HM Treasury Budget 2018

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

28th September 2018

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 and Social Care to support delivery of the Tobacco Control Plan for England. 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, which sets out our joint recommendations on tobacco policy in tax and related areas in advance of the forthcoming Budget, is endorsed by 19 other organisations (see Annex 1 for a full list). Recommendations relate to the UK as a whole with respect to reserved matters such as tobacco taxation and illicit trade, and to England with respect to public health funding, the NHS and the Tobacco Control Plan.

Summary

3. Increasing tobacco taxes above inflation[1] and reducing the illicit trade are complementary strategies which combine to reduce the affordability of tobacco and increase government revenues as well as reducing smoking prevalence.

4. Smoking remains the leading cause of preventable premature death, killing nearly 100,000 people a year in the UK. We support the government's objective – consistent with its wider fiscal objectives - of reducing the affordability of tobacco through increasing taxation, widely acknowledged as the most effective means of reducing smoking prevalence while increasing government revenues.

5. Tax increases have been shown to be a highly effective tool in reducing smoking prevalence and tackling inequalities, as poorer (and younger) smokers are more price sensitive than the general population and tobacco tax increases are the only

tobacco control intervention shown to reduce inequalities,[2] [3] [4] a key ambition in the Government's Tobacco Control Plan.[5]

6. The renewal of the tobacco tax escalator of 2% above inflation in the November 2017 Budget was welcome, however, the evidence is clear that only the largest tax increases have been effective in reducing affordability. [6] [7] [8] Furthermore, despite being no less harmful than factory made cigarettes, handrolled tobacco (HRT) is taxed at a significantly lower rate than factory made cigarettes which has led to smokers downtrading to HRT rather than quitting. This disparity needs to be addressed.

7. Quitting smoking is made more difficult by industry strategies to keep their product affordable, including the proliferation of cheap cigarette and hand-rolled tobacco brands and the undershifting of tobacco duty, particularly on cheaper brands.[8] These tactics all serve to widen the price gap between cheap and expensive products and allow smokers to downtrade to more affordable products, rather than quit, in the face of tobacco tax increases.

8. Furthermore, disadvantaged smokers who don't quit bear a disproportionate share of the tobacco tax burden, because of the greater concentration of smoking among these groups. In addition, due to their higher rates of smoking, these populations also bear a disproportionate share of the burden of disease caused by tobacco.

9. For example 42% of adult tobacco consumption in England is by those with mental health conditions,[9] who die 10-20 years earlier than people without such conditions, with tobacco playing a key role in this gap. However, people with mental health conditions are far less likely to receive help to quit smoking.[9] [10] [11]

10. This poses a dilemma which can be resolved by ensuring that all efforts are made to motivate and support smokers in quitting. A comprehensive approach by government to reduce smoking prevalence, has been highly effective[12] [13] and highly cost-effective[14] and needs to be sustained. This includes increasing taxes above inflation and tackling the illicit trade, but also a range of other measures including prohibiting all advertising, implementing smokefree legislation and health warnings on packs, mass media campaigns, helping smokers quit and enforcement of legislation. In addition, the positive health impact of taxes is greater when some of the revenues generated are used to support comprehensive tobacco control strategies.[1]

11. The health organisations which endorse the ASH Budget submission support the use of tobacco taxation to continue to reduce the affordability of tobacco, as long as at the same time the Government continues to ensure adequate funding is provided for measures to reduce smoking prevalence and uptake.

12. The Government consulted 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."* [15] Although at that time the decision was taken not to proceed with a levy, the principle still holds. The tobacco industry is highly profitable[16] [17] and can and should be made to pay for its regulation and for the recurring costs of measures to drive down smoking prevalence such as anti-smoking mass media campaigns, enforcement activity and smoking cessation treatment. This should be done in such a way as to help incentivise the manufacturers to move out of the market for combustible products.

13. There is strong public support for the licensing of tobacco retailers (net support 76%) and for requiring tobacco manufacturers to pay for measures to reduce smoking prevalence (net support 71%).[18] Surveys of small retailers show strong support for licensing with 69% of retailers supporting the introduction of a tobacco license that retailers could lose if they broke the law.[19]

14. Indeed there is strong public support in general for Government action to tackle smoking. The proportion of all respondents who think the government is not doing enough to tackle smoking has risen from 29% in 2009 to 39% in 2017. In total over three quarters (76%) of adults surveyed supported the government's activities to limit smoking or think they could do more, while only 11% believed that the government is doing too much.[20]

Recommendations

15. Set out below are our key recommendations, in line with the overall analysis set out above. The more detailed analysis which supports these recommendations is set out subsequently:

Taxation

1) Increase the tobacco tax escalator for this parliament from 2% above inflation to 5% above inflation.
2) Continue to increase taxes on hand-rolled tobacco above the escalator, by 15% above inflation, until, per typical cigarette, they are equivalent to those on factory made cigarettes taking into account the latest data on the quantity of tobacco used in HRT cigarettes.
3) Uprate the Minimum Excise Tax at every budget to ensure that the minimum tax for tobacco products is the rate due for products sold at the weighted average price (WAP).
4) Set a rate for the new heated tobacco products equivalent to that for 'other smoking tobacco and chewing tobacco' to be reviewed in future years.
5) Confirm that any e-cigarette which is licensed as a medicinal quitting aid will attract the same reduced VAT rate (5%) when sold over the counter as existing nicotine replacement therapies do.

Regulating the tobacco industry and illicit Trade

6) Require that standards for traceability under Article 15 of the EU TPD ensure full 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.
7) Implement a tobacco licensing system across the supply chain funded by the transnational tobacco manufacturers and importers.
8) Fund partnership working at regional level to support coordinated enforcement against the illicit trade in tobacco.
9) Require transnational tobacco manufacturers and importers to provide, for publication, comprehensive data on sales, prices and profits.

Tobacco Control Plan for England and public health funding

10) Tobacco Dependence Treatment to be embedded in the NHS as a core element of the long-term Plan, in line with the recommendations of the RCP and as committed to by the DHSC.

11) A fixed amount of funding should be raised from the tobacco manufacturers to support activity to reduce smoking prevalence, with the proportion paid by each tobacco manufacturer allocated on sales volume (with any tobacco industry involvement in setting and implementing policy precluded in line with the UK's obligations as a party to the FCTC).
12) Funding to local authorities for public health services should be protected and local authorities should pay regard to smoking outcomes when allocating resources.
13) Any long-term funding solution for local government's public health responsibilities should be properly, and equitably, funded, so as not to exacerbate health inequalities.

Taxation

16. The commitment in the recently published Tobacco Control Plan for England to *"Maintain high duty rates for tobacco products to make tobacco less affordable*"[5] is not being met due to the gaming of the tax system by the tobacco industry. Revisions to the tax structure are essential to ensure that this commitment can be met.

Taxation of smoked products

17. The methods used by the industry to undermine Government efforts to reduce the affordability of tobacco include the proliferation of cheap cigarette and hand-rolled tobacco brands and the undershifting of tobacco duty particularly on cheaper brands. These tactics all serve to widen the price gap between cheap and expensive products and smooth the price rises consumers face, reducing the impact of tax increases.[6] [7] [8]

18. Government efforts to use changes in tax structure and levels to narrow the price gap previously observed between cheap and expensive factory made cigarettes and between factory made cigarettes and hand-rolled tobacco (HRT) had some, albeit limited, impacts.[6] [7] [8] However, in the past such efforts have been undermined by industry pricing strategies.[8]

19. This has a detrimental impact on child as well as adult mortality and morbidity. Increases in the median price of cigarettes were associated with significant reductions in infant mortality across Europe between 2004 and 2014. However, pricing differentials between median and minimum cigarette prices were associated with significant increases in infant mortality.[21]

20. Although NHS Digital estimates that in 2016 tobacco was 27 per cent less affordable than it was in 2006, it is still as affordable now as it was in 1966.[22] Furthermore, existing measures of tobacco affordability use national measures of income and average cigarette prices, thus not accurately reflecting the changes in affordability for the individual smoker, in particular poorer more disadvantaged smokers who are more likely to smoke the cheapest cigarettes or HRT. For instance in 2014, because of the widening of the price gap between cheap and expensive products, smokers could still purchase factory made cigarettes at 2002 prices (and HRT at 2005 prices).[8]

21. In addition, downtrading to HRT is encouraged by the significant differential in taxation and price per cigarette between factory made cigarettes and HRT, which in

effect increases the elasticity of demand for factory made cigarettes, with a negative impact on tax revenues, without the health benefit conferred by quitting.

22. There is evidence from the Netherlands that consumption of HRT increases as the price differential between factory made and HRT increases,[23] and certainly this is the pattern we have 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.[24] We therefore recommend that in future calculations of tobacco affordability should include HRT as well as factory made cigarettes.

23. International comparisons also suggest that countries (US and Canada) which tax factory made and HRT similarly do not see a switch to HRT, while those with high taxes on factory made relative to HRT (UK, Australia) see a switch towards HRT use, although the US and Canada have lower tax rates.[7]

24. The UK Government acknowledged the health impacts of this differential, and narrowed the gap in tax levels between factory made cigarettes and HRT by increasing HRT taxes by an additional 3% above inflation in the March 2016 Budget and by an additional 1% in the November 2017 Budget.[25] This is not sufficient, as there is evidence that similar efforts in 2011 helped narrow the gap in price between HRT and factory made cigarettes, but that this price gap subsequently widened.[6 7] We therefore recommend continuing to increase taxes on HRT above the escalator, by 15% above inflation, until they are equivalent to those on factory made cigarettes taking into account the latest data on weight of HRT cigarettes.[26]

25. The equivalent tax rate for HRT can be accurately calculated using recent research on the average weight of tobacco per hand-rolled cigarette. This is likely to increase the tax take as well as reducing the likelihood of smokers downtrading to HRT rather than quitting. A 2010 survey found the median weight of a hand-rolled cigarette across 18 countries in Europe was approximately 0.75g, but England had the lowest mean weight of 0.48g.[27] More recent analysis of six waves (2006 to 2014) of International Tobacco Control (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.[26] We therefore suggest 0.5 grams be used as the average weight of a hand-rolled cigarette, and for this to be regularly assessed as the average quantity appears to be declining over time.

26. Evidence from overseas indicates that the tobacco industry will also try to exploit loopholes in tax legislation by selling HRT as pipe tobacco, if lower taxes are applied to pipe tobacco.[28] The fact that pipe tobacco is not subject to standardised packaging legislation provides an extra incentive to do this in the UK. For this reason we suggest keeping taxes on pipe tobacco in line with those on HRT and requiring the tobacco manufacturers to provide data on sales so any changes in use can be monitored in real time.

27. 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[29] and that the young, the poor, women and those living in areas of the country with high smoking rates are more likely to smoke the cheapest cigarette brands. This highlights the impact of the availability of cheap cigarettes on inequalities in smoking. [30]

28. The introduction of the Minimum Excise Tax on cigarettes in the Finance Bill 2017 (which set a floor below which tax on cigarettes cannot fall) happened subsequent to the research highlighted above. This will almost certainly have had an impact on factory made cigarettes, but needs to be regularly uprated if it is to continue to be effective. We recommend that the Minimum Excise Tax be uprated at every budget to ensure that the minimum tax for tobacco products is the rate due for products sold at the weighted average price (WAP). (NB It does not have an impact on HRT excise tax levels as they are fully specific with no ad valorem element.)

Taxation of Heated Tobacco Products

29. The Government recently confirmed that it would establish a separate category in the Tobacco Products Duty Act for heated tobacco products, with a duty rate on the basis of the weight of the tobacco, to be set at Budget 2018.[31] [32] The question is at what rate should the duty be set.

30. The independent scientific advisory body to the UK Government, the Committee on Toxicity (COT), with support from its sister organisations the Committee on Carcinogenicity and the Committee on Mutagenicity, was requested to assess the toxicological risks from novel heat-not-burn tobacco products, and compare these risks to those from conventional cigarettes.

31. Overall, the Committees concluded that *"while there is a likely reduction in risk for smokers switching to heat-not-burn tobacco products, there will be a residual risk and it would be more beneficial for smokers to quit smoking entirely. This should from part of any long-term strategy to minimise risk from tobacco use".*[33]

32. Heated tobacco products are regulated as tobacco products, so that all advertising promotion and sponsorship is prohibited, the age of sale is 18, there is a health warning on the pack and products can only come on the market after they have been notified. In 2017 awareness and use of heated tobacco products was very rare.[34]

33. Currently excise tax is being levied on heated tobacco products on a case by case basis. Although the tax rate for individual heated products has not been published, it is our understanding that it has been equivalent to the rate for *"other smoking tobacco and chewing tobacco"* which is a specific tax of £119.13 per kilogram, significantly lower than the rate for handrolling tobacco of £209.77.[35]

34. At the current time, given the assessment of COT that these products are likely to be less harmful than combustible products, we would support continuing to set a rate equivalent to that for *"other smoking tobacco and chewing tobacco"*. The tax rate levied on them should be reviewed in future years, as the evidence of relative risk grows, and the market for these products evolves. Furthermore, any so-called 'heated tobacco product' which is capable of being smoked in handrolled tobacco cigarettes should be taxed at the HRT rate.

Taxation of electronic cigarettes

35. HM Treasury has confirmed that the Government will not include e-cigarettes in the excise duty regime as *"E-cigarettes do not contain tobacco and are therefore not liable for tobacco duty".*[31] Consumer e-cigarettes, regulated under the EU Tobacco Products Directive, are therefore taxed at the standard VAT rate of 20%, which we support.

36. Medicinally licensed smoking cessation products sold over the counter have been taxed at 5% VAT rather than the standard rate since 2007.[36] [37] This should also be the case for e-cigarettes which are licensed as smoking cessation medications, however to date this has not been fully confirmed by HM Treasury and should be in the 2018 Budget. Significant investment is required by e-cigarette companies in order to acquire a medicines licence and to date no licensed product has come to market. Committing to taxing licensed e-cigarettes at 5% VAT would provide an additional incentive for e-cigarette companies to apply for a license, as well as making e-cigarettes more affordable for smokers.

Regulating the tobacco industry and controlling illicit trade

37. The UK has had an effective anti-smuggling strategy since 2000,[38] when the market share for illicit tobacco was over 20% for factory made cigarettes and over 60% for HRT. The illicit market has declined significantly since then and by 2016-17 the illicit market share for factory made cigarettes had fallen to 15% and for HRT to 28%.[39]

38. This has resulted in significant benefits to government revenues. Although the tax gap is the same now in monetary terms as it was in 2000, in real terms it is significantly less, and it would have been very much higher if the illicit trade had remained at the levels seen in 2000, particularly since tax rates have risen above inflation.[40]

39. In recent years, however, the illicit market for factory made cigarettes in the UK has stabilised in volume terms, at around 5 billion sticks per annum between 2010 and 2016. However, the market share has begun to grow again, from 10% in 2010/11 to 15% in 2016/17, as smoking prevalence has declined significantly in recent years from 20.2% in 2010/11 to 15.8% in 2016, so it is a bigger proportion of a smaller total. More positively, the size of the illicit market for handrolled tobacco has declined in both volume and market share, from 4.2 million kg (39%) in 2010/11 to 2.7 million kg (28%) in 2016/17.

40. We were disappointed by the lack of ambition in the most recent illicit strategy published in March 2015, which only committed to hold the cigarette market share at or below 10% and to contain the illicit market share for HRT and reverse the upward trend observed at that time.[38] Over the course of this Parliament the ambition should be to reduce the market share of illicit cigarettes back to the levels in the early 1990s, when it was about 5%, and to significantly reduce the illicit market share for HRT to similar levels as that for factory made cigarettes.

41. Proposals to improve both the effectiveness of enforcement of illicit tobacco legislation and provide additional dissuasion to individuals engaged in committing offences were set out in the HMRC consultation on tax evasion. In its response to the consultation in November 2017 HMRC said that it would, *"take forward further work on legislative and non-legislative options to strengthen the use of sanctions in light of the consultation feedback*."[41] The outcome of this work is still to be announced, and we hope that it will be by the time of the 2018 Budget.

42. We also urge the Government, in line with recommendations from the Public Accounts Committee[42], to do more to hold the industry to account given growing evidence of its ongoing complicity in the illicit tobacco trade.[43] Over the last few years, whistleblowers[44], researchers[45] , investigative journalists[46] and government reports[47] [48] suggest that industry involvement in the illicit tobacco trade has continued

subsequent to the four leading transnational tobacco companies one by one signing agreements with the EU to combat smuggling, starting in 2004. [49]

43. At best, the evidence indicates that tobacco companies are still failing to control their supply chain in the knowledge their products will end up on the illicit market.[49] Reports suggest, for example, that the tobacco industry is deliberately over-producing cigarettes in some markets (e.g. Ukraine) and oversupplying tobacco to others (e.g. the Benelux countries), in the apparent knowledge that these products will end up being sold on the illicit market.

44. This evidence is supported by data from diverse sources, including UK data commissioned by the Department of Health and Social Care (Operation Henry). While obtaining accurate data on the illicit tobacco trade is notoriously difficult- data at global, EU and UK level are remarkably consistent in showing that the majority of the illicit cigarette market still comprises tobacco industry product, with estimates varying from 58% (2016, EU level, industry funded data) to 69-73% (seizure data for 2011 and 2012 at global level and 2014 and 2016 at UK level).[49]

45. By comparison the problem of counterfeit tobacco products, which the industry repeatedly emphasises as the major problem, is minor, comprising around 5%-8% of the market. Illicit (or cheap) whites comprise around a fifth to a third of the illicit market, but these figures may hide tobacco industry illicit. For example, in the industry commissioned Project Sun report undertaken by accountancy firm KPMG, the Imperial Tobacco brand, Classic, was incorrectly classified as a cheap white during a period (2006-12) in which it was one of the most seized brands in Europe.[50]

46. Similarly, in the latest Operation Henry report[51], the two most seized brands, West and Winston, were coded as cheap whites yet are tobacco industry brands (sold in the UK by Imperial Tobacco and Japan Tobacco International respectively). Consequently, data may underestimate the total contribution of tobacco industry illicit.

47. It is important to take note of these data given the tobacco industry's documented attempts to deliberately distort the messaging and public discourse on illicit in order to emphasise the problems of counterfeit and illicit whites.[52] [53] [54] [55]

48. A recent systematic review has found that industry-funded data and reports on illicit routinely overestimate the scale of the problem and feature substantial methodological problems while failing to meet the standards of accuracy and transparency that are set by high-quality peer-reviewed publications.[56]

EU Tobacco Products Directive and WHO FCTC Illicit Trade Protocol

49. What is self-evident from the above is that better control of the legitimate supply chain, as required by the EU Tobacco Products Directive and the WHO FCTC Illicit Trade Protocol which the UK has ratified, is essential if we are to continue to reduce the size of the illicit market.[49]

50. The UK is implementing the tracking and tracing requirements of the Tobacco Products Directive, and has committed to Parliament that it will remain aligned with the EU after Brexit.[57] This will ensure that we can meet our obligations following ratification of the Illicit Trade Protocol to have in place an effective tracking and tracing system.

51. It is crucial that the UK ensures that the traceability system, application of security features, and at least the secondary repository of data generated by the traceability system, which are the key elements of the traceability regime required by the EU Tobacco Products Directive, be operated wholly independently of the tobacco industry. This is to ensure that it is in line with the criteria established in the Illicit Trade Protocol and consistent with Article 5.3 of the WHO Framework Convention on Tobacco Control.[49] [58]

52. The latest evidence suggests the tobacco industry is attempting, largely through the use of third parties, to have Codentify, the track and trace system it developed implemented as the global track and trace system of choice.[49] Not only is Codentify shown to be inefficient and inadequate as track and trace system[58] [59], but industry links and potential control over such a system would enable its ongoing involvement in tobacco smuggling and make the global illicit trade far harder to control.[49]

53. Given that the illicit tobacco trade is an international issue, the UK government can play a vital role in ensuring governments around the world do not fall prey to the tobacco industry's attempts to undermine the illicit trade protocol in this way.

Data Collection and publication

54. As a party to the WHO FCTC, the UK is required to implement stringent regulation of the tobacco industry, far greater than for 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.

55. Taxpayer confidentiality has been cited as a reason why publication of sales and other data is not possible in the UK. Yet such data are 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; in the US, the Federal Trade Commission issues reports on the tobacco industry, which cover sales, advertising and promotional expenditures. [60]

56. In Canada an act passed this year gives the Government power to require the industry to report on its sales and marketing activity and for this information to be put in the public domain. This will include (and there is a clause allowing supplementary information to be required once notified by the Minister) [61] :
    - the total sales, as well as the sales by brand and package type, monthly for cigarettes and cigarette tobacco, and quarterly for all other tobacco products; and
    - their records on research and development activities for all tobacco products every six months.

57. We strongly recommend that the UK Government implements a policy requiring the tobacco industry to provide for publication the following data in a standard agreed electronic format so as to be easily aggregated, accessible and analysable:

    At national and international level on an annual basis:
    - profits,
    - taxes (excise duties and corporation tax).

At national level, on a monthly basis:

- Brand specific price and sales data for all products;
- Marketing spend by category (consistent with Federal Trade Commission categorisations and also including spending on CSR);
- research spend by subject area.

At local authority level:

- Sales data by product type for all products (including factory made, HRT, heat not burn, e-cigarette).

58. The tobacco manufacturers already collect this data and some, if not all, is already provided to HMRC; all that is needed is for HMRC to publish the data.[62]

59. The importance of this in order to accurately measure tobacco prices and determine appropriate tobacco tax policy has been recently outlined in research on UK cigarette prices and highlighted above. 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.[30] 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.

60. Benefits to HM Government would include:
    - Better understanding of market developments to inform the development of tobacco control and tobacco tax policy, for example on tax structure.
    - Enabling future research on the price sensitivity of tobacco consumption by academic researchers to support work carried out by HMRC.
    - Better identification and 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.
    - More accurate assessment of whether tobacco companies are paying appropriate levels of corporation tax

Regional partnerships

61. 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 (NAO) 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. The NAO also encouraged HMRC to roll out such partnerships nationally.[63]

62. The success of such partnerships is shown by their impact in the North East and North West, which have had concerted multi-agency enforcement activity and effective evidence-based demand reduction measures in place since 2007, supported by the work of the Illicit Tobacco Partnership. Between 2009 and 2015 the illicit market had declined by more than a third in the North East from 15% to 9%, while the decline at national level was less than a fifth, from 12% to 10% - this followed a concerted multi-strand focus on illicit tobacco to reduce both the demand and supply.

63. Unfortunately, not only has there not been a further roll out of such regional partnerships nationally since the NAO report, but the only remaining regional partnership is now in the North East with the South West and North West partnerships disappearing following a total cut in funding. To date none of the funding for such partnership working or social marketing has come from HMRC, it has come either from localities or from the Department of Health and Social Care.

64. The trading standards staff, who cover a wide range of consumer protection responsibilities and are crucial to effective collaborative working on the illicit trade, are increasingly under threat. During the last six years, total spend nationally on trading standards has fallen from £213m in 2010 to £124m in 2016,[64] and by 2018-9 it is due to fall to just over half that, at £108 million.[65] Teams have been cut to the bone, with the NAO calculating that the number of full-time equivalent Trading Standards staff decreased by 56% in seven years, from 3,534 in 2009 to 1,561 in 2016, with 81% of services considering that funding reductions have had a negative impact on their ability to protect consumers in their area.[66] This underlines the benefit of working across a bigger footprint in order to achieve economies of scale and improved efficiency.

65. 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.

Licensing of the supply chain

66. In 2016 HMRC consulted on the introduction of licensing of the tobacco industry supply chain, but only went ahead with licensing the use and ownership of tobacco manufacturing machinery. The consultation also included licensing of the whole of the supply chain, which is recommended in the Illicit Trade Protocol. We support a licensing system:
    - **For manufacturers and importers**: a licence to import or manufacture combustible tobacco products, with the cost of the licence allocated on the basis of sales volumes; a requirement to only supply and distribute product through licensed distributors and wholesalers; and a requirement to provide information on sales volumes by region/locality each year
    - **For distributors and wholesalers**: a licence to transport combustible tobacco products, with mandatory security requirements and tracking controls; a license to sell products with a cost reflecting the harm caused; a requirement to provide customer and sales data; and a requirement only to supply retailers who have a valid current licence
    - **For retailers**: a licence to sell combustible tobacco products, covering both named premises and designated responsible individuals.

67. We have provided a detailed brief to HMT and HMRC pointing out that an effective positive licensing scheme could offer the following benefits:
    - Help incentivise quitting and/or switching to less harmful nicotine products.
    - Help drive out those involved in the criminal supply of illicit tobacco at all levels of the supply chain.
    - Act as an effective deterrent to participants in the licit tobacco supply chain also participating in the illicit tobacco supply chain, either through the direct supply of illicit tobacco or through negligence in applying appropriate supply chain controls.

- Help to protect the business of legitimate retailers who obey tobacco control legislation. These businesses make very low profit margins from selling tobacco itself, and contrary to claims by the tobacco industry, tobacco is no more a significant driver of "footfall" in small retailers than any other common product.[19] However, law abiding retailers clearly face economic losses if their business is undercut by sales of illicit tobacco.
- Help to protect tax revenues. Tobacco excise tax raised £9.5 billion in 2015/16, and the total tax revenue lost because of illicit tobacco was estimated to be £2.4 billion (HMRC mid-range estimate).

68. Legitimate retailers and wholesalers would be protected by licensing, since it would reduce unfair competition from the illicit tobacco trade. Surveys of small retailers show strong support for licensing. In a survey conducted for ASH in 2016, 69% of retailers supported the introduction of a tobacco license that retailers could lose if they broke the law.[19] While retailers make low profit margins on tobacco, the four major tobacco companies are some of the most profitable companies in the world, and could easily meet the costs of a licensing scheme.[16] [17]

69. The distribution of a proportion of the fees from a national 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.

70. Opinion poll results show strong public support for the licensing of tobacco retailers and for requiring tobacco manufacturers to pay for the costs of regulation of the industry.[18] Indeed, anecdotally most people think that retailers already need to have a licence to sell tobacco products and are surprised that there is no regime in place.

71. In YouGov polling conducted for ASH (February/March 2017), respondents were asked how strongly, if at all, they would support the following measure: requiring businesses to have a licence before they can sell tobacco. Net support for this statement was 76%.[18]

Comparison with Retailer Registration

72. In Scotland, a Tobacco Retail Register was introduced in 2011. Registration is free and can be done online. Anyone can be registered as there are no entry requirements. Applications can be made for multiple premises. As at August 2015, only five retailers had been banned from selling tobacco on a temporary basis.

73. A similar system has been introduced in Northern Ireland[67] following a formal consultation, and the Welsh Government has also published plans to create a Register. Unlike the Scottish and Northern Ireland Registers, in Wales there would be a registration fee, believed to be £30.

74. Although we consider registration schemes in these three jurisdictions as an important step forwards from previous arrangements, we consider that they do not offer the full range of desirable controls for the regulation of the tobacco supply chain.

75. Key issues with such schemes are:
    - They are limited to the retail component of the supply chain.

- Rather than being pro-active and prevention-oriented, negative licensing/registration is reactive and primarily a means to respond after problems have occurred.
- Negative licensing/registration does not allow for any prior assessment of whether a tobacco retailer is a fit and proper person to sell tobacco.
- If there is no licence fee there is no consequent revenue stream to support administration and enforcement programmes.
- Negative licensing sends a weak message to wholesalers and retailers about the importance of obligations under tobacco control laws, as compared with alcohol and gambling.

Tobacco Control Plan for England

76. The Tobacco Control Plan for England 2017 with its commitment to driving down smoking prevalence to achieve a smokefree generation is very welcome. However, experience elsewhere shows what can happen if we do not ensure that the strategy is properly funded. Since 2007 the UK has scored highest for tobacco control policy implementation in Europe.[68] 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.

NHS Long-term Plan

77. Health Ministers have put on the record in both houses of parliament a commitment that ensuring tobacco dependence treatment is provided by the NHS is a key priority for the NHS 10 year plan currently under development, in line with the recommendations in the Tobacco Control Plan for England and proposals made by the Royal College of Physicians.[69] [57] [70] This is in addition to, not instead of, the important public health role played by local authorities.

78. Delivering on this commitment will ensure in-year efficiency savings for the NHS, improving both treatment outcomes and quality of life for patients. It is crucial therefore when the NHS Plan is being reviewed by HM Treasury, that there is support for this element of the Plan.

79. There is a strong clinical justification for the treatment of tobacco dependency to be provided for all patients using the NHS, as quitting smoking will, almost without exception, prevent potential exacerbation of, or increased risk of complications for all presenting conditions.

80. On average smokers lose ten years of life, a loss of 11 minutes for every cigarette smoked,[71] 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, many of which, such as heart disease, respiratory diseases, and numerous types of cancer can lead to many years of disability before death.[72] [73]

81. Tobacco dependence treatment can also help deliver on the Government's ambition to have the best cancer outcomes in the world. A third of lung cancer patients still smoke at diagnosis currently, and the majority continue to smoke. Lung cancer patients who quit smoking live on average 1.97 years, compared to only 1.08 years for those who continue smoking, with improved quality of life. Yet currently only 24% of lung cancer patients who smoke are offered advice to quit by their GPs and only 13% are prescribed stop smoking treatment. [74]

82. In Ottawa a model of opt-out rather than opt-in specialist smoking cessation treatment, including behavioural support and medication, is being provided very successfully on site to patients in hospitals. The Ottawa model is very similar to the RCP report proposals for full NICE PH48 guidance implementation, and audited outcomes[75] show it to be highly effective and cost-effective:
    - 35% of the smokers who received model treatment were smoke-free at 6-month follow up, compared to only 20% of the usual care patients.
    - Smokers who received model treatment were 50% less likely to be re-admitted to the hospital for any cause, and 30% less likely to visit an emergency department in the 30 days following their initial hospitalization.
    - Smokers who received model treatment were 21% less likely to be re-hospitalized and 9% less likely to visit an emergency department, 2 years following their hospitalisation.
    - There was a 40% reduction in 2-year mortality risk among patients who received the Ottawa Model.

83. Longer-term benefits of a comprehensive approach to supporting smokers in the NHS to quit, in line with recent RCP proposals, would be even greater. The total recurring cost of smoking each year to secondary care is calculated by the RCP to be £890 million for current smokers which includes health costs of patients across 52 tobacco related diseases and the costs of absenteeism and lost productivity amongst NHS staff who smoke. Much of these costs are avoidable.[69]

Public Health Funding

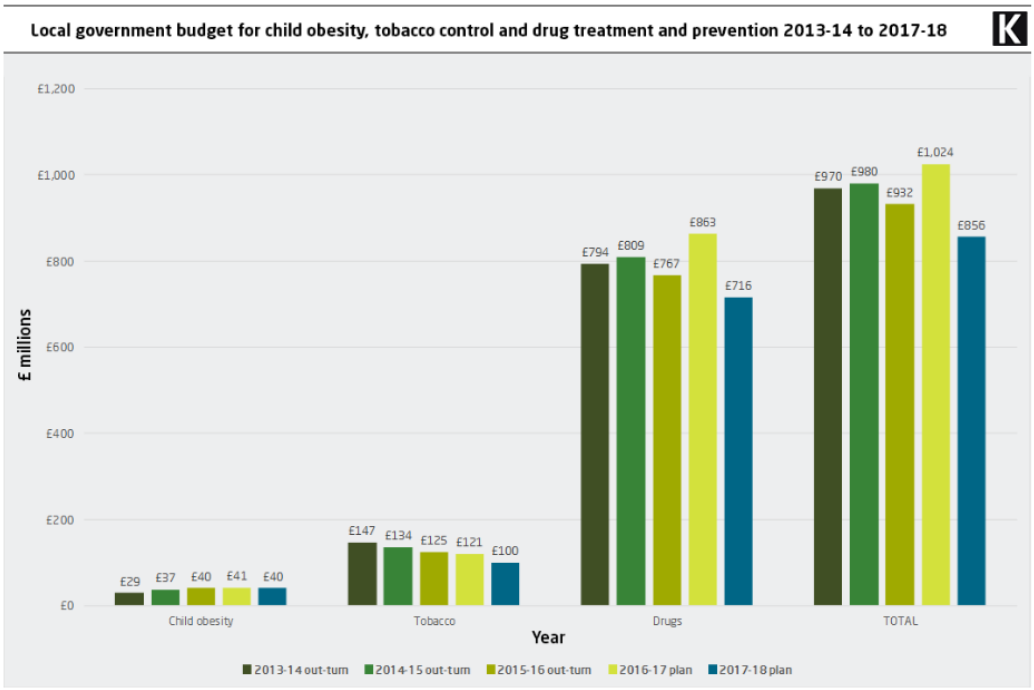
84. A properly funded prevention and public health system is essential to achieving the ambitions set out in the Tobacco Control Plan for England[5] as well as the sustainability of the NHS. The UK is rightly regarded as a global leader in tobacco control, and there has been a steady fall in smoking rates over several decades. 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.

85. Yet in practice there have 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.[76] Subsequently the Government announced a further cash reduction of 9.7% between 2016/17 and 2021.[77]

86. 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[78] were transferred from the NHS to local authorities in 2010, and are now being cut in response to these budget cuts. Local enforcement on age of sale of tobacco, smokefree laws and illicit trade, is also likely to disappear.

87. 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.[79]

88. An analysis by the King's Fund of DCLG returns (see below) shows that spending on tobacco control by local authorities declined by 32% between 2013-14 while spending on obesity increased by 38% and on drug treatment and prevention, from a much higher base, spending has only fallen by 12%.



Source: King's Fund analysis of local government budget and spending returns

89. The 2017 drugs strategy estimated the cost of illicit drugs to be £10.7 billion[80], just over half of which is attributed to drug-related crime, while the cost of smoking is estimated to be in excess of £11 billion.[5] In 2015 there were 2,479 deaths related to drug misuse in England and Wales compared to over 80,000 from smoking. Only 2.7 million people have reported using an illicit drug in the previous year, and the National Audit Office has estimated that only a small proportion of these (a third of a million in 2010[81]) are problem drug users. That compares with 6.1 million smokers[82], half of whom will die prematurely from smoking-related diseases losing on average 10 years of life.

Making the tobacco industry pay

90. Funding needs to be found to sustain a properly funded tobacco control strategy at national, regional and local level. 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 effective tobacco control measures. Such measures include mass media campaigns, smoking cessation services, and enforcement activity such as age of sale compliance and tackling illicit tobacco.

91. Tobacco manufacturers and importers in the UK are immensely profitable, such that they could certainly afford to make a greater contribution. In the UK the industry makes at least £1 billion in profits a year; this profitability has been increasing during

the period of analysis, and profitability is likely to be in the region of £1.5bn per annum in recent years.[16] [17]

92. Tobacco manufacturers and importers are also found to enjoy consistently high profit margins of up to 68%, compared with only 15-20% in most consumer staple industries.[16] Given UK based tobacco companies pay very little corporation tax despite reporting high profits earned in the UK[16] [17], they should be subject to the diverted profit tax at the higher 33% rate now applied to the banking industry.

93. Furthermore, 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.

94. 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%[83] and is the cause of a range of illnesses in children including being the leading modifiable risk factor for sudden infant death syndrome.[84]

95. For these reasons the Government consulted 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."* [15]

96. The Government decided not to proceed with a levy, but the principle that the tobacco industry should make a greater contribution remains. This could be achieved by a variety of means including through increased excise taxes, licensing, a surcharge on corporation tax, or imposing a 'user fee' or charge on the industry.

97. A *"user fee"* is in place in the United States[85] [86] to fund regulation of the tobacco manufacturing industry, in which a fixed amount is set for the industry to pay, allocated on the basis of their sales of tobacco products. A Legal Opinion for ASH concluded that such a licence fee or "*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.

98. We therefore recommend that tobacco manufacturers and importers be made to pay a fixed amount on the basis of the polluter pays principle, with the proportion paid by each manufacturer to be allocated on the basis of volume sales of cigarettes, to ensure that the industry makes a greater contribution to the damage it causes society. This would be used to make funding 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.

99. Respondents to the ASH YouGov poll were also asked how strongly, if at all, they would support the following measure: requiring tobacco manufacturers to pay a levy or licence fee to Government for measures to help smokers quit and prevent young people from taking up smoking. Net support for this statement was 71%.[18]

ANNEX 1

Organisations endorsing ASH's submission to the 2018 Budget

Association of Directors of Public Health	Yorkshire & the Humber ADPH
Association of Respiratory Nurse Specialists	Breathe2025
British Heart Foundation	British Thoracic Society
Cancer Research UK	Diabetes UK
Faculty of Public Health	Fresh – Smoke Free North East
Gateshead Smokefree Alliance	Plymouth City Council
Royal Borough of Kingston upon Thames	Royal College of Physicians
Royal College of Radiologists	Smoke Free Newcastle
South Tyneside Tobacco Alliance	The Lullaby Trust
Trafford Council	

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