Equality Impact Assessment

Towards a Smokefree Generation

Kent Tobacco Control Strategy 2010-2014

Name of Policy or Service	"Towards a Smokefree Generation" Kent Tobacco Control Strategy 2010-2014
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Equality Impact Assessment

Why this is important?

1. All individuals and population groups should have equal opportunity to benefit from Department of Health policy. But inequalities in health between different ethnic groups and between men and women are well documented and long-standing. We cannot simply assume that health policy will be equally beneficial for everyone. A professional approach to policy-making means testing our assumptions. By assessing potential effects of a policy on particular populations in a rigorous way, we can increase the probability that a policy will promote equity of outcomes.

2. Equality impact assessment is also a legal requirement. Public bodies have for many years been required not to discriminate in the delivery of their services or in employment on grounds of gender and race. Since 2002, public authorities have been required to assess and monitor the impact of all relevant policies on race equality. A similar duty came into force in December 2006 to assess the impact of policies on disabled people under The Disability Discrimination Act 2005. The Equality Act 2006 imposed a duty to promote equality between women and men from April 2007. Another part of the Equality Act will prohibit discrimination in service delivery on the basis of religion or belief and sexual orientation. We must also pay due regard to underpinning human rights issues.

3. If policies are assessed for their impact on different sections of the population from the outset, we are better placed to meet our legal obligations. More importantly, we are more likely to produce better policy that will benefit everyone in the population.

Introduction

4. Smoking is by far the biggest cause of preventable death and the significant contributor to the gap in health and life expectancy between the richest and the poorest. Smoking kills one-in-two of all lifelong users. There is a strong social gradient to smoking, with lower socio-economic classes being much more likely to smoke at higher rates within their community and being much more likely to smoke more individually, start smoking at an earlier age and smoke for longer. Smokers are also likely to be over-represented within certain vulnerable and minority groups. Health inequalities and differences in life expectancy between one community and another are central issues for comprehensive tobacco control.

5. *Towards A Smokefree Generation*, a new comprehensive tobacco control strategic framework for Kent, describes a raft of measures, which if implemented by local partners can deliver a vision of a smokefree future, free from the harms of tobacco use.

6. The measures and aspirations described in the strategy will have particular significance and impact on certain communities and disadvantaged, vulnerable and minority groups. This Equality Impact Assessment (EIA) examines the impact of this tobacco control strategy on particular groups who may be subject to discrimination on the grounds of race, age, gender, religion, sexual orientation or disability. This assessment also presents the possible impacts of proposed policies and ways to mitigate inequalities for particular groups. Wherever possible, the assessment is supported by evidence. This EIA also highlights areas where there continues to be gaps in the evidence base and where further research might usefully be commissioned. *This EIA will therefore serve as a reference point for Kent partners, for when they take forward their own plans for developing local tobacco control action.*

7. Narrowing health inequalities is a top priority for Kent partners. This strategy aims to narrow the gap in health outcomes across geographical areas, across socio-economic groups, between males and females, across different minority ethnic groups and age groups. Reducing smoking rates in disadvantaged groups and areas is a key factor in reducing the health inequalities gap.

Background to Strategy

8. Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and coordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

9. This strategy enables Kent partners to acknowledge the importance of supporting a comprehensive approach to tobacco control; for their own organisation and the communities that they serve, by incorporating tobacco control measures into their strategic plans and commissioning intentions.

Summary of Research and Issues

Health Inequalities & Social Economic Disadvantage

Issues

10. Tobacco use exhibits a strong social gradient. Historically higher socio-economic groups have reacted to the evidence on the harms from tobacco use by quitting smoking in ever greater numbers. However, the decline in smoking rates has been much slower for lower socio-economic classes.

11. Arguably, any tobacco control strategy is likely to result in a bigger decline for higher socioeconomic classes than for lower socio-economic classes, unless specific measures are taken to guard against this widening of the health inequalities gap by specifically targeting and influencing disadvantaged, vulnerable and minority groups with high rates of smoking.

12. Even with appropriate policies developed to guard against increasing health inequalities, it is likely that the effect of any tobacco control measures on higher socio-economic classes will be just as great as increasingly smoking is not seen as an acceptable habit

13. Other lifestyle diseases and unhealthy behaviours, such as alcohol abuse and drug misuse, very often accompany high rates of smoking within disadvantaged areas. It is clear that we cannot tackle the problem of health inequalities caused by smoking in isolation.

14. Some disadvantaged groups, such as prisoners, smoke at very high rates (70%+). Currently smokefree legislation describes exemptions for prisons, meaning prison wardens and other non-smoking prisoners are exposed to dangerous secondhand smoke.

Policies and impacts

15. The focus on reducing health inequalities in Spearhead areas has, to date, ignored pockets of deprivation and high smoking rates in otherwise wealthy (non-Spearhead) areas. The 2010 Public Sector Agreements for smoking targeted smoking rates within the general adult population and within routine and manual workers. The use of 'routine and manual workers' as a proxy for disadvantage in order to target health inequalities is not perfect – there are considerable differences in income within the routine and manual group. However, it does target high rates of smoking as despite routine and manual workers representing just one third of the adult population, they represent over half of all smokers. Also, by targeting routine and manual smokers, we are able to pick up on high smoking rates within non-spearhead areas. (N.B. There are no Spearhead areas within Kent).

16. To implement the Kent tobacco control strategy and most accurately target health inequalities attributable to smoking, we propose to combine an occupational measure (routine and manual) of smoking with a geographical measure. The details of this have yet to be finalised and its construction will be reliant on the accuracy and availability of ward-level data. One of the proposals in the strategy is to work with local delivery colleagues and the Kent and Medway Public Health Observatory to develop an adequate and robust geographical indicator to target health inequalities attributable to smoking.

17. This strategy, does not commit partners to a specific quantifiable aspiration for reducing smoking rates within disadvantaged local areas, as this will largely depend on the future national and local health inequalities strategy post the 2010 PSAs.

18. The Government will also be taking specific action to make available appropriate and accessible support to particular disadvantaged communities and groups, such as prisoners. We will also be working with local community leaders and local authorities to promote smokefree environments.

Race

Issues

19. Smoking rates vary considerably between ethnic groups and also between men and women within those groups.

20. There is evidence to show that some communities have higher smoking rates compared with the general population. For example, some black and minority ethnic (BME) groups have higher smoking rates than the general population. The national statistics reveal high prevalence rates among Bangladeshi men at 40%, Irish men at 30%, Black Caribbean men at 35% and Pakistani men at 29%. Among women, around 5% of Bangladeshi women smoke, compared with 25% of Irish women[1].

21. The evidence behind why some ethnicities have higher smoking prevalence than others is wide ranging and can be due to any number of social or cultural factors.

[1] NHS Information Centre. *Health Survey for England 2004*: Health of Ethnic Minorities. Available from: www.ic.nhs.uk

22. For example, there is some evidence around tobacco use amongst Bangladeshi and Pakistani men and this seems to be heavily linked to gender, age, religion, and tradition. Smoking is a widely accepted practice in Pakistan and in Bangladesh smoking for men is associated with socialising, sharing, and male identity. Smoking prevalence is lower for Pakistani and Bangladeshi women as it seems to be associated with stigma and shame[2].

23. Smoking rates are higher amongst lower socio-economic groups. Some BME groups experience higher levels of deprivation and their smoking rates may therefore be linked to disadvantage rather than, or in addition to, race and culture. Tobacco control policies will be developed and implemented in a way that addresses the inter-relationship between race, smoking and disadvantage[3].

24. There is some evidence to suggest religion can influence smoking behaviour. For example, smoking prevalence is high among Muslim communities globally[4]. However, a number of other factors including culture, traditions, attitude, family environment and socio economic status are likely to be more important.

25. Smokeless tobacco comes in many different forms around the world. We know that the use of such products is inconsistent across communities and age groups but emerging evidence is highlighting products are mainly imported from South Asia, and in England pockets of high prevalence have been identified amongst Bangladeshi, Indian and Pakistani populations. In contrast to the gender divide for smoking, a high prevalence of use has been observed among Bangladeshi women[5].

26. Smokeless tobacco of the types used by South Asian groups in the UK have been shown to cause oral cancers. Anecdotal evidence suggests that it is the older generation who are much more likely to use smokeless tobacco such as paan and zarda (chaat). Smokeless tobacco is largely unregulated and is sold in many different types of shops. It does not carry the same health warnings as smoked tobacco.

Policies and impacts

27. The Government currently funds pilots in two regions to evaluate smoking cessation interventions for BME communities, looking at shisha smoking and smokeless tobacco.

28. The deliver the strategic aim of reducing health inequalities within the strategy, it is assumed that local partner action will target specific action in minority and disadvantaged communities to tackle high smoking rates:

    a) improving the accuracy of local smoking prevalence data to identify those groups with high smoking rates, and work with Local Stop Smoking Services to develop best practice in reaching out to and supporting quit attempts within minority and ethnic groups with high smoking rates;

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[2] Bush J et al. Understand influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study. *British Medical Journal*. [Online]. 2003;326(7396):962. Available from: doi: 10.1136/bmj.326.7396.962

[3] Erens B (eds.) et al. Department of Health. *The Health of Minority Ethnic Groups, Health Survey for England 1999*. The Stationary Office Ltd. London. 2001

[4] Ghouri N et al. Influence of Islam on Smoking among Muslims. *British Medical Journal.* [Online]. 2006; 332: pp.291-294. Available from: doi:10.1136/bmj.332.7536.291

[5] McNeill A. Smokeless tobacco in the UK: products, populations and policy, Results of a Cancer Research UK funded project. *Conference presentation.* ASH Wales, Cardiff, October 2009

b) creating integrated public health care packages, tailored to the individual and supporting a wide range of health improvement interventions to improve general health and well being and to empower communities to take action against tobacco related harm to their communities;

c) recruiting well-known and trusted community leaders to help promote NHS Stop Smoking Services in minority and disadvantaged communities;

d) developing a communication strategy and cessation interventions for smokeless tobacco users where required.

Age

Issues

29. Smoking affects people of all ages, both directly and indirectly, through passive smoking. As such, the policies to address the issues here are wide ranging. Prevalence of smoking is strongly related to age.

30. Adult smoking rates have declined from 28% in 1998 to 21% in 2007 yet evidence shows that over a fifth of the adult population or 8.5 million people in England smoke today[6] and, in 2007, over 80,000 people died from a smoking related disease[7], the majority in middle age[8].

31. The highest rates of smoking are in the 20-24 age-group (32%) and the 25-34 age group (26%). The prevalence of smoking then declines with those over the age of 60 reporting the lowest prevalence[9].

32. Life-long smokers lose on average 10 years of life; whatever age a smoker quits they will see some benefit in terms of life years saved, though this benefit diminishes with age. However, pre-operative smoking cessation can bring about great benefits at any age in terms of reduced recovery time and bed-days. Within 8 hours of quitting, the chance of having a heart attack greatly diminishes and progressive conditions such a chronic obstructive pulmonary disease can be better controlled. This all supports the use of policies aimed at driving down prevalence of smoking among the older population.

33. Smoking in adults also perpetuates smoking uptake in youth as studies have shown that 16-17 year olds have a perception that 50% of adults smoke when this is far from the truth[10].

34. Quit attempts are relatively consistent across age groups but with younger people making more quit attempts. Though older people make fewer attempts they have a higher rate of success in stopping smoking[11]. Smokers over the age of 60 who set a quit date with the NHS Stop Smoking Services are more likely to be successful than any other age groups in quitting successfully with the support of these cessation services. In particular, the over-60 population are the most successful at

[6] Office for National Statistics. *General Household Survey 2007, Smoking and drinking among adults 2007*. Newport. 2007

[7] The NHS Information Centre. *Statistics on Smoking, England, 2009*. Health and Social Care Information Centre, United Kingdom. 2009

[8] Peto R. The hazards of smoking and the benefits of stopping: Cancer Mortality and overall mortality. *International Agency for Research on Cancer Handbooks on Cancer Prevention*. 2007;11:pp. 15-27

[9] The Information Centre for health and social care. *Statistics on Smoking, England, 2009*. United Kingdom. 2009

[10] West R. Smoking in England. The Smoking Toolkit Study. [Online]. Available from: http://www.smokinginengland.info/. Accessed 28 October 2009

[11] West R. Smoking in England. The Smoking Toolkit Study. [Online]. Available from: http://www.smokinginengland.info/. Accessed 28 October 2009

going smokefree[12]. Smokers on average have to make multiple quit attempts before they can remain quit.

35. Nationally, smoking prevalence among 11-15 year olds is down from 13% in 1996 to 6% in 2007. However, every year 250,000 people take-up smoking and of these 200,000 are below the age of 19. Approximately 100,000 16 year olds smoke or 17% of the total number of 16 years olds[13]. Children below the age of 14 are usually anti-smoking – the challenge for tobacco control policies is not behavioural change but behavioural maintenance.

36. A range of inter-related factors operating at the individual, family, social, community and societal levels influence whether a young person starts and continues to smoke. These include: growing up in an environment where smoking is the norm among family and friends, having positive beliefs about the benefits of smoking for example in terms of their image and mood control, having access to cigarettes, discounting health risks, and having disadvantaged social, educational and economic circumstances.

37. People who start smoking at an early age are more likely than other smokers to smoke for a long period of time and more likely to die prematurely from a smoking-related disease.

38. To prevent take-up of smoking previous government measures focused on reducing the appeal and supply of tobacco to young people through a combination of mass media and legislation such as raising the age of sale of cigarettes to 18, banning tobacco advertising and including picture warnings on tobacco packs.

39. Young people are more likely than adults to buy tobacco from vending machines and from friends. Under current rules, a retailer can be fined and prevented from selling tobacco if they are caught selling it to under-18s on three separate occasions.

Policies and impacts

40. Renewed focus by the NHS on smoking cessation in Secondary Care will bring about a reduction in bed-days and is likely to benefit older people more.

41. Increasing referrals through the health and social service should benefit all age groups. However, specific local prioritisation of resources can be used to target particular age groups as characterised by the service user. Prioritisation of smoking cessation resource will be informed by local commissioning plans.

42. Primary Care Health Professionals will be encouraged to promote smoking cessation interventions for all age groups, and outline the benefits of quitting at any age.

43. In 2010, the Department of Health will develop a new national marketing strategy for the period 2011-15. This will include a focus on young people to prevent uptake.

[12] The Information Centre for health and social care. *Statistics on NHS Stop Smoking Services in England, April to December 2007*. London. 2008

[13] West R, Smoking Prevalence Pipe Model, The Smoking Toolkit Study. [Online]. Available from: http://www.smokinginengland.info/. Accessed 28 October 2009

44. Young people are particularly price sensitive[14]: to reduce the affordability of tobacco, the Government will seek to maintain downward pressure on the illicit market and consider real increases in duty on a Budget-by-Budget basis.

45. To take action on the attractiveness of tobacco products, the Government will also consider the evidence for introducing plain packaging. To reduce exposure to tobacco the government has introduced a ban (from 2013) on the display of all tobacco products.

46. To restrict the availability of tobacco to young people, the government has introduced measures to ban the sale of tobacco from vending machines.

47. Promoting the voluntary adoption of smokefree environments in the home and in the private car, can have the potential benefit of protecting millions of children from the harms of secondhand smoke (SHS) and averting thousands of related hospital admissions. Cotinine testing in children in the Health Survey for England shows a constant decline in exposure to SHS over the past decade.

48. The national aspiration to reduce smoking rates in 11-15 year olds to 1% by 2020, is ambitious but achievable if adult smoking rates also fall significantly. However, it is likely that when we reach very low rates of smoking (1-2%), we will encounter other issues and lifestyle diseases one can expect to find clustered in disadvantaged areas. Therefore in order to achieve this aspiration, we will need to take a holistic approach to tackling health inequalities.

49. Smoking has a high impact on the mortality and morbidity of older people, but they are more likely to be successful in stopping smoking than are younger people. The evidence that much of the harm from smoking can be halted or even reversed challenges the view that is commonly held by older smokers that the damage has been done and is irreparable. Referrals of older people through NHS Stop Smoking Services will be encouraged.

Gender

<u>Issues</u>

50. In 1980, men were reported to smoke at a higher percentage at 42% than women at 36%. Today the statistics are still showing men at a higher rate though it has decreased considerably. Men are still more likely to smoke at 22% than women at 19%[15]. This disparity in attitudes to smoking and quitting between men and women is due to a number of factors, with women being more likely to access specialist support to quit.

51. Pregnant women from lower socio-economic groups are nearly twice as likely as pregnant women from higher socio-economic groups to smoke throughout pregnancy.

52. Among children aged 11-15 years, girls are two and a half times more likely to be regular smokers[16] but boys catch up with girls around ages 16-19[17].

53. There is limited understanding as to why there are gender differences in youth smoking. There are a wide range of factors that influence smoking uptake in youth

[14] Hopkins D et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. American Journal of Preventive Medicine. 2001;20: (2S): pp. 16-66

[15] The Information Centre for health and social care. *Statistics on Smoking, England, 2009.* United Kingdom. 2009

[16] The Information Centre for health and social care. *Statistics on Smoking, England, 2009.* United Kingdom. 2009

[17] Office for National Statistics. *General Household Survey 2007, Smoking and drinking among adults 2007*. Newport. 2007

such as: their attitudes, beliefs, self-esteem, risk taking age, educational attainment, personal environment e.g. family and friends, school, and the wider social cultural environment such as social norms and access to cigarettes. However, for the most part research on gender differences presents an unclear picture[18].

54. To date there has not been a huge amount of focus looking at gender in regards to smoking although mass media campaigns have used gender characteristics in marketing to help reduce smoking. An example of this is in anti-smoking advertising to show smoking as a habit that makes you unattractive, stains teeth and makes you smell unpleasant.

Sexual Orientation

55. There is some evidence showing minority groups such as lesbians, gays, bisexuals and transsexuals (LGBT) smoke at higher rates than the general population. The reasons behind this are not well known yet but there are suggestions that gay and lesbian social spaces (such as bars), violence, stress, and discrimination, as well as barriers to healthcare access and treatment services, contribute to the higher rates of smoking[19].

56. Related studies have shown also that smoking prevalence is also uncommonly high among gay men and women who are HIV positive and that quitting can help control their condition.

Policies and impacts

57. This strategy aims for all policies to have an overall positive effect in reducing gender differences in smoking. It is not anticipated that any of the policies will increase gender differences in smoking, as there is a strong evidence base for most policies promoted in this strategy.

58. A significant element of this strategy to protect young people, families and communities involves smoking cessation interventions aimed at pregnant women and young families, to protect both the woman and child from the harms of tobacco and secondhand smoke.

Disability

Issues

59. Whilst smoking rates amongst adults with disabilities varies, smoking rates are higher amongst those with mental health problems than the general population[20]. Sufferers of psychiatric disorders have a deep dependence on tobacco[21] and they are likely to be heavier, more dependent smokers and have smoked longer than smokers in general population[22].

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[18] Amos A et al. Young people, smoking and gender – a qualitative exploration. *Oxford Journals*. [Online]. 2006;22(6): pp.770-781. Available from: doi: 10.1093/her/cy1075

[19] Lee J G et al. Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tobacco Control*. [Online]. 2009;18: pp. 275-282. Available from: doi:10.1136/tc.2008.028241

[20] Lasser K et al. Smoking and mental illness: A population-based prevalence study. *JAMA*. [Online]. 2000;284(20): pp.2606-2610. Available from: http://jama.ama-assn.org/cgi/content/abstract/284/20/2606

[21] Farrell M et al. Nicotine, alcohol and drug dependence and psychiatric comorbidity, Results of a national household survey. *British Journal of Psychiatry*. [Online]. 2001; 179: pp.432-437. Available from: http://bjp.rcpsych.org/cgi/content/full/179/5/432

[22] Office for National Statistics. *General Household Survey 2007, Smoking and drinking among adults 2007*. Newport. 2007

60. Although from 2008, all mental health units were required by law to be smokefree, psychiatric in-patient settings seem to have the highest level of smoking, with up to 70% of patients being smokers, of which 50% are heavy smokers[23]. The extremity of these statistics has led to higher mortality rates for those with mental illness for example those with schizophrenia have a higher death rate from respiratory disease then the average person[24].

61. Successful quit rates for people with mental health problems are low. This is due to the level of dependence, but also cultural factors such as staff and patients believing nicotine helps patients to cope with the symptoms of their illness or with the side effects of medication[25].

62. There is a lack of treatment and support for smokers to manage their nicotine dependence in mental health settings[26]. Studies have also shown that staff working in mental health institutions lack knowledge about tobacco dependence and its treatment[27].

Policies and impacts

63. The evidence base on mental disabilities and smoking is strong and for some time, there have been policies in place, which have tried to address the considerable issues here. Although there has been difficulty assessing what the best type of intervention is for people with mental health problems, there has been a realisation that interventions for the general population can also work for those with mental illness. For example, pharmacotherapy and other support like counselling seem to increase abstinence rates of smoking in those with mental health problems similar to the general population[28].

64. As such, this strategy aims to go a step further and provide guidance to help cessation services embed their services and tailor plans to achieve long-term cessation, in high prevalence health and social care settings such as prisons and mental health services.

Human Rights

65. This strategy does not breach any human rights as set out in the Human Rights Act 1998.

66. Many of the current and proposed national tobacco control measures involve legislation and work at European Union level to prove the greater public health good versus intellectual property and competition rights of private business. This is the case for the ban on the advertising and sponsorship of tobacco and a similar legal case must be made if the Government were to pursue plain packaging and put public health benefits before the intellectual property rights of the tobacco industry.

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[23] Jochelson J, Majrowski B. *Clearing the air: Debating smoke-free policies in psychiatric units.* United Kingdom. Kings Fund; 2006

[24] Joukamaa M et al. Mental disorders and cause-specific mortality. *British Journal of Psychiatry*. [Online]. 2001;179: pp.498-502. Available from: http://bjp.rcpsych.org/cgi/content/abstract/179/6/498

[25] Jochelson J, Majrowski B. *Clearing the air: Debating smoke-free policies in psychiatric units.* United Kingdom. Kings Fund; 2006

[26] Ratschen E, Britton J, Doody GA, McNeill A. Smoke free policy in acute mental health wards: managing the pitfalls. General Hospital Psychiatry 2009a; 131-

[27] Ratschen E, Britton J, Doody GA, Leonardi-Bee J, McNeill A. Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. General Hospital Psychiatry 2009b; 31(6):576-82

[28] Department of Health. *NHS Stop Smoking Services, Service and monitoring guidance 2009/10*. London. 2009

67. When the Government reviews the current retailer scheme for tobacco, there will also be an opportunity to examine the existing powers of the police for confiscation of tobacco from minors (under the 1933 Children and Young People Act) and current sanctions on the supply of tobacco to young people. If required, we will seek to bolster these powers to protect the rights of children to the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life.

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