

TIGHTENING TOBACCO CONTROL LEGISLATION IN MALTA: A NATIONAL HEALTH PROMOTION INITIATIVE ON SMOKING

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ABSTRACT

Introduction: In Malta, individual smokers, doctors and the adult general public are recognising the ill effects of smoking, and are seeking to do stng adults and, more importantly, to trigger off a similar reduction among adolescents, with a consequent protection against disease and death.

Method: Local initiatives against smoking were compared to the WHO - World Health Organisation's Ten-Point Programme for Successful Tobacco Control, to a WHO model law for comprehensive tobacco control, and to European Union directives and resolutions.

Results: While procedures involving health education, smoking cessation, professionals' smoke-free example, and fiscal policies are all being implemented, Maltese tobacco control laws and regulations are still deficient.

Conclusion: A health promotion strategy of tightening tobacco control legislation needs to be introduced in Malta forthwith. This includes strict enforcement, more severe penalties, banning of sales to adolescents and in places frequented by them, the prohibition of smoking in enclosed public places, a total ban on advertising and sponsorship, and the introduction of maximum tar-yield levels and conspicuous and effective health warnings on all tobacco products. An overall priority is the setting-up of a coordinating tobacco control authority to effectively manage all efforts to stem the tobacco epidemic.

Keywords: Tobacco control, legislation, Malta, health promotion.

INTRODUCTION

The Ottawa Charter for Health Promotion describes health promotion as "the process of enabling people to increase control over, and to improve, their health"¹. It consists of the informed application of any combination of interventions (educational, legal, fiscal, economic, environmental and organisational) designed to facilitate the achievement of health and the prevention of disease. Health promotion can work at three levels: at the *primary* level to prevent illness or maintain health; at the *secondary* level to stop or reverse the process of illness; and at the *tertiary* level to prevent long-term sequelae or ameliorate the effects of illness².

After undertaking an assessment of needs in respect of tobacco and health in Malta, this initiative goes on to set appropriate aims and objectives. Strategies of intervention are then recommended, followed by methods of evaluation and feedback.

NEEDS ASSESSMENT

Purpose

A need is something people could benefit from. Just as a doctor systematically assesses the needs of a patient before prescribing the effective treatment, the optimal utilisation of the resources of health services (including health promotion) depends on a systematic assessment of the healthcare needs of the population³. Any worthwhile health promotion initiative

therefore should target an issue that has an appreciable effect on health.

Smoking is such an issue. The World Health Organisation has stated: "Tobacco products have no safe level of consumption. They are the only legal consumer products that cause ill health and premature death when used exactly as the manufacturer intends. Unless concerted action is taken quickly, 250 million of today's children will die prematurely from an avoidable cause - tobacco use."⁴ In Malta smoking is considered as the foremost preventable cause of premature death and disease⁵.

Process

A comprehensive assessment will include ascertaining the views of the professionals and the needs of the general public and the individual smoker.

The professionals' view

The role of health-care personnel is important in setting a non-smoking example to the public in general and their patients in particular. While in 1989 25% of Maltese doctors smoked⁶, preliminary results of a 1999 survey of members of the Medical Association of Malta revealed that this percentage has dropped to 13% (unpublished data). A study carried out in 2000 for EUROPREV (European Network for Prevention and Health Promotion in Family Medicine and General Practice) showed that 12% of family doctors in Malta smoke cigarettes while 3% smoke cigars or the pipe (unpublished data).

The general public

According to World Health Organisation figures, in the early-to-mid 1990s 42% of males and 24% of females in developed countries smoked, while in developing countries the corresponding percentages were 48% and 7% respectively⁷. The morbidity and mortality effects of smoking are well known. According to WHO estimates, there are currently 4 million deaths a year from tobacco, a figure expected to rise to about 10 million by the 2020s or early 2030s. By that date, based on current smoking trends, tobacco is predicted to be the leading cause of disease burden in the world, causing about one in eight deaths. Seventy per cent of those deaths will occur in developing countries⁸.

In Malta, while 54% of 25-64 year old men and 20% of women (of the same age) smoked in the mid-1980s⁹, in 1995 this percentage for men dropped to 38% with that for women only marginally decreasing to 17%¹⁰. Among Maltese adolescents too, cigarette smoking is common: 31% of the 20,815 schoolchildren aged 11-16 who took part in a Caritas/Pride/DISCERN Survey stated that they had smoked at least one cigarette in 1990¹¹. A follow-up survey in 1998 of a sample size of 1,100 schoolchildren showed that cigarette use was still high at 32%¹².

The WHO calculates that smoking causes 90% of cancer of the trachea, bronchus and lung, 75% of chronic bronchitis and emphysema, and 25% of ischaemic heart disease. Applying these percentages to local reported deaths from these diseases, the number of yearly deaths in Malta attributable to smoking had risen by 28% from 289 in 1987 to 371 in 1999, i.e. *one death every day* (Agius Muscat, H., personal communication).

Passive smoking (environmental tobacco smoke - ETS) is an established cause of disease and death. The harmful effects include asthma, middle ear infection and bronchitis or pneumonia in children, heart disease and lung cancer¹³. Researchers from the University of Minnesota Cancer Center reported a derivative of a tobacco-specific lung carcinogen (NNK) found in the urine of non-smokers exposed to ETS under real-life conditions, reportedly the first hard evidence of how passive smoking can cause cancer (214th National Meeting and Exposition of the American Chemical Society, Las Vegas, Nevada, USA, Sept. 7-11, 1997). A comprehensive meta-analysis of ten cohort and eight case-control studies has concluded that exposure to ETS in the home or workplace increases a person's risk of coronary heart disease by about 25%¹⁴. A phone-in survey carried out in Malta indicated that 77% of callers to a popular local television programme were against smoking in public places¹⁵. Even Malta's members of parliament have designated all indoor areas of the House of Representatives in the Presidential Palace, Valletta as smoke-free zones (apart from specially designated areas)¹⁶. This shows that the majority of the Maltese population have come to appreciate such dangers of ETS.

The individual smoker

In a study of the smoking habits of applicants for smoking cessation clinics in Malta, it was found that:

- 38% smoked all the time and everywhere,
- 15% when nervous, upset or angry,
- 12% with or after food or drink, and
- 9% at work.

Seventy-two per cent of smokers thought they would be much

healthier after quitting. This cohort of smokers also expressed a strong desire to quit, as shown by the results that about nine out of ten believed in quitting with help and had tried quitting more than once. Over half thought they would not be smoking a year later¹⁷.

Conclusion of needs assessment

It may therefore be said that individual smokers, doctors and the adult general public are recognising the ill effects of smoking, and are seeking to do something about it. This is however not the case with adolescents, where smoking in 1998 remained at the same level it had been eight years previously. There is an evident need for a health promotion initiative on smoking to accelerate the reduction in smoking among adults and, more importantly, to trigger off a similar reduction in smoking among adolescents.

SETTING AIM AND OBJECTIVES

Aim

The aim of this initiative is the improvement of the health status of the Maltese population in general (primary prevention) and of smokers in particular (secondary and tertiary prevention).

Objectives

In chapter 27 (entitled 'Tobacco Use') of 'Healthy People 2010', the United States' health goals for this decade, no less than 21 objectives are enumerated regarding tobacco use alone¹⁸, while the WHO document Health21 lists 21 general objectives¹⁹. On the other hand, the UK Department of Health's 'Saving Lives: Our Healthier Nation' rejects "the previous Government's scattergun targets" and limits its objectives to

priority areas, setting “tougher but attainable targets”²⁰. This is precisely what this strategy plans to do.

While the chance of getting a myocardial infarction is halved 24 hours after stopping smoking (British Medical Association Annual Scientific Meeting in Malta, 22-26 September 1992), according to a U.S. Surgeon General Report the added risk of disease suffered by smokers is reduced by a half or more within one year of quitting, and then declines more slowly to reach the risk of a never-smoker after some years²¹. A recent UK study in fact concluded that quitting smoking before middle age avoids more than 90% of the risk attributable to tobacco²².

Therefore, based on recent French experience following the introduction of tough tobacco control legislation²³, the first objective of this initiative is:

Objective 1: The reduction of the number of smokers in the general population by 15% over 5 years.

The measures proposed for this objective include:

Direct Measures:

- Population survey through the national census (next due in 2005);
- Targeted surveys, such as repetitions of those of adolescents carried out previously^{11, 12}.

Proxy Measures:

- Sales of tobacco (taking sales to the tourist population as a constant factor);
- Sales of smoking-cessation pharmaceuticals;
- Applications for smoking cessation clinics organised by the Health Promotion Department of Malta;
- Participation rates in ‘Quit & Win’ campaigns, also

organised by the Health Promotion Department.

The second objective is based on the targets set by the UK Department of Health²⁰ and comprises:

Objective 2: The reduction of mortality rates from smoking-related diseases:

- *respiratory cancer in people under 75 years by 20% over 15 years;*
- *chronic bronchitis and emphysema in people under 75 years by 30% over 15 years;*
- *coronary heart disease in people under 75 years by 40% over 15 years.*

Yearly mortality rates of the above diseases are a *direct measure* of this objective and may be obtained from the National Mortality Register kept at the Malta Department of Health Information.

DEFINING THE STRATEGY

From the WHO Ten-Point Programme for Successful Tobacco Control⁴ (see Table 1), point 4 emphasises the importance of **health education, smoking cessation** and the **smoke-free example** of healthcare professionals. This point is being actively pursued by the Health Promotion Department through a number of educational and other activities, amongst which the organisation of smoking cessation clinics since 1991¹⁷. As regards smoke-free example, the needs assessment (above) has shown a drop by one-half in the smoking rate among doctors over the past ten years.

The other nine points of the programme refer to **public policy** issues. Points 2, 3 & 9 concern the use of **fiscal policies** to discourage the use of tobacco, of tobacco taxes to finance other tobacco control measures, and of economic alternatives to tobacco growing and manufacturing. While the last of

W.H.O. TEN-POINT PROGRAMME FOR SUCCESSFUL TOBACCO CONTROL	
1.	Protection for children from becoming addicted to tobacco.
2.	Use of fiscal policies to discourage the use of tobacco, such as tobacco taxes that increase faster than the growth in prices and income.
3.	Use a portion of the money raised from tobacco taxes to finance other tobacco control and health promotion measures.
4.	Health promotion, health education and smoking cessation programmes. Health workers and institutions set an example by being smoke-free.
5.	Protection from involuntary exposure to environmental tobacco smoke (ETS).
6.	Elimination of socioeconomic, behavioural and other incentives which maintain and promote use of tobacco.
7.	Elimination of direct and indirect tobacco advertising, promotion and sponsorship.
8.	Controls on tobacco products, including prominent health warnings on tobacco products and any remaining advertisements; limits on and mandatory reporting of toxic constituents in tobacco products and tobacco smoke.
9.	Promotion of economic alternatives to tobacco growing and manufacturing.
10.	Effective management, monitoring and evaluation of tobacco issues.

Table 1: WHO Ten-Point Programme for Successful Tobacco Control⁴

the three may not be so relevant to Malta, tobacco taxes *have* been raised annually over recent years. In fact, tax increases have been shown to be the single most effective intervention to reduce demand for tobacco²⁴. A further step to be implemented is the channelling of part of such taxes towards the funding of health promotion and medical research²⁵, and towards the replacement of sponsorship of sports and cultural activities currently supported by the tobacco industry.

The remaining six points of the WHO Programme concern **legislation**: the banning of sales to and advertising targeted at children; protection from involuntary exposure to environmental tobacco smoke; the elimination of socio-economic, behavioural and other incentives which maintain and promote the use of tobacco (including direct and indirect tobacco advertising, promotion and sponsorship); controls on tobacco products, including prominent health warnings on tobacco products; and limits on and mandatory reporting of toxic constituents in tobacco products and tobacco smoke. Effective management, monitoring and evaluation of these tobacco issues are essential.

After comparing the local situation with international experience and evidence, it is evident that local tobacco control laws and regulations are still deficient, and this health promotion initiative on smoking thus proposes the tightening of such legislation as its strategy for Malta.

Health promotion approach & practice-model

Changes in tobacco use can be brought about in the environment and social structures using an authoritative/collective model with a top-down and expert-led approach, as long as

necessary preparations are made for political backing and public support^{26, 27}. While the tobacco industry advocates self-regulation, it is well known that the implementation of a tobacco control policy depends on legislation that is comprehensive, closely monitored and strictly enforced²⁸. As declared by Simpson, "the evidence that tobacco control policy cannot achieve maximum effectiveness without legislation becomes more abundant every year"²⁸.

International experience and evidence

Every country has to work out a specific strategy that is prepared taking into account international factors. Existing legislation in Malta was compared to a model of legislation for comprehensive tobacco control recommended by the World Health Organisation (Collishaw, N. E., former Acting Chief, WHO Tobacco or Health Unit, personal communication). The purpose of this model "is to provide a legislative response to a national public health problem of substantial and pressing concern and, in particular,

- (a) to protect the health of the people in the light of conclusive evidence implicating exposure to tobacco smoke in the incidence of numerous debilitating and fatal diseases;
- (b) to protect young persons and others, to the extent that is reasonable, from inducements to use tobacco products and consequent dependence on them;
- (c) to enhance public awareness of the hazards of tobacco use by ensuring the effective communication of pertinent information to consumers of tobacco products;
- (d) to protect people to the extent that is reasonable and possible from the

hazards of involuntary exposure to tobacco smoke; and

- (e) to regulate tobacco products and the distribution of these products in a way that is consistent with public health goals."

Investigations by Joosens²⁹ have concluded that a wide tobacco control strategy, incorporating advertising bans, is needed to maintain the downward trends in consumption shown to have followed a ban in tobacco advertising³⁰. The WHO document Health21 states that, together with greater availability of treatment products and cessation advice, the tighter regulation of tobacco products and a ban on the advertising and sponsorship of tobacco products will reduce the annual toll of up to 2 million deaths expected during the next 20 years¹⁹. The same document goes on to cite a case in point, namely the Evin Law in France. Five years after the introduction of this 1991 law (which banned cigarette advertising, created smoke-free public places and increased prices), cigarette consumption in France had fallen by 16%²³. Thus, effective legislation does seem to reduce tobacco consumption.

Legislation in Malta: present and proposed

Regarding local legislation on smoking and young people, at present this simply bans the selling of tobacco to those under 16 years of age. Besides voluntary measures against ETS taken in selected cases (Air Malta European flights, one guest-house, a handful of restaurants and some workplaces), smoking is presently only banned in public transport, cinemas, theatres, hospitals, clinics or other health institutions, local television studio broadcasts and schools. Advertising is prohibited on television, radio (or other broadcasting medium) and in cinemas, but

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there are no controls on sponsorship by tobacco companies (with a prominent tobacco brand in fact sponsoring the local premier football league). Health warnings are inconspicuous and ineffective, being confined to cigarette packets on one side only. However, the main problem is the lack of enforcement of these laws and regulations^{31, 32}.

As such, the following are the main components of the strategy proposed to tighten local legislation, based on the WHO model tobacco law (cited above) and European Union (EU) directives and resolutions (in the light of Malta's present negotiations to join the EU):

1. *Enforcement* regulations to designate health inspectors, police officers and local wardens as being responsible to enforce tobacco legislation.
2. The updating of tobacco legislation to make the breaking of such legislation liable to more severe *penalties* (and serve as a deterrent).
3. *Sales* legislation to be revised so as to protect the young through enforcing the ban of single cigarettes, and by prohibiting the sale of tobacco products in schools, colleges, universities, and sports or athletic facilities (amongst others). Sales through automated vending machines, using self-service displays, by mail order or the Internet, and to persons less than 18 years (presently under 16) would also be banned.
4. Regulations banning *smoking in enclosed public places* (with the exception of designated no-smoking rooms) to extend the present limited ban. These would come to include establishments where services are provided to the public, where elderly persons are received, where children or young

people are received or housed, where higher education and vocational training are given, in radio or TV studios open to the public, where exhibitions are held, where sports are practised, and in enclosed premises of ports and airports³³.

5. Tobacco *advertising* regulations to implement a total ban of advertising except at point of sale (with a one-year delay in respect of the press), and of *sponsorship* (after a two-year delay) and other forms of tobacco promotion (including free samples, discounts, gifts and contests), and to prohibit the use of tobacco trademarks on non-tobacco goods³⁴. In spite of the directive referred to here being annulled during a landmark case in the European Court of Justice in Luxembourg during October 2000, the European Commission is to press ahead with legislation to phase out tobacco advertising and sponsorship inside the E.U.³⁵
6. The introduction of conspicuous and effective *health warnings* on the front, back and one side of cigarette packets, and the extension of such warnings to all forms of tobacco^{36, 37}. Moreover, maximum *tar-yield* regulations are required to reduce the health damage caused by tar in cigarettes³⁸.

Time frame, financial requirements, feasibility and viability

The time frame for the implementation of such legislation must conform with the schedule imposed on the country by its negotiations for accession to the European Union.

A specific financial requirement incurred by the government would be the arrangement with a specialised overseas laboratory to perform

spot checks for tar levels in cigarettes (in addition to tests routinely done by the local tobacco industry). The government would also need to monitor the proper enforcement of legislation, which always costs money. Other expenses would of course be incurred by enclosed public establishments in setting up specific smoking rooms, and by tobacco companies in altering health warnings on tobacco products. The Maltese government can rest assured that a comprehensive tobacco control policy is not likely to harm the economy²⁴.

As such, besides the expected opposition of the tobacco industry to any measures that would affect their sales, it is envisaged that there would be no difficulties regarding the feasibility and viability of such legislative strategy against smoking.

EVALUATION & FEEDBACK

Point 10 of the WHO Ten-Point Programme for Successful Tobacco Control emphasises the importance of effective management, monitoring and evaluation of tobacco issues⁴. Evaluation is essential to appraise the success (or failure) of an intervention, so that the necessary feedback is available for the planning process.

Process

Both the process and the impact/outcome are evaluated. Process evaluation assesses the implementation of the strategy, in this case the tightening of local tobacco control legislation. This can be performed *prior* to the actual coming-into-force of the legislation by initially publishing it as a white paper to enable comments from interested parties and the general public. The process can also be evaluated *after* the

strategy is initiated through qualitative techniques including observations, interviews and case studies.

Impact and Outcome

Impact evaluation assesses the immediate effect of a health promotion strategy, while evaluation of the outcome is concerned with the long-term consequences. As legislative action uses the authoritative model for social change, the latter will only occur after a number of years have passed, therefore permitting only the long-term outcome to be measured here. One must keep in mind that evaluation may be influenced by difficulties in measurement, attribution, contamination and proliferation of the process. In this case, knowledge, attitudes and quality of life are difficult to measure, and so outcome evaluation should be based more on assessment of the following *direct measures*:

- behaviour: population and target surveys of smoking status;
- health status: of smoking-related diseases;
- mortality: from smoking-related diseases.

However, to assess the short-term impact, easy-to-measure performance indicators can also be used as *proxy measures*:

- sales of tobacco and smoking-cessation pharmaceuticals;
- participation rates in 'Quit & Win' campaigns and applications for smoking cessation clinics.

CONCLUSION

Health promotion can be attained only by the assessment of health needs, and their subsequent satisfaction through the

necessary strategic initiatives. The tightening of tobacco legislation is a prime example of health promotion not being the responsibility of just the health sector, but of going "beyond lifestyles to well-being", as the Ottawa Charter for Health Promotion concludes¹.

Thus, tobacco control must be not merely a top public health priority, but a top public policy priority with the government playing a central and crucial role⁴. Among the resolutions approved at the conclusion of the 11th World Conference on Tobacco or Health in Chicago, U.S.A. during August 2000, was the recommendation that all national health ministries have full-time staff charged with overall responsibility for ensuring sustained tobacco control programmes³⁹. Members of the U.K. House of Commons health committee have also recommended the creation of a tobacco regulatory authority⁴⁰. In fact, the setting-up of a coordinating tobacco control authority has been emphasised as a priority for Malta. Such authority must be given the mandate to manage all efforts required to stem the tobacco epidemic, not least the coordination of the different activities existing today to avoid duplication and increase effectiveness⁴¹.

Malta was one of the signatories of the 2002 Warsaw Declaration for a Tobacco-free Europe, which committed participating countries to the effective implementation of comprehensive policies with measurable impact on the reduction of tobacco use⁴². These include high taxes, bans on tobacco advertising, sponsorship and promotion, protection against involuntary exposure to environmental tobacco smoke in public places and workplaces, access to cessation measures and strict control on smuggling. As

declared by Sir George Young, a British health minister who understood the politics of tobacco: "The solution to many of today's medical problems will not be found in the research departments of our hospitals, but in Parliament. For the prospective patient, the answer may not be incision at the operating table, but prevention by decision at the cabinet table."²⁸

It is augured that the Maltese government will heed these wise words through supporting and implementing the development, monitoring and evaluation of national health promotion policies in general, and this initiative on smoking in particular.

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