SMOKING

What’s the issue?

“Tobacco is a unique product. It is the only consumable that, when used in the intended way, kills half of its users” [106]. “This makes it one of the biggest causes of death and illness in the UK. Every year around 100,000 people die from smoking, with many more deaths caused by smoking-related illnesses. Smoking causes almost 90% of lung cancers, but can also cause cancer in many other parts of the body. Smoking also increases the risk of developing heart and circulation problems such as coronary heart disease, stroke, peripheral vascular disease and cerebrovascular disease. It also damages the lungs increasing the risk of bronchitis, emphysema and pneumonia, and other chronic obstructive pulmonary disease” [107]. Smoking can also cause or exacerbate numerous other health problems, and there are further risks caused by smoking in pregnancy and breathing in second hand smoke. Smokers who die prematurely lose on average about 10 years of life [108, 109]. Health benefits are immediate after quitting smoking [110], within 2-13 weeks circulation improves and lung function increases [111], within 1-9 months coughing and shortness of breath decreases and people start to regain lung function [111], after one year excess risk of coronary heart disease is half that of a continuing smoker’s [112], after 2-5 years stroke risk falls to that of a non-smoker’s [112, 113], after five years the risk of cancer of the mouth, throat, oesophagus and bladder are cut in half, and cervical cancer risk falls to that of a non-smoker [112, 113], after 10 years the risk of dying from lung cancer is about half that of a person who is still smoking, and risk of cancer of the larynx and pancreas decreases [111, 112] and after 15 years the risk of coronary heart disease is that of a non-smoker’s [113].

What’s our situation?

In 2014/15, 777 out of 3,677 women (21.1%) were known to be smokers at the time of delivery, compared with 10.6% for England [26, 95, 114]. The rate in Hull continues to fall (29.6% in 2005/06), although it is the highest of 10 comparator areas.

The local Young People Health and Lifestyle Survey 2016 [86] found smoking rates had decreased slightly, although remaining high. Among 15 year olds, an estimated 6.8% of boys and 12.9% of girls smoked (9.5% overall). The prevalence among 15 year olds had decreased since the 2008 [115] and 2012 [74] surveys. In 2008, 11.3% of boys and 26.1% of girls smoked, and in 2012, 12.5% for boys and 18.0% for girls smoked. Rates of smoking were lower in the younger age groups. National estimates for Hull were slightly lower at 8.6% and comparable to England (8.2%) for 2014/15 [26, 95]. From the local survey [86], just under half of young people lived with someone who smoked (including around one third who lived with a smoker who smoked in the house) although this differed by deprivation (57% and 19% respectively for those in the most deprived fifth versus 29% and 6% respectively for those living in the least deprived fifth of areas of Hull). More boys (7.9%) used e-cigarettes compared to girls (5.9%). E-cigarette usage among boys was higher than tobacco use.

The prevalence of smoking among adults in Hull is high [114]. From the local adult Prevalence Survey 2014 [66], smoking prevalence among survey respondents was 30.7% (32.4% for men and 29.3% for women). Although the local prevalence had decreased from 34.0% in 2011-12, it still is nevertheless around 50% higher than England. It is estimated that there are 63,500 smokers in Hull, half of which live in the eight most deprived wards in Hull (which have a prevalence of 37.4% to 48.4% compared to 31.6% in the next highest ward and 14.3% in Beverley ward which had the lowest prevalence). Overall, 8.4% used e-cigarettes (3.7% every day) and virtually all were current or former tobacco / cigarette smokers. The majority were using e-cigarettes to quit or cut down their tobacco usage.

From the Local Tobacco Control Profiles [116], in 2014/15, there were 2,787 smoking-related hospital admissions per 100,000 residents aged 35+ years (67% higher than England), lung cancer
registrations for 2012-14 were 130 per 100,000 population (63% higher than England), emergency hospital admissions for COPD for 2014/15 was 755 per 100,000 population (82% higher than England), and smoking-attributable mortality for 2012-14 was 434 per 100,000 population (58% higher than England) with 1,546 deaths attributable to smoking [117]. Using a slightly different method of calculation, the number of deaths attributable to smoking was calculated, and in 2013-15, one in five deaths in Hull was attributable to smoking (1,505 out of 7,384 over the three years) meaning that there were over 40 deaths every month directly attributable to smoking [77, 118]. This rises to 23.6% of premature deaths before the age of 75 years with a total of 643 premature deaths out of 2,730 over the three year period. The total cost of smoking each year in Hull is estimated to be £62 million (economic loss of productivity costs of £45 million, NHS costs of £10 million and additional social care costs of £7 million) [119-121]. This does not include the cost of tobacco purchased by residents who smoke which could be around £118 million per annum [116, 119, 121, 122].

Social marketing research completed in Hull during September 2009 to assess general public knowledge and perception of chronic obstructive pulmonary disease found a perceived health danger relating to quitting smoking – “quit and you’ll die!” together with a denial “it’s not related to me” attitude [9]. Further local qualitative work revealed an attitude with a lack of immediate consequences in relation to health and a lack of concern over the future: “It doesn’t really affect you when you are young but it might catch up with you later” [123].

For more detailed information, see the JSNA Toolkit: Smoking report.

What are the strategic needs?

It is necessary to work together to ensure people understand the benefit of positive life choices and know how to access information and seek early support to change. In order to do this effectively, health care providers need to work together with different communities to use existing assets to realise the benefit of positive life changes. Not smoking should be seen as the norm, with the aim of creating a smoke free generation. It should be recognised that different approaches and support are required for different people, and any specific problems or changes that are required should not be dealt with in isolation, but by considering the needs of each individual separately. The aims of the stop smoking services are to actively promote a smoke-free Hull, harness the wider public health workforce to deliver very brief advice to those people with whom they have contact in their day-to-day work (“make every contact count”), effect a reduction in the number of adult residents and pregnant women who smoke, and increase the number of people who remain smoke-free. It can help if people know that stopping smoking has immediate health effects improving circulation and lung function within weeks, shortness of breath within months and that the risk of heart disease and stroke are substantially reduced within 1-5 years and the risk of most cancers are substantially reduced within 5-10 years.

The current adult Smokefree Hull Service has a priority focus on people living in the most deprived wards (where smoking prevalence is the highest), pregnant women, and people with chronic obstructive pulmonary disease and coronary heart disease, with a separate smoking cessation service for young people.

Helping users quit through the provision of a cost effective, targeted smoking cessation service is just one strand of Hull’s revised Tobacco Control Plan. The Hull Alliance on Tobacco (HALT) Plan recognises the need to deal with other aspects of tobacco use if smoking prevalence rates are to be reduced. This broader approach is supported by national guidance and through bodies such as the World Health Organisation, National Institute of Health and Clinical Excellence (NICE) and the Regional Tobacco Control Group. In practice this means that in addition to helping people quit, the availability of tobacco has to be controlled through effective regulation, making tobacco less affordable and limiting its promotion in communities. People also have to be protected from the harmful effects of second hand cigarette smoke which is proven to have a harmful effect on health.
There needs to be effective communication across all of the different strands of the tobacco control plan. There is a need to support people to make healthy lifestyle choices, to educate young people about the risks of starting smoking, to motivate users to quit, to provide information of how best to quit, to encourage communities to not see smoking as the norm and to promote compliance with tobacco control legislation which is aimed at protecting people from the harm caused by smoking.

References