Department of Health

Equalities Analysis

Tobacco Control Plan for England – Towards a Smokefree Generation

July 2017

Contents

1. Introduction

1.1. This equalities analysis examines the potential impact of the new tobacco control plan for England. This document considers issues relevant to the Secretary of State's duty to have regard to the need to reduce health inequalities under the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

1.2. *In accordance with the Public Sector Equality Duty, this equalities analysis also pays due regard to the need to:*

1.2.1. *eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010;*

1.2.2. *advance equality of opportunity between people who share a protected characteristic and people who do not share it;*

1.2.3. *foster good relations between people who share a protected characteristic and people who do not share it.*

1.3. The tobacco control plan presents the government's overarching approach to reducing smoking prevalence. We consider that overall, the plan will either have a neutral or beneficial impact on the matters highlighted in para 1.2 above. Where we have identified a neutral impact, this has been confirmed at paragraph 12.

1.4. As detailed in this document, the intended impact of the plan will directly address the disadvantages experienced by certain groups with protected characteristics, for example smokers with a disability (in relation to mental health) and those who are pregnant. The latter group, in particular, are much more likely to be socio-economically disadvantaged. The greatest health and wellbeing effects of the tobacco control plan are expected to be felt in those groups where smoking prevalence is highest. This includes those in lower socio-economic groups, people with mental health issues, the LGBT community and among particular ethnic/racial groups. Should further specific policy options be considered over the course of the plan, we will analyse them on an individual basis.

1.5. The evidence base supporting tobacco control measures and the benefit they provide for public health is substantial. However, for certain innovation such as e-cigarettes there is limited evidence available and as such we will keep the evidence under review to determine if more should be done in this area.

2. Engagement and Involvement

2.1. During the development of the tobacco control plan, a series of stakeholder roundtables were held on 7 key aspects of tobacco control including mental health and pregnancy. The insights and evidence presented at these events has directly informed the structure, priorities and commitments set out in the tobacco control plan.

3. Policy Objectives

3.1. The Department of Health has broad policy objectives to improve public health by:

- discouraging young people from taking up smoking;
- encouraging people to quit smoking;
- helping people who have quit, or who are trying to quit, to avoid relapse back to smoking; and
- reducing people's exposure to secondhand smoke from tobacco products.

3.2. The tobacco control plan works towards these policy aims and has the wider general ambition to reduce the prevalence of smoking in England across all population groups over the course of the plan.

3.3. Smoking remains the primary cause of preventable morbidity and premature death, accounting each year for over 100,000 deaths in the United Kingdom. One out of two long-term smokers will die of a smoking-related disease[1] and due to exposure to secondhand smoke, smoking is harmful not only to smokers but also to the people around them.

3.4. Although smoking prevalence has continued to decline, there are still certain population groups in which prevalence remains higher. The tobacco control plan therefore includes specific national ambitions and actions to support these groups.

3.5. National ambitions include:

- To reduce smoking prevalence amongst adults in England to 12% or less by the end of 2022.
- To reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population by the end of 2022.
- To reduce the prevalence of 15 year olds who regularly smoke to 3% or less by the end of 2022.
- To reduce the prevalence of smoking throughout pregnancy to 6% or less by the end of 2022.
- To continue after 2022 to reduce smoking prevalence further on our way to a smokefree generation.

3.6. In setting out priorities and action over the course of this tobacco control plan four main areas of focus are identified; prevention first, supporting smokers to quit, eliminating variation and effective enforcement. Together, these capture the various strands of effective tobacco control (mentioned below) and the different levels at which it is developed and delivered, from international policy through to organisational policies within buildings and institutions.

3.7. The UK government is a signatory to the World Health Organisation's Framework Convention on Tobacco Control (WHO FCTC) which seeks to protect the consumer from the harms of tobacco and ensure comprehensive tobacco control. In order to deliver this, the tobacco control plan for England will continue to deliver against each of the six internationally recognised strands of effective tobacco control.

- Helping Tobacco Users to Quit
- Reducing Exposure to Secondhand Smoke
- Effective Communications for Tobacco Control

- Stopping the Promotion of Tobacco
- Effective Regulation of Tobacco Products
- Making Tobacco Less Affordable

3.8. Over the past few years, innovation in e-cigarettes has resulted in them becoming the most commonly used quit aid in England in 2015[2] and the tobacco control plan seeks to maximise the benefit they provide in helping people to quit smoking whilst minimising the possible risks.

4. Age

4.1. Smoking uptake by young people is a significant public health concern. It remains an addiction which is largely taken up in childhood with the majority of smokers starting as teenagers. In England, 77% of smokers aged 16 - 24 in 2014 began smoking before the age of 18.[3] Very few people started smoking for the first time after the age of 25 (around 95% of all smokers started before the age of 25).[4] As a result many young people become tobacco dependent before they fully comprehend the health risks associated with smoking.

4.2. The introduction of standardised packaging is expected to further reduce the appeal of smoking to young people and continue to discourage uptake. There has been some concern that we would see an increase in the uptake of e-cigarettes by those young people who do not currently smoke. However evidence from UK studies indicates that whilst young people's awareness of, and experimentation with, e-cigarettes has increased, regular use remains rare and almost entirely confined to those who are current smokers or have smoked in the past.[5]

4.3. Protecting young people from the harms of tobacco has formed a major programme of work for Government to curtail the number of new smokers, break cycles of inequality and improve life chances for children. Over the course of the previous tobacco control plan, the smoking prevalence amongst 15 year olds dropped from 15% in 2009 to 8% in 2015 and the new tobacco control plan will focus on further action to continue this downward trend.

4.4. There is a national ambition to reduce prevalence amongst 15 year olds further by 2022 to improve their future health. However, as prevalence in this group continues to decline, we will need to widen our focus for future ambitions that covers prevalence amongst all young people under the age of 18. The new ambition will provide wider reach and if prevalence declines, the long term health of young people will improve.

<u>Effective Regulation of Tobacco Products</u>

4.5. Research shows that in 2014, 64% of pupils aged 11-15 who were current smokers were usually given cigarettes by others[6]. Just under half (46%) said that they usually bought their cigarettes in shops, despite the law which prohibits the sale of cigarettes to those under the age of 18.

4.6. The government has committed to reviewing how laws designed to protect children can be enforced and ensure that sanctions are fit for purpose. In developing effective sanctions, it is expected that it will become more difficult for young people to access tobacco products and will help drive a reduction in prevalence.

Helping Tobacco Users to Quit

4.7. Living with a smoker is a major risk factor for children, significantly increasing the likelihood that they will take up smoking. Children who have a parent who smokes are 2 to 3 times more likely to be smokers themselves.[7] In 2014, 82% of pupils who regularly smoked reported having a family member who smoked.[8] The influence that adult role modelling has on children is strong.

4.8. In focusing on reducing prevalence amongst adults – particularly in socio-economic groups where prevalence remains high – the tobacco control plan could reduce the prevalence of young people smoking further.

5. Socio-economic groups

5.1. Smoking is least common among those who earn the most, and most common among those who earn the least. In 2016, 11% of those earning £40,000 or more were smokers, compared to 19% of those earning less than £10,000. [9]

5.2. The prevalence of smoking by people working in jobs classed as routine and manual was 26.5%.[10] This is more than double that of people working in managerial and professional occupations.

5.3. NHS Digital analysis using data from the Health Survey for England 2013 found that smoking rates are highest amongst those living in the most deprived areas and that the proportion of smokers in the lowest two income quintiles was double the proportion in the highest two income quintiles.[11] This highlights that health inequalities exist between the most deprived and least deprived in society.

5.4. Michael Marmot's independent review into health inequalities in England, Fair Society, Healthy Lives 12 proposed "the most effective evidence-based strategies for reducing health inequalities in England" and made the following recommendation:

"*Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups".*

5.5. The tobacco control plan has a specific ambition to focus action on people working in routine and manual (R&M) jobs and reduce the inequality gap between them and the general population. If prevalence is successfully reduced, those from a lower socio-economic group are likely to see the biggest difference to their life expectancy and health. This ambition is particularly stretching as the R&M group is hard to reach. We have generally seen a recent increase in the relative gap and we will need to actively combat this if we wish to achieve the ambition.

5.6. The plan asks local authorities to tackle the health inequalities within their own area – particularly those with a higher prevalence – in which we could expect to see a higher proportion of routine and manual smokers. If local areas work to lower prevalence, it would be likely this group would benefit from lower smoker prevalence in particular.

Making Tobacco Less Affordable

5.7. As part of the tobacco control plan, the Government will continue its policy of maintaining high duty rates for tobacco products to improve public health. . The introduction of a minimum excise tax will also affect the price of the cheaper cigarette brands.

5.8. This may have a negative impact on people of low socio-economic status who have not yet been able to successfully quit smoking, remain addicted and will have to use a larger proportion of their disposable income, at any given time, to purchase tobacco products, rather than other essentials such as food or heating.

5.9. On the other hand, this may have a positive impact on people of low socio-economic status who may be more likely to quit smoking due to the higher price of packets. If people in this group choose to stop smoking, it has been estimated that 418,000 households would be lifted out of poverty[13] which would lead to benefits beyond the immediate impact on their health.

6. Gender

6.1. Today, smoking prevalence in the United Kingdom is similar for men and women.[14] If the policy aims of the tobacco control plan to reduce smoking prevalence are achieved then the both groups will be affected. There is some variation in minority ethnic groups in prevalence between men and women but this is covered separately.

7. Disability

Long term conditions

7.1. The link between smoking and health conditions such as Chronic Obstructive Pulmonary Disease (COPD) and cardiovascular disease is well established with smoking attributable to approximately 85% of deaths from COPD and 77% of deaths from chronic airway obstruction.

7.2. Evidence now suggests that smoking is also a risk factor for a number of other long term conditions including diabetes, dementia, asthma and blindness.[15] Smoking can affect the way the body responds to hormones such as insulin and is also known to damage blood vessels, impacting on circulation and blood pressure.[16] This damage affects the whole body and as such smoking not only increases the risk of developing some of these conditions, it can also worsen existing conditions and dramatically increase the risk of complications.

7.3. If the tobacco control plan achieves its aim to help people to quit smoking and stop them starting to smoke, people with long term conditions who stop smoking could benefit from fewer health complications.

8. Mental Health

8.1. Data from the Health Survey for England indicate that the proportion of people with a serious mental health condition who smoke is 40.5%[17]. This indicator represents

smoking status of people diagnosed with a Serious Mental Illness (SMI), schizophrenia, bipolar affective disorder and other psychoses, on GP lists (i.e., not living in an institution). It is more than double that of the wider population. Approximately 4 million people in England suffer from multiple health burdens as a result of both mental ill-health and smoking.[18]

8.2. People who live with severe mental illness die between ten to twenty years younger than the general population. Individuals with depression die on average 9 years younger than they would otherwise, and for people with personality disorders, as many as 18 years of life are lost.[19] Smoking is the single largest cause of the reduced life expectancy experienced by this population.

Helping Tobacco Users to Quit

8.3. The tobacco control plan includes the policy ambition to roll out NICE PH48 guidance in all mental health contexts. This would include making all mental health units smokefree by 2019 and improving the training available to NHS staff to deliver smoking cessation advice to people with mental health conditions.

8.4. The plan also includes the policy intention to deliver more smoking interventions across the health and care system more generally. If both policy aims are delivered, there will be an increase in the number of patients with mental health conditions who receive cessation support. This should lead to a reduction in prevalence beyond the benefits gained from a drop in smoking prevalence in the general population.

9. Race

9.1. People from some black and minority ethnic communities, particularly men, are more likely to smoke than the population generally. For example, 25% of Bangladeshi men self-report as smokers compared to less than 5% of Bangladeshi women[20].

Helping Tobacco Users to Quit

9.2. The tobacco control plan encourages local authorities to focus on their unique populations and to offer targeted smoking cessation support. This could include a focus on population groups such as black and minority ethnic communities where prevalence remains higher.

9.3. If the policy aims of reducing smoking prevalence is achieved then the impact may be greater in those groups in which smoking prevalence is the highest, such as in certain subsets of minority ethnic groups. This is likely to have a bigger impact on men in these communities.

10. Pregnancy and maternity

10.1. Smoking can have devastating consequences for expectant mothers and their babies. Smoking during pregnancy increases the risk of stillbirth and problems for the child after birth, and babies born to mothers who smoke are more likely to be born underdeveloped and in poor health. Maternal smoking after birth is associated with a threefold increase in the risk of sudden infant death.[21]

10.2. According to the 2010 Infant Feeding Survey, 12% of mothers across the UK continued to smoke throughout pregnancy and strong interactions exist between socio-economic status and smoking during pregnancy, as well as between age and smoking during pregnancy. Across the UK, the highest rates of smoking in pregnancy were observed in women in routine and manual occupations and mothers under the age of 20 were found to be almost six times as likely as those aged 35 or over to have smoked throughout pregnancy.[22]

10.3. Smoking prevalence in pregnancy dropped to 10.7% in 2016 but the tobacco control plan will continue to prioritise this group and will maintain a specific ambition to reduce prevalence.

Helping Tobacco Users to Quit

10.4. The tobacco control plan includes the policy ambition to reduce the local variation in smoking during pregnancy rates and improve how consistently the NICE guidance has been applied at a local level. If this policy achieves its aims, this would have a particular benefit in groups where there are high rates of smoking prevalence amongst pregnant women.

11. Sexual Orientation

11.1. Smoking rates are high among lesbian, gay and bisexual people.[23] If the policy aims of the tobacco control plan to encourage smoking cessation and reduce prevalence were achieved then the impact could be greater in those groups in which smoking prevalence is the highest.

12. Other

12.1. We have considered the impact of this policy on all groups with protected characteristics. No effects have been identified for people of different religions and beliefs or for people undergoing gender reassignment. Nor have we been able to identify any impact on people of different political opinions or carers.

12.2. We have also considered the need to foster good relations between those who share a protected characteristic and persons who do not share it, and are not aware of any evidence on the potential effects of the tobacco control plan on such relations.

12.3. We have not been able to identify any evidence to indicate that the Tobacco Control plan would impact on the Public Sector Equality Duty to eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010

13. Summary of Analysis

13.1. The main aim of the tobacco control plan is to set the national ambitions to reduce smoking prevalence further. The plan has a particular focus on reducing local variation and targeting groups where prevalence remains higher than the national rate. There are

specific commitments within the plan aimed at reducing smoking amongst particular subgroups including children, pregnant women and those from a lower socio-economic class.

13.2. The Department also recognises that individuals in some of these groups will also require greater support in order to quit and has included commitments within the plan to achieve a rapid improvement in the prevalence rate in these groups.

13.3. Alongside the implementation of the tobacco control plan, the UK Government will continue to implement recent legislative changes such as the Tobacco Product Directive and the Standardised Packaging of Tobacco Products to further discourage the initiation of smoking and reduce prevalence rates.

13.4. Overall, in its assessment of the impact on equality of this policy, the Department of Health has concluded that the policy would not lead to any unlawful discrimination, harassment or victimisation of any particular group by gender, race, religion, ethnicity, sexuality, sexual orientation or disability. It is a wide-ranging policy which also has a specific focus on reducing health inequalities.

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