HM Treasury Budget 2017

Representation from ASH and the UK Centre for Tobacco and Alcohol Studies to the Chancellor of the Exchequer

January 2017

Introduction

1. ASH is a public health charity set up by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. It has also received project funding from the Department of Health to support tobacco control. The UK Centre for Tobacco & Alcohol Studies (UKCTAS) was created in 2008 and includes research teams in twelve UK universities. It is one of six Public Health Research Centres of Excellence, funded by the UK Clinical Research Collaboration.

2. This paper sets out our joint recommendations on tobacco policy in tax and related areas in advance of the forthcoming Budget and is endorsed by 46 other organisations (see Annex A for a full list).

Summary and Recommendations

3. Following the introduction of a sustained and comprehensive tobacco control programme from 1998 onwards smoking prevalence has fallen by a third amongst adults and two thirds amongst children. Core elements have included successive tobacco control strategies, sustained tax increases above inflation to reduce affordability and very successful anti-smuggling strategies. [1] Indeed, tax increases have been shown to be most effective in reducing health inequalities as they have a greater effect on more disadvantaged smokers than the general population.[2] However, more needs to be done, particularly to reduce inequalities and the last tobacco strategy expired in December 2015, over a year ago.

1 RCP. Nicotine without smoke: Tobacco Harm reduction. A report by the Tobacco Advisory Group of the Royal College of Physicians. London. RCP. 2016.

2 Brown, T., S. Platt and A. Amos (2014). "Equity impact of European individual-level smoking cessation interventions to reduce smoking in adults: a systematic review." European Journal of Public Health **24**(4): 551-556.

4. The Prime Minister in her inaugural speech committed to *"fighting against the burning injustice that, if you're born poor, you will die on average 9 years earlier than others."*[3]

5. To achieve this will require a continued focus on reducing smoking prevalence, since, as the Government itself acknowledges, half the difference in life expectancy between the richest and the poorest is due to smoking prevalence. In responding to a Parliamentary Question on the issue, the Government quoted Sir Michael Marmot's independent review into health inequalities recommendation that *"Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups."* [4]

6. It will also require an approach which targets population groups with high levels of smoking prevalence. In particular, 42% of adult tobacco consumption in England is by those with mental health conditions[5] who die 10-20 years earlier than people without such conditions, with tobacco the single largest preventable cause. However, people with mental health conditions are far less likely to receive help to quit smoking.[6]

Recommendations

7. Set out below are our key recommendations:

Tobacco Control Plan and public health funding

1) Publish the new tobacco control strategy at the earliest opportunity, to include targets for reducing smoking prevalence and to reduce inequalities in specific groups such as smokers with mental health conditions; and funding for key measures such as mass media campaigns and stop smoking services.
2) Require government measures to reduce smoking prevalence, to be funded by the tobacco industry via a "*user fee"* or increased taxation in line with the principle established by the soft drinks industry levy.
3) Funding to local authorities for public health services should be protected with local authorities held to account for improving outcomes.
4) Any funding solution for public health in the context of the return of business rates to local authorities must be properly, and equitably, funded, so as not to exacerbate health inequalities.

Taxation

5) Increase the tobacco tax escalator from 2% above inflation to 5% above inflation.
6) Continue to increase taxes on hand-rolled tobacco (HRT) above the escalator, by 15% above inflation, until they are equivalent to those on manufactured cigarettes taking into account the latest data on weight of HRT cigarettes.
7) We support the introduction of a Minimum Excise Tax but recommend that it be changed to a minimum consumption tax (MCT) for all tobacco products.

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3 Statement from the new Prime Minister Theresa May. 13 July 2016.

4 Smoking: Written question - HL1194. 26 July 2016

5 McManus S, Meltzer H, Campion J (2010) Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research.

6 Szatkowski L, McNeill A (2013) The delivery of smoking cessation interventions to primary care patients with mental health problems. Addiction, 108(8), 1487-94.

8) Ensure that the specific tax element for manufactured cigarettes is the maximum allowed under the EU Tobacco Tax Directive.
9) Support the revision of the EU Tobacco Tax Directive to:
   - Continue to increase minimum excise levels for manufactured cigarettes
   - Eliminate the differential between manufactured cigarettes and HRT.
   - Include raw tobacco in the Directive as an excisable product so that it can be brought into the Excise Movement and Control System (EMCS).

Regulating the tobacco industry and illicit Trade

10) Introduce new targets of a market share for illicit cigarettes of no more than 5% by 2020 and for HRT to no more than 22% by 2020 and 11% by 2025.
11) Fund partnership working at regional level to support coordinated enforcement against the illicit trade in tobacco.
12) Implement a tobacco retail licensing system funded by the tobacco manufacturers.
13) Ratify the Illicit Trade Protocol to the WHO Framework Convention on Tobacco Control.
14) Require that standards for traceability under Article 15 of the EU TPD ensure the effective independence of the system from the tobacco industry in line with Article 8 of the Illicit Trade Protocol and Article 5.3 of the FCTC.

Tobacco Control Plan and public health funding

8. The Government committed in parliament in December 2015 [7] to publish a new strategy in summer 2016, to replace the Tobacco Control Plan for England published in 2011.[8] However, despite a statement from the Public Health Minister to Parliament about the importance of a new strategy with new ambitions[9], and a commitment to publication 'shortly',[10] there is as yet no publication date for its successor.

9. The UK is rightly regarded as a global leader in tobacco control, and there has been a steady fall in smoking rates over several decades. Smoking prevalence has declined rapidly in England amongst adults and children since the Government first implemented comprehensive tobacco strategies from 1998 onwards. The latest figures show adult smoking prevalence in England has declined by more than a third from 27% in 1998 to 16.9% in 2015.[11] The proportion of 15 year olds in England who are regular smokers fell by two thirds from 24% in 1998 to 8% in 2014, while the proportion of 11-15 year olds who have ever smoked fell from 47% to 18% over the same period.[12] These are the lowest figures, both for adults and children, ever recorded.

10. However, as smoking is uniquely lethal, it remains the leading cause of preventable premature death, and the major reason for differences in life expectancy between the richest and poorest in society. Many measures, such as the advertising ban, taxation and standardised packaging, do not incur significant ongoing government expenditure. However to succeed in reducing inequality, the Government also needs to ensure adequate funding for the recurring costs of measures that are known to be

7 Hansard http://www.publications.parliament.uk/pa/cm201516/cmhansrd/cm151217/halltext/151217h0001.htm December 2015

8 Department of Health: Healthy Lives Healthy People: A tobacco control plan for England. DH 2011

9 Hansard. Westminster Hall debate. Tobacco Control Plan. HC Volume 615. Column 192WH-196WH. 13 October 2016.

10 Hansard. Topical Question – HC Vol 617 column 122. 15 November 2016.

11 Annual Population Survey, 2015. ONS, 2016

12 Smoking drinking and drug use among young people in England in 2014. Health & Social Care Information Centre, 2015.

effective - mass media campaigns, smoking cessation services and tackling illicit tobacco.

11. Adequate funding for tobacco control is core to the *"radical upgrade in prevention and public health",* which the NHS Five Year Forward View recognised as essential to ensure the *"future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain".* The report notes that this has been long called for: *"Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences."* [13]

12. Experience elsewhere shows what can happen if we do not review and renew our tobacco control strategy, and ensure that it is properly funded. Since 2007 the UK has scored highest for tobacco control policy implementation in Europe.[14] While we've seen significant declines in smoking due to our comprehensive approach, smoking prevalence in France and Germany, which have not had such strategies in place, has barely shifted over the last twenty years.[15]

13. It cannot therefore be assumed that the long-term decline in smoking prevalence will continue unless we renew and review our strategy. In New York, for example, sustained investment in tobacco control, and particularly mass media campaigns, led to a sharp fall in prevalence between 2002 and 2010. But when funding was cut in 2010 this decline ceased. Following new investment from 2014, smoking rates began to decline again.[16]

14. Public health funding cuts hit spend on national mass media campaigns in England first. These were cut in advance of the general election in 2010 and were only reintroduced subsequently at a significantly lower level (see table below). In 2009-10 funding was nearly £25 million, in 2010-11 it was less than £1 million. Although it was subsequently increased it has been declining year on year since 2012-13 and was only £5.3 million for the year 2015-16 (see below). It was confirmed to Parliament that the marketing spend on tobacco for 2016-17 would be £4 million in total,[17] so the actual spend on mass media campaigns will be significantly lower than this.

Financial year[18]	**Mass Media Spend (£m)**
2008-09	23.38
2009-10	24.91
2010-11	0.46
2011-12	3.16
2012-13	8.21
2013-14	7.64
2014-15	6.92
2015-16	5.3

13 NHS England Five Year Forward View . NHS October 2014.

14 Nguyen L. Rosenqvist G. Pekurinen M. Demand for Tobacco in Europe. An Econometric Analysis of 11 countries for the PPACTE project. PPACTE 2012 p.30

15 ASH. Smoking Still Kills. London. June 2015.

16 Politico New York, NYC smoking rate drops to lowest on record, September 2015

17 Source: Hansard: Citation HL Deb 14 September 2016 vol 774 c1537

18 Source: Hansard: Citation: HC Deb, 3 May 2016, cW and HC Deb, 3 April 2014, c799W

15. In contrast between 2007 and 2015, UK Film Tax Relief provided subsidies worth an estimated £473 million to at least 90 top-grossing UK or US-UK films that contained tobacco imagery, with 97% of this granted to films which are youth-rated in the UK.[19] Exposure to smoking imagery in films has been found to be associated with smoking initiation in young people.[20] It is counterproductive for the UK Government to continue subsidising films that contain smoking while cutting spending on mass media anti-smoking campaigns.

16. Studies carried out on mass media spend in England show they have been effective in triggering quit attempts[21] and have been responsible for a significant proportion of the reduction in smoking prevalence,[22] and that the freeze on mass media campaigns was associated with a reduction in quitting activity.[23] A systematic review of economic evaluations of mass media campaigns noted that all evaluations found mass media campaigns to be cost effective,[24] but these campaigns need to have sufficient intensity and be sustained in order to have a meaningful effect.[25]

17. The cost per quality adjusted life year (QALY) of the FDA mass media campaign *Tips from Former Smokers* was calculated to be $383[26] way below the £20,000 to £30,000 cost per QALY threshold set by NICE.[27] In a UK context, Stoptober, which that year included substantial mass media spend, was estimated in 2012 to have generated an additional 350,000 quit attempts in England and saved 10,400 discounted life years (DLY) at less than £415 per DLY in the modal age group.[28]

18. There have also been significant cuts in local authority public health budgets which threaten resourcing for tobacco control at local and regional level. In the July 2015 Budget statement, the Chancellor announced an in year reduction of £200 million to the 2015/16 grant of £2.79 billion.[29] Subsequently the Government announced a further cash reduction of 9.7% between 2016/17 and 2021.[30]

19. These cuts have already translated into cuts in funding of tobacco control at local level. Smoking cessation services which used to be universally available to all smokers and increased the success of quit attempts fourfold[31] were transferred from the NHS to local authorities in 2010, and are now being cut in response to these

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19 Hopkinson N. Millett C. Glantz S. Arnott D. McNeill A. UK government should fund stop smoking media campaigns not give tax breaks to films with smoking imagery. Addiction. 2016.

20 U.S. Department of Health and Human Services. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.

21 Langley, T., McNeill, A., Lewis, S., Szatkowski, L., Quinn, C., 2012. The impact of media campaigns on smoking cessation activity: a structural vector autoregression analysis. Addiction, 107(11), 2043-2050

22 Sims M, Salway R, Langley T. et al.. Effectiveness of tobacco control television advertising in changing tobacco use in England: a population-based cross-sectional study Addiction. 2014 109 (6): 986-94

23 Langley T, Szatkowski L, Lewis S et al. The freeze on mass media campaigns in England: a natural experiment of the impact of tobacco control campaigns on quitting behaviour. Addiction 2014: 109: 995-1002

24 Atusingwize E, Lewis S, Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review Tobacco Control 2015: 24: 320-327

25 Durkin S & Wakefield M. Commentary on Sims et al. (2014) and Langley et al. (2014) Mass media campaigns require adequate and sustained funding to change population health behaviours. Addiction 2014: 109: 1003-1004.

26 Xu, Xin, et al.,. Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign American Journal of Preventive Medicine, 2014.

27 NICE. Measuring effectiveness and cost effectiveness: the QALY. 20 April 2010

28 Brown J, Kotz D, Michie S, Stapleton J, Walmsley M, West R. How effective and cost-effective was the national mass media smoking cessation campaign 'Stoptober'? Drug Alcohol Depend. 2014 Feb 1;135:52-8. doi: 10.1016/j.drugalcdep.2013.11.003. Epub 2013 Nov 20.

29 HM Treasury. Budget, 8 Jul 2015.

30 Local Government Association. Public Health Funding in 2016/17 and 2017/18. 11 February 2016.

31 Gibson J, Murray R, Borland R, et al. The impact of the UK's national smoking cessation strategy on quit attempts and use of cessation services: findings from the ITC 4 country survey Nicotine & Tobacco Research 2010;12 Suppl:S64-71.

budget cuts. Local enforcement of age of sale of tobacco, smokefree laws and illicit trade, is also likely to disappear. A survey by ASH and Cancer Research UK found that smoking cessation budgets were cut in 59% of upper-tier local authorities in England in 2016-17, up from 39% the year before. In almost half (48%) the cuts were greater than 5%. Wider tobacco control budgets were cut in 45% of local authorities.[32]

20. The NHS also has a key role to play given the burden on the NHS caused by smoking and the commitment in the NHS Five Year Forward View to deliver significant efficiency savings through a radical upgrade in prevention and public health, and in the Five Year Forward View for Mental Health to improve the physical health of those with mental health conditions.

21. Yet there is growing evidence that the NHS is not living up to its responsibility. A recent survey of hospitals found that over 70% of patients who smoked were not asked if they wanted help to quit and less than 8% were referred for hospital-based or community treatment for their tobacco addiction. And an increasing number of Clinical Commissioning Groups (CCGs) are refusing to fund the prescription of NRT and other stop smoking pharmacotherapies by GPs.[33]

Making the tobacco industry pay

22. Funding needs to be found to sustain a properly funded tobacco control strategy at national, regional and local level. Tobacco manufacturers and importers in the UK are immensely profitable, such that they could certainly afford to make a greater contribution. Research by Branston and Gilmore at the University of Bath suggests that in the UK the industry has made at least £1 billion in profits in each of the last 5 years, that this profitability has been increasing during the period of analysis, and that the profitability is likely to be in the region of £1.5bn per annum in recent years.[34] Tobacco manufacturers and importers are also found to enjoy consistently high profit margins of up to 68%, compared to only 15-20% in most consumer staple industries.

23. Tobacco is not like any other consumer product, it is lethal when used as intended, killing at least half all users prematurely in the longer-term and causing significant health problems in the short and medium term. On average smokers lose ten years of life, a loss of 11 minutes for every cigarette smoked,[35] but the loss of disease free life years is far greater than this. For every death caused by smoking, approximately 20 smokers are suffering from a smoking-related disease, and although some diseases caused by smoking, such as lung cancer, kill relatively quickly with five year survival rates of below 10%, many others like heart disease, respiratory diseases, and numerous types of cancer can lead to many years of disability before death.[36] [37]

24. Nonsmokers are also affected, exposure to tobacco smoke increases the risk of lung cancer in non-smokers by 20-30% and coronary heart disease by 25-35%[38] and is

32 Cutting Down: the reality of budget cuts to local tobacco control ASH and Cancer Research UK, November 2016

33 Medicines Commissioning News, March 2016: Wyre Forest CCG, South Worcestershire CCG, Redditch and Bromsgrove CCG.

34 Branston, J. R. and Gilmore, A., 2015. The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy. University of Bath.

35 Shaw M, Mitchell R, Dorling D. Time for a smoke? One cigarette reduces your life by 11 minutes. BMJ. 2000 Jan 1; 320(7226): 53.

36 U.S. Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: U.S.Department of Health and Human Services, 2010.

37 Smoking-attributable morbidity – United States, 2000. MMWR Weekly Report. 5 Sep. 2003

38 Tobacco smoke and involuntary smoking. IARC Monographs on the evaluation of carcinogenic risks to humans. Vol 83. Lyon, France, 2004.

the cause of a range of illnesses in children including being the leading modifiable risk factor for sudden infant death syndrome.[39]

25. In the 2014 Autumn Statement HM Treasury announced that it would consult on the introduction of a levy on the tobacco industry, stating that *"Smoking imposes costs on society, and the Government believes it is therefore fair to ask the tobacco industry to make a greater contribution."* [40]

26. This is a principle which has been adopted for the soft drinks levy, however, HMT decided not to proceed with a tobacco industry levy on the basis that *"the impact of a levy on the tobacco market would be similar to a duty rise, as tobacco manufacturers and importers would pass the costs of a levy on to consumers. This is supported by HMRC analysis which shows that a levy of £150 million would only raise £25 million after behavioural effects."*[41] The review of the evidence by DEFRA stated that, *"HMRC evidence suggests that the short-run price elasticity of demand for tobacco products is -0.57. This suggests that over the short-term demand is relatively inelastic and firms will be able to pass on a large proportion of any additional cost/tax to consumers should they wish to. HMRC data also shows that tobacco companies have passed on 100% or more of previous tobacco duty rate increases."* However, this review also went on to say that, *"Over the longer term firms will also look to reduce costs to maintain profitability and returns."*

27. The implication of the DEFRA analysis is that in the short-run revenues would increase not decrease, and in the long-run as stated the tobacco industry would reduce costs so as to absorb the levy and ensure that its profitability and returns were maintained. DEFRA's analysis does not therefore support HMT's conclusion that such a levy would be unsuccessful.

28. Furthermore it should be noted that long-run elasticities tend to be greater than short-run elasticities. For example, in Europe they are estimated to be between -0.2 and -1.5 with a typical value close to -1.0. However, they are also considered to be much more variable and less reliable than short-run elasticities and *"thus one should be very cautious about using the long-run price elasticity estimates"*.[42]

29. Other mechanisms than a tobacco levy as consulted on could be introduced, for example a *"user fee"* as is in place in the United States[43] [44] to fund regulation of the tobacco industry. A Legal Opinion for ASH concluded that such a "*user fee*" would be lawful, pointing out that such a mechanism is already utilised in the UK for the purpose of funding, in part or in whole, other regulatory functions for example the Prudential Regulatory Authority, Ofgem, Ofwat and the Human Fertilisation and Embryology Authority. Furthermore that it would be legal for the money raised to be used to fund recurring costs of tobacco control such as mass media campaigns, stop smoking services and local authority enforcement functions.

30. Alternatively tobacco manufacturers could be required to pay additional taxes either through the excise system or corporation tax. For example, a surcharge could be used to bring their corporation tax back to the rate set in 2010, of 28%. A precedent for such a surcharge already exists in the form of the Bank Corporation Tax

39 Passive smoking and children. Royal College of Physicians, London, 2010

40 HM Treasury. Autumn Statement 2014. CM 8961. December 2014

41 HM Treasury. Tobacco levy: response to the consultation. September 2015.

42 Nguyen L. Rosenqvist G. Pekurinen M. Demand for Tobacco in Europe. An Econometric Analysis of 11 countries for the PPACTE project. PPACTE 2012 p.89

43 Family Smoking Prevention and Tobacco Control Act 2009. Section 919 User fees.

44 US Food and Drug Administration. Rules, Regulations & Guidance. User fees. Accessed 20th January 2017.

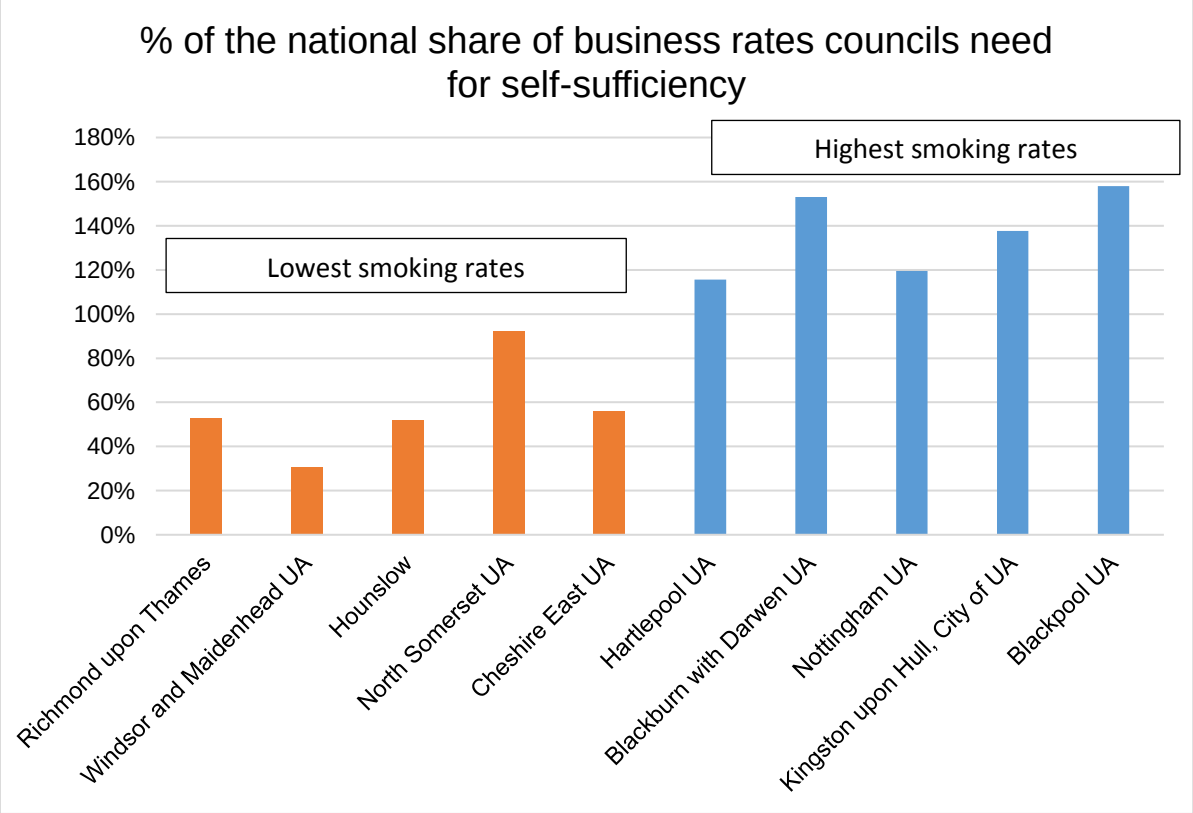
Surcharge. Given UK based tobacco companies pay very little corporation tax despite reporting high profits earned in the UK, they should be subject to the diverted profit tax at the higher 33% rate now applied to the banking industry. Such a higher charge will help ensure they pay their fair share, and this should be introduced irrespective of whether or not they are subject to a surcharge on corporation tax.

31. We therefore recommend the introduction of a levy on the industry, preferably through a *"user fee"* or via increased tobacco excise or corporation taxes to ensure that the industry makes a greater contribution to the damage it causes society. This would be used to ensure that funding was available to meet the cost of tobacco control measures, including mass media campaigns, and local and regional tobacco control measures such as enforcement and stop smoking services.

Potential Impact of Returning Business Rates to Local Authorities

32. We were deeply concerned by the proposal in the 2015 Autumn Statement that a future funding solution for public health could come through returning more of business rates to local authorities. In the absence of other measures, this could worsen health inequalities.

33. Local authority income from business rates varies widely, with richer authorities receiving more income than poorer ones. Richer areas generally have lower smoking rates than poorer ones. An analysis of the 'winners' and 'losers' from returning the national share of business rates to local authorities while ending the Revenue Support Grant [45] was applied to smoking rates across the country. This showed that the five areas (excluding London) which are the biggest 'winners' from this proposal have an average smoking rate of 16% while the five biggest 'losers' have an average smoking rate of 20%.



45 Calkin S. Business rates reform explained. Local Government Chronicle 7 Oct 2015

34. Looking at the areas of the country with the highest and lowest rates of smoking, those with the highest smoking rates are much more likely to lose out than those with lower rates. The five councils with the highest smoking rates would, on average, need 137% of the national share of the business rates to be self-sufficient while the five with the lowest smoking rates would need only 57%. Therefore, any funding solution for public health in the context of the return of business rates to local authorities will need to ensure that it is properly, and equitably, funded. (see chart above).

35. Many public health functions are not statutory duties, and many of the financial benefits likely to follow from funding public health do not accrue to local authorities, for example reductions in cost pressures on the NHS. For this reason, there is effectively a perverse incentive to cut funding in this area.

Taxation

36. Tax increases have been shown to be most effective in reducing health inequalities as they have a greater effect on more disadvantaged smokers than the general population.[46] [47] However, poorer smokers who don't quit are disproportionately disadvantaged in economic terms because of the negative impact of tobacco tax increases on their already small incomes. This poses a dilemma which can be resolved by ensuring that all efforts are made to motivate and support smokers in quitting. In addition the positive health impact of taxes is greater when some of the revenues generated are used to support comprehensive tobacco control strategies.[48]

37. Tobacco taxation has been at the heart of UK government policy to improve the health of the nation by driving down smoking prevalence for over 20 years. A tobacco tax escalator to reduce the affordability of tobacco was first introduced under a Conservative government in 1993, on the understanding that this *"is the most effective way to reduce smoking".*[49] An escalator of 2% above inflation is in force for the duration of the current parliament.

38. However, while successive Chancellors have used the rhetoric of progressive tobacco tax policies, in practice the UK has been overtaken by other countries in recent years, particularly Australia.[50] The Australian Treasury not only indexes tobacco tax increases to inflation twice a year, but in 2010 it increased tobacco excise taxes by 25% with the intention of producing a 15% increase in revenues.[51] Despite budgetary pressures stemming from the global economic crisis, revenues from tobacco taxes in 2010-11 increased by 13% compared with the previous financial year.[52]

39. Australia also committed to introducing staged 12.5% increases in tobacco excise over the subsequent four years *"to battle smoking-related cancer and help return the Federal Budget to surplus in 2016-17".* The most recent commitment in the 2016 Australian budget was for four further annual increases of 12.5% per year from 1 September 2017 until 2020. There was also an additional AU$7.7 million a year for the Tobacco Strike Team to combat illicit tobacco activity, provision for stronger

46 The World Bank. Curbing the epidemic: governments and the economics of tobacco control. May, 1999.

47 Amos A, Bauld L, Clifford D, et al. Tobacco control, inequalities in health and action at a local level. York, Public Health Research Consortium, 2011.

48 Chaloupka F, Yurekli A, Fong G. Tobacco taxes as a tobacco control strategy. Tobacco Control 2012; 21:172-180

49 Chancellor's Budget statement. House of Commons Hansard debates. 30 November 1993

50 Jha, P and Peto, R. Global effects of smoking, of quitting, and of taxing tobacco. New England Journal of Medicine 2014; 370:65.

51 Treasury, Australia. Issues in tobacco taxation. Accessed January 2016.

52 Australian Government Budget Outcomes 2009-10 and 2010-11. Accessed January 2016.

penalties and more support for the Border Force team responsible for enforcing tobacco importation restrictions**,** plus a reduction in duty free allowance to only 25 cigarettes per person.[53]

40. In comparison, while in the UK the government has committed to tackling the health impacts of smoking by increasing taxation, and has increased funding for action to tackle the illicit trade in tobacco, the current annual tobacco duty escalator is only 2% above inflation until the end of this Parliament. While this ensures tobacco duties rise by more than inflation each year, Australia now outstrips the UK and tobacco prices are much higher both in absolute terms and in relation to income. As early as 2010, cigarettes in Australia became less affordable in relation to per capita GDP than the UK, and indeed than in all high-income countries other than Norway.[54] Tobacco is still more affordable in the UK today than it was in the 1960s.

41. In Australia, which has a comprehensive tobacco control strategy which has led to declines in smoking prevalence, due to tax increases and other measures including mass media campaigns and plain standardised packaging, tobacco tax revenues have continued to increase following the tax increases, to a greater extent than expected. In 2013-14 the budget estimate was AU$7.8 billion, the outturn was AU$8.5 billion, and in 2014-15 the budget estimate was AU$8.280 billion while the outturn was AU$8.848 billion, respectively 8% and 7% higher than the budget estimate.[55]

42. In contrast over the last five financial years overall receipts in the UK have remained fairly stable and over the five years are 0.7% down (£66 million). This masks differences in the pattern for manufactured cigarettes and HRT. The revenue on manufactured cigarettes has fallen by 3.6% (£310 million) while revenues on HRT have increased by 28% (£250 million). In terms of the amount of tobacco consumed the change is greater, with the quantity of manufactured cigarettes falling by 28% while that of HRT has only fallen by 1.9%.

HMRC revenue receipts for all tobacco products – changes over the last five financial years 2011/12 to 2015/16

Financial Year	£ million	Change in £ million	% change year on year
2011/12	9,551		
2012/13	9,681	+130	+1.4%
2013/14	9,531	-150	-1.6%
2014/15	9,548	-17	-0.2%
2015/16	9,485	-63	-0.7%

43. The reasons for this are likely to be multi-factorial. In the UK we have seen significant downtrading by smokers both to cheaper brands of cigarettes and to HRT, which has been encouraged by the tobacco industry pricing strategy, in turn enabled by the UK tobacco tax strategy. Tobacco taxation can be revised to limit the tobacco industry's ability to use pricing in this way.

44. For example, following consultation, the government has committed to the introduction of a Minimum Excise Tax on cigarettes in the Finance Bill 2017, which will set a floor below which tax on cigarettes cannot fall. We would support the setting

53 Budget 2016-17. Making our tax system more sustainable so we can cover the Government's responsibilities for the next generation. Commonwealth of Australia 3 May 2016

54 Tobacco in Australia- Facts and Issues: A comprehensive online resource 13.4 The affordability of tobacco products. downloaded 22 August 2016.

55 Australian Government Budget Outcomes 2013-4 and 2014-15. Accessed January 2016.

of the highest possible MET in order to help reduce the tax differential between different price categories. To maximise taxation on lower than average priced cigarettes and set an effective floor below which the total tax burden can't fall, the MET should be set equivalent to the maximum total tax burden allowable based on the Weighted Average Price (WAP).

45. This is crucial as the MET consultation document noted that while real average cigarette prices have been increasing across the market as a whole in recent years, the difference between retail prices of the most expensive and cheapest cigarettes has widened by more than two thirds over the last 10 years. The research cited in the consultation document on tobacco industry pricing was carried out by Professor Gilmore and colleagues at the UKCTAS and demonstrates that this is because the tobacco industry has been absorbing tax increases on the cheapest brands rather than passing them on to consumers.[56] It can afford to do this by increasing prices and thus profits on its more expensive brands. The timing of industry initiated price changes appears timed to accentuate price differences between brand segments when tobacco duties increase at the time of the budget in spring each year.[56]

46. Cheaper brands are targeted at the young, the poor, women and those living in areas of the country with high smoking rates who are most in need of protection from tobacco industry marketing tactics. Related evidence shows that the increase in the use of cheap cigarettes is most marked in the youngest (16-24 year old) smokers, 71.4% of whom now use cheap brands[57] and that the young, the poor, women and those living in areas of the country with high smoking rates are more likely to use cheap (ultra-low price and economy) cigarette brands. This highlights the impact of the availability of cheap cigarettes on inequalities in smoking. [56] [57]

47. Further, downtrading is encouraged by the significant differential in taxation and price per cigarette between manufactured tobacco and HRT, which in effect increases the elasticity of demand for manufactured cigarettes, with a negative impact on tax revenues, without the health benefit conferred by quitting. There is evidence from the Netherlands that consumption of HRT increases as the price differential between manufactured and HRT increases,[58] and certainly this is the pattern we've seen in the UK. The proportion of smokers mainly using HRT has increased from 25% of men and 8% of women in 1998 to 40% of men and 23% of women in 2013.[59]

48. We were pleased to see that in the March 2016 Budget the UK government acknowledged the health impacts of this differential, and narrowed the gap in tax levels between manufactured cigarettes and HRT by increasing HRT taxes by an additional 3% above inflation. We recommend continuing to increase taxes on HRT above the escalator, by 15% above inflation, until they are equivalent to those on manufactured cigarettes taking into account the latest data on weight of HRT cigarettes.[60]

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56 Gilmore A, Tavakoly B, Taylor G, Reed H. Understanding tobacco industry pricing strategy and whether it undermines tobacco tax policy: the example of the British cigarette market. Addiction 2013; 108 (7): 1317-1326

57 Gilmore A, Tavakoly B, Hiscock R, Taylor G. Smoking patterns in Great Britain: the rise of cheap cigarette brands and roll your own (RYO) tobacco. J Public Health (2014) doi:10.1093/pubmed/fdu048. Published online: August 11, 2014

58 Mindell JS, Whynes DK. Cigarette consumption in the Netherlands 1970 – 1995: does tax policy encourage the use of hand-rolling tobacco? Eur J Public Health 2000;10:214-9.

59 Opinions and Lifestyle Survey. Smoking habits amongst adults, 2013 Office for National Statistics, November 2014

60 HMT. Budget 2016. HC901. March 2016.

49. The equivalent tax rate for HRT can be accurately calculated using recent research on the average weight of tobacco per hand-rolled cigarette. This would increase the tax take and reduce the likelihood of smokers downtrading to HRT rather than quitting. While recent work, based on a 2010 survey, shows the median weight of a hand-rolled cigarette across 18 countries in Europe was approximately 0.75g, England had the lowest mean weight of 0.48g.[61] More recent analysis of six waves (2006 to 2014) of the ITC study data showed the average grams of tobacco per hand-rolled cigarette for the UK sample to be between 0.45 - 0.55 grams.[62] We therefore suggest 0.5 grams be used as the average weight of a hand-rolled cigarette.

50. Furthermore we urge the Government to go further and substitute a Minimum Consumption Tax for the proposed Minimum Excise Tax. The MCT includes VAT as well as excise tax and therefore impacts not just on tax levels for manufactured cigarettes but also on HRT. Raising the tax levels at the lower priced end of the HRT market could help reduce the likelihood of downtrading within the HRT category. Ongoing research suggests this is likely to be a growing problem.[63]

51. Evidence from overseas indicates that the tobacco industry will try to exploit loopholes in tax legislation by selling HRT as pipe tobacco, if lower taxes are applied to pipe tobacco.[64] For this reason we suggest keeping taxes on pipe tobacco in line with those on HRT.

Review of the EU Tobacco Tax Directive

52. The EU Tobacco Tax Directive is currently under review. It is crucial that the UK take into account health as well as revenue impacts of the Directive, in line with the EU's obligations under the WHO FCTC and in particular Article 6 and its guidelines. On that basis we would like to see the UK advocating for the revised Directive to:
    - Remove the differential between taxation of HRT and manufactured cigarettes;
    - Include raw tobacco as an excisable product to enable full controls on the production, storage and movement of raw tobacco to be implemented.

53. As a result of the current Tax Directive, the minimum tax on HRT at EU level has risen from 36% of weighted average selling price previously, to 40% on 1 Jan 2011, 43% in 2013, 46% in 2015, and will continue to rise to 48% in 2018 and 50% in 2020.[65] However, tax rates on HRT are still much lower in many parts of Europe than in the UK, particularly the Benelux countries, leading to incentives for tax paid HRT to be smuggled into the UK from these jurisdictions. Indeed in November 2014 HMRC fined British American Tobacco (BAT) £650,000 for oversupply of HRT to Belgium for which there was not a local market. We therefore recommend that the UK advocate for the removal of the differential in taxation between HRT and manufactured cigarettes.

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61 Gallusa S, Lugoa A, Ghislandic S, La Vecchiaa C, Gilmore, A. Roll-your-own cigarettes in Europe: use, weight and implications for fiscal policies. European Journal of Cancer Prevention 2014; 23:186–192

62 Partos, et al. Availability and use of cheap tobacco in the UK 2002 - 2014: Findings from the International Tobacco Control Project. Nicotine and Tobacco Research (under review).

63 personal correspondence A Gilmore January 2017.

64 Clifford D, Ciercierski C, Silver, K, Gilmore A. PPACTE Work Package 5 – Milestone 5.2. Tobacco industry influence over tobacco taxation in Poland. Dublin. PPACTE, 2012

65 Council Directive 2010/12/EU of 16 February 2010 amending Directives 92/79/EEC, 92/80/EEC and 95/59/EC on the structure and rates of excise duty applied on manufactured tobacco and Directive 2008/118/EC

54. The exclusion of raw tobacco from the scope of the Directive means that it does not come under the Excise Movement and Control System (EMCS), which is a key element in the fight against tax fraud. While the registration scheme for raw tobacco being put in place by the UK is important, it is not sufficient. As concluded in the Ramboll study for the European Commission,[66] unless raw tobacco is included in the scope of the Directive it is not possible to ensure that adequate data becomes available through EMCS in a systematic and comparable format across the territory of the EU. The majority of manufacturers and importers of tobacco products already operate under the EMCS and will not face an increased administrative burden. We urge the Government to advocate for the inclusion of raw tobacco within the scope of the revised Directive.

Regulating the tobacco industry and controlling illicit Trade

55. The UK has had a very effective anti-smuggling strategy since 2000,[67] when the market share for illicit tobacco was over 20% for manufactured cigarettes and over 60% for HRT. The illicit market has been in decline in subsequent years and by 2015-16 the illicit market share for manufactured cigarettes had fallen to 13% and for HRT to 32%. This has resulted in significant benefits to government revenues, the tax gap has fallen over the same time period from £2.5 billion to £2.4 billion and would have been significantly higher than £2.5 billion if the illicit trade had remained at the levels seen in 2000.[68]

56. Yet the tobacco industry has misrepresented HMRC figures, and produced their own, misleading, estimates on the size of the illicit market to exaggerate the scale of the illicit tobacco trade. In turn they have used these data to promote their misleading messaging on illicit to the media and have distorted the public discourse on illicit by so doing.[69] [70] [71] [72]

57. This is despite the fact that the tobacco manufacturers' own reports for Europe show that the size of the illicit market is in decline, and that only a small proportion, less than 10%, comprises counterfeit product. The tobacco industry's own reports find that the majority of the illicit market, 56%, still comprises tobacco company product.[73] What is self-evident is that better control of the legitimate supply chain, as required by the WHO FCTC Illicit Trade Protocol which the UK has signed and committed to ratify, is essential if we are to continue to reduce the size of the illicit market.

66 Ramboll. Study on the measuring and reducing of administrative costs for economic operators and tax authorities and obtaining in parallel a higher level of compliance and security in imposing excise duties on tobacco products. *TAXUD/2012/DE/341 Specific contract No4 under FWC TAXUD/2012/CC116. European Commission June 2014.*

67 HMRC and Border Force. Tackling illicit tobacco: From Leaf to Light The HMRC and Border Force Strategy to tackle tobacco smuggling. HMRC March 2015

68 HMRC. Tobacco Tax Gap estimates 2015-16. 20 October 2016

69 Rowell A, Evans-Reeves K, Gilmore A.Tobacco industry manipulation of data on and press coverage of the illicit tobacco trade in the UK. Tob Control Published Online First 10 March 2014 doi:10.1136/tobaccocontrol-2013-051397.

70 Gilmore A, Rowell A, Gallus S, et al. Towards a greater understanding of the illicit tobacco trade in Europe: a review of the PMI funded, KPMG authored "project star" report Tob Control 2014;23:e51–61.

71 Evans-Reeves K A, Hatchard JL, Gilmore AB. 'It will harm business and increase illicit trade': an evaluation of the relevance, quality and transparency of evidence submitted by transnational tobacco companies to the UK consultation on standardised packaging 2012 Tob Control. doi:10.1136/tobaccocontrol-2014-051930 December 10, 2014

72 Evans-Reeves K A, Hatchard JL, Gilmore AB. 'It will harm business and increase illicit trade': an evaluation of the relevance, quality and transparency of evidence submitted by transnational tobacco companies to the UK consultation on standardised packaging 2012 Tob Control. doi:10.1136/tobaccocontrol-2014-051930 December 10, 2014

73 Project SUN. A study of the illicit cigarette market in the European Union, Norway and Switzerland. 2015 Results. June 2016. Prepared by KPMG for BAT, Imperial Tobacco, JTI and PMI.

58. To this end, we note that the tobacco industry is attempting to promote its own track and trace system, Codentify. There has so far been no full independent assessment of the security of Codentify, indeed the Codentify patent documentation states that 'the production codes can easily be imitated or cloned."[74] It therefore appears to be both inadequate in its function and, through its links to industry, fails to meet the criteria established in the Illicit Trade Protocol and is inconsistent with Article 5.3 of the WHO Framework Convention on Tobacco Control.[75] It is essential that the UK ratify the Protocol as soon as possible, while ensuring any standards set for track and trace systems, at UK level or under the EU Tobacco Products Directive, are fit for purpose and ensure independence from the tobacco industry.

59. The UK is a party to the WHO FCTC, which requires stringent regulation of the tobacco industry, far greater than any other legal consumer product. Under Article 20 the Treaty sets out requirements for Parties to carry out monitoring and surveillance of the tobacco industry, and provides for the collection and dissemination of such data.

60. Taxpayer confidentiality has been cited as a reason why this is not possible. Yet such data is already collected and published by commercial organisations such as Nielsen, but only available at significant cost (prohibitive given the budget constraints detailed above). Furthermore, in other jurisdictions 'taxpayer confidentiality' has not been an impediment to publication of such data. For example, New Zealand publishes monthly sales data and in the US, the Federal Trade Commission issues reports on the tobacco industry, which cover sales, advertising and promotional expenditures,[76] and the Canadian government requires the tobacco manufacturers to report quarterly in arrears on monthly tobacco sales by volume and value. [77]

61. We strongly recommend that the UK Government implements a policy requiring the industry to provide for publication sales data at national and local authority level, with the addition of marketing spend, brand specific price data at a national level, on a monthly basis. The industry should also be required to provide data for publication on its profitability, and the taxes it pays on an annual basis. The industry should be required to provide data in a standard agreed electronic format so as to be easily aggregated, accessible, and analysable.

62. The importance of this to accurately measure tobacco prices and determine appropriate tax policy has been recently outlined in research on UK cigarette prices, and making such data available to researchers and policy makers would be invaluable in helping with the development, implementation and evaluation of policy measures designed to reduce smoking prevalence.[78] Such data at local level could also provide useful insight into the illicit market, for example significant reductions in local sales over a short period of time is likely to be an indicator of illicit sales activity.

63. Benefits to HM Government would include:
    - Better understanding of market developments to inform the development of tobacco control and tax policy, for example on tax structure.

74 Framework Convention Alliance. Does the tobacco industry have a tracking and tracing system that governments can use? May 2015.

75 Joossens L, Gilmore A. Transnational tobacco companies' strategy to promote Codentify, their inadequate tracking and tracing standard. Tobacco Control 2012.

76 Federal Trade Commission Cigarette report for 2012.

77 Canadian Tobacco Reporting Regulations. Part 2 reports 13 Sales. SOR/2000-273. Consolidation current at January 25 2016.

78 Gilmore et al. Understanding tobacco industry pricing strategy and whether it undermines tobacco tax policy: the example of the UK cigarette market. Addiction 2013; 108 1317–1326. doi: 10.1111/add.12159

- Enabling future research on the price sensitivity of tobacco consumption by academic researchers to support work carried out by HMRC.
- Better understanding of illicit market trends over time at local level.
- Provision of proxy indicators for smoking prevalence changes at local level to enable local authorities to determine the effectiveness of their tobacco control activities (scaling up national surveys for this purpose is unfeasible because of the cost).
- Better understanding of the marketing strategies of the tobacco industry.

64. Successfully containing illicit trade requires continued vigilance, which is why we were pleased to note the announcement in the March 2016 Budget that the Home Office would receive £31 million of funding *"to form a dedicated group of border officers and intelligence officials to tighten the government's grip on the most prolific smuggling routes and intercept smugglers as they try to adapt their tactics."*[79] This was alongside the additional intelligence and investigative resources provided in the Summer 2015 Budget.

65. We strongly agree with the statement in the 2016 Budget that *"Coordinated enforcement, will work to further increase the seizure of illicit shipments and increase prosecutions for tobacco fraud."* In a 2013 report the National Audit Office pointed to the *"promising results"* from regional partnerships in the north of England between HMRC and other agencies such as the police, trading standards and health organisations, which helped provide the coordinated enforcement that is required.[79] The NAO also encouraged HMRC to roll out such partnerships nationally.

66. The success of such partnerships is shown by the impact in the northeast and northwest, which have had concerted multi-agency enforcement activity and evidence-based effective demand reduction measures in place since 2007, supported by the work of the Illicit Tobacco Partnership. The data demonstrate a significantly greater fall in the illicit trade in the northeast region than has been seen at national level. Between 2009 and 2015 the illicit market had declined by more than a third in the northeast from 15% to 9%, while the decline at national level was less than a fifth, from 12% to 10%.

67. Unfortunately, not only has there not been a further roll out of such partnerships nationally since the NAO report, but the only partnership outside the north of England, in the southwest, has disappeared following a total cut in funding. To date none of the funding for such partnership working has come from HMRC, it has come either from localities or from the Department of Health.

68. The trading standards staff who are crucial to effective collaborative working, are increasingly under threat. During the last six years, total spend nationally on trading standards has fallen from £213m in 2010 to £124m today. Teams have been cut to the bone, with a 12% drop in staff working in trading standards since 2014. This came on top of the 45% drop identified over the previous five years by an earlier survey.[80] The financial benefit from enhanced enforcement accrues to HM Government not to local authorities, so it would seem appropriate for funding to be found by HMRC, unless and until measures are put in place to require the tobacco manufacturers to pay for these costs.

79 HM Revenue & Customs. Progress in tackling tobacco smuggling. Report by the Comptroller and Auditor General. HC 226 SESSION 2013-14. June 2013

80 CTSI. Chartered Trading Standards Institute Workforce Survey. June 2016

69. Earlier this year HMRC consulted on the introduction of licensing of the tobacco industry supply chain, but in the Autumn Statement the Government committed only to legislating to control the use and ownership of tobacco manufacturing machinery. In our response we supported the introduction of a positive licensing scheme for retailers, with an adequate licence fee, which could provide valuable financial resources for enforcement authorities, including those at local level (e.g. Trading Standards departments) as well as regional partnerships. In a period of tight public spending constraints this could provide funds to ensure that enforcement of all legislation relating to tobacco control can continue at an appropriate level.

70. In our response we also pointed out that an effective positive licensing scheme could offer the following benefits:
    - The permanent removal of a large proportion of the final sellers of illicit tobacco, once a widespread system of detection and enforcement is in place.
    - Significant reductions in the leakage of tobacco from the licenced distribution system into grey and black markets in the UK.
    - Increased turnover for legitimate local retailers who obey tobacco control legislation. Although these businesses make very low profit margins from selling tobacco itself, it does draw customers into their shops regularly, and the resulting collateral sales are very important to these businesses.
    - A decline in the illicit tobacco trade should also result in fewer children obtaining cigarettes and becoming addicted in their teens.

71. In our consultation response we favoured recovering the cost of licences through a levy on manufacturers and importers, with the proceeds distributed to national and local enforcement authorities. While retailers make low profit margins on tobacco, the four major tobacco companies are some of the most profitable in the world, and could easily meet the costs of a licensing scheme.

72. The distribution of part or all of the fees from a licensing system to local government would help overcome two problems with local enforcement work against illicit trade: first, that Council budgets are being sharply reduced; and secondly that, unlike for central government, which benefits from increased tax revenues, there is no direct financial gain to Councils from enforcement action leading to reductions in the level of illicit trade.

ANNEX A

Organisations endorsing ASH's submission to the 2017 Budget

AF Association	Nottinghamshire Strategic Tobacco Alliance Group
Arrhythmia Alliance	Oral Health Foundation
ASH Northern Ireland	Public Health Action
ASH Scotland	Royal College of Midwives
ASH Wales	Royal College of Paediatrics and Child Health
Association of Directors of Public Health	Royal College of Physicians
Asthma UK	Royal College of Psychiatrists
Blackpool Council	Royal College of Radiologists
British Heart Foundation	Royal Society for Public Health
British Lung Foundation	Smoke Free Newcastle
British Thoracic Society	Smoke Free Northumberland Alliance
Buckinghamshire Tobacco Free Alliance	Smoke Free South Tyneside
Cancer Focus Northern Ireland	Smokefree County Durham Tobacco Control Alliance
Cut Films Project	Smokefree Yorkshire and the Humber
Diabetes UK	Socialist Health Association
Faculty of Public Health	Somerset County Council
Fresh North East	St Helens Metropolitan Borough Council
Hartlepool Smoke Free Alliance	STARS (Syncope Trust And Reflex anoxic Seizures)
Healthier Futures	The Lullaby Trust
Manchester Public Health Team	Tobacco Control Collaborating Centre
Middlesbrough Council Smokefree Alliance	UK Health Forum
National Centre for Smoking Cessation and Training (NCSCT)	University Hospitals of Leicester NHS Trust
Nottingham City Council	Worcestershire County Council