Taking Forward the Government Economic Strategy: A Discussion Paper on Tackling Poverty, Inequality and Deprivation in Scotland

June 2008

Executive Summary

- **Smoking has long been recognised as the biggest single preventable cause of ill-health and premature death in Scotland**
- **ASH Scotland asks the Government to consider adding a key principle that explicitly acknowledges the relationship between poverty, inequalities and deprivation and ill-health**
- **There is a strong correlation between smoking prevalence and socio-economic background, and the gulf in smoking rates, tobacco consumption and accessing quit services between rich and poor is growing**
- **ASH Scotland fully endorses the recommendation of the Ministerial Task Force on Inequalities that smoking cessation and prevention efforts within deprived communities should be prioritised**

Introduction

ASH Scotland welcomes the opportunity to engage with the Scottish Government's Discussion Paper on Tackling poverty, Inequality and Deprivation in Scotland. ASH Scotland, being the leading voluntary organisation for tobacco control in Scotland, is especially concerned about the health inequalities surrounding smoking, poverty and deprivation.

ASH Scotland considers that efforts to tackle both the causes and symptoms of poverty and deprivation are intrinsically worthwhile. Scotland's greatest asset is its people, and it is clearly unacceptable that such a significant minority of the Scottish population continues to live in poverty. But there are also powerful health arguments for tackling the inequalities linked with poverty and deprivation, not least those associated with smoking.

The negative impacts of smoking

Smoking has long been recognised as the biggest single preventable cause of ill-health and premature death in Scotland.

In 2004, the most recent year for which we have data, it was estimated that almost 13,500 deaths – nearly one in four of all deaths in Scotland – were attributed to smoking.[1] We know that smoking is linked to diseases of the heart and blood vessels, the lungs, stomach, kidneys and other organs. As a result, smoking-related illnesses cost the NHS in Scotland an estimated £200 million each year.[2] The total costs to the wider Scottish economy have been estimated at £837 million per year. [3] Among men in 2004, 40% of all cancer deaths and 91% of lung cancer deaths were attributable to smoking. For women, the figures were 29% and

88% respectively.[4] For men and women aged between 35 and 69, 22 years of life were lost on average per death from smoking.[5]

The Government's discussion paper

ASH Scotland asks the Government to consider adding a key principle that explicitly acknowledges the relationship between poverty, inequalities and deprivation and ill-health

ASH Scotland supports policies that will reduce inequalities and lift people out of poverty. The key principles that the Government has identified are all to be welcomed, but ASH Scotland believes that a further principle – an explicit acknowledgement that there is a relationship between poverty, deprivation and ill-health – should be considered.

ASH Scotland also welcomes the three key action areas, in particular that action to tackle poverty should address both the causes and the symptoms of the problem.

Smoking, poverty and deprivation

There is a strong correlation between smoking prevalence and socio-economic background, and the gulf between rich and poor is growing

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 [6]
- Among pregnant women, the smoking rates for the most deprived quintile are up to six times higher than for the least deprived quintile [7]
- 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[8]
- 41% of adults who live in deprived areas smoke, compared with 13% in the most affluent areas [9]
- Around half of the reduced life expectancy faced by poor communities is accounted for by tobacco use [10]
- As a proportion of their expenditure, the poorest households spend over five times more on tobacco than the richest [11]
- One or both parents smoke in 70% of two-parent households on income support [12]
- In such households, around 15% of disposable income is spent on cigarettes [13]
- Young smokers from deprived backgrounds are more likely to carry on smoking into adulthood than young smokers from more affluent backgrounds [14]

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.[15]

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%.[16]

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.[17]

It is clear that if we are to take effective action to tackle Scotland's stark health inequalities, then action to tackle our smoking rates must be part of the solution.

Reducing smoking-related health inequalities

ASH Scotland fully endorses the recommendation of the Ministerial Task Force on Inequalities that smoking cessation and prevention efforts within deprived communities should be prioritised

Given the strong cyclical relationship between poverty, deprivation and ill-health, it is possible that the only certain way to tackle Scotland's poverty-related health inequalities is to tackle the root causes of Scotland's poverty itself. There are however ways to mitigate the smoking-related health effects of poverty in the short to medium term.

Reducing the prevalence of smoking relies both on preventing young people from taking up smoking, and helping existing smokers to quit. There is, however, evidence that young people from deprived communities are more likely to carry on to become adult smokers than their more affluent counterparts, and that adult smokers in deprived areas perceive a lack of support to help them to stop smoking. Cessation rates are three times lower among the least well-off in society compared with the wealthiest.[18]

There are a number of reasons why those in deprived households and communities are more likely to smoke and less likely to quit. These include poverty and coping with living in a disadvantaged environment; unemployment; a pro-smoking culture reinforced by use of cigarettes to foster social participation and belonging; limited experience of environments which encourage cessation; and limited experience of cessation.[19] Other factors which reinforce smoking as a social norm – including advertising and visible displays of tobacco in shops – also make it harder for people to quit.[20]

The web of interactions linking smoking, ill-health, reduced quality of life, reduced economic wellbeing and deprivation is complex. While there is strong evidence to show that people in deprived communities are more likely to smoke, there are also potentially powerful feedback mechanisms at work. The ill-health caused by smoking, for example, can lead to reduced earning power and lower economic wellbeing. The financial stress that this causes can mean that people in this situation are more likely to continue to smoke and less likely to quit.[21]

The following policies all have a part to play in tackling smoking prevalence, particularly in deprived communities:

- Ensuring that all smokers have easy access to effective, supportive and ongoing cessation services
- Incrementally raising the price of tobacco products, while clamping down on the supply of illicit tobacco
- Embedding health education messages about smoking within all schools and children's services, and encouraging all schools and youth groups to adopt clear no-smoking policies
- Taking steps to engage with harder to reach groups, including those not in employment, education or training, or those who are in occupations or settings with higher than average smoking levels
- Developing cessation services and prevention policies tailored to the specific requirements and circumstances of those groups with the highest smoking levels
- Taking steps to minimise the availability, visibility and affordability of tobacco products to young people
- Reducing the social acceptability and cultural ubiquity of smoking within the most deprived sections of Scottish society

- Encouraging other agencies with whom smokers from deprived communities are likely to come into contact (benefits agencies, social work departments etc) to consider offering advice on smoking cessation.

The recently published Smoking Prevention Action Plan[22] offers Scotland the opportunity to introduce policies that will help to address the circumstances that lead to around 15,000 young Scots from becoming smokers each year.[23] Equally Well[24], the report of the Ministerial Task Force on Inequalities, contains a recommendation that:

> *"It should be a key priority within the Government's smoking strategy that NHS Boards and their local partners act to prevent young people in deprived communities from smoking, and to provide more effective support to smokers in those communities to quit."*

ASH Scotland is strongly supportive of this approach.

Policies to tackle the prevalence of smoking must always be introduced within the context of wider health initiatives, taking into account the various reasons why those living in poverty and deprivation are more likely to smoke in the first instance. Tobacco control initiatives, in order to remain relevant and fit for purpose, need to be sensitive to exclusion and to life circumstances from childhood to old age, and cessation services need to be specially tailored with and for socially excluded groups.

Conclusion

Smoking remains the largest single preventable cause of ill-health and premature death in Scotland. There is a clear correlation between smoking prevalence and socio-economic background, with those living in poverty and deprivation being significantly more likely to smoke – and to suffer the negative health consequences of smoking – than their more affluent counterparts.

While the relationships between smoking, ill-health and deprivation are complex, ill-health caused by smoking contributes to keeping poor people in poverty. Reducing smoking prevalence by preventing young people from becoming smokers and helping existing smokers to quit will help to deliver a healthier, more prosperous and more socially equitable Scotland.

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