DEMOS

MYTHS AND MISINFORMATION

MAPPING THE BARRIERS TO SMOKING CESSATION AND THE UPTAKE OF NICOTINE ALTERNATIVES

POLLY MACKENZIE
ALICE DAWSON

MAY 2022

We are grateful to Juul Labs for their sponsorship of this programme of research; our findings and analysis remain fully independent.

Published by Demos May 2022

15 Whitehall, London, SW1A 2DD
T: 020 3878 3955
hello@demos.co.uk
www.demos.co.uk

CONTENTS

FOREWORD

Growing up, most of my family smoked tobacco. In fact, me and just one of my grandparents were the only ones who never did. Thanks to several awareness raising talks on the harm of tobacco smoking I had at school, I was well aware of its potentially fatal consequences which put me and most of my friends off even wanting to try a cigarette. Unfortunately, this also meant that much of my childhood was riddled with worry about what would happen to my family if they continued to smoke.

Watching some of my family members struggle time and time again to quit made it obvious that cigarettes are not something someone can simply give up overnight. For 2 years my Mum tried almost every smoking cessation method you can imagine - nicotine patches, gum, going "cold turkey" and even self-help books. While these methods were not completely useless, any impact they had on her quitting was short lived and it wouldn't take long for her to revert back to smoking tobacco again.

After several unsuccessful attempts at trying to quit, she eventually took up vaping. Within 2 months of smoking e-cigarettes she had given up traditional cigarettes altogether and has not touched tobacco for 8 years and counting. This is a relief to say the least. Most of my other family members followed her lead and made the switch to e-cigarettes and have also been tobacco-free for several years now.

My family's experience highlights why it's so important that smokers and the general public alike are given access to accurate and positive information on the health benefits of e-cigarettes as a smoking cessation tool. Smokers need to have as many options as possible and be able to make informed decisions about what the right and most effective option is for them.

Alice Dawson

May 2022

EXECUTIVE SUMMARY

Smoking is one of the greatest contributors to health inequality in the UK. This report calls for a major step change in our approach to smoking cessation. The increasing availability of less harmful alternatives to smoking, including vaping, presents a remarkable opportunity to help more people to quit.

This paper is part of a programme of work on how to regulate the future of vaping. It also draws on wider Demos research on relational public service reform, in which we explore how people's personal and community relationships affect public service outcomes.

To inform this research we conducted a nationally representative survey of 2000 adults online; and a second survey of a representative sample of adults living in "Red Wall" constituencies.

WHERE ARE WE ON SMOKING CESSATION?

Smoking rates have been falling for decades, and now only about 14% of adults smoke. However smoking is substantially more prevalent among people on lower incomes and the government will not meet its target to be "smoke free" by 2030 unless we substantially increase the rate at which people quit.

Socio-economic inequalities are playing a big part in smokers' motivations to quit. People in the C2DE social grades were nearly 20 percentage points less likely to be planning to quit (56% compared with 37%).

A MISINFORMED PUBLIC

There is a huge and problematic gap in public understanding of how cigarettes cause harm to our health. The public health evidence could not be clearer: while nicotine is the addictive component of tobacco, it is not a carcinogen. In our survey we asked whether respondents believed the following statement to be true or false: "The nicotine in tobacco cigarettes is the chemical that causes most of the cancer"

The correct answer is false. However, 48% of respondents said it was true and only 26% said it was false. Smokers were slightly more likely to give the correct answer but over-60s, people who don't work and C2DEs were more likely to be wrong.

The public health evidence is that harm from vaping is unlikely to exceed 5% of the harm that comes from smoking, but only 10% of people knew this was the case. These misunderstandings affect smokers' motivations and confidence in trying nicotine alternatives.

GROUP PATTERNS OF BEHAVIOUR

Smokers' motivation to quit, and the success of their attempts to quit, are likely to be influenced by the people around them. We uncovered disparities in the patterns of relationship of smokers and non-smokers: smokers tend to have more close relationships with other smokers, and non-smokers tend to have more close relationships with non- or ex-smokers.

In two-adult households, Just 11% of non-smokers lived with a smoker; 46% of smokers said they lived with another smoker. Only 6% of non-smokers said "most" or "all" of their close friends and family smoke, compared to 24% of smokers.

In future papers we will be exploring how to operationalise a public health campaign to reach smokers with more accurate information. We asked people where they were accessing information about vaping and smoking. Smokers were more likely to say they "completely" or "mostly" trusted

information they got from friends and family about this issue. This suggests informal networks are an important influence on smokers' behaviour and choices.

THE POLITICS OF CHANGE

Smoking cessation policy has often been shaped by political considerations including fear of a "nanny state" imposing unwelcome lifestyle changes on people. We wanted to explore the political context for public health policy, in particular in key marginal seats.

90% of voters in Red Wall constituencies told us it was important for the government to reduce health inequality - with 52% describing it as "very important." These numbers are even higher than the 85% of the nationally representative sample who said it was important. Older respondents were most likely to say this issue was important to them. There was no difference between the responses of ABC1 groups and C2DE groups on this question in the Red Wall. Nationally, it was C2DE groups who were more likely to rate it as important.

We asked people to give us their thoughts on a range of possible approaches the government could take to tackle health inequality. Chosen priorities nationally were help with the cost of living (61%), help with healthy eating (41%), improvements to housing conditions (37%), and mental health support (34%). Smoking cessation was fifth most popular with 31% believing it is one of the top three measures the government should address. Results in the Red Wall were similar, with 33% prioritising smoking cessation, and a huge 67% asking for help with the cost of living.

We conclude that smoking cessation is not a culture war issue, or an electoral liability in the Red Wall. If anything, action is considered more important here than elsewhere, and there is greater support for policy change.

EMERGING RECOMMENDATIONS AND NEXT STEPS

This paper will be followed by a subsequent research study looking at the challenges we face in enforcing the current regime, in terms of product safety, advertising and promotion, and age restrictions.

We will then bring together the conclusions of this and additional stakeholder engagement into a white paper setting out a series of recommendations for a strong, enforceable regime for the future of vaping, and continued efforts to maximise smoking cessation as part of the levelling up agenda.

INTRODUCTION

In February 2022, the government put health inequality into the heart of its political agenda. The Levelling Up White Paper - described as a "moral, social and economic programme for the whole of government" - set out just 12 missions to define what progress should look like for the United Kingdom in the coming years. And one of those 12 is the mission to narrow the gap between the healthy life expectancy of the poorest and the richest people in our society. As the white paper sets out, this is "one of the gravest inequalities" in our society. This paper is part of Demos' contribution to the national mission to end it.

In the pages that follow we look at how the UK is doing on smoking cessation - and how we can improve our performance. We do so because smoking is the single greatest contributor to health inequality; smoking alone contributes about half of that gap in healthy life expectancy. If the government wants to achieve its goals on "levelling up" the population's health, there is no better place to start than with smokers: helping and enabling them to stop the pattern of self-harm that smoking constitutes. But the government must do so with compassion, care and understanding about the nature of addiction in general, and nicotine dependency more specifically. It must think creatively about how to reach smokers, how to persuade them, and how to celebrate their successes as they move away from burnt tobacco.

This paper fits into two programmes of ongoing work at Demos. First, it is part of a series of research studies and events looking at regulating the future of vaping, one of the most important pathways to quitting. This paper follows on from a discussion paper published in March and two stakeholder roundtables held during April. It looks at the barriers to smoking cessation, and presents the findings of new research into misinformation about smoking and vaping which we believe is causing substantial harm. Next month, we will publish a second research paper looking at the challenges of enforcing existing regulations on product safety and age verification, and how this is affecting young people. We are grateful to Juul Labs for their sponsorship of this programme of research; our findings and analysis remain fully independent.

This pamphlet is also linked to our programme of work on relational public service reform. As we set out in Chapter 3, we believe smoking cessation services can learn a lot from recent innovations in public service design that leverage people's relationships, instead of treating them as atomised individuals. Building on the evidence that smoking behaviour is reinforced by social cues, we make the case for a more relational approach within NHS Stop Smoking services.

Because this agenda is part of the 'levelling up' mission, we have added a political dimension to our analysis: exploring attitudes to these issues not just nationally, but also in the government's key marginal seats - known as the Red Wall. These places are key to the success of both the policy and the political story of levelling up. In our engagement work we have identified a real fear among some policy makers that the lower income voters the Conservative party has attracted in order to win these seats are likely to be opposed to 'nanny state' interventions to reduce smoking - just as health secretary John Reid feared that lower income voters would oppose the ban on smoking in public places back in 2004. This political fear could make the government cautious when it comes to tobacco control. Our research - set out below - suggests these fears are misplaced: Red Wall voters care deeply about health inequality and support policy change.

This is an exciting time for those of us who want to transform public health by eradicating smoking. In previous generations, it seemed the only way to stop people smoking was to get them to quit nicotine altogether, which we know can be extremely difficult. Now - whether as a transitional stage, or for the long term - it is possible for people to use nicotine without burning tobacco and inhaling the smoke. Gums and patches and inhalators that deliver nicotine are available, alongside consumer products like vaping and heated tobacco. The risk profiles of

each product is different, but they are all dramatically lower than the risk profile of smoking burned tobacco. The benefits of encouraging and enabling smokers to switch are huge.

These are controversial issues because nicotine is not a harmless drug, and there is limited evidence about the impacts of alternatives, such as vaping, over the long term. However, harm reduction - replacing a dangerous behaviour with a much less dangerous one - is controversial in all domains of public policy from drug treatment to gang violence. We believe that the controversy must not drive us away from the public health opportunity. There are lives to be saved.

METHODOLOGY

We conducted a nationally representative online survey of 2,000 adults in the UK as well as a survey of 2,000 adults living in "red wall" constituencies. We define the red wall as the fifty seats Labour lost to the Conservatives at the 2019 General Election in the North of England, the Midlands and Wales, plus Hartlepool which Labour lost in a 2021 by-election to the Conservatives.The fieldwork for this poll was conducted between 22nd April - 3rd May 2022. This is the base for all the poll results presented in this report, unless otherwise stated.

Our survey of adults included non-smokers and smokers alike to allow us to better understand smokers perceptions of the relative harms of vaping and their group patterns of behaviour, and make direct comparisons to those of non-smokers.

Smokers were identified in our survey as those who smoked burnt tobacco products, not people who had only ever smoked e-cigarettes. Our sample was nationally representative which meant we were able to analyse differences in harm perceptions between social grades which was essential for exploring our interest in the role socio-economic status plays in smoking cessation and the implications this has for national smoking cessation efforts. We conducted a red wall survey to allow us to better understand the views those living in these areas have on potential smoking cessation policies and how these views might impact the Government's willingness to make smoking cessation a core part of the levelling up agenda.

CHAPTER 1
WHERE ARE WE ON SMOKING CESSATION?

In this chapter we look at smoking cessation: how far we have come and how far we have to go. We explore why it matters from a health inequality perspective, which smokers are most likely to consider quitting, and what works when it comes to helping people to do so.

First: the good news. We have come a long way when it comes to public policy on smoking, and it has made a real difference to smoking rates. The table below, compiled by Ash from a series of government surveys over the years shows the dramatic change in the last fifty years. Now, only about 14% of adults smoke.

TABLE 1
PREVALENCE OF CIGARETTE SMOKERS BY SEX (GLS/OPN/APS), 1974 TO 2019, GREAT BRITAIN AND UK

%	'74	'78	'82	'86	'90	'94	'98	'02	'06	'10	'14	'15	'16	'17	'18	'19
MEN	51	45	38	35	31	28	28	27	23	21	20	19.3	17.7	17.0	16.5	15.9
WOMEN	41	37	33	31	29	26	26	25	21	20	17	15.3	14.1	13.3	13	12.5
ALL	45	40	35	33	30	27	27	26	22	20	18.1	17.2	15.8	15.1	14.7	14.1

Public health policy has made a huge difference; starting with information campaigns and advice, policy change has progressively expanded to include health warnings on packaging, a ban on advertising tobacco products, a ban on smoking in public places, and a ban on display of tobacco products in shops.

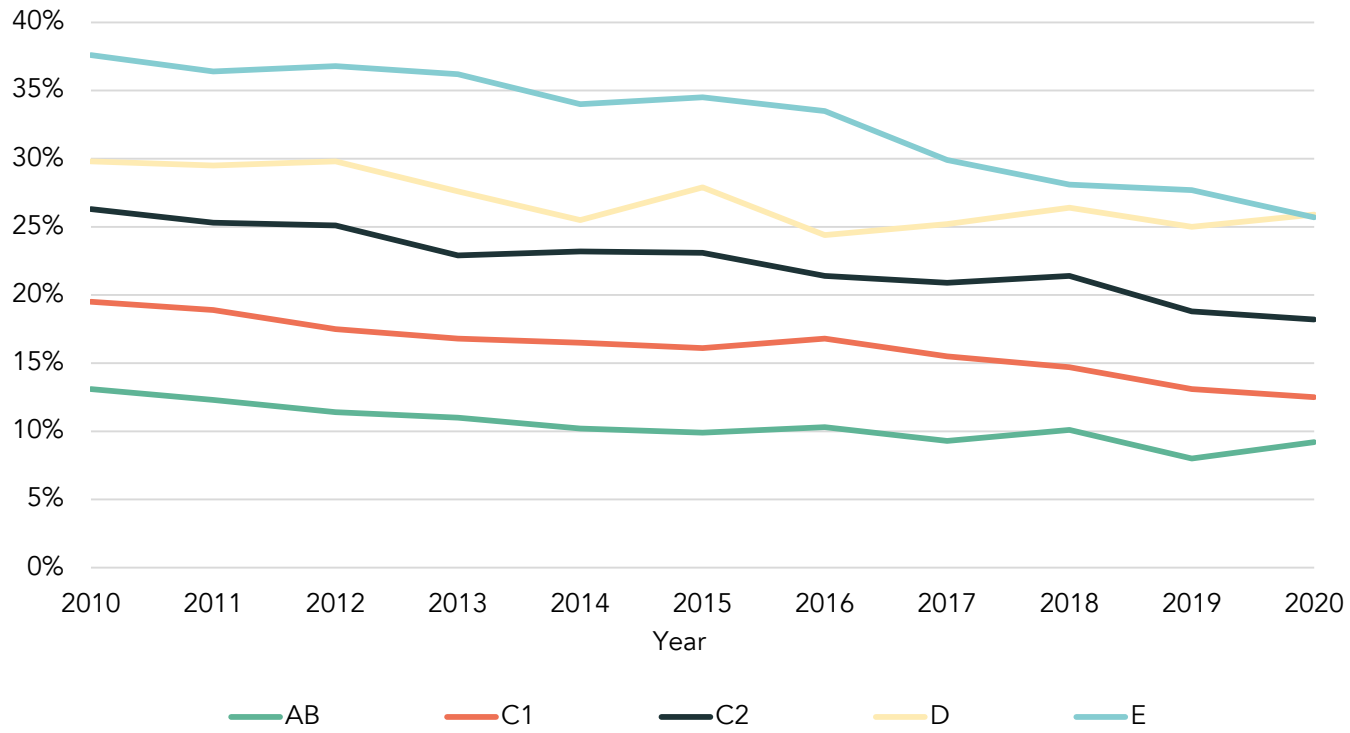
In 2019, the Government set out a laudable ambition to go even further, with the goal of a smoke-free[1] United Kingdom by 2030: this is usually defined as reducing smoking prevalence to less than 5% of the population. Last year, the Royal College of Physicians published their analysis that suggests - unless we do something radically different - we will not get to smoke-free status until 2050 at the earliest. As they say: "the odds of quitting would need to increase fivefold in females and sixfold in males … for the … target to be achieved by 2030."[2]

1 This is usually defined as smoking prevalence of less than 5%
2 Tobacco Advisory Group. Smoking and health 2021: A coming of age for tobacco control?. Royal College of Physicians, April 2021. Available at https://www.rcplondon.ac.uk/projects/outputs/smoking-and-health-2021-coming-age-tobacco-control

This is a public health problem - but it's also a health inequality problem. ONS research suggests nearly a quarter of those on incomes less than £10,000 are current smokers, in comparison with only 11% of those on incomes over £40,000. People who are unemployed are almost twice as likely to smoke as those in work. Smoking prevalence among adults with a serious mental illness is over two and a half times the national average. This translates into massive differences in the harm caused.

that socio-economic inequalities are playing a big part in smokers' motivations to quit. Overall, 16% of our sample told us they smoked; of this group 46% admitted they had no plans to quit. But non-working adults were 10 percentage points more likely than working adults to say this (53% compared with 43%); and those in the C2DE social grades were nearly 20 percentage points more likely to be planning to continue smoking (56% compared with 37%). Over-60s were the least likely to be planning to quit, with

FIGURE 1
SMOKING PREVALENCE BY SOCIO-ECONOMIC STATUS AMONG ALL ADULTS, ENGLAND 2010 TO 2020 (STS, WEIGHTED DATA)[3]



Source: McNeill, A et al. Vaping in England: an evidence update including vaping for smoking cessation, February 2021. 2021.

The good news is that smoking prevalence is still falling among most socio-economic groups, and falling fastest among those in the lowest income group. But we are not going fast enough, and the gap is still far too large. So what will make the difference?

In the next chapters of this report we explore new evidence to inform policy makers trying to make these changes. A key question is which smokers are considering quitting: our survey evidence suggests

62% giving this answer compared with 34% of 18-29s.

Smoking cessation work needs to take a different approach to these two kinds of smokers: the committed and the willing-to-quit.

For those considering a quit attempt, it's about encouragement, confidence and the availability of support. For those who are not considering quitting we need to think creatively about messages that

3 Age 18+. Unweighted bases: 2010=24,268; 2011=21,299; 2012=20,832; 2013=21,658; 2014=19,773; 2015=19,642; 2016=20,063; 2017=20,036; 2018=20,402; 2019=20,380; 2020 (to October) =15,294. Smoking prevalence included current smokers who smoked daily or smoked, but less than daily. Social grade definitions (44): A = High managerial, administrative or professional; B = Intermediate managerial, administrative or professional; C1 = Supervisory, clerical and junior managerial, administrative or professional; C2 = Skilled manual workers; D = Semi and unskilled manual workers; E = State pensioners, casual or lowest grade workers, unemployed with state benefits only. 2020 data available from January to October. The full year's data was used for all other years.

might persuade them to do so.

For those who do attempt to quit, there is a growing body of evidence about what works. People who try to quit with willpower alone are more likely to fail than those who get help. Nicotine is a powerfully addictive substance, and trying to quit without some form of nicotine substitute is difficult.

There are a range of alternatives when it comes to accessing nicotine to support a quit attempt, including gums, patches, inhalators and vaping. But there is a huge problem, which we will explore in the next chapter. Millions of smokers think it's the nicotine that's causing their health problems, rather than the smoke, tar and carbon monoxide in burned tobacco. That misperception could be a massive problem when it comes to persuading both groups of smokers to quit. Committed smokers who do not want to stop using nicotine may not realise that switching to an alternative source would be dramatically less harmful to their health; smokers considering a quit attempt may not use a nicotine alternative that makes them more likely to succeed.

We explore the scale of this misinformation barrier in the next chapter.

CHAPTER 2
A MISINFORMED PUBLIC

Most people understand that smoking is bad for you. Our survey confirmed this finding with 95% of respondents saying smoking was definitely or probably harmful.

However, previous research has identified a gap in public understanding of how cigarettes cause harm to our health. The public health evidence could not be clearer: while nicotine is the addictive component of tobacco, it is not a carcinogen. Lung cancer, heart disease and COPD are the leading causes of premature death among smokers, and it is the tar and smoke produced by burning tobacco that increase the chances of developing these illnesses. This reality is not, however, well understood by the public.

In 2019, a large study of smokers and ex-smokers was published by researchers at King's College London that suggested four in 10 believed nicotine caused more than half the health harms of cigarettes. This study also looked at perceptions of the relative harms of e-cigarettes compared with smoking, finding that the majority of adult smokers who had never tried vaping thought vaping was equally or more harmful than tobacco smoking and were therefore unlikely to try e-cigarettes.[4] Even more concerningly, this research, as well as research done by ASH, has shown that harm misperceptions have worsened over time, with the proportion of smokers who believed that vaping was more or equally as harmful as smoking four times higher than in 2013.[5, 6] The regular Smoking Toolkit Study also tracks this issue, surveying current smokers only.

Given our concern with the socio-economic disparities in smoking cessation, it is also important to consider to what extent these disparities exist in the context of harm misperceptions. Like smokers' willingness to quit, research by PHE has found that harm misperceptions are worse amongst the most deprived groups.[7] This is problematic as harm misperceptions are an important factor in switching. One study of adult smokers in the US found that perceived relative harm of using e-cigarettes predicts the likelihood of switching among both cigarette and e-cigarette dual users.[8] This suggests that these misperceptions are not only a barrier to the UK's goal of becoming smoke free by 2030, but also to narrowing the gap in healthy life expectancy of the poorest and richest.

Clearly, when it comes to making the choice to switch, smokers are the primary audience we want to understand the difference between smoking and nicotine alternatives. However, we are interested

4 McNeill, A et al. Vaping in England: an evidence update including vaping for smoking cessation, February 2021 A report commissioned by Public Health England. Public Health England, 2021. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962221/Vaping_in_England_evidence_update_February_2021.pdf (accessed 18/05/22)

5 McNeill, A et al. Vaping in England: an evidence update including vaping for smoking cessation, February 2021 A report commissioned by Public Health England. Public Health England, 2021. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962221/Vaping_in_England_evidence_update_February_2021.pdf (accessed 18/05/22)

6 Action on Smoking and Health (ASH). Use of e-cigarettes among young people in Great Britain. 2021. Available at https://ash.org.uk/wp-content/uploads/2021/07/Use-of-e-cigarettes-among-young-people-in-Great-Britain-2021.pdf (accessed 18/05/22)

7 McNeill, A et al. Vaping in England: an evidence update including vaping for smoking cessation, February 2021 A report commissioned by Public Health England. Public Health England, 2021.

8 Persoskie, A et al. Perceived relative harm of using e-cigarettes predicts future product switching among US adult cigarette and e-cigarette dual users. Society for the Study of Addiction, 2019. Available at https://onlinelibrary.wiley.com/doi/10.1111/add.14730 (accessed 18/05/2022)

in the scale of these misperceptions among the population at large, as smokers exist within a complex information eco-system. As our research set out in Chapter 3 shows, people share insights and information about smoking, vaping, quitting, and health between one another. We were therefore keen to study the perceptions of the relative harms of smoking and vaping, and perceptions about nicotine, among the population as a whole.

For our survey, we replicated some of the questions used by KCL in their research for a representative sample of the UK population, collecting data on whether people were current, former or never smokers.

The first question we asked was: According to what you know or believe, what portion of the health risks of smoking comes from nicotine in tobacco cigarettes? Response options were: 'none or very small; some but well under half the risk; around half the risk; much more than half the risk; nearly all the risk; don't know'. The correct answer is "none or very small risk". Only 7% of respondents gave the correct answer; 30% said nearly all the risk came from nicotine. Smokers were slightly more likely to give the correct answer: 12% said "none or very small risk", and only 21% said it was nearly all the risk.

There was a remarkable difference between age groups in responses; just 4% of over 60s gave the correct answer, while 48% said nicotine caused nearly all the risk. By contrast, only 15% of 18-29 year olds thought nicotine caused nearly all the risk; 6% gave the correct answer. The numbers giving the correct answer across the social grades was similar (7 and 8%) but the number giving the least correct answer - nearly all the risk - was very different. 27% of ABC1s gave this answer, compared with 36% of C2DE respondents.

The next question we asked was whether respondents believed the following statement to be true or false.

"The nicotine in tobacco cigarettes is the chemical that causes most of the cancer"

The correct answer is false. However, 48% of respondents said it was true, only 26% said it was false and the rest (26%) didn't know the answer. Smokers were slightly more likely to give the correct answer: 33% said this was a false statement, 42% said it was true, and 25% didn't know.

We see a familiar pattern in the demographic breakdown of respondents. Over 60s (60% vs. 43% of 18-29s), people who don't work (55% vs. 44% of those who are working) and C2DEs (53% vs. 46% of ABC1s) were more likely to say the statement was correct.

On top of this misunderstanding about tobacco, there are myths about vaping, too, in the public imagination. These perceptions are tracked by the Smoking Toolkit Study, which asks whether current smokers believe vaping is more, less, or equally harmful when compared with smoking. As before, we were interested to understand this perception among the public at large.

We asked two questions: the first to assess whether people thought vaping was harmful in and of itself, and the second to identify how they felt it compared to smoking.

The public health evidence is that harm from vaping is unlikely to exceed 5% of the harm that comes from smoking.

77% of our representative sample said they believed vaping was harmful, and 13% said they didn't know. Smokers were less likely to believe vaping is harmful, with only 67 saying it was definitely or probably harmful.

More important, however, is whether people understand the difference in the harmful effects of vaping when compared with smoking. We asked people to rate the difference on a scale from "completely safe (1)" to "more harmful than smoking (7)." As the harm of vaping is likely to be less than 5% of the harm of smoking, we counted responses of 1 or 2 as broadly correct[9], and 3-7 as broadly incorrect.

Only 10% of people gave a broadly correct answer; 90% gave an incorrect answer, with 5% estimating that vaping is more harmful than smoking. Smokers were more likely to give a correct answer, with 18% responding 1 or 2.

Together this evidence shows there is a serious problem when it comes to public understanding of how tobacco harms our health, and the harm reduction possibilities of switching as many smokers as possible to alternative sources of nicotine.

These misunderstandings will affect not just smokers' motivations and confidence in trying nicotine alternatives. They also skew the public policy landscape, reducing tolerance for regulations that might enable more people to switch. We explore public opinion about a range of possible policy interventions in chapter 5.

9 As the scale runs, effectively, from 0% of the harm to >100%, each point represents >14 percentage points. The RCPH 5% estimate would therefore be between 1 and 2. We describe 1 and 2 as "broadly" correct because they are close to this, recognising however that "completely safe" is not supported by the public health evidence.

CHAPTER 3
GROUP PATTERNS OF BEHAVIOUR

Human beings are social animals. Our relationships shape our reality in profound ways: they affect our experiences, our ideas, our capacity and lives in profound ways. Demos has been writing about the value of relationships in human societies for nearly 30 years, making the case for innovations in economic and social policy thinking that both leverage people's existing relationships and help them to build stronger relationships, with their families, communities, colleagues, peers and fellow citizens.

In 2022, this strand of thinking is focused primarily on public service design: we have made the case for relational reforms of local government services, employment support and policing. In this research, we wanted to understand whether a relational approach could also add value to NHS Stop Smoking services.

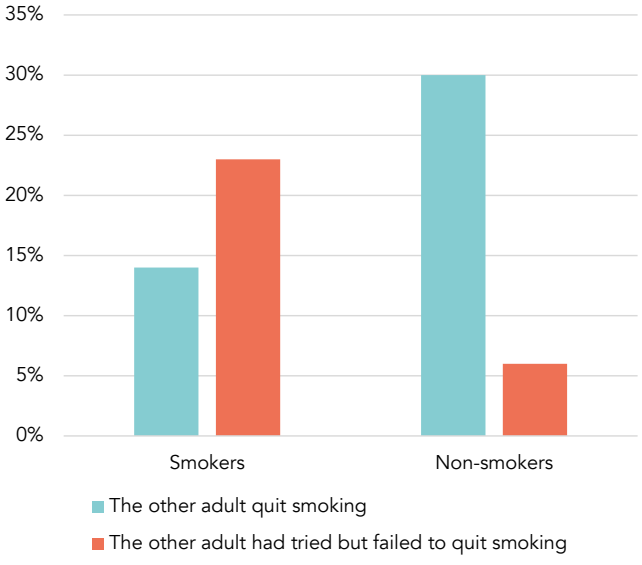
Our hypothesis is that smokers' motivation to quit, and the success of their attempts to quit, are profoundly influenced by the people around them: the people they live with and those with whom they socialise. If these people have successfully quit smoking, they may be a source of inspiration, and allyship during a quit attempt. If they are committed smokers, they may make it harder to quit, both by bringing cigarettes into social situations or by actively discouraging someone who is attempting to quit.

We therefore asked a series of questions exploring these issues.

First, we asked people how many other adults they lived with. Among those who lived with only one other adult, smokers were far more likely to live with other smokers. Just 11% of non-smokers lived with a smoker; 46% of smokers said they lived with another smoker. The pattern is similar among people who live with more than one other adult. 29% of non-smokers said at least one of the adults in their home smoked; 64% of smokers live with at least one other smoker. Overall, even including those who live alone, just under 40% of smokers live with another adult who smokes - potentially reinforcing their own smoking.

In fact, smokers were more likely to live with someone who has tried and failed to quit, and less likely to live with someone who has successfully quit. For example, in two-adult households, 30% of non-smokers said the other adult was an ex-smoker, and only 6% said the other adult had tried but failed to quit. Among smokers, 14% lived with another adult who had quit smoking, but 23% lived with someone who had failed to quit.

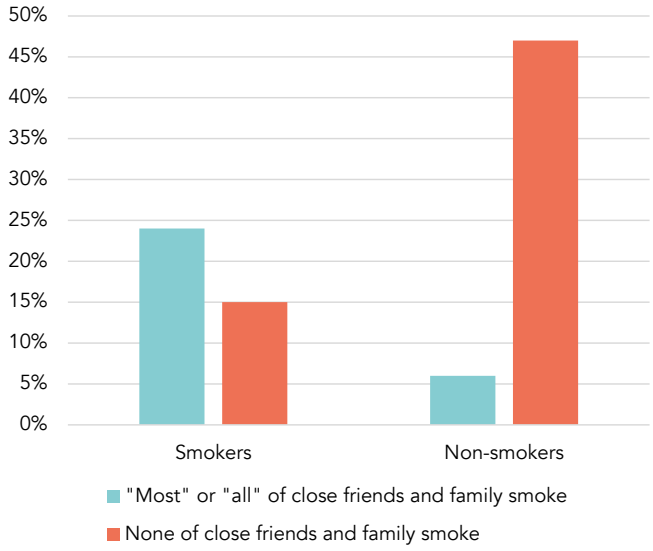
FIGURE 2



Important relationships exist outside of the home, too, of course. In our survey we asked people to tell us about the smoking behaviour of their "close friends and family." We see a similar pattern here that smokers tend to have more close relationships with other smokers, and non-smokers tend to have more close relationships with non- or ex-smokers.

Only 6% of non-smokers said "most" or "all" of their close friends and family smoke, compared to 24% of smokers. 47% of non-smokers said none of their close friends and family smoke, compared to just 15% of smokers. Smokers were also more likely to know people who had failed to quit (75% compared with 69%) or never tried to quit: 68% compared with 54% of non-smokers.

FIGURE 3



Finally, we asked questions to explore how people access information about smoking and vaping through these informal networks and personal relationships. We did so to identify whether people are, indeed, being influenced by those around them, and to inform future policy making about how to improve the quality of information people are receiving.

We asked people where they were accessing information about vaping and smoking; 27% mentioned friends and family, but this was slightly higher among smokers (at 32%) than it was among non-smokers (at 26%). 9% mentioned colleagues, but this was also higher among smokers at 15%. Most people (69%) told us they had not actively looked for information about smoking and vaping but had picked it up more generally.

We asked a series of questions about who respondents would trust to give them good information about smoking and vaping. Smokers were more likely to say they "completely" or "mostly" trusted information they got from friends and family about this issue: 73% compared with 64%. This suggests that informal networks are an important influence on smokers' behaviour and choices - there may also be the potential for a ripple effect if smokers who switch to nicotine alternatives can help to persuade others in their social and family groups to follow.

We asked what advice respondents would give to a friend or colleague hoping to quit, and it is clear that smokers and non-smokers would give quite different advice. The most popular suggestion was to get help from NHS Stop Smoking, but never-smokers were the most likely to recommend this, while current smokers were the least likely. Going cold turkey - the pathway least likely to be successful - was most likely to be recommended by ex-smokers. Switching to e-cigarettes - one of the most successful pathways - was only selected by 18% of respondents, but it was more a more popular suggestion among smokers and ex-smokers.

TABLE 2

	I HAVE NEVER SMOKED	I USED TO SMOKE BUT I HAVE GIVEN UP NOW	CURRENTLY SMOKE
Going "cold turkey" and stopping smoking completely rather than cutting down	26 %	36 %	23 %
Gradually reducing the number of cigarettes they smoke	40 %	31 %	46 %
Trying nicotine replacements like gum or patches	45 %	45 %	44 %
Switching to e-cigarettes	11 %	24 %	27 %
Not to bother trying to quit	2 %	1 %	3 %
Getting support from NHS "Stop Smoking" services	64 %	59 %	52 %
Other (please state)	2 %	3 %	2 %
Don't know	8 %	2 %	4 %

CHAPTER 4
THE POLITICS OF CHANGE

In 2004, then Health Secretary John Reid sparked outrage from public health and anti-smoking campaigners when he claimed that a cigarette was sometimes "the only enjoyment" low income people on "sink estates" got. "I just do not think the worst problem on our sink estates by any means is smoking,"he said, "but it is an obsession of the learned middle class."

This trope of a middle class imposition on the lives of lower income citizens is common in our political discourse. Crucially, it is a part of the framing in the culture war, in which the government is keen to be championing the views of people in left behind towns against the metropolitan liberal elite. This narrative has been a part of the ongoing realignment in our politics, with the Conservative party picking up increasing numbers of votes from lower income areas that had traditionally voted Labour, in particular the so-called Red Wall.

From a public health perspective, it is clear that smoking cessation is vital in those Red Wall seats, along with other lower-income parts of the country. Poorer areas like Red Wall seats have lower healthy life expectancy, and stopping people in these constituencies from smoking is of fundamental importance in addressing the problem.

However, the cultural narrative espoused by John Reid nearly sabotaged progress towards a ban on smoking in public places back in 2004. As a result of this cultural controversy, Labour's 2005 manifesto promised a ban smoking in public places - but with an exemption for pubs and clubs. It was only intensive lobbying after the election by anti-smoking campaigners that shifted the politics towards an all-out ban.

How do things stand today, politically? Is the choice to go with the preferences of John Reid's "learned middle class" part of what lost Labour those votes and seats? Should the Conservatives be wary of pushing for faster progress on smoking cessation? Could it harm their prospects in their key marginals? Political considerations like these have often shaped public health policy, so we wanted to explore these questions in some depth.

To do so, we conducted a comparator poll asking the same questions as in our national poll with a representative sample of "Red Wall" voters. We wanted to explore the extent to which their attitudes and preferences differed from the public at large. We wanted to know whether the politics of the Red Wall would encourage the government to move faster, or slower, on smoking cessation.

First, we wanted to know how important the government's health inequality agenda was in these key marginals. We asked the following question:

> *People on low incomes, and in the poorest parts of the country, tend to have lower healthy life expectancy than people on higher incomes, and in richer areas. "Healthy life expectancy" means the number of years a person lives in a state of good health rather than just how long they live in total. The government has said that it wants to reduce this health inequality. How important do you think this goal is for the United Kingdom?*

90% of voters in Red Wall constituencies told us this was important - with 52% describing it as "very important." These numbers are even higher than the 85% of the nationally representative sample who said it was important, of whom 47% said it was

very important. Interestingly, given the profile of Conservative support tends towards older people, older respondents were more likely to say this issue was important to them. In the Red Wall only 40% of 18-29 year olds said this was very important compared with 54% of over 60s.

There was also no difference between the responses of ABC1 groups and C2DE groups on this question in the Red Wall. Nationally, it was C2DE groups who were more likely to rate it as important.

Just because voters want health inequality to be addressed, that doesn't mean they automatically support policies on smoking cessation. We therefore asked people to give us their thoughts on a range of possible approaches the government could take to tackle health inequality. We asked them to choose the three most important policy areas from the following list, which was presented in a randomised order:

- Help and support for people on lower incomes to stop smoking
- Help with the overall cost of living
- Improvements to housing conditions for people on lower incomes
- Help with healthy eating for people on lower incomes
- Mental health support for people on lower incomes
- Funding for local government initiatives where I live
- Investment in sport and exercise facilities for people in poorer places
- Something else
- Don't know
- Nothing

Chosen priorities nationally were help with the cost of living (61%), help with healthy eating (41%), improvements to housing conditions (37%), and mental health support (34%). Smoking cessation was fifth most popular with 31% believing it is one of the top three measures the government should address; notably local government and exercise facilities scored much lower at 12% and 19% respectively. Results in the Red Wall were similar, with 33% prioritising smoking cessation, and a huge 67% asking for help with the cost of living.

Finally, we wanted to know if there would be a warm welcome or a hostile reception in the Red Wall to specific policies to help people quit smoking.

We tested seven policy ideas. Five had net support in these constituencies and two did not:

TABLE 3

POLICY PROPOSAL	TOTAL SUPPORT	TOTAL OPPOSE
Ban smoking, as smokers could all switch to e-cigarettes	42 %	26 %
Allow smokers to get e-cigarettes free or cheaply while they quit	40 %	33 %
Provide advice to smokers about the benefits of switching to e-cigarettes	67 %	9 %
Launch a major public health campaign to persuade smokers to switch	54 %	13 %
Try to stop people who aren't smokers from starting to vape	66 %	12 %
Make e-cigarettes available on the NHS	32 %	45 %
Make it legal to vape in public places where smoking is banned	30 %	51 %

Results were similar in our nationally representative sample, with slightly lower support for making e-cigarettes available on the NHS (27%), making it legal to vape in public places (28%) and providing advice to smokers about switching (62%).

In other words, smoking cessation is not a culture war issue, or an electoral liability in the Red Wall. If anything, action is considered more important here than elsewhere, and there is greater support for policy change. It is quite something when 42% of voters tell us they would even support an all out ban on cigarettes, including 39% of C2DE voters, and 44% of those intending to vote Conservative at the next election.

It is important to note that smokers and non-smokers had quite different views about the policy options set out above. Unsurprisingly a full ban on smoking was less popular with smokers: among Red Wall smokers, this policy secured 26% support and 54% disapproval. Policies to make switching cheaper and easier were most popular among smokers: 67% supported free e-cigarettes for quitters.

We should also note how important all kinds of voters think it is for us to keep those who do not currently vape or smoke from taking up the habit. We will turn to addressing these issues in the next research paper in our series.

CHAPTER 5 EMERGING RECOMMENDATIONS AND NEXT STEPS

As this programme of work continues we are starting to identify the priority areas where policy needs to improve in order to achieve the UK's ambitious goal of becoming Smoke Free by 2030.

This paper will be followed by a subsequent research study looking at the challenges we face in enforcing the current regime, in terms of product safety, advertising and promotion, and age restrictions. We are keen to explore the experiences of young people and non-vapers to see how they can best be protected from harm. In particular we are concerned with their perceptions of the relative harms of vaping, how appealing e-cigarettes may or may not be to them, and how accessible e-cigarettes are to those under the age of 18. We also want to explore how smokers experience the vaping market.

We will then bring together the conclusions of this and additional stakeholder engagement into a white paper setting out a series of recommendations for a strong, enforceable regime for the future of vaping, and continued efforts to maximise smoking cessation as part of the levelling up agenda.

Already the issues that white paper will need to address are becoming clear.

The research conducted for this paper makes a strong case for **a radically new approach to public health information on smoking and vaping**. Basic information about smoking and vaping is not getting through to people, and this is likely to be causing substantial harm: it contributes to a set of missed opportunities in terms of the number of people making quit attempts, using appropriate nicotine substitutes to help them quit.

In the next stages of our work we will start to develop policy recommendations for how this should be delivered, building on the insights we have identified here, including:

The need to reach smokers through trusted sources of information. Doctors could play a key role here and should be provided with improved clinical guidance and training on the relative harms of vaping so they can better convey this information to smokers.

- The need to reach smokers through targeted information. For example, this could be through pack inserts or targeted marketing.
- The need to engage with smokers through the networks they use to access information
- A public information campaign with accurate information on the relative harms of vaping with strong public support for this health information campaign

- Strong public support for trying to minimise the number of non-smokers or non-vapers taking up vaping

Our survey also suggests that **a relational approach to smoking cessation could help improve the impact of these services**. Smokers' social lives appear to involve far much more contact with other smokers than non-smokers' social lives do. We believe there may be huge potential in trialling innovations in smoking cessation that help couples, families or social groups quit together. There may also be potential in helping connect those who have successfully quit with people still trying: offering mentoring and encouragement.

The white paper will also address issues of enforcement and trading standards that emerge from the next paper in this series.

We remain keen to hear from anyone in the health, retail, consumer protection, trading standards or vaping sectors who can contribute to our programme of work.

Licence to publish

Demos – Licence to Publish

The work (as defined below) is provided under the terms of this licence ('licence'). The work is protected by copyright and/or other applicable law. Any use of the work other than as authorized under this licence is prohibited. By exercising any rights to the work provided here, you accept and agree to be bound by the terms of this licence. Demos grants you the rights contained here in consideration of your acceptance of such terms and conditions.

1 Definitions

a 'Collective Work' means a work, such as a periodical issue, anthology or encyclopedia, in which the Work in its entirety in unmodified form, along with a number of other contributions, constituting separate and independent works in themselves, are assembled into a collective whole. A work that constitutes a Collective Work will not be considered a Derivative Work (as defined below) for the purposes of this Licence.

b 'Derivative Work' means a work based upon the Work or upon the Work and other pre-existing works, such as a musical arrangement, dramatization, fictionalization, motion picture version, sound recording, art reproduction, abridgment, condensation, or any other form in which the Work may be recast, transformed, or adapted, except that a work that constitutes a Collective Work or a translation from English into another language will not be considered a Derivative Work for the purpose of this Licence.

c 'Licensor' means the individual or entity that offers the Work under the terms of this Licence.

d 'Original Author' means the individual or entity who created the Work.

e 'Work' means the copyrightable work of authorship offered under the terms of this Licence.

f 'You' means an individual or entity exercising rights under this Licence who has not previously violated the terms of this Licence with respect to the Work, or who has received express permission from Demos to exercise rights under this Licence despite a previous violation.

2 Fair Use Rights

Nothing in this licence is intended to reduce, limit, or restrict any rights arising from fair use, first sale or other limitations on the exclusive rights of the copyright owner under copyright law or other applicable laws.

3 Licence Grant

Subject to the terms and conditions of this Licence, Licensor hereby grants You a worldwide, royalty-free, non-exclusive, perpetual (for the duration of the applicable copyright) licence to exercise the rights in the Work as stated below:

a to reproduce the Work, to incorporate the Work into one or more Collective Works, and to reproduce the Work as incorporated in the Collective Works;

b to distribute copies or phono-records of, display publicly, perform publicly, and perform publicly by means of a digital audio transmission the Work including as incorporated in Collective Works; The above rights may be exercised in all media and formats whether now known or hereafter devised. The above rights include the right to make such modifications as are technically necessary to exercise the rights in other media and formats. All rights not expressly granted by Licensor are hereby reserved.

4 Restrictions

The licence granted in Section 3 above is expressly made subject to and limited by the following restrictions:

a You may distribute, publicly display, publicly perform, or publicly digitally perform the Work only under the terms of this Licence, and You must include a copy of, or the Uniform Resource Identifier for, this Licence with every copy or phono-record of the Work You distribute, publicly display, publicly perform, or publicly digitally perform. You may not offer or impose any terms on the Work that alter or restrict the terms of this Licence or the recipients' exercise of the rights granted hereunder. You may not sublicence the Work. You must keep intact all notices that refer to this Licence and to the disclaimer of warranties. You may not distribute, publicly display, publicly perform, or publicly digitally perform the Work with any technological measures that control access or use of the Work in a manner inconsistent with the terms of this Licence Agreement. The above applies to the Work as incorporated in a Collective Work, but this does not require the Collective Work apart from the Work itself to be made subject to the terms of this Licence. If You create a Collective Work, upon notice from any Licensor You must, to the extent practicable, remove from the Collective Work any reference to such Licensor or the Original Author, as requested.

b You may not exercise any of the rights granted to You in Section 3 above in any manner that is primarily intended for or directed toward commercial advantage or private monetary compensation. The exchange of the Work for other copyrighted works by means of digital file sharing or otherwise shall not be considered to be intended for or directed toward commercial advantage or private monetary compensation, provided there is no payment of any monetary compensation in connection with the exchange of copyrighted works.

c If you distribute, publicly display, publicly perform, or publicly digitally perform the Work or any Collective Works, you must keep intact all copyright notices for the Work and give the Original Author credit reasonable to the medium or means You are utilizing by conveying the name (or pseudonym if applicable) of the Original Author if supplied; the title of the Work if supplied. Such credit may be implemented in any reasonable manner; provided, however, that in the case of a Collective Work, at a minimum such credit will appear where any other comparable authorship credit appears and in a manner at least as prominent as such other comparable authorship credit.

5 Representations, Warranties and Disclaimer

a By offering the Work for public release under this Licence, Licensor represents and warrants that, to the best of Licensor's knowledge after reasonable inquiry:

i Licensor has secured all rights in the Work necessary to grant the licence rights hereunder and to permit the lawful exercise of the rights granted hereunder without You having any obligation to pay any royalties, compulsory licence fees, residuals or any other payments;

ii The Work does not infringe the copyright, trademark, publicity rights, common law rights or any other right of any third party or constitute defamation, invasion of privacy or other tortious injury to any third party.

b Except as expressly stated in this licence or otherwise agreed in writing or required by applicable law, the work is licenced on an 'as is' basis, without warranties of any kind, either express or implied including, without limitation, any warranties regarding the contents or accuracy of the work.

6 Limitation on Liability

Except to the extent required by applicable law, and except for damages arising from liability to a third party resulting from breach of the warranties in section 5, in no event will licensor be liable to you on any legal theory for any special, incidental, consequential, punitive or exemplary damages arising out of this licence or the use of the work, even if licensor has been advised of the possibility of such damages.

7 Termination

a This Licence and the rights granted hereunder will terminate automatically upon any breach by You of the terms of this Licence. Individuals or entities who have received Collective Works from You under this Licence, however, will not have their licences terminated provided such individuals or entities remain in full compliance with those licences. Sections 1, 2, 5, 6, 7, and 8 will survive any termination of this Licence.

b Subject to the above terms and conditions, the licence granted here is perpetual (for the duration of the applicable copyright in the Work). Notwithstanding the above, Licensor reserves the right to release the Work under different licence terms or to stop distributing the Work at any time; provided, however that any such election will not serve to withdraw this Licence (or any other licence that has been, or is required to be, granted under the terms of this Licence), and this Licence will continue in full force and effect unless terminated as stated above.

8 Miscellaneous

a Each time You distribute or publicly digitally perform the Work or a Collective Work, Demos offers to the recipient a licence to the Work on the same terms and conditions as the licence granted to You under this Licence.

b If any provision of this Licence is invalid or unenforceable under applicable law, it shall not affect the validity or enforceability of the remainder of the terms of this Licence, and without further action by the parties to this agreement, such provision shall be reformed to the minimum extent necessary to make such provision valid and enforceable.

c No term or provision of this Licence shall be deemed waived and no breach consented to unless such waiver or consent shall be in writing and signed by the party to be charged with such waiver or consent.

d This Licence constitutes the entire agreement between the parties with respect to the Work licenced here. There are no understandings, agreements or representations with respect to the Work not specified here. Licensor shall not be bound by any additional provisions that may appear in any communication from You. This Licence may not be modified without the mutual written agreement of Demos and You.

DEMOS

Demos is a champion of people, ideas and democracy. We bring people together. We bridge divides. We listen and we understand. We are practical about the problems we face, but endlessly optimistic and ambitious about our capacity, together, to overcome them.

At a crossroads in Britain's history, we need ideas for renewal, reconnection and the restoration of hope. Challenges from populism to climate change remain unsolved, and a technological revolution dawns, but the centre of politics has been intellectually paralysed. Demos will change that. We can counter the impossible promises of the political extremes, and challenge despair – by bringing to life an aspirational narrative about the future of Britain that is rooted in the hopes and ambitions of people from across our country.

Demos is an independent, educational charity, registered in England and Wales. (Charity Registration no. 1042046)

Find out more at **www.demos.co.uk**

DEMOS

PUBLISHED BY DEMOS FEBRUARY 2022

15 WHITEHALL, LONDON, SW1A 2DD
T: 020 3878 3955
HELLO@DEMOS.CO.UK
WWW.DEMOS.CO.UK