



## **SFP response to the EC Consultation on EU action to reduce health inequalities**

### **The Smokefree Partnership**

The Smoke Free Partnership is a strategic, independent and flexible partnership between the European Respiratory Society, European Heart Network, Cancer Research UK and the Institut National du Cancer. It aims to promote tobacco control advocacy and policy research at EU and national levels in collaboration with other EU health organisations and EU tobacco control networks.

### **General comments**

The SFP welcomes the Commission initiative to address issues linked to health inequalities. The SFP would like to remind the EC that tobacco is the number one cause of preventable death in the world today. Studies have shown that smoking is becoming increasingly concentrated in the lower socioeconomic groups. Thus tackling tobacco use can be shown to be crucial to any initiative on reducing health inequalities and poverty.

### **Key recommendations**

- Studies have shown that smoking is becoming increasingly concentrated in the lower socioeconomic groups. Tobacco control measures are essential to decrease income and health disparity among the population.
- Effective implementation of the Framework Convention on Tobacco Control (FCTC)
- Coordination and policy coherence is key to ensure that the best health outcomes possible: good health for all citizens across the whole EU MS.
- Health Impact assessment should be used in assessing the impact of all policies
- Effective policy evaluation processes should be put in place
- Provide support to smokers trying to quit. A study from Scotland suggests that the scope for reducing health inequalities related to social position may be limited unless many smokers in lower social positions stop smoking<sup>1</sup>

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<sup>1</sup> L Gruer et al, Effect of tobacco smoking on survival of men and women by social position: a 28 year cohort study, BMJ 2009; 338; b480

## Specific comments

*On general data:*

Q1: What do you think will be the trend regarding health inequalities? - are they increasing or decreasing for example: between MS (e.g. major differences in terms of health outcomes) and between socio-economic groups.

Over the past years a number of reports have shown the link between health inequalities and socio-economic status. More recently, the WHO Health determinants Commission report 'Closing the gap in one generation'<sup>2</sup>, highlighted that poverty, social exclusion, poor housing and poor health are among the social causes of ill health.

The example of tobacco illustrates this. Tobacco is the number one cause of preventable death in the world. Tobacco use deepens poverty as money spent on tobacco is money not spent on basic necessities such as food, shelter, education and healthcare<sup>3</sup>.

While in the past there has been debate about whether poverty causes tobacco use or tobacco use causes poverty, a recent large study from Scotland shows that tobacco use causes poverty. In a 28 year cohort study of over 15,000 people, among both men and women, never smokers had much better survival rates than smokers in all social positions. Smoking itself was a greater source of health inequality than social position and nullified women's survival advantage over men. This suggests the scope for reducing health inequalities related to social position may be limited unless many smokers in lower social positions stop smoking.<sup>4</sup>

Studies have also shown that tobacco is becoming increasingly concentrated in the lower socioeconomic groups. The Eurobarometer published in March 2009 shows that the prevalence of smoking is higher among the unemployed (19.2%) and among manual workers (43%) in the EU27<sup>5</sup>. A study published by the UK Department of Health revealed that only 10% of females and 12% of males in the highest socioeconomic group are smokers; in the lowest socioeconomic groups the corresponding figures are three-fold greater: 35% and 40%<sup>6</sup>. Similar findings were reported by a study published by the Estonian Ministry of Health on 'Health behaviour among Estonian adult population': in 1990 daily smoking was considerably higher among males with low education and low income and among the unemployed in all age groups from 16 to 64 years<sup>7</sup>.

Tobacco-related illness leads to loss of work and, in children exposed to tobacco smoke at home, to loss of education and to a 'cycle of disadvantage' as children of smokers become smokers themselves. A study by the British Medical Association<sup>8</sup> shows that children who live with smokers are more likely to be absent from school through respiratory illness or gastro intestinal illness. Children with asthma who are exposed to SHS are at particularly high risk of absenteeism. A study of Scottish secondary school pupils with asthma showed that those exposed to SHS were between 44 and 77 per cent more likely to be absent from school because of asthmatic symptoms than those who were not exposed. Absence from school is a cause of stress and anxiety to young people. It can lead to children falling behind their peers, and may also lead to social isolation.

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<sup>2</sup> WHO Commission on health determinants, Closing the gap in one generation, Geneva, 2008

<sup>3</sup> WHO, Report on the global tobacco epidemic, Geneva, 2008

<sup>4</sup> Laurence Gruer et al, Effect of tobacco Smoking on survival of men and women by social position: a 28 year cohort study, BMJ 2009;338:b480

<sup>5</sup> [http://ec.europa.eu/health/ph\\_determinants/life\\_style/Tobacco/Documents/eb\\_253\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/eb_253_en.pdf)

<sup>6</sup> [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4006684](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006684)

<sup>7</sup> [http://www.tai.ee/failid/TKU2004\\_kogumik.pdf](http://www.tai.ee/failid/TKU2004_kogumik.pdf)

<sup>8</sup> British Medical Association, Breaking the cycle of children's exposure to tobacco smoke, London, April 2007

The ASPECT report<sup>9</sup> notes that smokers from the lower socioeconomic groups and their families not only carry a larger burden of smoking-related costs, they also spend a disproportionately larger share of their income on tobacco products and on smoking-related medical care. The report also notes that the combination of reduced disposable income and lower earnings has effects on these smokers' investment and consumption decisions. Finally, a study by M Siahpush et al found that interventions to encourage cessation among disadvantaged groups are likely to enhance their material condition and standards of living, and to reduce socio-economic disparities in mortality<sup>10</sup>.

The studies abovementioned show the link between tobacco use and health inequalities. Tackling tobacco use can be shown to be crucial to any initiative on reducing health inequalities and poverty.

Q2: What kind of indicators do you think would be necessary to better monitor the extent of health inequalities in the EU?

The WHO Commission on Health Determinants report puts forward a framework, and a comprehensive list of indicators, that can be used to understand the extent of the problem and monitor progress. Adequate data collection is also essential to develop comprehensive and effective policy interventions targeted at those most affected and evaluating the impact of policies.

However, within the EU, surveillance and data collection system differ significantly. It is therefore crucial to harmonize the systems within the EU if we are to obtain comparable data.

The SFP notes that the HLY indicator<sup>11</sup> is an attempt to generate data from all Member States on an annual basis which could be used further to better monitor the extent of health inequalities in the EU; indeed, the HLY indicator could be a useful benchmarking instrument with regard to the health situation and health promotion between and within Member States, and could serve as relevant input for policies regarding labour market participation, pensions, health condition and lifestyles.

Unfortunately, as explained in the evaluation conducted by RAND Europe on behalf of DG Sanco, the uptake of the Healthy Life Years (HLY) needs to be improved within non-health policies. Indeed, even if awareness about the "concept" of HLY is widespread in the scientific literature, awareness of the HLY indicator differs by stakeholder group, most **Commission Officials are still *not* aware of the HLY indicator** and **the use** of the HLY indicator is *not* (yet) widespread, especially within Commission Services and by National and Regional Non-Health Ministries. Reasons for *not* using the indicator cited in the evaluation include:

- limited awareness of the *concept*,
- stage of development of the HLY indicator, use of a similar health indicators prior to the adoption of the HLY indicator (e.g. healthy life expectancy),
- Differences between health expectancy indicators and the HLY indicator are not (yet) well understood.

The HLY indicator could be important to measure progress towards reducing health inequalities because it provides information on health determinants of the population and access to, quality and structure of health information.

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<sup>9</sup> European Commission, Tobacco or Health in the European Union: Past, Present and Future - The ASPECT report, Luxembourg, 2004

<sup>10</sup> Mohammad Siahpush, Matt Spittal, Gopal K. Singh: Smoking cessation and financial stress, Journal of Public Health, 2007

<sup>11</sup> [http://ec.europa.eu/health/ph\\_overview/strategy/health\\_strategy\\_en.htm](http://ec.europa.eu/health/ph_overview/strategy/health_strategy_en.htm)

Q3: If you think monitoring and reporting needs improvement in this area, what kind of tools should be used?

The WHO report 'Closing the gap in one generation' indicates that data systems are essential for:

- Knowing the magnitude of the problem;
- Knowing who is most affected and whether the situation is improving or deteriorating over time
- Assessing entry-points for interventions; and
- Evaluating the impact of policies.

The EU has a clear role in promoting and harmonizing data collection. Together with Eurostat, which already has a data collection system in place, the EC could promote collection of more comparable data and make data collection on health inequalities more systematic via regular monitoring and analysis. To this end, the EC could develop a specific methodology and list of indicators, which could be integrated into the Eurostat data collection system and used to collect specific information on health inequalities. Furthermore, the EC could work with MS to ensure that the specific lists of indicators were implemented at national level.

However, the EC should avoid duplication and ensure coordination with already ongoing initiatives. The FCTC reporting system is a key example here. The FCTC has been ratified by the EC and 26 of the EU MS. Under the Treaty, Parties have to report on the implementation of the Treaty. The reporting system includes questions on the countries' demographics, smoking prevalence and tobacco use per socio-economic groups and implementation of policy interventions; and identifies resources and technical assistance required to implement policy interventions, as well as country specific priorities on tobacco control. The FCTC reporting system, although far from being ideal, offers an example of how existing mechanisms already in place can be used to collect data on health inequalities.

Also, as stated in the response above, better use and awareness of the **HLY indicator** seems crucial. The synthesis of all evidence collected during the Rand Europe evaluation shows that it is important to ensure that public health is strategically addressed in other EC policies and programmes. Also, **Health impact assessment (HIA)** could be an effective means in both mainstreaming health and evaluating how other policies affect health. Unfortunately, there is no sound and solid evidence on the systematic use of HIA across Community services, despite the recent revision of the IA guidelines. For HIA to become more useful there is a need to strengthen the logic used for predicting consequences of decisions, to improve estimates made of the magnitude of outcomes and to develop forms of participation that meet the needs of relevant actors.

The SFP therefore recommends that EC policy makers, particularly in services other than DG Sanco, become more acquainted with HIA. In addition to the recommendations to improve the uptake of the HLY indicator, the profile of HLY within non-health policies could be improved by:

- **Supporting HIAP in all EU policies**
- **Developing further coordinated action plans linking health with other policy areas** (e.g. health and safety at work, social affairs, tax, environmental health) to exploit synergies and focus efforts where HLY is at stake
- **Providing training on HIA to EC Services** (e.g. DG SANCO developed a practical guide for screening of proposals for possible health impacts and background material useful for putting discussions on HIA in a broader perspective<sup>12</sup>).
- **Finally**, a committee made up of MS could then be set up to analyse the information collected to define effective policy interventions, in close collaboration with civil society organizations. The committee could also work on an evaluation framework to evaluate policy interventions in place.

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<sup>12</sup> [http://ec.europa.eu/health/ph\\_overview/Documents/key07\\_en.pdf](http://ec.europa.eu/health/ph_overview/Documents/key07_en.pdf)

*On scope of level on EU action/subsidiarity:*

Q4: Do you think action at EU level could make a difference in addressing health inequalities? Why?

The EU has a key role to play in promoting exchange and dissemination of best practice and coordination data collection and policy interventions. However, the need for action at EU level should be assessed according to the topic being reviewed and taking into account evidence on best-practice available and ongoing initiatives at local, regional, national and international level as some binding legislative initiative are better dealt with at other levels than the EU. For example, the introduction of binding legislation for graphic warnings on packet of cigarettes should be dealt with at EU level whilst SFP considers that truly smoke-free legislation can and should be adopted, but that while the impetus should be provided at EU level through a solid and clear Council Recommendation, binding legislation for a smoke free workplace has to be brought about at national level in the first instance.

Through its various policies and funding programmes the EU can also contribute to reducing health inequalities across MS. The EC should work towards policy coherence across all DGs, to ensure that decisions made in one policy area do not adversely impact on other policy areas. The Health in all policies council conclusions should also serve as a platform to take action further. Through its funding programmes, the EC could fund initiatives at local, regional and national level, as well as within countries, to reduce health inequalities.

A comprehensive tobacco control strategy requires the involvement of policy areas other than health, as well as different levels of governance. The tobacco control community agrees that the implementations of specific interventions in a number of areas are key for tackling smoking use in Europe:

- Stopping tobacco industry influence on government's tobacco control policies and making the industry liable for its actions (Articles 4.5, 5.3 and 19);
- Comprehensive protection from tobacco smoke (Article 8)
- Strong measures to counter tobacco marketing, promotion and imagery (Articles 11, 12 and 13)
- Commitment to taxation as a tool to reduce smoking prevalence (Article 6)
- Tough new measures to control tobacco smuggling (a protocol to Article 15)
- Promotion of effective stop smoking measures (Article 14)

Q5: How should relevant stakeholders be supported and engaged at EU level in tackling health inequalities?

Good health can only be promoted and achieved on a platform of openness, strong science, good governance and civil society participation in the process of policy making. The EC has developed a number of tools to consult with stakeholders and the public; and a number of fora and working groups were set up in order to promote dialogue and exchange of best practices. The SFP welcomes all EC initiatives that are transparent and involve a wide range of interest and stakeholders to discuss policy interventions and implementation; and which also integrate on-going work at National level and across the various DGs. In particular, the SFP welcomes the DG Sanco "in-house" indicators to measure stakeholder participation in its consultations and major events as a way to monitor if the relevant stakeholders for are sufficiently engaged. This is particularly important for health inequalities as indicators evaluating the participation of MS level stakeholders (old/new, North/South) & European level organizations, the participation of local level stakeholders (where relevant); the participation of groups facing discrimination and social exclusion; and gender balance could be crucial for determining the level of health inequalities, not only between Ms but within MS.

However, in increasing its own transparency by engaging more widely with stakeholders, the Commission ought to consider the extent to which the stakeholders it engages with are themselves transparent. For

instance, as confirmed in the 5.3 guidelines adopted at the third session of the Conference of the Parties<sup>13</sup>, we would like to stress that, due to the toxic nature of the product it sells, the tobacco industry is special case in terms of consultative processes. In addition, a significant body of research demonstrates the way in which this industry has both withheld information concerning the health damaging consequences of its products and has actively attempted to undermine other evidence that has emerged in this area. Hence, we would like to encourage the Commission's approach to gathering data for health inequalities to incorporate mechanisms to explore the source and funding of this information (which may not be immediately apparent) to ensure the quality and credibility of the data employed in this process. Also, in order to conform with article 5.3<sup>14</sup> of the FCTC, all policy makers, both at European and national level, should protect the formulation and implementation of public health policies for tobacco control from the tobacco industry to the greatest extent possible.

Q6: Should there be a common commitment at EU level to reduce health inequalities for example by committing to common milestones and reducing targets? If yes, what do you think these milestones or targets should be (what variables? what extent?)

For a strategy to be effective it is key to identify milestones and targets, as they support policy development, implementation, effectiveness and review of policy interventions.

The SFP believes that milestones should be set and a mix of indicators should be identified to measure performance and implementation of the strategy. Indicators should be identified according to the policy area being assessed. Information collected should feed into the process of policy development and review of strategies and policies. Objectives, target values and milestones should be ambitious but feasible.

The SFP would like to take this opportunity to congratulate DG Sanco and DG Taxud for adding a public health objective in EU taxation policy and setting up the target of reducing consumption of cigarettes by 10% over the next 5 years. Indeed, as stated by Commissioner Kovacs, taxation forms part of an overall strategy of reducing tobacco consumption. According to the World Bank, price increases in tobacco products are the most effective single intervention to prevent smoking.

Q7: What would be the right tool to ensure that common goals are achieved on national and EU level (reporting, benchmarking, OMC, etc)?

The 'right tools' should be implemented according to the issue being assessed and reviewed, and taking into account initiatives at regional, national and international level, as well as the Union contribution being proposed.

Lessons from tobacco control in Europe have show that 'soft legislation' and voluntary codes are not effective in reducing smoking prevalence and legislation is needed in order to implement effective tobacco control strategies. The OMC can greatly contribute to improve comparable data collection and analysis, exchange of best practices and improve policy coordination, as well as policy interventions. However, legislation will be needed to ensure that common goals, such as reducing smoking prevalence, are achieved.

Indicators to assess the effectiveness of policy interventions and whether they are being implemented through the EU MS, as well as their impact should also be developed. Outcomes should feed into the development of policy interventions and review processes.

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<sup>13</sup> [http://www.who.int/fctc/guidelines/article\\_5\\_3/en/index.html](http://www.who.int/fctc/guidelines/article_5_3/en/index.html)

<sup>14</sup> [http://www.who.int/fctc/guidelines/article\\_5\\_3.pdf](http://www.who.int/fctc/guidelines/article_5_3.pdf)

The SFP would welcome an opportunity to discuss effective tobacco control measures further with the European Commission.

Q8: To what degree can health inequalities be addressed through health policy? How?

The WHO notes that poverty is the key social determinant of health. Poverty is a cross-cutting issue, which is dealt by a number of policy areas. Therefore any comprehensive strategy on tackling health inequalities should look not only at health initiatives but also at all policies that may potentially impact on health. The EC should promote Health in all policies across all EU policies to ensure that health inequalities are not exacerbated by decisions and initiatives made and taken by other DGs.

The SFP recognizes that making health a common theme in all policies involves forging new partnerships across all sectors at EU and national level, and putting in place the right systems, such as good impact assessments, to ensure a systematic scrutiny of their impact. The current impact assessment framework could be detrimental to Public Health policy and therefore should be considerably reviewed. The SFP responded to the Commission consultation on impact assessments and its response can be found on the link provided<sup>15</sup>

Q9: Which and to what extent should other policy areas, such as social policy, contributing to reducing health inequalities.

Other policies can have a cross-sectoral impact. Thus the SFP urges the Commission to seek ways to develop partnerships with other DGs and ensure that other policies take health consideration into account when proposing any policy initiatives. Policy areas include: research, pharmaceuticals, enterprise, internal market and economic policy, environment, social policy among others.

Tobacco control and taxation policy is a key example here. According to the World Bank, a high price due to high taxes on tobacco is the single most effective intervention to prevent smoking<sup>16</sup>. Furthermore, smoking rates are higher among poorer communities and therefore they suffer the greatest health burden. However, they could be responsive to tax increase. Taxation is thus an appropriate tool for governments to use both to tackle smoking rates and to re-balance health inequalities<sup>17</sup>.

DG Taxud published in 2008 a proposal to amend EU Directives on the rates and structure of taxes on manufactured tobacco. For the first time, Public Health is included as a key objective of the proposal. The proposal published demonstrates an extremely well coordinated action between DG Taxu and DG Sanco and is a very clear example of how other policies can contribute to reducing health inequalities.

Health safety at workplaces is another policy area that can have an impact on tobacco control. Recently, DG employment published a consultation on the protection of workers from risks related to exposure to environmental tobacco smoke at the workplaces. The SFP responded to this consultation and its response can be found on the link provided<sup>18</sup>. While welcoming the Commission initiative to protect workers, the SFP noted that the decision should be made at the best level possible and policy intervention should take into account ongoing policy initiatives in order to achieve the best outcome possible: introduction of total smoking bans in all EU Member States.

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<sup>15</sup> [http://www.smokefreepartnership.eu/IMG/pdf/SFP\\_impact\\_assessment.pdf](http://www.smokefreepartnership.eu/IMG/pdf/SFP_impact_assessment.pdf)

<sup>16</sup> Jpa P, Chaloupka Fj, Curbing the epidemic: governments and the economics of tobacco control. Washington DC: World Bank, 1999

<sup>17</sup> [http://www.smokefreepartnership.eu/IMG/pdf/Advocacy\\_toolkit\\_on\\_taxation.pdf](http://www.smokefreepartnership.eu/IMG/pdf/Advocacy_toolkit_on_taxation.pdf)

<sup>18</sup> The SFP response can be found at

[http://www.smokefreepartnership.eu/IMG/pdf/SFP\\_Response\\_to\\_DG\\_EMP\\_consultation\\_on\\_Exposure\\_to\\_ETS\\_at\\_Workplaces.pdf](http://www.smokefreepartnership.eu/IMG/pdf/SFP_Response_to_DG_EMP_consultation_on_Exposure_to_ETS_at_Workplaces.pdf)

According to the latest Flash Eurobarometer, published in March 2009, an overwhelming majority of EU citizens support smoke-free public places, such as offices (84%), restaurants (79%), bars, pubs and clubs (65%). These results are in line with those obtained in the 2006 Eurobarometer and confirm the overwhelming support that smoke-free policies have in the EU. Even if there seems to be a clear trend towards the reduction of exposure to tobacco smoke at the work place in Europe, a fifth of European workers are still exposed to tobacco smoke on a daily basis.

The examples provided above show how other policies can contribute to an overall strategy on reducing health inequalities. However, they also show that coordination and policy coherence is key to ensure that the best health outcomes possible.

*Possible actions and impacts:*

Q10: Given the current economic situation can you think of any immediate action that EU MS could take to avoid an increase of health inequalities in the short term?

Given the current economic situation, an immediate action by MS should be to increase Excise duties on manufactured tobacco products and alcoholic beverages. All EU Member States apply excise duties to these three product categories. The revenue from excise duties accrues entirely to the Member States.

Taxation is part of an overall strategy of prevention and dissuasion which also includes other reduction demand measures including protection from exposure to tobacco smoke, restrictions on advertising and regulation of the contents. However, according to the World Bank, price increases of tobacco products are the single most effective intervention to prevent smoking. A price increase of 10 % decreases consumption on average by about 4% in high income countries. Importantly, the impact of higher prices is likely to be greatest on young people, who are more responsive to price rises than are older people. The consumption of cigarettes in the EU decreased by slightly more than 10% between 2005-2006, mainly due to tax increases. After taxes are increased, smoking prevalence goes down in two ways: more people quit and fewer people start smoking. In addition, some smokers will consume fewer cigarettes. Studies from the US show that a 10 % increase in price in US results in 10 % of smokers who try to quit and 2% are successful. There will be an impact on life expectancy and quality of life with lives saved among people who smoked, more days worked and savings in medical costs.

Cigarette smoking has huge costs for society through lost productivity, ill health and premature death of smokers and those exposed to cigarette smoke. The funds raised through tobacco taxes represent a small proportion of both the society costs of smoking and represent a small share of government's budgets. If price rises on tobacco lead to a reduction in smoking prevalence, this in most cases increases the government revenue due to low price elasticity of cigarette demand. Even if all current smokers stop smoking, the loss of cigarette tax revenue will be overshadowed by the healthcare savings due to reduced incidence of tobacco related illnesses. The net result for government budgets will therefore be positive.

Finally, socio-economic inequalities do have a measurable impact on health and wellbeing, the WHO notes that poverty is the key social determinant of health. Smoking rates are higher among poorer communities and therefore they suffer the greatest health burden. However, they could be responsive to tax increases. Therefore tobacco consumption is already making health inequalities worse. Extra help and support to quit is needed for people living on tight budgets and higher cigarette prices can help people make the decision to stop smoking. Therefore some of the funds raised by tax increase could be channelled towards specific support tools to quit smoking for deprived communities. Taxation is one of the most efficient ways of influencing smoking rates. Therefore it is an appropriate tool for governments to use both to tackle smoking rates and to re-balance health inequalities.

The third edition of the 'Tobacco Atlas'<sup>19</sup> estimates that the direct costs of smoking are (in millions of US) 239.63, 220.62 and 977.39 to Finland, Spain and the UK respectively<sup>20</sup>. The report 'Beyond smoking kills' showed that the costs of smoking to the NHS was £2.7 billion in 2006/7<sup>21</sup>

Please see answer to Q9 where the example were provided on how other policies such health safety at workplaces can contribute to reducing health inequalities in the short-term.

Q11: What in your opinion are other areas that EU and MS should be encouraged to focus on to achieve a reduction of health inequalities?

The EU has a clear role to play in coordinating and supporting strategies at national level and facilitating cooperation between MS. Thus, the EU should focus on promoting good practices, exchange information, harmonise and coordinate data collection and EU MS policy interventions. Furthermore, EU should ensure that all its policies are in line with the Council conclusions 'Health in all policies' and it promotes policy coherence across all EC DGs.

The FCTC has been ratified by the EC and 26 EU MS. In order to meet the Treaty obligations, all EU MS that have ratified the FCTC will need to develop and implement comprehensive tobacco-control strategies encompassing prevention, protection, cessation and harm reduction. Implementation of the FCTC should be according to the strictest standards possible within national constitutional limitations.

Q12: To what extent would existing coordination and monitoring processes at EU level need to be improved to strengthen joint action on health inequalities?

The EC should ensure that indicators are put in place to monitor the implementation of the strategy and its impact on populations and MS. Furthermore, indicators should also be developed to assess whether the policy interventions are being effective in tackling health inequalities. Lessons learnt from the monitoring exercise should feed into mid-term reviews and into the further development of the strategy.

A good current example of research into the impact of policy interventions is the International Tobacco Control Project ([www.itc.org](http://www.itc.org)). The ITC project is studying how the different policy interventions are being implemented across countries, who is being covered by the intervention and whether the situation is improving overtime.

Q13: What could be possible actions in other EU policy areas on health inequalities and what could be there impact?

The various examples provided above show how tobacco control interventions can greatly contribute to reducing health inequalities and therefore the effective implementation of the FCTC should be a key priority area for action. The Treaty impacts on a number of policy areas other than health, and partnerships will need to be forged in order to implement the Treaty. Key areas include:

a) Regular increases in tobacco taxes

- Differences in tax rates should be harmonized on the basis of specific rates as opposed to ad valorem
- The tax on 'roll your own' should be raised to prevent substitution towards this form of tobacco products
- Tobacco should be removed from the Consumer Price Index

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<sup>19</sup> O Shafey, M Eriksen, H Ross, J Mackay, The Tobacco Atlas, Third edition, American Cancer Society and World Lung Foundation, 2009, p. 43

<sup>20</sup> Based on 2007 or latest available data

<sup>21</sup> ASH, BHF, CR-UK, Beyond Smoking Kills, ASH, London, 2008

- Increased international cooperation to coordinate taxation policies and combat smuggling is needed. The EC should develop European legislation building on the agreement between the EC, ten MS and Philip Morris International (PMI) to combat smuggling and counterfeit

b) Promote tobacco control as a global health issue.

- Acknowledging the immense social and economic burden of tobacco use and promoting public policies that address social determinants of health in low-and middle-income countries
- Make best use possible of all policy and funding instruments i.e. multilateral and bilateral assistance, to promote the implementation of the FCTC in low- and middle-income countries
- Promote implementation and enforcement of International Treaties such as the FCTC by investing more on capacity building of national authorities and civil society organisations and promote exchange of best practice