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Title:

Tobacco Control Policies, Social Inequality and Mental Health Populations: Time for a comprehensive treatment response.

Running Title:

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Corresponding Author:

Dr Sharon Lawn, BA, DipEd, MSW, PhD
Flinders Human Behaviour & Health Research Unit
Flinders University
Room 4T306, Margaret Tobin Centre
GPO Box 2100
Adelaide
South Australia 5001
Telephone: 61 8 8404 2321
Facsimile: 61 8 8404 2101
Email: sharon.lawn@fmc.sa.gov.au

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Tobacco Control Policies, Social Inequality and Mental Health Populations: Time for a comprehensive treatment response

A recent report conducted by Access Economics for SANE Australia has comprehensively reviewed the economic costs of smoking for Australian smokers with mental illness and found that the financial cost to these smokers is $33 billion (AUST) per year [1]. Internationally, research has estimated the economic costs of smoking to reach $500 billion (US) by 2010 [2]. This prompts a long-standing debate about tobacco control initiatives and their effectiveness and consequences for vulnerable populations. Chapman [3] has argued for increased tobacco control, stating that those who see tobacco as a legitimate product and tobacco control as jeopardising the financial benefits gained through tobacco excise are ill-informed regarding its social costs and the ethics of continuing to support its revenue-raising role. However, the price and demand relationship of some commodities may be very elastic for some groups within the population, that is, raising taxes on them will not necessarily lead to reduced demand for those commodities. It is time to unpack the debate and advocate for more to be done for smokers with mental illness, beyond mere broad population-based tobacco control strategies and policies and piecemeal support to quit.

The Costs of Smoking, Elasticity and People with Mental Illness:

People in lower socioeconomic groups have previously been found to quit smoking more in response to price rises than those with higher disposable incomes [4,5,6]. A global report by the World Bank [7] found that raising taxes on tobacco by 10% would lead to a 4% reduction in demand for cigarettes in high income countries and an 8% reduction in demand in low income countries. In a review of thirty-five years of policy on tobacco consumption, Bardsley and Olekalns [8] argued that increasing the price of cigarettes has had the greatest impact on consumption declining, with education and reduced advertising having minimal effects. However, their conclusions are strongly challenged by other researchers on methodological grounds [9,10]. Raising taxes is clearly effective in reducing consumption and is also thought to discourage children and adolescents from commencing

smoking, although some researchers have raised questions about the efficacy of this approach with adolescents [11].

Unfortunately, where government taxes on tobacco have increased, research has found that government revenue from those taxes has also been disproportionately high. That is, the expected decline in consumption from the act of raising taxes has not occurred. Increased revenue from increased taxes has been found to be disproportionately more, suggesting that some smokers are slow to respond to price rises. Their smoking behaviour has remained elastic, despite price rises. Smokers with a mental illness may fit this description. The World Bank report [7] expressed concern that increasing taxes on tobacco would have a disproportionate impact on poorer consumers because taxes consume a higher share of their income than richer consumers. It further suggested that the loss of perceived 'benefits' of smoking to lower income smokers may be comparatively greater than for higher income smokers.

A number of researchers have attempted to quantify the costs and benefits of tobacco smoking to the Australian community over the past two decades. A report by ACIL Economics and Policy [12], an independent body funded by the Tobacco Institute of Australia, concluded that smokers at that time, "more than pay their way in the community," by providing $12.5 billion net benefits; that they subsidise our health care services and are taxed over and above any costs to the community. In 1995, the Australian Federal Government collected $3.8 billion in sales and excise taxes for alcohol and tobacco; however, only $36 million of this was spent on programmes to decrease use. In South Australia, for the same year, only five per cent of revenue raised was returned to treatment programmes, with similar figures for other states [13]. Collins and Lapsley [14] conducted Commonwealth funded studies in 1988 and 1992 looking at the economic and social costs of smoking to the Australian community. Tangible costs to the smoker, other individuals, to business and to government such as costs of medical treatment, loss of productivity and work days, were quantified. Direct health care costs to the Australian community were estimated to be $833 million. Costs of passive smoking and reduced

productivity were not included. Intangible costs such as loss of enjoyment of consumption forgone and the value of loss of life to the deceased were also not quantified. Pain and suffering caused to the individual, family and friends and loss of enjoyment of life were not included. The total for tangible and intangible costs of smoking for 1992 was $12,736.2 million [14]. In 1996-7 the total number of hospital episodes attributable to drug use was 256,991, with 149,834 or approximately 60% being due to tobacco. The net total of government revenue from the sale of tobacco in 1991-2 was $2,473.9 million (AUST). In 1997-8 this figure was estimated to be $4,231.6 million (AUST) [15]. In 2007, this figure has risen to $2.8 billion (AUST), yet there is little evidence of equitable funding and few programs to help those who want to quit [1]. These figures suggest that smoking involves substantial costs for the smoker and the community and that these costs outweigh the benefits of revenue received from tobacco sales. Research by Collins and Lapsley [16] confirms that "governments gain a substantial economic benefit from smoking while the community as a whole bears very high economic costs greatly exceeding revenue from tobacco taxes".

Smoking is an expensive habit. The social implications for people on limited incomes are recognised [17]. Some have questioned whether people with mental illness who are chemically dependent should be allowed to spend their funds as they choose, without supervision, or to receive government payments at all. In the US, specific restrictions on pension eligibility have existed where the person is dependent on substances. Time restrictions on pension payments and the obligation to seek treatment have been part of these conditions 18]. Research has found that controlling the supply of pension funds to people with substance dependence does not necessarily alter their desire for substances, although it may assist in imposing some control and thereby improving treatment effectiveness, quality of life [19] and compliance with treatment [20].

Clearly, the human costs of smoking for the individual and the community are substantial [21, 22]. Tobacco control measures are needed and they have been internationally successful [23]. Of relevance here is the identification of who bears that

cost, how disproportionate that cost is and how the community and society respond to this. People with mental illness already experience high levels of social exclusion and health inequality, which are exacerbated by smoking [24]. In the UK, for example, 83% of prisoners smoke and 90% of homeless people smoke. Internationally, multiple research studies have confirmed that approximately 75% of people with a mental illness smoke. In Australia, 40% of smokers have a mental illness [1]. In the US, 45% of all cigarettes are smoked by people with mental illness [25]. In Australia, this figure is more than 42% for people with mental illness [1]. Social disadvantage and smoking go hand in hand [26] and this is likely to be an increasing trend as these groups increasingly and disproportionately make up those who continue to smoke, whilst those who are more able will successfully quit. Tobacco control strategies on their own are clearly inadequate and will be increasingly so.

Raising the cost of cigarettes to depress the demand for them has been shown to induce some smokers to quit or cut down their consumption, and to prevent others from commencing smoking [7, 27]. However, a Canadian study looking at disadvantage and low quit rates found that peoples' immediate circumstances were overwhelming motivators to continue smoking as a mechanism for coping with those circumstances, regardless of long-term goals for better health and financial stability [28, 29]. With this in mind, the impact of price rises on the smoking behaviours of people with mental illness has not been comprehensively studied and, therefore, price increases as sufficient motivators for change cannot be assumed for this group. What we do know is that they spend a great deal on cigarettes as a proportion of their income. A study by Lawn [30] found that smokers with a mental illness were returning approximately 27.7% of their total income to the government treasury in excise taxes on tobacco [17]. Another Study found that mentally ill smokers elevated the importance of cigarettes, often choosing them over food, security of accommodation and safe interactions with others. Few of these smokers altered their smoking behaviour when the price of cigarettes increased, though most expressing wanting to quit [31]. These smokers therefore demonstrated the elasticity of their responses to cigarette price rises.

A Role for Mental Health Services

Current tobacco control policies may well work at reducing the incidence and prevalence of smoking within the general population but they do little to reduce rates among vulnerable populations. Policies that increase the cost of cigarettes raise significant equity and social justice questions because of their potential to exacerbate the poverty of people with mental illness. The above evidence also suggests that such strategies largely do not work for these populations. Recommendations restricting payment of government benefits to mentally ill smokers as a means of reducing their spending on cigarettes and prevalence therefore of smoking in this group, may likewise be misdirected. Jarvis [32] asked, "If improved overall life expectancy as a result of current tobacco policy leads to a situation in which widening health inequalities mean that such disadvantaged groups are left behind, does this matter?" The answer must be "yes". If we consider that one in five people experience mental illness then they are not a minority that can be ignored. Therefore, strategies that are based on sound evidence and involve the full consultation with people with mental illness and the mental health sector [1] are needed to make support and treatment for nicotine dependence more readily available to these populations. One example of positive change is the recent New South Wales Cancer Council launch of its tobacco control and social equity strategy [33] to help guide policy in that state, one of the first nationally to clearly link the two initiatives and to see tobacco control firmly as a social justice issue. The time is ripe for mental health service staff to increase their advocacy and lobbying on this issue with and for people with mental illness. Smoking is a behaviour that has evolved over the past decades from a position of being a social choice to recognition that is a serious addiction that requires comprehensive support for people to quit. The complexity of this issue for people with mental illness means that a multi-layered and systematic clinical response is needed, as part of a holistic response that recognises the need to address social inequality fundamentally. Psychiatry is increasingly understanding and espousing the importance of the social world of people with mental illness and is therefore ready to lead this process.

References:

1) Access Economics. *Smoking and Mental Illness: Costs*. Report by Access Economics Pty Ltd for SANE Australia, 2007. [cited 18 Dec 2007] Available from URL: http://www.sane.org/images/stories/information/research/0712_info_smokecosts.pdf
2) Mackay J, Eriksen MP. *The Tobacco Atlas*. Geneva, Switzerland: World Health Organisation, 2002.
3) Chapman S. Tough on Drugs – Weak on Tobacco. *MJA* 2000; 172:612-614.
4) Chapman, S. Economic Debate about Smoking. *MJA* 1995; 163:118-119.
5) Townsend J, Roderick P, Cooper J. Cigarette Smoking by Socio-economic Group, Sex, and Age: Effects of Price, Income, and Health Publicity. *BMJ* 1994; 309:923-927.
6) Wasserman J, Manning WG, Newhouse JP, Winkler JD. The Effects of Excise Taxes and Regulations on Cigarette Smoking. *J Health Econ* 1991; 10:43-64.
7) Jha P, Chaloupka FJ. *Curbing the Epidemic: Governments and the Economics of Tobacco Control.* Washington, DC: The World Bank, 1999.
8) Bardsley P, Olekains N. The Impact of Anti-Smoking Policies on Tobacco Consumption in Australia. *Health J Aust* 1999; 9(3):202-205.
9) Chapman S. If You Can't Count It…It Doesn't Count: A Commentary on Bardsley & Olekains – The Poverty of Econometrics in Explaining Complex Social and Behavioural Change. *Health Prom J Aust* 1999; 9(3):206-207.
10) Borland R. On Apparent Consumption and What Goes Up in Smoke: A Commentary on Bardsley & Olekains. *Health Prom J Aust* 1999; 9(3):208-210.
11) Doran CM, Girgis A, Sanson-Fisher RW. Smoking by Adolescents: Three Years Later, There's Even Larger Revenue But Little For Prevention. *Aust N Z J Public Health* 1998; 22:321-323.
12) ACIL Economics & Policy. *Smoking: Costs and Benefits for Australia: An Independent Study.* Canberra: ACIL Economics & Policy Pty Ltd / Tobacco Institute of Australia, 1994.
13) Meade A. Drug Abuse Costs Us $1.4bn A Year. In K. Healey (Ed.) *The Drug Debate: Issues For The Nineties, Vol.43.* Balmain, Australia: The Spinney Press, 1995.

14) Collins D. Lapsley, H. *The Social Costs of Drug Abuse in Australia in 1988 and 1992, National Drug Strategy Monograph Series No. 30.* Canberra: Commonwealth Department of Human Services and Health, 1996.
15) Higgins K, Cooper-Stanbury M, Williams P. *Statistics on Drug Use in Australia 1998.* Canberra: Australian Institute of Health and Welfare, 2000.
16) Collins D. Lapsley H. The Social Costs Of Smoking In Australia, *N S W Public Health Bull* 2004; 15(5–6):92–94 [cited 18 Dec 2007] Available from URL: http://www.health.nsw.gov.au/public-health/phb/HTML2004/mayjune04html/article3p92.htm
17) McCreadie RG. Kelly C. Patients with Schizophrenia Who Smoke: Private Disaster, Public Resource. *Brit J Psychiatry* 2000; 176:109.
18) Rosenheck R. Disability Payments and Chemical Dependence: Conflicting Values and Uncertain Effects. *Psych Serv* 1997; 48(6):789-791.
19) Rosenheck R, Lam J, Randolph F. Impact of Representative Payees on Substance Use by Homeless Persons with Serious Mental Illness. *Psych Serv* 1997; 48:800-806.
20) Shaner A, Roberts LJ, Eckman TA, et al. Monetary Reinforcement of Abstinence from Cocaine among Mentally Ill Patients with Cocaine Dependence. *Psych Serv* 1997, 48(6):807-810.
21) Collins DJ. Lapsley HM. *Counting the cost: Estimates of the social costs of drug abuse in Australia in 1998–99.* National Drug Strategy Monograph Series No. 49, 2002. [cited 18 Dec 2007] Available from URL: www.health.gov.au/pubhlth/publicat/document/mono49.pdf
22) Wilkinson R. Marmot M. (Eds) *Social determinants of health: The solid facts.* Second Edition. Geneva: Switzerland: World Health Organisation. 2003.
23) Gostin LO. Global Regulatory Strategies for Tobacco Control. *JAMA* 2007; 298(17):2057-2059.
24) Office of the Deputy Prime Minister. *Mental health and social exclusion: social exclusion unit report.* London: ODPM, 2004).

25) Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D. Bor DH. Smoking and Mental Illness: A Population-Based Prevalence Study. *JAMA* 2000; 284:2606-2610.

26) Jarvis M. Wardle J. Social patterning of individual health behaviours: the case of cigarette smoking. In Marmot M. Wilkinson RG. (Eds) *Social Determinants of Health*. Second Edition. UK: Oxford University Press, 2005.

27) Centers for Disease Control and Prevention. *Strategies for Reducing Exposure to Environmental Tobacco Smoke, Increasing Tobacco-use Cessation, and Reducing Initiation in Communities and Health-Care Systems: A Report on Recommendations of the Task Force on Community Preventive Services.* Atlanta: Centers for Disease Control and Prevention, 2000.

28) Stewart MJ, Brosky G, Gillis A, Jackson SG, Johnston G, Kirkland S. Disadvantaged Women and Smoking. *Can J Public Health* 1996; 87(4):257-260.

29) Stewart MJ, Gillis A. Brosky G, et al. Smoking among Disadvantaged Women: Causes and Cessation. *Can J Nurs* 1996; 28(1):41-60.

30) Lawn SJ. Australians with mental illness who smoke. *Brit J Psychiatry* 2001, 178:85.

31) Lawn SJ, Pols RG. Barber JG. Smoking and Quitting: A Qualitative Study with Community-Living Psychiatric Clients. *Soc Science Med* 2002; 54:93- 104.

32) Jarvis M. *The relationship between smoking and social inequality: inequalities and addictions – an exploration of the relationship.* Public Address to the University of South Australia, 15 November 2002, Adelaide.

33) The Cancer Council NSW. *Lifting the Burden: Tobacco Control and Social Justice Equity Strategy July 2006 to June 2011*. Sydney: The Cancer Council NSW, 2007.