Tobacco Free Ireland

An Roinn Sláinte
DEPARTMENT OF HEALTH

hi
Healthy Ireland

Tobacco Free Ireland

Report of the Tobacco Policy Review Group

Department of Health

October 2013

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Minister's Foreword

Earlier this year I launched *Healthy Ireland*. I indicated that the current health status of people in Ireland, lifestyle trends and inequalities in health outcomes are leading us towards a dangerously unhealthy and unaffordable future.

Smoking is the leading cause of preventable death in Ireland. Each year at least 5,200 people die from diseases caused by tobacco use. This represents almost one in five of all deaths.

Ireland's last tobacco control policy was published in 2000. It is timely after 13 years since the introduction of that policy to now take stock of what we have achieved and to focus on what areas need to be tackled to continue the reduction of our smoking rates.

This is a battle that must be won. If the cigarette companies did not recruit new smokers they would disappear within a generation. Therefore, for the industry to simply maintain the size of its customer base in Ireland, it is estimated that 50 Irish children have to start smoking every single day. We know that half of them will ultimately die from their addiction. No-one, whether smoker or non-smoker, wants their children to smoke.

It is clear from international evidence that the most effective tobacco control strategies involve taking a multi-faceted approach. *Tobacco Free Ireland* contains a suite of measures based on this evidence.

I would like to thank the Tobacco Policy Review Group for their work in developing this report. I am pleased that the target date of 2025 has now been set for Ireland to become tobacco free – less than 5% of the population smoking. This is an ambitious target but I believe *Tobacco Free Ireland* has the advantage of bringing with it a significant amount of support from the public, the Government and health professionals everywhere.

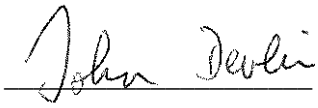
Dr James Reilly T.D.
Minister for Health

Acknowledgements

This new Tobacco Policy comes more than a decade after the publication of the previous national policy *Towards a Tobacco Free Society*. It is a timely successor because of the emerging non-communicable disease burden which is caused by risk factors that can be prevented. Tobacco is well known as a major contributor to ill-health and premature mortality. For the first time, we have set a target date for Ireland to be tobacco free.

I am very grateful to the hard working and enthusiastic Review Group who developed this policy. Work on the policy also benefited greatly from international experience including from a number of institutions and other countries.

Finally sincere thanks to the Health Promotion Unit within the Department who brought this policy to completion.



Dr John Devlin
Deputy Chief Medical Officer
Chairman of the Tobacco Policy Review Group

Membership of the Tobacco Policy Review Group

Dr Tony Holohan	Department of Health (assigned Chair to Dr. John Devlin in Sept. 2010)
Dr John Devlin	Department of Health
John Keegan	Department of Health (until 2012)
Siobhan Mc Evoy	Department of Health
Dilly O'Brien	Department of Health (Robbie Breen until 2011)
Dr Fenton Howell	Health Service Executive
Biddy O'Neill	Health Service Executive
Dave Molloy	Health Service Executive
Gavin Maguire	Health Service Executive (Martin Devine until end 2010)
Martina Blake	Health Service Executive
Marie Killeen	National Tobacco Control Office, HSE
Clare O'Reilly	Department of Health

Executive Summary and Recommendations

Part 1 sets out the background and provides the policy, legislative and smoking prevalence context for the report.

Chapter 1 sets out the background and the terms of reference of the review. It identifies the current Irish and international tobacco policy setting including the WHO's Framework Convention on Tobacco Control (FCTC).

Chapter 2 sets out the health impacts of smoking and of second-hand smoke and the economic costs of smoking including the fact that:

- 1.6 million deaths related to smoking occur every year in the WHO European Region
- 5,200 people die every year from smoking related diseases in Ireland
- Second-hand smoke (SHS) causes 600,000 premature deaths globally every year
- Approximately €500 million of health expenditure in Ireland was directly due to smoking related diseases in 2009.

Chapter 3 sets out data relating to smoking in Ireland for adults and children and compares them with international data. Data taken from the SLÁN Survey 2007 indicated a prevalence rate of 29%. Data taken from the National Tobacco Control Office for 2012 indicates a prevalence rate of 22% in 2012. In the 2010 Health Behaviour in School Children survey 12% of Irish 10 -17 year olds were identified as current smokers. The chapter also highlights the significant smoking trends in younger people especially young women and those in the lower socio-economic groups.

Chapter 4 sets out the progress which has been made to date in the area of tobacco policy and legislation.

Chapter 5 sets out information on the tobacco industry and introduces a recommendation regarding interaction with the industry in the context of Article 5.3 of the WHO FCTC.

RECOMMENDATION

- Take steps to ensure that all government officials, employees of state agencies and members of any government branch (executive, legislative and judiciary) responsible for setting and implementing tobacco control policies and for protecting those policies against tobacco industry interests are aware of their obligations under Article 5.3 of the WHO FCTC and are aware of the Guidelines developed to assist in meeting these obligations.

Part 2 sets out the plan for the future in achieving the goal of a tobacco free Ireland by 2025.

Chapter 6 sets out the policy and rationale for the *Tobacco Free Ireland* report based on the WHO MPOWER model and other additional themes.

Chapter 7 sets out recommendations for the protection of children and denormalisation of tobacco use in Ireland.

RECOMMENDATIONS

- The protection of children must be prioritised in all of the initiatives outlined in the policy.
- Denormalisation must be a complementary underpinning theme for all of the initiatives within the policy.
- Develop and introduce legislation to prohibit smoking within the campuses of primary schools, secondary schools and child care facilities.
- Promote tobacco free campuses for all third-level institutions in consultation with key stakeholders.
- Promote tobacco free campuses for all health care, governmental and sporting facilities in consultation with key stakeholders.
- Further develop the tobacco free playgrounds initiative in conjunction with the local authorities by way of voluntary measures or by the introduction of bye-laws.
- Promote tobacco free environments and in particular parks and beaches in conjunction with the local authorities by voluntary measures or by the introduction of bye-laws.
- Evaluate the tobacco free environment initiatives with a view to the introduction of legislation if required.

Chapter 8 sets out recommendations for building and maintaining compliance with tobacco control legislation and recommendations relating to the future regulation of the tobacco retail environment.

RECOMMENDATIONS

- Continue to actively promote compliance with and enforce all provisions of the Public Health (Tobacco) Act 2002 as amended.
- Introduce fixed penalty notices (on the spot fines) for offences.
- Develop capacity within the HSE's Environmental Health Service to maintain consistent and sustained enforcement of all aspects of the tobacco control legislation.
- Develop special investigation capacity within the HSE's Environmental Health Service to assess compliance by tobacco manufacturers.
- Introduce legislation for the publication of information in respect of any person on whom a fine, other penalty or conviction was imposed by a Court ('name and shame').
- Collaborate with other EU countries in relation to compliance measures for tobacco ingredient reporting.
- Develop a licensing system for retailers who sell tobacco products.
- Prohibit sales of tobacco in mobile units/containers.
- Prohibit the sale of tobacco at events/locations primarily intended for those persons under 18 years.
- Prohibit the sale of tobacco products by those under 18 years.
- Prohibit the operation of all self-service vending machines.
- Introduce a minimum suspension period for retailers convicted of an offence.

Chapter 9 sets out recommendations under the different WHO MPOWER themes i.e

Monitor Tobacco Use and Prevention Policies
Protect People from Tobacco Smoke
Offer Help to Quit Tobacco Use
Warn about the Dangers of Tobacco
Enforce Bans on Tobacco Advertising, Promotion and Sponsorship
Raise Taxes on Tobacco Products

RECOMMENDATIONS

Monitor Tobacco Use and Prevention Policies

- An active research and survey programme on tobacco should be put in place to include areas such as supply and demand, prevention and treatment, exposure to second-hand smoke and industry marketing initiatives.
- This survey programme is to include a single, reliable and regular collation of smoking prevalence rates.
- Tobacco control measures should be continuously evaluated to ascertain impacts and outcomes.

Protect People from Tobacco Smoke

- Develop and introduce legislation prohibiting smoking in cars where children are present, based on international evidence and good practice.
- Undertake a social marketing campaign focusing on the risks to children from exposure to second-hand smoke with particular reference to smoking in cars (and information on future legislation in this regard).
- Monitor the effectiveness of the current smoke free legislation, including the review of existing exemptions and the monitoring of compliance with these provisions.

Offer Help to Quit Tobacco Use

- Identify a lead person with clear lines of responsibility for the co-ordination of smoking cessation services within the health service to ensure a national approach.
- Develop comprehensive national smoking cessation guidelines. These to include the minimum level of service provision that each service provider needs to have in place.
- Undertake targeted approaches for specific groups, particularly young people, lower socio-economic groups, pregnant and post-partum women and patients with cardiac and respiratory disorders.
- Establish a national database for the collection and collation of data from all smoking cessation services.
- Train all frontline healthcare workers to deliver interventions for smoking cessation as part of their routine work.
- Examine evidence (national and international) regarding outcomes of the use of NRT and other approaches.
- Establish a regulatory framework for nicotine products in the context of discussions at EU level.

- Increase investment in mass media quit campaigns.
- Advocate for the removal of VAT from NRT.
- Make NRT more widely available, including in outlets where tobacco products are sold.

Warn about the Dangers of Tobacco

- Increase investment in social marketing campaigns to warn about the dangers of tobacco.
- Enhance educational initiatives aimed at preventing young people from starting to smoke, in line with best international practice within the *Healthy Ireland* framework.
- Monitor the implementation of regulations for pictorial warnings.
- Undertake continued evaluation of campaigns and programmes.

Enforce Bans on Tobacco Advertising, Promotion and Sponsorship

- Continued implementation and monitoring of the national inspection programme is required in order to ensure compliance with all tobacco legislation.
- Review existing legislation to ensure that it is fit for purpose to deal with new and emerging measures and marketing programmes adopted by the tobacco industry.
- Robustly defend the legal challenge by the tobacco industry to the point of sale measures introduced in 2009.
- Develop legislation for the introduction of standardised/plain packaging for tobacco products.
- Work with the EU to ensure successful implementation of the proposed revision of the Tobacco Products Directive.
- Work with media regulators and the entertainment industry around the portrayal of smoking in the media.
- Monitor developments in relation to brand stretching at a global and European level.
- Examine and monitor the existing tobacco legislation to ensure that it is inclusive of contemporary forms of communications.

Raise Taxes on Tobacco Products

- The Departments of Health and Finance and the Office of the Revenue Commissioners are to work in closer collaboration in relation to fiscal matters relating to tobacco and on measures to reduce the illicit trade of tobacco.
- Annual excise duty increases on tobacco products should be applied over a continuous five year period.
- Increase duty on roll-your-own and other tobacco products to reduce the price differential between cigarettes and other tobacco products.
- Remove tobacco from the consumer price index.
- Introduce a tobacco industry levy or similar mechanism which could be ring fenced to fund health promotion and tobacco control initiatives including support to end the illegal trade.
- Consider the introduction of an environmental levy in the context of the Government's waste policy "*A Resource Opportunity*", the application of economic instruments and the review of producer responsibility.
- Continue collaboration with national and international partners on strategies to reduce illicit trade.

Chapter 10 sets out recommendations in relation to National and International Partnerships.

RECOMMENDATIONS

- Government Departments, and state agencies including the Health Service Executive will continue to liaise and work with the non-governmental organisations in order to achieve policy aims set out in this report.
- Continued participation and engagement at EU level in the context of the revised Tobacco Products Directive.
- All Government Departments and state agencies should actively engage with and implement the WHO FCTC, the Protocol to Eliminate the Illicit Trade in Tobacco Products and the FCTC Implementation Guidelines.
- Collaboration with other national and international partners in the area of tobacco control should be continued to further develop the evidence base in support of new initiatives and to evaluate the impact of current measures.
- Collaborate on a North/South basis, in particular through the North South Ministerial Council, on measures to reduce tobacco consumption.
- Support greater national and international collaboration and participation on research programmes to strengthen the evidence base for new measures.

Chapter 11 sets out a target for the development of an action plan for the achievement of a tobacco free Ireland by 2025.

RECOMMENDATION

- Develop an action plan with timelines for the phased implementation of the recommendations in *Tobacco Free Ireland*.

PART 1

Chapter 1

Introduction

PART 1
CHAPTER 1
INTRODUCTION

TOBACCO POLICY REVIEW

The Department of Health initiated a review to identify what further policy proposals could be introduced aimed at reducing the prevalence and initiation of smoking in Ireland. The review was undertaken against a background of a very challenging economic environment.

The tobacco policy should be considered within the new health and wellbeing framework *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025*[1]. This new framework acknowledges that health is the responsibility of all sectors in society and that sustainable arrangements are needed to give effect to this. Health promotion and illness prevention are central to healthier lifestyles, resulting not only in the reduction of chronic diseases but also in the reduction of healthcare costs and the emergence of a healthier workforce, healthier children, positive ageing and greater participation of those with disabilities and mental health issues in society. Most of the disease burden in Ireland is caused by a small number of risk factors such as smoking, alcohol misuse, being overweight, poor diet and physical inactivity. These risk factors are more prevalent in the socially disadvantaged.

The high levels of smoking in Ireland require a more concerted effort to support the continued development of a tobacco free society where people can live longer and healthier lives free from the detrimental effects of tobacco. The direction given in this policy report seeks to de-normalise tobacco within Irish society, reduce initiation rates, assist smokers to quit, protect non-smokers, especially children, from the effects of second-hand smoke, by building on a stable policy and legislative framework. These measures will be achieved within existing resources.

The terms of reference of the review were as follows:

1. To examine Irish and international evidence and experience of effective measures and programmes to reduce smoking prevalence

2. To make policy proposals to the Minister aimed at reducing smoking initiation and prevalence.

THE TOBACCO POLICY REVIEW GROUP (TPRG)

A workshop involving various stakeholder groups was held in 2010 to examine tobacco control measures in Ireland. (The findings of this workshop are available on www.doh.ie and also give details of the workshop attendees.) Subsequent to the workshop, a Tobacco Policy Review Group was established. The Group was tasked with the production of a policy report informed by the discussions at the workshop and supported by international evidence that identifies what further measures might be taken at this time to reduce smoking in Ireland. The membership of the Group is set out on page 6.

IRISH POLICY SETTING

Ireland's public health policy objective in relation to tobacco control is to promote and subsequently move towards a tobacco free society. *Towards a Tobacco Free Society* (TTFS)[2] was adopted as Government

1 Department of Health (2013). *Healthy Ireland – A Framework for Improved Health* and Wellbeing 2013-2015: Dublin: Department of Health.

2 Department of Health and Children (2000). *Towards a Tobacco Free Society, Report of the Tobacco Free Policy Review Group*. Dublin: Department of Health and Children.

policy in 2000 and proposed an integrated strategy for tackling tobacco consumption in Ireland. It continues to be the main strategic document guiding the development and implementation of policy measures and services to reduce smoking in Ireland. That strategy recognised that it would take some time to fully achieve a tobacco free society. However, significant progress has been made in relation to the actions outlined in that document. Successive policy interventions have been instrumental in reducing tobacco consumption in Ireland. They have also impacted positively on health. For example, a recent study[3] has estimated that the workplace smoking ban in 2004 has led to more than 3,500 deaths being avoided due to tobacco consumption. While it is imperative that we continue to build on this 2000 Strategy, it is timely that Ireland now sets a target for achieving a tobacco free society.

It is now proposed that Ireland sets a date of 2025 to be tobacco free.

In Ireland a tobacco free society will mean the achievement of a smoking prevalence rate of less than 5% of the Irish population by 2025. Tobacco will still be available but at a higher price and in restricted outlets.

INTERNATIONAL POLICY SETTING

World Health Organisation

The World Health Organisation Framework Convention on Tobacco Control (WHO FCTC) was developed in response to the globalisation of the tobacco epidemic. Its purpose is to identify and progress the tobacco control measures required to be introduced by national governments in order to protect public health. The FCTC is a legally binding treaty and was ratified by Ireland in 2005.

European Union

The EU has adopted a number of Directives, Decisions and Recommendations relating to tobacco including:

- Directive 2001/37/EC of the European Parliament and of the Council of 5 June 2001 on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products
- 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
- Council Recommendation of 30 November 2009 on smoke free environments

3 Stallings-Smith S, Zeka A, Goodman P, Kabir Z, Clancy L (2013) "Reductions in Cardiovascular, Cerebrovascular, and Respiratory Mortality following the National Irish Smoking Ban: Interrupted Time-Series Analysis." PLoS ONE 8(4): e62063. doi:10.1371/journal.pone.0062063

PART 1

Chapter 2

Impacts of Tobacco Use

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CHAPTER 2
IMPACTS OF TOBACCO USE

The World Health Organisation Framework Convention on Tobacco Control describes the term tobacco control as 'a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke'.

The use of tobacco for many individuals is not a lifestyle choice but a nicotine addiction that has a significant health impact. One in every two smokers will die from a smoking-related disease. Ireland continues to have a high prevalence of smoking.

The burden of tobacco use is carried by individuals, their families, the health system and broader society. Key elements are set out as follows:

HEALTH IMPACTS OF SMOKING

- Smoking is a leading risk factor for premature mortality in the WHO European Region, causing about 1.6 million deaths a year.
- It causes half of all long-term smokers to die prematurely from smoking-related diseases.
- It results in half of all children who start smoking dying prematurely from a smoking-related disease.
- It is a major cause of morbidity, with smokers on average losing at least 10 quality years of life.
- It is expected that by 2030 tobacco smoking will kill 10 million people globally per year, half of whom will be aged between 35 and 69.
- Smoking-related deaths also account for a large proportion of the gender gap in mortality found in European countries (typically 40 to 60%).
- It is a significant factor in the development and maintenance of health inequalities at a population level.
- The World Bank estimates that if the number of adult smokers halved by 2020, there would be 200 million less tobacco-related deaths worldwide by 2050.

Irish Context

- Tobacco use is the leading cause of preventable death in Ireland.
- Each year at least 5,200 people die from diseases caused by tobacco use. This represents approximately 19% of all deaths. The breakdown of the 5,200 deaths is as follows:[4]
    - Cancers (44%)
    - Circulatory diseases (30%)
    - Respiratory disease (25%)
    - Digestive diseases (1%).

4 Howell F R Shelley E (2011). Mortality attributable to tobacco use in Ireland. The Faculty of Public Health Medicine RCPI Winter meeting; Dublin.

- Figures from the WHO tobacco control database[5] (2005) show that the percentage of all mortality attributable to tobacco use in Ireland was 20% for men and 16% for women. This compares to an EU-25 average of 23% for men and 7% for women.

- The Irish Heart Foundation has reported that smoking is the cause of up to 2,500 strokes and 500 stroke-related deaths a year.

SECOND-HAND SMOKE (SHS)

- SHS causes 600,000 premature deaths globally per annum (WHO).

- SHS consists of over 7,000 chemicals, including over 60 known carcinogens.

- Medical and scientific evidence shows that exposure to second-hand smoke increases the risk of serious medical conditions, such as lung cancer, cardiovascular disease, respiratory disease and sudden infant death syndrome.

- A study by the WHO on exposure to second-hand smoke[6] found that two-fifths of children and one-third of adult non-smokers were exposed to second-hand smoke in 2004. They estimated that this exposure contributed to 1% of worldwide mortality in 2004:

  379,000 deaths from ischaemic heart disease
  165,000 from lower respiratory infections
  36,900 from asthma
  21,400 from lung cancer.

ECONOMIC COSTS OF SMOKING

- In Ireland, the average cost per admission of treating a smoker in an in-patient setting for a tobacco-related illness is €7,700.

- An EU study[7] has estimated that Irish health expenditure on smoking-related diseases was approximately €500 million in 2009. That study also estimated that productivity losses and long-term incapacity due to smoking-related diseases cost the Irish state over €160 million in 2009.

- That study estimated that the costs to Ireland of premature mortality due to smoking-related diseases was over €3,500 million* in 2009.

- Revenue from excise duty on tobacco products in that same year (2009) was €1,216.5 million (2012 figure was €1,072 million).

- In the UK, smoking-related diseases have been estimated to cost the NHS £2.7–£5.2 billion a year (€3.1–€6.0 billion)[8].

- A health economic assessment found that for every 1,000 smokers who quit there was an average saving of Aus$373,000 (€277,370) in healthcare costs associated with acute myocardial infarction (MI), stroke, lung cancer, and chronic obstructive pulmonary disease (COPD).

  *This figure is estimated under several studies and utilises the 'value of one life year' (VOLY) estimate of €52,000.

5 http://data.euro.who.int/tobacco/
6 WHO Report on the Global Tobacco Epidemic, 2009: Implementing smoke free environments. Geneva, World Health Organisation, 2009
7 A Study on liability and the health costs of smoking DG Sanco (2008/C6/046) April 2012
8 Allender S, Balakrishnan R, Scarborough P, Webster P & Rayner M (2009). "The burden of smoking related ill health in the UK". Tobacco Control, 18:262/267

PART 1

Chapter 3

Tobacco Consumption in Ireland

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TOBACCO CONSUMPTION IN IRELAND

ADULT POPULATION

SLÁN Survey

According to SLÁN, the Survey of Lifestyle, Attitudes and Nutrition in Ireland, in 2007, 29% of Irish adults (31% men, 27% women) reported being current smokers, i.e. daily and occasional smokers (see Figure 1). SLÁN 2007 identified 24% of adults who reported smoking on a daily basis. Almost half of respondents (48%) reported having smoked at some point in their lives. This shows a slight reduction from SLÁN Survey 1998 when 33% reported being current smokers. Almost one in ten (9%) Irish smokers reported actively trying to quit, with an additional 50% reporting being in various stages of thinking about quitting.

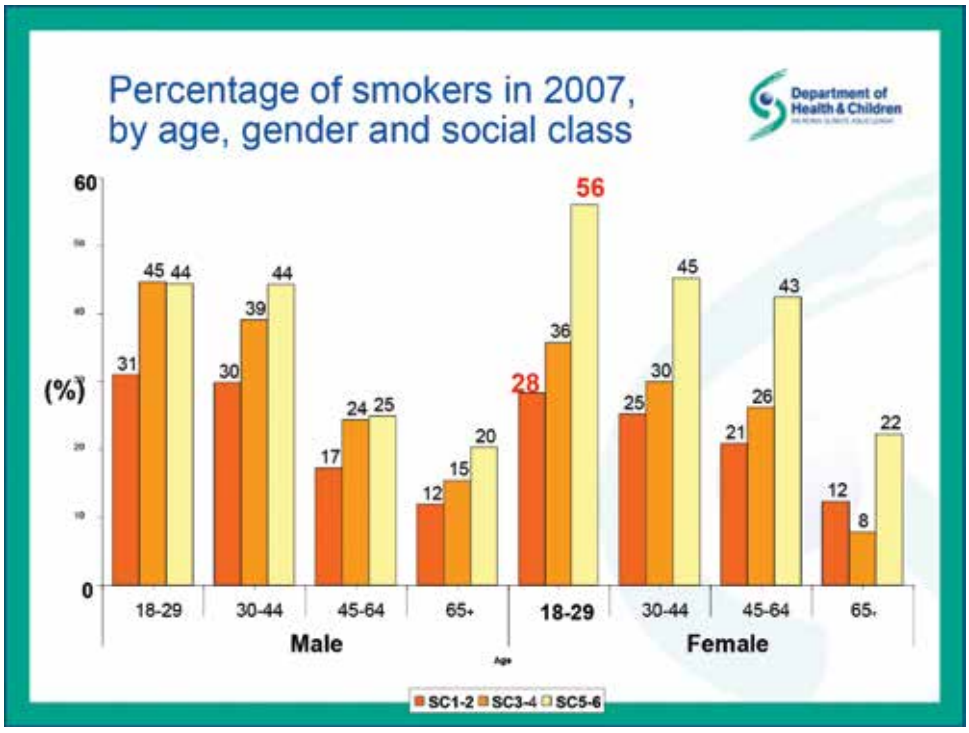

Figure 1: Percentage of smokers in 2007, by age, gender and social class
Source: SLÁN 2007

Data from National Tobacco Control Office[10]

The National Tobacco Control Office in the HSE monitors cigarette-smoking prevalence and behaviour on a monthly basis to gain a detailed picture of smoking patterns in Ireland and to identify trends in this pattern. The data are compiled from a monthly quota survey conducted on Ipsos MRBI's telephone omnipoll. The data consist of a collection of 1,000 respondents per month from July 2002. The research is conducted among Irish adults aged 15 years and over. The data are weighted by gender, age, social class and region.

9 Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E, Harrington J, Molcho M, Layte R, Tully N, van Lente E, Ward M, Lutomski J, Conroy R, Brugha R (2008). *SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland*. Main Report. Dublin: Department of Health and Children.

10 www.ntco.ie

Smoking was defined as responding yes to the question 'Do you smoke one or more cigarettes each week, whether packaged or roll your own?'

The overall prevalence of cigarette smoking in Ireland at June 2012 was 22%. There has been a decline in prevalence of 1.7% since June 2010.

A higher percentage of men (23.5%) reported being smokers than did women (20.5%). Smoking rates for both men and women have declined since June 2010.

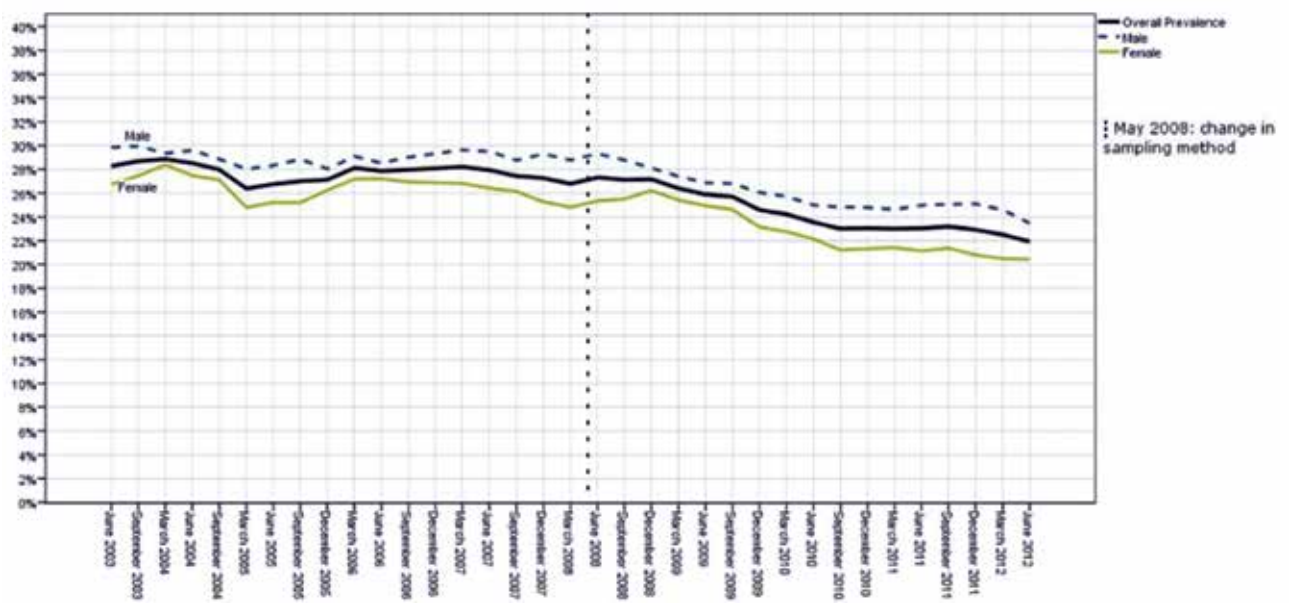

Figure 2: 12-month moving average trend in the prevalence of smokers to the end of June 2012, by gender, as reported by the NTCO
Source: http://ntco.ie/fig.asp?image=2010Charts/Fig_2.1.jpg Accessed 6 June 2013

International Comparison

A number of countries have successfully reduced smoking rates by pursuing sustained and comprehensive tobacco control programmes. These countries include the UK (21%), Australia (15%) and Canada (18%).

CHILDREN

The Health Behaviour in School Children (HBSC)[11] survey for 2010 showed that, overall, 27% of children report that they have 'ever smoked' tobacco. This is a decrease of 9 percentage points from the 2006 figure. Twelve% of children report that they are current smokers, i.e. smoke monthly or more frequently. This represents a 3 percentage point decrease from the 2006 figure of 15% (Table 1). While this represents progress, it does however indicate that smoking in childhood remains a public health challenge. In the 2010 study there are statistically significant differences across social class groups in current smoking status, with children from higher social class groups less likely to report current smoking behaviour. There are no statistically significant differences by gender.

11 Kelly, C, Gavin, A, Molcho, M, NicGabhainn, S (2012). Health Behaviour in School Children. Galway & Dublin: Health Promotion Research Centre, NUI Galway & Department of Health & Children.

Year	% of 10 – 17 year old current smokers
1998	21.2%
2002	18.6%
2006	15.3%
2010	12%

Table 1: Irish Health Behaviour in School-Aged Children (HBSC) studies 1998–2010
Source: Figures from HBSC

While the 2010 HBSC study indicated no significant statistical differences by gender, the International Study of Asthma & Allergies in Childhood (ISAAC) and the European School Survey Project on Alcohol and Other Drugs (ESPAD) studies have demonstrated a higher prevalence of smoking amongst young girls. The 2011 ESPAD study indicated that 19% of boys and 23% of girls smoke.

The 2006 Office of Tobacco Control (OTC) report *Children, Youth and Tobacco: Behaviour, Perceptions and Public Attitudes* indicated that, of those who smoked, 78% of children reported starting smoking before the age of 18 and 53% before the age of 15, showing that smoking initiation largely occurs among teenagers. Results from the HBSC survey indicate that girls in Ireland are more likely to start smoking at a younger age.

Trends

In overall terms, there has been a reduction in the prevalence of current smokers, among both boys and girls, from 21% in 1998 to 12% in the 2010 HBSC. There has also been a decline in reports of 'ever smoking' from 41% in 2002 to 27% in 2010. These trends are seen for both boys and girls and in all age groups (10–11, 12–14 and 15–17). The ISAAC and ESPAD studies have shown a consistent decline in smoking amongst 13–16 year olds over the past 15 years.

International Comparison

In an international comparison of smoking among 15-year-old children, Ireland ranked 19 out of 40 European and North American countries (ESPAD 2011). This is a further indication of the challenge that lies ahead for Ireland.

The Eurobarometer report *Attitudes of Europeans towards Tobacco*[12], published in May 2012, highlighted that for all current adult smokers, the average age of starting smoking is lowest in Ireland (16.4), followed by Denmark (16.6), Malta (16.8) and the UK (16.8).

OTHER SPECIFIC GROUPS

Smoking is the greatest contributor to health inequalities between the richest and poorest sections of society. It is also a significant factor in gender-based mortality differences.

Young Adults

The SLÁN survey in 2007 indicated that younger people 18–29 years were more likely to currently smoke (35%) than the other age categories. However, in overall terms, this is a decrease from 1998 when 43% smoked.

12 http://ec.europa.eu/health/tobacco/docs/eurobaro_attitudes_towards_tobacco_2012_en.pdf

Data from the National Tobacco Control Office surveys indicated that smoking rates were highest among young adults (18–34 years), reaching 30% in the 25–34 year age group. Prevalence was lowest among the 65+ age group at 11.6%. One in eight 15–17 year olds (12%) reported smoking. Rates have remained fairly steady since June 2010 in the 18–24 and 25–34 year age groups, with decreases in the 15–17, 35–44 and the oldest age groupings from 55 years upwards.

Socio-Economic Status

The SLÁN Survey indicated that in 2007 those in lower social class groups (Social Class 5–6) were more likely to currently smoke (37%) and to have 'ever smoked' (55%). This is particularly marked for women in the lower social classes, particularly those in the 18–29 year age groups.

Data from the National Tobacco Control Office surveys show that the highest cigarette-smoking prevalence rates were in the lower income groups. The lowest smoking rates (14.4% and 14.8%) were among farmers and higher socio-economic groups.

Gender

The SLÁN survey indicated that in 2007 rates of current smoking and having 'ever smoked' were higher in men than women. However, there has been a slight increase in smoking prevalence for middle-aged women (26%–27%). Women in the lower social classes, particularly those in the 18–29 year age groups, are more likely to currently smoke or to have 'ever smoked'. This has impacted on the epidemiology of lung cancer and chronic respiratory diseases. Lung cancer has now overtaken breast cancer as the commonest cause of cancer mortality in women.

	Males %		Females %	
	1998	**2007**	**1998**	**2007**
18–29	42	38	44	32
30–44	38	37	34	29
45–64	29	23	26	27
65+	19	17	16	13

Table 2: Changes in smoking prevalence, reported by SLÁN surveys, between 1998 and 2007, by age and gender

PART 1

Chapter 4

Progress to Date

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PROGRESS TO DATE

Ireland has a successful record in tobacco control and is regarded internationally as a leader in this area. *The Tobacco Control Scale 2010 in Europe*, published in March 2011, ranks Ireland second out of 30 European countries in terms of tobacco control. However, it is recognised that there is scope for improvement in areas relating to social marketing campaigns and treatment and cessation services.

NATIONAL POLICY

The 2000 national policy *Towards a Tobacco Free Society* set out a number of strategic objectives including:

- work to change attitudes
- help people give up smoking
- protect people from second-hand smoke
- a focus on children.

An action plan was agreed and progress to date is best summarised under action plan headings as outlined below:

- **Better Communication and Education**
  - Programme of conferences and seminars
  - National media campaigns

- **Specific Support for Smokers to Quit**
  - Nicotine Replacement Therapy (NRT) available free to all medical card holders
  - Development of national smoking cessation services
  - Establishment of the National Smokers' Quitline 1850 201 203
  - Establishment of social media and online cessation supports www.quit.ie and www.facebook.com/HSEquit
  - Media campaigns

- **Tougher Regulation of the Tobacco Industry**
  - Ban on tobacco advertising in newspapers and magazines
  - Ban on misleading descriptors, e.g. 'light' and 'mild', new maximum yields (tar, nicotine and carbon monoxide), and introduction of larger health warnings on tobacco products
  - Industry disclosure of ingredients

- Ban on sale of cigarettes in packs of less than 20 and sale of confectioneries that resemble cigarettes
- Ban on in-store advertising and display of tobacco products
- Prohibition on self-service vending machines except in licensed premises or registered clubs; machines must be operated in accordance with regulations
- Requirement for all retailers of tobacco products to register with the HSE
- Prohibition on sponsorship
- Requirement for all cigarettes to comply with fire safety standards
- The introduction of regulations providing for combined photo and text warnings.

- **Further Protection against Second-Hand Smoke**
  - Smoke free workplace legislation introduced
  - Guidelines on mental health settings published (*Best Practice Guidelines for Tobacco Management in Mental Health Settings*)

- **Better Compliance with the Law**
  - National Inspection Programme introduced
  - Effective enforcement of the legislation by Environmental Health Officers
  - Compliance level with smoke free workplace legislation is 97%[13]
  - 97% compliance with legislation on display of cigarettes in-store[13]
  - Refusal rate to sell cigarettes to those aged under 18 is 73% in retail premises[13]

- **International Co-operation**
  - Party to the Framework Convention on Tobacco Control (FCTC)
  - Ratification of the Framework Convention on Tobacco Control (FCTC)
  - High profile involvement in the FCTC process and in successive FCTC Conferences of the Parties
  - Lead facilitator in the development of Guidelines on Article 8 of the FCTC
  - Involvement at European level in the agreement of the various Directives and Decisions relating to tobacco, i.e. advertising and sponsorship and manufacture, presentation and sale of tobacco products
  - Active participation in the European Commission's Tobacco Products Regulatory Committee
  - Host country for visiting delegations in relation to the introduction of smoke free workplace legislation in other jurisdictions.

13 http://www.ntco.ie

HSE Tobacco Control Framework (TCF) 2010-2015

In addition to the progress outlined under the TTFS action plan, the HSE adopted its Tobacco Control Framework in 2010. The TCF is based on the MPOWER model presented in the WHO *Report on the Global Tobacco Epidemic 2008*. The MPOWER package includes the six most important, effective and evidence based tobacco control policies.

A National Implementation Group was established to deliver the 61 actions identified under the Framework.

Key actions progressed to date include:

- Implementation of a Tobacco Free Campus Policy in 20 acute healthcare settings, all newly opened primary care centres and all HSE administration sites
- Social marketing QUIT campaign
- Accredited national brief intervention training programme for smoking cessation
- Tobacco Control Stakeholder Network established with representation from 16 key non-governmental and professional bodies
- Audit of smoking behaviour among HSE staff
- Development of policy protecting HSE staff from exposure to second-hand smoke in domestic settings.

PART 1

Chapter 5

The Tobacco Industry

PART 1

CHAPTER 5

THE TOBACCO INDUSTRY

The 'tobacco industry' does not only consist of manufacturers of tobacco products; it also includes those engaged in all aspects of the growing, manufacture, distribution and sales of tobacco. Tobacco corporations can be either state-owned or national or multinational companies. The 'big four' tobacco companies in 2008 as indicated by *The Tobacco Atlas* are as follows:

- Philip Morris (includes Philip Morris, Philip Morris USA and Philip Morris International) with a market share of 20.0%
- British-American Tobacco (BAT) with a market share of 12.0%
- Japan Tobacco International (JTI) (include domestic and international) with a market share of 9.6%
- Imperial Tobacco with a market share of 4.9%.

In addition to these corporations, there are sixteen state-owned tobacco companies that are the leading cigarette manufacturers in specific countries. The China National Tobacco Corporation is the largest state-owned tobacco company globally, with a market share of 37.1%, producing more cigarettes than any other company in the world.

The Irish market is dominated by three main distributors: JTI Ireland, John Player & Co (Imperial Group) and PJ Carrolls & Co (BAT Group). The JTI Ireland group has the largest market share with over 50% of sales at June 2012.

The JTI Ireland Group distributes three of the top five most popular brands smoked: Benson and Hedges, Silk Cut Purple and Silk Cut Blue. These three brands have featured in the top five since August 2003. Benson & Hedges is the most popular brand, being smoked by 13.9% of smokers at June 2012. Over one half of smokers select from the five most popular brands.

There are two small manufacturers of tobacco products in Ireland.

The direction of tobacco companies is beginning to change. They are branching out into other areas of tobacco products and technology. In recent years, the major tobacco companies have purchased corporations that produce oral tobacco or alternative nicotine products.

In a publication entitled *Technical Resource for Country Implementation of WHO Framework Convention on Tobacco Control Article 5.3* the WHO outlined the various forms of tobacco interference and listed some examples of tobacco industry tactics to interfere with tobacco control measures. Litigation and threat of litigation is one of the forms mentioned.

The tobacco industry has taken and is currently taking a number of legal challenges internationally with a view to preventing pieces of legislation from operating. However, in the main these are viewed by tobacco control authorities as a means of delaying various legislative provisions from coming into operation and as a means of diverting resources away from other tobacco control and health promotion initiatives. Litigation also acts as a deterrent for other countries from developing and enacting new progressive pieces of tobacco control legislation.

A legal challenge was instigated against the Australian Government following its announcement that it would introduce plain packaging legislation. Industry proceedings were taken in Norway, challenging the point of sale advertising ban. Both of these cases were lost by the tobacco industry.

In Ireland the tobacco industry instituted proceedings in the High Court in late 2009 challenging the provisions relating to the point of sale advertising ban, the closed container requirement and the display ban, all of which were introduced in July 2009.

In developing new legislation it is imperative that it is devised in a considered and proportionate way so as to withstand the legal challenges that may occur. It is also important that tobacco control legislation be defended vigorously in the courts whether it is in the High Court or the District Courts so as to ensure the integrity of the principles and policies set out in the legislation.

In the context of Governments' involvement with the tobacco industries, Article 5.3 of the World Health Organisation's FCTC states: 'In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.' Guidelines were developed to assist parties in meeting their obligations under Article 5.3.

RECOMMENDATION

- Take steps to ensure that all government officials, employees of state agencies and members of any government branch (executive, legislative and judiciary) responsible for setting and implementing tobacco control policies and for protecting those policies against tobacco industry interests are aware of their obligations under Article 5.3 of the WHO FCTC and are aware of the Guidelines developed to assist in meeting these obligations.

PART 2

Chapter 6

Tackling the Problem

PART 2
CHAPTER 6
TACKLING THE PROBLEM

TOBACCO CONTROL POLICIES

The overall aim of a tobacco control policy is to reduce and eliminate tobacco-related harm in the population and the unnecessary and preventable deaths and disability caused by tobacco use. A more concerted effort is now required to support the continued development of a tobacco free society by 2025 where people can live longer and healthier lives, free from the detrimental effects of tobacco.

In order to reduce tobacco-related harm, there must be a decrease in smoking prevalence and a denormalisation of tobacco within society. Actions are therefore required to:

- prevent non-smokers including children and young people from starting to smoke
- encourage, motivate and support current smokers to quit
- reduce recidivism rates among those who have quit
- protect non-smokers, especially children, from the effects of second-hand smoke
- limit the societal impacts of smoking and protect society, especially those under 18 years, from the marketing practices of the tobacco industry.

Implementation of tobacco control policies must incorporate both population based approaches, which focus on the entire population, and risk based approaches, which target specific high risk groups within the population, such as children and adolescents, smokers in low income groups and young women.

Policy on tobacco control requires public support, and the attitudes of the public must, therefore, be considered. Engaging public support for the introduction of policies is critically important to ensure their success.

Recent Eurobarometer reports[14] highlight strong public support for various tobacco control policies among Irish citizens, well above the European average in all instances. For example:

- 65% are in favour of increasing taxes on tobacco products
- 83% are in favour of banning sales through the internet and 73% support a ban on sales through vending machines
- 82% support banning flavours that make tobacco products more attractive
- 82% are in favour of security measures on packs to limit smuggling/counterfeit even if it increased the price by a few cent
- 90% support the introduction of pictorial health warnings on all tobacco products
- 73% are in favour of introducing a fee on manufacturers to cover the health costs of tobacco use
- 81% are in favour of banning colours, logos and promotional elements from tobacco products.

14 http://ec.europa.eu/health/tobacco/docs/eurobaro_attitudes_towards_tobacco_2012_en.pdf

POLICY FRAMEWORK

The objectives articulated in the *Towards a Tobacco Free Society* remain a key focus of the revised policy and in particular the denormalisation of tobacco use in Irish society. The framework in this new policy has been further informed by the WHO MPOWER model which was developed to enable countries to implement the Framework Convention on Tobacco Control (FCTC) measures.

The WHO MPOWER model has identified the six most important, effective and evidence based tobacco control policies:

Monitoring of tobacco use and prevention policies

Protecting people from second-hand smoke

Offering help to people who want to quit

Warning of the dangers of tobacco

Enforcing bans on advertising, promotion and sponsorship

Raising taxes on tobacco.

This new policy, as well as incorporating the WHO MPOWER model, contains some additional themes which underpin the approach to reducing the harm caused by tobacco in Ireland today, namely:

- Protecting children
- Denormalisation of tobacco use
- Building and maintaining compliance with tobacco legislation
- Regulating the tobacco retail environment.

PART 2

Chapter 7

Protecting Children and Denormalisation

PART 2
CHAPTER 7
TACKLING THE PROBLEM

PROTECTING CHILDREN

The key area of concern is how best to prevent young people from starting to smoke. Given that about 2% of smokers quit and 5,200 smokers die every year, it is estimated that the tobacco industry needs to recruit at least 50 new smokers every day just to maintain the smoking rates at their current level; and since approximately 80% of smokers start when they are children, most of these new smokers are actually children.

Children are especially vulnerable to harm from both active and passive smoking. They become addicted very quickly, and the earlier they begin to smoke, the harder it becomes for them to quit at a later stage because of the impact that nicotine has on their developing brains. Of particular interest are the reasons why children and young people start to smoke. Children are vulnerable to the societal impact of smoking and to the marketing practices of the tobacco industry. Children are attracted to the new 'fashionable' cigarette packs. In essence, children and young people smoke because adults inadvertently or otherwise encourage children to smoke. This happens in many ways, either as direct role models, through films, through advertising and by selling tobacco to children. Children who come from households where one or other parent smokes are significantly more likely to become smokers themselves. In the Eurobarometer study *Attitudes of Europeans towards Tobacco* (May 2012)[15] 79% of European smokers and ex-smokers say they started because their friends smoked and 21% because their parents smoked.

There is ample evidence to show that the portrayal of smoking in movies targeted at children and young people also impacts on whether they smoke or not. The positive portrayal of smoking by models and other forms of advertising glamorises smoking and makes it attractive to children.

Despite it being illegal to sell tobacco to persons less than 18 years of age, the evidence shows that many outlets continue to do so. Children also report sourcing cigarettes from siblings and parents or by 'fishing', i.e. where children solicit an adult to buy cigarettes on their behalf, often for a small fee.

There has been much research on how to prevent children and young people from starting to smoke. Unfortunately there is no one 'magic bullet' in providing a solution. However, there is clear evidence that interventions with multiple components such as age restrictions for tobacco purchases which are properly enforced, introduction of point of sale display bans, the provision of tobacco free public places, evidence based mass media communications and special programmes in schools and local youth communities can have a positive effect on smoking and initiation rates. In addition, reducing smoking in the adult population also impacts significantly on children and young people.

RECOMMENDATION

- The protection of children must be prioritised in all of the initiatives outlined in the policy.

DENORMALISATION OF TOBACCO USE

A key component in moving towards the creation of a tobacco free society is the denormalisation of tobacco use at every opportunity. This is not an anti-smoker initiative but rather a desire to change our approach towards the use of tobacco across society. Making smoking less attractive to children and

15 http://ec.europa.eu/health/tobacco/docs/eurobaro_attitudes_towards_tobacco_2012_en.pdf

young people and increasing its social unacceptability are key elements in the denormalisation of tobacco. Denormalisation of tobacco at every level of society is one of the key strategies for protecting children.

The workplace smoking ban helps to de-normalise smoking and also limits opportunities for smoking. The development of further smoke free initiatives can only succeed in further de-normalising tobacco consumption in our society. International research demonstrates that there is strong public support for tobacco free schools and for restrictions in certain settings such as sports grounds and children's playgrounds. In order to increase the social unacceptability of smoking, it is important that areas where children congregate should move towards becoming tobacco free.

The HSE is committed to introducing a tobacco free campus policy in all of its sites by 31 December 2015. Considerable progress has been made, and by the end of 2013 all 49 acute hospitals, 35% of primary care centres and all administration sites will be tobacco free. The tobacco free campus initiative is part of an international move to make healthcare institutions completely smoke free as there is a growing recognition that allowing smoking on healthcare campuses significantly undermines the health promotion message of such organisations. This initiative has already been introduced in hospitals and healthcare facilities in the US, Canada, Britain, New Zealand and Spain.

In 2009 Ireland's first smoke free playground was launched in Donegal. Since then, numerous County, City and Town Councils have introduced similar initiatives in playgrounds in their respective areas with many more planning to move forward on the smoke free playground initiative.

Sports venues are also an important part of the picture in de-normalising tobacco use. Whilst some sports stadia in Ireland have introduced smoke free areas, the Aviva Stadium has made huge progress in this regard. The Aviva Stadium operates a 'no smoking' policy for all sporting fixtures and concerts. The policy also covers half-time and/or intervals as fans are not allowed to leave in order to smoke and then return to the stadium at any time for the duration of an event.

At an international level, other countries are taking similar steps. For example, in New York City as of 23 May 2011 smoking is banned in parks, beaches and boardwalks, public golf courses, sports stadia grounds and pedestrian plazas. Smoking was already prohibited in playgrounds, pools and inside stadia.

RECOMMENDATIONS

- Denormalisation must be a complementary underpinning theme for all of the initiatives within the policy.
- Develop and introduce legislation to prohibit smoking within the campuses of primary schools, secondary schools and child care facilities.
- Promote tobacco free campuses for all third-level institutions in consultation with key stakeholders.
- Promote tobacco free campuses for all health care, governmental and sporting facilities in consultation with key stakeholders.
- Further develop the tobacco free playgrounds initiative in conjunction with the local authorities by voluntary measures or by the introduction of bye-laws.
- Promote tobacco free environments and in particular parks and beaches in conjunction with the local authorities by voluntary measures or by the introduction of bye-laws.
- Evaluate the tobacco free environment initiatives with a view to the introduction of legislation if required.

PART 2

Chapter 8

Legislative Compliance and Regulating the Retail of Tobacco

PART 2
CHAPTER 8
LEGISLATIVE COMPLIANCE AND REGULATING THE RETAIL OF TOBACCO

BUILDING AND MAINTAINING COMPLIANCE WITH TOBACCO LEGISLATION

The effective enforcement of tobacco control legislation is a key element of a comprehensive tobacco control strategy. An effective programme has three elements: response to public complaints, a routine inspection programme and a programme strategically targeted at low compliance and high risk sectors. These elements must be supported by targeted stakeholder communications and on going training for enforcement personnel.

A notable feature of the Public Health (Tobacco) Act 2002, as amended, is the high compliance levels recorded each year. This contrasts with the position outlined in 2000 in *Towards a Tobacco Free Society* that poor compliance with many legal provisions was not uncommon. The improvement in compliance levels has been achieved by widespread public support for the measures, delivering stakeholder education initiatives and developing and implementing a proactive national enforcement programme.

The HSE's Environmental Health Service is responsible for the enforcement of tobacco legislation. The National Tobacco Control Inspection Programme (NTCIP) was launched in 2004 by the then Office of Tobacco Control to provide a framework to ensure a viable, consistent and sustained approach to compliance building and enforcement throughout the country.

A Memorandum of Understanding is in place between the Department of Health, the HSE and the Health & Safety Authority governing enforcement of the smoke free legislation in certain workplace settings.

Core elements of the NTCIP are: facilitating public engagement in respect of non-compliance and responding in a manner that demonstrates that public support and involvement is valued. In this way, the public are empowered to insist on compliance with the law and this in turn raises public expectations regarding the behaviour of retailers, the tobacco industry and proprietors of public premises. Each year, over 300 complaints are received by the National Tobacco Control Office from members of the public.

Notwithstanding the high compliance rates reported generally, enforcement of tobacco laws has not been without its challenges. Compliance with exemptions under the smoke free legislation has caused on going difficulties. Over 200 cases have been taken for breaches of Section 47 of the Public Health (Tobacco) Act 2002, as amended, since its enactment in 2004, increasingly relating to outdoor areas in licensed premises.

The sale of tobacco to minors is prohibited under Section 45 of the Public Health (Tobacco) Act 2002. The internationally accepted method of assessing compliance with these types of provisions is through a 'test purchase' programme using volunteer minors. Ensuring compliance with sales to minors legislation is a challenging area in terms of the resources required to organise and manage test purchasing programmes on an on going basis. Experience in Ireland and abroad shows that high compliance levels require sustained and credible enforcement action.

It is important that there is on going vigilance in relation to tobacco industry activities to ensure compliance with all provisions, particularly the recently commenced sections pertaining to prohibitions on advertising. The introduction and enforcement of tobacco control legislation has been the subject of substantial legal challenge by tobacco manufacturers. The legislation must be underpinned by a range of enforcement tools and sanctions/penalties which are effective, proportionate and dissuasive.

RECOMMENDATIONS

- Continue to actively promote compliance with and enforce all provisions of the Public Health (Tobacco) Act 2002 as amended.
- Introduce fixed penalty notices (on the spot fines) for offences.
- Develop capacity within the HSE's Environmental Health Service to maintain consistent and sustained enforcement of all aspects of the tobacco control legislation.
- Develop special investigation capacity within the HSE's Environmental Health Service to assess compliance by tobacco manufacturers.
- Introduce legislation for the publication of information in respect of any person on whom a fine, other penalty or conviction was imposed by a Court ('name and shame').
- Collaborate with other EU countries in relation to compliance measures for tobacco ingredient reporting.

REGULATING THE TOBACCO RETAIL ENVIRONMENT

In order to achieve the objective of a tobacco free society strict regulation on the retailing of tobacco products is necessary. The introduction of the Retail Register as provided for by the Public Health (Tobacco) Act 2002, as amended, is one such initiative. The purpose of the register is to establish a database of all tobacco retailers and to act as a deterrent against breaches of the tobacco legislation.

The register was launched in July 2009, and a once-off fee of €50 per applicant was prescribed. Compliance is very high and to date 10,750 retailers have been registered to sell tobacco in 13,139 locations. There is however a financial cost in maintaining the register.

The legislation provides for suspensions from the register for anyone convicted of an offence under the Public Health (Tobacco) Acts. The period of suspension is at the discretion of the Courts, up to a maximum period of 3 months. Almost half the suspensions applied to date were for a period of 1 day.

Despite the existence of the Retail Register, tobacco retailing is currently 'normalised', i.e. tobacco products can be sold by any person, at any location, at any time. This is in contrast to the regulation of the sales of alcohol, pharmaceuticals, and other goods and services. Having little or no restrictions on who can sell tobacco products or on where they can be sold is inconsistent with our vision of a tobacco free society and certainly undermines public understanding of how seriously tobacco damages health. There is a need, therefore, to put in place a more effective way of regulating who sells tobacco products and where these products are sold.

RECOMMENDATIONS

- Develop a licensing system for retailers who sell tobacco products.
- Prohibit sales of tobacco in mobile units/containers.
- Prohibit the sale of tobacco at events/locations primarily intended for those persons under 18 years.
- Prohibit the sale of tobacco products by those under 18 years.
- Prohibit the operation of all self-service vending machines.
- Introduce a minimum suspension period for retailers convicted of an offence.

PART 2

Chapter 9

World Health Organsiation MPOWER Model

PART 2
CHAPTER 9
WORLD HEALTH ORGANSIATION MPOWER MODEL

The following sections of the report utilise the WHO MPOWER model to outline further steps that need to be taken in order to achieve tobacco free status by 2025.

MONITOR TOBACCO USE AND PREVENTION POLICIES

In order to effectively implement and improve measures on tobacco control there must be on going accurate monitoring of tobacco use. The data obtained from surveillance can be used to assess the need for interventions, to evaluate initiatives, and to inform future policy direction or the need for targeted policy initiatives.

Currently in Ireland there are a number of surveys that look at smoking in adults and children using various methodologies. These include SLÁN, surveys of the HSE National Tobacco Control Office, Eurobarometer surveys on tobacco and the HBSC survey on children. Data are also available from the Revenue Commissioners on warehouse releases.

There is a need for a single, reliable and regular measure to monitor smoking prevalence in Ireland. Having a reliable measure of smoking prevalence is the single most important factor in determining whether our tobacco control policies are operating effectively. In conjunction with this, measures and/or indicators must be developed to determine whether the policies put in place are operating effectively.

On going research, informed by best practice internationally, on the key components of the supply of and demand for tobacco in the Irish setting is critical to assist the development of future policy developments in tobacco control.

In relation to prevention policies it is important that the State, whether at Government level or through services on the ground, evaluate policies continuously to ascertain whether they are effective. All services and policy makers should have in place a Performance Indicator Framework to allow them to measure success.

RECOMMENDATIONS

- An active research and survey programme on tobacco should be put in place to include areas such as supply and demand, prevention and treatment, exposure to second-hand smoke and industry marketing initiatives.
- This survey programme is to include a single, reliable and regular collation of smoking prevalence rates.
- Tobacco control measures should be continuously evaluated to ascertain impacts and outcomes.

PROTECT PEOPLE FROM TOBACCO SMOKE

In March 2004 legislation was introduced prohibiting smoking in most workplaces, including bars and restaurants. Compliance with smoke free legislation is consistently high, with compliance rates generally above 90%. The health benefits for workers are already accruing. A recent Cochrane review[16] found a

16 Callinan JE, Clarke A, Doherty K, Kelleher C. Legislative smoking bans for reducing secondhand smoke exposure, smoking prevalence and tobacco consumption. Cochrane Database of Systematic Reviews 2010, Issue 4. Art. No.: CD005992. DOI: 10.1002/14651858.CD005992.pub2.

rapid reduction in admissions for acute coronary syndrome after the introduction of restrictions on exposure to second-hand smoke. A study carried out in 2010 confirmed that 'the Irish smoke free legislation was a success as a policy initiative because of the timing, dedication, planning, implementation and the existence of strong leadership and a powerful convinced credible political champion'.[17] In 2005 the Research Institute for a Tobacco Free Society[18] examined the effect of the workplace ban on second-hand smoke (SHS) exposure in 42 Dublin bars and among 73 bar workers. This study found an 83% reduction in air pollution in bars, an 80% decrease in airborne carcinogens for patrons and staff, and an improvement in the respiratory health of bar workers. The self-reported workplace exposure to SHS was over 40 hours per week pre-ban, but dropped to about 25 minutes post-ban, showing a 99% decrease in exposure. These results confirm the success of the total ban on smoking in the workplace.

A study published in 2013[19] showed that the workplace smoking ban was associated with immediate reductions in early mortality, with specific benefits observed in cardiovascular, cerebrovascular and respiratory causes. That study estimated that 3,726 smoking-related deaths were likely prevented.

A limited number of exemptions are provided under the law, including certain outdoor places or premises where specific conditions are met. Other exemptions deal with settings of a domiciliary nature – prisons, psychiatric hospitals and nursing homes, hotel bedrooms, etc. In 2008 the HSE and Health Promoting Hospitals Network launched *Guidelines on Tobacco Management in Mental Health Settings* to assist in providing protection for workers and residents in these settings.

Enforcement of the smoke free law is the responsibility of the Environmental Health Service of the HSE and the Health and Safety Authority. Since the introduction of the law, the HSE has actively engaged in building compliance; and when compliance building efforts have been exhausted, in defending the legislation in the courts. While compliance with the legislation is generally very high, there is concern at the proliferation of newly created 'smoking areas/exempted areas' in licensed premises which test the limits of compliance. The HSE has been party to three High Court cases in relation to this particular exemption. The judgments in these cases have provided clarity on the interpretation of the exemption and restricted its application.

In respect of smoking in private spaces the 2007 SLÁN survey reported that 82% of respondents had some rules about smoking in their homes – 59% did not allow smoking anywhere inside their home, with an additional 23% reporting that smoking was allowed only in certain places or at certain times.

Exposure to second-hand smoke is a serious health hazard, especially for children. Second-hand smoke consists of over 7,000 chemicals, including more than 60 known carcinogens. Even brief exposure can cause damage. It is obvious that exposure to cigarette smoke is particularly dangerous in enclosed spaces, such as cars. In children, exposure to second-hand smoke is a recognised risk factor for the development of asthmatic symptoms; the worsening of pre-existing asthma; and increased risk of other illnesses such as pneumonia, bronchitis and middle ear infections[20]. Parents and others with responsibility for the welfare of children have a particular obligation to ensure that such exposure does not take place. An ISAAC survey[20,21] carried out in 2007 reported one in seven 13–14 year olds in Ireland were exposed to second-hand smoke in cars. The 2006 National Youth Tobacco Survey,[22] in the US indicated that 23% of the 11–15 year olds surveyed indicated that they had been an occupant in a car with someone who was smoking within the previous week of the questionnaire being answered.

17 Currie LM, Clancy, L (2011). "The road to smoke-free legislation in Ireland". Addicition 106(1): 15-24

18 Effects of the Irish Smoking Ban on Respiratory Health of Bar Workers and Air Quality in Dublin Pubs Patrick Goodman, Michell Agnew, Marie McCaffrey, Gillian Paul and Luke Clancy.

19 Stallings-Smith S, Zeka A, Goodman P, Kabir Z, Clancy L (2013) "Reductions in Cardiovascular, Cerebrovascular, and Respiratory Mortality following the National Irish Smoking Ban: Interrupted Time-Series Analysis". PLoS ONE 8(4): e62063. doi:10.1371/journal.pone.0062063

20 Kabir Z, Manning PJ, Holohan J, et al. (2009) "Prevalance of smoking inside cars in Ireland". Dublin: Research Institute for a Tobacco Free Society, Asthma Society of Ireland, Dublin Institute of Technology.

21 Kabir Z, Manning PJ, Holohan J, et al. Second-hand smoke exposure in cars and respiratory health effects in children. Eur Respir J 2009;34:629-33, published ahead of print 2009, doi:10.1183/09031936.00167608

22 http://www.cdc.gov/tobacco/data_statistics/surveys/nyts/pdfs/indicators.pdf

In 2011 an ASH Ireland Ipsos MRBI poll showed that 79% of Irish people supported a ban on smoking in cars where children are present.

In May 2012 the Minister for Health supported a Private Member's Bill, the aim of which is to prohibit smoking in cars where children are present. Work is on going on this Bill in consultation with the Senators who introduced the Bill, the Department of Justice and Equality, the Attorney General and An Garda Síochána to ensure that the resulting legislation operates effectively and is enforceable.

In parallel with the legislation a social marketing campaign to highlight the dangers associated with exposure to second-hand smoke and to educate the public regarding the new legislation will be required.

RECOMMENDATIONS

- Develop and introduce legislation prohibiting smoking in cars where children are present, based on international evidence and good practice.
- Undertake a social marketing campaign focusing on the risks to children from exposure to second-hand smoke with particular reference to smoking in cars (and information of future legislation in this regard).
- Monitor the effectiveness of the current smoke free legislation, including the review of existing exemptions and the monitoring of compliance with these provisions.

OFFER HELP TO QUIT TOBACCO USE

Cessation

Almost all smokers start smoking regularly before they are 18 years old. Nicotine is a highly addictive substance with evidence that children can become addicted within weeks of starting to experiment with tobacco. Most smokers say they want to quit and about 40% of all smokers try to quit every year. Only a small fraction (2–3%) actually successfully quit each year. The overwhelming majority quit unaided, using willpower alone. Smokers can double their chances of quitting using behavioural and/or pharmacotherapy supports and all smokers should be encouraged to use these types of supports when trying to quit.

The US Surgeon General's report in 2000[23] stated that smoking cessation was one of the most cost-effective healthcare treatments. An economic appraisal of the introduction of a comprehensive system for treating tobacco dependence in the UK found that the cost per life year gained ranged from £210 to £870 which was considerably cheaper than a range of over 300 other medical treatments.[24]

Treating tobacco addiction as a care issue is a critical principle underpinning this policy. The appropriate management of tobacco addiction can significantly reduce the burden of chronic disease on individuals, their family and the healthcare services. The UK's National Institute for Health and Clinical Excellence (NICE)[25] recommends that smoking cessation advice and support should be available in community, primary and secondary care settings. GPs, nurses in primary or community care, hospital clinicians, pharmacists, dentists and all other health professionals should advise all patients who smoke to quit when they attend for a consultation.

23 U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000. http://www.cdc.gov/tobacco/data_statistics/sgr/2000/complete_report/pdfs/frontMatter.pdf

24 http://www.treatobacco.net/en/page_159.php

25 National Institute for Health and Clinical Excellence: Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities. NICE public health guidance 10, February 2008. 2008. http://www.nice.org.uk/nicemedia/live/11925/39596/39596.pdf

Unfortunately, despite a wealth of evidence supporting it, engagement by healthcare professionals in treating tobacco use remains low. The SLÁN survey highlights that only 38% of current smokers who attended a GP or other health professional in the previous year reported that the professional had discussed quitting smoking with them during the consultation.

The evidence also recommends that the prevalence of smoking and the characteristics of smokers in the population served should be established, for example, the population served by a primary care team. Targeted and tailored smoking cessation interventions should be used where necessary, for example in socially disadvantaged areas.

Currently in Ireland several initiatives have been developed to help smokers quit. The National Smokers' QUITline 1850 201 203, run by the Irish Cancer Society on behalf of the HSE, provides a telephone support service managed by trained smoking cessation counsellors. Over 3,700 people sought advice using the QUITline in 2011. The HSE has developed a dedicated website (www.QUIT.ie) to help smokers to quit. Since June 2011 the HSE also has a presence on Facebook (www.facebook.com/HSEquit) with in excess of 53,000 likes registered to date and high levels of user engagement on a daily basis. In June 2011 the HSE launched a three-year social marketing campaign encouraging smokers to quit.

Specialist smoking cessation services are also provided by the HSE. Nationally, there are approximately 55 providers (20 Whole Time Equivalent posts). In 2011 over 10,000 smokers received support from a trained provider. This may have been a once-off intensive intervention or a structured programme over a period of 6 weeks. A 2007 evaluation of these services found them to be of a high standard. However, provision is patchy leading to inequitable access. Other health care providers, such as GPs, also provide cessation services. Data are lacking, however, on the extent of provision, the skill base of those who provide services and the outcomes achieved.

Harm Reduction

There is a requirement for alternative, less harmful forms of nicotine. While there are smokers who are able to quit abruptly, either alone or by using current support mechanisms, there are others who are unable to. These people need an alternative measure of support to reduce the harm they experience from tobacco use. This can involve the use of alternative safer forms of nicotine while they reduce their tobacco consumption in preparation to quit.

A Cochrane Review on Nicotine Replacement Therapy published in 2012[26] indicated that all forms of NRT made it more likely that a person's attempt to quit smoking would succeed. The chances of stopping smoking were increased by 50 to 70%. The evidence suggests no overall difference in effectiveness between different forms of NRT, nor a benefit for using patches beyond eight weeks.

However, currently there is a discrepancy in relation to the nicotine containing products available. Nicotine Replacement Therapy available currently from pharmacies is well regulated while other products such as Electronic Nicotine Delivery Systems (ENDS), e.g. e-cigarettes, are not regulated for specifically other than under general product safety legislation operated under the European Communities (General Product Safety) Regulations 2004. Nicotine containing products are becoming more popular. However, there is a dearth of reliable evidence regarding the safety and effectiveness of some of these products as a smoking cessation product. A WHO Study Group report (2010)[27] on electronic cigarettes in particular concluded

26 Cahill K, Stevens S, Perera R, Lancaster T. "Pharmacological interventions for smoking cessation: an overview and network meta-analysis". Cochrane Database of Systematic Reviews 2013, Issue 5. Art. No.: CD009329. DOI: 10.1002/14651858.CD009329.pub2.

27 WHO study group on tobacco product regulation: report on the scientific basis of tobacco product regulation: third report of a WHO study group. (WHO technical report series; no. 955). Geneva, World Health Organisation, 2010.

that the safety and extent of nicotine uptake has not been established and that not enough scientific evidence existed to validate the claim that the products were smoking cessation aids. Further research, studies and clinical trials were recommended. Overall the report concluded that there is growing concern internationally about the quality, safety and 'regulatory gap' of these emerging products, broadly called ENDS.

At European level the approach taken by the Member States in their treatment of ENDS/e-cigarettes varies considerably. There appears to be general consensus that there is a lack of research in relation to the long-term health effects of e-cigarettes and a lack of sufficient evidence that they aid with smoking cessation. This is under consideration as part of the on going work in the EU Tobacco Products Directive.

Nicotine replacement therapies, buproprion, and varenicline are available free of charge on GMS prescriptions. For those without medical cards, buproprion and varenicline are subsidised through the Drugs Payment Scheme.

RECOMMENDATIONS

- Identify a lead person with clear lines of responsibility for the co-ordination of smoking cessation services within the health service to ensure a national approach.
- Develop comprehensive national smoking cessation guidelines. These to include the minimum level of service provision that each service provider needs to have in place.
- Undertake targeted approaches for specific groups, particularly young people, lower socio-economic groups, pregnant and post-partum women and patients with cardiac and respiratory disorders.
- Establish a national database for the collection and collation of data from all smoking cessation services.
- Train all frontline healthcare workers to deliver interventions for smoking cessation as part of their routine work.
- Examine evidence (national and international) regarding outcomes of the use of NRT and other approaches.
- Establish a regulatory framework for nicotine products in the context of discussions at EU level.
- Increase investment in mass media quit campaigns.
- Advocate for the removal of VAT from NRT.
- Make NRT more widely available, including in outlets where tobacco products are sold.

WARN ABOUT THE DANGERS OF TOBACCO

Most people are not aware of, misunderstand, or underestimate the risks associated with tobacco use. A 2010 survey by the HSE[28] reports that only 7% of people know that smoking kills half of all long-term users.

Social marketing campaigns that are sustained over time are highly effective in changing social norms, reducing the number of people who start smoking, increasing the number of smokers who quit and reducing recidivism rates. The most effective campaigns combine 'why' to quit with 'how' to quit messaging. Campaigns are most effective when they are part of a broader, comprehensive tobacco control programme

28 http://www.hse.ie/eng/services/news/newsarchive/2011archive/dec2011/quitjan1.html

designed to change society's prevailing attitudes concerning tobacco use. Social marketing campaigns play a key role in the denormalisation of tobacco in society.

Several media campaigns have been run in Ireland over the past decade but investment has been limited and not sustained. QUIT is a HSE health education campaign that uses real life stories about smoking-related illness to help smokers to quit. The campaign, launched in June 2011, is based on international best practice and is a health service wide programme, grounded in local research. The campaign message is: '1 in every 2 smokers will die of a tobacco-related disease. Can you live with that? QUIT'.

QUIT incorporates paid media, public relations, online and phone support, counselling and clinics, special events and consumer information booklets, all aimed at the core target audience of smokers aged 25–39.

Good progress was made during the first 21 months of the campaign, with over 175,000 smokers availing of HSE support services. QUITline experienced a 24% increase in calls in the first 12 months; smokers also sought support from other sources including GPs, pharmacists and dentists.

The focus now must be on increasing investment to maintain this momentum and the success achieved to date so as to drive long-term behaviour change. Social marketing campaigns, if they are to be successful, need to be refreshed, updated and vigorously promoted.

Pictorial warnings on tobacco products are a cost-effective method of increasing public awareness of the harm caused by tobacco use. In addition to health warnings, labelling on packs should include meaningful information on product ingredients and emissions. Previously all cigarette packs sold in Ireland carried text-based warnings. Regulations were signed by the Minister for Health in December 2011 to provide for the introduction of combined text and pictorial warnings on tobacco products.

These warnings are an extremely cost-effective public health intervention, with pack-a-day smokers potentially exposed to the combined text and pictorial warnings 7,300 times a year. The regulations are therefore a further critical step in our on going efforts to encourage smokers to stop smoking and younger people not to take up smoking. In May of 2013 the Minister for Health announced that Government approval had been given to the development of legislation for the introduction of standardised/plain packaging for tobacco products. The key effects of this change will be to make the health warnings more prominent and effective, to reduce the ability of the pack to mislead people about the harmful effects of smoking and to make tobacco packs look less attractive to consumers.

As stated previously, children and young people typically begin to smoke because, as role models, adults encourage it. To actively counteract this, and to prevent children and young people from developing a smoking habit, it is important that health promotion programmes which address smoking are in place at an early stage of their lives.

Schools are a key setting for health promotion. The Health Promoting School (HPS), for example, provides an ideal model for the promotion of health and well-being. Through the HPS programme, and its four key areas for action many topics and issues, including smoking, can be addressed.

Smoking is specifically addressed through the substance use prevention education which is delivered through the Social Personal Health Education (SPHE) curriculum at both primary and post-primary level. At primary level, it is included in several Strand Units – Safety and Protection / Self Identity / Making Decisions/ Taking Care of My Body and Media Education. Through SPHE at post–primary level, the health and social implications associated with smoking are explored, together with the reasons why young people smoke and how smoking can be avoided.

As well as providing information about the product and its potential harm, this education focuses on the development of key skills relating to self-identity, decision-making and the ability to cope with a range of influences. At post primary level, in addition to SPHE, smoking is addressed through subjects such as Junior Certificate Science and Home Economics. Smoking should also be addressed in a school's substance use policy, a policy which all schools are required to develop.

In the new *Framework for Junior Cycle*[29] (October 2012) 'Wellbeing' is identified as one of the principles of the Framework. The learning at the core of the new junior cycle is described in twenty-four statements of learning which describe what students should know, understand, value and be able to do. In this context, the students will, *inter alia*, learn to take action to safeguard and promote their wellbeing and that of others.

RECOMMENDATIONS

- Increase investment in social marketing campaigns to warn about the dangers of tobacco.
- Enhance educational initiatives aimed at preventing young people from starting to smoke, in line with best international practice within the *Healthy Ireland* framework.
- Monitor the implementation of regulations for pictorial warnings.
- Undertake continued evaluation of campaigns and programmes.

ENFORCE BANS ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP

Studies have shown that tobacco advertising increases consumption. There is also evidence that children and young people are more receptive to advertising than are adults. Young people who are exposed to tobacco advertising and promotion are more likely to commence smoking. Adolescents who smoke are more aware of tobacco advertising than are their non-smoking peers.

There is strong evidence that advertising bans can lead to a drop in consumption of between 5 and 9%. Countries that have implemented comprehensive bans on tobacco advertising and promotion have reduced tobacco use at a much quicker rate and to lower levels than other countries.[30]

Advertising of tobacco products in Ireland is restricted under the Tobacco Products (Control of Advertising, Sponsorship and Sales Promotion) Regulations 1991, 1996 and 2000 and by the Public Health (Tobacco) Acts 2002 and 2004. In July 2009 all tobacco advertising and the display of tobacco products in retail outlets was prohibited. All tobacco products must now be kept out of view within a closed container which is only accessible to the retailer. Ireland was the first country in the European Union to introduce a ban on product display. Vending machines are only permitted in licensed premises or registered clubs and only under specific conditions. The measures introduced in 2009 also ended the placement of tobacco products in close proximity to everyday consumer goods, such as sweets and newspapers, and as well as being a very comprehensive and far-reaching body of legislation, will, over time, considerably assist on going efforts to de-normalise tobacco use in Ireland.

The tobacco industry has initiated legal proceedings in the High Court challenging key provisions in the 2009 measures including the point of sale advertising and display ban.

A survey conducted by the then Office of Tobacco Control[31] shortly after the introduction of the point of sale (POS) ban reported almost universal compliance (97%). Research published by the University of

29 http://www.education.ie/en/publication/Policy-Reports/A-Framework-for-Junior-Cycle-Full-Report.pdf

30 http://www.who.int/tobacco/mpower/

31 McNeill A, Lewis S, Quinn C, et al. Evaluation of the removal of point-of-sale tobacco displays in Ireland. Tob Control 2011; 20: 137–43.

Nottingham showed that amongst adults there was a 27% drop in the proportion who recalled seeing in-store tobacco displays, and the effect was greater amongst smokers than non-smokers.[31] The research confirmed the greater impact of POS displays on children, as prior to the introduction of the ban on POS displays a much greater proportion of children than adults recalled seeing tobacco packs (81 vs. 49%). There was a larger decrease in the proportion of children (60%) who recalled seeing in-store tobacco displays. There was a small but significant increase in the proportion of adult smokers who felt that the removal of displays had made it easier to quit smoking. There was also a decrease in the proportion of children who thought that more than 20% of children their age smoked, suggesting a possible effect on de-normalising smoking. These figures indicate that the 2009 legislation is further de-normalising smoking amongst children and will in the long term reduce childhood initiation.

Tobacco packaging is another persuasive advertising vehicle and tobacco companies invest substantially to exploit this opportunity fully and increase their brand's profile. Packaging is the tool that connects most directly with the consumer. Packaging has a persisting effect as the pack is retained by the smoker and is also displayed by the consumer in many conspicuous settings in the home or socially. Brand image, promoted by packaging, is particularly targeted at new young smokers, as older established smokers exhibit considerable brand loyalty. Brand identity can be promoted through brand logos, pictures, colours, fonts and pack shapes. Particular groups can be targeted such as young people and women. Packaging is also used to undermine the now obligatory health warnings and messages and to promote false beliefs that some products have less damaging health effects. Research has demonstrated how smokers relate brands and package designs to personal characteristics.[32] Young people use tobacco brands in portraying their own identity.

Australia has introduced legislation for the introduction of standardised/plain packaging which came into effect in December 2012. All cigarette products must be packaged in a generic green-coloured pack with no branding or design features. A number of EU countries are also considering the introduction of standardised/plain packaging. On 28 May 2013 the Minister for Health announced that he had received Government approval to proceed with the development of legislation for the introduction of standardised/plain packaging for tobacco products.

Smoking in films is now a major source of tobacco imagery in the mass media. There is considerable evidence that observing smoking in films and on television contributes to smoking initiation in young people. The National Cancer Institute in the USA[33] recently concluded that there is a causal relationship between exposure to depictions of smoking in movies and youth smoking initiation.

Despite the increased restriction of advertising and promotion the tobacco industry continues to reach new consumers through innovative marketing strategies including brand stretching, trade marketing programmes and the internet. It is important that there is on going vigilance in relation to tobacco industry activities to ensure compliance with all provisions, particularly the recently commenced sections pertaining to prohibitions on advertising. The introduction and enforcement of tobacco control legislation has been the subject of substantial legal challenge by tobacco manufacturers.

32 Moodie C, Stead M, Bauld L, McNeill A, Angus K, Hinds K, Kwai I, Thomas J, Hastings G, O'Mara-Eurs A (2012). *Plain tobacco packaging: a systematic review*.

33 National Cancer Institute. *The Role of the Media in Promoting and Reducing Tobacco Use*. Tobacco Control Monograph No. 19. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute. NIH Pub. No. 07-6242, June 2008.

RECOMMENDATIONS

- Continued implementation and monitoring of the national inspection programme is required in order to ensure compliance with all tobacco legislation.
- Review existing legislation to ensure that it is fit for purpose to deal with new and emerging measures and marketing programmes adopted by the tobacco industry.
- Robustly defend the legal challenge by the tobacco industry to the point of sale measures introduced in 2009.
- Develop legislation for the introduction of standardised/plain packaging for tobacco products.
- Work with the EU to ensure successful implementation of the proposed revision of the Tobacco Products Directive.
- Work with media regulators and the entertainment industry around the portrayal of smoking in the media.
- Monitor developments in relation to brand stretching at a global and European level.
- Examine and monitor the existing tobacco legislation to ensure that it is inclusive of contemporary forms of communications.

RAISE TAXES ON TOBACCO PRODUCTS

Robust evidence exists demonstrating that higher tobacco taxes and prices are the single most effective measure to reduce overall tobacco use; reduce prevalence of tobacco use among adults; induce current smokers to quit; reduce tobacco use among young people, particularly the transition from experimentation to regular use; lower the consumption of tobacco products among those who continue to smoke; improve population health; increase tobacco tax revenues; and produce additional public health benefits while not creating economic consequences. The FCTC specifically recognises the effectiveness of price and tax measures at preventing initiation in young people. An international group of health economists and tobacco control experts (PPACTE)[34] in their recent report called for an increase in the taxation of all tobacco products as the most effective way to make them inaccessible to consumers. The health gain from high-priced tobacco, however, can be adversely affected by the smuggling and sale of illicit tobacco products.

Ireland is one of the countries with the highest priced cigarettes and tobacco products in the EU. The most popular brand retails at €9.30 for a pack of 20 cigarettes. Taxation (excise and VAT) represents 78.6% of the retail price of cigarettes in Ireland. In the case of a 25g pack of roll-your-own (RYO) tobacco, taxation accounts for 79.9% of the retail price. A pouch of RYO tobacco, sufficient to make 25 cigarettes, currently retails for €10.15, 85 cent more than a 20-pack of cigarettes. Figures above provided by the Office of the Revenue Commissioners in March 2013.

In 2009 a European Court of Justice (ECJ) ruling found that the practice of setting a minimum price for cigarettes by Ireland to be in breach of Article 9(1) of Council Directive 95/59/EC. Primary tobacco legislation has been amended in order for Ireland to successfully comply with the ruling.

Where international and/or national evidence indicates reductions in smoking prevalence which can be linked directly to price increases, then increases in excise duty on tobacco products must be strongly considered. In 2012 the excise duty on a pack of twenty cigarettes increased by 25 cent and by 10 cent in 2013 and this increase was applied to other tobacco products on a pro rata basis. An additional 50 cent (VAT inclusive) was added to the price of a 25g pack of RYO, giving an overall increase of 60 cent (VAT inclusive) on this product.

34 http://www.ppacte.eu/

The health gain from high-priced tobacco needs to be supported by rigorous and sustained action against the illicit market in tobacco products.

The Office of the Revenue Commissioners view the illicit trade in tobacco products as a very serious matter, because of the threats that it poses to tax revenues, to legitimate law-abiding businesses and to the Government's policy of reducing smoking prevalence. Combating this illegal activity is a high priority for Revenue, and their work in this field has been guided in recent years by their *"Strategy on Combating the Illicit Tobacco Trade 2011-2013"*. The intention is that a further strategy will be put in place, when the current one comes to an end, to act as the strategic focus for the ongoing extensive work against the smuggling and sale of illicit products.

A 2011 survey carried out by the Office of the Revenue Commissioners and the HSE's National Tobacco Control Office reported that 15% of smokers were classified as having an illegal pack. A similar survey undertaken in 2012 found that the proportion of smokers classified as having such a pack was 13%.[35]

While these findings indicate that the level of consumption of illicit product is being contained, the Office of the Revenue Commissioners is determined to confront the illegal trade in tobacco products and to optimise levels of seizures of illicit tobacco product and to pursue those found to be involved in this illegal activity. Revenue's strategy for tackling the illicit trade is multi-faceted. It includes on going analysis of the nature and extent of the problem, developing and sharing intelligence on a national, EU and international basis, an on going review of operational policies, development of analytics and deployment of detection technologies and optimum deployment of resources both at point of importation and within the country to intercept internally the contraband product and prosecute those involved.

Revenue has also carried out a number of national tobacco blitzes, which concentrated additional resources at ports and airports and at various retail points throughout the State for the purpose of identifying and seizing illicit tobacco products. A number of arrests were also made and vehicles seized during these operations. Furthermore there is a close working relationship in place between the Customs Service and An Garda Síochána in tackling this form of criminality. Searches are regularly undertaken by the Gardaí as part of intelligence-led operations led by Revenue. An Garda Síochána also continue, on district and divisional levels, to target those involved in the sale and distribution of illegal products, at markets and via door-to-door sales.

Considerable success is being achieved against the illicit trade. Over 95 million cigarettes and more than 5,000 kilograms of tobacco were seized and there were 132 convictions for smuggling or selling illicit tobacco products during 2012. This action will continue to be a high priority for Revenue fully supported by An Garda Síochána.

The illicit trade in cigarettes is an international problem and, as such, countries cannot tackle the challenges posed in isolation from the global context. Revenue works closely with counterpart agencies in other countries and with international organisations, including the EU Anti-Fraud Office (OLAF), in combating this illegal activity.

Ireland is party to legally binding agreements between the EU and three major tobacco companies which aim to strengthen anti-smuggling measures. In addition, the Protocol to Eliminate the Illicit Trade in Tobacco Products was agreed at the FCTC Conference of the Parties in November 2012, and Ireland will sign and ratify that protocol.

35 http://www.revenue.ie/en/about/publications/annual-reports/2012/downloads.html

In terms of tobacco price and inflation, the World Bank has stated that the impact is modest. The WHO recommends that governments can reduce concerns about the potential inflationary aspects of tobacco price increases by using a price index that excludes tobacco products[36].

RECOMMENDATIONS

- The Departments of Health and Finance and the Office of the Revenue Commissioners are to work in closer collaboration in relation to fiscal matters relating to tobacco and on measures to reduce the illicit trade in tobacco.
- Annual excise duty increases on tobacco products should be applied over a continuous five year period.
- Increase duty on roll-your-own and other tobacco products to reduce the price differential between cigarettes and other tobacco products.
- Remove tobacco from the consumer price index.
- Introduce a tobacco industry levy or similar mechanism which could be ring fenced to fund health promotion and tobacco control initiatives including support to end the illegal trade.
- Consider the introduction of an environmental levy in the context of the Government's waste policy "A Resource Opportunity", the application of economic instruments and the review of producer responsibility.
- Continue collaboration with national and international partners on strategies to reduce illicit trade.

36 WHO Technical Manual on Tobacco Tax Administration. Geneva, World Health Organisation, 2011.

PART 2

Chapter 10

National and International Partnerships

PART 2
CHAPTER 10
NATIONAL AND INTERNATIONAL PARTNERSHIPS

It is widely recognised that no one single measure or no one single organisation can deal with the scale of the tobacco epidemic unilaterally. *Healthy Ireland – A Framework for Improved Health and Wellbeing 2013–2025* recognises the importance of partnerships across society and internationally in achieving our goals.

NON-GOVERNMENTAL ORGANISATIONS

Towards a Tobacco Free Society acknowledged the invaluable services provided by non-governmental organisations in the struggle against tobacco. This review endorses that view and re-iterates the importance of the work done by these agencies. It is important now more than ever when resources are strained for the statutory and non-statutory sectors to work together in our aim to move towards a tobacco free society.

RECOMMENDATION

- Government Departments, and state agencies including the Health Service Executive will continue to liaise and work with non-governmental organisations in order to achieve policy aims set out in this report.

INTERNATIONAL AND NORTH/SOUTH COOPERATION

The EU Tobacco Products Directive dates from 2001. New international, scientific and market developments required reflection on whether the Directive still fully guarantees an appropriate functioning of the internal market while ensuring a high level of health protection. In this regard the European Commission undertook a public consultation on the revision of the Tobacco Products Directive (2001/37/EC). The public consultation generated 85,000 responses. During its preparation, a thorough impact assessment was carried out, evaluating the economic, social and health effects of several policy options under consideration. Several external studies were commissioned during the process.

In December 2012 the Commission published a proposal for a new EU Tobacco Products Directive, the ultimate purpose of which is to reduce the numbers of people smoking. The proposal at the time of publication of this policy was being discussed by the European Parliament and Council of Ministers. The Commission has expressed the hope that it will be adopted by the European Parliament and Council in 2014.

This proposed tobacco legislation was the main health-related priority for the Irish Presidency from January to June 2013. The Minister for Health indicated his support for the measures outlined in the Proposal. The Irish objective was to build consensus and facilitate agreement among the Member States on the Commission's proposal during the Irish Presidency.

Areas covered by the new proposal include the following:

- Ingredients and emissions
- Labelling and packaging
- Traceability and security features
- Nicotine containing products
- Cross border distance sales of tobacco.

Specifically the draft Directive provides for, *inter alia*, larger public health warnings on packs, a total ban on flavouring such as menthol and maintaining the ban on tobacco for oral use. The proposal aims to ensure that provisions in the Directive are not circumvented by placing products on the market which are not compliant with the Directive.

The purpose of the WHO FCTC is to identify and progress the tobacco control measures that need to be introduced by national governments in order to protect public health. Nicotine is ranked by the World Health Organisation as more addictive than heroin, cocaine, alcohol, caffeine or cannabis and is consequently a notoriously difficult addiction to break.

Ireland played a significant role in drafting the FCTC Treaty which was ratified by the State in November 2005. Ireland is fully committed to its implementation.

The WHO has been instrumental in identifying and promoting many of the significant tobacco control public health measures that have been introduced including the Smoke Free at Work initiative and the advertising and display bans on tobacco products. The Conference of the Parties (COP) is the governing body of the WHO FCTC and is comprised of all Parties to the Convention. It keeps under regular review the implementation of the Convention and takes the decisions necessary to promote its effective implementation, and may also adopt protocols, annexes and amendments to the Convention. Observers may also participate in the work of the COP. Sessions of COP are held at two-year intervals.

The Protocol to Eliminate Illicit Trade in Tobacco Products, the first Protocol to the Convention, was adopted on 12 November 2012 at the fifth session of the Conference of the Parties in Seoul, Republic of Korea.

A number of guidelines have been developed under Articles 5.3, 8, 9, 10, 11, 12, 13 and 14[37] of the WHO FCTC to assist parties in the implementation of their obligations under the Treaty. These guidelines were taken into consideration when deciding on the additional measures needed. A number of other guidelines are currently being developed.

A new ten-year tobacco control strategy for Northern Ireland was launched in February 2012.[38] In line with Ireland's strategy a tobacco free society remains the overall objective. The strategy targets the whole population and focuses in particular on children and young people, pregnant women and their partners who smoke and the disadvantaged who smoke. The main objectives of the strategy are: fewer people starting to smoke, more smokers quitting and protecting people from tobacco smoke. The Public Health Agency in Northern Ireland has established a multi-agency implementation group to take the strategy forward.

37 Article 5.3 – Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry; Article 8 - Protection from exposure to tobacco smoke; Partial guidelines for Articles 9 and 10 – Regulation of the contents of tobacco products and regulation of tobacco product disclosures; Article11 – Packaging and labelling of tobacco products; Article 12 - Education, communication, training and public awareness; Article 13 – Tobacco advertising, promotion and sponsorship and Article14 – Demand reduction measures concerning tobacco dependence and cessation. http://www.who.int/fctc/en/

38 http://www.dhsspsni.gov.uk/tobacco_strategy_-_final.pdf

There is significant scope to share experiences in developing and implementing the range of tobacco control strategies in particular around research into childhood initiation into smoking, shared development of social marketing campaigns and research into what works in quit campaigns and the extension of smoke free public environments.

RECOMMENDATIONS

- Continued participation and engagement at EU level in the context of the revised Tobacco Products Directive.
- All Government Departments and state agencies should actively engage with and implement the WHO FCTC, the Protocol to Eliminate the Illicit Trade in Tobacco Products and the FCTC Implementation Guidelines.
- Collaboration with other national and international partners in the area of tobacco control should be continued to further develop the evidence base in support of new initiatives and to evaluate the impact of current measures.
- Collaborate on a North/South basis, in particular through the North South Ministerial Council, on measures to reduce tobacco consumption.
- Support greater national and international collaboration and participation on research programmes to strengthen the evidence base for new measures.

PART 2

Chapter 11

Next Steps

PART 2
CHAPTER 11
NEXT STEPS

The recommendations as outlined in this report will assist all those interested stakeholders from the political system, civil society, non-governmental organisations and the business sector in achieving our goal of having a tobacco free Ireland by 2025.

In order to ensure that these recommendations are implemented, a detailed action plan will be developed outlining the timeframes and responsibilities for the implementation of these actions.

As outlined in *Healthy Ireland* the creation of any positive change in health and wellbeing requires that the whole community, the whole of Government and all of society works in unison. Any successful tobacco control measure undertaken in the past is a result of just that – a common and accepted willingness to achieve a healthier society.

RECOMMENDATION

- Develop an action plan with timelines for the phased implementation of the recommendations in *Tobacco Free Ireland*.

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