This is the ninth in a series of articles looking at medical issues in Europe.

Europe and tobacco

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Europe, with the highest per capita consumption levels for manufactured cigarettes of any of the six World Health Organisation regions, faces an immediate and major challenge in meeting WHO targets that a minimum of 80% of the population should be non-smokers and tobacco consumption should be 50% lower by 1995.¹ The European Community's policy has gained momentum, but mainly in relation to specific issues of advertising and labelling. Within some countries there have been some hopeful changes in policy—but there is not yet the commitment to a radical strategy which could alone secure progress towards WHO targets.

There has been some reduction in the number of people smoking since the 1960s, but smoking rates among younger Europeans remain far higher than in the United States. Further growth in mortality from tobacco related disease has slowed down in EC countries, but not enough has been done, apart from the United Kingdom and Ireland, to reduce the likely toll. Policy too is much less broadly based or coherent than might appear from the occasional high points. The EC has seen spasmodic attention from commissioners interspersed with long periods of sub-committee inertia.

Outside the United Kingdom and Scandinavia there is little consistent information about trends in smoking. The late 1980s are much better documented, partly through the commission's own efforts in developing surveys but also because of new research in France. Figures 1 and 2 show the basic data from the EC surveys.²

Smoking rates

Overall smoking rates might seem reassuringly low with the community rate at 36%. This average is brought down, however, by the low rates of smoking among women in southern Europe, rates that are likely to rise over the next 10 years without strong policy

FIG 1—Proportion of smokers in European Community countries, 1989

FIG 2—Proportion of smokers aged 25-39 in European Community countries

initiative. For France the overall rate is affected by the low proportion of smokers among older men, which reflects the record up to the 1950s of relatively light smoking in France.

In many ways smoking rates for the under 40s are a much more telling indication of change and here the position is far less reassuring. The 25-39 age group should show a high demand for health where decisions can affect life expectancy. Smoking rates in Greece and Spain are in line with national stereotypes, but high rates of smoking are also found in northern Europe. Smoking rates for women in this younger age group are now as high or higher than for men. Fifty per cent of women in Spain aged 25-39, 49% in Denmark, and 43% in Italy are smokers, showing high levels of smoking at the age women are most likely to be pregnant. Reductions in smoking within the EC have been concentrated among older men. Smoking would seem to have increased recently among women in most EC countries and may well increase further as incomes rise.

In the United States and the United Kingdom specific groups gave a strong lead towards smoking cessation and more general changes in habit came about through a diffusion process. Doctors stopped smoking and were followed by other middle class groups.³ By the late 1950s smoking had reduced among British doctors. There are few signs of this diffusion process at work across the EC (table). British doctors are unique in their rejection of the habit, with only 10% now smoking. In Spain and Italy higher proportions of

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Percentage of smokers in the European Community

	General medical practitioners	Teachers	Whole population
Belgium	28	17	36
Denmark	38	34	45
West Germany	24	22	34
Greece	39	30	43
Spain	44	34	40
France	31	16	36
Ireland	20	15	34
Italy	41	36	32
Luxembourg	36	17	34
Netherlands	29	24	42
Portugal	39	21	28
United Kingdom	10	12	35
European Community	36	26	36

Source: Commission of the European Communities, 1989.²

doctors smoke than of the population as a whole. Smoking rates among teachers are a more hopeful indication.

New data from France about changes in cigarette consumption over time illustrates the size of the problem.⁴ Tobacco sold in the form of cigarettes rose from 54 000 tons in 1965 to 95 000 tons in 1986, an increase of 76% over a period in which the adult population rose by 19%. Smoking remains high among young people and has risen among younger women.

Costs of smoking

Survey results from the EC as a whole cast some doubt on the stereotype of the heavy smoking, happy go lucky south as against the health conscious north. Smoking is least common in Portugal, and German smokers are least likely to want to give up. Smoking rates in the north are particularly disquieting given the strength of the price disincentives. Forty five per cent of Danes smoke and pay 3.16 ecu for a packet of 20 (1986 prices), while 40% of Spaniards smoke and pay only 0.31 ecu a packet. Prices of cigarettes remained quite low throughout most of the EC. In the late 1980s only three member states had prices above 2 ecu (£1.40) a pack—the United Kingdom, Ireland and Denmark. There were four low price countries—Greece, Spain, France, and Portugal—where the price per pack was £1 or less; Benelux, West Germany, and Italy (all with high real incomes) were in the middle band.

"Atikah Cigarettes" by Katt Both, 1931. Reproduced by courtesy of Galerie Rudolf Kicken, Cologne

Detailed evidence is available from the United States on costs of smoking and gains from abstinence. As a result of the antismoking campaign, the surgeon general estimated 789 000 deaths were postponed during 1964-85, 112 000 in 1985 alone. The average increase in life expectancy was 21 years.⁵ The main forecast for Europe is a very broad one for the whole WHO area. It suggests that deaths from smoking related disease would increase from 0.8m in 1988 to 2m in 2025. Some of the increase is the result of demographic effects and the rising incidence of smoking in Russia and eastern Europe.⁶ Increases within the EC may be less extreme. There was a 25% rise in mortality from lung cancer in France and Germany in the 1980s.⁷ This increase may not be so steep in the 1990s and beyond, but much will depend on policy in the immediate future. There will already be high inescapable costs from past decisions and past increases in smoking—but Europe could take actions that would prevent yet further growth in mortality and cost on into the twenty first century. What are the chances of an effective strategy?

Approaches to a strategy on tobacco

Events over the past few months may have generated a false sense of optimism about the imminence of any such strategy. Much publicity has surrounded the initiative by the social affairs commissioner. As part of the EC's policy of extending the internal market, the commission has proposed a complete ban on advertising, apart from advertising in retail shops. The initial proposal will now be discussed by community health ministers. At present eight members seem to be in favour and four (Germany, Britain, Denmark, and the Netherlands) against. The European Parliament will also give its view on the total ban. Some progress has been made through bans on television advertising. National pressure groups, such as ASH, are clearly gaining more influence.

The commission's original policy moves were on pricing, as part of fiscal harmonisation designed to produce similar rates of taxation across the internal market. This process has been dragging on over 20 years but received some new impetus in the late 1980s as policymakers became more aware of the health issue. Proposals in 1989 set target rates designed to increase taxation on cigarettes in southern Europe. However, such rates would have had perverse effects in reducing prices in the north. The council's new proposals simply set a minimum tax at 57% of the retail price, and a ratio of specific duty to total tax of at least 25%. These conditions are not onerous or even very clear in their implications for pricing, and in effect pricing will be left to the discretion of each national government.

The Europe Against Cancer campaign has led to a number of useful moves and has provided a framework for policy moves on tar yield, labelling, and advertising. Measures on labelling are designed to strengthen warnings and to extend them to products other than cigarettes. The EC is extending the British ban on Bandit, a new kind of smokeless tobacco. The EC has also set standards for reducing smoking in public places.

Local activity

Effective action against smoking will depend on national governments in the 1990s as it is highly unlikely that the EC will be involved in actions which go beyond the symbolic and exemplary. EC actions can set a framework and stimulate local political activity but they do not seem likely to provide incentives powerful enough to bring about radical changes in

smoking behaviour in the short term. Experience in Britain and the United States now gives some guidance on what an effective response might be. Any strategy for reducing smoking over a period as short as five years must make use of price incentives. A rise in the relative price of cigarettes is a powerful and effective means of reducing consumption. Recent simulations have shown that a 14% increase in the real price will lead to a fall in consumption of about 10%.³ A doubling of the federal tax after 1982 was associated with a rapid decline in smoking in the United States and an increase in the state excise tax in California of 25 cents in 1988 led to an immediate decline of 19.4% in cigarette consumption. Reductions in smoking in the United Kingdom in the 1980s were concentrated in years when relative prices rose rapidly.

Authoritative statements about the health consequences of smoking from the government or from medical professions can influence the decision to smoke. The Royal College of Physicians in Britain and the Surgeon General's reports in the United States have influenced smoking behaviour. The Surgeon General has also created new issues, especially with his focus on passive smoking. Other measures, such as labelling, have a more minor impact, and even bans on advertising are less effective than price incentives.

There is some hope of a clearer and stronger strategy in France, where successive governments since 1988 have shown greater concern about the costs of smoking. France has also introduced new measures to restrict advertising and to limit smoking in public places, with accompanying fines. The issue seems, though, to get little attention in Germany, where discussion has tended to focus on the lighter types of policy measure involving peer group influence through sports stars and pop idols. There are now signs that Germany may adopt WHO targets.

Local political activity has increased and there have been some signs of coordination across the community, with European Bureau for Action on Smoking Prevention (BASP) playing a vital role in organising support for the directives. The United Kingdom has backed into a series of actions which have been relatively effective and it is now developing a strategy with possible targets of reducing smoking prevalence by about a third by 2000. The substantial increase in prices in the 1991 budget made a good start towards achieving these targets. Policymakers in the Netherlands are also giving the issue greater attention. Ireland has a good record but is doing more.

The outlook

Reductions in smoking have proved difficult in the EC area, and without strong policy initiatives rising real income would lead to a rise in smoking over the next decade. There are continuing conflicts of interest between agricultural policy and health issues, with community spending on subsidies to tobacco growers (£800m) still vastly greater than spending on the Europe Against Cancer campaign (£50m). The outlook for eastern Europe and Russia is even worse as there may be few competing forms of consumption over the

Main EC initiatives

Europe Against Cancer programme. The action plan covers:

- Cancer prevention
 - Reducing tobacco consumption
 - Research on nutrition and cancer
 - Screening and diagnosis
- Information and health education
- Training of health professions
- Research on cancer

Directive on labelling (1989)—harmonises the content of labelling throughout the EC and provides for stronger health warnings

Proposals for fiscal harmonisation (1989)—now agreed by the Council of Ministers in terms of a minimum tax of 57% of the total price, leaving countries free to make their own pricing decisions

Directives on tar yield (1989)—limits permitted tar yield throughout the EC to 15 mg by the end of 1991 and 12 mg by the end of 1997. Greece has an exemption allowing higher yield till 2007

Measures to reduce smoking in public places with at least 50% of space in cafés and restaurants to be smoke free by 1992

Ban on advertising in EC (1991)

next few years and a 30 year lag in information about smoking. For wider Europe the WHO could strengthen its role. It has already set targets of reducing smoking prevalence by 20% by 1995 and produced a series of reports on a smoke free Europe as part of the Health for All by the Year 2000 programme.¹ The WHO could well be given a larger role. For example, it could produce annual reports on smoking in Europe based on cross national data. This would require special funding from national governments. The WHO would seem to be a better base for this reporting role than the European Commission.

Many countries in Europe face critical choices over the next two years in whether to adopt more active antismoking policies. On these decisions will depend whether the incidence of smoking related disease continues to rise. There could be an increased role for the BMA over this period in mobilising opinion against smoking doctors. A clearer stand by national medical associations could contribute to the more active policy phase. On this issue governments have followed opinion rather than led it.

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