All Party Parliamentary Group
on Smoking and Health

Delivering the vision of a ‘Smokefree Generation’

The All Party Parliamentary Group on Smoking and Health response to ‘Prevention is better than cure’

February 2019

appg

About the All Party Parliamentary Group on Smoking and Health

The All Party Parliamentary Group (APPG) on Smoking and Health is a cross-party group of Peers and MPs which was founded in 1976 and is currently chaired by Bob Blackman MP. Its agreed purpose is to monitor and discuss the health and social effects of smoking; to review potential changes in existing legislation to reduce levels of smoking; to assess the latest medical techniques to assist in smoking cessation; and to act as a resource for the group's members on all issues relating to smoking and public health. The secretariat of the group is provided by Action on Smoking and Health.

This report was commissioned by the Chairman of the All Party Parliamentary Group on Smoking and Health from Action on Smoking and Health (ASH) which provides the Secretariat for the APPG. It was researched and written with support from the UK Centre for Tobacco and Alcohol Studies (UKCTAS), which is the centre of excellence in tobacco research in the UK and includes research teams in twelve UK universities.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. This report has been endorsed by the Chairman, Bob Blackman MP; Treasurer, Ian Mearns MP; and vice-chairs Alex Cunningham MP, Lord Faulkner, Baroness Finlay and Lord Rennard.

Date of publication: February 2019

ISBN 978-0-9934707-7-6

Contents

Foreword

'Prevention is better than cure' was published as a clarion call by the Secretary of State for Health & Social Care, a precursor to a Green paper due to be published this year which will turn the vision it set out into reality. At the time of the launch a commitment was made to work with stakeholders to develop the Green Paper and this report is our response.

The APPG has long been a strong and effective cross-party voice in parliament for innovative prevention measures. Indeed we provided the support needed by successive governments to implement measures such as a ban on all tobacco advertising, comprehensive smokefree legislation and standardised packaging of cigarettes. These measures have helped deliver sustained declines in smoking prevalence and uptake for more than a decade and made the UK a global leader in tobacco control.

Quite rightly the Secretary of State highlighted that reducing smoking is one of the two biggest health successes of the twentieth century. It has also been one of the biggest health successes, and certainly the biggest prevention success, of the twenty first century. Yet smoking remains the leading cause of premature death and health inequalities, so, as the Secretary of State recognises, for our prevention strategy to be successful, we need to continue to cut smoking.

The Government's Tobacco Control Plan for England sets out an ambition to achieve a smokefree generation, meaning a smoking prevalence of 5% of the population or less. However, the evidence is clear that for this to be delivered requires comprehensive and integrated Government and public sector action to fund and ensure effective tobacco control.

There were positive proposals in the Tobacco Control Plan, but public health funding to support them has declined year on year. The over-reliance in the Plan on local action is unrealistic at a time of budget restraints in local authorities. While the commitment in the NHS Long Term Plan to dedicated funding to help smokers being treated by the NHS to quit is welcome, this too is only part of the solution. This report, therefore, concentrates on what more can be done by central government to support delivery of the vision of a smokefree future throughout our communities.

As we pointed out in our last report in January 2017, given that public spending will be tightly constrained for some years to come, finding new ways of raising additional funds to pay for tobacco control measures is crucial.

It is our belief that the tobacco manufacturers, whose products cause so much health, social, environmental and economic damage, should make a greater contribution to mitigating that harm. The four major tobacco transnationals remain highly profitable companies, so they could certainly afford to contribute. This report reiterates our call for a charge or levy on the tobacco transnationals, in line with the *"polluter pays"* principle, while ensuring they have no influence over how the money raised is spent.

The commitment to reducing inequalities in smoking rates is laudable and essential if we are to truly achieve a smokefree future across all society. However, we have not seen reductions in the equalities gap in recent times and it is clear that new ideas are needed if this is to change in future.

The lesson of the past is that we must not be complacent and that further regulation is needed if we are to achieve our aspiration of a smokefree generation. The UK is currently a global leader in tobacco control, and if the recommendations in this report are taken forward, we will continue to be the global leader.

Bob Blackman MP
Chairman of the All Party Parliamentary Group on Smoking and Health

Introduction

1. This report sets out recommendations from the All Party Parliamentary Group on Smoking and Health for the Green Paper on prevention currently in development.[1] It highlights measures the Government should take to deliver the vision of a smokefree generation, set out in the 2017 Tobacco Control Plan for England.[2]

2. The conclusions and recommendations are in bold in the document and are brought together in one section at the end. Recommendations relate to England with respect to health measures and to the UK as a whole with respect to reserved matters such as tobacco taxation and illicit trade.

The Vision

3. Smoking remains the leading cause of premature death, killing nearly 80,000 people in England and 100,000 in the UK as a whole per year.[3] Half the difference in life expectancy between the richest and poorest in society is solely due to smoking.[4] If this is to change we need to realise the vision of a smokefree generation set out in the Tobacco Control Plan for England.[2]

4. This vision, for smoking prevalence to decline to 5% or less, is shared by a growing number of countries around the world.[5] The intermediate steps on the way to achieving this are laid out in a set of national ambitions for 2022 in the Tobacco Control Plan for England (see Box 1). There are three key elements: to reduce adult smoking prevalence, to reduce inequalities, and to reduce youth smoking. These three pillars provide the foundation for the realisation of a smokefree generation.

Progress to date

5. The UK's tobacco control strategy has, since the turn of the century,[6] comprised a synergistic set of policies, in line with the WHO Framework Convention on Tobacco Control (FCTC)[7] and World Bank recommendations,[8] that have been progressively ratcheted up over time.

6. The UK has benefited from strong cross-party political support for tobacco control, which has enabled us to go further and faster than other countries. The UK government is also working to promote implementation of the FCTC elsewhere, particularly in low and middle income countries, in line with our obligations as a party to the Convention.[9]

7. Since 2007 the UK has rated most highly across Europe in the Tobacco Control Scale which quantifies the implementation of priority measures to deliver comprehensive tobacco control programmes recommended by the World Bank. In 2016 the UK scored 81 out of 100 points, 11 points higher than its nearest rival, Ireland. More than half of the countries rated scored less than 50 points.[10]

8. Over the same period of time our smoking rates, which in 2006 were the same as the EU average, have declined much more rapidly than the rest of Europe. Smoking rates in the UK are now more than a third lower than the average, and we have the lowest proportion of adult tobacco users in the EU.[11] [12]

9. In the year 2000 more than one in four adults in England smoked,[13] and by last year this had declined to fewer than one in six.[3] Since the last Tobacco Control Plan was published in 2011,[14] smoking rates in England have fallen by a quarter, from 19.8% to 14.9% in 2017, bringing the estimated number of smokers down to 6.1 million.[15]

10. Smoking rates in children have also fallen rapidly. After two decades of little change, between 2000 and 2016 regular smoking by fifteen year olds fell from 23% to 7%, a decline of more than two thirds in the proportion of 15 year olds who smoke.[16]

11. **The UK's implementation of tobacco control measures over the last decade and more has significantly outstripped that of the rest of Europe and our smoking prevalence has declined much more rapidly. This clearly demonstrates the benefits of the UK's comprehensive strategy and the need for it to be sustained in the future.**

Box 1: Towards a Smokefree Generation

Tobacco Control Plan for England (July 2017)

Our National Ambitions

Our vision is to create a smokefree generation. We will have achieved this when smoking prevalence is at 5% or below. To deliver this, the government sets out the following national ambitions which will help focus tobacco control across the whole system:

1. The first smokefree generation

People should be supported not to start smoking, so we aim, by the end of 2022 to:

- Reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less.
- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less.
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.

To do this we need all public services to work together, leading the way in helping people to stop smoking.

After 2022, we will continue to reduce smoking prevalence further, on our way to a smokefree generation.

2. A smokefree pregnancy for all

Every child deserves the best start in life, so we aim, by the end of 2022 to:

- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.

3. Parity of esteem for those with mental health conditions

People with mental ill health should be given equal priority to those with physical ill health, so we aim to:

- Improve data collected on smoking and mental health to help us to support people with mental health conditions to quit smoking.
- Make all mental health inpatient services sites smokefree by 2018.

4. Backing evidence based innovations to support quitting

We are committed to evidence-based policy making, so we aim to:

- Help people to quit smoking by permitting innovative technologies that minimise the risk of harm.
- Maximise the availability of safer alternatives to smoking.

The risks of failure to achieve our ambitions

12. Smoking remains the leading cause of premature death, with smokers losing on average 10 years of life,[17] and for every death caused by smoking it is estimated that another twenty people are suffering from serious illnesses attributable to smoking.[18] It is clear therefore, that continuing to drive down smoking rates is essential if the Government is to meet its mission to ensure that people can enjoy at least five extra healthy, independent years of life by 2035.

13. If the current rate of decline in adult smoking prevalence is sustained, we may achieve the smokefree generation ambition that average adult smoking rates among the population as a whole will fall to below 5% of all adults by 2030. However, more needs to be done if we are to narrow the gap between the experience of the richest and poorest in society.

14. Although in Scotland the inequalities gap has narrowed,[19] in England it is widening, with the most recent published data[15] showing that:

    - 1 in 4 people in routine and manual occupations is a smoker compared to 1 in 10 in managerial and professional posts
    - The odds of smoking in the routine and manual group are more than twice those of other employed groups
    - People who are unemployed are almost twice as likely to smoke as those in work

15. Children growing up in homes with smokers are not only more likely to be exposed to smoking, they are also significantly more likely to become smokers themselves. In 2016 99% of children aged 11-15 who were regular smokers had friends who smoked, and 83% had family members who smoked.[20] Reducing adult smoking is also key to reducing youth smoking initiation, and the translation of inequalities in smoking across the generations.

16. While youth smoking rates have fallen to the lowest recorded levels since surveys began in 1982, between 2014 and 2016 more than 127,000 children a year aged 11-15 started to smoke in the UK, according to analysis by Cancer Research UK.[21] This amounts to around 350 young people a day, equivalent to 22 minibus loads of secondary school children.[22] Once started it is difficult to stop, with two thirds of those who try smoking going on to become regular smokers.[23]

17. And in the last three years from 2013 to 2016 the proportion of 15 year old regular smokers in England has only fallen from 8% to 7%[24] (most recent figures for Scotland 7% in 2015[25]). At this rate we could well fail to achieve the Tobacco Control Plan ambition for England of 3% by 2022.

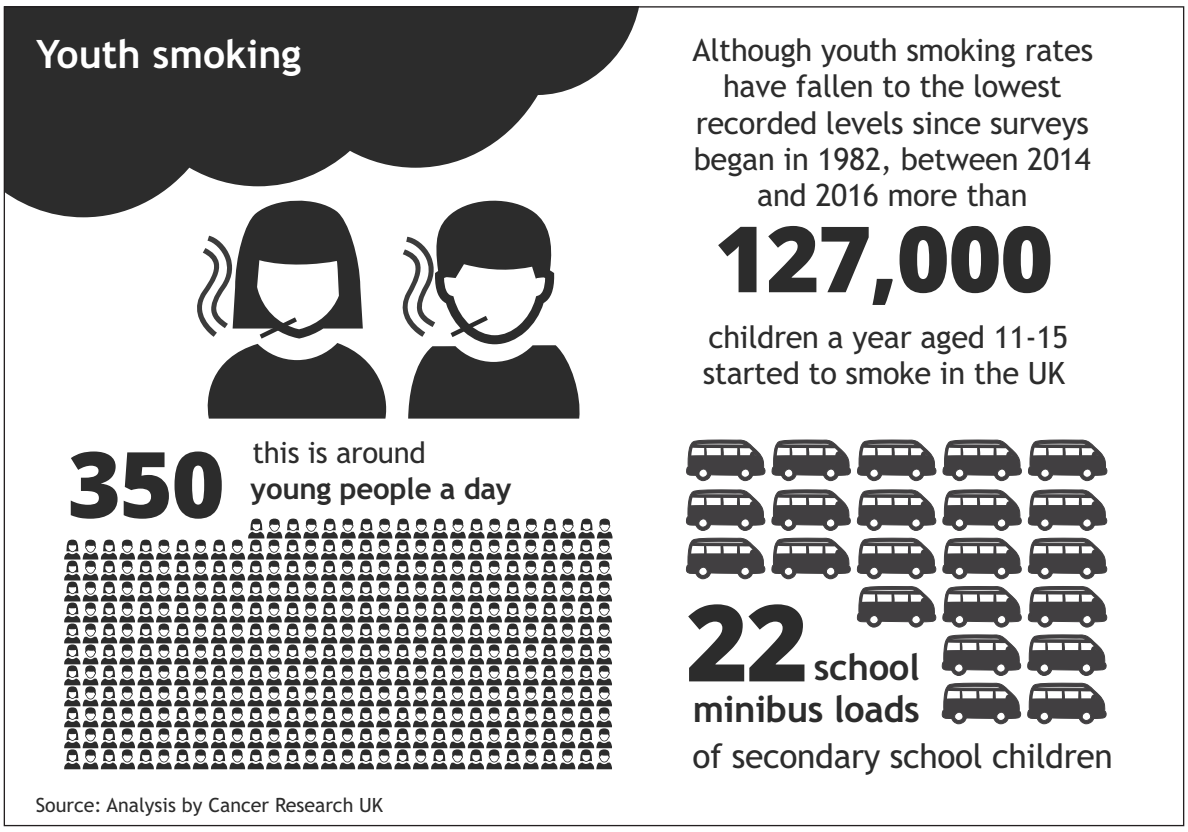

Figure 1 youth smoking

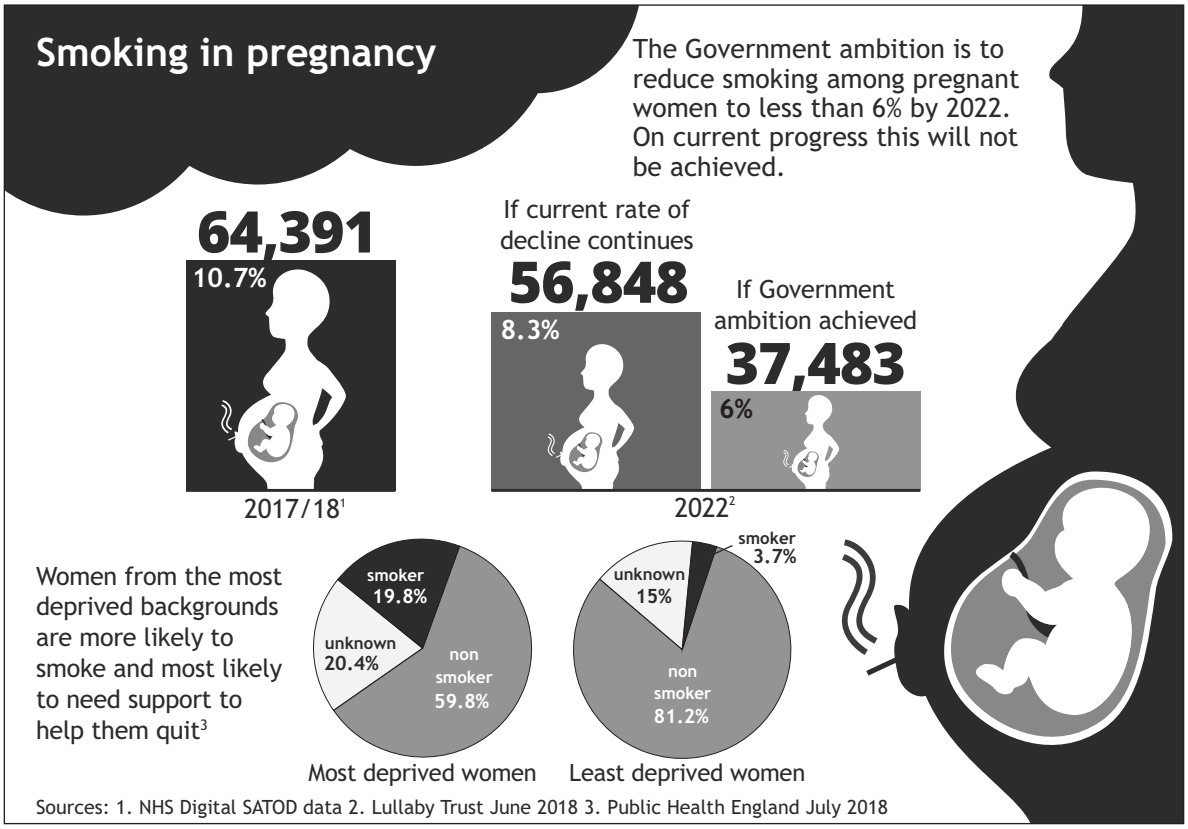

Figure 2 Smoking in Pregnancy

18. Smoking rates have fallen, but more than one in seven adults still smoke and this is concentrated in disadvantaged groups, whose children are therefore more likely to go on to become smokers themselves. It is essential to do more, therefore, to discourage smoking initiation and encourage quitting.

19. In addition, smoking in pregnancy is particularly concentrated in young mothers. Teenage mothers were nearly four times as likely to smoke before or during pregnancy as mothers aged 35 or over. As well as being more likely to smoke in the first place, younger mothers were less likely to quit before or during pregnancy. Teenage mothers were therefore almost six times as likely as those aged 35 or over to have smoked throughout pregnancy (35% and 6% respectively in 2010).[26]

20. Reducing smoking in pregnancy is crucial for delivering a smokefree generation, and the Government has an ambitious target that it should fall from 10.7% in 2016/17 to 6% or less by 2022. This requires a near doubling of the recent rate of decline in England[27] and if we are to succeed then reducing smoking in teenage mothers is a priority. However, rather than doubling the rate of decline, the data for 2017/18 show that smoking in pregnancy is no longer falling.[28]

21. **The evidence is clear, not just from the UK[29] but other jurisdictions too,[30] [31] [32] that smoking prevalence only continues to decline when tobacco control policies continue to be updated, invigorated and improved. Furthermore, the more extensive and comprehensive the tobacco control policies are, the more effective they will be in reducing youth initiation and increasing the number of adult smokers who quit.**[33]

Creating a smokefree generation

22. **However, by limiting its commitments and trying to shift responsibility for delivery over to localities, while at the same time demanding more from declining levels of public health funding, the Government did not ultimately pursue the challenge it set itself in the Tobacco Control Plan to achieve a *'Smokefree Generation'*.**

23. **The APPG agrees that localities have a major role to play, and our recommendations for local authorities and adequate funding for public health were set out in our last report in January 2017.**[34]

We also support the dedicated funding in the Long Term Plan to help smokers being treated by the NHS to quit. However, this report focuses on what more central government can do to deliver the national vision of a smokefree generation as an integral element in an effective prevention strategy.

24. The pioneering regulatory measures that the UK has adopted, such as the comprehensive advertising ban, smokefree laws, and packaging and labelling regulations including standardised packaging, have been highly effective and are largely self-sustaining.

25. They are not, however, sufficient to ensure smoking continues to decline, because it can be assumed that those who continue to smoke after a specific policy is put into effect have discounted it, so progressive strengthening of regulations over time is required. This report recommends, in particular, increasing the age of sale to 21, introducing retail licensing and government mandated cigarette pack inserts to encourage smokers to quit.

26. Furthermore, many of the important tobacco control measures likely to have most impact on reducing inequalities require significant and sustained funding; funding which has been cut in recent years. This includes cuts to national mass media public education campaigns, and cuts to public health budgets. These have translated into cuts in local authority funding of tobacco control,[35] [36] including smoking cessation services and enforcement measures to prevent illicit trade and underage sales, and collaborative working at regional level.

27. These measures are all crucial to reducing inequalities. They can be directed in such a way as to enable the most disadvantaged communities, where smoking is concentrated and the illicit trade is most common, to reduce consumption.

Making the Polluter Pay

28. **Making the leading tobacco transnationals responsible for the vast majority of tobacco sales in the UK pay toward the cost of reducing smoking prevalence, is a wholly justified extension of the "polluter pays" principle, supported by the APPG. At present it is the polluted who pay most, through the cost of their addiction and the burden of ill health that results.**

29. Cigarettes, unlike any other consumer product, are lethal when used as intended, killing at least half all users prematurely in the longer-term and causing significant health problems in the short and medium term. On average smokers lose ten years of life, a loss of 11 minutes for every cigarette smoked,[37] but the loss of disease-free life years is far greater than this. For every smoker who dies, another 20 are living with smoking-related diseases, many suffering years of disability before premature death.[18]

30. A mandatory levy, or charge on the industry, could raise a fixed total amount of money to support the recurring costs of tobacco control measures designed to prevent uptake and encourage quitting. The proportion of the total amount paid by each company would be based on their sales of combustible products (manufactured cigarettes and hand-rolled tobacco), as they are both the most lethal and the most widely used. In 1992 it was estimated that the industry spent £100 million[38] on advertising, money which it can no longer spend since advertising is prohibited. In 2018 prices this would amount to £144 million, and this is a useful benchmark for the minimum amount which could be raised by such a fund.

31. The amount would be fixed so that as combustible sales declined the amount per cigarette stick would increase. This would also serve to help incentivise tobacco manufacturers to move out of the combustible market. However, there should be no question of their being able to influence the content of any tobacco control measures, which would contravene Article 5.3 of the WHO FCTC[7] requiring the Government to protect its public health policies from the commercial and vested interests of the tobacco industry.

32. The four largest tobacco transnationals (British American Tobacco, Imperial Tobacco, Japan Tobacco International and Philip Morris International), are some of the most profitable businesses in the world, making over £1.5 billion in profits per annum in the UK alone in recent years. Tobacco manufacturers and importers are also found to enjoy consistently high profit margins of up to 67%, compared to only 15-20% in most consumer staple industries.[39] [40]

33. In the UK Philip Morris International (PMI) has been running a sustained campaign through advertisements in national newspapers and direct approaches offering to *"support Local Authority cessation services where smoking rates are highest"*. It has made similar offers to NHS Foundation Trusts.[41]

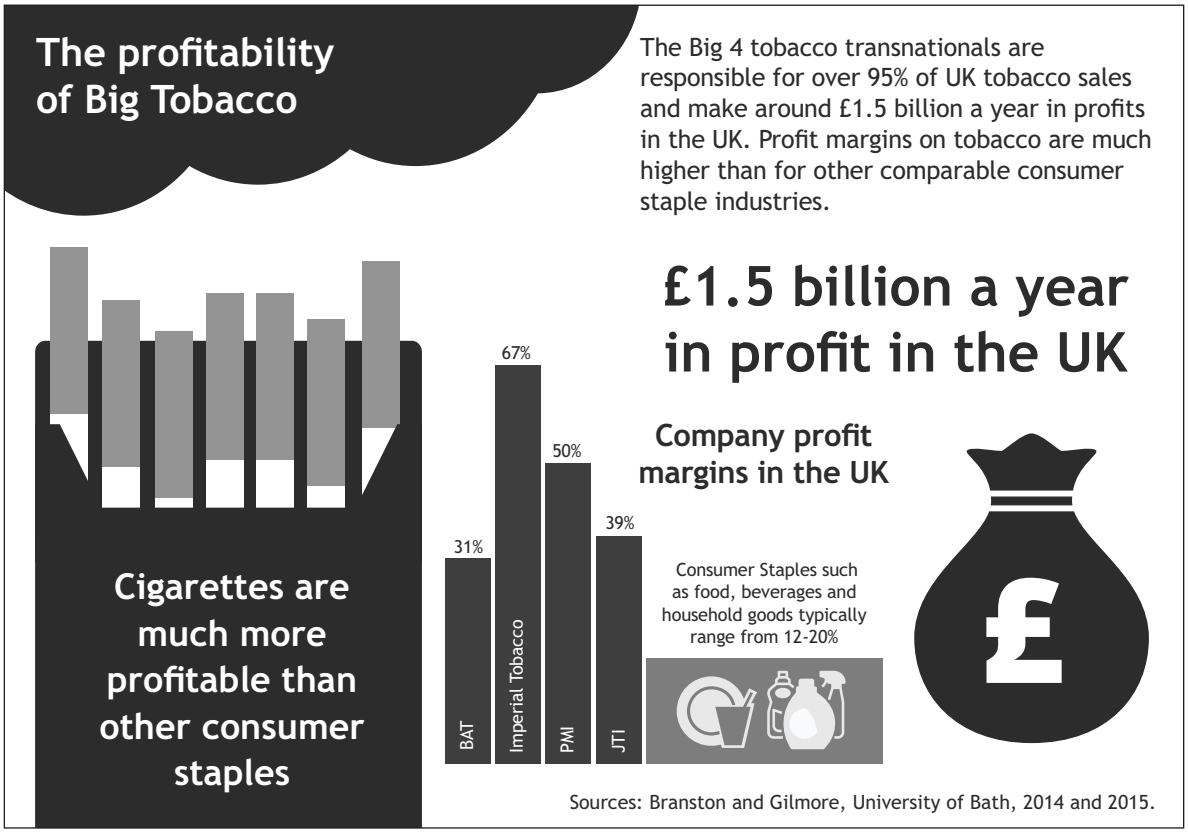

Figure 3 The Profitability of Big Tobacco

34. Any such funding, unless imposed as a legal requirement by government, would be counter to the UK's obligations as a Party to the WHO FCTC[7] to protect its public health policies from the commercial and vested interests of the tobacco industry. However, the fact that PMI made such an offer demonstrates that the big manufacturers have the money to pay a greater contribution to the costs of regulating their products and treating the range of health damage they cause.

35. A levy on the industry, with the money raised used to fund measures to help smokers quit and prevent young people from taking up smoking, is supported by the public (71%).[42]

36. ***The Government should impose a mandatory "polluter pays" levy on tobacco manufacturers and importers, to raise a fixed amount of money to help pay for the recurring costs of tobacco control.***

Reducing the affordability of tobacco (tax and illicit trade)

37. **Reducing the affordability of tobacco is highly effective in reducing smoking rates[43] [44] and can be achieved by Government both by increasing tobacco taxation and enforcement measures to reduce the size of the illicit market. Affordability has most impact on those who are most price sensitive, young people and poorer smokers, and cheap and illicit tobacco is disproportionately bought by poorer smokers. Reducing affordability is, therefore, crucial to reducing inequalities.**

38. ***The annual tobacco tax escalator should be increased to 5% above inflation (from 2%) with an additional uplift for hand-rolled tobacco of another 5% until the tax rate is equivalent to manufactured cigarettes.***

39. HMRC's illicit tobacco strategy has been in place since 2000 and remains well funded. The UK has ratified the Illicit Trade Protocol to the FCTC which has now come into force and will put in place tracking and tracing of cigarettes, in line with the requirements in the EU Tobacco Products Directive.

40. However, the success of the strategy in reducing the size of the illicit market in recent years[45] [46] has been undermined by cuts in funding to local authorities, limiting their ability to carry out enforcement activity.

41. Teams have been cut to the bone, with the National Audit Office (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 trading standards teams reporting that funding reductions have had a negative impact on their ability to protect consumers in their area.[47] In 2009 spending on trading standards was £213 million; in 2018-9 it is due to fall to just over half that, at £108 million.[48]

42. The 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.[49]

43. Experience from the North East has also demonstrated that demand reduction measures, including social marketing campaigns, are an effective way to generate intelligence for local trading standards teams and also to reduce 'comfort' levels towards illicit tobacco within communities.

44. The financial benefit from enhanced enforcement at local level accrues largely to HM Government rather than to local authorities who currently fund this work. It would seem appropriate therefore for funding of local authority enforcement to be found by HMRC, unless and until a levy is put in place to require the tobacco manufacturers to pay for these costs.

45. ***HMRC should fund regional trading standards activity to help tackle the illicit trade in tobacco.***

Retail licensing

46. Local authorities could also be supported in their enforcement work, to prevent underage and illicit sales of tobacco, by the introduction of a retail licensing scheme. Currently no licence is required to sell cigarettes, the most lethal legal product, so they can be sold anywhere, by anyone.

47. **Retailers of tobacco products have been implicated in or prosecuted for a number of supply chain offences, including sale of illicit tobacco[50] and sale of tobacco to minors, but for all but the most serious offences, without a licence to remove, they can simply carry on selling. More than a third of underage smokers buy their cigarettes from shops.**[51]

48. Both Scotland and Wales have a tobacco retailer registration system in place, but while useful, as recognised by the Scottish Government which is investigating strengthening their scheme,[52] this has limited benefit as there is no requirement for the retailer to meet any standards before being put on the register. A positive licensing scheme could:

    - 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.
    - Help to protect Government tax revenues.
    - Fund local enforcement activity.

49. The introduction of a licence that retailers are required to have before they can sell tobacco, is supported by the public (76%)[42] as well as retailers (69%) who support retailers losing their licence if they break the law.[53]

50. ***A licensing system for tobacco retailers should be implemented by national legislation to support enforcement activity against underage sales and illicit tobacco.***

Surveillance of tobacco industry behaviour

51. **It is a requirement of the WHO FCTC[7] that the UK implement stringent regulation of the tobacco industry for the protection of public health, far greater than for any other legal consumer product. This includes monitoring and surveillance of industry behaviour and ensuring that public policy is protected from the commercial and vested interests of the tobacco industry in line with Article 5.3 of the WHO FCTC.**

52. The tobacco industry has a track record of trying to interfere in policy development and implementation. Philip Morris International recently approached NHS Trusts offering to enter into partnerships with them.[54]

53. The Government has put on the record in Parliament that any such funding,[55] unless imposed as a legal requirement by government, would be counter to the UK's obligations as a Party to the WHO FCTC to protect its public health policies from the commercial and vested interests of the tobacco industry.

54. ***The Department of Health and Social Care should provide all parts of Government (including other Government departments, local authorities, NHS organisations and arm's length bodies) with advice on their responsibilities to protect public health policy from the commercial and vested interests of the tobacco industry based on the WHO FCTC Article 5.3 guidelines.***[56]

55. Publicly available data on tobacco sales, profits, marketing and research informs the development of tobacco control and tax policy, and aids the identification and understanding of illicit market trends over time at local level.

56. For example, academic analysis of industry pricing strategies, using commercially available data purchased from Nielsen was used by HMT and HMRC to inform the decision to implement a Minimum Excise Tax. However, just relying on commercially available data is not the answer, as they are not comprehensive and only available at significant cost (prohibitive given the budget constraints detailed above).

57. Taxpayer confidentiality has been cited as a reason why this is not possible, but in other jurisdictions 'taxpayer confidentiality' has not been an impediment to publication of such data.[57] [58] In Canada an act passed in 2018[59] 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:[60]

    - 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.

    Furthermore there is a clause allowing supplementary information to be required once notified by the Minister.

58. ***The Government should require collection and publication of industry sales and marketing data in line with best practice established in Canada.***

Mass media and social marketing campaigns

59. **Public education campaigns including well funded mass media and social marketing campaigns are an essential element of a comprehensive tobacco control programme.** Mass media anti-smoking advertising is an essential driver for effective social marketing campaigns. Such campaigns are effective and cost-effective in discouraging people from starting to smoke and encouraging existing smokers to quit,[61] [62] and can be effectively targeted at disadvantaged smokers. However, they need to be both intense and sustained in order to have a significant effect. [63]

60. The UK used to have a strong track record in this area, but in recent years national spending in England on such campaigns has fallen sharply, from a peak of £23.38 million in 2008/9.[64] Indeed government funding has been cut still further since the last APPG report raised concerns about this in January 2017. In 2015/16 spend was £5.3 million,[65] this was cut to £1.5 million in 2016/17, rising to £1.99 million in 2017/18[66] with £2.4 million allocated for 2018/19 but not yet confirmed.[67]

61. The allocation for 2018/19 is less than half that of 2015/6 and 10% of the amount spent ten years ago, not accounting for inflation. Over the same time period there has been a significant drop in the proportion of smokers trying to quit. In 2008 40% of smokers in England had tried to quit in the last year, in 2018 this had fallen by a quarter to only 30%.[68] If we are to increase the rate of decline in smoking prevalence it is necessary to increase the number of smokers trying to quit.

62. The lack of national campaigns has in the past to some extent been made up for by mass media campaigns at regional level backed up by proactive public relations activity. However, cuts in public health funding to local authorities have already led to the Southwest regional work coming to an end, and are now threatening funding in the North East of England too.

63. These campaigns have been part of comprehensive regional tobacco control strategies which have been associated with significantly higher rates of decline in smoking prevalence in the relevant regions than in regions without such strategies. Furthermore the highest rates of decline in these regions have been in routine and manual groups, thereby reducing health inequalities.

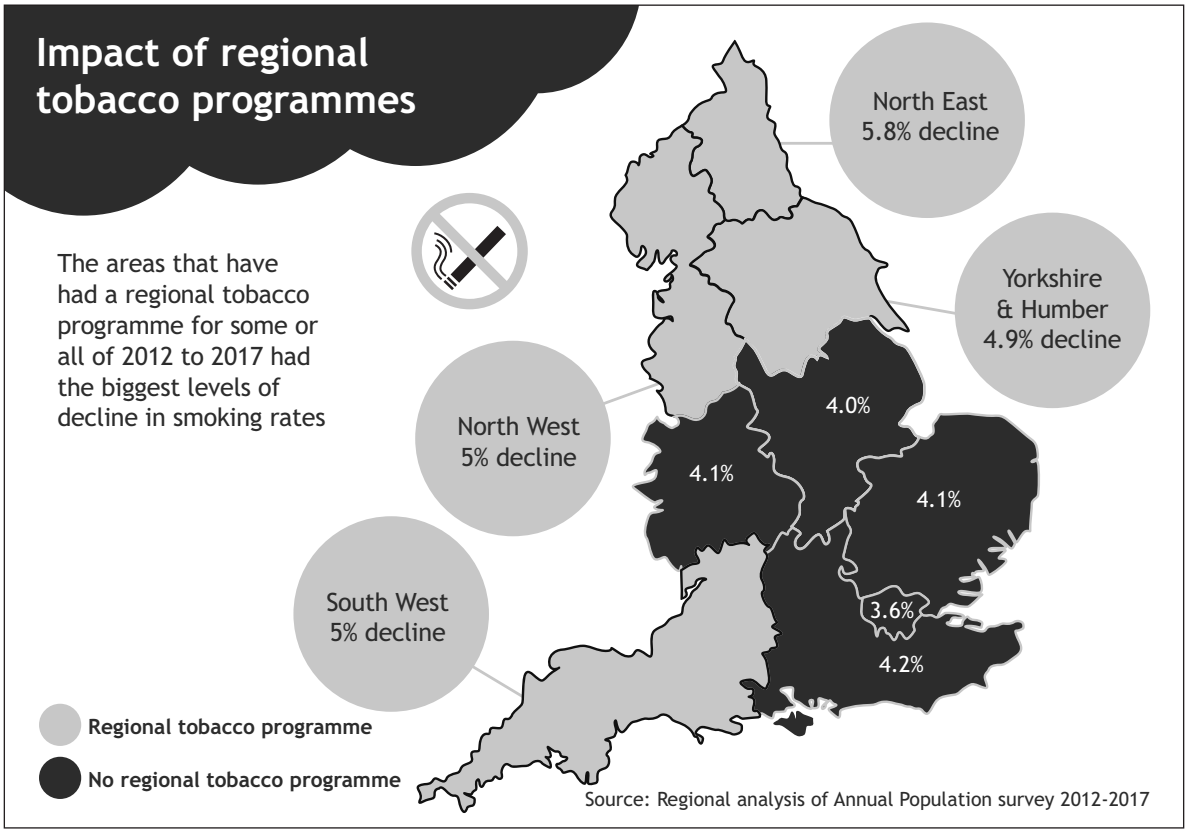

Figure 4 Impact of a regional tobacco programme

64. Greater Manchester Health and Social Care Partnership has committed to an ambitious new tobacco control strategy,[69] and will therefore pick up some of the slack in the North West, but funding for regional work in the North East and Yorkshire & Humber is threatened by local authority budget cuts. This is yet another argument for the 'polluter pays' levy on the tobacco manufacturers which could help fund such important regional activity on tobacco control. In the interim, however, it is essential that Public Health England sustains funding for such campaigns.

65. ***Public Health England should increase its funding for national mass media campaigns, backed up by social marketing and public relations activity, to motivate quitting and discourage uptake, in line with international best practice.***

Reducing children's exposure to smoking on screen

66. Prohibition of all advertising, promotion and sponsorship of tobacco means that the only remaining significant source of promotion of smoking is through its depiction in the entertainment media.

67. **There is substantial international peer-reviewed evidence that shows there is a causal link between exposure to smoking in the media and starting to smoke.**[70] This effect is dose-related, so that the greater the exposure, the greater the risk of smoking.

68. A recent survey in the UK found that in all media where questions were asked (TV, films, music videos, computer games and online) 11-18 year olds who had tried smoking were significantly more likely than those who have never smoked to report exposure to smoking imagery, particularly in TV and film.[71]

69. To date this issue has not been taken sufficiently seriously by the regulators for TV (Ofcom) and film (the BBFC). The APPG supports the recommendations made by ASH and the UKCTAS that:

    - Ofcom and the BBFC should monitor youth exposure to depictions of tobacco use on screen in the channels they regulate and publish these data in their annual reviews;
    - Ofcom and the BBFC should revise their guidelines with respect to smoking on screen in entertainment media viewed by under-18s to discourage any depictions of tobacco use; and require action to mitigate any remaining exposure.

70. ***The APPG urges the Department for Digital, Culture Media and Sport to ensure that the BBFC and Ofcom revise their guidelines on smoking to reduce the exposure of young people to depictions of smoking on screen.***

Age of sale legislation

71. Two thirds of those who experiment with smoking go on to become regular smokers, and experimentation is rare in adults over 21, so the more we can do to stop under 21s trying smoking the better. The tobacco industry recognise the importance of this age group, to quote Philip Morris (1986) *"Raising the legal minimum age for cigarette purchaser to 21 could gut our key young adult market (17-20) …"* [72]

72. Increasing the age of sale for the legal purchase of tobacco in 2007 from 16 to 18 was associated with reductions in regular smoking among youth in England and appeared to have a similar impact in different socio-economic groups.[73] Increasing the age of sale to 21 is popular and 57% of the British public support this, with only 19% opposing.[42]

73. In England 77% of smokers aged 16 to 24 in 2014 began smoking before the age of 18,[2] and data from the US show that about 95% of adult smokers begin smoking before they turn 21. The ages of 18 to 21 are also a critical period when many smokers move from experimental smoking to regular, daily use. US data show that while fewer than half of adult smokers (46%) become daily smokers before age 18, four out of five do so before they turn 21.[72]

74. **There is good evidence that raising the age of sale of tobacco to 21 will have a substantial positive impact on public health and save lives.** A report by the US Institute of Medicine strongly concluded that increasing the tobacco age will significantly reduce the number of adolescents and young adults who start smoking; reduce smoking-caused deaths; and immediately improve the health of adolescents, young adults and young mothers who would be deterred from smoking, as well as their children. [74] As of January 8, 2019, six US states (California, New Jersey, Massachusetts, Oregon, Hawaii and Maine) have already raised the tobacco age of sale to 21.[75]

75. ***The age of sale for tobacco products should be increased from 18 to 21.***

Helping smokers quit

76. As part of the NHS reforms responsibility for commissioning many public health services, including provision of smoking cessation services, was transferred to local authorities. However, with ongoing local authority funding cuts putting pressures on public health funding, services are disappearing up and down the country and universal access to smoking cessation treatment is no longer available.

77. The APPG recognises the important role of local authorities both in providing community-based support and as the local leaders of public health, which was comprehensively covered in the APPG's last report in January 2017.[34] However, this report concentrates on what more can be done by central government and arm's length bodies.

78. Furthermore while local authority funded smoking cessation support in the community is important it is not, and has never been, sufficient to reach all smokers. The NHS needs to do more to support the smokers in its care, prompting and supporting their quit attempts and linking into the services provided by local government. The Prime Minister, the Secretary of State for Health and Social Care and the Chief Executive of the NHS all recognised that the new NHS Plan[76] had to prioritise prevention, and that this included smoking cessation.

Tobacco dependence treatment in the NHS

79. The APPG is pleased therefore that the NHS Long Term Plan included dedicated funding for smoking cessation, not just for inpatients in acute settings, but also for pregnant smokers and their partners, and those with mental health conditions.[77] This is in line with NICE Guidance,[78] [79] and recommendations from the Royal College of Physicians,[80] the Smoking in Pregnancy Challenge Group,[27] the Mental Health & Smoking Partnership[81] and the APPG.

80. ***The APPG welcomes the NHS Long Term Plan commitment to dedicated funding for tobacco dependence treatment for all smokers in the care of the NHS. Comprehensive and effective implementation of these proposals is a prerequisite if we are to achieve the ambitions in the Tobacco Control Plan for England and the Government's vision for prevention.***

Access to alternatives to smoking

81. E-cigarettes are now the most popular aid for smokers trying to stop smoking, and are proving effective, both bought over the counter, and used in conjunction with behavioural support to quit provided by stop smoking services.[82] [83]

82. However, while the evidence is that e-cigarettes are less harmful than smoking,[29] [84] they are not risk-free and they should only be used by smokers when quitting smoking. UK regulation[85] of e-cigarettes as consumer products restrict advertising, and age of sale laws prohibit purchase by under 18s to minimise the risk of e-cigarette use by young people.

83. The UK regulations seem to be working. There is little or no regular use of e-cigarettes by children, and where it does occur it is among children who also smoke.[86] Furthermore, as required by the regulations, the Government must review whether they are effective and publish a report within five years (by 20 May 2021), and every five years thereafter.

84. However, medical organisations like the Royal College of Physicians[87] and the British Medical Association[88] believe that having medicinally-licensed e-cigarettes available as an additional option could be helpful as it could give health professionals confidence in the safety and efficacy of such devices. This could also help address the public misperceptions about the relative risks of smoking and vaping and so help encourage the 40% of smokers who have not tried e-cigarettes as a quitting aid to do so.[89] Furthermore medicinally licensed e-cigarettes could be made available on prescription, which is not allowed for unlicensed products.

85. The 2017 Tobacco Control Plan for England committed to *"ensure that the route to medicinal regulation for e-cigarette products is fit for purpose so that a range of safe and effective products can potentially be made available for NHS prescription"*.[2]

86. The Government has clarified that medicinally licensed e-cigarettes sold over the counter would be taxed at 5% VAT, the same rate as for currently licensed nicotine replacement therapies sold over the counter.[90] This is a helpful financial incentive to manufacturers and importers considering whether to apply for a licence. Yet so far this has not been sufficient.

87. To date one e-cigarette has been authorised by the Medicines and Healthcare products Regulatory Agency (MHRA) for medicinal use, but it has not been commercialised. One other company that made public its application for a product licence after publication of the Tobacco Control Plan, subsequently withdrew its application. Although the company says it believed that the MHRA's abridged application process for NRT products was fit for purpose in principle, in practice it found the MHRA was applying it so that there was negligible difference to what would be expected of any new medicinal product.

88. In particular the company found that the MHRA did not appear to take into account that the comparator for nicotine replacement therapies like e-cigarettes is continued smoking rather than simply following European Directives routinely applied to medicines, and that consumer satisfaction is crucial to the success of vaping.[91]

89. The Government has accepted the recommendation[92] of the Select Committee on Science and Technology[93] that the MHRA should review medicines licensing for e-cigarettes. **The MHRA is setting up an ad hoc working group under the sponsorship of the Commission on Human Medicines (CHM) to review how**

medicines licensing for e-cigarettes could be streamlined or simplified. The MHRA is "hoping" that the recommendation of the working group will be received by July 2019 and it will then be incorporated in the Government response to the select committee.[94]

90. ***The MHRA should ensure that the ad hoc working group on e-cigarettes delivers its recommendation by July 2019***.

Government mandated pack inserts to encourage quitting

91. Historically tobacco manufacturers included promotional material within cigarette packs, such as cigarette cards and coupons and therefore the UK's standardised packaging legislation prohibits pack inserts.[95]

92. In Canada, in contrast, there has been a legal requirement for manufacturers to include educational material within cigarette packs since 2000.[96] These are in the form of inserts highlighting the benefits of quitting, or providing tips on how to do so.

93. Canadian research has found that while reading on-pack health warnings significantly decreased over time, reading inserts significantly increased, with more frequent reading of inserts associated with self-efficacy to quit, quit attempts and sustained quitting at follow-up.[97]

94. Focus group research by academics at the University of Stirling found that smokers, diverse in age, gender and social grade, supported the use of such inserts in the UK to encourage them to quit.[98]

95. **Pack inserts provide an inexpensive and highly targeted means of supplementing on-pack warnings with messaging encouraging smokers to quit.**

96. ***Legislation should be brought forward to require manufacturers to include educational pack inserts, with the content determined by the Government***.

97. Set out overleaf are the conclusions and recommendations taken from the body of the report (paragraph number in brackets).

Conclusions and Recommendations

1. **The UK's implementation of tobacco control measures over the last decade and more has significantly outstripped that of the rest of Europe and our smoking prevalence has declined much more rapidly. This clearly demonstrates the benefits of the UK's comprehensive strategy to date and the need for it to be sustained in the future. [11]**

2. **The evidence is clear, not just from the UK but other jurisdictions too, that smoking prevalence only continues to decline when tobacco control policies continue to be updated, invigorated and improved. Furthermore, the more extensive and comprehensive the tobacco control policies are, the more effective they will be in reducing youth initiation and increasing the number of adult smokers who quit. [21]**

Creating a smokefree generation

3. **However, by limiting its commitments and trying to shift responsibility for delivery over to localities, while at the same time demanding more from declining levels of public health funding, the Government did not ultimately pursue the challenge it set itself in the Tobacco Control Plan to achieve a *'Smokefree Generation'*. [22]**

4. **The APPG agrees that localities have a major role to play, and our recommendations for local authorities and adequate funding for public health were set out in our last report in January 2017. We also support the dedicated funding in the Long Term Plan to help smokers being treated by the NHS to quit. However, this report focuses on what more central government can do to deliver the national vision of a smokefree generation as an integral element in an effective prevention strategy. [23]**

Making the Polluter pay

5. **Making the leading tobacco transnationals responsible for the vast majority of tobacco sales in the UK pay toward the cost of reducing smoking prevalence, is a wholly justified extension of the "polluter pays" principle, supported by the APPG. At present it is the polluted who pay most, through the cost of their addiction and the burden of ill health that results. [28]**

6. ***The Government should impose a "polluter pays" levy on tobacco manufacturers and importers, to raise a fixed amount of money to help pay for the recurring costs of tobacco control.[36]***

Reducing the affordability of tobacco

7. **Reducing the affordability of tobacco is highly effective in reducing smoking rates and can be achieved by Government both by increasing tobacco taxation and enforcement measures to reduce the size of the illicit market. Affordability has most impact on those who are most price sensitive, young people and poorer smokers, and cheap and illicit tobacco is disproportionately bought by poorer smokers. Reducing affordability is, therefore, crucial to reducing inequalities.[37]**

8. ***The annual tobacco tax escalator should be increased to 5% above inflation (from 2%) with an additional uplift for hand-rolled tobacco of another 5% until the tax rate is equivalent to manufactured cigarettes. [38]***

9. ***HMRC should fund regional trading standards activity to help tackle the illicit trade in tobacco.[45]***

Retail licensing

10. **Retailers of tobacco products have been implicated in or prosecuted for a number of supply chain offences, including sale of illicit tobacco and sale of tobacco to minors, but for all but the most serious offences, without a licence to remove, they can simply carry on selling. More than a third of underage smokers buy their cigarettes from shops. [47]**

11. ***A licensing system for tobacco retailers should be implemented by national legislation to support enforcement activity against underage sales and illicit tobacco.[50]***

Surveillance of tobacco industry behaviour

12. **It is a requirement of the WHO FCTC, that the UK implement stringent regulation of the tobacco industry for the protection of public health, far greater than for any other legal consumer product. This includes monitoring and surveillance of industry behaviour and ensuring that public policy is protected from the commercial and vested interests of the tobacco industry in line with Article 5.3 of the WHO FCTC.[51]**

13. ***The Department of Health and Social Care should provide all parts of Government (including other Government departments, local authorities, NHS organisations and arm's length bodies) with advice on their responsibilities to protect public health policy from the commercial and vested interests of the tobacco industry based on the WHO FCTC Article 5.3 guidelines.[54]***

14. ***The Government should require collection and publication of industry sales and marketing data in line with best practice established in Canada.[58]***

Mass media and marketing campaigns

15. **Public education campaigns including well funded mass media and social marketing campaigns are an essential element of a comprehensive tobacco control programme.[59]**

16. ***Public Health England should increase its funding for national mass media campaigns, backed up by social marketing and public relations activity, to motivate quitting and discourage youth uptake, in line with international best practice.[65]***

Reducing the exposure of young people to smoking on screen

17. **There is substantial international peer-reviewed evidence that shows there is a causal link between exposure to smoking in the media and starting to smoke.[67]**

18. ***The APPG urges the Department for Digital, Culture Media and Sport to ensure that the BBFC and Ofcom revise their guidelines on smoking to reduce the exposure of young people to depictions of smoking on screen. [70]***

Age of sale legislation

19. **There is good evidence that raising the age of sale of tobacco to 21 will have a substantial positive impact on public health and save lives.[74]**

20. ***The age of sale for tobacco products should be increased from 18 to 21.[75]***

Helping smokers quit

Tobacco dependence treatment in the NHS

21. ***The APPG welcomes the NHS Long Term Plan commitment to dedicated funding for tobacco dependence treatment for all smokers in the care of the NHS. Comprehensive and effective implementation of these proposals is a prerequisite if we are to achieve the ambitions in the Tobacco Control Plan for England and the Government's vision for prevention. [80]***

Access to alternatives to smoking

22. **The MHRA is setting up an ad hoc working group under the sponsorship of the Commission on Human Medicines (CHM) to review how medicines licensing for e-cigarettes could be streamlined or simplified. [89]**

23. ***The MHRA should ensure that the ad hoc working group on e-cigarettes delivers its recommendation by July 2019.[90]***

Government mandated pack inserts to encourage quitting

24. **Pack inserts provide an inexpensive and highly targeted means of supplementing on-pack warnings with messaging encouraging smokers to quit. [95]**

25. ***Legislation should be brought forward to require manufacturers to include educational pack inserts, with the content determined by the Government.[96]***

References

Links accessed 8 February 2019

1. Department of Health & Social Care. Prevention is better than cure: Our vision to help you live well for longer. 5 November 2018.
2. Department of Health. Towards a smokefree generation: tobacco control plan for England, 18 July 2017.
3. Office for National Statistics. Adult smoking habits in the UK: 2017, 3 July 2018.
4. Jha P, Peto R, Zatonski W, Boreham J, Jarvis MJ, Lopez AD. Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America. The Lancet. 2006 Jul 29;368(9533):367-70.
5. Malone, RE. The race to a tobacco endgame. BMJ Tobacco Control, 2016
6. UK Government. Smoking Kills: A white paper on tobacco. 1998
7. World Health Organisation. WHO Framework Convention on Tobacco Control.
8. World Bank. 1999. Curbing the epidemic - governments and the economics of tobacco control (English). Development in practice. Washington DC ; World Bank.
9. Department of Health. Official Development Assistance Project: Strengthening tobacco control in low and middle income countries, August 2017.
10. Association of European Cancer Leagues. The Tobacco Control Scale 2016 in Europe, March 2017.
11. Feliu A, Filippidis FT, Joossens L, Fong GT, Vardavas CI, Baena A, Castellano Y, Martínez C, Fernández E. Impact of tobacco control policies on smoking prevalence and quit ratios in 27 European Union countries from 2006 to 2014. Tobacco control. 2018 Feb 22: tobacco control-2017.
12. European Commission. Special Eurobarometer 458: Attitudes of Europeans towards tobacco and electronic cigarettes, May 2017.
13. Office for National Statistics. Smoking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey), 7 March 2013.
14. HM Government. Tobacco Control Plan for England, March 2011.
15. Public Health England. Turning the tide on tobacco: Smoking in England hits a new low, 3 July 2018
16. NHS Digital. Smoking, drinking and drug use among young people in England – 2016, 2 November 2017.
17. Doll R. Peto R. Boreham J. Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004;328:1519
18. Centers for Disease Control and Prevention (CDC). Cigarette smoking-attributable morbidity---United States, 2000. MMWR. Morbidity and mortality weekly report. 2003 Sep 5;52(35):842.
19. Cancer Research UK. Stop Smoking Inequalities, July 2018.
20. NHS Digital, Smoking, drinking and drug use among young people in England – 2016, Chapter 4 Smoking Context Table 4.2, 2 November 2017.
21. Calculated by the Cancer Research UK Statistical Information Team, using data from the Smoking, Drinking and Drug Use in Young People in England survey 2016
22. HM Government. Driving school minibuses. Advice for schools and local authorities. September 2013.
23. Birge M, Duffy S, Miler JA, Hajek P. What proportion of people who try one cigarette become daily smokers? A meta-analysis of representative surveys. Nicotine & Tobacco Research. 2017 Nov 4.
24. NHS Digital. Smoking, Drinking and Drug Use among young people in England 2016, Chapter 2 tables – smoking prevalence. Table 2.3, November 2017.
25. Scottish Government. Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) Smoking report. 2015
26. NHS Digital. The Health and Social Care Information Centre: Infant Feeding Survey 2010. 2012.
27. Smoking in Pregnancy Challenge Group. Review of the Challenge, July 2018
28. NHS Digital. Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 1, 2018-19, 6 September 2018.
29. Royal College of Physicians. Nicotine without smoke: Tobacco harm reduction, April 2016.
30. Hill DJ, White VM, Scollo MM. Smoking behaviours of Australian adults in 1995: trends and concerns. The Medical Journal of Australia. 1998 Mar 2;168(5):209-13. Insights from Australia's National Tobacco Campaign. Tobacco Control. 2003 Sep 1; 12(suppl 2): ii.
31. Pierce JP, Gilpin EA, Emery SL, White MM, Rosbrook B, Berry CC. Has the California tobacco control program reduced smoking? Jama. 1998 Sep 9;280(10):893-9.
32. Darzi A. Better Health for London. London Health Commission. October 2014.
33. Gravely S, Giovino GA, Craig L, et al. Implementation of key demand reduction measures of the WHO framework convention on tobacco control and change in smoking prevalence in 126 countries: an association study. Lancet Public Health 2017; 2:e166–74.
34. APPG on Smoking and Health. Burning injustice: Reducing tobacco-driven harm and inequality, January 2017
35. Cancer Research UK & Action on Smoking and Health. Feeling the heat: The decline of stop smoking services in England, January 2018.
36. The King's Fund. Local government spending on public health: death by a thousand cuts, 3 January 2018.
37. 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.
38. Smee C, Parsonage M, Anderson R, Duckworth S. (1992) Effect of tobacco advertising on tobacco consumption: A discussion document reviewing the evidence.

39. Branston JR and Gilmore A. The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy, University of Bath, 2015.
40. Branston, J.R. and Gilmore, A.B. 2017. The Failure of the UK to Tax Adequately Tobacco Company Profits, under review at *Tobacco Control*.
41. Campbell D. World's biggest tobacco firm under fire over 'disgraceful' PR stunt. Guardian. 19 July 2018.
42. Action on Smoking and Health. Opinion research by YouGov. Total sample size was 12696 GB adults 18+. Fieldwork was undertaken between 16th February 2017 and 19th March 2017.
43. World Health Organisation. Effectiveness of Tax and Price Policies for Tobacco Control IARC Handbooks of Cancer Prevention Volume 14, 2011.
44. World Health Organisation. Effectiveness of Tax and Price Policies for Tobacco Control, 2011.
45. HMRC. Tobacco Tax Gaps data. All figures based on mid-range estimates. October 2017.
46. Action on Smoking and Health. Press release: Tobacco Tax Gaps: Illicit cigarettes a growing proportion of a declining market – enforcement funding cuts must be addressed, 26 October 2017.
47. National Audit Office. Report by the Comptroller and Auditor General: Protecting consumers from scams, unfair trading and unsafe goods. NAO. HC851. 2016.
48. Labour Communities & Local Government. Local Government Health Check Report 4: Trading Standards. Labour Communities and Local Government, August 2018.
49. National Audit Office. Report by the Comptroller and Auditor General. Progress in tackling tobacco smuggling. 6 June 2013. HC 226 Session 2013-14.
50. HMRC. HMRC press releases on tobacco fraud
51. NHS Digital. Smoking, drinking and drug use among young people in England – 2016. 2017. Chapter 3 table 3.4.
52. Scottish Government. Improving Scotland's Health. Raising Scotland's Tobacco-free Generation. Our Tobacco-Control Action Plan 2018.
53. Action on Smoking and Health. Counter arguments: How important is tobacco to small retailers?, October 2016
54. The Guardian. World's biggest tobacco firm under fire over 'disgraceful' PR stunt, 19 July 2018.
55. House of Commons, Hansard. Debate: Tobacco Control Plan, 19 July 2018.
56. WHO FCTC. Guidelines for the implementation of Article 5.3. 2008.
57. Observatoire Francais des Drogues et Des Toxicomanies. Tableau de bord TABAC, 20 April 2018
58. Federal Trade Commission. Cigarette Report for 2016.
59. Government of Canada. Tobacco and Vaping Products Act (S.C. 1997, c. 13), 23 May 2018.
60. Government of Canada. Canadian Environmental Protection Act, 1999, 2 December 2017.
61. Langley, T., McNeill, A., Lewis, S., Szatkowski, L., Quinn, C., 2012. The impact of media campaigns on smoking cessation activity: a structural vector autoregression analysis. Addiction 107(11), 2043-2050
62. Sims M, Salway R, Langley T, Lewis S, McNeill A, Szatkowski L, Gilmore A. Effectiveness of mass media campaigns to change tobacco use in England: a population-based cross-sectional study. 2014; 109(6):986-94.
63. Atusingwize E, Lewis S, Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review. Tobacco Control. 2015 Jul; 24(4):320-7.
64. House of Commons, Hansard. Reply to parliamentary question tabled by Chris Ruane Col, 864W, 24 April 2012.
65. Hansard. Smoking: Written question 35653. 3 May 2016
66. Hansard. Smoking: Written question – 214029. 29 January 2019.
67. Hansard. Smoking: Written question – 198221. 3 December 2018.
68. Brown J, Proudfoot H, West R (2019) Smoking and smoking cessation in England: annual trends 2007-2018. www.smokinginengland.info.
69. Greater Manchester Combined Authority. Greater Manchester Health and Social Care Partnership: Making Smoking History: A Tobacco Free Greater Manchester. 2017-2021. 2017.
70. Surgeon General. Preventing tobacco use amongst youth and young adults, 2012.
71. Action on Smoking and Health and the UK Centre for Tobacco and Alcohol Studies. Evidence to the House of Commons Select Committee on Science and Technology, from the UK Centre for Tobacco and Alcohol Studies and ASH, April 2018.
72. Campaign for Tobacco Free Kids. Raising the tobacco age to 21, 30 August 2018.
73. Millett C, Lee JT, Gibbons DC, Glantz SA. Increasing the age for the legal purchase of tobacco in England: impacts on socio-economic disparities in youth smoking. Thorax. 2011;66(10):862-865. doi:10.1136/thx.2010.154963.]
74. IOM (Institute of Medicine). 2015. Public health implications of raising the minimum age of legal access to tobacco products. Washington, DC: The National Academies Press.
75. Campaign for Tobacco Free Kids. States and localities that have raised the minimum legal sale age for tobacco products to 21.
76. Theresa May MP. PM speech on the NHS, 18 June 2018.
77. NHS. The NHS Long Term Plan. January 2019.
78. National Institute for Health and Care Excellence. Smoking: stopping in pregnancy and after childbirth, June 2010.
79. National Institute for Health and Care Excellence. Smoking: acute, maternity and mental health services, November 2013.
80. Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS, 26 June 2018.
81. Action on Smoking and Health. The Stolen Years, The Mental Health and Smoking Action Report, April 2016.

82. Brown J, Beard E, Kotz D, Michie S, and West R. Real-world effectiveness of e-cigarettes when used to aid smoking cessation: A cross-sectional population study. Addiction 2014. 109:
83. Hajek P et al. A randomised trial of e-cigarettes versus nicotine replacement therapy. New England Journal of Medicine. DOI: 10.1056/NEJMoa1808779
84. Public Health England. Evidence review of e-cigarettes and heated tobacco products 2018, February 2018
85. Statutory Instruments. Consumer Protection. Tobacco and related products regulations 2016. 2016 No. 507.
86. Bauld L et al Young People's Use of E-Cigarettes across the United Kingdom: Findings from Five Surveys 2015-2017, International Journal of Environmental Research and Public Health 2017, 14, 29 August 2017
87. Royal College of Physicians. Nicotine without smoke: Tobacco harm reduction, April 2016.
88. BMA. E-cigarettes: Balancing risks and opportunities. 2017.
89. ASH factsheet. Use of e-cigarettes among adults in Great Britain. September 2018.
90. House of Commons, Hansard. Written Question on e-cigarettes asked by Bob Blackman, 17 October 2018.
91. Personal communication from NJOY to ASH. January 2019.
92. DH&SC The Government Response to the Science and Technology Committee's Seventh Report of the Session 2017-19 on E-cigarettes. December 2018. Cm 9738
93. House of Commons Science and Technology Committee. E-cigarettes. Seventh Report of Session 2017–19. July 2018. HC 505
94. Hudson I. E-cigarettes as medicinally licensed products. Letter to Chair Select Committee on Science and Technology. MHRA. 10 December 2018.
95. HM Government. The Standardised Packaging of Tobacco Products Regulations 2015, 20 May 2016
96. Health Canada. Regulatory impact analysis statement (Tobacco Products Information Regulations). Canada Gazette 2000;134:1738–848.
97. Thrasher JF, Swayampakala K, Cummings KM, et al. Cigarette package inserts can promote efficacy beliefs and sustained smoking cessation attempts: A longitudinal assessment of an innovative policy in Canada. Prev Med 2016;88:59–65.
98. Moodie C. Adult smokers' perceptions of cigarette pack inserts promoting cessation: a focus group study. Tobacco Control 2018;27:72-77.

This report was commissioned by the Chairman of the All Party Parliamentary Group on Smoking and Health from Action on Smoking and Health (ASH) which provides the Secretariat for the APPG. It was researched and written with support from the UK Centre for Tobacco and Alcohol Studies (UKCTAS), which is the centre of excellence in tobacco research in the UK and includes research teams in twelve UK universities.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. This report has been endorsed by the Chairman, Bob Blackman MP; Treasurer, Ian Mearns MP; and vice-chairs Alex Cunningham MP, Lord Faulkner, Baroness Finlay and Lord Rennard.

Date of publication: February 2019

ISBN 978-0-9934707-7-6