

Tackling Health Inequalities: consultation on a plan for delivery

Response from Action on Smoking and Health
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Introduction

This is the response of Action on Smoking and Health to the consultation document: *Tackling Health Inequalities – consultation on a plan for delivery*¹.

People in poorer social classes are more likely to die early due to a variety of factors. Among men, the dominant factor is smoking, which accounts for over half of the difference in risk of premature death between the social classes².

Smoking contributes heavily to the big killers of cancer, cardio-vascular disease and chronic respiratory illness – and to the extent that smoking is correlated with disadvantage- smoking is **the** major cause of health inequalities.

A joint ASH and Health Development Agency summary of the facts and statistics related to smoking and health inequalities is enclosed with this response.

In this submission we comment on the measures that have been included in *Tackling Health Inequalities*, and discuss other measures that have not been included. In each case, we recommend one or more action points to strengthen the proposal.

Options included in *Tackling Health Inequalities*

The consultation document identifies a range of measures directed at reducing health inequalities by taking action on smoking in section 3.18. ASH believes that some of these measures could be improved and makes the following recommendations.

Tobacco advertising

i) a ban on tobacco advertising and promotion to be introduced as soon as Parliamentary time allows

The Government believes that an advertising ban could reduce tobacco consumption in the longer term by 2.5%. This would translate into an estimated 3000 lives per year saved.

Rt. Hon Alan Milburn MP Secretary of State for Health, December 2000

The implication of this statement is that lives are lost for every month of delay in implementing the tobacco advertising ban. It is therefore imperative for Ministers to save lives by giving immediate Parliamentary time to the Bill - and not to allow this important manifesto commitment to be lost.

Tobacco advertising and promotion plays a large part in health inequalities because there is clear evidence to show that the tobacco industry specifically targets low-income smokers. It adopts marketing strategies that integrate mid-tar, relative cheapness, and wide distribution with the promotion of low price and high quality. The industry implements marketing strategies to ease any anxiety, embarrassment or perceptions of inferior quality from smoking lower cost brands.³

Internal documents from the UK's five main advertising agencies reveal a strong interest in low income smokers, and, as a result, the strategic importance of the mid-price sector of the market. An increase in price sensitivity and the relative market size of (and hence competitive advantage to be gained from) poorer smokers, means competition in the low price sector has intensified.

*"Not news I realise, but nevertheless highly significant to us marketers, is the fact that by the beginning of 1999, a momentous shift in the cigarette market will have occurred: The low price sector will be the UK's largest sector." Letter from Simon North to Barry Jenner Esq, 15 December 1998. **Submission from CDP to the Health Committee House of Commons – Gallaher Letters 1998.***

It is apparent from the documents that marketers target concerns about the image of cheaper brands by providing reassurance that they are just as acceptable and mainstream as the premium alternatives. The heavy advertising of mid-price and cheaper cigarettes serves to imply their quality and value – making cheaper brands more credible. Even the cheaper brand names such as Mayfair, Sovereign or Royals suggest higher class and quality.

*"They are uncomfortable with repeated reminders that they are smoking a cheaper cigarette. Almost all would rather be smoking a premium brand, and all know (because it is obvious) that a cheaper product is an inferior product. Thus anything which implies quality is gratefully received. **Sovereign, Research Implications for Advertising Strategy: A discussion paper. 5th May 1998***

Finally, when the government is spending substantial sums on pro-health campaigns, it is nonsense to allow millions of pounds of private expenditure to be devoted to achieving the

opposite effect. To put this in context, the tobacco industry spends £135m a year on advertising and promotion in the UK each year, in contrast to the £13m spent by the Government on anti-smoking education, of which £7 million is mass media advertising. A ban on tobacco advertising and marketing would remove much of £135 million tobacco money pulling in the opposite direction and increase the effectiveness of the pro-health public spending.

Action point

- ***Given that the government accepts that lives are at stake, it is essential that the Tobacco Advertising and Promotion Bill is given the utmost priority and is adopted as a Government Bill before the end of the current year.***

National education campaign

ii) **helping those with the highest rates of smoking by targeting national tobacco education campaign to populations with the highest prevalence**

The tobacco White Paper, *Smoking Kills*, committed the following.

“Adequately funded health education programmes as part of a comprehensive strategy and with sustained funding have a lasting effect on smoking behaviour. We are committing some £50 million over the next three years to develop a sustained and co-ordinated new campaign” **Department of Health, *Smoking Kills, a white paper on tobacco*. London. The Stationery Office. 2000**

A key plank of the evidence for the effectiveness of mass media campaigns was a trial in Yorkshire. Between October 1992 and May 1994 a prospective controlled trial was conducted in four TV regions in central and Northern England. One region received no intervention, two regions received TV anti-smoking advertising and one region received TV advertising plus locally organised anti-tobacco campaigning. Evaluation showed that the TV campaign was effective in reducing smoking and preventing relapse but, if such advertising is to have an impact, a prolonged campaign is necessary. It was concluded that anti smoking TV advertising should be undertaken routinely as an essential component of any population smoking reduction strategy.

Estimates from this trial suggested if the marginal success of their campaign were to be replicated nationally, *to achieve a 1% drop in smoking prevalence through media activity would require a media budget of £15 million and £20 million per annum*. Actual media budgets for anti-smoking campaigns until 1998 averaged £2 million and £3 million per annum. The White Paper budget is sufficient to have a good effect, but its effectiveness can be improved by strengthening the messages and spending more of the education budget on mass media.

Despite the commitment of £50 million over three years, expenditure on health education campaigns aimed at stopping people smoking in the current and last two years has decreased as follows⁴:

1999/2000 £15.9 million
2000/2001 £13.73 million
2001/2002 £13.3 million has been allocated

Although sustained funding for a health education campaign was identified as essential in the white paper– these figures show a clear decrease in spending.

It is also important that the funding allocated is spent on hard-hitting mass media campaigns. Nicotine Replacement Therapy (NRT) manufacturers spend approximately £15 million on gentle encouragement. Government funding should be spent on the harder messages and new themes and less on “tips” advertising, which has a lower impact. Mass media is effective in reaching low-income groups, which are high consumers of television, but messages have to be tailored for this group and tested on them.

Although it may have been difficult to quantify the overall success of anti-smoking mass media campaigns in the UK, it is interesting to look at international evidence from Massachusetts, California, Australia where such campaigns have been associated with declines in smoking prevalence.

The most effective state funded mass media campaign is the Massachusetts Tobacco Control. In Massachusetts since the introduction of this programme from June 1999:

- cigarette consumption has fallen by 33%, while consumption in the rest of the country declined just 10%
- smoking during pregnancy dropped sharply, from 25% to 13%
- From 1992, the prevalence of adult smoking in Massachusetts has declined annually by 0.43% compared with an increase of 0.03% in the comparison states

Passive Smoking and Children’s exposure in the home

Mass media campaigns are also one of the few ways that health authorities can influence behaviour in the home and therefore have an impact on passive smoking exposure of children who live with parents that smoke. Of the 42% exposed to passive smoking in the home, those from poor households are more likely (54%) to be exposed to passive smoking in the home than those who in professional classes (18%)⁵.

Action points

- ***Mass media campaigns have a central role to play in generating the motivation to quit and are especially important in reaching the poorest social classes. Mass media is important in supporting the public acceptance of broader tobacco policies. The education funding needs to be maintained at least at current levels- £17 million per year or more.***
- ***Within the funding allocated, the proportion spent on mass media should increase to at least two thirds.***
- ***For a given mass-media spend, messages should be strengthened to improve impact and effectiveness. It is important to learn from successful strategies employed in other countries.***
- ***Mass media promotion of self imposed restrictions in the home is one of the few ways to protect children from passive smoking at home***

Cessation support for pregnant smokers

iii) dedicated cessation help for pregnant smokers at a local level

Whilst it is important to work with low-income pregnant smokers at a local level – it is also necessary to ensure that help is available for **all** low-income smokers.

In 1995, the then Health Education Authority established the National Alliances Scheme, a network of local alliances, designed to link national and local actions on tobacco. Since April 2000, the Department of Health has been responsible for the co-ordination of the Network – which now has 25 alliances, covering 60% of the population. Diverse in structure, resources and working practices, these alliances are focussed on addressing local tobacco issues.

The Department of Health has already shown its commitment to working with the local alliances to make best use of resources by announcing in the Cancer Plan (2000) up to £1million would be available to support and develop the network of alliances. This work is crucial as it provides dedicated cessation help for all low-income smokers at a local level. Continued commitment to the Alliance Networks is essential.

Action points

- ***Commitment is needed for dedicated cessation help for all low income smokers at a local level***
- ***The Alliance Networks should be supported through continued support and funding***

Smoking cessation drugs

iv) removing the price barriers to those who want to quit among the most disadvantaged groups, by ensuring that nicotine replacement is available on prescription

The availability of NRT on prescription is an important measure, but it must be backed up by commitment from GPs. The importance of primary care interventions is that they are proactive and opportunistic, cost effective and have much greater reach (more people are seen, though the intervention is a lower intensity). It also allows the GP to target efforts at poorest smokers and offer advice or referral to services or the helpline – or other approved support. The primary care intervention needs to be properly negotiated into the GP contract and not just left to goodwill.

Primary care interventions have been stimulated by the reimbursement of NRT, and a further boost is expected following the NICE technology appraisal, which should report in the first quarter of 2002.

The specialist smoking cessation services play a vital 'energising' and capacity building role for lower intensity primary care interventions. By providing a centre of competence and training, and by proactively engaging primary care the services ensure more GP brief interventions of better quality happen. The most successful services in the country run on this model (eg. Shropshire) have the best overall results. The services are not alternatives to primary care interventions, but a prime mover in engaging primary care.

Action point

- **Ensure that GPs are pro-active in supporting smoking cessation measures, and are contractually bound to offer advice and support to patients**
- **Ensure the interventions in primary care and prescribing of drugs is backed up by high quality support services (see below).**

Smoking cessation services

v) continuing to improve the reach and impact of smoking cessation services and other local programmes

During the election campaign in May 2001, Alan Milburn, Secretary of State for Health, re-emphasised the commitment to smoking cessation:

“There will be a greater focus on prevention with more screening services and more help for smokers to quit” and “comprehensive smoking cessation services.”

Helping smokers stop is a highly cost effective use of NHS resources- continued funding of the NHS smoking cessation services is essential.

An estimated £10-40 million per year has been budgeted for expenditure on smoking cessation pharmacotherapies⁶. This compares to £20 million for NHS smoking cessation services. The services and support offered alongside NRT and bupropion improve the smoker's chances of stopping, and therefore improve the return on the drug expenditure.⁶ Early results from the new NHS smoking cessation services show how popular and successful they are already becoming. Over 62,000 smokers seen by these services between April and December 2000 had set a quit date and nearly half of them were not smoking at four weeks.⁷

Helping smokers stop will have a major effect on reducing health inequalities. About 60% of those attending the new cessation services are exempt from NHS prescription charges and are among the poorer members of society. As an example of the poorer social class emphasis, of those treated by Camden and Islington services, 68% were housed in rented accommodation (compared to a national average of 27%); 21% were unemployed or long term sick (national average: 8%); and 40% reported smoking within 5 minutes of waking - an indicator of dependence (average:15%).

Action point

- ***An early financial commitment to the services is critical. Considerable public sector resources have already been invested in building up capacity, which will be wasted if funding decisions are delayed and key staff are lost.***

Targeting specific groups

vi) action to target smokers in specific disadvantaged groups, such as prisoners

Disadvantaged groups - such as prisoners, individuals with mental health problems, and the homeless - have very high smoking prevalence rates. (See enclosed Fact Sheet). ASH is

currently involved in ground-breaking coalition work focussing on access to appropriate smoking cessation information and support for people with mental health problems. Initial research suggests that the smoking needs of service users are not addressed adequately.

Targeting smokers within disadvantaged groups requires a long-term funding commitment with broad ranging strategies that must be inclusive and representative.

Initiatives should include the following:

- Research through consultation with the disadvantaged groups to gain further insight in to their smoking cessation needs, what will help them to stop and stay off tobacco.
- GP and other Primary Care interventions are needed to encourage disadvantaged groups to take care of their physical health
- Smoke-free policies, e.g. within psychiatric and long-stay units, prisons, benefit offices
- Appropriate smoking cessation support e.g. NRT onprescription, smoking cessation groups specifically tailored to individuals who may have differing needs from the general population
- Materials, e.g. leaflets, posters, that specifically target the group should be developed and pre-tested with the target group
- Information provided should specifically include costs, side effects, medication and general health promotion information about diet, health and exercise

Action points

- ***Identify, assess and evaluate the smoking cessation needs of the disadvantaged groups to be targeted***
- ***Commit long-term funding to broad ranging inclusive and appropriate initiatives – especially including the Alliances as a means of delivery***

Harm reduction

vii) work to identify the scope for requiring tobacco companies to alter their products to make them less harmful, for example, by removing certain additives and reducing the level of carcinogens and other toxic components in tobacco smoke

Cigarettes are very dirty nicotine delivery devices and whilst it is the nicotine that is addictive, it is the tobacco not the nicotine that causes the vast majority of the harm. If less harmful nicotine delivery devices were available for those smokers that cannot or will not stop smoking, the health burden for poorer groups could be reduced.

There are three main approaches to harm reduction available:

1. Use of pharmaceutical nicotine as an alternative source of nicotine for people that also continue to use tobacco. We estimate this reduces risk by two orders of magnitude. This is currently not permitted by the MCA/CSM.
2. Use of tobacco in safer, non-combustible form, for example as chewing tobacco, oral pellets or snuffs. We estimate this reduces risk by one order of magnitude. Oral snuff is banned in the UK under EU directive 2001/37/EC.

3. Application of technical standards (for example banning additives and limiting nitrosamines) to the smoke of smoked tobacco. We cannot estimate the impact of this, but believe it will be a marginal change.

There is a pre-existing standard for tobacco 'purity' – the Gothiatek standard used for oral tobacco in Sweden – that could be used as a starting point for regulating oral tobacco, and potentially other tobacco in the UK.

The harm reduction option suggested in *Tackling Health Inequalities* is the third of these, and is the most technically difficult, most risky while offering the least certain results. We advise exploring the other harm reduction options with greater priority and approach the third more cautiously.

Action points

- ***ASH recommends the liberalising of NRT products for use in harm reduction and replacement of tobacco-delivered nicotine.***
- ***The Department should conduct an evaluation of the potential role of oral tobacco in harm reduction – and appropriate standards.***
- ***The regulation of tobacco product emissions and additives should proceed cautiously, starting with building the necessary scientific, regulatory and legal capacity.***

Options NOT included in *Tackling Health Inequalities*

Tax and Smuggling

According to the 1998 [Independent Inquiry into Inequalities in Health Report](#)⁸,

... the real price of tobacco has a disproportionate effect on the living standards of Britain's poorest households, for whom expenditure on tobacco is a larger proportion of disposable income. Households in the lowest tenth of income spend 6 times as much of their income on tobacco as households in the highest tenth. Over 70 per cent of two-parent households on Income Support buy cigarettes, spending about 15 per cent of their disposable income on tobacco. Approximately 55 per cent of lone mothers on Income Support smoke, smoking on average 5 packets of cigarettes per week. Studies of the cost of meeting basic needs, which explicitly exclude spending on tobacco, indicate that Income Support levels are insufficient to secure a basic but adequate standard of living, especially if the households contain children.

There is a trade off between the welfare disbenefits to those that continue to smoke despite price rises, and health and welfare benefits to those that quit in response to the price signal. We believe that prices should continue to rise to maintain the pro-health price signal, but that the taxation can only be deemed 'fair' if:

- Every effort is made to help smokers quit - especially those on low incomes - so that they can avoid the tax. The tobacco White Paper, [Smoking Kills](#), sets out a broad anti-tobacco strategy, and new [NHS Cancer Plan](#) extends this by introducing targets for reducing smoking among manual groups.
- The government has a broad based approach to health inequalities.
- The government has a broad-based policy of reducing poverty.

Given the high level of tobacco taxation in the UK, cuts in Department of Health expenditures on smoking cessation threaten to undermine the legitimacy of the government's tobacco tax policy. Tobacco taxation in the UK is currently around £134 per capita (based on revenues of £7.5 billion). Central government expenditure on tobacco policy is around 73 pence per capita for England (based on expenditure of £35 million outlined in the Tobacco White Paper). This 184-fold difference is striking and suggests there is considerable scope to return more of the money raised from smokers to services that would enable smokers to live a longer and more prosperous life by quitting smoking.

Hypothecation and funding smoking cessation initiatives

While we recognise, and sympathise with, the government's reluctance to earmark particular tax revenue streams to particular expenditures, there is a powerful argument for making an exception for tobacco. This is because of the imperative of countering the regressive effect of the tax itself. This is both an important ethical consideration - as discussed above - and would address the presentational problem of appearing to 'punish' smokers.

By allocating a share of the tobacco tax revenues to smoking cessation and anti-tobacco communications programmes, the government would be channelling funds straight back to the smoker and entering a 'social contract' in which smokers were offered something constructive in

return for their tax - and this would be protected ('ring-fenced') within general NHS expenditure for the foreseeable future.

ASH believes that only a small share of the tobacco tax take need be earmarked in this way (approximately one percent) to create a service to smokers on a par with the world's best. Guidelines published in the journal *Thorax*⁹ suggest that a fully comprehensive smoking cessation policy would cost approximately £86 million pounds per year – approximately 1.2 percent of total tobacco tax revenue– including VAT.

The experience of California shows that linking tobacco taxation and tobacco policy delivers improved health outcomes. According to the U.S Centers for Disease Control¹⁰:

California's tobacco control program began in January 1989, when the excise tax was increased from \$0.10 to \$0.35 per pack of cigarettes. Initially, consumption decreased rapidly. If price were the only factor contributing to these declines, the initial drop would have been followed by a pattern of slow decline, such as was experienced by the rest of the country. However, as a result of the implementation of a tobacco control program, tobacco use in California declined throughout the 1990s at a rate two or three times faster than that in the rest of the country.

In the case of California, the expenditure more than paid for itself in reduced health care costs.

The California Department of Health Services has estimated that for every US\$1 spent on the program between 1990 and 1998, an estimated US\$3.62 in direct medical costs has been avoided.

Given that the principle of allocating tobacco taxes to the NHS is already established¹¹, this simple extension of that principle would have the merit of both improving the reality and appearance of fairness in tobacco taxation.

Action points

- **The key pricing strategy is to make cigarettes less affordable over time– this was the approach adopted in the tobacco White Paper.**
- **At present, this can be best achieved by reducing smuggling. As changing tax rates would be ineffective to combat smuggling, the wholesale distribution of contraband must be addressed urgently. This approach has been effective in tackling smuggling in Spain, which had one of Europe's most severe tobacco smuggling problems.**
- **To address the regressive impact of tobacco taxation, consideration should be given to hypothecation of a small fraction of the revenue (one percent) to fund programmes focussed on low-income smokers – this would provide a fund of around £75 million per year.**

Workplace Smoking

The introduction of a workplace smoking policy, leading to a ban on smoking at the workplace, encourages smokers to give up the habit. Studies indicate a fall in the number of employees smoking (any cigarettes) of between 12% and 39%. The same studies also show that the

consumption of tobacco among smokers who continue to smoke also falls between 3 and 4 fewer cigarettes being smoked each day.^{12 13 14}

With smoking prevalence being higher among manual classes, a 1997 Health Education Authority study showed that those in manual jobs are more likely to be exposed to the risks of passive smoking at work. Twenty seven per cent of those in manual jobs worked in places where smoking is allowed anywhere, compared to 10% of non-manual workers. Passive smokers suffer an increased risk of a range of smoking-related diseases. Non-smoking manual workers have a right to breathe clean air while at work.

Workplaces that restrict smoking not only have an effect on the workers but also on anyone who enters a smoke-free building, for example, users of banks or public libraries cannot smoke while using the facilities, thus reducing the amount of cigarettes that the individual is able to smoke. Workplace restrictions in places used disproportionately by lower income groups would have a knock-on impact on the socio-economic health inequalities gradient. For example, a smoking ban in a Benefit Claims Office would not only protect the health of the workers, it would also limit the users' smoking habits.

While out of work it is unlikely that a smoker will face many restrictions on smoking. However on returning to work smoking will not be as ubiquitous - the smoker is likely to encounter more non-smokers and smoking bans.

The New Deal is part of the Government's Welfare to Work strategy and could have a key role to play in smoking cessation. The Personal Adviser who supports and advises the jobseeker could raise the issue of smoking status. During the first phase of the New Deal Programme intensive help is given to help the person into work, including help with job applications and interview practice. During this period, jobseekers have access to a range of services and opportunities to help them prepare for work. Personal Advisers should be aware of local smoking cessation services and be able to give advice to the jobseeker on how and where to get help.

Returning to work or joining a training scheme after a period of unemployment is often an incentive for an individual to give up smoking. Studies have shown that smoking cessation is often linked to feelings of optimism and actual or anticipated improvements in life circumstances. It is important that the smoker is aware of the help available for smoking cessation.

Action point

- **Workplace restrictions provide an incentive to quit. The Approved Code of Practice would provide a major stimulus to workplace tobacco control activity. The introduction of the ACoP should be made a matter of high priority.**

Community-based initiatives

Individual decisions about smoking are not made in isolation but are influenced by the broader social and cultural context in which people live. It is difficult for those living in deprived communities to tackle smoking in isolation - without support from their family and close peers. Research carried out in Scotland shows that pro-smoking low income community norms foster a climate of social participation and belonging.¹⁵

In a low income community there are many shared aspects of smoking, such as neighbours and families jointly collecting coupons, friends pooling finances to buy cigarettes and the daily lending and buying of cigarettes for others.

Community programmes and initiatives aim to reduce smoking by changing the social norms and attitudes to smoking in the community, thereby increasing smokers' motivation to quit, their number of quitting attempts and reducing their relapse rate.

There is no commonly accepted definition of what constitutes a community programme - they vary enormously on a number of characteristics making effective evaluation very difficult. However, the evaluated results of a Department of Health funded pilot Poverty and Smoking Community Project show that 38% of those smoking had stopped by the end of a six week programme. The cessation rate was higher among those who used NRT and those who attended all of the six weekly sessions. Results from a follow up telephone survey, carried out 12 months later, indicated that cessation rates had decreased to 21%. This level can be regarded as the best estimate of the proportion of participants who became long term ex-smokers as a result of the programme and therefore should be viewed as the overall definitive cessation rate and compares very favourably with clinical trials of nicotine replacement therapy (NRT).

Action points

- ***Funding must continue to be made available for pilot community-based projects.***
- ***More attention should be focussed on evaluating such initiatives in order to build the evidence base for future work in this area.***

No Smoking Day

No Smoking Day is a mass media led annual campaign to help UK smokers who want to stop. It works by creating an opportunity to stop, supported by wide publicity and extensive service provision. By its nature it is a populist campaign, aimed at the broad mass of smokers who want to stop. These are largely in the C2DE population sectors.

Annual research surveys consistently demonstrate high awareness of the Day among smokers in both sexes, and across all age ranges and social groups - in 2001¹⁶, 78% of smokers were aware that 14 March 2001 was No Smoking Day. However, participation in the Day varies across the social classes. Approx 43% of C2DE smokers aware of the 2001 campaign responded positively to it by making a quit attempt, cutting down on their smoking or actively discussing stopping. Only 33% of smokers in the AB group responded in these positive ways.

No Smoking Day's high reach and impact with smokers, particularly those in the more populous C2DE groups, make it a highly cost effective way to stimulate quit attempts: approx 900,000 attempts achieved with a campaign budget of approx £600,000.

Conclusion

ASH welcomes the recognition that there is a need for a new focus on “manual” smokers and a re-orientation of tobacco control policies with a poverty focus. ASH recommends that the elements of such a policy should include:

- **A powerful mass-media led education campaign** – this is essential in building motivation to quit and is effective in reaching low-income groups. Mass media campaigns provide a supportive context for all other measures.
- **A ban on tobacco advertising and promotion before the end of the year** – tobacco companies segment and target low-income groups. The effectiveness of other measures (such as the education campaign) is attenuated while the tobacco companies can spend £100 million promoting smoking.
- **The tax and price measure** has been rendered ineffective by smuggling and many low-income smokers now purchase tobacco at a lower real price than in 1997. The solution and revitalisation of the price effect lies in tackling smuggling.
- **Community based initiatives** – the idea is to change the environment in which smokers attempt to quit. The evidence and experience is mixed, but we recommend continuing on a pilot and evaluation basis.
- **Smoke-free workplaces** – there is a sharp social class gradient in smoke exposure at work and smoke-free workplace policies have been shown to be a driver of quitting. This suggests policies like the ACoP may have disproportionate impact on low-income smoking. There is also scope for interventions in government ‘return to work’ initiatives and the New Deal.
- **Smoking cessation services** – these disproportionately service low-income smokers and are effective and highly cost-effective. The services also ‘sponsor’ wider smoking cessation activity in primary care and increase the reach of the smoking cessation effort. It is essential to retain these services and, from a funding point of view, place them on a stable and secure footing.
- **Harm reduction strategies** – these recognise that many smokers will continue to use tobacco even if targets are met and attempts to find ways that tobacco or nicotine use can continue with reduced risk of serious disease. Options include regulating the toxicity of cigarettes, emphasising the reduced risk associated with oral tobaccos, and authorising new uses for nicotine replacement therapies and potentially new sources of clean nicotine.

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