# Spotlight on the FCTC:

# Tobacco Dependence and Cessation

**Article 14 of the FCTC**

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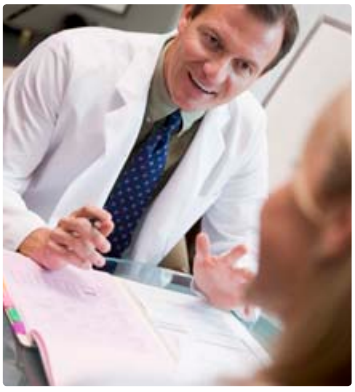



**What is the FCTC?**
The WHO Framework Convention on Tobacco Control (FCTC) is the world's first international public health treaty. It sets out legally binding objectives and principles that countries or organisations such as the European Union (known as Parties) who ratified and thus agreed to implement the Treaty must follow. It aims to protect present and future generations from the devastating health, environmental and socio-economic consequences of tobacco consumption and exposure to tobacco smoke, through evidence-based policies.

**What is Article 14 of the FCTC?**
Article 14 of the FCTC states that '*each Party shall develop and disseminate appropriate, comprehensive and integrated guidelines based on scientific evidence and best practices, taking into account national circumstances and priorities, and shall take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.*'

To achieve this, Parties shall endeavour to:
- Design and implement effective cessation programmes in a variety of locations.
- Include diagnosis and treatment of tobacco dependence and counselling services on cessation in national health and education programmes, plans and strategies.
- Establish programmes for diagnosing, counseling, preventing and treating tobacco dependence in health care facilities and rehabilitation centres.
- Collaborate with other Parties to facilitate accessibility and affordability for treatment of tobacco dependence.

***Cessation of tobacco use*** means all cessation, whether it occurs as a result of public health tobacco control measures or individual support of dependent smokers through treatment. ***Tobacco dependence treatment*** is the narrower activity of helping and supporting tobacco users to overcome their dependence on nicotine.

It is important to note that Article 14 should be read in the context of the FCTC and not in isolation.

SMOKEFREE PARTNERSHIP
A world without tobacco

# Spotlight on the FCTC: Tobacco Dependence and Cessation

**Why is Article 14 important?**

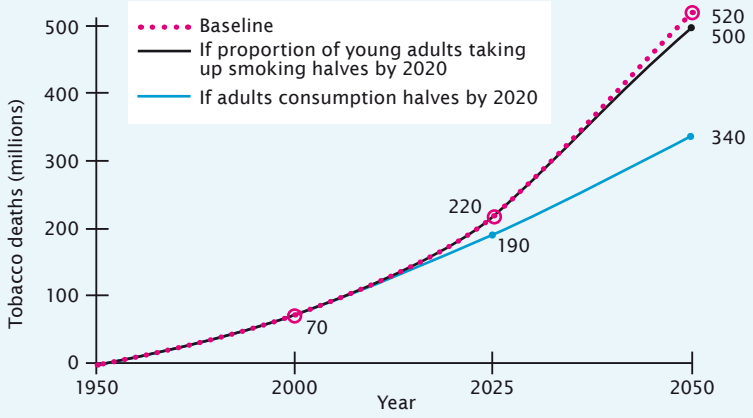
**a.** Increasing tobacco cessation is vital if we are to reduce the morbidity and mortality caused by tobacco use within the next half century. The World Health Organisation Tobacco Free Initiative states:

*'Tobacco use is one of the biggest public health threats the world has ever faced. It kills more than five million people a year – an average of one person every six seconds – and accounts for one in 10 adult deaths. Up to half of current users will eventually die of a tobacco-related disease.'*[1]

Obviously, all of these are current tobacco users and, therefore, only interventions that encourage and enable them to stop will reduce this morbidity and mortality in the short to medium term. In the long term, preventing young people taking up using tobacco is an important tobacco control strategy but will not begin to reduce tobacco-caused mortality and morbidity for some decades.

**Unless Current Smokers Quit, Tobacco Deaths will Rise Dramatically in the Next 40 years**

Estimated cumulative tobacco deaths 1950-2050 with different intervention strategies




Source: World Bank, *Curbing the epidemic: Governments and the economics of tobacco control.* World Bank Publications, 1999. p. 80

**b.** Evidence is emerging in high-income countries that smoking cessation interventions are very cost-effective in producing population health gain, compared with other preventive and medical interventions. The findings support the role of the healthcare system in prioritising and funding smoking cessation interventions. Expressed as cost per QALY (quality adjusted life year) England's National Health Service (NHS) Stop Smoking Services come in at less than £1000 (€1120) compared to, for example, over £4000 (€4485) for other substance abuse treatment.[2] [3]

**c.** Tobacco dependence and withdrawal syndromes are classified as substance use disorders under the World Health Organisation International Classification of Diseases (ICD-10).

**d.** In countries with a well-established tobacco control movement and where the health consequences of tobacco use are widely understood and accepted, 70% of adult users want to stop their tobacco use.[4] One-third or more of cigarette smokers attempt to quit annually.[5] However, each year only 0.5-5% of cigarette smokers achieve lasting abstinence and leave the pool of smokers by cessation, as opposed to death.[6] This is because most attempts to stop are unsuccessful, partly because nicotine dependence is a chronic, relapsing disorder. In addition, most tobacco users attempt to stop unaided, without any behavioural or pharmacological assistance.

**e.** Increasing cessation of tobacco use is likely to support efforts to prevent young people from using tobacco. The Royal College of Physicians estimates that 23,000 children in England and Wales start smoking by the age of 16 due to exposure to smoking by family members.[7] [8]

**f.** Treatment is more likely to be offered and used if integrated into healthcare systems, including a system to identify smokers or tobacco users.[9]

**g.** Post-certification training increases the likelihood of healthcare professionals intervening with smokers. Since a brief intervention by healthcare professionals has been shown to increase quit attempts, then it seems very likely that training will improve outcomes.[10]

**h.** Increasing the availability of pharmacological treatments (moving treatments from prescription-only to pharmacy or general sale) increases usage. This is likely to increase overall cessation attempts.

**i.** To be as effective as possible, tobacco control efforts should be comprehensive and multi-sectoral.[11] This approach includes implementation of measures to reduce the demand and supply of tobacco, in particular

1 http://www.who.int/mediacentre/factsheets/fs339/en/index.html

2 McConville, A (2009) (unpublished) cited by Bauld L in presentation to the All Party Parliamentary Group on Smoking and Health, London July 28 2010

3 For further reading, please see Hoogendoorn, M., Feenstra, T.L., Hoogenveen, R.T., Rutten-van Mölken, M.P.M.H., Long-term effectiveness and cost-effectiveness of smoking cessation interventions in patients with COPD, Thorax 2010;65:711-718 doi:10.1136/thx.2009.131631

4 Jha, P., Chaloupka F. J., The economics of global tobacco control, BMJ, 2000; 321:358 doi: 10.1136/bmj.321.7257.358

5 West, R. (2005) Smoking: prevalence, mortality and cessation in Great Britain, www.rjwest.co.uk/smokingcessation.htm; Canadian Tobacco Use Monitoring Survey, 1999

6 Hughes, J.R., Keely, J. and Naud, S. (2004), Shape of the relapse curve and long-term abstinence among untreated smokers. Addiction, 99: 29–38; Jarvis MJ, Patterns and Predictors of Smoking Cessation in the General Population. Bolliger, C.T., Fagerström, K.O. (eds): *The Tobacco Epidemic*. Prog Respir Res. Basel, Karger, 1997, vol 28, pp 151-164

7 Royal College of Physicians. *Passive smoking and children.* A report by the Tobacco Advisory Group. London: RCP, 2010, p. 180

8 Population of England and Wales is 54m

9 US Department of Health and Human Services. Treating tobacco use and dependence. A report of the Surgeon General. Rockville, MD: Agency for Healthcare Research Quality, 2000

10 West, R., McNeill, A., Raw, M., Smoking cessation guidelines for health professionals: an update, Thorax 2000;55:987-999, doi:10.1136/thorax.55.12.987

11 Ruger, J.P. Global Tobacco Control: An integrated approach to global health policy, *Development* (2005) 48, 65–69

FCTC Articles 6 (price and tax measures), 8 (protection from exposure to tobacco smoke), 11 (packaging and labeling of tobacco products), 12 (education, communication, training and public awareness), 13 (tobacco advertising, promotion and sponsorship), and 15 (illicit trade in tobacco products).

**Why the need for guidelines?**
Guidelines have been developed to assist Parties in meeting their obligations under Article 14, by laying out in greater detail the ways to promote tobacco cessation and treat tobacco dependence.

**What aspects of the guidelines should be prioritised?**
The Article 14 guidelines should be supported **in full**, however a list of measures that should be prioritised have been outlined below:

Parties should consider placing the cost of cessation support on the tobacco industry and retailers.

In a September 2010 report compiled by RAND Europe for the impact assessment on the revision of the 2001 Tobacco Products Directive,[12] it was recommended that:

1. Based on the 'polluter pays' principle, the external health costs of smoking should be internalised by requiring **full liability and payment of the health costs of smoking** by the tobacco industry to national health systems.
2. The health costs of smoking should be integrated into the calculation of market control fees.[13]

Introduced at EU level, it is estimated that either measure would lead to a substantial increase in the price of tobacco products, leading to a possible **25% reduction in prevalence. This in turn could prevent 45,000 smoking related deaths and 465,000 fewer cases of lung cancer, aerodigestive cancer and COPD annually** by 2027.

We recommend adoption of measure 1, or in the alternative, measure 2.[14]

Parties should implement measures to promote tobacco cessation and increase demand for tobacco dependence treatment contained in other WHO FCTC articles, particularly through Articles 6, 8, 11, 12, 13 and 15.

Each Party should establish a free, national quitline, which should be adequately staffed, widely publicised and advertised. The quitline number should be clearly visible on all tobacco product packaging.

Tobacco control and cessation should be incorporated into the training curricula of all health professionals, both at pre- and post-qualification levels.

Parties should make it mandatory to record tobacco use status in all medical records.

Brief advice should be integrated into all healthcare systems. Implementation should be monitored regularly.

Where resources allow, Parties should establish specialised tobacco dependence treatment services, delivered by specially trained practitioners. Such services should offer a combination of behavioural support and medication, and should be provided free or at an affordable cost.

All Parties should develop national tobacco dependence treatment guidelines, in collaboration with health professional organisations, nongovernmental organisations and other key stakeholders. The development of the guidelines should be free of any actual or potential conflicts of interest.

Parties should provide access to low cost, or free where possible, medications, including, where appropriate, making medications widely available in ordinary retail outlets and over the counter in pharmacies.[15]

Parties should utilise mass media communication and education programmes to increase public awareness of tobacco cessation services.

**Will Article 14 impact on the work of the European Commission?**
Yes and no. Although the European Community ratified the FCTC in 2005, the European Commission does not need to report back to the Conference of the Parties (COP) on the progress of Article 14 implementation, as cessation and dependence treatment is regarded as a Member State competence.

However, the Commission might have an indirect impact on the guidelines if the revision of the 2001 Tobacco Products Directive includes either of the two measures, placing the costs on industry, as described in the box above. Equally,

12 Directive 2001/37/EC http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2001:194:0026:0034:EN:PDF

13 RAND Europe, *Assessing the Impacts of Revising the Tobacco Products Directive: Study to support a DG SANCO Impact Assessment, Final Report*, TR- 823-EC, September 2010, pp. 159-162

14 For further reading on the topic of liability, see GHK, *A Study on Liability and the Health Costs of Smoking. Final Report. Study Commissioned by DG Sanco*, London: GHK, 2010

15 In the EU, it is our understanding that only Belgium, Cyprus, parts of Denmark, France, Ireland, the Netherlands and the UK permit reimbursement of medicinal nicotine products when prescribed by a doctor.

with the adoption of the Article 14 guidelines, it is the role of the Commission **to ensure that the legislative proposal for a revision of the 2001 Tobacco Products Directive includes mandatory quitlines on all tobacco packs**.

Finally, the European Commission's 'Help: for a life without tobacco' campaign has been implemented in all 27 EU Member States. As part of the campaign, tobacco users wanting to quit can participate in a web-based cessation effort.

**Will Article 14 impact on the work of the European Parliament?**
Yes. As the directly elected parliamentary institution of the EU, the European Parliament and its members should remind and encourage their national governments to implement Article 14, on behalf of all EU citizens.

The Parliament will have a role in supporting the legislative passage of the revised Tobacco Products Directive, in particular supporting mandatory quitlines on all packs, through the co-decision procedure.

**Will Article 14 impact on the work of the EU Member States?**
Yes. Those Member States that have ratified the FCTC (all except the Czech Republic) follow the objectives and principles set out in the treaty. So, they have agreed to take effective measures to promote cessation and adequate treatment for tobacco dependence.

**Will Article 14 impact on the work of the Council of the European Union?**
Yes. The Council will also have a role in supporting the legislative passage of the revised Tobacco Products Directive, in particular supporting mandatory quitlines on all packs, through the co-decision procedure.

## GLOSSARY OF TERMS

**Addiction:** Compulsive drug use, with loss of control, the development of tolerance, continued use despite negative consequences, and specific withdrawal symptoms when the drug use ceases.

**Behavioural Support:** Support, other than medications, aimed at helping people stop their tobacco use. It can include all cessation assistance that imparts knowledge about tobacco use and quitting, provides support and teaches skills and strategies for changing behavior.

**Brief advice:** Advice to quit given to tobacco users, usually of around 3 to 10 minutes, typically delivered during the course of a routine consultation by a healthcare worker. Used interchangeably with minimal intervention.

**Counselling:** Health professionals providing practical face-to-face smoking cessation advice and support to a client or patient. It involves discussing: the benefits of quitting; the difficulties in quitting; strategies to cope with problems; and how to avoid relapse. Counselling may be individual or with a group and may be combined with other types of treatment, including medication. The intensity of contact with the client/patient, as well as the content, may vary.

**Dependence:** The same as addiction, used interchangeably.

**Promotion of tobacco cessation:** Population-wide measures and approaches that contribute to stopping tobacco use, including tobacco dependence treatment.

**Tobacco cessation:** Stopping using tobacco, with or without assistance.

**Tobacco dependence treatment:** Support to help tobacco users quit which can include (singly or in combination) a broad range of behavioural and pharmacological interventions such as brief advice and counselling, intensive support, telephone quit lines and medications, that contribute to reducing or overcoming tobacco dependence in individuals and in the population as a whole.

The **Smoke Free Partnership** is a strategic, independent and flexible partnership between Cancer Research UK, the European Heart Network and the European Respiratory Society. It aims to promote tobacco control advocacy and policy research at EU and national levels in collaboration with other EU health organisations and EU tobacco control networks.

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