



The Impact of Tobacco Control Policies in the EU: Comparing Old and New Member States

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Abstract: This paper compares the changes in the structures, process, and outcomes related to tobacco control and population health between (1) the “old EU” 15 members and (2) the recent 12 accession members, mainly from Central and Eastern Europe. Based on the stages of the Tobacco Epidemic Model and coercive policy transfer through the EU, we expect to find that policies in these two sets of countries will increasingly converge and that establishment of stronger tobacco control policies will improve population health indicators in both parts of Europe, but more rapidly in Accession members than in old-EU members. Utilizing a large data set from WHO Europe, we compare both groups from 1990 to the present. In the old EU, more restrictive tobacco control policies have been adopted over time through both internal member-state processes and through policy transfer from the EU. Accession countries had few discernible tobacco control policies in place, but increased their policies enacted through having to adhere to the *acquis communautaire* of the EU as well as through other processes. We find convergence between Older and Accession countries both in number of policies adopted and in several smoking and population health outcomes although longer-term differences between men and women remain in Accession countries. Europeanization in tobacco control appears in both groups of countries, but the “coercive policy transfer” of the Accession process apparently acts to speed up policy learning and outcomes in CEE countries.

INTRODUCTION: Reducing The Tobacco Toll through International Cooperation

The deleterious health effects of primary and secondary exposure to tobacco smoke, including almost a dozen cancers and chronic diseases such as cardio- and cerebrovascular disease, are well known.¹ Paradoxically, while tobacco use is the second leading cause of death worldwide, estimated to cause eight million deaths annually by 2030 and result in one billion cumulative deaths during the 21st century, is it also the most preventable cause of death.² As the cost of treating and caring for those afflicted by tobacco use or exposure continues to rise and place enormous burdens on societal resources, tobacco control and use abatement is paramount.

While the causal links between smoking and health were definitively established in the 1960s,³ tobacco control policies did not begin to proliferate in developed countries until the mid-1980s after a sustained period of “policy hesitancy”⁴ whilst smoking prevalence remained at or above 40 percent in some populations⁵ and consequent health effects reached epidemic proportions. The barriers to implementing effective tobacco control policy in the developed world, often supported and promulgated by the tobacco industry,⁶ have been formidable. However, as evidenced by the recent announcement from the United States that smokers now comprise, for the first time, less than 20 percent of the population,⁷ developed countries are beginning to experience some of the expected benefits from sustained efforts to implement comprehensive tobacco control policies: While efforts in developed countries remain ongoing, the traditional barriers to comprehensive tobacco control policies are slowly being overcome, including legal challenges from the tobacco industry and garnering public support. As such comprehensive policies are gradually enacted and the societal benefits progressively realized in developed countries, efforts are increasingly focused on understanding the emergence of the tobacco epidemic in the developing world. While the tobacco epidemic in the developed world has unfolded over decades approaching three quarters of a century, it is not unreasonable to ponder if the policy and public health lessons learned in developed countries can be transferred



to developing countries, allowing them to truncate their tobacco epidemic thereby foregoing at least some of the enormous societal costs of tobacco use in developing countries, arguably those countries least able to absorb such avoidable costs.⁸ That is, an implicit goal has become compressing, even “skipping”, stages in the Tobacco Epidemic Model, based on the history of the tobacco epidemic in developing countries.⁹

The Tobacco Epidemic Model consists of four stages. In Stage 1, lasting 1-2 decades, male and female smoking prevalence starts at very low levels but rises rapidly, though few if any tobacco related deaths are evident. In Stage 2, lasting 2-3 decades, male smoking prevalence rises rapidly and reaches levels far higher than that for females, peaking at 50-80% of the male population being smokers. By the end of this stage, tobacco attributable illness and deaths are rising rapidly, accounting for ten percent of all male deaths. Tobacco restrictive activities in this stage are poorly developed, and cessation support activities are uncommon. In Stage 3, the prevalence of male smoking begins to decline and the prevalence of female smoking plateaus, though smoking prevalence among younger women can reach levels close to that of males. Knowledge of smoking health hazards is more widespread, yet because of the latency between tobacco exposure and tobacco related illness and death, during this stage the incidence and prevalence of tobacco attributable disease continues to rise rapidly and peak at 25-30 percent of male mortality, with tobacco-proportionate mortality even higher in the middle-age groups.

However, as knowledge of smoking hazards spreads, the receptivity for tobacco control increases, and tobacco control activities become more organized, successful, and comprehensive. In the final stage of this epidemic model, smoking prevalence for both genders continues to decline at slow but similar rates, but smoking attributable death rates remain high – 30-35% of all male deaths and 40-45 percent of male deaths in middle age. While smoking attributable male death rates begin to decline in the latter phases of this stage, smoking attributable female death rates continue to rise, as female smoking prevalence peaked after that

for males. The focus of tobacco control activities becomes ensuring a smoke-free environment, including smoke-free workplaces. Likewise, smoking cessation efforts expand, though socio-economic differences in smoking prevalence and smoking attributable death continues.

Tobacco control policy, cited by Lopez *et al* as not emerging until Stage 3 of the epidemic yet considered vital to ameliorating the individual and societal burden of tobacco use, has been the focus of much research. Policy learning and diffusion, leading to adoption of similar policies in different jurisdictions through the transfer of not only effective, evidence-based policies but also knowledge about needed infrastructure and strategies, has emerged as a key element for the international convergence of tobacco control policies through international treaties and transnational tobacco control agreements.^{10, 11, 12} The most prominent example of this international strategy for tobacco policy convergence, an attempt to transfer policy from developed to developing countries, is the WHO Framework Convention on Tobacco Control (FCTC), the first global public health treaty. However, while the treaty has 168 signatories, it is yet unclear how successful the FCTC will be in implementing common, effective policies throughout the diverse membership.

A second example of a mechanism for international policy convergence is the European Union (EU) tobacco control policy *acquis communautaire*, the common laws and policies in effect throughout all members of the EU. In tobacco control policy as in other policy areas, the EU has the potential to function as a “giant policy transfer platform,”^{13, 14} with progressive countries exerting larger influence on EU-adopted policy through “uploading” state-level policy which then must be adopted, or “downloaded”, by laggard states.¹⁵ The tendency to policy convergence across EU member states over time process has come to be called “Europeanization”.^{16,17,18} For existing members of the community, the “Europeanization” of tobacco control policy has evolved over decades of negotiation, compromise, and, in some cases, legal battles¹⁹ with the community *acquis* now including myriad directives addressing warning labels, advertising and promotion bans, maximum tar yields, workplace air quality and

safety, protection from environmental tobacco smoke, and resolutions and recommendations to reduce tobacco use.^{20,21,22} For new members entering the community (accession countries), adoption of the tobacco control policy *acquis* is an obligatory requirement of successful admission unless a derogation (permissible delay in policy implementation) is granted. Thus accession of new members to the EU represents a unique opportunity to study “mandatory” policy diffusion²³ and the factors contributing to the successful reduction of the harmful effects of tobacco consumption in countries transitioning into a community of developed countries.

Twelve countries acceded to the EU in 2004/2007, ten of which were Central and Eastern Europe (CEE) countries emerging from collapsed Communist regimes and decades of social, political, and economic oppression.²⁴ For these countries, EU accession represented a way to advance and stabilize democracy and free markets, as well as advance public health, standards of living and, ultimately, quality of life. While most of these states applied in 1995 or 1996 they were not admitted to full membership until 2004 (10) or 2007 (2),^{25,26} meaning a ten-year period in which to absorb and adopt the EU tobacco control *acquis communautaire*. The purpose of the present study is:

1. Assess the extent to which tobacco control policy convergence has taken place coincident with the 2004 and 2007 accessions, and characterize the nature of convergence, if any;
2. Assess the extent to there has been ‘convergence’ in tobacco-related population health outcomes. Specifically, characterize how accession countries compare to “old” EU countries and whether accession facilitated “catch-up” with regard to the following tobacco-related population health indicators and outcomes:
 - i. Prevalence of smoking
 - ii. Tobacco consumption
 - iii. Smoking attributable death rates

iv. Lung cancer death and incidence.

The Development of Tobacco Control in Old and New EU Members

Most of the Accession members were post-Communist emergent economies for whom the collapse of the socialist regime in the late 1980s, followed by the rapid application for admission to the EU, created a plethora of orthogonal societal and individual pressures. In pre-collapse communist societies, the tobacco market could typically be characterized as being a monopoly of one, domestic producer. Advertising for tobacco products was virtually immaterial, as was advertising for any consumer good. The government controlled the price of the cigarettes, and the revenue stream from these products was not insignificant. Smoking was nearly ubiquitous and a cultural norm, especially for men. As late as 1983 in Poland, cigarettes were included as rations with worker paychecks, and while early official statistics are difficult to find, some have estimated that 65-75 percent of men in Poland smoked.²⁷ The health care system, health information, and the public health agenda were controlled by the government and while it was not forbidden for physicians or other public health or policy makers to discuss an alternate agenda, such groups and messages received little if any reinforcement, and therefore success was unlikely.

In the vacuum left in all aspects of society by the departure of the communist regimes in Central and Eastern Europe, Western-based transnational tobacco companies (TTCs) saw tremendous market potential. Based on tobacco industry documents, researchers have reported the strategies, tactics, and actions engaged in by the TTCs to take advantage of these opportunities.^{28, 29, 30} Pressured by shrinking markets in the West, TTCs sought new markets in CEE countries where acceptance for and dependence on the product were high (see below). The approaches included but were not limited to: taking over domestic tobacco companies and plants; fostering relationships with policy makers at various levels of government and assisting in filling information and funding voids left in the wake of communism; finding and

supporting “content experts” to inform and assist at every step of the policy process; funding research to support tobacco industry positions and claims, including research to discredit studies showing tobacco associated harm; and intense lobbying and other tactics to keep tobacco prices (including taxes) low, and advertising bans and content standards impotent or non-existent. Finally, a key tactic in the TTC strategy was the explosion of advertising, in all forms and venues, and often targeted at women and children. In societies unaccustomed to the promotion of consumer goods, cigarette images and other forms of advertising appeared everywhere, promoting cigarettes and smoking as a normal and necessary accoutrement to everyday life.


EU Accession was an elaborate but compressed process, leading from formal application to acceptance of candidacy status to negotiations about how well the entrance requirements for membership were being met in different policy areas, to formal votes on entrance by EU institutions as well as the individual candidate members. As noted previously, although most states applied in 1995 or 1996, they did not become members until 2004 or 2007. The terms of membership were laid down by the EU, which further determined whether applicant countries had met them.^{31,32} Accession countries, lacking experience and infrastructure in some policy areas, especially tobacco control largely were policy takers; only once they had become full members of the EU did they have more leeway to become policy shapers as well.³³

Part of the *acquis communautaire* was the EU program on tobacco control. Starting in the mid-1980s, the EU as an organization began to pursue restrictive tobacco control policies through legislation (directives) and recommendations to its then-12 (15 in 1995) member states, in addition to policies developed at the state level or below, a process of multilevel governance.^{34,35} While the effects of EU policy adoptions might be expected to vary on older, established members depending on their own previous policies, it could be expected to have

considerably more influence on policy adoption and health outcomes in newly joining members without a substantial history and infrastructure in this policy, which is where almost all Accession countries found themselves. Thus, by both proximity and, more importantly, the process of joining the EU on terms that the EU controlled, this organization could be an obvious source of learning to shortcut the tobacco epidemic. While other factors, domestic and international, may have affected tobacco control policies in Accession countries, application for EU membership and the entire Accession process concentrated the minds of these countries on meeting EU common policies on tobacco control.


MATERIALS AND METHODS

All 27 EU countries are listed in Table 1, with their dates of application and admission. All countries were included as permitted by data availability; Cyprus was excluded from all analyses due to the absence of data for almost all indicators. Donabedian's structure-process-outcome conceptual model,³⁶ which argues that outcomes can be neither understood nor changed without knowledge of the structures and processes from which they result, guided the selection of variables to include in this analysis. Selected outcome variables were as outlined above: smoking prevalence, consumption, mortality rate due to selected smoking-related causes; and mortality rate due to and incidence of in trachea, bronchus, or lung cancer. Selected process variables included: the cost and the variation in the price of cigarettes; and an assessment of the number, timing, and type of tobacco control policy instrument adoption (described below). Finally, structural variables were selected based on their relevance to public health and their ability to frame and assist in interpreting the results of this analysis. Selected structural included: real GDP (\$PPP, USD), infant mortality rate, and spending on health care as a percent of GDP. A description of each indicator is included in Table 2, along with the publically available data source for each variable.



Data from the public sources were downloaded and reconstituted in an MS Access® database. After data manipulation and processing, data were exported for statistical analysis. Data were abstracted starting in 1990. To compensate for non-uniform collection times (i.e., different collection/reporting times in different countries), values were first averaged across five year intervals for each country. For the purposes of this analysis, countries were considered aggregately as an “Older EU Member” or an “Accession EU Member”. While variation in structural, process, and outcomes indicators has and continues to exist within these groups, the primary goal of this analysis was the comparison of the progress of the accession countries to the “average” established community standard. The period of 1990-1994 is considered the “baseline” time period as it both corresponds with the time frame when accession began to be considered for several countries, leading to the Copenhagen Criteria adopted by the EU in 1993 for assessing the applications for membership, and it is also the first time period for which complete data were available. The subsequent time periods of 1995-1999, 2000-2004 and 2005-2007 (the last year for which data, though not from all countries, were available) were also considered.

Information about a country’s tobacco control policy status and activity was obtained from the WHO-Europe Tobacco Control Policy database. Information about select policies in five policy areas was included: direct advertising (6 specific topics), indirect advertising (2), product distribution (3), smoke-free public spaces (7), and smoke-free public transit (4). Price of cigarettes, an important element of tobacco control policy, is considered separately below. Although the EU has been harmonizing tobacco excise taxes since 1972, most Accession countries received derogations (delays) upon their entry into membership, and prices still vary considerably in both old and new EU members.^{37, 38} A simple scoring system was devised that assigned 0.5 points if the specific topic was addressed by a policy restriction and 1.0 if the specific topic was addressed by a policy ban; voluntary agreements were not scored. A total of 22 points were possible. A country’s policy status – as a score out of a possible 22 points – was



assessed for each of the four time periods included in the study. The duration of tobacco policy activity was created for each country by subtracting the year of the first tobacco policy listed in the WHO database from 2007. Additionally, a variable counting the number of distinct tobacco control policy pieces of legislation (a count of the number of distinct years of policy instrument implementation as listed in the database) was included as a proxy for the sustained presence of tobacco control on the policy agenda. Finally, a ratio was created by dividing the duration of policy activity by the number of policy instruments to serve as a proxy for the level at which tobacco control policy activity was sustained on the policy agenda. Of final note, it was the intention of these scores to facilitate a quantitative assessment of the relative status of countries with regard to tobacco control policies for different time periods. The authors acknowledge that other scores for this purpose have been developed, specifically the Tobacco Control Scale (TCS) by Joosens and Raw.³⁹ It is not our current intent to replace or improve upon the TCS. However, as the TCS was calculated from some non-publically available data sources and for only one time period, we were required to develop an alternate, proxy summation score that would allow us to quantify policy and policy change over different time periods. For the score used in the current analysis, the correlation for the 2000-2004 time period score was 0.526 ($p=0.003$) with the TCS score.


All analyses were performed in SPSS[®]. The differences in means between old and new EU member countries were assessed at each of the study time periods for each variable. Where tests of statistical significance are presented, $p<0.05$ is used as the standard for determining a statistically significant difference.

RESULTS

Fifteen Older EU countries and eleven Accession countries were included in this analysis. As shown in Table 3, both Older and Accession countries experienced statistically significant growth during the 15-year study period. However, for each of the three variables selected – real GDP, infant mortality, and health care spending – Accession countries remained statistically significantly below Older countries. Change in Accession countries during the study period did not result in any reduction of the difference.

Table 4 summarizes the changes in prices and policies in Older and Accession EU countries. While time points for price data are somewhat different compared to other metrics, it is still possible to observe a trend in price changes. In 2001, the price of the most popular domestic cigarette was cheaper in Accession countries than in Older countries, though there was no difference in the price of an international brand cigarette. Additionally, while Older countries demonstrated consistent and increasing price increases, price increases in newer countries were less consistent. In 2000/2001 there was a price decrease in Accession countries followed by a substantial increase (larger than in Older countries) in 2001/2002. Further, while the average price increase from 1997/2001 was similar between Older and Accession countries, the average price increase from 2001/2005 was larger in Accession countries, approaching statistical significance.

With regard to tobacco control policy instruments, Older countries had significantly more policy elements in place compared to Accession countries during the baseline time period. However, this gap closed by the second (1995/1999) time period, and the number of policy instruments was not significantly different thereafter. Based on evaluation of the proxy variables, tobacco control policies had been on the policy agenda longer and more often than in Accession countries. This was particularly noticeable for policies addressing smoking in public areas and direct advertising policies, where Older countries had these types of policies in place for five and seven years longer, on average, compared to Accession countries.



Measures of intermediate health outcomes, in particular the specific targets of tobacco control policy – cigarette consumption and smoking prevalence, are compared in Table 5. Generally, this was a period of significant decline in smoking for many Older and Accession countries. While the average annual per capita cigarette consumption was slightly higher in Accession countries compared to Older countries, the difference was not statistically significant during any time period. Similarly, the overall prevalence of smoking was not different between Older and Accession countries during any of the study time periods. However, results from the examination of gender-specific smoking prevalence suggested a different pattern. Fewer women in Accession countries smoked compared to women in Older countries, and there was no detectable change in the prevalence in either group of countries during the study period. In contrast, while the prevalence of smoking in men in both groups of countries decreased during the study period, the prevalence of smoking in men in Accession countries started higher and remained higher throughout all study periods compared to men in Older countries.


Table 6 summarizes the comparison between these two groups of countries for the selected measures of population health outcomes. Standardized death rates due to selected smoking-related causes decreased throughout the study period for the total population, men, and women in both Older and Accession countries. However, for all three groups, death rates started and remained higher in Accession countries compared to Older countries. The difference in the death rates between the two country groups remained mostly constant throughout the study time periods for all three population groups, with the death rates in Accession countries averaging 1.5–2 times as high as in Older countries. Death rates attributable to trachea, bronchus, or lung cancer were largely unchanged during the study periods and similar in both sets of countries. However, while the incidence of these three diseases was also not different in Accession and Older countries during the study periods, there was a trend toward a flat incidence rate in Older countries but an increasing incidence rate in Accession countries.

In Table 7, countries are ranked based on their change in smoking prevalence during the study periods; countries with the highest decrease (most improvement in intermediate measure of population health) listed at the top. Countries in the bottom strata of the table experienced an increase in smoking prevalence during the study periods. There was not a statistically significant association between country group and prevalence change group (i.e., prevalence decreased or prevalence increased) or average change in prevalence (not shown). That is, Accession countries were just as likely as Older countries to have experienced a decrease (or increase) in smoking prevalence during the study period, and the change was similar in both groups, with the exception of female smoking prevalence, where the average increase in Accession countries (n=4) is strongly influenced by very large increases in Latvia and Lithuania.

Finally, Table 8 summarizes the results for a multiple regression analysis predicting the change in prevalence for the total and male populations over the entire study period, as well as the smoking prevalence in women for 2000-2004 only. These models explained 20-30 percent of the variance in the dependent variable. Change in health care spending (but not change in real GDP or infant mortality rate), combined with a ratio of the duration of policy activity to the number of policy instruments, maximized explanation of the dependent variable.

DISCUSSION


This study examined the extent to which there has been convergence in tobacco control policies and associated measures of population health between Older EU countries and the 2004 and 2007 Accession countries. Based on the results of the analyses presented here, there has been clear convergence in the number and types of tobacco control policies. Consistent with *a priori* expectations, Older EU countries had more policies in place during the study baseline period, but there was no difference in the number of policies for the remainder of the study time periods. Results suggested that baseline differences were related to sustained tobacco control policy activity, especially restrictions and bans on smoking in public areas and direct advertising, which have been in place in Older EU countries significantly longer compared



to Accession countries. The recent studies by Joossens and Raw⁴⁰ find similar trends of upward convergence. The 18 West European countries (15 EU members) rated slightly higher than the 12 Accession members, with 2006 medians of 53.1 versus 47.8. In 2005 the median scores were 48.4 and 42.8, respectively. While the current study cannot attribute causation, it appears that with regard to tobaccocontrol policies, EU accession was associated with a statistically significant policy downloading and policy convergence with Older countries, one which occurred relatively swiftly upon application for EU membership.

Results presented here suggest, however, that overall smoking prevalence is not different between older and newer EU members. Smoking in women is actually lower in Accession countries whereas smoking in men is higher compared to Older countries. Framing these observations within the Lopez et al. Tobacco Epidemic Model, based on declining male and female smoking, as well as declining smoking-related mortality rates, Older countries appear, on average, to be in late Stage 3 – Stage 4 (final stage). Classifying Accession countries, however, is more challenging. In some respects their smoking patterns, especially the male-female gap, are reminiscent of Stage 2. Perhaps the accelerated tobacco control activities continuing from the Accession process will bring down the male pattern while stifling the uptake of smoking by younger women. Latvia and Lithuania may have the worst smoking outcomes for women because of their tobacco taxes, lowest in the EU.⁴¹

In light of the aforementioned social pressures for tobacco use in post-Communist societies, results for smoking prevalence in Accession countries could be interpreted as encouraging. While smoking is higher in men compared to Older countries, it is declining, and smoking in women is both lower compared to Older countries, and flat (i.e., not increasing). Referring again to the stages of the Tobacco Epidemic Model, it appears that, on average, Accession countries are in Stage 3 of the epidemic model and some countries may be in Stage 4 (based on declining mortality rates).



Other points to fit in but I'm not sure how:

1. Hedge on data--FN
2. Modeling relationship b/t policy and difficult given unknown time lags--FN
3. Don't account for country-based policy preferences / tolerances and public image of smoking


CONCLUSIONS

This study confirms that Europeanization of tobacco control policy has occurred in both Older and Accession members, but more rapidly in the latter. While outcomes are becoming more convergent, some differences remain. In this policy area, the EU has acted as a giant policy transfer platform, a seemingly coercive one for Accession countries although we do not examine the process of policy transfer internally for individual members.

Most Accession countries in this study did not have prior tobacco control policies in place and adoption of EU tobacco control *acquis communautaire* represented a substantial obligatory “policy download.” The environment of increased tobacco control restrictiveness, combined with general social advancement, resulted in improved smoking-related population health (decreased prevalence and consumption, reduce smoking and related cancer SDRS). However, the increase in cancer incidence in accession countries likely foreshadows future upward pressure on tobacco related death rates due to the long incubation period for this disease.

The results of this present study must be interpreted in the context of social disruption in CEE countries. In their fledgling democratic state, most Accession countries relied upon the EU not only as a facilitator of policy learning, but also as a source of legitimacy and countervailing influence in their domestic struggles against the sophisticated tactics of aggressive transnational tobacco companies. The “opening” of these societies after the fall of Communism also meant access for other intergovernmental and nongovernmental public health groups to support nascent domestic anti-tobacco initiatives.⁴²

In conclusion, in examining progress in implementing comprehensive tobacco control policy and related population health outcomes, this study has provided some initial evidence that the EU has assisted in advancing this cause in Accession countries. As with all studies, the present study is limited by the quality of the publicly reported data, and was not able to account for processes of policy enforcement.



Nevertheless, this study has presented *prima facie* evidence that the process of “unequal negotiation” during the Accession process enables the EU to force applicant members to adopt tobacco control policies that harmonize with those of existing EU members. As noted earlier, however, once they are full members of the EU, they become part of the internal decision making process for further EU policies. Going through the Accession process is beneficial for stronger tobacco control policies and population health in the applicant countries. But the answer to the larger question about whether the deleterious consequences of progression through the tobacco epidemic can be effectively short-circuited through continuous policy learning lies in the behavior of these countries as full participants in both the uploading and downloading of policy once they are within the EU.



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⁴⁰ Ibid.

⁴¹ European Commission, op. cit.

⁴² Lipand, op. cit.