



UKCTAS
UK Centre for Tobacco & Alcohol Studies

ash.
action on smoking and health

HM Treasury Budget 2020

Representation from ASH and the UK Centre for Tobacco and Alcohol Studies to the Chancellor of the Exchequer

January 2020

Introduction

1. ASH is a public health charity set up by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. It has also received project funding from the Department of Health and Social Care to support delivery of the Tobacco Control Plan for England. The UK Centre for Tobacco & Alcohol Studies (UKCTAS) was created in 2008 and includes research teams in twelve UK universities.
2. This paper, which sets out our joint recommendations on tobacco policy in tax and related areas in advance of the forthcoming Budget, is endorsed by 24 other organisations (see Annex 1 for a full list). Recommendations relate to the UK as a whole with respect to reserved matters such as tobacco taxation and illicit trade, and to England with respect to public health funding, the NHS and the Tobacco Control Plan.

Summary

3. Achieving the ambition of a smoke-free England by 2030 is an essential component of the Government's prevention strategy.¹ Smoking remains the leading cause of preventable premature death, killing nearly 100,000 people a year in the UK, responsible for half the difference in life expectancy between the rich and poor in society. For every death, another 30 people are suffering serious disease and disability caused by smoking. After obesity smoking is the leading cause of years lived with disability.
4. Smoking not only harms our health it also damages the economy and increases pressures on our NHS and social care system. In 2018 alone, smoking in England cost around £12.5bn. These costs include:²
 - £2.4bn to the NHS in treatment costs for health problems caused by smoking
 - £8.9bn of lost productivity caused by early deaths, absenteeism and smoking breaks at work

- £880m of social care costs arising from additional social care needs due to disease and disability caused by smoking
 - £325m arising from the cost of fires caused by smoking
5. The Government recognises that for England to be smoke-free by 2030 is “*extremely challenging*”. In particular although smoking rates are falling overall they remain stubbornly high in certain groups, such as routine and manual workers, those with mental health problems and other disadvantaged groups.
 6. Tax increases have been shown to be highly effective in reducing smoking prevalence and tackling inequalities, as poorer (and younger) smokers are more price sensitive than the general population. Tobacco tax increases are the only tobacco control intervention proven to reduce inequalities.^{3 4 5}
 7. Increasing tobacco taxes above inflation⁶ and combatting illicit trade, are complementary strategies which combine to reduce the affordability of tobacco and increase government revenues as well as reducing smoking prevalence. Increasing tobacco taxes will help achieve a smokefree future not just in England but in the devolved nations too, which have similar ambitions.⁷
 8. The renewal of the tobacco tax escalator of 2% above inflation in the November 2017 Budget was welcome, however, the evidence is clear that only the largest tax increases have been effective in reducing affordability.^{8 9 10} Furthermore, despite being no less harmful than factory made cigarettes, handrolled tobacco (HRT) is taxed at a significantly lower rate than factory made cigarettes which has led to smokers downtrading to HRT rather than quitting.¹¹ This disparity needs to be addressed.
 9. Quitting smoking is made more difficult by industry strategies to keep their product affordable, including the proliferation of cheap cigarette and hand-rolled tobacco brands, and the undershifting of tobacco duty, particularly on cheaper brands.¹⁰ These tactics all serve to widen the price gap between cheap and expensive products and allow smokers to downtrade to more affordable products, rather than quit, in the face of tobacco tax increases. Such tax increases are further undermined by industry tactics of smoothing price changes, utilising smaller and more frequent price increases, rather than sudden jumps following tax rises.
 10. Furthermore, disadvantaged smokers who don't quit bear a disproportionate share of the tobacco tax burden, because of the greater concentration of smoking among these groups. In addition, due to their higher rates of smoking, these populations also bear a disproportionate share of the burden of disease caused by tobacco.
 11. This poses a dilemma which can be resolved by ensuring that all efforts are made to motivate and support smokers in quitting, particularly the most disadvantaged. A comprehensive approach by government to reduce smoking prevalence, has been highly effective^{12 13} and highly cost-effective¹⁴ and needs to be sustained. The evidence is clear that the positive health impact of taxes is greater when supported by comprehensive tobacco control strategies.¹⁵
 12. The health organisations which endorse the ASH Budget submission support the use of tobacco taxation to continue to reduce the affordability of tobacco, as long as at the same time the Government ensures that adequate funding is provided for measures to reduce smoking prevalence and uptake. The Government should make the tobacco manufacturers pay in line with the “polluter pays approach” referenced in

the Green Paper. However, rather than achieving this through additional taxation, as previously consulted on,¹⁶ this should be achieved utilising mechanisms allowed for in health legislation.

13. The tobacco industry is highly profitable^{17 18} and can and should be made to pay for the cost of tobacco control. Making tobacco manufacturers pay a levy or licence fee to Government for measures to help smokers quit and prevent young people from taking up smoking is supported by 72% of adults in England with only 7% opposed.¹⁹
14. Indeed there is majority public support in general for Government action to tackle smoking. In total in 2019 over three quarters (77%) of adults in England surveyed support the government's activities to limit smoking or think they could do more. Support for the government to do more has grown substantially over time from 29% in 2009, to 39% in 2017 and 46% in 2019. The proportion of respondents who think that the government is doing too much has fallen from 20% in 2009 to 11% in 2017 and to 7% in 2019.¹⁹

Recommendations

15. Set out below are our key recommendations, in line with the overall analysis set out above. The more detailed analysis which supports these recommendations is set out subsequently:

Strengthening tobacco tax policy

- 1) Reinststate the tobacco tax escalator for this parliament.
- 2) Set the annual escalator for manufactured cigarettes at 5% above inflation and the escalator for hand-rolled tobacco (HRT) at 15% above inflation. Once tax on HRT, per average weight stick, is equivalent to that on factory made cigarettes, the escalators should be aligned.
- 3) The Minimum Excise Tax should be updated annually to ensure that the minimum tax for tobacco products is the rate due for products sold at the weighted average price (WAP).
- 4) Enhance tobacco tax rules after we leave the EU, and are therefore no longer subject to the requirements of the EU Tobacco Tax Directive. This should include:
 - making excise tax on manufactured cigarettes specific only;
 - eliminating all duty free and any tax paid tobacco allowances from EU member states; and
 - applying WTO tariffs to all imported tobacco products.

Tackling the illicit Trade

- 5) Review and update HMRC's anti-smuggling strategy to include:
 - Targets to reduce the market share of illicit cigarettes to under 5% both for factory made and HRT by 2030.
 - A tobacco licensing system for retailers and wholesalers funded but not controlled by the transnational tobacco manufacturers and importers.
 - Funding for partnership working at regional level to support coordinated programmes to tackle the illicit trade in tobacco.
 - Strengthening of sanctions against those engaging in the illicit trade in tobacco.

- 6) Require that the tracking and tracing system that is put in place in the UK after leaving the European Union is in line with the requirements of the Illicit Trade Protocol and Article 5.3 of the WHO FCTC. And that HMRC supports the implementation of similar standards by other Parties to the ITP.

Supporting Tobacco Control in health policies

- 7) A 'polluter pays' approach using mechanisms set out in the Health Act 2006 should be implemented through legislation. This would require tobacco manufacturers to fund the costs of tobacco control (with any tobacco industry involvement in setting and implementing policy precluded in line with the UK's obligations as a party to the FCTC).
- 8) Funding to local authorities for public health services should be restored to the levels prior to the cuts introduced from the 2015 Budget onwards, and local authorities should have regard to smoking outcomes when allocating resources.
- 9) A long-term sustainable funding solution must be implemented which is sufficient to enable local authorities to deliver on their public health responsibilities, and equitably determined, so as not to exacerbate health inequalities.
- 10) Tobacco Dependence Treatment should be fully embedded in the NHS as a core component of the Long-Term Plan, with appropriate funding arrangements in place to support this on a sustainable basis, in line with the recommendations set out in the RCP report.²⁰
- 11) Transnational tobacco manufacturers and importers should be required to provide DHSC, for publication in aggregate, comprehensive data on sales, prices and profits and marketing spend by type of marketing.

Strengthening tobacco tax policy

16. The commitment in the Tobacco Control Plan for England to "*Maintain high duty rates for tobacco products to make tobacco less affordable*"²¹ is not being met due to the gaming of the tax system by the tobacco industry. Revisions to the tax structure are essential to ensure that this commitment can be met.
17. The methods used by the industry to undermine Government efforts to reduce the affordability of tobacco include the proliferation of cheap manufactured cigarette and hand-rolled tobacco brands, and the undershifting of tobacco duty particularly on cheaper brands. These tactics all serve to widen the price gap between cheap and expensive products and smooth the price rises consumers face, reducing the impact of tax increases.^{8 9 10}
18. Government efforts to use changes in tax structure and levels to narrow the price gap previously observed between cheap and expensive factory made cigarettes and between factory made cigarettes and hand-rolled tobacco (HRT) had some, albeit limited, impacts.^{8 9 10} However, in the past such efforts have been undermined by industry pricing strategies.¹⁰
19. This has a detrimental impact on child as well as adult mortality and morbidity. Increases in the median price of cigarettes were associated with significant reductions in infant mortality across Europe between 2004 and 2014. However,

pricing differentials between median and minimum cigarette prices were associated with significant increases in infant mortality.²²

20. Government measures of the affordability of tobacco use national measures of income and average cigarette prices, thus not accurately reflecting the changes in affordability for the individual smoker, in particular poorer more disadvantaged smokers who are more likely to smoke the cheapest cigarettes or HRT.²³ For instance, in 2014, because of the widening of the price gap between cheap and expensive products, smokers could still purchase factory made cigarettes at 2002 prices (and HRT at 2005 prices).¹⁰
21. In addition, downtrading to HRT is encouraged by the significant differential in taxation and price per cigarette between factory made cigarettes and HRT, which in effect increases the elasticity of demand for factory made cigarettes, with a negative impact on tax revenues, without the health benefit conferred by quitting.
22. There is evidence from the Netherlands that consumption of HRT increases as the price differential between factory made and HRT increases,²⁴ and certainly this is the pattern we have seen in the UK. The proportion of smokers mainly using HRT has increased from 25% of men and 8% of women in 1998 to 40% of men and 23% of women in 2013.²⁵ We therefore recommend that in future calculations of tobacco affordability should include HRT as well as factory made cigarettes.
23. Consistent with the evidence from the Netherlands, international comparisons suggest that countries (US and Canada) which tax factory made and HRT similarly do not see a switch to HRT, while those with higher taxes on factory made relative to HRT (UK, Australia) see a switch towards HRT use, although the US and Canada have lower tax rates overall.⁹
24. The UK Government acknowledged the health impacts of this differential, and narrowed the gap in tax levels between factory made cigarettes and HRT by increasing HRT taxes by an additional 3% above inflation in the March 2016 Budget and by an additional 1% in the November 2017 Budget.^{8 10} **Error! Bookmark not defined.**
25. The tobacco industry consistently argues that tax increases will lead to an increase in the illicit trade.²⁶ However, recently published research²⁷ demonstrates that the industry increased its prices beyond that required by tax changes. The industry always increased its prices, but did the increases were notably smaller when tax rises were larger and unexpected. This suggests first that the industry is not actually concerned by the threat of illicit, especially since handrolled tobacco had the highest levels of industry driven price increases despite higher levels of illicit, and secondly that there remains scope for further tax increases.
26. **We therefore recommend increasing the annual tobacco tax escalator from 2% above inflation to 5% above inflation.**
27. **The annual escalator for hand-rolled tobacco (HRT) should be increased from 3% to 15% above inflation. Once tax on HRT, per average weight stick, is equivalent to that on factory made cigarettes, the escalators should be aligned.**¹¹

28. The increase in price through taxation has additional benefits in reductions in smoking prevalence and costs to public finances.²⁸ The impact in year 1 of an increase in tobacco taxation from 2% to 5% for manufactured cigarettes and 3% to 15% for handrolled tobacco is estimated to be a reduction of -0.17 percentage points in smoking prevalence, and a net benefit to public finances of £439.7 million.
29. The ASH public finance model²⁸ shows the net effect on public finances of increased tobacco taxes on public finances, estimating the following impacts arising from lower smoking prevalence:
- Increased revenue from tobacco taxation.
 - Increased revenue from income tax and National Insurance Contributions arising from a higher working-age employment rate (due to lower incidence of incapacity for work caused by smoking) and lower absenteeism from work.
 - Reduced costs to the NHS (estimates in financial terms, but given the NHS is largely operating at capacity in effect this is reduced pressure on the system)
 - Reduced costs to the NHS (in financial terms, but given the NHS is operating at more than full capacity in many cases in effect this is mainly reduced pressure on the system).
 - Reduced spending on incapacity-related benefits.
 - Increased spending on pensions due to longer life expectancy for non-smokers compared to smokers.
 - The total figure for reduced spending on benefits is shown net of increased pensions spending.

Table 1: Estimated impact of increased tobacco taxes on public finances and smoking prevalence in year 1 ²⁸

Impact on public finances (£ million) and smoking prevalence	Cigarette component	HRT component	TOTAL
Increased revenue from tobacco taxation	222.6	146.3	369.0
NHS Cost savings – combined	11.1	8.3	19.3
Increased taxation from additional years working	16.5	12.3	28.9
Increased taxation from reduced absenteeism	7.0	5.2	12.2
Reduced spending on sickness/illness benefits	11.0	8.2	19.1
Increased spending on pensions	-5.0	-3.7	-8.7
Net public finances impact	263.2	176.6	439.7
Reduction in smoking prevalence (%)	-0.11	-0.06	-0.17

30. The elasticity of demand for consumption used for these calculations is HMRC's estimate of short-run elasticity of consumption for cigarettes of -0.57; that is, a 1 per cent increase in the price of cigarettes results in a fall in consumption of 0.57 per cent.²⁹ The analysis in this report uses this HMRC short-run estimate as the best available estimate of the initial consumption response to a tobacco levy, rather than long-run elasticity which is considered to be much more variable and less reliable than short-run elasticities and "thus one should be very cautious about using the long-run price elasticity estimates".³⁰ This analysis uses the same elasticity estimate for cigarettes and for hand-rolling tobacco (HRT).³¹

31. As well as using a realistic estimate for the price elasticity of tobacco consumption, in order to estimate the impact of an increase in the consumer price of tobacco on smoking prevalence the ASH public finances model also requires an assumption concerning the relationship between the price elasticity and smoking prevalence in the adult population in England. The standard assumption is that the elasticity of smoking prevalence is equal to half the consumption elasticity, i.e. -0.285.³² This is the assumption used in this report.
32. The equivalent tax rate for HRT can be accurately calculated using recent research on the average weight of tobacco per hand-rolled cigarette. This is likely to increase the tax take as well as reducing the likelihood of smokers downtrading to HRT rather than quitting. A 2010 survey found the median weight of a hand-rolled cigarette across 18 countries in Europe was approximately 0.75g, but England had the lowest mean weight of 0.48g.³³
33. More recent analysis of six waves (2006 to 2014) of International Tobacco Control (ITC) study data showed the average grams of tobacco per hand-rolled cigarette for the UK sample to be between 0.45 - 0.55 grams.¹⁰ We therefore suggest 0.5 grams be used as the average weight of a hand-rolled cigarette, and for this to be regularly assessed as the average quantity appears to be declining over time, with taxes then adjusted accordingly.
34. Evidence from overseas indicates that the tobacco industry will also try to exploit loopholes in tax legislation by selling HRT as pipe tobacco, if lower taxes are applied to pipe tobacco.³⁴ The fact that pipe tobacco is not subject to standardised packaging legislation provides an extra incentive to do this in the UK. Taxes on pipe tobacco should be kept in line with those on HRT and the tobacco manufacturers should be required to provide data on sales so any changes in use can be monitored in real time.
35. Cheaper brands are targeted at the young, the poor, women and those living in areas of the country with high smoking rates who are most in need of protection from tobacco industry marketing tactics. Related evidence shows that the increase in the use of cheap cigarettes is most marked in the youngest (16-24 year old) smokers, 71.4% of whom now use cheap brands³⁵ and that the young, the poor, women and those living in areas of the country with high smoking rates are more likely to smoke the cheapest cigarette brands. This highlights the impact of the availability of cheap cigarettes on inequalities in smoking.³⁶
36. The introduction of the Minimum Excise Tax on cigarettes in the Finance Bill 2017 (which set a floor below which tax on cigarettes cannot fall) happened subsequent to the research highlighted above. Subsequent research shows the introduction of MET had an impact on pricing of factory made cigarettes, but it needs to be regularly updated if it is to continue to be effective.
- 37. We recommend that the Minimum Excise Tax be updated annually to ensure that the minimum tax for tobacco products is the rate due for products sold at the weighted average price (WAP).**
- 38. We also recommend that tobacco tax rules are enhanced after we leave the EU, and are therefore no longer subject to the requirements of the EU Tobacco Tax Directive. This should include:**
- **making excise tax on manufactured cigarettes specific only;**

- **eliminating all duty free and any tax paid tobacco allowances from EU member states; and**
- **applying WTO tariffs to all imported tobacco products.**

Tackling the illicit Trade

39. During the 1990s the tobacco manufacturers fuelled rapid growth in the illicit market for tobacco, from around 5% to 20% for factory made cigarettes and to over 60% for HRT by the turn of the century.³⁷ To tackle this in 2000 the UK introduced an anti-smuggling strategy,³⁸ which has been successful in restricting the illicit market while taxes have continued to increase above inflation.³⁷ By 2017-18 the illicit market share for factory made cigarettes was 9% and 32% for HRT.³⁹
40. In volume terms the decline has been even bigger as the overall market has declined as smoking prevalence and tobacco consumption has gone down. In 2005-6 the smuggled market was estimated to be 10 billion cigarettes and 6.1 million kilograms of HRT, in 2017-18 it was 3 billion cigarettes and 3.1 million kilograms of HRT, declines of 70% and 49% respectively.
41. This has resulted in significant benefits to government revenues. In 2005-6 the loss to government revenues due to the illicit trade was £2.7 billion, in 2017-18 it was £1.8 billion (VAT and excise tax combined). If the volume of smuggled tobacco had not declined the losses would have been much greater.⁴⁰
42. The most recent illicit strategy is now four years old and only committed to hold the cigarette market share at or below 10% and to contain the illicit market share for HRT.³⁸ This looks very unambitious in the light of the Government's ambition to end smoking by 2030, and the coming into force of the WHO FCTC Illicit Tobacco Protocol. HMRC has always recognised that the illicit trade evolves in response to government strategy, which is why it has been regularly updated after the initial strategy was implemented in 2000, with a new strategy produced every 3-4 years since then. An update is therefore overdue.
43. Proposals to improve both the effectiveness of enforcement of illicit tobacco legislation and provide additional dissuasion to individuals engaged in committing offences were set out in the HMRC consultation on tax evasion. In its response to the consultation in November 2017 HMRC said that it would, *"take forward further work on legislative and non-legislative options to strengthen the use of sanctions in light of the consultation feedback."*⁴¹ The outcome of this work is still to be announced, and we hope that it will be by the time of the 2019 Budget.
44. We also urge the Government, in line with recommendations from the Public Accounts Committee⁴², to do more to hold the industry to account given growing evidence of its ongoing complicity in the illicit tobacco trade.⁴³ Over the last few years, whistleblowers⁴⁴, researchers⁴⁵, investigative journalists⁴⁶ and government reports^{47 48} suggest that industry involvement in the illicit tobacco trade has continued subsequent to the four leading transnational tobacco companies one by one signing agreements with the EU to combat smuggling, starting in 2004.⁴⁹
45. At best, the evidence indicates that tobacco companies are still failing to control their supply chain in the knowledge their products will end up on the illicit market.⁴⁹ Reports suggest, for example, that the tobacco industry is deliberately over-producing cigarettes in some markets (e.g. Ukraine)⁴⁶ and oversupplying tobacco to

others (e.g. the Benelux countries)⁵⁰, in the apparent knowledge that these products will end up being sold on the illicit market.

46. This evidence is supported by data from diverse sources, including UK data commissioned by the Department of Health and Social Care (Operation Henry).⁵¹ While obtaining accurate data on the illicit tobacco trade is notoriously difficult, data at global, EU and UK level are remarkably consistent in showing that the majority of the illicit cigarette market still comprises tobacco industry product, with estimates varying from 58% (2016, EU level, industry funded data) to 69-73% (seizure data for 2011 and 2012 at global level and 2014 and 2016 at UK level).⁴⁹
47. By comparison the problem of counterfeit tobacco products, which the industry repeatedly emphasises as the major problem, is minor, comprising around 5%-8% of the market. Illicit (or cheap) whites comprise around a fifth to a third of the illicit market, but these figures may hide tobacco industry illicit. For example, in the industry commissioned Project Sun report undertaken by accountancy firm KPMG, the Imperial Tobacco brand, Classic, was incorrectly classified as a cheap white during a period (2006-12) in which it was one of the most seized brands in Europe.⁵²
48. Similarly, in the latest Operation Henry report⁵³, the two most seized brands, West and Winston, were coded as cheap whites yet are tobacco industry brands (sold in the UK by Imperial Tobacco and Japan Tobacco International respectively). Consequently, data may underestimate the total contribution of tobacco industry illicit.
49. It is important to take note of these data given the tobacco industry's documented attempts to deliberately distort the messaging and public discourse on illicit in order to emphasise the problems of counterfeit and illicit whites.^{54 55 56 57}
50. A recent systematic review found that industry-funded data and reports on illicit routinely overestimate the scale of the problem and feature substantial methodological problems while failing to meet the standards of accuracy and transparency that are set by high-quality peer-reviewed publications.⁵⁸

Regional partnerships

51. We strongly agree with the statement in the 2016 Budget that "*Coordinated enforcement, will work to further increase the seizure of illicit shipments and increase prosecutions for tobacco fraud.*" In a 2013 report the National Audit Office (NAO) pointed to the "*promising results*" from regional partnerships in the North of England between HMRC and other agencies such as the police, Trading Standards and health organisations, which helped provide the coordinated enforcement that is required. The NAO also encouraged HMRC to roll out such partnerships nationally.⁵⁹
52. The success of such partnerships is shown by their impact in the North East and North West, which have had concerted multi-agency enforcement activity and effective evidence-based demand reduction measures in place since 2007, supported by the work of the Illicit Tobacco Partnership. Between 2009 and 2019 the illicit market had declined by a third in the North East from 15% to 10%, this followed a concerted multi-strand focus on illicit tobacco to reduce both the demand and supply.
53. Unfortunately, not only has there not been a further roll out of such regional partnerships nationally since the NAO report, but the only remaining regional

partnership is now in the North East. The only positive development has been the emergence of a comprehensive tobacco control strategy in the city region partnership in Greater Manchester, which includes tackling illicit tobacco.

54. To date none of the funding for such partnership working or social marketing has come from HMRC, it has come either from localities or from the Department of Health and Social Care. The result has been the establishment of pockets of local activity by individual local authorities to reduce illicit tobacco without the benefits of working across boundaries or the efficiencies achieved by co-ordination and partnership at a bigger scale.
55. The trading standards staff, who cover a wide range of consumer protection responsibilities and are crucial to effective collaborative working on the illicit trade, are increasingly under threat. During the last six years, total spend nationally on trading standards has fallen from £213m in 2010 to £124m in 2016,⁶⁰ and by 2018-9 it is due to fall to just over half that, at £108 million.⁶¹
56. Teams have been cut to the bone, with the NAO calculating that the number of full-time equivalent Trading Standards staff decreased by 56% in seven years, from 3,534 in 2009 to 1,561 in 2016, with 81% of services considering that funding reductions have had a negative impact on their ability to protect consumers in their area.⁶² This underlines the benefit of working across a bigger footprint in order to achieve economies of scale and improved efficiency.
57. The financial benefit from enhanced enforcement accrues to HM Government, not to local authorities, so it would seem appropriate for funding to be found by HMRC, unless and until measures are put in place to require the tobacco manufacturers to pay for these costs.

Licensing of the supply chain

58. In 2016 HMRC consulted on the introduction of licensing of the tobacco industry supply chain, but only went ahead with licensing the use and ownership of tobacco manufacturing machinery. The consultation also included licensing of the whole of the supply chain, which is recommended in the Illicit Trade Protocol. We support a licensing system to cover the retail and wholesale trade in tobacco products, covering both named premises and designated responsible individuals.
59. The tracking and tracing system now in place already requires all retailers and wholesalers of tobacco to have economic operator codes, with powers for these to be removed from non-compliant operators. This provides a very useful legal underpinning for a licensing scheme.
60. A positive licensing scheme for retailers could help to protect the business of legitimate retailers who obey tobacco control legislation. These businesses make very low profit margins from selling tobacco itself, and contrary to claims by the tobacco industry, tobacco is no more a significant driver of “*footfall*” in small retailers than any other common product.⁶³ However, law abiding retailers clearly face economic losses if their business is undercut by sales of illicit tobacco.
61. Legitimate retailers and wholesalers would be protected by licensing, since it would reduce unfair competition from the illicit tobacco trade. Surveys of small retailers show strong support for licensing. A survey of small independent retailers carried out in August 2019 found strong support for licensing with 84% of retailers supporting the

introduction of a tobacco license that retailers could lose if they broke the law and only 9% opposing.⁶⁴ While retailers make low profit margins on tobacco, the four major tobacco companies are some of the most profitable companies in the world, and could easily meet the costs of a licensing scheme.^{17 18}

62. A large majority of the public, 83%, support a requirement for tobacco retailers to be licensed, with only 4% opposing this measure.⁶⁵ Indeed, anecdotally most people think that retailers already need to have a licence to sell tobacco products and are surprised that there is no regime in place.
63. **We recommend that HMRC's anti-smuggling strategy should be reviewed and updated to include:**
- **Targets to reduce the market share of illicit cigarettes to under 5% both for factory made and HRT by 2030.**
 - **A tobacco licensing system for retailers and wholesalers funded by the transnational tobacco manufacturers and importers.**
 - **Funding for partnership working at regional level to support coordinated programmes to tackle the illicit trade in tobacco.**
 - **Strengthening of sanctions against those engaging in the illicit trade in tobacco.**

EU Tobacco Products Directive and WHO FCTC Illicit Trade Protocol

64. The UK implemented the tracking and tracing requirements of the Tobacco Products Directive.⁶⁶ The regulations came into force on 20 May 2019 but until May 2020 only apply to products manufactured or imported after 20 May 2019. While large retailers were expected to be able to implement the tracking and tracing requirements relatively smoothly, concerns were raised in advance of implementation about whether small independent retailers would be able to do so.⁶⁷
65. However, by August 2019 nearly two thirds (64%) of small independent retailers said they already had the required economic operator identifier code, while 14% said that did not, and 18% that they didn't know. More than a third, 37%, said their suppliers had sold them tobacco with the new track and trace labels, with 42% saying they had not and 17% they didn't know.⁶⁴ So the majority of independent retailers have already met the requirements which they must fulfil at the latest by 20 May 2020.
66. The UK has committed to Parliament that it will remain aligned with the EU after Brexit.⁶⁸ If there is not a deal then we will have to leave the EU system immediately, if there is a deal then we will still have to develop our own system once the transition period is over, which will need to be compliant with the WHO FCTC Illicit Trade Protocol as well as the EU. Concerns have been raised that the EU system is not fully aligned with the requirements for independence from the tobacco industry⁶⁹ set out in the WHO FCTC Illicit Trade Protocol and consistent with Article 5.3 of the WHO FCTC.^{49 70 71}
67. The latest evidence suggests the tobacco industry is attempting, largely through the use of third parties, to have Codentify, the track and trace system it developed implemented as the global track and trace system of choice.⁴⁹ Codentify has been shown to be inefficient and inadequate as a track and trace system^{64 72} and the industry's links to it make it non-compliant with it the Illicit trade Protocol, as noted by the WHO FCTC Secretariat.⁷³

68. The tobacco industry has a vested interest in controlling any tobacco track and trace system in order to avoid scrutiny and minimise its excise payments. As a result, should the industry have control over tracking and tracing, this would enable its ongoing involvement in tobacco smuggling and make the global illicit trade far harder to control.⁴⁹ Given that the illicit tobacco trade is an international issue, the UK government can play a vital role in ensuring governments around the world do not fall prey to the tobacco industry's attempts to undermine the Illicit Trade Protocol in this way.
- 69. We recommend that the tracking and tracing system which is put in place by the UK after leaving the European union is fully aligned with the requirements of the Illicit Trade Protocol (ITP) and Article 5.3 of the FCTC. And that HMRC supports the implementation of similar standards by other Parties to the ITP.**

Supporting Tobacco Control in health policies

70. Achieving the ambition of a smoke-free England by 2030 is an essential component of the Government's prevention strategy, which is currently under consultation.¹ Experience elsewhere shows what can happen if we do not ensure that tobacco control is comprehensively implemented and properly funded. Since 2007 the UK has scored highest for tobacco control policy implementation in Europe.⁷⁴ While we've seen significant declines in smoking due to our comprehensive approach, smoking prevalence in France and Germany, which have not had such strategies in place, has barely shifted over the last twenty years.

Making the tobacco industry pay

71. Making tobacco manufacturers pay a levy or licence fee to Government for measures to help smokers quit and prevent young people from taking up smoking is supported by 72% of adults in England with only 7% opposing.⁵⁸
72. Such funding is essential if a properly funded tobacco control strategy at national, regional and local level is to be sustained. While many measures, such as the advertising ban, taxation and standardised packaging, do not incur significant ongoing government expenditure others do and it is essential they are funded if we are to succeed in tackling the inequalities in smoking rates across society. There are recurring costs for cost-effective measures which can be targeted to help reduce inequalities, such as public education campaigns, smoking cessation treatment, and enforcement activity such as age of sale compliance and tackling illicit tobacco.
73. Tobacco manufacturers and importers in the UK are immensely profitable, such that they could certainly afford to make a greater contribution. In the UK the industry makes at least £1 billion in profits a year; this profitability has been increasing during the period of analysis, and profitability is likely to be in the region of £1.5bn per annum in recent years.^{17 18}
74. Tobacco manufacturers and importers are also found to enjoy consistently high profit margins of up to 68%, compared with only 15-20% in most consumer staple industries.¹⁷ Given UK based tobacco companies pay very little corporation tax despite reporting high profits earned in the UK^{17 18}, they should be subject to the diverted profit tax at the higher 33% rate now applied to the banking industry.

75. Furthermore, tobacco is not like any other consumer product: it is lethal when used as intended, killing at least half all users prematurely in the longer-term and causing significant health problems in the short and medium term.
76. For these reasons the Government consulted on the introduction of a levy on the tobacco industry, stating that *“Smoking imposes costs on society, and the Government believes it is therefore fair to ask the tobacco industry to make a greater contribution.”*¹⁵
77. The Government decided not to proceed with a levy, but the principle that the tobacco industry should make a greater contribution remains. In the consultation on prevention the Government said it was open to a 'polluter pays' approach requiring tobacco companies to pay towards the cost of tobacco control, which could include proposals to raise funds under the Health Act 2006. We support this suggestion.
- 78. We recommend the implementation in legislation of a ‘polluter pays’ Tobacco Control Fund using mechanisms set out in the Health Act 2006.⁷⁵ This would require tobacco manufacturers to fund the costs of tobacco control, while prohibiting any tobacco industry involvement in setting and implementing policy precluded in line with the UK’s obligations as a party to the FCTC.**
79. The Tobacco Control Fund would be collected by DHSC, in the same way as the pharmaceutical pricing scheme in place under powers set out in the Health Act 2006.⁷⁶ This would be for DHSC and PHE to allocate, with help from an advisory committee including tobacco control experts from the academic, regulatory, voluntary sector and clinical community. The fund would be dedicated in the legislation to pay for the recurring costs of tobacco control measures which have been proven to motivate successful quitting and reduce uptake. The pharmaceutical pricing scheme is administered by DHSC for the devolved administrations, and could be for the Tobacco Control Fund, if the devolved administrations so wished.

Public Health Funding

80. A properly funded prevention and public health system is essential to achieving the ambitions set out in the Tobacco Control Plan for England²² as well as the sustainability of the NHS. The UK is rightly regarded as a global leader in tobacco control, and there has been a steady fall in smoking rates over several decades. However, as smoking is uniquely lethal, it remains the leading cause of preventable premature death, and the major reason for differences in life expectancy between the richest and poorest in society.
81. Yet in practice there have been significant cuts in local authority public health budgets which threaten resourcing for tobacco control at local and regional level. While we would see a ‘polluter pays’ approach providing funding from tobacco manufacturers to redress this, that is not going to happen in the immediate future.
82. In the July 2015 Budget statement, the Chancellor announced an in-year reduction of £200 million to the 2015/16 grant of £2.79 billion.⁷⁷ Subsequently the Government announced a further cash reduction of 9.7% between 2016/17 and 2021.⁷⁸ Although in the 2019 Comprehensive Spending Review the cuts for 2020-21 were reversed,

with a 1% increase in real terms in addition, this is not sufficient. The Health Foundation and King's Fund have estimated that £1bn a year is needed to restore funding.⁷⁹

83. The cuts to date have already translated into cuts in funding of tobacco control at local level. Smoking cessation services which used to be universally available to all smokers and increased the success of quit attempts threefold⁸⁰ were transferred from the NHS to local authorities in April 2013.
84. A survey by ASH and Cancer Research UK, which is now in its fifth year, has found support to smokers and funding for other measures to reduce youth smoking and promote quit attempts fell by £41.3 million between 2014/15 and 2017/18, a decline of 30%. The biggest cuts in local services followed national government's 2015 decision to take £200 million out of public health budget in year with local authorities left with little choice but to rapidly cut services.⁸¹
- 85. We recommend that funding to local authorities for public health services should be restored to the levels prior to the cuts introduced from the 2015 Budget onwards, and local authorities should have regard to smoking outcomes when allocating resources.**
- 86. Furthermore, a long-term sustainable funding solution must be implemented which is sufficient to enable local authorities to deliver on their public health responsibilities, and equitably determined, so as not to exacerbate health inequalities.**

NHS Long-term Plan

87. The NHS Long-term Plan commits to providing tobacco dependence treatment is provided by the NHS for all patients admitted to hospital, for pregnant women and their partners, and long-term users of specialist mental health service, with full implementation by 2023-24.^{82 20 68 83} This is in addition to, not instead of, the important public health role played by local authorities.
88. However, welcome as this commitment is, the NHS Long-term Plan does not go far enough. Currently it only includes "users of high-risk outpatient services" not all outpatients, and it doesn't include staff, both of which were recommended by the Royal College of Physicians.
89. Nor does the NHS Long-Term Plan include any commitment for improving smoking cessation in primary care. Primary care is a crucial part of the prevention pathway which can reach a larger number of generally healthier and younger smokers before they develop diseases requiring hospital care, yet provision of support in primary care is patchy. The number of health practitioners who reported frequently prescribing pharmacotherapy for patients who smoke is relatively low, with 22% prescribing nicotine replacement therapy, 16% prescribing varenicline and 4% prescribing bupropion.⁸⁴
90. There is a strong clinical justification for the treatment of tobacco dependency to be provided for all patients using the NHS, as quitting smoking will, almost without exception, prevent potential exacerbation of, or increased risk of complications for all presenting conditions. Providing treatment for staff as well as patients would significantly improve productivity.

91. On average smokers lose ten years of life, a loss of 11 minutes for every cigarette smoked,⁸⁵ but the loss of disease free life years is far greater than this. For every death caused by smoking, approximately 20 smokers are suffering from a smoking-related disease, many of which, such as heart disease, respiratory diseases, and numerous types of cancer can lead to many years of disability before death.^{86 87}
92. Around 42% of adult tobacco consumption in England is by those with mental health conditions,⁸⁸ who die 10-20 years earlier than people without such conditions, with tobacco playing a key role in this gap. However, people with mental health conditions are far less likely to receive help to quit smoking.^{88 88 89}
93. Tobacco dependence treatment can also help deliver on the Government's ambition to have the best cancer outcomes in the world. A third of lung cancer patients still smoke at diagnosis currently, and the majority continue to smoke. Lung cancer patients who quit smoking live on average 1.97 years, compared to only 1.08 years for those who continue smoking, with improved quality of life. Yet currently only 24% of lung cancer patients who smoke are offered advice to quit by their GPs and only 13% are prescribed stop smoking treatment.⁹⁰
94. The total avoidable cost to the NHS from current smoking, arising from hospital care, postoperative infections, the higher doses of drugs for mental health problems, and loss of productivity in staff, amounts to around £890 million each year in England, and hence around £1 billion per year for the UK.⁸²
- 95. We recommend that Tobacco Dependence Treatment is fully embedded in the NHS as a core component of the Long-Term Plan, with appropriate funding arrangements in place to support this on a sustainable basis, in line with the recommendations set out in the RCP report.**

Data Collection and publication

96. As a party to the WHO FCTC, the UK is required to implement stringent regulation of the tobacco industry, far greater than for any other legal consumer product. Under Article 20 the Treaty sets out requirements for Parties to carry out monitoring and surveillance of the tobacco industry, and provides for the collection and dissemination of such data.
97. Taxpayer confidentiality has been cited as a reason why publication of sales and other data is not possible in the UK. Yet such data are already collected and published by commercial organisations such as Nielsen, but only available at significant cost (prohibitive given the budget constraints detailed above) and with increasingly stringent terms of use.
98. Furthermore, in other jurisdictions 'taxpayer confidentiality' has not been an impediment to publication of such data. For example, New Zealand publishes monthly sales data; in the US, the Federal Trade Commission issues reports on the tobacco industry, which cover sales, advertising and promotional expenditures.⁹¹
99. In Canada an act passed this year gives the Government power to require the industry to report on its sales and marketing activity and for this information to be put

in the public domain. This will include (and there is a clause allowing supplementary information to be required once notified by the Minister)⁹² :

- the total sales, as well as the sales by brand and package type, monthly for cigarettes and cigarette tobacco, and quarterly for all other tobacco products; and
- their records on research and development activities for all tobacco products every six months.

100. We recommend that the UK Government implements a policy requiring the tobacco industry to provide for publication the following data in a standard agreed electronic format so as to be easily aggregated, accessible and analysable:

At national and international level on an annual basis:

- profits,
- taxes (excise duties and corporation tax).

At national level, on a monthly basis:

- Brand specific price and sales data for all products;
- Marketing spend by category (consistent with Federal Trade Commission categorisations and also including spending on CSR);
- research spend by subject area.

At local authority level:

- Sales data by product type for all products (including factory made, HRT, heat not burn, e-cigarette).

101. The tobacco manufacturers already collect these data and some, if not all, is already provided to Government; all that is needed is for the Government to publish the data.⁹³

102. The importance of this in order to accurately measure tobacco prices and determine appropriate tobacco tax policy has been recently outlined in research on UK cigarette prices and highlighted above. Making such data available to researchers and policy makers would be invaluable in helping with the development, implementation and evaluation of policy measures designed to reduce smoking prevalence.³⁶ Such data at local level could also provide useful insight into the illicit market, for example significant reductions in local sales over a short period of time is likely to be an indicator of illicit sales activity.

103. Benefits to HM Government would include:

- Better understanding of market developments to inform the development of tobacco control and tobacco tax policy, for example on tax structure.
- Enabling future research on the price sensitivity of tobacco consumption by academic researchers to support work carried out by HMRC.
- Better identification and understanding of illicit market trends over time at local level.
- Provision of proxy indicators for smoking prevalence changes at local level to enable local authorities to determine the effectiveness of their tobacco control activities (scaling up national surveys for this purpose is unfeasible because of the cost).
- Better understanding of the marketing strategies of the tobacco industry.
- More accurate assessment of whether tobacco companies are paying appropriate levels of corporation tax

ANNEX 1

Organisations endorsing ASH's submission to the 2019 Budget TBC

ASH Northern Ireland	Faculty of Public Health
ASH Wales	Fresh North East
Association of Directors of Public Health	Greater Manchester Health and Social Care Partnership
Asthma UK	Health Behaviour Research Centre
Breathe 2025	Lullaby Trust
British Heart Foundation	National Centre for Smoking Cessation and Training (NCSCT)
British Lung Foundation	Oral Health Foundation
British Thoracic Society	Royal College of Physicians
Cancer Focus Northern Ireland	Royal College of Radiologists
Cancer Research UK	Smoke Free Newcastle
Chartered Trading Standards Institute	Smoke Free South Tyneside
Durham County Council	Somerset County Council

References

- 1 Cabinet Office and Department of Health and Social Care. [Advancing our health: prevention in the 2020s](#). CP110. July 2019.
- 2 ASH. [Ready Reckoner](#). September 2019.
- 3 Brown, T., S. Platt and A. Amos (2014). Equity impact of European individual-level smoking cessation interventions to reduce smoking in adults: a systematic review. *European Journal of Public Health*. 2014 May 31;24(4): 551-556.
- 4 The World Bank. *Curbing the epidemic: governments and the economics of tobacco control*. May, 1999. Development in practice. Washington DC ; World Bank.
- 5 Amos A, Bauld L, Hill S, Platt S, Robinson J. Tobacco control, inequalities in health and action at the local level in England. London, UK: Public Health Research Consortium; 2011 Mar 31.
- 6 Chaloupka F, Yurekli A, Fong G. [Tobacco taxes as a tobacco control strategy](#). *Tobacco Control* 2012; 21:172-180.
- 7 Population Health Directorate. [Raising Scotland's tobacco-free generation: our tobacco control action plan 2018](#). Scottish Government. June 2018.
- 8 Partos TR, Gilmore A, Hitchman SC, Hiscock R, Branston JR, McNeill A. [Availability and use of cheap tobacco in the UK 2002 - 2014: findings from the International Tobacco Control Project](#). *Nicotine & Tobacco Research*. 2018 May 3;20(6):714 - 724.
- 9 Partos TR, Branston JR, Hiscock R, Gilmore AB, McNeill A. Individualised tobacco affordability in the UK 2002–2014: findings from the International Tobacco Control Policy Evaluation Project. *Tobacco control*. 2019 May 1;28(Suppl 1):s9-19.
- 10 Hiscock, R., Branston, J.R., McNeill, A., Hitchmann, S., Partos, T., and Gilmore, A.B. 2017. Tobacco industry strategies undermine government tax policy: evidence from commercial data. *Tobacco Control* 2018;27:488–497.
- 11 Branston JR, McNeill A, Gilmore AB, Hiscock R, Partos TR. Keeping smoking affordable in higher tax environments via smoking thinner roll-your-own cigarettes: Findings from the International Tobacco Control Four Country Survey 2006–15. *Drug and Alcohol Dependence*. 2018 Dec 1;193:110-6.
- 12 Royal College of Physicians. [Nicotine without smoke: Tobacco Harm reduction. A report by the Tobacco Advisory Group of the Royal College of Physicians](#). London. RCP. 2016.
- 13 Gravely S, Giovino GA, Craig L, Commar A, D'Espaignet ET, Schotte K, Fong GT. Implementation of key demand-reduction measures of the WHO Framework Convention on Tobacco Control and change in smoking prevalence in 126 countries: an association study. *The Lancet Public Health*. 2017 Apr 1;2(4):e166-74.
- 14 National Cancer Institute and WHO. [NCI Tobacco Control Monograph Series 21 - The Economics of Tobacco and Tobacco Control](#). 2017 National Cancer Institute and World Health Organization.

-
- 15 Chaloupka F, Yurekli A, Fong G. Tobacco taxes as a tobacco control strategy. *Tobacco Control* 2012; 21:172-180.
- 16 HM Treasury. [Autumn Statement 2014](#). CM 8961. December 2014
- 17 Branston JR, Gilmore AB. The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy. University of Bath. 2015 Feb.
- 18 Branston JR, Gilmore AB. [The failure of the UK to tax adequately tobacco company profits](#). *Journal of Public Health*. 2019 Feb 6.
- 19 ASH smokefree England survey 2019. Total sample size in 2019 for England was 10338 adults. Fieldwork was undertaken between 12th February 2019 and 10th March 2019. The surveys are carried out online and the figures have been weighted and are representative of all English adults (aged 18+).
- 20 Royal College of Physicians. [Hiding in plain sight: treating tobacco dependency in the NHS](#). London: RCP, 2018.
- 21 Department of Health and Social Care. [Towards a smoke-free generation: tobacco control plan for England](#). July 2017.
- 22 Filippidis FT, Laverty AA, Hone T, Been JV, Millett C. [Association of cigarette price differentials with infant mortality in 23 European Union countries](#). *JAMA pediatrics*. 2017 Nov 1;171(11):1100-6.
- 23 NHS Digital. [Statistics on Smoking in England – 2018](#). July 2019
- 24 Mindell JS, Whynes DK. [Cigarette consumption in the Netherlands 1970 – 1995: does tax policy encourage the use of hand-rolling tobacco?](#) *The European Journal of Public Health*. 2000 Sep 1;10(3):214-9.
- 25 Office for National Statistics. [Opinions and Lifestyle Survey. Adult Smoking Habits in Great Britain, 2013](#). November 2014
- 26 Tobacco Manufacturers Association. [Tobacco smuggling and crossborder shopping](#). Accessed on 14/10/19
- 27 Hiscock R, Branston JR, Partos TR, McNeill A, Hitchman SC, Gilmore AB. UK tobacco price increases: driven by industry or public health? *Tobacco control*. Published Online First: 25 July 2019. doi: 10.1136/tobaccocontrol-2019-054969
- 28 Details of the ASH public finances model of the effects of tobacco taxation are given in Reed, H (2010), [The Effects of Increasing Tobacco Taxation: A Cost Benefit and Public Finances Analysis](#). ASH.
- 29 Czubek M, Johal S. [Econometric analysis of cigarette consumption in the UK](#). HM Revenue & Customs; 2010 Dec.
- 30 Nguyen L, Rosenqvist G, Pekurinen M. Demand for Tobacco in Europe. An Econometric Analysis of 11 countries for the PPACTE project. PPACTE 2012 p.89
- 31 Because HMRC do not publish a separate elasticity for hand-rolling tobacco or other tobacco products, we assume that the elasticity for HRT is the same as for cigarettes in the analysis in this report.
- 32 See for example, US Surgeon General. [The Health Consequences of Smoking – 50 Years of Progress](#). 2014.
- 33 Gallus S, Lugoa A, Ghislandic S, La Vecchia C, Gilmore, A. [Roll-your-own cigarettes in Europe: use, weight and implications for fiscal policies](#). *European Journal of Cancer Prevention* 2014; 23:186–192
- 34 Clifford D, Ciercierski C, Silver, K, Gilmore A. PPACTE Work Package 5 – Milestone 5.2. Tobacco industry influence over tobacco taxation in Poland. Dublin. PPACTE, 2012
- 35 Gilmore AB, Tavakoly B, Hiscock R, Taylor G. [Smoking patterns in Great Britain: the rise of cheap cigarette brands and roll your own \(RYO\) tobacco](#). *Journal of public health*. 2014 Aug 11;37(1):78-88.
- 36 Gilmore A, Tavakoly B, Taylor G, Reed H. [Understanding tobacco industry pricing strategy and whether it undermines tobacco tax policy: the example of the British cigarette market](#). *Addiction* 2013; 108 (7): 1317-1326
- 37 World Bank. [Confronting Illicit Trade in Tobacco: A Global review of Country experiences](#). Editor Sheila Dutta. 2019.
- 38 HMRC and Border Force. [Tackling illicit tobacco: From Leaf to Light](#). The HMRC and Border Force Strategy to tackle tobacco smuggling. HMRC March. 2015
- 39 HMRC. [Measuring Tax Gaps 2019. Tax gap estimates for 2017-18](#). All figures based on mid-range estimates. June 2019
- 40 HMRC. [Tobacco Tax Gap estimates 2015-16](#). 20 October 2016
- 41 HMRC. [Sanctions to tackle tobacco duty evasion and other excise duty evasion. Summary of responses](#). November 2017.
- 42 Public Accounts Committee. [PAC publishes report on tackling tobacco smuggling](#). 10th October 2013.
- 43 Gilmore AB, Fooks G, Drope J, Bialous SA, Jackson RR. [Exposing and addressing tobacco industry conduct in low and middle income countries](#) *The Lancet*. 2015 Mar 14;385(9972):1029-43.
- 44 Organised Crime and Corruption Reporting Project, [Big Trouble With Big Tobacco](#). November 2011. Accessed on 14/10/19
- 45 Skafida V, Silver KE, Rechel BP, Gilmore AB. [Change in tobacco excise policy in Bulgaria: the role of tobacco industry lobbying and smuggling](#). *Tobacco control*. 2014 May 1;23(e1):e75-84.
- 46 Lavrov V. [Ukraine's 'lost' cigarettes flood Europe: Big tobacco's overproduction fuels \\$2 billion black market](#). 19 May 2014. Accessed on 14/10/19

-
- 47 HMRC, Public Accounts Committee, [Progress in tackling tobacco smuggling](#), 10 October 2013.
- 48 HMRC, [Progress in tackling tobacco smuggling](#). 6 June 2013.
- 49 Gilmore AB, Gallagher AW, Rowell A. Tobacco industry's elaborate attempts to control a global track and trace system and fundamentally undermine the Illicit Trade Protocol. *Tobacco control*. 2019 Mar 1;28(2):127-40.
- 50 BBC News. [HMRC fines cigarette maker for oversupplying Belgium](#). 13 Nov 2014. Accessed on 14/10/19
- 51 MacGregor J. [Operation Henry 2 "OH2": A coordinated operation to tackle the supply of illicit tobacco in England](#). Commissioned by the Department of Health Tobacco Policy Team. Aug 2016. Accessed on 14/10/19
- 52 European Parliament, [European Parliament's Committee on Budgetary Control Workshop "Cigarette Smuggling" Proceedings](#). January 2014. Accessed on 24/09/18
- 53 [CTSI Operation Henry 2, 2016. Corrigendum published 20 June 2017](#). Accessed on 14/10/19
- 54 Rowell A, Evans-Reeves K, Gilmore A. [Tobacco industry manipulation of data on and press coverage of the illicit tobacco trade in the UK](#). *Tobacco control*. 2014 May 1;23(e1):e35-43.
- 55 Gilmore A, Rowell A, Gallus S, et al. [Towards a greater understanding of the illicit tobacco trade in Europe: a review of the PMI funded, KPMG authored "project star" report](#) *Tobacco Control*. 2014 May 1;23(e1):e51-61.
- 56 Evans-Reeves K A, Hatchard JL, Gilmore AB. ['It will harm business and increase illicit trade': an evaluation of the relevance, quality and transparency of evidence submitted by transnational tobacco companies to the UK consultation on standardised packaging 2012](#). *Tobacco control*. 2015 Jun 1;24(e2):e168-77.
- 57 Philip Morris International, [New KPMG report in the EU reveals largest increase of counterfeit cigarette consumption to date](#). June 11 2019. Accessed on 14/10/19
- 58 Joossens L, Gilmore AB, Stoklosa M, Ross H. Assessment of the European Union's illicit trade agreements with the four major Transnational Tobacco Companies. *Tobacco control*. 2016 May 1;25(3):254-60.
- 59 Comptroller and Auditor General. [Progress in Tackling Tobacco Smuggling, 2013](#). National Audit Office.
- 60 CTSI. [Chartered Trading Standards Institute Workforce Survey](#). June 2016
- 61 Labour Communities and Local Government. [Local Government Health Check Report 4: Trading Standards](#). August 2018.
- 62 National Audit Office. [Report by the Comptroller and Auditor General: Protecting consumers from scams, unfair trading and unsafe goods](#). NAO. HC851. 2016.
- 63 ASH. [Counter arguments: How important is tobacco to small retailers?](#) October 2016.
- 64 NEMS survey for ASH. Telephone survey of 558 independent retailers across all English regions. Respondents included convenience stores, off-licences, newsagents, independent fuel services and tobacconists. Fieldwork undertaken between 6th August and 21st August 2019.
- 65 ASH smokefree England survey 2019. Total sample size in 2019 for England was 10338 adults. Fieldwork was undertaken between 12th February 2019 and 10th March 2019. The surveys are carried out online and the figures have been weighted and are representative of all English adults (aged 18+).
- 66 HMRC. [The Tobacco Products \(Traceability and Security Features\) Regulations 2019](#)
- 67 Mannering R. [ACS raises concerns over tobacco 'track and trace' plans](#). Convenience Store. 19 September 2017. Accessed on 14/10/19
- 68 Hansard. [Tobacco Control Plan Debate](#). 19 July 2018. Volume 645
- 69 Framework Convention Alliance. [Why the EU tracking and tracing system works only for the EU](#). 2019
- 70 Joossens L, Gilmore AB. [The transnational tobacco companies' strategy to promote Codentify, their inadequate tracking and tracing standard](#). *Tobacco control*. 2014 May 1;23(e1):e3-6.
- 71 FCTC. [What Lessons Can We Learn From The EU Tobacco Tracking and Tracing System?](#) 1 August 2019. Accessed on 14/10/19
- 72 Ross H, Eads M, Yates M. [Why governments cannot afford Codentify to support their track and trace solutions](#). *Tobacco control*. 2018 Nov 1;27(6):706-8.
- 73 World Health Organization. [The Protocol to Eliminate Illicit Trade in Tobacco Products: Questions and Answers](#) Accessed on 01/09/19
- 74 Joossens L, Raw M. [The Tobacco Control Scale 2016 in Europe](#). A report of the European Association of Cancer Leagues. March 2017.
- 75 DHSC and ABPI. [The 2019 Voluntary Scheme for Branded Medicines Pricing and Access. Annex 2: Powers of the Secretary of State Deriving from the National Health Service Act 2006](#). December 2018.

-
- 76 Health Act 2006. Annex 2: Scheme Powers of the Secretary of State Deriving from the NHS Act 2006.
- 77 HM Treasury. [Chancellor announces £4½ billion of measures to bring down debt](#). 8 July 2015. Accessed on 14/10/19
- 78 Local Government Association. [Public Health Funding in 2016/17 and 2017/18](#). 11 February 2016.
- 79 The Health Foundation. [Urgent call for £1bn a year to reverse cuts to public health funding](#). 12 June 2019. Accessed on 14/10/19
- 80 Kotz D, Brown J, West R. [Prospective cohort study of the effectiveness of smoking cessation treatments used in the "real world"](#). In Mayo Clinic Proceedings 2014 Oct 1 (Vol. 89, No. 10, pp. 1360-1367). Elsevier.
- 81 Action on Smoking and Health & Cancer Research UK. [A Changing Landscape: Stop smoking services and tobacco control in England](#). March 2019
- 82 NHS England. [The NHS Long Term Plan](#). 2019
- 83 House of Lords Hansard. [The NHS](#). 5 July 2018. Vol 792.
- 84 Cancer Research UK. [Smoking cessation in primary care: A cross-sectional survey of primary care health practitioners in the UK and the use of very brief advice](#). 2019
- 85 Shaw M, Mitchell R, Dorling D. [Time for a smoke? One cigarette reduces your life by 11 minutes](#). BMJ. 2000 Jan 1; 320(7226): 53.
- 86 U.S. Department of Health and Human Services. [How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General](#). Atlanta, GA: U.S. Department of Health and Human Services, 2010.
- 87 Centers for Disease Control and Prevention. [Smoking-attributable morbidity – United States, 2000. MMWR Weekly Report, 5 Sep. 2003](#). Accessed on 14/10/19
- 88 McManus S, Meltzer H, Campion J (2010) [Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey](#). London, UK: National Centre for Social Research. 2010 Dec.
- 89 Szatkowski L, McNeill A (2013) The delivery of smoking cessation interventions to primary care patients with mental health problems. *Addiction*. 2013 Aug;108(8): 1487-94.
- 90 NIHR School for Primary Care Research. [Cancer Survivors who quit sooner can live longer](#). September 2017. Accessed on 14/10/19
- 91 US Federal Trade Commission. [Federal Trade Commission Cigarette report for 2012](#). March 2015.
- 92 Canadian [Tobacco Reporting Regulations](#). Part 2 reports 13 Sales. SOR/2000-273. Consolidation current at January 25 2016.
- 93 HMRC. [HMRC confirms country-by-country reporting format for multinationals](#). 15 August 2017.