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# Primary prevention: does it increase inequalities in health?

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- Primary prevention increases the social differentiation of risky behaviours,
- and it may also increase social inequalities.

# Primary prevention & the social differentiation of risky behaviours: the case of cigarette smoking.

"*I declare war on tobacco*" (Pdt Chirac, March 24, 2003)

2000-2007:

- **Cigarette tax increase:** 3.3 to 5.3 € per pack (+60%);
- **smoking ban:** in workplaces & enclosed public spaces;
- **Other bans:** selling to people <16, selling packs <20 cigarettes, using 'light' /'mild' brand descriptors;
- **Aggressive preventive messages:** *autopsy of a killer*, impact of passive smoking on non-smokers (esp. children), *toxic corp*...
- **Increasing help to quit:** 'Tabac Info service' phone number print on packs, development of smoking cessation consultations...

# 2000-2007: trends in smoking prevalence (INPES data).

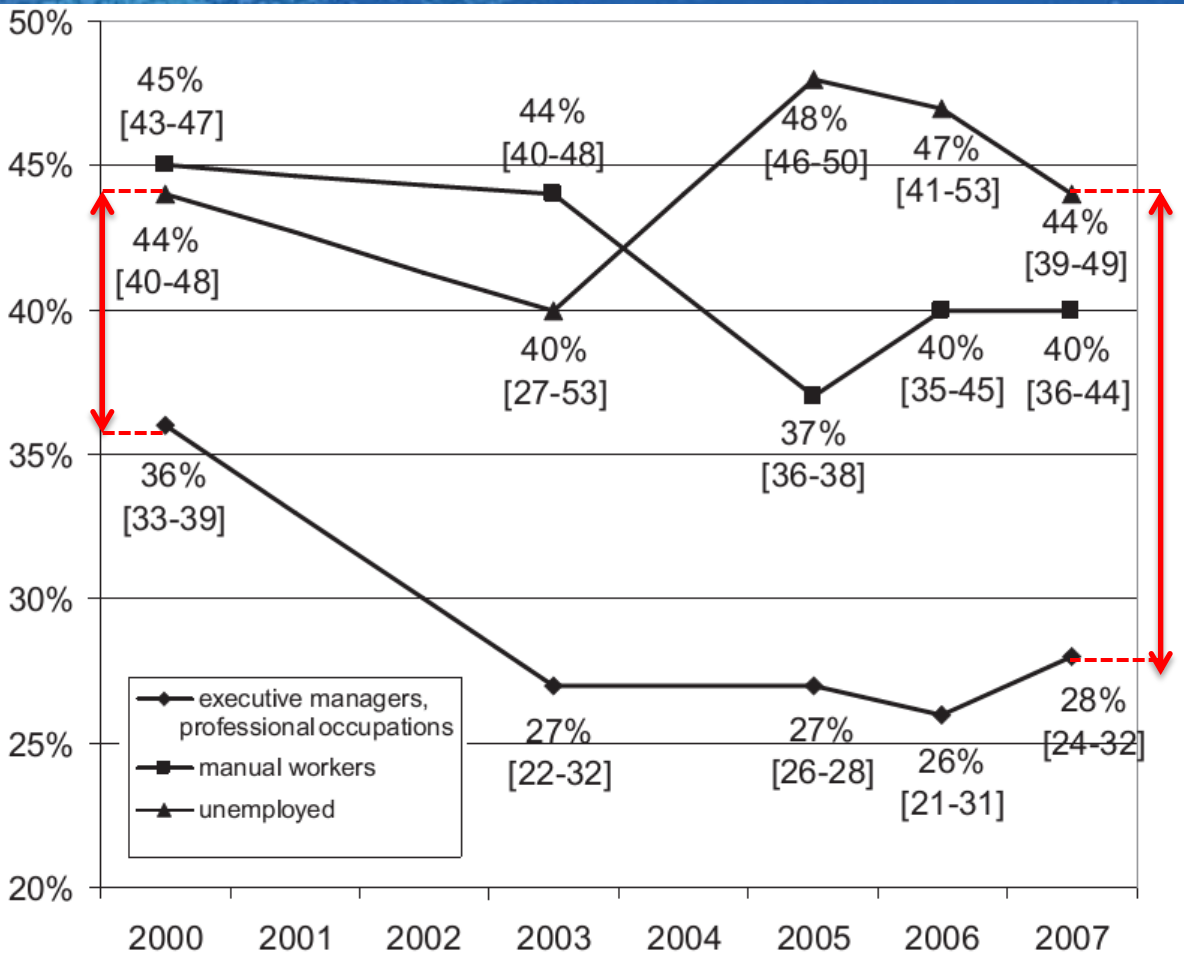



**Figure 1** Smoking prevalence for executive and professional occupations, manual workers and the unemployed, 2000–07, France [National Institute for Health Prevention and Education (INPES) surveys].

France, 2000-2007:

Intensification of tobacco control efforts

AND

Increasing social differentiation of smoking

Just a coincidence?

**France, 2000-2007:**

**Intensification of tobacco control efforts**

**AND**

**Increasing social differentiation of smoking**

**Just a coincidence?**

**<u>Hypothesis: tobacco control policies are more effective among wealthier and more educated people.</u>**

- higher quitting rate among wealthier & more educated smokers ;
(PW et al., *Addiction* 2009)
- poor smokers are more likely to reduce the cost of smoking, instead of quitting or reducing their consumption.
(PW et al., *Health Policy* 2012)

➢**Prevention campaigns are shaped by implicit hypotheses regarding their audience** (PW & Moatti, *Principe de prévention*, 2009)

→**first campaign conducted by the French Cancer League (1926) targeting *Homo Medicus*** (Pinell, *Naissance d'un fléau*, 1992)

➢**Two main hypotheses in contemporary prevention, regarding people's preferences…**

**people are supposed to value their long-term health much more than immediate pleasures;**

➢**…and their attitudes toward preventive information:**

**People are supposed to be confident & rational (behavioral change) instead of distrustful & rationalising (cognitive adjustment).**

**But low SES people… (INPES 2005, 2008)**

**…attach less importance to their long-term health;**

**….are more present-oriented;**

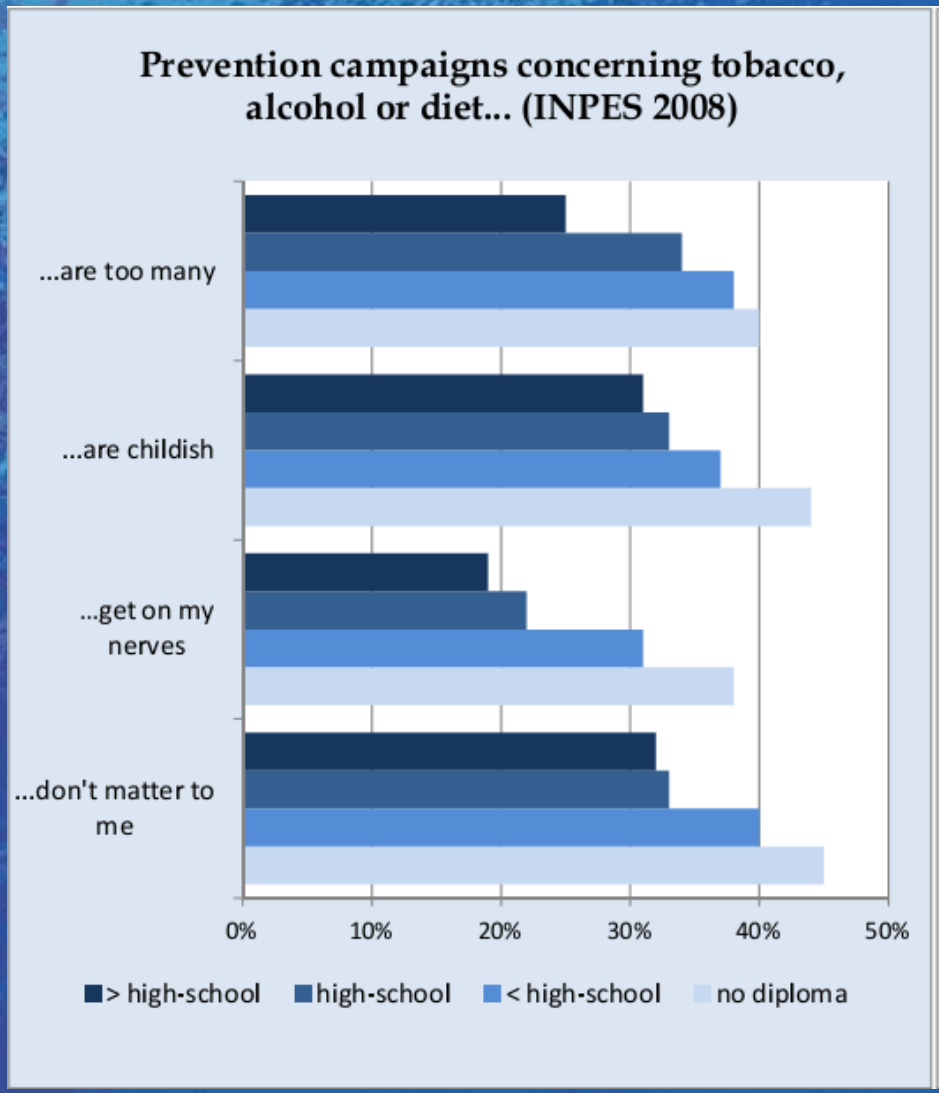
**…are more distrustful/indifferent/hostile toward prevention;**

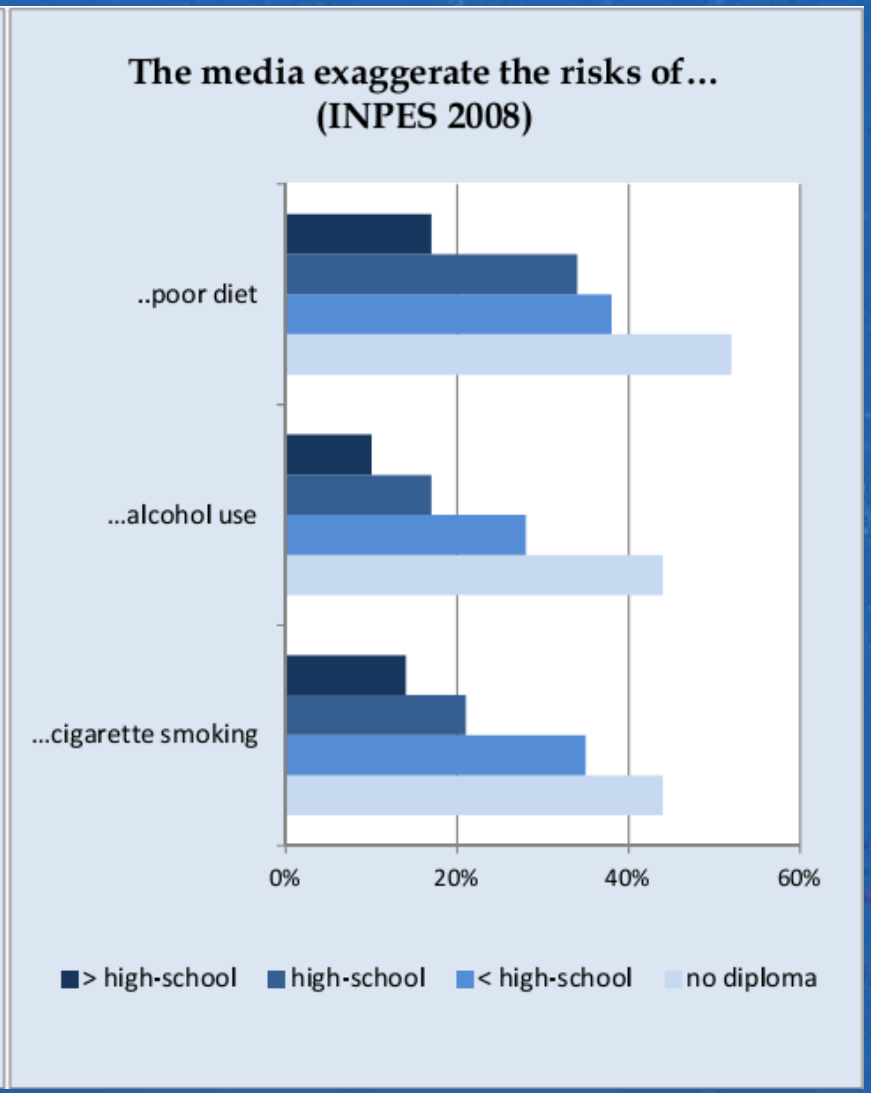
**…are more prone to risk denial.**

(PW et al., *Tobacco Control* 2007, *Evolutions* 2009; *EJPH*, 2013)

**→ Low SES people are far from the (implicit) ideal target audience of prevention.**

# Example: educational level & attitudes toward prevention (INPES 2008).



# Primary prevention & social inequalities: the case of overweight & cigarette smoking.

❖ Some prevention policies are designed to increase the "cost" of risky behaviours in order to incite people to abandon these behaviours...

➢ Financial cost: taxes on cigarettes, alcohol, junk food;

➢ Social cost (through stigmatization): portraying smokers or overweight people as unattractive, self-indulgent, lacking self-control...

❖ ...but as these behaviours are more prevalent among low SES people, who are also less sensitive to prevention...

❖...such policies make life harder for people who are already disadvantaged.

**Example: male overweight and smoking, state-sponsored campaigns, Australia 1993-1994** (Lupton, *The Imperative of Health* 1995).

*The truth is we feel uncomfortable _and not just because of the extra-weight we're carrying. What the hell's happening? It's not so much what we are gaining – It's what we're losing. Control. Youth. Dignity: "Dad's got a beer gut"* (Picture: Homer Simpson).

*There is a way out for smokers who want to escape. (…) If you have the will, we have the way. (…) You will find your new, clean, healthy image makes you more appealing to others (…) You will no longer feel like a social outcast.* (Picture: a man behind bars of floating smoke)

# Example: the cost of smoking for unemployed smokers, 2000-2005 (INPES)

(PW et al., *Addiction* 2009).

**Table 2** Share of the equivalized household income (EHI) devoted to cigarette purchase among executive and professional occupations, manual workers and the unemployed, in 2000 and 2005, France (INPES[a] Health Barometers).

| | *Monthly income per consumption unit* | | *Daily consumption of cigarettes* | | *Monthly cigarette budget* | | *Share of income per consumption unit devoted to cigarette purchase: (3)/(1)* | |
|---|---|---|---|---|---|---|---|---|
| | *(1)* | | *(2)* | | *(3)* | | | |
| *Distribution of the equivalized household income (EHI)* | *2000* | *2005* | *2000* | *2005* | *2000* | *2005* | *2000* | *2005* |
| Occupation and job status | | | | | | | | |
| Unemployed | €803 | €933 | 15.5 | 14.7 | €67 | €106 | 13% | 21% |
| Manual worker | €998 | €1119 | 16.6 | 15.5 | €72 | €107 | 9% | 13% |
| Executive manager, professionals | €2202 | €2089 | 13.3 | 11.8 | €58 | €78 | 3% | 5% |

Details regarding the calculation of monthly cigarette budget (3): [(number of cigarettes smoked per day) × (30 days)/(20 cigarettes per pack)] × (pack price: €2.9 in 2000, €5 in 2005). Reading example: in 2000, among the unemployed, smokers had an average monthly EHI of 8€03 (€ 933 in 2005), they smoked on average 15.5 cigarettes per day (14.7 in 2005), for a monthly cost estimated at €67 (€106 in 2005), which represented 13% of their monthly EHI (21% in 2005). [a]National Institute for Health Prevention and Education.

**Example:**

✓*Ceteris paribus*, **overweight people spend more time unemployed, and they have a lower probability of regaining employment.** (Paraponaris et al., *Economics & Human Biology* 2005)

✓ **30% of French GPs have negative attitudes toward overweight patients** (Bocquier et al., Obesity Research 2005)

✓**Inpes 2010: Among the French…**

**…27% view smoking as a personal failure;**

**…60% consider that smokers are a bad example for youth;**

**…53% would not accept to date a smoker;**

**…79% would not hire a smoker to take care of their kids.**

**Primary prevention may contribute to such stigmatization, but to what extent?**

# Conclusion:

- Primary prevention increases the social differentiation of risky behaviours,
  and it may also increase social inequalities;
- Primary prevention should question its own implicit hypotheses regarding its ideal target audience;
- Primary prevention should also try to assess more accurately its unexpected harmful effects.