

Action on Smoking and Health (ASH) and SPECTRUM representation to HM Treasury's Budget 2021

Closing date: 14th January 2021

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Introduction

1. This Budget representation is on behalf of ASH and SPECTRUM. SPECTRUM is a public health research consortium of academics from 10 UK universities and partner organisations funded by the UK Prevention Research Partnership. Action on Smoking and Health (ASH) is a public health charity set up by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco.
2. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. ASH has also received project funding from the Department of Health and Social Care to support delivery of the Tobacco Control Plan for England. Neither ASH nor SPECTRUM have any direct or indirect links to, or receive funding from, the tobacco industry, except for nominal shareholdings in Imperial Brands and BAT for research purposes.

Summary and recommendations

3. The rationale for our policy recommendations is that they will help deliver the Government's ambition for England to be Smokefree by 2030¹ and will also help deliver Spending Review and manifesto commitments to:
 - 'level up' economic opportunity across society while maximising productivity;^{2 3}
 - increase disability-free life years by five years by 2035 while reducing inequalities;^{4 5}
 - improve outcomes in public services, including by supporting the NHS; and
 - strengthen the UK's place in the world.

A healthy population drives a healthy economy (for more detail see paras 18-27)

4. Smoking remains the leading cause of preventable death and disease in the UK, responsible for half the difference in life expectancy between rich and poor, killing nearly 100,000 people a year prematurely in the UK,⁶ with thirty times as many suffering serious smoking-related disease and disability.⁷ This causes significant collateral damage to health and social care costs, and disastrous economic effects on productivity and employability, which are concentrated in the poorest most disadvantaged communities.
5. The cost to the NHS of treating smoking-related illness is estimated at £2.4 bn, and the cost of social care costs at £883.5m.⁹ If social care were provided to all who need it because of smoking-related disability, it would cost much more than this, an additional £19.8 bn.^{9,8}
6. Years of lost economic activity due to premature death from smoking are estimated to cost £3bn a year.⁹ Smokers lose £14.1bn a year from unemployment (£6.9bn) and reduced earnings (£7.2bn), linked to smoking.¹⁰
7. Tax increases are a highly effective tool in reducing smoking uptake and tackling inequalities, as poorer (and younger) smokers are more price sensitive than the general population.^{11 12} However, disadvantaged smokers who don't quit bear a disproportionate share of the tobacco tax burden, because of the greater concentration of smoking among these groups. In addition,

due to their higher rates of smoking, these populations also bear a disproportionate share of the burden of disease caused by tobacco.

8. The evidence is clear that tobacco taxes are most effective in reducing smoking prevalence when underpinned by a comprehensive and funded strategy to reduce smoking prevalence,^{13 14} an approach the UK has implemented very effectively and cost-effectively to date¹⁵ and needs to be sustained and enhanced if we are to achieve the Smokefree 2030 ambition.

Strengthening the UK's tax base: Closing gaps and maximising opportunity (for more detail see paras 28-44)

9. The Government recognises reducing the affordability of tobacco through tobacco taxation is an effective lever to motivate smokers to quit and discourage youth uptake, as well as generating significant tax revenues,¹⁶ amounting to £8.8bn in revenues in the financial year 2019/20.¹⁷ That is why a tobacco tax escalator is in place for this parliament.
10. Reported tobacco receipts in the year to date (April to October 2020) are £5.9 billion which is £0.7 billion higher than in the same period in the financial year ending 2019. Handrolled tobacco (HRT) receipts have more than doubled over the last ten years from £0.7 billion in 2010/11 to £1.5 billion in 2019/20 as the differential in tax rates between factory made and HRT have been eroded, although it still exists.¹⁸ COVID-19 combined with Brexit have reduced the opportunity for cross border shopping and illicit trade, and increased the potential for tax increases to generate increased revenue.
11. The changes we propose will raise revenues and reduce tobacco consumption, thereby increasing productivity and healthy life expectancy, and reducing the economic costs of smoking to society.

Recommendations

- 1) **Raise the annual tobacco tax escalator from 2% above inflation to 5% above RPI for all products except handrolled tobacco (HRT).**
- 2) **Increase the annual escalator for HRT to 15% above RPI until the tax paid per stick containing the typical weight of tobacco used, is equivalent to that on factory made cigarettes.**
- 3) **Sustain the enhanced uplift for the Minimum Excise Tax (MET) introduced in November for this and subsequent Budgets.**
- 4) **Now that the UK has left the EU we should:**
 - a. **strengthen tobacco tax rules by:**
 - i. **revising the definition of cigarillos so they are in the same tax bracket and are regulated in the same way as factory-made cigarettes.**
 - ii. **Reducing duty free allowances on HRT to be equivalent to that for manufactured cigarettes.**
 - b. **and consult on:**
 - i. **Restructuring excise tax on factory-made cigarettes to be entirely specific; and**
 - ii. **eliminating all duty-free tobacco allowances.**
- 5) **Apply the Bank Corporation Tax Surcharge to tobacco manufacturers, thereby imposing an additional 8% corporation tax surcharge on profits.**
- 6) **Require tobacco manufacturers to pay a windfall tax, in light of the abnormal profits made over many years, and the small amounts of corporation tax paid thereon.**
- 7) **Remove the right for tobacco manufacturers to offset marketing costs against corporation tax (including those defined as Corporate Social Responsibility).**

Strong and sustainable funding for an enhanced public health function (for more detail see paras 45-61)

12. The Government's Green Paper on prevention acknowledged that evidence shows investment in public health delivers £14 in savings for every £1 spent, both in healthcare savings but also through "longer-term gains in health and to wider society."^{1,63} Furthermore, in its recently published policy paper on the future of public health, the Government has committed to protect the public's health, improve population health resilience, and level up unacceptable variations in health.¹⁹
13. An analysis by the University of York suggests that the expenditure through the public health ring-fenced grant is three to four times as cost-effective in improving health outcomes than if the same money had been spent in the NHS baseline.²⁰
14. The latest analysis by the Health Foundation published just after the Spending review in November estimates that the resources needed include, as a minimum, £1.2bn to restore public health funding to its 2015 levels and a further £2.6bn to level up public health across the country. The Health Foundation recommends that Government should increase the public health budget in line with these estimates and commit to ensuring that public health funding keeps pace with NHS funding increases in future.²¹ We support those recommendations.

Recommendation:

- 8) The public health budget should be increased by £1.2bn to reverse the cuts that have taken place since 2015/16, and increased by £2.6bn to provide additional investment in the most deprived areas where there is greatest need. The Government should commit to ensuring that public health funding keeps pace with NHS funding increases in future.**

15. The Government has committed to consider a 'polluter pays' approach to funding tobacco control.¹ Such an approach is already in place in France and the USA, and should be implemented in the UK also. This could raise at least £300 million a year for tobacco control, freeing up the public health budget for use in other important areas of health improvement.

Recommendation:

- 9) The Government should establish a 'polluter pays' Smokefree 2030 Fund, administered by the Department for Health and Social Care (DHSC), to raise at least £300 million a year to fund the recurring costs of tobacco control at national, regional and local levels. Devolved nations should also be given the opportunity to opt-in to the Fund.**

Strengthening the UK's place in the world as a world leader in tobacco control (for more detail see paras 62-67)

16. Now we have left the European Union (EU) the UK has an opportunity to play a leadership role in international fora where previously the EU spoke on our behalf. The WHO Framework Convention on Tobacco Control (FCTC) is a good example. The UK already has a good international reputation, having invested £15 million in Official Development Assistance (ODA) funding into the WHO's FCTC 2030 project in 2016 to support low-and middle-income countries (LMICs) to implement tobacco control measures, in line with the FCTC and the Sustainable Development Goals.
17. The FCTC 2030 project has enhanced the UK's international reputation and delivered an impressive return for a small investment. However, there is still much to do before all LMICs will

have implemented the FCTC to the extent achieved by the UK, and it comes to an end at the end of this financial year. Sustaining and extending the UK's funding will accelerate progress in ending the global tobacco epidemic, support FCTC 2030 beneficiary countries to recover from COVID-19 domestically and, now the UK has left the EU, enable us to strengthen our position as a leader on the global stage.

Recommendation:

10) The UK should extend and renew its funding for the FCTC 2030 project for a further five years from 2021/22 onwards and continue to encourage other governments to join in funding the programme.

A healthy population drives a healthy economy

18. A population cannot be productive without also being healthy. The population's health is seriously undermined by smoking, which is why the Government has set an ambition for England to be Smokefree by 2030.¹ Smoking remains the leading cause of preventable illness and death in the UK, responsible for almost half a million hospital admissions and killing just under 80,000 people each year in England alone.⁶ For those who smoke, no other aspect of their life will impact their health as significantly – on average smokers die 10 years earlier²² and for every person killed by smoking, another 30 live with serious smoking-related illness.⁷
19. Smoking also has a significant economic impact. New analysis of UK longitudinal datasets carried out for ASH have found that, controlling for other key factors such as educational attainment, age and gender, long-term smokers are around 7.5% less likely to be in employment than non-smokers.¹⁰ Almost all of the relationship between smoking and employment is explained by smoking-related disability. Disabled smokers are 12.5% less likely to be in work than disabled non-smokers, controlling for other factors.¹⁰
20. The analysis also found that smokers earn on average 6.8% less than non-smokers. When this earnings penalty (£1,424) is combined with the average cost of buying tobacco (£1,335), this amounts to an average total penalty of £2,759 per year for every smoker.¹⁰
21. The cumulative impact of smoking on employment and earnings is substantial. In total, £7.2bn of income is lost each year through reduced earnings for smokers and £6.2bn of income is lost each year as a result of economic inactivity among smokers giving a total of £14.1bn lost in income across the UK every year.¹⁰ This figure is larger than previous estimates. For example, in 2017 the Department for Health (subsequently DHSC) estimated the cost of lost output due to economic inactivity, absenteeism and smoking breaks to be £6.3bn for England.²³ The £14.1bn includes previously uncalculated costs of under-employment linked to smoking, not just economic inactivity. Furthermore, previous analyses only included smokers who had applied for incapacity benefit, while this analysis includes all unemployed smokers. These estimates are UK-wide, whereas DHSC estimates were England only.
22. However, the costs from smoking do not stop there. Annually, smoking in England alone costs a further:
 - £3bn due to premature death during productive working life caused by smoking;
 - £2.4bn in NHS costs for treating ill-health caused by smoking;
 - £880m in social care costs from additional social care need resulting from smoking; and
 - £325m for Fire and Rescue Services to respond to fires caused by smoking materials.

23. The true cost of smoking-related social care is much greater than the £880m figure quoted above. If local authorities were to cover the costs of social care demand related to smoking which is currently met informally, for example by family members, or remains completely unmet, this would cost an additional £10.6bn and £9.1bn, respectively - £19.8bn extra in total.⁹
24. Using a different methodology and time period, the McKinsey Global Institute estimated that smoking has the single largest human-generated economic impact on the UK, at \$90bn each year, equivalent to 3.6% of GDP.²⁴ Smoking was closely followed by obesity, which has the second largest impact at \$73bn or 3.0% of GDP and alcoholism was also in the top 5 (\$44bn or 1.8% of GDP).²⁴
25. The burden of smoking is borne disproportionately by the most disadvantaged. Smoking is the leading cause of health inequalities, accounting for half the difference in life expectancy between the richest and poorest in society.²⁵ Around 1 in 4 people in routine and manual occupations smoke, compared to 1 in 10 in managerial and professional occupations.²⁶ Whilst smoking rates across all groups have steadily declined as a result of comprehensive tobacco control, inequalities between socioeconomic groups have widened.²⁶
26. The health consequences of these inequalities in the wake of the COVID-19 pandemic are even more severe. Smoking-related diseases which increase a person's risk of dying from COVID-19,²⁷ such as diabetes, respiratory and cardiovascular diseases are disproportionately common among those living in the most deprived areas.^{28,29,30} This likely provides part of the explanation for why people living in the most deprived areas of the country are twice as likely to die from COVID-19.³¹
27. Higher smoking rates also drive and compound wider socioeconomic inequality, further undermining resilience to societal shocks. The individual earnings penalty for smokers described above will have a greater overall impact on poorer smokers, because it leads to the loss of a greater proportion of total income than for a smoker from a higher socioeconomic group.^{32 33} ASH has estimated that in consequence half a million households, home to over 1 million people including 263,000 children, living in poverty as a direct result of income lost to tobacco dependency.³²

Strengthening the UK's tax base: Closing gaps and maximising opportunity

28. Tax increases are one of the most effective population interventions available for reducing smoking prevalence and are the only tobacco control intervention proven to reduce inequalities.^{34,35,36} Increasing tobacco prices through taxation reduces smoking prevalence, increases tax revenues, and reduces costs to public finances. It was estimated at the time of the 2020 March Budget that implementation of the ASH/UKCTAS recommendations on tax increases would have delivered a 0.17 percentage point reduction in smoking prevalence, while reducing inequalities, as well as a net benefit to public finances of £439.7 million in year 1 alone.³⁷
29. Tobacco manufacturers consistently argue that tax increases will lead to an increase in illicit trade, yet data analysis demonstrates that tobacco manufacturers increase prices beyond that required by tax changes.³⁸ However, increases were notably smaller when tax rises were larger and unexpected.³⁸ This suggests, first, that the industry is not sincerely concerned by the threat of illicit trade, especially since hand-rolled tobacco (HRT) had the highest levels of industry driven price increases despite higher levels of illicit trade, and second, that there remains scope for further tax increases. Therefore, we **recommend that the annual tobacco tax escalator be raised from 2% above inflation to 5% above inflation.**

30. HMRC's latest analysis of the illicit tobacco trade further supports the case for rebalancing taxes, showing that the market share for illicit tobacco has remained stable in recent years, despite annual declines in smoking prevalence.³⁹ Since the COVID-19 pandemic, illicit tobacco and cross border shopping has declined even more rapidly, leading to a significant increase in tax receipts for the period January to October 2020,⁴⁰ which are estimated by HMRC to have increased from £5.259 billion to £5.947 billion, a year-on-year rise of 13.1%.⁴¹
31. In its 2017 Tobacco Control Plan, the Government committed to "maintain high duty rates for tobacco products to make tobacco less affordable."²³ Measures such as a tax escalator of 2% above inflation and a minimum excise tax (MET) for factory made (FM) cigarettes are in place to help deliver on this commitment. However, these are undermined by the significant disparity in rates of taxation, and price per cigarette, between FM cigarettes and HRT, which encourage downtrading to HRT rather than quitting.⁴² Ultimately, this has a negative impact on tax revenues without the associated health benefits.
32. In 1998, 25% of male and 8% of female smokers mainly used HRT compared to 40% of men and 23% of women in 2013.⁴³ Questions on use of HRT are no longer asked by government surveys, but have been asked by the Smoking Toolkit Study (STS), conducted by UCL since 2007. In 2019 43.2% of past-year smokers in England predominantly used HRT, compared to 48.4% who predominantly used FM cigarettes.⁴⁴
33. The STS also found an increasing proportion of the population were using HRT, while the proportion using FM cigarettes was declining. In 2008, the prevalence of any, predominant and exclusive use of FM cigarettes was 16.4%, 15.3%, and 14.3%, respectively. In 2017, it was 9.7%, 9.2%, and 8.8% (a decrease of 40.9%, 39.9%, and 38.5%), respectively. By contrast, HRT use increased. In 2008, the prevalence of any, predominant and exclusive use of HRT cigarettes was 7.7%, 6.7%, and 5.6%, respectively. In 2017, it was 8.4%, 8.1%, and 7.5% (an increase of 9.1%, 20.9%, and 33.9% increase), respectively.⁴⁵
34. These trends are in line with evidence showing consumption of HRT increases as the price differential between FM cigarettes and HRT increases⁴⁶ and that countries which tax FM cigarettes and HRT similarly do not see downtrading to HRT, whilst those with a taxation differential do.⁴⁷
35. Whilst the commitment in the 2020 Budget to renew the tobacco tax escalator until the end of this parliament² was welcome, the differential between taxation of FM cigarettes and HRT remains significant. **To eliminate the differential the annual escalator for HRT should be increased to 15% above inflation. The escalators should be aligned once tax on HRT, as measured by the tax paid per stick containing the typical weight of tobacco used, is equivalent to that on FM cigarettes.**
36. The uprating of the MET on cigarettes by an additional 2% above the tax escalator to 4% above RPI for a pack of 20 in November 2020 was also welcome.¹⁶ Research has shown the introduction of MET had an impact on pricing of FM cigarettes, but it needs to be regularly updated if it is to continue to be effective. **We recommend that the enhanced uplift for the Minimum Excise Tax (MET) introduced in November be sustained for this and subsequent Budgets.**^{48 49}
37. Now the UK has left the EU, and is no longer subject to the requirements of the EU legislation, there are opportunities to deliver a dividend to public health.
38. To bypass legislation prohibiting the sale of mentholated cigarettes from May 2020, both Japan Tobacco International (JTI) and Imperial Brands have launched mint-flavoured cigarillos, aimed at cigarette smokers in packs of 10 in the UK (the minimum pack size for cigarettes is 20).⁵⁰ 'Cigarillos'

closely resemble cigarettes, the outer leaf wrapping, required for a cigarillo classification, covers a cigarette-like paper tube that contains the tobacco and appears to provide the main structure. This is not prohibited by the cigar/cigarillo definition but does highlight their cigarette-like nature. Cigarillos are taxed at the same rate as cigars by weight, which results in significantly lower tax per stick than that for factory made cigarettes.⁵¹ The resulting low pack purchase price enhances its consumer appeal, especially for socioeconomically disadvantaged smokers. The UK's classification of cigarillos as cigars and regulating them as such⁵² is taken from the EU Tobacco Tax Directive,⁵³ and now that we have left the EU should be revised so they are taxed and regulated in the same way as factory-made cigarettes.

39. The standard duty-free allowances have been extended to cover travel to GB from EU countries. However, the Government should now review the extent of those allowances both in terms of the overall size of imports allowed, and also the consistency between the allowances granted for different products. We believe allowances for all tobacco products should be set to the minimum possible levels, ideally zero, so that smokers have the maximum incentive to quit and so that taxation is paid towards the harms caused by tobacco use.
40. If duty-free allowances are to continue to be offered for tobacco products, the revised levels should be consistent so that they don't encourage smokers to switch to cheaper tobacco products. As currently set, allowances include up to 250g of tobacco for hand rolling, but on typical use this results in more than 500 cigarettes (since the average hand rolled cigarette has been found to contain less than 0.5g of tobacco),⁵⁴ a quantity far in excess of the duty-free allowance of 200 cigarettes. Reducing this allowance to 90g of HRT would be broadly consistent with the allowance of 200 cigarettes/ sticks of tobacco for heating, and would be in line with standard 30g pouches of HRT currently on the market.
41. Currently taxation of FM cigarettes is a mix of specific and ad-valorem because that was required by the EU Tobacco Tax Directive. Restructuring taxation of FM cigarettes to be 100% specific should be considered now we have left the EU, as this would minimise price differences between different market segments.⁵⁵
42. **Now that the UK has left the EU we recommend that the UK should:**
 - a. **strengthen tobacco tax rules by:**
 - i. **revising the definition of cigarillos so they are in the same tax bracket and are regulated in the same way as factory-made cigarettes.**⁵⁶
 - ii. **Reducing duty free allowances on HRT to be equivalent to that for manufactured cigarettes**
 - b. **and consult on:**
 - i. **Restructuring excise tax on factory-made cigarettes to be entirely specific; and**
 - ii. **eliminating all duty-free tobacco allowances.**
43. Further, given the abnormal profits of UK tobacco manufacturers, the small levels of corporation tax paid to the UK on those profits,^{57 58} and the impact on society of the product from which they profit (discussed in paras 50-53), **we recommend that tobacco manufacturers be made subject to:**
 - **the Bank Corporation Tax Surcharge (BCTC), thereby imposing an additional 8% corporation tax surcharge on profits; and**
 - **a windfall tax, in light of the abnormal profits made over many years, and the small amounts of corporation tax paid thereon; and**

- **an exemption on the right to offset marketing costs against corporation tax (including those defined as Corporate Social Responsibility).**

44. First, the BCTC surcharge would be supported by the use of existing frameworks such as the Diverted Profits Tax (including the higher rate currently paid by banks given the BCTC),⁵⁹ which would help prevent the transfer of profits outside of the UK in response to the extension of the surcharge, and the OECD Base Erosion and Profit Shifting (BEPS) framework that co-ordinates countries addressing tax avoidance.⁶⁰ Under the BEPS framework, the UK requires companies to report profits on a market by market basis, allowing the Government to respond to attempts by tobacco manufacturers to move profits from the UK.
45. Second, windfall taxes are often rejected because they are either seen to be unfair, or because they might negatively impact the future operation of an industry. Neither of these concerns apply to tobacco. As outlined above tobacco products cause significant harm to society, which is not offset by current tobacco taxes, so tobacco manufacturers should pay more. Furthermore, a negative impact on the future sales of tobacco is to be welcomed given this aligns with the Government's ambition for England to be smoke-free by 2030 and its ultimatum to the industry for smoked tobacco to be made obsolete,² in addition to all the associated health and economic benefits associated with reduced tobacco use.

Strong and sustainable funding for an enhanced public health function

46. Following the Government's announcement that Public Health England will be abolished, over 120 leading public health organisations including the Academy of Medical Royal Colleges, the Faculty of Public Health, the Association of Directors of Public Health, The Health Foundation, the Richmond group of health and social care organisations, Cancer Research UK, Mind as well as ASH, wrote to Government setting out the principles which must underpin any new health improvement system. Top of this list was the need for *"Sufficient funding at all levels to meet the ambitions of improving population health."*⁶¹
47. Following the publication of DHSC's policy paper on the future of public health in which the Government committed to protect the public's health, improve population health resilience and level up unacceptable variations in health,¹⁹ a second joint statement was issued setting out the six tests which Government proposals for a new health improvement system must pass to deliver truly world class outcomes in levelling-up health and securing a population resilient to future health risks.⁶¹ These are:
- Test 1:** Sufficient and secure funding to scale up health improvement interventions
 - Test 2:** Sufficient high-quality public health experts in health protection, health improvement and healthcare public health functions
 - Test 3:** The commitment and infrastructure to deliver health improvement at national, regional and local level
 - Test 4:** A stronger health intelligence function which supports both health improvement and health protection and underpins accountability
 - Test 5:** Improved co-ordination between the NHS and local government
 - Test 6:** Strong relationships across health protection and health improvement across all four nations of the UK
48. All of these tests must be passed for any new system to be successful in achieving its stated aims. However, test 1 is the linchpin, key to ensuring the other 5 tests can be met.
49. NHSE recognises that only 20% of health outcomes are determined by the ability to access good quality healthcare and the wider determinants of health play a crucial role,⁶² an area where public

health is a system leader. A systematic review of the return on investment (ROI) of public health interventions found the median ROI was 14.3 to 1, and median cost-benefit ratio (CBR) was 8.3.⁶³ An analysis by the University of York suggests that the expenditure through the public health ring-fenced grant is three to four times as cost-effective in improving health outcomes than if the same money had been spent in the NHS baseline.⁶⁴

50. By improving the population's health and productivity, investment in public health directly supports the UK's recovery from the COVID-19 pandemic whilst simultaneously delivering on its objectives to achieve a smoke-free England by 2030,² level-up society,² increase disability-free life years,⁴ and build back better from COVID-19.
51. The need for greater investment in public health right now is born of necessity. Local authorities have faced severe reductions in funding for their public health functions since 2015/16. Accounting for the 2.6% increase in funding for the public health grant announced in March 2020, analysis by the Health Foundation found that the grant is still 22% lower on real term per capita basis than in 2015/16.²¹
52. The effects of these cuts on local authority commissioned stop smoking services are clearly demonstrated by ASH's annual survey of local authority tobacco control leads, commissioned by Cancer Research UK.⁶⁵ Between 2018/19 and 2019/20, 35% of local authorities that still had a budget for stop smoking services cut this budget.⁶⁶ This was the fifth successive year in which more than a third of local authorities had cut their stop smoking service budgets – every year, the main reason provided for these cuts was ongoing cuts to the public health grant.^{66 21}
53. Stress on the public health system due to funding cuts is not restricted to tobacco control. There is pressure across the sector and clear consensus on the need for greater Government investment in health improvement both now and longer-term.⁶⁷ The consequences of not investing are not only a more vulnerable, less productive population but greater pressure on already over-stretched NHS and social care services because of preventable ill-health. As set out recently by the Office for National Statistics, this comes at a time when:⁶⁸
 - improvements in life expectancy are slowing;
 - health inequalities between the most and least deprived are widening; and
 - *“those living in the most deprived areas can expect to spend almost two decades less in good health than their counterparts in the least deprived areas.”*
54. To reverse these trends and ensure the UK is not undermined in its ability to achieve its ambitions for the new health improvement system, for recovery and in order to build back better, **funding cuts made to the public health budget since 2015/16 should be reversed in real terms and increased by a minimum of £2.6bn as estimated to be necessary by the Health Foundation to allow for additional investment in the most deprived areas where there is greatest need.**²¹ Such investment is highly cost-effective.⁶³ Indeed, smoking cessation treatment has been found to be cost-saving within the first year.⁶⁹

Funding for tobacco control – Making the polluter pay

55. Last year's Green Paper on prevention noted *“Other countries, such as France and the USA, have taken a ‘polluter pays’ approach requiring tobacco companies to pay towards the cost of tobacco control. We’re also open to other ideas for funding, including proposals to raise funds under the Health Act 2006.”*²² The polluter pays approach referred to in the USA, established via the Family Smoking Prevention and Tobacco Control Act, requires tobacco companies to pay an annual “user

fee” to the Food and Drug Administration to pay for tobacco regulation and wider tobacco control activity.⁷⁰

56. Existing primary legislation used for the Pharmaceutical Price Regulation Scheme (PPRS) provides such a mechanism to establish a “polluter pays” Smokefree 2030 Fund, similar to the USA’s “user fee”. A fixed total raised annually could be set out in legislation, in line with the model used by the US government.
57. The proposed levy would not be an additional tax but a specific charge which could raise £300 million per year, to pay for the full range of tobacco control measures needed at national, regional and local levels, to bring the smoking epidemic to an end by 2030, where the adult smoking rate is 5% or less. It would also be structured to incentivise industry switching from combustible to less harmful non-combustible products. This is in line with the Government’s ambition announced in the Green Paper and its *“ultimatum for industry to make smoked tobacco obsolete by 2030, with smokers quitting or moving to reduced risk products like e-cigarettes”*.²
58. The Fund would be dedicated in the legislation to pay for the recurring costs of tobacco control measures which have been proven to motivate successful quitting and reduce uptake and would be administered by DHSC. Devolved nations should be given the opportunity to opt-into the Fund, as they do with the PPRS – the amount raised by the Fund should then be uprated on a population basis.
59. The tobacco industry in the UK is an oligopoly, with four transnational tobacco manufacturers responsible for over 90% of tobacco sales. The tobacco transnationals are particularly profitable in the UK, despite having some of the highest taxes in the world. For example, while net operating profit margins for Imperial Brands globally in 2018 were 46%, in the UK they were 63%, much higher than for most consumer staples such as food, beverages and household goods of 12-20%. In 2018 it is estimated that the industry made over £900 million in profits in the UK alone.⁷¹ Despite such high profits being reported in both domestic and global markets, very little tax on these profits has been paid in the UK by tobacco transnationals.⁵⁷
60. The COVID-19 pandemic also appears to have had little impact on these profits. In British American Tobacco’s (BAT) 2020 First Half Pre-Close Trading Update, titled “Resilient and Growing”, the company’s CEO said, “I am pleased to say that we continue to perform well and expect a good performance in 2020.”⁷² In an update, profit and revenue forecasts were adjusted in response to COVID-19, however cuts amounted to a reduction of expected adjusted revenue growth to 1-3% this year, instead of 3-5%. BAT’s dividend pay-out to shareholders also remained unchanged, with the company stating, “strong operational performance is reflected in our continued commitment to our 65% dividend pay- out policy.”⁷²
61. Leveraging money from an industry which generates abnormal profits from a product which is directly antithetical to the UK’s recovery from COVID-19 and Government objectives to build back better, is wholly justified. This point is understood by experts and the public. A recent YouGov survey of over 10,000 adults in England found that 76% supported requiring tobacco manufacturers to pay a levy to Government for measures to help smokers quit and prevent young people from taking up smoking with just 6% opposing.⁷³ Further, the APPG on Smoking and Health as well as over 70 leading health organisations, including the British Medical Association, Royal College of Physicians, Association of Directors of Public Health and Faculty of Public Health, endorse the Smokefree Action Coalition’s Roadmap to a Smokefree 2030,⁷⁴ which calls for the introduction of the Smokefree 2030 Fund.

62. The Government should therefore **establish a polluter pays Smokefree 2030 Fund, administered by DHSC, used to fund the recurring costs of tobacco control at national, regional and local levels. Devolved nations should also be given the opportunity to opt-into the Fund.** For further details on how the Smokefree 2030 Fund would work, see ASH's briefing.⁷⁵

Strengthening the UK's place in the world as a world leader in tobacco control

63. The UK is a recognised global leader in tobacco control with wide ranging expertise in most areas of The World Health Organization's (WHO's) Framework Convention on Tobacco Control (FCTC), the world's only public health treaty, aimed at promoting evidence-based action to tackle tobacco-related death and disease internationally.⁷⁶

64. It is estimated that at least 8 million deaths around the world every year are linked to tobacco, more than for AIDS, tuberculosis and malaria combined. Over 80% of the world's 1.3 billion smokers live in low and middle-income countries (LMICs).⁷⁷ In addition to the human cost, and impact on already overstretched healthcare systems, this puts a heavy economic burden on these countries, all adding to the difficulties LMICs face in recovering from the global pandemic.²⁴

65. In 2016, the UK invested £15 million of Official Development Assistance (ODA) in the FCTC 2030 project until the end of the financial year 2021. This funding supports LMICs to achieve Sustainable Development Goal (SDG) target 3.a, which is to accelerate implementation of the FCTC.⁷⁸ Through the FCTC 2030 project, governments of countries eligible for ODA receive intensive tailored support to accelerate implementation of the WHO FCTC. The project has provided direct support to 15 LMICs, from all the WHO regions, and more general support and material accessible to all LMICs.

66. Australia and Norway have subsequently joined the FCTC 2030 project to provide additional funding, enabling the expansion of the programme to 9 additional countries in 2020. This means a total of 24 countries are now being directly supported to accelerate implementation of the FCTC. To quote the Public Health Minister the project *"has received praise from countries participating, as well as from the global public health and development communities. It has also helped to raise the UK's profile as a global leader in tobacco control, and is strengthening its global reach."*⁷⁹

67. The COVID-19 pandemic has stalled progress towards the FCTC 2030 project's aims and as we enter the UK's final year of funding for the programme, LMICs benefitting from the scheme are unlikely to reap the full benefits and opportunities intended to be delivered by the programme if it were to cease as the end of 2021. Further, as the Public Health Minister also acknowledged, *"there is high demand from such countries for help to implement tobacco control measures."*⁷⁹

68. Therefore, **the UK should extend and renew its funding for the FCTC 2030 project for a further five years from 2021/22 onwards and continue to encourage other governments to join in funding the programme.** This would not only provide vital support to LMICs worst affected by the global tobacco epidemic as they recover from COVID-19 but also strengthen the UK's role as a global leader in tobacco control as it leaves the EU.

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