The reciprocal relationship between social disadvantage, financial stress and smoking: What does the research tell us? What can community service organisations do?

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Executive summary
There is a reciprocal relationship between smoking and disadvantage. Social deprivation increases smoking and smoking reinforces disadvantage. Breaking this cycle should be a priority. Community services have much to contribute to this effort.

How disadvantage contributes to smoking
People in lower socio-economic positions have higher smoking rates than better off people. Groups facing multiple disadvantages have the highest smoking rates of all.

They are more likely to:
- Start smoking
- Smoke more heavily
- Smoke for longer (more years)

Why is this so? There are two main reasons:
- Smoking is 'normal' in very disadvantaged groups and communities. Growing up with and being surrounded by smokers reinforces this behaviour.
- Smoking is a means of coping with, and respite from, difficult and stressful circumstances:
  - The constant struggle to get by on a limited income
  - The strain of caring for children, especially as a single parent
  - The difficulties of living in an unsafe, and poorly resourced neighbourhood
  - Having very limited opportunities for respite and recreation

These factors also mean that people in disadvantaged groups and communities are:
- Less likely to quit smoking
- More likely to relapse if they do quit

How smoking reinforces and increases disadvantage
There is growing evidence that smoking reinforces and intensifies disadvantage:
- Disadvantaged smokers spend a greater amount and proportion of income on cigarettes than other smokers
- Spending on cigarettes means less money for essentials like food, clothing, housing
- Smokers have more illness and disability which reduces employment opportunities and income

Research shows that:
- Smoking increases financial stress and deprivation:
  - Smokers are twice as likely as non-smokers to report going without meals or being unable to heat the home
  - 42% of low income smokers reported spending money on cigarettes rather than on essentials like food
- Giving up smoking reduces financial stress and improves wellbeing

Community service organisations can assist by:
- Continuing advocacy to improve the employment, housing, education, safety and leisure options for disadvantaged people. This will reduce hardship and the need for smoking as a coping mechanism.
- Integrating concern about smoking and practical assistance to help people quit into routine service delivery.
- Having service environments that support people being smoke free.
Introduction
These notes describe the reciprocal relationship between social disadvantage and financial stress on the one hand and smoking on the other. Abundant research evidence demonstrates the association between social deprivation in its various forms and higher smoking rates. There is also a growing body of research that indicates the other side of the relationship - that smoking reinforces and intensifies financial stress and material hardship. The picture that emerges is of a vicious cycle between social deprivation, financial stress and smoking. Finding ways to break this cycle should be an urgent priority and is an area in which community service organisations have much to contribute.

How disadvantage contributes to smoking
The relationship between low socio-economic status and smoking is well established. Groups in lower socio-economic positions have higher rates of smoking [1]. Social deprivation in its various forms; unemployment, homelessness, isolation, drug and alcohol dependence, poor housing, single parent status etc, is associated with higher smoking rates and lower rates of quitting. And it is the most disadvantaged who have the highest rates of all.

The figures below show smoking rates for some very disadvantaged groups in Australia.

- Aboriginal and Torres Strait Islander people (50%) [2]
- homeless people (70%) [3]
- people with a mental illness (20-90%) [4]
- people with drug and alcohol problems (51-91%) [4]
- young people at risk’ (65%) [5]
- single mothers (46%) [6]

As well being more likely to smoke in the first place, disadvantaged groups are generally heavier smokers and smoke for more years than other smokers.

Siahpush et al [7] found that Australian households headed by a person with lower education or occupation spent more on tobacco than other households. Whitlock et al [8] found that people living in disadvantaged communities smoke more than other groups. People with substance abuse problems and severe mental illness also tend to be heavier smokers [9, 10].

Smokers from lower socio-economic groups also smoke for more years. Data from the 2001 National Drug Strategy Household survey showed that blue-collar workers smoked 14% longer from onset to cessation than professional groups. Those on incomes less than $300 per week smoked 38% longer than individuals earning $ 800 or more a week [7].

Social disadvantage and financial stress is not only associated with people starting and keeping on smoking, it also acts as a barrier to quitting and contributes to relapse.

Dorsett and Marsh [11] examined smoking among single mothers in the UK. They found that smoking was used as a means of stress relief and that financial hardship was the main barrier to quitting. Hardship was defined as being worried about money; having a debt that could not easily be paid and, not being able to afford food and clothes. Another English study among low-income women smokers found that
problems with; housing, income, employment and general living standards was a barrier to quitting smoking. The difficulty women had coping with these problems and the resulting stress they felt was also the main reason for relapse after quitting [12]. Similar issues were found in Australian research which reported that smokers with greater financial stress (having difficulty with bills, going without meals) were less likely to quit and more likely to relapse [13].

In summary then, disadvantaged groups are more likely to:
- Start smoking
- Smoke more heavily
- Smoke for longer (more years)

The difficulties of their circumstances and the stress they feel from this:
- Can act as a barrier to quitting
- Increases their chances of relapse

What is it about disadvantage that reinforces smoking?

The links between smoking and disadvantage are well established. But what are the mechanisms that explain this relationship? How does personal disadvantage and the experience of living in a disadvantaged community foster smoking? Qualitative research provides some insights into the factors at work and the roles that smoking plays among marginalised people. It is not just that poor material circumstances are harmful- it is what these circumstances mean to people that also matters.

The pivotal role of smoking among disadvantaged people is that of a coping mechanism. Vulnerable people see smoking as helping them to deal with the difficult and stressful aspects of their daily lives [14, 15, 17]. Some of the main difficulties include:
- The struggle to cope on a limited income and ongoing financial stress
- The strain of caring for children and others, especially as a single parent [16]
- Living in an unsafe (high crime, drug use) and poorly resourced environment
- Having limited opportunities for respite and recreation [17]

For many disadvantaged people smoking is accepted as part of the fabric of their lives [16, 17]. There is a real fear of being unable to cope without smoking and concern about the consequences of giving up cigarettes- particularly for women caring for children,[15]. Others are daunted by the lack of support from family or friends to quit or the absence of alternative pleasures activity to fill their time [17, 18].

"Your fags and a video. That’s the cheapest night out”

Other features of life in disadvantaged groups or communities that encourage smoking are [15]:

- **The normalisation of smoking:** Growing up with and being surrounded by smokers makes it seem normal and reinforces smoking behaviour. These factors also underlie high consumption and expenditure on tobacco ("cigarettes first, food second").
- **Isolation from the wider community:** Due to geographic features and poor transport infrastructure disadvantaged groups are often isolated from the wider, more affluent community. As a result they are less exposed to alternative norms and more negative views on smoking.
- **Smoking as a means to identity and social cohesion:** Disadvantaged groups and communities may feel excluded and stigmatised by the wider society. Smoking plays a role in compensating for this exclusion, binding people together in a common identity and experience, aiding social interaction and a sense of belonging and providing a means for sharing (lending and borrowing cigarettes).
- **A lack of optimism and confidence that change is possible:** A sense of self-efficacy (confidence in ability to make changes in your life) is associated with success in quitting smoking [19, 20]. Many disadvantaged smokers lack self-efficacy [16,17,19]. Moreover, it is suggested that people give up smoking more from optimism (a sense that things can improve or are improving). For many marginalised people and communities there are fewer causes for optimism. One study found that improvements in financial circumstances could trigger a quit attempt but that a deepening of financial hardship actually intensified the need for tobacco [15].

"Disadvantaged communities are not only rich in factors which foster smoking, they are poor in factors which foster giving up"

[15], p 339

**How smoking maintains and exacerbates disadvantage**

There is growing evidence that smoking contributes to social disadvantage with smoking being a strong predictor of financial stress [21]. Reasons for this include:

- Disadvantaged smokers have lower incomes to start with.
- Disadvantaged smokers spend a greater amount and greater proportion of income on cigarettes than other smokers
- Spending on cigarettes means less money for essentials like food, clothing and housing
- Smoking is associated with increased spending on alcohol and gambling
- Smokers have more illness and disability and therefore higher health care costs and reduced employment opportunities

Disadvantaged smokers who rely on income support payments or who are on low wages spend a greater proportion of their income on tobacco than other smokers [22]. In the US Steinberg et al examined the situation of people with severe mental illness who were attending outpatient treatment services. Most were on public benefit although some received financial support from their families. The study found this group spent an average of 27.36% of their monthly income on cigarettes. Families headed by someone with less education also spend more on tobacco [23]. One ex-
homeless person said in an interview for the Tackling Tobacco Program “When I was on the street, cigarettes were my sustenance”

Several Australian studies have added to our understanding of the impact of smoking on financial stress and material hardship:

- Siahpush, Borland and Scollo [24] examined data from a sample of 6892 households across all income levels taken from the 1998/99 Household Expenditure Survey conducted by the Australian Bureau of Statistics. Fourteen items were used to identify financial stress. Items such as: being unable to pay bills; having to pawn or sell something and; seeking financial help from family indicated financial stress. Items such as: going without meals; being unable to heat the home and seeking assistance from a welfare organisation indicated more severe financial stress. Together the items were collapsed into a single financial stress index. The results show that smoking households and those from low socio-economic backgrounds experience greater financial stress. Smoking households were one and a half times more likely to experience stress and twice as likely to experience severe financial stress than non-smoking households. Financial stress was also greater for households who spent more on tobacco and had lower income.

- Siahpush, Borland and Yong [25] assessed a sample of 7802 people taken from the International Tobacco Policy Evaluation Survey in Australia, US, UK and Canada. They examined responses to the question: “In the last 6 months have you spent money on cigarettes you knew would be better spent on household essentials like food. Yes/No” If people responded yes they were assessed as experiencing smoking induced deprivation. In Australia 33% of smokers responded positively to this question. However, when the sample was assessed by income brackets, 42% of smokers on low income (less than $30 000 per year) had spent money on cigarettes rather than essentials. This study also examined quit attempts. It found that smokers experiencing financially induced deprivation were more likely to want to quit and to plan and make a quit attempt but were less likely than other smokers to succeed. The stress they felt increased the likelihood of relapse.

The above studies are cross sectional in nature and so it is not possible to draw causal inferences from the data. Longitudinal data is required to analyse changes in financial stress in relation to changes in smoking and accurately determine the causal mechanisms involved. The following study meets these requirements:

Siahpush, Spittal and Singh [26] analysed data from Waves 1-3 (2001-2004) of the Household Income and Labour Dynamics Survey (HILDA) in Australia to examine the impact of smoking cessation on financial stress. In their analysis the researchers compared two groups of people; respondents who reported being a smoker in all three years of the study with those who were a smoker in Year 1 but who quit in year 2 and remained quit in year 3. This enabled the researchers to distinguish continuing smokers from those who had quit for a year or more. Once identified, the researchers compared these groups level of financial stress and material wellbeing to see if quitting had an effect on these circumstances.

Financial stress was measured by the question:
“In the past 6 months did any of the following happen to you because of shortage of money”
- Could not pay electricity, gas or phone bills on time
- Could not pay the mortgage or rent on time
Respondents were also asked to assess their material well being by responding to the question:

“Given your current needs and financial responsibilities, would you say that you and your family are: prosperous; very comfortable; reasonably comfortable; just getting along; poor or; very poor”

Of the 1747 smokers in Wave 1 92.2% (n= 16100) remained smokers during all three waves of the study. Approximately 63% of the smokers experienced financial stress and their mean wellbeing score was 3.6 in Wave 3. By contrast 49% of the quitters experienced financial problems and their mean wellbeing score was 3.8. After controlling for other variables the odds of experiencing financial stress in Wave 3 were 42% lower for people who quit than for continuing smokers. The researchers concluded that the results show that stopping smoking contributes to reduced financial stress. This provides additional incentives for smokers to quit and can be used by those who encourage cessation to underscore the benefits of quitting. They also concluded that campaigns and interventions to encourage smoking cessation were likely to help improve standards of living and reduce deprivation.

As disadvantaged smokers are likely to smoke more heavily and for a longer duration they are likely to suffer a longer period of impeded well being and compromised living standards than those who are better off. All this tends to reinforce and intensify their disadvantage.

**Conclusions and Implications**

The studies described above are part of growing evidence that the relationship between deprivation and smoking is reciprocal [1, 26]. Social disadvantage and deprivation encourage smoking, acts as a barrier to quitting and increases the risk of relapse and, smoking contributes to increased financial stress and social disadvantage.

As Michael Marmot and Richards Wilkinson state [27]:

"The causal pathway probably runs both ways.......Social deprivation-whether measured by poor housing, low income, lone parenthood, unemployment or homelessness- is associated with high rates of smoking and very low rates of quitting. Smoking is a major drain on poor people’s incomes and a huge cause of ill health and premature death”

[27] p 24
We can represent the relationship between smoking and disadvantage in the diagram below.

The Vicious Cycle of Smoking and Disadvantage

Disadvantage and deprivation in its various forms create conditions in which people may feel stressed, isolated, excluded and unable to cope*. This, together with smoking being seen as 'normal', leads to a vulnerability to smoking (and other addictions) which results in increased smoking and lower rates of quitting. Unfortunately, smoking offers no escape from adversity or genuine relief from stress [27]. In fact it intensifies users’ difficulties by taking money from essentials and increasing their financial stress at the same time as undermining their physical health. In the long term smoking erodes peoples' quality of life and reinforces or intensifies disadvantage and material hardship.

* Feelings of being isolated, stressed and unable to cope are clearly not restricted to disadvantaged people but they are likely to be more pronounced and prolonged for groups and communities in very adverse circumstances.
**What can be done?**

What can be done about this cycle of smoking and disadvantage and what role can community service organisations play.

There are two main points of intervention.

The first intervention point is to reduce the extent of social disadvantage and deprivation. The studies cited above remind us of the influence of the social environment on health behaviour [15]. Efforts to change addictive behaviours such as smoking must not only provide personal treatment and support but also address the patterns of social deprivation in which those problems are commonly rooted [27]. This means developing broad social and economic policy that can reduce poverty and deprivation and improve things like housing, education, and employment opportunities for the most disadvantaged. The strong links between smoking and neighbourhood disadvantage also calls for the revitalisation of local communities through investment in physical and social infrastructure [15].

Community service organisations have a clear role to play at both levels. Some are involved in advocacy for a more caring, just and equitable society and lobby for policy changes to that end. Many contribute in planning and most contribute in service provision for local communities. Community service organisations will not usually be thinking about reducing smoking related harm as they do this work- they will be trying to achieve other positive results for children, families and communities. Nevertheless, because so many social ills have common causes their efforts in these areas will also have an impact on smoking.

The second area of intervention relates to both the impact of service environments and direct support for smoking cessation within community services.

The research into smoking and disadvantage encourage us to think of strategies to address smoking not just as public health initiative [26]. Targeting smoking among disadvantaged groups and encouraging them to quit may assist their upward mobility and help reduce social inequality. This finding should encourage welfare and other social service organisations to integrate practical support for smoking cessation into their programs. [1]. This may require education for workers to provide knowledge about smoking and some skills in practical quit support. It will also motivate agencies to consider whether their service environment is one that encourages quitting or inadvertently reinforces smoking among clients and staff*. There is reason to believe that disadvantaged groups would welcome assistance with smoking. Single parents, the homeless and people with drug and alcohol problems are all groups that have appealed for help with smoking to be incorporated into the community services that they regularly use and already know and trust [16, 17]. They want information and practical support to quit smoking.** But they want it delivered in a way that recognises the role of the role of smoking in their lives and in the other issues they face[16, 18].

Ultimately no one group or sector will be able to bring about change on their own. Many players are needed to help reduce smoking related harm among our most vulnerable and disadvantaged people. But community service agencies are in a good position to make a very useful contribution to breaking the cycle of smoking and disadvantage and in so doing improve the wellbeing of the people they serve.

** For more ideas on this see: The Cancer Council NSW. Clearing the smoke: Best practice smoking cessation strategies for people with multiple disadvantages. Sydney: The Cancer Council NSW; 2008.
References


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