October 2021

Tobacco and Health Inequalities

Improving stop smoking support for people from more deprived groups

Investing in tobacco control is vital to the UK Government's levelling up ambitions. This briefing presents new research from CRUK which outlines the case for, and evidence on, how stop smoking support can be improved and how we can enhance support to help address tobacco-related health inequalities – specifically those due to deprivation.

Key Points

Smoking-related health inequalities

- Tobacco is the biggest preventable cause of cancer and death in the UK.[1,2]
- Decades of comprehensive policy action have meant adult smoking prevalence in the UK in 2019 was at a record low at 14.1%,[3] but this masks significant inequality.
- Differences in smoking rates make it one of the leading drivers of health inequalities, responsible for half the difference in life expectancy between the lowest and highest income groups in England.[4]
- An estimated 27,200 extra cases of cancer a year in England are attributable to socioeconomic deprivation.[5]

New analysis from Cancer Research UK

- It is estimated that the most deprived fifth of the population in England has **nearly double the number of smoking-attributable cancer cases each year**, compared with the least deprived.[6]
- **It is estimated that around 5,500 cases of deprivation-associated cancer could have been prevented each year** in England between 2013-2017 if in 2003-2007, everyone had the same smoking prevalence as the least deprived quintile.[6]
- In 2019/20 if every local authority in England had **matched their region's highest rate of people setting a quit date** through NHS Stop Smoking Services, even if they had kept their current success rates for those setting a quit date, there could have been **nearly 118,000 additional people who successfully stopped smoking**.[7] This suggests that increasing footfall to Stop Smoking Services even if current success rates are maintained could approximately double the number of people successfully stopping smoking through these services in England.
- **Improving the delivery of smoking cessation support in primary care across the UK should get us closer to smokefree targets,** and the largest absolute benefits in health outcomes should be seen by the lower socioeconomic group given their higher smoking rates. But because smoking prevalence would be reduced similarly across all socioeconomic groups, our modelling suggests that by itself improving this would not narrow the socioeconomic inequity in smoking rates.[8]
- 57% of GPs found it more challenging to engage patients from a lower socioeconomic group in remote consultations.[9]

Cancer Research UK's calls on addressing smoking-related health inequalities

- Our research shows that tackling smoking is key to levelling up health outcomes and the upcoming Tobacco Control Plan for England is a key opportunity to do so.
  The UK Government must deliver a comprehensive and ambitious Tobacco Control Plan for England that addresses smoking-related inequalities.
- A key priority should be to ensure that all people who smoke have access to effective support to help them stop. **Achieving this will require improving the delivery of smoking cessation support in primary care and increasing the number of people accessing Stop Smoking Services.**
- However, delivering the above and the wider measures needed for a robust Tobacco Control Plan will require additional and sustainable funding.
  The UK Government should implement a Smokefree 2030 Fund, making the tobacco industry pay for the damage caused by smoking but without letting them influence how the money is spent. Delivering a robust tobacco control strategy could significantly help reduce smoking prevalence and address a significant contributor of health inequalities – but for this, the strategy must be adequately resourced.

Smoking-related inequalities

There are substantial disparities in smoking rates across the population, with significantly higher smoking rates among the most deprived compared with the least deprived.[3,10] The smoking prevalence gap between people in routine and manual occupations and those in managerial and professional occupations in England has widened significantly since 2012,[3] because smoking rates are decreasing more slowly in routine and manual workers.[11] People experiencing financial difficulty are also less likely to be successful in a quit attempt.[12]

The UK Government has committed to England becoming 'smokefree'[a] by 2030.[13] However, based on Cancer Research UK modelling, only the least deprived quintile in England is projected to be smokefree by 2030, while the most deprived quintile is not estimated to achieve this target until the mid-2040s.[14]

New analysis from Cancer Research UK

Levelling up with tobacco control

The UK Government cannot level up without addressing smoking-related health inequalities.

New modelling by Cancer Research UK estimates the proportion of cancer cases which are attributable to smoking per year in England. The most deprived fifth of the population had an estimated 11,246 smoking-attributable cancer cases (21.1% of all cancer cases in this group) each year, compared to 6,200 (9.7% of all cancer cases in this group) in the least deprived – **nearly double the number of cases.**[6]

The study also found that if in 2003-2007, everyone had the same smoking prevalence as the least deprived quintile (e.g. if smoking inequalities were removed), an estimated **5,504 deprivation-associated cancer cases could have been prevented each year in England** between 2013-2017.[6] This highlights the importance of ensuring smoking cessation support reaches the most deprived communities.

The role of Stop Smoking Services

People attempting to quit using Stop Smoking Services, combining pharmacotherapy and specialist behavioural support, are around three times more likely to stop smoking successfully than those attempting to quit unaided.[15,16] However, these services are not universally available,[17] partly due to sustained reductions in the public health grant[18,19,20] which local authorities use to deliver a range of important public health measures, including Stop Smoking Services.

New modelling by Cancer Research UK shows that in 2019/20 if every local authority in England had:

- matched their region's highest **rate of people setting a quit date** through NHS Stop Smoking Services, even if they had kept their current success rates for those setting a quit date, there could have been **nearly 118,000 additional people who successfully stopped smoking** - that's around double the number of people stopping smoking.[7]
- matched their region's highest **success rate** for people setting a quit date through NHS Stop Smoking Services, even if they had kept their current rate of people setting a quit date, there could have been **around 44,000 additional people who successfully stopped smoking.** [7]
- matched their region's highest **rate of people setting a quit date** through NHS Stop Smoking Services, and **their region's highest success rate** for those setting a quit date, there could have been **around 217,000 additional people who successfully stopped smoking** - that's nearly triple the number of people stopping smoking.[7]

This reinforces the vital role that Stop Smoking Services play in helping people to stop smoking, and reiterates why it is so important that local authorities have enough resources to fund them sustainably: so that they can be available across the country. Our research also highlights that there is more potential benefit to getting more people through the door of Stop Smoking Services – the metric on which local authorities vary widely - than there is of improving success rates – the metric on which there is less

[a] "Smokefree" is defined in the 2017 Tobacco Control Plan for England as adult smoking prevalence being 5% or fewer.

variation. **This is why it is crucial more people are signposted and referred to Stop Smoking Services.** In order to ensure this helps reduce health inequalities, it will be important that measures to increase footfall are disproportionately aimed at the most deprived groups.

Improving delivery of smoking cessation support

One way to help people access Stop Smoking Services and therefore reduce smoking-related health inequalities is to improve the delivery of and signposting to smoking cessation support in primary care. This should lead to more referrals to services, which based on our modelling should lead to more people stopping smoking.[7]

A new report published by Cancer Research UK modelled the impact of improving the delivery of smoking cessation support across primary care on different socioeconomic groups across the UK. This found that improved delivery would result in substantial additional declines in smoking prevalence across all socioeconomic groups and get us closer to smokefree targets. Given the greater number of people who smoke in the lowest socioeconomic group, improving delivery of smoking cessation support would see the greatest number of people quitting from this group.[8]

However, smoking inequalities are still projected to widen by 2039 with or without improvement of smoking cessation support in primary care, given the modelled interventions would similarly benefit all socioeconomic groups.[8] **That's why alongside improving smoking cessation support in primary care for all, we need research to understand what tailored interventions could effectively enhance support for those in lower socioeconomic groups and reduce inequalities.** *See the full report and policy recommendations for more detail:* ***Making Conversations Count for All.***

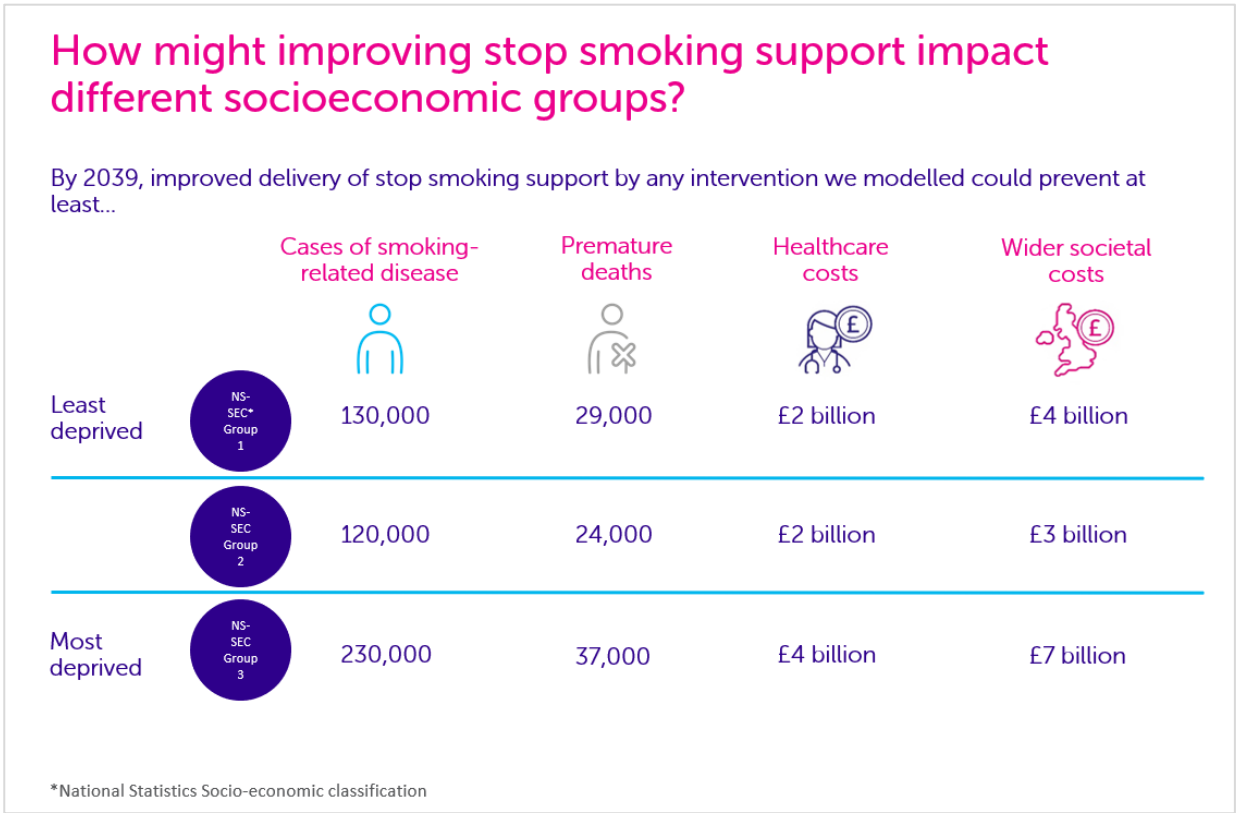

Figure sourced from Making Conversations Count for All: Benefits of improving delivery of smoking cessation interventions for different socioeconomic groups. UK-wide analysis.

The Impact of COVID-19

The COVID-19 pandemic has affected the delivery of smoking cessation support. A survey of UK GPs commissioned by Cancer Research UK found that the delivery of Very Brief Advice (VBA) through remote consultations has impacted their engagement with certain patient groups. **57% of GPs surveyed found it**

more challenging to engage patients from a lower socioeconomic group in remote consultations. **80% also found it more challenging to engage patients whose first language is not English in remote consultations.**[9] This highlights that, if consultations continue to be delivered remotely, more needs to be done to engage people from these groups. It also highlights the potential need to tailor existing training, or provide extra guidance or training on how to deliver VBA in a remote setting.

Cancer Research UK calls to address smoking-related health inequalities

We need an ambitious tobacco control plan for England…

Our research shows that tackling smoking is key to levelling up health outcomes and the upcoming Tobacco Control Plan for England is a key opportunity to do so. **The UK Government must deliver a comprehensive and ambitious Tobacco Control Plan for England that addresses smoking-related inequalities and adequately enhances interventions for groups who are at greater risk of tobacco-related harm.** This plan should include measures at all levels – national, regional and local - that reduce uptake of smoking and support cessation.

…Which enhances stop smoking support for people from the most deprived groups

A key priority of the plan should be to ensure that people who smoke, in particular those from more deprived groups, are motivated to quit and have access to effective support that helps them do so. Achieving this will require both improving the delivery of smoking cessation support in primary care as well as wider measures to increase the number of people accessing Stop Smoking Services.

- Improving the delivery of smoking cessation support (including Very Brief Advice) in primary care could accelerate a decline in smoking prevalence across all socioeconomic groups. Doing so will require:
    - **Enhancing identification and engagement of people who smoke by primary care professionals.**
    - **Ensuring services are equipped to support people to stop smoking by being able to advise patients on the different tools that can help to quit - including e-cigarettes - and, when appropriate, prescribing the most effective types of pharmacotherapy.**
- However, on its own, this will not help narrow the smoking inequalities gap. **This is why CRUK also recommends that the UK Government invests in more research to better identify and engage people from more deprived groups who smoke and on interventions which could disproportionately promote cessation among these groups.**
- Our research shows the gains that can be made by increasing the number of people accessing Stop Smoking Services. Anti-tobacco mass media campaigns can be highly effective[21,22,23] and cost-effective[24] in motivating people to stop smoking and discouraging uptake, but they must have sufficient intensity and be sustained to see continued benefit.[25] **The UK Government must ensure that robust media campaigns are delivered to promote smoking cessation and encourage people to access local Stop Smoking Services.** These should also target people from more deprived backgrounds.

To be effective, this plan will require increased and sustained investment in tobacco control

Increasing the amount of people accessing these services only works if the services are universally available and sufficiently resourced in the first place. Additional funding is vital to support local authorities to commission and adequately equip Stop Smoking Services. More widely, funding is also needed for smoking cessation campaigns and the wider tobacco control measures needed for a comprehensive Tobacco Control Plan to be effective.

Without additional and sustainable funding, it will not be possible to deliver all the measures that are needed in a comprehensive Tobacco Control Plan for England. **The UK Government should implement a Smokefree 2030 Fund, making the tobacco industry pay for tobacco control but without letting them influence how the money is spent. A Smokefree Fund would pay for a comprehensive tobacco control strategy, help free up budget for use in other important areas of public health, and address a significant contributor of health inequalities,** therefore leading to fewer smoking-attributable cancer cases and reduced socioeconomic inequality in preventable cancers.

For any questions on this briefing, please contact Olivia Cheek (Policy Advisor, Cancer Research UK: Olivia.Cheek@cancer.org.uk) or Alizée Froguel (Policy Manager, Cancer Research UK: Alizee.Froguel@cancer.org.uk)

[1] Brown KF, Rumgay H, Dunlop C, et al. The fraction of cancer attributable to modifiable risk factors in England, Wales, Scotland, Northern Ireland, and the United Kingdom in 2015. British Journal of Cancer: 118; 1130–1141. 2018.
[2] Global Health Data Exchange. Global Burden of Disease (GBD) Results Tool. Accessed October 2020.
[3] Office for National Statistics. Adult smoking habits in the UK: 2019. Published July 2020
[4] Marmot M, et al. Fair Society, Healthy Lives: The Marmot Review: strategic review of health inequalities in England post-2010. 2010.
[5] Calculated by the Cancer Intelligence Team at Cancer Research UK, April 2020. Based on method reported in National Cancer Intelligence Network Cancer by Deprivation in England Incidence, 1996-2010 Mortality, 1997-2011 (link is external). Using cancer incidence data 2013-2017 (Public Health England) and population data 2013-2017 (Office for National Statistics) by Indices of Multiple Deprivation 2015 income domain quintile, cancer type, sex, and five-year age band.

- *It is estimated that there are more than 27,000 extra cancer cases each year in England attributable to deprivation in those cancer sites where incidence rates are higher in more deprived areas (the corresponding figure for the UK is more than 30,000). These figures exclude cancer types where incidence rates are lower in more deprived areas, e.g. breast, prostate, and melanoma skin cancers.*

[6] Payne et al. Socio-economic deprivation and cancer in England: Quantifying the role of smoking (paper in preparation).

- *Number and proportion of cancer cases attributable to smoking calculated by combining smoking prevalence in 2003-07, cancer incidence in 2013-17, and relative risk of being diagnosed with cancer in current and ex-smokers versus never-smokers. All calculations split by deprivation quintile (assessed by the income domain of the Index of Multiple Deprivation for cancer incidence and Equivalised Household Income for smoking prevalence), sex and cancer site.*

[7] Calculated by the Cancer Intelligence Team at Cancer Research UK. Based on Statistics on NHS Stop Smoking Services in England April 2019 to March 2020. link. accessed July 2021.

- *In 2019/20 if every local authority in England had **matched their region's highest rate of people who smoke setting a quit date through NHS Stop Smoking Services**, even if they had kept their current success rates for those setting a quit date, there could have been **nearly 118,000 additional people who successfully stopped smoking** (nearly 232,000 compared with around 114,000) - that's around double the number of people stopping smoking.*
- *In 2019/20 if every local authority in England had matched their region's highest success rate for people who smoke setting a quit date through NHS Stop Smoking Services, even if they had kept their current rate of people setting a quit date, there could have been **around 44,000 additional people who successfully stopped smoking** (more than 158,000 compared with around 114,000).*
- *In 2019/20 if every local authority in England had matched their region's highest rate of people who smoke setting a quit date through NHS Stop Smoking Services, and their region's highest success rate for those setting a quit date, there could have been **around 217,000 additional people who successfully stopped smoking** (around 331,000 compared with around 114,000) - that's nearly triple the number of people stopping smoking.*

[8] Coker, T., Webber, L., Xu, M., Graff, H., Retat, L., Guzek, J., Courbould, E., Jain, R., Greenhill, T., Newberry Le Vay, J., Bullock, S., Cheek, O., Froguel, A., Vohra, J., Fitzgerald, K. 2021. "Making Conversations Count for All: Benefits of improving delivery of smoking cessation interventions for different socioeconomic groups." Cancer Research UK.
[9] Cancer Research UK GP Omnibus survey (2021) Unpublished findings. Data collected by medeConnect who interviewed 1000 regionally representative UK GPs online. medeConnect is a division of Doctors.net.uk.

- *Percentages are taken from UK GPs that answered the survey with the response 'significantly more challenging' or 'slightly more challenging' to engage patients whose first language is not English or are from a lower socioeconomic group.*

[10] Cancer Intelligence team, Cancer Research UK. Cancer in the UK 2020: Socio-economic deprivation. September 2020.
[11] Cancer Intelligence Team, Cancer Research UK. Smoking prevalence trends by occupation group in Health Survey for England. October 2019.
[12] Caleyachetty A, Lewis S, McNeill A, Leonardi-Bee J. Struggling to make ends meet: exploring pathways to understand why smokers in financial difficulties are less likely to quit successfully. European Journal of Public Health. 2012; 22(Suppl 1): 41–48.
[13] Department of Health and Social Care. Advancing our health: prevention in the 2020s – consultation document. DHSC: London; 2019.
[14] Cancer Intelligence Team, Cancer Research UK. Smoking prevalence projections for England, Scotland, Wales and Northern Ireland, based on data to 2018/2019. Published February 2020.
[15] Kotz D, Brown J, West R. 'Real-world' effectiveness of smoking cessation treatments: a population study. Addiction. 2014;109(3):491-9. doi: 10.1111/add.12429.
[16] Kotz D, Brown J, West R. Prospective cohort study of the effectiveness of smoking cessation treatments used in the "Real World". Mayo Clinic Proceedings. 2014;89(10):1360-1367.
[17] Action on Smoking and Health and Cancer Research UK. Stepping Up: The response of stop smoking services in England to the COVID-19 pandemic. 2021.
[18] The Health Foundation. Today's public health grant announcement provides some certainty, but more investment is needed over the longer-term. Published 17 March 2020. Accessed 18 May 2021.
[19] The Health Foundation. Briefing: Taking our health for granted – plugging the public health grant funding gap. The Health Foundation; 2018.
[20] The Health Foundation. Why greater investment in the public health grant should be a priority. 2021. Accessed 11 October 2021.
[21] Langley TE, McNeill A, Lewis S, Szatkowski L, Quinn C. The impact of media campaigns on smoking cessation activity: a structural vector autoregression analysis. Addiction;107(11):2043-50. doi: 10.1111/j.1360-0443.2012.03958.x.
[22] Sims M, Salway R, Langley R, et al. Effectiveness of tobacco control television advertising in changing tobacco use in England: a population-based cross-sectional study. Addiction. 2014;109(6):986-94. doi: 10.1111/add.12501.
[23] Kuipers MAG, West R, Beard EV, Brown J. Impact of the "Stoptober" Smoking Cessation Campaign in England From 2012 to 2017: A Quasiexperimental Repeat Cross-Sectional Study. Nicotine & Tobacco Research. 2020;22(9):1453-1459. doi: 10.1093/ntr/ntz108.
[24] Atusingwize E, Lewis S, Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review. Tobacco Control 2015;24:320-327.
[25] Durkin S, Wakefield M. Commentary on Sims et al. (2014) and Langley et al. (2014) Mass media campaigns require adequate and sustained funding to change population health behaviours. Addiction 2014: 109(6): 1003-1004. doi: 10.1111/add.12564.