It is my pleasure to write a preface to this timely report. This is the second National Report that the International Tobacco Control Policy Evaluation Project (the ITC Project) has prepared for the Netherlands. The ITC Netherlands Wave 1 to 3 National Report was released in 2010 and covered the years 2008 and 2009. This new report, covering data from seven survey waves collected between 2008-2014, is packed with even more numbers, percentages, and figures. It presents a comprehensive picture of how tobacco control measures have affected Dutch smokers in the last 6 years. But the ITC Project does more than that. Because the same type of data was collected in many other countries across the world, the ITC Project places Dutch tobacco control in a comparative global context. And these comparisons are revealing. The report forces us to look into the mirror.

What do we see in the mirror? The new data present a mixed state of affairs. There has been some progress. For example, awareness among smokers of the risks of some diseases associated with smoking has improved. Another finding is that smoking became less accepted over the survey period: while 56% of smokers believed that society disapproves of smoking in 2008, this increased gradually to 64% in 2014. Continuation of this trend in the future means that societal support for further tobacco control measures will continue to grow. However, the fact that all other high-income ITC countries have higher levels of society disapproval than the Netherlands, shows that smoking must still be further de-normalised in the Netherlands.

A real eye-opener for me is that many Dutch smokers report that they hardly ever see advertising or information about the dangers of smoking, while they notice things that promote smoking relatively often, compared to other ITC countries. There is a continuous battle between the tobacco industry, which strives to normalise its products, and the Government and health organisations, which aim to de-normalise smoking. The ITC data show that health organisations are not yet winning this battle. The industry is still able to apply its strategy of intrusive visibility: tobacco products are on sale everywhere, in full sight of children, and give the false impression that tobacco is a normal, safe consumer product. This can only be stopped by a full ban on the display of tobacco products in shops and a ban on vending machine sales. The report shows that support for point-of-sale restrictions has increased among Dutch smokers. There have been two formal resolutions from Dutch parliamentarians for such measures this year already, showing that there is political support for these measures as well as public support. I think that the time has now finally come to take firm action to initiate such a display ban.

Another finding that stands out is the low level of risk awareness among Dutch smokers. The Netherlands has the absolute lowest percentage of smokers who often think about what smoking might do to their health or the health of others. Smoking is still responsible for 13% of the total disease burden, according to the latest Public Health Status and Foresight Report by the National Institute for Public Health and the Environment. Dutch smokers should be better educated on the health risks of smoking and the Government should take responsibility by initiating media campaigns.

Smoking rates have been slowly decreasing in the Netherlands for some years now, both in the adult population and among youth. This is favourable, but also entails a risk, as the sense of urgency for tobacco control measures seems to have disappeared. Although the recent National Prevention Programme (‘Alles is Gezondheid’) mentions tobacco control as one of six priorities, it does not present anything that remotely resembles a comprehensive strategy to control tobacco use.
This may be a fatal mistake. There is absolutely no guarantee that the tobacco control flywheel will have enough momentum to continue turning in the right direction without taking extra measures. In 2011, the Council for Public Health and Health Care identified higher tobacco taxes as a priority and proposed to use some of the revenues for public health purposes. The ITC Report suggests that some of this should be allocated to well-funded campaigns to raise awareness of the risks of tobacco use. Another notable finding is that very few Dutch smokers report receiving advice about quitting from a doctor or health care provider. More should be done to help our smokers to quit.

I hope that policymakers will read this report, look into the mirror, and realise that the Netherlands deserves a comprehensive tobacco control policy, just like so many other countries have. Such a policy is a natural mix of tobacco marketing restrictions, taxation, strong smoke-free laws, support for smokers who want to quit, and health education.

Marc C. Willemsen
Professor in Tobacco Control Research
CAPHRI, School for Public Health and Primary Care, Maastricht University
EXECUTIVE SUMMARY

BACKGROUND

The World Health Organization Framework Convention on Tobacco Control (WHO FCTC) is the world’s first global health treaty which obligates 180 signatory Parties (to date) to implement evidence-based tobacco control policies to reduce the prevalence of tobacco use and exposure to tobacco smoke. It has been 10 years since the Netherlands adopted the FCTC – the treaty was signed in June 2003 and ratified in January 2005. This report evaluates the effectiveness of the Netherlands’ implementation of the FCTC. The findings are based on research conducted by the International Tobacco Control Policy Evaluation Project (the ITC Project) – an international comparative cohort survey conducted in 22 countries, designed to measure the impact of tobacco control policy measures on tobacco users over time. Between 2008 and 2014, seven survey waves of the full cohort (approximately 2,000 youth and adult smokers above the age of 15 years at Wave 1) were conducted in the Netherlands.\(^1\) The ITC Netherlands Survey was developed by an international research team from Canada (University of Waterloo) and the Netherlands (STIVORO (now discontinued), Maastricht University (CAPHRI), and University of Amsterdam (ASCoR)).

ITC Netherlands data collected over 6 years has demonstrated that progress has been made in some areas, but the Survey findings make it clear that the Netherlands needs to do more to strengthen tobacco control policies and meet its obligations as a Party to the FCTC. The ITC Netherlands research findings point to several specific opportunities for the Dutch government to address the leading cause of preventable death in the Netherlands as it enters the second decade of FCTC implementation.

Tobacco Price and Taxation

Substantially increasing tobacco taxes and prices is recognized worldwide as one of the most effective measures for achieving reductions in tobacco use. Increases in taxes on both cigarettes and roll-your-own (RYO) tobacco in recent years have reduced the affordability of tobacco products in the Netherlands. However, ITC cross-country comparisons indicate that compared to smokers in other countries, fewer Dutch smokers identify price as a reason to quit. Similarly, the percentage of smokers reporting that they think about the money they spend on smoking “often” or “very often” is relatively low in the Netherlands in comparison to other ITC countries. Although the excise taxes on RYO tobacco have been increased several times since 2008, the price differential between cigarettes and RYO tobacco has remained, and continues to drive high RYO use among Dutch smokers — the second highest use among 12 high- and middle-income ITC countries — as 82% of RYO users report that the cheaper price is a reason for using RYO tobacco.

Although the percentage of smokers who reported purchasing cigarettes or tobacco outside of the Netherlands, but within the European Union in the last 6 months increased significantly between 2008 and 2014, the frequency of these cross-border purchases has remained low: across all survey waves, a large majority of the smokers who made cross-border purchases reported to have made such purchases only once or a few times in the last 6 months.

---

\(^1\) Eight survey waves in total have been conducted, but the Wave 2 Survey only contacted a sub-sample of approximately one-third of the Wave 1 cohort and is not included in this report.
Recommendations

1. Further steps need to be taken to increase total excise tax on tobacco products to meet the WHO target of at least 70% of the retail price. The price advantage for RYO tobacco products should also be eliminated in order to minimize switching to cheaper products and reduce smoking initiation among youth.

2. Ensure continued reductions in tobacco affordability by using a combination of inflation- and income-adjusted tax increases.

3. Advocate higher excise tax burdens and floors at the level of the European Union to reduce price differentials, which would contribute to reduced cross-border tobacco purchasing.

Smoke-free Public Places

Smoke-free legislation is the most widely adopted tobacco control policy measure around the world. It is critical for protecting the public from the harms of secondhand smoke and for changing social norms and attitudes around smoking. However, the Netherlands has not kept pace with many other countries and with the requirements of the FCTC, which call for a comprehensive smoking ban in indoor public places, and other public places as appropriate, with no exceptions. While there is evidence of substantial progress in creating smoke-free restaurants since the 2008 hospitality industry smoking ban, smoking prevalence in bars and cafés remains a concern. At Wave 8 (2014), more than one-third (38%) of smokers still noticed smoking in bars and cafés during their last visit. The October 2014 decision to reinstate the smoking ban in small hospitality venues is a positive step, however, the allowance of designated smoking rooms means that the Dutch smoke-free policy falls short of best practice guidelines for Article 8 of the FCTC. As a result, it continues to place the public at risk from the harms of exposure to tobacco smoke. Evidence from ITC surveys in France, the United Kingdom, Australia, Canada, and other countries demonstrates that strongly enforced comprehensive smoking bans combined with effective public education campaigns can nearly eliminate indoor smoking in all hospitality venues.

Recommendations

4. Strengthen current smoke-free legislation by removing the allowance for designated smoking rooms in accordance with the FCTC Article 8 Guidelines which call for 100% smoke-free public places.

5. Implement strong education and enforcement activities to increase public awareness of the harms of secondhand smoke and the benefits of a comprehensive ban, and to further strengthen compliance with the ban.

Tobacco Health Warnings

Health warnings on tobacco packages are a low-cost, high-reach means of educating smokers on the harms of tobacco. Although the Netherlands was the first EU country to introduce the text health warnings included in the European Tobacco Products Directive (TPD) 2001/37/EC (covering 30% of the front and 40% of the back of cigarette and RYO tobacco packages) in 2002, the warnings did not change before or during the 6-year period of the ITC Surveys. ITC evidence demonstrates the low effectiveness and declining performance of the warnings over time. The percentage of smokers who reported noticing the health warnings “often” or “very often” in the last month decreased from 25% in 2008 to 13% in 2014 – the lowest rate of 19 ITC countries. Similarly, in 2014, the Netherlands had the lowest percentage of smokers (7%) who reported that warning labels made them think about the health risks of smoking “somewhat” or “a lot”.

Forthcoming pictorial warnings on 65% of the front and back of tobacco packages as required by the revised TPD will bring Dutch legislation into compliance with the requirements of Article 11 of the FCTC and stand to raise awareness of the harms of smoking and secondhand smoke and change social norms about tobacco use. Evidence from Australia shows that plain packaging further enhances the noticeability of pictorial health warnings and reduces the appeal of tobacco packs. Moreover, Australian smokers’ support for this policy almost doubled less than 6 months after the introduction of plain packaging.

**Recommendation**

6. Consider further actions to strengthen the effectiveness of forthcoming pictorial health warnings by implementing plain packaging – a strategy that is recommended in the FCTC Articles 11 and 13 Guidelines and has been implemented in Australia (2012), is forthcoming in Ireland and the United Kingdom, and is being seriously considered in various other countries, such as France and Norway.

**Education, Communication, and Public Awareness**

The Survey findings reflect the absence of sustained funding for mass media education campaigns in the Netherlands. Across all survey waves, only a small minority of smokers (approximately 1 in 10) “often” or “very often” noticed advertising or information that talks about the dangers of smoking or encourages quitting in the last 6 months. The impact of cuts in funding for public education campaigns and weak tobacco health warnings are evident in societal attitudes that are tolerant of smoking and alarming gaps in Dutch smokers’ knowledge of the harms of smoking and secondhand smoke. Although the percentage of smokers who “agreed” or “strongly agreed” that society disapproves of smoking increased between 2008 and 2014, the Netherlands still ranks last among 9 high-income ITC countries. In 2014, only 21% of Dutch smokers had a negative opinion of smoking – the second-lowest percentage of 13 high- and middle-income ITC countries.

Although smokers’ awareness of specific health risks of smoking has also improved between 2008 and 2014, ITC findings indicate that fewer Dutch smokers are aware of the full range of health risks of tobacco use compared to smokers in other countries. Dutch smokers were among the least likely to know or believe that smoking causes heart disease, stroke, and lung cancer, and that secondhand smoke causes heart disease in non-smokers. The Netherlands also has the lowest percentage of smokers who report “often” or “very often” thinking about the harm their smoking might be doing to themselves (18% in 2014) and to others (8% in 2014) compared to 15 other ITC countries.

**Recommendation**

7. The Dutch government is urged to provide well-funded and sustained educational media campaigns in order to promote greater public awareness of the harms of smoking and secondhand smoke, to encourage cessation, and to denormalize smoking.

**Tobacco Advertising, Promotion, and Sponsorship**

Bans on tobacco advertising, promotion, and sponsorship (TAPS) are highly effective in reducing tobacco use and initiation, but only if they are comprehensive. Although the Netherlands has banned several sources of direct and indirect TAPS, the legislation does not go far enough. In 2014, almost half of Dutch smokers reported noticing things that promote smoking in the last 6 months, with 12% noticing these things “often” or “very often”. Although this percentage has decreased from 2008 to 2014, it is still high compared to many other ITC countries. Measures such as a ban on sales through vending machines, a complete ban on point of sale (POS) advertising, POS display bans, and limits on the number of shops selling tobacco have not yet been implemented in the Netherlands, leaving the tobacco industry with several channels to promote their products.
There is growing international momentum in implementing POS display bans (Iceland, Thailand, Ireland, Norway, Australia, Canada, and the United Kingdom are examples of countries that have implemented these bans) and there is fairly strong support among Dutch smokers for stronger TAPS restrictions in the retail setting. In 2014, more than half of smokers supported a complete ban on tobacco advertising inside stores and 40% supported a complete ban on POS displays inside shops and stores. Evidence from ITC countries shows that point of sale display bans reduce exposure to tobacco marketing and reduce impulse purchasing of cigarettes.

**Recommendation**

8. Close the gaps in current national TAPS laws by banning tobacco vending machine sales, banning tobacco advertising and the display of tobacco products in all stores and shops, and generally reducing the number of tobacco sale outlets.

**Smoking Cessation**

ITC evidence indicates the need for stronger efforts to motivate and assist smokers in quitting through well-funded media campaigns, large pictorial health warnings, and improved linkages to cessation support. In 2014, about one-quarter of Dutch smokers reported plans to quit smoking within the next 6 months. The one-year Smoking Cessation Reimbursement Program (SCRP) that ran in 2011, along with the two-month mass media campaign that supported its introduction, had an impact on cessation-related thoughts and behaviours among Dutch smokers. For example, following the initial launch of the SCRP (which was discontinued in 2012 and reinstated in 2013), the percentage of smokers who made a quit attempt in the last year increased from 24% in 2010 to 30% at 2012. Evidence from the most recent Surveys suggests that the reinstatement of the smoking cessation program in 2013, which was not accompanied by a smoking cessation media campaign, has not had as strong of an impact.

Receiving cessation advice from doctors or other health professionals has been shown to increase quit rates. However, fewer than 1 in 5 Dutch smokers reported receiving advice on ways to quit smoking from the doctor or other health professionals over the 6-year survey period, suggesting the need for stronger efforts to engage health professionals in providing quitting advice and linking them to other cessation services. The percentage of smokers reporting to have made use of such other cessation services such as quitlines has consistently been at very low levels as well.

**Recommendations**

9. The reinstatement of the reimbursement program for smoking cessation treatment in 2013, which is still in place, is a positive step forward in efforts to increase cessation rates in the Netherlands. However, in order to be more effective, the reimbursement should be accompanied by education efforts such as mass media campaigns in order to enhance awareness of the reimbursement policy and the availability of various options for cessation support and services for smokers.

10. Greater efforts to engage physicians and other health professionals and encourage them to provide evidence-based smoking cessation advice to patients would help to improve smokers’ motivation to quit and greater use of cessation services.
“I hope that policymakers will read this report, look into the mirror, and realise that the Netherlands deserves a comprehensive tobacco control policy, just like so many other countries have. Such a policy is a natural mix of tobacco marketing restrictions, taxation, strong smoke-free laws, support for smokers who want to quit, and health education.”

Marc C. Willemsen
Professor in Tobacco Control Research
CAPHRI, School for Public Health and Primary Care
Maastricht University
# Table of Contents

i  Preface  
iii Executive Summary  
ix List of Tables and Figures  
1  ITC Policy Evaluation Project  
3  Background  

4  The Tobacco Landscape in the Netherlands  
13  ITC Survey Methods  
21  Findings  

21  Smoking Behaviour  
32  Tobacco Price and Taxation  
44  Smoke-free Public Places  
59  Tobacco Health Warnings  
64  Education, Communication, and Public Awareness  
78  Tobacco Advertising, Promotion, and Sponsorship  
84  Smoking Cessation  

93  Conclusions and Recommendations  

97  ITC Survey Project Contacts  
98  References
## List of Tables and Figures

<table>
<thead>
<tr>
<th>Table/Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Netherlands cigarette price and tax structure 2008-2014</td>
<td>7</td>
</tr>
<tr>
<td>Table 2</td>
<td>Demographic characteristics of the ITC Netherlands Wave 1 to 8 Survey samples</td>
<td>17</td>
</tr>
<tr>
<td>Figure 1</td>
<td>Netherlands’ tobacco control policy timeline in relation to the ITC Netherlands Surveys</td>
<td>15</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Attrition and replenishment in the ITC Netherlands Wave 1 to 8 Surveys</td>
<td>17</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Percentage of daily and non-daily smokers, by wave</td>
<td>21</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Mean number of cigarettes smoked per day (CPD) among daily smokers, by country</td>
<td>22</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Percentage of smokers who consider themselves “not at all”, “somewhat”, or “very” addicted to cigarettes, by wave</td>
<td>23</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Type of cigarette smoker, by wave</td>
<td>23</td>
</tr>
<tr>
<td>Figure 7</td>
<td>Percentage of smokers who smoke factory-made cigarettes only, roll-your-own tobacco only, or both types of cigarettes, by country</td>
<td>24</td>
</tr>
<tr>
<td>Figure 8</td>
<td>Percentage of smokers who “agree” or “strongly agree” that if they had to do it over again, they would not have started smoking, by wave</td>
<td>25</td>
</tr>
<tr>
<td>Figure 9</td>
<td>Percentage of smokers who “agree” or “strongly agree” that if they had to do it over again, they would not have started smoking, by country</td>
<td>26</td>
</tr>
<tr>
<td>Figure 10</td>
<td>Smokers’ overall opinion of smoking, by wave</td>
<td>27</td>
</tr>
<tr>
<td>Figure 11</td>
<td>Percentage of smokers who have a negative opinion of smoking, by country</td>
<td>27</td>
</tr>
<tr>
<td>Figure 12</td>
<td>Smokers’ e-cigarette use and purchasing behaviour, by wave</td>
<td>28</td>
</tr>
<tr>
<td>Figure 13</td>
<td>Percentage of smokers and quitters who have ever used e-cigarettes, by country</td>
<td>29</td>
</tr>
<tr>
<td>Figure 14</td>
<td>Frequency of e-cigarette use, by wave</td>
<td>30</td>
</tr>
<tr>
<td>Figure 15</td>
<td>Percentage of smokers and quitters who currently use e-cigarettes at least monthly, by country</td>
<td>31</td>
</tr>
<tr>
<td>Figure 16</td>
<td>Reasons for brand selection among smokers who had a regular brand of cigarettes, by wave</td>
<td>33</td>
</tr>
<tr>
<td>Figure 17</td>
<td>Reasons for smoking roll-your-own cigarettes (RYO) among smokers who reported exclusive RYO tobacco use, and factory-made and RYO use, by wave</td>
<td>34</td>
</tr>
<tr>
<td>Figure 18</td>
<td>Percentage of smokers and quitters who reported that the price of cigarettes led them to think about quitting (or to stay quit) “somewhat” or “very much” in the last 6 months, by country</td>
<td>35</td>
</tr>
<tr>
<td>Figure 19</td>
<td>Percentage of smokers and recent quitters who reported that they spent food money on cigarettes, by wave</td>
<td>36</td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Percentage of smokers who thought about the money they spend on smoking “rarely/never”, “sometimes”, or “often/very often” in the last month, by wave 37</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Percentage of smokers and quitters who reported that they thought about the money they spend (or have spent) on smoking “often” or “very often” in the last month, by country 38</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Affordability Index for factory-made cigarettes in the Netherlands, by wave 39</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Affordability of manufactured cigarettes and change in affordability per year in 17 ITC countries 40</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Source of last cigarette or tobacco purchase among smokers, by wave 41</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Percentage of smokers and recent quitters who reported purchasing cigarettes or tobacco outside the country but in the European Union (EU), and outside of the EU, in the last 6 months, by wave 42</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Smokers’ perceptions of rules and restrictions on smoking in cafés and pubs, by wave 45</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Percentage of smokers who noticed people smoking inside a café or pub at their last visit, by wave 46</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Percentage of smokers who noticed smoking in cafés and pubs among those who visited a bar, café or pub in the last year, by country 47</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Smokers’ perceptions of rules and restrictions on smoking in restaurants where they live, by wave 48</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Percentage of smokers who noticed people smoking inside a restaurant at their last visit, by wave 48</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Percentage of smokers who noticed smoking in restaurants among those who visited a restaurant in the last year, by country 49</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Percentage of smokers who reported smoking “inside,” “outside,” or “both” among those who visited a restaurant in the last year, by wave 50</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Percentage of smokers who think that smoking should “not be allowed indoors at all” in sport canteens, restaurants, and cafés, bars, and pubs, by wave 51</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Percentage of smokers and quitters who think smoking should not be allowed at all in indoor areas of pubs and bars, by country 52</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Percentage of smokers and quitters who think smoking should not be allowed at all in indoor areas of restaurants, by country 53</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Smokers’ perceptions of rules and restrictions on smoking at their workplace, among those who are employed outside the home, by wave 54</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Percentage of smokers who reported that smoking “should not be allowed” at the following places, by wave 55</td>
<td></td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Percentage of smokers who reported that smoking is allowed “anywhere inside”, “in some rooms”, “not allowed except in special circumstances”, or “never allowed” inside their home, by wave</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Percentage of smokers who “never allow” smoking in their home, by country</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Percentage of smokers who reported that smoking is “never”, “sometimes,” and “always,” allowed in their car(s) when there are children in the car, among those who have a car, by wave</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Impact of health warnings on smokers’ perceptions and behaviour in the last month, by wave</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Percentage of smokers who reported that they “often” or “very often” noticed warning labels on cigarette packages in the last month, by country</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Percentage of smokers who reported that warning labels made them think about the health risks of smoking “somewhat” or “a lot”, by country</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Percentage of smokers who noticed advertising or information that talks about the dangers of smoking, or encourages quitting in the last 6 months, by wave</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Percentage of smokers and quitters who reported that they “never” noticed advertising or information that talks about the dangers of smoking in the last 6 months, by country</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Percentage of smokers who noticed advertising or information about the dangers of smoking or encouraging quitting smoking in the last 6 months by media type, by wave</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Percentage of smokers who noticed advertisements for stop-smoking medications in the last month, by wave</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Percentage of smokers who “agree” or “strongly agree” that society disapproves of smoking, by wave</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Percentage of smokers and quitters who “agree” or “strongly agree” that society disapproves of smoking, by country</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Percentage of smokers who “often” or “very often” thought about the harm their smoking might be doing to themselves and others in the last month, by wave</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Percentage of smokers who “often” or “very often” thought about the harm their smoking might be doing to them, by country</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Percentage of smokers who “often” or “very often” thought about the harm their smoking might be doing to other people, by country</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Percentage of smokers who know or believe that smoking causes specific health effects, by wave</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Percentage of smokers and quitters who believe that smoking causes heart disease, by country</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Percentage of smokers and quitters who believe that smoking causes stroke, by country</td>
<td></td>
</tr>
</tbody>
</table>
## List of Tables and Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>56</td>
<td>Percentage of smokers and quitters who believe that smoking causes lung cancer, by country</td>
<td>75</td>
</tr>
<tr>
<td>57</td>
<td>Percentage of smokers and quitters who believe that secondhand smoke causes heart disease in non-smokers, by country</td>
<td>76</td>
</tr>
<tr>
<td>58</td>
<td>Percentage of smokers who noticed things that promote smoking “often” or “very often”, “sometimes”, “rarely”, or “never” in the last 6 months, by wave</td>
<td>78</td>
</tr>
<tr>
<td>59</td>
<td>Percentage of smokers and quitters who reported that they “often” or “very often” noticed things that promote smoking in the last 6 months, by country</td>
<td>79</td>
</tr>
<tr>
<td>60</td>
<td>Percentage of smokers who noticed things that promote smoking in the following places, among those who had noticed any smoking promotion in the last 6 months, by wave</td>
<td>80</td>
</tr>
<tr>
<td>61</td>
<td>Percentage of smokers who saw cigarette advertising on displays, and on signs or pictures in stores in the last month, by wave</td>
<td>81</td>
</tr>
<tr>
<td>62</td>
<td>Percentage of smokers and quitters who reported that displays made them buy, or think about buying cigarettes in the last month, by wave</td>
<td>81</td>
</tr>
<tr>
<td>63</td>
<td>Percentage of smokers who support complete bans on tobacco advertising inside shops and stores and point of sale displays either “somewhat” or “a lot”, by wave</td>
<td>82</td>
</tr>
<tr>
<td>64</td>
<td>Smokers’ reported intentions to quit, by wave</td>
<td>84</td>
</tr>
<tr>
<td>65</td>
<td>Percentage of smokers who have made any attempt to quit smoking in the last 12 months, by wave</td>
<td>85</td>
</tr>
<tr>
<td>66</td>
<td>Reasons related to tobacco control policies that “somewhat” or “very much” led smokers who were planning to quit and recent quitters to think about quitting smoking in the last 6 months, by wave</td>
<td>86</td>
</tr>
<tr>
<td>67</td>
<td>Personal reasons that “somewhat” or “very much” led smokers who were planning to quit and recent quitters to think about quitting smoking in the last 6 months, by wave</td>
<td>87</td>
</tr>
<tr>
<td>68</td>
<td>Percentage of smokers who received various forms of support for cessation in the last 6 months, by wave</td>
<td>88</td>
</tr>
<tr>
<td>69</td>
<td>Percentage of smokers who have used stop-smoking medications (SSMs) in the last year; percentage of smokers who “support” or “strongly support” insurance reimbursement for SSMs; and percentage of smokers who are “very likely” or “probably” planning to use SSMs in their next quit attempt, by wave</td>
<td>89</td>
</tr>
<tr>
<td>70</td>
<td>Percentage of smokers who were aware of the reimbursement from their health insurance for SSMs, by wave</td>
<td>90</td>
</tr>
<tr>
<td>71</td>
<td>Percentage of smokers who paid full price, got a discount, got free, or health insurance covered cost of SSMs, by wave</td>
<td>90</td>
</tr>
<tr>
<td>72</td>
<td>Percentage of smokers and quitters who agree, disagree, or neither agree nor disagree that the government should do more to help smokers give up smoking, by wave</td>
<td>91</td>
</tr>
</tbody>
</table>
The International Tobacco Control Policy Evaluation Project (the ITC Project) is a multi-country prospective cohort study designed to measure the psychosocial and behavioural impact of key policies of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) in more than 20 countries.

In late 2007, researchers from Maastricht University (CAPHRI), STIVORO (now discontinued), and University of Amsterdam (ASCoR) formed a collaboration with the ITC Project team at the University of Waterloo in Canada to create the ITC Netherlands Project. This report presents the results of Waves 1 to 8 of the ITC Netherlands Survey – a telephone (Waves 1 and 3 only) and web-based survey of a nationally representative sample of approximately 2,000 smokers conducted between 2008 and 2014.

**ITC Netherlands Survey Team**

*ITC Netherlands Investigators*

- Dr. Marc Willemsen* — Maastricht University (CAPHRI)
- Dr. Gera Nagelhout — Maastricht University (CAPHRI)
- Dr. Hein de Vries — Maastricht University (CAPHRI)
- Karin Hummel — PhD Student, Maastricht University (CAPHRI)
- Dr. Ciska Hoving — Maastricht University (CAPHRI)
- Dr. Bas van den Putte — University of Amsterdam (ASCoR)

*ITC International Team*

- Dr. Geoffrey T. Fong*, Dr. Mary E. Thompson, Dr. Christian Boudreau – University of Waterloo

*Principal Investigators*

**ITC Netherlands Project Management**

- Thomas Agar — Project Manager, University of Waterloo, Canada
- Ruth Loewen — Survey Manager, University of Waterloo, Canada
- Dr. Gera Nagelhout — Maastricht University (CAPHRI)
- Karin Hummel — PhD Student, Maastricht University (CAPHRI)

**ITC Netherlands Project Funding**

- ZonMw (The Netherlands Organisation for Health Research and Development)
- Roswell Park Transdisciplinary Tobacco Use Research Centre (TTURC – P50 CA111236), funded by the U.S. National Cancer Institute, National Institutes of Health (US)
- Canadian Institutes of Health Research (CIHR)
- Ontario Institute of Cancer Research (Canada) (Senior Investigator Award to Geoffrey T. Fong)
- Canadian Cancer Society Research Institute (CCSR)

Support for the preparation of this Report was provided by the Canadian Cancer Society Research Institute through a prevention scientist award to Geoffrey T. Fong.
Acknowledgements

This report was prepared by a team of collaborators at the University of Waterloo: Dr. Genevieve Sansone (writing and data visualization), Lorraine Craig (writing and project management), Wendy de Gomez (writing), Sophie He (data analysis), Dr. Gang Meng (data analysis), Mi Yan (data analysis), Thomas Agar (writing and editing), Dr. Anne Quah (editing), and Dr. Geoffrey T. Fong (reviewer). Further editing and review was provided by the ITC Netherlands collaborators: Dr. Marc Willemsen, Sanne Heijndijk, Karin Hummel, and Dr. Gera Nagelhout.

Graphic design and layout was provided by Sonya Lyon of Sentrik Graphic Design Inc.
BACKGROUND

The ITC Project Surveys

The International Tobacco Control Policy Evaluation Project (the ITC Project) is the first-ever international cohort study of tobacco use. Its overall objective is to measure the psychosocial and behavioural impact of key national level policies of the WHO Framework Convention on Tobacco Control (FCTC). The ITC Project is a collaborative effort with international health organizations, researchers, and policymakers in more than 20 countries (see back cover) so far, inhabited by more than 50% of the world’s population, 60% of the world’s smokers, and 70% of the world’s tobacco users. In each country, the ITC Project is conducting longitudinal cohort surveys to assess the impact and identify the determinants of effective tobacco control policies in each of the following areas:

- Health warning labels and pack descriptors
- Pricing and taxation of tobacco products
- Tobacco advertising and promotion
- Smoke-free legislation
- Education and support for cessation

ITC surveys evaluate the effectiveness of current policies and provide evidence of successes or the need for stronger action in each of the policy domains. The longitudinal design of the ITC surveys allows for a rigorous evaluation of whether the introduction of new policies such as smoke-free laws or tax increases led to greater impact on tobacco use behaviour.

In addition to policy evaluation, the ITC Project is improving the understanding of patterns of tobacco use and cessation over time and across countries, including factors that predict quit attempts and successful quitting. For example, ITC research is evaluating a broad range of influences on cessation such as policy-relevant factors, demographic factors, environmental factors, and beliefs and attitudes such as perceived risk, beliefs about the acceptability of smoking and use of other forms of tobacco, and reports of whether significant others are supportive of quitting. Such findings have important implications for the design and implementation of effective individual and population-level programs and policies to support cessation.

All ITC surveys are developed using the same conceptual framework and methods, and the survey questions, which include more than 150 questions directly relating to policy impact, are designed to be identical or functionally equivalent across all ITC countries in order to allow strong cross-country comparisons. The ITC Project aims to provide an evidence base to guide policies enacted under the FCTC, and to systematically evaluate the effectiveness of these legislative efforts.

The ITC Netherlands Survey

The ITC Netherlands Project was launched in 2008 by researchers from Maastricht University (CAPHRI), STIVORO (now discontinued), and University of Amsterdam (ASCoR), who formed a partnership with the ITC Project team at the University of Waterloo in Canada to create the ITC Netherlands Project. As with all ITC surveys, the ITC Netherlands Survey was tailored for the tobacco control environment in the country. Therefore, in addition to the core ITC survey questions, specific questions were added to the ITC Netherlands Survey to evaluate legislative efforts and tobacco control initiatives in the country, including additional questions about determinants of smoking cessation. Eight survey waves have been conducted between March 2008 and July 2014 with the following main objectives:

- To measure the effectiveness of tobacco control policy measures on Dutch smokers
- To investigate the psychological determinants of smoking
- To compare smoking behaviour and the impact of policies in the Netherlands with other ITC countries

In Waves 1 and 3, two parallel samples of approximately 2,000 youth (aged 15 to 17 years) and adult smokers were surveyed using different survey methods – Computer Assisted Telephone Interviewing (CATI) and Computer Assisted Web Interviewing (CAWI). In Wave 2, approximately one-third (n=643) of Wave 1 CAWI respondents were surveyed again using the CAWI mode. From Wave 4 to Wave 8, the ITC Netherlands Survey was conducted among the full cohort using CAWI only. Because of the different sampling method at Wave 2, results from this survey wave are not included in this report.

This report presents key findings from the ITC Netherlands Wave 1 to 8 Surveys to provide an overall picture of the impact of these tobacco control initiatives on Dutch smokers and to identify strengths and weaknesses in the implementation of tobacco control policies in the Netherlands.
THE TOBACCO LANDSCAPE IN THE NETHERLANDS

This section provides an overview of tobacco use and tobacco control policies in the Netherlands during the time of the ITC Netherlands Wave 1 to 8 Surveys (March 2008 – July 2014) as well as more recent initiatives. It also summarizes the findings of tobacco control policy evaluation research conducted in the Netherlands, including the Tobacco Control Scale and FCTC Implementation Shadow Reports.1-3

Smoking Prevalence

Tobacco use is the single most preventable cause of death in the world today.4 In the six World Health Organization (WHO) regions (Africa, South-East Asia, Americas, Eastern Mediterranean, Western Pacific, and Europe), adult smoking prevalence during 2013 was highest in Europe at 28%.5 In the Netherlands, overall smoking prevalence was 23% in 2014, a decrease from 25% in 2013.6 Smoking prevalence decreased from 26% to 24% among males from 2013-2014, and from 25% to 22% among women. In 2014, 17% of the Dutch population aged 15 years and older were smoking on a daily basis, and the average number of tobacco products smoked per day was approximately 13.6 Additionally, evidence from the ITC Project indicates that RYO tobacco prevalence is relatively high in the Netherlands (32% in 2008).7

Smoking prevalence among youth is similar to adults. In 2014, the smoking rate for youth aged 15-24 years was 24%, and 14% of all youth aged 15-24 years were daily smokers.6

Evidence indicates that educational attainment is associated with smoking prevalence, initiation, and cessation in the Netherlands, and that some educational inequalities are widening. From 2001-2008, lower educated respondents were found to be significantly more likely to be smokers, smoked more cigarettes per day, had higher initiation ratios, and had lower quit ratios compared to higher educated respondents.8

Modelling studies demonstrate the potential for effective tobacco control policies to achieve significant reductions in smoking prevalence and smoking-related deaths. Using the Netherlands SimSmoke simulation model, projections of smoking prevalence from 2010 to 2040 indicate that smoking prevalence among males would decrease by 10% with a substantial tobacco tax increase, by 8% with a comprehensive marketing ban, and by 7.5% with a well-funded tobacco control campaign.9 The total number of smoking attributable deaths (SADs) from 2010 to 2040 in the Netherlands also is expected to significantly increase to over 1 million if current policies remain the same, but if tobacco control policies are strengthened, the number of deaths averted over this period would exceed 100,000.9 This is especially critical in the European Region, which had the highest proportion of deaths attributable to tobacco (16%, along with the America Region) in 2012.5

Prevalence of Electronic Cigarette Use

In the Netherlands, electronic cigarettes (e-cigarettes) have been available for purchase since 2007. E-cigarettes were first classified as consumer products and were commercially promoted and advertised extensively. In 2008, the Dutch government claimed that e-cigarettes containing nicotine should be (at least temporarily) classified as medicines, awaiting a decision on the level of the European Union. This approach was accepted by the Dutch Courts. The decision included a ban on advertising of e-cigarettes, but it was still legal to sell them. At the same time, the government released a public warning about e-cigarettes, indicating that not enough information was known about the safety of e-cigarettes. However, in 2012, forced by a Court ruling, the classification of e-cigarettes was revised and they were reclassified as consumer products and therefore advertisements for e-cigarettes were allowed again.10

From 2012 to 2014, use of e-cigarettes has increased from 1% to 4% of the Dutch population, according to the Continuous Survey of Smoking Habits.11
The Netherlands signed the FCTC in June 2003 and later ratified the treaty in January 2005. Since the FCTC was ratified, however, progress in tobacco control has been slow. According to the Tobacco Control Scale in 2013, which quantifies the implementation of tobacco control policies at the country level, the Netherlands ranked 13th out of 34 European countries surveyed in relation to: tobacco prices, public place smoking bans, public information campaign spending, advertising bans, health warnings, and tobacco dependence treatment.\(^1\)

A 2011 report evaluating the status of Dutch tobacco control measures and implementation of the FCTC showed that the government was still far from achieving its obligations under the treaty, only exceeding minimum FCTC standards in the area of surveillance (Article 20).\(^2\) A follow up report published in 2015 noted some improvement in tobacco control efforts, but still concluded that much more needs to be done in the Netherlands in order to meet its obligations under the treaty and to reduce tobacco use and its associated harms in the country. The report showed that the Netherlands are significantly behind in terms of compliance with the FCTC, having only met FCTC obligations, recommendations, and suggestions in the case of Article 6 (Price and Tax) and Article 26 (Financial Resources). For major demand management policies including exposure to tobacco smoke (Article 8), packaging and labelling (Article 11), education/communication, and training (Article 12), and advertising, promotion, and sponsorship (Article 13), the Netherlands has not met all base-level obligations of the FCTC. In the case of cessation and treatment, although the Netherlands has met the obligations of the FCTC, it fell short in some of the treaty’s recommendations.\(^3\)

Between 2010 and 2012, a minority coalition between the Conservative-Liberal Party (VVD – People’s Party for Freedom and Democracy) and the Christian Democratic Party (CDA), with support from the populist Freedom Party (PVV) stopped considerable funding for tobacco control and also cut back on some other tobacco control initiatives. Since the end of 2012, a new government coalition between the VVD and the Labour Party (PvdA) has again taken some steps to strengthen tobacco control in the country. Further, the Minister of Health is no longer responsible for tobacco control, a role delegated to the deputy Minister of Health from the Labour Party who has been more supportive of tobacco control measures. As of 2013, tobacco control has a supportive majority of parliamentary members who advocate for stronger policies, mainly for stronger smoke-free legislation and specifically, to ban the exemption for small cafés and increase the legal age of purchase, policies which have now been implemented. Other policies, including motions to limit the number of shops selling tobacco, to implement a ban on sales through vending machines, and to introduce a display ban, were so far only supported by a minority.\(^4\)
Recent Tobacco Control Initiatives

In December 2012, the European Commission announced its intentions to revise its Tobacco Products Directive (TPD; 2001/37/EC) – rules that pertain to how tobacco products can be manufactured, presented, and sold throughout the 28 Member States. The new TPD (2014/40/EU) received approval from the European Parliament in February 2014, and from the Council of Ministers in March. The TPD entered into force on May 19, 2014 with a transposition period of 2 years for Member States to bring national legislation in line with the new TPD, meaning that the new rules will apply in the Netherlands by the first half of 2016.13

The new TPD (2014/40/EU) includes the following measures, which must be adopted by all member states:

- Enhanced constituent and ingredient reporting
- Prohibition of tobacco products containing characterizing flavours, vitamins, stimulants, and any other ingredients associated with health benefits or vitality
- The inclusion of combined health warnings (picture and text) that cover at least 65% of the front and back of cigarette and roll-your-own tobacco packages
- Strict guidelines on the minimum dimensions of cigarette packages
- The prohibition of product labeling that creates erroneous impressions about the products’ health effects, risks, and emissions
- Prohibition or tighter regulation of cross-border distance sales of tobacco products to consumers

Several of the TPD requirements have already been implemented in the Netherlands, including safety and quality requirements for e-cigarettes – such as maximum nicotine level requirements, additive restrictions, and text-based health warnings on the dangers of nicotine.

However, Member States are allowed a transitional period for certain product categories to give manufacturers and retailers time to sell off their existing stock. Specifically tobacco products manufactured, labelled and released for free circulation before May 20, 2016 have until May 20, 2017 to be in compliance with the new TPD.

In addition to the TPD measures, on January 1, 2014 the minimum age to purchase tobacco was increased from 16 years to 18 years of age. Non-compliance with the legal age limit by retailers is no longer only sanctioned through monetary fines. If a retailer violates the law by selling to a minor three times within a period of 12 months, they can be prohibited from selling tobacco for a specified amount of time.14

Price and Taxation

Raising taxes to substantially increase the price of tobacco products is recognized as the single most effective population-based strategy to reduce tobacco consumption, and encourage tobacco users to quit.15, 16 Article 6 of the FCTC obligates countries that have ratified the treaty to adopt price and tax measures that reduce tobacco consumption. The FCTC further recommends that more reliance on specific excise tax is the most effective way to reduce consumption rates provided the excises are adjusted for inflation and income in order to reduce the affordability of tobacco products.

Between Waves 1 through 8 (March 2008 to July 2014) of the ITC Netherlands Survey, taxes on cigarettes and RYO tobacco were increased four times, and since 2011 the percentage of specific excise tax has increased, while the percentage of ad valorem tax has decreased. The first cigarette tax increase occurred in July 2008 with an increase of €0.29 on a pack of 20 Marlboro cigarettes and €0.46 on a 50g pack of RYO tobacco. In March 2010, a smaller tobacco tax increase of €0.09 on a 19 pack of cigarettes and €0.02 on RYO tobacco (47.5g) occurred. A third increase was implemented in March 2011 at €0.22 on a 19 pack of cigarettes and €0.22 on RYO tobacco (45g). Finally, in January 2013, there was a tax increase of €0.35 on cigarettes (19 pack) and a €0.60 increase on RYO tobacco (40g). Government statistics indicate that between the ITC Netherlands Wave 1 to 8 Surveys, the price of cigarettes rose by 50.6%. The price of RYO tobacco increased by 56.9% during the same period.17 Excise duty on cigars did not change between 2007 and 2012, remaining at an ad valorem tax of 5%, and the price of cigars only changed cumulatively by 13%.18
Table 1 provides the price and tax structure on a 19-pack of Marlboro cigarettes between 2008 and 2014.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail price</strong></td>
<td>Euros</td>
<td>US $</td>
<td>Euros</td>
<td>US $</td>
<td>Euros</td>
</tr>
<tr>
<td>of 19 pack of Marlboro cigarettes</td>
<td>4.50</td>
<td>6.13</td>
<td>4.80</td>
<td>6.54</td>
<td>5.40</td>
</tr>
<tr>
<td><strong>Excise tax</strong></td>
<td>36.4%</td>
<td>36.5%</td>
<td>48.6%</td>
<td>53.8%</td>
<td>55.1%</td>
</tr>
<tr>
<td><strong>Ad valorem tax</strong></td>
<td>21.3%</td>
<td>20.5%</td>
<td>7.6%</td>
<td>2.4%</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>VAT tax</strong></td>
<td>16.0%</td>
<td>16.0%</td>
<td>16.0%</td>
<td>17.4%</td>
<td>17.4%</td>
</tr>
<tr>
<td><strong>Total tax</strong></td>
<td>73.7%</td>
<td>73.0%</td>
<td>72.2%</td>
<td>73.6%</td>
<td>73.4%</td>
</tr>
</tbody>
</table>

Guidelines for effective implementation of Article 6 were adopted by the Parties in 2014. Recommendations for implementing Article 6 include using the simplest and most efficient tax system, considering specific or mixed excise systems over ad valorem systems, re-evaluating and adjusting tax rates regularly to account for inflation and income growth, taxing all tobacco products in a comparable way to minimize shifts to cheaper products, dedicating tax revenue to tobacco control programmes, and considering sales restrictions and limitations on international travelers importing tax and duty-free tobacco products.

While the Netherlands follows some of these Guidelines, such as using a mixed excise system on cigarettes and RYO tobacco products, others have not been met. For example, differential excise duty rates still apply to different tobacco products in the Netherlands, such as cigarettes, cigars, and RYO tobacco; and tax revenues have not been earmarked for tobacco control or health programmes.

Since 2013, the tobacco industry in the Netherlands has reported that increased border shopping to Belgium and other EU member states has cost Dutch tobacco companies, gas service stations, and the Dutch State millions of Euros. Although tobacco taxes have not been cut as a result, an announced tax increase (of €0.09) for January 2014 was postponed for one year because of tax revenues falling short of expectations.

A 2011 study showed that 145,000 deaths could be averted in the next 30 years in the Netherlands by implementing stronger tobacco control policies, particularly by increasing tobacco taxes and prices. SimSmoke simulation model predictions showed that 41,000 of the predicted 145,000 lives saved between 2011 and 2040 could be achieved by increasing tobacco taxes alone. The increased revenues from tobacco taxation could be used towards other tobacco control initiatives, such as reimbursement of smoking cessation medications, which could save another 38,000 lives.

A 2011 study showed that 145,000 deaths could be averted in the next 30 years in the Netherlands by implementing stronger tobacco control policies, particularly by increasing tobacco taxes and prices.
Smoke-Free Policies

Article 8 of the FCTC requires Parties to “adopt and implement effective measures to provide protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor places, and as appropriate, other public places”. Smoke-free legislation not only reduces exposure to secondhand smoke, but it has also been shown to reduce tobacco consumption and motivate smokers to quit.

Article 8 Guidelines, adopted in 2007, recommend the following strategies for effective implementation of smoke-free environments: 1) implement a 100% comprehensive ban without designated smoking areas or exceptions; 2) ensure strong enforcement; and 3) raise awareness about the harms of secondhand smoke through educational campaigns.

Beginning in 1990, the Netherlands banned smoking in government buildings and public places and, in 2004, a workplace smoking ban was introduced. In July 2008, a smoking ban was implemented in the hospitality industry, sports sector, and the arts and culture sector. Enclosed smoking rooms were allowed, but the serving of food or drinks in these rooms was prohibited.

Studies to evaluate the hospitality industry smoking ban have found relatively low levels of support and compliance. At the end of 2008, 6 months after the implementation of the ban, only 44% of the Dutch population supported the legislation, which was the lowest level of support for smoking bans in all European countries. In 2009, it was reported that 1,269 cafés had violated the ban – an indicator of poor compliance. WHO data from 2012 on implementation of FCTC policies indicated that the Netherlands adheres to only three out of a possible 14 areas of smoke-free legislation: a national law requiring fines for smoking, fines levied against the establishment, and citizen complaints and investigations.

The weak impact of the 2008 smoking ban may be attributed to the lack of adherence to the Article 8 Guidelines: 1) The ban was not comprehensive, as it allowed for designated smoking rooms; 2) It lacked strong enforcement and penalties for violations – during the first 3 months after the ban, violators (the establishments) were first issued a warning, and then a fine between €300 to up to €2,400 – there was no fine for the individual smoker; and 3) The Dutch government did not frame the rationale for the smoke-free law in terms of benefits for public health - the educational campaign that was launched to correspond with the ban only focused on the ban implementation date. In fact, there was a well-organized media campaign about the negative effects of the smoking ban produced by the tobacco industry and other pro-smoking lobby groups at the same time.

Since 2008, there have been several policy decisions and changes regarding the hospitality industry smoking ban. It was first suspended in small cafés in July 2009 after two appeal courts ruled that the ban did not apply to cafés that do not employ staff. Subsequently in February 2010, the Supreme Court denied the judgement of the appeal court, and ruled that the law must apply to owner-run pubs and cafés without employees. However, in November 2010, the Minister of Health announced that smoking would again be tolerated in these places, and since July 6, 2011, this exemption of the smoking ban in the hospitality sector has been embedded in regulation. As a result, smoking was allowed in cafés smaller than 70 m² without employees, and in 2011, almost 50% of cafés were no longer smoke-free.

In February 2013, a motion was passed to reinstate the smoking ban in small restaurants, bars, and cafés. In March 2013, the appeal court in The Hague ruled that all cafés must be smoke-free, with no exception for small cafés run by the owner. A bill to this end was tabled by the Deputy Minister in November 2013, and was approved by the House of Representatives in July 2014. In October 2014, the Supreme Court sided with the appeal court and ruled that the exception for small cafés should be considered non-binding. Enforcement of this change in the law began immediately following this decision, although legally it came into effect January 1, 2015.
Warning Labels

Article 11 of the FCTC requires Parties to implement large, visible, rotating health warnings within 3 years of ratification. Guidelines for implementation of Article 11, adopted in November 2008 at the third Conference of the Parties to the WHO FCTC, recommend that warnings include full-colour pictures covering at least 50% of the principal display areas of the pack, and include two or more sets of rotating warnings with a range of messages.

In May 2002, 4 months earlier than required by the initial TPD 2001/37/EC, the Netherlands implemented text-only health warnings on the bottom 30% of the front and bottom 40% of the back of tobacco packages. However, the size of the Dutch warnings included the black border around the text, even though the European Union recommended excluding the border. The initial TPD prescribed two different health warning messages for the front and a list of 14 messages for the back, which were to be randomly rotated. The 2002 legislation also marked the first time the Netherlands provided a quitline telephone number on their tobacco packaging, which was included as part of one of the 14 messages on the back.

A cross-sectional study of 3,937 Dutch smokers from the Continuous Survey of Smoking Habits in 2003 measured the self-reported impact of the new text-only warnings. The survey found that the new health warnings did have an impact on smokers, especially among smokers who already intended to quit: 14% of smokers said they were less inclined to purchase cigarettes because of the new warnings, 32% preferred to purchase a pack without the new warnings, 18% reported that the warnings increased their motivation to quit, and 10% said they smoked less because of the warnings. However, a much greater impact has been observed in countries that have implemented stronger pictorial warnings. For example, after the introduction of pictorial health warnings in Canada, 19% of smokers said they smoked less because of the new warnings and 33% reported a greater motivation to quit.

Findings from the ITC surveys in France (2007), Germany (2007), the Netherlands (2008), and the UK (2006) suggest that warning label effectiveness is the lowest in the Netherlands and Germany, which may be related to a weaker tobacco control environment in these two countries, which could decrease receptivity to the warnings.

The health warnings remained the same in the Netherlands from their introduction in 2002 until 2014. Following the EU Directive 2012/9/EU, the Netherlands revised the 14 text warning messages on March 28, 2014 to address a wider range of health effects of smoking, such as mouth and throat cancer, visual impairments, dental and gum disease, and the role of parental smoking in initiating smoking. The quitline was also removed from the back of packs and was replaced with a referral to a quit smoking website. However, this regulation allowed a period of 2 years for manufacturers and importers to transition to the new warnings, which has been extended until May 2017 as a result of further revisions under the new TPD.

Under the new EU Tobacco Products Directive (TPD) 2014/40/EU, significant changes will be introduced with respect to health warnings on tobacco packaging. Health warnings will include pictorial warnings encompassing a colour photograph and corresponding text, covering 65% of both principal display areas of the packaging. On the lateral sides of the packaging, the text “Smoking Kills” or “Smoking Kills – Quit Now”, as well as the information message “Tobacco smoke contains over 70 substances known to cause cancer” will be displayed on the bottom 50% of each surface. As with all measures within the new TPD, the measures outlined for health warnings must be transposed into Dutch law by May 20, 2016, although the legislator may allow tobacco products that are manufactured, labelled and released for free circulation before May 20, 2016 and comply with the rules laid down in the initial TPD to be marketed until May 20, 2017.
Light/Mild Product Descriptions

Article 11 of the FCTC also restricts deceptive tobacco product labelling that “directly or indirectly creates the false impression that a particular product is less harmful than other tobacco products.” These may include terms such as “low tar”, “light”, “ultra-light”, or “mild”. The Netherlands, as with all EU Member States, eliminated these terms following the initial TPD 2001/37/EC. The Netherlands does not have a ban on quantitative statements of tar, nicotine, or carbon monoxide emission levels on cigarettes packages as recommended in the Article 11 Guidelines; instead, tobacco manufacturers are currently required to place these numbers on the sides of packs in accordance with the 2001 TPD.

Under the new TPD 2014/40/EU, however, all information with respect to emission levels are to be removed from cigarette packages, along with any other information that may be misleading with respect to the harm caused by the product. Therefore, the new TPD rules are in accordance with the Article 11 Guidelines.

These more comprehensive measures are necessary because the simple prohibition of terms such as “light” and “mild” have proved to be ineffective at curbing perceptions that some cigarettes are safer than others are. Studies have shown that smokers in Western countries, including EU countries, continue to falsely believe that some cigarette brands are less harmful than others as a result of descriptive words on packs other than the traditional “light” and “mild”, as well as tar/nicotine yields and elements such as package colouring. Even more restrictive packaging measures, such as Australia’s implementation of “plain packaging”, would further reduce smokers’ misunderstandings of the harm that occurs as a consequence of smoking.

Education, Communication, and Public Awareness

Under Article 12 of the FCTC, Parties must promote and strengthen awareness of tobacco control issues through education and public awareness campaigns on the health risks of tobacco consumption and the benefits of cessation; the tobacco industry, its strategies, and its products; and the adverse health, economic, and environmental consequences of tobacco production and consumption.

The 2011 introduction of the new smoking cessation treatment reimbursement policy in the Netherlands was accompanied by significant and positive media attention. Most notably, a media campaign was created by the then Dutch Expert Centre on Tobacco Control (STIVORO) and the Dutch Cancer Society to communicate to the public that smoking cessation treatment would be reimbursed from 2011. The campaign ran from December 2010 to January 2011 and was estimated to have an 80% exposure rate among smokers. The media coverage of the new Smoking Cessation Reimbursement Programme (SCRP) was significantly associated with an increase in reported quit attempts and higher quit rates.

From 2011 to 2013, the Dutch Ministry of Health stopped funding for all smoking education mass media campaigns, and instead decided to focus on educational programs in schools and information provided by health professionals. Starting in 2010, funding for STIVORO, the Dutch expert centre on tobacco control in existence since 1974, was gradually reduced until January 2013 when the entire program was discontinued. In 2011, the Ministry of Health further reduced funding for public health information about smoking, and transferred the remaining funding from STIVORO to the Trimbos Institute, the national centre of expertise on mental health and addiction.

Beginning in late 2013, there has been some renewed support for mass media campaigns. For instance, the Dutch government launched a campaign to accompany the 2014 law that increased the minimum purchase age of cigarettes to 18 and supported Stoptober, a nationwide smoking cessation campaign that was initiated by various health organizations.
Tobacco Advertising, Promotion, and Sponsorship

Article 13 of the FCTC requires Parties to implement effective measures against tobacco advertising, promotion, and sponsorship (TAPS). Guidelines for Article 13 recommend a comprehensive ban on TAPS (or apply restrictions that are as comprehensive as possible), covering radio, television, print media, and other media, such as the Internet. Also included among the recommended measures are bans on: cross-border advertising, promotion, and sponsorship; display of tobacco products at points of sale; tobacco product vending machines; internet sales; and attractive packaging and product features.

Tobacco advertising in the Netherlands has been banned from national TV, radio, print media, and the internet under national legislation, prior to the requirement to implement these bans under the EU legislation (Directives 2007/65/EC and 2003/33/EC). Sponsorship of events by tobacco companies, indirect advertising of tobacco products, advertising at cinemas, and outdoor billboards are also banned under national legislation. Currently, advertising of tobacco products at points of sale is not regulated under the EU legislation, but rather at the individual member state level. In the Netherlands, advertising at point of sale is not prohibited. According to the current laws, an advertisement of up to 2 square metres is allowed on the façade of specialty shops and convenience stores that sell tobacco, as well as advertising inside shops (such as on the counter) and the display of tobacco products within the store when displayed against a neutral backdrop. For all other points of sale, such as supermarkets, gas stations, newsstands, drug stores, and vending machines, advertising is banned, except for the regular display of tobacco products. While vending machines have measures to prevent the sale of cigarettes to minors (younger than 18 years), the Dutch government currently has no plans to ban the sale of tobacco through vending machines, meaning minors are still exposed to the tobacco products on display, and in some cases can still access tobacco through the vending machines.

Smoking Cessation

Article 14 of the FCTC promotes the implementation of programs for smoking cessation, including programs for diagnosing, counselling, preventing, and treating tobacco dependence, as well as facilitating accessible and affordable treatments. Of the various cessation aids, reimbursement for cessation treatment has proven effective in increasing the use of treatment, the number of attempts to quit, and the number of successful quit attempts.

Beginning in 2000, the Netherlands provided a national quitline. Since 2002, the quitline number was printed on cigarette packs; however, only one of the 14 different health messages contained the number; and as of 2015 it has been removed and replaced with a referral to a quit smoking website. Following the introduction of the quitline number on packages, the number of calls increased dramatically, and a larger and broader group of smokers were reached. A subsidy for the national quitline, which was hosted by STIVORO, was stopped in 2006, when smoking cessation treatment was considered to be eligible for health insurance coverage under the new health care system.
Currently, advertising of tobacco products at points of sale is not regulated under the EU legislation, but rather at the individual member state level. In the Netherlands, advertising at point of sale is not prohibited.

From January 2011 to January 2012, Dutch smokers were eligible for full reimbursement of one Smoking Cessation Reimbursement Programme (SCRP) per year, consisting of behavioural treatment (telephone counselling); which could be combined with pharmacotherapy. In most insurance policies, there are mandatory deductibles, which means that smokers who are using this treatment to quit may still have to pay for at least part of it in practice. The introduction of full health insurance coverage in 2011 was also accompanied by a significant increase in the number of (dispensed) prescriptions of stop-smoking medication, which decreased again after the program ended in 2012 due to budget cuts. In addition, there was a marked decrease in smoking prevalence in 2011 following the health insurance policy, and then an increase in 2012 after it was abolished, suggesting that the cessation program may have contributed to a reduction in smoking in the population. In 2013, the Dutch basic insurance plan re-enlisted smoking cessation treatment, most likely in response to various studies showing positive effects of the reimbursement. This time, the cessation reinstatement was not combined with a mass media campaign. From 2014 forward, smoking cessation treatment has remained reimbursable.

Although the rate of quitting advice from general practitioners is low in the Netherlands compared to other countries, perhaps due to greater reluctance among Dutch physicians to intervene in patients’ lifestyle choices, data suggests that the public has high confidence in the advice given to them and therefore, more emphasis on this in the future could have a beneficial impact.

There was a marked decrease in smoking prevalence in 2011 following the health insurance policy, and then an increase in 2012 after it was abolished, suggesting that the cessation program may have contributed to a reduction in smoking in the population.
METHODS

OVERVIEW

The International Tobacco Control Policy Evaluation Project (the ITC Project) is an international research collaboration across 22 countries – Canada, United States, United Kingdom, Australia, Ireland, Thailand, Malaysia, Republic of Korea, China, Mexico, Uruguay, New Zealand, France, Germany, the Netherlands, Bhutan, Mauritius, Brazil, India, Bangladesh, Kenya, and Zambia. The primary objective of the ITC Project is to conduct rigorous evaluation of the psychosocial and behavioural effects of national-level tobacco control policies of the WHO Framework Convention on Tobacco Control (FCTC). The ITC Project is conducting large-scale annual prospective cohort surveys of tobacco users to evaluate FCTC policies in countries inhabited by over 50% of the world’s population, 60% of the world’s smokers, and 70% of the world’s tobacco users. Each ITC survey includes key measures for each FCTC policy domain that are identical or functionally similar across the 22 countries to facilitate cross-country comparisons. The evaluation studies conducted from the ITC surveys take advantage of natural experiments created when an ITC country implements a policy: changes in policy-relevant variables in that country from pre- to post-policy survey waves are compared to other ITC countries where that policy has not changed. This research design provides high levels of internal validity, allowing more confident judgments regarding the possible causal impact of the policy. For description of the conceptual model and objectives of the ITC Project, see Fong et al. (2006)\(^{42}\); for description of the survey methods, see Thompson et al. (2006)\(^{43}\).

The International Tobacco Control Policy Evaluation Project in the Netherlands (the ITC Netherlands Project) was created in 2007 to rigorously evaluate the psychosocial and behavioural effects of Dutch tobacco control legislation and national-level smoking cessation mass media campaigns, using methods that the ITC Project has employed in many other countries throughout the world. The project objective is to provide an evidence base to guide policies enacted under the FCTC and to systematically evaluate the effectiveness of these legislative efforts. As with all ITC surveys across the 22 countries, the ITC Netherlands Survey was tailored for the tobacco control environment in the country. Therefore, specific questions about the Dutch situation and more questions about determinants of smoking cessation were added to the ITC Netherlands Survey. Figure 1 illustrates timeline of the ITC Netherlands Wave 1 to 8 Surveys in relation to the implementation of tobacco control policies and campaigns.

The ITC Project is conducting large-scale annual prospective cohort surveys in countries inhabited by over 50% of the world’s population, 60% of the world’s smokers, and 70% of the world’s tobacco users.
Sampling Design

The ITC Netherlands Survey is a prospective longitudinal survey of a nationally representative random sample of youth (ages 15-17 years) and adult (18 years and older) smokers. More than 2,200 smokers were first interviewed in March-April 2008, and the most recent wave (Wave 8) took place in May-July 2014. Respondents lost to follow-up between Waves 3 and 8 were replenished by new randomly selected respondents.

The ITC Netherlands Survey sampling design was chosen to yield a representative random sample of smokers residing in that country. Fieldwork has been conducted by the Dutch survey firm, TNS NIPO, and used a dual sampling frame. The first frame consists of the traditional random digit dialling (RDD) telephone survey, with computer assisted telephone interviews (CATI). The second frame is the web portion of the TNS NIPObase, which consists of over 140,000 respondents who have agreed to participate in TNS NIPO research on a regular basis. All respondents sampled from the second frame were invited to complete the survey using computer assisted web interviews (CAWI). It should be mentioned that members of the TNS NIPObase were randomly selected (mostly by mail and RDD), and are thus not a panel of self-selected volunteers. A subset of 744 of the 1,820 respondents who completed the Wave 1 CAWI survey were randomly selected to complete the Wave 2 Survey. Of these, 643 were successfully recontacted at Wave 2. None of the Wave 1 respondents who completed the CATI survey (i.e., RDD sample) were interviewed at Wave 2. Because the sampling design at Wave 2 differed from all other survey waves, the analyses conducted in this report did not include the Wave 2 dataset. The Wave 1 CATI respondents and the Wave 1 and Wave 2 CAWI respondents were invited to complete the Wave 3 Survey. To compensate for attrition of the web sample at Wave 3, 270 additional respondents were randomly sampled from the screened TNS NIPObase (the replenishment sample). The RDD sample was not replenished at Wave 3, and respondents from the RDD frame were not contacted after Wave 3. Replenishment of CAWI respondents who were lost to follow up was carried out in Waves 4 to 8.

Figure 2 presents a summary of the research design and sample sizes. Further information on the sampling design, construction of sampling weights, and retention rates is provided in the ITC Netherlands Technical Reports at www.itcproject.org.44, 45

The ITC Netherlands Survey is a longitudinal survey of a nationally representative random sample of approximately 2,000 youth (ages 15-17 years) and adult (18 years and older) smokers. Eight survey waves were conducted between 2008 and 2014.
Figure 1. Netherlands’ tobacco control policy timeline in relation to the ITC Netherlands Surveys

Wave 1
Mar – Apr 2008
Smoker N=1,820 (web)
Smoker N=404 (tel)

Wave 2
Nov – Dec 2008
Smoker N=643 (web)

Wave 3
Mar – May 2009
Smoker N=1,717 (web)
Smoker N=296 (tel)

Wave 4
May – Jun 2010
Smoker N=2,060 (web)

Wave 5
May – Jun 2011
Smoker N=2,101 (web)

Wave 6
May – Jun 2012
Smoker N=2,022 (web)

Wave 7
May – Jul 2014
Smoker N=2,008 (web)

Jul 2008
Smoking ban in hospitality industry, arts and culture sector, and sport canteens. Smoking allowed in designated areas not serviced by employees
€0.29 tax increase on cigarettes and €0.46 increase on RYO tobacco

Apr 2008 - Jan 2009
Mass media campaign to encourage quitting smoking

Jul 2009
Smoking ban suspended in small owner run cafés

Feb 2010
Ban reinstated in small owner run cafés

Mar 2010
€0.09 tax increase on cigarettes and €0.02 increase on RYO tobacco

Nov 2010
New Minister of Health announced reversal of smoking ban in owner run cafés and bars (<70 sq. m or 750 sq. feet)

May 2002
Text warnings on 30% of front and 40% of the back of the pack with 1-year transition period

Jan 2004
Smoking ban in workplaces

Jan 2005
FCTC ratification

Jan 2005
Smoking ban in workplaces

May 2008
Smoking ban in hospitality industry, arts and culture sector, and sport canteens. Smoking allowed in designated areas not serviced by employees
€0.29 tax increase on cigarettes and €0.46 increase on RYO tobacco

Apr 2008 - Jan 2009
Mass media campaign to encourage quitting smoking

Jul 2009
Smoking ban suspended in small owner run cafés

Feb 2010
Ban reinstated in small owner run cafés

Mar 2010
€0.09 tax increase on cigarettes and €0.02 increase on RYO tobacco

Nov 2010
New Minister of Health announced reversal of smoking ban in owner run cafés and bars (<70 sq. m or 750 sq. feet)

Apr 2008 - Jan 2009
Mass media campaign to encourage quitting smoking

Jul 2009
Smoking ban suspended in small owner run cafés

Feb 2010
Ban reinstated in small owner run cafés

Mar 2010
€0.09 tax increase on cigarettes and €0.02 increase on RYO tobacco

Nov 2010
New Minister of Health announced reversal of smoking ban in owner run cafés and bars (<70 sq. m or 750 sq. feet)
Dec 2010 - Jan 2011
Smoking cessation media campaign

Jan 2011
Smoking cessation treatment reimbursement program introduced

Mar 2011
€0.22 tax increase on cigarettes and RYO tobacco

Jan 2012
- Reimbursement of smoking cessation treatments discontinued
- Funding cut for mass media campaigns

Jan 2013
- €0.35 tax increase on cigarettes, €0.60 tax increase on RYO tobacco
- Reimbursement of smoking cessation treatments reinstated

Jan 2014
Legal age to buy tobacco increased from 16 to 18, accompanied by a mass media campaign to denormalize smoking among youth

Oct 2014
Supreme Court reinstated complete smoking ban in hospitality sector

---------------------------------------------------------------
Jul 2008
Smoking ban in hospitality industry, arts and culture sector, and sport canteens.
Smoking allowed in designated areas not serviced by employees

€
0.29 tax increase on cigarettes and €0.46 increase on RYO tobacco

Jul 2009
Smoking ban suspended in small owner run cafés

Feb 2010
Ban reinstated in small owner run cafés

Mar 2010
€0.09 tax increase on cigarettes and €0.02 increase on RYO tobacco

Nov 2010
New Minister of Health announced reversal of smoking ban in owner run cafés and bars (< 70 sq. m or 750 sq. feet)

Apr 2008 - Jan 2009
Mass media campaign to encourage quitting smoking

Jan 2005
FCTC ratification

Jan 2004
Smoking ban in workplaces

May 2002
Text warnings on 30% of front and 40% of the back of the pack with 1-year transition period
Characteristics of the Wave 1 to 8 Sample

Table 2 summarizes the demographic characteristics of the ITC Netherlands Wave 1 to 8 Survey respondents at each wave.

Table 2. Demographic characteristics of the ITC Netherlands Wave 1 to 8 Survey samples

<table>
<thead>
<tr>
<th></th>
<th>Wave 1</th>
<th>Wave 2</th>
<th>Wave 3</th>
<th>Wave 4</th>
<th>Wave 5</th>
<th>Wave 6</th>
<th>Wave 7</th>
<th>Wave 8</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1,042</td>
<td>46.9</td>
<td>283</td>
<td>44.0</td>
<td>942</td>
<td>46.8</td>
<td>992</td>
<td>48.2</td>
</tr>
<tr>
<td>Male</td>
<td>1,182</td>
<td>53.1</td>
<td>360</td>
<td>56.0</td>
<td>1,071</td>
<td>53.2</td>
<td>1,068</td>
<td>51.8</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;18</td>
<td>152</td>
<td>6.8</td>
<td>36</td>
<td>5.6</td>
<td>117</td>
<td>5.8</td>
<td>100</td>
<td>4.9</td>
</tr>
<tr>
<td>18-24</td>
<td>351</td>
<td>15.8</td>
<td>135</td>
<td>21.0</td>
<td>358</td>
<td>17.8</td>
<td>272</td>
<td>13.2</td>
</tr>
<tr>
<td>25-39</td>
<td>758</td>
<td>34.1</td>
<td>233</td>
<td>36.3</td>
<td>697</td>
<td>34.6</td>
<td>631</td>
<td>30.6</td>
</tr>
<tr>
<td>40-54</td>
<td>581</td>
<td>26.1</td>
<td>143</td>
<td>22.2</td>
<td>506</td>
<td>25.1</td>
<td>639</td>
<td>31.0</td>
</tr>
<tr>
<td>55+</td>
<td>382</td>
<td>17.2</td>
<td>96</td>
<td>14.9</td>
<td>335</td>
<td>16.7</td>
<td>418</td>
<td>20.3</td>
</tr>
<tr>
<td>Smoking status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily smoker</td>
<td>2,032</td>
<td>91.4</td>
<td>541</td>
<td>84.1</td>
<td>1,645</td>
<td>81.7</td>
<td>1,609</td>
<td>78.1</td>
</tr>
<tr>
<td>Non-daily smoker</td>
<td>192</td>
<td>8.6</td>
<td>47</td>
<td>7.3</td>
<td>103</td>
<td>5.1</td>
<td>191</td>
<td>9.3</td>
</tr>
<tr>
<td>Quitter</td>
<td>-</td>
<td>-</td>
<td>55</td>
<td>8.6</td>
<td>265</td>
<td>13.2</td>
<td>260</td>
<td>12.6</td>
</tr>
<tr>
<td>Highest level of education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>725</td>
<td>32.6</td>
<td>216</td>
<td>33.6</td>
<td>635</td>
<td>31.6</td>
<td>622</td>
<td>30.2</td>
</tr>
<tr>
<td>Medium</td>
<td>996</td>
<td>44.8</td>
<td>279</td>
<td>43.4</td>
<td>851</td>
<td>42.3</td>
<td>908</td>
<td>44.1</td>
</tr>
<tr>
<td>High</td>
<td>468</td>
<td>21.0</td>
<td>140</td>
<td>21.8</td>
<td>496</td>
<td>24.6</td>
<td>498</td>
<td>24.2</td>
</tr>
<tr>
<td>Not stated</td>
<td>35</td>
<td>1.6</td>
<td>8</td>
<td>1.2</td>
<td>31</td>
<td>1.5</td>
<td>32</td>
<td>1.5</td>
</tr>
<tr>
<td>Monthly household income (Euros)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (&lt;2000)</td>
<td>564</td>
<td>25.4</td>
<td>169</td>
<td>26.3</td>
<td>451</td>
<td>22.4</td>
<td>454</td>
<td>22.0</td>
</tr>
<tr>
<td>High (&gt;3000)</td>
<td>648</td>
<td>29.1</td>
<td>195</td>
<td>30.3</td>
<td>605</td>
<td>30.1</td>
<td>624</td>
<td>30.3</td>
</tr>
<tr>
<td>Not stated</td>
<td>535</td>
<td>24.1</td>
<td>138</td>
<td>21.5</td>
<td>534</td>
<td>26.5</td>
<td>540</td>
<td>26.2</td>
</tr>
</tbody>
</table>
**CONTENT OF THE ITC NETHERLANDS SURVEY**

The ITC Netherlands Survey was developed by an international team of tobacco control researchers from the University of Waterloo, STIVORO (now discontinued), Maastricht University, and University of Amsterdam (ASCoR). Most of the survey methods and survey questions were adapted from the standardized protocols and surveys that have been used in ITC surveys conducted in 21 other countries around the world. In the ITC Netherlands Survey, each respondent who was categorized as a smoker or quitter was asked to respond to the following types of questions:

**Smokers responded to the following questions:**

1. **Smoking- and cessation-relevant questions.** Smoking history and frequency, as well as current smoking behaviour and dependence, and quitting behaviours;

2. **Knowledge and basic beliefs about smoking.** Knowledge of the health effects of smoking and important beliefs relevant to smoking and quitting, perceived risk, and perceived severity of tobacco-related diseases;

3. **Policy-relevant questions.** Awareness of, impact of, and beliefs relevant for each of the FCTC demand reduction policy domains (warning labels, taxation/price, advertising/promotion, smoke-free policies, light/mild descriptors, public communication);

4. **Other important psychosocial predictors of smoking behaviour** and potential moderator variables (e.g., normative beliefs, self-efficacy, intentions to quit);

5. **Individual difference variables** relevant to smoking (e.g., depression, stress, time perspective);

6. **Demographics** (e.g., age, gender, marital status, income, education).

Several new questions were added in the ITC Netherlands Survey to measure awareness of alternative nicotine products, mass media smoking cessation campaigns, attitudes and beliefs towards health insurance reimbursement for stop-smoking medications, interpersonal communication on the smoking bans and smoking cessation, self-evaluative emotions, smoker prototypes, and smoker, quitter and group identity.

Respondents who quit smoking between waves were asked a similar set of survey questions, but with some questions rephrased to be relevant to those who had quit (e.g., using the past tense). Quitters were grouped with smokers when reporting results when there were no significant differences between the responses of quitters and smokers, except in cases where the measure of interest is especially relevant for quitters, or where the measure of interest is only relevant for smokers (e.g., noticing health warnings on cigarette packages, avoiding health warnings on cigarette packages, etc.).

The protocol and questionnaires of the ITC Netherlands Survey were first developed in English and then translated by the team members. The questionnaires are available on the ITC Project website at [www.itcproject.org/surveys](http://www.itcproject.org/surveys).
This report presents findings from seven waves of the ITC Netherlands Surveys (2008-2014). The focus of the report is to inform tobacco control policy development by evaluating the effectiveness of policies as they are implemented in the Netherlands over time. Comparisons with other ITC countries are also drawn. This section describes the analytic approach used in this report, including methods used to control for time-in-sample effects and the covariates used in the regression models.

**Time-in-sample effects**

The longitudinal nature of the ITC Netherlands Survey allows for the measurement of behavioural responses to tobacco control policies among smokers before and after a new policy is introduced. During the six years that the first eight waves of the ITC Netherlands Survey were conducted, respondents were lost to attrition, as they are in any longitudinal cohort study. To compensate for this attrition and maintain a sufficient sample size, new respondents were recruited in Waves 3 through 8. Therefore, at Waves 3 to 8, the total set of respondents consists of individuals with different levels of prior participation in the ITC Survey. For example, the Wave 4 sample of respondents consists of 583 smokers and quitters who participated in all four survey waves (Waves 1 to 4), 692 smokers and quitters who participated in three survey waves (Waves 2 to 4), 201 smokers and quitters who participated in two survey waves (Waves 3 and 4), and 579 smokers who participated in one survey wave (those who were newly recruited in Wave 4). The composition of the sample is important because responses to survey questions have been shown to vary systematically as a function of the number of times that a respondent has completed the ITC survey. Newly recruited respondents may vary in their responses compared to those with one prior wave, who may vary from those with two prior waves, and so on. These documented effects are known as “time-in-sample” (TIS) effects and have been found in the ITC surveys in other countries and in many other longitudinal surveys as well. The analytic methods described next provide adjustments for time-in-sample and some other potentially confounding factors.

**Analytic methods**

Statistical methods appropriate for analyzing data arising from complex surveys were employed and the results are weighted so as to be representative of the population of Dutch smokers. To assess temporal changes in any of the many variables measured in the ITC Netherlands Survey, data from Waves 1 to 8 (with the exclusion of Wave 2 data) of the ITC Netherlands Survey were used to estimate the longitudinal trends in a measure of interest, unless otherwise stated. Wave 2 data were not included as the sample only included a subset of the Wave 1 cohort. Quitters were grouped with smokers in the analysis where appropriate. The analytical dataset for respondents in Waves 1 to 8 is based on 4,536 unique smokers and has a total of 14,398 observations. Among these 14,398 observations, 2,224 are from Wave 1 smokers, 2,013 are from Wave 3 smoker and quitters, 2,060 are from Wave 4 smokers and quitters, 2,101 are from Wave 5 smokers and quitters, 2,022 are from Wave 6 smokers and quitters, 1,970 are from Wave 7 smokers and quitters, and 2,008 are from Wave 8 smokers and quitters.

If the same questions are asked across waves and an outcome of interest is categorical then a complex survey logistic regression approach is used to generate standardized or adjusted values of the descriptive statistics (proportions) over time, where feasible. Variables like sex, age group, city group, smoking status, wave, and time-in-sample (the number of times a respondent has participated in the survey, a time-varying quantity over time) can be included in the model as covariates, and the measure of interest is used as the response variable. Strata and cluster information as well as survey weights are also taken into account. Based on the logistic model generated, the time specific least squares means of the response variable can be calculated using the parameter estimates from the regression model, assuming the overall distributions of the covariates in the data combined across all waves. This approach is called a logistic regression adjustment for descriptive statistics. Similarly, if the measure of interest is continuous, a complex survey linear regression model is used for adjustment. This method is directly analogous to age adjustment when comparing mortality in two or more populations in epidemiology and demography.
Newly recruited respondents may vary in their responses compared to those with one prior wave, who may vary from those with two prior waves, and so on. These documented effects are known as “time-in-sample” (TiS) effects. The analytic methods provide adjustments for TiS and other potentially confounding factors.

It should also be noted that the percentages for the Netherlands presented in cross-country comparisons may vary slightly from the Wave 8 Survey results provided for the same measures due to differences in adjustment methods.
SMOKING BEHAVIOUR

Under the WHO FCTC, Parties are obligated to implement measures to prevent and reduce tobacco consumption and to monitor the magnitude and patterns of tobacco use, with the goal of protecting public health. The ITC Netherlands Wave 1 to 8 Surveys include several measures to assess tobacco use behaviour, such as consumption of cigarettes and other tobacco products, brand choice, and use of alternative nicotine products such as electronic cigarettes. The Surveys also measure smokers’ perceptions and attitudes about smoking, such as opinions about smoking and regret for smoking initiation.

Cigarette Consumption

The majority of cigarette smokers in the Wave 1 to 8 Surveys reported being daily cigarette smokers. Between 89% and 94% of smokers reported daily use across Waves 1 to 8 (see Figure 3).

Among daily cigarette smokers, the average number of cigarettes smoked per day (CPD) was 15 across all waves, except at Wave 3 when it was 16 CPD. This is less than a full-pack of 19 cigarettes. ITC cross-country comparisons indicate that on average, Dutch smokers are not heavy smokers in comparison with daily smokers in other high-income countries (see Figure 4).

Figure 3. Percentage of daily and non-daily smokers, by wave
Perceived addiction to cigarettes

The Wave 1 to 8 Surveys asked smokers if they considered themselves “not at all”, “somewhat”, or “very” addicted to cigarettes. Findings indicate that most smokers considered themselves addicted, with over 40% of smokers across Waves 1 to 8 who said they were “very addicted” to cigarettes, and between 38%-47% who said they were “somewhat addicted”. The percentage of smokers who considered themselves “not at all addicted” was lowest, although it increased between Wave 1 (9%) and Wave 8 (20%).
Type of cigarettes smoked

Smokers at each wave were asked what type of cigarettes they smoke – factory-made cigarettes only, roll-your-own (RYO) cigarettes only, or both. Figure 6 indicates that between Waves 1 to 8, the majority of smokers reported smoking exclusively factory-made (FM) cigarettes, with percentages increasing from 42% of smokers at Wave 1 to 55% at Wave 8. The percentage of smokers reporting exclusive RYO tobacco use decreased from 34% at Wave 1 to 26% at Wave 8, and use of both forms of cigarettes decreased from 24% to 18%.
Although the prevalence of RYO cigarette smokers has decreased from 2008 to 2014, the Netherlands still has the second-highest percentage of smokers who smoke exclusively RYO cigarettes (30%) among 12 high- and middle-income ITC countries, and the highest percentage of dual FM and RYO tobacco use (17%) (see Figure 7). ii

![Figure 7. Percentage of smokers who smoke factory-made cigarettes only, roll-your-own tobacco only, or both types of cigarettes, by country](image)

The Netherlands has the second-highest percentage of smokers who smoke exclusively RYO cigarettes (30%) among 12 high- and middle-income ITC countries, and the highest percentage of dual factory-made and RYO tobacco use (17%).

ii. As noted in the Analytic Approach section of this report, the percentages in Figure 7 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 7 differ slightly than the percentages shown in Figure 6.
Smokers’ regret for smoking

Smokers’ regret for ever having started smoking is an important indicator of societal norms about tobacco use and is also a predictor of future quitting behaviour. The Wave 1 to 8 Surveys asked smokers whether they would not have started smoking if they had to do it all over again. Approximately three-quarters of smokers across all waves “strongly agreed” or “agreed” that they would not have started smoking if they had to do it over again (see Figure 8).

![Figure 8. Percentage of smokers who “agree” or “strongly agree” that if they had to do it over again, they would not have started smoking, by wave](image)

Figure 9 indicates that although the large majority (74% at Wave 8) of smokers in the Netherlands regret smoking, Dutch smokers have among the lowest levels of regret for smoking initiation of 13 high- and middle-income ITC countries.

Although the large majority (74% at Wave 8) of smokers in the Netherlands regret smoking, Dutch smokers have among the lowest levels of regret for smoking initiation of 13 high- and middle-income ITC countries.
Smokers’ overall opinion about smoking

The Wave 1 to 8 Surveys asked smokers about their overall opinion of smoking. Figure 10 indicates that across all survey waves, the majority of smokers (61% to 67%) had a neutral ("neither a positive nor negative") opinion of smoking. About one-quarter of smokers (21% to 27% across all waves) had a “negative” or “very negative” opinion of smoking, while less than 15% of smokers had a “positive” or “very positive” opinion.
ITC cross-country comparisons indicate that smokers in the Netherlands are among the least negative about smoking compared to other high- and middle-income countries (see Figure 11). Only 21% of smokers in the Netherlands had a negative opinion of smoking – the second-lowest percentage of 13 ITC countries.

As noted in the Analytic Approach section of this report, the percentages in Figure 11 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 11 differ slightly than the percentages shown in Figure 10.
Non-cigarette smoked tobacco product use

The Waves 1, 3, 4, and 5 Surveys asked smokers if they had smoked tobacco products besides cigarettes or RYO tobacco in the past month. Use of another smoked product was reported by 8% of smokers at Wave 1, 7% at Wave 3, and 5% at Waves 4 and 5. At Wave 5 (2011), the main types of non-cigarette smoked tobacco products used by smokers were hand-rolled marijuana/joints (2%) and cigars (2%), while less than 1% reported using cigarillos, pipes, or waterpipes in the past month.

Smokers’ awareness and use of e-cigarettes

The Waves 1, 4, 7, and 8 Surveys asked smokers if they had ever heard of electronic cigarettes (e-cigarettes). Awareness of e-cigarettes was high, with over 90% of smokers reporting that they had heard of e-cigarettes at each wave (98% at Wave 1; 92% at Waves 4 and 7; 94% at Wave 8).

At Wave 1, 13% of all smokers reported that they had ever tried an e-cigarette and 12% reported ever trying an e-cigarette at Wave 4 (see Figure 12). This percentage increased in more recent waves, with 18% of smokers at Wave 7 and 38% at Wave 8 reporting ever having tried an e-cigarette. The percentage of smokers who reported that they had ever bought an e-cigarette was lower than the percentage who had ever tried them - only 6% of smokers had ever bought one at Wave 1 and 10% had bought one at Wave 7 (the only waves in which the question was asked).

Figure 12. Smokers’ e-cigarette use and purchasing behaviour, by wave

Cross-country comparisons indicate that rates of e-cigarette use in the Netherlands are much higher than in middle-income countries, but are comparable to other high-income countries such as the United States, United Kingdom, and Canada. Among 12 high- and middle-income ITC countries, the Netherlands has the second highest percentage of male smokers and quitters (41%, tied with the United Kingdom) and the third highest percentage of female smokers and quitters (36%, tied with Canada) who have ever tried e-cigarettes (see Figure 13). Previous research conducted with earlier waves of data from these same ITC countries shows that rates of e-cigarette use have increased in most high-income countries over the past few years.53
Figure 13. Percentage of smokers and quitters who have ever used e-cigarettes, by country

The Wave 1, 7, and 8 Surveys asked smokers who had ever tried e-cigarettes how often they currently use e-cigarettes. As shown in Figure 14, most smokers do not use e-cigarettes frequently. The majority of smokers currently used e-cigarettes less than once a month or had stopped altogether: 12% of all smokers at Wave 1, 19% of all smokers at Wave 7, and 20% of all smokers at Wave 8. Daily e-cigarette use was less than 1% of all smokers at Wave 1; less than 1% of all smokers at Wave 7, and increased to 5% of all smokers at Wave 8. Weekly or monthly e-cigarette use was 2% of all smokers at Wave 1, 2% of all smokers at Wave 7, and increased to 7% of all smokers at Wave 8.

Frequency of e-cigarette use

The Wave 1, 7, and 8 Surveys asked smokers who had ever tried e-cigarettes how often they currently use e-cigarettes. As shown in Figure 14, most smokers do not use e-cigarettes frequently. The majority of smokers currently used e-cigarettes less than once a month or had stopped altogether: 12% of all smokers at Wave 1, 19% of all smokers at Wave 7, and 20% of all smokers at Wave 8. Daily e-cigarette use was less than 1% of all smokers at Wave 1; less than 1% of all smokers at Wave 7, and increased to 5% of all smokers at Wave 8. Weekly or monthly e-cigarette use was 2% of all smokers at Wave 1, 2% of all smokers at Wave 7, and increased to 7% of all smokers at Wave 8.
ITC cross-country comparisons indicate that current (at least monthly) use of e-cigarettes in the Netherlands is higher than in most other countries where current use is evaluated, but comparable to rates of current use in the United Kingdom and United States. The Netherlands has the third highest percentage of male (13%) and female (12%) smokers and quitters who currently use e-cigarettes out of 8 ITC countries (see Figure 15).

At Wave 8, current e-cigarette users were asked about their plans for future use of e-cigarettes. Almost two-thirds of current users (63%) reported that they plan to “keep using” e-cigarettes, while 37% reported that they “plan to stop sometime in the foreseeable future”.

**Current (at least monthly) use of e-cigarettes in the Netherlands is higher than in most other ITC countries where current use is evaluated, but comparable to rates of current use in the United Kingdom and United States.**
Conclusions

The ITC Netherlands Wave 1 to 8 (2008-2014) Surveys showed that the majority (89% to 94%) of Dutch smokers are daily smokers. Exclusive use of factory-made cigarettes increased from 42% of smokers at Wave 1 to 55% of smokers at Wave 8. Although use of roll-your-own (RYO) cigarettes and both factory-made and RYO cigarettes decreased between Waves 1 to 8, the Netherlands still has the second-highest use of these forms of tobacco among 12 high- and middle-income ITC countries.

Across Waves 1 to 8, the majority of smokers reported that they were either “somewhat” (38% at Wave 8) or “very” addicted (42% at Wave 8) to cigarettes, while the percentage of smokers who reported that they were “not at all” addicted increased between Wave 1 (9%) and Wave 8 (20%). Although approximately three-quarters (74% at Wave 8) of smokers reported that they regret smoking, Dutch smokers have one of the lowest levels of regret among 13 high- and middle-income ITC countries. Only 21% of smokers had a negative opinion of smoking – the second lowest percentage of 13 high- and middle-income ITC countries.

The majority (94% at Wave 8) of Dutch smokers have heard of electronic cigarettes (e-cigarettes), and 38% of smokers at Wave 8 had ever tried them. ITC cross-country comparisons indicate that the Netherlands has the third highest percentage of ever trying e-cigarettes among 12 high- and middle-income ITC countries. However, at Wave 7, only 10% of all smokers had ever purchased an e-cigarette. Daily use of e-cigarettes increased from less than 1% of all smokers at Wave 7 to 5% of all smokers at Wave 8, and the rate of any current use (at least monthly) was 12% at Wave 8. The rate of current e-cigarette use in the Netherlands is higher than in most other ITC countries, but comparable to certain high-income countries such as the United States and United Kingdom. These findings support those published by Hummel et al. (2015), who noted that both awareness and current use of e-cigarettes among cohort respondents in the ITC Netherlands Survey decreased from 2008 to 2013, but increased again in 2014 following the removal of the ban on advertising. This increase is also consistent with trends in other countries.
TOBACCO PRICE AND TAXATION

Substantially increasing tobacco taxes and prices is recognized worldwide as the single most cost-effective measure of tobacco control and is a critical component of a comprehensive tobacco control strategy. Higher taxes and prices on tobacco products are known to: (1) reduce overall tobacco consumption and prevalence of tobacco use; (2) prevent initiation among youth; and (3) promote cessation among current users. Article 6 of the FCTC calls on Parties to adopt and maintain taxation and pricing measures that will “contribute to the health objectives aimed at reducing tobacco consumption”. Guidelines for Article 6 were adopted at the sixth Conference of the Parties (COP6) in October 2014 and recommend that Parties should establish long-term coherent taxation structures which emphasize mixed excise systems with minimum specific tax floors, and comparable tobacco product pricing. The taxation structures should also be monitored, increased, or adjusted on a regular basis in accordance with price and income elasticity of demand and inflation and changes in household income.

In addition to regular tax adjustments based on price changes, cigarette taxes were autonomously increased four times in the Netherlands between the Wave 1 (March - April 2008) and Wave 8 (May - July 2014) ITC Surveys, resulting in a 50.6% price increase on a 19 pack of cigarettes, and there have been four tax increases on roll-your-own (RYO) tobacco leading to a 56.9% price increase. In 2014, the total excise tax (both specific and ad valorem taxes) excluding VAT on a pack of 19 Marlboro brand cigarettes was 56%, which falls considerably short of the WHO target of at least 70% of the retail price. Of 28 countries in the European Union, the Netherlands had the fourth-lowest total tax share (73.4%, including VAT) in 2014 on the most sold brand according to data collected by the WHO.

This section presents ITC Netherlands Wave 1 to 8 Survey findings on the extent to which these tax increases, and the resulting prices of tobacco products, influenced smokers’ reasons for brand and product selection, thoughts about quitting, perceptions of smoking costs, and purchasing behaviour.

Reasons for brand choice

The ITC Netherlands Wave 1 to 8 Surveys asked smokers if they have a regular brand and variety of cigarettes. At least 88% of smokers across Waves 1 to 8 said that they do have a regular brand and variety. Smokers with a regular brand were then asked whether factors such as taste, the design of the pack, price, and concerns about health were reasons for their brand choice. Figure 16 indicates that taste was the most frequently reported reason for brand choice across Waves 1 to 8, ranging from 77% of smokers (at Wave 3) to 84% (Wave 8). Price was the second most common reason for brand choice and was reported by over one-third of smokers across all waves, with a significant increase from 34% of smokers at Wave 3 to 44% at Wave 7. This increase may be related to the various tax increases that were implemented in this period that resulted in a 30% total price increase on a pack of 19 Marlboro cigarettes between 2009 (€4.60 per 19 pack) and 2013 (€6.00).

Package design and concerns about health were the least common reasons for brand choice, with less than 12% of smokers selecting these reasons across Waves 1 to 8.

Price was the second most common reason for brand choice and was reported by over one-third of smokers across all waves, with a significant increase from 34% of smokers at Wave 3 to 44% at Wave 7.
Figure 16. Reasons for brand selection among smokers who had a regular brand of cigarettes, by wave

Reasons for smoking roll-your-own cigarettes

The Wave 1 to 8 Surveys asked smokers of roll-your-own (RYO) cigarettes whether they smoked RYO cigarettes because “they are less expensive”, and because “they taste better”. Figure 17 indicates that the majority of RYO smokers identified both price and taste as important reasons for smoking RYO cigarettes. Between Waves 1 and 8, the percentage of smokers who reported smoking RYO cigarettes because “they are less expensive” ranged from 74% to 82%, and the percentage of smokers who reported that they smoked RYO cigarettes because “they taste better” ranged from 72% to 79%.

These findings are consistent with previous studies demonstrating that price is a strong motivator for smoking RYO cigarettes, given that taxes on RYO tobacco are considerably lower than taxes on cigarettes throughout the world. This is even more true among youth, who are more likely to smoke RYO cigarettes because they are less expensive than adults.7,57
Figure 17. Reasons for smoking roll-your-own cigarettes (RYO) among smokers who reported exclusive RYO tobacco use, and factory-made and RYO use, by wave

Price as a reason to quit smoking

Smokers who reported that they were planning to quit smoking or who had recently quit were asked whether the price of cigarettes led them to think about quitting either “somewhat”, “very much”, or “not at all” in the last 6 months. Across Waves 1 to 8, over half of smokers who were planning to quit and recent quitters (50%-69%) reported that the price of cigarettes “somewhat” or “very much” led them to think about quitting smoking (see Figure 66 in the Cessation chapter). There was an increase in the percentage of smokers and quitters who reported price as a reason from 59% at Wave 4 to 69% at Wave 7. This increase corresponds with a tobacco tax increase of €0.22 on cigarettes (for a 19 pack) and RYO tobacco (per 45g) in March 2011 and another tax increase on cigarettes of €0.35 (19 pack) and €0.60 on RYO tobacco (40g) in January 2013.

While price was one of the most frequently reported reasons for thinking about quitting among smokers at Wave 8, ITC cross-country comparisons indicate that price is not as strong a motivator of thoughts about quitting in the Netherlands in comparison to other countries. Out of 9 high-income countries, the Netherlands has the second-lowest percentage of smokers and quitters (57%) who said that the price of cigarettes led them to think about quitting (or helped them to stay quit) “sometimes” or “very much” in the last 6 months (see Figure 18). This suggests that cigarettes are more affordable for Dutch smokers compared to smokers in other countries, and the price of cigarettes could be increased considerably in the Netherlands in order for price to be a stronger motivator of thoughts about quitting.

iv. As noted in the Analytic Approach section of this report, the percentages in Figure 18 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 18 differ slightly than the percentages shown in Figure 66.
Figure 18. Percentage of smokers and quitters who reported that the price of cigarettes led them to think about quitting (or to stay quit) “somewhat” or “very much” in the last 6 months, by country.

† Results were calculated for smokers who reported that they plan to quit, and for those who had quit more than 6 months ago.
* In Bangladesh, India, Mauritius, and Zambia, the response options were yes/no versus very much/somewhat/not at all. The percentage of respondents who answered “yes” is shown. In these countries, there was also no time frame of 6 months.
Concern about money spent on cigarettes

The Wave 1 to 8 Surveys asked smokers and quitters if they had spent money on cigarettes or tobacco that they knew would be better spent on household essentials like food in the last 6 months. Between Waves 1 to 8, less than one-quarter of smokers and quitters reported spending food money on cigarettes. There were two significant increases in the percentage of smokers and quitters who reported that they spent food money on cigarettes: from 15% at Wave 1 to 21% at Wave 3; and from 15% at Wave 4 to 20% at Wave 6. The time period for these increases corresponds with the July 2008 tax increase of €0.29 on cigarettes and €0.46 on RYO tobacco and the March 2011 tax increase of €0.22 on cigarettes and RYO tobacco (see Figure 19). However, there was no increase following the January 2013 tax increase on cigarettes and RYO tobacco, which was larger than the previous tax increases.

Smokers were also asked how often they thought about the money they spend on smoking in the last month. As shown in Figure 20, only about one-quarter of smokers (19%-28% across all waves) said they thought “often” or “very often” about the money they spend on smoking in the last month, with an increase from 22% at Wave 4 to 28% at Wave 6, after the March 2011 tax increase. About one-third (30%-38%) said they “sometimes” thought about the money they spend on smoking, and over one-third of smokers said they “never” or “rarely” thought about the money they spend. The percentage of smokers who said they “never” or “rarely” thought about the money they spend decreased overall from 51% at Wave 1 to 39% at Wave 8, with the sharpest declines between Waves 1 and 3, and between Waves 4 and 5, corresponding to the 2008 and 2011 tax increases on cigarettes and RYO tobacco. These findings suggest that price increases do affect how smokers think about their cigarette purchases. However, the same pattern was not observed after the January 2013 tax increase.
Comparisons with other ITC countries show that of 8 high-income countries, Dutch smokers and quitters have the lowest rates of reporting that they “often” or “very often” thought about the money they spend (or have spent) on smoking in the last month (23%), and the fourth-lowest percentage overall out of 18 ITC countries (see Figure 21).°

Dutch smokers and quitters have the lowest rates of reporting that they “often” or “very often” thought about the money they spend (or have spent) on smoking in the last month (23%) of 8 high-income countries, and the fourth-lowest percentage overall out of 18 ITC countries.

° As noted in the Analytic Approach section of this report, the percentages in Figure 21 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 21 differ slightly than the percentages shown in Figure 20.
Figure 21. Percentage of smokers and quitters who reported that they thought about the money they spend (or have spent) on smoking “often” or “very often” in the last month, by country.

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>High Income</th>
<th>Middle Income</th>
<th>Low Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>France 2012</td>
<td></td>
<td>61%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia 2013</td>
<td></td>
<td>56%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada 2013-14</td>
<td></td>
<td>52%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom 2013</td>
<td></td>
<td>49%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand 2008-09</td>
<td></td>
<td>47%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States 2013-15</td>
<td></td>
<td>46%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany 2011</td>
<td></td>
<td>35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands 2014</td>
<td></td>
<td>23%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brazil 2012-13</td>
<td></td>
<td></td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>Thailand 2012</td>
<td></td>
<td></td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Mauritius 2011</td>
<td></td>
<td></td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>Uruguay 2012</td>
<td></td>
<td></td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Zambia* 2012</td>
<td></td>
<td></td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Mexico 2012</td>
<td></td>
<td></td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td>Malaysia 2013</td>
<td></td>
<td></td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>India* 2012-13</td>
<td></td>
<td></td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>China* 2011-12</td>
<td></td>
<td></td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td>Bangladesh* 2011-12</td>
<td></td>
<td></td>
<td>19%</td>
<td></td>
</tr>
</tbody>
</table>

* In China, India, Zambia, and Bangladesh, the response options did not include “very often”, so the results shown are for “often” only.
Affordability of cigarettes

Data from the ITC surveys also allows for an analysis of the affordability of manufactured cigarettes across countries, which refers to the quantity of resources (or income) that is required to purchase a pack of cigarettes, and is a ratio of household income to the price of tobacco products. Higher affordability, for example, means that the price of a pack of cigarettes would require a lower percentage of one's daily income.

An Affordability Index was constructed using ITC Netherlands data to determine the changes in cigarette affordability between the Wave 1 (2008) and Wave 8 (2014) Surveys. This analysis took into account ITC data on price paid for the most recent factory-made cigarette purchase, number of cigarettes smoked per day, and household income. The Affordability Index was calculated as the reciprocal of the percentage of daily household income spent on a pack of cigarettes (cigarette price per daily income ratio or CPDIR); therefore, higher numbers of the Affordability Index represent greater affordability (a lower percentage of income spent on cigarettes).

The results show that factory-made cigarettes became more affordable between Wave 1 and Wave 4, with a 12.5% increase in affordability from Wave 1 (20.7) to Wave 4 (23.2) (see Figure 22). However, affordability then decreased from Wave 5 (18.3) to Wave 8 (17.3), with an overall 16.3% decrease in affordability between Wave 1 and Wave 8.

Figure 22. Affordability Index for factory-made cigarettes in the Netherlands, by wave

Notes:
(a) Data are for factory-made cigarette smokers.
(b) The percentages are adjusted by sex, age group, smoking status (daily/non-daily), number of adults in the household, and time in sample.
(c) This analysis took into account ITC data on price paid for the most recent factory-made cigarette purchase, number of cigarettes smoked per day, and household income in order to calculate the cigarette price per daily income ratio (CPDIR), which represents the percentage of household daily income spent on a pack of cigarettes. A lower CPDIR means that cigarettes are more affordable; therefore, we calculated the Affordability Index as the reciprocal of CPDIR so that higher affordability numbers represent greater affordability of cigarettes.

E.g., at Wave 8, the adjusted CPDIR = 0.0075. Therefore, the Affordability Index = 1/0.0075 = 13.3.
(c) Tax increases above are based on a pack of 19 Marlboro cigarettes, except for the increase in 2008, which was based on a pack of 20 cigarettes. Tax increases for RYO tobacco are based on 50 grams for 2008, 47.5 grams for 2010, 45 grams for 2011, and 40 grams for 2013.
A similar analysis was done to compare the change in the Affordability Index in the Netherlands to 16 other ITC countries. This analysis allows for a comparison of the average change in affordability of a pack of factory-made cigarettes per year over the entire survey period for each country. As shown in Figure 23, cigarettes became less affordable overall from Wave 1 to Wave 8 in the Netherlands, with an average annual decrease in the Affordability Index of 1.25%. This is similar to other high-income ITC countries, although other European countries have had larger average annual decreases in affordability, such as Germany (-1.56% per year) and France (-1.71% per year).

Figure 23. Affordability of manufactured cigarettes and change in affordability per year in 17 ITC countries

Figure 23 presents data for 17 ITC countries (males only): (a) Estimates were adjusted for age group, smoking status (daily/non-daily), number of adults in the household, and time in sample. (b) Data presented for Mauritius is for Wave 2 (2010) and Wave 3 (2011). Data for the South Korea is presented for Wave 1 (2005) and Wave 2 (2008). Data for all other countries is for the year of the first survey wave and of the most recent wave. (c) Note that CPDIR is the cigarette price per day to daily income ratio, (d) Affind Initial: the Affordability Index (the reciprocal of CPDIR) for the initial wave, which is the percentage of household income spent on cigarettes (e) Affind Latest: the Affordability Index (the reciprocal of CPDIR) for the most recent wave.

* Change in Affordability Index per year = (% change in Affind between the first survey wave and the most recent survey wave) / (Difference between the date at the 1/3 timepoint of the first survey wave interviewing period and the date at the 1/3 timepoint of the most recent survey wave interviewing period, in years). The date corresponding to 1/3 of the survey wave interviewing period was chosen because it was the approximate point at which 50% of the respondents had been interviewed for that survey wave in each country.
Source of last cigarette purchase

At Waves 1, and 4 to 8, smokers were asked where they last bought cigarettes for themselves. As shown in Figure 24, the most commonly reported source for purchasing cigarettes was from a grocery store (49%-58% of smokers across all waves). The percentage of smokers who reported last buying cigarettes from a grocery store decreased from 58% at Wave 1 to 54% at Wave 4, and again from 56% at Wave 6 to 49% at Wave 7. Other common sources for purchasing cigarettes were from a tobacconist (14%-17% of smokers across Waves 1 to 8) or a gas station (14%-20% across Waves 1 to 8).

Very few smokers from Waves 1 to 6 reported their last purchase as being from outside the country, but in the European Union (1%-5%), but this percentage increased from 5% at Wave 6 to 9% at Waves 7 and 8.

Findings also indicate that 4% of smokers or less reported purchasing cigarettes from other locations such as bars, restaurants, or entertainment establishments; newsstands; and outside of the European Union between Waves 1 to 8; and 1% or less last purchased cigarettes from a duty-free shop, from the Internet, from independent sellers (e.g., door-to-door, in the street), through the mail, or from vending machines.

Figure 24. Source of last cigarette or tobacco purchase among smokers, by wave

Note: At Wave 3, this question was only asked in the telephone survey, not the web survey. Due to the smaller sample size at Wave 1, the results were excluded from this figure.
Tax increases above are based on a pack of 19 Marlboro cigarettes, except for the increase in 2005, which was based on a pack of 20 cigarettes.
Tax increases for RYO tobacco are based on 50 grams for 2008, 47.5 grams for 2010, 45 grams for 2011, and 40 grams for 2013.
Tax evading purchases

The Wave 1 to 8 Surveys asked smokers and recent quitters if in the last 6 months, they had bought cigarettes or tobacco from outside the Netherlands, but inside the European Union (EU), or from outside the EU. Figure 25 indicates that the percentage of smokers and recent quitters who reported that they had bought cigarettes or tobacco in other EU countries in the last 6 months increased overall from 12% at Wave 1 to 26% at Wave 8. This increase may be related to the tax increases on cigarettes and RYO tobacco between 2008 and 2013. There were far fewer smokers and recent quitters who reported purchasing cigarettes or tobacco from outside of the EU (less than 9% across all waves), but this percentage increased from 5% at Wave 5 to 8% at Wave 7.

Figure 25. Percentage of smokers and recent quitters who reported purchasing cigarettes or tobacco outside the country but in the European Union (EU), and outside of the EU, in the last 6 months, by wave

Frequency and location of cigarette or tobacco purchases out of country, but within the European Union (EU)

Smokers and recent quitters who reported purchasing cigarettes or tobacco from outside of the Netherlands, but inside the EU in the last 6 months were asked how often they did so. The majority of smokers and recent quitters who reported purchasing cigarettes or tobacco out of country, but within the EU in the last 6 months did so only “once” (51% at Wave 8) or “a few times” (45% at Wave 8). Across all waves, less than 10% reported that they purchased out of country “many times” or “all of the time”, with the exception of Wave 3 (25%) and Wave 6 (20%).

In the Wave 6 to 8 Surveys, smokers who reported buying cigarettes or tobacco at their last purchase outside of the country, but in the EU (1% to 9% of smokers across Waves 1 to 8) were asked which country they made their purchase in. More than two-thirds of these smokers (74% at Wave 6, 67% at Wave 7, 75% at Wave 8) reported that Belgium was the country where they made their last tobacco or cigarette purchase. Other countries reported were: Luxembourg (4% at Wave 8); Germany (4% at Wave 8); and Spain (4% at Wave 8). Less than 5% of smokers who reported buying cigarettes or tobacco at their last purchase outside of the country, but in the EU, reported to have made their last cigarette or tobacco purchase in the following EU countries: Cyprus, Denmark, Greece, Italy, Austria, Poland, and the Czech Republic.
Conclusions

The ITC Netherlands Wave 1 to 8 (2008-2014) Survey findings indicate that the affordability of manufactured cigarettes has decreased over time in the Netherlands, which may be related to the various tax increases that occurred during this time. Although the majority of Dutch smokers and quitters identified price as a reason to quit and this percentage increased over time, ITC cross-country comparisons indicate that this percentage, as well as the percentage who said they thought often about the money they spent on smoking, is still lower than in other countries. These findings suggest that tobacco prices could still be increased further in the Netherlands in order to reduce affordability and increase motivation to quit.

There was a significant increase in the percentage of smokers who reported purchasing cigarettes or tobacco outside of the country, but within the European Union in the last 6 months, from 12% at Wave 1 to 26% at Wave 8. Over 65% of smokers who made such purchases did so in Belgium. However, the actual frequency of these cross-border purchases was low, with the majority of smokers reporting such purchases only once or a few times in the last 6 months between Waves 1 to 8. This is consistent with previous ITC research showing that frequent cross-border purchases were less common in the Netherlands than in European regions bordering countries with lower cigarette prices, such as certain provinces/states in France and Germany.

As noted in the Smoking Behaviour chapter, ITC cross-country comparison data indicate that roll-your-own tobacco use is high in the Netherlands, with the second-highest percentage of exclusively RYO smokers (30%) and the highest percentage of both factory-made and RYO smokers (17%) among 12 high and middle-income countries. Although there is no evidence of a significant increase in RYO use between 2008 and 2014, the fact that from 2012 to 2014 the cheaper price was cited by 82% of RYO users as a reason for smoking RYO tobacco suggests that further steps need to be taken to reduce the price advantage, particularly for youth smokers. Such steps should include harmonizing tax rates between cigarettes and RYO tobacco products in accordance with FCTC Article 6 Guidelines, in order to minimize the incentive to switch to cheaper products.

In addition, the findings indicate that the Dutch Government should ensure continued reductions in tobacco affordability by using a combination of inflation and income-adjusted tax increases. The minimum excise tax burdens and excise tax floors, set out in the European Union Directive 2011/64/EU will also help to reduce price differentials between lower income-earning European Union Member States, and increase overall tax harmonization in the European Union, both of which would contribute to reduced cross-border tobacco purchasing.
Article 8 of the FCTC obligates Parties to adopt and implement effective measures providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places. Article 8 Guidelines recommend a comprehensive ban on smoking in public places, and state that designated smoking areas or rooms do not provide adequate protection from exposure to secondhand smoke. The Guidelines also state that each Party should strive to provide universal protection from exposure to secondhand smoke within 5 years of the Convention’s entry into force for that Party. As a Party to the FCTC since 2005, the Netherlands was obligated to implement comprehensive smoke-free legislation by 2010.

In 2004, the Netherlands implemented a smoking ban in workplaces, and beginning in 2008, additional smoke-free legislation was introduced covering hospitality venues. During the ITC Netherlands Wave 1 to 8 (2008-2014) Surveys, four key smoke-free policy decisions were implemented:

1) In July 2008, smoking was banned in the hospitality industry, sports sector, and the arts and culture sector, except in designated areas not serviced by employees.

2) In July 2009, the ban was suspended in small owner-run pubs and cafés.

3) In February 2010, the Supreme Court overturned this decision and ruled that the ban applied to all pubs and cafés.

4) In November 2010, the new Minister of Health announced a partial reversal of the smoking ban, this time exempting cafés smaller than 70 m² without employees.

The ITC Netherlands Wave 1 to 8 Surveys evaluated the impact of these policy decisions. Specifically, the Surveys measured smokers’ awareness of smoke-free laws in hospitality venues and workplaces, compliance with smoke-free laws in these venues, smoking in the home, and support for smoke-free laws.

Smokers’ perceptions of smoke-free laws in cafés and pubs

The Wave 1 to 8 Surveys asked smokers about their awareness of smoke-free laws in cafés and pubs where they live. The percentage of smokers who reported that there were “no rules or restrictions” on smoking in cafés and pubs where they live decreased after the implementation of the smoking ban in hospitality venues in July 2008 from 43% at Wave 1 (3 months before the ban) to 2% at Wave 3 (9 months after the ban) and remained low at less than 5% across all subsequent survey waves (see Figure 26).

The percentage of smokers who reported that “smoking is not allowed in any indoor area” increased after the July 2008 smoking ban from 10% at Wave 1 to 41% at Wave 3 and then decreased to 32% at Wave 5 during the café ban suspension and reinstatement period (July 2009 to November 2010). During this same period, there was an increase in the percentage of smokers who thought that “smoking is allowed in some indoor areas”, from 38% at Wave 3 to 43% at Wave 6. These results suggest that the numerous changes in the smoke-free law in small cafés and bars in 2009 and 2010 may have caused confusion about the rules among smokers, in addition to poor compliance with the ban.

At Wave 3, a new response option “every café and pub has their own rules” was added to the answering options of the question in the survey. The percentage of smokers who selected this response ranged from 19% at Wave 3 to 24% at Wave 6, further supporting the finding that the smoke-free rules for small cafés and pubs were not clearly understood nor consistently enforced across all venues.

The percentage of smokers who stated that smoking was not allowed in any indoor areas in cafés and pubs increased after the Parliament voted in favour of the motion to reinstate the ban in February 2013 (from 31% at Wave 6 to 40% at Wave 7), although a complete smoking ban was not actually reinstated until October 2014, after the Wave 8 Survey.
Figure 26. Smokers’ perceptions of rules and restrictions on smoking in cafés and pubs, by wave

Noticing smoking in cafés and pubs

The Wave 1 to 8 Surveys asked smokers who visited a café or pub whether people were smoking inside the last time they visited. Figure 27 indicates that at Wave 1 (3 months before the ban), 93% of smokers who visited a café or pub saw people smoking in these venues during their last visit. At Wave 3 (9 months after the ban), this percentage decreased to 36%, demonstrating that the ban was effective in reducing smoking in these venues. However, the percentage of smokers noticing people smoking in cafés and pubs increased again between Wave 3 (36%) and Wave 5 (49%) (see Figure 27). The July 2009 suspension of the ban, followed by the February 2010 reinstatement of the ban and second suspension of the ban in November 2010 between the Wave 3 and Wave 5 Surveys may have contributed to confusion around the smoking rules in small cafés, resulting in the increase in observed smoking. The Wave 8 (2014) data shows that more than one-third (38%) of smokers still noticed smoking in cafés and pubs the last time they visited.

The Wave 8 (2014) data shows that more than one-third (38%) of smokers still noticed smoking in cafés and pubs the last time they visited.
ITC cross-country comparisons show that the Netherlands has the third highest percentage of smokers (43%) out of 8 high-income countries, and the eighth highest percentage overall out of 16 countries, who noticed smoking in bars, cafés and pubs among smokers who had visited a bar, café, or pub in the last year (see Figure 28). Figure 28 also shows that the percentage of smokers who noticed smoking in cafés and pubs is much lower in countries that have implemented comprehensive national smoke-free legislation, such as Uruguay (14%), France (7%), and the United Kingdom (6%).

Smokers’ perceptions of smoke-free laws in restaurants

The Wave 1 to 8 Surveys asked smokers about their awareness of smoking rules in restaurants where they live. As shown in Figure 29, the majority of smokers reported that “smoking is not allowed in any indoor area” in restaurants where they live. There was a significant increase in smokers who reported that smoking is not allowed after the implementation of the July 2008 hospitality ban — from 11% at Wave 1 to 71% at Wave 3, and this percentage remained high at 77%-81% in subsequent Waves. At Wave 1, over half (56%) of smokers thought that “smoking is allowed in some indoor areas” but this percentage decreased to 19% at Wave 3 and did not significantly change after Wave 3. Smokers who reported that “every restaurant has their own rules” decreased from 24% at Wave 1 to 4% at Wave 8. Finally, very few smokers reported that there are “no rules or restrictions” on smoking in restaurants where they live (8% of smokers at Wave 1, and less than 1% between Waves 3 to 8) (See Figure 29).

vi. As noted in the Analytic Approach section of this report, the percentages in Figure 28 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 28 differ slightly than the percentages shown in Figure 27.
Figure 28. Percentage of smokers who noticed smoking in cafés and pubs among those who visited a bar, café or pub in the last year, by country

- Republic of Korea (2010): 92%
- Germany (2011): 48%
- Netherlands (2014): 43%
- United States (2010-11): 34%
- France (2012): 7%
- Australia (2013): 6%
- United Kingdom (2013): 6%
- Canada (2010-11): 3%
- China (2011-2012): 88%
- India (2012-13): 85%
- Zambia (2012): 64%
- Thailand (2012): 49%
- Mexico (2012): 48%
- Mauritius (2011): 41%
- Brazil (2012-13): 19%
- Uruguay (2012): 14%
Noticing smoking and smoking behaviour in restaurants

The Wave 1 to 8 Surveys asked smokers who had visited a restaurant whether people were smoking inside during their last visit. Figure 30 indicates that there was a significant decrease in observed smoking in a restaurant at their last visit between Wave 1 (81%) and Wave 3 (4%) and this percentage remained low at Waves 4 to 8, demonstrating that the July 2008 hospitality industry smoking ban was effective in reducing smoking in restaurants.

Figure 30. Percentage of smokers who noticed people smoking inside a restaurant at their last visit, by wave
ITC cross-country comparisons show that observed smoking inside restaurants is low in the Netherlands compared to other countries (see Figure 31). The Netherlands has the fourth-lowest percentage of smokers (4%; the same percentage as the United Kingdom and Brazil) who observed smoking in restaurants out of 17 ITC countries. Only France, Canada, and Australia had lower percentages of smokers who noticed smoking in restaurants.

Figure 31. Percentage of smokers who noticed smoking in restaurants among those who visited a restaurant in the last year, by country

vii. As noted in the Analytic Approach section of this report, the percentages in Figure 31 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 31 differ slightly than the percentages shown in Figure 30.
Figure 32 indicates that among those smokers who said that they had visited a restaurant in the last year, there was a dramatic decrease in the percentage who reported that they smoked inside the restaurants the last time they visited — from 69% at Wave 1 (Mar-Apr 2008), before the July 2008 ban, to 3% at Wave 3 (Mar-May 2009), 9 months after the ban. This low rate of smoking indoors continued across Waves 3 to 8, to a low of 2% at Wave 8. The majority of smokers who smoked at restaurants after the ban said they smoked outdoors: 38-41% of smokers reported smoking outside of the restaurant between Wave 3 and Wave 8. The percentage of smokers who smoked both “inside and outside of restaurants” was low before the ban (4%) and remained low across Waves 3 to 8 (2% at Wave 8).

Support for smoking bans in hospitality and sports venues
The Wave 1 to 8 Surveys asked smokers if they support or oppose a complete smoking ban in restaurants and in cafés, bars, and pubs. Support was higher for smoke-free restaurants compared to cafés, bars, and pubs across Waves 1 to 8. Smokers who reported that they “support or strongly support” a complete restaurant smoking ban increased from 33% at Wave 1 (Mar-April 2008) to 54% at Wave 3 (Mar-May 2009) after the smoking ban, and continued to increase over subsequent waves, to a high of 68% of smokers at Wave 8. The percentage of smokers who reported that they “support or strongly support” a complete smoking ban in cafés, bars, and pubs increased more gradually from 22% at Wave 1 to 36% at Wave 8.

Under the July 2008 hospitality industry smoking ban, which also included the sports sector, enclosed smoking rooms remained permitted as long as no food or beverages were being served. The Wave 1 to 8 Surveys asked smokers if they thought that smoking should “not be allowed indoors at all”, “should be allowed in some indoor areas”, or “should be allowed in all indoor areas” in sports canteens; restaurants; and cafés, bars, and pubs. As shown in Figure 33, there was an increase in the percentage of smokers who support a complete ban on smoking in sports canteens, from 50% at Wave 1 to 79% at Wave 8; which may indicate opposition to the enclosed smoking rooms. Similarly, the percentage of smokers who support a complete ban on smoking in restaurants increased from 21% at Wave 1 to 63% at Wave 8. Support for a complete smoking ban was lower for cafés, bars, and pubs, but also increased over time, from 11% of smokers who said there should be no indoor smoking at Wave 1 to 30% at Wave 8.
Comparisons with other ITC countries show that there is still room for improvement in the level of support for smoke-free bars and restaurants in the Netherlands. Out of 8 high-income countries, the Netherlands has the third-lowest percentage of smokers and quitters who believe smoking should not be allowed at all in either pubs/bars (31%, see Figure 34)\textsuperscript{viii} or in restaurants (64%, see Figure 35).\textsuperscript{ix} Support for smoke-free bars and restaurants tends to be even higher in LMICs.

**Comparisons with other ITC countries show that there is still room for improvement in the level of support among smokers and quitters for smoke-free bars and restaurants in the Netherlands.**
As noted in the Analytic Approach section of this report, the percentages in Figure 34 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 34 differ slightly than the percentages shown in Figure 33.
Figure 35. Percentage of smokers and quitters who think smoking should not be allowed at all in indoor areas of restaurants, by country

ix. As noted in the Analytic Approach section of this report, the percentages in Figure 35 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 35 differ slightly than the percentages shown in Figure 33.
Smokers’ perceptions of smoke-free laws in indoor workplaces

The Wave 1, 6, 7, and 8 Surveys asked smokers who were currently employed outside of the home to describe the smoking policy where they work. Figure 36 indicates that the majority of smokers reported that smoking “is not allowed in any indoor area” of their workplace. There was an increase in reported workplaces with complete smoking bans from 54% at Wave 1 to 72% at Wave 8 and a decrease in workplaces that allowed smoking “in some areas” from 41% at Wave 1 to 26% at Wave 8. The percentage of smokers who said that smoking is allowed “in any indoor area” was low, ranging from 5% at Wave 1 to 2% at Wave 8.

Figure 36. Smokers’ perceptions of rules and restrictions on smoking at their workplace, among those who are employed outside the home, by wave

Noticing smoking in indoor workplaces

The percentage of smokers who reported that people smoked in indoor areas where they work in the last month at Waves 1, 6, 7, and 8 was almost identical to the percentage of smokers who said “smoking is allowed in some areas” in their workplace over the same time period, decreasing from 40% at Wave 1 to 26% at Wave 8.

Smokers’ support for smoking bans in outdoor public places and in cars

The Wave 1 to 8 Surveys asked smokers whether they think smoking should be allowed in various outdoor venues and in cars. Figure 37 indicates that across all surveys, smokers almost unanimously supported a ban on smoking in cars with pre-school children (96-97%) and in schoolyards of primary schools (95-96%). There was also very strong support for a ban on smoking in cars with non-smokers (84-89%). Less than half of smokers believed that smoking should not be allowed within 5 metres of building entrances, although this percentage increased from 25% at Wave 3 to 42% at Wave 8. Support was much lower for smoking bans on outdoor terraces at restaurants (from 4% at Wave 1 to 13% at Wave 8), or on outdoor terraces at bars and pubs (from 3% at Wave 1 to 7% at Wave 8).
Smoke-free homes

The Wave 1 to 8 Surveys asked smokers about rules on smoking inside their homes. Figure 38 shows that between Waves 1 to 8, the percentage of smokers who “never allowed” smoking inside their home increased, from 9% at Wave 1 to 30% at Wave 8. The percentage of smokers who allowed smoking anywhere inside their home decreased from 26% at Wave 1 to 18% at Wave 8, and the percentage who allowed smoking in some rooms also decreased from 60% at Wave 1 to 42% at Wave 8. These findings support other ITC research demonstrating progress on individual-level household smoking bans in Europe after the implementation of smoke-free policies.64
Although home smoking bans have increased over time in the Netherlands, Figure 39 indicates that in 2014, the Netherlands still had the lowest percentage of smokers who “never allow” smoking in their home (33%) among 9 high-income ITC countries, and the second-lowest percentage (the same percentage as Thailand) overall among 19 countries, higher only than in China.

**Figure 39. Percentage of smokers who “never allow” smoking in their home, by country**

As noted in the Analytic Approach section of this report, the percentages in Figure 39 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 39 differ slightly than the percentages shown in Figure 38.

x. As noted in the Analytic Approach section of this report, the percentages in Figure 39 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 39 differ slightly than the percentages shown in Figure 38.
Smoking in cars

The Wave 3 to 8 Surveys asked smokers about smoking rules when there are children in their car. Between Waves 3 to 8, over two-thirds of smokers who have a car said that smoking is “never allowed” when children are in their car, with an increase from 69% at Wave 3 to 79% at Wave 8 (see Figure 40). Less than one-quarter of smokers at each wave reported that smoking is “sometimes allowed”, from 20% at Wave 3 to 16% at Wave 8. A minority of smokers reported that smoking “is always allowed” in their car, and this percentage decreased over time from 12% at Wave 1 to 5% at Wave 8.

Figure 40. Percentage of smokers who reported that smoking is “never”, “sometimes,” and “always,” allowed in their car(s) when there are children in the car, among those who have a car, by wave

In 2014, the Netherlands still had the lowest percentage of smokers who “never allow” smoking in their home (33%) among 9 high-income ITC countries, and the second-lowest percentage overall among 19 countries, higher only than in China.
Conclusions

During the ITC Netherlands Wave 1 to 8 Surveys, overall progress towards implementing smoke-free policies in public places was slow in the Netherlands. Without a strong, well-enforced ban on smoking across workplaces, hospitality venues, and other public places without exceptions, the Netherlands has not yet fulfilled its commitment to the FCTC in implementing a comprehensive ban on smoking in indoor public places. The Supreme Court decision in October 2014 to reinstate the smoking ban in the entire hospitality sector should help to increase clarity regarding smoke-free rules, especially in cafés and pubs, and with strong enforcement should lead to greater compliance with the law. However, the current law is still not compliant with the FCTC Article 8 Guidelines as it allows for designated smoking rooms.

The ITC Netherlands Waves 1 to 8 Survey findings provide evidence that smoke-free legislation has had some impact on reducing exposure to secondhand smoke in cafés and pubs. However, the initial reductions in secondhand smoke that were achieved in the year following the implementation of the smoking ban in July 2008 in these venues (from 93% to 36%) did not progress further between 2009 and 2014, a period in which the law was reversed, then reinstated, and then reversed again for small cafés. In 2014, 38% of smokers still reported noticing people smoking in cafés and pubs during their last visit. Evidence from other ITC countries that have implemented successful smoke-free policies indicates that much higher reductions in indoor smoking can be achieved. For example, in France, observed smoking in bars was reduced from 97% of smokers noticing smoking before the ban, to 4% 10 months after the ban, and remained low at 6% more than 4 years after the ban.

The percentage of Dutch smokers who noticed people smoking inside restaurants decreased following the 2008 ban (from 81% to 4%) and remained low over time; and the percentage of smokers who reported that they smoked inside a restaurant followed a similar pattern, decreasing from 69% before the ban to 3% after the ban. It is encouraging to note that observed smoking inside restaurants is low compared to other countries - the Netherlands has the fourth-lowest percentage of smokers who observed smoking inside restaurants among 17 ITC countries.

Although voluntary bans on smoking in the home have increased from 9% (2008) to 30% (2014) of Dutch smokers, the Netherlands has among the lowest rates of home smoking bans compared to other ITC countries. ITC research indicates that strong smoke-free legislation stimulates the adoption of smoke-free homes by smokers, which not only protect their families from secondhand smoke, but may also help them to quit.

Dutch smokers almost unanimously support smoke-free policies to protect children from exposure to secondhand smoke in cars and in schoolyards. Support for complete smoking bans is higher for sport canteens (79% of smokers in 2014) and restaurants (63%) than for cafés, bars, and pubs (30%) or the outdoor terrace areas of restaurants (13%) or cafés and pubs (7%). The percentage of smokers who support smoke-free bars and restaurants is lower in the Netherlands compared to other ITC countries. However, support for smoke-free policies in these venues has increased over time, and the level of support for a complete smoking ban inside restaurants and pubs is higher than it was in Ireland (45% and 13% respectively) before the implementation of their very successful smoke-free law.

In addition, ITC evidence and other research suggests that support for complete smoking bans will increase after strong, comprehensive bans are implemented. Comprehensive smoke-free laws that are supported by the Government with enforcement and public education efforts will further reduce smoking in public places, continue to increase the adoption of home smoking bans, and will provide an environment that is supportive of quitting. Therefore, the Dutch Government should remove the allowance for designated smoking rooms and implement 100% smoke-free environments in all public places, in accordance with the FCTC Article 8 Guidelines.
TOBACCO HEALTH WARNINGS

Article 11 of the WHO FCTC requires Parties to implement large, visible, rotating health warnings covering at least 50% of the principal display areas of tobacco packs in the country’s principal language within 3 years of ratification. The Guidelines for the implementation of Article 11 recommend that warnings include full-colour pictures covering more than 50% of the front and back of the pack, and prohibit the display of any misleading terms or figures.

In May 2002, the Netherlands became the first European Union (EU) country to implement text-only health warning labels on 30% of the front and 40% of the back of tobacco packages in accordance with the EU Tobacco Products Directive (TPD) 2001/37/EC. The warnings, which were described in the Dutch “Labelling decree for tobacco products”, are positioned at the bottom of both sides of the pack and include two health warning messages for the front and a list of 14 additional messages for the back, which were to be randomly rotated.

There has been little progress since 2002 in strengthening health warnings in the Netherlands – the warnings remained unchanged until March 28, 2014 when the 14 additional text warnings in the Labelling Decree were revised to address a wider range of health effects of smoking. Because this regulation allowed for a two-year transition period for manufacturers to implement the revised warnings, the same warnings have remained on packs throughout the ITC Netherlands Wave 1 (2008) to 8 (2014) Surveys.

The Wave 1 to 8 Surveys evaluated the effectiveness of the current text-only health warnings that have been on packs since May 2002 on smokers’ perceptions and behaviours. The Survey also measured smokers’ support for plain packaging.

Salience of health warnings

The Wave 1 to 8 Surveys asked smokers how often they noticed warning labels on cigarette or on roll-your-own tobacco packages in the last month. Figure 41 indicates that the percentage of smokers who reported that they noticed warning labels on cigarette and roll-your-own tobacco packages “often” or “very often” in the last month decreased significantly from 25% at Wave 1 to 13% at Wave 8. This is consistent with other studies that have shown decreases in self-reported salience of the warnings in the Netherlands and Germany over time (both countries that have not changed their text warnings), demonstrating the “wear-out” effect of the warnings.

The Wave 8 Survey asked smokers who had noticed the warnings how often they read or looked closely at the warning labels on cigarette packages in the last 30 days. The results indicate that less than one-third of smokers who had noticed warning labels on cigarette packages “often” or “very often” in the last month (8%) read or looked closely at the warning labels. About two-thirds (69%) of smokers who had noticed warning labels “never” or “rarely” read or looked closely at the warning labels in the last 30 days at Wave 8.
Smokers’ perceptions ofbelievability of health warnings

The Wave 4 to 8 Surveys asked smokers “How believable do you think the health warnings are?” The findings show that well over one-third of smokers thought that the 2002 text warnings are “not at all” believable or “a little believable”, and this did not change across the survey waves. Less than one-quarter of smokers (20-22% across Waves 4 to 8) thought the warnings are “very” or “extremely” believable (see Figure 41).

Self-reported impact of health warnings on smoking behaviour

The Wave 1 to 8 Surveys asked smokers whether in the last month, the warning labels had ever stopped them from having a cigarette when they were about to smoke. Figure 41 indicates that the health warnings did not stop the majority of smokers from having a cigarette – less than 10% between Waves 1 and 8 reported that warning labels stopped them from having a cigarette at least once in the last month, with a low of 5% at Wave 8. Figure 41 also shows that the warnings did not make smokers think about the health risks of smoking or think about quitting – only about 10% of smokers across all waves said the health warnings made them think about the health risks “somewhat” or “a lot”, and this decreased to a low of 7% at Wave 8; and only 7-9% of smokers across the waves said the warnings made them “somewhat” or “a lot” more likely to quit. Overall, the results indicate that current text-only health warnings on cigarette and roll-your-own tobacco packages in the Netherlands have been ineffective at promoting behaviours that have been shown to lead to quitting among smokers.

ITC cross-country comparisons provide further evidence of the poor performance of the current text warnings. Among 19 ITC countries, the Netherlands had the lowest percentage of smokers (14%) at Wave 8 who reported that they “often” or “very often” noticed warning labels on cigarette packages in the last month (See Figure 42). This percentage is lower than in Germany (26%), where the same text warnings as the Netherlands had been implemented since 2003. This finding is consistent with previous research showing a larger decline in warning salience in the Netherlands compared to Germany, which may be due to the longer time period in which the warnings had been in place in the Netherlands, possibly leading to greater wear-out effects.
In addition, among 19 ITC countries, the Netherlands had the lowest percentage of smokers (7%) at Wave 8 who reported that warning labels made them think about the health risks of smoking “somewhat” or “a lot” (see Figure 43).

xi. As noted in the Analytic Approach section of this report, the percentages in Figure 42 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 42 differ slightly than the percentages shown in Figure 41.
Figure 43. Percentage of smokers who reported that warning labels made them think about the health risks of smoking “somewhat” or “a lot”, by country

*The ITC Malaysia Survey skipped this question if respondents answered “no” to noticing warning labels on cigarette packages.

† The ITC India and Bangladesh Survey asked the comparable question, “to what extent, if at all, do the warning labels on smoked tobacco packages make you more likely to think about the health risks (health dangers) of smoking?”
Support for plain packaging

In December 2012, Australia became the first country in the world to adopt legislation for tobacco plain packaging. All tobacco products in Australia must be sold in standardized packaging that does not include any tobacco industry logos, brand imagery, colours, or promotional text, but health warnings remain. Similar legislation is pending in Ireland, the United Kingdom, and France, and is under formal consideration in several other countries.

The ITC Netherlands Wave 5 to 8 Surveys asked smokers and quitters how much they agree with the statement: “Tobacco companies should be required to sell cigarettes in plain packages, that is, in packs without the usual brand colours and symbols, but keeping the warning labels”. Across Waves 5 to 8, less than 1 in 5 respondents “agreed” or “strongly agreed” that tobacco companies should be required to sell cigarettes in plain packages (15% at Wave 5; 14% at Wave 6; 17% at Wave 7; 18% at Wave 8). At Wave 8 (2014), almost half (45%) of respondents “disagreed” or “strongly disagreed” with this statement and 37% “neither agreed nor disagreed” with the statement.

Conclusions

Text-only health warnings that were implemented on 30% of the front and 40% of the back of cigarette and roll-your-own (RYO) tobacco packages in the Netherlands in May 2002 were not revised until March 28, 2014 when the Netherlands implemented EU Directive 2012/9/EU requiring 14 new messages to be on all cigarette and RYO tobacco packages on the Dutch market by March 28, 2016. Although the current health warnings that have been in place since 2002 meet the minimum requirements of Article 11, they fall far short of complying with the FCTC Article 11 Guidelines which recommend the use of full colour pictorial warnings. ITC evidence from Dutch smokers shows that these text warnings have been ineffective and ITC cross-country comparisons indicate that their impact on smokers was among the weakest of 19 ITC countries. Evidence of gaps in knowledge of specific harms of tobacco use and the harms of secondhand smoke (see Education, Communication and Public Awareness Section) suggests that the health warnings failed to inform smokers about the range of harms of tobacco.

The evidence is clear that pictorial health warnings are more effective than text-only warnings in attracting attention, eliciting stronger cognitive and emotional reactions, and increasing intentions to not start smoking and to quit smoking. Therefore, the upcoming changes under the revised EU TPD (2014/40/EU) which require the Netherlands to fully implement large pictorial warnings and additional text on cigarette and RYO tobacco packages by May 2016 will be an important step in enhancing the impact of health warnings on Dutch smokers’ knowledge of the harms of tobacco use and motivating thoughts and behaviour related to quitting.

The TPD also explicitly states that the 28 EU countries have the option of implementing plain packaging. Therefore, in addition to stronger health warnings, the Netherlands should consider following the lead of Australia, Ireland, the United Kingdom, and France in passing plain packaging legislation. Although less than one-quarter of Dutch smokers currently support plain packaging, evidence from the evaluation of plain packaging in Australia demonstrated that smokers’ support for the policy increased after it was implemented, from 28% to 49%. In addition, the appeal of the packs was reduced substantially and noticeability of the pictorial health warnings increased. This evidence suggests that the Netherlands could also benefit from implementing plain packaging, and that support for such a law is likely to increase after it is implemented.
EDUCATION, COMMUNICATION, AND PUBLIC AWARENESS

Article 12 of the FCTC requires Parties to adopt and implement measures to promote broad access to education, communication, and training to strengthen public awareness of: the health risks of tobacco consumption and exposure to tobacco smoke and the benefits of smoking cessation.

This section presents ITC Netherlands Wave 1 to 8 Survey findings on smokers’ awareness of advertising or information on the harms of smoking and the benefits of quitting through various forms of media, as well as perceived societal disapproval of smoking. Findings are also provided on smokers’ knowledge of the health effects of smoking and secondhand smoke between Waves 1 to 8 in the context of results in other ITC countries.

Noticing anti-smoking information and campaigns

The ITC Netherlands Wave 1 to 8 Surveys asked smokers how often they noticed advertising or information that “talks about the dangers of smoking or encourages quitting” in the last 6 months. Figure 44 indicates that across all survey waves only a minority of smokers (approximately 1 in 10) “often” or “very often” noticed this type of anti-smoking information. Between 2012 and 2014, more than half of smokers “never” or “rarely” noticed this information, while more than a third of smokers across all survey waves reported “sometimes” noticing this information. The percentage of smokers who noticed this information “often” or “very often” increased from 12% at Wave 1 to 17% at Wave 3. This increase occurred over the same period as the mass media smoking cessation campaign launched by STIVORO that ran on television and radio from April 2008 to January 2009 in conjunction with the introduction of the July 1, 2008 smoking ban in the hospitality sector. However, noticing advertising or information about the dangers of smoking could have been higher if the government campaign to introduce the smoke-free law had referred to the health risks of (secondhand) smoking. After 2009, there was a decrease in the percentage of smokers who reported noticing anti-smoking information “often” or “very often” from 17% at Wave 3 to 10% at Wave 4, and this percentage remained low at 10% at Wave 8.

Figure 44. Percentage of smokers who noticed advertising or information that talks about the dangers of smoking, or encourages quitting in the last 6 months, by wave
ITC cross-country comparisons show that of 9 high-income countries, the Netherlands has the third-highest percentage of smokers and quitters (25%) who said they “never” noticed advertising or information that talks about the dangers of smoking in the last 6 months (see Figure 45).

Figure 45. Percentage of smokers and quitters who reported that they “never” noticed advertising or information that talks about the dangers of smoking in the last 6 months, by country

- Germany (2011) 36%
- Republic of Korea (2010) 34%
- Netherlands (2014) 25%
- United States (2010-11) 22%
- United Kingdom (2013) 21%
- Canada (2010-11) 20%
- Australia (2013) 18%
- France (2012) 17%
- New Zealand (2008-09) 10%
- China (2011-12) 37%
- Brazil (2012-13) 26%
- Malaysia (2013) 13%
- Thailand (2012) 4%
Anti-smoking advertisements and information by media type

The ITC Netherlands Wave 6 to 8 Surveys asked smokers who reported noticing anti-smoking information in the last 6 months whether they noticed any anti-smoking information through various forms of media. Figure 46 indicates that television was the most prominent form of media for noticing anti-smoking advertisements or information (43% at Wave 8). About one quarter of smokers reported seeing advertisements or information in newspapers (24% at Wave 8). Less common forms of anti-smoking media were the radio (13% at Wave 8), and the Internet (14% at Wave 8). Social media was the least commonly noticed source of anti-smoking advertising or information (9% at Wave 8).

![Figure 46. Percentage of smokers who noticed advertising or information about the dangers of smoking or encouraging quitting smoking in the last 6 months by media type, by wave](image)

Noticing advertisements for stop-smoking medications

Beginning in January 2011, Dutch smokers were eligible for full reimbursement of one Smoking Cessation Reimbursement Programme (SCRP) per year, consisting of evidence-based behavioural treatment, or pharmacotherapy combined with behavioural treatment. Although the programme only ran for one year, research has shown that it increased the amount of dispensed stop-smoking medications (SSMs), led to a more than 10-fold increase in enrollment in the Dutch national quitline telephone counselling program, and that quit attempts increased. The reimbursement programme was accompanied by a smoking cessation media campaign that ran from December 2010 to January 2011, which mentioned types of SSMs but not specific brands.

Figure 47 indicates that the percentage of smokers who said they noticed stop-smoking medication advertisements in the last month increased significantly from 44% at Wave 3 to 78% at Wave 5. This increase occurred before and during the reimbursement programme and accompanying mass media campaign, although it may also be related to an increase in television advertising for NRT products by pharmaceutical companies during this time. After Wave 5, the percentage who noticed SSM advertisements gradually decreased significantly to 66% at Wave 8. Although a second reimbursement programme has been in place since January 2013, it has not been accompanied by a mass media campaign.
Figure 47. Percentage of smokers who noticed advertisements for stop-smoking medications in the last month, by wave

Society disapproval of smoking

The Wave 1 to 8 Surveys asked smokers whether they agree with the statement: “Society disapproves of smoking” as a measure of social norms. Less than two-thirds of smokers “agreed” or “strongly agreed” with this statement across the survey waves, although the percentage who agreed increased from 56% at Wave 1 to 64% at Wave 8 (see Figure 48).

Figure 48. Percentage of smokers who “agree” or “strongly agree” that society disapproves of smoking, by wave
While the increase in perceived society disapproval of smoking from Waves 1 to 8 is an encouraging finding, data from other ITC countries indicate that the percentage of smokers who think that society disapproves of smoking in the Netherlands is low compared to other high-income countries. The Netherlands has the lowest percentage of smokers and quitters (63%) who “agree” or “strongly agree” that society disapproves of smoking among 9 high-income ITC countries (see Figure 49). These findings indicate that there is still room for improvement in efforts to denormalize smoking in the Netherlands, which is important for reducing tobacco use. However, social norms against smoking are stronger in the Netherlands compared to most low-and middle-income countries, where smokers are less likely to agree that society disapproves of smoking.

Figure 49. Percentage of smokers and quitters who “agree” or “strongly agree” that society disapproves of smoking, by country

As noted in the Analytic Approach section of this report, the percentages in Figure 49 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 49 differ slightly than the percentages shown in Figure 48.
Smokers’ thoughts about the harms of smoking and secondhand smoke

The ITC Netherlands Survey findings indicate that in general, the majority of Dutch smokers do not frequently think about the harms of smoking or the harms to other people caused by exposure to their tobacco smoke. The Wave 1 to 8 findings show that from 2010 to 2014, less than one-quarter of smokers “often” or “very often” thought about the harms of smoking to themselves. Even fewer smokers (less than 10% between 2010 and 2014) “often” or “very often” thought about the harm their smoking might be doing to other people (see Figure 50).

Figure 50. Percentage of smokers who “often” or “very often” thought about the harm their smoking might be doing to themselves and others in the last month, by wave

ITC cross-country comparisons indicate that of 15 countries, the Netherlands has the lowest percentage of smokers (22%) who “often” or “very often” think about the harms of smoking (see Figure 51), as well as the lowest percentage of smokers (9%) among 16 countries who “often” or “very often” think about the harm that their smoking might be doing to others (see Figure 52).

The Netherlands has the lowest percentage of smokers (22%) who “often” or “very often” think about the harms of smoking of 15 countries, as well as the lowest percentage of smokers (9%) who “often” or “very often” think about the harm that their smoking might be doing to others among 16 countries.
xiii. As noted in the Analytic Approach section of this report, the percentages in Figure 51 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 51 differ slightly than the percentages shown in Figure 50.
Figure 52. Percentage of smokers who “often” or “very often” thought about the harm their smoking might be doing to other people, by country

- **United Kingdom 2006-07**: 41%
- **New Zealand 2008-09**: 40%
- **Republic of Korea 2005**: 39%
- **Canada 2006-07**: 39%
- **United States 2006-07**: 39%
- **Australia 2006-07**: 37%
- **France 2012**: 33%
- **Germany 2011**: 18%
- **Netherlands 2014**: 9%

High income

- **Thailand 2012**: 80%
- **Brazil 2012-13**: 48%
- **Uruguay 2012**: 46%
- **Mexico 2012**: 42%
- **Mauritius 2011**: 42%
- **China 2011-12**: 41%
- **Malaysia 2013**: 30%

Middle income

xiv. As noted in the Analytic Approach section of this report, the percentages in Figure 52 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 52 differ slightly than the percentages shown in Figure 50.
Smokers’ awareness of the specific health effects of smoking and secondhand smoke

At Waves 5-8, smokers were asked whether they know or believe that smoking causes each of several health effects. Overall, almost all smokers in the Netherlands (85%-89% across survey waves) were aware that smoking causes lung cancer. Figure 53 indicates that smokers were more likely to believe that smoking causes lung cancer, coronary heart disease (74%-78%), and mouth/throat cancer (72%-77%) compared to other smoking-related health effects, and the percentage of smokers who were aware of each of these three health effects increased from Wave 5 to Wave 8. About two-thirds of smokers believed that smoking causes stroke (an increase from 59% at Wave 5 to 64% at Wave 8), while the percentage of smokers who believed that smoking causes impotence was somewhat lower on average, although it increased from 51% at Wave 5 to 60% at Wave 8.

In general, awareness of the harmful effects of secondhand smoke was lower than awareness of health effects in smokers: from 2011 to 2014, less than two-thirds of smokers believed that secondhand smoke causes lung cancer in non-smokers (55%-57%) and less than half of smokers (40%-42%) believed that secondhand smoke causes heart attacks in non-smokers. Awareness that smoking causes blindness was the lowest of all smoking-related health effects, although the percentage of smokers who agreed that smoking causes blindness increased from 5% at Wave 5 to 12% at Wave 8.

Although at least 70% of smokers in the Netherlands were aware that smoking causes coronary heart disease across Waves 5 to 8, comparisons with smokers in other ITC countries indicate that this percentage is still lower than in other countries. ITC cross-country comparisons show that the percentage of smokers and quitters in the Netherlands who believed that smoking causes coronary heart disease (79%) was the third lowest (the same percentage as in Zambia) among 13 ITC countries (see Figure 54).\textsuperscript{xv}
Similarly, ITC cross-country comparisons indicate that the Netherlands has the fourth lowest percentage (63%) of smokers and quitters who believe that smoking causes stroke among 19 ITC countries (see Figure 55).\textsuperscript{xvi}

\textsuperscript{xv}. As noted in the Analytic Approach section of this report, the percentages in Figure 54 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 54 differ slightly than the percentages shown in Figure 53.
While Dutch smokers’ awareness that smoking causes lung cancer was the highest of all the smoking-related health effects across Waves 1 to 8, there is still room for improvement, as other countries have achieved much higher rates. Only 89% of smokers and quitters in the Netherlands believe that smoking causes lung cancer, compared to almost all smokers in other high-income countries (see Figure 56). Knowledge that smoking causes lung cancer is also lower in the Netherlands than in several low-and middle-income ITC countries, such as India (95%) and Mexico (97%).

xvi. As noted in the Analytic Approach section of this report, the percentages in Figure 55 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 55 differ slightly than the percentages shown in Figure 53.
ITC cross-country comparisons show that similar to the Netherlands Wave 1 to 8 findings, knowledge of other health effects of smoking, such as heart disease in non-smokers, impotence, and blindness, is lower overall in other high-income countries than knowledge of lung cancer, heart disease, and stroke.

†The India Survey asked a comparable question about smoked tobacco in general (cigarettes and bidis).
For example, while only 42% of smokers and quitters in the Netherlands believed that secondhand smoke causes heart disease in non-smokers – the second-lowest percentage of 14 ITC countries – smokers and quitters in other high-income countries also had lower levels of awareness that secondhand smoke causes heart disease in non-smokers (41%-64%) compared to low-and middle-income countries (57%-85%) (see Figure 57).
The Dutch government is urged to provide well-funded and sustained support for educational media campaigns in order to promote greater public awareness of the harms of smoking and secondhand smoke and to encourage cessation.

Conclusions

The ITC Netherlands Wave 1 to 8 Survey findings point to the need for public education campaigns in order to further increase awareness of the harms of tobacco use and secondhand smoke. Although awareness of the specific health risks of smoking has improved among Dutch smokers from 2008-2014, ITC cross-country comparisons indicate that the Netherlands still has the lowest percentage of smokers who think about the harms of their smoking to themselves and to others. In addition, levels of awareness of specific smoking-related health effects, such as lung cancer, coronary heart disease, and stroke, are lower in the Netherlands than in many other countries.

These findings most likely reflect the absence of sustained funding for mass media awareness campaigns. Since 2012, more than half of smokers reported that they “never” or “rarely” noticed advertising or information about the dangers of smoking or encouraging quitting – a higher percentage than in many other high-income countries.

The Dutch government is urged to provide well-funded and sustained support for educational media campaigns in order to promote greater public awareness of the harms of smoking and secondhand smoke and to encourage cessation. Educational and mass media campaigns are also an effective strategy for denormalizing smoking, which is an important strategy within the Dutch governmental tobacco policy. For example, research has shown that noticing anti-smoking information is associated with measures of negative social norms around smoking, such as feeling uncomfortable about smoking. ITC findings indicate that the percentage of smokers in the Netherlands who think that society disapproves of smoking is the lowest among all high-income countries, resulting in greater social acceptability of smoking. Therefore, mass media awareness campaigns that emphasize the harms of smoking in the Netherlands could help to reduce the social acceptability of smoking.
TOBACCO ADVERTISING, PROMOTION, AND SPONSORSHIP

Article 13 of the WHO FCTC requires Parties to undertake a comprehensive ban on all forms of tobacco advertising, promotion, and sponsorship (TAPS). The Treaty requires, at a minimum, that Parties ban TAPS on radio, television, print media, and other media, such as the Internet. Guidelines for Article 13 further recommend to ban cross-border advertising, promotion, and sponsorship; display of tobacco products at point of sale (POS); sale of tobacco products through vending machines; Internet sales; and attractive packaging and product features.

The basic requirements of Article 13 have been realised in the Netherlands under national legislation – including a ban on tobacco advertising on national TV, radio, print media, and the Internet; tobacco industry sponsorship of events; indirect advertising; and advertising at cinemas and on outdoor billboards. However, other TAPS measures such as banning sales through vending machines, POS display bans, and limits on the number of shops selling tobacco have not yet been implemented in the Netherlands. Recent motions for these restrictions have only been supported by a minority in the Dutch parliament.

This section presents ITC Netherlands Survey findings on the extent to which smokers notice tobacco advertising and promotion, and key sources of tobacco advertising and promotion, including exposure in the retail environment. Findings on smokers’ support for a complete ban on tobacco advertising and promotion in stores and a ban on the display of cigarettes are also presented.

Smokers’ awareness of tobacco promotion

The Wave 3 to 8 Surveys asked smokers how often they noticed things that promote smoking in the last 6 months. Only about a quarter of smokers across Waves 3 to 8 (an increase from 19% at Wave 3 to 26% at Wave 8) reported “never” noticing things that promote smoking in the last 6 months and one-quarter of smokers (26%-28%) “rarely” noticed things that promote smoking in the last 6 months (see Figure 58). Approximately half of smokers (46%-55%) said they noticed things that promote smoking either “sometimes” or “often/very often”, although the percentage who noticed promotion “often/very often” decreased overall from Wave 3 (19%) to Wave 8 (12%).

Figure 58. Percentage of smokers who noticed things that promote smoking “often” or “very often”, “sometimes”, “rarely”, or “never” in the last 6 months, by wave
Comparisons with other ITC countries show that while the percentage of smokers in the Netherlands who noticed things that promote smoking “often” or “very often” decreased from Wave 1 to Wave 8, it is still high compared to most other ITC countries. The Netherlands has the third highest percentage of smokers and quitters who said they noticed things that promote smoking “often” or “very often” in the last 6 months (14%) out of 9 high-income countries, and the fourth highest percentage overall (tied with Malaysia) out of 17 ITC countries (see Figure 59). Countries that have implemented bans on the display of tobacco products at POS, such as Canada, Australia, and United Kingdom, have much lower proportions of smokers who noticed promotion of smoking “often” or “very often”.

xvii. As noted in the Analytic Approach section of this report, the percentages in Figure 59 are based on the set of countries in the cross-country comparison model and are adjusted for age, sex, smoking status, and time-in-sample. Therefore, the percentages shown for the Netherlands in Figure 59 differ slightly than the percentages shown in Figure 58.
Promotion of smoking by type of media

As an absolute minimum, Article 13 requires Parties to undertake a comprehensive ban on TAPS on radio, television, print media and other media such as the Internet. In the Wave 6 to 8 Surveys, smokers who reported that they had noticed things that promote smoking in the last 6 months were asked whether they noticed such things in each of these specific media sources. The findings indicate that promotion of smoking is still noticed in these forms of media. As shown in Figure 60, from Waves 6 to 8, television was the most frequently noticed form of media promotion of smoking (29% of smokers at Wave 8). At Wave 8, 14% of those who noticed promotion of smoking in the last 6 months noticed it on the Internet, while 11% noticed promotion of smoking on social media. Across all three survey waves, smoking promotion on the radio was rarely noticed (2-5% of smokers), indicating that there is almost no promotion of smoking through the Dutch radio (see Figure 60).

Figure 60. Percentage of smokers who noticed things that promote smoking in the following places, among those who had noticed any smoking promotion in the last 6 months, by wave

Promotion of cigarettes inside stores and at point of sale

The Wave 4 to 8 Surveys asked smokers whether they noticed retail displays of cigarettes, as well as signs or pictures with cigarette brands or logos in stores or shops in the last month. With the exception of a drop at Wave 7 (58%), at least 65% of smokers saw retail displays of cigarette packages on shelves or on the counter in shops and stores (see Figure 61). This suggests that cigarette packages are highly visible in stores given that there is no ban on POS displays; however, not all smokers recalled noticing the displays in the last month. Far fewer smokers (approximately 10% from Wave 5 to 8) reported seeing signs or pictures with cigarette brands or logos in shops and stores in the last month.
The Wave 4 to 8 Surveys asked recent and long-term quitters: “Has there been a time when seeing a cigarette pack display or other signs that cigarettes were sold there, gave you an urge to buy cigarettes in the last month?” As many as 17% of quitters (at Waves 5 and 8) reported that cigarette displays and signs gave them an urge to buy cigarettes. The Wave 4 to 8 Surveys also asked current smokers: “Have you ended up buying cigarettes because you noticed cigarette packages displayed in the store or other signs that cigarettes were sold there, when shopping for things other than cigarettes in the last month?” Figure 62 indicates that only 10%-17% of smokers at each Wave (with an increase at Wave 5) reported purchasing cigarettes due to tobacco promotion inside of stores and shops.
Support for bans on tobacco advertising and point of sale (POS) displays

The Wave 4 to 8 Surveys asked smokers if they support a ban on POS displays of cigarettes inside shops and stores. Figure 63 indicates that at least one-third of smokers support a ban on POS displays “somewhat” or “a lot”, and this percentage increased from 32% at Wave 4 to 37% at Wave 5, and again from 36% at Wave 6 to 42% at Wave 8. At Waves 5 to 8, smokers were also asked whether they support a complete ban on tobacco advertising inside shops and stores. Approximately half of smokers across Waves 5 to 8 reported that they support a complete advertising ban in shops and stores, with an increase between Wave 6 (49%) and Wave 7 (55%).

Figure 63. Percentage of smokers who support complete bans on tobacco advertising inside shops and stores and point of sale displays either “somewhat” or “a lot”, by wave

Smokers’ support for restrictions on TAPS in the retail setting is fairly strong. At Wave 8, over half of smokers supported a complete ban on tobacco advertising inside stores and over 40% supported a complete ban on POS displays inside shops and stores and this latter support has increased over time.
Conclusions

The ITC Netherlands Survey findings suggest that despite the bans on tobacco advertising and sponsorship in the Netherlands, smokers still experience things that promote smoking. In 2014 (Wave 8), almost half of smokers reported noticing tobacco promotion in the last 6 months, with 12% noticing promotion “often” or “very often”, although it is unclear to what extent this is related to actual industry promotion of tobacco. This percentage is similar to other high-income countries in the ITC Project before they implemented complete bans on advertising and promotion. For example, 20% of smokers in Canada reporting noticing things that promote smoking “often” or “very often” in 2002, which decreased to 6% by 2008 after a POS display ban was implemented across the provinces. 81 Over the same time period, noticing promotion decreased from 20% to 5% in the United Kingdom and from 15% to 5% in Australia, whereas a smaller decline was found in the US (27% to 13%), where POS display bans were not implemented. This demonstrates what could be achieved in the Netherlands if a similar ban is introduced.

Television was the most frequently reported form of media for noticing TAPS, followed by the Internet and social media. The Dutch government should continue to strengthen and improve legislation banning all forms of TAPS.

Research evidence shows that POS displays are a valuable marketing strategy for tobacco companies, particularly for influencing youth. 82 POS displays are currently not banned in the Netherlands. As a result, almost two-thirds (65%) of smokers reported noticing this type of advertising in the last month at Wave 8. The findings also suggest that POS displays might actually influence spontaneous cigarette purchases in smokers and urges to purchase cigarettes among some who have quit. Previous studies from Australia and Canada have indeed demonstrated that noticing POS displays is associated with impulse or unplanned cigarette purchases, and that implementing bans on POS displays decreases impulse purchases. 83, 84

Smokers’ support for restrictions on TAPS in the retail setting is fairly strong. At Wave 8, over half of smokers supported a complete ban on tobacco advertising inside stores and over 40% supported a complete ban on POS displays inside shops and stores and this latter support has increased over time, which is an encouraging finding. Evidence from other ITC countries indicates that support for these two policy measures increases further after they are implemented. 85, 86 Additionally, a recent Eurobarometer Survey found that support for these measures is even higher among non-smokers compared to smokers in the EU. 87

The Dutch government should consider implementing even stronger TAPS restrictions covering a wider range of areas, such as vending machine sales and POS display bans, as recommended in the FCTC Article 13 Guidelines. Several other countries have already successfully implemented POS display bans, such as Iceland, Thailand, Ireland, Norway, Australia, Canada, and the United Kingdom. This is important as research evidence clearly demonstrates that tobacco advertising and promotion increases tobacco consumption and the likelihood of smoking initiation, and that TAPS bans are effective in reducing tobacco consumption. 88, 89
SMOKING CESSATION

Article 14 of the FCTC obligates Parties to take effective measures to promote smoking cessation and provide treatment for tobacco dependence. The ITC Netherlands Wave 1 to 8 Surveys measured smokers’ intentions to quit smoking, number of quit attempts, reasons to quit smoking, use of cessation assistance, and attitudes toward government support for cessation before, during, and after various national initiatives to promote smoking cessation. These initiatives included: a two-month long (December 2010 to January 2011) mass media campaign to encourage quitting smoking; the year-long (January 2011 to January 2012) Smoking Cessation Reimbursement Programme (SCRP); and the January 2013 re-enlisting of smoking cessation aids in the Dutch basic insurance plan, which is still in place.

Quit intentions and quit attempts

The Wave 1 to 8 Surveys asked smokers if they are planning to quit smoking, and in what timeframe. As shown in Figure 64, only about one-quarter of smokers had an intention to quit smoking in the near future – either in the next month or next 6 months. The percentage of smokers who said they planned to quit “within the next 6 months” ranged from 16%-22% across the waves, while a small minority of smokers (4-5%) reported plans to quit “within the next month”. The majority of smokers (ranging from 56-61% across all waves) reported that they were planning to quit “sometime in the future, beyond 6 months”. Finally, about 1 in 5 smokers (17-23% across the waves) reported that they were “not planning to quit”.

Figure 64. Smokers’ reported intentions to quit, by wave
The Wave 1 to 8 Surveys also asked smokers about their previous quit attempts. At Wave 1, about three-quarters (76%) of respondents reported that they had ever made a serious attempt to quit smoking. Figure 65 indicates that between the Wave 3 to 8 Surveys, at least 24% of smokers had made a quit attempt in the last 12 months. Following the Smoking Cessation Reimbursement Programme (SCRP) that ran from January 2011 to January 2012, there was a significant increase in the percentage of smokers who reported making a quit attempt in the last 12 months, from 24% at Wave 4 (2010) to 30% at Wave 6 (2012). The percentage of quit attempts observed at Wave 6, which was several months after the reimbursement period ended, is still high, possibly because the survey question asked about quit attempts made in the last 12 months, which overlapped for a large part with the reimbursement period.

Figure 65. Percentage of smokers who have made any attempt to quit smoking in the last 12 months, by wave

Following the Smoking Cessation Reimbursement Programme (SCRP) that ran from January 2011 to January 2012, there was a significant increase in the percentage of smokers who reported making a quit attempt in the last 12 months, from 24% at Wave 4 (2010) to 30% at Wave 6 (2012).
Reasons to quit smoking

The Wave 1 to 8 Surveys asked smokers who were planning to quit and recent quitters (those who quit within the last 6 months) which of several reasons related to tobacco control policies led them to think about quitting smoking “not at all”, “somewhat”, or “very much” in the last 6 months. Figure 66 indicates that the price of cigarettes was reported by over half of recent quitters and smokers who were planning to quit as “somewhat” or “very much” a reason to quit smoking in the last 6 months (see Price and Tax chapter for further details). Between Waves 4 and 5 (before and after the smoking cessation media campaign and before and during the SCRP), there was a significant increase in the percentage of smokers and quitters who reported that availability of the telephone helpline/quitline/information line made them “somewhat” or “very much” think about quitting (from 11% at Wave 4 to 16% at Wave 5). However, at Wave 6 this percentage decreased to 10%. The decrease corresponds to the discontinuation of the SCRP and accompanying media campaign and the cuts in direct funding for the national quitline by the Ministry of Health.²

Other reasons related to tobacco control policies that were reported to be “somewhat” or “very much” reasons to quit included:

- Smoking restrictions in public places like restaurants, cafés and pubs (28% at Wave 8)
- Free or lower cost stop-smoking medications (26% at Wave 8)
- Smoking restrictions at work (21% at Wave 8)
- Warning labels on cigarette packages (18% at Wave 8)
- A prevention message or campaign (16% at Wave 8)

Figure 66. Reasons related to tobacco control policies that “somewhat” or “very much” led smokers who were planning to quit and recent quitters to think about quitting smoking in the last 6 months, by wave
Figure 67 shows the percentage of smokers who reported other reasons, not directly related to tobacco control policies, that led them to think about quitting smoking “somewhat” or “very much” in the last 6 months. The most common reason was concern for one’s personal health (about three-quarters of smokers between Waves 1 to 8), followed by wanting to set an example for children (58%-68% of smokers across Waves 1 to 8). Less than half of smokers reported the following reasons as “somewhat” or “very much” reasons to think about quitting: close friends and family disapprove of smoking (40% of smokers at Wave 8); the effect of their smoking on non-smokers (38%); being told they have a smoking-related illness (37%); and advice from a doctor, dentist, or health professional (36%). Only about one-quarter of smokers across all waves (26%-29%) said that society disapproval of smoking was a reason that led them to think about quitting.

Figure 67. Personal reasons that “somewhat” or “very much” led smokers who were planning to quit and recent quitters to think about quitting smoking in the last 6 months, by wave

Use of cessation assistance

The Wave 1 to 8 Surveys asked smokers who had visited a doctor or other health professional in the last 6 months if they received various types of support for smoking cessation during any visit. Figure 68 indicates that a minority of smokers received any form of support for cessation from a doctor or health professional: the percentage of smokers who received advice concerning possible ways to quit smoking ranged from 12% to 17% across Waves 1 to 8, while the percentage of smokers who received pamphlets or brochures decreased overall from 17% at Wave 1 to 8% at Wave 8. Referrals to another cessation service by a doctor or health professional were less commonly reported (3%-9% of smokers across Waves 1 to 8). The percentage of smokers who received pamphlets or a referral from a doctor or health professional was highest at Wave 6 following the one-year SCRP, indicating that the program may have helped increase rates of cessation help. The percentage of smokers who reported receiving a prescription for stop-smoking medication ranged from 3% to 5% across all waves.
Smokers were also asked whether they had received advice or information about quitting from other sources, such as quitlines, the Internet, or local services. Figure 68 indicates that even fewer smokers reported that they received support from these other sources: less than 2% of smokers across all waves received advice or information from telephone or quitline services, and only 3%-5% across all waves received advice from local stop-smoking services such as clinics or specialists. Advice from the Internet was slightly more common, with 5%-9% of smokers using this source across Waves 1 to 8.

Figure 68. Percentage of smokers who received various forms of support for cessation in the last 6 months, by wave

Use of and support for stop-smoking medications

At Wave 1, 7% of smokers reported that they had ever used any stop-smoking medications (SSMs), such as nicotine replacement therapies like nicotine gum or patches, or other medication that requires a prescription, such as Zyban. The Wave 3 to 8 Surveys asked smokers if they had used any SSMs in the last year. Figure 69 indicates that the percentage of smokers who used SSMs ranged from 9-13% across the waves. There was an increase in the percentage of smokers who reported that they were planning to use SSMs with their next quit attempt from 14% at Wave 4 to 22% at Wave 5 (see Figure 69). This suggests that the smoking cessation campaign at the end of 2010 and the 2011-2012 SCRP may have increased smokers’ intentions to use SSMs. Support for insurance reimbursement of SSMs was consistently high among smokers, with about three-quarters of smokers across the Wave 1 to 8 Surveys stating that they “support” or “strongly support” reimbursement.
Figure 69. Percentage of smokers who have used stop-smoking medications (SSMs) in the last year; percentage of smokers who “support” or “strongly support” insurance reimbursement for SSMs; and percentage of smokers who are “very likely” or “probably” planning to use SSMs in their next quit attempt, by wave

Reimbursement for smoking cessation treatments

The Wave 1 to 8 Surveys asked smokers if they can get a reimbursement from their health insurance for the use of stop-smoking medications (SSMs). Figure 70 indicates that 37% of smokers indicated that they could get a reimbursement of SSMs at Wave 4 (May-June 2010), increasing to 83% at Wave 5 (May-June 2011) during the period of the mass media campaign (December 2010 to January 2011) and at the beginning of the SCRP that ran from January 2011 to January 2012. However, there was a sharp decrease to 31% at Wave 6 (May-June 2012) after the year-long program had ended, and then another increase to about half of smokers (51%) reporting that could get a reimbursement at Wave 8 (following the reinstatement of the smoking cessation reimbursement).

Smokers who had used SSMs in the last year and got them by prescription, over-the-counter or off-the-shelf, or from a friend were asked whether they paid the full price, got a discount, got it for free, or were reimbursed from their health insurance. The percentage of smokers who reported that they paid full price for their SSMs decreased from 90% at Wave 4 (May-June 2010) to 60% at Wave 7 (May-June 2013) following the 2011-2012 SCRP and reinstatement of the program in 2013 (see Figure 71). There was also an increase in the percentage of smokers who reported that their smoking medication was partially covered by health insurance, from 6% at Wave 4 (May-June 2010) to 25% at Wave 7 (May-June 2013). From Waves 4 to 8, the percentage of smokers who reported that their SSM was either free or discounted remained low across all waves at 5% or less.
Figure 70. Percentage of smokers who were aware of the reimbursement from their health insurance for SSMs, by wave

Figure 71. Percentage of smokers† who paid full price, got a discount, got free, or health insurance covered cost of SSMs, by wave

† Among those who used SSMs in the last year and got them by prescription, over-the-counter/off-the-shelf, or from a friend
Support for government smoking cessation assistance

The Wave 1 to 8 Surveys asked smokers and quitters if they thought that the government should do more to help smokers give up smoking. Figure 72 indicates that across Waves 1 to 8, the majority of smokers (36%-44%) “neither agreed nor disagreed” with the statement. Approximately one-third (22%-32%) of smokers and quitters “agreed” or “strongly agreed” with this statement and one-third (32%-34%) “disagreed” or “strongly disagreed”.

At Wave 8 (2014), approximately one-third (29%) of smokers “agreed” or “strongly agreed” that the government should do more to help smokers give up smoking; 39% “neither agreed nor disagreed”; and 32% “disagreed” or “strongly disagreed”.

Figure 72. Percentage of smokers and quitters who agree, disagree, or neither agree nor disagree that the government should do more to help smokers give up smoking, by wave
Conclusions

The ITC Netherlands Wave 1 to 8 findings provide evidence that the one-year Smoking Cessation Reimbursement Programme (SCRP) that ran in 2011, along with the two-month mass media campaign that preceded it, had an impact on cessation-related thoughts and behaviours among Dutch smokers. For example, the percentage of smokers who had made a quit attempt in the last 12 months increased from 24% at Wave 4 to 30% at Wave 6 during the period of the SCRP. This finding is consistent with other research that has found an increase in quit attempts and quit success among Dutch smokers following implementation of the reimbursement policy and accompanying media attention.\(^7\)

Although the percentage of smokers who reported that they were aware of the reimbursement for stop-smoking medications (SSMs) increased significantly during the period of the mass media cessation campaign and the SCRP, from 37% at Wave 4 to 83% at Wave 5, the percentage of smokers who reported actually using SSMs during the same period did not increase significantly (from 10% to 13%). However, the percentage of smokers who reported that they planned to use SSMs in their next quit attempt was higher, and increased significantly from 15% at Wave 4 to 22% at Wave 5.

Smokers also reported high levels of support for the insurance reimbursement of SSMs. Support was highest in 2011, immediately following the introduction of the program, and remained high at 74% at Wave 8 (2014). The percentage of smokers and quitters who thought the government should do more to help smokers quit was not particularly high (29% of smokers at Wave 8), with approximately equal percentages who agreed, disagreed, and neither agreed nor disagreed that the government should do more.

Advice concerning possible ways to quit smoking from a physician or health provider is another powerful motivator for quitting. However, the percentage of Dutch smokers who reported receiving cessation advice (15% at Wave 8) or other information from a doctor or health provider is lower than rates of over 50% achieved in other high-income countries, and very few Dutch smokers reported making use of other cessation services such as quitlines. The rate of physician advice in the Netherlands could be improved through greater efforts to encourage doctors to apply evidence-based smoking cessation guidelines, and to convince them that they have a responsibility to ensure their patients understand the health risks of smoking. This is important as it is well established that advice to quit from a physician or health provider is a powerful motivator for quitting.\(^41\)

The January 2013 re-enlisting of smoking cessation treatments in the Dutch basic insurance plan is a positive step forward in achieving similar reductions in smoking rates as the 2011-2012 program, when the smoking rate decreased from 27% in 2010 to 25% in 2011.\(^38,39\) In order to be more effective, however, it should also be accompanied by sustained mass media anti-smoking campaigns to promote cessation and greater awareness of and support for the reimbursement policy and initiatives to enhance access to tobacco dependence treatment through the health care system.
CONCLUSIONS AND RECOMMENDATIONS

Smoking Behaviour

Most (89% to 94%) Dutch smokers are daily smokers according to the ITC Netherlands Wave 1 (2008) to Wave 8 (2014) Surveys, and the majority (55% at Wave 8) smoke exclusively factory-made cigarettes. Although use of roll-your-own (RYO) cigarettes decreased between Waves 1 to 8, the Netherlands still has the second-highest use of RYO tobacco among 12 high- and middle-income ITC countries. Most smokers admit that they are addicted to smoking (80% at Wave 8) and that they regret having started smoking (74% at Wave 8), but Dutch smokers still have one of the lowest levels of regret among 13 high- and middle-income ITC countries. Given the devastating health consequences of tobacco consumption and exposure to tobacco smoke, it is alarming that the majority of Dutch smokers do not view smoking negatively: only 21% of smokers had a negative opinion of smoking – the second-lowest percentage of 13 high- and middle-income ITC countries.

There is high awareness of electronic cigarettes (e-cigarettes) among Dutch smokers. At Wave 8, 94% of Dutch smokers had heard of e-cigarettes, and 38% of smokers had ever tried them. ITC cross-country comparisons indicate that Dutch smokers have a relatively high rate of ever trying e-cigarettes (the third-highest of 12 high- and middle-income ITC countries), and higher rates of current use (12% at Wave 8) of e-cigarettes compared to most other ITC countries, but comparable rates to other high-income countries such as the United States and United Kingdom. Similar to other countries, daily use of e-cigarettes has increased from less than 1% of all smokers at Wave 7 to 5% of all smokers at Wave 8. However, reported purchasing of e-cigarettes is low as only 10% of smokers had ever purchased an e-cigarette at Wave 7.

Tobacco Price and Taxation

Substantially increasing tobacco taxes and prices is recognized worldwide as the single most cost-effective measure of tobacco control. There were several tax increases on cigarettes and RYO cigarettes in the Netherlands between 2008 and 2014 resulting in a 50.6% price increase on a 19 pack of cigarettes, and a 56.9% increase on a package of RYO tobacco. In line with these price increases, ITC affordability analyses indicate that cigarettes became less affordable overall from Wave 1 to Wave 8 in the Netherlands, with an average annual decrease in the Affordability Index of 1.25%. This is similar to decreases in other high-income ITC countries, although some other European countries have had larger average annual decreases in affordability, such as Germany (-1.56% per year) and France (-1.71% per year).

Despite this evidence of progress in reducing the affordability of manufactured cigarettes, ITC findings suggest that further tax increases on cigarettes and RYO tobacco are warranted. The majority of Dutch smokers and quitters identified price as a reason to quit and this percentage increased over time. However, ITC cross-country comparisons indicate that this percentage, as well as the percentage who said they thought often about the money they spent on smoking, is still lower than in other countries. The price differential between manufactured cigarettes and RYO tobacco continues to drive high RYO use in the Netherlands relative to RYO use in other ITC countries. Although there is no evidence of an increase in RYO use between 2008 and 2014, the fact that from 2012 to 2014, the cheaper price was cited by 82% of RYO users as a reason for smoking RYO tobacco suggests that further steps need to be taken to reduce the price advantage, particularly for youth smokers.

Although there was a significant increase in the percentage of smokers who reported purchasing cigarettes or tobacco outside of the country, but within the European Union in the last 6 months, from 12% at Wave 1 to 26% at Wave 8, the actual frequency of these cross-border purchases was low, with the large majority of smokers reporting such purchases only once or a few times in the last 6 months between Waves 1 to 8.
Recommendations

1. Further steps need to be taken to increase total excise tax on tobacco products to meet the WHO target of at least 70% of the retail price. The price advantage for RYO tobacco products should also be eliminated in order to minimize switching to cheaper products and reduce smoking initiation among youth.

2. Ensure continued reductions in tobacco affordability by using a combination of inflation- and income-adjusted tax increases.

3. Advocate higher excise tax burdens and floors at the level of the European Union to reduce price differentials, which would contribute to reduced cross-border tobacco purchasing.

Smoke-free Public Places

The ITC Netherlands Wave 1 to 8 Surveys show that in the absence of a comprehensive ban on smoking in public places without exceptions, the Netherlands does not yet fully protect the public from secondhand smoke (SHS). While there is evidence of substantial progress in creating smoke-free restaurants since the 2008 hospitality industry smoking ban, smoking prevalence in bars and cafés remains a concern. More than one-third (38%) of smokers in 2014 still noticed smoking in bars and cafés during their last visit. ITC surveys in France, the United Kingdom, Australia, and Canada show that a strongly enforced comprehensive smoking ban can achieve greater reductions in smoking in public places. Although there was an increase in the percentage of smokers with smoke-free homes from 9% at Wave 1 to 30% at Wave 8, the Netherlands still had the lowest percentage of home smoking bans among 9 high-income ITC countries in 2014. An increase in home smoking bans would be expected to continue following strong implementation of a comprehensive smoke-free law.

While the Supreme Court’s October 2014 decision to reinstate the smoking ban across the entire hospitality sector and the subsequent legal adjustments have been steps in the right direction, the law needs to go further in removing the allowance for designated smoking rooms in order to fully protect the public from the harms of secondhand smoke, as such allowances have proven to be ineffective. Approximately one-third (30%) of Dutch smokers support a comprehensive smoking ban in cafés, bars, and pubs, which is higher than the level of support in Ireland before the implementation of their very successful smoke-free law. ITC research in Ireland and several other countries suggests that support will further increase after a strong, comprehensive ban is implemented.

Recommendations

4. Strengthen current smoke-free legislation by removing the allowance for designated smoking rooms in accordance with the FCTC Article 8 Guidelines which call for 100% smoke-free public places.

5. Implement strong education and enforcement activities to increase public awareness of the harms of secondhand smoke and the benefits of a comprehensive ban, and to further strengthen compliance with the ban.

Tobacco Health Warnings

The Netherlands has had the same text warnings on 30% of the front and 40% of the back of cigarette and RYO tobacco packages since 2002. These warnings fall short of the minimum size requirements of the WHO FCTC of at least 50% of the principal display areas of the pack, as well as the recommendation that warnings should include full-colour pictures. The ITC Survey findings demonstrate the low effectiveness of the current text warnings on smokers' perceptions and behaviours, and show a decline in effectiveness over time.
ITC cross-country comparisons further demonstrate the weak impact of the warnings – of 19 ITC countries, the Netherlands has the lowest percentage of smokers who reported noticing the warnings “often” or “very often” and thinking about the health risks “somewhat” or “a lot” due to the warnings. Evidence from studies around the world shows that large pictorial health warnings are more effective than text-only warnings. The forthcoming large pictorial warnings and additional text on cigarette and RYO tobacco packages in the Netherlands by May 2016 (likely with a 1-year transition period) as required by the revised EU Tobacco Products Directive (TPD) (2014/40/EU) will indeed be critical to enhancing Dutch smokers’ knowledge of the harms of tobacco use and motivating thoughts and behaviour related to quitting.

Plain packaging is also gaining international momentum as a strategy to curb the industry’s use of misleading and promotional packaging elements, increase the effectiveness of health warnings, and decrease tobacco use. Although the Wave 5 to 8 Surveys found that less than one-quarter of Dutch smokers “support” or “strongly support” plain packaging, evidence from other countries suggests this level of support would increase if plain packaging were to be introduced. For example, ITC Australia data shows that smokers’ support approximately doubled from 28% 1 year before plain packaging was introduced to 49% less than 6 months after its introduction. In addition, appeal of the packs was reduced substantially and noticeability of the pictorial warnings increased.

Recommendation

6. Consider further actions to strengthen the effectiveness of forthcoming pictorial health warnings by implementing plain packaging – a strategy that is recommended in the FCTC Articles 11 and 13 Guidelines and has been implemented in Australia (2012), is forthcoming in Ireland and the United Kingdom, and is being seriously considered in various other countries, such as France and Norway.

Education, Communication, and Public Awareness

The ITC Netherlands Wave 1 to 8 findings reflect the absence of sustained funding for mass media public education campaigns. Across all survey waves, only a minority of smokers (approximately 1 in 10) “often” or “very often” noticed advertising or information that talks about the dangers of smoking or encourages quitting. In 2014, one-quarter of Dutch smokers and quitters reported that they never noticed this information, among the highest of 9 high-income ITC countries. Smokers’ awareness of specific health risks of smoking has improved between 2008 and 2014. However, ITC cross-country comparisons point to important gaps in Dutch smokers’ knowledge of the harms of smoking. Dutch smokers were among the least likely to believe that smoking causes heart disease, stroke, and lung cancer, and that secondhand smoke causes heart disease in non-smokers. The Netherlands also has the lowest percentage of smokers who think about the harm their smoking might be doing to themselves and to others. Although the percentage of Dutch smokers who “agreed” or “strongly agreed” that society disapproves of smoking increased between Wave 1 and Wave 8, this percentage was the lowest among 9 high-income ITC countries, suggesting that there is room to strengthen society disapproval by increasing public education on the harms of smoking and SHS in combination with implementing stronger tobacco control policies.

Recommendation

7. The Dutch government is urged to provide well-funded and sustained educational media campaigns in order to promote greater public awareness of the harms of smoking and secondhand smoke, to encourage cessation, and to denormalize smoking.

Tobacco Advertising, Promotion, and Sponsorship

The Netherlands has implemented bans on several sources of direct and indirect tobacco advertising, promotion, and sponsorship (TAPS); however, the ban falls short of meeting all of the recommendations of the FCTC Article 13 Guidelines, and as a result, is not as effective as would be expected with a
comprehensive TAPS ban. The current ban includes tobacco advertising on national TV, radio, print media, and the Internet; tobacco industry sponsorship of events; indirect advertising; and advertising at cinemas and on outdoor billboards. However, measures such as a ban on sales through vending machines, a complete ban on point of sale (POS) advertising, POS display bans, and limits on the number of shops selling tobacco have not yet been implemented in the Netherlands. Gaps in the implementation of a comprehensive TAPS ban are evidenced in the ITC Survey findings which show that in 2014, almost half of smokers reported noticing tobacco promotion in the last 6 months, with 12% noticing promotion “often” or “very often”. Although this percentage has decreased from 19% in 2009, it is still high compared to other ITC countries, particularly countries such as Canada, Australia, and United Kingdom (5%-6%) that have banned the display of tobacco products at points of sale. Dutch smokers’ support for stronger TAPS restrictions in the retail setting is fairly strong. In 2014, more than half of smokers supported a complete ban on tobacco advertising inside stores and 40% supported a complete ban on POS displays inside shops and stores.

**Recommendation**

8. Close the gaps in current national TAPS laws by banning tobacco vending machine sales, banning tobacco advertising and the display of tobacco products in all stores and shops, and generally reducing the number of tobacco sale outlets.

**Smoking Cessation**

The ITC Netherlands Wave 1 to 8 findings provide evidence that the one-year smoking cessation treatment reimbursement program that ran in 2011, along with the two-month mass media campaign that supported its introduction, had an impact on cessation-related thoughts and behaviours among Dutch smokers.

The number of quit attempts increased from 2010-2012 following implementation of the reimbursement program, from 24% of smokers who made a quit attempt in the last year at Wave 4 to 30% at Wave 6. Awareness of the reimbursement for stop-smoking medications also increased sharply from Wave 4 (37%) to Wave 5 (83%), although the actual percentage of smokers who reported using stop-smoking medications remained low across all survey waves at less than 15%. The findings demonstrate that the strong majority of smokers in the Netherlands support insurance reimbursement for stop-smoking medications, with the highest level of support (81% of smokers) immediately following the introduction of the program in 2011. Evidence from the Wave 7 and 8 Surveys suggest that the January 2013 reinstatement of the smoking cessation reimbursement program has not had as strong of an impact compared to the introduction of the program in 2011.

The findings also indicate the need for stronger efforts to motivate quitting among smokers. Only about one-quarter of Dutch smokers at Wave 8 reported plans to quit smoking within the next 6 months, and the use of various cessation aids is also low. For example, only 15% of smokers at Wave 8 reported receiving advice concerning ways to quit from a doctor or health provider, and very few smokers reported making use of other cessation services such as quitlines.

**Recommendations**

9. The reinstatement of the reimbursement program for smoking cessation treatment in 2013, which is still in place, is a positive step forward in efforts to increase cessation rates in the Netherlands. However, in order to be more effective, the reimbursement should be accompanied by education efforts such as mass media campaigns in order to enhance awareness of the reimbursement policy and the availability of various options for cessation support and services for smokers.

10. Greater efforts to engage physicians and other health professionals and encourage them to provide evidence-based smoking cessation advice to patients would help to improve smokers’ motivation to quit and greater use of cessation services.
For more information on the ITC Project:

Dr. Geoffrey T. Fong  
Professor  
Department of Psychology  
University of Waterloo  
200 University Avenue West  
Waterloo, Ontario N2L 3G1 Canada  
Email: itc@uwaterloo.ca  
Tel: +1 519-888-4567 ext. 33597  
www.itcproject.org

For technical information on ITC survey methodology or analyses:

Dr. Mary E. Thompson  
Professor  
Department of Statistics and Actuarial Science  
University of Waterloo  
200 University Avenue West  
Waterloo, Ontario N2L 3G1 Canada  
Email: methomps@uwaterloo.ca  
Tel: +1 519-888-4567 ext. 35543
REFERENCES


The International Tobacco Control Policy Evaluation Project

The ITC Project
Evaluating the Impact of FCTC Policies in...

20+ countries • 50% of the world’s population
60% of the world’s smokers • 70% of the world’s tobacco users

Australia
Bangladesh
Bhutan
Brazil
Canada
China (Mainland)
France
Germany
India
Ireland
Kenya
Malaysia
Mauritius
Mexico
Netherlands
New Zealand
Republic of Korea
Thailand
United Kingdom
Uruguay
United States of America
Zambia