Report of the second
WHO European meeting on
evidence-based treatment
of tobacco dependence

This report was prepared by Anne Hendrie and
Martin Raw for the World Health Organization

26 & 27 October 2000
Barcelona
TARGET 12

Reducing Harm from Alcohol, Drugs and Tobacco:

By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States.
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1. INTRODUCTION

This is the report of the second WHO European meeting on evidence based treatment of tobacco dependence. It describes progress in the development of evidence based treatment of tobacco dependence in the Partnership Project target countries (France, Germany, Poland, United Kingdom), and through the country reports and working groups, starts identifying what needs to happen in 2001 to continue this progress.

A range of treatments and programmes now exist to help smokers stop, including advice from a health professional, behavioural counselling, and the growing range of pharmaceutical products designed to aid cessation, such as NRT and bupropion. A large evidence base (summarised thoroughly in the US Public Health Service guideline and English smoking cessation guidelines, both published in 2000) shows that brief advice and more intensive behavioural support are effective (over and above control rates), and that the use of pharmaceutical products approximately doubles the success rates of stopping. The evidence also shows clearly that treatments to help dependent tobacco users stop are extremely cost effective. If widely implemented through health care systems, smoking cessation would eventually release badly needed resources for other priorities.

In the light of this evidence, effective help for tobacco users who want to stop should as far as possible be delivered through national health care systems. There are however quite substantial differences across the European region in the degree to which treatment for tobacco dependence is available and paid for through health care systems. It is important to note here that there are interventions not specifically mentioned or recommended because there is no – or insufficient – evidence of their effectiveness. Given limited budgets, a fact of life for all of us, it is important that healthcare systems do not spend money on interventions that do not work.

The WHO European Partnership Project to Reduce Tobacco Dependence has made the development of evidence based treatment of tobacco dependence a priority. In 1999, as an activity under the partnership project, the WHO Regional Office for Europe organized a meeting on evidence based treatment of tobacco dependence. One of the main purposes of the meeting was to begin the process of developing consensus in Europe on core recommendations on the treatment of tobacco dependence.

Through 2000 the World Health Organization continued the discussion with key stakeholders, in particular bodies representing health professionals, but also people working directly in the area of smoking cessation. The purpose of this meeting on evidence based treatment, held in Barcelona, was to:

- to present updated and new evidence on the effectiveness and cost effectiveness of tobacco dependence treatments
- to present the first European recommendations on the treatment of tobacco dependence, supported by European health professional organisations
- to share examples of progress and good practice from the target countries of the WHO European Partnership Project
- to launch new practical initiatives which will support the development of evidence based treatment, including a new training package and web database
- to start planning actions which will take forward the development of evidence based treatment in 2001.
2. EVIDENCE-BASED GUIDELINES

2.1 US Public Health Service Guideline: Treating tobacco use and dependence

Dr Michael Fiore, lead author, summarised the recently published US Public Health Service guideline on treating tobacco dependence. Most of the cases of cancer, heart disease, stroke or pulmonary disease in the US are caused or exacerbated by tobacco, which adds US$ 50 billion to annual healthcare costs. While 70% of smokers in the US have made ≥1 quit attempt, the success rate of unaided quit attempts at 1 year is only around 5%. Although quit rates with existing treatments are relatively modest, treatment-related quit rates must be viewed in the context of unaided success rates.

One of the main barriers to the treatment of tobacco dependence is failure among the medical profession to acknowledge or understand that tobacco dependence is a chronic long-term disease, with periods of relapse and remission, that requires ongoing care. However, effective treatments exist and these should be offered to all tobacco users. Simply recording tobacco use along with vital signs on patient medical records doubles the rate of physician intervention.

Moreover, although tobacco dependence treatments are also cost effective relative to other medical interventions, >50% of insurance plans, which pay for the outcome of tobacco use (such as cancer or cardiovascular disease), do not pay for the modest cost of treating tobacco dependence. One major recommendation of the guideline is that insurance plans should reimburse counselling and treatment, and physicians should be reimbursed for treating tobacco dependence. Effective first-line pharmacotherapy comprises bupropion and nicotine replacement therapy (NRT), but despite extensive safety data many smokers in the US remain concerned that NRT poses health risks.

These guidelines present a new standard of care in the US. However, in order to translate the guidelines into clinical practice, the messages need to be short and simple. A short algorithm can be used to assess tobacco use, followed by five points either to assist quitting or to enhance motivation to quit. The US guidelines have not been officially translated into languages other than English, but a summary is available in Spanish. However, as a public service document they may be freely translated.

2.2 Updated English guidelines on smoking cessation treatment


The original guidelines were evidence-based, expert and peer reviewed, and endorsed by 21 professional and other interested bodies. The 1998 guidelines focused on brief advice in primary care (low efficacy, high reach) and intensive specialist support (high efficacy, low reach) where appropriate. The professional endorsement led to guidance and/or action packs for doctors, nurses, pharmacists and dentists. The guidelines also assisted the development of policies on smoking cessation in the Government White Paper on tobacco. This delivered new NHS smoking cessation services, with funding of £60 million (US$ 90 million) over 3 years. The services comprised specialist, intermediate and brief interventions, to target groups of smokers (poor, pregnant, young), and a voucher scheme for 1 week's free NRT to those eligible for free prescriptions. These guidelines were supported by a report on the cost-effectiveness of smoking cessation interventions.

The updated guidelines are also evidence-based and expert reviewed, and have been endorsed by 25 organisations. The evidence base comes from systematic reviews (primarily the Cochrane Database, supplemented by additional findings, including the
US Public Health Service Guideline). In an attempt to reflect typical health care situations, the intervention categories have been reformulated into: (i) Brief opportunistic advice to stop from a healthcare professional, and (ii) Behavioural support to aid quit attempts. One conclusion was that GPs have an important role to play, and that they should opportunistically advise smokers to stop at least once a year during routine consultations, giving advice on and/or prescribing pharmacotherapy, and referring to specialist cessation services where appropriate. The first point of referral for smokers needing more intensive help should be specialist services, but it is essential that these are run by trained smoking cessation specialists employed specifically to do that work. The guidelines also recommend that NRT and bupropion should be reimbursable, and the recommendations cover how these should be prescribed.

The updated guidelines will be disseminated through a series of regional seminars in England over 2001. It is also envisaged that a summary version will be sent to all GPs, and that some endorsers will assist in dissemination by producing their own tailored resources, as happened with the original guidelines.

2.3 First European recommendations on treatment of tobacco dependence

Dr Martin Raw presented the European recommendations on evidence-based treatment. Tobacco dependence treatment includes behavioural and pharmacological interventions that contribute to reducing, or overcoming, tobacco dependence. Support and treatment complement other tobacco control policies (e.g. taxation, restrictions on use and advertising) but specifically address smokers who want to stop and need help. Smoking cessation is effective, cost-effective and produces relatively rapid public health gains (within 20-40 years, compared to 40-60 years for prevention). However, support and treatment for smoking cessation is not yet widely available, and is not generally integrated into European health care systems.

The European recommendations set out the core interventions of proven effectiveness that should be integrated into health care systems. The evidence base supports the development of three main types of intervention: brief opportunistic interventions, intensive support delivered by specialists (people who are trained and paid to provide support to smokers), and pharmacotherapy. There are also recommendations for specific populations of smokers (inpatients, pregnant, young) and for health care purchasers. Purchasing treatment for tobacco dependence is an extremely cost-effective way of reducing ill health and would eventually reduce the cost of treatment for tobacco-related disease. As treatment is so cost-effective, it should be reimbursed by both public and private health care systems.

The purposes of the recommendations are to raise awareness of the value and cost-effectiveness of treatment, and to draw attention to the evidence base. The recommendations have been endorsed by the European Forum of Medical Associations, the Europrev Network, the Europharm Forum, and the European Nurses & Midwives Against Tobacco, and each organisation has suggested ways in which they will help promote implementation of the guidelines (see ‘The next steps’, below). Following this meeting participants were invited to give feedback to Dr Raw on the European recommendations. They will then be revised taking this feedback into account and a final version be resubmitted for endorsement. They will then be submitted to the European Journal of Public Health (and possibly to other journals) for publication.

2.4 Discussion

Key points from the discussion following presentation of the US, English and European guidelines and recommendations:

- Terminology – earlier guidelines referred to ‘smoking cessation’, but the new US and European guidelines now use ‘tobacco dependence’. Several discussants felt that terminology was critically important in gaining acceptance among
the medical profession – smoking cessation is often interpreted as referring to (or implying) a decision that is made by the individual smoker, whereas ‘treatment of tobacco dependence’ medicalises the disease and emphasizes the importance of health care system involvement. Although no firm conclusion was reached it seems likely that different terms will be needed for different audiences. Some commentators suggested that the European guidelines are really (and should be called) recommendations.

- The European recommendations cannot be too detailed. They have to be general enough to be acceptable, and encourage widespread adoption in many different healthcare systems throughout Europe. However, in some countries, the proportion of light/social smokers remains high; as these individuals may not be tobacco dependent, some discussants felt that pharmacotherapy should not be recommended for all smokers. Dr Fiore responded that the adverse effects of tobacco use occur in a dose-dependent manner, even for those smoking as few as 1-5 cigarettes/day, so pharmacotherapy should be offered to all smokers.

- A shorter, pocket-sized version of the European recommendations should be produced for GPs and pharmacists.

- Recommendations on the education of health professionals and development of quitlines should be included in the European guidelines.

- Several members of the audience commented on a conflict between pressing for reimbursement of NRT (provided by GPs) and expanding over-the-counter (OTC) availability. In some systems (France for example) these two options are currently mutually exclusive. Others felt that wide availability was not incompatible with reimbursement and that regulatory systems should permit both; pharmacological treatment needs to be made available for poor smokers, and there is also the ethical issue of NRT versus other medications that are reimbursed.

3. PROGRESS IN THE DEVELOPMENT OF EVIDENCE-BASED TREATMENT IN THE TARGET COUNTRIES OF THE PARTNERSHIP PROJECT

An update on the status of evidence based treatment (EBT) was presented for each of the four target countries: France (presented by Dr Jacques Le Houezec), Germany (Dr Martina Pötschke-Langer), Poland (Dr Aleksander Mazurek) and the United Kingdom (Dr Dawn Milner). Each report covered government policy, range of services, availability of pharmacotherapy, significant advances since 1999, major barriers to progress, key advances hoped for in 2001, and any changes that need to be made in order to achieve the 2001 goals.

Comparisons among the four countries reveal enormous disparities in all aspects of tobacco control. Moreover, major obstacles remain, even in the more ‘advanced’ countries. On the positive side, some countries have recently made significant progress.

3.1 Government policy and range of services

France has an official governmental national policy on treatment, central government funding for treatment services, a national strategy on training and nationally funded research strategy (Table 1). Poland lacks funding for treatment services, and the UK lacks a national strategy on training – in contrast with Germany, where a national training strategy is the only existing policy. However, even in those countries with comprehensive policies in place further progress is needed; for example, French government policy has only recently been introduced, and NGO involvement is still required.

France and the UK have a comprehensive range of services, including brief opportunistic interventions by primary care professionals, intensive support in specialised centres and promotion of use of pharmacotherapy (Table 2). Poland has limited specialised centres, some of which are in the private sector. However, France noted that brief opportunistic
interventions are difficult to implement, while in the UK provision of specialised centres is slow because it takes time to recruit and train staff. Germany faces the greatest challenges, as the German government does not accept tobacco control as a health priority and there is therefore no national policy on treatment and no funding for services. Moreover, uptake of information among primary health care professionals is low, and there are few treatment facilities for the 24 million German smokers.

3.2 Pharmacological treatment – availability and reimbursement

The UK is the only country where all six NRT formulations are available, and also leads the way in terms of access to pharmacological treatment: all NRT products are available OTC, and nicotine 2 mg gum is also available on general sale (Table 3). The four NRT products approved in France (gum, patch, sublingual tablet, inhaler) all have OTC licences, but marketing has not yet commenced for the inhaler. The gum and patch are approved in Germany and Poland, and are available OTC in both countries. In addition, the nasal spray is available on prescription in Germany, and in Poland the 2 mg gum can be purchased at herbal drug stores. Bupropion is available on prescription in Germany, Poland and the UK, but has not yet been approved in France.

Prescriptions for NRT and bupropion are not reimbursable in France, Germany or Poland. In the UK, prescriptions for bupropion are reimbursable, but those for NRT currently are not (although a regulatory loophole means that NRT products first marketed after 1997 can be prescribed on the NHS, this is not widely known or used). However, the Secretary of State for Health has announced the Government’s intention to make all NRT products available on NHS prescription subject to the outcome of a consultation.

3.3 Significant advances in Evidence Based Treatment of tobacco dependence in the last two years

Major recent advances varied widely, with much depending on the ‘baseline’ situation in the four countries. One common theme was additional and/or wider availability of pharmacological treatment – bupropion became available in Germany, Poland and the UK, while some of the NRT products switched from prescription to OTC in France and Germany (the nasal spray is only available on prescription in Germany). Another common area was training: France introduced a 3-year plan on tobacco control, which includes training of health professionals, and Poland has focused on training in minimal intervention for doctors and nurses within the National Tobacco Control Programme. Advances in Germany include raising awareness of tobacco dependence among health professionals, establishment of a working group on Evidence Based Treatment (EBT) (due to report 2001), and drafting a new counselling manual for health professionals (publication imminent). Additional advances in the UK include funding for NHS services (currently limited to three years), a national service framework for coronary heart disease that set standards for the development of smoking cessation treatment services, the announcement that NRT will be available on prescription by 2001, and consideration of GSL status for other NRT products.
COMMENTS ON POLICY:

a Bernard Kouchner in 1999, then Dominique Gillot in 1999, both acting as State Secretary for Health, have announced and confirmed a 3-year plan on Tobacco Control. This includes training for health professionals, but also education professionals and any professional in contact with children or young adults (Professor Hirsch has been commissioned to co-ordinate this task, and 200 new jobs will be created). Since December 1999, all NRT products have been switched to OTC status (sales x 2.5 compared to last year). Free NRT is available for disadvantaged people. Reimbursement is considered but no decision has been taken yet. All hospitals with more than 200 beds should now have a smoking cessation clinic, and all hospitals must offer free NRT for hospitalised patients (Ministry Circular). Specific actions for pregnant women will comprise training in midwives schools, mandatory consultation (enquiring about smoking) during the first trimester of pregnancy, information in schools for young women on the danger about association between birth control pill and smoking. MILDT (Inter-Ministerial Mission to fight against drugs), which is now also in charge of alcohol and tobacco (previously only the so-called "hard" drugs), is in charge of developing research in the field (in collaboration with the academic domain; INSERM and CNRS). France supports and endorses the Framework Convention on Tobacco Control.

b The German Government does not accept tobacco control as a health priority, therefore there is no national policy on treatment and no funding for treatment services. Since 1995, the German Medical Association has distributed a programme to doctors for advising smokers to quit – but only 6,000 out of 350,000 physicians have ordered the material. The WHO Partnership Project was supportive in the stimulation of discussions among health professionals, especially doctors, and the translated WHO booklet ‘Leaving the pack behind’ and some articles in German medical journals raised some interest. A doctors’ commission is working on German recommendations on EBT of tobacco dependence. The paper will be published in 2001, and will be a milestone in Germany.

c Since the early 1990s, there has been an annual organised nationwide smoking cessation campaign entitled "Let’s Stop Smoking Together" (Great Polish Smoke-out) which includes a mass media campaign, a Quit and Win competition, smoking cessation and counselling activities, health education, scientific conferences and training of trainers. * This strategy was prepared within the framework of the National Tobacco Control Program 1997-2000 (training – goal no. 6; research and monitoring of the program – goal no. 7 and 8)

d Nationally funded research - yes

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Table 1. Policy – comparison across four target countries

<table>
<thead>
<tr>
<th>Official governmental national policy on treatment?</th>
<th>Francea</th>
<th>Germanyb</th>
<th>Polandc</th>
<th>UKd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Central government funding for treatment services?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Policy includes national strategy on training?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Policy includes national funded research strategy?</td>
<td>Yes</td>
<td>No</td>
<td>Yes*</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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* This strategy was prepared within the framework of the National Tobacco Control Program 1997-2000 (training – goal no. 6; research and monitoring of the program – goal no. 7 and 8)
Comments on Policy:

a Brief intervention: has been recommended by the French Consensus Conference on Smoking Cessation. Implementation is difficult because it is mostly dependent on the personal initiative of the primary care professionals. Intensive support: the number of smoking cessation clinics will increase (following the Ministry Circular).

b Germany remains a desert for smokers looking for professional advice: a recent national survey involving more than 10,000 hospitals, health centres and experts in smoking cessation identified only 818 institutions or experts advising smokers (for 24 million smokers in Germany). Many of these are not linked to, or controlled by, the health care system.

c At present, there are first of all the private treatment facilities offering help and care for people stopping smoking. However, the first public smoking cessation clinics are simultaneously organised on a local scale; in Warsaw, intensive support is provided by clinics organised at the Cancer Centre and at the Institute of Cardiology. The treatment is expensive: although physician’s advice is free, at least in the public clinics, there is still no governmental support to reimburse the cost of tobacco dependence treatment products.

d Situation is the same in all four countries (England, Scotland, Wales, N Ireland).

Table 2. Range of services (irrespective of official or other status of treatment policy) – comparison across four target countries

<table>
<thead>
<tr>
<th>Service</th>
<th>France</th>
<th>Germany</th>
<th>Poland</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief opportunistic interventions by primary care professionals?</td>
<td>Yes</td>
<td>Yes (but only a few)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive support in specialised treatment facilities?</td>
<td>Yes</td>
<td>Yes (but only a few)</td>
<td>No*</td>
<td>Yes</td>
</tr>
<tr>
<td>Promoting the use of pharmaceutical products?</td>
<td>Yes</td>
<td>Yes (but only a few)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Table 3. Pharmaceutical treatment – availability and accessibility in four target countries

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Approved?</th>
<th>General sale (in any shop)</th>
<th>Pharmacy sale (OTC)</th>
<th>Prescription (doctor’s Rx)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRT gum</td>
<td></td>
<td>France Germany Poland UK</td>
<td>Poland (2 mg)²</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>France Germany Poland (4 mg) UK (4 mg)</td>
<td></td>
</tr>
<tr>
<td>Patch</td>
<td></td>
<td>France Germany Poland UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sublingual tablet</td>
<td>Germany¹, Poland</td>
<td></td>
<td>France UK</td>
<td></td>
</tr>
<tr>
<td>Lozenge</td>
<td>France Germany³, Poland</td>
<td></td>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>Inhaler</td>
<td>Germany³, Poland</td>
<td></td>
<td>France¹ UK</td>
<td></td>
</tr>
<tr>
<td>Nasal spray</td>
<td>France Poland</td>
<td>Germany UK</td>
<td>UK</td>
<td>Germany</td>
</tr>
<tr>
<td>Bupropion</td>
<td>France</td>
<td>Germany Poland UK</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Approved but not yet marketed
² Packs of up 30 pieces available from herbal drug stores
³ Sublingual tablet and inhaler are allowed in Germany from a regulatory perspective but are not available yet on the market.

3.4 Main barriers to progress

The need to convince primary care and other physicians of the importance of smoking cessation remains a major obstacle in all four countries. Maintaining existing support is a concern in France (sustaining governmental policy) and the UK (competing pressure for NHS funding) but this issue does not arise in Germany, since there is no existing support. Relative to the other three countries, tobacco control policy in Germany is weak: the tobacco industry influence on politics blocks effective legislation and creates a positive social climate for smokers, insurance companies consider tobacco use a matter of choice rather than an addiction, the lack of public awareness of tobacco dependence means that there is no public funding for tobacco control programmes and health insurance companies do not cover the cost of treatment, and there is a lack of educational and financial support for health professionals. In Poland, barriers impeding progress include the need for further information campaigns targeted at smokers, lack of reimbursement for treatment, and lack of regulations that would make treatment of tobacco dependence mandatory in certain conditions and/or specialisations.
4. STATUS OF EVIDENCE-BASED TREATMENT IN SPAIN

Dr Joan Villalbi provided a brief overview of the prevalence of smoking and status of EBT in Spain. Between 1983 and 1998, the prevalence of smoking among adult (>15 years) males decreased from 55% to 45%, but increased among females from 23% to 28%. The greatest increase is among young women; in 1997, >40% of females aged 25-45 years smoked, compared to <15% of those aged 45-65 years. Most Spanish smokers are precontemplators; those currently quitting are concerned middle-aged adults, or older smokers with tobacco-related disease. However, smoking cessation rates are gradually increasing: figures from Catalunya show that in 1982, 19% of male and 5% of female ever-smokers had quit, and by 1998 these had risen to 21% and 12%, respectively.

There is a need for a comprehensive tobacco control policy, including fiscal policy, regulation of tobacco advertising/promotion, public information, smoke-free areas, support for those who want to quit and a prevention network. The Spanish health service is decentralised, with autonomous regions. There is no official or explicit health service policy on treating tobacco dependence, and minimal provision of advice/support in primary health care (plus 33% of physicians smoke). NRT is available OTC, and bupropion will be available from November 2000. Recent activities by the National Committee for Prevention of Smoking (CNPT) include strengthening the tobacco control movement (through meetings, Globalink etc), coordination with other EU countries, focusing interest on policy issues and facilitating the involvement of agencies and professionals in pilot projects.

Professor Helios Pardell and Dr Maria Jesus Azagra focused on the treatment of tobacco dependence in two autonomous regions, Catalunya and Navarra. In Catalunya, despite 16 years of ministry of health anti-smoking campaigns, tobacco-related illness still costs US$ 448 million each year. Involvement of health professionals in smoking cessation is far from adequate. Pharmacological treatment such as NRT is available, but used by relatively few smokers during quit attempts. The prevalence of smoking among health professionals remains high (>30%), but three smoking cessation programmes involving NRT use targeted at physicians, pharmacists and nurses who smoke have achieved encouraging results (1-year abstinence rates of 28-41%). A community-based smoking cessation programme will be implemented in the next few months as part of the CINDI programme. Intervention comprises two components – specific education programmes for health professionals, and community intervention through local media, community organizations, etc. Smokers who successfully quit will be reimbursed retrospectively for the cost of smoking cessation treatment.

Smoking cessation programmes were set up in Navarra in 1995; at that time smoking was considered a habit rather than an addiction, smokers were unaware of the health implications and there was no help available for smokers. The programmes involve primary health care teams and provide minimal intervention, with more intensive support available if needed. The programmes target highly motivated and highly dependent smokers, and offer either individual or group counselling with partial (one-third) reimbursement of the cost of NRT. There has been consistent growth of smoking cessation programmes in the 53 health zones: only 3 zones offered individual counselling in 1995, compared to 34 in 2000, and the corresponding figures for group counselling are 3 and 14, respectively. The current aim is to establish systematic and intensive support, including reimbursement of NRT, in all 53 health zones. The results of the programme show that 50% of smokers have been provided with advice on smoking cessation, with almost 2,000 smokers included in smoking cessation programmes, social awareness of the health risks of smoking have increased (63% are now in favour of smoke-free public places), and the number of smokers making quit attempts has increased from 29% in 1990 to 36% in 2000, with the proportion of ex-smokers increasing from 16% to 20%. Key factors for continuing progress include raising awareness of reimbursement of NRT among smokers, greater
emphasis on tobacco use as a dependence and health problem, training and co-ordination, and more input from primary health professionals. Major barriers comprise the high prevalence of smoking among health care professionals (nurses 43%, physicians 35%), social acceptability of smoking, and lack of time for smoking cessation interventions in primary health care.

Overall, the major issues in Spain are lack of government support and need to increase awareness that tobacco use is an addiction. Lack of knowledge of the health risks, combined with the widespread social acceptability of smoking, contribute to a high prevalence of smoking, particularly among young Spaniards but also among doctors and also other health professionals.

5. TAKING EVIDENCE BASED TREATMENT FORWARD IN 2001

5.1 New resources

Dr Peter Anderson and Dr Martin Raw presented two new resources, a training package and a database.

Helping Smokers Change is an evidence-based resource pack for training health professionals, commissioned by the WHO as part of the Partnership Project. The pack is for experienced trainers to use to train health professionals. The content of the pack is based on the stages of change model and developing skills. The pack will be available from WHO Europe in 2001 in English, and is designed to be translated and adapted for national requirements.

Treatobacco.net is a database of evidence-based information developed by the Society for Research on Nicotine and Tobacco, with support from the WHO Partnership Project, Centers for Disease Control, the Cochrane Group and the World Bank. The database will provide an authoritative, independent source of evidence-based data and recommendations on the treatment of tobacco dependence. The content includes current knowledge on five key areas: efficacy, safety, health economics, policy and demographics, with executive summaries supported by a second, more detailed level containing links to references and other sites. Information is accessible via the Internet, and is free. The main language is English, but with executive summaries available in Chinese, French, German, Japanese, Russian and Spanish and eventually, it is hoped, other languages.

5.2 Implementation of European treatment recommendations

Each of the four endorsing organisations presented plans to support the promotion and implementation of the European recommendations during 2001.

Following a meeting of the Liaison Committee during November, the European Forum of Medical Associations will prepare a formal statement for
adoption by the next Plenary in Ljubljana in March 2001. This will propose the formal adoption of the recommendations (or the recommendations as finally revised), and set out the manner in which National Medical Associations should promote their use among members. The Forum will also request an expert presentation of the recommendations at the next EFMA meeting. EFMA’s two other mechanisms for dealing with tobacco issues are:

- The Tobacco Action Group, which involves 28 countries: this will be convened to identify specific actions that can be taken to promote the recommendations nationally (e.g. publication in national medical journals).

- The Tobacco Control Resource Centre, which informs, stimulates and facilitates NMAs throughout Europe, through its communication network and country-based tobacco control workshops (e.g. identification of motivated leaders in different countries who can lead local workshops).

These mechanisms will facilitate promotion of the principles in the guidelines to the medical profession at both primary and secondary levels, and active implementation in daily practice.

Suggestions from Europrev Network for publicising and implementing the European recommendations during 2001 include:

- Publication of the recommendations in the European Journal of General Practice and/or the European Journal of Family Medicine, plus translation and publication in domestic language GP/family medicine journals.

- Disseminating the recommendations during the WONCA Congress (3-7 June 2001, Tampere), and running a specific workshop within the congress.

- Translating the recommendations and distributing them via national societies of general practitioners or family medicine.

- An international workshop on tobacco and alcohol addiction, organised by Europrev, which would discuss cessation interventions and strategies for implementation.

Europharm Forum plans to use the recommendations to encourage national pharmaceutical associations to implement and run training programmes for pharmacists; given that pharmacies are usually the places where smokers obtain NRT it is important that pharmacists provide advice and encourage smoking cessation. The recommendations will be published in the Europharm Newsletter and perhaps in national pharmaceutical journals.

The new evidence-based recommendations are particularly useful for European Nurses & Midwives Against Tobacco, as nurses and midwives have daily contact with patients who smoke and have an ideal opportunity to become active participants in tobacco control. ENMAT plans to promote the recommendations through:

- The network of European nursing meetings during 2001, such as the International Council of Nurses meeting.

- Addressing tobacco dependence in nursing journals.

- Involvement of national nursing associations in the production of policy documents.

5.3 The next steps

Each target country listed the most important advances that they would like to see during 2001, and identified factors that must change in order to achieve these goals. Working groups, for the target countries, plus Spain and the Rest of Europe, then reviewed these and drafted action plans to take evidence based treatment forward.

France highlighted progress in the Framework Convention on Tobacco Control (FCTC), plus greater involvement of health professionals in treating tobacco
dependence, particularly in hospitals. However, awareness of the health benefits associated with stopping smoking needs to increase, both among the general population and health professionals.

**Germany** also identified the FCTC as a key advance, mainly through the media support it may generate. Two key dates/events were identified – World No Tobacco Day, and the European Congress on Smoke-Free Workplaces, which will be held in Berlin in May – as ways of raising awareness of tobacco control in Germany. Other important issues are publication of guidelines for the treatment of substance abuse disorders (including tobacco) by different medical disciplines, inclusion of EBT treatment of tobacco dependence in health professionals’ education, and more communication about smoking cessation targeted towards the general public. In order to achieve these goals, direct comparison is needed between Germany and the other target countries in terms of tobacco control legislation and EBT of tobacco dependence in order to demonstrate how far Germany lags behind, plus more campaigns are needed to motivate smokers to quit.

Building on this, the action plan for Germany comprises:

- Guidelines (dissemination and media activity around guidelines in preparation)
- Raising awareness (comparisons showing situation in Germany versus other European countries, debate surrounding proposed legislation on passive smoking and protecting children, and news surrounding the FCTC)
- Further events in Germany throughout 2001 (the Berlin conference on workplace smoking, an exhibition of the WHO European Partnership Project artists initiative “if you want to stop smoking ask how”)
- Increasing involvement of the German medical associations, professional bodies and health charities (greater collaboration with other European health organisations, perhaps via a conference, and translation and dissemination of the BMA/Tobacco Control Resource Centre publication Doctors and Tobacco.)

Five key issues were identified in **Poland**: approval of combination pharmacotherapy; the introduction of more effective pharmacotherapy; reimbursement of the cost of tobacco dependence treatment; creation of a nationwide network of specialised smoking cessation clinics and support facilities (such as quit-lines), and more training for doctors and nurses in the treatment of tobacco dependence. The two major changes required are making the treatment of tobacco dependence a key element of health care and public health, and involvement of the sick fund in payment for treatment.

Key advances in the **United Kingdom** next year are availability of NRT on prescription, distribution of the updated English smoking cessation guidelines and the NICE (National Institute of Clinical Excellence) appraisal to all GPs, and supportive initiatives such as media campaigns, free telephone help lines and easily accessible treatment. These advances are likely to happen. The UK action plan contains:

- Training and skills development
- Guidance dissemination (reach and accessibility, with production of summary documents for different target audiences)
- Primary care buy-in/greater involvement in smoking cessation (through the British Medical Association, by emphasising references to smoking cessation in core NHS documentation, and capitalising on the NICE appraisal)
- Availability, pricing and regulation of NRT – simultaneous widening of NRT availability plus reimbursement, while ensuring that the latter does not lead to the demise of the OTC market.

The most important issue in **Spain** is the need for a change in climate, with comprehensive prevention
policies and involvement of the NHS beyond minimal advice. Pre-requisites include smoke-free health premises and professionals, and motivating cessation among health professionals and in medical/nursing schools. Existing services and support, including counselling by GPs and other health professionals, quitlines and self-help groups, specialist services, and training and skills development, should be expanded. New developments that are required include consensus guidelines, greater availability of pharmaceutical treatment, and public funding for pharmaceutical treatment.

With such a diverse group, it was not possible to formulate a general report/action plan. Some specific requests for 2001 include:

- help from WHO to train cessation specialists (Latvia/Lithuania)
- financial support to translate and print the European recommendations (Slovak Republic)
- assistance from WHO with a meeting in Moscow in Nov 2001 (Russia)
- admission to the Partnership Project (Spain, Italy, Latvia, Lithuania).

One repeated comment/plea is that pharmacological treatment should be more widely available, and cheaper.

6. CONCLUSIONS

Evidence-based guidelines on the treatment of tobacco dependence, although recent, are already having an impact on health policy. However, many health professionals and officials in many countries remain unaware that treatment for dependent smokers is effective and highly cost effective, even in some countries where guidelines exist. Many are also unaware that tobacco dependence and nicotine addiction are officially recognised medical conditions, even in countries where most progress has been made. There is also a general lack of understanding that tobacco dependence is a chronic condition that requires long-term care. Education of health professionals remains a huge and crucial challenge.

Another major challenge, even in countries with officially funded national policies, remains how to increase involvement of primary care doctors and other health professionals in the treatment of tobacco dependence. Education and involvement of health professionals are further complicated in countries where the prevalence of smoking remains high among these groups, such as Germany and Spain. A key issue is the need to persuade and help doctors and other health professionals to stop smoking.

Within Europe, and even within the four Partnership Project target countries, there are enormous differences in the acceptance and implementation of EBT of tobacco dependence. At an official level, this issue is not even on the agenda in Germany, but comparison with the progress made in the other target countries may help to influence this. Even in countries with official policy, the cost of treatment for tobacco dependence is often not covered by the health care system or by insurance companies, despite the cost-effectiveness of such treatment.
RESOURCES

The following resources have so far been produced by, or with the support of the Partnership Project:

Helping Smokers Change, a resource pack for training health professionals. WHO, Copenhagen, 2000, published by WHO.

Treatobacco.net, a web based database developed by the Society for Research on Nicotine and Tobacco, with the support of the Partnership Project. See www.treatobacco.net


Other resources presented to delegates included:
