Working for a tobacco-free Scotland

Single Outcome Agreements

A short briefing setting out the extent to which tobacco-related targets have been incorporated into the 2009 agreements between local authorities and the Scottish Government, a comparison between the smoking content of the 2008 and 2009 sets of agreements, and a list of targets relating to smoking that Community Planning Partnerships may consider including in SOA documents from 2010 onwards.

1. Introduction

During the summer of 2008, each of Scotland's 32 local authorities entered into a Single Outcome Agreement (SOA) with the Scottish Government, an agreement spelling out the actions that the councils would take in striving to meet a number of government-led national outcomes. The SOAs were designed to ensure that in return for government funding, each council would deliver a set of agreed outcomes, measured by specific indicators.

Following the publication of the 2008 SOA documents, ASH Scotland carried out an analysis of each of the 32 SOAs to identify the tobacco control related outcomes that each council had included. The 2008 analysis, available on the ASH Scotland website, shows that there is a wide variation in the tobacco control content of the 32 documents, with some councils including a range of challenging smoking-related indicators in their SOAs and others virtually failing to acknowledge the issue at all.

The SOAs were widened and updated in 2009 to become Community Planning Partnership (CPP) level documents, providing further opportunities to develop joined-up tobacco control work between agencies including health boards, fire and rescue services and local authority services such as education, health improvement and regulatory enforcement.

This document sets out – in general terms – the findings of ASH Scotland's 2009 analysis. While we recognise that an issue's absence within a written agreement does not necessarily mean a lack of action on the ground, we must conclude that many Scottish CPPs are still failing at strategic level to take full advantage of the long-term health benefits to be gained by explicitly embedding tobacco-related targets in their SOA documents.

2. National Outcomes and indicators

It is clear that resolute action at a CPP level to tackle smoking rates among both adults and young people, and to prioritise smoking cessation and prevention, will be vital if national outcomes are to be fully achieved. The following four national outcomes are most likely to be progressed through comprehensive tobacco control programmes:

- outcome 5: Our children have the best start in life and are ready to succeed
- outcome 6: We live longer, healthier lives
- outcome 7: We have tackled the significant inequalities in Scottish society
- outcome 8: We have improved the life chances for children, young people and families at risk.

Beneath the fifteen top level national outcomes lie a further 45 national indicators and targets. At this level we see the first direct reference to smoking: Indicator 17 aims to *Reduce the percentage of the adult population who smoke to 22% by 2010*. Other indicators where effective tobacco control can make a significant contribution include:

- indicator 16: Increase healthy life expectancy at birth in the most deprived areas
- indicator 21: Reduce mortality from coronary heart disease among the under-75s in deprived areas.

In addition to indicators such as these with a direct link to tobacco control, there are a number of indicators where effective tobacco control work can also make a contribution:

- indicator 10: Decrease the proportion of individuals living in poverty
- indicator 41: Improve people's perceptions, attitudes and awareness of Scotland's reputation
- indicator 43: Improve people's perceptions of the quality of public services delivered
- indicator 44: Improve the quality of healthcare experience.

3. Inclusion of smoking-related indicators within SOA documents

Smoking prevalence targets as indicators

The majority of CPPs include either the national or a local target for smoking prevalence. Six agreements include the national smoking prevalence target for either adults, young people or pregnant women[i], while 19 set their own local target. Many of the local targets are for reduced smoking rates by pregnant women or young people; eight agreements set their own quantitative smoking prevalence target for the adult population.

Smoking cessation targets as indicators

In total, 12 CPPs have adopted the NHS HEAT smoking cessation target of 8% of smokers being successfully quit at one month over the period 2008/09 - 2010/11. Fourteen have set themselves individual smoking cessation targets, with seven agreements adopting both the national 8% target and a local target of their own.

Altogether, 13 CPPs have set neither the national nor an individual target for smoking cessation. Again, ASH Scotland considers that this is a missed opportunity to show progress towards National Outcomes 6 and 7.

No smoking prevalence or cessation indicators

In 2008, five councils submitted SOAs that did not include any indicators for smoking prevalence or cessation. The 2009 round of SOA documents showed that this figure had fallen to three. Interestingly, the three CPPs failing to include smoking-related targets in 2009 were different from the five councils in this position in 2008.

Cancer and heart disease-related indicators

Smoking is closely linked with the increased incidence of a number of cancers, particularly lung cancer. Around 90% of lung cancers in men and 83% in women are estimated to be caused by the use of tobacco, either smoked directly or through indirect exposure.[1] As well as lung cancer, smoking is also associated with cancers of the pancreas, stomach, bladder, liver, kidney, larynx, oesophagus, oral cavity, cervix, and with myeloid leukaemia.[2,3]

[i] The Scottish Government has set targets of reducing the percentage of the adult population smoking to 22% by 2010; reducing the percentage of women who smoke during pregnancy to 20% by 2010; reducing the percentage of 13 year old smokers to 3% for girls and 2% for boys by 2014; reducing the percentage of 15 year old smokers to 14% for girls and 9% for boys by 2014; reducing the percentage of 16-24 year old smokers to 20.9% by 2012.

Heart disease is also closely linked with smoking. Death from coronary heart disease is 50% higher in smokers (and over 75% higher in heavy smokers) than in non-smokers; death from any cardiovascular disease is around 60% higher in smokers (and 85% higher in heavy smokers) compared to non-smokers[4]. It is estimated that in 2000 around 30,600 deaths or 27% of all smoking attributable deaths in the UK were due to cardiovascular disease[5].

Only eight out of the 32 CPPs included some form of target for the incidence of cancer, while 26 CPPs included a target for the incidence of heart disease. Of these, 12 focussed their targets solely on those living in deprived areas, while 14 applied their targets to the entire population. Only five councils included quantitative targets for heart disease mortality; the remainder seek generally to reduce the incidence of heart disease.

Inequalities-related indicators

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. Smoking rates among the most deprived decile of the population are almost four times higher than rates among the least deprived decile,[6] and this gulf looks set to widen in the future. 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 both mortality and life expectancy.[7] It has been calculated that around half of the reduced life expectancy faced by poor communities is accounted for by tobacco use.[8]

All but seven of the 32 Scottish CPPs included some form of indicator related to addressing health inequalities.

Of the 25 which did include targets related to inequalities:

- seven were for reduced smoking prevalence in deprived communities
- five were to address smoking prevalence among deprived pregnant women
- two related to general health inequalities
- six sought to improve life expectancy in deprived communities
- 19 set targets to tackle heart disease within deprived communities
- three set targets to reduce all cause mortality within deprived communities.

While a clear majority of councils set themselves indicators to address health inequalities, less than half of these adopted indicators specifically relating to smoking.

Other indicators, including fires and fire casualties and service delivery

In 2007, smokers' materials (i.e. cigarettes, cigars or pipe tobacco) were the most common ignition source for accidental dwelling fire deaths, accounting for 20 out of 40 fatal casualties in Scotland.[9]

26 of Scotland’s 32 councils included targets to reduce fires and fire casualties. 15 of these were specific quantitative targets; the others merely seek to “reduce” the incidence of fires.

A number of smoking-related services, including the delivery of smoking cessation services and the enforcement of smoke-free legislation, are provided by community planning partners. While a small number of councils included indicators for enforcement of smoking-related legislation in the 2008 SOA documents, no CPPs included similar indicators in the 2009 documents.

4. Comparison between smoking-related content of SOAs in 2008 and 2009

Category		2008	2009
22% National adult smoking prevalence target		7	2
Individual smoking prevalence indicators	Adults	10	11
	Young people	4	4
	Pregnant women	3	10
HEAT smoking cessation targets: 8% quit at one month		10	12
Individual smoking cessation indicators		7	14
Heart disease related indicators		26	26
Cancer related indicators		20	8
Health inequalities indicators	Smoking-related	4	12
	Not smoking-related	15	14
Fire reduction indicators		17	26

Table 1 – number of CPPs with smoking-related targets included in the 2008 and 2009 SOA documents

Table 1 shows how the tobacco control-related content of SOA documents has shifted between 2008 and 2009. Figures in the table refer to the number of agreements that included targets in these categories in each of the last two years. It must be borne in mind that the figures in the table refer only to the presence of an indicator, and tell us nothing about whether the indicator is quantitative or merely qualitative, nor about how challenging the indicator may or may not be for the partnership concerned.

It can be seen that while there has been no dramatic shift in the overall tobacco-related content of SOA documents, there has been a perceptible shift in the balance of content related to smoking, perhaps as a result of responsibility for the production of SOAs passing from councils to community planning partnerships. The increase in the number of SOAs including indicators relating to fires and fire casualties, for instance, may reflect the involvement of local fire and rescue services in the CPP framework.

Other changes include an increase in the number of smoking prevalence indicators for pregnant women, and a decline in the number of SOA documents including indicators related to cancer mortality. Given that there is no national indicator for cancer care as there is, for example, for heart disease, it is not surprising that more CPPs have put in place targets to tackle this condition than they have to reduce cancer mortality. But the decline in the number of SOAs from 20 to 8 which include goals to reduce the number of deaths from cancer must be a cause for concern.

On the other hand, it is greatly encouraging that more CPPs are adopting targets related to smoking cessation, with a doubling of the number of CPPs setting themselves quantitative targets for cessation.

5. Conclusion

In the conclusion to our 2008 analysis of SOA documents, ASH Scotland expressed a hope that Scottish councils, in future agreements, would consider including a range of tobacco control related indicators, including individual targets for smoking prevalence and cessation.

Having carefully looked at the tobacco control content of the 2009 agreements, we can only repeat this sentiment. Also worth repeating, are the bald facts surrounding smoking and its impact on Scotland's health:

- One in four deaths in Scotland is associated with smoking[10]
- 15,000 young Scots take up smoking each year[11]
- the younger a child starts smoking, the greater the chance that they will suffer adverse health consequences[12]
- smoking is strongly correlated with poverty, with smoking rates among the most deprived decile of the population almost four times higher than rates among the least deprived decile[13]
- it costs the NHS in Scotland more than £409 million[14] annually to treat smoking related diseases
- smoking costs the Scottish economy £837 million each year through direct costs of treating smoking-related diseases, lost output and productivity, and reduced consumer expenditure because of premature deaths. This is the equivalent of 1% of the total Scottish economic output in 2005.[15]

Earlier in this document, we highlighted four of the national outcomes most clearly linked with smoking and the health impacts of smoking:

- our children have the best start in life and are ready to succeed
- we live longer, healthier lives
- we have tackled the significant inequalities in Scottish society
- we have improved the life chances for children, young people and families at risk.

Given the continued prevalence of smoking in Scotland – particularly within deprived communities – and the known health impacts of smoking, it is clear that Scottish public bodies will have to embrace every opportunity to tackle both the causes and effects of smoking if these four national outcomes are to be achieved. The quality of smoking-related services delivered at local authority/health board level is also likely to be enhanced if indicators linked to service delivery, such as the quality of smoking cessation services, or the enforcement of smoke-free laws and other smoking-related legislation, are embedded in future SOA documents.

To that end, ASH Scotland would again urge all Scottish community planning partnerships to consider including quantitative indicators – together with clear baseline figures – for the following measures:

- adult smoking prevalence
- youth smoking prevalence
- access to and success rate of smoking cessation services
- reduced cancer mortality
- reduced heart disease mortality
- enforcement of smoking-related legislation

Embedding such targets within Single Outcome Agreements would greatly assist in driving Scotland's progress towards a healthier, more economically robust and more resilient society.

Sources

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