

EFFECTIVE TOBACCO CONTROL POLICIES IN 28 EUROPEAN COUNTRIES

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1.EXECUTIVE SUMMARY

The World Bank published in June 2003 the fact sheet 'Tobacco control at a glance', which describes six cost-effective interventions to reduce death and disease caused by tobacco use: Higher taxes; Bans/restrictions on smoking in public and work places; bans on advertising and promotion; better consumer information; warning labels and help for smokers who wish to quit.

While the effective tobacco control measures are known, it remained still unclear as to what weight should be given to each measure. The aim of this report is to give an overview of effective tobacco control policies and to quantify the tobacco control efforts of European countries according to a scale.

In preparation of this report, the European Network for Smoking Prevention (ENSP) convened a panel of international researchers and tobacco control experts to agree on the allocation of points on proven effective tobacco control policies. The panel came to an agreement on the allocation of points (points out of 100) under the coordination of world tobacco control expert Luk Joossens.

- Price/taxation policy (30 points)
- Workplace/public place smoking bans (22 points),
- Overall tobacco control budget (15 points),
- Advertising ban (13 points),
- Labelling/health warning (10 points),
- Tobacco dependence treatment (10 points).

This report describes the impact of tobacco control policies on smoking prevalence in Europe as well as the interventions which should be prioritised in comprehensive tobacco control policies. The panel clearly has invested a great deal of thought and expertise in proposing the following recommendations to address these interventions:

- More money should be spent on the evaluation of tobacco control policies in Europe.
- There is a need for more standardisation and harmonisation of smoking prevalence and tobacco use data in Europe, in order to make comparisons of the effectiveness of tobacco control policies between countries.
- Tobacco control programmes should be comprehensive and at least include the following components:
 - price increases through higher taxation;
 - comprehensive advertising and promotion bans of all tobacco products;
 - bans/restrictions on smoking in work places;
 - better consumer information, including counter advertising (public information campaigns), media coverage, and publicising research findings;
 - large, direct health warning labels on cigarette boxes and other tobacco products;
 - treatment to help dependent smokers stop, including increased access to medications.
- There is an urgent need for more investment in tobacco control programmes. In the European Union, only the UK spent more than

€1 per capita on tobacco control, while the Centers for Disease Control and Prevention (CDC) in the US estimate that states need to spend between \$1 and \$3 per capita per year over a sufficient period of time (e.g., 3 years) to be fully effective.

The purpose of the score system is not to praise or condemn national tobacco control policies, but rather to encourage those in charge of the policy to look at the scores of their country, analyse their tobacco control policy and make proposals to improve the weaker components.

Taking into account the necessary caveats and cautionary comments included in this report, the score system developed in this research can play a positive role in improving tobacco strategy in European countries.

2. THE SIX EFFECTIVE TOBACCO CONTROL INTERVENTIONS

The World Bank published in June 2003 the fact sheet: "Tobacco control at a glance", which describes six cost-effective interventions to reduce death and disease caused by tobacco use.¹ These are:

- Higher taxes on cigarettes and other tobacco products.
- Bans/restrictions on smoking in public and work places.
- Comprehensive bans on the advertising and promotion of all tobacco products, logos and brand names.
- Better consumer information: counter advertising, media coverage, research findings.
- Large, direct warning labels on cigarette boxes and other tobacco products.
- Help for smokers who wish to quit, including increased access to Nicotine Replacement (NRT) and other cessation therapies.

The best results are achieved when a comprehensive set of measures to reduce the use of tobacco are implemented together. Many countries have succeeded in reducing smoking prevalence dramatically.

1. According to the World Bank, **price increases** are the most effective and cost effective deterrent – especially for young people and others with low incomes, who must, by necessity,

¹World Bank. Tobacco control at a glance (2003)
<http://www1.worldbank.org/tobacco/pdf/AAG%20Tobacco%206-03.pdf>

be highly price-responsive. A price rise of 10% decreases consumption by about 4% in high-income countries.² The impact of a price increase can be illustrated by the example of France. According to two surveys, undertaken among 3,000 people aged 15 to 75 years old in November and December 1999 and 2003, the number of smokers in France has decreased from 15,300,000 in 1999 to 13,500,000 in 2003 (a decrease of 12% in smoking prevalence). More smokers wished to stop smoking in 2003 (58% in 1999 and 66% in 2003) and in 2003 the price became the top reason why smokers said they wished to stop smoking (compared to fourth place in 1999). In 2003 sales of cigarettes decreased by 13.5%.³ In 2003 there was a real increase in the price of Marlboro of almost 28%.

2. There are other ways to reduce smoking aside from raising cigarette prices by means of taxation: empirical evidence shows that a fully **comprehensive advertising ban** covering all media and all forms of direct and indirect advertising contributes to the reduction of tobacco consumption. A comprehensive advertising ban also lessens the social desirability of smoking, particularly among young people. Along with the promotion of a smoke-free environment, the regulation of advertising contributes to making non-smoking

² Jha P, Chaloupka F, Curbing the epidemic. Governments and the economics of tobacco control, The World Bank, Washington DC, 1999.

³ Inpes, Tabac, l'offensive: 1.8 million de fumeurs en moins. Press release, 1 February 2004, Paris

an accepted social norm. Tobacco advertising bans are effective according to the World Bank: "Since 1972 most high-income countries have introduced stronger restrictions (on tobacco advertising) across more media and on various forms of sponsorship. A study of 22 high-income countries based on data from 1970 to 1992 concluded that comprehensive bans on cigarette advertising and promotion can reduce smoking, but more limited partial bans have little or no effect. If the most comprehensive restrictions were in place, the study concluded, tobacco consumption would fall by more than 6 percent in high income countries. Modelling based on these estimates suggests that the European Union's (annulled) ban on advertising could reduce cigarette consumption within the European Union by nearly 7 percent."⁴

3. **Clean indoor air laws** may prohibit smoking in public places and on public transportation. The most extensive laws also include restaurants, bars and private workplaces. Smoke-free workplaces not only protect non-smokers, they also create an environment that encourages smokers to cut back or quit. A review of 26 studies on the effectiveness of smoke-free workplaces concluded that totally smoke-free workplaces are associated with a reduction in smoking prevalence of 3, 8% and 3.1 fewer cigarettes smoked per day per continuing

⁴ Jha, P, Chaloupka F, Curbing the epidemic. Governments and the economics of tobacco control, World Bank, Washington DC, 1999

smoker.⁵ Clean indoor air laws may make smoking less attractive by reducing opportunities to smoke and by supporting social norms against smoking. Workplace laws have the biggest effect, with restaurant laws comprising about 2-3% of the effect, and laws relating to schools and other places each comprising about 1%. Less strict bans are predicted to be 50% less effective than strictly-enforced bans.⁶ A large increase in the tax on cigarettes and a ban on smoking in bars and restaurants, which came into effect on 30 March 2003, are being credited with contributing to an 11% decline in the number of adult smokers in New York city from 2002 to 2003 - one of the steepest short term declines ever measured, according to surveys commissioned by the city. The surveys show that the number of regular smokers, after holding steady for a decade, dropped by more than 100 000 over the period. It is estimated that 19% of adults in New York smoked in 2003, down from 22% in 2002.⁷

In Europe complete bans on smoking in the workplace (including bars and restaurants) have been introduced in Ireland (since 29 March 2004), in Norway (1 June 2004) and will be introduced in Sweden on 1 June 2005. It is too early to

⁵ Fichtenberg C, Glantz S, Effect of smoke-free workplaces on smoking behaviour: systematic review, *BMJ*, 2002;325:188-91

⁶ Levy D, J Gitchell J, Chaloupka F, The effects of tobacco control policies on smoking rates: A tobacco control scorecard, PIRE Working Paper, Calverton, MD, 2003

⁷ Gottlieb S, New York's war on tobacco produces record fall in smoking, *British Medical Journal*, 2004;328:1222

measure the impact of the ban in Ireland, but figures released by Gallaher, Ireland's largest cigarette manufacturer show a 7.5% fall in sales during the first 6 months of the 2004. The Gallaher group, which has around 50% of the cigarette market in Ireland, said tax increases and the smoking ban had contributed to the drop in sales. Trade analysts Citigroup Smith Barney made the following comment on the Irish market at the beginning of September 2004: "Once again, the month-by-month data continues to look worrying. Overall, we believe the ban has probably reduced consumption by 5%. It will also make recruiting new smokers, and marketing to all smokers, much harder, we believe." ⁸

4. **Many smokers want to quit and could use help.** Quit rates can be substantially increased through advice from health care providers, telephone "quit-lines", formal and informal support-groups and cessation therapies including nicotine-replacement (NRT). Government cessation policies, such as mandating or subsidizing health care worker interventions or financial coverage of behavioural- and pharmaco-therapies or quit lines, may also play an important role in an effective strategies. They are likely to have relatively small effects (1%-2% reduction in prevalence) but these effects grow over time and may be important in helping those heavier smokers who have the most difficulty cutting back or quitting smoking.⁹

⁸ Citigroup Smith Barney, Gallaher, 9 September 2004

⁹ Levy D, J Gitchell J, Chaloupka F, The effects of tobacco control policies on smoking rates: A tobacco control scorecard. PIRE Working Paper, Calverton, MD,2003

5. **Mandated labels on tobacco products** are an effective way of informing smokers of the hazards of smoking, encouraging smokers to quit, and of discouraging non-smokers from starting to smoke. Many countries require health warnings on tobacco products. Evaluations of these warnings conclude that they are effective only if they contain multiple strong and direct messages that are prominently displayed. Evidence from Canada, Brazil, Australia¹⁰, Netherlands and Belgium shows that the large warnings introduced recently are effective in discouraging smoking and increasing public awareness of the health effects of smoking. In November 2002, the Dutch tobacco control organisation *Defacto* presented the results of studies on the effects of the new health warnings. These studies indicated that some adult smokers said that they smoked less and were more motivated to quit by the new health warnings. They found an even stronger effect among 13-18 year olds: 28% said that they smoked less because of the new health warnings.¹¹ A Belgian study released in May 2004 confirmed the Dutch findings and found that bigger, clearer warnings motivated smokers to stop smoking and made cigarette packs less attractive to youngsters.¹² Warnings on cigarettes have been compulsory in Belgium since 30

¹⁰ World Bank, Tobacco pack information at a glance, Washington, June 2003.

www.worldbank.org/tobacco

¹¹ Persbericht Defacto (2002). 28% van jonge rokers rookt minder door de nieuwe waarschuwingen opverpakking, Den Haag 26 november 2002.

¹² Joossens L, Onderzoek naar het effect van gezondheidswaarschuwingen op sigarettapakjes in België, Vlaams Instituut voor Gezondheidspromotie, Brussel, 2004

September 2003, and cover an average of 55% of the front and back of the package, making them the largest in the world. 29% of all smokers felt that the warnings were an additional motivation to stop smoking. Amongst those who declared that they wished to stop smoking within a year the percentage was 46%. As a result of the new warnings 8% of those questioned in Belgium smoked less, 2% more and 88% as much as before. Large health warnings have been found to be strongly linked with smokers' decisions to stop or reduce their smoking. Among Polish male smokers, 3% said they had quit following the introduction of new very large warnings, an additional 16% said they had tried quitting, and a further 14% said they understood the health effects of smoking better because of the warnings.¹³

6. Experience from the US and Australia¹⁴ shows that increases in **funding for tobacco control programs** reduce tobacco use. In the US several states have invested in large-scale comprehensive, tobacco-control programs and include components such as media campaigns, school-based tobacco prevention programs, smoking cessation support including telephone "quit-lines" and enforcement of smoking restrictions. Analysis of the data in the US indicates a consistent pattern

¹³ World Bank Report, Curbing the epidemic. Governments and the economics of tobacco control, Washington DC, 1999

¹⁴ Hill DJ, White VM, Scollo MM. Smoking behaviours of Australian adults in 1995: trends and concerns. Medical Journal of Australia 1998;168:209-13

that tobacco control expenditures impact cigarette sales.¹⁵ The effectiveness of mass media campaigns will depend on their scale and duration. Expenditure has to be at a high enough level to reach smokers a sufficient number of times and of sufficient duration. The Centers for Disease Control and Prevention (CDC) in the US estimate that The States need to spend between \$1 and \$3 per capita per year over a sufficient period of time (e.g., 3 years) to be fully effective.¹⁶

Levy, Gitchell and Chaloupka¹⁷ summarised the effects of tobacco control policies in the following way:

POLICY	EFFECT ON PREVALENCE RATES	STRENGTH OF EVIDENCE	SUBGROUPS AFFECTED	ISSUES IN IMPLEMENTATION
Taxes / Price	25% price increase yields a 7%-13% decrease with effects increasing over time.	Strong, according to relatively consistent evidence from many studies and many different	Greater effects on youth and low-income smokers.	The effects will depend on the size of the tax hike and initial price. Generates government funds that may be earmarked for other tobacco

¹⁵ Farelly M, Pechacek T, Chaloupka F, The impact of tobacco control program expenditures on aggregate cigarette sales: 191-2000, Journal of health economics, 2003, 22:843-859

¹⁶ Centers for Disease Control and Prevention, Best practices of comprehensive tobacco control programs, Atlanta, 1999.

¹⁷ Levy D, J Gitchell J, Chaloupka F, The effects of tobacco control policies on smoking rates: A tobacco control scorecard. PIRE Working Paper, Calverton, MD,2003

POLICY	EFFECT ON PREVALENCE RATES	STRENGTH OF EVIDENCE	SUBGROUPS AFFECTED	ISSUES IN IMPLEMENTATION
		nations.		control programs. Likely to be strongly opposed by tobacco industry, some smuggling may result from large tax increases.
Clean Air Law	5-10% decrease for workplace ban, 2-4% for ban in restaurants and other public places.	Moderate to strong. Many studies exist for high-income nations that generally find effects, but effect sizes vary.	Larger effects on high income, male and ages 24- 54, but depends on private restrictions in place.	Relatively low cost, but bans must be strict and may require publicity and government enforcement in areas without norms against smoking in public. Second-hand smoke issues may be used to mobilise political support for other programs. Likely to be opposed by the tobacco industry and some businesses.

POLICY	EFFECT ON PREVALENCE RATES	STRENGTH OF EVIDENCE	SUBGROUPS AFFECTED	ISSUES IN IMPLEMENTATION
Advertising Restrictions	6% decrease for comprehensive ban.	Moderate-weak. Studies have obtained mixed results.	Youth are found to recall ads, which are associated with more pro-smoking attitudes.	Relatively low cost, but bans must be comprehensive to avoid circumvention. Political concerns may be used to mobilize political support for other programs. Likely to be opposed by the tobacco industry and possibly other businesses.
Warning Labels	Indeterminate effects.	Weak. Mixed results and few studies in recent years.	May be most effective in low income countries.	Requires large graphic warnings. May be supplemented with government information campaigns, especially in low-income countries with growing smoking prevalence.

POLICY	EFFECT ON PREVALENCE RATES	STRENGTH OF EVIDENCE	SUBGROUPS AFFECTED	ISSUES IN IMPLEMENTATION
Media Campaigns	5-10% decrease in smoking rates.	Moderate, most studies obtain significant results but effect sizes vary and may depend on other policies in effect.	Unclear, but may have smaller effects on youth. May depend on whether campaigns are tailored to particular groups.	Expenditures must be sufficient in both scale and duration and content should be tested for recall. Most effective when combined with other policies. A relatively inexpensive way to reach many people in areas with good media reach. May be challenged by tobacco interests.
Mandating or Subsidising cessation treatment	1-2% reduction after 2 years depending on coverage breadth.	Low, especially regarding the long-term effects.	Low income and possibly youth.	Effects may depend on the extent of requirements placed on users and the encouragement to health care providers. Depends on health care payers and

POLICY	EFFECT ON PREVALENCE RATES	STRENGTH OF EVIDENCE	SUBGROUPS AFFECTED	ISSUES IN IMPLEMENTATION
				providers support.
Telephone Hotlines	1-3% reduction in first year.	Moderate-low, long-term effects not well known.	Appears to affect most smokers, but may need to be tailored to specific groups.	Most effect when well publicized. May be more effective when coordinated with more extensive programs. Costs likely to be a slight impediment, but likely to face little political opposition.

3. THE SCALE MEASUREMENT OF EFFECTIVE TOBACCO CONTROL POLICIES

While the effective tobacco control measures are known, it remains still unclear as to what weight should be given to each measure. For this reason, the ENSP convened a panel of international researchers and tobacco control experts to come to an agreement on the allocation of points, under the coordination of Luk Joossens. The project involved the gathering and benchmarking of tobacco control data from 28 European countries (25 EU countries and Switzerland, Norway and Iceland), according to these six tobacco control interventions, on a scale of 0 to 100. The panel included a leading American tobacco

control economist and experts from the different regions in Europe. On average the participants had more than 20 years of experience on tobacco control. The panel consisted of Professor Ken Warner, Director, University of Michigan Tobacco Research Network (USA); Professor Albert Hirsch, Vice President of the French League against Cancer (France); Professor Witold Zatonski Director, Division of Epidemiology and Cancer Prevention; Maria Skłodowska-Curie Memorial Cancer Centre, (Poland); Paul Nordgren, Public Health Planning Manager, National Board of Health & welfare (Sweden); Dr. Ann Mc Neill, Honorary Senior Lecturer, University College London (UK); Fiona Godfrey, Consultant to the European Respiratory Society (Luxembourg); Dr. Joan Ramon Villalbi, President of the Spanish national committee of smoking prevention –CNPT- (Spain); Tibor Szilagyi, CEO Health 21 Foundation (Hungary); Marc Willemsen, Research Manager of the foundation on Smoking or Health –Stivoro- (Netherlands); and, Luk Joossens Tobacco Control Manager, Belgian Cancer Federation (Belgium). This panel exchanged emails during the period January-April 2004 and met during the ENSP Network meeting in Krakow on 5 May 2004. They agreed on the following allocation of points.

Please note that this classification should be used only with caveats and cautionary comments. While there was agreement that prices and smoke free places should receive the most points, it was more difficult to decide the exact weight that should be attributed to an advertising ban or a ban in a specific medium. There is still some subjectivity with the allocation of the points. In addition, the reliability

and the comparability of the data may be questioned: how to define the enforcement of smoking restrictions, or to measure the extent of smoking cessation support networks? All experts on the panel agreed that the elaboration of the tobacco control scale is a worthwhile exercise, but that it is by no means a perfect scale. While a perfect scale is still out of reach the panel members felt that a clearly defined and simple to understand scale is nevertheless useful in the meantime. The rating system measures the comprehensiveness of different tobacco control policies, but the impact of each such policy can be different in the short and long term. Claude Vilain, WHO regional office for Europe, highlighted that the scale is lacking in dynamics. For example, when a tobacco control measure has been implemented and enforced it may have produced an immediate impact that can be reflected by a specific weight in an aggregate system. But after the impact has been achieved, the measure loses its effectiveness and therefore its weight should be adapted. Only regular price increases present an exception to this.¹⁸

GRAPHIC 1: TOBACCO CONTROL SCALE OF EFFECTIVE POLICIES (MAXIMUM = 100 POINTS)
<i>PRICE OF CIGARETTES: 30 POINTS</i>
10 points based on the price of Marlboro on January 2004, taking into account the Purchasing Power Standards (PPS) which are obtained by major price surveys covering a basket of goods and services which are

¹⁸ Claude Villain, WHO regional office for Europe, personal communication 29 June 2004.

both comparable and representative for the countries included in the comparison. The country with the highest price ratio (UK) will receive 10 points.

10 points based on the price of a pack of cigarettes on July 2003 taking into account the PPS. The country with the highest price ratio (UK) will receive 10 points.

10 points based on the increase in the real price of cigarettes for the period 1996-2003. The country with the highest increase during the period 1996-2003 (Cyprus) will receive 10 points.

SMOKE FREE PLACES (WORKPLACE, CAFÉS/RESTAURANTS/HOTELS, OTHER PUBLIC PLACES AND PUBLIC TRANSPORT) ON 1 JANUARY 2004: 22 POINTS

Workplace (excluding cafés, restaurants and hotels) complete ban without smoking rooms and enforced: 10 points

Workplace (excluding cafés, restaurants and hotels) complete ban with smoking rooms and enforced: 8 points

Workplace (excluding cafés, restaurants and hotels) meaningful restriction and enforced: 4 points

Unenforced legislation will receive 2 points

Cafés, restaurants and hotels: complete ban and enforced: 8 points

Cafés, restaurants and hotels: meaningful restriction and enforced: 4 points

Unenforced legislation will receive 2 points

Other public places and transportation would receive 4 points

Tobacco control funding in 2003: 15 points

The tobacco control spending in 2003 will be correlated with the Gross Domestic Product of that country in 2003. For example, it is logical that Norway can spend more than the Baltic countries. The country with the highest tobacco control spending ratio (Tobacco Control budget in 2003 in relation to GDP) – Iceland – will receive 15 points.

Advertising: 13 points

3 points are allocated for a complete ban on television advertising (which is the media which is mostly used in countries with no advertising restrictions)

2 points for outdoor advertising (which is mostly prominent when television advertising is banned)

2 points for print media (which is important for its indirect effects on the printed press)

2 points for indirect advertising (which is the industry favored loophole for ad. restrictions)

1 point for points of sale, cinema, and sponsorship.

Half a point for internet and radio.

Cessation: 10 points

Quit line: 2 points

Network of smoking cessation support:

A developed network: 3 points

A network: 2 points

A limited network: 1 point Reimbursement of smoking cessation: 3 points Reimbursement of pharmaceutical treatment products: 2 points
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<i>Labeling: 10 points</i>

Rotating warnings: 2 points Size of warning: 10 % or less of the package: 1 point 11 to 25%: 2 points 26 to 40%: 3 points 40% or more: 4 points Appropriate colours (such as black on white): 1 point A picture: 3 points
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Data were collected through correspondents in the 28 countries (see the list in annexe 4) and reflected the situation of tobacco control in these countries on 1 January 2004. The allocation of points was done by the author of this study. There were no interpretation problems for the allocation of points in the price and labelling categories. In order to avoid subjectivity in the allocation of points in the smoke free places, advertising and cessation categories, scores were sent to the experts in the 28 countries for comments. In some cases, the score of a specific country was adjusted when the score system described in graphic 1 was not correctly applied.

The most common problems for the attribution of points were in the following areas:

- **Funding:** the question was “How much money has been allocated by the government (for federal countries the sum of all funding by governments of the different regions) in 2003 to smoking cessation, to mass communication campaigns and to other tobacco control activities?” Some correspondents replied that these figures were not available and could not be communicated. When no figures were communicated, no points were attributed. This comment was more frequent in countries with low tobacco control activities. There was also some confusion whether money spent by local municipalities should be included in the overall budget. It was not our intention to include budgets of municipalities. The next survey should clarify this in a more precise way.
- **Advertising:** based on the replies of the correspondents, it was not always clear whether indirect advertising was totally banned and whether this ban was enforced. The next survey should include examples of indirect advertising (such as Marlboro clothes, Camel boots etcetera) in order to make a better judgement.
- **Smoking in the work place:** there are different types of legislation on smoking in the work place. The next survey should include more precise questions on the exceptions for each type of legislation.
- **Enforcement:** the extent to which legislation has been enforced was not always clear. We relied on the result of surveys or on

the observations of correspondents who are familiar with the situation in their country.

Graphic 2 shows the results of rating countries' tobacco control efforts according to a scale. The components were: price/taxation policy, workplace/public place smoking bans, overall tobacco control budget, advertising ban, labelling/health warning, and tobacco dependence treatment. The maximum potential points score totals 100. Countries are then rated on each component. The last two columns of the table show each country's total score and then the degree of fall in prevalence since 1985, in three categories. The advantage of this measure of prevalence change is that it is intra-country and uses the same methodology to measure prevalence each time. Thus between-country comparisons are not confounded by different methods of measuring prevalence. The countries' tobacco control programmes were rated at 1 January 2004, so this does not show policy over the 20 year period. However since most countries have built up a range of tobacco control policies gradually over many years, policy now reflects policy 20 years ago in the sense that active countries now are likely to be those active in the past and over a long period

It is important to acknowledge that this is not a precise science. It only gives a general impression of a relationship between tobacco control policy and smoking behaviour. Nor is it easy to quantify the relative importance of each policy element in each country and since we cannot do controlled trials on real life interventions, scientific precision will always be difficult within a country. However, if these data are combined with the World Bank analysis described at the beginning of

this section, then we can make an informed judgement on the policy components that influence outcomes in the successful countries.

Denmark, however, illustrates the danger of simplistic conclusions on what worked in a particular country, because it has had a large fall in prevalence and yet not had high cigarette prices, a policy known from scientific analyses to have a powerful and measurable effect on consumption. However, prevalence was very high in Denmark 20 years ago and so there was room for a large prevalence fall. There is evidence from the UK that as prevalence falls, average consumption rises. This is what would be expected if smokers who stop in response to health education and public information campaigns were lighter smokers originally. Eventually, when prevalence is low enough, we can expect that all smokers who can stop unaided will have done so. Then those still smoking will be addicted and need help. Thus it will be much easier for a country like Denmark to go from a smoking prevalence of 50% to 30%, a 20% reduction, than for the UK to go from 35% to 15%. The data show this. The UK has had a sustained and quite vigorous anti-tobacco campaign since at least the early 1980s, which has included taxation/price increases and relatively (compared to the rest of the EU, not to California or Massachusetts) generous government funding, two components which are much weaker in Denmark.

Graphic 2 shows countries in rank order by their total tobacco control score.

Graphic 2: Tobacco control policy components in place on 1 January 2004 and prevalence change from 1985 to 2003 in Europe: countries ranked by total tobacco control scores

Country	Price (30)	Public & workplace smoking ban (22)	TC budget (15)	Advertising ban (13)	Labelling/health warning (10)	Cessation treatment (10)	Total (100)	Decrease in prevalence
Iceland	24	16	15	13	6	2	76	XXX
UK	26	3-6	14	11	6	10	72	XX
Norway	23	16	6	12,5	6	3	67	XXX
Ireland	20	15	4	10-11	6	6-7	62	XX
Malta	23	12	0	9,5	7	6	58	
Sweden	15	15	3	11-12	6	3-5	55	XXX
NL	12	12	7	11,5	6	5	54	XX
France	20	6-7	4	11,5	6	5-6	54	XX
Finland	13	16	2	12,5	7	2	53	
Poland	13	15	0	11,5-12	5	7	52	XX
Hungary	14	7-11	1	10	6	9	49	
Estonia	16	16	2	9,5	1	2	47	
Slovenia	12	15	0	8-10	6	4-5	47	XXX
Cyprus	23	3-4	0	11-12	3	3	44	
Slovakia	14	10-12	0	11	3	4	43	
Denmark	13	2	3	10	6	6-7	41	XXX
Italy	11	7	2	10,5	6	4-5	41	X
Greece	15	7	-	4-5	6	7	40	
Belgium	13	6	0	10	7	1-2	38	XX
Portugal	13	6-7	-	9	6	2	37	?
Germany	15	2	0	3-4	6	8	35	
Lithuania	12	4-6	0	11,5	6	0	35	
Switzerland	13	5-7	5	3,5-5	3	4	35	
Spain	14	2	-	3-4	6	6-7	32	X

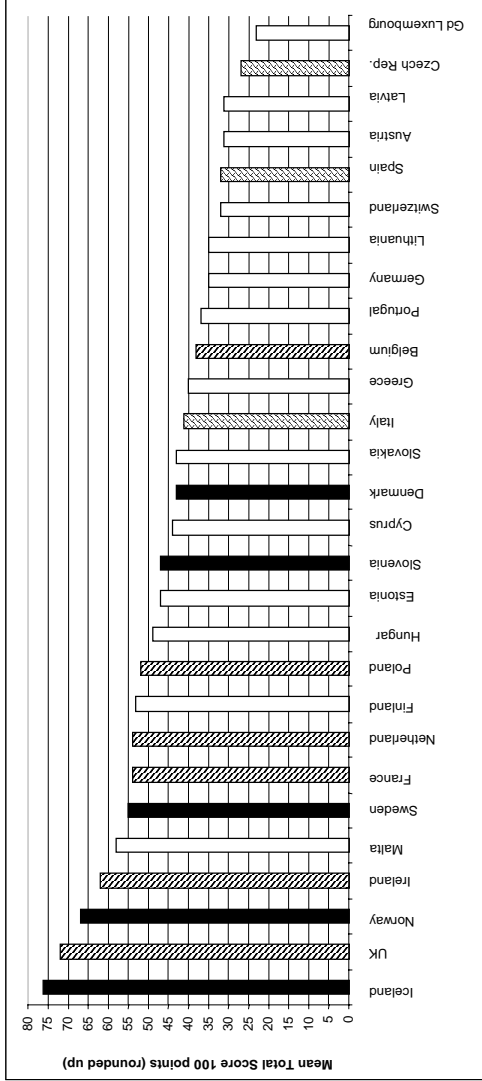
Latvia	11	7	1	6	6	0	31	
Austria	11	7	-	3,5-5	6	3	31	
Czech R.	11	6	1	4-5	2	2	27	X
Luxembourg	7	4	-	6,5	3	2	23	

Notes: the last two columns show the maximum points achievable out of 100 and the decrease in prevalence. **X** = a decrease in prevalence of more than 15% from 1985-2003, **XX** = decrease of more than 20%; **XXX** = decrease of more than 25%; **?** = used different prevalence measures during the period so do not know prevalence change. In order to make the table easier to read we have rounded halves up in the total score column, but left the scores for the individual components unaltered so that readers can see the actual totals.

Graphic 3

Countries ranked by 'Effective tobacco control policy' scores (out of 100)

NB. Data of 1 January 2004.



Decrease in prevalence during period 1985-2003 of : ■ more than 25% ▨ more than 20% ▩ more than 15% □ Less than 15%

Graphic 4: Smoking prevalence in Europe from 1985 to 2003

Country	Male adult smoking 1985	Male adult smoking 1995	Male adult smoking 2002-2003	% + or -	Female adult smoking 1985	Female adult Smoking 1995	Female adult smoking 2002-2003	% + or -	Remarks
Austria	40%	36% (1997)	32% (2000)	-20%	21%	23% (1997)	26% (2000)	+24 %	All smoker, 16+, statistik Austria, N=60000
Belgium	45%	33%	33% (2003)	-27%	27%	19%	22% (2003)	-19%	Daily smoker, 18+, N=2000, 1985-1995 CRIOC, 2003 Flemish Institute for health promotion
Cyprus	43% (1989)		39% (1997)	-9%	7% (89)		8% (1997)	+14 %	Daily smoker, 15y+, Cyprus household survey
Czech Rep	46%	39%	38%	-17%	26%	23%	23%	-12%	All smokers, 15y+, Institute of health information and statistics of the Czech Republic.
Denmark	51%	38% (1994-96)	30% (2003)	-41%	42%	34% (1984-86)	24% (2003)	-43%	Daily smoker, 15y+, N=3000, PLS Ramboll, 2003 survey 13+
Estonia	46% (90)	50% (1994-96)	45%	-2%	15% (1990)	23% (1994-95)	18%	+16 %	Daily smoker, 16-84y, N=2000
Finland	32%	29%	26%	-19%	14%	19%	19% (2003)	+36 %	Daily smoker, 15-64y, N=5000, KTL

France	50% (84-86)	42%	36%	-28%	32% (84-86)	31%	25%	-22%	All smoker, 15-75y, N=2000-3000, INPES
Germany	42% (only West Germany)	43%	39% (2000)	-7%	27% (only West Germany)	43%	30% (2000)	+11%	All smoker, 25-69y, N=8000, national health service.
Greece	54%	51% (1993)	51% (2001)	-5%	20%	31% (93)	39% (2001)	+95%	All smoker, 18-65y, different sample sizes
Hungary	49% (1986)	44% (1994)	42% (2003)	-14%	22% (86)	27% (1994)	29% (2003)	+24%	All smokers, 15y+94, 2003 : 18y+ National health behaviour survey, N=7000
Iceland	43%	29%	27% (2003)	-37%	37%	29%	21% (2003)	-43%	Daily smoker, 18-69y, N=1160-70.
Ireland	37%	29% (1993)	28%	-24%	32% (1993)	28%	26%	-19%	1985-1993: Regular cigarette smoker 15y+, N= 6539, Market research bureau. 2002: regular cigarette smoker, 18y+, N= 5992, SLAN
Italy	41% (1986)	34%	31% (2001)	-24%	17% (1986)	17%	17% (2001)	-	Regular smoker, 14y+ , N= 20000 families, Istat.
Latvia		51% (1998)	51%	-		19%	19%	-	Daily smoker, 15y-64y, Finbalt
Lithuania		43% (1994)	44%	+2%		6%	12%	+100%	Daily smoker, 20-64y, Finbalt.
Luxembourg	41% (1987)	32% (1993)	39% (2003)	-5%	25% (1987)	26% (1993)	26% (2003)	+4%	All smokers, 15y+, N= 2600 to 3800, Luxembourg foundation against cancer

Malta		26%	30% (2003)	+15 %		11%	21% (2003)	+91 %	1995: All smoker, 25-54y, census of population, N=324386 2003: daily smoker, 18-64y, N=528, lifestyle survey
Netherlands	46%	40%	33% (2003)	-28%	35%	32%	27% (2003)	-23%	All smoker, 18y+, N=20000, TNS NIPO
Norway	44%	34%	28% (2003)	-36%	32%	32%	26% (2003)	-19%	Daily smoker, 18-74y, N=2400-5000, statistics Norway.
Poland	54% (1996)	47%	39%	-28%	27% (1996)	23%	23%	-15%	All smoker, 15y+, N=1000-1500, Cancer centre Warsaw
Portugal	44% (88)	27%	31% (99)	-29%	14% (88)	8% ? (probably around 15%)	9% ? (99) (probably around 15%)	?	Daily cigarette smoker, 1988 and 1993 CECP 15y+, 1995 and 1999 INS 10y+ based on household survey which may underestimate female smoking
Slovakia	-	43% (1994-96: male and female)	48%	+12 %		43% (1994-96: male and female)	32%	-26%	All smoker, 18y+, N=1334, Markant-market research
Slovenia	42% (1988)	35% (1994)	28% (2001)	-33%	27% (1988)	23% (1994)	20% (2001)	-26%	Regular smoker, 1988, 1994: 18-64y, Slovenian Public opinion survey, 2001, 25-64y, CINDI
Spain	55%	48%	39%	-29%	23%	25%	25%	+8%	Daily cigarette smoker, 16y+,

		(1993)					(1995)			Encuesta nacional de salud
Sweden	30%	22%	16%	-46%	27%		24%	19%	-30%	Daily smoker 16-84y N = 7500, Statistics Sweden
Switzerland	40% (1987)	37% (1992)	36%	-10%	28% (1987)		24% (1992)	26%	-7%	All smoker, 1987: 15y+, N=8000, Swiss Health study, 1992-2002, 15-74y, N=10000, SFA
UK	35%	29% (1984-86)	26%	-26%	31% (1984-86)		27%	24%	-23%	Cigarette smoker, 16y+, 3000 families, General household survey.

Notes: The decrease in prevalence (5th and 9th columns) has been calculated by subtracting the difference between the percentage in the first reported year and the most recent reported year, multiplied by 100 and then divided by the % in the first reported year. For example, in Sweden in males: $(30-16) \times 100/30 = 46\%$. The increase in prevalence has been calculated by subtracting the difference between the percentage in the first reported year and the most recent reported year, multiplied by 100 and then divided by the percentage in the most recent reported year. For example: Malta, women: $(11-21) \times 100/21 = +47\%$. Crioc is the Centre for Research and Information of the Consumer organizations, KTL is the National Public Health Institute, INPES is the National Institute for Health Promotion, ISTAT is the National Institute of Statistics, SLAN is the Survey of Lifestyles Attitudes & Nutrition, CECP is the Centre for Studies of Preventive Cardiology, CINDI is the Countrywide Integrated Non-communicable Disease Intervention, SFA is the Swiss Institute for Alcohol and other drugs.

Graphic 5 shows that smoking prevalence from 1993 to 2002 has fallen in 15 year old girls only in Denmark and Scotland, and in boys only in Austria, Belgium, Finland, Latvia, Scotland, Sweden and Wales. Very poor progress indeed - and a worrying picture.

Graphic 5: Percentage of 15 year olds who smoke at least once a week¹⁹

Country	Girls			Boys		
	1993/94	1997/98	2001/2002	1993/94	1997/98	2001/2002
Austria	31	36	37	29	30	26
Belgium (Flemish)	18	28	23	32	28	23
Belgium (French)	21		24	23		22
Czech Republic	12	18	31	16	22	29
Denmark	24	28	21	14	20	17
England		33	28		25	21
Estonia	6	12	18	22	24	30
Finland	26	29	32	30	25	28

19 Currie C. et al (eds.) 2004. Young People's Health in Context: international report from the HBSC 2001/02 survey. WHO Policy Series: Health policy for children and adolescents Issue 4, WHO Regional Office for Europe, Copenhagen.

Currie C, Hurrelmann K, Settertobulte W, Smith R & Todd J. (eds) (2000) 'Health and health behaviour among young people. WHO Policy Series: Health policy for children and adolescents Issue 1, WHO Regional Office for Europe, Copenhagen.

King A, Wold B, Tudor-Smith C & Harel Y. (1996). The Health of Youth: A cross-national survey. WHO Regional Publications, European Series No. 69.

France	25	31	27	23	28	26
Germany	29	33	34	21	28	32
Greece		19	14		18	14
Hungary	19	28	26	25	36	28
Ireland		25	21		25	20
Italy			25			22
Latvia	14	19	21	33	37	29
Lithuania	4	10	18	15	24	35
Malta			17			17
Netherlands			24			23
Northern Ireland	25	28		23	20	
Norway	21	28	27	20	23	20
Poland	13	20	17	23	27	26
Portugal		14	26		19	18
Scotland	26	28	23	21	22	16
Slovakia	5	18		19	28	
Slovenia			30			30
Spain	27		32	20		24
Switzerland	18	25	24	17	25	25
Sweden	19	24	19	15	18	11
Wales	27	29	27	18	22	16

Source: Health Behaviour in School-aged Children (HBSC) study

4. CONCLUSIONS

Levy, Chaloupka and Gitchell described recently the effects of tobacco control policies on smoking rates and developed a tobacco control scorecard. According to these authors, a large increase in cigarette taxes and the passage of comprehensive clean air laws are the cornerstone of strategies that have been successful in reducing smoking rates. Each has the potential to reduce smoking prevalence by 10% or more.²⁰ The aim of this report was to give an overview of effective tobacco control policies and to quantify the tobacco control efforts of European countries according to a scale. For this purpose, ENSP convened a panel of international researchers and tobacco control experts to come to an agreement on the allocation of points of proven effective tobacco control policies.

The components of a comprehensive tobacco control programme were:

- Price/taxation policy (30 points)
- Workplace/public place smoking bans (22 points),
- Overall tobacco control budget (15 points),
- Advertising ban (13 points),
- Labelling/health warning (10 points), and
- Tobacco dependence treatment (10 points).

The maximum potential points score totals 100. Countries are then rated on each component. The countries' tobacco control programmes were rated at 1 January 2004, so this does not show policy over a 20-

²⁰ Falk J, Danish National Board of Health, personal communication, 31-8-2004

year period. However since most countries have built up a range of tobacco control policies gradually over many years, policy now reflects policy 20 years ago in the sense that active countries now are likely to be those active in the past and over a long period. It is important to acknowledge that this is not a precise science and therefore only gives a general impression of a relationship between tobacco control policy and smoking behaviour. Preliminary results of the report were presented at four conferences: The Open Forum - Health in the enlarged Europe (Brussels, 17 May 2004); the press conference of the Belgian Coalition Against Tobacco (27 May 2004, Brussels); the EU Presidency conference "The Future of Tobacco Control in Europe" (Limerick – Ireland, 18 June 2004); and the 6th Annual Conference of the Society for Research on Nicotine and Tobacco (SNRT) Europe (Tübingen, 9 October 2004). The presentation of the preliminary results attracted a lot of interest among the media, decision makers and non-governmental organisations. In a debate in the Belgian parliament, for instance, the point was made that Belgium was only nineteenth out of twenty-eight countries and that the country could do better for funding, prices and smoking cessation. The wish was expressed that Belgium should gain points (from 38 now to 55-60) in order to be in the top group of countries in Europe.²¹ Denmark was doing slightly better than Belgium (41 points), but was weak on smoke free places (only 2 points out of 22). The attention of the Danish Parliament was drawn to this weakness.²² But even the three leading countries (Iceland, UK and Norway) can analyse the weak spots of

²¹ Burgeon C, Chambre 2e session de la 51 E législature, CRIV 51, 10-6-2004, p.7

²² Falk J, Danish National Board of Health, personal communication, 31-8-2004

their tobacco control policies and improve their scores. Iceland and Norway can do better on cessation and the UK on smoke free places. Taking into account the necessary caveats and cautionary comments, the score system can play a positive role in improving tobacco strategy in European countries.

5. RECOMMENDATIONS

For the near future, we would like to make the following five recommendations:

- More money should be spent on the evaluation of tobacco control policies in Europe.
- There is a need for more standardisation and harmonisation of smoking prevalence and tobacco use data in Europe, in order to make comparisons of the effectiveness of tobacco control policies between countries.
- Tobacco control programmes should be comprehensive and at least include the following components: price increases through higher taxation; comprehensive advertising and promotion bans of all tobacco products; bans/restrictions on smoking in work places; better consumer information, including counter advertising (public information campaigns), media coverage, and publicising research findings; large, direct health warning labels on cigarette boxes and other tobacco products; treatment to help dependent smokers stop, including increased access to medications.

- There is an urgent need for more investment in tobacco control programmes. In the European Union, only the UK spent more than €1 per capita on tobacco control, while the Centers for Disease Control and Prevention (CDC) in the US estimates that states need to spend between \$1 and \$3 per capita per year over a sufficient period of time (e.g., 3 years) to be fully effective.
- The purpose of the score system is not to praise or condemn national tobacco control policies, but rather to encourage those in charge of the policy to look at the scores of their country, analyse their tobacco control policy and make proposals to improve the weaker components.

It is the intention of the European Network of Smoking Prevention to monitor this research in 2005 and to analyse the progress which has been made between 1 January 2004 and 1 January 2005 in the 28 countries.

6. ANNEXES

Annex 1 Survey results in the 28 European Countries

Country	Local currency	Exchange rate Euro	Price Big Mac Local currency	Price Big Mac Euro	PPS per capita	Tobacco control budget Local currency	Tobacco control budget Euro	GDP Per capita	Tobacco control budget in relation to GDP
Belgium	euro	1.0	3.20 euro	3.20	25850	230 000 euro	230 000	24508	906.23
Denmark	DKK	7.4452	27.75 DKK	3.73	27330	21 500 000 DKK	2 888 000	33037	16236
Germany	euro	1.0	2.60 euro	2.60	24060	1 000 000 euro	1 000 000	25123	482
Greece	euro	1.0	2.30	2.30	17820	/	/	11892	
Spain	euro	1.0	2.80 euro	2.80	21200	/	/	16058	

France	euro	1.0	3.45 euro	3.45 euro	25120	29 988 306	29 988 306	24747	
Ireland	euro	1.0	3.00 euro	3.00 euro	29600	2 000 000	2 000 000	28968	17436.80
Italy	euro	1.0	2.80 euro	2.80 euro	23890	11 355 969	11 355 969	21379	
Luxembourg	euro	1.0	3.29 euro	3.29 euro	45270	/	/	49078	
Netherlands	euro	1.0	2.75 euro	2.75 euro	26570	15 000 000	15 000 000	26501	34954
Austria	euro	1.0	2.65 euro	2.65 euro	26910	/	/	26373	
Portugal	euro	1.0	2.50 euro	2.50 euro	16830	/	/	11792	
Finland	euro	1.0	4.00 euro	4.00 euro	24530	1 262 000	1 262 000	26022	9313.65
Sweden	SEK	9.05	30 SEK	3:31 SEK	25340	30 000 000	3 314 917	27388	13535.80
United Kingdom	GBP	0.70545	£1.88	2.66	26370	£75 000 000	106 315 118	27053	66509.30

Czech Republic	CZK	32.398	59 CZK	1.82	15210	/	/	6683	
Estonia	EEK	15.6466	30 EEK	1.92	10230	700 000 EEK	44 738	4614	7101.27
Cyprus	CYP	0.58637	€1.30	2.22	18930	€13 745	23 441	12677	2298.14
Latvia	LVL	0.6715	1.09 LVL	1.62	8890	15 000 LVL	22 338	3685	2597.44
Lithuania	LTL	3.4525	6.00 LTL	1.74	10050	60 000 LTL	17 379	3829	1306.69
Hungary	HUF	261.93	520 HUF	1.99	13400	42 500 000 HUF	162 257	5701	2802.37
Malta	MTL	0.4316	1.25 MTL	2.90	16800	27 821 MTL	64 460	10955	14990.70
Poland	PLN	4.7029	5.99 PLN	1.27	10400	500 000 PLN	106 317	5420	513.36
Slovenia	SIT	236.85	480 SIT	2.03	16920	9 000 300 SIT	38 000	10900	1751.15
Slovakia	SKK	41.145	69 SKK	1.68	11900	658 320 SKK	16 000	4336	686.70
Iceland	ISK	89.36	439	4.91	26120	55 000 000	615 488	29498	72410.35

Annex 2: Purchasing Power Standards (PPS)

Country	Population 1000s 1-1-2003	GDP millions € 2003	Tobacco control budget € 2003	TC budget in relation to GDP	PPS ²³ millions € 2003	PPS per capita 2003	Price Marl- boro € Jan. 2004	Marl- boro to PPS Per capita
Belgium	10 356	253 800	230 000	906	267 931	25 850	3.85	14.89
Denmark	5 384	177 872	2 888 000	16 236	147 326	27 330	4.03	14.75
Germany	82 542	2 073 700	1 000 000	482	1 985 097	24 060	3.37	14.01
Greece	11 018	131 026	N.A.	N.A.	195 486	17 820	2.70	15.15
Spain	40 683	653 289	N.A.	N.A.	865 019	21 200	2.50	11.79
France	59 626	1 475 584	2 988 306	20 323	1 544 225	25 120	5.00	19.90
Ireland	3 961	114 743	2 000 000	17 430	117 104	29 600	6.15	20.78
Italy	57 072	1 220 147	11 355 969	9 307	1 388 502	23 890	3.30	13.81

²³ Purchasing power standards (PPS) are obtained by major price surveys covering a basket of goods and services which are both comparable and representatives for the countries included in the comparison.

Lux	448	21 987	N.A.	N.A.	20 402	45 270	2.90	6.41
NL	16 193	429 127	15 000 000	34 954	431 572	26 570	3.30	12.42
Austria	8 058	212 511	N.A.	N.A.	217 109	26 910	3.40	12.63
Portugal	10 414	122 801	N.A.	N.A.	175 749	16 830	2.35	13.96
Finland	5 206	135 468	1 262 000	9 316	127 748	24 530	4.00	16.30
Sweden	8 941	244 880	3 314 917	13 537	227 035	25 340	4.25	16.77
UK	59 086	1 598 454	106 315 118	66 511	1 565 533	26 370	6.60	25.03
Czech R.	10 203	68 189	231 500	3 395	155 333	15 210	1.64	10.78
Estonia	1 356	6 257	44 738	7 150	13 845	10 230	1.53	14.96
Cyprus	805	10 205	23 441	2 297	13 527	18 930	3.85	20.37
Latvia	2 332	8 593	22 338	2 600	20 717	8 890	1.04	11.69
Lithuania	3 463	13 259	17 379	1 311	34 796	10 050	1.30	12.94
Hungary	10 152	57 873	162 257	2 804	135 610	13 400	2.14	15.97
Malta	397	4 349	64 460	1 482	6 685	16 800	3.36	20
Poland	38 214	207 126	106 317	513	397 417	10 400	1.30	12.5
Slovenia	1 995	21 746	38 000	1 747	33 757	16 920	2.07	12.23
Slovakia	5 379	23 322	16 000	686	64 013	11 900	1.58	13.17
Iceland	289	8 525	615 488	72 198	7 601	26 120	5.76	22.05

Liechtenstein	34	/			/		/	
Norway	4 552	189 677	5 242 152	150 151	33 150	7.64	23.05	
Switzerland	7 321	279 911	6 404 099	206 574	28 170	3.33	11.82	

Annex 3: Tobacco Price Index / Tobacco Control Budget per Capita

Country	Tobacco price index 2003 (1996=100)	Consumer price index 2003 (1996=100)	Real price increase tobacco products Period 1996-2003	Retail price cigarettes Most Popular Price Category (MPPC) July 2003 in €	Price MPPC July 2003 In relation To PPS ²⁴ Per capita	Tobacco control budget per capita In €
Belgium	132,8	112,1	18,4	3,36	13,0	0,02
Denmark	112,8	115,7	-2,5	4,51	16,50	1,12
Germany	132,4	108,2	22,4	3,37	14,0	0,04
Greece	149,9	123,8	21,1	2,65	14,87	-
Spain	157,1	119,7	31,2	1,95	9,20	-
France	158,2	109,8	44,1	3,90	15,53	0,50
Ireland	160,1	124,6	28,5	5,81	19,63	0,50
Italy	128,0	116,8	9,6	2,50	10,46	0,20
Luxembourg	135,0	113,4	19,0	2,48	5,48	-
Netherlands	139,2	120,3	15,7	3,04	11,44	0,87
Austria	126,3	109,8	15,0	3,00	11,15	-
Portugal	142,7	121,9	17,1	2,10	12,48	-
Finland	115,1	113,5	1,4	4,00	16,30	0,24

²⁴ Purchasing power standards (PPS) are obtained by major price surveys covering a basket of goods and services which are both comparable and representatives for the countries included in the comparison.

Sweden	131,1	111,6	17,4	4,11	16,22	0,37
United Kingdom	158,8	108,2	46,8	6,64	25,18	1,80
Czech Republic	N.A.	N.A.	N.A.	1,27	8,34	
Estonia	175,9	129,4	36	1,21	11,83	0,03
Cyprus	214,1	120,9	77	2,26	11,94	0,03
Latvia	145	127	14,2	0,81	9,11	0,01
Lithuania	N.A.	N.A.	N.A.	0,71	7,06	0,005
Hungary	296,5	243,0	22	1,55	11,57	0,02
Malta	197,12	122	61,6	2,99	17,80	0,16
Poland	208,5	162,9	28	1,16	11,16	0,003
Slovenia	N.A.	N.A.	N.A.	1,47	8,69	0,02
Slovakia	236	166,7	41,6	1,23	10,34	0,003
Iceland	184,7	124,1	48,9	5,75	22,01	2,13
Norway	164,4	115,5	42,3	7,21	21,75	1,15
Switzerland	125,6	105,2	19,4	3,14	11,15	0,88

Annex 4 : National correspondents of the ENSP project on effective tobacco control policies in 28 European countries

Country	Name	Organisation
Austria	Manfred Neuberger	University of Vienna
Belgium	Luk Joossens	Belgian Federation against Cancer
Cyprus	Stelios Sycallides	Cyprus National Coalition for the Prevention of Smoking
Czech Rep	Katerina Langrova, Eva	Czech Coalition against Tobacco,

	Kralikova	Charles University of Prague
Denmark	Niels Thiem Kjaer	Danish Cancer Society
Estonia	Andrus Lipand	Ministry of Social Affairs of Estonia
Finland	Mervi Hara	Suomen ASH
France	Bertrand Dautzenberg	Office Français du prévention du tabagisme (OFT)
Germany	Martina Poetschke Langer	German Cancer Research Centre
Greece	Maria Pilali, Evangelos Polychronopoulos, Nicolas Kordiolas	Hellenic Cancer Society, Hellenic Cancer Society, St Savvas Cancer Hospital
Hungary	Tibor Szilagyi	Health 21 Hungarian Foundation
Iceland	Vidar Jensson	Tobacco Control Task Force of Iceland
Ireland	Valerie Cogan	ASH Ireland
Italy	Elizabeth Tamang	Centro Regionale di Referimento per la Prevenzione (CRP), Regione del Veneto
Latvia	Janis Caunitis	Health Promotion Centre
Lithuania	Aurelijus Veryga	Kaunas University of Medicine
Luxembourg	J. de la Gardelle	Fondation Luxembourgeoise contre le Cancer
Malta	Elaine Caruana	Health Promotion Department
Netherlands	Marc Willemsen	Foundation on Smoking or Health (Stivoro)
Norway	Siri Naesheim, Rita Lindbak	Directorate for Health and Social Affairs
Poland	Witold Zatonski	Cancer Centre and Institute of Oncology
Portugal	Luis Reis Lopez	Portuguese Smoking Prevention

		Council
Slovakia	Blazej Slaby	Stop smoking NGO
Slovenia	Tomaz Caks	University of Ljubljana
Spain	Joan Ramon Villalbi	National Committee for Smoking Prevention (CNPT)
Sweden	Margaretha Haglund	National Institute of Public Health
Switzerland	Verena El Fehri	Association Suisse pour la Prévention du Tabagisme
UK	Ben Youdan	No Smoking Day

Annex 5. Questionnaire of the measurement of efficient tobacco control policies in Europe

Prices and taxes

What is the price of a pack of Marlboro (20 cigarettes) on the 1 January 2004 in the local currency?

Amount :

Currency:

What is the price of a Big Mac (McDonalds hamburger) on the 1 January 2004 in the local currency? ²⁵

Amount :

Currency :

²⁵ The price of the Big Mac has been used as an indicator of Purchasing Power comparisons between countries see <http://tc.bmjournals.com/cgi/reprint/11/1/35.pdf>

Advertising

Is tobacco advertising on 1 January 2004 allowed, restricted or banned?

	Allowed	Restricted, but not enforced	Restricted and enforced	Banned, but not enforced	Banned and enforced
Television					
Radio					
Cinema					
Outdoor					
Print media					
Point-of-sales					
Sponsorship of national events					
Sponsorship of international events					
Internet					
Indirect advertising ²⁶					

²⁶ Indirect tobacco advertising is advertising which, while not specifically mentioning the tobacco product, tries to circumvent a tobacco advertising ban or restriction by using brand names, trade names, trade marks, emblems or other distinctive features of tobacco products with the aim or the indirect effect of promoting a tobacco product.

If the measure is a restriction, explain for each media the kind of restriction.

Television	
Radio	
Cinema	
Outdoor	
Print media	
Point-of-sales	
Sponsorship of national events	
Sponsorship of international events	
Internet	
Indirect advertising	

If the restriction or the ban is not enforced, explain for each media the manner it has not been enforced.

Television	
Radio	
Cinema	
Outdoor	
Print media	
Point-of-sales	
Sponsorship of national events	
Sponsorship of international events	
Internet	
Indirect advertising	

What is the law which applies to tobacco advertising?

Date of the law:

Date of coming into force:

C. Tobacco control funding

How much money has been allocated by the government (for federal countries the sum of all funding by governments of the different regions) in 2003 to smoking cessation, to mass communication campaigns and to other tobacco control activities?

1. Funding smoking cessation:

2. Funding mass communication campaigns:

3. Funding other tobacco control activities:

Total funding (1+2+3):

Currency:

D. Labelling

What legislation on labelling applies to your country from? 1 January 2004?

1. Are the text or the picture of the warnings rotating?

Yes :

No :

2. Percentage of size of the warnings (including the black border which may surround the warnings) on the front of the pack:

3. Percentage of size of the warnings on the back of the pack:

4. Percentage of size of the warnings on the side of the pack:

5. Use of the colours of the letters of the warnings?

Black on white :

Other colours :

6. Does the warning include a picture?

Yes :

No :

7. Does one of the warnings include the telephone number of a quitline?

Yes:

No:

What is the law which applies to tobacco labelling?

Date of the law:

Date of enforcement:

E Smoke free places

Is smoking allowed, restricted or banned in the following places on 1 January 2004?

	Allowed	Restricted, but not enforced	Restricted and enforced	Banned, but not enforced	Banned and enforced
Cafés/ bars					
restaurants					
Aircraft					
Trains					
Subway					
Public buses					
Health care facilities					
Government buildings					
Educational facilities					
Work place					
Other public places					

If the measure is a restriction or not applicable in certain places (for instance psychiatric hospitals, old peoples homes, prisons or at home), explain for each place what kind of restriction of exemption this is.

Cafés/bars	
Restaurants	
Aircraft	
Trains	
Subway	
Public buses	
Health care facilities	
Government buildings	
Educational facilities	
Work place(excluding cafés/ restaurants)	
Other public places	

If the restriction or the ban is not enforced, explain for each media the manner it has not been enforced.

Cafés/bars	
Restaurants	
Aircraft	
Trains	
Subway	
Public buses	
Health care facilities	
Government buildings	
Educational facilities	
Work place (excluding cafés/ restaurants)	
Other public places	

What is the law which applies to smoking at the work place:

Date of the law:

Date of coming into force:

What is the law which applies to smoking in cafés/restaurants/hotels:

Date of the law:

Date of coming into force:

What is the law which applies to smoking in public transport:

Date of the law:

Date of coming into force:

What is the law which applies to smoking in other public places:

Date of the law:

Date of coming into force:

F. Smoking cessation

1. Does your country on 1 January 2004 have a telephone quit line?

Yes , a reactive quitline (which provides answers or counselling, but does not initiate calls) :

Yes, a proactive quitline (which initiates calls by agreement with the smoker):

No :

2. Is there across the country a network of specialised smoking cessation experts or units offering individual or group support delivered by properly trained professionals?

No network

A limited network

A developed network

A very well developed network

If there is network, describe the smoking cessation network:

3. Is the support provided by the network of specialised smoking cessation

free of charge

partially free of charge

not free of charge

4. Is there reimbursement of effective pharmaceutical treatment aids such as nicotine replacement products and Zyban?

No these products are not for sale

No these products are not reimbursed

Only Partial reimbursement

Yes

If partially reimbursed, explain the kind of reimbursement (for instance only for certain groups of patients, only in specific regions or only a partial financial reimbursement):

Appendix : What is the smoking prevalence in your country among adults (man, woman, total) in the period 1985-2003 ? (if possible 18 years +)

Smoking prevalence in the period 1985-2003			
Year	Man	Women	Total
1985			
1986			
1987			
1988			
1989			
1990			
1990			
1991			
1992			
1993			
1994			
1995			
1996			
1997			
1998			
1999			
2000			
2001			
2002			
2003			

Which is the definition of a smoker used in the survey?

Daily smoker

Regular smoker

Regular/daily and occasional

Cigarette smoker

Smoker of any kind of tobacco product

Source of the survey:

Sample size:

Age group of the sample size

Website where the results can be consulted

Date:

Name:

Organisation: