Smoking cessation counseling from health care providers before and after the national smoke-free law : findings from the ITC France Study

Rd Kennedy, I Behm, L Craig, Me Thompson, Gt Fong, R Guignard, François Beck

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Smoking cessation interventions from health care providers before and after the national smoke-free law in France

Ryan David Kennedy[1,2], Ilan Behm[2], Lorraine Craig[3], Mary E. Thompson[3], Geoffrey T. Fong[3,4], Romain Guignard[5], Francois Beck[5,6]

1 Propel Centre for Population Health Impact, Waterloo, Ontario, Canada
2 Center for Global Tobacco Control, Harvard School of Public Health, Boston, MA, United States
3 University of Waterloo, Waterloo, Ontario, Canada
4 Ontario Institute for Cancer Research, Toronto, Ontario, Canada
5 French Institute for Health Promotion and Health Education (INPES), Saint-Denis, France
6 Cermes3-Cesames team (Research Centre Medicine, Sciences, Health, Mental Health, Health Policy), CNRS UMR 8211, Inserm U988, University of Paris Descartes, Sobonne Paris Cité, EHESS, Paris, France

Correspondence: Ryan David Kennedy, PhD, Scientist, Propel Centre for Population Health Impact, University of Waterloo, Waterloo, Ontario, N2L 3G1, Canada, Tel: +011 519 888 4520, e-mail: RDKennedy@uwaterloo.ca

Background: Smoking cessation advice from health care providers (HCP) is well-known to be associated with increased quitting. This study sought to understand the extent to which smokers in France who visited a HCP around the time of the implementation of the national ban on smoking received encouragement to quit from a HCP and what kinds of intervention were provided. HCP may have a unique opportunity during the implementation phase of smoke-free laws to address their patients' smoking behaviours to increase the likelihood of success at a time when smokers' readiness and interest in quitting may be higher. **Methods**: Telephone interviews were conducted among adult smokers (n = 1067) before and after the two-phase (2007 and 2008) national ban on indoor smoking as part of the International Tobacco Control (ITC) France Survey. In the survey, smokers were asked whether they had visited a HCP in the past 6 months and, if so, whether they had received cessation encouragement, and/or other interventions to support quitting such as prescriptions for stop-smoking medication. **Results:** Most smokers (61%) reported visiting a HCP in the 6 months prior to the first phase of the national smoke-free ban, and 58% after the time of the hospitality ban. Of these, most reported they did not receive any assistance from a HCP before (54%) or after (64%) the smoke-free law. Among those who reported an intervention, the most common were only encouragement to quit (58% in Wave 1 and 49% in Wave 2), or receiving both encouragement and a pamphlet (31% in both Wave 1 and 2). The combination of prescriptions for stop-smoking medicine and encouragement to quit increased from 8% in 2007 to 22% in 2008. The smokers who received an intervention were more likely (OR 1.9, 95% CI: 1.2–2.9) to report that they were thinking about quitting. **Discussion:** This study demonstrates that HCP in France are well positioned to provide smoking cessation encouragement and other interventions to a majority of smokers and thus the importance of taking measures to increase their involvement, particularly when population-level tobacco control policies, such as smoke-free laws, are being implemented.

Introduction

Tobacco use is a leading cause of preventable mortality in France, causing an estimated 60,000 cancer deaths annually.[1] The *France National Cancer Plan,* 2009–2013[2] prioritizes smoking cessation as a key strategy to reduce the incidence of cancer. The plan states that primary health care providers, particularly general practitioners, are well positioned to address their patients' tobacco use and provide counseling advice and other supports to assist successful cessation. Brief interventions by health care providers (HCPs) are known to be effective in increasing cessation.[3] Gorin and Heck (2004) conducted a meta-analysis of 37 randomized clinical trials and quasi-experiments on this topic and concluded that patients who receive advice to quit smoking from ''any health care provider'', including family physicians, achieve increased quit rates.[4] Although the absolute effect is small with only 1–3% of patients successfully quitting, these types of interventions can influence public health because in many countries a majority of smokers visit their physician each year.[5,6] The results of one multi-country study found that, of smokers who reported they visited a HCP, the likelihood of receiving encouragement to quit smoking varied between 20% to 66%.[6] Considering all smokers, the proportion who reported receiving advice to quit smoking from HCPs during their last visit ranged from less than 10% in the Netherlands to over 50% in the US.[6]

A comprehensive approach to addressing tobacco use also includes population level interventions like smoke-free laws. Smoke-free policies have the benefit of protecting people from exposure to tobacco smoke pollution,[7] and may help create a supportive environment for smokers who want to quit.[8] Laws that make workplaces smoke-free are associated with psychological measures related to quit intentions and may increase smokers' readiness to quit.[9] There is evidence that smoke-free legislation is associated with a temporary increase in the percentage of smokers attempting to stop,[10] and other quitting behaviour including seeking support from national cessation quitlines,[11] and increased sales and reported use of nicotine replacement therapy.[12,13] This suggests that providing additional individual support to smokers to promote or encourage quitting at times when smoke-free laws or other population-level interventions are being implemented may further increase quit success. HCPs have a unique opportunity during the implementation phase of smoke-free laws to address their patients' smoking behaviours to increase the likelihood of cessation and abstinence at a time when their readiness and interest in quitting may be higher.

France was the first European nation to ratify the World Health Organization's Framework Convention on Tobacco Control (FCTC) in 2004. The FCTC requires the adoption of effective measures to provide protection from tobacco smoke pollution (TSP; also known as secondhand smoke). France's nearly

comprehensive ban on smoking in work and public places was introduced in two phases.[14] In February 2007, all companies, transport, public administration buildings, educational and health care facilities implemented a ban on indoor smoking. In January 2008, all hospitality venues, including cafés, bars, hotels, restaurants, discotheques, and casinos, who were exempted from the first stage of the law, also implemented an indoor smoking ban. The ban permits smoking in separately ventilated smoking rooms, except on health premises and premises for use by minors. The technical specifications for these smoking rooms are extensive[14] and as a result few establishments offer them. Further, in France, starting in February 2007 the government introduced a program to reimburse citizens up to €50/year for nicotine substitutes and prescription medications.

This study sought to understand what proportion of French smokers reported they visited a HCP, and among them, who received an intervention to support cessation and what form of intervention was provided. We analyzed responses from a cohort study of smokers surveyed before the first phase of the national smoke-free law came into effect, and again 9–11 months after the second phase of the law was enacted.

This study also sought to understand if socio-economic status or gender is related to receiving smoking cessation advice from HCPs in France.

Methods

Survey design

The ITC France Survey is a national longitudinal cohort survey conducted by telephone interview using random digit dialing (RDD) in continental France (i.e., excluding the four overseas departments of Guadaloupe, Martinique, French Guiana, and Bourbon Island). Both smokers and non-smokers are included in the survey. Wave 1 was conducted prior to the first phase of the smoke-free law, between December 2006 and February 2007 and Wave 2 was conducted during September – November 2008, after the second phase of the smoke-free law. The complete survey methodology for the ITC France Survey, including construction of sampling weights for smokers and non-smokers, has been reported previously.[15,16, 17]

Sample

A total of 2260 respondents completed Wave 1 of the ITC France Survey, and 1645 respondents completed both Wave 1 and Wave 2, including smokers (n = 1067), non-smokers (n = 414) and respondents who had been smokers during Wave 1 and were abstinent at the time of Wave 2 (quitters, n = 164). This paper reports findings among respondents who were smokers in both waves as well as among those who were quitters in Wave 2; the retention rate for Wave 1 cohort smokers was 71%.[16] Those retained and those not retained did not differ on baseline measures of gender or education. Those not retained (M = 38.3 years) were younger than those retained (M = 40.2 years), t = −2.8, p=.0024 and were more likely than those retained to be of the lowest household income group, earning <1500 Euros a month ($\chi^2 = 10.2$, p = .006). Survey weights were applied to account for the sample design of the survey such that the weighted descriptive statistics are estimates of the population of smokers and non-smokers in continental France.[15]

Demographics and smoking history

Respondent demographics of interest included categorized age (18–24, 25–34, 35–44, 45–54, 55–64, 65+), level of education (<Baccalaureate, Bac–Bac+2, >Bac+2), monthly household income in Euros (<1500, 1500–3000, >3000), and gender.

Measures of visiting a health care provider and receiving smoking cessation interventions

In Wave 1 and Wave 2, respondents were asked ''In the last 6 months, have you visited a doctor or other health professional?''. If respondents had visited a HCP they were then asked, ''During any visit to the doctor or other health professional in the last 6 months, did you receive . . . Encouragement or support for quitting smoking?, Additional help or a referral to another service to help stop smoking?, A prescription for stop-smoking medicine?, A short test in order to assess your level of dependence on cigarettes? and, pamphlets or brochures on how to stay quit? The response options were ''yes'', ''no'', ''refused'', or ''don't know''. When classifying respondents as having received an intervention from a HCP or not, a 'yes' response to any of the above interventions was defined as a response in the affirmative, while no intervention was taken as reporting 'no' for all of the above.

Smoking frequency and intentions to quit

In Wave 1 and Wave 2, respondents were asked ''Do you smoke every day or less than every day?''. In Wave 1 and Wave 2, respondents were asked ''Are you planning to quit smoking . . .'' and the response options were, ''Within the next month'', ''Within the next 6 months'', ''Sometime in the future beyond 6 months'', or ''Not planning to quit?''. Responses were derived as intending to quit (for any quit intention) or not intending to quit; this measure was dichotomized this way because our primary interest was not on the strength of the intention but rather whether people had an interest in quitting or not.

Analysis

Analyses were centered on four outcomes of interest; (i) identify the characteristics of smokers who visited a HCP in Wave 1 and Wave 2, (ii) the extent to which smokers who reported a visit to a HCP in the six months preceding the survey received any intervention related to their smoking behaviour, (iii) the extent to which the intervention was solely in the form of encouragement and support versus the latter accompanied by supplemental supports such as a pamphlet, prescription for stop-smoking medication, referral to a service to assist with smoking cessation or a dependence test and, (iv) what characteristics of the smoker, if any, predicted receiving any form of smoking cessation intervention.

Characteristics of smokers receiving an intervention by a HCP in the 6 months prior to Wave 2 were analyzed using logistic regression. The regression was used to portray current response and not changes between waves and was thus only run on Wave 2 data. The binary outcome variable of interest was any type of intervention versus no intervention at all. Predictors in the model included gender (binary), education level (categorical), age (continuous), smoking frequency (binary), income (categorical) and intention to quit (binary). The results presented are weighted and were very similar to the unweighted results, an indication of the robustness of the model fit. All analyses were run in STATA 10.0 SE.

Results

Frequencies of reporting visiting a HCP according to demographics, smoking frequency and intention to quit are reported in Tables 1a and 1b below, for Wave 1 and Wave 2 respectively.

Most respondents in Wave 1, (61%; n = 677, 95% CI: 57.9–64.6), and Wave 2, (58%; n = 642, 95% CI: 54.8–61.7) reported visiting a HCP in the previous 6 months. A greater proportion of female smokers in Wave 1, (67%; n = 398, 95% CI: 61.8–70.9) and Wave 2 (69%; n = 402, 95% CI: 64.5–73.3) reported they visited a HCP in the preceding 6 months compared to male smokers in Wave 1 (57%; n = 279, 95% CI: 52.0–61.8), and Wave 2 (49%; n = 240, 95% CI: 44.3–54.2). Among smokers reporting a recent visit

with a HCP, 46% in Wave 1 (n = 309, 95% CI: 42.0–50.6), and 36% in Wave 2 (n = 235, 95% CI: 31.1–40.6) reported having received a smoking related intervention. Of the smokers who reported they went to see a HCP in either Wave 1 or Wave 2, 50% (n = 418, 95% CI 46.0–53.8) reported receiving advice during either of those visits whilst of those reporting a visit to a HCP in both waves, 27% (n = 126, 95% CI: 22.5–31.5) reported receiving advice during *both* of their visits.

Considering the entire sample of smokers, the proportion that reported visiting a HCP and receiving advice was 28% in Wave 1 (n = 309, 95% CI: 25.4–31.5), and 21% in Wave 2 (n = 235, 95% CI: 18.5–24.0).

Considering the respondents who had been smokers during Wave 1 and were abstinent at the time of Wave 2 (quitters, n = 164), approximately 70% reported that they visited a HCP within the previous 6 months in Wave 1 (n = 112, 95% CI: 61.2–76.9) and 35% reported receiving a smoking cessation intervention (n = 40, 95% CI: 25.4–45.3). These proportions are not significantly different from those for smokers in Wave 1 who did not report they were abstinent in wave 2 (p>0.05).

The details of all interventions reported by smokers who visited a HCP in Wave 1 and Wave 2 are outlined in Table 2 below.

In Wave 1, of smokers who reported recently visiting a HCP, 33% reported receiving encouragement to quit (n = 214, 95% CI: 29.2–37.5); this was 28% in Wave 2 (n = 175, 95% CI: 23.7–31.7). The second most common smoking cessation intervention reported by smokers was receiving a pamphlet from a HCP; approximately a fifth (19.7%) of smokers reported receiving a pamphlet to help support quitting in Wave 1 (n = 135, 95% CI: 16.5–23.4), and the proportion was approximately 14% in Wave 2 (n = 89, 95% CI: 11.1–17.3).

The proportion of smokers who reported receiving a prescription for stop-smoking medicines from a HCP to help them quit smoking increased from approximately 3% in Wave 1 (n = 24, 95% CI: 2.0–5.1) to approximately 8% in Wave 2 (n = 53, 95% CI: 5.7–10.1).

In Table 3 the proportion of smokers who received encouragement in conjunction with an additional form of cessation support is reported.

Smokers visiting a HCP reported encouragement and a pamphlet as the most common combination of interventions received. In Wave 1 approximately 8% (n = 19, 95% CI: 4.8–13.2) of smokers who received an intervention, received both encouragement and a prescription to support smoking cessation. In Wave 2, there was an almost 3 fold increase in encouragement associated with a prescription to approximately 22% (n = 43, 95% CI: 15.7–28.9).

The results of the logistic regression model constructed with Wave 2 smokers showed that the smokers who reported receiving a smoking cessation intervention from a HCP did not differ significantly from smokers who did not report receiving an intervention, by gender, education level, or age. Respondents classified as having a high income were significantly less likely (OR 0.59, 95% CI: 0.4–0.99), compared to low income respondents, to report they received quitting encouragement or other cessation interventions (p = 0.047). Respondents who indicated they had intentions to quit were more likely (OR 1.9, 95% CI: 1.2–2.9), compared to smokers not planning to quit, to report an intervention from a HCP.

Discussion

Since the 1990s France has made considerable efforts to denormalize tobacco smoking and support smoking cessation.[18] The French National Authority for Health (*Haute Autorité de santé*, HAS) published in 2007 recommendations for health care professionals to improve efficiency and efficacy of smoking cessation interventions.[19] The current study demonstrates that HCP in France are well positioned to provide smoking cessation encouragement and other interventions to a majority of smokers. However, most smokers reported that their visit to a HCP did not include any intervention around tobacco use. Comparing France to other western countries, including Australia, Canada, Germany, Ireland, the Netherlands, New Zealand, the UK, and the US, the proportion of smokers who reported they visited and received encouragement to quit smoking is higher everywhere except the Netherlands.[6] This suggests there is an opportunity to increase HCP interventions in France.

It is important to note the national smoke-free law in France was successful in reducing smoking in public places and workplaces, including the hospitality sector.[20] An ineffective law would likely have less impact on denormalizing smoking and

Table 1a Estimated frequency of reporting visiting a health care provider in the previous 6 months according to population characteristics at Wave 1

Wave 1	Visited a HCP		Did Not Visit a HCP		Difference (chi-square)
	n	*Percent (95% CI)*	*n*	*Percent (95% CI)*	
Total Sample	677	61.3 (57.9, 64.6)	390	38.7 (35.4, 42.2)	
Male	279	57.0 (52.0, 61.8)	211	43.1 (38.2, 48.0)	$X^2 = 10.15$, p = 0.006
Female	398	66.5 (61.8, 70.9)	179	33.5 (29.1, 38.2)	
18–24	67	50.3 (40.7, 59.9)	70	49.7 (40.1, 59.3)	$X^2 = 15.40$, p = 0.045
25–34	150	63.1 (56.0, 69.7)	82	36.9 (30.3, 44.0)	
35–44	202	60.9 (54.5, 66.9)	112	39.1 (33.1, 45.5)	
45–54	165	65.5 (58.4, 72.0)	84	34.5 (28.1, 41.6)	
55–64	70	65.6 (54.1, 75.4)	34	34.5 (24.6, 45.9)	
65+	23	73.9 (54.3, 87.1)	8	26.1 (12.9, 45.7)	
Low Income	177	55.7 (49.3, 62.0)	124	44.3 (38.0, 50.7)	$\chi^2 = 7.83$, p = 0.137
Moderate Income	312	63.1 (58.0, 68.0)	169	36.9 (32.1, 42.0)	
High Income	174	64.0 (56.9, 70.5)	89	36.0 (29.5, 43.1)	
Low Education	258	51.9 (46.7, 57.0)	211	48.1 (43.0, 53.3)	$\chi^2 = 40.16$, p < 0.001
Moderate Education	265	66.2 (60.4, 71.5)	124	33.8 (28.5, 39.6)	
High Education	154	74.6 (67.3, 80.8)	54	25.4 (19.2, 32.7)	
Daily Smoker	602	60.2 (56.6, 63.8)	362	39.8 (35.3, 43.4)	$\chi^2 = 5.70$, p = 0.023
Non–Daily Smoker	75	73.0 (62.4, 81.6)	28	27.0 (18.4, 37.7)	
Intend to Quit	484	63.2 (59.1, 67.1)	268	36.8 (32.9, 40.9)	$\chi^2 = 4.29$, p = 0.071
Do not Intend to Quit	183	56.2 (49.6, 62.7)	117	43.8 (37.3, 50.4)	

Note: The survey sample size (n) figures are unweighted; the percentages and corresponding 95% confidence intervals are weighted.

Table 1b Estimated frequency of reporting visiting a health care provider in the previous 6 months according to population characteristics at Wave 2

Wave 2	Visited a HCP		Did Not Visit a HCP		Difference (chi-square)
	n	*Percent (95% CI)*	*n*	*Percent (95% CI)*	
Total Sample	**642**	**58.3 (54.8, 61.7)**	**425**	**41.7 (38.3, 45.2)**	
Male	240	49.3 (44.3, 54.2)	250	50.8 (45.8, 55.7)	$\chi^2 = 47.33$, $p < 0.001$
Female	402	69.1 (64.5, 73.3)	175	30.9 (26.7, 35.5)	
18–24	57	42.5 (33.3, 52.3)	80	57.5 (47.8, 66.7)	$\chi^2 = 28.34$, $p < 0.001$
25–34	140	62.2 (55.2, 68.8)	92	37.8 (31.2, 44.8)	
35–44	189	58.0 (51.7, 64.0)	125	42.0 (36.0, 48.4)	
45–54	160	62.9 (55.8, 69.5)	89	37.1 (30.5, 44.3)	
55–64	73	64.2 (52.4, 74.4)	31	35.9 (25.6, 47.6)	
65+	23	74.0 (53.8, 87.5)	8	26.0 (12.6, 46.2)	
Low Income	168	54.8 (48.3, 61.1)	128	45.3 (39.0, 51.7)	$\chi^2 = 3.57$, $p = 0.463$
Moderate Income	285	57.5 (52.4, 62.5)	198	42.5 (37.5, 47.6)	
High Income	176	62.4 (55.2, 69.1)	89	37.6 (30.9, 44.8)	
Low Education	245	51.0 (45.8, 56.1)	218	49.0 (43.9, 54.2)	$\chi^2 = 24.42$, $p < 0.001$
Moderate Education	234	60.7 (54.8, 66.3)	150	39.3 (33.7, 45.2)	
High Education	163	70.7 (63.0, 77.4)	56	29.3 (22.7, 37.0)	
Daily Smoker	565	57.4 (53.7, 61.0)	390	42.6 (39.0, 46.3)	$\chi^2 = 3.34$, $p = 0.0951$
Non–Daily Smoker	77	66.8 (56.0, 76.0)	35	33.2 (24.0, 44.0)	
Intend to Quit	452	60.8 (56.6, 64.9)	263	39.2 (35.1, 43.4)	$\chi^2 = 5.44$, $p = 0.042$
Do not Intend to Quit	190	53.3 (47.2, 59.3)	159	46.7 (40.7, 52.8)	

Note: The survey sample size (n) figures are unweighted; the percentages and corresponding 95% confidence intervals are weighted.

Table 2 Reported smoking cessation interventions received from a doctor or other health professional among those reporting a visit to a health care provider in the past 6 months

Did you Receive . . . from your doctor or other health professional	Wave 1		Wave 2	
	n	*Percent (95% CI)*	*n*	*Percent (95% CI)*
Encouragement or support for quitting smoking?	214	**33.2** (29.2–37.5)	175	**27.5** (23.7–31.7)
Pamphlet or brochures?	135	**19.7** (16.5–23.4)	89	**13.9** (11.1–17.3)
A prescription for stop-smoking medicine?	24	**3.2** (2.0–5.1)	53	**7.6** (5.7–10.1)
A short test in order to assess your level of dependence on cigarettes?	89	**13.0** (10.3–16.2)	49	**6.8** (4.9–9.3)
Referral to another service to help you?	24	**3.2** (2.0–5.0)	25	**3.6** (2.4–5.4)
None of the above	368	**53.7** (49.4–58.0)	407	**63.7** (59.4–67.9)

Note: The survey sample size (n) figures are unweighted; the percentages and corresponding 95% confidence intervals are weighted. Column percentages do not sum to 100% due to smokers being able to report more than one option.

consequently less impact on smokers' intentions to quit and other quitting behaviours. Based on the literature, impacts of smoke-free legislation on quitting behaviour are temporary and there is evidence that smoke-free laws are not associated with reduced smoking prevalence.[21] Nevertheless, during times of smoke-free law implementation quitting intentions and other quitting behaviours increase.[9–13] Therefore there may be a unique window of opportunity to engage and support smokers in cessation during the time of implementation of these laws. For the majority of smokers in France, the HCP they visited missed this opportunity.

In Wave 2 it was found that smokers who were planning to quit were almost twice as likely to report a HCP provided encouragement or other supports. It may be that HCP–patient discussions about smoking and cessation are mainly originating from patients. Health communication campaigns to increase cessation may do well to focus on encouraging patients to seek support from a HCP.

Of smokers that reported they did receive an intervention to quit in Wave 2, just over half also received tools such as a pamphlet or a prescription to assist with quitting suggesting that there is considerable opportunity to improve the depth of interventions with patients. It is worth noting that the proportion of smokers that reported receiving prescriptions to assist with smoking cessation increased significantly in Wave 2. This could be due, in part, to the French policy of providing reimbursement for nicotine substitutes (implemented in February 2007) of up to 50 Euros per person per year, as this subsidy was not available during Wave 1 of the survey.

The proportion of quitters that reported they had visited a HCP and received an intervention was not significantly different than non-quitters in Wave 1. It will be important to continue to follow respondents to better understand how different interventions may influence or support sustained abstinence.

Time constraints may be a barrier to providing smoking cessation interventions and, depending on the patient's presenting symptoms, HCP may decide during their patient counseling time to address behaviours or risk factors other than tobacco use. One study has suggested that physicians in the Netherlands are reluctant to provide encouragement or other interventions since tobacco use is considered the right of their patients.[6] Other studies in Europe have found that physicians are concerned that providing cessation advice might jeopardize the doctor-patient relationship.[22] A recent survey of general practitioners in France found that two-thirds reported discussing tobacco consumption at least once with each patient.[23] The proportion of general practitioners who used tobacco dependence scales also dramatically increased between 2003 and 2009 from 6% to 34%. However, the present results suggest that

Table 3 Encouragement or encouragement in conjunction with an additional form of smoking cessation intervention among those receiving encouragement from a doctor or other health professional in the past 6 months

Did you Receive . . . from your doctor or other health professional	Wave 1		Wave 2	
	n	Percent (95% CI)	n	Percent (95% CI)
Encouragement only	117	**58.1** (50.4–65.5)	85	**48.8** (40.3–57.2)
Encouragement + Pamphlet	69	**30.7** (24.1–38.3)	52	**30.5** (23.1–39.2)
Encouragement + Dependence Test	46	**20.5** (15.0–27.4)	32	**17.0** (11.7–24.2)
Encouragement + Prescription	19	**8.0** (4.8–13.2)	43	**21.6** (15.7–28.9)
Encouragement + Referral	18	**7.2** (4.2–12.0)	19	**9.4** (5.8–15.0)

Note: The survey sample size (n) figures are unweighted; the percentages and corresponding 95% confidence intervals are weighted. Wave 1 n = 214, Wave 2 n = 175, note column percentages do not sum to 100% due to smokers being able to report more than one option.

this first questioning does not systematically lead to a regular follow-up and that tobacco cessation counseling is lacking in family physician practice. Further research in France focusing on understanding what barriers may exist to improving rates of brief physician cessation advice would be beneficial.

Further, it would be beneficial to understand if smokers are more or less open to hearing about cessation supports when jurisdictions are implementing smoke-free policies and whether or not it is best to try and address smoking before or after smoke-free laws are in place.

National cessation strategies need to reach all segments of the population and recognize that HCP may not reach all smokers. This study found that men and people with lower levels of education reported visiting a HCP less frequently than women and high education groups. These findings are particularly important given the high smoking prevalence and the higher reports of difficulties to quit smoking found in low education populations in France.[24] This paper found that of the smokers who reported visiting a HCP, those that received advice or other supports did not differ significantly based on gender, age, or education; however, those with higher incomes were less likely to receive advice relative to those with lower incomes. It is unknown why income would be associated with rates of intervention but it is possible that lower income smokers are more likely to present with smoking-related symptoms. It is also possible that HCP are concerned with lower income patients spending money on cigarettes. These findings differ from one of the few other similar studies conducted in the United States which found that women and older patients were more likely to receive advice to quit smoking compared to men and younger people respectively.[25] Further, the US study found that lower education is significantly associated with lower rates of advice to quit.

From the ITC France Survey, it is impossible to ascertain which type of HCP provided encouragement or other interventions. Given the evidence that advice from any HCP will achieve increased quit rates,[4] national cessation systems may wish to build capacity with HCP beyond family practitioners including obstetricians, dentists, pharmacists, nurses, and optometrists. Since the survey waves were conducted prior to the first phase of the national smoke-free law, and several months after the hospitality ban, it is possible the optimal time for increased quitting behaviour was missed – which would presumably be immediately following the ban.

Future ITC surveys in France will continue to monitor smokers' reporting of physician interventions and quitting behavior in relation to other population-level interventions that have been implemented since the second wave of the survey, including graphic warning labels, increases in cigarettes prices and several public campaigns about smoking-related risks and tobacco cessation. Future studies will review how HCP encouragement and other interventions are associated with quit attempts, cessation, and sustained smoking abstinence.

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