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The tobacco control plan: an opportunity to reduce smoking-related health inequalities

Introduction

PAGB (Proprietary Association of Great Britain) and its members are actively involved in efforts to support people to quit smoking, for example through supporting the annual Stoptober awareness campaign and ongoing support for pharmacy services. However, there are growing concerns that the impact of financial pressures on local authorities is resulting in significant disinvestment in stop smoking services, compounding the challenge of health inequalities in England. This is a false economy, since the economic burden of smoking on communities in England is estimated at approximately £13.6bn per year[i] - with the greatest burden being borne by specific regions and certain socio-economic groups.

The publication of the forthcoming tobacco control plan provides the opportunity to signal the Government's support for stop smoking services, by setting ambitious targets to bring down smoking rates in the regions and demographics that most need support to quit – and supporting these targets with the policies and the resources to ensure progress is made.

This paper is intended to support policymakers involved in developing the tobacco control plan. It:

- Describes the latest national statistics, revealing the scale of variation in smoking prevalence between different geographic and socio-economic groups – despite the number of 'quit attempts' being proportionately the same
- Includes recommendations on how the tobacco control strategy can proactively address this variation and the associated health inequalities, and how stop smoking services can be better supported

About health inequalities in England

Health inequality in England continues to be one of the country's greatest challenges: a baby boy born in Kensington and Chelsea can expect to live over nine years longer than a baby born in Blackpool, and a baby girl born in the district of Chiltern can expect to live nearly seven years longer than a baby girl in Middlesbrough.[ii] Likewise a 65-year-old man and woman from the most advantaged socio-economic group can expect to live 3.9 and 3.1 years longer respectively than their counterparts in the least advantaged group.[iii]

While income-related inequalities in life expectancy improved between 1999-2003 and 2006-2010, the King's Find has recently warned that recent constraints on public spending may have serious consequences for health inequalities in the future.[iv] It is therefore essential that the NHS and wider government re-establishes its focus on health inequalities in order to prevent the erosion of recent progress.[v]

Smoking and health inequalities

Smoking remains the principal cause of health inequalities in the UK.[vi] Because smoking is the single biggest preventable cause of death in England,[vii] smoking prevalence across the population translates directly into major differences in death rates and illnesses.[viii] For example:

- *Socio-economic groups and income.* Smoking accounts for more than half of the difference in premature deaths between the highest and lowest socio-economic groups.[ix] This impact is so substantial that someone in the least privileged socio-economic group who does not smoke has a better chance of survival than someone in the most privileged

group who does smoke.[x] On average, smokers in lower socio-economic groups start smoking earlier in the day, smoke more cigarettes per day, and consume more nicotine per cigarette than more affluent smokers.[xi]

Although the prevalence of smoking in England has declined dramatically in recent years, it remains stubbornly high in routine and manual occupations (Figure 1). This is reflected in similar patterns when smoking prevalence is broken down by income group (Figure 2).

Figure 1[xii]

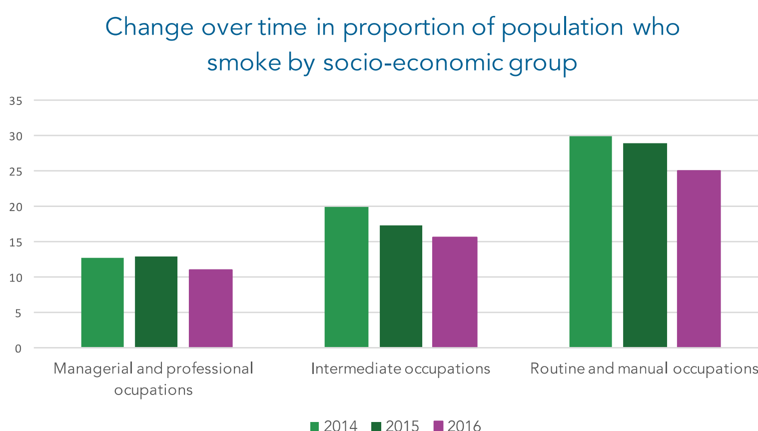
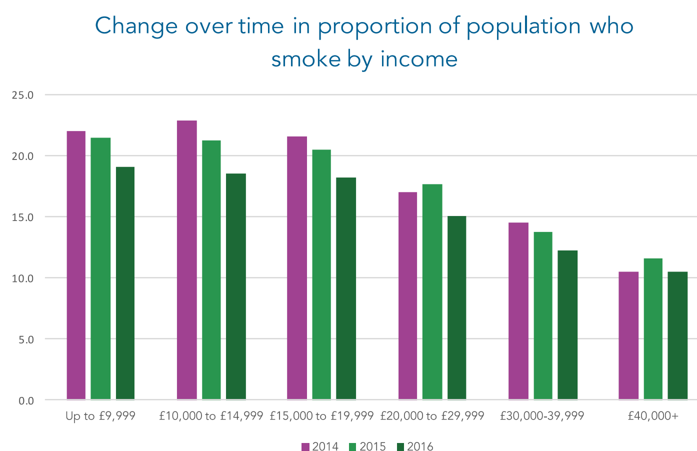


Figure 2[xiii]



- *Regional.* There is also variation in smoking prevalence between regions in England: there is a clear North/South divide in both smoking prevalence in general (Figure 3) and smoking during pregnancy specifically, which varies from 2% in NHS Central London CCG to 27% in NHS Blackpool CCG (Figure 4). This difference alone can have a dramatic impact on health inequalities as, for example, maternal smoking causes up to 5,000 miscarriages, 300 perinatal deaths and 2,200 premature births in the UK each year.[xiv]

Figure 3[xv]

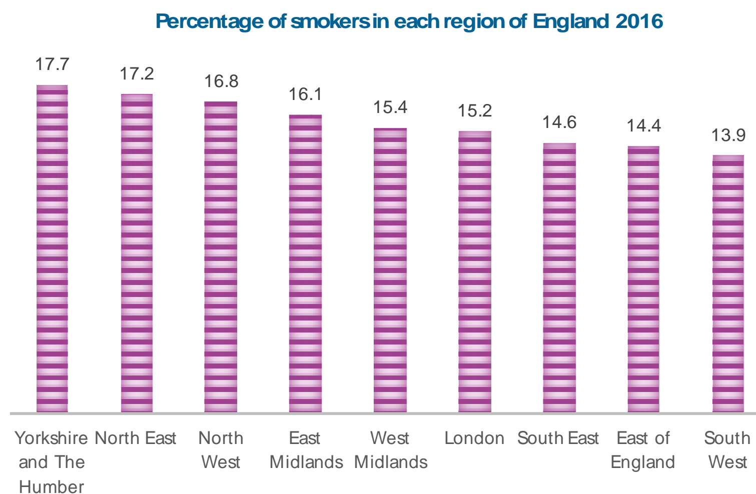
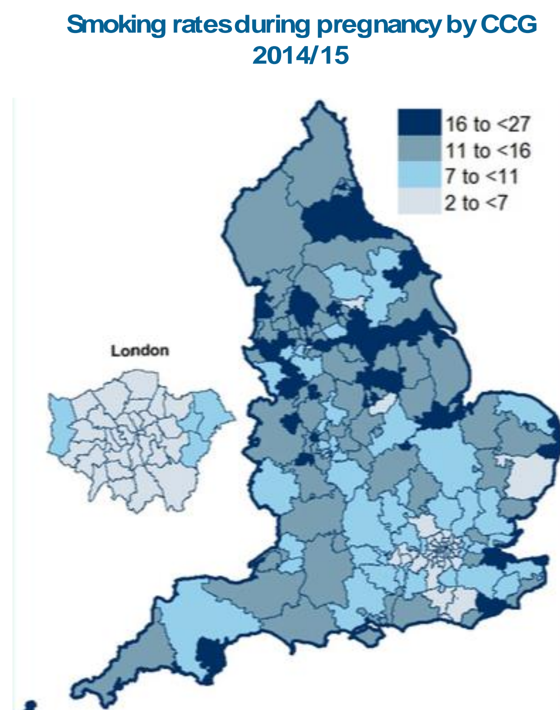


Figure 4[xvi]



Health inequalities and quitting

Variations in smoking rates between socio-economic groups and geographic areas are not due to a lack of quit attempts. For example:

- In 2014-15 it is estimated that the number of quitters per 100,000 smokers in the North East, North West and West Midlands were all higher than the South East[xvii]
- Smokers in the routine and manual socio-economic group try to quit as often as their peers in the professional and managerial group[xviii]

Therefore, it is apparent that – although the rate of quitting attempts is fairly uniform – people from more disadvantaged groups and regions do not succeed as often. A number of studies have explored the reasons for this and have concluded that causal factors include:

- A lack of social support
- Higher nicotine dependency
- Challenging life circumstances[xix]

Recommendations

When stop smoking services were first established in England, they were piloted in areas of greatest deprivation.[xx] It was intended that the services would prioritise supporting less affluent smokers to quit in recognition of smoking's contribution to health inequalities. As they were rolled out more widely this focus remained.

However, during the period of public spending restraint, these services have been forced to limit the scope of their services, disproportionally affecting certain geographic and socio-economic groups – and threatening the progress that has been made in reducing health inequalities.

The forthcoming tobacco control plan provides an opportunity to protect the progress made in reducing health inequalities, and push for greater improvements in the future. Our recommendations for the tobacco control plan include:

- **Setting ambitious targets to address regional variation in smoking prevalence, supported by commensurate funding:** although smoking prevalence nationally has fallen below the 18.5% target set in the 2011 national strategy on tobacco, variation in smoking prevalence persists, as stated above.[xxi] Therefore in addition to setting more ambitious national targets on smoking reduction, the tobacco control plan should contain targets aimed at making measurable reductions in regional variation in smoking prevalence to address health inequalities. Given the funding pressures facing local authorities, the Department of Health should ensure they are provided with sufficient funding to meet these targets.

- **Triggering a review of stop smoking services to ensure they account for the specific challenges facing smokers from disadvantaged socio-economic groups:** research has shown that smokers from disadvantaged backgrounds are less likely to use nicotine replacement therapy correctly and attend support sessions regularly.[xxii] However, it has been suggested that adjustments to stop smoking services, such as providing more drop-in group session may better support this population.[xxiii] Such modifications should be explored as part of a wider review of stop smoking services, to ensure the services are meeting the needs of disadvantaged smokers.

- **Mechanisms to share best practice in the commissioning and delivery of stop smoking services across the country**: although smoking prevalence varies by region, it is a national challenge and one which can only be resolved by drawing on the common expertise shared across the system. Mechanisms may include the establishment of a national oversight group which looks to drive improvement in smoking reduction by sharing best practice on evidence based solutions across the country.

Next steps

We would be happy to meet to discuss these recommendations in greater detail and provide further support as the Department of Health develops its plans for the tobacco control plan.

About PAGB

PAGB is the UK trade association representing manufacturers of branded over-the-counter medicines, self care medical devices and food supplements.

For more information on the PAGB and our recommendations please do not hesitate to contact Donna Castle, Director of Public Affairs and Communications, on:

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