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PGEU Response

Green Paper “Towards a Europe free from tobacco smoke: policy options at EU level [COM(2007) 27 final]

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1. Introduction

The Pharmaceutical Group of the European Union (PGEU) is the European association representing community pharmacists in 29 European countries including EU Member States, EEA countries and EU applicant countries. Within the enlarged EU, over 400.000 community pharmacists provide services throughout a network of more than 160.000 pharmacies, to an estimated 46 million European citizens daily.

PGEU's objective is to promote the role of pharmacists as key players in healthcare systems throughout Europe and to ensure that the views of the pharmacy profession are taken into account in the EU decision making process.

PGEU welcomes the public debate on the best way to promote smoke-free environments and the opportunity to respond to this consultation given the role of Community Pharmacists in smoking cessation.

Smoke-free environments, *per se*, will not stop smokers from smoking if they do not want to, but can be the trigger for start thinking about quitting smoking. Likewise, smoke-free environments contribute to preventing passive smoking. Nonetheless, tobacco control and prevention calls for a complex and comprehensive approach, where stand alone measures can have a null or negative effect.

Evidence shows that the key to quitting smoking is the combination of willingness to quit, with the appropriate conditions to facilitate quitting. These include a non-stressful friendly environment, and enrolment in a smoking cessation programme, where appropriate counselling and monitoring will facilitate the necessary compliance with pharmacological and non pharmacological treatment.[1,2]

All over Europe, Community Pharmacists are helping to implement smoking cessation programmes, as an integral part of community pharmacy practice.

It is with this in mind that we will answer the questions raised in the consultation.

[1] Hajek P. Withdrawal oriented therapy for smokers. Br J Addict 1989; 84: 591-598.

[2] West R, McNeill A, and Raw M. Smoking cessation guidelines for health professionals: an update. *Thorax*. 2000; 55: 987-999.

2. Answer to the questions

Question 1: which of the two approaches suggested in Section IV would be more desirable in terms of its scope for smoke-free initiative: a total ban on smoking in all enclosed public spaces and workplaces or a ban with exemptions granted to selected categories of venues? Please indicate the reason(s) for your choice.

PGEU considers that a total ban on smoking in all enclosed public spaces and workplaces would be the desirable final goal if passive smoking is to be radically decreased. However, for the sake of adherence to this measure, it might be necessary to have a transitional period where exemptions may be granted to promote a phased assimilation of non-smoking cultures and behaviours.

We fully agree with the need to complement this action with supporting measures such as increased access to cessation therapies (both behavioural and pharmacological) for persons who wish to stop smoking.

PGEU is also of the opinion that auditing the degree of implementation and assessing the impact of smoke-free action and associated support measures are extremely important.

Question 2: which of the policy options described in Section V would be the most desirable and appropriate for promoting smoke-free environments? What form of EU intervention do you consider necessary to achieve the smoke-free objectives?

First of all we would like to underline that there is a need to ensure that future Community action, whether in the form of legislation or 'soft' law, focuses directly on bringing additional benefits to national citizens which cannot be achieved by Member States acting alone, while respecting and reaffirming Member State competence.

Secondly, while PGEU applauds this initiative, there is still scope for EU action to support broader anti-smoking strategies (see our response to policy options below). Smoke free environments are one aspect of anti-smoking strategy – we must not of course neglect the fundamental importance of helping smokers to quit. This is ultimately the most effective way to tackle passive smoking.

Thirdly, the specific action considered for the implementation of smoke-free environments should be taken for this purpose and not to be generally applied to other areas without a case by case health impact assessment and public consultation.

Taking the above aspects into account, PGEU is of the opinion that:

- No change from the *status quo* is indeed insufficient to tackle the passive smoking issue;
- Encouraging voluntary measures including the establishment of a platform process similar to the one established in the area of diet and physical activity and to the one proposed for the development of an EU-wide strategy on alcohol could be a possible option to explore. However, PGEU believes that given the divergence of approaches so far adopted in Member States, and the fact that there is a degree of uncertainty as to what the most effective approaches might be (not just in respect of passive smoking, but also in respect of broader anti-smoking strategies), this is an area

where active exchange of best practice and policy experiences might be genuinely fruitful.

- For the reasons stated above, the Open Method of Coordination, by encouraging the sharing of experiences and best practices in order to stimulate Member States to make their smoke-free laws more convergent without there being a need for direct harmonisation seems to be the most appropriate solution;
- In PGEU's view a Commission or Council Recommendation, if it were to contain real substance, would not by its nature fully reflect the different cultural and behavioural settings relevant to the issue, and further, that given that in most Member States legislation in this area is relatively new, the emphasis of EU level action should be the examination of outcomes and exchange of policy experiences rather than firm policy Recommendations, at least for the time being.
- For the reasons given above, PGEU believes that binding Legislation is inappropriate and we are not convinced that legal competence to undertake broad legislation in this area is firmly established. This is an area where the most effective outcomes can be achieved by legislation at Member State level, in the context of course of exchange of best practice through e.g. the OMC.

Question 3: Are there any further quantitative or qualitative data on the health, social or economic impact of smoke-free policies which should be taken into account?

In our opinion, action at EU level has highly contributed to raise awareness about the complexity of tobacco control and prevention and the smoke-free environment initiative takes good account of the associated health, social and economic concerns of this important Public Health matter.

However, it seems to us that the costs of a) provision of treatment and b) training of the healthcare workforce to assist those who want or will have to quit smoking as a consequence of smoke-free measures have not been fully covered in the green paper.

Moreover, the health, social and economic impact of providing free and generalized access to nicotine replacement therapies (NRT) as an *ad hoc* support measure has not been addressed. This is a measure that certain governments could consider to incentive or facilitate the implementation of smoke-free environments and which PGEU discourages on public health grounds.

NRT is a traditional and well-known treatment therapy for smoking addiction. The method is popular for its convenience and relatively low cost; it also offsets the effects of nicotine withdrawal as smokers attempt to wean themselves off cigarettes. Despite its prominence, NRT only works for a minority of people who attempt to use it. While compared with placebo NRT has been efficacious in smoking cessation, the long term quit rates are relatively low. At the end of treatment abstinence rates are approximately 30%, decreasing to 20% after 6 months to 1 year.[3,4] Its failure as a therapy can be

[3] Hughes JR, Goldstein MG, Hurt RD, et al. Recent advances in the pharmacotherapy of smoking. JAMA 1999; 281: 72-6

[4] Fiore MC, Smith SS, Jorenby DE, et al. The effectiveness of nicotine patch for smoking cessation: a meta-analysis. JAMA 1994; 263: 2760-5

attributed to chronic nicotine addiction, misuse of nicotine replacement products or contraindications with other medications. Many (7-41%) smokers misuse nicotine gum by smoking cigarettes and chewing the gum concurrently. Among smokers who stop using the gum, many (35-90%) do not stop gum use by the recommended 3 months, and a substantial percentage (13-38%) persist in gum use for 1 year. Among quitters, long-term use of nicotine gum appears to be greater than that of placebo gum.[5] As more and more people quit smoking because of health risks, those left holding cigarettes are the ones who find it increasingly difficult to quit, both physically and psychologically and they often require different methods of treatment. An increased knowledge of the neurobiological nature of tobacco dependence and an emerging association between nicotine dependence and psychiatric illness has lead to investigation of the use of non-nicotine agents.[6]

Therefore, to produce significant health gain in the population, we believe that EU action should encourage the rational and cost-effective use of NRT, among other available treatment options, integrated within a smoking cessation programme.[7]

Question 4: Do you have any other comments or suggestions on the Green Paper?

In PGEU's opinion the approach of the green paper seeking as it does views on the scope of measures to tackle passive smoking, over emphasises the role of physical barriers for smokers to smoke, when in fact it should additionally be oriented to recognising the need for smokers to stop smoking. As we have mentioned above, we are aware of the difficulties inherent in quitting smoking and we agree that smoke-free environments may contribute to creating the conditions for considering quitting. Nonetheless, EU action could go further in the area of smoking cessation by encouraging Member States to exchange best practices on how to facilitate smokers' enrolment in such programmes and health professionals' commitment.

Another aspect which should be considered is the targeted use of marketing and media. PGEU believes this would be helpful if they could stress that "Stop Smoking Services" exist, referring people to a contact line where they can have more information about such services and/or referring then to the nearest pharmacy or health centre; publicity surrounding these should promote the services as often as possible and be broadly distributed in public places where smoking will be banned or restricted.

[5] Hughes JR. Dependence potential and abuse liability of nicotine replacement therapies. Biomed Pharmacother. 1989;43(1):11-7. Review.

[6] Covey LS, Sullivan MA, Johnston JA, et al. Advances in non-nicotine therapy for smoking cessation. Drugs 2000; 59 (1): 17-31

[7] Martin Raw, Ann McNeill, Robert West. Smoking cessation: evidence based recommendations for the healthcare system. *BMJ* Volume 318. 16 January 1999. www.bmj.com

3. Conclusions

PGEU believes that any future initiative as a follow up of this consultation should support a platform for Member States to exchange best practices on how to facilitate smokers' enrolment in smoking cessation and health professionals' commitment. As a minimum, such a forum should consider:

- rules facilitating the reimbursement of medical treatment and the cost of medicines for smoking cessation; in other words, smoking cessation interventions should be commissioned;
- facilitation where possible of health professionals training in smoking cessation;
- targeted campaigns about stop smoking services;
- work with health professionals to put systems in place to audit interventions for smoking cessation throughout the healthcare system.