

Health Inequalities Webinar: Questions & Answer Session

1. Is there data on smoking/inequalities/disadvantage for the transgender cohort?

Whilst data on smoking within the transgender, and broader LGBT+ community, is generally limited, evidence suggests that smoking rates are higher among LGBT groups than other communities. The Integrated Household Survey (2013) puts smoking rates among gay and lesbian people at 26% and bisexual people at 23%. It does not record smoking in trans groups.

Where data is available surveys suggest that trans people are more likely to smoke than the general populations and smoking rates are comparable to levels observed among lesbians ([Rooney, 2012](#)).

There are a [wide range of reported reasons](#) for higher smoking rates amongst the LGBT community including minority stress, the normalisation of smoking, lack of access to treatment and the tobacco industry targeting these groups.

Resources

- The National LGB&T Partnership: [Smoking and Lesbian, Gay, Bisexual and Transgender \(LGBT\) Communities: a guideline for local authority services](#)
- ASH Scotland: [Tobacco use and LGBTI communities](#).
- ASH: [Smoking: LGBT community](#)
- There have been several studies conducted in America. A fairly thorough overview of the key points and references for them can be found [here](#).

2. Isn't poverty the cause of inequality in health? Is it not a reverse framing to suggest the poor people could lift themselves out of poverty if they quit smoking?

The relationship between smoking and poverty is complicated. There is clearly a strong correlation between the two, but research shows that there are multiple factors at work. One single factor is almost never the sole cause of poverty or inequality in health.

However, income and disadvantage are clear risk factors for smoking. Smoking rates among those working in managerial and professional roles (e.g. Doctors and Lawyers) is around 12%. In comparison 28% amongst those from routine and manual occupations (e.g. labourers and bar staff) smoke ([ONS, 2014](#)).

Similar patterns are evident amongst other disadvantaged groups. People with no educational qualifications, people with mental health or long term medical conditions or those dependent on drugs and alcohol are all more likely to smoke.

Despite entrenched inequalities, reducing smoking can help draw people out of poverty. Research [carried](#) out by ASH shows that when net income and expenditure on tobacco products are taken into account 1.4 million households in England fall below the poverty line. If these smokers were to quit over 400,000 households could be elevated out of poverty, this includes over 300,000 dependent children.

This data does not aim to blame an individual for poverty, but rather points to the highly addictive nature of nicotine and highlights the social and financial benefits as well as the health benefits of quitting.

Resources

- ASH briefing: [Health Inequalities and smoking](#), 2016
- ASH: [Health Inequalities Resource Pack](#), 2015
- ASH: [Smoking and Poverty Calculator](#), 2015
- Reed, [Estimates of poverty in the UK adjusted for expenditure on tobacco](#), 2015

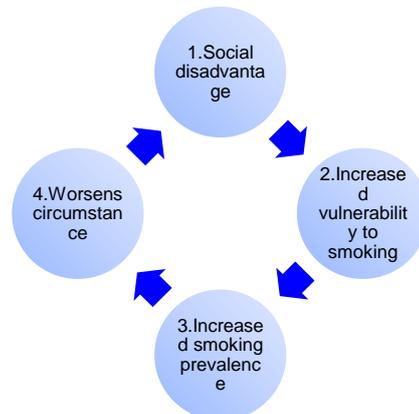
3. What is the desire to quit rate across the SES?

Motivation to quit is remarkably similar across the different socioeconomic groups ([Kotz and West](#), 2009 and [Reid et al](#), 2010) 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 (often more heavily addicted to nicotine and will need more support to quit).

4. Is there evidence on risk factors for smoking in different socioeconomic groups?

Social disadvantage is a clear risk factor for smoking. Whilst 19% of the population in Great Britain smoke (ONS, 2013), rates are higher among disadvantaged groups:

- No educational qualifications: 23%
- Unemployment: 35%
- Depressive episode: 37%
- Probable psychosis 40%
- Homelessness: 77%
- Prison population: 80%



For data sources see [ASH briefing on multiple needs](#).

The more disadvantaged a person is the more likely they are to smoke. The resulting illness and the cost of smoking can exacerbate already difficult situations

Young people from all backgrounds are significantly more likely to take-up smoking if they live in a household where others smoke. Children with at least one parent who smokes are, for example, 72% more likely to smoke in adolescence. It is estimated that each year at least 23,000 young people in England and Wales start smoking by the age of 15 as a result of exposure to smoking in the home ([RCP](#), 2010). However, this influence may be compounded within lower socioeconomic groups by higher rates of parental and peer smoking.

Additionally, although the illicit market has shrunk over the last decade, it still remains a major obstacle to effective tobacco control because the effect of tax increases is lost if smokers can obtain illicit or counterfeit cigarettes that are untaxed. This is a particular problem in poorer communities where illicit tobacco is more freely available (North of England Illicit Tobacco Study, 2011).

Resources

- ASH briefing: [Health Inequalities](#), 2016
- ASH briefing: [Smoking and multiple needs](#), 2015
- Royal College of Physicians. [Passive smoking and children](#). London, RCP, 2010

5. The number of poor smokers who would be lifted out of poverty if they quit was very dramatic. Is there any mileage in using this as a motivational media message?

There is good evidence on what is effective in reducing adult smoking and in 2003 the World Bank identified “price increases through higher taxes on cigarettes” as one of six areas which should be prioritised in comprehensive tobacco control. This was endorsed the World Health Organisation and cost increases through tax measures are key to the Framework Convention on Tobacco Control ([see Article 6](#)).

As part of motivational media messages, economic factors have previously in campaigns for Stoptober and No Smoking Day. For example, the ‘Health and Wealth Wheel’ (see [here](#)) which on one side shows the health benefits of stopping smoking for a day week etc., then on the other side shows how much money one could save over the same time frame. These resources demonstrate that there is definitely mileage in this style of media messaging.

This is also a useful message for local authorities to use to make the case for tobacco control in their areas. To find out how many people in your area are pulled below the poverty line because of smoking, see [here](#).

Reviews of the evidence around mass media campaigns have found that ‘health harms’ messaging is particularly effective. For example, [this Australian review of the evidence](#) on mass media campaign messaging found that amongst adults: ‘demonstration of negative health effects with high levels of emotional and personal testimony have the greatest potential impact on adult smokers.’

This principle has been illustrated in the success of Fresh North East’s recent 16 Cancer’s campaign, which highlighted how smoking causes 16 different types of cancer and can change lives and families forever. Amongst north east smokers who saw the campaign 8.4% made a quit attempt whilst 16% cut down the amount they smoke, emphasising the effectiveness of health harms messaging.

6. Is there any data showing if community development interventions have had an impact on smoking prevalence?

A 2008 [Cochrane review](#) concluded there was little evidence of community interventions having a notable impact on smoking rates. Similar results were found in [this literature review](#), with the exception of community interventions in relation HIV, showing that community based interventions were unsuccessful in reducing smoking prevalence alongside other risk behaviours.

7. Are poor two parent family less likely to smoke than a slightly richer one parent family?

Studies have shown that family structure is significantly associated with smoking prevalence. However, dual examination of family structure alongside socioeconomic status is harder to establish. A 2007 [study](#) illustrates smoking prevalence among teenagers growing up within different family structures, and demonstrates that those living in single parent, step-parent and no parent families had higher rates of smoking. However the study also examines smoking rates in relation to parental education, parental employment status and the number of people per room. These indicators show that employment and higher education are associated with lower smoking rates.

Studies generally indicate that divorced or separated adults are and two and a half times as likely as those who were married/cohabiting or widowed to smoke ([HSCIS, 2013](#)). However, higher socioeconomic status is associated with lower rates of smoking. Thus the smoking

status of these families is likely to vary between individuals, and also be influenced by a range of additional factors including peer smoking rates and whether grandparents or other relatives are smokers.

8. Some areas are reducing TV mass media in favour of social media led campaigns. Would you agree a risky approach, as there is a lack of evidence for social media other than in a supporting role to TV?

There is much evidence to support the use of mass media campaigns to promote smoking cessation (highlighted by a 2013 [Cochrane Review](#)) and it is largely accepted that mass media campaigns are highly cost-effective in encouraging smokers to quit and discouraging young people from taking up smoking. When funding was cut to mass media campaigns in 2010 there was a noticeable impact on quitting behaviour with demand for quit support packs falling by 98%, quitline calls falling by 65% and web hits falling by 34% ([Langley et al, 2014](#)).

The [Centre for Disease Control](#) in the US best practice recommendation for 'mass reach health communications' to reduce smoking is \$1.69 per capita. Using 2014 population figures this means that in England we should be spending in the region of £57 million a year on mass media campaigns in order to be evidence based. At present we are spending 8 times less than US authorities recommend.

In terms of social media, most studies look at the role of social media in relation to broader mass media campaigns rather than in isolation. However, there are studies which demonstrate that social media can be effective. For example, this 2014 [study](#) compared quit rates among young adults who had either used social media and telephone support to assist their quit attempt. Researchers found that those accessing support on social media fared better than those accessing telephone support.

However, in this study those accessing support via social media were already engaging in quit related activities, this is different to conventional mass media campaigns which can prompt quit attempts.

Due to the popularity and the amount of time young people in particular people spend on social media there is the suggestion that it is potentially an underutilised resource for supporting quit attempts, as demonstrated in this [research \(Duke et al, 2014\)](#).

Overall, this is an area where much more research is needed to establish the type and content of social media messaging that might be effective in promoting quit attempts and supporting those already attempting to quit.

9. London is looking at a telephone service rather than face to face – is the evidence for this robust?

Smokers are up [to four times](#) more likely to succeed with the stop smoking services (behavioural and medical support) than if they try to quit unaided.

[NICE Guidance PH10](#) lists telephone counselling as an effective intervention. A 2013 [Cochrane Review](#) found some evidence of a dose response; one or two brief calls are less likely to provide a measurable benefit. The review found that three or more calls increased the chances of quitting compared to a minimal intervention such as providing standard self-help materials, or brief advice, or compared to pharmacotherapy alone.

The effectiveness of the intervention largely depends on how it is used, whether in combination with other support mechanisms or individually, and whether it is proactive or reactive. In the case of telephone services, proactive services are more effective than reactive services.

Where telephone services are implemented there should be local pathways in place to ensure that CO monitoring can still be carried out and access to stop smoking pharmacotherapy on prescription is available throughout the treatment episode.

Resources

- NCSCT: [Local Stop Smoking Service](#), service Delivery and Guidance, 2014
- NICE: PH10 [Stop Smoking Services](#)

10. Is the ASSIST intervention cost effective and still relevant considering that it is over 10 years old?

ASSIST is a smoking prevention programme which trains year 8 students to work as 'peer supporters'. Peer supporters are trained and supported to have informal conversations with other Year 8 students about the risks of smoking and the benefits of being smoke-free.

ASSIST was formalised after a trial in which 59 schools were randomly allocated either to continue with their normal smoking education programme, or to do so with additional peer supporter training. The trial followed the students for two years to see whether smoking prevalence in the intervention schools was lower than in the schools which did not receive the training. It demonstrated that the programme reduced the prevalence of smoking by 10%.

A [2012 randomised controlled trial](#) concluded that ASSIST reduced smoking among adolescents at a modest cost. It estimated that the annual cost of extending the intervention to Year 8 students in all U.K. schools would be in the region of £38 million and could result in 20,400 fewer adolescent smokers.

For more information see here: <http://www.decipher-impact.com/publications/>