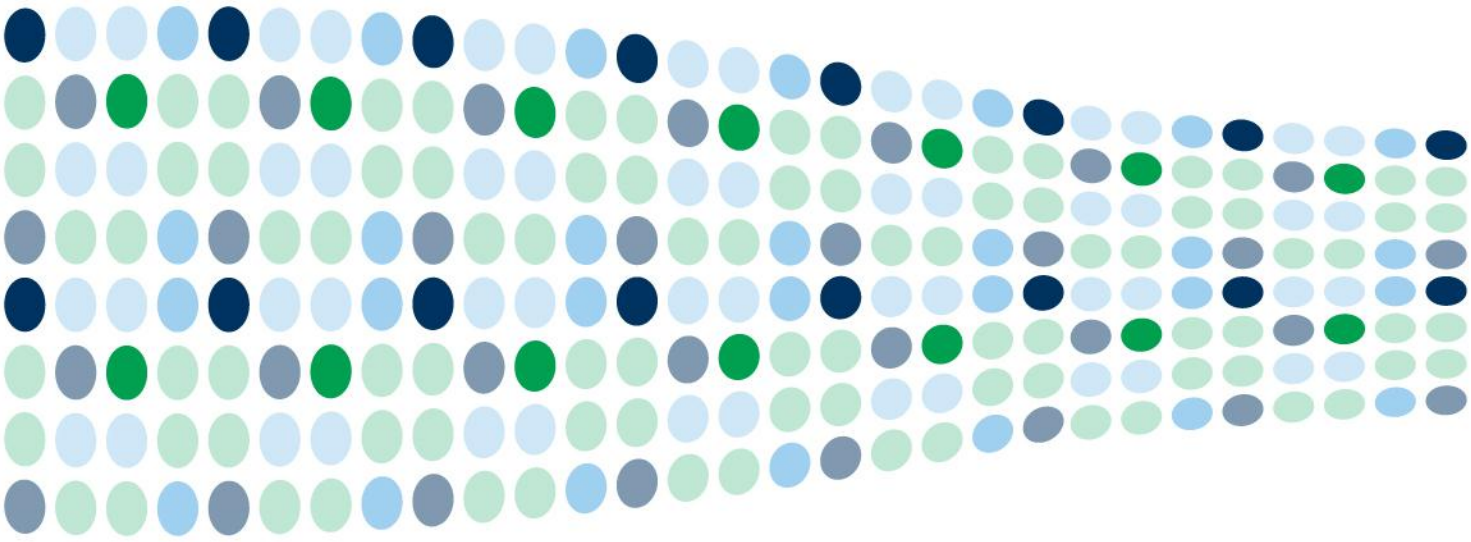
hscic Health & Social Care Information Centre

Statistics on Smoking

England 2014



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This report may be of interest to members of the public, policy officials and other stakeholders to make local and national comparisons and to monitor the quality and effectiveness of services.

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Contents

This is a National Statistics publication

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods; and
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Executive Summary

This is the ninth annual statistical compendium report which presents a range of information on smoking among adults and children including prevalence, habits, attitudes, NHS costs and the effect on health in terms of hospital admissions and deaths from smoking related illnesses. This information has been drawn together from a variety of sources.

It contains data and information previously published by the Health and Social Care Information Centre, Department of Health, the Office for National Statistics and Her Majesty's Revenue and Customs. The report also includes new analyses carried out by the Health and Social Care Information Centre.

The report is primarily concerned with cigarette smoking unless otherwise specified. These data relate to England where possible. Where figures for England are not available, figures for England and Wales, Great Britain or United Kingdom have been used.

Some changes are planned for the 2015 edition of this report and feedback is welcome on these proposals. More details are available in chapter 1.

Main findings

Smoking among adults and children

The main source of data for smoking prevalence among adults is the Opinions and Lifestyle, Smoking Habits Amongst Adults Survey 2012 carried out by the Office for National Statistics. The main source of data for smoking prevalence among children is the Smoking, Drinking and Drug Use among Young People Survey 2012.

- One in five adults (20 per cent) aged 16 and over were smokers in 2012, a rate that has remained largely unchanged in recent years, compared to just over one in four (26 per cent) a decade earlier in 2002.Unemployed people (39 per cent) (not working but seeking work) were around twice as likely to smoke as those either in employment (21 per cent) or economically inactive (17 per cent) (for example, students or retired people).
- Amongst 11 to 15 year olds in 2013, less than a quarter of pupils reported that they had tried smoking at least once. At 22 per cent, this is the lowest level recorded since the data were first collected in 1982, and continues the decline since 2003, when 42 per cent of pupils had tried smoking.

Availability and affordability of tobacco

- The price of tobacco has increased by 80.2 per cent over the last ten years from 2003 to 2013, making it 22.1 per cent less affordable.

Prescribing costs

- The number of prescriptions dispensed in England to help people stop smoking in 2013/14 was 1.8 million, compared to 1.6 million ten years earlier in 2003/4.
- In 2013/14 the Net Ingredient Cost[a] (NIC) of all prescription items used to help people quit smoking was nearly £48.8 million. This is a decrease of 16 per cent on the £58.1 million spent in 2012/13 and 26 per cent less than 2010/11 when NIC of all prescription items peaked at £65.9 million.

Hospital admissions in England in 2012/13 among adults aged 35 and over

- In 2012/13 there were approximately 1.6 million admissions for adults aged 35 and over with a primary diagnosis of a disease that can be caused by smoking. This is approximately 4,400 admissions per day on average. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was approximately 1.1 million.
- Around 460,900 hospital admissions were estimated to be attributable to smoking. This accounts for 4 per cent of all hospital admissions in this age group (35 years and over). It compares to 559,800 admissions in 2004/05 which is a decrease of 18 per cent.
- The proportion of admissions attributable to smoking as a percentage of all admissions was greater amongst men (6 per cent) than women (3 per cent).

Deaths in England in 2013 among adults aged 35 and over

- In 2013, 17 per cent (79,700) of all deaths of adults aged 35 and over were estimated to be caused by smoking. This proportion is unchanged from 2005.

1 Introduction

This is an annual statistical compendium report which presents a range of information on smoking among adults and children including prevalence, habits, attitudes, NHS costs and the effect on health in terms of hospital admissions and deaths from smoking related illnesses. This information has been drawn together from a variety of sources. The report is primarily concerned with cigarette smoking unless otherwise specified. The data relate to England where possible. Where figures for England are not available, figures for England and Wales, Great Britain or United Kingdom have been used.

Some changes have been made to this year's report and some more are planned for next year. We welcome comments from users on these specific changes plus any other comments users may have. The changes are:

- The General Lifestyle Survey which was conducted by the Office for national Statistics (ONS) and was a source for many of the tables in chapter 2 has been discontinued. Some of the questions were transferred to the Opinions and Lifestyle survey, which is also conducted by ONS, so some of the tables have been reproduced in chapter 2. However, in order to minimise the amount of additional analysis required before this report can be published and therefore publish as early as possible, data is presented at Great Britain (GB) level rather than England level. As the most of the respondents to the survey will be from England then the GB level figures represent a very good proxy for the England level results. We intend to continue this approach for future editions of this report and would welcome feedback from users.
- A large number of the tables in the report are lifted directly from other publications. For the 2015 report, we intend to stop this approach and instead refer to tables in other publications. However, we will continue to pull out the main findings from these other publications within this report in the commentary, and we will continue to produce tables which are underpinning charts in this report. Again we would welcome feedback from users.
- Data from other publications is currently spread across different chapters. The content of the report will be restructured for the 2015 report to ensure results from a specific data source are all together.
- The timing of the report will be reconsidered to maximise the timeliness of the other data sources. For example, this report is published in October just a few months before new results are available from the Health Survey for England and the Opinions and Lifestyle Survey.

Please send any comments to enquiries@hscic.gov.uk and including "Statistics on Smoking" in the subject heading.

A brief explanation and a short review of the quality of each of the sets of statistics used in this publication have been included in Appendix A of this publication.

Chapter 2 presents a range of information on cigarette smoking patterns in adults and children. Smoking prevalence, consumption and trends among different groups of society and geographical areas are explored. Information is also presented on tobacco expenditure and availability.

Chapter 3 reports on behaviour and attitudes to smoking in adults, including awareness of health risks associated with smoking and attitudes to the introduction of smoke-free legislation. Children's attitudes and smoking behaviour are also reported.

Chapter 4 looks at the health risks associated with smoking. Information on prescription drugs used to help people stop smoking and the costs of NHS Stop Smoking Services are presented. Information on the number of hospital admissions and the numbers of deaths that are attributable to smoking are also reported.

Throughout the report references are given to sources for further information.

Smoking definitions

Smoking definitions adopted by the main sources used in this report differ in some cases, especially between adults and children. Key definitions that differ between sources are highlighted below and clarified in the relevant section of the report.

Definitions for adult smoking behaviours

Current smoker: Adults who said that they do smoke cigarettes nowadays are classed as current smokers in the surveys used in this report.

Ex-smoker: Adults who said that they used to smoke cigarettes regularly but no longer do so are defined as ex-smokers (or ex-regular smokers).

The definitions for adults who are non-smokers, heavy or light smokers vary in the different surveys. Further information is provided in the relevant sections.

Definitions for child smoking behaviours

Regular smoker: is defined as a child who smokes at least one cigarette a week.

Occasional smoker: Those children who said they smoke less than one cigarette per week are defined as occasional smokers.

Current smoker: These include those who are regular and occasional smokers.

Sources of further reading on all classifications of smoking are listed in Appendix A of this report.

2 Smoking patterns in adults and children

Key findings

One in five adults (20 per cent) aged 16 and over were smokers in 2012, a rate that has remained largely unchanged in recent years, compared to just over one in four (26 per cent) a decade earlier in 2002.

Unemployed people (39 per cent) (not working but seeking work) were around twice as likely to smoke as those either in employment (21 per cent) or economically inactive (17 per cent) (for example, students or retired people). 12.0 per cent of mothers were recorded as smokers at the time of delivery for 2013-14, which is lower than 2012-13 (12.7 per cent) and continues the steady year-on-year decline in the percentage of women smoking at the time of delivery from 15.1 per cent in 2006-07.

Amongst 11 to 15 year olds in 2013, less than a quarter of pupils reported that they had tried smoking at least once. At 22 per cent, this is the lowest level recorded since the data were first collected in 1982, and continues the decline since 2003, when 42 per cent of pupils had tried smoking.

Regular smokers aged 11 to 15 years consumed, on average (mean), 31.1 cigarettes a week. Occasional smokers consumed 3.4 cigarettes a week in 2013.

Between1996 and 2013, releases of hand-rolling tobacco have increased by 179 per cent. This reflects the increase in the proportion of adults who smoke hand-rolled cigarettes.

In the United Kingdom in 2012 the average weekly household expenditure on cigarettes was £4.00.

The price of tobacco has increased by 80.2 per cent over the last ten years from 2003 to 2013, making it 22.1 per cent less affordable.

Between 2003 and 2013 the price of tobacco increased by 30.7 per cent relative to retail prices.

UK household expenditure on tobacco at current prices has nearly quadrupled from £4.8 billion in 1980 to £18.9 billion in 2013.

It is estimated that there are 2.1 million adults who are current users of electronic

2.1 Introduction

This chapter presents a range of information on cigarette smoking patterns in adults and children. Smoking prevalence, consumption and trends among different groups of society and geographical areas are explored. Information is also presented on tobacco expenditure and availability.

The main source of data for smoking prevalence among adults is the Opinions and Lifestyle, Smoking Habits Amongst Adults Survey (OPN) carried out by the Office for National Statistics. This is a national survey covering adults aged 16 and over living in private households in Great Britain. Each year questions are asked about adults' smoking habits. The latest OPN 2012 report is based on the survey which ran from January to December

2012. It replaced the General Lifestyle Survey (GLF) which used to be the source for several of the tables in this chapter.

The main source of data for smoking prevalence among children is the Smoking, Drinking and Drug Use among Young People survey (SDD). This is an annual survey of secondary school pupils in years 7 to 11 (mostly aged 11 to 15) published by the Health and Social Care Information Centre. The survey includes a core section of questions on smoking, drinking and drug use. From 2000, the remainder of the questionnaire has focused in alternate years on either; smoking and drinking, or on drug use. In 2013 the focus was on drug use, therefore the latest survey to focus on smoking and drinking was *Smoking, drinking and drug use among young people in England in 2012*[8] (SDD12) which summarised results from 7,589 pupils in 254 schools throughout England in the autumn term of 2012.

Information is also summarised from the Health Survey for England (HSE) which is part of a programme of surveys and has been carried out, since 1994, by NatCen and the Department of Epidemiology and Public Health at the University College London (UCL) Medical School. The surveys are designed to measure health and health-related behaviours in adults and children in England. Smoking, general health, drinking, fruit and vegetable consumption, height, weight, blood pressure and blood and saliva samples are core elements of the survey included every year. The latest report *Health Survey for England - 2012*[2] with associated trend tables[2] was published in December 2013.

The availability of tobacco is extracted from Her Majesty's Revenue and Customs (HMRC) Statistical Bulletins[9] and shown as the volume of tobacco released for home consumption.

The affordability of tobacco is described using information on tobacco price and retail price indices taken from the ONS publication: *Focus on Consumer Price Indices*[11] and households' disposable income data published by ONS in the *Economic and Labour Market Review*, formerly *Economic Trends*[12].

Data on tobacco expenditure and household expenditure are taken from two sources: ONS *Consumer Trends*[13] which gives annual figures for UK household expenditure on tobacco and total household expenditure, and the Living Costs and Food Survey[16] (LCF) a part of the Integrated Household Survey (IHS) managed by ONS and used to provide information for the Consumer Prices Index and the Retail Prices Index.

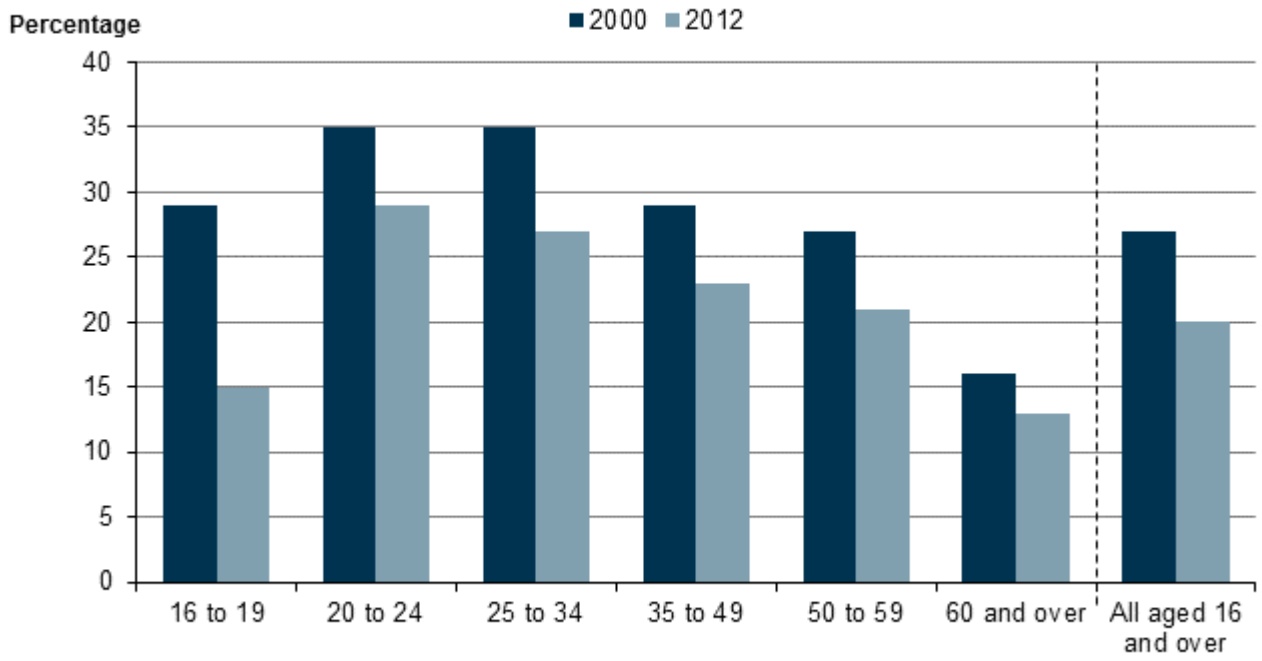
2.2 Smoking prevalence, consumption and trends in adults

2.2.1 Trends in smoking prevalence

Results from the Opinions and Lifestyle Survey 2012[1] show that overall, smoking prevalence has been decreasing in Great Britain. The rate of smoking in Great Britain has remained largely unchanged in recent years. In 2012, 20 per cent of adults (aged 16 and over) reported smoking, which is the same as 2011 and 2010 but lower than 26 per cent in 2002. Table 2.1

In 2012, those aged 20 to 24 and 25 to 34 reported the highest prevalence of cigarette smoking (29 per cent and 27 per cent respectively), while those aged 60 and over reported the lowest prevalence (13 per cent). The pattern of smoking prevalence by age is similar to the position twelve years ago although there has been a larger decrease for 16 to 19 year olds compared to the other age groups. Figure 2.1

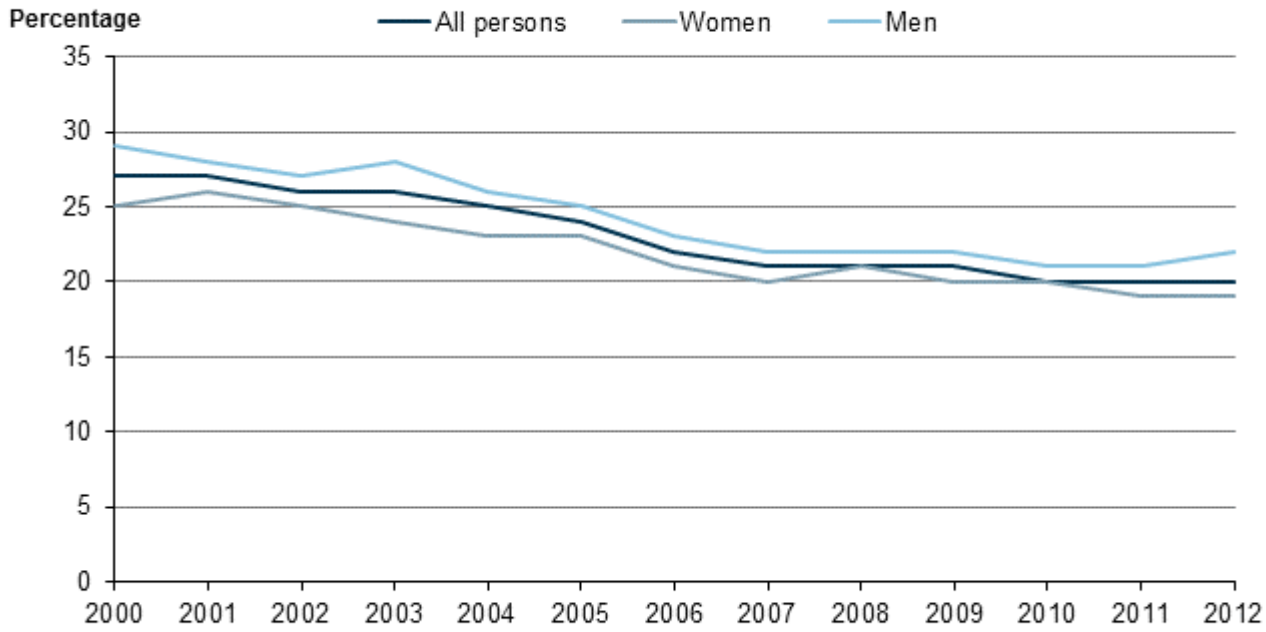
Figure 2.1 - Prevalence of cigarette smoking among adults in Great Britain, by age group, 2000 and 2012



Source: Opinions and Lifestyle 2012. , Office for National Statistics licensed under the Open Government Licence v.2.0.. Copyright © 2014, re-used with the permission of The Office for National Statistics.

Prevalence of cigarette smoking was higher for men (22 per cent) than women (19 per cent). This compares with 29 per cent of men and 25 per cent of women in 2000. Table 2.1 Figure 2.2

Figure 2.2 - Prevalence of cigarette smoking among adults in Great Britain, by age group, 2000 and 2012



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Smoking rates varied by whether people were in employment or not. Unemployed people (39 per cent) (not working but seeking work) were around twice as likely to smoke as those either in employment (21 per cent) or economically inactive (17 per cent) (for example, students or retired people).

The highest smoking prevalence for unemployed people was amongst those aged 25 to 34 (54 per cent). This age group also had the highest prevalence for employed people (25 per cent), whilst for those who were economically inactive the 35 to 49 age group had the highest rate (33 per cent). People aged 60 and over had the lowest rate of smoking for all three employment statuses (16 per cent for those in employment, 17 per cent for those unemployed and 12 per cent for the economically inactive. Table 2.2

2.2.2 Cigarette consumption

In 2012, current smokers smoked an average of 12 cigarettes a day. Table 2.9

The Health Survey for England 2013[2] (HSE13) found that the proportion of men who had never regularly smoked increased from 39 per cent in 1993 to 51 per cent in 2012 (the proportions for women were 52 per cent in 1993 to 61 per cent in 2012).

2.2.3 Cigarette type

Cigarettes in packets are the most popular type of cigarette smoked (52 per cent of men and 66 per cent of women) by current smokers. A higher proportion of men than women smoke hand-rolled cigarettes (38 per cent of men and 24 per cent of women) and they are most popular amongst men aged 50 to 59 years. Table 2.10

2.2.4 Smoking during pregnancy

In 2012, 7 per cent of pregnant women aged 16 to 49 were smokers and 18 per cent were ex-smokers. Table 2.4

The Infant Feeding Survey (IFS) was carried out in the UK every 5 years and discontinued in 2014. The last survey was carried out in 2010 and the results published by the Health and Social Care Information Centre in 2012. Chapter 11 of the IFS – UK, 2010[19] . It provides information on smoking during pregnancy and presents the information by age, socio-economic classification and region. Key findings from this chapter include:

In England in 2010:

- Twenty six per cent of women smoked in the 12 months before or during their pregnancy, a fall from 33 per cent in 2005
- Of the mothers who smoked before or during their pregnancy over half (55 per cent) gave up at some point before the birth
- Twelve per cent of mothers continued to smoke throughout their pregnancy, down from 17 per cent in 2005
- The highest levels of smoking before or during pregnancy were found among mothers in routine and manual occupations (40 per cent) and among those aged under 20 (57 per cent). Mothers aged under 20 were also the least likely to have given up smoking at some point before or during pregnancy (38 per cent) but by socio-economic group mothers who had never worked were the least likely to have done so (29 per cent).

Almost nine in ten mothers (88 per cent) who smoked before or during pregnancy received some type of information on smoking. Midwives were the most common source of information, mentioned by 85 per cent of mothers who had received information.

Statistics on Women's Smoking Status at Time of Delivery (SATOD) provides information on the prevalence of smoking among pregnant women at Commissioning Region, Area Team and Clinical Commissioning Group level.

The latest results for a full year (2013/14)[6] were published by Health and Social Care Information Centre in 2014 and found:

In England in 2014:

- 12.0 per cent of mothers were recorded as smokers at the time of delivery for 2013-14, which is lower than 2012-13 (12.7 per cent) and continues the steady year-on-year decline in the percentage of women smoking at the time of delivery from 15.1 per cent in 2006-07
- The smoking prevalence varied amongst the Area teams from 5.1 per cent in London to 20.6 per cent in Durham, Darlington and Tees
- The smoking prevalence varied amongst Clinical Commissioning Groups from 1.9 per cent in NHS Central London (Westminster) and NHS Richmond to 27.5 per cent in NHS Blackpool
- 82 (39 per cent) of the 211 Clinical Commissioning Groups (CCGs) had estimates meeting the national ambition of 11 per cent or less women smoking at the time of delivery
- Of the four Commissioning Regions, London had 31 of its 32 CCGs; South of England had 26 of its 50 CCGs; Midlands and East of England had 16 of its 61 CCGs and the North of England 9 of its 68 CCGs meeting the national ambition by the end of March 2014.

2.3 Smoking and demographic characteristics in adults

2.3.1 Smoking and marital status

The prevalence of cigarette smoking varies considerably according to marital status. In 2012, people who were Cohabiting were most likely to smoke (33 per cent), while those who were Married were least likely (14 per cent).

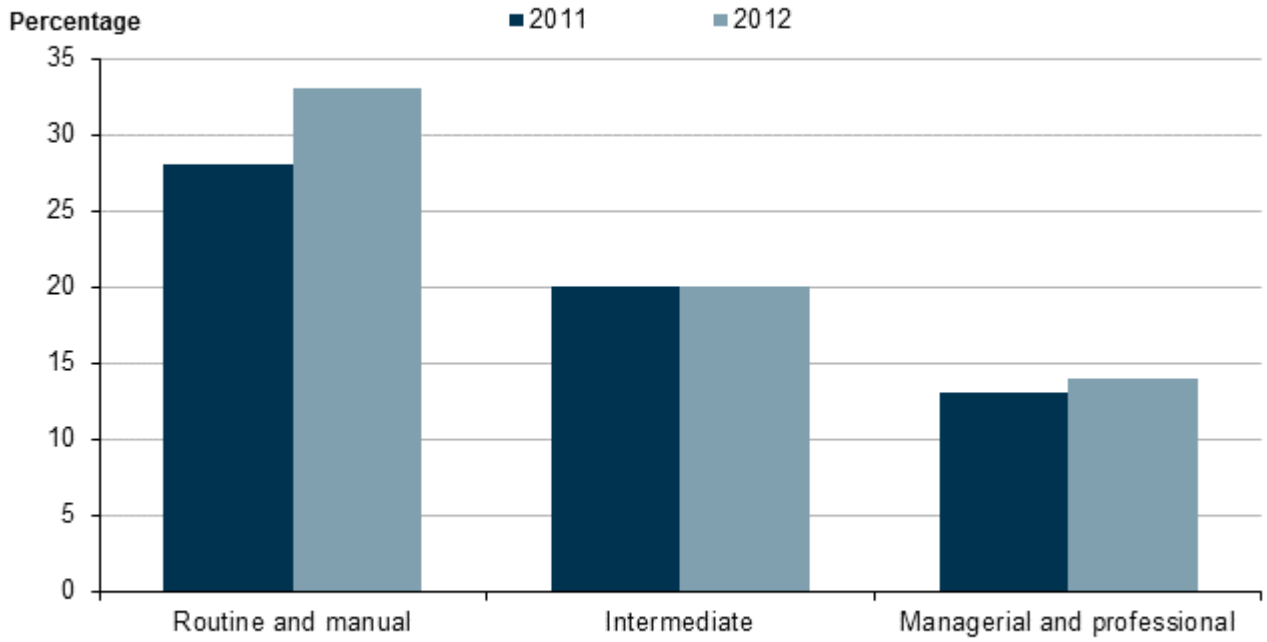
The highest proportion who had never smoked (54 per cent) were Single, whilst the age group with the highest proportion who had never smoked were Single people aged 16 to 24 (68 per cent). Table 2.5

2.3.2 Smoking and socio-economic class

In all socio-economic classifications, men had a higher prevalence of smoking than women with the exception of Large employers and high managerial (9 per cent of men and 12 per cent of women) and Lower supervisory and technical 30 per cent of men and 31 per cent of women).

The highest rise in the prevalence of smoking was amongst Routine and manual groups from 28 per cent in 2011 to 33 per cent in 2012. Managerial and professional rose from 13 per cent in 2011 to 14 per cent in 2012 and Intermediate was the same for both years at 20 per cent. Table 2.3 Figure 2.3

Figure 2.3 - Rates of cigarette smoking in Great Britain, by sex and socio-economic classification, 2011 to 2012



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Nearly all socio-economic classifications showed a fall from 2011 to 2012 in the average number of cigarettes smoked in a day. Table 2.9

2.3.3 Smoking and other factors

Table 9.4 from *Chapter 9: Adult Cigarette Smoking* in HSE 2009[22], the latest year that smoking was included in the HSE, shows that among both men and women, cigarette smoking prevalence was higher among those living in Spearhead Primary Care Trust (PCT) areas (the most health deprived areas of England) in 2009. However, as observed in previous years, greater variation was found by equivalised household income; a measure of income that takes into account the total number of people living in the household and is age-standardised. Table 9.3 in HSE 2009 shows that among both men and women, cigarette smoking prevalence was lowest in the highest income households (14 per cent for men; 11 per cent for women) and highest among the lowest income households (40 per cent for men and 34 per cent for women). It is notable that around two in five men and one in three women who live in the lowest income households were current cigarette smokers.

Smoking is included in the Health Survey for England in 2013 and the results are expected to be published towards the end of 2014.

The 2006 HSE report, *Health Survey for England 2006: Cardiovascular disease and risk factors in adults*[21] (HSE 2006), presents findings from an analysis using logistic modelling[a] to explore factors associated with current cigarette smoking. This analysis has not been updated in more recent editions of the HSE. Factors explored in the analysis were age group, equivalised household income, Index of Multiple Deprivation, educational attainment, household type and socio-economic classification of the household reference person. The association between current cigarette smoking and other health and lifestyle indicators such as general health status, fruit and vegetable consumption, alcohol consumption, levels of

[a] For information on logistic modelling and a summary of the results from this analysis please refer to *Statistics on Smoking: England, 2009*[23], Section 2.3.3 and Appendix B.

physical activity and Body Mass Index (BMI) status were also investigated. The findings from this analysis are presented in Table 8.6 of *Chapter 8: Cigarette Smoking* of the HSE 2006.

In 2004 the HSE included a boost sample to increase the sample size of people in ethnic minority groups. The relationship between smoking status and ethnicity was explored in *Chapter 4: Use of tobacco products* of the associated report *Health Survey for England 2004: The Health of Minority Ethnic Groups*[24] (HSE 2004).

Example findings include: self-reported cigarette smoking prevalence for men was 40 per cent among Bangladeshi, 30 per cent Irish, 29 per cent Pakistani, 25 per cent of Black Caribbean, 21 per cent Black African and Chinese, and 20 per cent in Indian men, compared with 24 per cent among men in the general population. After adjustment for age, Bangladeshi and Irish men were more, and Indian men less, likely to report smoking cigarettes than men in the general population. Self-reported smoking prevalence was higher among women in the general population (23 per cent) than most minority ethnic groups, except Irish (26 per cent) and Black Caribbean women (24 per cent). The figures for the other groups were 10 per cent Black African, 8 per cent Chinese, 5 per cent Indian and Pakistani, and 2 per cent in Bangladeshi women.

The findings in HSE 2004 are the latest available from the HSE on smoking and ethnicity.

2.4 Geographical comparisons in adults

National and regional prevalence is taken from the Integrated Household Survey: January 2012 to December 2012[5] (IHS 2013).

2.4.1 National comparisons

IHS 2013 reported that one in five adults (aged 18 and over) were current smokers in the UK in 2012. Regions in the North of England and Scotland had the highest proportions of current smokers in the UK. Table 2.14

2.4.2 Regional prevalence

IHS 2013 also shows that in England, Yorkshire and the Humber had the highest proportion of current smokers (22.7 per cent), whilst London and the South East had the lowest proportions of current smokers (18.0 per cent). Table 2.14

2.4.3 Local area prevalence

While survey estimates can provide information on regional variation, it is not possible to look at a smaller geographical level due to small sample sizes. To address this information gap, NatCen was commissioned by the HSCIC to produce model-based estimates using HSE for a range of healthy lifestyle behaviours. Estimates based on 2003-2005 data at Local Authority (LA), Medium Super Output Area and Primary Care Organisational level are available on the HSCIC website[23], and includes estimates of smoking prevalence. Results for the whole range of healthy lifestyle behaviours considered are published on the ONS Neighbourhood Statistics website[25].

In 2003-2005, it was estimated that just over 1 in 8 LAs had a significantly higher smoking rate than England as a whole, with 3 in 10 LAs reporting rates lower than the national average, showing no clear geographical pattern overall.

As part of Neighbourhood Statistics, analysis was also carried out on smoking prevalence by ethnic minorities at a sub-national level, for 2004 data. Results can be found on the Neighbourhood Statistics website[25].

2.5 Smoking in children

Pupils' smoking behaviour has been collected in the *Smoking, drinking and drug use among young people in England* survey since the series began in 1982. The survey covers children in years 7 to 11 who will be mostly all aged 11 to 15. From 2000, core smoking questions have been included each year and in alternate years more detailed smoking questions are also asked. The survey in 2013[7] focused on drug use and included the core smoking questions only. Chapters in the report which covered smoking are:

Chapter 3: Smoking reports on the prevalence of smoking among 11 to 15 year olds and patterns of cigarette consumption.

Chapter 5: Smoking, drinking and drug use compares the prevalence of smoking, drinking and drug use and explores the relationship between these behaviours in more detail. This chapter also reports on children's attitudes to these behaviours and on what schools teach about smoking.

2.5.1 Smoking prevalence and consumption

The key findings on smoking prevalence and consumption show that amongst 11 to 15 year olds in 2013:

- Less than a quarter of pupils reported that they had tried smoking at least once. At 22 per cent, this is the lowest level recorded since the survey began in 1982, and continues the decline since 2003, when 42 per cent of pupils had tried smoking
- 3 per cent of pupils said that they smoked at least one cigarette a week, the survey definition of regular smoking. This is also at the lowest level measured since 1982, and considerably below the 9 per cent who smoked regularly in 2003
- The prevalence of regular smoking increased with age. Less than 0.5 per cent of 11 year olds were regular smokers in 2013, and this increased to 8 per cent amongst 15 year olds
- Six per cent of pupils reported that they had smoked cigarettes in the last week. Older pupils were more likely than younger pupils to have smoked in the last week (13 per cent of 15 year olds, compared with 1 per cent of 11 year olds)
- Regular smokers consumed, on average (mean), 31.1 cigarettes a week. Occasional smokers consumed 3.4 cigarettes a week.

Further information can be found in the *Smoking, drinking and drug use among young people in England in 2012*[8] (SDD12) report which is the last year in which more detailed questions on smoking were asked Section 2.2 and in Tables 2.1 to 2.11.

2.5.2 Influences on pupils' smoking

SDD12, Section 2.3 Tables 2.12 to 2.23 provide information on the influences on pupils' smoking, including exposure to second hand smoke.

The key facts from this section show that in 2012:

- 67 per cent of pupils reported being exposed to second-hand smoke in the last year. This was most likely to be in someone else's home (55 per cent). 43 per cent said they had been exposed to second-hand smoke in their own homes, 30 per cent in someone else's car and 26 per cent in their family's car
- 68 per cent of pupils reported that members of their family smoked. About a third (32 per cent) reported that one or both of their parents smoked

- Almost all smokers knew at least one person who smoked (97 per cent of regular smokers and 98 per cent of occasional smokers) compared with about half (51 per cent) of non-smokers
- Pupils who lived with someone else who smoked were more likely to smoke themselves. Just 2 per cent of pupils who did not live with a smoker smoked regularly, compared with 5 per cent of those who lived with one person who smoked and 16 per cent of pupils who lived with three or more smokers.

2.5.3 Where pupils get cigarettes

SDD12, Section 2.4 and Tables 2.24 to 2.44 provide information on where pupils get cigarettes.

The key facts from this section show that in 2012:

- Pupils who smoked were most likely to get cigarettes given to them by other people (69 per cent), typically by other friends (57 per cent)
- As well as being given cigarettes by other people (63 per cent), regular smokers were also likely to report buying cigarettes from a shop (60 per cent) or from other people (46 per cent)
- 32 per cent of current smokers said they found it difficult to buy cigarettes from any shop. Just 5 per cent of pupils tried to buy cigarettes in a shop in the last year. Of these, 51 per cent had been refused at least once – in other words half (49 per cent) were always successful
- 8 per cent of pupils had asked someone else to buy them cigarettes from a shop in the last year. 88 per cent of these were bought cigarettes by someone else on at least one occasion. Friends were the most likely people to buy cigarettes on a pupil's behalf (77 per cent), with strangers being the next most common source (58 per cent).

2.5.4 Dependence on smoking

SDD12, Section 2.5 and Tables 2.45 to 2.53 provide information on dependence on smoking. Pupils who were regular smokers were likely to show signs of dependence on the habit. 67 per cent reported that they would find it difficult not to smoke for one week and almost three quarters (72 per cent) would find it difficult to give up altogether. Almost two thirds of regular smokers (63 per cent) had tried to give up smoking.

2.5.5 Attitudes and beliefs

SDD12, Section 2.6 provides information on pupils' attitudes and beliefs. Most pupils (84 per cent) believed that people smoked because they thought it made them look cool in front of their friends. Pupils were also very likely to agree that people of their age smoked because they were addicted to cigarettes (70 per cent), or their friends pressure them into it (70 per cent). Further information can be found in Tables 2.54 to 2.62.

2.5.6 Sources of information about smoking

SDD12 showed that pupils were most likely to say that they got helpful information about smoking from their parents (73 per cent), teachers (71 per cent) and television (69 per cent) Section 2.7 and Tables 2.63 to 2.65.

2.5.7 Factors associated with regular smoking

Factors strongly associated with smoking include being female, being older, other risky behaviours (drinking alcohol, drug use, truancy), and having friends and family who smoke. SDD12, Section 2.8 and Table 2.66. A logistic regression model was used to explore the

characteristics of pupils and their environments associated with regular smoking. Further information on logistic regression can be found in SDD12 Appendix B.

2.5.8 Regional comparisons

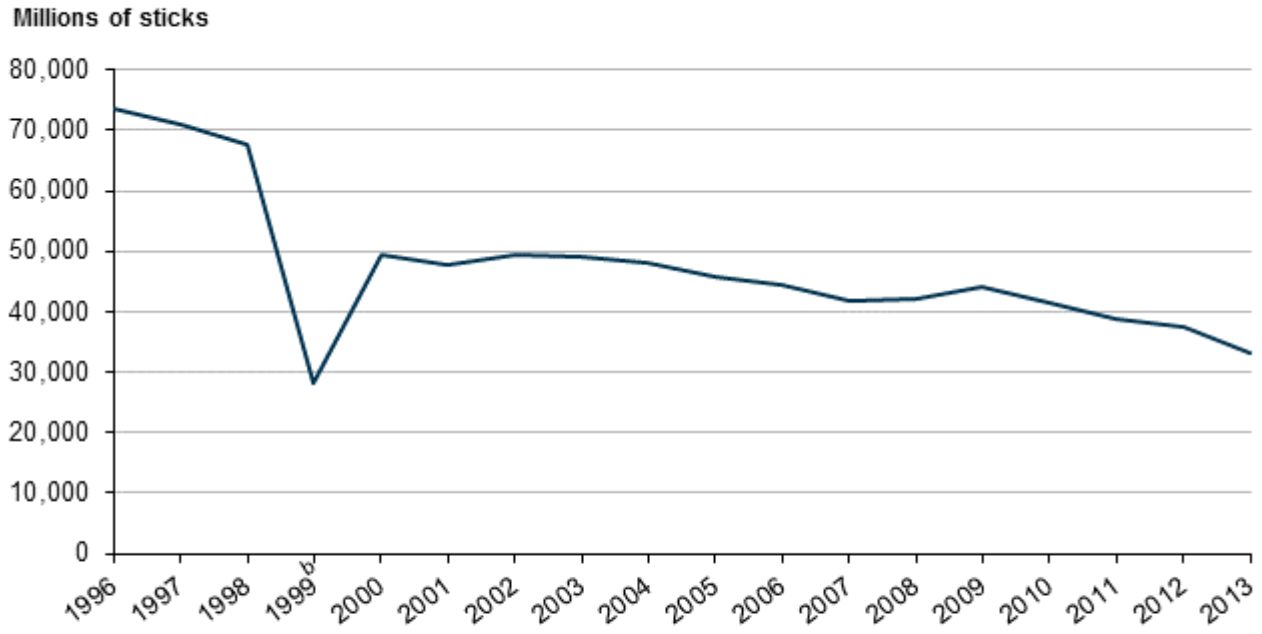
Data from 2011 and 2012 have been combined to enable analysis of key survey estimates by region and shows the proportion of pupils who had tried smoking varied between 22 per cent in London, the East Midlands and the West Midlands to 30 per cent in the North East. There was similar variation in the proportion of regular smokers, but this was not statistically significant. Further information on the findings can be found in SDD12 Chapter 6.

2.6 Availability and affordability of tobacco

2.6.1 Tobacco released for home consumption

Information on the quantities of tobacco released for home consumption is collected by Her Majesty's Revenue and Customs and relates to the United Kingdom as a whole[9]. Releases of cigarettes, both home produced and imported, have fallen since the mid-1990s; although much of the decline among home produced cigarettes occurred before 2000. Table 2.11, Figure 2.4

Figure 2.4 - Quantities of cigarettes released for home consumption in the United Kingdom, 1996 to 2013



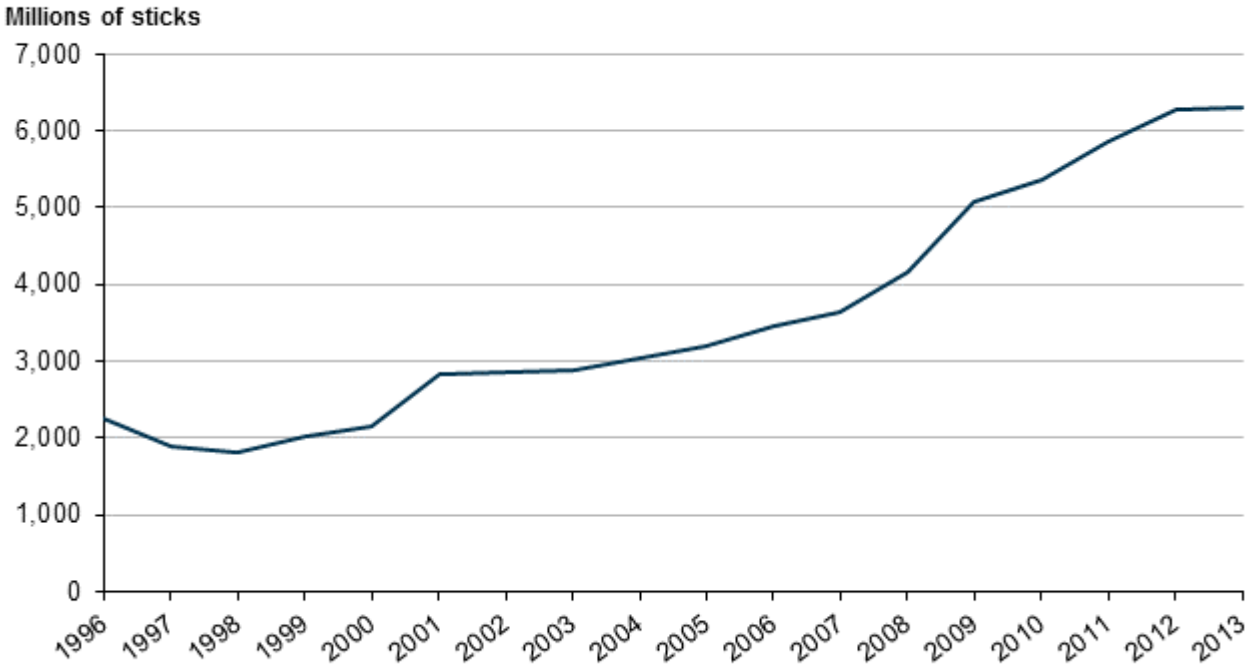
b Receipts were high in December 1998 following the November Budget and associated forestalling. The next Budget took place in March 1999 but as stocks were still available from the November forestalling, no further forestalling took place. The next Budget took place in March 2000. Manufacturers forestalled against this affecting April receipts. There was therefore no forestalling in the financial year 1999/00.

Forestalling is a tax avoidance practice. Whereby excessive quantities of goods are removed for home-use on payment of duty because an increase in the rate of duty is expected. (HMRC 2014)

Source: Statistical Bulletin: Tobacco duties. Her Majesty's Revenue and Customs

Since 1996, releases of hand-rolling tobacco have increased by 179 per cent. This reflects the increase in the proportion of adults who smoke hand-rolled cigarettes. Table 2.11 Figure 2.5

Figure 2.5 - Quantities of hand-rolling tobacco released for home consumption in the United Kingdom, 1996 to 2013



Source: Statistical Bulletin: Tobacco duties. Her Majesty's Revenue and Customs

2.6.2 Affordability of tobacco

The HSCIC has routinely published a series of indices derived from Office for National Statistics (ONS) data in its *Statistics on Smoking: England* reports. They include the Tobacco Price Index (TPI), Retail Price Index (RPI), Relative Tobacco Price Index (defined as TPI / RPI), Real Households' Disposal Income (RHDI) and the affordability of tobacco index (defined as RHDI / Relative Tobacco Price Index).

Since August 2010 the HSCIC has worked with key customers to investigate the scope for making methodological improvements to the way the affordability of tobacco index is derived. The Institute of Alcohol Studies (IAS) produced a research paper[30] in September 2010 proposing a number of adjustments to the affordability of alcohol index produced by the HSCIC. This paper also had implications for the affordability of tobacco index presented in this report.

As a result, from 2011 the HSCIC has implemented one of the proposed adjustments. The revised Real Households' Disposable Income (RHDI) index now tracks changes in real disposable income per capita. Previously, the RHDI index tracked changes in the total disposable income of all households and was not on a per capita basis. Consequently, the changes in the RHDI index over time were, in part, due to changes in the size of the population and not exclusively due to changes in real disposable income per capita. The RHDI index feeds into the affordability of tobacco index, and this was also affected.

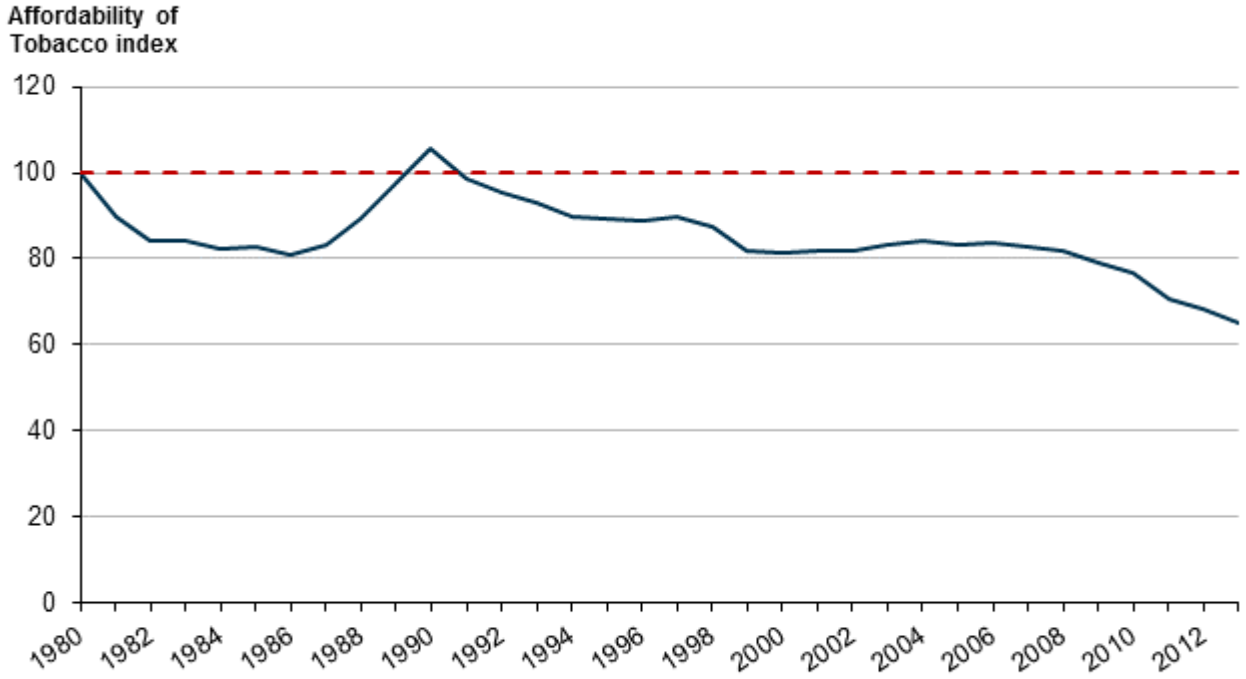
The adjustment was carried out using ONS mid-year population estimates of the adult population aged 18 and over, and was applied to all years in the index (1980 onwards). The adjusted RHDI index was then carried forward to produce an adjusted affordability of tobacco index. Table 2.12 and Figure 2.6 For further information on the methodology see Appendix A.

The source of the RHDI index is an ONS series known as *Economic Trends (Code NRJR)* and is closely related to a separate National Accounts ONS series known as *Gross Disposable Income (Code QWND).* This relates to all households in the UK and is defined in the *UK National Accounts Concepts, Sources and Methods*[10]*.* Whereas QWND is presented in current prices (i.e. values appropriate to the year for which they are presented), NRJR is adjusted for inflation, hence the 'Real' in 'Real households' disposable income'.

Further views on the affordability measure, in particular to the revision made in 2011 and the further proposed amendments contained in the IAS research paper, were sought during the Lifestyles Compendia Publications public consultation in 2011. All responses were in favour of the adjustment made in the 2011 report to calculate on a per capita basis and this adjustment will continue. Appendix C has more details of responses received via the public user consultation.

In the UK since 1980 (an arbitrarily chosen base year) prices of tobacco, as measured by the tobacco price index, have increased more than the retail price index. The price of tobacco has increased by 80.0 per cent over the last ten years from 2003 to 2013, making it 22.1 per cent less affordable, highlighting the overall trend of decreasing affordability over the period. Between 2003 and 2013 the price of tobacco increased by 30.7 per cent relative to retail prices. However, real households' disposable income (adjusted) increased by 1.8 per cent over the same period. Table 2.12 and Figure 2.6

Figure 2.6 - Tobacco revised affordability index: 1980 to 2013



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Further details of the tobacco affordability calculations and a worked example are presented in Appendix A. The HSCIC continues to investigate new and improved measures for calculating indicators and may include revised methodologies in future publications.

2.6.3 Spending on tobacco

Office for National Statistics (ONS) *Consumer Trends*[13] reported that the total UK household expenditure on tobacco has nearly quadrupled from £4.8 billion in 1980 to £18.9 billion in 2013. However, tobacco expenditure as a proportion of total household expenditure has decreased overall over the same period (from 3.6 per cent in 1980 to 1.8 per cent in 2013). Table 2.13, Figure 2.7

Figure 2.7 - Household expenditure on tobacco in United Kingdom, 1980 to 2013

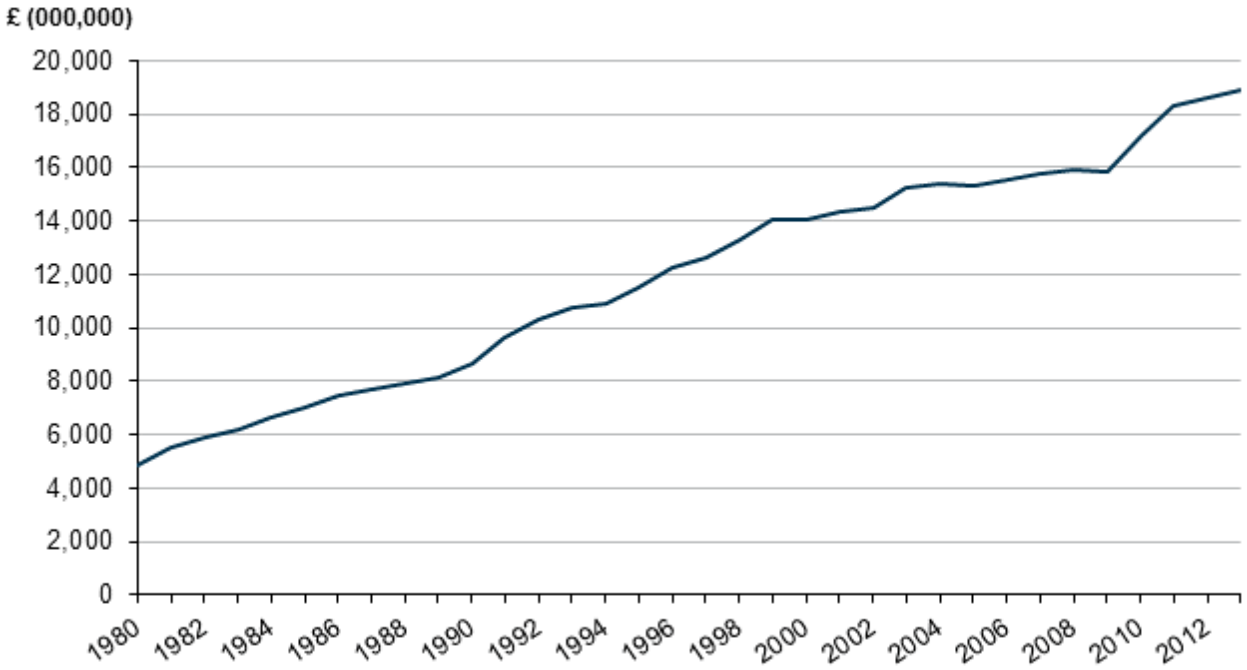
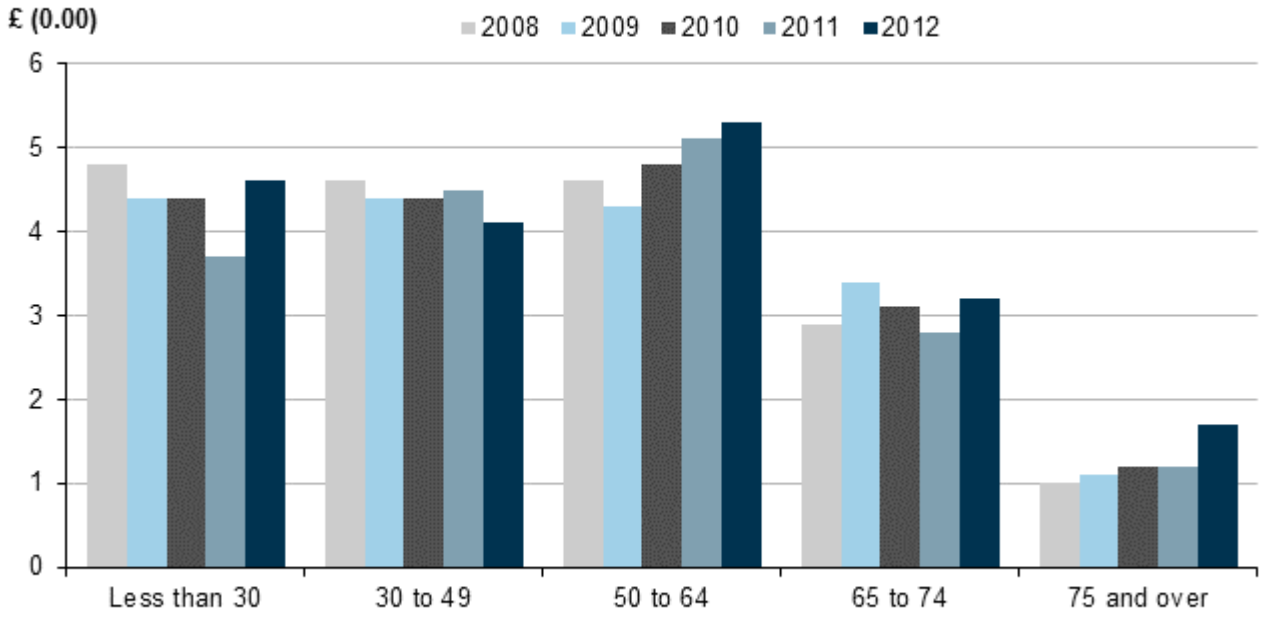


Table A11 of the *Family Spending, 2013, a report on the 2012 Living Costs and Food Survey*[16] shows average weekly household expenditure on cigarettes by age. In the United Kingdom in 2012 this was £4.00. Average weekly household expenditure on cigarettes varied by age group. The highest weekly expenditure was seen in the 50 to 64 year old age group (£5.30 a week) the lowest was seen in the 65 to 74 (£3.20) and 75 or over age group (£1.70). Figure 2.8

Table A11 of the *Family Spending, 2012, a report on the 2011 Living Costs and Food Survey*[15] shows average weekly household expenditure on cigarettes by age. In the United Kingdom in 2011 this was £3.90. Average weekly household expenditure on cigarettes varied by age group. The highest weekly expenditure was seen in the 50 to 64 year old age group (£5.10 a week) the lowest was seen in the 65 to 74 (£2.80) and 75 or over age group (£1.20). Figure 2.8

Figure 2.8 - Average weekly household expenditure on cigarettes in United Kingdom at current prices, by age of household reference person, 2008 to 2012



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Chapter 4 of *Family Spending, 2012* reports on trends in Household expenditure over time. The figures and tables in this chapter present figures that have been deflated using the All Items Retail Prices Index (RPI) data. This allows a comparison of expenditure in real terms to be made between the survey years. Further information on interpreting the time series can be found in Chapter 4 - Interpreting EFS/LCF time series data of the publication.

In 2011 average weekly expenditure on all tobacco was £4.70. This follows an overall long term decline from 1997-98 when expenditure (in 2011 prices) was £9.30. Family Spending 2012 Table 4.1. It is not possible to give comparative data for 2012 (*Family Spending, 2013)* as spending on tobacco has been grouped with alcoholic drinks and narcotics and therefore it is not possible to state how much is solely attributable to tobacco.

2.7 Use of electronic cigarettes

Electronic cigarettes are an electronic inhaler that vaporises a liquid solution into an aerosol mist, simulating the act of tobacco smoking. They are often designed to look and feel like cigarettes and have been marketed as cheaper and healthier alternatives to cigarettes and for use in places where smoking is not permitted since they do not produce smoke.

Electronic cigarettes are classed as nicotine containing products and are currently regulated as general consumer products. In May 2016 the European Union directive concerning the manufacture, presentation and sale of tobacco related products comes into force. This covers nicotine-containing liquid where the nicotine concentration does not exceed 20mg/ml, which delivers a dose of nicotine comparable to smoking a standard cigarette over the same period of time[32].

The directive includes sections on the consistent delivery of nicotine; potential health-risk when in the hands of children; safety and quality requirements for electronic cigarettes and

refills; labelling and packaging; advertising restrictions and reporting obligations of manufacturers and importers.

Action on Smoking and Health (ASH)[33] has estimated that there are 2.1 million adults who are current users of electronic cigarettes in Great Britain. Of these, ex-smokers account for Approximately 700,000 of these are ex-smokers and 1.3 million use both tobacco and electronic cigarettes.

The number of users is increasing; 2.7 per cent of smokers reported using electronic cigarettes on a regular basis in 2010, increasing to 17.6 per cent in 2014.

The main reason smokers reported having used electronic cigarettes is to “help me stop smoking entirely” (32 per cent); and “help me reduce the amount of tobacco I smoke, but not stop completely” (32 per cent). The main reasons ex-smokers reported having used electronic cigarettes are to “help me stop smoking entirely” (56 per cent); and “help me keep off tobacco (34 per cent).

The Health Survey for England collected some data on the use of electronic cigarettes in 2013 and this is expected to be published towards the end of 2014.

The HSCIC collects data from local authorities on a quarterly basis on NHS Stop Smoking Services from April 2014 data collected for ‘Number of people setting a quit date and successful quitters by pharmacotherapy treatment received’ will include both licensed and unlicensed nicotine containing products[35]. The last annual report covered 2013/14 and was published on 19 August 2014. Provisional data is also published on a quarterly basis in the Statistics on NHS Stop Smoking Services in England. Quarter 1 2014/15 is due to be published in October 2014. The reports on NHS Stop Smoking Services are available on the HSCIC website. http://www.hscic.gov.uk/lifestyles

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3 Behaviour and attitudes to smoking

Key findings

Adults' behaviour and attitudes to smoking

In 2008/09, two-thirds of current smokers reported wanting to give up smoking.

Three quarters of current smokers reported trying to give up smoking at some point in the past.

43 per cent of all current smokers sought help or advice for stopping smoking.

69 per cent of adults report that they do not allow smoking at all in their home.

Childrens' behaviour and attitudes to smoking

In 2012, 86 per cent of pupils who had been smoking for over year felt it would be difficult for them to give up smoking.

In 2010, 66 per cent of smokers said they started smoking before they were 18 years old.

3.1 Introduction

This chapter presents information from a number of sources about both adults' and children's behaviour and attitudes towards smoking.

Data on adults' smoking behaviour and attitudes are taken from the Office for National Statistics (ONS) Omnibus Survey. The last version of this report was *Smoking-related Behaviour and Attitudes, 2008/09*[1] and it was discontinued after this date. This survey was carried out during September and November 2008 and February and March 2009 and sampled adults aged 16 and over living in private households in Great Britain. The report presents results on smoking behaviour and habits, views and experiences of giving up smoking, awareness of health issues linked with smoking and attitudes towards smoking.

A further source of data on attitudes to smoking in adults is the General Lifestyle Survey (GLF) published by the Office for National Statistics. This report has also been discontinued and the latest edition covered 2011 survey[2] . The GLF was a national survey covering adults aged 16 and over living in private households in Great Britain. Each year questions are asked about adults' smoking habits.

NHS Stop Smoking Services information can also be found in this chapter and includes the number setting a quit date and of those, how many successfully quit. Information is taken from the latest report *NHS Stop Smoking Services: England, April 2013 to March 2014*[4].

Children's attitudes towards smoking are taken from *Smoking, drinking and drug use among young people in England in 2012*[5] based on the 2012 Smoking, drinking and drug use survey. Since 1998, this survey has included a core section of questions on smoking, drinking and drug use among children in secondary schools. From 2000, the remainder of the questionnaire has focused in alternate years on either smoking and drinking, or on drug use. In 2013 the focus was on drug use, the latest survey to focus on smoking and drinking was *Smoking, drinking and drug use among young people in England in 2012*[5] (SDD12).

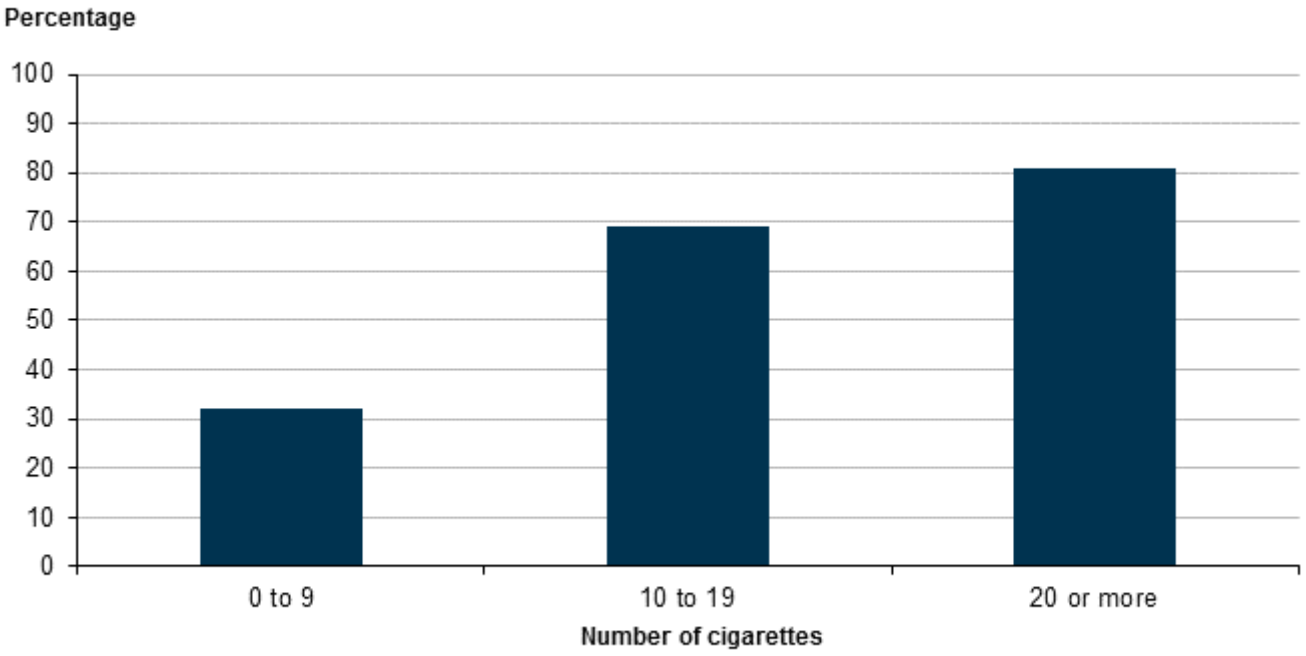
3.2 Adults' behaviour and attitudes to smoking

3.2.1 Dependence on cigarette smoking

In order to estimate people's dependence on cigarettes, GLF 2011 asked respondents questions on whether they would find it easy or difficult not to smoke for a whole day and how soon after waking they smoke their first cigarette.

In 2011, 60 per cent of smokers in England thought they would find it difficult to go without smoking for a day. Unsurprisingly, heavy smokers (those who smoke 20 or more cigarettes a day) were more likely to say they would find it difficult not to smoke for a day than light smokers (those who smoked less than 10 cigarettes a day) (81 per cent and 32 per cent respectively). Table 3.1, Figure 3.1

Figure 3.1 - Proportion of smokers in Great Britain who would find it difficult to go without smoking for a day by number of cigarettes smoked a day, 2011



Differences were also reported between socio-economic groups. Smokers in routine and manual groups were more likely to say they would find it difficult to go without smoking for a whole day than those in managerial and professional occupations (63 per cent and 52 per cent respectively). However, for those who smoked 20 or more cigarettes a day, there was less of a difference between the same two socio-economic groups in the proportion who would find it difficult to go without smoking for a day (87 per cent and 79 per cent). Table 3.1

Overall, 16 per cent of smokers reported having their first cigarette within five minutes of waking. Heavy smokers (those smoking 20 or more cigarettes a day) were more likely to smoke within five minutes of waking than light smokers (35 per cent and 3 per cent respectively). Smokers in managerial and professional occupations were less likely than smokers in routine and manual occupations to smoke within five minutes of waking (10 per cent and 18 per cent respectively). Table 3.2

3.2.2 Wanting to stop smoking

The information below is sourced from the Office for National Statistics (ONS) Omnibus Survey, *Smoking-related Behaviour and Attitudes 2008/09*[1]. The survey was last conducted in 2008/09 and the results were published in 2009. This is currently not being continued, therefore at the time of this publication there is no new information to add from this report.

An earlier version of this smoking compendium report, *Statistics on Smoking: England, 2009*[6] published by the Health and Social Care Information Centre (HSCIC) presented detailed summary information of the 2008/09 Omnibus Survey (for Great Britain). As this is still the latest information available, it is provided again below.

In 2008/09, the Omnibus Survey found that 67 per cent of current smokers in Great Britain reported that they wanted to give up smoking; this is lower than in 2007 when 74 per cent of smokers wanted to give up. There were no statistically significant differences in the percentage of men and women smokers who reported wanting to stop smoking. Table 3.3

Those who reported wanting to give up smoking were also asked why they wanted to do so and up to three of their answers were recorded. Eighty three per cent of respondents gave at least one health reason for wanting to give up smoking. Financial reasons were the second most common answer (31 per cent), followed by harms children (22 per cent) and family pressure (16 per cent). Table 3.4

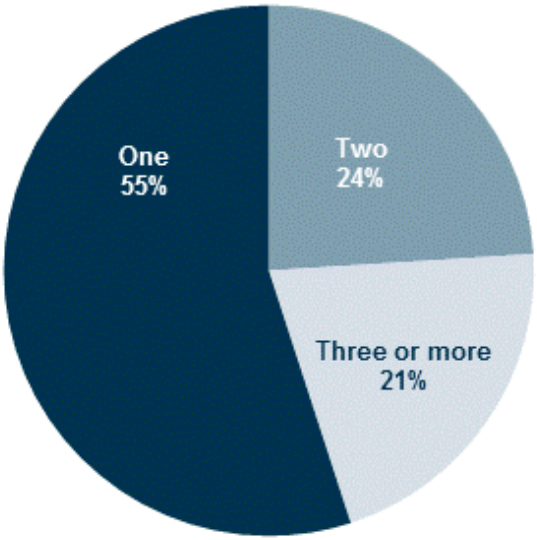
3.2.3 Attempts at stopping smoking

In 2008/09, 75 per cent of current smokers in Great Britain reported having tried to give up smoking at some point in the past. There was no significant difference between the proportion of men and women who have tried to stop smoking. Table 3.5

The percentage of smokers who had made an attempt to quit smoking in the 12 months before they were interviewed increased from 22 per cent in 2000 to 31 per cent in 2007, then fell to 26 per cent in 2008/09. Table 3.6

Smokers who had tried to give up smoking in 2008/09 were asked how many attempts they had made. Fifty five per cent reported making one quit attempt and 21 per cent reported making three or more quit attempts. Figure 3.2

Figure 3.2 - Number of attempts to give up smoking in Great Britain in 2008/09



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Smokers who had previously quit were also asked how long they had given up for on the last occasion before returning to smoking. Just over a fifth (22 per cent) had quit for a week, while 29 per cent had been successful for six months or more. Only 8 per cent had quit for two years or more. Table 3.7

Smokers who had stopped smoking for at least one day in the last year were asked why they had started to smoke again. Thirty eight per cent said they had started again because they had found life too stressful or it was just not a good time. The other most common reasons given by respondents were they liked smoking (20 per cent), their friends smoked (18 per cent), they missed the habit/having something to do with their hands (12 per cent) or they couldn't cope with the cravings (12 per cent). Table 3.8

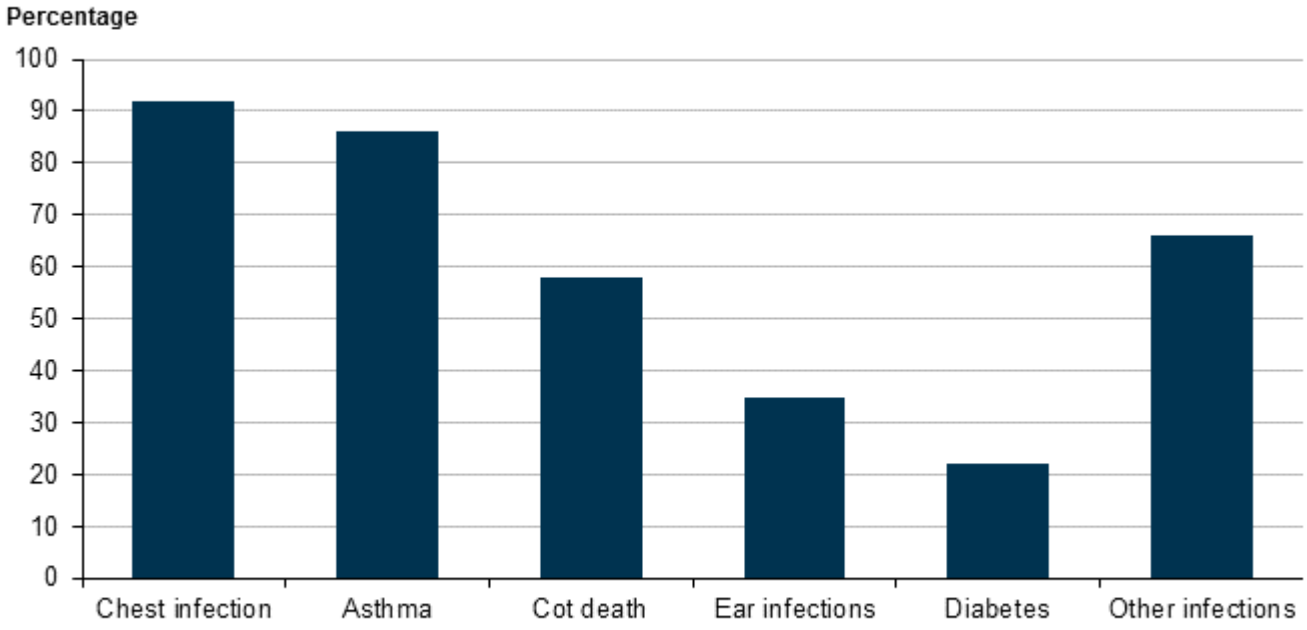
In 2008/09, 43 per cent of all current smokers had sought some kind of help or advice for stopping smoking in the last year. The most popular method used was reading leaflets/booklets on how to stop (33 per cent). Other methods included asking a doctor or other health professional for help (15 per cent), being referred/self-referred to a stop smoking group (8 per cent) or calling a smokers' telephone helpline (4 per cent). Nearly a quarter (23 per cent) had used Nicotine Replacement Therapy (NRT) or another prescribed drug such as Varenicline or Bupropion to help them stop. Table 3.9

3.2.4 Health risk awareness

To evaluate awareness of the effects of second-hand smoking, respondents to the Omnibus Survey were asked whether or not they thought that living with a smoker increased a child's risk of a range of medical conditions known, or thought, to be caused or exacerbated by second-hand smoking.

People appeared to be most aware of the effect of living with a smoker on a child's risk of chest infections and asthma (92 per cent and 86 per cent respectively). Respondents were less likely to be aware of the risks associated with cot deaths (58 per cent), ear infections (35 per cent) and diabetes (22 per cent). Table 3.10, Figure 3.3

Figure 3.3 - Percentage that agree that second-hand smoke increases a child's risk of certain medical conditions in Great Britain, 2008/09



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3.2.5 Non-smoker attitudes

Table 3.11 shows that in 2008/09, 62 per cent of non-smokers said that they would mind if other people smoked near them.

Women who did not smoke were more likely to mind others smoking near them than men who did not smoke (64 per cent compared with 59 per cent). Those who have never smoked regularly were more likely to mind people smoking near them than ex-regular smokers (67 per cent and 53 per cent respectively). Table 3.12

The main reasons why non-smokers said they would mind if people smoked near to them were the unpleasant smell of cigarette smoke (65 per cent), the residual smell of smoke on clothing (53 per cent) and the health effect of second-hand smoke (51 per cent). Table 3.13

3.2.6 Smokers' behaviour

Since 2006, respondents to the Omnibus Survey have been asked about the extent to which smoking was allowed inside their homes. The majority of respondents in 2008/09 said that smoking is not allowed at all inside their homes (69 per cent). A fifth (20 per cent) said that smoking is allowed in some rooms or at certain times and only 10 per cent said that smoking is allowed anywhere.

Heavy smokers (20 or more cigarettes a day) were the least likely to say that smoking was not allowed at all in their homes (21 per cent) compared with 38 per cent of light smokers (less than 20 cigarettes a day), 78 per cent of ex-smokers and 81 per cent of those who had never smoked. Table 3.14

Respondents in managerial and professional or intermediate occupations were more likely than those in routine and manual occupations, to report that they did not allow smoking anywhere (80 per cent and 69 per cent compared with 62 per cent respectively). People who were living in a household with children were more likely to say that they did not allow smoking anywhere (75 per cent compared with 67 per cent living with no children). Table 3.15

Those who were aware of the potential harm to children and non-smoking adults of second-hand smoke were more likely than others to say that smoking was not allowed at all in their home. For example, 74 per cent of people who were aware of the effect of second-hand smoke on a child's risk of asthma did not allow smoking at all in their home compared with 42 per cent of those who believed that it did not increase the risk. Table 3.16

Smokers were also asked if they altered their smoking behaviour when in the company of non-smoking adults or children. The majority of smokers (81 per cent) said that they modified their smoking behaviour when in the presence of non-smoking adults, with half (50 per cent) saying they did not smoke at all and 31 per cent reporting that they tended to smoke fewer cigarettes. 5 per cent said they modified their behaviour in another way such as asking permission to smoke but the remaining 14 per cent said they smoked the same number of cigarettes.

In the presence of children, smokers were more likely to alter their behaviour than in the presence of non-smoking adults. In 2008/09, just over nine in ten (91 per cent) smokers reported modifying their smoking behaviour when a child was present. The percentage of smokers who reported that they would not smoke at all in front of children has increased since 1997 from 54 per cent to 77 per cent in 2008/09. Table 3.17

3.2.7 Views on smoking restrictions

New legislation was introduced making enclosed public places smoke-free from March 2006 in Scotland, from April 2007 in Wales and from July 2007 in England. The Omnibus survey

questions from previous years asking respondents whether they thought there should be restrictions on smoking in certain places were therefore reworded to reflect this change and hence the results from 2007 are not comparable with those prior to this year.

In 2008/09, the vast majority of respondents agreed that smoking should be restricted in certain places; 94 per cent thought there should be smoking restrictions in indoor sports and leisure centres, 93 per cent in restaurants, 91 per cent in indoor shopping centres and 85 per cent at work or in railway and bus stations.

Current smokers were less likely to agree that there should be restrictions than ex-smokers and those who had never smoked. For example, 93 per cent of those who have never smoked regularly agreed with the restrictions at work, compared with 87 per cent of ex-smokers and 65 per cent of current smokers. Heavy smokers were also less likely to agree with the restrictions than lighter smokers. Table 3.18

Overall, 81 per cent of people agreed with the smoking ban (with 60 per cent strongly agreeing and 21 per cent agreeing), while 13 per cent disagreed and 6 per cent neither agreed nor disagreed. Overall, men were less likely to strongly agree with the legislation (57 per cent compared with 63 per cent respectively). There were no statistically significant differences between those in different age groups. Table 3.19

3.2.8 NHS Stop Smoking Services

The NHS Stop Smoking Services offer support to help people quit smoking. This can include intensive support through group therapy and where appropriate, one-to-one support. The support is designed to be widely accessible within the local community and is provided by trained personnel such as specialist stop smoking advisors and trained nurses and pharmacists. These services complement the use of pharmacotherapies. Statistics on NHS Stop Smoking Services presents statistics from the NHS Stop Smoking Services in England.

Statistics on NHS Stop Smoking Services: England, April 2013 to March 2014[7], is most recent publication in this series.

The main finding from this report are:

England - April 2013 to March 2014

- 586,337 people set a quit date through the NHS Stop Smoking Services in 2013/14 (down 19 per cent on 2012/13, and the first time this number has fallen for two consecutive years, since NHS Stop Smoking Services (previously Smoking Cessation Services) were set up in all Health Authorities in England in 2000/01). 300,539 people successfully quit (down 20 per cent) which gives a quit rate of just over half (51 per cent) which was similar to 2012/13.The success rate of giving up smoking generally increased with age, from 39 per cent for those aged under 18, to 58 per cent of those aged 60 and over.
- In 2013/14, 47 per cent (9,385) of pregnant women setting a quit date successfully quit, this success rate is the same as last year compared to a peak of 53 per cent in 2005/06.
- The North East region reported the highest number of people setting a quit date in 2013/14 (2,023 per 100,000 population) while the South East reported the lowest number (1,036 per 100,000 population).
- The City of London had the highest number of people setting a quit date per 100,000 population but their numbers are subject to relatively high variation each year due to the small size of the Local Authority. The next highest was Manchester City Council, although there are concerns around the quality of their data (see Data Quality

Statement for more information), followed by Blackpool Borough Council (Unitary). Borough of Poole Council (Unitary) had the lowest number of people setting a quit date per 100,000 population followed by Bury Metropolitan Borough Council and Surrey County Council.

- Just over nine out of ten people who reported they had successfully quit are known to have received pharmacotherapies in 2013/14. This has remained fairly consistent since 2008/09 (between 91 and 93 per cent).

3.3 Children's behaviour and attitudes to smoking

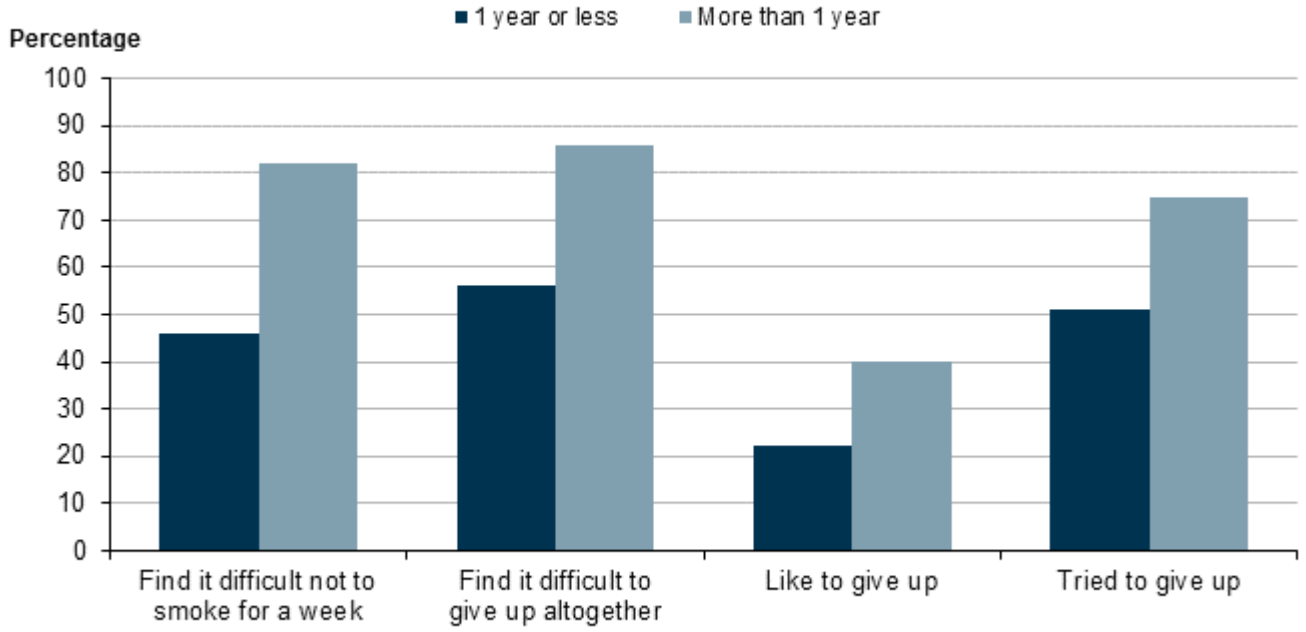
3.3.1 Children's dependence on smoking

The *Smoking, drinking and drug use among young people in England in 2012*[5] report (SDD12) focussed on smoking and drinking. In addition to the core questions on smoking, there were also a series of questions designed to estimate children's dependence on cigarettes by asking whether those who smoked thought they would find it difficult to stop smoking, whether they would like to give up smoking and whether they have tried to give up.

Findings from SDD 2012 showed that children's dependence on smoking was related to the length of time spent as a regular smoker (defined as those who smoke at least one cigarette a week). Of those pupils who were regular smokers and had been smoking for over a year, 82 per cent reported that they would find it difficult not to smoke for a week, compared with 46 per cent of those regular smokers who had been smoking for one year or less. Similarly, 86 per cent of regular smokers who had been smoking for over a year would find it difficult to give up altogether, compared with 56 per cent of those who had smoked for one year or less.

Almost two thirds (63 per cent) of pupils who were regular smokers had tried to give up smoking and 31 per cent reported that they wanted to give up. Among pupils who had smoked regularly for more than a year, 75 per cent had tried to give up smoking compared with 51 per cent of those who had smoked for less time. Similarly, those who had smoked for over a year were more likely to want to give up than those who had smoked for one year or less (40 per cent and 22 per cent respectively). Table 3.20, Figure 3.4

Figure 3.4 - Perceived dependency on smoking in England, by length of time as a regular smoker, 2012



Source: Smoking, Drinking and Drug use among Young People in England in 2012. The Health and Social Care Information Centre. Copyright © 2014

3.3.2 Help on giving up

Pupils who had tried to give up smoking, and those who smoked in the past, were asked whether they had made use of different types of help to give up smoking. Most had not tried any of the methods asked about. 43 per cent reported not spending time with friends who smoke and 22 per cent reported consulting friends or family for advice and 10 per cent reported using nicotine replacement products. Asking an adult at school for advice (5%), phoning an NHS smoking helpline (2%), using NHS Stop Smoking Services (1%) and visiting a GP to help give up (2%) were all less frequently reported methods of trying to stop smoking. Table 3.21

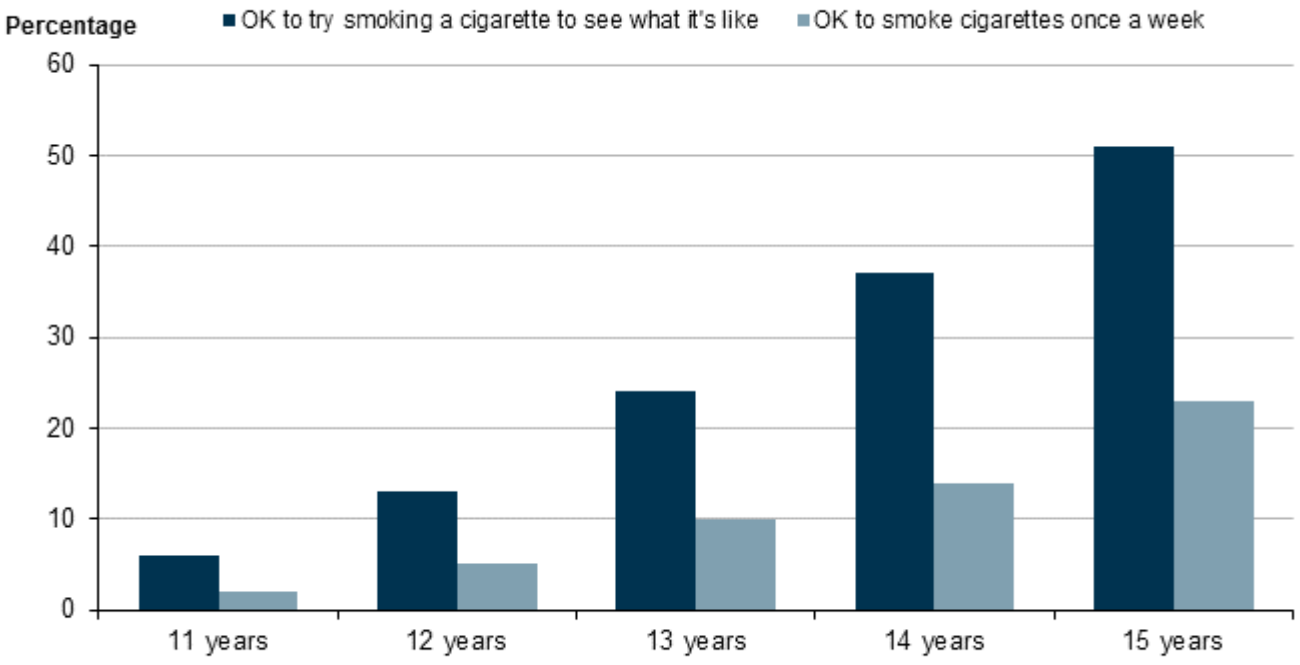
3.3.3 Children's attitudes towards smoking

In 2012, pupils were also asked whether they thought it was 'OK' for someone their age to try cigarettes to see what it is like or to smoke cigarettes once a week.

Since 1999, there has been a steady decrease in the proportion of pupils who thought it was OK to try smoking to see what it was like (54 per cent in 1999 to 31 per cent in 2012). Pupils were also less likely to think that it was OK to smoke cigarettes once a week; 13 per cent in 2012, down from 25 per cent in 2003 (when this question was first asked). Table 3.22

The acceptability of smoking increased with age, as shown in Figure 3.5. For example, 6 per cent of 11 year olds thought it was OK to try smoking to see what it was like, compared with 57 per cent of 15 year olds.

Figure 3.5 - Attitudes to smoking among secondary school children in England by age, 2012



Source: Smoking, Drinking and Drug use among Young People in England in 2012. The Health and Social Care Information Centre. Copyright © 2014

Boys and girls were equally likely to think that it was acceptable to try smoking or to smoke once a week, and older pupils were more tolerant of smoking than younger pupils. Table 3.23

Pupils' attitude towards the acceptability of smoking also reflected their own smoking status. Regular and occasional smokers were more likely to think that it was acceptable to try smoking than non-smokers (84 per cent, 85 per cent and 26 per cent respectively). Table 3.24

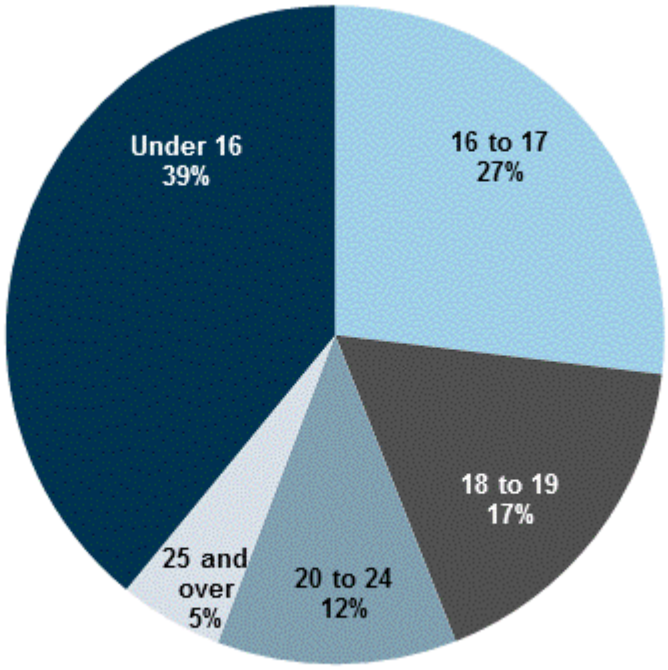
3.4 Age started smoking

The *Smoking Kills*[8] white paper introduced by the then government in 1998 noted that people who started smoking at an early age are more likely than other smokers to smoke for a long period of time and are more likely to die prematurely from a smoking-related disease.

Table 3.25 shows data from the GLF 2010 report, demonstrating that in England 66 per cent of current smokers or those who had smoked regularly at some point in their life started smoking before they were aged 18. Thirty nine per cent reported that they started smoking regularly before they were aged 16, which was until 2007, the lowest age person to whom cigarettes could legally be sold. Figure 3.6

Figure 3.6 - Age at which adults in England started smoking regularly, 2010

Percentages may not add to 100% due to rounding.



Source: General Lifestyle Survey 2010. Office for National Statistics licensed under the Open Government Licence v.2.0.
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The proportion of men who started smoking before they were 16 was 40 per cent compared with 38 per cent of women.

There was an association between the age of starting to smoke regularly and socio-economic classification based on the current or last job of the household reference person. Those in routine and manual households were more likely to have started smoking before they were 16 than those in managerial and professional households (45 per cent and 31 per cent respectively). Table 3.25

3.5 Smoking in cars

Tobacco use remains a significant challenge to public health and exposure to second-hand smoke (SHS) is hazardous to health, especially for children because they breathe more rapidly and inhale more pollutants than adults[9].

The Smoking, Drinking and Drug Use Among Young People in England survey 2012[5] (SDD12) reported that 26 per cent of 11 to 15 year olds were exposed to SHS in their family's car in the past year and 30 per cent in someone else's car.

Smoking in work vehicles has been illegal since 2007 and in February 2014, Parliament voted in favour of introducing legislation to make private vehicles carrying children smoke-free. An amendment to the Children's and Families Act 2014, Part 5, Section 95 paved the way to making smoking in a private vehicle carrying children illegal by 2015.

Government intervention is believed to be required to prevent SHS from adversely affecting the health of children in cars, where the levels of SHS can be significantly more concentrated. Intervention is further required on behalf of children as they cannot exert their choice to leave an SHS-exposed vehicle unlike adult passenger[9].

Action on smoking and health (ASH) YOUGOV survey[10] found that:

- 77 per cent of adults in Great Britain agreed smoking should be banned in cars carrying children younger than 18 years of age, including 63 per cent of smokers
- 46 per cent agreed that smoking should be banned in all cars.

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4 Smoking-related costs, ill health and mortality

Key findings

The number of prescription items dispensed in England to help people stop smoking in 2013/14 was 1.8 million, compared to 1.6 million ten years earlier in 2003/4.

In 2013/14 the Net Ingredient Cost[a] (NIC) of all prescription items used to help people quit smoking was nearly £48.8 million. This is a decrease of 16 per cent on the £58.1 million spent in 2012/13 and 26 per cent less than 2010/11 when NIC of all prescription items peaked at £65.9 million.

In 2012/13 there were approximately 1.6 million admissions for adults aged 35 and over with a primary diagnosis of a disease that can be caused by smoking. This is approximately 4,400 admissions per day on average. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was approximately 1.1 million.

Around 460,900 hospital admissions were estimated to be attributable to smoking. This accounts for 4 per cent of all hospital admissions in this age group (35 years and over). It compares to 559,800 admissions in 2004/05 which is a decrease of 18 per cent.

The proportion of admissions attributable to smoking as a percentage of all admissions was greater amongst men (6 per cent) than women (3 per cent)

Men accounted for 877,193 (55 per cent) admissions for diseases which can be caused by smoking in 2012/13 and women accounted for 723,009 (45 per cent). In both men and women, circulatory diseases were the most common reason for admissions (426,583 and 289,525 respectively).

In 2012/13, circulatory disease accounted for the largest number of admissions where there was a primary diagnosis of a disease that can be caused by smoking (716,108). The second most common diagnosis was for cancers which can be caused by smoking (323,287 admissions). An estimated 81 per cent of admissions with a primary diagnosis of cancers of the trachea, lung and bronchus were attributable to smoking.

In 2013, 17 per cent (79,700) of all deaths of adults aged 35 and over were estimated to be caused by smoking. This proportion is unchanged from 2005.

4.1 Introduction

This chapter presents information on the costs of smoking to the NHS including prescription costs and costs of the NHS Stop Smoking Service. Information is also presented on the number of hospital admissions and the number of deaths that are attributable to smoking.

Information on the prescription items used to help people stop smoking is produced using Prescription Analysis and Cost (PACT)[1] data, which are accessed from NHS Prescription Services.

This chapter looks at admissions to NHS hospitals in England with a primary diagnosis of diseases that can be caused by smoking. The most recent information available at the time of publication is taken from Hospital Episode Statistics (HES)[2] for the financial year 2012/13.

Information on smoking-attributable hospital admissions and mortality[3] are estimates of the numbers of admissions and deaths in England which were caused by smoking. The estimates of the proportion of hospital admissions and deaths attributable to smoking in this chapter follow a recognised methodology, which uses the proportions of current and ex-smokers in the population and the relative risks of these people dying from specific diseases or developing certain non-fatal conditions compared with those who have never smoked, see Appendix B for further details. Figures presented in this chapter relate to people aged 35 and over, as relative risks are only available for this age group.

4.2 Costs to the NHS

4.2.1 Estimated costs to the NHS

Illness and disease associated with smoking gives rise to costs in the NHS. Direct costs of smoking arise from GP consultations, prescriptions for drugs and various costs related to treating diseases attributable to smoking.

Research carried out by Christine Callum, Sean Boyle and Amanda Sandford and published in *Estimating the cost of smoking to the NHS in England and the impact of declining prevalence*[4] in August 2010 estimated the cost of smoking to the National Health Service (NHS) in England to be £2.7 billion in 2006. This took into account, smoking-attributable hospital admissions cost the NHS an estimated £1 billion in 2006, outpatient attendances cost £190 million, general practitioner (GP) consultations £530 million, practice nurse consultations £50 million and GP prescriptions £900 million; £2.7 billion in total. This represented 5 per cent of adult hospital admission costs, 4 per cent outpatients, 11 per cent GP and 8 per cent practice nurse consultations and 12 per cent of prescription costs. Smoking accounted for 24 per cent of respiratory disease hospital admission costs and 16 per cent of cancer and cardiovascular disease costs (people aged 35 years and over).

4.2.2 Prescribing costs for smoking cessation

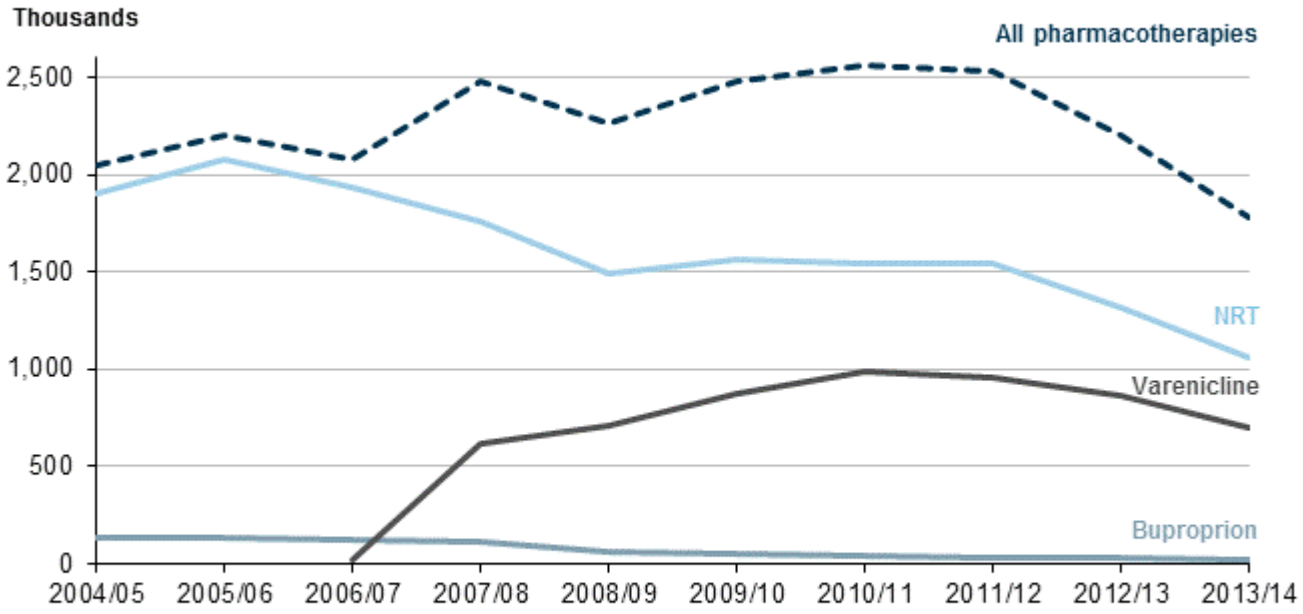
There are three main pharmacotherapies prescribed for the treatment of smoking dependence in England: Nicotine Replacement Therapy (NRT), Bupropion (Zyban) and Varenicline (Champix). Prescription items give a measure of how often a prescriber writes a prescription and it is not an ideal measure of the volume of drugs prescribed as different practices may use different durations of supply.

The number of prescription items dispensed in England to help people stop smoking in 2013/14 was 1.8 million, compared to 1.6 million ten years earlier in 2003/4. It peaked during this period at 2.6 million in 2010/11.

In 2013/14 1.1 million items were for NRT, 697,000 for Varenicline and 22,000 for Bupropion. The reduction in the number of items prescribed is not limited to one type of pharmacotherapy.

Prescription items for Varenicline have fallen for the third consecutive year. In 2010/11 Prescription items for Varenicline peaked at 987,000, in 2011/12 this fell to 957,000; in 2012/13 it fell again to 859,000 and again to 697,000 in 2013/14. Prescription items for Bupropion have been steadily falling since a peak of 136,000 in 2004/05 (it was actually higher in 2000/01 and 2001/02 when fewer alternatives were available). Prescription items for NRT peaked at 2.1 million in 2005/06 and has currently fallen to nearly half that number. Table 4.1 Figure 4.1

Figure 4.1 - Number of pharmacotherapies prescribed in primary care to help people quit smoking, 2003/04 to 2012/13



Source: Prescribing Analysis and Cost (PACT) from Prescription Services, part of the NHS Business Service Authority (NHSBSA). The Health and Social Care Information Centre.

In 2013/14 the Net Ingredient Cost[b] (NIC) of all prescription items used to help people quit smoking was nearly £48.8 million. This is a decrease of 16 per cent on the £58.1 million spent in 2012/13 and 26 per cent less than 2010/11 when NIC of all prescription items peaked at £65.9 million. However the current NIC of all prescription items is over three times the £15.6 million spent in 2000/01.

The average NIC per item was £27 in 2013/14, higher than in 2006/07 (£22) (the first year all three pharmacotherapies were available) but lower than in 2000/01 (£38). The cost per item for Bupropion (Zyban) rose sharply from £37 in 2008/09 to £44 in 2009/10 due to a price increase in February 2009. Table 4.1

Since April 2013 Strategic Health Authorities and Primary Care Trusts have ceased to exist and have been replaced by Commissioning Regions and Area Teams[6]. No comparison can be made between the two as the geographic boundaries are different and therefore no time series is currently available. The North of England Commissioning Region had the highest number of prescription items per 100,000 of the population (3,637 per 100,000 population) whilst London had the lowest (2,567) in 2013/14. Table 4.2

4.2.3 NHS Stop Smoking Services costs

NHS Stop Smoking Services costs are taken from the most recently available information published: *Statistics on NHS Stop Smoking Services in England, April 2013 to March 2014*[7]. NHS Stop Smoking Services are described in Appendix A of this publication. Chapter 4: Treatment and Expenditure of the above publication presents information on the types of

[b] The Net Ingredient Cost NIC is the basic cost of a drug as listed in the Drug Tariff or price lists; it does not include discounts, prescription charges or fees.

pharmacotherapy used within NHS Stop Smoking Services and provides information on the costs of the services provided.

Table 4.6 of *Statistics on NHS Stop Smoking Services: England, April 2013 to March 2014* shows total expenditure on NHS Stop Smoking Services in England (excluding Nicotine Replacement Therapy (NRT), Bupropion (Zyban) Varenicline (Champix) prescriptions). No data is given for 2013/14 as seven Local Authorities (LAs) were unable to provide a full dataset for 2013/14. No estimates have been produced for these LAs so national and regional totals are not available. Therefore the latest data available is for 2012/13 when the cost per quitter was £235, which is an increase on 2011/12 and 2010/11 when the cost was £220.

4.3 Smoking-related ill health

Perceived general health and smoking prevalence is taken from the *Integrated Household Survey: January 2012 to December 2012*[17].

When comparing smoking prevalence and general health, current smokers were less likely to report themselves to be in good health compared to those who have never smoked (Table 5). The age of adults also appeared to have an impact on the perceived general health of current smokers and non-smokers. When looking at adults aged 18 to 24 years old, 85.1 per cent of current smokers considered themselves to be in good health. This compared with 91.9 per cent who had never smoked, a difference of 6.8 percentage points.

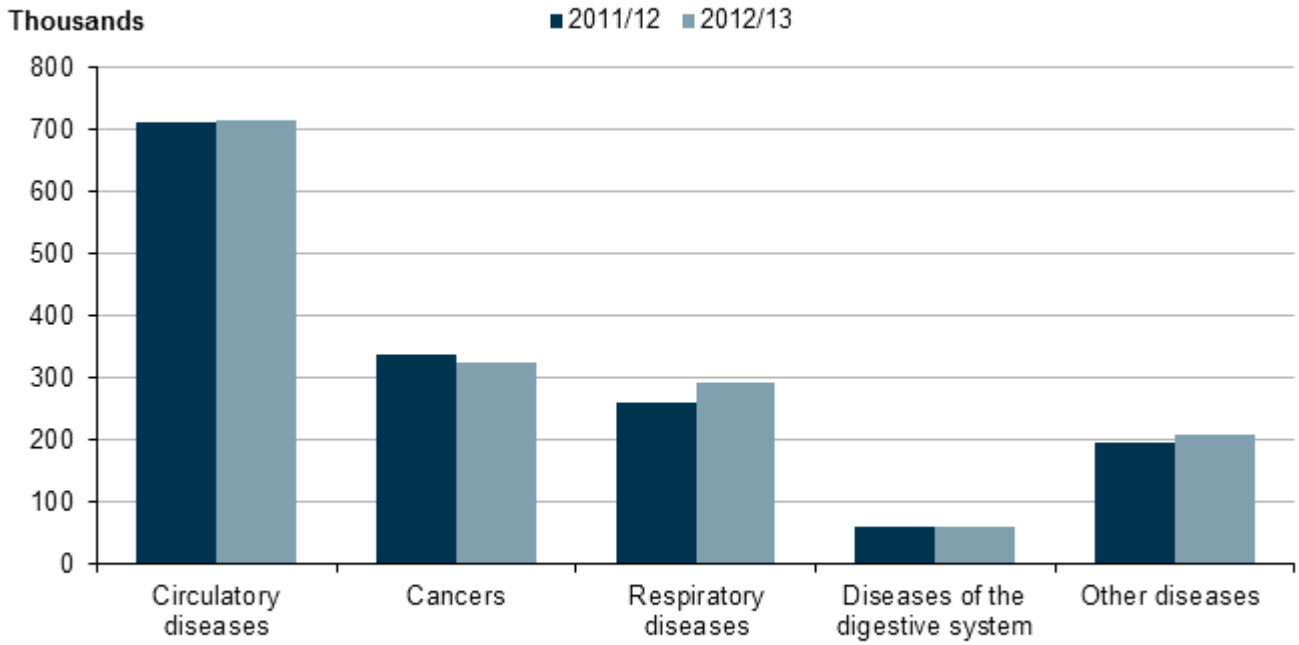
For adults aged 50 to 64 years old, the difference in the perceived general health between current smokers and adults who had never smoked was larger. 56.7 per cent of current smokers considered themselves in good health. This compared with 75.5 per cent of adults who had never smoked, a difference of 18.8 percentage points. This suggests smoking can have a bigger perceived effect on general health as age increases.

4.3.1 NHS hospital admissions for diseases that can be caused by smoking

Table 4.3 in this report shows that in England in 2012/13 there were approximately 1.6 million admissions for adults aged 35 and over with a primary diagnosis of a disease that can be caused by smoking. This is approximately 4,400 admissions per day on average. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was approximately 1.1 million.

In 2012/13, circulatory disease accounted for the largest number of admissions where there was a primary diagnosis of a disease that can be caused by smoking (716,108). The second most common diagnosis was for cancers which can be caused by smoking (323,287 admissions). Of the five categories only the number of admissions for cancers which can be caused by smoking had fallen from the previous year (2011/12). Figure 4.2

Figure 4.2 - NHS hospital admissions[1] in England with a primary diagnosis of diseases which can be caused by smoking, 2011/12 and 2013/13



1. Among adults aged 35 and over.

Source: Hospital Episode Statistics. Health and Social Care Information Centre, 2014.

Men accounted for 877,193 (55 per cent) admissions for diseases which can be caused by smoking and women accounted for 723,009 (45 per cent). In both men and women, circulatory diseases were the most common reason for admissions (426,583 and 289,525 respectively), though this accounted for 49 per cent of admissions for men compared with 40 per cent for women. Women accounted for 32,733 (54 per cent) diseases of the digestive system which can be caused by smoking and for 136,060 (65 per cent) 'other diseases' which can be caused by smoking. Table 4.5

4.3.2 Smoking-attributable NHS hospital admissions

The previous section showed that a large number of hospital admissions of adults aged 35 and over are due to diseases which can be caused by smoking. Not all of these admissions however, will be attributable to smoking as there are other contributory factors to these diseases. In order to estimate the number of smoking-attributable hospital admissions, the relative risks of these diseases for current and ex-smokers have been used.

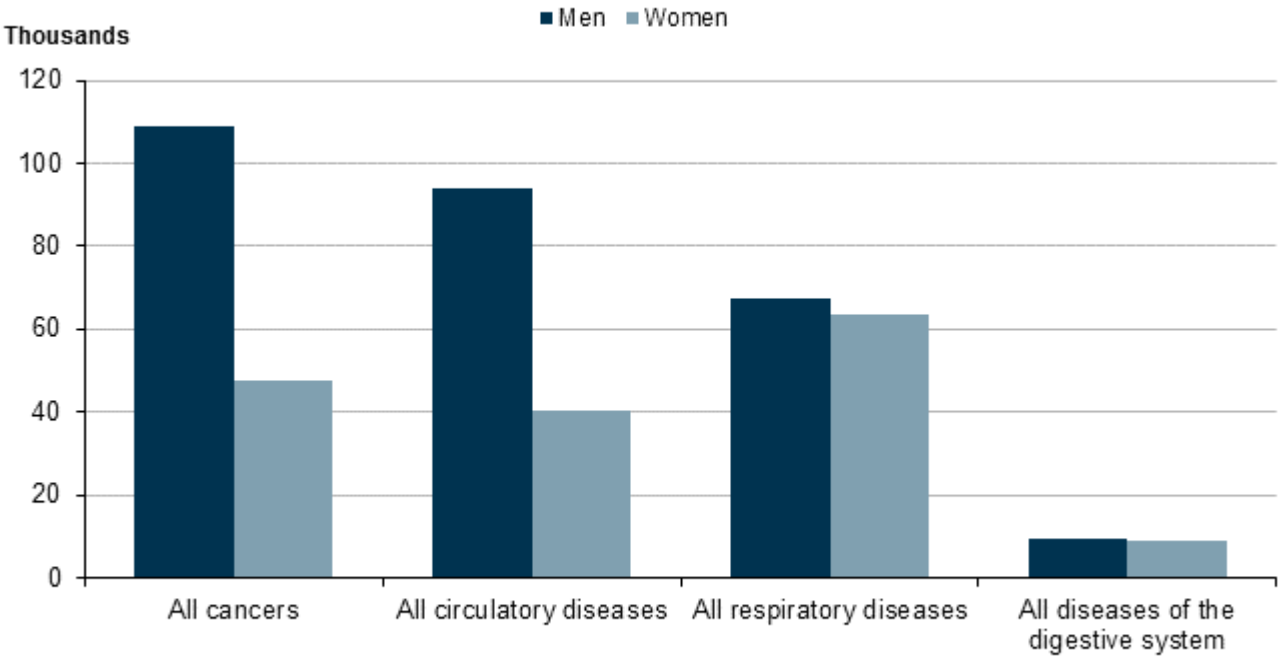
Estimates of the number of smoking-attributable hospital admissions have been calculated following the methodology developed by Callum and White for the report *Tobacco in London: The Preventable Burden*[8] produced by the London Health Observatory (now part of Public Health England) and Smoke-free London and by Hughes and Atkinson for the report *Choosing Health in the South East: Smoking*[9] produced by the South East Public Health Observatory. This report calculates smoking-attributable admissions using risk ratios for diseases associated with smoking-attributable fatalities employed by the Department of Health in their work for the *Health Profile of England 2007*[10], with additional risk ratios for non-fatal diseases attributable to smoking taken from *Tobacco in London: The Preventable Burden*[8].

The analysis relates to people aged 35 and over where a gender has been specified as relative risks are only available for this age group and differ by gender. Appendix B gives more details of the methodology used and lists the diseases for which smoking is an attributable factor and their corresponding risk ratios by age and gender where applicable. Note the figures in this chapter for smoking attributable hospital admissions are only estimates as there is no guarantee that in all cases the admissions were directly linked to smoking.

In 2012/13, there were approximately 10.3 million hospital admissions (for all diseases) for adults aged 35 and over in England. Around 460,900 (4 per cent) of these are estimated to have been attributable to smoking. It compares to 559,800 admissions in 2004/05 which is a decrease of 18 per cent. The number of admissions in 2012/13 can be broken down further by type of primary diagnosis which shows that an estimated 24 per cent of all admissions with a primary diagnosis of respiratory diseases were attributable to smoking, compared to 15 per cent of admissions with primary diagnosis of circulatory diseases, 10 per cent with a primary diagnosis of cancer and 1 per cent with a primary diagnosis of diseases of the digestive system. Table 4.4

A larger proportion of admissions among men than women were attributable to smoking. In 2012/13, there were an estimated 287,900 admissions that can be attributed to smoking for men compared with 173,000 among women. The proportion of admissions attributable to smoking as a percentage of all admissions was also greater amongst men (6 per cent) than women (3 per cent). Of those admitted for circulatory diseases or with cancer, men were noticeably more likely to have the disease as a result of smoking than women. A particularly big difference was found for cancer of the kidney and renal pelvis where 33 per cent of admissions for men were estimated to be caused by smoking compared to 8 per cent in women. Table 4.5, Figure 4.3

Figure 4.3 - Estimated number of NHS hospital admissions attributable to smoking, by disease[1], 2012/13



1. Among adults aged 35 and over.

Source: Hospital Episode Statistics. Health and Social Care Information Centre, 2013.

Of the 460,900 admissions estimated to be attributable to smoking, 156,600 were cancer related, 134,300 were for circulatory diseases, 131,000 were for respiratory diseases and a further 18,500 were for diseases of the digestive system.

An estimated 81 per cent of admissions with a primary diagnosis of cancers of the trachea, lung and bronchus were attributable to smoking. An estimated 80 per cent of admissions for cancer of the larynx and 66 per cent of cancers of upper respiratory sites and cancers of the oesophagus were attributable to smoking. Admissions with a primary diagnosis of chronic obstructive lung disease had the highest percentage of estimated admissions attributable to smoking (85 per cent).

Smoking is also recognised as the cause of admissions for other non-fatal conditions. For example, in 2012/13 10 per cent of admissions with a primary diagnosis of age-related cataracts (among people aged 45 and over) were attributed to smoking. Table 4.4

4.4 Smoking-attributable deaths

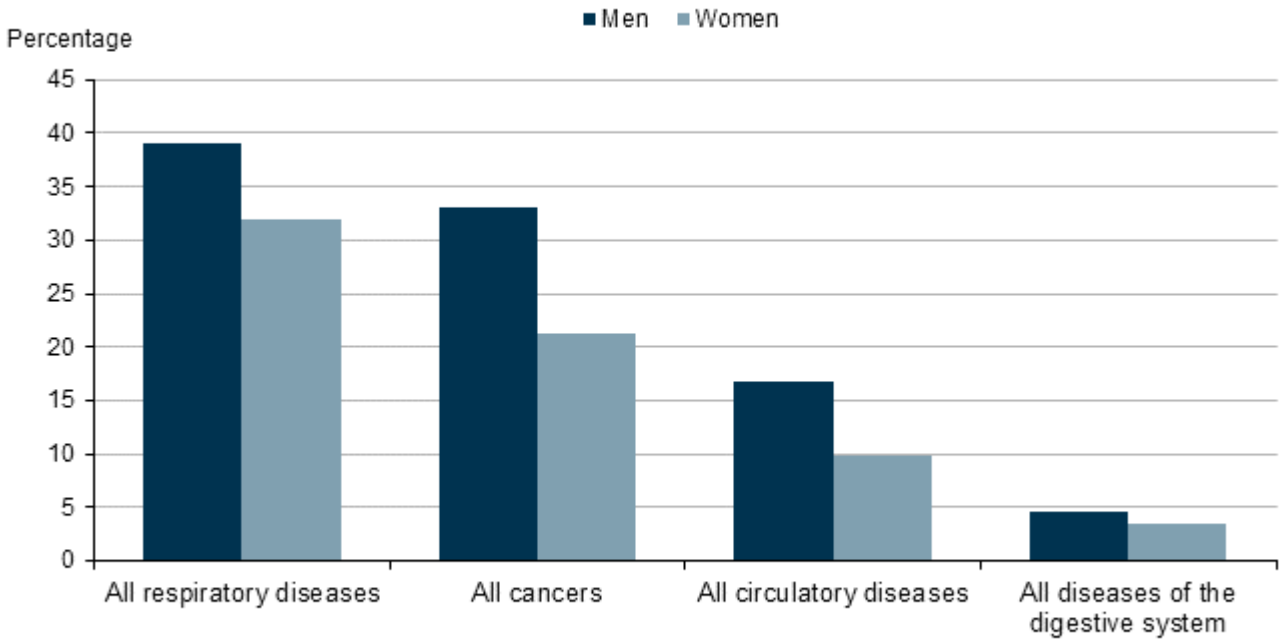
Estimated numbers of smoking-attributable deaths in England have been calculated using the methodology employed by the Department of Health (DH) in the *Health Profile of England*[10](HPE) which expands upon work undertaken by Twigg, Moon and Walker in the report *The Smoking Epidemic in England*[11] produced by the NHS Health Development Agency. This methodology is described in more detail in Appendix B. The methodology employed in this report is identical to that used in the HPE from 2008. The method differs slightly from the HPE 2007 as it does not reduce the deaths figure to take account of those diseases for which smoking decreases the relative risk, specifically Parkinson's disease and cancer of the uterus.

The estimates presented for 2013, are based on 2012 prevalence information (taken from the 2012 Opinions and Lifestyle Survey[12]) and 2013 deaths information[3] from Office for National Statistics, Annual Mortality Statistics, 2013 date of death registration.

In 2013, there were a total of 463,986 deaths of adults aged 35 and over in England, 79,700 (17 per cent) of which were estimated to be attributable to smoking. HPE 2009 estimated 82,580 deaths were attributable to smoking in 2008, using finalised 2007 mortality data and 2007 prevalence data. This is similar to the provisional figure (83,900) for 2008 presented in the *Statistics on Smoking: England, 2009*[14]. *Statistics on Smoking: England, 2007*[19] reported there were a total of 259,076 deaths of adults aged 35 and over in England, 81,900 (32 per cent) of which were estimated to be attributable to smoking.

It is estimated that in 2013, 35 per cent (24,300) of all deaths due to respiratory diseases and 28 per cent (37,200) of all cancer deaths were attributable to smoking. In addition, an estimated 13 per cent (17,300) of deaths from circulatory diseases and 4 per cent (900) of deaths from diseases of the digestive system were attributable to smoking. Figure 4.4 shows these results by gender. Table 4.6, 4.7

Figure 4.4 - Estimated deaths attributable to smoking, as a percentage of all deaths from that disease[1], by gender, 2013



1. Among adults aged 35 and over.

Source: Office for National Statistics, Annual Mortality Statistics, 2013 date of death registration : Crown Copyright

An estimated 85 per cent of deaths from chronic obstructive lung disease were attributable to smoking. This compares with 81 per cent of deaths from trachea, lung and bronchus cancer, which translates to the largest number of deaths of any disease (around 23,000). There were an estimated 18,900 smoking attributable deaths as a result of chronic airway obstruction, 77 per cent of observed deaths from this disease and the second largest number of smoking attributable deaths of any disease. An estimated 79 per cent of deaths from cancers of the larynx, 66 per cent of deaths from cancers of the oesophagus, 64 per cent from cancers of the upper respiratory sites and 59 per cent from aortic aneurysms were attributable to smoking. Table 4.6

A larger proportion of deaths among men than women were attributable to smoking with an estimated 21 per cent (47,900) of all deaths among men aged 35 and over being attributable to smoking. This compares with 13 per cent (31,800) of all deaths among women. Table 4.7

4.5 Local Tobacco Control Profiles

The Local Tobacco Control Profiles[15] for England presents information on smoking-attributable hospital admissions and mortality at both Local Authority (LA) and Primary Care Trust (PCT) level. These form part of a suite of indicators that are tailored to the needs of local users and cover the health problems caused by smoking, the prevalence of smoking at local level and the extent to which services across the NHS and LAs are tackling smoking and the problems it causes. They are outcome-focussed, relevant to the major modern challenges of tobacco control and provide local commissioners and services a set of up-to-date information as well as an indication of trends over time.

The smoking attributable data available within the Local Tobacco Control Profiles have been produced by the Public Health Observatories (PHOs) in England using Hospital Episode

Statistics (HES) data for admissions and Office for National Statistics (ONS) Mortality Statistics for the number of registered deaths.

The methodology used to derive estimates of the smoking attributable deaths and admissions is identical to the methodology set out in Appendix B. However, the Local Tobacco Control Profiles[18] use prevalence estimates derived from the Integrated Household Survey (IHS)[16] rather than the General Lifestyle Survey (GLF). This may account for any differences between the estimates in the two reports for any given year.

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Appendix A: Key sources

- Affordability data
- Availability of tobacco
- Living Costs and Food Survey
- General Lifestyle Survey
- Health Survey for England
- Hospital Episode Statistics
- Infant Feeding Survey
- International Classification of Diseases
- NHS Stop Smoking Services
- Office for National Statistics Mortality Statistics
- Office for National Statistics Omnibus Survey
- Opinions and Lifestyle Survey
- Prescription data
- Smoking-attributable deaths and diseases
- Smoking, drinking and drug use among young people in England

Affordability data

An important adjustment was introduced in *Statistics on Smoking: England, 2011* so that the revised Real Households' Disposable Income (RHDI) index exclusively tracks changes in real disposable income per capita, this was not on a per capita basis.

The adjustment was applied to all years in the index (1980 onwards). The adjusted RHDI index was then carried forward to produce an adjusted affordability of tobacco index

The tobacco price index as seen in Table 2.12 of this bulletin shows how much the average price of tobacco has changed compared with the base price (1980).

The Retail Prices Index (RPI) shows how much the prices of all items have changed compared with the base price (1980).

The relative tobacco price index is calculated as follows:

rtpi = *(*tpi/rpi)*100

rtpi = relative tobacco price index

tpi = tobacco price index

rpi = retail prices index

This shows how the average price of tobacco has changed since the base (1980) compared with prices of all other items. A value greater than 100 shows that the price of tobacco has increased by more than inflation during that period.

Adjusted real households' disposable income is an index of total households' income, minus payments of income tax and other taxes, social contributions and other current transfers,

converted to real terms (i.e. after dividing by a general price index to remove the effect of inflation) which tracks, exclusively, changes in real disposable income per capita.

The adjusted real households' disposable income index is calculated by dividing the real households' disposable income index by total number of UK adults (aged 18 and over). The rebase the resulting series so that 1980 equals 100 per cent.

Affordability of tobacco gives a measure of the relative affordability of tobacco, by comparing the relative changes in the price of tobacco, with changes in households' disposable income per capita over the same period (with both allowing for inflation).

The Relative Affordability of tobacco is calculated as follows:

*rat = (arhdi/ rtpi)*100*

rat = relative affordability of tobacco

arhdi = adjusted real households' disposable income index

rtpi = relative tobacco price index

If the affordability index is above 100, then tobacco is relatively more affordable than in the base year, 1980.

Affordability data is presented in Chapter 2 of this report.

Additional information can be found at:

- Focus on Consumer Price Indices, Office for National Statistics[1]
- Economic and Labour Market Review, Office for National Statistics[2]
- Final Mid-Year Population Estimates (based on 2011 census), Office for National Statistics[3]

Availability of tobacco

The availability of tobacco, shown as the volume of tobacco released for home consumption, is taken from HM Revenue & Customs (HMRC) statistical fact sheets[4]. Graphs, tables and charts are used to present a variety of data and to communicate information to the user. In places, commentary is provided to support the data. Fact sheets are not National Statistics. HMRC data is presented in Chapter 2 of this report.

Living Costs and Food Survey [NS][c]

In 2008 the Living Costs and Food Survey (LCF) became part of the Integrated Household Survey (IHS) run by the Office for National Statistics (ONS). The LCF provides data on food purchases and expenditure; historical estimates based on National Food Surveys (NFS) are available from 1940 to 2000.

Details of the adjustments to the NFS estimates can be found in *Family Food. A report on the 2002/03 Expenditure & Food Survey*[5].

The LCF collects diaries from around 6,000 households across the UK. Each household member over the age of seven years keeps a diary of all their expenditure over a 2 week period. Note that the diaries record expenditure and quantities of purchases of food and drink rather than consumption of food and drink.

Data from the LCF presented in Chapter 2 details expenditure on cigarettes by different variables. It is important to note that the average expenditure is for all households and not

[c] National Statistic

only those households where there is a smoker. The differences between subgroups in the average expenditure may be due to different proportions of smoking households and/or a real difference in the amount spent by individual smokers.

General Lifestyle Survey [NS][c]

The General Lifestyle Survey was a continuous survey carried out by the Office for National Statistics (ONS). It collects information on a range of topics from people living in private households in Great Britain. Questions about smoking were included in the survey in alternate years since 1974. Following a review of the GLF, questions on smoking have been included in the questionnaire every year from 2000 onwards.

Following consultation with users, GLF was discontinued at the end of 2011. Some of the questions on smoking were included in the new ONS Opinions and Lifestyles Survey.

Questions relating to smoking in the General Lifestyle Survey

Question Number	Code	Question
302	SmkIntro	Ask if respondent is 18+ and stated they smoked nowadays
303	SelfCom1	Ask all 16 and 17 year olds • Respondent accepted self-completion • Respondent refused self-completion • Data now to be keyed by interviewer
		Ask if respondent is 18+
304	SmokEver	have you ever smoked a cigarette, a cigar, or a pipe?
305	CigNow	Do you smoke / does *(name)* smoke cigarettes at all nowadays?
306	QtyWkEnd	How many cigarettes A DAY do you usually smoke at the weekend?
307	QtyWkDay	How many cigarettes A DAY do you usually smoke on weekdays?
308	CigType	Do you mainly smoke/ • filter-tipped cigarettes • or plain or un-tipped cigarettes • or hand-rolled cigarettes
309	CiglDesc	What brand of cigarettes do you usually smoke
310	CigCODE	Code for cigarette brand
311	CigPack	Brand checked by interviewer
312	NoSmoke	How easy or difficult would you find it to go without smoking for a whole day? Would you find it … • Very easy • Fairly easy • Fairly difficult or • Very difficult
313	GiveUp	Would you like to give up smoking all together?
314	FirstCig	How soon after waking do you USUALLY smoke your first cigarette of the day?
315	CigEver	have you ever smoked cigarettes regularly?
316	CigUsed	About how many cigarettes did you smoke IN A DAY when you smoked them regularly?
317	CigStop	How long ago did you stop smoking cigarettes regularly?
318	CigAge	How old were you when you started smoking cigarettes regularly?
319	CigarReg	Do you smoke at least one cigar of any kind per month nowadays?
320	CigarsWk	About how many cigars do you usually smoke in a week?
321	CigarEver	Have you ever regularly smoked at least one cigar of any kind per month?
322	PipeNow	Do you smoke a pipe nowadays?

323	PipEver	Have you ever smoked a pipe regularly?
324	GiveUpC	Which one of the following statements best describes you? I intend to give up smoking within the next month I intend to give up smoking within the next 6 months I intend to give up smoking within the next year I intend to give up smoking but not in the next year I intend to give up smoking , but I'm not sure when I don't intend to give up smoking

Questions relating to smoking in the Opinions and Lifestyle Survey

Code	Question
	ASK IF: (Age = 16) OR (Age = 17)
M210_in16	Do you smoke cigarettes at all nowadays?
CigsWkD	How many cigarettes a day do you usually smoke at weekends?
CigsWkE	How many cigarettes a day do you usually smoke on weekdays?
CigType	Do you usually smoke packeted cigarettes, hand-rolled cigarettes or both? • Packeted • Hand-rolled • Both packeted and hand-rolled, but mainly packeted • Both packeted and hand-rolled, but mainly hand-rolled

Health Survey for England [NS][c]

The Health Survey for England (HSE) comprises of a series of annual surveys commissioned by the Health and Social Care Information Centre. All of the surveys cover the adult population aged 16 and over living in private households in England. Since 1991, the HSE has included questions related to smoking.

Each survey consists of core questions and measurements (e.g. blood pressure and analysis of blood samples) plus modules of questions on specific issues that change periodically such as cardiovascular disease or on specific population groups such as older people or ethnic minorities.

Data from the HSE are presented in Chapters 2 and 3 of this report.

HSE publications from 2004 onwards are available on the Health and Social Care Information Centre website[6].

Earlier HSE publications are available on the Department of Health (DH) website[7].

Hospital Episode Statistics

Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions to NHS hospitals in England since April 1987. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England as well as detailed records of attendances at major A&E departments, single specialty A&E departments, minor injury units and walk-in centres in England.

HES data are classified using the International Classification of Diseases (ICD). The ICD is the international standard diagnostic classification for all general epidemiological and many health management purposes. It is used to classify diseases and other health problems

recorded on many types of health and vital records including death certificates and hospital records. The International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organisation (WHO) is currently in use. Figures presented in Chapter 4 of this report are based on finished admission episodes[d] with a primary diagnosis[e] of diseases that can be caused by smoking, as defined by a specific set of ICD-10 codes.

Details of ICD-10 codes used are included in Tables 4.4 to 4.7. The statistics on hospital activity in England are derived from data collected on NHS hospital in-patient care. Thus, they do not fully reflect hospital treatment of patients with smoking-related diagnoses or conditions, as local choice might favour outpatient treatment, for which detailed information is not available.

Infant Feeding Survey

The Infant Feeding Survey (IFS)[8] was last carried out in 2010 and was published by the Health and Social Care Information Centre in September 2012. The survey provided statistics on smoking behaviour among women before and during pregnancy. Information is provided on the smoking and drinking behaviours of women before, during and after pregnancy.

International Classification of Diseases

The International Classification of Diseases (ICD) is the international standard diagnostic classification for all general epidemiological and many health management purposes. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records.

The illnesses, diseases and injuries suffered by hospital patients are currently recorded using the International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organization (WHO)[9]. In 1995, the recording of diagnoses changed from the 9th to the 10th revision of the ICD. An alphanumeric coding scheme replaced the numeric one. The regrouping of classifications means that classifications may not map precisely between the two revisions.

Data that use the ICD-10 coding are found in Chapter 4 of this report.

NHS Stop Smoking Services

NHS Stop Smoking Services (formerly known as Smoking Cessation Services) provide counseling and support to smokers wanting to quit, complementing the use of stop smoking aids Nicotine Replacement Therapy (NRT), Bupropion (Zyban) and Varenicline (Champix).

The establishment and development of Stop Smoking Services in the NHS is an important element of the government's strategy to tackle smoking. Monitoring of the NHS Stop Smoking Services is carried out via quarterly monitoring returns. The quarterly reports present provisional results from the monitoring of the NHS Stop Smoking Services, until the release of the annual bulletin when all quarterly figures are confirmed.

Prior to October 2005, *Statistics on NHS Stop Smoking Services* were collected and published by The Department of Health[11]. This is now the responsibility of the Health and Social Care Information Centre[10].

Statistics on NHS Stop Smoking Services are presented in Chapters 3 and 4 of this report.

[d] A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider

[e] A primary diagnosis is the main condition treated or investigated during the relevant episode of healthcare.

Office for National Statistics Mortality Statistics [NS][c]

The Office for National Statistics (ONS) produce an annual extract of mortality statistics to the Health and Social Care Information Centre detailing the numbers of deaths by cause in England. Registered deaths in England are classified using ICD-9 to 2000 and by ICD-10 for both 1999, and from 2001 onwards.

ONS mortality data are shown in Chapter 4 of this report.

Office for National Statistics Omnibus Survey [NS][c]

The Omnibus Survey is a multi-purpose continuous survey carried out by the Office for National Statistics (ONS) on behalf of a range of government departments and other bodies.

In 2008/09, interviews for the smoking module of the survey were conducted with around 1,200 adults aged 16 or over living in private households in Great Britain each month, during October and November 2008 and again in February and March 2009. This survey is currently not being continued. The latest report on the smoking module *Smoking-related behaviour and attitudes, 2008/09* presents results on smoking behaviour and habits, views and experiences of giving up smoking, awareness of health issues linked with smoking and attitudes towards smoking.

The weighting system in the Omnibus Survey used from 2007 onwards adjusts for some non-response bias. The weighting ensures that the weighted sample distribution across regions and across age-sex groups matches that in the population. Trend tables from the *Smoking-related behaviour and attitudes, 2008/09*[12] *[NS]*[c] report show the 2007 estimates and bases weighted to population totals, and for unequal probability of selection (as in previous years) to give an indication of the effect of the revised weighting system. There appeared to be little effect on the estimates by introducing the new weighting system. Care should be taken when comparing 2008/09 estimates based on the new weighting system with those from previous reports using the old weighting system.

Data from the Omnibus survey are used in Chapter 3 of this report.

Opinions and Lifestyle Survey [NS][c]

The Opinions and Lifestyle Survey (OPN) provides information on smoking rates, average number of cigarettes smoked and smoking during pregnancy in Great Britain during 2012. This continues the series of releases on smoking; previously provided by the General Household Survey (GHS) and the General Lifestyle Survey (GLF). The OPN and GHS/GLF provide comparable results, however, there are some differences in the two surveys' design and content; see ONS Methodology for details http://www.ons.gov.uk/ons/rel/ghs/opinions-and-lifestyle-survey/smoking-habits-amongst-adults--2012/rpt-opinions-and-lifestyle-survey---smoking-habits-amongst-adults--2012.html#tab-Methodology-

Data from the Opinions and Lifestyle Survey are used in Chapter 2 of this report.

Prescription data [NS][c]

Information on prescription items prescribed in primary care settings in England is produced using Prescribing Analysis and Cost Tool (PACT). The PACT system covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Prescriptions written in England but dispensed outside England are included. Prescriptions written in hospitals/clinics that are dispensed in the community, prescriptions dispensed in hospitals and private prescriptions are not included in PACT data.

Hospital prescription information is taken from the Prescription Cost Analysis (PCA) system, and is based on a full analysis of all prescriptions dispensed in the community i.e. by community pharmacists and appliance contractors, dispensing doctors, and prescriptions

submitted by prescribing doctors for items personally administered in England. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. The data do not cover drugs dispensed in hospitals, including mental health trusts, or private prescriptions.

Prescriptions are written on a prescription form known as a FP10 and each single item on the form is counted as a prescription item. Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charges income.

The prescription data included in this report are not routinely available. Sub-national or primary care data may be available on request from Prescription Services. National data with a wider coverage is available from the Health and Social Care Information Centre.

Smoking-attributable deaths and diseases

Data on smoking-attributable NHS hospital admissions and deaths for those aged 35 and over are presented in Chapter 4 of this report. See Appendix B for more details on the methodology employed to calculate smoking-attributable hospital admissions and deaths.

Smoking, Drinking and Drug Use among Young People in England, 2013 [NS][c]

Smoking, Drinking and Drug Use Survey among Young People in England in 2013[13] (SDD13) is the latest in the series of surveys of secondary school children in England which provides the national estimates of the proportions of young people in school years 7 to 11 (who are mostly aged 11 to 15) who smoke, drink alcohol or take illegal drugs.

The first survey in the series, carried out in 1982 and since 1998 survey has included questions on drinking and drug use as well as smoking.

As well as these core measures, questionnaires since 2000 have included more detailed questions, with the focus alternating between smoking and drinking in one year and drug use the next. The focus in 2013 was on drug use and therefore 2012 was the last year to focus on smoking and drinking, and this report reflects that.

Following consultation with survey users, the design of the sample was changed in 2010. For surveys between 2000 and 2009, the sample of schools was stratified by school type and sex of intake, and selected across regions in proportion to the distribution of the population of 11 to 15 year olds. In 2010, the sample was stratified by Strategic Health Authority (SHA); within each SHA an equal number of schools was sampled. This design has been used since although from 2011 it is stratified by nine Government Office Regions rather than by ten Strategic Health Authorities. This change was designed to enable the publication of more up-to-date regional analyses of the data than was possible with the original design.

Smoking, Drinking and Drug Use Among Young People in England is published by the HSCIC and reports can be found at: http://www.hscic.gov.uk/article/2021/Website-Search?q=title%3a%22smoking+drinking+and+drug+use+among+young+people%22&sort=Most+recent&size=10&page=1&area=both#top

Information from the SDD reports can be found in Chapter 2

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Appendix B: Estimating smoking-attributable deaths and hospital admissions

Introduction

Estimates of smoking-attributable NHS hospital admissions and deaths given in Chapter 4 Tables 4.3 to 4.7 are based on three pieces of information:

1. Estimates of smoking prevalence for both smokers and ex-smokers
2. Relative risks for deaths and non-fatal diseases for both smokers and ex-smokers for those diseases known to be associated with smoking
3. Observed numbers of hospital admissions or deaths caused by those diseases which can be caused by smoking.

Smoking Prevalence

Estimates of the prevalence in England of current and ex-smokers by gender and age are taken from the results of Opinions and Lifestyle Survey (OPS). These estimates are used in order to estimate the number of smoking-attributable admissions and deaths.

Smoking prevalence information from the 2012 OPN is presented in Table B.1.

Relative Risks

Fatal diseases

In 2007 a review of the existing methodologies was undertaken by the Department of Health (DH) and a revised list of diseases for which there was an excess risk of death for current and ex-smokers compared to those people who have never smoked was produced which was then used to estimate numbers of smoking attributable fatalities in the Health Profile for England (HPE)[1]. This revised approach has been adopted for this report.

The methodology employed in this report is identical to that used by the DH in the HPE 2008 and HPE 2009. The method differs slightly from the HPE 2007 as it does not reduce the deaths figure to take account of those diseases for which smoking decreases the relative risk, specifically Parkinson's disease and cancer of the uterus.

The values presented in Table B.2 represent the risk of a person who smokes or is an ex-smoker, dying from that disease (unless list as a non-fatal disease, see below) compared to someone who has never smoked. That is, a value greater than 1 represents an increased risk of death. The risks are only applicable to people aged 35 and over and therefore only deaths of people aged 35 and over have been used in calculating the estimates.

Non-fatal diseases

The relative risks for non-fatal diseases (Crohn's disease; Periodontal disease/Periodontitis; Age-related cataract; Hip fracture and Spontaneous abortion) are also presented in Table B.2 to estimate the numbers of smoking-attributable hospital admissions in England. These risks have been taken from diseases used by Hughes and Atkinson in the report *Choosing Health in the South East: Smoking*[5] which was based on an update of a 1996 epidemiological study which have not since been reclassified by the DH review as a fatal disease.

The risks for these non-fatal diseases are presented in the same way as those for fatal disease, however they are not gender-specific (with the exception of hip fracture among the 75+ age group) and so the same risks are used to calculate the attributable proportions for

both men and women. In the case of spontaneous abortion, the risk is only given for current female smokers.

In order to be consistent with the methodology for fatal diseases, the risks for non-fatal conditions were only applied for hospital admissions of people aged 35 and over.

For fatal diseases, the risks of death were also applied to calculate smoking-related hospital admissions in England. There are some drawbacks to using mortality risks for health outcomes and these are discussed by Callum and White in *Tobacco in London: The Preventable burden*[3].

Deaths and admissions

The number of deaths for men and women in each of the specified age groups are taken from an annual extract of Office for National Statistics (ONS) mortality statistics by cause and by registrations (V53). The data used refer to the number of registered deaths in England.

Figures on hospital admissions are from Hospital Episode Statistics (HES) supplied by the Health and Social Care Information Centre (HSCIC). The data refer to hospital admissions of people who are resident in England for the specified period.

The tenth revision of the International Classification of Diseases (ICD) was used to identify hospital admissions and deaths from the diseases of interest. Tables B.2 list the ICD-10 codes used in Tables 4.3 to 4.7.

In January 2011 ONS introduced a new version of ICD-10 (version 2010) which replaced version 2001.2. This means that some figures for the number of deaths for 2011 onwards will not be directly comparable to figures for 2001 to 2010.

Further details are available from ONS:
http://www.ons.gov.uk/ons/rel/subnational-health3/results-of-the-icd-10-v2010-bridge-coding-study--england-and-wales--2009/2009/index.html

Calculation of Smoking-Attributable Deaths and Admissions

For each of the diseases or groups of diseases shown in Tables B.2, the attributable proportion is calculated as follows:

$$a = \left[p_{cur}\left(r_{cur} - 1\right) + p_{ex}\left(r_{ex} - 1\right)\right] / \left[1 + p_{cur}\left(r_{cur} - 1\right) + p_{ex}\left(r_{ex} - 1\right)\right]$$

where:

a = attributable proportion for each disease

p_{cur} = proportion of current smokers

p_{ex} = proportion of ex-smokers

r_{cur} = relative risk of current smokers

r_{ex} = relative risk of ex-smokers.

The equation is reduced where the risks are only given for ‘all smokers’ or ‘current smokers’ (as is the case for some non-fatal conditions).

The estimated number of smoking-attributable hospital admissions or deaths in England is found by multiplying the observed number by the attributable proportion.

Notes

1. Work by Callum and White in *Tobacco in London: The Preventable burden*[3], and further work done by Twigg, Moon and Walker in the report *The Smoking epidemic: Deaths in 1995*[4] use a correction to the estimates for the smoking-attributable proportion of unspecified site cancer deaths to account for the fact that only a proportion of the unspecified site cancers will be smoking-related. Callum and White states that this correction is arbitrary and this has not been adopted by the Department of Health in the Health Profile for England and has not been adopted here to ensure that our results are easily reproducible. Therefore, the number of unspecified cancer deaths attributed to smoking in this report may be an overestimate.
2. The risk for spontaneous abortion is for those women who were current smokers during their pregnancy. Data on smoking during pregnancy is not available from the Opinions and Lifestyle Survey and so smoking prevalence in the general population was used to calculate the smoking-attributable proportion of admissions in England with this condition.

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List of tables

Table B1 - Smoking Status by Sex and Age, England, 2012

Percentages

	Male		Female		Unweighted Bases	
Age group	Smoker	Ex-smoker	Smoker	Ex-smoker	Male	Female
35 and over	19	30	16	22	3,830	4,607
45 and over	17	34	15	23	3,035	3,567
35 to 54	24	20	20	17	1,640	1,991
55 to 64	20	33	15	25	837	913
65 to 74	14	43	14	28	778	873
75 and over	7	49	7	26	575	830
35 to 64	23	24	19	20	2,477	2,904
65 and over	11	45	11	27	1,353	1,703

Footnotes

1 Adults who said that they do smoke cigarettes nowadays are classed as current smokers

2 Adults who said that they used to smoke cigarettes regularly but no longer do so are defined as ex-smokers

Source

Opinions and Lifestyle Survey, Office for National Statistics licensed under the Open Government Licence v.2.0..

Table B2 - Relative risk ratios for diseases for current and ex-smokers in England, by gender

Numbers

			Men		Women	
Disease category	**ICD-10 code**	**Age**	**Current smokers**	**Ex-smokers**	**Current smokers**	**Ex-smokers**
Cancers which can be caused by smoking						
Trachea, Lung, Bronchus	C33-C34	35+	23.26	8.70	12.69	4.53
Upper respiratory sites	C00-C14	35+	10.89	3.40	5.08	2.29
Oesophagus	C15	35+	6.76	4.46	7.75	2.79
Larynx	C32	35+	14.60	6.34	13.02	5.16
Cervical	C53	35+	1.00	1.00	1.59	1.14
Bladder	C67	35+	3.27	2.09	2.22	1.89
Kidney and Renal Pelvis[2]	C64-C66,C68	35+	2.50	1.70	1.40	1.10
Stomach	C16	35+	1.96	1.47	1.36	1.32
Pancreas	C25	35+	2.31	1.15	2.25	1.55
Unspecified site[2]	C80	35+	4.40	2.50	2.20	1.30
Myeloid leukaemia[2]	C92	35+	1.80	1.40	1.20	1.30
Respiratory diseases which can be caused by smoking						
Chronic obstructive lung disease	J40-J43	35+	17.10	15.64	12.04	11.77
Chronic Airway Obstruction	J44	35+	10.58	6.80	13.08	6.78
Pneumonia, Influenza[2]	J10-J18	35 - 64	2.50	1.40	4.30	1.10
	J10-J18	65+	2.00	1.40	2.20	1.10
Circulatory diseases which can be caused by smoking						
Other Heart Disease	I00-I09, I26-I51		1.78	1.22	1.49	1.14
Ischaemic heart disease[2]	I20-I25	35 - 54	4.20	2.00	5.30	2.60
	I20-I25	55 - 64	2.50	1.60	2.80	1.10
	I20-I25	65 - 74	1.80	1.30	2.10	1.20
	I20-I25	75+	1.40	1.10	1.40	1.20
Other arterial disease	I72-I78	35+	2.07	1.01	2.17	1.12
Cerebrovascular disease[2]	I60-I69	35 - 54	4.40	1.10	5.40	1.30
	I60-I69	55 - 64	3.10	1.10	3.70	1.30
	I60-I69	65 - 74	2.20	1.10	2.60	1.30
	I60-I69	75+	1.60	1.10	1.30	1.00
Aortic aneurysm	I71	35+	6.21	3.07	7.07	2.07
Atherosclerosis	I70	35+	2.44	1.33	1.83	1.00
Diseases of the digestive system which can be caused by smoking						
Stomach/duodenal ulcer	K25-K27	35+	5.40	1.80	5.50	1.40
Crohns disease[3]	K50	35+	2.1	1	2.1	1
Periodontal disease/Periodontitis[3]	K05	35+	3.97	1.68	3.97	1.68
Other diseases which can be caused by smoking						
Age-related cataract[3]	H25	45+	1.54	1.11	1.54	1.11
Hip fracture[3]	S72.0-S72.2[4]	55 - 64	1.17	1.02	1.17	1.02
	S72.0-S72.2[4]	65 - 74	1.41	1.08	1.41	1.08
	S72.0-S72.2[4]	75+	1.76	1.14	1.85	1.22
Spontaneous abortion[3]	O03	35+			1.28	

Footnotes

1 Based on CPS-II 1982-88 data, taken from CHP2007 / SAMMEC / USDHHS2004 unless stated
2 Based on CPS-II 1982-88 data, taken from UK Smoking Epidemic (1998)
3 Based on CPS-II 1984-88 data, taken from Tobacco in London, The preventable burder (2004)
4 ICD-10 code S72 for hip fracture has ben refined to S70.0, S72.1 and S72.2 in reports from 2010 onwards

Sources

Health Profile for England 2007, Department of Health
Tobacco in London: The Preventable Burden, Smokefree London & The London Health Observatory, 2004

Appendix C: Government policy and targets

Introduction

Tobacco use remains one of the government's most significant public health challenges, and causes nearly 80,000 premature deaths in England each year.

The White Paper, *Healthy lives, Healthy people: Our strategy for public health in England* [1] sets out the Government's commitment to improving public health in communities across England. The White Paper promised a new plan for tobacco control in England.

The Government published its Tobacco Control Plan, *Healthy lives, Healthy people: A Tobacco Control Plan for England* [2] on 9 March 2011. An academic review of the evidence of the impact of the smoke-free legislation in England [3] was also published alongside the Tobacco Control Plan.

The Tobacco Control Plan sets out how tobacco control is currently being delivered in the context of the new public health system, over a five year period, due to end in 2015.

The plan sets out three national ambitions to reduce smoking rates in England by the end of 2015:

- From 21.2 per cent to 18.5 per cent or less among adults;
- From 15 per cent to 12 per cent or less among 15 year olds; and
- From 14 per cent to 11 per cent or less among pregnant mothers (measured at the time they give birth).

In the Tobacco Control Plan, the Government set out key actions in the following six areas:

- stopping the promotion of tobacco;
- making tobacco less affordable;
- effective regulation of tobacco products;
- helping tobacco users to quit;
- reducing exposure to second-hand smoke; and
- effective communications for tobacco control.

The revised *Tobacco Product Directive* (TPD) has been formally approved by European Union member states. The new Directive was published in the Official Journal of the European Union[5] on 29 April 2014. The Department of Health aims to launch a public consultation on the draft implementing regulations in 2015, with a view to bringing domestic rules into force by 20 May 2016.

The revised TPD regulates as consumer products those electronic cigarettes that are not classified as medicinal products under Directive 2001/83/EC or making a medicinal claim[f] such as "this product will help you to quit smoking".

- The TPD sets mandatory safety and quality requirements on nicotine content, ingredients and devices as well as refill mechanisms.

[f] E-cigarettes that make medicinal claims such as 'reduced harm' or helping people to 'cut down and quit' and/or which contain more than 20mg/ml will subject to medicines regulatory regime and will be licensed by the Medicines and Healthcare products Regulatory Agency.

- The new rules make health warnings and information leaflets mandatory and introduce notification requirements for manufacturers and importers of electronic cigarettes.
- There are stricter rules on advertising and closer monitoring of market developments.

The European Commission will report on the potential health risks associated with refillable electronic cigarettes by 20 May 2016.

It was not possible to introduce age of sale controls through the revised TPD. The Department of Health plans to prohibit the sale of e-cigarettes to under-18s through powers contained in the Children & Families Act 2014, with a consultation planned for October 2014. The consultation will seek views on draft regulations to introduce a minimum age of sale of 18 and to extend new 'proxy purchasing' laws for nicotine inhaling products, such as e-cigarettes.

The Department of Health recently consulted on regulations to protect children from second-hand smoke by ending smoking in private vehicles carrying children. Subject to parliamentary approval, the new regulations are anticipated to come into force in 2015.

Public Commitments

Published 9 March 2011

Reduce smoking prevalence among adults in England: To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015 (from 21.2 per cent) meaning around 210,000 fewer smokers a year.

Reduce smoking prevalence among young people in England: To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less (from 15 per cent) by the end of 2015.

Reduce smoking during pregnancy in England: To reduce rates of smoking throughout pregnancy to 11 per cent or less (from 14 per cent) by the end of 2015 (measured at time of giving birth).

Local Stop Smoking Services

Stop Smoking Services were first set up in 1999/2000 and rolled out across England from 2000/2001. Services provide free, tailored support to all smokers wishing to stop offering a combination of recommended stop smoking pharmacotherapies and behavioural support.

Following a change in the guidance in December 2005, Nicotine Replacement Therapy (NRT) was made available for the first time to adolescents over 12 years, pregnant or breast feeding women and patients with heart, liver and kidney disease. In September 2006, the European Commission approved Champix, generic name Varenicline, as a new pharmacotherapy to help adults quit smoking. The National Institute for Health and Clinical Excellence (NICE) issued guidance in, recommending the use of Champix as an aid to stopping smoking in the NHS[6].

NICE has since published a range of guidance to support the commissioning and delivery of stop smoking services and this is available on their website www.nice.org.uk

The National Centre for Smoking Cessation and Training (NCSCT) was established by the Department of Health in 2008 to standardise training for those providing support for and

delivering stop smoking services. The full range of training can be accessed at www.ncsct.co.uk/pub_training.php

The NCSCT is due to publish the latest version of the Local Stop Smoking Services Delivery and Monitoring Guidance 2014/15 in September 2014. This will be available from their website www.ncsct.co.uk

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Appendix D: Further Information

Readers may also find the following organisations and publications useful resources for further information on smoking:

Action on Smoking Health (ASH)

ASH is a London-based charity providing information on all aspects of tobacco and campaigning to reduce the unnecessary addiction, disease and premature death caused by smoking.
www.ash.org.uk

Eurobarometer

The survey of Europeans' attitudes towards tobacco was commissioned by the European Commission. The survey was carried out in two stages; in September and October 2005 in the 25 European Union Member States (EUMS) and in November and December 2005 in the two accession countries (Bulgaria and Rumania) and the two candidate countries (Croatia and Turkey) and the Turkish Cypriot Community.
ec.europa.eu/health/ph_information/documents/ebs_239_en.pdf

Her Majesty's Revenue and Customs (HMRC)

HMRC is the new department responsible for the business of the former Inland Revenue and HM Customs and Excise.
www.hmrc.gov.uk/

Data sets can be obtained from the internet at:
www.uktradeinfo.com

Home Office Research, Development and Statistics Directorate (RDS)

Further information and other RDS Home Office publications can be found on the internet at:
http://webarchive.nationalarchives.gov.uk/20110218135832/http://rds.homeoffice.gov.uk/rds/index.html

National Institute for Health and Clinical Excellence (NICE)

The NICE has taken on the functions of the Health Development Agency to create a single excellence-in-practice organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health:
http://www.nice.org.uk/

NHS Smoking Helpline

Information and help on quitting smoking is available from the NHS Smoking Helpline: 0800 169 0169.
http://smoke-free.nhs.uk/

Office for National Statistics (ONS)

Information about National Statistics can be found at:
www.statistics.gov.uk/

Summary of Public Health Indicators Using Electronic Data from Primary Care

This report was published by the Health and Social Care Information Centre (HSCIC) in September 2008. The purpose of the project was to report trends over recent years (2001-2007) in the completeness of recording of selected public health indicators (obesity,

smoking, blood pressures and cholesterol) within primary care electronic health care records, and to report on estimated population levels of obesity, smoking, blood pressure and cholesterol.

The project was jointly funded by the HSCIC and the Health Improvement and Protection Directorate (Department of Health); the work was undertaken by QRESEARCH.
http://www.hscic.gov.uk/searchcatalogue?productid=4287&q=title per cent3a per cent22A+summary+of+public+health+indicators+using+electronic+data+from+primary+care per cent22&sort=Relevance&size=10&page=1#top

Scientific Committee on Tobacco and Health (SCOTH)

The report of the SCOTH drew conclusions on the adverse health risks of smoking during and after pregnancy. Continuing to smoke during pregnancy was reported to increase the chance of miscarriage, reduced birth weight and prenatal death of the child. If mothers smoke after birth, the risk of sudden infant death syndrome is increased.
www.archive.official-documents.co.uk/document/doh/tobacco/contents.htm

Smoke-free Action

Provides various information relating to the smoke-free legislation.
http://www.smoke-freeaction.co.uk/

The World Health Organization (WHO) Framework Convention Alliance for Tobacco Control (FCTC)

In May 2003, the member countries of the World Health Organization adopted an historic tobacco control treaty, the Framework Convention on Tobacco Control (FCTC), to set internationally agreed minimum standards on tobacco control and to ensure international co-operation on matters such as the illegal trade of tobacco.
www.fctc.org

Tobacco control survey: England 2004/5

This report presents information about tobacco control activities undertaken by Local Authorities during the period April 2004 to March 2005 inclusive. The data were obtained from an online survey of Trading Standards Departments carried out during 2005.
www.lacors.gov.uk/pages/trade/lacors.asp

Appendix E: How are the statistics used?

Users and uses of the report

From our engagement with customers, we know that there are many users of the Smoking in England statistics. There are also many users of these statistics who we do not know about. We are continually aiming to improve our understanding of who our users are in order to enhance our knowledge on what the uses of these data are via recent consultations and feedback forms available online. Below is listed our current understanding of the known users and uses of these statistics. Also included are the methods we use to attempt to engage with the current unknown users.

Known Users and Uses

Department of Health (DH) - frequently use these statistics to inform policy and planning. The Public Health Outcomes Framework was published in January 2012 which sets out the desired outcomes for public health and how these will be measured. The Department of Health publishes policies such as Reducing Smoking (25 March 2013) and can be found via this link: https://www.gov.uk/government/policies/reducing-smoking

Public Health Observatories - frequently use these data for secondary analysis.

Media - these data are used to underpin articles in newspapers, journals, etc.

Public - all information is accessible for general public use for any particular purpose.

Academia and Researchers - a number of academics cite the Smoking data in their research papers.

NHS - frequently use the reports and tables for analyses, benchmarking and to inform decision making.

Public Health Campaign Groups - data are used to inform policy and decision making and to examine trends and behaviours.

Ad-hoc requests – the statistics are used by the Health and Social care Information Centre (HSCIC) to answer Parliamentary Questions (PQs), Freedom of Information (FOI) request and ad-hoc queries. Ad-hoc requests are received from health professionals; research companies; public sector organisations, and members of the public, showing the statistics are widely used and not solely within the profession.

We have received 2 ad-hoc requests and 1PQ since Statistics on Smoking 2013 was published in August 2013.

Unknown Users

This publication is free to access via the HSCIC website http://www.hscic.gov.uk/lifestyles and consequently the majority of users will access the report without being known to the HSCIC. Therefore, it is important to put mechanisms in place to try to understand how these additional users are using the statistics and also to gain feedback on how we can make these data more useful to them. On the webpage where the publication appears there is a link on the right-hand side to a feedback form which the HSCIC uses to capture feedback for all its reports.

The specific questions asked on the form are:

- How useful did you find the content in this publication?
- How did you find out about this publication?

- What type of organisation do you work for?
- What did you use the report for?
- What information was the most useful?
- Were you happy with the data quality?
- To help us improve our publications, what changes would you like to see (for instance content or timing)?
- Would you like to take part in future consultations on our publications?

Any responses via this form are passed to the team responsible for the report to consider. We also capture information on the number of web hits the reports receive, although we are unable to capture who the users are from this. Statistics on Smoking 2013 generated approximately 16,437 unique web hits since it was published in August 2013.

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