Tax and spend: a policy to help poor smokers

The contribution by Flint and Novotny in this issue of Tobacco Control shows, for the United States in 1983 to 1993, a large and persistent excess of smoking prevalence among Americans in poverty—essentially those in the bottom 15% of the relative income distribution. There is a corresponding deficit in smoking cessation rates among poor ever-smokers. This gap in smoking behaviour, and the long-term health penalties it almost certainly imposes on poor communities, remains independent of all important control variables associated with low income among American citizens.

These data almost certainly speak for other countries too. In Britain nearly a third of smokers are now confined to the bottom 10% of the income distribution and prevalence rates exceed 50% among families in public housing or receiving welfare. In addition, the British data showed directly that expenditure on smoking increased hardship, measured by the incidence of unmanageable debt and families' inability to afford essential items such as food, clothing, and basic durables. These findings also stood independently of the effects of background variables traditionally associated with increased risk of hardship.

The American and British governments have each set millennium targets for smoking cessation, reducing smoking prevalence respectively to 15% and 20%.1 The data referred to above suggest that those targets will not be met unless renewed anti-smoking efforts are directed to poor families, in addition to those aimed at women and ethnic minorities.

The main problem, as Flint and Novotny appear to show, is cessation rates.1 Quite large numbers of better-off young people take up smoking but give it up in their 20s and 30s, often when they have their own children. During the 1980s in Britain they walked away from smoking, halving prevalence among the top income quartile.2 For those in the bottom quartile quitting seemed far more problematic.

The difficulty may lie in the relation between inequality (rather than poverty itself) and optimism. Smokers quit for optimistic reasons: to look better, feel better, gain social approval, and avoid illness. Better-off people have all kinds of reasons to be optimistic about themselves. Crucially, they have many compensations for the temporary reduction in affect control that quitting may bring. But those who left school without qualifications and entered low-paid work, publicly subsidised housing, single parenthood, and so on, have little reason for optimism, and less reason to value their future. They find it hard to give up what many say is their "one luxury".2 Smoking may even have become a defiant badge of lower class status. In a world where many luxuries appear to be the daily entitlement of the majority, the one luxury of smoking can feel like a necessity to the poor.

This problem is made more urgent by the steady widening of income inequality, especially in Britain and the United States. Richard Wilkinson's work suggests that such inequality independently imposes its own penalties on national health and mortality rates.3 The large excess of smoking among the poor will be part of this mechanism of health disadvantage. Poverty increases smoking prevalence; inequality lowers optimism and discourages cessation; and the cost of smoking deepens hardship.

What can be done to break into this cycle? The aim will be to reduce smoking prevalence among people with low incomes who are aged 20 to 50. Among this age group, most of the poor have children, especially the growing numbers of lone (single) parents: in Britain they are a quarter of families and 60% of them smoke.4 It seems unlikely that spontaneous cessation will suddenly become popular among such families. Serious reductions in smoking will need serious help, and relying on taxation policy alone will not bring it about either. The irony of these data is that those who can least afford to smoke have responded least to the lead policy in tobacco control: ratcheting up tobacco taxes year after year beyond price inflation. Although tax hikes seem to depress tobacco consumption right across the income range, for a while at least, they appear to leave smoking prevalence untouched among low-income people. Are there ways out of this policy dilemma?

The first important point to make is that whatever is to be done about it, arguments that there is no money available to do it are not acceptable. In Britain, for example, most of the families receiving welfare benefits smoke. Through tobacco taxation, they return 16% of the value of their welfare cheques to the Treasury, equivalent to about a billion dollars (£600 million) a year.5 Flint and Novotny's data similarly imply that the annual tobacco tax take of $13 billion received by federal, state, and local governments in the United States6 is also contributed disproportionately from welfare incomes. We must take a new view of this money.

If even a small fraction of these sums are re-targeted into a serious programme of intervention among smokers receiving welfare benefits, health promotion could draw on resources on a scale previously only dreamt about. For example, poor smokers seem to cleave particularly to the anodyne qualities of smoking. This makes them especially suitable to nicotine replacement therapies. There are procedures in all welfare systems for delivering non-cash benefits to welfare families. Delivering otherwise costly gum and patches within the context of both professional and voluntary sector local health initiatives might be highly effective in breaking the malignant spiral of poverty and smoking.

But the increasing isolation of low-income communities means that seed-corn initiatives must be supported from within, to help poor families defend themselves against the millions spent promoting tobacco sales. It is impressive how, for example, few of the poorest members of black evangelical churches in Britain smoke, even if they are lone parents. In the United States, cigarette smoking prevalence has fallen noticeably among African American youth.8

Only among the poorest communities is smoking still a normative behaviour. A seriously funded assault on smoking in low-income communities could destroy this last protected habitat of what is still the most dangerous preventable threat to public health. Once smoking has gone, it will not return. And one of the worst pandemics in the whole story of public health in developed countries will be over. There is cause for real optimism, overshadowed only by the prospect that the contest will then have to be fought all over again in the Third World.

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*Tob Control* 1997 6: 5-6
doi: 10.1136/tc.6.1.5