ash at 50

Stubbing out smoking since 1971

Royal College of Physicians

ash
action on smoking and health

Foreword

This is the story of an inspired and enduring partnership established 50 years ago to try to reduce the terrible toll of death and disease in the UK from smoking. Realising that their academic but popular reports on smoking could not in themselves bring about the necessary change, in 1971 the Royal College of Physicians (RCP) set up Action on Smoking and Health (ASH) to lobby and campaign for tobacco control. With this act of extraordinary foresight began one of the most successful campaigning organisations not just in the UK, but in the world.

Grown and enhanced by its subsequent leaders and staff, ASH not only campaigned effectively, but also took on the vital role of coordinating a series of tobacco control alliances. It first brought together charities and medical organisations, then broadened the alliances to include local government and trade unions, in fact any organisation or body with the same aim of saving lives and reducing disease by reducing smoking.

The RCP settled into its core role – providing the academic evidence base for the campaigns with its continuing series of influential reports, making policy recommendations for action. The reports and relationship with ASH were rekindled with the setting up of the RCP's Tobacco Advisory Group in 1997, bringing together representatives from other branches of medicine, co-opting individual experts in previously unexplored areas, and always including the head of ASH to coordinate activity.

Meanwhile, the effectiveness of ASH and the alliances, which always included the RCP, grew and were instrumental in achieving the key protective public health legislation of the past few decades – banning smoking in cars and public places, outlawing tobacco advertising, achieving restrictions on the sale of tobacco and introducing plain packaging. These achievements are some of the greatest successes of public health lobbying in the world and show what we can do when we work together.

In the UK, we have progressed from a time when nearly two-thirds of men and more than four women in every ten smoked, to now, when one in six smoke. Despite our undeniable success, there is still much to do to make the UK smokefree – particularly in the area of health inequalities. We are not standing still. In the past year, both our organisations have produced further policy reports and we continue to push the government into taking action.

Neither of us want it to be another 50 years for our vision of a smokefree UK to become a reality. But inspired by the events of 50 years ago, we will keep going until it does...

Andrew Goddard
President, Royal College of Physicians

Nick Hopkinson
Chair, Action on Smoking and Health

Origins

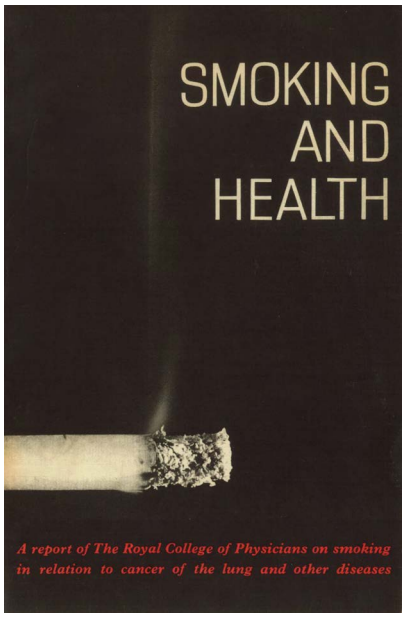
One hundred years before the foundation of ASH, hardly anyone in Britain smoked cigarettes. Tobacco consumption was limited to pipes and cigars, which remained the exclusive preserve of men, while handmade cigarettes were luxury items.

Then in 1880 James Albert Bonsack patented the cigarette rolling machine which revolutionised smoking. Machine-made cigarettes were cheap to make in very high volumes and highly addictive because they were easily inhaled, paving the way for the rapid growth in tobacco consumption that characterised the first half of the 20th century.

Lung cancer was the canary in the coal mine. A rare disease historically, it became the most common cause of death in the 20th century.

The alarm had first been raised in Britain by Richard Doll and Austin Bradford Hill in 1950. Their research drew attention to the strong association between smoking and lung cancer, first among patients in London hospitals, then within the medical profession itself.

The research convinced doctors to give up smoking but wasn't gaining traction publicly, partly because their epidemiological methods were relatively new and unfamiliar, but also because of the ubiquity of smoking and the influence of the tobacco companies in government circles. In 1957, the Medical Research Council and the government acknowledged the causal link between smoking and cancer, but action was very limited.



Once again it fell to the medical profession to intervene, and Charles Fletcher was just the man to lead the charge. Fletcher was a respected chest doctor and a fellow of the Royal College of Physicians (RCP). He knew Doll and Hill and had been just as surprised as they were when the evidence linking smoking to cancer and bronchitis emerged. He was also developing a reputation as a public communicator and was familiar to the general public as one of the first television medics in the series 'Your life in their hands', a role strongly disapproved of by many in his conservative profession.

Determined to press for change, he found the perfect ally in Robert Platt, the new RCP president, who supported his suggestion that the RCP should undertake an inquiry into smoking.

In 1971 the RCP published *Smoking and health now* and launched ASH… which quickly became a formidable advocacy organisation.

Fletcher chaired the committee and edited a groundbreaking report published in 1962, *Smoking and health*, ensuring that the language was suitable for politicians rather than doctors.

The popularity of *Smoking and health* had an impact on smoking behaviour but its recommendations for action were largely ignored. The government continued to drag its feet, not least because smoking was so important to tax revenues. By the end of the 1960s, both Fletcher and the RCP felt that the time was ripe to have another go, but this time any ensuing report should be supported by an anti-smoking organisation.

In 1971 the RCP published *Smoking and health now* and launched Action on Smoking and Health (ASH) with the support of around 75 organisations. Originally conceived as a channel for communication about the effects of smoking, ASH quickly became a formidable advocacy organisation, leaving information and education to the new Health Education Council. In 1973, ASH's first director, Dr John Dunwoody, returned to general practice and was replaced by Mike Daube, a professional activist who set about turning ASH into a fully-fledged campaigning organisation.

At the outset, the health minister Keith Joseph gave ASH a grant of £125,000 to get started and insisted that no more money would be forthcoming. But civil servants, parliamentarians, policy makers and government ministers soon recognised the value of this professional outside voice. Furthermore, Mike Daube's success in creating a cross-party group on smoking and health in the House of Commons secured an enduring foot in the parliamentary door. Government funding though sustained, was limited, but thanks to the steadfast support of the British Heart Foundation and Cancer Research UK, ASH was able to square up to the long-term challenge of transforming the smoking habits of the British population.

RCP's *Smoking and health* report is launched

1962

Royal College of Physicians sets up ASH

1971

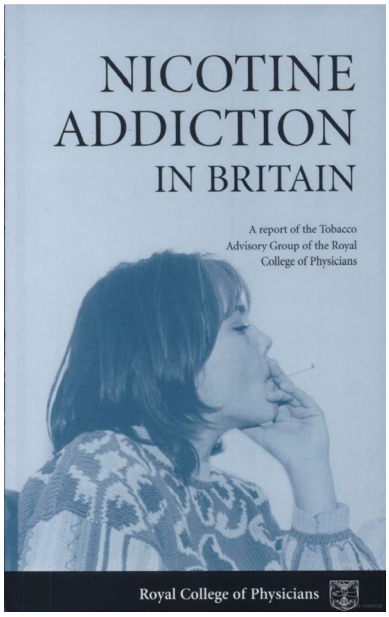
The tide turns

ASH was quick to exploit the media to advance the cause of non-smoking and tobacco control. Mike Daube focused on keeping the organisation in the news, believing that more could be achieved through good media coverage than through any number of leaflets or posters.

This media advocacy was vital when the government remained unwilling to intervene. The tobacco industry was powerful and close to government and successfully kept measures that would have damaged its interests off the negotiating table. A health warning on cigarette packs and restrictions on cigarette advertisements were a small price to pay for regulation based on voluntary agreement rather than legislation.

Twenty years after the foundation of ASH, in 1991, smoking was still commonplace, the industry was spending £100 million a year on advertising, and 'denormalisation' of smoking was unheard of. Yet the expansion of the smoking epidemic in Britain had been unequivocally put into reverse. The prevalence of adult smoking had fallen from 75% to 30% among men and 50% to 28% among women. Public awareness of the risks of smoking was having an impact.

During the 1990s the decline in smoking rates slowed dramatically, government action was limited and illicit tobacco sales rose rapidly because of the complicity of the tobacco industry. In 1998 the tide turned decisively with the publication of *Smoking Kills*, the first comprehensive government strategy on tobacco. Legislation and policy changed shortly



thereafter. In 2000, stop smoking services were rolled out across England, offering smokers treatment to tackle their addiction. From 2003, advertising and sponsorship were banned. This reflected a growing acknowledgement by government that smoking was not a simple personal lifestyle choice, but a serious addiction requiring tough regulation.

In 2005, after many years of lobbying, the WHO Framework Convention on Tobacco Control (FCTC) came into force, the first treaty of its kind. This brought civil society organisations together from across the world as a collective lobbying voice, countering the tobacco industry and formally excluding the industry from political lobbying.

In 2007, after a long campaign focusing on the risks to non-smokers of second-hand tobacco

Health warnings are introduced on packs

1973

The All-Party Parliamentary Group on Smoking and Health is founded

1976

In 1998 the tide turned decisively with the publication of *Smoking Kills*, the first comprehensive government strategy on tobacco. Legislation and policy changed shortly thereafter.

smoke, all enclosed workplaces and public places in the UK became smokefree. As well as protecting non-smokers, this groundbreaking legislation played a key role in shifting public attitudes to smoking. Smoking had been marginalised, literally, from social discourse.

All retail displays of cigarettes were gone by 2015, and plain packaging of tobacco products was mandated from 2016.

ASH played a central role in campaigning for each of these changes, led from 1997 by Clive Bates and from 2003 by Deborah Arnott, whose resilience in the face of industry and political opposition became legendary. Over 5 decades, ASH's *modus operandi* has been characterised firstly by building alliances and working in partnership, secondly by engaging the media and communicating the evidence, and thirdly by actively opposing the industry every step of the way.

Founded by advocates who were first and foremost academics and clinicians, ASH has always remained close to the medical and academic community, who have been active participants in ASH's many campaigns.

Over the years, ASH's advocacy networks grew to include parliamentarians, through the All-Party Parliamentary Group on Smoking and Health, and wider civil society.

The Smokefree Action Coalition, created by ASH to fight for the 2007 smokefree legislation, remains vital to ASH's advocacy work within the UK, and ASH's involvement in the Framework Convention Alliance of the FCTC has sustained its important role in international advocacy.

More recently, the rise of social media, the swirl of fake news, and the loss of trust in experts have provided fertile ground for public doubts to grow. The harms of smoking may no longer be challenged but persistence is needed to communicate the evidence and win public support.

Between the formation of ASH in 1971 and 2019, an estimated 7.8 million men and women died from smoking-related diseases in the UK. Every one of these deaths was preventable. Smoking prevalence may be at a historic low at a population level, but millions of people in Britain still risk their health and lives every day. There is a great deal still to do.

The government strategy *Smoking Kills* is published

1998

Ad ban and large pack warnings are achieved

2003

Annual UK smoking attributable deaths at 5-yearly intervals from 1950

Smoking attributed deaths – thousands per year (all ages)

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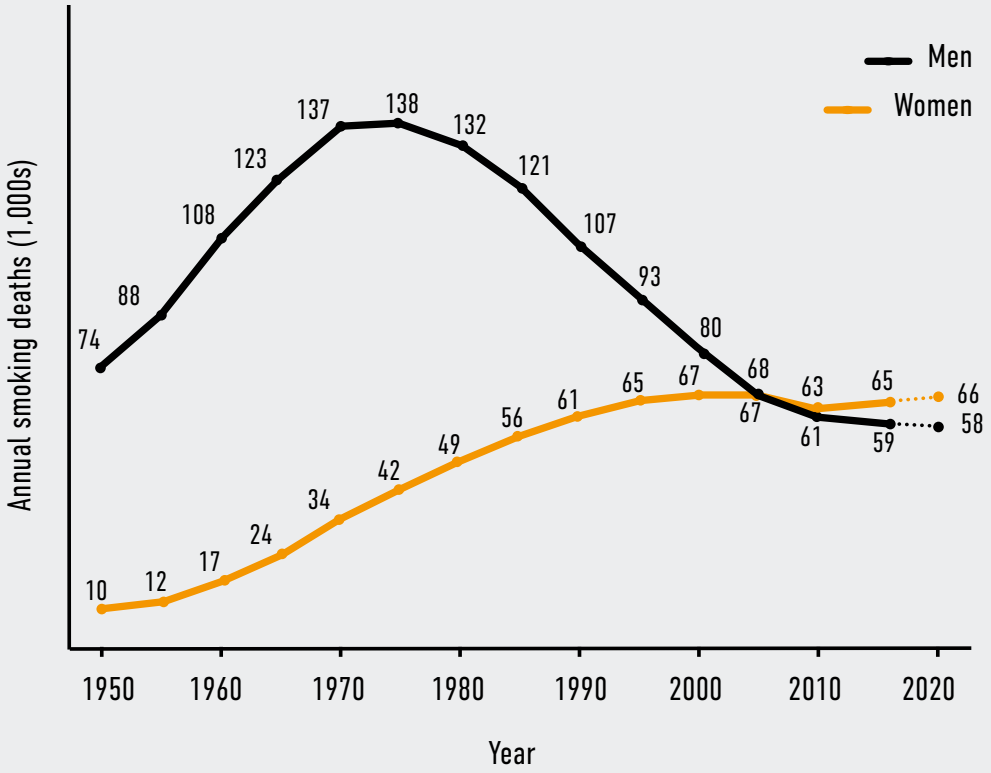

Smoking attributed deaths – % of all deaths (all ages)

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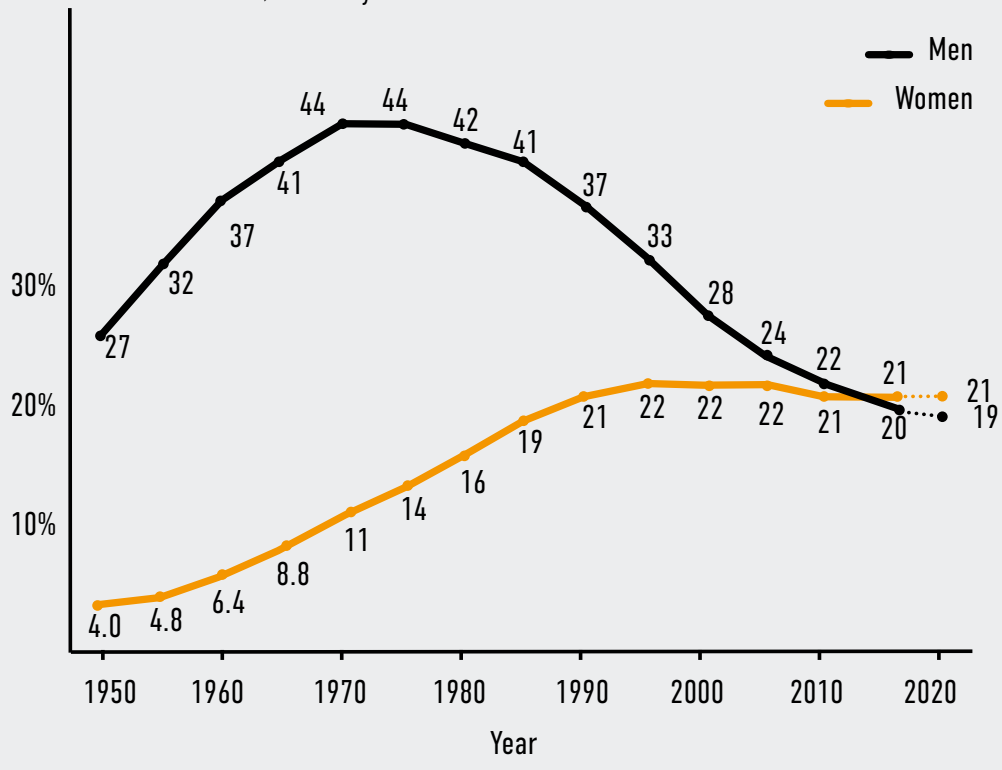
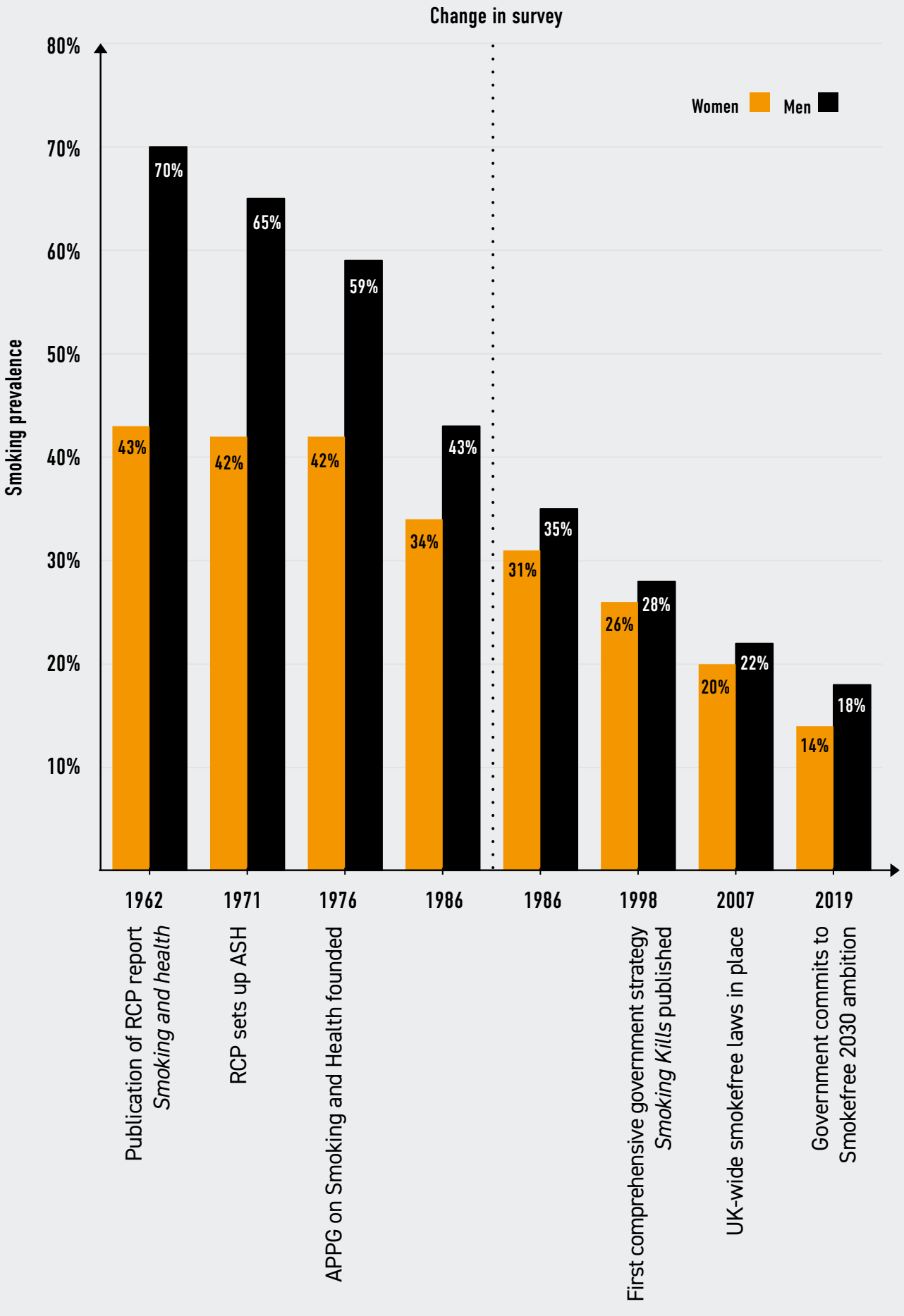
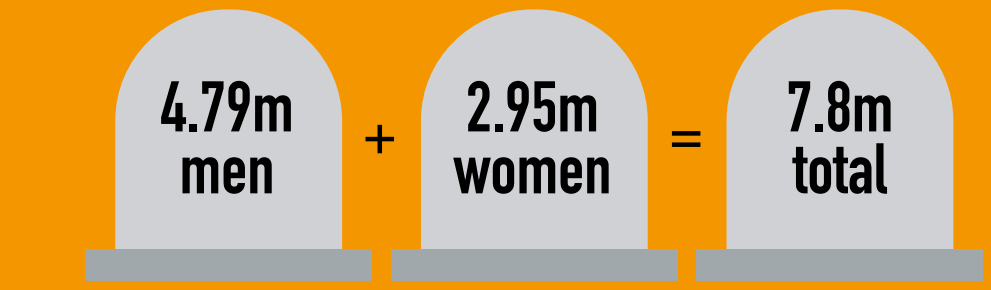


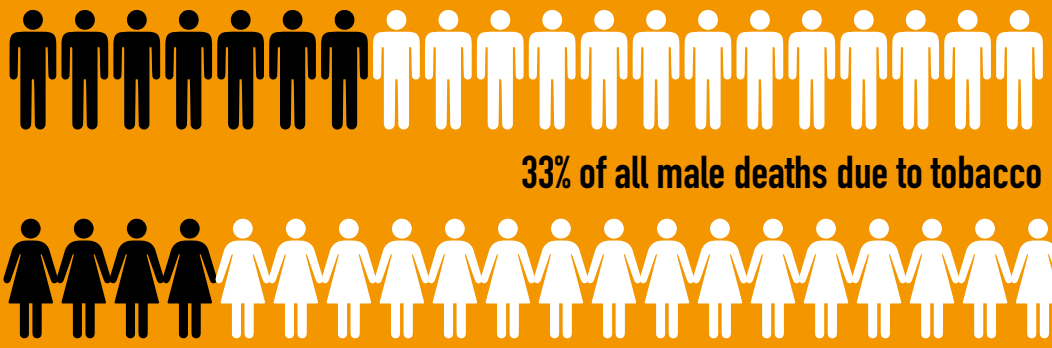
UK smoking prevalence 16+ at key dates



The toll of tobacco

Smoking deaths 1970–2019 (UK)





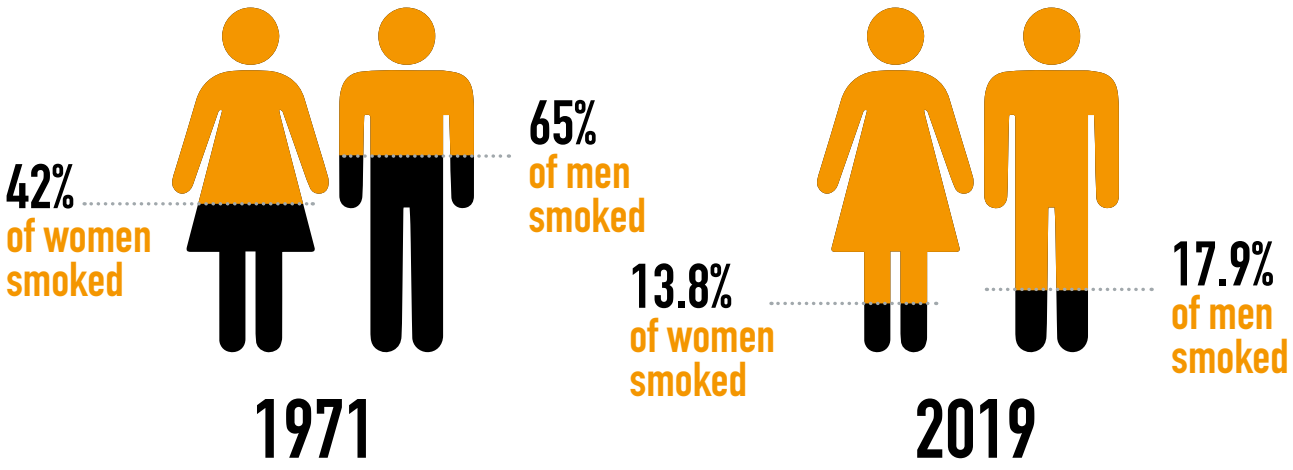
33% of all male deaths due to tobacco

20% of all female deaths due to tobacco

26% of all deaths due to tobacco

Decline in smoking rates 1971–2019

(adults 16+Great Britain)

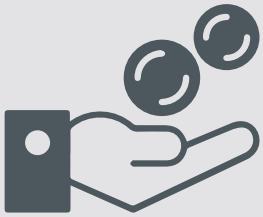


If smoking rates were still at 1971 levels, there would be **18 million additional 16+ smokers** in the UK in 2020.

Economics of smoking today

UK smokers spent £15.6 billion on tobacco in 2020 (including £1.3 billion on illicit tobacco).

More than half a million households are driven into poverty because of the cost of smoking, containing 330,000 children, 743,000 working age adults and 183,000 pensioners.

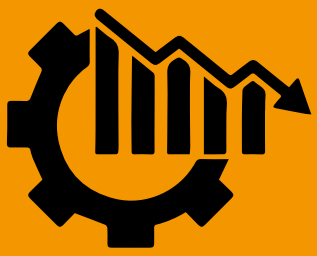


Tobacco excise tax duty raised £10 billion for the UK government in the tax year 2020/21.

Tobacco manufacturers in the UK made an average of 50% profits in 2018, a total of £900 million.

A 'polluter pays' levy capping manufacturer profits and setting cigarette prices could raise £700 million annually, more than enough to pay for the measures needed to stop people smoking.

Cost of smoking to society in 2020



Lost productivity
£13.2 billion

Cost to the NHS
£2.4 billion

Cost to social care
£1.2 billion

Economic benefits of ending smoking

Net benefit to public finances around +£600 million. Net increase in UK jobs around 500,000 as smokers switch to other goods and services.

The final frontier

The decline in smoking prevalence in the British population over the past 50 years masks a profound problem: the marked differences in prevalence within this population.

Smoking rates remain stubbornly high in many deprived groups. For example, nearly twice as many smoking-related cancers are diagnosed in the most deprived quintile of the adult population of England every year compared with the least deprived quintile. Similarly, in an international study of deaths among men aged 35–69, smoking was found to account for around half the difference in mortality between the top and bottom socio-economic groups.

The association between deprivation and higher smoking prevalence has become much more pronounced over the past 50 years. In 1973, 76% of adults in the most deprived quintile smoked compared with 42% in the least deprived quintile. Thirty years later, in 2003, smoking prevalence in the most deprived quintile had not changed whereas prevalence had fallen by more than half to 16% in the least deprived quintile.

In the past 20 years, smoking prevalence has come down across the entire population but large inequalities remain. Smoking prevalence is twice the national average among people who live in social rented housing and among people with no qualifications.

Smoking is also strongly associated with poor mental health. In 2019/20 in England the prevalence of smoking was 25.8% among people with a long-term mental health condition and people with anxiety and depression. Rates among people with serious mental illness are even higher (40.5% in 2014/15).

Not surprisingly, the use of other addictive drugs also predicts smoking: in 2019/20 in England, 70.2% of people admitted to treatment for opiate use smoked tobacco, as did 43.9% of those admitted to treatment for alcohol use. This clustering of smoking risks can be seen among people whose lives are burdened by layers of exclusion and disadvantage. In 2014, around 77% of people experiencing homelessness were smokers compared with 17% of the general population, and the quantity of cigarettes they smoked every day was unusually high.

Tackling smoking should be at the heart of any plan to 'level up' Britain precisely because smoking helps to sustain deprivation, just as deprivation sustains smoking.

ASH sets up the Smokefree Action Coalition

2003

Smokefree laws are achieved

2007

The iron chain linking smoking and deprivation can be broken, but only with substantial investment and strategic commitment across government and civil society.

Compound disadvantage and high smoking prevalence can also be seen geographically. An analysis by the Office for National Statistics (ONS) of smoking prevalence in 32,844 neighbourhoods in England (lower layer super output areas) found that those who lived in the most deprived decile were more than four times more likely to smoke than those in the least deprived decile.

Local authorities with high levels of deprivation within their local populations face the biggest challenge in reducing smoking and its adverse effects.

Reducing smoking prevalence in deprived towns, communities and households has multiple dividends. In the UK, half a million households on the brink of poverty are pushed into poverty when their spending on tobacco is taken into account. Enabling smokers in such households to quit has an immediate economic benefit as well as improving health and wellbeing. Given that such households may struggle to pay for food and heating, this is a vitally important outcome.

Tackling smoking should be at the heart of any plan to 'level up' Britain precisely because smoking helps to sustain deprivation, just as deprivation sustains smoking. It is not enough to tackle deprivation in the expectation that this will reduce smoking prevalence. Specific interventions to reduce smoking in deprived communities, such as targeted stop smoking services, have a direct impact on both smoking and deprivation.

The iron chain linking smoking and deprivation can be broken but only with substantial investment and strategic commitment across government and civil society. ASH will continue to advocate for such investment and strategy. The government's goal to be smokefree by 2030 must be genuinely a goal for all.

Plain packs are introduced and bans on smoking in cars carrying children are implemented

2015

The government commits to the Smokefree 2030 ambition

2019

Signature tobacco control reports from the RCP and ASH that influenced UK tobacco policy

RCP

By the late 1990s, the RCP was no longer undertaking any significant activity in tobacco control, but in 1997 established a new Tobacco Advisory Group (TAG) to revitalise its tobacco campaigning role.

Its aim was to produce authoritative reports and play a larger part in the campaigning alliances, hosting media events, lobbying and providing experts for the media and parliamentary inquiries. Crucially, TAG included not only physicians but also members from other medical royal colleges with an interest in tobacco control, ASH, to provide the advocacy expertise, and co-opted experts in specific fields such as psychology, statistics and ethics.

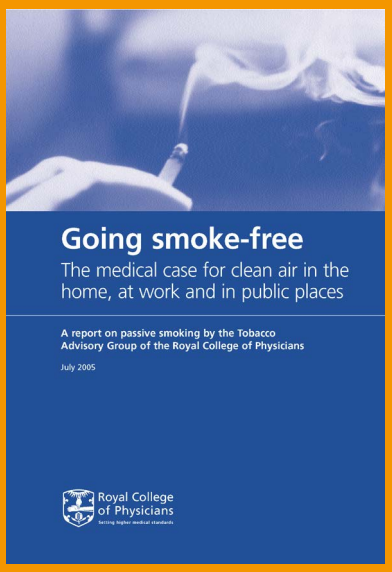
The Group began work by producing a comprehensive state-of-the-nation report *Nicotine Addiction in Britain* (2000), which brought together the relevant information needed to address smoking policy in Britain. Over the following years more seminal reports were published: *Going smokefree – the medical case for clean air in the home, at work and in public places* (2005), *Passive smoking and children* (2010) and *Nicotine without smoke: the case for tobacco harm reduction* (2016). The most recent report *Smoking and health: a coming of age for tobacco control* was published in 2021.

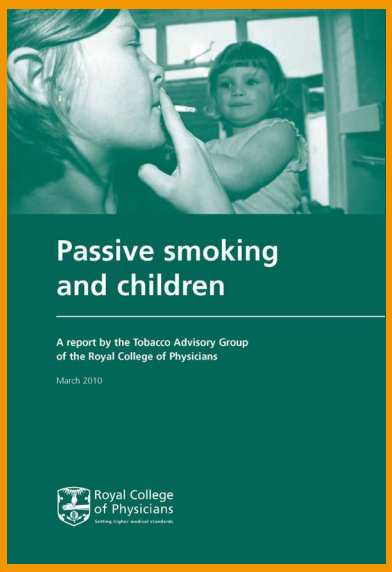
ASH

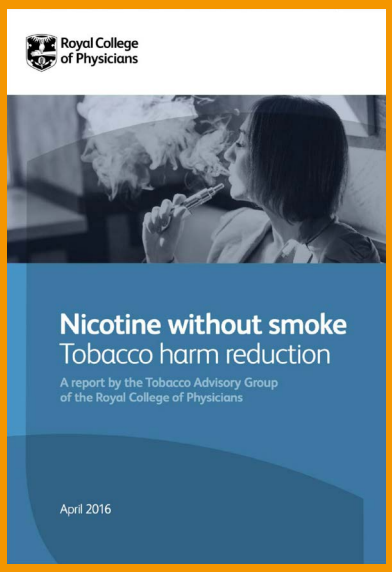
ASH built on the solid foundation of the expert reports published by the Royal College of Physicians, developing its own suite of publications, complementary to the more detailed RCP reports, which largely focused on the health impacts.

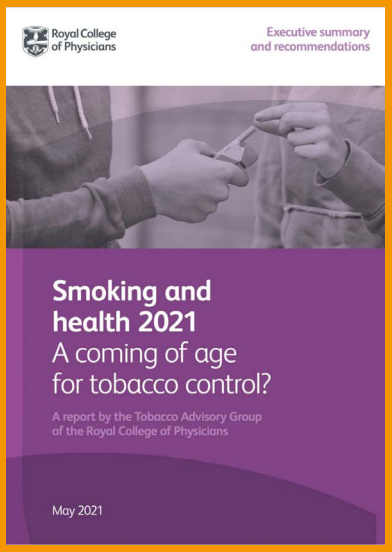
ASH has developed a specific expertise in the economics of smoking, publishing and regularly updating its analyses of the impact of smoking on productivity, employment, and public finances. ASH reports also cover societal costs, including smoking-related social care costs, the concentration of smoking in social housing; and the numbers of households, and children, living in poverty because of smoking.

Lastly, ASH has published a series of comprehensive policy recommendations for government, endorsed by the public health community including the RCP. *Beyond Smoking Kills* in 2008, first called on government to implement plain packaging. By the time *Smoking Still Kills* was published in 2015, plain packaging was underway and the priority was for government to set a smokefree ambition. By *Roadmap to a Smokefree 2030* in 2020, government had committed to a Smokefree 2030 ambition, and the priority, yet to be achieved, was a 'polluter pays' levy on tobacco manufacturers to deliver the ambition.


Going smoke-free
The medical case for clean air in the home, at work and in public places
A report on passive smoking by the Tobacco Advisory Group of the Royal College of Physicians
July 2005
Royal College of Physicians


Passive smoking and children
A report by the Tobacco Advisory Group of the Royal College of Physicians
March 2010
Royal College of Physicians

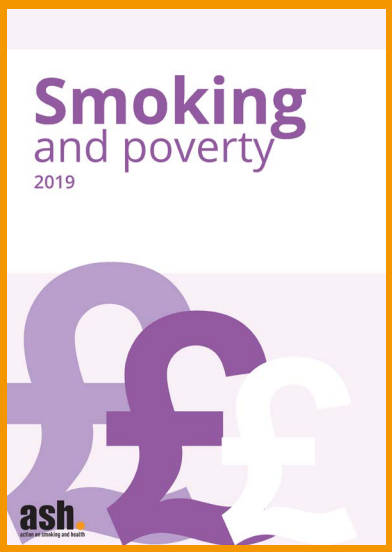

Royal College of Physicians
Nicotine without smoke
Tobacco harm reduction
A report by the Tobacco Advisory Group of the Royal College of Physicians
April 2016


Royal College of Physicians
Executive summary and recommendations
Smoking and health 2021
A coming of age for tobacco control?
A report by the Tobacco Advisory Group of the Royal College of Physicians
May 2021


BEYOND Smoking Kills:
PROTECTING CHILDREN, REDUCING INEQUALITIES
20 Cigarettes
Beyond
Smoking kills
Protecting children, reducing inequalities


Smoking Still Kills
PROTECTING CHILDREN, REDUCING INEQUALITIES
SMOKING STILL KILLS 200 PEOPLE EVERY DAY
Hundreds of children take up smoking every day
Brand name
Variant name
20 cigarettes


Roadmap to a
Smokefree 2030
We can make smoking history by 2030
.....for a smokefree childhood and smokefree lives
January 2020


Smoking and poverty
2019
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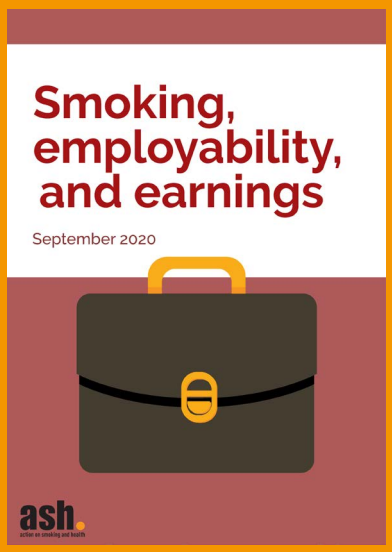
Smoking, employability, and earnings
September 2020
ash
action on smoking and health

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