

# Smoking out inequality: Smoking, health and social justice – a new RCP report

Since the 1960s, the RCP has been a leader in campaigning to prevent tobacco-related illness. Professor Ollie Minton, *Commentary* clinical editor, speaks to Professor Sanjay Agrawal, RCP special adviser on tobacco, about the changing landscape, after the latest report *Smoking, health and social justice* was published this May.

**It's been nearly 65 years since the RCP published the landmark report, *Smoking and health in 1962*. What is the impact of smoking and tobacco on UK health at the moment?**

Over many decades, tobacco has been the leading cause of ill health and death. It's entirely preventable in the UK; if people weren't driven to become addicted to tobacco, they wouldn't develop tobacco-related disease. The public and policymakers can become desensitised to the numbers because they're so enormous, and they switch off. So, the RCP tries to shine a light on the ongoing tobacco epidemic still affecting every country in the world.

The use of tobacco is ubiquitous; there are about 1.3 billion people worldwide who use tobacco regularly and at least 8 million deaths annually. In the UK, we have approximately 70,000 people who die from tobacco-related disease every year – a wholly preventable disease. If this was the case with any other disease, especially infections, we'd be acting urgently on prevention.

If someone smokes, they lose 10 years of life on average and are one-third more likely to be admitted to hospital or to see their GP than someone who does not smoke. Tobacco-related disease costs the health service about £2 billion per year. It has always been an enormous problem, and it remains one today.

Around 90% of people don't smoke, and many of them ask, 'why don't people just quit?'. People who don't smoke don't realise how strong nicotine addiction is. This addiction usually starts early in life, shaped by societal norms. If your family or friends smoke, you're far more likely to start smoking yourself. Unless we break that cycle of addiction by supporting smoking cessation treatment at every opportunity, tobacco can become a lifelong addiction, transmitted between generations.

In some ways, the UK has done a cracking job in reducing smoking prevalence. In the 1960s, about 80% of men smoked – now it's about 12%. That's great, but that's still many people smoking, despite people and society knowing the harms.

There is a constant threat in the background. The transnational tobacco industry is powerful and influential, lobbying at the very highest levels of government; ultimately, industry wants to maximise profit for shareholders. They want to perpetuate tobacco use and introduce new products and strategies to overcome or mitigate regulation and public health policy, utilising an 'industry playbook' to delay, dilute or block measures that would harm their interests.

If tobacco companies can't use a tactic in the UK, they certainly use them in other countries; 80% of the world's tobacco is used in low- and middle-income countries. Use is declining in Western countries, but it's growing elsewhere; it's the same companies working in all areas. Everything we do, they will try to counteract.

**Over the last 62 years, what's been the RCP's strategy and approach?**

In 1962, the RCP published *Smoking and health*, a seminal report that linked tobacco use with lung cancer and emphysema. Unusually for the time, the report didn't stop at scientific observation. It made recommendations to the government to combat the harm from tobacco, a strategy not previously not previously employed by the RCP.

The report set out recommendations that have become the pillars of tobacco control ever since; reducing the promotion and advertising of tobacco, implementing treatment for tobacco addiction, educating the public on the harms of tobacco, limiting the availability of tobacco, making products safer where possible and making tobacco less affordable.

Since then, the RCP has remained at the forefront of tobacco control.

During the 1970s, the RCP established the advocacy group 'Action on Smoking and Health' (ASH). Since then, we have continued to work closely with ASH on campaigns to advance tobacco control and promote public health. Our 2026 report and recommendations to government were developed through the RCP's tobacco advisory group (TAG) which has developed many RCP

reports on key areas of UK tobacco policy over the past 30 years.

The RCP's 2024 report, *E-cigarettes and harm reduction*, presented an evidence review on the place of nicotine alternatives in helping people quit smoking. It also looked at what regulations were needed to prevent young people or those who don't smoke taking up vaping. Prior to that, *Smoking and health 2021* looked at the entirety of tobacco control measures, including pricing, tobacco industry tactics, and greater media and advertising controls.

## How does smoking fit into wider trends of health inequalities?

The burden of tobacco use falls on those who can least afford it. That's true in every country. People who smoke are more likely to be living in poverty, have low-paid jobs, living in social / rented housing or be homeless, or have mental health disorders. People with multiple sources of stress are more likely to smoke and less likely to quit.

People who smoke are around 10% more likely not to be in work, more likely to be off sick and earn around 9% less, on average, than those who don't smoke. Tobacco addiction is a vicious circle. To improve social justice (ie to provide a fair distribution of health, wealth and opportunity), we need to break the addiction to tobacco at every opportunity.

## What is the purpose of the new RCP report? What are the key findings?

The RCP wanted to produce a new report because there is a danger that people think that the 'job is done', now that smoking prevalence has declined to around 10%.

We wanted to make it clear that the average prevalence hides the existing disparity between population groups. The report presents data on smoking prevalence by protected characteristics and by other markers of economic status, such as the Index of Multiple Deprivation (IMD).

Through this, we can see that the smoking rate is three times higher in the least advantaged communities, compared with the most advantaged communities. Smoking rates in people with mental health disorders are 30–60%, for people in prison, they are 80–90%. For the LGBTQ+ community, or routine and manual workers, smoking rates are often double the average.

This is an issue of social injustice; many members of our society are disproportionately affected. We need to invest more and take action, because these vulnerable groups carry the greatest burden.

We looked at the wider determinants of health; what is influencing this higher prevalence of smoking in different groups? We established that a lot of the reasons are structural aspects of society – poverty, employment,

education, housing etc.

The report goes through the trends for each protected characteristic, and looks at localities and regions across the UK – highlighting large differences in smoking prevalence between population groups and geographies.

We've made the case that we need more data on local and regional smoking prevalence; that granular data can be used to introduce locally delivered measures. When you know your local population, you can target treatment; in my town (Leicester), we have parts of the city where smoking prevalence – particularly, in maternity – is really high. If we have those data, then we can target interventions.

The report also found that there is a huge swathe of people that we do not collect data on. There are probably around 2 million people that national surveys don't include, because they have no fixed abode. There are hundreds of thousands of 'sofa surfers', living temporarily with relatives or friends, never captured by national surveys. People with mental health disorders may be more likely to have no fixed abode. Similarly, asylum seekers, prisoners, people living in institutions or communal dwellings often have a much higher smoking prevalence. Our national statistics are probably not capturing about a million people who smoke.

## What does the report say about the tobacco industry and their 'industry playbook'?

In this report, we've tried to shine a light on industry tactics and how we counteract them.

We looked through the lens of the 'commercial determinants of health'; what is industry doing to, essentially, target people in more deprived communities?

Tobacco companies use social media to advertise their products through influencers and product placement, on parts of the internet, gaming and streaming services that current tobacco advertising and promotion regulation does not sufficiently cover or enforce.

This means that many people are attracted to or continue smoking because of messages and exposure to tobacco imagery on these online platforms. The report also highlights the pricing strategies of commercial actors, who make tobacco products less expensive for people on low incomes, so as to maintain their tobacco addiction.

There are other recommendations to mitigate industry influence, eg not allowing industry actors have any role in governmental decision making on tobacco policies, and ensuring clear and transparent records of meetings between of industry actors and government.

## What are the recommendations of the report?

There are approximately 50 recommendations in total. Key themes include cross-government coordinated action to prevent health-harming industries widening health inequalities, doing more work on the availability and pricing of tobacco products, introducing opt-out models for treating tobacco dependency across the NHS, and gathering better quality data on smoking and deprivation to really target resources.

The report talks about what we can do to counteract tobacco companies making tobacco more affordable for low-income groups – for example, introducing minimum unit pricing for tobacco (effectively introduced for alcohol in Scotland), or setting a minimal excise tax. The RCP has recommended retail licensing schemes be introduced to limit the availability of tobacco products, which the new Tobacco and Vapes Act will have the power to introduce.

We also recommend introducing opt-out treatment models across every point of contact in the NHS, recently introduced in hospitals in England for inpatients and maternity services. Now we should extend this to other NHS settings such as primary outpatient and emergency care; automatically referring people to services, making treatment more accessible and less stigmatising.

The report also talks about financial incentives for smoking cessation. This has been hugely effective in maternity care, increasing quit rates 2–3 fold. We would like to see a greater use of incentives across other less advantaged populations. The report also talks about strengthening the accountability of smoking cessation services in the NHS and local government, to ensure that we get every bit of value from that investment.

## The RCP welcomed the government's Tobacco and Vapes Act. How will it deliver a truly 'smoke-free generation'?

The Tobacco and Vapes Act is a landmark piece of legislation that the UK should be proud of. It's going to reduce younger people's accessibility to tobacco – young people get hooked into tobacco addiction at an early age and smoke for life. The legislation will raise the age of sale by 1 year, every year, such that people born after 1 January 2009 will never legally be sold tobacco in the UK. This is an important way of preventing the cycle of addiction and life-long tobacco-related ill health and social injustice.

The Tobacco and Vapes Act will introduce other measures such as retail licensing to reduce tobacco availability and regulating other nicotine-containing products such as nicotine pouches, vapes, oral tobacco or heated tobacco products.

However, the legislation may do little for the 5.3 million

people who currently smoke in England. We know that people who smoke have children who are more likely to smoke and be exposed to second-hand smoke. If we're going to make the 'smoke-free generation' work, we've also got to support people to quit.

This report is about social injustice and making sure that the most deprived communities – where smoking prevalence is the highest – are not forgotten. So, we need to think about addressing the other drivers of smoking, like homelessness, mental health disorders, or the use of alcohol or drugs.

## What would be the impact of stopping smoking across society?

People often say that the government couldn't do without the revenue from tobacco. That's just not true.

We estimate that the cost of tobacco to society in the UK is approximately £52 billion pounds per year. That includes productivity losses, and social care and health costs. The revenue raised from tobacco is just £8 billion. Taxpayers are essentially subsidising a £44 billion gap.

Most of the profit from tobacco sales goes to transnational tobacco companies. Local shops take less than 8% profit on tobacco products that they sell, whereas the transnational tobacco companies have a 70% profit margin on tobacco products, which goes to shareholders – rather than going back into local communities.

If smoking were made obsolete, it is estimated that we could put £11 billion back into families and communities and around 250,000 children would be lifted out of poverty if their households became smoke-free.

Breaking the addiction to tobacco is cheap, effective and life-changing and will make a difference to children, communities and our society, helping to restore social justice.

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