

Brief Report

Examining if there is a differential association between smoking and chronic disease across socioeconomic groups: pooling of data from 15 prospective cohort studies

Carlos de Mestral^{1,2}, Steven Bell³, Emmanuel Stamatakis^{4,5}, G. David Batty¹

¹Research Department of Epidemiology and Public Health, University College London, London, UK; ²Institute of Social and Preventive Medicine, Lausanne University Hospital, Lausanne, Switzerland; ³Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK; ⁴Charles Perkins Centre, Epidemiology Unit, University of Sydney; ⁵ School of Public Health, University of Sydney, Sydney, Australia.

Correspondence to: Carlos de Mestral, Research Department of Epidemiology and Public Health, University College London, 1-19 Torrington Place, London, WC1E 7HB, United Kingdom, +44 020 3108 6281, carlos.demestral.17@ucl.ac.uk, cdemestral@gmail.com

[Running Head: Socioeconomic position, smoking and mortality](#)

[Conflict of interest: The authors declare no conflict of interest.](#)

Financial support: This work was supported by a grant (P1LAP3_174615) from the Swiss National Science Foundation (CdM), and by the UK Medical Research Council and the US National Institute on Aging (GDB). The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; or the decision to submit the manuscript for publication.

Statement of replication: The data sets are available to download upon approval via the UK Data Service. The codes to replicate analyses are available from corresponding author.

Abstract

Background: For the same quantity of cigarettes smoked, relative to the more affluent, socioeconomically disadvantaged people have higher levels of smoking biomarkers. This may be ascribed to inhaling cigarette smoke more deeply and more frequently, and/or choosing higher tar-containing brands. We investigated if this increased tobacco load, as captured using cotinine, is associated with a greater risk of mortality in lower social groups.

Methods: We used Cox proportional hazards models stratified by socioeconomic position to calculate hazard ratios in a pooled sample of 15 English and Scottish prospective cohort studies (N=81476).

Results: During a mean (SD) follow-up of 10.3 (4.4) years, 8234 deaths occurred. Risk of total mortality (Hazards Ratio; 95% confidence interval) for smokers relative to never-smokers in the high (2.5; 2.1, 3.1), intermediate (2.1; 1.8, 2.4), and low (2.0; 1.9, 2.2) educational groups did not differ markedly (p for interaction=0.61). Similar findings emerged when using cause-specific outcomes, and occupational social class and housing tenure as socioeconomic indices.

Conclusion: Contrary to our hypothesis, we found no indication that disadvantaged people were more vulnerable to the impact of smoking on chronic disease mortality.

Keywords: cotinine; smoking; socioeconomic position; cancer; cardiovascular disease; mortality

Introduction

It is well documented that cigarette smoking markedly increases the risk of developing chronic diseases, particularly several cancers and cardiovascular disease (CVD).¹ It is also well known that people in lower socioeconomic groups are much more likely to smoke than those from advantaged backgrounds²—in 2016, for instance, 21% of adults in England without formal qualifications smoked, compared with only 9% of those with a university degree.³ This inequality has increased in recent years—between 2001 and 2012, smoking prevalence decreased among those with managerial or professional occupations (from 20% to 14%) while it remained unchanged among people in routine and manual occupations in the UK (33%).⁴ Accordingly, the population impact of smoking is greater in the socioeconomically disadvantaged groups.^{2,5} In addition to a greater population prevalence of smoking among people in lower socioeconomic groups, there is evidence that, for the same quantity of cigarettes smoked, less advantaged people have higher levels of the smoking biomarkers than more advantaged people.² This may be due to the manner in which individuals from lower socioeconomic groups smoke by inhaling more deeply and more frequently, and/or choosing higher tar-containing brands.² This increased tobacco load may lead to the greater risk of mortality—that is, higher smoking-related vulnerability—among disadvantaged groups. The few studies that have tested this hypothesis have revealed inconsistent findings. For instance, in a large Danish cohort, Nordahl *et al.* found that self-reported smoking carried a greater risk of stroke mortality among lower educated groups compared with higher educated groups.⁶ However, in a large Belgian cohort, Charafeddine *et al.* found no evidence of differential vulnerability to self-reported smoking on all-cause mortality.⁷ Crucially, studies have exclusively relied on self-reported smoking,⁶⁻⁸ which is subject to reporting bias, particularly among people with lower education,⁹ and this may

generate an inflated hazard in poorer individuals. Thus, we pooled a series of cohort studies with cause-specific mortality and measured cotinine data to test the hypothesis that smoking may exert a greater influence on health in disadvantaged populations.

Methods

Participants originated from the Health Survey for England (HSE), and the Scottish Health Survey (SHS), both of which have been described in detail elsewhere.^{10,11} These are population-representative, cross-sectional health examination studies conducted in private households in England and Scotland. We pooled data from 12 HSE (1994 to 2008), and three SHS (1995, 1998, and 2003) studies in which response ranged from 68 to 77%.^{10,12} Following participation in these surveys, consenting participants (88%) were linked to National Health Service mortality records up to December 2009 (SHS)¹² and mid-February 2011 (HSE).¹⁰

We created a baseline smoking variable by cross-referencing participants' self-reported smoking against their measured salivary or serum cotinine levels (the correlation between salivary and cotinine levels is very high)¹³: 1) never smokers were defined by self-reported "never smoker" *and* salivary cotinine below 12 ng/mL or serum cotinine below 9 ng/mL; 2) ex-smokers self-reported being an "ex-smoker" *and* had salivary cotinine below 12 ng/mL or serum cotinine below 9 ng/mL; and 3) current smokers comprised self-reported smokers and individuals with salivary cotinine ≥ 12 ng/mL, or serum cotinine ≥ 9 ng/mL. We selected endpoints that are known to have a relationship with cigarette smoking:¹⁴ death from all causes, smoking-related cancers (lung, pancreas, esophagus, bladder, kidney, oral, liver, stomach, leukemia), all CVD, coronary heart disease (CHD), stroke, and chronic obstructive pulmonary disease (COPD). We used three socioeconomic position variables, including: age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or

below); occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations); and housing tenure (owner or renter). As covariates, we included sex, age at baseline (continuous), body mass index (weight in kilograms divided by height in meters squared), and dichotomized physical activity (any weekly moderate to vigorous exercise) and excessive alcohol intake (as ≥ 168 grams/week for men, and ≥ 112 grams/week for women).

Study members were included in the analytical sample if they had data on cotinine, self-reported smoking, socioeconomic variables, covariates (eFigure 1) and if they consented to mortality data linkage. For each socioeconomic and smoking group, we calculated age-standardized mortality rates per 10000 person-years (for 5-age groups) with the direct method using the 2015 European Standard Population as the standard. Subsequently, having ascertained via Schoenfeld residuals that the proportional hazards assumption was not violated, we calculated hazard ratios (HR) and associated 95% confidence intervals (95% CI) using Cox proportional hazard models. We stratified the analysis by socioeconomic position, adjusting the effect estimate first for age, sex, and cohort, then additionally for BMI, physical activity, and excessive alcohol intake. We imputed missing values for the last three variables using five imputations. Statistical significance for multiplicative interaction was assessed using the likelihood ratio test comparing the models with and without the product term of smoking and socioeconomic position. We also tested for additive interaction by calculating the Relative Excess Risk due to Interaction, the Proportion of Disease Attributable to Interaction, and the Synergy Index. In sensitivity analyses, we repeated the analysis focusing on premature all-cause and cause-specific mortality and three types of smoking exposure (number of cigarettes smoked

per day; cotinine level; and self-reported smoking). Analyses were conducted using Stata statistical software version 14 (StataCorp, College Station, TX).

Results

Our analytical sample comprised 81476 participants with complete data on cotinine, self-reported smoking, education, age, sex, and mortality (eFigure 1). The mean age of participants at baseline was 46 years (range: 16 to 97 years), and 53% were women (eTable 1). During a mean (SD) follow-up time of 10.3 (4.4) years, 8234 deaths occurred (1170 from smoking-related cancers, 4078 from CVD, 690 from stroke, 1412 from CHD, and 2568 from COPD). The age-standardized mortality rate was highest among smokers in lower socioeconomic groups. Thus, the rate (95% CI) per 10000 person-years for death from all causes was 243 (230, 256) among smokers with low education versus 182 (156, 208) among smokers with high education; for smoking-related cancer, the corresponding rates were 47 (42, 52) versus 28 (20, 36); and for CVD, 110 (102, 118) versus 95 (74, 116) (Figure). Both the basic and multivariable models yielded similar findings, thus we present results from the latter only. As anticipated, relative to non-smokers, cigarette smoking was related to an elevated risk of death from all causes in the high (HR; 95% CI: 2.5; 2.1, 3.1), intermediate (2.1; 1.8, 2.4), and low education group (2.0; 1.9, 2.2). Corresponding HRs (95% CI) for smoking-related cancers were 4.4 (3.0, 6.5), 4.4 (3.0, 6.6), and 4.3 (3.5, 5.2); and, for CVD, 3.8 (2.6, 5.5), 2.4 (1.8, 3.2), and 2.5 (2.2, 2.9) (Figure). There was, however, no indication that smoking in the more basic educational group yielded a greater impact on mortality in comparison to the higher educational categories as based on tests for interaction, multiplicative or additive (p-values for interaction ≥ 0.21). Similar patterns of association and mortality rates were observed for death from stroke, CHD, and COPD (eFigure 2). Results were also similar when substituting educational level for occupational social class

(eFigure 3) and housing tenure (eFigure 4) as the socioeconomic measure of interest. Our findings were robust under a range of sensitivity analyses, including three types of smoking exposure (eFigure 5-19). Finally, we found no strong evidence of heterogeneity in the association between mortality and smoking across the 15 included cohort studies.

Discussion

We found no support for the hypothesis of differential vulnerability to the effects of smoking on several chronic disease outcomes across different socioeconomic groups. Comparing our results to the literature is not straightforward due to differing methodological approaches, different smoking and socioeconomic indicators, and a range of mortality outcomes. However, Lewer *et al.*,¹⁵ in a similar analysis to ours, also found no evidence of interaction between smoking and socioeconomic position on death from all causes and from COPD, while revealing higher absolute risk of smoking among more disadvantaged groups.

Some strengths of our study include the large and representative sample size which provided sufficient power to test for interaction, the use of an array of smoking-related chronic disease outcomes, and, for the first time to our knowledge, the utilization of an objective indicator of smoking exposure. Our work is of course not without its shortcomings. Smoking was only measured at baseline, and given the continuous decline of smoking prevalence in the population, it is likely that many participants decreased their intake or ceased completely during follow-up.

In conclusion, in a large and representative series of cohorts of the English and Scottish populations, we found no indication of differential vulnerability to the detrimental effect of smoking on death from a range of major chronic diseases known to be linked to tobacco smoking.

References

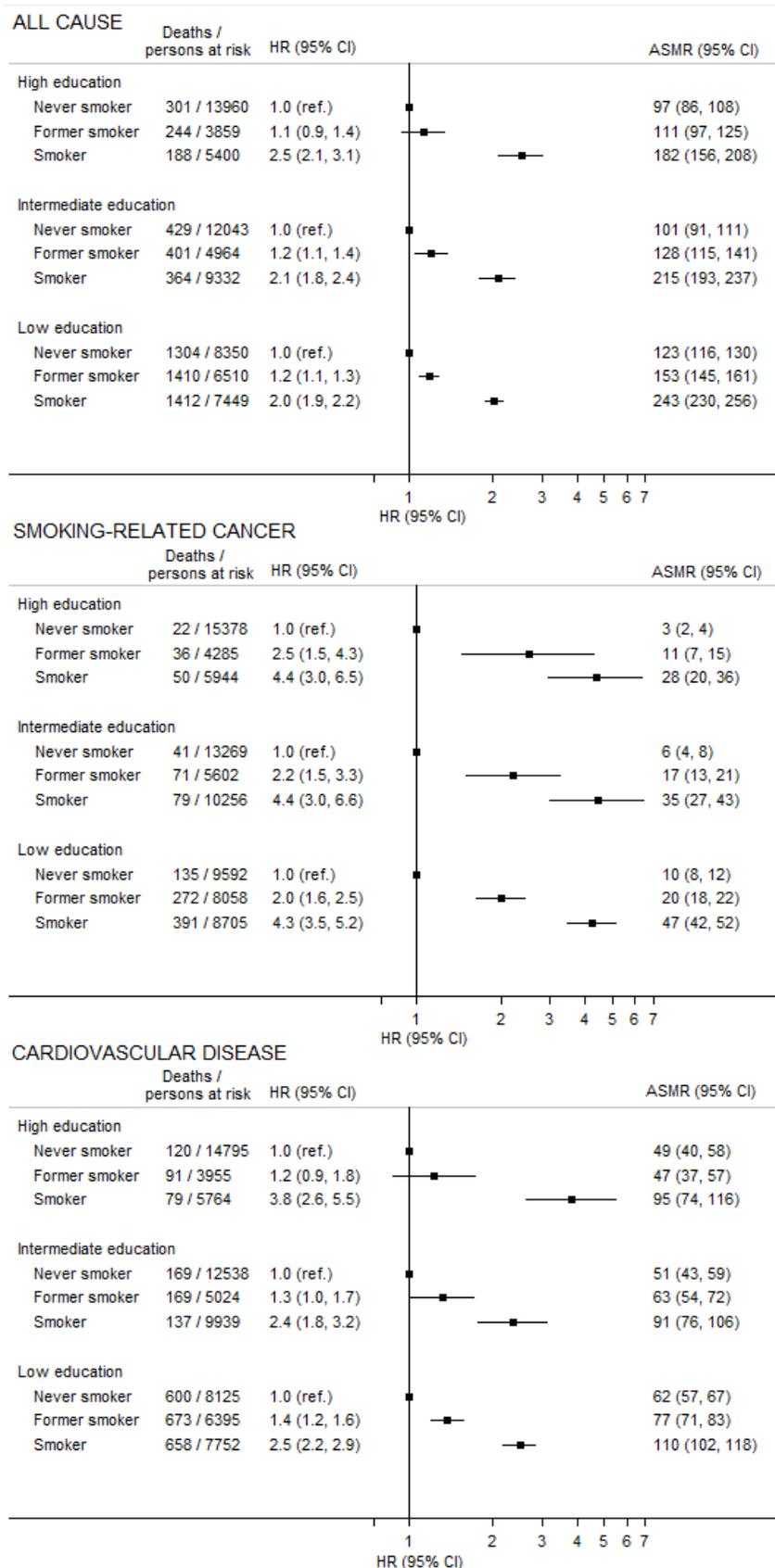
1. World Health Organization. WHO Global Report: Mortality Attributable to Tobacco. Geneva, Switzerland: World Health Organization, 2012.
2. Hiscock R, Bauld L, Amos A, Fidler JA, Munafò M. Socioeconomic status and smoking: a review. *Ann N Y Ac Sci* 2012;**1248**(1):107-123.
3. Office for National Statistics. Adult smoking habits in the UK: 2016. <https://www.ons.gov.uk/releases/adultsmokinghabitsingreatbritain2016>.
4. Cancer Research UK. Tobacco Statistics - Tobacco Statistics by Socio-economic Group. <http://www.cancerresearchuk.org/health-professional/cancer-statistics/risk/tobacco#collapseFour>.
5. Thun MJ, Carter BD, Feskanich D, Freedman ND, Prentice R, Lopez AD, Hartge P, Gapstur SM. 50-year trends in smoking-related mortality in the United States. *N Engl J Med* 2013;**368**(4):351-64.
6. Nordahl H, Osler M, Frederiksen BL, Andersen I, Prescott E, Overvad K, Diderichsen F, Rod NH. Combined effects of socioeconomic position, smoking, and hypertension on risk of ischemic and hemorrhagic stroke. *Stroke* 2014;**45**(9):2582-7.
7. Charafeddine R, Van Oyen H, Demarest S. Does the association between smoking and mortality differ by educational level? *Soc Sci Med* 2012;**74**(9):1402-6.
8. Rod NH, Lange T, Andersen I, Marott JL, Diderichsen F. Additive interaction in survival analysis: use of the additive hazards model. *Epidemiology* 2012;**23**(5):733-7.
9. Connor Gorber S, Schofield-Hurwitz S, Hardt J, Levasseur G, Tremblay M. The accuracy of self-reported smoking: a systematic review of the relationship between self-reported and cotinine-assessed smoking status. *Nicotine Tob Res* 2009;**11**(1):12-24.
10. Mindell J, Biddulph JP, Hirani V, Stamatakis E, Craig R, Nunn S, Shelton N. Cohort profile: the health survey for England. *Int J Epidemiol* 2012;**41**(6):1585-93.
11. Bell S, Russ TC, Kivimaki M, Stamatakis E, Batty GD. Dose-Response Association Between Psychological Distress and Risk of Completed Suicide in the General Population. *JAMA Psychiatry* 2015;**72**(12):1254-6.
12. Gray L, Batty GD, Craig P, Stewart C, Whyte B, Finlayson A, Leyland AH. Cohort profile: the Scottish health surveys cohort: linkage of study participants to routinely

- collected records for mortality, hospital discharge, cancer and offspring birth characteristics in three nationwide studies. *Int J Epidemiol* 2010;**39**(2):345-50.
13. Jarvis MJ, Primatesta P, Erens B, Feyerabend C, Bryant A. Measuring nicotine intake in population surveys: comparability of saliva cotinine and plasma cotinine estimates. *Nicotine Tob Res* 2003;**5**(3):349-55.
 14. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. *Jama* 2004;**291**(10):1238-45.
 15. Lewer D, McKee M, Gasparini A, Reeves A, de Oliveira C. Socioeconomic position and mortality risk of smoking: evidence from the English Longitudinal Study of Ageing (ELSA). *Eur J Public Health* 2017;**27**(6):1068-1073.

Figure footnote

Association between cigarette smoking and death from all causes, smoking-related cancer, and CVD, according to educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Survey studies conducted between 1994 and 2008 (N = 81476). Educational level derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. ASMR: Age-standardized mortality rates calculated using the 2015 European Standard Population as the standard.

Figure



Online Supplementary Material

Table of Contents

eTable 1. Characteristics of participants in analytic sample at baseline.....	1
eTable 2. Characteristics of participants included and excluded in analytic sample.....	2
eTable 3. Concordance between self-reported smoking and cotinine-verified smoking.....	3
eFigure 1. Flowchart of participant inclusion into main analytical sample.....	4
eFigure 2. Association between cigarette smoking and death from stroke, CHD, and COPD, separately by educational level.....	5
eFigure 3. Association between cigarette smoking and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by occupational social class.....	7
eFigure 4. Association between cigarette smoking and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by housing tenure.....	9
eFigure 5. Association between cigarette smoking and premature death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by educational level.....	10
eFigure 6. Association between cigarette smoking and premature death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by occupational social class.....	12
eFigure 7. Association between cigarette smoking and premature death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by housing tenure.....	14
eFigure 8. Association between cigarette smoking and death (limited to 6-y follow-up) from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by educational level.....	16
eFigure 9. Association between cigarette smoking and death (limited to 6-y follow-up) from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by occupational social class.....	18
eFigure 10. Association between cigarette smoking and death (limited to 6-y follow-up) from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by housing tenure..	20

eFigure 11. Association between number of cigarettes smoked per day and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by educational level.....	22
eFigure 12. Association between number of cigarettes smoked per day and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by occupational social class	24
eFigure 13. Association between number of cigarettes smoked per day and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by housing tenure	26
eFigure 14. Association between cotinine level and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by educational level.....	28
eFigure 15. Association between cotinine level and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by occupational social class	30
eFigure 16. Association between cotinine level and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by housing tenure	32
eFigure 17. Association between self-reported smoking and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by educational level.....	34
eFigure 18. Association between self-reported smoking and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by occupational social class	36
eFigure 19. Association between self-reported smoking and death from all causes, smoking-related cancer, CVD, stroke, CHD, and COPD, separately by housing tenure	38

eTable 1. Characteristics of participants in analytical sample at baseline, pooled data from 15 Health Survey for England and 3 Scottish Health Survey samples (N = 81 476)

	Smoking category ^a				<i>p-value</i> ^b
	Total N = 81 476	Never smoker	Ex-smoker	Smoker	
N (% of total)		38 333 (47.0)	18 228 (22.4)	24 915 (30.6)	
Women (N, %)	43 219 (53.0)	22 692 (59.2)	8 319 (45.6)	12 208 (49.0)	<0.001
Age (mean, SD)	45.8 (17.3)	45.4 (17.3)	55.7 (16.1)	42.1 (15.9)	<0.001
BMI (mean, SD)	26.6 (3.7)	26.6 (4.8)	27.7 (4.5)	25.8 (4.7)	<0.001
Occupational position ^c					<0.001
High	25 505 (32.7)	13 585 (37.4)	6 218 (34.7)	5 702 (24.0)	
Intermediate	18 848 (24.1)	9 947 (27.4)	3 942 (22.0)	4 959 (20.8)	
Low	33 725 (43.2)	12 824 (35.3)	7 756 (43.3)	13 145 (55.2)	
Educational level ^d					<0.001
High	25 435 (31.2)	15 257 (39.8)	4 304 (23.6)	5 874 (23.6)	
Intermediate	29 191 (35.8)	13 309 (34.7)	5 650 (31.0)	10 232 (41.1)	
Low	26 855 (33.0)	9 772 (25.5)	8 274 (45.4)	8 809 (35.4)	
Housing tenure					
Owner	59 278 (72.9)	30 371 (79.3)	14 442 (79.4)	14 465 (58.1)	<0.001
Renter	22 085 (27.1)	7 908 (20.7)	3 753 (20.6)	10 424 (41.9)	
Excessive alcohol ^e	27 510 (21.4)	4 333 (16.8)	3 115 (24.5)	5 451 (31.9)	<0.001
Physically active ^f	31 169 (59.7)	15 298 (65.5)	6 313 (59.0)	9 480 (61.8)	<0.001

^a Cotinine-checked smoking categories were as follows: 1) never smoker from self-reported “never smoker” and salivary cotinine below 12 ng/mL or serum cotinine below 9 ng/mL; 2) ex-smoker from self-reported “ex-smoker” and salivary cotinine below 12 ng/mL or serum cotinine below 9 ng/mL; 3) current smoker, irrespective of self-reported smoking behavior, salivary cotinine \geq 12 ng/mL or serum cotinine \geq 9 ng/mL.

^b Statistical significance for difference across smoking groups from Chi-square test for categorical variables, and from Student t-test for continuous variables.

^c Occupational social class based on the UK Registrar’s General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations).

^d Educational level categories were as follows: high corresponds to leaving full-time education at age 18 or older; intermediate to 16 to 17 years of age; low to 15 years of age or younger.

^e Physical activity dichotomized as any weekly moderate to vigorous physical activity.

^f Excessive alcohol consumption dichotomized as \geq 21 units/week for men, and \geq 14 units/week for women.

eTable 2. Characteristics of participants included in analytic sample and those excluded

	Included	Excluded
N	81476	8428
Age (mean, SD)	46.4 (17.5)	39.5 (19.9)
Women (%)	53.1	54.2
Occupational social class ^a (%)		
High	32.3	32.3
Middle	24.3	24.1
Low	43.4	43.6
Educational level ^b (%)		
High	31.2	37.3
Middle	35.8	32.6
Low	33.0	30.1
Housing tenure		
Owner	73.1	67.8
Renter	26.9	32.2
Body mass index (kg/m ² ; mean, SD)	26.5 (4.7)	25.5 (4.9)
Systolic blood pressure (mmHg; mean, SD)	132.1 (19)	127.8 (18.2)
Physical activity ^c (%)	63.0	62.5
Self-reported smoking status		
Never	49.1	59.8
Former	24.8	18
Current	26	22.2
Excessive alcohol ^d (%)	23.2	20.6
Diabetes (%)	2.8	2.6

^a Occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations).

^b Educational level categories were as follows: high corresponds to leaving full-time education at age 18 or older; intermediate to 16 to 17 years of age; low to 15 years of age or younger.

^c Physical activity dichotomized as any weekly moderate to vigorous physical activity.

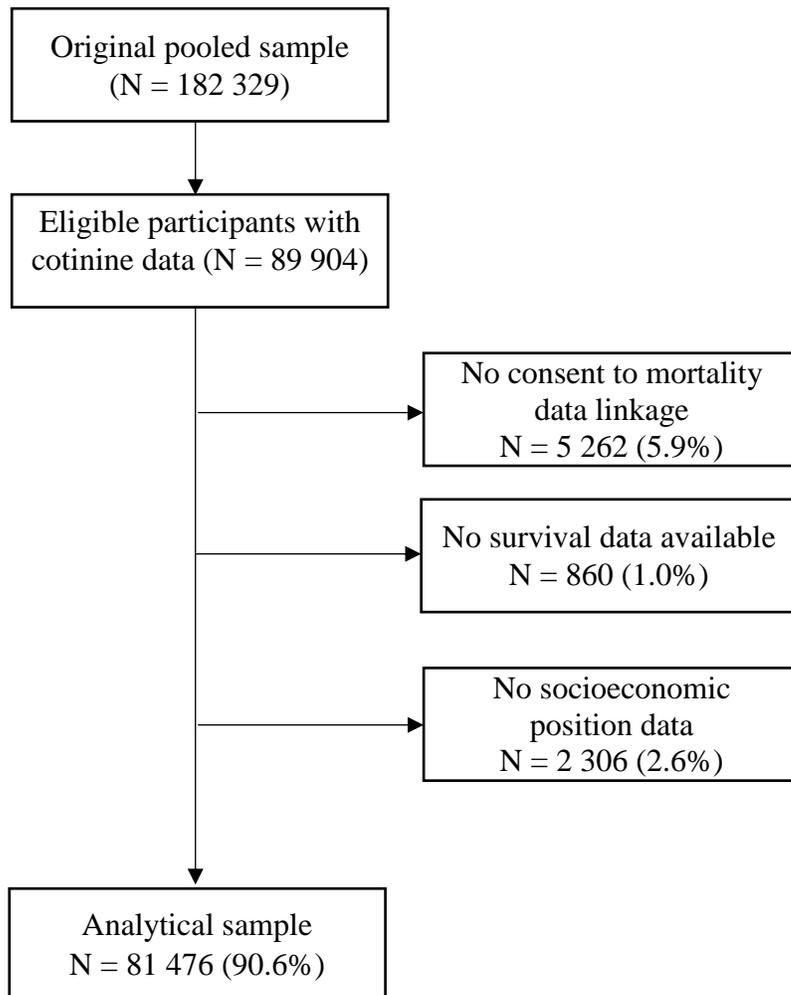
^d Excessive alcohol dichotomized as ≥ 21 units/week for men, and ≥ 14 units/week for women

eTable 3. Concordance between self-reported smoking and cotinine-verified smoking classification.

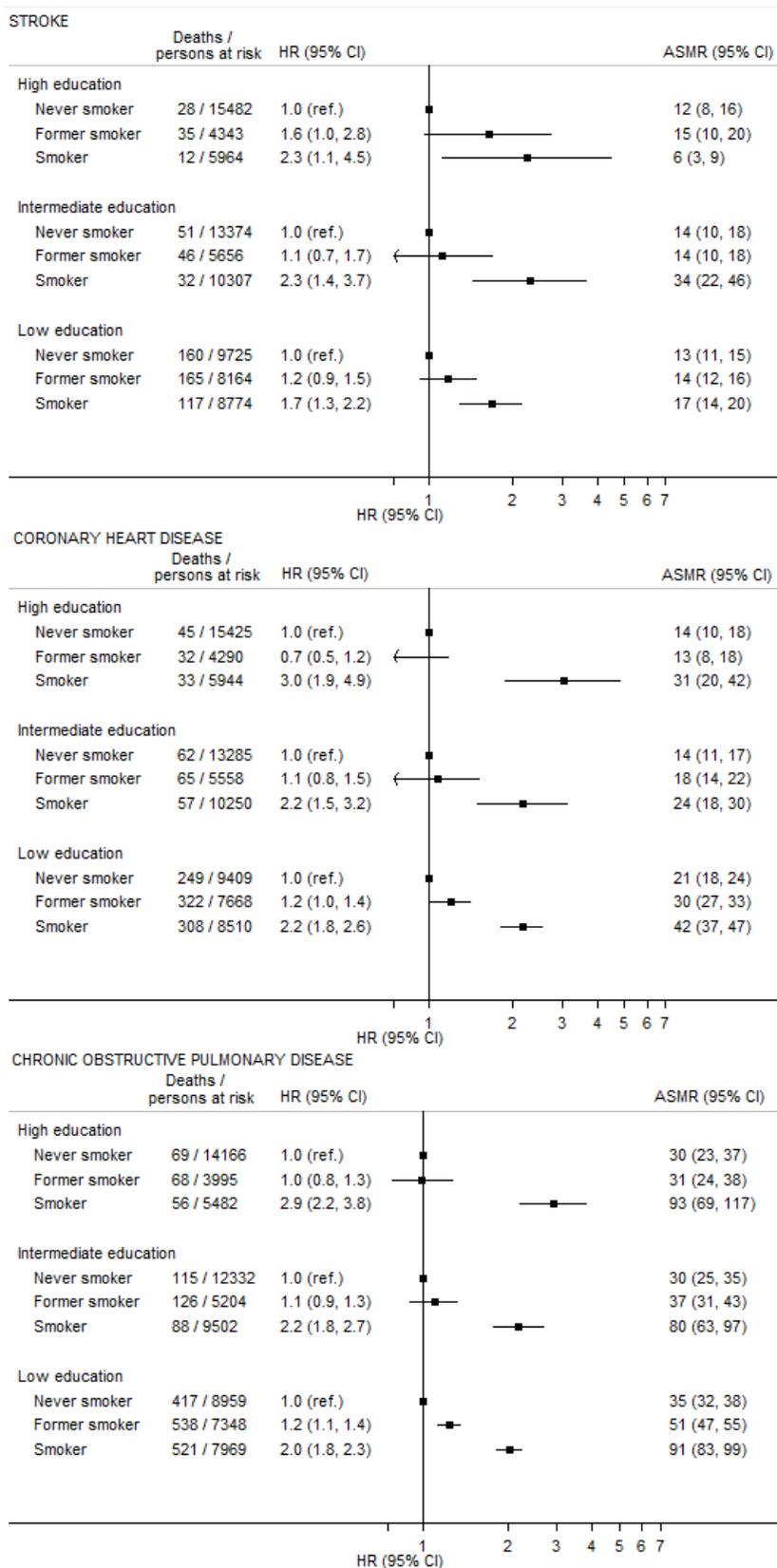
Self-reported smoking status	Cotinine-checked smoking status			% Reassigned
	Never	Ex-smoker	Current smoker	
Never	43 060	0	1 681	3.8%
Ex-smoker	0	19 396	2 344	10.8%
Current smoker	0	0	23 036	0.0%

^a Cotinine-based smoking categories were as follows: 1) never smoker from self-reported “never smoker” *and* salivary cotinine below 12 ng/mL or serum cotinine below 9 ng/mL; 2) ex-smoker from self-reported “ex-smoker” *and* salivary cotinine below 12 ng/mL or serum cotinine below 9 ng/mL; 3) current smoker, irrespective of self-reported smoking behaviour, salivary cotinine ≥ 12 ng/mL or serum cotinine ≥ 9 ng/mL.

eFigure 1. Flowchart of participant inclusion into main analytical sample



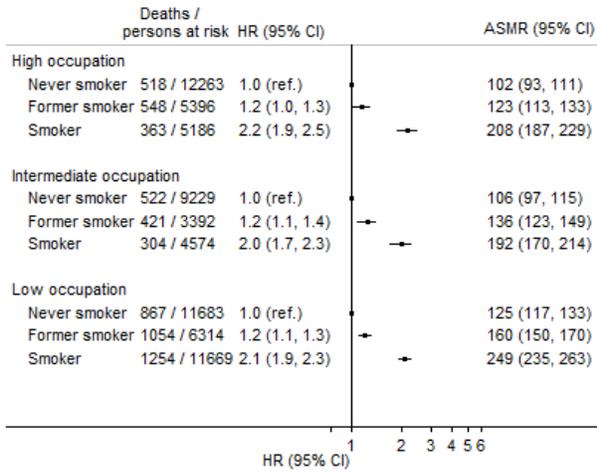
eFigure 2



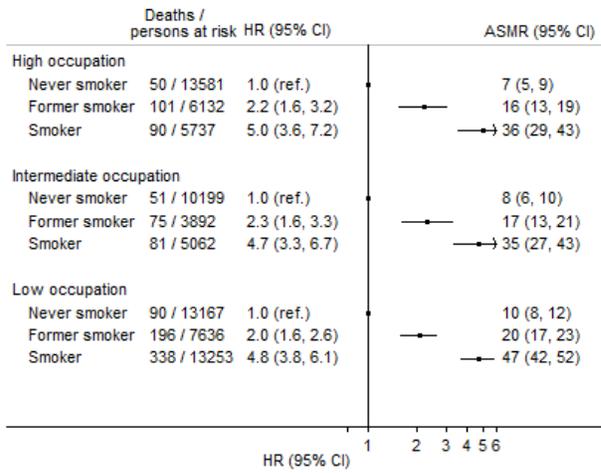
Association between cigarette smoking and death from stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Educational level derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population as the standard.

eFigure 3

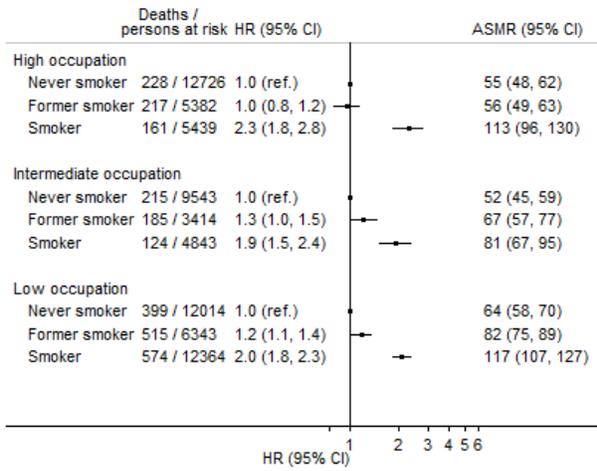
ALL CAUSE



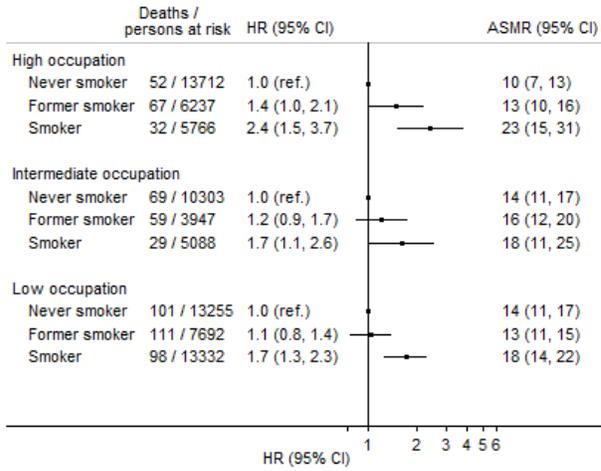
SMOKING-RELATED CANCER



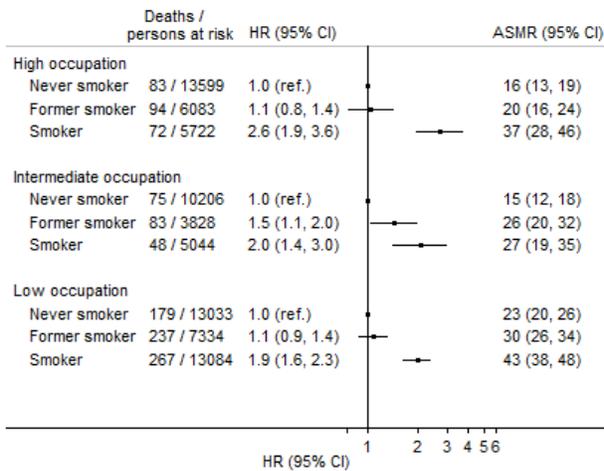
CARDIOVASCULAR DISEASE



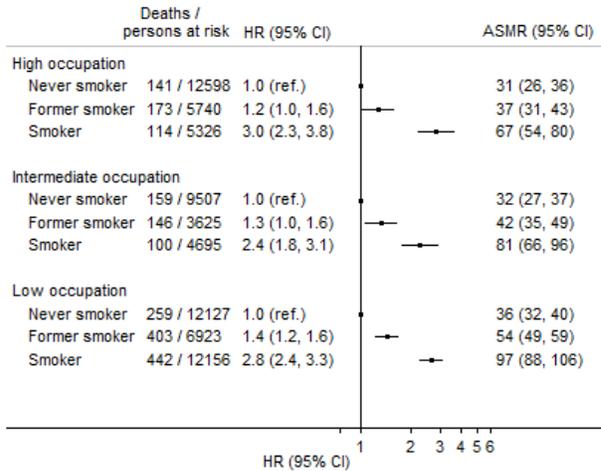
STROKE



CORONARY HEART DISEASE



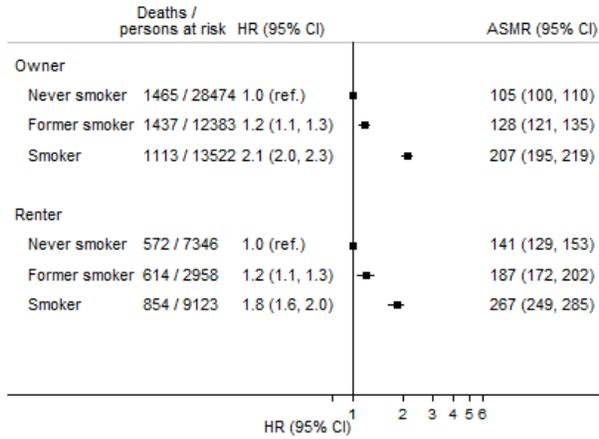
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



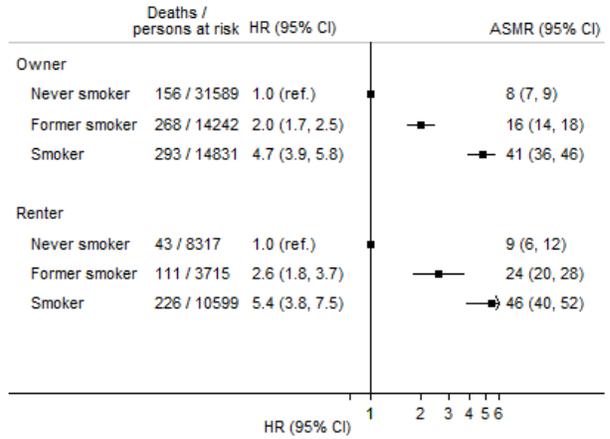
Association between cigarette smoking and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by occupational social class, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 4

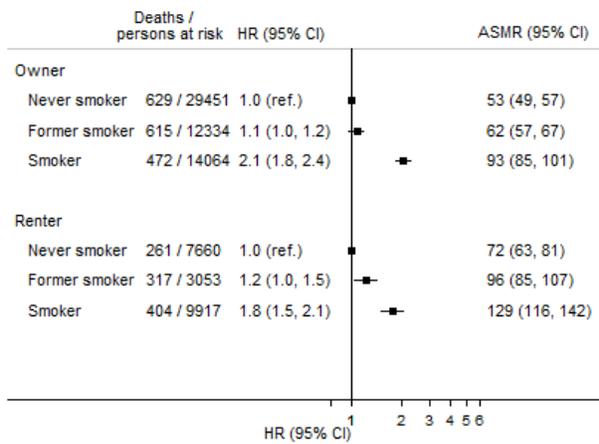
ALL CAUSE



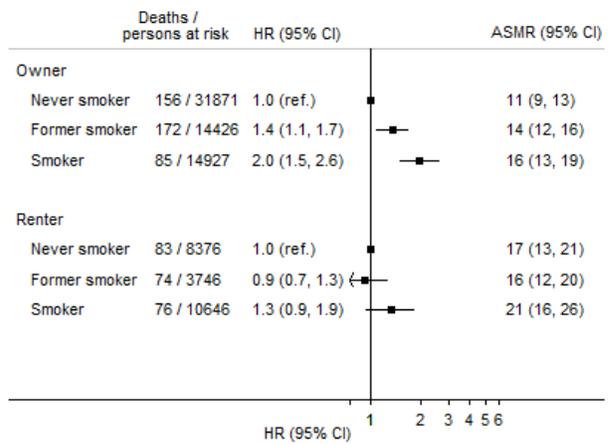
SMOKING-RELATED CANCER



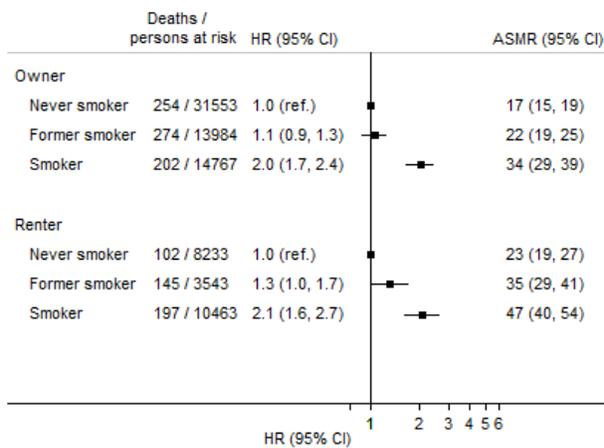
CARDIOVASCULAR DISEASE



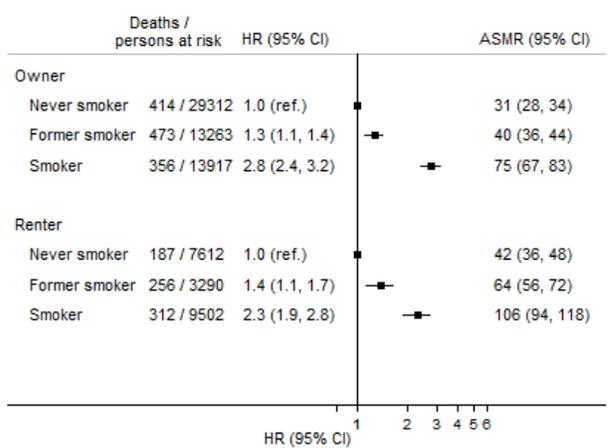
STROKE



CORONARY HEART DISEASE



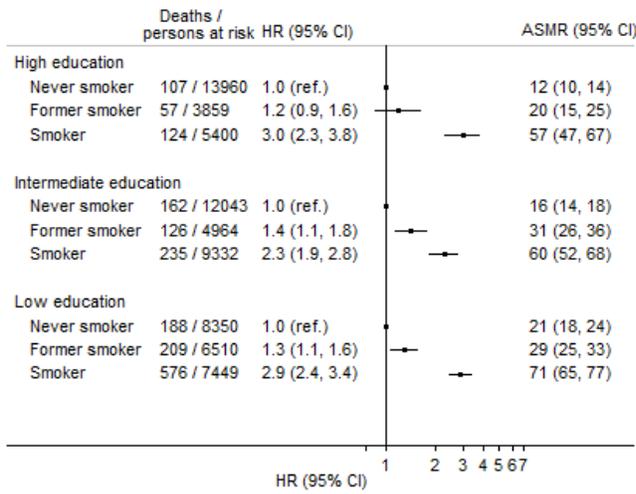
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



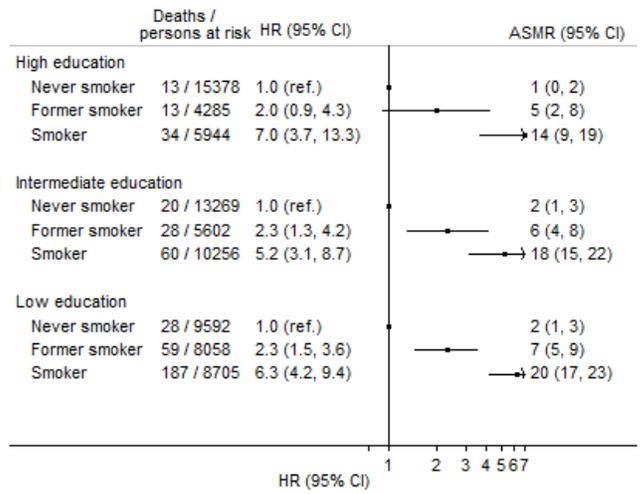
Association between cigarette smoking and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by housing tenure, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Housing tenure was divided into 1) Owner and 2) Renter. Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 5

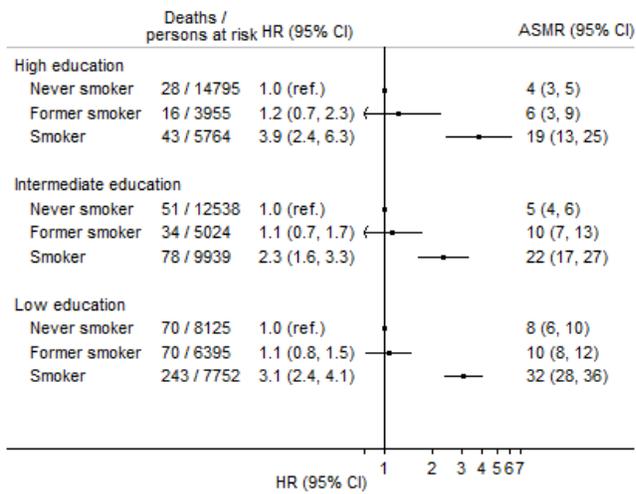
ALL CAUSE



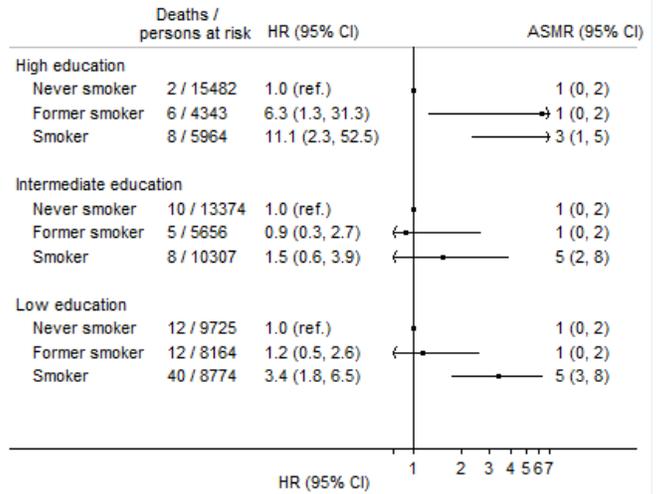
SMOKING-RELATED CANCER



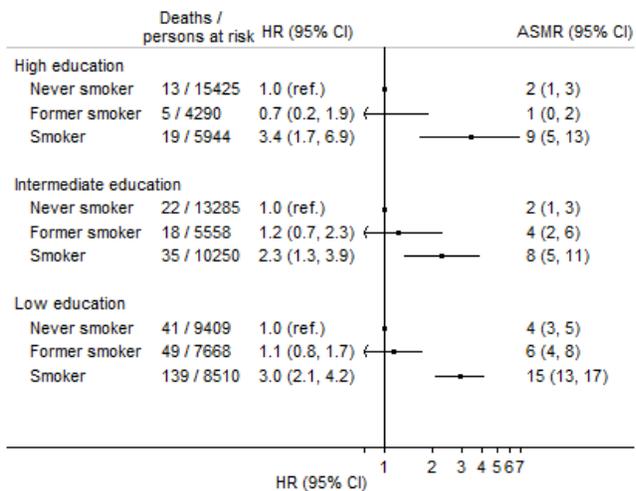
CARDIOVASCULAR DISEASE



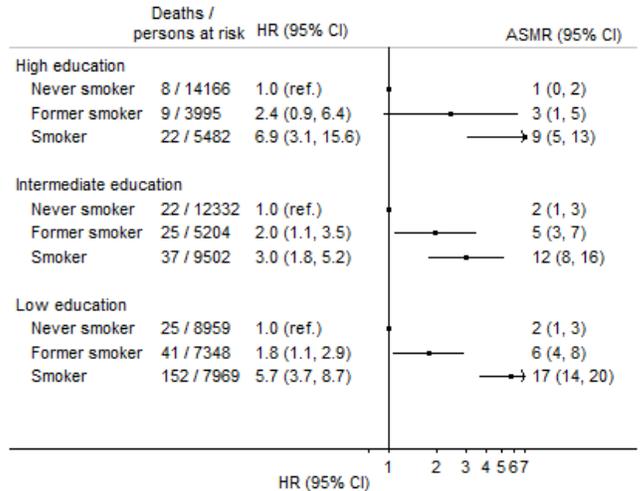
STROKE



CORONARY HEART DISEASE



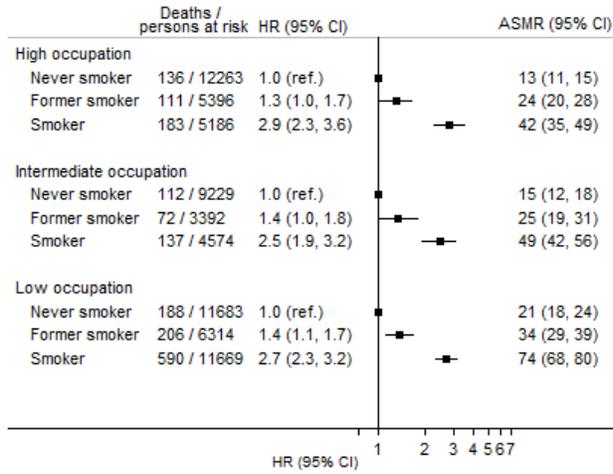
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



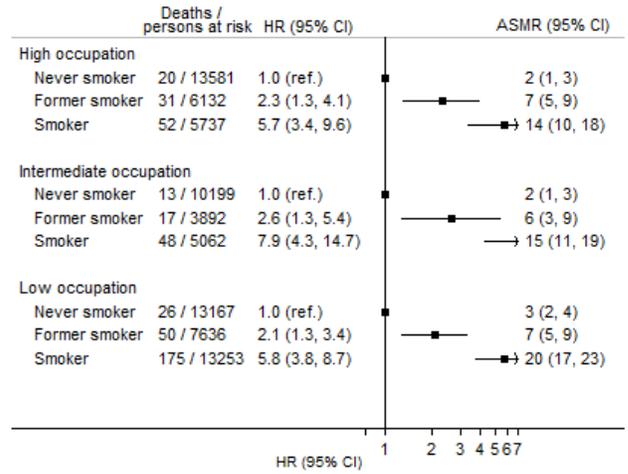
Association between cigarette smoking and premature death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 6

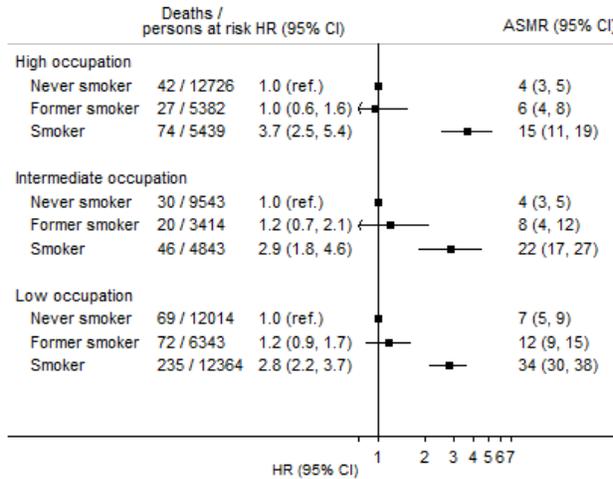
ALL CAUSE



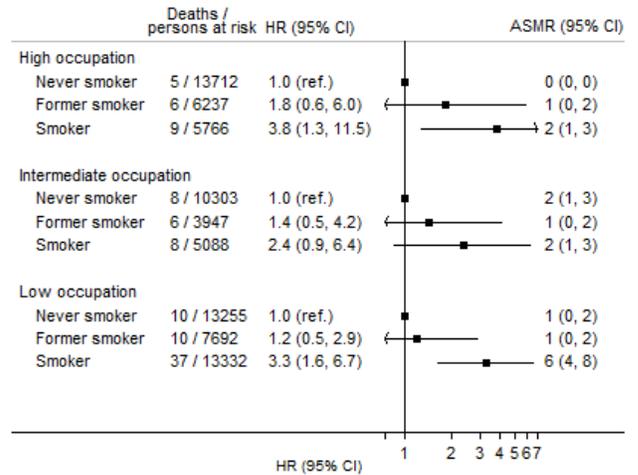
SMOKING-RELATED CANCER



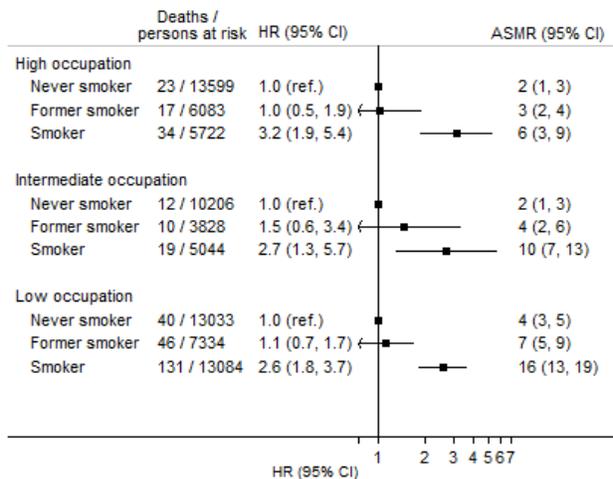
CARDIOVASCULAR DISEASE



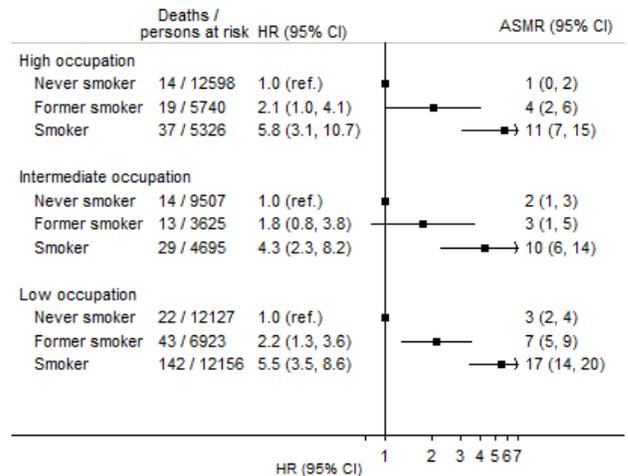
STROKE



CORONARY HEART DISEASE

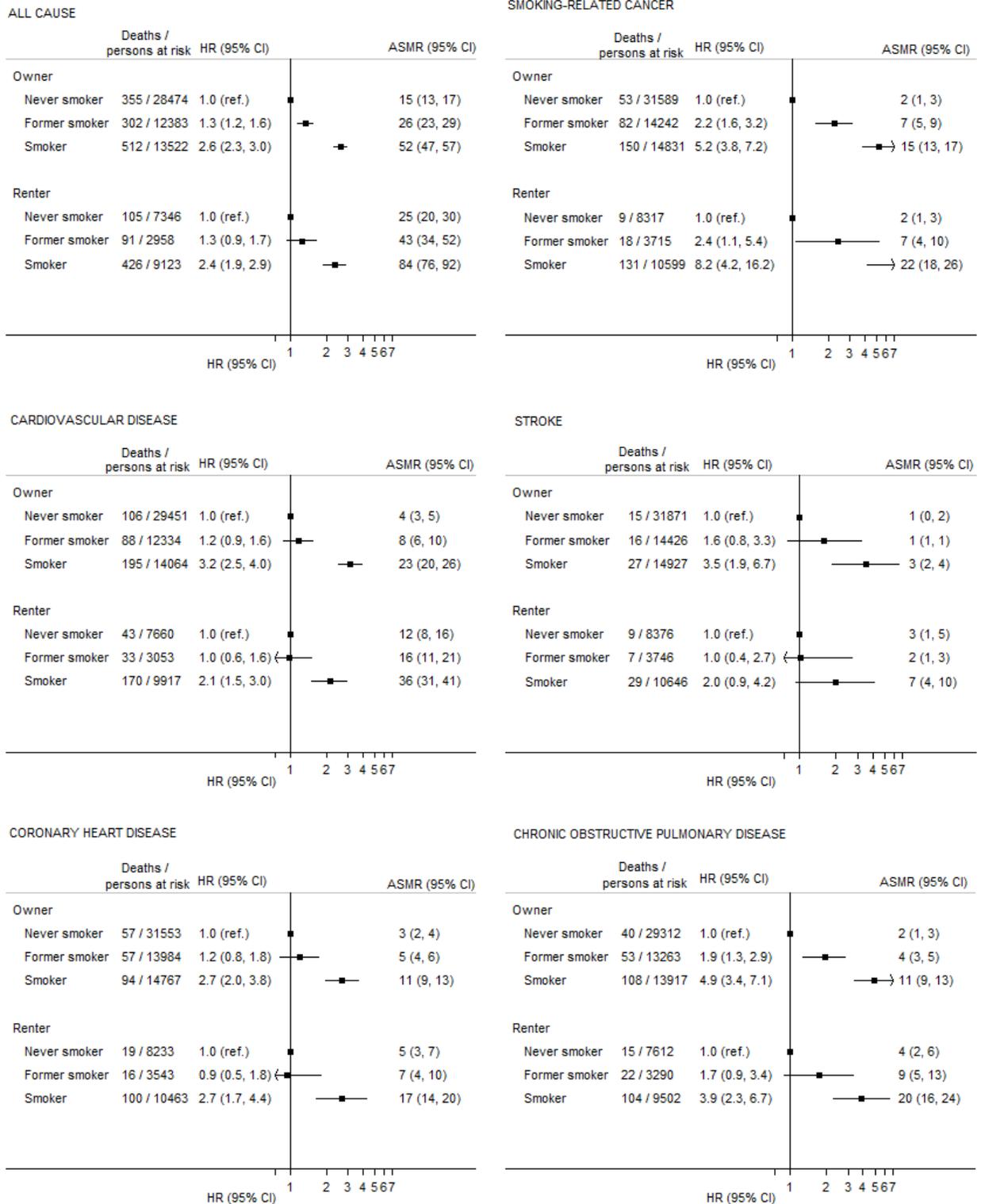


CHRONIC OBSTRUCTIVE PULMONARY DISEASE



Association between cigarette smoking and premature death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by occupational social class, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

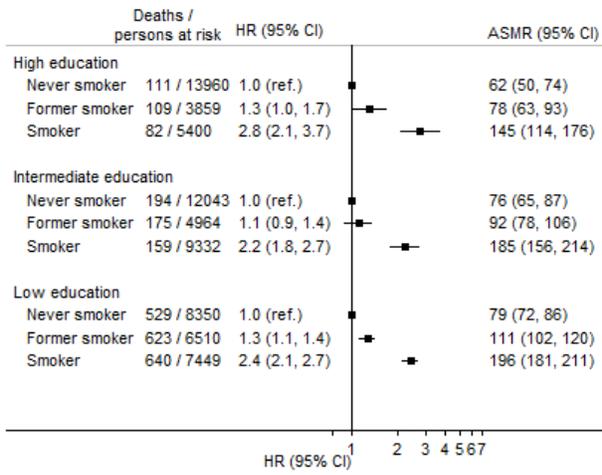
eFigure 7



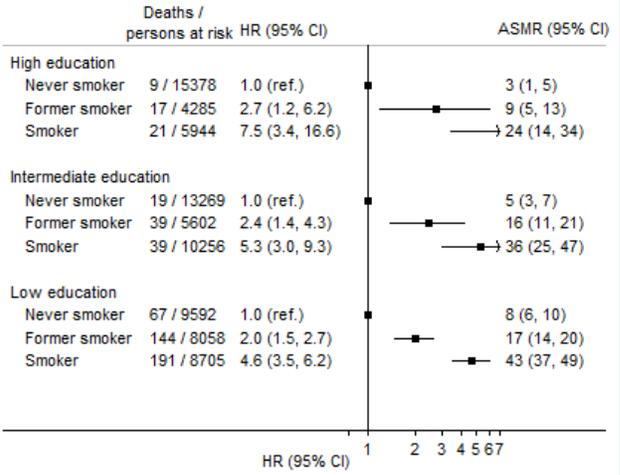
Association between cigarette smoking and premature death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by housing tenure, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Housing tenure was divided into 1) Owner and 2) Renter. Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 8

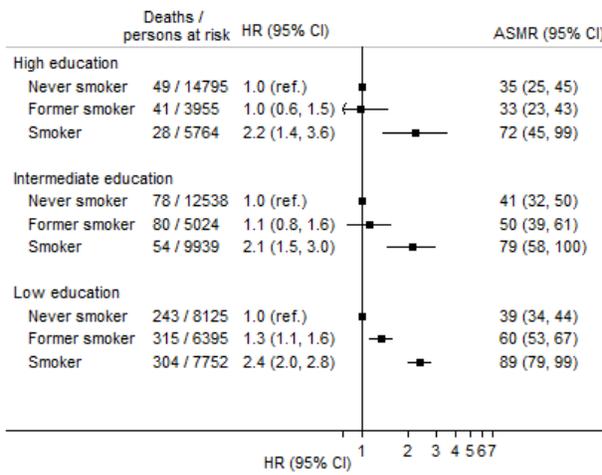
ALL CAUSE



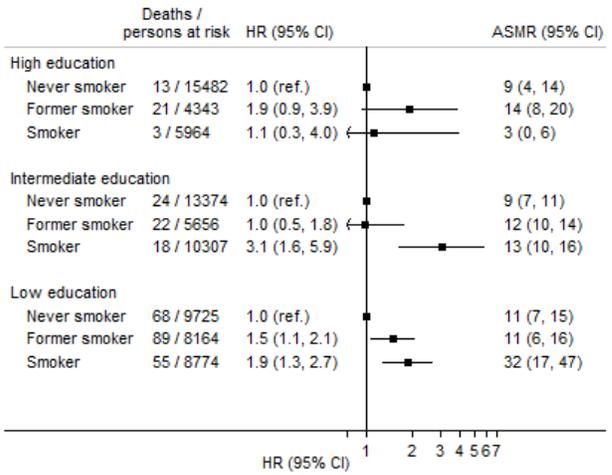
SMOKING-RELATED CANCER



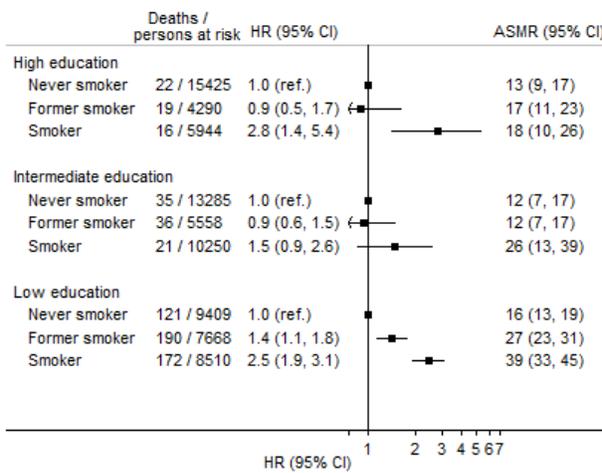
CARDIOVASCULAR DISEASE



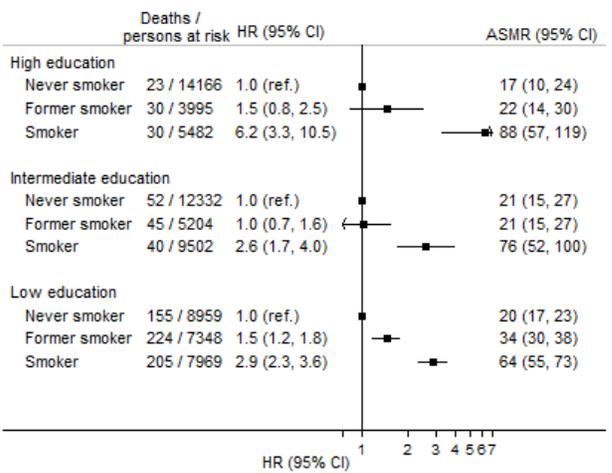
STROKE



CORONARY HEART DISEASE



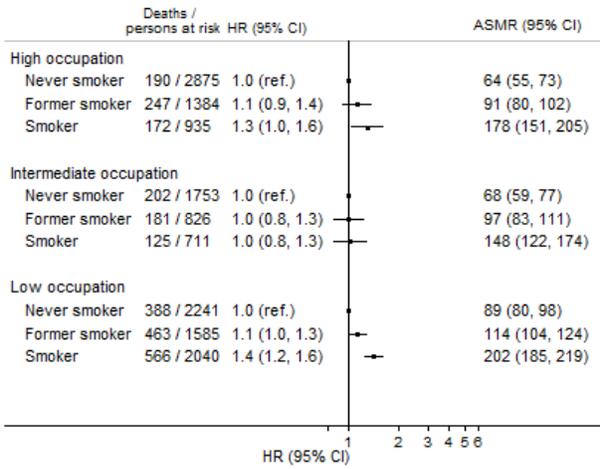
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



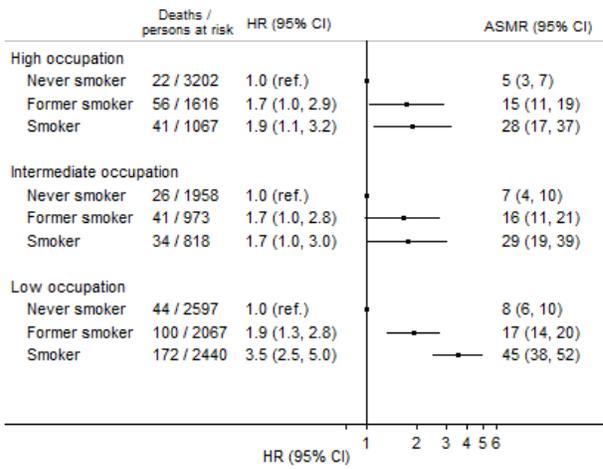
Association between cigarette smoking and death from all causes (limited to 6-y follow-up), smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 9

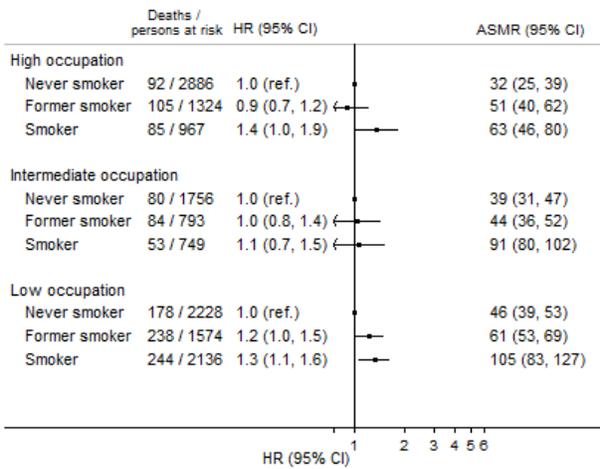
ALL CAUSE



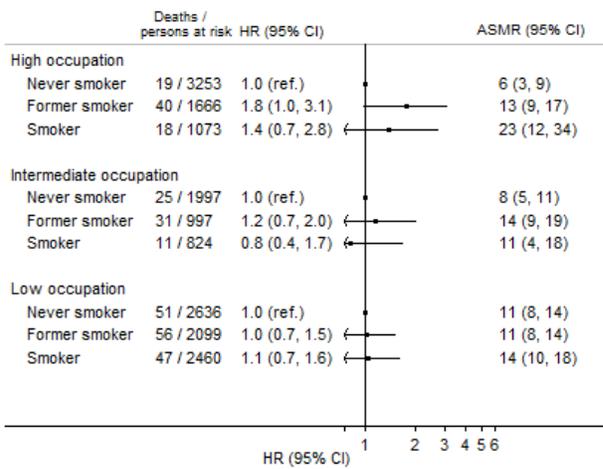
SMOKING-RELATED CANCER



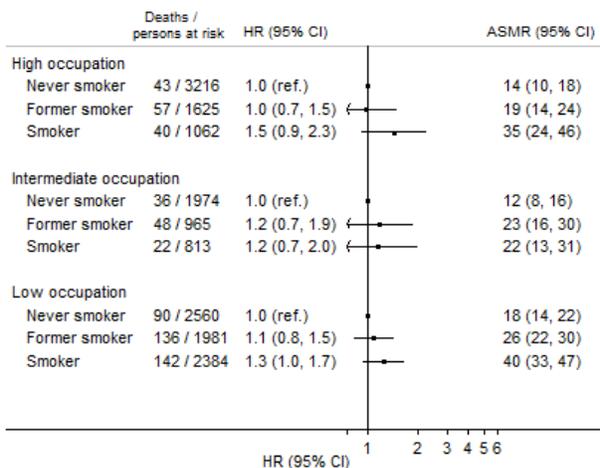
CARDIOVASCULAR DISEASE



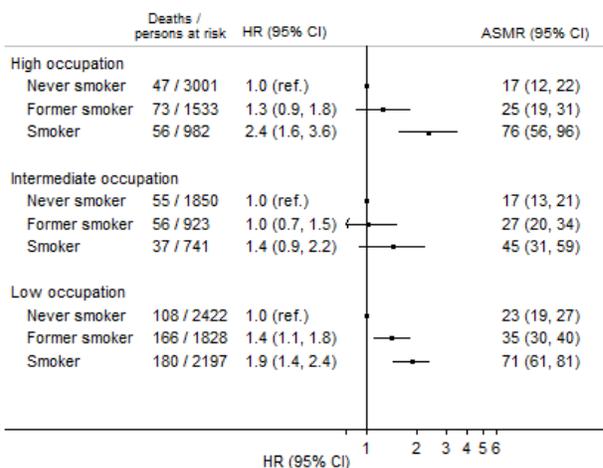
STROKE



CORONARY HEART DISEASE



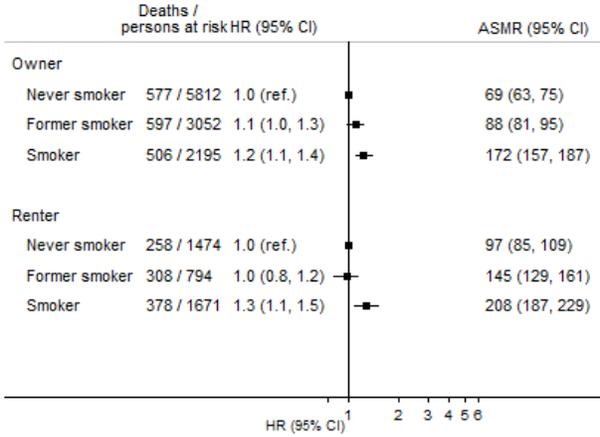
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



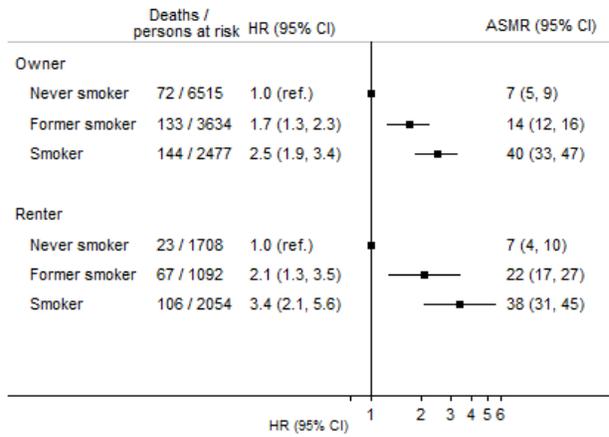
Association between cigarette smoking and death from all causes (limited to 6-y follow-up), smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by occupational social class, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 10

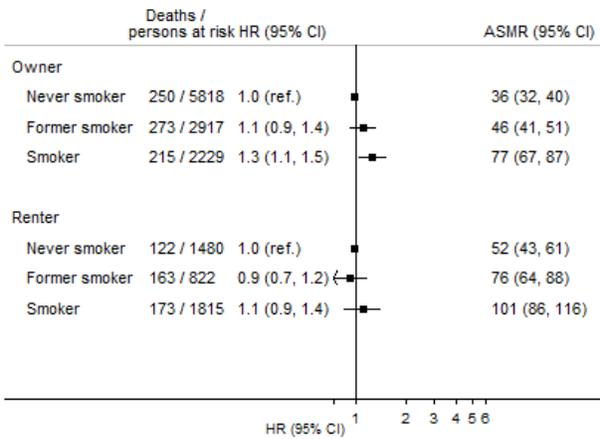
ALL CAUSES



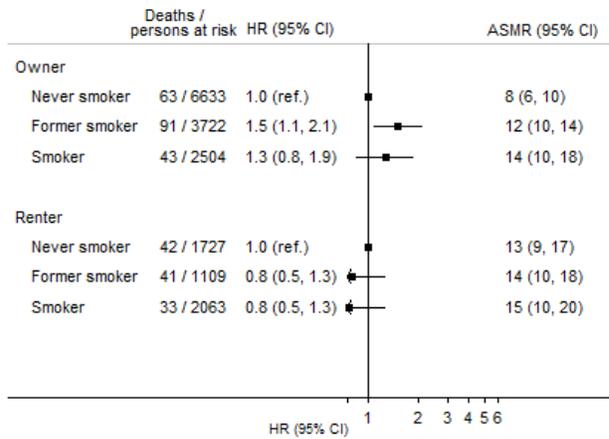
SMOKING-RELATED CANCER



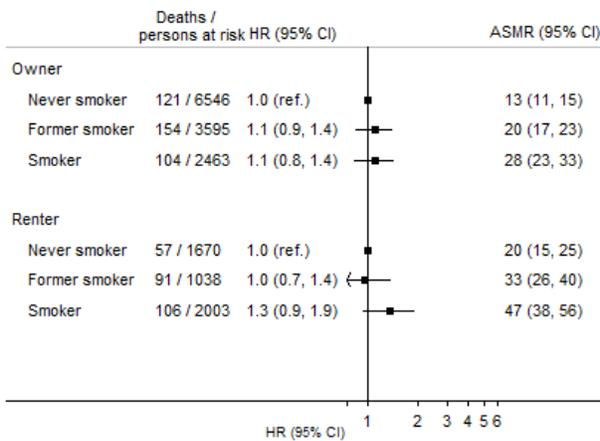
CARDIOVASCULAR DISEASE



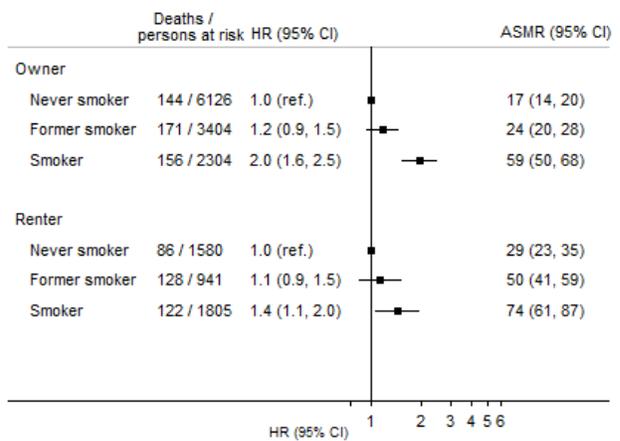
STROKE



CORONARY HEART DISEASE

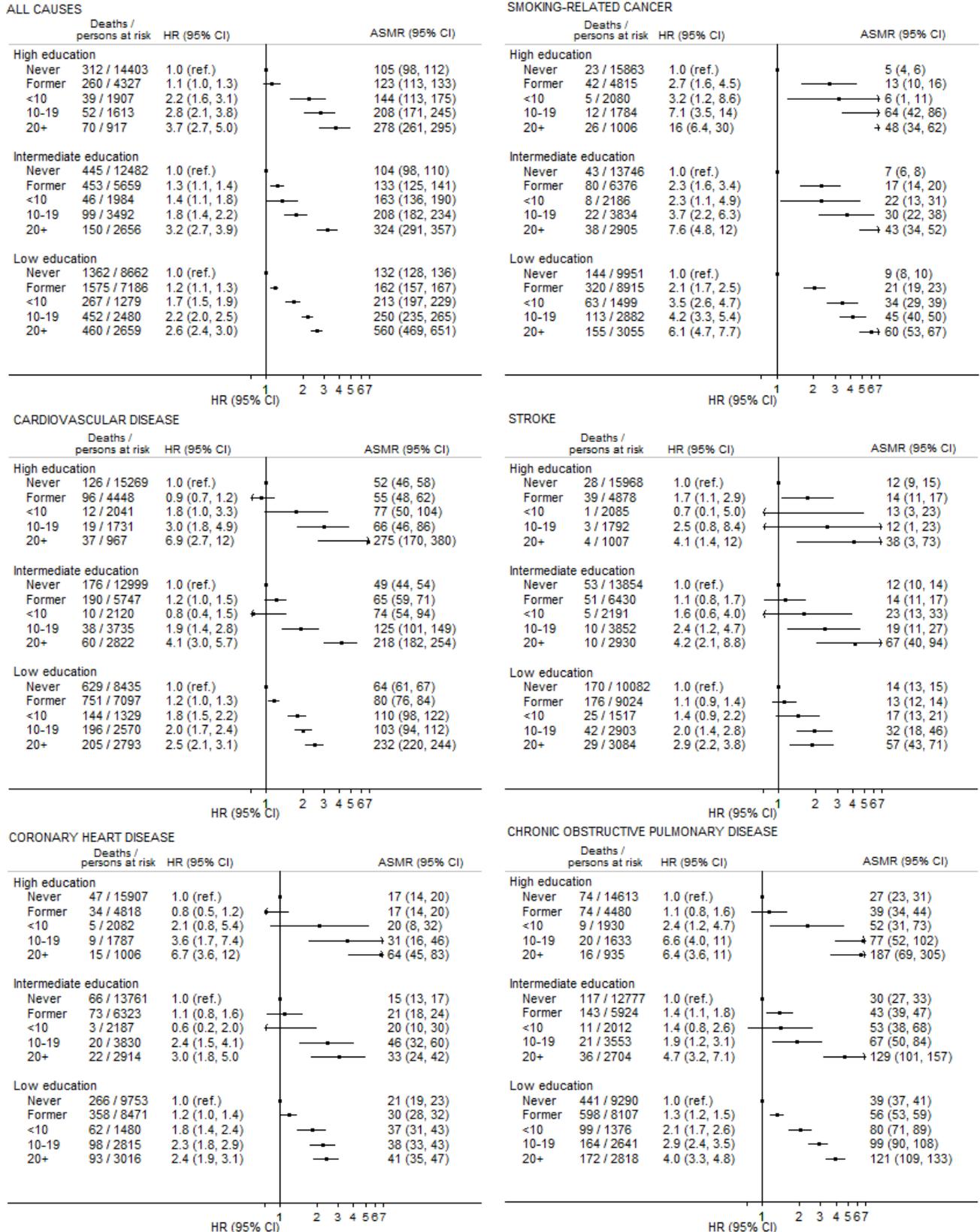


CHRONIC OBSTRUCTIVE PULMONARY DISEASE



Association between cigarette smoking and death from all causes (limited to 6-y follow-up), smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by housing tenure, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Housing tenure was divided into 1) Owner and 2) Renter. Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

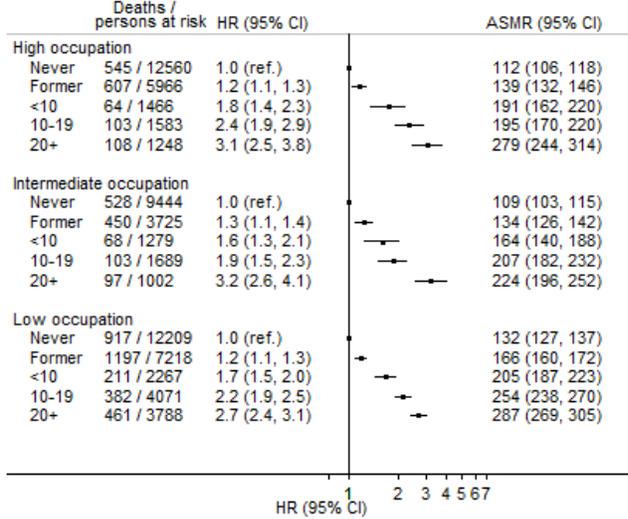
eFigure 11



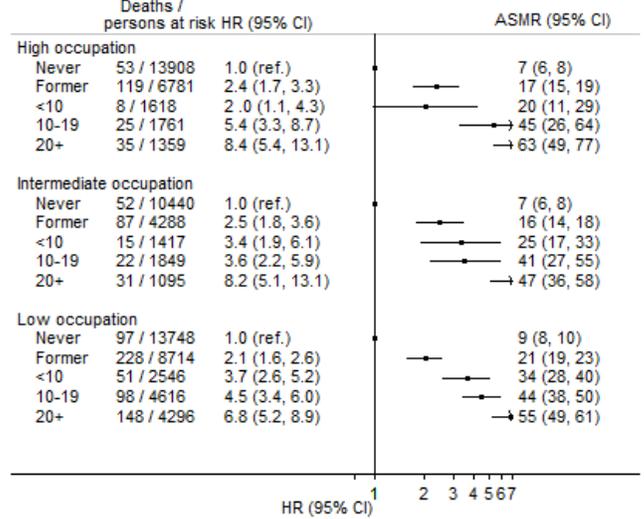
Association between cigarette smoking (number of cigarettes smoked per day) and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 12

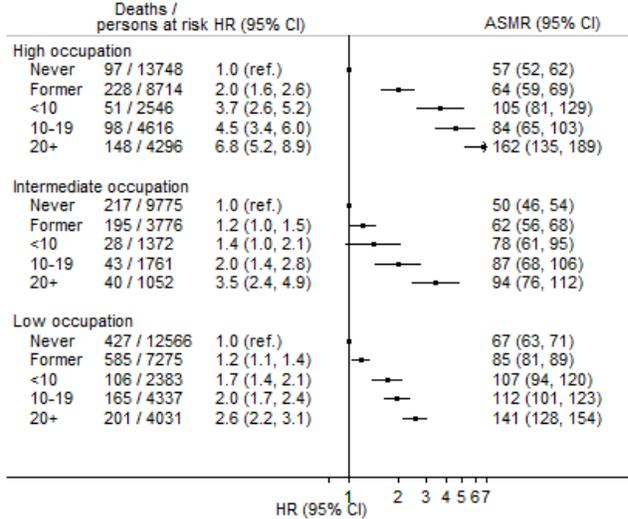
ALL CAUSES



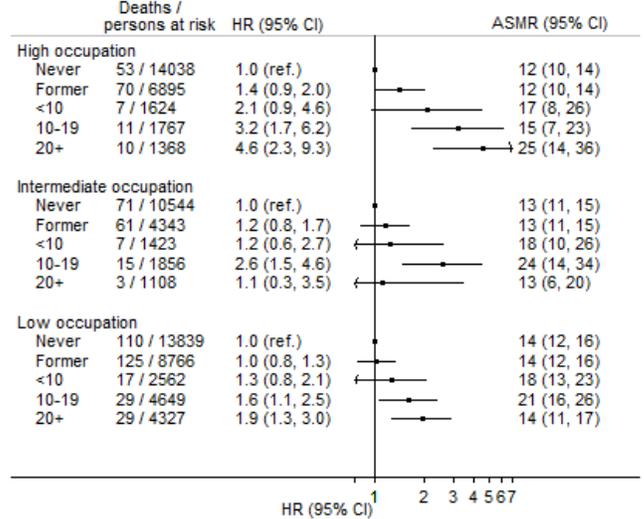
SMOKING-RELATED CANCER



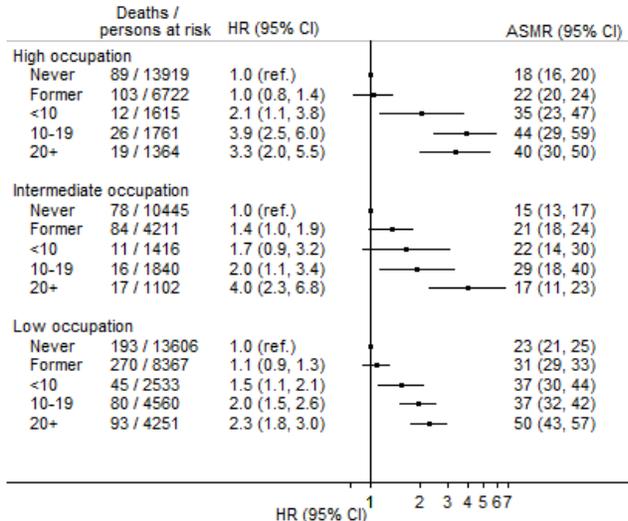
CARDIOVASCULAR DISEASE



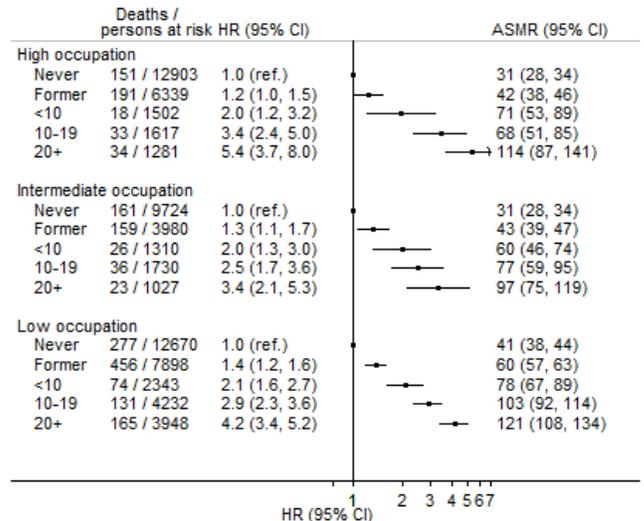
STROKE



CORONARY HEART DISEASE



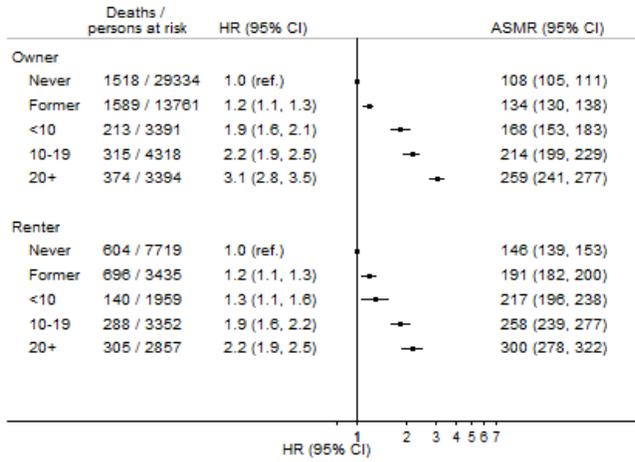
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



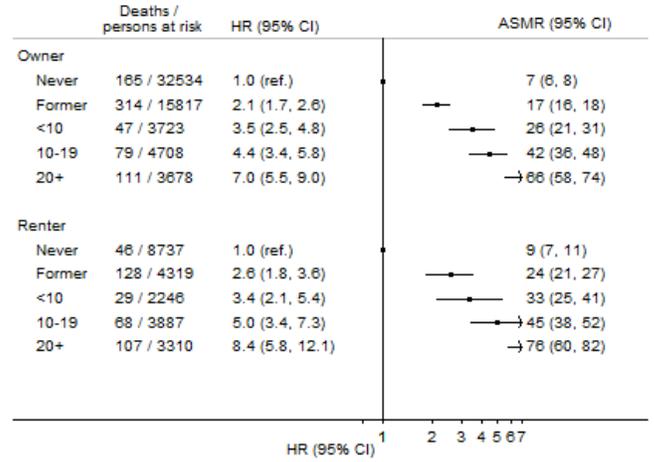
Association between cigarette smoking (number of cigarettes smoked per day) and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by occupational social class, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 13

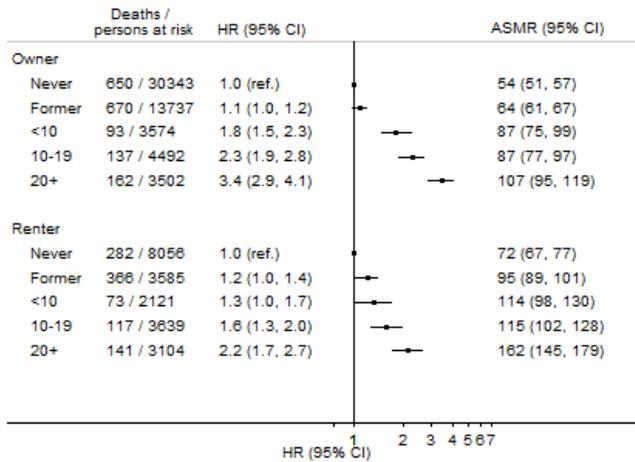
ALL CAUSES



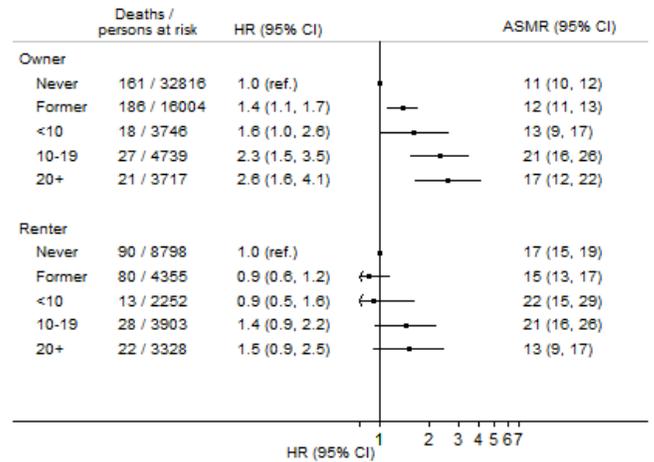
SMOKING-RELATED CANCER



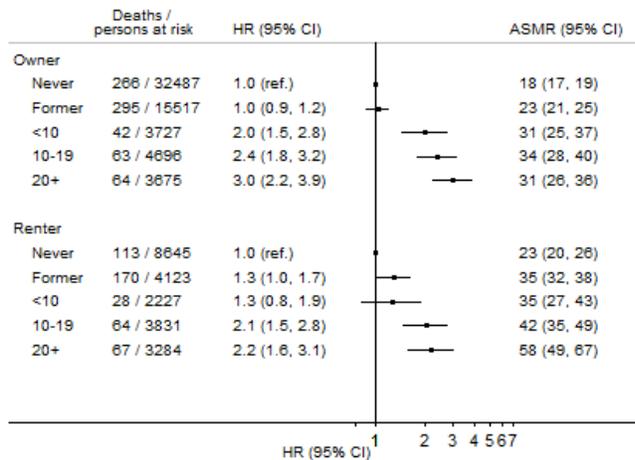
CARDIOVASCULAR DISEASE



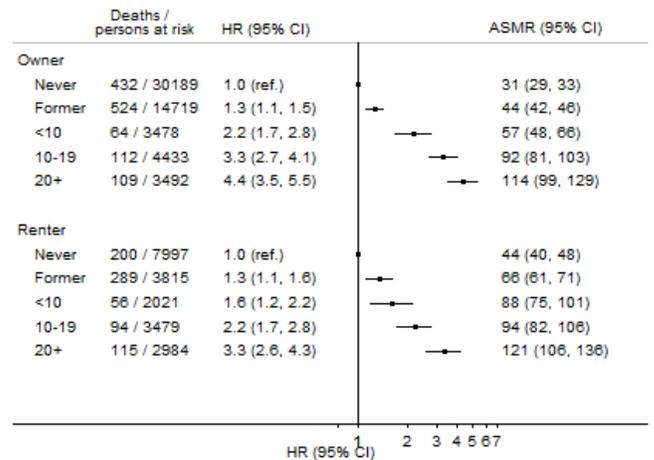
STROKE



CORONARY HEART DISEASE

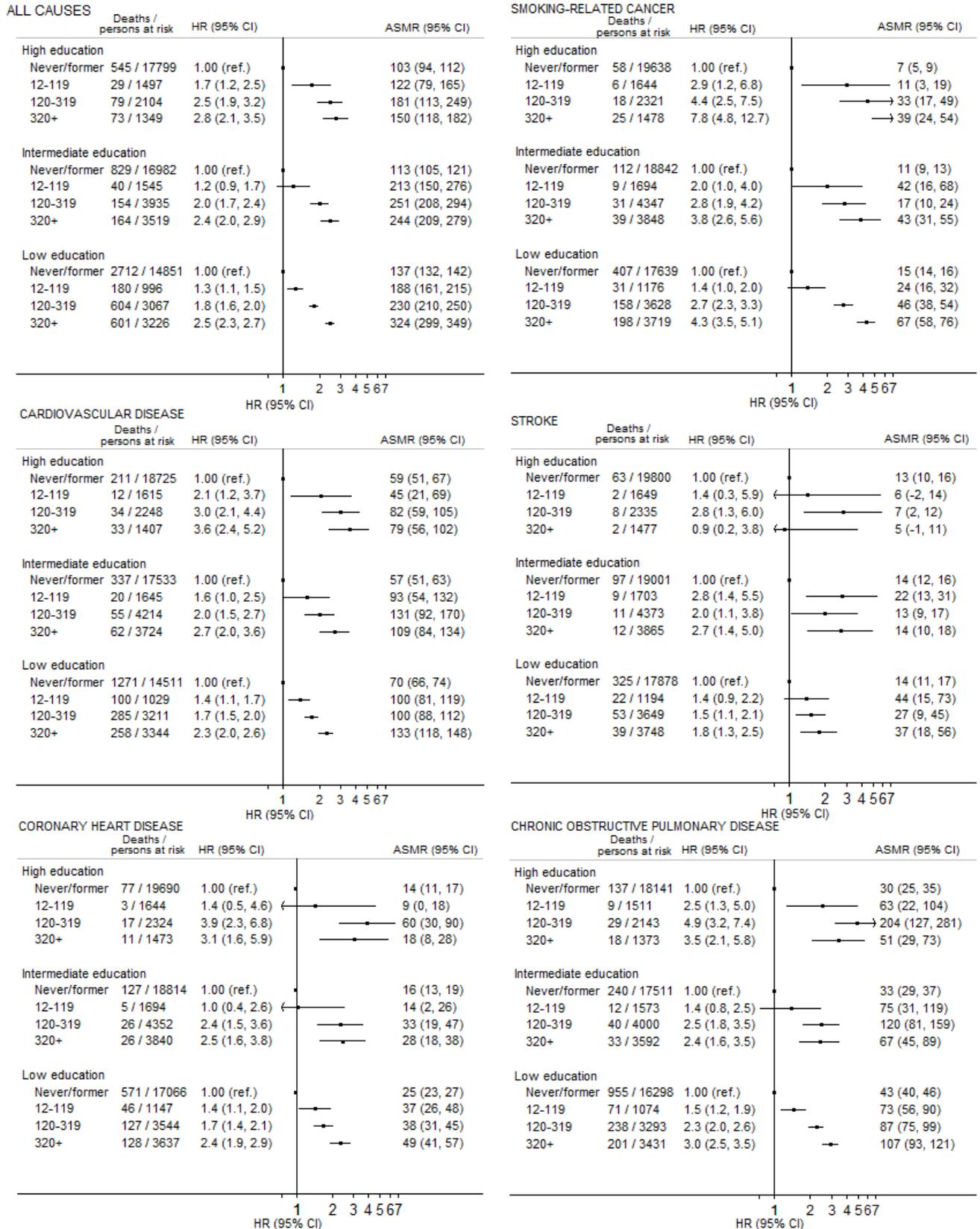


CHRONIC OBSTRUCTIVE PULMONARY DISEASE



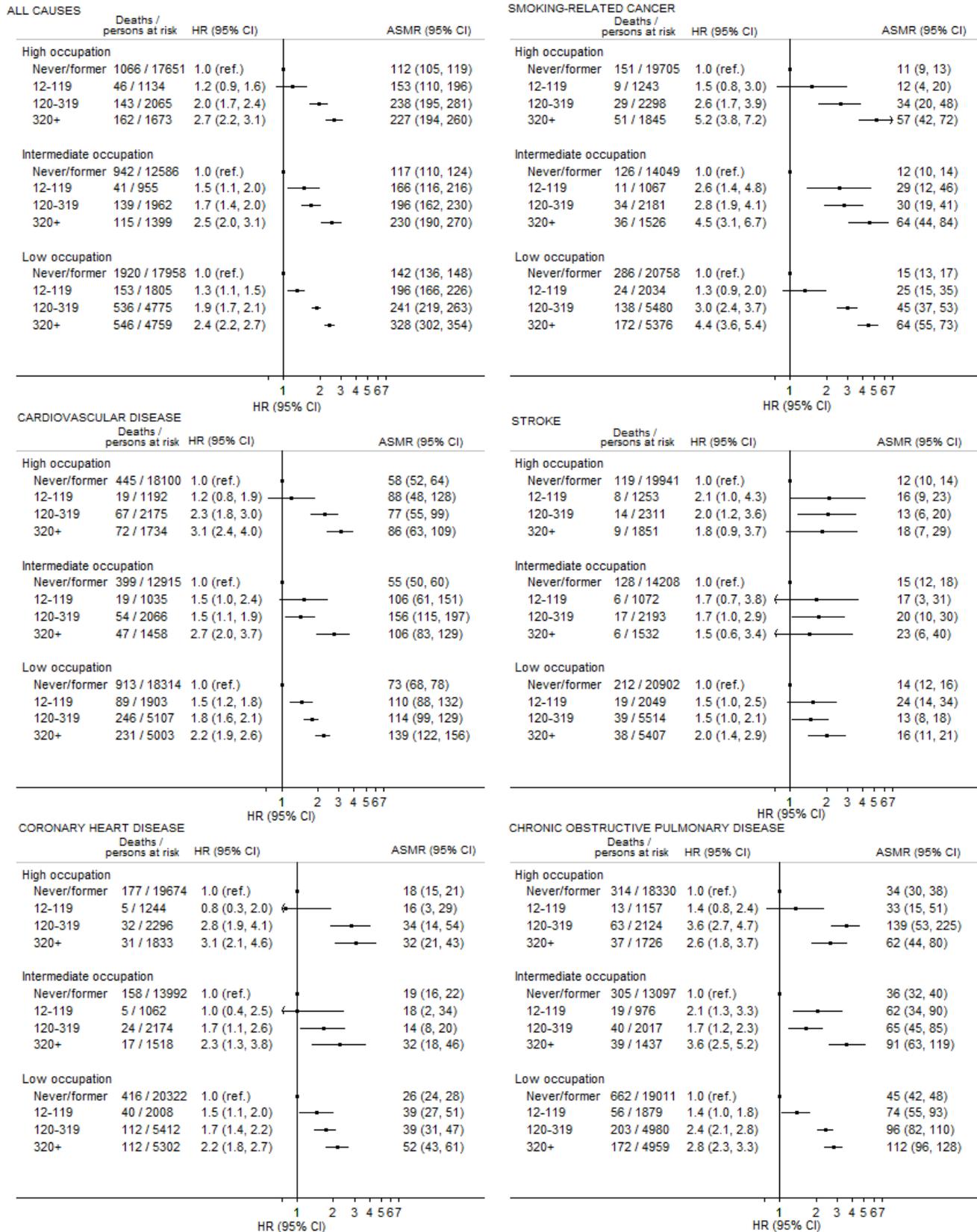
Association between cigarette smoking (number of cigarettes smoked per day) and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by housing tenure, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Housing tenure was divided into 1) Owner and 2) Renter. Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 14.



Association between cotinine level (ng/mL) and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

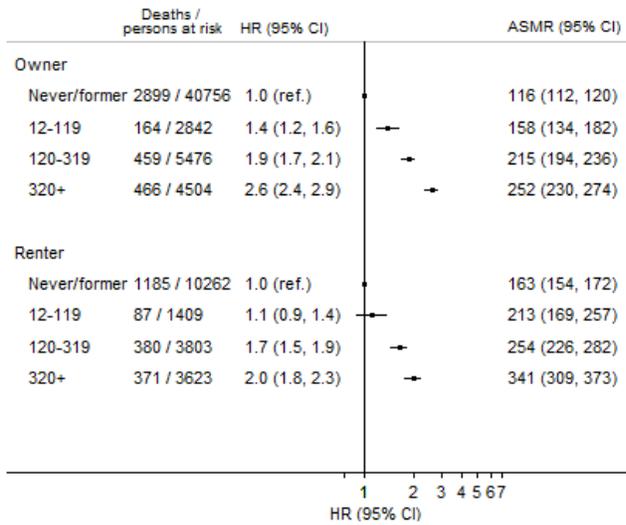
eFigure 15



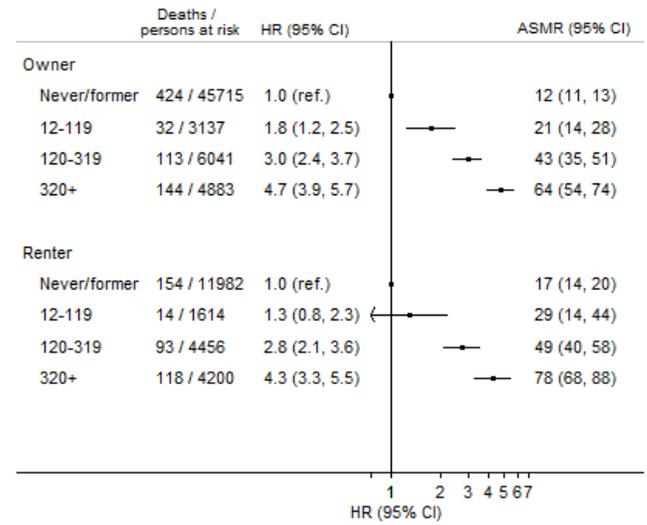
Association between cotinine level (ng/mL) and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by occupational social class, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 16

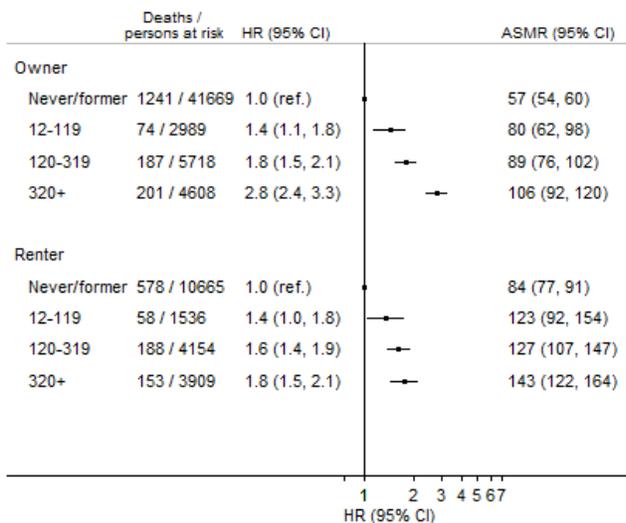
ALL CAUSES



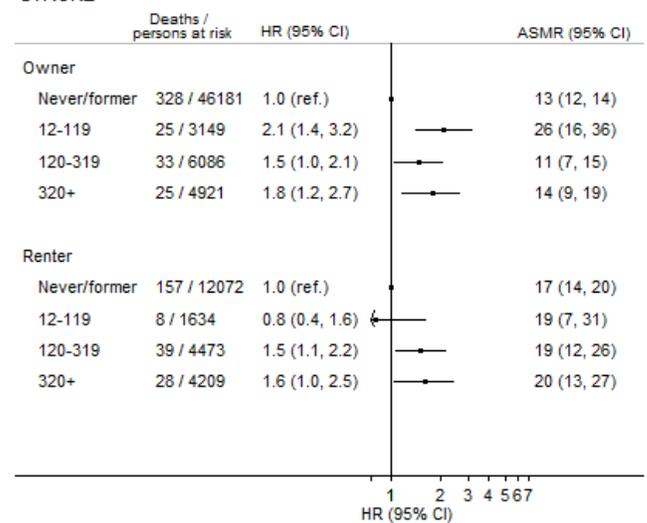
SMOKING-RELATED CANCER



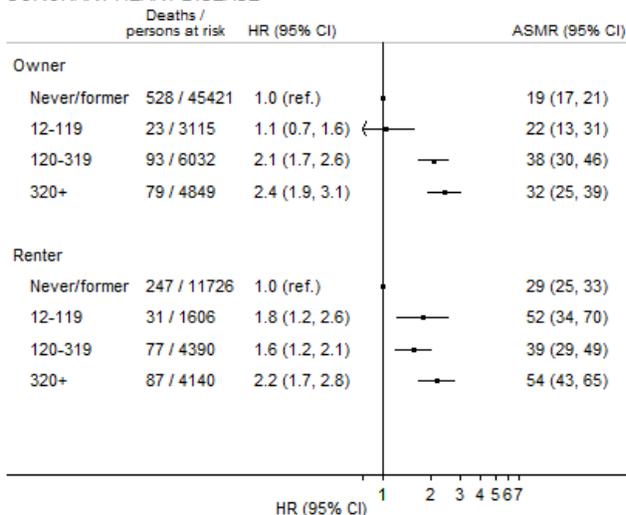
CARDIOVASCULAR DISEASE



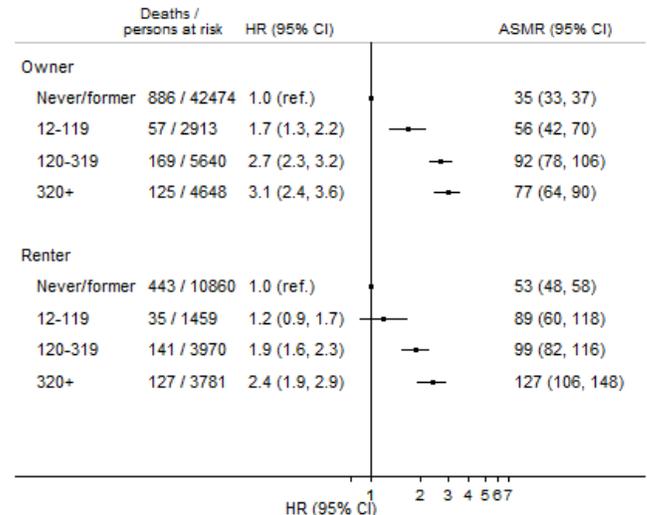
STROKE



CORONARY HEART DISEASE



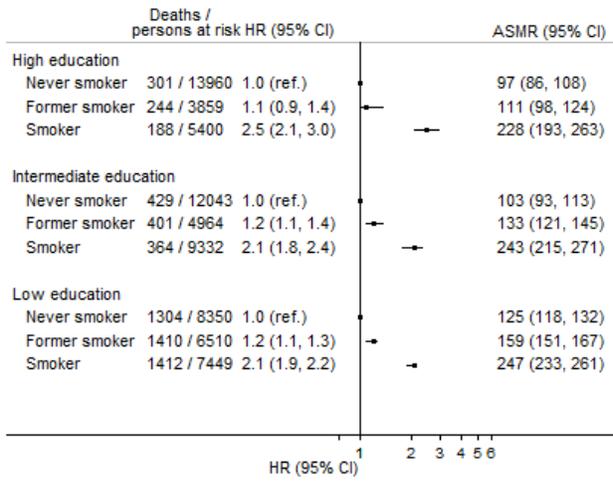
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



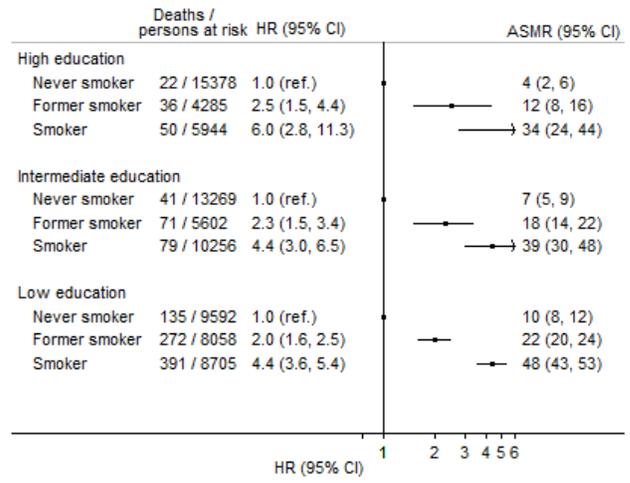
Association between cotinine level (ng/mL) and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by housing tenure, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Housing tenure was divided into 1) Owner and 2) Renter. Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 17

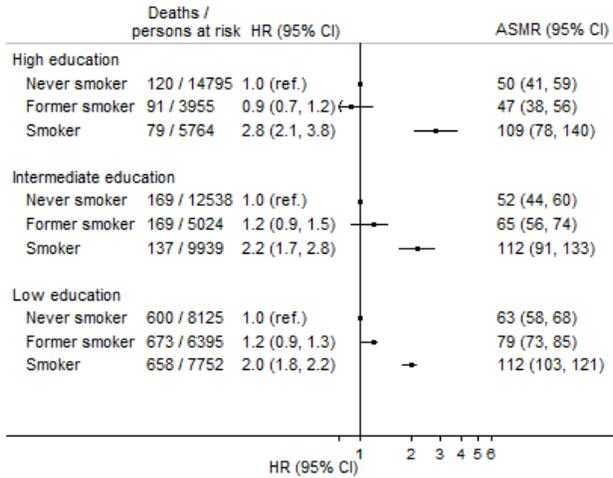
ALL CAUSES



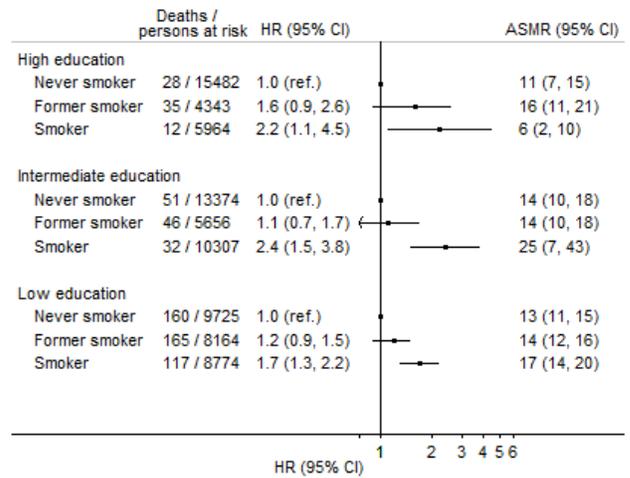
SMOKING-RELATED CANCER



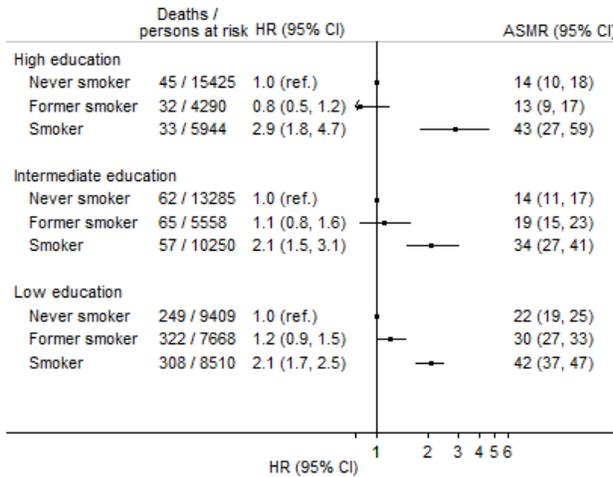
CARDIOVASCULAR DISEASE



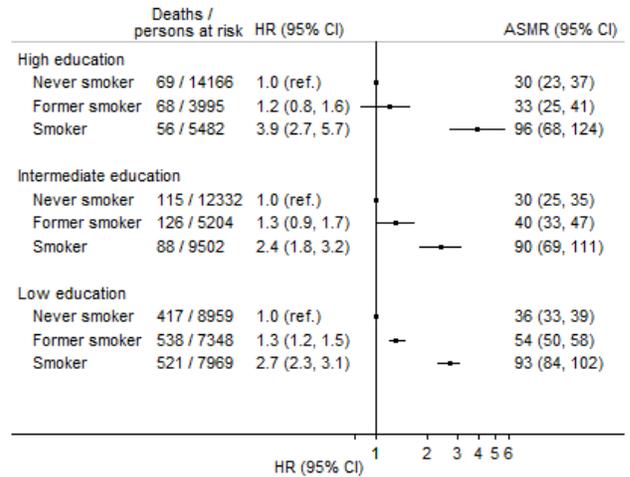
STROKE



CORONARY HEART DISEASE



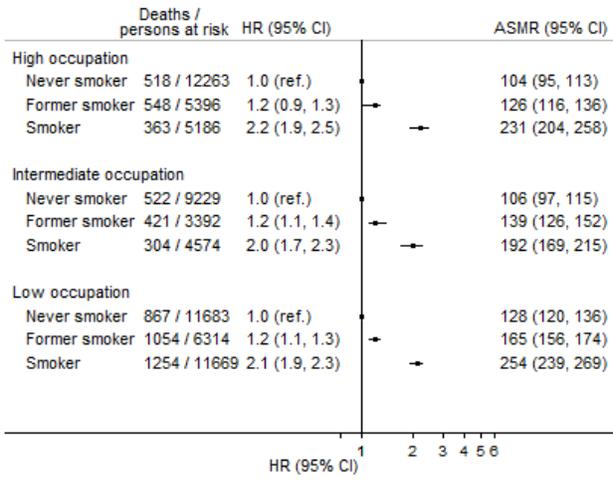
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



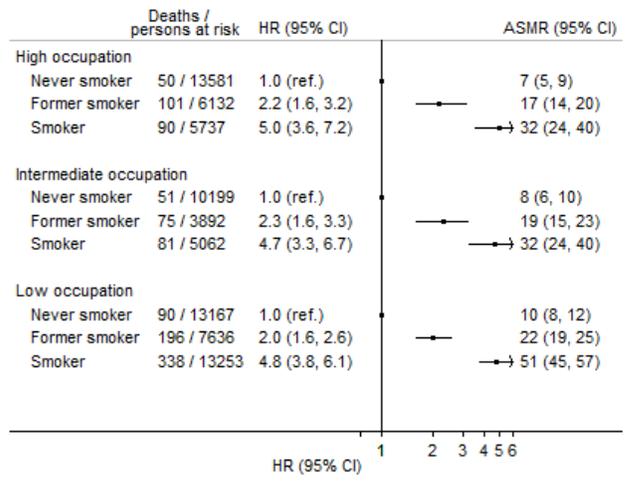
Association between self-reported smoking and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by educational level, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from age when finished full-time education: high (18 years or above), intermediate (16-17 years), and low (15 years or below). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.

eFigure 18

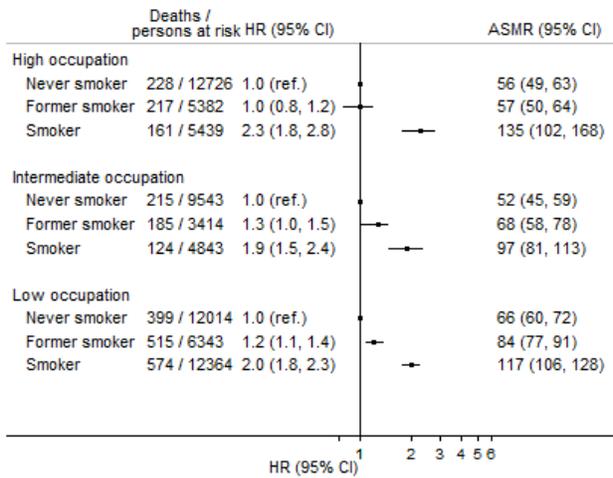
ALL CAUSES



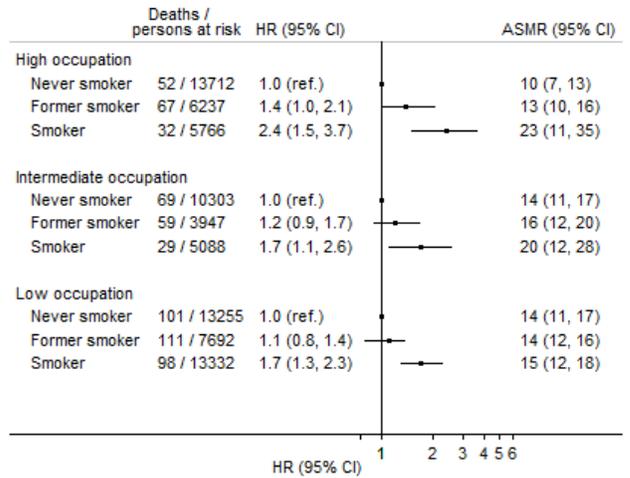
SMOKING-RELATED CANCER



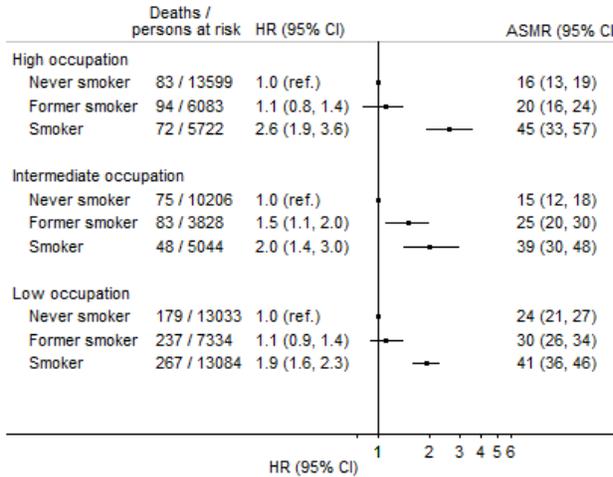
CARDIOVASCULAR DISEASE



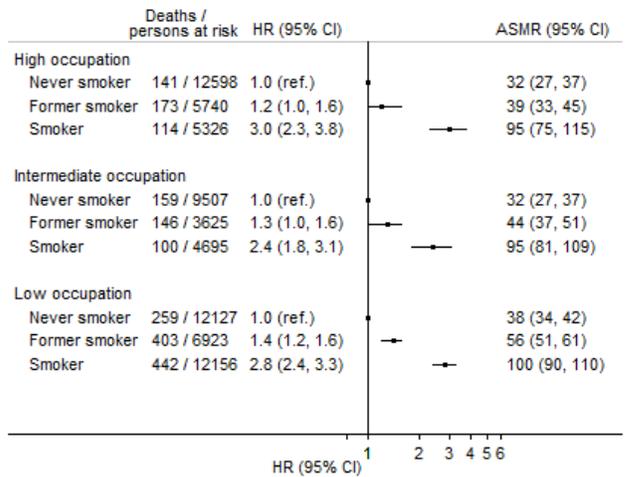
STROKE



CORONARY HEART DISEASE



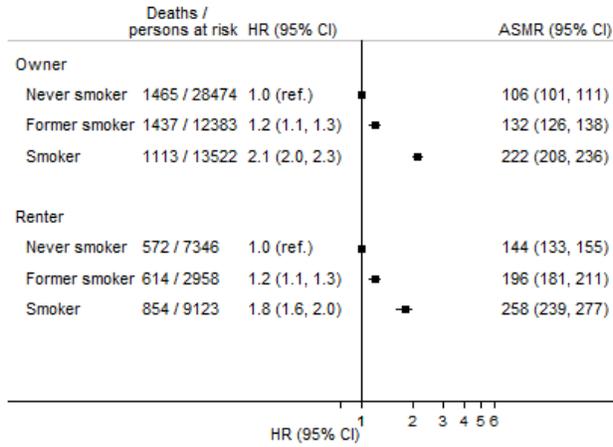
CHRONIC OBSTRUCTIVE PULMONARY DISEASE



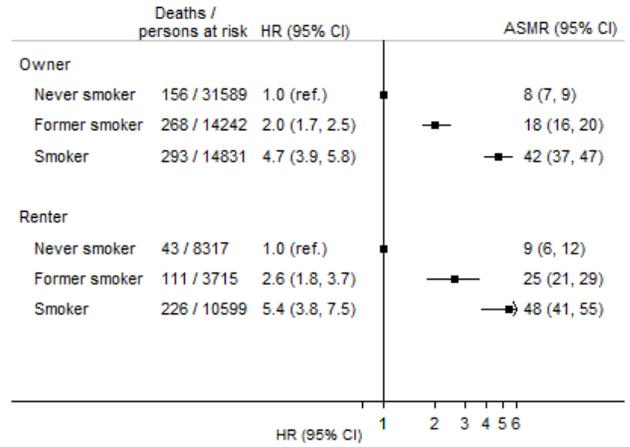
Association between self-reported smoking and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by occupational social class, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Socioeconomic position (SEP) derived from occupational social class based on the UK Registrar's General categories: high (professional, managerial and technical), intermediate (skilled non-manual), and low (manual occupations). Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population

eFigure 19

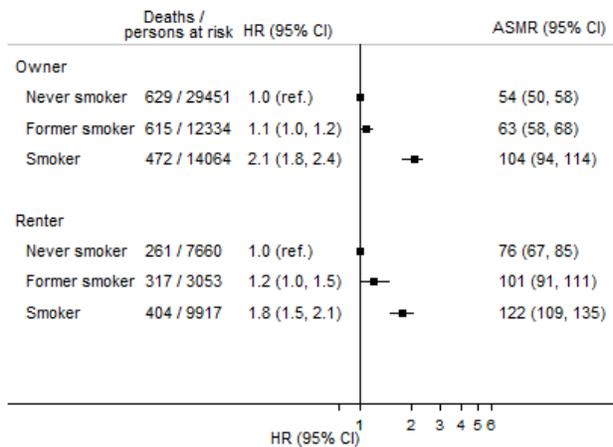
ALL CAUSES



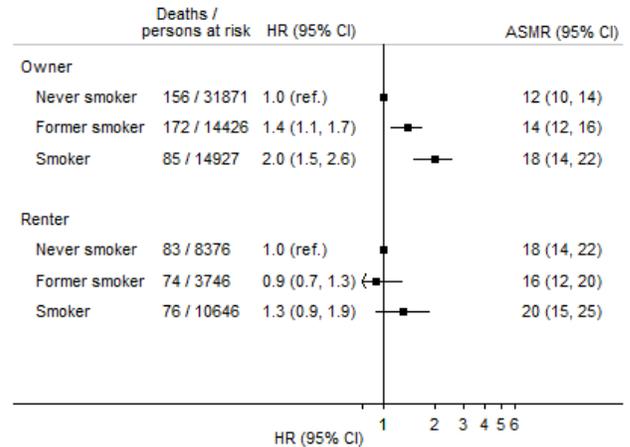
SMOKING-RELATED CANCER



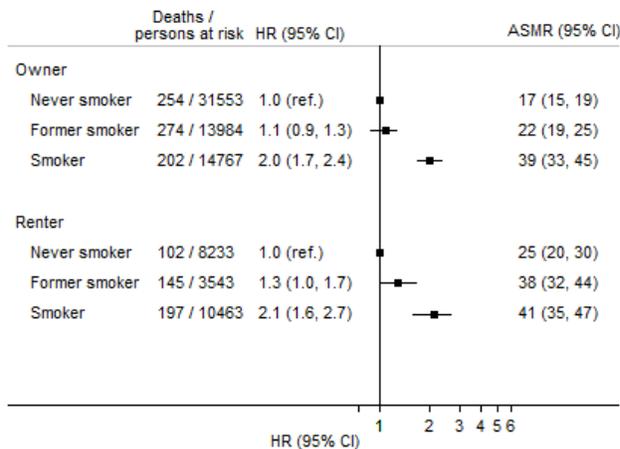
CARDIOVASCULAR DISEASE



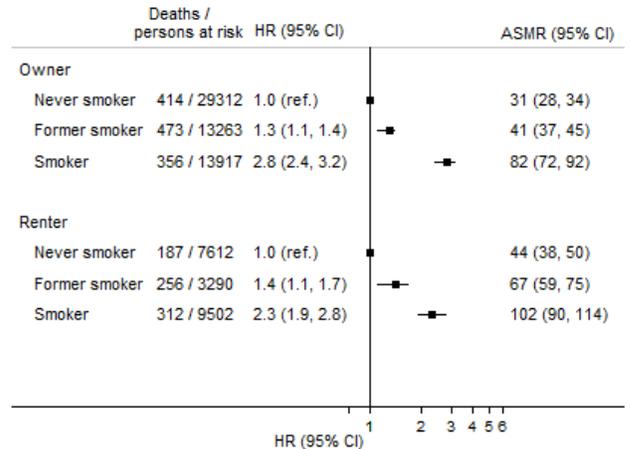
STROKE



CORONARY HEART DISEASE



CHRONIC OBSTRUCTIVE PULMONARY DISEASE



Association between self-reported smoking and death from all causes, smoking-related cancer, CVD, stroke, coronary heart disease, and chronic obstructive pulmonary disease, separately by housing tenure, from pooled cohort samples of 12 Health Survey for England and 3 Scottish Health Surveys conducted between 1994 and 2008 (N = 81476). Housing tenure was divided into 1) Owner and 2) Renter. Hazards ratios (95% CI) from Cox proportional hazards model are adjusted for age, sex, cohort, body mass index, physical activity and excessive alcohol, and are indicated by squares and the 95% confidence interval by the horizontal lines. X-axes are natural log-scaled. Age-standardized mortality rates calculated using the 2015 Standard European Population.