Consensus and Complacency.
The Failure of Tobacco Control in Austria

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While writing this report (January 2003 to July 2004), an estimated 14,250 to 22,200 Austrians died as a consequence of their smoking and an estimated 2,200 Austrians died as a consequence of the smoking of others.

ABSTRACT

Tobacco use is the leading cause of preventable death worldwide, accounting for about 9,000 to 14,000 deaths in Austria annually. Tobacco is a major health hazard not only to its users , but also to exposed non-smokers who experience a higher risk of smoking-related diseases. Yet, tobacco is also an important economic commodity seeking ever increasing markets, and opposition to regulation is very strong. The need to control its use is increasingly apparent from the growing numbers of smokers worldwide, in particular among very young people and women, the growing evidence of the effect of smoking on health of both smokers and non-smokers, and also the growing awareness of the hazards of environmental tobacco smoke.

This study examines tobacco policies in Austria, in particular in the context of European Union policies. A review of tobacco industry documents, literature on tobacco control measures in European and overseas countries, EU laws, and activities of the WHO and the EU with regard to tobacco control is followed by a description of smoking patterns in Austria, including new analyses of existing data, and an analysis of the health situation in Austria, with a focus on smoking-related diseases and mortality and a cohort analysis on lung cancer mortality. This leads to a critical analysis of tobacco control measures in Austria. The study concludes with an overall analysis of Austrian tobacco policy, seeking the reasons why so little has been done and the forces and key actors involved, and offers recommendations for further action.

The main findings are that party-political ties, economical considerations, and close relationships between the Austrian tobacco industry, the government, and leading “anti-smoking advocates”, experts and scientists have hampered the development of effective tobacco control policy in Austria. Compared to many other European and overseas countries, Austria’s tobacco policy lacks both political will and the implementation of effective measures to reduce smoking prevalence and to protect non-smokers from the hazards of tobacco smoke.

Doctorate in Public Health Summary Statement

The Doctorate in Public Health (DrPH) is a degree that has been designed for those who expect a career in public health practice rather than in research. The DrPH is aimed at leaders and future senior professionals and leaders in public health practice. It is comprised of three successive components: taught courses, a professional attachment affording the opportunity of reflecting on the practice of public health in a work setting, and a research project culminating in a thesis.

The taught element of the DrPH enhanced knowledge in specific areas, most notably in management and leadership, research methods and paradigms. The 3-month course on management and leadership was extremely valuable as I gained much needed skills for continued work in governmental organisations and future career. In particular, however, it provided the basic knowledge for the production of my professional attachment. In addition to these compulsory courses on leadership and management, research methods, evidence-based policy and practice (transferable skills in public health practice), and health policy, I took a course in health economics (London School of Economics) and took part in a workshop on qualitative methods. The Qualitative Workshop improved my qualitative skills and provided both theoretical and practical knowledge for research design and methods. Subsequently, I also took courses which seemed appropriate for the initially chosen research project on life expectancy and mortality in Austria, such as Statistical Methods in Epidemiology, Ageing and Health, and Health Care Planning, Management & Evaluation.

Starting the DrPH programme after finishing an MSc in Epidemiology at the London School of Hygiene and Tropical Medicine, the elective courses I was entitled to take during my training as a DrPH student allowed me to complement the preparation I received in the MSc programme. During the taught component and later in the process of writing up the results of my research, the exchange of experiences with other research students proved to be an enriching and significant part of my programme.

The professional attachment was carried out at a department of the Vienna City Health Administration where I have previously been working as head of the health reporting unit for almost three years. The professional attachment widened my perspective enormously. By using the newly acquired skills on policy-making, leadership and management, combined with my training as a sociologist using organisational analysis and the qualitative technique of participant observation, I could gain valuable insights into the decision-making process of large and con-

solidated administrative organisations, organisational structure of the department and organisation under research, and leadership qualities. It allowed me to observe this institution from a new viewpoint and develop a better understanding of the powers leading to leadership and decision-making in health policy in a regional, largely party-political driven organisation.

The third component of the DrPH is the research project. This component is intended to help students learn about the role of research in public health practice. In this way, the research must be described in terms of public health importance, and the ways in which the findings of the research and improved understanding might be expected to advance policy or public health practice. The research project thus should not only demonstrate a competence in carrying out a piece of research, but also an understanding of the wider role of research in good public health practice, and of the whole context within which research is commissioned and used.

I chose to conduct my thesis on tobacco control in Austria for several reasons. First, Austria is a country where remarkably little research has been carried out; second, tobacco control in this country is still underdeveloped; and third, policy-making in Austria is strongly consensus-driven, based on party-political ties and personal relationships, and thus seemed an interesting subject for policy analysis on tobacco control.

The DrPH was an appropriate match for my existing skills and my newly acquired skills in management and leadership and academic research. Most of what I learned, however, was due to the extremely supportive and valuable collaboration with my supervisor, Martin McKee, from whom I learnt not only many technical skills in academic research, but also new viewpoints in policy analysis. Although there is potential for improvement in the organisation, this programme will undoubtedly increase the capacity and effectiveness of public health practice.

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1 INTRODUCTION

Austria (8 million inhabitants) has been a member of the European Union (EU) since 1 January 1995. Its accession has impacted positively on its policies on tobacco control yet, within the EU, Austria is still seen as the 'smoker-friendliest' country; in an assessment of achievements in the area of tobacco control and the extent to which the climate is against smoking, Austria ranked last.[1]

Tobacco poses a major hazard not only to the health of those who use it but also to those around them who, while not actively smoking themselves, have an elevated risk of developing smoking-related diseases. Yet tobacco is also an important economic commodity, produced by powerful companies with an interest in increasing sales, so opposition to regulation is very strong. Widespread acceptance of these health hazards, the dangers of environmental tobacco smoke, and the failure to reduce smoking among young people have led more governments to confront the challenge of tobacco.[2] As yet, however, the Austrian government is not among them.

Tobacco use, and in particular cigarette smoking, is now recognised as the single leading preventable single cause of disease and premature death in industrialised countries. Smoking has two major health consequences. First, the smoker rapidly becomes addicted to nicotine, a substance whose addictive potential is often underestimated. Second, smoking leads to disabling and fatal diseases, such as cancers of the lung and other organs, ischaemic heart disease and other circulatory diseases, and respiratory diseases. The accumulated effects mean that half of all long-term smokers will eventually die as a result of smoking; of these, half will die before reaching retirement.[3-5] The average loss of life attributable to smoking has been calculated to be 8 years[2 5] but those who die in middle age will loose, on average, 22 years of life.[5 6] In Austria, an estimated 9,000 people[7] (according to previous estimates and estimates by Austrian officials, 12,000 to 14,000 people[8 9]) die every year from the effects of tobacco use; this equates to 25 to 38 people every day.

Although most smokers are aware of the health risks of smoking, smokers tend to minimize the impact on themselves. One factor is the addictive nature of nicotine, with addiction often established in adolescence or early adulthood.[10]

In Austria, almost one quarter of the population aged 16 years and over smoke on a daily basis, most of whom have been men but now are increasingly women. The highest rate of smoking is among young male adults, aged 20 to 24 years, of whom 48% smoke.[11] However, the use of data on over 16s, the standard approach in international comparisons, obscures the increasing smoking prevalence among adolescents, particularly among girls. In an international comparison, Austrian teenagers (girls more than boys) rank very high in both alcohol consumption and cigarette smoking. The Health Behaviour of School-aged Children (HBSC) study has reported that 20% of boys and 25% of girls in Austria smoke daily.[12 13]

According to Austrian mortality statistics, cardiovascular diseases are by far the greatest single category of causes of death, accounting for more than 50% of all deaths, followed by cancers, accounting for 25% of all deaths. Both are strongly related to smoking.

Apart from the severe health effects of tobacco on smokers and the highly addictive nature of nicotine, smoking is not just an irritation to those exposed to it, but also damages the health of non-smokers, with young children, who are not in a position to protect themselves, especially vulnerable.[2] Those at greatest risk of exposure to environmental tobacco smoke (ETS) include babies born to mothers who smoke, children in the presence of smoking parents, partners of heavy smokers, and people who work in smoky environments, such as the hospitality industry.

Unlike the situation in some countries, the issue of passive smoking has not yet reached the policy agenda in Austria. Emerging evidence on the health consequences of passive smoking are rarely reported in the media (or if they are, in a way that is misleading, reflecting the tobacco industry's disinformation campaign) and are therefore little known by the public. Public support for smoke-free environments still reflects an acceptance of smokers' rather than non-smokers' rights. Complaining non-smokers are typically viewed as intolerant and any problem is seen as theirs rather than society's. It is not surprising, therefore, that the health effects of passive smoking and the establishment of smoke-free environments have received so little attention.

Although, admittedly, there have been changes in attitude over the last ten or twenty years, Austrians – unlike, for example, the people in Finland, Norway, or California – show little respect for non-smokers and there is no evidence of the stigmatisation of those who smoke in the presence of non-smokers (not even if they are pregnant women or children) that can be discerned elsewhere. A discussion such as that underway at present in the United Kingdom about

the health effects of passive smoking is almost unimaginable, as is the possibility of introducing 'smoker-hostile' smoke-free pubs, bars/cafés and restaurants.

The consequences of smoking extend also to costs to the economy. Estimates from high-income countries suggest that smoking-related health care accounts for between 6 and 15% of all annual health care costs; inevitably the majority of the population who are non-smokers bear a significant share of these costs. Jha & Chaloupka[3] have shown how the cost of health care for smokers far exceeds that for non-smokers.[a] In Austria, the annual cost of treating the sequelae of smoking (cancer, cardiovascular diseases, chronic lung diseases) was estimated to be 15 to 20% of the total health care expenditure in Austria, amounting to €1.5 to 2 billion per year.[9 14 15]

Thus, given the evidence that smoking leads to serious health effects in smokers and non-smokers alike and both smoking itself and the resulting health effects also impose financial costs on non-smokers (through their contribution to health care costs, costs of additional cleaning, etc.), the argument that smoking is a 'private affair' and an 'individual right' can no longer be sustained.

It has been predicted that, without effective action, the burden of disease attributable to tobacco will increase dramatically over the next two decades. According to the World Health Organization's 2002 World Health Report, the immediate implementation of appropriate policies to reduce tobacco consumption is essential. Although the full benefits of action will be delayed for several years, due to the long time-lag between the onset of smoking and the occurrence of disease, these benefits would be very large and long-lasting.[2]

Measures to reduce smoking prevalence and to protect people from ETS exposure should therefore have a high priority in policy debates.[2] However, in many countries, and in particular in Austria, the impact of smoking on the health of the smoker and on the national health care system, and ultimately on the national economy, is poorly recognised and essentially ignored. There is a clear lack of political will to tackle smoking. Furthermore, the health damage due to passive smoking is still largely denied.

But not all countries have been as inactive as Austria. Many have drawn up comprehensive tobacco control plans, often including explicit goals linked to evidence-based health policies. Particularly known for their active tobacco control policies have been the American states of

[a] The argument that because smokers die earlier, lifetime health care costs may possibly be even smaller for smokers than for non-smokers, remains contentious.[3]

California and Massachusetts, Canada, Australia and New Zealand. In Europe, Norway, Finland and Sweden have been outstanding in their long-lasting and comprehensive efforts to tackle smoking. More recently, Italy has introduced smoke-free environments in restaurants and bars, making no-smoking increasingly the norm and smoking the exception, and Ireland's introduction of a smoking ban not only hit the headlines for being the first country of the EU to ban smoking in all restaurants, bars and pubs, and even stimulated some public discussion in Austria.

Despite the adverse impact of tobacco on the quality and quantity of life, the ultimately adverse impact of tobacco on the country's economy and health sector, the international experience of effectiveness of tobacco control policies, and the recognised need for co-ordinating tobacco control interventions, Austria has not yet developed any kind of tobacco control plan, or even fragments of one. So far, it has identified no goals or objectives to reduce smoking prevalence or the burden of tobacco-related disease and the measures adopted in recent decades have achieved little. Despite some half-hearted and small-scale youth campaigns, smoking prevalence among adolescents continues to rise, and services to help those who wish to quit smoking are few, often unprofessional and demand much initiative and commitment by frustrated smokers to access them.

The preceding paragraphs make the case a better understanding of the place of tobacco in Austria. This thesis examines smoking behaviour, the burden of tobacco-related disease, and implementation of tobacco control measures in Austria. It seeks to examine tobacco policies in Austria, in particular in the context of European Union policies. A qualitative methodological approach is used to develop a better understanding of Austria's tobacco control policies, to identify key actors and analyse their motivation and involvement in the decision making process. Based on the experience in other countries and findings from the literature, recommendations for more effective measures to reduce tobacco consumption will be developed, pointing the way towards a comprehensive and effective tobacco control plan that is applicable in the Austrian context.

The methods applied in this study comprise both quantitative and qualitative approaches, including secondary analysis of routine and survey data, discussions with key informants and documentary analysis. Chapter 2 describes the methods used in more detail; the structure of the remainder of the thesis is as follows:

Chapters 3, 4 and 5 review relevant literature, with Chapter 3 examining the tobacco industry in Austria, while Chapter 4 places the evidence for effectiveness of tobacco control policies within a strategic framework, and Chapter 5 examines the international context within which Austrian tobacco control takes place.

In Chapter 6 smoking patterns in Austria are described, looking at changes over time and between different groups in the population. Existing survey data are further analysed.

Chapter 7 comprises an analysis of the health situation in Austria, with a focus on the burden of smoking-related morbidity and mortality.

Chapter 8 provides a description and critical analysis of tobacco control measures in Austria.

Chapter 9 identifies key actors and analyses past and present tobacco policies in Austria.

Finally, in Chapter 10 the study concludes with an overall assessment of Austrian tobacco policy, providing recommendations for further action and implications for future research.

2 METHODS

This chapter presents the aims and objectives of the thesis, lists the main research questions examined during the work and summarises the methods used in addressing these questions. Quantitative and qualitative methods are used in answering specific aspects of the research questions and collecting different kinds of information.

2.1 Aims and objectives

The main objectives of this work were i) to describe past and current tobacco control policies in Austria, ii) to critically analyse these policies in the light of existing evidence of effectiveness, iii) to identify key actors and explain their roles in Austrian tobacco policies, and iv) to understand the opportunities and constraints faced by the Austrian government, with reference to the European Union's tobacco policy. Conclusions drawn from past and present tobacco control measures in Austria and from experiences reported from other countries should lead to an overall assessment of Austrian tobacco control policy. Secondary objectives were to describe current patterns of smoking behaviour in Austria and to determine the health status of the Austrian population with regard to smoking-related diseases. Table 2.1 lists the objectives of this thesis in more detail. The ultimate goal of the thesis was to develop recommendations to policymakers in Austria on how to best promote and support a comprehensive and effective tobacco control programme.

2.2 Research questions and methods

The main research questions in this study are to determine the effectiveness (or ineffectiveness) of Austria's tobacco control policies and to understand the powers and influential factors driving the few initiatives identified, as well as the reasons for the limited efforts invested in reducing tobacco consumption in that country. Another question was about the role of the Austrian tobacco industry in the decision making process leading to Austrian policies – for example, through the obstruction of tobacco control measures, the promotion of smoking, and the creation of a widespread pro-smoking climate in Austria, where public opinion remains very sympathetic to the convenience and rights of smokers and, ultimately, the interests of the tobacco industry. A final question concerned the identification of key factors that influence smoking behaviour in Austria.

Table 2.1 gives a summary of the study questions and the methods used to address them. Quantitative and qualitative methods were used to obtain information, including i) review of scientific journals, books and documents; ii) examination of 'grey' literature, media and conference reports; iii) data collection and qualitative analysis of information obtained through discussions with key actors and informants and through personal communication; and iv) secondary analysis of routine data and existing survey data.

Table 2.1 Objectives, research questions and methods

Objectives	Research questions	Methods
To describe the history and examine the role of Austria's tobacco industry in the promotion of smoking and pro-smoking policies	– What is the role of Austria's tobacco industry?	– Documentary analysis – Literature review – Additional information from Austria Tabak (Gallaher)
To provide a strategic framework within which to consider tobacco control measures	– What measures could possibly reduce tobacco consumption?	– Literature review – Documentary analysis
To assess the effectiveness of tobacco control measures providing evidence for successful tobacco control policies from international experience	– What is the experience of tobacco control in other countries? – Which measures have proven to be the most successful?	– Literature review – Documentary analysis
To describe the European legal framework for tobacco policy and to understand the opportunities and constraints faced by Austria	– What are the implications of EU tobacco control legislation for national tobacco control programmes?	– Literature and documentary review – Additional information by personal communication with key informants
To describe current patterns of smoking behaviour in Austria and re-analyse existing data on smoking of national and regional surveys, including international comparisons	– What are the differences in smoking behaviour with regard to time, region, age and sex? – What factors influence smoking prevalence in different groups of the population?	– Review of Austrian surveys on smoking behaviour (national and regional) – Secondary analysis and re-analysis of existing routine and survey data – Routine data review of international data –
To determine the level of smoking-related burden of disease in Austria	– What is the burden of tobacco-related disease in Austria? – What are the current trends in tobacco-related disease incidence and mortality? – Are there age- and cohort-specific differences in lung cancer mortality?	– Routine data review of health indicators (national data and international databases) – Analysis and re-analysis of national health data
To investigate and critically analyse Austrian tobacco policy by – describing and examining tobacco control measures in Austria, – identifying the most influential factors in the implementation (or non-implementation) of anti-smoking initiatives, – assessing the effectiveness of the implemented measures,	– What are the current and past activities to reduce smoking in Austria? What has Austria done to reduce tobacco consumption? – Are current measures and activities adequate/successful? – Why are or were certain measures or initiatives adopted and others not? – Why is there so little and why have the measures not been very	– Discussions with key informants – Additional information by personal communication with key informants (e-mail, telephone) – Literature review, documentary analysis and review of international databases – Outcome evaluation: Analysis of trends in smoking prevalence and qualitative approach in assessing effectiveness of tobacco control

– evaluating and discussing the chosen measures or initiatives, – assessing tobacco control policy in Austria compared with other European countries that have been more successful in reducing smoking prevalence, – determining the nature and influence of hidden forces	successful? – What is the level of implementation of tobacco control policy in Austria, compared with the rest of Europe?	measures – Review of 'grey' literature, media reports, etc.
To identify key actors in Austrian tobacco policy and examine their roles and interests	– Who are the key actors in Austrian tobacco policy? – What are their interests? – What is their role (double-role) and what have they achieved? – What are the crucial partnerships influencing related policies?	Stakeholder analysis: – Identification of key actors by snowball technique – Discussions with key actors – Additional information by discussions with key informants
To critically appraise existing evidence on the success of tobacco control initiatives and examine the reasons for that success.	– What is the potential for a comprehensive and successful tobacco control plan or programme in Austria? – What strategies need to be implemented? – Which measures and initiatives have proven to be the most successful in other countries? – Would these measures (used in other European countries) be acceptable and feasible in Austria? – What would be the legal, administrative, and cost constraints? – What would Austria need for a successful tobacco control programme?	–

2.2.1 Literature and document review

A series of reviews were conducted to examine published literature, including peer reviewed and other journals, books, and relevant published and unpublished documents such as reports and industry papers, including internal documents from *Austria Tabak* and international tobacco companies. The review also included statistics on tobacco production and sales in Austria, legislation and related material on European smoking and tobacco policy, reports of smoking surveys in Austria and Europe, data on health indicators, risk factors and the burden of smoking-related disease; information on tobacco control and anti-smoking measures in Austria and other countries, and literature on policy analyses.

Sources of information and methodology used in the searches are summarised below.

Peer reviewed and other journal articles

Electronic search for peer reviewed journal articles on smoking, tobacco industry, tobacco control, environmental tobacco smoke, anti-smoking measures, smoking behaviour, smoking cessation, smoking-attributable morbidity and mortality, and EU legislation on tobacco policies was done using PubMed and the search engine Google.

Initially, the following key words were used in the searches: "smoking"; "tobacco"; "tobacco industry"; "cigarette*"; "tobacco control"; "environmental tobacco smoke" or "ETS"; "anti-smoking measures/campaigns"; "(smoking) cessation"; "nicotine"; "smoking AND mortality / morbidity / disease* / cancer / lung cancer / cardiovascular disease*"; "smoking AND children / adolescents / youth / women", "addiction"; "smoking / tobacco AND European Union"; "tobacco polic*". Subsequently, searches were conducted using the names of known authors (experts) or the titles of known studies.

For reviews on tobacco control measures and international experience, and the effectiveness of interventions on smoking prevention and smoking cessation, the Cochrane Library and the Sigel Library were searched.

The website of the *British Medical Journal*[16] was searched separately for any articles related to smoking and tobacco policies.

For tobacco control policies, in particular experiences and measures in various countries, and environmental tobacco smoke, hand searching of later issues of the journal *Tobacco Control* and the *British Medical Journal* was undertaken. Articles often led to new issues and new literature, and references were followed-up. For data on smoking prevalence and smoking behaviour in Austria, the journal *Statistische Nachrichten* of the Austrian statistics institute *Statistics Austria* (not peer reviewed) was searched, and for Austrian publications on smoking, the journal *Wiener Klinische Wochenschrift* and *Wiener Medizinische Wochenschrift*.

Selection criteria were relevance to the study and, except for issues of tobacco-related mortality and historical perspectives, publication after 1997/98.

Reports

Reports on tobacco control policies and measures were searched in websites of the following organisations: the EU Public Health[17], the European Network for Smoking Prevention[18], the World Bank[19], the World Health Organization (in particular with regard to the Tobacco Free

Initiative[20] and the Framework Convention on Tobacco Control[21]), and the Centres for Disease Control[22]. In addition, reports were identified through electronic search of Google and PubMed, using the same key words as for the search on journal articles *(as listed above)*. Names of known authors (experts) and titles of known studies were also used to retrieve reports on tobacco control policies.

Several websites of countries in which successful interventions in tobacco control have been reported were searched by using Google.

Books

For issues such as policy analysis and strategies, relevant books were found in the library of the London School of Hygiene and Tropical Medicine. In addition, references found in the literature and references provided by experts were followed up.

Other sources

Industry documents

Industry documents were searched by looking at the various on-line archives and collections of industry documents and the search engine Google, using the term "Austria Tabak" in combination with the following key words: "Philip Morris", "Health Minist*", "Government", names of several past Austrian health ministers, names of key persons linked to Austrian tobacco policies or to *Austria Tabak* retrieved in previous searches, and names of anti-smoking activists or other key actors in Austrian tobacco control policies. The websites of *Austria Tabak*[23] and the *Monopolverwaltung* (Monopoly Administration)[24] were also searched. All websites searched more intensively are listed in Section 3.2.3.

To understand the various collections (partly industry-owned), a handbook and resource guide to tobacco industry documents[25] and a paper on archives of industry documents[26] were used. Information obtained from experts and in conference presentations such as the 12th World Conference on Tobacco or Health in Helsinki (2003) and various European Public Health conferences *(see below)* was followed-up.

Selection criteria were reference to Austria and relevance to the interpretation of results of this thesis.

Laws and regulations

To categorise the European legislative framework on tobacco control (EU directives and recommendations), a framework developed by Gilmore & McKee[27] was used. In addition, the websites of the European Union[28 29] were checked. Information was also obtained from the embassy of the EU in Austria, conference reports and presentations, and published literature on general issues relating to EU legislation.

For the search on Austrian legislation the government websites on federal laws[30 31] were examined. Documents and acts provided by government officials (Federal Ministry of Health and Federal Ministry of Justice) and by the embassy of the EU in Austria were reviewed. The main Austrian laws relating to smoking comprise the Tobacco Law (1995, amended in 2001 and 2003), the Tobacco Monopoly Law (1968 and 1996), and the Employees' Protection Law (1994, amended in 1999 and 2001).

Media reports

Electronically searchable archives of the leading Austrian newspapers *Kronen Zeitung*[32], *Kurier*[33], *der Standard*[34], and *die Presse*[35] were examined. Other relevant material was obtained by hand searches and following up leads identified throughout the study. For example, additional information on Austrian tobacco policies was sought in the quarterly *NichtRaucher-Zeitung*. An extensive article in the Austrian news magazine *Profil*[36] and two TV programmes[37 38], reflecting the public debate following the implementation of enlarged health warnings on cigarette packs in October 2003 and the introduction of the Irish smoking ban in public places in March 2004, were analysed more intensively, using qualitative methods.

Conference papers

Conference presentations and papers (abstracts, reports, folders) were another important source of information, in particular with regard to industry documents, international experience, and EU legislation. The 12th World Conference on Tobacco or Health in Helsinki (2003) was especially valuable, but so were presentations at various European Public Health conferences held in Paris (2000), Brussels (2001), Dresden (2002), and Rome (2003) and Austrian conferences held by the Austrian Public Health Society (Linz 2002 and 2004).

2.2.2 Data collection

Information from key informants

Meetings were sought with key actors involved in Austrian health and tobacco control policy (former and present national policymakers, experts and consultants) and key informants on policy measures to reduce tobacco consumption (government officials, experts from NGOs and advocates for anti-smoking policies). An initial list of people and organisations known to be involved or experienced in Austrian tobacco policies was prepared and completed using a snowball technique. The final list is given in Table 2.2.

Given the diversity of topics to be addressed, a variety of formats was used to conduct the discussions: face-to-face, by telephone, or in written form by e-mail communication after providing a list of questions, often following an initial enquiry by telephone. Often it was an iterative combination of e-mail- and telephone conversations. Only the meetings with high-ranking policymakers were structured more rigidly, and shorter or longer versions of lists of questions were used according to the time made available for the meeting. Otherwise there was no fixed framework for the discussions; they were open-ended and exploratory. Data were collected between March 2003 and April 2004.

Table 2.2 summarises the main topics addressed during the meetings. General questions explored the situation in Austria, eliciting views on the pro-smoking climate in this country; measures chosen by policymakers to reduce smoking; and possible reasons or, more subtly, hidden forces (in the form of financial interests and personal relationships) that might account for the diffidence, the lack of political will, and the widely known ineffectiveness of the chosen measures. Topics addressed with national policymakers focused on reasons for the (non-) implementation of effective measures to reduce smoking; exploring the depth of political motivation to reduce smoking prevalence; opposition against proposed effective measures; and what would be seen by them as opportunities, obstacles, and threats in the implementation of a comprehensive tobacco control plan.

Table 2.2 Discussions with key actors, key informants and experts

Data collection	March 2003 to April 2004
Sought discussions	**Past and present policy makers** Two previous Health Ministers Present State Secretary of Health **Key informants and experts from government and administration** Officials/administrators from the Federal Ministry for Health and Women Federal Ministry of Finance Federal Ministry of Justice Federal Ministry for Social Security, Generations and Consumer Protection Federal Ministry for Economic Affairs and Labour, including the Regional Labour Inspectorate *(Arbeitsinspektorat)* Federal Ministry for Education, Science and Culture Administrators from local governments and administration (Vienna Hospital Association; Vienna Health Authority; provincial governments of Vienna, Styria and Vorarlberg) Officials/administrators from social and health insurance funds (Federation of Austrian Social Insurance Institutions; Vienna District Health Fund; Upper Austria District Health Fund; Vorarlberg District Health Fund) Administrators of the national statistics institute *Statistics Austria* Representatives of the embassy of the European Union in Austria **Representatives of NGOs and various associations** Austrian Cancer Society; Vienna Cancer Society Anti-smoking associations Associations dealing with health promotion or youth campaigning (Fund for a Healthy Austria; *AKS Vorsorgemedizin* in Bregenz/Vorarlberg; various associations in Dornbirn/Vorarlberg) Austrian Medical Chamber Chamber of Pharmacists Public transport (Austrian Federal Railways; Vienna Public Transport; Austrian Airlines) Hospitality industry (Chamber of Economics for Austria – Section Hospitality Trade Association; Vienna guild of hospitality industry) **Science/research and smoking cessation** Leading representatives of University institutes (Institute of Social Medicine in Vienna; Institute of Social Medicine in Graz/Styria; Institute of Addiction Research in Bregenz/Vorarlberg) Head of Nicotine Institute in Vienna Head of research group on smoking among young people and youth campaigning Administrators of centres for smoking cessation (Vienna District Health Fund; City of Vienna) **Media** Journalist of print media Journalist of TV-programme Advertising agencies **Experts and government consultants** Four experts (two of them governments consultants, all of them either leading representatives or heads of anti-smoking associations) **Representatives from the tobacco industry**

	Austria Tabak (Media Relations Office) *Monopolverwaltung GmbH* (Tobacco Monopoly Administration Ltd.) *Tobaccoland Austria* **Others** *Law historian* *Contemporary witnesses*
Topics	**General** Views on pro-smoking climate in Austria Views and experiences on Austrian tobacco policy, at present and in retrospect Views on measures chosen by policymakers to reduce smoking Possible reasons and hidden forces (in the form of financial interests and personal relationships) for the diffidence of 'engaged' advocates, the lack of political will and the widely known ineffectiveness of the chosen measures **Topics addressed at national policy makers** Reasons for the (non-)implementation of effective measures to reduce smoking; opposition to proposed measures Depth of political motivation to reduce smoking prevalence Opportunities, obstacles, and threats in the implementation of a comprehensive tobacco control plan **Specific topics addressed at experts and key informants** Activities of anti-smoking associations Smoking cessation / smokeless tobacco Youth campaigns (including financing) Anti-smoking activities on the regional level Smoke-free environments in public places (public transport, restaurants and bars, workplace, schools and hospitals) Tobacco law and law on monopoly of distribution (contents and history) Tobacco advertising and offences against tobacco law Tax gains and earmarking of tobacco taxes Smuggling Anti-smoking policies in the 1930s and 1940s **Topics addressed at tobacco industry** History of *Austria Tabak* and the Austrian tobacco monopoly Distribution and tobacco monopoly laws Implementation of larger health warnings on cigarette packs Cigarette production and sales, market shares, cigarette prices Tax gains and turnover Tar- and nicotine yields Smuggling

Personal communication

The process of information gathering was iterative. While writing up this thesis, many issues arose where it was necessary to clarify specific questions. Consequently, many individuals were contacted or re-contacted for specific information.

Similarly, for issues not published in the literature, or to confirm issues open to misunderstanding or clarification, additional information was gathered by way of e-mail or telephone conversation from *Austria Tabak*, the Monopoly Administration, *Tobaccoland Austria*, the Health Ministry, the Finance Ministry, the Education Ministry, the social insurance funds, public transport, local governments, various organisations, associations and societies on the national and local level, centres for smoking cessation, *Statistics Austria*, etc.

Another important source of information, in particular with regard to industry documents and experiences in other countries, was the communication with experts at conferences, in particular the 12th World Conference on Tobacco or Health in Helsinki (2003).

2.2.3 Data analysis

Data analysis was performed both on quantitative and qualitative data. Quantitative analysis was based on analysis of secondary data. Qualitative data were collected through discussions and personal communication; an outcome evaluation approach was applied to assess the effectiveness of youth anti-smoking campaigns.

Secondary data analysis

Quantitative analysis included secondary analysis of i) data on tobacco production and sales, profits and tax gains; ii) national health indicators and routine data provided by *Statistics Austria* and retrieved from international data bases; and iii) data from Austrian and European surveys on smoking prevalence and behaviour.

Data on tobacco production and sales, profits and tax gains

Data on Austrian tobacco production and sales, profits and tax gains were mainly provided by the Austrian tobacco company *Austria Tabak* and the Austrian tobacconists' representation *Monopolverwaltung*. In addition, data from international compilations, such as published by the National Manufacturers' Associations[39], and the WHO tobacco control database[40] were used. These figures were summarised and where appropriate presented graphically.

Health indicators, routine data

A number of general and tobacco-related national health indicators were reviewed and analysed descriptively, using routine data on life expectancy, mortality, cancer incidence, and hospital discharge statistics published regularly in the statistical yearbooks of the Austrian national sta-

tistics institute *Statistics Austria*. For international comparisons with other European countries, the international databases of OECD[41] and WHO[42] were used.

To enable time series analysis, data were re-calculated in some cases. Standardised, age-specific death rates for lung cancer in five-year age bands were re-calculated by direct standardisation for every year from 1970 to 2001, using existing data from national mortality statistics and the national cancer registry. The reference population was the European standard population[43].

In addition, analysis of lung cancer mortality for birth cohorts in 5-year bands back to 1895 was performed. Yearly standardised death rates were calculated for age groups in five-year bands, starting at age 35 and covering the period 1970 to 2000 (year of death). In a second step, the central year of birth was calculated for every age group and for every year of death between 1970 and 2000. Subsequently, the association between calculated age-specific mortality rates and birth cohorts was examined graphically.

Surveys on smoking prevalence and smoking behaviour

Prevalence and behavioural patterns of smoking by age, sex, birth cohort, region, socio-economic status, and trends over time were examined by a review of Austrian surveys both on the national and regional level.[11 44-53] Results from surveys conducted by *Statistics Austria*[11 44 48] and by the City of Vienna[46-48] were summarised for this thesis. Access to the raw data from the Vienna Health and Social Survey[54] allowed further analysis and adjustments for key determinants of smoking behaviour: age, income, employment and education. Smoking behaviour, the dependent variable, was dichotomised into current daily smokers and others. Explanatory variables used were nationality (Austrian / other), education (compulsory schooling / apprenticeship / secondary schooling / university degree), income (<€730 / €730 to <1,310 / €1,310 to <2,200 / >€2,200), and employment status (experience of unemployment over the last three years: yes or no). Crude and adjusted odds ratio and 95% confidence intervals were obtained by logistic regression using the Statistical Package for the Social Sciences (SPSS). Three models were constructed. The first looked at each variable alone. The second adjusted for age. The third adjusted for age, nationality, income, education and employment. The analyses were undertaken separately for males and females.

For a European comparison, data on smoking prevalence from Eurostat (Eurobarometer)[55] were used and described.

Analysis of information provided by key informants

The qualitative data consist of information obtained by meetings with key actors and key informants and personal communication with experts and other informants. All discussions were conducted in the German language and later translated into English.

Notes from meetings with key informants, experts, and decision makers were typed immediately following the meetings and relevant information and impressions were summarised and incorporated into the study. The analysis of these discussions sought to identify the roles (or double-roles) and interests of key actors and the nature and influence of hidden forces behind the decision making process.

In particular, the results from meetings with former and present decision makers in national health policy were used i) to analyse the forces in Austrian tobacco policy; ii) to assess the political atmosphere in relation to measures to reduce tobacco consumption; and iii) to explore motivation and obstacles in creating an effective tobacco control policy.

Outcome evaluation

Outcome evaluation of effectiveness of youth campaigns allowed assessment of the effectiveness of the anti-smoking campaigns by comparing trends in smoking prevalence among youths with the adopted strategies of implementation and the chosen messages of the campaigns.

3 THE TOBACCO INDUSTRY IN AUSTRIA

3.1 Introduction

This chapter and the two that follow review the current context of Austrian tobacco control policies, highlighting the role and importance of the European Union's legislative framework and drawing on the strategic framework on tobacco control measures developed by the World Health Organization.

They pay particular attention to the binding directives developed by the European Community, directives that have been crucial factors underpinning the implementation of national tobacco control measures in countries that have otherwise resisted action and which, it is arguable, would continue to do so if not forced into action. In addition, for many European countries, among them Austria, an understanding of the nature of the debate at a European level is essential to understand the context within which reluctance to develop national tobacco control activities has persisted.[27]

As national tobacco control policies are often shaped by the position and activities of the tobacco industry in the country in question, this chapter looks more closely at the role of the Austrian tobacco company *Austria Tabak*, examining both its international and national activities, as well as the history of the company, which was a state-owned monopoly until 1997 before being privatised, step by step, and finally being bought completely by the British company Gallaher in 2001.

In addition to the review of published literature, identified mainly by using PubMed and Google, a considerable amount of information has been obtained from discussions with key informants and conference presentations, in particular at the 12th World Conference on Tobacco or Health of 2003. With regard to the tobacco industry, its meetings and its strategies, industry documents were searched for on the internet (the searched websites are listed in Section 3.2.3), but relevant material was also obtained from journals (*Tobacco Control*, *British Medical Journal*, etc.), industry and other reports and other published literature. Documents relating to the history of the Austrian tobacco company *Austria Tabak* were sought on the internet and from the company itself; documents relating to the company's activities were sought in press releases and annual company reports published on the homepage of *Austria Tabak*. In addition, information on various topics and data on production and sales were made available by the company

in response to a request. Further sources of information included specific enquiries and other communications with representatives of the *Monopolverwaltung* (Austrian tobacco monopoly administration, the representation of Austrian tobacconists) and officials of the Ministry of Health, the Ministry of Finance, the national statistics institute *Statistics Austria*, the embassy of the European Union in Austria, and other relevant informants. Information was also obtained through conference presentations, conference papers and personal communication with experts at the 12th World Conference on Tobacco or Health in Helsinki, 2003, and various European Public Health conferences.

3.2 Austria and the tobacco industry

Austria has a very long tradition of tobacco manufacturing. For more than 200 years, it was a state monopoly, member of the German *Verband der Cigarettenindustrie* (VDC) and an ally to the US companies Philip Morris and R.J. Reynolds. Even before 1989, *Austria Tabak* had strong business ties with Eastern European tobacco companies. After its partial privatisation in 1997 and in particular since 2001, when it was bought completely by the British Gallaher Group, *Austria Tabak* has been playing a key role as the home market for continental Europe and as a platform for the Eurasian region (new independent states[a] of the former Soviet Union).

However, these events taking place in Austria in the late 1990s were not unique; they were part of a global trend at that time in two ways. First, the multinationals merged into a few major conglomerates. Second, state monopolies were increasingly privatised and merged with multinationals.[4] One factor was that state tobacco monopolies, particularly in respect of tobacco production, no longer conformed to EU regulations. While in the past the strong monopolies in Europe could resist the aggressive post-war marketing strategies of U.S. tobacco companies[56], the pronounced market orientation of EU law, with its dismantling of state monopolies and the "opening of the market" now serves the interest of the global tobacco industry. It is also a striking fact that the industry seeks to transform both state-owned monopolies (for example in Europe) and private tobacco production (as, for example, in countries of the former Soviet Union) into industry-owned monopolies, either with the help of legislation and strong lobbying (as with the European Union[27], *Chapter 5; 5.2*), or by more aggressive methods, including bribing and corruption of weak and financially dependent governments (as, for example, British American Tobacco's actions in Uzbekistan[57]) – in both cases using the argument of "opening the market".

[a] The 12 New Independent States (NIS) of the former Soviet Union are: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, the Kyrgyz Republic, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

Following a successful legal action in Minnesota in 1998, formerly secret internal tobacco industry documents were made public, first in print and then on the internet and in depositories. The documents provide evidence of a 50-year conspiracy to resist smoking restrictions, restore smoker confidence and preserve product liability defence.[58 59] Meanwhile the publicly known tactics and strategies used by the tobacco industry to resist government regulation of its products include conducting public relations campaigns, buying scientific and other expertise to create controversy about established facts, funding political parties, hiring lobbyists to influence policy, using front groups and allied industries to oppose tobacco control measures (in particular the hospitality industry and trades unions), pre-empting strong legislation by pressing for the adoption of voluntary codes or weaker laws, and corrupting public officials.[58 60] Underlying these activities is the need to recruit a new generation of smokers and to promote the social acceptability of smoking.[61] According to David Simpson, a leading anti-tobacco campaigner, the three major strategies of the international tobacco companies at present are directed towards deliberate misinformation of the public about the dangers of smoking; support of (ineffective) children's and youth education campaigns (thus keeping tobacco control off the political agenda and preventing further action on tobacco control by governments); and campaigns to persuade the scientific community to re-admit tobacco industry scientists into the mainstream of the scientific research community.[60 62] As shall be shown, support for (or even initiation of) government campaigns by the tobacco industry as part of their public relations strategy can be seen clearly in Austria.

The tobacco industry and its strategies to sell its products have therefore been compared with the spread of an infectious disease, where tobacco manufacturers have been described as "vectors" to transport an agent to susceptible individuals, just like a mosquito is a vector for malaria.

> "Thus, in the development of nicotine addiction and tobacco attributable disease, tobacco manufacturers produce the agent and distribute it in ways that make the product appealing…. The industry uses packaging, advertising, and promotion to reach and influence as many people as possible. The price of the product (the lower the price, the more will be sold) and the ease with which it can be obtained (from vending machines, over-the-counter displays, and sales by street vendors) are also key distribution factors. In the case of tobacco, the vector also serves to undermine public health attempts to limit use by denying for decades the health consequences of use, and resisting many health-promoting programmes and policies".[4]

However, the tobacco industry's efforts have not been exhausted simply by good marketing. For decades the "vector" has manipulated the product in ways that have made it more addictive and potentially more harmful. For example, by manipulating the pH of inhaled smoke, manu-

facturers have enhanced the bioavailability of nicotine to the smoker.[4 63] In addition, the general public and in particular the consumers, governments, and even vast segments of the medical and public health community have long been deceived by the use of misleading claims for "Light" cigarettes *(see later)*. Now that it becomes more and more evident to all those concerned that all strategies to develop a "safer" cigarette over the last 50 years, from ineffective filters to the claimed reduction of tar yields, have not resulted in a decrease of the smoking-related disease burden[64], a new myth of a "safe drug" is beginning to emerge – smokeless tobacco. In 2003, various arguments for and against smokeless tobacco have been presented by the medical und public health community, by the tobacco industry, and by the media.[65] In Austria, although the issue is not yet publicly discussed, current opinion leaders as well as the media appear to be in favour[66-69], thus supporting the industry's aim of introducing smokeless tobacco to an otherwise shrinking market *(see later)*. Although there seems to be no doubt that smokeless tobacco causes less harm than cigarettes, there are well-founded concerns that the public health disaster with 'light' cigarettes may be repeated in the playing down of the risks of smokeless tobacco.

3.2.1 Austria Tabak (Gallaher Group Plc): The company

Austria Tabak (or *"Österreichische Tabakregie"* or *"Austria Tabakwerke AG"*, as the company was formerly named[b]), Austria's tobacco manufacturing association, was a state-owned enterprise until 1996. It is one of the oldest companies in the tobacco business, with the tobacco monopoly having been established in 1784 by Emperor Joseph II. The company also prides itself in having the oldest tobacco research laboratory in the world, established in 1851.[71] Remaining a state-owned monopoly for manufacturing and selling tobacco products for over 200 years, *Austria Tabak* was partly privatised in 1997, following EU accession, and bought by the British tobacco group *Gallaher* in 2001 *(Appendix A)*. Altogether, the company was sold for the sum of only five times its annual profit, an issue that has attracted criticism ever since.

In 1997, when still half government-owned, *Austria Tabak* was the sole producer and distributor of tobacco products in Austria, controlling 59% of the domestic tobacco market. In addition to tobacco manufacturing, *Austria Tabak* was also the sole tobacco wholesaler in Austria, the

[b] In 1784 *Austria Tabak* was founded by Emperor Joseph II with the designation *"Österreichische Tabakregie"*. In 1939, after transformation into a 100% state-owned joint stock company, the company was renamed into *"Austria Tabakwerke Aktiengesellschaft, vorm. Österreichische Tabakregie"*. Today, after the taking over of Austria Tabak by the British company Gallaher Group Plc in 2001, the company is called *"Austria Tabak AG & Co KG – Continental Europe Division"* (AT/CED), or *"Austria Tabak Gallaher"*.[70] In this study, the company is generally referred to with the commonly used name *Austria Tabak*.

leading tobacco wholesaler in Germany, and it also owned a wholesaling operation in Hungary.[72] *Austria Tabak's* tobacco manufacturing division produced cigarettes at three Austrian factories and one small factory in Malta (opened in 1984 and now closed down).[73] It also had built up business relationships with Japan, China, Cambodia, Taiwan and Russia, already anticipating that these countries had a potential for market growth that could offset stagnating and/or declining sales in Western Europe.[72]

Until EU accession in 1995, the Austrian market was thus characterized by a full monopoly, comprising a) cultivation, b) import and processing of tobacco, and c) import, production and distribution of tobacco products. This was according to the monopoly regulations, last laid down in the *Tabakmonopolgesetz 1968* (Tobacco Monopoly Law of 1968). Trading in tobacco products was exclusively reserved to *Austria Tabak* and those authorized by the company. The distribution by tobacconists was based on sale on commission. The history of the Tobacco Monopoly Law is described in more detail in Appendix B.[74]

As in Italy, France and Spain, a monopoly of retail sales by tobacconists still exists, its administration being subordinated to the Federal Ministry of Finance.[24] Thus, although privatised, the tobacco trade has brought large incomes for the state (whether through share of profits or taxes), which makes the state, understandably, rather reluctant to fight tobacco consumption.

Today, *Austria Tabak* belongs to Gallaher, placing this company in top spot in Austria and Sweden and making it the 4th largest cigarette manufacturer in western Europe, and the 6th largest in the world.[23] The company had chosen Vienna as the head office of the Continental Europe Division (CED) with responsibility for 35 countries in Europe, except UK and Ireland. As a trading company, *Austria Tabak* still holds important market positions in Austria, Germany and Hungary.[23]

A more detailed description of the company and its present position in the tobacco market can be found in Appendix A. Data on tobacco production and sales are summarised in Appendix C.

3.2.2 Distribution: The Monopoly Administration Ltd.

Prior to 1 January 1995, *Austria Tabak* had an 81% share of the Austrian distribution market. As already noted, since Austria's accession to the EU, *Austria Tabak* has lost its wholesale and retail trade monopolies. Any EU company or citizen is allowed to establish a wholesale distribution company for tobacco products or to apply for a retail license to trade in tobacco products in Austria. Nevertheless, the retail trade in tobacco products still requires a special license,

which is person- and site-related. Other outlets or operators of cigarette vending machines need a Tobacco Order Contract *(Bestellungsvertrag)*. This special license is issued by the *Monopolverwaltung GmbH* (Monopoly Administration Ltd*),* established by the Federal Minister of Finance in 1996, who also administers the share rights of this company. Therefore, while the retail trade monopoly still exists, it is no longer in the exclusive hands of *Austria Tabak*; indeed it does not now play any role in the retail trade. However, to fully understand the nature of this trade, one point must be borne in mind. By favouring disabled persons with a level of disability graded at least 50 percent when issuing the licence for a tobacconist shop, the retail trade monopoly is an instrument of Austria's social policy *(Appendix B)*.[75] [76]

At present (January 2004), there are about 8,200 tobacco retail outlets operating all over Austria. Of these, 3,007 are independent establishments called *'Trafik'* (special tobacconist shops dealing in tobacco products, 75% of which are operated by a beneficiary of a group representing disabled persons) and 5,201 are shops or outlets linked to other business establishments such as groceries, restaurants, and gas stations.[24] [c]

Restaurants have to buy the cigarettes from a tobacconist and must add an extra charge of at least 10% to the price.[75] A total of approximately 8,500 cigarette vending machines ("silent salesmen"[77]), half outside tobacconist shops and half in the catering business, are another important distribution outlet. *Austria Tabak* estimates 5-6% of cigarettes sold in Austria to be distributed via vending machines; the trend being said to be consistent over the last few years.[73]

3.2.3 Industry documents

Compared to the situation in Germany, where close relationships between the tobacco industry and government or other respected bodies have been discovered and written about, the search for industry documents that would compromise *Austria Tabak*, the Austrian Government or respected Austrian bodies, has yielded rather poor results, in part because much potentially relevant information is not covered by the disclosure provisions in the American court actions. However, some interesting documents could be found that give insight into the very close personal and financial relationships between *Austria Tabak*, the Austrian government, and the double-role of government consultants and so-called anti-smoking advocates, and scientists. It is a close circle of individuals who influence directly or indirectly Austria's tobacco policies

[c] These are slightly less than one year earlier. In January 2003, there were 8,292 tobacco retail outlets; 3,012 *Trafiken* and 5,280 other outlets.

and, although it is difficult to obtain real "proof", the relationships are known to many and in some cases displayed openly *(Chapter 9)*.

Methods

Apart from the methods already mentioned in Chapter 2 and in the introduction to this chapter, this section is based on a search of the following websites:

The websites of the University of California at San Francisco, including the Legacy Tobacco Documents Library[78] and the British-American Tobacco Document Collection from the Guildford Depository (Tobacco Control Archives)[79] proved to be the most useful websites and therefore form the basis for this section. The CDC's website on Tobacco Industry Documents[80], in particular the Philip Morris sites[81], was also examined. In addition, using the keywords "Austria" or "Austria Tabak" or names of certain key actors, the following sites and industry-owned archives were explored: the Guildford Document Depository[82]; the websites of Philip Morris[83] (good results), RJ Reynolds[84] (some results), Brown & Williamson[85] (no results), Lorillard[86] (no results), The Tobacco Institute Document Site[87] (no results) and The Council for Tobacco Research Document Site[88] (no results); Gobalink (Austria News Items; some results)[89]; and TobaccoPedia[90] (no results).

For *Austria Tabak's* internal papers, documents and press releases, the company's own homepages and websites were searched.[91-94] Even though these sites are controlled by the company, some relevant pieces of information could still be found. Questions about distribution of tobacco products were examined through the homepage of the Monopoly Administration *(Monopolverwaltung)*[24].

Industry meetings in Austria

When it was a monopoly, *Austria Tabak* hardly appeared as a player on the international tobacco industry stage. Within the documents found, Austria mainly appears as a favoured conference location for meetings of senior executives – e.g. for the BATCo Chairman's Advisory Conference in May 1981, the Research Conference in August 1981 (both held in Pichlarn), or the Research Policy Group Meeting held in the Hotel Schloss Fuschl, Salzburg, in September 1988. *Austria Tabak* was praised, however, as a "most effective" host of the 8th International

Scientific Tobacco Scientists' Conference of CORESTA[d] [95] in Vienna, 7-12 October 1984, and it was one of the co-sponsors for a major Vienna Conference, the Sixth World Tobacco Exhibition and Symposium, held from 22 to 25 October 1990.

However, apart from the Vienna meetings in 1984 and 1990, *Austria Tabak* participated in scientific work groups, task forces and meetings, in particular with chemists from its laboratory (Dr H. Kuhn and later his successor Dr Hubert Klus).

Detailed research on the strategies and policies pursued by the global tobacco industry have been described at length elsewhere.[59] [96] [97] For the purposes of the present study, examples are limited to those that involve Austria. Although the examples identified are now up to two decades old, other research suggests that the basic approaches adopted by the industry have not changed, even if their public face has.

The chosen examples are the BATCo[e]-Meetings that took place in Austria, one of them being hosted by *Austria Tabak*, and the Vienna Conference of 1990, consisting of a major exhibition and symposium, which was important in relation to developments in Eastern Europe. Apart from the Vienna Conference, the meetings were held in the 1980s; most of them involved senior executives – so permitting some deeper insights into the policies pursued. It can be assumed that the topics and strategies discussed reflect the general policies at that time, or represent the initiation of subsequent policies. Due to the limited space in this thesis, the contents of these meetings are described in Appendix D.

Symposiums funded and organised by the Austrian tobacco industry (such as the 1988 Vienna Passive Smoking Hearing or the 1993 Vienna Symposium on ETS) are discussed in Chapter 9.

Within the documents searched there are limited references to the Ministry of Health or individual Health Ministers. An exception are references to the 1988 Vienna Passive Smoking Hearing and the then Health Minister Franz Löschnak *(Chapter 9; Appendix S###)* and com-

[d] CORESTA is the Paris-based Cooperation Centre for Scientific Research Relative to Tobacco. It is an industry-related, non-profit association with the objective of enhancing scientific co-operation for research on tobacco. In a note by H.F.D. Dymond (accompanying other documents) to Mr. B.D. Bramley from March 1992, CORESTA is described as follows: "It was founded in 1956 and since those early days it has gained an international reputation not only within the Industry but also among standard organisations, regulators and government laboratories world-wide. **It is perceived as being objective, technical and independent. It is this perception which makes CORESTA unique and very valuable for the Industry, as it is not regarded as a lobbying organisation of the tobacco industry. It is the only organisation involved with the Industry where every major Company and organisation is a member.** To date, CORESTA has approximately 190 members." According to the attached list of members, Austria is represented by *Austria Tabak* (entered in 1956), *Papierfabrik Wattens* (1976), and *Kali-Export* (1991).[95] *[Bolding by the author.]*

ments on the "favourable environment" of Austria's Health Ministry with regard to environmental tobacco smoke[98].[f] Other references were more indirect, such as contemplation of the very high costs of the 1984 Conference in Vienna when *Austria Tabak* celebrated its 200th anniversary.[99]

The following sections deal with aspects of smoking and health and the industry's tactics in misleading the public and using politicians. This information forms background for later chapters where tobacco control measures in Austria will be discussed.

Smoking and health

Already from the mid of the 1970s, the issue of "Smoking and Health" had become a "concern" for the industry. One of the strategies discussed in a 1975 meeting of the German Verband said:

> "A smoker-ABC must be established for employees of the industry and for the trade, giving them information on 'Smoking and Health' and with this a new self-confidence."[100]

In 1980, in a response by D. von Specht (*B.A.T–Cigaretten Fabriken*, Germany) to a previous announcement of details regarding the Chairman's Advisory Conference by Sir Patrick Sheehy (former chairman British-American Tobacco), von Specht addressed certain matters of interest that should be dealt with in a forthcoming meeting.[101] One issue of particular interest to von Specht was the experience available with regard to "training our staff about the problems of 'Smoking and Health'", indicating that health, or rather concerns about health, was seen as an up-coming "problem" at that time. Another point focused on the significance of nicotine as a stimulant and the policy that individual companies would pursue in respect to nicotine levels during product development. "We assume that too great a reduction of the nicotine figures entails a big risk (quitting)".[102] As history proved, however, these fears of Mr. von Specht were unfounded.

This need was fulfilled by *Austria Tabak* in a 1982 publication for its employees on arguments on the topic of smoking and health. The company follows the traditional "low delivery line". In particular, it stresses its contribution to risk reduction, which would exceed by far any other health policy.

[e] BATCo = British American Tobacco Companies.

> "… the tobacco industry, and our firm in particular, has contributed more to rendering the problem harmless than all the campaigns and all the well-intentioned advice, all the protestations and all the anxious words. Our basic attitude, which is so simple, and which has been followed through so logically, in favour of the further development and promotion of the light cigarette, has a series of elements which are lacking in the anti-smoking action." [71]

This position is still maintained by the ex-general director, Beppo Mauhart, in public discussions *(Chapter 9; Sections 9.3.1 and 9.3.8. Appendix V###)*.

A 1975 inter-office correspondence of Philip Morris Europe SA related the internal approach to "Smoking and Health" at the Austrian company following a visit by Dr. Kuhn, the leading chemist at the then *Austria Tabakwerke*, in Neuchâtel in November 1975. The note also hinted at the activities of Philip Morris within the German *Verband der Cigarettenindustrie (VDC)*.

> "At the same time, he [Kuhn] wanted to discuss with me certain scientific aspects of "Smoking and Health" in view of the contacts we had with Dr. Kloimstein and our activities within the German Verband. …
>
> "I was explained the internal situation at Austria Tabak where – as in most Companies – the opinion is divided as to which policy to follow in the case of "Smoking and Health". A grouping around Director General Musil prefers to follow the principle of letting sleeping dogs sleep and to react as little and as carefully as possible.
>
> "Dr. Kloimstein, who is at the deputy level below Director General Musil, coming from an aggressive marketing background, would like to attack. His approach tends to be to disregard scientific findings except for following the traditional 'low delivery' line, and he has the tendency of engaging in trying to cash in on cheap effects. The latter has sensitized unnecessarily hitherto neutral scientific quarters. If I gauged my Austrian colleague's opinion right, he feels that Dr. Kloimstein's drive ought to be harnessed and directed along a less dangerous course. …
>
> "Needless to say, having Austria Tabak lining up with us would be of great importance in view of the effort directed towards the new German Verbandspolitik." [103]

Environmental tobacco smoke and health

In Austria, smoking in public had emerged as a "significant issue" at the end of the 1970s[104] although no official restrictions have ensued for many years. However, evidence linking passive smoking to disease and legislation to implement smoking bans are among the greatest threats to the tobacco industry. In a 1983 board of directors meeting (BAT, Imperial, Philip Morris, Reemtsma, R.J. Reynolds, and Rothmans) the industry was well aware of the "serious" issue of passive smoking.

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[f] Discussing the objectives of the research on environmental tobacco smoke (ETS) and the response of the tobacco industry (in particular Philip Morris) to critical epidemiological studies at the 1988 meeting in Salzburg, it was agreed that there was a need for more internal and external research. "The recent meeting in Austria, when scientists had given their views on both sides of the question to the Austrian Health Minister, showed what could be done when the environment was favourable".[98] – It is referred to the so-called Passive Smoking Hearing in May 1988, called by the then Minister of Health Franz Löschnak and sponsored, influenced and unofficially organised by the Austrian tobacco company *(Chapter 9; Appendix S###)*.

> "Perhaps the most serious aspect is the emphasis being placed on passive smoking and smoking in the workplace. Scientific papers to defend this issue are in the pipe-line, and some activity is planned for 1984, including publication of material dealing with social costs/social values."[105]

In an advertisement entitled "A message from those who do… to those who don't", authorised by John Dollisson, a well-known figure from the Tobacco Institute in Sydney (no date, presumably about mid/end 1980s), the industry perspective on health effects of passive smoking is expressed quite straightforwardly. It represents not only the industry's opinion on this subject, but also reveals some of the "favourable" studies that provided the scientific basis for its argument. In addition, these statements have been disseminated rather successfully by the industry via the hospitality industry and the media, and one still confronts them frequently in Austria – in particular statements on "intolerance of non-smokers", being "a people problem" rather than a "governmental or medical problem", "no scientific proof" of health hazards by passive smoking, and "smokers' rights" versus "minority group" (of non-smokers who express their dislike). Dollisson also refers to the 1984 Vienna Health Conference. As these statements not only summarise more or less the industry's arguments and its lobbying on these subjects, but also characterise quite well the present situation in Austria, this document is cited in full in the following footnote.[g]

[g] "Some smokers are annoyed by cigarette smoke. This is a reality that's been with us for a long time.

"Lately, however, many non-smokers have been led to believe that cigarette smoke in the air can actually cause disease.

"And yet there is little evidence and nothing which proves scientifically that cigarette smoke causes disease in non-smokers.

"The London Times reported findings from the Institute of Cancer Research in Surrey, England, published in this month's edition of the 'British Journal of Cancer', that 'passive smoking' for life-long non-smokers carries no significant increase in the risk of lung cancer, bronchitis or heart disease (all allegedly associated with smoking). The Institute's conclusions are based on a wealth of statistical detail from a study involving 12,000 people.

"In a study by a Vice-President of the American Cancer Society in 1981 which involved 175,000 people, it was reported that 'passive smoking' had 'very little, if any' effect on lung cancer rates among non-smokers. In the follow-up study published in 1985, no statistically significant increase in risk was reported.

"Researchers at the Harvard School of Public Health found that a non-smoker would have to spend 100 hours straight in the smokiest bar to 'absorb' the equivalence of a single filter tip cigarette.

"Major reviews on 'passive smoking' over the last few years have concluded that 'passive smoking' cannot be shown to be a health risk. The weight of evidence is summed up in the remarks at the conclusion of the 1984 Vienna Health Conference which was held in co-operation with the World Health Organisation: 'should law makers wish to take legislative measures with regard to passive smoking, they will, for the present, not be able to base their efforts on a demonstrated health hazard from passive smoking.'

"Often our own concerns about health can take an unproven claim and magnify it out of all proportion; so what begins as a misconception turns into a frightening myth.

"Alright, cigarette smoke may be annoying to some non-smokers, but how shall we deal with these problems? Confrontation? Segregation? Legislation? – No.

"We think annoyance is neither a governmental nor a medical problem. It's a people problem. Smokers can help by being more considerate and responsible. Non-smokers can help by being more tolerant. And both groups can help by showing more respect for each others rights and feelings.

"Don't let intolerant minority pressure groups use you to create divisions between Austr(al)ians." [106]
[Bold sections as in the original text; brackets in the last word added by author.]

Not surprisingly, in order to promote social acceptability of smoking, the industry's principal tactics include denial of scientific evidence and the funding of industry-friendly research to provoke controversy.[100] They also include the manipulation of public opinion, often with the participation of the hospitality industry.[61] The recent industry-funded study by Enstrom and Kabat[107], published in the British Medical Journal only a few days before voting on the World Health Organisation's Framework Convention on Tobacco Control in May 2003, is one example of this.[108]

Enemies and allies of the tobacco industry

In Austria, it is not quite clear who the real enemies or allies are. As already indicated above, the situation is characterised by a close circle of personally related and/or financially susceptible individuals, some of whom seemingly operate on both sides. In addition, as there is absolutely no interest from the state in any effective measures to reduce smoking[h], the linkage between the former state monopoly *Austria Tabak* and the government being traditionally very strong. The prolonged lobbying by Austria's tobacco industry of the hospitality industry, trade unions, the media, and the sports business (sponsoring of clubs and events) has been most effective so that its allies are not only strong and organised, but their number is clearly overwhelming the few, mostly rather diffident individuals engaged in anti-smoking activities *(Chapter 9)*. Similarly, it has not always been clear on which side the various Austrian health ministers and decision makers stand or stood. Apart from two engaged ministers, the motivation to implement anti-smoking measures has been very poor so far. This seems to confirm the finding of the previously cited John Dollisson, when he presented his insight at the 1990 Infotab Conference in Paris that politicians have never been a real threat or enemy to the industry. They were classified by him as being "mostly weather cocks who rotate to the whims of fashion and perceived advantage".[109] The real enemy was considered to be "much more formidable". "Our enemy is composed of a vanguard of clever, able and formidably persistent [anti-smoking] activists who have, after many years of relentless permeation, increasingly taken over the commanding heights of the health and other government bureaucracies of the world. … Our enemies are assisted in their 'long march through the institutions' by their ideological peers in the media, and in the universities".[109] Unfortunately, however, the rather flattering description of the "much more formidable" enemy and his assistants does not apply to the situation in Austria (except for one notable, but powerless individual).

[h] Just to mention the various tax gains from VAT, income taxes, or import purchases taxes for tobacco products from outside the EU, or the profits from the state's shares in the Monopoly Administration Ltd.

The recruitment of scientists to justify the position of the tobacco industry or to vilify opponents has been common for many years. John Dollisson praised, for example, Professor Peter Berger, "one of the most distinguished sociologists in America", whom he characterised as "the shrewdest observer of our condition and the sharpest analyst of our opponents" – in this case the anti-smoking activists. As well as classifying anti-smoking activists as "people who desire power, prestige, or income from the anti-smoking campaign" and the enthusiasts among them "think of anti-smoking in terms of a crusade", Berger points at the World Health Organisation as the major vehicle for the internationalisation of the anti-smoking phenomenon. As quoted by Dollisson: "The injection of the anti-smoking cause into the UN universe of discourse has had ideological as well as organizational ramifications. The UN is, above all, an organization of Third World governments. Logically enough, the anti-smoking cause has here become entangled with other strands of Third World ideology, notably hostility to multinational corporations. The tobacco industry has thus become targeted as yet another nefarious manifestation of multinational capitalism".[109] Berger also noted that the anti-smoking movement is class specific. While smokers are increasingly drawn from the lower income groups, the anti-smoking movement is largely upper middle class in its composition.

Concluding his speech at the Infotab-Conference, Dollisson reminds the audience of his "ten commandments" with regard to the industry's tactics, including that coalitions are essential and that one has to work on one's allies, maintain relations and "not leave everything to the last minute". He also stresses the point that "results are more important than claiming authorship", i.e. the involvement of the industry should not be openly visible, and argued that the industry defence against "the antis" should be put above petty corporate differences. Finally, Dollisson stated that it was time to complement "private affairs campaigning" with a major "public affairs campaign".[109]

Advertisement and advertising bans

In the 1980s, several reports published by the tobacco industry attempted to prove the ineffectiveness of tobacco advertising directed at children and youth. These included, for example, the industry-sponsored study by The Children's Research Unit in London on juvenile smoking initiation and advertising[110] or the report of the UK Tobacco Manufacturers' Association on children, smoking and advertising[111]. The introduction of the latter begins:

> "Anti-smoking campaigns frequently invoke the emotive argument that tobacco advertising encourages children to start smoking. In fact, however, there is no convincing evidence that such advertising causes **anyone** – adult or child, male or female – to start smoking, or to smoke more.

> "In the UK, companies advertise tobacco products to increase market share among existing, adult smokers. Such advertising encourages those smokers either to switch to, or to remain loyal to the brand being advertised.
>
> **"However, such advertising cannot – and does not – increase the size of the total market."** [111] *[Bold in original text]*

This report expands on various "frequently asked questions" and justifies (partly referring to the results of the previously mentioned and other industry-sponsored reports) why an advertising ban would not stop young people from smoking. Interestingly, some of the statements in this document can still be found, for example, in the contemporary self-portrayal by Gallaher *(Appendix E)*.

An *Austria Tabak* publication from 1982 to provide its employees with "balanced information", justifies the necessity of advertising in particular with the development and marketing of "light" (and "safer") cigarettes *(see below)* and the company's responsibility for risk reduction.

> "Development of new products *[light cigarettes]* makes sense only when they can be made acceptable on the market. For this purpose, corresponding advertising possibilities are necessary. The firm must therefore oppose limitations on advertising, must exploit all legitimate possibilities of getting round existing limitations on advertising, and must campaign in public for the further extension of advertising possibilities, taking into account the necessities of the health policy aspect."[71]

In contrast to official industry claims of the absolute ineffectiveness of advertising, John Dollisson emphasised in his speech at the Infotab-Conference in Paris 1990 the importance of resistance to advertising bans. "In the case of advertising bans, the consequential effects could be enormous, even possibly denying us whatever political and media clout we still have. The power of advertising is so great, we will probably only realize the scale of its influence after we lose our freedoms. The loss of the support of the media will further accelerate the decline of the industry's and smoker's social acceptability"[109] – as already mentioned, one of the greatest threats to the tobacco industry.

The myth of "light" cigarettes

Cigarette manufacturers have employed several tactics to encourage consumers to perceive filtered and low machine yield brands as safer than other brands. These tactics include using cosmetic (that is, ineffective) filters, loosening filters over time, medicinal menthol, high tech imagery, virtuous brand names and descriptors, adding a virtuous variant to a brand's product line, and generating misleading data on tar and nicotine yields. Earlier filters on cigarettes turned out to be not only completely ineffective, but to produce even higher delivery of tar and nicotine compared to unfiltered cigarettes. These reversals even occurred within brand fami-

lies.[112] In addition, machine-measured yields (those stated on the side of each cigarette pack) do not reflect the smoker's real tar exposure. For example, smokers tend to block the ventilation holes designed by the industry to reduce machine (but not actual) yields.[27 113 114]

While cigarette design has been changing over the last 50 years, first by the introduction of various filters and then by substantially lowering machine-measured tar and nicotine yields, they have not contributed importantly to any meaningful reduction in the disease burden caused by smoking. Thun reported in 1997 that the relative risks among smokers of all the major smoking-related diseases are higher today than they were in the 1950s and 1960s. According to Shopland, this is quite remarkable, considering that tar and nicotine levels are supposedly 60 percent lower today compared to 40 years ago.[115] Although claims are made for meaningful reductions, there are no standards as yet. As Jack Henningfield pointed out on the 12th World Conference on Tobacco or Health in Helsinki 2003, cigarettes are more addictive than is necessary to retain smokers. In summary, tobacco delivered nicotine is in a form that is highly toxic, addictive, and delivered explosively fast in a chemical cocktail which increases dose and speed, with additives reducing sensory barriers.[116]

A recent study by Pollay & Dewhirst[112] shows that advertisements of filtered and low tar cigarettes were intended to reassure smokers concerned about the health risks of smoking, and to present use of these products as an alternative to quitting. This approach was first developed in the early 1950s, when scientific and popular articles presented lung cancer research findings and consumers heard allegations about the possibility of fatal health risks. Tobacco companies reacted to this "health scare" with filtered products, accompanied by advertisements with explicit health assertions. The first Surgeon General's report on smoking in 1964, however, reawakened public concerns about the potential health consequences of smoking. In order to reduce these consumer concerns, the tobacco industry reacted quickly by offering an attractive alternative to quitting for many smokers – by switching to a lower yield cigarette. Light and Ultra Light cigarettes were first introduced in the 1950s and 1960s[i], followed by aggressive marketing that sought to diminish health concerns and to reassure smokers that they could smoke with less risk. The majority of the current generation of low yield products were first launched in the mid 1970s. By the end of that decade, 50 percent of the cigarette brands on the market were officially classified as "low tar" according to the FTC method[j].[115] In Austria, com-

[i] Manipulations of nicotine yields in cigarettes were already reported from Germany from the mid-1930s.[117]

[j] The FTC method was developed by the Federal Trade Commission (FTC) in the late 1960s, to test cigarettes on a routine basis for tar and nicotine levels. In June 1994, the accuracy and appropriateness of the FTC test was questioned and found "broke". However, this method is still used today.[113]

pared to many other European countries, 'light' cigarettes were marketed relatively early (1970s).

Many "Light" smokers still believe that smoking these cigarettes causes less harm to health.[118] According to a study by Shiffman *et al.*[119], this is partly due to their experience that 'light' cigarettes are less harsh and the belief that these cigarettes deliver less tar. Considering the fact that smokers, addicted to nicotine and desirous to get their required fix, compensate for reduced nicotine yields by smoking more intensively, i.e. inhaling more deeply and more often (a fact that has been known to the industry since the mid 1970s[120] – *see below*), it is not surprising then that the smoker's actual tar exposure may be as high, or even higher as when smoking regular brands.[27] It was recognised that a smoker's level of exposure is not based on the type of cigarette and the supposed amount of tar, nicotine, and carbon monoxide it allegedly contained, but on the smoker's own behaviour: the number and size of puffs taken on each cigarette, the depth of inhalation, the blocking of filter vents, the number of smoked cigarettes, etc.[64 113 114]

As was demonstrated in an article by William Farone, the former director of applied research of Philip Morris USA, in a recent issue of *Tobacco Control*, the cigarette industry has managed to avoid any real harm reduction in their products over the years. The differences in tar levels between 'Lights' and 'Low Tar' versions of cigarettes is minimal, and also the use of descriptors such as 'Lights' and 'Ultra Lights' creates more confusion than giving an informative description of composition. Farone proves that, while regular brands with a low tar level were already on the market, versions labelled 'Lights' were introduced to the market with equal or much higher tar levels.[121] Similar results were reported in a recent study by Pollay & Dewhurst on the illusion of harm reduction in cigarettes in the 1990s.[122 123]

Although numerous studies began document publicly how smokers who switched from higher tar and nicotine products to lower yield brands experienced exposure levels that were totally inconsistent with the published FTC-determined tar and nicotine values[115], the industry had earlier arrived at the same conclusion, leading to the massive marketing strategy for their new 'Light' products. The industry was also conscious of its endangered position. At the Research Conference in Pichlarn in August 1981, this fear was expressed quite clearly:

> "It is felt that the time is close when Government agencies worldwide will take more notice of compensation – and of the scale of the differences, for a given commercial product, between smoking machine numbers and the dose of smoke actually obtained by smokers".[124]

There are thus sound grounds for concern that the designation of 'light' cigarettes may undermine cessation as they are promoted as a reasonable (and easier) alternative to quitting. Over the past 30 years, as Canova and colleagues point out,

> "increasing numbers of smokers have switched to low tar cigarettes brands, in the hopes of reducing the harm from smoking. We now know, however, that the public health benefit of low tar cigarettes is likely negligible, or actually negative, because the evidence indicates that (1) the health risks of smoking have increased, not decreased…. and (2) it appears that more people are smoking than would be the case were these products not on the market".[64]

This can be seen in the Austrian 1997 survey on smoking habits where a change of brand and the switching to lighter cigarettes are seen by many people as a means to reduce their tobacco consumption or to avoid giving up smoking completely. One in four interviewees reported that he/she has changed brands between 1992 and 1997; women more often than men and individuals in urban areas more often than in rural parts of Austria *(Chapter 6; Appendix K###)*. Not surprisingly, therefore, according to the study of Shiffman and colleagues, "Light" smokers showed a greater interest in quitting than Ultra Light Smokers. In addition, strong promotion of "light" cigarettes seeks to draw more female smokers into the market.[119 125]

This change in smoking behaviour is already apparent in epidemiological trends. According to Christian Vutuc from the Vienna University Cancer Research Institute *(Chapter 9; 9.3.3 and Appendix U###)*, a clear shift in the localisation of lung cancer from central to peripheral foci can be observed over recent decades. While in the 1970s, 11% of carcinomas in Austria were peripheral, in 1990, it was already 28%. Today, this figure amounts to 57%.[126] A recently published study by Harris and colleagues on the risk of lung cancer among smokers of cigarettes with different tar levels concluded that risk is similar in people who smoke medium tar cigarettes (15-21mg), low tar cigarettes (8-14mg), or very low tar cigarettes (≤ 7mg).[127 k]

The increased market share of new "Light" brands and the realisation that these cigarettes do not reduce risk have led to increased concerns within the medical and public health community. The Surgeon General's report of 1981, therefore, strongly cautioned smokers not to increase their smoking or change their behaviour in other ways. The report ended with the advice that there is no safe cigarette. The only way to reduce one's risk from smoking completely was to quit or not to begin smoking. As Shopland points out, that advice is as true today as it was 20 years ago.

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k In Austria, these kind of studies have been carried out by Kunze and Vutuc since the late 1970s. At least some of them were financed by the Austrian and German tobacco industry *(Chapter 9; 9.3.3 and Appendix U###)*. However, the results are still treated as something 'new'.[128]

> "Although the public may believe that the major change in terms of cigarette design over the past 40 years has been the reduction of risk posed by low tar filter cigarettes, cigarettes today are just as deadly as they were back in the 1950s, and perhaps even worse".[115]

Therefore, as stated by Thun & Burns, tobacco control policies should not allow changes in cigarette design to subvert or distract from interventions proven to reduce the prevalence, intensity, and duration of smoking[129], and the medical and public health community should no longer recommend that smokers switch to lower yield cigarette brands as a means of reducing their future disease risks.[114 115]

At present, activities similar to the marketing of 'Light' cigarettes can be observed with smokeless tobacco, which is praised as a 'healthier' option to cigarettes. In the US, every three or four months new tobacco products are launched on the market, with new claims (e.g. nicotine water, nicotine lollipops, nicotine wafers, etc.), in addition to the promotion for smokeless tobacco (snuff).[130] As in other countries, hidden advertising for this product is now starting in Austria, pointing to the long tradition of *snus* (moist snuff) and the low lung cancer rate among men in Sweden. Michael Kunze, the leading smoking cessation expert in Austria, and Karl Fagerström from Sweden are pushing for a "controlled legalisation" of *snus* in Europe, allegedly with a view to it becoming an alternative for heavy smokers *(Chapter 9; 9.3.3 and Appendix U###)*. Scientific 'proof" of the safety of this "largely harmless" and "mild" nicotine drug can also be found in a recent corporate article by Ernest Groman, head of the Vienna Nicotine Institute and colleague (and son-in-law) of Michael Kunze, and Karl Fagerström[66]. The results of this study and the product itself were praised (or advertised) in two *(sic)* newspaper articles in the *Wiener Zeitung* of 31 May 2003.[67 68] Of course, nothing was mentioned about any risks from this "replacement drug". Yet in the end, as the majority of public health advocates have noted, advertising this product as a 'safer' drug might easily lead to the same results as the public health disaster with 'Light' cigarettes, preventing smokers from quitting and resulting in an increase of tobacco consumers. In any case, the issue of its use as a substitute for cigarettes raises scientific and ethical questions, as Lynn Kozlowski formidably demonstrated in her recent article.[65] Perhaps the most that can be said is that consumers of smokeless tobacco at least are not posing a risk to others.

It seems that the once freely expressed opinion by the tobacco industry that people have to die from something and that "cancer is an essential ingredient of life" has not been really overcome as yet, although since the publication of many formerly secret industry documents, industry staff are certainly more careful with these kinds of statements. As cited in Kozlowski, one can

read in a proposal from 1978, prepared for the UK's Tobacco Advisory Council by the UK firm *Campbell Johnson Ltd*:

> "2.7. This last point, a brutally realistic one, implies that, with a general lengthening of the expectation of life we really need something for people to die of. In substitution for the effects of war, poverty and starvation, cancer, as the disease of the rich, developed countries, may have some predestined part to play. The argument is obviously not one that the tobacco industry could use publicly. But its weight, as a psychological factor in perpetuating people's taste for smoking as an enjoyable if risky habit, should not be under-estimated.
>
> 2.8. …. in its controlled and positive aspects, cancer is an essential ingredient of life without which the cells of the human body would be unable to renew themselves".[65]

3.2.4 Self-portrayal of Austria Tabak (Gallaher)

Although definitely meant for the public and therefore a 'lighter' version of the industry's position, the present self-portrayal of Gallaher still reflects the same tradition and the same justification with regard to advertising and other smoking-related topics. However, the industry is now aware of the higher sensitivity on the part of governments and the public with regard to smoking and smoking-related problems. The concept of corporate social responsibility has been taken up, at least in rhetorical terms. So, in its overall concept, Gallaher sees itself as a "responsibly behaving, good corporate citizen", boasting of its success and its strong position on the stock market.

Smokers are described as "those people who choose to smoke", i.e. as "informed adult smokers", and the classification of smoking not being an addiction but rather a "habit", although possibly a "very strong habit". Environmental tobacco smoke is not considered as a health hazard to others; at worst, it might be "a source of considerable annoyance to non-smokers".[131] As the issue of environmental tobacco smoke is closely related with programmes to tackle the harmful effects of tobacco it will be dealt with later in Chapter 4, Section 4.3.3. A more detailed view of the company's homepage is presented in Appendix E.

4 TOWARDS A STRATEGIC FRAMEWORK FOR ACTION: TOBACCO CONTROL MEASURES

4.1 Introduction

By looking at the various tobacco control interventions[a] reported in the literature and employed in other countries it is possible to examine what has been done in Austria in the field of tobacco control and what is still to be done. However, while the situation in Austria will be examined more closely in Chapter 8 and 9, this chapter will primarily look at the international evidence and experience, thus providing the basis for the later analysis.

Several measures to reduce tobacco consumption have been recommended by various sources, based on the experience of many countries. Most important is the insight that it is not the implementation of a single measure that accounts for the success of a tobacco control programme, but the simultaneous implementation of a whole package of measures, which should complement and reinforce each other. Thus, a comprehensive, sustainable, adequately funded programme, supported by decision makers, stakeholders such as cancer societies or anti-smoking groups, committed individuals, health professionals, service providers, and the public, has proven to be very effective in reducing tobacco consumption, smoking prevalence, and smoking-related disease and mortality.

The strategic framework in this chapter is based on the WHO-publication European Strategy for Tobacco Control (ESTC)[132], which sets out strategic directions for action. Examples of successful tobacco control policies in other countries were found via the internet (using Google) and by hand search of later issues of some journals, in particular *Tobacco Control* and the *British Medical Journal*. The methods used were described in more detail in Chapter 2.

The industry perspective is represented by excerpts from literature on Gallaher's position on the World Health Organization's Framework Convention on Tobacco Control.[133] Other influential factors known to deter key actors from the implementation of a comprehensive and effective tobacco control plan – such as the promise of enormous financial gains for both the tobacco industry and the state – are also discussed. Experiences from other (particularly European)

[a] According to the definition of the WHO intervention means "any health action – any promotive, preventive, curative or rehabilitative activity where the primary intent is to improve health".[2]

countries, which could serve as models of good practice for Austria, have been reviewed and described.

4.2 Measures to reduce the demand for and supply of tobacco products

The World Health Organisation distinguishes demand-side and supply-side measures. Measures to reduce the demand for tobacco products include price and taxation; prevention of exposure to environmental tobacco smoke (passive smoking); control of advertising, promotion and sponsorship; information, training and public awareness; smoking cessation; product control and consumer information. Measures to reduce the supply of tobacco products involve reduction of illicit trade; availability to young people; and tobacco subsidies. The latter, however, are in general less effective, while demand-side measures work well, in particular when implemented simultaneously. However, it has also been recognised that

> "Member States and the European Community, when applicable, will have to adopt different sets of measures, based on their concrete needs, resources, and the stage they have reached with their tobacco control policy, and according to a realistic time frame. In the meantime … national tobacco control policies should be comprehensive enough to cover all major aspects of the demand for and supply of tobacco products".[132]

Despite the fact that cigarette smoking damages human health, leading to chronic disease and premature death, many governments (including Austria and Germany) have avoided taking action to control smoking because of concern about potential economic harm, but also due to the strong, long-term influence of the tobacco industry in the form of very close and friendly relationships between government and industry and most the latter's effective lobbying. Yet while it cannot be said that Austria has been inactive in enacting public health measures, what is striking is that, from the range of possible interventions, most measures chosen have been from the category "less/not effective" rather than "very effective" or even "likely to be effective", as presented by Heather Selin[134] in the following overview (Box 4.1) of the effectiveness of key measures *(see also Section 4.3.4)*.

Box 4.1 Evidence-based measures in tobacco control that have proven to be very effective or less effective

Very effective measures	Less effective measures
• Significant tax increase	• Controls on sales (age limits)
• Comprehensive legislation, including adequate penalties for violations of the law	• Controls on production
• Complete ban on direct and indirect advertising	• Measures focussed exclusively on youth
• 100% smoke-free environment	

• Large, meaningful package messages (health warnings), memorable images • Widespread and sustained media campaign addressing the whole population and different audiences • Tackling of smuggling • Tobacco tax used for health promotion funds, particularly targeting smoking behaviour	

For example, Austria's efforts to control tobacco consumption concentrate on (mostly ineffective, or even counter-productive) youth campaigns, the formal (yet not enforced) setting of age limits for the consumption and purchase of tobacco products (while permitting vending machines), and a very weak tobacco law with few provisions for sanctions or, even where they exist (as in the case of regulations of tobacco advertising), no enforcement. Although a certain percentage of tobacco tax is used to finance the national Fund for a Healthy Austria (activities in health promotion), and in 2002 the Federation of Austrian Social Insurance Institutions received a certain amount of the tax income, this money is not earmarked and the anti-smoking activities of both recipients are thus negligible or null. The delayed implementation of enlarged health warnings in September 2003 was more or less "enforced" by the European Union. The circumstances in which cigarettes are sold suggest that they are harmless, and information on health hazards is very limited.

The following measures have been recognised to affect tobacco consumption.[132] Again, in order to be effective, the importance of comprehensiveness, i.e. the implementation of several measures at the same time, has to be emphasised *(Section 4.3)*.

- Legal and regulatory measures
- Taxation and fiscal measures
- Environmental tobacco smoke (passive smoking): Smoking bans and restrictions
- Tobacco advertising, promotion and sponsorship
- Anti-smoking campaigns and other educational measures (information, training and public awareness)
- Therapeutic measures, smoking cessation
- Product control and consumer information
- Control of illicit trade (smuggling)
- Youth access

Due to the limited space in this thesis, the various measures, together with the response of the industry, are explored in more detail in Appendix F.

4.3 Reducing smoking: What works? Influential factors on policies

4.3.1 Introduction

Several countries have established successful measures to reduce smoking and may serve as "models of good practice" for other, less successful or less committed states, or for policymakers who still doubt the effectiveness of incisive tobacco control programmes. Apart from demonstrating the effectiveness of tobacco control interventions, the experiences of those countries that have committed themselves to reduce smoking prevalence, smoking-related death and disease also make it possible to reach conclusions about what are the most effective elements of tobacco policies.

Compared to the achievements in tobacco control in the United States (particularly in California and Massachusetts), Canada, Australia and New Zealand, but also other countries such as Thailand or South Africa, Europe as a whole can seem far behind. However, the Scandinavian countries, Sweden, Finland, and Norway, although not Denmark, can boast a long tradition of tobacco control policies. They have implemented very successful interventions for reducing smoking and are certainly the leaders in progressive anti-smoking policies within Europe. From the viewpoint of the situation in Austria, though, where anti-smoking policies remain underdeveloped, other European countries with comparatively limited programmes, such as Poland, France, Italy, the UK, or Ireland could also serve as examples. A particularly important issue at present in many European countries is that of smoke-free environments in restaurants, pubs and bars.

In Austria, anti-smoking policies from overseas (particularly in the United States, for Austrians the best known "negative" example of smoking restrictions), no matter how successful, are viewed as being rather eccentric, puritanical, militant, dictatorial, exaggerated and, all in all, "too extreme" – and by no means to be followed. Potentially, examples of successful interventions from other European countries might be viewed as more acceptable models. Therefore, this overview of successful interventions in controlling tobacco consumption puts more weight upon the achievements by European countries, the underlying assumption being that these countries elicit fewer adverse responses in Austria and also that they seem to be more promising as arguments for a change in Austrian policies. Perhaps a glance over its own border could reassure those who fear hordes of desperate smokers in the streets and grieving restaurant owners in their empty premises, with the economy of the country in tatters.

However, given that the space available in this thesis is limited, a detailed overview of experiences from other countries has been placed in Appendix G###. While in the following section only tobacco control programmes in European countries are discussed, the results from broader international experience will be considered when discussing the issue of environmental tobacco smoke and measures to restrict or ban smoking in workplaces. This seems legitimate as this discussion is based largely on evidence from outside Europe. Similarly, a summary of experiences in tobacco control from both European and further afield countries in the form of "lessons learned" will be presented in Section 4.3.4 and Appendix G###. In due course these will form the basis for the development of recommendations for effective Austrian tobacco control measures in Chapter 10.

4.3.2 National strategies in selected European countries

This section will deal with those European countries that are at the cutting edge of tobacco control, featuring the most successful characteristic of each country. In particular the Scandinavian countries Sweden, Norway and Finland are outstanding within Europe in their sustained tobacco control policies, having begun their efforts to reduce tobacco consumption decades ago. In these countries, non-smoking has become a socially accepted cultural norm, and a smoke-free environment is part of the notion of a healthy environment. To some degree, smoking in northern European countries is now seen as a sign of social exclusion and deprivation.[135-139] A detailed description of the history of tobacco policies and the measures taken in these Nordic countries can be found in Appendix G###.

The important achievements of other countries should not however be ignored. France, for example, is known for its early introduction of a total advertising ban (direct and indirect advertising, and sponsorship) in 1993[140] and a commitment to tobacco control by a series of health ministers since 1988 (starting with François Mitterand's administration but with the exception of Jacques Chirac), spearheaded by a strong media-based lobbying of a handful of committed medical practitioners.[141 142]

Austria's neighbour Italy, too, has had advertising bans since 1962, with provisions for fines since 1983 and the inclusion of indirect advertising and sponsorship since 1991.[140] In 2000, the Italian health minister introduced a proposal to ban smoking in public and private indoor areas open to the public, including bars, restaurants, prisons, and police stations, and to enable law suits against tobacco producers. People caught smoking in public places are fined €250, a sum that can be doubled if children or pregnant women are present. If restaurants and other public

places wish to permit smoking they must set aside a smoking room and install a ventilation system – or risk a fine of €2,000 and temporary closure, a real revolution[143-145] *(Appendix G###).* A second law which came into force on New Year's Day 2004 limits the availability of cigarettes in vending machines.[146] Since 1 March 2004, smoking has also been banned on Italy's Eurostar trains.[147] While similar to Austria with its high smoking prevalence, a predominantly pro-smoking climate, and the notion of a "very tolerant society", Italy's achievements indicate that even in such conditions legal measures are effective, but also reflect the commitment of its health ministers Umberto Veronesi and Girolamo Sirchia.

Ireland has introduced a ban on smoking in all workplaces, including restaurants, pubs and bars in March 2004, thus being the first country within the European Union with a complete ban on smoking in the workplace *(Section 4.3.3)*. The ban also provides severe fines of around £2,000 (€3,000) for those caught smoking illegally. Ireland seems to play a particularly important role in initiating discussions on smoking bans even in reluctant countries such as Austria. In addition, as with Italy, the public approval if these measures in a country considered to be as individualistic and non-law-abiding as Ireland, with a traditional "pub smoking culture" nobody could imagine could be changed, shows that anti-smoking measures are not necessarily dictatorially enforced upon people, as argued in other countries. Examples like these will at least make counter arguments less believable. Italy and Ireland also demonstrate the importance of engaged and courageous health ministers.

In the United Kingdom, despite growing public support for a complete ban on smoking in public places, at present, there are no official restrictions for smoke-free environments in restaurants, pubs and bars; these are purely a matter of voluntary agreement. The government has, however, committed considerable resources to support smokers wishing to quit. While some commentators wanted to see the experience of the Irish smoking ban, a similar ban in England under the present health minister it is not very likely.

Poland, on the other hand, is outstanding within the formerly eastern European countries. Despite enormous pressure from the tobacco multinationals, the Polish government has enacted comprehensive tobacco control legislation first in 1995 (being far ahead its time compared to most western European laws on tobacco control) and amended by a law in 1999 *(Appendix G###)*.[148 149]

Given the extent of the current debate about the scope for legislating for smoke-free environments in restaurants, pubs and bars, a debate that presumably will also reach Austria at some stage, the following section is dedicated to this issue.

4.3.3 Smoke-free environments in restaurants, pubs and bars

Restaurants, pubs and bars are among the most frequented public places where both smokers and non-smokers are involuntarily exposed to environmental tobacco smoke (ETS). Since the 1970s there has been growing evidence that second-hand smoke endangers non-smokers and, at least in the United States and north European countries, a reduction in social acceptability of smoking has accelerated its decline. This decline in social acceptability has been recognised by the tobacco industry to be one of the most serious problems it faces. Furthermore, smoke-free environments have led to a significant decrease in cigarette consumption and, consequently, to a loss of profits for the tobacco industry. In 1993, an analyst of Philip Morris observed:

> "Financial impact of smoking bans will be tremendous. Three to five fewer cigarettes per day will reduce annual manufacturer profits a billion dollar plus per year".[150]

The industry also recognised that declining social acceptability also increases voluntary quitting and weakens the industry's ability to develop allies.

In the face of these developments, by the late 1980s and early 1990s, the industry realised that it urgently needed to address these issues in a proactive manner, rather than simply reacting to some countries' tobacco control initiatives before they would spread out to other countries. To do this, several approaches were taken, one of these being attacks on science. A study by Drope *et al.* reveals the industry's deliberate strategy to use scientific consultants to discredit the science on ETS. They summarise their findings:

> "The industry built up networks of scientists sympathetic to its position that ETS is an insignificant health risk. Industry lawyers had a large role in determining what science would be pursued. The industry funded independent organisations to produce research that appeared separate from the industry and would boost its credibility. Industry organised symposiums were used to publish non-peer reviewed research. Unfavourable research conducted or proposed by industry scientists was prevented from becoming public."[151]

As will be shown in Chapter 9, Austrian scientists were also part of this game.

Other approaches were directed at influencing the public's perceptions, invoking arguments about "courtesy", "choice", "freedom", and (with a view to those who complained about smok-

ing) "tolerance". It also used arguments that business would decline, accompanied by the promotion of ventilation as the best solution.[b]

> "The industry adopted two main approaches to address the problem of declining social acceptability of smoking: attacking the science demonstrating that second hand smoke was dangerous (as it had done with active smoking) and working to change the public's perception of smoking in public. The industry's original defence against restrictions on smoking (creation of non-smoking sections) in the 1970s was to invoke arguments about 'courtesy', 'choice', and 'freedom' as well as to claim that any limitations on smoking would hurt business … (without mentioning the fact that tobacco industry sales and profits would suffer). In the 1980s they also began to promote ventilation as a solution." [150]

While these arguments clearly reflect the situation in California and northern Europe at that time, they also correspond to the present situation in Austria where the industry's early arguments about "courtesy", "personal freedom" and "own choice" are still courted, and where there is still a conviction that there is a simple solution: good ventilation systems *(Chapters 8 and 9).*

However, as a result of these pressures from other countries, the tobacco industry started to focus increasingly on the debate about clean indoor air and smoke-free environments in the hospitality industry (restaurants and bars). Knowing that its public credibility is low, the tobacco industry has a well established practice of speaking through front groups.[150] In this case, the core message which was used to recruit allies in the hospitality industry and which is still dominant in Austria's perception of "tolerance", has been "accommodation" of smoking and non-smoking patrons *(Chapter 8; 8.4 and Appendix Q###)*. Of course, there was no mention of the interests of employees. As has since been discovered, a key element in this strategy has been "to commission and release studies claiming that smoking restrictions have major negative economic effects on the hospitality industry, a claim even a PM *[Philip Morris]* lobbyist reported was untrue".[150]

Meanwhile, surveys particularly in California and northern European countries, but also in some other countries, indicate strong and increasing public support for smoke-free restaurants, pubs and bars. Apart from the forerunners in North America, Canada, North Europe, Australia and New Zealand *(Appendix G###)*, now several more countries, including France, Italy, Ireland, The Netherlands, and many cities in the USA (New York, for instance, banned smoking in

[b] At least in some countries, this argument about ventilation "eventually lost credibility because a consensus developed that workers should not be forced to breathe the toxic chemicals in second hand smoke, and business saw no need to install expensive ventilation systems (that would not solve the problem anyway). In addition, many employers (particularly large employers) independently concluded that smoke-free workplaces were good for business".[150]

public places in April 2003), have been enacting legislation to ban smoking in bars and restaurants.

However, despite the positive results achieved by smoking bans in restaurants and the strong community support found in many studies, the tobacco industry, hospitality associations, restaurant lobbying groups, and many restaurant owners have been consistently opposing proposals to restrict smoking in restaurants, arguing that smoke-free policies would result in a loss of business by successfully echoing the unfounded arguments developed and reinforced by the industry.

To date the industry has remained constant in its encouragement to maintain the "controversy" on ETS (although there is no real controversy). As pointed out by Bartosch & Pope[152] and other authors, tobacco and restaurant industry funded studies claim that restaurant jobs would be lost and/or restaurant sales would decline under such restrictive policies – arguments still used by Austrian media and health politicians. Yet these claims are unwarranted. Dearlove and colleagues describe how the tobacco industry used the "accommodation" message to mount an aggressive and effective worldwide campaign to recruit hospitality associations, such as restaurant associations, to serve as the tobacco industry's surrogate in fighting against smoke-free environments.[150]

In reality, there is good evidence from independent studies in the USA, Canada and Australia that turnover is not affected, or has even increased after the introduction of smoke-free restaurant and bar laws.[153 154]

The strongest argument in favour of smoking bans in all public places is the scale of the health hazards from environmental tobacco smoke that both non-smoking patrons and employees are exposed to. An investigation in New Zealand tried to quantify the actual extent of exposure of hospitality workers to ETS during the course of a work shift, relating the results to the customer smoking policy of the workplace. The results of this investigation showed that hospitality workers in premises allowing smoking by customers had significantly greater increases in salivary cotinine concentrations than workers in smoke-free premises and those in premises with no restrictions on customer smoking were more highly exposed to ETS than workers in premises permitting smoking only in designated areas. Overall, there was a clear association between within-shift cotanine concentration change and smoking policy. In addition, workers in premises permitting customer smoking reported a higher prevalence of respiratory symptoms and irritation than workers in smoke-free workplaces. Concentrations of salivary cotanine found in

exposed workers in this study were at levels consistent with substantial involuntary risks of cancer and heart disease[155] *(Chapter 7; Appendix L###)*.

A recent study from the United Kingdom estimates that one hospitality worker a week dies from passive smoking.[156] Not even these alarming results are enough to stimulate a serious prospect of public smoking bans, neither in the United Kingdom itself nor in Austria, where this study was also reported in the media.

According to an Australian study by Trotter *et al.* to assess the perceived effects of smoking bans in bars, nightclubs, and gaming venues on smoking behaviour, 70% reported that they would smoke more (socially cued smokers) and 25% (especially young people aged under 30 years) indicated that they would be likely to quit if smoking were banned in social venues.[157] Thus, these findings confirm what is already known from other countries where smoking bans have been established for a couple of years: that the introduction of smoke-free policies could reduce cigarette consumption and increase quitting among smokers.

In England, a total ban on smoking in public places, including pubs, bars, restaurants, and other workplaces, was proposed by the chief medical officer, Sir Liam Donaldson, who pointed to the increased risks of passive smoking, especially for children and babies, but also for adults. He even noted that action on second-hand smoke was what the tobacco industry has long feared most.[158] Reacting to this proposal, Simon Clark, director of pro-smoking and industry-funded group *Forest*, used the standard formulation of the tobacco industry and their allies in the restaurant business:

> "We are against a total smoking ban in public places, we believe there is no justification for it. Pubs, restaurants and clubs are private business and they should be free to choose their own policy… We would actually like to see more non-smoking areas. We are prepared to compromise but the anti-smoking industry is not willing to do the same".[158]

It is not quite clear what Mr. Clark imagines to be the "anti-smoking industry" (obviously some sort of organised, relentless and very powerful enemy) but what is very clear is that the health hazard of passive smoking is not at all an issue for him. Sir Liam Donaldson's proposal was not, however, supported by his health minister, who favours local action where agreement can be achieved.

Forest's arguments are similar to the view expressed by the Austrian State Secretary of Health, Reinhart Waneck, who is strictly opposed to smoking bans in restaurants and bars, using strong words when arguing that smokers should not be "criminalised" and ignoring successfully the fact of health hazards in favour of further gains from tobacco taxes.[159]

Luckily, there are several states that have been more successful in the past and can report positive effects of smoking restrictions based on lengthy experience, although obviously attribution of health effects to smoking bans is complicated by the co-existence of other measures. Some states in North America (in the forefront are California and Massachusetts), Canada and Australia long ago banned smoking in restaurants and bars *(Appendix G###)*, and there is evidence that not only smoking rates but also smoking-related mortality decreased significantly.[160] For example, Canada, California and Massachusetts report a significant decline in smoking rates.[160-166] California has also experienced a significant decrease in mortality from myocardial infarction and lung cancer.[161] In Canada, too, the impact of the decline in smoking prevalence is beginning to show in decreased lung cancer rates among Canadian males aged 20 years and over.[167]

Other countries, states or cities have recently issued a total smoking ban in public places (including restaurants and bars), as, for instance, Thailand, New York, Ireland, and Norway. Other countries are following.

In the Nordic countries (especially Norway, Sweden, Finland, and Iceland), in general, ETS has been tackled fairly heavily over the last years. Although Denmark still has much to do, all countries share the challenge of transforming restrictions into bans, but Norway is the only country that has a complete smoking ban in restaurants and bars, entering into force on 1 June 2004. Sweden will follow suit on 1 June 2005. The Norwegian bill ensures equal protection for all employees in their working environment, but also protection of customers and removal of an important setting in which teenagers might start smoking. A glance behind the curtains reveals some of the key criteria that influenced the passing of this bill:

> "A success criterion for the progressive legislation is the fact that the influential labour unions gave their full support and campaigned actively for the outcome. Another was the decision of the Supreme Court that ruled in favour of a plaintiff who sued for damages due to illness caused by exposure to passive smoking in a bar. The new act is an example that legislation enacted at an opportune time can be a powerful public health tool".[137]

In Norway, separate areas for smokers and non-smokers in restaurants and cafés have been highly appreciated for many years. According to a survey conducted in 2001, about two thirds of the population prefer the non-smoker's area. Only 10% found the 50/50 areas too strict – 90% found it balanced or too weak. The new provisions for totally smoke-free restaurants have more moderate, but still majority support. A poll conducted in May 2003 showed 53% in support, while 44% were against and 3% were 'don't knows'.[137] However, experience of previous

restrictions and experience in other countries show that public support increases after the introduction of smoking restrictions.

In Finland, despite considerable effort and the general success of tobacco control policies, it has been difficult to enforce smoke-free legislation for bars and restaurants. Restaurant and bar owners reported finding it hard to implement the legislation, and a softer approach did not have the intended effect. Restaurants and bars have to set aside non-smoking areas, but these can hardly be called smoke-free as they adjoin smoking areas. The three-year transition period ended on 1 July 2003. Now restaurants and bars of 50m^2 or over must reserve half of their seats for non-smokers. Smoking areas must be ventilated so that tobacco smoke does not spread to the smoke-free area.[137]

In summary, therefore, smoke-free environments not only offer protection from passive smoking; they also constitute a key element in reducing smoking prevalence among young people.[137]

Counter arguments

One of the most frequently used counter arguments against total smoking bans is the magic word "ventilation". Ventilation systems are not effective because ETS consists of particulate and gaseous materials that are difficult to remove. Also factors such as design of the room, number of patrons, building materials and temperature make it impossible to design a ventilation system that will remove all the constituents of ETS.[168-170] To achieve a "clean" indoor air quality which is within limits set for outside air pollution, the ventilation would need the strength of a tornado, with about 40,000 air-changes per minute.[169-172] In addition, ventilation systems that make any difference to air quality are very expensive and not easily affordable. The introduction of smoke-free environments is certainly the cheaper and more effective intervention to reduce both harm and annoyance.

Another argument is the allowance that "everybody" (i.e., in particular, smokers) has the "right" to smoke, being a matter of freedom of choice and implying that neither the state nor "intolerant" non-smokers have the right to interfere.

Confronted with evidence of the health hazards of ETS for non-smokers, it is often argued that the case is not scientifically proven. Although studies on health hazards resulting from second-hand smoke are difficult (due to the difficulty in measuring previous exposure to ETS and conducting appropriate follow-up studies), there have been numerous studies (more than 42 case-control studies and 6 longitudinal studies) from many countries over the last two decades that

demonstrate a relationship between exposure to ETS and increased risk of smoking-related diseases in non-smokers – particularly increased risk of lung cancer and other respiratory diseases in hospitality workers and life partners of heavy smokers, and increased risk in respiratory diseases in children of smoking parents. ETS contains more than 50 human or animal carcinogens and because much of it arises from smouldering cigarettes, burning at lower temperatures than with active smoking, it is more toxic than smoke inhaled actively.

When all its arguments proved unsuccessful, the industry and its allies attempted a last try: surely one can solve this problem with less dramatic measures, usually involving another magic word: "tolerance" (by non-smokers, obviously, whatever that means). But many restaurants and bars may find it difficult to separate their premises so that non-smokers will not feel harassed by the smoking of others and, as already noted, the cost of a "good" ventilation system is high (and it does not make much difference either). For most restaurants and bars it would therefore be easier to provide total smoke-free environments than divided sections.

4.3.4 Lessons learned

The experiences in tobacco control in countries and states that have been examined most closely (United States, Canada, Australia, New Zealand, Norway, Finland, Sweden, Brazil, Poland, South Africa, and Thailand), all point to one main finding: tobacco control measures can work. Although the situation in each continent, in each country, state, or city is different and to a certain degree unique, there are commonalities that are applicable to other countries in different settings.[173] Many lessons have been learned about what works, from both the successes and the setbacks and may now serve as guidelines for other countries.

A summary of measures that have proven to be effective in tobacco control in various countries as well as measures that meet the interests of the tobacco industry (many of them to be found in Austria's tobacco policies) is given in Appendix G###.

The following chapter presents the international framework European tobacco control policy is embedded in. This consists in particular of the binding laws and regulations of the European Commission, but also of various policy initiatives by the World Health Organization and the European Union.

5 THE INTERNATIONAL FRAMEWORK: EUROPEAN SMOKING AND TOBACCO POLICY

Since 1989, when the European Community passed its first directives on labelling, advertisement and smoking restrictions in the workplace, and particularly since 1999, when negotiations for the Framework Convention on Tobacco Control (FCTC) "have opened the door to global agreements that aim to reduce tobacco consumption and the related death toll worldwide"[132], the tobacco control climate has changed considerably. The decision by the European Union to legislate on tobacco and the FCTC process launched by the WHO were responses to the increasingly global nature of the tobacco industry with its inventive and aggressive strategies to undermine national legislation (e.g. smuggling, cross-border advertising in television and printed media, etc.).[174 175] These new developments made it increasingly necessary to enact supranational legislation.[27 142]

Therefore, within the wider framework of European tobacco policy, particularly with regard to the laws and regulations on production, marketing, taxation and advertising of cigarettes established by the European Union, tobacco control is no longer a national issue and policies pursued by individual governments in Europe cannot be seen in isolation from those being pursued by the European Union.[27] For Austria, like most other European countries, the need for effective supranational tobacco control policies becomes evident from the persistence of weak national policy measures. Where changes have taken place they have often been in response to European law and would otherwise not have been initiated.

This chapter, therefore, identifies the main actors in European tobacco policy, describes the legislative situation at the European level and addresses the various actions and programmes initiated by these actors.

5.1 Actors on the European level

The two main actors in European tobacco policies are the World Health Organisation (WHO) and the European Union (EU), formerly the European Community (EC).[a] The World Bank, an important actor on the global level, also has some influence on European tobacco policies. For example, after reviewing the evidence regarding the effects of cigarette advertising, the World Bank concluded that advertising increases cigarette consumption so that legislation ending ad-

vertising would reduce consumption – provided that it was comprehensive, covering all media and uses of brand names and logos. A modelling exercise applying these data to the entire European Union (then 15 countries) led the World Bank to conclude that the comprehensive advertising ban outlined in the – later annulled – 1998 EC directive (98/43/EC) would have reduced overall cigarette consumption within the EU by 7%. From a public health perspective, such a reduction in cigarette consumption would have immediate short-term and long-term benefits.[176] In tobacco control, the World Bank itself sees its role as a partner with the World Health Organization, which is recognised as the lead organisation in responding to the epidemic (particularly with its Tobacco Free Initiative), while offering in particular its economic perspective.[3]

The United States Centers for Disease Control and Prevention (CDC) also have some indirect influence on European tobacco policy through their important publications (e.g. reports of the Surgeon General) but cannot be considered a major actor at the European level.

Last but not least, many non-governmental or EU-funded organisations and agencies, such as the now disbanded Bureau for Action on Smoking Prevention (BASP), the Association of European Cancer Leagues (ECL), the International Union against Cancer (*Union Internationale Contre le Cancer*, UICC), the British advocacy organisation Action on Smoking and Health (ASH), or the International Agency on Tobacco and Health (IATH), have all played an important role in influencing European tobacco policy.

5.1.1 The European Community (European Union)

According to Article 95a, the EC is mandated to pursue "a high degree of public-health protection". As of 2003, EC tobacco control legislation is still generally weak, although two recent directives, 2003/33/EC which bans cross-border advertising and sponsorship and 2001/37/EC which, inter alia, bans misleading product descriptions such as "light" or "mild", have led to considerable strengthening of efforts to reduce cigarette consumption in Europe, particularly in the context of enlargement, although as noted above, some acceding countries such as Poland have more stringent laws than existing member states.

Starting in 1989 with the first directives on tobacco control – i.e. the television advertisement (or broadcast) directive "Television without frontiers" 89/552/EEC; directive 89/622/EEC concerning labelling of tar and nicotine yields and health warnings; and directive 89/654/EEC con-

[a] After the Maastricht Treaty in 1992, the former European Community (EC) became the European Union (EU).

cerning the minimum safety and health requirements for the workplace – the European Union has enacted several directives and recommendations to control tobacco consumption, in particular with regard to product labelling, maximum yields for tar and nicotine in cigarettes, tax levels, advertising and sponsorship *(Section 5.2 and Table ### in Appendix I ###)*.

A major set-back that had far-reaching significance was the annulment by the European Court of Justice (ECJ) in October 2000 of directive 98/43/EC that had established a comprehensive ban on tobacco advertising *(see later)*. The ECJ's verdict illustrated the legal subordination of public health to internal market issues, or the so-called harmonisation of the single market. Although the treaties require that the European Union pursue a "high level of protection for public health", they place constraints on the scope to pass legislation for purely public health purposes. Most tobacco control legislation has therefore been enacted on the basis of internal market provisions – even though it concerns trade in a substance that kills more of its citizens than any other. The advertising directive was overturned on the grounds that it was enacted as an internal market issue but was deemed to obstruct rather than facilitate trade in tobacco products.[175]

Thus, overall, the role of the European Union in combating tobacco consumption has been somewhat disappointing. According to Collin & Gilmore, the weakness of the European position can be explained "by a combination of the deficiencies in European tobacco control legislation and a lack of political will".[175]

However, although the weaknesses, delays and omissions in European tobacco control legislation and the economic might of the tobacco industry cannot be ignored, the positive influence of the existing directives on the progress of national tobacco policies, at least in some countries, has to be recognised. Section 5.2 will explore in more detail the legislative framework for European tobacco control.

5.1.2 The World Health Organization

In the 1980s and 1990s, policymakers became increasingly aware that smoking is not only – as previously believed – an issue of personal responsibility and individual behaviour (arguments successfully propagated by the tobacco industry), but also a social issue that should be subject to health policy. The scale of the health consequences of smoking compelled the World Health Organization, the principal international agency responsible for health, to give concrete recommendations to its member states for containing tobacco consumption over many years.

Since 1987, three five-year European Action Plans on Tobacco have been launched (1987–1991; 1992–1996; 1997–2001).[177] Meanwhile, the WHO has taken the lead in responding to what is now termed the "tobacco epidemic" through its Tobacco Free Initiative (TFI). The most significant action arising from this initiative is the WHO Framework Convention on Tobacco Control (FCTC) *(Appendix H###)*. Prior to the launch of negotiations in October 2000, the following statement was issued jointly by EU Health and Consumer Affairs Commissioner, David Byrne, and WHO Director General, Dr Gro Harlem Brundtland.

> "Tobacco use is the most significant avoidable source of disease and premature mortality. In the European Union alone, over 500,000 deaths per year are caused by tobacco consumption while globally 4 million die annually from tobacco. Smoking leads to significant death and disease from cancer, cardiovascular disease and respiratory disease in adults as well as severe health effects in children exposed to tobacco smoke. The death toll caused by tobacco consumption can and must be avoided."[29]

The FCTC is a unique framework-protocol approach[b] which will come into force only after 40 countries ratify. Ratification, acceptance, approval and accession are international acts by which states that have already signed the FCTC signify their consent to be bound by it. To date (4 August 2004) there are 168 signatures; Austria signed on 28 August 2003. Twenty-five countries have ratified the convention so far, with Norway being the first.[179] As soon as 40 countries expressed their consent by ratification, the Convention will become law for those countries and thereafter for other countries that become contracting parties to it.

The FCTC process arose from the recognition that individual states can no longer effectively control the global factors that drive the tobacco epidemic. This convention offers a unique opportunity to tackle this pandemic, although progress has been inhibited by some key states *(Appendix H###)*.[174 175]

Despite known problems with implementation of the convention (scientific uncertainty, complex technical details, and – presumably most importantly – lack of political will)[178], the FCTC process has already had a major impact in advancing global and national tobacco control efforts. So far, the tobacco industry has been relatively mute (or is still offended at not being in-

[b] Frameworks describe an agreement on broadly stated goals. Subsequently, the parties will possibly conclude separate protocols with specific measures to implement these goals. Unlike a framework, a protocol is an international agreement, which can be adopted or accepted.[178]

cluded[c]) but is expected to engage in the fight at the national level, trying to ensure that implementing legislation is weak with many loopholes and continuing to promote self regulation as the answer to the tobacco pandemic.[181] Consequently, it is most important that more countries ratify and implement tobacco control legislation as soon as possible. In the words of Hammond and Assunta: "Without a swift and concerted action to bring the FCTC into force and ensure that countries implement it to the fullest, there is the danger that the treaty will end up as just another well intentioned resolution."[181]

However, the role of the WHO was not always as pronounced against smoking. A 1979 industry memorandum regarding the industry-organised International Public Smoking Symposium (ICOSI) discloses that the then WHO sub-director, Mr. Tibblen, would though "not be totally on our *[the industry's]* side" but his remarks would be "fairly moderate". He would thus help a "balanced" or even "controlled controversy" where his views were then going to be discredited.[182] [183] [d]

In 1993, the WHO was described by the industry as rather weak (due to its limited funding), though influential.[e]

An overview of effective interventions, actions and programmes by the WHO and the EU can be found in Appendix H###.

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[c] In its position paper on the FCTC of 21 February 2003 Gallaher expresses its disappointment at being passed over (something it has not been used to, obviously): "Gallaher is disappointed that tobacco manufacturers have been largely excluded from the process of developing the Framework Convention, other than an opportunity to submit a four page written statement and to make a five minute presentation at the October 2000 Geneva Convention. Article 5.3 of the Framework states that the parties are asked 'to avoid undue interference by the tobacco industry'. No matter what views those responsible for the proposed Framework may have, Gallaher contends that balanced debate, that truly takes account of the interests of all parties, is more likely to result in principles and goals that are more appropriate and more proportionate in their aims".[133]

BAT spokesman Michael Prideaux expressed the industry's anger as follows: "The WHO has been taken over by a coalition of anti-tobacco activists whose stated purpose is to hound tobacco companies out of business… Tobacco is not an environmental issue which needs a supra-national convention. It is a consumer product and best regulated by the people that consumers vote for." This argument becomes more transparent when he says shortly afterwards: "National governments earn ten times as much money from the tobacco industry as we do. They have no desire to put us out of business." What he did not quite understand was why, "while BAT and the other tobacco companies could not take part in negotiations with the WHO, anti-tobacco groups such as Ash were involved in the talks".[180]

[d] This just shows the carefully prepared tactics of the industry: "If Tibblen makes his point … The response to Tibblen will come from carefully briefed and placed floor discussing people."[120]

[e] "In light of its poor funding arrangements, the WHO cannot be looked upon as the powerhouse for smoking control around the world. The monies it does have available are basically 'seedcorn', to provide the framework and climate through the media for the growth of smoking control strategies in the Member States."[184]

5.2 EU legislation and non-binding provisions

Although much of this section has had to be placed in Appendix I### because of space limitations, it is mainly drawn from the framework developed by Gilmore & McKee[27] and the publications by Gilmore & Zatonski[149] and Gilmore *et al.*[185], updated by the latest information from EU websites[28 29].

The various EU Directives regulate the contents, packaging and labelling of tobacco products; they impose an obligation to provide health warnings; and they ban direct tobacco advertising in print media, on television, on the radio, and on the Internet.[29]

As European law takes primacy over domestic law, member states must incorporate Directives enacted by the European Council and Parliament into national law within a defined period (usually two years). A failure to do so means that the directive automatically becomes legally enforceable in the state in question.[27]

Where the law dictates that the EU cannot (or does not want to) legislate, but the member states can, the EU has developed a complementary set of non-binding recommendations for member states. These are, for example, the Council Recommendation 2003/54/EC on the prevention of smoking and on initiatives to improve tobacco control – including tobacco sales to children and adolescents; tobacco advertising and promotion that has no cross-border effects; provision of information on advertising expenditure; environmental effects of tobacco smoke – or Council Resolutions on combating tobacco consumption, on reduction of smoking, and on banning smoking on the workplace and in places open to the public.[28 29 149]

The issue of smoking in the workplace and other public places has yet to be addressed effectively at a European level. A directive regulating smoking in the workplace (89/654/EEC) and a specific directive on measures for the safety and health at work of pregnant or breastfeeding workers (92/85/EEC) are being revised[186] *(Appendix I###).*

Similarly, a weak, non-binding resolution of 1989 invites member states to adopt measures to end smoking in public places and on all forms of transport[176]. David Byrne, the outgoing EU Commissioner for Health and Consumer Protection, has recently asserted his determination to strengthen smoke-free policies in Europe.[187]

Although there are also some other regulations in effect (e.g. a directive regulating taxes (99/81/EC), the television broadcast or advertisement directive (89/552/EEC), etc.), the present

legislative situation with regard to tobacco control is characterised by the three latest directives and recommendations of the European Commission: the Tobacco Products Directive (2001/37/EC)[188], the Advertising and Sponsorship Directive (2003/33/EC)[189], and the Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control (2003/54/EC)[190]. These and an overview of all major EU tobacco control regulations since 1989 are presented in two tables in Appendix I###.

Appendix I### also gives a more detailed description of regulations on advertising and sponsorship, labelling and cigarette composition, and smoking in public places and workplaces.

6 PATTERNS OF SMOKING IN AUSTRIA

6.1 Introduction

This chapter analyses current and historic smoking patterns in Austria. In particular, it looks at the social determinants of and attitudes towards smoking. Existing surveys containing information on smoking were identified and explored. However, the various studies available differ in the questions used, sample size and sampling methods, and methods of analysis. Thus, it was concluded that the most useful aggregate information was that from a recent survey on smoking behaviour in Austria, based on the results of the December 1997 Microcensus. This report, published in 2002, includes comparisons with comparable previous surveys and contains both a detailed description of the methods of data analysis and a comprehensive interpretation of the results. Where appropriate, these data were complemented with information from the latest Microcensus on health in 1999, although this included only one question on smoking status. In the case of Vienna it was possible to obtain access to the raw data from the Vienna Health and Social Survey, conducted in the winter months 1999/2000 and 2000/2001, and thus to undertake a more detailed analysis in which the relationships of various correlates with smoking could be explored using logistic regression.

6.2 Surveys on smoking

Most national surveys containing information on smoking in Austria have been performed by Statistics Austria. In particular, these are the *1997 Microcensus* with its special section on smoking habits (December 1997, hereafter abbreviated as smoking survey)[11], the *1986 Microcensus* with its special section on smoking habits and health (September 1986), and the *1991 and 1999 Microcensus* focussing on health, which included one question on smoking status (December 1991 and September 1999).[44] All surveys in the microcensus programme are conducted in form of oral interviews in private households and comprise sample sizes of about 60,000 persons aged 15/16 years and over *(Appendix J###)*.[a]

[a] The quarterly conducted microcensus surveys are established in law since 1967 (BGBl. Nr. 334/1967). The survey consists of a basic part with a set of consistent questions and a special part with varying topics from the areas of social or health statistics. However, while everyone is obliged to give information as to the basic part, the interviewees are free to answer the questions of the additional special part of the microcensus (e.g. microcensus on health, microcensus on smoking habits, microcensus on smoking and health).

Separately from these surveys, a small self-completed questionnaire survey was conducted by the Austrian Nicotine Institute and the associated Institute of Social Medicine of the University of Vienna on a sample of nearly 5,000 individuals at the end of the 1990s.[53] This survey was primarily done to assess the Austrian market for measures on smoking cessation.[b] This and the fact that this survey is less representative than the microcensus are the reason why this survey will only be considered regarding its findings about the smoker's willingness to reduce or stop smoking when discussing the attitudes towards smoking in Austria *(Section 6.3.5 and Appendix K)*.

For children and young people, data from the WHO Study on Health Behaviour in School-Aged Children (HBSC study[12 13 192]) are used.

On the regional level, there have, however, been a variety of other surveys conducted in individual cities or federal provinces. Vienna (being both a city and a federal province) in particular has been the setting for several surveys which address, among other subjects, smoking behaviour. The City of Vienna, for example, commissioned the *Vienna Health and Social Survey 2000/2001*. Some results, so far only partly analysed, have been published in a variety of reports.[46 49] It also commissioned and published the regional analysis of the *1999 Microcensus on Health in Vienna*.[48] Examples of other surveys initiated and financed by local governmental offices are the 1995 mega-survey on *Life in Vienna,* undertaken by the Institute for Empirical Social Research (IFES)[52], which was repeated in 2003, and the series of surveys from the *Vienna Study on Addictive Drugs*, last conducted also by IFES in 2001.[51] A more detailed description of the various surveys can be found in Appendix J###

The federal provinces that were traditionally more active in the area of health surveys and health promotion are Vienna, Upper Austria (in particular the capital Linz), Vorarlberg (Bregenz and Dornbirn) and Styria (Graz). Apart from Vienna, however, only Styria has data on smoking behaviour at a regional level, drawn from cross-sectional health surveys conducted between 1989 and 1993, which included 14 questions on smoking.[50] However they are not fully representative as they were conducted in 79 rural communities and thus exclude cities. All other regions must use data from the microcensus, disaggregated by provinces.

[b] For example, by referring to the result of a 'representative' Austrian survey by the two institutes *(Chapter 9)*, according to which the majority of smokers would like to reduce smoking rather than quit, Kunze and Groman state that they would rather prefer campaigns for those willing to reduce smoking than campaigns aiming to get people to stop smoking *(sic)*.[191] (In fact, there are no campaigns at all that are targeted at adults, whether suggesting to reduce or to stop smoking.) Being the national representatives for Austria in all international committees, Kunze and Groman also provided these data on smoking prevalence to international bodies.

There are, however, several relevant activities currently underway in some of these provinces. Upper Austria, for example, has been targeting smoking as a major health issue, with the declared target of reducing the number of young smokers to less than 95% of the present rate by 2004. A survey is currently (2003) being planned that will cover 8,000 children in Linz. In Vorarlberg, the Institute for Addiction Research (Dornbirn) is currently (2003) planning a survey addressing alcohol consumption and smoking among teenagers.

6.3 Data on smoking in Austria

In essence, therefore, there are two main sources of data on smoking in Austria: the microcensuses that have specific sections on smoking; and those that only ask a single question. However the figures differ and other sources, derived from other surveys or international studies (e.g. Eurobarometer, HBSC study) produce figures that are not identical with either of these. It should be noted, though, that figures for smoking prevalence derived from Eurobarometer in other countries are also suspect, producing rates that are often inconsistent with specific health surveys.[193]

This chapter is therefore based mainly on the results of the survey on smoking habits, last conducted in 1997 within the framework of the microcensus programme of *Statistics Austria*[11], supplemented where possible by the results of the latest 1999 microcensus on health[44 194]. For the discussion on smoking in Vienna, however, the 1999 microcensus had to be used. Both surveys are based on interviews of 60,000 individuals aged 16 years and over (1997 survey) or 15 years and over (1999 survey). However, in addition to the minor differences in the age coverage and the two years time span, the two surveys are not comparable. The 1997 survey was an explicit survey of smoking behaviour, using several questions and filters, whereas the 1999 survey was a general health survey, including only one question on cigarette smoking.[c] There is also reason to believe that the substantial differences in smoking rates between the two surveys might arise from important flaws in the statistical process of imputation[d] used in the 1999 survey.[195]

Consequently, the different results of the two types of surveys are not strictly comparable and allow no conclusions to be reached about developments over time. Comparisons are possible

[c] The questions contained in the two surveys are listed in Appendix J###

[d] To counteract the problems of non-response (total non-response or item non-response), *Statistics Austria* developed a method of imputing missing values. Using socio-demographic characteristics, the most resembling respondent is being determined and the missing values complemented accordingly.[195]

only within each type of survey, for instance comparisons between the 1991 and 1999 micro-census on health (although even these surveys are not really comparable because of different questions), or comparisons between the 1997 smoking survey and similar surveys in 1986, 1979 and 1972. Taking all these factors into account, an in-depth analysis on the most recent data is only possible on the basis of the 1997 smoking survey with its comprehensive and altogether more reliable data, which was therefore chosen as main source for this chapter.

Notwithstanding these limitations, it is possible to infer some broad trends over time, with different developments among men and women, and those of different ages and social groups, etc., while not attributing unjustifiable precision to the numbers of smokers, which can only be approximations.

Again, due to the limited space in this thesis, a more detailed analysis of smoking rates in Austria may be found in Appendix K###.

6.3.1 Smoking rates in Austria

According to the 1997 Microcensus on Smoking Behaviour, conducted by *Statistics Austria*, almost 30% of the Austrian population aged 16 years and over smoke, and nearly one quarter (24%) smoke on a daily basis. Roughly one quarter of the daily smokers are considered heavy smokers, smoking 20 or more cigarettes per day. Nevertheless, the number of ex-smokers is increasing and in 1997 represented 17% of the Austrian population, corresponding to a quit rate of 37%. More than half of all interviewees (53%) had never smoked (never-smokers) and 17% had given up smoking (ex-smokers), totalling 70% of non-smokers. The rate of non-smoking among females is even higher (77%).

As in other countries, Austrian men smoke more frequently than women; they are also more likely to be ex-smokers. In 1997, 36% of men and 23% of women smoked, the vast majority of them daily (men 30%, women 19%).

Of Austria's population, 17% of men and 4% of women are heavy smokers (more than 20 cigarettes per day), thus representing 29% of all men who smoke daily and 14% of all women who smoke daily. The majority of daily smokers (51% of men and 48% of women) smoke 11 to 20 cigarettes per day.

In 1997, the highest smoking rate was found among young male adults aged 20 to 24 years (48%). However, while for men, smoking becomes less common with age, the proportion of

female smokers rises until the age of 35 to 39 years (37%) before declining again. Very low smoking rates are found in older age groups, in both men and women. Of 60 to 64 year old men, only 19% smoke, and in the age group of 75 years and over the figure is even lower (11%). Of 60 to 64 year old women, 9% are smokers, but the rate hardly decreases in women aged 75 year and over.

As in other countries, smoking among adolescents is increasing in Austria, and a clear gender difference in trends in teenage smoking can be observed over the last decade. While tobacco consumption among boys has declined, daily smoking among 15 year-old girls has become more frequent. In an international comparison, Austrian teenagers (especially girls) rank very high with regard to both alcohol consumption and cigarette smoking. One in four girls and one in five boys aged 15 years smoke daily, placing Austrian teenagers in fifth position among all countries surveyed.

The average age of taking up smoking has changed dramatically over recent decades and a clear shift towards younger age groups can be observed, especially in women. In 1997, more than half of daily smokers had started smoking habitually before the age of 17. Above this young age smoking is rarely commenced.

Particularly for women, but also for men, smoking is more frequent in urban than in rural areas. Vienna, for example, has the highest proportion of heavy smokers. More than half of the Viennese population aged 15 years and over smoke at least occasionally; 44% smoke daily. While the figures must be interpreted with caution because of methodological limitations, among the female population an apparently dramatic increase of daily smokers by 45% between 1991 and 1999 is observed, while the increase for men was only 12.5%. In 1999, 48% of Viennese men and 40% of Viennese women were daily smokers. However, 'only' 10% of men and 5% of women are heavy smokers, indicating a marked decrease in heavy smokers since 1991 – especially in men, who show a reduction of 50%. There has also been an increase in daily smoking among teenagers and young adults, especially among females.

6.3.2 Socio-economic determinants

Socio-economic factors, such as education, employment status, income and job position, are known to affect lifestyle and behavioural patterns, such as alcohol consumption or smoking. [196] Education, for example, is not only an important determinant of achievement of social and professional status; it is also related to health awareness and the ability to adopt health conscious

behaviour. It therefore influences receptiveness to both tobacco advertising and health promotion activities. The usual indicator for assessing educational level is the highest school graduation level or academic degree achieved by an individual.

In developed countries it is now a common finding that members of higher social strata smoke less than those in lower social strata. In Austria, however, this assumption cannot wholly be confirmed as yet.[11] Although men with the highest educational level (university degree) indeed have the lowest smoking rates, due both to the high proportion of ex-smokers and never-smokers, and men with the lowest educational levels had the highest rates of smokers and an above-average proportion of ex-smokers, hardly any differences could be identified for the groups in between. Women showed a strong polarisation in the lower educational groups but no obvious differences could be found in university graduates.

I undertook a more detailed analysis (using logistic regression) of the Vienna Health and Social Survey looking at socio-economic determinants of smoking. Data were adjusted for the factors that appear to have the strongest influence: age, employment and education *(Chapter 2; 2.2.3)*. This analysis shows clearly that unemployment in particular plays a significant role in smoking behaviour, especially for men. Other influential variables are age (for both sexes) and education (for men). Results of this analysis are described in more detail in Appendix K.

6.3.3 Trends over time

A comparison of smoking rates in Austria over the last three decades reveals that the increase in smokers has not been steady; in addition, tobacco consumption patterns have developed differently for men and women. From the beginning of the 1970s until the mid-1980s, the proportion of smokers and ex-smokers rose steadily. Since the 1980s, however, the proportion of smokers has decreased slightly while the proportion of ex-smokers has increased markedly. Nevertheless, while smoking seems to be becoming less common among men, smoking rates among women have increased noticeably. Since 1986, however, the proportion of daily smokers has declined for both men and women, accompanied by a preference for lighter cigarettes.

Altogether, between 1972 and 1997, the male smoking rate decreased by 21% (from 45% to 36%), while the female smoking rate increased by 78% (from 13% to 23%). As with men, the proportion of women who had stopped smoking (ex-smokers) increased markedly over that period of time. Accordingly, since 1972, the proportion of never-smokers has been growing slightly but continuously among the male population, while falling significantly among the

female population. Nevertheless, the proportion of non-smokers is much higher among the female than the male population.

6.3.4 Smoking in Austria compared to other EU countries

In comparison with the rest of Europe, smoking rates among both men and women in Austria lay well above the European average in 1999. According to these figures, Austrian men rank fourth, Austrian women fifth among the 15 EU member states.

6.3.5 Attitudes towards smoking / smoking cessation

In 1997, 1.1 million ex-smokers were living in Austria. The general quit rate for Austrian men is reported to be 38%, for Austrian women 35%. There are, however, certain groups of the population who are more successful (i.e. display a higher quit rate) than others. For example, the tendency to stop smoking increases with age. For young women, pregnancy and childbirth represent the main reasons for giving up smoking. Education also plays a significant role. However, reflecting the success of the tobacco industry in promoting their vision of a "safer" cigarette, many people see switching to lighter cigarettes as an alternative to giving up smoking completely. Almost one in four of daily smokers have changed their preferred brand over the last five years, women more frequently than men.

6.3.6 Hazards from passive smoking

In 1997, one third of all employees reported that they were exposed to second-hand smoke at their work place, and more than one third of those affected felt harassed by the smoking of their colleagues, women more often than men and non-smokers more often than ex-smokers.

As noted, a detailed analysis of smoking patterns in Austria can be found in Appendix K###.

The next chapter will examine what is known about the impact of tobacco on health in Austria.

7 TOBACCO-RELATED DISEASE AND MORTALITY IN AUSTRIA

7.1 Introduction

While aggregate measures, such as life expectancy, can act as indicators of the general level of health of a country, the health impact of certain risk factors, such as tobacco or alcohol consumption, is more effectively assessed by looking at trends in those disease processes with which they are most closely linked. While it must be borne in mind that the relationship between smoking and disease, as with many lifestyle factors, is characterised by long time-lags between exposure and outcome (sometimes many decades), the causal relationship between smoking and certain diseases is well established, leading to a growing body of research on smoking attributable disease.[197] Peto and colleagues have estimated that 12% of all deaths in Austria (i.e. 116 of every 1,000 deaths or, in total, roughly 9,000 deaths per year) are tobacco related.[7]

As noted in Chapter 6, the increase in smoking prevalence among youths in Austria (particularly among girls) and young women is of growing concern. In addition, there is a clear lack of information and education on possible health hazards resulting from smoking and, in particular, the risks associated with passive smoking. This chapter provides an overview of the health of the Austrian population and, in particular, the burden of disease attributable to smoking, including the harmful effects of passive smoking. It is one of the cornerstones of the later recommendations on the necessity of effective and comprehensive tobacco control policies in Austria.

7.2 Risk factors and burden of smoking-related disease

There is no doubt that tobacco damages human health. Furthermore, tobacco, and in particular cigarette smoking, has been recognised as the single largest avoidable cause of premature death and the most important known carcinogen to humans.[2] It is estimated that 25% of all cancer deaths and 15% of all deaths in the European Union could be attributed to smoking.[17] Among smokers in industrialised countries, the average loss of life is 8 years. Those who die in middle age have lost 22 years of their life on average.[5 6]

The relationship between smoking and certain diseases is complicated by the long delay between the onset of smoking and the occurrence of disease and, on the population level, a long delay between an increase in smoking rates within a population and the full effect on that popu-

lation's death rates from tobacco-related diseases.[198] Due to the high number of people who started to smoke many years ago, tobacco has created a major public health disaster in many countries of the developed world over recent decades, and it is emerging as a global public health disaster over the next few decades.[5] In addition, risks to smokers increase greatly the longer they smoke. This becomes especially important in view of the tendency to start smoking at an ever younger age.[199]

Tobacco smoke can contain over different 40,000 chemicals, including hundreds that are toxic, radioactive or carcinogenic[200 201] and of course including the alkaloid nicotine, an addictive compound that is a constituent of all tobacco products.[202] The highly addictive nature of nicotine may lead to addiction even after just starting to smoke.[96 203 204] More than 40 constituents of tobacco smoke are known to cause cancer, particularly tar.[6] Therefore, the direct health effects of tobacco consumption are two-fold. One effect is nicotine addiction (experts conclude that nicotine is as addictive as hard drugs, such as heroin, and that smoking meets both the DSM-IV and ICD-10 criteria for substance dependence[6 130]), another effect is the development of chronic diseases.

In addition to lung cancer, the health effect most closely associated with smoking, prolonged smoking causes many other diseases. For instance, smokers experience increased risks of heart attacks, strokes, and chronic respiratory diseases. They also have a significantly higher risk of developing cancers, both of organs that are directly exposed to smoke – such as the oral cavity (mouth, lips, tongue, etc.), oropharynx, oesophagus, larynx, and lungs – and of organs and tissues that are not directly exposed – such as the pancreas, bladder, kidney, stomach, cervix, and haematopoietic tissues.[2 205 206] According to a meta-analysis by Meltzer[207] in 1994, the most frequent tobacco-related diseases are cardiovascular diseases (acute myocardial infarction, diseases of the cerebrovascular system, peripheral arterial obstructive disease), cancer (particularly of the lungs), and diseases of the respiratory organs (e.g. chronic bronchitis and COPD). Very recently, an IARC (International Agency for Research on Cancer) working group added additional sites to the list of smoking-related cancers, including cancers of the stomach, liver, uterine cervix, and kidney (renal cell carcinoma) and myeloid leukaemia. In addition, so the findings of this group, the risks of developing some cancer sites increases when combined with exposure to other known carcinogens.[199]

Due to the variety of components, including thousands of chemicals, among them known poisons and carcinogens, tobacco smoking has proved to be a cause of multisystem disease.[208] Some of the components of tobacco and tobacco smoke damage blood vessels, others cause

cancer, but in summary they can harm almost every part of the body.[6] Altogether, nearly 40 diseases have been found so far to be positively associated with cigarette smoking.[209] The "major killers" are known to be coronary heart disease ('heart attacks'), chronic obstructive pulmonary disease (COPD), lung cancer and other smoking-related cancers.[6] The principal diseases caused in part by smoking are listed in Box 5.1: [2 6 199 208-214]

Box 7.1 Diseases caused in part by smoking

Principal diseases

Cancers
lung, mouth, pharynx, larynx, oesophagus, pancreas, bladder

Cardiovascular diseases
ischaemic heart disease, hypertension, myocardial degeneration, pulmonary heart disease, other heart disease, aortic aneurysm, peripheral vascular (arterial obstructive) disease, arteriosclerosis, cerebral vascular disease (stroke)

Respiratory diseases
chronic bronchitis and emphysema (chronic obstructive pulmonary disease, COPD), pulmonary tuberculosis, asthma, pneumonia, other respiratory diseases

Other major diseases
peptic ulcer

but also

Cancers
lip, nose, stomach, kidney (pelvis and body), liver, uterine cervix, myeloid leukaemia

Other harmful effects
reduced growth of foetus, Crohn's disease, osteoporosis, periodontitis, tobacco amblyopia, age-related macular degeneration, reduced fertility

some evidence

increased risk of
cataracts, impotence, reduced production of sperm

small increase in risk of
cancer in children as a result of mutations produced in the father's gonads

no evidence as yet

unaffected cancer risks
breast cancer, endometrial cancer, prostate cancer

Doll contends that the discovery of so many diseases being related to smoking is one of the most remarkable medical research findings of the 20th century.[209] Evidence of the harmful effects of smoking has been accumulating for 200 years, since the end of the 18th century, but it was not until the late 1920s, the 1930s and early 1940s with the publication of studies in Germany[215-220] and Austria[221] (although these studies were not known or essentially ignored in an-

glophone countries)[117 222 a] and then the 1950s with the publication of a number of case-control studies in the United States[b] and Britain that the relationship between smoking and lung cancer began to gain credence.[209 223] Two large cohort studies followed, confirming the health hazards of smoking, particularly emphasizing the increased risk with duration of smoking. One was by Doll and Hill, on British doctors, which covered a 40-year period of observation[210 224-226], confirming the enormous health impacts of tobacco on population health, and showing that overall mortality was twice as high in smokers as in non-smokers, and three times as high in middle age.[209] The other was the second American Cancer Society Cancer Prevention Study (CPS-II) observing a cohort of over 1.2 million adults, with comparisons with CPS-I, initiated 20 years earlier.[211] Similarly, an association between smoking by pregnant women and infant mortality, stillbirth and miscarriage was already reported from Germany in the late 1930s[117] and, although initially weak, an association between maternal smoking and premature delivery and low infant birth weight was reported from the United Kingdom and the United States in the late 1950s.[209]

Richard Doll describes the additional risk of lung cancer for smokers as varying from about 30% to double.[227] A recent review of epidemiological data on cancer by the IARC provides

[a] Reports of the ill-effects of tobacco already exist from the times of the First World War (by the German military physician E. Beck), and a call to "all German Doctors" to combat smoking as both a cause of harm to the body and a financial drain on the German nation was published in 1921. In 1924, the Viennese gynaecologist, Robert Hofstätter, addressed the particular vulnerability of women who smoked and in 1938, Martin Stämmler argued that tobacco use by pregnant women was responsible for the growing incidence of stillbirth and miscarriage. The interference of smoking with male sexual performance was also reported as early as 1941. Various medical theses dealt with the health hazards of tobacco from as early as 1927.

The relationship between smoking and cancer of the mouth was already established in the 19th century but it was Isaac Adler in 1912 who for the first time hinted a link between smoking and lung cancer and the German physician Fritz Lickint (Chemnitz, Dresden) who for the first time published statistical evidence (case series) joining lung cancer and cigarettes in 1929 and subsequently published his monumental 1,100 page volume and standard work *Tabak und Organismus* (Tobacco and the organism) in 1939, linking smoking to cancers all along the *Rauchstrasse* ("smoke alley") lips, tongue, lining of the mouth, jaw, oesophagus, windpipe, and lungs, but blaming smoking also for arteriosclerosis, infant mortality, ulcers, halitosis, and dozens of other maladies.[220] He also compared tobacco addicts to morphine addicts and made a convincing argument that "passive smoking" (*Passivrauchen* – he seems to have coined the word) posed a serious threat to non-smokers.[117]

The Argentinean Angel H. Roffo, who published much of his work in German cancer journals, established a link between tars derived from tobacco smoke and cancer already in 1930, and Fritz Lickint stated by 1935 that benzpyrene was more likely as a carcinogenic potency than nicotine. Neumann Wender of Vienna showed in 1933 that tobacco smoke contained not only tar and nicotine but also methyl alcohol and other toxins. In the same year, Enrico Ferrari of Trieste related tar to lung cancer.[117] Rudolf Fleckseder of Vienna reported on the relationship of smoking and lung cancer in 1936. In 1939, a paper by Franz Hermann Müller of Cologne, which presents the world's first controlled epidemiological study of the tobacco-lung cancer relationship[215], and in 1943 a paper by Eberhard Schairer and Erich Schöniger[216] provide the most sophisticated proofs up to that time that smoking was the major cause of lung cancer.[117]

In March 1939, 15,000 people attended a German conference (Frankfurt) on the hazards of tobacco and alcohol consumption. In 1941, there was scientific consensus in Germany that tobacco was behind the explosive rise in lung cancer.[117]

[b] It is thus hardly believable that German born and US immigrant Ernst Wynder, who was in Germany towards the end of World War II as a US intelligence officer, did not know about these studies when later (after a 1950 publication in the JAMA, together with E.A. Graham, on a case control study) being praised as the "first" to relate lung cancer to smoking. *(See Appendix S### (Footnote … ###) and Appendix U###.)*

evidence that not only is the harm caused by smoking greater than previously thought – implicating tobacco in cancer sites not previously shown to be associated with smoking *(see above)* – but it also demonstrates that second-hand smoke causes an increased risk of cancer for non-smokers.[228] [229] It is now beyond dispute (although still contended by the tobacco industry) that there are major health risks from passive smoking – for the foetus, for children of smokers, for life partners of smokers, and for all those exposed to passive smoking at their workplace *(Section 7.2.5 and Appendix L###)*.

A Norwegian study [230] [231] examined the influence of smoking on the duration of chronic disease before death. The follow-up study, covering 23 years, demonstrates that smokers, on an average, tend to develop chronic diseases nine years, and to die five years before non-smokers; on an average, they are ill for four years longer than non-smokers before they die.

As a result of the close association between smoking and a variety of diseases, in populations where smoking has been common for many decades, tobacco use accounts for a considerable proportion of mortality, as illustrated by estimates of smoking-attributable deaths in industrialised countries.[197] Estimates by WHO and other sources suggest that about half of persistent smokers who started in early adult life (not counting those who started already in childhood or adolescence) and who do not give up smoking will eventually die as a result of their smoking.[c] In addition, about half of them will die prematurely in middle age, before age seventy, losing on an average 20-25 years of life.[5] [209] [232]

Smoking has long been a serious public health problem in many European countries, and as more young people, teenagers and children have been taking up smoking in recent years, this will produce a marked increase in tobacco deaths over the next half century.[5] Especially among girls and young women, deaths can be expected to increase further, which is particularly worrying as, according to the US Surgeon General's Report on women and smoking [206], women are even more vulnerable to the health hazards of smoking *(Section 7.2.6 and Appendix L###)*. In the developed world tobacco now accounts for about one-third of all male deaths in middle age.[8] For women, however, particularly in European countries, the epidemic has just begun, while in the United States tobacco-related mortality in middle age is already almost equal in men and women.[206]

[c] Although the main diseases developed by smoking are substantially different in various countries all over the world – for instance, America with a predominance of cardiovascular diseases, China with a predominance of chronic obstructive pulmonary disease, or India with increased risk of death from tuberculosis – the overall 50% risk of death from persistent smoking is estimated to be about the same in all populations.[5]

7.2.1 Risk assessment

According to the WHO's World Health Report 2002, which focuses on risks to health as a key to preventing disease and injury, *risk* is defined as a "probability of an adverse outcome, or a factor that raises this probability". Accordingly, *risk assessment* is defined as a "systematic approach to estimating the burden of disease and injury due to different risks".[2]

Diseases are very often not caused by one single risk factor, but by the joint action of two or more risk factors (multi-causality). In addition, the sum of the separate contributions of two or more risk factors can easily be more than 100% (e.g. smoking and alcohol consumption). It is essential that the whole of the causal chain is considered in the assessment of risks to health. But just as one outcome can be caused by many risk factors, one risk factor can also lead to many outcomes. Similarly, a whole set of interventions can be employed to achieve the same goal (e.g. control of blood pressure, cigarette smoking and cholesterol to reduce cardiovascular disease) while some interventions will reduce the burden associated with multiple risk factors and diseases (e.g. interventions against cigarette smoking to reduce cancers and cardiovascular disease). In general, risk reduction strategies are more likely to be effective if based on a combination of interventions rather than just one.[2]

To assess risk and burden of disease within a population, standardised comparisons and common outcome measures are used. One common metric, for example, combines loss of quality of life with loss of life years, measured in DALYs (disability-adjusted life years) whereby one DALY is equal to the loss of one healthy life year. According to the WHO, tobacco is the leading risk factor in industrialised countries, accounting for about 12% of the total disease and injury burden, followed by alcohol and high blood pressure (9–10% of DALYs) and cholesterol and body mass (overweight) with 6–7% DALYs.[2]

Mortality attributable to smoking

In its World Health Report 2002, the World Health Organization differentiates between attributable versus avoidable burden of disease. Attributable burden is the current burden due to past exposure, while avoidable burden denotes the proportion of future burden that could be avoided if current and future exposure levels were reduced. To date, risk assessments have typically been based only on attributable risk estimates. More policy-relevant, however, is the question of the likely future effects if the current exposure was partly removed. The difference between attributable and avoidable burden becomes especially important for exposures with a long time-lag between exposure and health outcome – as is the case with smoking.[2]

Attributable burden

About one third of all cancers can be attributed to smoking *(Box 7.1~~Box 7.1~~)*, as can a substantial amount of cardiovascular disease, as well as conditions such as peptic ulcer, low birth weight and sudden infant death. According to WHO estimates, approximately 90% of all lung diseases are tobacco-induced; for the development of several other diseases (e.g. cardiovascular diseases) the harmful components of smoking are seen to be at least partly responsible.[2]

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For certain diseases the contribution of smoking to mortality is estimated to be up to 90% (e.g. lung cancer or cancer of the oral cavity). In its latest World Health Report, the WHO estimates that about one quarter of all deaths due to myocardial infarction as well as a substantial portion of diseases such as chronic bronchitis, peripheral circulatory disturbances – to name but a few – can be attributed to tobacco smoking. Deaths due to tobacco consumption exceed deaths due to illegal drug consumption by far.

Yet, it is difficult to assess the precise impact of smoking on health as other factors, such as diet, air pollution, dust and occupational harmful exposure also contribute to many smoking-related diseases. For example, smoking combined with alcohol consumption greatly increases the risk of oral and oesophageal cancer.[233-236] Air pollution and dust exposure at work can have additive effects to smoking in the development of chronic bronchitis.[237] Female smokers taking oral contraceptives have a higher risk of thrombosis, heart attacks, stroke or cerebral haemorrhage. [6 238 239]

But not only is active smoking harmful to the health of the smoker. As described in more detail later, passive smoking is also very harmful for both children and adults, healthy people and those who suffer from chronic disease, smokers and non-smokers alike *(Section 7.2.5 and Appendix L###).*

Avoidable burden

To assess the risk of future disease burden that could be avoided if adult smokers stopped smoking and young people did not start smoking, Peto and colleagues have estimated the potential scale of tobacco-related deaths worldwide over the next two to five decades.[8 210] According to these projections, a high quitting rate over the next decade or two would halve global cigarette consumption per adult by the year 2020 and prevent about one third of tobacco deaths in 2020 and almost one half of tobacco deaths before 2050. If, on the other hand, the proportion of young adults who become smokers were to be halved by 2020, this would avoid hundreds of

millions of deaths from tobacco worldwide after 2050. It would, however, avoid very few of the millions of tobacco-related deaths in the first quarter of the century, and avoid only a relatively small proportion of the deaths from tobacco in the second quarter of the century. These calculations show that quitting by adult smokers (preferably before or at least in middle age) offers the only realistic way to prevent large numbers of tobacco deaths over the next half century, while helping large numbers of young people not to become smokers could avoid millions of tobacco deaths in the second half of the century.[5] Therefore, to achieve substantial changes in smoking behaviour, both strategies are needed: getting adult smokers to quit and preventing children, teenagers and young people from starting smoking.

The following section will examine smoking-related morbidity and smoking-attributable mortality in Austria.

7.2.2 Smoking-related mortality in Austria

In Austria, according to the most recent country-specific estimates of Peto and colleagues[7], roughly 9,000 individuals[d] die as a consequence of smoking every year, i.e. one in eight adult deaths. According to estimates of the Austrian Social Insurance Funds and the Institute of Social Medicine of the University of Vienna, 15 to 20 percent of the annual expenditure on health care in Austria may be accounted for by the treatment of diseases primarily due to smoking (such as cancer, cardiovascular diseases, chronic lung diseases). The yearly smoking-related healthcare costs to the social insurance funds are estimated to be €1.5 to 2 billion.[240] [241]

To overcome the lack of data on smoking in many countries, Peto and colleagues used lung cancer mortality rates to estimate smoking attributable mortality as a measure of population exposure to tobacco.[8] This approach estimates indirectly the mortality from tobacco in developed countries by assuming that the excess lung cancer rate of smokers compared to non-smokers in a population is the best indicator of cumulative population exposure to smoking hazards; so the absolute lung cancer rate in a particular population is used as an indicator of the proportion of deaths from various other diseases that can be attributed to smoking.[242] According to these estimates by Peto, Lopez *et al.* (last updated 2003[7]), the effects of smoking can particularly be seen in smoking-related deaths in middle age (35 to 69 years). In Austria, the mean years lost per death from smoking was 23 years in this age-group in 2000 (*Table 7.1~~Table 7.1~~*). The proportion of smoking-related deaths within all cancers was 41% for men and 13% for

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[d] Previous estimates by the WHO, as still cited by the Federation of Austrian Social Insurance Institutions and Austrian health politicians, report 12,000 to 14,000 individuals.

women *(Table 7.2~~Table 7.2~~)* and the number of smoking-attributed deaths amounted to 3,200 in middle-aged men and 700 in middle-aged women in 2000, representing 26% (male) or 12% (female), respectively, of all deaths in this age-group *(Table 7.2~~Table 7.2~~ and Figure 7.1~~Figure 7.1~~)*. Among all ages, smoking-attributable deaths in 2000 amounted to 6,300 among men and 2,600 among women, representing 18% (male) and 6% (female), respectively, of all deaths. The estimated share of mortality attributable to smoking is shown in Figure 7.1. The clear decrease in mortality in men and the marked increase in women is apparent.

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Table 7.1 Relative importance of deaths in middle age (35–69 years), Austria 2000

Age range (years)	Deaths attributed to smoking / total deaths (thousands)		Mean years lost per death from smoking
	Male	Female	
0–34	– / 1.4	– / 0.6	–
35–69	3.2 / 12	0.7 / 6.3	**23 years**
70+	3.2 / 22	1.8 / 35	8 years
All ages	6.3 / 35	2.6 / 42	15 years

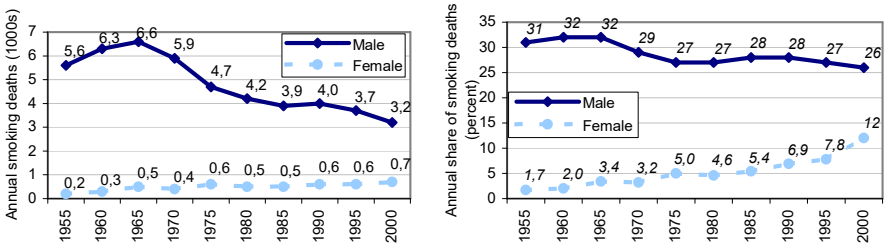
Source: *PETO, LOPEZ et al. 2003.*[7]

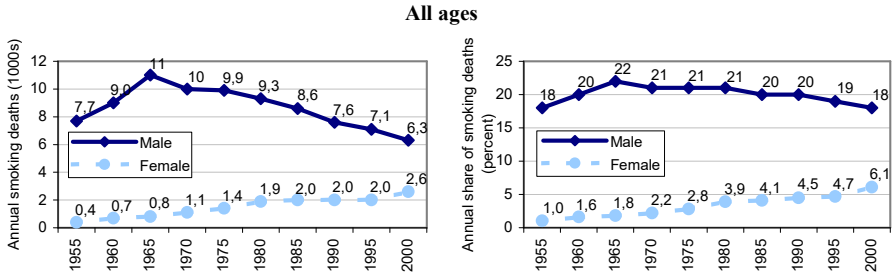
Table 7.2 Numbers of deaths attributed to smoking / total deaths (thousands), Austria 2000

Cause	Males (by age)			Females (by age)		
	0-34	35-69	70+	0-34	35-69	70+
Lung cancer	–/0.0	1.1/1.2	0.9/1.1	–/0.0	0.3/0.4	0.3/0.5
All cancer	–/0.1	1.7/4.1 *(41%)*	1.4/5.3 *(26%)*	–/0.1	0.4/3.0 *(13%)*	0.5/6.2 *(7%)*
Vascular	–/0.1	1.0/4.2	1.0/12	–/0.1	0.2/1.7	0.8/22
Respiratory	–/0.0	0.3/0.5	0.6/1.5	–/0.0	0.1/0.2	0.5/1.9
All other	–/1.2	0.3/3.4	0.2/2.8	–/0.5	0.1/1.4	0.1/4.5
All causes	–/1.4	3.2/12 *(26%)*	3.2/22 *(15%)*	–/0.6	0.7/6.3 *(12%)*	1.8/35 *(5%)*

Source: *PETO, LOPEZ et al. 2003.*[7]

Figure 7.1 Smoking-attributed deaths: thousands per year and percent of all deaths. Austria 1955–2000





Source: *PETO, LOPEZ et al. 2003.*[7]

Given the nature of the relationship between smoking and lung cancer, this cause of death seems to be the best marker for smoking-related mortality and will therefore be looked at more closely. Cardiovascular diseases, although less appropriate as a marker than lung cancer, as they are also attributable to other risk factors, also play an important role in the overall total of smoking-related diseases and deaths and are discussed in Appendix L*###)*.

7.2.3 Cancer (incidence and mortality) in Austria

About one third of all cancers can be attributed to smoking. Besides the lungs, the organs most affected by smoking are oral cavity, lips, pharynx, larynx, trachea, oesophagus, bladder, kidneys, pancreas and stomach.[2 199 205 209-212] Although all of these cancers have causes other than just smoking, cancer of the respiratory system including oral cavity (ICD-9 140-149, 160-165), oesophagus (ICD-9 150), stomach (ICD-9 151), pancreas (ICD-9 157) and urinary tract (ICD-9 188, 189) accounted for 51% (male) and 32% (female) of all cancers in Austria in 2001.[243]

However, lung cancer accounts for the greatest share of cancer directly related to smoking, although the proportion of male deaths resulting from cancer of the lips, oral cavity and throat (e.g. cancer of the tongue, etc.) should not be underestimated. In Austria, more than 3,000 people die of lung cancer every year, i.e. one in six (17.3%) of all cancer deaths or 4.3% of all deaths, respectively.

Lung cancer (including bronchi and trachea)

Malignant neoplasms of the trachea, bronchi and lungs (ICD-9 162) are the most common cancers attributable to smoking. According to WHO- and other estimates[2 8 209], approximately 90% of all lung diseases are tobacco-induced. The actual development of the disease is preceded by

many years of tobacco consumption. Thus the peak incidence is only reached at about 50 to 60 years of age.

The increased consumption of low-tar, "light" cigarettes (often related with an increase in the quantity of cigarettes and deeper inhaling of the smoke, called "compensation") is already being reflected in the types of lung carcinoma encountered: while earlier cancers tended to be central, cancer is increasingly likely to arise in the peripheries of the lungs.[a] [126]

Incidence and mortality

Over the last two decades, after a peak in incidence among men in 1993, a marked downward trend in lung cancer has been observed for men *(Figure 7.2~~Figure 7.2~~)*. Between 1993 and 1999, the latest year for which data were available, incidence fell by more than 20%. In women, on the contrary, there has been an increase in incidence of more than 17% between 1990 and 1999. This is consistent with the rising rate of female smoking since the early 1970s *(see below)*, a phenomenon that can be expected to lead to further increases over future decades.

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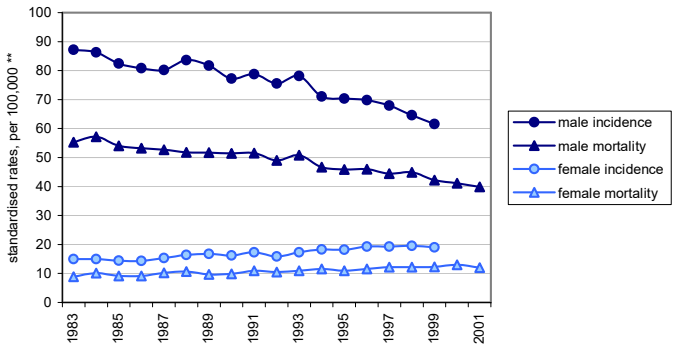
In 1999, 3,602 persons – 70% of them men – developed lung cancer. This corresponds to an age-standardised incidence rate of 61.6 per 100,000 for men compared to 19.0 per 100,000 for women.[243]

Figure 7.2 Lung cancer. Age-standardised incidence- and mortality rates by sex, Austria 1983–2001*



* Cancer incidence: latest available year under review 1999.

** Age-standardisation based on European standard population (World Health Statistics Annual 2001, online version).[43]

Source: Statistics Austria – cancer registry and mortality statistics.[243]

a According to Christian Vutuc (Vienna University Cancer Research Institute) a clear shift in the localisation of lung cancer is observable over the last decades. While in the 1970s, 11% of carcinomas were peripheral, in 1990, it was already 28%. Today, this figure amounts to 57%.[126]

Male mortality from lung cancer fell significantly over the last two decades; between 1983 and 2001 it dropped by –28%. Over the last decade, however, the decrease was especially marked (–22.5% between 1991 and 2001). Still, lung cancer constitutes the second most frequent type of cancer (after intestinal carcinoma) in Austrian men. In women, consistent with the increase in lung cancer incidence, lung cancer mortality is on the rise, increasing by 35% between 1983 and 1999. In 1999, 19.0 of 100,000 Austrian women (age-standardised) were diagnosed with lung cancer and 12.0 of 100,000 women died of this type of cancer *(Figure 7.3~~Figure 7.3~~)*.[243] While the risk of developing lung cancer remains disproportionately higher for men, the female to male ratio dropped from 1:4.9 to 1:3.2 over the past decade (1989 to 1999). This marked increase in female lung cancer can be interpreted as a consequence of the growing share of female smokers in the population. With regard to mortality, the female to male ratio dropped from 1:4.7 in 1991 to 1:3.3 in 2001.

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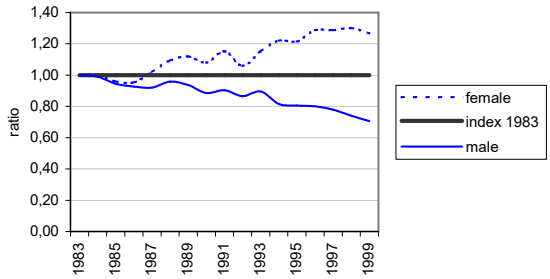
Figure 7.3 Lung cancer incidence, relative development by sex, Austria 1983–1999



Source: Statistics Austria – cancer registry[243]; own computations. Standard population: World Health Statistics Annual 2001, online version[43].

In conclusion, one can say that the incidence rate as well as the mortality rate is more than three times as high in men as in women and, although still very high, male mortality rates are decreasing while female rates are rising slightly.

Age-specific lung cancer mortality

Standardised death rates for lung cancer were calculated by direct standardisation for every year from 1970 to 2001 and for age groups in five-year bands. The reference population was the European standard population *(Chapter 2; 2.2.3)*.[244]

In total, and disregarding minor fluctuations, the trends in age-specific lung cancer mortality confirm what has been already reported in the general analysis. While for men mortality rates

are clearly decreasing, particularly in the age groups 60 years and over, women show a slow but continuous increase in mortality rates in all age groups. A noteable increase in female lung cancer mortality can be observed between 1995 and 2001 for the ages 50 to 59 years. This seems to reflect a cohort effect among those born between 1940 and 1950, who as young adults experienced the economic recovery in the late 1950s and 1960s and the women's liberation movements in the late 1960s and 1970s *(see below)*.

Although there are still clear differences in lung cancer mortality between men and women, this reversal of trends has led to an increasing equalisation of age-specific mortality rates between the sexes *(Figure 7.4~~Figure 7.4~~)*.

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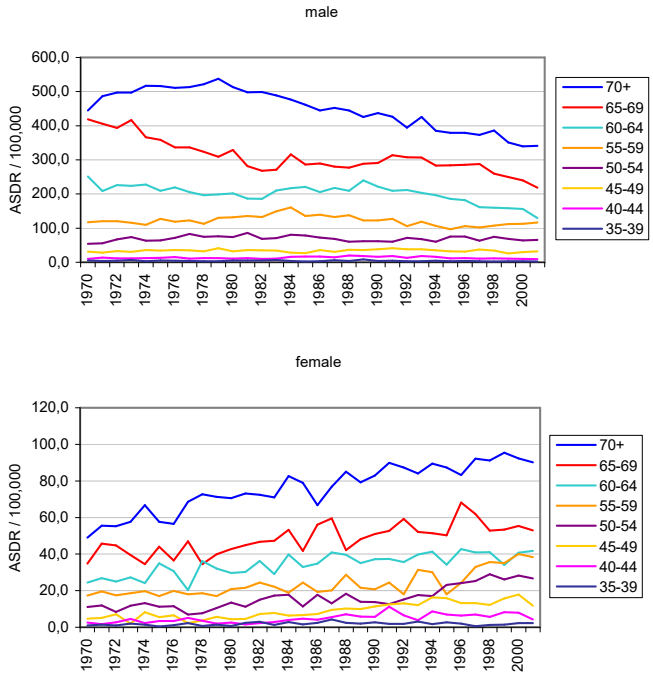
Figure 7.4 Age specific lung cancer mortality in Austria 1970-2001, by sex (N.B. different scales)

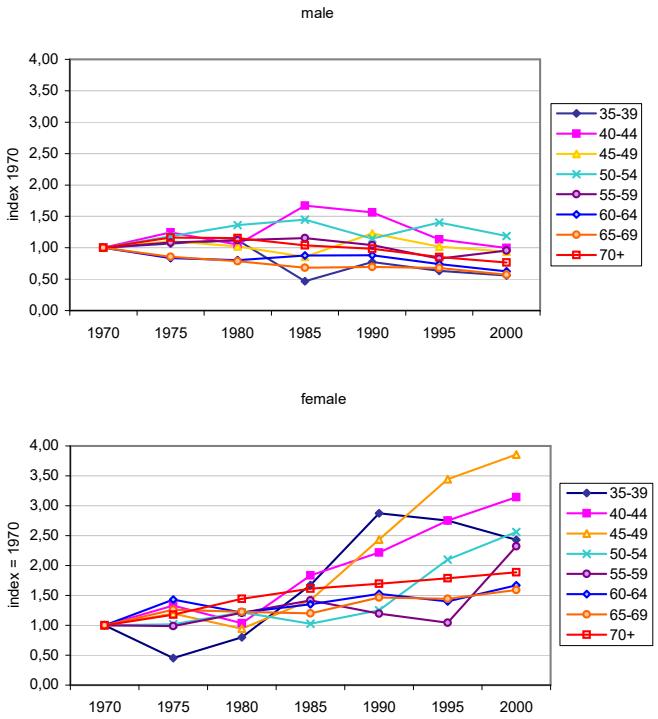


Source: Statistics Austria – mortality statistics (crude data)[245]; own computations. Standard population: World Health Statistics Annual 2001, online version[43].

Figure 7.5, which shows the relative mortality over the last three decades, illustrates this development even better.[b]

[b] To maintain the five-year gaps, 2000 was chosen as last year of reference.

Figure 7.5 Relative lung cancer mortality by age groups (5 year bands) in Austria, 1970–2000, by sex

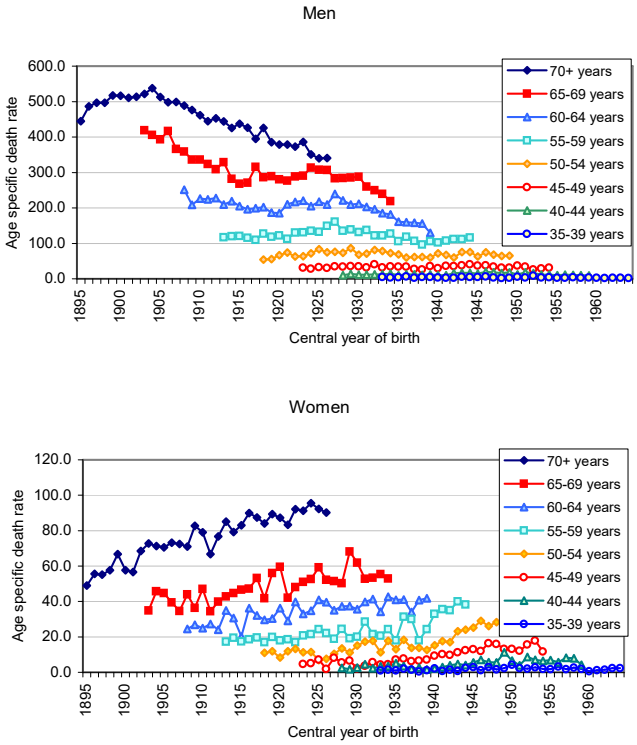


Source: Statistics Austria – mortality statistics (crude data)[245]*; own computations. Standard population: World Health Statistics Annual 2001, online version*[43]*.*

Cohort analysis

A cohort analysis of lung cancer mortality makes these findings even clearer. The analysis is based on yearly standardised death rates[245] for age groups in five-year bands, starting at age 35 and covering the period 1970 to 2000 (year of death). In a second step, the central year of birth was calculated for every age group and for every year of death. For example, those who died in 1970 aged 35 to 39 years were born between 1931 and 1935; the central year of birth for this cohort was assumed to be 1933. Accordingly, those who died in 1971 (the same age group) were born between 1932 and 1936 and the central year of birth was calculated to be 1934. Figure 7.6~~Figure 7.6~~ below will illustrate more clearly the procedures and the associations revealed between birth cohorts and lung cancer mortality.

Figure 7.6 Lung cancer mortality by birth cohorts and age groups in Austria, 1970–2000, by sex (N.B. different scales) *



* As the female rates are markedly lower than the male, different scales were chosen. A direct comparison of the two graphs is therefore not possible.

Source: Statistics Austria (crude data)[245]; own computations.

Cohort effects are the manifestation of influences acting on individuals at different stages in their life. For social, cultural and economic reasons, smoking was generally initiated at a later age at the beginning of the 20th century than at the end.[11] There are, of course, also gender-specific differences. While the main increase in cigarette smoking among young men took place during the first half of the 20th century, women increasingly started to smoke during the second half of the century.[5] In Austria, however, this increase in female smoking was even longer delayed than, for example, in the United Kingdom or the United States.[11]

Within the male population, a noticeable peak in lung cancer mortality is visible in those born between 1899 and 1905. This is the cohort that experienced the First World War (1914–1918) as adolescents or young adults. Contemporary accounts describe how, during war times, ciga-

rettes have been distributed freely to soldiers by many governments.[117] World War I occurred soon after mass production of cigarettes had begun and is particularly well-known for the widespread distribution and popularisation of cigarettes; smoking among young men in industrial countries began to increase dramatically.[246] With nicotine serving as a psychotropic agent, cigarettes had a relaxing effect, repressing fatigue, weariness, feelings of hunger, and helping establish contacts. Almost all soldiers smoked. During World War II, the consumption of cigarettes quadrupled worldwide.[246 247] It may, therefore, be assumed that for many young men the foundation of a prolonged smoking career was laid then. Similarly, although to a lesser degree than with Word War I, the effects of the Second World War on male lung cancer mortality are visible in this cohort analysis *(Figure 7.6~~Figure 7.6~~)*. In addition, with a time lag following developments in the United States, the active marketing of cigarettes after World War II showed marked results in tobacco consumption in the beginning of the second half of the twentieth century.[246 248] *(Appendices C and R ###).*

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Compared to previous birth cohorts, a clear decrease in age-specific mortality rates can be seen in those men born at the beginning or in the middle of the 1930s. As with those who experienced the depression between 1930 and 1935 as young adults, the vulnerable period for this cohort fell in the post-war period when tobacco products were simply not affordable for most young people, leading to an imposed abstinence from tobacco *(Appendix R###)*.[45] At later ages there was less interest in starting smoking. However this decrease in lung cancer mortality applies only to the age groups from 50 years onwards. The earlier experience of lung cancer mortality in this cohort does not follow any consistent pattern, in part it even shows an increase. It is possible that, with these early deaths, other reasons than smoking might be decisive – as for instance, environmental factors such as asbestos at the workplace[c].[126]

For women, apart from the general trend of a slow but continuous increase in lung cancer mortality and a noticeable peak in lung cancer mortality in the birth cohort from 1925 to 1930, a particularly pronounced increase can be observed in those born between 1940 and 1945. (In men, this trend is also seen, but to a lesser degree.) The main reason for the increasing uptake of smoking among women was the new marketing strategy adopted by the tobacco industry, emphasising modern, independent women, and the manufacture of brands specifically targeted towards females. Although increasing cigarette consumption cannot be linked precisely with

[c] Although, according to documents of the tobacco industry from the 1970s, studies from the United States could show that 97% of the asbestos workers who died of lung cancer were smokers (RJR 500872076, memo by E. Brueckner of the German Verband[120]) – thus allowing the industry to point "safely" at the risks of occupational diseases.

trends in economic development (level of industrialisation or per capita income)[246], these birth cohorts also enjoyed the period of economic recovery that started at the end of the 1950s. At least it made it more affordable to respond to cigarette advertisements, particularly for the young. The clear increase in age-specific mortality rates continued in females born between 1945 and 1950. This cohort might have been influenced by the feminist movement of the late 1960s and 1970s. As with men, early lung cancer mortality among women follows only partly the trend seen at older ages, with a possible added factor being the relatively low numbers.

The increase in mortality in this birth cohort (1945 to 1950), although also in the younger age groups, can also be observed in a cohort analysis in west Germany.[249]

Lung cancer in a European comparison

While in other countries, such as the United Kingdom, Denmark, or Spain, a rather spectacular decrease in lung cancer mortality has been identifiable since the mid 1980s, the development in Austria is rather continuous and no evidence of a consistent decrease is as yet visible for both sexes combined. Until the early 1980s, the Austrian values were somewhat below the European average *(Figure 7.7~~Figure 7.7~~)*.[250]

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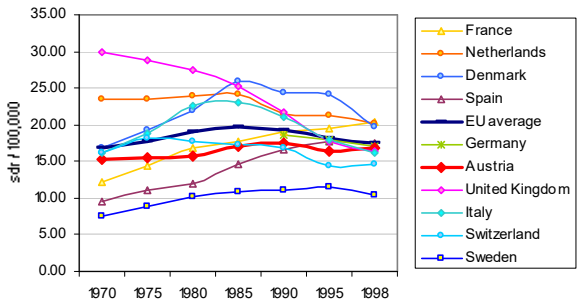
Figure 7.7 Development of lung cancer mortality in selected European countries* and EU average, ages 0-64 years, 1970–1998, standardised rates**



* Including the western neighbour country Switzerland.

** Unequal intervals, as due to incomplete availability of data 1998 was selected as year of reference (Switzerland: 1997).

Source: WHO – Health for All database, last update January 2002.[250]

In a ranking of all EU member states plus Switzerland and Norway, Austria still lies below European average in 1998 *(Figure 7.8~~Figure 7.8~~)*.[250]

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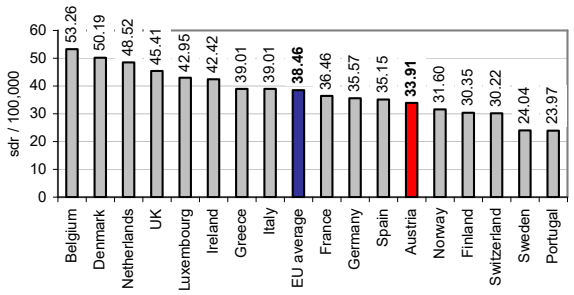
Figure 7.8 Trachea, bronchi and lung cancer mortality in Europe* 1998, all ages, standardised rates



* EU member states plus Switzerland and Norway.

Source: WHO – Health for All database, last update January 2002.[250]

7.2.4 Other smoking-related diseases

Other smoking-related diseases include cancer of the upper respiratory tract (oral cavity, lips, pharynx, larynx) and oesophagus *(Appendix L###)*, but also asthma, bronchitis, respiratory infections, and chronic obstructive pulmonary disease (COPD).[2 130 206 209 212] In most industrialised countries COPD is one of the three major killers in adult life.[6] In Austria, about 400,000 persons are estimated to suffer from COPD, representing 5% of the whole population or more than 10% of over 40 year olds, although this is likely to be an underestimate. 90% of sufferers are reported to be smokers, most aged 40 years and over.[251] According to the European White Book the risk of COPD in smokers compared to non-smokers is sixfold higher. For Austria, though, there are no relevant studies.[252]

There is a lack of representative statistics on the incidence of other smoking-related diseases, in particular as related to the individual's smoking behaviour, so no data for Austria can be given here. The 1999 microcensus on health asks about difficulties in breathing and 3.8 per 1,000 men and 4.0 per 1,000 women stated they suffered from one of these ailments.[253]

International comparisons of overall mortality data from bronchitis, emphysema, and asthma are problematic, in particular because of different national coding traditions for deaths at old age where multiple processes are present.

7.2.5 Diseases related to passive smoking

Although important for the discussion of smoking bans in public places, due to limited space, discussion of diseases related to passive smoking has had to be shifted to the Appendices. In

this context, therefore, only an overview in the form of Box 7.2 can be given. For a more detailed description please refer to Appendix L###.

Box 7.2 Health effects associated with exposure to environmental tobacco smoke (ETS)[254]

Effects causally associated with ETS exposure

Developmental effects
- Foetal growth: low birth-weight or small for gestational age
- Sudden infant death syndrome (SIDS)

Respiratory effects
- Acute lower respiratory tract infections in children (e.g. bronchitis and pneumonia)
- Asthma induction and exacerbation in children
- Chronic respiratory symptoms in children
- Eye and nasal irritation in adults
- Middle ear infections in children

Carcinogenic effects
- Lung cancer
- Nasal sinus cancer

Cardiovascular effects
- Heart disease mortality
- Acute and chronic coronary heart disease morbidity

Effects with suggestive evidence of a causal association with ETS exposure

Developmental effects
- Spontaneous abortion
- Adverse impact on cognition and behaviour

Respiratory effects
- Exacerbation of cystic fibrosis
- Decreased pulmonary function

Carcinogenic effects
- Cervical cancer

In Austria it is estimated that every year about 13,500 people die as a consequence of the smoking of others.[255]

7.2.6 Women and smoking

Women not only feel more disturbed and harassed by the smoking of others *(Chapter 6; Appendix K###*), they are also more vulnerable to health hazards from both active and passive smoking. In addition, the issue of female smoking is becoming ever more important in view of the increasing smoking prevalence rates among girls and women in nearly all countries in both the developed and less developed world. Women are also actively targeted by the tobacco industry's marketing strategies, associating social desirability and independence and featuring slim, attractive, athletic models in their advertisements.[4 206] A study of young female adoles-

cents indicates that the importance placed on being slim predicts future smoking initiation.[256] Tobacco companies have also produced brands specifically designed for women.

The issue of ETS becomes particularly important in view of the fact that, although the majority of women are non-smokers, many non-smoking women have a smoking partner, resulting in a life-long exposure to ETS in their homes. The increased incidence of lung cancer in wives of heavy smokers was already reported two decades ago[257 258], and more recently particularly by Fontham and others[259], Jarvis and others[260], and the review by Hackshaw[261]. According to the epidemiological studies reviewed, women who are lifelong non-smokers have a statistically significant excess risk of developing lung cancer (24%, CI 95%) if exposed to ETS by their spouse, increasing with the number of cigarettes smoked and duration of marriage.[261] If these women, who are already exposed to passive smoke in their homes, are additionally exposed to ETS in their workplace, their risk increases even further. According to the Fontham study, women who do not smoke and who have never smoked face a 30% greater risk of developing lung cancer if their husbands smoke in the home, a 39% greater risk of lung cancer if they are exposed to second-hand smoke in the workplace, and a 50% greater chance of lung cancer if they are in social settings.[259]

For more studies on women and smoking please see Appendix L###.

7.2.7 Smoking cessation

No matter at what age one stops, smoking cessation decreases health risks.[262] Some excess risks due to smoking are significantly reduced within a very short time *(please see Appendix L###)*.

7.3 Conclusion

In Austria, currently 11.6% of all deaths are attributed to smoking. For Austrian men, however, this rate is markedly higher than for Austrian women. For 18% of all male deaths and 6.2% of female deaths the cause of death is related to their prolonged previous smoking.[7] As in many other western European countries, smoking-attributable death-rates are decreasing significantly in Austrian men and increasing markedly in Austrian women.

About half of the persistent smokers (those who start young and do not give up) will die as a result of their smoking and half of them (i.e. a quarter of all smokers) will die in their middle age, losing on average about 20-25 years of life.[5]

The predominant diseases attributable to prolonged smoking are lung cancer and cardiovascular diseases, in particular increased risk of heart attacks and strokes. In general, smokers have a greater risk of developing cancers, both of organs that are directly connected to smoking – such as oral cavity, pharynx, larynx, oesophagus, and of course lungs – and of organs and tissues that are not directly connected to smoking – such as the pancreas, urinary track, kidney, stomach, and haematopoietic tissues. In addition, women experience specific risks related to reproductive health. In pregnancy, smoking increases the risk of adverse birth outcomes.[2 206]

A cohort analysis of lung cancer mortality of Austrian men and women shows the impact of events, in particular both world wars for men and the feminist movement for women, on smoking behaviour.

Smoking not only harms consumers, but also people exposed to their smoke. Over the last 20 years or so epidemiological evidence as to the harmful effects of environmental tobacco smoke (ETS) to non-smokers has accumulated and exposure to ETS has been linked to a variety of adverse health outcomes. ETS is harmful to all who are exposed to it, but especially harmful to children, people with respiratory and heart problems, and pregnant women. It also has significant effects on hospitality employees who are exposed to ETS continuously and for many hours every day.

Giving up smoking would reduce the excess risk of many diseases relatively quickly, and the promotion of cessation would benefit not only the health of the ex-smoking individual and all non-smoking individuals, including children, around him, but also significantly reduce the enormous excess health care costs for smokers.

Despite all these findings and more active approaches in other European countries, in Austria public awareness is still very low to non-existent, and legislation on smoke-free environments is still rather weak. However, in view of the serious health consequences and the high prevalence of cigarette smoking in the population, the enormous negative impact on public health should be sufficient to justify measures to restrict smoking in all public places and workplaces, and to discourage people from smoking in their homes.[261 263] In the words of Hackshaw: “Passive smoking is an avoidable cause of mortality and morbidity. Prevention strategies to reduce the amount of cigarette smoking in public places should be part of public health policy”.[261]

The following chapter will examine the measures taken by the Austrian government to restrict smoking in public places and reduce smoking rates in the population.

8 ANTI-SMOKING MEASURES IN AUSTRIA – A CRITICAL ANALYSIS

8.1 Introduction

Chapters 3, 4 and 5 have explored the various frameworks that can be used to understand tobacco policy, the forces driving that policy, and assessed the overall effectiveness of tobacco control measures. This chapter expands on these findings and attempts to apply these frameworks to the situation in Austria. It focuses on the current status of its tobacco control policy, provides an overview of initiatives taken over the last two decades, and assesses its overall approach to tobacco control.

Among western European countries, Austria has been found to be the "smoker-friendliest" country[264], priding itself on its "tradition of tolerance" (i.e. at least in the matter of tobacco and alcohol). A recent study conducted in EU countries, plus Poland, distinguished Austria as having the least developed anti-smoking climate, with Germany almost equally bad. In contrast, Poland showed the most developed anti-smoking climate, closely followed by Sweden.[1]

Austria's legal situation is characterised by weak laws with little provision for enforcement and virtually no sanctions. It is not surprising that adherence is poor. Therapeutic support for those willing to quit is still very limited and often handled unprofessionally. A lack of information or educational measures is reflected in the poorly developed public awareness about smoking in public places and the smoking-related health hazards to both smokers and non-smokers. The issue of environmental tobacco smoke in the workplace, including restaurants, pubs and bars, is not yet on the political agenda or subject to public discussion. Although Austria's EU entry in 1995 led to regulations on smoking in the workplace, this law is rather weak and noncommittal, even after two recent amendments designed to strengthen it. The issue of smoking in restaurants, pubs and bars has been cautiously tackled by a small part of the diminutive Austrian public health community over recent years but has not penetrated the political agenda, nor has it attracted media interest. The public is therefore mostly unaware of any concern. Equally, the issue of reduction of the toll of premature death from smoking-related disease is not a key element of Austrian health policy.

Although the government is not inactive in its efforts to tackle smoking, almost all of the few measures taken are those which have been shown to be not at all or hardly effective, or even

counter-effective. In addition, those feeling harassed by the smoking of others and favouring restrictions on smoking consider themselves as a minority and are not organised. Generally, non-smokers in Austria have been very reluctant to express or assert their rights, often not even knowing that they have rights. Although the employees' protection act regulates smoking in the workplace, the approach of 'voluntary agreement' between employers and employees is predominant and complaints are rarely, if ever, brought to court as this would often be tantamount to losing one's job.

Using the ESTC framework, outlined in Chapter 5, this chapter examines tobacco control measures in Austria with regard to legislation, taxation and pricing, advertising, education, campaigning and support offered for those who want to quit smoking. Smuggling and youth access are also addressed. Present and past measures and policies are described, asking why some measures have been adopted and others not. Since Austria has become a member of the European Union in 1995, its tobacco control policy must be seen within the wider European political and legislative framework. However, while other countries are already far ahead of the requirements stipulated in the European Commission's recent directives on tobacco control *(Chapter 4)*, for Austria these minimum requirements may be seen as a chance to stimulate and accelerate measures that otherwise would not have been set.

8.2 Concept and rationale of Austrian tobacco control policies

8.2.1 Implementation of EU legislation

Austria is in conformity with EU legislation but does not go beyond it. Considering that, for example, the advertising and sponsorship directive 2003/33/EC sets only the minimum standard that the European countries could agree upon, it is noteworthy that even these minimum requirements are met only very reluctantly and 'at the last minute', and are widely seen as "too extreme". In August 2003, the European Commission sent "reasoned opinions" to the governments of Austria, Italy and Luxembourg over their failure to implement the tobacco products directive 2001/37/EC.[265] They should have done so by 30 September 2002 at the latest. Only as late as September 2003, after this rebuke from Brussels[266] and the threat of taking the Austrian government to the European Court of Justice, were larger warning labels placed on cigarette packs and terms such as "light" or "mild" excluded, one year later than they should have been. The reason for this delay, so the Health Ministry reports, was the premature termination of the Federal Government following elections in 2002. Given the federal legislative system in Aus-

tria, this excuse has been accepted by the European Commission.[267] *Austria Tabak*, on the other hand, had claimed the reason lay with the paper industry and the prolonged time required for conversion.[268] In reality, it seems more likely that this delay can be ascribed to a lack of political will to implement any restrictions on tobacco. This is also evident in the latest amendments of the already weak 1995 tobacco law. The 2001 amendment (BGBl. I Nr. 98/2001) only concerned the substitution of Euro for Schillings of fines for violations of advertising restrictions[30] (which now, because of the regulation that all fines established in Austrian legislation had to be rounded down, are even less than in 1995[a]). In any case, these fines certainly do not pose a threat to the tobacco industry and, as no-one takes responsibility to enforce this regulation, it is a purely theoretical matter. The latest amendment in 2003 (BGBl. I Nr. 74/2003), took EU law formally into national law, but adopting only the absolute minimum requirements.

Austria may therefore be described as one of those member states with a very weak stand on tobacco control. It does not even "hide behind the European position"[27], but complacently distances itself from this "extreme" position *(Chapter 9)*.

8.2.2 Tobacco control plans

Effective national tobacco control programmes are multisectoral and comprehensive, linked to specific targets and implemented by a designated body. The Warsaw declaration and the resulting ESTC resolution urged the WHO's Member States to draw up national action plans on tobacco.[61]

The current implementation status of tobacco control policies in the various WHO member states differs widely. In 2001, approximately half of WHO's European Member States had national action plans and three quarters had intersectoral coordinating bodies, but only half had both. Austria had neither a national tobacco control action plan, nor specific targets on tobacco, nor a national coordinating body for tobacco control. At the end of 2001, Austria, Belgium, Germany and Greece were the only countries in the EU region without a tobacco control plan.[b] The status in Austria in 2003, compared with the most recent overview of Europe as a whole (2001)[132 269] is shown in the following table.

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[a] The correct amount after conversion would have been €7,267 instead of €7,000, and €14,535 instead of 14,000.

[b] For comparison (although limitations of these statistics have to be borne in mind), Armenia, Azerbaijan, Bosnia and Herzegovina, Denmark, Finland, France, Georgia, Iceland, Ireland, Lithuania, the Netherlands, Norway, Poland, Portugal, the Russian Federation, Slovakia, Slovenia, Spain, Sweden, the former Yugoslav Republic of Macedonia, Turkey, and the United Kingdom had all three of them, and many other countries had at least two of these important elements of a comprehensive tobacco control policy.[61]

Table 8.1 Implementation of a comprehensive tobacco control policy, status at end of 2003

WHO EUROPEAN MEMBER STATES: 2001	AUSTRIA: 2003
Only half of all European member states had drawn up national action plans.	Austria has been far from having a tobacco plan as yet.
Only half of all countries had introduced partial restrictions or total bans on both direct and indirect forms of advertising of tobacco products.	Austria has had only partial restrictions on advertising in cinemas (in films aimed at youth) and a complete advertising ban in television and domestic print media.
Only one third of all countries had sustainable and gender-based public information campaigns.	Austria has been focusing exclusively on teenagers over the last couple of years, by launching or supporting some (mostly ineffective) youth-oriented anti-smoking campaigns.
Under one quarter had earmarked tobacco taxes.	Tobacco taxes in Austria are not earmarked; however, in 2002 a small proportion of the tobacco tax revenues were dedicated to the Federation of Austrian Social Insurance Institutions (uncommitted, however, but aimed to minimise the overall deficit). In September 2003, the use of part of this amount for a more comprehensive voluntary screening test programme was under discussion, but ceased again. In addition, a certain percentage of the income purchase taxes of tobacco products are used to finance the Fund for a Healthy Austria, a government funded institution for national health promotion activities. However, only a very small part of this money is used for anti-smoking activities; in particular, this relates to only one small youth campaign in 2002.
Under one quarter had restricted access to tobacco products for people under 18 years, at the same time also eliminating all major impersonal modes of sale.	By law, smoking is prohibited until age 16. The age limit for the purchase of tobacco products differs in the nine provinces, but is not less than 16. However, with a view to cigarette vending machines, the latter may not be seen as a relevant measure to control tobacco consumption. There are no sanctions whatsoever for the consumption, purchase, or sale of tobacco products of/to minors.
Almost no countries reimbursed the cost of treatment of tobacco dependence.	Apart from the rehabilitation centre *Josefhof*, where heavily dependent smokers with a serious smoking-related disease are treated (initially free of cost, now, as with other cures, requesting a small contribution), cessation is neither particularly encouraged nor reimbursed. The few (and often unprofessional) counselling centres offer free advice but treatment has to be paid for by the patient.
Almost no countries published comprehensive national reports on tobacco control.	So far, there is no national report on tobacco control in Austria.
Almost no countries had introduced health warnings and requirements for tar and nicotine at the levels recommended by the Third Action Plan of the ESTC.	Health warnings did not meet the requirements of the EU until September 2003. Tar and nicotine levels, however, are in accordance to EU standards.

Source: Left-hand column: WHO – European Strategy for Tobacco Control[132]; right-hand column: respective measures implemented in Austria.

As in almost all countries of the European WHO Region, Austria has established school-based educational programmes, while coordinated, sustainable and gender-based public information and education programmes, strategies or campaigns to promote tobacco control on a population basis are still lacking *(see later)*.[61]

8.2.3 Approaches to tobacco control policy and guiding principles

According to the tobacco control strategies developed by the WHO, the policies adopted by European countries can be grouped "on the basis of their comprehensiveness and multisectorality, their sustainability and progressiveness, the duration and history of implementation, and their outcomes in terms of affecting smoking prevalence and exposure to tobacco smoke".[132] Three basic approaches have been identified:

1) an approach that generally has a weak impact on reducing tobacco use and exposure to environmental tobacco smoke;
2) a transitional approach;
3) an approach that generally has a strong impact on reducing tobacco use and exposure to environmental tobacco smoke.

While, for example, countries such as Norway, Finland and Sweden are already in the third category, the modest achievements in Austria clearly fit in the first category, characterised as follows:

> "Such an approach in general fails to reduce tobacco use. Smoking remains prevalent in all male social classes and continues to grow among young people and women, despite the fact that the majority of adults do not smoke and increasingly favour tobacco control. It is therefore a lack of political will, rather than a lack of public support, that prevents the implementation of a more successful approach."[132]

For countries in such a position, the WHO identifies as a high-priority challenge "to put tobacco control on the political agenda as a key public health issue".[132]

The next stage, the transitional approach, mainly relies on the impact of legislation and information, and attempts to alter society's perception of smoking ('de-glamorising' smoking and increasing people's knowledge). Finally, stage three, is characterised by a set of comprehensive measures and multisectoral strategies.[132]

In conclusion, the ESTC makes the following three points: i) it is the responsibility of governments to make the health of citizens and the protection of human life a priority; ii) it should be acknowledged that non-smoking is the norm and all citizens have the right to smoke-free air

and protection from the damaging effects of environmental tobacco smoke; and iii) it is necessary to decrease daily smoking prevalence, year by year and for every segment of society.[132]

8.2.4 Goals and objectives

As noted above, Austria, Belgium, Germany and Greece are the only European countries of the western hemisphere where no national tobacco action plan exists; nor do these governments have specific goals on tobacco control (except Germany).[61] [c] Yet in all WHO European member states there are interventions to protect non-smokers – although to varying degrees.[40] [269] [270] It must be noted, however, that the information provided to the WHO is very often restricted to a Yes or No answer, allowing only very cursory interpretation and, at least in the case of Austria, some responses are not correct. It may be assumed, therefore, that the results of these tables are not always reliable. This deficiency in data quality becomes evident, for example, in the responses regarding interventions to support smoking cessation[61] where Austria is supposed to have help lines, cessation clinics, and training of health professionals and medical students. In reality, help lines are information lines, which may not even function; there was only one cessation clinic for heavy nicotine addicts who already suffer from smoking related disease, although there are now a few similar clinics, run by social insurance companies; in some provinces smoking cessation courses have been offered recently; training of health professionals consists more or less of a voluntary visit by medical students to the Nicotine Institute where they are shown around; otherwise attendance at educational courses depends on the individual doctor's commitment. Austria's National Awareness Day on 1 January (probably not the best date) and the National Cessation Day on 7 November are largely unknown by the population and pass more or less unnoticed, with virtually no media coverage and accompanied by no campaigns or events[d].

So far, Norway and Ireland are the only countries in western Europe that have banned smoking from restaurants, pubs and bars. In Austria, the only places where smoking is completely banned are the auditoriums of theatres and cinemas, local public transport, and airplanes. In principle, smoking is also not allowed in universities, schools or school sports grounds, but in some universities smoking still takes place in corridors, stairways and refectories, and smoking

[c] Being not a legally binding instrument, Austria has also voted for the so-called Warsaw Declaration and the WHO developed European strategy for tobacco control (ESTC)[132]. On 28 August 2003 Austria signed the Framework Convention on Tobacco Control (FCTC). *(Chapter 5)*

[d] The National Cessation Day in November 2003 was characterised by a hardly advertised campaign of the pharmaceutical company Pfizer with Austrian apothecaries which offered free specimen of nicotine replacement therapy to the first 10 customers on the 6th and 7th November.[271]

in schools is subject to the school's administration as teachers are excluded from the ban and students over 16 years may be allowed to smoke in outdoor premises (some schools are known still to provide smoking rooms for pupils). There are partial restrictions on smoking in health care facilities, education facilities, government facilities, indoor workplaces and offices. However, smoking in workplaces is based on a very vaguely formulated law which is not always adhered to, and restrictions are not uniform. Smoking in hospitals is regulated by the individual hospital directors and is often allowed in lounges, corridors, the hospital cafeteria, and nurses' rooms. Smoking in train stations and airports is not banned but subject to voluntary agreement, as for example the installation of "smokers' corners" at airports *(Section 8.4 and Appendix Q###)*.

These examples not only illustrate the deficiencies in Austrian tobacco policy but also the limited validity of such data compilations.

In view of the flexible attitude to smoking restrictions it is not surprising that Austria's discos, bars, restaurants, hospitals, schools and universities are found to be the smokiest and most polluted in a survey of seven EU countries. While in Austrian discos and bars 154.4 microgram nicotine per cubic meter were measured, the comparable figure for Italy was only 26.8 microgram. Average figures for Austrian restaurants were measured to be 29.8 microgram, and Austrian hospitals had 12.2 microgram.[272]

Unlike in some other European countries, as for example France, there is no special unit of the Austrian health insurance fund devoted to smoking. Likewise, there is no separate budget for anti-smoking activities. But there is also no tradition of public health in Austria and reports such as those of the US Surgeon General are only known to very few people.

At present, the Austrian government does not plan to enhance the legal situation (apart from the necessary implementation of the minimum requirements of the European Commission) and no goals or objectives have been set for reduction of smoking prevalence and smoking-related disease, the protection of non-smokers, or the development of an effective tobacco control plan *(Chapter 9; ### 9.4)*.

The following section will examine those measures that have been adopted in Austria to reduce the demand for and supply of tobacco products and to protect non-smokers.

8.3 Strategic framework: tobacco control measures

8.3.1 Legislation and sanctions

Smoking and other unhealthy behaviours are, of course, to some extent a matter of personal responsibility. Yet this responsibility is not solely a matter for the individual but is shared with governments, who should create a supportive legal environment.[2] However, enactment of legislation does not automatically imply its implementation. In Austria, for example, the regulations stipulated in the tobacco law or the employees' protection law are not always observed by those who should do so; nor are they enforced by official bodies (especially in the case of smoking in public places – to the extent that there are restrictions at all).

There is no doubt that the implementation of the 1995 tobacco law was an important step towards tobacco control in Austria. However, as in the case of the European advertisement and sponsorship directive, the history of this law reflects the dominance of economic interests over health concerns, accompanied by ruthless lobbying. After the first drafts of a comprehensive tobacco law in 1992/1993, which, for example, had included a complete advertising ban and noticeable restrictions on smoking in public places (including restaurants and cafés), the final version was much weaker than had been originally planned *(Chapter 9; 9.3.2)*. Apart from the formal implementation of the recent directives of the European Commission, there are now no more far-reaching proposals.

To better understand the present legal situation and the economic interest of the Austrian government in the tobacco business, a brief history of the tobacco monopoly law is given in Appendix …###. The next section will give an overview on tobacco control regulations. Later the relevant laws will be examined in more detail.

Laws and regulations for tobacco control measures

Over the past three decades, but in particular since Austria's entry to the European Union in 1995, a growing number of legal measures against tobacco consumption have been adopted, with introduction of restrictions on tobacco advertising and smoking in certain public places.

On 15 February 1979, a decree of the Federal Ministry of Health and Environmental Protection on smoking in hospitals was issued, followed by the requirement for warning labels on cigarette packs (becoming effective in 1982), subsequently strengthened in September 1992. These warnings were not, however, required on point-of-sale promotional material. Three warnings

(in German) had to be used, in rotation: "smoking damages your health", "smoking during pregnancy can damage your child's health", "protect your children from tobacco smoke".[273]

The Employees' Protection Act *(Arbeitnehmerschutzgesetz)* of 1972, as amended by the Federal Act of 20 October 1982, requires employers to ensure that non-smokers are protected from the effects of tobacco smoke in the workplace; when smokers and non-smokers work together in a single room, smoking is forbidden unless non-smokers can be adequately protected by means of additional ventilation.[269 273 274] Apart from the removal of the term 'additional ventilation' this regulation remains in place, despite claims that the law has become "much stricter" following the enactment of a 1995 act which was required to conform to EU law. At the end of 2003, smoking in the workplace (except in the catering business) is regulated by the 1995 Employees' Protection Act, with amendments made in 1999 and 2001[275] *(Appendix M###)*.

In 1993, the Minister of Health, Sports and Consumer Protection, Michael Ausserwinkler, proposed a draft tobacco act, which ushered in a total ban on advertising, planned to begin in 1996, along with severe penalties for importers of strong cigarettes. The draft act was subject to harsh criticism and Parliament only passed a much weaker version in 1995.[269 276] *(Chapter 9; 9.3.2)*.

The provisions of the present Tobacco Act, which became effective on 1st July 1995[277], was expected to supplement existing regulations on tobacco consumption. It stipulated a legal restriction on advertising, which was previously subject only to voluntary agreement. Together with other measures (such as, for example, the introduction of smoking 'bans' in schools and with other measures (such as, for example, the introduction of smoking "bans" in schools and the setting of a minimum age[e] for the purchase of cigarettes), it was expected that the rate of uptake of smoking would be reduced.

The act also regulates advertising and strengthens the protection of non-smokers through smoking restrictions in certain premises.[f] By these means, an employees' right to a smoke-free workplace was at last legally anchored, although importantly, employees in the hospitality industry and in enterprises where smoking is allowed by customers were excluded. Finally, some smoke-free environments must be provided in transport facilities. The establishment of smoke-free

[e] Being part of the *Jugendschutzgesetz* (youth protection law), setting a minimum age to purchase cigarettes is a responsibility of the Länder. Regulations differ, but all Länder have a ban on tobacco sales to young people under 16 years of age. Before the introduction of the Tobacco Act, in some Länder it was legal to buy cigarettes from 14 years onwards; smoking, however, was only legal for those aged 16 years and older![278]

[f] In the 1995 tobacco act, smoking is only restricted in premises used for education, negotiations and school sporting activities; rooms accessible to the general public in public authority buildings; universities and vocational training establishments; and establishments used for performances or exhibitions.

environments (or rather, non-smoking zones) in restaurants and cafés was suggested but not regulated.

Another feature of the 1995 tobacco law was that smokers themselves were to be 'protected' by regulations on the quality of tobacco products, limits on some harmful ingredients (such as additives, pesticides, residues, etc.), as well as provisions for labelling.[g] However, until now, the Health Ministry has issued no order regarding cigarette additives. Thus, additives are not regulated by any law, making law suits very difficult[279] *(Chapter 9; 9.4)*.

The Tobacco Act of 1995 was amended in 2001 to take account of the introduction of the Euro[30] *(see above)* and in 2003 with regard to the formal implementation of the EC Directive 2001/37/EC into Austrian law.[277] The main amendments affect labelling in respect of tar-, nicotine- and carbon monoxide content, warning labels and more detailed justification of additives. The amendments do not make provisions for more restrictive bans on smoking in public places or for any kind of enforcement. They also do not offer a means to increase existing fines or create new fines for violations of the act.

Notwithstanding these changes, following the 1995 tobacco law restricting advertisements, the World Tobacco File 1998 reported that "in comparison with other parts of the European Union, restrictions and regulations concerning smoking and tobacco advertising in Austria are relatively relaxed".[72] This conclusion still holds today.

A more detailed description of laws on advertising and sponsorship and laws on product control and consumer information can be found in Appendix M###.

Summarising laws on smoking restrictions in public places, the following regulations are in force: Smoking is restricted by the 1995 tobacco law in public buildings, schools and universities, cinemas and theatres. The employees' protection law regulates smoking in the workplace. Voluntary restrictions exist on local public transport, underground stations, trains and airlines, with the provision of a "sufficient number of smoke-free environments in fixed location facilities" being suggested. No restrictions are in force in restaurants or bars. Taken together, this

means that there is no law on clean indoor air; the only places where smoking is completely banned by law are the auditoriums of cinemas and theatres.

A more detailed overview of smoking restrictions in schools, workplaces, and hospitals is given in Appendix M###.

Sanctions

Unlike in Canada, where employers who violate smoking regulations are subject to fines ranging from C$500 (€310) for a first offence, to C$10,000 (€6,200) for each offence after the third[165], or in Italy, where individuals caught smoking in public places are fined €250, or even €500 if children or pregnant women are present, and restaurant owners who do not install proper ventilation in areas designated for smoking risk a fine of €2,000 and temporary closure *(Chapter 4)*, the situation in Austria is much more relaxed. Except for a fine of less than €7,000 for violating the advertising law (or up to €14,000 in the case of repeat offence) no legal sanctions exist. Employers who do not make provisions to protect non-smokers, children under 16 years of age caught smoking, or individuals smoking in non-smoking zones may be 'admonished'. As usual, 'voluntary agreement' and 'mutual understanding and tolerance' are the basic approaches to these issues in Austria. Instead of sanctions, the handling of infringements of health regulations by employers is seen to be more promising by the provision of "information and advice to employers and employees by officials of the Regional Labour Inspectorate *(Arbeitsinspektion)*, as well as co-operation with workers' councils and internal experts in prevention".[280] According to the Chambers of Labour *(Arbeiterkammer)*, though, repeated violations of non-smoking regulations have been reported to have led to dismissal in some cases.[274]

Smoking in public transport and underground stations is regulated by transportation rather than tobacco law. Although smoking is prohibited in underground stations, this ban is only occasionally enforced by staff. The fine is, however, only €40 (compared to €60 for fare dodgers)[281] *(Appendix Q###)*. An official from the Austrian Federal Railways stated that he would wish to

[g] Subsequently, and in compliance with EU regulations, the content of condensates in the smoke of cigarettes (tar yields) was limited to 15mg per cigarette by 31 December 1995 and 12mg per cigarette by 31 December 1997. Nicotine and tar yields had to be displayed on the small side of every cigarette pack. The wording of warning notices on cigarette packs was also tightened, in order to comply with EU regulations. Therefore, the front side of each cigarette pack had to display the warning 'smoking endangers your health'. In addition, on the flipside of the pack, one of four warnings had to be used alternatively (with the same frequency of occurrence), printed clearly and covering at least 4% of the pack: "smoking causes cancer", "smoking causes cardiovascular diseases", "smoking endangers your child's health already during pregnancy", and "stopping smoking reduces the risk of serious diseases".

have stronger powers for sanctions in railway stations but would meet strong opposition from others.[282]

EU law requires member states to impose "proportional, effective and deterrent sanctions" where an offence takes place.[283] As noted above, the only sanction currently existing in Austrian tobacco law is a relatively low fine for violating advertising restrictions. It must be doubted whether this is a "proportional, effective and deterrent" sanction against the tobacco industry, the media, or the advertising agencies. At present, no further sanctions are planned. In addition, inquiries to various departments at federal and provincial level identified no-one responsible for enforcing this law.[h]

In summary, the efforts of all concerned to avoid any kind of 'confrontation', and ignorance of who is responsible to ensure compliance with the law (even if, in theory, it should be the Ministry of Health), mean that any sanctions are essentially symbolic. Yet, according to the State Secretary and his staff, no other measures are under discussion.

8.3.2 Price and taxation

Cigarette prices

At the end of 2003, most packets of 20 cigarettes[i] were sold at a price between €3.00 and €3.30.[75] According to *Austria Tabak*, the average price of most popular cigarette packets was €3.30 in 2003.[70] The highest sales (in this order) were of Marlboro, Memphis, Milde Sorte (now: Meine Sorte), Gauloises, Hobby, HB, Dames, Philip Morris, Camel, and Casablanca *(Appendix C###)*.

Taxes and Duties

For decades, *Austria Tabak* has controlled the government's tobacco taxation agenda and, whenever the question of raising tobacco taxes arose, it was common to ensure its representatives were party to preliminary talks. In various discussions this was explained by the fact that *Austria Tabak* was a state-owned enterprise and its chief executives were closely linked with government representatives at the highest level *(Chapter 9)*.

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[h] Finally it was found that it is handled on the district level *(sic)*, where complaints have to be specified with the exact description and location of this violation when presented at the respective district office – which is not very likely to be done by anyone. From the individuals contacted, nobody remembered if this was ever the case; however, as there are no data available as to number of law suits or amount of fines one would have to contact each of these district offices in the whole country separately to get more information.[284]

[i] Unlike in some other countries, packets with less than 20 cigarettes are not on the Austrian market.

Since Austria became a member of the EU, it has been possible to observe a sharp rise in taxes. Before EU entry, taxes had remained constant for a very long time, with the highest tax rate (excluding VAT[j]) being for cigarettes (55% of the retail price), followed by fine-cut tobacco (47%), pipe tobacco etc. (34%) and cigars (only 13%) – which is interesting from a social point of view, as cigars are usually smoked by wealthy people who could afford to pay more taxes.

Austria's EU entry also led to a reorganisation of tobacco taxation, i.e. the change from an *ad valorem* tax system to a composite tax rate. In August 2002, the total taxes for cigarettes were 58.67% (42.00% *ad valorem*; 16.67% V.A.T.), that is €21.38 per 1000 pieces. Based on the most popular price class, the overall tax burden of a cigarette pack with the retail price of €3.00 was €2.19, that is 72.9% *(Appendix N###)*.[70]

According to the World Tobacco File 1998, the increase in cigarette prices in Austria between 1994 and 1997 amounted to 30%; in subsequent years no data were made available by *Austria Tabak*. The price increases in 1994 and 1995, following sharp rises in taxes, have been linked to a growth in cross-border and contraband sales and hoarding by consumers, but also to a slight decrease in the number of cigarette smokers,[72] consistent with evidence on the price elasticity of tobacco *(Appendix F###)*.

The scale of tax revenues from the sale of tobacco products is enormous. Only considering consumption of cigarettes, which constitute the biggest share by far within all tobacco products, the revenues from taxes for all EU member states amounted to nearly €55bn (excluding VAT) in 2001. The highest sums were raised in the United Kingdom (€11.8bn), Germany (€11.6bn) and France (€8.2bn).[39]

In 2002 in Austria, the tax income from tobacco products amounted to €1.3 billion, corresponding to an increase in tax revenues of 35% since 1997, although this excludes 20% VAT, amounting to an additional €456.5 million, so that total tax revenues in 2002 amounted to €1.8 billion *(Figure 8.2~~Figure 8.2~~)*.[70] This is consistent with evidence that increasing tax rates both decreases consumption and increases total tax take.

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It is, however, important to note that data on tax revenues differ slightly according to whether they are supplied by the Ministry of Finance[285] or by *Austria Tabak (Figure 8.1~~Figure 8.1~~ & Figure 8.2~~Figure 8.2~~)*.

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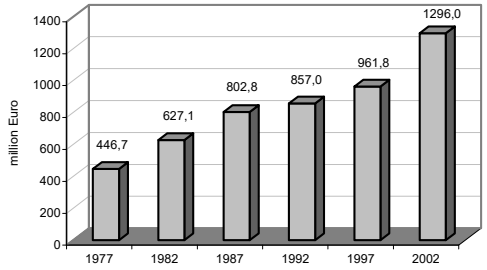
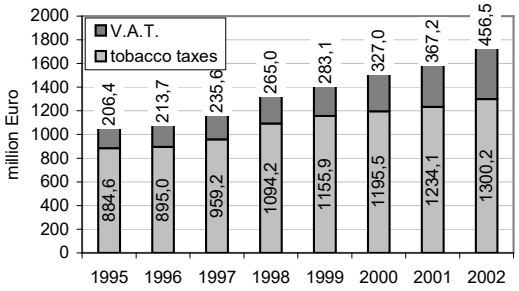
[j] VAT (Value Added Tax) in Austria: 1973-1975: 16%; 1976-1983: 18%; since 1984: 20%.

Figure 8.1 Annual tax incomes from the sale of tobacco products in Austria from 1977 to 2002 (in million Euro) (excluding V.A.T.)



Source: Austrian Federal Ministry of Finance, balance of accounts (Bundesrechnungsabschlüsse).

Figure 8.2 Tax revenues from tobacco taxes and V.A.T. from the sale of tobacco products in Austria from 1995 to 2002 (in million Euro)



Source: Austria Tabak Gallaher.

Use of tax revenues

In Austria, tobacco taxes are not earmarked. There was only one attempt, made by the former health minister Michael Ausserwinkler in 1993/1994, to allocate tobacco taxes to anti-smoking activities – the, informally, so-called *"Rauchermilliarde"*, with the term reflecting the approximately ATS 1 billion to be raised by the proposed extra charge of 50 Groschen (€0.04) on every pack of cigarettes. These funds should have been transferred to the Fund for a Healthy Austria to finance treatment and support of anti-smoking campaigns. However, due to strong opposition (economists argued that this measure would promote inflation) this initiative could not be realised *(Chapter 9; 9.3.2)*.[276] Although a small proportion of tobacco taxes have been used to fund general health promotion activities for many years, these are not specifically related to particular anti-smoking activities.

In 2002, a regulation enacted within the framework of the general social insurance law (*Allgemeines Sozialversicherungsgesetz)*[286] decreed that the Federation of Austrian Social Insurance Institutions' (in short: Social Insurance Funds) equalisation fund should receive additional income following the rise in tobacco taxes in August 2002. This was to be a flat rate of about €82 million for every year.[k] However, the advance payments made to the equalisation fund exceeded the tax gains and an amendment to the law *(Budgetbegleitgesetz)* seemed necessary. At the time of writing (April 2004), however, there has been no agreement between the Finance Minister and the Health Minister on this issue.[l] [14] [285]

Thus, these funds have never been used specifically for any kind of anti-smoking initiatives[m] although they have been used to support the Social Insurance Funds which have been (and still are) badly in debt. Despite evidence of the very high health care expenditure attributable to smoking-related diseases (estimated to be 15-20% of total expenditure, i.e. €1.5 to €2bn[14]), there is no special unit within the Federation of Austrian Social Insurance Institutions responsible for smoking prevention and no particular anti-smoking activities have been established so far, nor are there any plans for them. The only specific expenditure on combating smoking is funding for 3-week courses of treatment for heavy nicotine addicts with severe smoking-attributable disease. These costs are, however, met by regional health insurance funds[n] *(Section 8.3.5)*. A contribution of approximately €50,000 from the Social Insurance Funds to the Fund for a Healthy Austria for general health promotion measures is obviously thought to cover all responsibilities by Austria's health insurance system. However, the activities of the Fund for a Healthy Austria targeted at smoking are considered very weak *(see later)*.

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[k] It is not yet clear if this amount will be financed by the tobacco tax or the sales tax.

[l] In 2002, the equalisation fund received advance payments for the months September, October and November, estimated on the expected tax gains, totalling about €82 million. In December 2002, the Finance Ministry realised that, in contrast to these expectations, total tax revenues have not increased as expected, and no more money was transferred for December. Thus having transferred too much money to the Social Insurance Funds, which could not be returned to the Finance Ministry, a change of this flat rate seemed necessary.[285] While Reinhart Waneck, the Austrian State Secretary of Health (Austrian Freedom Party, FPÖ), would be in favour of a fixed amount, the Austrian People's Party (ÖVP) and its Finance Minister Karl-Heinz Grasser (formerly FPÖ, now 'independent' but close to ÖVP) are opposed to it, preferring, if at all, a yearly modified amount.

[m] Although the State Secretary of Health, Reinhart Waneck, claims that the spokesman of the executive board of the Social Insurance Funds, Josef Kandlhofer, assured that 'every penny' received from the tobacco taxes would be used for preventive measures in tobacco control[287], whereas, according to a newspaper article, Kandlhofer himself declared that (only) part of this funding will be used for "preventive" measures for smokers[288] (i.e. support of treatment for severely ill smokers). Instead, according to information received from Josef Kandlhofer, this additional funding will go (and has gone) into an equalisation fund where an accurate mode of account is not possible. Therefore, no information could be given as to how much money was actually spent for measures on smoking prevention as this money has not been earmarked and the present accounting mode does not allow money to be traced.[14]

[n] Although the regional health insurance funds also receive indirectly funding by this equalisation fund, this money is not earmarked for any purposes.

In September 2003, on the occasion of the delayed implementation of the EC directive 2001/37/EC, Austria's State Secretary of Health, Reinhart Waneck, voiced his view that a planned reform of voluntary screening programmes should be financed by tobacco taxes.[o] The question of further increases in tobacco taxes was rejected by Waneck, arguing that this expansion of screening programmes did not require an increase in tobacco taxes.[159] However, an enquiry in July 2004 at the Social Insurance Funds about the state of affairs revealed that, due to lack of money, the programme, which is planned to start on 1 January 2005, should comprise even fewer examinations than it did previously but will instead offer more information for smokers about harms of smoking and advice on smoking cessation. Doctors would be given a manual on how to proceed.[p 290]

The mainly government-funded Fund for a Health Austria *(Fonds Gesundes Österreich, FGÖ)* is the national organisation for health promotion activities. It receives funds from the government as a fixed amount of import duties on tobacco products purchased outside the EU, amounting to €7.25 million per year. However, the anti-smoking activities of the FGÖ are confined to the minimum expectations of EU-wide (and rather ineffective) efforts to tackle smoking among young people *(see next section)*. According to personal communication with one of the organisers of a European road show, the Austrian response, particularly in Vienna, was very poor and badly organised.[291]

8.3.3 Advertising and sponsorship

Advertising

Austria will have to implement the EU directive on advertising restrictions. However, despite occasional lip service paid by politicians to the importance of banning advertising[q], there have

[o] These screening tests, used only by approximately 12-13% of the population, should include cancer-, skin- and lung examinations for smokers. A critical article in the Austrian newspaper *Kurier* expatiates on the fact that, although cigarette prices and taxes have been increased continuously over recent years, justified by the need of financing the health care system, these funds in fact have seeped away somewhere.[289]

[p] No answer could be given regarding the apparent lack of offers for smoking cessation *(see later)*. As usual, it was only referred to the *Josefhof* in Graz as a kind of model cessation project *(see later)*, where severely ill smokers are treated in a three weeks cessation programme – one could say, a kind of 'last chance' for smokers.

[q] One example was a letter from the then Health Minister, Herbert Haupt, and the State Secretary of Health, Reinhart Waneck, to the then Director General of the WHO, Gro Harlem Brundtland, dated at the beginning of 2003. This letter emerged in the course of the preparations for the final negotiations for the Framework Convention on Tobacco Control, which includes Article 13 referring to a total advertising ban. Haupt and Waneck affirm that, from the viewpoint of health politics, a total advertising ban would be 'very desirable'. Tobacco advertisement would contribute to tobacco consumption and therewith to tobacco-related diseases. Experts would therefore see a total advertising ban as one of the most effective means to counteract the increase of smoking.[278]

been no signs whatsoever that Austria has any intention to either hurry or go beyond the minimum requirements demanded by the European Commission.[r]

In the international literature, Austria's attitude towards tobacco advertising has therefore rightly been described as "very relaxed", with a "mild climate" based on "broad consensus". Almost every measure is seen as 'too extreme' or 'militant' *(Chapter 9)*. In the Austrian newspaper *der Standard*, the recent advertising directive of the European Commission is described as a "missionary fight" by the EU Health Commissioner David Byrne against cigarette consumption. In some member states, so the commentary reports, advertising restrictions were followed more strictly, in others regulations were rather of the "mild sort" [s].[292] Although the situation is similar to that in Germany, where strong pressure on decision makers has been reported [t], it probably does not need great pressure from interest groups on the government in Austria for it to reach a 'broad consensus'.

As noted, the 1995 Tobacco Act stipulates that tobacco advertising should not attract young people and models should therefore not be (or appear to be) younger than 30 years of age. In addition, no cartoons should be used. Although nobody ever complained about it, cigarette advertising often portrays seemingly young people (even if they are reported to be above 30) and the Casablanca cartoon[u] in underground stations (see Picture 2### in Appendix Q###) is apparently one of the exceptions.

Hidden advertising (with pictures of smokers) in the media is not uncommon, in particular in articles dealing with the subject of non-smoking *(Chapter 9; 9.3.8)*.[39 264]

The 1990 youth campaign provides insight into images of smokers and non-smokers. According to the advertising agency involved, the image to be projected should be a strong, self-confident, independent, freedom-loving, humourous, sporting, sociable, and modern youth. In fact, this image is identical with that advertised for smokers. However, a survey among youth reported that the 'undesirable' characteristics ascribed to non-smokers would be good, well-behaved, conform, unsociable, puritanical and health conscious.[293]

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[r] In 1993, the Health Ministry issued a draft tobacco law which ushered in a total ban on advertising to begin in 1996. The draft law was subject of harsh criticism and was among the main reasons behind the removal of the then Health Minister Michael Ausserwinkler *(Chapter 9)*. Only in 1995, when Austria's EU entry made action necessary, did Parliament pass much weaker legislation, which included only partial advertising restrictions.

[s] Hinting at the Austrian bestseller brand 'Milde Sorte'.

[t] According to David Byrne, these initiatives were meant to be a "coffin nail" for the tobacco industry. The German newspaper editors, however, sensed that it would also be a coffin nail for them and, with a view to the present crisis in the advertising business, made pressure on the German government.[292]

Several Austrian advertising agencies have been commissioned by *Austria Tabak* to undertake cigarette advertising. For example, BBDO has been commissioned to promote *Milde Sorte*; FCB Kobza, *Memphis Classic*; Saatchi & Saatchi, *Memphis Blue*, etc. Only one agency, however, volunteered limited information about target groups, advertising objectives, compliance with tobacco law, client briefs and information on brand characteristics. Two explicitly declined any kind of information and hung up immediately. The information presented below is based on discussions with a key informant who did not wish to be named.

According to the industry's briefing to the agency, the general aim of cigarette advertising is to confirm regular smokers in their choice of brand (brand loyalty), to promote preference for domestic (Austria Tabak) brands, in particular from the 'light' range, to promote a positive image, and, of course, also to win new customers. In previous years, when *Austria Tabak* was still state-owned, the foreign brands *Marlboro, Gauloises,* etc., have represented the foe. Today, this is different and in the future, a decline in home brands and an increase in foreign brands are predicted.

The definition of target groups is based on market research. For example, the original target group for *Memphis Classic* were men aged 35 years and over, from rural rather than urban areas. However, this target group has been expanded. On the other hand, the target group for *Milde Sorte*, Austria's most popular 'light' cigarette, are young women of the 'housewife-type', aged 25 years and over.

With regard to the age limits for models it was assured that, before shooting, every model had to sign a statement that he or she was not under 30 years old. It was stated that, if the model lied, at least, the advertising agency has covered itself with this signature. Of course, if the shooting takes place outside the Schengen zone, passports are needed – and checked.

Advertising strategies are developed through team work, drawing on past experience. Although the agency receives a basic briefing by the tobacco company (more detailed information was not disclosed), the concepts and designs are said to come from the agency.

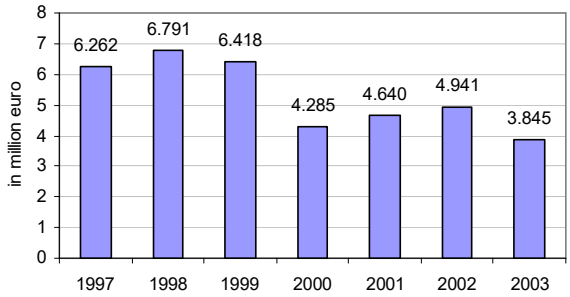
As noted above, tobacco advertising is permitted in cinema (G-rated films, but not in films targeted at children and youth), outdoor advertising (billboards etc.), and print media (local weekly magazines, magazines, professional journals). The breakdown of expenses incurred by the German tobacco industry shows that the biggest share (37.4%) is spent for outdoor advertis-

[u] Casablanca is the 10th popular cigarette brand in Austria *(see Appendix C###)*.

ing.[294] No data were provided by the Austrian tobacco company about its annual advertising budget. However, an Austrian market research company was able to give information on expenditure on cigarette advertising since 1997 *(Figure 8.3~~Figure 8.3~~)*. From the beginning of privatisation of the Austrian tobacco company in 1999/2000, a striking decrease in cigarette advertising can be observed. Since then, however, expenses have risen, amounting to almost €5 million in 2002, before decreasing to less than €4 million in 2003.

Formatiert: Schriftart: Kursiv

Figure 8.3 Expenditure on cigarette advertising in Austria, 1997–2003



Source: Media Focus Research.[295]

It has been commonly said by politicians[296] and government officials[297] that *Austria Tabak* has been the biggest advertising client. However, analysis of advertising expenditure (i.e. 'classical' advertising, including print media, bill boards, and cinema advertising but excluding hidden advertising in the form of sponsoring) shows that tobacco advertising is by far not as predominant as, for example, advertising for telecom companies, cars, washing powders, or supermarkets.[295]

Sponsorship

Although no data were provided by *Austria Tabak* about its promotional budget, the company is known to spend heavily on cigarette advertising and, probably less transparently, for sports sponsorship. With its former General Director Beppo Mauhart being at the same time head of the Austrian Football Federation, the involvement of *Austria Tabak* in sports is self-evident *(Chapter 9; 9.3.1)*.

In Austria, it is widely known that sports clubs, in particular football clubs, are sponsored by *Austria Tabak*. The company also sponsors the Austrian ski team (which uses the logo of

Memphis)[298] and, until it was banned, it also sponsored Formula One. At least until privatisation, *Austria Tabak* has been known to sponsor arts, horse races[v], and many other events. A 1987 article reports that "Austria Tabak, despite restrictions on advertising, builds its image through sponsorship of arts and sport". It adds that the company is "the largest non public sponsor in Austria".[300] It was not possible to get information on the subject of 'donations' to political parties.

Reinhart Waneck, the Austrian State Secretary of Health, claims that he has been trying to persuade the pharmaceutical industry and other industries to take over sponsorship at football pitches, so one would "not be dependent on Memphis". So far, however, these companies have not shown much interest. Waneck's account shows that the relationship between the government and *Austria Tabak* is characterised by mutual understanding of the respective interests and assumed goodwill.

> *"Interestingly, the tobacco industry would have no problems at all with that [being stopped from advertising at football pitches]. They have told me that they do not need that, because people do smoke anyway. And the more it is prohibited, the more business they make. That means, here you really have to think about new ways, together with the tobacco industry, but it would be far better to win other companies. It is also an issue for the Finance Minister with regard to tax policy. He would need to grant that anti-tobacco advertising can be written off against taxes in any event."*[287]

8.3.4 Information, campaigning and training of health professionals

At present, the government's few efforts to reduce smoking have been confined to pointing to alarming rates of smoking among young people, particularly among young women, and to small and mostly ineffective youth campaigns which are supposed to prevent children and adolescents from taking up smoking. The reduction of the toll of premature death from smoking-related disease, the high health care costs for smoking-related disease, and the protection of non-smokers are essentially missing from Austrian health policy.

Annual anti-smoking days, such as the Non-Smoking Day on 31 May, the National Cessation Day on 7 November, and the National Awareness Day on 1 January, pass more or less unnoticed – at least in Vienna. Apart from some media coverage and expressions of good-will by national health politicians, no public events or campaigns are taking place. However, unlike the situation in Vienna, activities in Vorarlberg and Tyrol were reported.[301] [302]

[v] An Austrian 1988 sports newspaper reads: "Austria Tabak – long-known for its sponsorship of various football clubs – has now donated a prize for horse-racing. The 'Maverick' Grand-Prix was run for the first time on Vienna's Freudenau course on 1st May".[299]

The only comprehensive anti-smoking campaigns that targeted the whole population took place at the beginning of the 1980s and, to a limited extent, in the mid 1990s. Population-wide dissemination of information and implementation of educational measures about the dangers of smoking and the recognised difficulty in quitting are lacking, and therapeutic support for those willing to quit are still limited and often unprofessional.

In particular, there is not much information about the dangers of second-hand smoke, and no appeal to those who smoke to consider non-smokers. In addition, although smoking is restricted in some public places by the 1995 tobacco law, these regulations are not always adhered to. In contrast with countries like Norway, Finland, Sweden, the United States, Canada, Australia, or New Zealand (to take just the best known examples), smoking in Austria is mostly still seen as a matter of 'personal freedom' and 'personal choice' and little consideration is given to those who feel harassed by this activity.

Although efforts directed at adolescents are doubtless very important as adolescence is "a critical life stage when life-style choices are established, including health-related behaviours with impacts throughout life"[2], it has been shown repeatedly that youth campaigns must be part of a population-wide and comprehensive anti-smoking programme to yield positive results *(Chapter 4)*.

Apart from these limited activities, information on smoking-related issues is provided by a website served by the *Initiative Ärzte gegen Raucherschäden* (Austrian Council on Smoking and Health – or: Initiative of Physicians against Harms of Smoking), formed by the Austrian Society for Lung Diseases and TB, the Institute of Environmental Hygiene of the Medical University of Vienna, the Institute of Social Medicine of the Medical University of Vienna, the Austrian Cancer League, and the Austrian Medical Council. Its activities, however, seem confined to the provision of this website.[303]

Anti-smoking campaigns

In 1980, the first anti-smoking campaign was launched in Austria, followed in 1985 by a second campaign using the same name. Both campaigns were very short but profited from the popular slogan *Ohne Rauch geht's auch* ("Same Without Smoke")[w] which is still remembered today, even among younger people. In 1990, a small youth campaign with the vacuous slogan "Smoke

[w] The only one who complained and wanted to sue the Ministry (which eventually did not happen, though) was the Austrian manufacturer of fruit juices with the same name 'Rauch' as, due to its popularity, the slogan was jokingly used in variations.[304]

off" took place. In 1994, the second (or third, if one counted the small 1985 repetition campaign) was launched, repeated in 1995 (although with a much smaller budget than the 1994 campaign). While these two major campaigns with their small-scale repetition were directed at the whole population, the few subsequent campaigns have been targeted exclusively at children and teenagers. All campaigns are described in more detail in Appendix O###.

The population campaigns were initiated solely by the Austrian Ministry of Health and can be ascribed to the two health ministers Herbert Salcher and Michael Ausserwinkler, who were both very engaged in anti-smoking politics despite facing strong opposition and even personal attacks *(Chapter 9)*. While the predominant features of the 1980 campaign (Herbert Salcher) were its effective slogan, intense media coverage, and targeting of the entire population, the main goal of the 1994 campaign (Michael Ausserwinkler), which consisted essentially of an information brochure and stickers, was to promote the tobacco law and to address political opinion leaders as an important target group *(Chapter 9)*.[x] The cost of the 1980 campaign was particularly low at only about ATS 7 million (equivalent to €500,000), largely due to media support with free cost services[y]. Considering that this campaign lasted a very short time, it may be considered very successful. According to an accompanying survey, about 200,000 people stopped smoking at that time. Although this effect was very short lasting, it shows the potential for intense and prolonged tobacco control programmes. The cost of the 1994 campaign was higher, about ATS 20 million (€1.5 million) – a considerable proportion of the health ministry's budget, but still only about 5% of the advertising (and sponsorship) expenditure of Austria's tobacco company for one single campaign at that time (including hidden advertising).[276]

Over recent years, Austria's anti-smoking policy has thus been focused on children or rather teenagers, with the intention of preventing them from taking up smoking. Apart from the brief 1990 youth campaign "Smoke off", the exclusive focus on children and youth started in 1996/1997 with the Ministry's commission of an association named "Young and Non-Smokers" with a health education campaign aiming to initiate a rethinking of the symbolic power and meaning of cigarette consumption. This campaign passed more or less unnoticed. In 1998, the equally unnoticed, but industry-funded government campaign "smoke sucks" followed. In 1999,

[x] While today the health ministry claims that this campaign actually resulted in the successful implementation of the Austrian tobacco law in 1995, it may safely be assumed that the greater force behind its implementation was Austria's EU entry. Although much weaker than the original draft *(Section 8.3.1)*, the new law at least included smoking restrictions in public buildings and constraints on advertising.

[y] This fact was obviously not well received by *Austria Tabak* who complained about the "inequality of weapons". The campaign, so the company publication, "not only received time free of charge in the electronic media, which are forbidden to us, but which also involved speakers, sometimes very prominent speakers, who were prepared to make spontaneous comments".[71]

the Austrian Cancer Society ("Don't start, be smart") and in 2002, the Fund for a Healthy Austria (*Ich (b)rauch(s) nicht* = "I don't need it, I don't smoke") have also initiated anti-smoking youth campaigns. Recent initiatives include a project entitled *Rauchfreie Schule* ("Smoke-free Schools") and participation in the EU-wide youth campaign "Feel Free to Say No" *(Appendix O###)*. In the course of these campaigns, information has been made available on the dangers of tobacco use. Some of the most recent anti-smoking campaigns have included efforts to work with teachers and students to create smoke-free classes or schools. In May 2004, a small and little advertised campaign as part of the international "Quit and Win" programme was launched, also supported by the health ministry.

Other funds or organisations or even individuals acting at local level (especially in the federal provinces Vorarlberg, Tirol, and Upper Austria) have also launched initiatives for children and teenagers recently, or are giving educational talks at schools.

As was already mentioned, a more detailed description of the various campaigns which have been mounted in Austria since 1980 can be found in Appendix O###. Chapter 9 will also explore in more detail the background of the 1980 and 1994 campaign *(Section 9.3.2).*

According to the Health Ministry, the reason for this exclusively youth-targeted approach has been the results of the HBSC studies which report a significant increase in smoking among children and teenagers over the last 15 years and the continuous decrease in the age at which smoking commences. In a two-minute conversation before suddenly rushing off, a government official, who is responsible for health promotion including anti-smoking campaigns, said at the Helsinki Conference that campaigns targeted at the general population would not be effective *(sic)*, and it would be much better to focus on youth campaigns. The fact that youth smoking rates have not decreased but rather increased over recent years (and still are increasing), despite various youth campaigns, was brushed off with the remark that "one has to target one's efforts", because of limited resources.[305]

In the light of continuously increasing smoking rates among Austrian teenagers, which are now among the highest in any EU country, the effectiveness of various youth campaigns may be summarised as being very limited at best, counter-productive or profoundly ineffective at worst. Furthermore, it would seem that this is not only the fault of the rather meaningless slogans selected in English language, which cannot even be translated into German in a way that makes sense (e.g. "smoke off", or the rather unappealing "smoke sucks") but also due to the often patronising manner of the campaigns.

Nevertheless, Austria's health politicians seem to be rather pleased with themselves and the results of their efforts. Reinhart Waneck, State Secretary of Health and president of the Fund for a Healthy Austria, stated in the foreword of its 2002 report that the slogan "I don't need it – I don't smoke' "encouraged children and youth not to start smoking"[306]. Whatever he meant by "encouraged", it is perhaps the most one can say about this very short campaign (lasting only a couple of weeks) without it becoming an overstatement.

Maria Rauch-Kallat, Austria's present Health Minister, in a statement made to coincide with World No Tobacco Day on 31 May 2003 (while again referring to the alarming HBSC data) called for increased prevention, particularly for young women. The Social Insurance Funds also took this opportunity to "affirm to intensify its activities"; so far, however, without visible results. In her statement, the Health Minister proposed a "broad health promotion movement" to animate Austrians – particularly certain target groups – for more health conscious behaviour, including reducing smoking. Once more, 14-15 year olds were seen as the main target group.[288] As of March 2004, however, nothing has been heard about it, and no actions have taken place.[z]

Given the evidence from elsewhere of tobacco industry support for youth smoking campaigns, it does seem to be the case that, for most of the campaigns, the funding seems to be 'clean'. Inquiries to the Austrian Cancer Society about its campaign "don't start, be smart" revealed that much care was taken to assure that no tobacco industry money was contributed. Despite persistent rumours of *Austria Tabak's* involvement in the government campaigns, only one was reported to have been funded by the Austrian tobacco company: the youth campaign with its unappealing "smoke sucks" slogan and its equally unappealing pictures of youth and its symbols (as, for instance, a raised middle finger in the form of a cigarette).[307] As to the youth campaign with the equally mysterious slogan "Smoke off", where sponsorship had been necessary because of the very modest health ministry's budget[293], no information could be obtained about the identity of sponsors.

In summary, all of the Austrian campaigns can be described as rather small-scale, low-budget and short-lasting. The very first campaign in 1980 was certainly the one whose effects lasted longest and possibly, despite an increase in smoking rates between 1981 and 1984 after a brief decline following the campaign, also the most successful. Both the 1980 and the 1994 campaign, however, could have been much more successful if they had lasted longer and the two

[z] Another advertised campaign that nobody ever heard of again was a 'planned' anti-smoking initiative to target pregnant women ('even' funded by the Austrian tobacco company!), announced after the TV programme on anti-smoking measures on 5 November 2003.[302]

motivated ministers had faced less opposition. Even in relation to the small overall budget for health promotion activities, the budget for anti-smoking initiatives has been very small so far (with the exception of the 1994 campaign) and efforts particularly over the last 15 years have been decidedly unimpressive. In particular, they can be contrasted with the expenditure on advertising campaigns by *Austria Tabak*, which in the mid 1990s amounted to ATS 300 to 500 million (ca. €21 to 35 million) for each campaign[276 278] (apparently including indirect advertising and sponsorship), Austria's anti-smoking campaigns are declining to the point of non-existence. According to the State Secretary of Health, Reinhart Waneck, the main constraint on the health ministry from launching a sustainable and effective anti-smoking campaign is the limited budget. Needless to say that there are currently no discussions whatsoever regarding a comprehensive package of tobacco control measures or at least a well-designed population-wide campaign.

Training of health professionals

In Austria, health professionals are not specifically trained to give advice and support to those willing to quit. If physicians or pharmacists are interested they may attend some continuing educational courses.[271 308 309] Medical students are invited to pay a visit to the Nicotine Institute (which does not, however, offer cessation courses) to be shown around for one or two hours.[191] The new health screening programme, proudly announced by the State Secretary to be partly financed with tobacco taxes, should provide information and advice for smokers to quit. "Training" of doctors consists of handing them a manual on how to proceed. As the following section on smoking cessation programmes shows, it remains unclear yet where smokers who should wish to quit smoking and who are not already ill enough for the *Josefhof (see below)* will be sent to for help.

8.3.5 Smoking cessation, therapeutic measures

On the occasion of the 2003 World Tobacco Conference in Helsinki, the WHO "urged governments to include smoking cessation and treatment services as part of comprehensive tobacco control programmes, stressing that therapies for tobacco dependence can contribute substantially and immediately to health gains".[310] The guidelines, developed by experts, should provide countries that wish to implement the FCTC with an evidence-base. However, as Vera da Costa e Silva, WHO's director for tobacco control noted, despite overwhelming evidence of the health benefits of quitting smoking, and the effectiveness of treating tobacco dependence, "the public health sector in many countries is not investing in smoking-cessation services, and in

most countries only limited steps have been taken to provide treatment, train health-care providers, and release financial resources. Smoking cessation is very often not seen as a public health priority, or included in governments' tobacco control strategies," she said. Because of tobacco's addictiveness, many smokers will need support to quit."[310]

Smokers who want to give up smoking require various forms of support. However, as advised by the WHO and other experts, a multisectoral approach should be the aim *(Chapter 4; Appendix F###)*. In addition, a "supportive environment is needed to encourage smokers to quit: higher tobacco taxes, advertising bans and smoke-free public places contribute to raising awareness and decreasing access to tobacco products".[297]

Although Austria proudly points to the fact that it was "one of the first countries to sign the FCTC"[297] there are no signs whatsoever of it implementing any of its provisions. At present, smoking cessation is definitely one of the least important elements in Austria's tobacco policy and accordingly plays a little part in shaping the population's attitude towards smoking.

There is very little support for smokers who are considering the idea of giving up smoking, and even less information about where help can be found. Neither is there any kind of advertisement of even the few cessation programmes in the media.[aa] Not surprisingly, giving up smoking is widely seen as very difficult task and, above all, a 'personal' or 'individual' problem. In general, therefore, smokers who have already reached a stage where they are really willing to give up smoking have to search actively by themselves for support. There is no help-line now although one did exist previously for a short period, operating for three hours a day, but it was not very successful and no-one would accept responsibility to pay for it. Potential quitters inquiring at the Nicotine Institute have their details noted and, once there is a sufficient number (usually once or twice a year), a one-hour talk will be given in a rented location to all who are still interested. The official approach is essentially that "one has to earn the treatment", and difficulty in accessing these services is seen as something positive, showing the real commitment of the individual. According to Ernest Groman, head of the Nicotine Institute,

> *"one cannot expect anyone sitting there for three hours or more and answering the same 20 or 25 questions all over again. ... If someone really is committed to quit, he/she will also wait a few weeks or months until this meeting takes place".*[191]

The lack of support for quitters is, in part, a reflection of the emphasis over recent years on adolescents, and there seems little recognition that isolated measures are not – and cannot be –

[aa] Apart from Vorarlberg, where cessation programmes are 'advertised' in the media.

successful. As already noted, smoking rates among children and adolescents continue to rise, and many of these activities are patronising and/or targeting young people when they are already at an age where they will have started smoking. Cessation programmes for adult smokers seem to be politically less 'attractive' than youth programmes. Although the higher health care cost of smokers than non-smokers is known by the health insurance companies, they are still reluctant to provide financial support to these activities.

Much emphasis has been given to the 'flagship' project *Josefhof* ('Joseph Court') in Graz (Styria), an interdisciplinary, multimodal 20 day inpatient smoking cessation programme, developed and evaluated by the University of Vienna (Institute of Social Medicine and Nicotine Institute). It is usually presented as an activity of the Federation of Austrian Social Insurance Institutions. However, the *Josefhof* was actually founded by the miner's social insurance company in 1997 (and still belongs to this company). It is an institution for seriously nicotine-addicted individuals (Fagerström index >5) who already suffer from smoking-related diseases. The Vienna District Health Fund and some smaller insurance companies for certain occupational groups (miners, employees of the Federal Railways, industrial economy, and federal civil servants) have contracts with the miner's insurance company and send members there to aid cessation.[311]

Between 2001 and 2003, 185 smokers with high levels of nicotine dependence have been recruited. The intervention consists of 34 hours of group treatment (25 participants) using a behavioural approach, individual counselling upon request and a accompanying sports and relaxation programme led by psychologists and sports therapists.[312] [313] During the three week stay, smoking is still allowed for the first week, followed by a psychological programme and ending with the signing of a "non-smoking contract".[314]

For members of the Vienna District Health Fund, access is difficult and it is considered to be a privilege to be allowed to participate. Every year, the Fund could send 100 severely ill nicotine addicts for a three-week treatment to the *Josefhof* in Graz; this yearly quota has not yet been achieved. For self-paying patients, the cost of the programme is €2,235;[311] if paid by the Vienna District Health Fund, the cost of therapy amounts to €1,620.30 per patient (March 2004).[314] Initially, the treatment (classified as cure) was free of charge to the patient. Now, as with other cures, the patient has to pay a small contribution *(Kurbeitrag)*, presently (March 2004) €6.19 per day if monthly gross income exceeds €653.20. The treatment is counted as rehabilitation and therefore as sick leave.[314]

The programme also offers follow-up assessments for one year.[bb] It claims an abstinence rate at completion of the course of 100% but by six months this has fallen to 55%.[314] After 12 months, 36% of patients are reported to be non-smokers, 24% have reduced their tobacco consumption, 13.5% still smoke and 27% have never presented themselves to any follow up assessments and are therefore classified as smokers.[312]

There are therefore no therapeutic activities whatsoever at national level and no plans for any in the future.[14]

At the regional level some of the District Health Funds can be identified as being more active in offering or supporting smoking cessation. Apart from the support of the *Josefhof* by the Vienna District Health Fund, the Upper and Lower Austrian District Health Funds must be mentioned *(see later)*. Among the remaining social insurance funds[cc], the fund for federal civil servants is undertaking a small amount of activity (in-patient cessation courses within a "preventive cure" concept, adopted from the *Josefhof* model), but the insurance fund for the Länder civil servants is inactive so far. This is even more surprising as civil servants are reported to have high smoking rates. Interestingly, the insurance fund for employees of *Austria Tabak* offers out-patient cessation and, in individual cases, bears the expenses for "medically necessary out-patient or in-patient smoking cessation".[315]

In 2003, the Lower Austria District Health Fund (NÖGKK) in co-operation with the Nicotine Institute in Vienna was establishing ambulatory services in Lower Austria. In summer 2003, four Lower Austrian towns offered outpatient treatment centres (one in every town) for smokers willing to quit. The treatment covers a period of five weeks and is paid by the District Health Fund, with only the nicotine-replacement (drugs or patches) being paid by the quitters themselves. It involves a combination of behavioural change and medication (single therapy, once a week). Every week, about 12 to 24 quitters get an appointment; by the end of 2003, about 500-600 smokers had participated. The Nicotine Institute claims a success rate of 80% after five weeks.[191] The Upper Austria District Health Fund offers three in-patient cessation centres based on the concept of the *Josefhof*.

Despite having the highest smoking rates, Vienna remains far behind. Although similar cessation centres have been proposed by the Nicotine Institute, this has not happened due to lack of

[bb] After treatment, the Vienna District Health Fund also offers its residents who have participated a monthly *Jour Fixe* (one hour in the evening) for one year. The number of participants at these meetings is about 30 to 40.[314]

financial support by the Vienna District Health Fund (WGKK) which is only willing to support its own few centres for smokers and the *Josefhof* in Graz. By comparison, the Lower Austria District Health Fund has agreed to pay for those attending the previously mentioned treatment centres from any province, as long as the numbers are not excessive.

The first smoking cessation activities initiated by the WGKK only started in 1997/98 when heavy smokers who wished to quit were treated in hospital. Only recently has ambulatory care (or rather, information) also been offered. By the end of 2003, however, only one centre offered both information and treatment; two centres offered only information, one being a chest clinic. The centres of the WGKK offer a smoker's anamnesis, the Fagerström Tolerance Test[dd] to measure exhaled carbon monoxide and grade dependence. This is free of charge, with only a referral from a doctor required. The official responsible for this programme at the WGKK reported that the organisation is more interested in the enlistment of organisations, such as schools or companies, to distribute information, or to be visible at public events (e.g. the fair for elderly people – perhaps a surprising choice) rather than investing in treatment programmes or advertising.[314]

The City of Vienna Health Authority has one 'advice centre' for smokers, open once a week between 15.30 and 18.00 for advice on smoking, nutrition and stress, all given by the same staff, including a secretary who gives 'common sense' advice on the telephone. It appears highly unprofessional, displaying a very formal attitude that can be seen as a deterrent by smokers seeking help. One official described the programme as having two parts: first advice from a general practitioner followed by advice from a psychologist. The approach is based on autogenic training and drawing on the work of Allen Carr. It is free of cost.[316] One person reported his experience at this centre as follows:

> "It was very short. The doctor said, I should put the money I would spend on smoking aside and set a goal of giving myself a real good treat – for example, buying a pair of expensive shoes. The psychologist said I should register at one of the Allen Carr seminars. I was really quite annoyed when I left because I have been reading this Carr book at least ten times over the last couple of years. It usually worked but I started again when being out with friends. Only this time it won't work, so I wanted to seek professional advice."

In the course of hospital treatment for heavy smokers with existing smoking-related disease, the "Medical Fitness Team" at the Lainz Hospital (Vienna) offers information, advice and support

[cc] Austria boosts 27 social insurance companies, headed by the Federation of Social Insurance Institutions. Health insurance is part of the social insurance system.

[dd] Karl Fagerström is closely related to Michael Kunze and Ernest Groman (see publications on smokeless tobacco).

for cessation.[317] Some efforts are also made by the Institute of Environmental Hygiene of the University of Vienna to tackle smoking in companies.[318-321]

The level of activity in other provinces varies, the most active being Vorarlberg, where cessation programmes for adults have been running since 2001. Withdrawal programmes are part of a wider health programme and are offered throughout the province. They last three weeks, with sessions twice a week. On average, each group contains ten persons; however, the courses also run with fewer participants. Following the start-up phase there is now great demand and new courses are offered twice a month. Since autumn 2003 activities have been extended into companies, in a joint effort between the occupational medicine and health care systems, and linked to a programme to tackle obesity. There has been extensive media publicity. The courses cost €100 for each client and are not reimbursed by the health insurance scheme[ee].[322]

Upper Austria has eight locations offering smoking cessation support; Salzburg, Styria, Carinthia and Tyrol one each.

The already mentioned initiative *'Ärzte gegen Raucherschäden'* (Austrian Council on Smoking and Health) provides information on smoking-related issues on its website, and the programme *Jetzt Aufhören* ("Quit Now") offers a list of participating physicians. In theory, all general practitioners should also provide advice[271] but a lack of training means that this is not common and the involvement of health professionals in cessation is very modest.

Pharmaceutical treatments for tobacco dependence

In Austria, nicotine gum, patches and inhalators are available without prescription; these products are, however, only available in pharmacies, relatively expensive and – compared, for example, to the UK – not advertised (except that pharmacies display them in their windows). Bupoprion (Zyban), however, is a prescription drug, as is nicotine nasal spray. Ideally, pharmacological and psychological interventions should be combined. However, the lack of information in Austria on either approach has created little interest in either and for Pfizer (the market leader) the Austrian market is too small to invest in extensive advertising.

8.3.6 Illicit trade, smuggling

Especially in the eastern border areas of Austria, notably the Burgenland (bordering Hungary), cigarette smuggling is reported as an increasing problem. Other border areas in Lower and Up-

per Austria (Slovakia and Czech Republic), Styria (Slovenia), and Carinthia (Italy and Slovenia) are also affected, although to a markedly lesser degree.

It is reported from Austrian officials that, over the last three years, between 60 and 80 million cigarettes have been confiscated every year in Austria and the figure is increasing by about 20% per year. Large-scale activities are an increasing problem, presently accounting for 70% of the overall volume confiscated. Approximately 90% of the confiscated cigarettes are counterfeit brands made in China, mostly destined for the United Kingdom. Only about 10% of these counterfeit brands are destined for Austria. In total, the black market share in Austria is estimated to be no more than 10%.[323] [324] More detailed information on the issue of smuggling is in Appendix P###.

8.3.7 Availability to young people

The widespread distribution of cigarette vending machines and the absence of sanctions against the sale, purchase or consumption of tobacco products to/of minors under 16 years means that children and adolescents are free to purchase cigarettes wherever and whenever they want to.

The 2003 symposium of the Austrian study group on addiction prevention in Carinthia focussed on tobacco. 120 experts demanded the establishment of a fund for addiction prevention, the drafting of a national action plan and a ban of cigarette vending machines. In October 2003, an initiative to involve tobacconists in curbing sales to children was launched and test purchases by youths have also been planned.[325] However, in addition to a brief media report in an Austrian health magazine, no reactions to these appeals from the government can be recorded.

8.3.8 Monitoring, evaluating and reporting

In the absence of effective tobacco control policies, there is little need for monitoring. There is, however, information on smoking prevalence, as reported earlier.

8.4 Examples of smoking and no-smoking policies in Austria

In many industrialised countries there is increasing concern about the health effects of passive smoking. Not so in Austria.

[ee] Except for one private complementary insurance company (UNICA) who contributes half of the cost.

The 1995 Tobacco Act, last amended in 2001 and 2003, restricts smoking in public buildings, schools and universities. The 1995 Employees' Protection Act, last amended in 2001, regulates smoking in the workplace. However, these regulations are not always adhered to. In addition, these regulations are rather weak, display considerable ambiguity, and are rarely enforced. The only area in which Austria has gone beyond the minimum required by EU law is an advertising ban in films aimed at young people (since 1995). Other films, however, are generally preceded by at least one cigarette advertisement (usually Memphis Blue). There is no clean indoor air law or any kind of regulation as to non-smoking areas in public places. Even the most recent amendments of the tobacco act contain no provisions for separated areas for non-smokers in the hospitality business.

In the area of voluntary agreement, where 'voluntary' often means the result of pressures against which opposition is no longer opportune (for example, pressure from international airlines landing in Vienna) or where economic interests predominate (for example, greater demand by non-smoking customers, or the expected reduction in cleaning costs), there have been some developments. For example, Austrian Airlines had to offer non-smoking flights and establish smoking restrictions on Vienna Airport, Austrian Federal Railways increased non-smoking compartments in trains, and smoking in underground stations has been banned since 17 April 1990 while in railway stations smokers are only asked to be considerate and kindly refrain from smoking, littering the place or annoying other people. Local public transport has banned smoking for a long time. In the restaurant business, voluntary arrangements are usually limited to non-smokers' corners somewhere at the edge of the (usually least comfortable) room, or beside a draughty entrance, or beside the door to the toilets. These unattractive areas are not separated from the smoking area and can hardly be called a smoke-free environment.

Compared with the lobbying groups from industry (tobacco, hospitality, retail, paper manufacturing, advertising, etc.), 'lobbying groups' (in Austria rather the few dedicated individuals) in the field of health are small in number, weak and not organised (health ministry, anti-smoking advocates or associations). The lack of political will to implement tobacco control measures and the strong lobbying of the Austrian tobacco industry directed at policy makers, unions and the public (via the media), means that it is therefore often more correct to speak of Austria's 'smoking' rather than 'no-smoking' policies.

Overall, despite various commitments on the international level, Austria does not fully implement guidelines of the WHO with regard to tobacco prevention and protection of non-smokers

and it even lags behind the minimum requirements of the European tobacco legislation. The following sections present some examples of why Austria is often called a smokers' paradise.

Smoke-free or smoke-full environments?

According to the 1995 smoking survey, 53% of the Austrian population aged 16 years and over are never-smokers and 17% are ex-smokers, at 70% in total representing a clear majority of non-smokers. In both cases the share of female non-smokers is even higher (total 77%). Adding the percentage of children and adolescents up to 15 or 16 years of age, those who suffer from bronchial asthma, heart disease, respiratory disease, or allergies, those who are pregnant or breast-feeding, and all those who feel annoyed or harassed by the smoking of others, this is a distinct majority of persons that should have the right to be protected from passive smoking. This figure may easily be compared to the 24% of daily smokers aged 15 or 16 years and over who claim their 'right' to smoke anywhere and anytime.[ff]

Women not only represent a higher share of non-smokers, they also report feeling disturbed and harassed by tobacco smoke more frequently *(Chapter 6; Appendix K###)* and may also be more vulnerable to tobacco smoke (when pregnant or breast-feeding), both as active as well as passive smokers *(Chapter 7; Appendix L###)*.

Despite all these facts, passive smoking and the health hazards resulting from it are not an issue of public discussion or political debate in Austria as yet, nor have they attracted any serious public health concern or great scientific interest. Where the issue is discussed it focuses on children, babies and foetuses (and thus also on pregnant women), as if these were the only ones needing protection. Although the health of children is always a politically attractive argument, it somehow diminishes the far-reaching effects of smoking on the entire population exposed to it.

Consequently, residents and 'spoiled' visitors to Austria who feel annoyed, disturbed or harassed by exposure to tobacco smoke and therefore try to avoid any contact with it will soon feel frustrated. For example, arriving at the Vienna train station in the evening, maybe after a trip in a non-smoking compartment where people just step outside to have a smoke in the gangway in front of the (sometimes open) door, the station is not only littered with discarded butts but there is smoke everywhere. Similarly when arriving at the airport one is confronted with so-called

[ff] It must be said, however, that a considerable part of smokers would not mind refraining from smoking for an hour or two.

smokers' corners every few metres.[gg] Trying to get into town, it is difficult to find a non-smoking taxi (the driver may offer not to smoke during this trip) and, longing for somewhere to enjoy a dinner or drink, one will be disappointed to find not even one smoke-free facility (with the notable exception of the American chains McDonalds and the newly introduced Starbucks). Being pregnant or in company of children or babies, or suffering from asthma or having a cardiovascular condition affords no relief. In coffee shops one can find smoking mothers beside prams and see oneself surrounded by groups of smoking teenagers (especially girls). Among the famous Vienna coffee houses, only three were found to provide a non-smoking area (although not completely separated from the smoking section) and a few provide two or three tables located so unattractively that smokers would not want them. Complaints to the waiter would not help but rather result in a rebuke about why one is here and not staying at home if one is disturbed.[hh] At one's hotel, especially if it is a smaller one, asking if a room is a non-smoking room, one will be reassured that, of course, smoking is allowed anywhere.

In Appendix Q### the present situation in Austrian public transport and the restaurant business is described in more detail.

8.5 Discussion

Over the last two decades the Austrian government has launched a few small anti-smoking campaigns and related measures to combat smoking-related disease. However, since 1995, no campaign aimed at the whole population has been launched, nor are there effective anti-smoking measures or any concept of comprehensive tobacco control. Restrictions on smoking (partial smoking bans) in public places and workplaces do exist but are rather weak, not enforced, and not always adhered to. Smoking in restaurants, pubs and bars is subject to 'voluntary agreement'. Exposure of hospitality workers has not been a concern in Austrian health policy and even pregnant employees in the hospitality business are not protected effectively by any law.

Although Austria's restaurants, pubs, cafés, discos, etc. are known to be among the smokiest among EU countries, public awareness of the harm from environmental tobacco smoke is generally very low. Smoking in public places is strongly influenced (and successfully supported by

[gg] Whenever the distance between the numerous pubs and cafés, where smoking is allowed, is too long, that is.

[hh] What a waiter in a Viennese coffee house actually said was: "People have ALWAYS smoked in coffee houses, and this will never change. If you feel disturbed by the smoke, you must not go to a coffee house." *(Chapter 9)*

the media) by associations with terms such as 'personal choice', 'one of life's joys', or part of 'good living', while smoking bans are seen as 'patronising' and 'pleasure hostile'.

Austria has not been inactive in tobacco control but, strikingly, out of all possible measures, it has chosen those that are known to be not very, or not at all effective. Apart from the Hospital Act, which has been regulating smoking in hospitals since 1974, and the regulation of smoking in public transport, all important laws with regard to smoking restrictions have only been enacted or 'tightened up' either in connection with Austria's EU entry in 1995 or because they have been required by EU law. For example, the 1995 Austrian Tobacco Act, amended in 2001 and 2003, prohibits smoking in public buildings and establishments where young people were being educated or looked after (schools, etc.). The 1994 Employees' Protection Act, amended in 1999 and 2001, intends to protect non-smokers by "technical or organisational measures", such as heightened ventilation, local smoking bans and physical separation of smokers and non-smokers, "wherever this is possible".

Since 1998, starting with an industry-funded campaign, the chosen measures have been focussing exclusively on youth campaigns, aiming to prevent the up-take of smoking by youths. The predictable failure of these small-scale, isolated and mostly unattractive campaigns is reflected in the continued and alarming increase of smoking prevalence among youth over recent years, making Austrian teenagers (especially girls) rank among top within EU countries. No efforts are put into information and support of smokers in relation to cessation and existing cessation services are few in number and often unprofessional. Accordingly, awareness of and interest in cessation is low among smokers. Furthermore, even advertisements for nicotine replacement therapy are virtually non-existent, as it is not profitable for the pharmaceutical industry due to lack of demand. Of course, demand would increase after the launch of population-wide and effective anti-smoking campaigns within a wider set of comprehensive measures.

In summary, the measures adopted to reduce smoking rates and prevent people from taking up smoking must be assessed as largely ineffective and lacking any kind of conceptual underpinning. The extremely industry-friendly approach towards tobacco policy seeks to maintain the smoker-friendly environment, a trademark Austria has long been internationally known for. As the Austrian government does not see any problem with its tobacco control policy, avoiding any unnecessary action and focusing on its meagre youth-campaigns, it may be assumed that the existing situation will continue for some time.

Having examined the initiatives to reduce tobacco consumption that exist in Austria, the following chapter examines the role of the key actors in Austrian tobacco policy and attempts to discover why some measures have been taken and others not.

9 ACTORS IN AUSTRIAN TOBACCO POLICY

9.1 Introduction

This chapter seeks to identify policy actors in Austrian tobacco policies, describing their understanding of smoking policies, determining their position, interest and influence on this issue, and identifying their inter-relationships. Discussions with key informants and key actors, analysis of media reports, and analysis of policy measures are used to analyse the role of Austrian tobacco industry and the Austrian government with regard to past and present tobacco policies. The chapter concludes with an overall analysis of Austria's tobacco policies.

The most dominant actors in Austrian tobacco policies are the national government (including several ministries: health, finance, economics and labour, sports, education, labour, and social affairs) and the tobacco industry with its main ally, the hospitality industry, but also the advertising industry. The media have been recognised to be an important opinion leader by disseminating mostly industry-friendly arguments particularly over the last two decades. Thus they have created a pro-smoking climate in the population. There are, of course, other potential actors, such as national and regional associations or organisations engaged in health promotion and tobacco control, local governments, non-smokers' associations, or other NGOs such as the Austrian Cancer Society. However, as political support is lacking and public awareness is underdeveloped, their role is very limited and their activities have had little effect on the government's tobacco control strategy. Besides, the role of some so-called anti-smoking advocates is not transparent.

In general, Austrian policy making may be characterised as the result of a close circle of persons of various interest groups, mostly well known to each other, partly cordially related as 'old pals'. With regard to tobacco policy this is expressed by displaying mutual benevolence and tolerance, and preparedness to let the other play his part in the game as long as it does not result in any disadvantages for the other party. Some of the key actors are reported to play on both sides of the field. In addition, as outlined in the preceding chapter, laws to restrict smoking are interpreted in a rather lax fashion in Austria.

Austria's tobacco policy must also be seen in the context of its overall health policies, which are characterised by a lack of consistency. Apart from the fact that the post of a Minister for Health (as with Ministers for Social Affairs) is not always the most rewarding one, being pro-

vided with a very limited budget while facing seemingly ever increasing costs, the frequent shift of the health agenda from one ministry to another and the frequent exchange of health ministers (and often also of key officials) have resulted in a lack of continuity, also seen in Austrian tobacco policies. Campaigns have been very short and have been addressed exclusively at 'politically attractive' target groups (children and youths). Since 1994, no health politician has been deeply engaged in tobacco control.

9.2 Role of Austria's tobacco policies

9.2.1 Tobacco policies in Germany and Austria in the 1930s and 1940s

Unlike Germany, where the equally strong pro-smoking climate has been explained by some by historical events, i.e. the strict anti-smoking regulations during the Nazi-era[326], Austria's reluctance to adopt any kind of enforceable law requires a different explanation. As shown in Appendix R###, these arguments are based on a misjudgement of the situation in Germany, with persisting stereotypes. While most arguments may not even be applicable to Germany, they certainly cannot be applied to the situation in Austria. However, they have entered the Austrian media and have been readily taken up by the public and, at least indirectly, by health politicians.

It is thought, however, that the cultivation of this artificial justification helps to impede an engaged tobacco control policy in Germany and Austria. The implied but unwarranted linkage of all kinds of tobacco control measures with authoritarian Nazi-methods are in the interest of the industry, which could not have found a better argument.

9.2.2 Austria's policies in the international field

In the early 1990s, in particular during the term of Health Minister Michael Ausserwinkler, Austria was reported to be among the pioneer countries at WHO talks on tobacco control. Within the Austrian government there was even a consensus about tobacco control policies. Then an order came to abstain from this pioneering role, the strongest opponents being Victor Klima and Wolfgang Schüssel *(Section 9.4)*, both representing strong economic interests.[276]

In the late 1990s, during the development of European tobacco control legislation, Austria did not exactly cover itself in glory. Loyally on the side of Germany, it voted against the comprehensive advertising and sponsorship directive (98/43/EC), which subsequently was annulled by the European Court of Justice in 2000 *(Chapter 5)*.

However, things have changed again over the last years. Being no longer opportune, Austria has not exactly changed sides but tries to refrain from developing visibility on this issue. At least it did not oppose the recent EU advertising ban, as did Germany. The reasons for this change, which took place in November 2000 with the new conservative coalition government, were very difficult to elicit, as nobody seemed to remember, it being "too long ago". Nevertheless, an official from the press office of the State Secretary of Health put it quite bluntly and showed the Austrian approach to this issue:

> *"This was so long ago, honestly, I can't remember at all… Initially we did not want to criminalise smokers. Besides, that would have been – as with all advertising bans – an enormous danger for the economy. But we promised our support in November 2000. The reason was that the hitherto strategy was unpromising."*[327]

Presently, Austria's strategy in the international arena distinguishes itself by a certain ambiguity. While one is always ready to raise its hand or sign a declaration – as long as it is noncommittal, of course – to demonstrate some sort of interest and conformity (after all, one does not want to be a dog in the manger), things look different 'at home'. As with other issues agreed upon in meetings of the European Community, there is a tendency among Austrian politicians to present Austria as the poor victim of the 'bad' and omnipotent EU who imposes all these things upon us. For example, Austria signed the Warsaw Declaration and the Framework Convention on Tobacco Control (28 August 2003), but there are no signs whatsoever of implementing any of the proposed measures. Quite the opposite, all these measures have been somewhat ridiculed and criticised for being 'too extreme' *(see later)*. The implementation of directive 2001/37/EC only took place in October 2003, after a rebuke from Brussels *(Chapter 8)*. At the same time, when necessary, Austrian health politicians do not tire from pointing to Austria's "active role" in international tobacco control committees *(Section 9.4)*.

Consequently, it would seem more correct to describe Austria not as a player but a cautious watcher in the international field of tobacco control. However, the threat posed by Ireland (whose EU presidency emphasised tobacco control) as the first country in the EU imposing a total smoking ban in all public places in March 2004 and Austria's transgression of the minimum labelling guidelines were obviously so great that Austria was shaken out of its cautious state. Again on the side of its old ally Germany and driven by the Ministry of Economics, it demonstrated its opposition to what might become exemplary for other European countries, in particular by objecting this generous interpretation of the EU labelling guidelines (which also extended to other product groups) as a technical trade barrier.[328]

9.2.3 Recent tobacco policies and policy climate in Austria

Tobacco policy has had no real priority for many years and, until recently, there has been no public debate of anti-smoking measures. Only in October/November 2003, following the introduction of enlarged health warnings on cigarette packs, and in the beginning of April, following the implementation of the Irish smoking ban, the Austrian public was aroused for a week or two and health politicians were forced to react. Some public discussion started, mostly expressing dismay or and lack of understanding of these exaggerated measures, but things soon returned to normal.

Before attempting to give an overall analysis of Austria's tobacco policies, the key actors and their roles in the decision-making process are described in the following section.

9.3 Actors and their roles in Austrian tobacco policy

The key actors in Austrian tobacco policy have been listed earlier and include the Federal Government with various ministries and the Austrian tobacco industry with its economic allies (in particular the hospitality and the advertising industry). In a wider sense, one would also have to add the seemingly industry-influenced Austrian media for disseminating mostly smoker-friendly opinions and, in the sense of a conspicuous abstinence from action, some self-proclaimed anti-smoking advocates. The public, or rather, public opinion, is another important influential factor for political decision-making.

The core group of actors, consisting of representatives of the government and the tobacco industry as well as some opinion leaders and former government consultants, is characterised by a small and often very close circle of individuals, despite their allegedly different interests. Information as to the kind of relationships of these key players was very difficult to elicit as policy-oriented questions were directly or indirectly declined; in one case the researcher was given to understand that it would be better for her "not to play the detective" (as it proved, a well-founded concern). However, from what is known and has been confirmed by informed circles, most actors have been personally, economically, or party-politically related for a long time, sometimes very closely, and sometimes even so closely that it has become difficult to determine on which side they operate. In the course of searching industry documents, evidence was found that substantiated rumours about "financial incentives" for obliging scientists and self-

proclaimed opinion leaders. However no firm evidence could be found concerning party donations given by the Austrian tobacco industry.

On the other hand, although not answering all questions put to them, the 'good citizen' *Austria Tabak* – following the new approach by the industry, defined by 'communication with society' and 'social responsibility' – was rather compliant in providing information, after enquiring about the purpose these data are needed for and details of the thesis (name of University and supervisor).[a]

Without expecting Austria to come up with many high-calibre anti-smoking activists to engage in tobacco policies on the highest political level such as, for example, the *cinq sages* in France[141], the overall climate in Austrian tobacco policy is a self-righteous consensus, accentuating the tolerance in Austria and the "good conversational basis" between all parties concerned. Certainly, nobody would embark on a collision course on either side.

To provide a better understanding of the decision-making process in the government, the most influential key player, the tobacco industry with its allies, will be presented first.

9.3.1 Austrian tobacco industry and allies

Austria's tobacco industry consists of the until recently state-owned tobacco company *Austria Tabak* (now *Austria Tabak – Gallaher Group Plc*); its subsidiary *Tobaccoland Austria*, and the representation of Austria's tobacconists, *Monopolverwaltung GmbH* (Monopoly Administration Ltd.). Incidentally, the laboratory ÖKOLAB, which has been commissioned by the Austrian government to control the constituents of tobacco (in particular cigarettes) is also a subsidiary company of *Austria Tabak* (although, curiously, this fact seemed to be 'unknown' to all health politicians and government officials questioned).

In a confidential 1979 Philip Morris report one can read about the "good access" of the Austrian tobacco company to "all of the media, prominent scientists and MDs *[medical doctors]* and members of government and parliament"[104]. Although there are some changes since the privatisation of the company, the "good relationships" between all parties are maintained.

Research on smoking and health has been supported by the Austrian tobacco industry for many years (as reported by M. Kunze, already in 1974[329]) and the influence of the Austrian tobacco

[a] Interestingly, the only others that asked these questions were three leading so-called anti-smoking advocates, two of whom were subsequently too busy to find time for a meeting.

industry on the government's policies has been known to be very strong. Top representatives of *Austria Tabak* have always been involved in governmental discussions[276] (in particular with regard to regulations on taxes and prices, but in some cases also in the planning stage of campaigns[b]). Even today, the tobacco company, the hospitality industry and the advertising industry are seen by politicians as the main parties the government would have to 'negotiate' with in relation to any move on smoke-free environments.[297]

The Austrian media have been equally influenced. Being a very important advertiser, the company has been using the Austrian media for both indirect advertisement[c] and dissemination of industry friendly arguments *(Section 9.3.8)*.

Austria Tabak has also been known for its very high advertising expenditure on smoking campaigns (thus creating economic allies in the advertising business) and sports sponsorship (acquiring allies in sports clubs, in particular football clubs; Formula One; presently also sponsor of the Austrian Ski Team).

Beppo Mauhart, General Director of *Austria Tabak* before privatisation, has certainly been the most striking figure in the history of the company, its advertising strategy and, in particular, its close involvement in all tobacco-related activities of the Austrian government. Prior to his career in the tobacco business, Mauhart, an economist, was employed in the Ministry of Finance (1970-1972), working as secretary of the then Finance Minister (and later Vice-Chancellor) Hannes Androsch, the latter known as the 'crown prince' of Chancellor Bruno Kreisky. In 1972, he was appointed to the Board of Directors of *Austria Tabak* (then *Austria Tabakwerke AG, ATW)*. In 1976, he became Vice Chairman and between 1988 and 1995 (under Federal Chancellor Franz Vranitzky) he was Chairman of the Board (General Director). He has always maintained strong party-political ties and close personal relationships to senior members of the Austrian social-democratic government (in particular to his former colleagues Hannes Androsch and Franz Vranitzky) and has been noted for his "excellent lobbying".

In addition, while directing the Austrian tobacco company, sports enthusiast Mauhart was also President of the Austrian Football Union between 1984 and 2002. Accordingly, *Austria Tabak* was (and still is) a main sponsor for sports clubs (in particular football clubs) and sports events.

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b As, for example, was the case under Health Minister Christa Krammer (SPÖ).[330]

c Recent examples for indirect advertising can be seen in an article in the economic section of the *Kurier*, the second most sold daily Austrian newspaper, where new "cigarette creations" (the two new brands *Silk Cut Ultra* and *Silk Cut Ultra Mild*) and the economic success of the Austrian tobacco company are elaborately praised[331], or in the cover story of the Austrian news magazine Profil[264] *(Section 9.3.8)*.

Still today, Mauhart prides himself on the 144 international matches played under his presidency.[332]

Beppo Mauhart was very skilful in marketing not only cigarettes, but also his person, having millions of Austrian Schillings of advertising budget at his disposal. There was hardly a beauty contest, a private art viewing, a football game, or a high society meeting where he did not appear as *'Mr. Tschick'* (Tschick = fag). He has had excellent relationships with opinion leaders in the media, these being permanently strengthened by generous advertisements by the tobacco company. His power has become much greater than the Health Minister's and his influence was noticeable in all public decisions. In 1992, with the war in Yugoslavia, another component of his power, this time of a social nature, was added: the Austrian tobacco company supported the initiative *'Nachbar in Not'* ('Neighbour in Distress') by sponsoring ten lorries. This led to television portrayal of him as a benevolent sponsor, an effective contribution to indirect advertising. Mauhart's connections even reached into Austrian justice *(Footnote j unterhalb~~j below~~)*.[333]

Still today, despite his resignation almost ten years ago, Mauhart has been invited to television discussions on anti-smoking *(sic)* measures[d] as *the* "advocate of smokers", *the* representative of the Austrian tobacco industry, and *the* expert in anti-smoking policies par excellence. As his statements clearly dominated both discussions, they will be presented in Section 9.3.8 and Appendix V###. In February 2004, he was awarded by the head of the provincial government of Lower Austria, Erwin Pröll, "one of the highest awards the province of Lower Austria has to offer". Mauhart, so Pröll said, had "used his talents in all his functions in economy and sport", thus making tremendous achievements for Lower Austria.[e] The celebration was attended by numerous friends, including sports journalists, former national football players, and politicians.[332]

For years Beppo Mauhart maintained the industry position that tobacco advertising did not target young people but only supported the maintenance of market shares and helped people (people, not only smokers!) to choose less risky cigarettes. He also argued that in countries with an advertising ban tobacco business had actually increased and that, without smoking, much worse dependencies (drugs) would occur, an argument which effectively has become ingrained in public opinion. The Austrian media have continuously repeated these views. Even health politi-

[d] One following the introduction of enlarged health warnings in November 2003, the other following the implementation of the smoking ban in Ireland in March 2004 *(Section 9.3.8)*.[37 38]

[e] Pröll referred to Mauhart's merits as General Director of *Austria Tabak* for securing one of its sites in an economically particularly weak region and his function as president of the Austrian Football Union, for sponsoring the Lower Austrian football association.[332]

cians and economists are influenced by this 'sound' argument. The "confrontation" between smokers and non-smokers has therefore been created systematically. Besides, the fact that Austria's tobacco policy has more or less been unchanged since the 1970s is a visible result of this underlying paradigm.[333]

As already noted in Chapter 3, *Austria Tabak* (under Beppo Mauhart) even published a brochure[f] for its employees on arguments on smoking and health in 1982, destined for the company's employees as "balanced information" and an "argumentation basis" for "talks with friends and acquaintances, in discussions" (including rules for conducting talks to achieve a "controlled dialogue"). Apart from many arguments, often based on "scientific proof"[g] which can still be recognised in public opinion and which were still used by Mauhart in TV discussions,[h] the focus of this briefing is on the responsibility of the firm to develop and sell "the modern, light cigarette".[71] The reader is also reminded repeatedly that all this is a matter of tolerance – or rather: the problem of intolerance from the part of non-smokers[i] – and, of course, good ventilation:

> "As two scientists from Harvard University, USA, were able to show, it was necessary to spend 100 hours without interruption in a smoky bar in order to breathe the smoke contents of one single filter cigarette. Thus if smokers are together with non-smokers who feel troubled by the smoke, this becomes a question of mutual consideration and tolerance (and of ventilation). Smokers and non-smokers (as distinct from fanatical anti-smokers) can get along together very well. Both sides should make efforts not to allow walls to be erected between them, with every conceivable type of decree and regulation."[71] [j] *[Orig.l translation]*

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[f] A special edition of the internal news magazine *Austria Tabak Information.*

[g] By citing, for example, Ernst Wynder, Peter Lee (the statistician working together with Richard Peto) and Michael Kunze.

[h] Arguments: Tobacco would be a luxury good like tea or coffee, every culture would possess its specific stimulants and their consumption would be something specifically human, the sum of all vices would remain constant, cigarette smoking being described as "pure enjoyment" which would be "difficult to describe" but had "undeniably positive effects", no "chain of causality in the strictly scientific sense between cigarette smoking and illness", all being a "question of mutual consideration and tolerance (and of ventilation)", distinguishing "tolerant" non-smokers versus "fanatical anti-smokers", freedom to decide whether, "to improve the quality of life", "adult and articulate people in this country" should "continue to consume a stimulant that for centuries has been a component of our civilisation".[71]

[i] To illustrate the importance of tolerance against the "dealers in anxiety" (fanatical anti-smokers), the Austrian-American psychiatrist Professor Friedrich Hacker is cited with a remarkable insight: "The psychoterror of everyday life is from us and in us. The infectious bacillus of intolerance contaminates our environment and poisons our interior world with horrifying images of anxiety". [71]

[j] To demonstrate the futility of smoking restrictions, it is continued with the following example from the United States: "In Seattle, USA, for instance, two restaurants introduced non-smoking zones. After one month, 9,389 meals had been served in the smoking zone and only 21 in the non-smoking zone. In another, out of 17,421 customers, only 23 asked to be separate from smokers."[71] Without wishing to comment on this "example", one is reminded to the present situation in Austria: As hardly any non-smoking zones or rooms are offered, nobody asks for them and those who ask are soon discouraged by the way the answer is given *(see later)*.

An appeal, apparently only for heavy smokers, is made to be "particularly considerate in the presence of small children and asthmatics, or in rooms that are difficult to ventilate (e.g. lifts or similar spaces)".[71]

This "active part in the smoking-related issues" of *Austria Tabak* – despite its sometimes "unorthodox" views – was positively mentioned at the Infotab meeting in Bath 1983. The reference also indicates the opposition against Health Minister Salcher's efforts to ban advertising *(see later)*.[k]

> The Austrian Tabakwerke "has taken an active part in the smoking-related issues and strongly defended its position in a National Assembly resolution of July 3, 1980 to ban advertising. It has also produced a guide to the smoking and health question for its employees.
> …
> "The monopoly's views on certain smoking-related issues are unorthodox and would be rejected on legal issues by INFOTAB members. Nevertheless, interest in the basic issues is quite strong."[105]

Hospitality industry

As in most other countries, the hospitality industry in Austria has been a close ally to the tobacco industry. Successfully convinced by the tobacco industry that smoke-free environments would ruin business, and in turn successfully convincing politicians of a dramatic economic impact on the state, both Austria's hospitality industry and politicians are strictly opposed to any kind of legal smoking restrictions in public places such as restaurants and cafés. Arguments are directed towards "voluntary agreements" and the installation of "good ventilation".

Industry-funded associations

The Austrian representative of Forces International, "*Verein der Toleranz* (Association of Tolerance) – Forces Austria" advertises itself as a smokers' rights group, fighting the "criminalisation" and "discrimination" of smokers[l] through a possible future threat of smoking bans in restaurants and bars "even in Austria". The arguments made are either similar to those from the anti-smoking side (e.g. ignorance of smoker-friendly articles in the one-sided, i.e. non-smoker-friendly media – *sic*) or consolidate the confrontational image of smokers and non-smokers by using militant language. It accuses the EU of having an economy-devastating approach, the

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k This reference provides also information on the contacts between INFOTAB, the Verband (of which *Austria Tabak* was a member) and the monopoly. "Indirect contacts between INFOTAB and the Austria Tabakwerke have been made via the Verband, and informal direct links through Dr. Zimmel, the Public Relations Manager." It was felt desirable that "more regular informal contacts should be developed with Dr. Zimmel either directly or through the Verband". [105]

l Interestingly, the terms "criminalisation" and "discrimination" of smokers seem to be very popular among both industry representatives and health politicians.

"ever so respectable" WHO of manipulating the public, "probably in the interest of the pharmaceutical industry", and dwells on causes with "much greater" risks of dying, such as alcohol, HIV, and road accidents. Not missing the opportunity, it also hints at a certain fanatic leader in the past and the association between anti-smoking measures and a totalitarian state: Between two pictures of Albert Einstein (or someone who looks like him) the big slogan says: "Better a smoking freedom than a non-smoking tyranny".[m]

Smoking bans in restaurants and bars are seen as a particular threat to both "freedom of choice" of the smoker and the economy. According to this propaganda, "numerous bankruptcies and loss of employment for many" are to be feared.[334]

9.3.2 Government, ministries, governmental organisations

The government and its various ministries with their respective representatives is the official key actor in Austrian tobacco policy. The ministries most involved in the decision-making process are the Federal Ministries for Health, Finance (taxes and shares), Economics (hospitality industry and various other economical interests), Education (schools), Labour (employees' protection), and Sports (sponsorship).

Federal Ministry of Health

For the first time in 1972, a ministry dealing with the health agenda was established, named the Federal Ministry of Health and Environmental Protection. However, it was only 15 years later that a separate Minister was allocated the health agenda (1987-1990). This represents a notable exception as, since then, matters of health have always been associated with social or environmental affairs. In fact, the Ministry has changed names more or less after every election, being attached to various other ministries *(Table 9.1~~Table 9.1~~)*. In 1997, the Health Ministry was dissolved entirely and most of its responsibilities were taken over by the Ministry of Social Affairs. It is only since 1 May 2003 that there has again been a separate health ministry, called the Federal Ministry for Health and Women.

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Over this period, numerous health ministers have appeared on and disappeared from the scene. With a few exceptions they usually held their office for a short term, sometimes only for a few

[m] Citation: "Due to current political manipulations (in particular by the economy-destructive EU) and the present 'witch hunt' against smokers, the VdT *[Verein der Toleranz]* as the Austrian Club of 'Forces International' has determined to work in the future! Fortunately, most people, including non-smokers, are tolerant! Only, unfortunately, there are a few fanatics who can make a lot of noise and probably even bribe politicians *[sic]* – but democracy has something to do with majority and the majority in Austria, for example, is against any smoking bans, particularly in the hospitality business."[334] *[Translation by author]*

months *(Table 9.1~~Table 9.1~~)*. This and the fact that it is one of those ministries which in coalition governments are usually given to the less powerful party (or to female ministers), reflects not only its unpopularity but also its low status. The position of the Health Ministry is also characterised by its having to stand up to the interests of other ministries (particularly the Ministry of Finance and the Ministry for Economics). In addition, these frequent changes contribute to the lack of continuity within Austrian health policies in general and tobacco policies in particular.

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Table 9.1 Austrian Health Ministers since 1972 (status April 2004)

Name of Minister	Political party	Term of office from		to	Duration of term	Name of Ministry
Dr. Ingrid Leodolter *(physician)*	SPÖ[1]	2. 2. 1972	–	8. 10. 1979	6 years, 8 months	Federal Ministry for Health and Environmental Protection (1.2.1972 – 1.2.1989)
Dr. Hertha Firnberg *(social history & history of economics)*	SPÖ[1]	8. 10. 1979	–	5. 11. 1979	1 month	
Dr. Herbert Salcher *(jurist)*	SPÖ[1]	5. 11. 1979	–	20. 1. 1981	1 year, 3 months	
Dr. Kurt Steyrer *(physician)*	SPÖ[1]	20. 1. 1981	–	17. 12. 1985	3 years, 11 months	
Franz Kreuzer *(TV journalist)*	SPÖ[1]	17. 12. 1985	–	21. 1. 1987	1 year, 1 month	
Dr. Marilies Flemming* *(jurist)*	ÖVP[2]	21. 1. 1987	–	31. 3. 1987	2 months	
Dr. Franz Löschnak *(jurist)*	SPÖ[1]	1. 4. 1987	–	2. 2. 1989	1 year, 10 months	
Harald Ettl	SPÖ[1]	2. 2. 1989	–	3. 4. 1992	3 years, 2 months	Federal Ministry for Health and Public Services (2.2.1989 – 1.2.1991)
Dr. Michael Ausserwinkler *(physician)*	SPÖ[1]	3. 4. 1992	–	17. 3. 1994	2 years	Federal Ministry for Health, Sports and Consumer Protection (1.2.1991 – 12.3.1996)
Dr. Christa Krammer *(political science)*	SPÖ[1]	17. 3. 1994	–	28. 1. 1997	2 years, 10 months	
						Federal Ministry for Health and Consumer Protection (12.3.1996 – 15.2.1997)
Eleonore Hostasch	SPÖ[1]	28. 1. 1997	–	3. 2. 2000	3 years	Federal Ministry for Labour, Health and Social Affairs (15.2.1997 – 1.4.2000)
Dr. Elisabeth Sickl *(study of law and high school teacher)*	FPÖ[3]	3. 2. 2000	–	24. 10. 2000	9 months	Federal Ministry for Social Security and Generations (1.4.2000 – 1.5.2003)
Herbert Haupt *(veterinary surgeon)* and State Secretary Dr Reinhart Waneck *(radiologist)*	FPÖ[3]	24. 10. 2000	–	28. 2. 2003	2 years, 6 months	
Maria Rauch-Kallat *(secondary school teacher)* and State Secretary Waneck, *FPÖ*	ÖVP[2] FPÖ[3]	28. 2. 2003	–	dato		Federal Ministry for Health and Women (since 1.5.2003)

* Consigned to the direction.

1) SPÖ = Social Democratic Party of Austria.
2) ÖVP = Austrian People's Party.
3) FPÖ = Freedom Party of Austria.

Source: Information from the Austrian Health Ministry.

Two Austrian health ministers have been very interested and active in tobacco policies, despite their short term of office. These were Dr Herbert Salcher (a jurist from Innsbruck/Tyrol) and Dr Michael Ausserwinkler (a physician from Klagenfurt/Carinthia). The first Austrian Health Minister, Dr Ingrid Leodolter, has tried to promote anti-smoking legislation but without success. A 1979 Philip Morris report described her as "a weak politician and her policies are in conflict with those of the Minister of Finance, Mr. H. Androsch, who is also in charge of the Austrian tobacco monopoly".[104] It was also clear that anti-smoking legislation would require a change in the Constitution and thus the legislative situation remained unchanged until 1995.

Herbert Salcher, Austria's Health Minister for just over a year (November 1979 to January 1981, SPÖ), started the first Austrian anti-smoking campaign in 1980. He gathered a young team around him, consisting of scientists (Michael Kunze), a popular radio speaker (Rudi Klausnitzer), artists and athletes and secured strong media support by keeping up intense contacts to print, radio and television journalists.[304]

In the discussion Minister Salcher seemed unaware of the double-role of Michael Kunze, appreciatively describing him as a "publicity genius" and the first expert in this field, taking health education seriously.[304] At that time, Kunze seemingly already received funds from the Austrian and German tobacco industry *(Appendix U###)*. Thus he was not only a "publicity genius" but, by working for both sides, also economically and tactically very clever *(Section 9.3.3 and Appendix U###)*.

Objecting to any kind of prohibition or an aggressive campaign "spreading horror", as in other countries, Salcher and his team wanted to initiate a campaign against smoking, not against smokers, thus promoting a positive image for non-smokers.[335] Designed as a whole programme or package, this campaign should be a first, psychological step to create awareness and gain the consent of people.[304] Results of studies which accompanied the campaign showed that – as a short-lasting effect – smoking rates among men declined slightly while rates among females increased.[304] Nevertheless, considering the short term of the Health Minister and the very short time of this campaign (only about 6 weeks), this initiative was very successful *(Chapter 8 and Appendix O###)*.[a]

[a] Thus already in 1980, when the first anti-smoking campaign was launched, concerns were expressed about increasing smoking rates among young people, especially among young women. However, although the Health ister already pointed to the health hazards and the harassment of passive smoking in 1980, emphasising that non-smokers had to be protected, it took another 15 years to adopt the Tobacco Law with at least a few weak regulations.

Although Salcher welcomed the then emerging trend for 'light' cigarettes, which were reported to be less harmful, from a health policy point of view, he objected to a proposal from the then *Austria Tabakwerke* to conduct joint action in support of 'light' brands. In his opinion, smoking had to be combated at its roots; 'lighter' smoking, so Salcher argued, would not lead to anywhere and, in accordance with the Surgeon General's Report, a 'healthy' or 'safe' cigarette could not exist.[336]

Salcher also proposed warning labels on cigarette packs, a proposal continued by his successor, Kurt Steyrer. However, the latter could not stand up to the various interest groups and thus the thread was lost.[304]

Another element in Salcher's anti-smoking campaign was the fight against cigarette advertising, an effort which seemed quite promising at the beginning. However, the Austrian tobacco company with its then General Director Deputy, Beppo Mauhart, beginning to feel a kind of 'stiff breeze', soon took steps to stop this. A National Assembly resolution regarding a whole package of measures, including warning labels, advertising bans, etc., was declined – by only one NA member: Hannes Androsch, then Finance Minister and official representative of the Austrian tobacco company. This success for the company was even appreciated in a senior executive meeting of the international tobacco industry[105] *(see citation in Section 9.3.1)*.

It is noteworthy that, according to the Health Minister in 2004, this advertising ban was only thought as a basis for discussion. Like later Franz Löschnak, Salcher had been convinced that an advertising ban would not have been feasible because of the German magazines and newspapers being distributed in Austria. "We did not want to be at war with all newspapers".[304]

Although Chancellor Bruno Kreisky (SPÖ) was in accordance with Salcher, he needed an assertive Finance Minister and thus the term of office of the Health Minister was rather short. However, under Salcher's office as Finance Minister and thus representative of *Austria Tabak*, Mauhart did not ascend to the position of a General Director. Salcher had chosen Leidinger who was considered a better option for the company, where "one would not need a trouble maker". It was only when Franz Vranitzky, a close friend of Mauhart, came to power that the latter became General Director of *Austria Tabak,* in 1988.[304]

Still, due to the weakness of subsequent Health Ministers, Kurt Steyrer[b], Franz Kreuzer, Franz Löschnak, and Harald Ettl (all SPÖ), Beppo Mauhart had no more obstacles to his advertising strategy which became more and more aggressive under his reign. None of the health ministers undertook any serious attempts to restrain the 'Tobacco General' during his hegemony. It was Michael Ausserwinkler (1992-1994) who had the courage to step up. As a physician he knew the issues but as a politician he lacked allies. Even his own party friends helped to strip down his planned comprehensive tobacco law *(see later)*. Finally, Chancellor Franz Vranitzky (SPÖ) declared: no tobacco advertising ban, no sanctions, and everything to remain more or less the same. This was a clear victory for Beppo Mauhart and the Austrian media.[333]

In 1988, although the potential health hazards from passive smoking were already known for many years (at least in informed circles), Health Minister Franz Löschnak (SPÖ) still seemed unconvinced.[c] He initiated a scientific meeting to ask whether passive smoking would indeed cause any health risks. This was the so-called *Passivraucherenquete* (Passive Smoking Hearing) *"Krank durch Passivrauchen?"* ("Ill by passive smoking?"), held on 3 May 1988. This meeting was not only sponsored but also participated in, influenced and, in fact, organised by the Austrian tobacco company, as several industry documents show *(Appendix S###)*. [338 339]

Participants were mostly known for their industry-friendliness or 'harmlessness', some even have been working for the industry for many years (as, for example, Wynder, Überla, Adlkofer, etc.). Participants came also from the Austrian tobacco company (General Director Beppo Mauhart and the head of the company's research unit, Dr Klus, who was also one of the speakers). Speakers and participants were proposed or approved by the tobacco industry (i.e. *Austria Tabak* and Philip Morris). Most of the industry-proposed speakers came from Germany and the United Sates. Among the Austrian experts were Michael Kunze and Christian Vutuc *(Appendix S###)*.[d 338 340]

Not surprisingly, the results of this meeting, as presented by Löschnak to the press shortly afterwards, were poor: there was no proof of anything, and therefore one could do nothing (or hardly anything) against the harassment of non-smokers. The scientific methods would not yet be elaborate enough to assert a relationship between diseases and passive smoking, so said Lö-

[b] In 1988, the former Health Minister Kurt Steyrer was also chosen by *Austria Tabak*, the real organisers (behind the scene) of the Passive Smoking Hearing, to preside the hearing on the side of Health Minister Löschnak.

[c] Already in 1987 Health Minister Löschnak's statements with regard to passive smoking, smoking bans, etc. seem to anticipate the findings of the hearing taking place one year later *(see Appendix S ###)*.[300 337]

[d] It was not possible to obtain a full list of participants (or any detailed information about this meeting) from sources in Austria. The Philip Morris archive, however, proved more successful. *See Appendix S###.*

schnak. However, at the symposium itself some scientists seemed to be of a 'controlled' different opinion. Agreement was only achieved about the issue of dangers for unborn babies and children. It was recognised that children of smoking mothers had a higher risk of premature birth, a lower birth weight, and are more susceptible to bronchial diseases and pneumonia in their first year of life. Infants and employees would have to be protected from tobacco smoke. Asked if he would set an example within his own department, Löschnak replied smilingly to the horde of puffing journalists that, at the next press conference, he would hang up a poster advertising the protection of non-smokers. This, so Löschnak said, should demonstrate that "one just could not regularise and execute everything". Löschnak would only become active against the smoking rooms in schools, whose existence were heavily criticised by many participants at the symposium. However, returning to the usual Austrian attitude, should it not be possible to disestablish the smoking rooms, one would at least launch an educational campaign in the schools.[341] (Obviously, it was not possible, as it was only in 1995 when smoking rooms in schools were abolished by the Minister of Education, Erhard Busek (ÖVP). The first youth campaign was initiated in 1990.) Löschnak also promised that health warnings on cigarette packs would be enlarged.[341-345]

Mauhart spoke of this meeting (where the "presentations and discussions went as expected"[339] and which thus was a success from the viewpoint of industry) of a confrontation of "speculations and real scientific results", recognising only those results as 'scientific' which were not disadvantageous for the tobacco industry. The industry (with the aid of these well-known experts) tried to prove that "all this would not be as bad" and at worst apply only to some individuals with a tobacco allergy or an impaired cardiovascular system. And, if a problem at all, for the majority of non-smokers smoking would be a minor issue. These tactics, spreading uncertainty about the harm of passive smoking, have been successful for a very long time. Non-smokers thus did not find an ally in Health Minister Löschnak.[341] A more detailed description of this hearing and the events around it can be found in Appendix S###.

In 1990, Health Minister Harald Ettl (SPÖ) initiated the first youth campaign with the vacuous slogan "smoke off" *(Appendix O###)*. At that time, 'negotiations' about health warnings on cigarette packs and bill boards were still underway with the then *Austria Tabakwerke* (following a proposal by Parliament in autumn 1989).[293] Ettl mildly criticised the tobacco company for their indirect, subtle advertising scheme, which appealed to unconscious needs of youths, being "good from a technical point of view but problematic for health policy". He even warned the tobacco company 'with a raised forefinger' that, if negotiations with the company about its

aggressive advertising strategy and the application of health warnings should be unsuccessful, the health commission of the National Council would deal with it and "might draw close to a total advertising ban", including indirect advertising, such as chocolate cigarettes under popular brand names.[346]

This, however, was certainly no threat for the tobacco industry, and not even a preparation for the 'shock' still to come.

In 1993, the Minister of Health, Sports and Consumer Protection, Michael Ausserwinkler (1992-1994, SPÖ), issued a draft tobacco act which ushered in a total ban on advertising to begin in 1996, along with severe penalties for the import of strong cigarettes. The draft law was subject to harsh criticism and was among the main reasons that led to the departure of the health minister in 1994.[269 276]

As reported in the telephone conversation with the former health minister in February 2004, reactions to these first drafts were quite extreme. They caused massive resistance particularly from parts of the coalition party ÖVP, in particular from the then Minister of Economics and now Federal Chancellor Wolfgang Schüssel, though not from the two ÖVP-spokesmen on health. However, even elements of his own party (SPÖ) were against this law. The strongly influenced workers' council of *Austria Tabak* was threatened with unemployment in the industry. The issue of an advertising ban was even discussed in the parliamentary committee, although eventually leading to agreement between the two coalition parties, SPÖ and ÖVP, to proceed. However, shortly afterwards, a proposal came from the conservative party that, to prove the effectiveness of cigarette advertising, an advertising psychologist had to be consulted. Ausserwinkler agreed, not knowing that the same expert had also designed the advertising strategy of *Austria Tabak*.[276]

Reactions even came from an obviously deeply troubled Germany. Volker Hauff, the then president of the *Deutscher Zeitungsherausgeberverband* (newspaper editors' association of Germany) and former German Minister of Sciences, whose relationship with the tobacco industry was later exposed by the magazine *Stern*[347], paid a personal visit to Ausserwinkler, threatening that, if the health minister succeeded in enforcing this law, he would have to face "strong adverse winds" from the international press.

Ausserwinkler also initiated a population-wide campaign *(Appendix O###)*, primarily aimed at facilitating the passage of the tobacco act. Reactions to this campaign were equally strong.

Beppo Mauhart, General Director of the Austrian tobacco company and President of the Austrian Football Union, felt personally offended. Michael Ausserwinkler, being Minister of Health, Sports and Consumer Protection, was threatened that football clubs would receive no more money from the tobacco company (the main sponsor) and the clubs were instructed accordingly. Being a most influential force in the parliamentary party (SPÖ), Mauhart also campaigned against Ausserwinkler within the party. In particular, the axis of Androsch and Mauhart, friends and former colleagues in the Finance Ministry *(see above)*, was most active in opposing the health minister's plans, resulting even in personal disparagements. In a written dedication in a biography about Beppo Mauhart on the occasion of the latter's 60th birthday[e], Hannes Androsch tried to portray Michael Ausserwinkler as a ridiculous figure.[276]

Given the willingness of the Austrian tobacco industry to spend 20 times as much on one cigarette campaign, these reactions to a small campaign, which was no competition to the massive campaigns of *Austria Tabak*, seem quite exaggerated, but obviously expose the tobacco industry's and their allies' fears of possible damaging effects and the threatening effects of even small and 'harmless' campaigns. One could assume, therefore, that the tobacco industry has been more aware of the effectiveness of anti-smoking campaigns than most public health politicians have ever been.

Equally vocal reactions followed the Health Minister's proposal for smoke-free environments in restaurants and cafés, a political issue raised for the first time in 1992 *(Appendix Q###)*.

To cap it all, Michael Ausserwinkler also proposed allocating tobacco taxes to anti-smoking activities – the informally named *"Rauchermilliarde"*, indicating the approximately ATS 1 billion to be raised by the proposed extra charge of 50 Groschen (€0.04) on every pack of cigarettes. These funds should have been transferred to the Fund for a Healthy Austria to finance therapies and anti-smoking campaigns. However, due to strong opposition (economists argued that this measure would promote inflation), this initiative could not be realised.[276] Although tobacco taxes have been used for funding general health promotion activities for many years now, these funds have never been related specifically to any anti-smoking activities *(Chapter 8)*.

[e] The title of this biography is: *Politik, Tabak und 60 Jahre* (Policy, Tobacco and 60 Years), edited by Hans Dibold, the known editor of various general and special gourmet guides *(Appendix Q ###)*, including, for example, the European Cigar Cult Journal ("The Journal for Fine Smoke & Savoir Vivre").

Finally, increased pressure led to the health minister's removal to Carinthia in March 1994. Only with EU accession in 1995, when action became necessary, a much weakened, minimal version of the original tobacco law was passed by Parliament.[276] The new law only included partial advertising restrictions and despite two amendments in 2001 and 2003, no major changes have been made *(Chapter 8)*.

After Michael Ausserwinkler, a long silence on tobacco policies followed, regardless of which of the three political parties held the health portfolio, with all dreading the political unpopularity and destiny. Health Minister Christa Krammer occasionally commissioned studies on the effects of passive smoking but apart from the brief and very low-budget repetition of Ausserwinkler's campaign in 1995 nothing happened.

The present Health Minister, Maria Rauch-Kallat (ÖVP), has transferred all smoking-related issues to the State Secretary of Health, Dr Reinhart Waneck (FPÖ).[f] Apart from the obligatory and well-known phrases expressing concerns about alarmingly high and rising smoking rates among Austrian youths and the necessity to tackle this problem by youth campaigns, no other measure has been proposed by the Health Minister. Presently, even the youth campaigns of the Ministry are more or less confined to the minimum expectations from EU-wide campaigns *(Appendix O###)*. Particularly after the introduction of the Irish smoking ban, Austria's tolerant approach based on "voluntary agreements" has been emphasised by both the Health Minister and the State Secretary. The Health Minister occasionally announces that "steps will be taken", but as yet implementation is lacking. In a recent television discussion following the Irish smoking ban, the Health Minister emphasised that one has to proceed against smokers moderately, i.e. "with the right measure" *(Appendix V###)*.

More recently, in particular following the discussion after the introduction of the Irish smoking ban, the Health Minister announced an intention to "rigorously fight" smoking in the workplace with existing laws to be enforced, and with pressure on the hospitality industry for voluntary agreements on more non-smoking areas. During the summer, she would like to develop a bill in co-operation with the Ministry of Economics *(sic)* to be presented in autumn 2004 before agreed upon in parliament.[348]

When occasionally citing the Health Minister for her "courageous" stepping up for the protection of non-smokers, the name of her "forgotten" predecessor, Michael Ausserwinkler, who had certainly tried with more commitment, has never been mentioned. Again, this follows an appar-

ent scheme in Austria that whatever concerns tobacco policies is treated as something new or unique – and, as it is with new things in Austria, these should not be rushed.

The State Secretary, who is also president of the Fund for a Healthy Austria, is (or was[g]) in charge of all addictive drug-related issues. Although frequently making public statements on the health hazards of smoking, referring to the burden of disease and loss of years of life, he is strictly opposed to any kind of ban or restrictions in public places or to tax increases on cigarettes. Even in the field of public health, tobacco control measures which have been found to be effective elsewhere are seen as 'unnecessary' in Austria, where things are handled on a 'voluntarily' basis, being otherwise too 'authoritarian' and an undue interference into people's life. He (and his office) speak repeatedly of not wanting to "criminalise" smokers. Measures should not be "rushed" but taken step by step – and stopped again as soon as one could see an improvement *(sic)*, so people would no longer be patronised. Both he and the Health Minister emphasise that "strict laws" already exist and it would be enough if these were adhered to. Whether deliberately or unknowingly, both politicians have been using the phrase "it is not allowed to smoke publicly" in this connection, thus mixing up smoking in public buildings and public places. This mistake is repeated by the print media.

The worst thing, so Waneck argues, would be to be puritanical on this issue. There is a clear 'Yes' to curbing measures and making access more difficult, but no need to "throw the baby out with the bathwater". As with alcohol, everything should be done in moderation.

> *"If you do not smoke more than 3 cigarettes per day, you will never stand out as a smoker, also from a health point of view."*[287]

According to an interview with the State Secretary by the newspaper *der Standard*, the reason for his strict opposition to smoking bans in public places is the protection of youths: By pushing them out from the bars in the street one would bring them closer to drugs *(sic)*. He continues:

> *"Health also means not to drink alcohol and not to go to McDonald's… If we prohibit smoking in restaurants and bars, we would also have to prohibit alcohol because this is at least equally damaging… One can forbid nobody to be or to get ill."*[349]

The principal problem facing any legal measures, so Waneck contends, would be the shared competences of various Federal Ministries (Economics and Labour, Finances, Health, Social Affairs, Education). Many decisions would also be the responsibility of the Länder.

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[f] Since July 2004, the State Secretariat for Health has been dissolved.

[g] See Footnote f.

In the meeting, when asked what, in theory, he would see as the main goals in an anti-smoking campaign, Waneck said that he would focus on two things: First, he would stop youths taking up smoking and second, he would try to make adults stop smoking before the age of 40. Anything else would not make any difference.[287] He summarised his (theoretical) approach to tobacco control measures in five points:

1. curbing consumption
2. added difficulties of access (as late as possible, i.e. not under 16)
3. stopping again all anti-smoking measures as soon as possible
4. maximal non-smokers' protection
5. and rigorous adherence to existing laws – thus no smoking in public environment (restaurants etc. are seen as private environment)

However, no definite answers could be given as to how to curb consumption, nor what would be a "maximal non-smokers' protection" without smoking bans in public places. It is also not clear what he really means with reduced access for youths as at the same time he opposes the removal of cigarette vending machines and stricter laws including sanctions. With regard to cigarette vending machines he proposes "let's first see what the Germans will accomplish" and with regard to youth smoking he shifts responsibility to the Minister of Education, Elisabeth Gehrer, who is strictly opposed to a total smoking ban in schools, for pupils and teachers alike.

Present EU policies are described by Waneck as a policy of prohibition. Apart from being too extreme, they certainly would not work, segregating a whole group of the population who cannot kick the habit of smoking. Later on in this discussion, though, he defended Austria when criticised for being so demonstratively reluctant in the implementation of effective tobacco policies by pointing to the "active role" Austria played in international discussions that led to the Warsaw Declaration and the FCTC which, of course, were also signed by Austria. This peculiar Austrian attitude with regard to unpleasant political questions was already discussed earlier.

The reason cited as to why nothing has been done on a population level to reduce smoking is that this would require great effort and expenses, the latter being not available. Besides, it would "not make much sense to initiate a campaign when the structure for sustainability is missing".[287] In view of the very brief youth campaigns, which neither show sustainability nor are they embedded in any kind of 'structure', this claim lacks consistency. More notes from this meeting can be found in Appendix T###.

Taking all these points together, the discussion in Austria on tobacco policies can be summarised under the heading "Liberty versus Addiction" (as was indeed the title of the Ministry's

Health Dialogue on Smoking of 27 February 2004). Besides, Austria's approach is characterised by a "policy of small steps", combined with a general lack of political will, and the dogged defence of voluntary agreements and youth campaigns as the most promising measures to tackle smoking and health hazards.

Other Ministries

Other ministries involved in anti-smoking measures have been the Ministry of Education (another ministry that changed names frequently, presently the Federal Ministry for Education, Science and Culture), the Ministry for Labour and Economics (presently combined in the Federal Ministry for Economic Affairs and Labour), the Ministry of Finance, and the Ministry of Sports (until 1 May 2004 Federal Ministry for Sports and Public Services; since then only State Secretariat for Sports while the Federal Chancellor, Wolfgang Schüssel, is also Minister of Sports).

The Ministry of Education has been co-operating in youth campaigns held in schools. Presently the Ministry supports the campaign "Smoke-free School". Erhard Busek, Minister of Education in 1995 and Vice Chancellor from 1991-1995 (ÖVP), was responsible for introducing a total smoking ban in schools and the removal of smoking rooms for pupils. This total smoking ban did not last long; Elisabeth Gehrer (ÖVP), Minister of Education since 1995 and former primary school teacher, was, and still is, opposed to a general smoking ban in schools.

The Ministry for Economic Affairs and Labour is responsible for the Employees' Protection Act, which excludes employees of the hospitality industry and all other establishments where customers are allowed to smoke. One relevant factor is that this ministry presently also represents the interests of the economy and industry, although when enacted it was a separate ministry hold by the Social Democratic Party.

A chief player is, of course, the Ministry of Finance with its economic interest in both high tax revenues from tobacco consumption and its stock ownership of the Tobacco Monopoly Administration (distribution of tobacco products). In the past, when *Austria Tabak* was still state-owned and under the responsibility of the Finance Ministry, there were also financial interests in the fortunes of the company.

The Sports Ministry has been important with regard to sports sponsorship, in particular sponsorship of football clubs and football matches, but also sponsorship of the Austrian ski team and other sports events by *Austria Tabak.*

9.3.3 National institutes, researchers, addiction specialists

Although not key actors in tobacco policies in the narrow sense, some of the actors mentioned below are important side-players, occupying key positions and being closely related to key players. They are best characterised as key 'non-actors' or even key blockers, and therefore contributing decisively to Austria's stagnation in tobacco policies by simply refraining from action, blocking effective measures, or contributing to the 'controversy' about certain issues, such as passive smoking.

The following institutes, research departments and individual scientists are involved with smoking, either by initiating campaigns, providing information on smoking habits, offering help for nicotine addicts, or doing research in smoking-related diseases.

Smoking behaviour (university institutes):

- Institute for Social Medicine of the Medical University of Vienna (headed by Michael Kunze) with its adjacent Nicotine Institute (headed by son-in-law Ernest Groman), which promote themselves as the main contact for all tobacco-related issues, in particular cessation. Tobacco industry funded studies *(see later)*.
- Institute for Environmental Hygiene of the Medical University of Vienna, department for prevention (headed by Manfred Neuberger), which provides a website with information on tobacco-related issues and does some smaller studies on smoking in the workplace.
- Ludwig Boltzmann Institute for Medical and Health Sociology, which has been involved in the WHO's HBSC-study. It also initiated the Austrian youth campaign "Smoke-Free School" (key person Wolfgang Dür).
- Ludwig Boltzmann Institute for Addiction Research, studying smoking behaviour.
- Institute for Social Medicine of the University of Graz, studying smoking behaviour.

Epidemiological research in tobacco-related disease and cessation (university and hospital departments, individual scientists):

- University of Vienna, Institute for Cancer Research, Department for Epidemiology (headed by Christian Vutuc, cancer epidemiologist, publishing on lung-cancer incidence and mortality, tobacco industry-funded studies on health effects of light cigarettes in cooperation with Michael Kunze).
- Lainz Hospital (City of Vienna), department for pulmonary diseases (headed by Hartmut Zwick, also head of the 'Medical Fitness Team'; research on chronic pulmonary disease and support for hospitalised nicotine addicts).
- Otto-Wagner hospital, department for pulmonary diseases (key person Wolfgang Kössler, study on smoking cessation).

Finally, the National Fund for a Healthy Austria is the institutionalised conscience of the government for all kinds of health promotion activities. Although funded exclusively by tobacco taxes, the Fund's activities in anti-smoking campaigns are very modest and more or less confined to its role as the national partner in EU campaigns. So far, it has no impact on smoking rates among youths.

As indicated, some of these actors play a greater role in Austrian tobacco policies than it would seem at first. Some of the names mentioned above are Austria's leading anti-smoking advocates, heading Austrian anti-smoking associations *(see following section)*.

One name, however, that turns up immediately whenever the issue of smoking, smoking cessation, and tobacco control is raised, is Michael Kunze, professor of "public health", head of the Vienna Institute for Social Medicine, long-time expert in tobacco control, national counterpart for WHO and EU institutions for tobacco control, and former government consultant to some SPÖ Health Ministers. Politically very astute and well connected to top members of the Social Democratic Party, this institute was established for him in 1983. He has been known for a long time for his advocacy of pharmaceutical products for smoking cessation. Recently he has also become known for another controversial substitute. Together with Ernest Groman, head of the adjacent small Nicotine Institute and his son-in-law, and the Swedish scientist Karl Fagerström, he is pushing for the legalisation of smoke-less tobacco (snuff), ostensibly as an alternative to cigarettes for heavy smokers.

The activities of these two institutes, though, might be characterised by ambiguity and ineffectiveness. Passing more or less unnoticed, they have been organizing the National Awareness Day on 1 January (a perhaps surprising choice). The Nicotine Institute shows remarkable concern for heavy smokers, in particular all those where "complete abstinence is not possible" by offering possibilities for "controlled smoking" and pleading for the legalisation of moist snuff *(snus)* in Europe.[69] [350] It also uses the results of one of its own small surveys to "argue" for campaigns to reduce smoking rather than to quit smoking (neither of which exist anyway). Although claiming to be a "competence centre" and the 'first address' to be contacted for smoking cessation, the Nicotine Institute neither offers a help-line nor cessation courses. The reasons have been reported to be lack of funding by both government and health insurance funds, as well as "failure" in the past. However, both institutes developed the concept for the *Josefhof* in Graz, copied by similar centres supported by the Upper Austria District Health Fund and the insurance fund for civil servants, and the outpatient treatment centres supported by the Lower

Austria District Health Fund. In Vienna, occasional meetings are held about twice a year to inform smokers seeking help who have the patience to wait for this event *(Chapter 8; 8.3.5)*.

Otherwise, the Nicotine Institute (or rather, its head) distinguishes itself by an uncritical attitude towards smoker-friendly media reports, considering them better than no reports at all[191], drawing attention to industry-funded studies (as, for example, the study by Enstrom & Kabat[107]) or to its own studies suggesting the merits of smoke-less tobacco[67 68] *(Section 9.3.8)*, regarding the effects of passive smoking as still being controversial, categorising help-lines as being quite useless, and describing discussions about industry tactics as exaggerated.[191]

Michael Kunze, the self-proclaimed "Non-Smokers' Pope", who advertises himself as the "most dangerous man for the tobacco industry", has always been closely related to the Austrian tobacco industry, personally and, as we shall see, also financially. He was a school friend of Dr Hubert Klus, the previous head chemist of *Austria Tabak* (now retired but still acting as company consultant), and has maintained a "good communication basis" to *Austria Tabak*[330] (following the Austrian tradition of having a relaxed relationship between all parties).

Considering his involvement in tobacco control for decades and his almost equally long participation in international committees as Austria's national representative[h], his achievements in Austria so far have not been especially impressive. Although it is true that Kunze had a renowned consultancy status with various Austrian SPÖ Health Ministers (starting with his 'patroness' Ingrid Leodolter and including at least the Health Ministers Herbert Salcher, Franz Löschnak, and Michael Ausserwinkler, possibly also others), there is also information about his close relationship to the Austrian and German tobacco industry which financed at least some of his studies *(Appendix U###)*. Thus playing successfully a double role for decades, with his "balanced" or "controlled" expertise, his (and members of his institutes) occupying relevant positions and blocking effectively "undesired" measures, he has been an important though untransparent key player. However, due to the very limited space available, the full discussion of his activities is in Appendix U###.

[h] Both Kunze and Groman have been members of the EU Regulatory Committee on Tobacco and the EU Expert Tobacco Working Group and participated in the process of developing the FCTC as members of the Austrian delegation. Kunze was also a member of the International Union against Cancer (UICC) *(present status not confirmed). (See also further down this section.)*

9.3.4 Anti-smoking groups and non-smokers rights associations

Those favouring restrictions on smoking are not well or even at all organised in Austria. There is no strong non-smokers' organisation. Basically one can say that there has not been much action in Austria – either because of corruption and deliberate blocking, lack of political and public support, or weakness and anxiousness of possible personal disadvantages.

The most active and certainly most committed organisation is the *Österreichische Schutzgemeinschaft für Nichtraucher* (Austrian Association for the Protection of Non-Smokers), active since 1975 and officially founded as an association in 1987. In earlier years, this association had branches in Vienna, Salzburg, Bregenz (Vorarlberg) and Graz (Styria). However, due to the lack of interest and the advanced age of its members, these branches have literally become extinct (no successors) and the only 'survivor' is its founder and head Robert Rockenbauer in Innsbruck (Tyrol). At its latest annual meeting in January 2004, only 8 participants turned up.

Since 21 June 1975, the *Schutzgemeinschaft* has been publishing a quarterly journal and since 1988 it has been initiating and conducting anti-smoking campaigns, in particular posters, stickers, leaflets and other information material. In addition, Robert Rockenbauer has been giving (for free) educational talks at schools for many years. He is the contact point for journalists seeking information on smoking-related issues and (despite the profile of another self-proclaimed 'advocate') generally known among insiders as "the" expert and real non-smokers' advocate in Austria. The association has been demanding an amendment of the tobacco law for a long time, in particular the inclusion of measures to protect non-smokers in public places and penalties for violations.[i]

Despite its activities the association receives virtually no public funding; nor does the government pay any tribute to its achievements. Reasons may include party-political issues, the physical distance between Vienna and Innsbruck and the attitude of Vienna towards activities in the provinces, which very often are not taken seriously. The government prefers to maintain direct control over the entire health promotion budget through the Fund for a Healthy Austria, despite its limited success with regard to smoking prevention activities.

Robert Rockenbauer, being a notable exception within the otherwise rather diffident and very cautious group of Austrian non-smokers' advocates, may be described as a very dynamic, altru-

[i] In 1980, the *Schutzgemeinschaft* initiated also the 'Year of Non-Smoking', an idea which, according to Rockenbauer, was taken up by the WHO, putting the 1980 World Health Day (31 March) under the motto "Smoking or Health – Your Choice".[302]

istic, self-confident, unafraid and dedicated individual from Tyrol, a region known for the bravery of its freedom fighters. Uniquely in Austria he has taken on the tobacco industry in court.[j] He was also the only anti-smoking advocate who readily agreed to a meeting, which ultimately lasted almost four hours. Of the other three anti-smoking advocates, all members of the Austrian Council on Smoking and Health, no one found time for a discussion, not even by telephone, despite several attempts. The arguments varied from mostly "no time" and "too busy", to "can't say very much, the situation is far too complicated", or just answering 'harmless' questions and missing the point, while referring to websites and (often irrelevant) publications. One could also sense a fear of investigation.

The contacted individuals were:

- Manfred Neuberger, long-time expert and anti-smoking advocate, studies on smoking in the workplace, former government consultant (SPÖ), past president and now vice-president of the anti-smoking association Austrian Council on Smoking and Health and provider of its website.
- Kurt Aigner, medical expert and president of the Austrian Council on Smoking and Health.
- Michael Kunze, vice-president of the Austrian Council on Smoking and Health *(see above)*.

Both, Manfred Neuberger and Michael Kunze, were government consultants to some SPÖ Health Ministers in the past and thus influenced Austrian tobacco policies to some degree.

9.3.5 Health insurance

Almost one fifth of Austria's health care expenditure is spent on the treatment of smoking-related diseases. In fact, Austria's health insurance should be one of the major interest groups in supporting measures to reduce smoking. However, the Federation of Austrian Social Insurance Institutions has neither been providing support for smoking cessation, nor has it initiated or supported anti-smoking campaigns. It has no staff specialising in smoking-related diseases. Repeatedly. health politicians have given the misleading impression that the *Josefhof* is a project of the Federation.

[j] On 22 November 1988, Robert Rockenbauer was sued by the tobacco industry for millions of Austrian Schillings for defaming the advertising of Camel cigarettes (the so-called 'Camel Process'). Instead of the original slogan 'I am walking miles for a Camel' he produced a poster saying 'Only a camel would walk miles for a cigarette'. His position was upheld in the Higher Regional Court in Innsbruck but was challenged again and the case went to the High Court of Justice in Vienna where damages were awarded against him of ATS 150,000 (€11,000) for honour defamation as 'camel' may suggest a person who is not very intelligent.[302] Interestingly, in Vienna this case was decided by a senate for economic affairs, who had connections to the Austrian tobacco company and its General Director (then deputy) Beppo Mauhart.[333] Far from being intimidated or awed, though, he continued to produce this poster in variations (e.g. 'only a … [dot-dot-dot] … walks miles for a cigarette' or 'not even a donkey would walk miles for a cigarette').

The Vienna District Health Fund employs one person to be in charge of its very few information centres on cessation. It sends severely ill nicotine addicts for a three-week treatment to the *Josefhof* in Graz but, as noted earlier, the possible yearly quota of 100 patients has not yet been achieved. The Lower Austria District Health Fund supports four ambulatory treatment centres and the Upper Austria District Health Fund offers three in-patient cessation centres based on the concept of the *Josefhof (Chapter 8)*.

In summary, therefore, the Austrian health insurance does not play a role in Austria's tobacco control policies (apart from receiving money from tobacco taxes to reduce its deficit).

9.3.6 Other non-governmental organisations

Among the non-governmental organisations only the Austrian Cancer Society, which initiated a youth anti-smoking campaign, and the regional *Arbeitskreis für Vorsorge und Sozialmedizin (AKS)* in Bregenz/Vorarlberg, whose health promotion activities in education and smoking cessation are outstanding within Austria, can be identified as playing an active role in tobacco control. However, they have no influence on decision making on tobacco control. The Austrian Medical Chamber does not play any role.

9.3.7 Local governments

Local governments and health authorities do not play a role in tobacco control policies. The City of Vienna's only information centre for smoking cessation is highly unprofessional *(Chapter 8)*. In response to a question from a journalist asking whether Vienna could do anything at a regional level to ban smoking in public places (following media reports on the Irish smoking ban), the then City Councillor for Health in Vienna, Elisabeth Pittermann, said this would be "impossible" and could only be dealt with on the national level. (National health politicians, on the other hand, cite the autonomy of the Länder as a reason for inaction.) Although a declared non-smoker and one who states she is annoyed by tobacco smoke, she has been emphasising repeatedly her aversion to smoking bans, thus reflecting the wide-spread opinion among policy makers.

9.3.8 Media

The media, as one of the most important opinion leaders, play a crucial role in the creation, dissemination, and consolidation of public opinion and attitudes. On the issue of smoking, Austrian media coverage has been somewhat one-sided, contributing to the smoker-friendly climate

in Austria. One important reason has been the excellent relationship between the media and the Austrian tobacco industry, in particular during the reign of Beppo Mauhart *(see above)*. Another reason is perhaps the fact that most journalists are (often heavy) smokers themselves.[351]

Given the diverse nature of this coverage it was not possible to be systematic. Instead, selected Austrian media reports, in particular following the recent implementation of enlarged health warnings on cigarette packs and the introduction of the Irish smoking ban in public places, which briefly aroused the interest of the otherwise disengaged tobacco-landscape within the media, were placed under greater scrutiny and analysed. Media reports on the use of tobacco taxes have already been presented *(Chapter 8)*. It was not possible to arrange discussions with a TV journalist and one from an Austrian news magazine. The results of this media analysis are presented by topic.

The two TV discussions, one following the introduction of health warnings and another following the introduction of the Irish smoking ban in all workplaces, were particularly interesting as they reflected public opinion and showed who the real opinion leaders were. Both discussions were dominated by the personality (and speaking time) of the retired Ex-General Director of *Austria Tabak*, Beppo Mauhart. His frequent presence as the representative of smokers (and, unspoken, as the representative of the tobacco industry) is seen as contributing to a "balanced" debate.

General characteristics of smoking-related media reports

In general, media reports on tobacco control measures are introduced by a paragraph or two on lung cancer rates, the alarmingly high or rising smoking rates among Austrian teenagers and women, and/or statistics on cigarette consumption. They are often supplemented by at least one picture of smoking individuals and indirect advertising.

Very often, the language chosen to describe non-smokers or anti-smoking measures uses a very combative vocabulary, while smoking is presented as a matter of personal choice and great pleasure, enjoyed by sociable, emancipated and self-determined individuals. The terms used in the media reports analysed can be summed up as follows:

Smokers and smoking	Non-smokers and anti-smoking measures
liberal, free, self-determined; right for pleasure (of smoking)	fascistic, protofascist, authoritarian, totalitarian, patronising, intolerant, militant, exaggerated; discrimination of smokers
pleasure of smoking; to smoke with pleasure/	pleasure-hostile

gusto; to enjoy/relish smoking; tobacco pleasure	
"sexy smoke", association with movie stars (Humphrey Bogart, etc.)	puritanical
century-long smoking culture (with the attached pleasure); originally therapeutic means of tobacco; sacral function;	bait, crusade against smokers; pursue of smokers; criminalisation of smokers; social exclusion of smokers; battle, battlefield between smokers and non-smokers
examples of famous smokers in history (politicians, writers, movie stars, etc.)	most famous non-smoker: Adolf Hitler

Most media reports are defiant against the "militant" anti-smoking campaign of the EU with its "fascistic" and "pleasure-hostile" approach. The overall tone is that the dangers of smoking (especially passive smoking) are exaggerated, thus discounting the rights of non-smokers. The issue of smoking and measures to reduce smoking is considered most controversial, a confrontation of "liberalism against prohibition"[352], a battle between (suddenly having become) intolerant non-smokers who want to interfere with a smoker's pleasure against discriminated, criminalised smokers who only claim their right for a 'little pleasure'. Articles in favour of tobacco control measures are often "balanced" by smoker-friendly articles on the same page[353] and articles presenting alarming results on environmental tobacco smoke or high smoking rates in Austria are "balanced" by pointing at length to the ineffectiveness of tobacco control measures *(Appendix V###)*. In addition, some of the few reports on smoking are based on industry-friendly information provided by Austrian scientists and so-called anti-smoking advocates, as recent examples show.[67] [68] Furthermore, articles trying to appear 'objective' in their reporting on tobacco control measures, in particular on smoking bans, and thus to present 'all sides', usually cite the expert opinion of a so-called anti-smoking advocate who has been known to be very closely related to the tobacco industry. However, despite this clear under-representation of those favouring restrictive measures and the more than cautious or even vacuous statements of this Austrian expert, it is interesting that many people have indeed the impression of facing a new development where 'discussion' on these issues starts.[354] Austrians have never faced vehement statements from opinion leaders, including the exposure of the tobacco industry and revealing the real harms of active and passive smoking. Still in 2004, occasional statements regarding the harmfulness of "light" cigarettes[128] [355] are treated as something "new" in the Austrian media (and perceived as something new by large parts the public)[354]. Still, a most recent article in the *Kronen Zeitung*, Austria's most widely-read tabloid, reported critically on the harmfulness of "light" cigarettes and some smoking-related issues, citing not Michael Kunze but the German expert Dr Martina Pötschke-Langer from the Cancer Research Centre in Hei-

delberg.[355] The *Kronen Zeitung,* to give it credit, also offers a website with information for smokers seeking to quit.[356]

The cover story of the news magazine *Profil* of 24 November 2003[264], which claimed to present this controversy "objectively", never spoke just of smoking, but always in terms such as the "pleasure of smoking". The term "addiction", though, was hardly used. Smoking was "delicious and wonderful", although it may also be dangerous. The dangers of passive smoking, it argued, were exaggerated; it was only considered that children and pregnant women were adversely affected.[k] A list of "famous smokers" in history was presented, as well as much indirect advertisement: almost every one of the numerous photos pictures a smoker, a cigarette butt, a cigarette pack (Marlboro), or a celebrity with a cigarette or a cigar. Critics were cited alluding to a relapse to "past times". The stealthy "prohibition" of the "free smoking culture" would be characterised by austerity and puritanism *(Lustfeindlichkeit)* as in periods of suppression, evoking a "protofascist approach" behind this EU "anti-smoking-military campaign". In summary, the report (incidentally written by a heavy smoker) is clearly dominated by compassion for smokers, who would now be criminalised and discriminated, accompanied by justification for smoking, while mocking tobacco control measures.

The very few articles on passive smoking are usually short and presented as something "new"[128] while studies on the benefits of smoking on mind and emotion[357] or the merits of smoke-less tobacco[67 68] are presented at great length.

In December 2002, on the occasion of the discussion of the EU advertising directive, the Austrian newspaper *der Standard* reported on "the individual's responsibility for itself". Smoking bans in public places, as in the United States, would be a "massive interference in the individual's freedom". Even if an advertising ban was independent of a smoking ban, the risk was summarised as "Where will it all end? After all, riding a motorbike, drinking Coca Cola and eating meat may be dangerous for the individual and for the society."[292]

Two recent events which evoked some media discussion, the introduction of larger health warnings on cigarette packs in Austria in October 2003 and the introduction of the smoking ban in Ireland, were analysed in more detail. The two television discussions[37 38], which covered various tobacco control measures, were analysed separately. These more specific analyses are presented in Appendix V###.

[k] These arguments were based on the results of the industry-funded study by Enstrom & Kabat[107], which was provided to the journalist by Ernest Groman from the Nicotine Institute.

Altogether, analysing the Austrian media landscape on the issue of smoking, one is reminded of the concepts towards the media developed in 1975 by the German *Verband der Cigarettenindustrie* which realised that it had to become "more active" in the discussion about smoking and health *(bolding by E.B.)*:

> "One must make sure that articles discharging the cigarette are made available to magazines and daily press. … for this, **a liaison between the 'Verband' and journalists is necessary**.
> …
> "It is suggested to hire a photograph agency specialised in **press pictures showing well known personalities smoking publicly**.
> "It must be tried to launch press articles in which the **anti-smoking measures, resp. the intolerance of the smoking opponents are mocked in a sympathetic way**."[100]

It seems that in Austria, Beppo Mauhart has not only made a most successful job out of this proposed strategy; it also demonstrates that, even under slightly changed conditions and supported by unambiguous statements of opinion leaders, public opinion (and thus also the opinion of journalists) will take some time to change.

9.3.9 Public

Public opinion and public awareness closely reflect media coverage. Discussions with citizens of different countries on the issue of smoking in public reveal the effectiveness of opinion leaders in constructing public opinion and awareness. In Austria, these opinion leaders are mostly industry-friendly and consist primarily of high-ranking representatives of the tobacco industry, scientists, and the media – the latter, however, may also be seen as part of the public, i.e. reflecting public opinion. The public, therefore, is both evidence of successful socialisation (in either way, pro- or anti-smoking) and an actor in the sense of influencing political decision making in several ways. Firstly, "expert opinions" of politicians and journalists are very often individual opinions; secondly, health politicians, in general, do not want to become unpopular; and thirdly, public with little awareness will not support anti-smoking groups and thus will not interfere with the established pro-smoking policy.

In Austria, public awareness on smoking-related issues is very low and discussions are clearly dominated by the magic word "tolerance". Appendix W### illustrates the climate in Austria.

9.4 Policy Analysis

Austria has often been praised as a land of harmony, dreading confrontation but rejoicing in cordiality, joviality and agreeability ("one can talk about everything"); a land of proportion (everything is just a problem of moderation and a little bit of consideration; sanctions are not even discussed) where nothing is exaggerated or rushed ("let's see first what Germany is doing"; "we need to proceed step by step"; "one does not have to throw out the baby with the bath water"); a land of selective tolerance (in particular towards its own weaknesses) and of distorted self-perception ("we are one of the most active in European tobacco control" versus "this is all far too extreme and exaggerated"); and, most of all, a land of 'old pals' and 'buddies', best described with the well known and often applicable Austrian term *'Freunderlwirtschaft'* (cronyism). On the tobacco stage, the atmosphere is characterised by mutual understanding, tolerance, and a 'good communication basis' among all interested parties. Already in a confidential Philip Morris 1979 report on the situation in Austria one can read that the Austrian tobacco company "has good access to all of the media, prominent scientists and MDs *[medical doctors]* and members of government and parliament"[104]. Before privatisation of *Austria Tabak*, the relationship between the company and the government was also characterised by strong party-political ties.

Despite publicity about these close relationships, the reactions of key informants who either declined meetings or evaded answers were interesting. It proved exceedingly difficult to get people to talk about this subject. While most of the key informants answered 'harmless' questions relatively freely, such as on tobacco-related tax income and smoke-free environments in public transport, or provided material on laws, statistical data on smoking rates, etc., responses from many in the field of Austrian tobacco policy[l] were very difficult to elicit when it came to questions relating to tobacco policy. In particular when seeming to probe about why so little was done or indicating an interest in the relationships between *Austria Tabak* and those involved in Austrian tobacco policies, the reactions were usually evasive, even anxious, often declining to answer. Most notably, repeated attempts to obtain the opinion of acknowledged advocates in Austrian anti-smoking policy, some of whom have been long-term consultants to the government and being official national representatives in the international field, were unsuccessful due to their 'absolute lack of time' for a meeting or even discussions by telephone.

[l] In particular officials and administrators in the Ministry of Health, external experts and government consultants, and even individuals engaged in anti-smoking activities and self-proclaimed advocates.

It may also seem one of the ironies that it is repeatedly reported by health politicians, governmental officials and the media that "despite" numerous anti-smoking campaigns over the last years, cigarette consumption has hardly decreased[348], thus being used as an argument that campaigns do not work anyway.[m]

Taken together, Austria's approach to tobacco control may be summarised as non-committal and hypocritical, as also described by Constance Nathanson for France[141]. While expressing concern about the alarmingly high and still increasing smoking rates among Austrian children and adolescents, one can observe an extraordinary ambivalence and high level of hypocrisy on the part of the Austrian authorities toward any restrictive measures that might be effective. For example, while forbidding the purchase of tobacco products by young people under 16 years, thousands of cigarette vending machines are operating in Austria and no sanctions exist for selling cigarettes to minors. Even smaller children can get their cigarettes whenever and wherever they want. They are also strictly opposed to complete smoking bans in schools (although an Austrian study certifies that schools above all are the places where youths are becoming "habitual smokers"[358]) and smoking bans in bars, pubs, cafés or restaurants where young people also 'learn' to smoke, trying to appear equally 'adult' as those around them. Any kind of restrictions are countered with arguments such as "that will not work anyway", or "this is not a solution", or "one cannot forbid everything", or "they would only do it secretly and smoke even more because then it just becomes more interesting". At the same time, politicians do not tire of lamenting about the high youth smoking prevalence and expressing their determination to tackle this problem with yet another (more or less unsuccessful) youth campaign.

On the whole, the attitude of smokers in Austria may be described as cultivated inconsiderateness and ignorance. Non-smokers are either portrayed as "victims" (e.g. children and pregnant women) or, when protesting against another's smoke, as intolerant, pleasure-hostile troubleseekers who just want to interfere with another's 'small pleasure'. As cited by Constance Nathanson in relation to France:

> " 'The smoker … does not for a moment believe that the non-smoker is truly bothered. No, he simply wants to annoy, to deprive the smoker of a little pleasure'… This construction of smoking as *un petit plaisir* with which it is simply churlish to interfere largely explains why smoking restrictions are more readily respected aboard buses, trains, and airplanes than in cafés and restaurants. The latter are defined as zones of pleasure, whereas the former are not. …

[m] As noted, the last anti-smoking campaign targeted at the whole population was in 1994/95 – following 14 or, when incorporating the small repetition campaign in 1985, nine years after the first (and in fact only) real population wide media anti-smoking campaign *(Chapter 8; Appendix O###)*.

> "Images of the smoker out in the cold, of 'civil war between smokers and non-smokers' are invoked to argue against any overzealous enforcement of restrictions on when and where smoking will be allowed."[141]

It should be noted, though, that, especially after some discussion, some of the key actors (Austrian Federal Railways and Hospitality Trade Association) who contributed to this information gathering would be prepared to do something but expressed some uncertainty about the chances of success. In addition, it became clear that smoking bans would only be introduced if they were part of a wider net of measures, suggesting action should first come from policymakers on both the national and regional level.

So far, measures in northern Europe and Italy have been essentially ignored in Austria. Only the extensive international media coverage of the Irish smoking ban in March 2004 made Austria pay attention for an instant before reinstating the veil of silence over this whole unpleasant issue. It is to be expected that, should effective measures be introduced by Austria in the future, these will only follow international pressure or very strong economic interests.

Passive smoking has thus not been a topic of public discussion in Austria, nor of serious public health concern for politicians, nor of great scientific interest. Only very recently estimates were published on the incidence or mortality due to passive smoking in Austria.

Role of tobacco industry

The Austrian tobacco industry has been playing an important role in both the government's activities and the Austrian media. At least during the time when *Austria Tabak* was state-owned, representatives of the company were always involved in preliminary talks on tax issues, reportedly also in the planning stage of campaigns. For the media, particularly under Beppo Mauhart's reign since the late 1980s, the tobacco industry has been a very important advertiser and client, and Austrian media have carried much indirect advertisement. Finally, *Austria Tabak* has also had a very high expenditure on advertising, smoking campaigns and sports sponsorship. All these factors have made it difficult for smoking adversaries to be heard in the media. Considering later developments, the early media co-operation in Austria's first anti-smoking campaign in 1980 must be seen as an exceptional success.

While *Austria Tabak's* privatisation brought a certain disentanglement of the Austrian tobacco industry from the Austrian government, the former General Director of *Austria Tabak*, Beppo Mauhart, is still treated as THE expert in smoking-related issues (including anti-smoking measures) by the media. To get an idea about the relationship between *Austria Tabak* and Aus-

tria's government, one has to bear in mind that Beppo Mauhart was previously employed at the Finance Ministry as secretary of the then Finance Minister Hannes Androsch with whom (as with former Finance Minister and later Federal Chancellor, Franz Vranitzky) he has been close friends. He has always maintained a strong party political position and has been known as an "excellent lobbyist".[276 296 304] The role of *Austria Tabak* in sports sponsorship was facilitated by Mauhart being at the same time president of the Austrian Football Association, making *Austria Tabak* the main sponsor for sports clubs (in particular football clubs) and sports events; the company is also sponsoring the Austrian ski team.

In 1980, *Austria Tabak*, with the support of its representative in government, Finance Minister Hannes Androsch, could "strongly defend its position in a National Assembly resolution"[105] to reject Health Minister Salcher's package of tobacco control measures including advertising ban and health warnings. Another example of the tobacco industry's power is the rejection of the proposed comprehensive advertising ban under Health Minister Ausserwinkler, this time with the help of government opponents (ÖVP).[n]

The company which for decades has been commissioned by the government with surveillance of tobacco (in particular cigarette) constituents, *ÖKOLAB*, is a subsidiary company of *Austria Tabak*. Politicians seemed mildly surprised that this should indeed be so but were otherwise unconcerned.

Finally, as in most other countries, Austria's hospitality industry has been successfully influenced by the industry, with misleading stories about the adverse consequences for business of smoking bans, providing them with a means to argue that the government must avert this economic catastrophe.

Role of government

In addition to the general opposition to tobacco control measures by all three major political parties (SPÖ, ÖVP, FPÖ)[o] and in particular the close party-political ties between *Austria Tabak* and the SPÖ, the two most vehement opponents of tobacco control measures were (or are) oriented to economic issues: One was Victor Klima (SPÖ), Minister of Economy (1992-1996),

[n] Government opponents (ÖVP) had invited an expert in advertising psychology to consider whether cigarette advertising would indeed *(sic)* tempt individuals to start smoking. The expert could find no proof and this argument was used to reject the advertising ban. Incidentally, this expert had previously designed *Austria Tabak's* advertising strategy.

then Minister of Finance (1996-1997), and finally, after Chancellor Franz Vranitzky's resignation, Federal Chancellor of Austria and party chairman of the Social Democratic Party of Austria (1997-2000). Under his chancellorship, an order was issued to restrain from excessive engagement in international tobacco control activities and to oppose the subsequently annulled EU advertising directive.[276] Klima was himself also a heavy smoker.

> "Klima used to be a heavy smoker and was probably one of the last politicians who smoked in public. During his premiership he was even hospitalized due to a nicotine-related illness."[360]

The other was and is, though not as openly as in the past, Wolfgang Schüssel (ÖVP), at that time Minister of Economy (1989–1995) and then Vice-Chancellor (1995–2000), who was the most vehement opponent of Health Minister Michael Ausserwinkler's proposal for the first tobacco act including a comprehensive advertising ban and his proposal of smoking bans in restaurants.[276] Presently (since February 2000), Schüssel is Federal Chancellor and also Minister of Sports. That a politician's smoking status is not necessarily an indicator of his or her attitude towards tobacco control measures, is best demonstrated with Wolfgang Schüssel. Being a non-smoker and a sports enthusiast, he is still, above all, economy-oriented, observing the interests of the hospitality and the tobacco industry.

The reason why the company *Austria Tabak* has always been courted by the government were said to be mainly of economic nature, apart from political reasons (lobbyismus). Former Health Minister Salcher said that it has always been the interest of the government to represent the interest of lucrative or even profit increasing companies.[304] Neither Salcher nor Waneck nor other governmental informants saw anything "bad" with the tobacco industry, apparently completely unaware about its tactics.

Unlike in other countries, as yet there has been no law suit against the tobacco industry in Austria. The legal situation in Austria would make this very difficult. According to the 1995 Tobacco Act (§3 [1]) the Health Ministry is authorised to decree an ordinance regarding additives of cigarettes (including additives for smell and taste, pesticides, etc.) "if it is necessary for the protection of the consumer from preventable health hazards". However, to date no such ordinance can be found. This means that additives are not regulated by any law.[279] In case of litigation this would mean that it would have to be the litigator who has to prove which substances pose a risk to health and that he or she has become ill due to the consumption of these ciga-

[o] Although indicating within all drugs the legal drugs alcohol and nicotine as the greatest danger for the population, due to their wide prevalence, the party programme of Austria's Greens does not include any position on tobacco control.[359]

rettes. Instead, if such an ordinance would exist, it would have to be the tobacco industry who has to prove that these substances are not harmful to the consumer's health.[361]

Attitudes by Austria's health politicians towards the FCTC and other declarations seem to be limited to a signature, showing 'officially' one's interest and obviously not wishing to appear a killjoy. 'Back home', however, they not only ignore all goals and commitments, but even declare them as 'ridiculous' and 'much too exaggerated' to be followed.

Another striking element in Austria's tobacco policy is the fact that policy makers are proud of things they are not responsible for, i.e. things not regulated in the tobacco act. For example, they repeatedly point out how well smoking bans in hospitals or local transport systems work – either to demonstrate the effectiveness of voluntary agreements, or to show that Austria has already done a lot ("What more can we do?"). They even proudly refer to Austria's (weak) tobacco law while nobody seems to remember the initial difficulties or the real reason for its implementation (EU entry). Occasionally one even points complacently to the smoking bans at Austrian Airlines flights or Austrian airports – without mentioning the strong international pressure leading to it.

Similar to the earlier mentioned letter by the then Health Minister Herbert Haupt and his State Secretary of Health, Reinhart Waneck, to Gro Harlem Brundtland, where both health politicians declare their support for the FCTC, in particular referring to the desirability of a total advertising ban[278 p], Austria's hypocrisy in this matter is again expressed in a reply of July 2003 from the Health Ministry to an anti-smoking advocate who reproaches the government for its inactivity:

> "On the level of the WHO and the EU there are framework conceptions and guidelines which support us very much in our efforts on the national level, as for example the action plans for a tobacco-free Europe or the… WHO Framework Convention for Tobacco Control, which has to be characterised as a mile stone in cross-country tobacco control and on whose development the Federal Ministry for Health and Women has also taken part… Important impulses are also to be expected by the… tobacco advertisement and sponsorship directive 2003/33/EC."[362]

In another, more recent letter by Reinhart Waneck of February 2004, answering a reproach to the Austrian government for its ineffective activities in tobacco prevention from an active member of the Austrian Association for the Protection of Non-Smokers *(Österreichische Schutzgemeinschaft für Nichtraucher)*, the position of Austria's policy towards smoking prevention is summed up quite clearly. Apart from the usual phrases regarding the Ministry's

p See Footnote q in Chapter 8.

"regular campaigns", in particular targeted at youths, the self-congratulation for the exemplary tobacco law, and drawing attention to the fact that this would not only be the responsibility of the Health Ministry alone, it cautions against too "rigorous measures" such as smoking bans in restaurants, pubs and cafés as these would "endanger a violation of the individuality of the constitutional state".

> "…the existing frameworks and guidelines on WHO and EU level are a great support to us in the implementation of national measures regarding the protection of non-smokers. However, on no account one must overlook the fact that exactly these inter- and supranational instruments have been worked out by the various member states, thus also including Austria. Therefore, these are not measures ordered from outside, but it is the common will of all member states. This, however, should not and must not curtail the individuality of every single one. **Rigorous actions against smokers, as proposed by you, would be welcome to a certain extent from the viewpoint of health; however, ignorance of regulations regarding respective areas of authority, apart from constitutional problems, would in particular endanger a violation of the individuality of the Austrian constitutional state.**
>
> "The protection of non-smokers is a cross-sectional matter, i.e. the various aspects fall under the competence of the respective departments… such as the Federal Ministry for Social Security, Generations and Consumer Protection; the Federal Ministry for Education, Science and Culture; and the Federal Ministry for Economics and Labour; it also affects the responsibility of the Länder. Therefore, various acts such as the Employees' Protection Act and the various Youth Protection Laws of the Länder have encompassed regulations regarding the protection of non-smokers for a long time.
>
> "The smoking bans laid down in the Tobacco Act cover those areas which previously lacked regulation. **After carefully weighing the needs of passive smokers** *(sic)* **against the needs of smokers, the regulations in the Tobacco Act for the protection of non-smokers are primarily based on the thought to contribute to the harmonious living together of smokers and non-smokers.**[363] *[Bolding by E.B.]*

Of course, there is no discussion about asking the views of the population as to whether it is equally "harmonious" or if, as in Ireland and all other countries where a poll preceded these measures, the majority would approve of smoking bans.

Altogether, the predominant impression of Austria's policy makers in the field of tobacco control is their hope that the whole problem would solve itself – by consideration, tolerance, and voluntary action. Till then, however, one should proceed with moderation.

Role of the public health community

Austria's public health community is small; even fewer are the individuals engaged in tobacco control measures; and of these few, some are either close friends with representatives of the tobacco industry, therefore not wishing to hurt the other party, or are too anxious about their own position to go beyond small, cautious studies or come forward with clear statements regarding the need for action.

Public awareness and anti-smoking groups

In general, public awareness as to the harm of smoking and effects of environmental tobacco smoke is very low in Austria. Besides, Austrian people have a general aversion to direct intervention into something believed (or portrayed as) a completely 'private affair' and one of life's enjoyments. Therefore, any kind of suggestion as to smoking restrictions in public places, such as restaurants, pubs and bars, arouses arguments about not wishing to become 'a second America' or being patronised by the European Union or being 'criminalised' by a few 'militant' non-smokers. Arguments regarding the high health care costs caused by smoking are either ignored or countered with arguments relating to other lifestyle factors, such as unhealthy food or air pollution, or set in the context of other, 'much more dangerous and harmful' drugs, such as alcohol, hashish or other illegal drugs.

Despite the fact that the total of never-smokers, ex-smokers, children and adolescents, those who suffer from respiratory or heart disease, pregnant or breast-feeding women represent the far majority of the population, the need to protect non-smokers by establishing non-smoking environments in all public places is not recognised by the public (and policymakers). Those who feel annoyed or harassed by tobacco smoke have not been used to complain, with apparently little awareness of their rights.

Apart from the not very known Austrian Association for the Protection of Non-Smokers there is no strong non-smokers' rights association such as ASH in the United Kingdom. In view of the predominant pro-smoking climate in Austria and the open lack of political will, it would take an above-average amount of commitment and enthusiasm for activists to engage in anti-smoking activities.

9.5 Discussion

Smoking policy should be considered in a broad sense, aiming to reduce the burden of smoking-related diseases through different policy means such as regulation on access to tobacco and where it can be used, fiscal policy, and education.

According to differing estimates, smoking kills about 9,000 to 14,000 people each year in Austria, equivalent to 25 to 38 individuals per day. Recent estimates assume that in 2003, a total of 1,412 individuals died due to passive smoking. To date, Austria's health policy has done very little to reduce this death toll. There is no comprehensive tobacco control plan, nor even effec-

tive measures to curb tobacco consumption. Austrian politicians lament the high rates of cardiovascular diseases (especially heart diseases) and cancer, the high and still rising smoking prevalence among children and youths, and the high costs to the health care system, including the problems of present and future affordability. But two of the major factors underlying all this – smoking and alcohol – appear sacrosanct. The experience of countries that have introduced tobacco control measures, some of them for a prolonged period, shows that these measures are often followed by a significant decrease in smoking prevalence among both young people and adults and a decrease in smoking-related disease and mortality. However, this appears to have passed unnoticed in Austria – or rather, seems to be deliberately ignored. With its 'balanced' debate, drawing on the arguments of the industry, Austria's position remains stuck in the 1990s at best. In both past and present, Austrian pro-smoking policies can be summarised as pursuing narrow economic interests.

The very few and mostly ineffective measures have been directed towards youth campaigns and the praise of a small therapeutic clinic for severely ill smokers as a "model project for smoking prevention", thus keeping tobacco control off the political agenda. Again and again, politicians have expressed their concern about the high smoking rates among Austrian youths, occasionally followed by another study or by another (more or less unsuccessful) small-scale youth campaign. The high smoking rates among adults, the lack of any kind of support of or promotion for smoking cessation, the high health care costs of smoking-related diseases, and the high number of smoking-related deaths have been of no concern for Austria's policymakers. Similarly, smoking bans in public places, such as restaurants, pubs and cafés, are still regarded as taboo and, demonstrating tolerance and liberty, are rejected in favour of voluntary agreements. Somehow there seems more unity in averting effective tobacco control measures than in promoting them. For decades, the strikingly smoker-friendly climate in Austria has thus remained unperturbed.

Lacking both public support and a non-smokers' rights group, the issue of non-smokers' rights has yet to reach the political agenda. However, even if it may take some time, the issue of passive smoking will pose a challenge for Austria's health policy. As with many other European countries, hope lies with the binding directives from the European Commission and the guidelines from the WHO. Apart from the importance of binding EU legislation, international pressure on Austria to introduce smoking bans and indirect pressure from more European countries, which have implemented effective tobacco control measures before Austria, will continue to be

an important impetus to Austria's policymakers and the public to create a non-smoker-friendlier environment.

Strong opposition must be expected, however. Once the situation will become serious, it will invoke a major response on all sides (not only from the primary interest groups, i.e. the tobacco industry and hospitality industry, but also supported by public health politicians and the media) to convince the public of the ineffectiveness, ridiculousness and outrageousness of these measures, not missing the opportunity to compare it with the 'horrible' scene in the United States. By combining forces, Austrian decision makers in health policy, economics and social policy, in close 'co-operation' with the tobacco industry, the hospitality industry and other interested parties, will continue to delay any restrictions proposed or imposed by the European Commission or the WHO as long as possible and ensure that legislation does not exceed the absolute minimum requirements, is weak and, where possible, provides loopholes.

In the end, however, Austria will have to change like everyone else. It seems possible, though, that public opinion will change faster than politicians' preparedness and 'courage' to initiate legal changes. A courageous, engaged and determined health minister as in Italy, Ireland and North European countries is presently not in sight. It may be presumed, however, that soon many more European countries will have joined those who are already leading the way in tobacco control. Perhaps rumours of their success will also pass across Austria's borders.

Some approaches will not be open to Austria's decision makers. With the opening of the East to the European market, in particular with four new EU countries bordering Austria, all of them offering cheap cigarettes and "good smuggling opportunities", an active tobacco price policy will be difficult. This problem will also be faced by many other "old" EU countries. Therefore, a uniform price policy for tobacco products for all EU countries may become necessary for Europe wide tobacco control policies.

10 CONCLUSIONS AND RECOMMENDATIONS

10.1 Limitations of the study

Before reviewing what this thesis has contributed, it is first necessary to discuss the limitations of the research. In carrying out this study, different methods (quantitative and qualitative) were used to achieve the diverse objectives. These involved first setting the scene, by presenting a comprehensive overview of past and current tobacco control policies in Austria, identifying key determinants of smoking and describing the health status of the Austrian population with a focus on smoking-related diseases. These paved the way for the main objective: a critical analysis of Austria's tobacco control policy, gaining insight into the powers behind it and its policy implications, so leading to recommendations for the establishment of a comprehensive tobacco control programme in Austria.

The policy analysis is based on a critical analysis of the tobacco control measures that have been implemented in Austria and personal communications with key informants (some also key actors). However, it was impossible to conduct a comprehensive stakeholder analysis as many people would not talk about this subject. In particular, it was very difficult to elicit direct information about the roles and relationships between certain key players. Similarly, the question of why so little has been done in tobacco control in Austria was very difficult to address directly as enquiries were directly or indirectly declined. The tactics varied, such as an absolute "lack of time" for many months (as, curiously, was the case with all but one leading anti-smoking advocates) or "urgent departures" without cancelling the meeting. Others denied all knowledge, missed the point, enquired cautiously if any publications were planned, or reacted in an evasive manner. One even suggested "not to play the detective" as this would "not pay off" – concerns which were apparently not unfounded. Consequently, access to detailed insider information was not possible. Nevertheless, a very few informants were willing to disclose some information, although some wished to remain anonymous.

Constraints in the time available and the permitted length of this thesis, as well as personal characteristics of the researcher also help to explain why a detailed stakeholder analysis could not be performed. In-depth interviews with all key actors require much patience and persistence, a well-founded political background knowledge (which, in the case of the researcher, developed only over time) to focus the questions, and, above all, a more aggressive, "journalistic" approach.

Apart from unwillingness to answer "unpleasant" questions about Austria's tobacco policy, another limitation is the absence of an anti-smoking "body" such as ASH (Action on Smoking and Health) in the United Kingdom that could offer information and advice.

As explained in the methods section, interviews were carried out in German and direct quotes were translated into English by the author. Similarly, abstracts from letters, laws, newspaper articles, homepages, or other documents were translated from German into English by the author. Although careful attention was paid to avoid changed meanings during translation, slight changes may have occurred.

The quantitative data used in this study include survey data and data from mortality statistics and the cancer registry, the last two being received from the national statistics institute. These statistical data can be considered good quality and were used for further computations on lung cancer mortality *(see contributions)*.

However, some limitations with regard to survey data need to be acknowledged. Data on smoking prevalence and smoking behaviour from the microcensus can be considered representative but are not entirely comparable with other surveys because of differences in statistical methods and in some questions. Other surveys differ in their questions, sampling techniques, size, and method of analysis from survey data used for European comparisons (e.g. HBSC, Eurobarometer). Thus data on smoking prevalence can only be interpreted as an estimate and comparisons must be undertaken with great care.

A more detailed analysis (using logistic regression) of determinants for smoking was performed on the data set of the Vienna Health and Social Survey to which the researcher had access to. Although every effort was made to make the most of these data, it must be acknowledged that the quality of data is limited. Available survey data on smoking in Austria are limited and there is no information on attitudes and beliefs, etc. *(see further research)*.

Another limitation of this thesis is the fact that, although many findings from elsewhere can be generalised and applied to the Austrian tobacco industry (in particular since the takeover of *Austria Tabak* by the British tobacco company Gallaher), the researcher had only access to documents from the international (American) tobacco industry, sometimes reporting about *Austria Tabak* or company members, but no documents from the Austrian tobacco company itself.

Perhaps the greatest limitation is, however, the limitations on length imposed by the regulations for this degree. At the outset, it was not anticipated that so much information would be ob-

tained, so that the draft thesis became much longer than intended. As a consequence, it has been necessary to move much of the material into appendices which, it is conceded, compromises the flow of the text.

10.2 Contributions of this study

Austria is a country subject to remarkably little public health research. While recognising the limitations of this study, noted above, it does make several new contributions to knowledge. For the first time, a comprehensive overview and analysis of tobacco policies in Austria has been undertaken. In addition, by performing logistic regression on data for Vienna, it is the first time that anyone has looked in such detail at determinants of smoking in Austria. It is also the first time that anyone has performed a cohort analysis on lung cancer mortality in Austria.

Most important, however, is the study's contribution to the limited international knowledge about Austrian policy on tobacco control and the understanding of this policy within the wider framework of the tactics of the tobacco industry, the evidence on tobacco control measures, and EU legislation.

Insights into policies were gained by analysis of Austrian media reports on smoking-related issues and television discussions on tobacco control measures, analysis of tobacco industry documents with relevance to Austria, discussions with policy makers and key informants, personal communication and information gathering from various experts and bodies.

By these means, the study provides additional evidence about tactics and strategies of the tobacco industry, confirming findings from other countries about involvement of government and scientists in pursuit of the industry's goals.

A major contribution of this research is the discovery of how social, inter-personal and individual factors, but also economic issues are crucial elements in health policy making in Austria, and possibly in other countries as well. What makes Austria possibly more interesting is the strong interweaving of the small number of key players, mostly due to party-political ties and personal relationships, which makes it very difficult to get useful information about powers behind policymaking.

The most important strength of this research is its comprehensiveness, using a variety of methods and thus allowing a better assessment of Austria's policy-making in relation to tobacco control. This, however, is an area that still requires further research *(see later)*.

10.3 Implications for policy

Experience in many countries has shown that influencing smoking behaviour requires a range of specific interventions linked in a comprehensive tobacco control programme. The goals of tobacco control measures are, however, not only changes in smoking behaviour but ultimately a decrease in smoking-related disease incidence and mortality.[364]

The aim of this thesis was to analyse Austria's tobacco control policies, identify the forces behind them, and develop a set of recommendations for comprehensive tobacco control. We have seen that party-political ties, economical considerations, and close relationships between the Austrian tobacco industry, the government, and leading "anti-smoking advocates", experts and scientists have hampered the development of an effective tobacco control policy in Austria. Compared to many other European and overseas countries, Austria's tobacco policy lacks both political will to implement effective measures to reduce smoking prevalence and to protect non-smokers from the hazards of tobacco smoke. A call for action is necessary.

Based on scientific evidence about health effects of active and passive smoking and evidence on the effectiveness of tobacco control measures implemented in other countries, several measures have been shown to be very effective in reducing tobacco consumption and ultimately also tobacco-related mortality and disease burden. However, single initiatives have been shown to be insufficient. As these measures reinforce each other, several should be implemented simultaneously. The maximum impact comes from a combination of education and information, legislation, taxation, media campaigns, professional involvement, prevention and cessation programmes in various settings, bans on smoking in all public places, and a complete ban on advertising and promotion of tobacco products. Thus, sustained, comprehensive policy elements are crucial, as well as earmarked funding maintained over a long period of time. The ultimate goal, therefore, is a comprehensive tobacco control plan that becomes a permanent part of the public health infrastructure.

The following measures have been shown to be effective elements of a comprehensive tobacco control policy:[132 365 366]

- Increased tobacco taxes (and thus cigarette prices).
- Implementation of smoke-free environments in public places, including restaurants, pubs and bars, to reduce both smoking prevalence and health hazards from passive smoking.

- Increase of information and building of public awareness by population-wide campaigns with adequate, long term funding and ability to administer the campaign free from political interference.
- Advice and support for treatment and cessation, training of health professionals.
- Ban on advertising, promotion and sponsorship of tobacco products.
- Product control and consumer information.
- Fighting illicit trade in tobacco products on a pan-European level.
- Reduction of availability of tobacco products to young people (regulations on distribution) and of opportunities to smoke (smoke-free environments).

The strategic approach should be population-based, aiming to make non-smoking behaviour the norm and thus lowering the risk in the entire population. As outlined in the 2002 WHO World Health Report, "small shifts in some risks in the population can translate into major public health benefits".[2] As Geoffrey Rose noted, "it makes little sense to expect individuals to behave differently from their peers". It would be "more appropriate to seek a general change in behavioural norms and in the circumstances which facilitate their adoption".[367] However, changes in social norms and the social environment of local communities must come from the grass-roots and, while the state can foster a supportive environment, this cannot be mandated from the top.

Sound research and evidence are extremely important as a basis for good policy decisions. In many countries, generating and publishing a solid information base proved enormously useful to policymakers and advocates and helped promote changes in public attitudes and awareness that gradually led to changes in social norms. A comprehensive and integrated programme of surveillance has often been a key component, addressing a wide spectrum of planning, implementation, and evaluation needs.[368] Therefore, monitoring, evaluating, and reporting on tobacco use and tobacco control policies should be an additional part of a comprehensive tobacco control programme.[132]

When developing measures to reduce tobacco consumption one has also to take account of the established strategies adopted by the tobacco industry, in particular with regard to concealing and distorting evidence and confusing and misleading the public (and thus also health politicians) about the health impacts of active and passive smoking.[27 369] Continued raising awareness among the public is therefore an important step preceding and accompanying anti-smoking measures. Another successful strategy of the tobacco industry one should adopt is the practice of lobbying.

Particularly for reluctant countries such as Austria, strong and binding EU legislation on smoke-free environments in public places (especially smoking in the workplace, including restaurants and bars) could be important to stimulate changes, with pressure from other countries (so Austria can no longer exclude itself) and the public (pressure groups and increased demand by customers, including tourists), making economic interests the thriving force. Although 25 years later, the situation today is not much different from 1979, when a Philip Morris report stated: "No major change in the present situation of Austria can be anticipated. However, any increased spill-over effect from other countries concerning the health question might force the Austrian Government to reconsider its position."[104]

The assessment of the success (or failure) of Austrian tobacco policies was examined within the wider framework developed by the WHO's European Strategy for Tobacco Control (ESTC), which is based on the best available evidence, and on the lessons learnt from European and international experience.[132] Although Austria agreed with its signature to the Warsaw Declaration and the WHO Framework Convention on Tobacco Control to allocate a share of tobacco tax revenues to anti-smoking campaigns and to develop a comprehensive tobacco control programme, nothing has happened as yet and there are no signs that this will change. It is a striking fact that Austria has been concentrating its already very limited efforts in measures that are widely known to be not very or not at all effective, or even counter-effective – and still defends this approach. Particularly over the last decade, campaigns have only been targeted at youth, and have been very small-scale and mostly conducted in a patronising manner, while those measures recognised as effective are mocked, brushed off or contested. Legislation is weak, smoking prevention has become synonymous with treatment for severely ill smokers, cessation is not an issue, and tax revenues from tobacco products are used to balance budgets and finance health promotion projects but are not earmarked for anti-smoking campaigns or tobacco control measures. The next section therefore proposes recommendations as to what steps are needed to implement an effective and comprehensive tobacco control programme in Austria.

Smoke-free legislation, clean indoor law

International experience demonstrates how comprehensive legislation is absolutely crucial to achieve effective tobacco control. Generally, legislative measures are far more effective than voluntary agreements. The latter usually only work where there is strong economic or other external pressure that makes the *status quo* no longer tenable (as shown, for example, with non-smoking flights by Austrian Airlines or smoking restrictions at Vienna Airport). Furthermore,

to be effective, legislation must be coupled with an emphasis on implementation and enforcement, including substantial fines and other sanctions.

To achieve smoke-free environments in the hospitality business strong and binding laws are needed, whereas ventilation, voluntary agreements and partial smoking bans have been shown not to be effective.[135] Additional benefits of smoke-free environments include a decrease in smoking prevalence and in tobacco-related morbidity and mortality (above all cancers and cardiovascular diseases).[364]

In Austria, discussion of smoke-free environments at workplaces (including restaurants, pubs and bars) is dominated by the viewpoint of smokers. Instead, the rights of the majority non-smoking public should have priority. There is also no reason why this should not apply to hospitality employees.

Although laws restricting smoking in some environments do exist, they are often vaguely formulated, barely adhered to and not enforced. Almost all of these bans are in laws and regulations other than the Austrian tobacco act, such as the employees' protection act or the local public transport regulations, or are individually regulated by the hospital or school management. Austria's health politicians are strictly opposed to smoking bans in restaurants and bars, while relying on the market and favouring the voluntary agreements advocated by the Austrian tobacco industry and hospitality industry. Arguments are either based on the "tolerant" view that "these kind of laws" are not needed in Austria or on the misplaced fear of economic damage to the hospitality business. There is a current danger of pre-emptive legislation, suggesting that only premises above a certain size should be obliged to offer a non-smoking environment. There is no discussion of making non-smoking the norm and separating smokers in specially designed rooms.

Smoke-free environments have been successful not only in the notorious United States (in Austria widely cited as an example of extremist and puritanical measures) but also in Canada, Australia, New Zealand, and in many European countries. It can be demonstrated that not only non-smokers benefit from smoke-free legislation, but also smokers themselves: first, smokers smoke less; second, smoke-free environments offer a greater chance to quit; third, there is less need and less opportunity for young people to start smoking; and fourth, the public (including smokers) will support legislation once enacted. Public approval following introduction of smoke-free

environments in restaurants and bars is reflected in results of surveys as, for example, was shown in Scandinavian countries or in Australia.[a]

Conducting a population poll before enactment of smoke-free legislation, especially after a phase of sensitisation to counteract continued misinformation of the public, could make a strong argument for the implementation of smoke-free environments in all workplaces, including restaurants and bars. At the same time the public would see that it is the preference of the majority and not the pressure of a few "intolerant" and "militant" non-smoking fanatics or a patronising law forced upon the people. Thus the role of the media becomes very important.

Ultimately, it will probably not only be a question of laws but rather a change in public attitude and social awareness, in particular of an increased awareness and self-confidence of non-smokers. Therefore, what is most needed in Austria are strong educational campaigns to influence the public opinion and strengthen the rights of non-smokers rather than those of smokers; to convince patrons, employees as well as customers of the benefits of smoke-free environments in the catering business; to help make non-smoking the social norm and smoking the exception; and to enact comprehensive smoking bans in all workplaces, backed by significant sanctions.

Taxation

Taxation is another most effective measure to control tobacco consumption, particularly among children and young people. Tax revenues can also be used to finance comprehensive and sustainable educational campaigns and treatment.

Information, educational campaigns and public awareness building

The third pillar in an effective tobacco control policy is information and education of the public. This should involve large-scale, multi-level, long-running and aggressive mass media campaigns, targeted at the whole population, supplemented with group-specific and more narrowly focused campaigns targeted specifically at children, youths and women, the main targets of cigarette advertising. Media campaigns are not only known to be successful transmitters of educational programmes but crucial in any tobacco control programme. Success depends on intensity of measures and aggressiveness of implementation. Administration of state-level campaigns should be free from political interference[366].

[a] One Australian survey was even conducted by Philip Morris but, due to its unhelpful results, was not adver-

The ultimate goal of information and educational campaigns is a change in social norms, declaring smoking to be "out" and altogether an irresponsible behaviour, and to build up public awareness not only towards health hazards of smoking, but also towards hazards from passive smoking and towards advertising strategies of the tobacco industry (exposure of tobacco industry tactics allows smokers to feel they are victims rather than villains). The latter should in particular address the marketing of low tar cigarettes and the disclosure of the "light cigarette lie", which aims to reassure smokers and deter them from quitting. In addition, due to skilful marketing and very attractive packet design, cigarettes have a strong appeal, especially to young people. Therefore, campaigns would also have to include broad and continued counter-advertising.

Population-wide campaigns should offer information about and support for quitting *(see below)* while prevention campaigns would have to start already with young children. Along with a change in social norms, long-term goals would be a decrease of smoking rates and an increase of ex- and non-smokers, and ultimately a decrease in tobacco-related diseases and mortality.

The argument that there are insufficient funds for these admittedly very expensive campaigns can easily be countered with a substantial tax raise for all tobacco products and the allocation of a certain amount of tobacco tax gains to fund campaigns. In addition, fines for violating smoking bans or other tobacco laws could be used for anti-smoking activities. These extensive and long-running campaigns would also counter the continuing argument against tobacco advertising bans concerning purported losses by the advertising industry, as these losses would turn into gains.

Cessation

The fourth pillar is the promotion of cessation, which as yet is not an issue in Austria. The importance of quitting can now be seen to be more important than ever in the light of the recently published follow-up to the British doctors' study.[371] Cessation is not advertised and existing initiatives are not supported. There are virtually none of the helplines or quitlines that exist in other countries. Medical students, doctors, pharmacists and other health professionals are not trained in advising and supporting smokers to quit.

A stronger approach to cessation is thus essential, including information on possible cessation techniques, contact numbers (helplines), and advertising of effective products (the latter would also contribute to awareness building). Specific training courses for health professionals should

tised.[370]

be offered to increase their involvement in cessation and improve support. High-quality courses for leaders of smoking cessation courses are also needed. As yet, the involvement of health professionals in cessation is very modest. The fact that smoking is primarily an addiction and not a matter of "choice" and "pleasure" should be stressed. It has also to be pointed out that cessation is the only proven way to reduce illness and death caused by tobacco products. The implementation of helplines and quitlines would be essential and one of the less expensive first steps in tobacco control; even if not very successful initially, use of both, quitlines and cessation programmes increase after the onset of anti-smoking campaigns.

Examples for a stronger approach to cessation are reported from Norway, where Week 3 and Week 36 have been established as regular weeks for starting six-week cessation courses, or from Finland, where bigger pharmacies have their own advisor specialising in smoking cessation.

Recommended steps

In summary, the following steps are recommended as a comprehensive tobacco control programme in Austria.

Pillar 1: Legislation

- Clean indoor air law, with non-smoking being the norm and smoking the exception (specified and clearly divided rooms for smoking). Prevention of pre-emptive legislation. Smoke-free environments in all workplaces, including restaurants, pubs, bars and cafés. Similarly, smoking bans in all public buildings, including airports, train stations, etc. – controlled by officials, with fines.
- Complete ban (with enforcement) for advertising and promotion of tobacco products, as well as ban on sponsorship.

Pillar 2: Taxation and financing of anti-smoking campaigns, cessation and treatment

- Sharp tax rise on all tobacco products.
- Allocation of a certain amount of tobacco tax revenues to anti-smoking campaigns and tobacco control measures, cessation (courses, helplines, quitlines) and treatment.

- Sharp increase or imposition of substantial and rigorously enforced fines for violations of advertising bans and smoking bans. Present (and not enforced) fines[b] should be increased at least 10- or even 20-fold. Revenues from fines should be earmarked for tobacco control measures.

Pillar 3: Anti-smoking campaigns, information, education, public awareness building

- Launch of strong, multilevel, broad, sustainable, i.e. long-term orientation, and aggressive media anti-smoking campaigns, targeting the whole population. Media advertisements should be targeted at different audiences. As with all campaigns, they should have a clear goal and be kept "simple". The use of a popular slogan is recommended, either the old "same without smoke", or another good one (in German language). Campaigns should encompass education about health hazards of smoking, information about and support for cessation, strong advertisements targeting tactics of the tobacco industry, and building public awareness about passive smoking hazards. They should also address false hopes that "light" or "low-tar" cigarettes are less harmful.
- Long-term goals should be a change in social norms, in particular that smoking is not only unhealthy but altogether an irresponsible behaviour, leading to a decrease in smoking rates and an increase of ex- and non-smokers, and ultimately the decrease in tobacco-related diseases and mortality.
- Youth prevention is important but will only work when part of a population-wide campaign. It would also have to start at a much earlier age than it is done now, i.e. at primary school. In particular, campaigns addressed at teenagers should not be patronising or pretend to make non-smoking appear to be "cool" or demonstrate "real" self-confidence. Education about the tactics of the tobacco industry and how cigarette advertising works should be crucial elements of all campaigns, regardless of age. In addition, youth prevention programmes "should not shy away from anti-tobacco advertisements that feature the serious consequences of smoking. These types of ads *[advertisements]* are the ones perceived as most effective by teenagers regardless of their smoking status, age, sex or ethnicity."[372] Adolescents and youths are also very aware of adult-focused, i.e. population-wide campaigns, thinking it relevant to them.[373] It can be assumed that youths probably respond even better to adult-focused campaigns than to

[b] Present fines stipulated by the 1995 Tobacco Act are only restricted to violations of advertising restrictions (approximately €7,000 for a first and approximately €14,000 for repeated violations). The Vienna local transport regulations foresee fines of €40 for smoking in underground stations.

youth-specific school-campaigns. The latter should therefore be concentrated on younger children.

- Varying, impressive and highly visible health warnings on cigarette packs accompanied with illustrative photos (power of images).
- Sensible presentation of portrayals of real life scenarios of people going through treatment for smoking-related diseases in the mass media (TV, newspapers). They evoke strong emotional reactions and have proven to be memorable and powerful tools.
- Promotion of feeling of responsibility of smokers towards non-smokers (not only "politeness" and "courtesy" but irresponsible behaviour).

Pillar 4: Cessation

- Promotion of cessation is most important when aiming to reduce smoking prevalence. The establishment of quitter telephone lines, offering objective information on all cessation techniques, support or even intervention, is an essential first step to support cessation.
- Advertisement for quitting on posters at point of sale (together with tobacco advertisement, where the latter is not yet banned completely), in pharmacies, underground trains, magazines, etc. Advertisements should include information about various cessation techniques and provide contact addresses or telephone numbers (helplines, quitlines) for advice and support. The fact that smoking is an addiction and not a matter of "choice" and "pleasure", and that cessation is the only proven way to reduce illness and death caused by tobacco products, should be stressed.[374]
- Promotion of effective treatments for tobacco dependence by health insurance funds.
- Training of leaders of smoking cessation courses and health professionals (but not by experts with close relations to the tobacco industry).
- Establishment and advertisement of certain weeks every year for starting cessation courses all over the country, following the example in Norway.

Strategy

1. Preparing the ground

- Design and strategy planning for a comprehensive tobacco control plan.

- Education of the public and awareness building: advertising campaigns, well-briefed media, public opinion polls (public opinion usually favours tobacco control once the issues are explained).
- Moral and financial support of non-smokers' rights associations and other civil society anti-smoking groups.
- Lobbying, allies and coalition building: Collaboration between government and health authorities, NGOs, civil society groups, and committed individuals is essential. Trying to gain allies in the catering industry trade unions, making them aware of their right to have a smoke-free workplace. Commissioning of studies on employees of the hospitality business (can be used for public awareness building and justification for clean indoor air law). Winning mass media over to smoking prevention campaigns.
- Neutralising opponents (framing message to own advantage).

2. Swift and concerted action, decisive and forceful

- Raise tobacco taxes.
- Onset of aggressive, multilevel, broad, and long-term oriented media anti-smoking campaigns, targeting the whole population. Stress on cessation and information about possible support.
- Simultaneously group-specific campaigns, targeted at young children and women.
- Clean indoor air law with provision of sanctions (to be enforced), preceded and evaluated by a population poll.
- Complete ban on advertising, promotion and sponsorship, demonstrating that alternative sources of sponsorship does emerge.

10.4 Further research

Although wide-ranging, providing insights into many aspects of Austria's policy-making on tobacco, this study has scratched only the surface. Research on tobacco and health is still extremely sparse in Austria.

Deeper research into the powers behind decision-making process and into the apparent role of key players is needed to fully understand the failure of Austria's tobacco control policies. Therefore, a more detailed stakeholder analysis in particular on the role of government (i.e.

certain politicians), media, NGOs, opinion leaders and scientists, health insurance funds, the pharmaceutical industry and, of course, the tobacco industry would be necessary.

More and better surveys are badly needed to provide information not only on smoking prevalence but, in particular, on attitudes and beliefs, the development of the "smoker career", and cessation efforts. Among children there is a need for surveys that assess attitudes towards smoking and, to understand the impact of advertising and sponsorship, studies of brand recognition, as, for example, was done in a survey in Turkey among primary schoolchildren.[375]

There is also a need for more research on the future impact of tobacco on disease and mortality[7] [376], in particular the development of models that can predict the scale of future mortality reduction achievable through smoking cessation as, for example, done by Mulder *et al.*[377].

Another important area for further research is to measure exposure to environmental tobacco smoke and thus to estimate the attributable burden of disease due to passive smoking in the Austrian population, as in the 1998 German Environmental Survey[378], studies on the impact of passive smoking on employees of the hospitality industry[155] [156] and on never-smokers living with smokers[379].

More studies are also needed to assess the net economic burden of smoking[380] and passive smoking in Austria.

More detailed work is also needed for surveillance of strategies of the tobacco industry to circumvent anticipated advertising bans by strengthening existing brands, product alterations, and stretching loopholes in the legislation as far as possible. According to a study by Carter, who analysed 172 tobacco industry documents, "a range of activities have been used in combination, including guerrilla marketing, advertising in imported international magazines, altering the pack, sponsorships, brand stretching, event promotions, lifestyle premiums, and the development of corporate websites".[381] Thus, the development of a prospective monitoring system well in advance of the implementation of a total advertising ban would be necessary.

Lessons learnt

In the process of this research I have learned a great deal about methods, study design, technical aspects of scientific writing, the manipulative tactics of the tobacco industry, and Austrian politics, but also about myself.

By performing logistic regression and cohort analysis and collecting and analysing qualitative data, I have developed new methodological skills. In particular in the process of information gathering, due to the absence of real willingness by people to engage in a debate on tobacco control policies in Austria, I realised my own limitations, both with regard to "insider" and party-political background knowledge and my technique of questioning evasive key actors. As noted in the limitations of this study, this would probably need a more "professional" or "journalistic" approach. However, this is increasingly difficult to do with the extension of ethical models based on biomedical research, in which those formally interviewed are considered research subjects and so must be excluded unless they give written informed consent. This is a matter that requires further discussion if more detailed research in contentious areas such as this is to be pursued.

However, by experiencing these difficulties, I have learned much about Austrian politics and, in particular, health policy. I have thus realised the strong forces behind the decision-making process in relation to tobacco control in Austria. Another insight was the confirmation that, in the field of health, only a small number of individuals, occupying key positions, exert influence and control – on policies, media coverage, public opinion, studies and study results. In addition, Austria's health politicians, health experts, and officials working on tobacco control and health promotion in the Health Ministry (even if, occasionally, they are physicians), have very limited public health expertise. Either they are guided by their own opinion, driven by "external forces", or influenced by experts who play a double role. Finally, while until 2000, tobacco control policies were dominated by party-political ties and the fact that Austria's tobacco industry was a state enterprise, the new conservative government stresses more outspoken economic interests (now *Austria Tabak* is just one among several big companies to be courted for taxes, employment, etc.).

These insights lead me to conclude that only a very dedicated and courageous health minister, building on a sustained programme to increase awareness among the public about non-smokers' rights, and linked to pressure from other countries (including complaints by tourists and thus economic pressure), and, most importantly, strong and binding EU legislation will be able to force Austria to confront its complacency and so to implement effective measures to reduce smoking and protect non-smokers from the hazards of tobacco smoke. The very recent (June 2004) shift of the Health Minister towards a more "rigorous" approach towards smoking in the workplace and possibly also in restaurants, pubs and bars, following discussions on the Irish smoking ban and in anticipation of new EU legislation on smoke-free environments, confirms

the well-known Austrian motto, first coined by Habsburg Emperor Frederick III (1440-1493)[382] and re-interpreted by Frederick II of Prussia, that Austria will "always survive" – or, according to another interpretation, will be "the last one":

AEIOU – Austria Erit In Orbe Ultima.[c]

[c] "Austria will be in existence until the end of the world". But also: "Austria will be the last (of all) in the world."

APPENDICES

REFERENCES

1. Fagerstrom K, Boyle P, Kunze M, Zatonski W. The anti-smoking climate in EU countries and Poland. *Lung Cancer*. Apr 2001;32(1):1-5.

2. WHO (World Health Organization). The World Health Report 2002. Geneva: WHO, 2002.

3. Jha P, Chaloupka F. Curbing the epidemic: governments and the economics of tobacco control. Washington D.C.: The World Bank, 1999.

4. Asma S, Yang G, Samet J, Giovino G, Bettcher DW, Lopez AD, et al. Tobacco. In: Detels R, McEwen J, Beaglehole R, Tanaka H, editors. *Oxford Textbook of Public Health. Vol. 3: The Practice of Public Health*. Fourth ed. New York (Oxford University Press), 2002:1481-1502.

5. Peto R, Lopez AD. The future worldwide health effects of current smoking patterns. In: Koop CE, Pearson CE, Schwarz MR, editors. *Global Health in the 21st Century*. New York, 2000.

6. Crofton J, Simpson D. *Tobacco: A Global Threat*. Oxford: Macmillan, 2002.

7. Peto R, Lopez AD, Boreham J, Thun M. Mortality from smoking in developed countries 1950-2000 (2nd edition: data updated 15 July 2003). 2003. http://www.ctsu.ox.ac.uk/~tobacco/MN_AP_4010.pdf; http://www.ctsu.ox.ac.uk/~tobacco/FINALP1.pdf; accessed September 2003.

8. Peto R, Lopez AD, Boreham J, Thun M, Heath CW, Jr. Mortality from Smoking in Developed Countries 1950-2000. Oxford, 1994.

9. Estimates by the Federation of Austrian Social Insurance Institutions and the Institute of Social Medicine of the University of Vienna.

10. WHO (World Health Organization). Smoking, drinking and drug taking in the European region. Copenhagen: WHO Regional Office for Europe, 1997.

11. Urbas E, Klimont J. Rauchgewohnheiten. Ergebnisse des Mikrozensus Dezember 1997 (Smoking Habits. Results from the Microcensus of December 1997). Vienna: Statistics Austria, 2002.

12. Currie C, Hurrelmann K, Settertobulte W, Smith R, Todd J, eds. Health and Health Behaviour among Young People, Health Behaviour in School-aged Children: A WHO Cross-National Study (HBSC). International Report. Health Policy for Children and Adolescents Series No.1. Copenhagen: WHO Regional Office for Europe, 2000.

13. Dür W, Kernbeiss G, Mravlag K, Stidl T, Schuss I. Gesundheit und Gesundheitsverhalten bei Kindern und Jugendlichen. Bericht zur Gesundheit der 11-, 13- und 15-jährigen SchülerInnen in Österreich. Ergebnisse des 5. HBSC-Surveys 1998 und Trends für die 90er Jahre. Reihe Originalarbeiten / Studien / Forschungsberichte 2/2000. Wien: BMSG, 2000.

14. Kandlhofer J. (Spokesman of the executive board of the Federation of Austrian Social Insurance Institutions). Written information by e-mail, 25 August 2003.

15. Federation of Austrian Social Insurance Institutions. Press release at the occasion of the World No Smoking Day 2002.

16. British Medical Journal. TC Online. http://tc.bmjjournals.com/misc/searchbrowse.shtml; accessed March - June 2003.

17. European Commission. EUROPA - Public Health - Lifestyle - Tobacco. http://europa.eu.int/comm/health/ph_determinants/life_style/Tobacco/tobacco_en.htm; last accessed January 2004.

18. European Commission. European Network for Smoking Prevention (ENSP). http://www.ensp.org/; accessed September 2003.

19. The World Bank Group. Economics of Tobacco Control. http://www1.worldbank.org/tobacco/; accessed January - February 2004.

20. WHO (World Health Organization). Tobacco Free Initiative (TFI). http://www.who.int/tobacco/en/; accessed June 2003.

21. WHO (World Health Organization). Framework Convention on Tobacco Control (FCTC). http://data.euro.who.int/?TabID=3763; http://www.who.int/tobacco/fctc/en/; http://www.who.int/gb/fctc/PDF/inb6/einb65.pdf; accessed March - August 2003.

22. CDC (Centers for Disease Control) / National Center for Chronic Disease Prevention and Health Promotion. Tobacco Information and Prevention Source (TIPS). http://www.cdc.gov/tobacco/.

23. Austria Tabak/Gallaher. Press release: Austria Tabak: Gallaher's Zentrale für Europa. Copy provided by Austria Tabak; September 2003.

24. Monopolverwaltung (MVG). Homepage. http://www.mvg.at/; last accessed January 2004.

25. MacKenzie R, Collin J, Lee K. *The tobacco industry documents: an introductory handbook and resource guide for researchers*. London: Centre on Global Health and Change, London School of Hygiene and Tropical Medicine, 2003.

26. Malone RE, Balbach ED. Tobacco industry documents: treasure trove or quagmire? *Tob Control*. 2000;9:334-338.

27. Gilmore A, McKee M. Tobacco control policy: the European dimension. *Clin Med*. Jul-Aug 2002;2(4):335-42.

28. European Commission. EUROPA - Public Health - Legal documents. http://europa.eu.int/comm/health/horiz_legal.htm#4; accessed July 2003 and January 2004.

29. European Union. EU Law and Policy Overview: EU Smoking and Tobacco Policy. http://www.eurunion.org/legislat/smoking/smoking.htm; accessed June - August 2003.

30. Bundeskanzleramt (BKA) - Rechtsinformationssystem (RIS). Bundesrecht. http://www.ris.bka.gv.at/bundesrecht; last accessed September 2003.

31. Österreichisches Parlament. http://www.parlinkom.gv.at/; accessed June 2003.

32. Kronen Zeitung. Archive. http://www.krone.at/index.php?http://dev01.krone.at/cgi-bin/search.cgi; accessed January 2004.

33. Kurier. Archive. http://www.kurier.at/archiv/; accessed January 2004.

34. Der Standard. Archive ("Suchen"). http://derstandard.at/; accessed January 2004.

35. die Presse. Archive. http://www.diepresse.com/services/archiv/default.asp; accessed January 2004.

36. Profil. Homepage. http://www.profil.at; last accessed January 2004.

37. ORF (Austrian Broadcasting Company). Kampf den Rauchern. Series: Help TV (ORF2), 5 November 2003 (protocol provided by the ORF).

38. ORF (Austrian Broadcasting Company). Feldzug gegen die Raucher? Genuss oder Sucht? Verbot oder Eigenverantwortung? Eine emotionelle Debatte. Series: Offen gesagt (ORF2), 4 April 2004 (video).

39. National Manufacturers' Associations. The European tobacco industry - facts and figures 2000. Brussels: Confederation of European Community Cigarette Manufacturers (CECCM), March 2002.

40. WHO (World Health Organization) - Regional Office for Europe. Tobacco Control Database. http://data.euro.who.int/tobacco/; accessed September 2003.

41. OECD Health Data 2002.

42. WHO (World Health Organization). European health for all database (HFA-DB). WHO/Europe; updated June 2003.

43. WHO (World Health Organization). Discussion Papers No. 31: Age Standardization of Rates: A New WHO Standard (Download). www.who.int/whosis/discussion_papers/; accessed January 2004.

44. Urbas E. Gesundheitszustand und Konsum medizinischer Leistungen. Ergebnisse des Mikrozensus September 1999 (Microcensus on Health 1999). Vienna: Statistics Austria, 2002.

45. Friedl HP. Rauchgewohnheiten der österreichischen Bevölkerung. Ergebnisse des Mikrozensus 1986. *Statistische Nachrichten*. 1987;42(5):330-.

46. Freidl W, Stronegger W-J, Neuhold C. Wiener Gesundheits- und Sozialsurvey / Vienna Health and Social Survey. S1/2001. Vienna: City of Vienna, 2001.

47. Stronegger W-J, Freidl W. Tabellenband zum Wiener Gesundheits- und Sozialsurvey. Vienna: City of Vienna, 2002.

48. Urbas E. Mikrozensus 1999 - Ergebnisse zur Gesundheit in Wien / Microcensus 1999 - Results on Health in Vienna. Vienna: City of Vienna, 2002.

49. Freidl W, Stronegger W-J, Neuhold C. Lebensstile in Wien / Lifestyles in Vienna. S3/2003. Vienna: City of Vienna, 2003.

50. Freidl W, Neuhold C. *Gesundheitssurveyforschung im regionalen Setting: Gesundheitsberichterstattung in der Steiermark unter Berücksichtigung psychosozialer Aspekte*. Frankfurt/M.: VAS, 2002.

51. IFES (Institut für Empirische Sozialforschung). Suchtmittelstudie: Monitoring 2001. 01113bericht. Vienna: IFES, November 2001.

52. IFES (Institut für Empirische Sozialforschung). Leben in Wien (Gesamtergebnisse, Tabellenband). Vienna: IFES, 1995.

53. Groman E, Bayer P, Kunze U, Schmeiser-Rieder A, Schoberberger R. Diagnostik und Therapie der Tabakabhängigkeit - eine Analyse des Bedarfs in Österreich. *Wiener Medizinische Wochenschrift*. 2000;150(6):109-114.

54. Full data set of the Vienna Health and Social Survey 2001/2002.

55. European Commission. Eurostat Pocketbook on Key Figures of Health. Eurostat, 2002.

56. Goodman J. *Tobacco in History: The cultures of dependence*. London, New York: Routledge, 1994.

57. Gilmore A. Conference presentation: Pushing the pandemic: "Winning or losing now in Uzbekistan will dictate our opportunities in central Asia for the next 10 years": BAT's entry into Uzbekistan. 12th WCTOH; 5 August 2003; Helsinki.

58. Saloojee Y, Dagli E. Tobacco industry tactics for resisting public policy on health. *Bull World Health Organ*. 2000;78(7):902-10.

59. Glantz SA, Balbach ED. *Tobacco War. Inside the California Battles*. Berkely, Los Angeles, London: University of California Press, 2000.

60. Simpson D. Submission to the World Health Organization's public hearings on the Framework Convention on Tobacco Control. International Agency on Tobacco and Health, 31 August 2000.

61. WHO Europe. European Ministerial Conference for a Tobacco-free Europe, Warsaw, 18-19 February 2002: The European Report on Tobacco Control Policy. Review of implementation of the Third Action Plan for a Tobacco-free Europe 1997-2001. Copenhagen: World Health Organization, Regional Office for Europe, 2002.

62. Simpson D. Conference presentation: Industry health education campaigns. 12th WCTOH; 5 August 2003; Helsinki.

63. Hurt RD, Robertson CR. Prying open the door to the tobacco industry's secrets about nicotine: the Minnesota tobacco trial. *Journal of the American Medical Association*. 1998;280:1173-81.

64. Canova D, Myers ML, Smith DE, Slade J. Changing the future of tobacco marketing by understanding the mistakes of the past: lessons from "Lights". *Tob Control*. 2001;10(Suppl I):i43-i44.

65. Kozlowski LT. First, tell the truth: a dialogue on human rights, deception, and the use of smokeless tobacco as a substitute for cigarettes. *Tob Control*. Mar 2003;12(1):34-6.

66. Bates C, Fagerstrom K, Jarvis MJ, Kunze M, McNeill A, Ramstrom L. European Union policy on smokeless tobacco: a statement in favour of evidence based regulation for public health. *Tob Control*. Dec 2003;12(4):360-367.

67. Karas C. Newspaper article: Aktuelle Nikotin-Forschung: Verteufelte Droge ist weitgehend harmlos. Newspaper *Wiener Zeitung,* 30/31 May 2003.

68. Karas C. Newspaper article: Schweden als guter Modellfall: Snus statt Rauch wäre Alternative. Newspaper *Wiener Zeitung,* 30/31 May 2003.

69. Kunze M. Conference presentation: Differences in male lung cancer rates in Austria, Germany, Sweden and Finland: can they be explained by different forms of nicotine intake? (E. Groman, C. Unterluggauer, M. Kunze). 12th WCTOH; 4 August 2003; Helsinki.

70. Austria Tabak Gallaher (Public Relations Office). Written information upon request, 22 September 2003.

71. Austria Tabak. Smoking and Health - Arguments. June 1982. Philip Morris. Bates No. 2501443946/3979. http://www.pmdocs.com/PDF/2501443946_3979.PDF. (Accessed 25 June 2004).

72. Market Tracking International Ltd. *World Tobacco File 1998*. Vol.1 and 2. London: MTI, 2001.

73. Austria Tabak Gallaher. Written information, September 2003.

74. Austria Tabak. Haupttätigkeitsbereiche der Emittentin. First page of chapter 4.1 (book title not available). Copy provided by Austria Tabak.

75. Monopolverwaltung (MVG). Enquiries by telephone, June 2003.

76. Monopolverwaltung (MVG). Tabakmonopolgesetz 1996. http://www.mvg.at/inhalt_gesetz.html; last accessed January 2004.

77. Austria Tabak. Tobaccoland (homepage). http://www.tobaccoland.at; accessed November 2003 - January 2004.

78. University of California - San Francisco. Legacy Tobacco Documents Library. http://www.legacy.library.ucsf.edu/; accessed June - September 2003.

79. University of California - San Francisco. British-American Tobacco Document Collection: Documents from the Guildford Depository. http://www.library.ucsf.edu/tobacco/batco/index.html; accessed June - September 2003.

80. CDC (Centers for Disease Control and Prevention). Tobacco Industry Documents. http://www.cdc.gov/tobacco/industrydocs; accessed June - September 2003.

81. CDC (Centers for Disease Control and Prevention). Tobacco Industry Documents - Philip Morris. http://www.cdc.gov/tobacco/industrydocs/phillipmorris.htm; accessed June - September 2003.

82. Guildford Document Depository. Tobacco Archives. http://www.TobaccoArchives.com/; accessed June - September 2003.

83. Philip Morris USA Inc. Document Site. http://www.pmdocs.com; last accessed June 2004.

84. RJ Reynolds Tobacco Company. Document Archive. http://www.rjrtdocs.com; accessed June - September 2003.

85. Brown & Williamson. Search Collection. http://www.bwdocs.com/public.asp; accessed June - September 2003.

86. Lorillard Tobacco Company. Document Site. http://www.lorillarddocs.com/; accessed June - September 2003.

87. The Tobacco Institute. Document Site. http://www.tobaccoinstitute.com/; accessed June - September 2003.

88. The Council for Tobacco Research USA Inc. Document Site. http://www.ctr-usa.org/; accessed June - September 2003.

89. UICC GLOBALink - The International Tobacco Control Network. Austria News Items on Tobacco. http://member.globalink.org/archive/hammond/eu-docs/euat.html; accessed June - September 2003.

90. TobaccoPedia. The online tobacco encyclopedia. http://www.tobaccopedia.org/; accessed June - September 2003.

91. Gallaher Group Plc. Tobacco documents site. http://www.gallaher-docs.com/subindex.htm; accessed June - September 2003.

92. Gallaher Group Plc. Homepage. www.gallaher-group.com; accessed June - September 2003.

93. Austria Tabak. Homepage. http://www.austriatabak.at/new/; accessed July-December 2003.

94. Austria Tabak. Homepage, CED facts. http://www.austriatabak.at/new/en/continental.htm; accessed July - December 2003.

95. Dymond HFD. CORESTA [Various documents about Coresta including a note to B.D. Bramley from H.F.D. Dymond and a list of members by country]. "B" Corp. Date: 31 March 1992. Bates No. 401349242/9364. http://www.library.ucsf.edu/tobacco/batco/html/12700/12706. (Accessed 29 June 2003).

96. Glantz SA, Bero LA, Hanauer P, Barnes DE, Slade J. *The cigarette papers*. San Francisco, CA: University of California Press, 1996.

97. Dubois G, Tramier B. The responsibility of the tobacco industry for the tobacco pandemic. *Int J Tuberc Lung Dis*. Apr 2001;5(4):304-6.

98. Heard AL. Meeting Minutes of the Research Policy Group Meeting September 19 to 21, 1988, Hotel Schloss Fuschl, Salzburg, Austria. 19 September 1988. British-American Tobacco Company. Bates No. 401018120/8132. http://www.library.ucsf.edu/tobacco/batco/html/9900/9992/. (Accessed 5 April 2003).

99. Blackman LCF. 8th International Scientific Tobacco Scientists' Conference of CORESTA [Tour Report] 16 October. 1984. British-American Tobacco Company. Bates No. 109874200/4202. http://www.library.ucsf.edu/tobacco/batco/html/12300/12364/index.html. (Accessed 28 June 2003).

100. Philip Morris Office. Bruckner. Notes on the Enlarged Managing Committee of the "VERBAND", on October 24, 1975. Re: PR activity and "Smoking and Health". 5 November 1975. Philip Morris. Bates No. 2024965211. http://www.pmdocs.com/PDF/2024965211_5217.PDF; http://www.pmdocs.com/getallimg.asp?if=avpidx&DOCID=2024965211/5217. (Accessed 30 June 2004).

101. Sheehy P. Tobacco - Chairman's Advisory Conference Austria May 1981 [letter]. 13 August 1980. British-American Tobacco Company. Bates No. 109877263/7264. http://www.library.ucsf.edu/tobacco/batco/html/8200/8276/. (Accessed 5 April 2003).

102. JT. Tobacco - Chairman's Advisory Conference Austria May 1981 [letter]. 21 August 1980. British-American Tobacco Company. Bates No. 109877259/7260. http://www.library.ucsf.edu/tobacco/batco/html/8200/8274/. (Accessed 5 April 2003).

103. Gaish H. Visit of Dr. Kuhn to Neuchatel. 18 November 1975. Philip Morris. Bates No. 1000011229/1230. http://legacy.library.ucsf.edu/tid/acs94e00. (Accessed 14 February 2004).

104. Philip Morris. Austria - Smoking and Health. (Confidential report: Five Year Plan 1980-1984). 1979. Philip Morris. Bates No. 2500006019/6024. http://www.pmdocs.com/PDF/2500006019_6100.PDF. (Accessed last: 18 June 2004).

105. Simpson B. INFOTAB Board of Directors Meeting, Bath, October 30-31, 1983. 1983. Philip Morris. Bates No. 2025013509/3614. http://www.pmdocs.com/PDF/2025013509_3614.PDF. (Accessed 30 June 2004).

106. Dollisson J. A message from those who do... to those who don't (Advertisement). (No date). Bates No. 2024986472. http://legacy.library.ucsf.edu/tid/vws21e00. (Accessed 14 February 2004).

107. Enstrom JE, Kabat GC. Environmental tobacco smoke and tobacco related mortality in a prospective study of Californians, 1960-98. *Bmj*. May 17 2003;326(7398):1057.

108. Broccard N. Wissenschaftler im Dienst der Tabakindustrie. December 2003. http://www.at-schweiz.ch/tabakindustrie/tabakindustrie_wissenschaft Arbeitsgemeinschaft Tabakprävention Schweiz; accessed 28 February 2004.

109. Dollisson J. Public Affairs Campaigning or Reflections on the Tobacco Wars. Presented to the 1990 Infotab Conference in Paris, October 15-18, 1990. 1990. Bates No. 2023027897. http://dlxs.ckm.ucsf.edu/cache/rth46e00/2023027897. (Accessed 30 June 2003).

110. The Children's Research Unit - edited by J.J. Boddewyn and sponsored by Infotab. Juvenile Smoking Initation and Advertising: A 16 Country Study of the Perceived Role of Advertising and Other Factors Bearing on Juvenile Smoking Initiation. March 1989. International Advertising Association. Bates No. 500261396-500261451. http://www.library.ucsf.edu/tobacco/batco/html/15300/15343/. (Accessed 14 February 2004).

111. Tobacco Manufacturers Association. Children, Smoking and Advertising: Facts and Fallacies. 2003. BATCo document for Legal Services: Health Canada 21 October 1999. Bates No. 502602330/2338. http://www.library.ucsf.edu/tobacco/batco/html/500/567/. (Accessed 28 June).

112. Pollay RW, Dewhurst T. The dark side of marketing seemingly "Light" cigarettes: successful images and failed fact. *Tob Control*. 2002;11(Suppl I):i18-i31.

113. FTC (Federal Trade Commission). Up In Smoke: The Truth About Tar and Nicotine Ratings. May 2000. http://www.ftc.gov/bcp/conline//pubs/alerts/smokealrt.pdf; accessed 1 March 2004.

114. National Cancer Institute, editor. *Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2001.

115. Shopland DR. Historical perspective: the low tar lie. *Tob Control*. 2001;10(Suppl I):i1-i3.

116. Henningfield J. Conference presentations: (1) Tobacco harm reduction products: core principles. (2) Tobacco addiction: control by product regulation. 12th WCTOH; August 7 2003; Helsinki.

117. Proctor RN. *The Nazi War on Cancer*. Princeton, N.J.: Princeton University Press, 1999.

118. Kozlowski LT, Pillitteri JL. Beliefs about "Light" and "Ultra Light" cigarettes and efforts to change those beliefs: an overview of early efforts and published research. *Tobacco Control*. 2001;10(Suppl I):i12-i16.

119. Shiffman S, Pilliteri JL, Burton SL, Rohay JM, J.G. G. Smokers' beliefs about "Light" and "Ultra Light" cigarettes. *Tob Control*. 2001;10(Suppl I):i17-i23.

120. Hirschhorn N. Shameful Science: Four Decades of the Tobacco Industry's Hidden Research on Smoking and Health. 1999. http://www.globalink.org/tobacco/docs/secretdocs/0002verband.html; accessed 26 June 2004.

121. Farone WA. Harm reduction: 25 years later. *Tob Control*. 2002;11:287-288.

122. Pollay RW, Dewhurst T. A Premiere example of the illusion of harm reduction in cigarettes in the 1990s. *Tob Control*. 2003;12:322-332.

123. Pollay RW, Dewhirst T. Marketing Cigarettes with Low Machine-Measured Yields. In: National Cancer Institute, editor. *Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine*. Smoking and Tobacco Control Monograph No. 13. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2001.

124. Blackman LC. Research Conference in Pichlarn, Austria; 24 through 28 August 1981 [Meeting Minutes]. 9 September 1981. British-American Tobacco Company. Bates No. 109882558/2574. http://www.library.ucsf.edu/tobacco/batco/html/12200/12252. (Accessed 5 April 2003).

125. Shiffman S. Conference presentation: "Light" cigarettes as reduced-risk tobacco products: a cautionary tale. 12th WCTOH; 6 August 2003; Helsinki.

126. Vutuc C, et al. Epidemiology of Cancer (EU Countries). 8th Central European Lung Cancer Conference 1-4 September 2002, proceedings; Vienna. CD-Rom 2002:1-5.

127. Harris JE, Thun MJ, Mondul AM, Calle EE. Cigarette tar yields in relation to mortality from lung cancer in the cancer prevention study II prospective cohort, 1982-8. *Bmj*. Jan 10 2004;328(7431):72.

128. APA (Austria Presse Agentur). Auch "leichte" Zigaretten gefährlich. *APA Journal Gesundheit*. 12 January 2004(No.3):4.

129. Thun MJ, Burns DM. Health impact of "reduced yield" cigarettes: a critical assessment of the epidemiological evidence. *Tob Control*. 2001;10(Suppl I):i4-i11.

130. Conference presentations. 12th World Conference on Tobacco or Health; 3-8 August 2003; Helsinki.

131. Gallaher Group Plc. Homepage - Corporate Responsibility. www.gallaher-group.com/pages/behave_resp.html or http://www.gallaher-group.com/corporate/behaving_english.asp; accessed 10 June 2003 and 14 February 2004.

132. WHO (World Health Organization). European Strategy for Tobacco Control (ESTC). Copenhagen: WHO, Regional Office for Europe, 2002.

133. Gallaher Group Plc. Gallaher's position on the World Health Organisation Framework Convention on Tobacco Control. 21 February 2003. http://www.gallaher-group.com/corporate/relationship_gallaherwho.asp#5; accessed 21 February 2004.

134. Selin H. Conference presentation: Developing legislation for tobacco control. 12th WCTOH; 4 August 2003; Helsinki.

135. Arnott D. (Director of anti-tobacco group ASH) in an article by Rebecca Mowling: Ban smoking in public. Newspaper *Evening Standard,* 3 July 2003.

136. Finnish Centre for Health Promotion, editor. Smokefree Europe. A Forum For Networks. Conference on Tobacco or Health; 2-4 October 1996; Helsinki. Jyväskylä, Gummerus Printing.

137. Nordic Council of Ministers. Nordic tobacco control - towards smokefree societies. Copenhagen: ANP:737, 2003.

138. Bjartveit K. The History of the Norwegian Ban on Tobacco Advertising. In: Lock S, Reynolds LA, Tansey EM, editors. *Ashes to Ashes: The History of Smoking and Health*. Amsterdam - Atlanta - GA, 1998:216-220.

139. Cancer Society of Finland. Reduction of smoking in Finland. The success continues. Helsinki, 2003.

140. WHO (World Health Organization). Tobacco or Health: A Global Status Report. Country Profiles by Region. 1997. http://www.cdc.gov/tobacco/who/whofirst.htm#regprof; accessed 1 March 2004.

141. Nathanson CA. Liberté, Egalité, Fumée: Smoking and tobacco control in France. In: Feldman E, Bayer R, Brandt A, Marmor T, editors. *Unfiltered: Conflicts over tobacco policy and public health*. Harvard: Harvard University Press, 2004:138-160.

142. Gilmore A, McKee M. Tobacco-Control Policy in the European Union: The Legal, Ethical, and Policy Debates. In: Feldman E, Bayer R, editors. *Tobacco Control and the Liberal State: The Legal, Ethical and Policy Debates*. Harvard University Press, (in press):219-254.

143. ABC News Online. Italy to ban smoking in public places. 2002. http://abc.net.au/news/newsitems/s724317.htm; accessed 1 March 2004.

144. Israely J. [Intl-tobacco] In Italy, smoking curbs face an uphill battle. Newspaper *The Boston Globe,* 20 July 2000. (http://lists.essential.org/pipermail/intl-tobacco/2000q3/000222.html; accessed 1 March 2004).

145. NewsEdge. [Intl-tobacco] Smoking Ban Approved by Italian Government. 1 September 2000. http://lists.essential.org/pipermail/intl-tobacco/2000q3/000264.html; accessed 1 March 2004.

146. Willan P. Italy turns on its smokers with new year resolution. Newspaper *Guardian,* 29 December 2003.

147. AP. Smoking to be banned on Italy's Eurostar trains. Newspaper *International Herald Tribune - The IHT Online,* 5 February 2004. (http://www.iht.com/articles/128087.html; accessed 1 March 2004).

148. Zatonski W. Democracy and Health: Tobacco Control in Poland. In: de Beyer J, Brigden LW, editors. *Tobacco Control Policy*. 2003:97-120.

149. Gilmore A, Zatonski W. Free trade v. the protection of health. How will EU accession influence tobacco control in Poland? *Eurohealth*. 2002;8(4):Special Issue Autumn 2002.

150. Dearlove JV, Bialous SA, Glantz SA. Tobacco industry manipulation of the hospitality industry to maintain smoking in public places. *Tob Control*. Jun 2002;11(2):94-104.

151. Drope J, Chapman S. Tobacco industry efforts at discrediting scientific knowledge of environmental tobacco smoke: a review of internal industry documents. *J Epidemiol Community Health*. Aug 2001;55(8):588-94.

152. Bartosch WJ, Pope GC. Economic effect of restaurant smoking restrictions on restaurant business in Massachusetts, 1992 to 1998. *Tob Control*. Jun 2002;11 Suppl 2:ii38-42.

153. Lam TH, Janghorbani M, Hedley AJ, Ho SY, McGhee SM, Chan B. Public opinion on smoke-free policies in restaurants and predicted effect on patronage in Hong Kong. *Tob Control*. Sep 2002;11(3):195-200.

154. Scollo M, Lal A, Hyland A, Glantz S. Review of the quality of studies on the economic effects of smoke-free policies on the hospitality industry. *Tob Control*. Mar 2003;12(1):13-20.

155. Bates MN, Fawcett J, Dickson S, Berezowski R, Garrett N. Exposure of hospitality workers to environmental tobacco smoke. *Tob Control*. Jun 2002;11(2):125-9.

156. Coombes R. One hospitality worker a week dies from passive smoking, study shows. *BMJ*. 22 May 2004;328:1222.

157. Trotter L, Wakefield M, Borland R. Socially cued smoking in bars, nightclubs, and gaming venues: a case for introducing smoke-free policies. *Tob Control*. Dec 2002;11(4):300-4.

158. Mowling R. Newspaper article: Ban smoking in public. Newspaper *Evening Standard,* 3 July 2003.

159. Newspaper article: Gesundheitsvorsorge soll aus Tabaksteuer finanziert werden. Newspaper *Kurier,* 21 September 2003.

160. Fichtenberg CM, Glantz SA. Effect of smoke-free workplaces on smoking behaviour: systematic review. *Bmj*. Jul 27 2002;325(7357):188.

161. Fichtenberg CM, Glantz SA. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. *N Engl J Med*. Dec 14 2000;343(24):1772-7.

162. California Department of Health Services. Tobacco Control Update. Sacramento, CA: California Department of Health Services, Tobacco Control Section, November 2002.

163. TEROC (Tobacco Education and Research Oversight Committee). Toward a tobacco-free California 2003-2005. The Myth of Victory. Master Plan of the Tobacco Education and Research Oversight Committee. January 2003.

164. Robbins H, Krakow M, Warner D. Adult smoking intervention programmes in Massachusetts: a comprehensive approach with promising results. *Tob Control*. Jun 2002;11 Suppl 2:ii4-7.

165. Manfredi CP, Maioni A. Tobacco control and the liberal state: The legal, ethical and policy debates. The case of Canada. Final Draft. Montreal, June 2001.

166. Sweanor D, Kyle K. Legislation and Applied Economics in the Pursuit of Public Health: Canada. In: de Beyer J, Brigden LW, editors. *Tobacco Control Policy*. 2003:71-98.

167. Canadian Cancer Society (CCS) / National Cancer Institute of Canada / Statistics Canada / Provincial/Territorial Cancer Registries and Health Canada. Canadian Cancer Statistics. Toronto, 2002 (available at http://www.cancer.ca).

168. Woodward A, Fraser T. Passive smoking in New Zealand: health risks and control measures. The New Zealand Health Report (http://www.ash.org.nz/doc/1-doc/0000381.html; accessed June 2003). May 1997.

169. Repace JL, Lowrey AH. An indoor air quality standard for ambient tobacco smoke based on carcinogenic risk. *N Y State J Med*. Jul 1985;85(7):381-3.

170. Repace J, Kawachi I, Glantz S. Fact Sheet on Secondhand Smoke. Presented at the 2nd European Conference on Tobacco or Health and the 1st Iberoamerican Conference on Tobacco or Health Canary Islands, Spain. 1999, February 23-27. http://repace.com/SHSFactsheet.pdf; accessed October 2003.

171. Repace J. Conference presentations: (1) Secondhand smoke: Exposure, dose, risk, and control. (2) Global overview on exposure to secondhand smoke. 12th WCTOH; 6 August 2003; Helsinki.

172. Repace JL. Can Ventilation Control Secondhand Smoke in the Hospitality Industry? 2000. http://www.dhs.ca.gov/tobacco/documents/FedOHSHAets.pdf; accessed October 2003.

173. de Beyer J, Brigden LW, editors. *Tobacco Control Policy. Strategies, Successes, and Setbacks*. Washington, Ottawa: World Bank & Research for International Tobacco Control, 2003.

174. Gilmore AB, Collin J. The world's first international tobacco control treaty. *Bmj*. Oct 19 2002;325(7369):846-7.

175. Collin J, Gilmore AB. Tobacco control, the European Union and WHO. Two conventions provide opportunities to advance public health. *Eur J Public Health*. December 2002;12(4):242-43.

176. Neumann M, Bitton A, Glantz S. Tobacco industry strategies for influencing European Community tobacco advertising legislation. *The Lancet*. 2002;359:1323-1330.

177. WHO Europe. The European Report on Tobacco Control Policy. Review of implementation of the Third Action Plan for a Tobacco-free Europe 1997-2001. European Ministerial Conference for a Tobacco-free Europe 2002; Warsaw, 18-19 February 2002. WHO Regional Office for Europe.

178. Galbraith S, Onzivu W. Conference presentation. 12th WCTOH; 4 August 2003; Helsinki.

179. WHO (World Health Organization). Updated status of the WHO Framework Convention on Tobacco Control. http://www.who.int/tobacco/fctc/signing_ceremony/countrylist/en/; accessed 19 February 2004.

180. Murray-West R. [Intl-tobacco] BAT fuming over WHO Convention. 16 March 2000. http://lists.essential.org/pipermail/intl-tobacco/2000q1/000102.html The intl-tobacco archives; accessed 3 February 2004.

181. Hammond R, Assunta M. The Framework Convention on Tobacco Control: promising start, uncertain future. *Tob Control*. 2003;12:243-244.

182. Unknown author (Hirschhorn N. Dokumente zur Beziehung zwischen der US-amerikanischen und deutschen Tabakindustrie, insbesondere dem Verband der Cigarettenindustrie. http://www.ni-d.de/Doc/tabusvdc.htm; 4 July 2004.

183. . Marcotullio. ICOSI - International Public Smoking Symposium (memorandum). 17 December 1979. RJR. Bates No. 502122771/2778. http://www.rjrtdocs.com/rjrtdocs/index.wmt?tab=home. (Accessed June 2004).

184. Philip Morris. The Activist Movement (Report). July 1993. Philip Morris. Bates No. 2028455321/5333. http://www.pmdocs.com/PDF/2028455321_5333.PDF. (Accessed 18 June 2004).

185. Gilmore A, Österberg E, Heloma A, Zatonski W, Delcheva E, McKee M. Free Trade versus the protection of health: the examples of alcohol and tobacco. In: MacLehose L, McKee M, editors. *Health and accession: managing the transition*. Open University Press, (in press).

186. Puska P. Conference speech. 12th WCTOH; August 2003; Helsinki.

187. Byrne D. Conference speech. EUPHA; November 2003; Rome.

188. Directive 2001/37/EC of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco products (Tobacco Products Directive). (*Official Journal of the European Communities*, L 194/26, 18.7.2001). 5 June 2001.

189. Directive 2003/33/EC of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States relating to the advertising and sponsorship of tobacco products (Advertising and Sponsorship Directive). (*Official Journal of the European Communities*, L 152, 20.6.2003). 26 May 2003.

190. Council Recommendation on the prevention of smoking and on initiatives to improve tobacco control. (*Official Journal of the European Communities* L 022, 25.1.2003). 25 January 2003.

191. Groman E. (Head of Nicotine Institute). Discussions at meeting, enquiries by telephone, and e-mail communication, September and December 2003.

192. Dür W, Dietscher C. Die Gesundheit junger Menschen in Wien. Untersuchung zum Gesundheitszustand von Jugendlichen. In: Bachinger E, editor. *Gesundheitsbericht Wien 1997 (Vienna Health Report 1997)*. Vienna: City of Vienna, 1997.

193. McKee M. Personal communication, January 2004.

194. Költringer R, Urbas E. Fragen zur Gesundheit. Gesundheitsverhalten, Risiko- und Belastungsfaktoren: Mikrozensus September 1999. *Statistische Nachrichten*. 2002;8:588-601.

195. Burg T. Imputation fehlender Werte in Labour Force Surveys. *Österreichische Zeitschrift für Statistik*. 1996(2).

196. Waller H. *Gesundheitswissenschaft. Eine Einführung in Grundlagen und Praxis von Public Health*. 3rd ed. Stuttgart: Kohlhammer, 2002.

197. Peto R, Lopez AD, Boreham J, Thun M, Heath CW, Jr. Mortality from tobacco in developed countries: indirect estimation from national vital statistics. *Lancet*. 1992;339:1268-78.

198. Jha P, Chaloupka FJ. The economics of global tobacco control. *Bmj*. Aug 5 2000;321(7257):358-61.

199. IARC (International Agency for Research on Cancer). Tobacco Smoke and Involuntary Smoking. Monographs (Vol 83). June 2002.

200. USDHHS (US Department of Health and Human Services). Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General. DHHS Publication 89-8411. Rockville, MD: US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1989.

201. Hecht SS. Tobacco smoke carcinogens and lung cancer. *Journal of the National Cancer Institute*. 1999;91:1194-1210.

202. USDHHS (US Department of Health and Human Services). The health consequences of smoking: nicotine addiction. A report of the Surgeon General. DHHS Publication 88-8406. Rockville, MD: US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, 1988.

203. Nicotine Addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians. Royal College of Physicians of London, 2000.

204. Gray N, Kozlowski LT. More on the regulation of tobacco smoke: how we got here and where next. *Ann Oncol*. Mar 2003;14(3):353-7.

205. Jha P, Chaloupka FJ, editors. *Tobacco control in developing countries*. New York: The World Bank, 2000.

206. CDC (Centers for Disease Control and Prevention). Women and Smoking. A Report of the Surgeon General. US Department of Health and Human Services, 2001 (http://www.cdc.gov/tobacco).

207. Meltzer EO. Prevalence, Economic and Medical Impact of Tobacco smoking. *Annuals of Allergy*. 1994;73:381-399.

208. USDHHS (US Department of Health and Human Services). The health consequences of involuntary smoking. A report of the Surgeon General. DHHS Publication 87-8398. Rockville, MD: US Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, Office on Smoking and Health, 1986.

209. Doll R. Uncovering the effects of smoking: historical perspective. *Statistical Methods in Medical Research*. 1998;7:87-117.

210. Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *Bmj*. Oct 8 1994;309(6959):901-11.

211. Thun MJ, Day-Lally CA, Calle EE, Flanders WD, Heath CW, Jr. Excess mortality among cigarette smokers: changes in a 20-year interval. *Am J Public Health*. Sep 1995;85(9):1223-30.

212. U.S. Environmental Protection Agency (U.S. EPA). Respiratory Health Effects of Passive Smoking: Lung Cancer and Other Disorders. EPA/600/6-90/006 F. 1992.

213. SCOTH (Scientific Committee on Tobacco and Health). Report of the Scientific Committee on Tobacco and Health. London: HMSO, 1998.

214. Deutsches Krebsforschungszentrum Heidelberg - Krebsinformationsdienst. Rauchen und Passivrauchen. August 2003. http://www.krebsinformation.de/body_rauchen_und_p..html KID; accessed 23 September 2003.

215. Müller FH. Tabakmissbrauch und Lungencarcinoma. *Zeitschrift für Krebsforschung*. 1939;49:57-85.

216. Schairer E, Schöniger E. Lungenkrebs und Tabakverbrauch. *Zeitschrift für Krebsforschung*. 1943;54:261-69.

217. Schönherr E. Beitrag zur Statistik und Klinik der Lungentumoren. *Zeitschrift für Krebsforschung*. 1928;27:436-450.

218. Lickint F. Tabak und Tabakrauch als ätiologischer Faktor des Carcinoms. *Zeitschrift für Krebsforschung*. 1929;30:349-65.

219. Lickint F. Der Bronchialkrebs der Raucher. *Münchener Medizinische Wochenschrift*. 1935;82:122-124.

220. Lickint F. *Tabak und Organismus: Handbuch der gesamten Tabakkunde*. Stuttgart: Hippokrates, 1939.

221. Fleckseder R. Über den Bronchialkrebs und einige seiner Entstehungsbedingungen. *Münchener Medizinische Wochenschrift*. 1936;83:1585-88.

222. Proctor RN. Commentary: Schairer and Schöniger's forgotten tobacco epidemiology and the Nazi quest for racial purity. *International Journal of Epidemiology*. 2001;30:31-34.

223. Doll R. The First Reports on Smoking and Lung Cancer. In: Lock S, Reynolds LA, Tansey EM, editors. *Ashes to Ashes: The History of Smoking and Health*. Amsterdam - Atlanta, GA, 1998:130-142.

224. Doll R, Hill AB. A study of the aetiology of carcinoma of the lung. *Br Med J*. Dec 13 1952;2(4797):1271-86.

225. Doll R, Hill AB. The mortality of doctors in relation to their smoking habits; a preliminary report. *Br Med J*. Jun 26 1954;4877:1451-5.

226. Doll R, Hill AB. Lung cancer and other causes of death in relation to smoking; a second report on the mortality of British doctors. *Br Med J*. Nov 10 1956;12(5001):1071-81.

227. Doll R, Hill A. Smoking and carcinoma of the lung. Preliminary report. *British Medical Journal*. 1950;2:739-48.

228. IARC Monographs (Vol 83). Tobacco Smoke and Involuntary Smoking. IARC (International Agency for Research on Cancer), June 2002.

229. Dyer O. Harm from smoking is even greater than previously thought. *BMJ*. 29 June 2002;324:1544.

230. Sandvik L, Erikssen G, Thaulow E. Long term effects of smoking on physical fitness and lung function: a longitudinal study of 1393 middle aged Norwegian men for seven years. *Bmj*. Sep 16 1995;311(7007):715-8.

231. Sandvik L, Mowinckel P. The impact of smoking on duration of chronic disease until death. Oral presentation in plenum. IEA/SSM joint conference; September 2001; Oxford, UK.

232. WHO (World Health Organization). Fact Sheet No 221. April 1999. http://www.who.int/inf-fs/en/fact221.html; accessed June 2003.

233. Blot WJ, McLaughlin JK, Winn DM, Austin DF, Greenberg RS, Preston-Martin S, et al. Smoking and drinking in relation to oral and pharyngeal cancer. *Cancer Res*. Jun 1 1988;48(11):3282-7.

234. American Cancer Society. Alcohol & Cancer. 2002. http://www.cancer.org/downloads/PRO/alcohol.pdf; accessed October 2003.

235. American Cancer Society. What are the risk factors for oral cavity and oropharyngeal cancer? 2003. http://www.cancer.org/docroot/CRI/content/CRI_2_4_2X_What_are_the_risk_factors_for_oral_cavity_and_oropharyngeal_cancer_60.asp?sitearea=CRI; accessed October 2003.

236. Simpson D. The Smokey Planet guide to the Framework Convention. *Tob Control*. Winter 1999;8(4):365-6.

237. Herrmann H, Liehs F. Die Rauchgewohnheiten und ihr Einfluss auf die Entwicklung chronisch broncho-pulmonaler Erkrankungen - Ergebnisse der epidemiologischen Bronchitisforschung in der DDR (Smoking Habits and Their Influence on Development of Chronic Bronchopulmonary Diseases). *Z. Erkrank. Atm. Org.* 1977;148:5-24.

238. Lidegaard O, Bygdeman M, Milsom I, Nesheim BI, Skjeldestad FE, Toivonen J. Oral contraceptives and thrombosis. From risk estimates to health impact. *Acta Obstet Gynecol Scand*. Feb 1999;78(2):142-9.

239. Women's Health Research Symposia. Conference proceedings. Consensus Conference on Oral Contraceptives and Smoking; 7-9 November 1997; Montreal, Canada. http://medschool.umaryland.edu/womenshealth/whrg/ocs_smoke.html, retrieved 13/10/2003.

240. Newspaper article: Rauch Kallat gegen das Rauchen. Newspaper *Kurier,* 28 June 2003.

241. Austrian Social Insurance Funds. Information by e-mail, August 2003.

242. Peto R. Conference presentation: Use of country-specific trends in lung cancer to estimate trends in overall tobacco-attributable mortality. 12th WCTOH; August 6 2003; Helsinki.

243. Statistics Austria. Jahrbuch der Gesundheitsstatistik 2001 / Statistical Yearbook 2001. Vienna: Statistics Austria, 2003.

244. WHO - World Health Statistics Annual 2001, online version [program].

245. Statistics Austria. Mortality data 1970-2001; raw data set received from Statistics Austria, July 2003.

246. Goodman J. *Tobacco in History: The cultures of dependence*. London, New York: Routledge, 1993,1994.

247. Kohaut A. Rauchen. Missbrauch, Abhängigkeit, Sucht *(brochure)*. Chapter 1: Zur Geschichte des Rauchens. 2001 / 03. Bayerisches Gesundheitsministerium: http://www.lzg-bayern.de/zis/online/indexrau.htm; accessed January 2003 2003.

248. Rogozinski J. *Smokeless Tobacco in the Western World, 1550-1950*. New York: Praeger, 1990.

249. Nolte E. The health impact of German unification. London School of Hygiene & Tropical Medicine, 2001.

250. WHO Health For All database, last updated January 2002. accessed March-June 2003.

251. APA (Austria Presse Agentur). "Raucherseuche" im Vormarsch. *APA Journal Gesundheit*. 7 January 2003.

252. Zwick H. COPD (unpublished draft for the Vienna Tobacco Report). Vienna, May 2004.

253. Microcensus on Health 1999. Data set received by Statistics Austria, own computations.

254. California Environmental Protection Agency (Cal/EPA). Health effects of exposure to environmental tobacco smoke: final report. Sacramento, CA: California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, 1997.

255. Estimate by the Institute for Social Medicine of the University of Vienna. Published in Redl J & Klikovits P. Der letzte Zug im Büro? News magazine Format No. 24. 11 June 2004:56-61.

256. Honjo K, Siegel M. Perceived importance of being thin and smoking initiation among young girls. *Tob Control*. Sep 2003;12(3):289-95.

257. Hirayama T. Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan. *Br Med J (Clin Res Ed)*. Jan 17 1981;282(6259):183-5.

258. Trichopoulos D, Kalandidi A, Sparros L, MacMahon B. Lung cancer and passive smoking. *Int J Cancer*. Jan 15 1981;27(1):1-4.

259. Fontham ET, Correa P, Reynolds P, Wu-Williams A, Buffler PA, Greenberg RS, et al. Environmental tobacco smoke and lung cancer in nonsmoking women. A multicenter study. *Jama*. Jun 8 1994;271(22):1752-9.

260. Jarvis MJ, Feyerabend C, Bryant A, Hedges B, Primatesta P. Passive smoking in the home: plasma cotinine concentrations in non-smokers with smoking partners. *Tob Control*. Dec 2001;10(4):368-74.

261. Hackshaw A. Lung cancer and passive smoking. *Stat Methods Med Res*. 1998;7(2):119-36.

262. USDHHS (US Department of Health and Human Services). The health benefits of smoking cessation. Report of the Surgeon General. DHHS Publication 90-8416. Rockville, MD: US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1990.

263. Law MR, Hackshaw AK. Environmental tobacco smoke. *Br Med Bull*. Jan 1996;52(1):22-34.

264. Buchacher R. Schall & Rauch. *Profil* 48. 24 November 2003:114-122.

265. European Commission. Press release: Don't take tobacco lightly: infringement proceedings against Austria, Italy and Luxembourg. 15 July 2003.

266. EU Issues Tobacco Health Warning to Four States. 14 July 2003. http://us.news.globalink.org/171791.shtml GLOBALink (Yahoo ! News); accessed 1 March 2004.

267. APA (Austria Presse Agentur). EU-Tabak-Richtlinie nicht umgesetzt. *APA Journal Gesundheit*. 21 July 2003(No.30/31).

268. Austria Tabak (Public Relations Office). Telephone conversation and e-mail communication, 2 June 2003.

269. Shafey O, Dolwick S, Guindon GE, editors. *Tobacco Control Country Profiles (incl. Appendix B)*. 2nd ed. Atlanta (GA): American Cancer Society, World Health Organization, International Union Against Cancer (see also http://www.who.int/tobacco/media/en/Austria.pdf; accessed 29 February 2004), 2003.

270. WHO (World Health Organization). Tobacco control database, country profile. http://cisid.who.dk/tobacco/Country; last accessed 29 February 2004.

271. Austrian Chamber of Physicians and Austrian Academy of Physicians. Enquiries by telephone, September 2003.

272. APA (Austria Presse Agentur). Österreichs Raucher legen zu. *APA Journal Gesundheit*. 26 January 2004(No.5).

273. Corrao MA, Guindon GE, Sharma N, Shokoohi DF, editors. *Tobacco Control Country Profiles (incl. Appendix B)*. Atlanta, GA: American Cancer Society, 2000.

274. Chambers of Labour (health department). Enquiry by telephone, 30 March 2004.

275. ASchG BGBl. 450/1994, idF *(version)* BGBl. 70/1999 and BGBl. 159/2001 (1.1.2002) - ArbeitnehmerInnenschutzgesetz *(Employees' Protection Act)*. 1995.

276. Ausserwinkler M. (Former Austrian Minister of Health, Sports and Consumer Protection). Discussions by telephone 5 February 2004, 2004.

277. BGBl. No. 431/1995: Tabakgesetz *(Tobacco Law)*. Last amended in 2001 (BGBl. I Nr. 98/2001) and 2003 (BGBl. I Nr. 74/2003). 1995.

278. Federal Ministry for Health and Women (Press Office). Enquiries by telephone, e-mail communication and written information upon request, June - October 2003.

279. Davani K. Der Konstruktionsfehler der Zigarette nach dem PHG in Österreich. *ecolex (Fachzeitschrift für Wirtschaftsrecht)*. June 2004;06:437-440.

280. Federal Ministry for Economic Affairs and Labour. Enquiry by telephone and written information by e-mail, October 2003 and March 2004.

281. Vienna Public Transport. Enquiries by telephone, June and August 2003.

282. Austrian Federal Railways. Enquiry by telephone, 13 August 2003.

283. European Commission - Representation in Austria. Fact Sheet: Initiativen der Europäischen Kommission hinsichtlich Rauchen und Tabakkonsum (Initiatives of the European Commission on smoking and tobacco consumption). 9 July 2001.

284. City of Vienna - Executive Office. Enquiries by telephone and e-mail communication, January 2004.

285. Federal Ministry of Finance. Enquiries by telephone, June 2003.

286. Allgemeines Sozialversicherungsgesetz, ASVG, § 447a,b.

287. Waneck R. (Austrian State Secretary of Health). Discussions at meeting, 11 March 2004.

288. Newspaper article: Rauch Kallat gegen das Rauchen. Newspaper *Kurier,* 28 June 2003.

289. Commentary: Rauchverbot. Newspaper *Kurier,* 21 September 2003.

290. Federation of Austrian Social Insurance Institutions. Enquiry by telephone and information brochure on new screening programme, 21 July 2004.

291. Gunsenheimer U. (Advertising agency 'Media Consulta'; Public Relations Senior Advisor). Personal communication at the 12th WCTOH, Helsinki, 3-8 August 2003.

292. Wojahn J. Kommentar: Sargnägel für die Tabakindustrie. Newspaper *der Standard,* 3 December 2002.

293. APA (Austria Presse Agentur). Press release: "Smoke off" - Anti-Rauch-Kampagne des Gesundheitsministeriums. 31 May 1990.

294. Infografik: Werbeausgaben der Tabakwirtschaft (provided by Reuters). Newspaper *der Standard,* 3 December 2002.

295. Media Focus Research GesmbH. Enquiries by telephone and information by e-mail, 13 March 2003 and 14 May 2004.

296. Rasinger E. (Spokesman for Health of the Austrian People's Party). Discussion by telephone, 7 May 2004.

297. Stuller G. (Office of the State Secretary of Health, expert in tobacco control). Discussions at meeting, 11 March 2004.

298. Newspaper article: Tabak-Sport: Eine Frage der Fristen. Newspaper *der Standard,* 3 December 2002.

299. Philip Morris. AT sponsors flat race. Article in the Austrian sports newspaper "Sport und Toto". 26 April 1988. Philip Morris. Bates No. 2025827730 (2025827726/7730). http://www.pmdocs.com/PDF/2025827726_7730.PDF. (Accessed last: 19 June 2004).

300. Philip Morris. Tabak-Manager ärgern sich (Tobacco managers are annoyed). Article in the German magazine "Werben und Verkaufen", September 1987, No. 38, pp. 26,27. 1987. Philip Morris. Bates No. 2022811185. http://www.pmdocs.com/PDF/2022811185.PDF. (Accessed 19 June 2004).

301. Newspaper *Vorarlberger Nachrichten* (Bregenz). Second Vorarlberg Non-Smoking Day. 15 November 1988. Philip Morris. Bates No. 2028369824.A. http://www.pmdocs.com/PDF/2028369824A.PDF. (Accessed last: 20 June 2004).

302. Rockenbauer R. (Austrian association for the protection of non-smokers). Discussions at meeting, 5 February 2004.

303. Austrian Council on Smoking and Health. Homepage. http://www.aerzteinitiative.at; accessed September 2003 to March 2004.

304. Salcher H. (Former Austrian Minister for Health and Environmental Protection). Discussions by telephone, 22 July 2004.

305. Federal Ministry of Health and Women. (Expert in health promotion and anti-smoking campaigns). Personal communication, 4 August 2003.

306. FGÖ (Fonds Gesundes Österreich). Annual Report 2002.

307. Hrabcik H. (Federal Ministry for Health and Women). Letter answering questions addressed at the Ministry. (GZ: 22180/31-III/B/11/03). 22 November 2003.

308. Vienna Chamber of Physicians. Enquiry by telephone, September 2003.

309. Austrian Chamber of Pharmacists (Press Office). Enquiry by telephone, 7 April 2004.

310. WHO (World Health Organization). WHO calls on governments to include smoking cessation in tobacco control strategies. 6 (18) August 2003. http://www.health.fgov.be/WHI3/krant/krantarch2003/kranttekstaugust3/030818m04a-who.htm; accessed 24 March 2004.

311. Josefhof. Information leaflet. 2004.

312. Püringer U, Atzler B, Schoberberger R. The Josefhof model of smoking cessation - a multimodal approach (submitted abstract). EUPHA 2004; Oslo.

313. Josefhof. Homepage - alle Programme. http://www.josefhof.at; last accessed April 2004.

314. Vienna District Health Fund. Enquiries by telephone and e-mail communication, November 2003 and 25 March 2004.

315. Federation of Austrian Social Insurance Institutions. Copy of a report on activities of the Austrian Social Insurance Funds and contact addresses in the provinces, provided November 2003.

316. Vienna Health Authority. Enquiry by telephone, November 2003.

317. Medical Fitness Team. Homepage. www.med-fit-team.at; accessed 2 December 2003.

318. Neuberger M. Passive Opfer der Luftverschmutzung durch Tabakrauch - können Ärzte helfen? *Umweltmed Forsch Prax*. 2003;8(5):283-8.

319. Neuberger M. Chemikalienmanagement am Arbeitsplatz: Sonderfall Tabakrauch. No date, unpublished.

320. Neuberger M. Gesundheitsfolgen des Passivrauchens. *Sichere Arbeit*. 2002;2-3:5.

321. Neuberger M. Rauchen und Prävention am Arbeitsplatz. *Wiener Medizinische Wochenschrift*. 1995;45:90-94.

322. AKS Vorsorgemedizin. Enquiry by telephone, November 2003.

323. Spaly J. (Anti-Fraud Co-ordinator for the eastern region of Austria, Austrian Customs Office/Senate of Finance). Discussions by telephone, June 2003.

324. Official from the Ministry of Finance. Enquiry by telephone, June 2003.

325. APA (Austria Presse Agentur). Nikotinsucht beginnt in der Jugend. *APA Journal Gesundheit*. 3 November 2003(No.45).

326. Davey-Smith G, Egger M. Smoking and health promotion in Nazi Germany. *J Epidemiol Community Health*. Feb 1996;50(1):109-10.

327. Federal Ministry for Health and Women (Press Officer of the Austrian State Secretary of Health). Enquiry by telephone, September 2003.

328. Federal Ministry for Health and Women (expert for EU affairs). Enquiry by telephone, 29 April 2004.

329. BAT (British-American Tobacco Company). Tso TC. Report of the fifteenth meeting, tobacco working group: Lung cancer task force: September 10 and 11, 1974: Bethesda, Maryland. 1974. British-American Tobacco Company. Bates No. 302058730/8735. http://www.library.ucsf.edu/tobacco/batco/html/9300/9338/otherpages/2.html. (Accessed 4 February 2004).

330. Kunze M. Brief personal communication at the 12th WCTOH in Helsinki, August 2003.

331. Newspaper article: Austria Tabak dreht neue Kreationen. Newspaper *Kurier,* 4 April 2003. (http://kurier.at/wirtschaft/112074.php; accessed 10 June 2003).

332. Österreich Journal - Aktuelles aus Österreich. Silbernes Komturkreuz für Beppo Mauhart. 18 February 2004. http://www.oe-journal.at/Aktuelles/!2004/0204/W3/41802mauhartNlk.htm; accessed 19 April 2004.

333. Rockenbauer R. Newspaper article: Die Macht des Beppo Mauhart. Indianerpolitik auf Kosten der Gesundheit des einzelnen. Newspaper *Nichtraucher-Zeitung,* 1/ 1993.

334. Forces Austria. Verein der Toleranz - im Zusammenleben von Rauchern und Nichtrauchern! 2004. http://www.verein-der-toleranz.com; accessed 16 May 2004.

335. Ministry for Health and Environmental Protection. Reynolds RJ. Aktion "Ohne Rauch geht's auch" - eine Aktion des Gesundheitsministers. 17 November 1980. Bates No. 500875607/5608. http://legacy.library.ucsf.edu/tid/yka69d00. (Accessed June 2003 and 15 April 2004).

336. Mayer G. Press release for initiative "Ohne Rauch geht's auch". 17 November 1980. Reynolds. Bates No. 504845098/5098 and 502825150/5153. http://legacy.library.ucsf.edu/cgi/getdoc. (Accessed 27 June 2003).

337. Republic of Austria Federal Chancellery. Parliamentary Correspondence 11-540 of the Supplements to the Verbatim Proceedings of the National Council - XVII Legislature. 5 May 1987. Philip Morris. Bates No. 2028369855/9857. http://www.pmdocs.com/PDF/2028369855_9857.PDF; http://www.pmdocs.com/getallimg.asp?if=avpidx&DOCID=2028369855/9857. (Accessed 19 June 2004).

338. Philip Morris Europe (F.T.R. Research and Development - Neuchâtel). Vienna hearing on passive smoking (memorandum from W. Fink to T.S. Osdene and R. Pages; confidential). 12 January 1988. Philip Morris. Bates No. 2023542458/2461. http://www.pmdocs.com/PDF/2023542458_2461.PDF. (Accessed last: 18 June 2004).

339. Philip Morris Europe (FTR Science and Technology - Neuchâtel). Monthly report highlights of May 1988 (memorandum from H.W. Gaisch). 31 May 1988. Philip Morris. Bates No. 2001208938/8952. http://www.pmdocs.com/PDF/2001208938_8952.PDF. (Accessed last: 19 June 2004).

340. Federal Ministry for Health and Environmental Protection. Einladung zum Symposium "Krank durch Passivrauchen?" (Invitation to the symposium "Ill by passive smoking?"). 2 May 1988. Philip Morris. Bates No. 2028525449/5453. http://www.pmdocs.com/PDF/2028525449_5453.PDF. (Accessed last: 19 June 2004).

341. Rockenbauer R. Newspaper article: ATW sponsern Passivraucherenquete (Austria Tabakwerke sponsor passive smoking hearing). Citation of an article in the Tiroler Tageszeitung of 4 May 1988. Newspaper *Nichtraucher-Rundschreiben,* May 1988:3.

342. APA (Austria Presse Agentur)? (Press release) Loeschnak/Symposion "Passivrauchen". Loeschnak: Zunehmend Beschwerden ueber den Zwang zum Passivrauchen. 2 May 1988. Philip Morris. Bates No. 2028369839. http://www.pmdocs.com/PDF/2028369839.PDF. (Accessed last: 20 June 2004).

343. APA (Austria Presse Agentur)? (Press release) Loeschnak/Steyrer/Passivraucher. Loeschnak: Abschaffung der Raucherzimmer an Schulen. Steyrer: Gefahr des Passivrauchens eindeutig fuer werdende Kinder. Wynder: Beweis fuer Lungenkrebs durch Passivrauchen nicht moeglich. 3 May 1988. Philip Morris. Bates No. 2028369840, 2028369840A, 2028369840B. http://www.pmdocs.com/PDF/2028369840.PDF. (Accessed last: 20 June 2004).

344. Krank durch Passivrauchen? Grundproblem bleiben die Raucher - Verbote nicht vorgesehen. Newspaper *Neue Tiroler Zeitung (Innsbruck), Salzburger Volkszeitung (Salzburg), Volkszeitung (Klagenfurt), Observer (Wien),* 4 May 1988. (http://www.pmdocs.com/PDF/2021627001.PDF (accessed: 19 June 2004)).

345. Skills in Public Relations (Vienna) to Philip Morris EEC (Lausanne). Smoking and Health - Results of Austrian ETS Symposium. Weekly Issues Management Report/Austria No. 18. (Abbreviated translation of the information for the press). 5 May 1988. Philip Morris. Bates No. 2025827726/7730. http://www.pmdocs.com/PDF/2025827726_7730.PDF. (Accessed last:19 June 2004).

346. APA (Austria Presse Agentur). Press release: "Smoke off" 2 (cont.). APA235. 31 May 1990.

347. Kämpfer für den Qualm. *Stern.* 31 October 2002.

348. Redl J, Klikovits P. Der letzte Zug im Büro? (The last drag in the office?). *Format* No. 24. 11 June 2004:56-61.

349. Stanzl E. Neue Rauchverbote rücken näher. Newspaper *der Standard,* 31 March 2004.

350. Kunze M, Fagerstrom K. Conference presentation: The "Swedish Approach" as a model to reduce the risk for dependent smokers. 12th WCTOH; August 2003; Helsinki.

351. Rauscher H. Smoke gets in my eyes. *Format* 24. 11 June 2004:5.

352. Pintor L. Ein Hauch von Rauch. Newspaper *der Standard,* 19 January 2004.

353. Von Ignoranten und Demagogen - Wie glaubwürdig ist die Antiraucherkampagne der EU? A: "Forscherappell: Rauf mit den Tabakpreisen! (Article by cancer specialists justifying tobacco control measures, in particular raise of tobacco taxes). B: Ein Hauch von Rauch (Article by the chain smoking writer Luigi Pintor, comparing smoking with alcohol, exhaust gases from traffic, and public stultifying by television). Newspaper *der Standard,* 19 January 2004.

354. Personal communication with acquaintances, March - June 2004.

355. Krulei D. Tödlicher Qualm: Kein feiner Zug. Newspaper *Kronenzeitung (Sunday's special issue),* 27 June 2004:36-37.

356. Kronen Zeitung. Website "Nichtrauchen". http://www2.krone.at/anwendungen/jetzt-oder-nie/index_jon.php?http://wcm.krone.at/krone/C15/S62/kmprog/index.html; Accessed 27 June 2004.

357. Griesser D. Die Angst verraucht, die Geselligkeit gehoben. Neue Studie aus Graz belegt: Nikotin wirkt sich positiv auf die Emotion von Raucherinnen und Rauchern aus. Newspaper *der Standard,* 2 November 2002.

358. Dür W. Project "Smokefree School", financed by the Federal Ministry of Education, Science and Culture. 2003.

359. Die Grünen. Grundsatzprogramm der Grünen. 2001:78.

360. Encyclopedia. Viktor Klima. http://encyclopedia.thefreedictionary.com/Viktor%20Klima and http://en.wikipedia.org/wiki/Viktor_Klima; accessed 16 April 2004.

361. Gallhuber H. (jurist). Personal communication, 14 July 2004.

362. Hrabcik H. (Federal Ministry of Health and Women). Answer to a letter of Hans Köchler with regard to the 2003 amendment of the tobacco law., 15 July 2003 (published in the NichtRaucher-Zeitung No.3/2003).

363. Waneck R. Answering letter of 12 February 2004 to a letter from Professor Hans Köchler of Innsbruck University of 24 November 2003 with regard to Austria's ineffective measures in smoking prevention (translation). Newspaper *NichtRaucher Zeitung,* 1/2004. 2004.

364. Siegel M. The effectiveness of state-level tobacco control interventions: a review of program implementation and behavioral outcomes. *Annu Rev Public Health*. 2002;23:45-71.

365. Bornhäuser A. Gesundheit fördern - Tabakkonsum verringern: Handlungsempfehlungen für eine wirksame Tabakkontrollpolitik in Deutschland. Rote Reihe, Sonderband. Heidelberg: DKFZ Deutsches Krebsforschungszentrum, 2002.

366. Cummings KM, Clarke H. The Use of Counter-Advertising As a Tobacco Use Deterrent. (Making the Case: State Tobacco Control Briefing Papers). Advocacy Institute, http://www.advocacy.org/publications/mtc/counterads.htm (last accessed: 10 July 2004), 14 April 1998.

367. Rose G. *The strategy of preventive medicine*. Oxford: Oxford University Press, 1992.

368. Tobacco Research Implementation Group. Tobacco Research Implementation Plan. Priorities for Tobacco Research Beyond the Year 2000. Bethesda, MD: National Cancer Institute, National Institutes of Health, November 1998.

369. Edwards R, Bhopal R. The covert influence of the tobacco industry on research and publication: A call to arms. *J Epidemiol Community Health*. 1999;53:261-2.

370. SmokeFree Australia. Public support for smokefree workplaces. http://www.ashaust.org.au/SF'03/support.htm; last accessed: 15 June 2004.

371. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. *Bmj*. Jun 26 2004;328(7455):1519.

372. Biener L. Anti tobacco advertisements by Massachusetts and Philip Morris: what teenagers think. Tobacco Control. *Tob Control*. 2002;11(Suppl II):ii43-ii46.

373. White V, Tan N, Wakefield M, Hill D. Do adult focused anti-smoking campaigns have an impact on adolescents? The case of the Australian National Tobacco Campaign. *Tob Control*. Sep 2003;12 Suppl 2:II23-II29.

374. McKee M. Supplement on smoking cessation. *Eur J Public Health*. Dec 2001;11(4):461.

375. Emri S, Bagci T, Karakoca Y, Baris E. Recognition of cigarette brand names and logos by primary schoolchildren in Ankara, Turkey. *Tob Control*. Winter 1998;7(4):386-92.

376. Makomaski Illing E, Kaiserman M. Mortality attributable to tobacco use in Canada and its regions, 1998. *Can J Public Health*. Jan-Feb 2004;95(1):38-44.

377. Mulder I, Hoogenveen RT, Smit HA, Bueno de Mesquita HB. Modelling future mortality reduction through smoking cessation in the European Union. *Eur J Public Health*. Mar 2004;14(1):79-85.

378. Heinrich J, Holscher B, Seiwert M, Carty CL, Merkel G, Schulz C. Nicotine and cotinine in adults' urine: The German Environmental Survey 1998. *J Expo Anal Environ Epidemiol*. May 19 2004.

379. Hill S, Blakely T, Kawachi I, Woodward A. Mortality among "never smokers" living with smokers: two cohort studies, 1981-4 and 1996-9. *BMJ*. 24 April 2004;328:988-989.

380. Warner KE, Hodgson TA, Carroll CE. Medical costs of smoking in the United States: estimates, their validity, and their implications. *Tob Control*. Autumn 1999;8(3):290-300.

381. Carter SM. Going below the line: creating transportable brands for Australia's dark market. *Tob Control*. Dec 2003;12 Suppl 3:iii87-94.

382. Brook Shepherd G. *The Austrians*. London: Harper Collins, 1986.