

provided through an existing Quitline service considerably enhances access to NRT for smokers.

A nationwide programme to provide subsidised NRT was implemented from November 2000 through the New Zealand Quitline, a free telephone service for people wanting to quit smoking. Long term cessation rates have been found to improve when NRT is used as part of a behavioural intervention such as counselling.^{2,3}

When smokers call the New Zealand Quitline they are assessed for their eligibility to receive vouchers for subsidised NRT (patches or gum). Eligibility criteria include being: a "heavier" smoker (10+ cigarettes/day); motivated to quit; and 18+ years of age. The subsidisation reduces the cost of NRT to the smoker from a maximum of NZ\$199 (US\$109) for eight weeks' product to NZ\$5 (US\$2.70) for the first four weeks' supply, and NZ\$10 (US\$5.40) for the second four weeks' supply. This fee covers dispensing costs and provides a means of encouraging some degree of motivation to quit among smokers. Redeemed NRT vouchers are claimed by pharmacists through the Ministry of Health's Health Payments, Agreements and Compliance Unit.

There was significant media interest as a result of the government coordinated NRT media release in November 2000 and the Quitline service was flooded with calls following the launch. Since this time calls have levelled to 9000 per month. Currently, around 41 000 smokers a year register with the Quitline to give up smoking and are issued with vouchers for NRT (from a national smoker population of 740 000). This is a large increase on the number of smokers accessing the Quitline only service before the introduction of the NRT voucher scheme.

Redemption analysis shows that 73% of vouchers issued through the Quitline are redeemed, considerably higher than that experienced by Miller *et al*¹ (39%).⁴ Additional New Zealand research found that delivery of the voucher programme through the Quitline is enhancing access to NRT.⁵ A survey of Quitline callers who were positively assessed for NRT found that the process of receiving vouchers and redeeming these for nicotine patches and gum ran smoothly for respondents. Once respondents had the NRT, they were quick to start using it (80% started using their first four week supply within three days of receiving it) and they appeared to have a good understanding about how to use the patches and gum appropriately. Overall, there was little wastage of the nicotine patches and gum. Of those who redeemed their first voucher most (70%) reported using the whole four week course.

The enhancement of the New Zealand Quitline service through the provision of subsidised NRT has been viewed positively by smokers using the service and has greatly increased the number of people accessing the Quitline. Research results indicate that considerable subsidisation of NRT (92% in New Zealand's case) as part of an enhanced Quitline counselling service indeed provides an incentive to smokers who want to quit.

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Smoking among workers from small companies in the Paris area 10 years after the French tobacco law

Since the introduction of a tobacco law in 1991, smoking in enclosed public areas, including the workplace, has been forbidden in France. At the time this law was introduced we conducted several studies concerning smoking behaviour and the implementation of smoking regulations in the workplace.¹ We believed that it was interesting to repeat this study 10 years later: (1) to assess the prevalence of active smokers in small companies in the Paris area; (2) to assess the prevalence of passive smokers in these companies; (3) to describe the impact of the French tobacco ban in these places of work.

In the French occupational health system, every worker undergoes a medical examination at least once a year regardless of whether they are exposed to occupational hazards. The occupational physician is required to spend one third of their time studying each worker's work station. The data were collected among a population of 900 000 workers employed in all job categories in the Paris area. These workers belonged to companies employing between one and 3500 workers. The mean number of employees was nine, indicating that most of these companies were very small. We choose a double observation method: one in the physician's office and the other in the workplace. During September 2001, 173 physicians interviewed 3065 workers selected at random. A total of 3044 questionnaires were suitable for analysis. The sample consisted of 1654 men (54.3%) and 1390 women (45.7%). The mean (SD) age was 36 (11) years (range 15-77 years).

In the whole sample, the prevalence of regular smokers was 36.9%, the prevalence of workers exposed to environmental tobacco smoke at work was 14.6%, and the prevalence of workers who were disturbed by environmental tobacco smoke at work was 18.3%. Nearly all regular smokers smoked cigarettes (98%) and the mean (SD) consumption was 15 (8) cigarettes per day (range 1-60 cigarettes). The 296 non-smoking workers (9.7%) who were exposed to a tobacco smoke environment at work were considered to be passive smokers. Over two thirds (68.4%) of the workers were banned from smoking at their work station,

with the highest rate among clerks (72.2%). About three quarters (76%) of workers worked in a public room. Thirty eight per cent of workers stated that their direct supervisor was a smoker.

During the same period, 160 occupational physicians completed 690 questionnaires in workplaces selected at random, 678 of which could be analysed. The physician noted whether smoking was banned in every workplace (company or agency). Several questionnaires were completed for a single workplace if it included several departments (offices, workshops, etc). Smoking was banned in 68% of workplaces (n = 461). Bans were most prevalent in shops, workshops, and warehouses. Smokers and non-smokers worked together in 66% of the workplaces visited (n = 447). Smoking was banned in the whole company for 51% of them, and more often in those employing more than 300 workers (76.2%).

The results allowed us to address our three objectives:

(1) The prevalence of smokers (37%) in small companies in the Paris area has decreased with time. The prevalence was 44% in 1979, 42% in 1987, and 43% in 1991.¹ During this 12 year period the prevalence remained stable; however, it seemed to fall by about 6% between 1991 and 2001.

(2) The prevalence of passive smokers in these small companies was 9.7%, according to our restrictive definition of passive smoking. This restrictive definition did not make it possible to compare our data with those published in the literature. Several factors were significantly associated with passive smoking: being male, being a blue collar worker, being 25-34 years old, and having a supervisor who smoked.

(3) The ban on smoking at the work station was mentioned by 68% of the workers and smoking was banned in 68% of the workplaces visited. This percentage is higher than that reported by Grizeau and Baudier in 1995 (59%).² This difference may represent progress in the last six years since the application of the French tobacco law.

The 1991 French tobacco law, the initial purpose of which was to protect non-smokers, seems to have led to a decrease in the prevalence of smoking and to a decrease in cigarette consumption, as shown by other studies on smoking policies.³ The prevalence of regular smokers decreased by 6% in accordance with the conclusions of Farrelly *et al* that "the ban on smoking in all workplaces should reduce the prevalence of smokers by 10%".⁴ In the Paris area, real progress in the fight against smoking in the workplace was only made after the introduction of a national smokefree legislation, as in Finland.⁵ This situation could probably be enhanced further if the authorities boosted the French tobacco ban by introducing new stronger national smoking legislation.

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One suggestion for Philip Morris . . . err, sorry, Altria's new logo . . .