

Smoking Still Kills

PROTECTING CHILDREN, REDUCING INEQUALITIES





**SMOKING STILL
KILLS 200 PEOPLE
EVERY DAY**

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STILL KILLS**

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The five-year strategy set out in the Government's Tobacco Control Plan for England comes to an end in 2015. This report proposes new targets for a renewed national strategy to accelerate the decline in smoking prevalence over the next decade. The recommendations have been developed by an editorial board in consultation with an advisory board of academics and experts, and following feedback back from four regional events with local and national tobacco control professionals.

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ORGANISATIONS ENDORSING THE RECOMMENDATIONS OF THIS REPORT

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 ASH Scotland
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 Association of Respiratory Nurse Specialists
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LOCAL AND REGIONAL

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 Cornwall Council
 Coventry Smokefree Alliance
 Darlington Borough Council
 Darlington Tobacco Control Alliance
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 West Yorkshire Fire and Rescue Service
 Wiltshire Council
 Worcestershire Tobacco Control Alliance



SUMMARY AND RECOMMENDATIONS

A new vision

The smoking epidemic is an entirely modern phenomenon. It is the product of the technical ingenuity and entrepreneurialism of the Victorian era, which saw the invention of both the cigarette-rolling machine and mass marketing. More than a century later, we know that the early pioneers of the tobacco industry unleashed a tidal wave of death and disease on their expanding markets. We must therefore match their ingenuity and resourcefulness to reverse all their gains. As we created this epidemic, so we can end it.

Over the last 35 years, smoking prevalence in England has halved: fewer than one in five adults smoke today. This remarkable change is principally the result of government action, both supporting smokers to quit and discouraging and denormalising smoking in society as a whole. Since the publication of the first national tobacco control strategy, *Smoking Kills*, in 1998, more than 70,000 lives have been saved due to the subsequent decline in smoking prevalence.

But smoking still kills. No one can say that the job of tobacco control is done when millions of smokers in England face the risks of smoking-related illness and premature death, hundreds of young people start smoking every day, and smoking remains the principal cause of health inequalities. We have a duty to our children to protect them from an addiction that takes hold of most smokers when they are young. To meet this duty, we must sustain and renew our collective effort to tackle smoking and drive down smoking prevalence at an even faster rate.

The success of tobacco control in England and the broad public support for further action make possible a vision for the future in which the smoking epidemic is finally brought under control. We propose that, by 2035, adult smoking prevalence in England should be no more than 5 per cent in all socio-economic groups.

This goal is powerful and extraordinarily challenging. For although the prevalence of smoking in England has declined dramatically, prevalence remains stubbornly high in lower socio-economic groups and disadvantaged groups including people with mental health problems, people with long-term conditions and people within the criminal justice system. In 2013 smoking prevalence in the Routine and Manual group was 28.6 per cent compared to 12.9 per cent in the Professional and Managerial group. Tackling these inequalities is the core challenge for tobacco control in the years ahead.

A new strategy

A new tobacco control strategy for England is urgently needed to replace the five year strategy pursued by the last government. *Healthy Lives, Healthy People: a tobacco control plan for England* was ambitious and progress over this period had been impressive, though many key measures are yet to be implemented, including standardised packaging, the prohibition of smoking in cars carrying children, and the EU Tobacco Products Directive.

The work of tobacco control professionals in England has gained an enviable international reputation in large part thanks to the comprehensive approach taken by government, in partnership with civil society, the NHS, local authorities and regional offices for tobacco control. It is clear from experience in other countries that tobacco control strategy must be comprehensive and sustained in order to achieve on-going reductions in smoking prevalence. Without such an approach, smoking prevalence could easily start to rise again.

This report proposes new targets for a national strategy, consistent with the long-term vision described above, that challenge all stakeholders in tobacco control to increase their efforts and accelerate the rate of decline of smoking prevalence over the next decade, specifically to:

- Reduce smoking in the adult population to 13% by 2020 and 9% by 2025
- Reduce smoking in the routine and manual socio-economic group to 21% by 2020 and 16% by 2025
- Reduce smoking among pregnant women to 8% by 2020 and 5% by 2025
- Reduce regular and occasional smoking among 15-year-olds to 9% per cent by 2020 and 2% by 2025

A new approach to funding

Spending on tobacco control is extremely cost-effective. Yet national and local resources for tobacco control and Stop Smoking Services are far from secure. In some areas, funding for these services is already in decline. A long-term vision to end the epidemic will only be achievable if resources are guaranteed. There is a simple way to achieve this that is fair and reasonable regardless of the state of the public finances: making the polluter pay.

The tobacco industry is in rude health, unlike many of those who consume its products. It is reasonable, therefore, to insist that the industry meets the costs of the damage it causes. In the UK, there is already a major industry that pays to reduce the pollution caused by its everyday business: the energy industry. The Energy Companies Obligation (ECO) places a legal requirement on energy companies to reduce environmental pollution by reducing demand for its core product, principally through energy efficiency measures. A Tobacco Companies Obligation would follow the same logic. Tobacco companies would be charged a levy, based on the volume of their sales, which would be used to fund measures to help smokers quit and to discourage young people from starting to smoke.

The Tobacco Companies Obligation will be a major innovation for public health. It will therefore be essential to ensure that it is administered, distributed and spent in a manner that meets the highest standards of transparency. This should not, however, be at the cost of a new burden of administration. In England, the Obligation should be managed by the Department of Health and spent against approved tobacco control plans at national, regional and local levels. In accordance with Article 5.3 of the WHO Framework Convention on Tobacco Control and its Guidelines, the tobacco industry should be entirely excluded from the oversight of the Tobacco Companies Obligation and the dispersal of the funds raised.

A comprehensive package of measures

Many of the measures proposed in this report are already in place but need to be strengthened or renewed with a stronger focus on tackling inequalities. This is especially true of the support offered to smokers to quit. Local specialist Stop Smoking Services are at the heart of this offer, as they give smokers their best chance of quitting. At a time of fiscal pressure within local authorities, it is vital that these services are sustained and better targeted to reach disadvantaged groups. Across the NHS as a whole, opportunities ought to be seized whenever possible to engage with smokers and help them find a way out of their addiction, yet many of these opportunities are currently missed. This reflects inadequate professional training and a failure by NHS providers to adopt the basic smoking cessation interventions recommended by NICE.

For smokers who want to quit but cannot overcome their nicotine addiction, the emergence of a wider range of alternative nicotine products, including electronic cigarettes, has created new opportunities to escape

the harm of tobacco. Although there are reasonable concerns about the long-term impact of electronic cigarettes, and an appropriate regulatory framework is essential, the potential value of these products to smokers should be recognised and exploited. Public confusion about the relative risks of nicotine products compared to tobacco products is a key obstacle to achieving this.

The regulatory framework for the sale of tobacco products is itself weak as retailers in England do not require a licence to sell tobacco. The introduction of such a scheme would enable local authorities to build more proactive relationships with retailers, raising awareness of the law and promoting good practice. It would also make it much easier for local authorities to stop retailers from selling tobacco if they find evidence of underage or illicit sales on the premises.

Wider action is also needed at regional, national and international levels to tackle illicit tobacco sales as the illicit market share has begun to rise after a long period of decline (which was due to a strong enforcement strategy, not to any link with the price of legal tobacco which rose during this period). The implementation of the WHO Illicit Trade Protocol, which includes an international tracking and tracing regime for tobacco products, is central to this task.

Raising the price of tobacco products remains the most effective means of reducing demand and consequently there is a good case for increasing the annual duty escalator from 2 per cent above inflation to 5 per cent above inflation. Other measures are also needed to remove anomalies in the market. In particular, a minimum unit price for cigarettes, aligned to a minimum excise tax, should be introduced to prevent tobacco companies from keeping ultra-cheap cigarettes on the market. The tax differential between cigarettes and hand-rolling tobacco should also be removed, in order to reduce the affordability of the latter.

Mass media and social marketing campaigns should also remain at the heart of government action on tobacco control as they have proved to be effective in reducing smoking prevalence. However, these communications need to be sustained across the year as well as carefully targeted.

The success of smokefree legislation is now clear and should be built on. Given the range of alternative nicotine products available, there is now a good case for removing the exemptions in the legislation for prisons, theatrical performances and merchant shipping. The case for extending existing legislation on smoking in cars carrying children to all cars should also be considered, given the impact of smoking in cars on the health of vulnerable adults, the road safety risks, and the likely challenges of enforcing a law limited to cars carrying children. As smokefree outdoor spaces are growing in popularity, especially where children play, it is also timely to review the ways in which children can be better protected from the normative influence of smoking in outdoor public spaces. The adoption of smokefree homes will remain a voluntary issue but is worth monitoring as the adoption of smokefree environments beyond the home has consistently resulted in wider adoption of smokefree homes.

There is already good evidence that children and young people are affected by witnessing smoking in films. Here there is even a dose-response effect: the more films that young people watch that portray smoking, the more likely they are to try smoking themselves. A first step in addressing this would be to screen short anti-smoking advertisements before films which portray smoking that children and young people are permitted to watch.

The delivery of this broad package of measures will require the involvement of many stakeholders including government, local authorities, the NHS, offices of tobacco control and civil society. The recommendations in this report, summarised below, relate both to UK-wide policies, such as those relating to smuggling, taxation and product regulation, and to policy in England. As government responsibility for health is devolved, and

each of the nations of the United Kingdom have their own strategy and targets to tackle smoking^{1,2,3}, the recommendations on health policy are principally addressed to government and stakeholders in England. The recommendations here are consistent with the aspirations for Wales, Scotland and Northern Ireland and represent a strong vision for England towards a long-term goal of ending the smoking epidemic for all.

RECOMMENDATIONS

1. Strategy and data

- 1.1 Publish a new comprehensive tobacco control plan for England with a commitment to tackling inequalities at its heart.
- 1.2 Define a long-term vision to end the smoking epidemic: reducing adult smoking prevalence to less than 5% in all socio-economic groups by 2035.
- 1.3 Set new national targets that define achievable mid-term objectives:
 - Reduce smoking in the adult population to 13% by 2020 and 9% by 2025
 - Reduce smoking in the routine and manual socio-economic group to 21% by 2020 and 16% by 2025
 - Reduce smoking among pregnant women to 8% by 2020 and 5% by 2025
 - Reduce regular and occasional smoking among 15-year-olds to 9% per cent by 2020 and 2% by 2025
- 1.4 Ensure full implementation of legislative measures already underway including standardised packaging, the prohibition of smoking in cars carrying children, the prohibition of proxy purchasing for young people, and the EU Tobacco Products Directive.
- 1.5 Support tobacco control teams in local authorities to develop strategic approaches to reducing smoking prevalence in local communities, exploiting all the opportunities offered by the local government setting.
- 1.6 Promote evidence-based supra-local/regional action on tobacco control throughout England where the evidence indicates this is appropriate, such as in tackling inequalities, controlling illicit trade, mass media work and research and evaluation.
- 1.7 Provide expert support and encouragement to low and middle income countries to help implement the WHO Framework Convention on Tobacco Control and its Guidelines.
- 1.8 Improve national statistics to ensure that timely and robust data are available on smoking prevalence including data on all socio-economic groups, people with long-term conditions, people with mental health problems, minority ethnic groups, the LGBT population and other disadvantaged groups.
- 1.9 Improve national data on mortality by requiring smoking history to be recorded on death certificates when it is judged to have been a significant contributory factor.

2. The tobacco industry and the costs of tobacco control

- 2.1 Introduce a new annual levy on tobacco companies, the Tobacco Companies Obligation, to help fund evidence-based tobacco control and Stop Smoking Services in England.
- 2.2 Establish a clear mechanism for the calculation of the Tobacco Companies Obligation, based on the costs of evidence-based tobacco control interventions at national, regional and local levels. Apply the levy in proportion to companies' market share in order that monies raised from each company are commensurate with harm caused.

- 2.3 Establish a transparent and accountable process for administering the Tobacco Companies Obligation.
- 2.4 Seek a revision of the EU Tobacco Tax Directive to prevent the tobacco industry from passing on the costs of the Tobacco Companies Obligation to smokers.
- 2.5 Require tobacco companies to make public their sales data, marketing strategies and lobbying activity.
- 2.6 In accordance with Article 5.3 of the WHO Framework Convention on Tobacco Control and its Guidelines:
 - Ensure the tobacco industry is excluded from public health policy-making at all levels of government
 - Prohibit tobacco companies, and their subsidiaries and agents, from using advertising or 'corporate social responsibility' communications to promote their interests and influence public policy
- 2.7 Encourage all local authorities to act in accordance with Article 5.3 of the WHO Framework Convention on Tobacco Control and its Guidelines.

3. Helping smokers quit

- 3.1 Ensure that good quality evidence-based Stop Smoking Services are accessible to all smokers, particularly those from lower socio-economic groups and disadvantaged populations.
- 3.2 Include training on providing very brief advice on smoking cessation within the core curricula of all education programmes for healthcare professionals.
- 3.3 Ensure that smokers with mental health problems and smokers with long term conditions receive stop smoking interventions as a routine part of their care.
- 3.4 Promote universal adherence to NICE guidance on tobacco, especially:
 - Brief interventions and referral for smoking cessation
 - Smoking cessation in secondary care: acute, maternity and mental health services
 - Quitting smoking in pregnancy and following childbirth
- 3.5 Ensure that midwives have the training, equipment and time to undertake carbon monoxide screening with every pregnant woman.
- 3.6 Ensure that Stop Smoking Services and all health professionals are equipped to provide accurate, high quality information and advice to smokers about the relative risks of nicotine and all nicotine-containing products.
- 3.7 Increase the support and information available to smokers who are unable to quit to switch to less harmful sources of nicotine, in line with the principles set out in the NICE guidance on tobacco harm reduction.
- 3.8 Regulate the market for electronic cigarettes and other non-tobacco nicotine-inhaling products to maximise their value to smokers and minimise the risk of uptake by non-smokers.
- 3.9 Promote improvements in the quality, safety and efficacy of electronic cigarettes and other non-tobacco nicotine-inhaling products.
- 3.10 Closely monitor the impact of the market for electronic cigarettes and other non-tobacco nicotine-inhaling products on smoking behaviour, smoking uptake and public attitudes to smoking.

4. The affordability and sale of tobacco

- 4.1 Increase the tax escalator on tobacco products to 5 per cent above the level of inflation.
- 4.2 Remove the tax differential between manufactured and hand-rolled cigarettes.
- 4.3 Adjust the current national tax regime to raise the price of the cheapest cigarettes and prevent down-trading, and seek a revision of the EU Tobacco Tax Directive to enable the creation of a minimum

unit price for all tobacco products.

- 4.4 Fully implement the WHO Illicit Trade Protocol including an international tracking and tracing regime for tobacco products.
- 4.5 Strengthen and resource national, regional and local partnerships to enable co-ordinated action on illicit trade.
- 4.6 Set new targets for the control of tobacco smuggling:
 - Reduce the illicit market share for cigarettes to no more than 5% by 2020
 - Reduce the illicit market share for hand-rolled tobacco to no more than 22% by 2020 and no more than 11% by 2025.
- 4.7 Introduce a positive licensing scheme for all tobacco retailers and wholesalers, to be paid for by the tobacco industry.
- 4.8 Develop best practice guidelines for using the licensing scheme to enforce the law on the sale of tobacco, communicate with retailers and control the tobacco supply chain.

5. Mass media campaigns and social marketing

- 5.1 Target mass media and social marketing campaigns on lower socio-economic groups and disadvantaged populations, and provide adequate resources to ensure that their reach, duration and frequency are in line with best practice.
- 5.2 Ensure that all mass media campaigns signpost and promote local Stop Smoking Services.

6. Smokefree environments

- 6.1 Increase the proportion of homes occupied by adult smokers and dependent children that are smokefree to 80% by 2020 and 90% by 2025.
- 6.2 Remove the smokefree exemption for prisons and provide support to prisoners to remain tobacco-free when they return to the community.
- 6.3 Remove the smokefree exemption for theatrical performances.
- 6.4 Extend smokefree regulations to cover sea-going shipping and inland waterway vessels.
- 6.5 Review the evidence and consult on the prohibition of smoking in all cars and motor vehicles.
- 6.6 Ensure universal compliance with NICE guidance on a smokefree NHS and promote a smokefree estate including primary care, secondary care, maternity services and mental health services.
- 6.7. Consult on legislative and non-legislative options to make outdoor environments smokefree where there is good evidence that this would improve public health.

7. Smoking in films and the wider media

- 7.1 Require short anti-smoking films to be shown before films and programmes that portray smoking and can be seen by children and young people, including those viewed in cinemas, on TV and on pay-to-view internet.
- 7.2 Raise awareness among policy-makers of the harm to children and young people of smoking in films, and consult on options to reduce their exposure to images of smoking in films and other media including the internet, music videos and computer games.

CHAPTER 1

WE CREATED THIS EPIDEMIC, SO WE CAN END IT

The foundations of modern public health are often said to lie in the great urban reforms of the Victorian era: efficient sewers, clean water and decent public housing. Yet this heroic story of collective human endeavour for the public good is undercut by tragedy. For the greatest public health disaster of the twentieth century was also the product of nineteenth century ingenuity. The invention of the cigarette-rolling machine in the 1880s enabled the creation of a global mass market for tobacco, leading in time to hundreds of millions of smoking-related deaths.

In England, cholera is a disease of the past but lung cancer and other smoking-related diseases are still very much with us. Today's smoking epidemic is not, however, a fact of life: just as we created it, so we can end it. We have the tools to achieve this. If we match the vision, ingenuity and ambition of the Victorian public health reformers, we too can leave a legacy that future generations will celebrate. Since the middle of the twentieth century, the efforts of successive governments have driven smoking prevalence in England down from more than 50 per cent to less than 20 per cent today. This change, achieved not by prohibition but by comprehensive and effective regulation, is remarkable, but there is still much to do.

Over the last 20 years public attitudes to smoking have changed dramatically. This is the result of a virtuous interplay between government intervention and public debate. The tobacco advertising ban and the introduction of smokefree legislation both had public support at the time but each in turn helped to shift public attitudes and 'denormalise' smoking behaviour. Consequently public support for new government measures to limit smoking continues to grow. The tobacco industry always claims that new controls on tobacco will lead to unintended adverse consequences elsewhere. Yet exactly the opposite is true. For example, far from triggering a rise in smoking in the home, smokefree legislation has been followed by widespread voluntary adoption of smokefree homes. This momentum for change, driven both by individual choice and by government action, must be sustained.

The goal of tobacco control is to reduce the harm of tobacco by helping smokers quit, reducing exposure to secondhand smoke and preventing young people from starting to smoke. It is not to stigmatise smokers. A careful balance must be struck: in order to deter young people from smoking and to encourage smokers to quit, the public perception of smoking ought to be consistent with the clinical reality of a deadly disease, but this should not extend to stigmatisation of smokers who remain key partners in the long-term effort to end the epidemic.

The biggest obstacle to ending the smoking epidemic is not smokers, most of whom want to quit, but the tobacco industry. The industry does not support the goals of public health and has consistently sought to oppose and undermine governmental and international efforts to reduce the harm of tobacco. As tobacco companies continue to make large profits at the expense of the nation's health, we need new ambition not only in seeing off their opposition but also in demanding that they pay for the damage they cause.

There was a time, long before the Victorian era, when no-one in England died of tobacco-related disease. This distant past could become our not-so-distant future, for it is possible today to imagine an end to the epidemic: a society where smoking is so rare that smoking-related harm is almost, if not completely, non-existent. This document presents a new strategy for tobacco control for the next ten years that sets us on a trajectory towards this future.

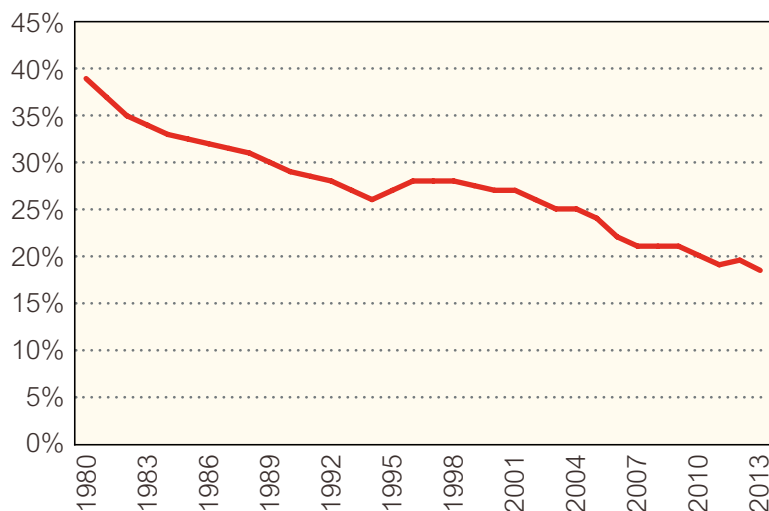
BUILDING ON SUCCESS

2.1 The long view

In the last 35 years, the number of people in England who smoke has halved. In 1980, nearly two in every five adults (39.0 per cent) smoked. By 2013, fewer than one in five (18.4 per cent) smoked (Figure 2.1). Nonetheless, prevalence of 18.4 per cent in England – 21 per cent of men and 16 per cent of women – equates to more than eight million adult smokers, half of whom are likely to die prematurely as a result of smoking if they do not quit⁴. Smoking remains by far the biggest preventable cause of illness and death in the country.

The decline in smoking in England over this period was by no means inevitable. It was the outcome not only of individual choices but also of the ambitious tobacco control policies that have shaped those choices. *Smoking Kills*, the first comprehensive government strategy to tackle smoking, was published in 1998. This strategy put smoking prevalence back on a downward trend after stalling in the mid-1990s. The decline in smoking prevalence in England since 1998 has saved more than 70,000 lives and improved the quality of life of hundreds of thousands of people⁵.

Figure 2.1 Adult smoking prevalence in England 1980-2013⁶



Comparison with experience elsewhere illuminates the importance of tobacco control in bringing down smoking prevalence. Figure 2.2 compares smoking prevalence rates in six legislatures over the last 30 years: England, France, post-unification Germany, Australia, Canada and California. The methods used to record smoking prevalence are not consistent across these nations and states, so Figure 2.2 is not an accurate picture of differences in prevalence at any one time. Nonetheless the chart provides a good indication of long-term trends within each nation or state.

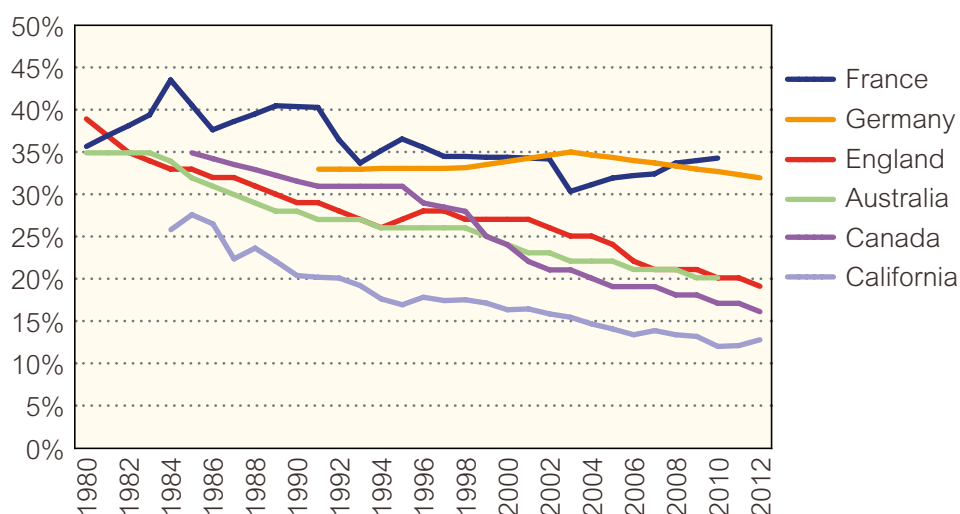
The rate of decline of smoking prevalence in England is comparable to the rates of decline in Australia, Canada and California, where governments have consistently tackled the harms of smoking through strategic and comprehensive tobacco control programmes. In contrast, smoking prevalence in France and Germany has barely shifted over the last 20 years.

There have been important changes in these countries, including the EU-wide prohibition of tobacco advertising and sponsorship, but they have lacked the comprehensive and strategic approach that has defined efforts to tackle smoking in England, north America and Australia.

We cannot assume that the long-term decline in smoking prevalence in England will continue. Prevalence could stabilise or, as in France⁷, start to rise again. Further progress requires further action on all fronts.

There is substantial public support for further action on tobacco control: 37% of adults in England feel that the government is not doing enough to limit smoking and 39% feel that government action is about right. Only 14% feel that the government is doing too much. (YouGov, *Smokefree Britain Survey*, ASH, 2015)

Figure 2.2 Adult smoking prevalence 1980-2012 in France, Germany, England, Australia, Canada and California



2.2 The last five years

In 2011 the newly elected Coalition government published *Healthy Lives, Healthy People: a tobacco control plan for England*. The strategy set out a comprehensive approach encompassing the following arenas of action:

- Stopping the promotion of tobacco;
- Making tobacco less affordable;
- Effective regulation of tobacco products;
- Helping tobacco users to quit;
- Reducing exposure to secondhand smoke; and
- Effective communications for tobacco control.

Five years later, progress across this framework has been impressive, though some key measures await implementation:

Stopping the promotion of tobacco

- The large displays of tobacco products that once dominated supermarkets disappeared in 2012, followed by displays in smaller shops in April 2015. Tobacco vending machines met the same fate in 2011. Tobacco products are now all but invisible at the point of sale.
- Standardised packaging of tobacco products was approved by Parliament in March 2015 and is scheduled for implementation in May 2016. This measure removes the tobacco industry's last significant opportunity to promote its products in the UK.
- The revision of the EU Tobacco Products Directive in 2014 requires changes to packaging and labelling including health warnings on cigarette packs to cover 65 per cent of both sides of the pack including a picture warning on the front. These measures will be implemented in the UK in May 2016.

Making tobacco less affordable

- Since 2008 the government has raised taxes on tobacco products at a rate higher than inflation. The price of a packet of premium cigarettes in the UK is now the second highest in Europe after Norway⁸. However tobacco companies have been adept at manipulating prices across their brands in order to minimise price rises for their cheapest brands⁹.
- In 2012-13, the size of the illicit market for tobacco products in the UK reached a new low of 7 per cent for cigarettes and 36 per cent for hand-rolled tobacco. However the illicit market has grown in the two years since, indicating the need for sustained investment in anti-smuggling action¹⁰. The UK is not yet a party to the WHO Illicit Trade Protocol which includes an international tracking and tracing regime for tobacco products.
- The revision of the EU Tobacco Products Directive in 2014 included a minimum pack size of 20 for manufactured cigarettes and a minimum weight for hand-rolled tobacco of 40g. In practice, these changes reduce the affordability of tobacco products.

Regulation of tobacco products and nicotine-containing products

- Since November 2011 all cigarettes sold in the UK have had to conform to a Reduced Ignition Propensity standard. This EU-wide standard is designed to reduce cigarette-related fires and related deaths by preventing cigarettes continuing to burn when they are not being actively smoked.
- The revision of the EU Tobacco Products Directive in 2014 established a framework for the regulation of electronic cigarettes, including the prohibition of products that are presented as having curative or preventive properties or containing more than 20 mg/ml of nicotine, unless they are licensed as medicines. The Directive also prohibited additives and flavourings that make tobacco products more attractive, with a phase out period of four years for products with a market share of more than 3 per cent, such as menthol cigarettes.
- In England, legislation prohibiting the sale of electronic cigarettes to under 18s will come into force on October 1st 2015.

Helping tobacco users to quit

- In the three years from 2011-12 to 2013-14, more than two million smokers set a quit date with Stop Smoking Services¹¹. Of these, half (51%) reported that they were still not smoking four weeks after their quit date. However the number of people using Stop Smoking Services

has fallen significantly over the last two years.

- In 2013 NICE published new guidelines on harm reduction in tobacco control that set out pathways for smokers to reduce their exposure to tobacco by substituting tobacco products with alternative licensed nicotine-containing products, either temporarily or indefinitely but with a primary focus on quitting nicotine altogether¹².

Reducing exposure to secondhand smoke

- Compliance with smokefree legislation has been high and public support for smokefree environments has increased year-on-year¹³. A review of the impact of smokefree legislation in England, published in 2011, found evidence of significant health benefits including a reduction in hospital admissions for heart attacks¹⁴.
- In England, legislation prohibiting smoking in cars carrying children under 18 years old will come into force on October 1st 2015.

Effective communications for tobacco control

- The government has pursued a high profile marketing campaign for tobacco control including smokefree, 'Stoptober' and 'Quit Kit' campaigns, supported by pharmacy-based resources to support quitting. However, the resources put into mass media campaigns fell from an average of £16.5m per year between 2004-05 and 2009-10 to an average of £4.3m between 2010-11 and 2012-13¹⁵.

Healthy Lives, Healthy People set out three national ambitions for tobacco control in England:

- To reduce adult (18+) smoking prevalence in England to 18.5 per cent or less by the end of 2015.
- To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.
- To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

The first of these ambitions was achieved when adult smoking prevalence in England fell to 18.4 per cent in 2013. The second ambition had already been reached in 2011, the year of the strategy's publication, when the rate of regular smoking among 15 year olds dropped to 11 per cent. This rate subsequently fell to 8 per cent in 2013. The third ambition is likely to be missed, but only just: the rate of smoking in pregnancy has fallen by around 0.5 percentage points every year, reaching 11.5 per cent in the last quarter of 2013/14.

Recommendation

- Ensure full implementation of legislative measures already underway including standardised packaging, the prohibition of smoking in cars carrying children, the prohibition of proxy purchasing for young people, and the EU Tobacco Products Directive.

2.3 A new strategy with new ambitions

The on-going success of tobacco control in England makes possible a vision for the future in which the smoking epidemic is finally brought under control. This vision may take a generation to realise but the very fact that we can now imagine such a future is transformative. The business of tobacco control is not simply to contain the epidemic and reduce its harms; it is to end the epidemic and eradicate its harms.

This vision is powerful and extraordinarily challenging. For if we are to imagine a smokefree future, it must be a smokefree future for everyone. Although the prevalence of smoking in England has declined

dramatically, prevalence remains stubbornly high in lower socio-economic and disadvantaged groups. In 2013 smoking prevalence in the Routine and Manual group was 28.6 per cent compared to 12.9 per cent in the Professional and Managerial group¹⁶ (see Chapter 3). Tackling this inequality is the core challenge for tobacco control in the years ahead.

Figure 2.3 describes a future trajectory of smoking prevalence in England where prevalence falls to below 5 per cent in all socio-economic groups by 2035. In practice, this would mean nearly zero prevalence in all groups other than the Routine and Manual group, which comprises approximately one quarter of the adult population.

The current ten-year trend for adult smoking prevalence in England, shown in red in Figure 2.3, is a decline of 0.66 percentage points per year. The blue target trajectory proposed in Figure 2.3 is a steeper decline of 0.80 percentage points per year. This would result in an adult population prevalence of less than one per cent by 2035. The green line describes the decline needed in the Routine and Manual socio-economic group over this period to achieve a prevalence of less than 5 per cent by 2035. This rate of decline, of 1.1 percentage points per year, is nearly twice the rate seen over the last ten years, when prevalence in this group fell by only 5.5 percentage points.

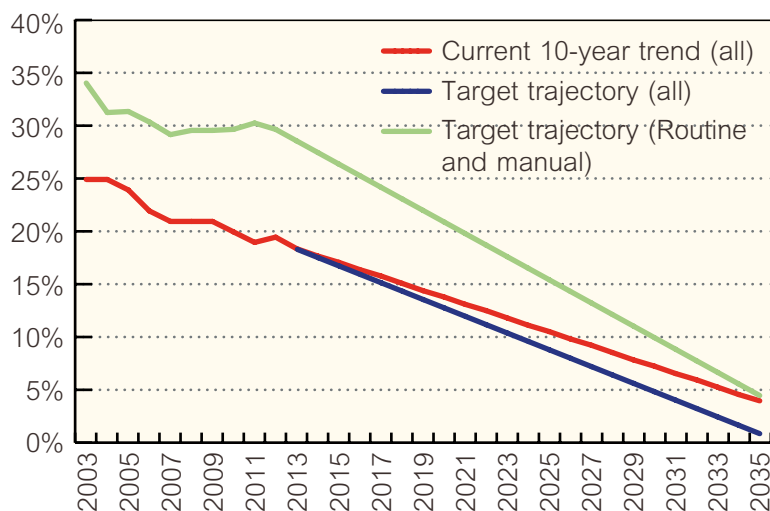
Although national data are currently only available on socio-economic groups, attention must also be paid to the needs of disadvantaged groups including people with long-term conditions, people with mental health problems, minority ethnic groups, and the LGBT population. Improvements in surveillance are needed to monitor changes in smoking prevalence in these groups. The timeliness and size of existing population surveys of smoking prevalence also need to be improved.

The rates of decline described in Figure 2.3 translate into the following mid-term ambitions:

- Reduce smoking in the adult population to 13% by 2020 and 9% by 2025
- Reduce smoking in the routine and manual socio-economic group to 21% by 2020 and 16% by 2025

The linear model that underpins these targets is consistent with the long-term trend in adult smoking prevalence shown in Figure 2.1. To achieve this, however, the size of the decline within the smoking population must necessarily increase year-on-year. When adult smoking prevalence reaches 9 per cent, a further 0.8 percentage point decline is arguably a tougher call than the same percentage point fall when prevalence is 18 per cent. However, as smoking becomes ever more marginal to most people's lives, the effect of denormalisation is likely to strengthen. As smoking becomes increasingly invisible, the everyday

Figure 2.3 Projection of smoking prevalence in England to achieve prevalence of less than 5% in all socio-economic groups by 2035



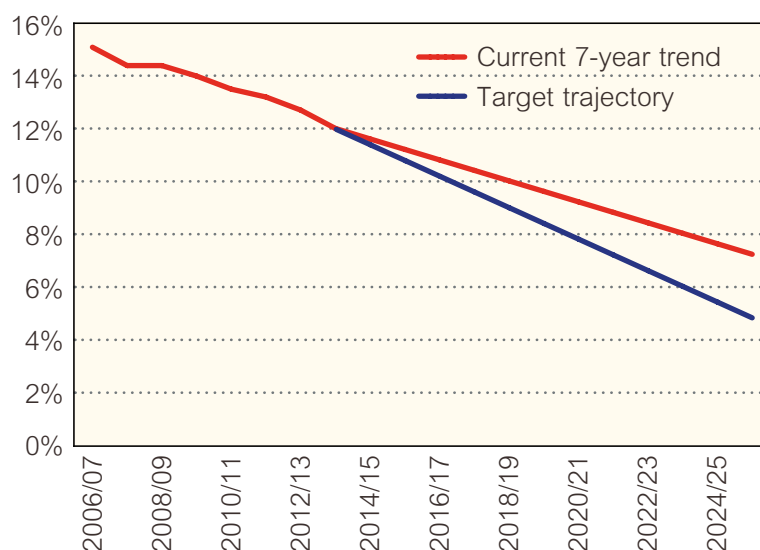
cues that encourage and sustain smoking will likewise begin to disappear. The recent dramatic decrease in the prevalence of smoking among young people also suggests that, in the long-term, a linear decline in the smoking population is achievable.

New mid-term ambitions are also needed to reduce smoking among pregnant women and among children and young people. Figure 2.4 illustrates the recent trend in smoking prevalence among pregnant women, measured at time of delivery, and projects this forward to 2025. This trend, representing a decline of 0.4 percentage points per year, would result in a 7 per cent prevalence in 2025. The more challenging projection, shown in blue, would see a 0.6 percentage point decline every year, which translates into the following ambitions:

- Reduce smoking among pregnant women to 8% by 2020 and 5% by 2025

The monitoring of prevalence of smoking in pregnancy is currently too dependent on self-report and is inappropriately focused on time of delivery. A more robust approach including the use of bio-markers is needed.

Figure 2.4 Projection of smoking prevalence in pregnant women (at time of delivery) to 2025



The recent decline in smoking among young people has been particularly striking. Between 2004 and 2013, the prevalence of regular smoking among 15-year-olds fell from 21 per cent to 8 per cent, a decline of 1.44 percentage points per year. Consequently, the use of 'regular smoking' to define future ambitions is no longer realistic as, on this trend, there will be no regular smokers in this age group by 2019 (Figure 2.5).

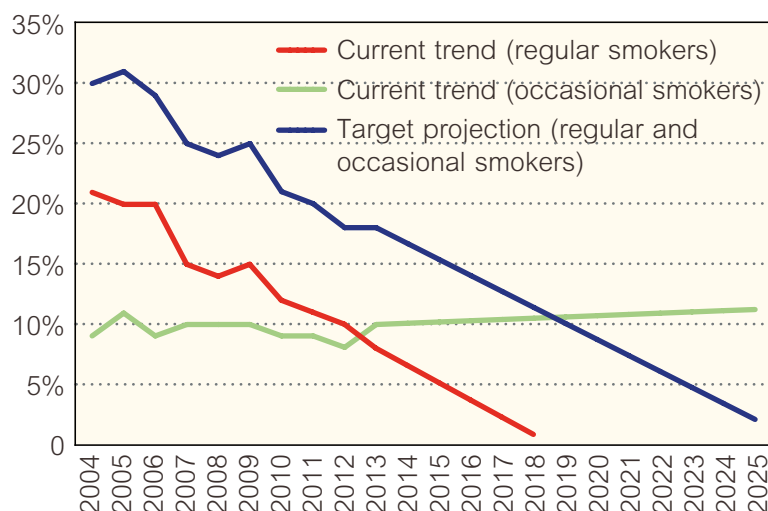
Unfortunately the proportion of 15-year-olds who are occasional smokers has barely changed over this period. It therefore makes sense to define future ambitions in terms of all smokers, both regular and occasional. The prevalence in this inclusive group was 18 per cent in 2013.

The target projection for 'regular and occasional' 15-year-old smokers in Figure 2.5 follows the recent decline in this group of 1.33 percentage points per year. However, as this decline has to date been entirely due to change among regular smokers, this projection is challenging for all 15-year-old smokers.

This projection translates into the following ambitions:

- Reduce regular and occasional smoking among 15-year-olds to 9% per cent by 2020 and 2% by 2025

Figure 2.5 Projection of smoking prevalence among 15-year-olds to 2025



These targets, and the vision that underpins them, will only be achieved through concerted action at every level of government, the NHS and society as a whole. National leadership must be complemented by commitment and action at local, regional and international levels.

Since the publication of the last national tobacco control strategy in 2011, upper tier local authorities have taken on a more strategic role in tobacco control following the transfer of public health teams to local government in 2013. This has created opportunities for tobacco control professionals to work not only with their traditional partners in trading standards and environmental health but also with other council colleagues, for example in social care, planning, leisure, education and parks. However local authorities face serious cost pressures and political support for tobacco control is weak in some areas¹⁷, so the work of these professionals needs to be supported wherever possible.

Regional action on tobacco control remains highly variable across England. Currently there are only three regional offices for tobacco control, in the northeast, northwest, and southwest. However there are other forms of regional and supra-local support elsewhere and the evidence for effective supra-local collaboration on tobacco control is widely understood, especially in tackling inequalities, controlling illicit trade, mass media work and research and evaluation.

Internationally, the UK is a party to the WHO Framework Convention on Tobacco Control and its guidelines and contributes to the development of EU Directives on tobacco, for example in relation to advertising, taxation and tobacco products. The UK should continue to play a lead role in ensuring that the international framework is ambitious and evidence-based.

As a party to the WHO Framework Convention on Tobacco Control, the UK government also has a duty to support international efforts to reduce the harm caused by tobacco. As the UK becomes an increasingly 'dark market' for the tobacco industry, thanks to effective regulation of advertising and promotion, tobacco

companies inevitably look elsewhere to increase sales. British experience, expertise and political commitment could potentially play an important role in the long-term effort to bring the smoking epidemic under control in low and middle income countries across the world.

Recommendations

- Publish a new comprehensive tobacco control plan for England with a commitment to tackling inequalities at its heart.
- Define a long-term vision to end the smoking epidemic: reducing adult smoking prevalence to less than 5% in all socio-economic groups by 2035.
- Set new national targets that define achievable mid-term objectives:
 - Reduce smoking in the adult population to 13% by 2020 and 9% by 2025
 - Reduce smoking in the routine and manual socio-economic group to 21% by 2020 and 16% by 2025
 - Reduce smoking among pregnant women to 8% by 2020 and 5% by 2025
 - Reduce regular and occasional smoking among 15-year-olds to 9% per cent by 2020 and 2% by 2025
- Improve national statistics to ensure that timely and robust data are available on smoking prevalence including data on all socio-economic groups, people with long-term conditions, people with mental health problems, minority ethnic groups, the LGBT population and other disadvantaged groups.
- Support tobacco control teams in local authorities to develop strategic approaches to reducing smoking prevalence in local communities, exploiting all the opportunities offered by the local government setting.
- Promote evidence-based supra-local/regional action on tobacco control throughout England where the evidence indicates this is appropriate, such as in tackling inequalities, controlling illicit trade, mass media work and research and evaluation.
- Provide expert support and encouragement to low and middle income countries to help implement the WHO Framework Convention on Tobacco Control and its Guidelines.

THE COSTS OF SMOKING

3.1 The human cost of smoking

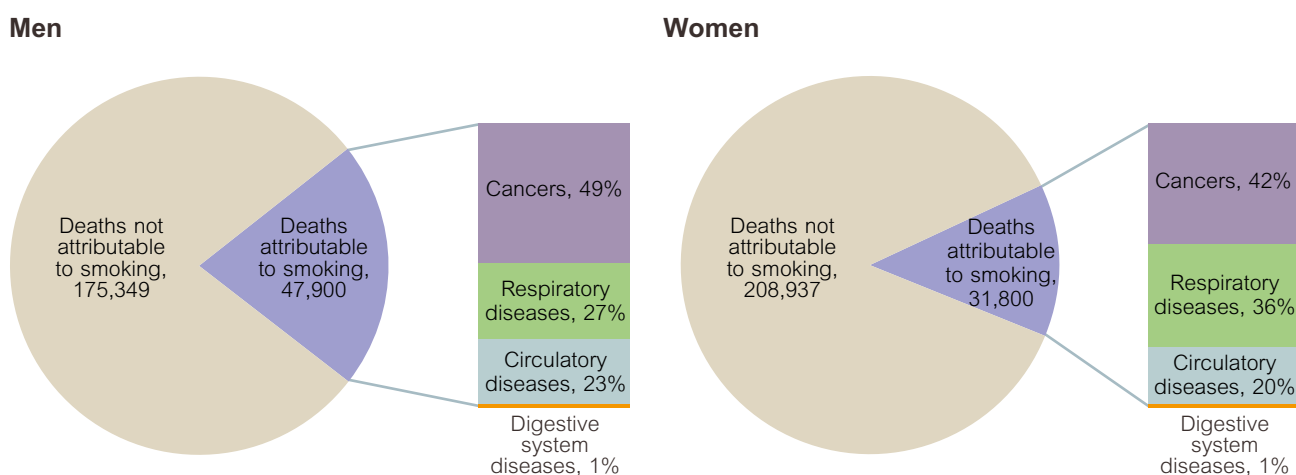
Every day in England more than 200 people die from smoking-related illnesses. In 2013, around one in six (17 per cent) of all deaths among people aged 35 and over – around 79,700 people – were attributable to smoking¹⁸. Smoking causes more deaths every year than obesity, alcohol, road traffic accidents, illegal drugs and HIV combined¹⁹.

The size of the impact of smoking on mortality is illustrated in Figure 3.1 which describes the deaths of all men and women aged 35 and over in England in 2013. In this age group, more than a fifth of deaths among men (21 per cent) and more than one in eight deaths among women (13 per cent) were attributable to smoking. Cancer is the most common immediate cause of smoking-related deaths, among both men and women. However smoking contributes to a greater proportion of respiratory deaths: it is the cause of 35 per cent of respiratory deaths, 28 per cent of cancer deaths and 13 per cent of deaths from cardiovascular disease.

Unfortunately more extensive data on smoking-related deaths are not available as smoking is not routinely recorded on death certificates. In order to improve national surveillance, a history of smoking ought to be recorded on death certificates when it is judged to have been a significant contributory factor to the death.

Globally, the annual death toll from tobacco use was estimated to be almost 6 million people in 2011, including approximately 600,000 people who died from involuntary exposure to secondhand smoke. Four in five of these deaths were in low- and middle-income countries. Smoking-related deaths are expected to rise to 8 million a year by 2030²⁰.

Figure 3.1 All deaths in men and women aged 35 and over in England, 2013



These high mortality rates translate into a world of illness and disability. For every death caused by smoking, approximately 20 smokers are living with a smoking-related disease²¹. In addition to the suffering caused by the conditions described above, many smokers experience years of illness and disability from the many other serious medical conditions that can be caused or aggravated by smoking. These include Alzheimer's disease, angina, asthma, influenza, Crohn's disease, gastric and duodenal ulcers, gum and tooth disease, osteoporosis, rheumatoid arthritis, cataracts, macular degeneration, psoriasis, reduced fertility, impotence, depression, hearing loss, multiple sclerosis and diabetes²².

Every year, hundreds of thousands of people are admitted to hospital in England because of smoking-attributable illness. In 2012-13, among people aged 35 and over, there were 287,900 hospital admissions of men and 173,000 admissions of women due to smoking-attributable disease. These admissions include a quarter (24 per cent) of all hospital admissions for respiratory disease²³.

Recommendation

- Improve national data on mortality by requiring smoking history to be recorded on death certificates when it is judged to have been a significant contributory factor.

3.2 Children and young people

Children and young people are on the front line of the smoking epidemic. Every year, tens of thousands of infants, children and young people are harmed by tobacco. They are harmed by exposure to secondhand smoke in homes and cars, which they have little control over. They are harmed by the impact of smoking on the health, wellbeing and economic security of their families. And they are harmed by their own experimentation with smoking, which so often presages a lifetime of smoking and ill health. Youth smoking remains the driver of the epidemic: 80 per cent of all adult smokers started before they were 20 years old²⁴. This is not a fact that is lost on the tobacco industry.

For many children, the harm of tobacco begins before birth. In 2013/14, 1 in 8 pregnant women (12 per cent) was still a smoker at the time of the delivery of their baby. Smoking in pregnancy increases the risks of miscarriage, premature birth, still birth and low birth-weight. Exposure to tobacco smoke in the womb also affects outcomes for infants after birth: they are at higher risk of infant mortality, wheezy illnesses and psychological problems such as attention and hyperactivity problems²⁵.

Children born into households where adults or siblings smoke may face years of exposure to secondhand smoke. However a majority of all children experience secondhand smoke: in 2012, two thirds (67 per cent) of 11-15 year-olds reported being exposed to secondhand smoke with 43 per cent experiencing secondhand smoke in their own home and 55 per cent being exposed in other people's homes²⁶. Many children and young people in this age group were also exposed in cars: 26 per cent in their family car and 30 per cent in other people's cars²⁶.

This early exposure to secondhand smoke contributes to many adverse health outcomes including lower respiratory tract infections, asthma, wheezing, middle ear infections and invasive meningococcal disease. There is also evidence linking exposure to secondhand smoke with impaired mental health and with increased school absenteeism²⁷.

Children and young people who live in households with low incomes also suffer the consequences of the daily economic burden of smoking. Currently approximately 1.2 million children in the UK are living in poverty in households where adults smoke. If these adults quit and the costs of smoking were returned to household budgets, 365,000 of these children would be lifted out of poverty²⁸ (Figure 3.2).

Figure 3.2. The impact of cigarette smoking on household, child and adult poverty in the UK

	Currently in poverty	Lifted out of poverty if smoking costs removed
Households with smokers	1,788,000	512,000
Children in households with smokers	1,244,000	365,000
Adults in households with smokers	3,192,000	866,000

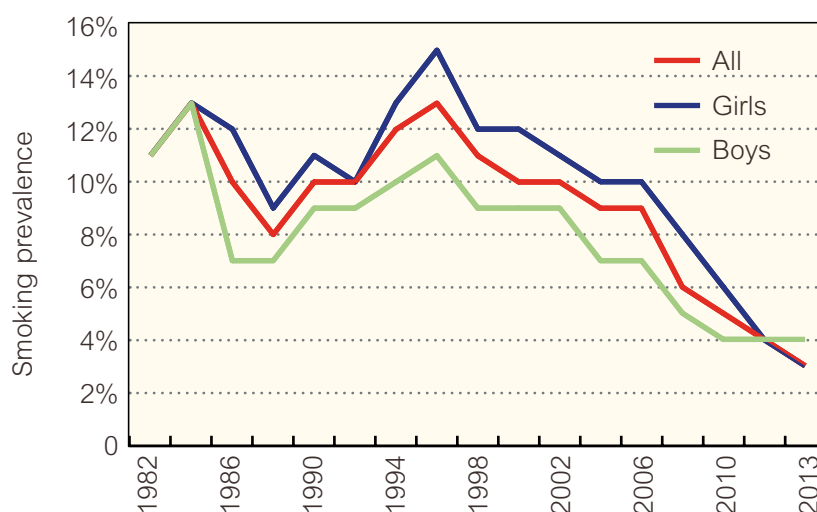
Living with adults or siblings who smoke also makes it much more likely that a young person will start and continue smoking²⁹. Other factors that influence smoking uptake in this age group include smoking by friends and peer group members, the ease with which young people can obtain cigarettes, exposure to tobacco marketing, and depictions of smoking in films, television and other media³⁰. The social, economic and cultural transmission of smoking behaviour to young people is evident in the gradient of youth smoking across socio-economic groups, which matches the gradient among adults (see Section 3.3 below).

Children and young people who smoke risk damaging their respiratory health in both the short and the long term. Compared to their non-smoking peers, children who smoke are two to six times more susceptible to coughs, increased phlegm, wheeziness and shortness of breath³¹. Smoking impairs the growth of children's lungs and begins a decline in lung function that increases the risk of chronic obstructive lung disease later in life. The earlier that children become regular smokers, the greater their risk of developing lung cancer or heart disease as adult smokers³².

Happily, the prevalence of smoking among children and young people has declined markedly over the past 20 years. The prevalence of regular smoking among 11-15 year-olds in England has fallen from a peak of 13 per cent in 1996 to 3 per cent in 2013³³, with a particularly sharp decline occurring over the last decade (Figure 3.3). This suggests that the major policy interventions such as the advertising ban and the introduction of smokefree environments are having a profound cohort effect.

Looking specifically at 15-year-olds, however, current prevalence of regular smoking stands at 8 per cent. If occasional smokers are also included, this figure rises to 18 per cent (Figure 2.5). Unfortunately we know that nicotine is so addictive that children who experiment with cigarettes can quickly become addicted before they start daily smoking³⁴. Smoking just one cigarette in early childhood doubles the chance of a teenager becoming a regular smoker by the age of 17³⁵. There is, therefore, no room for complacency. Further action is needed to denormalise smoking and remove secondhand smoke and images of smoking from the everyday experience of young people growing up in England today.

Figure 3.3 Prevalence of regular smoking among 11-15 year-olds in England, 1982-2013

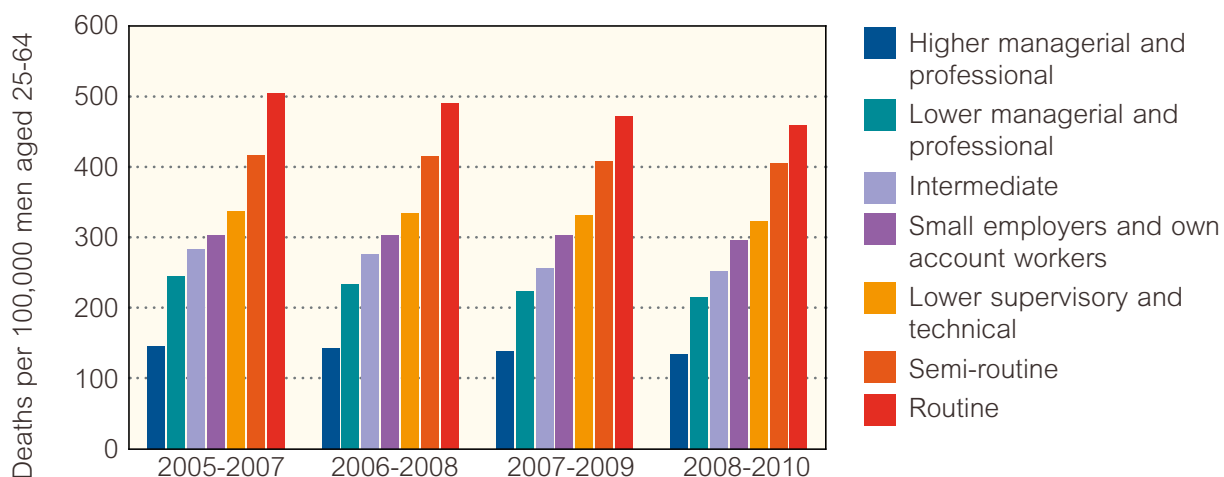


3.3 Smoking drives inequalities

The premature death rate in the ‘routine’ socio-economic group in England is more than three times higher than the rate in the ‘higher managerial or professional’ group. Although death rates in all socio-economic groups have declined in recent years, the differences between groups are still startling (Figure 3.4).

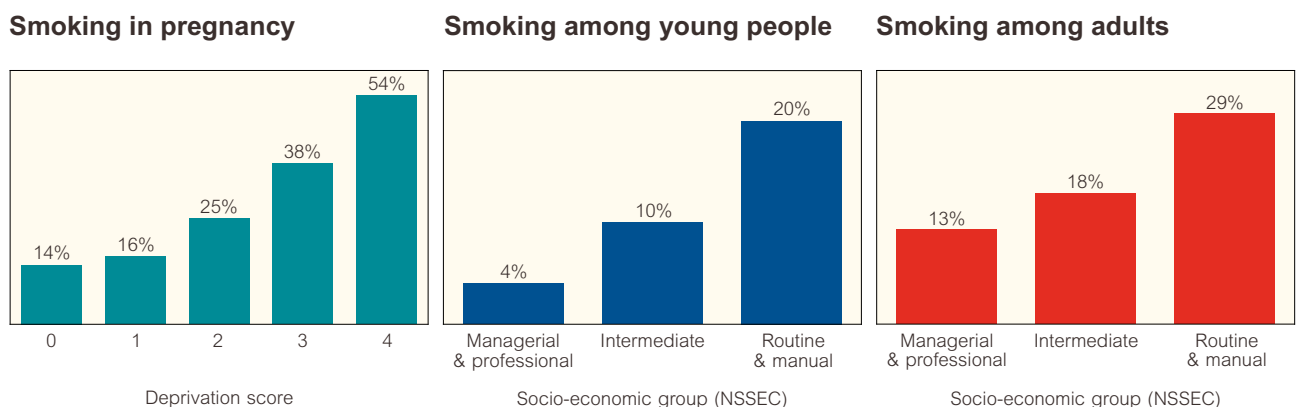
Smoking is a key driver of this inequality. More than half of the difference in premature deaths between the highest and lowest socio-economic groups is attributable to differences in smoking rates between these groups³⁶. Although there are many factors that affect this inequality, the contribution of smoking is so great that someone in the least privileged socio-economic group who does not smoke has a better chance of survival than someone in the most privileged group who does smoke³⁷.

Figure 3.4. Deaths among working age men in England and Wales, 2005-2010, by socio-economic classification (ONS)



The differences in the prevalence of smoking across the socio-economic spectrum are just as striking: in 2013, smoking prevalence in the routine and manual group was 28.6 per cent, more than twice the rate in the professional and managerial group (12.9 per cent). This inequality is transmitted across generations: women in the lowest socio-economic group are most likely to smoke during pregnancy and young people in this group are most likely to take up smoking (Figure 3.5).

Figure 3.5 Smoking prevalence across the socio-economic spectrum in England: smoking throughout pregnancy (2010)³⁸, smoking among young people aged 16-19 (2006-2012)³⁹, and smoking in the adult population aged 18+ (2013)⁴⁰

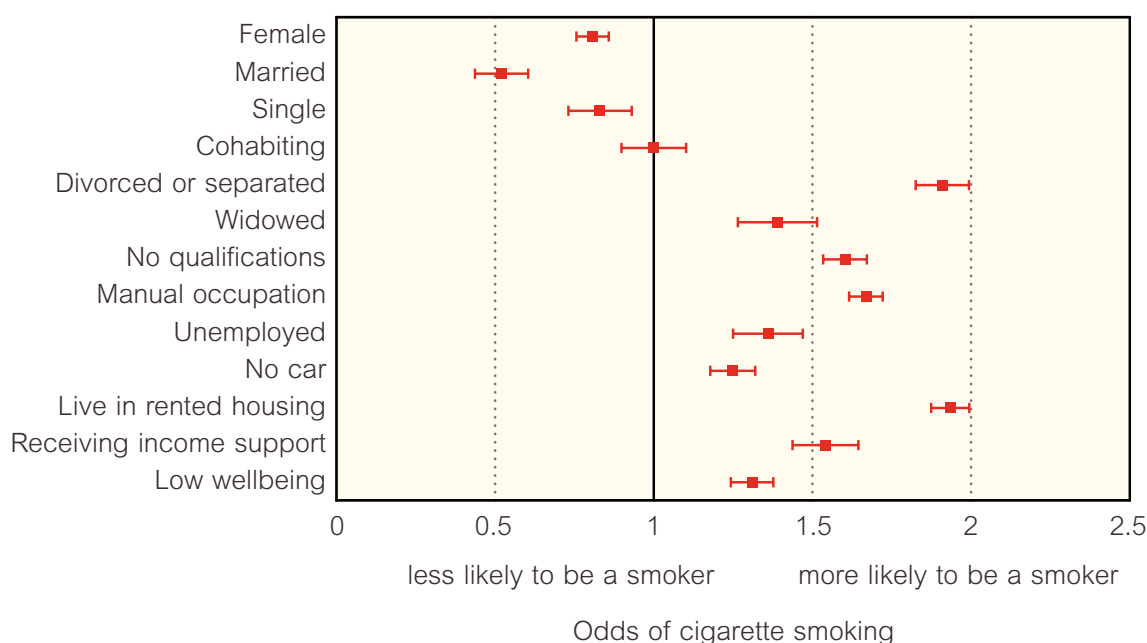


Differences in smoking prevalence can also be seen across many other indicators of disadvantage. Figure 3.6 describes the higher rates of smoking among people with manual occupations, people with no qualifications, people who are divorced or separated, people who are unemployed, people who live in rented housing, people who receive income support and people with low wellbeing. Every one of these factors is *independently* associated with higher rates of smoking.

Smoking rates are also high among people with mental health problems. People with longstanding anxiety, depression or another mental health condition are twice as likely to be smokers as those who do not have any mental health problems⁴¹. Rates of smoking increase with the severity of the disorder, ranging from 25 per cent among people with eating disorders to 56 per cent among those with probable psychosis⁴². Over the last 20 years, smoking prevalence has changed little in those with severe illness⁴³.

The highest rates of smoking are found among those who are most disadvantaged⁴⁴. People whose control over their daily lives is highly constrained and who do not have the resources and opportunities to thrive are most likely to be smokers and least likely to successfully quit. For example, in 2013, 73 per cent of the single homeless clients supported by St Mungo's in London smoked⁴⁵. Rates are even higher in prisons and across the criminal justice system: nationally, around 80 per cent of prisoners smoke⁴⁶.

Figure 3.6. Likelihood of being a smoker (odds of smoking adjusted for age and year of survey)⁴⁷



The higher prevalence of smoking in deprived groups is compounded by more frequent smoking and more intensive smoking in these groups. On average, smokers in lower socio-economic groups start smoking earlier in the day, smoke more cigarettes per day⁴⁸, and consume more nicotine per cigarette than the most affluent smokers⁴⁹. This helps to explain why they have less success in quitting than smokers in the professional and managerial group, despite being just as likely to try to quit (see Chapter 5).

In *Fair Society, Healthy Lives*, Michael Marmot's team urged public health professionals to target the whole social gradient, with proportionately greater emphasis on the lower end of this gradient⁵⁰. In practice, this means pursuing both universal and targeted policies and paying close attention to outcomes for those who are worse off. This approach should inform all the work of tobacco control. Every effort must be made to

ensure that interventions designed to further reduce smoking prevalence have a greater impact among smokers who are economically deprived or socially excluded. These smokers must not be left behind in the push to bring smoking prevalence down to single figures.

The work of tobacco control is necessarily focused on the ‘downstream’ behaviour of smoking. However tobacco control professionals know that they must understand and take full account of the socio-economic context of smokers’ lives if they are to facilitate changes in this behaviour. Furthermore, success in tobacco control is itself integral to the achievement of the six Marmot goals (Table 3.1). Tobacco control is therefore an essential component of wider public health strategies to reduce inequalities and improve opportunities for health and wellbeing for all.

Table 3.1: Contribution of Tobacco Control

<i>Marmot principle</i>	<i>Contribution of tobacco control</i>
Give every child the best start in life	The best start in life necessarily involves protection from secondhand smoke before birth and throughout childhood.
Enable all children, young people and adults to maximise their capabilities and have control over their lives	Addiction is a loss of control. Preventing smoking initiation gives individuals greater control of their health and wellbeing in everyday life.
Create fair employment and good work for all	Smokefree regulations have transformed workplaces, making them healthier and safer for everyone.
Ensure a healthy standard of living for all	Smokefree homes and workplaces are a prerequisite for a healthy standard of living. Reductions in household expenditure on tobacco improve household incomes and help to lift low-income households out of poverty. Every fall in smoking prevalence translates into a reduction in illness and disability in the population and a smaller caring burden for families.
Create and develop healthy and sustainable places and communities	Smokefree environments and public spaces are welcoming to all members of a community
Strengthen the role and impact of ill health prevention	Preventing people from starting smoking and helping them to quit remains the single most effective way of improving health outcomes for individuals.

3.4 Economic and social costs

The economic burden that smoking places on society is huge. Nationally, in England, the cost to society of smoking is conservatively estimated to be £13.8 billion per year⁵¹. This includes the direct health and social care costs of smoking-related illness, lost productivity, and the costs of smoking-related fires. These estimated costs are broken down as follows:

- The total annual cost to the NHS as a result of smoking-related illnesses: £2bn

- The additional cost to the NHS of illnesses among non-smokers due to exposure to secondhand smoke: £242m
- The cost to individuals and local authorities of meeting care needs arising from smoking-related illness: £1.1bn (£608m to local authorities and £451m to individuals to self-fund their care)
- Lost productivity due to smoking breaks: £6.5bn
- Lost productivity due to smoking-related early deaths: £3bn
- Lost productivity due to smoking-related sick days: £1bn
- The costs arising from smoking-related fires (there are more than 2,700 in England every year): £259m
- The cost of disposal of 32bn cigarette filters every year (5,494 tonnes): not quantified

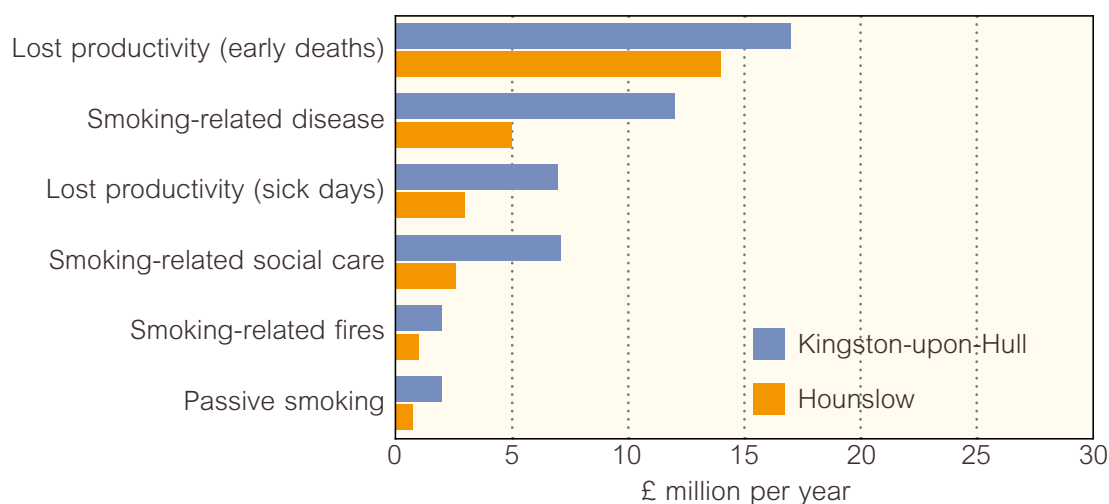
These costs are derived from a robust methodology and estimates are conservative⁵². Although the model has its limitations, the overall picture is unassailable: the cost of smoking to society in England is immense. In 2013/14, smokers in England paid approximately £9.5bn in excise duty to the Exchequer but the cost to society of smoking was roughly one and half times this.

Smoking imposes an economic burden on every community in England. Figure 3.7 illustrates the economic impact of smoking in two English local authorities: Kingston-upon-Hull and the London Borough of Hounslow. These local authorities have similar populations (257,589 and 262,407 respectively⁵³) but very different rates of smoking. In 2013, Hull had a smoking prevalence of 29.4 per cent, the highest in England, and Hounslow had a prevalence of 13.2 per cent, the fifth lowest in England⁵⁴.

The difference in smoking prevalence between the two local authorities translates into a comparable difference in the smoking-related health and social care costs in these areas. Annual NHS and social care costs due to smoking are estimated to be £19.1m in Hull and £7.6m in Hounslow. However the difference in productivity losses due to early death between the local authorities is less pronounced because Hounslow has a larger working population than Hull and so is more sensitive to the productivity impacts of smoking.

This comparison demonstrates both the value of driving down smoking prevalence locally and the universality of the problem in England. Even in areas of relatively low prevalence, the sheer number of people who smoke has profound consequences for local services and the local economy. From a local perspective, the duty smokers pay to the state can be seen as an additional burden: money spent on tobacco products does not stay in the local economy, except for the small profit made by retailers, and does not improve the wellbeing of anyone other than the shareholders of tobacco companies.

Figure 3.7. The local cost of smoking in Kingston-upon-Hull and London Borough of Hounslow, 2015



CHAPTER 4

THE POLLUTER SHOULD PAY

4.1 Investing to end the epidemic

Substantial and sustained investment is required to bring down smoking prevalence and reduce the human, social and economic costs of smoking. The US Surgeon General could not be clearer on the matter⁵⁵:

States that have made larger investments in comprehensive tobacco control programs have seen larger declines in cigarettes sales than the nation as a whole, and the prevalence of smoking among adults and youth has declined faster, as spending for tobacco control programs has increased.

Spending on tobacco control is an extremely good investment. In Britain, an inquiry by the All Party Parliamentary Group on Smoking and Health concluded that 'Government expenditure on tobacco control is excellent value for money and provides a net annual revenue benefit of £1.7 billion'⁵⁶. Yet the demonstrable cost-effectiveness of tobacco control interventions and Stop Smoking Services is not enough to guarantee them a secure future at a time of fiscal austerity and severe cuts in local government budgets.

This context demands ambition and innovation. If we are serious about ending the epidemic, we have to secure a comprehensive tobacco control programme at national, regional and local levels for the long term. There is a simple way to achieve this that is fair and reasonable regardless of the state of the public finances: making the polluter pay.

4.2 The Tobacco Companies Obligation

The engine of the smoking epidemic is the tobacco industry. This industry is legal but it is not benign. As well as keeping smokers supplied with an extraordinarily addictive product, tobacco companies actively seek to sustain or expand their markets by attracting new smokers. The industry also has a long and dishonourable history of obstructing and delaying advances in tobacco control^{57, 58, 59}. Every delay means more profits for the industry and more lives lost.

The profits made by the industry are huge. In 2009, the combined UK profit of the four companies with 94 per cent of UK market share – Imperial Tobacco, JTI (Gallagher), Philip Morris International and British American Tobacco – was more than £1 billion⁶⁰. Globally, tobacco sales have started to decline but the profits of the industry have not. The industry has been ingenious in manipulating prices, often under the cover of increases in tax, to ensure that profits rise faster than volumes fall^{61, 62}. For example, the global profits of Imperial Tobacco, which holds the biggest share of the UK market, have been rising year-on-year despite falling sales. In 2014, Imperial's global profits increased by 20 per cent to £1.5 billion, despite a 7 per cent decline in the overall volume of cigarettes sales⁶³.

The tobacco industry is in rude health, unlike many of those who consume its products. It is reasonable, therefore, to insist that the industry meets the costs of the damage it causes. If a company operating a chemical plant in the UK released toxins into the environment that harmed human health, the company would be fined. The polluter would pay. The same principle ought to apply to the tobacco industry, which is responsible for far more human suffering than the chemicals industry.

Tobacco smoke is a legal pollutant. But this does not exempt the polluter from paying the costs of the pollution it causes. There is already a major industry in the UK that pays to reduce the legal pollution caused by its everyday business: the energy industry. The Energy Companies Obligation (ECO) places a legal requirement on energy companies to invest in energy efficiency measures, especially for poor and vulnerable households. The principal component of the ECO, the Carbon Emissions Reduction Obligation, makes explicit the statutory obligation on the industry to reduce environmental pollution by reducing demand for its core product.

A Tobacco Companies Obligation would follow the same logic. The pollution and harm caused by smoking cannot be eliminated overnight by prohibition or technological innovation, just as carbon-intensive energy sources cannot be banned or, in the short-term, entirely substituted by renewable technologies. So, just as the considerable profits of the energy companies allow for investment in interventions to reduce demand for energy, it is right and proper for government to draw on the excessive profits of the tobacco industry to reduce demand for tobacco products.

Box 4.1. The American precedent

In the United States, the principle of charging the tobacco industry for the specific costs it imposes on the public purse is well-established. In 2009, the Family Smoking Prevention and Tobacco Control Act required tobacco companies to pay an annual 'user fee' to the Food and Drug Administration (FDA) to fund tobacco regulation. This levy is independent of the wider US fiscal regime and its proceeds are controlled directly by the FDA.

The value of the levy was based on a detailed calculation of the costs of tobacco regulation in the USA. This calculation was made prior to the legislation being laid down and subsequently incorporated within it. Furthermore, the legislation made clear that the funds raised could only be used for what they were intended for: the regulation of the tobacco industry.

The costs of the levy are apportioned to tobacco companies with a presence in the USA according to their market share in the country. These companies play no part in deciding how much money is raised or how it is spent, nor is there any scope for lobbying on these issues, thanks in part to the careful specification of the levy before its implementation.

The concept of the tobacco industry user fee received broad-based support within Congress because it was understood to be a charge related to a specific cost rather than an addition to general taxation.

Charging the tobacco industry for some of the specific costs it imposes on the state is not a new idea. In the USA, the Food and Drug Administration already levies such a charge (see Box 4.1) and the Tobacco Companies Obligation would be designed in a similar way. Its value would be based on a fair assessment of the annual costs, currently borne by the state, of tobacco control and Stop Smoking Services (a relatively modest cost when compared to the full economic cost of tobacco to the state). This cost would then be charged to tobacco companies every year according to their market share in the UK. A focus on sales rather than profits would mean that each tobacco company would pay its Obligation precisely in proportion to the damage it causes.

The Tobacco Companies Obligation should principally be used to help smokers quit and to discourage young people from starting to smoke. Its purpose is not to pay for the current healthcare costs of past smoking behaviour, but rather to drive down smoking prevalence, bring an end to the epidemic, and eliminate the long-term human and economic costs of smoking. A focus on reducing future harms ensures that companies in the market today will be paying for the harm they cause by selling tobacco today and not for harms caused by past polluters. Nonetheless, the Obligation would free up substantial resources that will be of great value to the wider NHS.

63% of adults in England support a policy of putting an additional 25 pence on a packet of cigarettes, with the money being used to help smokers quit and discourage young people from taking up smoking. 19% oppose the idea and 13% neither support nor oppose it. (YouGov, *Smokefree Britain Survey*, ASH, 2015)

The introduction of the Tobacco Companies Obligation could lead to an increase in the price of tobacco products to smokers if the industry chose to pass on the cost to its consumers. Although there is public support for a policy of increasing the cost of tobacco to raise money to help smokers quit and discourage youth smoking (see box), the cost of the Obligation ought to be borne by the industry and its shareholders, not by individual smokers. This would be consistent with the principle that the polluter should pay.

Recommendation

- Introduce a new annual levy on tobacco companies, the Tobacco Companies Obligation, to help fund evidence-based tobacco control and Stop Smoking Services in England.
- Seek a revision of the EU Tobacco Tax Directive to prevent the tobacco industry from passing on the costs of the Tobacco Companies Obligation to smokers.

4.3 The operation of the Tobacco Companies Obligation

The Tobacco Companies Obligation will be a major innovation for public health. It will therefore be essential to ensure that it is administered, distributed and spent in a manner that meets the highest standards of transparency. This should not, however, be at the cost of a new burden of administration.

The particular form that the administration of the Obligation takes will be a matter for discussion and consultation in each of the nations making up the United Kingdom. The following is an initial template for such discussions in England:

1. Funds raised by the Obligation should be spent against an approved tobacco control plan or strategy.
2. National oversight should be the responsibility of the Department of Health, which should directly receive the monies raised by the Obligation. The Department should be supported by an advisory group to include healthcare professionals, academics with expertise in tobacco control, Public Health England, local government representatives and relevant third sector organisations.
3. Local and regional allocations should be apportioned according to the volume of local tobacco sales in order that areas with larger populations of smokers receive higher allocations. A consistent procedure for estimating levels of local illicit trade should also be applied.
4. An assessment of the overall cost of the Obligation will be required at the outset, based on a review of the costs of local, regional and national tobacco control plans. Once established,

the Obligation should increase with inflation every year and be fully reviewed every four years, taking account of changes in the epidemic and the needs of smokers.

5. To ensure independence from the general fiscal process, as in the United States, the core algorithm for calculating the levy should form part of the primary legislation.
6. In accordance with Article 5.3 of the WHO Framework Convention on Tobacco Control and its Guidelines, the tobacco industry should be entirely excluded from the process of determining how the funds should be spent. The industry should also be prohibited from using the Obligation to demonstrate corporate social responsibility.

The scope of what the money is spent on will also be a matter for consultation. The focus should be on evidence-based interventions that contribute to reducing smoking prevalence. Box 4.2 maps out the core activities of tobacco control at national, regional and local levels that would be funded through the Tobacco Companies Obligation. The work of HMRC in tackling the illicit tobacco market is not included in Box 4.2 because investment in this area is a highly cost-effective revenue protection measure with a direct benefit to HM Treasury and a historic return on investment of 10 to 1.⁶⁴ In addition to the activities described in Box 4.2 there is potential for a specific funding stream that supports and evaluates innovative local and regional tobacco control projects.

Currently tobacco companies' data on sales are not available to government and the public health community. As well as being a prerequisite for the fair dispersal of the funds raised through the Tobacco Companies Obligation, these local data would be invaluable in profiling tobacco use in local communities, describing inequalities, targeting stop smoking services and gaining greater control and oversight of the tobacco supply chain. To this wider purpose, tobacco companies should be required to make public not only their sales data but also their marketing and pricing strategies.

77% of adults in England, including 65% of smokers, agree that tobacco companies should be required to disclose the amount they spend on lobbying politicians, front groups and promoting their products. Only 4% disagree, including 6% of smokers.

(YouGov, *Smokefree Britain Survey*, ASH, 2015)

Recommendations

- Establish a clear mechanism for the calculation of the Tobacco Companies Obligation, based on the costs of evidence-based tobacco control interventions at national, regional and local levels. Apply the levy in proportion to companies' market share in order that monies raised from each company are commensurate with harm caused.

Box 4.2. Core tobacco control activities to be funded via the Tobacco Companies Obligation

National

- National tobacco control team
- Mass media campaigns
- Industry monitoring
- Enhanced national statistics
- National Centre for Smoking Cessation and Training
- Policy evaluation and research

Regional

- Regional offices of tobacco control
- Mass media campaigns
- Programmes to tackle illicit sales
- Stop smoking services in secondary care (funded through CCGs)
- Commissioning support

Local

- Local authority tobacco control teams
- Stop smoking services
- Enforcement of existing legislation on illicit tobacco, smokefree environments, age of sale, tobacco displays, and plain packaging.
- Licencing of retailers and the costs of enforcement
- Tobacco control alliances

- Establish a transparent and accountable process for administering the Tobacco Companies Obligation.
- Require tobacco companies to make public their sales data, marketing strategies and lobbying activity.
- In accordance with Article 5.3 of the WHO Framework Convention on Tobacco Control and its Guidelines:
 - Ensure the tobacco industry is excluded from public health policy-making at all levels of government
 - Prohibit tobacco companies, and their subsidiaries and agents, from using advertising or 'corporate social responsibility' communications to promote their interests and influence public policy.
- Encourage all local authorities to act in accordance with Article 5.3 of the WHO Framework Convention on Tobacco Control and its Guidelines.

ENDING THE EPIDEMIC 1: HELP SMOKERS QUIT

5.1 Smokers are partners in the solution

If you are an adult who smokes, the benefits of quitting are far-reaching. Your health improves and your life expectancy dramatically increases; you no longer put others at risk by exposing them to secondhand smoke; and you contribute to the denormalisation of smoking by ceasing to be an unwitting advocate for smoking among your friends and family, especially your children. Helping people quit smoking is central to the work of tobacco control because every successful quit has so many positive outcomes.

Smokers are therefore key partners in the journey towards a smokefree future. Although it is right for government to raise the price of tobacco products to deter people from smoking and to exclude smokers from places where secondhand smoke may harm others, such measures must go hand-in-hand with a commitment to meet the needs of smokers, above all to help them stop smoking in whatever way works for them.

The denormalisation of smoking has been crucial to changing attitudes and behaviour across society but the outcome of this process must not be the stigmatisation of smokers. Stigma is unfair and counterproductive, not least because it risks alienating smokers from the services that can support them to quit.

5.2 Stop Smoking Services

Stop Smoking Services are key to the long-term effort to end the smoking epidemic in England because they offer smokers their best chance of quitting⁶⁵. There is clear evidence that the combination of personal support and treatment offered by these services is the most effective way for smokers to successfully quit and remain smokefree⁶⁶.

Specialist services have a particularly important role to play in tackling the inequalities that define the smoking epidemic. For whereas smokers in lower socio-economic groups are just as likely as more affluent smokers to try to quit, they are less likely to succeed⁶⁷. Poorer smokers find it harder to quit than more affluent smokers in part because their levels of addiction are greater. Consequently they typically need more intensive support to succeed. Stop Smoking Services are best placed to provide this treatment and support.

Since their inception Stop Smoking Services have sought to attract low income smokers and in 2013/14 138,733 smokers with routine and manual occupations set quit dates through these services⁶⁸. This was, however, 30 per cent fewer than in 2011/12, consistent with a 28 per cent decline in total service uptake over these two years. The reasons for this decline are not yet clear though they may include a loss of signposting in mass media campaigns, the disruption caused by the reorganisation of public health and the wider use of electronic cigarettes. In this changing context, Stop Smoking Services must renew their efforts to reach all smokers, especially those from lower socio-economic and disadvantaged groups

The new home of Stop Smoking Services within upper tier local authorities potentially presents new opportunities for providers to develop a model of service provision that combines high quality standards with greater flexibility and a stronger community focus. However, these services are also vulnerable to the unprecedented cost pressures currently experienced by local government. In 2014, Stop Smoking Services suffered in some areas despite the public health budget ring-fence: 13 per cent of tobacco control leads reported a decline in their budgets for Stop Smoking Services following the transition from the NHS⁶⁹.

The cost-effectiveness of Stop Smoking Services ought to make them unassailable yet the direct costs that are avoided when a smoker quits are primarily long-term NHS costs rather than local authority costs. With the loss of Department of Health oversight of Stop Smoking Services, there is a real risk of decline in areas where political support for tobacco control is not forthcoming. It is vital that Stop Smoking Services remain central to national policy, with their long-term funding secured through the Tobacco Companies Obligation.

Recommendations

- Ensure that good quality evidence-based Stop Smoking Services are accessible to all smokers, particularly those from lower socio-economic groups and disadvantaged populations.
- Ensure that all mass media campaigns signpost and promote local Stop Smoking Services.

5.3 Exploiting every opportunity to help smokers quit

Although Stop Smoking Services lie at the heart of the national effort to help smokers quit, many smokers have never got anywhere near them. Currently only around one in 20 quit attempts by smokers involve the use of specialist services. Greater innovation by these services in reaching local smokers must be complemented by a more holistic view of the opportunities to quit within smokers' everyday lives.

Many smokers engage with health and social services for reasons other than their smoking behaviour. For these individuals, such encounters can be golden opportunities to take a step towards quitting if the professionals they meet use them as such. Unfortunately, although the principle of 'making every contact count' is widely understood by health professionals, it is less widely practised. Universal adherence by healthcare professionals to the NICE guidance on brief interventions and referral for smoking cessation⁷⁰ would transform the engagement between smokers and the services that exist to help them quit.

NICE has also drawn attention to the importance of providing stop smoking support during and after pregnancy⁷¹ and in acute, maternity and mental health services⁷². Greater adherence to these guidelines would help to reduce inequalities in smoking, given the significant socio-economic variation in smoking prevalence among pregnant women and the high prevalence among mental health service users and people with long-term conditions. Midwives have a key role to play in reducing smoking prevalence among pregnant women but this role is yet to be universally valued and properly resourced.

In order to achieve a long-term shift in practice, training in smoking cessation needs to be included within education programmes for all healthcare professionals. Current educational practice is extremely patchy. For example, only around half (54 per cent) of medical schools include information on the role of Stop Smoking Services in their curricula and training on very brief interventions is far from universal – only two thirds (68 per cent) of medical schools report providing this⁷³.

The highest smoking prevalence is among young adults, the age group that is least likely to use health services. Many of these smokers think of themselves as healthy and in no need of professional help. Consequently they are unlikely to encounter any offer of support to quit in their daily lives and may be unaware that specialist Stop Smoking Services exist. A study of manual workers on building sites in London found that smokers were aware of the negative consequences of smoking for their health, and many wanted to quit, but few were aware of the services or aids available⁷⁴. The simplest way to increase the offer to these smokers in the course of their everyday lives is to position alternative nicotine products alongside the toxic products they currently buy.

Recommendations

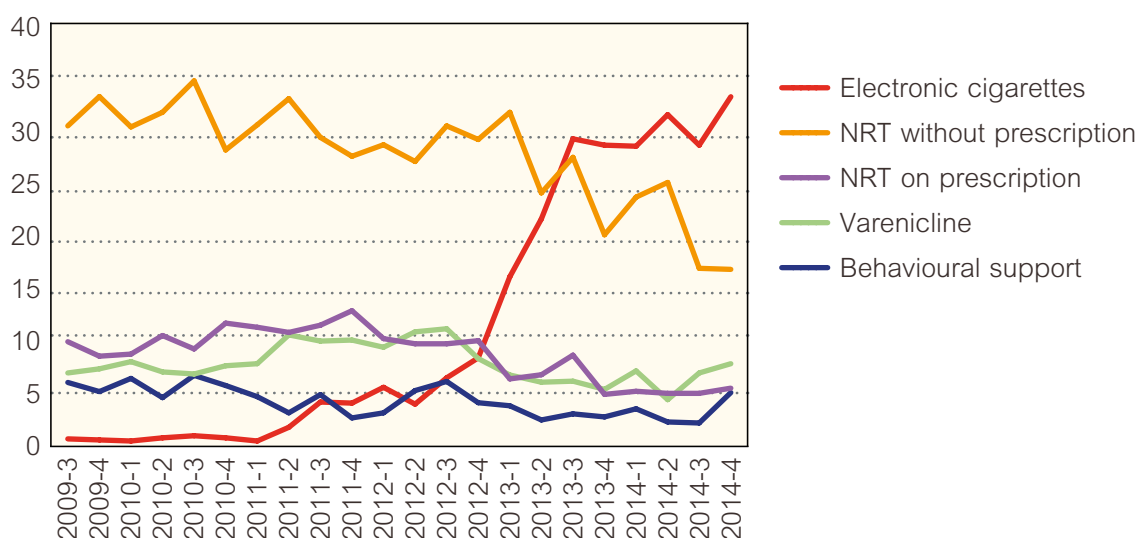
- Promote universal adherence to NICE guidance on tobacco, especially:
 - Brief interventions and referral for smoking cessation
 - Smoking cessation in secondary care: acute, maternity and mental health services
 - Quitting smoking in pregnancy and following childbirth
- Ensure that midwives have the training, equipment and time to undertake carbon monoxide screening with every pregnant woman.
- Ensure that smokers with mental health problems and smokers with long term conditions receive stop smoking interventions as a routine part of their care.
- Include training on providing very brief advice on smoking cessation within the core curricula of all education programmes for healthcare professionals.

5.4 Alternative nicotine products

In the last five years the market for non-tobacco nicotine-containing products has diversified and expanded. The range of products licensed for nicotine replacement therapy (NRT) now includes oral and nasal sprays as well as gum, patches and lozenges. At the same time, the unlicensed market for electronic cigarettes has grown rapidly with many different products being promoted and sold through ordinary retailers. This has raised concerns that the use of electronic cigarettes could lead to the ‘renormalisation’ of smoking and provide a gateway to smoking for young people. Yet so far there is little evidence that this is happening. The use of electronic cigarettes by people who have never smoked has been, and remains, negligible⁷⁵.

If electronic cigarettes are a gateway, they currently appear to be a gateway out of smoking. Smokers’ use of electronic cigarettes in their attempts to quit rocketed from fewer than one percent of quit attempts in 2009 to one in three (33 percent) quit attempts at the end of 2014. They are now the single most popular aid to quitting used by smokers (Figure 5.1) and the increase in their use has been accompanied by a rise in the overall rate of successful quits⁷⁶. The promotion and sale of electronic cigarettes in many ordinary retail settings has offered smokers a comparatively safe alternative to tobacco at the point of sale.

Figure 5.1 Aids used by smokers in quit attempts 2009-2014⁷⁷



Nonetheless, risks remain. The market for electronic cigarettes is young and the increasing control that the tobacco industry holds over this market could lead to adverse outcomes if tobacco companies manipulate the market to the advantage of their principal source of income: tobacco products. The challenge for government is to maximise the opportunities presented by nicotine products while also minimising the risks. This will necessarily involve paying close attention to the impact of this expanding market and ensuring that the nascent regulatory framework, defined principally by the EU Tobacco Products Directive 2014 (see Box 5.1), is sufficient to prevent adverse outcomes without stifling innovation. In-depth surveillance and monitoring are needed to ensure that the market for electronic cigarettes, and those who control it, does not undermine the long-standing achievements of tobacco control.

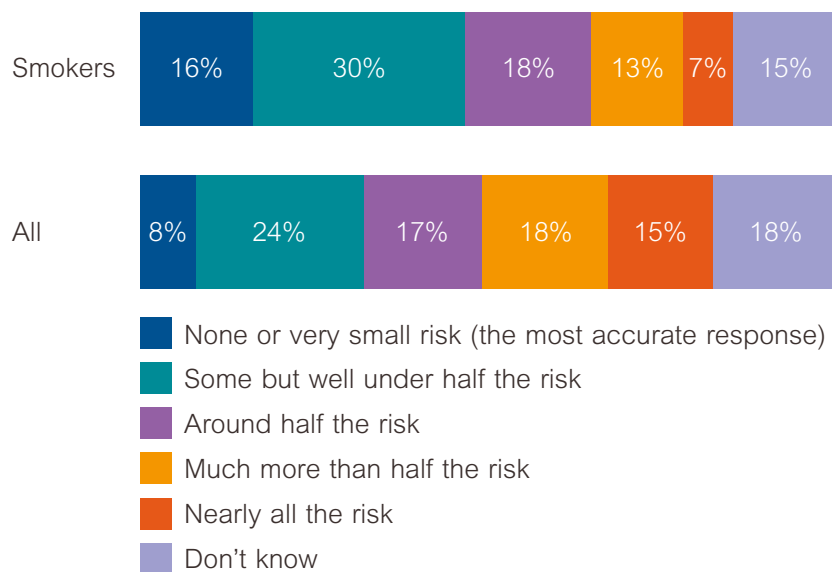
Box 5.1. The EU Tobacco Products Directive and electronic cigarettes

The Directive, due for implementation in 2016, applies to products which contain less than 20 mg/ml of nicotine and are not licensed as medicines. In the UK, the implementation of the Directive will include the following:

- New product safety and quality standards
- Child-proof packaging
- Health warnings and details of addictiveness and toxicity on packaging
- Prohibition of promotional elements on packaging
- Prohibition of cross-border advertising such as print, internet and broadcast advertising
- Annual company reporting of sales volumes, types of users and their preferences and trends.

Products which contain 20mg/ml of nicotine or more must be licensed and regulated as medicines in the UK

There is, however, an additional risk that the uncertainty and controversy created by this expanding market will increase public misunderstanding of the risks of nicotine. Currently, most adult smokers in England mistakenly think that nicotine is a significant contributor to the health risks of smoking (Figure 5.2). In addition to mass media campaigns on this issue (see section 6.3), health professionals have a duty to inform smokers about the relative risks of tobacco products and alternative nicotine-containing products. If they fail to do this, smokers may continue to smoke because they do not fully appreciate the benefit of switching to alternative nicotine products. This would be a disaster for them and for public health.

Figure 5.2 Public perceptions of the contribution of nicotine to the health risk of smoking^{78, 79}

Recommendations

- Ensure that Stop Smoking Services and all health professionals are equipped to provide accurate, high quality information and advice to smokers about the relative risks of nicotine and all nicotine-containing products.
- Increase the support and information available to smokers who are unable to quit to switch to less harmful sources of nicotine, in line with the principles set out in the NICE guidance on tobacco harm reduction.
- Regulate the market for electronic cigarettes and other non-tobacco nicotine-inhaling products to maximise their value to smokers and minimise the risk of uptake by non-smokers.
- Promote improvements in the quality, safety and efficacy of electronic cigarettes and other non-tobacco nicotine-inhaling products.
- Closely monitor the impact of the market for electronic cigarettes and other non-tobacco nicotine-inhaling products on smoking behaviour, smoking uptake and public attitudes to smoking.

ENDING THE EPIDEMIC 2: DISCOURAGE AND DENORMALISE SMOKING

6.1 The affordability of tobacco

Smokers are no different to other consumers when spending money: price dominates their decision-making. Consequently, increasing the price of tobacco through taxation remains the single most effective way of reducing smoking prevalence⁸⁰. As poor smokers are more sensitive to price increases than wealthier smokers, this core fiscal intervention can also help to reduce inequalities in smoking prevalence⁸¹. However, poor smokers who do not quit in response to price rises are disproportionately disadvantaged by them, so this policy must be pursued in parallel with investment in targeted Stop Smoking Services.

There are various ways in which the effectiveness of price rises can be undermined. Firstly, if the retail price of tobacco products does not rise faster than incomes and the cost of other consumer products, the affordability of tobacco will not be affected. Tobacco will only be perceived by consumers to be an increasingly expensive choice if, over time, its price rises markedly relative to other everyday purchases. The current annual tobacco duty escalator of 2 per cent above inflation barely achieves this. Given the power of price on smoking behaviour, there is a strong case for this escalator to be increased to 5 per cent above inflation. This would ensure that changes in the price of tobacco products are distinct from the rising prices of other retail products, such that cigarettes are increasingly perceived to be an unaffordable personal cost.

Secondly, if smokers respond to price rises by switching to cheaper products, the effect of the price rise is lost. This is most obvious when smokers switch from cigarettes to hand-rolled tobacco. Over the last fifteen years, as prices have risen, there has been a steady increase in the market share of hand-rolled tobacco with around one third of smokers now rolling their own⁸². Although hand-rolled tobacco is by its nature a cheaper product than manufactured cigarettes, this switching is incentivised by the tax differential between the two products, as hand-rolled tobacco attracts a lower rate of duty. The removal of this tax differential would eliminate the incentive.

Smokers also 'downtrade' by switching from premium cigarette brands to cheaper brands. When the duty on cigarettes rises, tobacco companies tend to load the price rises on their premium brands, increasing prices by more than the rise in duty, while limiting price rises for their cheaper brands, especially their ultra-low price cigarettes⁸³. The result is a growing price differential and an increasing incentive for smokers to downtrade to cheaper brands, with young smokers and smokers in lower socio-economic groups especially likely to buy the cheapest brands⁸⁴. The most effective way of overcoming this problem would be to establish a minimum unit price for all cigarette sales, aligned to a minimum excise tax. This would ensure that any rise in the tax on cigarettes is passed on to the consumer, regardless of the brand purchased.

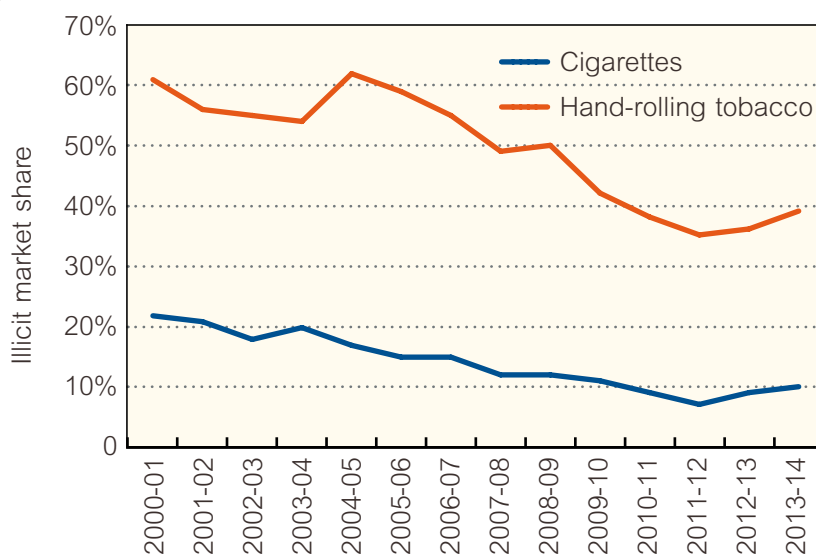
Thirdly, smokers who have access to illicit tobacco products can circumvent the fiscal regime altogether. In 2013/14 an estimated 10 per cent of the cigarettes consumed in the UK, and 39 per cent of the hand rolling tobacco, were smuggled or counterfeit⁸⁵. The tobacco industry is quick to claim that this market is driven

In England, 53% of adults agree with a policy of using tax to increase the price of tobacco products 5% faster than inflation every year while 20% disagree.

(YouGov, *Smokefree Britain Survey*, ASH, 2014)

by increases in duty or other tobacco control interventions, such as standardised packaging, yet there is no evidence to support these claims. In fact, as the price of legal tobacco products has risen, the illicit market share has gone down: in 2000, 21 per cent of cigarettes and 61 per cent of hand-rolling tobacco were illicit⁸⁶ (Figure 6.1). This is because the size of the market is determined principally by the extent of investment in enforcement: low income countries where cigarettes are cheap but enforcement is poor have much larger illicit markets than high income countries such as the UK where cigarettes are expensive but enforcement is substantial⁸⁷.

Figure 6.1 Market share of illicit cigarettes and hand-rolling tobacco in the UK, 2000-2014 (HMRC midpoint estimates)



In recent years the National Audit Office⁸⁸ and the House of Commons Public Accounts Committee⁸⁹ have recognised HMRC's success in reducing the size of the illicit market since 2000. However they both concluded that the measures introduced following the 2010 spending review were not effective in achieving revenue targets and that the promised levels of investment in tackling the illicit market were not delivered. In particular, the Public Accounts Committee suggested that the number of UK prosecutions for tobacco smuggling and organised crime were not commensurate with the £1.9 billion annual cost to the taxpayer of tobacco fraud, and criticised HMRC for not taking a tougher stance against the tobacco industry, which has been complicit in sustaining the illicit market by over-supplying tobacco products to European countries with weaker fiscal regimes.⁹⁰

In March 2015 a new government strategy was launched, *Tackling illicit tobacco: from leaf to light*⁹¹. This strategy includes a commitment to setting up a cross-ministerial group on smuggling, and pledges support for EU ratification of the WHO Illicit Trade Protocol, which requires the creation of an international tracking and tracing regime for tobacco products. The strategy also seeks the involvement of key agencies at local, regional, national and international levels, including civil society organisations. However, the strategy fails to acknowledge the role played by the tobacco manufacturers in sustaining the illicit market, and the targets set for reducing the illicit market are weak: holding the illicit market share for cigarettes at or below 10 per cent and reversing the upward trend in illicit hand-rolled tobacco.

As public spending on tackling illicit tobacco shows a return on investment of about ten to one⁹², there is every reason to pursue a more ambitious course, investing for a future in which illicit cigarettes and hand-rolled tobacco are scarce in all communities in England.

Recommendations

- Increase the tax escalator on tobacco products to 5 per cent above the level of inflation.
- Remove the tax differential between manufactured and hand-rolled cigarettes.
- Adjust the current national tax regime to raise the price of the cheapest cigarettes and prevent down-trading, and seek a revision of the EU Tobacco Tax Directive to enable the creation of a minimum unit price for all tobacco products.
- Fully implement the WHO Illicit Trade Protocol including an international tracking and tracing regime for tobacco products.
- Strengthen and resource national, regional and local partnerships to enable co-ordinated action on illicit trade.
- Set new targets for the control of tobacco smuggling:
 - Reduce the illicit market share for cigarettes to no more than 5% by 2020
 - Reduce the illicit market share for hand-rolled tobacco to no more than 22% by 2020 and no more than 11% by 2025.

6.2 The responsible sale of tobacco

Despite being a lethal drug, tobacco products can be sold by anyone in England, almost anywhere. A licence is not required. The sale of tobacco used to require a licence. Signs above many pubs and shops from this period still state that they are 'licensed to sell alcohol and tobacco'.

Local authorities in England have powers to shut down a tobacco retailer if necessary. This is known as 'negative licensing'. However this requires the local authority to take legal action against the retailer, which is time-consuming and resource-intensive. In 2013/14, there were only 34 convictions in England for selling tobacco products to young people, and no restricted premises or sales orders⁹³, yet 44 per cent of young people who smoked said they obtained tobacco from shops⁹⁴. The entire legal market for tobacco products, which in the UK is worth £9.5 billion a year in tax receipts alone⁹⁵, is subject to the lightest of touch controls.

The reintroduction of a positive licensing scheme would enable government and local authorities to promote higher standards in the retail market and clamp down further on illicit sales. Currently, local authorities only engage with tobacco retailers through the enforcement actions of trading standards officers. A positive licensing scheme would enable local authorities to build more proactive relationships with retailers, raising awareness of the law and promoting good practice. It would also make it much easier for local authorities to stop retailers from selling tobacco if they find evidence of underage or illicit sales on the premises.

A positive licensing scheme for tobacco retailers should form part of a wider programme of licensing across the supply chain, in line with the WHO Illicit Trade Protocol, which recommends licensing as a best practice measure. This would make it easier to determine the legality of tobacco as products sold by unlicensed premises would automatically be illegal. This would benefit licensed suppliers and enable better enforcement.

There is extensive public support for a new tobacco licensing scheme: 84% of adults in England, including 71% of smokers, agree that businesses should have a valid licence to sell tobacco which can be removed if they are caught more than once selling to underage smokers. Only 5% oppose the idea. (YouGov, *Smokefree Britain Survey*, ASH, 2014)

The licensing of tobacco retailers should not increase the financial burden on local authorities, especially at a time when trading standards departments are suffering severe cuts. The full costs of enforcing the scheme should be met by the tobacco industry, through the mechanism of the Tobacco Companies Obligation, as described in Chapter 4.

Recommendations

- Introduce a positive licensing scheme for all tobacco retailers and wholesalers, to be paid for by the tobacco industry.
- Develop best practice guidelines for using the licensing scheme to enforce the law on the sale of tobacco, communicate with retailers and control the tobacco supply chain.

6.3 Mass media and social marketing

Public communication and social marketing have long been an integral part of national and regional tobacco control programmes in England. Mass media campaigns remain at the heart of these programmes as they are known to be effective in educating the public about the harms of smoking, changing attitudes and beliefs, increasing quit attempts, and reducing adult smoking prevalence⁹⁶. In England, 13 per cent of the decline in smoking prevalence between 2002 and 2009 is attributable to mass media campaigns⁹⁷.

The effectiveness of mass media campaigns depends not only on their reach but also on their intensity and duration: they should be sustained across the year to ensure that their effects do not decay and smokers receive regular motivational prompts⁹⁶. A government freeze on mass media campaigns in April 2010 led to dramatic falls in quitting-related activity. For example, calls to the national Quitline fell by 65 per cent⁹⁸.

Today, the use of mass media is often complemented by other methods of public engagement including social media and direct one-to-one messaging, for example through SMS. Campaigns which exploit multiple media, and use earned as well as bought media, have been shown to be effective (see Box 6.1). In general, campaigns that focus on the negative health consequences of smoking tend to be the most effective in motivating quit attempts⁹⁶, though recent evidence from the UK suggests that positive emotional content can have similar impacts⁹⁹. However the content of campaigns should always be attuned to the changing expectations and opportunities of smokers. In particular, public confusion about the health impacts of alternative nicotine products needs to be addressed as there is evidence that many smokers incorrectly perceive nicotine to present a substantial risk to health (see Figure 5.2).

Most smokers who are motivated to quit after viewing a television campaign will try to do so without any support. Yet they are far more likely to succeed if they seek help from local Stop Smoking Services. As many smokers are not aware of these services, mass media campaigns should always signpost specialist services and promote their benefits to smokers.

Box 6.1. Example of effective mass media campaign

The Don't Be the One campaign run by FRESH Smoke Free Northeast in 2014 combined television and radio advertisements, a website, online advertising via Facebook, a campaign toolkit and editorial coverage in the regional press. Two thirds of the smokers in the area saw the campaign, of whom 57 per cent said it made them more likely to quit.

Recommendations

- Target mass media and social marketing campaigns on lower socio-economic groups and disadvantaged populations, and provide adequate resources to ensure that their reach, duration and frequency are in line with best practice.
- Ensure that all mass media campaigns signpost and promote local Stop Smoking Services.

6.4 Smokefree environments

The introduction of smokefree legislation in 2007 has been a great success and will be remembered as a major advance for public health in England in the twenty-first century. There is clear evidence of immediate improvements in population health including reductions in hospital admissions due to heart attacks¹⁰⁰ and asthma¹⁰¹. Compliance with the legislation has been high and public support has increased from 72 per cent of adults in 2007¹⁰² to 82 per cent in 2014¹⁰³. Crucially, there is now majority support for smokefree legislation even among smokers (54 per cent).

The creation of smokefree environments has sensitised the public to the presence of tobacco smoke and made people newly aware of the importance of clean air to their health and wellbeing. As a result, contrary to the expectations of the critics of the legislation, there has been a rise in the number of households inhabited by smokers that are now voluntarily smokefree¹⁰⁴. This trend is vitally important to the long-term goal of ending the epidemic as it is principally within homes that children are exposed to secondhand smoke and learn to become smokers themselves.

Given the extent of public support, there is now scope to close the exemptions within the 2007 legislation and consider extending smokefree environment further:

- Firstly, all prisons should be smokefree. Given the range of alternative nicotine products now available, including electronic cigarettes, the exposure of prisoners and prison staff to secondhand smoke is no longer acceptable. Prisoners who want to quit smoking should be supported to do so both during their time in prison and at the time of their release.
- Secondly, the exemption for theatrical performance should be removed. Theatre audiences should not have to suffer exposure to secondhand smoke when the creation of a persuasive performance can easily be achieved without actors being required to smoke.
- Thirdly, smokefree legislation ought to cover all merchant shipping including shipping leaving UK ports. Merchant ships can be extremely confined workplaces where workers may be exposed to high levels of secondhand smoke.
- Fourthly, the ban on smoking in cars carrying children provides a platform for considering a wider ban on smoking in all motor vehicles. This is justifiable on road safety grounds alone: the distraction caused by finding, lighting, smoking and disposing of cigarettes and other smoking materials is known to contribute to road accidents ¹⁰⁵. A universal ban would also enable effective enforcement of existing legislation ¹⁰⁶, which is currently compromised as children are not always visible in vehicles. Adults with cardiovascular disease – drivers and passengers alike – would also be protected from the risk of tobacco smoke triggering a heart attack ¹⁰⁷.

49% of adults in England agree with a policy to ban smoking in prisons and 24% disagree.
(YouGov, *Smokefree Britain Survey*, ASH, 2015)

59% of adults in England agree with a complete ban on smoking in cars while 25% disagree.
(YouGov, *Smokefree Britain Survey*, ASH, 2014)

National legislation to extend smokefree environments should be complemented by actions at local level by the NHS and local authorities. The NHS ought to be an exemplar of smokefree policy yet there are still hospitals where smoking is permitted within their grounds. The 2013 NICE guidance on smoking cessation in secondary care recommended 'strong leadership and management to ensure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smokefree – to help to promote non-smoking as the norm for people using these services'. This recommendation needs to be fully implemented.

Local authorities have extensive opportunities to improve the local environment by promoting smokefree public spaces. These include places where secondhand smoke is a nuisance to other people, such as doorways and open-air venues, and places designated principally for children and young people, where smoking by adults is likely to be perceived by children as normative. Many local authorities have already acted on these concerns by introducing voluntary smokefree places in children's play areas and by making key parts of pedestrianised town centres smokefree. Bristol City Council is currently trialling smokefree city squares and the London Health Commission has called on the Mayor of London, local councils in London, and the City of London Corporation to make parks and some open spaces in the city smokefree, starting with Trafalgar Square and Parliament Square ¹⁰⁸. Given the extent of innovation, there is scope to conduct a national consultation on how best to universalise these measures.



Regional tobacco office Smokefree South West has been working with local councils to introduce a voluntary smokefree code in environments where children play and learn. A toolkit and tested signage have been developed. Many local places have adopted the voluntary code, such as Apex Park in Sedgemoor Somerset.

Recommendations

- Increase the proportion of homes occupied by adult smokers and dependent children that are smokefree to 80% by 2020 and 90% by 2025.
- Remove the smokefree exemption for prisons and provide support to prisoners to remain tobacco-free when they return to the community.
- Remove the smokefree exemption for theatrical performances.
- Extend smokefree regulations to cover sea-going shipping and inland waterway vessels.
- Review the evidence and consult on the prohibition of smoking in all cars and motor vehicles.
- Ensure universal compliance with NICE guidance on a smokefree NHS and promote a smokefree estate including primary care, secondary care, maternity services and mental health services.
- Consult on legislative and non-legislative options to make outdoor environments smokefree where there is good evidence that this would improve public health.

6.5 The portrayal of smoking in films and other media

The rapid decline of smoking prevalence among children and young people suggests that the 'denormalisation' of smoking over the last twenty years, including the removal of all images of smoking from advertising, is having a cohort effect. Young people are no longer growing up in a society where smoking is presented, or accepted, as a norm. Yet in one area of their common experience, smoking remains prominent and normative: film.

There is strong evidence from across the world that the representation of smoking in films contributes to smoking uptake among young people^{109, 110, 111}. This evidence includes a clear dose-response relationship: the more exposure young people have to smoking on screen, the more likely they are to smoke. The effect is far from marginal. For example, researchers at the University of Bristol found that 15-year-olds who saw the most films showing smoking were 73 per cent more likely to have tried a cigarette than those exposed to the least films showing smoking¹¹². The characterisation of smokers on screen is irrelevant: glamorous and dissolute smoking stars leave similar impressions on young people.

Smoking is mentioned – once – in the guidelines used by the British Board of Film Classification¹¹³ but there is little evidence that the issue is taken seriously in the Board's decisions. A study of the 15 highest grossing films in the UK box office in every year between 1989 and 2008 found that 56 per cent of the films in which people smoked were classified as suitable for children aged under 15 and 92 per cent were suitable for young people aged under 18¹¹⁴.

Currently, public awareness of the impact of smoking in films on the behaviour of young people is low and consequently there is resistance to excluding young people from viewing films in which people smoke. However there are other ways to address the problem which potentially have wider impacts. In particular, there is scope to screen short anti-smoking films before films which portray smoking and are classified as being suitable for young people to view. This would simultaneously mitigate the effect of the on-screen smoking on the behaviour of the young people who watch the films¹¹⁵ and, potentially, make film producers think twice about whether it is worth including smoking in their work in the first place.

The idea of screening short anti-smoking advertisements before films that include images of smoking is supported by 40% of adults in England and opposed by 34%, leaving 23% who neither support nor oppose the idea and 3% who do not know.

(YouGov, *Smokefree Britain Survey*, ASH, 2014)

The portrayal of smoking on television has declined markedly, in part because the current Ofcom guidelines have been more effective than the BBFC's in shaping editorial decisions. Most smoking on television is now in films broadcast on television, so changing the practice of film-makers is important for this medium too. However the representation of smoking in music videos is a cause for concern. There is less evidence available of the impact on young people of exposure to smoking in music videos but it is likely that their effects are significant: one recent study identified tobacco imagery in 22 per cent of the Youtube music videos watched by adolescents in Great Britain¹¹⁶. In order to develop effective policy measures in this area, we need a better understanding of where young people are exposed to images of smoking and how this exposure can be reduced or mitigated.

Recommendations

- Require short anti-smoking films to be shown before films and programmes that portray smoking and can be seen by children and young people, including those viewed in cinemas, on TV and on pay-to-view internet
- Raise awareness among policy-makers of the harm to children and young people of smoking in films, and consult on options to reduce their exposure to images of smoking in films and other media including the internet, music videos and computer games.

CONCLUSION

Some of the recommendations in this report, such as those relating to smuggling, taxation and product regulation, concern government policies that affect the whole of the United Kingdom. As government responsibility for health is devolved, however, and each of the devolved nations has its own strategy and targets to tackle smoking, the recommendations on health policy are principally addressed to government and stakeholders in England. These recommendations are consistent with strategy in the other nations of the United Kingdom but are designed to offer a clear agenda for action in England.

Although it is up to government to take a lead and set a new course for tobacco control over the next five years, the achievement of the vision described in this report will require the full participation of stakeholders across society including local authorities, the NHS, regional offices of tobacco control and civil society. The long-term goal of bringing smoking prevalence down to below 5 per cent in all socio-economic groups by 2035, and the medium-term targets that this translates into, will only be achieved through a genuinely comprehensive and collaborative approach.

The commitment to tackling inequalities in this report is articulated in the goal and targets using the indicator of smoking prevalence in the routine and manual socio-economic group. The projected decline in prevalence described for this group is exceptionally challenging and will require a keen focus by everyone with a stake in helping smokers quit and discouraging and denormalising smoking. However this is only one indicator of the challenge of inequalities and no group should be left behind as we seek to bring the epidemic to an end. New and renewed efforts are needed to tackle smoking in all disadvantaged groups including people with mental health problems, people with long-term conditions and people within the criminal justice system. A smokefree future, in which children and young people are rarely, if ever, exposed to smoking behaviour, is a real possibility but it must be a future for all.

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**SMOKING STILL
KILLS 200 PEOPLE
EVERY DAY**



**Hundreds of children
take up smoking
every day**

Brand name
Variant name

20 cigarettes

50 cigarettes

Brand name
Variant name

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take up smoking
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Smoking Still Kills

PROTECTING CHILDREN, REDUCING INEQUALITIES

