PHPRO Spain

Public Health Policy:

Spanish Smoking Law

Assessment of public health policies in Spain:
Smoking control, 1980-2010.

Report Content:

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Part 1. Background

Spain went through the restauration of democracy and civil rights in the late 70s, after death of dictator Franco in 1975. During the following years, dominated by heavy economic, social and political changes, public health issues were often neglected. In this regard, it is illustrative to highlight that we faced a period (1980-1981) of unusually high meningitis incidence, yet it hardly had any media impact. Interestingly, in 1996 we had another meningitis peak, that although did not reach half of the maximum incidence of that of 1981, caused a great social alarm and determined a change in the Spanish vaccine policy.

In this context, some initial smoking prevention initiatives developed linked to health care services, basically departments of Pneumology in University hospitals, as well as some pilot programs oriented to primary prevention at school level and promoting cessation at primary care level. In these days public administration role was basically giving support to pilot and demonstration inititiatives and trying to influence key professionals, mainly health care physicians, through specific programs.

The first comprehensive nation-wide law facing smoking control was enacted in 1988 (RD 192/88) and addressed for the first time restrictions to smoking in public places, as well as limitations on publicity and points of sale. Smoking was prohibited basically in public offices open to public, workplaces where there were pregnant women, educational centers and transportation means. This law led to some problems of interpretation, since it established that in case of doubt, right to health should prevail, but this was hard to assess in some particular cases. In any case, the legislation came through and progressively, smoking in many workplaces was starting to become an odd behavior, after many years where smoking everywhere was the rule. In this period we faced the opposition of the tobacco industry, that launched an aggressive campaign comparing the risk of passive smoking to drinking water or eating a cookie. At that time, the documents of the industry (that we only knew long afterwards) were stressing the values of social tolerance, as a characteristic of the Spanish society as opposed to the old times, where personal freedom was severely limited; that is, to keep pace with new

times and democratic life we should not prohibit, but try to manage through “education” and social harmony the conflicts of rights.

Along the 80s, there was a growing of smoking cessation programs in hospitals and primary health care centers, very often supported or promoted by public administrations. In this context, some smoking treatment units emerged, bringing about a controversy about the pros and cons of providing smoking treatment a status of special care (within the general health care system), or, on the contrary, should be linked to primary care services. Despite the fact that the controversy never ended completely, and both systems coexist in Spain, the vast majority of antismoking programs have been carried out by the primary care providers. In this regard, it has to be recognized the fundamental role of the Society of Family Medicine

In 1986 a group of health professionals supported by several of the major health associations (Society of Family Medicine, Society of Pneumology and Society of Epidemiology amongst them) launched the National Committee for Smoking Prevention (NCSP), that has been ever since the umbrella organization of the tobacco prevention movement in Spain. In 15 years the NCSP has become a key stakeholder in the smoking prevention policies, and has played a crucial role in the advocacy of smoke-free environments. In this period it has being joined by dozens of organizations, particularly associations of health professionals and medicine, as well as some prominent and relevant professionals, and maintains links with other organizations involved and interested in tobacco prevention. It is a member of the European Network of Smoking Prevention, which groups similar coalitions of the various European Union countries.

Since its founding, the NCSP has worked to expand the prevention of smoking in Spain. This work is because in our country, the snuff is the first single cause of premature death and avoidable: it is estimated that in fifteen years has caused 600,000 deaths, especially in males attacked mercilessly. Although it is starting to see an encouraging decline in the overall prevalence of smoking and a clear decrease in the proportion of men who smoke, a lot remains to be done.

The NCSP has developed a wide range of activities oriented to educating and informing the general population, working with health professionals and health authorities, in close contact with members of Parliament and other elected political representatives. It has also developed several projects for mid-term, projects which may allow greater articulation of prevention efforts in Spain by building a communication infrastructure so as to support the key players, a network which is missing until now. Recently it has been passed and approved legislation allowing to hold research grants so as to support prevention with available funds.

During the 90s there was a continuous work of all stakeholders, led by health professionals, that was progressively turning the perception from a “bad habit” to a “risky behavior”. As predicted by models of diffusion of smoking epidemic, the change of attitudes occurred when the health consequences of smoking achieved the maximum visibility, i.e., the rates of lung cancer among males were historically high. This increase in social visibility, reinforced by messages from health authorities and scientific institutions, had as a consequence the social acceptance that smoking was a highly addictive and seriously harmful behavior, so that the proportion of smokers seeking assistance to quit started to raise. During those years the European Union was facing serious smoking, and as a result the first Directive on Tobacco contents was enacted in 2001. During that time, the tobacco industry started to focus on limitation of smoke-free policies, through campaigns stressing the primacy of social tolerance, opposite to strict rules. Nevertheless, at the turn of 21st century the majority of the population in Spain was supporting restriction of smoking, and the way to a new phase in the regulation of smoking in Spain was initiated.

Part 2. Development and assessment of the smoking public health policy

Decision for having a smoking public health policy

In 2003 the Ministry of Health started the process of developing a comprehensive law regulating all aspects of smoking, including sales, publicity, consumption and

assistance to cessation. The tobacco industry heavily lobbied against the law in many ways, basically through menacing the hospitality sector with the threat of enormous economic loses, and using some intellectuals and artists to spread the message that smoking is cool, is a personal right, and need not to be regulated by law. After months of negotiation, supported by an enormous effort of the NCSP, at the end the government adopted what was called “the Spanish model”, where small venues could decide whether to permit or to prohibit smoking. We came to know later that this model was inspired by the industry to the hospitality sector and the politicians close to their positions, and this model was later on spread in those countries still not having a defined smoking policy. The basic message was that “self-regulation” is good enough, therefore no prohibitions are needed. This position has been explicitly found in the secrets industry documents that had to be released after the US court forced Philip Morris to do it, and is usually stated as “traditional hospitality” or “courtesy of choice” (cita).

After 2005, it was soon clear that the smoking law had consolidated in all indoor workplaces the rule of no-smoking, but at the same time it created a new inequity, by leaving exposed to smoking only workers at the hospitality sector, estimated to be around 1.200.000 people. Over another period of few years the debate was growing, until the government decided to reform the law. That was done in December 2010, when a complete ban was enacted. The decision was taken by the Ministry of Health, after the complaints and requests of a wide range of relevant stakeholders, including media, health associations, scientific institutions, patients and consumers’ organizations and unions, during the period 2005-2010.

Formulation and approval of the smoking public health policy

The new policy was developed by the Congress Health Committee as a reform of the existing law (law 28/2005 of health measures facing smoking), as it was not possible to reach a wide political consensus between the main political parties (Socialist Party and Popular Party) to develop a new comprehensive law. Although historically health policies have been out of political controversies and they been approved usually by wide majorities, the level of political tension has been growing in Spain during the last

few years, and, as a consequence, the 2005 smoking ban was interpreted differently in autonomous regions according to the ruling party. Given this lack of agreement, a reform of the existing law, instead of a new comprehensive law, was decided, since it requires a much less complex political procedure, was initiated early in 2010 and approved by the committee at the end of November 2010. After discussion and amendments by Senate members, it came back to Congress for final approval by December 27, and was published by December 28. The law had to be ruling by January second, 2011. All the regional public health departments were informed and could discuss the law during the meetings of the Interegional Health Council, a consultancy body created to coordinate public health between regions, there is a Interegional Committee of Health, with ad hoc commissions created for every specific topic, meeting periodically, usually in Madrid.

Implementation of the smoking public health policy.

Spain being a highly decentralized state, implementation of health-related laws are usually implemented by the regional governments, since most of the content of the law has do to with the health sector (i.e. inspection of venues), while only a few aspects of smoking policies (like prices) are dependent of the central government. For the sake of clarity, in annex 2 the functions and competences of central and regional governments regarding health services, public health and smoking control are summarized. To deal with smoking there is a subcommittee of the Interegional Committee of Health dealing with public health and health promotion, that decided in the last meeting previous to the law enactment to act in a consistent and homogeneous way, in order to transmit a clear message of policy enforcement across the whole country. Learning from the experience of the 2005 law, it was agreed to stablish a detailed set of activities, including information on prohibition, inspections and fines. Nevertheless there was still some confusion during the first week of January, regarding the specific characteristics of graphical and written signs, and about the policy regarding smoking outside facilities where consumption was banned (i.e., in the accesses or campus surrounding hospitals). In addition, in January 2011 there were a few bar owners declaring publicly (through the media) they would not commit to the new law, appealing to their freedom to rule their own business, although they were likely to be backed by the tobacco

industry through the hospitality patrons association. An immediate response from the regional authorities (in Catalonia and Andalucia) imposing them very high fines, that were conveniently publicized through the media, were very effective to give the message of zero tolerance to rebellion. Besides attending to these hot spots, all regional health authorities have been conducting a large number of inspections during the first 3 months after implementation (see annex 3).

Monitoring and evaluation of the new smoking policy

As mentioned in the previous chapter, there has been an intensive program of inspections in the hospitality sector from the law enactment. In addition, the government has established a two years period for monitoring and evaluation of the law, that will be conducted by a newly created body named "Observatory for smoking policies". Nevertheless, scientific and professional associations (such as the Spanish Society of Epidemiology) have started specific studies in order to evaluate effectiveness of the law. Among the main indicators that will be collected are the economic indicators (trends in the number of employments and in the benefits of hospitality sector); prevalence of smoking; prevalence of exposure; concentration of environmental tobacco smoke in samples of hospitality venues; cessation treatment demands; and consultations for cessation at the health services. At the first meeting of the Observatory Board, on May 9th, some prelimnar indicators were presented, basically showing that no negative effects have been observed in the economic indicators of the hospitality sector that could be attributed to the Smoking law (see annexes 4 and 5). By the end of June it is expected to have data from the study of nicotine concentration before and after the law in a sample of bars and cafeterias; preliminary data suggest there has been a dramatic reduction (more than 95%) of the exposure to ETS in those venues.

Conclusion

The smoking law was a norm long time demanded by a large proportion of the society. It has the extremely important goal of ending with unwanted exposure to environmental

tobacco smoke at the workplace; unlike the previous law, there is no room for much interpretation (i.e, about the surface of the venues). However, there is still some ambiguity regarding definition of terraces and open spaces, and needs enforcement from the regional administrations. In addition, there is the threat of the tobacco industry, that keeps saying (even though the numbers and facts do not support this message) that there will be a major economic problem because of the law.

Annex 1. Summary of smoking control activities in Spain 1980-2010

Programs and activities	Setting and timing	Situation
Regulación de la publicidad	Desde 1985 en algunas CCAA en vallas en la vía pública y medios de comunicación institucionales. Prohibición en la televisión gracias a la Ley General de Publicidad de 1988, que traspone una Directiva Europea. Prohibición general mediante ley en 2005.	Sin publicidad visible desde 2006. Probable publicidad subliminal en medios, mediante *product placement* y visibilidad de personas fumando en medios, teleseries, etc.
Regulación del consumo en lugares públicos	Desarrollada desde 1985 en algunas CCAA, reforzada por el Decreto Ley 192/1988 modificado en 1999 para transporte. Extendido al grueso de lugares de trabajo mediante ley 28/2005.	Se ha documentado un cumplimiento elevado, salvo en locales de ocio nocturno. Los pequeños locales de restauración y hostelería, así como los de ocio nocturno mantienen un amplio margen de decisión. La ley podría modificarse en 2010.
Programas educativos de prevención en las escuelas	Implantados nominalmente desde finales de los ochenta	Desarrollados sistemáticamente en la práctica sólo en pocos casos y por iniciativa municipal o autonómica.
Intervenciones desde la atención primaria y el sistema sanitario	Impulsadas desde 1987 por administraciones locales (como programas piloto) o asociaciones profesionales	Ampliadas de forma muy general por los servicios autonómicos de salud, de forma paralela a la disminución de la prevalencia

	(PAPPS de la SEMFYC). Organizadas desde los servicios autonómicos de salud, a veces de forma muy intensiva (Navarra, Andalucía, Cataluña...).	entre los médicos y la extensión de la reforma de la atención primaria de salud. Disponibilidad amplia de fármacos en Navarra y La Rioja, con ciertas restricciones en algunas CCAA.
Unidades especializadas de tratamiento	Tipología muy variable. Pueden estar vinculadas a iniciativas de hospitales y universidades. En algunas CCAA las asumen los centros que atienden a las adicciones. Pueden ser fuente de impulso a la formación y de nuevas iniciativas, como las líneas telefónicas de cesación	Aunque no cubren a toda la población, han ido creciendo en número e implantación territorial. En algunas CCAA se ha alcanzado un despliegue territorial integral y homogéneo.
Programas comunitarios de cesación	Iniciados de forma local en 1988, vinculados a iniciativas OMS (Dia mundial sin fumar) y continuados con esquemas del tipo *Quit & Win*.	Continuados en algunas CCAA, y a menudo con uso del teléfono, SMS, correo, e internet.
Incremento de la fiscalidad sobre el tabaco	Directiva Europea desde 1992, modificada en 2001 y 2010. Ampliación del componente lineal del impuesto en 2006 y 2010.	La Directiva de 1992 se tradujo en un mayor incremento de precios, especialmente entre 1992-97. En 2006 se adoptaron cambios orientados a incrementar el precio de las marcas más baratas, reforzados en 2010 y ampliados a la picadura para liar.

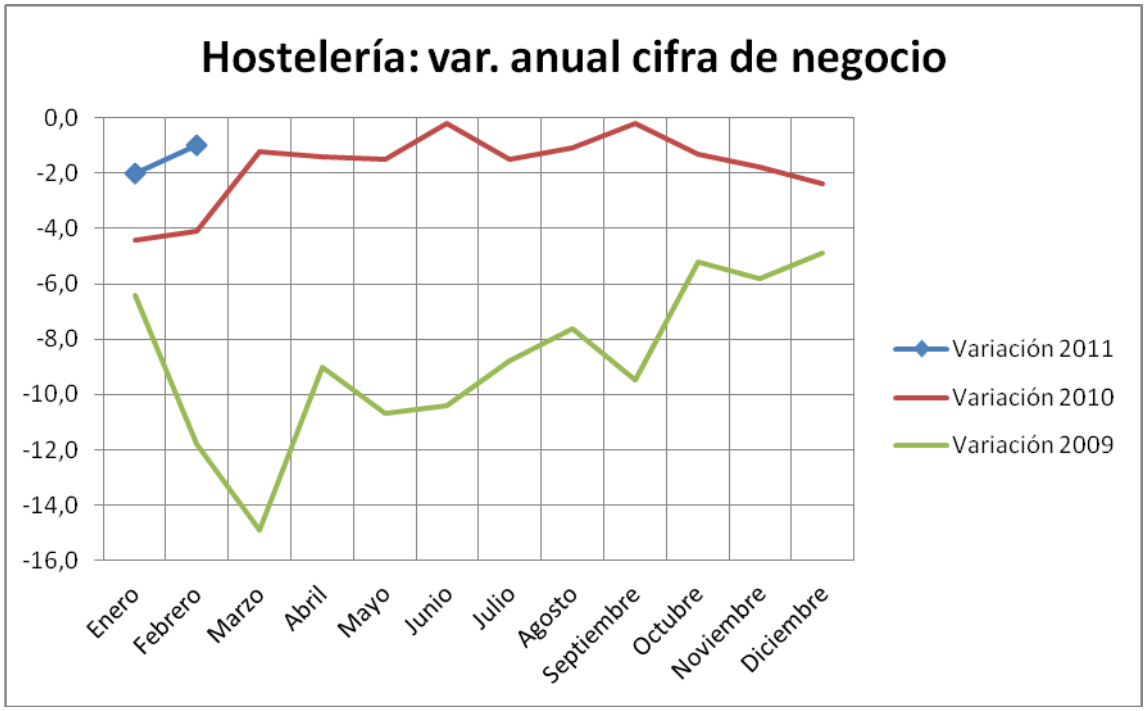
Annex 2. summary of main competences of the central and regional governments regarding health services, public health and smoking prevention

	Central government	Regional governments
Health services		
	Basic legislation (law on smoking; law on quality of health services; law on attention to vulnerable and dependent groups etc)	Planning, management and evaluation of health services, including primary care, hospitals, specialized care and social services
Public health		
	Drug approval Health surveillance of foreign health problems amd alerts Representation at supranational bodies (i.e. EC, WHO)	, planning, management of public health services including surveillance, heaqlth protection, health information systems and health promotion
Smoking control		
	Legislation Law 28/2005 Law 41/2010 Prices and taxes Publicity at national media	Inspection and enforcement, information, monitoring, evaluation

Annex 3. Inspections perfomed during the first month after enactment of the smoking law 43/2010 in Aragón. January 2011

Tipo de control	Nº inspecciones	Nº Inspecciones con incidencias	A.1 Señalización del establecimiento	A.2 Señalización máquina expendedora	B. Control acceso menores (máquina expendedora)	C. Consumo de tabaco	D. Otras
1.Control sistemático (hostelería)							
Huesca	230	33	28	4	2	0	2
Teruel	187	7	5	2	0	0	0
Zaragoza	389	69	37	24	7	1	0
Aragón	***806***	***109***	***70***	***30***	***9***	***1***	***2***
Porcentajes del total	***Huesca***	*14,35*	*12,17*	*1,74*	*0,87*	*0,00*	*0,87*
	Teruel	*3,74*	*2,67*	*1,07*	*0,00*	*0,00*	*0,00*
	Zaragoza	*17,74*	*9,51*	*6,17*	*1,80*	*0,26*	*0,00*
Aragón		***13,52***	***8,68***	***3,72***	***1,12***	***0,12***	***0,25***
2. control de incidencias (resto establecimientos)							
Huesca	50	0	0	0	0	0	0
Teruel	17	1	0	1	0	0	0
Zaragoza	50	28	27	0	0	1	0
Aragón	***117***	***29***	***27***	***1***	***0***	***1***	***0***
TOTAL	*923*	*138*	*97*	*31*	*9*	*2*	*2*

Annex 4. Trends in benefits from the hospitality sector 2009-2010-February 2011



Annex 5. Trends in occupation in the hospitality sector 2009-2010-February 2011