

TOBACCO IN LONDON

Facts and issues

SmokeFree London

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Introduction

*Sublime tobacco! Which from east to west
Cheers the tar's labour or the Turkman's rest;*

. . .

*Magnificent in Stamboul, but less grand,
Though not less loved, in Wapping or the Strand...*

LORD BYRON, *The Island*

When Byron wrote those lines at the beginning of the 19th century, London was indeed involved in a love affair with tobacco that had begun in the 16th century. By the 20th century, it had developed into an epidemic causing more than 18,000 Londoners to die prematurely every year. Now smoking is the greatest single preventable cause of illness and premature death in London. It is also the principle cause of inequalities in health between rich and poor.

This report is one of a series commissioned by SmokeFree London, entitled *Tobacco in London*, which takes a close look at tobacco use in the capital as its inhabitants move into a new century.

SmokeFree London is an alliance of agencies operating under the auspices of the London Health Commission. It aims to stimulate the drive, by a range of agencies, to reduce tobacco use at a London-wide level and to improve the health of all Londoners by reducing exposure to tobacco in all its forms.

The *Tobacco in London* reports offer a picture of Londoners' smoking habits, how they feel about others smoking around them, how they protect their children's health, how much the smokers want to give up, what might help them to do so. Effective action to help smokers break their addiction to tobacco and to prevent children from falling into the same trap must be built on reliable research knowledge and evidence. These reports give those concerned with the health of Londoners a much firmer foundation on which to base programmes and initiatives to address these problems.

This report brings together summaries of the data in two other volumes in the *Tobacco in London* series: *Charting smoking in the capital* and *Attitudes to smoking in the capital*, jointly published with the Health of Londoners Programme. In addition it contains information from a range of projects that SmokeFree London has completed in the past two years. These include:

- A survey of London tourists' attitudes to smoking
- A quantitative survey of exposure to other people's smoke in London bar staff
- A submission to the Greater London Assembly's Smoking in Public Places Investigative Committee
- The Case for Commissioning Smoking Cessation Services
- Smoking and Mental Health: a review of the literature
- A submission to the Department of Health's *Tackling Health Inequalities* consultation.

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1 Tobacco use in London

Since the 16th century, London has played a leading role in promoting tobacco in England, through the Crown, clubs and coffeehouses of the capital. In the past century, the city also became the focus of the first serious public opposition to the widespread, addictive and socially accepted practice of smoking through the Royal College of Physicians of London. This chapter traces 400 years of tobacco use in London and includes current rates of smoking in the city.

1.1 16th-17th century: London adopts tobacco

Tobacco had been in use for at least a millennium when Christopher Columbus and the other European explorers of the Americas first observed the native inhabitants smoking at the end of the 15th century. By the mid-16th century, seeds and plants had found their way to Portugal and Spain.

Jean Nicot, a French diplomat attached to Portuguese Court, was keen to explore all the new discoveries pouring into Lisbon from the Americas and to pass intelligence on to France. In 1560 Nicot seized on this new herb, promoting it to the French Court as a cure for a number of complaints from headache to cancerous tumours. In continental Europe, tobacco came to be prized for its supposed curative properties, but in England it was perceived from the first as a habit to be enjoyed¹.

Tobacco smoking was introduced to Britain about the same time by sailors in the crews of Sir John Hawkins and Sir Francis Drake. However, it was not until some of Sir Walter Raleigh's Virginia colonists returned to England in 1586 with their pipes that smoking entered into fashion in London. Raleigh, an enthusiastic and dedicated smoker, introduced the habit to the Elizabethan court, even persuading the Queen to try it once, although history does not relate if she inhaled. By the end of Elizabeth I's reign, smoking was observed in all classes of society, although the high cost (tobacco was literally worth its weight in silver) meant that pipes were often shared communally in London's taverns and inns¹.

Elizabeth's successor, James I, is renowned for his hatred of smoking. James felt England had fallen into a moral decline that was typified by tobacco:

*"there cannot be a more base, and yet hurtfull, corruption in a Countrey, then is the vile use ... of taking Tobacco in this Kingdome..."*¹.

However, the commercial value of tobacco ultimately overcame all objections.

The sale of tobacco grown in the Jamestown colony by John Rolfe and his wife, Pocahontas, became the saviour of Jamestown, and ultimately the whole English colonial enterprise in America. Virginia tobacco was first sold in London in 1614 and by the late 1620s about 500,000 lbs were being brought into London every year². James had decreed a Royal Monopoly requiring that all trade of Virginia tobacco to be made through London and by the second half of the century the tobacco trade had become a major business.

1.2 18th-19th century: Snuff, pipes and cigars

Snuff became the fashion for London's aristocrats after Charles II and his courtiers returned to London in 1660 at the restoration of the monarchy, bringing with them the French habit of taking snuff. Unlike pipe smoking, taking snuff was acceptable for women; so much so that George III's wife was known as 'snuffy Charlotte'¹.

While the demand for tobacco continued to rise, some physicians began to warn of the dangers of tobacco use. A London physician, Dr John Hill, carried out what was probably the first clinical study of the effects of tobacco use. His 1761 *Cautions against Immoderate Use of Snuff* noted that snuff takers were vulnerable to nasal cancer. He followed this in 1791 with further case reports².

Pipe smoking was practiced in the coffeehouses of London, which were the hotbeds of much of political life. Caricaturists like William Hogarth and James Gillray satirised political opponents, portraying them in the use and abuse of tobacco³. London's coffeehouses and 'smoking clubs' were to give rise to the gentlemen's Pall Mall clubs that were home to the various political factions.

The 19th century saw the decline of snuff and the rise of the cigar. A popular culture of smoking emerged accompanied by the publication of pamphlets, books and periodical articles preaching the 'art of smoking' to the expanding middle class. No young gentleman's education would be considered complete without knowledge of the paraphernalia of smoking. Protagonists in fiction were noted for their tobacco consumption, none more so than Conan Doyle's Sherlock Holmes, London's most enduring detective.

The cigarette, initially seen as rather effeminate, had been brought to England by soldiers returning from the Crimean War (1853-56). In 1854, Philip Morris, a Bond Street tobacconist, began to manufacture his own brand of handmade cigarettes. In 1880, Richard Benson and William Hedges opened a shop nearby. It was the invention of the manufactured cigarette that made smoking a mass habit⁴.

1.3 20th century: Age of the cigarette

Tobacco consumption changed dramatically in Great Britain during the 20th century, doubling in the first half of the century from 4.1g per adult per day in 1905 to 8.8g in 1945/46². By mid-century, about four in five men and nearly half of women smoked. As deaths from lung cancer, a previously rare disease, began to rise sharply, investigations were launched in the UK and the USA. However, the groundbreaking reports by Richard Doll and Sir Austin Bradford Hill in 1950 proving the link between smoking and lung cancer went largely unreported in the press. The government of the day not only failed to act to reduce smoking, but even went out of its way to downplay the weight of evidence. Finally, frustrated by its failure to address the problem through traditional channels, the Royal College of Physicians of London made its first intervention in a public health debate since 1725 when it had opposed cheap gin⁵.

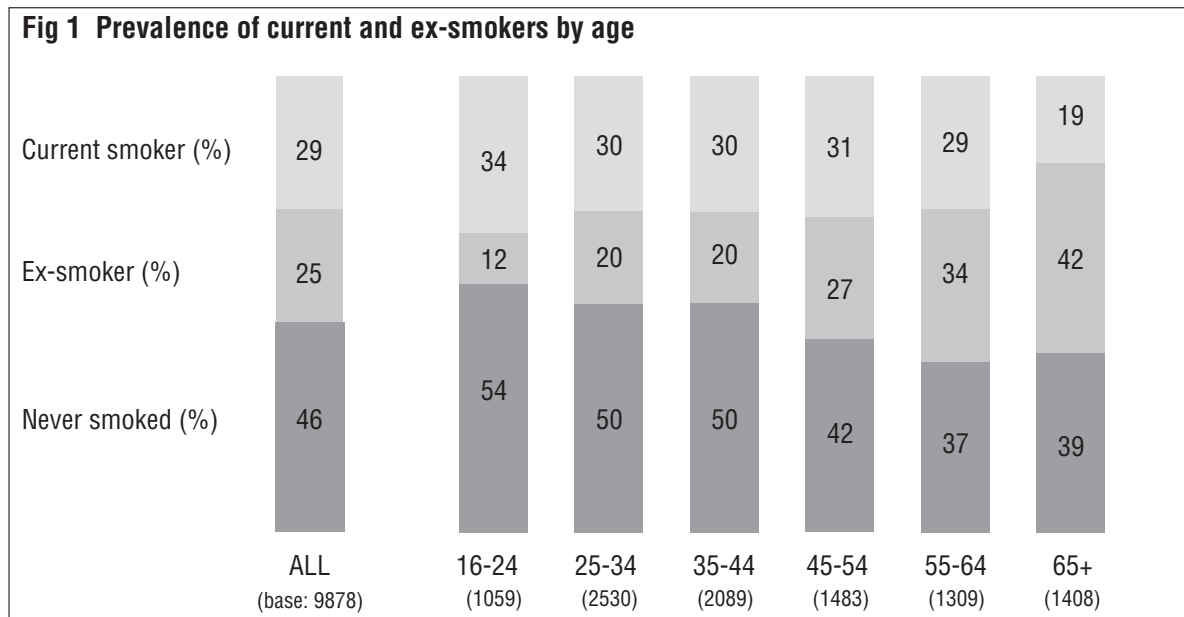
The *Report of the Royal College of Physicians on Smoking and Health*, published on 7 March 1962, was written for the educated public rather than a strictly scientific audience. It attracted enormous press coverage, causing cigarette sales to fall. The Health Minister, Enoch Powell, said in Parliament that the report “demonstrates authoritatively and crushingly the causal connection” between smoking and cancer.

The report was not a scientific paper so much as a call to arms. The vision of the authors was remarkable; the policy programme they recommended stands up today, albeit with the modification of 40 years of research, analysis and programme experience. What is shocking is that its proposals are largely unimplemented even now. In the 40 years since publication, despite an impressive reduction in prevalence, an estimated trillion cigarettes have been smoked and five million people have died due their addiction to tobacco⁵.

1.4 21st century: Adult smoking in London

About two million of London’s men and women smoke tobacco. The ill health cause by smoking affects Londoners regardless of sex, age, social group and ethnic origin. The data below are taken from a survey, the largest of its kind ever carried out in London, commissioned by SmokeFree London in 2001⁶. They provide a picture of Londoners’ smoking rates and cigarette consumption at the turn of the century.

- Just under a third of Londoners (29%) regularly smoked at the time of interview. This was higher than the proportion of adults (27%) who smoked regularly in 2000 in Great Britain as a whole.
- While there is no gender difference in smoking rates of Londoners, age is important. The youngest group (aged 16-24) is most likely to smoke but prevalence declines with age. One in three (34%) 16-24 year olds is a current smoker compared with one in five (19%) of those over 65 years of age.
- There are nearly as many ex-smokers in London as there are current smokers. A quarter of all London adults who used to smoke regularly have now given up.

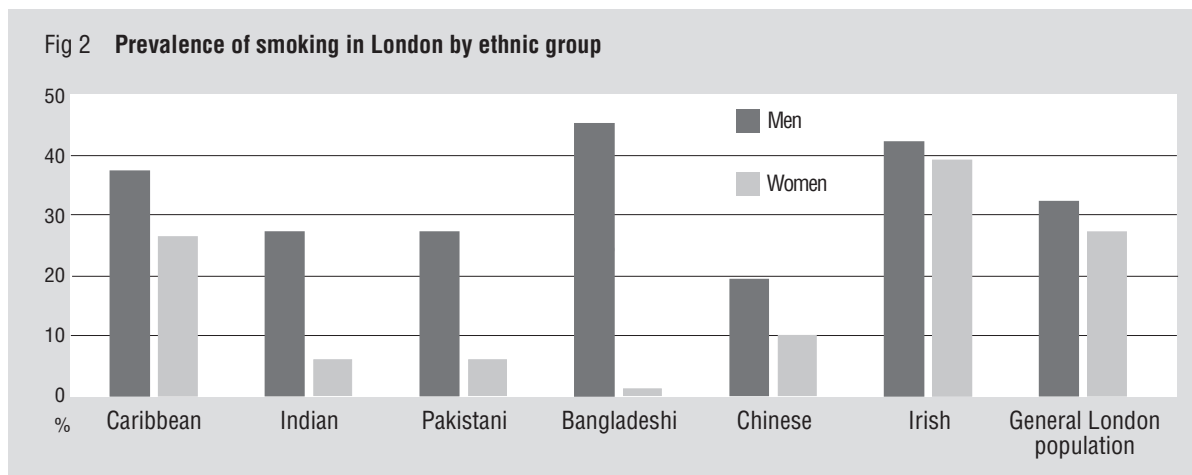


Low income smokers

- As in the rest of the country, Londoners on lower incomes and with fewer educational qualifications are more likely to smoke. A significant difference in smoking prevalence between social groups in London can be seen as about one in five (21%) of social group AB is a current smoker compared with nearly two in five (38%) of group DE. Social groups ABC1 include professional, managerial, clerical and administrative grades; C2DE groups include skilled manual, unskilled manual and those on state benefits.
- But these headline figures disguise an even greater difference when age is taken into consideration. People over the age of 65 are less likely to be smokers not only because some have given up but also because the smokers are beginning to die off in larger numbers by that age. Over-65s are over-represented in social group E because that is the group into which people living on state pension fall. Thus, when only the under-65s are considered, the proportion of DE smokers in London goes up to 43%. Likewise, non-white Londoners are much less likely to smoke than white Londoners. Nearly half (49%) of white Londoners in social group DE under the age of 65 is a current smoker⁶.

Minority ethnic groups

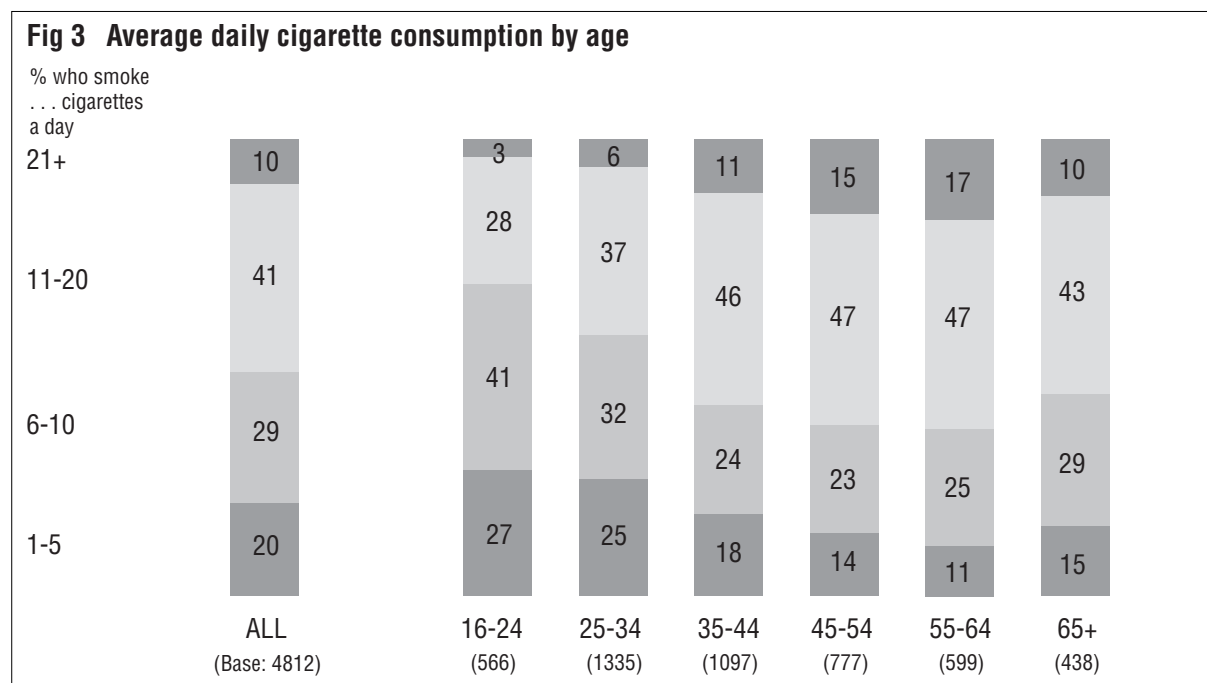
- Non-white Londoners are on average younger (13% are aged 55+ compared with 30% of whites) and more likely to be social grade DE (34% compared with 29% of whites). These factors should point to higher smoking rates, but this is not the case.
- Only 24% of non-white Londoners smokes compared with 31% of whites, with lowest rates among Asians at 18% prevalence.
- However, there are large differences between minority communities and between genders. For example, while smoking among Bangladeshi men, at 45%, is considerably higher than that in the general male population, a very small proportion of Bangladeshi women smoke (about 1%), although 25% chew tobacco. Likewise, in the Indian and Pakistani populations, just over a quarter of men smoke, compared with about 6% of women⁹.



1.5 Cigarette consumption in London

There is a great variation in the number of cigarettes Londoners smoke. Asked to assess the daily average number of cigarettes smoked respondents in the SmokeFree London survey⁶ replied:

- 20% smoked 1 to 5 cigarettes a day
- 29% smoked 6 to 10
- 41% smoked 11 to 20
- 10% smoked more than 20
- Younger people may be more likely to smoke, but they consume fewer cigarettes a day. Over two thirds (69%) of 16-24 year olds smoke 10 or fewer cigarettes a day, compared with just two fifths (40%) of smokers aged 35 and over.



- Not only are poorer Londoners more likely to smoke, they also tend to be heavier smokers, despite having less disposable income. Just under half (47%) of ABC1 smokers consumed more than 10 cigarettes a day compared with 55% of C2DEs.
- In contrast, not only are non-white Londoners less likely to smoke than whites, they also consume fewer cigarettes. More than two-thirds (71%) of non-white smokers smoke 10 or fewer cigarettes a day compared with just 43% of white smokers.

1.6 Londoners' choice of tobacco

Three quarters of London smokers (77%) use only manufactured cigarettes, but a significant proportion of Londoners use different types of cigarette and tobacco.

Hand-rolling tobacco

- Smoking hand-rolled cigarettes is mostly a habit of older men. Only 14% of women ever smoke hand-rolled cigarettes compared with 36% of male smokers over the age of 35 and 26% of those under 35.
- Heavy smokers and those in social group DE are more likely to smoke hand-rolled. The relative cheapness of hand-rolled cigarettes may explain this, although most heavy smokers only smoke manufactured cigarettes and only 16% of heavy smokers smoke hand-rolled cigarettes alone.

Low tar cigarettes

In recent years there has been much concern about low tar or so-called 'light' and 'mild' brands of cigarettes. Some smokers, concerned about the health risks of smoking, may be switching to low tar brands rather than quitting smoking. However, there is evidence that not only are these brands not safer than those of regular strength, they may actually be more harmful as smokers change the way they smoke low tar cigarettes, by inhaling more or taking more frequent puffs, to get a bigger dose of nicotine. Among Londoners who smoke manufactured cigarettes, just over half (54%) smoke low tar brands.

In England as a whole, as in other parts of Europe, low tar smokers tend to be female, older, and better educated^{7,8}.

- In London, men were more likely to smoke regular cigarettes than women (47% compared with 41%).
- Only 30% of AB smokers and 39% of C1 smokers chose regular strength brands compared with 51% of C2DE smokers.
- Younger smokers, who are least likely to be heavy smokers, and least likely to smoke hand-rolled cigarettes, are much more likely to smoke regular strength brands. More than half of 16-24 year old smokers choose regular strength cigarettes compared with 33% of the oldest age group.

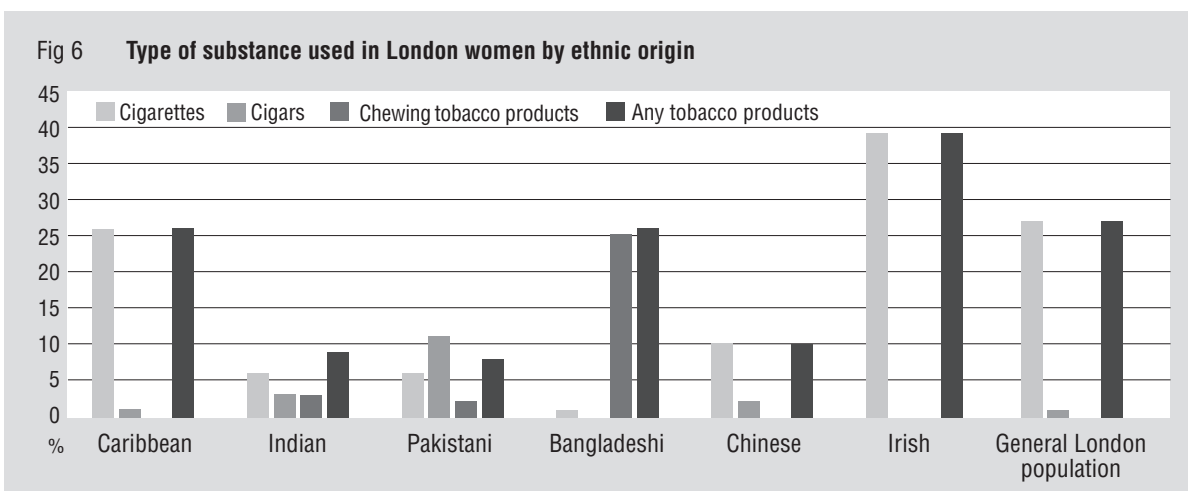
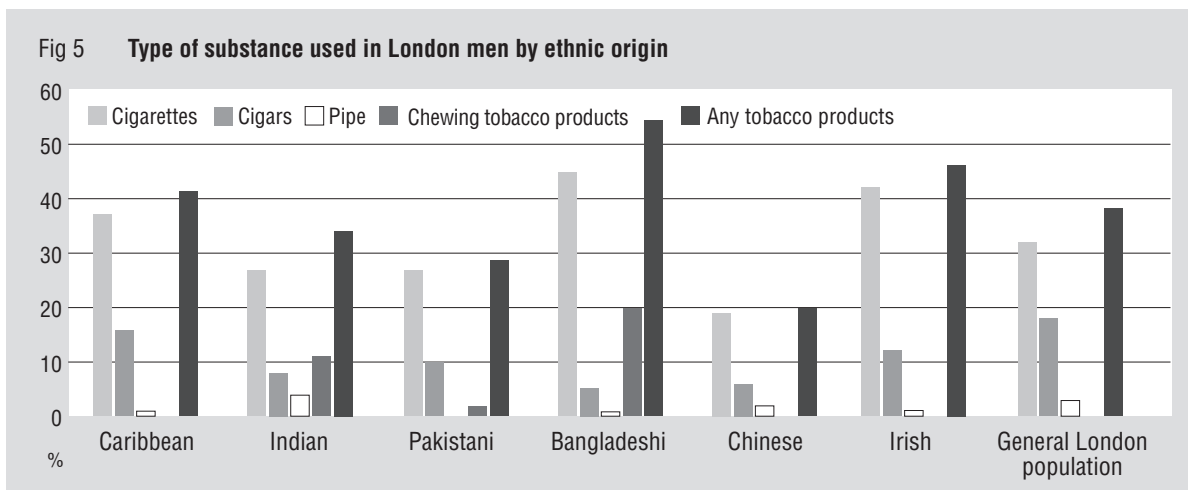
Fig 4 Smokers' use of low tar, mild, lights or regular strength cigarettes

%	ALL smokers of ready-made cigarettes	Sex/Age					
		Male			Female		
		16-34	35-54	55+	16-34	35-54	55+
Low tar or mild or lights	54	51	49	48	56	55	64
Regular strength	44	48	47	46	43	43	33
<i>Base</i>	<i>4214</i>	<i>775</i>	<i>645</i>	<i>287</i>	<i>990</i>	<i>929</i>	<i>588</i>

Oral tobacco

Use of chewing tobacco is prevalent in London's South Asian communities. Chewing tobacco comes in three forms: plain chewing tobacco, tobacco paste (zarda) and paan masala (tobacco mixed with betel nut). Tobacco paste is generally eaten wrapped in betel leaf.

- Use of chewing tobacco is highest among Bangladeshi women and men, at 25% and 20% respectively⁹.
- Other forms of tobacco use, such as hukka (water pipe) and bidi (rolled tobacco leaf) are also used in ethnic communities. Figures 5 and 6 show prevalence of tobacco used in different ethnic groups⁹.

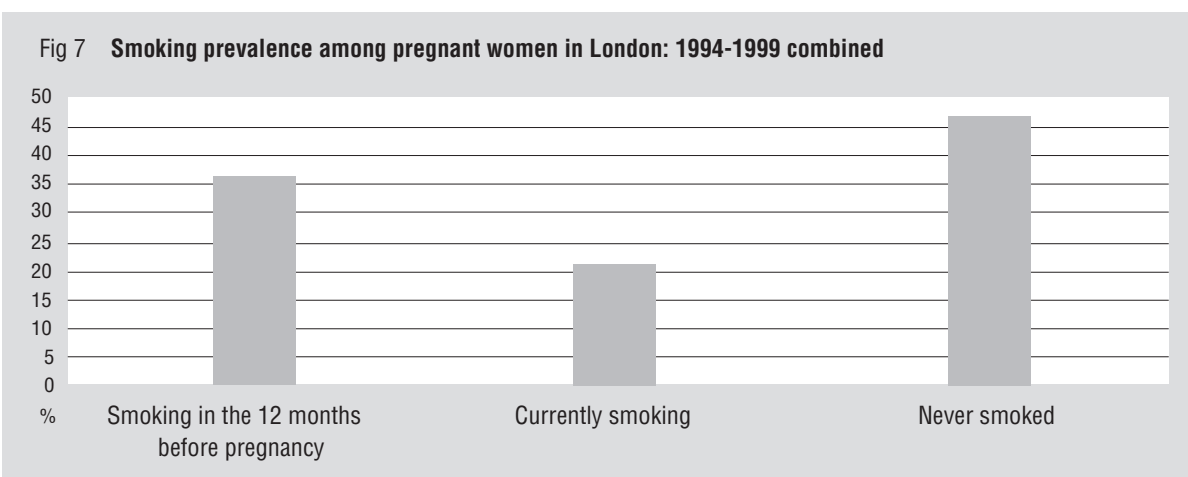


1.7 Smoking in pregnancy

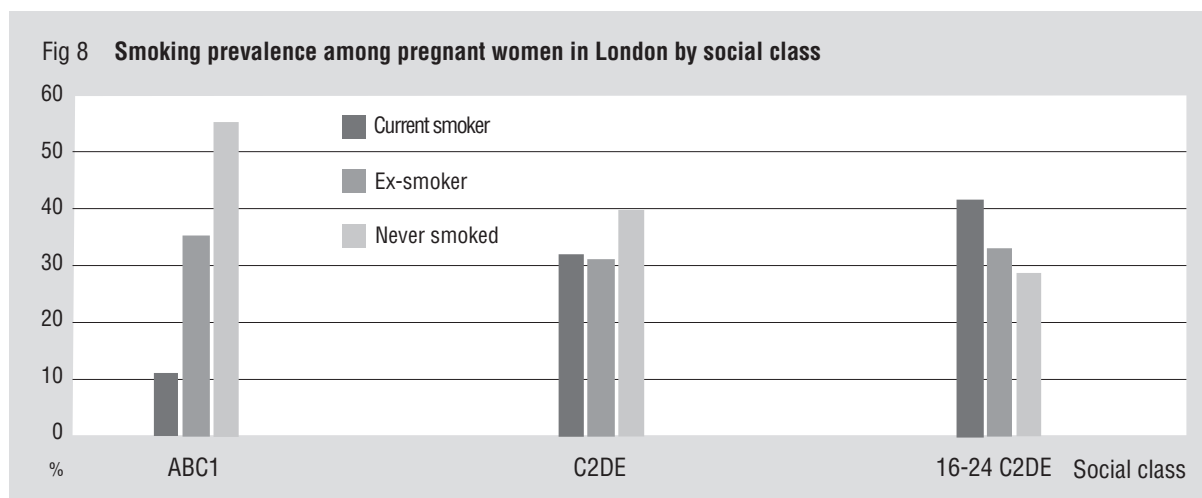
Smoking during pregnancy is a danger to the mother as well as the unborn child. Maternal smoking is associated with many foetal and neo-natal problems such as low birth weight, pre-term delivery, placental damage, and sudden infant death syndrome. It is also associated with ectopic pregnancy and miscarriage¹⁰.

The Health Education Authority’s smoking in pregnancy tracking surveys consistently found that a proportion of women do give up smoking either before or at some stage during pregnancy. The data from these surveys have been re-analysed by SmokeFree London to look specifically at London⁹.

- The proportion of pregnant women in London who had never smoked was 47%, while the proportion of pregnant ex-smokers was 32% with 21% reporting current smoking.



- Smoking prevalence among pregnant women in London was strongly related to social group, rising from 11% of pregnant women in social groups ABC1 to 31% in social groups C2DE.
- Among young London pregnant women (aged 15-24) from social groups C2DE, smoking prevalence was especially high, with 41% reporting that they were smoking currently.



- Looking at current smoking by trimester of pregnancy shows clearly that the proportion of women who stop during pregnancy is small and that those who do manage to quit do so in the first trimester of pregnancy.

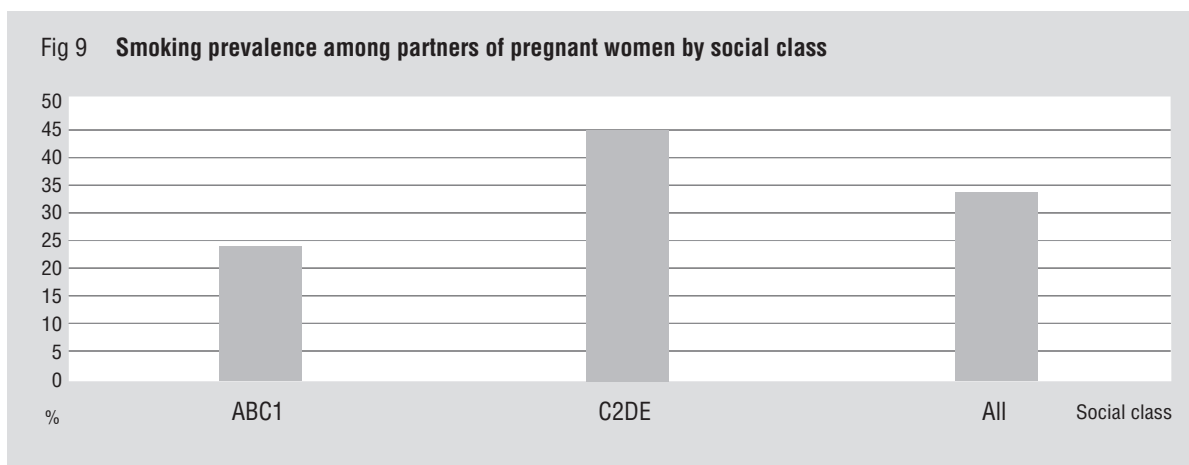
Tobacco consumption by pregnant Londoners

Over the six years of the Health Education Authority surveys, the proportion of pregnant Londoners smoking fewer than ten cigarettes a day averaged 37%; those smoking between ten and nineteen cigarettes a day averaged 38%; and the proportion smoking twenty or more cigarettes a day averaged 22%. This last figure is very much higher than seen in other surveys. For example, the proportion of female heavy smokers (defined as smoking 20 or more cigarettes a day) in Great Britain as a whole was 6% in 2000¹¹.

Smoking by pregnant women's partners

Attempts to reduce smoking during pregnancy must do more than narrowly target the women themselves. Women who smoke throughout pregnancy are more likely to have smoking partners than those who manage to give up or who have never smoked.

- Among London respondents, 87% reported being married or living with a partner and around one third (34%) of pregnant women with a husband or partner reported that their partner smoked. Women in social groups C2DE were more likely to have a partner who smoked (45%) compared with those from social groups ABC1 (24%).
- Two out of three pregnant smokers reported that their partners smoked. Among non-smoking women, those who had given up recently were nearly twice as likely to have a partner who smoked (37%) compared with women who had never smoked (19%).



1.8 Smoking and mental health

Smoking by people with mental health problems has been largely ignored by health professionals or deemed to be too difficult a problem to address. Smoking prevalence is significantly higher among people with mental health problems than among the general population. SmokeFree London commissioned a review of the literature review in order to examine the relationship between mental health and smoking and organised a national symposium to examine why this important public health issue has remained largely unaddressed¹². Among the key issues identified were:

- Nicotine dependence is the most prevalent, deadly and yet most treatable of all psychiatric disorders but is often overlooked by the psychiatric professions.
- Studies have shown smoking rates to be as high as 80% among schizophrenics.
- People with psychotic disorders who live in institutions are particularly vulnerable: over 70 % of this group smoke including 52% who are heavy smokers.
- Daily cigarette consumption is considerably higher among smokers with mental health problems who may also inhale more deeply from their cigarettes.
- Nicotine may help alleviate some of the positive and negative symptoms associated with psychiatric illnesses and may also help to alleviate the side effects associated with their medications.
- A significant proportion of people with schizophrenia recognises that smoking is a problem, want to quit and will attend smoking cessation therapy.
- Effective treatments exist to help people stop smoking and are not yet being routinely offered to people with mental health problems.
- Attempts to stop smoking do not appear to exacerbate psychotic symptoms.

2 Quitting smoking

2.1 Government initiatives for reducing smoking

Nationally, greater emphasis than ever has been placed on public policies and services to help people give up smoking. These 'smoking cessation services' form a key part of the NHS modernisation agenda and the cross-governmental programme of addressing inequalities.

A number of key policy papers have been published in recent years setting out national targets and initiatives to achieve those targets. These are summarised below.

Targets

In the 1998 White Paper, *Smoking Kills*, the Government set three targets to lower smoking among adults, pregnant women and children by the year 2010:

- To reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by 2010; with a fall to 26% by the year 2005.
- To reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010; with a fall to 18% by the year 2005.
- To reduce smoking among children from 13% to 9% or less by the year 2010; with a fall to 11% by the year 2005¹³.

In 2000, the NHS Cancer Plan introduced a new target to address inequalities in smoking:

- reduce smoking rates among manual groups from 32% in 1998 to 26% by 2010¹⁴.

Services

Key government documents give a central place to smoking cessation services and promote the leading role of primary care.

- The White Paper *Smoking Kills* outlined the need for smoking cessation services and said that up to £60 million would be allocated for services over three years¹³.
- The Health Service Circular (HSC) 1999/087 prioritised the development of smoking cessation services for each health authority and PCG. These services are now established and substantial numbers of smokers are stopping by using them¹⁵.
- The NHS Plan set out the government's commitment to establish 'world-leading smoking cessation services'. It also announced the availability of NRT on prescription from GPs¹⁶.
- National Priorities Guidance (NPG) 1999/00 to 2001/02 highlighted the role of smoking cessation in achieving targets to reduce cancer and coronary heart disease¹⁷.
- NHS Smoking Cessation Services Service and Monitoring Guidance 2001/02 makes clear that smoking cessation services will be part of core NHS provision for the foreseeable future and that evidence based guidelines must inform service provision¹⁸.

Pharmaceutical treatment

Nicotine replacement therapies (NRT) and bupropion (Zyban) are now available on prescription. Following a 'technological appraisal', the National Institute for Clinical Excellence (NICE) has recommended the use of bupropion and NRT for smokers who wish to quit.

Guidance from NICE says that these therapies should normally be prescribed as part of an 'abstinent-contingent treatment', that is, to smokers who have made a commitment to stop smoking by a certain date and who continue to abstain. NICE recommends that smokers should also receive advice and encouragement to aid their quit attempt¹⁹.

2.2 Effectiveness and cost-effectiveness of smoking cessation services

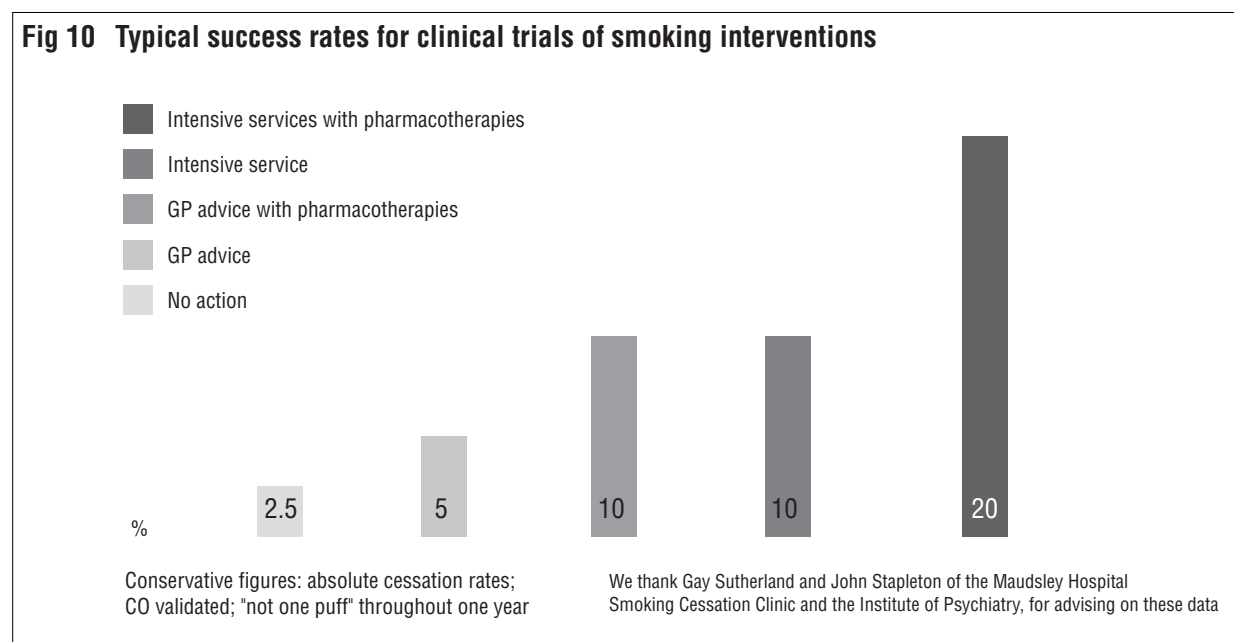
Information in this section is detailed more fully in *The Case for Commissioning Smoking Cessation Services*²⁰, which SmokeFree London produced in collaboration with the WHO Europe Partnership Project.

Treatment is effective

Clinical guidelines for smoking cessation published in the journal *Thorax* in December 1998 and updated in December 2000²¹ reviewed the evidence base and set out recommended treatments.

The guidelines were based on the evidence provided by the Cochrane Collaboration's Tobacco Addiction Review Group²² and other authoritative reviews. They were extensively peer reviewed, and are endorsed by a wide range of professional bodies including many Royal Colleges.

- NRT and bupropion roughly double the chances of success in stopping smoking. Additional 'behavioural support' (counselling and advice) significantly increases the chances of success; broadly speaking, more support leads to higher smoking cessation rates.



- Brief advice from a GP routinely given to all patients who smoke leads to about 40% attempting to quit and about 5% stopping for at least six months (a strong predictor of permanent success).
- Face to face behavioural support from a smoking cessation specialist enables about 10% to succeed long term.
- For pregnant smokers, this type of support has a similar level of success – about 10% long term.
- Intensive behavioural support plus NRT or bupropion enables about 20% of those who try to quit to stop long term.

Treatment is cost effective

The cessation rates shown in Figure 10 may seem low, but they are worthwhile because they are so cost effective compared with most other health service interventions and will save time and money treating conditions for which smoking is a significant risk factor²³.

The cost per life year saved of a fully integrated, comprehensive cessation service is less than £1,000, which is much cheaper than other medical interventions. The median cost of a range of 300 medical interventions was estimated at £17,000 per life year gained²³.

The comparison with statins is instructive. Muir and colleagues²⁴ examined the eligibility of patients in general practice for statin therapy using recommended screening guidelines (the Sheffield Tables) in which statins would be prescribed to those with a risk of heart attack in excess of 3% per year. They showed that if smokers who were assigned to statins at screening stopped smoking, over 80% would fall below the threshold needing statin therapy. Yet currently far more is spent on statins than on smoking cessation: £12m per year compared with £3m per year in London alone.

2.3 Londoners' awareness of health risks of tobacco use

It is a commonly held view that 'everybody knows about the dangers of smoking' but, in reality, Londoners show significant confusion about the risks⁶. While most were aware that smoking causes lung cancer, they were much less knowledgeable about other serious conditions, such as heart disease, which

causes more deaths among smokers. Likewise, smokers were also ignorant of the constituents of cigarette smoke, a large proportion believing that nicotine is a carcinogen. Such confusion may be reflected in decisions to continue smoking or reluctance to use NRT because of misplaced fears about the dangers of nicotine.

Knowledge of diseases caused by smoking

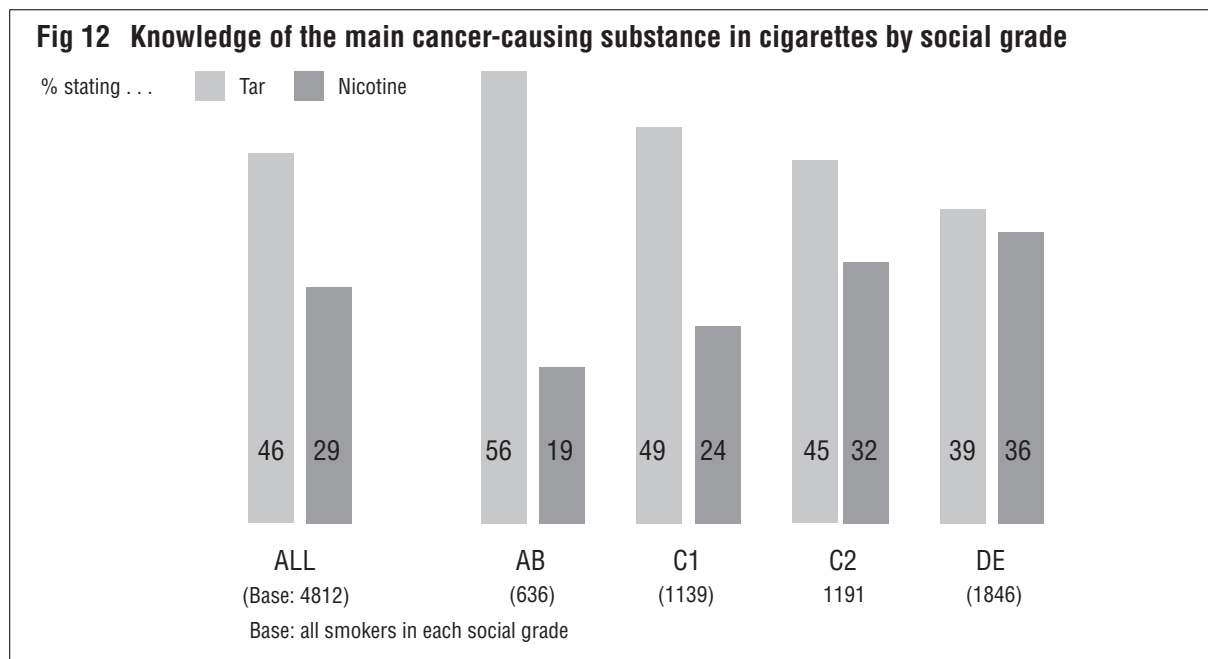
- When asked about the diseases that smoking causes, nearly four out of five (79%) Londoners mention lung cancer readily. Heart disease is the second most commonly mentioned disease at 36%, only half as often as lung cancer.

Illness or disease %	ALL
Cancer of the lung	79
Heart disease (generally)	36
Emphysema/pneumonia/bronchitis/asthma	31
Cancer of the throat	18
Other respiratory problems (problems breathing/cough)	15
Cancer – unspecified	14
Hardening of the arteries/circulatory diseases	9
MI/heart attack	8
Cancer of the mouth	7
Stroke/thrombosis	6
Bad for skin	2
<i>Base</i>	<i>9878</i>

- Smokers from social grade ABC1 seem to be more aware of the diseases caused by smoking with 45% mentioning heart disease compared with 35% of C2DE smokers. The gap between AB and DE groups mentioning heart disease is especially striking – 50% and 34% respectively.
- Among Londoners, age is a strong predictor of knowledge of the diseases caused by tobacco. For example, only 55% of smokers aged 65 and over mention lung cancer as a disease caused by smoking (compared with 78% of those under 65) and only 28% mentioned heart disease (compared with 41% of those under 65).
- According to the survey, non-white smokers are less well informed than are white smokers, even controlling for social grade. Non-white smokers mentioned the main diseases caused by smoking less frequently than did white smokers. Seventy per cent non-white smokers mentioned lung cancer (whites: 77%), 30% heart disease (whites: 42%) and 18% lung diseases (whites: 28%).

Knowledge of cancer-causing substances in tobacco

- Fewer than half of Londoners (42% of both smokers and non-smokers) are aware that tar is the major cancer-causing substance in cigarettes. Nearly a third (29%) of smokers wrongly believe it to be nicotine. Women smokers were more likely to believe this than were men smokers (32% compared with 26%).
- The biggest factor in determining knowledge of the constituents of tobacco is social grade. Among DE smokers, nearly as great a proportion believe nicotine to be the main cause of cancer (36%) as tar (39%). This compares to 56% of smokers in social grades AB citing tar as the main cause of cancer and 19% naming nicotine.



2.4 Beliefs in the advantages and disadvantages of quitting

- Thinking about the benefits of giving up smoking, most smokers (73%) say that giving up would improve their health 'in general' rather than lessen the chances of getting cancer or heart disease. Only 10% mention that they will have less chance of getting cancer and 7% mention that it would be better for their heart. Slightly more (18%) say it would help improve their breathing.
- In contrast, nearly two thirds (60%) of smokers think they will save money by giving up.
- While smokers can think of a wide variety of disadvantages to giving up, more than a quarter (27%) cannot think of any at all. A very small minority (3%) thought it would be bad for their health if they gave up.
- Some 30% think they would feel depressed or restless and have trouble concentrating if they gave up. A further 19% mentioned cravings from nicotine withdrawal. Young people aged 16-24 were particularly likely to mention this (23% compared with the 19% average).
- Potential weight gain was a concern, but more so among female than male smokers (35% compared with 23%). Even with this gender difference, older men (35+) were just as likely to mention this disadvantage as mention depression and restlessness (26% compared with 28%).

2.5 London smokers want to quit and most try to quit

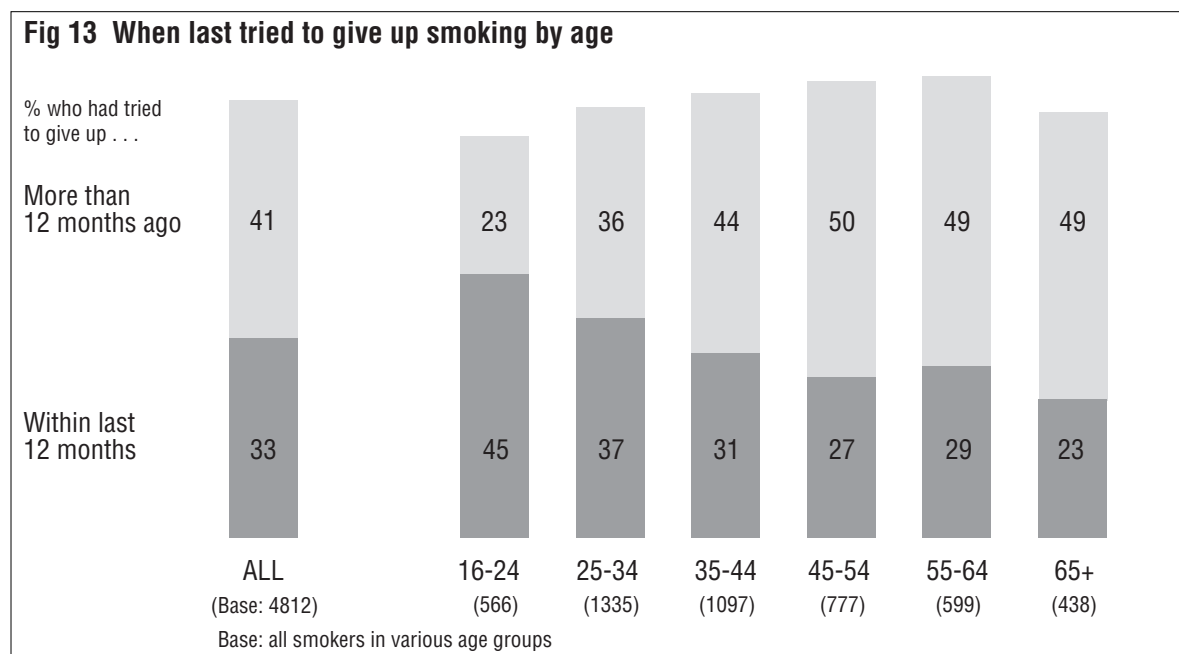
A large majority of London smokers, like those elsewhere in the country, say they want to stop smoking. Seventy-three per cent of smokers in London said they wanted to quit compared with 72% for Great Britain¹¹.

- In London, the proportion of women who said they would like to stop smoking (76%) was greater than that of men (70%).
- Manual workers were just as likely to want to give up as those in non-manual occupations.
- Older smokers were the least likely to want to stop smoking. Just over half (54%) of those aged 65 and over wanted to quit compared with 70% or more of the younger age groups.
- Smokers living with children under the age of 16 were more likely to want to quit than those without children (81% compared with 69%).
- Nearly three in four London smokers who wanted to quit gave health as the reason they wanted to do so. The next most commonly given reason was the cost of smoking, cited by 10% of those who said they wanted to quit⁹.

Most London smokers not only want to quit smoking but have also made an attempt to do so⁶.

- Three quarters of all current London smokers had made an attempt to quit some time in the past and nearly half of these had made at least one attempt in the last 12 months.

- Fewer young smokers had made an attempt to quit, but they were most likely to have tried in the last 12 months.
- Just over two-thirds (68%) of 16-24 year old smokers had ever tried to give up compared with 80% of 55-64 year olds.
- Nearly half (45%) of 16-24 year old smokers had tried to quit in the last year compared with less than a quarter (23%) of those aged 65 and over.
- Neither sex nor social grade had much impact on attempts to quit.

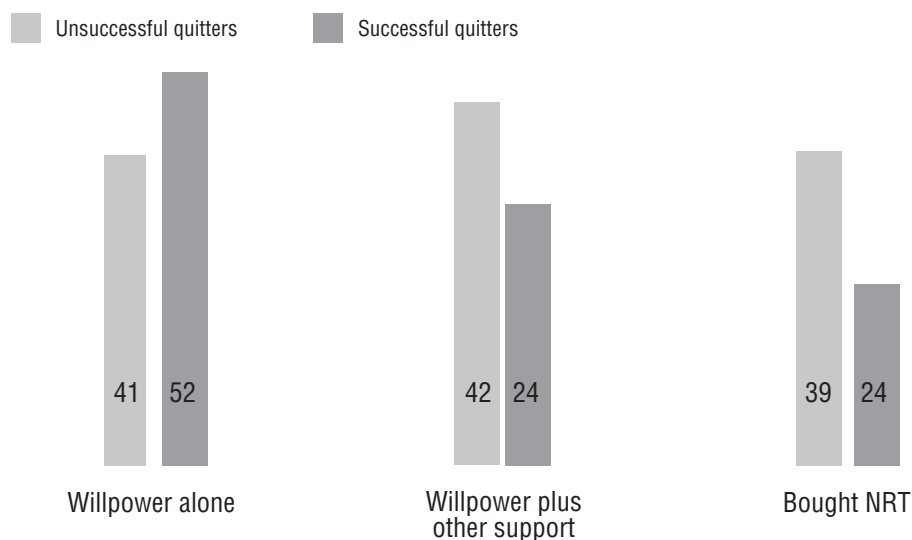


- Heavier smokers were less likely to have tried to quit recently: only 24% had tried to stop smoking in the last 12 months compared with the average of 33%.

2.6 Awareness and use of available help

When Londoners were asked if they knew what sources of help or advice were available in their local area, nearly all (93%) knew that NRT could be purchased and two thirds overall (and 69% of smokers) were aware of leaflets or booklets. Nearly as many smokers knew there is a telephone helpline and about one in three had heard of NHS ‘specialist support’.

- Age was the most prominent factor affecting awareness of sources of help. The youngest age group (16-24) was the most aware that NRT could be purchased and of the availability of leaflets and the helpline. However, young smokers were the least aware of the availability of local cessation services.
- Half of successful quitters said they had used ‘willpower’ alone (not consulting their doctor or pharmacist, using NRT or any other aid).
- Young people (16-24) were most likely to use ‘willpower’ alone and the use of any form of support increases with age. This may be because older smokers are more addicted or have more failed attempts behind them and feel the need for support.
- White respondents were more likely to try NRT than were non-whites (37% compare to 26%).
- Heavy smokers were much more likely to have bought NRT than were medium or light smokers.
- Overall, 68% of London smokers had sought some sort of help or advice. There were no significant differences in the type of help or advice sought between current smokers from manual and non-manual social classes⁹.

Fig 14 Actions taken to try to give up smoking

Figures as percentages. Base: all who tried to give up in the past 12 months but are still smoking (1608) or who gave up in the past 12 months (237)

Usefulness of sources of aid

Respondents in the SmokeFree London survey⁶ were asked to rate sources of help they had used to quit smoking from 'very helpful' to 'not helpful at all'.

- Advice from a pharmacist was valued more highly than talking to a doctor or calling the helpline. Nearly three quarters of those who had spoken to a pharmacist found it helpful.
- Although numbers were small, those who had seen specialist counsellors rated them very highly (90% found them helpful). Clinics and support groups were also found useful (67%).
- In contrast, only 53% found talking to a doctor helpful and 21% said the doctor was 'not helpful at all'.
- Telephone helplines were seen as the least helpful form of support, although 41% of users thought a helpline was helpful, including 12% who found it very helpful. However, more than one in four found helplines 'not at all useful'.

Fig 15 How helpful did you find... in helping you try to give up smoking?

%	Doctor	Pharmacist	Other health professional	Helpline
Very helpful	25	30	30	12
Quite helpful	28	43	37	29
Not very helpful	23	18	18	29
Not helpful at all	21	7	11	26
HELPFUL	53	73	67	41
NOT HELPFUL	44	26	29	55
Don't know	3	2	3	5
Base	450	257	200	109

Usefulness of NRT and bupropion

- Views of the usefulness of NRT as an aid to giving up were varied, although it is more difficult for people to judge the impact of a pharmaceutical on their quit attempt than it is to form a judgement about the usefulness of advice. While just over half (54%) of those who bought NRT found it helpful, 43% did not
- Likewise, with the small number who had used bupropion, 45% found it 'very helpful' and 33% said it was 'not helpful at all'.

2.7 Stopping smoking in pregnancy

For the sake of both the mother and the child, it is both important and possible to quit smoking in pregnancy (see 1.7 above).

Pregnant women's beliefs about smoking during pregnancy

London pregnant women acknowledged the importance of quitting smoking during pregnancy, but there are marked differences between smokers and non-smokers in the perceived seriousness of the risk of smoking⁹.

- Asked to rate the importance of six lifestyle changes, eight in ten (84%) of pregnant women thought stopping or cutting down on smoking was very important. Three quarters thought cutting out or cutting down on alcohol important, 65% thought eating a healthier diet and 63% thought taking folic acid tablets was very important.
- Not surprisingly, current smokers were substantially less likely than both ex-smokers and never smokers to consider stopping or cutting down very important (45% compared with 91% and 95% respectively).
- Three out of four respondents thought that they were more likely to have a small baby if they smoked during pregnancy. Non-smokers were twice as likely as smokers to agree with this (83% and 39% respectively). However, both smokers and non-smokers were less clear about the consequences of having a small baby.

Experience of quitting before or during pregnancy

- Time of having a first cigarette of the day is taken as a marker of strength of addiction. Current pregnant smokers were asked how soon after waking that they normally smoked their first cigarette. Thirteen per cent reported smoking their first cigarette within five minutes of waking with a further 16% having one within fifteen minutes.
- A significant proportion of women who give up in pregnancy start again before their baby is born: 6% reported that they had stopped and started smoking again during their pregnancy.
- Smokers or recent ex-smokers from social groups ABC1 were one and a half times as likely to have given up compared with pregnant women from social groups C2DE (50% and 32% respectively).
- Women were also asked if their partner had quit smoking. Nearly one quarter (24%) were reported to have made a change during the current pregnancy but 38% had made no change and a further 38% were said to have changed their habits before the pregnancy.

Cutting down vs. giving up

Although the majority of pregnant smokers make some change to their smoking habits during pregnancy, they do not all quit completely. Pregnant smokers in London were just as likely to say they had cut down (35%) as had quit (38%). A further 18% said they made no change at all.

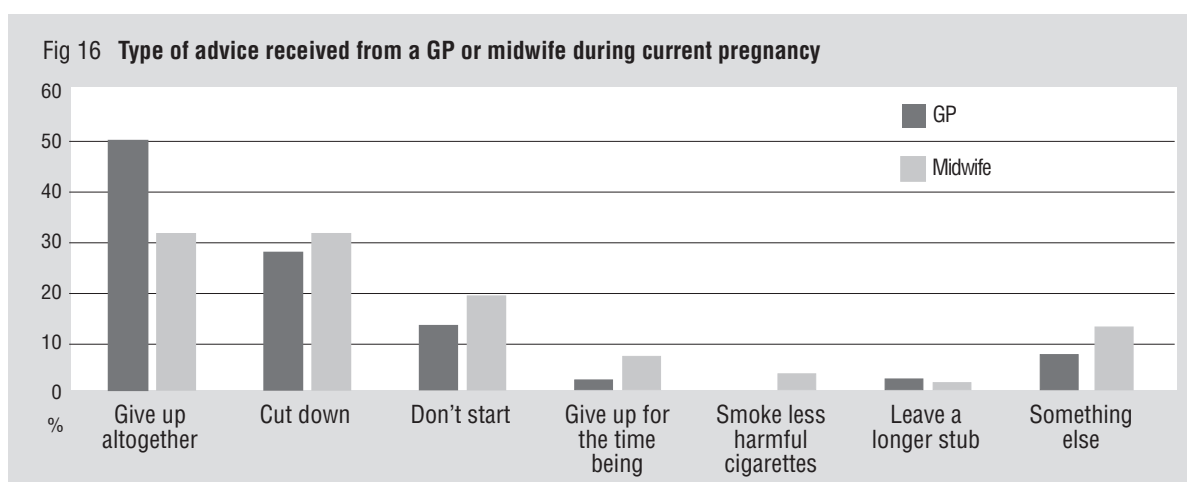
To publicise No Smoking Day 2001, SmokeFree London joined other agencies to examine whether cutting down smoking (both by smokers in general and by pregnant smokers) was a good strategy either in health terms or as a step to giving up smoking²⁵. Among the findings was that:

- There was no evidence to suggest that either reducing the number of cigarettes smoked daily or switching to a lower yield brand ('light' cigarette') resulted in a reduction of risk.
- There was no adequate evidence to suggest that cutting down made a quit attempt any more likely to succeed.
- There was no risk-free number of cigarettes that could be smoked in a day.
- The reduction of risk of tobacco induced disease only starts when a smoker stops completely.

Pregnant women's use of help and advice to quit

A surprisingly small proportion – only 17% - of pregnant women in London said they had received advice on smoking from a health professional during their current pregnancy. It is important to note that these data were taken from surveys that were conducted before the NHS smoking cessation services were established. Nevertheless, the figures both for the proportion of women receiving advice and the appropriateness of the advice leave plenty of scope for improvement.

- The main source of advice was from a GP (53%) or a midwife (46%).
- The most frequently given advice from a GP was to quit smoking (50%) followed by advice to cut down (28%) and advice not to start smoking (13%). Smaller numbers recalled advice to leave a longer stub (2%) or give up for the time being (2%).
- Midwives were just as likely to advise giving up altogether (31%) as to cut down (31%). Smaller numbers recalled midwife advice to switch to less harmful cigarettes (3%), leave a longer stub (1%) or give up for the time being (7%).
- Just over half (52%) of those receiving advice from a GP found it useful, while 38% did not. Similarly, just over half (51%) of those receiving advice from a midwife found it useful, while 36% did not.



3 Reducing exposure to secondhand smoke

Being able to live and work in an atmosphere unpolluted by secondhand smoke (also known as environmental tobacco smoke or ETS) is of growing importance to authorities and private citizens alike. The information in this section is taken primarily from a submission by SmokeFree London²⁶ to the Greater London Assembly's Smoking in Public Places Investigative Committee in 2001. The GLA's inquiry reported in April 2002, making a number of recommendations to protect the health of workers and to increase choice for patrons of bars, restaurants, and other public places²⁷.

The health hazards of exposure to the 4000 chemical compounds²⁸ in tobacco smoke have been known for decades, although the tobacco industry has gone to great lengths to give the impression that scientists are divided on the issue. Only the industry and its apologists dispute the evidence. There is now, moreover, a growing understanding of the importance of smokefree public and private places in preventing the uptake of smoking by young people.

3.1 The health consequences of passive smoking

Clinical evidence of the harm children suffer from passive smoking has been accumulating since the 1970s. In the 1980s the first large-scale studies of harm inflicted on non-smoking adults by long term exposure to ETS began to be published in medical journals. Early reviews of the evidence were undertaken by authorities such as the US National Research Council²⁹, the US Surgeon General²⁸, the National Health and Medical Research Council of Australia³⁰ and the UK Independent Scientific Committee on Smoking and Health³¹. This process culminated in a major review by the US Environmental Protection Agency published in 1992³², which classified ETS as a Class A (known human) carcinogen.

More recently, further major reviews on passive smoking have been published including studies by the UK Scientific Committee on Tobacco and Health³³, the Wolfson Institute of Preventive Medicine^{34,35} the World Health Organization³⁶, the International Agency for Research on Cancer³⁷ and a report by the California Environmental Protection Agency³⁸ which identified passive smoking as a cause (or likely cause) of:

- In childbirth and infancy: low birth weight, cot death (SIDS).
- Illnesses in children: middle ear infection, induction & exacerbation of asthma, bronchitis and pneumonia, meningococcal infections.
- Illnesses in adults: heart disease, stroke, lung cancer, nasal cancer, spontaneous abortion (miscarriage), exacerbation of cystic fibrosis, cervical cancer.

Studies in the early 1990s^{39,40} estimated that passive smoking was the third leading preventable cause of death in the United States, ranking behind active smoking and alcohol, and that non-smokers living with smokers had an increased risk of heart disease of around 30%. It appears that even a small exposure to tobacco smoke has a large effect on heart disease, with further exposure having a relatively small additional effect.

Recent information on ETS and health, from both primary research and meta-analyses, includes the following key findings:

- Passive, as well as active, smoking has a significant effect on lung growth in adolescents. This effect is dose-related⁴¹.
- Secondhand smoke exposure in the workplace results in an increased lung cancer risk similar to that resulting from household exposure⁴²⁻⁴⁶. Furthermore, lung cancer risk may be seriously underestimated where exposure, other than that studied, exists⁴⁷.
- Secondhand exposure is associated with a 20% increase in the progression of atherosclerosis. Current smokers have a 50% increase and past smokers have a 25% increase. Some of these effects may be cumulative and irreversible⁴⁸.

3.2 Existing laws and regulations on ETS

Aside from legislation that deals with fire prevention and food hygiene, the most pertinent legislation concerns workplace health and safety. Legislation concerning consumer protection, disability discrimination and human rights may also be relevant.

Health & Safety at Work Act 1974

For more than 25 years, UK employers have been required “to provide and maintain a safe working environment which is, so far as is reasonably practicable, safe, without risks to health and adequate as regards facilities and arrangements for their welfare at work”. The Health and Safety Executive (HSE) has issued voluntary guidance to employers on smoking in the workplace. Following an undertaking in the *Smoking Kills* White Paper, the Government has consulted at length on an Approved Code of Practice (AcoP) on passive smoking. An AcoP is guidance to employers which clarifies the current legislation. If the AcoP on passive smoking is approved, employers will be obliged to take all reasonable and practical steps to ensure that employees can work in a smokefree environment. The AcoP also offers protection for the employer against prosecution for failure to provide a safe working environment if he or she can show that all practicable steps have been taken to reduce tobacco smoke in the environment.

European Union Law

Smoking is also potentially covered under several EU Directives that have resulted in changes relating to health and safety in the workplace: the Workplace Health and Safety Directive, the Health and Safety of Workers Framework Directive, the Pregnant Workers Directive, the Carcinogens at Work Directive.

Voluntary approaches

In keeping with the British tradition of legislation as the last resort, successive governments have pursued voluntary measures instead of regulation.

The White Paper, *Smoking Kills*, describes a voluntary scheme proposed by the hospitality industry, the Public Places Charter. Businesses signing up to this self-regulatory regime must have a smoking policy and display appropriate signage. However, one of the five options under the Charter is ‘smoking allowed throughout’. It is not clear how many of those pubs and restaurants signing up to the scheme have taken this option.

3.3 Beliefs about the health risks of ETS

There is now a growing awareness of the inappropriateness of smoking in many circumstances. Londoners are particularly conscious of the effect of passive smoking on children’s health⁹.

Children’s health

- When Londoners were asked if they thought that living with a smoker would increase a child’s risk of various diseases, a large majority were aware of the effect of passive smoking on chest infections (90%) and asthma (84%) in children. However just over half (55%) thought it was related to cot death and fewer than four in ten (37%) thought passive smoking might increase the risk of ear infections in children.
- Smokers tended to be less aware of the risks. For example, of those who had never smoked, 91% said passive smoking increased a child’s risk of asthma and 66% said it increased the risk of cot death. This compared with only 67% and 42% respectively of those who smoke 20 or more cigarettes a day.

Adults’ health

Although a smaller proportion of Londoners thought passive smoking could be harmful to adults, there was still a substantial majority who believed this⁹.

- Four out of five Londoners thought that a non-smoking adult’s risk of lung cancer, bronchitis and asthma would be increased by passive smoking. Fewer (71%) thought that passive smoking would increase the risk of heart disease.
- Eight out of ten pregnant women surveyed in London thought that someone smoking near a pregnant woman was likely to be dangerous to the woman herself while 84% thought it would be dangerous for the unborn child.

3.4 Smoking around children

Londoners have strong views about the appropriateness of smoking around children⁶.

- Only 10% of those Londoners who live in household with children said that smoking was allowed anywhere. Only 17% of smokers who live in households with children are allowed to smoke anywhere, but 45% of those who live in adult only households are allowed to do so.
- Nine in ten Londoners (91%) agree that it is never acceptable to smoke in a car when children are present. Agreement is strongest among non-smokers, but even 84% of smokers agree.
- Nine in ten Londoners (93%) believe that childminders should not be allowed to smoke in front of the children in their care. Although 17% of smokers who live in households with children are allowed to smoke anywhere in the house, only 8% think that childminders should be allowed to smoke in front of children in their care.
- Some 92% of London smokers say they modify their smoking when in the presence of children: 59% say they do not smoke at all and 33% say they smoke fewer cigarettes⁹.

3.5 Smoking at home

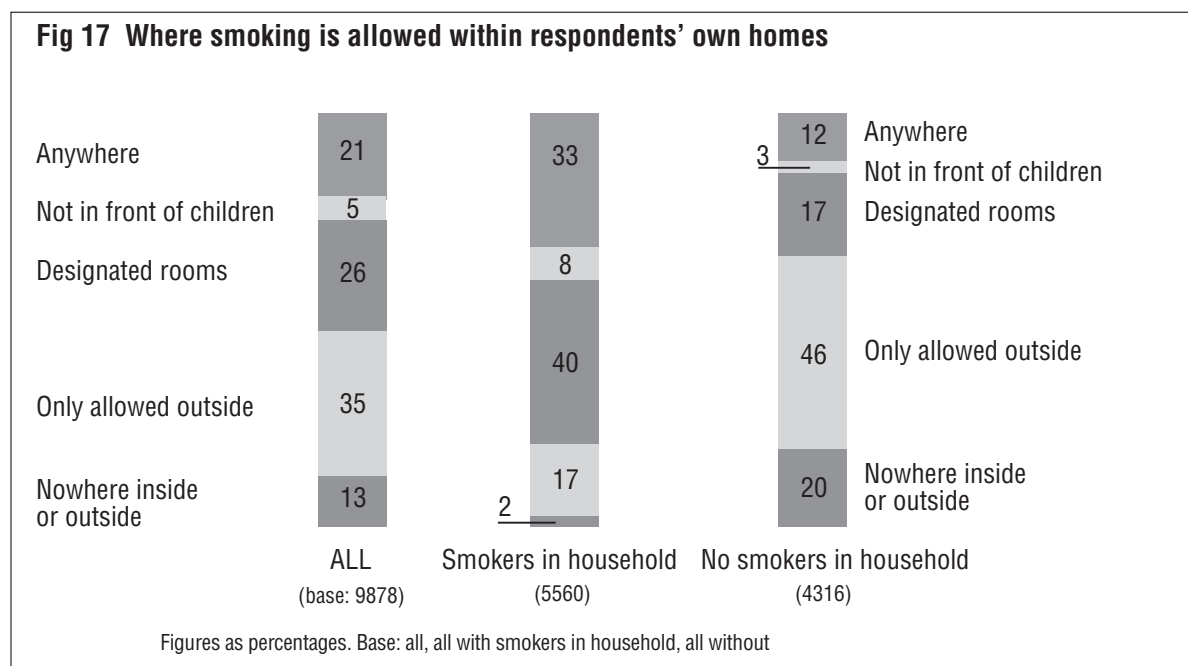
In London one third of smokers (32%) live in households with at least one other smoker but only 15% of non-smokers live in a household with a smoker⁶.

- About one in four (24%) of pregnant women in London report being exposed to passive smoking at home⁹.
- Almost two fifths (39%) of London’s 11-15 year olds lives with at least one parent who smokes and are likely to be exposed to passive smoking at home⁹.

Restrictions in the home

Four out of five London households have some sort of restrictions on smoking inside and outside the home⁶.

- One in eight Londoners (13%) said it was not allowed anywhere inside or outside the home.
- Just over a third of Londoners (35%) said that smoking was only allowed outside (garden, balcony or doorstep).
- Obviously there were fewer restrictions where smokers live, but only one third of those who lived in households with smokers reported smoking was allowed anywhere in the house. In one in five (19%) households smokers had to smoke outside or nowhere at all.
- One in eight smokers (13%) said it was not allowed anywhere inside or outside their home.



3.6 Smoking at work

Six in ten Londoners work outside the home and 15% study outside the home.

Restrictions at work or place of study

- Only 7% of those interviewed say smoking is unrestricted where they work or study.
- 31% say it permitted in designated areas.
- 60% say smoking is banned inside the premises.
- 12% say it is banned outside the premises as well.

There are significant differences between the workplace restrictions for smokers and non-smokers:

- Nearly half of smokers (45%) can smoke somewhere inside their work/study premises although mostly in designated areas.
- Only a third (34%) of non-smokers work or study in places where smoking is allowed inside.
- Women are much less likely to work in places where smoking is permitted (30% compared with 43% of men).
- Those in higher social grades are less likely to work where smoking is permitted (34% of ABC1s compared with 44% of C2DEs).

Smoking outside normal breaks at work

Nearly four in five (78%) Londoners agree with the statement that ‘while at work, smokers should only be allowed to smoke during normal breaks’. Even 70% of smokers agree with this.

- Smokers from social grade DE are most opposed to smoking outside normal breaks and those from AB the least opposed (75% compared with 59%).
- There were sharp differences of opinion between AB and C1 smokers – only 59% of AB smokers agreed with the statement compared with 68% of C1 smokers. This may suggest unequal impact of workplace restrictions on those in lower paid jobs.

3.7 Smoking in public places and public transport

Eating places

The vast majority of Londoners think that smoking should be restricted or banned in eating places.

- More than two thirds (69%) of Londoners believe there should be a complete ban on smoking in fast food outlets. This includes 57% of smokers (compared with 74% of non-smokers). Only 3% thought smoking should be unrestricted.
- Over four in ten (43%) support a complete ban in cafes or restaurants. Only 2% of Londoners thought smoking should be unrestricted, including 4% of smokers.

Pubs and bars

- A minority of Londoners (24%) wants the current situation of largely unrestricted smoking in pubs to continue. Even smokers are in favour of limiting smoking to designated areas: only 38% support unrestricted smoking in these venues.
- Six per cent of smokers and 23% of non-smokers want a complete ban on smoking in pubs and bars.
- Only a third of frequent pub users (once a week or more often) wants smoking to remain unrestricted.

Health concerns for bar staff

Of course, all public places are also workplaces. Places like pubs and bars, where smoking has been considered the norm, can pose special problems for health and safety at work. The exposure of workers in bars and pubs to ETS was measured in a specially commissioned survey for SmokeFree London⁴⁹. Cotinine, a metabolite of nicotine and a standard measurement of exposure to tobacco smoke, was assessed in non-smoking staff in pubs in central and inner-suburban London in 2001.

- Non-smoking bar staff were about 40 times more likely to have a high exposure than those from non-smoking households and nine times more likely than non-smokers who live with a smoking partner.
- The average cotinine levels in the bar staff surveyed put them in the most heavily exposed 5% of all adult non-smokers.
- The study repeated one that was conducted ten years earlier in London by the same researcher. There was little difference in the findings.

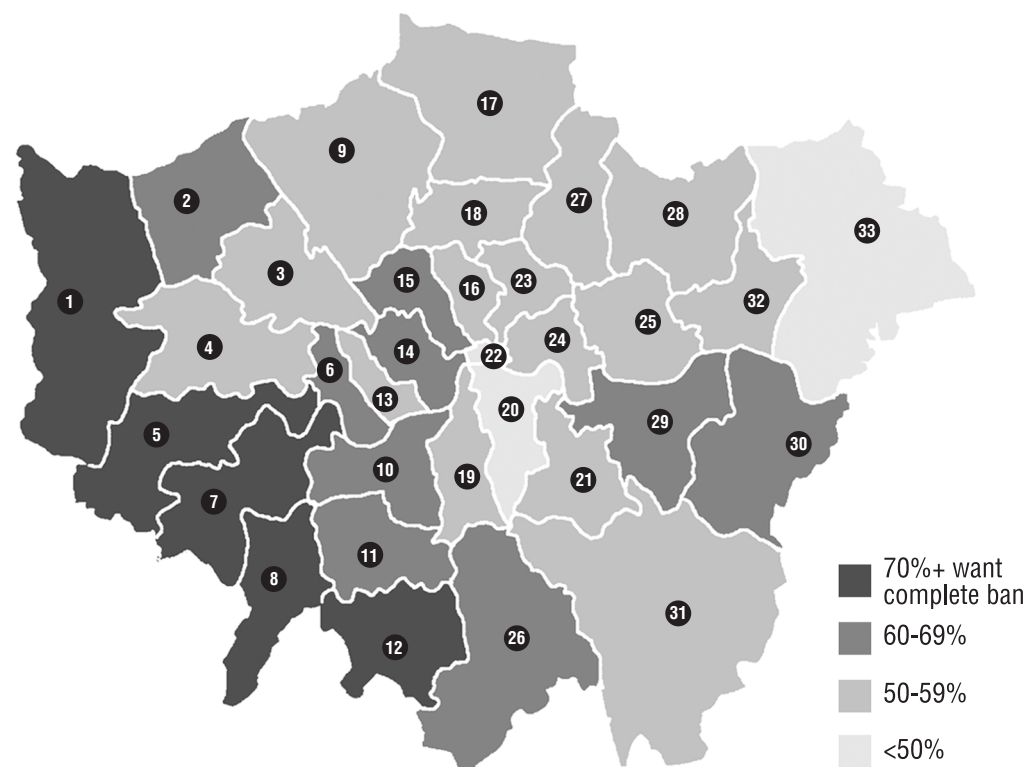
Previous studies have found direct links between cotinine concentrations and number of diseases. Since cotinine-based exposure in bar staff is much greater than in domestically-exposed non-smokers, it must be anticipated that bar staff's occupational exposure to tobacco smoke will result in significant adverse effects on their health.

Professor Martin Jarvis, University College London

Shopping centres

The past decade has seen an increase in 'mall culture' in London. Shopping malls are now leisure facilities as well with coffee bars, cinemas, and restaurants that appeal to young people and families with children. As such, they are a priority area for clean air. The majority of Londoners agrees:

- Seven in ten Londoners want a complete ban on smoking in enclosed shopping centres and malls and one in five (21%) thinks they should be mainly smokefree. Only 8% support unrestricted smoking.
- There is a marked geographical bias in Londoners' views. The London average for smokers supporting a ban is 60%, but in Hillingdon, Hounslow, Richmond, Kingston and Sutton more than 70% of smokers support a ban. In contrast, only 42% of smokers in Havering and 52% of smokers in Barking & Dagenham support a ban.

Fig 18 Smokers' attitudes towards smoking in shopping centres (borough)

- | | | |
|---------------|----------------|-------------------------|
| 1 Hillingdon | 12 Sutton | 23 Hackney |
| 2 Harrow | 13 Kensington | 24 Tower Hamlets |
| 3 Brent | 14 Westminster | 25 Newham |
| 4 Ealing | 15 Camden | 26 Croydon |
| 5 Hounslow | 16 Islington | 27 Waltham Forest |
| 6 Hammersmith | 17 Enfield | 28 Redbridge |
| 7 Richmond | 18 Haringey | 29 Greenwich |
| 8 Kingston | 19 Lambeth | 30 Bexley |
| 9 Barnet | 20 Southwark | 31 Bromley |
| 10 Wandsworth | 21 Lewisham | 32 Barking and Dagenham |
| 11 Merton | 22 City | 33 Havering |

Base: All smokers in each borough (app. 150 in each)

Other public places

- Only a tiny minority (12%) are opposed to complete bans in hospitals, clinics and health centres.
- Four in five London residents (80%) support complete smoking bans in sports and leisure centres.
- About half (46%) of Londoners think smoking should be banned completely in colleges and universities; 49% say specified areas should be set aside for smoking.

Transport areas and taxis

Londoners are now accustomed to travelling on smokefree public transport. The London Underground system has been completely smokefree since 1985; London commuter trains within a 30-mile radius that use underground tunnels have been smokefree since 1990; London buses have been smokefree since 1991.

The remaining areas of public transport where smoking is still allowed is peripheral areas, such as railway station platforms and taxis. A majority of Londoners want this changed:

- Over half (56%) thought smoking should be banned completely in major railway stations like Paddington or Kings Cross.
- Just over half (52%) thought smoking should be banned on the platforms of overground railway stations

- Nearly two thirds (63%) thought smoking should be banned in bus or tram shelters.

By law, taxi drivers are currently only allowed to request, not insist, that passengers do not smoke in their cabs. However, 95% of London residents believe that taxi drivers should have this right, including 88% who agree ‘a lot’. Even 91% of smokers overall agree that taxi drivers should have this right.

Cigarette litter

The Greater London Assembly recognises that cigarette butts account for 40% of the litter on London’s streets⁵⁰. More than four in five Londoners (84%) agree that ‘litter caused by cigarette butts dropped in public places is really annoying’.

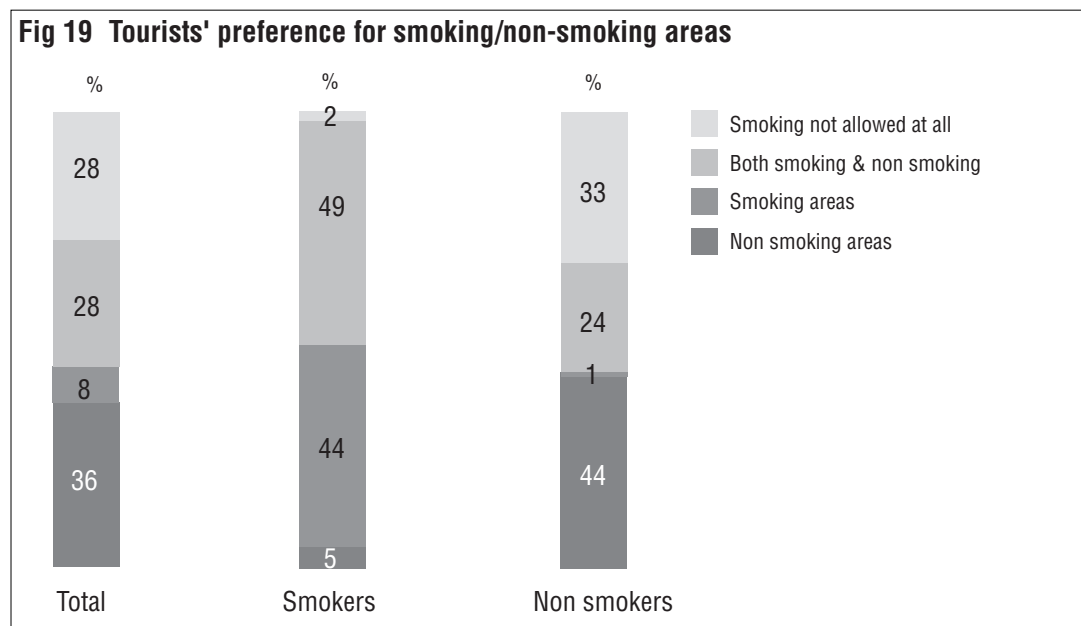
Given research findings from the Tidy Britain Group that only 53% of smokers had ever used a bin to dispose of butts and that 75% admitted dropping them on the ground⁵¹, it would not be surprising if smokers were not disturbed by cigarette litter. However, three quarters of smokers (73%) agreed that litter is annoying.

Smoking in London: the tourists’ view

As always becomes clear when London’s tourist numbers fall, tourism is a large and vital part of the capital’s economy, which employs more than 250,000 people.

SmokeFree London commissioned a survey of over 1,000 overseas visitors’ attitudes to smoking in London in early September 2001⁵². The survey was weighted toward North Americans, given their importance to London tourism.

- All respondents had dined out or visited a pub and their average expenditure in London, excluding accommodation, was about £350 per week.
- Nearly seven in ten (68%) claimed the smoking policy of a venue always or sometimes affects whether they choose to go there. North Americans were the group most influenced by venues’ smoking policies (75%) while Europeans were less concerned (56%).
- Almost two-thirds (64%) of all respondents said they prefer to go to a venue that provides no smoking areas or is completely smokefree.
- A sizeable minority (29%) said they had been bothered by smoke during their visit and almost a fifth had taken action (i.e. moved or left the venue) as a result.



4 Preventing uptake of tobacco

Preventing initiation of smoking in young people has been a primary concern for tobacco control in the last 40 years. It has also been one of the most extensively researched areas of policy. There is now a growing understanding that interventions aimed solely at children, especially in the absence of adult strategies, have little if any impact on the uptake of smoking^{53,54}. The argument that smoking among adults should be tackled ahead of teenagers is fivefold.

- First, reducing smoking among adults will lead to a quicker and larger reduction of tobacco related harm because there is a higher level of smoking-related mortality and morbidity among adults than teenagers.
- Second, reducing smoking among adults will protect the unborn and recently born from exposure to direct and indirect tobacco smoke.
- Third, quitting by adults (especially by parents) reduces the likelihood of children taking up smoking.
- Fourth, while there are clear ethical reasons for educating children about what is the largest preventable cause of death, beyond this, the methods of delivering interventions are fraught with practical problems and the evidence of effectiveness of interventions aimed at young people is poor.
- Finally, the fact that the tobacco industry itself supports anti-smoking campaigns targeted at teenagers, should be taken as a warning signal, ‘Even Phillip Morris was confident that [anti smoking] youth campaigns could do them little damage’⁵⁴.

Policies to prevent uptake should be part of a comprehensive package that ‘de-normalises’ tobacco use. Key policies to address smoking in children as well as adults include ensuring that smokefree air is the standard in public as well as private, that public education addresses smoking cessation and passive smoking and that the price of tobacco is maintained.

4.1 Smoking behaviour by school children in London⁹

- Just over one in ten (11%) children in London aged 11-15 were regular smokers (in children ‘regular’ is defined as usually smoking one or more cigarettes a week). In England as a whole, prevalence has been stable between 9 and 11 per cent since 1998 and was 10% in 2000 and 2001⁵⁵.
- Secondary school-aged girls in London were more likely to be regular smokers than boys (12% of girls compared with 9% of boys). This has been the pattern in England as a whole for several years. In 2001, 11% of girls in England smoked compared with 8% of boys⁵⁵.
- A further 5% of pupils said they were occasional smokers (on average less than one cigarette a week). In all just under half (44%) of London pupils aged 11-15 said that they had tried smoking at some time.
- Smoking prevalence among London schoolchildren increases sharply with age: two per cent of 12 year olds are regular smokers compared with almost a quarter (24%) of those aged 15.

4.2 Where do children get their cigarettes?

- Three in ten (29%) London pupils had tried to buy cigarettes from a shop and four in ten (39%) had been refused at least once in the previous year.
- Most current smokers said they usually got their cigarettes from shops, with newsagents/tobacconists (54%) being the most common sources.
- Younger smokers were more likely than older smokers to have been given cigarettes by friends or to have bought them from other people.

Londoners’ views of penalties for selling cigarettes to children

It is against the law for retailers to sell any tobacco product to children under the age of 16 under the Children and Young Persons Act (Protection from Tobacco) 1991. Most London adults (94%) think there should be penalties for retailers who do so⁶.

- A quarter of London residents believe those who break the law should face a substantial fine of more than £500, while 18% believe the fine should be less than £500.

- More than four in ten (43%) said a retailer should be banned from selling cigarettes to anyone, although there is currently no tobacco licensing scheme in the UK. Loss of a license would potentially be a more punitive measure than most fines.
- One in twenty thought prison was the most appropriate punishment.
- Two thirds (67%) of London adults said if they wanted to report a retailer who was selling cigarettes to children they would contact the police.
- One in ten (11%) said they would contact Trading Standards and a similar number mentioned the local council⁶. In fact, Trading Standards Officers are responsible for investigating sales of cigarettes to minors.

4.3 Smoking in the family

Numerous studies have shown that smoking by parents and older siblings is the strongest influencing factor on children to begin a career as a smoker. Therefore, addressing smoking in the family is among the most important measures in preventing young people's smoking.

Parental smoking

In the 1990s, 30% of secondary school pupils in London said their mother smoked and 39% said their father smoked.

- London pupils were more than twice as likely to be regular smokers if both their parents smoked than if neither did (18% compared with 7%).
- Pupils who had two non-smoking parents were the least likely to be regular smokers compared with other groups and the least likely to have tried smoking.
- Twenty-four per cent of children in lone parent families where that parent smoked were themselves regular smokers compared with 12% where the lone parent did not smoke.

Siblings' smoking

Smoking by older siblings is an even stronger factor in influencing children's smoking than is parental smoking.

- Those pupils who had a brother or sister who smoked were more than four times as likely to be regular smokers as were those who had no siblings who smoked (32% compared with 8%).
- Thirteen per cent of those who had no siblings (or whose siblings did not live at home) were regular smokers, compared with 8% of those with non-smoking siblings.

4.4 Young people and smoking cessation

While there is great concern about the rates of smoking among young people, there is very little specialised help available in the UK for schoolchildren who want to quit smoking. However, sizeable proportions of London secondary schoolchildren already express a desire to give up smoking.

- Four in ten of current smokers among London 11-15 year olds said they wanted to give up smoking.
- Two thirds (66%) said that they had already tried to give up smoking.

An expert seminar convened by the Health Development Agency in 2000 assessed the evidence of effectiveness of programmes to help young people quit and made recommendations⁵⁶. The experts concluded that there was, globally, almost no good evidence on effective smoking cessation interventions for young people and little experience in the UK with setting up such services. They recommended that a range of pilot interventions should be carried out and the most promising should be evaluated through control trials.

Prescribing to young people

Guidance from NICE has recommended that those under the age of 18 should talk to a health professional before deciding to use NRT. It has recommended that bupropion not be prescribed to smokers under the age of 18 because its safety and efficacy has not been evaluated for this group¹⁹.

5 Advancing tobacco control policy

After 40 years of international experience in tobacco control, it is now recognised that what the Royal College of Physicians of London first recommended in their 1962 report was sound: namely that a comprehensive basket of policies is needed to lower a heavily promoted and relatively inexpensive addictive substance like tobacco. This is the basis on which UK government has built the tobacco control policy spelt out in the *Smoking Kills* White Paper.

Previous chapters have dealt with two of the most important elements of a comprehensive policy: ensuring the availability of smokefree public places and help and encouragement for smokers to quit. This chapter comments briefly three more important areas for action: banning tobacco promotion, controlling tobacco price and dealing with tobacco smuggling.

5.1 Tobacco advertising and promotion

The government elected in May 1997 had a manifesto commitment to legislate for a ban on tobacco advertising. In the first instance this was pursued through a Directive from the European Union which would have effectively banned tobacco advertising and promotion throughout the 15 EU countries. The Directive was approved in December 1998, but was subsequently struck down in the European Court of Justice.

It now appears that a government-backed Bill to ban tobacco advertising and promotion will come into effect in the UK in 2003. In doing so, the UK will become the ninth EU state to ban tobacco advertising along with New Zealand, Australia and other countries. Experience in other jurisdictions shows that a legislated ban is not the end of the story. Every available avenue is likely to be exploited to continue to nurture new tobacco markets.

London's tobacco control advocates will need to be vigilant in collecting and documenting examples of where the law has not been observed as well as those cases where a promotion may be legal but not within the spirit of the law.

5.2 Tobacco taxation and price

The importance of price in reducing tobacco consumption has been recognised by the World Bank and World Health Organization. Increasing price encourages current smokers to smoke less or to quit and discourages young people from taking up smoking. The Tobacco White Paper *Smoking Kills* expresses the Government's commitment to increasing tobacco tax ahead of the rate of inflation.

Public acceptability of tobacco tax increases

Despite years of steady tax rises the majority of Londoners is still in favour of raising the price of tobacco⁹:

- Nearly six in ten adults (58%) living in London said tobacco tax should be increased by more than the rate of inflation.
- There was unsurprisingly a wide divergence of views between smokers and non-smokers: 24% of current smokers agreed with this view compared with 67% of never smokers.

5.3 Smuggling

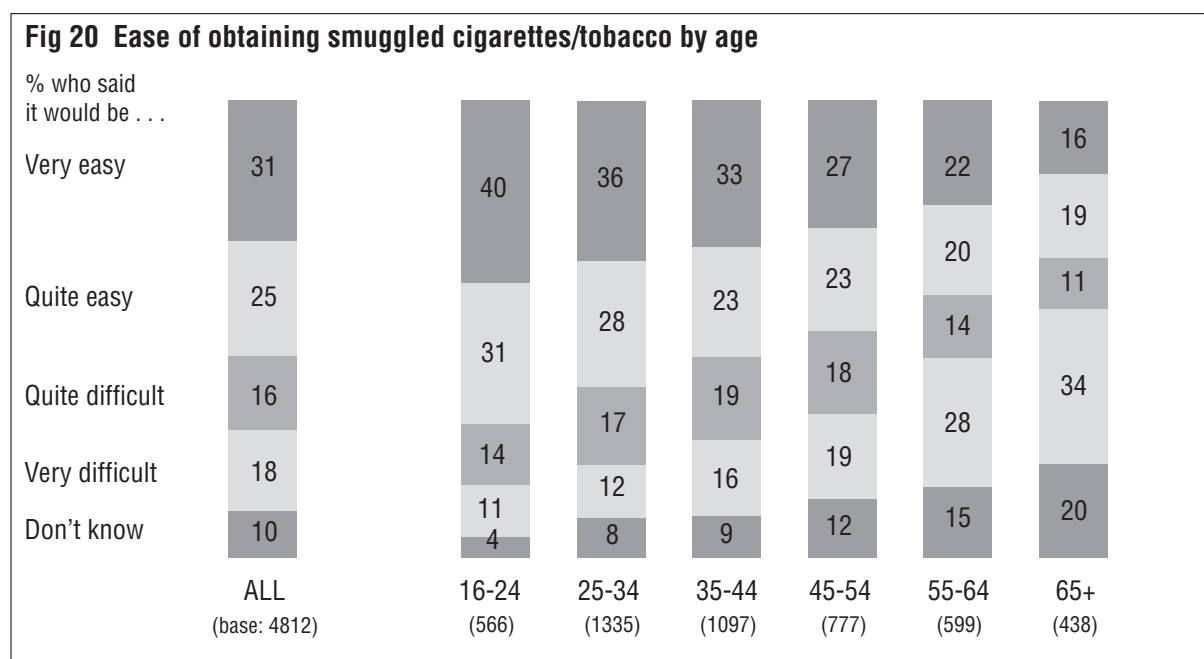
Smuggled tobacco is a huge public health problem for the UK as it brings cheap tobacco on to the market and undermines the policy of using tobacco price to discourage smoking in both young people and adults. Moreover, contraband tobacco is especially targeted at low income areas and estates, further increasing inequalities in health⁵⁷.

- The size of the problem has grown rapidly. Customs and Excise estimate that the black-market in cigarettes increased from 3% in 1996/97 to 22% in 2000 and the lost revenue to £3,800 million in 2000⁵⁸.
- Bootlegging (bringing into the country tobacco on which tax has been paid from other, lower tax countries) accounts for only 20% of the contraband market.
- The other 80% is container smuggling (containers of cigarettes on which no tax has been paid)⁵⁹.
- The UK's chief problem is with domestic brands that are exported to places where there is no market for them and then smuggled back into the country. The tobacco industry's own documents sometimes refer to this as the 'DNP' (or duty not paid) market⁶⁰.

Ease of buying smuggled cigarettes in London

The SmokeFree London survey⁶ established that Londoners find it remarkably easy to buy contraband tobacco.

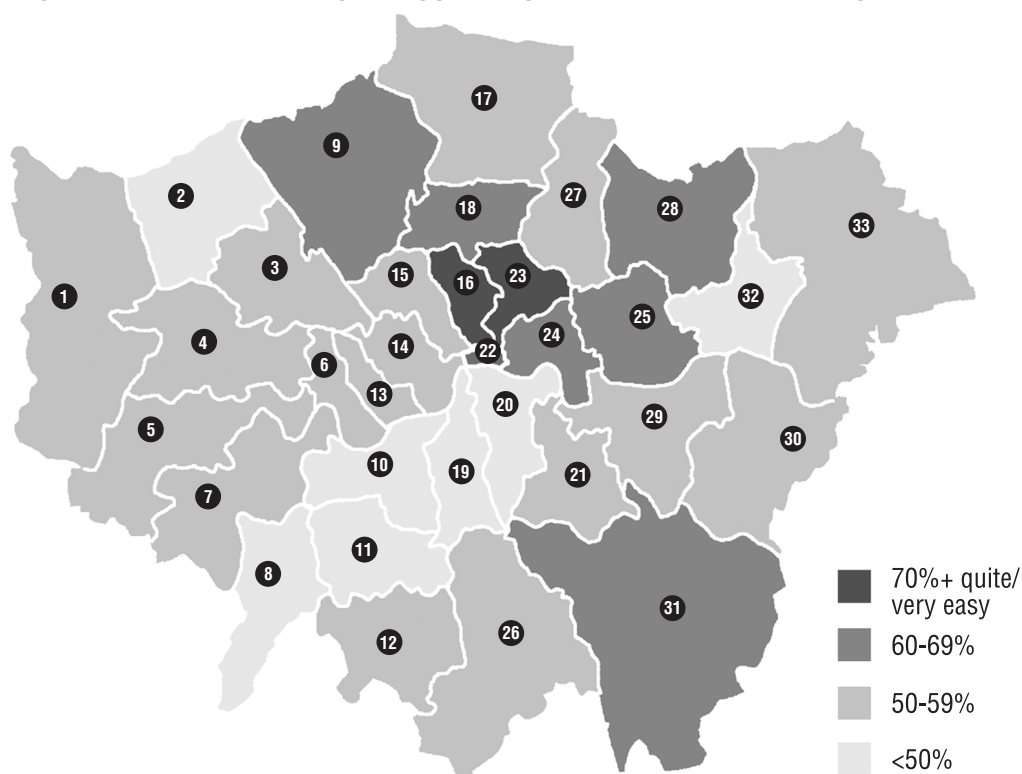
- More than half (56%) of London smokers said it would be easy to purchase smuggled cigarettes if they wanted them, including a third (31%) who said it would be very easy.
- Men were more likely than women to say it would be easy to get smuggled cigarettes. Two thirds (64%) of male smokers said it would be easy, compared with less than half (48%) of female smokers.
- Younger people were more likely to consider it easy to obtain smuggled cigarettes. Although generally women thought it less easy than did men, young women (aged 16-24) were more likely to find it easy than men over the age of 35.
- Overall, 71% of 16-24 year old smokers said it would be easy to purchase smuggled cigarettes.



A large variation was found between London boroughs, which is unlikely to be related to differences in social grade.

- Eighty per cent of Islington smokers think smuggled cigarettes would be easy to find and neighbouring Hackney was also above the London average.
- In contrast on 45% of Wandsworth smokers though it would be easy.
- Lambeth, which has a similar social grade profile to Islington is actually much closer to Wandsworth in perceived ease of obtaining contraband cigarettes.

Fig 21 Ease of obtaining smuggled cigarettes/tobacco (borough)



- | | | |
|---------------|----------------|-------------------------|
| 1 Hillingdon | 12 Sutton | 23 Hackney |
| 2 Harrow | 13 Kensington | 24 Tower Hamlets |
| 3 Brent | 14 Westminster | 25 Newham |
| 4 Ealing | 15 Camden | 26 Croydon |
| 5 Hounslow | 16 Islington | 27 Waltham Forest |
| 6 Hammersmith | 17 Enfield | 28 Redbridge |
| 7 Richmond | 18 Haringey | 29 Greenwich |
| 8 Kingston | 19 Lambeth | 30 Bexley |
| 9 Barnet | 20 Southwark | 31 Bromley |
| 10 Wandsworth | 21 Lewisham | 32 Barking and Dagenham |
| 11 Merton | 22 City | 33 Havering |

Base: All smokers in each borough (app. 150 in each) All data shown are weighted

Who has bought smuggled cigarettes?

Overall, a third of London smokers admit to having purchased contraband tobacco. Younger smokers were much more likely to have done so than older smokers.

- Nearly half (47%) of 16-24 year old smokers admitted they had bought smuggled cigarettes. This figure declines to 18% of those over the age of 65.
- Men of all ages were more likely to buy contraband cigarettes than were women. Overall, 41% of men had bought smuggled cigarettes compare to 25% of women. The difference was smaller in the younger age groups.
- Heavy smokers were much more likely to have purchased smuggled cigarettes than were medium or light smokers (45% compared with 35% and 29% respectively).

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