Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Transformation Programme

...to enable people live healthier and more fulfilled lives

Easy Access - public confidence - staff pride

The Health Service Executive

Tobacco Control Framework

February 2010

Acknowledgements

It would not have been possible to bring this work to completion without the valuable input and contribution of the Tobacco Control Framework Project and Steering groups whose stewardship was greatly appreciated. Please see appendix 1 and 2 for a list of all members.
The contribution of staff within smoking cessation and environmental health services, other HSE staff who participated in focus groups and staff from agencies external to the HSE who participated in consultations to inform this document is also greatly appreciated.

Table of Contents

Table of Contents

Foreword

This framework document was developed by the Health Service Executive (HSE) Tobacco Control Framework project group guided by a national steering group in order to inform HSE policy and provide a coherent HSE approach to tobacco use in Ireland. In developing the Tobacco Control Framework a population health approach has been considered as outlined in the HSE's Population Health Strategy.

Half of all smokers are killed as a direct result of their smoking, and half of them die prematurely. On average, smokers lose 10 healthy quality years of life.Tobacco use is a significant cause of ill health and mortality in the population. In Ireland smoking kills up to 6,500 people annually and exacerbates health inequalities.

The HSE will support its management and staff to fully engage with and support this framework with a view to understanding their own roles in its implementation.
The framework has six national standards based on the WHO Report on the Global Tobacco Epidemic 2008. That report outlines the MPOWER package, a package of the six most important, effective and evidence based tobacco control policies which are:
Monitoring of tobacco use and prevention policies,
Protecting people from second-hand smoke,
Offering help to people who want to quit,
Warning of the dangers of tobacco,
Enforcing bans on advertising, promotion and sponsorship, and
Raising taxes on tobacco.

While the HSE will implement the actions outlined in this framework by seeking to address the determinants of tobacco use and reduce health inequalities, it recognises that it is not the only sector to play a role in the prevention and treatment of tobacco use. Relevant government departments including those responsible for taxation together with social and community sectors all play a role. The HSE needs to continue to work and support these other relevant sectors at strategic and operational levels to implement the national standards that are outside the remit of the health sector.

Dr Patrick Deerley

National Director of Population Health
Health Service Executive

Introduction

Tobacco use is a significant cause of ill health and mortality in the population. In Ireland smoking kills up to 6,500 people annually and exacerbates health inequalities. The problem of tobacco use has been acknowledged by government at a policy level as evidenced by:

- the implementation of recommendations from Building Healthier Hearts,
- the development by the Oireachtas Joint Committee on Health and Children of ”A National Anti-Smoking Strategy- A Report on Health and Smoking”,
- their adoption of “Towards a Tobacco Free Society” as a policy document,
- the passing of the Public Health (Tobacco) Acts 2002, 2004 and 2009 and the enactment of various sections of these acts, and
- their ratification of the World Health Organisation Framework Convention on Tobacco Control.

The Health Service Executive (HSE), which provides services that improve, promote and protect the health and welfare of the public, is deeply concerned about the harmful effects of tobacco use on the population. In its Corporate Plan (2008-2010) it recognises the need for a shift towards prevention and better self care rather than a focus on acute care and treatment. This will require strong illness prevention initiatives, health promotion and population health strategies. To underscore its commitment in this area, smoking prevalence is identified as a key performance indicator in achieving its corporate priorities.

Under its Transformation Programme the HSE is committed to tackling the problem of tobacco related harm within the population as a whole and in particular in vulnerable groups such as children and adolescents and those at the margins of society.
The HSE has developed this Tobacco Control Framework to provide an evidence based approach to address tobacco and to outline national standards for service provision.

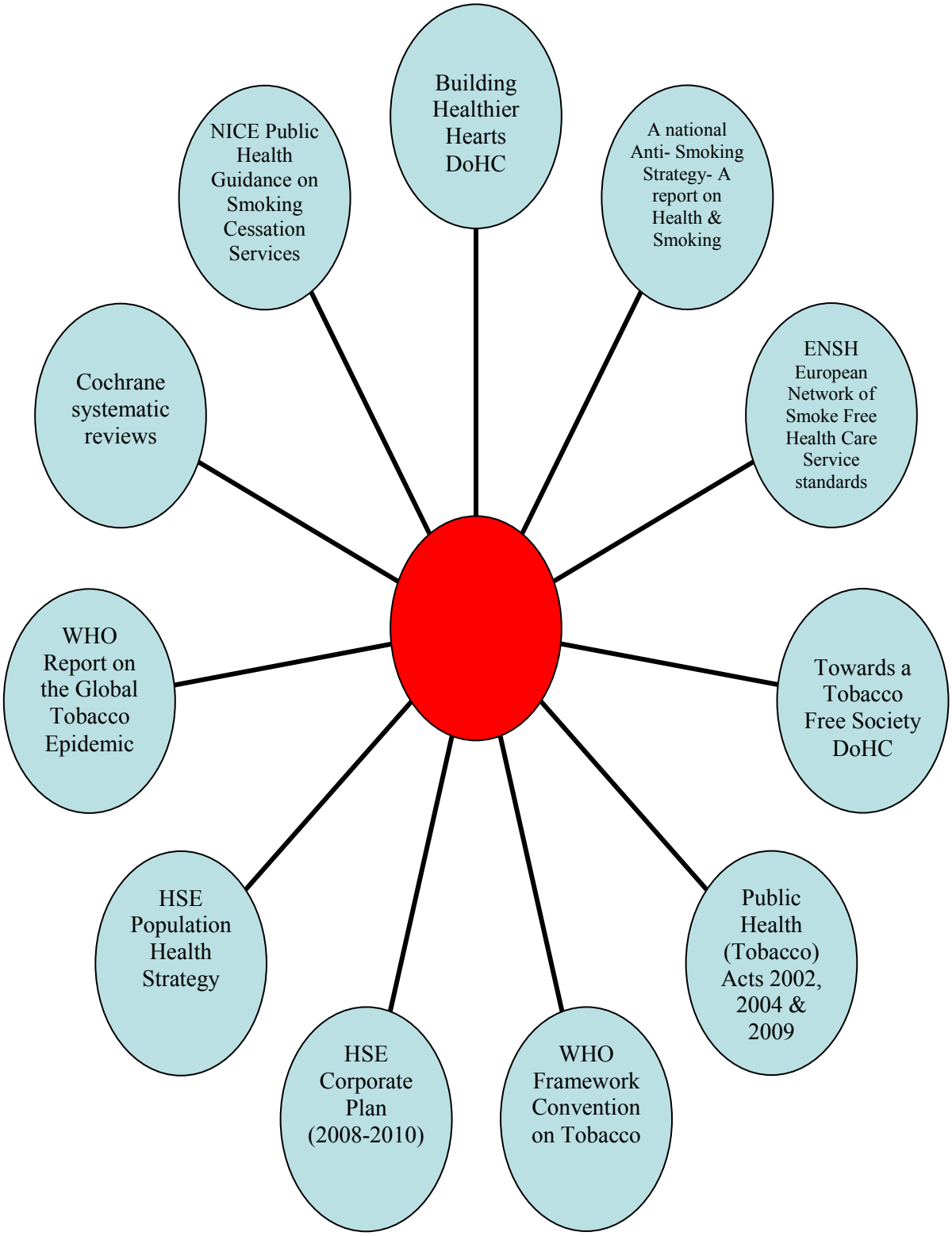
In developing the Tobacco Control Framework both the WHO MPOWER principles for tobacco control and a population health approach have been considered. The key elements of the population health approach as contained within the HSE’s Population Health Strategy * are outlined below:

1. Addressing the wider determinants of health and tackling health inequalities,
2. Planning for health and social well being and not just health and social care services,
3. Developing and employing reliable evidence to improve health and social care outcomes,
4. Making choices for health investment,
5. Measuring and demonstrating the return for investment in health and social care services,
6. Shifting the balance from hospital to primary care and health promotion,
7. Integrating services across the continuum of care,
8. Proactively engaging and working with other sectors to improve health,
9. Engaging the population on the issue of their own health.

See Figure 1. for the context of framework development.

* The recommendations contained within this report have considered the nine elements of the population health strategy above and will be indicated within the report with an astrix followed by the number where appropriate. (For example *1, *5)

Figure 1. Context for Framework Development and Implementation



Background to the Development of the Tobacco Control Framework

A steering group was set up in 2007 to guide the development of the Tobacco Control Framework. It comprised representatives from the; Population Health Directorate of the HSE, Department of Health and Children (DoHC), and the Office of Tobacco Control (OTC). The purpose of the steering group was to provide strategic direction in the development of the framework. The terms of reference for the steering group were to:

- Oversee the development of the tobacco control framework.
- Review best practice in terms of tobacco control nationally and internationally with particular reference to how the HSE can develop national standards.
- Outline the current tobacco control situation in Ireland and actions the HSE will take in order to meet best practice standards where required.
- Advise and support the tobacco control project group on the development of the framework.
- Agree with the tobacco control project group processes for engaging with and working in partnership with all relevant stakeholders.
- Advise on the establishment of the monitoring and evaluation group for the framework once the document has been completed.

A project group was also established which included representatives from the three service delivery directorates within the HSE. The role of the project group was to carry out a literature review on the evidence base in relation to tobacco control, to consult extensively with key stakeholders both internal and external to the HSE and to develop an outline of the framework document including the development of national standards for service provision. Please see Appendix 1 and 2 for project and steering group membership.

Whilst much remains to be done in the battle against tobacco, it must be acknowledged that there have been considerable inroads into controlling and preventing tobacco use in Ireland over the past 50 years or so. These are outlined in Appendix 3.

Prevalence of smoking in Ireland

Adults

In Ireland the most recent survey of lifestyles and health behaviour SLÁN, 2007 (Brugha et al., 2009) found that 29% of adults reported being current smokers (31% men and 27% women). Younger people were more likely to smoke (35% of those aged 18-29 years compared with 25% of those aged 45-64). Smoking is also more prevalent among lower social class groups. In the 2007 report, 37% reported to be smokers in social class group 5-6 compared with 24% reporting to be smokers in the highest social class group 1-2. The decrease in smoking rates that was evident between 1998 and 2002 has now ceased with no reduction in smoking from 2002 to 2007. Overall rates for smoking were 33% in 1998, 27% in 2002 and now 29% in 2007. It is estimated that there are 940,000 adult smokers in Ireland in 2007.

Children

In the most recent report (Health Behaviour in School Aged Children 2006) which looked at smoking prevalence in children and adolescents in Ireland 15% of children overall, between the ages of 10 and 17 years reported to be current smokers although this varied greatly in the different age categories. Smoking among girls was higher than boys for children aged 12-14, with 11.3% of girls aged 12-14 reporting that they were current smokers compared with 9.3% of boys the same age. Similarly 27.3% of girls aged 15-17 reported to be current smokers compared with 21% of boys. There is evidence of an overall reduction in reported smoking across all age ranges between the 2002 and 2006 surveys with the most significant drop of 9.3% in boys aged 15-17 from 30.3% in 2002 to 21% in 2006. Overall about 63,000 children 10-17 years are current smokers in Ireland.

Further data on smoking prevalence for adults and children is outlined in Appendix 4.

The health effects of tobacco use

The combined evidence of thousands of published scientific papers confirms that there is undisputable evidence that tobacco use has detrimental health effects for those who use tobacco and for those exposed to second-hand smoke (SHS). Worldwide, tobacco killed more than 100 million people during the 20th century and it is estimated that it will kill more than one billion people in the 21st century; about 5.4 million people a year from lung cancer, heart disease and other illnesses.

Half of all smokers are killed as a direct result of their smoking, and half of them die prematurely. On average, smokers lose 10 healthy quality years of life. In Ireland smoking kills up to 6,500 people annually. By virtue of the mortality caused by smoking and the many acute and chronic illnesses caused and exacerbated by smoking, it places a huge burden on individuals, their families and friends, the health and social services and on society. On a positive note, the evidence base is also fairly clear that quitting smoking brings many benefits.

Tobacco use and health inequalities

Large proportions of our society particularly those living in underprivileged communities remain exposed to the significant health risks from smoking. Smoking not only has detrimental health effects, but is also a contributory factor in poverty and health inequalities. Money spent on tobacco by those with low incomes means money not spent on basic necessities such as food, shelter, education and health care.

There is a strong relationship between tobacco use and health inequalities. Smoking rates are higher among lower socio-economic groups than in more affluent groups. It has been shown that because of the severe health effects of tobacco use, this contributes greatly to socio-economic differences in health. In Britain cohort studies following participants over two decades have revealed that those from unskilled and manual backgrounds were more likely to be current smokers than those from professional and non manual backgrounds. A World Bank report on the economics of tobacco analysed the impact of smoking on the survival of men of varying social classes in four countries where smoking is an established social norm – Canada, Poland, the United Kingdom and the United States. In Poland in 1996 it found that men with a University degree had a 26% risk of death in middle age compared to a 52% risk for men with just primary level education. Tobacco was responsible for about two thirds of the excess risk in the group of men with primary level education.

Ireland is no different in that lower socio-economic groups have higher smoking prevalence rates as outlined earlier and therefore smokers in lower socio-economic groups have poorer health outcomes.

Economic Considerations

The social and economic cost of smoking is detrimental to society in terms of time lost from work due to tobacco related diseases, productivity losses, medical, disability and mortality costs. In high income countries like Ireland smoking related health care costs account for between 6% and 15% of all annual healthcare costs.

An Australian study conducted by Hurley & Matthews in 2007 developed a 'Quit Benefits Model' which assessed the consequences of quitting smoking in terms of the avoided cases of four smoking related diseases; acute myocardial infarction, stroke, lung cancer and chronic obstructive pulmonary disease. It also reports on the quality adjusted life years (QUALYs) and health care costs saved and the tool can be adapted for use in other countries as an evaluation tool. The study found that for every 1,000 smokers who quit smoking there was an average saving of A$373,000 in health care costs associated with the four medical conditions above. Overall forty of these individuals would be spared a diagnosis of four of the most common smoking related diseases and eighteen deaths prevented per 1,000. Therefore not only is it important from a health protection and promotion perspective to address tobacco use in a comprehensive way, reducing tobacco consumption will also save the health services and general economy millions.

Components of comprehensive tobacco control programmes

In addition to the thousands of peer reviewed scientific papers on the harmful effects of tobacco use, there are thousands more which evaluate the effectiveness or otherwise of methods to reduce the prevalence of tobacco use.

The World Health Organisation has carried out a comprehensive analysis of the research and has identified the key strategies countries need to adopt to reduce tobacco use. These are outlined in some detail in the WHO Report on the Global Tobacco Epidemic 2008. In that report it outlines the MPOWER package, a package of the six most important, effective and evidence based tobacco control policies which are:

Monitoring of tobacco use and prevention policies,
Protecting people from second-hand smoke,
Offering help to people who want to quit,
Warning of the dangers of tobacco,

Enforcing bans on advertising, promotion and sponsorship, and
Raising taxes on tobacco.

Most of these same measures were recommended in previous reports published by the World Bank and the US Department of Health and Human Services. Some of these measures the HSE can implement itself, for others it will need to work in partnership with other interested parties and for others it will need to advocate to government for action.

The HSE Tobacco Control Framework is modelled on the six proven policies contained within the MPOWER report as well as the nine elements of the Population Health Strategy. These are outlined below. For each of the six areas identified, the current situation is outlined followed by the National Standards which have been set and the actions the HSE needs to put in place in order to maximise the effect of these broad policy statements.

In addition, the HSE in recognising the need to work in partnership with other bodies will establish a national expert group on tobacco control in partnership with key stakeholders to assist in the development of a coordinated national approach to address tobacco use. This national expert group will include representation from the Department of Health and Children, the OTC and various other non governmental organisations which have an interest in tobacco control. The group will help coordinate and communicate work within the various bodies and avoid duplication of tobacco control work.

The timeframe for implementing this framework is five years. A yearly implementation plan will be developed which will outline how the framework will be implemented. The priorities and action areas in this document will be implemented using a well structured project management approach linked to the Transformation Programme * of the HSE. It will also cross reference and complement other projects within Programme 4 (Implement a model for the prevention and management of chronic illness and improve the health of the population). Other projects which are included in programme 4 include the following:

- Develop and implement a health inequalities framework,
- Develop and implement a chronic illness framework,

- Develop and implement a population health strategy,
- Develop and implement a framework for action on obesity,
- Implement the 5 year strategic action plan on breastfeeding.

* The Transformation Programme 2007-2010 consists of six transformation priorities. They are as follows:

1. Develop integrated services across all stages of the care journey,
2. Configure primary community and continuing care services so that they deliver optimum and cost effective results,
3. Configure hospital services to deliver optimum and cost effective results,
4. Implement a model for the prevention and management of chronic illness and improve the health of the population,
5. Implement standards based performance measurement and management throughout the HSE,
6. Ensure all staff engage in transforming health and social care in Ireland.

The MPOWER Model

1- Monitor tobacco use and prevention policies

Data from monitoring is necessary to ensure the successes of the five other policy interventions in the MPOWER package. Comprehensive monitoring of the tobacco problem informs those involved in tobacco control at every level about the size of the problem we face. It also shows whether various policies are working and how they need to be tailored to the population.

Good monitoring systems need to track several indicators, including

- prevalence of tobacco use,
- impact of policy interventions,
- tobacco industry marketing, promotion and lobbying.

Current situation in Ireland

Agencies other than the HSE are directly involved and funded for monitoring of tobacco use and prevention polices

Monitoring of tobacco prevalence in Ireland

Ireland has at its disposal three ongoing measures of smoking prevalence which provide prevalence data by gender, age, and socio economic status. These include the SLÁN and Health Behaviour in School Aged Children (HBSC) surveys, both of which are published every four years. In addition the OTC carries out a monthly monitoring rolling telephone survey on smoking prevalence which is also weighted by geographic area.

Data is also available from the Revenue Commissioners as to the quantity of tobacco products sold on an annual basis and the tax receipts from tobacco sales.

Other surveys - once off research studies (e.g. ISAAC) and EU surveys may also present data on tobacco prevalence.

Monitoring the impact of policy interventions

Research carried out by the OTC and other research bodies monitor the effectiveness of policy interventions – e.g. studies on the effectiveness of the smoke free at work tobacco legislation introduced in 2004. The OTC conducted a baseline survey in 2007 providing a national overview of behaviour among tobacco retailers in respect of sales to minors' legislation as set out in the Public Health (Tobacco) Acts 2002 to 2009. This survey, which was repeated in 2008 and 2009, enables tobacco control progress in the retail environment to be monitored.

Research is also carried out on the impacts of social marketing campaigns and the operation of the *Quitline*. The Environmental Health Services of the HSE and the OTC monitor compliance with the 2004 smoke free at work tobacco legislation and report compliance levels on an annual basis.

Monitoring of tobacco industry marketing, promotion and lobbying

The OTC ensures that that the tobacco industry in Ireland is closely monitored in terms of its marketing, promotion and lobbying practices.

As a result of the ongoing surveys and monitoring outlined above, the HSE has access to significant data on tobacco use and prevention polices; however, there are gaps in that data. In the first instance definitions of smoking for prevalence surveys often differ. In addition, more robust local data would assist in targeting resources at areas of maximum need.

National Standard - HSE Actions

In order to support the MPOWER policy of monitoring tobacco use and prevention polices the HSE will:

1.1 Seek to analyse SLÁN, HBSC (4 yearly intervals), OTC surveys and other research findings on tobacco prevalence when such data becomes available with a view to targeting interventions appropriately. (*3)

1.2 Make the output from the analysis mentioned above widely accessible to the public and health care professionals by placing it on the HSE website. (*9)

1.3 Work with all stakeholders to get an agreed definition of smoking for use in future prevalence surveys. (*8)

1.4 Advocate for the introduction of a common definition of a smoker/ tobacco user for all surveys on tobacco prevalence and that tobacco use prevalence statistics are available more frequently (every two years). (*3)

1.5 Develop structures and implement mechanisms to ensure that the tobacco use, smoking status and exposure to SHS of service users is routinely recorded along with the interventions applied by HSE health professionals to assist cessation. (*6)

1.6 Develop a process to monitor the prevalence of tobacco use among HSE staff. (*3)

1.7 Monitor on a frequent basis the roll out and sustainability of in-house HSE tobacco policies. (*4)

1.8 Develop evidence based audit methodology to evaluate the provision of tobacco cessation services, the work of cessation providers and the outcomes of the services. (*5)

1.9 Develop and audit all social marketing campaigns to the standard set out in the Campaign Development Tool Kit - International Guide for Planning and Implementing Stop Smoking Campaigns. (*3)

1.10 Ensure that systems are put in place to facilitate the Environmental Health Services in operating a more streamlined national approach to the collection, collation and auditing of data in checking the compliance or otherwise with tobacco control legislation. (*3)

1.11 Support research to improve the monitoring of tobacco use and prevention policies. (*3)

1.12 Engage with the relevant stakeholders to establish a national expert group on tobacco control which will help coordinate and communicate work within the various bodies and avoid duplication of tobacco control work. (*8)

2 - Protect people from Tobacco Smoke

Research clearly shows that there is no safe level of exposure to SHS. Numerous health organisations concur that SHS exposure contributes to a range of diseases, including heart disease and many cancers. For example, SHS exposure increases the risk of coronary heart disease by 25–30% and the risk of lung cancer in non-smokers by 20–30%.

The US Surgeon General's report in 2006 reviewed research on exposure to SHS and concluded that complete smoke free policies were the most economic and effective approach for providing protection from exposure to SHS and that they provide the greatest health impact.

Current Situation in Ireland

Legislation which came into force on the 29th March 2004 prohibits smoking in most workplace settings. HSE Environmental Health Services and the OTC have developed a National Tobacco Control Inspection Programme to monitor the legislation. In 2008, 97% of workplaces inspected were found to be compliant with the legislation.

However, the legislation does not protect all persons from exposure to SHS equally. There were some exceptions contained within the legislation. It does not extend to cover smoking within HSE residential and day-care services: mental health services, community hospitals, nursing homes, intellectual disability services and the prison services. As a result clients and employees within these services remain exposed to SHS. In order to address some of these issues, in 2008 the HSE in conjunction with the Irish Health Promoting Hospital Network finalised and launched *Best Practice Guidelines for Tobacco management in the Mental Health Setting.* The HSE have made a commitment to implement these guidelines in mental health services nationally.

National Standard - HSE Actions

In order to support the MPOWER policy of protecting people from tobacco smoke the HSE will:

2.1 Develop and implement a tobacco free policy applicable to all its services. (*6)

2.2 Under the above policy develop a protocol to protect all staff from SHS where service provision includes going into a domestic setting. (*6)

2.3 Put procedures in place to protect children under the care of the HSE from SHS in all settings. (*2)

2.4 Implement the comprehensive standards for health services as defined by the European Network of Smoke Free Health Care Service (ENSH) standards. (*6)

2.5 Through their Environmental Health Service continue with a uniform approach throughout the HSE to implement the National Tobacco Control Inspection Programme Protocols which relates to compliance with the smoke free at work legislation. (*4)

2.6 Sustain and further develop social marketing campaigns to inform the public on the dangers of SHS and how they might mitigate that danger to themselves and others. (*9)

2.7 Work with the Department of Health and Children to enhance the legislation in order to further protect people from the hazards of SHS, especially those not covered under existing legislation. (*2)

3- Offer help to quit tobacco use

Nicotine is the highly addictive drug contained within tobacco and understanding it and the nature of addiction can ultimately help when supporting smokers to quit. Smokers who try to quit smoking without support have a less than 2% chance of quitting successfully after one year. There are a range of different treatments and supports to help smokers quit.

In addition to the MPOWER report, two comprehensive and evidence based sources of information on best practice were consulted to decide the best practice standards for promoting smoking cessation for this framework document. These included the:

- National Institute for Health and Clinical Excellence (NICE) Public Health Guidance on Smoking Cessation Services,
- Cochrane systematic reviews of published and peer reviewed papers on smoking cessation.

There are seven proven smoking cessation activities or inventions.
These include: Brief interventions, Individual behavioural counselling, Group behaviour therapy, Pharmacotherapies, Self help materials, Telephone counselling via quitlines, and Mass media campaigns.

Current Situation in Ireland

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 counsellor.
The Research Institute for a Tobacco Free Society conducted comprehensive research on smoking cessation services provided directly by the HSE during 2007/08. Data from that research shows that where direct smoking cessation services are available, those who carry out the services do so to a high standard. However, the provision of direct smoking cessation support services is sub-optimal and very patchy throughout the country. In addition, the research found that the

collection, collation and analysis of follow up data varied among providers as there is little in the way of standardisation as to how such data are managed.
Whilst GPs and others provide some smoking cessation service, there are no data on the extent that this happens, the skill base of those who provide the service or the uptake and outcome of such services.

Finally, nicotine replacement therapies, buproprion and varenicline are available by prescription free to all GMS registered patients who smoke. For the remainder of the smoking population, buproprion and varenicline are subsidised via the Drugs Payment Scheme.

National Standard - HSE Actions

In order to support the MPOWER policy of offering help to quit tobacco use the HSE will:

3.1 Further develop the skills of all trainers who deliver tobacco cessation training so that they themselves are trained to a satisfactory standard. (*3)

3.2 Develop national tobacco cessation training standards for use by all health and social care professionals. (*3)

3.3 Provide nationally recognised and accredited Brief Interventions training to all front line health care staff and primary care staff. (*6)

3.4 Incorporate tobacco cessation services into both primary care and front line services making the delivery of brief advice and referral to specialist services a core role for staff working in these areas. (*7)

3.5 Further develop tobacco cessation services so that that all health care providers delivering tobacco cessation support/services (either through specialist services or primary care) adhere to a set of nationally agreed standards/guidelines and that consistent service provision is delivered nationally. (*3)

3.6 Develop and extend tobacco cessation services specifically targeting areas of inequalities and high smoking prevalence using trained lay health advocates. (*1)

3.7 Advocate to third level institutions and health professional associations for the compulsory introduction of brief intervention training/tobacco cessation training in all undergraduate and postgraduate education across all health disciplines. (*8)

3.8 Incorporate information on supports available to people to stop smoking when developing social marketing campaigns. (*9)

3.9 Further develop multimedia smoking cessation tools. (*4)

3.10 Maintain an active register of specialist tobacco cessation service providers. (*3)

3.11 Work towards the integration of services in all regions and prioritise areas of highest smoking prevalence i.e. lower socio-economic areas, also mental heath and maternity settings when planning and delivering tobacco cessation services. (*1)

3.12 Set realistic performance targets for both the number of people using the service and the proportion who successfully quit smoking and tobacco use based on the demographics of the region. (*5)

3.13 Produce a simple clear resource for GPs and pharmacists on tobacco cessation. (*6)

3.14 Maintain an efficient *Quitline* service with computerised recording of tobacco use, smoking status and interventions along with cessation follow up monitoring data.

3.15 Continue to provide evidence based pharmacotherapy free to GMS patients. (*4)

3.16 Use social marketing methodologies to advertise the availability of free nicotine replacement products under the GMS scheme. (*9)

3.17 Advocate for the introduction of all evidence based pharmacotherapy including nicotine replacement therapy on the drug refund scheme. (*4)

3.18 Encourage health insurers to provide refunds to their clients for evidence based pharmacotherapy medicines used to support smoking cessation. (*8)

3.19 Advocate for nurse prescribing of evidence based smoking cessation pharmacotherapy medicines. (*6)

3.20 Sustain and develop social marketing campaigns to advertise the *Quitline* tobacco cessation service. (*9)

3.21 Support research into new ways of supporting tobacco users and smokers to quit particularly targeting disadvantaged communities where tobacco use and smoking rates are higher. (*3)

3.22 Actively support HSE staff who wish to quit smoking. (*2)

3.23 Work with procurement services to introduce stop smoking messages on all newly printed HSE stationery. (*9)

4 - Warn about the dangers of Tobacco

The international evidence base points to the need for governments and health services to change the image of tobacco. People need to see that tobacco is extremely addictive with dangerous health consequences and is socially undesirable. Despite conclusive evidence on the dangers of tobacco, relatively few tobacco users worldwide fully grasp its health risks. People may know generally that tobacco use is harmful, but it is usually seen merely as a bad habit in which people choose to indulge. The extreme addictiveness of tobacco and the full range of health dangers are not adequately understood by the public. Consequently, people believe they can reduce or stop tobacco use before health problems occur. The reality is that most tobacco users will find it extremely difficult to quit, and up to half will die from tobacco-related illnesses. Most people are unaware that even the smallest level of tobacco use is dangerous, in part because this is not the case with other behavioural health risks. Many tobacco users cannot name specific diseases caused by smoking other than lung cancer, and do not know that smoking also causes heart disease, stroke and many other diseases, including many types of cancer. Comprehensive warnings about the dangers of tobacco are critical to changing its image, especially among adolescents and young adults. People need to associate tobacco with its extreme addictiveness and dangerous health consequences, and to see it as socially undesirable and negative.

The US Centers for Disease Control and Prevention recommend that governments generally spend US $2–4 per person per year on anti-tobacco health communication and counter-advertising efforts, which research shows is very effective at reducing tobacco use. This type of advertising should comprise about 15%–20% of total tobacco control programme costs.

Current Situation in Ireland

There have been a number of social marketing campaigns developed in Ireland over the past number of years. These include the ‘Break the Habit for Good: NICO’ campaign which commenced in 2000 focusing on youth, the 2004 OTC campaign on

the dangers of SHS and the 2003/2004 “Every Cigarette is doing you Damage” campaign. ‘The Beauty of Quitting’ campaign in 2007 focused specifically on young women and the negative effects of tobacco use on their image. 2007 and 2008 saw social marketing campaigns to promote the National Smoking Cessation Quitline. In 2009 a radio, billboard and television campaign was launched which targeted parents and guardians encouraging them to think about how their smoking effects and influences their children. In addition the EU has worked closely with Member States in warning about the dangers of tobacco through its “Feel Free to Say No” and “HELP” campaigns.

The HSE inputs into the Department of Education and Science’s health education programme entitled SPHE (Social, Personal and Health Education) which has a tobacco element. It provides written materials on the harms from tobacco use and cessation support materials which are widely circulated. The HSE has also developed an online element which makes up part of the multimedia approach to the promotion of smoking cessation. This includes elements to address the needs of young people and the general public and includes both internet and HSE intranet components. Appropriate promotional activity is planned to raise the profile of this support.

Through its Environmental Health Services, it provides an important educational support base for retailers of tobacco products and bar owners on the dangers of tobacco and associated SHS.

Health warnings on the packaging of all tobacco products are guaranteed to reach all users. Health warnings on tobacco packages increase smokers’ awareness of their risk. Use of pictures with graphic depictions of disease and other negative images has greater impact than words alone, and is critical in reaching the large number of people who cannot read. Pack warnings in Ireland are dual language and a consultation process has recently been completed regarding the introduction of pictorial pack warnings.

National Standard - HSE Actions

In order to support the MPOWER policy of warning about the dangers of tobacco the HSE will:

4.1 Formulate sustainable 3-5 year social marketing campaigns to address tobacco issues using best evidence as outlined in the Campaign Development Tool Kit and recommendations from the NCI Tobacco Control Monograph 19 - The role of the media in promoting and reducing tobacco use. (*3)

4.2 Progress an awareness campaign to advise all HSE staff of the dangers of tobacco use. (*6)

4.3 Maximise the health promoting ability of its 100,000 plus staff in order to ensure that the wider community are aware of the dangers of tobacco use. (*6)

4.4 Ensure that information disseminated on the harm from tobacco use also includes information on the health risks associated with exposure to SHS. (*9)

4.5 Work in partnership with other agencies to deliver comprehensive coordinated public awareness messages in relation to tobacco use. (*8)

4.6 Continue to encourage and support the use of the SPHE tobacco module at all schools. (*8)

4.7 Continue to support and engage with the 'Campaign Advisory Group' which is a national expert group made up of staff working in the areas of tobacco both within the HSE and from external stakeholders to develop anti tobacco advertisement campaigns including counter advertising (*8)

4.8 Promote the *Quitline* service through multimedia channels. (*9)

4.9 Through its Environmental Health Services, deliver retailer education campaigns on the dangers of tobacco and the need for compliance with legislation in order to raise awareness of the retailer's responsibility in relation to the sale of tobacco products to minors. These education campaigns will give priority to areas where sales to minors are known to have occurred in the past and to retailers located near schools and in disadvantaged and lower socioeconomic areas. (*1)

4.10 Use HSE infrastructural facilities (transport, buildings etc) as a resource to assist in running social marketing campaigns on the dangers of tobacco use. (*6)

5 - Enforce bans on tobacco advertising, promotion and sponsorship

Comprehensive advertising bans reduce tobacco use among people of all income and all educational levels. A ban on marketing, sponsorship and promotion is a powerful weapon against the tobacco industry and the tobacco epidemic generally. In order to comply with best practice and be effective, bans must be complete and apply to all marketing and promotional categories.

Current Situation in Ireland

Advertising of tobacco products is restricted under the Tobacco Products (Control of advertising, sponsorship and sales promotion) Regulations 1991, 1996 and 2000 and by the Public Health (Tobacco) Acts 2002 to 2009. From 1 July 2009 no advertising or display of tobacco products is permitted. Tobacco products must be out of view within a closed container or dispenser only accessible by the retailer and retail staff. Self-service vending machines are prohibited except in licensed premises and registered clubs and must be operated in accordance with Regulations. All retailers wishing to sell tobacco products must register with the Office of Tobacco Control. Section 33 of the Public Health (Tobacco) Acts 2002 to 2009 provides that a person who advertises or causes the advertisement of a tobacco product in contravention of Directive 2003/33/EC shall be guilty of an offence.

Sales of tobacco products to minors are also illegal. The OTC has developed an Information Guide for Retailers and Staff which commenced in 2008 and outlines the law in relation to sales to minors, together with frequently asked questions. The information guide is available in English, Irish, Chinese (Mandarin) and Polish. In addition to the guide a training DVD for retailers and staff was also produced and circulated both directly to tobacco retailers from the OTC and through Environmental Health Departments nationally. A media campaign highlighting the availability of these resources was also developed using radio advertising on both national and regional radio stations. The Public Health (Tobacco) Acts 2002 to 2009 introduced a ban on advertising or display of tobacco products with some exemptions for specialist and duty free stores.

National Standard - HSE Actions

In order to support the MPOWER policy of enforcing bans on tobacco advertising, promotion and sponsorship the HSE will:

5.1 Continue to engage with the OTC and the DoHC in updating Environmental Health staff on policy implementation issues which are specifically targeted within agreed business plans. (*8)

5.2 Through its Environmental Health Services submit quarterly reports to the OTC outlining the figures on the activities and outcomes of the National Tobacco Control Inspection Programme for example: the numbers of inspections and non compliant premises along with details of enforcement actions taken. (*5)

5.3 Through its Environmental Health Services roll out the National Tobacco Control database which will improve the efficiency and consistency of data collation and provide for regular reports to the OTC on activities and outcomes from the inspection programme. (*4)

5.4 Continue to engage with the OTC and the DoHC to review the National Tobacco Control Inspection Programme Protocols in light of the introduction of new legislation in relation to point-of-sale advertising and the formulation of a tobacco retail register. (*8)

5.5 Prioritise and allocate environmental health staff within the HSE to police all legislation in relation to tobacco(*6)

5.6 The HSE will investigate the possibility of publicising on the HSE website the names and addresses of those premises convicted of being non-compliant with the relevant legislation. (*9)

6 - Raise taxes on tobacco

Raising the price of tobacco products is the single most effective measure to reduce tobacco consumption and encourage tobacco users to quit. It is also the most cost effective and successful measure to tackle health inequalities resulting from tobacco use.

Increases in tobacco excise taxes by 10% worldwide would according to the World Bank reduce demand for cigarettes by about 4% in high income countries like Ireland. Young people, minority groups and low income smokers in particular are '*two to three times more likely to quit or smoke less in response to price increases'* . Tax increases also benefit governments by increasing revenues which can be used for tobacco control. The most effective type of tax increase is one that is levied on a given quantity of tobacco such as a tax paid per pack of cigarettes. Taxes should be:

- Regularly adjusted for inflation and consumer purchasing power in order to maintain their ability to reduce tobacco use.
- Applied at the manufacturer level and certified by a stamp rather than being levied at the wholesale or retail level to reduce administrative costs on these smaller businesses and reduce the possibility of evasion.
- Applied to all tobacco products on a pro rata basis to avoid substitution from more expensive tobacco products such as cigarettes onto cheaper tobacco products.

Current Situation in Ireland

Ireland has one of the highest tax takes on cigarettes in the EU with the tax component of the price of a pack of twenty cigarettes now set at over 70%. The HSE does not have the ability to adjust the tax on tobacco products and can only advocate to government for tax increases pointing out its importance as one of the most significant and effective tobacco control measures.

National Standard - HSE Actions

In order to support the MPOWER policy of advocating for further increases in price on tobacco products the HSE will:

6.1 Continue to play a significant role in encouraging government to increase the price of tobacco products and remove tobacco products from the consumer price index. (*8)

6.2 Prepare pre budget submissions on an annual basis outlining the cost effectiveness and health benefits of increasing taxes on tobacco products. (*8)

6.3 Support research which strengthens the argument for raising the price of tobacco products. (*3)

Appendix 1 – Members of Tobacco Control Framework Project Group

Dr Fenton Howell - Director of Public Health, Population Health (Joint Chair)

Ms. Maria Lordan Dunphy - Health Promotion Development Manager, Population Health (Joint Chair)

Ms. Ann O' Riordan / Miriam Gunning - Irish NPH Network, Population Health

Ms. Imelda O'Neill - Senior Health Promotion Officer, HSE Dublin Mid Leinster

Mr. Paul Hickey Senior Environmental Health Officer, HSE West

Ms. Geraldine Hanna - Health Promotion Functional Manager: Communication, Social Marketing & Advocacy

Mr. William Ebbitt - Health Promotion Functional Manager: Policy and Strategy

Ms. Teresa Hanrahan – General Manager Wexford County Hospital

Ms. Biddy O' Neill - Health Promotion Functional Manager: National Health Promotion Programmes

Ms. Martina Blake- Project Manager Tobacco Control Framework, Health Promotion, HSE South

Appendix 2 – Members of the Tobacco Control Framework Steering Group

Ms. Cathérine Murphy Assistant National Director Population Health, Health Promotion (Joint Chairperson)

Mr. Martin Devine Assistant National Director Population Health, Environmental Health (Joint Chairperson)

Mr. Eamonn Rossi CEO, Office of Tobacco Control

Mr. Robbie Breen – Assistant Principal Officer, Health Promotion Policy Unit, Dept of Health and Children

Ms. Siobhan McEvoy – Acting Chief Environmental Health Officer, Dept of Health and Children

Ms. Maria Lordan Dunphy, Health Promotion Development Manager, Population Health

Dr. Fenton Howell, Director of Public Health, Population Health

Mr. Dave Molloy, Area Chief EHO, Dublin North East

Mr. Richard Dooley, Hospital Network Manager, HSE South

Appendix 3 – Key developments in tobacco control in Ireland 1964-2009

1964	A voluntary code on advertising was introduced.
1971	Tobacco advertising was banned on Television.
1978	The Tobacco Products Control of Advertising, Sponsorship and Sales Promotion Act 1978 was enacted
1988	The Health Promotion and Protection Act was passed which banned the sale of tobacco products to under 16 year olds and made the sale of smokeless tobacco products illegal in Ireland
1991	Regulations under the 1978 Act set out that advertising could only take place internally in premises at points of retail sale provided the advertising did not use electronic media or sound. Advertising in print media which was directed primarily at under 18's was banned. Health warnings were introduced on tobacco products. Tobacco industry sponsorship and selling cigarettes at discount prices was restricted.
1994	Shaping a Healthier Future - a strategy for effective healthcare in the 1990s' was published and set targets for a reduction in smoking prevalence. A Smoking Target Action Group (STAG) was set up by the CEOs of the health boards in response to the targets set out for tobacco control in the health strategy. Its membership included representatives from the Office for Health Gain, the eight health boards, the Department of Health and Children, the Irish Cancer Society, the Irish Heart Foundation and ASH Ireland. The function of the STAG group was to co-ordinate work towards achieving the reduction in smoking levels targeted in the National Health Strategy of 1994. Further amendments to the list of health warnings on tobacco products were enacted.
1997	The Irish Cancer Society established the 'Quitline' service to support smokers in quitting. Subsequently they entered into partnership with the Health Boards and Eastern Regional Health Authority to provide this service. The service is now funded by the HSE.
1999	The Department of Health and Children published Building Healthier Hearts, a national strategy for dealing with heart disease. It included recommendations in tackling the tobacco epidemic, with particular emphasis on cessation supports.

	The Oireachtas Joint Committee on Health and Children published 'A national anti-smoking strategy – A Report on Health and Smoking. Budget increase of 50 pence (64 cent) on the price of a packet of cigarettes (16% increase) to help fund Building Healthier Hearts
2000	The DoHC Tobacco Free Policy Review Group published their report on Health and Tobacco 'Towards a Tobacco Free Society', European Ministers enact new laws on disclosure of content in tobacco products and ensures that warnings about the dangers of the product are to be included on each pack. A ban on all tobacco advertising in the print media other than limited retail and trade advertising was introduced in Ireland. Sponsorship by tobacco companies was also ended. The Office of Tobacco Control was set up on an administrative basis. The Research Institute for a Tobacco Free Society (RIFTFS) was established to form a transdisciplinary academic community around the issue of tobacco control and to support the development of a tobacco free society by engaging in all aspects of research from a public health perspective.
2001	Joint Oireachtas Committee on Health and Children published 2nd report on Smoking The Public Health Tobacco Bill (2001) was published. Free nicotine replacement therapy for medical card holders was introduced. The legal age at which a person can be sold tobacco products was raised to eighteen years.
2002	The Public Health (Tobacco Act), 2002 was passed. The Office of Tobacco Control became a statutory body.
2003	The report on 'The Health Effects of Environmental Tobacco Smoke in the Workplace' was published by the Health and Safety Authority (HSA) and the Office of Tobacco Control (OTC). World Health Assembly adopted the Framework Convention on Tobacco Control (FCTC) The European Communities Manufacture Presentation and Sale of Tobacco Products Directive was transposed into Irish Law. This set out the nicotine and tar levels in tobacco products, and imposed certain restrictions on the colour font

	of tobacco advertising on products as well as setting a minimum size for health warnings. Hospitals and health services working within the Irish HPH Network adopt and commence implementation of the European Network of Smoke Free Health Care Service (ENSH) standards. These standards include in addition to tobacco control, staff training and education, development of cessation services and systematic monitoring and review procedures for tobacco policies
2004	The Public Health (Tobacco) (Amendment) Act 2004 (Commencement) Order 2004 came in to operation. It banned smoking in specified enclosed buildings in order to protect the public from second-hand smoke (SHS). It made it compulsory to display no smoking signage and made it an offence to obstruct the work of an environmental health officer who was trying to ensure compliance. An EU Conference on the 'Future Directions in Tobacco Control' was hosted in Ireland by the Office of Tobacco Control, the EU Commission, the Department of Health and Children and the Mid Western Health Board.
2005	The Irish government ratified the World Health Organisations' Framework Convention on Tobacco Control (FCTC).
2006	The High Court (Mr Justice Roderick Murphy) supported the protocol which facilitates Environmental Health Officers of the HSE in using children to test-purchase cigarettes in retail outlets. An EU Court of Justice decision ensures that individuals must continue to pay domestic custom duties when buying tobacco products from another EU country and having it delivered to their home.
2007	A number of plaintiffs, including PJ Carroll & Company Ltd, John Player & Sons Limited and Gallaher (Dublin) Limited, discontinued their legal challenge to key provisions of the Public Health (Tobacco) Acts 2002 and 2004. The plaintiffs agreed that it was appropriate for the Court to make an order that the plaintiffs would pay the full costs of the state in relation to the litigation. Sections 38(1) and 38(3) of the Public Health (Tobacco) Acts 2002 to 2009 were commenced banning the sale of cigarettes in packets of less than 20 and confectionary which resembles tobacco products. Hospitals and health services working within the HSE Irish HPH Network work towards the full implementation of the revised European Network of Smoke Free

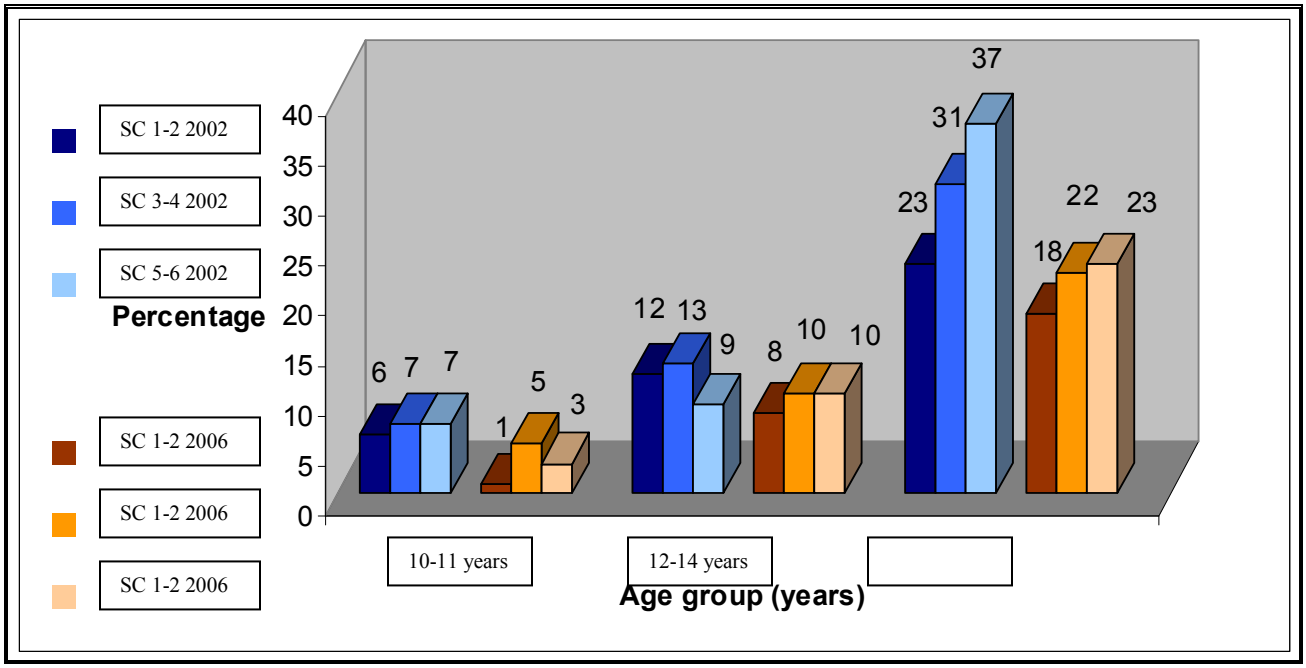
	Health Care Service Standards (ENSH) that moves health services towards being totally tobacco free. HSE Tobacco and Mental Health Services develop at National and European level a set of Guidelines for Tobacco Management in the Mental Health Setting.
2008	Guidelines for Tobacco Management in the Mental Health Setting are launched and endorsed for implementation within all HSE Mental Health Services. It is announced that further provisions of the Public Health (Tobacco) Acts 2002 and 2004 are to be commenced on 1 July 2009 which relate to in store advertising of tobacco products Dual language health warnings (Irish and English) on tobacco products commence. Public consultation takes place on graphic pictorial warnings.
2009	St Vincent's Hospital entire campus in Dublin 4 became a no smoking zone on January 1, 2009. Connolly Hospital, Blanchardstown became smoke free on the 31st May 2009. The IMO calls on all health sector organisations to follow the leadership shown by St. Vincent's Hospital in making their respective campus' smoke-free. From 1 July 2009 no advertising or display of tobacco products is permitted in retail outlets with some exemption for specialist and duty free stores. Tobacco products must be out of view within a closed container or dispenser, only accessible by the retailer and retail staff. Self-service vending machines are prohibited except in licensed premises and registered clubs and must be operated in accordance with Regulations. All retailers wishing to sell tobacco products must register with the Office of Tobacco Control. Section 33 of the Public Health (Tobacco) Act 2002 to 2009 provides that a person who advertises or causes the advertisement of a tobacco product in contravention of Directive 2003/33/EC shall be guilty of an offence. HSE CEO Professor Brendan Drumm signed the Tobacco Free United (TFU) Charter and appealed to all health care professionals to always ask their patients and clients about their tobacco consumption and give them advice on how to quit.

Appendix 4 Data on smoking prevalence

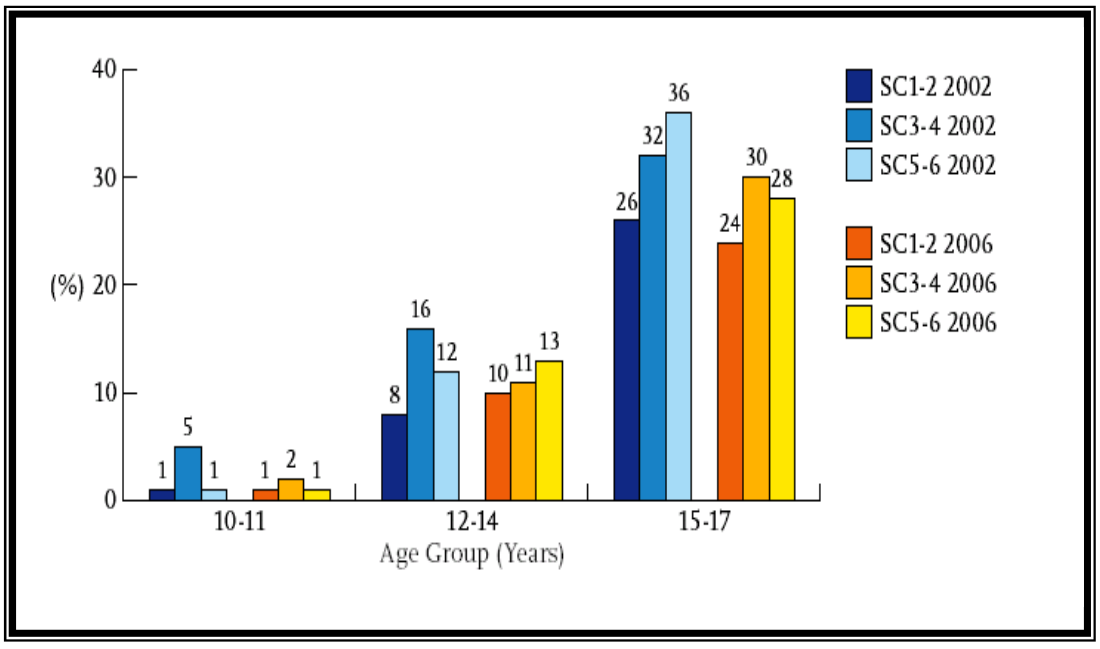
Percentage of respondents smoking by gender, age, social class and year (1998, 2002, 2007) (Reproduced from the SLÁN Report 2008, pp 76)

	Men			Women			Total		
	1998 %	2002 %	2007 %	1998 %	2002 %	2007 %	1998 %	2002 %	2007 %
Total	34	27	**31**	32	27	**27**	33	27	**29**
Age Group									
18-29	42	29	**38**	44	31	**32**	43	30	**35**
30-44	38	33	**37**	34	32	**29**	36	33	**34**
45-64	29	23	**23**	26	25	**27**	28	24	**25**
65+	19	20	**17**	16	14	**13**	17	17	**14**
Social Class									
1-2	30	19	**24**	31	19	**23**	30	19	**24**
3-4	36	27	**33**	37	27	**28**	36	27	**30**
5-6	39	33	**34**	38	38	**41**	39	35	**37**
UNC**	32	32	**35**	27	33	**20**	30	33	**25**

Percentages of boys who report that they are current smokers
(Reproduced from the HBSC Report 2007)



Percentage of girls who report that they are current smokers
(Reproduced from the HBSC Report 2007)



Appendix 5 Abbreviations

DoHC	Department of Health and Children
ENSH	European Network of Smoke Free Health Care Service
FCTC	Framework Convention on Tobacco Control
GMS	General Medical Services
HBSC	Health Behaviour and School aged Children Report
HPH	Health Promoting Hospitals
HSE	Health Service Executive
ISAAC	International Study of Asthma and Allergies in childhood
NICE	National Institute of Health and Clinical Excellence
NCI	National Cancer Institute
OTC	Office of Tobacco Control
PCCC	Primary Community and Continuing Care
QUALYS	Quality adjusted life years
RIFTFS	Research Institute for a Tobacco Free Society
SHS	Second hand smoke
SLÁN	Survey of Lifestyle, Attitudes and Nutrition
SPHE	Social Personal and Health Education
STAG	Smoking Target Action Group
WHO	World Health Organisation

Bibliography

Brugha, R., Tully , N., Dicker, P., Shelley, E., Ward, M. and McGee, H. (2009) SLAN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Smoking Patterns in Ireland: Implications for policy and services, Department of Health and Children. Dublin: The Stationary Office.

Department of Health and Children. Building Healthier Hearts: The Report of the Cardiovascular Health Strategy Group. Dublin: The Stationary Office; Government Publications; 1999.

Department of Health and Children. Health Promotion Unit. Survey of Lifestyle, Attitudes and Nutrition, (SLÁN) & The Irish Health Behaviour in School-Aged children survey (HBSC). The Stationery Office; Government Publications; 1999.

Department of Health and Children. Towards a Tobacco Free Society: Report of the Tobacco Free Policy Review Group. Dublin: The Stationary Office; Government Publications; 2000.

Department of Health and Children. Health Behaviour in School Aged Children, Galway: Health Promotion Research Centre, 2007.

Department of Health and Children. Statement of Strategy 2008-2010. Dublin: The Stationery Office; 2008.

Guindon, G.E. et al. The cost attributable to tobacco use: a critical review of the literature. Geneva, World Health Organization, 2006. February, 86(2): 214–220.

Health (Miscellaneous Provisions) Act, 2001. Dublin. The Stationery Office; Government Publications; 2001.

Jefferis, BJMH, Power, C, Graham, H, Manor, O. Changing social gradients in cigarette smoking and cessation over two decades of adult follow-up in a British birth cohort. Journal of Public Health. 2004 26 (1): 13-18.

Joint Oireachtas Health and Children Committee. A National Anti-Smoking Strategy – A Report on Health and Smoking'. The Stationery Office; 1999.

Morgan, K., McGee, H., Watson, D., Perry, I., Barry, M., Shelley, E., Harrington, J., Molcho, M., Layte, R., Tully, N., van Lente E, Ward, M, Lutomski, J,, Conroy, R., Brugha, R.. SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland. Main Report. Dublin: Department of Health and Children, 2008.

Ogilvie, D & Petticrew, M. Reducing social inequalities in smoking: can evidence inform policy? A pilot study. Tobacco Control. 2004 13: 129-131.

Peto, R. Lopez, A. D., Boreham, J., Thun, M. Mortality from smoking in developed countries 1950-2000, 2nd edition revised June 2006. Available at: www.deathsfromsmoking.net. Accessed 27th May 2008.

Public Health (Tobacco) Bill, 2001. Dublin. The Stationery Office; Government Publications; 2001.

Public Health (Tobacco) Bill, 2002. Dublin. The Stationery Office; Government Publications; 2002.

Public Health (Tobacco) Bill, 2004. Dublin. The Stationery Office; Government Publications; 2004.

Public Health (Tobacco) (Amendment) Act 2002 (Commencement) Order 2007. Dublin. The Stationery Office; Government Publications; 2007.

Public Health (Tobacco) (Amendment) Act 2004 (Commencement) Order 2004. Dublin. The Stationery Office; Government Publications; 2004.

The Public Health (Tobacco) Act 2002 (Commencement) Order 2003. Dublin. The Stationery Office; Government Publications; 2003.

The World Bank/The International Bank for Reconstruction and Development Curbing the Epidemic: Governments and the Economics of Tobacco Control. Development in Practice. Washington D.C., 1999.

Tobacco (Health Promotion & Protection) Act, 1998. Dublin. The Stationery Office; Government Publications; 1998.

U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

World Health Organisation. WHO Framework Convention on Tobacco Control. Geneva, Switzerland: WHO Press; 2003. Available at: http://www.who.int/tobacco/framework. Accessed 15th July 2008.

World Health Organisation. WHO Report on the Global Tobacco Epidemic, 2008: The MPOWER package. Geneva, World Health Organisation, 2008.