

# HMT Spending review 2015

## Representation from Action on Smoking and Health

### About ASH

1. ASH (UK) is a health charity set up by the Royal College of Physicians in 1971, working towards the elimination of harm caused by tobacco. ASH receives core funding from the British Heart Foundation and Cancer Research UK and has received project funding from the Department of Health for work to support delivery of the Government's tobacco strategy for England. ASH does not have any direct or indirect links to, or receive funding from, the tobacco industry.

### Our proposal

2. ASH recommends an additional investment of £100 million per annum for tobacco control measures over the next five years, plus an increase in the tax escalator for cigarettes to 5% above inflation, together with other tax adjustments. Together these measures would deliver a return on investment (ROI) of almost 1100% over 5 years and increase the rate of decline in smoking prevalence by an additional 0.57 percentage points per annum.

### Rationale, costs, benefits and deliverability

3. Smoking is the major cause of preventable premature death, killing nearly 80,000 people per annum in England<sup>1</sup>, more than the next five causes put together, including obesity, alcohol and illegal drugs.<sup>2</sup> Half die before normal retirement age,<sup>3 4</sup> during productive life years, with twenty times as many smokers as die each year suffering from disease and disability caused by their smoking.<sup>5 6</sup>
4. There is good evidence that measures to reduce smoking prevalence are highly effective and cost-effective. For example, stop smoking services are considerably cheaper than treating long-term conditions caused by smoking such as lung cancer and coronary heart disease<sup>7 8</sup>, and there is considerably stronger evidence for the effectiveness of stop smoking services compared with many prevention interventions such as, for example, NHS Health Checks.<sup>9</sup>
5. Indeed measures to reduce smoking prevalence are not just cost-effective but also revenue generating because they lead to increased productivity and reductions in expenditure on the NHS, social care and benefits. The Tobacco Control Plan for England has been revenue generating over the last five years achieving an annual reduction in smoking prevalence of 0.66 percentage points per annum through a combination of a tobacco tax escalator of 2% above RPI and investment of around £200 million per annum in a comprehensive strategy. In public finance terms if this level of investment and the current escalator are sustained it would equate to a return on investment of just over 300% over the next five years.
6. Even better value for money would be an additional investment of £100 million pa for tobacco control measures over the next five years, plus an increase in the tax escalator for cigarettes to 5% above inflation (with tax on handrolled tobacco increased by 15% above inflation for four years, until tax is equivalent with that on manufactured cigarettes, and then increasing by 5% above inflation, in line with the cigarette tax escalator, in the fifth year ) and the introduction of a Minimum Consumption Tax. This proposal could reduce smoking by an additional 0.57 percentage points per year and deliver a return on

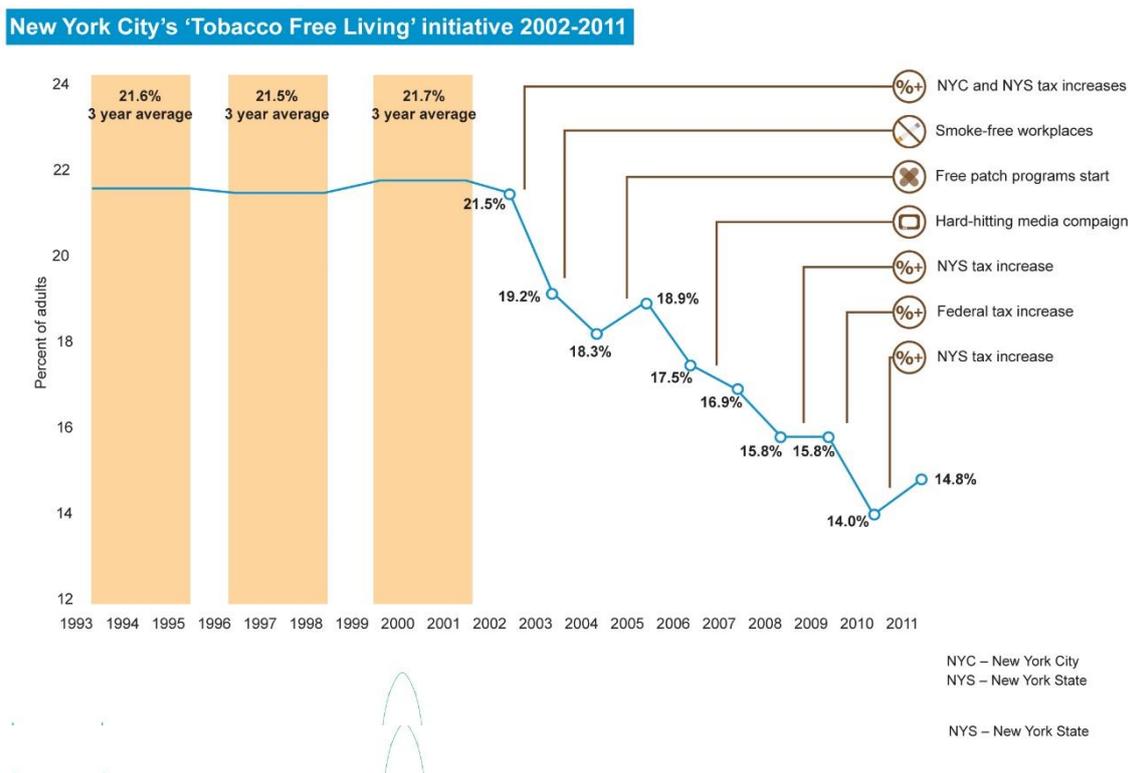
investment (ROI) of almost 1100% over 5 years. ASH, supported by 129 health organisations<sup>10</sup>, supports the implementation of a tobacco levy with money raised to be used for measures to reduce smoking prevalence. However, given this was ruled out by HMT in the summer budget, following consultation, increasing the tobacco tax escalator to 5% above RPI, with a commitment to increase funding for tobacco control, is the next best option.

### Return on Investment (ROI) of existing tobacco control policies and ASH's policy recommendations

Policy	NPV (gross fiscal benefits), 2016-20, £m	NPV (tobacco control spending), 2016-20, £m	ROI (%)
2% escalator and £200m/year tobacco control spending	3,925	932	321
Increase escalator to 5%/15%, increase tobacco control spending to £300m/year	5,539	466	1,088

7. This proposal meets the priorities for spending outside the core protected areas, as set out in HMT's Spending Review consultation document including "*promoting growth and productivity*", and "*driving efficiency and value for money across the public sector*".<sup>11</sup> It is effective and feasible and represents good value for money from a relatively small public spending investment in addition to easy to achieve tax changes, and will help the NHS "*to deliver on its commitment to achieve significant efficiency savings by 2020-21, as set out in the Five Year Plan*".<sup>11</sup>
8. The Tobacco Control Plan for England has been revenue generating over the last five years, achieving an annual reduction in smoking prevalence of 0.66 percentage points per annum, through a combination of a tobacco tax escalator of 2% above RPI and investment of around £200 million per annum in a comprehensive strategy. This is probably an upper estimate of the level of investment, including £140 million for stop smoking services<sup>12</sup> and interventions, £20 million for wider tobacco control at local level,<sup>12</sup> a £15 million marketing budget<sup>13</sup> and an estimated £25 million to cover the DH and PHE policy teams, regional activity and local enforcement.
9. ASH is deeply concerned that the £200 million in-year cuts to DH funding for local authority controlled health budgets recently announced by the Chancellor, amounting to a reduction of 6.2% in what is supposed to be a 'ring-fenced' budget will result in significant cuts to local authority tobacco control budgets. Worse still that further cuts are threatened in the current Spending Review <sup>11</sup> which is designed to deliver a further £20 billion cuts in departmental budgets over the next four years. This is a particular issue for public health budgets, given that spending on the NHS is prioritised.
10. The Tobacco Control Plan for England runs out at the end of 2015 and the Government's commitment to developing a successor is welcomed. However, if it is to be effective the evidence, not just from the UK but also internationally, is that substantial and sustained investment is required.<sup>14</sup> While smoking rates have fallen significantly year on year in England over the last decade, they have not in France and Germany. The difference is that while France and Germany have implemented European wide tobacco policies, on advertising promotion and sponsorship, and product regulation, they do not have country-specific comprehensive strategies like that in England.<sup>15</sup>

11. In addition current spending levels in England are not yet optimal. The US Centers for Disease Control and Prevention outlines the elements of an evidence-based state tobacco control program and provides recommended state funding levels to substantially reduce tobacco-related disease, disability, and death in its *Best Practices for Comprehensive Tobacco Control Programs*.<sup>1617</sup>
12. CDC's current best practice recommendation for spend on tobacco control is \$10.53 per capita.<sup>16</sup> At current population levels of 54 million, this would be equivalent to \$568.62 for England, equivalent to about £375 million at today's exchange rates. The ASH recommendation that tobacco control funding be increased from £200 to £300 million per annum is by comparison modest.
13. States that made larger investments in tobacco prevention and control have seen larger declines in cigarettes sales than the United States as a whole<sup>14</sup> and the prevalence of smoking has declined faster as spending for tobacco control programs has increased.<sup>18</sup><sup>19</sup>
14. Furthermore there is evidence that when tobacco control funding is cut, smoking rates go back up. In New York City a sustained strategy from 2002 onwards, including a range of measures (see graph below) led to declines in smoking year on year, until after 2010 following funding cuts smoking rates immediately began to rise again.<sup>20</sup>



Taken from [Better Health for London](#), the report of the London Health Commission

15. Attached as an annex to this representation is a short report setting out the methodology and detailed calculations behind this proposal by Howard Reed of Landman Economics, the economist working for Action on Smoking and Health.

## **Appendix: the public finance impacts of an increased tobacco duty escalator and increased investment in measures to reduce smoking prevalence**

**by Howard Reed (Director, Landman Economics)**

### **Introduction**

This report uses an econometric model of the public finance impacts of changes in smoking prevalence and tobacco taxation in England to estimate the impacts on the public finances public finance impacts of the recommendations made by ASH in its submission to the 2015 Spending Review.

### **The ASH model of the public finance impacts of changes in smoking prevalence and tobacco taxation**

The ASH model of the public finance impacts of changes in smoking prevalence and tobacco taxation was originally developed by Johnson<sup>21</sup> to assess the impact of the illicit trade measures in the Framework Convention on Tobacco Control (FCTC) on smoking prevalence in the UK. The model was then expanded and modified by Landman Economics to model the impact of changes to tobacco duties on the public finances.<sup>22</sup> Our analysis of the impact of smoking on public finances is a conservative one, recent US estimates of the productivity losses from smoking in the US amounted to \$151 billion,<sup>23</sup> which would equate to around £20 billion for England, much higher than ASH estimates as quoted in the HMT consultation of the tobacco levy of £12.9 billion.<sup>24</sup>

The model estimates the direct impact on the public finances of increases in duty for cigarettes and hand-rolling tobacco (HRT) using assumptions about the price elasticity of demand for tobacco consumption. The consumption elasticity we have used is -0.5 with an estimate of prevalence elasticity of -0.35 which is in line with the majority of UK and international estimates.<sup>25 26 27</sup> It should be noted that estimates by HMRC have been considerably higher than international comparisons ranging from -1.3 to -1.05.<sup>28</sup> Modelling by Reed and Langley<sup>29</sup> does not support such higher rates of elasticity, nor do international comparisons.

The tax structure, and industry manipulation of the structure, for both manufactured cigarettes and handrolled tobacco encourages youth uptake (young people are particularly price sensitive) and downtrading among adult smokers. Indeed the increase in recent years in the use of cheapest cigarettes is most marked in the youngest (16-24 year old) smokers, 71.4% of whom now use cheap brands or HRT.<sup>30 31</sup>

In order to minimise the opportunities for such manipulation and for down trading ASH is recommending changes in the tax structure as well as an increase in the tobacco tax escalator for manufactured cigarettes from 2% above RPI to 5% above RPI. Specifically we recommend an increase the escalator for HRT to 15% above RPI until the tax burden is equivalent to that for manufactured cigarettes, and the introduction of a Minimum Consumption Tax, as consulted on by HMT.<sup>32</sup>

Hand-rolling tobacco is analysed as a separate (and growing) market segment; this enables the model to estimate the impact of different rates of duty increase for cigarettes and HRT. As outlined in the main submission, ASH is recommending an increase in the escalator for HRT escalator to 15% above RPI until tax is brought into line with that for manufactured cigarettes, using a conversion rate of 0.75 g per handrolled cigarette.<sup>33</sup>

Currently the total excise tax burden per gramme of tobacco on HRT is only 61% of that for the weighted average price of cigarettes. It will take 4 years with an enhanced escalator of

15% for the tax levels to become equivalent, at which point the HRT escalator will revert to 5%.

We have not attempted to model in detail the impact of the introduction of a minimum consumption tax, which we have also recommended, suffice it to say that, as set out in the HMT consultation document, “establishing a minimum structural tax level has the potential to influence pricing behaviour and strengthen a price point below which cigarette prices are less likely to go”,<sup>32</sup> thereby reducing the opportunity for downtrading.

Concerns raised by the tobacco industry that increasing taxation leads to an increase in the illicit trade are mitigated by HMRC’s comprehensive, effective and regularly updated anti-smuggling strategy,<sup>34</sup> funding for which was increased in the July 2015 budget.<sup>35</sup> This will be strengthened in future by the introduction of strengthened international controls on the illicit trade, through the implementation of the EU Tobacco Products Directive<sup>36</sup> and the WHO Framework Convention on Tobacco Control Illicit Trade Protocol.<sup>37</sup>

The model also estimates the indirect impacts on the public finances of reductions in smoking prevalence, whether caused by increases in tobacco taxation (which give rise to reductions in the number of smokers) or by other measures to reduce smoking prevalence such as stop smoking services and mass media campaigns. Six dimensions of impact are considered:

#### **i) NHS cost savings**

Smokers impose additional costs to the NHS due to higher rates of incidence for a range of smoking-related health conditions (such as myocardial infarction) for current smokers and recent ex-smokers compared to people who have never smoked. The National Institute for Health and Care Excellence (NICE) maintains a tool developed by researchers at the Brunel University Health Economics Research Group (HERG)<sup>38</sup> which estimates the overall costs of smoking to the NHS using data on the hospital admission rates (for various conditions) of smokers compared to ex-smokers and people who have never smoked. The latest (February 2015) version of the NICE model estimates that the overall costs of smoking to the NHS in England are approximately £2 billion per year. The ASH model calculates savings to the NHS based on reductions in prevalence (due to a combination of some people quitting smoking and others not taking up smoking in the first case), based on recent evidence regarding the reduction in the risks of smoking-related health conditions for ex-smokers compared to current smokers, and the relative risks of experiencing various health conditions for never-smokers compared to smokers.<sup>1</sup>

#### **ii) lower social care expenditure**

As well as costs to the NHS, smoking also imposes additional costs to local authorities due to greater social care needs among smokers than ex-smokers and people who have never smoked. This is due to a combination of two factors: smokers require social care services at an earlier age on average than non-smokers, and smokers who are in receipt of social care services require a greater extent of services (and hence more expenditure per week) than non-smokers). In 2014, Landman Economics used data from the English Longitudinal

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<sup>1</sup> See: Reed H. [The Effects of Increasing Tobacco Taxation: A Cost Benefit and Public Finances Analysis](#) London, ASH, 2010 for more details of the assumptions on risks for ex-smokers relative to current smokers and never-smokers.

Survey of Ageing to estimate the costs of smoking to local authority social care budgets for the first time in England.<sup>39</sup> <sup>2</sup> These were estimated at around £600 million for 2015.

**iii) increased tax receipts from longer, healthier working lives**

There is substantial evidence that smoking leads to an increased risk of premature mortality and working age morbidity (e.g. incapacity for work). The ASH model uses variations in mortality rates for smokers and non-smokers by age to calculate the number of deaths before retirement in the population which could be averted by a reduction in smoking prevalence. Using data from the Annual Survey of Hours and Earnings on the distribution of weekly wages in the population, the estimate on the number of working lives saved by a reduction in smoking prevalence is used to calculate the amount of tax receipts from income tax, employee and employer National Insurance Contributions (NICs), and VAT (paid on the goods and services bought with wage income) paid by workers enjoying longer working lives as a result of lower smoking prevalence.

**iv) increased tax receipts from lower absenteeism**

Recent research<sup>40</sup> suggests that smokers have a higher incidence of absence from work than non-smokers (an average of 2.74 days per year). Assuming that smokers are less productive than non-smokers due to this higher rate of absenteeism, the ASH model calculates the increased tax receipts from income tax, NICs and VAT arising from reduced absenteeism due to lower smoking prevalence.

**v) reduced sickness and disability benefits**

Smoking is linked to higher rates of working age incapacity and a higher proportion of current and ex-smokers are in receipt of disability-related benefits such as Disability Living Allowance (and its replacement, Personal Independence Payment) and Employment and Support Allowance. The ASH model calculates fiscal savings arising from lower expenditure on sickness and disability-related benefits as a result of lower smoking prevalence.

**vi) higher pensions payments**

Lower smoking prevalence leads to a lower incidence of working age mortality in the population but it also leads to longer retired lives on average, and hence an increase in expenditure on the state Retirement Pension and Pension Credit. The model takes these factors into account, as higher pensions expenditure offsets a proportion of the fiscal savings from other factors such as higher tax receipts and lower benefit spending.

## **The modelled package**

The model was used to estimate the savings to the public finances from a combination of two policies:

- an increase in the escalator for tobacco duties from 2% per year above inflation to 5% per year for cigarettes; and from 2% per year to 15% for hand rolling tobacco;

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<sup>2</sup> See Reed H (2014) – ref 43. Note that the Landman Economics estimate of the costs of smoking to the social care system is for people aged 50 and over only (due to the limitations of the sampling frame of the English Longitudinal Survey of Ageing data) and only includes an estimate for additional costs of domiciliary social care (i.e. social care received in the clients' own home); it does not include an estimate of the costs of smoking, if any, to the residential care system (people receiving social care in care homes).

- an increase in the budget for expenditure in England on initiatives designed to reduce smoking prevalence (such as stop smoking services) from £200 million per year to £300 million per year.

The time period modelled is the next five years, from 2016 to 2020.

Based on recent trends in smoking prevalence, we assume that the current 2% escalator, plus a £200 million per year investment in tobacco control policies, is delivering a reduction in smoking prevalence of 0.66 percentage points per year.

## Results

### *Fiscal impact of ASH policy recommendations*

Table 1 shows the fiscal impact of increasing the tobacco duty escalator from 2% above inflation to 5% for cigarettes and 15% for hand rolling tobacco, plus an increase in expenditure on tobacco control policies from £200 million per year to £300 million per year.

**Table 1. Fiscal impact of ASH's recommended policy package (£m, 2015 prices)**

Category of Impact	2016	2017	2018	2019	2020	NPV
Increased tobacco tax revenue	267	510	731	933	1,024	3,166
Savings to NHS	23	46	71	96	117	321
Savings to LA social care	20	39	57	75	89	255
extra tax from increased years of healthy life	85	171	258	343	408	1,152
extra tax from reduced absenteeism	19	40	61	84	103	279
Reduced disability benefits	56	109	160	207	241	706
Increased pension payments	-26	-51	-77	-101	-119	-341
<b>TOTAL</b>	<b>444</b>	<b>864</b>	<b>1,261</b>	<b>1,638</b>	<b>1,862</b>	<b>5,539</b>

Table 1 shows that the net fiscal benefits from ASH's policy recommendations raise almost £1.9 billion per year by 2020. Around £1 billion of this benefit comprises increased revenue from tobacco taxes. The rest is made up of a combination of savings to the NHS, savings to local authority social care budgets, extra tax receipts from longer healthy lives and reduced absenteeism and reduced disability benefit expenditure. Increased pension payments offset a small proportion of the net improvement in the public finances. The net present value over five years of the benefits from the increased escalator and increased investment in tobacco control (using a 3.5% annual discount rate as recommended in the Treasury Green Book) is around £5.5 billion. The increase in the tobacco escalators for cigarettes and HRT and the increase in spending on tobacco control measures deliver a combined reduction in smoking prevalence of 0.57 percentage points per year *in addition to* the 0.66 percentage points per year reduction achieved by the 2% escalator and tobacco control expenditure of £200 million per year.

### ***Return on Investment***

By comparing the net present value of the fiscal benefits from ASH's recommendations to the Spending Review with the NPV of the cost of extra spending on tobacco control

initiatives, it is possible to calculate a figure for return on investment (ROI) of tobacco control policies. The upper row of Table 2 presents the estimated ROI from current tobacco policies (the 2% escalator plus expenditure of £200 million per year on tobacco control initiatives) relative to a situation in which there was no expenditure on tobacco control initiatives, and tobacco duties were simply raised in line with price inflation. The lower row of Table 2 presents the estimated ROI from the additional measures proposed by ASH (increasing the escalator and increasing tobacco control expenditure by an extra £100 million per year) relative to previous policy (2% escalator and £200 million per year expenditure).

**Table 2. Return on Investment (ROI) of existing tobacco control policies and ASH's policy recommendations**

Policy	NPV (gross fiscal benefits), 2016-20, £m	NPV (tobacco control spending), 2016-20, £m	ROI (%)
2% escalator and £200m/year tobacco control spending	3,925	932	321
Increase escalator to 5%/15%, increase tobacco control spending to £300m/year	5,539	466	1,088

Table 2 shows that tobacco control policies are extremely cost-effective from a public finances perspective. The policies followed during the 2010-15 Government – of a 2% annual price escalator and £200m per year expenditure – deliver a return of over 3 pounds for every pound invested. The recommendations proposed by ASH for this Spending Review – increasing the escalator to 5% for cigarettes and 15% for HRT, and increasing tobacco control policy spending to £300m per year – deliver an even higher return, of almost 11 pounds for every pound invested.

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