**Information On Smoking Prevalence Rates in Areas of Higher Deprivation**

**Introduction**

[The Scottish Health Survey for 2019](https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/) informed us that smoking prevalence rates in Scottish Index of Multiple Deprivation (SIMD) 1 areas (those most deprived) was 32%, the same as it was in 2018. Smoking prevalence rates in SIMD 5 areas (the least deprived) had fallen to 6% from 9% the previous year. The smoking prevalence rate for Scotland as a whole is 17%.

Just under [10,000](https://www.scotpho.org.uk/behaviour/tobacco-use/data/smoking-attributable-deaths/) people in Scotland die each year from smoking –related diseases. This figure is well in excess of alcohol ([1,136](https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/pages/7/) alcohol-specific deaths) and drugs ([1,187](https://www.nrscotland.gov.uk/files/statistics/drug-related-deaths/2018/drug-related-deaths-18-pub.pdf) drug-related deaths).

In Scotland people who smoke use an average [12 cigarettes a day.](https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/pages/8/) At £10 for a pack of 20 this would quickly add up to £187.50 a month, or £2190 a year.

Smoking tobacco has an adverse effect on [mental health](https://www.ashscotland.org.uk/media/6671/ASHScotlandSmokingandmentalhealth.pdf) and renders some mental health [medications less effective.](https://impact.scot/wp-content/uploads/2019/10/HO4-Maudsley-Prescribing-Guidelines-2018.pdf)

Smoking tobacco has a very negative impact [on our environment.](https://www.ashscotland.org.uk/media/7613/21%20Litter.pdf)

The harm caused by tobacco goes way beyond the obvious health harms to lungs, hearts and throats. Physically, it affects every organ in your body and increases recovery time from illness or injury. Mentally, it causes anxiety and stress, is linked to worsening symptoms of depression and makes medication less effective. Financially, it contributes to and exacerbates poverty. Environmentally, it litters our streets and parks and poisons our rivers and seas.

All of these harms fall disproportionately on people living in areas of high deprivation, causing inequalities in health. This from ["Tobacco and Inequities"](https://www.euro.who.int/__data/assets/pdf_file/0005/247640/tobacco-090514.pdf), World Health Organization.

*“Children from less-affluent families are more likely to be exposed to smoking in the home, more likely to become smokers themselves, and take up smoking at a younger age. Smoking cessation rates are lowest in adults who experience multiple aspects of disadvantage. Inequities in smoking have been observed based on education level, sex, occupational level, ethnicity, housing tenure and other measures of wealth. Prisoners, homeless people and people with mental health problems are often more likely to smoke. Multiple factors can interact to amplify the resulting inequities in tobacco use. In the United Kingdom, smoking-related death rates are 2–3 times higher in the most disadvantaged groups than among those that are better off.”*

In Scotland [smoking attributable death-rates](https://www.scotpho.org.uk/behaviour/tobacco-use/data/smoking-attributable-deaths/) in 2018 were 3.2 times higher in SIMD 1 areas compared to SIMD 5

**Why is this happening?**

The inequities described by WHO above are observed internationally, not just in Scotland. This illustrates that it is tobacco that is the cause of these and not cultural or social factors on their own.

Research has highlighted some of the probable causes.

* **Addiction.** People in areas of high deprivation are more addicted to smoking tobacco. This may be partly the result of people taking up smoking earlier and smoking more cigarettes per day. They may be more likely to smoke cheaper brands and hand-rolled tobacco which often contain a higher nicotine level,1
* **Young people** in areas of high deprivation tend to take up smoking at an earlier age. Various factors such as: modelling parental smoking, peer pressure, social norms amongst peers, access to tobacco in the home and lack of knowledge about tobacco all contribute to this.**1**
* **Number of tobacco outlets, availability of tobacco and price.** Several studies have also found that areas of high deprivation have more access to cigarettes through relatively higher numbers of cigarette retail outlets and higher levels of tobacco advertising and promotion.**1**Analysis of individual brands showed that for 3 of the 12 cigarette brands considered, average prices were 12–17 pence lower in more deprived neighbourhoods with the most popular roll-your-own brand 15 pence lower.**2** Illicit tobacco products are available. 21% of people in the UK state they have been offered these. 77% of people who buy illicit tobacco do so because it is cheaper and easily available.**5**
* **Support to quit.** Nearly two-thirds of people from SIMD 1 areas who accessed NHS stop-smoking services had dropped-out within 4 weeks. Three-quarters of people who do quit use Pharmacy services rather than NHS.There is less social support to quit available in areas of high deprivation. Support can be an important factor to increase chance of quitting. Non-smokers can provide important support in the short-term, but smokers are less likely to know non-smokers.**1**
* **Motivation to quit.** People in areas of high deprivation are often more focused in dealing with current, treatable short-term health issues rather than future issues.Feeling judged and unworthy of medical helpbecause of their perceived social standing or lifestyle deterred medical help seeking, particularly when difficult life circumstances and traumatic events led to tobacco addiction. **1,3**
* **Stress.** People in areas of high deprivation may experience greater levels of stress and boredom at home and at work also. Stress and disadvantage reduce self-efficacy, which in turn sees people turn to smoking as a coping mechanism. Despite trying to quit, many fail to become smoke-free and feel victimised by (as they see it) punitive tobacco-control policies that coerced change without supporting it. **1,4**

**What can be done to address this?**

* **NHS Stop Smoking Services.** Within 4 weeks of first contacting a stop-smoking service, over 63% of people from SIMD 1 areas have dropped-out/lost contact with the service. After 12 weeks this figure increases to over 71%. What can be done to encourage and motivate people to stick with this support? People are 3-4 times more likely to quit smoking if they combine NRT (Nicotine Replacement Therapy; gum, lozenges, patches etc.) with counselling and support.**6**
* **Access to a Pharmacy.** Pharmacy stop smoking services accounted for just over three quarters (75.9%, 37,017) of quit attempts made in Scotland in 2019/20, compared to just under a quarter (24.1%, 11,732) of quit attempts made at specialist stop smoking services. Access to Pharmacy services are important to help people quit.**7**
* **Improve general health and other life chances.** Poor health outcomes and lack of opportunityinfluence higher smoking prevalence rates in areas of high deprivation. People focus on the immediate hazards from, poor housing, working conditions, environment and accidents, as they are more likely to suffer poor health, injury or die from these causes. Gains from quitting smoking seem marginal and incentives to quit less clear. People in areas of high deprivation put resources into dealing with the hazards that affect daily life, and work on removing these.**8**
* **Understand the factors in a community that predict cessation or quit attempts.** These include:**9**
* Strong anti-smoking community norms.
* Strong anti-smoking social norms.
* Perceived anti-smoking norms.
* Household bans.
* Workplace bans.
* **Understand the individual predictors of cessation.** These include:**9**
* Age, (18-30), (31-59) and 60+.
* Gender.
* Race/ethnicity.
* Living with a spouse/partner.
* One or more children under 18 at home.
* Education level/attainment.
* Household income.
* **Understand smoking patterns in the community associated with cessation.** Focus on the people in your community displaying these smoking patterns:**9**
* Not being a dependent smoker. (Dependent smoker being 20 or more-a-day; smoking within 30 minutes of waking).
* Made a quit attempt in the last year.
* Planning to quit in the next 30 days.

Addressing smoking prevalence rates in areas of high deprivation requires an approach which considers all the factors that negatively impact on individuals, families and communities and understanding the role that smoking tobacco plays in this. Addressing only the issue of smoking has not worked at reducing smoking prevalence rates at the same pace as in less deprived areas. If the Scottish Government is to achieve its goal of a smoke-free generation, **10** smoking prevalence rates will have to fall by at least 1% every year up to 2034 for the general population but by at least by 1.6% each year in areas of high deprivation.

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