Alcohol, Drugs and Tobacco in Lancashire
Section 3: Tobacco

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Introduction

Tobacco use remains one of the most significant global public health challenges today and is a key government public health priority. Smoking is the most harmful form of tobacco use and continues to be the major cause of preventable morbidity and premature death, responsible for more than 80,000 deaths per year in England, 18% of all deaths of adults aged 35 and over. With up to 10,000 dying from the effects of inhaling secondhand smoke, tobacco is killing more people per year than the next six most common causes of preventable deaths combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).[i]

Smoking rates are much higher in some social groups, including those with the lowest incomes. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. In Lancashire, large inequalities exist in terms of tobacco use, as well as health outcomes between the affluent and the deprived. Tobacco control has therefore been identified as a goal to address these inequalities and improve the health and wellbeing of Lancashire residents. [ii]

In recent times, obesity, alcohol and physical activity have all been the focus of attention and additional investment. However, it should be remembered that amongst the challenges facing public health, smoking remains *the* major contributor to ill-health and inequalities and furthermore, the level of evidence available to support interventions to reduce smoking is more robust than for many other alternative uses of healthcare

This joint strategic needs assessment (JSNA provides data, analysis and recommendations to aid commissioners to make informed decisions about tobacco control across Lancashire.

Policy context

The World Health Organisation (WHO) Framework Convention on Tobacco Control[iii] (FCTC) (2003) is an international treaty developed in response to the globalization of the tobacco epidemic. Its provisions include measures to reduce both the demand for and supply of tobacco. The UK government is a signatory to this treaty. The UK policy context for the current approach to tobacco control extends back to Smoking Kills: A White Paper on Tobacco (1998). Most recently Healthy Lives, Healthy

People: A Tobacco Control Plan for Englandiv, (Department of Health, 2011) outlines the government's strategy to reduce smoking prevalence and tobacco use over the next five years.

Tobacco Free Lancashire's A Draft 5-Year Tobacco Control Strategy for Lancashire 2011-2016 complements the national strategy, and aims to "make tobacco less desirable, acceptable and accessible in Lancashire" (Tobacco Free Lancashire, 2012) to reduce the harm caused by tobacco.

There is a significant body of evidence on the harms to health caused by tobacco use, and guidance on effective tobacco control measures. For further information or links to key documents and evidence sources see:
http://www.ash.org.uk/information/resources/information-sources

Tobacco Products

Tobacco products include both smoked and smokeless tobacco. Smoked tobacco includes machine manufactured cigarettes, hand rolled cigarettes, cigars, pipe tobacco, and other hand rolled products used in South Asian communities. There is no safe level of tobacco use. All forms of tobacco products contain nicotine and can cause addiction and health problems. More than 4,000 different chemicals have been found in tobacco and tobacco smoke, many harmful to health and at least 80 of which could cause cancer. Smokeless tobacco is consumed in its unburned form. It is sniffed (e.g. snuff), sucked (dipping) or chewed.

Prevalence

There are about 10 million adult cigarette smokers in Great Britain and about the same number of ex-smokers. Tobacco use varies widely according to race, sex, age, educational level and socio-economic status. In the UK since the mid 1970s and early 80's cigarette consumption amongst adults (16 plus) has fallen steadily among both men and women. Since 1982, the rate of decline has slowed, and remained static at 21% between 2007-2009 before dropping to 20% in 2010. [v]

The total prevalence figure for the 12 Lancashire districts for April 2010 – March 2011 is just above the England average at 20.9% and has remained similar over 5 quarterly rolling average periods. The districts of Blackburn with Darwen and Blackpool are both higher, at 27.8% and 30.5% respectively. Compared to figures from the previous year, prevalence has increased in six areas: Blackburn with

Darwen, Chorley, Lancaster, Pendle, Fylde and Wyre. Blackburn with Darwen increased most, by 4.8%. Seven districts showed an annual decrease in prevalence.

Smoking in pregnancy

Smoking during pregnancy is one of the most preventable causes of foetal and infant morbidity and mortality. In Lancashire the prevalence rate for smoking at delivery shows a wide difference between PCTs, with North Lancashire at 18% and Blackpool at 29.7 %. The rate for Lancashire 14 has improved by 0.8 % compared to the same period of the previous year. 3 out of 5 Lancashire PCTs have also improved, but rates all Lancashire PCTs were above both the England and North West average. The greatest reduction has been in Blackpool PCT, where smoking at time of delivery has improved by 3.5% % for 2010/11 – 33.2 % to the current 2011/12 position of 29.7%.

Gender and age

Historically smoking prevalence has been higher among men than women, but since the early 1990s there has been an increase in the proportion of women taking up smoking before the age of 16. Smoking prevalence is highest in the 20-24 age group among women (28%) and in the 25-34 age group among men (27%) but thereafter declines and is lowest among people aged 60 and over. Most long term smokers start smoking in their teens. Around 200,000 children and young people start smoking in England every year. Overall, the prevalence of regular smoking among children aged 11-15 remained stable at between 9 and 11% from 1998 until 2006. However, in 2007 there was a fall in overall prevalence from 9% to 6%, and a further decline in 2010 to 5% overall and to 12% among 15 year olds. [vi]

In Lancashire survey results report reductions in young people aged 14-17 from 24% in 2009 to 20% in 2011, slightly higher than for the North West as a whole. Girls are more likely to smoke than boys and the majority of young people who smoked said they had started between the ages of 13-14.[vii]

Inequalities

Social deprivation is associated with high levels of smoking and low rates of quitting. There is a strong link between cigarette smoking and occupation. In 2009, 30% of men and 27% of women in routine and manual occupations smoked compared to 15% of men and 14% of women in managerial and professional occupations. There

are differences in both smoking prevalence and tobacco use according to ethnicity, with higher prevalence among Bangladeshi, Irish, Pakistani, and Black Caribbean men than those in the general population, and lower among Black African, Chinese, Indian men. Smoking prevalence was higher among women in the general population, except among Irish and Black Caribbean women. Whilst only 2% of Bangladeshi women reported that they smoked cigarettes, 16% reported that they chewed tobacco, which is associated with high rates of oral cancer. There is little reliable data on usage and prevalence of niche tobacco products like shisha and smokeless forms.

Smoking rates are much higher among people with mental illness, and among prisoners.[viii] Approximately 410,000 people registered with Lancashire GPs are known to be living with long term conditions such as high blood pressure, coronary heart disease, stroke, diabetes or coronary pulmonary obstructive disease (COPD), all of which are either caused by and/or exacerbated by smoking.

Second-hand smoking

Between the 1980s and 1990s, surveys in the UK found that about 50% of all children in lived in a house with at least one person who smoked. By 2007 this figure had dropped to around 40% and since the introduction of smokefree legislation in 2007 has continued to fall to 37%. The number of children who live in a smokefree home has increased from 21% in 1996 to 37% in 2007. However for most children living in a smoking household there has been little reduction in exposure to secondhand smoke.[ix]

Acute adverse effects associated with the use of tobacco

Tobacco use can lead to both acute and chronic conditions. The main acute conditions are heart disease and stroke, chest and lung diseases (including lung cancer) and several other cancers. Smoking during pregnancy contributes to low birth weight babies, with higher risks of diseases and death in infancy and early childhood. In 2010, the percentage of low birthweights in England was 7%. In Lancashire (14) the highest percentage was in Blackburn with Darwen at 9.3%. Lancashire (12) equalled the England figure at 7.0%.

Smoking attributable hospital admissions and deaths

It is estimated that around 5% of all hospital admissions in 2008/09 were attributable to smoking, which accounts for approximately 5.5% of the NHS budget. In 2010/11 hospital admissions attributable to tobacco use were significantly higher than the national average in all but 5 of Lancashire's 14 local authority areas.[x].Six Lancashire districts with a greater number of smoking attributable deaths than the North West and England averages The highest number of deaths occur in the most deprived districts, except Pendle which, whilst in the 2nd most disadvantaged quintile, is lower than the regional average. Many Lancashire districts have higher rates of infant mortality than the national average of 4.6 deaths per 1,000 live births, particularly Blackburn with Darwen, Pendle, and Blackpool.

Enforcement, community safety and illicit tobacco

According recent survey figures 21.0% of Lancashire 15-16 year olds smoke and 12.1% claimed to purchase their own cigarettes. These figures are roughly in line with the North West as a whole.xi Most young people purchase their own cigarettes from off licences/newsagents. However, since 2007, fewer have bought from retailers and more are getting them from older siblings and friends.

Illicit tobacco includes both 'counterfeit/fake' tobacco and 'smuggled' tobacco products. It is much cheaper than legitimate tobacco products and therefore undermines efforts to use price as a lever to reduce smoking prevalence, especially among children and young people and in deprived communities. Efforts to availability in Lancashire are lead by the Trading Standards Service, by means of test purchasing operations, seizures and prosecutions, and training for retailers on Age Restricted Products.

Community Safety

Smoking can cause fires, and also impair dexterity and concentration whilst driving. Tobacco products are sometimes offered as gifts in victim/offender grooming relationships. Discarded cigarette butts create littering. Between April 2005 and March 2012 over 9,000 accidental dwelling fires occurred across Lancashire (14) resulting in 1,500 fire-related injuries and almost 50 deaths.xii

Stop Smoking Services

The Tobacco Control Plan for England (2011) reasserts the government's commitment to the provision of local Stop Smoking Services tailored to the needs of local communities, particularly groups which have high prevalence, as a contribution to reducing inequalities in health.[xiii] There is strong evidence which demonstrates that Stop Smoking Services are highly effective both clinically and in terms of cost. Department of Health guidance recommends that all smokers should be routinely offered advice to quit and a referral to the Stop Smoking Service.[xiv]

Specialist Stop Smoking Services are currently commissioned by PCTs across Lancashire from a range of providers including NHS, pharmacists and community based providers. In 2010/11 Stop Smoking Services in Lancashire had a combined target of 12434 quitters; actual achievement fell slightly short of this at 12406, with 3 out of 5 services meeting or exceeding their target. The overall percentage of smokers setting a quit date who were successfully quit at 4 weeks was 49% in Lancashire, compared with 44% overall for the North West as a whole.[xv] The quit rate for pregnant women was slightly lower for Lancashire than the North West as a whole, at 36% compared against 30%. Both the numbers quitting, and the success rate improved in Lancashire in 2010/11 when compared with the previous year.[xvi]

Tobacco Economics

Not only does tobacco use have a high toll on the health of smokers and non smokers, it also remains a major contributor to health inequalities with higher rates of uptake and lower rates of quitting amongst those who are most disadvantaged. It has a significant cost to individuals and society. Tax revenue from smoking is estimated to be around £10 billion per year but the cost of smoking to society is estimated at £13.74billion per annum.,[xvii] in health social care and informal care costs, and productivity losses resulting from smoking attributable diseases and premature mortality. In recent times, obesity, alcohol and physical activity have all been the focus of attention and additional investment. However, it should be remembered that amongst the challenges facing public health, smoking remains the major contributor to ill-health and inequalities and furthermore, the level of evidence available to support interventions to reduce smoking is more robust than for many other alternative uses of healthcare.

Using the model from the tobacco control toolkit[xviii] developed by Brunel University, it is possible to estimate significant financial savings t across Lancashire in both the short and medium term if local stop smoking services are maintained, or a sub-national tobacco control programme is in place.

Recommendations

To address the issues of tobacco related harm it is recommended that:

- The Lancashire Tobacco Control strategy is fully implemented across all local authorities in Lancashire (14) i.e.
    - Stop the promotion of tobacco
    - Make tobacco less affordable
    - Effectively regulate tobacco products
    - Help tobacco users to quit
    - Reduce exposure to second-hand smoke
    - Effectively communicate for tobacco control
- That tobacco is included in the revised health inequalities JSNA to provide further evidence and information of its impact on health inequalities in Lancashire.
- Tobacco control is prioritised in cross-cutting policies, guidance and funding.

Conclusion

Tobacco Free Lancashire is well placed to address tobacco control from a holistic perspective and has recently developed its five year strategy and delivery plan in conjunction with a wide ranging group of partners. The strategy mirrors the government's new national tobacco plan as well as local priorities and adopts the six internationally recognised strands of comprehensive tobacco control measures. It is supported by a detailed delivery plan which will be updated on a yearly basis to reflect progress. As current statistics reveal, smoking rates in Lancashire are some of the highest in the country and this strategy aims to change that through its mission to: "To make smoking history for the children of Lancashire whilst improving the lives of Lancashire residents by reducing overall tobacco consumption"

This JSNA provides the data and evidence base to support the strategy and delivery plan and shows the size and scale of the tobacco epidemic in Lancashire.

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