tobacco raw material (binding in the entire EU). | Profitability of production of tobacco raw material irrespective of prices of imported tobacco. |

## Programmes for national health

In recent years, one of the main tasks in improving and strengthening public health has been to control tobacco-smoking. This is being achieved in the context of two programmes that define the national health policy:

- the National Health Programme;
- the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking.

The National Health Programme has been implemented since 1990 and was based on the WHO health for all strategy. This represented the first attempt to include all the branches of the national economy, central government institutions and all of society in activities aimed at promoting health. In its second edition (September 1995), the National Health Programme included 18 operational objectives addressing key health risks. Reducing the spread of tobacco-smoking was one of the objectives *(43)*.

The National Health Programme for 2007–2015, adopted by the Council of Ministers in May 2007, is coordinated by the National Institute of Public Health in collaboration with the Ministry of Health. Reducing the spread of tobacco-smoking was included as operational objective 1, in the wider context of health risk factors and promotion measures *(47)*.

The scope and distinct fields of action, tasks requiring implementation and rules of collaboration between various institutions in achieving the objective are defined by the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking adopted by the Council of Ministers pursuant to Article 4 of the 9 November 1995 Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products. The key measures of the Programme in this area include:

- protecting the health and development of children from exposure to tobacco smoke, through eliminating tobacco-smoking by pregnant women;
- disseminating educational programmes encouraging rejection of tobacco-smoking;
- ensuring tobacco-free environments at work, school and recreation;
- stimulating increases in the prices of tobacco products;
- providing medical and other therapeutic help to tobacco-dependent individuals to free themselves of the addiction;
- creating an atmosphere of social acceptance for a tobacco-free life;
- effectively controlling the market in tobacco products.

## Poland and the Framework Convention on Tobacco Control

Poland joined the WHO Framework Convention on Tobacco Control (FCTC) on 15 September 2006.

The obligations arising from the FCTC are consistent with Poland's health policy defined in the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products, whose aims coincide with those of FCTC and scope and mode of regulation are consistent with the provisions of the FCTC.

A substantial number of the tasks required under the FCTC have been incorporated into the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking.

Table 16 shows the relationship of the FCTC's provisions to Polish national legislation and the strategic tobacco-smoking control measures included in the Programme. Poland's membership of the FCTC is of primary importance in maintaining positive health trends

and strengthening health policy to overcome the challenges of tobacco-smoking (including smoking among the disadvantaged population, protection of children's and women's health from tobacco smoke, and making public spaces smoke-free). The FCTC also provides for the coordination of measures aimed at reducing tobacco consumption in Poland with action taken by other signatories of the FCTC, including EU countries and the non-EU countries of central and eastern Europe. This collaborative approach heightens the effectiveness of legal regulation of the tobacco products market and diminishes the risk arising from the lack of a comprehensive common approach at international level to issues related to the manufacture and consumption of tobacco (such as smuggling and the illegal production of cigarettes).

Table 16. Polish legislation and the provisions of the FCTC

| **FCTC** | | | **Polish legal regulations** |
|---|---|---|---|
| **Article** | **Scope** | **Aimed at** | |
| 4 | - The right to knowledge about the harmful nature of tobacco consumption;<br>- The right to protection from tobacco smoke | Whole population | Consistent with act (a) |
| 13 | - Prohibition of advertising and promotion of tobacco products;<br>- Information about chemical features of tobacco products and tobacco smoke;<br>- Application of specific rules to packaging and labelling of tobacco products | Manufacturers of tobacco products | Consistent with act (a) and ordinance (b) |
| 14 | Diagnosis and treatment of tobacco dependence | Medical professionals | The Government programme (c) provides for training of doctors |
| 14 | Ensuring accessibility to diagnostics and treatment of tobacco dependence | Health care units | Consistent with acts (a, h) |
| 16 | Prohibitions on sales of:<br>- tobacco to minors;<br>- cigarettes by the piece;<br>- cigarettes in vending machines | Sellers and distributors | Consistent with act (a) |
| 16 | Limit on accessibility of tobacco products to minors | Children and young people | Consistent with act (a) |
| 20 | Conduct of research on nicotine consumption and addiction | Scientific research institutions | Consistent with effective laws (e, f) |
| 4, 8 | Introduction of legal and administrative measures for protection of the population from passive smoking | Administrative bodies of the state | Consistent with act (a) |
| 5 | Adoption of a national scheme for overcoming tobacco dependence | | Government programme (c) executed pursuant to act (a) |
| 9 | Setting of norms for tobacco content and products of its combustion; testing their levels | | Consistent with act (a) |
| 10 | Regulation of information on tobacco products | | Consistent with act (a) and ordinance (b) |
| 12 | Provision of public education and training on the health hazards of tobacco consumption | | Achieved under government programme (c) |

Table 16. Polish legislation and the provisions of the FCTC (cont'd)

| FCTC | | | Polish legal regulations |
|---|---|---|---|
| **Article** | **Scope** | **Aimed at** | |
| 20 | Organization and support of research on nicotine consumption and addiction | | Setting of priorities consistent with effective law (a, g) achieved under government programme (c) |
| 6 | Conduct of taxation policies reducing demand for tobacco | | Consistent with act (a), provided for under programme (c) |
| 13 | Elimination of advertising and promotion of tobacco products | | Consistent with act (a) |
| 13 | Elimination of cross-border advertising, promotion and sponsoring of tobacco products | | Requires regulation |
| 15 | Elimination of illegal commerce in tobacco products | | Consistent with the effective law (d);<br>Requires more detailed specification |
| 17 | Support for commercial activities other than cultivation of tobacco | | Requires regulation |

(a) Act of 9 November 1995 on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products (*Journal of Laws,* 1996, 10:item 55, as amended).
(b) Ordinance of the Minister of Health of 24 February 2004 on Testing Levels of Certain Substances in Tobacco smoke and on Information and Warnings to be Placed on Packaging of Tobacco Products (*Journal of Laws,* 31:item 275).
(c) Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland. Objectives and Tasks for
2002–2006, defining the state policy, its directions and scope, for limiting consumption of tobacco.
(d) Act of 23 January 2004 on Excise Duty Tax (*Journal of Laws,* 29:item 257).
(e) Act of 25 July 1985 on Research and Development Entities (uniform text: *Journal of Laws,* 2001, 33:item 388 as amended).
(f) Act of 12 September 1990 on Tertiary Education (*Journal of Laws,* 65:item 385 as amended).
(g) Act of 8 October 2004 on Rules of Financing Scientific Research (*Journal of Laws,* 238:item 2390).
(h) Act of 27 August 2004 on Health Care Benefits Financed with Public Funds (*Journal of Laws,* 210 :item 2135).

## Current tobacco control policy objectives and directions

Experience gathered in applying the law to date, with the programmes (which have been drafted and tested in practice), with local contacts and cooperation and with the teams of well-prepared medical professionals, educators and local community leaders, represents both capital and a starting point for the implementation of the policy nationally. Certain regional disparities persist, arising from the inadequacy of relevant centres of initiative in some areas.

The identified patterns of behaviour related to tobacco-smoking and the characteristics of the highest risk groups permit fine-tuned definition of the directions for future activity, with the aim of concentrating the most effective means and measures of intervention (Table 17).

Table 17. Directions of tobacco control policy based on Public Health Department analysis

| Key fields of action | Existing resources and experience | Deficiencies |
|---|---|---|
| Protection of the youngest section of the population through elimination of tobacco-smoking by pregnant women and around small children | Organized health care for women in pregnancy and the postpartum period; tried and tested action programmes for doctors, nurses and midwives; advantageous states of motivation accompanying maternity and infant care | Inadequate scope of implementation. |
| Ensuring healthy conditions for development and upbringing of children through freeing the school environment of tobacco smoke and preventing commencement of smoking | Well-prepared and tested elements of tobacco-smoking prophylaxis integrated into educational programmes | Insufficient number of schools involved in effective implementation of the programme objectives; schools are not free of tobacco smoke |
| Protection from exposure to tobacco smoke at the workplace | Necessary legal regulations and educational programmes encouraging smoke-free workplaces in place. | Limited scope of implementation and insufficient interest by employers and labour protection services; lack of calculation of social costs of tobacco-smoking in the workplace |
| Ensuring of generally accessible assistance to smokers in stopping smoking | Organization of health care ensuring effective monitoring of smokers in treatment; methodologically developed and successfully implemented short anti-tobacco medical intervention | Limited scope of training of doctors and nurses; limited outreach to smokers in treatment with diagnostic and therapeutic advice |
| Creation of social climate conducive to marginalizing tobacco-smoking in public places through mass education in and promotion of tobacco-free lifestyles | Mass public campaigns enabling collaborative involvement of many sectors of society – local administrations, schools, enterprises, nongovernmental organizations | Limited geographical outreach |
| Effective control of the tobacco products market through upgrading legal solutions and the state inspection system | Confirmed effectiveness of the tax instruments in regulation of demand for tobacco products; correctly set norms and organized laboratory control of tobacco products | Inconsistent tax policy; lack of funding for expensive testing of tobacco products on sale |

## Economic aspects of development of the tobacco control policy

### *Stimulation of rises in prices of tobacco products*

The price of cigarettes has a decisive impact on smoking, with less well-off people being more sensitive to it. Studies conducted in 1999, when there were substantial increases in cigarette prices (27% on average), revealed that:

- approximately 10% of smokers in challenging financial circumstances considered giving up smoking;
- only 2–5% of wealthy individuals thought they would;
- 30% of children aged 13–15 years stopped smoking for some time or gave up smoking completely.

The prices of tobacco products are not set by administrative decisions, so that the sole instrument available to the authorities is tax affecting the retail prices of goods. These

taxes have an important impact on demand for and consumption of tobacco products. The tax payable (excise duty plus value-added tax) represents 79.5% of the price of popular (cheap) cigarettes, but the current excise duty rates do not yet meet the EU minimum tax requirement of €64 per 1000 cigarettes. It is hoped to achieve this by the end of 2008. The tax element of the policy to curb tobacco consumption could be used more effectively: its lack of impact on tobacco consumption has resulted from inconsistent tax policies, in which concern for budgetary revenues has outweighed the needs related to health care. As a result:

- the excise duty on cigarettes is being raised and the price indicators of manufactured cigarettes are increasing, all for the benefit of health policy;
- the maintenance of a high share of the percentage rate in cigarette excise duty enables the suppliers to keep a broad segment of cheaper cigarettes on sale;
- the maintenance of substantial differences in tax on cigarettes and loose tobacco makes for the substitution of more expensive cigarettes by cheap and easy to use roll-ups which are 30% to 35% cheaper than manufactured cigarettes;
- inconsistencies in tax policy are exploited by suppliers of tobacco products:
  - to hoard large stocks of up to six months' worth of cigarettes, thus delaying the market effects of the annual increases in the excise duty;
  - to reduce the price of cigarettes through manipulating the most popular price category (minimum excise duty rates: Zl 150.00 per 1000 pieces in 2006 and Zl 146.33 per 1000 pieces in 2007).

The threat of a sudden increase in the supply of illegal cigarettes (through smuggling or illegal production) is argued as a reason to continue and justify market developments that are unfavourable from the health policy perspective. Studies conducted by tobacco companies and independent research centres have, however, revealed relative stability in the proportion of cigarettes from illegal sources on sale at 5–7%, irrespective of any rise in cigarette taxes and/or prices.

The domination of fiscal objectives over social and health objectives is informed by short-term benefits for the budget and takes no account of the cost–benefit analysis over the longer term (for example, more than two years). Unfortunately, no such analysis based on empirical studies has yet been conducted in Poland. From the results of research carried out by the World Bank, it can be assumed that losses to the national economy on account of tobacco-related diseases are two- to three-fold higher than revenues from the manufacture and consumption of tobacco products.

### *Creation of smoke-free environments*

The changes observed in attitudes relative to tobacco-smoking in the presence of others (in particular non-smokers) under the influence of external policy and the apparent acceleration in marginalizing tobacco-smoking in other EU countries (France, Ireland, Italy, Malta, Norway, Sweden and the United Kingdom (Scotland)) have created a favourable climate for similar changes in Poland, specifically the elimination of tobacco-smoking outright from educational facilities and health care units. The current legal permission for facilities designated for tobacco-smoking in these places is irreconcilable with the protection of minors both from tobacco smoke and from becoming dependent on

tobacco, as well as with the social (formative) function of those environments. The studies conducted in 2007 demonstrate that 89% of the population is in favour of banning smoking in educational facilities, 88% in health care units and 84% in cultural venues, indicating that both non-smokers and smokers support such measures. Important changes are also expected in catering and entertainment establishments, which can unfortunately still avail themselves of the regulatory leniency that allows for designation of areas (and individual tables in the case of small establishments) for smokers. Some 54–66% of the population favour a ban on smoking in these places.

Parliament is currently working on an amending bill, which incorporates some far-reaching tobacco control measures. These would provide for:

- the removal of any possibility of tobacco-smoking in designated facilities from schools and health care units;
- the introduction of a complete ban on tobacco-smoking in catering establishments, with the option of making separate facilities available for smoking purposes (smoking-rooms);
- the introduction of a complete ban on tobacco-smoking in all other public areas, for example, at stops or stations on the public transport system.

Work on the parliamentary legislative initiative in this field is taking into account the needs so that, with support from the government, these issues should soon be regulated to the benefit of health.

The current level of cigarette sales against a possible fall in tobacco consumption resulting from an increase in tobacco-free zones is not being defended directly, but rather through public discussions in the name of personal freedom and support for the objections of specific occupation groups (catering staff) against a probable decline in turnover in catering establishments.

The experience of the MANKO Association of Students of the Cracow Academy of Economics, which has successfully implemented its Cigarette-Free Premises programme, shows that the entrepreneurs' reservations about the supposed detrimental economic effects of banishing tobacco-smoking from the catering world are groundless.

### *Bans on tobacco advertising, promotion and sponsorship by tobacco companies*

The elimination of advertising and promotion of tobacco products is a key element in tobacco control policy. The results of research conducted in the early 1990s in Poland proved that:

- young people are most receptive to advertisements and promotional offers;
- adult smokers have established preferences and demonstrated limited susceptibility to marketing incentives;
- the content and the social and emotional context of cigarette advertising shows that it is aimed at young people as potential consumers who are offered formative lifestyle propositions.

These observations have been confirmed in the studies conducted within the framework of the WHO Health Behaviour of School-Aged Children (HBSC) project, which suggest that in the peak years of cigarette advertising (1990–1998), smoking incidence among 15-year-old girls rose from 16% to 28% *(27)*. When the ban on tobacco advertising was introduced, approximately 40% of non-smoking students declared that they were influenced by the lack of advertisements as well as the discussions and comments that had accompanied it.

The ban on tobacco advertising was introduced in 1996 and gradually expanded to include, in 1999 (with effect from 2001), all the print media and billboards in addition to radio and television (Article 8 of the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products). The ban also encompassed the promotion of tobacco products and sponsorship by tobacco companies of sports, cultural, educational, health and social and political activities. The broad scope and radical nature of the legislation gave Poland a leading position in this field in Europe, as it was only in 2003 that the EU adopted directive 2003/33/EC limiting some forms of tobacco advertisement *(48)*. On the basis of that directive, the tobacco advertising ban was further expanded to include (in 2003) the electronic media.

The bans on tobacco advertising, promotion and sponsorship have been effective. There soon surfaced, however, some new and unanticipated practices, such as "non-public" forms of advertisement and promotion or abuse of the legally permitted provision of information on tobacco products. This experience will be helpful in fine-tuning the legislative amendment currently in preparation to eradicate such undesirable sales developments.

### *Packaging and labelling of tobacco products*

The packaging and labelling of cigarettes has an important bearing on their attractiveness, and even on access to them by some groups of consumers. Small packs containing few cigarettes are more accessible to children and young people, who typically only have pocket money to spend. This kind of practice was eliminated as early as in 1996 with the passage of a statutory ban on the sale of cigarettes by the piece or in packs smaller than the standard 20-piece pack.

The regulator also introduced (in June 1998) labels bearing a radical warning of the risk related to tobacco-smoking to be placed on tobacco product packaging. The requirement to allocate 30% of each of the largest cigarette pack surfaces for warning labels was a pioneering measure (in European terms). At the same time, a requirement was also introduced to include information on tar and nicotine levels on the narrower side surface of cigarette packs.

The first unambiguous image-altering warnings caught the consumers' attention. In 1998, 14% of smoking men and 16% of smoking women attempted to cut down on smoking, and 3% of men and 4% of women said they had stopped smoking under the influence of such warnings.

Since 2004, the form and content of warnings on cigarette packs have complied with directive 2001/37/EC.

In compliance with the tobacco control policy adopted by the EU and the provisions of the WHO FCTC, the regulator is preparing to replace the current warnings with warnings combining written and graphic communications. A library of illustrated labels approved for use by decision of the European Commission will be drawn on for that purpose.

**Box 6. Key points on tobacco control policy**

- The Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking is one of the pillars of the preventive health care strategy built on the premises of the WHO strategies for health for all by the year 2000 and the document World Health Report 2001 *(49)*.
- The tobacco control policy expressed in the Programme and the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products is consistent with the provisions of the WHO FCTC.
- The main tobacco control policy measures concentrate on: protecting the population from exposure to tobacco smoke; building a social climate conducive to the marginalization of tobacco both culturally and economically; organizing assistance for smokers seeking to stop; and establishing effective mechanisms and economic incentives to reduce tobacco consumption.
- The priority for improving the relevant legislation involves an expansion in the smoke-free zones and elimination of the ambiguities that are abused for advertising and promotion of cigarettes.
- The excise duty structure and its rising rates only have a limited impact on curbing tobacco consumption: the demand has been redirected towards hand-rolled cigarettes.
- Investment in limiting tobacco-smoking has been underused in policies such as that aimed at tobacco control because of the failure to run calculations of the costs accruing to the budget from tobacco-related diseases against the benefits to the budget from additional tax revenue.

# Mechanism for coordinating tobacco control programmes

## National tobacco control programmes

Since 2007, pursuant to a decision of the Minister of Health, coordination of the National Health Programme has been vested with the Chief Sanitary Inspector, who has overall responsibility for public health. The Tobacco-smoking Prophylaxis Unit is currently being formed within the State Sanitary Inspectorate, with the primary task of coordinating and overseeing the tasks laid down in the National Health Programme for 2007–2011, based on binding legal regulations *(50)*.

As part of the national coordination of the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland (pursuant to provisions of the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products of 9 November 1995, as amended), the government is obliged to develop a long-term programme defining health, social and economic policies aimed at curbing tobacco-smoking. The government submits an annual report to Parliament on implementation of the projects undertaken by respective ministries, with the leading participation of the Ministry of Health.

## Funding

The provisions of the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products specify that funding for implementation of the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland should be equivalent to 0.5% of budgetary revenue from excise duty on tobacco products. The transfer to the Chief Sanitary Inspector in 2007 amounted, however, to Zl 1 million, which constitutes only approximately one sixty-third of the amount stipulated.

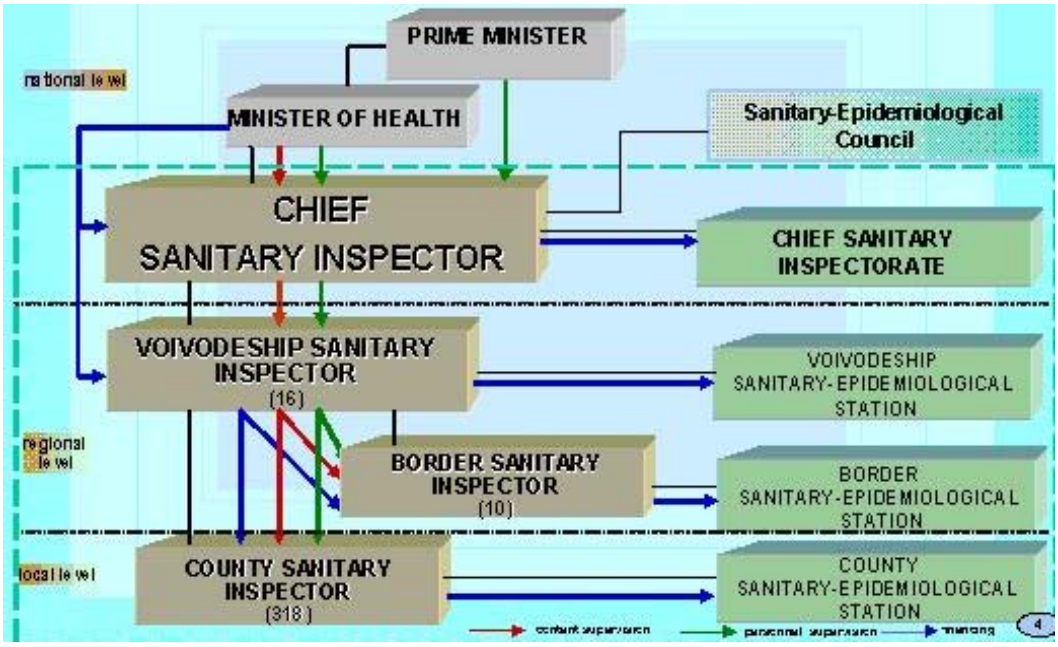
## Intersectoral coordination and cooperation inside government

In view of the extensive range of tasks and the need to ensure intersectoral cooperation at national level, the President of the Council of Ministers, in Ordinance 3 of 12 January 2004, established the Interministerial Coordinating Team, composed of representatives of relevant ministries and other institutions engaged in the task of improving the general health of the population, and specifically in the prevention of tobacco-smoking. The team members meet periodically to discuss the current status of implementation of tasks by the respective ministries and any problems and the adoption of decisions on such implementation. The work of the team is coordinated by the Chief Sanitary Inspector, who uses the means available to him/her for the purpose of communicating important and urgent information.

In keeping with the structure of the State Sanitary Inspectorate (Fig. 14) and its statutory task of safeguarding public health, the coordination and management of the Programme in 16 regions has been vested in the 16 regional sanitary inspectors, who employ interdisciplinary specialist teams involved in health promotion. At local level, the Programme is coordinated through 318 local sanitary inspectors who employ specialists to implement health prophylaxis and promotion tasks. In total, these 334 government

institutions employ 600 staff who initiate, organize, monitor and assess the effects of the activities implemented in the field of health promotion, including anti-tobacco activities.

Fig. 14. Organizational structure of the State Sanitary Inspectorate




*Source:* State Sanitary Inspectorate *(51).*

The State Sanitary Inspectorate includes, at its Sanitary and Epidemiological Station in Łódź, the Laboratory for National Control of Harmful Substances in Tobacco Products which verifies the tar, nicotine and carbon monoxide levels in cigarette smoke declared by the manufacturers.

For its research and specialist postgraduate training needs, the State Sanitary Inspectorate draws on the scientific research capabilities of the following research institutions: the National Institute of Hygiene, the National Food and Nutrition Institute, the Cancer Centre and Institute of Oncology and the Institute of Cardiology, all in Warsaw, and the Institute of Occupational Medicine in Łódź.

## Monitoring of implementation of the tobacco control programmes

Monitoring of the health effects and benefits anticipated in the tobacco control measures is chiefly based on surveys of social attitudes towards tobacco-smoking among the adult population and the epidemiological analysis of mortality ascribed to tobacco-related diseases, with lung cancer being the model indicator in assessing the health consequences of exposure to tobacco-smoke. These monitoring activities are also conducted within the framework of the national programmes for prevention of social diseases, and particularly the National Anti-Cancer Programme. The Cancer Centre and Institute of Oncology in Warsaw has for many years coordinated these activities.

Research into attitudes towards tobacco-smoking is based on the results of the national representative opinion poll conducted since 1974 on representative random samples of 1000–1500 of the population aged over 15 or 18 years.[14] The assessment of the spread and of the social and demographic characteristics of tobacco-smoking takes into account the results of the studies conducted by the Cancer Centre and Institute of Oncology in Warsaw in collaboration with various opinion polling institutions (OBOP, CBOS, RUN).

In recent years, the State Sanitary Inspectorate has monitored compliance with the ban on tobacco-smoking in educational and child care facilities, health care units, catering establishments and other places of employment within the framework of its continuing hygiene oversight and inspection of such facilities.

**Box 7. Key points on implementation of tobacco control mechanisms**

- The reduction of the spread in tobacco-smoking has been designated an operational objective of the National Health Programme for 2007–2015.
- In accordance with the National Health Programme and the provisions of the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products in Poland, the government has developed a Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland, coordinated by the Chief Sanitary Inspector through the Tobacco-smoking Prophylaxis Unit in the Public Health and Health Promotion Department of the State Sanitary Inspectorate.
- In view of the extensive range of tasks and the need to ensure intersectoral cooperation at national level, the Minister of Health has established the Interministerial Coordinating Team, composed of representatives of relevant ministries and other institutions engaged in the task of improving public health, and specifically in the prevention of tobacco-smoking.
- Monitoring of the implementation of tobacco control measures is chiefly based on the survey of social attitudes towards tobacco-smoking among the adult population and the epidemiological analysis of mortality ascribed to tobacco-related diseases.
- The Chief Sanitary Inspector oversees compliance with the ban on tobacco-smoking in educational and child care facilities, health care units, catering establishments and other workplaces.

## Intersectoral cooperation with governmental institutions and nongovernmental organizations

The Public Health and Health Promotion Department of the State Sanitary Inspectorate manages tobacco-smoking prevention activities through specialists employed in the organizational units of the Inspectorate. It also assesses activities conducted throughout the country through monitoring and through analysis and assessment of the statements and reports on the activities directed to the Inspectorate.

[14] For a description of the study and its results, see the section on Human Resources Engaged in Tobacco Control Activities below.

Depending on local opportunities and capacities and the activity and creativity of leaders and other individuals involved in prevention and health care of local populations, the coordinators of the tobacco-smoking prevention activities in the state institutions form alliances and coalitions with local government administrations and representatives of other institutions (health care units, educational and cultural institutions, sport centres, religious centres and the mass media) as well as of the private sector. These representatives participate in implementing programmes and educational campaigns aimed primarily at children and young people of school age as well as at society generally.

In the field of tobacco-smoking prophylaxis, Poland has been active for more than 10 years in organizing campaigns on World No Tobacco Day (31 May) and the World Quit Smoking Day (third Thursday of November). At national level, these activities have been coordinated by the Cancer Centre and Institute of Oncology in Warsaw, whereas at regional and local level they have been organized in broad local community partnerships and coordinated and/or managed by the health promotion specialists of the State Sanitary Inspectorate. Various institutions and organizations also implement projects of their own design, aimed at their employees or members. Irrespective of their geographical location, these organizers are given teaching aids and materials published centrally by the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland. Moreover, the organizers of local projects publish their own information and educational materials addressed to various target groups.

In the course of implementing the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland in 2007, its coordinator, the Chief Sanitary Inspector, supported and cooperated with the following nongovernmental organizations:

- the MANKO Student Association of Cracow – implementing its Cigarette-Free Premises social campaign;
- the Family Physicians College in Poland – applying Programme funds to developing guidelines for primary health care doctors on interventions for tobacco-smoking prevention among smoking patients;
- the Polish Health Education Society, which brings together health promotion professionals and which has for years provided the State Sanitary Inspectorate with organizational support;
- scouting organizations (Związek Harcerstwa Polskiego and Związek Harcerstwa Rzeczpospolitej) and student associations, whose members provide (usually) voluntary support to events organized by the sanitary and epidemiological stations and other bodies throughout the country.

Activities in the field of tobacco-smoking control involve many other institutions and nongovernmental organizations, such as: the Occupational Medicine and Environmental Health Institute, Sosnowiec; the Association of Healthy Polish Cities, Łódź; the “Oddech” Association, Warsaw; the “Verum” Academic Association, Lublin; the “Oddech Nadziei” Foundation, Bydgoszcz; the “Promocja Zdrowia” Foundation, Warsaw; the “Sport Dzieci i Młodzież” Association, Warsaw; the “Zdrowie i My” Association, Warsaw; the “Ciechanowskie Konsorcjum Zdrowia” Association, Ciechanów; the Association for Rzecz Tobacco-Free Childhood, Warsaw; the Prophylaxis and Dependence Prevention Society, Toruń, and the Związek Harcerstwa Polskiego, a national scouting organization.

This wide coalition has been joined by additional members: the "Metanoia" Psychological and Pastoral Centre, Płock; the "Laboratorium Reportażu" Foundation, Warsaw; the "Zdrowe Miasto" Foundation, Chojnice; the Pomeranian Anti-Tobacco Society, Gdańsk and many more.

## Human resources engaged in tobacco control activities

The intersectoral nature of tobacco control activities necessitates the involvement of a broad range of social groups if the objectives are to be achieved. The key social groups include: doctors and nurses, teachers, civil servants and local government employees, the police and other law enforcement agencies, the clergy and social activists. The prominent role of these groups in curbing tobacco-smoking is, to a great extent, linked to the nature of their professions and vocations, and appropriate preparation is needed if their activities are to be effective.

For more than a decade, training at national level for organizers of anti-tobacco projects has been organized by Professor W. Zatoński, while regional and local level training has been provided by institutions reporting to the Ministry of Health (sanitary and epidemiological stations, hospitals, medical academies and research institutes). The participants have primarily included the coordinators and organizers of anti-tobacco activities throughout the country as well as physicians, who have upgraded their skills in anti-tobacco interventions among smoking patients.

There is a continuing need for training to be organized at local level to help representatives of national and local government, nongovernmental organizations and the private sector in their efforts to prepare leaders and partners for joint, integrated and comprehensive activities targeting non-smokers, smokers (to help them break the habit) and the wider public.

There is also a need to prepare an anti-tobacco campaign which could be conducted systematically over a number of years. Selected target groups should be reached through various channels and with the participation of committed and responsible institutions, nongovernmental organizations, the media and other means of communication. At the present level of funding of the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland this is not possible, as the costs of a broad-based campaign are more than the funds available under the Programme.

In addition to information and educational activities, another important area of action is to motivate and mobilize the local authorities to designate public spaces as smoke-free zones, including public transport stops/stations and playgrounds.

Local leaders, public figures and volunteers need to upgrade their skills and preparedness in order to carry out campaigns and other activities in the local communities, and medical professionals (doctors and nurses) need to do likewise so that, while they carry out their routine duties in health care units, they can provide assistance and support to patients intent on giving up smoking.

**Box 8. Key points on the level of capacity for implementing tobacco control**

- Many different state and local government institutions and nongovernmental organizations are involved in activities aimed at curbing the spread of tobacco-smoking.
- The majority of these activities are coordinated and supported by the Chief Sanitary Inspector in the context of the Programme for Limiting the Health-Threatening Consequences of Tobacco-smoking in Poland in 2007.
- The social groups with key roles in curbing the spread of tobacco-smoking include doctors and nurses, teachers, civil servants and local government employees, the police and other law enforcement agencies, the clergy and social activists.
- There is a need to prepare an anti-tobacco social campaign which could be conducted systematically over a number of years.
- Local leaders, public figures and volunteers need to upgrade their skills and preparedness in order to carry out campaigns and other activities in the local communities, and medical professionals (doctors and nurses) need to do likewise so that, while they carry out their routine duties in health care units, they can provide assistance and support to patients intent on giving up smoking.

## Summary and conclusions

Both comprehensive tobacco control legislation and the government strategy and action plan that came into force in the 1990s have substantially influenced the decline in smoking prevalence. Development of the tobacco control policy was based on long-term and comprehensive research and strengthened by social trends when democracy came to the country. Some legislative measures introduced at that time were up to the best world standards, notably those concerning big health warnings on cigarette packs and total bans on the advertising and promotion of tobacco and sponsorship by tobacco companies.

The problems associated with tobacco must also be considered within the broader context of noncommunicable diseases. Chronic noncommunicable diseases have for many years constituted the most significant health, social and economic problems in Poland. Cardiovascular diseases, malignant tumours, respiratory diseases and metabolic disorders have a vital impact on morbidity and mortality indicators as well as ability to work and disability. Cardiovascular diseases and tumours alone are responsible for approximately 72% of all deaths in Poland. Despite noticeable improvements in mortality indicators as well as in cardiovascular diseases over the last few years, life expectancy in Poland is still close to eight years lower than in other EU countries. Tobacco control activities should, therefore, be comprehensive and coherent.

Additionally, in this context, the present situation as regards tobacco requires new strategies for tobacco control that must be adapted to the country's needs and harmonized with new EU and WHO standards.

The key elements of such a strategy must simultaneously address children and adults, especially women and less educated and economically disadvantaged people. They must include the following elements:

- the establishment of a progressive tax and price policy for tobacco products according to the best EU standards and enforcement of a multisectoral strategy to prevent cigarette smuggling in and out of the country;
- the enforcement of a complete ban on smoking in all public places and worksites, including bars and restaurants, which must be constantly adapted to the law so that under changing circumstances it will still be possible to fight effectively against tobacco-smoking and producers who take advantage of loopholes;
- the introduction of pictorial health warnings on cigarette packs;
- bans on tobacco advertising on the internet and tobacco promotion by free distribution in the mail or other means and by promotional discounts;
- sufficient funding for government programmes relevant to tobacco control and public health needs, and consideration of whether, in the fight against tobacco-smoking, educational programmes, social campaigns and suchlike should be treated as investments in the health care system rather than as additional costs to it: limiting tobacco-smoking will result in lower spending related to treating smokers (including hospitalization costs) and their return to healthy functioning in society;
- broader and more effective multisectoral collaboration, especially with social movements and local communities;

- the development of programmes in many sectors (health funds, insurance and pharmaceutical companies, governmental, nongovernmental and medical agencies) which aim to support economically disadvantaged social groups and help them to stop smoking tobacco;
- the broader engagement of health professionals (mainly doctors and nurses) in tobacco control, requiring: (i) their training in treatment of tobacco dependence, (ii) including tobacco dependence treatment in medical practice and the curricula of medical schools, and (iii) building capacity for smoking cessation programmes and services at national and community level, and ensuring that anti-tobacco interventions will be a permanent element in contractual commitments with the national payer;
- the implementation of community-based educational and intervention programmes aimed at preventing children from smoking and protecting both them and adult non-smokers from involuntary tobacco smoke in the home and those public places and worksites where smoking is allowed;
- constant monitoring and studying of tobacco-smoking through statistical studies of the population.

## References

1. *WHO report on the global tobacco epidemic 2008: the MPOWER package*. Geneva, World Health Organization, 2008.
2. *Demographic yearbook*. Warsaw, Central Statistical Office, 2007.
3. *Statistics on the regional health status of the Polish population in 2004*. Warsaw, Central Statistical Office, 2006.
4. European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/hfadb, accessed 20 October 2008).
5. *Health at a glance 2007: OECD indicators*. Paris, Organisation for Economic Co-operation and Development, 2007 (http://www.oecd.org/document/11/0,3343,en_2649_33929_16502667_1_1_1_1,00.html, accessed 18 October 2008).
6. Didkowska J, Wojciechowska U, Zatoński W. Spożycie tytoniu w Polsce w latach 1923–1995 [Tobacco consumption 1923–1995]. In: Zatoński W, Przewoźniak K, eds. *Palenie tytoniu w Polsce: postawy, następstwa zdrowotne i profilaktyka. Cz. I, Rozdz. 3. Wydanie drugie [Tobacco-smoking in Poland: approach, health consequences and prevention,* 2nd ed., Part I, Chapter 3*]*. Warsaw, Central Oncology Institute, 1999:111–126.
7. *Basic urban statistic report.* Warsaw, Central Statistical Office, 2006.
8. *Roczniki statystyczne GUS 1928–2005 [Annual statistics GUS 1928–2005].* Warsaw, Central Statistical Office, 2005.
9. Szczepaniak W. Miliardy złotych [Billions of zlotys]. *Puls Biznesu [Business Pulse]*, 21 January 2008.
10. Zatoński W, Przewoźniak K, Gumkowski J. Palenie tytoniu w Polsce – obraz zjawiska, nowe trendy i wyzwania [Tobacco-smoking in Poland – picture of the threat, new trends and challenges]. In: Jaworski R, ed. *Palenie tytoniu – aspekty medyczne, psychiczne i duchowe [Tobacco-smoking – medical, spiritual and psychological aspects]*. Płocki Institute Wydawniczy, 2006:111–120.
11. Zatoński W, Przewozniak K. Palenie tytoniu w dorosłej populacji Polski w latach 1974–1995 [Tobacco-smoking among the adult population of Poland in years 1974–1995]. In: Zatoński W, Przewoźniak K, eds. *Palenie tytoniu w Polsce: postawy, następstwa zdrowotne i profilaktyka. Cz. I, Rozdz.4. Wydanie drugie [Tobacco-smoking in Poland: approach, health consequences and prevention,* 2nd ed., Part I, Chapter 4*]*. Warsaw, Central Oncology Institute, 1999:127–163.
12. Forey B et al. *International smoking statistics,* 2nd ed*. A collection of historical data from 30 economically developed countries*. Oxford, The Wolfson Institute of Preventive Medicine, 2002:511–533.
13. Gilmore A et al. Prevalence of smoking in 8 countries of the former Soviet Union: results of the Living Conditions, Lifestyles and Health Study. *American Journal of Public Health*, 2004, 94:2177–2187.
14. Zatoński W. *Tobacco-smoking in central European countries: Poland.* In: Boyle P et al., eds. *Tobacco and public health: science and policy*. Oxford, Oxford University Press, 2004:235–252.
15. Boyle P et al. Characteristics of 10 295 smokers in representative samples from 17 European countries. *European Journal of Public Health*, 2000, 10(3):5–14.

16. Fagerström K et al. Nicotine dependence versus smoking prevalence: comparisons among countries and categories of smokers. *Tobacco Control*, 1996, 5:52–56.

17. Fagerström, K et al. The antismoking climate in EU countries and Poland. *Lung Cancer*, 2001, 32(1):1–5.

18. Jaworski JM et al. Profilaktyka chorób odtytoniowych – ogólnopolskie kampanie zdrowotne [Prevention of tobacco-related diseases – national health campaigns]. In: Zatoński W, Przewoźniak K, eds. *Palenie tytoniu w Polsce: postawy, następstwa zdrowotne i profilaktyka. Wydanie drugie [Tobacco-smoking in Poland: approach, health consequences and prevention,* 2nd ed.]. Warsaw, Central Oncology Institute, 1999, 127–163.

19. Zatoński, W. *Democracy and health: tobacco control in Poland*. In: de Beyer J, Brigden W, eds. *Tobacco control policy: strategies, successes and setbacks*. Washington DC, World Bank and Research for International Tobacco Control, 2003.

20. Zatoński W, Przewozniak K. Cel operacyjny nr 3 "Zmniejszenie rozpowszechnienia palenia tytoniu" [Operative objective No. 3 "Reducing the spread of smoking"]. In: Gorynski P, Wojtyniak B, Kuszewski K, eds. *Monitoring oczekiwanych efektów realizacji Narodowego Programu Zdrowia 1996–2005 [Monitoring of the expected results of the National Health Programme 1996–2005].* Warsaw, Ministry of Health, 2005:64–76.

21. Kaczmarczyk-Chałas K, Gdulewicz T, Szadkowska-Stańczyk I. Nawyk palenia tytoniu w środowisku lekarzy w Polsce [Tobacco-smoking habit among physicians in Poland]. *Polski Tygodnik Lekarski [Polish Physicians Weekly]*, 1984, 42:1395–1398.

22. Zatoński W, Gottesman K. Szkodliwość palenia tytoniu w świadomości polskich lekarzy [Tobacco-related health risk among physicians]. *Pneumonologia Polska [Polish Pneumunology]*, 1988, 3:151–156.

23. Przewozniak K, Zatonski W. *Sharp decline in smoking prevalence in Polish female doctors: they reach world standards.* Abstract book and programme of the 3rd European Conference on Tobacco or Health, Warsaw, 2002.

24. Przewoźniak K, Zatoński W. Palenie tytoniu przez polskich lekarzy [Tobacco-smoking by Polish physicians. In: Zatoński W, Przewoźniak K, eds. *Palenie tytoniu w Polsce: postawy, następstwa zdrowotne i profilaktyka. Cz. I, Rozdz.6. Wydanie drugie [Tobacco-smoking in Poland: approach, health consequences and prevention,* 2nd ed., Part I, Chapter 6*]*. Warsaw, Central Oncology Institute, 1999:183–209.

25. Mierzecki A et al. Ocena interwencji lekarzy POZ u pacjentów uzależnionych od tytoniu [Health assessment by first contact physicians with patients addicted to tobacco]. *Problemy Medycyny Rodzinnej [Family Medicine Problems]*, 2003, 5(suppl):29.

26. Przewozniak K, Zatonski W. *Smoking prevalence and patterns in primary school teachers in Poland*. Abstract book and programme of the 3rd European Conference on Tobacco or Health, Warsaw, 2002.

27. HBSC: Health Behaviour in School-Aged Children: a World Health Organization collaborative cross-national study [web site]. Edinburgh, Child and Adolescent Health Research Unit, University of Edinburgh, 2002 (http://www.hbsc.org/overview.html, accessed 20 October 2008).

28. Mazur J, Wojnarowska B, Kołoło H. *Zdrowie subiektywne, styl życia i środowisko psychospołeczne młodzieży szkolnej w Polsce [Subjective health, lifestyle and psychosocial environment among school teenagers in Poland].* Warsaw, Epidemiology department, Mother and Child Institute, 2007.

29. Mazur J, Wojnarowska B, Kowalewska A. *Zdrowie młodzieży szkolnej w Polsce. Palenie tytoniu [Schoolchildren's health in Poland. Tobacco-smoking]*. Warsaw, University of Warsaw, Faculty of Education, 2000.

30. Wojnarowska B, Mazur J. *Zachowania zdrowotne, zdrowie i postrzeganie szkoły przez młodzież w Polsce w 2002 roku [Health behaviors, health and school perception by teenagers in Poland in 2002]*. Warsaw, University of Warsaw, Faculty of Education, 2002.

31. Przewoźniak K, Zatoński W. *Smoking prevalence, patterns and determinants in Polish schoolchildren.* Abstract book and programme of the 3rd European Conference on Tobacco or Health, Warsaw, 2002.

32. Baska T et al. Findings from the Global Youth Tobacco Survey (GYTS) in the Czech Republic, Hungary, Poland and Slovakia – smoking initiation, prevalence of tobacco use and cessation. *Preventive Medicine*, 2006, 51:110–116.

33. Global Youth Tobacco Survey Collaborative Group. Tobacco use among youth: a cross country comparison. *Tobacco Control*, 2002, 11:0–18.

34. Global Youth Tobacco Survey Collaborating Group. Differences in worldwide tobacco use by gender: findings from the Global Youth Tobacco Survey. *Journal of School Health*, 2003, 73(6):207–215.

35. Brzeziński Z, Szymborski J, Zatoński W. *Zdrowotne następstwa biernego palenia tytoniu [Health consequences of passive smoking]*. In: Zatoński W, Przewoźniak K, eds. *Palenie tytoniu w Polsce: postawy, następstwa zdrowotne i profilaktyka. Cz. I, Rozdz.6. Wydanie drugie [Tobacco-smoking in Poland: approach, health consequences and prevention,* 2nd ed., Part I, Chapter 2*]*. Warsaw, Central Oncology Institute, 1999:249–264.

36. Zatonski W, Hodge M, Przewoźniak K, eds. *Report on the effects of tobacco smoke on the health of Polish children*. WHO Tobacco Free Initiative. UNF Youth and Tobacco Project. Geneva, World Health Organization, and Heath Promotion Foundation, Poland, 1999.

37. Przewoźniak K et al. *Secondhand smoke (SHS) exposure among Polish women and children at their home environment: Measurement of nicotine concentration in air and hair.* Abstract book and programme of the 13th World Conference on Tobacco or Health, Washington DC, USA, 14 July 2006.

38. Peto R et al. *Mortality from smoking in developed countries 1950–2000.* Oxford, Oxford University Press (1994, updated in 2006).

39. Wojciechowska U et al. *Nowotwory złośliwe w Polsce w 2004 roku [Cancer in Poland 2004]*. Warsaw, Central Oncology Institute, 2006.

40. Didkowska J. *Prognoza umieralności z powodu nowotworów złośliwych płuca w Polsce. Analiza epidemiologiczna [Mortality prediction due to lung cancer in Poland. Epidemiological analysis]* [rozprawa] [dissertation]. Warsaw, Central Oncology Institute, 2005.

41. Smoke Free Partnership. *Lifting the smokescreen. Ten reasons for a smoke free Europe.* Brussels, European Respiratory Society, 2006.

42. The Commercial Inspection Act of 15 December 2000. *Journal of Laws*, 2001, 4 (item 25).

43. *National Health Programme 1996–2005*. Warsaw, Ministry of Health and Social Welfare, 1996.

44. Council Directive 92/79/EC of 19 October 1992 on the approximation of taxes on cigarettes. *Official Journal*, 1999, L 211:47.

45. Council Directive 95/59/EC of 27 November 1995 on taxes other than turnover taxes which affect the consumption of manufactured tobacco. *Official Journal,* 6 December 1995, L

291:0040–0045 http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=celex:31995L0059:en:html, accessed 26 October 2008).

46. Ordinance of the Minister of Agriculture and Rural Development on the Tobacco Growing Regions of 10 November 2006. *Journal of Laws,* 2006, 209 (item 1547).

47. Schedule to Resolution 90/2007 of the Council of Ministers on the National Health Programme of 15.05.2007.

48. Directive 2003/33/EC of the European Parliament and of the Council of 26 May 2003 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products. *Official Journal*, 20 June 2003, L 152/16 (http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:152:0016:0019:EN:PDF, accessed 24 October 2008).

49. *The world health report 2001*. Geneva, World Health Organization, 2001.

50. Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products in Poland. *Journal of Laws*, 1996, 10 (item 55, as amended).

51. Chief Sanitary Inspectorate [web site]. Warsaw, Chief Sanitary Inspectorate, 2006 (http://www.gis.gov.pl/index.php?option=com_content&task=view&id=160&Itemid=155, accessed 20 October 2008).

*Annex 1*

# ACT ON THE PROTECTION OF HEALTH AGAINST THE CONSEQUENCES OF THE CONSUMPTION OF TOBACCO AND TOBACCO PRODUCTS OF 9 NOVEMBER 1995

(*JOURNAL OF LAWS*, 30 JANUARY 1996, 96.10.55)

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|---|---|---|---|---|
| 1997-10-22 | amended by | *Journal of Laws*, | 97.121.770 | article 82 |
| 1998-09-01 | amended by | *Journal of Laws,* | 97.88.554 | article 5 §2 point 47 |
| 2000-01-01 | amended by | *Journal of Laws,* | 99.96.1107 | article 1 |
| 2000-01-03 | amended by | *Journal of Laws*, | 99.96.1107 | article 1 |
| 2000-12-04 | amended by | *Journal of Laws,* | 99.96.1107 | article 1 |
| 2001-01-01 | amended by | *Journal of Laws,* | 99.96.1107 | article 1 |
| 2001-12-04 | amended by | *Journal of Laws,* | 99.96.1107 | article 1 |
| 2004-01-15 | amended by | *Journal of Laws,* | 03.229.2274 | article 1 |

With a view to preventing addiction to tobacco and tobacco products, there shall be enacted as follows:

**Article 1.** The central and local government bodies shall undertake to protect the health of the public against the consequences of the consumption of tobacco and tobacco products. Any such body may choose to support relevant actions of professional medical government, community organizations, foundations, institutions and workplaces, and co-operate with churches and other religious associations.

**Article 2.** In this Act:

1. tobacco means cultivated tobacco plants (Nicotiana);

2. tobacco products means all products made of tobacco, including cigarettes, cigars, cigarillos, pipe tobacco, sacred tobacco, sneezing powder and other produce containing tobacco, tobacco components, save the pharmaceuticals with nicotine content;[1]

3. smokeless tobacco products means the tobacco produce intended for sniffing (sneezing powder), sucking (snus), chewing, or otherwise entering in the body, save the pharmaceuticals with nicotine content;[2]

4. tobacco accessories means the articles and devices assisting consumers of tobacco and include: cigarette boxes, mouthpieces, cigarette roll-up papers, rolling

[1] Article 2 point 2 amended by virtue of article 1 point 1 letter a) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[2] Article 2 point 3 amended by virtue of article 1 point 1 letter b) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.

machines, pipes and tools for their cleaning and stuffing, ashtrays, cigar cutters, etc. (except lighters and matches);

5. tobacco advertising means any public dissemination of images of tobacco product brands, or logos thereof, and the names and logos of tobacco companies, substantially the same as the names and logos of tobacco products used for tobacco brands promotion; tobacco advertising shall not include the commercial information exchanged by the manufacturers, distributors and traders of tobacco products;[3]

6. information of tobacco products means any information on tobacco product brands and the content of harmful substances, without any message encouraging purchase or consumption of such products, posted solely in the retail outlets offering tobacco products;[4]

   6a) tar means raw, dehydrated, nicotine-less condensate of tobacco smoke condensate;[5]

   6b) nicotine means nicotine alkaloids;[6]

   6c) carbon monoxide means the colourless and odourless gas, the result of the incomplete combustion of organic substances, present in the gas phase of tobacco-smoke;[7]

   6d) additives means all and any substances, or components thereof, save the tobacco leaves, or other, natural or unprocessed components of tobacco used throughout manufacturing of tobacco products and present in the finished tobacco product, transformed or otherwise, in having regard to the paper, filters, paints and glue;[8]

7. tobacco products promotion means the public, free-of-charge distribution of tobacco products or accessories, orchestrating sampling, bonus sales of tobacco products, along with other schemes of public encouragement, or consumption of tobacco products;[9]

8. sponsoring means support, financial, or in-kind, of the actions by individuals, or institutions that involve display of the names of products and companies, and their logos.[10]

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[3] Article 2 point 5 added by virtue of article 1 point 1 letter c) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[4] Article 2 point 6 added by virtue of article 1 point 1 letter d) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 4 December 2000.
[5] Article 2 point 6a added by virtue of article 1 point 1 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[6] Article 2 point 6b added by virtue of article 1 point 1 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[7] Article 2 point 6c added by virtue of article 1 point 1 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[8] Article 2 point 6d added by virtue of article 1 point 1 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[9] Article 2 point 7 added by virtue of article 1 point 1 letter e) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[10] Article 2 point 8 added by virtue of article 1 point 1 letter f) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.

**Article 3.** The protection of health against the consequences of the consumption of tobacco shall be by setting out health, economic and social policy, including the following:

1. protection of the right of non-smokers to live in an environment free from tobacco-smoke;

2. promotion of health by putting pressure on the healthy lifestyle free from addiction to smoke cigarettes and consume other tobacco products;

   2a) upbringing and awareness raising;[11]

3. ensuring economic and legal conditions that encourage curbing of the consumption of tobacco;

4. information on the detrimental effects of smoking, stating the content of the harmful substances on the tobacco products packaging and information matter;[12]

5. reduction of the permissible rate of harmful substances content in tobacco products; and

6. treatment and rehabilitation of tobacco addicts.

**Article 4.**

1. The Council of Ministers shall define the programme of the health, social and economic policy focused on limiting consumption of tobacco products.

2. The Council of Ministers shall each year report to Parliament on the programme delivery, by April 30th.

3. The programme referred to in item 1 shall be funded from the public purse, with the total balance accounting for 0.5% on the excise tax on tobacco products.[13]

**Article 5.**

1. Smoking shall be forbidden outside the dedicated and adequately equipped rooms:[14]

   1) in health care centres, subject to provisions of item 2;
   2) in schools and other educational establishments; and
   3) in workplaces and other public facilities, and, in small, one-room catering outlets, outside of the places clearly marked as smoking areas.

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[11] Article 3 point 2a added by virtue of article 1 point 2 letter a) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[12] Article 3 point 4 amended by virtue of article 1 point 2 letter b) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 4 December 2000.
[13] Article 4 item 3 added by virtue of article 1 point 3 of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 1 January 2000.
[14] Article 5 item 1 amended by virtue of article 1 point 4 letter a) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 1 January 2001.

1a) The owner, or user of the facilities shall be held accountable for the introduction of the smoking ban on the premises referred to in item 1.[15]

2. The doctor responsible for the patient's treatment may in specific circumstances allow the patient admitted to the health care centre, to be allowed to smoke.

3. The minister competent for health, the minister competent for interior and the minister competent for justice shall each by Order determine the rules of consuming the tobacco products in the facilities under their authority.[16]
4. *Gmina* [district] Council may by Resolution define for the *gmina* the smoke-free public areas and spots, other than referred to in item 1.

**Article 6.**
1. Tobacco products shall not be sold to those under 18 years of age.

1a) If the age of the buyer cannot be established right away, the shop assistant shall be authorized to request the document verifying the age of buyer.[17]

2. Tobacco products shall not be sold at health care centres, schools, other educational outlets and the sporting and recreation facilities.[18]

3. Tobacco products shall not be available in vending machines.

4. Cigarettes shall not be sold in the packs of fewer than twenty pieces, or bulk with no packaging.

**Article 7.**
1. No smokeless tobacco products other than sneezing powder shall be manufactured, or distributed to the market.[19]

2. (Repealed).[20]

**Article 7a.** It shall be forbidden to use any additives that increase addictive properties of nicotine.[21]

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[15] Article 5 item 1a added by virtue of article 1 point 4 letter b) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[16] Article 5 item 3 amended by virtue of article 1 point 4 letter c) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[17] Article 6 item 1a added by virtue of article 1 point 2 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[18] Article 6 item 2 amended by virtue of article 1 point 5 of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[19] Article 7 amended by virtue of article 1 point 6 of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000.
[20] Article 7 item 2 repealed by virtue of article 1 point 3 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[21] Article 7a added by virtue of article 1 point 4 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

**Article 7b.** Packaging of tobacco products shall not display any inscriptions, names, trademarks, symbols or any markings whatsoever, suggesting that the product shall have been less harmful than other products.[22]

**Article 8.**

1. It shall be forbidden to advertise and promote tobacco products and accessories, and the products that imitate tobacco products, or accessories, and symbols alluding to the consumption of tobacco, notably:[23]
   1) on TV and radio, in cinemas, health care centres, schools and other educational establishments, the press addressed to children and the youth, sporting and recreation facilities and other public places;
   2) in the press other than referred to in point 1;
   3) on posters in that displayed on large area advertising boards; or
   4) in IT media.[24]

2. It shall be forbidden for tobacco companies to sponsor sporting, cultural, community and political activities, health care and education.

**Article 8a.**

1. By December 31st each year, every manufacturer, or importer of tobacco products shall present the list of all additives and the volume thereof, used over at manufacturing the tobacco products, by their brands and types. The first list, advising on the additives used in 2004 shall be presented by December 31st 2004.[25]

2. The manufacturer, or importer of tobacco products shall attach to the list referred to in item 1 the rationale for using each additive present in any given tobacco product, defining its functions and categories.

3. The manufacturer or importer of tobacco products shall attach to the list referred to in item 1 toxicological data thereby held, on the additives, combusted or un-combusted, as the case may be, with particular focus on their impact on health, including addictive consequences.

4. The lines of list referred to in item 1 shall be sequenced in decreasing order, by the mass of each of the additives contained in the product.

5. The manufacturer or importer of tobacco products shall present the list referred to in item 1 to the minister competent for health, who shall distribute it to the public

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[22] Article 7b added by virtue of article 1 point 4 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[23] Article 8 amended by virtue of article 1 point 7 of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000, however provisions of item 1 point 3 shall come into force on 4 December 2000 and provisions of item 1 point 2 and item 2 shall come into force on 4 December 2001.
[24] Article 8 item 1 point 4 added by virtue of article 1 point 5 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[25] Article 8a added by virtue of article 1 point 6 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

on the Official Journal of the minister competent for health, in accounting for the need to protect trade secrets of the manufacturer, or importer of tobacco products.

**Article 8b.**

1. The minister competent for health may request the manufacturer, or importer of tobacco products to carry out certain studies in designated test laboratories to determine the substances other than referred to in article 2 point 6a through to 6c, emitted by tobacco products, and the assessment of impact of these substances on the human health, in having regard to the addictive properties of each substance.[26]

2. The studies referred to in item 1 shall be carried out on the cost of the manufacturer, or importer of tobacco products.

3. The results of the studies referred to in item 1 shall be presented to the minister competent for health, who shall give credit to them in the information for consumers, in observing the trade secrets of the manufacturer, or importer of tobacco products.

4. The minister competent for health shall publish the information referred to in item 3 forthwith upon receipt thereof, in the Official Journal of the minister competent for health.

**Article 9.**

1. Each unit packet of cigarettes entered in the market of the Republic of Poland shall have the following affixed, visibly, legibly and permanently:[27]
   1) two different warnings on the harmful consequences of the consumption of tobacco that is one universal and one extra warning;
   2) the information on the content of tar, nicotine and carbon monoxide in one cigarette.

2. The warnings referred to in item 1 point 1, in Polish shall occupy no less than 30% of the largest surfaces of the unit pack and no less than 40% of the second largest surface of the that unit pack.

3. Provisions of 1 point 1 and item 2 shall apply to other tobacco products, having regard for item 4 and 5, as appropriate.

4. The packaging of the smoking tobacco products other than cigarettes, distributed to the retail market, whose largest and best displayed surfaces total over 75cm$^2$, the warning statements on the harmful effects of smoking shall occupy no less than 22.5cm$^2$ of every such surface.

5. The sneezing powder packs shall display one warning statement that shall have occupied no less than 30% of the single, best visible surface of the pack.

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[26] Article 8b added by virtue of article 1 point 6 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.
[27] Article 9 amended by virtue of article 1 point 7 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

6. The warning statement referred to in item 1 point 2, in Polish, shall occupy no less than 10% of one of the side surfaces of reach unit pack of cigarettes.

7. Moreover, the statements referred to in item 1 point 1 shall be displayed on the transport packing in the retail market, occupying at least 30% of one of the largest surfaces thereof, and at least 40% of the second largest surface of the packing.

8. The information on tobacco products referred to in article 2 point 6, shall include clearly displayed and legible universal warning on the harmful effects of the consumption of tobacco, occupying at least 20% of the surface provided for the information.

**Article 10.** The minister competent for health shall by order determine the permissible content of tar, nicotine and carbon monoxide in the smoke, manner of selection and the list of the test laboratories authorised to establish the actual content of these substances, along with the content, layout and the fashion of placing of warning statements and the information referred to in article 9, in accounting for the need to break the warning statements down into the universal and extra warning statements, and in having regard to the goals of the health care policy pursued by the Act, notably the following:[28]

1) curbing distribution and intensity of consumption of the tobacco products;
2) reduction of the volume of damages to health, caused by tobacco-induced diseases;
3) effective oversight of tobacco products, and

the fundamental standards applicable to tobacco products set out in the EU regulations.

**Article 11.**
Tobacco dependence shall be treated free of charge in the public health care centres.

**Article 12.** Any person who

1) manufactures, or introduces to the market the tobacco products, where the content of harmful substances exceeds the permissible limits;
2) manufactures, or introduces to the market the smokeless tobacco products other than the sneezing powder;
3) introduces to the market the tobacco products, whose packaging do not display the warning statements on the detrimental effects of tobacco consumption, or the content of the harmful substances, or
4) advertises, promotes, or sponsors the tobacco products contrary to provisions of article 8;

[28] Article 10: amended by virtue of article 1 point 9 of the act of 5 November 1999 (Journal of Laws, 99.96.1107) amending this Act effective as of 3 January 2000; amended by virtue of article 1 point 8 of the act of 28 November 2003 *(Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

shall be guilty of an offence and liable to a fine not exceeding Zl 200 000 or imprisonment, or both.[29]

**Article 12a.** Any person who affixes, on packing of tobacco products, any inscriptions, names, trademarks, symbols and other markings suggesting that the product is less harmful than other products, shall be guilty of an offence and liable to a fine not exceeding Zl 200 000 or limitation of freedom, or both.[30]

**Article 12b.** Any person who, when manufacturing the tobacco products, uses the additives that addictive properties of these products, shall be guilty of an offence and liable to a fine not exceeding Zl 500 000 or limitation of freedom, or both.[31]

**Article 13.** 1. Any person who

1) sells tobacco products in violation of the bans referred to in article 6;
2) smokes tobacco in the places where smoking is prohibited as set forth in article 5; or
3) allows smoking at the site within the person's responsibility, contrary to the bans referred to in article 5;[32]

shall be guilty of an offence and liable to a fine.

2. In any of the events referred to in item 1, decisions shall be adjudicated in pursuance of the petty offence handling procedure.

**Article 14.** Should any of the acts referred to in article 12, 12a and 12b, or in article 13 item 1 point 1 be committed as part of business, the perpetrator shall be the person responsible for launching the production process, commercial introduction of the tobacco products, or organization of the market for the tobacco products.[33]

**Article 15.** Should any of the acts referred to in article 12 point 1 through to 3, 12a and 12b, or in article 13 item 1 point 1 be committed, the court may decide on forfeiture of

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[29] Article 12: amended by virtue of article 5 § 2 point 47 of the act of June 6th 1997: regulations introducing the Penal Code (*Journal of Laws,* 97.88.554) effective as of September 1st 1998; amended by virtue of article 1 point 10 of the act of 5 November 1999 (*Journal of Laws,* 99.96.107) amending this Act effective as of 3 January 2000; amended by virtue of article 1 point 9 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004;

[30] Article 12a added by virtue of article 1 point 10 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

[31] Article 12b added by virtue of article 1 point 10 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

[32] Article 13 item 1 point 3 added by virtue of article 1 point 11 of the act of 5 November 1999 (*Journal of Laws*, 99.96.1107) amending this Act effective as of 3 January 2000.

[33] Article 14: amended by virtue of article 82 of the act of August 20th 1997: regulations introducing the National Court Register Act (*Journal of Laws,* 97.121.770) effective as of October 22nd 1997; amended by virtue of article 1 point 12 of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000; amended by virtue of article 1 point 12 letter b) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 4 December 2000; and amended by virtue of article 1 point 11 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

the tobacco products being the subject matter of that act, even if they be the property of the person other than the perpetrator.[34]

**Article 16.** In the decree on Tobacco Growing and Manufacture of Tobacco Products, of June 24th 1953 (J.L. No. 34/1953, item 144, No. 41/1988, item 324, No. 35/1989 item 192 and No. 47/1993, item 211) there shall be deleted article 8a.

**Article 17.** This Act shall come into force three months upon promulgation hereof.

[34] Article 15: amended by virtue of article 1 point 12 letter b) of the act of 5 November 1999 (*Journal of Laws,* 99.96.1107) amending this Act effective as of 3 January 2000; and amended by virtue of article 1 point 11 of the act of 28 November 2003 (*Journal of Laws,* 03.229.2274) amending this Act effective as of 15 January 2004.

*Annex 2*

# NATIONAL HEALTH PROGRAMME

The national health programme for 2007–2015 was adopted by resolution of the Council of Ministers in May 2007, who vested its implementation in the National Institute of Public Health in collaboration with the Ministry of Health. Reducing the spread of tobacco-smoking was included in the programme as Operational Objective 1, within the wider context of the risk factors and measures of health promotion. The key measures of the programme in this area include:

- Protecting the health and development of children and young people, in particular against exposure to tobacco smoke through eliminating tobacco-smoking by pregnant women and disseminating educational programmes aimed at prevention of tobacco-smoking by children and young people;
- guaranteeing all employees workplaces free of contamination by tobacco smoke;
- executing measures aimed at implementing the WHO Framework Convention on Tobacco Control, including drafting and passing relevant executive regulations;
- disseminating treatment for tobacco-dependence syndrome;
- increasing awareness of activities aimed at limiting the health-threatening consequences of tobacco-smoking;
- encouraging an atmosphere of social acceptance for a tobacco-free lifestyle;
- controlling effectively the market in tobacco products;
- developing and disseminating prophylaxis programmes aimed at children and young people, teachers and parents;
- increasing the skills of teachers, educators, cultural instructors and animators and psychologists in prophylaxis of problems of children and young people, including nicotine problems;
- increasing accessibility to preventive assistance for children and young people in the higher risk groups.

In connection with the assumptions in the national health programme and the Act on Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products of 9 November 1995, the Government has developed a Programme for Limiting the Health-Threatening Consequences of Tobacco-Smoking in Poland.

*Annex 3*

# FUNDING OF THE PROGRAMME FOR LIMITING THE HEALTH-THREATENING CONSEQUENCES OF TOBACCO-SMOKING FROM THE STATE BUDGET

| Year | ZI (millions) | Estimated in € (millions) |
|---|---|---|
| 1999 | 6.6 | 1.6 |
| 2000 | 24 | 5.7 |
| 2001 | 5 | 1.5 |
| 2002 | 0.5 | 0.1 |
| 2003 | 0.5 | 0.1 |
| 2004 | 0.5 | 0.1 |
| 2005 | 0.5 | 0.1 |
| 2006 | 1 | 0.2 |

*Source:* Chief Sanitary Inspectorate [web site]. Warsaw, Chief Sanitary Inspectorate, 2006 (http://www.gis.gov.pl/index.php?option=com_content&task=view&id=160&Itemid=155, accessed 20 October 2008).

*Annex 4*

# LIFE EXPECTANCY AT BIRTH, EU COUNTRIES, RUSSIAN FEDERATION, TURKEY AND UKRAINE, 2004–2006

| Male | | | | | Female | | | |
|---|---|---|---|---|---|---|---|---|
| **Country** | **2004** | **2005** | **2006** | | **Country** | **2004** | **2005** | **2006** |
| Austria | 76.52 | 76.81 | 77.31 | | Austria | 82.18 | 82.37 | 82.93 |
| Belgium | – | – | – | | Belgium | – | – | – |
| Bulgaria | 69.08 | – | – | | Bulgaria | 76.28 | – | – |
| Cyprus | 76.95 | – | – | | Cyprus | 82.18 | – | – |
| Czech Republic | 72.62 | 72.97 | – | | Czech Republic | 79.24 | 79.32 | – |
| Denmark | – | – | – | | Denmark | – | – | – |
| Estonia | 66.48 | 67.31 | – | | Estonia | 77.96 | 78.23 | – |
| Finland | 75.39 | 75.81 | – | | Finland | 82.46 | 82.77 | – |
| France | 76.89 | – | – | | France | 83.99 | – | – |
| Germany | 76.57 | – | – | | Germany | 82 | – | – |
| Greece | 76.67 | 76.92 | 77.48 | | Greece | 81.46 | 81.76 | 82.14 |
| Hungary | 68.77 | 68.75 | – | | Hungary | 77.23 | 77.23 | – |
| Ireland | 76.46 | 77.32 | – | | Ireland | 81.43 | 81.79 | – |
| Italy | – | – | – | | Italy | – | – | – |
| Latvia | 66 | 65.44 | 65.42 | | Latvia | 76.31 | 76.62 | 76.44 |
| Lithuania | 66.38 | 65.37 | – | | Lithuania | 77.79 | 77.4 | – |
| Luxembourg | 76.15 | 76.99 | – | | Luxembourg | 82.74 | 82.23 | – |
| Malta | 77.36 | 77.24 | – | | Malta | 81.3 | 81.41 | – |
| Netherlands | 77.02 | – | – | | Netherlands | 81.65 | – | – |
| Poland | 70.67 | 70.81 | – | | Poland | 79.28 | 79.42 | – |
| Portugal | 74.94 | – | – | | Portugal | 81.62 | – | – |
| Romania | 68.3 | 68.76 | 69.24 | | Romania | 75.59 | 75.77 | 76.23 |
| Russian Federation | 59.08 | 58.98 | – | | Russian Federation | 72.36 | 72.4 | – |
| Slovakia | 70.47 | 70.32 | – | | Slovakia | 78.2 | 78.23 | – |
| Slovenia | 73.58 | 74.04 | 74.55 | | Slovenia | 80.87 | 80.93 | 82.03 |
| Spain | 77.04 | 77.09 | – | | Spain | 83.88 | 83.8 | – |
| Sweden | 78.33 | – | – | | Sweden | 82.67 | – | – |
| Turkey | – | – | – | | Turkey | – | – | – |
| Ukraine | 62.03 | 61.52 | 62.34 | | Ukraine | 73.63 | 73.37 | 73.84 |
| United Kingdom | 76.8 | 77.11 | – | | United Kingdom | 81.18 | 81.38 | – |
| EU average | 69.88 | 70.03 | – | | EU average | 77.95 | 78.05 | – |

*Source:* European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/hfadb, accessed 17 June 2008).

*Annex 5*

# REGULAR DAILY SMOKERS AGED 15+ YEARS, EU COUNTRIES, RUSSIAN FEDERATION, TURKEY AND UKRAINE, 2004–2006

| Male | | | | | Female | | | |
|---|---|---|---|---|---|---|---|---|
| **Country** | **2004** | **2005** | **2006** | | **Country** | **2004** | **2005** | **2006** |
| Austria | – | – | 27.3 | | Austria | – | – | 19.4 |
| Belgium | 28 | 23 | 29 | | Belgium | 20 | 16 | 16 |
| Bulgaria | – | – | – | | Bulgaria | – | – | – |
| Cyprus | – | – | – | | Cyprus | – | – | – |
| Czech Republic | 31.1 | – | – | | Czech Republic | 20.1 | – | – |
| Denmark | 29 | – | – | | Denmark | 23 | – | – |
| Estonia | 42 | – | 40.9 | | Estonia | 21 | – | 19.5 |
| Finland | 27.1 | 26 | 24.4 | | Finland | 19.5 | 18.2 | 18.9 |
| France | – | – | – | | France | – | – | – |
| Germany | – | – | – | | Germany | – | – | – |
| Greece | – | – | – | | Greece | – | – | – |
| Hungary | – | – | – | | Hungary | – | – | – |
| Ireland | 24.2 | 24.2 | 24.7 | | Ireland | 23.6 | 23.6 | 24.7 |
| Italy | – | 28.7 | 29.2 | | Italy | – | 16.4 | 17.2 |
| Latvia | 47.3 | – | – | | Latvia | 17.8 | – | – |
| Lithuania | 39.4 | 42.1 | – | | Lithuania | 14.2 | 9.8 | – |
| Luxembourg | 36 | 32 | 29 | | Luxembourg | 26 | 22 | 21 |
| Malta | – | – | – | | Malta | – | – | – |
| Netherlands | 35.1 | 35.4 | 35.5 | | Netherlands | 26.7 | 26.3 | 26.2 |
| Poland | 38 | 42 | 37 | | Poland | 25.6 | 25 | 23 |
| Portugal | – | – | 30.8 | | Portugal | – | – | 11.8 |
| Romania | – | – | – | | Romania | – | – | – |
| Russian Federation | 61.3 | – | – | | Russian Federation | 15 | – | – |
| Slovakia | – | – | – | | Slovakia | – | – | – |
| Slovenia | – | 24 | – | | Slovenia | – | 22 | – |
| Spain | – | – | – | | Spain | – | – | – |
| Sweden | 15 | 13.9 | – | | Sweden | 17.5 | 18 | – |
| Turkey | – | – | 50.6 | | Turkey | – | – | 16.6 |
| Ukraine | – | 62 | – | | Ukraine | – | 17 | – |
| United Kingdom | 26 | – | – | | United Kingdom | 23 | – | – |
| EU average | – | – | – | | EU average | – | – | – |

*Source:* European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/hfadb, accessed 17 June 2008).

*Annex 6*

# SMOKING-RELATED DEATHS PER 100 000 POPULATION, EU COUNTRIES, RUSSIAN FEDERATION, TURKEY, AND UKRAINE, 2004–2006

| Male | | | | Female | | | |
|---|---|---|---|---|---|---|---|
| **Country** | **2004** | **2005** | **2006** | **Country** | **2004** | **2005** | **2006** |
| Austria | 302.42 | 292.83 | 286.3 | Austria | 163.42 | 155.89 | 150.62 |
| Belgium | – | – | – | Belgium | – | – | – |
| Bulgaria | 534.87 | – | – | Bulgaria | 303.51 | – | – |
| Cyprus | 235.48 | – | – | Cyprus | 102.34 | – | – |
| Czech Republic | 472.95 | 480.7 | – | Czech Republic | 252.57 | 269.48 | – |
| Denmark | – | – | – | Denmark | – | – | – |
| Estonia | 701.1 | 667.72 | – | Estonia | 336.58 | 316.98 | – |
| Finland | 353.88 | 345.67 | – | Finland | 168.73 | 166.22 | – |
| France | 204.25 | – | – | France | 75.23 | – | – |
| Germany | 302.54 | – | – | Germany | 156.63 | – | – |
| Greece | 317.61 | 296.93 | 291.08 | Greece | 181.25 | 167.07 | 163.31 |
| Hungary | 668.14 | 685.38 | – | Hungary | 343.18 | 353.67 | – |
| Ireland | 332.4 | 308.69 | – | Ireland | 187.1 | 174.58 | – |
| Italy | – | – | – | Italy | – | – | – |
| Latvia | 782.59 | 780.73 | 746.42 | Latvia | 389.16 | 378.82 | 362.82 |
| Lithuania | 741.04 | 781.44 | – | Lithuania | 377.87 | 398.05 | – |
| Luxembourg | 295.83 | 263.59 | – | Luxembourg | 134.21 | 128.36 | – |
| Malta | 346.12 | 366.49 | – | Malta | 181.55 | 193.15 | – |
| Netherlands | 275.13 | – | – | Netherlands | 137.83 | – | – |
| Poland | 429.45 | 417.61 | – | Poland | 190.39 | 187.13 | – |
| Portugal | 282.73 | – | – | Portugal | 147.22 | – | – |
| Romania | 650.08 | 647.91 | 630.24 | Romania | 396.21 | 398.01 | 383.48 |
| Russian Federation | – | – | – | Russian Federation | – | – | – |
| Slovakia | 590.53 | 570.43 | – | Slovakia | 313.65 | 303.6 | – |
| Slovenia | 338.44 | 327.39 | 287.02 | Slovenia | 149.4 | 138.47 | 118.11 |
| Spain | 264.34 | 263.56 | – | Spain | 96.99 | 95.92 | – |
| Sweden | 260.4 | – | – | Sweden | 156.64 | – | – |
| Turkey | – | – | – | Turkey | – | – | – |
| Ukraine | 1080.94 | – | – | Ukraine | 585.6 | – | – |
| United Kingdom | 333.84 | 317.81 | – | United Kingdom | 194.03 | 186.67 | – |
| EU average | 539.97 | 537.09 | – | EU average | 281.8 | 283.07 | – |

*Source:* European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (http://www.euro.who.int/hfadb, accessed 17 June 2008).

*Annex 7*

# EUROPEAN COUNTRIES RANKED BY TOTAL TOBACCO CONTROL SCALE ACCORDING TO PROGRESS IN TOBACCO CONTROL, 2005–2007

| Country | Price (30) | | Bans on smoking in public places (22) | | Spending on public information campaigns (15) | | Bans on advertising (13) | | Health warnings (10) | | Treatment (10) | | Total (100) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2005 | 2007 | 2005 | 2007 | 2005 | 2007 | 2005 | 2007 | 2005 | 2007 | 2005 | 2007 | 2005 | 2007 |
| United Kingdom[(a)] | 30 | 30 | 1 | 21 | 15 | 15 | 11 | 11 | 6 | 6 | 10 | 10 | 73 | 93 |
| Ireland | 23 | 23 | 21 | 21 | 3 | 3 | 12 | 12 | 6 | 6 | 9 | 9 | 74 | 74 |
| Iceland | 25 | 22 | 11 | 17 | 13 | 14 | 13 | 13 | 6 | 6 | 2 | 2 | 70 | 74 |
| Norway[(b)] | 26 | 22 | 17 | 17 | 5 | 4 | 13 | 13 | 6 | 6 | 4 | 4 | 71 | 66 |
| Malta | 19 | 22 | 17 | 17 | 3 | 3 | 9 | 12 | 7 | 7 | 7 | 1 | 62 | 62 |
| Sweden | 19 | 19 | 15 | 15 | 2 | 1 | 13 | 13 | 6 | 6 | 5 | 7 | 60 | 61 |
| France | 23 | 21 | 6 | 12 | 4 | 3 | 11 | 11 | 6 | 6 | 6 | 6 | 56 | 59 |
| Finland | 18 | 17 | 12 | 12 | 1 | 2 | 13 | 13 | 7 | 7 | 7 | 7 | 58 | 58 |
| Belgium | 16 | 16 | 8 | 13 | 2 | 3 | 12 | 12 | 7 | 9 | 5 | 5 | 50 | 58 |
| Italy | 16 | 17 | 17 | 17 | 2 | 1 | 10 | 10 | 6 | 6 | 6 | 6 | 57 | 57 |
| Estonia | 14 | 11 | 9 | 13 | 2 | 5 | 11 | 13 | 1 | 6 | 8 | 8 | 45 | 56 |
| Spain[(a)] | 12 | 12 | 3 | 15 | 3 | 5 | 3 | 12 | 6 | 6 | 4 | 5 | 31 | 55 |
| Bulgaria | 19 | 22 | 6 | 8 | 0 | 0 | 9 | 12 | 6 | 6 | 6 | 6 | 46 | 54 |
| Netherlands | 16 | 14 | 9 | 9 | 4 | 4 | 12 | 12 | 6 | 6 | 5 | 5 | 52 | 50 |
| Romania[(a)] | 13 | 18 | 6 | 8 | 0 | 1 | 0 | 12 | 3 | 6 | 5 | 5 | 27 | 50 |
| Poland | 16 | 14 | 10 | 12 | 0 | 0 | 12 | 12 | 6 | 6 | 6 | 6 | 50 | 50 |
| Slovakia | 18 | 17 | 8 | 8 | 0 | 0 | 11 | 11 | 6 | 6 | 6 | 6 | 49 | 48 |
| Switzerland | 15 | 14 | 5 | 6 | 4 | 10 | 4 | 4 | 3 | 6 | 4 | 7 | 35 | 47 |
| Cyprus[(b)] | 21 | 17 | 6 | 6 | 1 | – | 12 | 12 | 6 | 6 | 5 | 5 | 51 | 46 |
| Denmark | 17 | 16 | 3 | 3 | 2 | 3 | 10 | 10 | 6 | 6 | 7 | 7 | 45 | 45 |
| Lithuania | 11 | 10 | 6 | 14 | 1 | – | 9 | 10 | 6 | 6 | 1 | 4 | 34 | 44 |
| Hungary[(b)] | 17 | 14 | 6 | 6 | 1 | – | 10 | 10 | 6 | 6 | 7 | 7 | 47 | 43 |
| Portugal | 17 | 20 | 5 | 5 | – | – | 10 | 10 | 6 | 6 | 1 | 1 | 39 | 42 |
| Latvia | 9 | 9 | 6 | 12 | 1 | 4 | 6 | 9 | 6 | 6 | 1 | 1 | 29 | 41 |
| Czech Republic | 12 | 13 | 6 | 6 | 0 | 0 | 9 | 10 | 6 | 6 | 5 | 5 | 38 | 40 |
| Slovenia | 13 | 12 | 6 | 6 | 0 | 0 | 7 | 12 | 6 | 6 | 4 | 4 | 36 | 40 |
| Germany | 20 | 19 | 2 | 2 | 0 | 0 | 4 | 5 | 6 | 6 | 4 | 5 | 36 | 37 |
| Greece | 17 | 15 | 7 | 7 | 0 | 0 | 4 | 4 | 6 | 6 | 4 | 4 | 38 | 36 |
| Luxembourg | 7 | 6 | 4 | 11 | 0 | 0 | 5 | 9 | 7 | 7 | 3 | 3 | 26 | 36 |
| Austria | 14 | 13 | 4 | 4 | 0 | 0 | 4 | 9 | 6 | 6 | 3 | 3 | 31 | 35 |

[(a)] Three countries with the greatest increase in total tobacco control scale score during the two years studied;
[(b)] Three countries with the greatest decrease in total tobacco control scale score during the two years studied.

*Source:* Joossens L, Raw M. *Progress in tobacco control in 30 European countries*. Brussels, European Network for Smoking Prevention, 2007 (www.ensp.org, accessed 17 June 2008).

*Annex 8*

# WHO STRATEGIC ANTI-TOBACCO DOCUMENTS

For many years WHO has been emphasizing the importance of threats from noncommunicable diseases, as shown in resolutions such as the following:

Regarding prophylactics and control (WHA53.17)
Regarding diet and physical activity (WHA57.17)
Children end emphasis nutrition (WHA55.25)
Public health problems in the light of alcohol abuse (WHA58.26)
Cancer prevention and control (WHA58.22)
Disabled people (WHA58.23)
Health promotion in the united world (EB117.R9).

Those strategies were a starting point for agreements between Member States such as the:

European Strategy for Tobacco Control (EUR/RC52/R12)
Framework for alcohol policy in the WHO European Region (EUR/RC55/R1)
Nutrition Policy and an Action Plan for the European Region of WHO (EUR/RC50/R8)
Children's Environment and Health Action Plan for Europe (EUR/RC54/R3)
Mental Health Declaration for Europe Action Plan (EUR/RC55/R2)
European strategy for child and adolescent health and development (EUR/RC55/R6).

The document *Gaining health. The European strategy for the prevention and control of noncommunicable diseases* adopted at the 56th Session of the WHO Regional Committee for Europe and published in 2006 is another example of the fight against tobacco use. The strategy presents activities in the field of noncommunicable diseases with the following main elements:

- lobbying for health
- knowledge and education
- financial
- capacity
- social support for health care.

The European Strategy for Tobacco Control (ESTC).

The WHO European Strategy for Smoking Cessation Policy.

**The WHO Regional Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

**Member States**

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

**Original: English**

**World Health Organization**
**Regional Office for Europe**

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