



Unit 2: Can we think of health as capital ?



2. The efficacy of tobacco prevention policies

- ➔ My name is Anne-Laurence Le Faou and I am a doctor. I am the director of the addiction outpatient center at the Georges-Pompidou European Hospital. I have a PhD in economics and for my thesis I worked on aligning macro- and micro-economic interests in health care system reform. As a teacher of public health what interests me particularly is prevention because I work in France a country in which little money is allocated to prevention and in which little research is being done despite the fact that France has a considerable need for prevention. My research concerns tobacco smoking. France is particularly affected by the tobacco epidemic: 34% of French people smoke and 29% smoke daily. That is a significant proportion especially compared to our neighbors such as Belgium, Germany Spain, Italy and of course the United Kingdom where the prevalence of smoking is very low. In France, smoking rates are higher among those in difficult social conditions. Therefore, consumption rates rose between 2000 and 2016. So, against this particular backdrop my research questions revolve around the effects of tobacco control policies on the behavior of smokers. In order to carry out my research I work with a database the CDTnet database of tobacco treatment consultations. I have been its scientific director since 2001 when it was started and it gathers data from all across France about patients who seek tobacco treatment as well as those who quit smoking. What has CDTnet shown us over the years with regard to public policy measures? When tobacco prices were increased in 2003-2004 we were able to compare the tobacco consumption of people who sought treatment during the periods 2001-2003 and 2004-2006. We found that the number of cigarettes smoked per day was significantly lower over the second period but that the biochemical indicator of smoking meaning the amount of carbon monoxide exhaled per cigarette was significantly higher. So, rather than celebrate the fact that the number of cigarettes smoked went down we were disappointed to find that people were inhaling more deeply. This is what always happens if we raise the price of manufactured cigarettes without raising the price of other tobacco products. All prices must therefore be raised together so that the behavior of smokers is not directed toward cheaper products as we are currently observing in 2017. Over time, we also found through CDTnet that the number of people who smoked ten cigarettes or fewer per day went up among smokers who sought treatment. Furthermore, we found that people who said they were light smokers had difficulty with smoking cessation and in the end expressed very particular worries about their fear of addiction. There again, we found that people for whom quitting would seem easy for whom it should be very simple are in fact people who are addicted and who will need very effective treatment. Lastly, tobacco denormalization strategies allowed us to demonstrate that smokers eventually felt they had become social pariahs as they wrote in the file but these denormalization strategies showed in the end that having non-smokers in the social circle that the smoker spends time with raises the rate of quitting. That's why it is extremely interesting when as part of public health we offer, as we did in 2016 and 2017 a campaign like My Month Without Tobacco because it seems that collective effort or team encouragement push you to want to quit which perhaps you didn't plan on initially. How effective are such measures? Funnily enough, the efficacy that we were able to measure was extremely high in the range of 44% after one month. The UK smoking cessation services use this criteria as a predictive factor to judge the likelihood to quit after one year.





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- ➔ This is why the campaign slogan for My Month Without Tobacco was: a smoker who stops for one month is five times more likely to remain abstinent at the end of a year. Aside from these positive results we highlighted groups of people for whom smoking cessation is much more difficult. These are young people less-educated people, people in difficult social situations and pregnant women. For these groups we must be able to offer specific care which we must therefore study. Similarly, specific public policy measures must be put in place. I will finish with the example of a study, using CDTnet, on the effects of smoke-free laws in the workplace. This was established by the Bertrand Decree in 2007. France had already adopted smoke-free laws in public spaces in 1991 but a study published in 2007 had shown that its application was not sufficiently effective. In 2007, it became illegal to smoke in the workplace which includes in communal buildings. Smoking areas could be designated so long as there were automatically closing doors so as not to expose people to second-hand smoke. During the implementation of the new decree we studied smokers who sought tobacco treatment. When this happens behavioral economists consider smoking to no longer be a choice and to no longer reflect the desires of the smoker and thus smokers make an informed decision to quit smoking. In the database, two groups were created: those in employment and those not in employment who can be retired, withdrawn from the labor force on minimum welfare or in training. From 2004 to 2008 we analyzed a number of centers that were active throughout the whole of this period. We observed 45 consultations in total and we then studied the number of tobacco treatment consultations during the period of publication of the Bertrand Decree. It turns out that there was a 24% increase in the number of tobacco treatment consultations just before the introduction of the decree which shows that smokers were anticipating it. The results showed that the number of new patients in treatment centers was indeed about equal between the employed and the unemployed from 2004 to 2007. Nonetheless we then observed a peak that you can see on the graph. The peak showed a rise of 37.5% in the number of tobacco treatment consultations by people in employment compared to those not in employment. This large separation showed the efficacy of this tobacco control policy in the workplace. Furthermore, the rise in consultations was significantly greater in cold and rainy regions which shows that the cost of wasting time at work to go down several floors to smoke turned out to be discouraging for smokers who then preferred to quit smoking rather than go out in bad weather. Finally, we were interested in the efficacy of smoking cessation in people in employment compared to those not in employment. There, it was found that the efficacy of cessation was greater around 7.5% greater with a cessation rate of around 40% at three months in people in employment. We can therefore see rather easily the efficacy of public policy measures and this measure was effective for one year. We found that nearly one year later the two data sets, employed and unemployed were perfectly superimposable. This is an extremely important field of research for the efficacy of public policy and above all to show the help that we can provide to groups of smokers who have specific characteristics and are resistant to cessation but who absolutely need to quit smoking considering that now the only way to reduce the consequences of smoking is to get current smokers to quit. Thank you for watching – I am available if you have any questions.

