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COUNTRY VISITS

**Report of the Sub-Committee of the Regional Committee on
Programmes and Technical Cooperation, Part I**

The Sub-Committee of the Regional Committee on Programmes and Technical Cooperation met from 19 to 21 June 1995 to review and finalize the report on the country visits made by four of its members to Australia, China and Singapore within the framework of item (5) of its terms of reference, regarding WHO's collaboration in the field of healthy lifestyles, with a focus on tobacco-or-health activities. The attention of the Regional Committee is drawn to the conclusions and recommendations of the Sub-Committee presented in this document, which indicate the significance of this topic for the Region, and draw attention to the need for strong public policies, in conjunction with appropriate environments, and the related need for commitment to healthy lifestyle policy and programme development at the highest levels.

1. INTRODUCTION

The Sub-Committee of the Regional Committee on Programmes and Technical Cooperation held its tenth meeting in Manila, from 19 to 21 June 1995. The terms of reference of the Sub-Committee are set out in Annex 1.

A list of members attending the meeting is found in Annex 2.

The report to the Regional Committee is on the country visits made by four of the Sub-Committee's members to Australia from 5 to 7 June, China from 9 to 13 June, and to Singapore from 14 to 15 June. It summarizes the Sub-Committee's observations, conclusions and recommendations. The visits were undertaken within the framework of item (5) of the terms of reference, with particular reference to WHO's collaboration in the field of healthy lifestyles, with a focus on tobacco-or-health activities.

The meeting was opened by Dr S.T. Han, Regional Director. Dr Andres Galvez was elected Chairman of the meeting and Ms Denna Connell and Dr Ho Keong Bin as Rapporteurs.

2. REVIEW AND ANALYSIS OF WHO'S COLLABORATION WITH COUNTRIES: REPORT ON THE COUNTRY VISITS TO AUSTRALIA, CHINA AND SINGAPORE

2.1 Perspectives and findings during the country visits

Within the framework of item (5) of its terms of reference, the Sub-Committee reviewed and analysed WHO's cooperation with Member States in the field of healthy lifestyles, with a focus on tobacco-or-health activities.

A summary of key policy statements is attached as Annex 3 (WHA resolutions, etc.).

In the course of reviewing the report of the members' visits, the Sub-Committee made a number of comments, conclusions and recommendations, which are reflected in the final text of the

report on the country visits, adopted by the Sub-Committee and presented as Annex 4 to this document.

Within the constraints of time and the availability of relevant information, the members reviewed examples of healthy lifestyles and tobacco-or-health activities in Australia, China and Singapore, and appraised the strategies developed and used in those countries. The Sub-Committee noted the following three key points common to all three countries:

1. Many of the major health problems in the Region relate to changes in lifestyles and living conditions linked with industrialization, urbanization, and modernization. If lifestyles change, individuals' responsibilities also change to live a healthy life, hence the need for development of healthy lifestyles.
2. There is evidence in the Region of the positive influence that strong public policies, in combination with supportive environments, can exert on individual behaviours. This evidence can be used elsewhere in the Region to reinforce or introduce policies and programmes on healthy lifestyles.
3. The success of healthy lifestyle policy and programme development is heavily dependent on commitment at the highest levels of government. Lesser commitment endangers the capacity and sustainability of its implementation.

2.2 Conclusions and regional implications

1. WHO has a very high profile in the Region, and is therefore in an ideal position to facilitate the exchange of resources and information on a wide range of health promotion activities, and in particular on healthy lifestyles.
2. The WHO Action Plan on Tobacco or Health has created a strong focus for countries and areas of the Region as a means of creating an environment supportive of healthy lifestyles and for guiding actions in tobacco control. The Regional Director has called for a Region free of tobacco advertising by the year 2000.
3. WHO has done much to raise awareness of the need to regard healthy lifestyles and health promotion as policy issues. There are many successful health promotion projects in the Region which, if approached comprehensively, can work in other environments. Implementation is still

constrained by inadequate health promotion awareness and by the lack of personnel in all sectors with health promotion skills.

4. Some form of tobacco control legislation exists in 11 countries and areas of the Region. It would be helpful to those experiencing difficulties in formulating or revising legislation, to draw upon the lessons learnt in other countries and areas, which may include legislative and enforcement models.

5. For the success of health development, consultation and involvement in healthy lifestyles must take place with all who are involved. Significant work has already been undertaken to research multisectoral approaches to health promotion but this must be strengthened and supported.

6. Adolescent smoking uptake rates are continuing to rise in the Region and this is a major cause of concern. Countries and areas are focusing anti-smoking activities on this group.

2.3 Recommendations

WHO should:

1. provide guidance on healthy lifestyles and living conditions throughout the Region, whether through direct collaboration in the implementation of health promoting activities, for example, through health-promoting schools, or through facilitating exchange of information and experience.
2. strengthen and broaden its coordinating and supporting role in healthy lifestyle programmes carried out by other organizations and provide models of successful legislative frameworks;
3. strengthen and support research on lifestyles and their impact on health, and multisectoral approaches to health promotion;
4. support the development of human resources in health promotion through linking relevant expertise in training in the Region; and
5. support countries in implementing *New horizons in health*, and the Action Plan on Tobacco or Health for 1995-1999, and monitor the progress in their implementation.

Member States should:

1. give high-level policy commitment and support to the implementation of health promotion, including tobacco control;
2. actively strengthen multisectoral coordination and community involvement in the promotion of health;
3. ensure consistency with the approaches of *New horizons in health* in health-promoting activities;
4. implement the Action Plan for Tobacco or Health for 1995-1999, developing a comprehensive policy on tobacco control, with clear legislative support and enforcement;
5. positively promote social environments which encourage lifestyles free of tobacco use in young people; and
6. share resources in health promotion, including tobacco-or-health activities, with other countries and areas in the Region.

The Sub-Committee proposed that, subject to finalization of details at the time of the Regional Committee session in September 1995, the topic to be reviewed in 1996, in the context of item (5) of its terms of reference, should be Health systems reform. The Sub-Committee also proposed that either Fiji or New Zealand, and either Malaysia or Viet Nam should be visited in 1996, subject to the agreement of the governments concerned.

3. ACKNOWLEDGEMENTS

The Sub-Committee particularly wishes to express its appreciation of the excellent programmes prepared for its members by the Governments of Australia, China and Singapore, and the generous and warm hospitality shown by these host countries.

ANNEX 1**TERMS OF REFERENCE**

The terms of reference for the Sub-Committee on Programmes and Technical Cooperation are as follows:

- (1) To review, analyse and make recommendations on the development and implementation of the General Programme of Work as it affects the Western Pacific Region, especially in setting priorities and addressing policy issues.
- (2) To examine and approve for submission to the Regional Committee the periodic regional reports on monitoring and evaluation of the regional strategy for health for all by the year 2000.
- (3) To study and provide policy guidance on specific issues related to the health-for-all strategy which may be requested by the Regional Committee.
- (4) To make recommendations to the Regional Committee on the action to be taken in the Western Pacific Region to develop national self-reliance in matters of health by fostering technical cooperation among countries or areas in the Region in ways that are relevant to the population.
- (5) To undertake country visits to review and analyse the impact of WHO's cooperation with Members States and/or observe developments in relation to the implementation of the regional strategies for health for all.

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WHO KEY POLICY STATEMENTS

The first policy statement was made in 1970 during the Twenty-first World Health Assembly in resolution WHA23.32. Four other resolutions followed between 1971 and 1980.

The broad scope of tobacco control measures was outlined in 1986 in the Health Assembly resolution **WHA39.14 (4)** and has been updated by several further resolutions. The nine aspects of tobacco control listed in that resolution are:

- "(1) measures to ensure that non-smokers receive effective protection, to which they are entitled, from voluntary exposure to cigarette smoke, in enclosed public places, restaurants, transport, and places of work and entertainment;
- (2) measures to promote abstention from the use of tobacco so as to protect children and young people from becoming addicted;
- (3) measures to ensure that a good example is set in all health-related premises and by all health personnel;
- (4) measures leading to the progressive elimination of those socioeconomic, behavioural, and other incentives which maintain and promote the use of tobacco;
- (5) prominent health warnings, which might include the statement that tobacco is addictive, on cigarette packets, and containers of all types of tobacco products;
- (6) the establishment of programmes of education and public information on tobacco and health issues, including smoking cessation programmes, with active involvement of the health professions and the media;
- (7) monitoring of trends in smoking and other forms of tobacco use, tobacco-related diseases, and effectiveness of national smoking control action;
- (8) the promotion of viable economic alternatives to tobacco production, trade and taxation;

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(9) the establishment of a national focal point to stimulate, support, and coordinate all the above activities."

In addition, resolution **WHA43.16** in part:

"URGES all Member States:

(1) to implement multisectoral comprehensive tobacco control strategies which, at a minimum, contain the nine elements outlined in resolution WHA39.14;

(2) to consider including in their tobacco control strategies plans for legislation or other effective measures at the appropriate government level providing for:

(a) effective protection from involuntary exposure to tobacco smoke in indoor workplaces, enclosed public places and public transport, with special attention to risk groups such as pregnant women and children;

(b) progressive financial measures aimed at discouraging the use of tobacco;

(c) progressive restrictions and concerted action to eliminate eventually all direct and indirect advertising, promotion and sponsorship concerning tobacco."

Among the series of resolutions, the following important sections have been extracted from the original resolutions because of their precise importance to tobacco control:

In May 1991 resolution **WHA44.26** was adopted which states in part:

"The Forty-fourth World Health Assembly, ...

Recognizing that there is no safe level of exposure to tobacco smoke;

Aware of the technical problems of ensuring a smoke-free environment in many public conveyances, especially trains and aircraft;

Congratulating the transport authorities and companies that have adopted measures to offer their passengers a smoke-free environment and encouraging all those responsible for public transport to do likewise;

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Deeply concerned about the dangers to health, and the violation of the right to health, of non-smokers caused by enforced, or passive, smoking and about the WHO-approved estimates that the annual number of deaths in the world attributable to smoking will be about three million in the 1990s,

1. URGES all Member States:

- (1) to adopt appropriate measures for effective protection from involuntary exposure to tobacco smoke in public transport;
- (2) to ban smoking in all public conveyances where protection against involuntary exposure to tobacco smoke cannot be ensured, and to adopt effective measures of protection wherever possible;
- (3) to promote educational activities necessary to make people aware of the importance of protecting themselves and their families, especially children, against passive smoking, for example while travelling in private cars."

In May 1993 over forty members of the World Health Assembly passed resolution **WHA46.8**, from which the following is taken:

"The Forty-sixth World Health Assembly,...

1. CALLS ON the Director-General as a matter of importance to approach the Secretary-General of the United Nations urging him:

- (1) to take the necessary steps to ban the sale and use of all kinds of tobacco products in all buildings owned, operated or controlled by all organizations and specialized agencies of the United Nations system and that are used to carry out its business;
- (2) to ensure that the progressive implementation of this ban takes a maximum of two years from the date of this Health Assembly;
- (3) to encourage and assist employees who are smokers, but who wish to cease smoking, to take part in smoking cessation programmes, and provide open-air sheltered areas for those who wish to continue smoking."

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It is of interest to note the strong support for the draft resolution which was proposed by 42 countries, 15 of which were from the Region (those in bold):

Australia, Austria, Bahamas, Benin, Bhutan, Botswana, Canada, **China**, **Cook Islands**, Cote d'Ivoire, Finland, France, Ghana, Hungary, Iceland, India, Iran, (Islamic Republic of), Ireland, Jamaica, Jordan, **Kiribati**, Kuwait, **Malaysia**, Malta, Mauritius, **Micronesia (Federated States of)**, Morocco, Netherlands, **New Zealand**, Norway, **Papua New Guinea**, **Philippines**, **Republic of Korea**, Saint Kitts and Nevis, **Samoa**, **Singapore**, **Solomon Islands**, Sri Lanka, Thailand, **Tonga**, United Kingdom of Great Britain and Northern Ireland, and **Vanuatu**.

In May 1995, in resolution **WHA48.11** on an international strategy for tobacco control:

"The World Health Assembly, ...

- (1) COMMENDS the International Civil Aviation Organization response to ban smoking on all international flights as of 1 July 1996;
- (2) URGES those Member States that have already successfully implemented all or most of a comprehensive strategy for tobacco control to provide assistance to WHO, working with the United Nations system focal point on Tobacco or Health (located in United Nations Conference on Trade and Development), so that these bodies can effectively coordinate the provision of timely and effective advice and support to Member States seeking to improve their tobacco control strategies, including health warnings on exported tobacco products;
- (3) REQUESTS the Director-General:
 - (1) to report to the Forty-ninth World Health Assembly on the feasibility of developing an international instrument such as guidelines, a declaration, or an International Convention on Tobacco Control to be adopted by the United Nations, taking into account existing trade and other conventions and treaties;
 - (2) to inform the Economic and Social Council of the United Nations of this resolution;
 - (3) to strengthen WHO's advocacy role and capacity in the field of "tobacco or health" and submit to the Forty-ninth World Health Assembly a plan of action for the tobacco or health programme for the period 1996-2000."

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REPORT ON COUNTRY VISITS**1. INTRODUCTION**

Members of the Sub-Committee visited Australia, China and Singapore from 5 to 15 June 1995. The purpose of the visit was to review and analyse the impact of WHO cooperation with these countries in the field of healthy lifestyles with a focus on tobacco-or-health activities. Dr Andres Galvez (Philippines) was elected as the Chairman and Ms Denna Connell (Australia) as the Rapporteur. The other Sub-Committee members who made the country visits were Mr Wu Guogao (China) and Mr Jefferson Benjamin (Federated States of Micronesia).

1.1 Role of the Sub-Committee

The Sub-Committee of the Regional Committee on Programmes and Technical Cooperation provides information, analysis and recommendations to the Regional Committee on technical aspects of health development in the Region. The terms of reference (Annex 1) require the Sub-Committee, *inter alia*, to report on countries' progress towards achieving the health-for-all goals, to submit periodic regional reports, to provide guidance on the strategy as requested, to make recommendations, and to make country visits.

1.2 Purpose of mission

Healthy lifestyles, with a focus on tobacco-or-health activities, was the topic chosen for the 1995 visits by the Sub-Committee to Australia, China and Singapore. The specific purpose of this mission was to examine how well these countries have included healthy lifestyle concerns in their planning for development, to review WHO's past collaborative activities in the field of healthy lifestyles; and to consider how WHO cooperation could be used to promote and facilitate better integration of healthy lifestyles in the overall health development process.

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1.3 Initiatives globally and in the Region on promoting healthy lifestyles

Many of the major health problems in both developing and developed countries relate to changes in lifestyles and living conditions linked with industrialization, urbanization, modernization, and migration. If lifestyles change, people's responsibilities also change. Fresh approaches are needed in order to take charge of these changed responsibilities and reach health-for-all goals.

As social situations change, individual behaviour may also be subject to constant evolution. Behaviour involving a health risk is thus seen not just as a result of an individual decision, but, above all, in terms of its social, cultural and economic dependence, and in terms of the function it fulfils. To influence health-related behaviour, the complex relationships between living conditions, social situations, and lifestyles of individuals and groups must be considered, as they are interrelated and affect each other in many ways.

The WHO Glossary of Terms, used in the "Health for All" series, defines health promotion as an evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors which support health.

WHO has helped to build awareness of concepts of health promotion through a series of global conferences. The first conference in 1986 resulted in the Ottawa Charter for health promotion, which defined five areas for health promotion: building health-supportive public policies, creating supportive environments, strengthening community action, developing personal skills, and monitoring health services. The Ottawa Charter stressed that health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. The second conference was held in Adelaide, Australia, in 1988, and discussed health-supportive public policies. The third conference was held in Sweden in 1991 and provided, with the Sundsvall Statement on Supportive Environments for Health, a framework for action that would further stress the link between living conditions and lifestyles.

The Forty-second World Health Assembly in 1989 strongly endorsed the messages of the global conferences, and stressed the importance of the Declaration of Alma-Ata in 1978, which identified primary health care as the way to achieve health for all. Resolution WHA42.44, *inter alia*, called upon Member States to develop, in the spirit of the Alma-Ata, Ottawa and Adelaide conferences, strategies for health promotion and health education as an essential element of primary

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health care and to strengthen the required infrastructure and resources at all levels. It also called upon the Director-General to provide support to Member States in strengthening national capabilities in all aspects of health promotion and public information and education for health, particularly the training of manpower.

A WHO Working Group on Health Promotion in Developing Countries, convened following the Health Assembly in 1989, stated that health promotion strives to contribute to health development through three principal strategies: advocacy of policies, developing strong alliances and social support systems, and empowering people.

An example of the implementation of the principles and strategies of health promotion is the worldwide development of the concept of "healthy cities", in which individuals, community groups and different sectors of the local government take action to create positive living conditions and lifestyles which support health.

A health promotion programme was developed and endorsed by the Regional Committee at its forty-fourth session in September 1993. In a resulting resolution (WPR/RC44.R11), Member States were urged to facilitate community action that contributes to the development of lifestyles and living conditions conducive to health. The health promotion programme highlights health as something which can be promoted at every stage of life. It stresses individual action for health, balanced by support for healthy living to be given by the community and government. Settings of everyday life, such as the home, school, workplace, the entire community, city or island provide the frameworks for action.

The health promotion programme was further developed in the light of the document, *New horizons in health*, which was endorsed by the Regional Committee at its forty-fifth session in 1994.

Ten goals have been set within the global health policy framework for the period covered by the Ninth General Programme of Work. These include: "To enable universal access to safe and healthy environments and living conditions" (Goal 9), and "To enable all people to adapt and maintain healthy lifestyles and healthy behaviour" (Goal 10). The indicators to be developed in relation to the three themes in *New horizons in health* will take this further in considering determinants for health which are related to sectors other than health.

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The four interrelated policy orientations, proposed as a focus for action in the Ninth General Programme of Work, are also in line with the approaches outlined in *New horizons in health*.

- (a) integrating health and human development in public policies;
- (b) ensuring equitable access to health services;
- (c) promoting and protecting health; and
- (d) preventing and controlling specific health problems.

1.4 Initiatives globally and in the Region on tobacco or health

The World Health Assembly has adopted 13 resolutions which stress the dangers of tobacco use and call for a global approach to controlling the marketing and promotion of tobacco. Among these, WHA46.8 is particularly significant. This resolution was proposed by 42 Member States, 15 of which were from the Western Pacific Region.

WHO's programme on tobacco or health guides worldwide tobacco control measures, provides material for the observation of World No-Tobacco Day on 31 May each year, and has established a global database on smoking or health. The programme has recently been included into the plans for the programme on Substance Abuse.

In the Region, considerable progress has been made in setting up tobacco control measures during the Eighth General Programme of Work, which has a distinct programme on tobacco or health.

The first Regional Working Group on Tobacco or Health was convened in Tokyo, Japan, in November 1987 and made a series of recommendations. In March 1990, the second Western Pacific Regional Working Group on Tobacco or Health met in Perth, Australia, and drafted the first Regional Action Plan on Tobacco or Health for 1990-1994.

The Regional Committee at its forty-fifth session reviewed the progress made in implementing the Action Plan on Tobacco or Health for 1990-1994. It was noted that despite encouraging progress made, the per capita tobacco consumption was still increasing in the Region. The Committee endorsed the Tobacco or Health Action Plan for 1995-1999 and urged Member States

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to take all the necessary steps in implementing it, especially with regard to establishing comprehensive tobacco control policies and programmes, data collection, advocacy and education, legislation and pricing policy. The Working Group on Tobacco or Health had drafted the Action Plan during its third meeting in April 1993 in the Regional Office and recommended activities in five specific areas for priority target groups.

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2. AUSTRALIA

2.1 Background

The members of the Sub-Committee visited Australia from 5 to 7 June 1995.

GENERAL

Australia is a federation of states and territories. The Australian Federal Government has responsibility for health throughout Australia, but devolves health delivery and management to State and Territory Governments.

Australia covers an area of 7 682 300 square kilometres. Nearly 39% of its land mass lies within the tropics; Cape York, the northernmost point, is only 10° south of the equator. Australia's population in 1990 was 17 086 000 giving a density of only 2.2 inhabitants per square kilometre, one of the lowest national figures in the world. Estimates for 1995 indicate a population of 18 338 000, with 85.2% in the urban areas, and 14.8% living in the rural areas. The rate of population growth has been low during the 1980s, averaging around 1.6% per year. Much of the increase has resulted from net immigration, which has contributed approximately 50% of the population growth during the decade of 1980-1990. In terms of population, as well as land use, Australia can be divided into three broad zones: one part almost unpopulated, another sparsely populated and the third containing the great majority of the people.

Australia's per capita gross national product in 1990 totalled US\$16 650. The economy is very open and has a sizeable public sector. The average distribution of labour force by sector in 1989-91 was as follows: agriculture, 15%; industry, 23%; services, 62%. The adult literacy rate is 100%.

HEALTH POLICY AND STRATEGY

In 1985, Australia established the National Better Health Commission, which recommended national health goals for three major health problem areas - cardiovascular disease, nutrition, and injury - and recommended that goals be developed in several other areas.

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In March 1987, the Australian Health Ministers' Conference established the Health Targets and Implementation (Health for All) Committee to develop comprehensive health goals and targets for Australia by the year 2000. This Committee issued a report in 1988, entitled "Health for All Australians".

A National Health Strategy was set up in 1990 to identify ways of improving the effectiveness and efficiency of the health system, with a correspondingly strong emphasis on financing health services.

In 1993, revised "goals and targets for Australia's Health in the Year 2000 and Beyond" were presented. They create, together with the Medicare Agreement, an environment in which health promotion has an opportunity to flourish. The chapter on healthy lifestyles and risk factors addresses health areas such as nutrition, a healthy society and mental health. Issues paper No. 07 of the National Health Strategy on "Pathways to better health" was published in March 1993, which gives directions for health promotion.

In 1994, the document on *Better Health Outcomes for Australians* was published. It represents a policy framework for the Australian health system, developed and endorsed by the Federal Government of Australia, State and Territory governments, nongovernmental organizations and affected groups, including health professionals and consumers. The document details national health goals and targets, and strategies for their achievement.

The National Drug Strategic Plan 1993-1997 provides goals and objectives, key national indicators and programme priorities for focusing national attention and action in minimizing the harmful effects of drug use (including tobacco) on Australian society.

The National Drug Strategy is a cooperative venture between all governments (Federal Government of Australia, State and Territory) and the nongovernmental sector in Australia.

The National Health Policy on Tobacco in Australia details the national tobacco policy and provides examples of strategies for implementation of that policy. A Ministerial Council comprising Ministers responsible for health and law enforcement in all States and Territories oversees this strategy.

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The National Tobacco Strategy, developed in consultation with health advisory groups in the Federal Government of Australia, provides a way of building on the National Health Policy on Tobacco and ensuring that tobacco harm minimization activities of government and nongovernmental organizations take place within a wider strategic framework.

In 1995, the Australian Government provided significant funding over three years to a new programme *Health Australia - Tobacco Harm Minimization*. It aims to establish techniques to restrict the harmful effects of smoking. This experience will be used as a model for new strategies for other health promotion programmes and to report to the Minister on future directions for health promotion in Australia to be implemented under the Health Advancement budget initiative.

THE HEALTH SYSTEM

Since 1984, Australia has had a publicly funded national insurance system for health care, known as "Medicare". Under Medicare and the complementary Pharmaceutical Benefits Scheme (PBS), Australian residents are covered for out-of-hospital medical services with free access to public hospitals and to a comprehensive range of drugs.

A number of options are being considered to strengthen a comprehensive primary health care system in Australia. These include:

- options for restructuring the funding of general practitioners;
- coordinating mechanisms and incentives between private, public, nongovernmental and self-help sectors;
- strategies and incentives for the integration of primary and secondary levels of the health care system; resources and workforce planning; consideration of overseas models and experience; and refining the respective roles of the Federal Government of Australia and States and Territories in any future arrangements.

COMMUNITY INVOLVEMENT

Australia already has a number of mechanisms in place for consultation as well as forums for public involvement in setting priorities and strategies for health promotion and meeting needs in the

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health area. There are, however, differences in the level of community participation between states and territories.

Much of the success of attaining the goals and targets of the strategy for health for all by the year 2000 will depend on the mobilization and involvement of communities and their health workers in the pursuit of their own health goals.

The Healthy Cities project is one such example, providing a new approach to urban administration which encourages coordination of services to make the physical and social environment positive for health. It aims to bring together the organizations and individuals whose decisions affect health, in order to identify the health impact of their actions.

Significant progress is being made in adopting a policy of health-promoting schools which involve parents, students, teachers and the community in determining preferences and in the decision-making process.

INTERSECTORAL COOPERATION

The Federal Government's Social Justice Strategy has created a favourable environment for intersectoral collaboration. The Strategy addresses the disadvantages that result from factors such as gender, inadequate income, race, location and disability, all of which can contribute negatively to people's health.

A necessary requirement for all is access to quality health services. The introduction of Medicare in 1984 has ensured a stable health system in Australia. Medicare, which is administered by the Health Insurance Commission, is supplemented by programmes such as the National Women's Health Program, the National Better Health Program and various Aboriginal health initiatives, to meet the special health needs of disadvantaged groups.

HEALTH STATUS

Overall, Australians have a high level of health. Average life expectancy has risen continuously during the twentieth century, except in the early 1960s when it levelled off because of increasing death rates caused by cardiovascular disease, especially among males. Between 1905 and 1988, life expectancy at birth increased by 18 years to 73.1 years for males and by 21 years to 79.5

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years for females. The infant mortality rate was 8 per 1000 live births in 1989. The proportion of newborn infants with birth weight of less than 2500 grams was approximately 5.5%. This figure has remained fairly constant over the last few years.

The principal cause of death remains heart disease, although the proportion it represents has decreased from 34.6% of deaths in 1983 to 32.4% of deaths in 1988. The crude death rate for ischaemic heart disease has declined by approximately 25% over the last 20 years, from 278 per 100 000 in 1968 to 197 per 100 000 in 1987. The death rate for cancer, the second largest cause of death, has continued to increase, from 23.2% of deaths in 1983 to 24.6% of deaths in 1988. The five top ranking types of cancer in 1982 were lung, breast, colon, prostate and melanoma. The death rate for diseases of the respiratory system is somewhat erratic, but from 1986 to 1988, it increased from 6.8% of deaths to 7.4% of deaths. The death rate for cerebrovascular disease is gradually decreasing from 11.8% of deaths in 1983 to 10.6% of deaths in 1988. The fifth largest cause of death is accidents. The death rate for accidents has been fairly stable over the five years from 1984 to 1988, at about 4.6% of deaths.

TOBACCO PRODUCTION, TRADE AND INDUSTRY

Agriculture In 1990, 4581 hectares were harvested for tobacco, down from 5422 in 1985. Less than 0.01% of all arable land is used for growing tobacco.

Production and trade In 1990-1992, about 12 610 tons of unmanufactured tobacco were produced or about 0.2% of the world total. Each year, Australia produces about 35 000 million cigarettes, accounting for about 0.6% of world production. Australia exports relatively little tobacco but imports of unmanufactured tobacco account for about 0.6% of all global imports. Australia earned about US\$8.7 million in 1990 from tobacco and cigarette exports, up from about US\$5 million in 1985. Import costs of tobacco in 1990 amounted to US\$55.4 million, or 0.1% of all import costs.

Industry About 3000 people are engaged full time in the tobacco manufacturing industry. This is about 0.03% of the labour force.

Tobacco consumption Almost all tobacco consumed in Australia is in the form of manufactured cigarettes. Hand-rolled cigarettes were estimated to be about 10% of manufactured

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cigarette consumption in the early 1970s, but since then this form of tobacco use has declined further. Per capita consumption peaked around 1975 at around 3300 cigarettes per adult per year, and since then has fallen by almost 25%. In 1990, male smokers smoked an average of 22 cigarettes per day and females smoked 19.

Tar, nicotine, filters In 1990, tar levels of cigarettes ranged from 0.4 mg to 14.0 mg, and nicotine levels from 0.10 mg to 1.30 mg. Almost all (96%) of cigarettes sold are filter-tipped.

Relative cost of cigarettes Data for the State of Victoria suggests that about 16 minutes of labour, at the average industrial wage, are required to purchase a packet of 20 cigarettes.

Prevalence Overall prevalence has declined dramatically since the early 1990s. Currently, about 1 in 4 adult males (or 25%) smoke, and 1 in 5 (or 20%) adult females. As recently as 1964, almost 60% of males smoked and 28% of females.

- *Tobacco use among population subgroups:* Data for 1990 indicate that smoking is lowest in professional or managerial workers (20%(M); 22%(F) rising to 27%(M) and 26%(F) in clerical and sales workers, to 32%(M) and 28%(F) in skilled workers, and is highest in semi-skilled workers (43%(M) 31%(F). In 1975, 14% of physicians were current smokers and 38% were ex-smokers.
- *Age patterns:* According to a 1989 survey, the highest prevalence of tobacco use by both sexes occurs at ages 20-24 years (41% (males); 28% (females). Between 1980 and 1989, prevalence of male smoking at ages 20-24 declined from 56% to 41% whereas prevalence of female smoking has only changed slightly, from 40% to 38%. Figures released in 1994 by the Center of Behavioural Research into Cancer also show a disturbing increase in smoking among 13-17 year-olds. It found that some 260 000 secondary schoolchildren now smoke a total of about 330 million cigarettes, costing them more than A\$49 million.

Mortality from tobacco use It is estimated that between 1950 and 2000, tobacco will have killed 675 000 Australians. This would be 13% of all deaths since 1950. The annual number of tobacco-attributable deaths among men is estimated to have peaked in 1985 at around 15 000 deaths but is still rising rapidly for women. It is projected that during the 1990s, there will be 12 000 male deaths each year related to tobacco use, and just under 5000 female deaths annually. Twenty-five

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per cent of all deaths among men in middle age (35-69) are due to tobacco, as are 15% of female deaths in this age group. Sixteen per cent of all deaths in Australia in 1990 were due to tobacco use, and 25% of all cancer deaths. Lung cancer rates for men peaked around 1980 and are declining rapidly. Conversely, lung cancer mortality is rising rapidly among women.

In the 30 and over age group, men are more likely to be smokers than women. Thirty-seven per cent of males and 27 per cent of females in the 30 to 54 age group are current smokers, while almost half of both males and females are past smokers.

In the under 30 age categories, male and female smoking behaviour is similar. The number of regular (everyday or on most days) smokers is approximately the same for both males and females, as are the proportions of past smokers.

Overall, there is very little difference between men and women in the average number of cigarettes smoked a day by regular smokers.

In 1994, it was reported that 25% of sick leave was attributable to smoking or alcohol. The estimated costs for smoking were A\$16 500 000.

TOBACCO CONTROL MEASURES

Control of tobacco products Since 1993, a national ban on tobacco advertising has been in effect. Sports sponsorship by tobacco companies has been banned, although exemption may be granted in exceptional circumstances for international events. In most states and territories, State Health Promotion Foundations have compensated for funding losses and provided funding for health promotion signs and anti-smoking messages.

Since 1994, six rotating warnings (smoking is addictive; smoking kills; smoking causes heart disease; smoking harms your baby; your smoking can harm others; smoking causes lung cancer) have been required on Australian cigarette packs. The warnings cover 25% of the front of the pack. Further health information covers one-third of the back and toxic substance information on one side.

Most states ban the sales of cigarettes to those under eighteen. Cigarette taxes are high - about 100% over and above the federal excise tax. The excise levied on tobacco at the Government

level has steadily increased over a number of years. Since the 1993 Federal Budget there have been three 5% increases in tobacco excise levied every six months.

In the 1995 Federal Budget, tobacco excise was increased by 10% from midnight on 9 May 1995. This increase brought forward and replaced the final six-monthly increase scheduled for August 1995 and imposed an immediate and additional 5% increase. Since that time, a number of states have imposed an additional franchise fee as a cost substitution for tax reduction in other areas.

Most states operate health promotion foundations that use part of state tobacco taxes to finance various health promotion and community development projects. Victoria was the first state to establish such a foundation in 1987.

Protection for non-smokers Smoking was banned in all workplaces of the Federal Government in 1988. Since then, protection from involuntary exposure to tobacco smoke has become widespread in both the public and private sectors. The first Australian smoke-free environments law, the Smoke-free Areas (enclosed public areas) Act 1994 took effect from 6 December 1994.

Successful legal actions by non-smoking employees and Australian smoking control advocacy groups have spurred employers to provide protection from involuntary exposure to tobacco smoke.

Smoking is banned in many public places, on domestic aeroplane flights, and a growing number of international flights. The Federal Government has declared that Australian international flights will be smoke-free from July 1996. This will affect all Ansett and Qantas flights.

In 1994, two of Western Australia's major outdoor sporting venues became smoke-free - Parry Field (the home of baseball) and Subiaco Oval (Australian Rules Football).

Health education Generous funding from tobacco tax-supported health promotion foundations means that Australia has some of the world's best anti-smoking, and health promotion and education programmes. The Victoria Health Promotion Foundation, for example, has a budget amounting to A\$6.00 per capita. Money is used to replace tobacco sponsorship of sports and arts events by health promotion sponsorship. In addition, funding is extended to a variety of other cultural events that did not receive tobacco sponsorship.

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Special emphasis is given to school health promotion. Smoking is addressed in the context of drug education. There is increasing intersectoral collaboration, involving teachers, students, parents, and the community. Several states have developed health-promoting schools, which are supported by a nationwide network.

A major national mass media campaign aims at reducing the attractiveness of smoking for young people.

Smoking cessation is facilitated through a variety of offers, ranging from cessation classes to telephone hotlines. The "Quit" campaign of the New South Wales Health Department uses the mass media to provide a supportive environment for cessation. In 1993, the Department also launched a first campaign for non-smokers and children, to address the issue of passive smoking.

2.2 Visits and findings

Visits were made to the Commonwealth Department of Human Services and Health and the Health Departments of the Australian Capital Territory (ACT) and New South Wales (NSW). Field visits were also made to the ACT Cancer Society, and to the National Centre for Health Promotion of the University of Sydney. A briefing was provided by the Victorian Health Promotion Foundation.

2.3 WHO collaboration

WHO collaborative activities focused on professional and academic collaboration. The country budget provides for fellowships. One of these, in the 1994-1995 programme budget, has been used for health promotion studies. In addition, Australia contributes to WHO's goals and targets through activities such as hosting global and regional meetings and conferences and through its WHO collaborating centres. A wide variety of study programmes in health promotion are offered for WHO fellows from other countries.

2.4 Conclusions and recommendations

The Sub-Committee, after discussion with senior staff in the Commonwealth Department of Human Services and Health and State Health Departments, and after making visits to nongovernmental organizations, believes that the Government has a strong commitment to the

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development of lifestyles and living conditions conducive to health. The policy document, published in 1994, on National Goals, Targets and Strategies, provides the framework for better health outcomes into the next century. A well funded body, the National Health and Medical Research Council, guides research for health promotion and its funding.

The Sub-Committee was impressed by the measures taken in recent years to control tobacco use, which include a national ban on advertising, rotating health warnings, the ban of tobacco product sales to youths under eighteen years of age in all states, and the 1994 first Australian Smoke-free Environment Law. There is a National Drug Strategic Plan for 1993-1997, which encompasses tobacco use. Considerable funds are made available for creating an environment in which smoking is no longer a social norm.

The Government measures are supported by state policies and activities. This comprehensive approach may be applicable in other countries, for which the Australian experience could serve as a model.

The Sub-Committee makes the following conclusions and recommendations:

- (1) In line with WHO orientation and policies, Australia has placed emphasis on the health of its population and undertakes comprehensive measures for the development of healthy lifestyles. Given the success of the different programmes, Australia should be encouraged to share its experience, such as in multisectoral cooperation with other countries in the Region, in a systematic and coordinated way. Multisectoral collaboration should be strengthened still further in Australia.
- (2) Consistent with WHO resolutions on tobacco or health, Australia has developed comprehensive national policies and programmes on tobacco control. The central strategy is to prevent the uptake of smoking and to minimize harm. Information on Australia's innovative models for tobacco control should be provided within the Region, and their adaptation and implementation in other countries should be supported with expertise and funding.
- (3) School health promotion, including tobacco issues, should continue to involve a wide range of members of the community, including teachers, students, parents, and representatives of different sectors. Australia's network of health-promoting schools should be extended so that the schools can share their experience with others in the Region.

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(4) There have been only a few collaborative activities in health promotion and tobacco or health between Australia and WHO. This is entirely appropriate given the expertise in this field that has been developed in Australia over the last ten years.

(5) The experiences of Australia's governmental and nongovernmental organizations should be considered in an extended way as a resource, especially in the area of joint activities, training, and on-site support for other countries and areas in the Region. There are several countries, notably China and Pacific island countries, where the approaches used in Australia are applicable to the planned activities.

(6) Centres of excellence should provide support to the Region through WHO collaborative arrangements.

3. CHINA

3.1 Background

The members of the Sub-Committee visited China between 9 and 13 June 1995.

GENERAL

The People's Republic of China covers an area of 9 600 000 square kilometres and extends about 4000 kilometres from north to south and 4800 kilometres from east to west, making it the third largest country in the world. Administratively, China is divided into 23 provinces, 5 autonomous regions and 3 municipalities directly under the central government. These are in turn divided into 165 prefectures, 321 cities, 2046 counties and 620 urban districts. According to the 1990 census, China's total population was 1 133 682 501, representing more than one-fifth of the world's population. In 1994, the population was estimated to be 1 198 500 000. More than 330 million people in China live in cities and towns, but it is still predominantly a rural country, with around 74% of the population living in the countryside. Since 1979, population growth has been 1.121% per annum - a rate still above official targets. China's per capita gross national product in 1993 was 2111 Yuan or US\$270.82.

HEALTH POLICY AND STRATEGY

The Government of China has responded actively to the resolution adopted by the World Health Assembly in 1977 on the implementation of the global strategy for health for all by the year 2000. In line with the actual conditions in the country, the Government has formulated a series of strategic programmes, a plan of implementation, principles and policies for the promotion of health and a system of health services. All this is consistent with the global strategy for health for all by the year 2000, which has become widely recognized and accepted.

The Constitution of China explicitly states that "the State develops health undertakings, develops both modern medicine and traditional Chinese medicine, and encourages collective economic organizations, state enterprises as well as street organizations to run medical and health

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establishments, and carry out mass movements to protect people's health". Thus, the basic policies on developing national health services are established in a form of national legislation.

In order to achieve the health-for-all goals, conditions in China indicate that priority should be given to the rural areas, where the greatest difficulties are encountered because of population levels, and the imbalance in education, culture and economy between urban and rural China. Accordingly, the Ministry of Health, the State Planning Commission, the Ministry of Agriculture, the National Committee for the Patriotic Health Campaign and the Ministry of Environment Protection have jointly issued a statement on programme objectives for achieving health for all by the year 2000 in rural areas. The statement describes 12 indicators and outlines steps for achieving the objectives. At the same time, management procedures for primary health care work and evaluation standards for health for all by the year 2000 were also worked out. The Ministry of Health has established three strategic priorities for the development of medical and health services in China, namely: strengthening preventive services; reinforcing rural health work; and encouraging traditional Chinese medicine. At present, the Ministry of Health is developing the "Ninth Five-year Plan for the development of Medical and Health Services", to be implemented in 1996.

THE HEALTH SYSTEM

The health care system consists of a network of administrative villages (neighbourhoods in the case of urban areas), townships, counties (districts in the case of urban areas), prefectures (administered directly by province), and provinces (including autonomous regions). There are now 191 742 medical and health institutions, including 67 857 hospitals, 105 984 out-patient departments and clinics, 3611 health and epidemic prevention stations and 2857 maternal and child health centres. There is thus a nationwide medical and health network down to grassroots level. The number of hospital beds has been increased to 3 133 617, averaging 2.41 per 1000 population. There are 5 307 000 professional health workers of all categories. A multitude of approaches has been employed to develop China's health services. Efforts have been made to promote the development of the collectively run health institutions, and permit and support private practice, while developing the state-run health institutions. Improved medical and health services have been provided to people living in urban areas by hospitals, maternal and child health centres, epidemic prevention stations, "Red Cross" health stations and other health institutions at neighbourhood and district levels. For those living in rural areas, there are three-tier medical and health networks embracing county medical

and health institutions (hospitals, health and epidemic prevention stations and maternal and child health centres), township (health centres) and village (health organizations in diverse forms). These give full play to the initiatives from the state and the community, and combine efforts by both professionals and part-time health workers.

At present, the country has a decentralized financial management system. Health financing is shouldered by the Government at all levels through the budgets of central government, provinces, autonomous regions and municipalities.

Since the implementation of the policy of reform and the opening up of China to the outside world, the mechanism of financing health services through diversified channels and at different levels has been gradually established. Funds mainly come from the following sources:

- (1) the central and local governments;
- (2) the medical care insurance system, including free medical care insurance service, labour insurance service and various kinds of cooperative medical services in rural areas;
- (3) patient fees;
- (4) other sectors;
- (5) donations and loans from foreign governments, international organizations, compatriots from Hong Kong, Macao and other overseas Chinese; and
- (6) health input by private medical institutions or private practice.

Government and medical insurance systems are the major sources for total health input in China. The present medical care insurance system in China includes free medical care services enjoyed by government functionaries and university or college students, and labour insurance medical service for the employees of state industrial and communication enterprises. In rural areas, various forms have been adopted on a voluntary basis, to run medical and health services for the population to ensure the availability of doctors and medicine for disease prevention and treatment. Measures have been taken to reform the current medical insurance system. Pilot projects have already been initiated in some cities.

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Health legislation has been strengthened, and considerable achievements have been made. Since 1982, the People's Congress has enacted four health laws: The Food Hygiene Law; The Drug Administration Law; The Border Quarantine Law; and The Infectious Diseases Prevention and Control Law.

The State Council has issued a number of health regulations and the Ministry of Health has formulated more than 100 health rules and regulations and 700 health standards. Health legislation at local levels has also been reinforced, with increased personnel assigned to its enforcement.

Intersectoral cooperation The National Patriotic Health Campaign Committee, established in 1952, is composed of 45 members from 43 different ministries, such as the Ministry of Agriculture, Ministry of Environment, Ministry of Education, Ministry of Communication, and Ministry of Broadcast, Film and Television. The Committee meets two times each year to coordinate health activities. The Office of the National Patriotic Health Campaign Committee is a department of the Ministry of Health.

HEALTH STATUS

The health status of the population can be assessed from the following:

Average life expectancy and rate of population increase The birth rate in 1994 was 17.7 per 1000, and death rate was 6.49 per 1000; hence a gross population increase rate of 11.21 per 1000. The average life expectancy of the Chinese people reached 70 years of age.

Infant mortality rate The infant mortality rate in 1993 was approximately 40 per 1000 live births with a wide difference between urban and rural areas. The rates in Beijing and Shanghai have dropped to about 14 per 1000 live births, a similar rate to that of developed countries. The average infant mortality rate was noticeably lower than that of other developing countries.

Maternal mortality ratio According to a survey conducted in 1991 at 247 surveillance centres on maternal death, the maternal mortality ratio was 80.0 per 100 000 live births. The highest rates were found in the northwestern and southeastern parts of the country at 137.1 per 100 000 live births and 169.9 per 100 000 live births, respectively. The main causative factor for maternal death was obstetric haemorrhage. This constituted 49.9% of the total. Almost half of the maternal deaths occurred at home or on the way to the medical unit. The maternal mortality ratio of home delivery in

rural areas was 122.7 per 100 000 live births whereas that at township hospitals was 42.9 per 100 000 live births.

Causative factors of death The four leading causes of death among the urban population were: cerebrovascular diseases, malignant tumours, diseases related to the respiratory system, and heart diseases. The leading causes in the rural population were: diseases related to the respiratory system, malignant tumours, cerebrovascular diseases, trauma and injuries, and poisoning.

Prevalence of diseases According to a national survey conducted in 1993 on the health services of the country, the two-week morbidity rate of the population was 142.9 per 1000 and for chronic diseases, 132.1 per 1000. The average rate of absenteeism from work was 6.3 days per year, and from school, 4.8 days per year, both higher than the figures shown in a survey on health services from 1985-1986. The average number of days of sickness per person per year was an average of 29.0 days.

Infectious diseases and parasitic diseases The control of infectious diseases and parasitic diseases have remained as the priority issues in health services in China. The morbidity and mortality rates from the reportable infectious diseases were 203.68 per 100 000 and 0.49 per 100 000 respectively in 1994. However, an increase has been seen in the incidence of viral hepatitis and venereal disease.

Chronic diseases A survey conducted in certain municipalities and provinces on urban and rural health services showed that morbidity from chronic diseases in urban areas was 23.66%.

Hypertension accounted for 7.58% of cases and chronic bronchitis, 8.79%. Gastro-enteritis accounted for 10.34% of the cases, rheumatoid arthritis accounted for 8.62% of the cases, and coronary artery disease constituted 5.02%.

The morbidity rate of chronic diseases in the rural areas was 8.6%. A wide difference has been seen in the pattern and distribution of chronic diseases between urban and rural areas.

The *China Daily Newspaper* of 3 March 1995 reported that data from the Ministry of Health indicated that about 90 million people suffer from hypertension throughout China.

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Each year about 1.5 million people are found to have developed cerebro-vascular disease, which kills about one million people in China each year.

Each year about 1.6 million new cancer cases appear in China. The disease annually claims about 1.3 million lives in the country.

The number of diabetes cases also has risen, totalling around 30 million across China.

Major endemic diseases The number of population under the threat of endemic diseases decreased significantly, if compared with the seventh five-year plan period. Prevalence of those preventable endemic diseases has been brought under control. However, there was an increase of incidence of schistosomiasis and iodine deficiency disorders in certain areas.

Control of certain occupational diseases Similarly, an average of 25 000 new cases of occupational diseases are recorded, of which 66.7% are pneumoconiosis, 12.9% poisoning, 8.5% acute poisoning, and 10.8% other occupational diseases. A survey revealed that 40% of silicosis cases are not reported. It is therefore estimated that a more realistic figure would be 35 000 annual cases of occupational diseases.

TOBACCO PRODUCTION, TRADE AND INDUSTRY

China is the largest producer and largest consumer of tobacco in the world. China produces four times as much tobacco as the next largest producer, the United States of America. The 180 cigarette factories are gradually being modernized and reduced in number, and 18 factories currently produce 80% of the cigarettes in China.

Agriculture In 1995, 200 000 hectares were harvested for tobacco. About 2% of all arable land is used for growing tobacco, a decrease from 220 000 hectares in 1991.

Production and trade In 1995, 2 400 000 tons of unmanufactured tobacco were produced. In 1992, China imported 15 850 tons of unmanufactured tobacco, and exported 110 500 tons, which accounts for about 6.5% of all global exports. Since 1980, China has changed from being a net importer to being a net exporter of unmanufactured tobacco.

In 1995, China produced about 1 675 000 million cigarettes. In 1991, China imported 9000 million manufactured cigarettes and exported 13 500 million cigarettes (2.7% of the world total cigarette exports), a figure that decreased to 10 000 million cigarettes in 1995.

China earned about US\$7.1 billion in 1995 from tobacco and cigarette exports, ten times more than in 1985. Import costs of tobacco and cigarettes in 1990 amounted to US\$130 million, or 0.3% of all import costs. Smuggling is a major problem, with 26 100 million cigarettes confiscated between 1988-1992, although the actual level of smuggling is estimated to be many times higher, at 5%-9% of China's annual production.

The transnational tobacco companies, active in China from the last century, left in the early 1950s. They have now returned, opening joint venture factories (RJ Reynolds in Xiamen, 1988; Rothmans in Shandong, 1992), and in 1993, Philip Morris and the China National Tobacco Corporation announced a multifaceted Cooperation Agreement, covering sharing of resources, including technology, people and blending techniques. China signed an agreement with the United States that by December 1994 all import licensing requirements for cigarettes, cigars, smoking tobacco and cigarette filters will be lifted, as well as all scientifically unjustified phytosanitary standards (standards related to health) on tobacco within one year. It is expected that the current market share of foreign cigarettes (currently officially 1%) will increase rapidly after that date.

In 1995, China and the United States became enmeshed in confrontation over trade, in which cigarettes featured prominently.

Industry The China National Tobacco Corporation employs over half a million workers in manufacturing, with 10 million farmers growing leaf tobacco, and 3 million retailers.

Tobacco consumption Per adult capita consumption more than doubled between 1965 to 1990, since when it has been relatively stable, at around 1200 cigarettes per person per year. Tobacco is increasingly consumed in the form of manufactured cigarettes (currently 87%).

Tar, nicotine In 1990, tar levels ranged from 16 mg to 34 mg, and nicotine levels from 2 mg to 3 mg.

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Relative cost of cigarettes A pack of 20 local cigarettes costs between US\$0.2 to US\$2, although most are cheaper than the imported cigarettes which cost about US\$1. Farmers near Shanghai are spending more on cigarettes and wine than on grain, pork and fruit. In 1990, it was estimated that 20 cigarettes cost 25% of average daily income, up from 10%-15% in 1987.

Prevalence The 1984 first national prevalence survey on 519 600 people showed that 61% of males and 7% of females over the age of 15 years were daily or occasional smokers. Data released by the National Statistics Bureau in 1993 indicate that smoking rate over 15 years was 34.9%, an increase of 1.02% as against 1984.

Tobacco use among population subgroups The 1984 prevalence survey data showed that smoking in males was lowest in students (27%), rising to 49.3% in technical personnel, 59.2% in government functionaries, 63.7% in peasants and 65.7% among workers. Among women, smoking was lowest among technical personnel (3.3%), rising to 6.5% among government functionaries, 6.6% among peasants and 7.3% among workers.

The highest smoking rates (M+F) were in Tianjin (42.8%), followed by Tibet (42.2%), Heilongjiang (39.1%), Inner Mongolia (37.9%), and Beijing (37.8%). The lowest rate was in Ningxia Hui Autonomous Region (27.7%). The highest rates of smoking among females was in Tianjin (23.6%) and lowest in Henan (2.4%). Urban (28.9%) and rural (30.5%) rates were similar.

The rate of ex-smokers was 4.2% among males and 9.7% among females. The main reasons given for quitting were illness, followed by awareness of the harmfulness, cost, opposition of spouse or parents, and relatives suffering from passive smoking.

A 1986 study reported that smoking among male students had decreased to 22.5%, but increased among male workers to 86.4%. In 1989, 67.5% of male physicians in Beijing were smokers, higher than the national average of 56.4% in 1984. In Beijing in 1990, 64.6% of male teachers smoked (females 1.2%), up from 50.1% in 1980.

Age patterns According to the 1984 prevalence survey, 75% of both urban and rural male smokers start before the age of 24, in contrast to only 50% of female smokers. The highest prevalence occurs between 45-49 years in males and 60-64 years in females. Studies in Beijing in 1990 indicate that smoking is rising rapidly among adolescents.

Mortality from tobacco use Currently, there are about 1.16 million annual tobacco-related deaths, and this is predicted to rise to 2 million by 2025.

Age-standardized death rates per 100 000 from lung cancer in 1990 were 56.8 for males and 23.5 for females, and rising. Currently smoking kills more people from chronic obstructive lung disease than from cardiovascular disease.

Tobacco control measures The National Patriotic Health Campaign Committee is responsible for coordinating national smoking control activities.

The Chinese Association for Smoking and Health, the Chinese Academy of Preventive Medicine, the National Health Education Institute and the Chinese Academy of Medical Sciences have also been active. WHO and the International Union Against Cancer have supported tobacco control activities, and tobacco plays a major part in the World Bank III project on noncommunicable diseases.

Control on tobacco products Tobacco is the top revenue earner for the Government. In 1994, tax revenue from tobacco products was predicted to top US\$7 billion but the health debit to the economy is substantial. In 1993, China gained about US\$4.9 billion in tobacco sales, but medical costs for smoking-related disease, lost productivity and the cost of fires caused by careless smoking together cost the country over US\$7.8 billion.

The 1992 Law of the People's Republic of China on Tobacco Monopoly contained three health causes, which cover:

- reduction of tar and other harmful substances, and printing of tar levels and a health warning on cigarette packs;
- improved health education on the harmful effects of smoking;
- ban or control of smoking on public transport and in public places;
- ban on smoking by elementary and high school students; and
- ban on tobacco advertising on television, radio, newspapers and magazines.

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A draft law on tobacco smoking harm minimization is being considered by the Central Government, before being submitted to the People's Congress.

Subsequently, China has faced rapid increases in advertising in other media, such as billboards, television, sponsorship of sports, arts, pop music shows on radio, and other events. In February 1995, a national advertising law was implemented, extending the 1992 tobacco advertising ban to include all kinds of waiting rooms, cinemas and theatres, meeting rooms and halls, sports stadia, etc.

Protection for non-smokers Smoking is banned in many public places, and in some workplaces (usually because of fire hazard). Since 1949, smoking has been banned on public transport vehicles such as buses and trolley-buses in all big cities. In 1986, no-smoking carriages were introduced on trains, and smoking is now banned on subway trains and stations. All domestic aeroplane flights have been totally smoke-free since 1983 and, in 1993, China announced a total ban on smoking on all flights by January 1995. Smoking is partially banned in hospitals and health facilities, and from 1993 it has been banned on Ministry of Health premises.

In December 1994, Shanghai declared virtually all indoor public places smoke-free.

In Beijing, the central railway station became a smoke-free area, after initial trials in 1987 with several smoke-free waiting rooms. More than 50 million people pass through this station annually, making it the country's most frequented public place. The internal regulation for fining is endorsed by the relevant governmental system. A similar arrangement exists for other stations in the capitals of the provinces and autonomous regions and municipalities.

In 1991, the Education Committee in Beijing collaborated with the Municipal Committee of the Youth League in starting activities for smoke-free schools with reference to the Law of Protection of Adolescents. Since this time, a considerable number of schools have become smoke-free. Smoking by staff and parents in kindergartens is banned. Workplaces are requested to control smoking, and smoke-free work units are rewarded.

Health education Health information campaigns commenced in the 1980s. The first "No-smoking Day" was held in Shanghai in 1987, and since 1988, WHO's World No-Tobacco Day has been celebrated nationally every year; it is reported that cigarettes are not sold throughout China on that day. The following have been awarded the WHO Tobacco-or-Health medals: Dr Weng Xin

Zhi, Professor Wu Jieping, the Chinese Association for smoking and health, the Health Bureau of Jishan County, Shanxi Province, and CCTV television station.

The Rural Farmers Quitting Project, organized by the National Health Education Institute, is aimed at illiterate rural farmers. "Quit" perfumes and sweets, teas, acupuncture, qigong, quitting clinics and mass media means of encouraging smokers to stop have been used. A television film was produced to create a supportive environment for no-smoking.

The Chinese Association on Smoking and Health carries out and supports a range of activities, for example social mobilization in the provinces aiming at making ten cities in each of the participating provinces smoke-free, in each city 100 institutions, 1000 families, and 10 000 individuals.

Smoking is also addressed in the comprehensive activities of the National Patriotic Health Campaign Committee, which include health contests in public gardens, or the regular column in the *Beijing Evening News* called "Expressway to health".

In 1994, the Soong Ching Ling Foundation, a nongovernmental organization with high level support, launched in 1994 an anti-smoking campaign addressing children and young people under 18 years of age, as one of the principles of this organization is to care for children's welfare. The objectives of the campaign are not only to prevent children from taking up the habit, but also to make them advocates for non-smoking in their environments. Many activities are carried out in close cooperation with schools and they are given strong support by the media, for example the *Beijing Youth Daily* and the *Star Torch News*.

3.2 Visits and findings

Visits were made to two departments of the Ministry of Health, the National Patriotic Health Campaign Committee and the National Health Education Institute, a WHO Collaborating Centre for Health Education and Health Promotion. A meeting was held with representatives of the Chinese Association on Smoking or Health. Field visits were also made to the Soong Ching Ling Foundation, to the Beijing Central Railway Station, and No 6 Middle School in Beijing's Xicheng District.

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3.3 WHO collaboration

WHO collaborative activities in China have been in the area of health education planning and evaluation, health education training, and smoking control measures. In addition to the country budget, a number of other activities have been carried out through the intercountry budgets and extrabudgetary funds. These include a three-year health promotion project among industrial workers in Shanghai; the development of guidelines for workplace health promotion; a video production, recording community activities in Shanghai in the context of the healthy urban China project; support to the local adaptation and distribution of the press-kit for a campaign on health promotion through the family with the theme "Health for all begins at home"; and the preparation for the Tenth World Conference on Tobacco or Health, which will be held in Beijing in 1997.

3.4 Conclusions and recommendations

The Sub-Committee, after discussion with senior staff of the Ministry of Health, namely from the National Patriotic Health Campaign Committee and the National Health Education Institute, after discussion with the Chinese Association on Smoking or Health, and after making various visits, believes that the Government of China has a strong commitment to the development of healthy lifestyles and to smoking control. Given the magnitude of the country's population and the size of some health problems, including that of smoking, China has made remarkable progress in implementing various measures to improve living conditions, and in making healthier choices easier. Emphasis is given to public information and education for health. This is facilitated by a well-organized system which reaches from the central level through the provincial and the prefecture level down to the county level of health education institutes, epidemic prevention stations and branches of the National Patriotic Health Campaign Committee.

The structure of the National Patriotic Health Campaign Committee, which represents 43 different sectors and has a department in the Ministry of Health (which also acts as its secretariat), represents a unique mechanism for intersectoral cooperation. In addition, the Committee coordinates activities of the National Health Education Institute and liaises with specialized organizations, such as the Chinese Association on Smoking or Health.

The Sub-Committee makes the following conclusions and recommendations:

- (1) It is particularly pleasing to see that China has a structure in place that allows for the intersectoral collaboration required to transfer the concepts of the WHO strategy expressed in *New horizons in health* into action, and thus make further progress in developing healthy lifestyles and health-supportive environments. The existing collaboration between the health and education sectors needs to be further strengthened and extended to other sectors.
- (2) As China is the world's largest producer and consumer of tobacco products, tobacco control is a major task. The Ministry of Health has already demonstrated its strong commitment to comprehensive national control measures and has put in place, in line with relevant World Health Assembly resolutions and the Action Plan on Tobacco or Health for 1995-1999, important legislation for the control of tobacco advertising and the banning of smoking in public places. It is recognized that there is a need for more enforcement in order to implement the regulations appropriately.
- (3) It was noted that considerable effort has been made by the National Health Education Institute, by the Provincial Health Education Institutes, and by the Chinese Association on Smoking and Health, to raise awareness about the dangers of smoking. Their activities were recently complemented by the activities of the Soong Ching Ling Foundation, which uses a broad spectrum of methods to raise health consciousness in children, prevent them from smoking and help them to become advocates for non-smoking and quitting smoking in their families. Schools, workplaces and whole communities and cities have taken on the challenge of becoming smoke-free.
- (4) The important activities noted in raising awareness about the dangers of smoking need to be further supported and extended to nongovernmental organizations in order to change the social norms and values which still prevail, and to implement the Action Plan on Tobacco or Health for 1995-1999.
- (5) There is a great shortage of trained personnel in health promotion. While there are training officers for health education planning, implementation and evaluation, the broader concept of health promotion still needs to be introduced as a concept and practice in existing training curricula for health workers and into their inservice training. Given the intersectoral nature of health promotion, it is essential that health promotion training should be extended to other sectors. Health promotion studies abroad, for example in Australia, and experience and skill exchange through study visits, for

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example with Singapore, would strengthen China's efforts in manpower development for health promotion.

(6) Lifestyles and living conditions are changing rapidly in urban and rural areas of China. Lifestyle research is needed to assess the health impact of those changes and to design health promotion strategies that are suitable for different population groups.

(7) The past WHO collaborative activities in the field of health education and tobacco or health appear to be successful. WHO-supported health promotion projects in workplaces and schools have commenced. China collaborates with WHO in the Healthy Urban China Project, that furthers the activities of the National Patriotic Health Campaign Committee in establishing "hygienic and healthy" cities (of which there are now 650). These projects, which integrate health promotion and environmental activities, contribute to the creation of lifestyles and living conditions conducive to health and should be further strengthened and expanded.

(8) Further WHO collaborative activities in China should be oriented towards the concepts of the document *New horizons in health* and continue to focus on the settings described above. This should include training and research, consolidation of existing data, and exchange of experience, and will require special support from external support agencies. This should include strong support to the Tenth World Conference on Tobacco or Health, in 1997, and to the activities that would demonstrate to the world community China's commitment to the control of tobacco use.

(9) WHO should assume a coordinating and supporting role for activities in health promotion carried out in China by other international organizations such as UNDP, UNESCO, UNICEF and the World Bank.

4. SINGAPORE

4.1 Background

The Sub-Committee visited Singapore between 14 and 15 June 1995.

GENERAL

The Republic of Singapore is an insular territory, with an area of 626.4 square kilometres; lying to the south of the Malay Peninsula, to which it is joined by a causeway 1.2 kilometres long, carrying a road, a railway and a water pipeline across the intervening Straits of Johore. The population in 1990 numbered 2 700 000, giving a population density of 4250 per square kilometre, which is one of the highest in the world. Gross national product per head has continued to grow, from US\$7576 in 1988 to US\$9183 in 1989.

HEALTH POLICY AND STRATEGY

The policy of the Ministry of Health is to build a fit and healthy nation and to ensure the best possible level of health for the entire population. The long-term strategy is to promote healthy lifestyles, reduce preventable diseases and upgrade medical care to the highest level possible for those who do fall sick.

In 1991, a Review Committee on National Health Policies chaired by the Minister of State for Health recommended the adoption of a health promotion and disease prevention approach to reduce morbidity, mortality from lifestyle-related diseases, and reduce health care costs. The Committee also set targets for the reduction of risk factors for the major diseases to be achieved by the year 2000. In response to the recommendations of the Review Committee, the Government implemented the National Healthy Lifestyle Programme in April 1992.

The Ministry has prioritized five major national programmes involving both the public and the private health sectors, on which special emphasis and additional resources will be placed for the next decade. These programmes are: improving the health of the elderly; managing the main killer

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diseases, namely cancers, heart disease, stroke, diabetes mellitus, and injuries; improving mental health care; enhancing child health services; and health education.

The Ministry will strengthen cost containment measures and ensure that medical care is available to all Singaporeans regardless of their socioeconomic standing.

Free health education will continue to be provided to all. Organizations will be supported in their activities to promote health and prevent illness. Preventive and curative health care services for children and the elderly will continue to be heavily subsidized.

Health promotion is further enhanced through a programme of new health education activities during the year such as Nutrition Week, Dental Health Week, National Health Fair, and Smoke-Free Week. At the same time, certain existing programmes have been upgraded and expanded. These include AIDS education, a health screening programme for senior citizens, an obesity control programme, and an eye-care programme.

To realize the Government's vision of building a cohesive, vibrant, refined and robust society, six advisory councils were set up on a national level. Their roles are to advise on the disabled, the aged, youth, family and community life, sports and recreation, and culture and the arts. The Ministry of Health and the Ministry of Community Development work together to implement recommendations for the disabled and the elderly.

Efforts will be made to improve the quality and standard of medical care further. This will be achieved through better coordination between public and private health services, upgraded facilities and more specifically trained human resources. Singaporeans will be able to choose, based on cost, between private and public-sector health care.

Upgrading and improving primary health care services to ensure high standards of health care for all will continue to be emphasized. The government polyclinics will set the benchmark for professional standards of primary health care and provide affordable and accessible primary medical care to the poor and the needy.

THE HEALTH SYSTEM

The Ministry of Health is responsible for providing the preventive, curative and rehabilitative health services in Singapore. Environmental health and the control of occupational hazards are administered by the Ministry of the Environment and the Ministry of Labour respectively.

The mission of the Ministry of Health is to build a healthy nation, and to provide a comprehensive, modern and efficient health care service through the planning and development of the public and private health sectors to ensure a high standard of medical care for all Singaporeans.

Singapore has a dual system of health care - a public assistance system run by the Government, and a private system provided through private clinics and hospitals. The public is free to choose medical care in either the public or private sectors. In terms of treatment service, the Ministry provides about 30% of the ambulatory medical care and 80% of the hospital services in the country.

There are seven government hospitals providing secondary and tertiary care, a skin disease centre and two mental hospitals. The seven government hospitals provide a total of about 5244 beds.

The Ministry also has a network of 16 polyclinics, outpatient dispensaries and maternal and child health clinics providing general medical, maternal and child health, home nursing and day care for the elderly, and health education and counselling. The Ministry also provides a wide range of dental services through its school, hospital and community dental services. Children in schools receive free medical and dental services which include treatment, periodic screening, immunization, and health education.

Medical treatment at government clinics and hospitals is not totally free but the fees charged are heavily subsidized by the Government. The government subsidy on the recurrent expenditure of the Ministry of Health in 1988 was 68%.

The Ministry has restructured its hospital services to give the hospitals greater autonomy in managing their operations so that they can be more responsive to the needs of patients. The restructured hospitals have to be more cost-conscious and observe stricter financial discipline, which should result in better cost control. This will help to limit cost escalation and will ultimately benefit the patients.

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COMMUNITY INVOLVEMENT

Mechanisms to involve people in the implementation of strategies have been established or strengthened, and are functioning.

The needs of the aged, the chronically sick and the disabled have called for an integrated approach on the part of the family, the community and the state. Voluntary and clan associations will be further encouraged to help care for the destitute aged and for those whose children, for reasons beyond their control, are unable to look after them.

Health education programmes are being conducted which combine the use of mass media and interpersonal communication strategies. Talks, courses, seminars, film shows, exhibitions, etc., are organized to inform and motivate the population to stay healthy. Grass-roots and community organizations are coopted into national campaigns and health promotive programmes.

Good coordination is also maintained among nongovernmental organizations, with private practitioners and hospitals and with voluntary organizations such as the Singapore Cancer Society, the Diabetes Society, and the National Health Association.

Existing legislation and guidelines allow the Ministry to work closely with other ministries, as well as voluntary, community and religious groups. This legislation and the guidelines are reviewed from time to time to ensure that quality care is provided and the health and welfare of the community is protected.

INTERSECTORAL COOPERATION

In connection with the National Healthy Lifestyle Programme, a Coordinating Committee was established with high level representation from key ministries, statutory boards, employers' federation, the unions and health professional bodies, to coordinate and monitor the implementation of the programme. A Healthy Lifestyle Unit within the Ministry of Health was also set up to coordinate, monitor and evaluate the National Healthy Lifestyle Programme. There are three key programmes in the National Healthy Lifestyle Programme, for which different ministries are responsible. The National Healthy Lifestyle Campaign is carried out by the Ministry of Health. The Trim & Fit Programme is implemented in schools by the Ministry of Education. The Workplace Healthy Lifestyle Programme is provided by both the public and private sectors for their employees.

Besides the three key programmes, various ministries and organizations also organize other ongoing programmes.

HEALTH STATUS

The general health status of the 2.82 million people in Singapore has remained satisfactory. The average life expectancy at birth in 1990 for males was 72.1 years and for females was 76.8 years. The infant mortality rate in 1990 was 6.7 per 1000 live births.

The pattern of ill health in Singapore has changed over the years with improvements in the standard of living and health services. Before and immediately after the Second World War, the main causes of death were infectious conditions like tuberculosis and diarrhoeal diseases. Today, they are mainly degenerative conditions such as heart diseases, cancers and cerebrovascular diseases. In 1990, these accounted for 57% of all deaths in Singapore. The most common type of heart disease is ischaemic heart disease while common types of cancer are lung, colorectal, stomach and liver cancer. Septicaemia was also among the top ten causes of death in 1988, displacing tuberculosis, which was among the top ten in 1985. On the other hand, general symptoms and benign neoplasms had displaced mental disorders among the top ten morbid conditions in 1988.

Among the notifiable diseases, dengue and dengue haemorrhagic fever are the most frequent, with 1733 cases reported in 1990. The others include tuberculosis, viral hepatitis, malaria, typhoid and paratyphoid fever, and chickenpox.

The national coverage of infants immunized against tuberculosis was 99%; poliomyelitis, 86%; and diphtheria, pertussis, tetanus, 86%. The proportion of children below the age of two years immunized against measles was 82%. In 1987, hepatitis B immunization was introduced for newborn infants, and parents are encouraged to immunize all children against this disease.

TOBACCO PRODUCTION, TRADE AND INDUSTRY

Agriculture Only six hectares were harvested for tobacco in 1990, representing 0.6% of all arable land.

Production and trade In 1992, Singapore produced about 11 760 million cigarettes, accounting for about 0.2% of world production. Singapore imported 24 110 tonnes of

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unmanufactured tobacco or about 1.6% of all global imports, and exported 12 300 tonnes or about 0.7% of global exports. Singapore imported 26 600 million cigarettes or 5.1% of global imports and exported 34 878 million cigarettes or 5.0% of global exports. Singapore is thus a net importer of unmanufactured tobacco and a net exporter of cigarettes.

Import costs of tobacco and cigarettes in 1990 amounted to US\$490 million, or 0.7% of all import costs. Singapore earned about US\$458.9 million in 1990 from cigarette and tobacco exports, a considerable increase from about US\$56.7 million in 1985.

Duty rates on cigarettes in 1994 were: imported tax S\$115 per kg., and excise tax S\$60 per kg.

Industry About 730 people were engaged full time in the tobacco manufacturing industry in 1990.

Production and trade Per capita consumption peaked in the mid-1970s at around 2700 cigarettes per adult per year, which fell to about 1600 in the 1990s. In 1987, male smokers smoked on average 8-12 cigarettes per day.

Tar, nicotine, filters The Poisons Act of 1990 provides that any cigarette containing 1.3 mg of nicotine and 15 mg of tar will be classified as poison, so that sales of cigarettes containing more than these levels are prohibited. Almost all (95%) of cigarettes sold are filter-tipped.

Relative cost of cigarettes In 1987, it was estimated that 20 cigarettes a day would cost 0.16% of a median household income at the-then price of US\$0.75 per pack. The price has been greatly increased since that time, e.g., US\$2.40-3.00.

Prevalence Singapore vies with Hong Kong for the lowest prevalence of smoking in the world. Prevalence has declined since the 1970s, when 42% of men smoked. Currently, less than 1 in 3 adult males smoke, and only 1.5% of adult females smoke.

TOBACCO USE AMONG POPULATION SUBGROUPS

Smoking prevalence has always been higher among the Malay population (18.8% in 1990) than in the Chinese (12.8%) and the Indian population (12.3%). A 1992 survey on first and final year medical students revealed that 0% of males or females were daily smokers, 4% of males and 0% of

females were occasional smokers, 3% of males and 2% of females were ex-smokers, and 93% of males and 98% of females were non-smokers.

In 1986, 2% of male doctors and 0% of female doctors smoked.

Age patterns According to a 1990 survey, the highest prevalence for smoking among males occurs between 50 and 65 years (34.6%) while in females, it increases with age (0.5% aged 20-24 to 7.9% aged 70+). Between 1984 and 1987, male smoking prevalence at ages 20-24 declined from 27.5% to 19.2% whereas female smoking prevalence in the same age group changed only slightly from 0.7% to 0.5%.

In 1992, prevalence of smoking of at least 1 cigarette a week among youth aged 9 to 20 years was: males 3%; females 0.2%; total 2%.

Mortality from tobacco use Lung cancer rates for men peaked around 1980 and have now begun to decline. Rates peaked later for women (1985-1989) but also appear to be decreasing. In 1991, it was estimated that there were 2 519 tobacco-attributable deaths per year.

Tobacco control measures Singapore currently has the most outstanding government commitment, strongest legislation (with substantial penalties), and the most comprehensive health education programmes in the world with regard to tobacco control. The Government has implemented many tobacco control measures since 1970. In 1990, the Ministry of Health received a WHO Tobacco-or-Health medal, as did Singapore Airlines in 1995.

Control on tobacco products Singapore was the first country to implement a tobacco advertising ban, the Prohibition of Advertisements relating to Smoking Act 1970, followed by an Act to Amend the Prohibition of Advertisements in 1989, the Smoking (Control of Advertisements and Sale of Tobacco) Act 1992, and the Smoking (Control of Advertisements and Sale of Tobacco) Act 1993. Currently, no advertising or sponsorship occurs (with fines up to US\$13 000), except for very limited point-of-sales packet display, and sponsorship at the discretion of the Minister of Health. However, Philip Morris sponsored the ASEAN Art Award 1994, the first such comprehensive fine arts competition, held in Brunei Darussalam, Malaysia, the Philippines, Singapore and Thailand. In addition, cigarette promotion from neighbouring Malaysia reaches Singapore via the electronic media, neutralizing Singapore's ban, at least in part.

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Incoming duty-free cigarettes were banned in 1991. In 1992, taxation was increased, and tobacco became the second highest revenue earner for the Government. In 1994, it was reported that 20% of government revenue was from tobacco taxes.

Distribution of free cigarettes, sales to minors, vending machines, and smoking by under-18-year olds in public, are all banned. From 1993, military personnel caught smoking in public while in uniform are fined and disciplinary action is taken. On the military bases, they may only light up in designated open-air "yellow-boxes".

The Consumer Protection Regulations of 1989 require a statement on tar and nicotine content on tobacco product containers. Health warnings were introduced in 1980, and the 1993 Amendment to the Consumer (Product Labelling of Tobacco Product Containers) Regulations requires four new rotating health warnings, on the two largest surfaces, covering 20% of the surface.

Smoking or using smokeless tobacco during sale or preparation for sale of any food was banned in 1973.

Protection for non-smokers The first law restricting smoking in public places was passed in 1970, banning smoking in cinemas, theatres and other specified buildings (The Prohibition of Smoking in Certain Places Act 1970); this was followed by banning smoking in lifts (the Environmental Public Health Regulations 1973); amusement centres (1982); government hospitals and clinics (1985); all public buildings (1987); all hospitals and clinics, fast food restaurants, indoor roller-skating rinks and roller discotheques (Smoking Notification 1988); air-conditioned restaurants, department stores, supermarkets, mini-supermarkets, indoor stadiums, bowling alleys, billiard saloons, gymnasiums, aerobics and fitness centres, convention halls and other specified meeting places (the Smoking Act 1989); and hairdressing salons, barber shops, banking halls, private buses, private hire buses, schoolbuses and taxis (the Smoking [Prohibition in Certain Places] Notification Amendment 1992); and smoking in all air-conditioned workplaces in 1994, with the inclusion of Changi Airport in 1995. Singapore Airlines has progressively introduced no-smoking flights since the late 1980s, and since October 1994, all Singapore Airlines' flights, except those originating or terminating in Japan, are non-smoking flights. Through these measures, 90% of its services are smoke-free.

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Health education Since 1979, the Training and Health Education Department of the Ministry of Health has systematically organized public information programmes on smoking. A systematic effort has been made to involve health professionals in public and patient education on smoking since 1984. The National Smoking Control Campaign was launched in 1986, coordinating the annual Anti-Smoking Campaign Day, then Week then, from 1990, Month. In 1995, the slogan of the campaign was "Cigarettes are addictive. Before you know it you are hooked", focusing on the addictive nature of nicotine.

There are currently 50 governmental and nongovernmental organizations participating in the national tobacco control programme (e.g., Singapore Cancer Society, Singapore National Heart Association, Singapore Anti-tuberculosis Association, Youngberg Adventist Memorial Hospital), with the Ministry of Health playing a pivotal role. Smoking prevention education is on the formal curriculum of secondary schools, vocational institutes and pre-universities and junior colleges, and in primary schools from 1994.

In 1994, the Training and Health Education Department of the Ministry of Health produced stop-smoking kits for general practitioners entitled 'Talk to your patients about smoking: A Guide for the Busy Health Professional'. In addition, a telephone counselling service was added to the ongoing "Healthline" service. Quit kits were available on request.

4.2 Visits and findings

Visits were made to three departments of the Ministry of Health: the Training and Health Education Department, the Healthy Lifestyle Unit, and the Food and Nutrition Department. The Sub-Committee was welcomed by the Deputy Director of Medical Services and provided with an overview of the Primary Health Care Division.

4.3 WHO collaboration

WHO collaborative activities in Singapore have been focused on manpower development. In addition, through the intercountry programme, a variety of activities have been carried out, which included a working group on health promotion planning, a workshop on school health promotion, and training courses for facilitators in workplace health promotion.

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4.4 Conclusions and recommendations

The Sub-Committee had discussions with senior officials of the Ministry of Health and visited three of its departments that are directly involved in the development of healthy lifestyles and in tobacco control. It was very impressed with the comprehensive approach and the success of the Singapore Government, especially in the control of tobacco use. Singapore's Healthy Lifestyle Programme has high-level political support and requires the involvement of and coordination between different sectors.

Singapore's tobacco control policies and programmes are comprehensive. The Sub-Committee noted the strong political commitment which had been a major reason for the programme's success. Improved living conditions provide the basis for the development of healthy lifestyles.

It was also considered that Singapore has already made considerable progress in implementing the principles outlined in the document *New horizons in health*. The Sub-Committee recognized that Singapore's small size and population, and the fact that it is highly urbanized with easy access to all kinds of media, are favourable factors for health promotion and tobacco control.

The Sub-Committee makes the following conclusions and recommendations:

- (1) The high-level commitment of Singapore's Government to the development of healthy lifestyles is demonstrated in the level of support given to the Healthy Lifestyle Programme and the extent of participation by different sectors in the key activities of this programme. The Ministry has also established a Healthy Lifestyle Unit in the Primary Health Care Division to coordinate activities. Other departments of the Ministry of Health, especially the Training and Health Education Department and the Food and Nutrition Department are strongly involved. High-level commitment is crucial for the success of health promotion programmes and should be sought for all projects.
- (2) The degree of integration of health education in the health care delivery system was particularly impressive, ensuring that issues of healthy lifestyles, especially smoking, are part of all services. Health education based on individuals and patient-groups provides an important back-up to national-level activities. This reorientation of health service delivery towards health promotion and health education should be further strengthened as a means to control cost increases in the health care system. These experiences should be shared with other countries and areas in the Region.

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(3) Singapore enforces tobacco control stringently. This approach to tobacco control has proved to be effective and might serve as a model for other countries in the implementation of World Health Assembly resolutions and the Action Plan on Tobacco or Health. Singapore shares the concerns of Australia and China, about the increase in cigarette smoking among young people. This highlights further the need for measures tailored for this age group. Action at the regional level should be considered. The call for a tobacco-advertising-free Western Pacific Region is highly valued in this context.

(4) Within the healthy lifestyle programme, the healthy lifestyle campaign works with a variety of innovative approaches. For the last two years, the annual theme has highlighted the importance of physical activities, and this will also be the focus in the years to come. The experience from the campaign should be shared with other countries and areas in the Region.

(5) There have been a few collaborative activities in support of the further development of the regional health promotion programme. The Training and Health Education Department, a WHO Collaborating Centre for Health Education and Health Promotion, has received WHO fellows and other visitors and provided them with substantial information.

(6) The role of the Training and Health Education Department for international exchange of experience, and its role as a resource centre for health promotion material should be further expanded. Exchange visits with China could usefully be supported by WHO. In following up the Workshop on School Health Promotion, which was held for countries in the northern part of the Region in Singapore in January 1995, and in the light of the excellent school health promotion programme already in place in Singapore, the Department should also play a key networking role in WHO's health-promoting schools project. The experiences of Singapore in terms of comprehensive tobacco control policies and programmes are valid and should be shared with all other countries and areas in the Region.

5. ACKNOWLEDGEMENTS

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