



## **ASH Scotland's response to the Scottish Government's consultation on Better Coronary Heart Disease and Stroke Care**

October 2008

### **Introduction**

ASH Scotland is pleased to submit a response to the Scottish Government's consultation on Better Coronary Heart Disease and Stroke Care. Our response will focus on areas where ASH Scotland's tobacco control remit has a bearing on CHD and stroke care and prevention.

ASH Scotland, as the leading voluntary organisation for tobacco control in Scotland, is especially concerned about the strong links between smoking and both coronary heart disease (CHD) and cardiovascular disease (CVD); about the need for stronger action on youth smoking prevention in order to foster a culture of healthy lifestyles; about the large and growing health inequalities and the role of tobacco use as a cause – but also as a symptom – of such inequalities; and about the need for smoking cessation to play a key role in cardiac rehabilitation for smokers.

In particular, ASH Scotland would like to see the following actions to help tackle the role of smoking in causing heart disease and stroke:

- effective tobacco control measures aimed at preventing young people from becoming smokers
- sustained funding for smoking cessation services, giving these services the confidence to plan for the future
- tobacco control policies aimed at reducing the significant health inequalities that exist within Scottish society
- a recognition that smoking cessation advice should form part of cardiac rehabilitation for smokers.

### **Smoking, stroke and heart disease**

The links between smoking and heart disease are well documented.<sup>1</sup> Death from CHD is 50% higher in smokers (and over 75% higher in heavy smokers)

than in non-smokers; death from CVD is around 60% higher in smokers (and 85% higher in heavy smokers) compared to non-smokers.<sup>2</sup> It is estimated that in 2000, around 30,600 deaths or 27% of all smoking attributable deaths in the UK were due to CVD.<sup>3</sup>

Smokers are almost twice as likely to have a heart attack as people who have never smoked because smoking:

- causes a build up of fatty material in the arteries
- produces carbon monoxide which deprives the heart of oxygen and reduces the ability of blood to transport oxygen around the body
- causes blood platelets to become stickier and more likely to clot
- produces nicotine which causes blood pressure to rise, forcing the heart to work harder.

Giving up smoking is the single most modifiable lifestyle factor which smokers can change to protect their hearts.

Smoking, because it causes arteries to clog, can also increase the risk of stroke. Stopping smoking can cut the risk of a stroke in half, irrespective of how old a person is or how long they have smoked.<sup>4</sup>

### **Healthy lifestyles**

ASH Scotland welcomes government support for actions designed to promote healthy lifestyles, particularly measures to prevent smoking initiation among young people and increased support for smoking cessation services.

Around 15,000 young Scots become smokers each year,<sup>5</sup> and ASH Scotland considers that measures designed to reduce the availability and visibility of tobacco products to young people can help to reduce this figure.

The Scottish Government is to be commended for the publication earlier this year of *Scotland's Future is Smoke-Free: a Smoking Prevention Action Plan*,<sup>6</sup> in which it laid out a number of areas where action to tackle youth smoking initiation could be taken through both legislative and non-legislative means. The pledge to introduce a health bill during the coming parliamentary year that will include a register of tobacco retailers and further restrictions on the display of tobacco products in retail outlets was also welcomed by ASH Scotland.

These legislative measures will be most effective when set against a backdrop of enhanced health education and promotion, and ASH Scotland was pleased to see that the action plan included strong action under this heading.

As well as tackling youth smoking initiation, existing smokers should also be supported to quit. But government funding for smoking cessation services is being pegged at 2008-09 levels for the next three years, leading to a real

terms drop in funding<sup>7</sup>. ASH Scotland is concerned that this real terms reduction, combined with the short term nature of the funding settlement, means that Scottish smoking cessation services frequently find themselves without the long term financial stability required to plan for the future. We consider that smoking cessation professionals working within the health service should receive permanent contracts, as do other vital health workers.

ASH Scotland does welcome the additional funding allocated for pharmacy led smoking cessation advice, although it remains to be seen how effectively this new scheme will be integrated with existing smoking cessation services.

## Health inequalities

Health inequalities arise for a number of different reasons. But there is abundant evidence of a strong connection between smoking, ill-health and socio-economic deprivation. These statistics demonstrate the link:

- smoking rates among the most deprived decile of the population are almost four times higher than rates among the least deprived decile<sup>8</sup>
- among pregnant women, the smoking rates for the most deprived quintile are up to six times higher than for the least deprived quintile<sup>9</sup>
- the proportion of deaths attributable to smoking is around 32% for the most deprived quintile, and around 15% for the least deprived quintile. It is likely that this inequality could increase over the coming years, reflecting an increasing inequality of prevalence and the time lag between starting smoking and its effect on mortality<sup>10</sup>
- 41% of adults who live in deprived areas smoke, compared with 13% in the most affluent areas<sup>11</sup>
- around half of the reduced life expectancy faced by poor communities is accounted for by tobacco use<sup>12</sup>
- as a proportion of their expenditure, the poorest households spend over five times more on tobacco than the richest<sup>13</sup>
- one or both parents smoke in 70% of two-parent households on income support<sup>14</sup>
- in such households, around 15% of disposable income is spent on cigarettes<sup>15</sup>
- young smokers from deprived backgrounds are more likely to carry on smoking into adulthood than young smokers from more affluent backgrounds.<sup>16</sup>

When it comes to smoking-related ill-health, the gulf between rich and poor is growing. In 1961, there was no difference in lung cancer mortality between the social classes, but by the 1980s a man in an unskilled manual occupation was more than four times as likely to die of lung cancer as a professional and twice as likely to die of coronary heart disease. For women there is a threefold difference for lung cancer and a fourfold difference for heart disease.<sup>17</sup>

Between 1972 and 2004, smoking rates of highly skilled Scottish workers fell from 45% to 14%, while among low-skilled workers, the fall was from 50% to

33% over the same period. The gap in smoking rates between high- and low-skilled workers grew therefore from 5 to 19 percentage points.<sup>18</sup>

Smoking rates are also correlated with employment status. It is known that economically inactive members of all socio-economic classes are more likely to smoke than those who are in work. Around 45% of unemployed routine and manual workers smoke, compared with around 35% of their employed counterparts.<sup>19</sup>

ASH Scotland considers that while effective cessation services should be available to all smokers, increased efforts should be made to ensure that harder to reach groups are fully engaged with, including those not in employment, education or training, or those who are in occupations or settings with higher than average smoking levels.

Cessation services and prevention policies should be tailored to the specific requirements of those groups with the highest smoking levels.

## **Services for CHD**

### *Cardiac rehabilitation*

Cardiovascular disease remains a major cause of death among the one in four Scottish adults who continue to smoke. Evidence shows that smoking cessation results in a 36% reduction in relative risk of mortality.<sup>20</sup> But the addictive nature of nicotine means that many people find it extremely difficult to stop smoking, and only 2-3% of those who make quit attempts by themselves will remain abstinent after one year.<sup>21</sup>

While many cardiac patients manage to remain abstinent while in hospital following a cardiac event, without active smoking cessation advice they may relapse soon after leaving hospital and not make another quit attempt. Active smoking cessation advice should therefore be part of any cardiac rehabilitation process, with physicians and nursing staff having a key role in prompting quit attempts by advising smokers of the health risks of continued smoking, and the health benefits of stopping. All patients should be asked if they smoke, and all smokers who are motivated to make a quit attempt should be referred to specialist stop smoking services to increase their chances of success.<sup>22</sup>

While the nicotine in tobacco smoke is harmful to the cardiovascular system, nicotine replacement therapy and medications such as bupropion are safe to use in smokers with stable cardiovascular disease. Even in patients with unstable CVD, the risks of using NRT are small in relation to the risks of continued smoking.<sup>23</sup>

ASH Scotland recommends that all staff involved in the care and treatment of cardiac patients should receive appropriate training in the impacts of smoking on CHD and CVD, the benefits of smoking cessation to cardiac patients, the

importance of early interventions for all cardiac patients, and the usefulness of NRT and other medications in successful smoking cessation.

## Conclusion

Smoking remains the largest single preventable cause of ill-health and premature death in Scotland, with it being a significant risk factor for CHD, CVD and stroke. The single most modifiable lifestyle factor which smokers can change to protect their hearts is to give up smoking.

ASH Scotland considers that in order to minimise the incidence of heart disease and stroke within Scotland, efforts should be targeted at both smoking cessation and youth smoking prevention. Both policies must seek to address the very real health inequalities that exist in Scotland and which are strongly linked to inequalities in smoking prevalence.

As well as helping to reduce the numbers of people affected by smoking-related heart disease, additional resources for smoking cessation as part of cardiac rehabilitation can help to prevent the recurrence of life-threatening cardiac events.

## Sources

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