

Health inequalities and smoking

Key points

- Health inequalities are preventable differences in health outcomes between different population groups. Reducing health inequalities remains a key goal of public policy in England.
- Because smoking is so harmful, differences in smoking prevalence across the population translate into major differences in death rates and illness. Smoking is the single most important driver of health inequalities.
- Smoking is far more common among unskilled and low income workers than among professional high earners. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death.
- Improving social conditions is not, however, a sufficient strategy to reduce smoking prevalence in more disadvantaged groups. The specific drivers of smoking uptake and tobacco addiction must also be addressed.
- Smoking is transmitted across the generations in a cycle underpinned by social norms, familiarisation and addiction. In poorer communities, young people are more exposed to smoking behaviour, more likely to try smoking and, once hooked, they find it harder to quit.
- Smoking is so corrosive to individual, family and community health that any success in reducing smoking in disadvantaged groups has knock on benefits for the wider determinants of health, above all through reductions in poverty.
- Smoking affects health inequalities across many other axes. The poorer health of people in the north of England compared to the south is in part due to higher rates of smoking in the north. Smoking rates are also higher among people with a mental health condition, prisoners, looked-after children, and LGBT people.
- Health inequalities will be reduced through measures that have a greater effect on smokers in higher prevalence groups. In practice, this means both prioritising population-level interventions which disadvantaged smokers are more sensitive to and targeting interventions on these smokers.

What are health inequalities?

Health inequalities are preventable differences in health outcomes between different population groups. For example, people who live on low incomes tend to experience more disease and die earlier than people who live on high incomes. Likewise people in the north of England tend to die earlier than people in the south of England. These are population differences: they don't apply to every individual but they can be seen across the population as a whole.

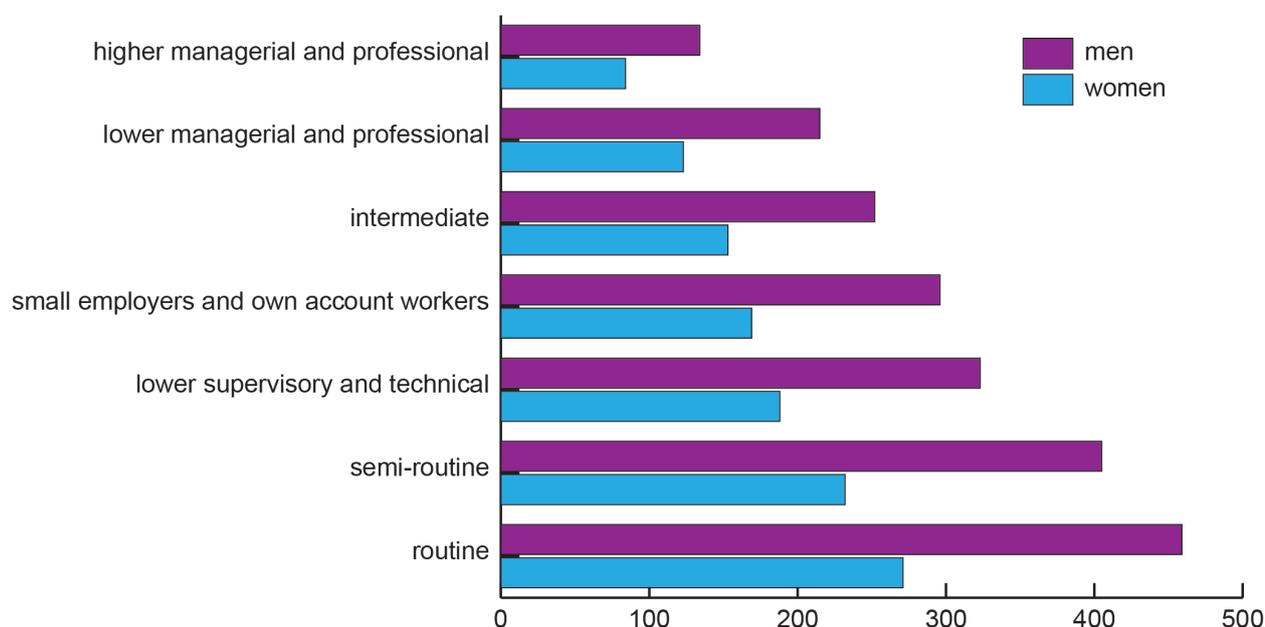
These differences are most often described across the socio-economic spectrum, for example between people with professional and managerial occupations (and incomes to match) and people with 'routine and manual' occupations such as labourers and bar staff. Figure 1 shows the differences in premature (under 65) death rates across this spectrum. More than three times as many people in the lowest socio-economic group die early compared to the highest socio-economic group. Figure 1 also reveals a big difference in the premature death rates for men and women: far more men of working age die than women of working age.

These differences are called ‘inequalities’ because we recognise that they are unfair. In a fair society, we would expect everyone to have the same life expectancy, regardless of who they are and where they live. Yet today a baby boy born in the London borough of Kensington and Chelsea has a life expectancy of 83.3 years compared to 74.7 years in Blackpool. Likewise a baby girl born in the district of Chiltern in Berkshire has a life expectancy of 86.7 years compared to 79.8 years in Middlesbrough.¹ In his landmark 2010 report, *Fair Society, Healthy Lives*, Michael Marmot and his team began by making clear the moral dimension of tackling inequalities in health:

Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socioeconomic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unacceptable.

Reducing health inequalities is a key goal of public policy in England. Box 1 identifies the policy and legislation that promotes this goal at both national and local levels.

Figure 1. Premature deaths per 100,000 adults of working age (25-64) by socio-economic group and gender, 2008-2010 (ONS)



What contribution does smoking make to health inequalities?

Smoking remains by far and away the single biggest preventable cause of death and illness in England. In 2013, 78,200 people aged over 35 died from smoking-related causes in England, 17 per cent of all deaths in this age group.² That’s over 200 people every day. Likewise the impact of smoking on ill health is huge: in 2013/14 an estimated 28% of all the hospital admissions in England in the 35+ age group were attributable to smoking.³

As smoking is so harmful, any differences in smoking prevalence across the population inevitably translate into different rates of illness and mortality, i.e. health inequalities. Figure 2 shows the difference in smoking rates in England between the three core socio-economic groups. Smoking is more than twice as common in the ‘routine and manual’ group than in the ‘managerial and professional’ group. This translates into a similar wealth divide: in Great Britain, 23% of those with an annual income of less than £10,000 are current smokers, compared with 11% of those with an annual income of £40,000 or more.⁴

Box 1: Legislation and policy underpinning work on health inequalities

Health and Social Care Act 2012

- The Act enshrines explicit duties on the Secretary of State, NHS Commissioning Board and clinical commissioning groups (CCGs) to have regard to the need to reduce inequalities in the benefits which can be obtained from health services. The duty on the Secretary of State extends to functions in relation to both the NHS and public health.
- The Act defines CCG responsibilities to help reduce health inequalities through integrating local services, the quality reward and public involvement in planning and commissioning.
- The Act enables providers – including the independent and third sector – to develop innovative services to tackle complex problems such as health inequalities.

NHS Five year forward view 2015

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.

Public Health England: From evidence into action: opportunities to protect and improve the nation's health, 2014

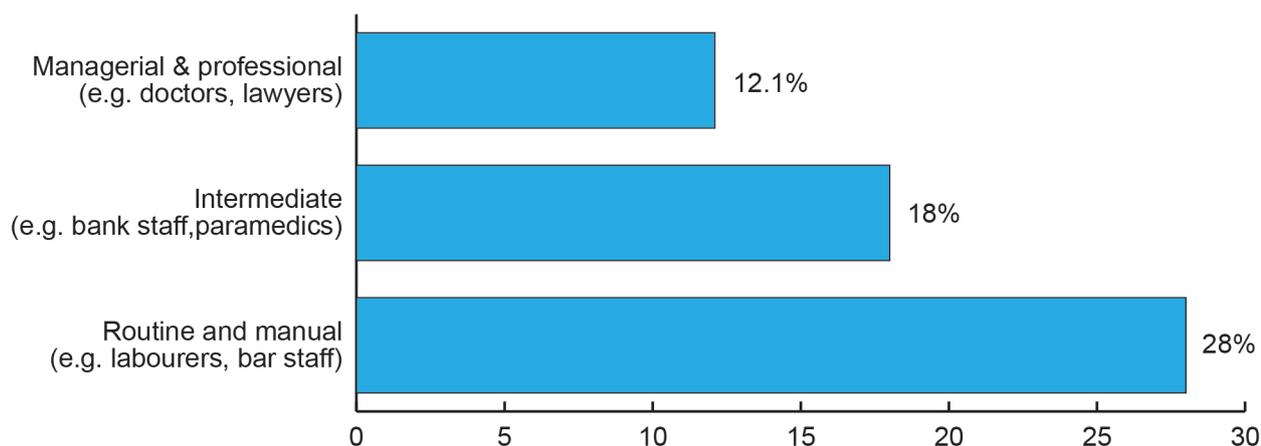
Reducing smoking and stopping children starting is a priority, to be pursued in a way that reduces health inequality and ensures everyone is able to benefit.

The best way to stop children smoking is to reduce smoking in the world around them, helping adults to quit so that smoking is no longer the norm. We want to secure a tobacco-free generation; our most disadvantaged communities have the most to gain from this.

Mental Health Task Force: The five year forward view for mental health, 2016

People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.

Figure 2. Smoking prevalence by socio-economic group, 2014 (Integrated Household Survey)



Various studies have sought to quantify the specific contribution that smoking makes to health inequalities. Studies which examine death rates over long periods or large datasets tend to provide the most powerful results. For example:

- In a long-term study of over 10,000 civil servants in London, including workers in all socio-economic groups, smoking was found to account for around a third (32% - 35%) of the difference in death rates between the lowest and highest socio-economic groups over a period of 24 years.⁵

- In an international study of deaths among men aged 35-69, which included data on 600,000 men, smoking was found to account for around half the difference in mortality between the top and bottom socio-economic groups. In England and Wales, the effect of smoking was especially pronounced: in 1996, professional men had a 21% risk of dying before they reached 70 including a 4% risk due to smoking, whereas unskilled men had a 43% risk of dying including a 19% risk due to smoking.⁶
- A long-term study of 15,400 residents of Renfrew and Paisley in Scotland, followed up over 28 years, found that smokers in the highest socio-economic group were more likely to die than non-smokers in the lowest socio-economic group, i.e. the effect of smoking on health outcomes across socio-economic groups is so great that the inequality is reversed if the characteristic pattern of smoking prevalence is reversed. The effect was clearest for men: compared to non-smokers in the highest socio-economic group, non-smokers in the lowest socio-economic group were 43% more likely to die, whereas smokers in the highest socio-economic group were 211% more likely to die.⁷

Smoking drives many other health inequalities. Wherever there is a difference in smoking prevalence, the result is a corresponding difference in health outcomes. Remarkably, we see higher smoking prevalence associated with almost every indicator of deprivation or marginalisation. For example, compared to the population as a whole, smoking is more common among:

- People with a mental health condition
- People who are unemployed
- People who are homeless
- People who are incarcerated
- People who receive welfare benefits
- People with no qualifications
- Lone parents
- Gay men and lesbians

Cumulative disadvantage ratchets up the likelihood that someone will smoke. A study of young women in the south of England found smoking prevalence of 18 per cent among women with no indicators of disadvantage. This rose to 36 per cent among those from disadvantaged backgrounds, 44 per cent among those who additionally left school when 16 years old, 55 per cent among those who additionally became mothers before the age of 22, and 63 per cent among those who experienced all these aspects of disadvantage and additionally lived on means-tested benefits.⁸

The highest rates of smoking are consistently found among those who are most disadvantaged. People whose control over their daily lives is highly constrained and who do not have the resources and opportunities to thrive are most likely to be smokers and least likely to take the necessary steps to quit. For example, in 2013, 73 per cent of the single homeless clients supported by St Mungo's in London smoked.⁹

Whichever way you look at the problem, it is clear that smoking has an extraordinary impact on health inequalities. Investment in tobacco control and smoking cessation services is therefore essential to the long term goal of overcoming these inequalities.

Meeting socio-economic needs

Any smoker who is struggling to cope with life on a daily basis because basic socio-economic or psychosocial needs are unmet is unlikely to see quitting as a priority and may consider smoking to be vital to everyday coping and stress relief. Social policy that aims to address these unmet needs will always be important to the long-term goal of ending the smoking epidemic.

However, social policy designed to improve socio-economic conditions is not sufficient. Once these needs have been met, there is no guarantee that a smoker will be able to quit. Smoking is too addictive and too ingrained in particular communities for this to be true. Once basic needs are met, the problem shifts.

Take, for example, Joe: an unskilled labourer hired on zero-hour contracts on construction sites in London. Joe has no qualifications, his wages are poor, and he lives in a small privately-rented flat with his wife and young daughter. He is also a smoker, like many other men in his circumstances. Consider what would happen if these socio-economic conditions improved as a result of social policy:

- If his in-work benefits increased and his income rose, Joe would be more likely to smoke as cigarettes would become more affordable.
- If Joe had the opportunity to gain new skills in construction, he would still find himself in the same working environment, just with more ready cash. Construction sites are notorious for smoking, as much by skilled bricklayers as by unskilled labourers.
- If Joe's housing improved, he would be more likely to have space at home where he could smoke away from his daughter – good for her but not for him if this reduced his incentive to quit.

These improvements in Joe's living and working conditions will have positive effects on his health and that of his household through, for example, access to better food and improvements in the warmth and quality of his living space, which may in turn enable him to engage more with his wider family and social network. But, other than reducing his stress levels, they won't do much to help him quit smoking.

It is essential, therefore, to distinguish between the basic socio-economic needs which, if unmet, can undermine personal health and inhibit any attempt to quit smoking, and the more complex issues – related to addiction, social norms and attitudes – that sustain high rates of smoking in lower socio-economic groups, even when these basic needs are met.

Tobacco control, poverty, and the Marmot principles: reversing the flow of the river

For some time there has been a debate in public health about the relative importance to policy of unhealthy behaviours, such as smoking, versus the wider socio-economic determinants of health. In *Fair Society, Healthy Lives*, Michael Marmot emphasised the latter and identified six principles that should underpin public policy designed to promote health in society:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

The analysis of socio-economic needs and smoking presented above recognises the value of these principles but shifts the focus to the last one, and specifically to the ‘downstream’ interventions that focus on enabling people to quit smoking. This shift does not, however, involve a neglect of the other principles. In fact, smoking is so corrosive to individual, family and community health that any success in reducing smoking has knock on benefits for the wider determinants of health. Table 1 describes how efforts to reduce the ‘downstream’ behaviour of smoking actually reverse the flow of the river and improve conditions ‘upstream’, as defined by the six Marmot principles.

Poverty is the central issue. As spending on tobacco consumes a relatively high proportion of the household income of poorer smokers, smoking helps to trap these households in poverty as well as damaging personal and family health.¹⁰ Based on 2009 prices, poorer smokers proportionately spend five times as much of their weekly household budget on smoking than richer smokers.¹¹ This spending, which can be as much as £2,900 per year for a 20-a-day smoker, is money largely lost to the local economy.

Table 1: Contribution of tobacco control to achieving the six Marmot goals

Marmot goal	Contribution of tobacco control
Give every child the best start in life	The best start in life necessarily involves protection from secondhand smoke before birth and throughout childhood.
Enable all children, young people and adults to maximise their capabilities and have control over their lives	Addiction is a loss of control. Preventing smoking initiation gives individuals greater control of their health and wellbeing in everyday life.
Create fair employment and good work for all	Smokefree regulations have transformed workplaces, making them healthier and safer.
Ensure healthy standard of living for all	Smokefree homes and workplaces underpin a healthy standard of living.
Create and develop healthy and sustainable places and communities	Smokefree environments and public spaces are welcoming to all members of a community
Strengthen the role and impact of ill health prevention	Preventing people from starting smoking and helping them to quit remains the single most effective way of improving health outcomes for individuals.

Almost half of all the children living in poverty in the UK – around 1.1 million children – live with at least one parent who smokes.¹² In these households, low incomes are driven down further by spending on tobacco, squeezing resources for basic needs like food and warmth.¹³ A further 400,000 children would be classed as being in poverty if the calculation of household income excluded the income currently spent on tobacco.

These low-income households are the most price sensitive, so raising the price of tobacco has the biggest impact here, thereby helping to reduce inequalities. However those who continue to smoke despite price rises face even greater financial pressure, so price strategies must always be accompanied by other interventions targeting the most disadvantaged groups (see below).

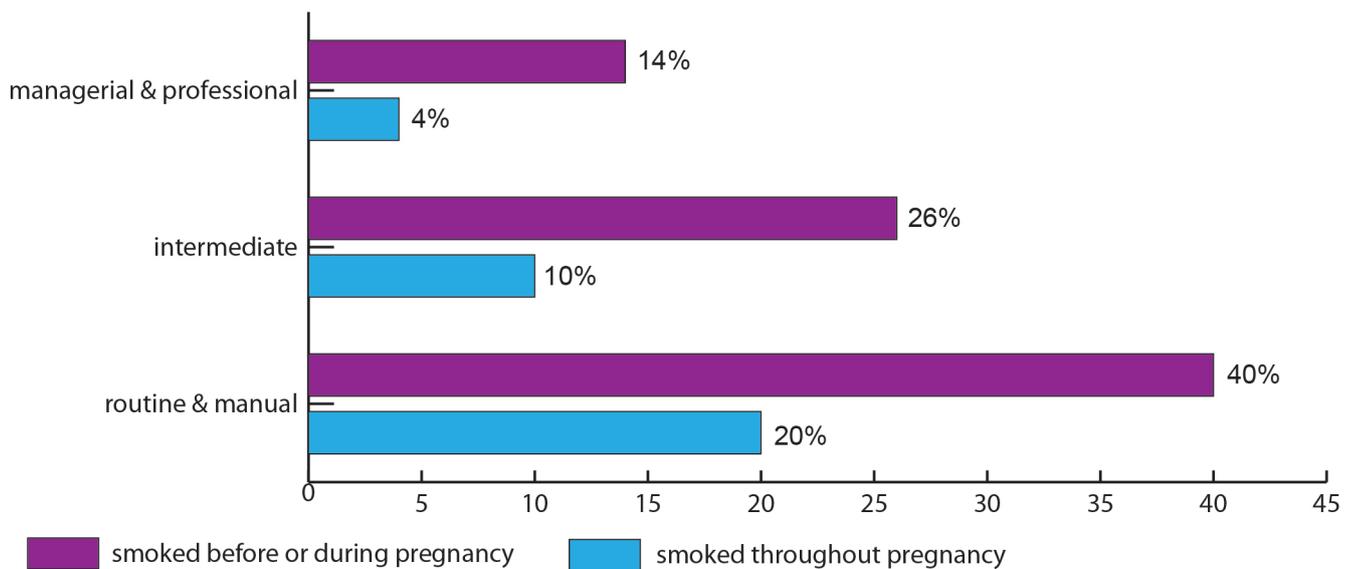
The inter-generational transmission of smoking

Why is smoking so much more common in poorer and working class communities, if socio-economic conditions are only part of the story? The answer is that smoking is transmitted across the generations in a cycle underpinned by social norms, familiarisation and addiction: young people in these communities are more exposed to smoking behaviour, more likely to try smoking and, once hooked, they find it harder to quit,¹⁴ thereby sustaining the higher prevalence and the inequality.

If you grow up around smokers, the risk that you too will start smoking is much greater. Children and young people who live with parents who both smoke are nearly three times more likely to become smokers themselves than their peers who do not live with smokers.¹⁵ If smoking is perceived to be normal behaviour, the obstacles to experimentation may be low. In fact, there may be considerable peer pressure to smoke. Access to tobacco may also be easier, both in the home and in the wider community. Consequently the socio-economic variations in smoking prevalence shown in Figure 2 are replicated in the uptake of smoking by children and young people. Figure 3 shows the prevalence of smoking in 16-19 year olds in England by deprivation score. Young people in the most deprived quintile are three times more likely to be smokers than young people in the least deprived quintile.

This process starts at birth: Figure 4 compares the rates of smoking by pregnant women across the three main socio-economic groups. The differences are marked: not only is prevalence highest in the 'routine and manual' group but women in this group are also the least successful at quitting during pregnancy. In addition, young mothers (under 20 years old) are nearly six times more likely to smoke during pregnancy than mothers aged 35 years or more.¹⁶ These differences have immediate impacts on health inequalities as maternal smoking causes up to 5,000 miscarriages, 300 perinatal deaths and 2,200 premature births in the UK each year.¹⁷

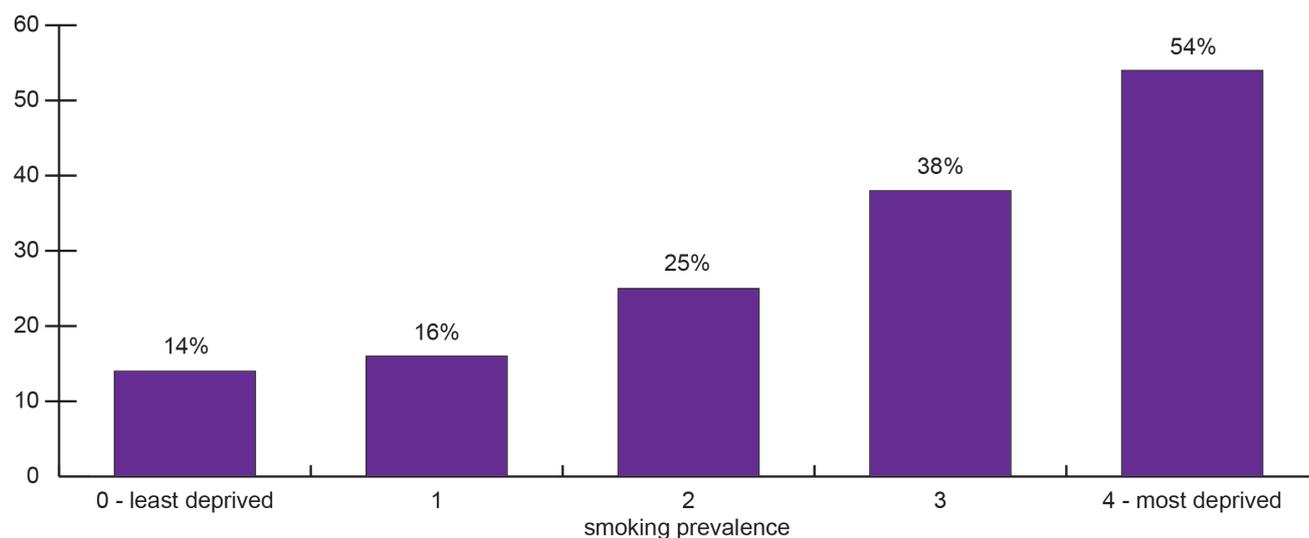
Figure 4. Smoking during pregnancy by socio-economic group (Infant Feeding Survey 2010)



A socio-economic gradient in quit rates is seen across all smokers and has had a huge long-term impact. At the top end of the socio-economic spectrum, quit rates have been highest over the past 20 years, creating a virtuous circle in which smoking has been slowly denormalised and ever fewer children and young people have been exposed to smoking behaviour. At the bottom end of the socio-economic spectrum, low quit rates by adult smokers have kept smoking far more visible in homes and communities. Smoking has not been denormalised in the same way and many children and young people continue to see their peers and role models with cigarettes in their hands.

In general, smokers in the routine and manual socio-economic group try to quit as often as their peers in the professional and managerial group, but they do not succeed as often.¹⁸ This is partly because they are more dependent on nicotine: they start smoking earlier in the day, smoke more cigarettes per day,¹⁹ and consume more nicotine per cigarette than the most affluent smokers.²⁰

Figure 3. Prevalence of smoking in 16-19 year olds by deprivation score (Health Survey for England 2006-2012 pooled)



Other factors that can affect their chances include:²¹

- A lack of social support. Smokers who are trying to quit benefit from continuing, non-directive social support, which may be harder to find when smoking is more common and more acceptable within your family and community. Long-term abstinence is also harder for ex-smokers if they routinely find themselves in the company of smokers, especially if they experience social pressure to smoke.
- A focus on present needs over future plans. People in lower socio-economic groups tend to be more focussed on the present and are more likely to be motivated by immediate health concerns. They are less likely than people in higher socioeconomic groups to be motivated to quit by a concern for health in the future.
- Stress and boredom. People who experience enduring stress may turn to smoking to cope and may feel that quitting is a low priority, given the rest of life's daily concerns.
- Failure to adhere to treatment. Smokers in lower socio-economic groups are more likely to stop taking treatment early and less likely to complete programmes of behavioural support.

These are the key factors that have emerged through the academic literature. A slightly different, but consistent, picture is gained through market research (Box 2).

The ways in which social norms operate to replicate and sustain smoking behaviour can be complex and place-specific. For example, a study of two schools in England found social norms working in opposite ways to drive smoking uptake. In a suburban school, a culture of attainment marginalised a minority of students from disadvantaged families, for whom smoking became integral to an alternative identity. In contrast, in an urban school, smoking was normative within the dominant gang-focussed student culture.²² Such differences make the work of tobacco control a great deal more challenging. Nonetheless, the achievement of tobacco control in England to date has been precisely to shift social norms and public attitudes. It is vital that this work continues in all communities where smoking is still in any way normative.

Key policy/guidance:

- *From evidence into action: opportunities to protect and improve the nation's health.* Public Health England, 2014
- *Smoking: harm reduction.* NICE guidelines PH45, 2013
- *Smoking: stopping in pregnancy and after childbirth.* NICE guidelines PH26, 2010
- *Smoking cessation in pregnancy: a call to action.* Challenge Group, 2013

Box 2: Marketing insights into 'routine and manual' smokers

- Routine and manual workers tend to establish standard routines in which smoking is entrenched.
- The family and local community are very important to routine and manual smokers and many live in close proximity and socialise regularly. Quitting smoking can be isolating to routine and manual smokers as they are surrounded in their communities and social groups by other smokers, and this often leads to relapse.
- Routine and manual smokers may be daunted by the prospect of quitting; they know from personal experience, and from others, that it is hard and painful, and feel that it is likely to end in failure. The short-term benefits of quitting are perceived as minimal when compared against the pain of quitting and the fact that the long-term benefits will not be felt for some time.
- Routine and manual smokers can see smoking as integral to who they are rather than something they do. Smoking may fulfil many needs: it is a fix, it is a coping mechanism, it fills a gap, helps them to relax and have some 'me' time, or it can act as a reward. As such, attempting to become a non-smoker or even an ex-smoker may not only seem daunting but out of character.

Source: *Tackling health inequalities – Targeting routine and manual smokers in support of the public service agreement smoking prevalence and health inequality targets*, Department of Health National Support Team, 2009.

Other axes of smoking-related inequalities

Geography

The strength of the link between socio-economic status and smoking translates into wide regional and local variations in smoking prevalence and health outcomes in England. Table 2 compares rates of smoking, smoking-related mortality and smoking-related hospital admissions across the regions of England, in order of smoking prevalence. Although there is only a 3.5 percentage point difference in smoking prevalence across the regions as a whole, this translates into a 30% increase in smoking-related deaths and a 55% increase in hospital admissions.

Table 2 makes plain the north-south divide in smoking-related inequalities in England. The lowest rates of smoking, deaths and hospital admissions are in the south and the highest rates are in the north. This is consistent with the wider picture of health inequalities across England where there is a long-standing difference in premature mortality between north and south.²³

Differences between individual local authorities are much greater. For example, smoking prevalence in Kingston-upon-Hull is 26.4%, more than double the prevalence of 9.8% in Wokingham in Berkshire. Smoking-related deaths are also over twice as common in Hull as in Wokingham (434 vs. 197 deaths per 100,000 people per year). The difference between the smoking rates in the routine and manual socioeconomic group is smaller: prevalence in this group is 35.0% in Hull and 26.7% in Wokingham. However the difference in the size of the routine and manual population in these two local authorities exacerbates the overall inequality. In Hull, the routine and manual socio-economic group comprises 36.7% of the population compared to 14.6% in Wokingham.²⁴

Data on individual local authorities can be found at www.tobaccoprofiles.info.

Table 2. Regional differences in smoking prevalence and smoking-related health outcomes in England (Local Tobacco Profiles)

	South East	South West	West Midlands	London	East of England	East Midlands	North West	North East	Yorkshire & Humber
smoking prevalence	16.6%	16.9%	16.9%	17.0%	17.9%	18.8%	19.9%	19.9%	20.1%
routine/manual prevalence	26.4%	28.3%	26.4%	25.3%	29.3%	29.2%	28.6%	28.2%	30.7%
smoking-related deaths*	241	238	273	261	247	272	329	359	313
smoking-related hospital admissions**	1291	1563	1669	1517	1594	1701	1885	2446	1995

*estimated smoking-attributable mortality per 100,000 population aged 35+
 **age-standardised hospital admissions in per 100,000 population aged 35+

Mental health

The links between mental health and smoking are profound. Smoking rates are consistently higher among people with a mental health condition and prevalence tends to increase with the severity of the condition.

In 2014, 31% of men who had ever had a diagnosis of a mental health condition smoked compared to 19% of men who had never had such diagnosis. Likewise, 23% of women who had ever had a diagnosis of a mental health condition smoked, compared to 13% of women who had never had a diagnosis.²⁵ Hence having any history of a diagnosed mental health condition dramatically increases the likelihood that someone is a smoker.

The 2007 Adult Psychiatric Morbidity Survey described different rates of smoking prevalence across different mental health conditions:²⁶

- 32% of people with 'common mental disorders' such as anxiety or depression were smokers, compared to 20% of people without such disorders
- 37% of people with depression were smokers
- 40% of people with probable psychosis were smokers
- 46% of people with alcohol dependence were smokers
- 57% of those who had attempted suicide in the past year were smokers

In the same year, an estimated two fifths (42%) of all the cigarettes smoked in England were smoked by people with a mental condition.²⁶

Key policy/guidance:

- *The Five Year Forward View for Mental Health*. Mental Health Task Force, 2016
- *Smoking: acute, maternity and mental health services*. NICE guidelines PH48, 2013

Prisoners

Smoking rates among prisoners have long been exceptionally high. A government survey in 2007 found smoking prevalence of 78% and 88% in two prisons in England.²⁷ This reflects

the compound disadvantage borne by so many of those who enter prison, including high rates of mental health problems, rather than the experience of prison itself. A study of women entering prison in England found that 85% of women were smokers when they were first incarcerated. The proportion who remained smokers a month later remained the same, though the amount of tobacco smoked per day had declined.²⁸

Prisons in England were given a partial exemption from the 2006 smokefree legislation to allow smoking in cells. However, from October 2015 open prisons became smokefree in all enclosed areas and from May 2016 all prisons in Wales and in southwest England will go fully smokefree indoors and out. This begins a process of change that will eventually extend to all prisons in England. Given the high levels of smoking in prisons, this programme of change could have major impacts on smoking among highly disadvantaged people. However this requires that they are fully supported to quit or switch to alternative nicotine products both during their incarceration and after their release.

Key policy/guidance:

- *Smoking in Prisons in England and Wales: An examination of the case for public health policy change.* Offenders Health Research Network, 2014

Looked-after children

Children who are in, or have been through, the care system are among the most vulnerable people in society. Most children become looked-after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health condition and two-thirds have special educational needs.²⁹

Looked-after children are far more likely to smoke than children of the same age who are not in the care system. A study in 2003 found that as many as two thirds of children in residential care smoke.³⁰ This level of smoking is consistent with the multiple disadvantages that characterise looked-after children.

Looked-after children are at high risk of long-term disadvantage, marginalisation and poor health and life outcomes. Smoking is a key factor driving this risk, undermining health, well-being and financial security. It is therefore vital to reduce the risk of smoking uptake among looked-after children, especially through placement in smokefree homes, while also ensuring that looked-after children who do smoke have every opportunity to quit.

Key policy/guidance:

- *Foster care, adoption and smoking.* Action on Smoking and Health and The Fostering Network, 2016

LGBT people

Compared to the majority heterosexual population, smoking rates are significantly higher among gay, lesbian and bisexual adults (see Table 3). The highest smoking prevalence is among bisexual men, nearly a third of whom smoke. There are currently no national data available on smoking prevalence among trans people.

Higher smoking prevalence among LGBT adults is likely to be linked, at least in part, to higher stress levels and poorer mental health in this population.³¹ An analysis of the GP Patient Survey in 2009/10 found that gay men and lesbians were twice as likely as their heterosexual counterparts to report a longstanding psychological or mental health condition. Bisexual men and women were three times as likely to report such a condition.³²

Table 3. Smoking prevalence by gender and sexuality in England, 2014 (ONS)

	gay/lesbian	bisexual	heterosexual
men	23.7%	32.5%	19.7%
women	25.0%	22.7%	16.7%
all	24.2%	25.4%	18.1%

Key policy/guidance:

- *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document*. Department of Health, Public Health England and the National LGB&T Partnership, 2013

Black and minority ethnic groups

The relationship between smoking and ethnicity is complex. For example, above average rates of smoking are reported among Pakistani and Bangladeshi men, but women in these ethnic groups are unlikely to smoke: in 2004, 40 per cent of Bangladeshi men smoked compared to only 2 per cent of Bangladeshi women.³³ Only in the Irish population is smoking prevalence higher than average among both men and women. Smoking prevalence in ethnically Indian, Chinese and Black African populations is consistently lower than average.

These results do not, however, capture the full range of ethnic groups in England. There are other ethnic groups that are invisible in the standard ONS classification of ethnicity which have their own cultural and social norms within which smoking may play a part. For example, a study of smoking in the Turkish, Polish and Somali communities in London found that participants' perceptions of attitudes to smoking in Turkey, Poland and Somalia respectively affected their own attitudes and smoking behaviour.³⁴ Such differences should always be examined by local needs assessments.

Reducing smoking-related health inequalities

The health inequalities that are driven by differences in smoking prevalence will only be reduced through measures that have a greater effect on smokers in higher prevalence groups. In practice, this means both prioritising population-level interventions which disadvantaged smokers are more sensitive to and targeting interventions on these smokers.

This balance between using population measures that impact on everyone and targeting those in most need is captured in the following recommendation from *Fair Society, Healthy Lives*:

Implement evidence-based programme of ill health preventive interventions that are effective across the social gradient by focusing public health interventions such as smoking cessation programmes and alcohol reduction on reducing the social gradient.

The following measures are central to a comprehensive package of measures to reduce health inequalities:

- **Effective taxation to reduce the affordability of tobacco.** Increasing the price of tobacco is the one population-level intervention that unequivocally has a greater effect on lower income smokers.^{35,36} As poorer smokers are more price sensitive, they are more likely to quit than wealthier smokers when the price of tobacco rises. To be effective, however, the tax regime needs to minimise opportunities for smokers to downtrade, above all by preventing tobacco companies from manipulating the prices of their brands to ensure that ultra-low price brands are minimally affected by tax increases.
- **Tackling the illicit market.** The effect of tax increases is lost if smokers can obtain illicit or counterfeit cigarettes that are untaxed. The illicit market has shrunk over the last decade³⁷ but still remains a major obstacle to effective tobacco control, especially in poorer communities. Ongoing action is needed at local, national and European levels to control and monitor the tobacco supply chain.
- **Mass media campaigns.** There is evidence that mass media campaigns can have a greater impact on more disadvantaged smokers if they are carefully tailored and targeted.³⁶ This requires both that the content and the tone of the campaigns are suitable for the target audience and that the promotion of the campaigns ensures maximum exposure in this audience.
- **Targeted specialist stop smoking services.** From the outset, specialist stop smoking services were designed to target disadvantaged communities. However, they have had limited impact on inequalities because smokers from disadvantaged areas find it more difficult to stop with the help of stop smoking services than their more affluent neighbours.^{38,39} These services need to refocus on the task of reducing inequalities and examine every aspect of their referral and treatment pathways to ensure that they are geared to this task. In particular, referral partners who have everyday contact with disadvantaged smokers, such as GPs, mental health services, criminal justice services and children's services, need to be fully engaged to ensure that opportunities to support people to quit are not missed, both through brief intervention and through referral to specialist services. Recent research in Scotland has identified a key role for debt and money advice providers in identifying and referring smokers on low incomes.⁴⁰
- **Harm reduction.** Smokers who are highly addicted to nicotine can dramatically reduce their risks without having to overcome their addiction by switching to alternative nicotine products.⁴¹ Given the high nicotine dependency of many of the most disadvantaged smokers, and the many socio-economic obstacles that inhibit their motivation to quit and engage with services, such products have the potential to play a major role in reducing smoking prevalence in these groups, especially if they are designed, delivered and priced in ways that make them more attractive than cigarettes. These products include both licensed nicotine replacement therapies, such as gums and sprays, and unlicensed nicotine vapourisers (e-cigarettes).

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