Smoking, health and social justice

Protecting health, promoting equity

Executive summary and recommendations

Royal College of Physicians

The Royal College of Physicians

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About this report

Led by the RCP special adviser on tobacco Professor Sanjay Agrawal, this report was developed with members of the RCP Tobacco Advisory Group and approved by RCP Council.

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Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

www.rcp.ac.uk

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Introduction

In 2026, smoking is still the biggest avoidable cause of death and disability in the UK. Although tobacco use has declined markedly over recent decades, smoking remains particularly prevalent among less advantaged groups. This means that the devasting effects of smoking are increasingly concentrated among people already living in poverty, poor health and with social exclusion, reinforcing persistent cycles of disadvantage and inequality.

Although the UK has been an international leader in reducing smoking prevalence, these gains have not been equal. While national and regional differences in smoking prevalence across the UK have narrowed significantly over the past decade, substantial differences remain between the most and the least advantaged areas. For example, smoking prevalence in Blackpool, the most deprived area in the UK, is almost 20%, while in affluent Woking, only 4% of people smoke.

Smoking prevalence varies considerably by protected characteristics and factors associated with higher smoking prevalence include living in rented accommodation, working in manual occupations, and lower educational attainment. Smoking rates in 2024 approached or exceeded 40–80% among vulnerable groups, including people with significant mental illness and those experiencing homelessness, far exceeding the 10.6% among the general adult population. These groups are often absent from or under-represented in national data because they are less likely to be included in household surveys or respond to data collection. It is estimated that there is a 'hidden population' of around 1.9 million adults in England with a smoking prevalence of between 58% and 66%. This equates to over 1 million additional people who smoke and means that UK smoking prevalence data underestimate the true figures. As a result, policy and funding decisions fall short of what is needed to protect the most affected groups from smoking-related harm and inequality.

People experiencing disadvantage are often motivated to quit smoking and make repeated quit attempts, but social stressors reduce their chances of success. Evidence shows that opt-out tobacco dependence treatment models help overcome some of these barriers by shifting responsibility from the individual to the system. When treatment is offered routinely across NHS settings, rather than relying on self-referral, it reaches those who need it most, with the highest quit rates in the most deprived communities.

Smoking continues to represent a significant cost to the UK. In 2024, premature deaths caused by smoking resulted in approximately £1.35 billion in lost productivity across the UK.

The principles of social justice demand that everyone should have a fair opportunity to lead a healthy life. The increasing concentration of smoking-related harm among the most disadvantaged in society therefore represents not only a public health challenge, but a moral, humanitarian and economic priority for government and its institutions. The evidence-based interventions needed to tackle the social injustice of smoking inequalities are well established – what is now required is the collective commitment to implement them at scale, including the adoption of opt-out tobacco treatment across all points of contact in the NHS.

This report examines the structural factors that contribute to smoking inequity, including the social determinants of health and the substantial influence of the tobacco industry in perpetuating smoking. It reviews trends in smoking behaviour across numerous indicators of social disadvantage and protected characteristics to identify potential levers and the financial case for change. It is intended for policymakers, system leaders and commissioners across the NHS and local authorities who play a role in shaping action on tobacco and health inequalities. The report sets out policy options to reduce the gap in smoking-related inequality and to realise a 'smoke-free dividend' for people and society, underpinned by a clear ethical case for change.

What this report calls for

To reduce smoking-related health inequalities and realise a smoke-free dividend, the UK government and system leaders should:

- **introduce opt-out smoking cessation services into all NHS settings**
- **rebalance national tobacco control policy towards high-prevalence and underserved groups**
- **strengthen regulation of the pricing, retail availability and marketing of tobacco products**
- **invest in better data collation that captures 'hidden populations' to enable targeted action**
- **adopt a coherent cross-government approach to counter how health-harming industries shape the availability, affordability and appeal of tobacco, alcohol, food and gambling products.**

Social determinants of health and tobacco

Health inequalities are rooted in structural and systemic forces, including poverty, inadequate housing, poor education and social exclusion. They are not factors of individual choice.

Smoking is a strongly socially determined behaviour, shaped by socio-economic disadvantage, life conditions and cumulative stressors. A stark social gradient exists in health outcomes, with smoking prevalence and health deterioration increasing with greater disadvantage, resembling a cliff rather than a gradual slope. Interventions to tackle tobacco-related health inequalities that only target the behaviour of individuals will be insufficient. Structural, social and environmental factors must be addressed simultaneously to enable appreciable change.

Recommendations

- Policymakers must prioritise policy changes that address poverty, housing, education and employment as key enablers of smoking cessation.
- Effective conventional tobacco control policies should be expanded and accelerated to reduce smoking in high prevalence groups.
  These policies include:
  - price policies to make tobacco less affordable
  - limiting the appeal of tobacco products through regulation of product design
  - restricting exposure to tobacco marketing and promotion across all forms of media
  - utilising mass media campaigns to promote cessation
  - providing opt-out treatment services across healthcare and community settings
  - promoting tobacco harm reduction approaches by switching to a safer form of nicotine, such as e-cigarettes for those who still smoke.
- Sustained funding for national and local tobacco control programmes should continue to be prioritised according to the principles of proportionate universalism – offering universal services but targeting more resources and focus to those with the greatest need.

How the tobacco industry exacerbates inequalities

Industry exerts a significant influence on the social determinants of health, influencing housing, physical activity, work environments, food choices, smoking, alcohol use, gambling and many other factors. Major corporations across sectors consistently use the same political, scientific and reputation management practices to create confusion over the harm of their products and oppose effective public health policies. These tactics are sometimes referred to as the 'industry playbook'.

There is increasing recognition of strategic similarities across health-harming industries, including their comparable impacts on health, health inequalities and society, as well as common drivers of consumption and effective policy interventions. However, efforts to develop coordinated approaches to tackling these commercial determinants of health have so far been limited.

The tobacco industry uses pricing strategies to attract and retain customers. It responds to price sensitivity in customers by offering less expensive tobacco products to lower-income consumers. Through market segmentation, the industry ensures that less expensive tobacco is readily available in more deprived areas, perpetuating smoking among low-income groups. In the UK, tobacco availability follows a social gradient, with higher density of retailers in more disadvantaged communities. Tobacco use continues to be normalised through its portrayal in popular media, including on social media, TV programmes and movies on both terrestrial and streaming platforms. This sustained exposure suggests that current regulations and penalties on media companies are inadequate or insufficiently enforced. Evidence indicates that some population groups may be particularly susceptible to such media influences, further exacerbating existing inequalities in smoking behaviour.

Recommendations

- Tax and wider regulatory measures should be applied to address industry pricing strategies. These might include a minimum excise tax and a minimum unit price for tobacco, which will make it more difficult for the industry to supress the price of economy brands.
- Price-based interventions should be coupled with support to stop smoking to avoid widening disparities in people who continue to smoke, particularly among low-income groups. Support should include the provision of less harmful nicotine products as a consumer alternative to smoking.
- A tobacco retail licensing scheme should be introduced to control the density and location of tobacco outlets.
- Policy should be developed to regulate tobacco imagery in online and streaming services, particularly those that are widely seen by children and young people. Similar attention should be paid to visual exposure of tobacco and vaping products on social media platforms used by young people.
- There is a need for a coherent broader cross-government policy approach across unhealthy commodities (alcohol, tobacco, food, gambling) to manage interactions with commercial sector actors and address health inequalities through targeting the availability, accessibility and appeal of health-harming products.

Smoking trends and patterns

The UK benefits from a wide range of data on smoking, including population surveys, administrative and clinical records and market data. However, national averages can hide large disparities in smoking rates, levels of consumption, quitting and harm between different groups. Some groups with high smoking rates are not routinely identified or reported in national datasets, creating a 'hidden population' of people who smoke, most of whom represent the least advantaged people in society. As a result, overall smoking figures underestimate the true scale and impact of smoking inequality.

When smoking data are broken down by characteristics such as age, gender, ethnicity, socio-economic status and health status, they become a powerful tool for targeting interventions where it is most needed. Evidence from smoking cessation trials consistently show that people are more likely to quit when they receive support than when they try to quit without help. Real-world evidence from large-scale NHS opt-out tobacco dependency treatment pathways for hospital inpatients shows that these services reach people from all backgrounds, with the greatest number of people making a quit attempt or successfully quitting coming from the least advantaged areas.

To accelerate progress in reducing smoking-related health inequalities, monitoring systems must evolve. Linking administrative datasets, analysing clinical and research data on markers of deprivation such as employment or housing, identifying overlapping risk factors such as drug use or mental health disorders and adopting innovations in data collection and communication will ensure that tobacco control is guided by evidence that reflects the true distribution of harm.

Recommendations

- To focus resource allocation and improve health equity, data on tobacco use should be systematically collected and reported in population groups with high smoking prevalence, specifically:
  - 'hidden populations' that include people living in temporary housing, communal dwellings, immigration detention centres, bed and breakfasts and unsupported temporary accommodation, 'sofa surfers', people who are sleeping rough, Gypsy, Roma and Traveller populations
  - mental health populations with a high prevalence of smoking, such as those with serious mental illness
  - users of non-cigarette tobacco products, such as waterpipe, smokeless tobacco, cigars and cigarillos
  - asylum seekers accessing third-sector organisations and community groups that have already established trust within these communities.
- Comprehensive regional data should be routinely collected to inform national and regional approaches to reducing the supply of and demand for illicit tobacco as part of wider strategies to reduce smoking-related health inequalities.
- Data from cessation services and research trials should routinely collect, analyse and report quits by multiple measures of deprivation and marginalisation (particularly relating to cessation aids) to provide policymakers and commissioners with information on how to improve treatment for these populations.

The smoke-free dividend

Tobacco addiction exacerbates household poverty. Because smoking rates are disproportionately high among many less advantaged groups, the financial and productivity losses linked to smoking fall most heavily on people who already face challenges such as poverty, poor health and social exclusion.

People who smoke earn approximately 9 % less than those who have never smoked, and economic inactivity due to long-term ill health or disability affects one in nine working-age adults in England who smoke compared with one in 30 people who have never smoked. This increase in economic inactivity among people who smoke has occurred despite overall declining smoking prevalence. Total annual earnings loss attributable to smoking in the UK is approximately £11 billion. Reversing this trend would likely improve individual wellbeing, labour market inclusion and national productivity.

The 'smoke-free dividend' in England, defined as the value that could be added to local economies each year through the money that people who smoke tobacco would save if everyone quit smoking, is estimated to be £10.9 billion and would be associated with a net increase in employment of 135,865 full-time equivalent jobs. The high service demand and costs driven by smoking in disadvantaged groups underline the importance of targeted tobacco control measures. Addressing smoking inequalities offers a major opportunity for the NHS and wider society to achieve both fiscal savings and improved population health outcomes.

Recommendations

- To benefit from the smoke-free dividend, additional measures should be introduced to expand and accelerate smoking cessation interventions in high prevalence populations and settings. For example, prioritisation of smoking cessation in public health and employment strategies for working-age adults in less advantaged areas with high rates of economic inactivity.

Policy options to treat tobacco dependency equitably

UK tobacco control policy has been successful in lowering smoking prevalence across the general population, achieved through evidence-based sequential national tobacco control plans, sustained investment and evaluation. However, more can and should be done to address smoking in higher prevalence groups.

People who smoke, especially population groups where smoking prevalence is high, typically have higher levels of contact with public service organisations, including the NHS and local government services such as housing, employment, retail, prisons and education. This creates multiple and recurring opportunities for intervention. Local government and NHS tobacco dependency services play complementary roles that are essential for tackling smoking-related disparity. They receive national funding from different streams enabling broader access, coordination of cessation services and long-term planning for populations with a higher smoking prevalence. Regional and sub-regional tobacco control programmes, such as Fresh in the north east of England, provide an important bridging role between national and local teams and are effective in reducing overall smoking prevalence and absolute inequality in smoking.

The interventions to reduce smoking-related disparities by local government and the NHS will be enhanced by the Tobacco and Vapes Bill and the incremental increase in the age of sale of tobacco products. The bill also sets out a range of powers for a tobacco retail licensing scheme for the UK. Such a scheme would further support the enforcement of product and age of sale regulations and has the potential to reduce the availability of illicit products in more deprived communities.

While the extension of powers to ban smoking and vaping in most public places within the Tobacco and Vapes Bill is welcome, careful implementation is essential to avoid unintended increases in smoking and related health inequalities. Hospital sites require particular attention – smoking is prevalent among hospital patients and visitors, and nicotine vapes are a proven critical component of treatment pathways. Permitting vaping on hospital grounds to enable smoking abstinence is therefore an important element of an equitable policy approach.

Alongside these measures, the UK has adopted above-inflation annual tobacco prices increases to make tobacco products less affordable. Evidence shows that this policy can lower overall smoking prevalence and reduce smoking inequalities, with a greater impact in more deprived groups. However, it is critical that price increases are coupled with enforcement resource and support to stop smoking to avoid widening disparities in people who continue to smoke.

Opt-out cessation pathways reduce inequalities in access to tobacco dependence treatment, particularly in socially deprived areas where prevalence of smoking is high and awareness of tobacco cessation services is low. NHS primary and secondary care settings offer a sizeable opportunity to deliver opt-out tobacco dependency treatment working in conjunction with local government services. Providing financial incentives to support smoking cessation is both effective and cost effective. Incentives create an expectation of reward, a key mechanism for changing behaviour, including among less advantaged groups. Digital cessation interventions appear to be equally as effective for people in the least and most advantaged groups.

Recommendations

- To close the tobacco-related health inequalities gap, national tobacco control policy should be weighted towards high prevalence groups. A national tobacco control plan in England should be published to provide a clear strategy and targets to achieve this policy objective.
- Opt-out smoking cessation treatment models should be introduced in every NHS setting – including emergency departments, primary care, outpatient services and neighbourhood health.
- Funding and commissioning structures should be aligned to enable primary care providers to deliver smoking cessation treatment and pharmacotherapies, ensuring equitable access for less advantaged groups who are more likely to smoke and frequently visit GPs.
- Financial incentives and digital interventions are effective in populations with a high prevalence of smoking, and their use should be expanded to make smoking cessation more effective and accessible to high prevalence populations.
- All NHS regions and integrated care boards should establish regional and supra-local tobacco control programmes based on successful models such as Fresh in the north east to reduce smoking-related inequalities by coordinating action on illicit tobacco, streamlining cessation pathways and policy implementation.
- NHS and local authority tobacco treatment services should be protected from decommissioning through ring-fenced funding, and the quality of service delivery in these settings should be effectively assured by responsible organisations in the NHS and local government.
- Powers that are taken as a result of the Tobacco and Vapes Bill to ban vaping in most public places should exclude hospitals where smoking prevalence is high and nicotine vapes are a proven critical component of treatment pathways.

Ethical considerations

The empirical evidence is consistent that smoking correlates strongly with economic and social inequality. The ethical imperative for action to end the harms caused by smoking, to stop young people from starting to smoke, and ensure that everybody who smokes is supported to quit, is clear. Any policy should be cost effective and represent an efficient use of resources, in order to ensure a total allocation of resources that maximises health gain and/or minimises health harm. Commissioners of health services have a duty to secure the most cost-effective use of resources for the population.

This report shows that policies aimed at reducing smoking are highly efficient and cost effective, especially when compared to the use of resources to treat the health harms of smoking.

Recommendations

- As population smoking rates decrease, justice demands active and ongoing measures to ensure that all groups across society, especially the most marginalised and ignored, are no longer vulnerable to the tobacco industry and that they have support to quit smoking delivered in ways that are tailored to their specific needs. To do otherwise would be unjust.

Royal College of Physicians

11 St Andrews Place
Regent's Park
London NW1 4LE

The Spine
2 Paddington Village
Liverpool L7 3FA

www.rcp.ac.uk

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