A tobacco-free future

National strategy for tobacco control

2013–2016

Our vision is a tobacco-free future – a future in which individuals and communities are no longer affected by tobacco's many harmful effects on health and where children and adults live healthier and longer lives.

We shall win the battle

There are those who believe that the struggle against tobacco is about authoritarianism. It is about something far more serious. The struggle against tobacco concerns an epidemic that kills. It also concerns health inequalities.

Every year more than 5,000 Norwegian men and women die from diseases caused by smoking. They have lost an average of 11 years of their lives. That is a lot of life. A lot of pain and grief.

If we are to create a future without tobacco, we must succeed in two areas: we need to ensure that those who use tobacco choose to make the decision to quit, and we must do what we can to prevent others from starting. Both of these efforts are important. We have a tradition of protecting children and young people. It is an important social responsibility to prevent children and young people from starting to use tobacco and to ensure that they are not exposed to hazardous smoke.

In Norway, 28 per cent of the population is still smoking, 17 per cent on a daily basis. In several other countries, the daily smoking prevalence has dropped to 10 per cent. This has been achieved by policy instruments such as taxes, campaigns, legislation and cessation aids. This shows us that it is still possible to set goals that reduce tobacco's burden on health, and that there are tools that work.

Among both boys and girls the use of snus has increased significantly in recent years. This is disturbing. The use of snus is less harmful than smoking, but snus use also has serious health consequences. When we have such knowledge, we have a responsibility to take it seriously.

The effort to reduce the harmful effects of tobacco is also an effort to tackle social inequalities in health. People with less education start smoking earlier than those with a longer education. They are exposed to more second hand smoke and are less likely to quit smoking than people with a longer education. People with less education are also overrepresented in the statistics relating to illness and death caused by smoking.

This strategy for combating the harmful effects of tobacco includes many different measures that will take us forward in tobacco control, and can bring us closer to our vision, a tobacco-free Norway.

We humans have won battles against epidemics before. We shall win this one too.

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I. INTRODUCTION

Smoking is the single factor with the greatest negative impact on public health. In Norway, about 5,100 people die each year from diseases caused by smoking (13 per cent of all deaths). On average, each of them has lost 11 years of their lives. Smoking increases the risk of cardiovascular disease, COPD and many forms of cancer, especially lung cancer. Most cases of lung cancer in Norway could have been avoided if nobody smoked.

Smoking is a major cause of social inequality in health. People with less education start to smoke earlier, are exposed to more second hand smoke and tend to stop smoking in a less extent than those with a longer education. We can help to reduce social inequality in health through efforts to limit tobacco use,.

Around 700,000 people still smoke on a daily basis in Norway. It is estimated that approximately 100,000 children under the age of 13 are exposed to second hand smoke in their homes every day. Although we have seen a decline in the proportion of smokers in the population, the decline is not occurring fast enough. The proportion of adolescents who use the smokeless tobacco snus (smokeless tobacco) has risen dramatically. It is necessary to strengthen our efforts if we are to reach the goals of a significant reduction in tobacco use in the years to come.

Several western countries have a significantly lower smoking prevalence than Norway. In 2010 for example, the smoking prevalence in both Sweden and the UK was significantly lower. In the state of California, a total of only 12 per cent were daily and occasional smokers. In Norway, the total of daily and occasional smokers was 29 per cent. Thus there is still a great potential for reducing smoking in the population.

The Directorate of Health estimates that the socio-economic costs related to smoking in Norway is 8 or 80 billion Norwegian kroner per year, depending on whether one estimates the costs for health care only, or also add the costs for the society as a whole.

The proportion of smokers in the population has declined in recent years, while the proportion of young people who use snus has increased sharply. This is worrisome because snus can also cause serious harm.

The government will renew and reinforce its efforts in tobacco prevention work. The basis of the new strategy (2013-2016) is the experiences from the previous strategy period and the conclusions from the World Health Organization's evaluation of the tobacco control work in Norway in 2010 (WHO 2010). We have also relied on international experiences in the strategy, particularly those of our Nordic neighbours.

In the previous strategy period, we succeeded in reducing the percentage of smokers in the general population and in halving smoking among youths. The goals of halving the

proportion of pregnant women who smoke and halting the increase in the use of snus were not achieved.

Although Norway has come far in tobacco control, we are no longer "the best in the world." The government wants Norway to once again play a leading role in tobacco control. This will be achieved by stronger and more systematic efforts.

New focus will be given to mass media campaigns and the establishment of a national smoking and snus cessation service. The policies of high taxes and tightening of regulations will continue. The goals are preventing children and adolescents from taking up smoking and snus use, helping those who already use tobacco to quit, and protecting people from the harmful effects of exposure to second hand smoke.

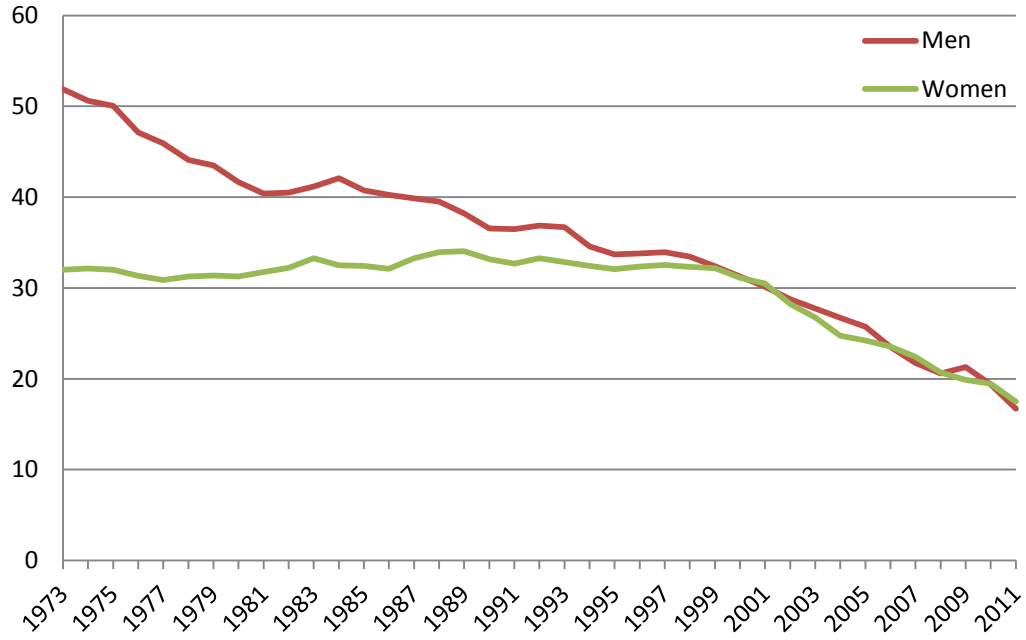
Several policy instruments can influence the development of tobacco use in the population. However, changes in tobacco use are only partly a result of government policies on tobacco control. We are unable to influence some factors. For example, the decline in men's smoking started before tobacco control measures were established, and snus use has increased despite the high taxes, age limits, a ban on advertising and widespread knowledge of harmful effects.

II. STATUS OF TOBACCO USE

2.1 Trends

Daily smoking prevalence has declined distinctively from 1973 to 2011 (Figure 2.1). In 1973, 51 per cent of the men and 32 per cent of the women smoked daily. In 2011 about 17 per cent of the population (ages 16-74) smoked daily, about the same number of women and men. This means that almost 700,000 people are still smoking on a daily basis in Norway. In addition, 11 per cent, or about 450,000 people, smoke occasionally. Occasional smoking prevalence has remained stable at around 10 per cent over the last 30 years, despite the fact that daily smoking prevalence has dropped sharply during the same period.

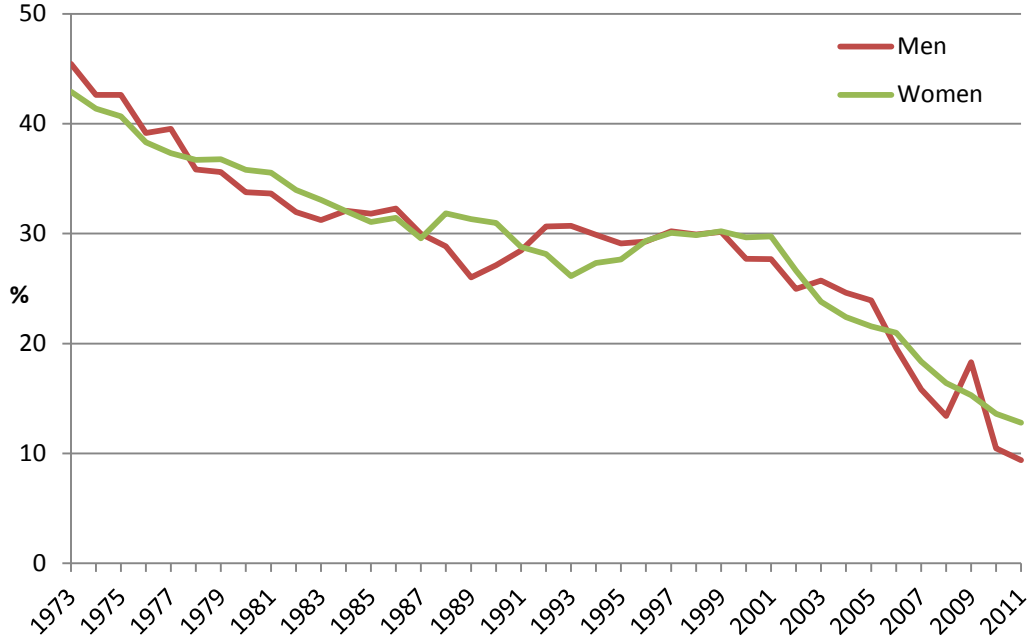
Figure 2.1 Daily smoking prevalence among men and women, aged 16-74, 1973-2011



(Source: Statistics Norway)

Among young people (ages 16-24), there has also been a positive trend (Figure 2.2). Over the past decade the reduction has been greater than in the population as a whole. Youth smoking was halved during the previous strategy period. In 2011, daily smoking prevalence in this age group was 11 per cent.

Figure 2.2 Daily smoking prevalence among men and women, aged 16-24, 1973-2011



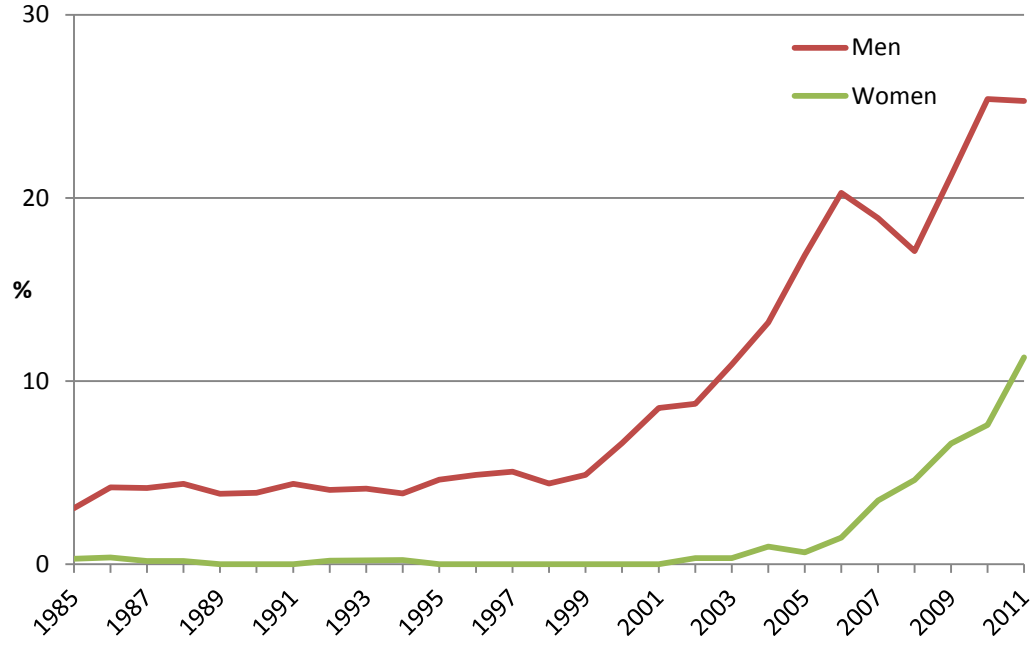
(Source: Statistics Norway)

Approximately one in five (18 per cent) of all pregnant women in 2011 smoked (daily or occasionally) at the beginning of the pregnancy and seven per cent at the end of the pregnancy. Smoking is more common among the youngest women. In 1999, 25 per cent of all pregnant women smoked at the beginning of the pregnancy, and 18 per cent at the end of the pregnancy. The decline in smoking prevalence among pregnant women has levelled off after 2006.

There are also large regional differences. In Oslo in 2011 under three per cent of pregnant women smoked at the end of the pregnancy. The proportion was highest in Finnmark (12 per cent), followed closely by Aust-Agder (11 per cent) and Nordland (10 per cent).

Eight per cent of the population (ages 16-74), primarily men, used snus on a daily basis in 2011 (about 300,000 people). Among young men (ages 16-24) 25 per cent used snus daily, compared to 11 per cent of women in the same age group. In addition, 16 per cent of young men and 11 per cent of young women used snus occasionally. The use of snus has increased significantly among young men in recent years, and is currently more common than smoking. Also among young women the use of snus has increased sharply (Figure 2.3).

Figure 2.3 Prevalence of daily snus use among men and women, aged 16-24, 1985-2011



(Source: Statistics Norway)

2.2 New products in Norway

Water pipe

Water pipe has been most commonly used in countries around the eastern part of the Mediterranean, but its use also appears to be spreading to other areas. In Norway, 16 per cent of the population has tried to smoke a water pipe, but only one per cent smokes a water pipe more frequently than once a week. A survey of 1,000 young people aged 15-25 showed that more than 20 per cent had smoked a water pipe in Norway several times or many times (Directorate of Health, 2010). In Sweden, 27 per cent of the population had tried a water pipe, and more than 60 per cent of 18 year-olds in upper secondary school (Institute of Public Health, 2009).

Water pipe smoking among young people may be a possible introduction to subsequent tobacco smoking. Water pipe smoking also causes dependency and is at least as harmful as cigarettes, but there seems to be little awareness of the health risks. The manufacture, import and sale of shisha tobacco is banned in Norway.

Electronic cigarettes

Electronic cigarettes are a relatively new product and are marketed mostly as a smoking cessation aid. Electronic cigarettes contain nicotine vials of different strengths, but may also be free of nicotine. The electronic cigarette is used in the same way as a conventional cigarette, and the person inhaling ingests nicotine through a vaporisation

process. A nicotine vial is equivalent to 10-15 cigarettes, depending on the strength of the vial.

In 2009, The World Health Organization concluded that the efficacy of electronic cigarettes as a smoking cessation aid was not proven, and that there is a need for knowledge about whether electronic cigarettes help to maintain nicotine addiction and whether they can act as a gateway to smoking. The manufacture, importation and sale of electronic cigarettes is generally prohibited in Norway.

III. STATUS OF TOBACCO CONTROL WORK

Norway has been a pioneer in tobacco control in Europe since the 1960s. Smoking cessation work got an early start. Norway was the first country to sign the World Health Organization Framework Convention on Tobacco Control (FCTC) on 16 June 2003.

In 2010, Norway ranked third among 31 European countries according to a scale for tobacco control measures recommended by the World Bank (Association of European Cancer Leagues' Tobacco Control Scale 2010). Norway scored high on price, smoking bans in public places and advertising bans, but relatively low on mass media campaigns and smoking cessation.

Following an invitation from the Ministry of Health and Care Services in 2010, the World Health Organization evaluated the work on tobacco control in Norway (WHO 2010). The report was both positive and negative. According to the report, the biggest challenges to continued progress in tobacco control are:

1. Tobacco control has lost momentum in recent years, and resources are inadequate.
2. Norway has stopped using mass media campaigns although these are a very effective tool in reducing smoking in all groups.
3. Designated rooms for smoking in workplaces are still allowed, in contradiction to the smoke-free recommendations of the WHO FCTC.
4. Children in private spaces remain relatively unprotected from second hand smoke.
5. Cessation services are almost non-existent, despite this being a high priority in the National Strategy for Tobacco Control for 2006-2010.

The World Health Organization presents five key recommendations that should be considered as priorities:

1. The Ministry of Health and Care Services should provide stronger national leadership for tobacco control, including significantly increased resources.

2. The Ministry should renew its dedication to mass media campaigns. It is recommended that two to three large "hard hitting" campaigns be conducted each year and that the campaigns have a broad approach.
3. All workers and the general public should be ensured universal and equal protection against second hand smoke by eliminating designated smoking rooms, by introducing clearer definitions of terms used in the Tobacco Control Act (e.g. indoor spaces) and by establishing effective enforcement strategies.
4. A mass media campaign that raises awareness on the need for adults to protect children from second hand smoke in private homes should be initiated. In addition, legislation should be considered.
5. Smoking cessation should be given high priority in the new tobacco strategy. As a first step, the cessation potential of the quit line and cessation website should be maximized. There should be developed a strong national, regional and local infrastructure for the delivery of brief interventions and referrals to the quit line, in addition to interventions at every visit to the health services. This should be followed by referral to evidence-based, appropriate and financially suitable smoking cessation services when appropriate.

Other key recommendations in the report are:

6. Establish a licensing system to regulate the sale of tobacco products.
7. Apply the legislation on pictorial health warnings to all tobacco products, including smokeless tobacco.
8. More active collaboration with civil society.
9. Monitor the tobacco industry activities nationally and internationally.
10. Reduce the difference in tax rates between combustible products and non-combustible tobacco products (snus).

IV. GOALS FOR THE 2013–2016 STRATEGY PERIOD

The Government has set the following goals for the year 2016:

1. Prevent young people from taking up smoking and snus use

- Children and young people born after the year 2000 shall not take up smoking or snus use.
- Daily smoking prevalence among children and young people (ages 16-24) should be below six per cent (2011: 11 per cent).
- The sharp increase in daily snus use among children and adolescents (ages 16-24) should be halted (2011: men 25 per cent, women 11 per cent).

2. Motivate and provide assistance for snus and smoking cessation

- Daily smoking prevalence in the population (ages 16-74) should be below ten per cent (2011: 17 per cent).
- Daily prevalence of snus use in the population (ages 16-74) should not exceed eight per cent (2011: eight per cent).

3. Protecting the population and society against the harmful effects of tobacco

- No children should be exposed to second hand smoke.
- Smoking prevalence among pregnant women in late pregnancy should be below four per cent (2011: seven per cent).

These are ambitious goals that will require strong efforts going forward. Experience from the previous strategy period and from other countries suggests that a halving of the proportion of daily smokers in the population (adults, pregnant women and children/young people) is within reach. The highest priority must be given to the goal of preventing new generations from taking up using tobacco.

The use of snus has in recent years increased dramatically among young people and it will be difficult to reverse this trend in the course of one strategy period. However, it should be a realistic goal to halt the increase during the period.

The goal that no child shall be exposed to second hand smoke is a result of new knowledge about its harmful effects on health. Exposing children to second hand smoke is no longer acceptable.

V. RENEWED EFFORTS

The correlation between tobacco use and the harmful effects on health is well documented. We also have a good knowledge of the measures that have proven effective when it comes to limiting and preventing tobacco-related damage. The broad approaches have the greatest long-term effect on tobacco consumption in a population. That is, the use of regulatory and economic policy instruments along with campaigns and initiatives in the health sector. The WHO FCTC emphasizes precisely the need for broad efforts across sectors.

> ”Many OECD countries have achieved remarkable progress in reducing tobacco consumption over the past decades, although it still remains a leading cause of early death and hence an important public health issue. Much of this decline can be attributed to policies promoting public awareness campaigns, advertising bans and increased taxation.”
>
> **Health at a Glance 2011. OECD indicators**

Mass media campaigns, in addition to high taxes and restrictive legislation, shall prevent more people from taking up smoking and snus use. Those who currently smoke or use snus shall be offered professional cessation services.

5.1 Use of the legal instrument

Through legislation we can restrict the access to and the demand for tobacco products. Legislation can also ensure the population protection from second hand smoke. Such measures are effective in reducing social inequalities in tobacco use.

Despite a sound legal basis, there is an on-going debate about the extent to which and by what right the government may restrict the individual's possibilities to smoke. There are compelling arguments for the legitimacy of the government's right to use legislation to limit tobacco use:

1. The extent of harm
According to the World Health Organization smoking is the most important risk factor for both premature death and loss of healthy years in high-income countries such as Norway.

2. The choice of smoking is made by minors with misperceptions about the risk
Most people start smoking early in life. More than 70 per cent start smoking before the age of 20, more than 50 per cent before the age of 18. More than 80 per cent of smokers later regret that they started smoking. Children and young people usually have strong misperceptions about the health risks, and young smokers underestimate the possibility that they themselves will become addicted to nicotine compared with others.

3. The freedom to stop is limited by addiction
Young smokers show signs of addiction after just a few weeks of smoking. In a study of adolescents from the Norwegian region Trøndelag (NTNU Ung-HUNT 2011), very few experimental smokers managed to maintain a low consumption over time. Most went on to become daily smokers. The freedom to choose whether to continue or stop is thus severely limited by an addiction that can be both physiological and psychological.

4. Smoking affects innocent third parties
Smoking affects other people. Exposure to second hand smoke can lead to serious health consequences. In Norway, there are still around 100,000 children below the age of 13 who are exposed to second hand smoke in the home every day. The youngest are the most at risk of being exposed to second hand smoke. Smoking also has a number of negative consequences such as treatment costs, fires, etc., which are paid for by society.

Legislative status
Norway was one of the first countries to adopt a tobacco control act (Act of 9 March 1973 relating to the prevention of the harmful effects of tobacco). The current Tobacco Control Act regulates the sale and use of tobacco products. The age limit for the purchase and sale of tobacco products is 18; there is a total ban on all forms of tobacco advertising; health warnings are mandatory on tobacco packages; there is a display ban on tobacco products in retail outlets; and there is a ban on smoking (with certain exceptions) in workplaces, institutions, restaurants, and premises and means of transport with public access.

The advertising ban in particular, played an important role in the success of the tobacco prevention during the first years. In recent years, the smoking bans that were introduced in 1988 (workplaces, premises and means of transport to which the public have access) and 2004 (bars and restaurants), have had a major impact on people's attitudes to smoking and the decline in the number of smokers.

On 14 December 2012 the Ministry of Health and Care Services presented the bill *Proposition to the Storting 55 L (2012-2013) Amendments to the Tobacco Control Act (licensing system etc.)*. This bill includes several amendments to the Act with the aim of preventing children from access to tobacco products, increasing tobacco-free areas and strengthening the protection against exposure to second hand smoke. The Storting (= the Parliament) will consider the bill during the spring session of 2013.

The single most important proposal is the introduction of a municipal licensing system for the sale of tobacco products. Today, no one supervises the age limit of 18 years for the purchase of tobacco products, despite the fact that nearly half of the minors who smoke or use snus, buy their own tobacco. To a certain extent, the proposed scheme is based on the existing licensing scheme for the sale of alcoholic beverages. The proposal implies that all outlets wanting to sell tobacco products must apply for a permit from the municipality, which will supervise that the outlet complies with the age limit and other provisions of the Act. It also proposes a ban on self-service and a ban on smaller tobacco packages. The proposals are intended to restrict the access of children and young people to tobacco products by making tobacco products less accessible both physically and cost-wise.

A number of measures are further proposed to limit children and young people's demand for tobacco products, and to strengthen the protection against exposure to second hand smoke. The proposals include a total ban on smoking in workplaces and premises to which the public has access, smoke-free outdoor entrances to health care institutions and public buildings, tobacco-free schools and kindergartens both indoors and outdoors, and a ban on tobacco use for pupils during school hours. Other proposals include a normative provision on children's right to protection from exposure to second hand smoke, national regulations on smoking at outdoor serving areas, and that the long-term vision of a tobacco-free society is included in the Act's objective clause.

During the strategy period the Ministry of Health and Care Services will follow up the Parliament's enactment by drawing up detailed regulations for a licensing system for the sale of tobacco products and for outdoor restaurants. Furthermore, the need for regulations concerning smoke-free entrances and the ban on smaller tobacco packages will be considered. The legislation will also be continuously developed in the light of new knowledge, experiences from other countries and the on-going work associated with the WHO FCTC.

A Protocol to Eliminate Illicit Trade in Tobacco Products was adopted at the Conference of the Parties to the WHO FCTC in November 2012. The protocol aims to reduce all forms of illicit trade in tobacco, including smuggling. It includes provisions on the regulation of the supply chain from manufacture to retail outlet. During the strategy period the Ministry will consider ratification of the protocol.

Box 4.1 Continuous development of legislation

In the course of the strategy period the Ministry of Health and Care Services will follow up the Parliament's enactment, including:

- Introducing a municipal licensing system for the sale of tobacco products.
- Introducing a ban on self-service and smaller tobacco packages.
- Increase the number of tobacco-free areas Strengthening protection against exposure to second hand smoke.

The Ministry will also:

- Consider the ratification of the Protocol to Eliminate Illicit Trade in Tobacco Products.
- Continuously develop legislation in light of new knowledge and international experience and to follow up the WHO FCTC.

5.2 Economic policy instruments

There has been a special tax on tobacco since 1915. Thus, there is a long tradition for using taxation as a policy instrument of tobacco control in Norway. Originally the rationale was to raise revenues for other purposes. Currently the health argument that higher tobacco taxes reduce consumption is also used.

When the price rises, demand falls. This is true despite the use of tobacco being addictive. Taxes have the greatest effect in groups with little education and low income. Such measures can therefore contribute to the reduction of social inequality in health behaviour.

Young people are particularly sensitive to changes in the price of tobacco, two to three times more than adults. It is estimated that an increase of 10 per cent in retail price will

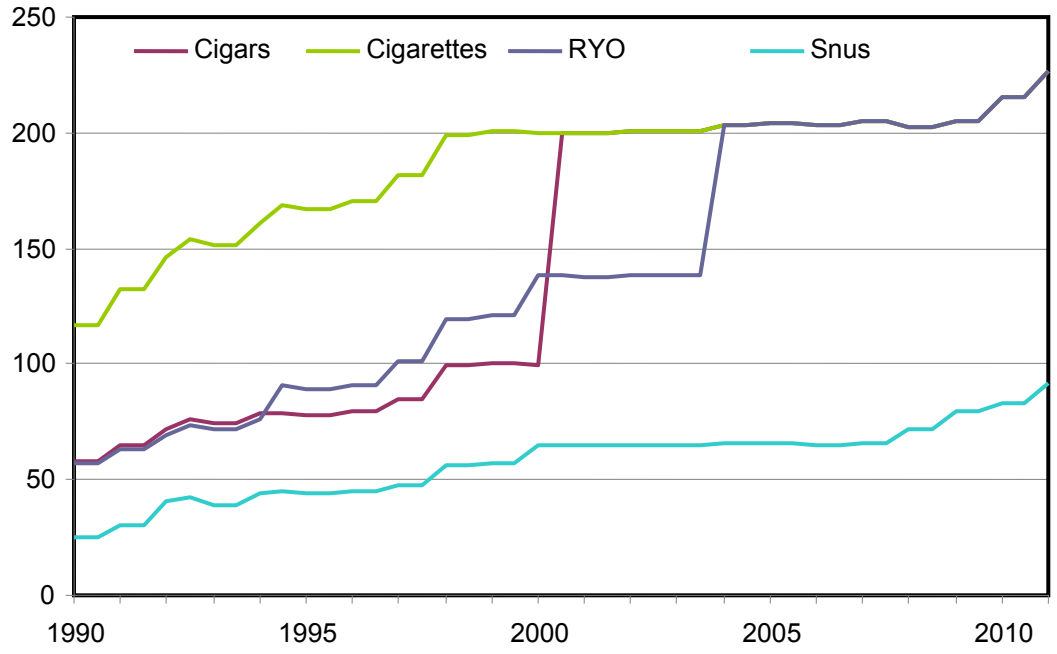
reduce overall consumption by around five per cent and youth consumption by around 15 per cent (SIRUS 2007).

The Tobacco Control Act prohibits special discounts on the sale of tobacco products. In January 2012 tobacco tax and VAT made up 73 per cent of the retail price of tobacco products in Norway.

In 2010, the government revenue from tobacco taxes was 7,4billion Norwegian kroner (Figure 5.1). The estimated tobacco tax revenue of 2012 calculates to 8,2 billion Norwegian kroner (not including VAT).

The sale of snus has increased during this period, especially since the year 2000. Total sales of tobacco products are currently more than 35 per cent lower than in 1990. After 2006, sales increased somewhat, and the snus sales account for the increase. However, total sales have declined since 2009 and are back at 2005 levels. In addition there are unregistered sales such as border trade, duty-free sales (tax free) and smuggling. About 35 per cent of cigarettes and 25 per cent of snus products were bought abroad in 2009. This does not include smuggling.

Figure 5.1. Tax levels on tobacco products. ***2010 kroner per 100 grams/pcs.***



(Source: Ministry of Finance and Statistics Norway)

In an international context, Norwegian tobacco taxes are relatively high, but in terms of purchasing power, the price of tobacco has dropped since 1950. At the beginning of the 1950s an industry worker had to work for around one hour to buy a packet of 20 cigarettes. Around 1980 it was sufficient to work for slightly more than quarter of an hour (SIRUS 2005). The increase in purchasing power meant that the relative price of cigarettes was dramatically reduced. The annual tax increases on cigarettes were

somewhat higher than wage increases until the mid-1990s. Over the past decade, the price of cigarettes has been relatively stable. Since 1980, price increases for cigarettes have only been marginally higher than the developments in purchasing power, while the price of rolling tobacco has increased sharply.

High tax rates in combination with mass media campaigns are the two most important measures to combat tobacco use among young people (World Health Organization). In its 2010 evaluation report the World Health Organization recommends that the difference in tax rates between snus and smoking tobacco in Norway be reduced, despite the fact that there is general agreement that smoking is more harmful than snus use.

In the Official Norwegian Report *NOU 2007: 8 An assessment of excise duties,* the committee concludes that the current level of tobacco taxes approximately equals the sum of the socio-economic costs + welfare costs. The committee also pointed out that the general public health argument of limiting the use of tobacco over time further justifies a high tax on tobacco. It also pointed out that high tobacco prices can prevent young people from starting to smoke.

In a more recent report, the Directorate of Health (Directorate of Health 2010) estimates that the socio-economic costs of smoking in Norway are 8 billion Norwegian kroner or 80 billion Norwegian kroner per year, depending on whether one simply assumes costs for health care or also costs to society as a whole.

Box 5.2 Use of taxes as a policy instrument

Economic policy instruments have an impact on tobacco consumption in a population. A high level of taxation on tobacco products will be maintained.

5.3 Mass media campaigns

Mass media campaigns can communicate well-defined messages to large groups of people repeatedly and over time at a low cost per head. Mass media campaigns can lead to behavioural changes in defined target groups, and are suitable for creating awareness and influencing attitudes to other tobacco control measures. Such campaigns are also well suited to motivate smokers to quit smoking and to show smokers where they can seek help to quit smoking. Australia and the United States have used mass media campaigns in tobacco-control work for several years with well-documented effect.

Experience shows that mass media campaigns against tobacco are more likely to succeed if (i) the campaign is extensive and intensive, (ii) the target audience is clearly defined, (iii) messages are based on the needs and interests of the target audience, (iv)

the campaign lasts long enough and (v) the campaign is supported by other community-based measures against smoking. However, this requires extensive and long-term financial investment.

Mass media campaigns with strong messages on the negative health consequences of tobacco use are more effective than campaigns with a humorous slant or campaigns with a neutral presentation of the message. Population-oriented information campaigns with a negatively charged message are also more effective than campaigns aimed at particular groups by nationality, age and gender. Campaigns that provoke an emotionally negative response also appear to be effective in preventing young people from starting to smoke.

In 2003, the proportion of smokers in Norway dropped by three percentage points following two mass media campaigns and extensive debate on the introduction of a stricter anti-smoking act. Regular and frequent use of media campaigns have shown a positive correlation with the reduction in smoking in the United States.

The use of social media in tobacco prevention is in its infancy but should be tested. In a survey of 1,000 young people more than 30 per cent responded that they had discussed smoking and snus use in social media on one or several occasions (Directorate of Health 2010). Commercial parties also use social media in various ways, such as marketing, rumour spreading, promotional games and social marketing. Tobacco Free Florida (www.tobaccofreeflorida.com) is an example of the use of social media for tobacco control.

Focusing on mass media campaigns and initiatives to improve services for smoking cessation are the most important policy instruments in this strategy period to encourage those who already use tobacco to quit.

In Norway, no major mass media campaigns were implemented in the 2007–2011 period. However, in keeping with recommendations from the World Health Organisation's 2010 evaluation report, health authorities started such campaigns again in 2012. In 2012 and 2013, 19 million Norwegian kroner was allocated over the state budget for mass media campaigns against tobacco use, and these campaigns will be used systematically and strategically to achieve the objectives of the strategy period.

Box 5.3 Continued use of mass media campaigns

Mass media campaigns are very effective in reducing tobacco use among all groups. In the strategy period mass media campaigns against tobacco will be implemented to:

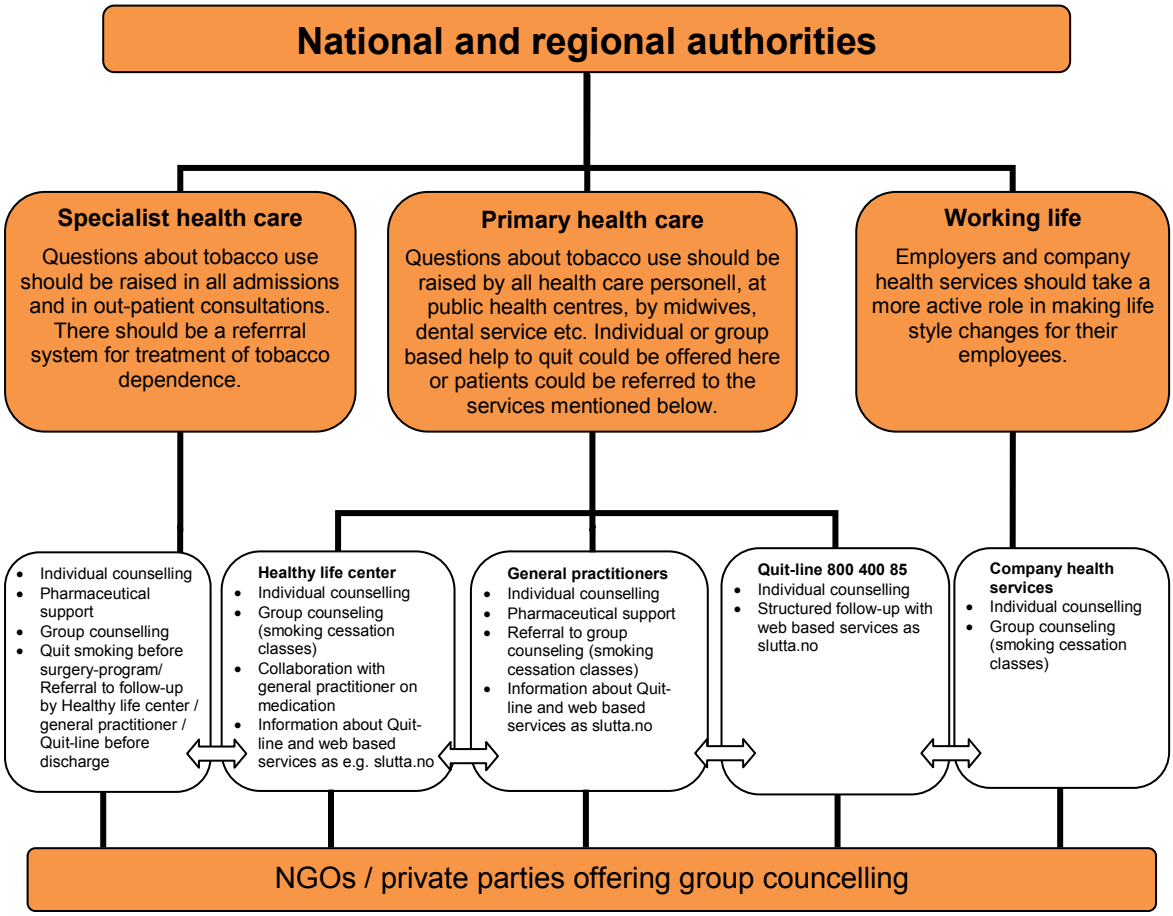
- Help prevent children and young people from taking up tobacco use.
- Motivate people who already smoke or use snus to quit.
- Motivate pregnant women to quit. Inform parents about the child's right to grow up in a smoke-free environment.

5.4 Tobacco cessation

If the goal of less than 10 per cent daily smokers by the end of 2016 is to be reached, approximately 300,000 of the approximately 700,000 current smokers must quit.

Arenas and parties involved in tobacco cessation
Nationwide services for tobacco cessation are available through the quit line and the www.slutta.no website. Local services to individuals or groups are offered through the health services, working life and voluntary organizations. The parties and the interaction between them can be described as follows:

Figure 5.2 Arenas and parties involved in tobacco cessation



(Source: Directorate of Health)

The figure shows the different stakeholders that work with tobacco cessation in Norway. There is a need to strengthen cooperation among the different levels and parties so that anyone who wants help with tobacco cessation receives an appropriate service.

Tobacco cessation work must primarily take place where people live and work. The primary health care service will have the leading role in this work, together with the dental health service, healthy life centres and nongovernmental organizations (NGOs). The specialist health services and occupational health services also play important roles.

The quit line and website for smoking cessation
There are already two easily accessible and free services for everyone; the quit line (Røyketelefonen) and www.slutta.no website. It is important to continue these services and make them even better.

Figure 5.3 Free tobacco cessation services from the Directorate of Health

(Source: http://www.helsedirektoratet.no/tobakk)

Tobacco cessation in the primary health care services
Most people stop smoking and using snus without help. However, with professional efforts the result can be almost tenfold, and more intensive support provides better results. The health services, including healthy life centres, which currently number 150, have a particularly important role to play in tobacco cessation. Patients take information conveyed by health personnel seriously.

NGOs do not offer tobacco cessation services in all municipalities. Work on tobacco cessation should be done in cooperation with NGOs, where available.

To increase the demand for assistance for tobacco cessation, it is important that the use of tobacco be raised as a topic in as many consultations with the health care services as possible. "Brief intervention" is asking about tobacco use, and this is something all health professionals can do. Brief intervention is the most important tool in the primary health care services and is considered to be very cost-effective. National guidelines from several countries agree that brief intervention should be recommended.

Brief intervention, the quit line and the website for smoking cessation (slutta.no) should be promoted by health workers and managers in the municipal/county health services.

Systematic use of patient contacts is important for tobacco cessation and can be done in several ways. It is common to distinguish between on the one hand "brief intervention" that all health workers can carry out without any prior knowledge, and on the other a more comprehensive guidance program for tobacco users with special needs.

Figure 5.4 Tobacco cessation with brief intervention

Tobacco cessation

1. Brief intervention
    1. Do you smoke/use snus?
    2. Would you like to quit?
    3. I would recommend that you quit, and I can help you.

2. Further guidance
    - Provide information on, or offer, medical treatment
    - Provide information on healthy life centres, the quit line and slutta.no
    - Agree on follow-up

If the patient does not want to quit: Ask permission to raise the issue again at the next consultation.

There is a correlation between the intensity of the counselling and treatment and the efficacy of the measures. More intensive counselling and treatment improves the outcome. There are methods for more comprehensive guidance that are cost-effective, easy to learn and simple to implement. Best results are obtained when supplementing qualified counselling with pharmaceutical interventions. Guidelines from Sweden, New Zealand and the United States recommend pharmacological support for smoking cessation.

Patients who require more extensive counselling should be offered assistance and/or be referred to assistance from trained supervisors. More comprehensive guidance can be performed by interested physicians and other health workers, non-governmental organizations and at workplaces.

Tobacco cessation in the specialist health service
Smoking cessation in health care institutions works and is cost-effective. Smoking cessation reduces the risk of complications during surgery, the number of inpatient days and the risk of re-operation. A study shows that stopping smoking before elective surgery resulted in 18 per cent having complications, while 52 per cent of the control group had complications after surgery. In another study, mortality after a heart attack was halved by means of a smoking cessation programme. In comparison, mortality was reduced by 34 per cent when using pharmaceuticals after the heart attack.

The specialist health service should play a stronger role in tobacco prevention. This is in keeping with the Coordination Reform. The letter of assignment for 2012 to the regional health authorities requires public hospitals to provide patients and staff assistance with tobacco cessation. The scheme should be standardized in accordance with the Directorate of Health's professional guidelines. This means that the patient's tobacco use should be listed in the records at admission, and a "brief intervention" should take place early on. One department at the hospital where individual smoking cessation is carried out continuously should be the place for referrals for other departments.

Hospital departments in the following areas should have standardized procedures on how to follow up patients who smoke:
- Medicine (especially cardiac and pulmonary departments)
- Surgery
- Ear, nose and throat
- Cancer
- Gynaecology/obstetrics
- Neurology
- Substance abuse/psychiatry

Patients who are called for elective surgery, should receive standardized information about the importance of smoking cessation before elective surgery takes place. At the same time an offer of help to quit through the quit line, healthy life centres, the primary care doctor or a separate program at the hospital should be provided.

Long-term follow-up of smoking patients after discharge is best done at outpatient clinics or contacting the patient by phone by a nurse who has had conversations with the patient during his/her stay. It can also take place through the quit line, healthy life centres or by the primary care doctor. The relevant department is responsible for ensuring that all patients who smoke are offered follow-up of smoking cessation upon discharge from the hospital.

A systematic and knowledge-based plan for tobacco cessation
Experience from countries that have progressed further than Norway in tobacco control, shows that simultaneous focus on high taxes on tobacco, restrictive legislation that reduces access to tobacco, mass media campaigns and a systematic and

knowledge-based cessation service is the most effective way to achieve a reduction in the proportion of tobacco users.

The Norwegian health system, including health care education, is primarily focused on diagnosis and treatment. It is a goal that smoking cessation should be a systematic part of health services for the population and readily available to everyone. The professional quality of tobacco cessation should be strengthened and coordinated nationally, regionally and locally.

On behalf of the Ministry of Health and Care Services, the Directorate of Health in 2011 therefore prepared a plan for systematic and knowledge-based services for help in smoking and snus cessation (Directorate of Health 2011). Key topics from this plan to be pursued in the strategy period are:

Quality requirements in the work with tobacco cessation
Guidelines are needed for how smoking cessation in the health care services is systematically carried out and implemented. (e.g. hospitals, maternity care, general practice, primary care service, dental care and in chemists). Appropriate material for ethnic minorities, groups with a high percentage of smokers, pregnant women, patients due for surgery and patients with chronic diseases is also needed.

The quality of the quit line and the www.slutta.no website should be evaluated and updated by the Directorate of Health in the strategy period. This is to ensure that the service is still knowledge-based and of high quality. The quit line must have sufficient capacity to meet increased use in conjunction with mass media campaigns.

The Directorate of Health should also evaluate the scope and quality of the training of counsellors, and the implementation of the tobacco cessation service.

Use of pharmaceuticals in tobacco cessation
The World Health Organization recommends that nicotine addiction should be classified as a disease, in keeping with the International Classification of Diseases (ICD-10).

In a review from 2010 the Norwegian Knowledge Centre for the Health Services concludes that 10 per cent have quit smoking after a year of using a placebo, while 16 per cent, 18 per cent and 26 per cent have quit using nicotine preparations, bupropion and varenicline respectively. Bupropion and varenicline are considered cost-effective compared to no treatment. Varenicline emerges as the most cost-effective option. In a 2009 report the Directorate of Health suggests that the National Insurance Act is amended to allow for pharmaceuticals for tobacco cessation to be on free prescriptions.

The National Council for Priority Setting in Health Care considered the use of pharmaceuticals in tobacco cessation in September 2012. The Council pointed out that pharmaceuticals are only used to a small extent in Norway, even though research shows that it is efficient and cost-effective. The Council recommended the introduction of a refund scheme for pharmaceuticals for smoking cessation and the amendment of the regulations relating to pharmaceuticals.

The Ministry of Health and Care Services is of the opinion that pharmaceuticals for tobacco cessation should be used more actively, especially in conjunction with counselling , and will consider this in more detail during the strategy period.

Whether pharmaceuticals for tobacco cessation may be prescribed by health care workers other than doctors in connection with tobacco cessation services will also be considered during the strategy period. Nicotine replacement products such as patches and gum do not require prescription from a doctor, while pharmaceuticals for tobacco cessation do require prescriptions.

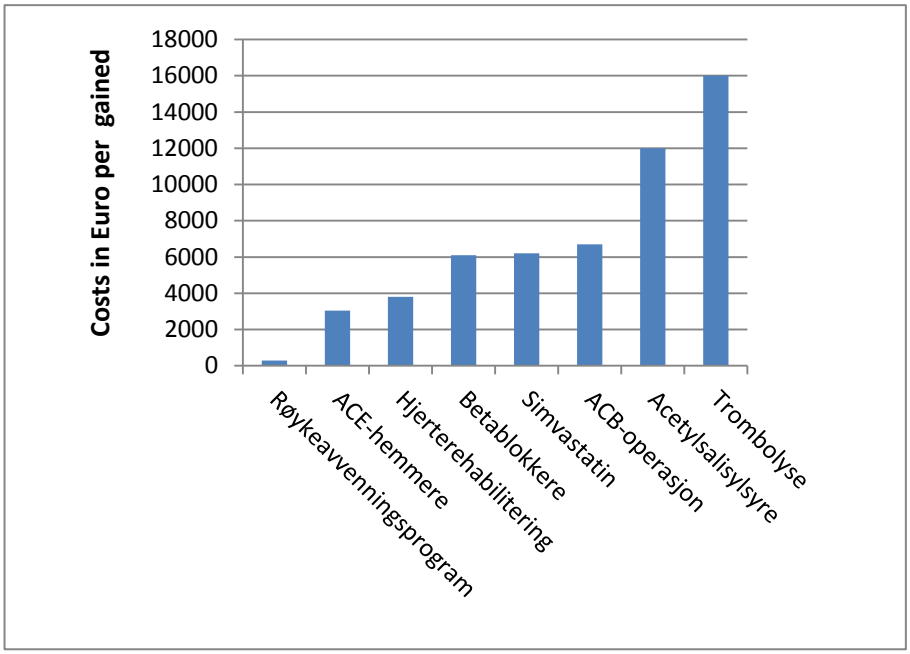
Snus is not recommended as a mean to quit smoking
Some studies suggest that snus use may have a beneficial impact on smoking cessation and decreased smoking intensity. On the other hand, the use of snus also has harmful health effects and leads to nicotine addiction. There is a lack of longitudinal studies over longer periods of time that show whether the use of snus for smoking cessation leads to complete freedom from nicotine in the long term, to only the use of snus, or to the combined use of cigarettes and snus.

The Ministry does not recommend snus as a general method to quit or cut down smoking. It is a goal to halt the increase in snus use, particularly among young people. This policy is in accordance with the recommendations of the World Health Organization in their 2010 evaluation report.

Promote an effective smoking cessation program
The World Health Organization recommends that the Ministry of Health and the Directorate of Health investigate the possibility of using the fee system to encourage general practitioners to play a more active role in the work on tobacco cessation. The registration of tobacco use, the implementation of brief intervention and smoking cessation is recommended included in any fee. The proposal will be considered during the strategy period.

Smoking cessation is cost-effective compared with other preventive measures
Figure 5.5 shows the cost-effectiveness of smoking cessation following heart attacks compared with other treatment for patients with cardiovascular disease.

Figure 5.5 Cost per year of life gained for different interventions for heart disease



(Source: Quist-Paulsen et al., 2006 (42))

High intensity interventions, which begin at admission to a hospital and that include at least one month follow-up after discharge, promote smoking cessation among hospitalized patients (Ministry of Health, Canada 2010). This applies regardless of the diagnosis for which the patient is admitted.

Box 5.4 National plan for tobacco cessation

In the strategy period the Ministry of Health and Care Services will:

• Give the Directorate of Health the task of implementing a nationwide plan for tobacco cessation by:
- Making tobacco cessation a systematic part of health services to the population
- Strengthen the quality of tobacco cessation services
- Consider measures to increase the use of pharmaceuticals in tobacco cessation- Further develop the quit line and the slutta.no website
• Consider the need to change the fee system for general practitioners to better stimulate work on tobacco cessation.

5.5 Other measures

Tobacco work in the municipalities
The municipalities have numerous tools at their disposal in their tobacco prevention work as owner, authority and service provider. According to the Tobacco Control Act, the municipality is responsible for the supervision of the smoking bans at public places, including restaurants. The municipality has a management prerogative as an employer and business owner and can thus prohibit tobacco use in its businesses. In that regard, the municipality can to a certain extent also ban smoking during working hours.

The Directorate of Health is developing a guide for local tobacco control to strengthen local tobacco control work. The guide is expected to be completed during 2013.

School programmes
Many countries often provide uncritical support to school programmes to prevent smoking initiation among students under 16 years of age (WHO 2010). Although this is a desirable goal, the value of and opportunities for such programmes should be considered in light of these factors:

- *Effectiveness:* School programmes can be effective in the short term, but there is a lack of documentation as to long-term effects.
- *Cost-effectiveness:* School-based tobacco control programs can be cost-effective.. More cost-effective tobacco control measures should be considered before more is invested in school programmes – for example taxes on tobacco products and mass media campaigns.
- *Long time before possible effects:* Focus on preventing smoking initiation in children will not have visible results such as reduction of morbidity and mortality for at least 50 years.

FRI is a school-based tobacco control programme that has proven effective. The programme has been implemented across the country since 1997, and the content has been revised. More than half of students aged 13-15 years attend annually. The Directorate of Health and Directorate for Education and Training collaborate on the programme.

The role of school programmes in tobacco control efforts will be evaluated during the strategy period.

Monitoring the tobacco industry
For decades, the tobacco industry has opposed government efforts to limit tobacco use. The WHO FCTC Article 5.3 requires parties to ensure that tobacco policy is not influenced by the tobacco industry. Guidelines to the provision have been adopted. To keep abreast of changes in the country's tobacco market and to be aware of the products, brands and the tobacco industry's presence is important to anticipate opposition from the industry and others working to advance its interests. The Ministry

of Health and Care Services will in the course of the strategy period review the WHO FCTC guidelines to assess the need for further action in this area in Norway.

In the programme agreement Norway has with the World Health Organization for 2012-2013, Norway will contribute 19 million Norwegian kroner to the World Health Organization's work on tobacco and alcohol. The funding for tobacco will be used to strengthen the organization's monitoring of the tobacco industry.

Cooperation with non-governmental organizations (NGOs)
As part of the work on the new tobacco strategy, NGOs participated in several joint meetings with the Ministry of Health and Care Services. Valuable input was provided, and the ministry wishes to have regular meetings with NGOs during the strategy period.

Strengthening the knowledge base
It should be considered whether there is a need to further develop the tobacco statistics and reporting systems, including possible changes in the questionnaire that Statistics Norway uses to collect data for the Directorate of Health on tobacco use. Furthermore, it may be appropriate to consider new data collection.

The expert community on the tobacco area beyond the central health administration is limited.

- The Norwegian Institute for Alcohol and Drug Research (SIRUS) conducts social science research, documentation and communication on alcohol, drugs and tobacco. The Institute does not have scientific expertise.
- The Norwegian Institute of Public Health (FHI) has expertise in epidemiology, indoor air and toxicology relevant to tobacco, but lacks a centre of expertise on clinically related, biologically-based tobacco issues.
- The Norwegian Centre for Addiction Research (Seraf) has an emphasis on clinically relevant drug research and provides education and guidance in this field. Activities do not include tobacco.

There is a need to improve the knowledge base in terms of e.g. exposure to second hand smoke, tax-free sales of tobacco products and the tobacco market.

Box 5.5 Other measures

The Ministry of Health and Care Services will:

- Ensure that the school programmes' role in the tobacco control work are reviewed.
- Review the guidelines of the WHO FCTC Article 5.3 and assess the need for a national guide.
- In collaboration with the Ministry of Foreign Affairs provide support to the World Health Organization's monitoring of the tobacco industry, and its efforts to prevent the industry's promotion of tobacco products in developing countries.
- Continue collaboration with the NGO sector working against the harmful effects of tobacco.
- Further develop the tobacco statistics and reporting systems.
- Consider strengthening of the bio-medical expert community in the tobacco area and in particular improve knowledge about second hand smoking and the tobacco market.

APPENDIX – FACTS AND BACKGROUND OF THE STRATEGY

Contents:

I. CONSEQUENCES OF TOBACCO USE

According to the World Health Organization, tobacco use remains the leading single cause of death in high-income countries such as Norway (1). In this group of countries, tobacco use is also the main cause of lost healthy years of life, known as DALY (Disability Adjusted Life Years). DALY is the sum of years of life lost and years of impaired quality of life due to chronic illness. In the two tables below the World Health Organization ranks the various risk factors for death and DALY respectively.

Table 1 Ranking of selected risk factors as cause of death in high-income countries, 2004 (1)

Ranking	Risk factors	Deaths (millions)	per cent
1	Tobacco	1.5	17.9
2	Hypertension	1.4	16.8
3	Obesity/overweight	0.7	8.4
4	Physical inactivity	0.6	7.7
5	High blood sugar	0.6	7.0
6	High cholesterol	0.5	5.8
7	Low intake of fruits/vegetables	0.2	2.5
8	Urban outdoor air pollution	0.2	2.5
9	Alcohol	0.1	1.6
10	Occupational risks	0.1	1.1

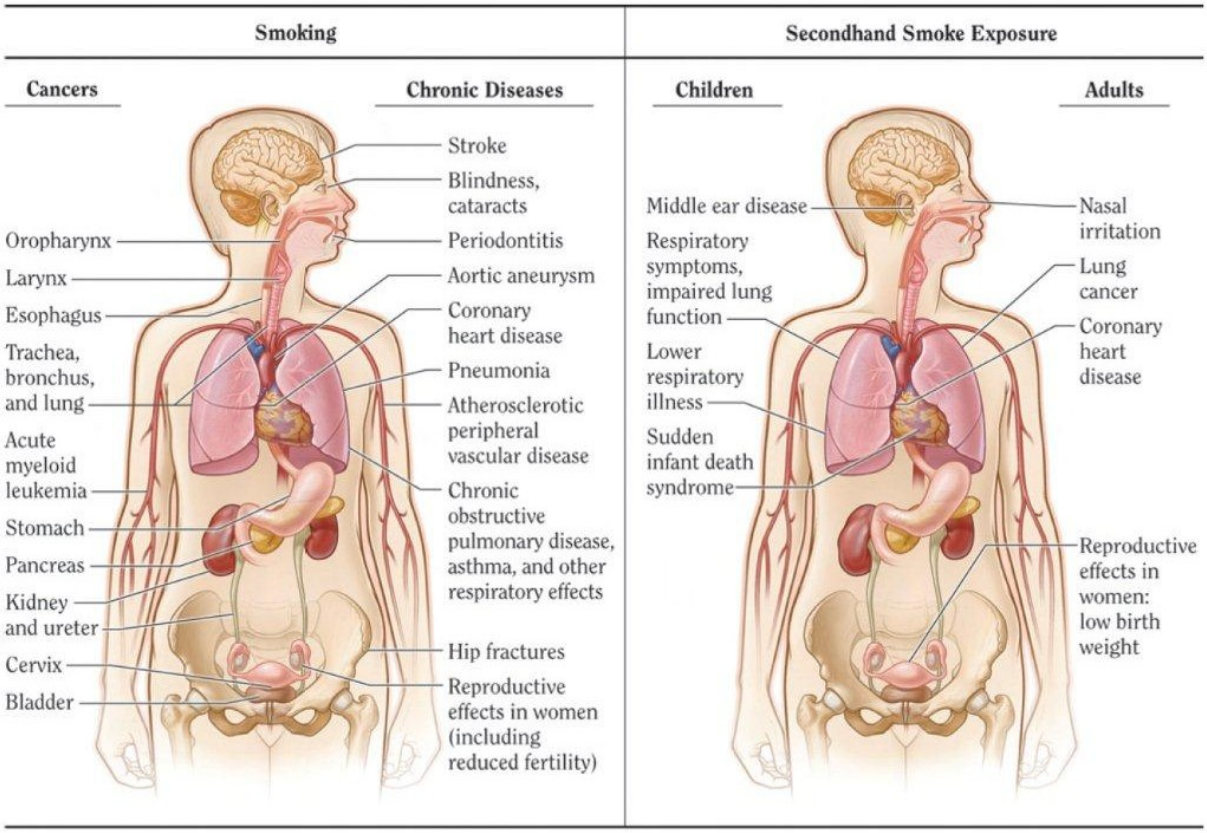
Table 2 Ranking of selected risk factors as cause of DALY in high-income countries, 2004 (1)

Ranking	Risk factors	DALY (mill)	Per cent
1	Tobacco	13	10.7
2	Alcohol	8	6.7
3	Obesity/overweight	8	6.5
4	Hypertension	7	6.1
5	High blood sugar	6	4.9
6	Physical inactivity	5	4.1
7	High cholesterol	4	3.4
8	Drugs	3	2.1
9	Occupational injuries	2	1.5
10	Low intake of fruits/vegetables	2	1.3

Half of those who smoke daily for many years die prematurely from tobacco-related disease.

One in four who die from smoking are aged between 35 and 69 years (2). In 2006 the Institute of Public Health estimated the proportion of deaths between 40 and 70 years that could be attributed to smoking. They found that smoking caused 26 per cent of deaths among women, while the corresponding figure for men was 40 per cent (3).

Figure 1 The health consequences causally linked to smoking and exposure to second hand smoke



Source: U.S. Department of Health and Human Services(4)

As Figure 1 illustrates, smoking causes disease in a variety of organs. The most important are cardiovascular diseases, cancer and respiratory diseases:

- Almost half of the deaths related to smoking among people between 40 and 70 years are due to cardiovascular disease. Heart attacks and strokes are the most common of these diseases. Smoking doubles the risk of blood clots in the brain (4).
- Smoking causes at least 85 per cent of all lung cancer, but also increases the risk of cancer in a number of other organs (4).

- Chronic obstructive pulmonary disease (COPD) is mainly caused by smoking. According to the COPD Council around 370,000 people in Norway suffer from COPD. Incidence increases with age, and mortality from COPD is high (5).

Exposure to second hand smoke

The negative consequences of exposure to second hand smoke are now far better documented than in the previous strategy period. This applies to both an extended injury pattern, the extent of injuries and increased risk of disease due to exposure to second hand smoke. Around one per cent of the total global mortality is attributable to exposure to second hand smoke. Of the total morbidity caused by second hand smoking, 66 per cent affects children according to a recent Swedish study (6). Estimates made by the EU in 2002 showed that 7,000 annual deaths in the EU countries could be attributed to exposure to second hand smoke at workplaces, while around 72,000 deaths were due to exposure to second hand smoke in the home (7). In Norway, hundreds of people die each year from diseases caused by exposure to second hand smoke (3).

There is no good data on the population's exposure to second hand smoke in Norway. The Institute of Public Health has estimated that six to 30 per cent of the adult population is exposed to second hand smoke on a daily basis (8). In 2010 SIRUS estimated that around 100,000 Norwegian children under 14 years are exposed to second hand smoke in the home daily[1] (9).

Currently, there is relatively little research on exposure to second hand smoke outdoors, but some studies have shown that the exposure to tobacco smoke outdoors can equal indoor exposure, depending on site conditions and proximity to the smoker (10-16).

Exposure to second hand smoke is harmful throughout life, but is especially dangerous to the foetus and small children, if exposure occurs during pregnancy or early in the child's life.

The negative consequences of smoking during pregnancy are numerous. When pregnant women smoke, there is an increased risk of complications during pregnancy, such as miscarriage, stillbirth, premature birth, reduced birth weight and Sudden Infant Death Syndrome (SIDS). In addition, the risk of the child developing asthma increases (17;18).

Studies have shown that the prevalence of asthma and allergy increases proportionally with tobacco exposure during pregnancy, regardless of whether exposure occurs through the mother's active smoking or if she is exposed to second hand smoke (19).

[1] SIRUS underlines in its report that there is considerable uncertainty associated with the estimate.

In a study from the Child Allergy Study in Trondheim (PACT), exposure to tobacco by pregnant women and children in the first year of life was studied using blood samples (cotinine in plasma). The result shows that 14 per cent of four-month-old children in 2004–2005 were exposed to tobacco, either through breast milk or through exposure to second hand smoke, while the corresponding figure for one-year-olds was 10 per cent. In the same study, blood samples from children of the same age were also studied, but from 2001–2002. Here, the figures were 22 per cent and 28 per cent respectively (20). This shows that there has been a welcome reduction in the number of children exposed to tobacco smoke in infancy. At the same time the study shows that the number of children who are exposed to the hazardous effects of tobacco smoke is still very high.

There is evidence that the following health conditions in children are related to exposure to second hand smoke: Sudden Infant Death Syndrome (SIDS), lower respiratory disorders, middle ear disorders such as acute and repeated inflammation and chronic discharges, coughing, mucous and wheezing in the chest, asthma and decreased pulmonary function throughout childhood (21).

Exposure to second hand tobacco smoke may also pose a health risk for adults with chronic lung disease (including asthma and COPD). Longer exposure to second hand smoke can cause lung cancer and heart attacks in non-smokers. In the U.S., an expert committee commissioned by the Centre for Disease Control and Prevention (CDC) examined the relationship between exposure to second hand smoke and heart disease in 2010. The conclusion is that exposure to second hand smoke increases the risk of heart disease by 25-30 per cent and that higher doses increases the risk compared to smaller doses (22). According to a 2010 report from the Surgeon General (U.S.), even small amounts of second hand smoke can cause cardiovascular disease and for example trigger heart attacks (4).

Snus as a risk factor for disease and death

Although there is agreement that the use of the Swedish smokeless tobacco snus is much less harmful than smoking, snus nevertheless has serious, adverse health consequences: In 2005 the Swedish Institute of Public Health published the report "Hälsorisker med svenskt snus" [Health risks of Swedish snus] (23), that concluded that Swedish snus is carcinogenic. Studies from Scandinavia have indicated an association between snus use and cancer of the pancreas and oesophagus (24). There are also results showing a possible link between Swedish snus and stomach cancer (25). The World Health Organization's cancer research institute IARC concluded in 2007 and in 2012 (26) that snus is carcinogenic, and the EU expert group SCENIHR arrived at the same conclusion in 2008 (27). Snus use is also associated with elevated blood pressure and increased mortality after heart attacks and strokes (28;29).

Because the use of snus is increasing especially among young people, the use of snus during pregnancy is a growing problem. A large Nordic study showed a marked increase in the risk of stillbirths. The risk of stillbirth among women who used snus

was greater than for women who smoked less than ten cigarettes per day (30). Others have shown a link between snus use and premature births and preeclampsia (31).

Tobacco use and addiction

Nicotine has both a refreshing and soothing effect and is highly addictive. There are individual differences in the disposition of becoming dependent. Hereditary factors may play a role in these differences (32), and social, economic, personal and political decisions have an impact on the prevalence of smoking and smoking cessation.

Dependence on nicotine is stronger than drugs such as heroin or cocaine (32). Most people continue to smoke because they have become addicted to nicotine. Around one third of everyone who has tried smoking become daily smokers. Of those who try to quit, less than five per cent manage to quit permanently on their own at the first attempt. Although not everyone becomes addicted to nicotine, the prevalence of nicotine-dependent individuals is higher than for other addictive substances (4).

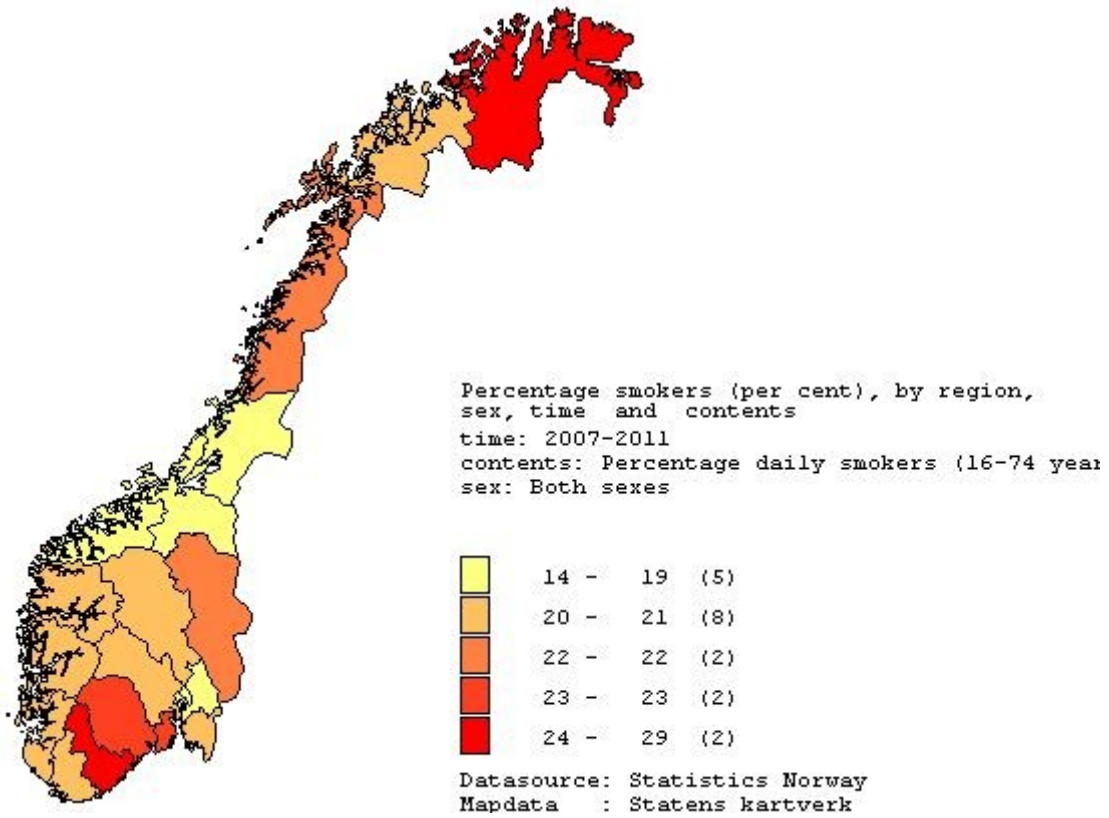
Eighty-five per cent become addicted to nicotine after repeated use (33). Nicotine addiction can develop rapidly. Some can become addicted after only a few days of use, while 80 per cent will become addicted if they smoke or use snus daily for a few months. Nicotine addiction develops particularly rapidly in children and adolescents, and addiction can develop even if they only smoke or use snus occasionally. Nicotine addiction may be considered a chronic condition that can be treated (34).

Tobacco use leads to social inequality in health

Average figures for smoking conceal large social differences. Those who smoke are over-represented in groups with low income, low education and in manual work. In 2011 there were 35 per cent daily smokers in the group "25 years and older with only primary education." Among those with upper secondary school in the same age group, the proportion of daily smokers was 20 per cent, while it was nine per cent among those with a university or university college education. Nevertheless, we see that the gradual reduction in the proportion of smokers in the population occurs in all three education groups, even though the relative distance between education groups increases. However, occasional smoking is more prevalent among those with a longer education (35;36).

As Figure 2 shows, there are also large geographical differences; and the lowest proportion of daily smokers is in Oslo with 14 per cent, and the highest in Finnmark with 29 per cent.

Figure 2 County distribution of the percentage of the population who were daily smokers in the period 2007–2011.



Social inequality in health have many causes – from basic factors such as economy and the conditions when growing up, through risk factors such as working and living environment to more immediate factors such as health behaviour and use of health care services. Research shows that smoking, diet and physical activity are all interlinked with socio-economic status. Tobacco is however in a class of its own when it comes to health consequences. In a study from the Institute of Public Health differences in mortality among both men and women is explained mainly by different smoking behaviour between people with long and short educations (37). In the age group from 45 to 60 years, cardiovascular disease, lung cancer and COPD are responsible for 60 per cent of the difference in mortality between people with long and short educations, and differences in smoking habits are assumed to be the main cause (38). Smoking is the single most important cause for the differences in life expectancy between the different social groups (39-41).

Studies show a similar correlation between level of education and the extent to which children are exposed to second hand smoke both during and after pregnancy. Exposure to tobacco smoke can therefore contribute to social inequality in health and disease being established early in life (42).

Social Costs

The Directorate of Health estimated in 2011 that the socio-economic costs related to smoking in Norway is eight billion Norwegian kroner or 80 billion Norwegian kroner per year, depending on whether one assumes costs for health care services or also costs to society as a whole (43). This is a broad estimate where the lowest amount only includes the cost of health care and loss of production due to increased morbidity and premature death, while the highest amount also includes an economic valuation of 150-180,000 years of life lost. The value assumed for welfare related to years of life and quality of life is therefore of great importance for the magnitude of the costs.

The report estimates the magnitude of the socio-economic costs related to tobacco use in Norway. The estimates are based primarily on translation of Danish, Swedish and British figures. In addition, methodological assessments, assessments of the relevance of consumer sovereignty versus paternalism, causes of market failure and assessments of the costs' magnitude based on other sources of cost estimates have been made.

The welfare costs of smoking as estimated here are based on assumptions of market failure due to addictive and partly uninformed behaviour, and may be an upper estimate. The Directorate of Health nevertheless believes that such estimates are significantly closer to the real magnitude of costs than estimates based on assumptions on consumer sovereignty. The report does not consider specific measures, but it is still important to make a number of reservations with regard to application of the results.

The Directorate of Health concludes that it is socio-economically profitable to spend more resources on tobacco prevention.

II. MILESTONES IN NORWEGIAN TOBACCO POLICY

1965	The Parliament appoints a public committee with the following mandate: "... to submit a report... on which measures can be implemented in order to prevent people from starting to smoke and to encourage smokers to cease smoking or reduce their consumption."
1967	The committee presents a unanimous report: "Influencing smoking behaviour." Among other things, the committee recommends the introduction of an advertising ban, health warnings, information measures and smoking cessation initiatives.
1969	Report No. 62 to the Storting with Action plan against smoking is presented.
1971	The National Council on Tobacco and Health is established by royal decree.
1973	An Act on restrictive measures on the trading of tobacco products with advertising bans and order on health warning labels (Act relating to prevention of the harmful effects of tobacco) is adopted. The Act also includes a prohibition against selling tobacco to people under 16.
1975	The Act relating to prevention of the harmful effects of tobacco (the Tobacco Control Act) enters into force.

1985	The report "The air is for everyone" is presented. The report is the National Council on Tobacco and Health's proposal for regulation of protection against exposure to second hand smoke.
1988	Amendments to the Tobacco Control Act to ensure protection against the harmful effects of tobacco come into force. This entails that protection against exposure to second hand smoke in premises and means of transport to which the public has access, becomes statutory. Work premises and institutions are also included. On certain strict conditions, it is still possible to permit designated smoking rooms in such places. Restaurants are exempt from the ban.
1989	Regulations concerning the import, sale and production of new nicotine and tobacco products come into force.
1996	The Tobacco Control Act is further tightened: a ban on smoking in open restaurants is introduced and the age limit for buying tobacco is raised from 16 to 18. A ban on indirect advertising comes into force. A ban on smoking in school and kindergarten premises is introduced in the regulations. A quit line is established as a free service under the National Council on Tobacco and Health.
1998	A tightening of regulations on smoking in restaurants and bars takes effect, such that it is allowed to permit smoking at half of the tables.
1999	The Strategic Plan for Tobacco Control in Norway 1999–2003 from the Ministry of Health and Social Affairs and the National Council on Tobacco and Health is presented. The National Cancer Plan sets aside funds for the hiring of public health consultants at the county governors' offices.
2002	The EU Tobacco Products Directive is implemented in Norwegian law through the Tobacco Control Act: Ban on misleading product names such as "light" and "mild", larger health warnings and the authority to demand product information from the tobacco industry. The National Council on Tobacco and Health is integrated in the Directorate of Health in connection with the reorganization of the central social and health administration.
2003	Several amendments to the Tobacco Control Act are adopted, including a total ban on smoking in bars and restaurants. The Directorate conducts the mass media campaign "Every cigarette is doing you damage" and a campaign focusing on the tobacco industry's methods. Norway ratifies the World Health Organization Framework Convention on Tobacco Control.
2004	The ban on smoking in bars and restaurants enters into force on 1 June. The Directorate of Health conducts a mass media campaign on everyone having the right to a smoke-free workplace.
2005	The WHO Framework Convention on Tobacco Control enters into force.
2006	The "National Strategy for Tobacco Control 2006–2010" and the "National Strategy for the COPD area 2006–2011" are presented by the Ministry of Health. The Directorate of Health conducts a mass media campaign on COPD.
2007	The National COPD Council is established with the Directorate as secretariat. The Ministry of Health wins a case in the Supreme Court on the application of the smoking ban in so-called smoking clubs.
2009	Mandatory pictorial warnings on tobacco packages are introduced with effect from 1 June 2011 for cigarettes and 1 January 2012 for other tobacco products,

	except for smokeless tobacco.
2010	The tobacco display ban at retail outlets comes into force on 1 January 2010. Tobacco manufacturer Philip Morris Norway AS sues the Ministry of Health, alleging that the display ban is in violation of the EEA Agreement. The World Health Organization performs an evaluation of Norwegian tobacco control work. Companies that produce tobacco are excluded from the Government Pension Fund for ethical reasons in accordance with guidelines established by the Ministry of Finance 1 March 2010.
2011	The Ministry of Health wins a case in the Supreme Court on the application of the smoking ban for outdoor restaurants. A requirement on self-extinguishing cigarettes comes into force from 17 November.
2012	The Ministry of Health wins the case against Philip Morris when the Oslo District Court finds that the display ban is not in violation of the EEA Agreement. The Ministry presents a bill with proposals for numerous changes to the Tobacco Control Act, including the introduction of a municipal licensing system for the sale of tobacco products, repeal of the possibility to have designated smoking rooms, the introduction of tobacco-free school hours for students up to and including upper secondary school and a normative provision on the right of the child to protection against exposure to second hand smoke.

III. NORWAY'S INTERNATIONAL OBLIGATIONS IN THE TOBACCO AREA

World Health Organization

The World Health Organization Framework Convention on Tobacco Control

The World Health Organization Framework Convention on Tobacco Control (WHO FCTC) came into force in February 2005 and is the first convention negotiated under the auspices of the World Health Organization (34). No other UN convention has been ratified by as many parties so rapidly. In March 2011, the FCTC had 174 parties.

The FCTC is an evidence-based international legal agreement that aims to reduce tobacco-related morbidity and mortality, and tobacco's social and environmental impact. Countries may have stricter rules than stipulated by the FCTC and decide themselves how they want to implement it in national legislation.

The FCTC consists primarily of two parts: 1) measures to reduce the demand for tobacco and 2) measures to limit access to tobacco. The Parties to the Convention may also negotiate protocols and guidelines. Protocols are legally binding for the parties, while the guidelines provide guidance on how the articles should be implemented by the parties. Table 1 shows the guidelines that the parties have adopted so far.

Table 1 Adopted guidelines for the FCTC provisions

FCTC	Content
Article 5.3	Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry
Article 8	Protection from exposure to tobacco smoke (
Article 9	Regulation of the contents of tobacco products
Article 10	Regulation of tobacco product disclosures to the authorities, as well as to the public
Article 11	Regulation of packaging and labelling of tobacco products
Article 12	Education, communication, training and public awareness
Article 13	Bans on tobacco advertising, promotion and sponsorship
Article 14	Measures to reduce tobacco dependence and cessation

EU tobacco regulations
The EU has in recent years had an active tobacco policy. Due to the EEA agreement, Norway is bound by two EU directives on tobacco. In addition, the EU Council of Ministers has issued two recommendations on tobacco (44). EU as an organization is an independent party to the WHO FCTC .

The *Tobacco Advertising Directive* (2003/33/EC) includes a ban against cross-border tobacco advertising in print, radio and the Internet, as well as sponsorship of events involving several member states (45). Tobacco advertising on television has been banned since 1989 (46). The Council of Ministers has recommended member states to go beyond the minimum requirements of the directive and ban a number of other forms of tobacco advertising, such as samples, the use of tobacco as prizes, special discounts, etc. The Norwegian ban on advertising is stricter than the EU rules.

The *Tobacco Products Directive* (2001/37/EC) sets maximum limits for tar, nicotine and carbon monoxide, and requires the industry to submit annual reports to the health authorities on the ingredients of tobacco products (47). The directive also requires the use of specific health warnings on tobacco packages. Member states can choose to adopt pictorial warnings on smoking tobacco, where the warnings must cover 40 per cent of the one surface of the package. Images must be chosen from an image archive developed by the European Commission. Norway introduced such pictorial warnings on tobacco packages from 2011.

The Tobacco Products Directive is under revision in 2012/2013. Norwegian tobacco policy in the upcoming strategy period is likely to be affected by the outcome of this directive revision.

IV. COLLABORATION AGAINST TOBACCO

Through the report to the Parliament on the *National Health Care Plan* (2011-2015) the Government has laid down the policy direction for the health and care services and public health work in the coming years (48). Through the Coordination Reform the Government wants to ensure a sustainable, comprehensive and coherent selection of services of good quality, where emphasis is on health promotion and prevention work. In the spring of 2013 the Government will present a report to the Parliament on public health (a national interdepartmental public health strategy), where the tobacco control work will be included.

One of the main initiatives is to develop a future municipal role which to a greater extent than at present can fulfil aspirations for prevention and efforts in the early stages of disease (49). Through the new Public Health Act and the new provisions in the Health and Care Services Act and Specialist Health Service Act, prevention has been strengthened in the legislation.

Participants in tobacco control work

The Ministry of Health and Care Services has the overall responsibility for the tobacco control work. The Ministry appoints the National Council for Tobacco Control, which provides the authorities with expert advice on tobacco issues. The Directorate of Health provides expert recommendations as a basis for policy development in the area and also has responsibility to implement the adopted policy. The Directorate of Health has further been awarded interpretative authority and a number of supervisory duties pursuant to the tobacco legislation. The Directorate is also responsible for the development of national guidelines and campaigns. The public sector, including municipalities, counties and the state, has the responsibility to take care of the health of the population, including through tobacco prevention activities.

Effective prevention requires active collaboration with NGOs and trade unions. The umbrella organization Tobacco-Free is a coalition of organizations which in various ways are involved in the fight against tobacco. The establishment of Tobacco-Free in 1994 was in accordance with the World Health Organization's recommendation to establish a non-governmental coalition against tobacco. Tobacco-Free maintains the individual organizations' need to act as one towards political authorities and the media.

The collaborating organizations in Tobacco-Free are:
The Norwegian Association of Midwives
The Norwegian Association Against Tobacco
The Cancer Society
The National Association for Public Health

The Norwegian Dental Association
The Norwegian Nurses Organisation
The Norwegian Asthma and Allergy Society
The Norwegian Medical Association
The Norwegian Olympic and Paralympic Committee and Confederation of Sports
The Norwegian Heart and Lung Patient Organization

The NGOs contribute in varying degrees to the tobacco control work with expertise and advice, development work, tobacco cessation services, influencing opinion, influencing politics, etc.

Local tobacco control work

The role of municipalities
The Act of 24 June 2011 No. 29 on Public Health (Public Health Act) aims to contribute to the development of a society that promotes public health, including reducing social inequality in health. Pursuant to this Act, the municipality must have an overview of public health challenges, and through the municipal planning process establish goals and strategies for health promotion and implement necessary measures to meet the municipality's challenges. Tobacco use is one of our biggest health challenges nationally and will consequently also be so in most municipalities. The Public Health Act requires each municipality to have an overview of public health challenges and take appropriate action.

The role of county municipalities
Counties support public health efforts in the municipalities. They do this by being attentive to aspects of developments that may create or maintain social or health problems or social inequality in health and make such information available to municipalities.

The role of the municipal health and care services
The health and care services' responsibility for health promotion and prevention is emphasized in the Act of 24 June 2011 No. 30 on municipal health and care services, etc. Section 3-3: *"The municipality must in the provision of health and care services promote health and seek to prevent disease, harm and social problems. This should be done through information, advice and guidance. The health and care services must contribute in the municipalities' public health work, including to the overview of public health and health determinants pursuant to Section 5. "*

New to this act is a more distinct justification requirement for prevention work as well, cf. Proposition to the Storting No. 90 L (2010-2011) page 223: *"If the necessary measures are not taken to prevent or mitigate the development of disease, and this is the most*

effective in terms of preventing or limiting the development of a disease, this may be indefensible."

Health and care services may be broadly said to have three roles in prevention work:

1. Prevention as an integral part of the health and care services, such as prevention in general practice, in care services, etc.. The health and care services and medical staff have a particularly good position to identify people with established risk factors, including lifestyle habits that increase the risk of developing disease, such as smoking. Research shows that health personnel are the group of professionals that the population has the greatest confidence in when it comes to getting lifestyle advice. There is also evidence that guidance from health professionals on lifestyle habits is effective in changing behaviour and reducing the risk of disease.

2. Responsible for separate arenas for preventive health and care services and activities, such as health checks, health education and lifestyle counselling. Healthy life centres are a municipal service for people who need to change their lifestyles. Their tasks include tobacco cessation. Up to now, around 150 healthy life centres have been established. Some of these are operated in inter-municipal cooperation.

3. Responsible for contributing to cross-sectoral public health promotion, such as creating overviews lists and acquiring knowledge on health issues, causal relationships and measures. This also means that the health care services pursuant to the Public Health Act have the responsibility to ensure that tobacco prevention, for example, is handled by other parts of the administration in the municipality.

<u>The role of the specialist health service</u>
Although the specialist health service is not a key player in public health work, it plays an important role in preventing disease and promoting health in the population. As part of the Coordination Reform the specialist health service's responsibility for prevention and public health work was emphasized. In the Act of 2 July 1999 No. 61 relating to the specialist health service, Section 2-1a now states: *"The regional health authority must ensure that health institutions that they own, or receive grants from the regional health authorities for operation, must contribute to the promotion of public health and prevent disease and harm."*

The specialist health service's responsibility to promote health and prevent disease, injury, suffering and disability may be specified in three main areas: 1) Prevention and health promotion measures for people who come in contact with the specialist health services, 2) monitoring of disease and risk factors and the exchange of knowledge and expertise exchange, and 3) generally contribute to health promotion and prevention measures.

Prevention and health promotion aimed at people who come in contact with the specialist health services means that the specialist health service in its dealings with those who have a health problem, must be in a position to provide information about conditions that affect health and disease. This applies to both the disease for which the patient is receiving treatment for, and advice and guidance on other risk factors that the patient is exposed to, and that can cause illness.

When the specialist health service discovers disease or risk factors, which form a basis for preventive or health promotion measures, the service itself must ensure that this information is conveyed to municipalities and counties. This will make it possible to make the effort to prevent problems arising or developing.
Through the "National Health Care Plan (2011 - 2015)", a message has been given to increased attention on health promotion and prevention work. When it comes to risk factors such as tobacco use, the plan points out that society should facilitate healthy choices by increasingly adopting structural measures such as price measures and legislation.

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