

CSI 18: Adult smoking in Great Britain

Summary

- Smoking and number of cigarettes smoked have decreased progressively over time, although these changes have slowed in the past decade
- Overall smoking and strength of addiction are greater in people with lower qualifications, and lower social class
- Exposure to passive smoke among non-smokers is also more common in people with lower qualifications and lower social class
- Wanting to give up smoking does not vary clearly by education or social class, but having stopped smoking is more prevalent in people with higher qualifications, and higher social class

Introduction

The health risks of smoking are clear: in 2013, 17 per cent of deaths among adults aged 35 and over in England were due to smokingⁱ. Approximately half of life-long smokers are expected to die as a consequence of smoking, losing on average 20 years of lifeⁱⁱ. This is more than deaths due to obesity, alcohol, road traffic accidents, illegal drugs and HIV combinedⁱⁱⁱ. Smoking also incurs large financial costs, including annual costs of £2.7 billion in NHS costs and £2.5 billion in lost productivity and sick leave^{iv}. Long-standing public health campaigns have therefore sought both to discourage people from taking up smoking as well as promoting stopping smoking.

How have smoking patterns changed over time?

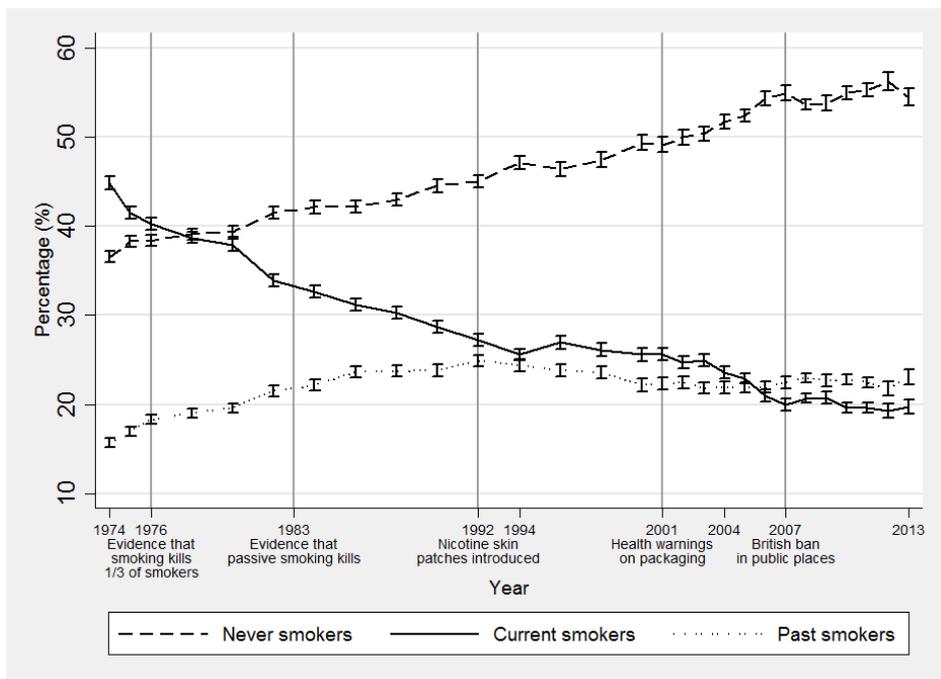


Figure 1: Adult smoking in Britain declined progressively between 1974 and 2013

Sources: General Household Survey (1974-2011), Health Survey for England (2008-2013), Welsh Health Survey (2008-2013), Scottish Health Survey (2008-2013)

The proportion of current smokers more than halved between 1974 and 2013, although there has been little change since 2006. Correspondingly, the proportion of people who have never smoked regularly continues to increase. The proportion of past smokers also increased throughout this period and has remained fairly stable since the year 2000. This group is important

because the health benefits of stopping smoking appear gradually^v. In 2006, the proportion of past smokers overtook the proportion of current smokers, a pattern that has persisted. These changes can be related to progressive anti-smoking policy measures. Following publication of evidence that smoking is harmful both to smokers and those around them, smoking declined throughout the 1970s and 1980s, while the proportion of past and never smokers increased. These patterns persisted throughout the 1990s, during which time nicotine skin patches were available for the first time. Smoking declined and never smoking increased further in the 2000s, as health warnings on tobacco packaging became more prominent. It is perhaps surprising that trends in current and past smoking have changed very little since bans on smoking in public places were introduced in Scotland in 2006 and England and Wales in 2007. It is however important to recognise that this chart provides no evidence that these policy changes were responsible for changes in smoking behaviour.

Technical details

People may not be fully truthful when disclosing behaviours that are generally considered socially undesirable, such as smoking. Some surveys use self-completion sections to ask smoking questions to encourage honest and accurate answers, but this method is not always used and may not fully address the problem.

Between 2008 and 2013 it is possible to compare rates of past smoking and never smoking, distinguishing between 'regular' and 'occasional' smoking. The proportion of past smokers is approximately six percentage points higher and the proportion of never smokers is correspondingly lower when previous smoking status is defined as 'occasional' than 'regular'. Due to data availability, rates of current smoking referred to in this briefing note relate to regular smoking, which will underestimate the proportion of current smokers.

The proportion of smokers who have quit (in Figures 6 and 7) is calculated as the proportion of people who said that they have smoked regularly, but do not currently smoke.

Smoking varies between age groups and between men and women, so all figures have been adjusted for age and sex. Population changes mean that this adjustment allows comparisons to be made over time. All figures relate to people aged 16 and older. The figures reported here only cover cigarettes, not cigars, pipes or e-cigarettes.

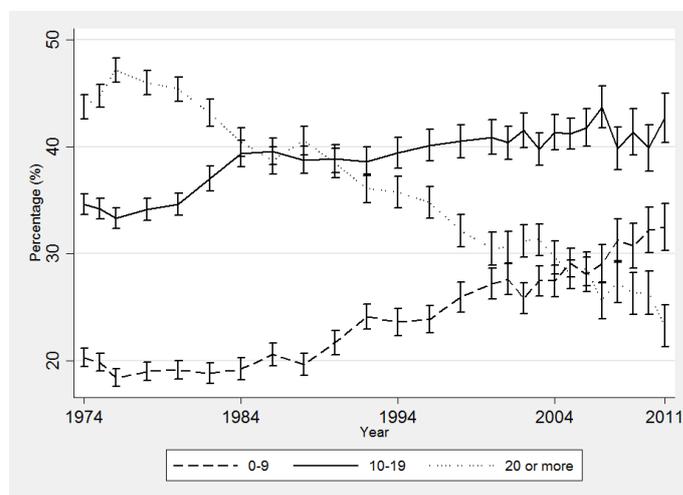
The vertical error bars show the degree of certainty around each estimate, where larger error bars indicate greater uncertainty. Overlapping error bars indicate that estimates are not significantly different between groups.

How many cigarettes do people smoke?

Figure 2: Number of cigarettes smoked each day declined in Britain between 1974 and 2011 *Source: General Household Survey*

The proportion of smokers who smoked 20 or more cigarettes every day nearly halved between 1974 and 2011. The proportion of smokers who smoked 10-19 cigarettes per day conversely increased significantly, although this did not fully account for the declining size of the heaviest smoking group. The proportion of smokers who smoked 0-9 cigarettes every day increased progressively throughout this period. By 2007, the proportion of lightest smokers outweighed the proportion of heaviest smokers, and this trend has persisted. These figures demonstrate encouraging reductions in smoking trends over time.

It is however possible that underestimating cigarette smoking increased over this period as smoking became less socially acceptable, although this is only speculative. This time series only runs to 2011 because no data are available from Wales after this date.



How do smoking patterns vary between groups?

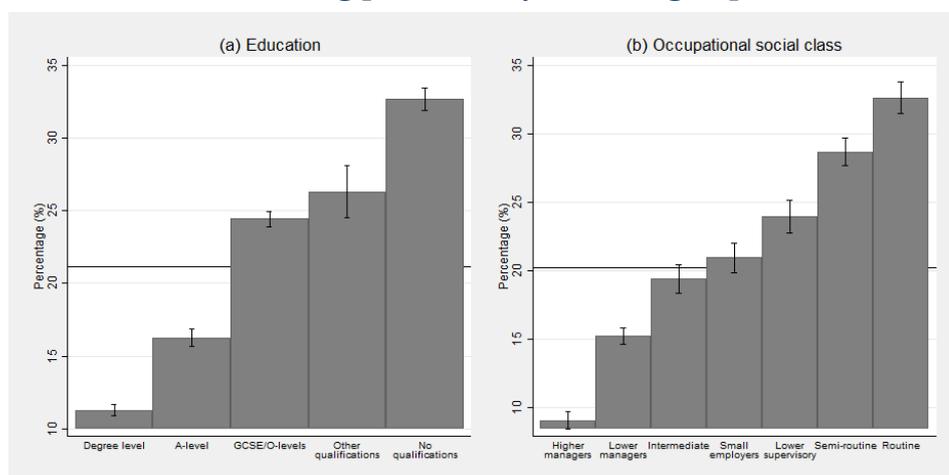


Figure 3: Adult smoking in Britain is more prevalent among those with lower qualifications and lower social class, 2008-2013 *Sources: Health Survey for England, Welsh Health Survey, Scottish Health Survey*

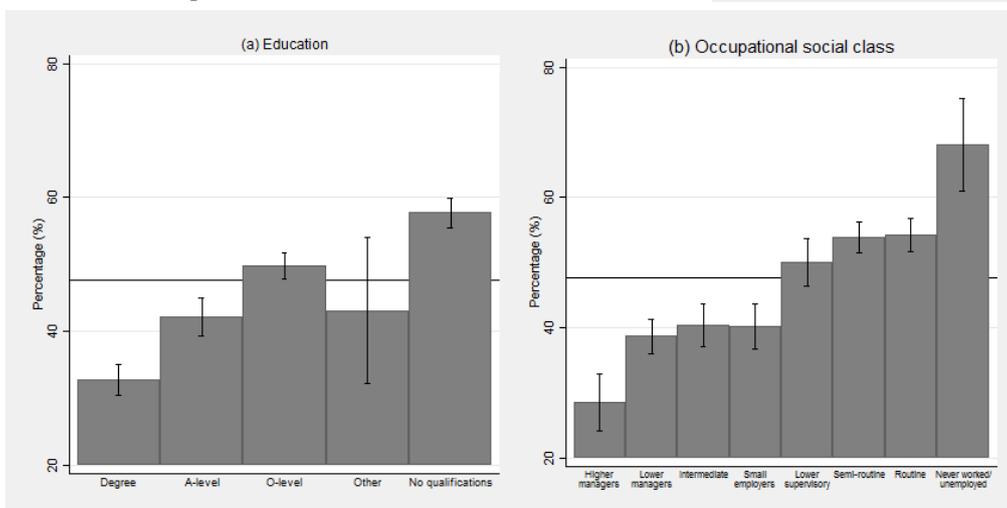
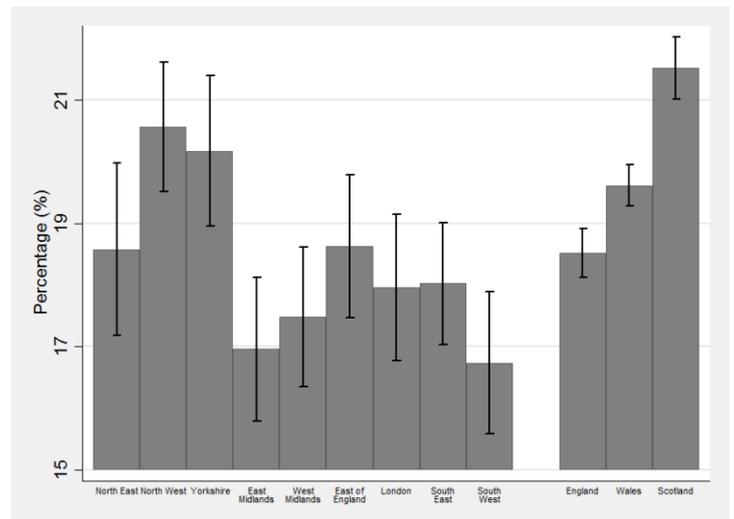
There are clear social gradients in smoking, which is more prevalent in people with lower educational qualifications and those living in households with lower occupational social class. A higher proportion of men

than women smoke, and this pattern has persisted over time (not shown). In 2013, smoking deaths were more common in men than women (21 and 14 per cent of people aged 35 and over in England)^{vi}.

Figure 4: Smoking is more prevalent in Wales and Scotland than England after accounting for social class, 2008-2013

Sources: Health Survey for England, Welsh Health Survey, Scottish Health Survey

Smoking is significantly more prevalent in Scotland and Wales than England. The overall smoking prevalence in England conceals some regional differences, where smoking is less prevalent in the East and West Midlands and the South West, and more prevalent in the North West and Yorkshire. These figures have been adjusted for age, sex and household social class, so they do not reflect differences in population structure or social class. They instead suggest that social support for smoking may be greater in certain parts of Britain.



How does smoking addiction vary between groups?

Figure 5: Addiction in English adults is more prevalent among those with lower qualifications and lower social class, 2008-2013

Source: Health Survey for England

Smoking addiction is typically measured as people who smoke within 30 minutes of

waking up. Addiction follows a clear social gradient, and is more common than average in smokers with no qualifications, those working in semi-routine and routine jobs, and people who have never worked or are long-term unemployed. This high level of addiction was significantly less prevalent than average for smokers with a degree or A-levels, and those working in managerial or intermediate roles or small employers. These figures are available for England only.

How many people have stopped smoking?

Figure 6: Wanting to give up does not vary clearly by social class, but there is a clear social class gradient in stopping smoking, 2008-2013

Sources: Health Survey for England, Welsh Health Survey, Scottish Health Survey

The proportion of people who reported wanting to stop smoking did not vary clearly by occupational social class. In contrast, the proportion of smokers who have stopped smoking

shows a clear social class gradient: having stopped smoking was significantly more common than average in smokers in managerial and intermediate professions and small employers, and significantly less common in smokers working in semi-routine and routine occupations.

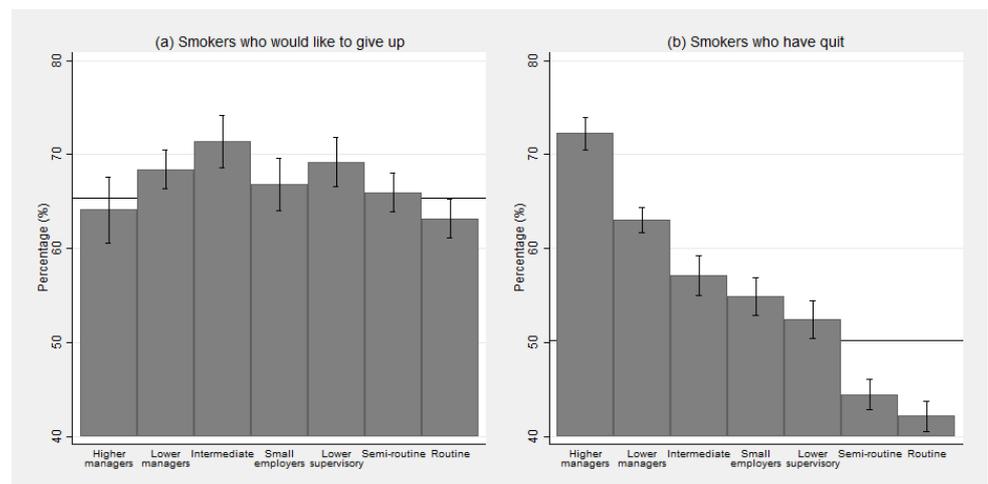
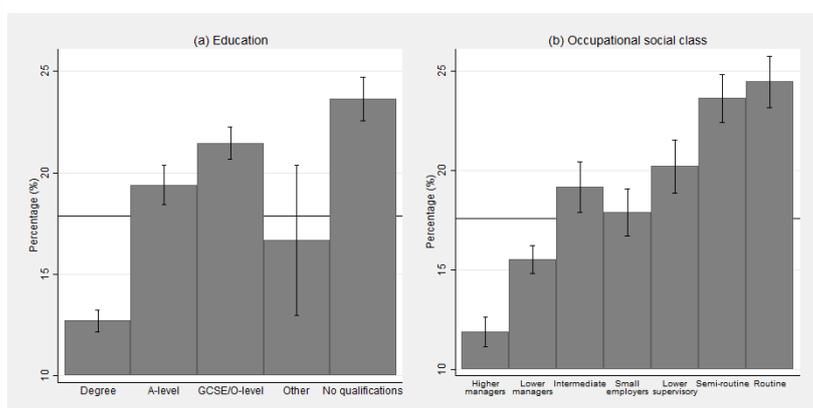
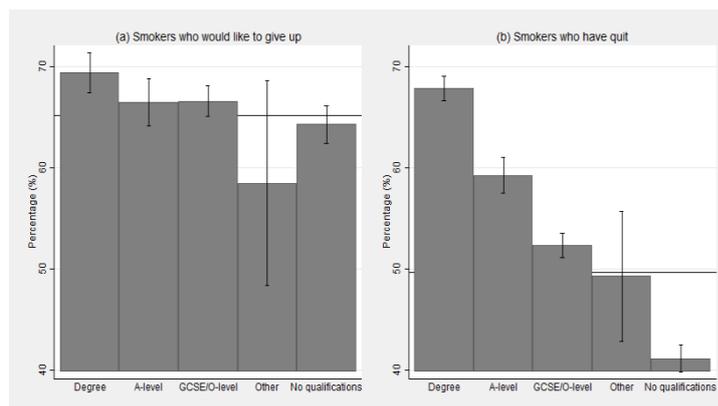


Figure 7: Wanting to give up does not vary clearly by education, but there is an education gradient in stopping smoking, 2008-2013 Sources: *Health Survey for England, Welsh Health Survey, Scottish Health Survey*

The proportion of smokers who reported wanting to stop smoking did not vary clearly by education. There is an educational gradient in the proportion of smokers who have stopped smoking, which was highest for those with degree-level qualifications and lowest for those with no qualifications.

Figures 6 and 7 suggest that while wanting to stop smoking does not vary systematically by either occupational social class or education, actually stopping smoking follows a clear and consistent social gradient. This suggests that more advantaged groups are more successful at stopping smoking.



How many people are exposed to passive smoke?

Figure 8: Exposure to passive smoke in Britain follows a social gradient, 2008-2013, Sources: *Health Survey for England, Welsh Health Survey, Scottish Health Survey*

The negative health consequences of smoking are not confined only to smokers; exposure to passive smoke is also a public health concern^{vii}. Passive smoking was measured as the proportion of respondents who did not smoke themselves but reported being exposed to

others' smoke. Slightly different questions are asked in England, Wales, and Scotland, so this has been adjusted in analysis. Exposure to passive smoke varies by education, and is lowest among people with degree-level qualifications and highest among those with no qualifications. Exposure to passive smoke also follows a social class gradient, and is lowest among managerial employees and highest among semi-routine and routine employees.

What can we conclude?

The declining rates of smoking over the past 40 years are highly encouraging, as is evidence that heavy smoking is also reducing over time. Since 2003 over half of respondents reported never smoking, suggesting large changes in social norms surrounding smoking. These changes have however slowed in recent years, and changed little following bans on smoking in public places, although rates of never smoking continue to increase. What is more worrying is the persistent social gradient in smoking. Smoking is three times as prevalent in people with no qualifications as degree-level qualifications, and in people living in households headed by a routine employee compared with a higher managerial employee. People with lower qualifications and lower social class are also more likely to be strongly addicted to smoking and to report exposure to passive smoke, and less likely to have stopped smoking. There is clearly work to be done both in discouraging these groups from starting smoking, and in supporting existing smokers to stop smoking.

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ⁱ <http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf> [accessed 04/12/2015]

ⁱⁱ Doll R., Peto, R., Boreham, J. & Sutherland I. (2004) Mortality in relation to smoking: 50 years' observations on male British doctors. *BMJ*; 328: 1519. Available at <http://www.bmj.com/content/328/7455/1519> [accessed 07/12/2015]

ⁱⁱⁱ http://ash.org.uk/files/documents/ASH_107.pdf [accessed 04/12/2015]

^{iv} <http://bma.org.uk/working-for-change/improving-and-protecting-health/tobacco/smoking-statistics> [accessed 04/12/2015]

^v http://ash.org.uk/files/documents/ASH_116.pdf [accessed 04/12/2015]

^{vi} <http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf> [accessed 04/12/2015]

^{vii} Jamrozik, K. (2005) Estimate of deaths attributable to passive smoking among UK adults: Database analysis. *BMJ*; 330: 812. Available at <http://www.bmj.com/content/330/7495/812> [accessed 07/12/2015]