



Public Health
England

Protecting and improving the nation's health

Health inequalities briefing for London Tobacco (use): Inequalities by protected characteristics and socioeconomic factors

Public Health England (London): key facts on social inequalities in tobacco (use).

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Background

Public Health England's (PHE) mission is to improve and protect the nation's health and wellbeing and improve the health of the poorest fastest. This includes PHE's core aim of reducing health inequalities. Health inequalities are systematic, avoidable differences in health between different groups of people. Health inequalities arise from social inequalities in factors that influence health like housing, the environment, income, employment and education.

Complementary to work on health inequalities is a focus on advancing equality, which is underpinned by provisions in the Equality Act 2010. Work on equality and diversity focuses on having due regard to eliminating discrimination, advancing equality of opportunity and fostering good relations between people or persons in relation to certain "protected characteristics" set out in the Equality Act 2010¹. Legislation exists to protect the rights of individuals and promote equality of opportunity for all. The Act includes a public sector Equality Duty which requires "public authorities", such as Public Health England, to have due regard to the following in their work:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and people who do not
- foster good relations between people who share a protected characteristic and those who do not

Purpose of the briefings

This initial suite of briefings provides a summary description of inequalities in relation to protected characteristics (under the Equality Act) and socioeconomic factors. They will be updated for new data and evidence, periodically. The aim is to:

- increase awareness of health equality and socioeconomic differences across PHE London's five priority areas, as well as tobacco and Health Checks
- inform decision making in the implementation of plans to reduce health inequalities and support compliance with the Equality Act 2010

This briefing provides a summary description of inequalities in tobacco use in the Equality Act in relation to the protected characteristics and socioeconomic factors. They are not systematic reviews but they have been developed with local, regional and national experts in the field. This equalities briefing contains descriptive information. We hope that providing background information on what we know about how tobacco use might impact upon key equalities groups will be helpful to public health teams in shaping

how they design and implement their local programmes. PHE London is using the information to inform our support work.

The protected characteristics include:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion and belief
- sex
- sexual orientation
- socioeconomic factors

The socioeconomic factors include, for example, deprivation, employment status, educational attainment level, housing status.

Context

Tobacco control is central to any strategy to reduce 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 groups².

Nationally smoking prevalence among adults (aged 16 and over) has been declining. Regionally, London has a lower smoking prevalence than England (18% vs 19.5% respectively³). In London, there are currently around 1.2 million smokers; however there are marked differences in smoking rates in different parts of the capital's population.

The age-standardised death rate for causes attributable to smoking is statistically significantly lower in London than England (279.3 vs. 291.9 per 100,000, respectively⁴). Smoking has a direct impact on four of the top five biggest killers in London: heart disease, stroke, lung cancer and COPD⁴. Therefore it is essential to reduce smoking prevalence and target resources proportionately.

Tobacco (use): Inequalities by protected characteristics and socioeconomic factors

Age

Children growing up with parents or siblings who smoke are 90% more likely to become smokers themselves than those who do not⁵. Every year, over 160,000 children are adversely affected by second-hand smoke costing the NHS in England over £23 million⁵. Within a sample of London children aged 4-15 years in 2006-2008 who did not smoke, 51% of boys and 61% of girls had recently been exposed to second hand smoke⁶.

Two-thirds of smokers start smoking before age 18 and more than 80% before the age of 20⁷.

Nationally it was estimated that more than 200,000 children aged 11- 15 years old started smoking in 2011⁸. Between 2006-2008, 31% of London's young people aged 11-15 tried smoking at least once, while 5% smoked regularly⁹.

There are approximately 10 million adults, 18 years and above, who smoke cigarettes in Great Britain, approximately a sixth of the total population⁸. Smoking caused 8,406 deaths among Londoners aged 35 and over during the period 2008-10⁹.

Many young people come into the care system as smokers. Others become smokers while being looked after in care¹⁰. A survey of the mental health of looked after children by local authorities in England) reported that 32% of the 11- to 17 year-old looked after children questioned were, at the time of publication, current smokers¹¹.

Nationally, smoking is lowest among people aged 60 and over and highest in 25-35 year olds¹², however, they are more likely than younger people to have ever been smokers⁸.

Disability

At the time of writing we found limited published data on smoking and disability on a London wide basis. However, one in three of the UK's 10 million current smokers have a mental health disorder. Approximately 40% of people diagnosed with a mental health disorder smoke, they smoke more cigarettes than the general population and are more addicted to nicotine¹³.

Tobacco use contributes significantly to the main causes of ill-health and death in people with mental health disorders¹⁴. People with schizophrenia have life expectancy 20% shorter than the general population¹⁵, a ten-fold increase in risk of dying from respiratory disease¹⁶ and two thirds will die of cardiovascular disease¹⁴.

Adults with learning disabilities who use learning disability services smoke less than the general population¹⁷. However, people with asthma and learning disabilities are twice as likely to be smokers as those with learning disabilities who do not have asthma¹⁸. Rates of smoking among adolescents with mild learning disabilities are higher than among their peers¹⁹.

Gender reassignment

At the time of writing we found little published evidence regarding the presence of inequalities and tobacco use among people who have undergone gender reassignment or are in the process of doing so. However, a European study assessing death, ill health and criminal activity after sex reassignment in transsexual persons concluded that persons with transsexualism, after sex reassignment, have considerably higher risks for death than the general population²⁰. The study found that deaths due to cardiovascular disease was significantly increased among sex reassigned individuals, albeit these results should be interpreted with caution due to the low number of events²⁰.

In a separate study, the prevalence of smoking was reported at 50% by males-to-females and almost 20% by female-to-males²¹, which may possibly explain the increase in deaths due to cardiovascular disease. However, again, the numbers in the study were small and caution should be taken in the generalisation of results.

Marriage and civil partnership

At the time of writing we found little published evidence regarding the presence of inequalities and tobacco use among individuals in a same sex marriage or civil partnership. Nationally the prevalence of cigarette smoking varies according to marital status. Smoking prevalence was lower among individuals who are in an opposite sex marriage (13%) than among those who were single (27%); cohabiting (29%); widowed, divorced or separated (21%)¹². There is no current evidence relating to tobacco usage and civil partnership.

Those who were divorced or separated were around twice as likely to be heavy smokers (20 or more cigarettes a day) than those who were single²².

Pregnancy and maternity

Smoking in pregnancy harms both the mother and unborn child. Maternal smoking is a major risk factor for low birth weight and babies who are small for their gestational age²³. A recent study in the USA concluded that smoking remains a major cause of stillbirths, neonatal deaths, premature births and babies born with low birth weight¹³.

Maternal smoking increases the risk of perinatal death (if it occurs between 20-24 weeks of pregnancy and the first week of life) by 26% and, according to one study, 3% to 7.5% of all miscarriages could be attributable to smoking⁵. Babies born to mothers who smoke during pregnancy are 40% more likely to die in their first year of life²⁴.

This means that nationally smoking in pregnancy causes up to 5,000 miscarriages, 300 perinatal deaths and also around 2,200 premature births each year⁵. Nationally, at least 300 babies die suddenly and unexpectedly every year from what is called Sudden Infant Death Syndrome. Smoking is one of the risk factors for SIDS and parents can reduce the risk of this by not smoking while pregnant or after the baby is born²⁵.

Smoking during pregnancy accounts for about a third of the difference in infant deaths between the most and least deprived groups in the population²⁶. Mothers in routine and manual occupations had the highest levels of smoking in 2010 (40%) and mothers under the age of 20 were nearly four times as likely to smoke before or during pregnancy than mothers aged 35 or over (57% compared with 15%)²⁷.

Nationally 11% of women (16-49 years) smoke during pregnancy¹². London region has the lowest smoking in pregnancy rate in the country, approximately one in 17 (5.7% during 2012-13), the lowest in the last six years⁸. However smoking status at the time of delivery varies between London boroughs, with Westminster having the lowest prevalence (2.3%) and Barking and Dagenham the highest (14.2%)²⁸. Barking and Dagenham is the only London borough with a prevalence higher than the England average, which is 12.7%²⁸.

To note, it is possible that these smoking rates for pregnant women are underestimated. Given the health risks associated with smoking while pregnant, it may be perceived to be less socially acceptable and as a result respondents may be less likely to admit smoking when pregnant.

Race

Smoking rates vary considerably between ethnic groups but are generally lower among people from ethnic minorities, although there are gender differences.

While smoking rates have decreased in the general population, this pattern is not reflected among black and minority ethnic communities²⁹.

Nationally, smoking rates among men are particularly high in Black Caribbean (37%), Bangladeshi (36%) and Chinese men (31%) The rate for White English men is 27%. Indian men have lower smoking rates (15%)³⁰.

Nationally among women, smoking rates among minority ethnic groups are low compared to the general population (at 8% or below) with the exception of Black Caribbean (24%) and Irish (26%).

Religion and belief

Religion and cultural beliefs may have an influence on some communities' attitudes towards tobacco use³⁰.

The use of smokeless tobacco is embedded in many aspects of South Asian culture and cultural beliefs, in particular chewing tobacco which is either chewed alone or with betel quid/pan. It has symbolic implications at religious and cultural ceremonies³⁰. Chewing tobacco is most commonly used by the Bangladeshi community with 9% of men and 19% of women reporting that they use chewing tobacco³¹. However these figures may reflect a degree of under-reporting by some respondents.

Cancer Research UK cites chewing tobacco as a risk factor for cancer³², and furthermore one systematic review of health effects associated with smokeless tobacco concluded that evidence (in India) showed an association between chewing betel quid and tobacco with a risk of oral cancers³³.

Some Islamic religious leaders believe that smoking and the sale of tobacco should be prohibited by Islam³⁴. Haredi Jewish men have a lower prevalence of smoking compared with the general population³⁵.

Sex

In 2012 nationally the prevalence of smoking was 22% in men and 19% in women³⁶. Nationally smoking prevalence among men is highest in the 25-34 age group at 32%. Smoking is highest among women at 29% in the 20-24 year old age group⁸.

Nationally, of those who smoke, more men (40%) smoke hand-rolled cigarettes than women (23%)¹².

Sexual orientation

Lesbian, Gay, Bisexual and Transgender people over the age of 16 are more likely to be current smokers, less likely to have never smoked, and less likely to have given up smoking³⁷ than the general population.

Nationally 67% of gay and bisexual men have smoked at some time in their life compared to half (50%) of heterosexual men. 26% of gay and bisexual men currently smoke compared to 22% of men in the general population³⁸. Smoking rates are higher for men who have sex with men compared to their heterosexual counterparts³⁹.

Nationally two thirds of lesbian and bisexual women have smoked compared to half of heterosexual women. Just over a quarter currently smoke⁴⁰.

Socioeconomic factors

Smoking is the primary behavioural reason for the gap in healthy life expectancy between rich and poor in communities. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups⁴¹.

There is a strong association between cigarette smoking and socio-economic group. Nationally, 29.7% of routine and manual workers smoke compared to 14% of managerial and professional occupations¹². In London 25.7% of routine and manual workers smoke⁴.

There is significant variation between London boroughs, with the lowest routine and manual smoking prevalence in Brent (14.2%) and highest in Waltham Forest (39.3%).

Although there is limited evidence of the health of Gypsies and travellers, studies have found that their health status is much poorer than that of the general population and other marginalised groups⁴². An Ipsos MORI poll found that that 47% of Gypsies and travellers smoke⁴³, statistically significantly higher than the general population.

Other

There is a connection between smoking cannabis and infective lung conditions such as tuberculosis (TB) and Legionnaires' disease⁴⁴.

Approximately a third of adults in the UK have tried cannabis¹ and an estimated 2.2 million people have used cannabis during 2010 and 2011. Among young people,

cannabis is the most commonly used illicit drug (17.1 per cent of 16- to 24-year olds in 2010-2011)².

Evidence of the use of waterpipe (Shisha, Narghille, Hookah) is still emerging and regular use among adults in Great Britain is low (roughly 1% of adults >18 years). Females, those in the lowest social grade and White ethnic groups are less likely to have ever used waterpipes. Ever smoking cigarettes and being Asian or mixed ethnicity increased the odds of ever using a waterpipe.

Further information on tobacco control data across London and nationally can be found in the local tobacco profiles: <http://www.tobaccoprofiles.info/profile/tobacco-control/data>

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