

Introduction

Why Do People Smoke?

Smoking prevention has been on the agenda for health professionals and politicians, NGOs, Member States and the European Commission for several years now. Nevertheless, approximately one third of the adult population throughout Europe still smokes (this figure is lower in some countries, in others higher), despite the fact that people are fully aware of the risks of smoking and know that the rate of tobacco-related diseases and deaths is high. It is estimated that tobacco kills some 650,000 Europeans every year, i.e. one in seven of all deaths across the EU. Smoking harms nearly every organ of the human body, causing a wide range of diseases. Half of all regular smokers will be killed by their smoking and smokers who die in middle-age lose on average 22 years of life, with a large proportion of that shortened life span being spent in ill health. Over 13 million more Europeans suffer from a serious and chronic disease directly related to their smoking. In addition, it is estimated that passive smoking kills more than 79,000 adults every year in the EU25. Evidence also exists that passive smoking at the workplace accounted for some 7000 deaths in 2002, while exposure at home was responsible for a further 72,000 deaths¹.

However, the fight against tobacco has had a significant impact. Nearly two decades ago smoking prevalence for males was around 50%; this figure has been successfully reduced by as much as 15% to 20%. Thousands of lives have been saved and in addition an important message is sent out: tobacco control works. Nevertheless, smoking remains the largest single cause of preventable death and disease in Europe. In some Member States smoking rates for women are on the rise and in some European countries the average age for smoking initiation is eleven years.

Therefore, a need still exists to understand better what reasons people have to continue to smoke. The main focus of this report is on the individual smoker, how nicotine affects the body and why the individual smokes. Issues such as how the body reacts to tobacco are also raised. Certain myths surrounding tobacco and the reality are compared. Do cigarettes really have a calming effect when we feel stressed? Can cigarettes be a substitute for food? Does smoking help us lose weight? These are just a few of the popular (mis)conceptions that are examined in the report. Several leading scientists share their knowledge, based on years of research in their expert fields, of how tobacco affects both the body and the mind.

The tobacco industry itself also has a vested interest in understanding why people smoke and has funded many studies to this end. Internal documentation provides some crucial insights. One of the most important factors is that nicotine, delivered from tobacco by smoking or oral use, is a highly addictive drug. The tobacco industry was aware of this fact already in the early 1960s.

The most common form of nicotine delivery is cigarette smoking. Cigarette smokers have precise control of their nicotine intake. The very rapid absorption of nicotine (once tobacco smoke is in the lungs, nicotine takes just ten seconds to reach the brain) and the high blood pressure levels that result, promote rapid and strong behavioural reinforcement from smoking.

Chapter 1 of this study examines how the tobacco industry uses its knowledge of the different reasons people have for smoking in various marketing campaigns. In fact, the tobacco industry understood from quite early on how to tailor marketing to specific target groups in such a way that these target groups will respond to the subliminal messages being put out, by exploiting their weaknesses, preferences and tastes.

Chapter 2 provides important insights into the role of nutrition in the uptake/quitting of smoking. It also demonstrates how tobacco smoking and an unhealthy diet together are the most modifiable risk factors for excess morbidity and mortality at the population level.

Chapter 3 discusses drug and substance use in association with smoking and how cigarette smoking is a high co-morbidity factor in drug and substance use disorders. An important aspect is the discussion on why most drug abuse treatment programmes discourage simultaneous smoking cessation because it is assumed that only one addiction behaviour can be targeted at a time.

Chapter 4 examines the associations between alcohol consumption, dependence and smoking. Smoking rates are twice as high in alcohol abusers than in the general population. Alcohol-dependent smokers represent a specific group of smokers with higher cigarette consumption and nicotine dependence and higher mental and physical impairments. The mechanisms underlying the link between smoking and drinking are examined closely.

Chapter 5 continues the discussion pointing towards the heavy incidence of smoking in mental hospitals and its impact on both patients and health professionals. This chapter also studies the myth that smoking has a calming effect and asks whether this really is the case or whether it is rather nicotine dependency that kicks in.

Chapter 6 looks at the need for physical activity and how it is routinely recommended as an aid in smoking cessation. The chapter examines the benefits of physical activity as an aid in smoking cessation.

Chapter 7 discusses how pharmacogenetic research into smoking behaviour and smoking cessation provides insights into understanding why people smoke and how we can better help people to quit smoking.

Chapter 8 provides an overview of patterns, trends and causes of socio-economic inequalities in smoking in the European Union. As smoking is increasingly more concentrated in lower socio-economic groups, reaching these groups is essential to achieve significant reductions in tobacco consumption across Europe. It is primarily among men and women with socio-economic disadvantaged backgrounds where most work has to be done in the fight against tobacco.

Chapter 9 focuses specifically on women. Throughout Europe a trend is evident: female smoking has been on the rise for several years now, while male smoking has been on the decline. The chapter examines women's reasons for taking up and maintaining smoking, which are quite different from men's.

Finally, the additional material contained in the CD included with this publication features a report presenting an overview of a qualitative and quantitative study in five countries that was commissioned by ENSP and conducted by Ipsos MORI Social Research Institute during November and December 2005 (qualitative phase) and January and February 2006 (quantitative phase). The project team comprised Michele Corrado, Director of Health and Social Research and Mehreen Chandan, Research Executive. The first qualitative phase informed the development of the quantitative phase. In the qualitative phase four discussion groups were held in each country, one per category of smokers, i.e. heavy, medium, light and ex-smokers. In the quantitative study, all data have been weighted to the known profile of the adult population of each country. Telephone surveys were carried out among representative samples of approximately 1000 adults, aged 16+, in each of the five European countries. The main objectives of both phases of the study were to examine (1) the full range of underlying reasons why people smoke and (2) the influences on smoking uptake.

Likewise included in the CD is a graphical summary of the overall results for the motivations involved in smoking, prepared by Julia Critchley, Senior Lecturer in Epidemiology at Newcastle University, UK. This summary also endeavours to provide an interpretation of the figures obtained across countries.