Op-Ed/Editorials: Lay Epidemiology and Smoking Rates in Social Classes

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Researchers and the public have observed the relationship between social class and likelihood of smoking; for example, professionals are less likely to smoke than unskilled laborers (Petersen, Mockford, & Rayner, 1999; Wald, Kiryluk, Darby, Doll, Pike, & Peto, 1988). In a recent commentary, Lawlor, Frankel, Shaw, Ebrahim, and Smith (2003) claim that lay perceptions of quality of life disparities between social classes best explain differential rates in smoking. They argue that poor housing conditions, occupational hazards, and other environmental dangers all pose a more immediate threat to health than smoking. As a result, for the poor, smoking becomes a rational choice. Indeed, when coping with such day-to-day challenges, quitting smoking seems less of a priority and comparatively might have lesser benefits: if a person is not likely to live long enough to experience the negative consequences of smoking, giving up the pleasures smoking provides might not seem worthwhile.

Poverty is undoubtedly a major contributor to disparities in general health. Poverty also contributes more specifically to the continuation of smoking in lower socio-economic groups. To effectively address smoking addiction among the economically disadvantaged, one must also account for the powerful psychological influence of poverty. The persistent resistance of disadvantaged populations to past and current anti-smoking initiatives is a "rational response within a particular cultural context" (Lawlor et al., 2003, p. 266). The "cultural context" is an expression of the psychological impact of living in poverty with all of its sequelae. One illustration of this circumstance relates to problem gambling: people of lower socio-economic groups tend to spend a greater proportion of their income gambling than their more affluent counterparts because they seemingly have more to gain by winning. The hope and desire to relieve financial problems by a large gambling win minimizes

the perceived risk of gambling and perhaps rationalizes the amount of money lost—after all, the poor will not become poor by losing, but they might become wealthy, even if it is only a remote possibility. This is the psycho-economics of gambling. There is a similar psycho-economics of smoking. Smoking might seem less dangerous to those living in poverty because this population has less to gain by quitting; the wealthy have more to lose by not quitting.

It is also important to consider the global cultures represented in impoverished populations when defining the "cultural context." In Britain, for example, ethnic minorities are much more likely than whites to fall in the low-income bracket. In 2001, 68% of Pakistani and Bangladeshi households, 49% of Black Non-Caribbean households, and almost 40% of "other" households in Great Britain were considered "low income;" comparatively, only 21% of White households were low income (National Statistics: United Kingdom, 2001). Hence, economic social groups are in many ways heterogeneous and are unlikely to hold a single common rationale for smoking.

Though Lawlor et al. acknowledge that medical and public health approaches to smoking intervention have reduced smoking rates successfully across socioeconomic groups, they note that these approaches have not been particularly successful with impoverished segments of the population and question their validity. They argue that such interventions distract from the real issue—social inequality. Dismissing current medical and public health prevention models seems too drastic a response to the powerful influence of poverty. Current treatment models have proved to be effective tools for some people attempting to quit smoking. This is because these approaches address the chemical components of nicotine addiction common to all who try to quit smoking. Now, it is time to adjust these models to be more effective across social groups, account for differences that might lie within, and draw more attention to the socio-economic differences among population groups that increase resistance to stopping smoking.

The effects of smoking pose a great threat to the health of those who engage in this activity and those around them. Therefore, it is important to find interventions that are effective regardless of socio-economic

attributes. Socio-economic status seems to have a marked impact on both the likelihood of smoking and the motivation to quit. It is time to increase our collective efforts to deal with both the physical and psychological consequences of poverty. Both of these conditions deserve more scientific attention. Current medical and public health approaches to smoking intervention should not be scrapped, but new efforts can make these strategies more effective. To accomplish this goal, health workers must consider and address the physical and psychological manifestations of poverty, as well as the rich diversity of social groups.

What do you think? Comments on this article can be addressed to Siri Odegaard.

References

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