

**BEYOND *Smoking Kills*:**

PROTECTING CHILDREN, REDUCING INEQUALITIES



20 Cigarettes

20

Protecting children,  
reducing inequalities

**Beyond**

**Smoking  
kills**

Protecting  
reducing

**kills  
smoking**

# **BEYOND *Smoking Kills*:**

## PROTECTING CHILDREN, REDUCING INEQUALITIES

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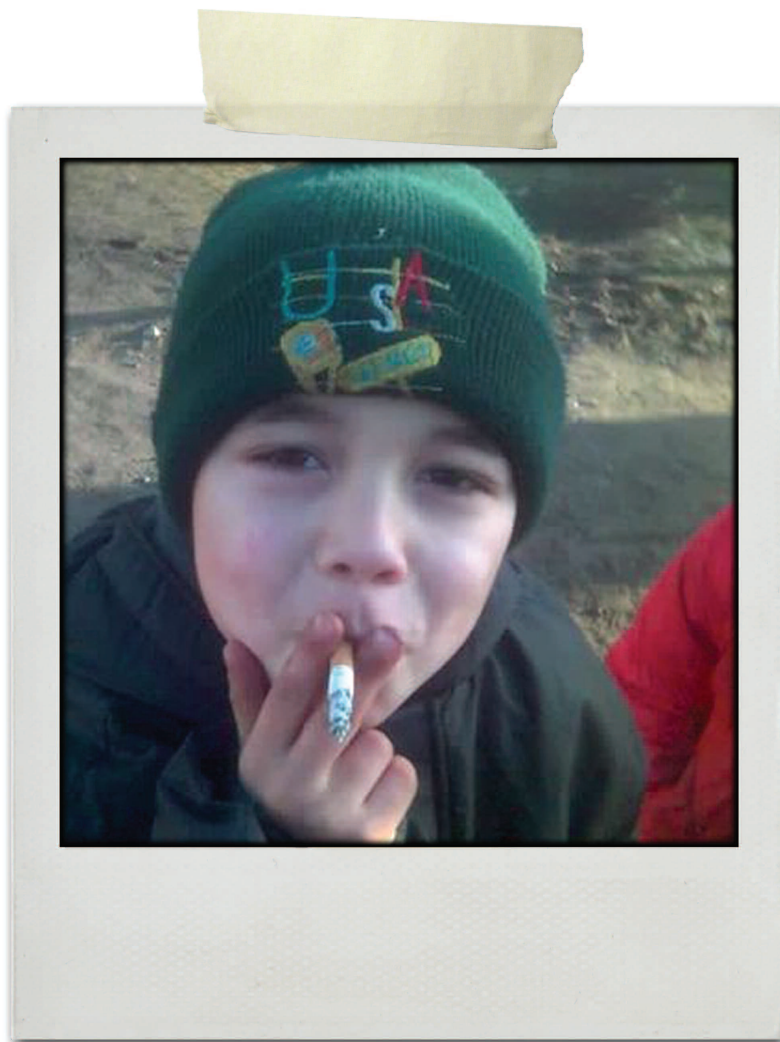
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 Gateshead PCT  
 Heart of Birmingham PCT  
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 Kingston PCT  
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 London Health Observatory  
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## FOREWORD

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### **Children and young people are the primary victims of tobacco in the 21st century.**

They suffer today when they get addicted to smoking before they know the meaning of addiction, when they are forced to breathe tobacco smoke in their homes and, in the earliest moments of their lives, when they are exposed to tobacco toxins in the womb. They will suffer tomorrow when they face the reality of the harm of smoking, when they struggle to quit, and when the consequences of not quitting finally hit home. One in every two life-long smokers is killed by tobacco and most smokers lose many years of active life. Smoking remains the largest preventable cause of death in England.

There have been huge advances in tobacco control in England since the publication of the white paper *Smoking Kills* in 1998. Cigarette advertisements have disappeared from billboards and the pages of magazines and sporting events are no longer emblazoned with the colours and logos of tobacco brands. Above all, no-one is forced to breathe tobacco smoke in the workplace or in enclosed public places. These are huge achievements - achievements which are the envy of the world - but no-one beyond the tobacco industry takes pride in the fact that a new generation of young smokers is growing up in England today.

Some smokers may feel that enough has been done to restrict their behaviour and that they should be left alone to enjoy the choices they freely make. Yet this misses the point. The focus of tobacco control today is not restriction but protection, above all the protection of children and young people from the harm of smoking. This can be achieved in many different ways:

*Children are more likely to become smokers if their parents smoke. Helping adult smokers to quit is vital in reducing smoking initiation and so achieving a long-term decline in smoking prevalence.*

*Adults in England today can now enjoy their everyday lives without ever coming into contact with secondhand tobacco smoke. Millions of babies and children do not have this freedom. New initiatives are needed to protect them from exposure to secondhand smoke.*

*Smoking is the main reason why people from poor and deprived backgrounds have lower life expectancy than the affluent. An effective strategy to reduce adult smoking will also help to reduce health inequalities and add to the disposable income of millions of poor families in England.*

New investment and new ideas are needed to achieve these goals. This report explores these ideas, defining a new agenda for tobacco control which aims to reduce the harm to children and to reduce the inequalities which define the smoking epidemic in England.

The government has signalled its intention to develop a new national tobacco control strategy. This document welcomes this renewed government commitment and advocates for a comprehensive, long-term strategy, underpinned by vision and ambition. There is much to be proud of. There is much to be done.

# EXECUTIVE SUMMARY

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## Introduction

The white paper *Smoking Kills*, published in 1998, was a milestone in public health in the United Kingdom. It defined a comprehensive tobacco control strategy that has put the UK among the world leaders in tobacco control. Ten years later much of what *Smoking Kills* set out to do – and more – has been achieved. This report takes stock of these achievements and sets out an agenda for action for the next ten years.

*Smoking Kills* related to the whole of the UK. As a result of subsequent devolution, tobacco control policy in the UK is now, for the most part, tackled separately in England, Scotland, Wales and Northern Ireland. There are, however, important aspects of public policy related to health and tobacco use which remain the preserve of the UK Government in Westminster such as taxation, customs, competition and some aspects of consumer protection. This report relates to tobacco control strategy for England and the recommendations reflect the current balance of devolved and reserved powers in England and the UK today.

## 1. The goal and aims of tobacco control

The goal of tobacco control is shaped by an astonishing context: despite the importance of consumer protection in British society, products which are known to kill one in every two of their life-long users are available for sale in shops throughout the land. As banning tobacco products is not an option, the very best that tobacco control can do is to reduce the harm that tobacco inflicts on smokers, on smokers' children and families, and on society as a whole. As the harm of tobacco recedes, so the benefits of improved health and wellbeing increase.

The harm of tobacco can be reduced by helping smokers to quit, reducing exposure to secondhand smoke and preventing people from starting smoking in the first place. For heavily addicted smokers who are currently unable or unwilling to quit, there is also the possibility of switching to pure nicotine products (which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives). As smoking is responsible for half the difference in deaths across socio-economic groups, tobacco control also has a major role to play in reducing health and social inequalities.

These aims are profoundly inter-linked. Children who live with parents who smoke will breathe cleaner air, and be less likely to become smokers themselves, if their parents quit or switch to pure nicotine products. Poor families will also benefit from the financial savings of quitting.

## 2. Ten years of progress

The publication of *Smoking Kills* in 1998 was the first time that the scale of the harm caused by tobacco received a proportionate response from government. Subsequent achievements have been remarkable, above all the prohibition of most tobacco advertising, the creation of NHS Stop Smoking Services and the enactment of smokefree legislation. The UK now leads Europe in tobacco control.

In the last ten years smoking prevalence has been driven down in England from 28% to 22% and all the targets in *Smoking Kills* have been, or are likely to be, met. Although the cost of smoking to the NHS in England has risen over this period, from £1.7 billion a year to £2.7 billion in 2006-07, the current annual cost saving from the reduction in smoking prevalence is estimated to be £380 million.

Despite the achievements of the last ten years, millions of children and young people in England are still harmed by tobacco on a daily basis and the deep health inequalities created by smoking have barely shifted.

Over a fifth of the adult population still smokes and smoking remains by far the largest cause of preventable premature death, killing more people each year than alcohol, obesity, road accidents and illegal drugs put together.

The momentum for change built up over the last decade must be exploited. Public support for tobacco control interventions has never been higher and international evidence demonstrates that greater investment in tobacco control could intensify the decline in smoking prevalence. Ongoing improvement cannot be taken for granted; a comprehensive and sustained approach is needed from government.

*Recommendations: 1*

### **3. Children and young people**

One in seven fifteen year olds is a regular smoker. One in six mothers smoke throughout pregnancy. Millions of children and young people are exposed to tobacco smoke in homes and cars every day. These shocking facts must be addressed head on: the protection of children and young people from the harms of tobacco should lie at the very heart of a new national tobacco control strategy.

Nearly all smokers start young so deep, long-term cuts in smoking prevalence will only be achieved by preventing children and young people from starting smoking. Every effort should be made to reduce the attractiveness of smoking and the accessibility of cigarettes to young people. The context of everyday life is crucial; children and young people who live with adult smokers are much more likely to start smoking than those who live in smokefree homes. Reducing adult prevalence is therefore essential to stopping youth initiation. Smokefree homes and cars are also vital in cutting the exposure of children and young people to the toxins in secondhand tobacco smoke.

Pregnant women who smoke are not always given access to specialist stop smoking services and therapies. Greater investment is needed to ensure that all women smokers are supported to quit both before and during pregnancy. This requires better generic support – appropriate advice and referrals from midwives in particular – and universal access to specialist support.

*Recommendations: all, especially 11, 12, 18, 19, 20, 23, 24, 25, 31 & 32 (for maternity services), 33.*

### **4. Health inequalities**

The more deprived you are, the more likely you are to smoke. Almost every indicator of social deprivation, including income, socio-economic status, education and housing tenure, independently predicts smoking



behaviour. Consequently individuals who are very deprived are also very likely to smoke. These differences in smoking behaviour translate into major inequalities in illness and mortality, inequalities which have deepened over the last thirty years.

Smokers in lower socio-economic groups are just as likely to try to quit as affluent smokers but are less likely to succeed. Their lower success rate is partly due to stronger nicotine addiction. In every age group, smokers from deprived backgrounds take in more nicotine than more affluent smokers, even when the number of cigarettes smoked is the same.

As smoking prevalence is highest in the population groups least able to afford to smoke, smoking deepens deprivation, social inequalities and child poverty. Smokers from disadvantaged backgrounds are also more likely to die or suffer injury from smoking-related fires.

*Recommendations: 14, 21, 22, 27, 35, 36, 39 - 44.*

## **5. Public opinion**

Public support for tobacco control remains strong. Support for smokefree legislation rose following implementation in 2007 and now stands at 77% of the adult population in England. Experience of the benefits of smokefree enclosed public places appears to have increased public enthusiasm for new initiatives in tobacco control.

The interventions currently being implemented by government, including picture warnings on cigarette packs and fixed penalty notices for under-age sales, enjoy wide public support. There is also majority public support for hypothecated price increases, removal of retail displays, prohibition of tobacco sales through vending machines, prohibition of smoking in cars carrying children, expansion of stop smoking services and increased access to nicotine replacement therapy.

Smokers tend to support measures that protect children or assist their own efforts to quit but tend not to support increases in tobacco prices.

Members of the public care about individual liberty and will not support measures that constrain liberty unless there are very good grounds for this, such as protecting the health of children. Supporting smokers to quit is felt to be a particularly appropriate policy response.

## **6. The regulation and use of tobacco**

Two powerful marketing tools are still available to the tobacco industry: product branding and point of sale displays. These are used not only to increase the visibility and attractiveness of cigarettes but also to exploit public misunderstandings about the relative safety of different tobacco products. Even though the terms 'light' and 'mild' are now prohibited, many people still identify low tar cigarettes as less harmful, signalled by subtle differences in pack branding, when in reality tobacco smoke is always toxic and dangerous. Any standard for tobacco product content or emissions risks being exploited in this way.

Tobacco advertising and branding encourage children and young people to start smoking. These young people then have little difficulty obtaining tobacco products: enforcement of the minimum age limit is weak and vending machines offer under-age smokers easy access to cigarettes. Young people are also sensitive to the glamourisation of smoking in films, on TV and on the internet.

There are many ways of discouraging initiation into smoking and encouraging quitting. Mass media public communication campaigns are particularly cost-effective. Overall, however, the most effective way of reducing smoking prevalence is to increase the price of tobacco. The affordability of cigarettes has barely changed in the last ten years and the illicit market share is still substantial. The illicit trade reduces the real price of tobacco, especially in more deprived communities, and so exacerbates health inequalities. About one in eight cigarette packs and one in two packs of hand-rolled tobacco are illicit.

Despite the huge step forward of smokefree legislation, millions of people, especially children and young people, are exposed to secondhand smoke in homes and cars every day.

*Recommendations: 11-26.*

## **7. Help to quit**

England leads the world in providing free stop smoking services but the level of investment in these services is below the level of need, despite their demonstrable cost-effectiveness. Variations in the content and quality of current stop smoking services are also problematic.

Stop smoking services ought to be visible and attractive to all smokers who want to quit yet many smokers are unaware of local services or have a poor understanding of the range of services offered. Clinical settings are not ideal locations for stop smoking services given that smokers do not see their behaviour as an illness. However, people who use the NHS for other reasons (maternity services, dentists and secondary care are especially relevant) should always have easy access to specialist stop smoking services during their care. Provision in secondary care is particularly inadequate despite the importance of quitting for people already suffering from smoking-related disease. All health professionals should have the skills to offer basic stop smoking advice to smokers including an offer of treatment and referral to specialist stop smoking services.

As most smokers quit without accessing free NHS services, it is crucial that they are not deterred from using treatment to support their efforts because of the cost of prescriptions and over-the-counter medicines. Many smokers and health professionals have a poor understanding of the risks and benefits of using nicotine replacement therapy and other stop smoking aids.

*Recommendations: 27-38.*

## **8. Alternatives to smoking**

Smoking prevalence is declining but not fast enough. Too few people successfully quit every year and too many people start smoking. New ways of driving down smoking prevalence are needed.

Smokers are addicted to nicotine but are harmed by the tar and toxins in tobacco smoke. It is therefore possible for smokers who are currently unable or unwilling to quit to satisfy their nicotine craving at much lower risk by switching to pure nicotine products (which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives). Although these products are not 100% safe, they are many orders of magnitude safer than smoking. Given the higher levels of addiction among the most disadvantaged smokers, the promotion of wider access to pure nicotine products as an alternative to smoking is an important means of tackling health inequalities.

Currently pure nicotine products are not attractive to smokers as direct replacements for cigarettes as they do not mimic the speed and intensity of nicotine intake that a cigarette provides. Regulation difficulties inhibit the development of more efficient and effective pure nicotine products. As a result, the most toxic nicotine products – cigarettes – are barely regulated while the safest products – medicinal nicotine – are highly regulated.

If they are to compete with tobacco products, pure nicotine products must be sold on equal terms or better: pricing should favour pure nicotine products over tobacco. Public education is also needed as many smokers (and health professionals) have a poor understanding of the relative safety of pure nicotine products including nicotine replacement therapy.

*Recommendations: 39-44.*

## **9. New commitment, new targets.**

A new national tobacco control strategy is an opportunity to build on the success of the last decade and create an even more ambitious agenda for change for the next ten years and beyond. In order to be robust, the strategy should be underpinned by evidence, tested and developed by ongoing evaluation, overseen by a wide coalition of experts and focused on clear and challenging targets.

The tobacco control community looks forward to working with government in defining this new strategy and shaping a new era in tobacco control.

*Recommendations: 1-10.*

## RECOMMENDATIONS

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### **National strategy**

1. Develop a new comprehensive national tobacco control strategy with clear goals and challenging targets for both the medium and long term.
2. Establish a national evaluation programme to test and refine the strategy against new evidence.
3. Establish a non-executive Tobacco Control Commission with responsibility for overseeing the evaluation, review and development of the tobacco control strategy.
4. Undertake a full review of the scope and timeliness of population research into smoking prevalence in England, taking account of national, regional and local needs.
5. Set ambitious but achievable smoking prevalence targets for 2015:
  - 11% smoking prevalence in the adult population
  - 17% smoking prevalence in the adult routine and manual socio-economic group
  - 4% smoking prevalence in the 11-15 year old age group
  - 9% smoking prevalence in the 16-17 year old age group
6. Set new targets for the number of smoking households with children with no smoking policies at home:
  - 25% of homes where both parents are smokers operate a smokefree policy by 2015
7. Establish a regular programme of cotinine testing of adult non-smokers and children to provide objective measures of exposure to secondhand smoke and set targets for reductions in cotinine levels.
8. Set new targets for the control of tobacco smuggling:
  - Reduce the illicit market share for cigarettes to no more than 8% by 2010 and 3% by 2015
  - Reduce the illicit market share for hand-rolled tobacco to no more than 45% by 2010 and 33% by 2015
9. Establish a programme of cotinine testing among pregnant women in order to accurately measure smoking prevalence in this group.
10. Commit to undertaking a full mid-term review of the new tobacco control strategy in 2012, including setting new targets for 2020.

### **Tobacco regulation**

11. Prohibit branding of any kind on tobacco product packaging.
12. Prohibit all point of sale display and advertising of tobacco products.
13. Reintroduce an annual above-inflation price escalator for tobacco products.
14. Develop a fully-resourced local, national and international strategy to control tobacco smuggling and the sale of illicit tobacco.
15. Prohibit the advertising and promotion of tobacco accessories such as cigarette papers.
16. Replace the current information on tobacco products about tar and nicotine emissions with qualitative information about the risks of smoking.
17. Include the number of the national NHS Smoking Helpline on all tobacco packaging.
18. Require all tobacco retailers to be licensed and include the sale of nicotine replacement therapy and other pure nicotine products as a condition of the licence.
19. Improve enforcement of the minimum age limit for the sale of tobacco products.
20. Prohibit the sale of tobacco from vending machines.
21. Implement a standard for fire safer cigarettes based on the internationally accepted ASTM standard.

### **Mass media**

22. Increase and sustain investment in mass media education and social marketing campaigns and prioritise health inequalities in the targeting of anti-smoking messages.
23. Improve film licensing guidelines to reduce the exposure of young people to images of smoking. Screen anti-smoking advertisements prior to films or TV programmes, including DVDs, which condone or glamourise smoking.

### **Secondhand smoke**

24. Promote smokefree homes and cars through national and local campaigns.
25. Evaluate the legislative option of prohibiting smoking in cars.
26. Use the 2010 review of smokefree legislation as an opportunity to identify, and build on, best practice internationally.

### **Stop smoking services and treatment**

27. Prioritise deprived and marginalised groups, including routine and manual socio-economic groups, in the design and targeting of all stop smoking services, campaigns and interventions.
28. Increase national and local efforts to promote stop smoking services, particularly in community settings where smokers are likely to encounter them in their daily lives.
29. Implement stop smoking treatment protocols based on evidence of effectiveness.
30. Improve the selection, training, assessment and supervision of stop smoking specialists.
31. Include basic skills in stop smoking advice in the undergraduate training and professional development of all health professionals.
32. Require all NHS services to record patient smoking behaviour, provide basic advice and actively refer smokers to stop smoking services and therapies.
33. Develop and evaluate new services and incentives to support the efforts of pregnant smokers to quit.
34. Allow dentists to prescribe nicotine replacement therapy and strengthen links between stop smoking services and dentists.
35. Maintain free provision of stop smoking services.
36. Abolish prescription charges for nicotine replacement therapy for all smokers who want to quit.
37. Educate smokers and health professionals about the benefits and safety of nicotine replacement therapy.
38. Promote wider sale of stop smoking therapies, including through all the outlets where tobacco is currently available.

### **Pure nicotine products**

39. Develop a strategy and an appropriate regulatory structure to improve the acceptability, attractiveness and accessibility of pure nicotine products for use as an alternative to smoking for those smokers who are currently unable or unwilling to quit.
40. Encourage commercial development of pure nicotine products designed for long-term use as a replacement for smoking.
41. Develop a communications strategy to counter public misunderstanding of the health impacts of nicotine. This should promote nicotine replacement therapy for quitting and encourage the longer-term use of pure nicotine products as alternatives to tobacco.
42. Tax pure nicotine products at the lowest rate of VAT.
43. Evaluate the cost-effectiveness of providing pure nicotine products free on prescription to smokers for as long as they are unable or unwilling to quit.
44. Increase investment in research into the long-term impacts of nicotine.

CHAPTER 1

## THE GOAL AND AIMS OF TOBACCO CONTROL

### Summary

The goal of tobacco control is shaped by an astonishing context: despite the importance of consumer protection in British society, products which are known to kill one in every two of their life-long users are available for sale in shops throughout the land. As banning tobacco products is not an option, the very best that tobacco control can do is to reduce the harm that tobacco inflicts on smokers, on smokers' children and families, and on society as a whole. As the harm of tobacco recedes, so the benefits of improved health and wellbeing increase.

The harm of tobacco can be reduced by helping smokers to quit, reducing exposure to secondhand smoke and preventing people from starting smoking in the first place. For heavily addicted smokers who are currently unable or unwilling to quit, there is also the possibility of switching to pure nicotine products (which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives). As smoking is responsible for half the difference in deaths across socio-economic groups, tobacco control also has a major role to play in reducing health and social inequalities.

These aims are profoundly inter-linked. Children who live with parents who smoke will breathe cleaner air, and be less likely to become smokers themselves, if their parents quit or switch to pure nicotine products. Poor families will also benefit from the financial savings of quitting.

### A lethal anomaly

Tobacco is an extraordinarily harmful consumer product, responsible for the premature death of half of all life-long smokers. Over 80,000 people die from smoking-related disease in England<sup>1</sup> every year including 29% of all cancer deaths, 13% of cardiovascular deaths and 30% of deaths from respiratory disease<sup>2</sup>.

As a consumer product, tobacco is also a remarkable anomaly. British citizens are accustomed to living and shopping in a society where consumer protection and health and safety are paramount yet a product with a truly lethal track record is available from every corner shop and supermarket in the nation.

There is no easy way to overcome this anomaly: banning smoking is not an option. No-one wants the supply of tobacco to be controlled entirely by criminal gangs. A society with zero public demand for tobacco is a potent ideal but not currently a practical goal.

In this context, the very best that government can do is to reduce the harm caused by smoking: the harm to smokers; the harm to smokers' children, families, friends and colleagues; and the harm to society as a whole. As the harm of tobacco recedes, so the benefits of improved health and wellbeing increase.

Tobacco control cannot entirely eliminate the harm of tobacco. Like any other aspect of public health, it confronts the risks to human health of modern life and identifies realistic strategies to reduce those risks.

This report draws special attention to the many ways in which children and young people are harmed by tobacco. This harm must never be considered a reasonable price to pay for the freedom to smoke. New efforts are needed to tackle it in all its forms.

### Aims

Becca is twelve and lives in a household where both of her parents and her older sister smoke. Both parents

have tried to quit in the past, without any support or treatment, and failed. Neither parent works, so the cost of cigarettes takes a significant slice out of the household weekly income. Becca does not smoke regularly but she has recently been experimenting with cigarettes left in the house.

Even in this brief vignette, the multiple harms of tobacco are obvious: the harm to the smokers addicted to nicotine, to the young non-smoker who must breathe secondhand smoke on a daily basis and who risks becoming addicted herself, and to the whole family through impoverishment. It also illuminates the core aims of tobacco control:

- Helping smokers to quit
- Reducing exposure to secondhand smoke
- Preventing people from starting smoking

Each of these strategies has the potential to reduce the harm suffered by Becca. Reducing the prevalence of adult smoking not only dramatically improves the health prospects of adult (ex)smokers, it is also the single best way of reducing harm to children and young people because it eliminates secondhand smoke and the normative, tacit support for smoking.

Beyond these immediate aims, this example illustrates the importance of two further aims for tobacco control:

- Reducing health inequalities
- Enabling smokers to switch to less harmful products

Reducing health inequalities is a vital issue for tobacco control because smoking plays such a major role in perpetuating these inequalities, accounting for half of the difference in life expectancy between social classes I and V<sup>3</sup>. Furthermore, the higher prevalence of smoking in more deprived groups leads not only to more illness and mortality in these populations but also to greater impoverishment. Becca might eat better, as well as breathe better, if her parents quit.

If Becca's parents are currently unable or unwilling to quit, they could still reduce the harm of smoking by switching to using pure nicotine products. These are products which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives and which offer heavily addicted smokers the rewards of nicotine at a greatly reduced health risk. If Becca's parents, who have tried and failed to quit smoking, were able to switch to such products, their own health would immediately improve and she would no longer be exposed to tobacco smoke.

These five aims for tobacco control can be pursued through a very wide range of interventions. Some areas of work, such as the prohibition of tobacco advertising, are well developed although more could still be done. Others, such as helping smokers quit or switch to cleaner products, still have great potential. Some, such as reducing the toxicity of smoking, have little potential (tobacco smoke is unavoidably toxic). It is fair to say, however, that in every policy area there is scope for further action. With concerted effort, the rate of decline of smoking prevalence in all age groups could be not only sustained but increased.

A broad government agenda should not be interpreted as a prescription for a 'nanny state'. If adults in England want to smoke, they can - a remarkable freedom, given the toxicity of the product. Government does, however, have a role in reducing the harm of smoking in ways which are proportionate and evidence-based. It is entirely appropriate that the state should do what it can to promote the health and well-being of Becca and her family.

## The marketing mix

The types of intervention available to government to control tobacco are comparable to the interventions used by the tobacco industry in promoting its products. This range of tools is known as the marketing mix and is characterised by a four-fold focus on product, price, promotion and place. Just as the deployment of these tools by the industry to sell tobacco should be controlled, so their use in supporting quitting or making pure nicotine products more widely available should be encouraged. Figure 1.1 categorises specific tobacco control interventions against this framework.

Any intervention usually has multiple impacts. For example, reducing the affordability of tobacco products through the control of smuggling not only reduces the number of people starting smoking and increases the number quitting but, in consequence, also reduces exposure to secondhand smoke.

Decisions about which interventions to pursue are shaped by many considerations: equity, effectiveness and cost are all key concerns, as are ethics and public and political acceptability. Secondary, potentially negative, outcomes of any policy option must also be considered.

Such thoughtful and critical consideration of the rights and wrongs of different approaches to tobacco control must, however, always be sustained by commitment, ambition and clarity of purpose. Every smoking-related death is preventable. Every child growing up in England today should have the chance of a smokefree life.

Figure 1.1 Current tobacco control options described by the marketing mix

Focus	Product	Price	Promotion	Place
<b>Tobacco products</b>	Regulate design, packaging and labelling of tobacco products.  (Regulation of the toxicity of smoked tobacco products has little potential.)	Increase real price of tobacco through taxation and control of smuggling.	Remove residual promotion of tobacco products at point of sale.  Reduce visibility of tobacco products in TV and film.  Sustain media campaigns about the dangers of smoking.	<i>Place of sale</i> Restrict tobacco sales outlets. Enforce age restrictions on sale. Ban vending machines.  <i>Place of consumption</i> Further restrict or discourage smoking in places where others may be harmed.
<b>Quitting services</b>	Improve quality and range of NHS Stop Smoking Services and therapies.	Extend free NHS provision of stop smoking services and therapies. Reduce taxation and price of OTC therapies.	Sustain and expand local and national social marketing of stop smoking services and therapies.	Expand opportunities for accessing stop smoking services and therapies.  Encourage all health professionals to offer stop smoking advice.
<b>Alternatives to tobacco</b>	Introduce pure nicotine products that will be attractive to heavily addicted smokers.	Manipulate price of pure nicotine products to undercut tobacco products.	Promote pure nicotine products as a safer alternative to tobacco.	Make pure nicotine available through all outlets where tobacco products are sold.

*Pure nicotine products are products which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives and which offer heavily addicted smokers the rewards of nicotine at a greatly reduced health risk.*



## CHAPTER 2

## TEN YEARS OF PROGRESS

**Summary**

The publication of *Smoking Kills* in 1998 was the first time that the scale of the harm caused by tobacco received a proportionate response from government. Subsequent achievements have been remarkable, above all the prohibition of most tobacco advertising, the creation of NHS Stop Smoking Services and the enactment of smokefree legislation. The UK now leads Europe in tobacco control.

In the last ten years smoking prevalence has been driven down in England from 28% to 22% and all the targets in *Smoking Kills* have been, or are likely to be, met. Although the cost of smoking to the NHS in England has risen over this period, from £1.7 billion a year to £2.7 billion in 2006-07, the current annual cost saving from the reduction in smoking prevalence is estimated to be £380 million.

Despite the achievements of the last ten years, millions of children and young people in England are still harmed by tobacco on a daily basis and the deep health inequalities created by smoking have barely shifted. Over a fifth of the adult population still smokes and smoking remains by far the largest cause of preventable premature death, killing more people each year than alcohol, obesity, road accidents and illegal drugs put together.

The momentum for change built up over the last decade must be exploited. Public support for tobacco control interventions has never been higher and international evidence demonstrates that greater investment in tobacco control could intensify the decline in smoking prevalence. Ongoing improvement cannot be taken for granted; a comprehensive and sustained approach is needed from government.

**Recommendation**

- *Develop a new comprehensive national tobacco control strategy with clear goals and challenging targets for both the medium and long term.*

**A changed world**

In 1998 it was quite normal to sit in a pub and breathe air laden with the pollutants of tobacco smoke, bombarded by tobacco advertising in a televised sporting event or in the casually considered pages of a glossy magazine. Leaving the pub, one might well confront a billboard promoting yet another tobacco product, overlooking the sponsored signage of the local corner shop. Entering the shop, advertisements for cigarettes would crowd the sales desk, framing a wall of products that, by its very proximity to the till, could not be avoided.

Ten years on, this experience is consigned to history. The wall of cigarette packs remains but the images, advertising and - above all - the smoke have gone. Smoking is increasingly marginalised in public life and smokers can no longer assume that their behaviour will be accepted by others around them.

The document which set the agenda for change in 1998 was the white paper *Smoking Kills*, a milestone in the history of public health. This was the first time that the scale of the harm caused by tobacco had received a proportionate response from government and it established a momentum for action that would transform the place of tobacco products in society. The fact that this momentum is with us still, driving forward new initiatives on tobacco control today, reflects both the ambition and the impact of *Smoking Kills*.

## Achievements

At the heart of *Smoking Kills* was an acknowledgement, based on experience in other countries, that significant reductions in smoking would only be achieved through an extensive and integrated package of measures. Putting a stop to the multi-million pound tobacco industry budgets for billboard and magazine advertising was not enough; new millions of public money were also needed for education about the risks of smoking. The price of cigarettes had to be increased to suppress demand but this had to be balanced by real investment in services to help smokers to quit. A determination to reduce smoking prevalence among both adults and younger people was complemented by a commitment to tackling the health inequalities across social classes.

If it is to succeed, a tobacco control strategy today requires a comparable breadth of vision and determination to pursue action in many different arenas at once. Comprehensive strategies have been critical to the success of advanced tobacco control programmes in other countries where cuts in smoking prevalence have deepened over time<sup>4,5,6</sup>.

Figure 2.1 maps the main points of the *Smoking Kills* action plan against the tobacco control marketing mix outlined in Chapter 1. This reveals the priorities of tobacco control in 1998 and provides a framework for describing subsequent achievements.

### **Tobacco: the product**

Health labels on tobacco products had existed for some time before *Smoking Kills* but the white paper sought to increase their impact. This led in time to the proposal, driven by Europe and announced in the subsequent white paper, *Choosing Health*<sup>7</sup>, that such warnings should include pictures - finally a reality in 2008.

*Smoking Kills* also supported European efforts to set limits on the tar and nicotine delivered by tobacco products but unfortunately it became clear that such limits could mislead smokers about the harmfulness of the products they smoke. Descriptors such as 'low tar' can no longer be used and the government is advocating the removal of emission yields from packs.

### **Tobacco: price**

*Smoking Kills* sought to erode the affordability of tobacco products through annual increases in taxation of at least 5% above inflation but in practice these increases have stuck close to inflation since 2001. The affordability of cigarettes has not changed.

*Smoking Kills* committed the government to a determined drive against smuggling which was undermining its tobacco taxation strategy. A £200m initiative was launched in 2000 which brought the illicit market share down from a peak of 21% in 2000-01 to 13% in 2005-06. In 2006 the Treasury announced plans to extend the campaign and set a target to reduce the size of the UK's illicit market for hand-rolled tobacco by 1,200 tonnes.

Figure 2.1 The relationship of the Smoking Kills action plan to the tobacco control marketing mix

Smoking Kills action plan	Tobacco Products					Quitting services			
	Product	Price	Promotion	Place of sale	Place of consumption	Product	Price	Promotion	Place
End tobacco advertising, promotion and sponsorship			●						
Minimal tobacco advertising in shops			●						
Tobacco tax increases		●							
Action against tobacco smuggling		●							
Pressure for European-wide fiscal action		●							
New NHS services to help smokers quit						●			
A week's free NRT (nicotine replacement therapy) on the NHS						●	●		
Quitting advice from all NHS professionals						●			●
Co-operation with the pharmaceutical industry (re NRT)						●			
Mass media health promotion campaigns			●					●	
An approved code of practice for smoking in the workplace					●				
Choice for smokers and non-smokers in pubs & restaurants					●				
Enforcement of law against tobacco sales to children				●					
A single cross-industry proof of age card				●					
Code to prevent sales to children from vending machines				●					

**Tobacco: promotion**

The top priority for *Smoking Kills*, supported by the concurrent European Tobacco Products Directive, was to radically reduce the attractiveness and visibility of tobacco products to smokers and non-smokers alike. It was very clear to policy-makers that the visual presence of tobacco brands in everyday life was a primary obstacle to long-term success in tobacco control. However controversial the prohibition of advertising, promotion and sponsorship may have been at the time, in retrospect the achievement is unassailable.

Other than at the (oft-visited) till, the names, colours and logos of tobacco brands that were once a seamless part of the lives of smokers and non-smokers alike have largely faded from public view. However, smoking is still glamourised in films and, to a lesser extent, on television and the internet.

*Smoking Kills* also promised significant investment in public education campaigns. This investment grew from £6m in 1999-2000 to a peak of £24m in 2004-05. These campaigns have sought not only to increase knowledge of the harm of tobacco products but also to encourage quitting and to reduce exposure to secondhand smoke.

**Tobacco: place of sale**

The interventions in *Smoking Kills* designed to control access to tobacco products were limited to enforcement of existing law, particularly in relation to children, rather than proposing changes to the modes of sale of tobacco products or their licensing.

Although Proof of Age Standard Scheme (PASS) cards are now well established and there is greater vigilance among many trading standards officers and magistrates in policing tobacco sales, it remains far too easy for underage smokers to get hold of tobacco products. Enforcement of the law is simply not adequate.

From 1st October 2007, the minimum age for the purchase of tobacco was raised to 18 and new provisions to control retailers who repeatedly sell tobacco to young people are being introduced.

**Tobacco: place of consumption**

*Smoking Kills* identified place of consumption as an important issue but did not propose radical action to tackle it. In retrospect the proposal in the white paper for voluntary action by businesses combined with a consistent premises labelling scheme seems rather timid. Yet it was well-timed: starting a process of dialogue that prepared the ground for a tougher agenda in *Choosing Health* and ultimately the smokefree legislation for enclosed public places and workplaces. The implementation of this legislation on 1st July 2007 is one of the great achievements of public health in England.

Exposure to secondhand smoke is still common in homes and cars where millions of children are exposed on a daily basis.

### **Stop smoking services: product, price, promotion and place**

Enabling quitting was a major theme of *Smoking Kills*, reflected in the innovative introduction of NHS Stop Smoking Services, the call to all NHS professionals to encourage quitting, and the promotion of nicotine replacement therapy (NRT).

Funding for stop smoking services has increased year-on-year since their creation, rising from £5m in 1999 to £61m in 2007-08<sup>8</sup>. Spending on nicotine replacement therapy on prescription has grown at a similar rate and stood at £40m in 2006-07. The prescription-only stop smoking therapies bupropion (introduced 2000) and varenicline (2007) have also played a significant role in supporting smokers' efforts to quit.

In 2004 *Choosing Health* signalled a renewed government commitment to NHS stop smoking services, including a move to tailor services to better address the needs both of individuals and of specific communities. Stop smoking services are now established throughout the country. No other country in the world has this level of professional support at a local level.

### **Alternatives to tobacco**

*Smoking Kills* began a new process of engagement with the pharmaceutical industry about access to, and use of, nicotine replacement therapy. *Choosing Health* opened up this debate further, encouraging a more liberal medicines licensing regime for NRT and the sale of NRT products alongside tobacco products. This radical change in the way NRT is sold has yet to happen and pure nicotine products are still designed and promoted exclusively to encourage quitting, not as replacements for tobacco products.

### **Targets**

*Smoking Kills* defined its own evaluation criteria with three key aims and targets for children, adults and pregnant women in England. They were:

- To reduce smoking among children (11-15 year olds) from 13% to 9% or less by the year 2010; with a fall to 11% by 2005.
- To reduce adult smoking in all social classes so that the overall rate falls from 28% to 24% or less by the year 2010; with a fall to 26% by the year 2005.
- To reduce the percentage of women who smoke during pregnancy from 23% to 15% by the year 2010; with a fall to 18% by the year 2005.

In 2004 the Department of Health set a further Public Sector Agreement (PSA) target:

- To reduce smoking rates to 21% or less by 2010 (from 26% in 2002), with a reduction in prevalence among routine and manual groups to 26% or less (from 31% in 2002).

Figure 2.2  
Smoking prevalence among adults in England 1978 - 2006  
(General Household Survey)

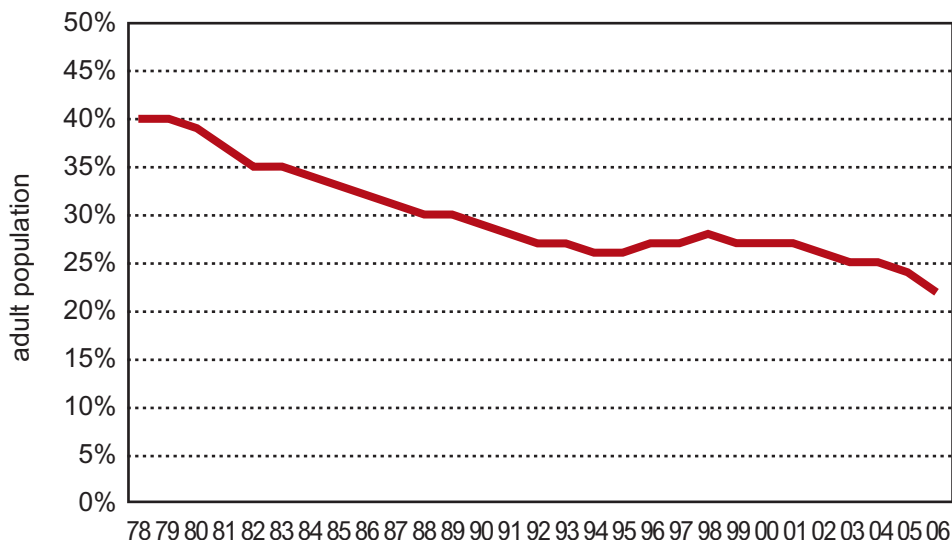


Figure 2.3  
Smoking prevalence in adults in England 1998 - 2006 by socio-economic group  
(General Household Survey)

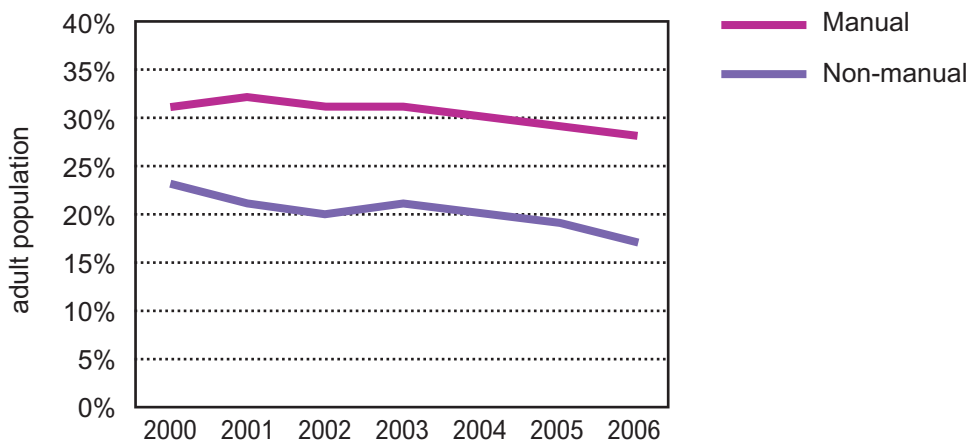
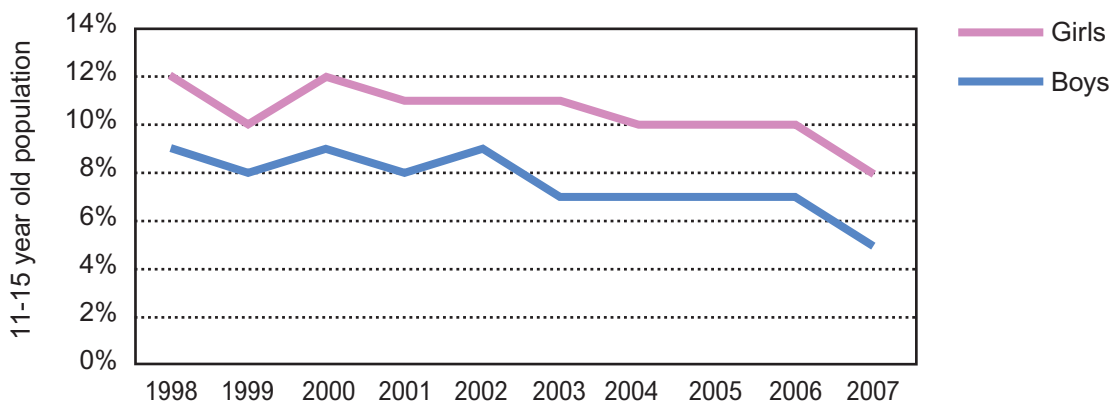


Figure 2.4  
Prevalence of regular smoking in 11-15 age group in England 1998 - 2007 by sex.  
(smoking, drinking and drug use among young people in England in 2007)



## Outcomes

The steady fall in the prevalence of adult smoking, following a period of little change in the 1990s, suggests that the policies in *Smoking Kills* did work through to real changes in individual choices and behaviour.

Figure 2.2 shows the decline in smoking prevalence among adults from 1978 to 2006 in England<sup>9</sup>. In 2006, 22% of all adults in England smoked (23% of men and 21% of women). This overall rate meets the *Smoking Kills* targets for both 2005 and 2010 and suggests that the PSA target of 21% by 2010 is achievable.

Over the three decades from 1974 to 2005 the average number of cigarettes smoked declined among men from 18 to 14 per day but remained stable at 13 per day for women.

Figure 2.3 shows the change in smoking prevalence in manual and non-manual socio-economic groups from 1998 to 2006. Prevalence fell from 22% to 17% in the non-manual population and from 33% to 28% in the manual population. The gap between the groups has not diminished but the 26% target for the manual socio-economic group is achievable.

Figure 2.4 shows the change in smoking prevalence among young people (aged 11-15 years) from 1998 to 2007. In 2007 smoking prevalence was 5% among boys and 8% among girls. Again, both the 2005 and 2010 *Smoking Kills* targets have been met. A rise in prevalence in the 1990s was not sustained and there has been a gradual decrease in prevalence over the last eight years.

Nationally smoking in pregnancy fell from 23% in 1995 to 19% in 2000 and then to 17% in 2005<sup>10</sup>. Thus on current measures the *Smoking Kills* target for 2005 was met and the 2010 target is achievable. There is, however, evidence of significant under-reporting of smoking in pregnancy<sup>11</sup>. Consequently current measures do not provide a reliable indication of the prevalence of smoking among pregnant women, nor its rate of decline.

Although HM Revenue & Customs has been successful in significantly reducing the illicit market share for cigarettes, there has been little change in the illicit market share for hand-rolled tobacco. This is despite the introduction of a new strategy for tackling smuggling in 2006 which specifically targeted this issue, with an additional 200 staff devoted to tackling hand-rolled tobacco<sup>12</sup>.

When *Smoking Kills* was published, the cost of smoking to the NHS in England was estimated to be up to £1.7 billion a year. Despite the decline in smoking prevalence over the last ten years, this cost rose to £2.7 billion in 2006-07. Although the cost of smoking is still a huge burden on the NHS, the current annual cost saving from the reduction in prevalence over this period is estimated to be £380 million<sup>13</sup>.

## **The international perspective**

Other countries, states and cities have also enjoyed significant success in tobacco control in the last two decades. The efforts made by California and Canada are particularly well regarded: both invested in major and wide-ranging campaigns which have had significant impacts on smoking prevalence.

### **California**

The state of California has a long and hard-fought history of tobacco control. In 1988 California voters enacted Proposition 99 which increased tobacco tax by twenty-five cents per pack and devoted 20% of the money raised to fund a tobacco control programme. A sustained period of effective campaigning followed which tripled the rate of decline in tobacco use. This rate then slowed, not least because of the vigorous response of the tobacco industry and its political allies<sup>14</sup>, but smoking prevalence continued to fall from 21% in 1989 to 14% in 2005<sup>15</sup>.

The California Tobacco Control Program funds mass media campaigns, local health department initiatives and services and campaigns run by community based organisations. Many important successes in the state, such as the elimination of self-service tobacco sales and the prohibition of smoking in bars and restaurants, were driven by grass roots campaigning. The overall approach of the California Tobacco Control Program is 'social norm change': indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible<sup>16</sup>.

### **Canada**

Canada has pursued a comprehensive approach to tobacco control since the mid 1980s including mass media campaigns, public education, regulation of packaging and labelling, community action, point of sale restrictions and tax increases<sup>17</sup>.

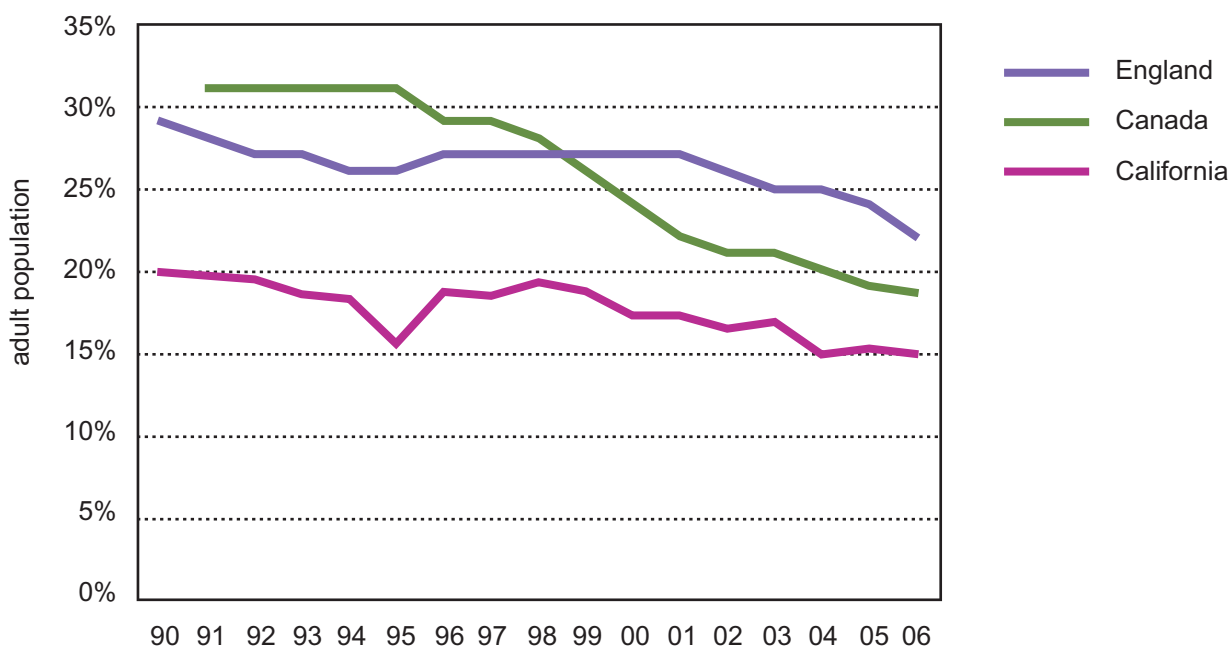
Canada first required health warnings on cigarette packs in 1989 and was the first country to require picture warnings on packs in 2000. The communication of health messages and stop smoking advice on Canadian cigarette packs is now acknowledged internationally to be an example of best practice. Tobacco advertising is limited and twelve out of thirteen provinces prohibit retail display of tobacco products. Control of secondhand smoke has grown since the first federal restrictions on smoking in the workplace were introduced in 1989. Local and provincial jurisdictions have tightened these restrictions and extended them to enclosed public places such as workplaces and bars.



The decline in smoking prevalence in Canada in the last twenty years has been impressive. Although it is difficult to attribute this achievement to individual measures, the importance of an adequately resourced, comprehensive approach is clear. In 2007 the federal government agency Health Canada employed around 140 people to regulate the tobacco industry. The federal government reviews and updates its strategy on a regular basis and has recently adopted a new target to reduce current smoking prevalence from 19% in 2006 to 12% by 2011.

In England the prevalence of smoking is substantially higher than in both California and Canada, principally because the development of an integrated tobacco control strategy began much later here and smoking prevalence has historically been higher - in the 1950s England had the highest smoking prevalence in the world. The rate of decline in prevalence in England has been very similar to that of California but not as impressive as that of Canada (Figure 2.5).

Figure 2.5  
 Prevalence of smoking in England, Canada and California, 1990-2006  
 (General Household Survey, Centers for Disease Control Behavioral Risk Factor Surveillance System, Health Canada)



NB: A new definition of smokers was introduced in California in 1995 which led to raised prevalence from 1996 and subsequent years.

As a result of the concerted efforts and strong leadership of the last ten years, at both national and regional levels (See *Fresh Smoke Free North East* case study), England and the other jurisdictions in the United Kingdom are now acknowledged to lead Europe on tobacco control. An independent review of tobacco control policies in 28 European countries revealed that the UK scored the highest of all European nations in a range of tobacco control measures<sup>18</sup>.

### **Building on success**

Tobacco control in the ten years since the publication of *Smoking Kills* has been ambitious, determined and effective. Each success stimulated public support for further intervention, sustaining the pace of change. Legislation prohibiting smoking in enclosed public places was only possible because so much had already been achieved in changing public attitudes to tobacco.

Having established this momentum for change, every effort must be made to exploit it. Despite the successes of the last ten years, millions of children and young people in England are still harmed by tobacco on a daily basis and the deep health inequalities created by smoking have barely shifted. Over a fifth of the adult population still smokes and half of these smokers will die prematurely from smoking-related illness unless they quit. Smoking remains by far the largest cause of preventable premature death in England, killing more people each year than alcohol<sup>19</sup>, obesity<sup>20</sup>, road accidents<sup>21</sup> and illegal drugs<sup>22</sup> put together.

As Figure 2.2 demonstrates, smoking prevalence cannot be assumed to march steadily downwards. The stagnation in the 1990s is a reminder that lives will only be saved through on-going investment and intervention.

The general public supports renewed action to reduce the harm of smoking (Chapter 5) and the government has signalled its own willingness to build on the success of the last ten years. The time is therefore ripe to create a new, comprehensive national tobacco control strategy which protects children and young people, reduces health inequalities and improves the health and well-being of millions.

*Figure 2.6 Key provisions in the WHO Framework Convention on Tobacco Control*

#### Parties will:

- Establish a national coordinating mechanism for tobacco control
- Involve civil society in national and international tobacco control efforts
- Prevent the tobacco industry from interfering in the setting of public health policies
- Consider increasing tobacco taxes as a means of reducing tobacco consumption
- Protect citizens from exposure to tobacco smoke in workplaces, public transport and indoor public places
- Require large health warnings on tobacco packaging
- Prohibit the use of misleading and deceptive terms such as 'light' and 'mild'
- Promote public awareness of tobacco control issues, including the impact on health, using all available communications tools
- Enact comprehensive bans on tobacco advertising, promotion and sponsorship
- Include tobacco cessation treatment in national health programmes
- Implement specific measures to combat tobacco smuggling
- Prohibit sales of tobacco products to minors
- Consider litigation to make tobacco companies pay for the harm caused by their products
- Develop and promote research into tobacco control
- Support tobacco control in developing countries and countries in transition

## CASE STUDY:

### Fresh Smoke Free North East

Fresh Smoke Free North East is a coalition of health bodies and local organisations that extends from Berwick-upon-Tweed on the Scottish border to Redcar and Cleveland in the south of the North East region. At the heart of this coalition is a dedicated tobacco control office responsible for overseeing the development and successful implementation of a Regional Tobacco Strategy.

The tobacco control office takes international best practice and national policy and ensures that it is delivered in a consistent and compelling way at a regional and local level. In doing so, it has become a model of best practice in its own right and similar regional bodies are now being established elsewhere in England.

The success of Fresh Smoke Free North East reflects the strength of its partnerships: as well as harnessing the energy and expertise of local NHS organisations and practitioners, Fresh has developed close relations with local authorities, NGOs, local business organizations and the trades unions. Having gained a strong regional voice, Fresh also influences national policy through the Smokefree Action Coalition and the Department of Health's National Tobacco Programme Board.

The first challenge that faced the organisation was the campaign for a comprehensive law on smokefree workplaces and public places. This was a cause that galvanised the region and, as a result, more responses to the government's consultation were received from the North East than from any other part of the country. It was a campaign which also provided Fresh with a recognisable cause which helped secure a place for the organisation in the consciousness of both the public and the media. Fresh is proud to have helped the North East deliver not only record levels of support for smokefree legislation but also the highest levels of compliance.

From its inception, Fresh fully exploited the power of branding and communications. The Fresh brand is designed to sell the positive aspects of tobacco control. It is obviously for safe and healthy environments and lifestyles as well as against smoking – though it is definitely not anti-smoker.

Fresh will ultimately be measured on smoking prevalence. The journey towards single-digit smoking levels has only just begun but the most recent General Household Survey revealed that prevalence in the North East had fallen by 4% from 2005 to 2006 – double the average decline across England as a whole.

Fresh is currently funded by the region's primary care organisations and by the Department of Health through the Public Health Group North East.



## CHAPTER 3

## CHILDREN AND YOUNG PEOPLE

**Summary**

One in seven fifteen year olds is a regular smoker. One in six mothers smoke throughout pregnancy. Millions of children and young people are exposed to tobacco smoke in homes and cars every day. These shocking facts must be addressed head on: the protection of children and young people from the harms of tobacco should lie at the very heart of a new national tobacco control strategy.

Nearly all smokers start young so deep, long-term cuts in smoking prevalence will only be achieved by preventing children and young people from starting smoking. Every effort should be made to reduce the attractiveness of smoking and the accessibility of cigarettes to young people. The context of everyday life is crucial; children and young people who live with adult smokers are much more likely to start smoking than those who live in smokefree homes. Reducing adult prevalence is therefore essential to stopping youth initiation. Smokefree homes and cars are also vital in cutting the exposure of children and young people to the toxins in secondhand tobacco smoke.

Pregnant women who smoke are not always given access to specialist stop smoking services and therapies. Greater investment is needed to ensure that all women smokers are supported to quit both before and during pregnancy. This requires better generic support – appropriate advice and referrals from midwives in particular – and universal access to specialist support.

**Recommendations**

- *Prohibit all tobacco promotion including point of sale displays and pack branding.*
- *Require all tobacco retailers to be licensed and improve enforcement of the minimum age limit.*
- *Prohibit the sale of tobacco from vending machines.*
- *Ensure all pregnant women are offered support from specialist stop smoking services as part of routine antenatal care.*
- *Train midwives to provide appropriate stop smoking advice and referrals to all pregnant smokers.*
- *Develop and evaluate new services and incentives to support the efforts of pregnant smokers to quit.*
- *Promote smokefree homes and cars through national and local campaigns.*
- *Evaluate the legislative option of prohibiting smoking in cars.*

**A national scandal**

Of all the harms inflicted by burning tobacco, the harms suffered by children and young people are perhaps the hardest to reconcile with the values of a modern safety-conscious society. The problem is immense yet so commonplace that it is disregarded even by people who are otherwise committed to protecting the health of children.

One in seven 15 year olds is already a regular smoker, facing adulthood with the burden of a highly toxic addiction. One in six babies is exposed to these toxins in the womb throughout gestation. Every day, millions of children breathe secondhand tobacco smoke. Despite the many successes of the last ten years, these facts remain truly shocking. The consequences for the health of infants, children and young people are described in Figure 3.1. For families on low incomes, the cost of smoking also plays a significant role in perpetuating child poverty.

The protection of children and young people from the harms of tobacco should lie at the very heart of a new national tobacco control strategy. For government and civil society alike, there can be no stronger rationale for intensifying efforts to curb smoking and exposure to smoke.

It is only through radically reducing the uptake of smoking among children and young people that long-term success in reducing adult smoking prevalence will be achieved. Unfortunately, however, there is no quick fix for children and young people. The harms they suffer, especially initiation into smoking, are principally due to the behaviour of adult smokers and the most effective way of reducing these harms is by reducing the prevalence of adult smoking. Consequently almost every intervention described in this report has the potential to reduce the harm inflicted by tobacco on children and young people. Education is not enough; only a comprehensive and sustained approach is likely to make a substantial difference to long-term outcomes.

*Figure 3.1 The impacts of smoking on children (summarised from The BMA Report 'Breaking the cycle of children's exposure to tobacco smoke')*

### **Children as smokers**

Child and adolescent smokers increase their short- and long-term risks of:

- Respiratory disease
- Cancer (one in every three cancer deaths is due to smoking)
- Cardiovascular disease

### **Smoking and pregnancy**

Smoking during pregnancy is the largest preventable cause of neonatal and infant ill health and death in the UK. It increases the risks of:

- Ectopic pregnancy, miscarriage, placental abnormalities and premature rupture of the foetal membranes.
- Still-birth, low birth-weight, infant mortality and cot death.
- Neonatal cleft lip and cleft palate, attention deficit/hyperactivity disorder (ADHD), impaired lung function, asthma and cardiovascular damage.

Mothers who smoke are less likely to start breast-feeding their babies than non-smoking mothers and tend to breast-feed for a shorter time and produce less milk.

### **Secondhand smoke**

Maternal exposure to secondhand smoke during pregnancy increases the risk of giving birth to low birth-weight babies. The exposure of infants and children to secondhand smoke increases their risk of:

- Cot death (86% of cot deaths occur in families where the mother smokes)
- Asthma attacks among those already affected
- Impaired lung function and respiratory disease
- Middle ear disease
- Tobacco addiction

Less conclusive evidence links exposure to secondhand smoke in childhood with the development of asthma, exacerbation of the symptoms of cystic fibrosis and cancer in adulthood.

### **Other impacts**

Children who live with smokers are more likely to be absent from school through respiratory or gastrointestinal illness.

Smoking households are 35% more likely to have a house fire than non-smoking households. More than 1500 children under 16 years are injured in house fires in the UK annually and around 40 die. Tobacco products are among the top causes of poisoning in children in the UK.

CHAPTER 3

Figure 3.2 Smoking prevalence in 11-15 year olds by number of smokers they live with (Smoking, drinking and drug use among young people in England in 2006)

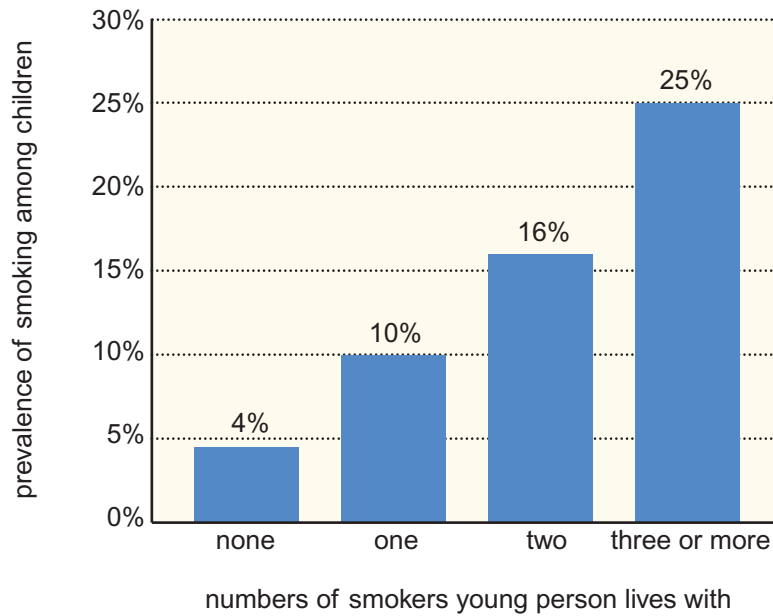
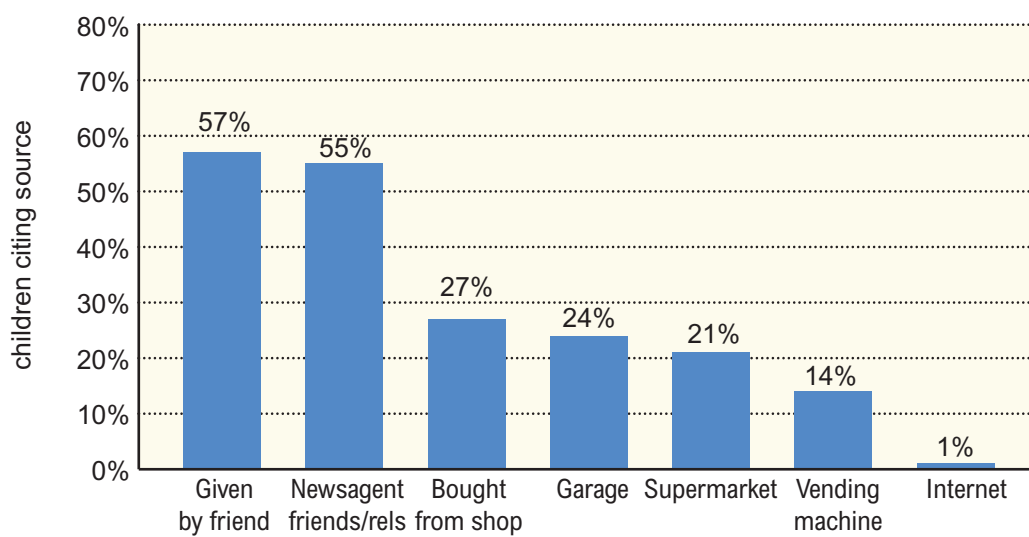


Figure 3.3 Usual sources of cigarettes for 11-15 year olds in England (Smoking, drinking and drug use among young people in England in 2006)



## Young smokers

Most adult smokers start smoking young. Two thirds (66%) of regular smokers start before the age of 18 and two fifths (39%) start before the age of 16. Nearly all regular smokers (95%) start before the age of 25<sup>23</sup>. The long-term success of tobacco control is therefore highly dependent on reducing smoking initiation among children and young people.

Young people sometimes assume that they can experiment with smoking, or just smoke socially, without getting addicted. Unfortunately, however, even one cigarette is highly predictive of regular smoking and young people show signs of addiction within four weeks of starting to smoke.

In 2007, 6% of 11-15 year olds smoked at least one cigarette per week: 8% of girls and 5% of boys (Figure 2.4). Among these regular smokers the average number of cigarettes smoked was six per day. Prevalence of regular smoking ranged from 1% among 11 year olds to 15% of 15 year olds<sup>24</sup>. Inequalities in smoking prevalence in this age group mirror those among adults.

Smoking initiation in children is very strongly related to the smoking behaviour of parents. Children who live with two adult smokers are four times more likely to be smokers themselves than children who live with non-smokers (Figure 3.2)<sup>25</sup>. Sixteen per cent of regular smokers among 11-15 year olds report that other family members do nothing to stop them smoking, compared to 1% of non-smokers in this age group<sup>25</sup>.

Figure 3.3 illustrates where 11-15 year olds get their cigarettes from. A majority of children still have little difficulty buying cigarettes from shops. In 2006 only a quarter (24%) of this age group said they found it difficult to buy cigarettes from a shop and only 22% had been refused on the last occasion they had tried<sup>25</sup>. This is double the refusal rate in 1996 but demonstrates the low levels of law enforcement. The increase in the minimum age of sale from 16 to 18 years will only be effective if law enforcement also improves.

The most effective way of reducing smoking prevalence among children and young people is for parents to quit as smokefree homes nearly double the chances that children who begin to smoke will quit<sup>26</sup>. Smokefree environments beyond the home also help to make non-smoking the norm in the eyes of young people. Interventions designed to reduce adult smoking, such as stop smoking services and treatments, are therefore vitally important in stopping young people from starting to smoke (Chapter 7).

Tobacco imagery has a particularly strong effect on children and young people, so comprehensive prohibition of advertising, including point of sale displays and pack branding, plays a major part in reducing youth smoking (Chapter 6). Price increases are effective in deterring initiation into smoking as young people are three to four times more price sensitive than adults<sup>27</sup>.

Other interventions that are likely to have an impact include age restrictions on the sale of tobacco, restrictions on where tobacco is sold, and mass media campaigns. There is little evidence that schools-based information and education campaigns have much impact beyond delaying the uptake of smoking<sup>28, 29</sup>.

Figure 3.4 Smoking and pregnancy by socio-economic status (Infant Feeding Survey 2005)

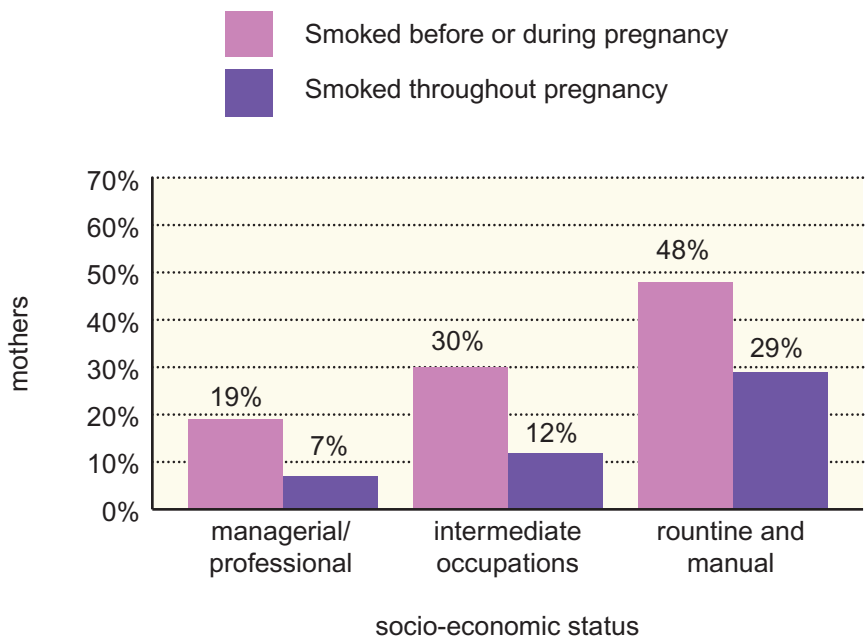
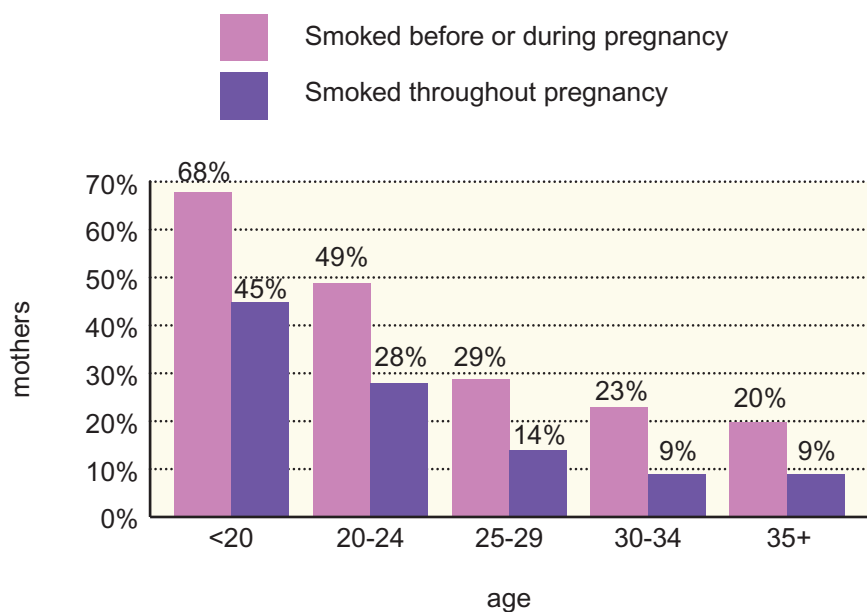


Figure 3.5 Smoking and pregnancy by age (Infant Feeding Survey 2005)





### **Smoking and pregnancy**

In 2005, 32% of mothers in England smoked in the 12 months before or during their pregnancy and 17% smoked throughout their pregnancy. The highest prevalence of smoking was among mothers in routine and manual occupations (Figure 3.4) and among those aged 20 or under (Figure 3.5) <sup>30</sup>.

As pregnancy is such a powerful trigger for quitting, maternity services are an obvious and proven locus for investment in stop smoking services <sup>31</sup>. Specialist stop smoking services should be more available and more accessible to pregnant women and evidence-based guidelines on smoking cessation in pregnancy should be developed. The professionals directly involved, above all the midwives, need a better understanding of the risks of smoking in pregnancy in order to give advice at the right time and make appropriate referrals. Innovative ways of encouraging pregnant women to quit are also needed. Schemes which offer food vouchers to pregnant women who successfully quit smoking are a good example of such innovation.

Ideally, women of child-bearing age should be supported to quit long before they become pregnant. Public campaigns and stop smoking services should target this group as a priority.

Although the key concern is getting mothers to quit, fathers and potential fathers should also be targeted. In England, 38% of unborn babies are exposed to tobacco smoke at home during gestation <sup>30</sup>. Not only will a father who continues to smoke at home expose the unborn child to secondhand smoke but his behaviour may also undermine the mother's efforts to quit <sup>32</sup>.

### **Exposure to secondhand smoke**

Children's exposure to secondhand tobacco smoke is commonplace and has clear, measurable effects. Prior to the implementation of smokefree legislation in 2007, 80% of children under ten years old from the most affluent backgrounds were found to have biological markers of exposure to smoke, rising to 95% of children from the least affluent backgrounds <sup>33</sup>.

Children may no longer breathe tobacco smoke in enclosed public places but the primary locus of exposure remains: the home. Although it is possible to reduce smoke levels by opening windows, smoking less or smoking away from children, these strategies still leave children exposed to dangerous levels of secondhand smoke as there is no safe level of exposure. Smokefree homes offer the only sure protection <sup>33</sup>.

Children and young people are also regularly exposed to secondhand smoke in cars where levels of toxins can get extremely high, even when windows are opened <sup>34,35</sup>. Effective measures to protect people from the harmful effects of tobacco smoke in cars should be investigated. Although legislation is not specifically advocated in this document, serious consideration should be given to the option of prohibiting smoking in cars, a step that has already been taken in South Africa and in various jurisdictions in America, Canada and Australia. A proper evaluation of the costs and benefits of this option should be undertaken for England.

## CHAPTER 4

## HEALTH INEQUALITIES

**Summary**

The more deprived you are, the more likely you are to smoke. Almost every indicator of social deprivation, including income, socio-economic status, education and housing tenure, independently predicts smoking behaviour. Consequently individuals who are very deprived are also very likely to smoke. These differences in smoking behaviour translate into major inequalities in illness and mortality; inequalities which have deepened over the last thirty years.

Smokers in lower socio-economic groups are just as likely to try to quit as affluent smokers but are less likely to succeed. Their lower success rate is partly due to stronger nicotine addiction. In every age group, smokers from deprived backgrounds take in more nicotine than more affluent smokers, even when the number of cigarettes smoked is the same.

As smoking prevalence is highest in the population groups least able to afford to smoke, smoking deepens deprivation, social inequalities and child poverty. Smokers from disadvantaged backgrounds are also more likely to die or suffer injury from smoking-related fires.

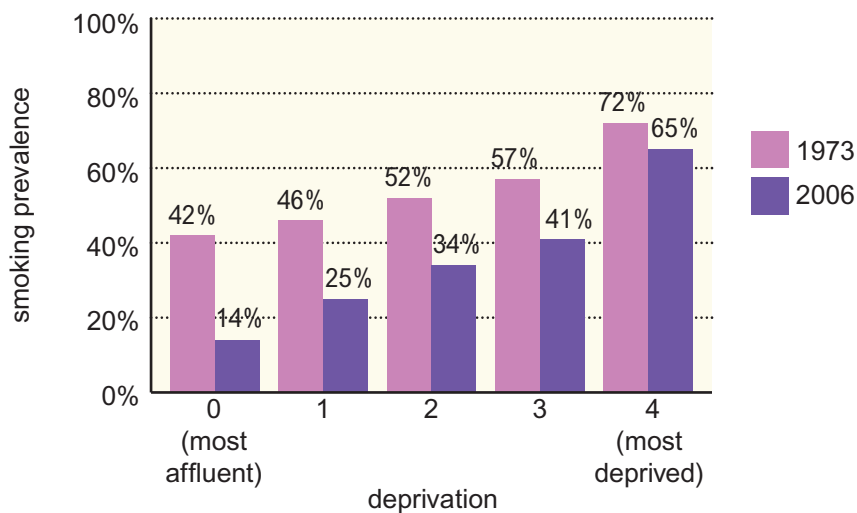
**Recommendations**

- *Prioritise deprived and marginalised groups, including routine and manual socio-economic groups, in the design and targeting of all stop smoking services, campaigns and interventions.*
- *Increase and sustain investment in mass media education and social marketing campaigns and prioritise health inequalities in the targeting of anti-smoking messages.*
- *Maintain free provision of stop smoking services.*
- *Abolish prescription charges for nicotine replacement therapy for all smokers who want to quit.*
- *Implement a standard for fire safer cigarettes based on the internationally accepted ASTM standard.*
- *Develop a fully-resourced local, national and international strategy to control tobacco smuggling and the sale of illicit tobacco.*
- *Develop a strategy and an appropriate regulatory structure to improve the acceptability, attractiveness and accessibility of pure nicotine products for use as an alternative to smoking for those smokers who are currently unable or unwilling to quit.*

Figure 4.1 Socio-economic factors and cigarette smoking. Odds of smoking ( $\pm$  95% confidence interval) adjusted for age group, ethnic group and year of survey (Health Survey for England 1998-2004 pooled)



Figure 4.2 Prevalence of cigarette smoking 1973 and 2006 (General Household Survey)



### **An intractable problem**

For all the successes of the last ten years, tobacco control policy-makers must now confront a very harsh reality. The population-wide interventions that have brought significant reductions in the prevalence of smoking and exposure to secondhand smoke have had no impact on the extraordinary demographic skew that characterises the population of smokers in England. If anything, inequalities have got worse (Figure 2.3).

Smoking is the primary cause of health inequalities between rich and poor in England, responsible for half the difference in premature deaths across socio-economic groups<sup>3,36</sup>.

If you have a routine or manual job, you are more likely to smoke than someone with a professional or managerial occupation. If you live in rented housing you are more likely to smoke than someone who owns their home. If you receive welfare benefits you are more likely to smoke than someone who does not. This list goes on: you are more likely to smoke if you are divorced, or suffer from mental illness, or have no educational qualifications or live in crowded accommodation (Figure 4.1). Every one of these factors *independently* predicts smoking, so the greatest harms of tobacco are suffered by the most deprived people in England. In this population, smoking prevalence has barely changed in the last three decades (Figure 4.2).

Standard measures of social disadvantage illustrate the persistence of the inequality (as in Figure 4.3) but disguise the severity of the problem among the most disadvantaged groups. For example, 80% of people with schizophrenia smoke<sup>37</sup>, as do at least 80% of people in prison<sup>7</sup>. Smoking and mental health are inexorably linked: 40% of those with mental health problems smoke, as do 70% of psychiatric patients admitted to mental health wards<sup>38</sup>. Nearly half (48%) of gay men with diagnosed HIV smoke, as do 40% of gay men generally<sup>39</sup>.

The reasons for the existence of these inequalities are complex. People who suffer higher levels of deprivation may be more likely to turn to smoking for stress relief, yet the principal stress that smoking relieves is simply the stress of nicotine withdrawal which every smoker experiences. Similarly it is argued that people whose lives lack rewards will value smoking more highly than those who find rewards elsewhere. This is a persuasive argument for those in the most deprived circumstances, such as prison, but in general people from deprived backgrounds are just as keen to quit as people from affluent backgrounds – they just do not succeed as often.

Figure 4.3 Prevalence of cigarette smoking in 16-19 year olds by deprivation score (Health Survey for England 1996-2003 pooled)

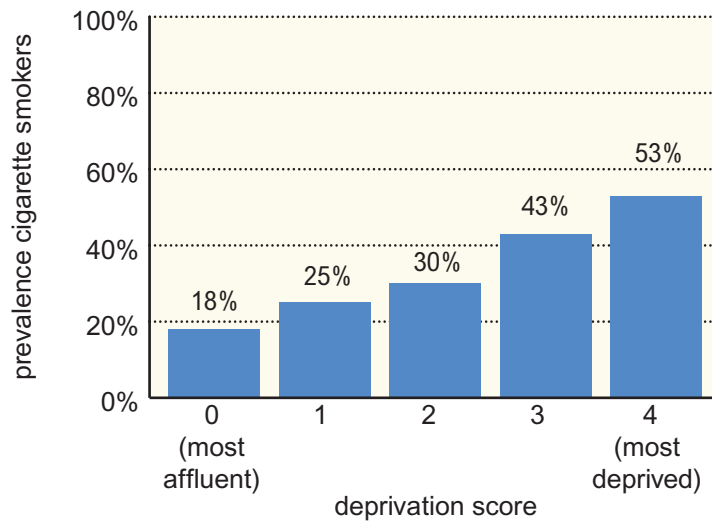
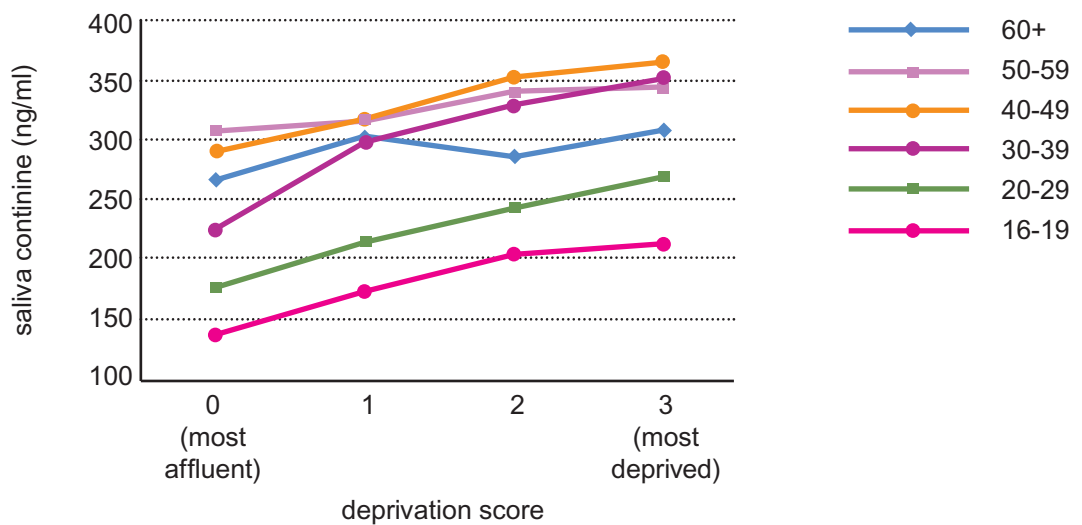


Figure 4.4 Nicotine intake in smokers by age and deprivation score (Health Survey for England 1998-2004 pooled)



For some groups, the persistence of high smoking prevalence can be understood as a self-perpetuating cycle of addiction. Mothers from deprived backgrounds are more likely to smoke than their more affluent peers, so their babies are more likely to be exposed to secondhand smoke in infancy. These babies mature into children who take smoking for granted as part of everyday life. As a result, their likelihood of starting to smoke is heightened (Figure 4.3). Children of parents who smoke are up to four times more likely to smoke than those who come from non-smoking homes (Chapter 3).

Children also appear to adopt the intensity of smoking of their adult role-models: in every age group smokers from deprived backgrounds take in substantially more nicotine than more affluent smokers (Figure 4.4), reflecting higher levels of nicotine dependence. Smokers in routine and manual occupations consume more cigarettes than smokers in professional occupations, find it harder to last a day without smoking and are more likely to have their first cigarette of the day within five minutes of waking<sup>40</sup>. The strength of their addiction makes the challenge of quitting greater, a challenge intensified by the greater acceptance of smoking in communities where smoking prevalence is high.

When these nicotine-addicted children become adults and then parents, the cycle begins again.

### **Wider impacts**

The higher prevalence of smoking in poor and disadvantaged populations not only increases their risk of tobacco-related disease. They also suffer disproportionately from the costs of smoking and from smoking-related fires.

The population groups least able to afford to smoke have the highest smoking prevalence. In 2003 the poorest 10% of households spent 2.43% of their income on cigarettes compared to 0.52% in the richest 10% of households<sup>41</sup>. Smoking therefore deepens deprivation and exacerbates child poverty.

This presents a dilemma, as increases in tobacco tax reduce smoking prevalence in all socio-economic groups, and so alleviate poverty for those who quit, but also increase poverty for those who do not quit. This dilemma can only be resolved by making the greatest possible efforts to motivate and assist smokers to quit in response to increases in taxation.

There is a positive correlation between social deprivation and the incidence of smoking-related fires. Nearly half (47%) of deaths due to fires in dwellings are caused by cigarettes or other tobacco products. These deaths are more common in areas with a higher social deprivation index and there is a high prevalence of disability, alcohol problems, ill health and mental health problems among victims of fires<sup>42</sup>. Fire safer cigarettes, currently being developed within the European Union, would save lives and reduce injuries from these fires.

### New approaches are needed

The failure to close the inequalities gap over the past ten years suggests that new approaches are needed to reducing smoking prevalence in disadvantaged groups and communities. This is despite the success of NHS Stop Smoking Services in attracting smokers in deprived areas. Such services are an important and cost-effective part of the tobacco control portfolio but make only a modest contribution to annual falls in smoking prevalence<sup>43</sup>. The higher level of nicotine addiction among poorer people also presents a harder task for these services.

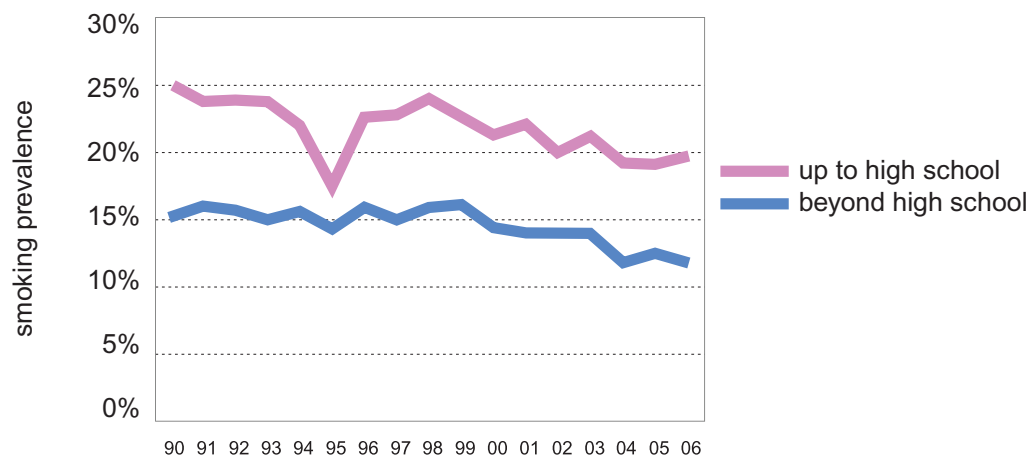
Across the world, other legislatures that have pursued concerted, long-term tobacco control policies face the same difficulty. Figure 4.5 illustrates the gradual reduction of smoking prevalence in California, the US state with the strongest track record in tobacco control. The considerable gap in prevalence between those of different educational experience (the best available proxy for socio-economic status in the US) is sustained throughout the period despite the broad range of interventions implemented in the state.

There is clearly scope for improving the targeting of current tobacco control interventions. The current Department of Health tobacco control marketing strategy, for example, is focused principally on smokers from more deprived socio-economic groups. New community-based initiatives to address the harms of smoking will also be important.

Tackling tobacco smuggling is also vital. Smuggling has a disproportionate effect on less affluent socio-economic groups, who are far more likely to use illicit tobacco than affluent smokers<sup>44</sup>. If the price signal is to be used as a meaningful policy tool in reducing smoking prevalence, the real price of tobacco must approximate the retail price. A renewed effort to tackle smuggling is required to achieve this (Chapter 6).

If, however, the population of lower income and deprived smokers is characterised by high nicotine dependence, options beyond supporting and incentivising quitting need to be brought forward. The use of pure nicotine products as a long-term alternative to smoking offers the best hope of reducing the risks to individual smokers who are currently unable or unwilling to quit. New initiatives are needed to make pure nicotine products more acceptable, attractive and accessible to these smokers (Chapter 8).

Figure 4.5 Cigarette smoking in California 1990-2006 by level of education (CDC Behavioral Risk Factor Surveillance System)



## CHAPTER 5

## PUBLIC OPINION

**Summary**

Public support for tobacco control remains strong. Support for smokefree legislation rose following implementation in 2007 and now stands at 77% of the adult population in England. Experience of the benefits of smokefree enclosed public places appears to have increased public enthusiasm for new initiatives in tobacco control.

The interventions currently being implemented by government, including picture warnings on cigarette packs and fixed penalty notices for under-age sales, enjoy wide public support. There is also majority public support for hypothecated price increases, removal of retail displays, prohibition of tobacco sales through vending machines, prohibition of smoking in cars carrying children, expansion of stop smoking services and increased access to nicotine replacement therapy.

Smokers tend to support measures that protect children or assist their own efforts to quit but tend not to support increases in tobacco prices.

Members of the public care about individual liberty and will not support measures that constrain liberty unless there are very good grounds for this, such as protecting the health of children. Supporting smokers to quit is felt to be a particularly appropriate policy response.

**An appetite for change**

A new and challenging agenda for tobacco control will only succeed if it is underpinned by wide public support. This is both politically and practically necessary: reducing smoking prevalence is a long-term goal requiring the collective efforts of government, civil society and the general public.

Happily the public is behind this agenda. The achievements of tobacco control over the last ten years have increased public enthusiasm for further action and in many cases change in public opinion preceded the change in policy. Far from seeing the implementation of smokefree legislation as the occasion to leave smokers alone for a while, the public continues to support serious action to reduce the harms of tobacco. Support for smokefree legislation has risen consistently over time and stands at 77% in England and 81% in Scotland, which went smokefree a year earlier (Figure 5.1)

Figure 5.1 Support for smokefree enclosed public places in England, 2004-2008 (MORI and YouGov)

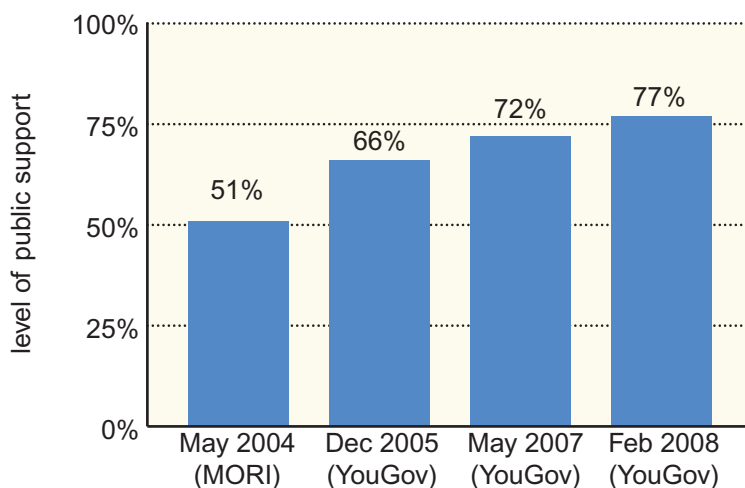




Figure 5.2 *The impact of smokefree legislation in England (YouGov 2008)*

- 77% support the law making all enclosed public places and workplaces smoke free
- 73% reported being exposed to less secondhand smoke compared to before the implementation of smokefree legislation
- 79% feel that pubs, bars and restaurants are more pleasant places to be since they went smokefree
- 87% feel that the law banning smoking in the workplace is good for the health of bar workers
- 76% feel that the law banning smoking in the workplace is good for their own health

People recognise that smoking brings an unacceptable burden of ill-health, especially on the lives of the young and the socially disadvantaged. Their experience of the benefits of smokefree legislation (Figure 5.2) has almost certainly strengthened their own support for further action to protect non-smokers and help smokers to quit.

This chapter draws on the results of two recent studies into public views on smoking both of which were commissioned by ASH. The first is a YouGov survey of 1055 English residents, conducted in February 2008. The second is a citizens' jury conducted by Dr Foster, also in February 2008.

The citizens' jury of twenty people was recruited in Hackney, London. Half the group were smokers (twice the national average), around half were from Black and Minority Ethnic communities and the range of their incomes reflected the lower income of the community from which they were drawn.

Over three days the panel listened to expert evidence from politicians, academics and clinicians supporting and opposing a variety of tobacco control measures. The members had time to discuss the issues in some detail and come to their own conclusions and policy recommendations.

### **Attitudes to current policy**

All the tobacco control interventions that are currently being implemented by government enjoy wide public support.

Two changes directly affect the products smokers buy. First, picture health warnings on tobacco products were introduced in October 2008. Sixty-six per cent of YouGov respondents in England supported this change. Second, the European Commission is developing new standards requiring cigarettes to be made in such a way that they go out when they are left burning while not being smoked. Seventy-five per cent of respondents supported this change.

Two further changes increase the possible penalties for selling tobacco to young people. The Criminal Justice and Immigration Bill introduces powers to prohibit retailers from selling tobacco if they are convicted of selling cigarettes to people under 18 years old. Eight-five per cent of respondents supported this change. For the same offence, the Regulatory Enforcement and Sanctions Bill gives powers to issue fixed penalty notices to retailers. Ninety per cent of respondents supported this change.

These initiatives are not particularly controversial. Even among smokers in the YouGov survey, only a minority opposed these changes. More than a quarter of smokers (28%) supported the introduction of picture warnings on packaging (33% opposed) and 60% supported changing cigarettes to prevent them burning when not being smoked (8% opposed).

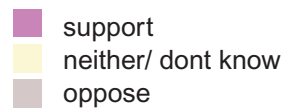
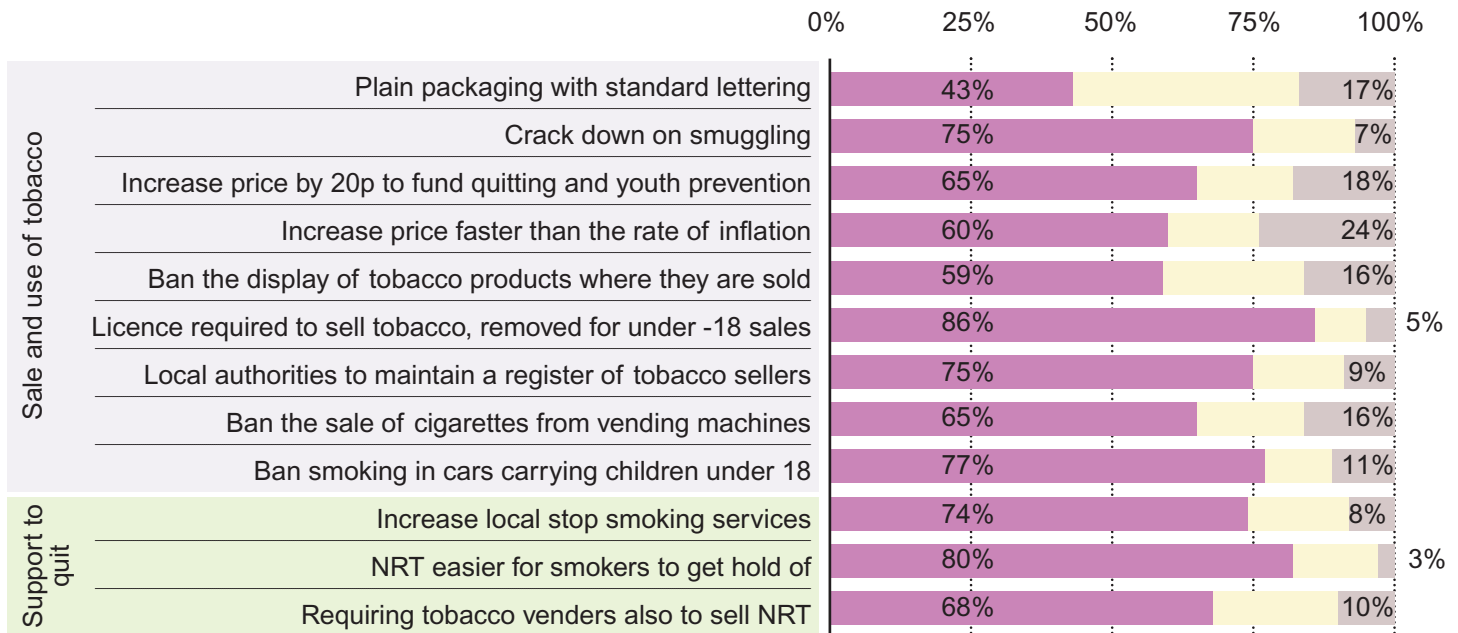


Figure 5.3 Attitudes in England to new and expanded measures in tobacco control, 2008 (YouGov)



**Attitudes to new policy proposals**

Figure 5.3 describes the level of public support for a wide range of policy proposals for new or renewed intervention in tobacco control. The principal message of this chart is clear: there is overwhelming public support for new action to reduce the harm from smoking. Only one proposal did not gain majority support, the use of plain packaging and lettering for tobacco products. However at 43% the level of support for this proposal was still far greater than the active opposition expressed by 17%, and the large proportion of undecided respondents may reflect a lack of familiarity with the concept of plain packaging.

The importance that the public attaches to protecting children is evident in these results. The most popular proposal, supported by 86% of respondents, is the licensing of tobacco retailers with provision for removal of the licence if caught selling to people under the age of 18. A very different approach to protecting children, prohibiting smoking in cars in which they are travelling, is potentially a more controversial measure yet it still attracted the support of over three quarters (77%) of respondents. Nearly two thirds (65%) of respondents also support the removal of vending machines selling tobacco, one of the means by which children currently get hold of cigarettes.

Initiatives which help smokers to quit enjoy wide support and minimum active opposition: 74% of respondents would like to see an increase in local stop smoking services and 82% would like to see NRT made more widely available. The proposal to require retailers to sell NRT alongside tobacco products, on the government agenda since *Choosing Health*, is supported by over two thirds (68%) of respondents.

The government has already proposed a new strategy on tobacco smuggling, an initiative supported by three quarters (75%) of respondents and opposed by only 7%. Proposals for more direct increases in the price of tobacco are not quite as popular but still enjoy substantial majority support: 65% of respondents would support a 20p increase in the price of a pack of cigarettes if this money was used to prevent young people taking up smoking and encourage smokers to quit. Increasing the price of tobacco faster than inflation was supported by 60% of respondents.

Prohibiting the display of tobacco products where they are sold was supported by 59% of respondents. If past experience in tobacco control is anything to go by, it is likely that support for this proposal and for plain packaging will grow as the public gains a better understanding of the policy.

### **Smokers' views**

Four of the proposals in Figure 5.3 gained the support of a majority of smokers among the respondents. Nearly three quarters (73%) felt that retailers ought to be licensed to sell tobacco, a licence rescinded from anyone selling to under-18s, and 59% agreed that local authorities should maintain a register of tobacco retailers (59% of smokers). They also supported the expansion of local stop smoking services (58%) and the sale of NRT through tobacco vendors (76%).

Not surprisingly, smokers were less likely to support proposals that directly affected the product, price and sale of tobacco. However there was only one proposal for which a majority of smokers expressed active opposition: above inflation price increases (67% opposed vs. 11% support). The hypothecated price increase was more acceptable (49% opposed vs. 28% support) though the indirect price measure of a crack down on smuggling was most attractive (20% opposed vs. 49% support).

There was also weak opposition among smokers to plain packaging (33% opposed vs. 21% support), removal of retailer displays (35% opposed vs. 30% support) and prohibiting the sale of tobacco through vending machines (44% opposed vs. 26% support). The proposal to prohibit smoking in cars travelling with children was supported by many more smokers (48%) than opposed it (27%).

Overall, there is a remarkably low level of opposition to new tobacco control measures among smokers, especially when compared with the consistently high support for these measures in the population as a whole. Measures which benefit their own efforts to quit or which protect children are generally welcomed.

### **The view from the jury**

The members of the citizens' jury also expressed majority support for new tobacco control interventions. They were willing to support government interventions that they thought:

- Would work and would be enforceable (i.e. would prevent people smoking in the first place and would help people quit)
- Would not be too costly to the public purse to enforce
- Would not infringe adults' civil liberties, (unless the health of children and young people was at risk)

For example, they were sceptical that branding encouraged people to start smoking or to continue smoking and so did not believe that plain packaging would reduce the number of smokers significantly. Yet they had few objections in principle to regulating the tobacco manufacturers' powers to market their products in this way. They did not think it would cost tax payers money to enforce such legislation and it would not infringe anyone's civil liberties in the process.

The jurors were especially keen on measures to support smokers who wanted to quit. They wanted to see greater community involvement in the design of stop smoking services in order that services met local needs. They thought low-income smokers might be reluctant to approach GP primary care teams for help and support and might be more confident about attending a service in a local community centre or venue.

Schools were suggested as a good place to deliver a stop smoking service to the whole community especially smokers.

The jurors recognised that smoking around babies and children was bad for their health and that the children of smokers were significantly more likely to smoke themselves. They did not want to ban this activity but felt that the government should do more to encourage people not to smoke around babies and children (e.g. through mass media campaigns). However they stressed that people should not be lectured about what to do in their own homes.

Shocked by the social inequalities in smoking and smoking related disease, our jurors gave priority to measures designed to tackle smoking in communities with high smoking prevalence. They believed that high rates of smoking were driven by a variety of interrelated challenges faced by people living on very low incomes including social isolation, the stress and anxiety of making ends meet and the overall lack of opportunity within which they live. But they also wanted to encourage and support quitting among smokers from deprived backgrounds, especially among parents to break the cycle of smoking within low-income families.

The following emerge as key concerns in the jurors' decision-making:

### **Individual freedom**

They were passionate about individual liberty and needed to be confident that any restrictions on people were justified by the protection of the health of others, especially children.

### **Corporate culpability**

They were much less concerned about protecting the rights of the businesses that profit from the manufacture and sale of tobacco products. They wanted to minimise harm done by cigarettes and thought the chemicals in cigarettes should be listed on the pack. They expressed shock that there was no independent industry regulator and believed one should be established urgently. They also believed that the conduct of tobacco manufacturers should be scrutinised and their misconduct publicised.

### **Support for smokers**

The strongest support was for measures to help smokers who wanted to quit or cut down. They felt that the promotion of much safer alternatives to tobacco might help to reduce the impact of smoking among low income smokers who are more heavily addicted and find it harder to quit. They thought this could help to tackle health inequalities.

The jurors recognised the links between smoking and health inequalities but perceived smoking to be as much an expression of health inequalities as a cause of them. In their verdict they prioritised tackling poverty, improving the lives of children in poverty, developing community-led stop smoking services and encouraging smokers not to smoke in front of children.

The evidence from both the jury and the survey suggests that the public is ready, even eager, for further action to reduce the harm from smoking. They may be wary of restricting individual behaviour without sound justification but they are especially supportive of helping smokers to help themselves and have few reservations about constraining an industry that makes its money at the expense of its customers' health.

## CHAPTER 6

## THE REGULATION AND USE OF TOBACCO

**Summary**

Two powerful marketing tools are still available to the tobacco industry: product branding and point of sale displays. These are used not only to increase the visibility and attractiveness of cigarettes but also to exploit public misunderstandings about the relative safety of different tobacco products. Even though the terms 'light' and 'mild' are now prohibited, many people still identify low tar cigarettes as less harmful, signalled by subtle differences in pack branding, when in reality tobacco smoke is always toxic and dangerous. Any standard for tobacco product content or emissions risks being exploited in this way.

Tobacco advertising and branding encourage children and young people to start smoking. These young people then have little difficulty obtaining tobacco products: enforcement of the minimum age limit is weak and vending machines offer under-age smokers easy access to cigarettes. Young people are also sensitive to the glamourisation of smoking in films, on TV and on the internet.

There are many ways of discouraging initiation into smoking and encouraging quitting. Mass media public communication campaigns are particularly cost-effective. Overall, however, the most effective way of reducing smoking prevalence is to increase the price of tobacco. The affordability of cigarettes has barely changed in the last ten years and the illicit market share is still substantial. The illicit trade reduces the real price of tobacco, especially in more deprived communities, and so exacerbates health inequalities. About one in eight cigarette packs and one in two packs of hand-rolled tobacco are illicit.

Despite the huge step forward of smokefree legislation, millions of people, especially children and young people, are exposed to secondhand smoke in homes and cars every day.

**Recommendations**

- *Prohibit branding of any kind on tobacco product packaging.*
- *Prohibit all point of sale display and advertising of tobacco products.*
- *Reintroduce an annual above-inflation price escalator for tobacco products.*
- *Develop a fully-resourced local, national and international strategy to control tobacco smuggling and the sale of illicit tobacco.*
- *Prohibit the advertising and promotion of tobacco accessories such as cigarette papers.*
- *Replace the current information on tobacco products about tar and nicotine emissions with qualitative information about the risks of smoking.*
- *Include the number of the national NHS Smoking Helpline on all tobacco packaging.*
- *Improve film licensing guidelines to reduce the exposure of young people to images of smoking. Screen anti-smoking advertisements prior to films or TV programmes, including DVDs, which condone or glamourise smoking.*
- *Require all tobacco retailers to be licensed and include the sale of nicotine replacement therapy and other pure nicotine products as a condition of the licence.*
- *Improve enforcement of the minimum age limit for the sale of tobacco products.*
- *Prohibit the sale of tobacco from vending machines.*
- *Increase and sustain investment in mass media education and social marketing campaigns and prioritise health inequalities in the targeting of anti-smoking messages.*

- *Promote smokefree homes and cars through national and local campaigns.*
- *Evaluate the legislative option of prohibiting smoking in cars.*
- *Use the 2010 review of smokefree legislation as an opportunity to identify, and build on, best practice internationally.*

### **Cigarettes are still attractive**

The tobacco industry has responded vigorously to the many constraints placed on the sale and advertising of tobacco over the last ten years. A teenager buying sweets in the local shop is unlikely to be completely disinterested in the sparkling, holographic cigarette packet advertised behind the counter – just one of many recent innovations. Tobacco brands still sell.

At every point on the marketing mix – product, price, promotion and place – opportunities still exist to reduce the attractiveness of tobacco products and encourage non-smoking. Every one of these opportunities should be seriously addressed in the development of a new national tobacco control strategy.

### **The product**

#### **Cigarette emissions**

Governmental efforts to regulate the emissions of tobacco products have been largely counterproductive to date, for two key reasons. First, the combustion of tobacco unavoidably produces harmful substances so tobacco smoke will always be toxic and smoking will never be safe. Second, any regulation of emissions necessarily requires the setting of standards but standards of any kind offer the tobacco industry an opportunity to present one product as safer, or even healthier, than another.

Attempts to improve the safety of tobacco products can result in a greater risk to smokers if they are persuaded that their actions are safer than they really are. This was infamously the outcome of the ‘low tar’ debacle in which consumers were persuaded that their cigarettes were safer to smoke while in practice being exposed to the same level of toxins<sup>45</sup>, a misconception sustained to the present day<sup>46</sup>. Even the current quantitative labelling of tar, nicotine and carbon monoxide emissions should be removed and replaced with qualitative information, given the potential for this information to mislead.

At an international level, work to understand and limit the toxicity of tobacco products should continue but currently there is no case for setting new industry standards for the emissions of tobacco products.

#### **Labelling and packaging**

The introduction of picture health warnings in 2008 marks an important change to the visual impact of tobacco products, intensifying the health message while also diminishing the power of the brand. The impact of this change on smokers’ attitudes and behaviour should be closely monitored. In Australia and Canada, for example, picture warnings have helped to discourage young people from smoking<sup>47</sup>.

Although the health message diminishes the brand, the opposite is also true: the brand diminishes the health message. Every detail of the design of cigarette and tobacco packaging is used by the tobacco industry to communicate positive messages about the product.

European Commission Directive 2001/37/EC states that ‘texts, names, trade marks and figurative or other signs suggesting that a particular tobacco product is less harmful than others shall not be used on the packaging of tobacco products.’ It also prohibits the use of the words ‘low tar’, ‘light’, ‘ultra-light’, or ‘mild’.

Yet the legacy of 'low tar' branding is a range of associations in the minds of smokers that connect words, colours and design with a more healthy choice. These associations are exploited relentlessly by the tobacco industry<sup>48,49</sup>. 'Smooth' means the same as 'Light'. Silver is healthier than red or purple. Such seemingly minor variations have a real effect on consumer perceptions of the safety of the product.

## New research: consumer perceptions of tobacco branding

Does the branding and design of tobacco products really affect consumer perceptions of their safety and desirability? ASH commissioned a new study to find out.

Over a thousand individuals participated: 516 adult smokers and 806 young people (both smokers and non-smokers) aged 11-17 years. Each participant was shown a series of pairs of cigarette packs and, for each pair, asked to assess differences in taste, tar delivery, health risk and attractiveness. Adult smokers were asked to judge which product would be easier to quit. Young participants were asked which they would choose if they wanted to try smoking.

When packs bearing the words 'smooth' and 'gold' were compared to regular packs, participants were much more likely to identify the former as lower tar, lower health risk, easier to quit (adults) and better to try (young people). The addition of the word 'smooth' to two otherwise identical packs resulted in over ten times as many young people thinking that the cigarettes delivered less tar.

The use of lighter colours had a similar effect. *Marlboro Red* and *Marlboro Gold* have different coloured chevrons but are equally harmful. Yet 65% of adult smokers thought that *Marlboro Gold* delivered lower tar, 53% though it had a lower health risk and 31% felt it would be easier to quit. Similarly, when asked to compare a light grey *Benson & Hedges* pack with an otherwise identical dark grey pack, 38% of adult smokers reported that cigarettes from the light grey pack delivered less tar (compared with 3% the dark grey pack) and 32% a lower health risk (compared with 3% the dark grey pack). Among the young participants, 28% rated the lighter grey pack as delivering less tar (compared with 4% the darker pack) and 24% as being less harmful (compared with 5% the darker pack).

Participants were also asked to compare plain versions of cigarette packs which had colours and stylistic features removed, leaving only the name of the brands printed against either a brown or white background. This resulted not only in the brands appearing less attractive but also in a reduction in misconceptions about safety. For example, when presented with plain versions of *Mayfair King Size* and *Mayfair Smooth*, participants were more likely to indicate that there were no differences between the risks of these brands – the correct response.

These findings are compelling: the branding of cigarette packs profoundly affects consumer perceptions of the attractiveness and relative safety of the products. Remove this branding and the result is immediate: young people find cigarettes less attractive and smokers are less likely to be misled about the safety of the cigarettes they smoke.



The removal of all brand details from tobacco packaging, leaving only a name in standard type (known as plain or generic packaging) removes most of these subtle marketing indicators and strips the social value of the product. The brand appeal is radically reduced, especially for young people, and the product is far less attractive to purchase. Once the branding has been removed, consumers find it very difficult to distinguish between the tastes of different cigarettes<sup>50</sup>.

## Price

### Tax

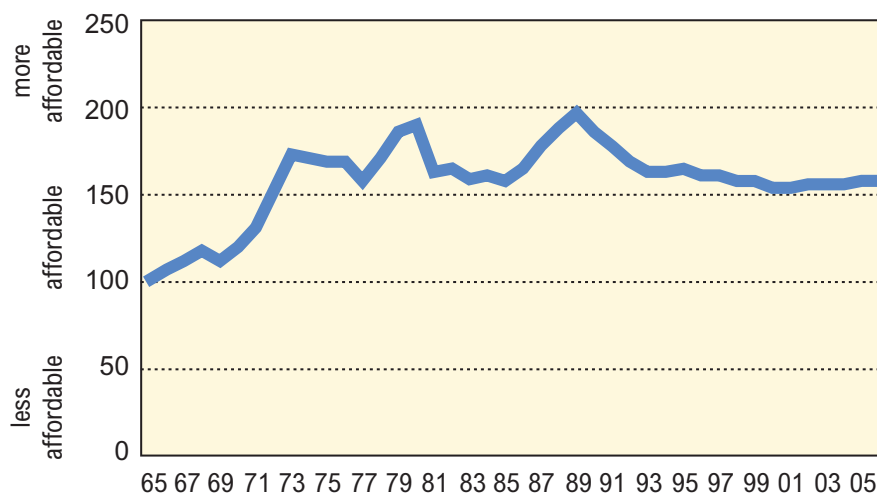
The most effective way of reducing smoking prevalence is to increase the price of the product<sup>51,52</sup>. In the United Kingdom, a 10% rise in the price of tobacco typically leads to a 4% decline in consumption<sup>51</sup>, with higher quit rates among lower-income smokers<sup>53</sup> and among younger smokers<sup>54</sup>. No other intervention can match this level of success. For example, an analysis of the decline in smoking prevalence in California between 1990 and 1992 estimated that 78% of the decline was attributable to tax increases and 22% to the state media campaign<sup>55</sup>.

In England in 2006 tobacco was 20% less affordable than in 1989 (Figure 6.1), a relatively small decline for such a long period. Over the last ten years, the affordability of cigarettes has barely changed, so there is clearly scope for further action to decrease affordability through taxation.

Tobacco tax is strongly regressive and risks increasing health inequalities yet it is unquestionably a powerful means of reducing smoking prevalence. This presents a dilemma, which can be resolved only by making the greatest possible efforts to motivate and assist smokers to quit in response to increases in taxation. Such taxes are inevitably unpopular among smokers but become more acceptable if the tax increases are hypothecated to prevent young people taking up smoking and to encourage smokers to quit. Tax increases on cigarettes are supported by a majority of the public in general (see Chapter 5).

VAT reductions for nicotine replacement products and other pure nicotine products should be sustained in order to increase the incentives for smokers to quit or switch to less harmful products (see Chapter 8). More generally, tobacco tax increases should always be balanced by investment in support and services to help people quit.

Figure 6.1. Affordability of cigarettes 1965 – 2006 (1965=100) (Townsend J, London School of Hygiene and Tropical Medicine)





### Control of smuggling

Smuggled and counterfeit tobacco products suppress the real price of tobacco and make smoking a more attractive choice for the consumer. The illicit tobacco trade is therefore far from being a victimless crime as people who would otherwise try to quit continue to smoke at greatly reduced cost. Smuggling also reduces public funds and feeds wider criminal activity.

Illicit tobacco and tobacco bought abroad for personal use are typically conflated in the consumer’s mind as ‘cheap cigarettes’. Less affluent smokers are much more likely than affluent smokers to use illicit sources of cheap cigarettes, exacerbating health inequalities<sup>57</sup>. One in four of the least affluent smokers buys smuggled cigarettes, including hand-rolled tobacco, compared to one in eight of the most affluent but the latter are far more likely than the former to buy cheap cigarettes abroad (Figure 6.2)<sup>41</sup>.

Illicit tobacco also has a disproportionate effect on smoking behaviour among young people. Three in every ten 16-24 year olds sometimes buy cigarettes from illicit sources (Figure 6.3).

High tobacco taxes do not necessarily lead to high rates of smuggling; there are countries with low tax regimes and significant smuggling problems (and vice versa). Smuggling is driven by a much wider range of factors than the retail price of tobacco and must be tackled on its own terms.

Figure 6.2 Sources of ‘cheap cigarettes’ by socio-economic group (Smoking Toolkit Study)

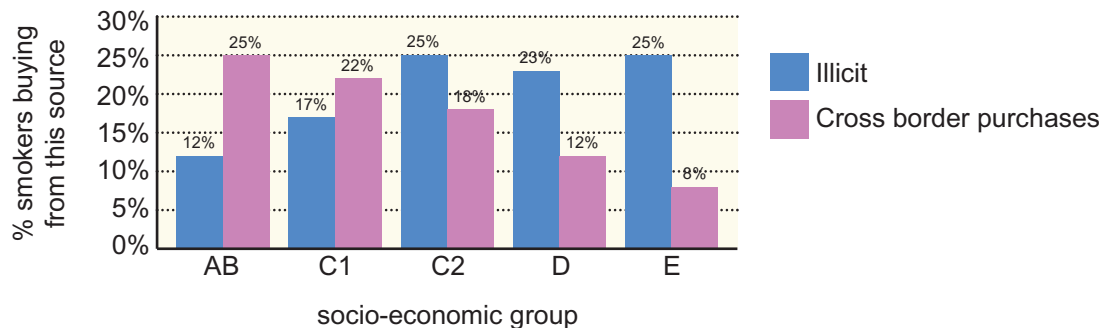
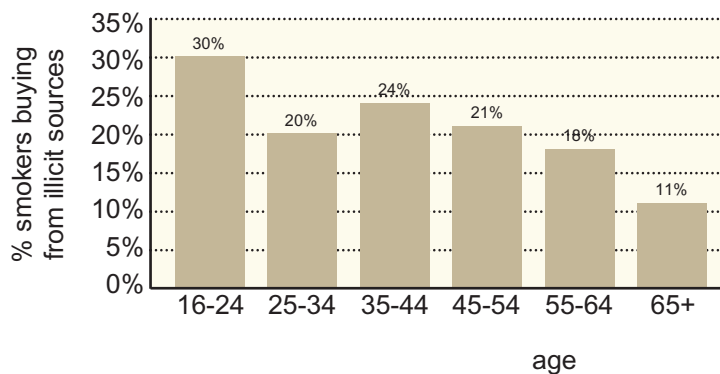


Figure 6.3 Smokers who buy illicit cigarettes by age group (Smoking Toolkit Study)



In 2005-06, the illicit trade in tobacco comprised approximately 13% of the UK market for cigarettes and 56% of the market for hand-rolled tobacco. The total annual revenue loss from tobacco smuggling was around £2.4 billion<sup>58</sup>. Although HM Revenue and Customs has been successful in reducing the illicit market share for cigarettes, down from 20% in 2000-01, there has been little change in the large illicit market share for hand-rolled tobacco, which is used by 40% of male routine and manual smokers compared to 23% of managerial and professional smokers<sup>59</sup>.

Smuggling is by definition an international problem and it will only be through international efforts that the illicit trade is curtailed in the long term. As a signatory to the WHO Framework Convention on Tobacco Control, the United Kingdom is committed to working with its international partners to curtail the smuggling of tobacco. To this end, the government must actively support the development of a legally enforceable, comprehensive illicit trade protocol with a timetable for adoption by 2010. This will cover the marking of tobacco products so they can be tracked and traced from manufacture to point of sale, licensing of participants within the supply chain, obligations on manufacturers to control the supply chain for their products with serious financial penalties for those that fail to do so and enhanced law enforcement measures.

The new national tobacco anti-smuggling strategy must link international work to the efforts of regional and local stakeholders. At regional and local level, greater collaboration is needed between the NHS, local government, the police, HMRC and the UK Border Agency to tackle tobacco smuggling. Local strategic partnerships and community safety partnerships are vehicles for achieving this.

Challenging new targets are required to further drive down the illicit market share of both cigarettes and hand-rolled tobacco (Chapter 9).

## **Promotion**

### **Point of sale tobacco displays**

Despite the remarkable successes of the last ten years in removing tobacco advertising and branding from public view, tobacco products continue to be vigorously promoted at the point of sale. Large gantries displaying tobacco products are features of everyday life, framing the till at the corner shop and welcoming shoppers into the supermarket. Tobacco industry expenditure on point of sale displays has gone up with increased restrictions elsewhere and the lack of regulation has been exploited by the industry to maximise the visibility and attractiveness of tobacco products<sup>60,61</sup>. The size of the displays has increased, in part because so many new brands have been introduced. Research commissioned by ASH for this report provides a snapshot of current efforts by the tobacco industry and retailers to promote tobacco products against the spirit of existing point of sale legislation (see New Research, page 46)

Point of sale displays encourage positive attitudes towards smoking and help to recruit young people to smoking. There is very strong evidence that tobacco advertising encourages young people to start smoking<sup>62</sup>, a fact not lost on the tobacco industry which actively targets this age group<sup>63</sup>. Young people are regular users of the shops and newsagents where point-of-sale displays are so prominent; these are the places they go to spend their pocket money and exercise their limited financial freedom.

The primary function of point of sale displays is *not* to inform existing smokers about the choices available to them. Most smokers (86%) always buy the same brand of tobacco and only 6% say their decision about what brand to buy is based on the shop display<sup>64</sup>. These displays do, however, encourage unplanned purchases and so increase tobacco sales by an estimated 12-28%<sup>65</sup>. Young people are particularly likely to make impulse purchases at the till. Ex-smokers and smokers who are trying to quit are also vulnerable to these impulse purchases, leading to relapse.

## New research: promoting tobacco at point of sale in 2008

How far is it possible to stretch current point of sale regulations to promote tobacco products in shops and supermarkets? ASH commissioned a study to find out.

Twenty local authorities in diverse parts of England agreed to undertake a survey of local tobacco retailers, focusing on shops and supermarkets in walking distance of secondary schools. A written record and photographs were taken at each site. Key findings were:

- In all premises packs were prominently displayed near checkouts in such a way as to promote the product to customers.
- In 19% of premises health warnings were obscured by shelf markers.
- In 53% of visits, tobacco products were positioned within one metre of confectionery.
- In 84% of premises overt reference was made to the need for proof of age before purchase, yet underage smokers still find it easy to purchase cigarettes through retailers.
- Many methods are used to promote specific brands. Paraphernalia such as clocks and towers highlighting branded packs are still used but there is a greater emphasis on blocks of product and the careful use of colour, lighting and design in the gantry itself.



*Clockwise from top left: 6.8 square metres of display, health warnings obscured, cigarette packs displayed in blocks, tobacco next to confectionery, creative use of colour and design, the Marlboro clock.*

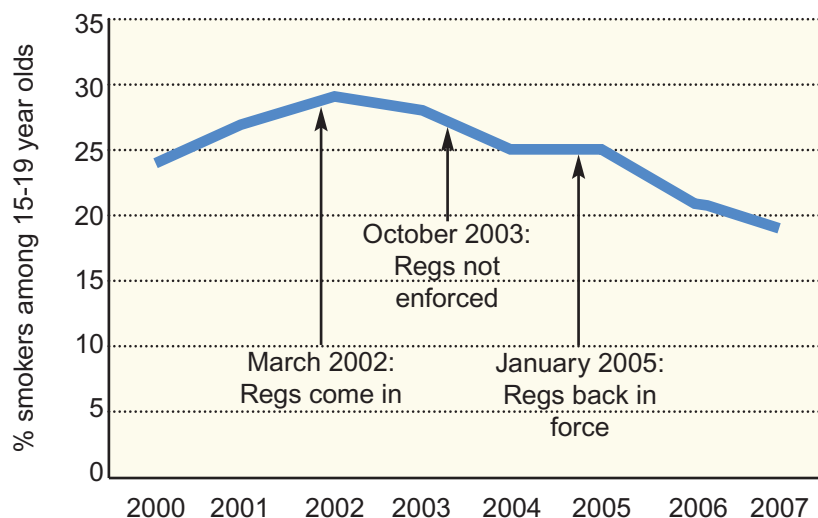
Government already has the power to prohibit the display of tobacco products at the point of sale under the terms of the Tobacco Advertising and Promotion Act 2002. Such a prohibition would be a logical extension of the systematic efforts since *Smoking Kills* to eliminate tobacco advertising. Similar measures have been successfully implemented in other jurisdictions such as Thailand, Iceland and various provinces of Canada and have contributed to significant falls in smoking prevalence among young people.

In Saskatchewan, Canada, point of sale restrictions contributed to a 10 percentage point fall in prevalence (from 29% to 19%) in youth smoking in only five years<sup>66</sup>. Figure 6.4 illustrates this fall against the timeline over which the point of sale restrictions were imposed and temporarily withdrawn.

### Other residual advertising

Children and young people are particularly vulnerable to positive images of smoking in visual media including film and television. Despite the evidence that the visibility of smoking in films encourages smoking initiation<sup>67</sup>, cigarette smoking is depicted in three quarters of box-office hits<sup>68</sup>. Cigarettes and smoking are also being promoted through social networking websites popular with young people. Tobacco control efforts must keep pace with the widening range of media accessed by children and young people.

Figure 6.4 Smoking prevalence among 15-19 year olds in Saskatchewan with key events in the province's enforcement of point of sale restrictions (Canada Tobacco Use Monitoring Survey)



### Public communication campaigns

Mass media campaigns are an effective means of reducing smoking prevalence<sup>69,70,71</sup>. Although expensive, they are highly cost-effective. They can be targeted on specific groups, such as disadvantaged smokers or young people, with messages tailored to different needs. They play a vital role in:

- Informing people about the dangers of smoking and discouraging initiation of smoking. Mass media campaigns are effective in reducing the initiation of smoking among young people<sup>72</sup>.
- Supporting smokers to quit and promoting stop smoking services and therapies. Campaigns can impact on every step of the smoker's journey: motivating quit attempts, triggering action to quit and making quit attempts more effective. (See Chapter 8)
- Promoting smokefree homes and cars and discouraging smoking in front of children and young people.

Mass media campaigns are only successful if they are substantial (i.e. well-funded), consistent and sustained<sup>73,74,75,76</sup>. Public memory is short, as commercial advertisers know well. Mass media work should therefore be a foundation for all other tobacco control interventions, informing and influencing the population as a whole and continually reinforcing the messages of stop smoking services, health professionals and product labeling. Any national campaign should have strong regional links to maximise the value of mass media messages for local stop smoking campaigns and services.

The Department of Health's mass media campaigns, including those delivered by health organisations, have been innovative and wide-ranging but there is a strong case for more substantial investment in this work. The US Centers for Disease Control assessed the spending on mass media in four states where campaigns had been successful in changing smoking attitudes and behaviours. Their recommendation of an average spend of between \$1 and \$3 per capita<sup>77</sup> is equivalent to an annual spend in England of between £45million and £135million per year at current exchange rates. Even the lower of these estimates is far higher than current government spend on mass media campaigns.

### **Place of sale**

#### **Underage sales and tobacco licensing**

From 1st October 2007, the minimum age for the purchase of tobacco was raised to 18 and retailers now face stronger penalties for repeatedly selling tobacco to young people. It remains the responsibility of trading standards officers to enforce these regulations.

The impact of these changes has not yet been assessed but without more substantial changes to the enforcement of sales restrictions, it is likely that young people will continue to face little difficulty in obtaining tobacco. In 2006 only a quarter (24%) of 11-15 year-olds said they found it difficult to buy cigarettes from a shop and only 22% had been refused on the last occasion they had tried (see page 25).

Currently retailers need a licence to sell alcohol but not tobacco. Consequently the sanctions against retailers for repeatedly mis-selling do not appear to threaten any special privilege sought and held by tobacco retailers. A national licensing scheme would give retailers something specific to lose and so provide a much stronger incentive to comply with the law. Such a scheme would also make it easier to tackle smuggling, as any tobacco sales outside licensed premises would automatically be illegal, and to promote quitting, as the sale of NRT and other pure nicotine products should be included as a condition of the licence.

#### **Vending machines**

Vending machines have long offered an easy opportunity for under-age smokers to buy cigarettes. Seventeen percent of 11-15 year old regular smokers in England say they get their cigarettes from vending machines<sup>24</sup>. Prohibiting the sale of tobacco through vending machines is therefore a simple way of reducing the harm to young people without significantly compromising the choices of adult smokers. Efforts to make vending machines selling tobacco child-proof are unlikely to succeed<sup>78</sup>. However, vending machines could still be used as sources of nicotine replacement therapy or other pure nicotine products.

**Place of consumption: exposure to secondhand smoke**

The successful implementation of smokefree legislation in England in 2007 has significantly reduced public exposure to secondhand tobacco smoke. However, many non-smokers still breathe secondhand smoke on a daily basis in their homes and cars. These may not be appropriate targets for legislation but there is still much that can be done to reduce the harm of secondhand smoke in these places.

This problem is acute for children and young people who have little control over their exposure to secondhand smoke from adult smokers at home and in cars. Adults whose health is already compromised by respiratory or heart disease are also particularly vulnerable, as are pregnant women.

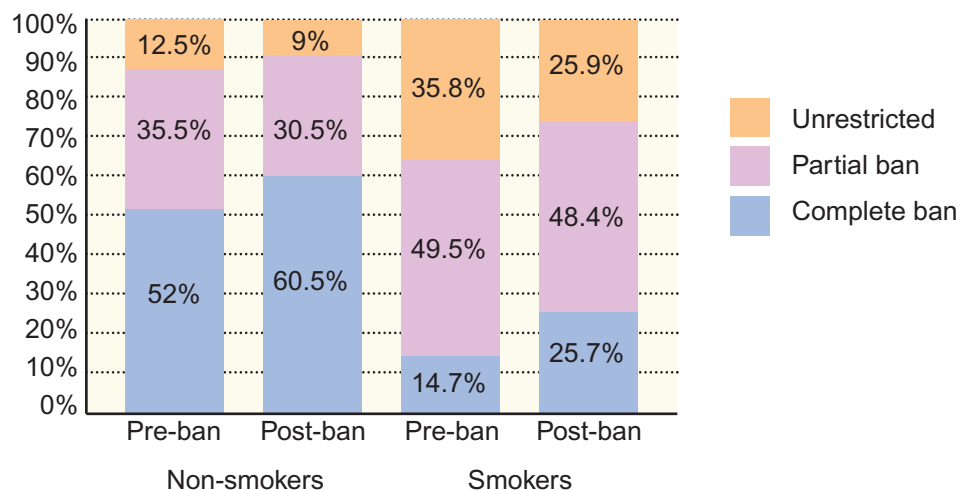
Smokefree homes become more attractive to smokers and non-smokers alike as wider restrictions on tobacco shift public attitudes to smoking. The international evidence indicates that smokefree homes become more common when smokefree legislation is introduced. In Scotland, there has been a 75% increase in the number of smokers choosing to make their homes smokefree since the introduction of Scottish smokefree legislation in 2006 (Figure 6.5)<sup>79</sup>. In Australia, the proportion of family homes with smoking restrictions more than doubled from 25% to 59% after smokefree workplaces were introduced<sup>80</sup>.

Media campaigns have also played a role in promoting smokefree homes, raising awareness of the risks to children and encouraging adults to see smokefree homes as practical and appropriate choices. The single most effective way of reducing children’s exposure to secondhand smoke is for parents to quit but, if this is not achievable, smokefree homes offer the second-best protection. Smokefree homes also radically reduce the chances of young people becoming regular smokers themselves.

Similar efforts are needed to encourage smokers not to smoke in their cars when travelling with others. Smokefree legislation does not appear to have a secondary benefit in this context, possibly because smokers see cars as sanctuaries where smoking restrictions do not apply<sup>81</sup>. Smoking in cars with young children has been prohibited in South Africa and in various jurisdictions in America, Canada, and Australia. In England public support for controls over smoking in cars carrying children is strong (see Chapter 6) but more international evidence is needed on this issue. The 2010 review of smokefree legislation will be an opportunity to build on evidence and best practice from across the world.

Smokers who are currently unable to quit but want to make their homes or cars smokefree should be encouraged to use nicotine replacement therapy to deal with their cravings.

Figure 6.5 Impact of smokefree legislation on smoking restrictions in homes in Scotland (NHS Health Scotland)



## CHAPTER 7

## HELP TO QUIT

**Summary**

England leads the world in providing free stop smoking services but the level of investment in these services is below the level of need, despite their demonstrable cost-effectiveness. Variations in the content and quality of current stop smoking services are also problematic.

Stop smoking services ought to be visible and attractive to all smokers who want to quit yet many smokers are unaware of local services or have a poor understanding of the range of services offered. Clinical settings are not ideal locations for stop smoking services given that smokers do not see their behaviour as an illness. However, people who use the NHS for other reasons (maternity services, dentists and secondary care are especially relevant) should always have easy access to specialist stop smoking services during their care. Provision in secondary care is particularly inadequate despite the importance of quitting for people already suffering from smoking-related disease. All health professionals should have the skills to offer basic stop smoking advice to smokers including an offer of treatment and referral to specialist stop smoking services.

As most smokers quit without accessing free NHS services, it is crucial that they are not deterred from using treatment to support their efforts because of the cost of prescriptions and over-the-counter medicines. Many smokers and health professionals have a poor understanding of the risks and benefits of using nicotine replacement therapy and other stop smoking aids.

**Recommendations**

- *Prioritise deprived and marginalised groups, including routine and manual socio- economic groups, in the design and targeting of all stop smoking services, campaigns and interventions.*
- *Increase national and local efforts to promote stop smoking services, particularly in community settings where smokers are likely to encounter them in their daily lives.*
- *Implement stop smoking treatment protocols based on evidence of effectiveness.*
- *Improve the selection, training, assessment and supervision of stop smoking specialists.*
- *Include basic skills in stop smoking advice in the undergraduate training and professional development training of all health professionals.*
- *Require all NHS services to record patient smoking behaviour, provide basic advice and actively refer smokers to stop smoking services and therapies.*
- *Develop and evaluate new services and incentives to support the efforts of pregnant smokers to quit.*
- *Allow dentists to prescribe nicotine replacement therapy and strengthen links between stop smoking services and dentists.*
- *Maintain free provision of stop smoking services.*
- *Abolish prescription charges for nicotine replacement therapy for all smokers who want to quit.*
- *Educate smokers and health professionals about the benefits and safety of nicotine replacement therapy.*
- *Promote wider sale of stop smoking therapies, including through all the outlets where tobacco is currently available.*



## Quitting is popular

Most smokers want to quit. In 2007, 43% of smokers in England tried to stop<sup>82</sup> yet only 2-3% will follow this through with success in the long term<sup>83</sup>.

This extraordinary gap between motivation and success demonstrates both the addictive power of nicotine and the extent to which smokers underestimate this power. This is why interventions to support people to quit are so important for, without such support, smokers are unlikely to succeed even with the very best intentions<sup>84</sup>. If all smokers trying to stop used the best evidence-based methods available, the quitting success rate could increase to as much as 8-12%.

There is huge scope for improving stop smoking services in this country. England is recognised as a world leader in the provision of publicly funded stop smoking services but this reflects the immaturity of the field internationally rather than a good match between need and services at home.

Stop smoking services are very cost effective. Combined with the use of pharmacotherapies, they can increase a smoker's chances of quitting by a factor of four compared to using willpower alone<sup>85</sup>. The average cost per life year gained for every smoker successfully treated by these services is less than £1,000, well below the NICE guidelines of £20,000 per QALY (quality-adjusted life year)<sup>86</sup>. The case for increasing investment in stop smoking services is therefore very strong.

Despite this, investment in stop smoking services is still relatively low. A comparison with treatment costs for illicit drug users is informative: £585 million is currently committed<sup>87</sup> for only around 350,000 problem drug users<sup>88</sup>, compared to £56 million for over 9 million users of tobacco. The difference is dramatic with only £6.20 committed to treatment for each smoker, compared to £1,670 per illegal drug user.

## The product: stop smoking services and therapies

A variety of services and therapies are currently available to smokers to help them quit: specialist stop smoking services, including one-to-one consultation and group support; telephone helplines; advice from health professionals such as GPs, dentists and practice nurses; nicotine replacement therapy (NRT) and prescription-only stop smoking therapies (bupropion and varenicline).

The method with the highest long-term success rate is attending a multi-session stop smoking service staffed by trained specialists who are employed for the task using a combination of behavioural advice and assistance and NRT, bupropion or varenicline. Currently, however, the content and quality of stop smoking services are highly variable and there is little way of knowing which services are performing well.

As in other areas of healthcare, all stop smoking services should be highly professional services working to clear standards and outcome measures. This will require:

- Improvements in the selection, training, assessment and supervision of specialists
- Implementation of treatment protocols based on evidence of maximum effectiveness
- High quality administrative support for services
- Appropriate space and facilities

A flexible approach is also required which responds to smokers' individual needs, values their efforts and does not dismiss them when they fail. The best stop smoking services are tailored to the language and literacy of their users, provide on-going support and reinforcement for smokers who succeed in quitting, and encourage those who fail to stay with the service and try again.

## Case study: Fag Ends

Roy Castle Fag Ends has been providing client-led stop smoking support on Merseyside since 1994. Fourteen years of grass roots action have shaped a service that is now recognized as a model of effective stop smoking support in the community.

The service is delivered through community-based groups which run continuously in a rolling programme. The programme is designed to ensure access is easy and barriers are minimised. Essential principles of the model are:

- No waiting list
- No appointment needed
- No requirement to be referred by a third party (although referral systems are in place)

Most people access the service simply by walking in to their local group. However referrals are also made by GPs and other health professionals using a fax system or via smokers' contact with local and national telephone helplines.

The teams in Liverpool and Knowsley offer stop smoking support in community settings, hospitals, workplaces and mental health residential establishments. Support is also provided for specific communities including young people, pregnant smokers, homeless people and Black and minority ethnic communities.

Roy Castle Fag Ends continues to explore new and innovative ways to deliver stop smoking support to the communities it serves as well as seeking continuous improvement and high standards in the work undertaken. The service is commissioned by Liverpool and Knowsley primary care trusts.

Most supported quit attempts do not involve engagement with NHS stop smoking services but simply the use of NRT, either on prescription or bought over the counter. Although this approach is less likely to be successful than using stop smoking services, the value of NRT is recognized even by those who fail to quit as they usually return to using it at their next attempt. Over the course of a year, 48% of smokers who attempt to quit use NRT or medication, including 36% who buy NRT over-the-counter<sup>82</sup>.

### **Price**

Access to stop smoking services is free of charge but there is still a cost to the participant in the form of prescription fees. As prescriptions are typically renewed every month, this amounts to a significant cost for smokers who are not eligible for free prescriptions. Some service users have had difficulty obtaining repeat prescriptions because success at four weeks is recorded as a completed quit attempt after which further pharmacotherapy has to be obtained over the counter. Highly addicted smokers often use combinations of NRT products and this also brings an additional cost.

Given that smoking cessation treatments are among the most cost-effective treatments available on the NHS<sup>86</sup>, there is a strong case for abolishing prescription charges for nicotine replacement therapy for all smokers who want to quit.

As most smokers try to quit without accessing NHS services, the price of over-the-counter NRT remains a crucial factor limiting supported attempts to quit. Many smokers who are trying to quit use as little NRT as possible but the less NRT they use, the more likely they are to fail. Every effort should therefore be made to minimise the price of NRT including maintaining the lowest possible level of VAT.

### **Promotion and targeting**

Britain's National Health Service is generally seen as an illness service rather than a health service, especially by people who do not think of themselves as being unwell (above all, young people). This is partly why so few smokers turn to the NHS to seek support for their quit attempts: between 3% and 6% of smokers use NHS Stop Smoking Services per year<sup>82</sup>. Hence there is still much to do to promote these services and attract the widest possible range of smokers.

Many stop smoking services have made concerted efforts to target sections of the population with high smoking prevalence, including people from the most disadvantaged areas<sup>89</sup>. In 2006 smokers from routine and manual groups were more likely than those from professional/managerial groups to have attended a stop smoking group or obtained NRT on prescription<sup>90</sup>. This makes a modest but important contribution to reducing health inequalities<sup>91</sup>. The higher failure rate of quit attempts in more deprived groups, including people suffering mental ill health<sup>92</sup>, suggests that even greater efforts are needed to understand why these differences exist and to target and tailor services accordingly.

To increase take-up of stop smoking services, smokers need to be a) familiar with the services, b) attracted to them and c) aware of the advantages of using them over less effective methods. This will require a more substantial and more sophisticated approach to advertising stop smoking services both nationally and locally. Broad brush mass media campaigns about the benefits of stop smoking services should be complemented by community-based initiatives to promote local services. Putting the number of a telephone helpline on the cigarette pack has been successful elsewhere and is very cost-effective. Retail outlets are also ideal locations for these messages.

Smokers who access the health service for reasons other than their smoking are a key target for the promotion of stop smoking services. Yet many health professionals do not recommend or refer smokers to such services as a matter of course. According to smokers, only a minority are advised by their GP to use stop smoking services and informal observation suggests that only a small minority of hospital patients who smoke are advised to use stop smoking services by their doctors. As smokers are likely to be particularly receptive to professional advice at these encounters, this is a huge missed opportunity.

In all populations, social networks offer a valuable target for cessation work because, just as smoking behaviour is sustained within such social networks, so quitting behaviour is also enabled and supported by them<sup>93</sup>. Ultimately stop smoking services will only become an obvious choice for the majority of smokers if the users of these service are satisfied with their experience and communicate the value of the service to others. Regular evaluation of client experience is necessary if this is to be achieved. Successful quitters and community advocates can also be trained to encourage others to use the service.

Although NRT for quitting is advertised through mass media campaigns, there is still public misunderstanding about the risks and benefits of using NRT. In the UK, 49% of smokers wrongly think that nicotine is the chemical which causes most of the cancer contracted by smokers (57% in low income groups)<sup>94</sup>. The public are also concerned about the addictive potential of nicotine products<sup>95</sup>.

As a result, many smokers who buy NRT over the counter use less than the optimum amount needed to enable quitting. There is clearly scope for public education about the value of NRT *per se*, as opposed to the promotion of specific brands (see Chapter 8).

### **Place**

If stop smoking services are to reach all smokers with an interest in quitting, they must break out of narrow clinical settings. They ought to be sited in places where people are likely to encounter them in the course of their everyday lives, such as in work places, job centres, shopping centres, schools and pubs. They should also be offered at times that are amenable to young, working people. This is a major challenge for stop smoking services which, for professional and practical reasons, are often sited in healthcare premises and run during office hours.

A wider range of approaches is also needed. Telephone support, in particular, offers a cost effective and highly accessible alternative to face to face consultation. Tailored internet-based services also have great

potential<sup>96</sup>. It should be easy for smokers to access stop smoking services. Every extra step they have to take, such as waiting for a referral letter, risks weakening their motivation.

Within the health service itself, access to stop smoking services is still far too limited. Even in contexts such as maternity services, dentistry and secondary care, access is not guaranteed. Dentists, for example, are ideally placed to promote quitting. Many of their patients consider themselves to be perfectly healthy and so may not be seen by other healthcare professionals. Dentists can explain to this captive audience the impact of tobacco on oral health and, where appropriate, refer patients to NHS Stop Smoking Services<sup>97</sup>. Currently, however, dentists are not permitted to prescribe NRT.

Stopping smoking is the only intervention that changes the natural history of chronic obstructive pulmonary disease (COPD) or reduces the risk of lung cancer, but only half of all UK chest specialists have direct access to a Stop Smoking counsellor<sup>98</sup>. Every smoker in hospital should be identified on admission, given brief advice and offered medicinal help and referral to stop smoking services. Smoking rates should be monitored on discharge and there should be seamless transfer to community stop smoking services for ongoing support and relapse prevention.

All health professionals should be able to offer basic stop smoking advice to smokers including an offer of treatment or referral to specialist stop smoking services. Many smokers, including smokers not actively considering quitting, will respond positively to this offer<sup>99</sup>. The advice offered in primary and secondary care has been shown to help smokers quit<sup>100,102</sup> but doctors and other healthcare professionals still need guidance about what constitutes effective brief advice.

Although NRT is available through pharmacists, these products ought to be sold through the same outlets as tobacco products. This is especially important for smokers who want to switch long-term to nicotine replacement products (see Chapter 8).

### **Driving up quit rates**

There is great potential to improve current quit rates through concerted effort across all these areas of action. Smokers' motivation to quit must be more effectively exploited. Insubstantial or ineffective support will only lead to relapse and potentially the weakening of this motivation.

A realistic target is for at least 50% of smokers to make a serious quit attempt in a given year using an effective method:

- NHS Stop Smoking Service and medication
- Medication on prescription or bought over the counter
- Telephone support and medication
- Internet support and medication

Realistic targets should be set for stop smoking services based on the number of smokers per primary care trust expected to be treated each year in a range of 5% to 10% of local smokers. Four week quit rates should continue to be used as a success measure but they must be validated by testing carbon monoxide levels.

## CHAPTER 8

## ALTERNATIVES TO SMOKING

**Summary**

Smoking prevalence is declining but not fast enough. Too few people successfully quit every year and too many people start smoking. New ways of driving down smoking prevalence are needed.

Smokers are addicted to nicotine but are harmed by the tar and toxins in tobacco smoke. It is therefore possible for smokers who are currently unable or unwilling to quit to satisfy their nicotine craving at much lower risk by switching to pure nicotine products (which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives). Although these products are not 100% safe, they are many orders of magnitude safer than smoking. Given the higher levels of addiction among the most disadvantaged smokers, the promotion of wider access to pure nicotine products as an alternative to smoking is an important means of tackling health inequalities.

Currently pure nicotine products are not attractive to smokers as direct replacements for cigarettes as they do not mimic the speed and intensity of nicotine intake that a cigarette provides. Regulation difficulties inhibit the development of more efficient and effective pure nicotine products. As a result, the most toxic nicotine products - cigarettes - are barely regulated while the safest products - medicinal nicotine - are highly regulated.

If they are to compete with tobacco products, pure nicotine products must be sold on equal terms or better: pricing should favour pure nicotine products over tobacco. Public education is also needed as many smokers (and health professionals) have a poor understanding of the relative safety of pure nicotine products including nicotine replacement therapy.

**Recommendations**

- *Develop a strategy and an appropriate regulatory structure to improve the acceptability, attractiveness and accessibility of pure nicotine products for use as an alternative to smoking for those who are currently unable or unwilling to quit.*
- *Encourage commercial development of pure nicotine products designed for long-term use as a replacement for smoking.*
- *Develop a communications strategy to counter public misunderstanding of the health impacts of nicotine. This should promote nicotine replacement therapy for quitting and encourage the longer-term use of pure nicotine products as alternatives to tobacco.*
- *Tax pure nicotine products at the lowest rate of VAT.*
- *Evaluate the cost-effectiveness of providing pure nicotine products free on prescription to smokers for as long as they are unable or unwilling to quit.*
- *Increase investment in research into the long-term impacts of nicotine.*

### **Smokers who are currently unable or unwilling to quit**

England is at the forefront of tobacco control, not just in Europe but in the world, yet progress in bringing down smoking prevalence is slow. Improvements can be made to current interventions, as described elsewhere in this report, but additional approaches are needed if smoking is not to remain the primary cause of health inequalities and the major preventable cause of death for many years to come.

Crucially, smokers are harmed by the tar and toxins in tobacco smoke and not by the addictive chemical which keeps them hooked: nicotine. Unfortunately there is no way of avoiding these toxins if you inhale the smoke from burning tobacco; there is no such thing as a toxin-free cigarette. There are, however, other ways of consuming nicotine without having to light up.

It is possible for smokers to satisfy their nicotine dependence without being exposed to the risks of tobacco smoke by switching from tobacco to pure nicotine products. These are products which, like the current medicinal products on the market, contain only nicotine and not other tobacco derivatives.

Currently pure nicotine products are not marketed or priced in a manner that makes them attractive as direct alternatives to smoking, rather than as aids to quitting. As a result, smokers who are currently unable or unwilling to quit are denied the choice of maintaining their nicotine dependency at greatly reduced personal risk.

### **Ten years of progress**

Concerns have been raised that a strategy which made pure nicotine products more widely available might be positive for the individual smoker but could have negative impacts at the population level if it led to increased use of nicotine products and consequently a higher level of addiction in society as a whole. The overall balance of costs and benefits could be negative.

Such unintended consequences have been experienced before in tobacco control. 'Low tar' cigarettes were found to be no safer in use than the cigarettes they replaced but allowed smokers who might otherwise have quit to continue smoking in the belief that the products were less harmful<sup>45</sup>. Reducing the tar in cigarettes is now considered to have no potential as a strategy for reducing the health risks faced by smokers.

Population outcomes have, however, been shown to be positive when smokers have switched not to low tar cigarettes but to smokeless tobacco products. In Sweden, for example, more men use smokeless tobacco than smoke. The type of smokeless tobacco used in Sweden, known as snus or oral snuff, is much less harmful to health than either smoked tobacco or other forms of smokeless tobacco<sup>102</sup>. Although snus was not introduced into the Swedish market for public health reasons, there is evidence that its use in Sweden has reduced the risk of people starting smoking<sup>103,104,105</sup> and helped smokers quit<sup>103,105</sup>. Sweden has the lowest rate of lung cancer incidence in the developed world, around half that of the UK<sup>106</sup>, and much lower incidence of heart and lung disease.

Snus is currently prohibited in the EU, except in Sweden, and any change to this status should only be considered within the context of a reformed regulatory system for all nicotine and tobacco products. This report does not consider the wider use of snus as a policy option or propose any change to the legal status of smokeless tobacco. Current efforts to improve choices for smokers must focus on the even safer option of using pure nicotine products.

Extensive experience with nicotine replacement therapy in clinical trials has shown pure nicotine products to be very safe. They are not, however, 100% safe. Nicotine causes catecholamine release and vasoconstriction, leading to an increase in blood pressure and heart rate. This could in theory lead to acute cardiovascular problems but there is no clear evidence to support this. There is some evidence of an increased risk of minor musculoskeletal anomalies in babies born to mothers using pure nicotine products <sup>107</sup>.

There is a lack of evidence about the long-term impacts on personal health of using pure nicotine products as a replacement for tobacco products. More research is needed in this area. Nonetheless it would be a perverse use of the precautionary principle to await the outcomes of this research before encouraging smokers to switch from tobacco to pure nicotine products, given that the use of pure nicotine products is many orders of magnitude safer than smoking <sup>108,109,107</sup>.

With pure nicotine products, the trade-off between the risks of population exposure and the benefits to individual smokers swings very convincingly in favour of change. If, however, these products are to be adopted as alternatives to tobacco, the following criteria must be met:

- Nicotine products must be attractive as direct replacements for cigarettes
- Consumers must understand the benefits of using pure nicotine products as an alternative to smoking
- The products should be widely available and highly visible on the high street
- The price of nicotine products should provide an incentive to switch from tobacco

None of these criteria are currently met.

### **The product: replacing cigarettes**

The current range of nicotine products does not provide smokers with the same satisfaction as tobacco. A cigarette is, without doubt, an extremely effective nicotine delivery device; inhaling tobacco smoke deep into the lungs produces a rapid and intense spike of arterial nicotine. Oral snuff, a form of smokeless tobacco, comes closest to cigarettes in rate of delivery but takes longer and delivers less nicotine. Among the pure nicotine products only the nasal spray acts as quickly as a cigarette but delivers less nicotine.

Nicotine gum and patches both deliver nicotine relatively slowly over a much longer period of time than a cigarette. To a degree, they mimic the experience of chain-smoking, a behaviour that attempts to maintain a constant level of nicotine in the body ('trough avoidance'). In contrast, smokers who seek the hit of a cigarette ('peak seekers') will not get what they want from these forms of nicotine replacement. In practice, both the quantity and speed of nicotine delivery are critical factors <sup>110</sup>.

Despite evidence that faster acting nicotine products are more effective with heavily addicted smokers <sup>111</sup>, the pharmaceutical industry has not brought more efficient nicotine products to market. This is partly because pure nicotine products are regulated by the Medicines and Healthcare Products Regulatory Authority (MHRA) and obtaining a product licence requires expensive clinical testing. More efficient products also have more addictive potential and historically the MHRA would not have licensed such products for smoking cessation. Consequently the pure nicotine products that are available in England have little addictive potential and are not attractive as direct alternatives to cigarettes.



In 2005 the MHRA accepted the principle that users of pure nicotine products would otherwise be smoking tobacco, which is many times more harmful than pure nicotine. This resulted in a significant relaxation of the restrictions on its use including an extension of the licence period to nine months, combination use of patches and gum, and permission for its use by pregnant and young smokers, smokers with cardiovascular disease and smokers who want to reduce their smoking. Little has yet been done to promote these new applications.

In 2007 a licence was given for NRT to be used for temporary abstinence but long-term use of pure nicotine products is not yet sanctioned by the MHRA. The pharmaceutical industry has intimated<sup>112</sup> that it would not be interested in producing more efficient products for nicotine maintenance without strong government support and a clear regulatory structure. Pure nicotine products which are marketed as alternatives to smoking, and not as aids to quitting<sup>113</sup>, have been allowed on sale unlicensed by the MHRA and unregulated by the Department of Health. However, as long as the regulatory position remains unclear and ambiguous<sup>114</sup>, there is little incentive for companies to enter this market.

The public health community supports the Royal College of Physicians' call for the reform of the nicotine market and creation of a new regulatory framework which would include<sup>115</sup>:

- Providing smokers with safer sources of nicotine that are acceptable and effective cigarette substitutes
- Encouraging the development of innovative, more effective and user-friendly pure nicotine substitutes for cigarettes
- Changing nicotine product regulation to make it easier to produce and market pure nicotine products
- Creating a nicotine regulatory authority to take control of all aspects of regulation of all nicotine products and reverse the advantage cigarettes have in the marketplace

In the absence of such an authority, reform of the nicotine market is possible within existing structures. Figure 8.1 describes the pros and cons of four current options for the regulation of pure nicotine products for longer-term use as direct substitutes for smoking: MHRA regulation, light regulation by the Department of Health (DH), food regulation and no regulation (the current situation). Any change to the regulatory framework would have to be properly evaluated to identify population-level costs and benefits.

Table 8.1 Regulation options for pure nicotine products designed as long-term substitutes for smoking

Approach	Pros	Cons
Medicines regulation	Existing regulatory structure already handles nicotine. Ensures coherent regulatory framework for all nicotine products. Enables VAT to be levied at a reduced rate of 5% (this may not be possible under other regulatory structures).	Potentially bureaucratic and inflexible. Costly to develop faster acting new products under current system so would lead to high prices to consumers. Time consuming to get products to market. Products likely to be limited to prescription only in the first instance, which would limit access.
Food regulation	Existing regulatory structure.	Unlikely food regulators would pass nicotine products as reaching food standards.
Light touch regulation (e.g. by DH)	Already regulates tobacco. Enables DH to take the strategic lead to encourage the development and promotion of such products.	Potential lack of capacity in DH to take on such a role.
Retain current situation (no regulation)	Change might be quicker. No regulatory costs to meet. Possible to promote such products.	Lack of clarity about regulatory position. Lack of control and monitoring. To date, this approach has not encouraged well funded new entrants to the market.

### Promotion: improving public and professional understanding

Many smokers wrongly believe that it is nicotine rather than tobacco smoke that harms them and so worry that pure nicotine products are potentially harmful. Half of smokers in the UK mistakenly think that nicotine is the chemical which causes most of the cancer contracted by smokers<sup>94</sup>.

A communications strategy is needed to improve public understanding of the benefits of using pure nicotine products rather than smoking. This should also increase the numbers of smokers using pure nicotine products, and using it effectively, to quit. Quitting should continue to be promoted as the gold standard with nicotine maintenance the option for those unable to do so.

Many health professionals are also unclear about the relative risks of tobacco and nicotine. In one study, a substantial proportion of GPs incorrectly asserted that nicotine in cigarettes causes CVD (51%), strokes (49%) and lung cancer (41%)<sup>116</sup>. As they are likely to play a major role in any programme promoting safer alternatives to smoking, it is crucial that health professionals are fully informed of the benefits and risks of using pure nicotine products.

Public and professional misunderstanding needs to be addressed both by government, through its varied media campaigns and educational work, and by the pharmaceutical industry, which has not tackled this issue effectively.

### Place: availability and visibility

Smokers can get hold of cigarettes any time of day or night from corner shops, garages and supermarkets. In contrast, getting hold of pure nicotine products is much more difficult. Although products are available from pharmacies and most supermarkets, they are rarely sold through the thousands of small retailers and garages that sell tobacco.

Figure 8.2 illustrates the relative priority given to tobacco and pure nicotine products in a newsagent where both are on sale. The tobacco products occupy a large area immediately behind the counter and are heavily promoted, despite the prohibition of advertising. Nicotine gum, just visible on the very left of the gantry, enjoys no promotion at all.

Figure 8.2 Tobacco gantry in London newsagent (inset highlights nicotine gum)



Pure nicotine products need to be widely available and prominently displayed. Unfortunately, however, retailers only stock products they know will sell. For pure nicotine products to sell, they need to be promoted both by companies and by the government as an alternative to smoking.

### **Price: an incentive to switch**

The price of pure nicotine products is currently comparable to that of tobacco. A smoker seeking the same amount of nicotine from medicinal products as they get from smoking will pay a very similar price. If the market is to encourage the use of pure nicotine products as an alternative to tobacco, its relative price must come down. In particular, it must become more affordable to people on the lowest incomes.

The VAT for pure nicotine products bought over the counter has been reduced from 17.5% to the 5% minimum allowed, which has led to a concomitant decline in the price paid by the consumer<sup>117</sup>. However there is no reason why low-taxed pure nicotine products should cost as much as cigarettes, the most heavily taxed product on sale. Given the cost-effectiveness of nicotine replacement therapy for people trying to quit<sup>86</sup>, there is a case for providing pure nicotine products free on prescription to smokers for as long as they are unable or unwilling to quit.

### **The status quo is perverse**

The current regulatory regime in the EU results in the most dangerous form of nicotine use - cigarette smoking - being the least regulated. In contrast certain forms of smokeless tobacco are illegal (but not all - south Asian chewing tobacco is still legal despite the fact it is more harmful than Swedish snus) and pure nicotine products, the least harmful form of use, is heavily regulated. It would make more sense to apply controls to nicotine and tobacco use in proportion to the amount of harm they cause.

Calls to reform the nicotine market have been made by the Health Select Committee in 2000<sup>118</sup>, the Royal College of Physicians in 2007<sup>117</sup> and the British Medical Association in 2008<sup>119</sup>. The development of a progressive pure nicotine products strategy does not, however, need to await the setting up of a new regulatory authority. The following is an immediate agenda for government action which has the potential to significantly reduce death and disease:

- 1.** Commit to supporting an evidence-based nicotine substitution strategy to improve access to more efficient pure nicotine products as an alternative to smoking
- 2.** Set up a working group to determine the regulatory structure for such a strategy, involving the Department of Health, MHRA, independent experts and civil society
- 3.** Meet with the pharmaceutical companies already involved in the production and sale of pure nicotine products, as well as any other companies interested in this market, to encourage the development of such products
- 4.** Develop and fund a consumer communications strategy to counter misunderstanding of the health impacts of nicotine
- 5.** Commit to taxing pure nicotine products at the lowest rate of VAT and investigate the cost effectiveness of providing such products free on prescription long-term to smokers

## CHAPTER 9

## NEW COMMITMENT, NEW TARGETS

**Summary**

A new national tobacco control strategy is an opportunity to build on the success of the last decade and create an even more ambitious agenda for change for the next ten years and beyond. In order to be robust, the strategy should be underpinned by evidence, tested and developed by ongoing evaluation, overseen by a wide coalition of experts and focused on clear and challenging targets.

The tobacco control community looks forward to working with government in defining this new strategy and shaping a new era in tobacco control.

**Recommendations**

- *As part of a new comprehensive tobacco control strategy, establish a national evaluation programme to test and refine the strategy against new evidence.*
- *Establish a non-executive Tobacco Control Commission with responsibility for overseeing the evaluation, review and development of the tobacco control strategy.*
- *Undertake a full review of the scope and timeliness of population research into smoking prevalence in England, taking account of national, regional and local needs.*
- *Set ambitious but achievable smoking prevalence targets for 2015:*
  - *11% smoking prevalence in the adult population*
  - *17% smoking prevalence in the adult routine and manual socio-economic group*
  - *4% smoking prevalence in the 11-15 year old age group*
  - *9% smoking prevalence in the 16-17 year old age group*
- *Set new targets for the number of smoking households with children with no smoking policies at home:*
  - *25% of homes where both parents are smokers operate a smokefree policy by 2015*
- *Establish a regular programme of cotinine testing of adult non-smokers and children to provide objective measures of exposure to secondhand smoke and set targets for reductions in cotinine levels.*
- *Set new targets for the control of tobacco smuggling:*
  - *Reduce the illicit market share for cigarettes to no more than 8% by 2010 and 3% by 2015*
  - *Reduce the illicit market share for hand-rolled tobacco to no more than 45% by 2010 and 33% by 2015*
- *Establish a programme of saliva cotinine testing among pregnant women in order to accurately measure smoking prevalence in this group.*
- *Commit to undertaking a full mid-term review of the new tobacco control strategy in 2012, including setting new targets for 2020.*

## Introduction

The government has signalled its commitment to developing a new, comprehensive and integrated tobacco control strategy for England. This is very welcome and very timely. It is an opportunity to build on the success of the last decade and create an even more ambitious agenda for change for the next ten years and beyond.

There will be much to consider in the development of this strategy. Liaison with the devolved administrations of the United Kingdom will be particularly important to ensure that a consistent and complementary approach is taken across the UK to all the issues of tobacco control. Regional partners must also be closely involved to ensure that their contribution is both valued and optimised within the strategy.

This chapter addresses three key areas of concern: evaluation, oversight and targets. These issues are intimately linked: a strategy that evolves through learning must be critical, reflexive and focussed.

## Evaluation is vital

The new strategy should be rooted in current evidence of effectiveness but must also include a mechanism for evaluation that will deliver an ever richer understanding of the methods and outcomes of the interventions specified within it. This should in turn feed a process of review which constantly tests the strategy against the evidence and so refines and develops the strategy's aims, targets and content.

A systematic, integrated evaluation programme would clarify and prioritise tobacco control research questions; prevent the unnecessary duplication of research effort; establish a clear mechanism for the assimilation and communication of evidence; provide the foundation for decision-making and resource allocation; and ensure that the guardians of the strategy are constantly challenged to improve its performance.

As this report demonstrates, the scope of tobacco control is very broad. Interventions include mass media campaigns, clinical prescribing and the control of smuggling. This presents a challenge for evaluation as there are so many different ways of pursuing the aims of tobacco control. A national evaluation programme would be an opportunity to describe and logically model the relationships of all interventions with all potential outcomes and so map the impact of the strategy and the efficiency of each intervention in achieving these outcomes. This level of critical investigation is likely to be vital to the long-term success of the strategy.

The primary outcomes of the tobacco control strategy will be defined in terms of smoking prevalence, rates of initiation and quitting, the rate of switching to pure nicotine products, inequalities, exposure to secondhand smoke and smoking in pregnancy. However there are many other intermediate and secondary outcomes that provide a valuable focus for evaluation. The monitoring of public attitudes to new interventions, both before and after implementation, has proved particularly useful in recent years in demonstrating the consistency with which opposition to tobacco control measures turns to support over time.

A new evaluation programme should build on the work of existing bodies such as the Public Health Observatories and the UK Centre for Tobacco Control Studies (UKCTCS). A necessary first step would be a review of the scope and timeliness of population research into smoking prevalence in England. The two year delay in publishing adult prevalence data and the lack of local data remain significant problems for all those involved in tobacco control.

## **Making it happen**

The new national tobacco control strategy should be defined and led by government. As a signatory to the WHO Framework Convention on Tobacco Control (FCTC), the government is committed to 'develop, implement, periodically update and review comprehensive multi-sectoral national tobacco control strategies, plans and programmes' (Article 5.1).

This is not, however, a task for government alone. The FCTC also obliges the government to 'establish ... and finance a national coordinating mechanism or focal points for tobacco control' (Article 5.2a) and emphasises, in its preamble, 'the special contribution of non-governmental organisations and other members of civil society not affiliated with the tobacco industry ... to tobacco control efforts nationally and internationally and the vital importance of their participation in national and international tobacco control efforts'.

Although the government should take the executive role in implementing the strategy, there is a strong case for a non-executive body to oversee and critically review progress. Such a body would include representatives from non-governmental, professional and academic bodies with a strong commitment to tobacco control, plus regional stakeholders. This document proposes the creation of a new Tobacco Control Commission, reporting to the Prime Minister and working alongside government, to take forward the development and implementation of the new strategy. The role of the Commission would be to:

- Oversee the process of monitoring, evaluation and review
- Ensure that strategy is constantly tested against evidence of effectiveness
- Present recommendations for improvement and change
- Advise the government on all aspects of tobacco control

The Tobacco Control Commission would play an important role in sustaining a long-term tobacco control strategy across the tides of political life. A non-executive, advisory partnership would not only help to keep government and ministers focused on their commitments but would also ensure that the wider tobacco control community participated in a collaborative, critical process with a clear focus on delivering results for the population of England.

## **Targets**

Targets have proven their worth over the past ten years in helping to drive forward action on tobacco control and should be an integral part of the new national strategy.

Targets need to be realistic but challenging. They should be informed by experience but also reflect the ambition of the new strategy. Recently smoking prevalence has taken a sharp downward turn, both among adults and among children and young people, so a balance has to be struck between projecting from a medium-term trend and hoping for an on-going enhanced effect from smokefree and other recent legislation - while also including the impact of new initiatives.

Targets have been set, and should continue to be set, in terms of the annual rate of decline in general population prevalence. However, as the population of smokers becomes an ever smaller part of this general population, every percentage point decline in population prevalence represents a larger slice of the remaining population of smokers. A consistent annual rate of decline may therefore become harder to achieve as time progresses. Consequently current target setting is probably only meaningful to 2015. Specific targets for 2020 should be set by a mid-term strategy review in 2012.

## The adult population

Internationally, jurisdictions that have pursued substantial tobacco control programmes have achieved rates of decline in population prevalence of between 0.39 and 1 percentage points per year (Figure 9.1). In the period between 1998, when *Smoking Kills* was published, and 2006, the year for which we have the most current data, smoking prevalence in the adult population of England declined from 28% to 22%, an average drop of 0.75 percentage points per year. This, however, includes the 2 percentage point drop in prevalence between 2005 and 2006. The average decline from 1998 to 2005 was 0.57 percentage points per year.

There is evidence that the recent increase in the rate of decline has been sustained. The Smoking Toolkit Study found a 2 percentage point decline in population prevalence (annual equivalent rate) in the nine months prior to the implementation of smokefree legislation in 2007 and an even steeper decline (7 percentage point annual equivalent rate) in the nine months following the start of the legislation. Given this evidence, it is reasonable to project further 2 percentage point reductions in adult smoking prevalence for both 2007 and 2008.

Although it may be difficult to sustain this rate of decline in the longer term, new measures such as the prohibition of point of sale displays and a nicotine substitution strategy should put new pressure on prevalence. A nicotine substitution strategy has the potential to increase the rate of prevalence decline by as much as 0.4 percentage points per year<sup>120</sup>. A decline in population prevalence of one percentage point per year from 2009 to 2015 is a reasonable target, assuming that these measures are introduced early in the life of a new tobacco control strategy.

Historically the rate of decline of smoking prevalence in the routine and manual socio-economic group has been lower than that of the population as whole. A comparable rate of decline can, however, be projected, assuming that smokers in the routine and manual socio-economic group will be a primary focus for tobacco control intervention and investment in the years to come.

Figure 9.1 Changes in smoking prevalence in jurisdictions with substantial tobacco control programmes

Jurisdiction	Period	Prevalence at start	Prevalence at end	Average annual rate of decline
England	1998-2006	28%	22%	0.75 percentage points
Canada	1995-2007	31%	19%	1 percentage point
New South Wales, Australia	1997-2005	24%	17.7%	0.8 percentage points
California, USA	1990-1995	19.8%	15.5%	0.86 percentage points
	1996-2007	18.6%	14.3%	0.39 percentage points

*The rise in the recorded prevalence of smoking in California between 1995 and 1996 was due to a revision of the definition of smoker by the Centers for Disease Control.*

These projections define the following targets for 2015:

- 11% smoking prevalence in the adult population
- 17% smoking prevalence in the adult routine and manual socio-economic group

### **Children and young people**

Targets for children and young people should be defined for two separate age groups: 11-15 year olds and 16-17 year olds. The former group are of school age and are the subject of the annual school survey in England of drug use, smoking and drinking among young people. The latter are an important new monitoring focus, given the recent increase in the minimum legal age for buying tobacco to 18 years.

Smoking prevalence among 11-15 year olds fell from 10% in 2000 to 9% in 2006 and then by 3 percentage points to 6% in a single year in 2007. However, these results for the entire 11-15 age group mask better results among 14 and 15 year olds, who are especially at risk of smoking initiation. Over the period 2000-2006, prevalence declined by 0.33 percentage points per year among 14 year olds and 0.5 percentage points per year among 15 year olds. In 2007, prevalence fell by 4 percentage points among 14 year olds and 5 percentage points among 15 year olds.

Given the recent dramatic fall in prevalence, and the priority focus on children and young people recommended for a new national tobacco control strategy, it is reasonable to project rates of decline in smoking prevalence to 2015 of 0.5 percentage points per year for 14 year olds (resulting in a 2015 prevalence of 5%) and 0.6 percentage points per year for 15 year olds (resulting in a 2015 prevalence of 10%). Assuming that the current low (1%-3%) prevalence levels in 11-13 year olds do not change, this defines the following target for 2015:

- 4% smoking prevalence in the 11-15 year old age group

Smoking prevalence among 16-17 year olds rose to a peak of 26% in 2003 but has since fallen to 20% in 2006 (21% among women, 19% among men). Given the recent drop in prevalence among 14 and 15 year olds, further significant reductions in the 16-17 year old prevalence can also be expected.

As with the adult population, the current high rates of decline may be hard to sustain but the clear direction of travel should not be. A 2 percentage point decline in both 2007 and 2008 followed by an average annual decline of one percentage point per year over the next seven years defines the following target for 2015:

- 9% smoking prevalence in the 16-17 year old age group

### **Pregnant women**

The prevalence of smoking among pregnant women is currently measured by self-report. Unfortunately, however, pregnant women are known to significantly under-report their smoking <sup>11</sup>, a problem that is likely to increase as exposing others to tobacco smoke becomes less and less socially acceptable. This problem could be addressed by setting up a national programme of unlinked anonymous monitoring of saliva cotinine among pregnant women, in the manner of the current antenatal programme of unlinked anonymous testing for HIV. Appropriate targets for smoking amongst pregnant women for 2015 could be set once an independent measure of smoking prevalence in this population has been established.



### **Secondhand smoke**

No routine data is currently collected nationally on exposure to secondhand smoke. However, data from the Health Survey for England can be used to calculate the proportion of households with children where one or both of the adults smoke but a non-smoking policy inside the home is operated. On average, across the years from 1996–2003, 32% of homes where only the father smoked appeared to have a policy, 16% where only the mother smoked but only 9% where both parents were smokers.

Given that legislation prohibiting smoking in public places has been found to stimulate smokefree policies in homes, and the strategic importance of this issue in reducing the harm of tobacco experienced by children and young people, the following target is ambitious but reasonable for 2015:

- 25% of homes where both parents are smokers operate a smokefree policy

This target ought to be measured directly through self-report, rather than through secondary analysis of the Health Survey for England. Data should also be collected on the proportion of adults who smoke in cars and a new target set.

An objective measure of exposure to secondhand smoke is also needed, given the under-reporting of smoking behaviour. As with pregnant women, this is best achieved using saliva cotinine testing. Cotinine levels should be monitored and reported annually and targets set for reductions in cotinine levels in both adult non-smokers and children.

### **Smuggled tobacco**

Although the government has met its targets for reducing tobacco smuggling, the market share occupied by illicit tobacco is still high: approximately 13% for cigarettes and 56% for hand-rolled tobacco in 2005-06.

Responsibility for tackling smuggling will in future be a joint responsibility between HMRC and the new UK Border Agency. New targets for these agencies for 2010 and 2015 are essential if tobacco smuggling is to continue to be driven down

The average decline in the total market share occupied by illicit cigarettes was 1.3 percentage points per year between 2000 and 2005. Assuming a more conservative current and future rate of decline of one percentage point per year, the following are the targets for 2010 and 2015:

- Reduce the illicit market share for cigarettes to no more than 8% by 2010 and 3% by 2015

The market share of hand-rolled tobacco has remained fairly static since it was first measured in 2001. As hand-rolled tobacco is more commonly used by routine and manual groups, exacerbating health inequalities, this is a key focus for new investment. The following are ambitious but achievable targets for 2010 and 2015:

- Reduce the illicit market share for hand-rolled tobacco to no more than 45% by 2010 and 33% by 2015

### **Local targets**

National targets should be complemented by regional targets, identified by regional tobacco control programmes, and by local targets. Primary care trusts, local authorities and other members of local strategic partnerships should adopt smoking prevalence targets as core commitments within local area agreements.

Local efforts to reduce smoking prevalence are currently hampered by a lack of local data. This forces primary care trusts and local authorities to work without a clear understanding of the scale of the problem they face, to forego meaningful targets and to proceed without the means to fully evaluate the effectiveness of their interventions. This problem should be addressed nationally, as part of a review of population research into smoking prevalence.

## CONCLUSION

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A decade after the publication of *Smoking Kills*, the ambition of the tobacco control community is undimmed. Success has bred determination not complacency. For all the achievements of the last ten years, the scale of the harm inflicted by tobacco on society, especially on children and young people, demands a long-term commitment to action.

The tobacco control community looks forward to working with government to shape a new era in tobacco control such that, in another ten years time, the achievements of *Smoking Kills* will be viewed as the foundations of a radical and ambitious approach to tackling the harm of tobacco, still the leading cause of preventable premature death in England.

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**BEYOND Smoking Kills:**

PROTECTING CHILDREN, REDUCING INEQUALITIES

20

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Protecting children,  
reducing inequalities



Smoke contains **benzene,**  
**nitrosamines, formaldehyde**  
and **hydrogen cyanide**

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Protecting  
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