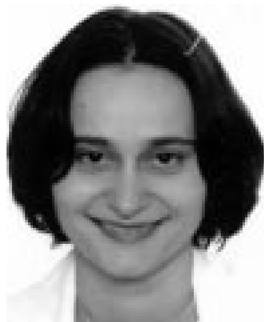
Tobacco use, a major public health issue in south-east Europe



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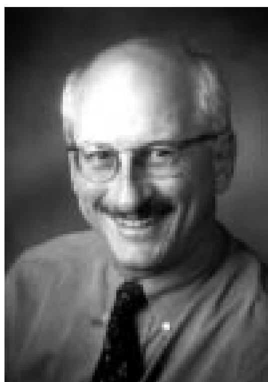

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South-east Europe (SEE), including the countries of Albania, Bosnia and Herzegovina (B&H), Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia, Romania, and Serbia and Montenegro, is Europe's poorest region. It has undergone enormous changes in the last 15 years with the demise of communism, conflicts among the countries of former-Yugoslavia, and economic deterioration. This considerably weakened the public health infrastructure, and thus, particularly in war areas, attention focused on providing care for the wounded and displaced and on controlling communicable diseases. With increasing stability, attention must now address the major preventable health problems facing the region. As a recent comprehensive review of tobacco control issues in SEE demonstrates,[1] SEE health authorities must prioritise tobacco as a public health issue. This paper, based on the above report, summarises the key issues for tobacco and health in SEE and makes recommendations for action.

The limitations of current data

A barrier to understanding the magnitude of the tobacco problem is the paucity of accurate health and lifestyle data. For example, although regular youth smoking surveys are now conducted in most countries of the region as part of an international collaboration, no SEE country performs routine behavioural surveys of adult tobacco use. Only market-based cigarette consumption data are regularly collected across the region, although their accuracy is limited by widespread cigarette smuggling.

There are also major concerns with the accuracy of data on the health impact of tobacco use. This concern relates in part to the scarcity of vital statistics, demographic, and health care data, but also to other systemic problems. For example, age-specific lung cancer death rates for the former-Yugoslav countries vary markedly from year to year and death rates from bronchitis, emphysema, and asthma in Romania increased almost three-fold after 1998 compared with the period 1995 to 1998. Chronic disease mortality rates do not generally fluctuate so widely over time. Therefore, in SEE, such data must be treated with caution

Smoking prevalence and tobacco consumption

The available youth smoking data, based largely on surveys of 15-year olds, suggest that smoking among boys ranges from 22% in the Former Yugoslav Republic of Macedonia to 53% in Bosnia and Herzegovina, similar to rates seen in European Union countries. Among girls, the range is from 10% in Romania to 47% in Bosnia and Herzegovina (below and above EU rates, respectively). Trends over time, available only for Croatia, show that the prevalence increased between 1995 and 1999 from 27% to 31% among boys and from 18% to 25% among girls.

Adult prevalence data have been collected from various specially commissioned surveys that differ widely in methodology, thereby limiting between-country comparisons. The available data nevertheless indicate that rates are lowest in Romania and highest in the countries of the former-Yugoslavia. Very high rates of smoking are seen among men (49% in Bosnia and Herzegovina, 46% in Serbia), while rates in women peak at approximately 30% in Bosnia & Herzegovina and Serbia. In the Former Yugoslav Republic of Macedonia, an estimated 40% of male and 32% of female physicians smoke, suggesting that rates in the general population may be even higher.

Historical data suggest that while smoking in men in SEE is a well-established addic-

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tion, smoking among women is relatively new but steadily increasing.[1] This finding is supported by data from Albania and Bulgaria, which show higher rates among younger compared with older women and a positive (albeit non-significant) relationship with education, a pattern traditionally seen early in the tobacco epidemic.[2,3] Moreover, in Albania the majority of female smokers reported that they had only been smoking for the last five years. Higher smoking rates in urban areas are also seen among women in Albania, Bulgaria, and Serbia,[1] suggesting that smoking is initiated more in cities, where advertising is likely to be more intense. Similar findings of higher rates among women in cities compared to rural areas and among younger compared with older women have been seen in the former Soviet Union (FSU).[4]

Cigarette consumption data, although of questionable accuracy, also suggest that consumption is increasing and that the rates in SEE are very high; 5% higher on average than in central and eastern Europe and 35.2% higher than in the EU.

Disease burden from tobacco use

Estimates of the health impact of smoking show that smoking is the leading cause of mortality and disability among men in SEE and the fourth leading cause among women.[5] The smoking-attributable proportions of death among men aged 35–69 in 1995 were 30.3% in Bulgaria, 32.4% in Romania, and 42.2% in the countries of the former Yugoslavia. Among women, the proportions were 7.7%, 5.3%, and 10.3% respectively.[6] In both genders, smoking attributable deaths have increased considerably over time and as female smoking rates continue to increase, so will female mortality from tobacco.

Despite concerns about its accuracy, lung cancer mortality data also indicate the high toll of tobacco use, most notably in Bosnia and Herzegovina, Croatia, and Serbia and Montenegro. The International Agency for Research on Cancer's data for 2000 indicates that countries of this region have some of the highest age-standardised male lung cancer incidence and mortality rates in Europe. The highest lung cancer incidence rates were seen in Hungary (95.5/100,000), followed by Croatia (82.5/100,000), Bosnia and Herzegovina (81.2/100,000), and Serbia and Montenegro (80.9/100,000).[1] In Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, female lung cancer incidence rates are now also higher than the western European average.

The tobacco industry

The countries of south-east Europe both grow and manufacture tobacco, and the tobacco industry, until recently dominated by state-owned monopolies, has traditionally been economically and politically influential. The collapse of communism and the opening of these markets to imports and private investment has led to the growing presence of transnational tobacco company (TTC) and other smaller but locally influential companies. These changes are of concern for public health, as increased tobacco market competition reduces prices, increases advertising (which was unknown in the communist era), and thus increases consumption.[7]

The TTCs already dominate the Romanian market. In the 1990s, Philip Morris, British American Tobacco (BAT), and RJ Reynolds (now part of Japan Tobacco International) all established factories in this nation. In 2003, Philip Morris also acquired the largest Serbian tobacco company, and BAT a smaller plant.[1] In the former Yugoslav Republic of Macedonia, the German manufacturer Reemtsma (now part of Imperial Tobacco) acquired one of three cigarette factories, and BAT and Philip Morris have expressed interest in the other two, which have been due for privatisation for several years. In Bosnia and Herzegovina, Japan Tobacco International acquired a 60% interest in the Mostar factory, and a subsidiary of Reemtsma entered a cooperative effort with the Banja Luka plant.

"Health authorities in south-east Europe must prioritise tobacco as a public health issue"

The private tobacco company Rovinj supplies almost all the legitimate domestic market in Croatia, and it has growing export markets in Bosnia and Herzegovina and in Serbia and Montenegro. BAT has acquired the smaller Croatian tobacco company Zadar, and in 2003 moved its regional office from Budapest to Zagreb. It is now negotiating the acquisition of Rovinj.[1] BAT's investments in Serbia and Croatia have occurred despite considerable criticism from European Union customs officials on BAT's alleged support of smuggling in the region.[8]

Many TTCs have expressed an interest in the failed privatisation of Bulgartabac, the Bulgarian state monopoly, which has been a major regional cigarette producer with large export markets in Eastern Europe. Albania is the only country in SEE without direct TTC presence, although manufacturing there has virtually ceased due to the enormous smuggling problem.

> *"Tobacco smuggling is a major issue"*

Smuggling of tobacco products

Tobacco smuggling is a major issue in SEE, with contraband cigarettes easily and cheaply available. Given that price is a major determinant of tobacco use, smuggling is a major barrier to effective tobacco control and deprives SEE governments of much needed income.

Officially recorded cigarette imports in SEE are considerably lower than official exports from the supplying countries.[1] It is estimated that up to 25% of total cigarette consumption in Croatia and Romania is unreported smuggled cigarettes. This figure is 38% in Bulgaria, 36.5% in Serbia and Montenegro, 40% in the former Yugoslav Republic of Macedonia, 47% in Bosnia and Herzegovina, and an estimated 80% in Albania.[9] Thus, smuggling is lowest in the country where the TTCs have the largest presence and official market share (Romania) and highest in Albania where they are absent. Given the evidence of the tobacco industry's complicity in smuggling this is unlikely to be a coincidence.[10,11]

Cigarette smuggling benefits TTCs in a number of ways. It stimulates consumption through the sale of cheap cigarettes, while the industry profits regardless of whether cigarettes are legal or illegal. It enables the TTCs to enter markets that would otherwise be closed to them, and it undermines local tobacco companies, making them easier and cheaper to acquire.

The smuggling problem in SEE is further facilitated by the possible direct involvement of government officials;[11,12] widespread corruption and organised crime; limited coordination between criminal justice and health agencies; limited regulatory, police, and judicial systems; weak border controls; and inadequate tobacco taxation policies. Without an improved rule of law and recognition by political leaders that the economies of their countries suffer from such laxity in the enforcement of trade and price policies, tobacco use will continue to cause increasing economic and human hardship throughout SEE.

Tobacco control

All the SEE countries now have inter-sectoral coordinating committees on tobacco. However, the extent to which government departments other than the ministries of health (finance, education, and internal affairs for example) are involved is inadequate. Moreover, only Bulgaria has developed a national action plan for tobacco. Civil society groups, which elsewhere play a vital role in tobacco control, are relatively new to the region, and often excluded from mainstream policy formulation or from meaningful leadership in tobacco control.

Although some SEE countries have quite strong tobacco control legislation on record, it is too often inadequately enforced. All countries have a complete ban on tobacco advertising on national television and radio, but many allow other forms of advertising or weakly enforce existing restrictions. Billboard advertising has been completely banned in Bulgaria, Croatia, the Former Yugoslav Republic of Macedonia, and Serbia and Montenegro, but the industry uses advertisements identical to banned cigarette advertisements with no cigarette seen in the display. Indirect tobacco advertising through brand stretching and sponsorship of events by the tobacco industry is completely banned only in Bulgaria, Bosnia and Herzegovina and Croatia, but again enforcement is a major issue.

Excise taxes are generally low, rates on the most popular domestic brands range from 33% in Romania to 49% in Croatia, compared with the 57% EU minimum. Thus, even legally traded cigarettes are cheap, and in almost all countries the most popular domestic brand costs less per pack than a kilo of apples and less than or the same as a loaf of bread.

Greater restrictions on smoking in public places and worksites and better enforcement of existing smoke-free legislation are needed, in addition, in many countries, to improved product labelling and regulation. Access to smoking cessation services is limited. Nicotine replacement therapies are not available in Albania, nor are cessation clinics in the Former Yugoslav Republic of Macedonia, Serbia and Montenegro and Albania. Although cessation clinics operate elsewhere, they are usually privately run and not covered by health insurance, thereby limiting accessibility.

Conclusions

These findings emphasise that tobacco is already a major threat to public health in SEE and that if current patterns prevail, its impact will worsen, with major cost implications for health systems and for the well-being of society in general. Urgent and comprehensive actions to curb tobacco use are therefore needed. This will require concerted action by governments in the region, to whom we make the following recommendations:

- Comprehensive national programmes on

preventing and reducing tobacco use should be developed as a public health priority and involve a wide range of government departments and non-governmental organisations (NGOs).

- Dissemination of information about the dangers of both active and passive smoking should be strengthened.
- Tobacco taxes should increase and consideration be given to allocating at least 1% of the revenue raised to fund tobacco control activities.
- Countries without comprehensive bans on direct and indirect tobacco advertising should enact them. Countries with such bans should ensure their enforcement.
- All countries should work towards ensuring smoke-free environments in public facilities and in the workplace.
- Action against smuggling must be prioritised.
- Access to smoking cessation services should be widened, ideally by making such services part of a basic health insurance package.
- Health professionals should play a more active role in tobacco control by urging their governments to recognise its importance and providing smoking cessation services. Medical undergraduate and post-graduate curricula should improve their coverage of smoking-related issues.
- Health professionals in SEE need to quit smoking before their advice will be taken seriously. Hospitals and clinics that are not already smoke-free should become so, and medical staff should be offered access to smoking cessation services.
- The development of new NGOs and support for existing NGOs with expertise in tobacco control and public health advocacy is essential.
- Data collection systems must be improved to provide regular and accurate data on tobacco consumption, smoking prevalence, knowledge and attitudes about smoking and accurate mortality and morbidity data. This will require, inter-alia, national surveys of smoking prevalence, national household surveys which can estimate expenditure on, and consumption of, legally and illegally purchased cigarettes and improved health data collection systems. Questions on smoking habits should be added to death certificates.
- Health impact assessments should be performed before further tobacco industry privatisation so that the potential negative impacts of privatisation can be identified and mitigated.
- The countries of SEE should be encouraged to sign and ratify the WHO Framework Convention on Tobacco Control.

"Tobacco control legislation is too often inadequately enforced"

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