Health Inequalities and Smoking

September 2019

KEY POINTS

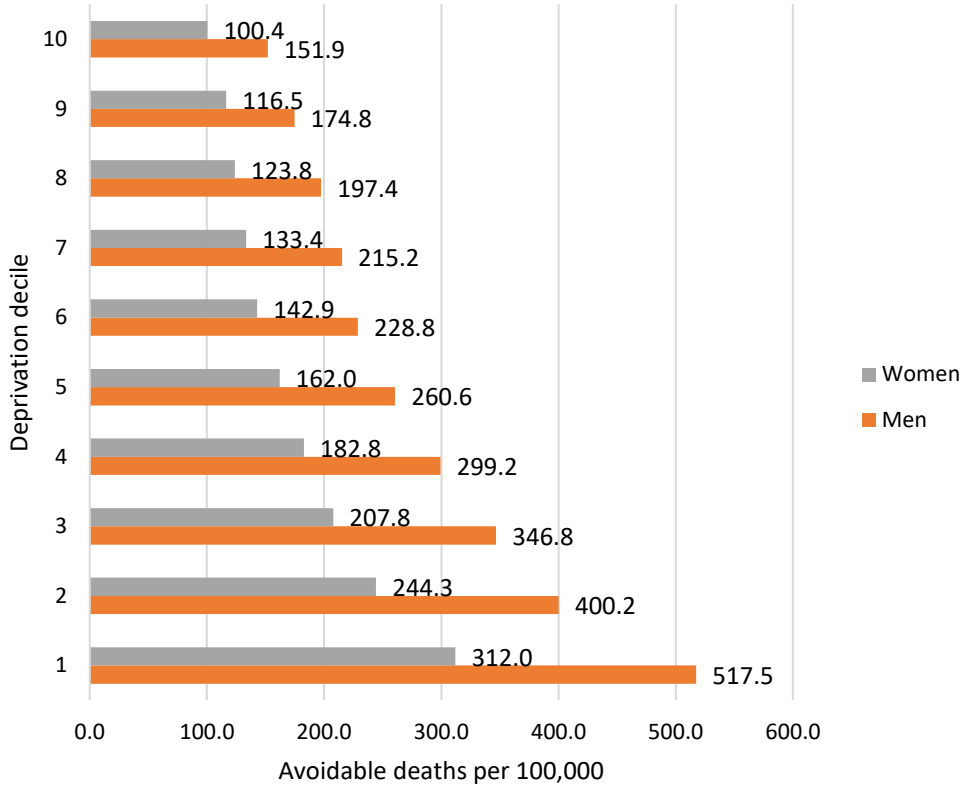
- Health inequalities are preventable differences in health outcomes between different population groups. Reducing health inequalities remains a key goal of public policy in England.
- Because smoking is so harmful, differences in smoking prevalence across the population translate into major differences in death rates and illness. Smoking is the single largest driver of health inequalities in England.
- Smoking is far more common among people with lower incomes. 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. Young people with parents who smoke 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, including through a reduction in poverty.
- Smoking related health inequalities are not restricted to socio-economic status. 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, people in contact with the criminal justice system, 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.[1] Likewise, people in the north of England tend to die earlier than people in the south of England.[2] 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 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.

Figure 1. Age-standardised avoidable mortality rates per 100,000 adults by socio-economic group and gender in England, 2017 (ONS)[3]



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 a baby boy born in the London borough of Kensington and Chelsea has a life expectancy of 83.2 years compared to 74.2 years in Blackpool. Likewise, a baby girl born in Rutland has a life expectancy of 85.8 years compared to 79.9 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.

WHAT CONTRIBUTION DOES SMOKING MAKE TO HEALTH INEQUALITIES?

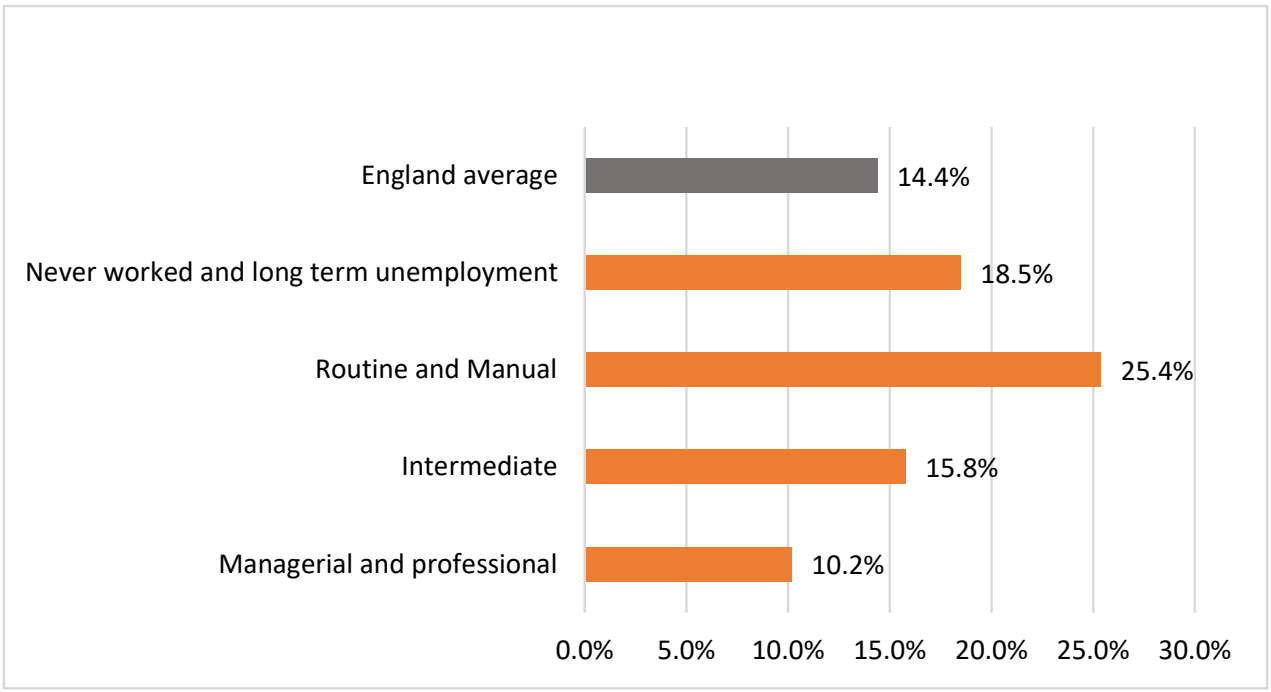
Smoking remains the single biggest preventable cause of death and illness in England. In 2017, 77,800 people died from smoking-related causes in England.[5] That's over 200 people every day. Likewise, the impact of smoking on ill health is huge: in 2017/18 an estimated 489,300 hospital admissions in England were attributable to smoking.[5]

Higher smoking prevalence is associated with almost every indicator of deprivation or marginalisation. Compared to the population as a whole, smoking is more common among:

- People with a mental health condition
- People with lower incomes
- People who are unemployed
- People who are experiencing homelessness
- People in contact with the criminal justice system
- People who live in social housing
- People without qualifications
- Lone parents
- LGBT people

Cumulative disadvantage increases the likelihood of smoking. One study, using a large database of primary care patient data in the UK aged 16+, found that the highest smoking rates were recorded among groups and localities characterised by single-parent households, living in socially rented accommodation, few, if any, educational qualifications, no access to a car and who reported feeling the area they lived in offered little community support.[6] The highest rates of smoking are consistently found among those who are most disadvantaged. For example, in 2014, 77% of people experiencing homelessness smoked.[7] Figure 2 shows the difference in smoking rates in England between the socio-economic groups.

Figure 2. Smoking prevalence by socio-economic group, 2019 (Public Health England)[8]



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."*

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."*

Department for Health, Towards a Smokefree Generation: A tobacco control plan for England, 2017

- Central components of the tobacco control plan were commitments to eliminating inequalities and reducing smoking prevalence in groups with the highest rates and those where harm is greatest
- Reducing rates of smoking during pregnancy, among people with mental health conditions and among those in low socio-economic groups are key focuses of the plan

NHS, The NHS Long Term Plan, 2019

- Chapter 2 of the 7-chapter NHS Long Term Plan is titled "More NHS action on prevention and health inequalities" - a key element of the Plan's strategy to meet this objective is through greater focus on the prevention of avoidable illness.
- Smoking cessation is a prominent feature of NHS prevention plans, with commitments to treating tobacco dependency in the NHS outlined in the Plan. Specific commitments were made for pregnant smokers and smokers with mental health conditions.

Public Health England, PHE Strategy 2020-25, 2019

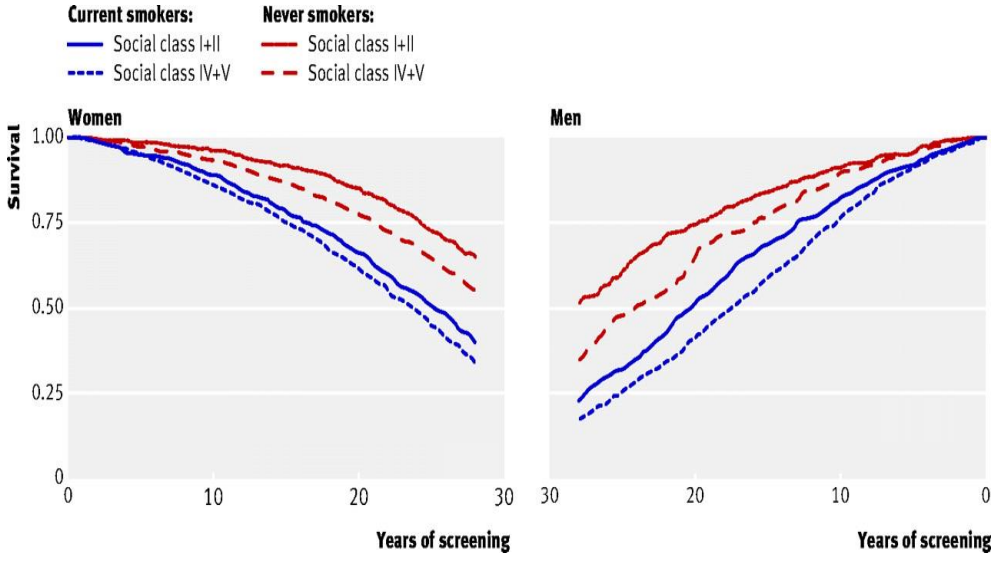
- Public Health England's latest strategy includes a "smoke-free society" as one of its ten areas identified as being able to deliver the biggest impact for the public's health over the next five years
- There is also a significant focus on "persistent and growing inequalities" with many of the commitments made around smoking focussed on targeted interventions to support quit attempts and smoking prevalence reduction among areas and groups with the highest need

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.

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.[9]
- 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.[10]
- 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 (see Figure 3 below, taken from the study). 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.[11]

Figure 3. Age adjusted survival curves for women and men in the highest and lowest social classes by smoking status[11] ('Years of screening' refers to the follow-up period for participants of the study)



Laurence Gruer et al. BMJ 2009;338:bmj.b480

MEETING SOCIO-ECONOMIC NEEDS

Any smoker who is struggling because their 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 and, more broadly, creating a more equal society. However, meeting these needs does not substantially alleviate inequality in life expectancy between smokers and non-smokers.

In both men and women, survival of people who smoke in the top socio-economic classes (in Figure 3 Social class I+II) is not substantially higher than survival of people who smoke in the bottom socio-economic classes (in Figure 3 Social class IV+V) see Figure 3, above. Rather, survival of those in the bottom socio-economic classes who do not smoke is substantially better than survival of those in the top socio-economic classes who do smoke. Figure 3 illustrates that one of the most effective things we can do to reduce and eliminate health inequalities is supporting people to quit smoking.

TOBACCO CONTROL, POVERTY, AND THE MARMOT PRINCIPLES: REVERSING THE FLOW OF THE RIVER

There is 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.

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.

Poverty is the central issue. As spending on tobacco consumes a relatively high proportion of the household income for people with low incomes who smoke, tobacco addiction can lock people into poverty as well as damaging personal and family health.[12] Social tenants who smoke lose a higher proportion of their income on tobacco (12.4%) than both private renters (8.8%) and home owners (8.4%).[13] On average, social tenants who smoke lose £50 per week to tobacco – more than £2,600 per year.[13]

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.[14] In these households, the costs of tobacco addiction can exacerbate wider socio-economic pressure, putting a strain on financial resources required for basic needs like food and warmth.[15] A further 230,000 children would be classed as being in poverty if the calculation of household income excluded the income currently lost to tobacco expenditure.[16]

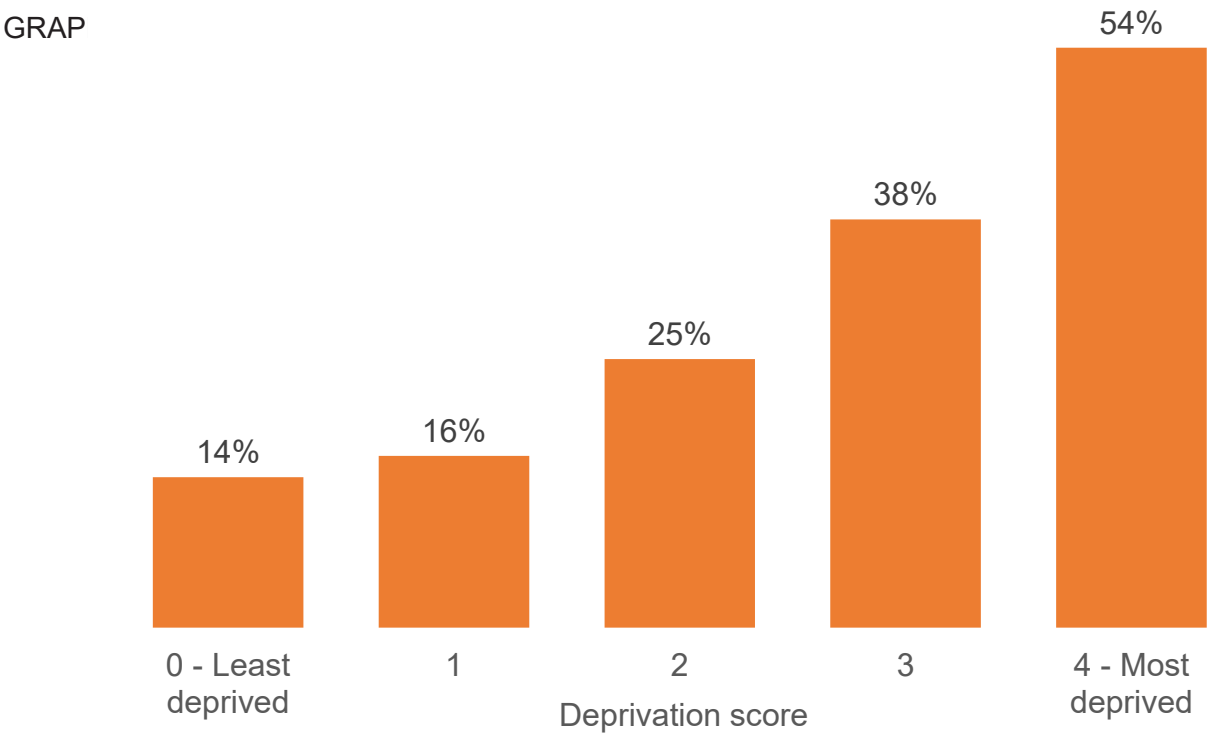
Raising the price of tobacco is one of the most effective measures for reducing smoking rates and due to its greater impact on those who are more price sensitive, it is crucial for the reduction of health inequalities.[17] However, those who continue to smoke despite price rises face even greater financial pressure, so price strategies must always be accompanied by other interventions targeting the most disadvantaged.

THE INTER-GENERATIONAL TRANSMISSION OF SMOKING

Smoking is transmitted across the generations in a cycle underpinned by social norms, familiarisation and addiction: where there are higher smoking rates, young people are more exposed to smoking behaviour, more likely to try smoking and, once hooked, they find it harder to quit,[18] 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.[19] 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 4 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.

Figure 4. Prevalence of smoking in 16-19 year olds by deprivation score (Health Survey for England 2006-2012 pooled)



This process starts at birth: Figure 5 compares the rates of smoking by pregnant women at their booking appointment by deprivation decile. The differences are marked, with a clear gradient in smoking status observable. 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.[20]

A socio-economic gradient in quit rates is seen across all smokers, as demonstrated by Figure 6. Quit rates are higher among those in high socio-economic groups, 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 other end of the socio-economic spectrum, lower quit rates by adult smokers have kept smoking 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.

Figure 5. Smoking status at booking appointment by deprivation decile of mother's residence, January to June 2017[21]

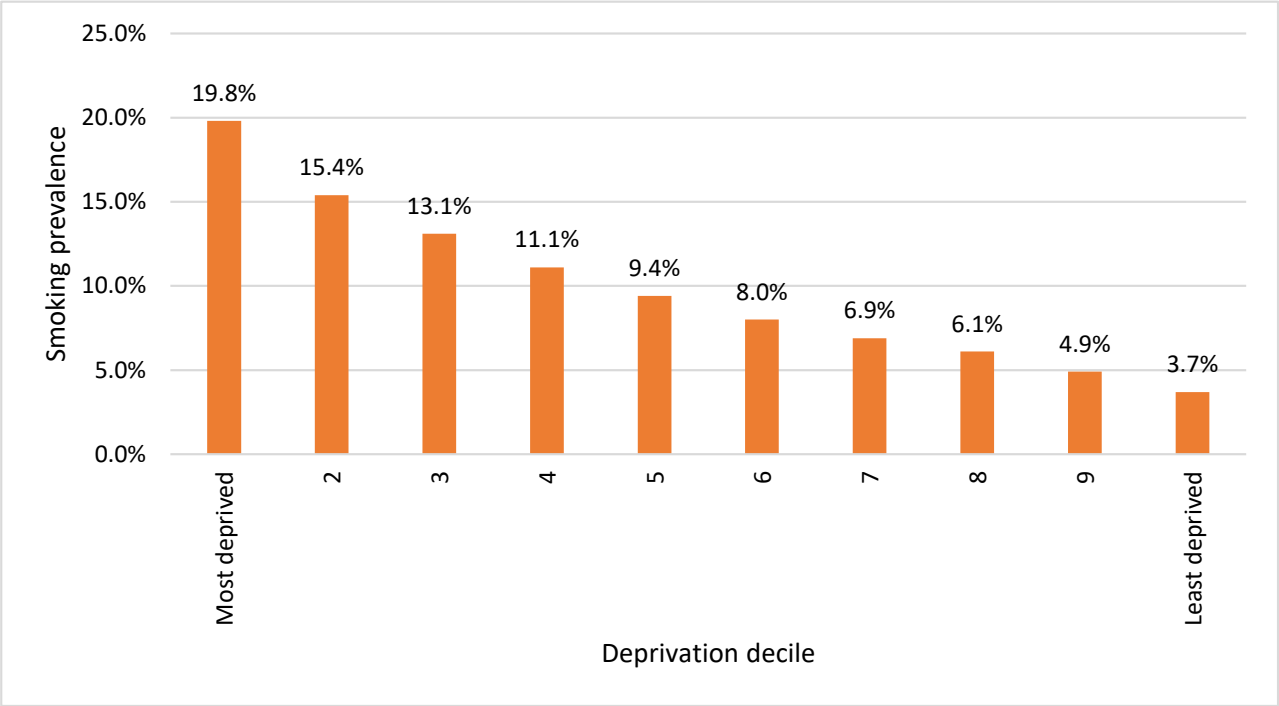
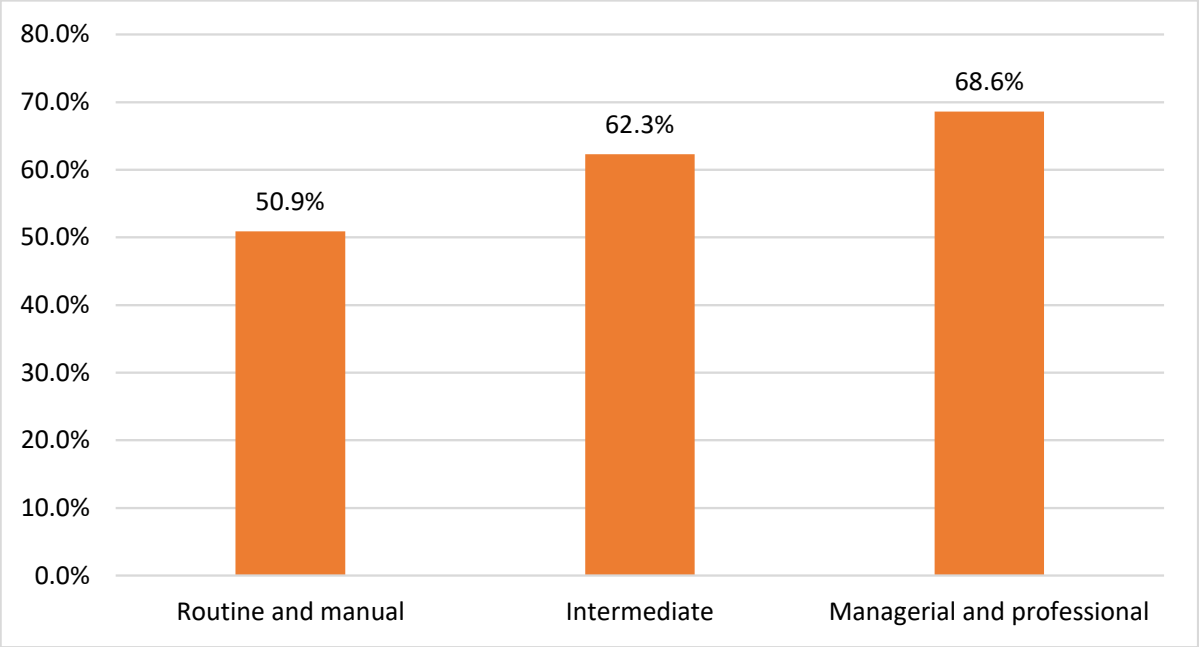


Figure 6. Percentage of cigarette smokers who quit by socio-economic classification[22]



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.[23] This is partly because they are more dependent on nicotine: they start smoking earlier in the day, smoke more cigarettes per day,[24] and consume more nicotine per cigarette than the most affluent smokers.[25] Other factors that can affect their chances include:[26]

- **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 low 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 high socio-economic 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 low socio-economic groups are more likely to stop taking treatment early and less likely to complete programmes of behavioural support.

These are key factors that have emerged through academic literature.[26] 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 inner-city school, smoking was normative within the student culture meaning pupils were more likely to start smoking.[27] Such differences make effective tobacco control 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 the norm.

KEY POLICY/GUIDANCE:

- The NHS Long Term Plan. NHS, 2019
- Review of the Challenge. Smoking in Pregnancy Challenge Group, 2018
- Towards a Smokefree Generation: A tobacco control plan for England. Department for Health, 2017
- PHE Strategy 2020-25. Public Health England, 2019
- Smoking: harm reduction. NICE guidelines PH45, 2013
- Smoking: stopping in pregnancy and after childbirth. NICE guidelines PH26, 2010

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 ASPECTS 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 3.8 percentage point difference in smoking prevalence across the regions as a whole, this translates into a 40% difference in smoking-related deaths and a 63% difference in hospital admissions.

Table 2 highlights 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.[28]

Differences between individual local authorities are much greater. For example, smoking prevalence in Kingston-Upon-Hull is 26.1%, more than triple the prevalence of 8.2% in Wokingham in Berkshire. Smoking-related deaths are also more than three times as common in Hull as in Wokingham (1,696 vs. 434 deaths per year). The difference between the smoking rates in the routine and manual socioeconomic group is smaller: prevalence in this group is 33.0% in Hull and 23.1% in Wokingham. However, the difference in the size of the routine and manual population in these two local authorities exacerbates the overall inequality.

Data on individual local authorities can be found at https://fingertips.phe.org.uk/profile/tobacco-control.

Table 2. Regional differences in smoking prevalence and smoking-related health outcomes in England (Local Tobacco Control Profiles, 2019)

	South East	South West	West Midlands	London	East of England	East Midlands	North West	North East	Yorkshire & Humber
Smoking Prevalence	12.9%	13.9%	14.5%	13.9%	14.0%	15.8%	14.7%	16.0%	16.7%
Routine/Manual Prevalence	25.0%	25.5%	23.4%	23.6%	25.7%	26.2%	26.1%	26.3%	27.4%
Smoking-related deaths*	230.0	228.6	259.1	231.5	240.7	268.7	320.5	344.3	299.7
Smoking-related hospital admissions**	1149	1409	1570	1370	1500	1584	1749	2221	1823

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

MENTAL HEALTH

The links between mental health and smoking are profound. A third of all cigarettes smoked in England are smoked by people with a mental health condition.[29] Smoking rates are consistently higher among people with a mental health condition and prevalence tends to increase with the severity of the condition:

- 25.8% of people with anxiety or depression smoked in 2016/17
- 27.8% of people with a long-term mental health condition smoked in 2017/18
- 40.5% of people with a serious mental health condition smoked in 2014/15

Among people in inpatient mental health services, smoking rates can be as high as 70%.[30] Smoking prevalence among the general population has declined consistently over the last 20 years, whereas smoking prevalence among people with a mental health condition has remained high, at an average of around 40%.[31] Two thirds of smokers with a mental health condition report wanting to quit,[32] however they face greater barriers to cessation, often smoke more and are more addicted.[33 29]

KEY POLICY/GUIDANCE

- The NHS Long Term Plan. NHS, 2019
- Towards a Smokefree Generation: A tobacco control plan for England. Department for Health, 2017
- The Five Year Forward View for Mental Health. Mental Health Task Force, 2016
- Smoking: acute, maternity and mental health services. NICE guidelines PH48, 2013

PEOPLE IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

Smoking rates among people in contact with the criminal justice system (PCCJS) have long been high. In 2013, around 80% of PCCJS smoked compared with around 20% of the general population.[34] This reflects the compound disadvantage borne by so many of those who enter prison, including high rates of mental health conditions, rather than the experience of prison itself.[35] 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.[36]

By July 2018, all closed prisons in England and Wales had gone smokefree (a total of 103 in England and 3 in Wales, accommodating over 82,000 people). Prisons in Scotland went smokefree from November 2018 whilst Northern Ireland continues to implement an exemption in legislation allowing people to smoke in their cells.[37] An evaluation of air quality in Scottish prisons following smokefree implementation found second-hand smoke (SHS) levels fell by 80% inside premises, with levels of fine particles in prison air comparable to levels measured in outdoor air in Scotland, confirming that exposure to SHS has been drastically reduced as a result.[38]

PCCJS often come from disadvantaged backgrounds. Addressing health inequalities among PCCJS benefits themselves, their family, their local community and wider society. Therefore, issues relating to health and justice directly affect all local authorities, CCGs, NHS and social care commissioners and all communities. With prisons going smokefree in England, Wales and Scotland, local authorities need to be ready to support individuals moving from prison to the community and ensure that the transition from restricted smokefree environments is accompanied by effective stop smoking support.

KEY POLICY/GUIDANCE:

- Stop smoking interventions and services. NICE Guidelines NG92, 2018
- Reducing smoking in prisons: Management of tobacco use and nicotine withdrawal. Public Health England, 2015
- Smoking: Harm-reduction. NICE Guidelines PH45, 2013

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 or 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.[39]

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.[40] 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
- The Fostering Network position statement on smoking and the use of e-cigarettes. Action on Smoking and Health and The Fostering Network, 2014

LGBT PEOPLE

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

Higher smoking prevalence among LGBT adults may be linked to higher stress levels and poorer mental health in this population.[41] A recent report by Stonewall found 52% of LGBT people reported experiencing depression in the last year (2017/18).[42] Overall, LGBT people were at a higher risk of experiencing common mental health problems than the general population; however, this gap is narrowing.[42]

Table 3. Smoking prevalence by gender and sexuality in England, 2017 (ONS)[43]

	Gay/Lesbian	Bisexual	Heterosexual
Men	22.1%	25.5%	16.7%
Women	24.9%	22.0%	14.9%
All	23.1%	23.3%	15.9%

KEY POLICY/GUIDANCE:

- LGBT Action Plan: Improving the lives of Lesbian, Gay, Bisexual and Transgender people. Government Equalities Office, 2018
- Towards a Smokefree Generation: A tobacco control plan for England. Department for Health, 2017
- Smoking and Lesbian, Gay, Bisexual and Transgender (LGB&T) Communities. The National LGBT Partnership, 2015
- 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

ETHNIC MINORITY GROUPS

The relationship between smoking and ethnicity is complex. Smoking rates vary considerably according to ethnicity.[44] On average, rates of smoking among ethnic minority groups in England are lower than rates among their white peers. However, rates within ethnic groups are also often gendered, with rates among men generally higher than rates among women.[44] For example, smoking rates among black men (16.7%) are higher than rates among white men (16.3%), whilst rates among black women (6%) are much lower than rates among white women (13.6%).[45] The highest rates of smoking across both genders are among those of mixed/multiple ethnicity.[45]

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.[46] This can be particularly relevant where people have recently immigrated to the UK from countries with higher smoking rates and where different legal and cultural frameworks are taken to tobacco use.[44] Such differences should always be examined by local needs assessments.

KEY POLICY/GUIDANCE:

- Tobacco and Ethnic Minorities. Action on Smoking and Health, 2019
- Local action on health inequalities: Understanding and reducing ethnic inequalities in health. Public Health England, 2018

REDUCING SMOKING-RELATED HEALTH INEQUALITIES

The health inequalities that are driven by differences in smoking prevalence will only be reduced though 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*:[4]

> *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:

- **Requiring tobacco manufacturers to pay for the costs of tobacco control.** Tobacco manufacturers should be made to pay the recurring costs of tobacco control, in line with the 'polluter pays' principle. This would ensure sustainable funding for tobacco control measures capable of tackling and eliminating health inequalities such as targeted mass media campaigns and stop smoking services.[17]
- **Raising the age of sale for tobacco to 21.** Smoking is a disease of childhood, not an adult choice. Experimentation, which often leads to smoking initiation, rarely occurs in adults aged over 21. Therefore, the more that can be done to prevent experimentation in those aged under 21, the more people will be prevented from becoming addicted to tobacco. This is particularly pertinent for people at higher risk of smoking. Raising the age of sale of tobacco to 21 will help to breakdown cycles of inequality driven by the transmission of tobacco addiction between generations.17
- **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.[17 47] As people who smoke with low incomes 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 people who smoke to trade down to less expensive products, this means ensuring illicit tobacco is tackled and bringing the rate of tax for hand-rolled tobacco up to match the rate for manufactured cigarettes.[17]
- **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 decade 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.[17]
- **Mass media campaigns.** There is evidence that mass media campaigns can have a greater impact on more disadvantaged smokers if they care 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 stop smoking support.** 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.[48 49] 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.[50]
- **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. 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 vaporisers (e-cigarettes).

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