2016 Budget submission to the Chancellor of the Exchequer

Introduction

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. It receives funding from the British Heart Foundation and Cancer Research UK for this work. The UK Centre for Tobacco & Alcohol Studies (UKCTAS) was created in 2008 and includes research teams in nine UK universities. It is one of five Public Health Research Centres of Excellence, funded by the UK Clinical Research Collaboration. Neither organisation has any direct or indirect links to, or receive funding from, the tobacco industry.

1. This paper sets out our joint recommendations on tobacco policy in tax and related areas in advance of the forthcoming Budget.

Recommendations

2. Set out below are our key recommendations:

Tobacco Levy and public health funding

1) Introduce a tobacco levy to raise £500 million with funds to be used to support an evidence-based strategy at national, regional and local level to discourage youth uptake and help smokers to quit.
2) Require tobacco manufacturers and importers to make publicly accessible marketing and price data at national level; and aggregate data on sales by volume broken down to local authority level.
3) Ensure that any funding solution for public health in the context of the return of business rates to local authorities is properly, and equitably, funded, so as not to exacerbate health inequalities.

Taxation

1) Increase the tobacco tax escalator from 2% above inflation to 5% above inflation.
2) Set corporation tax on tobacco manufacturers at 28%, a return to the level for 2010, and ensure that tobacco companies are liable to the diverted profit tax at the higher 33% rate applied to the banking industry. The extra funds raised by both measures to fund measures to reduce smoking prevalence.
3) Increase taxes on hand rolled tobacco (HRT), using a 15% tax escalator, until they are equivalent to those on manufactured cigarettes.
4) Introduce a minimum consumption tax (MCT) for all tobacco products.
5) Ensure that the specific tax element for manufactured cigarettes is the maximum allowed under the revised EU tax directive.
6) Support the revision of the EU Tobacco Tax Directive to:
    - 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); and
- Oppose the inclusion of electronic cigarettes as an excisable product.

7) Require that VAT levied on electronic cigarettes licenced as medicines is set at 5% in line with other medicinally licenced nicotine replacement therapies.

Illicit Trade

8) Introduce new targets of a market share for illicit cigarettes of no more than 5% by 2020 and for hand-rolled tobacco to no more than 22% by 2020 and no more than 11% by 2025.
9) Fund inland work to reduce the illicit trade in tobacco, to replace the funding being cut from public health budgets
10) Name, shame and fine manufacturers who fail to adhere to supply chain controls set out in legislation, and publicly critique industry attempts to misrepresent the data on the size of the illicit market
11) Ratify the Illicit Trade Protocol to the WHO Framework Convention on Tobacco Control
12) Launch the consultation on licencing of tobacco machinery and retailers without further delay
13) 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.

Tobacco levy and public health funding

3. Since 1999 the government has ensured that there is a comprehensive strategy in place driving down smoking prevalence. Over time this strategy has had considerable impact. Smoking prevalence in England, as measured by government surveys, has fallen significantly over the last ten years, by an average of 0.66 percentage points per annum, from 25% in 2003 to 18.4% in 2013.[1] The fall has been as fast, or faster, than in other countries with strong anti-tobacco policies such as Australia.[1] Smoking rates among children aged 11-15 have fallen even faster over the same time period, from 9% to 3%, a fall of two thirds.[2]

4. However, smoking remains the primary cause of preventable premature death, killing just under 80,000 people per annum in England[3] and 100,000 in the UK, more than the next five causes put together, including obesity, alcohol and illegal drugs.[4] Half die before normal retirement age,[5] during productive life years, with twenty times as many smokers as die each year suffering from disease and disability caused by their smoking.[6] [7]

---

[1] Smoking Still Kills. Protecting children reducing inequalities. ASH, 2015.
[2] Smoking drinking and drug use among young people in England in 2014. HSCIC, 2015
[3] Statistics on Smoking, England - 2015 HSCIC, 2015
[4] ASH. Fact Sheet: Smoking statistics. Illness and death November 2014.
[5] Doll R, Peto R, Boreham J, Sutherland I. Mortality from cancer in relation to smoking: 50 years' observations on male British doctors. British Journal of Cancer 2005: 92: 426-429.
[6] US 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: USA, 2010.
[7] Cigarette smoking-attributable morbidity – United States, 2000. Cigarette smoking-attributable morbidity – United States, 2000 MMWR Weekly Report. 5 Sep. 2003

5. The costs of this to society in England alone were quoted at £12.9 billion in HMT's Tobacco Levy consultation document[8] made up of:
    - £2 billion cost to the NHS of treating diseases caused by smoking
    - £3 billion loss in productivity due to premature death
    - £5 billion cost to businesses of smoking breaks
    - £1 billion cost of smoking-related sick days
    - £1.1 billion of social care costs of older smokers
    - £391 million cost of fires caused by smokers' materials

6. Subsequently the figures have been updated by ASH and now amount to an estimated £13.9 billion[9]. Yet when the Chancellor decided not to proceed with the tobacco tax levy, it was based on an HMRC analysis of the impact of the levy which did not include indirect economic effects of policy changes in the policy costings. With public health policy in general (and tobacco control policy in particular), most of the positive effects arise through indirect channels (e.g. reduced mortality and morbidity, increased productivity etc) and restricting policy costings to direct yield from a policy instrument (a levy in this case) almost inevitably downplays the positive potential for public health and economic gain. In other words this particular methodology leads to a bias against public health interventions in HMT's spending allocation decisions.

7. Furthermore, according to the NHS Five Year Forward View, even after the £8 billion additional NHS funding promised by the Government there will be a funding gap of £22 billion by 2020. The report acknowledges that *"The future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."*

8. Yet funding for tobacco control in key areas of tobacco control in England has been cut and is being cut still further. The cuts hit spend on 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 is estimated to be only £5.86 million for the year 2015-16 (see below).

9. Mass media campaigns to reduce smoking are proven to be highly cost-effective, if properly funded. CDC's 2014 best practice recommendation for spend on what they call 'mass reach health communication interventions' is $1.69 per capita. At 2014 population estimates of 53.01 million for England, this would be equivalent to $90 million, around £57 million at today's exchange rates, around ten times the amount currently being spent.

Financial year[10]	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

[8] HM Treasury. Tobacco Levy: consultation document. December 2014.
[9] ASH factsheet. The economics of tobacco. December 2015.
[10] Data taken from Parliamentary questions: http://bit.ly/1UyijYs updated by PHE to include figures for 2013 onwards. Figures for 2015-16 are provisional.

2015-16*	5.86

10. The cost per quality adjusted life year (QALY) of the recent FDA campaign *Tips from Former Smokers* was calculated to be $383[11] (the equivalent of £240 at current rates of exchange) way below the £20,000 to £30,000 cost per QALY threshold set by NICE.[12] In a UK context, Stoptober 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.[13]

11. Other studies carried out in England in the past few years have found that mass media campaigns have been effective in triggering quit attempts and have been responsible for a significant proportion of the reduction in smoking prevalence,[14] and that the freeze on mass media campaigns was associated with a reduction in quitting activity.[15] A systematic review of economic evaluations of mass media campaigns noted that all of these found mass media campaigns to be cost effective[16], but these campaigns need to have sufficient intensity and be sustained in order to have a meaningful effect[17].

12. Furthermore there have been significant cuts in local authority public health budgets which threaten resourcing for tobacco control more broadly. In 2013/14, local authorities received £2.7 billion as a ring-fenced grant for public health services, in 2014/15 the grant was £2.79 billion, and the original grant for 2015/16 was also £2.79 billion (a reduction of 2% in real terms) [18] [19] However, in his July 2015 Budget statement, the Chancellor announced a further in year reduction in the 2015/16 grant of £200 million.[20]

13. Yet more cuts are on the way. Most recently in the Spending Review in November 2015 the UK Government announced that the public health system in England faced cuts of 3.9% a year in real terms between now and 2020/21.[21] This translates into a further cash reduction of 9.6% in addition to the £200 million of savings that were announced in July 2015. From the baseline of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21.

---

[11] Xu, Xin, et al.,. Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign American Journal of Preventive Medicine, 2014.
[12] NICE. Measuring effectiveness and cost effectiveness: the QALY. 20 April 2010
[13] 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.
[14] 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
[15] 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
[16] Atusingwize E, Lewis S, Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review Tobacco Control 2015: 24: 320-327
[17] 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.
[18] Public Health England's grant to local authorities: National Audit Office 17 Dec 2014
[19] LGA Briefing on Public Health Settlement for 2015/16: Local Government Association 3 Oct 2014
[20] HM Treasury. Budget, 8 Jul 2015.
[21] HM Treasury. Autumn Statement, 25 Nov 2015

14. We have serious concerns about the impact that these cuts are already having, and will have, on tobacco control delivery at local level. Smoking cessation services which used to be universally available to all smokers and increased the success of quit attempts fourfold[22] were transferred from the NHS to local authorities in 2010, and are now being cut in response to these budget cuts as noted in point 33 above. Local enforcement of age of sale of tobacco, smokefree laws and illicit trade, is also likely to disappear.

15. The Department of Health has conducted a public consultation on how public health funding should be allocated between local authorities from April 2016 onwards. The consultation closed on 6th November 2015. [23] Analysis by the Faculty of Public Health suggests that the DH proposals could result in a reduction in the share of resources going to poorer local authority areas relative to richer ones, from a ratio of about 2.5 to 1 per head to about 2 to 1, making the impact on public health worst in those areas with the greatest problems, including the highest smoking prevalence rates. [24]

16. There are already wide variations in council spending on reducing smoking. Using local authority revenue expenditure and financing for 2015 to 2016, ASH calculated the intended spend per smoker by each local authority for this financial year. [25] The average intended spend is £21 per smoker and the range is from £4 per smoker to £49 per smoker (excluding City of London and Isles of Scilly). There is no strong correlation between local authority areas with high rates of smoking and their spending on reducing smoking. The average spend among the ten authorities with the lowest rates of smoking is £21 per smoker (ranging from £11 to £31). Among the ten authorities with the highest rates of smoking the average spend is actually lower at £19 per smoker (ranging from £6 to £38).

17. There is already evidence of disinvestment in tobacco control at a local level. Councils faced with cuts to their budgets are reducing their investment in stop smoking services and in other areas of tobacco control. A survey by ASH and Cancer Research UK found that smoking cessation budgets were cut in 39% of upper-tier local authorities in England in 2015-16, including 29% where the cut was greater than 5%. Budgets increased in 5% per cent of local authorities. Wider tobacco control budgets were cut in 28% of local authorities and increased in 10%.[26]

18. England has three regional offices of tobacco control operating at a subnational level, funded by local authorities in the northeast, northwest and southwest. These have been found to be highly effective and cost-effective in increasing the rate of decline in smoking prevalence above the national average, and they are included in the NICE return on investment tool for tobacco control as a good return on investment. The work they do is highly innovative, for example they have run successful paid for mass media campaigns backed up by intensive media advocacy, and campaigns to reduce the supply of, and demand for, illicit tobacco. The regional office in the southwest has just had its funding terminated with six months' notice. Funding for the offices in the northeast and northwest, both areas of deprivation with high smoking rates, are also

[22] 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.
[23] Public health formula for local authorities from April 2016: Department of Health consultation, first published 8 Oct 2015
[24] Barr B & Taylor-Robinson D. Spending review - public health funding cuts set to increase health inequalities: University of Liverpool, 7 Dec 2015
[25] Letter to the Chancellor: Smokefree Action Coalition, 26 Nov 2015
[26] Reading Between the Lines: results of a survey of tobacco control leads in local authorities in England: ASH and Cancer Research UK, Jan 2016

under threat. Three local authorities in the northwest have already given notice of termination of funding for 2016/17.

19. Early indications are that funding cuts in mass media spend and public health budgets are already threatening our ability to continue to reduce smoking prevalence. The latest data from the Smoking Toolkit Study, a monthly household survey of representative samples of approximately 1800 adults per wave (16+ years old) in England amounting to more than 20,000 respondents per year, suggests that smoking prevalence has stopped declining and may have started to go up again (headline figures are 18.5% in 2014 to 18.7% in 2015 with 95% confidence intervals of ±0.5%).[27] This is the first time since the survey started in 2007 we have seen an increase in the headline figure; prior to that the average annual decrease over the previous 7 years was 0.8 percentage points per annum.

20. This is in line with what has happened in other jurisdictions when funding has been cut. For example New York City, where sustained investment from 2002 led to declines in smoking rates until 2010, when the decline ceased following funding cuts. Investment was reinstated in mass media campaigns in 2014 and the rates began to decline again.[28]

Potential Impact of Returning Business Rates to Local Authorities

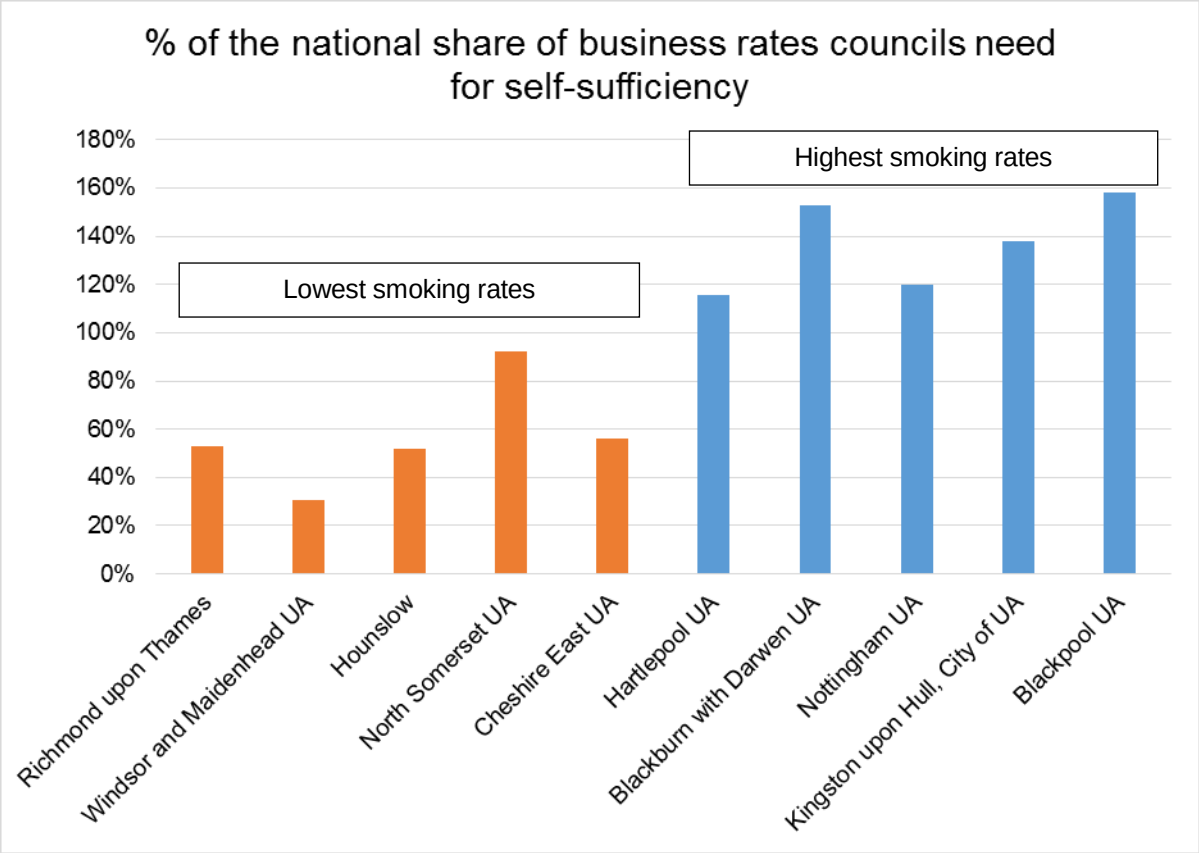
21. In the 2015 Autumn Statement the Chancellor proposed that a future funding solution for public health could come through returning more of business rates to local authorities. Absent other measures, however, this could worsen health inequalities.

22. 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. The Local Government Chronicle undertook an analysis in October 2015 to determine the 'winners' and 'losers' from returning the national share of business rates to local authorities while ending the Revenue Support Grant.[29]

23. ASH has applied their analysis to smoking rates across the country. 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%. 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. Using the LGC calculations the 5 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%.

24. 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. This may require increases in the ring-fenced grant for public health, and changes in the way in which it is distributed (see chart below).

[27] Smoking Toolkit Study. STS 140721. Top Line Findings from the STS. 31 December 2015.
[28] Goldberg D. NYC smoking rate drops to lowest on record. Politico New York, 16 Sept 2015
[29] Calkin S. Business rates reform explained. Local Government Chronicle 7 Oct 2015



25. In particular, the Budget should include:
    - Proposals to ensure that public health activity at a local level is not further reduced as a result of funding imbalances produced by returning the central share, *including* any required increase in the ring fenced public health grant, and changes in the way in which it is distributed to ensure that it properly reflects health inequalities
    - Specific funding for local tobacco control policies, including but not limited to stop smoking services. As far as possible, the cost should be borne by the tobacco industry, which is highly profitable and whose products still kill around half of all lifetime smokers. This could be achieved through a further increase in the tobacco tax escalator, or a levy on tobacco industry profits, or both.

26. Policy work has already been carried out to determine alternative ways through which the necessary investment in tobacco control activity could be guaranteed. For example, a recent report published by the All Party Parliamentary Group on Smoking and Health sets out the evidence for higher investment in tobacco control, funded through higher rates of taxation on tobacco products. The report found that an increase of £100 million per year in funding to reduce smoking, combined with a 5% tax escalator on tobacco products, could deliver a return on investment of around 11 to 1, from various factors including gains in productivity, reductions in sickness absence from work, reductions in disability benefits, and reductions in costs to the NHS and to local authority social care budgets.[30]

27. A report for ASH by Mr Howard Reed of Landman Economics suggested that £500 million a year could be raised through a tobacco levy of 25p per packet of 20 cigarettes in 2015-16, rising to between 28p and 29p per packet by 2019-20 (depending on

[30] Representation to the 2015 Spending Review. All Party Parliamentary Group on Smoking and Health Oct 2015

assumptions made about how much of the levy would be passed on in price rises to consumers). Around four-fifths of the total levy payment would come from the two firms with the biggest presence in the UK tobacco market, Imperial and JTI. If the revenues from a tobacco levy were distributed equitably across health service providers in the four countries of the United Kingdom, England would receive around 83 percent of total revenues, compared with 10 percent for Scotland, 5 percent for Wales and 3 percent for Northern Ireland. [31]

28. The Chancellor rejected the idea of a tobacco levy partly on the basis that the costs would be passed on to consumers. However, even if the industry did pass on the full cost of any levy, the public would support such additional taxation if it were spent on tobacco control measures. Indeed 78% of the adult population, including a majority of smokers, would support a levy that raised an additional £500 million if the money raised were to be used to discourage youth uptake and help smokers to quit.[32] If any money raised simply went into the Consolidated Fund this would be an unfair additional burden on smokers, who are predominantly amongst the poorest and most disadvantaged in society.

29. However, the main reason for not proceeding with the levy was an economic analysis by HMRC which showed that a levy of £150 million would only raise £25 million after behavioural effects.

30. A review of HMRC's analysis conducted by the chief economist at the Department of Environment, Food and Rural Affairs quotes an HMRC estimate a *"short-run price elasticity of demand for tobacco products of -0.57".* However, the predicted amount by which levy proceeds would be offset by a fall in tobacco duties suggests that a higher estimate of elasticity was in fact used (perhaps the HMRC's current *"long-run"* estimate of elasticity, which is -1.19). Alternatively it may be that the HMRC analysis includes assumptions about likely downtrading by smokers to cheaper tobacco brands as prices rise. HMRC has not published their full workings, and these are not set out in the report of the DEFRA review.

31. In any event, we are sceptical of HMRC's long-term elasticity estimate, which is much higher than the results of recent published meta-analyses and studies would suggest. For example, a study for Cancer Research UK, which used HMRC duty-paid cigarette clearances data and a similar time series model to HMRC's, produced an elasticity estimate of -0.4,[33] which is in line with the international consensus for high income countries.[34] Obviously, if this estimate is preferred, then the amount of the offset predicted in the HMRC analysis would be sharply reduced.

32. Unfortunately the tobacco industry was unwilling to allow our economists access to sales data in the HMRC datalab despite the fact it was anonymised, so our UK analysis was based on clearance data which are subject to a high degree of volatility from month to month, due particularly to increases in clearances immediately prior to Budgets (to escape increases in tobacco duty).

---

[31] A UK tobacco levy: The options for raising £500 million per year A research report by Howard Reed, Landman Economics Feb 2015

[32] West R. Public support for a tobacco levy. Smoking Toolkit Study. 2006

[33] **Review by Tessa Langley Lecturer in Health Economics, University of Nottingham, and Howard Reed, Director, Economist, Landman Economics London. Funded by Cancer Research UK**

[34] Effectiveness of Tax and Price Policies for Tobacco Control. IARC Handbooks of Cancer Prevention. Tobacco Control. Volume 14, 2011.

The refusal of the tobacco industry to allow access to its data to researchers outside of HMRC is extremely unhelpful to the development of effective public health policy with respect to tobacco. There is a strong case for the UK Government to require tobacco manufacturers to put this information in the public domain for the benefit of public health.

33. Tobacco is not like any other consumer product, it is lethal when used as intended, killing 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 smoke[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]

34. Because of the death and disease caused by smoking, we have an international treaty on tobacco, the WHO FCTC, to which the UK is a party. The Treaty requires stringent regulation of the tobacco industry, far greater than any other legal consumer product, including, for example, complete bans on advertising promotion and sponsorship, and 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.

35. 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.[38] And the Canadian government requires the tobacco manufacturers to report quarterly in arrears on monthly tobacco sales by volume and value. [39]

36. We strongly recommend that the UK Government implements a policy requiring the industry to provide 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 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.

37. 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

---

[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] Federal Trade Commission Cigarette report for 2012.

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

designed to reduce smoking prevalence.[40] 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.

38. This would have a number of benefits to HM Government:
    - Provide information which could be used to analyse market developments and inform the development of tobacco control and tax policy, for example on tax structure.
    - Enable future research on the price sensitivity of tobacco consumption by academic researchers to support work carried out by HMRC.
    - Inform analyses of illicit market trends over time at local level.
    - Provide 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).
    - Support and inform analyses of the marketing strategies of the tobacco industry.

39. Our ability to meet future targets for reductions in smoking prevalence are under serious threat. The World Health Organisation (WHO) set an objective to reduce the mortality from the four main preventable noncommunicable diseases – cardiovascular disease, cancer, chronic lung disease and diabetes – by 25% between the year 2010 and 2025 with a target for a reduction in smoking prevalence of 30%. The UK Government signed up to the "25 by 25" goal in 2012. England has a more ambitious target of reducing adult smoking prevalence to less than 13% by 2020 and less than 5% by 2035, as set out in the cancer strategy[41] and Smoking Still Kills.[42]

Taxation

40. Putting tobacco taxes up is potentially, in economic and health terms, a progressive rather than regressive measure because poorer smokers are more likely to quit, and youth less likely to take up smoking, as they are more sensitive to price increases.[43] Indeed tax increases are the only tobacco control intervention which have been proven to have a greater effect on more disadvantaged smokers at population level and so contribute to reducing health inequalities.[44]

41. 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. Furthermore, the positive health impact of taxes is greater when some of the revenues generated are used to support comprehensive tobacco control strategies.[45]

Tobacco tax escalator

---

[40] 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

[41] Achieving world-class cancer outcomes. A strategy for England 2015-2020. Report of the Independent Cancer Task Force, 2015.

[42] Action on Smoking and Health. Smoking Still Kills. ASH, 2015.

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

[44] 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.

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

42. Tobacco remains more affordable now in the UK than it was in the 1960s. While successive Chancellors have used the rhetoric of progressive tobacco tax policies, the UK has been overtaken in practice by a number of countries.[46] The Australian Treasury, for example, indexes tobacco tax increases to inflation twice a year, in addition to this, in 2010 it increased tobacco excise taxes by 25% with the intention of producing a 15% increase in revenues.[47] Despite Budgetary pressures stemming from the global economic crisis, 2010-11 revenues increased by 13% compared with the previous financial year.[48]

43. In addition the Australian Government committed to introducing staged 12.5 per cent 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 increases commenced on 1 December 2013, with further 12.5% increases on 1 September 2014, 1 September 2015, and 1 September 2016.

44. Despite 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.[49]

45. We therefore recommend increasing the tax escalator on cigarettes from 2% to 5% above inflation in the 2016 and subsequent Budgets.

Taxation of handrolled tobacco

46. We were disappointed that the March 2015 Budget did not narrow the gap in tax levels between manufactured cigarettes and hand-rolled tobacco. There is evidence from the Netherlands that consumption of hand-rolled tobacco increases as the price differential between manufactured and hand-rolled tobacco increases,[50] 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.[51]

47. The equivalent tax rate for HRT can be accurately calculated using recent research on the average weight of tobacco per hand-rolled cigarette.[52] This would increase the tax take and reduce the likelihood of smokers downtrading to HRT rather than quitting. 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

[46] Jha, P and Peto, R. Global effects of smoking, of quitting, and of taxing tobacco. New England Journal of Medicine 2014; 370:65.
[47] Treasury, Australia. Issues in tobacco taxation. Accessed January 2016.
[48] Australian Government Budget Outcomes 2009-10 and 2010-11. Accessed January 2016.
[49] Australian Government Budget Outcomes 2013-4 and 2014-15. Accessed January 2016.
[50] 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.
[51] Opinions and Lifestyle Survey. Smoking habits amongst adults, 2013 Office for National Statistics, November 2014
[52] 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

tobacco.[53] For this reason we suggest keeping taxes on pipe tobacco in line with those on HRT.

48. We therefore urge the government to take further action to reduce the tax differential between different market segments and between manufactured cigarettes and HRT. In particular, by applying a tax escalator on HRT in this and subsequent years of 15% above inflation, until, using an average conversion rate of 0.7 grammes per handrolled cigarette,[52] the tax on manufactured cigarettes and handrolled cigarettes is equivalent. At this point the escalator on HRT should become the same as that for manufactured cigarettes.

Specific taxation on cigarettes

49. To minimise as far as possible the tax differential between different price categories and thereby reduce the growing price gap between expensive and cheap products[54] and so help prevent downtrading, we recommend that the UK ensure that specific tax is set at the maximum allowed under the new EU regulations.

50. The EU tax directive allows for specific tax to be up to 76.5% of the total tax burden on the weighted average retail selling price (WAP) from 1 Jan 2011 onwards.[55] Currently specific tax is estimated to be only 61.4% of the total tax of a typical pack of cigarettes in the ultra low price category cigarettes allowing significant room for further rebalancing, as it will be an even lower proportion of the total tax burden of the weighted average price.[56] However, the most recent factsheet available is November 2013 and now HMRC is consulting on reducing the frequency of the monthly tobacco bulletins too. These are both important sources of information which need to be maintained.

Minimum Excise Tax

51. The consultation on a Minimum Excise Tax (MET)[57] finished in October 2014 and there has still been no announcement about whether the government will proceed or not.

52. Recent work suggests that the industry differentially shifts tax increases between brand segments so that, on average, taxes on premium brands are overshifted, while taxes on ultra-low price (ULP) brands are not always fully passed onto consumers.[58] The smaller the ad valorem tax element and therefore the tax differential between high and low priced tobacco products, the more costly it is for the industry to do this.

53. We recommend the introduction of a Minimum Consumption Tax rather than a Minimum Excise Tax because it includes VAT as well as excise tax and therefore impacts not just on tax levels for manufactured cigarettes but also on hand-rolled

---

[53] 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

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

[55] 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

[56] HMRC. Tobacco Factsheet. Table 3.7 Taxation on Cigarettes. November 2013.

[57] HM Treasury. Consultation Minimum Excise Tax. 26 August to 6 October 2014.

[58] Gilmore AB, Tavakoly B, Taylor G, Reed H. Understanding tobacco industry pricing strategy and whether it undermines tobacco tax policy: the example of the UK cigarette market. Addiction. 2013 Jul; 108(7): 1317–1326.

tobacco. Raising the tax levels at the lower priced end of the HRT market could help reduce the likelihood of downtrading within HRT.

54. The introduction of a MCT, underpinned by setting specific tax on manufactured cigarettes at the maximum allowed under the EU Tobacco Tax Directive, is the best way to minimise the difference in tax levels for different price categories.

Review of the EU Tobacco Tax Directive

55. 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 handrolled tobacco (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.

56. 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.[59] 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. We therefore recommend that the UK advocate for the removal of the differential in taxation between HRT and manufactured cigarettes.

57. 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[60], 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.

Corporation tax

58. Further it should be noted that the tobacco multinationals currently pay little or no corporation tax. For example, British American Tobacco plc (BAT) and Imperial Tobacco Group PLC (Imperial) are both based in the UK, and in the 2013 financial year it was recently estimated that Imperial had a 35.4% share and BAT an 8.7% share of the UK tobacco market as measured by value. Imperial reports they made £623m in adjusted operating profits in the UK market, and whilst BAT don't offer a

[59] 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

[60] 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.*

profit breakdown by market, it has been estimated that BAT made at least £78.2m and perhaps as much as £150m in operating profits in the UK.[61]

59. Yet British American Tobacco paid no UK corporation tax in the 2013 financial year, despite being domiciled in the UK and making about £6 billion in global operating profits.[62] Imperial only paid £6m in UK corporation tax for the 2013 financial year despite their profitability in the UK market and global adjusted operating profits of £3.2bn.[63]

60. The main rate of corporation tax companies operating in the UK has of course fallen from 28 percent in 2010 to 20 percent in 2015, and is scheduled to fall further to 18 percent in 2020 as a result of changes announced in the July 2015 Budget. It is hard to see how such tax reductions are justified for an industry whose products kill when used as intended, leading to 100,000 preventable premature deaths in the UK each year.

61. Tobacco manufacturers should be required to pay a surcharge to bring their corporation tax back to the rate set in 2010, of 28%. This might be an alternative to the tobacco levy, which the government has decided not to proceed with at the current time, with funds being used to fund the government's tobacco control policy implementation. A precedent for such a surcharge already exists in the form of the Bank Corporation Tax Surcharge.

62. 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.

VAT on medicinally licensed nicotine products

63. ASH advocated for differential taxation on nicotine products, related to the harms caused, and we were pleased when HMT committed to reduced VAT on nicotine replacement therapy products licensed by the MHRA at the minimum allowed of 5%.

64. The MHRA has announced a licence for two novel nicotine containing products for use in harm reduction, Voke which is an inhaled nicotine product, and the e-voke, which is a type of electronic cigarette. We would ask the Chancellor to confirm, as should be the case, that such medicinally licensed products will have VAT levied at the same rate as other nicotine replacement therapy products,that is at 5%.

Tackling Illicit Trade

65. We were pleased to see the new HMRC and Border Force strategy for tackling illicit tobacco, launched just after the Budget in March 2015.[64] We were particularly pleased to note the acknowledgement of the global nature of the illicit trade and the importance of working internationally and supporting EU-wide ratification of the Illicit Trade

[61] Branston, JR and Gilmore AG.The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy. University of Bath
[62] BAT Annual Report 2013, downloaded from http://www.bat.com/
[63] Imperial Tobacco Annual Report and Accounts 2013, downloaded from http://www.imperial-tobacco.co.uk/
[64] HMRC and Border Force. Tackling illicit tobacco: From Leaf to Light The HMRC and Border Force Strategy to tackle tobacco smuggling. HMRC March 2015

Protocol; and the commitment to setting up a cross-government ministerial group to oversee future evolution of the anti-illicit tobacco strategy.

Setting targets

66. We were, however, disappointed by the lack of ambition in the new illicit strategy published in March, 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 recent upwards trend.[64]

67. Over a period of time when we expect to see the implementation of the Tobacco Products Directive, the ratification and implementation of the WHO FCTC Illicit Trade Protocol, and substantial increases in tobacco taxation globally, in line with guidelines on Article 6 of the WHO FCTC, we believe the Government should be more ambitious than this about its ability to reduce the illicit market thereby increasing government revenues.

68. The UK Government set outcome measures for a quantified reduction in the market share of illicit cigarettes and tobacco between 2000 and 2007-8 which were achieved in advance of the deadline and proved very effective in helping maintain the incentive to put resources into this area, while helping ensure consistency and transparency.

69. Over the course of this Parliament our 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. We urge the Government to introduce new targets of a market share for illicit cigarettes of no more than 5% by 2020 and for hand-rolled tobacco to no more than 22% by 2020 and no more than 11% by 2025, in line with the recommendations set out in Smoking Still Kills.[1]

Funding for inland activity

70. We were pleased to see the commitment in the new strategy to drive down demand by using targeted media and educational campaigns. However, it was disappointing that the work of the Tackling Illicit Tobacco for Better Health partnership in this area was not acknowledged, nor was the importance of continuing to work collaboratively at local and regional level. The importance of collaboration with such regional partnerships and of rolling out such an approach more widely was recognised both by the National Audit Office and the Public Accounts Committee.[65]

71. And while we were pleased with the announcement in the July 2015 budget of increased funding for international work on illicit trade, it was very disappointing that there was no such commitment for inland work. The DH has funded some inland work through the Chartered Trading Standards Institute acting in collaboration with local authorities. This is now under threat because of cuts to DH funding. Public health funding cuts also threaten funding for the Tackling Illicit Tobacco for Better Health partnership funded and managed by the three regional tobacco control offices in the northeast, northwest and southwest.

72. Indeed the regional office in the southwest has just had its funding terminated with six months' notice. Funding for the offices in the northeast and northwest, both areas of

[65] House of Commons Committee on Public Accounts. HM Revenue & Customs: Progress in tackling tobacco smuggling. Twenty Third report of session 2013-14.

deprivation with high smoking rates, are also under threat. Three local authorities in the northwest have already given notice of termination of funding for 2016/17.

73. We would therefore like to highlight the need for the Government to commit to supporting the development of effective regional partnerships across England and work to tackle illicit trade at local level. This could include direct funding where required, for example by using any HMRC underspends, or could be funded by the tobacco levy once it is implemented. HMRC should collaborate with the Tackling Illicit Tobacco for Better Health partnership as well as the Chartered Trading Standards Institute, both of which can play a key role in supporting this work.

Naming and shaming

74. While we note the growing role of illicit white and counterfeit product within the illicit market, we also note that tobacco manufacturers' brands are also present in substantial numbers in the illicit market. Trading standards officers across nine English regions recently took part in "Operation Henry", a programme of search and seizures of illicit tobacco. Between May and November 2014, more than 2.5 million cigarettes were seized together with other tobacco products including HRT, raw tobacco, and shisha tobacco. More than 70% of the cigarettes seized were genuine products diverted into illicit channels. [66]

75. The latest industry data (Project Star) show that in the EU 61% of the illicit market comprises the manufacturers' brands demonstrating that this remains a substantially greater problem than counterfeit and illicit white although the latter is increasing most rapidly.[67] In the EU, the proportion of the illicit coming from outside the EU also highlights the need for global and not just European action.
76. We were pleased to see that in November HMRC fined British American Tobacco £650,000 for oversupplying its products to Belgium. We would like to see a policy of naming and shaming manufacturers who fail to co-operate put in place as part of the upcoming strategy, in line with the Home Affairs committee recommendations.[68]

Misrepresentation of data

77. We also note growing evidence that the tobacco industry and those it funds have been misrepresenting HMRC figures on the size of the illicit market to exaggerate the scale of the illicit tobacco trade, backed up by their own misleading estimates. They have promoted their misleading messaging on illicit to the media and have distorted the public discourse on illicit by so doing.[69] [70] [71] We believe that it is only after public

---

[66] Operation Henry: Tackling the Supply of Illicit Tobacco Products in England. 2014 Trading Standards Institute (Commissioned by the Department of Health Tobacco Policy Team)
[67] Gilmore A et al Towards a greater understanding of the illicit tobacco trade in Europe: a review of the PMI funded 'Project Star' report Tobacco Control doi:10.1136/tobaccocontrol-2013-051240 Published online 11 Dec 2013
[68] Home Affairs Committee. Tobacco smuggling. First Report of Session 2014-15 Recommendations. 11 March 2014
[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

criticism of such data that more accurate estimates are produced, albeit largely hidden. For example, following criticism of its previous data[72], KPMG's latest report for the tobacco industry revised its previous estimates for the UK illicit trade downwards. We therefore call on HMRC to publicly critique any data they believe to be inaccurate.

Illicit Trade Protocol

78. HMRC highlighted its championing of the WHO FCTC Illicit trade Protocol in its current anti-illicit strategy[64] and a commitment was made in the Autumn statement 2015 to consult on measures requiring legislation which are included in the protocol, in particular, licensing of machinery manufacture and tobacco retailers[21]. However, as yet the consultation has not been launched, and the UK has not ratified the protocol. We urge the Government to ratify the protocol and launch the consultation without further delay.

79. Of particular concern are the supply chain controls that are central to the Protocol's provisions, including licencing of the supply chain down to retail level and the development of an international tracking and tracing regime for tobacco products in line with Article 5.3 of the FCTC (and Article 8 of the Protocol).

80. 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."[73] At the current time it 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. It is essential that the UK individually and the EU collectively ratify the Protocol as soon as possible, while ensuring any standards set for track and trace systems are fit for purpose and ensure independence from the tobacco industry.

---

tobacco companies to the UK consultation on standardised packaging 2012 Tob Control. doi:10.1136/tobaccocontrol-2014-051930 December 10, 2014

[72]. KPMG Project Sun: a study of the illicit cigarette market in the European Union, 2013 results, 2014

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