EQUIP REPORT COMPLETE

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4 authors, including:

Luke Clancy
TobaccoFree Research Institute Ireland

Antonella Cardone
The Work Foundation

Witold A Zatonski
Health Promotion Foundation

EQUIPP

EUROPE QUITTING: PROGRESS AND PATHWAYS

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00.01 ENDORSING ORGANISATIONS

The following organisations have endorsed the EQUIPP report.

ENSP
European Network for Smoking and Tobacco Prevention

The European Network for Smoking and Tobacco Prevention (ENSP) considers that the opinions expressed in this study by the well-known editorial partners and the interviewees are in line with and support Article 14 of the FCTC. ENSP therefore endorses the present report and its recommendations.

Bundesverband der Pneumologen

DEUTSCHE GESELLSCHAFT FÜR PNEUMOLOGIE UND BEATMUNGSMEDIZIN
DGP

The German Society for Pneumology (DGP, Deutsche Gesellschaft für Pneumologie und Beatmungsmedizin) together with the Bundesverband der Pneumologen (BdP) (German Association of Pulomonologists) very much welcomes the EQUIPP Report, which underlines the shortcomings in tobacco prevention in Germany, and in particular in combating tobacco dependence.

The DGP is a member of the German Coalition for Non-Smoking, which has developed a position paper for the 17. legislative period (2009-2013) of the German Parliament (Deutscher Bundestag). Here, ten main postulates for better and consequent tobacco prevention in Germany are outlined, amongst them "Development of counselling and therapy for tobacco cessation", which is urgently needed in order to help smokers quit (www.abnr.de).

ERS EUROPEAN RESPIRATORY SOCIETY
every breath counts

The European Respiratory Society endorses the Europe Quitting: Progress and Pathways report (EQUIPP).


ASSIS

Editorial Partners

Antonella Cardone, MS, MBA
Expert in Tobacco Control and Public Health
Director, Global Smokefree Partnership
Rome, Italy

Prof. Luke Clancy, BSc, MB, MD, PhD, FRCPI, FRCP (Edin), FFOMRCPI
Director General
TobaccoFree Research Institute Ireland
Dublin, Ireland

Dr. med. Thomas Hering, MD
Physician for pneumology, allergies and sleep medicine
Vice-Chairman of the German Association of Pulmonologists
Berlin, Germany

Prof. Witold Zatoński, MD, PhD
Director, Department of Cancer Epidemiology & Prevention
Maria Sklodowska-Curie Memorial Cancer Center
& Institute of Oncology
Warsaw, Poland

Editorial Partner contributions

Each Editorial Partner was involved in the conceptualisation, development, and approval of this report. See section 11.02 for more details.

Acknowledgements

Pfizer provided the funding for this project and has worked in collaboration with the Editorial Partners, Bridgehead and the external experts to produce the report. The final report, its content and recommendations are the work and opinions of the Editorial Partners. This project does not focus on any specific products or treatments.

The Editorial Partners are particularly grateful to the interviewees who freely gave their time and responded knowledgeably and independently on the topics discussed (see Appendix in section 11.02).

Editorial support for this project was provided by Bridgehead International (Dr Deborah Hooker and Suzanne Elvidge).

Competing interests

Prof. Luke Clancy and Prof. Witold Zatoński have undertaken research and consultancy for companies that develop and manufacturing smoking cessation medications.

Dr Thomas Hering has received speaker and advisor fees from a variety of pharmacotherapy manufacturers including Novartis, Pfizer, Johnson & Johnson and GlaxoSmithkline.

Antonella Cardone has worked on projects receiving financial support from companies manufacturing smoking cessation medications.

Terminology usage

Tobacco dependence treatment and smoking cessation

The World Health Organization's (WHO's) European guidelines define tobacco dependence treatment such that it "includes (singly or in combination) behavioural and pharmacological interventions such as brief advice and counselling, intensive support, and administration of pharmaceuticals, that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole."[1]

Tobacco dependence treatment is helping and supporting tobacco users to overcome their dependence on nicotine and is a narrower term than the broader term of smoking cessation which encompasses all cessation whether that is as a result of broader tobacco control measures (such as smoke-free legislation) or through support of an individual to quit through tobacco dependence treatment.

Smoking

The term smoking is used in this document for the sake of brevity but this should be taken to include all tobacco use.

EXECUTIVE SUMMARY

01.01 INTRODUCTION

Tobacco use continues to be the single largest cause of death and disease in the European Union (EU).[2] Tobacco kills as many as 650,000 Europeans every year – more than the population of Malta or Luxembourg.[3] Smoking causes more health problems than, for example, alcohol, illicit drugs, blood pressure, obesity or cholesterol.[4] The economic cost of smoking was estimated at €98-€103 billion in 2000 or around 1% of the gross domestic product of the EU.[5]

Smoking accounts for 12–20 years of life lost and up to 21% of deaths according to the World Health Organization (WHO)/Europe tobacco control database,[6] and is a major cause of death from cancer, cardiovascular disease and pulmonary disease.[7] Tobacco smoking kills half of all lifetime users, with half of these dying in middle age (between 35 and 69 years old).[8]

In Europe, the estimated daily smoking prevalence is around 28.6%[9] but even a small reduction in this figure could lead to a reduction in the number of smokers dying prematurely.[10] Smoking prevalence rates are generally stabilising or decreasing, however smoking rates for females are slightly increasing in some Eastern EU Member States.[11] Youth smoking is also still a significant problem in some European countries,[12] and the rate of smoking amongst European school children (aged 13-15) is 18%, which is about twice the global average for that age.[13] Children are starting smoking at a younger age and in some Member States, the average age for initiation has been reported as low as 11 years old.[14]

Thus, tobacco use continues to be a major public health problem within Europe.

The economic burden of smoking on society is tremendous, with the annual global cost of tobacco use estimated by the WHO at US$500 billion.[15] This figure includes direct healthcare expenditure, lost earnings and reduced productivity, and other costs. Quitting, or reducing smoking, has both economic and health benefits for the smoker[16] and there are also health benefits to the households of smokers when second-hand smoke is removed.[17] Similarly, the introduction of smoke-free legislation is associated with health benefits to co-workers.[18]

Twenty years ago, smoking was regarded purely as a habit but now the WHO has provided an International Classification of Disease code (ICD-10 code[19]) for tobacco dependence.

Likewise, nicotine dependence is listed by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR 305.10[20]).

The WHO estimates that 75%-85% of smokers would like to quit and that around one-third have made at least three serious attempts. However, less than half of smokers succeed in stopping permanently before the age of 60.[21] Although a smoker can quit without help, long-term abstinence is higher when the attempt is aided medically.[22]

Smoking cessation services such as brief interventions, behavioural therapy, self-help materials, provision of pharmacotherapy or a combination of tactics can be a cost-effective way to help smokers quit.[23] Smoking cessation services led by General Practitioners (GPs) are cost-effective[24] and good value for money. However, other healthcare professionals (HCPs) such as secondary care physicians, pharmacists, dentists and oral health professionals, nurses, and respiratory therapists can all provide valuable smoking cessation interventions. For example, smoking cessation interventions for in-patients have been shown to reduce rehospitalisation and total mortality.[25,26]

01.02 FRAMEWORK CONVENTION ON TOBACCO CONTROL

The Framework Convention on Tobacco Control (FCTC) is the first international public health treaty and it has contributed to a change in public perceptions about the need for regulations, and given new impetus to efforts to control the harm caused by tobacco.[27] The FCTC requires that signatories enact comprehensive legislation to, amongst other things, restrict exposure to second-hand smoke, raise tobacco taxes, reduce smuggling, restrict tobacco advertising and increase the health warnings on tobacco packaging.[28] The FCTC came into force in February 2005, and as of October 2010 it had been ratified by 172 countries.[29]

It is important to remember that smoking is a disease of dependency that can be successfully treated, and this should be in the forefront of debate on smoking cessation. Article 14 of the FCTC represents a clear commitment of parties to the FCTC to tackle tobacco dependence. Guidelines on how countries should implement Article 14, produced by a working group of national experts, have recently been adopted by parties to the FCTC.[30]

This report assesses the preparedness of 20 European countries (including Switzerland and the Czech Republic which have yet to ratify the FCTC)[31] to enact the required legislation and implement policies compliant with the FCTC.

01.03 REPORT METHODOLOGY

Experts in each of the 20 countries studied were interviewed from June to October 2010 and, where possible, factual information was verified and appropriate references supplied. The country-specific reports and country-specific recommendations were drawn from the views of the interviewees and their recommendations were endorsed by the Editorial Partners.

01.04 KEY RECOMMENDATIONS

This report makes a number of recommendations to reduce smoking prevalence and the demand for tobacco products. These recommendations are based on country-specific recommendations provided by the interviewees combined with the Editorial Partners' own experience and views. The following recommendations are presented in the order of the themes within this report (rather than editorial preference) and have been endorsed by the Editorial Partners.

Increase tobacco prices
Increasing tobacco prices (through increased taxation), is supportive of the FCTC and has been proven to lead to a decrease in tobacco consumption.[32,33] Increasing tobacco prices increases government revenue,[34] whilst encouraging smokers to quit and seek help,[35,36] and thereby decreasing the demand for tobacco.[37]

Reimburse time for providing smoking cessation counselling (or increase existing reimbursement)
The addictive nature of smoking makes it difficult for smokers to quit, however, they can quit, especially if provided with additional support such as behavioural therapy, counselling, primary care interventions and/or pharmacotherapy.

Reimbursed smoking cessation services such as GP interventions and referral to specialist smoking cessation counselling have been shown to successfully attract significant numbers of people from deprived areas.[38] Smoking cessation services should therefore be made fully available and accessible in all European countries to avoid health inequalities.

Reimburse smoking cessation medications
Reimbursement of smoking cessation medications has been shown to increase access to such medication,[39] the numbers making a quit attempt,[40] the number of successful quitters[41] and those using smoking cessation services.[42] Medication reimbursement is cost-effective in primary care when associated with GP training.[43]

Based on considerations of their effectiveness and cost-effectiveness, patients should have access to, and reimbursement for, smoking cessation medications.

Provide national guidance and clinical guidelines (or implement existing ones)

National guidance
National guidance should be prepared and implemented to ensure that smoking cessation services are directed where they are most needed and to provide a standardised service across the particular country.

National clinical guidelines
Development of appropriate guidelines and measures to promote tobacco cessation and adequate treatment for tobacco dependence are a requirement of the FCTC.[44] It is thought that such clinical guidelines will increase the ability of healthcare providers to deliver evidence-based services and ensure service consistency across the nation.

Further training for primary care physicians
Based on the research for this report, it is thought that a shift in attitude is required for many primary care physicians who currently do not consider smoking to be a disease or a condition that needs to be treated. Training, delivered nationally with a unified curriculum, is considered important so that primary care physicians will be confident to establish their patients' smoking habits, treat smoking as a disease, promote and support smoking cessation programmes and follow up with their patients as required.

More involvement of primary care physicians in smoking cessation programmes
Motivating GPs to become more involved in smoking cessation requires training, but this could also be combined with personal incentives to GPs for identifying smokers, counselling them to quit smoking, referring them to the appropriate smoking cessation programmes or treating them with smoking cessation medications, and making follow-up appointments.

Improve training for all healthcare professionals
All HCPs have a role in providing smoking cessation advice to their patients. Therefore, HCPs should be empowered by the provision of appropriate education and training.

01.05 COUNTRY-SPECIFIC RECOMMENDATIONS

In addition to the above key recommendations, this report provides recommendations relevant to each country such as tightening the existing smoke-free legislation, providing the healthcare professionals with guidelines in their local language and improving education for the general public so that they can better understand smoking as a disease and the resources available to help them quit (e.g. quitlines).


Smoking
kills

INTRODUCTION

Summary

- Tobacco dependence is a disease that causes other diseases and takes a heavy toll both on the individual's health and well-being and on society as a whole[45]
    - Tobacco dependence is a major cause of death from cancer, and is a factor for cardiovascular disease and pulmonary disease.[46]
- The Framework Convention on Tobacco Control (FCTC) is the World's first international public health treaty[47]
    - The FCTC came into force in February 2005 and has been ratified by 172 countries (as of October 2010).[48]

02.01 BACKGROUND

Tobacco dependence is a disease that causes other diseases and takes a heavy toll both on the individual's health and well-being and on society as a whole.[49] Smoking is a major cause of death from cancer, cardiovascular disease and pulmonary disease and a risk factor for many other diseases (e.g. respiratory tract and other infections, osteoporosis, and diabetes.)[50]

Europe has battled with the problem of tobacco dependence for decades. Pressure is finally mounting on national governments to mobilise resources and enforce restrictions to minimise the impact of smoking on public health.

The Framework Convention on Tobacco Control (FCTC) is the World's first international public health treaty, which came into force in February 2005. It was the first ever health treaty sponsored by the World Health Organization (WHO) and as of October 2010 it has been ratified by 172 countries, covering 87.3% of the world's population.[51]

The core demand reduction provisions in the FCTC consist of:[52]

- Price and tax measures to reduce the demand for tobacco (Article 6)
- Non-price measures to reduce the demand for tobacco (Article 7), including:
    - Protection from exposure to tobacco smoke (Article 8)
    - Regulation of the contents of tobacco products (Article 9)
    - Regulation of tobacco product disclosures (Article 10)
    - Packaging and labelling of tobacco products (Article 11)
    - Education, communication, training and public awareness (Article 12)
    - Tobacco advertising, promotion and sponsorship (Article 13)
    - Demand reduction measures concerning tobacco dependence and cessation (Article 14).

The European Union (EU) Council Recommendation on smoke-free environments of 30 November 2009 supports the effective implementation of Article 8 of the FCTC (protection from exposure to tobacco smoke).[53] The EU Council Recommendation calls upon Member States to:

- Adopt and implement laws to protect citizens from exposure to tobacco smoke in enclosed public places, workplaces and public transport within three years from the adoption of the recommendation.
- Enhance smoke-free laws with supporting measures such as protecting children, encouraging efforts to give up tobacco use and the use of pictorial warnings on tobacco packaging.
- Strengthen cooperation at EU level by setting up a network of national focal points of tobacco control.

The EU Council proposes that national, binding legislation, rigorously enforced, monitored and evaluated, is an appropriate way to deal with the problem of second-hand smoke.

Governmental intervention is paramount in the efforts to reduce the demand for and supply of tobacco. However, the Editorial Partners believe it is unlikely that government policies on issues such as tobacco advertising and smoke-free legislation alone will be sufficient. Instead, a concerted effort is likely to be the most successful and will require:

- Stronger legislation and enforcement
- Guidelines on smoking cessation integrated into each individual country's healthcare system
- Targeted smoking cessation advice and education for both healthcare professionals and smokers
- Provision of appropriate infrastructure to provide tobacco dependence services.

World Bank[54]

The best results are achieved when a comprehensive set of measures to reduce the use of tobacco are implemented together.

02.01.1

02.02 PURPOSE, TARGET AUDIENCE, METHODOLOGY AND SCOPE OF THIS REPORT

02.02.1 OBJECTIVES OF THE REPORT

This report aims to assess the current status of smoking cessation services across Europe and to provide recommendations to countries for improving their smoking cessation infrastructures.

Secondary objectives of the report include:

- Reviewing country-specific data and opinion
- Highlighting which measures are already in place for the management of smoking cessation in the European countries covered
- Providing examples of best practice so other countries may be able to implement these actions in order to improve their own situation
- Providing recommendations to help countries improve their services, in order to improve patient care and reduce the prevalence of smoking by increasing cessation through tobacco control
- Providing recommendations to help European parties signed up to the FCTC to fulfil their commitment to implement the treaty in full and in particular to implement the Article 14 guidelines at a national level.

02.02.2 TARGET AUDIENCE

This report should be of interest to:

- Public health policy leaders responsible for European, national or regional healthcare
- Non-governmental organisations (NGOs) active on tobacco control issues
- Healthcare professionals (HCPs)
- Patient organisations (e.g. cancer, cardiology, respiratory care groups etc.)

02.02.3 METHODOLOGY

Desk research
PubMed, Cochrane reviews and various other Internet resources were used by Bridgehead International to conduct desk research for this report.

Interviews
In order to establish the current status of smoking cessation services across Europe, interviews were conducted with expert stakeholders in each country covered in this report (see Appendix in section 11.02). Interviews were conducted from June to October 2010 utilising a structured interview guide but broader, free-ranging qualitative questions were also included.

The interviewees were chosen because of their knowledge and experience in the field of smoking cessation. As far as possible, an attempt was made to include a cross-section of stakeholders, representing NGOs involved in smoking cessation, healthcare professionals, health policy makers and those advising national governments.

In total, 57 experts were interviewed with generally three interviewees per country. The Editorial Partners would like to thank these stakeholders for their valuable contributions, both during the interview programme and in reviewing the country-specific elements of the report (section 08). Where possible, factual information was verified and appropriate references were supplied.

Each country-specific report was reviewed and approved by the interviewees and therefore includes their views and opinions. In particular, the country-specific reports and recommendations were drawn from the views expressed by the interviewees and these recommendations have been endorsed by the Editorial Partners.

With editorial approval, additional information has been added to the country-specific reports where the situation has evolved since the interviews took place (e.g. a new law was enacted).

Roles
For further details on the roles of those involved please see section 11.03. Briefly this can be summarised as follows:

- Editorial Partners
  The four Editorial Partners were selected for their broad range of knowledge in the field of tobacco control and they also cover a number of geographical areas. The Editorial Partners have reviewed and endorsed the content of the entire report and its recommendations. The opinions and recommendations contained within are those of the Editorial Partners and should not be attributed to Pfizer.
- Bridgehead International
  Bridgehead International were commissioned by Pfizer to help facilitate the preparation of the report and to conduct the interviews.
- Pfizer
  Pfizer initiated this project and provided the funding. Pfizer worked in collaboration with the Editorial Partners, Bridgehead and the external experts to contribute to this report.

02.02.4 GEOGRAPHICAL SCOPE OF THE REPORT

Countries covered in this report are:

- Austria
- Belgium
- Czech Republic
- Denmark
- Finland
- France
- Germany
- Greece
- Hungary
- Ireland
- Italy
- Luxembourg
- Netherlands
- Norway
- Poland
- Portugal
- Spain
- Sweden
- Switzerland
- United Kingdom

These countries were chosen, based on the quality and depth of the data available from desk research, and to provide a broad overview of smoking cessation services across Europe.

THE SMOKING EPIDEMIC

Summary

- Cigarette smoking is the most common type of tobacco consumption[55]
- 28.6% of Europeans smoke daily[56]
- Tobacco smoking is a leading cause of premature death, killing half of all lifetime users, with half of these dying in middle age (between 35 and 69 years old)[57]
    - In industrialised countries, tobacco-related deaths represent one in five of all deaths[58]
    - Smoking is a major cause of death from cancer with 1 in 4 of all deaths from cancer in the European Union (EU) caused by smoking[59]
    - Tobacco use is a major cause of death from cardiovascular disease, and pulmonary disease[60]
    - Smoking is a risk factor for respiratory tract and other infections[61] and increases the risk of death in those with asthma[62]
    - Even a small reduction in smoking prevalence can lead to a reduction in the number of smokers dying prematurely.[63]
- Smoking is an addiction[64]
- There is no safe level of exposure for second-hand smoke[65]
- The annual global cost of tobacco is US$500 billion[66]
    - This includes direct healthcare expenditure, lost earnings and reduced productivity, and other costs.
- There are economic and health benefits to smokers of reducing smoking, as well as health benefits to the households and co-workers of smokers
- Social and health inequality can affect smoking prevalence

03.01
SMOKING PREVALENCE

Cigarette smoking is the most common type of tobacco consumption and, according to the World Health Organization (WHO), 1.3 billion people worldwide smoked in 2004.[67]

In the WHO European Region, the overall adult daily estimated smoking prevalence (population-weighted) has stabilised at around 28.6%.[68] The estimated average smoking prevalence among males is 40%: in 14 (mostly eastern European) countries there is a higher prevalence of male smoking, while in 12 (mostly western European) countries the male smoking prevalence is below 30%.[69] The estimated average female smoking prevalence is 18.2%: in 24 (mostly western European) countries the prevalence rate is higher, while in eight eastern European countries it is below 10%.[70]

The rate of tobacco smoking varies considerably between European Countries, as shown in Table 1.

However, within a country, smoking prevalence is not evenly spread across the whole population. For instance, in Scotland, the overall smoking prevalence is 25.2% but in the most deprived areas this rises to 42.0%.[91] Various factors can increase smoking prevalence such as:[92]

- Educational level
- Occupational class
- Accumulated wealth (measured by household assets rather than income)
- Housing tenure (tenants rather than owner-occupiers).

It is, therefore, particularly important to try to reach the lower socio-economic strata of society with tobacco control messages and smoking cessation services. However, as Graham *et al.* point out, such actions may be insufficient if the barriers actually lie in the social disadvantage to which the smokers are exposed.[93]

Country	% of regular daily smokers in the population (age 15+)	Survey year
Austria	34% (assumed daily and occasionally)[71]	2009
Belgium	20.5%[72]	2008
Czech Republic	26.3% (15-64 years)[73]	2009
Denmark	21.5%[74]	2009/2010
Finland	18.6%[75]	2009
France	28.7%[76]	2010
Germany	23.4%[77] (regular smokers)	2009
Greece	35%[78]	2008
Hungary	30%[79]	2007
Ireland	27%[80]	2008
Italy	23% (14 years+)[81]	2009
Luxembourg	19%[82]	2009
Netherlands	28%[83]	2009
Norway	21% (aged 16-74) 6% daily snuff[84]	2009
Poland	30.3%[85]	2009/2010
Portugal	22%[86]	2008
Spain	26.4%[87]	2006
Sweden	18%[88]	2008
Switzerland	20%[89] (aged 14-65)	2007
United Kingdom	21%[90]	2007

Table 1: Rates of smoking in certain European countries

In a report in 2009, the WHO acknowledged the progress of Ireland, the UK, Norway and Iceland in reducing the smoking prevalence over the preceding decades but they highlighted the significant problem with youth and adolescent smoking in many countries.[94]

Despite the efforts of smoke-free legislation, around one-third of Europeans continue to smoke, although there does appear to be a downwards trend in active smoking, as reported in a recent Cochrane Review by Callinan *et al.*[95]

There is currently a limited evidence base for the impact of smoke-free legislation on active smoking (Table 2). However, these studies do confirm a decrease in smoking prevalence after the implementation of smoke-free legislation.

It should be noted that even a small reduction in smoking prevalence can lead to a reduction in the number of smokers dying prematurely. A single percentage reduction in smoking prevalence has been predicted to lead to 2,000 fewer chronic heart-disease deaths per year in the UK.[100] Therefore, more needs to be done to optimise the impact of smoke-free legislation by providing appropriate support to smokers who wish to quit.

Country	Smoking prevalence before the smoke-free law	Smoking prevalence after the smoke-free law
Canada (Saskatoon)[96]	24.1% (23.8% in control Saskatchewan region)	18.2% (23.8% in control Saskatchewan region)
Italy[97]		8% decrease in cigarette consumption in the short term
Norway[98]	51.8% (prevalence in food service workers)	-4.6% initial reduction -6.8% at 4 months -6.8% at 11 months
USA (Lexington-Fayette County)[99]	25.7% (28.4% in the control group of 30 counties)	17.5% (27.6% in the control group)

Table 2: Smoking prevalence before and after the implementation of smoke-free legislation

03.02 MORBIDITY AND MORTALITY

Tobacco use continues to be the single largest cause of death and disease in the EU and the WHO estimates that smoking kills as many as 650,000 in Europe each year.[103] The WHO also states that a long-term tobacco user has a 50% chance of dying prematurely from tobacco-related diseases.[104]

Even with its life-threatening and well-known consequences, tobacco smoking continues to be a leading cause of premature death, killing half of all lifetime users, with half of these dying in middle age (between 35 and 69 years old).[105]

Cigarette smoking is a major public health concern and tobacco dependence should be recognised as a chronic disease like hypertension or diabetes.[106] Tobacco is the leading contributor to the disease burden in more than half the European Member States.[107] It is a major cause of death from cancer (1 in 4 of all deaths from cancer in the EU is caused by smoking),[108] cardiovascular disease and pulmonary disease.

In industrialised countries, tobacco-related deaths represent one in five of all deaths.[101]

In one European country (population of roughly 50 million), the number of people killed by smoking is the equivalent of a jumbo-jet crashing each day with the loss of all on board.[102]

03.02.0

It has been estimated that smoking is responsible for at least two-thirds of chronic obstructive pulmonary disease (COPD) deaths[109] and that smoking cessation is an effective way to slow the decrease in lung function.[110]

Cigarette smoking is a risk factor for respiratory tract and other infections, osteoporosis, reproductive disorders, adverse post-operative events and delayed wound healing, duodenal and gastric ulcers, periodontal disease[111] and diabetes.[112]

Smoking is also a risk factor for the development of asthma and is associated with an increased risk of mortality, asthma attacks and exacerbations as well as decreased asthma control.[113] Smoking, particularly heavy smoking, is reported to increase susceptibility to rheumatoid arthritis. Smoking also adversely affects the clinical course of the diesease.[114]

The results of a study into the long-term association of smoking in middle age with dementia, Alzheimer's disease and vascular dementia were recently published.[115] This large cohort study found that heavy smoking in mid-life was associated with more than a 100% increase in dementia, Alzheimer's disease and vascular dementia more than two decades later.

03.03 SMOKING IS AN ADDICTION

The terms addiction and dependence are often used interchangeably when referring to smoking. According to Gray *et al*.,[117] the appropriate term with regard to smokers is 'addiction' rather than 'dependence'. Addiction, it is argued, provides the broad umbrella term for the compulsive, generally harmful, pattern of drug self-administration as is characteristic of most cigarette smokers and many users of other tobacco products. The authors assume that 'addiction' is equivalent to the term 'dependence' as used by the WHO (International Classification of Disease, 10th revision (ICD-10), 1991)[118] and the American Psychiatric Association.[119]

> Cigarette smoking is probably the most addictive and dependence-producing form of object-specific self-administered gratification known to man.
> **Russell *et al*. (1978) cited in Gray *et al*. (2005)[116]**

03.03.0

A recent study focused on nicotine as a determinant of addiction to tobacco. The author clearly indicates that smoking is an addiction, concluding that "tobacco addiction (like all drug addictions) involves the interplay of pharmacology, learned or conditioned factors, genetics and social and environmental factors (including tobacco product design and marketing)".[120]

The addiction or dependence generated by smoking has been likened to addiction to heroin and cocaine.[121] In 2000, the UK's Royal College of Physicians summarised the body of research by concluding that nicotine is an addictive drug on a par with heroin and cocaine and that the primary purpose of smoking tobacco is to deliver a dose of nicotine rapidly to the brain.[122]

The WHO estimates that 75-85% of smokers would like to quit and that around one-third have made at least three serious attempts to do so, however, less than half of smokers succeed in stopping permanently before the age of 60.[123]

03.04 SECOND-HAND SMOKE

Second-hand tobacco smoke is the smoke emitted from the burning end of a cigarette (also known as 'side-stream smoke') or from other tobacco products, in combination with the 'mainstream smoke' exhaled by the smoker. Second-hand smoke (SHS) is variously called involuntary smoking, passive smoking and environmental tobacco smoke. The International Agency for Research on Cancer has declared SHS as carcinogenic.[124]

Article 8 of the Framework Convention on Tobacco Control (FCTC) focuses on "protection from exposure to tobacco smoke" and signatories to the FCTC have agreed to recognise that "scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability."[125] Signatories agreed to adopt effective legislation in order to provide protection from second-hand smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.

In 2002, before the introduction of smoke-free policies, second-hand smoking at work appeared to account for over 7,000 deaths across the EU every year. Second-hand smoking at home appeared to account for 72,000 deaths per year.[126]

Since the introduction of smoke-free policies, a Cochrane review by Callinan *et al.* has found consistent evidence of reduced exposure to SHS in workplaces, restaurants, pubs and in public places.[127] Callinan *et al.* also found consistent evidence of a reduction in cardiac events as well as some improvement in other health indicators after the introduction of smoke-free legislation.

In Scotland, following the introduction of smoke-free legislation covering all enclosed places, hospital admissions for acute coronary syndrome decreased by 17%, compared with only a 4% decrease in England (where the legislation was not in place at the time). Although 67% of the decrease involved non-smokers, fewer admissions among smokers also contributed to the overall reduction.[128]

A study in northern Italy (Piedmont region) reported the number of admissions for acute myocardial infarction (AMI) decreased significantly after the introduction of the smoke-free legislation: from 922 cases in February-June 2004 to 832 cases in February-June 2005 (sex- and age-adjusted rate ratio, 0.89; 95% Confidence Interval (CI) 0.81-0.98 in those aged under 60 years). The authors postulated the effects on AMI admissions might be due to the reduction of passive smoking.[129]

In Italy, after the smoke-free legislation there was a statistically significant reduction in acute coronary events in the adult population, suggesting that public interventions that prohibit smoking can have enormous public health implications.[130]

03.05 ECONOMIC BURDEN OF SMOKING

Smoking places a tremendous economic burden on society. The WHO estimates that the annual global cost of tobacco is US$500 billion. This drain on the world economy is so large that it exceeds the total annual expenditure on health in all low- and middle-resource countries.[131] Tobacco's total economic costs reduce national wealth in terms of gross domestic product (GDP) by as much as 3.6%.[132] In France for instance, the total economic cost of tobacco as a percentage of the GDP is just over 1%.

According to the WHO, the economic burden is particularly high in the developing world – four out of five tobacco-related deaths will be in this region by 2030. The poor are disproportionately affected, because the money that people spend on tobacco cannot be spent on necessities, including food, shelter, education and healthcare.[133]

Tobacco's economic costs extend beyond the direct costs of tobacco-related illness and death and the related productivity losses. The substantial economic impact of tobacco can be traced to three central elements:[134]

- Direct healthcare expenditures attributable to the treatment of tobacco-related diseases – in both active smokers and those affected by second-hand smoke

- Employee absenteeism and reduced workplace productivity
- Other consequent costs, such as:
    - Fire damage related to smoking
    - Costs related to cleaning up after smoke and discarded litter (e.g. cigarette filters or 'butts')
    - Widespread environmental harm from, for example, large-scale deforestation required for further tobacco farming, pesticide and fertiliser contamination from this tobacco farming and discarded litter (e.g. cigarette filters or 'butts').

This compares with estimates of the annual cost of alcohol-related harm in England at £20-£55 billion, including alcohol-related disease, crime and antisocial behaviour, loss of productivity, domestic violence and other issues.[135]

03.05.1 DIRECT MEDICAL EXPENDITURES ATTRIBUTABLE TO THE TREATMENT OF SMOKING-RELATED DISEASES

The World Bank estimates that in high-income countries, smoking-related healthcare accounts for between 6% and 15% of all annual healthcare costs.[136] According to Lightwood in 2000, the gross healthcare costs associated with smoking in high-income countries was 0.10% to 1.1% of GDP.[137] Studies conducted in the European Region suggest that these costs could be even higher.[138]

The direct and indirect costs of smoking in the EU were estimated at €98-€103 billion in 2000 or around 1% of the GDP of the EU.[139] The WHO quotes annual tobacco-related healthcare costs are nearly US$7 billion in Germany.[140]

Available data show that the costs are more substantial in some of the newer EU member states, where the burden of disease and the death rates related to smoking are higher. For example, studies in Hungary concluded that the cost of smoking represented 3.2% of GDP. SHS exposure also imposes economic burdens, both for the costs of direct healthcare, as well as indirect costs, such as reduced productivity. For example, SHS exposure in the USA costs an estimated US$5 billion annually in direct medical costs.[141]

03.05.2 LOST EARNINGS AND WORKPLACE PRODUCTIVITY

A study in the UK estimates the annual economic costs of smoking-related lost earnings and productivity at more than £10 billion, broken down as follows:[142]

- Loss in productivity from smoking breaks – £2.9 billion
- Increased absenteeism – £2.5 billion
- Loss in economic output from the deaths of smokers – £4.1 billion
- Loss in economic output from the deaths of second-hand smokers – £713 million.

The economic costs of tobacco use in the USA related to productivity losses are US$96.8 billion.[143] Second-hand tobacco smoke exposure in the USA costs an estimated US$5 billion annually in indirect costs caused by productivity losses from lost wages due to disability and premature death.[144]

03.05.3 OTHER CONSEQUENT COSTS

These costs include fire damage and increased cleaning costs, as well as damage to the environment from deforestation, contamination caused by pesticides/fertilisers, and litter.

Worldwide, it is estimated that 10% of all fire deaths involve smoking materials. Table 3 (page 26) highlights the socio-economic impact of smoking-related fires.

A recent publication indicated that the annual cost to the UK economy of smoking-related house fires is £507 million, whilst cleaning up cigarette butts costs £342 million each year.[146]

The global environmental burden of discarded cigarette filters is significant: it is estimated that 845,000 tons (1.69 billion pounds) of cigarette butts finish up as litter worldwide each year.[147]

	United States (2005)	Canada (2002)	UK (2005)	Japan (2003)	Worldwide (2000)*
Number of fires	82,400	7,700	3,200	3,300	1.1 million
Deaths	800	140	140	230	17,300
Injuries	1,660	470	1,100	No data	60,000
Property damage (US$)	575 million	84 million	No data	89 million	27 billion

*10% of all fire deaths involved smoking materials

Table 3: Cost of fires caused by smoking, selected countries[145]

03.06 BENEFITS OF REDUCING SMOKING PREVALENCE

03.06.1 ECONOMIC BENEFITS

The PESCE report (General Practitioners and the Economics of Smoking Cessation in Europe) was a partly EU-funded programme involving clinicians and researchers from 27 European countries. One of the work packages within the PESCE project examined the health and economic benefits that could result from a reduction in smoking of 3%. An economic model was used to predict the health and economic effects of this level of reduced smoking for each country providing data.[149]

An analysis of ten European countries showed that a 3% reduction in smoking prevalence would yield annual savings in disease-specific healthcare costs alone (related to a reduction in incidence of lung cancer, chronic heart disease, stroke and COPD) amounting to over €166 million by 2030 (Table 4).[150]

A reduction in smoking of 3% would bring about the following annual savings (€'000)			
Country	2010	2020	2030
Austria	2,049	9,393	13,412
France	2,921	18,412	33,234
Germany	714	4,044	7,082
Netherlands	1,325	10,392	19,673
Switzerland	132	1,560	2,218
Ireland	259	2,173	4,478
Poland	3,628	22,721	37,950
Portugal	339	3,687	7,466
Romania	565	2,419	3,686
UK	6,470	27,255	37,141
Total (€'000)	18,398	102,056	166,340

Note: Totals may not add exactly due to rounding

Table 4: Annual reduction in disease-specific healthcare costs in 10 European countries[151]

Using the UK as an example, it can be seen that the economic benefits are even greater when the value of deaths avoided, reduced sickness absence and reduction in fires are taken into account (Table 5).

For every US dollar spent on smoking cessation programmes, it has been estimated that between $4 and $4.70 is saved on healthcare costs.[148]

03.06.1

	2010 savings (€ million)	2020 savings (€ million)	2030 savings (€ million)
Reduction in health service costs from 4 diseases	6.47	27.25	37.14
Value of deaths avoided	11.08	67.13	95.00
Value of reduced sickness absence	20.95	19.52	18.18
Value of reduction in fires	7.92	7.39	6.88
Total (€ million)	46.42	121.28	157.20

Note: Totals may not add exactly due to rounding

Table 5: UK annual savings from a reduction in smoking of 3%[152]

Naidoo and colleagues postulated that reducing the UK smoking prevalence in accordance with government targets (from 28% in 1996 to 26% by 2005, and 24% in 2010) would prevent 6,386 hospitalisations for acute myocardial infarction (AMI) and 4,964 hospitalisations for stroke by 2010, saving a total of £524 million in healthcare costs.[153] Reducing smoking prevalence to the more ambitious targets observed in California (from 28% in 1996 to 22% in 2005, and 17% in 2010) would prevent 14,554 hospitalisations for AMI and 11,304 hospitalisations for stroke, saving £1.14 billion in healthcare costs by 2010.

A Danish study considered the economic effects of smoking cessation from a lifetime perspective and showed that the total, direct and productivity lifetime cost savings of smoking cessation in moderate smokers who quit smoking at the age of 35 years were €24,800, €7,600, and €17,200 in men, and €34,100, €12,200, and €21,800 in women, respectively.[154] (This study calculated costs in Danish Krone and subsequently converted these to Euros.)

The UK's National Institute for Health and Clinical Excellence (NICE) found GP smoking cessation services to be highly cost effective.[155] Such services provide a quit rate between 3 and 15%. Relative to their cost, these services are just about the most cost-effective interventions available to health services.[156]

In 2004, Parrott *et al.* found that face-to-face cessation interventions offer excellent value for money when compared with some other healthcare interventions such as aspirin after myocardial infarction and statins in primary prevention.[157]

03.06.2 HEALTH BENEFITS FOR SMOKERS WHO QUIT

Stopping smoking has substantial immediate and long-term health benefits for smokers. The excess risk of death from smoking falls soon after cessation and the onset of the initial benefits from smoking cessation are rapid (Table 6 page 28). However, it takes up to 15 years for the former smoker to approach or completely revert to the life expectancy of a non-smoking individual.[158]

The increased risk of death from smoking begins falling shortly after quitting, and the initial benefits from smoking cessation rapidly become apparent. Although it may take as long as 15 years for the overall health status and mortality risk to return to a non-smoking level,[171] former smokers live longer than continuing smokers, no matter at what age they stop smoking.[172] Smokers who stop at age 50 halve the hazard and those that stop before 30 avoid almost all of the hazard.[173]

Timeframe	Effect on health of smoking cessation
Within days	The excess risk of acute coronary syndrome associated with smoking decreases within days after smoking cessation.[159]
Within 1 month	Rapid and substantial improvement in self-reported respiratory symptoms in COPD patients.[160]
Within months	Reduced incidence of respiratory infections.[161]
0-9 months	Smoking cessation interventions in pregnancy reduce low birth weight and preterm birth.[162]
0 to 12 months	The excess risk of death from smoking falls soon after cessation and the onset of the initial benefits from smoking cessation are rapid.[163]
Within 1 year	The excess in heart disease mortality due to smoking is halved.[164] COPD patients will experience an improvement in FEV1 (forced expiratory volume in 1 second) of 47 ml or 2%.[165]
Within 5 years	The excess risk of oral and oesophageal cancer caused by smoking is halved within five years of cessation.[166] Quitting provides a significant 13% reduction in the risk of all-cause mortality within the first 5 years of quitting smoking compared with continuing to smoke.[167]
Within 15 years	Within 15 years, the absolute risk of mortality is almost the same as in people who have never smoked.[168] Around a 40% reduction in the risk of hospital admissions for COPD in previously diagnosed COPD patients.[169] Sustained ex-smokers had a risk of dying from certain tobacco-related diseases that did not differ significantly from sustained never-smokers. Lung cancer in males was the only exception.[170]

Table 6: Smoking cessation has substantial immediate and long-term health benefits for smokers

As for the increased morbidity, the rate and extent of reduction of risk varies between diseases. For example, in the case of lung cancer, the risk falls over 10 years to about 30-50% of that of continuing smokers, but the risk remains raised even 20 years after quitting. Stopping smoking before the age of 30 removes 90% of the lifelong risk of lung cancer, but quitting at any age is still beneficial.[174]

Within a year of quitting, the increase in heart disease mortality due to smoking is halved, and within 15 years, the absolute risk is almost the same as in individuals who have never smoked. Smoking cessation also reduces the risk of death after a stroke and of death from pneumonia and influenza.[175]

Cessation results in a small increase in lung function compared to those who continue to smoke who have an accelerated rate of decline in lung function with age. Upon smoking cessation, the smokers' rate of decline in lung function reverts to that in non-smokers.[176]

The PESCE study concluded that if ten countries out of the 27 project countries could achieve a 3% reduction in the number of people smoking, then by 2030 there would be over 4,000 fewer deaths per year from chronic heart disease, COPD, lung cancer and stroke alone. Reductions in the incidence of these four diseases would lead to healthcare cost savings in the EU of over 160 million Euros.[177]

Cost implications of providing smoking cessation services

Section 03.06.1 reviewed the evidence that providing smoking cessation interventions are cost-effective on an individual basis. However, those responsible for funding smoking cessation services often worry that the cost of such services, if offered to all smokers, will exceed their available resources due to the large number of smokers.

This logic is flawed for a number of reasons:

- Not all smokers wish to give up smoking
    - A population-based survey of 1,750 smokers in Germany, Greece, Poland, Sweden and the UK found that on average, 15.0% would rather not quit smoking and 10.2% definitely do not wish to quit smoking.[178]

Year	Number setting a quit date	Number of successful quitters (at 4-week)	Percentage who successfully quit (at 4-week)
2003/04	361,224	204,876	57
2004/05	529,567	298,124	56
2005/06	602,820	329,681	55
2006/07	600,410	319,720	53
2007/08	680,289	350,800	52
2008/09	671,259	337,054	50
2009/10	757,537	373,954	49

* A client counted as having successfully quit smoking at the 4-week follow-up if he/she has not smoked at all since two weeks after the quit date.

Table 7: Summary of English Smoking Cessation Services – uptake and quit rate[183]

Year	Total expenditure (£ millions)*	Cost per quitter (£)
2003/04	36.2	177
2004/05	47.1	158
2005/06	51.9	158
2006/07	51.2	160
2007/08	60.8	173
2008/09	73.7	219
2009/10[183]	83.9	224

* Excludes cost of pharmacotherapies such as nicotine replacement therapy (NRT), bupropion and varenicline. Financial figures presented do not take into account inflation and are presented in cash terms only.

Table 8: Summary of English Smoking Cessation Services – total expenditure and cost per quitter[184]

- Not all smokers who wish to give up smoking seek help from smoking cessation services
  - France: 62% of French smokers did not use any support to quit smoking and only 13% sought help from a physician when they made several attempts to quit smoking[179]
  - England: Less than half of English smokers (49%) surveyed used evidence-based smoking cessation treatment when making a quit attempt. 48% use some form of medication (mainly over-the-counter NRT) and 6.2% used the National Health Service (NHS) Stop Smoking Services.[180]
  - Poland: 77% of Polish smokers attempted to quit smoking on their own in a survey of 618 smokers and former smokers.[181]

Experience has been gained from a number of countries which shows that uptake of smoking cessation services among smokers is far from universal. As such, the provision of smoking cessation services has been affordable and indeed cost-effective in these countries.

The cost of the English Stop Smoking Service

In England, Stop Smoking Co-ordinators provide a smoking cessation service for the NHS Stop Smoking Services. Stop Smoking Co-ordinators are required to monitor all NHS Stop Smoking Services and this information is collected and published every quarter (Table 7). These Stop Smoking Co-ordinators normally offer weekly support for at least the first four weeks of a quit attempt and this may be by telephone. Smokers are deemed to have quit if they have not smoked at all during the two weeks after their quit date.[182] See tables 7 and 8.

The total expenditure on NHS Stop Smoking Services in England in 2009/10 (excluding nicotine replacement therapy (NRT), bupropion and varenicline prescriptions) was just under £83.9 million, over £10 million more than in 2008/09 and almost £60 million more than in 2001/02[185] (Table 8).

The percentage of smokers in Great Britain (England, Scotland and Wales) has been estimated at 21% of those over 16 years[186] and this percentage has been estimated to be the same in England.[187] Using these data and data regarding the population in England,[188] it can be estimated that England's smoking cessation services saw 6.2% of the smoking population in 2008 and 6.5% of the smoking population in 2007.

03.06.3 BENEFITS TO NON-SMOKERS – HOUSEHOLDS OF SMOKERS

The risk of both lung cancer and coronary heart disease is about 25% higher in non-smokers who live with a partner who smokes.[189]

03.06.3

In adults, SHS causes serious cardiovascular and respiratory diseases, including coronary heart disease and lung cancer.[190] It can therefore be inferred that the absence of SHS in the home would bring substantial benefits for the families of smokers. For babies exposed to tobacco smoke either during pregnancy or after birth, there is an increased risk of premature birth and low birth weight and a doubling of the risk for sudden infant death syndrome. Children exposed to SHS have a 50-100% higher risk of acute respiratory illness, a greater incidence of ear infections and an increased likelihood of developmental disabilities and behavioural problems.[191]

Around 40% of all children are regularly exposed to SHS at home and 31% of the deaths attributable to SHS occur in children.[192] A reduction in exposure to SHS would clearly have a marked impact on the health and lives of these children.

A recent study by Holliday *et al.* of schoolchildren aged 10-11 utilised self-reported questionnaires and cotinine assays of saliva samples. Cotinine is the main specific metabolite of nicotine and a well-established biomarker for SHS exposure. The study illustrated that the introduction of smoke-free legislation in Wales has not increased the SHS exposure of children. Holliday *et al.* concluded that although the findings indicate positive rather than harmful effects of legislation on children's SHS exposure, they highlight the need for further action to protect those children most exposed to SHS.[193]

A similar study on Scottish children aged 7 to 11 found that smoke-free legislation has reduced exposure to SHS among all children, with the greatest absolute reduction in cotinine observed in the lowest socio-economic group. However, the cotinine levels in this group were the highest, suggesting that the smoke-free legislation may be increasing inequality in this group.[194]

Exposure of children to smoke also occurs outside the home, for example, in cars where children are put at risk of adverse respiratory health. In Ireland, for example, as many as one in seven children are exposed to SHS in cars.[195]

03.06.4 BENEFITS TO NON-SMOKERS – CO-WORKERS

Workplace interventions, such as smoke-free legislation are generally instigated with the aim of protecting or improving the health of the workers, be they smokers or non-smokers. Various studies have reviewed the impact of smoke-free legislation on the health of workers previously subjected to passive smoking. The main conclusions of European trials looking at cotinine levels after the implementation of smoke-free legislation are highlighted in Table 9.

Country	Effect on non-smokers
Ireland	In Ireland, smoke-free legislation was implemented in public places including bars in March 2004. A study of 35 hospitality workers were found to have their cotinine levels reduced by 69% ($p<0.005$) and in 60% of the hospitality workers there was a halving of exposure levels at follow-up. The authors concluded that passive smoking and associated risks were significantly reduced but not totally eliminated.[196] A larger study by Allwight *et al.* looked at 329 bar workers in both the Republic of Ireland and Northern Ireland before and after the introduction of legislation for smoke-free workplaces in the Republic. In non-smoking bar workers from the Republic of Ireland, salivary cotinine concentrations dropped by 80% after the smoke-free law. In Northern Ireland over the same period, there was a 20% decline. The authors concluded that the smoke-free law in the Republic of Ireland protected non-smoking bar workers from exposure to SHS.[197]
Italy	In Italy, smoke-free legislation was introduced in all indoor public places and was enforced on 10 January 2005. A study of 40 public places (14 bars, six fast-food restaurants, eight restaurants, six game rooms and six pubs) in Rome, found the concentration of urinary cotinine among non-smoking workers decreased from 17.8 ng/ml to 5.5 ng/ml ($p<0.0001$) to 3.7 ng/ml ($p<0.0001$) after the introduction of the ban. The authors concluded that the application of the smoking ban led to a considerable reduction in the exposure to indoor fine and ultrafine particles in hospitality venues, confirmed by a contemporaneous reduction of urinary cotinine.[198]
Norway	In Norway, a study reviewed the impact of a total smoke-free policy on the level of airborne contaminants and the urinary cotinine levels in the bar and restaurant workers. Ninety-three employees were initially included in the study with 73 participating. The authors found that urinary cotinine levels were reduced in non-smokers.[199]
Spain	In Spain, a tobacco control law was introduced on 1 January 2006, which included workplaces being smoke-free and the imposition of partial limitation on smoking in bars and restaurants. A small study of 431 hospitality workers of whom 222 were smokers looked at the salivary cotinine concentrations in smokers from baseline to one year after the legislation was implemented.[200] The proportion of workers with a high nicotine dependence was reduced by half (19.5% vs. 9.7%, $p = .03$) and salivary cotinine decreased by 4.4% after legislation was implemented. Martínez-Sánchez *et al.* concluded that the smoke-free legislation had reduced the number of cigarettes smoked, the cotinine levels and the dependency of hospitality workers who smoked.[201]
Spain and Portugal	A study of 431 hospitality workers in Spain and 45 workers in Portugal and Andorra by Fernández *et al.* looked at the impact of partial smoke-free legislation among hospitality workers by assessing SHS. In the bars and restaurants where smoking was allowed, the exposure of non-smokers to SHS remained similar to pre-legislation levels indicating that partial restrictions on smoking do not sufficiently protect hospitality workers against SHS.[202]
Sweden	Larsson *et al.* studied exposure to SHS of hospitality workers in bingo halls, casinos and bars in nine Swedish communities one year after extended smoke-free legislation was introduced. The study showed that there was a substantial reduction in respiratory and sensory symptoms, as well as reduced exposure to environmental tobacco smoke at work after the introduction of the smoke-free legislation.[203]
UK (Scotland)	In Scotland, smoke-free legislation was implemented in March 2006 and a study found that cotinine concentrations in adult non-smokers fell by 39% after legislation ($p<0.001$). The authors of this study concluded that implementation of Scotland's smoke-free legislation was accompanied within one year by a large reduction in exposure to second-hand smoke, which has been greatest in non-smokers living in non-smoking households. However, non-smokers living in smoking households continued to have high levels of exposure to second-hand smoke.[204] A prospective observational study in Tayside, Scotland of 105 non-smokers found that the number of bar workers with respiratory and sensory symptoms decreased by 26% in the non-smoking bar workers who enrolled in the study. The authors concluded that smoke-free legislation was associated with significant early improvements in symptoms, spirometry measurements, and systemic inflammation of bar workers.[205]

Table 9: Summary of studies on cotinine levels after smoke-free legislation

It can be concluded that for non-smokers, smoke-free legislation has been shown to reduce the respiratory and sensory symptoms and reduce their exposure, as measured by cotinine levels.

03.07 TACKLING SOCIAL AND HEALTH INEQUALITY

Social deprivation (which can be measured by poor housing, low income, lone parenthood, unemployment or homelessness), is associated with high rates of smoking and very low rates of successfully quitting.[206] A study on socio-economic inequalities in mortality and self-assessed health across 22 European countries suggested that inequalities in access to good-quality healthcare have a role in generating inequalities in mortality.[207]

Compounding the problem for the socially deprived is that smoking is a major drain on their limited income and a significant cause of premature death and ill health.

Concomitant diseases may also lead to social inequity with regards to smoking. For example, people with schizophrenia are more likely to smoke than the general population.[208] Despite this, healthcare providers and tobacco control specialists have previously been reticent in offering tobacco dependence treatment to patients with schizophrenia. A number of reasons for this inaction have been suggested, including lack of information and the perceived hopelessness of such patients ever successfully quitting.[209]

03.08 SMOKING CESSATION SERVICE COSTS

A UK NICE report on the costs of implementing the NICE guidance on smoking cessation suggested that offering a smoking cessation service that includes the latest pharmacotherapy,[210] as well as behavioural support could cost an additional £5.9 million.[211] Similarly, implementation of public health intervention guidance on brief interventions for smoking cessation (PH1[212]) could add £5.4 million.[213]

Increasing the number of smokers accessing NHS Stop Smoking Services by 10% could increase the costs of smoking cessation services by £8.6 million. If there was no change in the number of smokers accessing the service but the proportion of smokers treated in groups increased from 30% to 50%, the cost of providing smoking cessation services would decrease by £6.9 million (and the success rate of smokers quitting in groups is at least as good as that of smokers quitting with one-to-one counselling).The report does not estimate the cost saving of implementing the guidelines.[214]

This compares with a cost of around £6.8 million to implement the NICE guidelines on alcohol-use disorders (physical complications), which could translate to a saving of around £7.1 million nationally.[215]

LEGISLATION AND POLICY ON TOBACCO CONTROL

Summary

- The Framework Convention on Tobacco Control (FCTC) was the world's first international public health treaty[216]
- It came into force in 2005 and has been ratified by 172 countries (October 2010)[217]
- Article 14 of the FCTC covers demand reduction measures concerning tobacco dependence and cessation[218]
- The FCTC includes measures to:[219]
    - Protect people from exposure to tobacco smoke by adopting effective smoke-free legislation and policy
    - Control access to tobacco by children
    - Limit tobacco advertising, promotion and sponsorship
    - Increase tax on tobacco products
    - Legislate against illicit tobacco trade.
- There are challenges to legislation and enforcement of tobacco controls because of concerns about the reduction in income from tobacco tax

04.01 FRAMEWORK CONVENTION ON TOBACCO CONTROL

In 2005, the World's first international public health treaty, the Framework Convention on Tobacco Control (FCTC) came into force. It has been ratified by 172 countries as of October 2010 and covers over 87.3% of the world's population.[220]

The FCTC's core demand reduction provisions are:[221]

- Price and tax measures to reduce the demand for tobacco (Article 6)
- Non-price measures to reduce the demand for tobacco (Article 7), namely:
    - Protection from exposure to tobacco smoke (Article 8)
    - Regulation of the contents of tobacco products (Article 9)
    - Regulation of tobacco product disclosures (Article 10)
    - Packaging and labelling of tobacco products (Article 11)
    - Education, communication, training and public awareness (Article 12)
    - Tobacco advertising, promotion and sponsorship (Article 13)
    - Demand reduction measures concerning tobacco dependence and cessation (Article 14).

The core supply reduction provisions in the FCTC are aimed at:
- Illicit trade in tobacco products (Article 15)
- Sales to and by minors (Article 16)
- Provision of support for economically viable alternative activities to growing tobacco (Article 17).

The FCTC, as currently drafted, is more a guideline for international cooperation and national policy development rather than a rigidly detailed international treaty. As such, protocols will be drafted that will have more detailed binding obligations, perhaps focusing initially on smuggling, labelling, and advertising restrictions.[222]

Unfortunately, no specific evaluation measures were set up before the FCTC was implemented and so it is not possible to compare results after implementation. However, the Framework Convention Alliance (FCA)[223] suggests that the FCTC has:
- Contributed to a change in public perceptions about tobacco and the necessity of passing and enforcing strong laws and regulations to control its use
- Given new impetus to efforts to enact or strengthen national legislation and action to control the harm caused by tobacco
- Helped mobilise national and global technical and financial support for tobacco control
- Brought new ministries, including those dealing with foreign affairs and finance, more deeply into the tobacco control effort
- Mobilised non-governmental organisations (NGOs) and other members of civil society in support of stronger tobacco control
- Raised public awareness of marketing tactics used by multinational tobacco companies.

Under Article 14, parties agree to implement demand reduction measures concerning tobacco dependence and cessation. Article 14 guidelines have now been adopted by the parties to the FCTC and the guidelines specifically encourage parties to:[224]
- Strengthen or create a sustainable infrastructure which motivates attempts to quit
- Ensure wide access to support for tobacco users who wish to quit
- Provide sustainable resources to ensure that such support is available
- Identify the key, effective measures needed to promote tobacco cessation
- Incorporate tobacco dependence treatment into national tobacco control programmes and healthcare systems
- Share experiences and collaborate.

There is also evidence to suggest that such public health interventions at the population level (i.e. groups with different demographic or socio-economic characteristics) have the potential to benefit more disadvantaged groups and thereby contribute to reducing healthcare inequalities.[225,226]

04.02 PROTECTION FROM EXPOSURE TO TOBACCO SMOKE

The stronger the anti-tobacco environment, the more cessation is attempted, and the more people seek treatment.[227]

04.02.0

04.02.1 SMOKE-FREE LEGISLATION AND POLICY

Although it is reasonable to assume that smoke-free legislation and restrictions have the potential to affect a large number of individuals in a population at minimal cost and may help to create a supportive environment for smokers to quit, or at least reduce their tobacco consumption, the evidence as to whether they decrease the prevalence of smoking or overall tobacco consumption is far from clear.

A Cochrane review of workplace interventions for smoking cessation found that workplace smoke-free legislation can decrease cigarette consumption during the working day by smokers and exposure of non-smoking employees to environmental tobacco smoke at work.[228]

A systematic review that assessed the effects of smoke-free workplaces on daily cigarette consumption and smoking prevalence, estimated that such policies reduced smoking prevalence by 3.8% and led to 3.1 fewer cigarettes being smoked per day per continuing smoker.[229] However, a similar approach by Chapman *et al.,* in their review published in 1999, did not conclusively reduce daily consumption in totally smoke-free worksites.[230]

A further Cochrane review of legislative smoking bans for reducing second-hand smoke (SHS) exposure, smoking prevalence and tobacco consumption, concluded that the introduction of a legislative smoking ban does lead to a reduction in exposure to SHS. However, there was limited evidence about the impact on active smoking, although the trend was downwards.[231]

Since Ireland became the first country to implement smoke-free legislation in March 2004, most European countries have followed suit and implemented smoke-free legislation in public places, at least to some extent. However, the degree of enforcement varies considerably between countries. See the individual country reports in section 08.00 for further details.

Since the implementation of Ireland's smoke-free legislation in March 2004, there is some evidence from studies of bar workers to suggest that whilst the smoking prevalence may not have decreased significantly, there has been a significant reduction in consumption (average of four cigarettes per day).[232] Among Irish smokers who quit in the post-legislation period, 80% reported that the law had helped them to quit and 88% reported that the law had helped them to stay tobacco free.[233]

In Norway, the implementation of a smoking ban in public places produced a significant decline in the prevalence of daily smoking (-3.6%, $p<0.005$), and a reduction in the number of cigarettes smoked by those who continued to smoke (-1.55, $p<0.001$) between the start of the ban (baseline) and four months after it was implemented. These variables did not change eleven months after the ban was implemented. The authors noted that smoking cessation was consistently associated with smokers' intentions to quit within 30 days, which suggested that motivational and support programmes could play a significant role in enhancing cessation rates.[234]

In Italy, a smoking ban in enclosed public places was implemented on 10 January 2005 and smoking prevalence decreased by 1.9% between 2004 and 2006: from 26.2% in 2004, to 25.6% in 2005 and to 24.3% in 2006. The drop in smoking prevalence in 2005-2006 versus 2003-2004 was significant ($p<0.05$) but there was no significant difference comparing smoking prevalence in 2003-2004 versus 2001-2002. Therefore, the authors concluded that the drop in smoking prevalence (and consumption) was due, at least in part, to the comprehensive smoke-free legislation adopted in Italy.[235]

The disparity in smoking control policies between countries may explain, in part, the large differences observed in smoking prevalence across Europe.

04.02.1

As can be seen in section 08.00, a number of other countries have now implemented smoke-free legislation. Partial bans on smoking were introduced in some countries such as Spain and Greece, however partial bans appear to have a minimal effect on smoking prevalence.[236] Both Spain and Greece have now implemented more restrictive smoke-free legislation.

It can be concluded that there is some evidence that smoke-free legislation encourages current smokers to stop smoking, and makes it easier for them to succeed. Smoke-free legislation also reduces the average consumption of tobacco by those who continue to smoke. However, in order to take advantage of the opportunity provided by smoke-free legislation, it is important that those motivated to stop smoking are also provided with smoking cessation support to help them capitalise on the opportunity to quit smoking.

04.02.2 MEASURES TO CONTROL CHILDREN'S ACCESS TO TOBACCO

Controlling access is one approach to try to reduce the consumption of tobacco products by children. Interventions that increase compliance with tobacco access legislation may help prevent young people from starting to smoke.[237]

A number of policy options are being pursued by European governments to control access to smoking, particularly for children. See the individual country reports in section 08.00 for further details.

04.03 LEGISLATION ON TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP

In addition to restricting access to tobacco, advertising practices must be changed. Limiting positive advertising by tobacco companies can dissuade people from becoming smokers. In Germany, for example, appreciation of tobacco advertising among adolescents was correlated with increased current smoking (from 21.3% to 28.3%) and daily smoking (from 10.0% to 14.2%) over a 5-year period (1995-2000).[238] Daily smoking among girls in particular rose from 9.1% to 14.7% (a 62% increase). Similarly, in Spain from the 1970s to 1980s, smoking prevalence increased rapidly among women under 50 years of age, coinciding with extensive advertising campaigns promoting 'light' cigarettes that were popular among women.[239] In addition, a study among Spanish adolescents correlated awareness of cigarette billboard advertising with increased smoking and an increased risk of becoming a smoker.[240] Moreover, several studies have linked adolescent smoking with exposure to scenes featuring smoking in movies among US[241] and German populations.[242]

In addition to restricting advertising for tobacco, anti-smoking advertising may encourage existing smokers to quit. The effectiveness of the Health Education Authority for England's anti-smoking advertising campaign was evaluated and found to be effective in reducing smoking prevalence: applying the study results to a typical population suggested that the campaign would reduce smoking prevalence by about 1.2%.[243] The authors also suggested that a prolonged campaign is necessary to maximise effectiveness.

Advertising quitlines on cigarette packaging was studied in seven European countries and it was found that in the first year after introduction, quitline call volumes were significantly increased. Although this effect lessened after the first year, call volumes were still significantly higher than before the introduction of the quitline number on cigarette packaging.[244]

Pictorial warnings have been reported to deter UK smokers from having a cigarette and to think about quitting. As with quitlines on cigarette packaging, the salience and impact waned over the follow-up period after introduction (2.5 years).[245]

Internet tobacco cessation programmes are also promising. Even though they have had limited success rates to date, they could become highly cost-efficient and widely effective. Several studies indicate that interactive, web-based interventions for smoking cessation can be effective in aiding smoking cessation or changing smoking behaviour.[246,247]

"Tobacco is a communicated disease – communicated through marketing."
Dr Gro Brundtland, Former Director General WHO. Sanam Luang, Bangkok May 2000

04.03.0

04.04
PRICE AND TAX MEASURES

04.04.1
INCREASING TAX ON TOBACCO PRODUCTS

It is estimated that a 10% increase in tobacco prices would, on average, reduce smoking by about 4% in high-income countries and by about 8% in low- and middle-income countries.[249] This figure is higher in:

- Younger smokers
- Developing countries
- Lower-income smokers
- Pregnant smokers.

Similarly, a survey in Europe found that for every 10% increase in the real price of cigarettes, tobacco consumption decreases from 5 to 7%.[250] This range is consistent with other similar research.[251,252] There is also some evidence that tobacco taxes are somewhat more effective in reducing consumption amongst those from poorer socio-economic backgrounds.[253]

France increased the price of cigarettes by 40% in the space of just over one year. This was accompanied by a 31% decrease in consumption and a temporary doubling in calls to their smoking cessation 'quitlines' as well as the purchasing of medications to aid cessation.[254]

However, it should be noted that a reduction in consumption does not necessarily equate to a similar reduction in smoking prevalence as some smokers reduce the number of cigarettes they smoke per day because of the increased price but do not give up smoking altogether.[255]

Tax and price increases are thought to encourage people to quit smoking and to seek help in their quit attempt (e.g. using smoking cessation medications), particularly young smokers.[256]

Increased taxes and equity benefits
In New Zealand, for example, there is (limited) evidence that there are some equity benefits from taxation increases.[257] However, there is still a concern that increasing tobacco prices for some marginalised groups such as teenagers or homeless individuals might lead to them taking up more risky smoking behaviours such as eliminating the filter, using hand-rolled cigarettes, inhaling more deeply, leaving shorter cigarette butts, sharing the same cigarette or adding other substances to the cigarettes.[258]

In the UK it was found that the price responsiveness was inversely related to social class, with tax increases having the greatest impact on those in the lower social-economic groups.[259]

Tax increases must be levied on all forms of tobacco (e.g. cigars and loose tobacco) otherwise, an increase in cigarette price will drive smokers to other tobacco products.

Support for taxation
The European Commission understands the need to ensure a higher level of public health protection by raising minimum excise duties on cigarettes across Member States.[260] One of the aims of their 2008 directive was to contribute to reducing tobacco consumption by 10% within the next 5 years. However, individual Member states will be given the ability to set minimum taxes as the Commission wishes to maintain a "level playing field for manufacturers."[261]

…economic studies have shown that increasing prices through taxes on tobacco products has been proven to be the most cost-effective tobacco control intervention.[248]

04.04.1

The World Health Organization (WHO) has just published a technical manual that aims to help governments by providing a set of 'best practices' for tobacco taxation. This manual provides readers with examples of existing approaches to tobacco taxation, reviews the barriers to using tobacco taxes to achieve health and revenue objectives and provides case studies of effective tobacco tax administration.[262]

It can be concluded that tax increases can, therefore, be seen as a cost-effective intervention to increase public health and may also have the advantage of reducing the number of people who start smoking, although there are varying opinions on this particular issue.[263,264,265]

04.05 LEGISLATION ON ILLICIT TRADE IN TOBACCO PRODUCTS

A major issue that arises in relation to tax increases is that of smuggling and tax fraud. Therefore a taxation policy needs to be accompanied by vigorous and adequately funded law enforcement to combat this problem.[266]

Illicit trade in tobacco products tends to undermine high tobacco taxation policy. For example, smuggling is known to be high in China and this helps to support commercial enterprise to increase smoking.[267]

This illicit trade in tobacco products deprives governments of billions of dollars in taxation, thereby reducing the funding available for public health and other policies.[268] The FCA estimates that the global illicit cigarette trade represents approximately 10.7% of global sales, or 600 billion cigarettes annually, and that losses to government revenue as a result of illicit trade in tobacco products total approximately $US 40 to 50 billion annually.[269]

04.06 CHALLENGES TO LEGISLATION AND ENFORCEMENT

04.06.1 ECONOMIC ISSUES

Despite the fact that the great majority of smokers who want to quit could be assisted by more extensive programmes, funded by the extra revenue from tobacco tax increases[270] there are persistent concerns from some that if smoking prevalence is decreased, tax revenue will be reduced to the detriment of the economy. This is a contentious issue. Advocates of such tax increases will point out that increasing cigarette taxes could lead to quitters with better health and savings in terms of medical care, which would otherwise have to be utilised on these smokers. However, others will cynically point to the loss of revenue from the reduced number of smokers.

In the USA, a computer-simulation model was used to estimate the impact of raising taxes on cigarettes by up to 100% over a twenty-year period. The model predicted that a 60% increase in cigarette price would lead to an estimated saving of $945 billion in medical costs and that the increased tax revenues could also be employed elsewhere.[271]

Ross *et al.* looked at the economics of tobacco taxation in Russia and estimated that if Russia implemented tobacco tax to 70% of the retail price, Russia would save 2.7 million tobacco-related deaths and the government would collect an additional RUB 153 billion (US$ 6 billion) in excise tax revenue per year.[272]

Both the literature and experience shows that the negative consequences of tax increases have been overestimated.[273]

04.06.2
POLITICAL ISSUES

The prospect of forthcoming elections can influence politicians and cause them to waver on smoke-free policies that had previously been put in place. An example of this can be found in the German State of Bavaria where a public referendum on the proposed tough new smoking legislation was held to ensure that it had public support. German state law allows smoking in beer tents and pubs with special smoking rooms and in some cases throughout smaller pubs. However, when put to the public vote, 61% of Bavarians voted in favour of introducing the smoking ban on Bavarian hospitality venues. It should be noted that only 37.7% of the eligible population voted.[274]

In some countries, there is support for the pro-tobacco groups from politicians. For example, the President of the Czech Parliament, Václav Klaus, has openly opposed smoke-free legislation, claiming that it would deny smokers their rights.[275] A former Minister of Health in the UK has remained a strong advocate of the tobacco industry and has earned in excess of £1 million from his role as an ambassador for the international cigarettes trade.[276]

04.06.3
THE POWER OF TOBACCO INDUSTRY LOBBYING

There is evidence from around the world that the tobacco industry have used their influence to shape European policy on tobacco control in a manner advantageous to the tobacco industry.[277,278,279] For example, the WHO found that the tobacco industry used a variety of strategies to influence and undermine their tobacco control policies and programmes. These strategies have included:[280]

- Discrediting WHO or WHO officials
- Establishing inappropriate relationships with WHO staff
- Leveraging influence through other United Nations' agencies
- Using surrogates, such as front groups and trade unions
- Distorting WHO research.

04.06.4
TOBACCO SUBSIDIES

A Member of the European Parliament reported that the European Union (EU) spends £260 million each year on tobacco subsidies for farmers.[281] However, the EU is also spending millions on researching and advertising the harm caused by tobacco and the EU provides the Community Tobacco Fund with millions for anti-smoking information campaigns.[282]

The tobacco subsidies provided through the Common Agricultural Policy are being reformed and involve a 'de-coupling' of subsidies, so that subsidies are no longer linked to production.[283,284] Starting in 2010, half of the money currently set aside for crop production will be used to fund wider rural development programmes, with the remainder paid to farmers in the form of single farm payments so that tobacco production is not encouraged.[285]

According to the European Commission, "Tobacco subsidies used to be an important but controversial agricultural policy issue in the EU. In the interest of public health, direct tobacco subsidies were phased out by 2010."[286]

SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Summary

- Smoking is an addiction and giving up can be very hard for some[287]
  - Only around one in ten people who quit remain non-smokers after six months[288]
- Smoking cessation strategies are cost-effective[289]
- Support for smokers includes brief interventions, behavioural therapy, self-help materials, pharmacotherapy or a combination of tactics
  - Group behavioural therapy is effective[290]
- General Practitioners (GPs) may be reluctant to offer smoking cessation services
- Quitting rates in GP-led services are 3-15%[291]
  - This is cost-effective and good value for money[292,293,294]
- Smoking cessation interventions for in-patients are effective and reduce rehospitalisation and total mortality[295,296]
- Pharmacists, dentists and oral health professionals, nurses, and respiratory therapists can also provide important smoking cessation interventions
- Workplace interventions can help smokers to quit.[297]

05.01 STRATEGIES TO PROMOTE SMOKING CESSATION

Giving up smoking has real health benefits, both immediately and in the longer term (see section 03.06). Many smokers quit smoking unaided, i.e. using willpower[299], but although it is possible to quit smoking unassisted, it can be very difficult for nicotine-dependent smokers.

There is also a significant gap between the proportion of smokers who have tried to quit and those who actually succeed, indicating that intentions alone are not enough.[300] In a Danish study looking at the cost-effectiveness of smoking cessation interventions versus smokers receiving no assistance, the authors concluded that smoking cessation strategies

were cost-effective. The study found that in general, smoking cessation strategies were more cost-effective when offered to men, older persons and light smokers than when offered to women, young persons and heavy smokers.[301]

Support for smokers can be provided in different ways, through brief interventions, behavioural therapy, self-help materials, pharmacotherapy or a combination of tactics. Evidence-based guidelines tend to recommend the implementation of comprehensive smoking cessation programmes, tailored to the individual's needs with a combination of pharmacological and non-pharmacological methods for optimum results.[302] There is some evidence to suggest that such support improves long-term quit rates with prolonged quit rates of 5 to 10% with interventions compared to 3 to 5% for self-quitters.[303]

"It is very, very difficult to stop smoking without help."

"About 90% of people who try will be smoking again six months later..."[298]

05.01.0

05.01.1
BEHAVIOURAL THERAPY SUPPORT TO HELP PEOPLE STOP SMOKING

Behavioural therapy support, provided on an individual basis or in a group setting, is effective for smoking cessation.[304] The chances of quitting are approximately doubled with group therapy, compared to being given self-help materials without face-to-face instruction and group support.[305]

A systematic review of literature looking at smoking cessation and various supportive therapies found that smoking cessation support increased the number of individuals successfully quitting smoking.[306] For instance, an international study involving 2,600 people in a trial in Norway, New Zealand and Britain has shown that programmes that use text messaging to help people with smoking cessation could potentially double the quit rate.[307] This has been further confirmed by a Cochrane review that concluded that individually delivered smoking cessation counselling can assist smokers to quit.[308] However, a US report noted there was a strong dose-response relationship between the intensity of tobacco dependence counselling and its effectiveness.[309]

05.01.2
PRIMARY CARE SMOKING CESSATION SERVICES

Although GPs play an important role in providing smoking cessation services, they can be reluctant to do so for a number of reasons. Previous studies in a number of European countries[311] (United Kingdom,[312,313] Sweden, Norway, Finland, and Iceland[314] and Germany[315,316]) have found that GPs believe that providing smoking cessation services:

- Is an issue as they lack the time[317]
- Is ineffective
- Is unpleasant to discuss
- Requires training and skills that they lack[318]
- Calls for access to smoking cessation experts
- Requires smokers to actually want to quit
- Could jeopardise the patient-physician relationship.

Factors influencing a GP's willingness to engage in smoking cessation discussions include:

- The GP's own smoking status[319]
- Whether patients present with smoking-related symptoms, are pregnant, or heavy smokers[320]
- Reimbursement[321,322]
- What their peers are doing.

Primary care smoking cessation services are cost effective.
"…one premature death will have been avoided with every two smokers a clinician persuades and helps to stop smoking."[310]

05.01.2

The PESCE project (General Practitioners and the Economics of Smoking Cessation in Europe) aimed to promote smoking cessation interventions, initiated and delivered by GPs. As part of the PESCE project, Professor David Cohen of the University of Glamorgan, Wales, undertook an economic analysis based on the efficacy of GP-initiated smoking cessation efforts.[323] The review showed that GP smoking cessation services are associated with typical quitting rates of between 3 and 15%. Professor Cohen analysed these quitting rates with respect to prevention of smoking-related deaths and reduction of the incidence of four major smoking-related illnesses (lung cancer, chronic heart disease, stroke and chronic obstructive pulmonary disease (COPD)) and found that, in the UK alone, a 3% quitting rate would result in a cost benefit of nearly £3 billion over 25 years, whilst a 15% quitting rate would yield a benefit of nearly £14 billion over 25 years. Extending the scope of the analysis to 10 European countries, Professor Cohen found that a 3% reduction in smoking prevalence would yield annual savings amounting to over €166 billion by 2030.[324] This data provides a strong rationale for supporting and promoting GP smoking cessation services, as these are likely to be highly cost-effective.

A more recent systematic review and meta-analysis by Papadakis *et al.* was conducted to evaluate evidence-based strategies for increasing the delivery of smoking cessation treatments in primary care clinics. Papadakis *et al.* concluded that strategies that combined two or more interventions (e.g. asking smoking status and advising smokers to quit) improved smoking cessation outcomes in the primary care setting.[325]

Indeed, in 2004, Parrott *et al.* found that cessation interventions offer excellent value for money when compared with some other healthcare interventions.[326] Similarly, in 2008, the UK's National Institute for Health and Clinical Excellence (NICE) produced a new review that showed GP smoking cessation efforts to be highly cost-effective.[327] However, despite this evidence, many countries do not have the necessary infrastructure to provide smoking cessation interventions.

05.01.3
HOSPITAL-BASED INTERVENTIONS

A Cochrane Review by Rigotti *et al*. found that people who are hospitalised are likely to be more receptive to smoking cessation counselling interventions and more likely to quit smoking. Interventions delivered during hospitalisation that include follow-up support lasting at least one month following discharge, increase smoking cessation rates. It was estimated that such interventions increase the odds of successfully quitting by 65% at six to twelve months after hospital discharge.[328]

Interestingly, it is not just those who are hospitalised for smoking-related diseases that benefit from such interventions. The hospital-initiated interventions were effective when administered to all hospitalised smokers, regardless of the smoker's diagnosis at admission.[329]

In a study of hospitalised high-risk smokers with acute cardiovascular disease, it has been shown that intensive smoking cessation interventions (lasting at least three months) effectively helped patients to quit but also reduced hospitalisations and total mortality in this set of high-risk patients. The absolute risk reduction in mortality was 9.2% with a number needed to treat of eleven.[330]

05.01.4
BRIEF INTERVENTIONS BY OTHER HEALTHCARE PROFESSIONALS

As well as GPs, other healthcare professionals regularly come into contact with patients including pharmacists, dentists and oral health professionals, nurses, and respiratory therapists. A Canadian study of these healthcare professionals found they were more likely to provide smoking cessation counselling if they believed that counselling was part of their role; that they would be effective at engaging in counselling; and thought they had sufficient knowledge of the communities smoking cessation resources.[331]

Community pharmacists
As community pharmacies serve local communities they have the potential to reach and treat large numbers of smokers. According to the UK's NICE, they are also able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services.[332]

As with the UK, Finnish guidelines on smoking cessation emphasise healthcare cooperation and community pharmacists' involvement. Nearly half of community pharmacist respondents in Finland were familiar with the guidelines and this was thought to enhance guideline implementation.[333]

Although there are a limited number of studies, there is a suggestion that trained community pharmacists, providing counselling and record-keeping support to their customers may have a positive effect on smoking cessation rates.[334]

Dentists and oral health professionals
A consensus report was generated on behalf of the second European Workshop on Tobacco use Prevention and Cessation for Oral Health Professionals in 2008.[335] The report identified tobacco use as a major risk factor for oral disorders and proposed that oral health professionals should act as advocates to promote tobacco use prevention and cessation.

A survey of UK dentists in 2002 found that one-fifth of respondents were asked for advice on tobacco cessation with 64% offering advice.[336] Although 68% agreed that offering patients advice about tobacco cessation was their duty, as with GPs, barriers to dentists providing tobacco cessation advice include concern over patient resistance, lack of knowledge on smoking cessation and of referral services, lack of time and reimbursement.[337,338]

A Cochrane Review by Carr and Ebbert commented on the limited amount of published literature but thought the available evidence was consistent with the hypothesis that dental interventions conducted in the dental office are more effective than usual care for promoting tobacco cessation.[339]

Nurses
Advice and support from nursing staff can increase the chance of smokers successfully quitting, especially in a hospital setting. Advice or counselling given by other nurses is reasonably effective, particularly when given by nurses whose main role is health promotion or smoking cessation.[340]

Hospital-based nursing staff may have an important 'window of opportunity' to intervene with patients or at least to introduce the notion of their patients not resuming smoking after discharge from the hospital.[341]

05.01.5
WORKPLACE SMOKING CESSATION

The majority of adults spend a great deal of their day in the work setting and given this, the workplace can be an effective setting and a convenient place for smokers to access counselling and supportive services. Workplace interventions can help smokers to quit, particularly when combined with smoke-free workplaces.[342]

In the UK, the NICE was asked by the Department of Health to produce public health guidance on workplace health promotion with reference to smoking and what works in motivating and changing employees' behaviour.

The resultant guidance entitled 'Workplace health promotion: how to help employees to stop smoking'[343] stated that brief interventions including the provision of pharmacotherapy are cost effective. The brief interventions have been proven to be effective and may include one or more of the following:

- Simple opportunistic advice
- An assessment of the individual's commitment to quit
- Pharmacotherapy and/or behavioural support
- Self-help material
- Referral to more intensive support such as the NHS Stop Smoking Services.

The guidance concluded that the most effective smoking cessation interventions in workplace settings are those that have been proven to be effective more broadly, such as group therapy, individual counselling and pharmacological treatment. These effective smoking cessation aids and services are also highly cost effective.

The Irish Cancer Society offers Smoking Cessation Services for workplaces that include providing literature, information sessions and health promotion services to the public on health- and cancer-related issues.[344] The service includes smoking cessation information days, one-to-one advice, six week smoking cessation courses and training for smoking cessation facilitators, which is targeted at healthcare professionals, and non healthcare professionals who want to facilitate stop smoking groups.

Workplace health promotion (WHP) programmes are being integrated into company policies and ultimately into legislation in Finland, where there is an agreement between the central labour market parties in Finland (1990) an Amendment of Finnish Labour Protection Act (1997) and The Finnish Occupational Health Services Act (2001). These WHP programmes include interventions on smoking, alcohol, diet, physical activity and early detection of breast and cervical cancer.

05.01.6 SCHOOL-BASED INTERVENTIONS

Schools provide an excellent route for communicating with large numbers of young people regarding smoking prevention.

A smoke-free youth campaign organised by the German Federal Centre for Health Education providing a combination of media aimed at youths, personal communication and setting-based interventions was studied between 2003 and 2008. This study found that over the years of the study, participation in school-based prevention increased and there was an increase in the knowledge of the participants on the harmfulness of tobacco products. They also found that the proportion of smokers declined substantially from 27.5% (2001) to 15.4% (2008).[345]

A school-based substance abuse prevention programme covering seven European countries in 170 schools found that while a 12-hour curriculum based on a social influence approach was effective for persistent positive effects over 18 months on alcohol abuse and cannabis use, it did not provide such effects for cigarette smoking.[346]

A systematic review of school-based tobacco use prevention interventions found that there was strong evidence that such programmes are largely effective, at least in the short term.[347]

As can be seen from the above examples, the results of such studies are extremely variable. A Cochrane review published in 2006 found that despite a number of well-performed, randomised studies on different social influence interventions, the results have been inconclusive, with half of the studies finding a short-term effect on children's smoking and with the highest quality and longest trial showing no effect.[348]


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13

GUIDELINES (EUROPEAN, NATIONAL AND REGIONAL)

Summary

- The Framework Convention on Tobacco Control (FCTC) require signatories to develop and disseminate appropriate guidelines and take measures to promote tobacco cessation and adequate treatment for tobacco dependence[349]
- There are a number of different guidelines across Europe
- Key common themes in the guidelines are:
    - Increased availability and accessibility of services
    - Implementation of comprehensive smoking cessation programmes, combining pharmacological and non-pharmacological methods
    - Delivery of smoking cessation interventions through healthcare services as a cost-effective way to reduce mortality and ill-health
    - Guidelines can help in clinical practice and treatment monitoring
    - Documentation and monitoring is important.

06.01 THE NEED FOR GUIDELINES

The Framework Convention on Tobacco Control (FCTC) requires all signatories to "develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities."[350] To this end, the FCTC recommends that each Party shall endeavour to:

- Design and implement effective programmes aimed at promoting the cessation of tobacco use, in locations such as educational institutions, healthcare facilities, workplaces and sporting environments
- Include diagnosis and treatment of tobacco dependence and counselling services on cessation of tobacco use in national health and education programmes, plans and strategies, with the participation of health workers, community workers and social workers as appropriate
- Establish in healthcare facilities and rehabilitation centres programmes for diagnosing, counselling, preventing and treating tobacco dependence

- Collaborate with other Parties to facilitate accessibility and affordability for treatment of tobacco dependence including pharmaceutical products. Such products and their constituents may include medicines, products used to administer medicines and diagnostics when appropriate.

The FCTC's third Conference of the Parties (COP3), held in South Africa in 2008 established a working group for the elaboration of guidelines for implementation of Article 14 and to invite relevant intergovernmental and non-governmental organisations with specific expertise in this area to actively participate.[351]

06.02 EUROPEAN SMOKING CESSATION RELATED GUIDELINES

Table 10 (see pages 52-53) provides an overview of some of the smoking cessation related guidelines available in Europe.

The International Primary Care Respiratory Group (IPCRG) has produced international guidelines on tackling smoking. The group's first international guidance on smoking cessation in primary care entitled 'Tackling the smoking epidemic' was launched in November 2007.[395]

Many interviewees have mentioned that their country reviews and/or follow guidelines from the USA.[396]

06.03 KEY PRINCIPLES ADDRESSED BY GUIDELINES

A review of the guidelines in Table 10 identifies some common themes and principles:

- A need for an increase in the availability and accessibility of high-quality services for the treatment of tobacco dependence
    - All individuals willing to make a serious attempt to quit should be given the best opportunity to achieve success.
- Implementation of comprehensive smoking cessation programmes, tailored to the individual's needs, with a combination of pharmacological and non-pharmacological methods for optimum results.
- Smoking cessation interventions delivered through healthcare services are an extremely cost-effective way of preserving life and reducing ill-health.
- Guidelines can assist in both defining clinical practice and also in providing the basis on which effective treatment can be monitored.
- The importance of documentation and monitoring
    - The smoking status of all patients and the offered/used treatments should be documented
    - Follow-up/audit systems can lead to treatment that is more effective and help ensure more successful quit attempts.

06.04 APPROACHES SUGGESTED BY THE GUIDELINES

In terms of an approach to quitting smoking, many of the guidelines suggest that the following key factors can be important in assisting individuals with smoking cessation:

- Assessment of the individual's willingness and readiness to quit
  - Outline the benefits of quitting
  - Understand individual barriers to smoking cessation
  - Assess the willingness to make a quit attempt.
- Assisting in the quit attempt – the importance of an integrated approach and follow-up
  - Primary care physicians (PCPs) can opportunistically advise smokers to stop during routine consultations, giving advice on and/or prescribing medications to help them and referring them to specialist cessation services (where available)
  - Specialist smokers' services can provide behavioural support (in groups or individually) and recommend effective medications
  - Follow-up should be arranged for all healthcare service users.
- Smoking cessation advice may need to be tailored for certain groups, for example:
  - Pregnant women
    - Interventions to obtain abstinence in pregnancy/ relapse prevention after abstinence has been attained
    - Interventions aimed at reducing exposure to second-hand tobacco smoke in homes with children.
  - Young people/adolescents
    - To prevent young people from starting to smoke
    - To promote relevant stop-smoking initiatives
    - To protect non-smokers from second-hand smoking.
  - Smokers with concomitant diseases (e.g. COPD or mental health issues)
  - Ethnic minority and/or disadvantaged communities
  - Healthy smokers
  - Employed smokers in the workplace
- The most effective strategy is the combination of smoking-cessation methods based on behavioural treatment with pharmacotherapy:
  - Individual/group behavioural counselling
  - Pharmacotherapies – three pharmacotherapies have been approved and shown to be cost-effective in aiding smokers attempting to quit:
    - NRT
    - Bupropion
    - Varenicline.
- Other services can be an important adjunct to the behavioural/ pharmacotherapy approach, for example:
  - Self-help materials
  - Telephone counselling and quitlines
  - Web-based smoking cessation services.

ERALS

Smoking Now

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TABLE.10
A SELECTION OF EUROPEAN NATIONAL SMOKING CESSATION GUIDELINES

	SOURCE	NOTES
AUSTRIA	Austrian Society of Pneumology	Guidelines generally written by medical societies (e.g. Austrian Society of Pneumology).[352]
BELGIUM	Société Scientifique de Médecine Générale (SSMG)	Peer-reviewed national guidelines for general practitioners (GPs), 'Recommendations for good practice – quitting smoking' were published in 2005.[353] These have been recently updated.
	Flemish Association for Respiratory Health and Tuberculosis (VRGT) and Fonds des Affections Respiratoires (FARES)	Guidelines intended for use by obstetric/gynaecology specialists and paediatricians to enable them to help pregnant women to quit smoking. Published by FARES in September 2010.[354] These guidelines were also published in the Flemish community by VRGT.
CZECH REPUBLIC	Working Group for Prevention and Treatment of Tobacco Dependence at the Czech Medical Association	Smoking cessation guidelines published in 2005 and endorsed by 19 medical associations. It is understood that an updated version is being developed (February 2011).
	Psychiatric Association	Guidelines for the treatment of tobacco dependence (2010).
	The Czech Association of Nurses	Guidelines for the treatment of tobacco dependence (2010).
	The Czech Chamber of Pharmacists	Guidelines for the treatment of tobacco dependence (2010).
DENMARK	National Board of Health	Guidelines for individual smokers on how to quit smoking.[355]
		Developing guidelines from the United Kingdom's National Institute for Health and Clinical Excellence (NICE, February 2008) and the United States' Surgeon General (May 2008). No publication date has yet been officially announced.
	The Danish College of General Practitioners	Guidelines for chronic obstructive pulmonary disease (COPD) patients.[356]
	The Danish Society of Respiratory Medicine	Developing guidelines for use of smoking cessation in secondary care.[357]
FINLAND	Finnish Association for General Practice	National Current Care Guideline on smoking entilted 'Smoking, nicotine dependence and nicotine withdrawal.' Since the first publication in 2003, these guidelines were updated in 2007[358] and the next update is currently under way.
FRANCE	Haute Autorité de Santé (HAS)	Guidelines on therapeutic strategies for quitting smoking (2006).[359] The French Society of Tobacco Research is attempting to have these guidelines updated.
GERMANY	The German Medical Association (BÄK) and the German Cancer Research Center	Stop smoking – physicians prevention and therapy (2005).[360]
	German Respiratory Society	Guidelines for smoking cessation in patients with COPD (2008).[361] It is anticipated that these guidelines will be revised during 2011.
	German Society for Addiction Research and Addiction Therapy and the German Society of Psychiatry, Psychotherapy and Neurology	Guidelines that focus on the psychosocial aspects of smoking cessation.[362] These guidelines are currently being updated.
	Institute for Epidemiology and Social Medicine	Guidelines for interventions to prevent health risks due to tobacco smoke in pregnant women, postpartum women and their infants were issued in 2004.[363]
GREECE	Thoracic Society	There are no specific national guidelines for smoking cessation or the treatment of tobacco dependence in Greece, however guidelines have been set by the Thoracic Society.
HUNGARY	Ministry of Health	Smoking cessation guideline updated in 2009.[364]
	Pulmonary Society	Guidelines that focus more on therapeutic interventions rather than prevention of smoking.
IRELAND	Health Service Executive (HSE)	National Tobacco Control Framework sets out the strategic direction for Tobacco Control for the coming five years. A yearly implementation plan will be developed which will identify priorities and action areas.[365]
	HSE and the Irish Thoracic Society	A national COPD programme is in development.
	HSE	Best Practice Guidelines for Tobacco Management in Mental Health Settings have been developed.[366]

	SOURCE	NOTES
ITALY	National Health Institute	National guidelines for GPs were updated in 2008.[367]
	Italian Association of Hospital Pulmonologists	Guidelines were published in 2000 on smoking cessation activities in a respiratory medicine setting.[368]
	Various regions	There are regional guidelines (e.g. Toscana, Emilia-Romagna) where smoking cessation interventions are described in detail.[369]
	European Respiratory Society (ERS)	Respiratory patient guidelines have been translated into Italian.
LUXEMBOURG		There are no national guidelines for tobacco dependence or smoking cessation in Luxembourg.
NETHERLANDS	Partnership on Smoking Cessation	Clinical guidelines for healthcare professionals originally developed in 2004[370] and updated in 2009 and were endorsed by all participating organisations.
	Dutch Physicians Association	Have developed a user-friendly version of the guidelines and distributed these to their members.
NORWAY	Department of Health	National guidelines for primary care were published in 2004[371] and are currently being revised. Publication was anticipated before the end of 2010 but appears delayed.
POLAND	Polish Chamber of Physicians and Dentists	Tobacco dependence guidelines published in 2006[372] and 2008.[373] The latest revision has been prepared but not yet published.
	Various medical societies	Guidelines and recommendations prepared by medical societies e.g. pulmonologists, cardiologists[374] and oncologists.
	Polish Forum for Prevention of Cardiovascular Disease	Published recommendation on smoking cessation quite similar to the earlier Polish Chamber guidelines.[375]
PORTUGAL	Portuguese General Directorate of Health (Direcção-Geral da Saúde)	Provide access to a number of publications and guidelines relating to tobacco dependence and smoking cessation, including: Consumo de Tabaco – Estratégias de Prevenção e Controlo (Tobacco consumption: Strategies for Prevention and Control);[376] Guidelines on Smoking Cessation Treatment from the Evidence-based Medicine Centre of Lisbon University of Medicine (February 2008);[377] There is also the 'Programa-tipo de actuação em Cessação Tabágica', which also reflects the US clinical guidelines.[378]
SPAIN	Comité Nacional para la Prevención del Tabaquismo (CNPT)	CNPT presented guidelines in 2008, resulting from a task force with representatives of various health professional societies.[379]
	Spanish Society of Pneumology and Thoracic Surgery (SEPAR)	Since 1999, SEPAR has created a number of different guidelines.[380,381,382]
	Consensus from various Spanish scientific societies	Consensus document on smoking cessation treatments.[383]
SWEDEN	National Board of Health and Welfare	Guidelines providing national support for the governance and management of healthcare (2010).[384]
	Swedish Council on Health Technology Assessment (SBU)	The SBU produced a government approved, and peer-reviewed technical assessment report on smoking cessation (1998).[385]
SWITZERLAND	Cornuz *et al.*	Government approved, national smoking cessation guidelines issued in 2004.[386] A new edition of the guidelines was being prepared for release at the end of 2010 but does not seem to be available yet (February 2011).
UK (ENGLAND AND WALES)	National Institute for Health and Clinical Excellence (NICE)	Guidance 39 on the use of nicotine replacement therapy (NRT) and bupropion for smoking cessation (2002).[387] Now superseded by PH10 – Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities.[388] PH1 – Brief interventions and referral for smoking cessation in primary care and other settings[389] PH5 – Workplace health promotion: how to help employees to stop smoking.[390] TA 123 – Technology appraisal for varenicline (2007).[391]
	Department of Health	Guidelines for everyone involved in managing, commissioning or delivering National Health Services (NHS) Stop Smoking Services (2010).[392]
UK (SCOTLAND)	Health Scotland and Action on Smoking & Health (ASH)	Smoking Cessation Update 2007.[393]
UK (N. IRELAND)	Department of Health, Social Services and Public Safety	Have found NICE guidance (PH5 and TA 123) to be applicable and therefore endorsed it for implementation by the Health Service Executive.[394]

EDUCATION

Summary

- Healthcare professionals have a significant role in smoking cessation
    - Many do not provide advice because they feel they lack the skills
- Many medical students have a poor understanding of smoking-related mortality[397]
    - Medical schools have a critical opportunity to educate and motivate medical students
- Nurses who have been trained are most likely to deliver smoking interventions[398]
- Postgraduate training is available for general practitioners (GPs) and specialists (e.g. cardiologists, oncologists, and respiratory medicine specialists) in some countries
- In some countries, teachers, social workers and health workers receive training
- Educating and informing the general public is important for tobacco control policies
- Some countries have formal qualifications for smoking cessation service providers.

07.01 THE ROLE OF THE HEALTHCARE PROFESSIONAL

Healthcare professionals (HCPs) have an important leadership role in motivating and helping smokers to quit. Their efforts helping adult smokers to quit will also help to deter children from taking up tobacco use, as it will help portray smoking as less widespread and less socially acceptable.

It is important to provide all HCPs, not just those in primary care, with appropriate education so that they understand the importance of smoking cessation and their ability to help and influence smokers to quit.

A multi-country literature review by Stead *et al.* highlighted the fact that although new patients in primary care are generally asked questions about their smoking status, fewer ask existing patients or advise them to stop smoking.[399]

Section 05.01 of this report highlighted that healthcare professionals can be unwilling to provide smoking cessation interventions because of a lack of training and a feeling that they lack the skills required.[400]

07.02 SMOKING CESSATION EDUCATION FOR MEDICAL STUDENTS

Medical schools have a critical opportunity to educate and motivate emerging physicians and it is therefore important that medical students are taught about smoking cessation techniques during their medical school training, so that they can be informed about the health effects of tobacco use and learn to assist smokers to quit.

In a survey of German and British medical students, smoking-related mortality was underestimated by students and a substantial number of students wrongly assumed that nicotine causes coronary artery disease.[401] The students demonstrated a poor knowledge of the long-term effectiveness of smoking cessation methods. For example, "willpower alone" was thought by medical students from Göttingen to be more effective than comprehensive group smoking cessation programmes. Strikingly, less than a third of the medical students felt competent to provide smoking cessation counselling to smokers.[402]

A worldwide survey of practices in medical schools was performed to look at the teaching of smoking cessation techniques as part of the medical curriculum.[403] The questionnaire was distributed to all existing medical schools (n = 2,090) in 171 countries and completed questionnaires were received from 665 medical schools (107 countries). A further 67 medical schools responded to a single question on whether they taught about tobacco. The results showed that 27% of responding medical schools taught a specific module on tobacco and 77% included teaching on tobacco in other topic areas; only 4% reported that tobacco was not taught at all. Of those reported specific teaching on tobacco, the most common topics taught were:

- Health effects of smoking (94%)
- Health effects of exposure to tobacco smoke (84.5%)
- Epidemiology of tobacco use (81%)
- Tobacco dependence (78%)
- Taking a smoking history (75%).

Section 08.00 of this report provides more details on the availability of education for medical students on smoking cessation at a country level. Where possible, details of the depth and coverage of this education is provided.

07.03 SMOKING CESSATION EDUCATION FOR POSTGRADUATE PHYSICIANS

A study using desk research and surveys looked at the provision of postgraduate smoking cessation training for physicians within Europe.[404] It found that these training courses include brief intervention training (93%), pharmacotherapy (96%), motivational interviewing skills (85%) and training in the stages of change (89%). However, physician attendance at these training programmes was reported as low (15 to 1,100 per country), meaning that although programmes are available they may not be effectively reaching their intended targets.

07.04 SMOKING CESSATION EDUCATION FOR PRIMARY CARE PHYSICIANS

In the UK, smoking cessation has been inserted into the Quality and Outcomes Framework (QOF) performance management contract with General Practitioners (GPs). The QOF offers GPs an incentive to meet targets for a range of patient services and disease areas; it includes targeting smokers in six key disease areas because of the impact of smoking on health outcomes.[405] The GPs do not generally deliver the smoking cessation therapy themselves but will advise smokers on the best way to stop smoking with support and treatment and direct them to specialist smoking cessation services as required (e.g. the Stop Smoking Service). The GP's practice receives a payment when these standards are achieved.

A survey into the practices of Swiss primary care services to support smoking cessation found that the majority of physicians taking part in the survey recommended smoking cessation interventions to those motivated to stop smoking.

However, the authors concluded that number of physicians practising these interventions could be increased and implementation of the interventions could be improved; smoking cessation training courses for GPs are an effective means of achieving both goals.[406]

Training GPs in smoking cessation counselling has been shown in a Swiss model to be both effective at helping smokers to quit and cost-effective.[407]

Section 08.00 of this report provides more details on the education available to primary care physicians in the various European countries studied.

07.05 SMOKING CESSATION EDUCATION FOR SECONDARY CARE

Many medical specialists have an interest in smoking cessation, for instance, cardiologists, oncologists, and respiratory medicine specialists.

Cardiology
The European Society of Cardiology (ESC) provides a Core Syllabus of the clinical knowledge that a general cardiologist needs to possess. This Core Syllabus provides a structure for the ESC's educational activities both internally and externally. General cardiologists are expected to have the knowledge to describe special treatment and prevention strategies for smoking.[408]

Oncologists
The European Society for Medical Oncology (ESMO) and the American Society of Clinical Oncology (ASCO) have developed recommendations for a global Core Curriculum in Medical Oncology to provide common guidelines for the clinical training required for physicians to qualify as medical oncologists. These guidelines include patient education and the need for the medical oncologist to counsel patients and their families on known risk factors for subsequent malignancy including smoking.[409]

Respiratory medicine specialists
The European Respiratory Society (ERS) has developed a European Core syllabus listing the core competencies all respiratory specialists should possess.[410] Education in smoking-related disease and smoking cessation are considered mandatory for respiratory specialists.

Section 08.00 of this report provides more details on the availability of education for specialist physicians on smoking cessation at a country level. Where possible, details of the depth and coverage of this education is provided.

07.06 SMOKING CESSATION EDUCATION FOR PHARMACISTS

There is data to suggest that pharmacists trained in smoking cessation have a positive effect on smoking cessation rates.[411] Such community-based pharmacists also have the advantage that they service diverse communities and may also be able to meet the needs of ethnic and disadvantaged groups who may otherwise have difficulty accessing other community services.[412]

Familiarity with smoking cessation guidelines is thought to enhance the implementation of the guidelines[413] and therefore education for pharmacists is important.

07.07 SMOKING CESSATION EDUCATION FOR DENTISTS AND ORAL HEALTH PROFESSIONALS

Tobacco use has been identified as a major risk factor for oral disorders and a European Workshop on Tobacco use Prevention and Cessation for Oral Health Professionals proposed that oral health professionals should act as advocates in this area.[414]

The limited available evidence on smoking cessation in the dental setting was found in a Cochrane Review to be consistent with dental interventions being more effective than usual care for promoting tobacco cessation.[415]

Barriers to dentists providing advice on tobacco cessation are thought to include lack of knowledge on smoking cessation and lack of knowledge regarding referral.[416,417]

07.08 SMOKING CESSATION EDUCATION FOR NURSES

A Cochrane Review found that nurse-led smoking cessation advice and/or counselling was effective as an intervention.[418] However, where the nurse's main role was not health promotion or smoking cessation, the evidence of an effect was weaker.

A survey of US nurses found that those who were trained in smoking cessation with an eight-hour course were significantly more likely to report delivery of all aspects of smoking interventions (Five 'A's: Ask, Advise, Assess, Assist, Arrange) to their patients.[419]

07.08.1 SMOKING CESSATION EDUCATION OF OTHER PUBLIC OFFICIALS (E.G. TEACHERS, SOCIAL WORKERS AND HEALTH WORKERS)

Norway's National Strategy for Tobacco Control 2006-2010 includes training for teachers and other relevant occupational groups such as social and health workers.[420]

Similarly, in Northern Ireland the Tobacco Action Plan of 2002 acknowledges that fundamental to the achievement of their objective to support people addicted to nicotine to stop smoking, is the appropriate education and training of health- and social care professionals and others involved in the delivery of smoking cessation counselling and support.[421] To this end, a Training Framework was put together by the Department of Health, Social Services and Public Safety that sets the standard for best practice among all individuals delivering smoking cessation services.

07.09 SMOKING CESSATION EDUCATION FOR THE GENERAL PUBLIC

It is thought that continuous and intensive information and education programmes will be effective in increasing general public awareness and thus acceptance of policy measures. Without such education, it is possible that these policies could be undermined by the tobacco industry. Therefore, educating and informing the general public is important for the successful development and implementation of tobacco control policies.

All of the countries covered by this report participate in the World Health Organization (WHO's) World No Tobacco Day on 31 May each year, although Belgium participates on a regional basis. Some countries organise their own national awareness day(s) e.g.

- Austria: 1 January organised by Institute of Social Medicine of the University of Vienna and 17 November organised by the Nicotine Institute in Vienna
- Portugal: 17 November organised by the Confederação Portuguesa de Prevenção do Tabagismo
- United Kingdom: Second Wednesday in March.

Section 08.00 of this report provides more details on the availability of education on the risks of smoking and the availability of smoking cessation advice and help for the general public.

07.10 FORMAL QUALIFICATIONS FOR SMOKING CESSATION SERVICE PROVIDERS

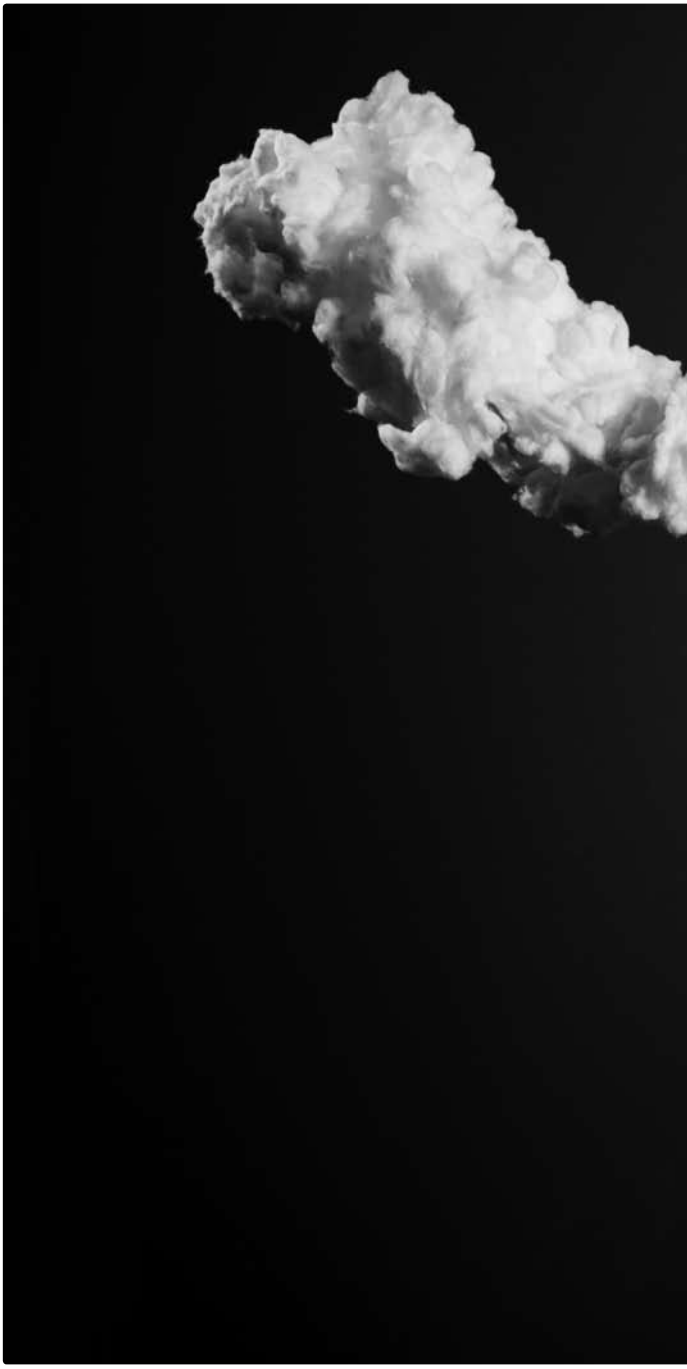
A few countries have instituted formal qualifications for those that provide tobacco dependence and smoking cessation counselling. In France, such tobaccologist training is available for physicians, pharmacists, dentists, those who have completed at least four years of medical school and, upon individual review, psychologists, midwives, and nurses.

The training includes 66 hours of lectures, 22 hours of practical sessions and a final examination, and the whole course takes a year to complete. The training covers tobacco dependence, smoking-related diseases, therapies and care for smokers.[422]

Similarly, Belgium organises training courses in conjunction with French and Flemish universities, which result in the title tobaccologist. The training covers all aspect of smoking cessation, takes around 72 hours over the course of a year, and includes workshops, examinations and a dissertation. The training is available to all healthcare professionals including GPs, nurses and psychologists.

The UK is currently developing a system for certifying stop-smoking practitioners. These formal qualifications will be provided by the National Health Service (NHS) Centre for Smoking Cessation and Training (NCSCT), which is funded by the Department of Health. The courses will be open to all those who wish to acquire smoking cessation competency.[423]

Unfortunately, there are still many countries without formal qualifications for smoking cessation competency.



COUNTRY-SPECIFIC DETAILS

The following country-specific information has been prepared following structured, qualitative interviews with various stakeholders in each country (see section 02.02.3 for more details). The Editorial Partners would like to thank these stakeholders for their valuable contributions, both during the interview programme and in reviewing the country-specific elements of the report.

Considerable effort was made to ensure the accuracy of the information within these country-specific reports and where possible, factual information was verified and appropriate references were supplied. Each country-specific report has been reviewed and approved by the interviewees and therefore includes their views and opinions. The recommendations are based on the opinions of the interviewees and do not necessarily provide detailed information on how the recommendations might be implemented. Please note that the country-specific recommendations are not presented in order of preference or by any ranking, instead they are presented in the order of the themes presented at the beginning of this report.

With Editorial approval, additional information has been added where the situation has evolved since the interviews took place e.g. a new law was enacted.

Icon key
The following icons are used throughout the report.

- Recommendations for improving tobacco control
- Smoking prevalence, issues and targets
- Tobacco control issues
- Healthcare professionals' attitudes
- Smoking cessation services and infrastructure for tobacco dependence support
- Guidelines
- Education

AUSTRIA

Introduction

The following information on the tobacco control and smoking cessation services in Austria has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Austria.

08.01.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Health Organization (WHO) database records 23.2% of the Austrian population as regular smokers in 2006 (27.3% for males and 19.4% for females).[424,425] However, The Eurobarometer 2010 Survey of Smoking across the European Union (EU) conducted in October 2009 reports that 34% of Austrian respondents regard themselves as tobacco users (cigarettes, cigars or pipe).[426] 21% of smokers have tried to give up smoking in the previous twelve months and Austria has the highest use of nicotine replacement therapy (57%) in Europe. [427]

The prevalence of smoking in young people has increased considerably in Austria since 1986.[428] The proportion of women smoking has increased from about 10% of the female population in the 1970s to the present level of around 19%.[429]

The General Practitioners and the Economics of Smoking Cessation in Europe (PESCE) project estimated that a reduction of 3% in the prevalence of smoking would result in healthcare savings of €9.4 million by 2020 and €13.4 million by 2030.[430]

A model developed to investigate the economic costs of smoking in Austria was presented recently at the European Conference on Health Economics. The model calculated the medical and social costs of smoking and also the possible fiscal benefits such as lower pension payments and tobacco tax revenues. The effects of passive smoking were especially investigated. It was found that pensions paid to the widows or widowers of deceased smokers mitigated any pension savings made on the premature death of the smoker.[431]

Smoking prevalence targets

There are no specific targets for reducing the prevalence of smoking and there is no published Austrian policy on smoking.

08.01.1

Smoking prevalence in Austria (2009)
34% = tobacco users (cigarettes, cigars or pipe).[426]

08.01.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
Austria's current legislation on smoking is considered to be a compromise and is particularly lenient when compared with other European countries.[432] Austria's progress on tobacco control was ranked lowest of 30 European countries in the report by Joosens *et al.* (2005-2007).[433] This report scored 30 European countries on their progress on price, smoke-free environments, advertising bans, health warnings and smoking cessation services and treatments. Of a possible 100 points, Austria scored just 35. By comparison, the UK achieved the highest score with 93 points.

In Austria, public buildings and institutions that are open to children and young people are smoke-free. Although smoking is not allowed in offices there are exceptions in the workplace legislation that allow smoking and non-smoking rooms. For smaller bars (<80m^2), the owners may opt to be a smoking or smoke-free bar in certain circumstances.[434,435] This allowance for small bars may set the wrong example to the general public. Stricter smoke-free legislation may need to be implemented to support other legislation on health protection and occupational health. Smoke-free regulations are not enforced in Austria, and no personnel have been assigned to enforce the legislation. Instead, the Federal Ministry of Health relies on the general public to report when the law is broken.

In public transport such as buses, taxis, trains, domestic and international air transport, smoking has been restricted since 1995. In 2005, these transport systems, along with domestic and international water transport were made smoke-free.[436] Local trains were already smoke-free but in 2007, it is understood that customer demand was cited as the reason for extending the regulation to all state run railways.

Legislation on tobacco advertising, promotion and sponsorship
The minimum legal age for buying tobacco in Austria is 16 whereas most European countries have a minimum legal age of 18.[437]

Tobacco advertising is prohibited on television and radio, and in 2007 it was prohibited on billboards and cinemas. Sponsored events with the brand name are prohibited but advertising of non-tobacco products with a tobacco brand name is allowed.[438] Tobacco advertising is still allowed at the point of sale.[439]

Challenges to legislation and enforcement
Within Austria, smoking is perceived by many as merely a habit rather than an addiction and this social background makes smoke-free legislation more difficult.[440]

To compound this situation, the management of tobacco dependence is generally not considered a political priority. The Freedom Party of Austria and the Alliance for the Future of Austria have called upon the ruling Social Democratic party to scrap the existing rules and hold a referendum over smoking in pubs and restaurants.[441] Interestingly, a similar referendum in the German State of Bavaria demonstrated that most voters were in favour of completely smoke-free restaurants and bars.[442]

However, there is some support for a general smoking ban in all public places without exception or compromise and this has been reported in a recent edition of the Wiener Klinische Wochenschrift as the only solution to the smoking problem.[443]

08.01.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

The Austrian healthcare system is based on a social insurance system that is implemented through the Federation of Austrian Social Insurance Institutions (Hauptverband der österreichischen Sozialversicherungsträger, and its 19 sickness funds (Krankenkassen). Approximately 98% of the population is covered by social health insurance.[444]

Smoking cessation services are managed regionally. There are a range of advisory centres and services run by the provinces, the local health centres, the health insurance funds as well as those run by hospitals and other institutions.[445] The city of Linz, for instance, through its public health insurance, provides free smoking cessation courses.[446]

Brief interventions by the primary care General Practitioners (GPs) are not thought to be systematically implemented and will depend on the physician. Some physicians will advise the smoker not to smoke but will not take the issue any further or offer advice on how the smoker could quit smoking.

In general, primary care patients will be referred to specialist smoking cessation clinics if they have a smoking-related disease or if they refer themselves for help. The waiting lists for such specialist smoking cessation clinics range between weeks and months but patients paying for themselves will get an appointment more quickly. It is thought that patients at such special smoking cessation clinics are not routinely followed-up and they are not monitored to ensure they have stopped smoking.

There are some workplace smoking cessation programmes that include specialist support or group counselling.[447]

A national quitline (www.rauchertelefon.at) provides smoking cessation advice organised by the Lower Austrian Gebietskrankenkasse and funded by a collaboration of health insurance funds, the provinces and the Federal Ministry for Health. The quitline provides information on counselling on topics related to smoking through telephone and online services.

Reimbursement for smoking cessation services
A fee contract was negotiated between Vienna's medical community and the Vienna Health Insurance Fund (Wiener Gebietskrankenkasse) regarding a fee schedule for pulmonary specialists to provide smoking cessation services (e.g. smoking cessation counselling aimed at nicotine withdrawal). However, this was terminated at the end of 2009. Since then, there have been no further agreements on the reimbursement of smoking cessation services between the Austrian Medical Chamber and any of the regional health insurance funds in Austria.

In most of the Austrian provinces, smoking cessation programmes are offered at the secondary care level (out-patients and in-patients) by the regional health insurance funds. Most are reimbursed although some funds charge for these services. This approach is not uniform across the provinces. Patients with severe disease are covered by insurance if they are sent to a smoking cessation clinic.

Nicotine replacement therapies are available over the counter. However, current Austrian law prohibits the reimbursement of smoking cessation treatments.

08.01.4 GUIDELINES

There are no national guidelines for tobacco dependence and smoking cessation and the guidelines that exist are generally written by medical societies (e.g. Austrian Society of Pneumology[448]) or non-governmental organisations (NGOs). Smoking cessation is included in the guidelines for the secondary prevention of stroke, as part of a range of strategies.

It is thought that medical society guidelines are not always followed and it was noted that there are no specific guidelines for primary care physicians.

The lack of national guidelines may contribute generally to the feeling that there is a lack of concern over the management of tobacco dependence.

08.01.5 EDUCATION

In Austria, tobacco dependence is now referred to in the curriculum as a disease rather than a lifestyle choice. It is believed that this may prompt future healthcare providers to take tobacco dependence more seriously.

Medical students
Smoking cessation education has been added to the curriculum for medical students but is only a small part of the curriculum and thought not to be significant in changing students' attitudes towards smokers and their ability to help smokers quit.

Primary care
Although there are no formal education programmes run at a national or regional level, there is still some tobacco dependence education for primary health providers. Such programmes are established by medical societies and run at some of the medical schools to provide postgraduate diplomas for GPs and specialists. In Austria, GPs have to gain a certain amount of continuing medical education (CME) points by attending postgraduate courses. This means that some GPs attend the courses to collect CME points but they do not necessarily implement this knowledge in their surgery.

However, there is no equivalent training for other healthcare providers such as nurses or physiotherapists.

Secondary care
Education of healthcare professionals in secondary care is dependent on the views of the Head of the secondary care unit.

General public
The general public in Austria is provided with a great deal of information through the television and print media encouraging them to quit smoking, including advertising campaigns initiated by the Austrian Medical Chamber. Social insurance undertakes various health promotion activities, including workplace health promotion activities that highlight issues such as smoking cessation, dental health, nutrition and exercise.[449]

Austria has two national tobacco/smoking awareness days organised by the Institute of Social Medicine of the University of Vienna (1 January) and the Nicotine Institute in Vienna (17 November).

At the primary care level, there is some rudimentary education for patients, some of which is provided in conjunction with the pharmaceutical industry. However, access to such education will depend on the physician.

For patients within secondary care, the education available for those who smoke is limited and is decided on by the hospital.

08.01.6 RECOMMENDATIONS

Recognise tobacco dependence as a disease
Medical students are now taught that tobacco dependence is a disease but this needs to be reinforced with qualified, practising healthcare professionals who should routinely be questioning and counselling smokers.

Increase tobacco prices
The Austrian government raised the tax on tobacco products at the beginning of 2011 and they increased the cost of a pack of cigarettes by 15 to 20 cents. There is a plan to raise the cost again in July of 2011 by a further 5 to 10 cents per pack.[450] This tax should be raised on a regular basis and tax revenue generated should be used to help support those wishing to quit smoking and to help stop people from starting smoking. This recommendation is an important step in the fight against tobacco.

Reimburse time for smoking cessation services and reimburse treatments
Although most Austrian provinces offer smoking cessation programmes for secondary care patients funded by the regional health insurance funds, this approach is not uniform across Austria. Additionally, Austrian law specifically prohibits the reimbursement of smoking cessation medications.

It is important that it is understood that tobacco dependence is a disease and therefore it should be covered as such by the social security system.

Involve primary care physicians more
Along with the implementation of national guidelines, it is necessary to involve primary care physicians more in the provision of smoking cessation services. These primary care physicians should be obliged to ask patients about their smoking status and be reimbursed appropriately for their time in doing this. Currently GPs are not specifically incentivised for the time they dedicate to smoking cessation.

Organise smoking cessation services nationally from a central organisation
A centralised organisation would enable processes to be identified and disseminated nationally. A central organisation could also take on preparation, implementation and tracking of national guidelines.

Prepare and implement national guidelines
Currently, the Federal Ministry of Health has national plans for many diseases. However, there is a lack of national guidelines for tobacco dependence and smoking cessation although there are some medical society and NGO guidelines available. Without these national guidelines, there is an inference that the management of tobacco dependence is not a key concern to the government.

It is recommended that national guidelines should be prepared by the medical societies and endorsed by the government. Therefore, the Federal Ministry of Health should make provision for guidelines on smoking dependence support.

This is considered to be a very important recommendation, which needs implementing swiftly. It is thought that national guidelines will emphasise the important role that primary care physicians play in helping smokers to quit – thus supporting the recommendation to increase involvement of primary care physicians.

Introduction

The following information on the tobacco control and smoking cessation services in Belgium has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Belgium.

08.02.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The Institut de Santé Publique (ISP) database records that 20.5% of the Belgian population (aged 15 years and over) were current, daily smokers and 4% were occasional smokers in 2008.[451]

It has been estimated that smoking-related medical costs in Belgium were between €1,800 million and €2,300 million, which amounts to 12-15% of all medical expenses of the National Health Insurance in 2003.[452]

Smoking prevalence targets
It is thought that although there is the political will to reduce the prevalence of smoking, there is no formal target. However, the governments of the Flemish region and the German-speaking community have set objectives to reduce the number of smokers, particularly among young adolescents.[453]

08.02.1

Smoking prevalence in Belgium (2008)
20.5% = current, daily smokers (aged 15 years and over)[451]

08.02.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
Since January 2006, Belgium has enforced smoke-free enclosed workplaces. Smoking is only allowed in designated areas although employers are not obliged to create such areas.[454]

In 2010, after a general smoking restriction had been discussed, including all types of bars becoming smoke-free, this was weakened to bars being smoke-free only when food is served. The government has announced that even premises that do not serve food will be smoke-free by 2012 and certain organisations within Belgium (National Coalition against Tobacco) are trying to have this smoke-free change implemented earlier.

Public transport such as buses, taxis, trains, and domestic/international air transport have all been smoke-free since 1982. Domestic and international water transports have not yet introduced smoke-free legislation.[455]

To try and limit the sale of cigarettes to children in Belgium, it is prohibited to sell packets of less than 19 cigarettes, or, if the packet contains less than 19 cigarettes, then the price must be the same as for 19 cigarettes. Since young people tend to have less money, it is a deterrent if they have to buy the whole packet.

Legislation on tobacco advertising, promotion and sponsorship
Tobacco advertising, promotion and sponsorship have been banned in Belgium on the television and radio, in magazines and newspapers, on billboards and at the cinema since 1999. It is not yet banned at the point of sale.[456]

Belgium was the first European country to introduce pictorial health warnings on cigarette packets.[457] In addition, from the 1 January 2011 the quitline number was added on the cigarette packets.

Challenges to legislation and enforcement
It is thought that some members of the general public in Belgium are putting up resistance to smoke-free legislation because they consider it to be an invasion of their private life.

Although the Ministry of Health is very positive towards smoking cessation, it is possible that the Ministry of Finance is less positive, as it feels (incorrectly) that reduced smoking will lead to reduced taxes. (Please see section 04.04 for the rationale behind taxation.)

New legislation preventing smoking in bars is scheduled for 2012. If this does not happen, it will become the responsibility of the next government who could then put it off until 2016.

08.02.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

General Practitioners (GPs) can provide advice on stopping smoking for their patients, but in the past there has been some reluctance to interfere in what was considered to be a patient's personal life. There is reimbursement for the consultation but, under new rules, there is also now an additional fee for intervention (e.g. prescribing smoking cessation therapies), so GPs may be more motivated to assist with smoking cessation.

The Fonds des Affections Respiratoires (FARES) has set up centres to help smokers wishing to quit and runs smoking cessation clinics for the French community. The Flemish Association for Respiratory Health and Tuberculosis (VRGT) is the sister organisation to FARES and provides smoking cessation clinics for the Flemish community.

In these smoking cessation clinics, smokers can consult with a multidisciplinary team, e.g. physician, nurse, psychologist, or dietician to address all aspects of smoking cessation.

A free quitline (Tabacstop) is very active in Belgium, taking more than 13,000 calls in 2009 with good results. There are two types of intervention:

- Providing information to smokers regarding specialist stop smoking centres/tobaccologist and informing them of the type of treatments available to help them quit.
- Providing coaching to assist with smoking cessation, usually over the phone for 6 to 8 sessions.

Reimbursement for smoking cessation services

There is reimbursement for consultations with healthcare professionals by patients wishing to stop smoking both in primary care and within hospitals (in-patients and out-patients). According to experts in Belgium, at present this is €30 for the first consultation of 45 minutes and then €20 for each of the next seven consultations of 30 minutes (€30 for pregnant women), for a maximum of eight consultations over two years. This is in addition to the normal consultation fee.

However, some physicians refuse to limit their services to the cost of reimbursement, so the patient may have to pay a small amount on top. The same reimbursement is available for consultations with tobaccologists who are not physicians.

The FARES centres described above are also partly funded by the national social security which reimburses the initial and follow-up consultations with the multidisciplinary team for smoking cessation at a similar level to that of the GP consultations.

The reimbursement of drugs for smoking cessation in Belgium is somewhat complex, changes regularly and can be dependent on the fund paying for it. For example:

- Some drugs are restricted to specific diseases (e.g. bupropion is reimbursed in chronic obstructive pulmonary disease (COPD) patients at stage 2 or higher).
- Nicotine replacement therapy (NRT) is not reimbursed. In the French-speaking community, it used to be partially reimbursed in some circumstances, e.g. for those with lower incomes, for the husbands of pregnant women.
- The patient must pay for the first two weeks of varenicline therapy. After this, the remaining ten weeks of drug therapy are partially reimbursed and this reimbursement is only provided once in the lifetime of the patient.
- Some health insurance companies will pay a fixed amount (e.g. maximum of €50) for any smoking cessation medication, but only as a one-off payment.
- There is a People in Poverty Scheme in part of the Flemish community which aims to fully reimburse smoking cessation treatments for those on low incomes. During 2011 it is anticipated that this project will probably be implemented in the whole Flemish part of Belgium and then in 2012 it should be implemented in the French speaking part of Belgium.

08.02.4 GUIDELINES

Peer-reviewed national smoking cessation guidelines for GPs were published in 2005.[458] They were recently updated but reportedly without effective peer review by tobacco experts, so there are some concerns on the quality of the updates.

There are also more recent guidelines from pharmacists ('Quitting smoking') which have been peer-reviewed by experts and are reported to be of good quality.

Guidelines have been prepared for helping pregnant women to quit smoking. These are intended for use by obstetric/gynaecology specialists and paediatricians and were published by FARES in September 2010.[459] These guidelines were subject to consultation and were also published in the Flemish community with the co-ordination of VRGT.[460]

The enforcement of guidelines is limited in Belgium, and it is thought that they are not followed by all healthcare professionals. Reimbursement criteria tend to dictate physician prescribing but reinforcement and enforcement of guidelines is usually organised by medical associations.

08.02.5 EDUCATION AND HEALTHCARE PROFESSIONALS' (HCPs') ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
There are no national programmes for medical students with each university being responsible for the content of its courses. There is minimal course content on smoking cessation with just a few hours per course at the most.

Primary care
Domus Medica (association of GPs) organises group workshops of around 15 physicians with members of the scientific steering committee of the VRGT in conjunction with private sector organisations, where smoking cessation is on the curriculum. Primary care professionals are not obliged to attend and so very few participate.

There is also a training course organised by FARES and the three French-speaking universities, covering all aspects of smoking cessation, comprising around 72 hours of study over one year, with workshops, an examination and a dissertation. This leads to the title of tobaccologist, and is open to all healthcare professionals including GPs, nurses and psychologists. This course has been running for around 10 years, with around 50 to 60 students each year. Similarly, the same course is organised by VRGT in collaboration with the Flemish universities and leads to recognition as a tobaccologist, which is essential for the reimbursement of smoking cessation.

The Vlaams Instituut voor Gezondheidspromotie en Ziektepreventie provides online training for all healthcare professionals with help and advice on motivational interviewing.[461]

Secondary care
There is a network of smoke-free hospitals (coordinated by VRGT and FARES) which produce general recommendations about smoking and smoking cessation. These reach hospital physicians and nurses and so can be influential.

General public
There are no national programmes specifically targeted at the general public. However, a number of different initiatives focussing on cessation exist:

- There is the TABACSTOP quitline which provides advice. In addition there are various organisations with informative websites (e.g. www.cancer.be, www.fares.be or www.vrgt.be) but it is for the individual to seek out the necessary information.
- There was an educational programme targeting pregnant women[462] some years ago where they were encouraged by a specific reimbursement for themselves and their partners when consulting specialised services, but the uptake was low.
- There was also a recent campaign utilising public transport to advertise the availability of reimbursement for smoking cessation support.
- There is a children's book on passive smoking that is handed out in paediatricians' offices to try to encourage parents towards smoking cessation.

08.02.6 RECOMMENDATIONS

Increase reimbursement for smoking cessation treatments
Consultations with GPs, specialists or tobaccologists are reimbursed, but pharmacological smoking cessation treatments are not currently fully reimbursed. There should be reimbursement of medication (in particular NRT) so that people can quit for free. In addition, repeated courses of treatment should be reimbursed, otherwise motivated quitters would have to wait two years before they can again attempt quitting with reimbursed medications.

It is thought that this recommendation is the most important as it will ensure that everyone has access to smoking cessation medications, particularly those on low incomes. These low-income groups tend to have the highest rates of smoking, the lowest rates of smoking cessation, and the least ability to pay. Therefore this recommendation will be particularly important for these smokers.

The Minister of Social Affairs makes decisions on the reimbursement of pharmaceutical products based on the recommendations of the Commission for Reimbursement on Medicines (National Institute for Health and Disability Insurance (RIZIV/INAMI)). Thus, implementation of this recommendation will be the responsibility of the Minister of Social Affairs.

Organise smoking cessation services nationally from a central organisation

Currently, there are a number of ministers across national and regional government with responsibilities for health including prevention, which is arranged regionally. There are seven ministers in charge of health so there is no real national focal point within government for smoking cessation. Ideally, a single national agency acting as a focal point for smoking cessation would be more effective. In reality, it may be that the most effective approach could be to create two national agencies to represent the Dutch-speaking region of Flanders in the north and the French-speaking region of Wallonia in the south.

Involvement and training of more healthcare professionals

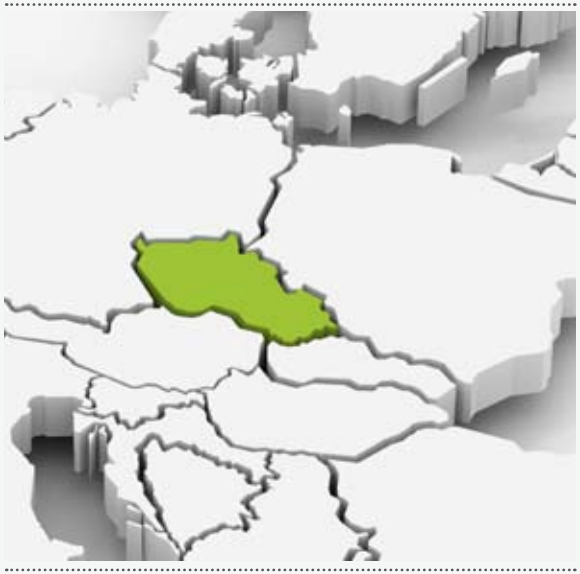
Healthcare workers need to be better trained in how to speak to patients about smoking cessation (for instance using a motivational interview). To this end, programmes were set up in hospitals in 2009 and an e-learning model (Flemish section) is now available from the Vlaams Instituut voor Gezondheidspromotie en Ziektepreventie which provides online training for all healthcare professionals with help and advice on motivational interviewing.[463]

It is important to involve and train all healthcare professionals (e.g. physicians, nurses, pharmacists, physiotherapists, psychologists, dieticians) in smoking cessation advice and guidance. Reiteration is very important as it reinforces the message. It is more effective if a number of healthcare professionals are all giving the same 'message' to the patient.

Support for this important recommendation will need to come from the appropriate medical associations who are in a position to provide such training. The Belgium Society for General Practitioners/Family Physicians (Domus Medica/Société Scientifique de Médecine Générale, SSMG) is currently providing training with a focus on primary care but there is little training provided for secondary care healthcare professionals.

Continuing professional medical education (CME) is organised by the government who could include smoking cessation as a required element of CME to ensure that all physicians are updated regularly.

CZECH REPUBLIC



Introduction

The following information on the tobacco control and smoking cessation services in Czech Republic has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Czech Republic.

08.03.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Health Organization (WHO) database records 21.8% of the adult population of the Czech Republic as regular smokers in 2008.[464] The Eurobarometer 2009 Survey on Tobacco reported on fieldwork conducted in 2008 and found the prevalence of daily smoking to be 26%, with 10% smoking occasionally.[465] A recent research report on smoking from the Czech National Institute of Public Health (NIPH) conducted in 2009 puts the daily smoking prevalence among those aged 15 to 64 at 26.3%.[466]

It has been estimated that in 2004, smoking cost the Czech Republic at least $373 million from the state budget annually; nearly 0.8% of the country's gross domestic product (GDP).[467]

Smoking prevalence targets
There are no national targets for the reduction of smoking prevalence.

08.03.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
The Czech Republic has a Smoke-Free Law, which came into force on 1 January 2006. Smoking is prohibited in public places (e.g. in closed spaces accessible to the public such as public transport, shelters and waiting rooms), schools, closed entertainment facilities (e.g. cinemas, theatres, galleries, concert halls, sport halls), medical facilities and buildings of public administration – but not in restaurants.[468]

Under the 2006 law, in restaurants, cafés and bars, owners have to provide a space reserved for smokers marked with a visible sign, but unfortunately the sign can be placed anywhere. Amendments were tabled to enforce separate smoking and non-smoking facilities in restaurants, cafés and bars. However, on 11 June 2009, members of the Czech Parliament backed a proposal allowing bars and restaurant owners to decide whether their establishment is smoke-free, combined or allows smoking.

From 1 July 2010, owners were required to put a notice on the door saying where their establishment stands.[469]

On public transport such as buses, taxis, trains, domestic water transport and domestic air transport, the Czech Republic has been smoke-free since 2006. There is also a voluntary agreement for smoke-free international air transport that has been in place since 1996.[470]

Legislation on tobacco advertising, promotion and sponsorship

Tobacco advertising, promotion and sponsorship on the television and radio, in magazines and newspapers, on billboards and at the cinema have been banned in the Czech Republic since 2004. It is not yet banned at the point of sale.[471] However, the use of tobacco products' names is only banned on radio and television and this allows tobacco companies to promote a range of clothes on billboards.[472]

Warning labels have to be placed on cigarette packets but there are no pictorial warnings.

08.03.01

Smoking prevalence in the Czech Republic (2009)
26.3% = Daily smoking prevalence among those aged 15-64. [466]

Challenges to legislation and enforcement

The Czech Republic is the only European Union country that has not yet ratified the Framework Convention on Tobacco Control (FCTC).[473]

The President of the Czech Republic, Mr Klaus, has openly opposed smoke-free legislation, claiming that it would deny smokers their rights.[474]

The Eurobarometer 2009 analytical report on tobacco across Europe (conducted 2008) found that only 41% of the general poluation are totally in favour of smoke-free restaurants and this plummets to 27% for those in favour of smoke-free bars, clubs and pubs.[475]

08.03.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

At the primary care level, treatment of tobacco dependence is not fully integrated in the Czech Republic.[476] However, there is a network of tobacco dependence hospital-based clinics across the country that can offer patients behavioural therapy and pharmacotherapy. At the clinic, patients have a screening visit with a nurse, who takes the patient's history, completes various questionnaires and may take a blood sample. The patient then goes to the physician for intervention, which may involve behavioural therapy and at the end of the session, the physician will decide if pharmacotherapy is required. Patients generally have around eight visits during one year.

There is a national quitline which is available in all major regions of the country and is staffed by trained counsellors. There are also a number of independent groups which campaign against tobacco use and provide support for people who wish to quit, including:

- Society for Treatment of Tobacco Dependence[477]
- Czech Coalition Against Tobacco[478]
- Smoking cessation support[479]

Reimbursement for smoking cessation services
Intensive smoking cessation support from specialist smoking cessation clinics is free but patients pay the standard regular fee for seeing a physician (30 CZK). However, there is no reimbursement of smoking cessation medications in the Czech Republic and smokers have to purchase their medication from the pharmacy.[480] Nicotine replacement therapy is available over-the-counter at pharmacies.[481]

08.03.4 GUIDELINES

There are guidelines in place for smoking cessation. These were published in 2005 and have been endorsed by 19 medical associations. The group responsible for developing the guidelines is the Working Group for Prevention and Treatment of Tobacco Dependence at the Czech Medical Association. A new version was planned for 2010, but it is understood that it has been delayed. The new version, once available, should then be included in other guidelines. According to experts, there are recent guidelines for the treatment of tobacco dependence from the Psychiatric Association (2010), the Czech Association of Nurses (2010), and the Czech Chamber of Pharmacists (2010).

There is a need for publications on the cost-effectiveness of smoking cessation in the Czech Republic.

08.03.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
There is collaboration between the seven medicine faculties in the Czech Republic. Every student in each of the seven faculties of medicine now takes a course in tobacco control and the treatment of tobacco dependence. Each medical faculty should have at least one member of staff responsible for ensuring that students receive tobacco control education. Tobacco education coordinators from each medical faculty also meet once a year to share their experiences.[482]

Though each medical faculty varies, students will receive at least three hours training on the treatment of tobacco dependence, with some receiving more information on subjects such as epidemiology, and pharmacotherapy. Some medical students may also write a thesis on smoking.

Primary care
Seminars for primary care staff are organised by the Czech Society for Treatment of Tobacco Dependence, the Czech Medical Association or the Czech Medical Chamber. Several hundred General Practitioners (GPs) have been educated to date.

The general attitude of primary healthcare professionals towards smoking cessation is not very proactive. They usually cite lack of time and lack of reimbursement for their low involvement in smoking cessation programmes. They are now starting to be interested but improvement is slow to take place.

Secondary care
Seminars for secondary care physicians are organised by the Czech Society for Treatment of Tobacco Dependence, the Czech Medical Association or the Czech Medical Chamber.

General public
There is little education on smoking cessation for the general public. It is mostly organised by the Institute of Public Health, public health centres across the country and non-governmental organisations (NGOs) such as the Cancer Leagues.[483]

National smoking cessation websites are available at www.dokurte.cz and www.odvykani-koureni.cz. www.stop-koureni.cz.[484]

A number of public educational materials have been produced, including:
- Smoking and pregnancy; a disease – a chance to stop smoking
- Mental health and smoking by the Society for Treatment of Tobacco Dependence.[485]

The Czech Republic has participated in a number of anti-smoking events including the annual WHO World No Tobacco Day.

08.03.6 RECOMMENDATIONS

Recognise tobacco dependence as a disease
As tobacco dependence is a disease, smoking cessation services should be provided for smokers who wish to quit in the same way that treatment is provided for any other disease. More use should be made of medical society journals where articles and studies that illustrate and reinforce the message that tobacco dependence is a disease should be published.

Ratify the FCTC
The Czech Republic has not yet ratified the FCTC[486], and although there is smoke-free legislation, exceptions are allowed for restaurants, cafés and bars. The FCTC should be ratified and it is the responsibility of the government. Patient, medical and scientific associations should encourage ratification of the FCTC.

Implement more stringent smoke-free legislation in all public places
Although there is smoke-free legislation, exceptions are allowed for restaurants, cafés and bars. Currently owners are only required to put a notice on the door to say where their establishment stands on smoking.[487]

It is recommended that action is taken to enforce more stringent smoke-free legislation in all public places. Enforcement of the smoke-free legislation is supportive of the WHO's MPOWER approach which includes protecting people from second-hand smoke.[488] This strengthened legislation will also help the general public to understand that smoking is not the 'norm'.

Increase taxes on cigarettes
Tobacco prices in the Czech Republic are 25% less than the average 2009 price of 27 countries in the European Union.[489] It is recommended that taxes on cigarettes should be increased. This will help to reduce demand and encourage those who smoke to quit, particularly the younger smokers. Earmarked taxes should be introduced so that tobacco tax revenue can be directed to help smokers to quit.

Reimburse smoking treatments
Currently, the lack of reimbursement for smoking cessation medications means that such drugs are applied to the physician's budget and this may make them disinclined to prescribe such medications.

It is recommended that smoking cessation medications should be at least partly reimbursed. For example, Luxembourg provides reimbursement for up to 50%, up to a maximum of €100, if a patient stays in the programme as described above.[490] Additionally, if medications are at least partially reimbursed, patients will feel that they are more effective treatment options.

Provide healthcare professionals with guidelines and advice in Czech
It is thought that healthcare professionals are somewhat passive in terms of following smoking cessation guidelines. To support implementation, the guidelines should be published in the journals of the different medical associations and distributed to their members. The guidelines should also be discussed at major conferences, and translated into Czech and included in other important Czech journals.

There is currently little support for guidelines from the health insurance companies – gaining their support would also help implementation. For this to succeed, the guidelines need to include clear pharmacoeconomic arguments.

Involvement and training of more healthcare professionals
There should be systematic training and education in the field of smoking cessation for all healthcare professionals. Such training and education will encourage physicians to be more involved with smoking cessation with their patients.

As a minimum, physicians should be trained to provide brief interventions before, if necessary, referring the patient to a specialist smoking cessation clinic.

DENMARK

Introduction

The following information on the tobacco control and smoking cessation services in Denmark has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Denmark.

08.04.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The daily smoking prevalence in Denmark is one of the highest of all Nordic countries. Although smoking has declined over the years (Table 11), the remaining smokers have a higher degree of tobacco dependence and there is a tendency for these smokers to have poorer education[491] and hold unskilled jobs or be unemployed.

One Danish expert believes that the overall prevalence may decrease to around 15% over the next 10 or 15 years. However, even though the percentage of daily smokers has decreased from 25.6% in 2005 to 21.5% in 2010, the total number of smokers (including occasional smokers) has only decreased from 28.0% in 2005 to 26.5% in 2010 (see Table 11).

The net costs to the healthcare sector due to smoking were estimated in 2006 to be around $592 million per year (3,327 Danish Krone; 1$=5.7 DKK).[499] Absence from work due to smoking-related illness and early death costs Danish society around $3,648 million in indirect costs (human capital method) (20,792 million Danish Krone; 1$=5.7 DKK).[500] Based on data from the World Health Organization Statistical Information Services (WHOSIS) database, in 2002, the cost-effectiveness (in US dollars per disability-adjusted life-year (DALY)) of tobacco control interventions (a combination of a tax increase up to 89% of the final retail price, clean indoor air law enforcement, a comprehensive advertising ban, information dissemination and nicotine replacement therapy (NRT)) could be $274 per DALY in Denmark.[501] Olsen *et al.* (2006) found the incremental cost-effectiveness ratio of smoking cessation to be around €1,300 per life-year gained compared with no intervention, based on data from the Danish smoking cessation database.[502]

Based on the most recent national smoking habit survey by the National Board of Health, the Danish Heart Association, the Danish Lung Association and the Danish Cancer Society, 61% of smokers plan to stop smoking at some stage; 57% would stop smoking if they became ill, 31% would stop smoking if their General Practitioner (GP) recommended them to quit, 22% would stop smoking, if smoking cessation medication was prescribed by

Year	Overall prevalence (smoking every day)	Prevalence details	Source
1984	47%	51.0% of men 43.0% of women	OECD[492,493]
1995	35.5%	38.0% of men 33.0% of women	OECD[494]
2000	30.5%	32.0% of men 29.0% of women	OECD[495]
2005	25.6%	27.9% of men 23.4% of women 2.4% occasional smokers	Rygevaneundersøgelsen, 2005[496]
2008	23.2%	24.1% of men 22.3% of women 4.8% occasional smokers	Rygevaneundersøgelsen, 2008[497]
2009-2010	21.5%	22.4% of men 20.5% of women 5.0% occasional smokers	Rygevaneundersøgelsen, 2010[498]

Table 11: Smoking prevalence in Denmark

the GP with full reimbursement, and 20% would stop smoking if cigarettes became more expensive.[503]

Smoking prevalence targets

In October 2009, the Danish government presented a national plan for prevention aimed at increasing life-expectancy by three years within the next ten years.[504] The plan was launched as a follow-up to the government-appointed Prevention Commission, which in April 2009 presented 52 specific recommendations to increase life-expectancy through better prevention, including around eight focused on smoking.[505] The government's new plan did not include a specific target for the reduction of smoking prevalence.

A new advisory body, the National Prevention Council, was appointed by the government in 2009 to promote evidence-based prevention. Smoking cessation is a prominent focus area of the Council. The Council advises the National Board of Health under the Ministry of Interior and Health.

08.04.2 LEGISLATION ON SMOKING

Denmark signed the Framework Convention on Tobacco Control (FCTC) on 16 June 2003 and ratified it on 16 December 2004.[506] Smoke-free legislation was implemented in August 2007 and should have been revised in 2010. However, the Minister of Health postponed a revision until 2011, to allow more debate and to collect data about the effects of the current restrictions. This move was backed by the majority of Parliament in an amendment to the original legislation in 2009-2010.

In January 2010, cigarette tax was increased by approximately 10% (DKK 3.00).[507] The Danish Heart Association estimated that the number of smokers could be reduced by approximately 43,000, with a tobacco tax increase of 50%.[508] This Danish Heart Association analysis found that tobacco tax increases would have the greatest effect on the youngest smokers (those under 30 years).[509]

Smoke-free legislation and policy

In Denmark, healthcare facilities, education facilities, government facilities, indoor workplaces and offices, and theatres and cinemas were all made smoke-free from August 2007. While schools are smoke-free, teachers can smoke in a specific room.[510]

By law, smoking is not permitted on buses and trains and is very limited in taxis and on international water transport. Domestic and international air transport and domestic water transport have voluntary smoke-free restrictions.[511] The law still allows smoking in one-person offices, in smoking rooms and in smoke stations, as well as in bars with less than 40 square metres of serving area.[512] Danish experts consider smoke-free legislation as very important, as nobody should be exposed involuntarily to tobacco smoke. Although the law still needs strengthening, the effect of the law will increase over time, according to experts.

The introduction of smoke-free legislation was met with some initial resistance by the general public, but was considered a necessary step by many health experts to de-normalise smoking, reduce passive smoking, reduce smoking prevalence and thereby reduce tobacco dependence. More recently, around two-thirds of the population have acknowledged that they would like stronger legislation against smoking.[513]

A 2009 government evaluation of the smoke-free legislation, documented that while the restrictions have caused fewer people to be exposed to second-hand smoke, the restrictions had so far had no impact on smoking prevalence [514] or the level of acute myocardial infarction.This was further corroborated by the lead author of an evaluation report presented at a government sponsored hearing in October 2010.[515]

Legislation on tobacco advertising, promotion and sponsorship

The minimum legal age for buying tobacco in Denmark is 18 years, like most European countries. The minimum age requirement went into effect 1 September 2008 and carries penalties, if retailers break the law and sell to minors. However, Danish experts believe that it is still very easy for minors to buy cigarettes and much more should be done to uphold the law.

08.04.1

Smoking prevalence in Denmark (2009 – 2010)
21.5% = daily smokers 2009 – 2010[498]

A small group of health and communication experts (The Pinocchio Group) have presented the concept of an ID-debit card for the purchase of cigarettes to prevent minors from buying cigarettes. This group also want cigarettes to be sold only in certified tobacco shops with licenses that could be revoked, if the rules were broken. The proposal has so far not enjoyed any widespread political support.

Direct tobacco advertising is banned in Denmark on television and radio, on billboards, in the cinema, and in local magazines and newspapers. Sponsored events with tobacco brand names, direct mail giveaways and promotional discounts are also banned. Point of sale advertising is still permitted.[516]

08.04.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

The official Danish quitline (www.stoplinien.dk) is operated by the National Board of Health and Copenhagen City Health Administration and serves smokers in all of Denmark.[517] It was updated in 2009 and was widely promoted in connection with a recent information campaign organised by the National Board of Health – 'Every Cigarette Hurts You'.

The Danish Cancer Society and the National Board of Health have collaborated to develop a programme of smoking cessation courses involving five meetings for motivated quitters over six months. (Many instructors and municipalities reportedly invite motivated quitters to 6-7 meetings). Over 5,000 smoking cessation instructors have received training to provide this service.[518]

More than 372 smoking cessation units (including hospitals, pharmacies, municipalities and primary care units) in Denmark use the Smoking Cessation Database. This is a quality assurance database, to document and evaluate smoking cessation

activities.[519] The database includes data from more than 46,000 participants, and is funded by the Danish National Board of Health and the Bispebjerg Hospital, where the administration is located.[520] The database is free of charge to smoking cessation units in Denmark – units in other countries may pay a fee and join (two units in Norway have become members).[521] This database facilitates monitoring of quit rates with participating units at individual and aggregate level. However, GPs and smoking cessation counsellors are still responsible for individual follow-up.

Based on analysis of data from the Danish Smoking Cessation Database, a study by Kjaer *et al.* looked at the effectiveness of smoking cessation interventions at a national level. Kjaer ` concluded that uniform smoking cessation interventions at a national level are possible and can be achieved with the same level of abstinence rates as clinical trials. The study reported a quit rate of 16% after 12 months (intention to treat result). Importantly, these smoking cessation interventions were run by nurses and equivalent staff who had only received three days of training and had no other particular therapeutic skills.[522]

A recent review of 18 Scandinavian studies evaluating smoking cessation courses, quitlines and quit and win competitions (behavioural modification smoking cessation programmes (BMSCP)), including the study referred to above by Kjaer *et al.*, revealed that most of the reviewed studies of BMSCP were analysed by using the per-protocol (PP) approach and were based on self-reported point prevalence estimates. The intention to treat (ITT) approach is more conservative and has continuous quit rates with biochemical verification of abstinence.[523] The risk of the PP approach is that the results from Scandinavian BMSCPs may be too optimistic regarding their ability to help people quit smoking.

Smoking cessation practices in primary care

According to a Danish expert, the provisions for smoking cessation in primary care have improved over the last few years. Primary care services are provided by GPs who are independent contractors that are reimbursed on a pay-for-fee basis by the regional government entities. Primary care practitioners can therefore decide themselves which areas of health they will focus on.

With the Government Reform Act implemented in 2007, the direct responsibility for preventative efforts was shifted from the counties to the municipalities. Almost all of the 98 municipalities now offer smoking cessation, e.g. group therapy sessions at community health centres or pharmacies. Neither municipal health personnel, nor pharmacies can prescribe medication. The Danish media has reported that the municipal smoking cessation services have experienced recruiting problems and only 10,000 smokers are reported to use the municipal services.[524] This can be compared with GPs who undertook 1.2 million prevention consultations about patient risk factors in 2009, though smoking-related consultations are not specified.[525]

The standard smoking cessation course allows patients two meetings before their fixed date to give up smoking (normally Sunday evening), then two shortly after the quit date, and a final follow-up meeting after six months. Although many patients drop out after the first two visits, they may start again as many times as they wish.

Although there is no standard follow-up for smoking cessation, most clinics offer a six-month follow-up, sometimes with biochemical verification. Some specialist services report their results and findings to the central smoking cessation database but this is not compulsory. Courses funded by the local municipality usually have to report their efficacy.

Physicians are not required to ask if a patient smokes and there is a widespread belief that many do not ask, even if the patient has symptoms of a smoking-related disease. Although all patients should have an offer to help quit, this varies from physician to physician. Apparently, GPs may be concerned that some patients are not interested in quitting and should therefore not be confronted with the issue every time they consult their GP about another health issue. Therefore, it is important that the GP assesses each patient individually.

Experts in Denmark believe that around 10% of physicians who ask about smoking will also offer brief interventions and some of these physicians will refer the patient to a smoking cessation service.

The physician may suggest a community programme or a pharmacy programme, but not all physicians are aware that these are available.

A Danish expert reported that it is believed that only a few physicians refer patients to the official Danish quitline (www.stoplinien.dk).[526]

Smoking cessation practices in secondary care
With the Government Reform Act implemented in 2007, the direct responsibility for preventive efforts was shifted from the counties to the municipalities. The related funding was also transferred from the regional level to the municipal level. Therefore, several hospitals have reduced or eliminated smoking cessation efforts.

In some hospitals, in-patients are offered cessation advice and pharmacotherapy free of charge for the duration of their stay and for two weeks after hospitalisation, or are offered a free three-month course with pharmacotherapy. The patients are monitored by carbon monoxide measurement. Some hospitals also offer free smoking cessation courses with counselling and medication for the staff.

However, in general, within the five Danish health regions, smoking cessation is not currently considered a primary task for the regional hospitals, but a responsibility for the municipalities, which is a separate local government level. The municipalities have the responsibility and the budget for prevention services, including smoking cessation. For example in the region of Southern Denmark, patients who smoke are referred to the municipal health clinic or their GP for smoking cessation. It can be expected to be the same in the other regions.

Reimbursement for smoking cessation services
Municipal smoking cessation support courses are free of charge to smokers. However, pharmacies and other private practice smoking cessation units take a fee for their courses.

GPs do not charge patients for prevention consultations or smoking cessation advice, as GPs are remunerated by regional government on a pay-for-service contract.

While prescription and over-the-counter smoking cessation pharmaceutical products are available in Denmark, administrative regulation issued by the Ministry of Interior and Health has directly barred any form of reimbursement for more than a decade. In late 2009, Parliament agreed to provide earmarked funding in 2010-2014 for projects for socially vulnerable people including the possibility of providing free smoking cessation medication, i.e. outside of the regular reimbursement system. The National Board of Health was expected to approve appropriate projects submitted by the municipalities before the end of 2010, but at this point is difficult to assess any substantial gains or new evidence from such projects, because no funding to such projects has been given yet. Some municipalities reportedly offer NRT with smoking cessation support today, but the extent has not been verified.

According to one expert, many patients feel that smoking cessation medicines are too expensive and this is a disincentive to quitting. For instance, patients treated with a prescription medicine make one payment for the first four weeks of treatment, and then another payment for the next eight weeks. Overall, this is about the same cost as smoking, but the required level of upfront co-payment is discouraging to smokers.

Recent international recommendations from WHO[527] and from a Canadian government research institution[528] about the provision of reimbursement for medicines to improve quit rates and counter health inequality have so far not surfaced in the public debate.

Current Danish law offers companies a 100% tax deduction on the expenses related to employee health programmes, including smoking cessation schemes since January 2005.[529] However, few companies appear to be aware of this option regarding smoking cessation.

Political influence and cultural obstacles
The Danish government states that smoking cessation is high on its political agenda, as reflected in a recent prevention policy paper (October 2009).[530] However, a recent European study comparing 30 countries indicated that the Danish government appeared less committed to smoking cessation than other Scandinavian countries.[531]

A Danish expert remarked that the Danish government apparently believes that smoking cessation is primarily a matter of personal responsibility. Politicians in particular tend to think that smoking is voluntary and that quitting is a matter of willpower and they do not see smoking as a disease of dependency.

Compounding the issue is that politicians believe that smoking cessation will cost them money in the short-term and that it will take too long to see a return on their investment.

When the government lowered the price of tobacco a few years ago (to reduce cross-border trade), it sent the wrong message to the general public about the desirability of smoking.

However, there is now a consensus among decision-makers, patient organisations, etc., that structural approaches such as higher cigarette taxes, comprehensive smoke-free public spaces, supported by municipal smoking cessation courses can reduce smoking prevalence significantly. This consensus was reflected in the Prevention Commission's recommendations in early 2009 that also called for a build up of municipal capacities.[532]

Despite several tobacco control initiatives in recent years, total smoking prevalence is still at more than 26% with 21.5% being daily smokers in 2010.[533]

08.04.4 GUIDELINES

Official, national guidelines on smoking cessation for healthcare professionals do not exist in Denmark, although a guide for individual smokers (Rygestop-guide) has been issued by the National Board of Health on how to quit smoking.[534]

In 2008, the Danish College of General Practitioners issued guidelines for chronic obstructive pulmonary disease (COPD),[535] that include smoking cessation, adapting national recommendations issued by the National Board of Health in 2007 on screening, diagnosis, treatment and rehabilitation of COPD patients.[536] The Danish Society of Respiratory Medicine is working on developing guidelines for use of smoking cessation in secondary care.

In line with the government's recent prevention policy document (October 2009), the National Board of Health is working on developing a Danish version of the guidelines from the UK's National Institute for Health and Clinical Excellence (NICE, February 2008) and the United States' Surgeon General (May 2008) to be used in GP clinics, local government health centres, hospitals etc. No publication date has yet been officially announced, but launch is expected in early 2011.

08.04.5 EDUCATION

Medical students
Smoking cessation is not routinely taught in Danish medical schools.

Primary care physicians and other healthcare professionals
There are no national educational programmes for primary care physicians about smoking cessation. The Danish Cancer Society educates smoking cessation counsellors[537] in collaboration with the National Board of Health. These counsellors are employed by local government health services, in GP clinics, hospitals and private healthcare companies, and are qualified nurses.

An expert in Denmark believes that primary care physicians primarily receive their education from either the Danish Cancer Society or from pharmaceutical companies.

The Danish Cancer Society's training concept for smoking cessation counsellors involves a three-day course with a refresher course each year for counsellors such as nurses and other equivalent staff.[538] However, the current 2008 version of the training material[539] has only a limited focus on the pharmacological support of smoking cessation.

Secondary care physicians
There are no national educational programmes for secondary care physicians in smoking cessation.

General public
There have been a number of health campaigns over the last 30 years. Most recently, the National Board of Health ran a campaign – 'Every Cigarette Hurts You' – in the autumn of 2009 and early 2010. This campaign included short television spots and was based on a concept originally developed in Australia.[540]

The Danish Cancer Society is carrying out Internet-based and school-based programmes against smoking and to encourage smokers to quit, including the X:IT project, which aims to prevent smoking among young people in Aalborg and Herning. The Danish Cancer Society is launching a new Internet-based smoking cessation programme in the autumn of 2010.[541]

08.04.1

$592 MILLION

The big numbers
The net costs to the healthcare sector due to smoking were estimated in 2006 to be around $592 million per year.[499]

National smoking cessation websites can be found at www.stoplinien.dk (adults) and www.xhale.dk (adolescents).

There are no national programmes of education for patients in primary care, but it is thought that some individual physicians are proactive, providing posters, leaflets, education and therapy sessions, but this depends very much on the individual GP.

There are some programmes for patients in secondary care, run on a hospital-by-hospital basis, where patients are visited by a member of staff, or can go to clinics at the hospital that have a dedicated nurse or physician. Three or four hospitals in Copenhagen have serious programmes that focus on specific high-risk patients such as those with heart disease, cancer or COPD.

08.04.6 HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Primary care physicians
According to experts, some GPs are very aware of smoking and its dangers, and they are active about smoking cessation and referral to community counselling programmes. These GPs may provide the services themselves in an integrated clinic with other GPs, practices nurses and other staff. Other GPs are aware of the importance, but feel that it is the patient's own choice to smoke and the smoker's responsibility to quit and that there is little that they, as a physician can do.

One Danish expert believes that many GPs lack smoking cessation education and information, with probably only half of GPs having sufficient knowledge about smoking cessation.

Secondary care physicians
The attitude of secondary care physicians varies from department to department, with increased concern amongst cardiovascular, vascular, and pulmonary physicians.

As previously stated, the primary responsibility for smoking cessation efforts has been moved from the regions (hospitals) to the municipalities (community health centres).

08.04.7 RECOMMENDATIONS

Targets should be set for reducing the smoking prevalence
A number of specific recommendations about smoking are contained within the government's national plan aimed at increasing life-expectancy, however a specific target for reducing smoking prevalence is not part of the national plan.[542]

It is recommended that a specific, achievable target should be set for reducing the number of smokers in Denmark.

Implementation of these targets would be the responsibility of the National Board of Health.

Increase tobacco prices
The Danish Heart Association estimates that a 50% increase in tobacco taxes would reduce the number of smokers by approximately 43,000 and that tax increases would have the greatest effect on the youngest smokers (those under 30 years).[543] Data from the most recent national smoking habit survey suggested that 20% would stop smoking if cigarettes were more expensive.[544]

Tobacco prices should be increased to make it harder for the young to start smoking. Increased prices may also increase the number of people who try to quit.

Implementation of this recommendation would be the responsibility of the Danish government.

Reimburse smoking cessation therapies and services
Data from the most recent national smoking habit survey indicated that 22% would stop smoking if smoking cessation medications were prescribed by the GP were reimbursed.[545]

GPs should be reimbursed for their time providing smoking cessation services.

The administrative barriers against reimbursement for medicine should be removed, so smoking cessation medications can be reimbursed in the regular reimbursement system with a patient co-payment. In particular, those smokers in high-risk groups need economic incentives to help support their quit attempts.

For this recommendation, the Danish Minister of Interior and Health needs to take administrative steps to change the regulation that prevents reimbursement. No legislation is necessary.

Parliament has agreed that free-of-charge smoking cessation medications for socially vulnerable smokers can be tested by the municipalities in individual projects. However, no funding to such projects has been given yet by the National Board of Health and so the scope and potential effect on quit rates are still undetermined.

Demonstrate the return on investment in smoking cessation in the short term
The Danish Cancer Society reports that the population is ready for stricter tobacco control measures but the politicians are not.[546] There is also a perception that politicians believe they are doing enough and that quitting smoking is down to the patient and their willpower.

According to one Danish expert, it is important in the current political and economic situation to explicitly demonstrate the need to invest in smoking cessation and the positive return on investment that can be expected in a relatively short time frame.

Primary care physicians need to be more involved in smoking cessation
The most recent national smoking habit survey suggested that 31% of smokers would make an attempt to stop smoking if their physician recommended them to do so.[547] Previous surveys indicate that many smokers expect to be asked about smoking by their GP.

Danish experts suggest that physicians should be more proactive with smokers. They should ask about smoking, offer help to

quit and record the results. A separate appointment should be scheduled with the smoker to discuss smoking cessation or the patient should be referred to a local smoking cessation service, e.g. in community health centres. Further follow-up with the smoker to review progress is also important.

Logically, it is assumed that once national guidelines are developed, this recommendation will be incorporated within the guidelines.

Improve access to smoking cessation services
Smoking cessation clinics should be available locally to the GPs, so that they can easily refer patients. Further efforts are needed to link GPs and community health services. In particular there is a need to target smoking cessation services to certain groups such as high-risk smokers, parents, children and people on a low income.

Develop and implement national guidelines
Formal national guidelines for healthcare professionals, e.g. GPs, should be developed to include:

- Recommendations and financial incentives for healthcare professionals to treat smoking as a disease, i.e. tobacco dependence
- Promote usage of the integrated approach (combining counselling and medication) from the UK and US guidelines
- Measurement of the efficacy of the services provided.

Guidelines for implementing smoking cessation in primary care should be prepared by the National Board of Health in collaboration with the GP association.

Such collaborative efforts on smoking cessation can be based on the comprehensive efforts to improve detection and treatment of diabetes and COPD in primary care, which have provided excellent results.

Separate guidelines for specific groups and therapy areas are required, e.g.

- Young people, people on low incomes, ethnic minorities and people with low educational levels
- Patients with cardiovascular disease, diabetes, etc.

Recent recommendations from the WHO and Canada should be incorporated to increase quit rates.

Introduction

The following information on the tobacco control and smoking cessation services in Finland has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Finland.

08.05.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

Smoking is a significant cause of avoidable premature death and illness in Finland. The World Health Organization (WHO) database recorded 20.4% of the Finnish population (aged 15+) as regular, daily smokers in 2008.[548] In 2009 the proportion of regular smokers was recorded in the annual national survey as 18.6% (22% of men and 16% of women).[549] Between 4,000 and 6,000 people in Finland die every year of smoking-related diseases.[550]

58% of Finnish male daily smokers and 59% of Finnish female daily smokers in 2009 wanted to stop smoking, and 40% of male smokers and 43% of female smokers seriously attempted to quit smoking in 2009.[551]

In 1987, Pekurinen estimated the gross healthcare cost of smoking in Finland to be between 0.14% and 0.15% of gross domestic product (GDP). He then updated his estimates and found that the estimated costs for 1995 were 0.17% of GDP.[552]

Male Finnish smokers observed over a 19-year period were found to have incurred additional healthcare costs and a loss of productivity compared with non-smokers. However, quitting smoking could save at least 60% of the losses related to excess mortality and disability in those aged 25 to 59.[553]

Smoking prevalence targets

The goal of Finland's tobacco policy is to end the use of tobacco products and to protect the population from involuntary exposure to tobacco smoke (second-hand smoke). The first section of the Finnish Tobacco Act was approved unanimously by Parliament and set this goal on 1 October 2010, when the amended section of the Tobacco Act came into force.

The State Secretary of the Ministry of Social Affairs and Health stated in 2010 that "The goal is to get rid of smoking once and for all. It is a long-term goal, but still we are going to achieve it."[554] This new goal of tobacco policy will mean stronger and stricter rules and regulations.

Health 2015
In 2001, the government adopted a resolution on 'Health 2015' which outlined the target for Finland's health policy over the following 15 years. The main focus is on health promotion rather than on developing the health service system and the programme was prepared by the Public Health Committee set up by the government. One of the targets is to decrease smoking by young people (aged 16 to 18 years) to less than 15%.[555]

Smoke-free 2040
This non-governmental initiative aims to persuade Finland's government to make Finland Smoke-free by 2040. A broad range of around 50 groups such as trade unions, institutes and organisations have signed the initiative and are supporting the initiative which they hope will provide families with the support they need to raise smoke-free generations. The group believes that a smoke-free Finland will not be attained unless as many adults as possible quit smoking.[556] The Smoke-free Finland 2040 initiative has been successful and the new Article 1 of the Tobacco Act concerning the goal to stop smoking in Finland was enacted and came into force 1 October 2010. The Ministry of Health is preparing governmental strategy on how the goal of the Act on Tobacco-free Finland will be attained.

08.05.2 LEGISLATION ON SMOKING

Finland is one of the leading countries in Europe with respect to legislation on smoking. As early as 1976 Finland introduced legislation to prohibit the advertising and promotion of tobacco and to utilise up to 0.45% of the annual tobacco taxes to fund health education and evaluation.[557] In practice, the proportion has been 0.7-0.9% for many years.

This same bill also ensured that cigarette packets had health warnings on them and that cigarettes may only be sold from supervised dispensing machines.

08.05.1

Smoking prevalence in Finland (2009)
18.6% = regular smokers[549]

This original legislation was enacted in 1976 and came into force on 1 January 1977 and prohibited tobacco sales to children who were or appeared to be under 16 years of age. By 1995, a more comprehensive amendment to tobacco legislation was proposed and the age limit was raised to 18 years in 1995.[558]

In 1994, Finland legislated for smoking bans in workplaces, indoors and in public areas. This was followed up with smoke-free legislation for restaurants in 2007. Since the very beginning of smoke-free legislation in Finland, the general public's attitude has been supportive. The introduction of smoke-free workplaces in 1995 significantly changed public opinion, so that non-smoking is widely accepted as the social norm in Finland.

At the municipal level, the city of Helsinki, as one of the biggest employers in Finland, has banned smoking during working hours, allowing it only during one or two official 15-minute coffee breaks and lunch. Many other municipalities and companies have launched similar bans. Nowadays, employers have realised the importance of a smoke-free work force and the meaning of a smoke-free environment, not only for the wellbeing of their employees but also because of increased productivity. US

research suggests that smokers miss more days of work and experience more unproductive time at work compared with former smokers and non-smokers and this translates into higher costs for the employers.[559]

Consideration of the productivity losses provides a new economic view on tobacco policy. For example, if an employee smokes a cigarette per hour during his/her working hours and spends 5 to 8 minutes per cigarette, daily he/she spends from 35 to 42 minutes smoking. This means, that in total a smoker spends from 17 to 19 working days annually in smoking. This is a big loss of productivity for the employer.

On 1 April 2009 an amendment to the tobacco legislation on licensing the retail sale of tobacco products came into force. Before this amendment there were 25,000–30,000 retail outlets selling tobacco products in Finland but after the amendment to the legislation, there were 13,000 and all these retail outlets are now controlled by the authorities.

On 1 October 2010 an amendment to the tobacco legislation was enacted which bans:

- The display of tobacco products in retail outlets
- The possession of tobacco products by minors (under 18 years)
- Minors being given tobacco products by others
- Vending machines.

This amendment forms one of the steps to attaining the new goal of the new Finnish tobacco policy to completely stop the use of tobacco products.[560]

Challenges to legislation and enforcement

The October 2010 amendment to the tobacco legislation regarding the display, purchase and possession of tobacco products by minors provides a very strong message from society to minors, their friends and parents, that preventing young people from smoking is important. Legislation is just one part of what is needed, and it will also be necessary to change the social attitudes of the whole society.

Since 2006, sales of nicotine replacement therapy (NRT) have been deregulated in Finland, allowing them to be sold by grocery stores, petrol stations and not just pharmacies. Deregulation has brought the average price down by about 15% mainly due to the exemption of NRT products from pharmacy fees and increased competition.[561] This deregulation may help improve access to smoking cessation support but it has been noted that, since deregulation, pharmacists' motivation to counsel clients on smoking cessation has been diminished.[562]

08.05.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Treatment of tobacco dependence and preventing people from smoking is part of national health programme in Finland and there are programmes for prevention, diagnosis and treatment of tobacco dependence as part of primary healthcare.[563]

Patients tend to be asked about their smoking status in primary care and physicians are encouraged to document this and so the situation has improved in the last ten years. However, the current emphasis is more on patients with smoking-related symptoms rather than all smokers. The advice given to smokers will vary depending on the skill and confidence of the particular physician. Patients who smoke will be followed up at their next visit but there is usually no formal follow-up arranged.

Some primary care physicians will refer smokers to a nurse specialist within their practice. Alternatively, there are specialist smoking cessation clinics and the patients who tend to be referred to these specialist clinics will be the ones who are really motivated to quit or have specific smoking-related symptoms that might progress. However, there are not many of these specialist clinics and the delay from referral to appointment might be anything from a few weeks to a few months. Once within a specialist clinic, patient follow-up lasts for six months or longer.

It is very common that employers, through their occupational health services, organise and pay for their employees to receive free smoking cessation services including medications. The cost to the employer is partially reimbursed by the Social Insurance Institution.

Reimbursement for smoking cessation services
Public health insurance covers everyone in Finland and this is managed by the Social Insurance Institution (Kansaneläkelaitos, Kela).[564] Smoking cessation services organised by occupational health services are partially reimbursed by the Social Insurance Institute. In the public sector, services are mainly organised free of charge. In the private sector, reimbursement of cessation services varies. Some private pharmacies also offer unreimbursed smoking services, according to the Pharmacists Action on Smoking and charge up to €80 for these services with NRT costing the patient extra.[565]

Smoking cessation medications are not reimbursed although it is thought that they should be reimbursed just as they are for other diseases. For other diseases, a product's cost and benefits are compared with alternative treatments and are reviewed by the Pharmaceuticals Pricing Board (Lääkkeiden hintalautakunta), which operates under the auspices of the Ministry of Social Affairs and Health.[566] The Board reviews this information in the context of Finland's social and healthcare services. After a reasonable wholesale price has been approved, a product will automatically qualify for reimbursement under the Basic Refund Category.

08.05.4 GUIDELINES

The Finnish national Current Care Guideline ('Smoking, nicotine dependence and nicotine withdrawal') was developed and written by the Finnish Association for General Practice and funded by the Ministry of Social Affairs and Health.[567] Since the first publication in 2002, these guidelines were updated in 2006[568] and the next update is currently underway.

The key features of these guidelines are that they:
- Help physicians to define and diagnose tobacco dependence
- Emphasise the key role that physicians play in helping patients to quit smoking
- Provide guidance for all the different groups involved such as primary care, secondary care and the private sector.

08.05.5 EDUCATION

Medical students
For the last five years there has been a project tackling the education of medical students. The National Institute for Health and Welfare and the University of Eastern Finland collaborate to provide medical student education in four of the five Finnish medical schools. The fifth medical school provides some smoking cessation education through its pulmonary and public health studies courses.

Primary care
There is some training available for physicians in primary care but this is organised locally and regionally, not nationally. For instance, there is a programme at the University of Helsinki providing educational material for continuing professional development. However, it was thought that too few healthcare providers attend this training due to budgetary constraints.

Secondary care
Training for secondary care staff is not readily available.

General public
Campaigns for the general public are mostly co-ordinated by non-government organisations, but mostly financed by government. The Cancer Society has been targeting young people to try and prevent them from taking up smoking. The Respiratory Association promotes respiratory health and provides many anti-smoking resources including a quitline. Similarly, the Finnish Heart Association in cooperation with North-Savo Heart District and the National Institute for Health and Welfare is building a

comprehensive Internet-based site about tobacco dependence and the health effects of tobacco aimed at the general public.

In addition, there are other regional programmes and a growing movement for local 'smoke-free' communities organised by local government where any building owned by the local government has to be smoke-free.

National tobacco cessation websites are available at www.tupakka.org and www.stumppi.fi, and for adolescents at www.fressis.fi. The homepage of the government-run website (www.tupakkainfo.fi) acts as a feeder page for the other Finnish tobacco cessation services and it is this website that is included on tobacco packs.

08.05.6 RECOMMENDATIONS

Smoking cessation should be a fixed/regular part of treatment and prevention of diseases
Tobacco dependence is a recognised disease and causes many other serious diseases. In this regard, as a cause of diseases, it is fully comparable with the serious risks of high cholesterol, hypertension and high blood sugar, which are conditions always treated in Finland. Therefore, for every disease that is fully or partially caused by smoking, smoking cessation needs to be part of the treatment and prevention. The government policy programme on health promotion (2007) strongly underlines this and the role of physicians in the provision of smoking cessation services.

More and more, physicians are starting to understand this important point and are increasingly paying attention to smoking when treating their patients. The Finnish national Current Care Guidelines ('Smoking, nicotine dependence and nicotine withdrawal') have an important role in communicating the message to physicians on their responsibilities for tobacco cessation to prevent disease as well as to treat diseases.

Reimburse time for providing smoking cessation services and reimburse treatments
Although tobacco legislation is strong in Finland, smoking cessation services offer a weak point in the system. Smoking cessation services are widely accepted as scientifically proven to be effective and a worthwhile investment to reduce smoking and to improve the health of the population and they therefore should be reimbursed.

There is reimbursement for medications for the treatment of alcoholics and drug users, however, although tobacco dependence is a treatable disease, medications for treatment of this disease are not reimbursed.

It is recommended that smoking cessation services and medications are reimbursed in the same manner as services and treatments for other addictive diseases.

The Ministry of Health and Ministry of Finance should be more aware of tobacco dependence (nicotine dependence) as a disease, as a cause of many other diseases, of the role of smoking in public health and the cost-effectiveness of tobacco cessation. Based on this information they should approve the reimbursement of tobacco cessation medications in a timely fashion.The patient, medical and scientific associations should advocate for reimbursement.

Emphasise the importance of a co-ordinated approach to manage smokers
The current guidelines emphasise that it is not just the physicians that are important in tobacco cessation but that it involves different healthcare professionals throughout the care pathway. The goal for a smoke-free Finland and the supportive legislation that is now in place will require a co-ordinated approach to the management of smokers from healthcare professionals.

Although the primary care physician has a key role in helping patients who smoke, there needs to be a co-ordinated response by other healthcare professionals who see smokers throughout the care pathway. This will be aided by increased physician and healthcare professional smoking cessation education and training, which will help physicians to collaborate with other healthcare providers.

Increase the number of specialist smoking cessation clinics
Access to smoking cessation services needs to be improved. With the new legislation on smoke-free Finland, including the goal for 2040, the next step is to provide better support to nicotine-dependent people and give them the help they need to quit.

The recommendation is to increase the availability of specialist care by having more smoking cessation specialists in hospitals and primary care centres.

Educate physicians on tobacco dependence so that the vital importance of their role in smoking cessation is appreciated
Over the last five years there has been a project in Finland to educate undergraduate and postgraduate healthcare professionals organised through the University of Eastern Finland. Four of the five Finnish medical schools now implement this programme and the fifth incorporates smoking cessation training within the pulmonary and public health studies training.

However, too few healthcare professionals attend these smoking cessation educational courses, presumably because of budget constraints. This means there is a lack of training for both primary and secondary care but especially primary care physicians.

Smoking cessation training should be ongoing as part of continuing professional education and smoking cessation has to be a priority. Such training will help remind physicians of their responsibility for preventing disease as well as treating disease. Physician advice is hugely influential with patients and therefore every physician should be obliged to ask their patients if they smoke, to offer advice on quitting smoking and to provide smoking cessation treatment and medications or referral as appropriate.

Smoking cessation, particularly at the primary care level, involves teams of healthcare professionals and ideally the undergraduate training should reflect this and offer a team approach. Therefore groups of physicians, nurses and pharmacists should be brought together for training. In certain areas, there are local groups that work in preventative medicine that should be trained to include smoking cessation as part of the services they provide.

Finland is at the beginning of the process to provide tobacco cessation services. The education and training of physicians and other healthcare professionals on tobacco dependence, the role of smoking as a cause of diseases, and the treatment of tobacco dependence, is the most important recommendation.

Introduction

The following information on the tobacco control and smoking cessation services in France has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in France.

08.06.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The prevalence of daily smoking in France was reported in 2010 to be approximately 28.7% among people from 15-75 years old, 31.8% among men and 25.7% among women.[569]

With about 66,000 deaths each year directly or indirectly attributable to its use, tobacco remains the leading cause of avoidable mortality in France.[570]

The General Practitioners and the Economics of Smoking Cessation in Europe (PESCE) project estimated that a reduction of 3% in the prevalence of smoking in France would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke and chronic obstructive pulmonary disease (COPD) of €18.4 million by 2020 and €33.2 million by 2030.[571]

Smoking prevalence targets
As part of the Public Health Law passed in 2004, the objective was to reduce the smoking prevalence from 33% to 25% in men and from 26% to 20% in women by 2008.[572]

The objective of the Cancer Plan (2009-2013) was to reduce smoking prevalence from 30% to 20% for the French population as a whole.[573] However, this objective has not yet been met.

08.06.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
In 1991 (Évin law), smoking was restricted on trains and domestic/international water transport and in public places (restaurants, cafés, etc), with smoking and non-smoking sections. Smoke-free legislation was implemented in buses and taxis in 1991 and on domestic air transport in 1992.[574]

On 1 February 2007, France prohibited smoking in public places, including offices, hospitals and schools.[575] The smoke-free

restriction was extended to restaurants, dance clubs, casinos and some bars on 1 January 2008. Under the new regulations, smoking rooms are allowed, but are subjected to very strict conditions relating to their size, ventilation and cleaning etc.

France was one of the first countries to ratify the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) treaty as a European Union (EU) member on 19 October 2004[576] and to ensure that the treaty's core principles were reflected in its own national tobacco control policy.

Legislation on tobacco advertising, promotion and sponsorship
Tobacco advertising, promotion and sponsorship have been banned in France on the television and radio, in magazines and newspapers, on billboards and at the cinema since 1991. Tobacco advertising is also restricted at the point of sale.[577]

Challenges to legislation and enforcement
Although the French Minister of Health wished to increase the price of cigarettes by more than 10%, the government agreed a 5.7% increase with tobacco manufacturers in November 2009. Unfortunately, this has had little effect on tobacco consumption and it was reported by the Public Health Committee in September 2010 that this increase in tobacco prices was merely a budgetary measure and not a public health measure.[578]

Before the summer of 2010, the tobacco manufacturers responded to increasing smoke-free legislation by threatening price cuts. The French Minister of Health, Roselyne Bachelot, stated that she was shocked by the plan which the government had no power to stop. The Office Français de Prévention du Tabagisme (OFT) declared that the price cut would attract new smokers, especially young people and women.[579]

A 6% increase in the price of cigarettes and tobacco was put in place on 8 November 2010[580] in the budget, even though the Ministry of Health requested a 10% increase in price.[581]

08.06.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Some General Practitioners (GPs) provide smoking cessation support, but there is no formal structure to this. Some GPs are not always well trained in smoking cessation and a national survey demonstrated that questionnaires to identify risk factors in patients were only used by 6.3% of physicians and pharmacists.[582]

In addition, some GPs do not seem to view smoking cessation and the necessary follow-up as a high priority. This may be because they see other issues, such as diet and compliance to any treatments provided as being more important.

There is an annual €50 voucher to help pay for medications for each patient.[583] However, once this is utilised, any further medications recommended or prescribed have to be paid for by the patient.

The main smoking cessation support in France relies on the tobacco treatment specialist or tobaccologist system, and specialists (cardiologists, psychiatrists, lung physicians, etc.) increasingly refer smokers to these services. The society representing the tobacco treatment specialists (Société Française de Tabacologie) organises annual meetings and is a counsel for health authorities for smoking-related issues.

There is currently one tobacco treatment specialist for every 5,000 smokers which does not satisfy all the demand for smoking cessation support. It is therefore desirable that more GPs be involved in smoking cessation.

Since 2000, each hospital with more than 500 beds has to have someone responsible for the management of tobacco dependence for patients, staff and visitors. At these specialist smoking cessation clinics there will be, for example, one or two physicians, a nurse, a psychologist and a dietician.

These hospital-based smoking cessation clinics provide a team approach and participate in a nationwide electronic database that helps to monitor the consequences of anti-smoking measures on smoking behaviours.[584,585]

In 2008, the OFT database of smoking cessation clinics recorded 303 hospital-based clinics and 343 clinics in the community (generally a GP trained in smoking cessation). The OFT provides a centralised database used by all of the clinics and believes that these clinics support about 5% of all smokers who seek assistance to quit.[586]

Tabac-Info-Service is the French national quitline (phone and website) which provides basic information on smoking and giving up smoking as well as details of nearby smoking clinics. The service also provides services for the more complex call and may refer such callers immediately to a smoking cessation specialist or make an appointment for such a discussion.[587]

For the general public there are also media advertisements and a website to help with smoking cessation and there are also some smoking cessation programmes in workplaces.

08.06.1

Smoking prevalence in France (2010)
28.7% = adults[569]

Reimbursement for smoking cessation services
Hospital-based smoking cessation out-patient services are free with a social security card, but patients have to pay for almost all the medications (except for the annual €50 voucher contribution). Similarly, GP visits are reimbursed but not the treatments. The cost of the smoking cessation drugs to the patient varies according to different pharmacists – the price is not fixed as it is not reimbursed. Some people cannot afford it, especially smokers on benefits.

Reimbursement of prescribed pharmacological treatment for tobacco dependence is supported in France, but, despite appeals for full reimbursement, the government has ruled to subsidise prescribed treatment only up to a maximum of €50 annually.[588]

A new regulation will allow €150 reimbursement for smoking cessation medications per year for pregnant women and people with low incomes (who may have additional Complementary Universal Healthcare Coverage, which covers 4.3 million beneficiaries). However, though this was announced with the new development of the Cancer Plan in December 2009, it has not yet been implemented.

Political influence
France's proactive approach to targeting tobacco dependence has been driven in part by non-governmental organisations (NGOs) working under the umbrella of the Alliance Against Tobacco. The Alliance Against Tobacco comprises more than 30 French NGOs that provide information, support and contribute to the implementation of the WHO FCTC, and participate in the organisation of major gatherings of the tobacco control community. After the Évin law of 1991 (which banned all direct and indirect tobacco advertising), the role of the NGOs increased significantly through their efforts to help implement the advertising ban. The Alliance was also key in the struggle for smoke-free public places. In 2005, it published a report on passive smoking, which helped lead to all covered and enclosed public places in France being smoke-free from 1 January 2008.

08.06.4 GUIDELINES

France's Haute Autorité de Santé (HAS) published guidelines on therapeutic strategies for quitting smoking in 2006[589] entitled "Stratégies thérapeutiques d'aide au sevrage tabagique: Efficacité, efficience et prise en charge financière". In practice, these are suggested guidelines and they are not enforced, although it is thought that most specialist clinicians will follow the guidelines.

These guidelines are considered outdated and the French Society of Tobacco Research (SFT) is attempting to have these guidelines revised and made less complicated, more practice oriented, and more concise.

08.06.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
The curriculum for physicians, dentists, midwives, nurses, pharmacists and physiotherapists includes around six hours on addiction, including tobacco dependence. In some medical schools this is not mandatory and the numbers of students who opt to study addiction varies considerably.

Primary care
There are no formal smoking cessation training programmes for primary care staff.

A study published in 2005 found that 33.9% of male GPs and 25.4% of female GPs in France were smokers.[590] The prevalence of smoking of both male and female physicians was about 3% lower than their counterparts in the French population in general.

Traditionally, there has been a problem of motivating GPs to undertake smoking cessation training. It was thought that this is because GPs have not been reimbursed for the extra time they would need to spend with patients to properly assist with smoking cessation. A solution to this could be to include smoking cessation advice in the newly created 'pay for performance' scheme, which is part of the social health insurance.

Secondary care
There are some educational programmes for the treatment of tobacco dependence for physicians in secondary care, but this is dependent on the smoking cessation clinics' activities. These programmes usually focus on specific areas, such as cardiovascular and lung diseases, and may also include training on screening smokers and giving minimal counselling and treatment before referring them to a specialist smoking cessation clinic run by tobacco treatment specialists (tobaccologists).

There have been five postgraduate medical courses running for more than 10 years, training around 200 graduates per year as tobacco treatment specialists. Participants are mainly physicians (80%) but also include psychologists and midwives. These courses address all aspects of tobacco (epidemiology, dependence, smoking-related diseases, health burden, pharmacological and non-pharmacological interventions etc.). Participants obtain a diploma after a written exam, thesis and clinical practice office training, and this is recognised by the National Order of Physicians. It allows participants to obtain state-funded positions in hospitals and out-patient smoking cessation clinics, or run private practices focused on smoking cessation.[591]

08.06.1

66,000

The big numbers
With about 66,000 deaths each year directly or indirectly attributable to its use, tobacco remains the leading cause of avoidable mortality in France.[570]

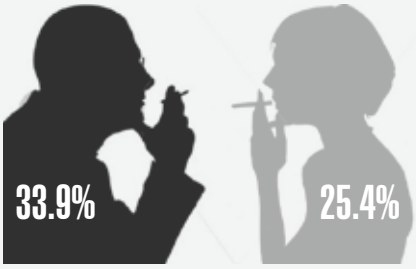
General public
The National Institute for Prevention and Health Education provides materials, brochures and leaflets that are sent to all physicians as patient information to be left in the waiting room (and available for health professionals at www.inpes.sante.fr). They also organise national campaigns on, for example, the risks linked with tobacco consumption.

On the annual World No Tobacco Day there are informational campaigns and press conferences.[592]

Many hospitals run group sessions and educational programmes. These are run by the smoking cessation team and are usually led by physicians, but it is common to have nurses involved as well. They can be adapted for different groups, including high-risk patients.

There are educational programmes in schools for teenagers that teach them about the harm of tobacco, using television and the newspapers, but they do not cover much about smoking cessation.

National smoking cessation websites are available at www.tabac-info.net, www.doctissimo.fr/html/dossiers/tabac_stop.htm and www.tabac-info-service.fr.



08.06.5

Fact
A study published in 2005 found that 33.9% of male GPs and 25.4% of female GPs in France were smokers.[590]

08.06.6 RECOMMENDATIONS

Demonstrate the economic benefits of smoking prevention and cessation to the healthcare system
There is still a perception that smoking is a lifestyle choice. People need to understand that smoking behaviour is motivated by needs and influenced by many factors such as life circumstances and stress factors, that have to be taken into consideration. Tailored programmes to reach specific sub-groups of smokers are needed, for example, for those certified with long-term illnesses who smoke. Demonstrating that health expenditures could be controlled by reducing the prevalence of smoking could influence public health policies.

In September 2010, the Public Health Committee provided advice on Tobacco Control.[593] The Committee reported on research that showed pharmacological treatments for tobacco dependence to be cost-effective for both secondary and primary prevention. This research needs to be utilised by those advocating for the economic benefits of smoking prevention and cessation within the French healthcare system.

Increase reimbursement for smoking cessation treatments
The Public Health Committee in September 2010 reported that to help stop people smoking, there should be reimbursement of those drugs that have been shown to be effective. The report emphasises that the current €50 voucher scheme is insufficient.[594]

It is recommended that smoking cessation treatments that have shown sufficient evidence of their efficacy should be fully reimbursed. The Public Health Committee report suggests that 100% of the cost of smoking cessation medications should be reimbursed for expectant mothers, those with low incomes and those certified with long-term illnesses who smoke.[595] In low-income groups, the smoking prevalence is higher and, because of the cost of medications, these groups may have difficulty accessing treatments.

These low-income smokers in particular and patients with smoking-related diseases in primary or secondary care should be reimbursed.

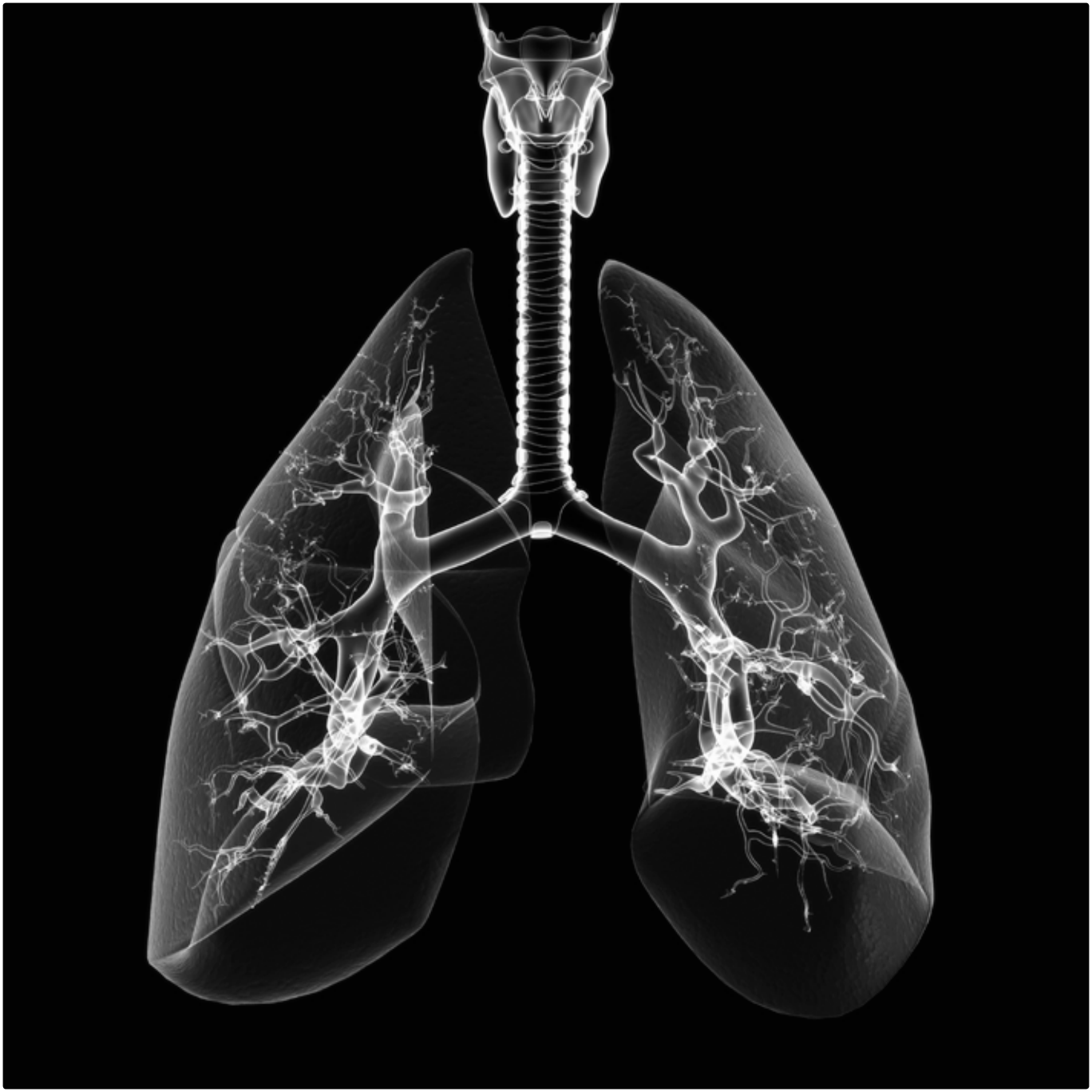
Such reimbursement also helps with patient adherence to treatment, as it validates the medication's efficacy in the minds of the smokers. Even partial reimbursement would help smokers to access and use smoking cessation treatments.

Provide better educational programmes on smoking cessation, especially for primary care
The Public Health Committee suggested in their September 2010 report that GPs and midwives should be trained in tobacco cessation. In addition, the Committee recommends that this training is registered as part of the continuous professional education that these physicians and nurses receive.[596]

It is therefore recommended that better educational programmes on smoking cessation should be implemented to encourage primary care healthcare professionals to work in smoking cessation. Increased education in smoking cessation is key to providing all healthcare professionals with the necessary skills and confidence to effectively deliver smoking cessation such as brief interventions.

Specifically, a practical strategy for GPs needs to be devised and provided (e.g. how to discuss smoking cessation with the patient in one minute, five minutes or ten minutes).

It would be the responsibility of the appropriate societies to provide this professional education and it would seem sensible to have a standardised course agreed by the societies and delivered to their respective members.



GERMANY

Introduction

The following information on the tobacco control and smoking cessation services in Germany has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Germany.

08.07.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Health Organization (WHO) database records 33.9% of the German population (age 15+) as regular, daily smokers in 2003.[597] More recently a micro-census recorded the age-standardised prevalence of regular smokers (>15 years old) to be 23.4% with 28.6% of men and 18.5% of women being regular smokers in 2009.[598]

The average age of starting to smoke regularly is 13-14 years.[599] People in urban areas are more likely to smoke, and tend to smoke more heavily, than smokers in rural areas.[600]

In 2003 in Germany, there were 114,647 deaths and 1.6 million years of potential life lost that were attributable to smoking. This led to total costs of €21 billion, broken down to:

- €7.5 billion for acute hospital care, in-patient rehabilitation care, ambulatory care and prescribed drugs
- €4.7 billion for the indirect costs of mortality
- €8.8 billion for costs due to work-loss days and early retirement.[601]

The proportionate mortality attributable to smoking in Germany rose slightly, from 13.0% to 13.4% between 1993 and 2003, with deaths in men falling by 13.7% and deaths in women climbing by 45.3%.[602]

A modelled estimate of disease-related productivity costs attributable to smoking in the year 2005 suggested that there would be 107,389 deaths, 14,112 invalidity cases, and 1.19 million cases of temporary disability, with a productivity cost of €9.6 billion in Germany.[603]

According to the WHO Statistical Information Service (SIS) database in 2002, the cost-effectiveness (in US dollars per disability-adjusted life-year (DALY)) of smoking cessation interventions (a combination of a tax increase up to 89% of the final retail price, clean indoor air law enforcement, a comprehensive advertising ban, information dissemination and nicotine replacement therapy) could be $274 per DALY.[604]

The total (direct and indirect) costs of tobacco use in Germany are $23,746 million per year.[605] The General Practitioners and the Economics of Smoking Cessation in Europe (PESCE) project estimated that a smoking prevalence reduction of 3% in Germany could save €4.0 million a year in disease-specific healthcare costs in 2020, rising to €7.1 million by 2030.[606] (These disease-specific healthcare costs are related to chronic heart disease (CHD), chronic obstructive pulmonary disease (COPD), lung cancer and stroke.)

Smoking prevalence targets
Germany has no formal targets for the reduction in the prevalence of smoking. However, Germany has ratified the WHO Framework Convention on Tobacco Control (FCTC) and so is bound by the Act. The Association of Health Objectives (gesundheitsziele.de), initiated by the former Minister of Health defined objectives for the Tobacco Control policy in Germany and the reduction of tobacco use is a primary objective.

A National Action Programme was initiated in June 2008 by the former Federal Commissioner for Addiction and Drugs and the Advisory Council for Addiction and Drug Illnesses. This programme is based on three pillars: preventive measures for non-smokers, smoking cessation assistance and legal regulation in tobacco politics. However, since this programme was initiated, Germany elected a new government in autumn 2009.

The German Cancer Research Centre (Deutsches Krebsforschungszentrum, DKFZ) is a WHO Collaborating Centre on Tobacco Control and is supported by the government. The DKFZ is encouraging smoking prevalence reduction.

08.07.2 LEGISLATION ON SMOKING

Germany signed the FCTC in 2003 and ratified it in December 2004.[607] Starting in 2004, Germany progressively raised the tax on tobacco. There was some concern that increasing the tax on tobacco products all at once would significantly reduce tobacco consumption and therefore the size of the tobacco industry,[608] and so Germany has raised the tax in steps.

Smoke-free legislation and policy
In 2007, Germany passed a law to provide smoke-free public and federal buildings, hospitals, airports, and railway stations. Public transport in Germany only has voluntary restrictions on smoking.[609]

The smoking laws vary for each Federal area, for example, some regions have to provide smoking areas or rooms in bars, restaurants and clubs. According to Dr Martina Pötschke-Langer of the German Cancer Research Centre and Head of the WHO Collaborating Centre on Tobacco Control, 74% of the German population support smoke-free hospitality venues and 71% want uniform laws throughout the country.[610] However, an article in *Der Spiegel* in 2009 claimed that German smoke-free legislation in bars is only weakly regulated.[611]

The Bavarian government was fearful that stricter smoke-free laws would be unpopular with the general public. However, according to the results of a public referendum this year, 61% of Bavarians voted in favour of introducing the smoke-free legislation in Bavarian hospitality venues which were previously excluded, such as beer tents and pubs with special smoking rooms and smaller bars.[612] Bavaria now has the strictest laws on smoking in public places, with a total smoke-free policy being enforced in August 2010.[613] It is thought that the Bavarian poll has allowed smoke-free legislation to gain new momentum in Germany.

GERMANY

08.07.1

Age-standardised smoking prevalence in Germany (2009)
23.4% = regular smokers[598] 28.6% = regular male smokers[598]
18.5% = regular female smokers[598]

Legislation on tobacco advertising, promotion and sponsorship
The minimum legal age for buying tobacco in Germany is 18,[614] and there is a penalty for selling it to minors. Vending machines are available although there are moves to restrict access to minors by requiring an identity card to operate the machine.

In Germany, tobacco advertising is allowed in magazines and newspapers and at point of sale.[615] Direct advertising is banned on billboards, at point of sale, television and radio, and in cinemas before 1800 hours,[616] but indirect advertising is allowed in the form of product placement on television, in film, and in direct mail giveaways. Companies can put tobacco brand names on non-tobacco products, and use non-tobacco brand names for tobacco products. Sponsored events with tobacco brand names are restricted.[617]

Challenges to legislation and enforcement
Germany has repeatedly challenged legislation on advertising and sponsorship. During the 1990s, Germany challenged the Tobacco Advertising Directive (TAD1) and had it annulled by the European Court of Justice in 2000. A revised version of the Tobacco Advertising Directive (TAD2) was also challenged by Germany but still remains in place.[618]

Many Germans are addicted to tobacco and for some smoking is considered part of the German culture. Therefore it is essential to continue with education for all healthcare professionals and the general public and to maximise the resonance of positive public opinion such as that demonstrated by the Bavarian referendum.

08.07.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Smoking cessation services vary across Germany, especially in the new Federal states (those from the German Democratic Republic States are Brandenburg, Mecklenburg-Vorpommern, Saxony, Saxony-Anhalt and Thuringia in 1990). In the new Federal states, the supply of smoking cessation services is insufficient.[619] Etzel *et al.* report that around a quarter of the providers of smoking cessation services lack the specialised skills needed for smoking cessation counselling and treatment. They also found that physicians were more likely to lack the skills needed than other healthcare professionals.[620]

In a survey in 2005, the motivation for involvement in smoking cessation was high, but more than half of the General Practitioners (GPs) reported engagement with smoking cessation in less than 1% of all patients treated within the last three months.[621] The barriers against engagement most commonly reported included:

- Lack of adequate reimbursement
- Lack of training in smoking cessation promotion
- Lack of demonstration materials.

A survey among hospital physicians at one hospital found that one-third did not feel it was their responsibility to help smokers to quit. One-third of respondents reported lack of time and 22% reported lack of training.[622]

In a study in Western Pomerania published in 2007, 42% of out-patients said that they had been asked about their smoking behaviour by their GP compared with 27% the year before and these tended to be the patients who were older and smoked more cigarettes (i.e. those in whom the impact of smoking was more obvious).[623]

As supported by the study above, some GPs and hospital physicians are likely to advise patients to stop smoking or offer some level of smoking cessation advice. However, physician knowledge of effective treatments is limited and without this knowledge, they may recommend treatments that have proven to be ineffective (e.g. acupuncture). They are also unlikely to adapt the treatment relative to the risk assessment or the degree of tobacco dependence.

German medicine is highly specialised with physicians tending to focus on their own areas of expertise. Therefore, although awareness of the importance of smoking cessation and how to achieve it will be high amongst people working in cancer, heart, and lung disease, it may be less so in other areas.

There is a network of rehabilitation hospitals in Germany, and physicians within these hospitals tend to be more aware of smoking cessation than physicians in other hospitals.

Patients that attend specialist smoking cessation clinics generally refer themselves. Such counselling is performed by a specialist nurse and is free of charge to the smoker but because pharmacotherapy is not covered, a six-week smoking cessation course with medication will cost around €150. Health insurance companies will reimburse smoking cessation courses provided that they are certified, but they will not reimburse the pharmacotherapy.

There are five quitlines available in Germany (e.g. www.rauch-frei.info) and some primary care physicians will promote these to their patients.

According to a recent guideline on smoking cessation for patients with respiratory disease, the German healthcare system does not give smoking cessation adequate priority.[624]

Reimbursement for smoking cessation services

The Regional Association of Statutory Health Insurance Physicians (ASHIP; Kassenärztliche Vereinigung (KV)) specifies the reimbursement for services provided by physicians within the German compulsory health insurance system. Smoker counselling is not reimbursed, but smoking cessation services are reimbursed. Whilst prescription and over-the-counter smoking cessation therapies are available, they are not reimbursed.

Most German health insurance funds provide reimbursement for cognitive-behavioural group-based courses for smoking cessation and a literature review showed that these methodological approaches are effective and recommendable.[625] However, the reimbursement for non-pharmacological interventions which is around €75-100 is insufficient to cover the staff costs for providing these services. Appropriate reimbursement for GPs providing smoking cessation treatment and follow-up might motivate them more.

One study by Twardella *et al*. found that providing reimbursed pharmacotherapies along with improved training for the GP increases the extent and the success of smoking cessation promotion in general practice.[626] A similar study by Salize found that providing reimbursed pharmacotherapies along with training for the GPs was cost-effective at reducing smoking in primary care.[627]

Although physicians, hospital departments and insurance companies may provide smoking cessation services, smokers have to pay for any pharmacotherapies they receive.[628]

As part of the national COPD disease management programme (DMP)[629] it is proposed to fund pharmacotherapy and cognitive behavioural therapy for COPD patients, but this has not yet been passed into law.

08.07.4 GUIDELINES

Physicians in Germany have access to a number of different guidelines, including:

- The German Medical Association (BÄK)[630] and the German Cancer Research Centre
  - Stop smoking – physicians prevention and therapy (Dem Tabakkonsum Einhalt gebieten – Ärzte in Prävention und Therapie der Tabakabhängigkeit.) (2005)[631]
- German Respiratory Society (Deutsche Gesellschaft für Pneumologie und Beatmungsmedizin) (2008)[632]
  - Guidelines for smoking cessation in patients with COPD
  - It is anticipated that these guidelines will be revised during 2011.
- German Society for Addiction Research and Addiction Therapy and the German Society of Psychiatry, Psychotherapy and Neurology guidelines (published by Batra *et al*.[633])
  - Guidelines focus on the psychosocial aspects of smoking cessation
  - These guidelines are currently being updated.

However, these guidelines are not enforced and a physician must be curious enough to actively seek out the smoking cessation guidelines.

08.07.5 EDUCATION

Germany has age- and gender-based promotional and educational programmes aimed at encouraging cessation of tobacco use, but treatment of tobacco dependence is not part of its national health programme or its primary healthcare programme.[634]

Medical students
Some of the universities provide training for medical students, for example, in Heidelberg, Tubingen and Munich. However, medical students tend to be taught about the consequences of smoking, and not the treatments. Also, medical students are not examined on their knowledge and skills regarding smoking and cessation and so it is thought there is little incentive for them to learn.

Primary care
In a survey of GPs in the Rhein-Neckar Region in Germany, 23% had not received any training or education in the promotion of smoking cessation, and only 19% had received more than ten hours' training. Only 34% felt that their training was sufficient for providing smoking cessation promotion.[635]

Some GPs will use materials provided by the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung) or the pharmaceutical industry, but it is thought that this information is not routinely offered to smokers.

The German Medical Board (Bundesärztekammer) has developed a training programme and qualification in tobacco cessation. The training is reportedly designed to convey detailed information to physicians about the social and health-related aspects of

08.07.2

$23,746 MILLION

The big numbers
The total (direct and indirect) costs of smoking in Germany are $23,746 million per year.[605]

tobacco consumption, as well as provide successful approaches to motivation and therapy that help smokers to quit.[636] The Bundesärztekammer offers a formal qualification.[637]

There is also a specific diploma in preventive medicine that physicians can take which is organised by the German Academy for Preventive Medicine (Deutsche Akademie für Präventivmedizin).

Apart from these programmes, there are occasional continuing medical education workshops on smoking cessation available and these are usually funded by the pharmaceutical industry.

Secondary care
The European Network of Smoke-Free Hospitals (ENSH) records that smoking cessation training courses are available and provided by a number of different centres and agencies. These include brief intervention training (general, maternity and mental health and drug abuse), smoking cessation training (general, maternity and mental health and drug abuse) and training for participants so that they may train others.[638]

As part of the German network of smoke-free hospitals, 174 hospitals have implemented ENSH standards.[639] Adherence to the standards, however, is thought to be variable.

General public
There are few educational programmes for the general public but literature is widely available to support smoking cessation.[640] Educational programmes that exist are not part of a national infrastructure and tend to be run by the local or regional government or the Cancer Foundation. There is no national smoking awareness day but Germany does take part in the World No Tobacco Days (31 May). Cigarette packets carry warnings.

There are a few programmes in schools in Germany covering drugs and smoking, but these tend to be run by non-government organisations, and can include initiatives such as not smoking as a class.

GPs will provide posters, leaflets and booklets and some clinics offer smoking education, but this tends to be for higher-risk patients. There are a number of national smoking cessation websites available:

- www.rauchfrei-info.de (adults)
- www.rauch-frei.info (adolescents)
- www.ein-plan.de/rauchfrei
- www.aok.de/ich-werde-nichtraucher/htm/sitemap.php

One of the interviewees deems the government's interactive website to be very good but insufficiently publicised.

08.07.6 RECOMMENDATIONS

Implement smoke-free legislation in all public places without exceptions
The German Cancer Research Centre recommends federal legislation making all public places smoke-free to protect the health of non-smokers without any exceptions for the hospitality industry.[641] The FCTC should be supported and smoke-free legislation should be nationwide rather than regional.

Implementation of this recommendation will require new, stricter laws being passed by federal and local governments to protect non-smokers.

If this recommendation is implemented (without exceptions), it is thought that this will have the greatest immediate benefit to smokers and non-smokers.

Prohibit indirect advertising of tobacco products
Although direct advertising is banned on television, radio, and in cinemas before 18:00 hours,[642] indirect advertising in the form of product placement is allowed in Germany. Similarly, sponsored events with tobacco brand names are restricted but using those tobacco brand names for non-tobacco products is still allowed.[643]

Indirect advertising of tobacco products should be reduced. This would mean that event sponsorship and advertising would be banned as per the FCTC guidelines.[644]

Currently vending machines are prohibited to the under 18s,[645] and there is a penalty for selling tobacco to minors. However, it is thought that prohibiting vending machines completely might be effective at reducing initiation and will also make cigarettes less visible for all smokers.

Implementation of this recommendation will be important to support the FCTC guidelines and it will be the responsibility of the government and the individual Federal states.

Increase the tax on tobacco
The WHO Report on the Global Tobacco Epidemic established that raising taxes is one of the six most important and effective tobacco control polices available to a government.[646]

Previously, Germany raised tax in a stepwise manner[647] as the government was concerned that a single large tax rise would significantly reduce tobacco consumption[648] and thus the size of the tobacco industry. This government policy of incremental tax rises continues.

The WHO Report on the Global Tobacco Epidemic confirms that raising taxes is one of the six most important effective tobacco control policies avaiable to a government and it increases government revenues.[649] A notable increase on tobacco products will help to support Article 6 of the FCTC which calls for price and tax measures to reduce the demand for tobacco.

This recommendation needs implementing by the Federal government and to avoid smokers becoming used to small price increases, the price should not be raised in a stepwise manner. Although politicians are likely to continue with the policy of small incremental tax increases, the DKFZ should add their experience and advocate skills to this political discussion.

Reimburse time for providing smoking cessation services and medications
Smoking cessation treatment includes behavioural therapy and medication. There is currently little budget in primary care for smoking cessation and budget holders do not recognise its importance and the need to make it a main focus of their activities.

The COPD disease management programme was updated in October 2009,[650] and experts in Germany report that there is a proposal to finance smoking cessation treatment but this has not yet been passed into law. Such a proposal would enable these high-risk patients to receive important treatment. Smoking cessation is a key element of the national COPD disease management programme.

Health insurance companies, public welfare funds and the federal government, through the Ministry of Health, could create a new foundation or a pooled reimbursement source.

Involve primary care physicians more and incentivise them for their smoking cessation services
Smoking cessation therapy should be easy to use, and quick to access through treatment specialists. GPs should be at the centre of smoking cessation therapy and they should be encouraged to ask every patient whether they smoke, and to offer some form of effective smoking cessation therapy, or refer the individual to a specialist.

A system of pay for performance, similar to the one in the UK, has been recommended. Such a scheme that monitors the counselling and treatment of smokers might be useful in Germany as a performance indicator. Reimbursement could help to enhance motivation.

Implementation of this recommendation would be by the Regional Association of Statutory Health Insurance Physicians (KV) but this will require the Ministry of Health to be supportive as well. It is assumed that smoking cessation services will need to be reimbursed before this recommendation is likely to be undertaken.

Integrate smoking cessation networks
Smoking cessation services vary across Germany. Therefore a regional network of smoking cessation clinics with primary care physicians, nurses and psychologists needs to be implemented. This would standardise the services provided and ensure that in each area, all smokers have good access to standardised smoking cessation clinics.
Such a network of smoking cessation clinics would be endorsed by the Federal government.

Educate medical students and all healthcare professionals on smoking cessation
The foundations for acquiring good counselling skills for tobacco dependence are laid in undergraduate medical school education. Therefore, smoking cessation training should be integrated into the medical school curriculum. Regional medical boards could provide mandatory training in prevention strategies for GPs and medical students.

All healthcare professionals, including nurses, dieticians and counsellors should receive training (not just specialists). GPs should be provided with training designed specifically for their role in first-line intervention.

The education of healthcare professionals would be the responsibility of the scientific societies in the field.

Providing physicians with printed copies of appropriate smoking cessation guidelines or official recommendations might encourage physicians to review and utilise the guidelines. This particular aspect of the recommendation would be the responsibility of the National German Disease Management Guidelines.[651]

GREECE

Introduction

The following information on the tobacco control and smoking cessation services in Greece has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Greece.

08.08.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

Greece has the highest smoking prevalence not only among members of the European Union (EU) but also among all members of the Organisation for Economic Co-operation and Development (OECD).[652] The World Health Organization (WHO) database records 37.6% of the adult population of Greece as regular smokers in 2000 (46.2% of men and 33.5% of women).[653] Since then, a Eurobarometer 2009 Survey on Tobacco reported on fieldwork conducted in 2008 and found the prevalence of daily smoking to be 35% with 7% smoking occasionally.[654]

According to the Greek Ministry of Health, smoking-related diseases kill about 20,000 people a year in Greece,[655] costing the country an annual €2.14 billion.[656] Recent estimates raise this figure to €3.3 billion or 14.4% of total health expenditure in Greece.[657]

Smoking prevalence targets
The key target for Greece is to reduce the prevalence of smoking in adults by 10% by 2012.[658] This was incorporated in the National Action Plan for smoking published in 2008[659] by the previous government but it is thought to still be a valid target for the current Ministry of Health.

08.08.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
Greece enacted smoke-free legislation in July 2009 with the legislation taking effect in January 2010. The legislation prevents smoking in all work places, transportation stations, in taxis and passenger ships (smoking was already prohibited in trains, buses and airplanes), as well as in all enclosed public places including restaurants, night clubs etc.

However, small establishments of less than 70m^2 have the option to be designated as smoking areas. Also, larger establishments may provide separate enclosed smoking rooms with special air

conditioning. Up to 30% of the area (or 40% for night clubs with live music) can be designated as a smoking area which has to be separated with a door from the rest of the establishment and have a separate ventilation system.

The previous partial smoking bans were generally ignored.[660] However, from 1 September 2010, all public enclosed places went smoke-free and this included offices and businesses and has resulted in the closure of smoking rooms,[661] and to the abolishment of all exceptions to the previous law (e.g. establishments smaller than 70m^2). Smokers violating the law will be fined between €50 and €500 and businesses violating the law will be fined between €500 and €10,000.[662] However, casinos and bars larger than 300m^2 will be given eight months to apply the law.[663]

Although current legislation forbids the selling of tobacco products to minors, it is thought that this is not strictly followed by vendors.

Historically, Greece has had some of the lowest prices in Europe for tobacco products. However, smoking is becoming more expensive. In talks with the EU and the International Monetary Fund (IMF) in May 2010,[664] the Greek government agreed to increase excise tax on cigarettes by 10% as part of austerity measures aimed at plugging the country's large budget deficit.[665]

Legislation on tobacco advertising, promotion and sponsorship

According to the WHO, tobacco advertising, promotion and sponsorship have been banned in Greece on the television and radio since 1987. There have been restrictions on advertising, promotion and sponsorship in magazines and newspapers, on billboards and at the cinema since 1989. It is not yet banned at the point of sale.[666]

Another source states that Greek law forbids advertisement of tobacco products in magazines and the press but allows tobacco companies to freely advertise using posters and billboards.[667]

Challenges to legislation and enforcement

Smoking is currently a socially accepted habit in Greece and is embraced by a large part of the culture in which tolerance and individual choice play an important role.[668] Therefore, the attitudes of the general population are obstacles in themselves and the public is not receptive to the idea of tighter controls to an individual's habit. However, the recent tightening of the smoke-free legislation (September 2010) was greeted positively by the Greek Prime Minister, George Papandreou who said "It will contribute to the work we're doing today that's aimed at changing attitudes, norms and behaviour to improve our quality of life and to make our country viable – not just its economy but in everyday life."[669]

The agricultural produce in some regions of Greece is largely tobacco, thus creating a 'pro-tobacco norm'.[670]

08.08.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

At the primary care level, patients wishing to quit smoking are mainly given advice by their physician and secondarily may be referred to a specialist smoking cessation clinic depending on the availability and accessibility of such a clinic. However, primary care is somewhat fragmented with rural health centres undertaking a public health role in smoking; whilst in urban areas there are smoking cessation clinics, although some are accessed through the hospitals and some are available privately.

At the secondary care level, patients may also be referred to a specialist smoking cessation clinic. There are now about 50 anti-smoking clinics in governmental hospitals but the interviewees anticipated more clinics being established. Consultations at these clinics are provided by a team of experts (specialised physicians, psychologists etc.), who provide any necessary medication and behavioural support. Specific protocols for the treatment of the patient are followed.

A dedicated website[671] and a telephone hotline are available providing information as well the opportunity for the public to report any violations of the smoke-free laws.

Reimbursement for smoking cessation services
Smoking cessation services in Greece are free and nicotine replacement therapy (NRT) is available over the counter with other smoking cessation medications provided on a prescription basis.

At the beginning of 2011, prescription medications for smokers were included on a draft negative list and industry experts[672] indicated that by March 2011 this negative list should be implemented and therefore prescription smoking cessation drugs will not be reimbursed. However, back in November 2010, after consultation with the Central Health Council of Greece (KESY), the Social Security Funds announced proposals to reimburse smoking cessation medications at 75% for those with serious chronic diseases such as myocardial infarction, diabetes or chronic obstructive pulmonary disease (COPD). For the remainder of the smoking population, reimbursement coverage was proposed at 25%. Such reimbursement would be dependent on attending public smoking cessation clinics. Although this proposal has been accepted and endorsed by the key stakeholders, the Ministerial decision on whether to implement this has yet to be made.

08.08.4 GUIDELINES

There are no specific national guidelines for smoking cessation or the treatment of tobacco dependence in Greece.

Some guidelines have been set by the Thoracic Society, and some anti-smoking clinics in governmental hospitals, but these are only local guidelines. The function of these could be improved and the guidelines could be stronger. Similarly, in some hospitals the guidelines are followed and in others they are not. Specialist centres may follow international guidelines on smoking cessation, or locally developed guidelines.

It is thought that in primary care, General Practitioners (GPs) do not follow any particular guidelines, and there is no supervision or organised monitoring over the use of guidelines.

08.08.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
There is no official training on smoking cessation for medical students in Greece and it is not on the curriculum. *Ad hoc* programmes are given by medical societies, academics and/or specialists but nothing is run by the Ministry.

Primary care
There is no official training on smoking cessation for primary care physicians in Greece. There are some programmes but they are given *ad hoc* and they are neither centrally controlled nor compulsory.

08.08.1

Smoking prevalence in Greece (2009)
35% = daily smoking[654]

Secondary care
The situation is the same in secondary care as in primary care and there is very little official training on smoking cessation for secondary care physicians in Greece.

The only exception is specialist smoking cessation clinics where the physicians involved consider smoking cessation a specialisation requiring appropriate training and these people therefore have additional education in smoking cessation.

General public
Anti-tobacco education is not incorporated into the school curriculum and although school smoking prevention legislation does exist, it is not always enforced.[673]

Before the new smoke-free legislation was introduced there were a few anti-smoking 'spots' on television but nothing was organised nationally, such as anti-smoking campaigns or educational programmes. Since the implementation of the legislation, the government has implemented public awareness campaigns with several television 'spots'.[672]

08.08.6 RECOMMENDATIONS

Recognise tobacco dependence as a disease
Tobacco dependence is a disease and not a lifestyle habit. Tobacco dependence should therefore be treated as a disease and therefore smoking cessation services and medications should be fully reimbursed.

This is seen as a particularly important recommendation, as once tobacco dependence is established as a disease, it should therefore be covered by social insurance for all smokers.

Reimbursement for smoking cessation treatments
Greece introduced smoke-free legislation in January 2010 and it is essential that those encouraged to quit by the restrictions are subsequently provided with the appropriate help and support.

Following conversations with industry experts in Greece, it is understood that at the beginning of 2011, prescription medications for smokers were included on the draft negative list[674] and will therefore not be reimbursed. Implementation of this negative list is anticipated in March 2011. However, there are already efforts underway to change the reimbursement status of prescription smoking cessation medications so that prescriptions are covered and reimbursed, especially if the smoking is related to a serious, chronic disease. The latest proposals for the reimbursement of smoking cessation medications announced in November 2010, suggested that reimbursement should be at 75% for those with a serious, chronic disease. As of late January 2011, this proposal had been accepted and endorsed by the key stakeholders but a Ministerial decision as to whether to implement this has been delayed.[675]

Yet there is evidence to show that these drugs are cost-effective (and highly cost-effective for certain groups of smokers) and thus full reimbursement makes sense on health-economic grounds. Part of an integrated plan would be to raise awareness with smokers of the effectiveness and cost savings of quitting smoking, but this would only resonate if smoking cessation services including medications are fully covered.

It is recommended that smoking cessation treatment should be extensively or fully reimbursed to support all smokers wishing to quit.

The medical societies and the non-governmental organisations concerned with tobacco dependence could act to support this recommendation. However, ultimately the decision on funding of smoking cessation treatments will be the responsibility of the government.

Develop national guidelines on smoking cessation
National guidelines on smoking cessation should be developed, based on international guidelines but adapted for the Greek situation. The Central Health Council of the National Health System operates through *ad hoc* committees. Therefore if an *ad hoc* committee could be called and issued official national guidelines, it was thought that these guidelines would be

respected by medical health professionals of the National Health System. If in this procedure, medical societies were also involved (e.g. Hellenic Thoracic Society), national guidelines would have a greater acceptance, particularly by practising physicians of the private sector and thus a greater impact would be achieved.

It is thought that such guidelines would be followed in specialist smoking cessation clinics and would probably be followed in primary care after appropriate awareness raising and training of primary care physicians and with appropriate monitoring.

More training and education on smoking cessation for healthcare professionals
There is no official smoking cessation training for medical students, primary care physicians and secondary care physicians, although those involved with specialist smoking cessation clinics do have further specialist education on smoking cessation.

Ad hoc programmes are provided by medical societies, academics and/or specialists but nothing is run by the Ministry and these programmes are not organised centrally and they are not compulsory.

The Hellenic Thoracic Society organises training for all healthcare professionals but other medical societies should be involved and sponsorship by the Ministry of Health would be beneficial. It is thought that the first steps are being made towards this recommendation with the Ministry of Health collaborating with Harvard University to provide sponsorship to a smoking cessation congress and to gather data on the effect of smoke-free legislation, including the impact of the legislation on Greek hospitality workers.[676]

It is most important to have thorough education for healthcare professionals from undergraduate level upwards. Implementation of smoking cessation education for undergraduates is the responsibility of the universities.

In particular, more educational programmes are needed for primary care teams who play an important role in helping smokers to quit. With more education, these primary care teams may more fully realise their responsibility to their patients who smoke.

More training and education on smoking cessation for the general public
In 2009, the Ministry of Health ran a public awareness campaign that was designed to support the smoke-free legislation and it is understood that this campaign was well received.

There is a need for more of these educational programmes for the general public, particularly children and young adults. Education for children and young adults will help support the existing legislation regarding the underage purchasing of cigarettes and will warn of the dangers of starting to smoke.

This recommendation could be supported by involvement of the relevant patient associations such as those for patients with COPD or cardiovascular disease.

Introduction

The following information on the tobacco control and smoking cessation services in Hungary has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Hungary.

08.09.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

In 2007, 36% of the Hungarian adult population smoked cigarettes daily or occasionally (41% of men and 32% of women), with 30% being daily smokers (35% men and 25% women).[677] The overall prevalence of daily smoking has increased since 1990, and this increase has been substantially higher in women than men.[678] Risk factors for smoking include male gender, lower age, lower education, unemployment, lower socio-economic status and parental smoking.[679]

28,000 smoking-related deaths each year were reported in 2003[680] and more recently, smoking-related deaths have been said to represent more than one in five deaths.[681] Men in Hungary have the highest lung cancer mortality rate in the world, attributed to smoking as well as other lifestyle risk factors.[682] In a survey of three health-promoting behaviours (non-smoking, healthy eating and physical activity), only 5.5% of Hungarians answered positively for all three behaviours surveyed.[683]

According to the World Health Organization Statistical Information Services (WHOSIS) database in 2002, the cost-effectiveness (in US dollars per disability-adjusted life-year (DALY)) of smoking cessation interventions (a combination of a tax increase up to 89% of the final retail price, clean indoor air law enforcement, a comprehensive advertising ban, information dissemination and nicotine replacement therapy (NRT)) could be $3,689 per DALY in Hungary.[684]

Smoking prevalence targets

The Johan Béla National Programme for the Decade of Health (2003) includes a primary prevention programme to stop young people taking up smoking, and a 'Quit and Win' programme to help people to stop smoking, and describes controlling smoking as one of its key targets.

The goal of this programme was to cut cigarette smoking by 8% a year until 2005, and to reduce the prevalence of regular smoking by 6% (to about 35% among males) by 2010.

However, it is thought that this goal has not yet been reached. Other goals included:

- A 20% reduction in the time individuals spend exposed to tobacco smoke
- Increase in the number of 'never smokers'
- Adopt European Union and World Health Organization (WHO) recommendations
- Reduce the social acceptance of smoking.

The Hungarian National Heart Foundation and the Hungarian Society of Cardiologists jointly signed the European Heart Health Charter. This was endorsed by the Minister of Health and leaders of 18 professional and civic organisations within Hungary. One of the three key areas the signatories to the Charter prioritised for immediate action was forceful regulatory and taxation measures implemented against active and passive smoking so that all workplaces are smoke-free.[685]

08.09.2 LEGISLATION ON SMOKING

Hungary signed the Framework Convention on Tobacco Control (FCTC) on 16 June 2003 and ratified it 7 April 2004.[686] Although Hungary was one of the first to ratify the agreement, it has been suggested that there has been insufficient progress on enacting the policy. However, Hungary are currently hosting the presidency of the European Union (January 2011 – July 2011) and therefore, 2011 would be an ideal time for Hungary to act on smoking.

Taxes on tobacco have risen regularly between 1990 and 2010 and this was above the rate of inflation.[687] However, cigarettes are still cheap in Hungary, and tobacco is around half the cost of the average of the 27 European Union countries.[688]

Smoke-free legislation and policy

There was a law passed in Hungary in 1999 making all healthcare facilities, education facilities, government facilities, indoor workplaces and offices, and theatres and cinemas smoke-free. However, Hungary allows smoking in separate rooms. Smoking is restricted in restaurants, pubs and bars, but is allowed in separate rooms.[689] In 2009, a proposal making most public places including restaurants and bars smoke-free was placed on hold.

In Hungary, smoking is restricted on buses, taxis, trains, international air transport, and domestic and international water transport, and the smoking restrictions are voluntary on domestic air transport.[690] Since September 2010, a new smoke-free regulation allows authorities to fine those who smoke in any of the underpasses or entrances to Budapest's underground network.[691]

Legislation on tobacco advertising, promotion and sponsorship

The minimum legal age for buying tobacco in Hungary is 18, in common with most European countries, and there is a penalty for selling it to minors.[692] However, practically, there is little or no control over purchasing tobacco.

Direct tobacco advertising is banned in Hungary on television, radio, billboards, in cinemas, local magazines and newspapers but allowed in international magazines and newspapers. Tobacco advertising is restricted at point of sale – it must not be visible

08.09.1

Smoking prevalence in Hungary (2007)
30% = daily smoking[677]

from outside the shop.[693] Indirect tobacco advertising was banned in Hungary in June 2008 and vending machines are prohibited.[694]

Challenges to legislation and enforcement
The Hungarian government gives financial incentives for growing or manufacturing tobacco and farmers are supported by the tobacco industry.[695]

There is some optimism that the new government, which took power in spring 2010, will focus more on smoking policies. There was a feeling that the new government will be lobbied by different medical groups for new and stricter legislation.

08.09.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

At the primary care level, it is thought that although General Practitioners (GPs) are supposed to ask about smoking status and offer advice, only some do so, if they have the time.

The Hungarian Network of Smoke-free Hospitals is in development.[696] The Smoking Cessation Centre Budapest was established in 2009, sponsored by a grant from Pfizer.[697] This is the only specialist clinic in Hungary running a quitline providing proactive telephone counselling. The Smoking Cessation Centre is trying to create a network of smoking cessation centres, and has been active in training GPs and nurses in helping people to quit.

However, there are around 100 pulmonology clinics, which are established to detect and treat pulmonary disease as well as promote smoking cessation. Pulmonologists have been taught about smoking cessation and will encourage smokers to join a three-month smoking cessation programme which includes medications. However, time constraints within pulmonology clinics which have to also service other pulmonary diseases mean that there is not always time for the pulmonologist to provide smoking cessation advice.

The three-month smoking cessation programme consists of an evaluation visit where the smoker and the healthcare professional discuss quitting smoking and the habit of smoking. The smoker will complete a questionnaire and have a carbon monoxide evaluation. The physician will then advise the smoker on quitting either alone or with medication. After this, the three-month smoking cessation programme begins and the smoker is followed up one year later.

Reimbursement for smoking cessation services
In Hungary, treatment of tobacco dependence is part of the national health programme and primary care programmes for prevention, diagnosis and treatment of tobacco dependence are managed at a regional level. Private tobacco dependence programmes are available but are relatively expensive. Most of these do not follow the guidelines, or provide evidence-based treatment.

Attending a public smoking cessation clinic is free and prescription and over-the-counter smoking cessation therapies are available in Hungary, but they are not reimbursed.[698] The cost of smoking cessation medications are prohibitive for some patients, leading to inequality of access. Prescription medications for secondary care (ambulatory or in-patients) are not reimbursed.

It is also noteworthy that pharmaceutical expenditure was significantly reduced by the government's reform policy by increasing co-payment rates for patients.[699]

Political influence
Smoking cessation in Hungary has not been a focus for the previous government due to a lack of finance and knowledge regarding the management of smoking cessation.

However, the new government is expected to put health as a priority for its plans. The current Health Minister is a non-smoker and it is hoped the Health Minister will be more open to change.

08.09.4 GUIDELINES

Hungary's first smoking cessation guidelines were published in 2006 by the Ministry of Health, with an update in 2009. These peer-reviewed guidelines are national and government approved and are based on Cochrane reviews and US smoking cessation guidelines.[700] These guidelines suggest a three-month smoking cessation programme which was discussed above and guideline recommendations include:[701]

- Brief interventions
    - Ask – Advise – Assist – Arrange (follow up)
- Intensive behavioural support
- Use NRT and varenicline (bupropion is not approved for use in smoking cessation in Hungary)
- Cost-effectiveness evidence.

There are also specific medical society guidelines such as those provided by the Pulmonary Society which focus more on therapeutic interventions rather than prevention of smoking.

While pulmonary physicians are likely to follow guidelines, it was felt that such guidelines are not closely followed by all physicians and that this was probably due to lack of knowledge and confidence in being able to implement the guidelines. Adherence to the guidelines is not enforced or followed up.

08.09.5 EDUCATION

In Hungary, treatment of tobacco dependence is part of its national health programme and there are initiatives as part of its primary healthcare programme at regional level. It does not have age- and gender-based promotional and educational programmes aimed at encouraging cessation of tobacco use.[702]

Medical students

Smoking cessation education is taught at some medical schools, but this is under the control of individual lecturers and is not part of the official curriculum – for example, there is a programme at the Medical University in Budapest.

Primary care physicians
Many GPs believe that smokers cannot change. Some universities and groups, including the Hungarian Academy of Teaching Family Physicians, have worked to educate GPs to change their attitudes through lectures, workshops and communications skills programmes and studies have suggested some slight improvement.

Secondary care physicians
The Hungarian Society of Pulmonology runs some courses for secondary care physicians, training them to work with patients who smoke. Some hospitals run courses, especially for newly qualified physicians, but these are on a hospital-by-hospital basis.

General public
There are few educational programmes for the general public and those that exist are not part of a formal plan and tend to be run by non-governmental organisations (NGOs) or by individual pulmonologists. The programmes include websites and campaigns, such as those by the Hungarian Pulmonary Association and events, including World No Tobacco Day events, and events in Budapest's large shopping centres. Some of these events are funded by grants or sponsored by pharmaceutical companies.

In 2010, there was a Guinness World Record attempt at getting the most smokers to quit, and this got onto the television news.

For patients, physicians have leaflets in out-patient clinics, pulmonary clinics and pharmacies, but efforts are not co-ordinated. For instance, some organisations will run a programme with a 'cessation corner' in a cardiovascular or out-patient clinic. Similarly, one hospital has a special ambulance set up as smoking cessation unit with posters and leaflets. Every department in the hospital is invited to the ambulance to receive more information on smoking cessation.

Cigarette packets carry warnings, and though there is anti-smoking education in schools this is considered to be insufficient as it lasts only about an hour.

There are a number of national smoking cessation websites such as www.kozegeszsegtan.sote.ju/qandw/index.htm and www.oefi.ju/color/adat.htm.

08.09.6 HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

It is thought that some GPs believe that smokers cannot change and only some GPs and pulmonologists in clinics in Hungary will offer smoking cessation advice or treatment.

08.09.7 RECOMMENDATIONS

Recognise tobacco dependence as a disease
Tobacco dependence is a disease and for those that need help to quit, there should be help available. This message needs to be communicated to healthcare providers who offer the smoking cessation support and also to the smokers who can then request support to quit smoking.

This topic should be included in the compulsory continuing medical education (CME) programmes of each specialisation, implemented by the Ministry of Health.

Ratify and enforce existing smoke-free legislation
Although there is smoke-free legislation for public places, it has not yet been ratified. This legislation should be ratified by the Hungarian government and enforced to ensure that the importance of a smoke-free environment is understood by the general public and to protect them in the workplace.

Increase taxes on cigarettes
In Hungary, the price of tobacco is around half the average price of 27 European Union countries.[703] Therefore, the cost of cigarettes should be increased by the Ministry of Finance and the increased tax revenues used to fund smoking cessation programmes.

Reimburse time for providing smoking cessation services and reimburse treatments
Smoking cessation services should be at least partially funded by insurance companies. Smoking cessation services such as the three-month smoking cessation programme should also be available in every region of Hungary, implemented by the Ministry of Health.

Currently smoking cessation medications are not reimbursed in Hungary. Partial reimbursement for smoking cessation medications was recommended, and this should be implemented by the Ministry of Health. This will increase access to smoking cessation and smokers will be encouraged to make every effort to quit because they too will be contributing financially to quit smoking. Such partial reimbursement should also consider payments by the smoker that can be made over the course of the smoking cessation programme and not all at once, so that smokers can spread the cost of their treatment.

Involve primary care physicians more
It is recommended that GPs should be encouraged to ask whether patients smoke and to record this information. Every GP should also offer advice and recommend brief interventions, as well as referring patients to specialist services if this is requested and/or required. Support from the Ministry of Health will be necessary to implement this recommendation.

Increase smoking cessation education for primary care physicians and specialists
Due to their heavy workloads, it is thought that GPs will be a difficult-to-reach group, but their leading role in smoking cessation has to be supported with further education. Suggestions for reaching these GPs include one-day educational programmes, 'lunch and learn' activities or even provision of copies of any new smoking cessation guidelines. Increasing the education of primary care physicians will help them to be more confident in providing smoking cessation services.

This education should be a compulsory part of the CME provided to physicians by the universities. Ideally, this nationwide training should be at least partially financed by the Ministry of Health.

The role of specialists such as cardiologists and pulmonologists should not be overlooked and they too require training and/or additional training.

Increase smoking cessation education for the general public
To keep smoking cessation at the forefront of mind for both the general public and the government, more education on the dangers of smoking and the support for smokers to quit is required. The Ministry of Health should provide a budget for this and could collaborate with the broadcasting media to implement their educational campaigns, thus possibly reducing costs and sharing social responsibility.

The media should be involved, particularly television to increase awareness regarding the dangers of smoking. This education should target children and young people to try to prevent them starting to smoke. If parents smoke, children can have a positive effect on influencing their parents to quit smoking. In addition, the importance of smoke-free environments needs to be communicated to the general public.

Introduction

The following information on the tobacco control and smoking cessation services in Ireland has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Ireland.

08.10.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Heath Organization (WHO) database records 27% of the Irish adult population (age 15+) as regular daily smokers in 2008.[704] The Survey of Life, Attitudes and Nutrition (SLÁN) completed in 2007 found the overall prevalence of current smokers (regular and occasional) to be 29% with higher rates for men (31%) than for women (27%).[705] The same study identified sub-groups of particular concern for example, those in the lower socio-economic groups (37%).[706]

Tobacco use is the leading cause of preventable death in Ireland:[707] each year smoking kills up to 6,500 people.[708]

The General Practitioners and the Economics of Smoking Cessation (PESCE) project[709] estimated that a reduction of 3% in the prevalence of smoking in Ireland would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke and chronic obstructive pulmonary disease (COPD) of €2.2 million by 2020 and €4.5 million by 2030. It costs the State €1 billion per year to provide health services for smokers.[710]

The WHO Tobacco Atlas reported that the Irish economy lost €684 million[711] in 2007 as a result of tobacco use. The figure includes the cost of absenteeism from work, lost productivity and premature death. Smoking-related healthcare costs account for between 6% and 15% of all annual healthcare costs in a high income country such as Ireland.[712]

Smoking prevalence targets

The Department of Health and Children published the 'Changing Cardiovascular Health: National Cardiovascular Health Policy 2010–2019' in May 2010. This policy statement outlined a target to reduce the overall prevalence of smoking by 1% per annum from 29% to 19% and to reduce smoking initiation rates by 1% per annum from 31% to 21% by 2019.[713]

Under its Transformation Programme, the Health Service Executive (HSE) committed to tackling the problem of tobacco

related harm within the Irish population.[714] In February 2010, the HSE developed the Tobacco Control Framework to provide an evidence-based approach to address tobacco use and to outline national standards for service provision. The framework document was developed by the HSE Tobacco Control Framework project group guided by a national steering group to inform HSE policy and provide a coherent HSE approach to tobacco use in Ireland.[715] Although the Tobacco Control Framework contains a section on treating dependence and offering help to smokers wanting to quit there are no specific targets set out in the document.[716]

08.10.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
In accordance with the Public Health (Tobacco) Act 2002, Ireland went "smoke-free" with smoking prohibited in enclosed buildings, workplaces, bars and restaurants, to protect the public and employees from second-hand smoke.[717]

All forms of public transport in Ireland, including buses, taxis, trains, and domestic/international air and water transport are smoke-free.[718]

Legislation on tobacco advertising, promotion and sponsorship
Since 1986, tobacco advertising, promotion and sponsorship have been banned on the television and radio. They have also been banned in magazines and newspapers, on billboards, and at the cinema.[719]

In 2007, the legal age at which a person can be sold tobacco products was increased to 18 years.[720] Also in 2007, the sale of cigarettes in packets of less than 20 and the sale of confectionery resembling tobacco products were prohibited.[721]

A ban on point of sale advertising came into effect in July 2009.[722] The same legislation prohibited self-service vending machines except in licensed premises and all retailers who wish to sell tobacco products must now register with the Office of Tobacco Control.

Challenges to legislation and enforcement
At the time that smoke-free legislation was being planned (2002-2004), there were some challenges, but these have been overcome:

- There was a sense at the time that making public places smoke-free would never work. However, there was political will and, in less than ten years, it is now socially unacceptable to light up in a public place
- Around the time of the introduction of the smoke-free act, the publican lobby (landlords from bars) was an obstacle but that was circumvented.

Enforcement of legislation falls primarily to HSE Environmental Health Officers with the Office of Tobacco Control also playing a role in conducting compliance testing in tobacco control.

08.10.1

Smoking prevalence in Ireland (2008)
27% = regular daily smokers (age 15+)[704]

08.10.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Smoking cessation advice and assistance is available via primary care services including physicians, nurses and pharmacists. However, it has been reported that the low levels of smoking cessation advice given by health professionals to smokers in Ireland suggest that General Practitioners (GPs) and primary care settings are a neglected resource for helping people to quit smoking.[723]

In 2006, there were 93 smoking cessation service providers. These were defined as services that could be based in a healthcare or community setting providing an intervention (by phone, in groups or individually) by specially trained personnel. While smoking cessation services were available in all HSE areas, the authors concluded that there was little uniformity or consistency countrywide in the scope and structure of these services.[724] However, research also acknowledges that where direct smoking cessation services are available, those who carry out these services do so to a high standard.[725]

Most smoking cessation service providers (63%) are based in general hospitals.[726] At the secondary care level, smoking cessation is run at specialist clinics providing smoking cessation services to their patients, the general public and staff. Services are provided regionally and there is no central organisation. Patients are generally physician-referred to the smoking cessation specialist clinic, but in some hospitals, any staff member can refer, with nurses being the highest referrers.

The HSE funds the National Smokers quitline which, in conjunction with the Irish Cancer Society, provides a smoking cessation support service Monday to Saturday from 8am to 10pm. This provides the public with access to a telephone support service from a trained smoking cessation advisor. Smokers who ring the quitline have the option of:

- Having an information pack sent to them by post
- Receiving follow on smoking cessation counselling by trained staff at the Irish Cancer Society
- Being referred for professional help in their own local HSE area.

Reimbursement for smoking cessation services

In Ireland, a Medical Card entitles holders to free hospital care, GP visits, dental services, optical services, aural services, prescription drugs and medical appliances. The Medical Card is available to those receiving welfare payments, low earners, those with certain long-term or severe illnesses and in certain other cases. It is estimated that just over 30% of the population holds a Medical Card. Those on slightly higher incomes are eligible for a GP Visit Card which entitles the holder to free GP visits. The remaining population who are not entitled to a Medical Card or GP Visit Card pay fees for certain healthcare services and drugs.

All smoking cessation services and smoking cessation drugs are reimbursed for those patients with a Medical Card. However, from 1 October 2010 a prescription charge of €0.50 per item has been recently implemented which may impact on the number of patients filling a prescription.

Smoking cessation services provided by the HSE are free for all. For most of the population, drugs are not reimbursed or are only partially reimbursed. These people have to pay for prescription items in addition to fees for attending GPs to obtain a prescription. GPs generally charge on a per consultation fee basis.

Bupropion and varenicline are subsidised via the Drugs Payment Scheme. Under this scheme, residents of Ireland pay a maximum of €120 a month (from January 2010) for approved prescribed drugs, medicines and certain appliances for use by the individual and their family in that month.[727]

Political influence

Although the savings from reducing smoking are significant they may only be realised in the longer term. However, in the current financial climate, the government does not appear to take a long-term view, especially with an issue such as smoking cessation, which is perceived to have a long latent period.

08.10.4 GUIDELINES

The HSE's recently published National Tobacco Control Framework sets out the strategic direction for Tobacco Control for the HSE for the coming five years. A yearly implementation plan will be developed that will identify priorities and action areas.[728] Although these guidelines are recent and not yet implemented, they are already being anticipated in secondary care.

There is a national COPD programme in development through the HSE and the Irish Thoracic Society – guidelines on smoking cessation might be developed as part of this overall programme.

There are 'Best Practice Guidelines for Tobacco Management in Mental Health Settings'.[729]

Guidelines would be of benefit especially in primary care – current recommendations are sporadic, and an improved focus on how to best manage smokers in primary care is warranted.

08.10.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

In 2009, the former HSE Chief Executive Officer, Professor Brendan Drumm, signed the Tobacco Free United (TFU) Charter which aims to ensure that hospitals and health services become settings of good practice in themselves and work towards a tobacco-free society.[730] The TFU encourages hospitals and healthcare services to assume a role not only in ensuring tobacco-free organisations but also to offer smoking cessation services for patients, staff and the community. To date, St. Vincent's University Hospital, Connolly Hospital, Cork University Hospital, and the Mater Misericordiae University Hospital are Ireland's first smoke-free campuses with many other facilities currently working towards that goal with the support of the Health Promoting Hospitals Network.[731]

Medical students
Overall, education for medical students in smoking cessation is very limited and is focused more in relation to general health promotion. There is a degree of smoking cessation education during respiratory and pharmacology lectures.

Student health professionals rarely receive guidance on smoking cessation counselling or formal training in the treatment of tobacco dependence.[732]

Whilst currently there is no standardised approach to delivering smoking cessation training to undergraduates, the HSE provide training on request from tertiary level institutions. The HSE's Tobacco Control Framework prioritises advocating compulsory introduction of brief intervention and tobacco cessation training in all undergraduate and postgraduate education across all health disciplines.[733]

Primary care
Training for primary care is delivered by the smoking cessation service across the nation but it is more comprehensive in some places than in others.

There are insufficient structures in place to train primary healthcare workers to highlight the significant problems of tobacco. If primary healthcare professionals were trained, then they would better understand the importance of brief interventions.

The National Cancer Control Programme, in conjunction with the HSE Health Promotion Services, is currently conducting research on the impact of providing evidence-based brief intervention training to Primary Care Teams. This will enable staff to use brief interventions and, where necessary, refer patients to smoking cessation services.[734]

Secondary care
Most hospitals have smoking cessation officers (as part of a full-time role) who provide specific education to other healthcare professionals on smoking cessation. Services are provided regionally and there is no central organisation. The services

provided can vary from a one- to two-day course dedicated to smoking cessation to a 15-minute presentation at a team meeting within the hospital. Attendance at the longer courses is generally dominated by nurses and other healthcare support staff with only a few physicians attending.

General public
Literature is available in GPs' waiting rooms. There are also advertisements on websites, television and radio. There is a national media campaign to highlight World No Tobacco Day.[735]

Smoking cessation services within hospitals may provide some education for patients.

National smoking cessation websites are available at www.cancer.ie/quitting/cycle.of.change.php and www.giveupsmoking.ie.

There are a limited number of public awareness campaigns throughout the year mainly focused on identifiable quit seasons such as early New Year, National No Smoking Day and World No Tobacco Day.

08.10.6 RECOMMENDATIONS

Realign current smoking cessation services under one central national body
The existing smoking cessation services were increased to provide smoking cessation support before the introduction of the smoke-free legislation in 2004. The smoking cessation services provided are carried out to a high standard but it has been reported that there are insufficient direct smoking cessation support services throughout Ireland.[736]

To address this and other issues, it is thought that the smoking cessation services in general need to be better aligned and co-ordinated by one central, national body. This body would be directly responsible for all aspects of smoking health awareness and smoking cessation, for instance, health promotion as well as the provision of smoking cessation clinics and smoking cessation education for healthcare professionals. Currently some of these aspects are devolved so that health promotion covers smoking cessation along with many other health issues. It is thought that this recommendation would allow for direct accountability with the national body being held to scrutiny on whether they are achieving the guidance of the Tobacco Control Framework.

In addition, it is believed that the existing services are now underfunded and that they therefore do not have the capacity to follow up smokers trying to quit smoking. In particular, additional funding is essential for the National Smokers Quitline to provide an effective service. Currently there is a lack of advertising on the quitline and so the service is not reaching those who might benefit most.

The government through its relevant departments are responsible for setting policy and strategy and establishing any national body with a remit for tobacco control initiatives. The HSE plays a key role in the national body responsible for the coordination and delivery of smoking cessation services and awareness campaigns.

Increase reimbursement for smoking cessation medications
The availability of medications is good but some patients can still be put off by the cost. Smoking cessation medications are not currently fully reimbursed for all of the population. Full reimbursement for everyone could be a very positive incentive. It is important to encourage smokers to quit by making medications more readily available to the general smoking population.

Responsibility for this recommendation would lie with the Department of Health and Children and related state agencies who make reimbursement decisions. This recommendation is supported by the non-government organisations (NGOs) active in the field including Action on Smoking and Health (ASH), the Irish Cancer Society and the Irish Heart Foundation.

Provide nationally recognised evidence-based educational programmes on smoking cessation for all healthcare professionals
The Tobacco Control Framework has highlighted that they need to action the development of national tobacco cessation training standards for use by all healthcare professionals and to further develop the skills of tobacco cessation trainers so that they themselves are trained to a satisfactory standard.[737]

The importance of brief interventions needs to be communicated to primary care physicians and medical students. In addition, there is a need for all healthcare professionals to be provided with the opportunity and encouragement to learn more about smoking cessation from a standard programme of education.

Standardised training for smoking cessation specialists is required to ensure that all those providing smoking cessation specialist services are equally knowledgeable. These specialists can be used to educate others.

There is an initiative being led by the Irish College of General Practitioners which aims to provide smoking cessation education to healthcare professionals via e-learning. However, for maximum impact this educational tool should be made available and accessed by all healthcare professionals working in primary care.

Implementation of the actions identified in the new national guidance
The Tobacco Control Framework[738] document has been published but implementation is in the early stages. Those in both primary and secondary care are eagerly anticipating this national guidance to be implemented, as some currently utilise British or American guidelines.

In addition, national guidelines should be developed to include guidance for referral and medications, with lists of additional support services and the National Smokers Quitline.

The HSE developed the Tobacco Control Framework and will be responsible for its implementation, however the support of the various medical societies will be required for effective implementation of this recommendation.

Sustained education for the general public
Existing efforts to educate the general public such as marketing campaigns need to be sustained and extended. It is important that there is continued research into tobacco dependence. Specific targeted interventions for young people and also for smokers in disadvantaged communities need to be addressed.

This would be best achieved with a partnership between the HSE and the relevant NGOs.

Introduction

The following information on the tobacco control and smoking cessation services in Italy has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Italy.

08.11.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

Although a steady decline in the prevalence of smoking has been observed in Italy since the 1960s, in 2008 22.4% of the adult population still smoked regularly according to the World Health Organization (WHO) database.[739] Smoking prevalence in those over 14 years of age was recorded following face-to-face interviews with 60,000 people at 22.8% in 2008, rising slightly to 23% in 2009.[740] The highest percentage of smokers are found in central Italy (24.3%) followed by the north (23%).[741]

The introduction of smoke-free legislation in Italy in 2005 might have contributed to the decrease in smoking prevalence in recent years,[742] with some evidence of women and the younger population being more affected by the smoke-free legislation.[743] However, this effect appears to have waned, as a survey on smoking prevalence conducted in 2009 showed a significant 5.0% increase in smoking prevalence in young individuals and an unexpected rise in relapse of smokers who had previously quit.[744]

A survey conducted during 2009-2010 by the Health Behaviour in School-aged Children (HBSC) in collaboration with the WHO Regional Office for Europe surveyed 77,000 teenagers in 2009-2010. It can be seen that for those smoking at least once a week, the percentage rises dramatically between the age of 13 and 15 years old (Table 12).[745]

Age (years)	Male	Female
11	1%	0.2%
13	4.14%	3.68%
15	19.08%	19.42%

Table 12: Percentage of Italian teenagers smoking at least once a week (2009-2010)[746]

According to a Ministry of Health report from 2009, an estimated 70,000 to 83,000 die from smoking each year.[747] In the year 2000, 14% of all the deaths were attributable to smoking.[748] Over 25% of the deaths are from those aged between 35 and 65 years.[749]

Permanent abstinence is known to reduce the risk of lung cancer, heart disease, chronic lung disease, stroke, and other cancers. In a study of around four million Italian residents in the Piedmont region (northern Italy), Barone-Adesi *et al.* found that smoke-free policies might be responsible for a decrease in admissions for acute myocardial infarction (AMI).[750] The health implications of passive smoking are also significant. Table 13 summarises some of the potential effects of second-hand smoking in Italy as assessed by Forastiere *et al*.[751]

Therefore, smoking remains a serious public health threat in Italy.

Smoking prevalence targets
There is no specific target for reducing smoking prevalence in Italy in terms of a percentage reduction in prevalence or absolute reduction in numbers of smokers. However, in the National Prevention Plan[752] it is clearly stated that there is a goal of implementing prevention efforts targeting smoking, especially among young people through specific tailored programmes in schools.

Population exposed	Outcome	Number of events
New-born babies	Low birth weight (<2,500g)	2,033
	Sudden infant death syndrome	87
Children 0-2 years	Acute lower airways infections	76,954
	Bronchial asthma (prevalence)	27,048
Children and adolescents 6-14 years	Chronic respiratory symptoms (incidence)	48,183
	Otitis media (incidence)	64,130
Adult deaths	Lung cancer	545
	Ischaemic heart disease	2,131

Table 13: Health implications of second-hand smoke in Italy

08.11.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
Italian legislation has prohibited smoking in the workplace and public places since 2005. However, enclosed and separately ventilated rooms for smokers are permitted in bars, restaurants, airports, and stations.[753] This smoke-free policy has generated a small short-term reduction in cigarette consumption.[754] Despite the initial enthusiasm, this legislation has not been adequately enforced, due mainly to lack of specific national funding. Public transport, buses, taxis, trains and domestic air and water transport were all supposed to be smoke-free from 1975.[755] Anecdotally, this smoke-free law has not been respected and there has been little effort to enforce it.[756]

Italy has an official plan from the Ministry of Health to promote a tobacco-free life, and has designated a section of the National Institute of Health (Istituto Superiore di Sanità) to focus on smoking, alcohol and drug-related matters – the Observatory on Smoke, Alcohol and Drugs of Abuse (the Osservatorio Fumo, Alcol e Droga; OssFAD).

Legislation on tobacco advertising, promotion and sponsorship
In Italy, the main problems in sucessfully establishing anti-smoking law are:

- Lack of national funding to accompany the law
- Cultural issues
    - Some physicians have little interest in tobacco dependence treatment
    - Some patients believe that there is no medical treatment for tobacco dependence.

Tobacco advertising, promotion and sponsorship have been banned in Italy on the television and radio, in magazines and newspapers, on billboards and at the cinema since 1983. Advertising is not yet banned at the point of sale.[757]

Challenges to legislation and enforcement
It should also be noted that according to the European Commission, Italy is the biggest producer of raw tobacco in the European Union (EU), producing 36%.[758]

The Italian government has increased taxation on tobacco products and fixed a minimum price for cigarettes. The introduction of a fixed minimum price has been subject to legal proceeding by the Commission of the European Communities in 2008/9. The Commission suggests that fixing a minimum price infringes the rights of manufacturers and importers to set a maximum retail selling price. Furthermore, the Commission maintains that the minimum price cannot be justified on the grounds of public health. The Commission believes the public health objective can be achieved by increased taxation.[759] The counter-argument from the Italian government was that increasing the tobacco price too much might result in increased smuggling and counterfeiting. The issue has now been resolved by rewording the bill.

Once smoke-free legislation had been introduced, there was an increase in public support.[760] After the ban had been in place for three years, between 80 and 90% (depending on the region) of the surveyed general population had the perception that the smoking ban was respected in bars, cafes and restaurants.[761]

The Italian Institute of Statistical Research and Public Opinion Analysis (Doxa) reported in 2008 that 80.6% of Italians think that access to smoking cessation services is an impressive measure initiated by the government to reduce smoking and to help people to quit smoking.[762]

As regulations change region by region, it can be difficult to organise national policies and there are differences in smoking cessation services available across the regions.[763]

08.11.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Ragazzoni *et al.* reporting from literature published in 2003, found that 74% of Italian general practitioners (GPs) reported that they were constrained from providing smoking cessation services to their patients by lack of time.[764] Unfortunately there does not appear to be any more recent data to see if this situation has changed over the intervening period.

Italian experts interviewed for this research have suggested that GP-led smoking cessation services are very dependent on the GP and their knowledge and skills. These experts believe there is no systematic routine screening and few brief interventions given to patients.

In 2007, 346 smoking cessation clinics were reported to operate within the Italian public health system.[765] Typically, these smoking cessation clinics provide individual counselling, group therapy and pharmacotherapy. They also provide access to physicians and other professionals such as nurses, physiotherapists and clinical psychologists. Generally the clinics are led by at least one physician in a team with clinical psychologists and other health professionals. Unfortunately, some of these clinics do not appear to be using evidence-based methodology as a basis for their services.[766]

In addition to legislation, initiatives have been taken in Italy to promote smoking cessation. These include: news releases and updated guidelines for health professionals by OssFAD; provision of a free quitline and an online inventory of existing smoking cessation clinics (also by OssFAD); and the production and dissemination of educational materials for lay people.[767]

08.11.1

Smoking prevalence in Italy (2009)
23% = current smokers (aged 15+)[740]

Reimbursement for smoking cessation services
In general, with some regional exceptions, smoking cessation services and treatments are not reimbursed in Italy. Private smoking cessation services are still popular but must be paid for by the smoker.

The Italian health service does not reimburse smoking cessation products. Nicotine replacement therapy (NRT) is available over the counter (OTC), while bupropion and varenicline are only available via a medical prescription. Bupropion can be reimbursed if the clinical indication is major depression.

There is strong Italian advocacy towards reimbursement of smoking cessation treatments led by National Institute of Health's OssFAD department and many professional and consumer associations. When an OssFAD survey directly asked those interviewed what they would like to ask of the Health Authorities to reduce smoking and promote smoking cessation, 83.6% of respondents requested free access to smoking cessation services and 76% requested full reimbursement of smoking cessation drugs.[768]

08.11.4 GUIDELINES

There are national guidelines for GPs that were updated in 2008 by the National Institute of Health based on revised clinical data.[769] These guidelines advise GPs to regularly monitor smoking status of known smokers, advise them to stop, help them to quit with follow-up appointments and recommend the use of pharmacotherapy. GPs are also advised to refer smokers to a specialist smoking cessation clinic for additional assistance. Although the smoking cessation guidelines are government endorsed, there is no official enforcement.

The Italian Association of Hospital Pulmonologists published guidelines in 2000 on smoking cessation activities in a respiratory medicine setting.[770]

There are also regional guidelines (e.g. Toscana, Emilia-Romagna and Veneto) where smoking cessation interventions are described in detail.[771]

The European Respiratory Society guidelines for respiratory patients are also available and have been translated into Italian.

08.11.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
There are no specific programmes in place for training medical students about tobacco dependence and smoking cessation apart from at a few Universities e.g. La Sapienza – Università di Roma, the University of Verona, and the University of Florence (which offers a Masters degree (MSc) in smoking control).

Primary care
Despite their detailed knowledge of the health risks associated with tobacco smoking, the prevalence of smoking among Italian physicians is thought to be particularly high at around 28% when reported in 2003.[772]

It is thought there is little official interest in teaching smoking cessation as part of the curriculum of primary care physicians.
For primary care physicians, there is also a lack of the necessary skills to provide smoking cessation services and a lack of incentives.

Secondary care
Similarly, there are no national initiatives to provide education in smoking cessation to physicians in secondary care.

As for primary care physicians, some specialists in Italy appear somewhat disinterested in smoking cessation and some of them trivialise the problem of tobacco dependence and undervalue tobacco dependence treatment. In contrast to most other medical specialties, there are no financial benefits involved in smoking cessation (this is particularly important when considering the substantial amount of time spent with each patient).

For pregnant women who smoke, the Ministry of Health is promoting a project across the Italian regions to provide standard interventions by midwives. These pregnant women will be helped to quit smoking and there will be follow-up with both the women and their families during the puerperal period (i.e. for approximately six weeks after giving birth). The programme is called 'Smoke Free Mums'[773] and currently there are more than 3,000 midwives participating in the project.

General public
OssFAD produces and distributes educational materials for the general public. The Italian anti-smoking helpline has been operating in Italy since 2000 and is centrally operated by the Italian National Institute of Health. The quitline is promoted nationally with media campaigns and provides free services such as cessation information. However, the quitline does not provide active counselling or follow-up calls.[774]

Within the National Prevention Plan there is a goal to reduce smoking initiation among young people through a specific tailored school programme.[775]

Anti-smoking campaigns are occasionally broadcast mainly via television at a national level, whereas brochures and free smoking cessation activities are provided at the local level.

08.11.6 RECOMMENDATIONS

The burden of smoking-related diseases and the cost-effectiveness of tobacco cessation therapies needs to be demonstrated
In Italy, there is a need for detailed economic data about the burden of smoking-related diseases to Italian society and the healthcare system in particular. Also, the cost-effectiveness of treatments for tobacco dependence within the Italian healthcare system need to be further demonstrated.

This economic data needs to be researched and published as it will support those advocating for other related issues (e.g. increased reimbursement for smoking cessation treatments).

Universities would be in a position to contribute to the research required.

Set a measurable target for reducing the smoking prevalence and monitor success
Although the National Prevention Plan aims to implement prevention efforts targeting smoking,[776] there is no specific target in terms of a percentage reduction.

A specific measurable target for reducing the smoking prevalence should be set by the government. Importantly the success (or otherwise) of achieving this target should be monitored and recorded so that there is accountability. The patient, the medical and scientific associations should advocate this monitoring. Implementation of this recommendation will be important as it will help to assess and monitor the results of the smoking cessation services which in turn will help to motivate healthcare professionals to work towards measurable targets.

Provide reimbursement for smoking cessation treatments
Smoking cessation medications are not reimbursed by the Italian health service. NRT is available over the counter but other medications require a prescription and must be funded by the patient. The National Institute of Health's OssFAD is the leading advocate for reimbursement for smoking cessation medications.

76% of respondents from smoking cessation clinics across Italy, when asked what they would like the Health Authorities to do to reduce smoking and promote smoking cessation, requested full reimbursement of smoking cessation medications.[777]

Therefore, total or at least partial reimbursement of smoking cessation medications would help provide access to medications for people to quit.

This is a key recommendation and implementation will rely on the Italian government for implementation.

Create a national network of services to help with smoking cessation
A network of national services would ensure that all smokers have access to high-quality services. For example, every hospital should have a recognised centre for smoking cessation with basic requirements such as the presence of a physician, a psychologist, an instrument to measure exhaled carbon monoxide, and a 24-hour phone service.

Health units currently organise and implement smoking cessation services but there is a need for greater collaboration to network these. The National Coalition on Tobacco control will have an important role advocating for this recommendation to be implemented.

Expanding resources and creating a national network will enable the network to standardise guidelines and services and provide smokers with a standardised quality service across the country.

Provide improved healthcare professional educational programmes on smoking cessation
As noted above, medical students are not provided with formal education on tobacco and smoking cessation. A study in the Lombardy region conducted between 2000 and 2002 concluded that 67% of physicians lacked specific training in smoking cessation and 87.4% would welcome further training or a qualification in smoking cessation.[778] Similar studies in the Torino, Tuscany Basilicata and Naples region have been conducted with GPs.

Therefore, there is a need for improved education of healthcare professionals on tobacco dependence and smoking cessation. Such educational programmes should focus on primary care physicians and be taught to medical students early in their career. However, other healthcare professionals such as pharmacists would also benefit from this training.

Undergraduate training is the responsibility of the Ministry of Universities whilst healthcare professional training would be the responsibility of the respective professional associations. For GPs, the Union of GPs should be able to advocate for this additional training.

This recommendation is important and should be implemented once targets have been set.

Introduction

The following information on the tobacco control and smoking cessation services in Luxembourg has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Luxembourg.

08.12.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Health Organization (WHO) database records 25% of the adult population of Luxembourg as regular smokers in 2008.[779] More recently, in 2009, the prevalence of daily smoking was recorded as 19%. A total of 24% were reported as regular and occasional smokers (28% of males and 21% of females).[780]

From an adult population of only just over 400,000, around 500-600 people die each year as a result of smoking.[781]

Smoking prevalence targets
There are no official smoking prevalence targets in Luxembourg, although there are annual evaluations of the numbers of smokers.

08.12.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
In Luxembourg there is smoke-free legislation on smoking in certain public places:

- Schools and public buildings are also totally smoke-free.
- Workplace regulations are more complex: the employer has the obligation to take all reasonable efforts to ensure that workers are protected from passive smoking.
- Smoking is generally forbidden in restaurants in Luxembourg (although separate smoking rooms are permitted if these account for less than 25% of the total area). In café-restaurants, it is forbidden during dining hours, i.e. from noon to 2pm and from 7 to 9pm. However, cafés and bars that only serve snacks are exempt from the law, as are nightclubs.[782]
- In terms of public transport, Luxembourg has had smoke-free buses and restriction on trains and domestic/international air transport since 1989. However, Luxembourg has not yet formally restricted or made taxis or domestic/international water transport smoke-free.[783]

The Ministry of Health has stated that it will re-visit the smoking laws of August 2006 with a view to extending them. A project known as Plan Tabac will be put into force with a particular emphasis on the protection of young people from smoking.[784]

Legislation on tobacco advertising, promotion and sponsorship
Tobacco advertising, promotion and sponsorship have been banned in Luxembourg on the television and radio and at the cinema since 1991. It is also restricted in magazines and newspapers, on billboards and at the point of sale.[785]

Challenges to legislation and enforcement
Luxembourg has low taxes on tobacco products in comparison with the other countries that border it. In 2005, 89% of all cigarettes sold in Luxembourg were bought by foreigners.[786]

08.12.1

Smoking prevalence in Luxembourg (2009)
19% = daily smoking[780]

08.12.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Since 2007, The Ministry of Health, together with physicians and healthcare insurers, has designed what is referred to as 'The Programme for smoking cessation'. Many General Practitioners (GPs) run this programme, as well as some secondary care physicians in relevant disciplines, e.g. cardiology and respiratory.

There are four or five specialist smoking cessation clinics in Luxembourg with teams of physicians, nurses and psychologists. The specialist clinics provide 'The Programme' which comprises of a first consultation about health in general followed by a nurse consultation covering the basics of smoking cessation. The smoker will then return to the clinic between three to five times during the eight-month programme, but the number of visits is dependent on the smoker. After eight months the smoker returns to the clinic to receive reimbursement for their medication, which is 50% of the expense to a maximum of €100.[787]

Tabac-Stop is a quitline provided by the Luxembourg Foundation Against Cancer which offers free counselling and other information such as brochures.[788]

Reimbursement for smoking cessation services
The smoking cessation services involve a variety of primary and secondary care staff and are fully reimbursed. Smoking cessation medication is reimbursed up to 50%, up to a maximum of €100, if a patient stays in the programme as described above.[789]

Political influence
The Health Minister is known to be a supporter of smoke-free legislation and has campaigned regularly for a complete restriction on smoking in Luxembourg, to bring it in line with other countries in Europe.

08.12.4 GUIDELINES

There are no national guidelines for tobacco dependence and/or smoking cessation in Luxembourg. People are free to use whatever guidelines they want and there is no enforcement of any guidelines.

08.12.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
Medical students usually study in Belgium, in France or in Germany. The set-up of third cycle (graduate) studies on tobacco dependence needs to be considered and discussed in Luxembourg.

Primary care
There was a national programme on smoking cessation four years ago for all the GPs in the country which was run on Saturdays with a very large audience and speakers from abroad. All those physicians who participated are now well qualified.

Ideally, it would be useful to run a similar two- or three-day programme every few years for every physician in the country, inviting tobacco experts to speak.

Secondary care
When questioned in 2010, the expert in Luxembourg stated that there were no organised programmes at the national level. Some secondary care physicians go to France or Belgium and undertake postgraduate education in tobacco dependence to become experts in the area.

General public
International Stop Smoking Day is observed with lectures and educational programmes for the general public. A considerable amount of money is invested in public health campaigns for tobacco cessation, e.g. adverts on television and radio. Leaflets and booklets in French and German are available in the primary care settings.

08.12.6 RECOMMENDATIONS

Extend the law so that all public places are smoke-free
Luxembourg has ratified the Framework Convention on Tobacco Control (FCTC)[790] which includes Article 8 on the protection from exposure to tobacco smoke.[791] Despite this, there are many exceptions to the smoke-free laws in Luxembourg and the Plan Tabac project has been initiated to extend the smoke-free legislation.

It is recommended that the existing legislation should be enhanced, particularly in restaurants, bars and nightclubs and extended to all enclosed public places. This recommendation would encourage people to quit smoking.

The government's Ministry of Health would be responsible for implementation of this recommendation.

Increase the cost of smoking
Tobacco prices in Luxembourg are 12% less than the average price across 27 countries in the European Union.[792] Cigarettes and tobacco are considered relatively inexpensive compared with neighbouring countries.

It is recommended that the price of cigarettes and tobacco is increased to bring them into line with neighbouring countries and to discourage young people from starting to smoke.

The national government is responsible for increasing the price of cigarettes and tobacco products.

Simplify the requirements for reimbursement of smoking cessation services and treatments
The procedures necessary to complete the smoking cessation programme and subsequently apply for reimbursement are perceived as being complicated. Thus some physicians are providing their patients with many of the elements of the programme but not following the whole programme because it is complicated. Then because the patients have not completed the whole programme, the patients are not being reimbursed for these services and medications.

There is therefore a need to simplify the procedures that the healthcare providers must go through to provide the programme and thus ensure that all patients are reimbursed. Reimbursement is particularly important for those on low incomes.

Provide more educational programmes on smoking cessation, especially for primary care
A national programme for GP training on smoking cessation was successfully organised a number of years ago, however, newly qualified physicians have not received this training. This type of education would help motivate physicians to keep providing smoking cessation to their patients.

It is recommended that a two- or three-day educational programme on smoking cessation is provided for every physician in the country with other European tobacco experts invited to speak.

Educational programmes will help keep healthcare professionals motivated. More emphasis on training and updating skills is needed. The medical associations will have an important role to play to implement this recommendation.

Introduction

The following information on the tobacco control and smoking cessation services in the Netherlands has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in the Netherlands.

08.13.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The Dutch Foundation on Smoking and Health (STIVORO) estimated smoking prevalence at 28% of the population in 2009.[793]

According to the Ministry of Health, Welfare and Sport, more than 20,000 people die every year in the Netherlands from smoking-related diseases.[794] Tobacco smoke also causes health damage to non-smokers and every year, thousands of people die as a result of exposure to second-hand smoke.[795]

A Health Council study in 2003 concluded that every year, second-hand smoke in the Netherlands causes approximately 10 cases of sudden infant death syndrome (cot death), several hundred deaths from lung cancer, several thousands of deaths from heart disease and many tens of thousands of respiratory tract disorders in children.[796]

The General Practitioners and the Economics of Smoking Cessation (PESCE) project[797] estimated that a reduction of 3% in the prevalence of smoking in the Netherlands would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke, and chronic obstructive pulmonary disease (COPD) of €10.4 million by 2020 and €19.7 million by 2030. The same reduction would also result in 158 fewer deaths per year by 2020, and 269 fewer per year by 2030.

Smoking prevalence targets
In July 2005, the Dutch Asthma Foundation, the Dutch Heart Association, the Dutch Cancer Society and the Minister of Health, Welfare and Sport signed the 'Tobacco Control Declaration of Intent'. This document established that in 2005, smoking was still the major avoidable risk factor for premature death due to COPD, cardiovascular disease and cancer, and that second-hand smoke causes health damage and premature death. The signatories to the Declaration of Intent wanted to set a clear target for a reduction in smoking prevalence. Their aim was to decrease the percentage of smokers to 20% between 2008 and 2010. The

results of the elaboration of the Declaration of Intent are published in a document called "National Tobacco Control Programme 2006-2010".[798] The Netherlands has now entered the last year of the programme, and the 20% target has not yet been achieved as smoking prevalence is still 28%.

According to one report, a combination of factors, including the effects of anti-smoking campaigns (focusing on the dangerous health effects of smoking) and the population's growing health awareness, together with smoke-free legislation, is predicted to lead to a reduction in the number of smokers in the Netherlands.[799] However, the International Tobacco Control Project in Ontario, Canada, co-produced a national report on the Netherlands which showed strong pro-smoking attitudes. Only 22% of smokers, the lowest figure in 16 countries, had a negative opinion of smoking and were therefore likely to quit.[800]

08.13.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy

The Dutch Tobacco Act contains measures for controlling the use of tobacco and protecting non-smokers against exposure to tobacco smoke. The 1988 Tobacco Act came into force in January 1990, and government buildings, schools, universities and all healthcare-related buildings became smoke-free.[801] It was amended in 2002 (tobacco advertising and sponsorship), 2003 (age limit for the purchase of tobacco products) and 2004 (most workplaces and all enclosed public transport to be smoke-free).[802]

The 2004 amendment stipulated that employers take measures to ensure that employees were not exposed to workplace tobacco smoke, and that travellers should be able to travel from one destination to another without being exposed to tobacco smoke. Exemptions from the legislation included areas designated for the public in restaurants, bars, hotels, casinos and specialised tobacco stores, as well as private and outdoor areas. In July 2007, the government agreed to go forward with a proposal to create smoke-free cafés, restaurants, hotels and sports facilities, to be implemented starting July 2008. The hospitality industry requested an exemption until 2011 but this was rejected.

On 1 July 2008 the smoke-free workplace was introduced in catering (bars, restaurants), sports and the cultural sector. At this point, employers in those three industries lost their exemption from the statutory duty (held since January 2004) to protect their employees from exposure to tobacco smoke. The government stated that all catering establishments should be smoke-free to ensure that there would be no undesirable division between operators with and without employees.[803] Separate and designated smoking facilities are permitted, although service is not provided in these areas to protect employees' health.

According to the Ministry of Health, Welfare and Sport,[804] the Dutch tobacco control policy has three objectives: decreasing the percentage of smokers, preventing young people from taking up smoking and protecting non-smokers from tobacco smoke.

Cigarette volume sales decreased in 2009 as a result of the introduction of smoke-free public places and the high taxes on tobacco introduced in 2008.[805]

08.13.1

Smoking prevalence in Netherlands (2009)
28% = adults[793]

The Netherlands ratified the World Health Organization's (WHO's) Framework Convention on Tobacco Control (FCTC) on 27 January 2005.[806]

Legislation on tobacco advertising, promotion and sponsorship
Tobacco advertising, promotion and sponsorship on television and radio has been banned in the Netherlands since 1990, and this was followed by cinemas in 1996. It has also been banned on billboards since 2002 and printed media since 2003. It has been restricted to the point of sale since 2002.[807]

Challenges to legislation and enforcement
The Ministry of Health, Welfare and Sport reported in January 2009 that 90% of the 42,500 bars and restaurants in the Netherlands were compliant with the smoke-free legislation imposed on catering establishments in July 2008. This was revealed by a study commissioned by the Food and Consumer Product Safety Authority (VWA).[808] The International Tobacco Control survey reported that respondents witnessed smoking in 83% of restaurants before the smoke-free legislation and in only 5% after the legislation was imposed.[809]

Small bars, which are often unable to create the required separate zones for smokers and non-smokers, increasingly allow their clients to smoke indoors. However, the Supreme Court decided in April 2010 that a number of convicted owners who broke the smoking law should not be acquitted, and that they will have to re-appear before the court.[810]

The smoke-free legislation has not been as successful in cafés and bars, where before the implementation of the legislation smoking was observed in 94% of venues but after legislation this figure decreased to only 36%.[811]

Although there is opposition to smoke-free legislation, especially from bars and particularly the smaller bars, the existence of smoking rooms could undermine the success of the smoke-free legislation.

08.13.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Smoking cessation support offered at primary care level depends on the individual General Practitioner (GP) involved, with some GPs being very aware of their role in providing smoking cessation support but others being less aware. Many GPs work with a minimal intervention strategy (MIS) for smoking cessation which has been shown to be effective in Dutch general practice compared with usual GP treatment.[812]

It is thought that patients in primary care are not systematically asked if they smoke by their GP and this is probably because the GPs do not see this as part of their role. They see smoking as a behavioural choice and think there is little they can do to help the patient. Physicians may be more inclined to question their patients on their smoking status if the patient is at high risk, has a smoking-related disease, or is pregnant.

Patients from primary care may then be referred to a specialised nurse practitioner or a specialist smoking cessation clinic; there are sixty hospital-based smoking cessation clinics in the Netherlands. The specialist smoking cessation clinics are organised by local healthcare organisations and involve group courses that run two or three times per year with ten to twelve people attending each course.

The STIVORO website aims to inform visitors about important aspects of smoking and smoking cessation. STIVORO is supported by the Dutch Ministry of Health and three health organisations: the Dutch Asthma Foundation, the Dutch Cancer Society, and the Dutch Heart Foundation. The website offers comprehensive and detailed information on all relevant topics regarding smoking and smoking cessation, tailored to three targeted audiences: professionals, adults and adolescents.[813]

There is a national quitline (run by STIVORO) providing active behavioural support and pro-active (multi-session) counselling to help smokers quit.

Reimbursement for smoking cessation services
On the 1 January 2011, a new Smoking Cessation Integrated Care Package started, whereby a patient's health insurance provides reimbursement for smoking cessation services at the primary care level.[814] The new Smoking Cessation Integrated Care Package will reimburse all effective pharmacological support (e.g. NRT, bupropion, nortryptiline and varenicline) when delivered in combination with behavioural support.[815] It is anticipated that there will be an individual annual limit of €250.[816]

Previously, smoking cessation medications were seen as 'lifestyle' drugs and they were not reimbursed on the grounds that the burden that they would impose in terms of reimbursement would outweigh the benefits that they offer to the patient population as a whole.[817] Nicotine replacement therapy (NRT) is available over-the-counter.

08.13.4 GUIDELINES

Clinical guidelines for healthcare professionals were funded by the Ministry of Health through the Partnership on Smoking Cessation project. This is a platform of 25 organisations in public and private healthcare concerned with smoking and cessation such as physician organisations, dentists, nurses, and specialists. The guidelines were developed using evidence-based methodology and written for the entire healthcare system.[818] The original guideline was developed in 2004 and it was updated in 2009 and endorsed by all participating organisations.

Healthcare organisations work according to these guidelines; some scientific healthcare organisations translated the guidelines into protocols or standards for their own profession: STIVORO, the national tobacco control institute, developed interventions and provides a support telephone line according to the guidelines. Some concern has been expressed about the Dutch Physicians Association not implementing the updated guidelines, although they did develop a user-friendly version of the original guidelines which they distributed to all their members.
It is thought that although the guidelines are available and GPs are aware of the guidelines, they do not always follow them.

There are also specific guidelines for COPD patients that cover smoking cessation but again, these are not always followed by healthcare professionals.

08.13.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

It is thought that in the Netherlands, smoking is seen as a lifestyle choice or habit, or a part of patients' private lives. Tobacco dependence is not widely seen as an addiction or a disease.

Medical students
It is thought that there are no educational programmes about smoking cessation for medical students in the Netherlands.

Primary care
STIVORO has a programme to train physicians (STIMEDIC), and also offers courses for nurses and other healthcare professionals who meet smokers. There were specific protocols for cardiology, gynaecology and pulmonology, and one under development for dentists. There are manuals for both physicians and patients. To make it more uniform, these have recently been transformed into just one protocol, with additional information for specific professionals.

There are no government-funded or organised educational programmes for the treatment of tobacco dependence for healthcare professionals within primary care, that target those patients at high risk. It is left up to specialist smoking cessation advisers, non-governmental organisations (NGOs) and charities, where such education is provided at both a regional and national level, usually within a conference or another programme. Such programmes take about four hours and address the scale of the smoking problem and the effects of smoking, as well as teaching motivational interviewing.

Secondary care
STIVORO offers training for all specialists seeing smokers and there are specific protocols for cardiology, gynaecology and pulmonology specialists to utilise.

Only some hospitals have a smoking cessation clinic. It is up to the individual pulmonology department – if they show initiative then there is a programme. However, if there is no initiative and no programme, other specialists will not talk to their patients about smoking because they have no service to refer their patients to. For example, the cardiologists will not talk to patients and the paediatricians will not talk to parents.

General public
STIVORO's website (www.stivoro.nl) aims to inform the general public about important aspects of smoking and smoking cessation.

There are self-help materials and brochures for GP surgeries and pharmacies, financed by the government, on how to quit. There is the perception of sufficient education targeting mothers, pregnant women and children exposed to smoke.

The Netherlands participate in the annual World No Tobacco Day.

There is a national quitline providing information and counselling for those wishing to stop smoking. There are also national smoking cessation websites such as www.smokealert.nl, www.stivoro.nl and www.stopeffectief.nl.

08.13.6 RECOMMENDATIONS

Implement smoke-free legislation in all public places
According to the report from the International Tobacco Control survey, "Dutch smoke-free law is effective in reducing the prevalence of smoking in restaurants, but less so in cafés and bars."[819]

Implementing comprehensive smoke-free legislation in all public places, including small bars, will provide smokers with increased motivation to quit and increase the number of quit attempts by making smoking in public places more difficult. Comprehensive smoke-free legislation will make smoking increasingly socially unacceptable and assures societal support of further tobacco control measures.

This recommendation will also support Article 8 of the FCTC which requires all indoor workplaces and public places to be completely smoke-free. This recommendation is seen as a key priority to implement in the Netherlands.

Ensure adequate budget for reimbursement of smoking cessation services and medications
The changes introduced in 2011 will provide reimbursement for both smoking cessation services and medication and will be very important as they will help to bring the Netherlands closer to best practice. There have been two pilot projects, and both showed that if the cost of the treatment is reimbursed, it is an incentive to stop smoking, and it is also more effective.[820,821]

Most smokers (81%) 'support' or 'strongly support' health insurance reimbursement for smoking cessation medications and 38% thought that smoking cessation medication would make it easier for them to quit.[822] It is thought that the planned reimbursement of smoking cessation will also increase access to smoking cessation services, particularly for smokers with lower incomes.

Given increasing restrictions on smoking and smoke-free legislation, the government has a moral obligation to these smokers to provide the smoking cessation services they might need as they try to quit. This means that the government should allocate sufficient budget for local smoking cessation services.

Provide incentives for primary care physicians to provide smoking cessation services
There should be a positive incentive for physicians to reduce smoking amongst their patients. For example, if a physician manages to reduce the number of smokers, there should be a financial reward for the physician. This would encourage them to engage with their patients because it is an emotional topic and physicians fear that there is some kind of interference with the patient/physician relationship. This idea was suggested in a STIVORO consultation at the beginning of 2010, and was one of their top six recommendations. However, although this recommendation will be useful to increase participation in smoking cessation programmes, it was not thought to be a priority compared with the others.

Increase knowledge and awareness amongst healthcare professionals on smoking cessation
There should be more training nationwide, starting with medical students, then GPs, then secondary care. This training should include information on combining behavioural support and pharmacological support, as these efforts should be integrated instead of separated. Those providing smoking cessation services should more thoroughly understand how to prescribe the available medication and the potential side-effects of such therapy. The training should also include instructions on how to conduct motivational interviewing.

Other healthcare professionals such as dentists should be encouraged to take a more active role. Dentists, for instance, see their clients twice a year and could provide important information on smoking cessation to their clients.

Implementation of medical student education would be the responsibility of the medical schools but implementation of other healthcare professional education would be the responsibility of the professional societies. These professional societies could also help by reminding their members of the educational services provided by STIVORO.

Provide targeted education and increase awareness with smokers of lower socio-economic status
Smoking prevalence is high in those with a lower socio-economic status and targeted education should be utilised to motivate them to stop smoking. Again, this recommendation would be supportive of Article 12 of the FCTC.

Media campaigns for the general public are typically provided by the government and STIVORO. With the change to smoking cessation treatment reimbursement in January 2011, these campaigns will be important to motivate all smokers to get additional help.

Introduction

The following information on the tobacco control and smoking cessation services in Norway has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Norway.

08.14.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The proportion of daily smokers in Norway has declined significantly in the last few decades, from more than half of the population in 1973, to 21% in 2009.[823] While smoking prevalence is declining, smokeless tobacco (snus) is increasing,[824] and 6% used snus daily in 2009.[825]

The proportion of smokers in the adult male population has declined from more than half in 1973 to around 20% in 2009.[826] In 1973, just over 30% of the female population smoked, and this had fallen to 20% in 2009.[827]

Smoking is three times more common in people with only primary level education compared with people with university and college education.[828]

Use of snus is more common in young people, with 7% of young women and 21% of young men using it. While smoking prevalence is declining, the prevalence of smokeless tobacco use is increasing.[829] Despite the negative health effects of snus, its use by young males increased dramatically between 1998 and 2010.[830]

It has been estimated that for every percentage fall in smoking prevalence, the associated costs to the Norwegian healthcare system will be reduced by 2-3 billion Norwegian Krone (NOK),[831] assuming a current smoking prevalence of 21%.[832]

A report published by the Norwegian Directorate of Health (DoH) in October 2010 looked at the societal costs of tobacco smoking in Norway by transferring cost estimates from Denmark and Sweden into a Norwegian context. The report summarised that tobacco smoking costs NOK 8 billion per year if healthcare costs and production losses associated with morbidity and premature mortality are included. If the economic evaluation of the welfare loss (lost life years and health-related quality of life) due to tobacco smoking is included, this estimate rises to NOK 80 billion per year.[833] Around 6,700 Norwegians die each year from smoking-related diseases, along with around 350-550 from passive smoking.[834]

Assuming that passive smoking contributes to about 5% of smoking-related deaths and welfare costs associated with morbidity, the societal costs related to passive smoking were estimated in 2010 to be NOK 4 billion per year.[835]

Smoking prevalence targets
In 2002, the Minister of Health set a goal to halve the uptake of smoking in those below 25 years old within five years.[836] The Directorate for Health and Social Affairs was set the task of devising a strategy to achieve this goal. This target was achieved within a few years and, after the smoke-free legislation was introduced there was a further decrease in prevalence.

Norway's National Strategy for Tobacco Control 2006-2010 aims to ensure that everyone who wants to stop smoking has easy access to a good service through the health service and workplaces.[837] This National Strategy recognised that Norway was relatively weak in smoking cessation and focused on this area, particularly targeting pregnant women and parents of small children. The target was to reduce the proportion of daily smokers to less than 20% by 2010.[838] A revised strategy is expected during 2011, but this will take around five years to implement and attain its goals.

08.14.2 LEGISLATION ON SMOKING

Norway has been one of the leaders in tobacco control in Europe since the 1960s and was an early adopter of smoking cessation programmes.[839] Norway was the first country to sign and approve the Framework Convention on Tobacco Control (FCTC) on 16 June 2003.[840]

Smoke-free legislation and policy
Norway introduced smoke-free policies in public buildings, in meeting rooms, workplaces and institutions where two or more people are gathered (under these rules, smoking is still allowed in an individual's office).[841] Staff wearing uniform are not allowed to smoke within hospitals.

03.14.1

Prevalence of tobacco users (2009)
21% = adults[823] 6% = use snus daily[825]

Public transport in Norway is smoke-free (buses, taxis, trains and domestic water and air transport), and international air transport is voluntarily smoke-free. Smoking is allowed on international water transport.[842]

Legislation on tobacco advertising, promotion and sponsorship
The minimum legal age for buying tobacco in Norway is 18, in common with the most European countries, and there is a penalty for selling tobacco to minors.[843]

The act relating to Prevention of the Harmful Effects of Tobacco, published in 1973, includes:
- Banning of selling tobacco products to people under 18
- Banning of tobacco advertising (both direct and indirect)
- Provisions concerning the content and labelling of tobacco products.[844]

In January 2010, Norway banned the sale of cigarettes from vending machines (other than secure dispensers requiring proof of age), as well as the display of cigarettes, cigars, pipe tobacco and other tobacco products.

Direct tobacco advertising is banned in Norway on television and radio, on billboards, in the cinema, at point of sale and in local magazines and newspapers, but is allowed in international magazines and newspapers. Although indirect tobacco advertising is banned in Norway it is allowed on cable television.[845]

Challenges to legislation and enforcement
Norway's Ministry of Health and Care Services (MoH) requested a joint assessment of Norway's capacity to implement tobacco control policies. The World Health Organization (WHO) headquarters, the regional WHO office for Europe, and the Public Health Department in the Ministry along with the Directorate of Health organised and conducted this assessment. The WHO report of this assessment was published in April 2010 and highlighted the following challenges for Norway:[846]

- Limited resources (both financial and personnel) have been allocated to tobacco control since 2007
- Inadequate resources assigned for mass media campaigns to educate smokers on the dangers of smoking, including those smokers in the lower socio-economic groups
- Lack of monitoring and enforcement of smoke-free areas
- Although smoking cessation has been prioritised in national policy documents, there is insufficient budget to provide the necessary smoking cessation services.

08.14.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

At the primary care level, General Practitioners (GPs) are likely to both enquire about the smoking status of their patients and to try to provide smoking cessation services themselves. Some GPs may not provide this service because they do not feel there is an alternative referral route for patients. However, patients that have been referred to a specialist smoking cessation programme are unlikely to be followed-up at the primary care level.

Some specialist smoking cessation programmes are provided by 'polyclinics' where patients pay to participate, although the payment is reduced for employees. If the smoker remains smoke-free after one year, the money they spent on the programme is reimbursed.

In addition, a number of the cancer, heart and lung organisations and other non-governmental organisations (NGOs) run smoking cessation courses, as do some workplaces, and these are all free to access.

At the secondary care level, some pulmonary departments in hospitals have walk-in smoking cessation services. However, smoking cessation for patients in secondary care differs from department to department and hospital to hospital, although patients in cardiovascular and pulmonary wards are more likely to receive advice.

The Norwegian Medical Association has a computer program for physicians working in smoking cessation, known as 'Cessare'.[847] This helps physicians in both primary care and hospitals to provide personalised smoking cessation counselling and information.

There are quitlines available in Norway.[848]

Reimbursement for smoking cessation services
Primary care physicians are reimbursed for "initiating individual structured smoking cessation as part of treating an illness, following an approved programme". However, reimbursement can only be used twice annually for each patient, and smoking cessation groups are specifically not reimbursed. Currently around 50,000 people per year utilise this reimbursement out of the estimated 800,000 daily smokers in Norway.[849]

Prescription and over-the-counter smoking cessation therapies are available in Norway, but are they are not reimbursed.[850]

Although GPs are reimbursed if they put a patient into a smoking cessation programme, the patient must already have a smoking-related disease.

08.14.4 GUIDELINES

The DoH published national guidelines for primary care use based on Cochrane reviews and were approved by the government. These guidelines were published in 2004[851] and the recommendations include:[852]

- Brief interventions
- Intensive behavioural support
- Use of nicotine replacement therapy (NRT)
- Use of bupropion
- Evidence of cost-effectiveness.

These guidelines are currently being revised and should be available shortly. It is thought that there is a good tradition in Norway for creating guidelines and for healthcare professionals to follow these guidelines.

08.14.5 EDUCATION

In Norway, treatment of tobacco dependence is part of the national health programme and the primary healthcare programme. It has age- and gender-based promotional and educational programmes aimed at encouraging cessation of tobacco use.[853]

Norway's National Strategy for Tobacco Control 2006-2010 aims to improve the focus of healthcare professionals (HCPs) and improve their competence relating to lifestyle change. Another aim is also to ensure that tobacco-related diseases and cessation methods are included in training for teachers as well as social and health workers. Goals include:[854]

- Developing the quitline and educating HCPs about it
- Providing local services, improving public knowledge and increasing referrals from primary care
- Introducing totally smoke-free workplaces and making working hours smoke-free
- Improving advertising of cessation courses and documenting the effect of the courses
- Developing self-help materials
- Making use of mobile phones and Internet technology for follow-up
- Training personnel in the social and health sectors on the health hazards of tobacco and on smoking cessation
- Working with educational institutions and vocational organisations to implement tobacco control and cessation methods though courses in the social and health sectors
- Simplify the initiation and follow-up of patients' cessation attempts in primary care
- Provide training courses for primary care HCPs
- Develop and implement cessation guidelines for primary care health personnel and GPs
- Develop and implement cessation guidelines for secondary care, for use in hospitals and other health institutions
- Prepare information for patients in secondary care and for their relatives on smoking cessation services in the community
- Increase the focus on individual or group cessation services at hospitals, out-patient clinics, and coping and learning centres
- Include both counselling and treatment medication for smoking cessation.

Medical students
Medical students receive smoking-related information as part of the curriculum, but it is very short – around one hour on preventative cardiology and only ten minutes on smoking cessation.

Primary care physicians and healthcare professionals
The Director of Public Health has written a publication called "Smoking cessation in general practice".[855] The country Governor and the Norwegian health directorate collaborated to provide a primary care training programme which includes a section on

preventative medicine, with education on smoking cessation. This training is provided for both GPs and other interested healthcare professionals.

Medical Associations fund and organise two to three smoking cessation courses a year for GPs and the 'Lungs in Practice' group (LIP) also provide courses and meetings for GPs with a special interest in pulmonology and smoking cessation. The LIP group is part of the umbrella International Primary Care Respiratory Group (IPCRG).[856]

Secondary care physicians and healthcare professionals
Education at the secondary care level is provided for physicians and other healthcare professionals working in tobacco-related diseases. In addition, specific training for disease specialists (e.g. those interested in chronic obstructive pulmonary disease (COPD) and diabetes) is available.

General public
Norway's Directorate for Health and Social Affairs has run mass media campaigns since 2003, particularly aimed at reducing smoking in young people.[857] The 'BE smoke-FREE' (VAER røykFRI) anti-smoking programme has been active since the 1990s, is targeted at lower-secondary schools and was reviewed and revised in 2006 in collaboration with the Directorate for Education and Training.

There is a feeling that the campaigns run by the Directorate provide better results when they integrate smoking cessation, with other support such as weight management, promoting healthy eating, and an active lifestyle.

There is a website called 'slutta' which is available to help people stop smoking.[858] Other national smoking cessation websites include:
- www.lhl.no
- www.tobakk.no
- www.kimo.no
- www.nasjonalforeningen.no
- www.shdir.no/tobakk
- www.kreftforeningen.no/stumprøyken
- www.opptur.kreftforeningen.no
- www.happyending.no

Norway also has pictorial warnings on cigarette packets.[859]

08.14.6 HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

In a study of GPs in Nordic countries, 29% of GPs in Norway ask all their patients if they smoke, but 94% will ask their patients who demonstrate smoking-related symptoms if they smoke. The top four stated barriers to this are:[860]
- Discussions are too time-consuming (60%)
- Lack of knowledge on the subject (25%)
- Do not perceive discussing peoples' smoking habits as part of their job (29%)
- They feel uncomfortable asking people about their smoking behaviour (33%).

In the same study, 67% of GPs in Norway who know that a patient smokes will inform them about the health benefits of giving up.[861]

08.14.7 RECOMMENDATIONS

Set targets to reduce the smoking prevalence and the use of smokeless tobacco (snus) to make politicians and others more accountable
The WHO's Joint National Capacity Assessment report on Norway found that the National Strategy for Tobacco Control was inadequately implemented and that there are no action plans for smoking cessation at the national, county or local levels.[862]

Targets for smoking prevalence and the use of smokeless tobacco should be set so that those responsible can be held accountable if these targets are not met. Similarly, the Norwegian Medical Association should also be encouraged to be accountable for achieving such targets.

Reimburse time for providing smoking cessation services and reimburse treatments
Except for the reimbursement for primary care physicians following the cessation programme and for those patients with smoking-related diseases, there is no reimbursement for treating tobacco dependent smokers.[863]

To encourage physicians to provide smoking cessation services, primary care physicians should be reimbursed for their time providing such services. Currently, smoking cessation services are only reimbursed if the patient already has a smoking-related disease and this does not focus on primary prevention. Fully reimbursed smoking cessation services or at least a reimbursed follow-up should be provided.

Based on the Health Insurance Law (Folketrygdloven) and a medicine regulation (Legemiddelforskriften) the reimbursement of smoking cessation medications is explicitly legislated against for those without a smoking-related disease.[864] It is thought that new smoking cessation guidelines for patients with COPD will recommend smoking cessation counselling and the reimbursement of smoking cessation medications. These guidelines will therefore be important for advocating for reimbursement of smoking cessation in those patients with other smoking-related diseases.

To improve access to smoking cessation medications, reimbursement is recommended. This should, at the least, be provided for some groups such as those with heart and lung problems, those who require relapse prevention, and those on low income.

To implement this recommendation, it is necessary that the politicians and government are willing to arrange reimbursement. The new COPD guidelines will support smoking cessation treatment reimbursement and it is thought that national medical societies will be able to help facilitate the process.

Involve primary care and secondary care physicians more
The Joint National Capacity Assessment report highlighted that smoking cessation services are “almost non-existent” and that such services can be instrumental in helping smokers, including those with lower levels of education.[865]

These services need to be increased and all primary care physicians should be tasked with asking their patients if they smoke and then giving them appropriate advice, support and follow-up to help them quit.

In the secondary care setting, patients admitted to hospital should also be asked if they smoke and if they do, they should be advised to quit. They should be offered nurse assisted help and follow-up.

Assuming that reimbursement is implemented, then this will help physicians to become more involved and will help with this recommendation.

Educate healthcare professionals more about smoking cessation
The National Strategy for Tobacco Control 2006–2010 states that improving the knowledge of healthcare professionals regarding smoking cessation is one of the priorities.[866]

It is recommended that access to educational programmes for physicians including GPs (who see the most patients), secondary care physicians (particularly pulmonologists) and other healthcare professionals involved with patients is increased. Such educational programmes should be provided for smoking cessation leaders and lifestyle leaders to give them the ability to help smokers, particularly those that are heavy smokers.

It is thought that increased training at a primary care level will help to increase the number of smokers being referred to specialist smoking cessation services.

Educational programmes should be developed and standardised by the Directorate of Health.

Organise smoking cessation services nationally from a central organisation
The WHO's Joint National Capacity Assessment report noted that Norway lacked well-established mechanisms for cooperation between different national, county and municipal stakeholders in tobacco control which has hindered the Ministry of Health and Care Services from providing leadership in this area.[867]

It would therefore be sensible to standardise smoking cessation services and deliver them nationally from a central organisation. Smoking cessation services should be provided by primary care physicians and hospitals rather than the current dependence on patient organisations and NGOs.

Currently, there is a lack of specialist smoking cessation clinics and this needs to be addressed so that primary care physicians can refer patients as required.

The MoH would be responsible for commissioning this recommendation whilst the DoH would be responsible for developing and implementing the service.

Endorse and promote national guidelines
The current smoking cessation guidelines for primary care use were published in 2004. They are currently being revised and publication was anticipated before the end of 2010 but appears delayed.

There is a need for national, government approved guidelines which incorporate practical help for healthcare professionals, hospitals and communities, and allow treatments to be standardised. These guidelines should ensure they cover patients admitted to hospital as well as primary care patients.

Norway has a good tradition of creating guidelines for other diseases and for healthcare professionals following these guidelines.

These national guidelines should be endorsed and promoted by the MoH. Accountability for their implementation needs to be decided. The various medical societies would be responsible for promoting awareness of the guidelines amongst their members.

More education for the general public
It has been noted that Norway has stopped using government-led mass media campaigns with the general public. In 2003, following a mass media campaign and the debate on strengthening the smoke-free legislation in Norway, smoking prevalence dropped by 3%.[868]

There is overwhelming evidence that mass media campaigns have worked in Norway but insufficient resources are targeted at this effort now.[869]

It is important that budget is provided so that these very effective mass media campaigns for the general public can be reintroduced.

The MoH would be responsible for allocating the funds that the DoH expends on such media campaigns and these campaigns would benefit from support by the medical societies.

POLAND

Introduction

The following information on the tobacco control and smoking cessation services in Poland has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Poland.

08.15.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Health Organization (WHO) database recorded 29% of the adult population of Poland as regular smokers in 2006.[870] A national survey conducted in 2007 indicates that 34% of men and 23% of women smoked on a daily basis.[871] This survey also found that 2% of respondents were occasional smokers, 19% were former smokers and 45% never smoked. In women, these percentages were, respectively 3%, 10% and 64%.[872] A recent survey conducted in 2009-2010 found that 30% of Polish adults smoke either daily or occasionally, with 33.5% of men and 21.0% of women smoking daily.[873] In men with only vocational-level education, the prevalence of smoking is 47.4%.[874]

The results of the Health and Economic Consequences of Smoking model, developed in collaboration with the WHO in the mid-1990s, estimated that if smoking rates observed in Poland in that period did not decrease over the following 20 years, approximately 1.2 million people who were currently smoking would die from tobacco-related diseases, primarily from coronary artery disease, cerebral infarction, other cardiovascular diseases, chronic obstructive pulmonary disease (COPD), bronchial asthma, lung cancer, and other cancers.[875]

The General Practitioners and the Economics of Smoking Cessation (PESCE project)[876] estimated that a reduction of 3% in the prevalence of smoking in Poland would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke and COPD of €22.7 million by 2020 and €37.9 million by 2030.

Smoking prevalence targets

There is a recent national "Programme for Limiting the Health Consequences of Tobacco Smoking in Poland" for the period 2010-2013 which has a national target to reduce the daily smoking prevalence to 32% for men and 22% for women.[877] This programme has been approved by the Minster of Health and is organised by the National Sanitary Inspectorate.

08.15.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
According to the European Public Health Alliance,[878] on 29 April 2010, Poland's Acting President Mr Komorowski signed new anti-tobacco legislation which gave six months to implement the Act. As a consequence, smoke-free restrictions are operational in:

- hospitals and other out-patients clinics and premises for patients
- all educational premises
- workplaces (employers can provide smoking rooms but they have to be specially prepared, with automatic ventilation)
- all means of public transport
- bars and restaurants (the owner can provide a smoking room)
- public cultural and leisure venues
- bus, tram, and train stops
- sport stadiums and other premises
- children's playgrounds
- other public access venues (not specified).

Additionally, owners of the following premises may build (but are not obliged to) special enclosed smoking rooms with ventilation in retirement homes, hotels, airports and universities.

On public transport such as buses, taxis and air transport, smoking has been banned in Poland since 1999. There is a restriction on smoking on trains and water transport which has also been in place since 1999.[879]

Legislation on tobacco advertising, promotion and sponsorship
Since 1995, tobacco advertising, promotion and sponsorship were banned in Poland on television, radio and at the cinema. Similarly tobacco advertising, promotion and sponsorship were banned in magazines, newspapers and on billboards from 1999. It is not yet banned at the point of sale.[880]

Challenges to legislation and enforcement
According to the European Commission, Poland is the European Union's (EU's) second biggest producer of raw tobacco, producing 16% of the crop.[881] The tobacco industry has worked hard against comprehensive smoke-free legislation in public places aiming to convince the government that such regulations would lower revenue from tobacco taxes.

Despite this, in a survey completed in March 2010, it was reported that 64.7% of adults in Poland supported the introduction of smoke-free workplaces with 46.9% supporting a ban on smoking in restaurants.[882]

However, influential public health politicians in Poland are smokers and there is resistance from smokers themselves on the grounds of individual choice.[883]

08.15.1

Smoking prevalence in Poland (2009-2010)
30% = adults (daily or occasional)[873]

08.15.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Poland is divided into 16 regions, each with a population of between one to eight million. The locally-elected governors (marshals) have budgets and are responsible for hospitals and

medical care in the region, which makes them very important drivers for programmes in the field.

Smoking cessation services are offered in primary care and at specialised walk-in clinics. There is a national programme known as "Programme for Limiting the Health Consequences of Tobacco Smoking in Poland"[884] which covers all of the Polish regions at the primary care level.

There are specialised smoking cessation clinics in 14 of the 16 regions funded by the National Health Fund. Each clinic provides a physician and a nurse but may also have a psychologist and/or nutritionists. The goal of these specialist clinics is to increase the number of people who quit smoking.

It is thought that the reach of these clinics is very limited. Latest surveys show that half of patients visiting GPs are asked about smoking and only half of those asked have been offered advice. However, 25.2% of patients claim that they are using some form of medication to help quit smoking.[885]

The national Polish quitline began providing counselling in November 1996. It is now a legal requirement that the quitline telephone number is included on cigarette packets.

Reimbursement for smoking cessation services
There has been a lack of funding and financial support for smoking cessation from the state and the Polish National Health Fund. The costs of smoking cessation pharmacotherapy are not reimbursed by the state although nicotine replacement therapy (NRT) is available over the counter.[886]

In some regions and clinics, where a contract with the National Health Fund is available, reimbursement is provided for smoking cessation services provided by General Practitioners (GPs).[887] However, in private clinics that have no contract with the National Health Fund, patients have to pay for both the smoking cessation service and the medications.

08.15.4 GUIDELINES

Polish guidelines for the treatment of tobacco dependence were published in 2006[888]and 2008.[889] These guidelines were delivered to all Polish physicians by the Polish Chamber of Physicians and Dentists and are available on the Chamber's website (http://www.nil.org.pl).[890] The latest revision has been prepared but not yet published.

There are also guidelines and recommendations prepared by medical societies, e.g. pulmonologists, cardiologists[891] and oncologists. The Polish Forum for Prevention of Cardiovascular Disease (which was founded by several medical societies, including the Polish Cardiac Society, and the College of Family Physicians in Poland) published a recommendation on smoking cessation about two years ago and there are a few differences from the Chamber's earlier guidelines. These cardiovascular experts have now prepared updated recommendations for the government and these have recently been published.[892]

These guidelines are not enforced and they provide recommendations only.

08.15.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
At present, the syllabus followed when training physicians, nurses, pharmacists and other medical professionals, focuses only on general information about the detrimental effects of smoking and misses out the components supporting effective interventions to help patients who smoke.[893]

For medical students, smoking and smoking cessation can be included as part of the cancer or cardiovascular disease programme. Again, the education focuses mostly on the risks of smoking and not on smoking cessation treatments and advice.

Primary care
Nationally, at the primary care level, the Health Promotion Foundation has trained more than 10,000 GPs on treating tobacco dependence. At the regional and local level, training has been provided by institutions reporting to the Ministry of Health. The participants include the coordinators and organisers of anti-tobacco activities across the country, as well as physicians who wish to upgrade their skills in anti-tobacco interventions.[894]

As with many other European countries, many primary care practitioners comment that they do not have the time to advise patients, that there should be additional reimbursement for these activities, and that they do not have enough knowledge or skills to provide smoking cessation services.

Secondary care
At the secondary care level, oncologists, cardiologists, and pulmonologists are taught about tobacco dependence and smoking cessation although this teaching tends to focus more on the risks related to smoking instead of smoking cessation treatments.

General public
Poland participates in the annual World No Tobacco Day dedicated to educating people about the dangers of tobacco. There is also every November a 'Quit and Win' event helping people to quit smoking.

The main education for the general public is in the form of information leaflets targeting different groups, e.g. pregnant women, COPD sufferers.

A public campaign called 'Let's Quit Smoking Together' has been running every year since 1991 with smoking cessation as the main aim. There have also been one-off media campaigns, for example: 'Cigarettes Are Eating You Alive', 'Poland without smoke'[895] and 'Cigarettes Are Eating You and Your Baby Alive.'

There is anti-smoking education in schools designed to curtail the start of smoking, and education on the addictive nature and health hazards of smoking.

Poland has a national smoking cessation website (www.promocjazdrowia.pl) run by a private foundation and not by the state. www.jakrzucicpalenie.pl is another national smoking cessation website.

08.15.6 RECOMMENDATIONS

Implement and enforce the Smoke-free Act
According to the WHO's report on Poland (2009)[896] a complete ban of smoking in public facilities is required and to this end, the legislation from April 2010 provides for important smoke-free restrictions that are to be enacted within six months of the Act (15 November 2010). Despite opposition from certain groups, 64.7% of adults in Poland are supportive of the introduction of smoke-free workplaces, with 46.9% supporting a ban on smoking in restaurants.[897]

The implementation and enforcement of the smoke-free Act in a comprehensive manner, is urgently required. Responsibility for this recommendation lies with government (Department of Health).

Ban the point of sale displays of tobacco products
The WHO reported in 2009 that Poland needs to prevent "advertising of tobacco products under the guise of non-public forms of promotion."[898] Currently, point of sale promotion is still allowed.[899] Supportive of the WHO's recommendation would be a ban on point of sale displays of tobacco products which effectively advertise the products.

Parliament would be responsible for implementing this legislation.

Increase reimbursement for smoking cessation treatments
The Polish Forum for Prevention of Cardiovascular Diseases has already called for the wider reimbursement of smoking cessation therapy.[900]

Any medications necessary for smoking cessation should be reimbursed, or at least partially reimbursed, as the price of these medications is currently a barrier for many smokers and providing reimbursement may encourage more smokers to give up smoking.

This recommendation will require the Health Minister to act and the implementation of this recommendation is important once there are more trained healthcare professionals.

Increase the number of smoking cessation programmes
There should be more budget available to tackle the tobacco epidemic on different levels. The number of smoking cessation programmes in primary care should be increased. Interventions at the primary care level are extremely cost-effective and help more people to think about quitting, as well as providing them with counselling to help them quit. This recommendation should be complementary to other tobacco control activities such as raising taxes on tobacco products, educational campaigns etc. It is important to implement this recommendation and the Polish Health Minister will need to act on this.

Additionally, there are insufficient specialist clinics that GPs can refer patients to that are free of charge for the patient. Such specialist clinics may be useful for those that have particular difficulty quitting smoking. Adequate financing is required to encourage physicians to start and develop these specialist clinics. The Polish Health Minister will need to act on this recommendation as it is seen as an important recommendation for Poland.

Increasing the number of smoking cessation programmes will require an increase in the funds that are allocated to the national tobacco control programme specified by the current law.

Train more healthcare professionals
There should be wider and more comprehensive smoking cessation education for healthcare professionals, including physicians, nurses, physiotherapists etc. This education should be supported by public funding.

This recommendation is seen as the most important recommendation for Poland and its implementation will have the most impact. The Health Minister, in conjunction with the relevant medical societies will be in a position to act upon this recommendation.

Educate the general public
According to the Framework Convention on Tobacco Control (FCTC), each country should provide public education and training on the health hazards of tobacco consumption. The 2009 WHO report[901] considers that this has been achieved under the government's 'Programme for Limiting the Health Consequences of Tobacco Smoking in Poland'. However, it is thought that there should be more education for the general public including the provision of smoking information at primary care clinics.

A comprehensive national tobacco control communications strategy that includes public education needs to be developed and disseminated. The public education should be based on hard-hitting messages communicated utilising mass media communication and it should be comprehensively evaluated.

The Act (on the Protection of Health against the Consequences of the Use of Tobacco and Tobacco Products) covers the requirement to place warnings on the harm of smoking on the packaging of tobacco products. For larger packs, this warning must cover 30% of the pack surface.[902] The WHO 2009 report[903] found that a shortcoming of the Polish anti-tobacco policy was the lack of warnings in the form of graphics or pictures on the tobacco product packaging. It is thought that the introduction of pictorial warnings on cigarette packaging would help to reinforce the messages regarding the harm of smoking.

The Health Minister, together with the Minister of Education, will be in a position to act upon this recommendation.

Introduction

The following information on the tobacco control and smoking cessation services in Portugal has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Portugal.

08.16.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The Eurobarometer 2009 Survey on Tobacco was an analytical report on fieldwork conducted in December 2008.[904] This survey found that 22% of the Portuguese respondents smoke every day, with a further 4% smoking occasionally. A review of Eurobarometer reports from 1995 to 2007 found that although Portugal has relatively low smoking prevalence rates compared with the rest of Europe, Portugal has witnessed a substantial increase in the prevalence of smoking in the young adult female population.[905]

The General Practitioners and the Economics of Smoking Cessation (PESCE) project estimated that a reduction of 3% in the prevalence of smoking in Portugal would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke and chronic obstructive pulmonary disease (COPD) of €3.7 million by 2020 and €7.5 million by 2030.[906]

Borges *et al.* (2009)[907] report that 11.7% of deaths in Portugal are attributable to smoking. Using disability-adjusted life-years (DALYs) to measure the burden of disease they found that 11.2% of DALYs resulting from mortality in Portugal are attributable to smoking. The gender distribution of this amount is very unequal; 15.4% of the male burden of disease and 17.7% of all male deaths can be attributed to smoking, but only 4.9% of the female burden of disease and 5.2% of all female deaths. The paper also presents estimates of the burden of reducible disease, that is, the reduction in mortality and DALYs that would occur if all current smokers quit and thus experienced the mean risk of ex-smokers. This is lower than for current smokers but typically not as low as for never-smokers. The authors estimated that the burden of disease would decrease by 5.8% (7.8% in men and 2.8% in women), and that deaths would decrease by 5.8% as well (with an 8.5% and 2.9% decrease in men and women, respectively).

PORTUGAL

08.16.1

Smoking prevalence in Portugal (2009)
22% = smoke every day [904]

Smoking prevalence targets
Prevention and treatment of tobacco dependence is part of the National Health Programme (2006-2010) in Portugal, and programmes for prevention, diagnosis and treatment of tobacco dependence are part of primary healthcare programmes.[908] The National Health Service considers tobacco dependence to be a priority and one of the major health threats in Portugal.

The existence of any numerical targets for smoking cessation are not known but Portugal, along with other European countries, is committed to reducing the usage of and dependence on tobacco.

08.16.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
Portugal introduced a partial ban on 1 January 2008 but the rules were not as strict as in some other European countries. Portuguese bars smaller than 100m² (1,076ft²) can still opt to allow smoking. Public buildings can still have smoking zones, if they are clearly signposted and ventilated.

Healthcare, education and government facilities, as well as indoor workplaces, offices, theatres and cinemas are all smoke-free, though smoking is allowed in psychiatric hospitals. Public transport is also smoke-free but there have been reports of complaints from passengers, especially from those on long journeys who report that some fellow passengers are smoking in the toilets. There have also been reports that taxi drivers and clients are smoking in taxis, particularly during the night.

The legislation on smoking in enclosed public places is enforced through fines, with smokers who flout the legislation fined up to €1,000, more than twice the penalty incurred by a person caught using illegal drugs in public places. Establishments that break the law face a fine of up to €2,500.[909]

Opinion is somewhat divided on the success of the legislation but most public places appear to be adhering to the smoke-free legislation and the public are thought to support and accept the legislation. Although there has been clear progress, there is still room for improvement, as it is thought that some restaurants are reverting to allowing smoking.

Enforcement teams lack expertise and training, and do not have access to equipment to measure continine, particulate matter or nicotine levels.

Legislation on tobacco advertising, promotion and sponsorship
In Portugal, tobacco advertising, promotion and sponsorship has been banned on the television and radio, in national and local magazines and newspapers, on billboards and at the cinema since 1983. It is not yet banned at the point of sale.[910]

Promotional activities are becoming more aggressive, and cheaper brands are becoming more popular.

Challenges to legislation and enforcement
The hospitality industry members that complied with the ban initially are starting to question the fairness of the legislation, because they see no enforcement action on other establishments that do not comply with the ban. This is particularly common in areas with large populations of students or other young people.

08.16.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Each primary healthcare physician has software in their clinic prompting them to ask patients if they smoke, and recording responses. It is thought that the use of brief interventions is probably dependent on the knowledge of the physician and that follow-up is restricted to the patients next scheduled visit.

Portugal has five regional health administrations, which are responsible for the implementation of smoking cessation programmes in each region. There is a network for smoking cessation support consisting of physicians, nurses and psychologists across the five regions. It is thought that most patients have access to these services and patients who are referred are usually seen by a specialist within a few weeks, but this may be extended to a few months depending on the smoking cessation clinic, the infrastructure and the complexity of the region.

This network of specialist clinics is listed on the Portuguese Ministry of Health website and on regional administration websites. It is also available at health centres and hospitals, so that patients can identify their nearest clinic. However, the level of knowledge on the health system and information technology literacy in the population over 50 years old is thought to be low, and so information campaigns that can be accessed by this target population would be very useful.

This list of specialist clinics is regularly updated, however, and despite efforts, there are missing clinics and others that no longer operate. The new health centres system may have created gaps in the service, as not all of these have contracted the smoking cessation services. In addition, at other health centres, smoking cessation activities are perceived as time-consuming and may be discouraged. However, the introduction of a new computer system might have alleviated some of these problems.

Brief interventions and intensive smoking cessation support are an important and well-defined element of the current smoking cessation programmes, involving support from a physician, a nurse, a psychologist and a nutritionist. The programme consists of 4-6 consultations per year in a clinic, together with two telephone contacts. Carbon monoxide testing is routine, and patients are followed-up for between three months and one year.

The Portuguese quitline 'SOS Deixar de Fumar' started providing counselling services in April 2002. The quitline aims to provide information to all, advice and support to smokers wanting to quit, and people wanting to support others to quit.

Reimbursement for smoking cessation services
Smoking cessation services at primary and secondary care level within the National Health Service are fully reimbursed but there is a fee for private smoking cessation clinics.

There have been smoking cessation clinics in Portugal since the 1980s, but after the smoke-free legislation came into effect, smoking cessation clinics increased and have spread through the country, mostly at primary care health facilities. However, it is thought that essential financing in the form of a specific budget to support ongoing initiatives has not emerged and so although most professionals are willing to provide the services, there is a lack of organisation and financial support within the healthcare system. This is a major constraint, because people in low socio-economic classes cannot afford the costs of medication. More transparency is needed.

Pharmacotherapy to support smoking cessation is not currently reimbursed in Portugal, so medication has to be purchased by the patient. This is a major limiting factor to uptake, as half the population report a net monthly income of €900 or less, and the cost of nicotine patches is €150 for one month's supply, and non-nicotine medications are around €100 a month. To help with such finance problems, a new card programme has been introduced (Farácias Portuguesas) which allows smokers to pay for their medication monthly over twelve months.

Political influence
Although Portugal has ratified the Framework Convention on Tobacco Control (FCTC), there is a concern that politicians will not put the treaty into practice. For some, the impression is that signing the treaty was so that Portugal would not need to go ahead with full control of second-hand smoke exposure by implementing a partial ban, and that together with Spain, it will be a model for similar policies elsewhere.

Regarding Article 14 – although bans are in place at educational institutions, healthcare facilities (except psychiatric services), workplaces and sporting venues, little has been done regarding promoting the cessation of tobacco use, and breaches at the workplace are thought to be frequent.

08.16.4 GUIDELINES

In 2007, Portugal approved a national programme on smoking, and this has been fully adopted in the clinical setting.[911]

The Portuguese General Directorate of Health (Direcção-Geral da Saúde (DGS)) provides a national online portal with access to general information on all official health programmes.[912] Tobacco is regarded as one of the government's areas of intervention and there are a number of publications and guidelines relating to tobacco dependence and smoking cessation, including:

- Consumo de Tabaco – Estratégias de Prevenção e Controlo (Tobacco consumption: Strategies for Prevention and Control)[913]
- Guidelines on Smoking Cessation Treatment from the Evidence-based Medicine Centre of Lisbon University of Medicine (February 2008)[914]
- There is also the 'Programa-tipo de actuação em Cessação Tabágica', which reflects the US clinical guidelines.[915]

Professionals working in smoking cessation also use the US or other similar guidelines – these reflect the US Clinical Practice Guidelines of Fiore *et al*. (2008).[916]

However, there is some scepticism about whether these guidelines are used or followed and it was noted that there are no evaluation programmes – however, the guidelines are promoted, mainly by the government but also by the medical societies.

08.16.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Some physicians in the primary healthcare setting do not consider smoking to be a health issue but a lifestyle choice. The key barrier to improved management at this level relates to physicians who do not see it as their role to interfere in a patient's lifestyle choice. This also reflects the type of medical education received and the inability of some physicians to update their knowledge according to the current state of affairs, for the benefit of their patients and patients' families.

In the secondary care setting, Portuguese physicians do not really view dependence as a major risk factor for other diseases. For instance, for patients in a coronary unit who are smokers, they will be forced to be abstinent while they are in the coronary unit but most of the time, once they are discharged, they will not be provided with any additional help or advice to maintain abstinence.

Medical students
Limited training on tobacco and smoking cessation is available as part of medical student training, and in some schools, it is in the form of an optional, non-structured elective. It is thought that there is only one medical school in Portugal that has a skills programme with motivation interviewing for smoking cessation for medical students.

In addition, there are initiatives run by groups such as the pharmaceutical industry, but other than that, it is very limited.

Primary care
At the time the smoking legislation was passed, there was an attempt to provide training to health professionals within teams, but the impetus to do so is now very much reduced. Within each of the five health administration regions there are educational courses for doctors, nurses and psychologists provided by these regions. Also some educational programmes are provided at the primary care level by medical societies (e.g. the Portuguese Pulmonology Society or the Portuguese Association of Family Doctors) or with support from the pharmaceutical industry, on an irregular basis. However, these programmes are usually aimed at physicians.

Even for those patients at high-risk, educational programmes for healthcare professionals within the primary care and the hospital setting are limited.

Secondary care
Most hospitals that have a pulmonology clinic have consultations for smoking cessation for both in-patients and out-patients, as smoking cessation is an issue that such clinics must cover.

Pulmonology interns are obliged to cover smoking cessation in their training and the Portuguese Pulmonology Society has a goal to introduce training for these pulmonologists. This training will be introduced through the School of Pulmonology by the Portuguese Society of Pneumology on an e-learning basis.

General public
In general, there has been limited funding for tobacco control awareness or smoking prevention activities with the public. Furthermore, there is a lack of evaluation on the effectiveness of these initiatives over the years. Only the annual official reports of the Direcção-Geral da Saúde (DGS) are evaluated and subsequent reports are not independent. The DGS reports suggest that the implementation of smoke-free legislation in Portugal has been successful at reducing the smoking prevalence but an expert consulted for this EQUIPP report disagrees.

Portugal participates in the annual World No Tobacco Day, organising national and local conferences, and initiatives in schools, health centres and hospitals. Several non-governmental organisations (NGOs) also launch initiatives to mark this day. There is also a National COPD and no smoking day on 17 November.

There are leaflets and posters in clinics, and handouts distributed through healthcare professionals, including pharmacists, physicians, nurses and psychologists. This material is produced by the Ministry of Health. There are also initiatives developed by medical, nursing and other health professional students, usually supervised by tobacco control specialists.

There is no specific educational programme, but high-risk patients (those with underlying medical conditions, smoking more than 20 cigarettes per day and smoking their first cigarette within 20 minutes of waking) will have access to a physician and a team including nurses and a psychologist, based in a public health setting. They will receive more intensive counselling, but other than that, are not treated significantly differently from other smokers.

Portugal has a national smoking cessation website (www.parar.net). The country also has a national coalition, COPPT (Confederação Portuguesa de Prevenção do Tabagismo), which includes 17 private organisations representing medical, educational and environmental interests.

The Portuguese quitline 'SOS Deixar de Fumar', started providing counselling services in April 2002. The quitline aims to provide information to all, as well as advice and support to smokers wanting to quit and to people wanting to support others to quit. However, it should become multidisciplinary, as it is currently run only by psychologists.

08.16.6 RECOMMENDATIONS

Evaluation and enforcement of smoke-free legislation in all public places
The implementation of smoke-free legislation in Portugal has not been independently evaluated and unpublished research suggests that there are breaches of the regulation that can not be adequately controlled within the existing legislation.

Enforcement of the smoke-free legislation is supportive of the World Health Organization's (WHO's) MPOWER approach which includes protecting people from second-hand smoke.[917]

If this recommendation is implemented along with further education of the general public, it is thought that this will have the greatest effect on public health.

Increase tobacco prices
Tobacco taxation should be increased significantly, as the current taxation is too low and the tobacco industry reduces prices to accommodate tax increases, maintaining prices and making cigarettes affordable. A substantial part of the tax revenue should be used to support tobacco control activities and provide partial reimbursement for medications.

In periods of financial crisis, the public usually accepts price increases in non-essential goods and so now might be an opportune time to introduce a major tax increase to support smoke-free legislation and encourage people to quit. On the other hand, smokers claim they can not afford cigarettes, therefore providing reimbursed medication to assist them to quit will be important.

This initiative should be led by Portugal's Finance and Health ministries.

Reimbursement for smoking cessation treatments
Lack of reimbursement is thought to be a major barrier to smokers gaining access to smoking cessation treatments in Portugal, where the cost can be a considerable proportion of the smoker's monthly wages.

To achieve best practice in Portugal, there is a need for greater access to, and financial support for, smoking cessation medications so that treatment for tobacco dependence is available to everyone. Tobacco dependence is a disease and it should be treated as such with reimbursed medications.

It is thought that the clinical and health economic benefits for pharmacotherapy are well established, so there should be controlled access to reimbursed medication.

Funding for this recommendation should come from the budget of the Finance and Health ministries.

Involve primary care physicians more
General practitioners (GPs) should play a major role in systematically identifying patients and motivating them to change their smoking habits. Smoking cessation ought to be integrated into the daily practice of all healthcare professionals including GPs. To achieve this, a patient's smoking habits should be recorded and brief interventions should be offered at every visit to a GP. Separate appointments must be provided to treat and follow-up on the patient's progress with smoking cessation. GPs should receive an extra payment when they work with difficult, highly addicted patients.

The Ministry of Health and the professional societies should support this initiative.

Provide more specialist smoking cessation services in primary and secondary care
The Clinical Practice Guidelines provide for highly addicted smokers to have access to professional smoking cessation support from physicians, nurses and psychologists as appropriate.

Therefore, once a smoker has expressed a wish to quit, they should be referred to a specialised smoking cessation service where a number of different healthcare professionals can provide this support. These healthcare professionals should be able to focus exclusively on smoking cessation.

Both professional societies and the Ministry of Health should support this initiative.

Implementation and monitoring of national guidelines
The government/Ministry of Health has the responsibility to develop and implement guidelines. Rather than having new guidelines, it would be better to implement the current ones effectively, to monitor and document progress, and to provide support for smoking cessation programmes and medication. Portugal has established a very practical approach to smoking cessation, but the recording, monitoring and analysis of results is still inadequate since there is no programme of evaluation.

Provide more educational programmes for all healthcare professionals
Medical student education on tobacco dependence is limited and optional in Portugal. Limited education for primary care physicians, nurses and psychologists is provided by the regional health administrations and there are some educational programmes at the primary care level provided by the medical societies. Secondary care physicians who undertake tobacco dependence are mainly pulmonary interns.

When the smoke-free legislation was implemented, more training was provided to health professionals in teams but there is now a need to put increased emphasis on the provision of these educational programmes. Physicians and other healthcare professionals such as nurses, psychologists, dieticians etc. require further education on smoking and smoking cessation and the provision of an integrated service to smokers.

The pre and postgraduate education on prevention and treatment of tobacco dependence should be the task of the boards of the medical schools and the scientific societies.

Educate the general public
Portuguese legislation is clear that second-hand smoke should be controlled. It is important that tobacco control be considered as a societal problem and not just a medical problem. Therefore, public health education through media, health services and schools should be integrated into the communities. Community leaders should be fully involved and promote participation.

A consistent and targeted education campaign is required with messages tailored to specific groups such as children, young adults, and pregnant women. For children and young adults, the goal should be to try to prevent them from taking up smoking, as well as eliminating exposure to second-hand smoke.

To change the social 'norm' is a complex task. WHO has developed its MPOWER[918] approach that clearly emphasises its six strategies:

- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans (advertising, promotion, and sponsorship)
- Raise taxes.

This integrated strategy should be supported by the government as a whole, the Ministry of Health, the professional societies, the community and its organisations. This recommendation is considered a key recommendation for Portugal.

SPAIN

Introduction

The following information on the tobacco control and smoking cessation services in Spain has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Spain.

08.17.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

According to the latest National Health Survey (Encuesta Nacional de Salud 2006), 26.4% of the Spanish population smoke daily (31.6% of males and 21.5% of females), with a further 3.1% (3.8% of males and 2.4% of females) smoking occasionally.[919]

A more recent Eurobarometer Survey of Smoking across the European Union (EU) conducted in October 2009 reports that 35% of Spanish respondents smoke with around 23% having tried to quit smoking within the past year.[920]

In terms of age groups, 25% of men aged between 16 and 24 years old, 29% of the women of the same age group smoke daily.[921]

Tobacco smoking caused 16.15% (58,573) of all deaths in 2006 in Spain, with 45,028 in men and 13,545 in women.[922]

In 2008, the Spanish state was estimated to have lost €5,444 million due to tobacco[923] and expansion of smoke-free policy could save this amount.

The direct healthcare cost for the five main illnesses associated with the consumption of tobacco (chronic obstructive pulmonary disease (COPD), asthma, lung cancer, heart disease and cerebrovascular disease) reportedly amounted to €6,870 million. Additionally, the indirect cost to Spanish companies was estimated at around €7,840 million. Of this amount, 76% is attributed to lost productivity, 20% to additional costs in cleaning and the maintenance of facilities, with the remainder due to absenteeism.[924] The total direct and indirect costs attributable to smoking in 2008 were estimated at €14,710 million whereas the tax revenues were only €9,266 million. However, since the main costs of smoking are indirect, these figures should be used with caution.

The National Committee for the Prevention of Smoking (Comité Nacional para la Prevención del Tabaquismo (CNPT)) represents more than 40 scientific societies and professional associations in the health sector in Spain, and claims that there are at least 29 different health problems associated with smoking, headed by heart disease and lung illnesses.[925]

Smoking prevalence targets
Spain has a decentralised health service with 17 different regional health services. Each of these regional health services is responsible for tobacco prevention and tobacco dependence treatment. Therefore to date there have been no national goals established, although during 2010 there have been more agreements between the different regional health services regarding tobacco dependence.

Whilst the national government might choose to make any treatment or service compulsory, the regional governments might demand a renegotiation of their yearly budget to have sufficient budget to pay for this service.

Each of the regional health services provides different tobacco services (such as prevention programmes and programmes for the treatment of tobacco use and dependence) and some regions have specific targets to reduce the prevalence by 1-2%.

The current target population and the main concern for CNPT are teenagers in high school, young students and, specifically, women aged 16-24, who have a prevalence of more than 29%.[926]

08.17.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
Smoking legislation in Spain came into effect on 1 January 2006[927] and it has been suggested that in order to achieve a majority vote, concessions were made, and thus the so-called 'Spanish model' was created.

08.17.1

Smoking prevalence in Spain (2010)
35% = smokers [920]

All offices, shops, schools, hospitals, cultural centres and public transport were smoke-free. However, the owners of bars, restaurants and other recreational places that were less than 100m^2 in surface area were able to choose whether they were smoke-free or not. This was one of the major flaws of the Spanish smoke-free legislation. The law was approved at a national level, but implementation had to be carried out by the regional governments. A lack of consultation with the regional governments responsible for implementing the law had a negative effect. In addition, political allegiances within some regional governments make them less willing to collaborate on national government policies.

The Spanish Society of Pneumology and Thoracic Surgery (SEPAR) conducted a survey among a representative sample of the Spanish general population, both before and after the implementation of the 'Spanish model'. SEPAR's main findings were that in those places where smoking had been completely banned (e.g. workplaces and educational establishments) the overall reduction of exposure to second-hand smoke was high (more than 50%). In those places where smoking had not been completely forbidden (e.g. at home and in recreational places) the reduction was low, only 8% to 27%.[928]

The Catalan Institute of Oncology studied the impact of the 'Spanish model' on those working in bars and restaurants. In these places, 5% of staff had stopped smoking, and the number of cigarettes smoked by those who still smoked had fallen by almost 9%.[929] One of the authors argued that changing the partial restrictions on tobacco consumption in bars and restaurants, for a total smoke-free policy would have beneficial effects on the health of all the workers in this sector.[930]

On 20 October 2010, a new law was approved by the Low Chamber (Congress) and it came into effect on 2 January 2011. The new law does not allow smoking in any closed public space, except in psychiatric and geriatric residences and in prisons, where isolated smoking rooms are permitted. Smoking is allowed on terraces, defined as rooms with no more than three walls (including the ceiling). Smoking is forbidden in any open health and educational premises and in children's parks. Smoking is permitted in 30% of hotel rooms and private smokers' clubs are permitted as well. According to survey results, 84% of the population was in favour of increasing health measures to control the consumption of tobacco in public places, when questioned in 2005.[931]

Despite this, further restrictions face tough opposition from some organisations such as Spain's Hotel and Catering Federation, which claims that implementation of full, smoke-free legislation would badly damage the hospitality and tourism industry.[932] There were therefore some fears that the hospitality and tourism industries could apply pressure to dilute the law, making restrictions less severe and implementation harder.
However, the interviewees believe that studies on the economic impact of introducing smoke-free environments in various countries have not revealed negative consequence for the hospitality sector[933] and, if there is an effect, it is a positive one.[934]

Legislation on tobacco advertising, promotion and sponsorship
Tobacco advertising, promotion and sponsorship have been banned in Spain on television, cable television and radio since 1994, and in magazines and newspapers, on billboards, at the point of sale, and in the cinema since 2006.[935] However, these restrictions do not apply in the Canary Islands.

There is no legislation to ban indirect tobacco advertising and there are problems regarding new forms of promotion, such as product placement in television programmes that are still unresolved.

Challenges to legislation and enforcement
The previous Minister of Health stated that the unanimous support of the new smoke-free law showed political, parliamentary and social maturity, and said the climate was very favourable to go even further and be more ambitious to reach an important public health goal.[936]

However, when the 'Spanish model' or the 'Tobacco Industry model' was originally approved, it was not anticipated that the tobacco industry and other countries (in the European Union and Latin America) would propose using similar legislation for relatively smoke-free environments (rather than completely smoke-free environments).[937,938]

The Spanish government has traditionally focused on smoke-free legislation in public places and enforcing legal restrictions. However, there has been some concern that the government is not providing smoking cessation support services or educating health professionals on smoking cessation as required to facilitate their smoke-free legislation.

08.17.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

In theory, every Spaniard who wants to quit can go to his or her primary physician and ask for a smoking cessation service regardless of the region they live in. Treatments for tobacco dependence are mainly carried out by primary care physicians all over the different regional health services. However, the interventions provided differ greatly in quality between and within regions.

Specialised tobacco units provide smoking cessation services, particularly at the secondary care level. Within each region, a network of these units exists. These specialist smoking cessation units offer a combination of pharmacological and psychological treatments, individually or as a group, and also by using telephone calls. Unlike primary care smoking cessation services, specialist smoking cessation is delivered by physicians, nurses and psychologists. In June 2010, SEPAR suggested guidelines for the accreditation of the specialised tobacco units.

In a survey conducted recently, it was stated that 60-70% of healthcare professionals always ask patients if they smoke. Those healthcare professionals who ask patients will also offer advice, but most will just advise people to quit without telling them how to quit. Most General Practitioners (GPs) will refer the patient, rather than treat the patient. If GPs offer brief interventions they will include pharmacotherapy and counselling and they will follow up patients after three to six months, either by telephone or at the next visit.

The likelihood of referral for smoking cessation services is greater if the patient is at a higher risk of smoking-related diseases and requires more intensive action.

The Spanish Red Cross and the Spanish Cancer Association give counselling and advice to patients referred to them, but they do not provide free pharmacological treatment.

Reimbursement for smoking cessation services
Assistance from a physician to help with quitting smoking is in theory available to all patients (including primary care and specialised tobacco units) at no cost.

Although most medications are reimbursed at the national level in Spain, smoking cessation medications will not generally be reimbursed. However, Spain's decentralised healthcare system is very variable, funding and reimbursement differs across the regions. For instance, the regional Health Services of Navarra and of La Rioja and the local one of Ceuta, will reimburse smoking cessation treatments but overall they cover just 2% of the Spanish population.

There have been some pilot programmes covering nearly two-thirds of Spain, which provide totally free treatment for either role-model professionals (e.g. those working within the healthcare or education system and civil servants) or for patients who suffer from smoking-related conditions.

For instance, in the region of Madrid, smokers with smoking-related disorders have access to free smoking cessation medications. According to the results of a study that was conducted in a specialised tobacco unit in Madrid, the cost of medication for each smoker attending the clinic was €125, and the cost of medication for each smoker who was successful in quitting was €241.[939]

Political influence
The Spanish government organises a network of those involved in tobacco control and those from expert groups (e.g. scientific societies, regional health services, and non-governmental organisations) to take action against smoking, with the aim of preventing young people from starting to smoke and helping people to quit smoking. The network is called the Tobacco Prevention Observatory[940] and several meetings were held during 2010. The Observatory's objective is to comply with the Framework Convention on Tobacco Control (FCTC) by 2012, but this is a difficult process.

In June 2010, the European Public Health Alliance (EPHA) sent an open letter to the Spanish Minister of Health, supporting the proposed reform of the Spanish tobacco legislation.[941] The letter warned that it was crucial that new legislation was supported by complementary measures such as pictorial warnings on tobacco packages. These warnings are being introduced in Spain and were highlighted for praise by the EPHA. However, the EPHA suggest that a targeted media campaign to raise awareness of the new measures be implemented as such campaigns have proven effective in other member states.

08.17.4 GUIDELINES

Several professional societies have developed guidelines concerning smoking cessation. The CNPT presented guidelines in 2008,[942] resulting from a task force which worked for over a year with representatives of various health professional societies. Whilst the guidelines are evidence-based and have a good scientific background, they are still only suggested guidelines and are not enforced. As these guidelines have not been updated since they were first prepared they now require updating. Also, the guidelines were published in a medical society journal and so not all healthcare professionals will have had access to them.

Since 1999, SEPAR has created a number of different sets of guidelines. Three of these sets of guidelines were focused on smoking cessation interventions, and the most recent was written in 2008.[943,944,945] The latest guidelines included a proposal for the reimbursement of pharmacological treatments for smoking cessation.

SEPAR also played a leading role in writing and approving a consensus document on smoking cessation treatments with different Spanish scientific societies.[946]

Overall, the different guidelines contain recommendations but they lack evidence-based methodology and would benefit from being simpler and clearer. There is a tendency for each regional service or scientific society to produce their own guidelines. In the past, this was sometimes achieved by copying from the previous version of the guideline and in some instances this lead to the perpetuation of misconceptions and inaccuracies. However, this situation seems to have improved recently.

08.17.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Primary care physicians usually focus on cardiovascular and cancer risk factors, but they are not immune to the 'social denial' of the smoking problem and they usually consider themselves unsure of how to confidently handle patients who smoke.

Some Spanish physicians, whilst more comfortable when prescribing medicines, can feel uncomfortable trying to change their patient's lifestyle or behaviour. This could be improved if they are able to receive training and education on tobacco cessation treatment.

Medical students
There is no national curriculum on tobacco dependence and even modification of disease risk factors is not usually included in the national curriculum. Some medical schools (e.g. the University of Zaragoza, the University of Extremadura in Badajoz, and the University of Cantabria in Santander) have brief training courses on tobacco use and tobacco-dependence treatment which are sometimes included in a broader programme on tobacco dependence.

Each university is responsible for the content of its courses. It is thought that there is minimal course content on smoking cessation although optional credits are available for training on smoking cessation methods as part of a course on drug dependence.

Primary care
Primary care physicians sometimes have a little training on smoking cessation during their four-year foundation course. In addition, most regional governments and different scientific societies, especially those related to primary care offer training

courses. These include the Spanish Society of Family and Community Medicine (SEMFYC), the Spanish Society of Primary Care Doctors (SEMERGEN), the Spanish Society of Pulmonology and Thoracic Surgery (SEPAR), the Spanish Anti-Cancer Association (AECC), and the Spanish Society of Specialists in Smoking Cessation (SEDET).

The Spanish Respiratory Society offer annual training courses for all healthcare professionals.

There is some support from the regional government bodies to fund and organise such workshops.

Secondary care
SEPAR and some other societies also offer annual training courses for all healthcare professionals in secondary healthcare. However, secondary care physicians not directly involved in pulmonary or cardiology disciplines will usually need to refer patients, since they do not feel properly trained for cessation programmes, or even for a basic approach to patients who smoke.

Funding of hospital-based smoking cessation educational programmes is provided in some regions but not all. For physicians in secondary care in Cataluña, specialised training is organised by the Health Department, and sometimes delivered by Scientific Societies or Professional Colleges who have educational programmes on smoking cessation.

A postgraduate masters degree in tobacco dependence has been set up which is available to those professionals willing to specialise in this field.

General public
There are few national programmes specifically targeted at the general public although some autonomous regions have quitlines, offering advice and information.In Cataluña, a quitline, educational programmes and public health campaigns, leaflets and periodical programmes are used. 'Quit and win' was a programme developed to try to stimulate the general public's cessation. Competitions are used at a local level, but there is nothing general throughout the country.

A 2009 cost-benefit analysis of a school-based smoking prevention programme in Barcelona concluded that, from a societal perspective, the benefits of school-based tobacco prevention programmes, in terms of healthcare costs and productivity losses avoided, are far greater than the costs of such programmes. These results support universal application of this type of intervention.[947]

08.17.6 RECOMMENDATIONS

Increase tobacco prices
Spain is one of the lower-priced countries in Europe for tobacco products (below the average price of 27 European Union countries).[948] An increase in the price of tobacco products should be implemented by the Spanish government to support the smoke-free legislation, stop teenagers taking up smoking, and to encourage people to quit.

According to the Spanish experts, when the last increase in tobacco tax (around 5%), was applied, most tobacco companies increased their sale prices by around 10%. Despite this, the Finance Ministry has previously refused to apply large tax increases, although they claim they would like to keep tax increases above inflation.

Were this recommendation to be properly implemented, the responsibility would lie with the Spanish government. It is thought this is one of the most achievable recommendations in the short term, and will have the most impact.

03.17.6

Comparative tobacco prices
Spain is one of the lower-priced countries in Europe for tobacco products.[948]

*Average price across 27 countries in the European Union

Increase reimbursement for smoking cessation treatments

Different Spanish governments have tried to implement tobacco control policies to follow the recommendation of the WHO's FCTC and Tobacco Free Initiative. There are some stakeholders that really understand tobacco control policies and some that work in the tobacco field who consider that more attention should be paid to the "Offer help to quit tobacco use" policy which is one of the six key policies of the WHO's MPOWER project.[949]

The professional societies in Spain need to have a clear position on smoking cessation reimbursement to ensure their arguments are heard and to work towards the goal of full reimbursement of evidence-based pharmacological treatment and drugs. The general population, the medical societies, and associations of smokers with smoking-related disorders can have a strong influence on the implementation of this recommendation. The goal of full reimbursement for evidence-based pharmacological treatment and drugs needs to be agreed by the central government and the autonomous regional authorities.

The central and regional authorities will need to pay for the time that healthcare professionals dedicate to smoking cessation and to pay for smoking cessation treatments. However, if they do this, then they will not need to pay as much for treatments for smoking-related diseases. It is important that those managing healthcare provisions understand that tobacco dependence is a disease and that cost-effective treatments are available for patients who have a right to be treated for their high-risk condition.

This recommendation will help people to make serious attempts to stop smoking, giving more smokers the chance to successfully quit smoking with appropriate support. It is thought that this is an achievable recommendation in the short term and reimbursement should be implemented by the Spanish government.

Improve the treatment of hospitalised patients who smoke and have a smoking-related disease

There are a few existing protocols for treating hospitalised patients who smoke and these should be improved and extended. This will help some smokers quit and it will help some others to make a serious quit attempt after they leave hospital.

Within each of the different Spanish regions, such set protocols for treating tobacco-dependent hospitalised patients, particularly those with smoking-related diseases, should be put in place. These patients should be provided with advice and counselling and any necessary medications whilst they are in hospital. Since 2008, these patients are followed up by the network of smoke-free hospitals but this is only after the patient is discharged and this is a needless delay.

The general population, the medical societies, and associations of smokers with smoking-related disorders can have a strong influence on the implementation of this recommendation. If this recommendation is implemented many hospitalised smokers will quit. This is thought to be an achievable recommendation in the short-term and it needs to be implemented by the regional and local governments.

Involve primary care physicians more

All healthcare professionals in primary care can be influential in bringing about change. Therefore, these professionals should be focused on smoking cessation. When appropriately trained, they should record whether or not their patients smoke, provide brief interventions and, depending on the characteristics of their setting, provide more intensive interventions.

This might include offering pharmacological and psychological support where appropriate, together with follow-up for at least six months. In addition, criteria should be established for referring smokers to specialists.

The general population and the medical societies can have a strong influence on the implementation of these recommendations. These recommendations should be implemented by the regional health governments and there will need to be collaboration between the medical societies and the local and regional administrations.

Implementation of national guidelines
National clinical evidence-based guidelines that illustrate a clear and well-developed structure of patient management, will be key to achieving best practice and helping people to quit. Ideally, these guidelines should be endorsed by the Ministry of Health, together with the regional health governments, not just the medical association(s) that develop them.

The writing and implementation of national guidelines, implemented by the medical societies, may help to provide a more homogenous approach to smoking cessation, which currently is highly dependent on the individual primary care physician.

If this recommendation is implemented, most smokers will receive the right intervention and it will increase the possibility of them successfully giving up smoking. Implementation of this recommendation will require the CNPT to collaborate with the Ministry of Health.

Provide compulsory educational programmes for all healthcare professionals
Healthcare professionals should be trained in counselling tobacco users and in tobacco dependence treatments so that they can offer more than just palliation of withdrawal or pill dispensing.

Compulsory education, training and evaluation on smoking cessation skills for healthcare professionals, provided either by the national or the regional health systems, is recommended. In particular, every medical student should receive good quality training of at least 5-10 hours on tobacco and smoking cessation. This should provide both the knowledge and the skills needed to treat people and to help them quit.

Although this recommendation should be endorsed by the Spanish government, it should be implemented by the body that regulates the curricula of the medical schools. The medical societies and the heads of the different universities will have a strong influence on the implementation of this recommendation.

This is one of the recommendations that will have a great effect, as implementation will allow more health professionals to increase their knowledge and skills and therefore their ability to help their patients to quit.

SWEDEN

Introduction

The following information on the tobacco control and smoking cessation services in Sweden has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Sweden.

08.18.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The prevalence of daily smoking in Sweden is one of the lowest in Europe with 14.4% (aged 18 to 80) recorded as daily smokers in 2006-2008.[950] More recently, the Eurobarometer 2009 Survey on Tobacco reported on fieldwork conducted in 2008 with around 1,000 respondents and found the prevalence of daily smoking to be 18% with 7% smoking occasionally.[951]

The 1993-1994 Tobacco Act, and the 2005 ban on smoking in the hospitality sector is thought to be attributable to the decrease in smoking from the 1995 levels (22% of men and 24% of women).[952]

Daily smoking among men is lower than in other European countries, but due to the high consumption of smokeless tobacco (snus),[953] total nicotine consumption in Sweden is still high. This use of alternative forms of tobacco in Sweden means that it may be more appropriate to talk of tobacco cessation rather than smoking cessation.

The total (direct and indirect) costs of smoking in Sweden are $804 million,[954] and about 7,000 people die each year as a result of smoking-related illnesses.[955] Additionally, smoking has been shown to increase sick leave in Sweden.[956]

Smokers are costing Swedish municipalities 2.6 billion kronor ($367 million) per annum in the form of breaks and sickness absences, as reported by the Swedish Public Health Institute (Statens Folkhälsoinstitut).[957] According to the World Health Organization Statistics Information Services (WHOSIS) database in 2002, the cost–effectiveness (in US dollars per disability-adjusted life-year (DALY)) of tobacco cessation interventions (a combination of a tax increase up to 89% of the final retail price, clean indoor air law enforcement, a comprehensive advertising ban, information dissemination, and nicotine replacement therapy (NRT)) could be $274 per DALY in Sweden.[958]

In a smoking cessation study in Sweden, cost-effectiveness analyses estimated health gains and considerable cost savings,

08.18.1

Smoking prevalence in Sweden (2009)
18% = daily smoking (2009)[951]

which can be extrapolated to show that tobacco control programmes in this country would result in overall cost savings.[959]

Smoking prevalence targets
According to the Swedish National Institute of Public Health, the target of the Riksdag (parliament) and government is to reduce smoking. There are government-set tobacco prevention goals for 2014 so that no one will be subjected to tobacco smoke against their will.[960]

There are four national targets set up in the national healthcare plan to decrease the use of tobacco in Sweden by 2014:[961]

- All newborns should be welcomed into a tobacco-free environment
- The number of children and young adults that start tobacco use should be halved
- The number of smokers in the social groups that are most affected by smoking should be halved
- No one should be exposed to second-hand smoke against their will.

08.18.2 LEGISLATION ON SMOKING

Sweden signed the Framework Convention on Tobacco Control (FCTC) on 16 June 2003 and ratified on 7 July 2005.[962]

Smoke-free legislation and policy
The Swedish Tobacco Act was enacted in 1993 and 1994. Smoking has been prohibited by law in businesses selling food and drinks, including restaurants, bars and nightclubs[963] since June 2005.

There are also smoke-free policies in healthcare facilities, education facilities, government facilities, indoor workplaces and offices, theatres and cinemas, and restaurants, pubs and bars. However, smoking may be allowed in separate designated smoking rooms in restaurants and bars that serve food and these rooms must only take up a small proportion of the premises. Food cannot be served in or taken into these areas.[964,965]

Smoking is prohibited on buses, trains, taxis, domestic and international air transport and domestic water transport in Sweden. International water transport is voluntarily smoke-free.[966]

Legislation on tobacco advertising, promotion and sponsorship
The minimum age limit for buying cigarettes and other tobacco products in Sweden is 18 and vending machines are restricted to prevent underage purchases.[967,968] The sale of snus is allowed in Sweden but is legislated against elsewhere in the European Union.[969]

Direct tobacco advertising is banned in Sweden on television, radio, in local magazines and newspapers, but is allowed in international magazines and newspapers and at point of sale (only information on type and price is allowed). Restricted (non-invasive) advertising is allowed on billboards, and restricted advertising is allowed at the cinema.[970] Indirect tobacco advertising in the form of product placement in film and television, sponsored events, promotional discounts, and using tobacco brand names for

non-tobacco products and non-tobacco product brand names for tobacco products is restricted in Sweden. Direct mail giveaways are banned.[971]

Challenges to legislation and enforcement
The current economic climate means that funding for tobacco cessation services, which is already unpredictable, may become very tight.

08.18.3 TOBACCO CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Three out of four adult smokers in Sweden want to quit, and many of these would like professional help and support.[972] Between 56% and 73% of primary care units provide help to tobacco users who want to quit but there is a large variation in the intensity between different county councils.[973] Some physicians will offer such patients brief interventions, but it is thought that there is little follow-up with the patient. At the primary care level, due to lack of resources, regions differ in the amount of money they allocate for tobacco cessation and this can be insufficient for the needs of the local population.

It is thought that due to the different local governing bodies in Sweden, specialist tobacco cessation services are currently variable. Most hospitals will try to identify and help high-risk patients to quit smoking. However, a study in 2009 showed that less than half of Swedish hospitals provide help for secondary care patients to quit and there are only about five clinics producing research on these services.[974]

A toll-free national quitline is scientifically evaluated and reports outcome data to the National Institute of Public Health.[975] The Karolinska Institute in particular, tries to promote the quitline so that primary care physicians will know where to refer their patients if they need additional help.

Reimbursement for tobacco cessation services
In Sweden, the quitlines are free, and clinic attendance is either free or low-cost.

The current standard medication for tobacco cessation in Sweden is NRT and this is not reimbursed but it is available over the counter and can be bought in pharmacies, some grocery stores and petrol stations. Prescription products such as bupropion and varenicline are reimbursed as second-line medications.[976] There are regional differences, but this might change now that the National Board of Health and Welfare's guidelines have been published.

Political influence
The county councils hold the budget for primary care in Sweden and each of these councils individually decides where to focus their budget.

Recently, market-oriented, demand-driven healthcare reforms were introduced in Sweden, providing patients with a free choice of healthcare provider. Although patients may not utilise their choice, in theory at least, the existence of patient choice may stimulate healthcare providers to improve the quality of their care. However, the concern with these reforms is that the public funds follow the patient. For instance, in Stockholm, the capitation part of the new primary care reimbursement system takes into account age but disregards socio-economic factors with physicians being paid for the number of visits.[977] Under the new system, extra resources have been withdrawn from primary care in disadvantaged areas.[978] The concern is that it is these disadvantaged areas that have the highest proportion of smokers who need access to support to help them to quit smoking.

08.18.4 GUIDELINES AND HEALTH TECHNOLOGY ASSESSMENTS

The Swedish Council on Health Technology Assessment (SBU) produced a government approved, and peer-reviewed technical assessment report in 1998.[979]

Guidelines have now been drafted and these were issued by the National Board of Health and Welfare in October 2010.[980] The guidelines will provide national support for the governance and management of healthcare.

The guidelines have been developed in conjunction with experts in the field and other relevant non-governmental organisations. The goal of the guidelines is to help ensure that healthcare resources are used effectively and that healthcare resources are distributed according to need and guided by systematic and transparent prioritisation decisions. Work on the guidelines focused on the major diseases and on issues where the need for policy makers and healthcare professionals to have guidance was seen as particularly large. Ultimately, the aim is to promote good healthcare for patients.

The guidelines include recommendations for prioritisation of healthcare support at all levels of healthcare (e.g. primary care and secondary care).

08.18.5 EDUCATION

In Sweden, treatment of tobacco dependence is part of the national health programme and its primary healthcare programme.[981]

Medical students
Education of medical students is on a university-by-university basis. The Karolinska Institute, for example, provides about eight hours of training.

Primary care physicians and nurses
The ENSH's (European Network of Smoke-Free Hospitals) tobacco cessation training courses are available in Sweden. The training is usually carried out by tobacco prevention units and not linked to hospitals, and most people who attend are non-hospital-based workers. The courses include brief intervention training (general and mental health and drug abuse), tobacco cessation training (general) and and provide participants with training so that they may train others.[982] It is thought that interest in such training has increased over the last few years and that ten or twelve institutions across Sweden deliver such courses.

Although the courses for primary care physicians are open for all to attend, it was reported by a Swedish expert that they mainly attract nurses, with perhaps only one physician to every 25 or so nurses.

General public
There is some education for secondary care patients but it varies from hospital to hospital. Some specialities are showing increasing interest, such as those from orthopaedic and rheumatology clinics.

The World Health Organization (WHO) claims that age- and gender-based promotional and educational programmes aimed at encouraging cessation of tobacco use are in place in Sweden,[983] but others believe that there have been few educational programmes for the general public since the 1990s.

Sweden has a number of national tobacco cessation websites:
- www.cancerfonden.se
- www.nonsmoking.se/www/index.asp
- www.ragnarok-sweden.nu
- www.slutarokalinjen.org
- www.somt.se
- www.tobaksfakta.org

08.18.6 HCPs' ATTITUDES TOWARDS SMOKING AND TOBACCO CESSATION

Primary care physicians
In a study of General Practitioners (GPs) in Nordic countries, 39% of GPs in Sweden will ask all patients if they smoke, and 92% will ask those patients with smoking-related symptoms about their smoking status.

The top four stated barriers to this are:[984]

- Discussions are too time-consuming (53%)
- Lack of knowledge on the subject (23%)
- Perception that peoples' smoking habits are not part of their job (14%)
- Uncomfortable asking people about their smoking behaviour (15%).

In the same study, 76% of GPs in Sweden who know that a patient smokes will inform them about the health benefits of giving up.[985]

Secondary care physicians
At the secondary care level, there is increasing interest in tobacco cessation within various specialities. For instance, it is thought that surgeons are still interested in making sure that their patients are smoke-free by the time of their operation.

08.18.7 RECOMMENDATIONS

Continue to tighten existing legislation and introduce new legislation
With the help of politicians it should be possible to improve and tighten legislation, for instance there is a need for legislation to ensure that photographic warnings are printed on cigarette packs. Legislation to ensure that tobacco products are not visible and therefore 'advertised' as they are being sold in shops needs to be implemented, e.g. under-the-counter sales should be mandatory. Consideration needs to be given to new products such as hookahs (tobacco water pipes) so that appropriate legislation can be implemented.

The non-government organisations have recently appointed a full-time lobbyist to help advocate with politicians to achieve this recommendation.

Involve primary care physicians more
Primary care physicians should be more involved so that smokers are identified at the primary care level. Primary care physicians are then in the position to provide smokers with the best advice, the appropriate counselling if the patient wants support, and additional pharmaceutical therapy as required.

Guidelines have now been drafted and these were issued by the National Board of Health and Welfare in October 2010.[986] These guidelines will provide national support for the governance and management of healthcare and it is thought that they will draw attention to the tobacco cessation field and evoke interest among physicians, administrators, and politicians.

The guidelines have been developed in conjunction with experts in the field and other relevant non-governmental organisations. The goal of the guidelines is to help ensure that healthcare resources are used effectively and that healthcare resources are distributed according to need and guided by systematic and transparent prioritisation decisions. Work on the guidelines focused on the major diseases and on issues where the need for policy makers and healthcare professionals to have guidance was seen as particularly large. Ultimately the aim is to promote good healthcare for patients.

The guidelines include recommendations for prioritisation of healthcare support at all levels of healthcare (e.g. primary care, secondary care). However, consideration must be given to the different incentive compensation models being used by the different county councils which will affect access to healthcare services.

The recommendation of increasing the involvement of primary care physicians is seen as particularly important in Sweden.

Emphasise national specialist tobacco cessation services
Although there are some specialist tobacco cessation services in Sweden, these are thought to be insufficient and lack a national structure. It is thought that a national structure should provide additional drive to the tobacco cessation services.

Currently there is a concern that the ability of patients to decide on their own healthcare providers and different compensation models across the county councils mean that there may be inequalities in the Swedish healthcare system.[987] This recommendation may help to standardise the approach of the county councils and prevent the health inequalities from worsening.

It would be the responsibility of each of the county councils to agree and arrange the implementation of such a national structure. The National Institute of Public Health could offer support to the county councils on the implementation of this recommendation. They could also advise on the importance of tobacco cessation and appropriate programmes to address tobacco cessation.

Provide sufficient funds for tobacco cessation services
It was thought that when compared with other countries that get the best results from their tobacco cessation programmes, Sweden does not provide sufficient budget for tobacco cessation programmes. The Swedish national healthcare budget for 2011 is imprecise and hard to interpret and although there is talk of future initiatives, there are no promises.

There is a need to increase the funding for tobacco cessation services.

Decisions on the allocation of resources for tobacco cessation are made by the county councils who will decide how the healthcare budget is distributed. Therefore, it is these budget holders who must be provided with the existing evidence that demonstrates that tobacco cessation services are cost-effective in the long term.

Education of primary care physicians
Now that the smoking prevalence has been significantly reduced, some primary care physicians feel that smoking is under control and they therefore do not see smoking as a significant problem. Instead, they focus on drug or alcohol dependence because they see that as having a wider social impact.

Therefore, there is a need to continue the education of primary care physicians so they understand the value of the services they can provide to their smoking patients. Such educational programmes should be provided nationally so that the standard is the same across Sweden.

It is the responsibility of the county councils to encourage healthcare providers to take part in tobacco cessation training. The county councils could consider linking a requirement for physicians to be appropriately educated with their incentive scheme.

Ensure that the general public is aware of the help and support available to them
It should be common knowledge that there is help available for all smokers if they want to quit. The general public must know that they can get help by using the quitline or at primary care units across the country.

The National Institute of Public Health is responsible for the provision of education to the general public and they could ensure that tobacco cessation is incorporated into their public health campaigns.

SWITZERLAND

Introduction

The following information on the tobacco control and smoking cessation services in Switzerland has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in Switzerland.

08.19.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The World Heath Organization (WHO) database records 20% of the adult population of Switzerland as regular smokers in 2007.[988] According to the Federal Office of Public Health, 29% of the resident Swiss population aged between 14 and 65 are smokers, with 20% of them smoking every day and 9% occasionally as recorded in 2007.[989] The proportion of smokers among men is 33% and among women is 24%.[990] By 2008, the overall smoking prevalence (daily and occasional) had fallen to 27%.[991]

Tobacco consumption causes an estimated 12% of premature deaths in Europe.[992] Every year, around 8,300 people die in Switzerland as a consequence of tobacco consumption. In addition, around 16,000 of the registered cases of invalidity in Switzerland can be attributed to smoking.[993]

The consumption of tobacco costs the Swiss economy around 10 billion francs per year as reported in 2008. 1.2 billion of this is spent on medical treatment, with 3.8 billion resulting from lost working hours, disability costs etc. 5 billion can be attributed to loss of quality of life. In contrast, income from tobacco tax used to finance old age and survivors' insurance amounts to slightly over 2 billion francs per year.[994]

The General Practitioners and the Economics of Smoking Cessation (PESCE) project estimated that a reduction of 3% in the prevalence of smoking in a country like Switzerland would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke and chronic obstructive pulmonary disease (COPD) of €1.6 million by 2020 and €2.2 million by 2030.[995]

Smoking prevalence targets

Switzerland has a National Tobacco Programme (2008-2012)[996] with a mission to reduce the level of tobacco-related death and disease. The following overall objectives have been set to be achieved by the end of 2012:

- The proportion of smokers in the population of Switzerland is to be decreased to 23% from 29% (in 2007)

- The proportion of smokers in the age group 14-19 is to be decreased to below 20% from 24% (in 2007)
- The proportion of people who are exposed to seven hours a week or more of exhaled tobacco smoke (passive smoking) is to be reduced by 80%, from 27% (2006) to around 5%.

The following organisations are responsible for the implementation of the National Tobacco Programme:
- The Federal Office of Public Health
- The Federal Commission for Tobacco Control
- The Swiss Conference of the Cantonal Ministers of Public Health
- A representative of non-governmental organisations (NGOs) active in tobacco control.

08.19.2 LEGISLATION ON SMOKING

Smoke-free legislation and policy
The Federal Labour Law was imposed in 1993 and this imposed partial restrictions on smoking in government facilities and indoor workplaces and offices. Since then, voluntary agreements in some cantons (regions) have provided some smoke-free healthcare and educational facilities, restaurants, bars, pubs, theatres and cinemas.[997]

Public pressure within Switzerland, from neighbouring EU countries and from international organisations such as the WHO, helped persuade the Swiss government to introduce tougher nationwide smoke-free legislation.[998]

Thus, tougher, binding national smoke-free legislation aimed at protecting the public against second-hand smoke were introduced in May 2010. However, as a confederation of 26 cantons, Switzerland is characterised by a high level of political decentralisation and canton rulings often take precedence over federal legislation. Therefore, some cantons are still considering exceptions to this smoke-free legislation but despite this, as a general rule, all publically accessible places in Switzerland are smoke-free.[999]

In terms of public transport, there is a voluntary agreement in place that prevents smoking on most forms of public transport in Switzerland, including buses, trains, domestic/international air transport and domestic/international water transport, although this does not apply to taxis.[1000]

Legislation on tobacco advertising, promotion and sponsorship
Tobacco advertising, promotion and sponsorship has been banned in Switzerland on the television and radio since 1997. It has been restricted in magazines and newspapers, on billboards and at the cinema since 1995. It is not yet banned at the point of sale.[1001] Warning labels are required on cigarette packs.

Challenges to legislation and enforcement
Switzerland is one of the few European countries that has not ratified the Framework Convention on Tobacco Control (FCTC).[1002]

08.19.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Smoking cessation services are available in primary care and secondary care settings across Switzerland.

The National Stop Smoking Programme has been in existence since 2001 and is funded into 2012. It is led by the Swiss Cancer League, Swiss Heart Foundation, Swiss Association for Smoking Prevention (AT) and supported by the Tobacco Control Fund.[1003]

The main goals of the National Stop Smoking Programme are to both motivate and facilitate healthcare professionals to provide smoking cessation counselling. The programme enables smokers interested in quitting to obtain professional support, which relies on the latest scientific findings.

Name of project	Activities	Main target groups
Free From Tobacco	Smoking cessation intervention training for physicians	General Practitioners (GPs)
Tobacco – intervention in dental practices	Smoking cessation lessons in undergraduate education and in further education for dentists, dental hygienists, prophylaxis assistants	Dental practices
Smoking Cessation in Pharmacies	Smoking cessation lessons in undergraduate education and in further education for pharmacists and pharmacy assistants	Pharmacies
Hospital Quit Support	Implementation of hospital-based smoking cessation services	Major Swiss hospitals
Brief intervention in cardiovascular and diabetes practices	Smoking cessation intervention training for cardiologists	Cardiologists
Brief intervention by non-medical staff for cardiovascular patients and diabetes patients	Smoking cessation intervention training for advisers for diabetes patients	Advisers for diabetes patients
Quit and Win Contest	National contest organised around the World No Tobacco Day	Smokers who want to quit, aged 25–45

Table 14: Projects established as part of the National Stop Smoking Programme in Switzerland

A number of projects have been established as shown in Table 14.

The Hospital Quit programme started in 2005 and provides smoking cessation support for hospitalised patients.

The Swiss Cancer League runs a quitline, the number of which has to be displayed on all cigarette packs. This national quitline is staffed by trained counsellors and is available in the three national languages (German, French and Italian), providing professional information on:

- Tobacco and tobacco consumption in general
- Health risks of smoking and health benefits of quitting
- Methods and aids for smoking cessation
- Promoting a smoke-free lifestyle.

If required, staff at the quitline will call quitters back at agreed times to review progress and offer further assistance.

Reimbursement for smoking cessation services
The Swiss Federal Office of Public Health decides on the coverage for all medical services and drugs and they have deemed smoking cessation to be a preventative measure and therefore not reimbursable. Therefore, smoking cessation medications are not reimbursed in Switzerland except for the rare exception of a few private insurance companies who partially reimburse these medications to provide additional services for their members.[1004]

NGOs have repeatedly tried to obtain reimbursement for smoking cessation treatments but they have mostly failed.

08.19.4 GUIDELINES

Switzerland has national smoking cessation guidelines that recommend brief interventions, intensive behavioural support and medications. These guidelines were issued in 2004, are government approved and draw upon Cochrane data.[1005]

08.19.1

Smoking prevalence in Switzerland (2008)
27% = smokers (daily and occasional)[991]

A new edition of the guidelines was being prepared for release at the end of 2010 but does not seem to be available yet (February 2011). This will include recommendations for physicians on treatment, management and follow-up and will be based on the US guidelines. However, these guidelines are not enforced: physicians may ignore them if they wish.

08.19.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

Medical students
There are five medical schools and each has its own local curriculum. There is no national training programme on smoking cessation for medical students. In 2008, a revised version of the 'Swiss Catalogue of Learning Objectives for Undergraduate Medical Training' was introduced by the Joint Commission of Swiss Medical Schools in order to standardise undergraduate training. However, it has been reported that this has not yet been systematically implemented.[1006]

Primary care
Under the umbrella of the AT, the "Free From Tobacco" programme provides smoking cessation programmes for primary care physicians in the private sector. Training consists of a half a day on smoking cessation and the use of medication, and a clinical diploma is provided to those completing the training. It is thought that this training has been relatively successful: during the five years 40 trainers have been provided with training and these trainers then train the GPs. Altogether, around 4,000 people have attended training.

Secondary care
A one-year, government-supported national intervention resulted in a substantial increase in the number of hospitals allocating trained staff and smoking cessation services to smokers. After the programme, 22 hospitals (50% of those studied) had an active smoking cessation service staffed with at least one trained physician and one nurse.[1007]

General public
It is thought that there is relatively little general public education on smoking although occasionally there is a campaign to try to sensitise the general public to the dangers of smoking.

Free pamphlets on the dangers of smoking in general and in specific patient groups may be available in primary care physician waiting rooms or the physicians may hand these out to patients who are smokers.

A national quitline is available in German, French and Italian, providing information on smoking cessation for the general public.

There are also a number of NGOs and campaigning groups working actively to reduce smoking in Switzerland, including:
- Swiss Lung Association (www.lung.ch)
- Swiss Association for Smoking Prevention (www.at–schweiz.ch)
- Swiss Cancer League (www.swisscancer.ch)
- Associazione Svizzera Nonfumatori (www.nonfumatori.ch)
- Zurich Smokefree (www.zurismokefree.ch)
- Pro Aere (www.proaere.ch).

08.19.6 RECOMMENDATIONS

Introduce more stringent smoke-free legislation
In many places across Switzerland, there is weak state smoke-free legislation, however some areas (for example, Geneva) have very strict legislation. It is suggested that the legislation should be the same across the nation, and similar to that of Geneva.

Some progress on this recommendation has been made by a broad alliance of interested parties such as many of the medical associations and patient group organisations, as well as well-known physicians and national politicians, with the alliance being led by the Swiss Lung League.[1008] On 18 May 2010, this alliance submitted a petition aimed at introducing binding national legislation to ban smoking in all public rooms and workplaces. As this legislation would amend the Swiss constitution it would guarantee a consistent and uniform law in all the cantons. A public vote on the new legislation is expected in the 2012-13 timeframe.[1008]

This recommendation is probably the mostly easily achievable recommendation and should therefore be implemented as a priority.

Provide reimbursement for nurse-led smoking cessation treatments in secondary care
In hospitals, medical insurers have created tariffs to reimburse the physician's time providing smoking cessation services. However, it is thought that their time could be more effectively spent referring smokers to nurse-led smoking cessation services. Thus a nurse tariff should be instituted by the medical insurance companies.

Increase reimbursement for smoking cessation treatments
It is suggested that the insurance companies should clearly acknowledge that smoking cessation treatments are a medical treatment for a medical condition. As such, smoking cessation treatments are not a luxury, and should be fully reimbursed.

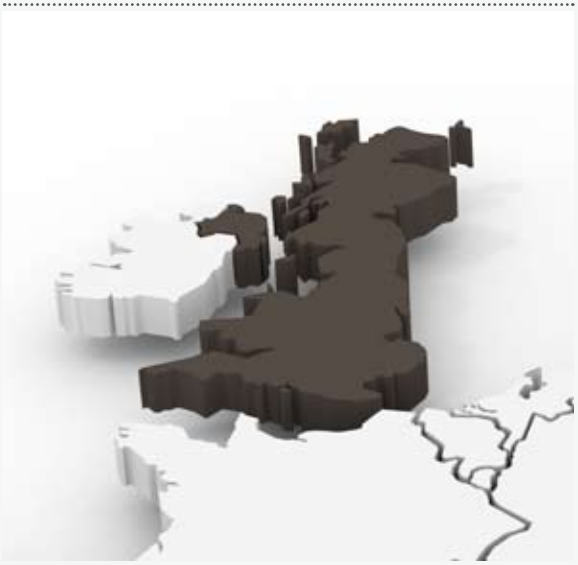
Increasing reimbursement for smoking cessation treatments is the responsibility of the Federal Office of Public Health.

Continue to provide educational programmes for clinicians on smoking cessation
Smoking cessation training courses have been organised for clinicians in the past but these have now been cut back. There are many reasons for this cut-back, mostly due to the state withdrawing financial support.

This lack of education contributes to primary care practitioners being reluctant to prescribe medications that they are not totally familiar with.

Increased funding is needed to enable smoking cessation education to continue and grow. The medical schools, the medical societies and NGOs will be in a position to help advocate for this increased training provision.

UNITED KINGDOM



Introduction

The following information on the tobacco control and smoking cessation services in the UK has been compiled from interviews with experts and literature research. The interviewees have also provided their recommendations for improving the situation in the UK with a particular focus on England.

08.20.1 SMOKING PREVALENCE AND COST OF SMOKING-RELATED ILLNESSES

The The World Health Organization (WHO) database records 21% of the UK adult population (aged 15+) as regular smokers in 2007.[1010] However, there are variations across the four nations of the UK (England, Wales, Scotland and Northern Ireland) as shown in Table 15 (page 179).

Smoking remains the leading cause of morbidity and mortality in the UK.[1024] For the UK as a whole, there were estimated to be 109,164 deaths attributable to smoking in 2005 (19% of all deaths).[1025] Smoking is still a considerable public health burden.[1026]

The General Practitioners and the Economics of Smoking Cessation (PESCE) project[1027] estimated that a reduction of 3% in the prevalence of smoking in the UK would result in annual healthcare savings related to lung cancer, chronic heart disease, stroke and chronic obstructive pulmonary disease (COPD) of €27.3 million by 2020 and €37.1 million by 2030.

Up to the mid-1950s, smoking was at similar rates for all socio-economic groups. However, since then, there has been a gradual trend for routine and manual workers as well as disadvantaged and vulnerable communities, including particular minority and ethnic groups to have higher rates of tobacco use.[1028]

Smoking prevalence targets
Smoking cessation targets are the responsibility of the governments of the four nations (England, Wales, Scotland and Northern Ireland). See Table 16 (page 180).

08.20.2 LEGISLATION ON SMOKING

United Kingdom-wide policy and law applies to issues such as taxation and the provision of health warnings on tobacco packaging. However, procedures for enforcement may vary to reflect the differing legal systems.

	Smoking prevalence (adults over 16 years)	Health consequences
England[1011]	21% (2007) 22% (2006) 39% (1980)	Over 83,000 people died from a smoking-related illness in England in 2008.[1012] However, progress has been made and in 2007, there were 2 million fewer adult smokers than there were a decade previously.[1013]
Wales	24% (2009)[1014]	6,000 deaths a year in Wales are attributable to smoking.[1015]
Scotland[1016]	25.2% (2008) 42.0% in the most deprived areas (2008)[1017] 26% of men (2005/6) 25% of women (2005/6)[1018]	In 2004, it was estimated that 13,473 deaths were attributed to smoking, equating to 24% of all deaths in Scotland.[1019]
Northern Ireland[1020]	24% (2009-2010)[1021] 41% for those in the most deprived areas (2009/2010)[1022]	Each year, approximately 2,300 people die in Northern Ireland from smoking-related illnesses.[1023]

Table 15: Smoking prevalence and health consequences across the UK

Smoke-free legislation and policy

Each nation within the UK implemented smoke-free legislation at different times as follows:[1040]

- England: On 1 July 2007, workplaces and enclosed public places in England became smoke-free environments. The Health Act 2006 defines enclosed public places and workplaces as being offices, factories, shops, pubs, bars, restaurants, membership clubs, public transport and work vehicles that are used by more than one person.
- Wales: The Welsh Assembly first voted in favour of smoke-free legislation in 2003 and enclosed public places became smoke-free on 2 April 2007. Most public places, including restaurants, pubs and bars are now smoke-free. The Welsh Assembly has set a target for the National Health Service (NHS) to ban smoking in all public places within the NHS (e.g. NHS hospitals).[1041]
- Scotland: Implemented its smoke-free legislation on 26 March 2006 and this legislation covers all pubs, restaurants, bars, shops, cinemas, offices, hospitals, work vehicles and sports centres. Exemptions include private residential homes, private vehicles and designated rooms in care homes, prisons and hotels.
- Northern Ireland: Smoke-free legislation has been in effect since 30 April 2007. It is illegal to smoke in all enclosed workplaces. This includes bars, restaurants, offices (even if the smoker is the only person in the office) and public buildings.

In terms of public transport, there is a voluntary agreement in place that prevents smoking on all forms of public transport in the UK, including buses, taxis, trains, domestic/international air transport, and domestic/international water transport.[1042]

Legislation on tobacco advertising, promotion and sponsorship

Tobacco advertising, promotion and sponsorship have been banned in the UK on the television since 1990, on the radio, in magazines and newspapers, on billboards and at the cinema since 2003.[1043]

The Health Act was passed in 2009[1044] and it allows for the prohibition of vending machines which will be implemented from October 2011 in England.[1045] The Act also gives the Northern Ireland Assembly and the Welsh National Assembly the powers to prohibit vending machines in those nations. The Northern Ireland Assembly is currently consulting on draft regulations, with a deadline for responses set in December 2010.[1046] The Welsh Assembly is expected to prohibit vending machines in October 2011, following consultation on their draft regulations that ended in July 2010.[1047] The Scottish government introduced a bill to ban tobacco sales from vending machines in March 2010[1048] However, until these laws come into effect, the sale of tobacco from vending machines will continue.[1049]

	Targets
England	A Department of Health (DH) publication, A Smokefree Future,[1029] published in February 2010, outlined the previous government's tobacco control strategy. It had three main objectives outlined to make significant progress towards a smoke-free society, each with an aspiration for what could be achieved by 2020: • To stop young people being recruited as smokers: aspiring to reduce the smoking rate among 11-15 year-olds to 1% or less, and the rate among 16-17 year-olds to 8% by 2020. • To motivate and assist every smoker to quit: aspiring to reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and in the most disadvantaged areas by 2020. • To protect families and communities from tobacco-related harm: aspiring to increase to two-thirds the proportion of homes where parents smoke (but not indoors) but that are entirely smoke-free indoors by 2020. There has been a General Election since 'A Smokefree Future' was published in February 2010, and the UK's government has changed. It is expected that the new coalition government will publish its own Tobacco Control Plan in early 2011. It is thought this plan will support changes regarding public health service delivery in England.
Wales	'Our Healthy Future' is the Welsh Assembly government's strategic framework for public health in Wales. A 2010 public summary of this document claimed that action will be stepped up to cut the level of smoking and therefore reduce smoking prevalence.[1030] The Welsh Assembly government has also produced 'NHS Wales. Annual Operating Framework 2010-2011' which has reducing the smoking prevalence as one of their ten priorities. In particular, they are aiming to increase the numbers of smokers undergoing elective surgery who are referred to the smoking cessation service by 30%.[1031] The Welsh Assembly government is drafting a 'Tobacco Control Strategy for Wales' which is expected to be completed early in 2011 with implementation from April 2011. Additionally, the local health boards (LHBs) are required to maintain and build upon the Stop Smoking Wales service, with particular emphasis of the agreed priority areas of maternity services, mental health, young people and socially disadvantaged groups to reduce smoking prevalence.[1032]

	Targets
Scotland	Scotland's government has established a national indicator to reduce the smoking prevalence to 22% by 2010.[1033] Scotland's Health Improvement (HEAT) targets cover a variety of key public health issues and are regularly updated with targets. For 2010/2011, the HEAT target for smoking is "Through smoking cessation services, support 8% of each board's smoking population to have successfully quit at 1-month follow-up over the period 2008-2011."[1034] NHS Health Scotland has committed to supporting all the health boards in Scotland to meet this HEAT smoking cessation target. The Scottish government's 2008 'Scotland's Future is Smoke-free: A Smoking Prevention Action Plan' set new targets for youth smoking with the aim of reducing smoking by:[1035] • 13-year-old boys to 2% and girls to 3% by 2014 • 15-year-old boys to 9% and girls to 14% by 2014 • 16-to 24-year-olds to 22.9% by 2012.
Northern Ireland	The government led priorities for action for 2008 were to reduce the smoking prevalence in adults to 21% and the subset of manual workers to 25% by March 2011.[1036] An earlier Tobacco Action Plan (2003-2008) set targets to increase the proportion of:[1037] • 11-16-year-old children who do not smoke to 89% by 2006 • Pregnant women who do not to 82% in 2005 • Adults who do not smoke to 75% in 2006/07 • Non-smokers in the manual groups to 69% in 2006/07. A working group was established in 2009 to review this plan and to develop a new ten-year strategy for tobacco control in Northern Ireland.[1038] The Regional Cancer Framework has recommended that action be taken to reduce smoking levels in younger people. This is part of an overall programme of lifestyle skills that will include increasing the provision of smoking cessation services and improve the targeting of services.[1039]

Table 16: Smoking prevalence targets across the UK

The same 2009 Health Act includes the prohibition of the display of tobacco products at the point of sale in England, Wales and Northern Ireland.[1050] In England, larger retailers will have to remove such displays by October 2011.[1051] As with the prohibition of vending machines, consultation details are the same for Northern Ireland and the Welsh Assembly. In Scotland, the Tobacco and Primary Medical Services (Scotland) Act was introduced in March 2010[1052] however, legal challenges[1053] relating to the ban on the display of tobacco products have put the Act on hold.[1054]

From October 2007, the laws in England, Wales and Scotland were changed so that it became illegal to sell tobacco products to anyone under 18, whereas it was previously illegal for those under 16.[1055] Researchers at the University College London surveyed more than 1,000 teenagers aged 16 and 17 before and after the change in law. They found that smoking rates in this age group had dropped significantly from 24% to about 17% after the law change.[1056]

Challenges to legislation and enforcement

In July 2010, the possibility was raised that the new coalition government might scrap previous English legislation to ban cigarette vending machines from pubs and tobacco displays from retailers. The possibility of revoking the Tobacco Authority and Promotion (Display) (England) Regulations 2010 emerged in a reply to a parliamentary question to the Department of Health, which stated that "…given the challenges facing business competition and costs…", it would give further consideration to the policy on display of tobacco products and sales from tobacco vending machines.[1057] In January 2011, the UK's government confirmed that legislation on vending machines in England will come into effect later in 2011.[1058] However, legislation on point of sale display in England is "being reviewed".[1059]

08.20.3 SMOKING CESSATION SERVICES AND INFRASTRUCTURE FOR TOBACCO DEPENDENCE SUPPORT

Smokers are up to four times more likely to successfully quit smoking with NHS support compared with smokers who try without any form of support.[1060] The NHS offers comprehensive support on smoking cessation for the whole of the UK (Table 17, page 180).

Reimbursement for smoking cessation services

Smoking cessation services, including prescription medications (bupropion, nicotine replacement therapy (NRT), varenicline), are all available free of charge to patients in the UK. However, some nations utilise a prescription charge where the patients pays a fixed fee regardless of the prescription medication received.

- England: There is a prescription charge of £7.20 per item in England, unless patients are exempt (e.g. the elderly)
- Scotland: The prescription charge will be phased out in Scotland by 2011
- Wales: There is no prescription charge in Wales
- Northern Ireland: There is no prescription charge in Northern Ireland.

NRTs can be prescribed but are also available over the counter, as well as on general sale in shops, including supermarkets.

	Smoking cessation services
England	Primary care physicians and nurse prescribers offer support and advice, and can prescribe and dispense drugs to assist in quitting. They can also refer patients to the NHS Stop Smoking Service (NHS SSS). Nurses and pharmacists can offer support and advice, and recommend over-the-counter (OTC) medications. Patient group directions allow other healthcare professionals (HCPs) who are not 'independent prescribers' to legally provide prescription-only medications on the NHS.[1061] One of the main points of contact for people who want to quit smoking throughout England is the NHS SSS, which was launched in 2000 and offers a range of free treatments, advice and support.[1062] Options available include: local group sessions, one-to-one sessions with a trained adviser, at home support, online counselling and a range of materials to aid smoking cessation. • The Health and Social Care Information Centre reports annually on the results from the monitoring of the NHS SSS in England. The most recent report that covers the period April 2010 to September 2010 shows that the 341,455 people set a quit date through NHS SSS, with 48% of these people quitting at the four week follow-up.[1063] A free quitline (the NHS Stop Smoking Helpline)[1064] is available from Monday to Friday 9am to 8pm and Saturday and Sunday 11am to 5pm. Trained advisers provide information on free local NHS Stop Smoking Services, smoking cessation therapies and advice on managing cravings. The NHS Smokefree website[1065] offers smoking cessation 'tools' such as brochures, leaflets, CDs/DVDs and mobile phone applications to assist smokers who want to quit. In addition there are specific website/quitlines for the different regions.
Wales	The Stop Smoking Wales[1066] website and quitline is funded by the Welsh assembly government and the service is delivered by Public Health Wales.
Scotland	The Can Stop Smoking[1067] website and quitline provides smoking services for Scotland delivered by NHS Health Scotland. The Information Services Division (ISD Scotland) monitors the service provided by NHS SSS in Scotland on an annual basis. The most recent report that covers the period 1 January to 31 December 2009 during which period there were 69,882 quit attempts made with the help of NHS smoking cessation services in Scotland After four weeks, 38% successfully quit (self-reported).[1068]
Northern Ireland	Across Northern Ireland, over 600 smoking cessation services are now provided in a range of settings including pharmacies, GP surgeries and community centres.[1069]

Table 17: Smoking cessation services across the UK

08.20.4 GUIDELINES

- England and Wales: The National Institute for Health and Clinical Excellence (NICE) has produced a number of guidelines related to smoking cessation:
  - NICE guidance 39 on the use of NRT and bupropion for smoking cessation was published in March 2002. NICE recommended both as a possible treatment to help smokers who wish to stop smoking.[1070] These guidelines have now been superseded by the NICE Public Health Intervention Guidance PH10 – Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities.[1071]
    - PH10 cross-references and is consistent with other NICE Guidance such as PH1 – Brief interventions and referral for smoking cessation in primary care and other settings[1072], and PH5 – Workplace health promotion: how to help employees to stop smoking.[1073]
  - TA 123 – a NICE technology appraisal for varenicline, which was published in July 2007. NICE guidance recommended varenicline as a treatment option to help smokers who have said they want to stop smoking.[1074]
  - Guidelines have also been produced by the Department of Health intended for everyone involved in managing, commissioning or delivering NHS Stop Smoking Services. These were updated in 2010 and cover commissioning, delivering and monitoring all the services and treatments covered by the NHS Stop Smoking Services.[1075] It is anticipated that these guidelines will be updated when the new Tobacco Control Plan is published.
- Scotland: NHS Health Scotland and ASH Scotland published their own Smoking Cessation Update 2007: Supplement to the 2004 Smoking Cessation Guidelines for Scotland.[1076]

- Northern Ireland: The Department of Health, Social Services and Public Safety reviews all NICE guidance published after 1 July 2006, for its applicability to Northern Ireland. They found the following NICE guidance to be applicable and therefore endorsed it for implementation by the Health and Social Care:[1077]
    - Public Health Intervention Guideline No PH 5 – Workplace Smoking
    - Technology Appraisal TA 123 – Varenicline for Smoking Cessation.

08.20.5 EDUCATION AND HCPs' ATTITUDES TOWARDS SMOKING AND SMOKING CESSATION

As an example, England provides the following education:

- England: The NHS Centre for Smoking Cessation and Training (NCSCT)[1078] was set up in April 2009 and is being funded by the Department of Health to develop evidence-based national standards for smoking cessation training, competence-based training programmes and professional development systems for the NHS stop smoking workforce.[1079]
    - Medical students. Smoking cessation is covered in most medical schools but to different depths, as there is no compulsory curriculum on smoking cessation for medical students. Currently smoking cessation tends to be taught as an optional module to the students.
    - Primary care. As noted above, the NCSCT is developing a comprehensive national training programme. The online and face-to-face training courses are currently being piloted (2009 to 2010). From April 2010 through to 2012, the training will be rolled out across the country.[1080] The online Stage 1 Training and Assessment Programme will be available to anyone interested, but only practitioners contracted to deliver smoking cessation interventions on behalf of NHS Stop Smoking Services will be able to qualify for the NCSCT Stage 1 Certification on passing the Stage 1 Assessment. Any NHS Stop Smoking practitioners who have the NCSCT Stage 1 Certification will be able to take part in the online Stage 2 assessment.[1081]
    - Secondary care. There is no compulsory training or specific programmes in smoking cessation for secondary care staff.
    - General public. There are national campaign materials in GP surgeries, and locally-generated materials adapted from national materials. These may target all smokers, or specific groups such as pregnant smokers, or users of smokeless tobacco.

In Wales, it has been noted that the LHBs are required to maintain and build upon the current level of smoking cessation brief intervention training by Public Health Wales to healthcare professionals and community workers in all local authorities across Wales.[1082]

General public

Health education campaigns are the responsibility of the four nations of England, Scotland, Wales and Northern Ireland.

The annual national No Smoking Day is every second Wednesday in March.[1083]

There are a number of local and national patient support groups and networks, and these can offer practical help and support, often based on personal experience, to people who are trying to stop smoking.

There are a number of smoking cessation websites, including patient group websites:

- www.ash.org.uk, www.ashscotland.org.uk, ashwales.co.uk
- www.asianquitline.org
- www.canstopsmoking.com (Scotland)
- www.givingupsmoking.co.uk
- www.muslimhealthnetwork.org
- www.nonsmoking.org.uk
- www.quit.org.uk
- www.smokefree.nhs.ukwww.stopsmokingwales.co.uk (Wales)

08.20.6 RECOMMENDATIONS

Increase the cost of tobacco products
According to the government's tobacco control strategy reported in February 2010 (before the change in the UK government), taxation on tobacco products or profit from tobacco products can be used to reduce the affordability of tobacco products.[1084] Article 6 of the Framework Convention on Tobacco Control (FCTC) which is concerned with demand reduction, recognises that price and tax measures are an effective and important means of reducing tobacco consumption, particularly in younger people.[1085]

It is recommended that the cost of tobacco products should be increased using legislation. This recommendation would be implemented across the UK's four nations. Although relatively straightforward to implement, it is dependent on political will and support.

Increase efforts to stop illegal tobacco trade
Her Majesty's Revenue and Customs (HMRC) has a partnership with the UK Border Agency which is central to the government's strategy to combat tobacco smuggling. In a 2008 report, it was claimed that the size of the illicit cigarette market share has been reduced by a third since 2000. However, they still recognise that there is more to do[1086] and recently legislation was introduced into the Finance Bill 2010 to strengthen HMRC's powers to tackle tobacco smuggling in the post.[1087]

Regulation for legal tobacco products is seen as very good, however there is a need to stop the illegal tobacco trade. The illegal trade is obviously entirely unregulated and allowing it to continue undermines legislation and public health messages. It is the illegal tobacco trade that is providing the young and poor with increased access to tobacco.

There is a need, therefore, for continued support in terms of finance and appropriate government legislation to combat the illegal tobacco trade.

Prevent tobacco advertising at point of sale
Implementation of the law prohibiting vending machines is anticipated in October 2011 in England.[1088] Similarly, the display of tobacco products at the point of sale was prohibited by the same Health Act and implementation is expected during 2011.[1089] However, legal challenges in Wales[1090] and Scotland[1091] have delayed implementation. The Scottish government considered that despite the contentious nature of their bill, a key reason for implementing the bill was that it would support their efforts to tackle youth smoking.[1092] However, for England, the coalition government has stated that the prohibition on point of sale display is "being reviewed".[1093]

It is important to note the Health and Sport Committee who considered the bill, thought that such a ban would have a positive effect in the long-term and that the measure would be "disproportionate to the costs associated with it."[1094]

It is recommended that point of sale advertising is prevented in all of the nations of the UK. The individual national parliaments will be responsible for implementing the necessary legislation.

Incentivise GPs to refer smokers
Currently under the Quality and Outcomes Framework (QOF), GPs in England are given financial incentives to check the smoking status of their patients especially in patients with diabetes,[1095] COPD, coronary heart disease (CHD) and other chronic diseases. However, GPs are not incentivised to refer their patients to the appropriate services. In the future, it is thought that beneficial changes to the QOF for these long-term conditions will be led by NICE.

With the existing system, many GPs feel they have to confirm a smoker is willing to quit before offering advice. Offering this advice without such screening might increase the smoking cessation service uptake considerably. The increased interaction between the GP and smokers as they discuss possible referral may also increase uptake of smoking cessation services.

Key to this would be incentivising GP referrals which will help to motivate GPs to refer smokers and this will increase the numbers taking up specialist smoking cessation services. Similarly, secondary care staff should also be incentivised to provide referrals to specialist smoking cessation services.

This recommendation is considered to be the most important, as it improves access for those who need treatment.

Continued reimbursement for smoking cessation medications
In Scotland, Wales and Northern Ireland, by 2011 all smoking cessation drugs will be free on an NHS prescription. In England, non-exempt patients have to pay a prescription charge. Free prescriptions for all for smoking cessation drugs would be an improvement as prescription charges can be an issue for lower income smokers.

Offer improved educational programmes on smoking cessation
According to the previous UK government, "We also need to support training opportunities to make sure that all doctors, nurses, pharmacists and other healthcare professionals understand the importance to health of smoking cessation."[1096]

Although there has been a change in government, there is still a need for a national training programme on smoking cessation for undergraduates at medical school, GPs in training and student nurses and pharmacists. There is no formal training for healthcare professionals in secondary care at present.

08.20.7 THE NEW GOVERNMENT'S PLANS WILL IMPACT ENGLAND'S HEALTHCARE SYSTEM AND POSSIBLY THEIR SMOKING CESSATION PROVISION

It should be noted that at the time of writing this report, England's healthcare system is set for some major changes. In autumn 2010, a health bill was introduced in parliament to transform the provisions of the White Paper into statute. The government's plans have not yet been implemented but it is anticipated that there may be significant changes to commissioning and delivery of smoking cessation services in the future.

KEY RECOMMENDATIONS

Summary

- Key recommendations were compiled utilising the recurrent country-specific recommendations combined with additonal Editorial Partner recommendations based on their experience
- Key recommendations from stakeholders include:
  - Increase tobacco prices
  - Reimburse time for providing smoking cessation counselling
  - Reimburse smoking cessation medications
  - Provide national guidance and clinical guidelines
  - Further training for primary care physicians
  - More involvement of primary care physicians in smoking cessation programmes
  - Improve training for all healthcare professionals.
- Future steps:
  - Combine efforts to control the smoking epidemic
  - Establish a European Smoking Control Centre (ESCC).

09.01 BACKGROUND

A number of demand reduction measures are considered highly cost-effective[1097] and are commonly accepted as important tenets of tobacco control. Based on international experience, it is thought that the best results are obtained when these measures are implemented concurrently, including:

- Price increases through higher taxes on tobacco products
- Providing smoke-free workplaces and public environments
- Better consumer information, including public information campaigns
- Comprehensive bans on the advertising and promotion of all tobacco products
- Large, direct health warning labels on tobacco products
- Treatment to help dependent smokers stop, including increased access to medications.

09.02 HOW THE KEY RECOMMENDATIONS WERE COMPILED

In this section, we review the key country-specific recommendations made in section 08.00 that evolved from the

interviews with various stakeholders from the twenty European countries covered by this report. The Editorial Partners reviewed the country-specific recommendations and combined these with their own experience to put forward overall key recommendations. These recommendations have been reviewed and endorsed by the Editorial Partners. These recommendations are not presented in order of preference or by any ranking, instead they are presented in the order of the themes presented at the beginning of this report.

09.03 INCREASE TOBACCO PRICES

Background
Analysis of sales and consumption data before and after price increases has proven that raising prices leads to a decrease in consumption of tobacco[1098,1099], or is predicted to lead to a decrease.[1100] Increasing tobacco prices is a productive and cost-effective tobacco control intervention which reduces the demand for tobacco[1101] and provides an increase in government revenue.[1102]

Increasing tobacco prices also encourages smokers to quit and to seek help in their attempt to quit.[1103,1104] Further analysis indicates that this impact is more pronounced amongst younger smokers and those from poorer socio-economic backgrounds.[1105]

Current situation
It was noted that:

- Denmark: Increased tobacco tax by DKK 3.00 (or by approximately 10%) in January 2010. The Danish Heart Association has calculated that a tax increase of 50% would reduce the number of smokers by approximately 43,000.[1106]
- Finland: Introduced legislation to utilise up to 0.45% of the annual tobacco taxes to fund health education and evaluation.[1107]
- Germany: Experts believe Germany raised tobacco taxes incrementally over a period of years from 2004,[1108] because it was feared that a large one-off price increase would significantly reduce tobacco consumption and detrimentally affect the tobacco industry.[1109]

Recommendation
Raising taxes on all forms of tobacco was recommended by nearly half of the countries in the study (n=9) who considered it an effective way of lowering consumption. Any additional tax revenues thus generated could then be used to finance smoking cessation programmes and to pay for the healthcare expenditure arising from smoking-related illnesses.

This measure would also be supportive of the Framework Convention on Tobacco Control (FCTC).

Anticipated outcomes from this recommendation:

- Decreased consumption of tobacco products
- Decreased smoking prevalence
- Possible decrease in young people taking up smoking.

09.04 REIMBURSE TIME FOR PROVIDING SMOKING CESSATION COUNSELLING (OR INCREASE EXISTING REIMBURSEMENT)

Background
As has been described in section 03.03 of this report, there is sound clinical evidence to show that smoking is an addiction and a disease. Smokers may give up smoking unaided but Hughes *et al.* in a systematic literature review found that only 3 to 5% will achieve prolonged abstinence for 6 to 12 months, whilst smoking cessation interventions produce abstinence rates of 5 to 10%. However, data on self-quitters was limited.[1110]

Therefore smokers may need the added impetus of intervention by healthcare professionals (HCPs) to encourage them to make a smoking cessation attempt and to guide them to the appropriate information and support that is available. It has been suggested that for every two smokers a clinician persuades and helps to quit smoking, one premature death will be avoided.[1111]
However, General Practitioners (GPs) can be reluctant to address smoking cessation issues because they perceive it takes up too much of their time[1112] and they are not reimbursed for their time.[1113]

Current situation
With respect to reimbursement for smoking cessation services, some countries:

- Do not generally reimburse smoking cessation services, e.g.:
  - Italy: In general, with some regional exceptions, smoking cessation services are not reimbursed.
- Have partial reimbursement or reimbursement that varies by region e.g.:
  - Austria: Austria manages smoking cessation services regionally. Some regions reimburse services, but this is not standardised.
  - Germany: Most German health insurance funds provide reimbursement for cognitive-behavioural group-based courses for smoking cessation.
  - Finland: Smoking cessation services organised by occupational health services are partially reimbursed by the Social Insurance Institute.
  - Poland: In some regions and clinics, where a contract with the National Health Fund is available, reimbursement is provided for smoking cessation services provided by GPs.[1114]
- Have smoking cessation service reimbursement that varies according to the patient or the patient's condition e.g.:
  - Norway: Reimburses GPs if they put patients into a smoking cessation programme but the patient must already have a smoking-related disease.
- Reimburse smoking cessation services, except those organised through private companies, e.g.:
  - Belgium
  - Czech Republic
  - Denmark: Municipal smoking cessation services are free of charge.
  - France: Hospital-based smoking cessation out-patient services are free with a social security card.
  - Greece
  - Hungary
  - Ireland: Reimburse smoking cessation services provided by the Health Service Executive (HSE).
  - Luxembourg
  - Netherlands: From 1 January 2011, a patient's health insurance provides reimbursement for smoking cessation services.[1115]
  - Portugal
  - Spain
  - Sweden: Attending clinics is either free or low-cost.
  - Switzerland: Reimbursed, but it is thought that the current reimbursement levels provide little financial incentive for the provision of smoking cessation services.
  - United Kingdom (UK): Incentivises physicians to offer smoking cessation services.

Recommendation
This important policy measure was suggested by the majority of the countries as a mechanism to lower the prevalence of smoking.

It has been shown that in the lower socio-economic strata of society, smoking prevalence is greater and there are lower quit levels.[1116] It has also been shown that the United Kingdom's reimbursed smoking cessation services are successfully attracting significant numbers of people from deprived areas.[1117] This suggests that providing reimbursed smoking cessation services might lead to greater social equality.

Anticipated outcomes from this recommendation:

- Increased access to smoking cessation services (particularly for those from lower socio-economic groups)
- Increased uptake of smoking cessation services
- Increased numbers making a quit attempt
- Increased number of successful quitters.

09.05 REIMBURSE SMOKING CESSATION MEDICATIONS

Background
It is recognised that smoking is an addictive disease and that there are effective treatments available to support smoking cessation. There is evidence that reimbursement of medications:

- Increases access to smoking cessation medication
  - For instance, reimbursement of nicotine replacement therapy (NRT) increases access to NRT.[1118]
- Increases the numbers making a quit attempt[1119] and those using smoking cessation services[1120]

    - As seen in German primary care when combined with GP training[1121]
    - When combined with reimbursement, counselling is associated with higher quit rates and continued cessation in expectant mothers[1122]
    - Increases the use of smoking cessation treatment.[1123]
- Increases the number of successful quitters[1124]
    - Reimbursement may double the abstinence rate during a 6-month study (although numbers in the cited study were small)[1125]
    - Increases abstinence rates, even after two years (compared to control group with no reimbursement or information on smoking cessation treatment).[1126]
- Is cost effective
    - Reimbursement of NRT and/or bupropion has been shown to be cost-effective in primary care when combined with GP training[1127]
    - Reimbursement is cost-effective assuming €18,000 per quality-adjusted life-year (QALY) is deemed acceptable.[1128]

Current situation

Full reimbursement of smoking cessation medications is provided only in the United Kingdom. However, positive schemes that are moving in the direction of full reimbursement have been established for some countries, for example:

- Belgium: The 'People in Poverty Scheme' provides full reimbursement for smoking cessation treatments for those on low incomes. During 2011 it is anticipated that this project will probably be implemented in the whole Flemish part of Belgium and then in 2012 it should be implemented in the French speaking part of Belgium.
- Greece: Proposals for the reimbursement of smoking cessation medications issued in November 2010, suggest that reimbursement should be at 75% for those with a serious, chronic disease and 25% for other smokers. As of late January 2011, this proposal had been accepted and endorsed by the key stakeholders but a Ministerial decision (necessary for its implementation) has been delayed.[1129]
- France: Smoking cessation prescribed treatments are subsidised only to €50 annually. It is planned that people with low income and pregnant women may be reimbursed up to a maximum €150 annually.
- Ireland: The poorer members of the population with a Medical Card are fully reimbursed for smoking cessation medications. For the majority, there is a maximum payment of €120 a month per individual or family toward medicines under the Drugs Payment Scheme, which covers bupropion and varenicline.
- Luxembourg: Smoking cessation medication is reimbursed up to 50% of the cost to a maximum of €100 per smoker, if the smoker stays in 'The Programme' for smoking cessation.[1131]
- Netherlands: Starting in 2011 a new Smoking Cessation Integrated Care Package was introduced.[1132] It is hoped it will be sufficient to cover the whole care required for a smoker including the smoking cessation medication but it is thought there will be an annual limit.
- Spain: The regional Health Services of Navarra and of La Rioja and the local Health Service of Ceuta, will reimburse smoking cessation treatments but other regions vary.
- Sweden: Bupropion and varenicline are reimbursed as second-line drugs.

Reimbursement is not provided in:

- Austria
- Czech Republic
- Denmark: Reimbursement is not currently provided but Parliament has agreed that free-of-charge smoking cessation medications for socially vulnerable smokers can be tested by the municipalities in individual projects. However, no funding to such projects has been given yet.
- Finland
- Germany
- Hungary
- Italy
- Norway
- Poland
- Portugal
- Switzerland: Generally not reimbursed except for a few private insurance companies.

One of the reasons given for the lack of reimbursement of smoking cessation medications is the concept that such medications are 'lifestyle drugs'. In Germany, the Federal Joint Committee (G-BA) has legally excluded lifestyle drugs from coverage by insurance companies.[1133] The G-BA considers that the primary motive for using these drugs is personal lifestyle, rather than treatment of a disease and on that basis they have excluded treatments for obesity, tobacco dependence and erectile dysfunction. Part of the national chronic obstructive pulmonary disease (COPD) disease management programme (DMP) proposes funding for pharmacotherapy and cognitive behavioural therapy for COPD patients. However, this particular law has not yet been passed.

Recommendation
Patients should have access to and reimbursement for smoking cessation medications, based on considerations of their effectiveness and cost-effectiveness. This recommendation was made by the majority of countries.

Anticipated outcomes from this recommendation:
- Increased numbers making a quit attempt
- Increased number of successful quitters.

09.06 PROVIDE NATIONAL GUIDANCE AND CLINICAL GUIDELINES (OR IMPLEMENT EXISTING ONES)

09.06.01 NATIONAL GUIDANCE

Background
National smoking cessation guidance from the national government provides targets but also provides information on the service provision required to attain these targets. For instance, the public health guidance on workplace health promotion provided by the UK's National Institute for Health and Clinical Excellence (NICE).[1134]

Current situation
The current situation in the countries covered is summarised below:
- Austria: The interviewees reported that there are no specific targets for reducing the prevalence of smoking and there is no written Austrian policy on smoking.
- Belgium: There is no formal target but the governments of the Flemish region and the German-speaking community have set the objective of reducing the number of smokers, particularly among adolescents.[1135]
- Czech Republic: There are currently no national targets for reducing the smoking prevalence and there is no national guidance.
- Denmark: In October 2009, the Danish government presented a national plan for prevention aimed at increasing life-expectancy by three years within the next ten years.[1136] This plan follows on from the National Prevention Council who in April 2009 presented 52 specific recommendations to increase life-expectancy through better prevention, including around eight regarding smoking.[1137]
- Finland: There is a national Current Care Guideline entitled 'Smoking, nicotine dependence and nicotine withdrawal'. This was developed and written by the Finnish Association for General Practice and funded by the Ministry of Social Affairs and Health.[1138] The Ministry of Health is preparing governmental strategy on how the goal of the Smoke-free Finland 2040 Act will be attained.
- France: France has passed a Public Health law with the aim of reducing the prevalence of smoking. France's Cancer Plan (2009-2013) also aims to reduce the smoking prevalence from 30% to 20%.[1139] Haute Autorité de Santé (HAS) published guidelines on therapeutic strategies for quitting smoking.[1140]
- Germany: Germany has no formal targets for the reduction in the prevalence of smoking and no national guidance on smoking cessation.
- Greece: A National Action Plan was published in 2008[1141] by the previous government and it is thought their target to reduce the smoking prevalence in adults and young adults by 10% by 2012 will be kept by the new government.
- Hungary: The Johan Béla National Programme for the Decade

of Health (2003) includes a goal to cut smoking by 6% by 2010. A European Heart Health Charter endorsed by the Minister of Health and others, prioritises regulatory and taxation measures against active and passive smoking.[1142]

- Ireland: Targets have been set by the Department of Health and Children to reduce the overall prevalence of smoking by 1% per annum from 29% to 19% and to reduce smoking initiation rates by 1% per annum from 31% to 21% by 2019.[1143] The National Tobacco Control Framework sets out the strategic direction for tobacco control for the HSE for the coming five years. A yearly implementation plan will be developed which will identify priorities and action areas.[1144]
- Italy: There are no specific smoking prevalence targets although there is a goal to reduce smoking initiation especially among young people.[1145] The National Health Institute has issued national guidelines for GPs.[1146]
- Luxembourg: There are no official smoking prevalence targets or national guidelines for tobacco dependence and/or smoking cessation.
- Netherlands: The 'Tobacco Control Declaration of Intent' with signatories including the Minister of Health, Welfare and Sport set a target to reduce smoking to 20% between 2008 and 2010.[1147] The Partnership on Smoking Cessation project (a platform of 25 organisations in public and private healthcare concerned with smoking and cessation such as physician organisations, dentists, nurses, and specialists) was funded by the Ministry of Health and has produced clinical guidelines for healthcare professionals in the entire healthcare system.
- Norway: The National Strategy for Tobacco Control 2006-2010 focuses on smoking cessation and had a target to reduce the prevalence of daily smokers to less than 20% by 2010,[1148] and a revised strategy is expected during 2011. The Department of Health has issued national guidelines for primary care (2004).[1149]
- Poland: A national target to reduce the daily smoking prevalence to 32% for men and 22% for women has been set in the national 'Programme for Limiting the Health Consequences of Tobacco Smoking in Poland' for the years 2010-2013.[1150] This programme has been approved by the Minster of Health and is organised by the National Sanitary Inspectorate.
- Portugal: Although there do not appear to be any numerical targets, the prevention, diagnosis and treatment of tobacco dependence is part of the National Health Programme (2006-2010).[1151] The Portuguese General Directorate of Health (Direcção-Geral da Saúde) provides a national online portal with access to general information on all official health programmes.
- Spain: Each of the 17 different regional health services are responsible for tobacco prevention and tobacco dependence treatment activity and, so far, national goals have not been established.
- Sweden: The target of the Riksdag (Parliament) and government to reduce smoking by 2014 has been set.[1152] The National Board of Health and Welfare provided guidance on the governance and management of healthcare (October 2010).[1153]
- Switzerland: A National Tobacco Programme (2008-2012) has an objective to reduce the prevalence of smokers from 29% to 23%.[1154] Responsibility for the implementation of this National Tobacco Programme has been allocated. National smoking cessation guidelines were being updated and prepared for release at the end of 2010 but these guidelines do not seem to be available yet (February 2011).
- United Kingdom: Each of the nations has its own smoking prevalence targets and there is national guidance to achieve these targets.

Recommendation

Write and implement national guidance on smoking cessation to ensure that services are directed where they are most needed and to provide a standardised service across the particular country.

Anticipated outcomes from this recommendation:

- Increased provision of appropriate services
- Evidence-based standardisation of services.

09.06.02 NATIONAL CLINICAL GUIDELINES

Background
As previously noted, the FCTC requires signatories to develop and disseminate appropriate guidelines and take measures to promote tobacco cessation and adequate treatment for tobacco dependence.[1155]

Current situation
Desk research summarised in Table 10 (see pages 52-53) shows that most countries included in the study have some form of national guidelines that were developed by at least one professional medical society and endorsed by the national health authority. In most countries, guidelines exist for smoking cessation in specific groups, e.g. pregnant women, COPD, patients etc.

A key finding of this report is that even where guidelines exist, experts in many countries believe they are not followed by either primary care or specialist physicians. The importance of having guidelines and using them lies in establishing a uniform standard of care for smoking cessation. It also encourages recording, monitoring and analysis of the results of smoking cessation measures, which will benefit future iterations of the guidelines. Awareness of the existence of guidelines and their use will ensure that physicians treat tobacco dependence as a disease and adopt those smoking cessation measures endorsed by the national health authorities.

Seven countries (Austria, Denmark, Greece, Ireland, Norway, Portugal and Spain) identified the provision of national guidelines as important. Implementation of such guidelines requires continuing medical education (CME) and initiatives to promote the guidelines to all relevant healthcare professionals and to provide on-going monitoring of compliance.

Recommendation
Prepare and implement national guidelines.

Anticipated outcomes from this recommendation:
- Recognition that tobacco dependence is a disease
- Increased ability of healthcare providers to deliver evidence-based services
- National consistency of treatment
- Provision of tools for monitoring and surveying progress
- Protection from unproven, ineffective and expensive treatments
- Cost-effective resource utilisation.

09.07 FURTHER TRAINING FOR PRIMARY CARE PHYSICIANS

Background
In most countries, the interface between the smoker and any potential smoking cessation programme is the GP. An ideal strategy to enhance smoking cessation would have the GP play a pivotal role.

Current situation
Based on the interview programme, it is thought that many GPs do not consider tobacco dependence to be a disease or a condition that needs to be treated *per se*. Typically, GPs ask about a patient's smoking habits only when the patient presents with a smoking-related problem. The usual response from the GP on learning that the patient is a smoker is a verbal encouragement to reduce consumption or stop. If there is a system and process in place for smoking cessation, the GP may refer the patient to that programme but follow-on visits for smoking cessation are rarely considered.

The consensus view was that the required shift in attitude can only be achieved through training and education. It was proposed that GPs should be obliged to participate in structured training, either as part of their continuing medical education (as is required in some countries), or as part of a specialisation or certificate in smoking cessation. Such programmes should be run at the national level with a unified curriculum and should ensure attendance by all GPs. Post-training, GPs would be expected to establish their patients' smoking habits, treat smoking as a disease, promote and support smoking cessation programmes and follow-up patients as needed.

Currently, there are various training programmes available to GPs. These are usually run locally, with different curricula, and attendance is, for the most part, voluntary. Examples are listed below:

- Austria: Medical schools offer postgraduate diplomas on managing tobacco dependence. GPs must gain a certain amount of continuing medical education (CME) points by attending such postgraduate courses.
- Belgium: Domus Medica (association of GPs) organises group workshops of around 15 physicians on smoking cessation. Further, Fonds des Affections Respiratoires (FARES) and some universities offer courses with 72 hours of training over one year in smoking cessation with examination and dissertation giving participants the title of tobaccologist. The course is open to GPs and other healthcare professionals such as nurses. An e-learning model (Flemish section) is now available from the Vlaams Instituut voor Gezondheidspromotie en Ziektepreventie which provides online training for all healthcare professionals with help and advice on motivational interviewing.[1156]
- Czech Republic: Seminars are organised by the Czech Society for Treatment of Tobacco Dependence, the Czech Medical Association and the Czech Medical Chamber.
- Denmark: The Danish Cancer Society and some pharmaceutical companies in Denmark provide smoking cessation education for GPs.
- Finland: Local and regional courses organised, e.g. one offered by the University of Helsinki
- Germany: Courses offered by the German Medical Association and the German Academy for Preventive Medicine.
- Hungary: Some universities and groups, including the Hungarian Academy of Teaching Family Physicians, have worked to educate GPs through lectures, workshops and communications skills programmes.
- Ireland: Training is delivered by the smoking cessation service but it is more comprehensive in some places than in others.
- Luxembourg: There was a national programme for GPs on smoking cessation which was well attended and many GPs were trained.
- Netherlands: The Dutch Foundation on Smoking and Health (STIVORO) has a programme to train GPs and also offers courses for nurses and other healthcare professionals who meet smokers.
- Norway: The Medical Associations fund and organise two or three smoking cessation courses per year and the 'Lungs in Practice' group also provide courses and meetings for GPs with a special interest in pulmonology and smoking cessation.
- Poland: The Health Promotion Foundation has trained more than 10,000 GPs on treating tobacco dependence. At the regional and local level, training is provided by institutions reporting to the Ministry of Health.[1157]
- Spain: Training workshops in smoking cessation are offered to GPs during their residency. Regional governments and different scientific societies also offer training courses.
- Sweden: The ENSH (European Network of Smoke-Free Hospitals) provides tobacco cessation training courses open to GPs.
- Switzerland: The Swiss Association for Smoking Prevention provides smoking cessation programmes for GPs in the private sector.
- UK: There are comprehensive national training programmes being rolled out in England by the National Health Service (NHS) Centre for Smoking Cessation and Training.

Recommendation

Training should be delivered nationally, with a unified curriculum, with certification and continuing education as needed.

Anticipated outcomes from this recommendation:

- GPs will establish their patients' smoking habits and treat smoking as a disease
- GPs will promote and support smoking cessation programmes and follow-up patients as needed.

09.08 MORE INVOLVEMENT OF PRIMARY CARE PHYSICIANS IN SMOKING CESSATION PROGRAMMES

Background

Training primary care physicians through courses in smoking cessation should be combined with ensuring that these physicians are fully involved in the smoking cessation programmes running in the country.

Current situation
This was another very important recommendation that was voiced by interviewees from most countries. The interviewees reasoned that GPs are not currently motivated enough to identify smokers and treat them because of a lack of time, a lack of the necessary skills, a lack of knowledge of existence of smoking cessation programmes to which smokers may be referred, a lack of awareness of the magnitude of healthcare expenditure due to smoking-related illnesses and the associated cost-benefit dynamics.

Recommendation
This recommendation encompasses further training of primary care physicians in smoking cessation as described earlier, combined with personal incentives to GPs for identifying smokers in their practice, counselling them to quit smoking, referring them to the appropriate smoking cessation programmes running in the country or treating them with smoking cessation medications, following up to make sure that the patient is compliant and that the treatment is successful. Also, the GP should be motivated to play his or her role in a co-ordinated response if the patient is referred to a special smoking cessation clinic.

Very few of the countries included in this study have such incentives in place to motivate GPs to engage actively in smoking cessation efforts. There are a few exceptions: GPs in Belgium receive an incentive payment for every smoker they treat. In the Netherlands, STIVORO (The Dutch Foundation on Smoking and Health) has recommended a similar incentive payout for GPs who can demonstrate a reduction in the number of smokers in their practice. As previously mentioned, England also provides GPs with financial incentives (through a performance-related pay system) to check the smoking status of their patients.[1158]

Anticipated outcomes from this recommendation:
- Helps to establish tobacco dependence as a disease
- Likely to increase the volume of research into the disease
- Provides evidence-based standardisation of services
- Increased provision of validated smoking cessation services
- Greater use of known successful interventions.

09.09 IMPROVE TRAINING FOR ALL HEALTHCARE PROFESSIONALS

Background
Along with GPs, who are generally the key players in smoking cessation, specialists, psychologists and nurses play important roles in lowering the burden of smoking related illnesses in the population.

Current situation
It was proposed that there should be an enhanced training drive for all relevant HCPs. This was considered critical, in view of the need for co-ordination between GPs, who will generally initiate a smoking cessation programme and specialist clinics to which patients may be referred, where physicians, nurses and/or psychologists will have an important role to play in helping the patient to break their tobacco dependence. Lack of skills or motivation in any one of the links in this treatment chain will deliver sub-optimal results.

The national training programme for nurses, GPs and stop smoking advisers that was developed by the NHS Centre for Smoking Cessation and Training (NCSCT) is currently being rolled out in the UK and may be considered best practice for developing training programmes for HCPs in other countries.

Recommendation
National-level stakeholders highlighted the need for improved training and education for all healthcare professionals involved in the smoking cessation effort. As with GPs, training should be delivered nationally, with a unified curriculum, with certification and continuing education as needed.

Anticipated outcomes from this recommendation:
- Helps to establish that tobacco dependence is a disease
- Likely to increase the volume of research into tobacco dependence
- Provides evidence-based standardisation of services
- Increased provision of validated smoking cessation services
- Increased reach of smoking cessation services to a wider population
- Facilitate team building and network formation between healthcare professionals.

09.10 COUNTRY-SPECIFIC RECOMMENDATIONS

The above recommendations were considered key and applicable across many countries but section 08.00 of this report also provides recommendations relevant to each country. These country-specific recommendations include tightening the existing smoke-free legislation, providing healthcare professionals with guidelines in their local language and improving the education for the general public so that they can better understand smoking as a disease and the resources available to help them quit (e.g. quitlines).

09.11 AN 'IDEAL' COUNTRY AND HOW THE OTHERS COMPARE

Utilising all of the interview respondent recommendations, the Editorial Partners concluded that an ideal country with respect to tobacco control, would offer the following to its citizens (Table 18).

TABLE.18 FEATURES OF AN IDEAL COUNTRY

Yes – Country implementing; Medium – Implementation to some extent; No – Country not implementing

	IDEAL COUNTRY
Policy	
Widespread understanding and official recognition that tobacco dependence is a disease	Yes
Surveillance of smoking prevalence and monitoring success of smoking cessation services	Yes
Smoking prevalence targets set and tracked	Yes
Tobacco prices set at a high level	Yes
Reimbursement of time for providing smoking cessation services and reimbursement of treatments	Yes
Full access to smoking cessation services	Yes
Full implementation and enforcement of smoke-free legislation	Yes
No tobacco industry advertising or promotional activities	Yes
Services	
Physicians comprehensively involved in smoking cessation	Yes
All healthcare professionals comprehensively involved in smoking cessation	Yes
Smoking cessation services organised from a central organisation with a network of smoking cessation centres	Yes
Smoking cessation strategy with guidance on service provision available and with government endorsement	Yes
Medical society approved treatment guidelines disseminated and implemented	Yes
Education	
Physicians educated and trained on smoking cessation	Yes
All healthcare professionals educated and trained on smoking cessation	Yes
The general public (particularly children and people in lower socio-economic groups) educated on smoking and smoking cessation	Yes
Medical student education on smoking and smoking cessation	Yes

AN "IDEAL" COUNTRY AND HOW THE OTHERS COMPARE

TABLE.19
POLICY FEATURES COMPARED TO AN IDEAL COUNTRY

	AUSTRIA	BELGIUM	CZECH REPUBLIC	DENMARK	FINLAND	FRANCE	GERMANY	GREECE	HUNGARY	IRELAND
% of regular daily smokers (age 15+)	*34%[1160]	20.5%[1161]	26.3% (15 to 64 years)[1162]	21.5%[1163]	18.6%[1164]	28.7%[1165]	23.4% (regular smokers)[1166]	35%[1168]	30%[1169]	27%[1170]
Widespread understanding and official recognition that tobacco dependence is a disease	Taught in medical schools	No	No	No	Medical professionals understand but some still do not understand the seriousness of the health problem	Addiction to tobacco is recognised as a dependence, not a disease	There is no common standard in the curricula of medical schools	Some progress but more required	No	To some extent
Surveillance of smoking prevalence & monitoring success of cessation services	No	Yearly surveys of prevalence but no regular monitoring of cessation services	2009 National Institute of Public Health survey but no monitoring of cessation services	Regular surveys and monitoring of cessation services with Danish Smoking Cessation Database	Smoking prevalence and success of smoking cessation services monitored annually	Regular surveys and monitoring of smoking cessation policies but no monitoring of cessation services	Few small-scale surveys but no obligatory monitoring of cessation services	There are some local surveys on prevalence	Some surveys but no monitoring of cessation services	Regular surveys but periodic monitoring of cessation services
Smoking prevalence targets set and tracked	No written Austrian policy on smoking	No numerical target but there is a government strategy to reduce prevalence	No national targets	No numerical target set by national government	'Smoke-free 2040' with goal to end the use of tobacco products	French Cancer Programme '09-'13 target to reduce the prevalence from 30% to 20%	No national targets	Target set	Targets set but not tracked	Yes, target to reduce overall prevalence by 1% per annum[1171]
Tobacco prices set at a high level[1159]	3% below European Union (EU) 27 average	8% above EU27 average	25% below EU27 average	Above EU27 average	Above EU27 average	Above EU27 average	Above EU27 average	28% below the EU27 average	49% below the EU27 average	Yes, more than double the EU27 average
Reimbursement of time for providing smoking cessation services and reimbursement of treatments	Most services free but treatments not reimbursed	Most services free but reimbursement of treatments is complex	Smoking cessation clinics free but treatments not reimbursed	Majority of municipalities offer free smoking cessation counselling, but medicines are not reimbursed	Public sector and occupational health services reimbursed. Private sector services reimbursed by Social Insurance Institute. Medication not reimbursed	Hospital-based smoking cessation out-patient services are free with a social security card but medications only reimbursed up to €50 voucher	Most health insurance funds provide reimbursement for group-based courses for smoking cessation and for medications	Services reimbursed and new legislation proposed to provide partial reimbursement for medications	Smoking cessation services are free but treatments are not reimbursed	All smoking cessation services and drugs are reimbursed for those with a Medical Card. However, not all are fully reimbursed for medications
Full access to smoking cessation services	Organised regionally	Yes (separate for Flanders and Wallonia)	Limited. Network of tobacco dependence hospital-based clinics	Yes and services monitored	Yes but lack of specialist clinics	Lack of formal structure at primary care level	Services vary across the Federal states and are "high-thresholds"	Somewhat fragmented	Have a network of smoking cessation services but limited provision	Yes
Full implementation & enforcement of smoke-free legislation	Small bars exempt and enforcement is an issue	Bars only smoke-free when food is served	Smoking rooms allowed with a note on the door	A few exceptions such as single-person offices	Yes	Strictly forbidden to smoke in areas for collective use but it is possible to smoke outside. Smoking rooms are permitted under very strict conditions	The smoking laws vary for each Federal area	Smoke-free legislation strengthened in September 2010 but implementation could be strengthened	Smoke-free legislation for public places has not yet been ratified	Yes
No tobacco industry advertising or promotional activities	No direct advertising but advertising of non-tobacco products with tobacco brand name is allowed. Point of sale advertising allowed	Not yet banned at the point of sale	Not yet banned at the point of sale	Not yet banned at the point of sale	Yes and banned at point of sale in 2010	Yes and also scheduled to be restricted at point of sale	Advertising allowed on billboards, in movie theatres after 6:00pm.and at point of sale[1167]	Not yet banned at the point of sale	Yes, restricted at point of sale (not visible from street)	Yes and point of sale ban in 2009

*Assume figure is for daily and occasional smokers

KEY — Yes country implementing | Medium implementation to some extent | No country not implementing

	ITALY	LUXEMBOURG	NETHERLANDS	NORWAY	POLAND	PORTUGAL	SPAIN	SWEDEN	SWITZERLAND	UNITED KINGDOM
% of regular daily smokers (age 15+)	23% (14 years+)[1172]	19%[1174]	28%[1175]	21% (aged 16-74) 6% daily snuff[1178]	30.3%[1184]	22%[1185]	26.4%[1186]	18%[1187]	20%[1189]	21%[1191]
Widespread understanding and official recognition that tobacco dependence is a disease	Understanding could be improved	Considered a disease	No, smoking still seen as 'lifestyle' choice	To some extent	No	To some extent	Generally there is still a belief that smoking is a bad habit. Healthcare professionals are increasingly assuming it's a disease	To some extent	No, smoking needs to be seen as a medical condition	To some extent
Surveillance of smoking prevalence & monitoring success of cessation services	Regular surveys and yearly monitoring of cessation services and success	Yearly surveys but no monitoring of cessation services	Regular surveys but no monitoring of cessation services	Regular surveys but no monitoring of cessation services	Some surveys but no monitoring of cessation services	Regular surveys but no monitoring of the quality / success of smoking cessation interventions	Regular surveys but no monitoring of cessation services	Regular surveys but no monitoring of cessation services	Regular surveys but no monitoring of cessation services	Yes and success of cessation services tracked
Smoking prevalence targets set and tracked	National Prevention Plan aim to implement smoking prevention efforts but no specific numerical target[1173]	No official prevalence targets although there are annual evaluations of the numbers of smokers	National Tobacco Control Programme 2006-2010 set target of 20%[1176]	National Strategy target to reduce daily smokers to less than 20% by 2010[1179] but inadequately implemented[1180]	Targets set but not achieved so reset	Portugal committed to reducing tobacco use but numerical targets do not appear to exist	No national goals	The Riksdag has a target to reduce smoking[1188]	National Tobacco Programme (2008-2012) with numerical targets[1190]	Yes, each nation has separate targets and targets are tracked
Tobacco prices set at a high level[1159]	4% above EU27 average	12% below EU27 average	11% above the EU27 average	Yes, more than double the EU27 average	48% below the EU27 average	15% below the EU27 average	27% below the EU27 average	Yes, 30% above the EU27 average	4% above the EU27 average	Yes, 66% above the EU27 average
Reimbursement of time for providing smoking cessation services and reimbursement of treatments	With some regional exceptions, smoking cessation services and treatments not reimbursed	Services reimbursed but treatments only partially reimbursed	Smoking cessation services and treatments reimbursed from January 2011	There is no reimbursement for smoking cessation except for those following 'The programme' and for those patients with smoking-related diseases[1181]	Some reimbursement for some smoking cessation services but treatments are not reimbursed	Smoking cessation services at primary and secondary care level are fully reimbursed but medications are not reimbursed	Smoking cessation services available. Medications not reimbursed at a central level in the same way as other medications but with some regional exceptions	Clinics are either free or low-cost and prescription products are reimbursed second-line	Medications are not reimbursed except through complimentary private insurance	Yes, smoking cessation services and treatments reimbursed
Full access to smoking cessation services	Yes, smoking cessation clinics	Yes, there is a 'Programme for smoking cessation'	Yes	Joint National Capacity Assessment report highlighted that cessation services are "almost non-existent"[1182]	Smoking cessation clinics in 14 of the 16 regions	A network for smoking cessation support exists	Yes, full access in primary care and regional network of Specialised Tobacco Units but limited public knowledge	Variable, because of the different local governing bodies in Sweden	Yes, in the primary care and secondary care setting	Yes
Full implementation & enforcement of smoke-free legislation	Lack of enforcement	Ministry of Health will re-visit the smoking laws of 2006 with a view to extending them	Some issues with exemptions and enforcement	Yes but lack of monitoring and enforcement of smoke-free areas[1183]	Smoke-free legislation in place	The implementation of smoke-free legislation in Portugal has not been independently evaluated and unpublished research suggests enforcement is an issue	From 2 January 2011, smoke-free environments in all enclosed public places	Yes, and restricted at point of sale	There is a need to introduce more stringent smoke-free legislation	Yes, each nation has own legislation with Scottish legislation being firmer on some issues
No tobacco industry advertising or promotional activities	Not yet banned at the point of sale	Yes	Yes and restricted at the point of sale since 2002[1177]	Yes and banned at point of sale since 2010	Not yet banned at the point of sale	Not yet banned at the point of sale	There is no legislation to ban indirect tobacco advertising, such as product placement on the television	Improved legislation required	Not yet banned at the point of sale	Vending machine ban expected late 2011. Legal challenges on point of sale ban

TABLE.20
SERVICE FEATURES COMPARED TO AN IDEAL COUNTRY

	AUSTRIA	BELGIUM	CZECH REPUBLIC	DENMARK	FINLAND	FRANCE	GERMANY	GREECE	HUNGARY	IRELAND
% of regular daily smokers (age 15+)	*34%[1192]	20.5%[1193]	26.3% (15 to 64 years)[1194]	21.5%[1195]	18.6%[1196]	28.7%[1197]	23.4% (regular smokers)[1198]	35%[1199]	30%[1200]	27%[1201]
Physicians comprehensively involved in smoking cessation	Primary care physicians need to be more involved	Primary care physicians need to be more involved	Primary care physicians not very proactive	Primary care physicians should be more proactive with smokers	Patients tend to be asked about their smoking status	No formal structure for GPs	Increasingly more physicians involved but need to be at the centre of services, starting at the lowest levels	Differs in rural areas to urban areas	Primary care physicians need to be involved	Not particularly comprehensive
All healthcare professionals comprehensively involved in smoking cessation	Healthcare professionals need to be more involved	Healthcare professionals need to be more involved	Systematic education in the field of smoking cessation required	Some healthcare professionals are involved in smoking cessation	Nurse specialists at primary care level	Insufficient specialists	Specialist smoking cessation clinics involve other healthcare professionals	Healthcare professionals not particularly involved	Nurses being trained but not particularly involved	Yes, nurses heavily involved
Smoking cessation services organised from a central organisation with a network of smoking cessation centres	Smoking cessation services are managed regionally	No real national focal point within government for smoking cessation	Network of tobacco dependence hospital-based clinics	Organised locally by municipalities	The regions and hospital districts should have a more co-ordinated smoking cessation service provided by health centres	Hospital-based smoking cessation clinics participate in a nationwide electronic database	No central organisation	Hospital-based clinics increasing in number but not all are part of a network	Organised nationally but implementing could be improved	Realignment of current smoking cessation services under one central national body required
Smoking cessation strategy with guidance on service provision available and with government endorsement	No strategy and no government endorsed guidance	Government wishes to reduce smoking but no government endorsed guidance	No strategy and no government endorsed guidance	National plan for prevention but no guidelines on service provision	Yes	Government guidelines but need updating and not enforced	No strategy and no government endorsed guidance	National action plan	Peer-reviewed guidelines are national and government approved	National Tobacco Control Framework[1202]
Medical society approved treatment guidelines disseminated and implemented	Some medical society guidelines but not widely implemented	Peer reviewed guidelines available but enforcement limited	19 medical associations have endorsed guidelines	New national guidelines from the National Board of Health expected early 2011	Yes but no data on dissemination and implementation	The French Speaking Society for Chest Medicine (SPLF) has approved guidelines for smoking cessation treatment in COPD	Yes, partially (guidelines are approved, partially disseminated and implementation could be improved)	Yes, but tend to be local	Peer-reviewed guidelines	Yes, but primary care guidelines need a focus

*Assume figure is for daily and occasional smokers

KEY — Yes country implementing — Medium implementation to some extent — No country not implementing

	ITALY	LUXEMBOURG	NETHERLANDS	NORWAY	POLAND	PORTUGAL	SPAIN	SWEDEN	SWITZERLAND	UNITED KINGDOM
% of regular daily smokers (age 15+)	23% (14 years +)[1203]	19%[1206]	28%[1207]	21% (aged 16-74) 6% daily snuff[1209]	30.3%[1212]	22%[1213]	26.4%[1215]	18%[1216]	20%[1218]	21%[1219]
Physicians comprehensively involved in smoking cessation	Yes, but dependent on knowledge	Yes, primary care physicians part of 'The Programme'	Yes, but not always	Yes and GPs may refer if do not feel qualified	Need for more smoking cessation programmes in primary care	Yes and GPs have software to help but need to be more involved	Yes, GPs starting to get more involved and they do refer patients	Increasing the involvement of primary care physicians is seen as particularly important	Increasing the involvement of primary care physicians is seen as particularly important	Yes, particularly with referral to smoking cessation services
All healthcare professionals comprehensively involved in smoking cessation	Yes, smoking cessation clinics with access to nurses, physiotherapists and clinical psychologists	GPs do not subscribe to 'The Programme' as much as desired	Specialised nurse practitioners and GP assistants are involved	To some extent	Nurses, psychologist and nutritionists at specialised smoking cessation clinics	Yes, there is a network for smoking cessation support consisting of physicians, nurses and psychologists across the 5 regions but could involve healthcare professionals more	Yes, there are Specialised Tobacco Units, but more involvement of primary care and hospital-specialist physicians is needed	Varies a lot depending on the individual and there is a need for broader engagement	Nurse-led smoking cessation should be encouraged	Yes, stop smoking services are particularly active and all healthcare professionals encouraged to provide smoking cessation services
Smoking cessation services organised from a central organisation with a network of smoking cessation centres	No, a coordinated network of national services is required	No central organisation	No	No and lack mechanisms for cooperation between different national, county and municipal stakeholders in tobacco control[1210]	National programme at the primary care level but regional implementation	Smoking cessation services are organised in the 5 regional health administration units. There is a network of smoking cessation services (hospital and primary care units) in all the 5 regions	Decentralised health service but have Tobacco Observatory which is a network of tobacco control groups	There is a lack of a national structure	National Stop Smoking Program available	Yes, each nation organises it's own services from a central organisation
Smoking cessation strategy with guidance on service provision available and with government endorsement	National Prevention Plan[1204]	No official smoking prevalence targets or national guidelines	National Tobacco Control Programme 2006-2010[1208]	National Strategy for Tobacco Control 2006-2010[1211]	Yes, strategy in place	National Programme on Smoking Cessation[1214]	No, but some regional agreements. Latest smoke-free legislation makes a general recommendation to put in place smoking cessation programmes and foster new smoking cessation services	Guidelines from the National Board of Health and Welfare issued in October 2010[1217]	National Tobacco Programme	Each nation has their own strategy
Medical society approved treatment guidelines disseminated and implemented	Yes, national guidelines for GPs from the National Health Institute[1205] and regional guidelines	No national guidelines	Yes, clinical guidelines through the Partnership on Smoking Cessation project	Yes and an update was being prepared in 2010 but publication appears delayed	Yes	Yes, but need greater implementation	Yes, but greater implementation is required	Yes and issued by the National Board of Health and Welfare	Yes, and government approved	Yes

TABLE.21
EDUCATION FEATURES COMPARED TO AN IDEAL COUNTRY

	AUSTRIA	BELGIUM	CZECH REPUBLIC	DENMARK	FINLAND	FRANCE	GERMANY	GREECE	HUNGARY	IRELAND
% of regular daily smokers (age 15+)	*34%[1220]	20.5%[1221]	26.3% (15 to 64 years)[1222]	21.5%[1223]	18.6%[1224]	28.7%[1225]	23.4% (regular smokers)[1226]	35%[1227]	30%[1228]	27%[1229]
Physicians educated and trained on smoking cessation	Physicians can obtain a certificate on smoking cessation	Limited for GPs but tobaccologist training available	Seminars for primary care staff	No national programmes	Some education available for physicians in primary care but this is organised locally, in districts and in regions	No formal GP training on smoking cessation and secondary care is hospital-specific	Some education available and a diploma in preventive medicine available	No official training	Limited GP training but medical association training for pulmonologists	Yes, mainly GPs but is more comprehensive in some places than in others
All healthcare professionals educated and trained on smoking cessation	No formal education programmes	Organised by medical societies	Seminars for primary care staff	Training courses provided by the Danish Cancer Society	Improvement but not enough healthcare professionals attend course	Tobaccologist training available	No formal training of healthcare professionals; if training occurs, it does so by chance	More training required	Pulmonary nurses only	Limited but HSE's Tobacco Control Framework advocates compulsory smoking cessation training for all healthcare professionals[1230]
The general public (particularly children and lower socio-economic groups) educated on smoking and smoking cessation	Advertising campaigns initiated by the Austrian Medical Chamber but rudimentary at primary care level	There are no national programmes	Little education on smoking	A number of health campaigns over the last 30 years	Yes, mostly co-ordinated by non-government organisations (NGOs), and financed by government	Yes, from the National Institute for Prevention and Health Education	Few educational programmes but literature available	More education required	A few programmes co-ordinated by NGOs	Limited number of public awareness campaigns throughout the year
Medical student education on smoking and smoking cessation	Taught that tobacco dependence is a disease, but smoking cessation is only small proportion of education	No national curriculum and limited smoking cessation education	Yes, collaboration between medicine faculties and students must take courses	Not routinely taught	Yes	Some provided in some medical schools and not always mandatory	Some provided but focuses on damage smoking causes rather than treatments	No official training	Not part of the curriculum of all medical schools	Limited but HSE's Tobacco Control Framework advocates compulsory smoking cessation training[1231]

*Assume figure is for daily and occasional smokers

KEY — Yes country implementing — Medium implementation to some extent — No country not implementing

	ITALY	LUXEMBOURG	NETHERLANDS	NORWAY	POLAND	PORTUGAL	SPAIN	SWEDEN	SWITZERLAND	UNITED KINGDOM
% of regular daily smokers (age 15+)	23% (14+ years)[1232]	19%[1233]	28%[1234]	21% (aged 16-74) 6% daily snuff [1235]	30.3%[1237]	22%[1238]	26.4%[1239]	18%[1240]	20%[1241]	21%[1242]
Physicians educated and trained on smoking cessation	Little official GP training as part of curriculum	GP training provided some years ago but needs repeating	STIVORO provides GP education but nothing from the government	Yes, provided	Both national and regional	Some educational programmes provided at the primary care level but more education required	Mostly provided by medical societies and organised regionally	There is a need to continue the education of primary care physicians	Yes, 'Free From Tobacco' programme for private primary care physicians but greater education and support required	There is a need for a national training programme on smoking cessation. The National Smoking Cessation Training Centre (NSCTC) does not currently cover GPs, secondary physicians or nurses
All healthcare professionals educated and trained on smoking cessation	No national initiatives to provide education for secondary care	Nothing provided and some go to neighbouring countries for training	Specialists trained by STIVORO but no information on other HCPs	Education at the secondary care level is provided for physicians, specialists and other healthcare professionals but more is recommended	Student nurse education is limited to the damage smoking causes. Some *ad hoc* smoking cessation training is provided	More training required	Compulsory education on smoking cessation, either by the national or the regional health systems, is recommended	Tobacco cessation training courses available from the European Network of Smoke-Free Hospitals	Yes, in hospital-based clinics	The NSCTC offers standard, basic training for all smoking cessation advisers (existing and new)
The general public (particularly children and lower socio-economic groups) educated on smoking and smoking cessation	Campaigns are occasionally broadcast, mainly via television at a national level	Money invested into public health campaigns for tobacco cessation	Yes, provided by government and STIVORO but targeted education required	Inadequate resources assigned for mass medial campaigns[1236]	More education for the general public required	Generally limited by funding but a consistent and targeted education campaign is required	No national programmes although there are some regional initiatives	Need to ensure the general public is aware of the help and support available	Little education although there are occasional campaigns	Yes, each nation arranges their own public health campaigns
Medical student education on smoking and smoking cessation	No specific programmes in place for training medical students	Medical students generally study abroad	No smoking cessation education for medical students	Just one hour as part of curriculum	Medical student education focuses on the damage smoking causes	Medical student education on tobacco dependence is limited and optional	No national curriculum on drug dependence	Education of medical students is on a university-by-university basis	Each medical school has own curriculum and nothing is national	Yes, but varies by medical school

09.12 FUTURE STEPS FOR CONSIDERATION

09.12.1 RESEARCH INITIATIVES

According to the World Health Organization (WHO),[1243] the cornerstone of a well-informed tobacco control policy involves surveillance, monitoring and evaluation and the WHO FCTC requires such data collection (Article 20 on research, surveillance and exchange of information).[1244] A key barrier to achieving the goals of the FCTC has been identified as the lack of investment in research on control of tobacco use and tobacco-attributable disease.[1245]

There is a need to illustrate that reducing the prevalence of tobacco use will provide certain benefits and that these benefits will accrue to the whole country as well as to the smokers.

Therefore further research initiatives are required to better understand the interaction of the various tobacco control measures and to evaluate specific measures. Such research drives advances in the field.

Research is required into many areas of tobacco control as suggested below:

- Epidemiology including prevalence, treatments and attitudes, e.g.
    - An audit of smoking cessation services provided and the outcomes achieved
    - Research into health inequalities (e.g. those in lower socio-economic groups have less access to specialist services)[1246]
    - The WHO has commented on the importance of understanding the contribution of HCPs to "not only improving health but also in possibly reducing such inequalities"[1247]
    - Research to test interventions and strategies to reduce barriers to smoking cessation by all groups in society.
- Health benefits of quitting smoking
    - Research to better establish the health benefits of quitting smoking for the individual
    - Research from the perspective of governments, health funds, and employers to understand the economic benefits of improved health following smoking cessation.
- Interventions to help people quit smoking, for example, research into:
    - Behavioural interventions
    - Alternative, safer nicotine delivery systems to replace smoking
    - Other pharmacological interventions
    - Relapse prevention.

WHO[1248]
"Monitoring activities can provide critical evidence to bolster the case for stronger tobacco control."
09.12.1

09.12.2 ESTABLISH A EUROPEAN SMOKING CONTROL CENTRE (ESCC)

The European Union (EU) Council Recommendation on smoke-free environments of 30 November 2009[1249] calls upon Member States to "strengthen cooperation at EU level by setting up a network of national focal points of tobacco control."

To facilitate smoking control on an international level, a European Smoking Control Centre (ESCC) should be established to work in conjunction with the established parliamentary system of the EU. The mission of the ESCC would be to promote the reduction of tobacco smoking throughout Europe. This multinational organisation would become a central base of knowledge of the dangers of smoking, existing anti-smoking

policies for each member country, therapies and treatments for tobacco dependence.

The ESCC would track the anti-smoking measures of each country and investigate how well these existing smoking control policies are implemented and enforced. From this knowledge, the ESCC could report on the effectiveness of various smoking control policies, as well as weaknesses that need to be addressed in each country.

Furthermore, multinational anti-smoking research initiatives could be funded and overseen by the ESCC. Comparisons between countries could be made, based upon correlations between countrywide smoking prevalence and smoking control policies enacted and enforced in individual countries. Such country comparisons would allow the ESCC to evaluate factors that may contribute to lower smoking prevalence and to develop new strategies based upon these findings. The ESCC could disseminate this knowledge to its member countries through anti-smoking educational campaigns (e.g. through media advertising, scientific and medical publications, public outreach programmes, etc.), as well as to countries outside of the EU (many of which lack sufficient smoking control policies). Through the ESCC, countries would thus be enabled to learn more easily from each other and to provide mutual assistance in the fight against tobacco dependence.

CONCLUSION

10.01 AN INTEGRATED APPROACH

Based on international experience, it is thought that the best results to reduce tobacco demand are obtained when various tobacco control measures are implemented together. Therefore, the next step is to create an integrated approach based on the recommendations of this report.

The aim of an integrated approach is to combine treatment with prevention and follow-up, to stop people starting to smoke, to encourage them to quit, maintain abstinence and to support quitters who relapse.

As well as focusing on treatment, tobacco control should be combined with preventative measures and long-term follow-up.

10.02 KEY RECOMMENDATIONS

This report makes a number of recommendations to reduce smoking prevalence and the demand for tobacco products based on country-specific recommendations provided by the interviewees, combined with the Editorial Partners' own experience and views. These key recommendations are:

- Increase tobacco prices
- Reimburse time for providing smoking cessation counselling (or increase existing reimbursement)
- Reimburse smoking cessation medications
- Provide national guidance and clinical guidelines (or implement existing ones)
- Further training for primary care physicians
- Involve primary care physicians more in smoking cessation programmes
- Improve training for all healthcare professionals.

APPENDICES

11.01 APPENDIX A: TERMS AND ABBREVIATIONS

AMI	Acute myocardial infarction
ASCO	American Society of Clinical Oncology
ASH	Action on Smoking and Health
AT	Swiss Association for Smoking Prevention
BÄK	German Medical Association
CHD	Coronary/chronic heart disease
CI	Confidence interval
CME	Continuing medical education
CNPT	Comité Nacional para la Prevención del Tabaquismo (National Committee for the Prevention of Smoking)
COP	Conference of the Parties
COPD	Chronic obstructive pulmonary disease
DALY	Disability-adjusted life-year
DGS	Portuguese General Directorate of Health (Direcção-Geral da Saúde)
DKFZ	German Cancer Research Centre (Deutsches Krebsforschungszentrum)
DKK	Danish Krone
DMP	Disease management programme
DSM	Diagnostic and Statistical Manual of Mental Disorders
ENSH	European Network of Smoke-Free Hospitals
EPHA	European Public Health Alliance
ERS	European Respiratory Society
ESC	European Society of Cardiology
ESCC	European Smoking Control Centre
ESMO	European Society for Medical Oncology
EU	European Union
EU27	27 European Union countries
FARES	Fonds des Affections Respiratoires
FCA	Framework Convention Alliance
FCTC	Framework Convention on Tobacco Control
FEV_1	Forced expiratory volume in 1 second
G-BA	Federal Joint Committee
GDP	Gross domestic product
GP	General Practitioner
HAS	Haute Autorité de Santé
HCP	Healthcare professional
HEAT	Scotland's health improvement targets
HMRC	Her Majesty's Revenue and Customs
HSE	Health Service Executive
ICD	International Classification of Diseases
IPCRG	International Primary Care Respiratory Group
KV	Kassenärztliche Vereinigung
LHBs	Local health boards
NCSCT	National Health Service Centre for Smoking Cessation and Training
NGO	Non-governmental organisation
NHS SSS	NHS Stop Smoking Service

NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NOK	Norwegian Krone
NRT	Nicotine replacement therapy
OFT	Office Français de Prévention du Tabagisme
OssFAD	Observatory on Smoke, Alcohol and Drugs of Abuse (the Osservatorio Fumo, Alcol e Droga)
OTC	Over-the-counter
PCP	Primary care physician
PESCE	General Practitioners and the Economics of Smoking Cessation in Europe
QALY	Quality-adjusted life-year
QOF	Quality and Outcomes Framework
SBU	Swedish Council on Health Technology Assessment
SEPAR	Spanish Society of Pneumology and Thoracic Surgery
SHS	Second-hand smoke
SPLF	French-Speaking Society for Chest Medicine
SSMG	Société Scientifique de Médecine Générale
STIVORO	The Dutch Foundation on Smoking and Health
TFU	Tobacco Free United
UK	United Kingdom
USA/US	United States of America
VRGT	Flemish Association for Respiratory Health and Tuberculosis
WHO European Region	In 2007 this included Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, San Marino, Serbia and Montenegro (Serbia), Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom, and Uzbekistan
WHO	World Health Organization
WHOSIS	World Health Organization Statistics Information Services
WHP	Workplace health promotion

11.02 APPENDIX B: INTERVIEWEES

The authors are grateful to the following interviewees who contributed substantially to this report by providing valuable insight into the healthcare systems of their countries.

AUSTRIA

Dr Sylvia Hartl
Head of the Department
Department of Pulmonary and Critical Care Medicine, Otto Wagner Hospital, Vienna, Austria

Vice-president of the Austrian Society of Pulmonology and Secretary General of the European Respiratory Society

Prof. Dr med. Ernest Groman
Professor in Public Health
Institute of Social Medicine, Center for Public Health, Medical University of Vienna, Vienna, Austria

Prof. Kurt Grünewald
Member of Parliament
Austrian Parliament, Vienna, Austria

Science and Health Spokesperson for the Green Party

Prof. Dr med. Michael Kunze
Director
Institute for Social Medicine, Vienna Medical School Vienna, Austria

BELGIUM

Prof. Pierre Bartsch
Pneumologist
University of Liege and Centre Hospitalo-Universitaire (CHU), Liège, Belgium

Honorary President of Fond des Affections Respiratoires (FARES) and Chairman of the inter-university scientific committee about tobaccology

Prof. Jacques Prignot
Pneumologist and Tobaccologist
Université Catholique de Louvain, Jambes, Belgium

Honorary President of FARES and member of the Interuniversity Scientific Committee of Smoking Control

Mr Jean Michel Wouters
Social Nurse Coordinator and Tobaccologist
Vlaamse Vereniging voor Respiratoire Gezondheidszorg en Tuberculosebestrijding (VRGT) – Flemish Association for Respiratory Health and Tuberculosis, Brussels, Belgium

CZECH REPUBLIC

Dr Eva Kralikova
Head of Centre
Tobacco Dependence Treatment Centre, 3rd Department of Medicine – Department of Endocrinology and Metabolism, First Faculty of Medicine, Charles University in Prague and General University Hospital in Prague Praha, Czech Republic

Head of the Society for the Treatment of Tobacco Dependence, Czech Republic

Dr Alexandra Kmetova
Tobacco Dependence Physician
General University Hospital in Prague, Center for Tobacco Dependent, Praha, Czech Republic

DENMARK

Prof. Torben Jørgensen
Director
Research Centre for Prevention & Health, The Capital Region of Denmark, Glostrup Hospital, Glostrup, Denmark

Dr Philip Tønnesen
Chief of Department
Department of Pulmonary Medicine, Pulmonology Department, Gentofte University Hospital, Hellerup, Denmark

A representative from a Patient Organisation who has requested to remain anonymous

FINLAND

Dr Matti Rautalahti
Chief Medical Officer
Suomen Syöpäyhdistys (Cancer Society of Finland), Helsinki, Finland

Mr Patrick Sandström
Researcher
Department of Epidemiology and Health Promotion, The National Institute of Health and Welfare, Helsinki, Finland

Dr Olli Simonen
MD, Ministerial Adviser
Retired from Ministry of Social Affairs and Health, Helsinki, Finland

Previously responsible for tobacco policy issues in Finland

Chairman of Doctors Against Tobacco (DAT) Finland

FRANCE

Dr Ivan Berlin
Physician and Clinical Pharmacologist
Service de Pharmacologie, Hôpital Pitié-Salpêtrière–Université P. & Marie Curie, Faculty of Medicine
Paris, France

President of French Society of Tobacco Research (Société Française de Tabacologie (SFT))

Prof. Bertrand Dautzenberg
Pneumonologist
Hôpital Pitié-Salpêtrière, Paris, France

French representative on the European Network for Smoking and Tobacco Prevention

President of the Office Français de Prévention du Tabagisme (OFT)

Prof. Isabelle Durand-Zaleski
Health Economist
Professor of Medicine, University of Paris XII, Paris, France

Hôpital Henri Mondor, Créteil, France

Dr Anne-Laurence Le Faou
Tobaccologist and Senior Lecturer in Public Health
Universités Paris-VII Denis-Diderot, Paris, France

Head of the smoking cessation service of Hôpital Européen Georges-Pompidou, Assistance Publique-Hôpitaux de Paris, Paris, France

Head of the French database of smoking cessation services (CDTnet)

GERMANY

Dr Andreas Jähne
Head of the Working Group for Tobacco Cessation
Department of Psychiatry and Psychotherapy, Comprehensive Cancer Center, University Medical Center, Freiburg, Germany

Prof. Dr med. Wulf Pankow
Head of the Department of Internal Medicine
Pneumology and Infectiology, Vivantes Klinikum Neukölln, Berlin, Germany

Dr. med. Tobias Raupach
Head of Smoking Cessation Clinic
Department of Cardiology and Pneumology, University Hospital, Göttingen, Germany

GREECE

Mr Konstantinos Athanasakis
Health Economist
Research Fellow
Department of Health Economics, National School of Public Health, Athens, Greece

Prof. Panagiotis Behrakis
Associate Professor of Respiratory Physiology
School of Medicine, University of Athens, Athens, Greece

Professor of School of Public Health at Harvard, USA

Chairman of National Committee for Smoking and Tobacco Control and President of European Network of Smoking Prevention

Dr Elpida Pavi
Senior Lecturer
Department of Health Economics, National School of Public Health, Athens, Greece

Member of the Council of European Chief Dental Officers

HUNGARY

Prof. Róbert Gábor Kiss
Head of Cardiology Department
ÁEK Hospital Budapest, Budapest, Hungary

Previous secretary-general of Hungarian Cardiology Society, Hungary

Dr Gábor Kovács
Vice Director
Korányi National Institute of TB and Pulmonology Budapest, Hungary

Chairman of the Hungarian Medical Society of Pulmonologists, Hungary

Dr Peter Vajer
Project Manager
Smoking Cessation Centre, Department of Family Medicine, Budapest, Hungary

Founder and Leader of the Hungarian Smoking Cessation Centre, Hungary

IRELAND

Norma Cronin
Health Promotion Manager/Tobacco Control
Irish Cancer Society, Dublin, Ireland

Dr Kirsten Doherty
Senior Health Promotion Officer
Department of Preventive Medicine and Health Promotion, Education and Research Centre, St. Vincent's University Hospital, Elm Park, Dublin, Ireland

Dr Terry O'Connor
Consultant Respiratory Physician
Mercy University Hospital, Cork, Ireland

President of the Irish Thoracic Society (ITS)

ITALY

Dr Daniela Galeone
Medical Officer
Department of Prevention, Ministry of Health, Rome, Italy

Key contact for tobacco control issues

Prof. Stefano Nardini
Director of the Pulmonary Disease Unit
Vittorio Veneto General Hospital, Vittorio Veneto, Italy

Former Chairman of WG 6-3 (Tobacco, smoking control and health education) within the European Respiratory Society (ERS)

Prof. Riccardo Polosa
Director of Institute of Internal Medicine
Director of Centre for Smoking Prevention and Cure, University of Catania, Catania, Italy

European Respiratory Society (ERS) expert in smoking cessation and education

LUXEMBOURG

Dr Catherine Charpentier-Chaix
Chest Physician
Pneumologie, Centre Hospitalier de Luxembourg, Luxembourg City, Luxembourg

THE NETHERLANDS

Dr Pauline Dekker
Pulmonologist in general practice
Department of Pulmonology, Rode Kruis Ziekenhuis, Beverwijk, The Netherlands

Co-Chair of the Dutch Pulmonologist Workgroup on Tobacco Addiction

Dr Lies Van Gennip
Director
Dutch Foundation on Smoking and Health (STIVORO), Den Haag, The Netherlands

Prof. Marc Willemsen
Professor Tobacco Control Research
Department of Health Promotion, School for Public Health and Primary Care (CAPHRI), University of Maastricht, Maastricht, The Netherlands

NORWAY

Dr Eli Heggen
Senior Physician
Department of Preventive Cardiology, Oslo University Hospital, Ullevål Hospital, Oslo, Norway

Else Karin Rong Kogstad
Internal Medical Department
Division for Prevention of Cardiovascular Diseases, Central Hospital, Akershus, Oslo, Norway

Dr Svein Høegh-Henrichsen
General and Family Medicine Specialist
Oslo, Norway

Member of National Board for Smoking Cessation/Prevention

POLAND

Magdalena Cedzynska
Director of Smoking Cessation Services
Cancer Epidemiology and Prevention Department, Cancer Centre and Institute of Oncology, Warsaw, Poland

Prof. Piotr Jankowski
Department of Cardiology and Hypertension
Jagiellonian University, Medical College, Kraków, Poland

Chair of the working group on the prevention and epidemiology of the Polish Cardiac Society, Poland

Anna Kozieł
National Professional Officer NCE
Bloomberg Initiative (Poland) World Health Organization Warsaw, Poland

PORTUGAL

Prof. José M. Calheiros
Professor of Epidemiology and Preventative Medicine
Beira Interior University, Colvilhã, Portugal

President of the Portuguese Tobacco Control Society (a multi-professional Society)

Deputy Director
The Instituto Nacional de Saúde Doutor Ricardo Jorge, Lisbon, Portugal

Prof. Carlos Robalo Cordeiro
Professor of Pulmonology
Department of Pulmonology and Allergology, Coimbra University Hospital, Coimbra, Portugal

President of the Portuguese Pulmonology Society

Prof. Luís Rebelo
Professor of Family Medicine
Lisbon University, Lisbon, Portugal

One of five regional coordinators for smoking cessation

President of the Portuguese Coalition of Smoking Prevention (COPPT)

President of the Lisbon Regional Administration of Smoking Cessation (Health Ministry)

SPAIN

Dr Carlos Jiménez-Ruiz
Pulmonologist
Chief of the Smoking Cessation Unit, Madrid, Spain

Coordinates the Tobacco Group of SEPAR (Spanish Respiratory Society)

Chair of the Smoking Group of the European Respiratory Society (ERS)

Director of SEPAR Journal *Prevención del Tabaquismo*

Dr Francisco Rodríguez Lozano
Dentist
Vice President of National Committee for the Prevention of Smoking (CNPT)

Participated in the development of smoking cessation guidelines for dentists

Dr Esteve Saltó Cerezuela
Public Health Physician
Associate Professor, University of Barcelona, Barcelona, Spain

Chief, responsible for the Prevention and Control Tobacco Program, Catalonian Government

Delegate Member of the Spanish Hypertension Society in the CNPT

SWEDEN

Prof. Hans Gilljam
MD, Professor of Public Health
Karolinska Institutet, Stockholm, Sweden, Tobacco prevention expert

Margareta Pantzar
Psychologist
Swedish Psychologists against Tobacco, Stockholm, Sweden

Project Manager
Department of Drug Prevention, Swedish National Institute of Public Health, Östersund, Stockholm, Sweden

SWITZERLAND

Prof. Christoph Bolliger
Pulmonologist
Division of Pulmonology, Faculty of Health Sciences, University of Stellenbosch, Tygerberg, South Africa

Head of Hospital QuitSupport
Basel, Switzerland

Dr Jean-Pierre Zellweger
Chest physician with private practice in Switzerland

Medical advisor to the Swiss Lung Association – a NGO working with the Swiss Federal Office of Public Health, Switzerland

UNITED KINGDOM

Dr Robert Hampton
General Practitioner (GP) and Occupational Physician
Bushloe End Surgery, Leicestershire, UK

GP in Leicestershire Primary Care Trust (PCT)

Member of Leicestershire County and Rutland PCT Professional Executive Committee

Prof. Peter Hajek
Professor of Clinical Psychology
Head of Psychology, Director of Tobacco Dependence Research Unit, Barts and The London School of Medicine and Dentistry, London, UK

Nicky Willis
Chief Executive
National Health Service (NHS) Centre for Smoking Cessation and Training, NHS South London and Maudsley Trust, London, UK

Previously the national lead for smoking cessation for the Department of Health

11.03 APPENDIX C: BACKGROUND INFORMATION

11.03.1 THE EQUIPP REPORT

This EQUIPP report aims to highlight the current preparedness of a number of countries across Europe to implement Article 14 of the FCTC which covers demand reduction measures concerning tobacco dependence and cessation.[1250]

The report will highlight the current situation in each country along with issues and challenges faced by those working in tobacco control.

The report contents and recommendations are the work and opinions of all those involved in the project.

11.03.2 THE EDITORIAL PARTNERS' ROLE

The four Editorial Partners were selected for their broad range of knowledge in the field of tobacco control and they also cover a number of geographical areas. Pfizer and Bridgehead approached the Editorial Partners to become involved in the initiative based on their interest and work in the area of tobacco control.

Each Editorial Partner was involved from the very beginning of the project when the aims and objectives were developed and the methodology of the research decided. Throughout the project the Editorial Partners have attended many face-to-face meetings to develop the report and approve the content. The Editorial Partners have provided their approval on the content of this report.

Formal agreements are in place with the Editorial Partners and they have been paid a fee for their time. Pfizer also covered the costs associated with travel and accommodation for the Editorial Partner meetings.

11.03.3 BRIDGEHEAD'S ROLE

Bridgehead International were commissioned by Pfizer to help facilitate the preparation of the report and to conduct the interviews. Bridgehead wrote and edited the report and have implemented the suggestions and comments from the Editorial partners, the interviewees and Pfizer.

11.03.4 PFIZER'S ROLE

Pfizer initiated this project and provided the funding. Pfizer has worked in collaboration with the Editorial Partners, Bridgehead and the external experts to produce the report.

This project has been a collaboration with the Editorial Partners, Pfizer and the external experts who have brought significant insight and expertise to the project. While Pfizer has contributed to the research process, the final report, its content and recommendations represent the opinions of the Editorial Partners and interviewees, and do not represent Pfizer's position. This project does not focus on any specific products or treatments.

11.03.5
SELECTION OF COUNTRIES

Twenty countries were selected for research (see section 02.02.4). Selection was based on the quality and depth of the data available from the desk research but also the desire to provide a broad overview of the various smoking cessation services across Europe.

11.03.6
SELECTION OF INTERVIEWEES

A key part of the report has been the involvement of experts who were interviewed for the report and who reviewed and commented on their country-specific reports. These experts were chosen because of their knowledge and experience in the field of smoking cessation and they included stakeholders representing non-governmental organisations involved in smoking cessation, healthcare professionals, health policy makers and those advising national governments.

Generally there were three interviewees per country and a total of 57 experts were interviewed for this report across the 20 countries.

Each interviewee freely gave of their expertise and time.

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