Hitting in the Quit Target:

Smoking and low income groups

A Bevan Foundation report

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THE BEVAN FOUNDATION REPORT

Bevan FOUNDATION CHANGING WALES

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SUMMARY AND RECOMMENDATIONS

- The Welsh Government's Tobacco Control Action Plan aims to reduce the prevalence of smoking amongst adults to 20 per cent by 2016 and 16 per cent by 2020.
- This target is very challenging, especially in the context of higher rates of smoking, lower rates of quitting and higher rates of relapse amongst people from lower socio-economic groups compared with those from higher groups.
- To find out more about the views and experiences of people in lower socio-economic groups, the Bevan Foundation conducted a survey of 1,000 adults in Wales, which included 340 smokers.
- It found that the majority of smokers want to quit but have not done so successfully. The most popular methods of attempting to quit are the least successful methods.
- Smokers from lower socio-economic groups face practical and other barriers to participating in the most effective methods.
- Smokers in lower socio-economic groups are more likely to live with other smokers and to report that friends and family were very unhelpful to their quit attempts than people from higher groups.
- Smokers from lower socio-economic groups are more likely to take-up smoking, continue to smoke and relapse because of stress than those in other socio-economic groups.
- The report recommends:

    - **That active steps be taken by NHS Wales to reach the large number of smokers in Wales who are ready and willing to quit.**
    - **Resources should be specifically concentrated on reducing the prevalence rate and increasing the quit rate of smokers in lower socio-economic groups.**
    - **A range of effective smoking cessation products and services needs to be available along to smokers wanting to quit.**
    - **Effective treatments should be offered immediately a smoker is interested in quitting.**

- **Barriers to accessing products and services should be minimised. This requires:**
  - **Ensuring Stop Smoking Wales services are offered in a variety of settings at a variety of times, with branding appropriate to target groups.**
  - **Providing effective alternatives to Stop Smoking Wales services for smokers unable or unwilling to use Stop Smoking Wales services.**
  - **Ensuring active involvement in treatment for smoking by health professionals throughout the NHS, including in those in secondary care, ante-natal services, GP practices and community pharmacies.**
- **The socio-economic context of smoking must be recognised and addressed e.g. through partnerships with Communities First groups and social landlords.**

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1. INTRODUCTION

The Welsh Government's Tobacco Control Action Plan has adopted challenging targets to reduce Wales's smoking prevalence to one of the lowest in the world. Reducing the number of people who smoke would also reduce the incidence of smoking-related diseases, from cancer and other lung diseases to heart disease and stroke.

Despite the Welsh Government's ambitions, the decline in the proportion of people who smoke that was recorded in the first half of the 2000s has now stalled, and it is extremely unlikely that the target will be achieved unless there is radical action to increase the number of successful quits from smoking.

Differences in the proportion of people who smoke and in the rate of quitting are now well-known. People in lower socio-economic groups are more likely to smoke and less likely to quit than others. Ensuring that these groups of people are able to get as much help as possible with quitting smoking is therefore key, not only to reaching the Welsh Government's targets but also to reducing inequalities in health between lower and higher socio-economic groups.

This report summarises for a non-specialist audience research that was undertaken by the Bevan Foundation in summer 2012. This research looked at the behaviours and attitudes of lower socio-economic groups to quitting smoking. It included market research of 1,000 people in Wales carried out by ORS Research, a review of relevant literature and statistics and a seminar on innovative approaches to smoking cessation. That research and a full report of the findings were funded by Pfizer Ltd, and a copy of the full report is available on request for those with a professional interest in smoking cessation. This summary is the views of the Bevan Foundation only.

2. SMOKING AND SOCIO-ECONOMIC DISADVANTAGE IN WALES

Smoking is one of the main causes of differences in the health and life expectancy between people from higher and lower socio-economic groups. It costs the NHS in Wales millions of pounds, and it causes long-term illness and premature death for thousands of people. An increasing number of research studies have begun to explore the reasons for the higher rates of smoking amongst people on low incomes, and the lower rates of quitting and relapse.

This section summarises what is already known about smoking and social and economic disadvantage.

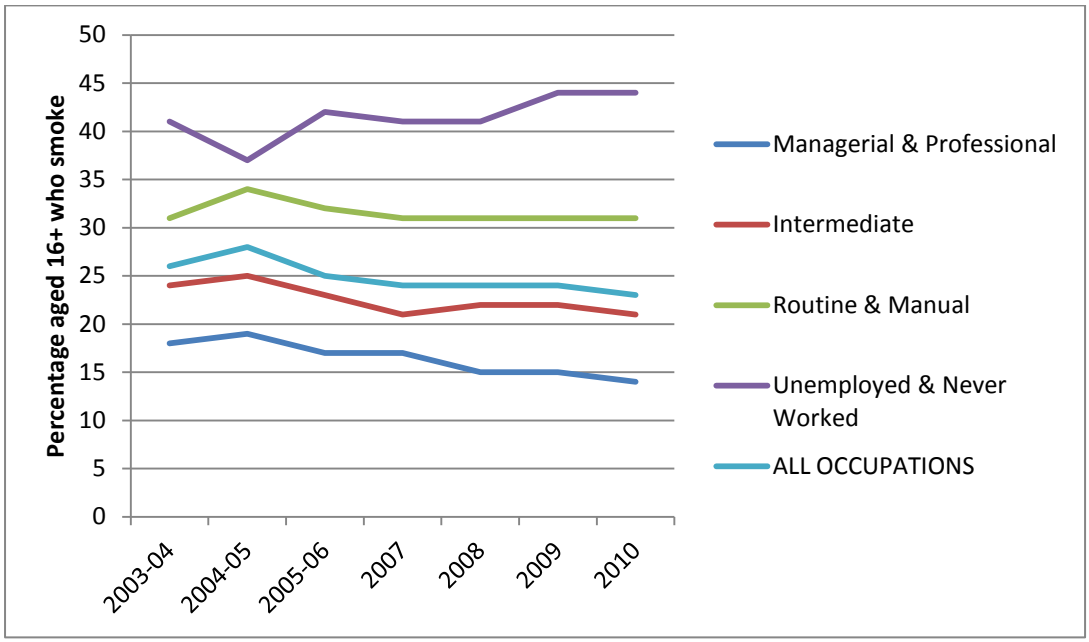
Smoking in Wales

In 2010, 23 per cent of adults in Wales smoked.[1] People in lower socio-economic groups are more likely to smoke than people in higher groups: people in manual occupations are twice as likely to smoke as people in professional and managerial jobs, whilst people who are unemployed are nearly three times more likely to smoke as people in professional and managerial jobs.[2]

In Wales as in the UK as a whole, the proportion of the population which smokes has decreased over the last ten years,[3] but it has not decreased at the same rate across all socio-economic groups. The proportion of people in managerial and professional occupations who smoke has decreased from 18 per cent in 2003/04 to 15 per cent in 2010. In contrast the proportion of people in routine and manual occupations who smoke has remained broadly static since 2003/04 at 31 per cent, whilst the prevalence of smoking amongst people who are unemployed or have never worked has ***increased*** from 41 per cent in 2003/04 to 44 per cent in 2010.

The consequence is that the gap between the highest and lowest socio-economic groups has widened from 23 to 30 percentage points in just six years (Figure 1).[4]

Figure 1 Smoking Prevalence by Occupational Group, Wales

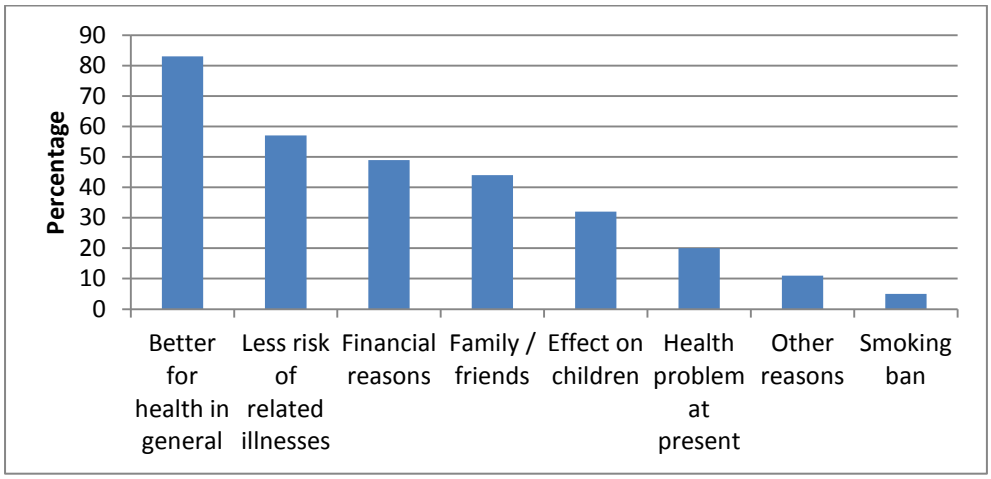


The Welsh Government's Tobacco Control Action Plan aims to reduce the proportion of the population who smoke from 23 per cent in 2010 to 20 per cent by 2016 and 16 per cent by 2020.[5] Achieving the 2016 and 2020 targets will need a sharp decrease in the proportion who smoke in the next eight years. To do this, the Welsh and UK Government will need to reach smokers in lower socio-economic groups.

Smoking Cessation

In Wales, an estimated 70 per cent of smokers want to quit.[6] The triggers for a quit attempt are, in Wales as elsewhere, a mixture of health concerns, financial concerns and pressure from family and friends (see Figure 2).

Figure 2 Percentage of adult smokers in Wales citing a specific reason for wanting to give up smoking, 2010



Source: Welsh Government (2012) Tobacco and Health in Wales. Figure 22

International studies suggest that smokers with low educational qualifications and low incomes are less likely to want to quit than others,[7] [8] and there is some evidence that lower socio-economic groups are more likely to cite cost issues and existing (rather than future) health conditions as reasons for wanting to quit than higher socio-economic groups.[9]

Cessation Support

Some methods of quitting are more successful than others. Work by West and Brown[10] shows that the success rates of a wide range of different kinds of support vary widely. Paradoxically, the most successful cessation methods are least likely to be used by potential quitters. Just 4.1 per cent of all quit attempts use the most successful approaches, whilst most quits (46.5 per cent of quitters) use the least successful method of unaided attempts.[11] [12]

Cessation and Socio-economic Status

People in low socio-economic groups are less likely to quit successfully than those in higher groups[13] [14] and are also less likely to stay a non-smoker than others.[15] A number of reasons are suggested for this.

First, smokers in lower socio-economic groups may have limited knowledge about the best method of stopping smoking.[16] [17] Nicotine replacement therapy (NRT) is the best-known and most widely used method amongst people in lower socio-economic groups, as in the population as a whole.[18] [19]

Second, there are socio-economic differences in use of the most successful method, which is group-based behavioural support. Research shows that smokers from disadvantaged areas are ***more*** likely to participate in NHS Stop Smoking Services but are ***less*** likely to quit than those from less disadvantaged areas.[20] Reasons for this include being less likely to follow a course of treatment (for example not attending regularly or for the full course).[21] There also appears to be widespread misunderstanding about what group support is,[22] for example with some people thinking it is like Alcoholics Anonymous, to involve 'group hugs', or to be only for people who are really desperate or ill.[23] Some people fear being judged or being seen to fail[24] or are unused to talking about problems openly.[25] [26] Practical obstacles such as the timing of groups, lack of transport to the group and lack of childcare are also factors.[27]

Third, a number of studies have highlighted that smokers in lower socio-economic groups do not have supportive social environment for quitting. Some disadvantaged communities have no 'culture' of quitting, [28] while some smokers live with another adult smoker who may undermine attempts to quit.[29]

Last but by no means least, higher stress levels amongst people in lower socio-economic groups, for example associated with financial difficulty, unemployment or boredom, are a contributory factor.[30] [31] [32] Some studies describe how smoking is seen as a 'loyal friend' that relieves difficult times.[33] As a result, it has been suggested that attempts to encourage

and support people attempting to give up smoking will need to address lower socio-economic groups' social and economic circumstances as well as their nicotine addiction.[34]

There is very little evidence available on the use of different methods of smoking cessation for Wales. The data on participation in NHS Stop Smoking Wales services show that smokers from disadvantaged areas are more likely to be offered treatment than those from less disadvantaged areas. However, they are less likely to complete a course of treatment, mainly because of the 'drop-out' rate between an appointment being offered and attendance at the session[35]. This suggests that factors such as timing and location of groups, access by public transport and availability of childcare, and misunderstanding or dislike of group-based support may be relevant.

However, unlike other parts of the UK, in Wales there are only small differences between more disadvantaged areas and less disadvantaged areas in the proportion of smokers who attend an appointment and who have managed to quit after 4 weeks. This suggests that the challenge for the NHS in Wales is to get people from lower socio-economic groups to attend stop smoking sessions in the first place, rather than ensuring they carry on attending.

It is important to note that only about 15 smokers out of every thousand attend NHS Stop Smoking services. The Welsh Government has set a target of 5 per cent of adult smokers accessing NHS smoking cessation services although it is not clear if the target refers to an offer of an appointment or attendance. Also, no date for achievement of the target is given.[36] Achieving the target would require nearly doubling of the appointments offered by NHS Stop Smoking Wales and more than tripling the number of people attending the service – a major challenge.

Unfortunately, even if a smoker manages to stop for 4 weeks it is difficult to maintain being a non-smoker. Reasons for relapsing include stress, environmental factors such as alcohol, coffee or being in a smoking environment, and the influence of friends and relatives. Ineffective aids to quitting are sometimes a factor, although people from lower socio-economic groups often blame lack of their own will-power.[37] It can take some time for a smoker to recover from a failed quit attempt and try again.[38]

Conclusion

There is considerable evidence that smoking and quitting are influenced by socio-economic factors. These shape the likelihood of wanting to quit, the methods used to help to quit, and pressures to relapse. In particular, smokers from lower socio-economic groups seem reluctant to participate in the most effective treatments and in the method that is preferred by the Welsh Government.

The Welsh Government and health boards thus face a major challenge. They need to take action to reduce dramatically the proportion of the population who want to quit, but in doing so, they face the conundrum that the most effective methods appear to be particularly unpopular with smokers from disadvantaged groups.

3. THE SURVEY RESULTS

The Bevan Foundation commissioned an independent research company, ORS, to undertake a random, telephone-based survey of adults (aged 16+) in Wales. The survey was conducted in May and June 2012. A total of 1,600 interviews were completed which are representative sample of the population of Wales. In this, 346 people who had smoked in the last two years were identified and provided responses to the rest of the survey. This sections sets out the main results.

Smoking

Overall, 26 per cent of the sample said they had smoked tobacco in the last two years. The survey found:

- Younger people are more likely to smoker than older people
- Lower socio-economic groups are more likely to smoke than higher groups
- Single adult households are more likely to smoke than other households
- Adults in households with at least one child under the age of 16 are more likely to smoke than in childless households.
- People in rented housing are more likely to smoke than people in owner-occupied housing.
- People with a limiting long-term health condition or disability are more likely to smoke than those without.

There were no statistically significant differences in smoking prevalence between men and women.

Quits and Quit Attempts

More than half the smokers interviewed wanted to quit. Four out of ten said they had tried to quit but without success and 15 per cent wanted to quit but had not attempted to do so. Just over a quarter of those interviewed said that they did not want to quit.

There were clear differences between socio-economic groups in attempts to quit and how successful they were. Only 10 per cent of smokers from socio-economic group C2DE had quit compared with 26 per cent of those from group ABC1. On the other hand, nearly half the smokers from socio-economic group C2DE had tried and failed to quit compared with 30 per cent from group ABC1.

There were also marked differences between age groups, with more than a quarter of smokers aged 16-34 years saying they had successfully quit compared with less than 1 in ten of smokers over the age of 55.

Reasons for Quitting

The main reasons all smokers had attempted to stop smoking were health concerns and cost. Advice of a health professional and influence of family, friends or colleagues were much less important. Other reasons given by those who had attempted to quit included 'for their children', wanting to get physically fit, concerns about the impact on personal appearance and smell, and being bored or fed up with smoking. Amongst those who had not attempted to quit, concern about the impact on a child or partner were mentioned as reasons that might make them try to stop.

Interestingly, there are no significant differences in reasons to quit between social groups, except on the role of advice from health professionals. Advice from a health professional was much more likely to be mentioned by older people and by people with a limiting long-term illness or disability than others. This is an important finding that suggests that broad health promotion messages do reach and affect all socio-economic groups. However health professionals' impact appears to be mainly focused on older people and those with a health condition.

Support to Quit

Those who had attempted to quit were most likely to have used nothing other than their own willpower to help them. A close second was use of Nicotine Replacement Therapy (NRT). Use of prescription medicines and NHS stop smoking groups were relatively uncommon and accounted for only 15 per cent and 10 per cent of responses respectively.

There are some minor differences between socio-economic groups in use of cessation aids. People from higher socio-economic grades were more likely to say that they used no help other than willpower in their quit attempt and they were also more likely to be positive about the success of willpower alone. There were no differences in the use of NRT or other aids.

It is worth noting that a significant minority of people who had not attempted to quit – 22 per cent - thought that nothing would help them.

Reasons for Lack of Success

Smokers who had tried to quit but were unsuccessful gave a very wide range of reasons for this, ranging from enjoying smoking, boredom and stress, social pressures and availability of cigarettes to difficulties with NRT or medicines.

More than a quarter of those who did not succeed blamed lack of willpower and a further quarter blamed 'going through a difficult time / stress'. People from lower socio-economic groups were more likely to blame lack of willpower than higher groups.

Overall, a quarter of smokers lived with another adult who smoked. Four out of ten respondents said their family and friends were very helpful to their quit attempt. People in lower socio-economic groups were significantly more likely to say that friends and family

had been very helpful than those in higher groups. However they were also more likely to say that friends and family had been very **unhelpful**.

Conclusions

This results from the survey of 346 smokers in Wales confirms that smokers in lower socio-economic groups are more likely to smoke than other groups, as likely to want to quit, but less likely quit successfully. General messages about health and cost have had an effect on smokers, but advice from health professionals has tended not to reach them.

The survey demonstrates that smokers in lower socio-economic groups most likely to use the least successful methods to help them to quit and least likely to use the ones with the highest chances of success. Social factors seem to play an important role in smokers starting to smoke after a quit attempt, with friends and family and a 'smoking environment' being important as well as stress and boredom.

4. TIME FOR ACTION

These findings confirm that in Wales, as in England, the proportion of people who smoke, their attempts to quit and the success of their attempt are shaped by socio-economic factors and in particular socio-economic group. In addition, the findings suggest that smoking is also associated with living in a single person household, living with children, living in rented housing, and having a long-term health condition. These associations are highly relevant to planning services to help people to quit in the future and need to be investigated further.

The differences between socio-economic groups suggest that action to help people to quit cannot assume that one type of service is the best for everyone. In particular, **services need to take account of the experiences and circumstances of people from lower socio-economic groups.**

Consideration should be given to prioritising action for lower socio-economic groups (and in particular people who are unemployed or have never worked), families and people in rented accommodation. As these are groups of people with very high rates of smoking, it is vital that services meet their needs and circumstances.

The lack of socio-economic differences in the reasons for quitting suggest that general health-related messages do reach the population as a whole, although there is a 'hard core' of people who do not want to quit. Health professionals have a role to play reaching people from disadvantaged backgrounds although their main impact appears to be on older people and people with a long-term health condition or disability.

The differences in success of quit attempts have implications for service delivery. They suggest that help to quit should be targeted on people in lower socio-economic groups. This might involve enhancing access to other methods of smoking cessation support as well as providing NHS Stop Smoking support. Other methods include, for example, enabling people to get free NRT direct from a pharmacy without having to visit their GP for a prescription (called a level 2 or level 3 pharmacy service), encouraging GPs in disadvantaged areas to be actively engaged in getting people to quit e.g. by immediate treatment of a smoker expressing an interest in quitting.

The most commonly used ways of quitting were either to make an unaided quit attempt or to use NRT alone. These are the least successful methods and are likely to result in failure. Resources are wasted, smokers' willingness to try again in future is affected and the rate os smoking barely touched. It is imperative that smokers are informed about the success rates of different methods, so that they can make informed choices.

Having made their choice, it is also vital that smokers are able to exercise it with ALL methods being readily available, with minimum hoops to jump through, waiting times or

other barriers. No effective method should be prohibited by health boards nor not prescribed by GPs. [39]

Although NHS stop smoking services are the most effective method, many people simply do not like the approach or are unable to attend. Increasing take-up is therefore especially challenging. Other methods of getting people who do not want to participate need to be found. There is a role for increasing understanding of what happens in stop smoking groups, re-branding them to appeal to different groups,[40] or exploring new methods of delivery e.g. with social landlords.

But no amount of rebranding and relocating will overcome a dislike of group activities or practical barriers such as lack of transport and childcare. There must be alternatives offered for quitters, whether this is one-to-one support in people's homes, at GP surgeries or by other means. These methods may have lower overall quit rates than stop smoking services, their success is nevertheless considerably better than unaided quits or over-the-counter NRT. In addition, they have potential to reach a larger number and wider range of smokers than NHS Stop Smoking Services alone.

Given that GPs are seen as a source of information and support for smokers wanting to quit[41] and the greater use made of GP services by lower socio-economic groups[42] there seems to be very considerable scope to increase GPs' engagement and role in smoking cessation. The review of the Quality and Outcomes Framework (QOF) provides an opportunity for these issues to be addressed, with the views of GPs about the role of QOF[43] needing further discussion.

There seem to be no significant differences in the effectiveness of different methods for different groups, which suggests that the differences in quit rates are not due to the methods themselves but to factors such as the availability and take-up, and the social environment.

It is critical that policy-makers and service delivers ensure that they not only provide a range of smoking cessation treatments but that the treatments are accessible to ALL social groups. The conventional model of referring people only to NHS Stop Smoking Wales does not achieve this objective - there has to be a wider range of services, delivered immediately, pro-actively and effectively.

Action to help smokers to quit must also recognise the wider social context in which smokers live. A substantial minority of people from lower socio-economic groups found family and friends to be very unhelpful, which suggests that people from lower socio-economic groups and those where smoking is still the norm may need more intensive support to quit.

This and the wider issues about the role of material factors suggest that stop smoking activity could be linked with other types of support, such as financial advice or debt counselling, return-to-work groups and community-based activity. Similarly, there might be

scope to develop partnerships with social landlords. In other words there new routes into help to stop smoking could be developed in addition to the existing routes.

The challenge for the Welsh Government, Public Health Wales and health boards is not necessarily to persuade more people of the need to quit, but to increase the success rate of those who already want to quit. It is imperative that help offered to smokers not only follows evidence on 'what works' clinically but also suits people's socio-economic circumstances and preferences.

Recommendations

The findings presented here suggest a number of actions that Public Health Wales, Stop Smoking Wales and local health boards should take to achieve the Welsh Government's Tobacco Control Action Plan targets for smoking prevalence.

1. Active steps need to be taken to reach the large number of smokers in Wales who are ready and willing to quit. One service, Stop Smoking Wales, is not sufficient to reach them.
2. The needs and preferences of the smoking population and different sub-groups within it need to be understood better so that cessation services and products can be delivered in ways which are appealing to them and meet their needs. Advice from marketing experts could be of considerable benefit.
3. The high prevalence and lower quit rates of smoking amongst lower socio-economic groups means that resources should be specifically concentrated in the most disadvantaged areas and actively targeted at people in routine and manual occupations and the unemployed or never worked group.
4. A range of effective smoking cessation products and services needs to be available to potential quitters, along with information about success rates, so that smokers wanting to quit can make informed choices about the methods that most suit their circumstances and preferences.
5. As unsuccessful quit attempts damage future intentions to quit, effective treatments should be offered immediately a smoker is interested in quitting.
6. Barriers to accessing products and services and to complying with treatment should be minimised. This requires:
    a. Ensuring Stop Smoking Wales services are offered in a variety of settings at a variety of times, with branding appropriate to target groups.
    b. Providing effective alternatives to Stop Smoking Wales services for smokers unable or unwilling to use Stop Smoking Wales services.

c. Ensuring active engagement in treatment for smoking by health professionals throughout the NHS, including in secondary care, ante-natal services, GP practices and community pharmacies.

7. The socio-economic context of smoking must be recognised with cessation linked to attempts to improve quitters' wider material and emotional well-being. Partnerships with Communities First groups, social landlords and money advice services should be piloted.

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ENDNOTES

[1] Welsh Government (2011) Welsh Health Survey 2010, Table 4.2

[2] Welsh Government (2011) Welsh Health Survey 2010, Table 4.3. Rate for managerial and professional groups is 14%, for manual groups is 30% and for unemployed and never worked is 44%.

[3] Welsh Government (2012) Tobacco and Health in Wales. Figure 4.

[4] Gap in 2003-04: 41%-18%=23%; Gap in 2010: 44% - 14% = 30%

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[35] Welsh Government (2012) Tobacco and Health in Wales. Figures 25 and 26.

[36] Welsh Government (2012) Tobacco Control Action Plan for Wales. Cardiff.

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[42] Welsh Government (2011) Welsh Health Survey 2011, Table 5.4 shows that 15% of professional and managerial groups had visited their GP in the previous two weeks compared with 17% of intermediate groups, 19% of routine and manual groups and 24% of people who were unemployed or never worked.

[43] BMA Wales have commented that QOF should be used only for evidence-based medicine, and have questioned whether the effectiveness of GPs in smoking cessation can be measured.