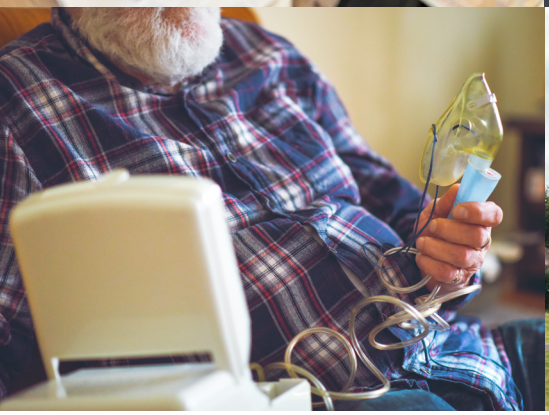
Ending smoking inequality

An Action Plan to reduce poverty and improve health



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action on smoking and health

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Foreword

Why ending smoking in all groups should be a Government priority

Liam Loftus, Development Director at Cambridge City Foodbank, and Senior Advisor at the Health Equity Evidence Centre

We are at a fork in the road. In one direction lies the tranquil path of business as usual and the steady, slow decline in smoking rates. This path will end smoking within the most affluent quintile in the next 15 years but leave around half a million people in the most deprived still smoking.

In the other direction lies the steeper, trickier path where, through the hard ascent, we speed progress for the most deprived, effectively ending smoking for the whole population over the next 15 years. This report sets out an action plan, a map, to help us navigate that harder but more impactful path.

As a former GP and Development Director at Cambridge City Foodbank, I have seen first-hand the realities of everyday hardship faced by many smokers. I have seen how smoking can add to the financial strain families face and how reducing it can ease pressure on household budgets as well as improve health. These pressures are not abstract; they shape daily decisions about food, heating and affording the essentials.

The Government's 10 Year Health Plan marks the beginning of a decisive shift from sickness to prevention. It sets out the measures to achieve a country fit for the future and to empower the nation to make the healthy choice. Reaching these goals will require action on smoking, given the profound contribution it makes to health inequalities.

Government is undeniably taking strong, positive action to deliver on the promise in the 10 Year Health Plan to create a Smokefree UK. The Tobacco and Vapes Act is the first step in this process, making it illegal to sell tobacco products to anyone born on or after 1 January 2009. It ensures today's children can never legally be sold cigarettes and are protected from the harms of tobacco. This approach will protect future generations in every community from smoking. That said, it will not in itself address the needs of those who currently smoke and who disproportionately live in the kinds of households food banks like ours support.

Smoking is already heavily concentrated in the most deprived areas. As more affluent smokers continue to quit, this pattern will intensify. Smokers can already face stigma, but if the only people who smoke live in communities already stigmatised, there is every chance this will worsen, leaving people further excluded in addition to the terrible health and financial burden smoking causes.

Without narrowing the difference in smoking rates, the Government's commitment to halve the gap in healthy life expectancy will be very challenging to achieve. Half the difference in life expectancy is already attributed to smoking.

The Government's Child Poverty Strategy recognises that without decisive action, child poverty risks reaching record levels. Reducing smoking rates among the most deprived families will boost disposable incomes and prevent many from falling below the poverty line. It is one of the most effective ways to put money back into the pockets of those who need it most.

This action plan sets out key recommendations for government to ensure the harms of smoking are not borne by the communities least able to escape them. The Government must act now and ensure that these communities are not left behind. Increased investment in local authority stop smoking services and embedding greater treatment in the NHS is a strong start, but without a clear plan with tangible targets, this investment could miss those who need our support the most.

Supporting rapid declines in smoking among the most deprived would deliver returns far beyond health. It would strengthen household finances, support participation in work and ease pressure on public services and the NHS.

The Government is acting decisively to create a smokefree generation for the future. This ambition must be matched with focused measures to tackle the entrenched inequalities smoking causes today. Without targeted support, the benefits of this progress will not be felt equally, and those facing the greatest financial and health pressures will fall further behind.

So, Government has a choice, take the path of business as usual or set out on the more ambitious track. I know which view I would prefer to see at the end of the road.

Executive Summary

This report sets out a comprehensive strategy to reduce smoking-related inequalities and ensure disadvantaged communities are not left behind in the transition to a smokefree society.

Smoking remains one of the most significant drivers of poverty, ill health and reduced life expectancy. Smoking prevalence is around 2.5 times as high in the most deprived areas compared to the least deprived, and current rates of decline mean the difference is not narrowing.[1] Without a more targeted approach, affluent communities are projected to reach less than 1% smoking long before disadvantaged populations, entrenching inequality further.

People who smoke should not be blamed or stigmatised for their addiction. Smoking is not a lifestyle choice; it is a highly addictive behaviour that the vast majority of smokers regret starting. Most begin in childhood or adolescence, long before they are fully able to understand the long-term consequences.[2] While the picture is not uniform across all measures, disadvantaged smokers generally face greater barriers to quitting. As a result, **when disadvantaged smokers try to stop, they are less likely to succeed.**[3]

The impact of people's addiction to smoking goes far beyond the health impact. New analysis for this report estimates that tobacco expenditure pushes an additional **417,000 households below the poverty line,** including 137,000 children. Smoking also deepens hardship among households already living in poverty by reducing money available for essentials such as food, heating and housing. The analysis finds that **955,000 households are in deeper poverty** when tobacco expenditure is accounted for. **Altogether 1.37m households are living in poverty when smoking is taken into account.**[4, i]

The economic hardships associated with smoking has a significant impact on people's lives. People who smoke are nearly three times **as likely to attend food banks as never-smokers (20% of smokers, 7% of never-smokers)** with 1 in 4 smokers (24%) reporting they skipped a meal and went hungry last year compared to 1 in 10 (10%) of those who have never smoked.[ii]

The report draws on evidence, expert roundtables and lived experience, identifying three key challenges:

- Smoking cessation attempts and success is heavily influenced by wider social, financial and mental health pressures.
- People experiencing disadvantaged need much greater access to quit support to increase their chances of becoming smokefree.
- Current plans, targets, partnerships, workforce capacity and service design are insufficient to achieve the scale of change required.

i All findings for the impact of tobacco expenditure on household poverty, used here, were made using the relative after housing costs (AHC) poverty measure. See Estimates of poverty in the UK adjusted for expenditure on tobacco – update 2026 by Landman Economics for reference.

ii Reference: ASH adult survey conducted by YouGov. Total sample size was 13,259 adults. Fieldwork was undertaken between 18/02/2026 - 19/03/2026. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+). Sample sizes: smokers=1,431; never smokers=7,699

Recommendations

Create an action plan with clear targets

1. Publish a national roadmap for a smokefree country
2. Develop local plans
3. Take a regional approach

Expand access to support, cessation aids and quit campaigns

4. Improve service reach and quit success
5. Deliver support in high-contact healthcare settings
6. Make access to quit aids equitable
7. Scale digital cessation support
8. Use targeted communications and campaigns

Design support to meet the needs of disadvantaged groups

9. Design services around need
10. Deliver flexible services for the community
11. Embed evaluation, learning and knowledge sharing

Smoking inequality in the UK

Smoking is increasingly concentrated among people facing disadvantage. While smoking rates have fallen substantially across the population, the harms caused by smoking often fall on communities experiencing deprivation, poverty, insecure housing, poor health and other forms of social disadvantage.[iii]

As a result, smoking remains one of the most important drivers of health inequality in the UK. It is the leading cause of the gap in healthy life expectancy between the richest and poorest communities and contributes to substantial inequalities in disability and long-term illness.[5] About half of all lifelong smokers will die prematurely, losing an average of ten years of life.[6]

Smoking greatly increases a person's chances of needing social care. Smokers are 2.5 times more likely to need care support at home and need care on average 10 years earlier than non-smokers. In England, smoking-related ill health means social care is being provided informally by friends and family for approximately 922,000 people.[7]

Smoking-related inequalities are also passed between generations. Smoking in pregnancy is the single biggest modifiable risk factor for miscarriages, stillbirths, premature birth and birth defects.[8] Pregnant women in the most deprived areas of England are over five times as likely to smoke than those in the least deprived areas.[9]

Smoking rates are highest among some of the most disadvantaged and often overlooked groups. In 2024, prevalence among people experiencing homelessness and those living with severe mental illness ranged from 40% to 80%. The Royal College of Physicians (RCP) estimates that of the 1.9 million adults in these 'hidden' populations, between 58% and 68% smoke. As result, there may be a further million smokers who are unaccounted for in prevalence estimates and missed in policy discussions.[10]

Smokers across all socioeconomic groups are motivated to quit and make quit attempts, although these are generally lower in more disadvantaged groups, reflecting greater social stressors.[11] This pattern, however, is not uniform and varies across different indicators of deprivation, as set out in the following section.[iv]

iii This report uses 'deprivation' and 'poverty' to explain the effect of smoking on inequality and disadvantage. 'Deprivation' as used here refers to a serious lack of something which is a basic necessity in society, i.e. healthcare or housing. 'Poverty', on the other hand, is where a household or individual lacks the financial resources to meet basic needs and participate fully in society, i.e. food, housing, activities.

iv See Figure 4.28 in the Royal College of Physicians' recent report, *Smoking, health and social justice*, which provides a direction of effect plot for outcomes, including quit attempts, quitting success and use of cessation aids (electronic cigarettes and over-the counter NRT), by each indicator of socio-economic position and subcategories.

Narrowing the smoking inequality gap

This section examines the unequal progress being made towards a smokefree UK using data from the Annual Population Survey (APS).[12] Although smoking prevalence continues to decline nationally, progress has been uneven across the population. At the national level, absolute inequalities have narrowed as smoking rates have fallen across all groups. However, relative inequalities have widened, meaning that smoking is becoming increasingly concentrated among the most disadvantaged groups.

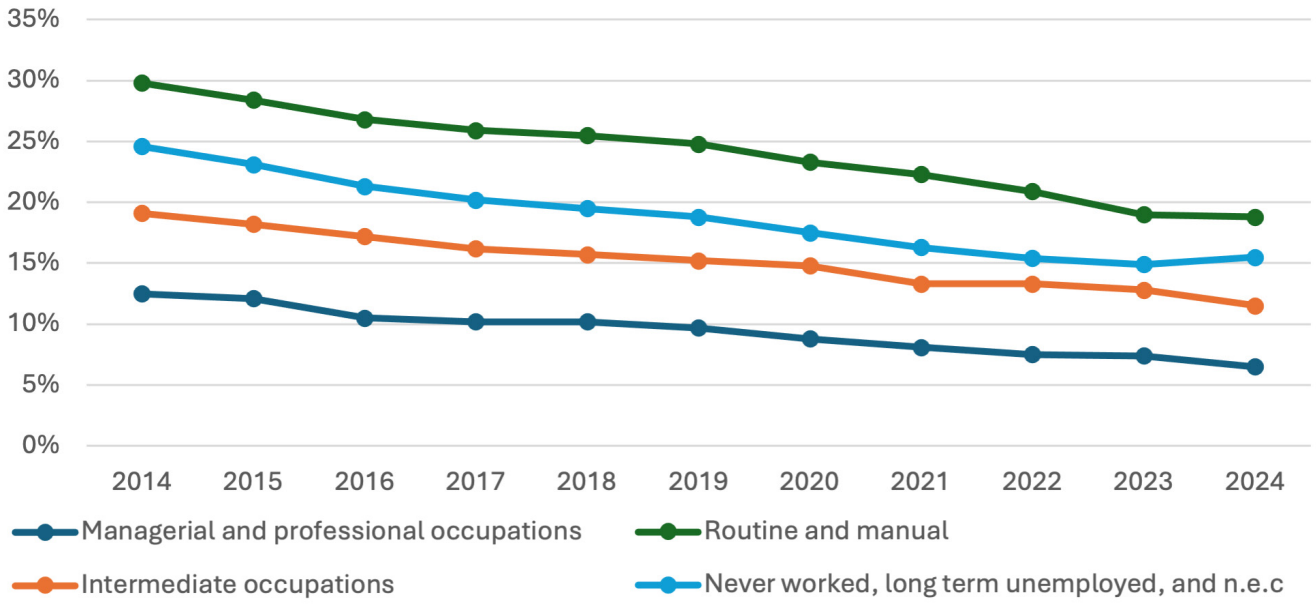
This pattern reflects wider evidence on smoking inequalities. Data from the Health Survey for England (HSE) shows that smoking prevalence is around 2.5 times as high in the most deprived areas compared to the least deprived, underlining the enduring link between smoking and disadvantage.[13] The picture presented in the APS is the same, with the survey showing smoking is concentrated among disadvantaged groups.[v]

Looking beyond current prevalence, this analysis assesses whether different population groups are on track to achieve the Smokefree Action Coalition's ambition of reducing smoking prevalence to 1% or below by 2040. The findings suggest that many are not. For several groups with the highest smoking prevalence, rates are not declining fast enough to reach the target, raising the prospect of a smokefree future that is achieved for some communities long before others. Without faster progress among these groups, national smoking rates may continue to fall while inequalities become ever more entrenched.

Current differences in smoking rates

There are many different groups that experience disadvantage and have higher rates of smoking. Historically the government have set targets for reducing smoking among routine and manual workers where smoking rates have fallen from 30% in 2014 to 19% by 2024. While this is considerable progress, smoking rates among routine and manual workers in 2024 were nearly three times higher than managerial and professional workers.

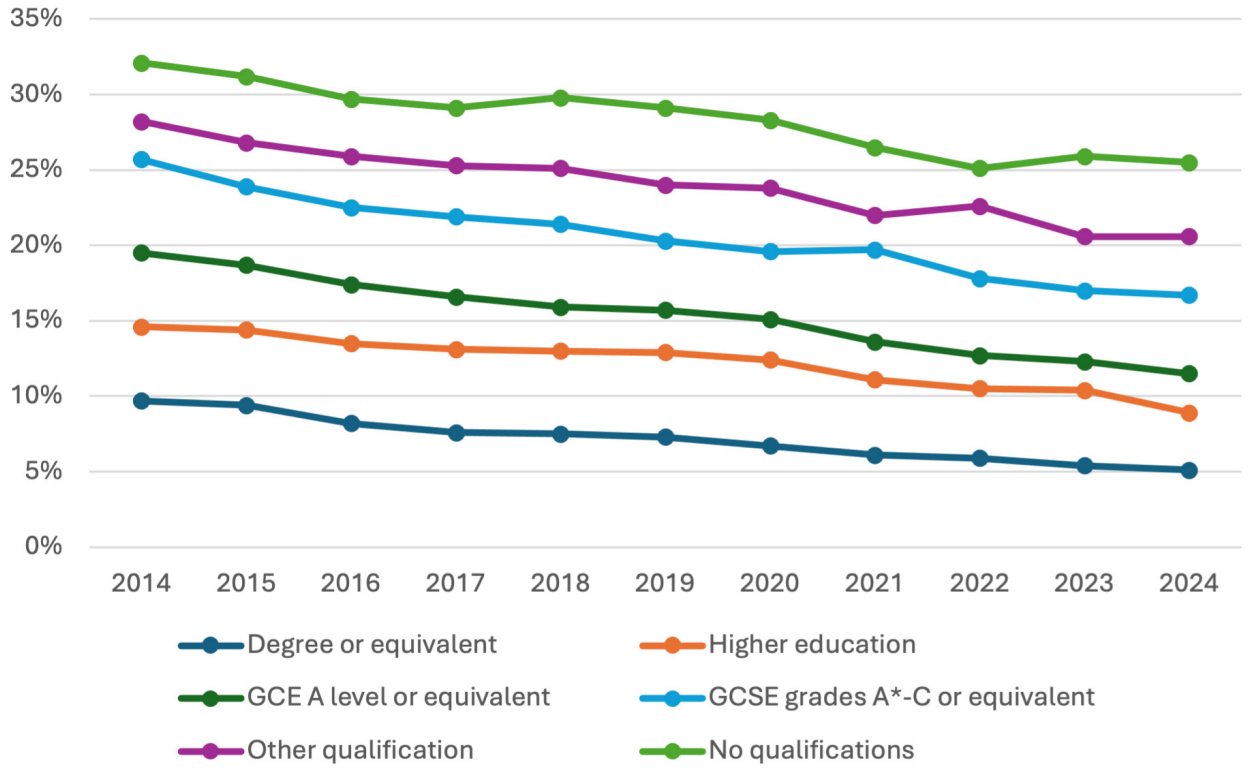
Chart 1 | Smoking rates by occupational group



v While the APS analysis presented here is not directly comparable, as it draws on a different survey and examines a broader range of demographic and socioeconomic characteristics rather than area-level deprivation alone, the message is the same: smoking is concentrated among groups facing the greatest disadvantage and relative inequalities are widening.

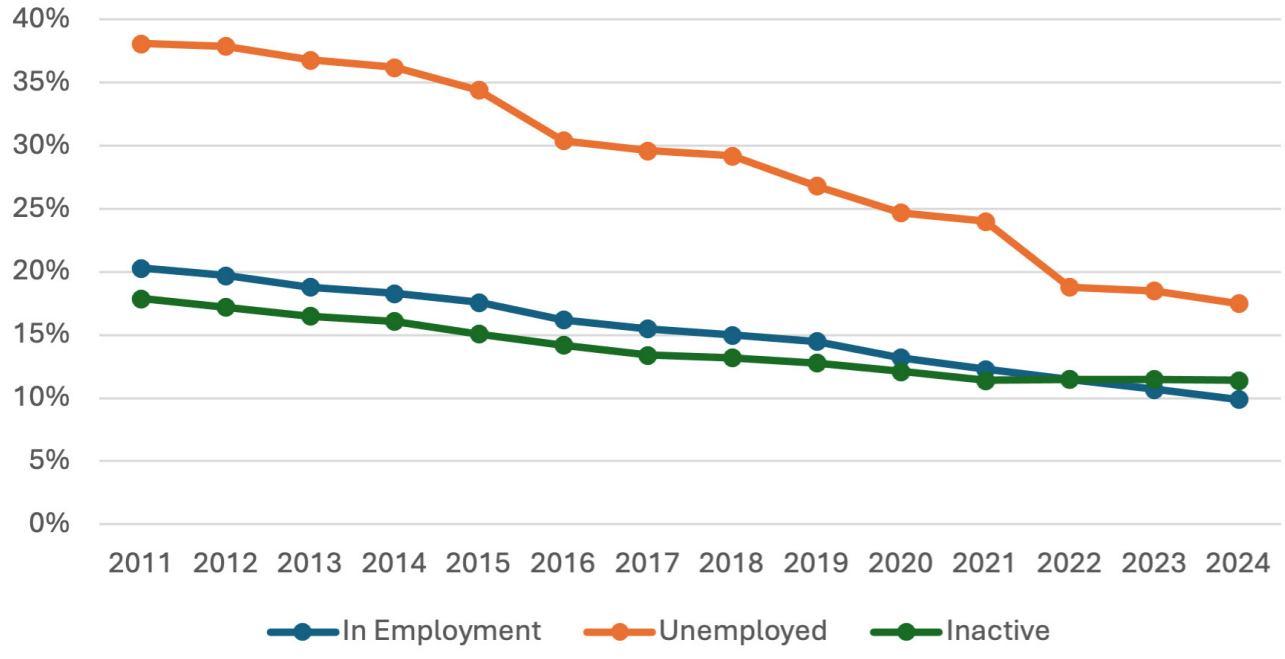
There are other groups where the difference in smoking rates has widened significantly over recent years. In 2014, people with no qualifications were just over 3 times more likely to smoke as those with a degree (32% vs 10%). While progress has been made in both groups, the inequality has grown, meaning people with no qualifications are now 5 times more likely to smoke than those with a degree.

Chart 2 | Smoking rates by level of education



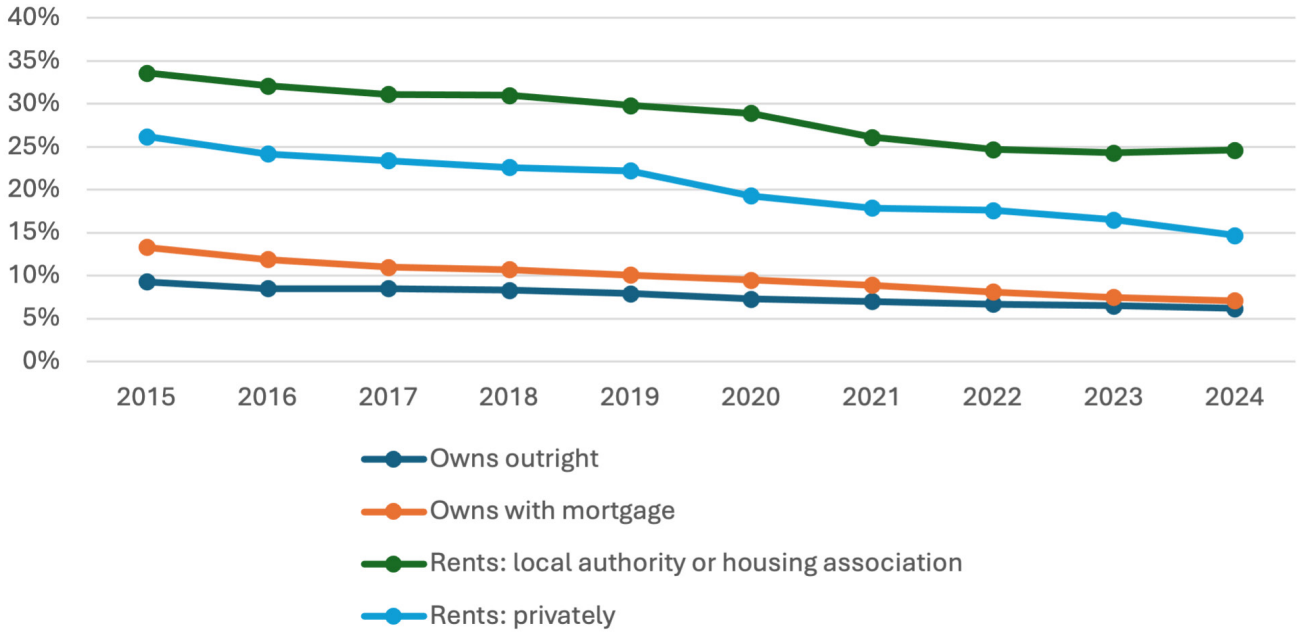
Focusing on employment, in 2014 those who were unemployed were twice as likely to smoke as those in work. However, this difference has narrowed slightly, so in 2024 they were 1.8 times as likely to smoke. At the same time, among those who are inactive, rates of smoking have gone from being below those in employment, in 2014, to above in 2024.

Chart 3 | Smoking rates by employment status



Where people live also makes a difference. While overall regional inequalities in smoking rates have narrowed,[14] within our communities disparities endure. People in social housing are more likely to smoke than those in other tenures. In 2015 they were 3.6 times as likely to smoke than those who owned their property outright and 2.5 times as likely than those who owned with a mortgage. By 2024 the difference had grown, and they were 4 times as likely to smoke than those who owned property outright and 3.5 times as likely than those who owned with a mortgage.

Chart 4 | Smoking rates by housing tenure



For many of these groups, widening inequalities in smoking prevalence are likely to reflect broader socioeconomic forces. Although smoking rates have fallen across most groups, the relative gap between the most and least advantaged is growing. Current rates of decline suggest that the most advantaged communities are on track to achieve smokefree status long before the most deprived, risking an increasingly unequal path to a smokefree UK.

Table 1 | Predicted date in which groups will reach less than 1% smoking prevalence, at the rate of decline between 2014-2024 (2015-2024 for education level).

	When smoking will reach less than 1%
Has a degree	2033
Unemployed	2033
Managerial and professional	2034
In employment	2035
Own home outright	2040
Routine and manual	2041
Economically inactive	2045
Rents in social housing	2048
No qualifications	2062

A target for closing the gap

The Smokefree Action Coalition has set a goal for smoking rates to be below 1% by 2040. To achieve this equitably, we need to improve our rate of progress for many groups in the population.[2]

In the past, the government's inequalities target has been focused on routine and manual workers. The rate of progress for this group is impressive, with an average decline of 1.1% per year between 2014 and 2024, indicating that they would only be marginally above 1% by 2040.

However, other groups will be much further behind, and it is these groups where targets are needed to accelerate progress and achieve the 2040 target.

Table 2 | Current annual rate of decline and needed rate of decline to reach less than 1% smoking by 2040

	Current rate	Needed rate	Needed pp increase in rate of decline
Unemployed	1.9%	On track	-
Routine and manual	1.10%	1.11%	0.01%
Economically inactive	0.50%	0.65%	0.15%
Social housing	1.00%	1.48%	0.48%
No qualifications	0.66%	1.53%	0.87%

These groups are likely to make up a substantial proportion of smokers. For example, around a quarter of smokers are estimated to be in social housing.[15]

What these groups likely have in common is that they have low incomes. It is therefore reasonable to expect that a target which focused on deprivation would help to deliver for most of these groups. A target for the 20% most deprived – an approach taken by the NHS's Core20 Plus5 model – could be effective.[16] However, the data published from the government's annual population survey is too limited for us to make a reasonable estimate of current and needed progress by level of deprivation.

Achieving a smokefree UK by 2040 will require more than continued national progress. The greatest reductions in smoking prevalence must occur among the most deprived communities, where smoking remains highest and the burden of harm is greatest.

It is both achievable and essential for all groups to reach smoking prevalence below 1% by 2040. However, without targeted action, smoking inequalities will continue to reinforce wider inequalities in health, poverty and life expectancy across the UK.

Smoking and poverty

To effectively close the gap in smoking rates we need to understand the wider poverty crisis and the relationship smoking has with poverty and deprivation. This section explores this context, the cost of smoking and how smoking effects households who already sit below the poverty line.

The wider poverty crisis

Poverty rates in the UK have stagnated. For over 20 years there has been no meaningful decline, with over 14 million people still living below the poverty line.[17] This includes around 7.9 million working-age adults and 4.5 million children, meaning 3 in every 10 children and 2 in every 10 working-age adults lack financial security.

Poverty has persisted and remains concentrated in disadvantaged groups. Social housing tenants, unemployed people, ethnic minorities, and those with a disability are significantly more likely to be in poverty.[18] This illustrates how poverty is structurally embedded in disadvantaged communities.

Poverty has not only stagnated; it has deepened. The Joseph Rowntree Foundation reports that almost half of those below the poverty line experience very deep poverty.[19] Households in very deep and deep poverty have incomes respectively below 50% and 40% of the UK median income (after housing costs). Last year alone, a further 200,000 children fell into deep poverty, taking the total to 3.1 million.[20] These households were unable to meet their most basic needs. There was not enough money for food, heating, fixing the stove, going to the dentist, getting the bus into town.

Successive governments have failed to reverse the trend and bring about change. Despite repeated warnings from charities, health organisations and anti-poverty groups, the underlying drivers such as low pay, insecure employment, high housing costs and poor health remain largely unaddressed. The result is a poverty crisis that has been allowed to stagnate and deteriorate.

The impact of smoking on poverty

Smoking plays a significant and often overlooked role in this crisis. Our fourth commissioned report with Landman Economics provides the most detailed analysis to date of the link between smoking and poverty in the UK. The report demonstrates that tobacco expenditure, both before and after housing costs, pushes households below the poverty line.[vi]

The analysis looks at the impact on absolute and relative poverty rates, before and after housing costs are included. For every assessment of poverty, tobacco pushes hundreds of thousands of people into poverty and deeper financial hardship. Here we report the relative poverty rates after housing costs, the full data tables are in the appendix and the published report.[vii]

Our findings show that, when household income is adjusted for tobacco spending, an additional 417,000 households fall below the poverty line. This places the real number of people in poverty closer to 15 million, with a further half a million working-age adults (499,000), an extra 193,000 pensioners, and a further 137,000 children falling below the line.

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vi The Landman Economics *Estimates of poverty in the UK adjusted for expenditure on tobacco – 2026 update* uses both before (BHC) and after housing cost (AHC) measures and provides findings for both absolute and relative poverty.

vii See Appendix, which includes data tables on household, working age adult, pensioner, and child poverty rates before and after tobacco expenditure is taken into account.

Smoking pushes already disadvantaged households into poverty. When tobacco spend is included in poverty calculations, the proportion of disadvantaged households below the poverty line increases significantly. Poverty rises by 3.4 p.p. for social renters compared with 1.0 p.p. for homeowners, by 2.3 p.p. for no-earner households compared with 0.8 p.p. for households with two or more earners, and by 2.4 p.p. for semi-routine or routine worker households compared with 0.4 p.p. for managerial and professional households.[viii]

This means that households that contain smokers have an alarming rate of poverty. Households that spend on tobacco and are without an earner are hit the hardest, with 79% falling into poverty after tobacco costs, nearly double one-earner smoking households (42%) and five times smoking households with two earners or more (17%).

Smoking and deep poverty

Many smoking households already sit below the poverty line. An estimated 28% (955,000) are in poverty before ever buying any tobacco.[ix] Tobacco expenditure doesn't push these households into poverty, rather it pushes them deeper, exacerbating financial strain. In practical terms, smoking turns financial strain into severe hardship, contributing to skipped meals and inability to cover basic living costs.

This impact is clearly reflected in food insecurity. Skipped meals and food bank parcels are one of the clearest indicators of deepening poverty.[21,22] The Trussel Trust distributed 2.9 million parcels in the UK last year, with nearly two thirds going to families with children. There were more than 2.5 times the number of parcels distributed in 2024/25 than in 2014/15.[23] According to a You Gov survey for ASH, smokers are disproportionately affected, attending food banks and skipping meals at roughly treble the rate of never-smokers. Around 1 in 4 smokers (24%) went hungry last year, compared with 1 in 10 never-smokers (10%), while 1 in 5 smokers (20%) had ever relied on food banks to cover basics, compared with 1 in 14 never-smokers (7%).[x]

Our analysis was not designed to assess deep poverty but it is plausible that the 955,000 households in poverty before their expenditure on smoking is taken into account are experiencing significant hardship.

Smoking is a measurable driver of poverty. It pushes hundreds of thousands of people below the poverty line, drives the most disadvantaged into poverty at alarming rates, and worsens financial hardship for millions across the UK. Poverty cannot be eradicated overnight, but we must confront the scale of the problem. Reducing smoking rates is not just a public health priority, it is a crucial strategy for alleviating poverty.

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viii All findings for the impact of tobacco expenditure on poverty using housing tenure, household employment patterns and NS-SEC classification of the head of household are made using the **relative AHC poverty measure.** This is the most widely used headline measure of poverty in recent discussions of trends in household incomes and poverty rates by researchers and campaigners.

ix This range includes both the BHC and AHC relative and absolute poverty measures.

x Reference: *ASH adult survey conducted by YouGov. Total sample size was 13,259 adults. Fieldwork was undertaken between 18/02/2026 - 19/03/2026. The survey was carried out online. The figures have been weighted and are representative of all GB adults (aged 18+). Sample sizes: smokers=1,431; never smokers=7,699*

Ending smoking inequality: what it will take

Our objective is clear: to end smoking inequality and achieve 1% smoking rates for all populations by 2040.

Although absolute smoking rates in England continue to fall overall, the relative inequality gap has not narrowed. As of today, people living in social housing, those who are economically inactive, and those who have no qualifications, will be left behind as the country transitions to a smokefree future.

Reducing overall smoking prevalence will not, by itself, close this gap. Targeted action is required to ensure that those who face the greatest disadvantage receive the greatest support.

What we learned

To understand what ending smoking for all populations requires in practice, ASH convened a series of expert roundtables between 2025 and 2026. These discussions brought together service leaders, academics and officials, alongside a panel of lived experience experts with direct experience of low income, smoking and health inequality.[xi] Across these discussions, three consistent themes emerged.

1. **Services are not sufficiently reaching those who need them most.** While some services have started to tailor offers and reach populations across the socio-economic spectrum, these remain limited. Support must not only be available, but genuinely reachable and responsive to the realities of poverty, unstable employment, housing insecurity and mental health challenges.

2. **Services alone cannot end smoking inequality, ambition and strategy must match the challenge.** A whole system approach is needed to speed progress. This starts with ambitious strategy and includes driving changes in workforce capacity, commissioning and at scale reach. Without a realistic planning and investment, ambitions to end smoking inequality risk outstripping delivery.

3. **Quitting smoking does not happen in isolation.** Understanding the practical, social and psychological conditions of sustained quitting is essential to align services with people's lives.

The discussions also reinforced that smoking behaviour is often embedded within high-stress life contexts shaped by structural inequality, financial instability and poor health. Circumstances differ widely depending on employment stability, household composition, income sources and support networks. Effective policy must therefore be targeted, flexible and responsive to these diverse realities.

xi Excerpts from the ASH lived experience roundtable 2025 are quoted on the page below and throughout the following chapter.

I had a really good stop smoking advisor. He was absolutely brilliant. **We had a good laugh, you know, at the same time.** So that really did work and I think that's what worked better this time.

Participant SW

They should always remember that, you know, they are dealing with people with real financial pressure. **People [whose] rent money is tight. You know, the stress is high.**

Participant AL

[They] must put in a place, a programme that would that wouldn't cost [us] a fortune. **That wouldn't... make [us], you know, [pay] out of [our] pockets to get help.**

Participant TW

The hardest thing about giving up smoking, especially for me, **I would say stress at the warehouse...** the job can be full, long shifts, heavy lifting, you know, constant rushing... and for the fact that my mates at work, **all of them smoke,** so it's just something that if you're not smoking you're awkward or you're odd.

Participant AL

In estates you have a community of people all looking out for each other and I didn't work at one point in my life and you go to each other's houses and you borrow cigs and you go chat about your kids to someone, to another single mum... **your day-to-day life revolves around your little community of all your friends smoking.**

Participant GC

No one ever regrets stopping smoking, but you'll always regret smoking.

Participant GC

There isn't individualised care when it comes to giving up smoking... it's... not bespoke. It's very much tailored to all, instead of each individual.

Participant HM

The action plan

This action plan draws directly on those insights and sets out the practical shifts across services, communications, and systems to ensure that the people facing the greatest disadvantage have the best opportunity to quit. It points to the changes needed to end smoking inequality, ensuring that disadvantaged populations are not left behind as we transition to a smokefree Britain.

The plan focuses on three priority recommendations:

Create an action plan with clear targets

1. Publish a national roadmap for a smokefree country
2. Develop local plans
3. Take a regional approach

Expand access to support, cessation aids and quit campaigns

4. Improve service reach and quit success
5. Deliver support in high-contact healthcare settings
6. Make access to quit aids equitable
7. Scale digital cessation support
8. Use targeted communications and campaigns

Design support to meet the needs of disadvantaged groups

9. Design services around need
10. Deliver flexible services for the community
11. Embed evaluation, learning and knowledge sharing

Create an action plan with clear targets

Ending smoking inequality requires a clear framework for success. To reduce smoking rates in the most deprived populations we need to chart our progress and set ambitious national targets. This needs to be backed by strong system-wide leadership that galvanises services to do what they know works and to go further than ever before.

Publish a national roadmap for a smokefree country

The government needs to publish a national roadmap as a matter of urgency, building on the progress set in the Tobacco and Vapes Act. This landmark piece of legislation will prevent future generations from becoming addicted to tobacco, but it will not address smoking among the 5.3 million existing adult smokers in the UK. Many deprived communities will continue to experience high smoking rates years, if not decades, after the most advantaged have quit. The health sector must go beyond the Act to ensure that no communities are left behind.

The Government must adopt the Smokefree Action Coalition goal of less than 1% smoking rates by 2040 in all communities that we have accurate data for, setting out targets for improved decline to ensure that all groups reach this goal. Modelling by ASH shows that to achieve less than 1% in all communities by 2040, quit rates need to increase among people living in social housing, those who are economically inactive, and those who have no qualifications. Where data is unavailable, steps must be taken at a national level to ensure no community remains hidden.

Develop local plans

Local tobacco plans must include clear objectives to address smoking in disadvantaged groups. National datasets can lack the scale needed for local government to accurately assess the levels of need in their local population. Using local surveys and datasets, such as GP records, can provide rich insights into geographical and cultural groups where interventions can be targeted.

Plans should also explicitly seek to engage in wider partnerships with stakeholders that work with and in the communities where smoking rates are highest. Including them and smokers as partners in the development of local approaches and in local tobacco alliances can support innovation.

There are many other local plans that could also support reductions in smoking among target groups, including social housing, economic regeneration and child poverty.

Take a regional approach

There are many opportunities for economies of scale to improve outcomes for disadvantaged groups. These include developing targeted approach for numerically small but high prevalence disadvantaged groups (e.g. Gypsy and Traveller communities), pooling resources around things like training and communications approaches, and developing models that cross local government boundaries. For example, many social housing providers work across a wide geography.

Most areas now have some regional co-ordination capacity which can and should be further developed.

Expand access to support, cessation aids and quit campaigns

To successfully support smokers to quit we need to strengthen and extend what works. Smoking cessation support is most effective when it is delivered in settings people already attend and trust, and when services are flexible enough to respond to people's circumstances.[24,25] Expanding these approaches is essential to reach disadvantaged communities.

Improving service reach and quit success

Stop smoking services are uniquely positioned to drive progress. Last year services achieved a record increase in quits, with the number of people quitting up by 23% from 104,000 in 2023-24 to 128,000 in 2024-5.[26]

More than half of people accessing Stop smoking services successfully quit at four weeks, demonstrating the effectiveness of the support available. Equity-oriented services achieve strong engagement among disadvantaged smokers, increasing reach and quit attempts and partially offsetting lower quit success rates at a population level, highlighting the value of targeted support in improving outcomes.[27]

While smoking prevalence remains higher among routine and manual workers, it has fallen substantially over the past decade. This suggests that targeted delivery is helping align support with need, though further progress is required to reduce inequalities.

With funding committed for the next three years, local authorities are well placed to contribute to the national smokefree ambition of less than 1% smoking prevalence by 2040. However, success will depend not only on how many smokers are reached, but on ensuring continued engagement with those from the most disadvantaged groups.

Services must ensure that they keep track of various measures of disadvantage and ensure they are reaching the right people and develop their outreach, engagement and service design with these populations in mind.

Deliver support in high-contact healthcare settings

Cessation support should be integrated in healthcare settings people already use. Opportunistic interventions in emergency departments, lung screenings, and in-patient pathways, can significantly increase engagement by leveraging existing relationships and teachable moments.

People living in the most deprived communities are around twice as likely to attend hospital emergency departments as those in the least deprived areas,[28] meaning these settings reach populations with higher smoking prevalence and complex health needs. Evidence from the COSTED trial shows that interventions delivered in emergency departments can be highly effective.[29]

NHS Targeted Lung Health Checks provide another proven opportunity,[30] offering behavioural support and nicotine replacement therapy during screening can improve quit success.[31] Extensive evidence shows that cessation support should be an integral part of lung cancer screening, with intensive and personalized interventions showing the most promising results.[32]

In-patient pathways remain crucial. Funding for acute, mental health, and maternity Tobacco Dependence Treatment Services (TDTS) must be protected to ensure patients with complex needs continue to receive support.[33] Maternity and mental health services are especially vital, seeing particularly high numbers of people from deprived communities and delivering essential support to those with complex needs.

> I had a relapse in my mental health, and I think stress is a factor in not giving up smoking
>
> **Participant HM**

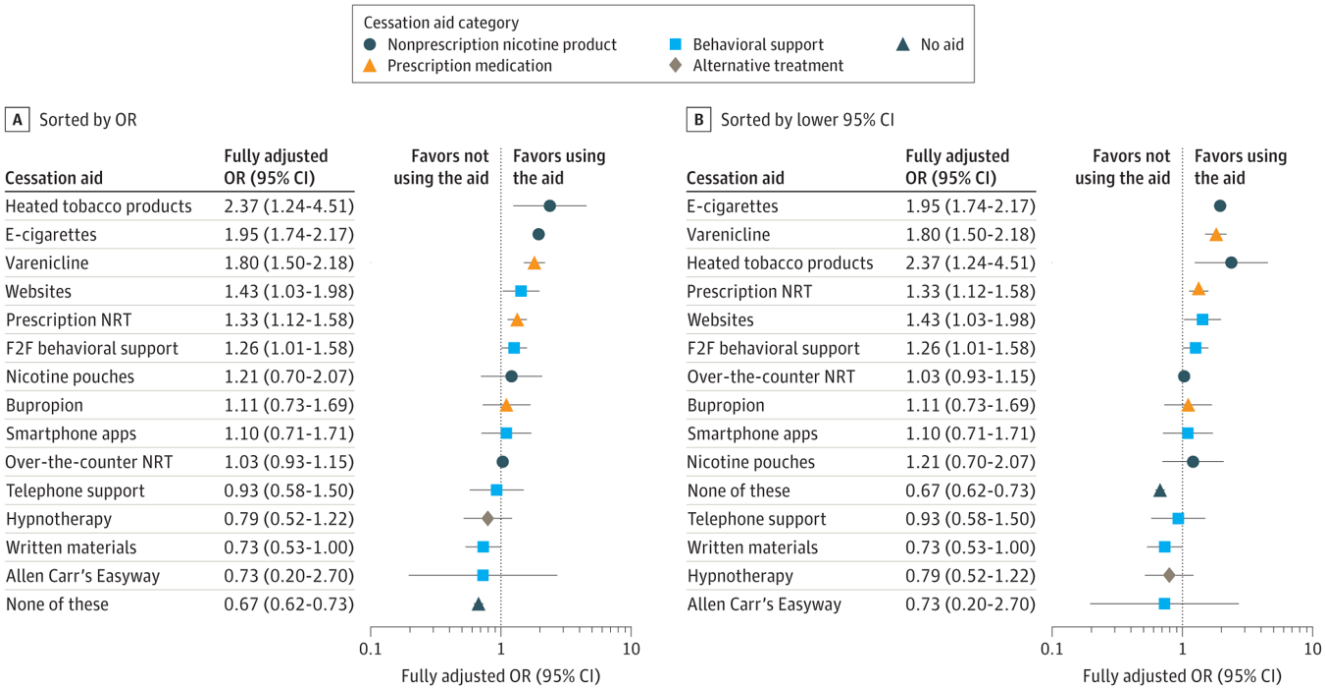
All effective interventions, whether in ED units, in-patient settings or screenings, must not only be maintained but scaled. Funding proven interventions should be a priority when reducing prevalence among the most disadvantaged smokers.

Make access to quit aids equitable

Using an effective aid to quit makes a significant difference to outcomes. For smokers in disadvantaged groups, it is vital to connect them to effective aids as their quit success rate is generally lower than other groups.

The most effective NICE recommended aids are vapes and varenicline.

Figure 1 | Fully Adjusted Associations Between Use of Cessation Aids and Quit Success[xii]

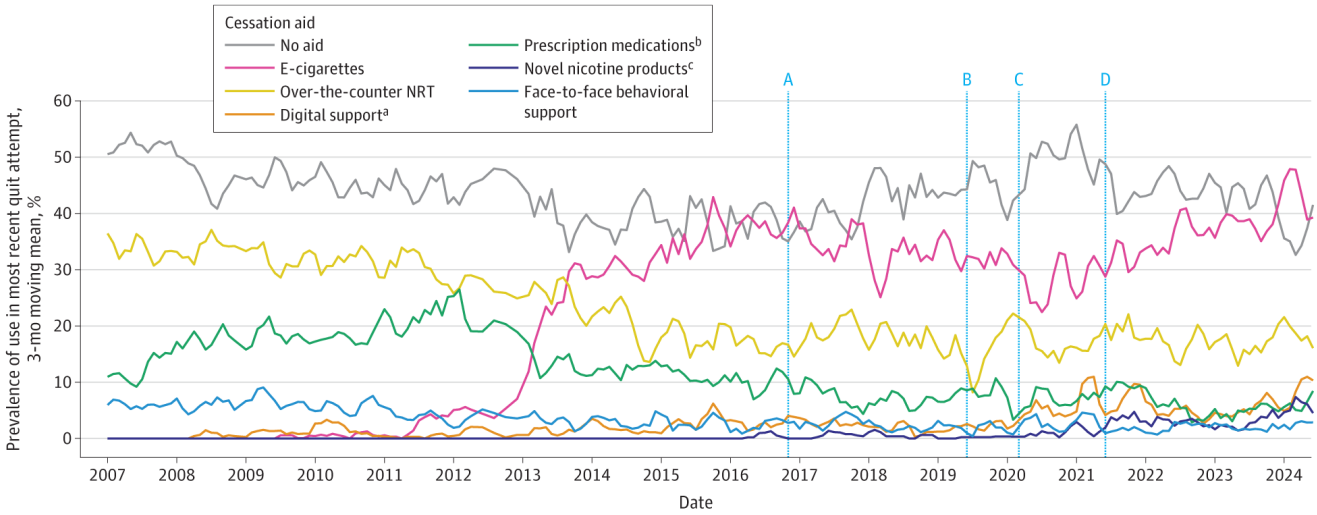


Source: Jackson SE, Brown J, Buss V, Shahab L. Prevalence of Popular Smoking Cessation Aids in England and Associations With Quit Success. 2025.

While vapes are a commonly used quit aid, effective medications like varenicline continue to have low uptake.

xii While this study found that heated tobacco products were the most effective cessation aid, the size of the association was less certain due to the small number of participants using this aid (72). In contrast, over 4,000 participants used e-cigarettes and over 1,000 used varenicline, making those findings more certain.

Figure 2 | Monthly Prevalence of the Use of Smoking Cessation Aids in Quit Attempts in England[xiii]



Source: Jackson SE, Brown J, Buss V, Shahab L. Prevalence of Popular Smoking Cessation Aids in England and Associations With Quit Success. 2025.

Access to the most effective stop smoking treatments, particularly Varenicline and Cytisine, must be simplified and standardised.[34] Prescription medicines remain some of the hardest treatments to obtain and are chronically underused due to strict prescribing rules, costs, and administrative barriers such as forms. Anecdotal evidence suggests this disproportionately affects those who are most disadvantaged, price sensitive, and in need of simple, low-barrier access.[35]

The work of Fresh in establishing a region-wide Patient Group Direction has shown what can be achieved through coordinated action.[36] This approach has helped standardise access and enable wider prescribing across services, and it should be replicated in other regions to reduce variation and improve uptake.

Commissioning decisions further complicate access to quit aids, particularly where charges for nicotine replacement therapy (NRT) still apply, although some regions have removed these costs entirely for both nicotine replacement therapy and vaping products.[37]

> I think to help people with financial hardship... local shops should sell NRT, or people should get vouchers to be able to get NRT for free.
>
> **Participant GC**

Creating a level playing field requires the most effective quit aids, including cytisinicline and varenicline, to be affordable and accessible. Without this, cost and complexity will continue to limit uptake among those most in need. Equitable access to all quit aids should be standard across the UK, with greater effort to make prescription medicines readily available.

> People on benefits... get NRT [for free], but people on low income who have got jobs, who are on minimum wage don't. And I think it should be NRT for free or reduced.
>
> **Participant HM**

Vaping products have also been shown to be highly effective quit tools.[38] The price of vape liquids is likely to increase when the government introduces a vape excise tax in October 2026. Continued provision of 'swap to stop' initiatives, targeted towards those who most need support could help to mitigate the impact of any price increase on disadvantaged smokers.

xiii Vertical lines indicate the timing of (A) the launch of heated tobacco products in November 2016, (B) the launch of nicotine pouches in July 2019, (C) the start of the COVID-19 pandemic in March 2020, and (D) the start of the varenicline supply disruption in England in June 2021. NRT indicates nicotine replacement therapy. Digital support includes websites and smartphone apps. Prescription medications include prescription NRT, varenicline, and bupropion. Novel nicotine products include heated tobacco products and nicotine pouches.

Scale digital cessation support

Digital programmes extend the reach of services, giving people flexible access when work, childcare or other barriers make clinics hard to attend. Messaging tools, apps and 24/7 digital assistance offer help anytime, anywhere. Digital interventions are rapidly growing in popularity and are now among the most used quitting tools.[39] Local authority commissioning of apps has jumped 25%, reflecting this demand, with 52% of local authorities surveyed now commissioning phone apps.[40]

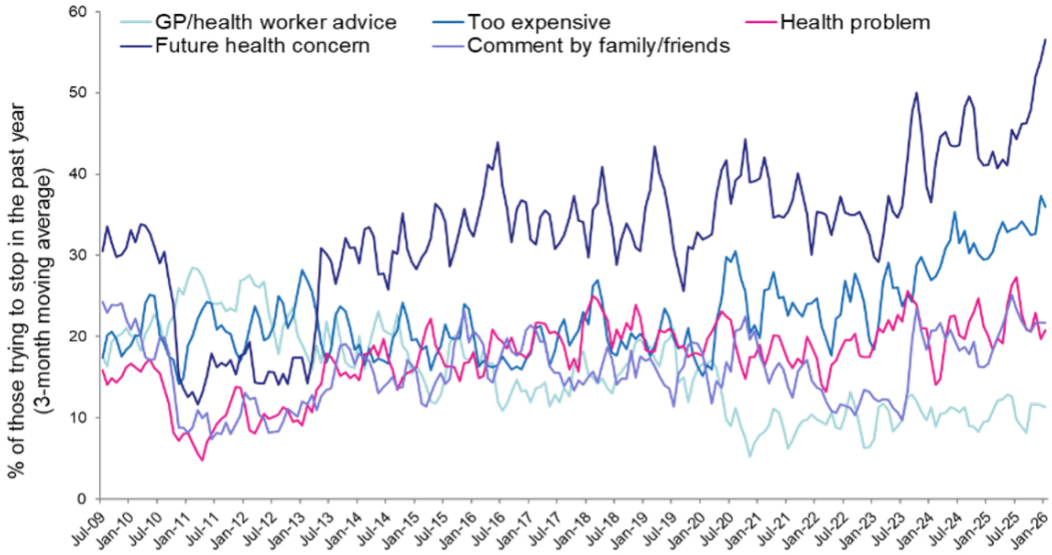
Where there is evidence of impact, successful digital pilots should be scaled. London's Smokefree app pilot, for example, engaged lower-income users most, with highest uptake in the most deprived quintile.[41] It also showed people accessed support outside standard hours, highlighting the power of flexible, on-demand help.[42,43] Other tools, including the NHS Smokefree app and Personal Quit Plan, should also be evaluated and expanded where effective.

> The Smokefree app... would be beneficial if it was made available to a wider audience, children at schools or colleges, people living on low incomes and workplaces.
>
> **Participant GC**

Use targeted communications and campaigns

Population-level communication campaigns remain one of the most effective ways to raise awareness and motivate quitting.[44] When funding for mass media campaigns froze between 2010 and 2013, the number of quit attempts dropped significantly.

Figure 3 | Percentage of those trying to stop smoking in the past year (3-month moving average) by motivating factor



Source: Koch, L. Presentation - Boosting Quit success and Reducing Smoking Prevalence: Data from the Smoking Toolkit Study. Mar 2026.

Tailored messaging that combines harm, hope, finances and practical help is particularly effective.[45] Messaging should be actively segmented and refer each group to the services best placed to provide support; this should become standard practice.

Campaigns that feature trusted local voices can be especially effective in reaching deprived communities and building trust in cessation services. Effective examples include the What Will You Miss Campaign rolled out by Greater Manchester and used by Humber and North Yorkshire ICB and NHS Cheshire and Merseyside, and Fresh in the North East's Smoking Survivors campaign.[46,47]

Embedding local voices within campaigns should become standard practice for communications and messaging aimed at reducing health inequalities.[48] This will ensure that messaging is realistic, motivating, aware and inclusive.

Design support to meet the needs of disadvantaged groups

Ending smoking inequality requires a focus on people facing the greatest disadvantage. This goes beyond scaling existing approaches; it requires redesigning, delivering and embedding services that are flexible, accessible, and rooted in communities.

Design stop smoking services around need

Services must be designed to meet the needs of people experiencing the highest levels of disadvantage. A one-size-fits-all approach is no longer sufficient, and strong commissioning is essential to ensure services are effective.

Smoking is increasingly concentrated in groups who have complex needs, financial difficulties, fall below the poverty line, experience food insecurity, and have complex mental health. Traditional models, delivered in 9–5 clinical settings, based in town centres, and limited to 12-week programmes with little follow-up, are not equipped to support these groups.

> I stopped smoking and at 12 weeks that's it, your job done, you know, you're left to your own devices, where if you've got a drop-in centre...and I feel as though I'm struggling a little bit then I can go there to say, you know what, I've been so tempted to pick a cigarette up, because that's where you find the downfall is and people start smoking again."
>
> **Participant SW**

Commissioning needs to change. Smoking is a relapsing condition, with around three-quarters of people who try to quit relapsing within the first six months[49] and rates higher in deprived populations.[50] Local authority and NHS models can no longer prioritise cost effective quits alone. Supporting deprived smokers will require a mixture of high intensity and long-term interventions, which are more resource intensive.

> It probably took me around... 7-8 years actually... because I tried and then went back to [smoking]... you think a cigarette solves all your problems and you think your cigarettes are your best friend in times of need.
>
> **Participant GC**

Commissioners need to respond effectively as smoking becomes concentrated in deprived communities. Embedding poverty awareness training as standard practice will help ensure services are designed with these populations in mind.[xiv]

Early evidence suggests that effective programmes are flexible, longer-term and community based. Pilots should test approaches that extend beyond 12 weeks, offer multiple points of engagement, and adapt to local need. These should be supported by robust evaluation to identify what works and inform future service design.

xiv Fresh invited CNE to provide a *Poverty Proofing Stop Smoking Interventions* webinar to local authorities in the North East in March 2026.

Deliver flexible services for the community

Delivery should reflect design. Services must be flexible and accessible, offering drop-in appointments, extended hours, financial incentives and community-based provision. Embedding support in trusted and well-attended settings, such as housing schemes, local hubs, foodbanks and community organisations, reduces barriers to access and improves engagement.[51,52,53]

> I stopped smoking when they did the £200 incentive... I managed to get this laptop with that £200 and that's like my bonus; that really did work for me.
>
> **Participant SW**

> Your AA type thing I think really is something that you could do with, somebody who stopped smoking for a long time ago, you can go to meetings once a week, that's your goal to get through, to not smoke to the next week, it's having them little goals.
>
> **Participant SW**

Collaboration with community organisations and local leaders is critical. They can mobilise communities, share information, build trust, and catalyse change.[54] Where possible, local leaders and community champions should be involved in service delivery ensuring interventions are responsive to local needs.[55]

All staff should be supported with NCSCT training and clear policies to avoid inadvertently undermining quit attempts. They should all receive basic training on smoking and mental health, alongside clear, evidence-based information on e-cigarettes, which remain a barrier to effective referrals.

Embed evaluation, learning and knowledge sharing

As services evolve, evaluation, learning and knowledge sharing must be core to delivery. Government, the NHS and local services must prioritise interventions that work. All pilots and programmes should be properly evaluated, with findings shared to inform wider practice. This is especially important for community-based approaches, which are often more flexible and harder to monitor.

Government should take steps, following the findings of the RCP report, to capture 'hidden populations' in data collection.[56] This is essential to enabling targeted action and ensuring no communities are left behind in the move to a smokefree generation.

Existing tools and data, including the ASH Ready Reckoner and Fingertips, provide a strong foundation for understanding need and tracking outcomes.[57] These should be used consistently and alongside local insight to capture impact effectively. Self-assessment tools like CleaR should also be updated to support commissioning.[58]

All programmes should be commissioned with clear objectives and robust evaluation frameworks, including measures of quit attempts, sustained quits, relapse and engagement among priority groups. Evaluation should be built into service design, not added retrospectively.

Learning must also be shared systematically. Establishing a central repository for evidence, case studies and evaluation findings would reduce duplication, strengthen the evidence base, and support more effective service design.

Embedding these approaches will enable services to adapt, scale what works, and accelerate progress in reducing the smoking gap.

Conclusions

Ending smoking inequality will only be achieved by both strengthening what works and redesigning services for those most disadvantaged. This plan sets out practical, evidence-based steps across services, communications, and systems to ensure no one is left behind.

By delivering support in high-contact healthcare settings, ensuring equitable access to quit aids, scaling digital cessation tools, and using targeted campaigns, we can maximise the impact of interventions where they are most needed. Complementing this, designing services around deprived populations, embedding flexible community-based delivery, and prioritising robust evaluation and knowledge sharing will ensure support reaches those with the greatest need.

These measures need to form part of a wider plan to bring about a smokefree country. This process must be equitable, and we must map out how to ensure that no community is left behind. To reach 1% smoking rates by 2040 in known populations, we need to need to take a regional approach and develop clear and effective local plans.

Implementing these recommendations in full will create a system that is flexible, accessible, and responsive, giving every smoker, regardless of circumstance, a fair chance to quit and driving meaningful progress toward a smokefree country.

Appendix

This appendix includes the overall proportion and numbers of households, working age adults, pensioners and children who fall below the poverty on account of tobacco expenditure. For a detailed breakdown by characteristic and geography see *Estimates of poverty in the UK adjusted for expenditure on tobacco – 2026 update* by Landman Economics.

Table 2a | Household poverty rates before and after taking tobacco expenditure into account

	Whole sample	Households with positive tobacco expenditure only
Proportion of households in poverty	%	%
Before tobacco expenditure	20.5	28.1
After tobacco expenditure	22.0	40.4
Percentage point increase in poverty rate once tobacco expenditure is taken into account	1.5	12.3

Source: Landman Economics analysis of LCF data

Table 2b | Number of households in poverty before and after taking tobacco expenditure into account

	Whole sample	Households with positive tobacco expenditure only
Number of households in poverty (1000s)		
Before tobacco expenditure	5,909	955
After tobacco expenditure	6,326	1,372
Increase in number of households in poverty once tobacco expenditure is taken into account	417	417

Source: Landman Economics analysis of LCF data

Table 3a | Working age adult poverty rates before and after tobacco expenditure is taken into account

	Whole sample	Households with positive tobacco expenditure only
Proportion of working age adult in poverty	%	%
Before tobacco expenditure	19.4	24.9
After tobacco expenditure	20.6	33.9
Percentage point increase in poverty rate once tobacco expenditure is taken into account	1.2	9.0

Source: Landman Economics analysis of LCF data

Table 3b | Number of working age adults in poverty before and after tobacco expenditure is taken into account

	Whole sample	Households with positive tobacco expenditure only
Number of working age adults in poverty (1000s)		
Before tobacco expenditure	7,907	1,383
After tobacco expenditure	8,406	1,882
Increase in number of working age adults in poverty once tobacco expenditure is taken into account	499	499

Source: Landman Economics analysis of LCF data

Table 4a | Pensioner poverty rates before and after tobacco expenditure is taken into account

	Whole sample	Households with positive tobacco expenditure only
Proportion of pensioners in poverty	%	%
Before tobacco expenditure	15.7	25.6
After tobacco expenditure	17.3	46.1
Percentage point increase in poverty rate once tobacco expenditure is taken into account	1.6	20.5

Source: Landman Economics analysis of LCF data

Table 4b | Number of pensioners in poverty before and after tobacco expenditure is taken into account

	Whole sample	Households with positive tobacco expenditure only
Number of pensioners in poverty (1000s)		
Relative AHC poverty measure		
Before tobacco expenditure	1,889	241
After tobacco expenditure	2,083	434
Increase in number of pensioners in poverty once tobacco expenditure is taken into account	194	193

Source: Landman Economics analysis of LCF data

Table 5a | Child poverty rates before and after tobacco expenditure is taken into account

	Whole sample	Households with positive tobacco expenditure only
Proportion of children in poverty	%	%
Relative AHC poverty measure		
Before tobacco expenditure	30.5	35.2
After tobacco expenditure	31.5	43.0
Percentage point increase in poverty rate once tobacco expenditure is taken into account	1.0	7.8

Source: Landman Economics analysis of LCF data

Table 5b | Number of children in poverty before and after tobacco expenditure is taken into account

	Whole sample	Households with positive tobacco expenditure only
Number of children in poverty (1000s)		
Before tobacco expenditure	4,452	622
After tobacco expenditure	4,589	759
Increase in number of children in poverty once tobacco expenditure is taken into account	137	137

Source: Landman Economics analysis of LCF data

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