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Submission to the Comprehensive Spending Review 2007

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Executive Summary and key recommendations

1. This document sets out ASH's recommendations to the Comprehensive Spending Review supported by 15 health organisations.¹
2. Currently around one in four of the population smoke and smoking prevalence is declining by only 0.4% of the population a year². Smokefree legislation will not drastically change this and without further action, at current rates of decline, we will not meet the Wanless fully engaged scenario target of 17% prevalence by 2010³ until after 2020.
3. Reductions in smoking prevalence would lead to reductions in morbidity as well as mortality, leading to significant immediate as well as longer-term savings to the health service.
4. Reducing smoking prevalence is also key to achieving the Government's health inequality targets, given that smoking has been estimated to be the cause of two thirds the difference in survival to 70 years of age between social class 1 and V.⁴
5. Tobacco control must remain a priority for health funding. Smoking is a chronic, relapsing, addictive behaviour and the single largest preventable cause of death and disease. In England over 85,000 smokers die each year as a result of their habit⁵, and for every one that dies around another twenty are suffering from smoking-related diseases, many of whom will go on to die.⁶ There is good evidence that smoking prevalence only continues to go down when policy levers continue to be used to the full.^{7 8 9}
6. There is a relatively rich evidence base, from jurisdictions with such strategic tobacco control frameworks, such as California and Australia, on how to bring smoking prevalence down and such measures are both inexpensive and highly cost-effective compared to health interventions to treat disease once it has developed. Population measures rather than measures targeted at individual subgroups have been found to be particularly effective.
7. The most effective means of reducing smoking prevalence is price increases through taxation. An econometric analysis of the decline in consumption in

¹ See Appendix A for full list.

² Jarvis MJ. Monitoring cigarette smoking prevalence in Britain in a timely fashion. *Addiction* 2003;98:1569-74.

³ Wanless D. *Securing Good Health for the Whole Population. Final Report.* London. HM Treasury, February 2004.

⁴ Jarvis, M. J. and Wardle, J (2005) Social patterning of health behaviours: the case of cigarette smoking. In: Marmot, M. and Wilkinson, R. (eds) *Social Determinants of Health*. Oxford: Oxford University Press, 2nd edition.

⁵ Twigg L., Moon G and Walker S (2004) *The Smoking Epidemic in England*. Health Development Agency: London.

⁶ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5425a1.htm>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5235a4.htm>

⁷ Hill DJ et al: Smoking behaviours of Australian adults in 1995: trends and concerns. *Med J Aust* 1998; 168: 209-213.

<http://www.mja.com.au/public/issues/mar2/hill/hill.html>

⁸ Tobacco Control journal supplement : 2003; 12 Supplement ii.

⁹ Pierce, J et al. Has the California Tobacco Control Program Reduced Smoking? *JAMA*. 1998;280:893-899.

cigarettes in California between 1990 and 1992 estimated that 78% was attributable to tax increases and 22% to the media campaign.¹⁰

8. Currently HM Treasury has made clear that it does not believe that increasing taxation is a lever it can use given the continuing high levels of smuggling. We disagree and believe the time has come to re-introduce a tax escalator above inflation.
9. But what is needed in addition is a comprehensive tobacco control strategy. In *Securing Our Future Health* Wanless recommended “*bringing spending on interventions to reduce smoking in line with expenditure in California where ambitious targets have been met.*”¹¹
10. This should be framed within a radical new National Tobacco Strategy to include tobacco and nicotine regulation and harm reduction with a proper process in place for monitoring, evaluation and updating the strategy over time. Ever since *Smoking Kills* in 1999¹², while many significant measures have been achieved, such as a ban on advertising and promotion and comprehensive smokefree legislation, these have been in response to political pressure and have not been within a co-ordinated national strategy which has been properly evaluated and updated. Such a strategy is also a requirement of the WHO’s global health treaty, the Framework Convention on Tobacco Control, which the UK has ratified.
11. Such a strategy needs to include spending on comprehensive social marketing approaches, including mass media, to highlight the dangers of smoking and to encourage people to quit. This should be funded at double the current levels, £50 million a year instead of around £25 million a year, as recommended by the US Center for Disease Control.¹³ It would also require maintenance of effective funding of the NHS Stop Smoking Services, currently £56 million per annum, and their extension to ensure effective smoking cessation provision in hospitals. To add significant capacity for regulation would not add a great deal, for example, in 2005 the Canadian tobacco regulatory authority employed around 140 people at an annual cost of under £50 million.
12. So total funding, including the cost of regulation and of a harm reduction strategy (but not of control of illicit trade initiatives overseen by HM Revenue and Customs), would come in at under £250 million a year. In contrast the Government currently spends £736 million on treatment and prevention on illegal drugs¹⁴ (not including all the crime and enforcement costs of illegal drugs), yet it is estimated there are only around a total of 350,000 problem drug users.¹⁵ Investment in drug treatment alone is increasing from £253 million in 2004/05 to £478 million by 2007/08. This boost in funding will see the budget of every Drug Action Team increase by around 55% by 2008, to quote,

¹⁰ Hu T-W, Sung H-Y, Keeler TE. Reducing cigarette consumption in California: tobacco taxes vs. an antismoking media campaign. *Am J Public Health* 1995b;85(9):1218-22

¹¹ Wanless D. *Securing our Future Health: Taking a Long-Term View*. Final Report. London, HM Treasury, 2002.

¹² Department of Health. *Smoking Kills*. A White Paper on tobacco. London: The Stationery Office, 1998.

¹³ Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, August 1999.

¹⁴ <http://www.drugs.gov.uk/drug-strategy/funding/>

¹⁵ Drugs – facing facts The report of the RSA Commission on Illegal Drugs, Communities and Public Policy. RSA March 2007.

“demonstrating the Government’s commitment to increasing drug treatment services for all drug users.” Yet illegal drug use is estimated to cost the health service only around £0.5 million each year compared to the annual cost of smoking-related disease of £1.7 billion.

13. Set out below are more detailed recommendations for comprehensive tobacco control measures which would have the potential to bring reductions in smoking prevalence into line with the *‘fully engaged scenario’* and save in the order of 60,000 lives over 10 years.¹⁶
14. Funding tobacco control at this level is cost-effective because of the benefits of cutting smoking prevalence, many of which accrue immediately as well as having long-term impacts. For example the smoking rates envisaged in the *‘fully engaged scenario’* were calculated in Wanless to lead to a reduction in statin use alone of over £1 billion a year by 2022³ and the cost of many other medications are significantly reduced when smokers quit. More work needs to be done on the immediate impact of reductions in smoking prevalence on costs to the health service. Other immediate reductions in costs that have not been properly quantified include reductions in average time spent in hospital following operations¹⁷, fewer premature and low birth weight babies, and fewer heart attacks and strokes.¹⁸ Smoking is also a major cause of bronchitis and pneumonia which often leads to acute beds being occupied and cancellations of routine operations and other medical treatments, particularly in winter months.

Key Recommendations

15. The fully engaged scenario target for smoking prevalence proposed by Wanless of 17% by 2010 is not achievable in this time frame. This and the Wanless target of 11% by 2022 can only hope to be reached if a comprehensive tobacco control strategy at Californian levels of investment is maintained and strengthened, with the addition of a harm reduction strategy as a vital extra lever.
16. In particular:

Strategic planning and oversight of tobacco control strategy

- 1) A radical, clear strategic vision for tobacco control needs to be developed and implemented to update and build on *Smoking Kills*.¹⁹ It is essential that such a strategy is effectively evaluated and updated.
- 2) We recommend that the government develops a 5 year National Tobacco Strategy in collaboration with the public health community which contains long-term, comprehensive, evidence-based and coordinated plans to reduce smoking prevalence and the harm caused by tobacco. It should be properly funded at a cost of around £250 million a year. The strategy should be

¹⁶ Lewis S, Arnott D, Godfrey C, Britton J. Public health measures to reduce smoking prevalence in the UK: how many lives could be saved? *Tobacco Control* 2005;14:251-254

¹⁷ Choosing Health: Making Healthy choices easier. Public Health White Paper. 16th November, 2004. Cm 6374.

¹⁸ Modelling the short term consequences of smoking cessation in England on the hospitalisation rates for acute myocardial infarction and stroke Bhash Naidoo, Warren Stevens and Klim McPherson *Tob. Control* 2000;9:397-400 doi:10.1136/tc.9.4.397

¹⁹ Department of Health. *Smoking Kills. A White Paper on tobacco.* London: The Stationery Office, 1998.

evaluated, reviewed and updated at least every five years. This would meet the requirements of the Framework Convention on Tobacco Control, to which we

- 3) are a Party. Such a model is in place in Australia and has proved very effective.²⁰

Key elements that need to be included are set out below.

Implementation, monitoring and evaluation

- 4) Tobacco control is a key element of public health strategy and commitments made in the Public Health White Paper¹⁷ need to be adhered to. In particular, that the “*Secretary of State for Health will coordinate action through the new Cabinet Sub Committee, set up to oversee the development and implementation of the Government’s policies to improve public health and reduce health inequalities.*” (p.177 para. 12). Plans to establish “*a Health Information and Intelligence Task Force to lead action to develop and implement a comprehensive public health information and intelligence strategy.*” (p.191 para.24) also need to be implemented.
- 5) Furthermore, the Wanless recommendation that “*A commitment of adequate resources for monitoring and feedback should be an integral part of the planning of any national programme to tackle the key determinants of health. (Paragraph 3.97)*”³ must be implemented urgently. This would enable us for the first time to disaggregate the impact of different policies and will rely on timely access to appropriate data to assess changes in prevalence.

Smoking Cessation

- 6) Realistic targets should be set for Stop Smoking Services based on numbers of smokers per PCT expected to be treated each year in a range of 5% to 10% of local smokers.
- 7) 4-week quit rates should continue to be used as a success measure but validated by testing CO-levels.
- 8) Exception reporting is needed to identify and then audit unusually high or low performance outcomes.
- 9) Telephone counselling should be introduced as a cost-effective and efficacious alternative to one-to-one counselling.
- 10) GP practices should be used more effectively to give smokers brief advice to quit and refer patients to Stop Smoking services. This could be achieved by rebalancing the Quality Outcomes Framework (QOF) to award most of the points for ensuring that 90% of all smokers are given smoking cessation advice and referred to stop smoking services at least once every fifteen months.²¹
- 11) All smokers in secondary care should have access to smoking cessation treatment with seamless transfer to community treatment for ongoing support and relapse prevention.
- 12) Ring-fenced funding for Stop Smoking services is needed at the PCT level.

Social Marketing

- 13) Social marketing and mass media campaigns must be maintained and increased to the Center for Disease Control¹³ mid-range recommendation of \$2 per capita (per head of population) equivalent to around £50 million per annum.

²⁰ This is the model in Australia which has so far published two national strategies, 1999-2003 and 2004-2009. <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-strateg-drugs-tobacco-policy.htm>

²¹ Notes on 2004/5 Quality and Outcomes Framework data for England

Advertising, Promotion and Marketing

- 14) Regulations to ban the display of tobacco products at the point of sale should be introduced and bans on other residual marketing, including support for international efforts to reduce cross-border advertising.
- 15) Generic packaging should be required for all tobacco products.

Graphic Health Warnings

- 16) EU recommendations for inclusion of pictorial health warnings on all tobacco products should be adopted as soon as possible and an amendment should be sought to the EU Tobacco Products Directive in order to allow the inclusion of picture warnings on both the front and back of tobacco packaging.

Protection from secondhand smoke

- 17) The mandated three year review of the smokefree legislation should be thorough and include, for example, currently exempted premises such as prisons, and external areas with potentially high concentrations of smoke. Where necessary the regulations should be updated and improved.

Control of sale to underage smokers

- 18) Penalties and enforcement of underage sales laws should be strengthened significantly at the same time as the age of sale is increased to 18, with a presumption of guilt on the part of the retailer if they do not insist on seeing proof of age.
- 19) Licensing of retailers should be implemented together with increased fines and potential loss of licence for non-compliance.
- 20) The sale of cigarettes from vending machines should be banned as there is evidence that they are a relatively easily accessible source of cigarettes to under age smokers.²² Instead of cigarettes NRT products should be made available through vending machines to help increase their availability and accessibility.

Tax and smuggling

- 21) HM Treasury and HMRC should support the development of a legally enforceable, comprehensive illicit trade protocol under the FCTC as this will play a significant role in reducing the global scale of tobacco smuggling.
- 22) Reducing smuggling needs to remain a priority and it would seem sensible to set new and stronger targets after the current target deadlines are reached in March 2008, for both cigarettes and Hand-Rolled Tobacco.
- 23) A real price escalator of 3% above inflation should be reintroduced to increase tobacco taxes above inflation each year to prevent tobacco becoming more affordable year on year.

Regulatory reform and harm reduction

- 24) We welcome the Chancellor's announcement in the Budget that VAT on nicotine replacement products would be reduced to 5% for one year from 1 July 2007 as a step in the right direction, but would urge the Treasury to sustain this reduction in taxation of such products permanently.
- 25) The Department of Health should set up a working group immediately with responsibility for:
 - a. Defining a harm reduction strategy for tobacco;

²² Smoking, drinking and drug use among young people in England in 2004. National Center for Social Research, 2004

- b. Determining what bodies are needed to implement a harm reduction strategy; and
- c. Developing an implementation strategy.

Targets

17. Current Government targets on smoking are taken from the Department of Health's Public Service Agreement, *Smoking Kills* and the Cancer Plan.²³ As Wanless states, "reducing smoking will be a key determinant of success against the PSA target on CHD, cancer and health inequalities."
- To reduce smoking prevalence from 28 per cent in 1996 to 26 per cent in 2005 (*Smoking Kills*). This has been substituted by a PSA target of 21% by 2010;
 - To reduce smoking prevalence by manual groups from 32 per cent (1998) to 26 per cent by 2010 (Cancer Plan – stayed same in PSA);
 - To reduce smoking prevalence in 11-15 year olds from 13 per cent (1996) to 11 per cent by 2005 and 9 per cent by 2010 (*Smoking Kills*);
 - To reduce smoking among pregnant women from 23 per cent (1995) to 18 per cent by 2005 and 15 per cent by 2010 (*Smoking Kills*).
18. These targets are unambitious. Wanless estimated that to achieve the fully 'engaged scenario', smoking prevalence would need to decline to Californian levels of 17% by 2010 and 11% by 2022, with the largest reductions amongst those in the most deprived populations, falling to 26% by 2010.³
19. However, in order for smoking prevalence to continue to decline, the range of tobacco control measures currently being implemented by the government needs to continue to be supported and strengthened. To achieve the 'fully engaged scenario', and in particular for the target for the reduction in health inequalities to be achieved, much more needs to be done.

Strategic Planning, Monitoring and evaluation of the impact of tobacco control policies

20. Given that more than one in four of the population suffer from nicotine addiction²⁴, that it kills over 85,000 people in England each year⁵, and for every one that dies around another twenty are suffering from smoking-related diseases, many of whom will go on to die²⁵, it is without doubt the most deadly and disabling long-term condition there is. Furthermore, because it causes up to 50 diseases and disorders²⁶ and cuts across a multiplicity of different medical disciplines it is vital that a strategic approach is taken to its treatment and to attempting to reduce smoking prevalence.
21. In 1998 the Government published its white paper *Smoking Kills*.¹² However, the Government has not formally reviewed progress in tobacco control since

²³ The NHS Cancer Plan. Department of Health. September 2000.

²⁴ Office for National Statistics (2006). General Household Survey 2005. <http://www.statistics.gov.uk/ghs>

²⁵ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5425a1.htm>

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5235a4.htm>

²⁶ Cigarettes: what the warning label doesn't tell you. American Council on Science & Health, 1997.

Smoking Kills was published. *Choosing Health*¹⁷, the public health white paper did not set out a revised and updated strategic plan for tobacco control.

22. The lack of long term, co-ordinated planning is shown by the inclusion in *Choosing Health* of partial smokefree legislation which would have exacerbated health inequalities. It was only because of effective intervention from the public health community and its supporters in Parliament that the legislation was revised to become comprehensive. It is now held up as landmark legislation.
23. ASH recommends that the government develops a National Tobacco Strategy in collaboration with the public health community which contains long-term, comprehensive, evidence-based and coordinated plans to reduce the harm caused by tobacco and reduce smoking prevalence and is evaluated, reviewed and updated every five years. Such a model is in place in Australia and has proved very effective.²⁰
24. Such a model is also mandated by Article 5.1 of the Framework Convention on Tobacco Control²⁷, which the United Kingdom has ratified, which states that *'Each Party shall develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with this Convention and the protocols to which it is a Party.'* The preamble and *Article 4*, the guiding principles, also specify that the participation of civil society is essential in achieving the objective of the Convention and its protocols.
25. Key elements included in *Choosing Health* which gave political priority to public health have not been implemented. For example, that the *"Secretary of State for Health will coordinate action through the new Cabinet Sub Committee, set up to oversee the development and implementation of the Government's policies to improve public health and reduce health inequalities."* (p.177 para. 12).¹⁷ And plans to establish *"a Health Information and Intelligence Task Force to lead action to develop and implement a comprehensive public health information and intelligence strategy."* (p.191 para.24)¹⁷ also need to be implemented.
26. Wanless also recommended that, *"A commitment of adequate resources for monitoring and feedback should be an integral part of the planning of any national programme to tackle the key determinants of health. (Paragraph 3.97)*³
27. ASH supports this recommendation. For many years we have been suggesting that more work is needed to assess adequately the impact of tobacco control policies and in particular of taxation, as the price mechanism is known to be one of the most effective means of reducing smoking prevalence especially among young people .
28. Tobacco taxation is an important health and fiscal policy, yet very little data are published about the structure of this £9 billion tax base and the response of consumers to changes in tax rates and other changes in policy such as legislative changes. There are data in the General Household Survey, Consumers' Expenditure Survey and the Family Expenditure Survey.

²⁷ Framework Convention on Tobacco Control. World Health Organisation Geneva. 2003. http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf

However, there is no consolidated report on the tobacco market, and the data collected by HM Revenue and Customs is not fully used.

29. ASH has recommended to the Treasury for a number of years the release of regular reports on the tobacco market detailing its structure, price variations within categories, calculated price-elasticities, consumption patterns by socio-economic group, age and other demographics, market share by brand and so on, in order to support the econometric work necessary to determine the impact of various different policy levers on smoking prevalence.
30. Evidence suggests that following implementation of the tobacco control strategy set out in the White Paper *Smoking Kills*¹², smoking prevalence, which had stopped declining in the 1990s, began to decline again at around 0.4% per annum², and it appears that this decline has continued through to 2005.
31. However, ONS, and HM Revenue and Customs have refused to give prompt access to up to date data on smoking prevalence in order to allow Professor Martin Jarvis to update his work² analysing rates of decline. This is unfortunate as the Department of Health, which does have access to this information, has not used it to determine and publish the most up to date rates in decline of smoking prevalence. The datasets available through the national data archive are 18 months out of date [the September 2005 omnibus has just become available], with the consequence that publicly available sources do not make it possible to estimate reliably the impact of policy on current smoking prevalence.
32. The current published overall rate of 24 per cent²⁸ hides major societal differences; 29 per cent of manual workers smoke compared with 19 per cent of those in non-manual occupations, with the differential not reducing significantly; 25 per cent of men smoke compared with 23 per cent of women; smoking in pregnancy has fallen to 17 per cent²⁹, and 9 per cent of 11 to 15 year olds are regular smokers (more girls than boys).³⁰
33. On these trends the Government is meeting its overall targets, but is unlikely to meet those for routine and manual workers and is nowhere near reaching the targets envisaged in the *'fully engaged scenario'*.³ On pregnant women it has met its Smoking Kills target, but this has been replaced by a Priorities and Planning Framework target which requires a one percentage point reduction per year in the proportion of women continuing to smoke. It should also be noted that pregnant women are known to significantly under-report smoking leading to about a 3 per cent underestimate of cigarette smoking in pregnancy.³¹
34. Furthermore, in order to assess the value of the various elements of a comprehensive tobacco control policy the impact of the various elements on the rate of decline in smoking prevalence needs to be disaggregated. For major pieces of legislation, such as the advertising ban and smokefree legislation, the Government has to make predictions to meet the requirements of its regulatory

²⁸ General Household Survey, 2005.

²⁹ Infant Feeding Survey 2005: Early results. The Information Centre, 2005.

www.ic.nhs.uk/pubs/breastfeed2005

³⁰ Smoking, drinking and drug use among young people in England in 2004. London, National Centre for Social Research, 2005

³¹ Owen L., McNeill A. Saliva cotinine as indicator of cigarette smoking in pregnant women. *Addiction* 2001;96:1001-6.

impact assessments, but it has not, to our knowledge, revisited such calculations to assess their accuracy.

35. For example, it was estimated that the advertising and promotion ban implemented in 2003 would lead long-term to a reduction in smoking prevalence of up to 5 per cent.³² Since the legislation was implemented there has been no published analysis to determine how far this prediction has been, or is being, fulfilled.
36. There is now have a further piece of legislation about to be implemented, when England goes smokefree at the beginning of July 2007. It has been estimated that this will lead to a one-off decline in smoking prevalence in England of 1.7%.³³ It is necessary to disentangle the impact of past tobacco control policy changes on smoking prevalence in order to evolve and improve future tobacco control strategy to ensure the greatest possible declines in smoking prevalence over time.
37. ASH would urge the Treasury to ensure that the funding and resource is made available for effective monitoring and evaluation of all public health programmes to tackle the key determinants of health, as suggested by Wanless, but particularly the impact of tobacco control policies.

Californian example

38. Wanless recommended funding for tobacco control in line with that seen in California¹³ and we see no reason for changing that conclusion. Comprehensive tobacco control programmes are proven to be effective in helping drive down prevalence.
39. It should be noted, however, that part of the reason for the decline in smoking prevalence in California in recent years, to current rates of around 15% in 2004³⁴ has been a change in the demographics of the population. In particular an increase in the proportion of the population of Hispanic and Asian origin³⁵ with lower smoking prevalence rates than non-hispanic white and African American peoples.³⁶ This has helped to continue to drive down prevalence even when funding for tobacco control has been cut back.
40. The implication of this is that the rate of decline in smoking prevalence in England may continue to be slower than in the US and that to reach Californian rates of 17% and below may not be achievable in a reasonable time scale without radical new policies. Local changes in England, such as migration from eastern Europe, where smoking rates, particularly amongst men, are significantly higher than in the UK (with male smoking rates above 30% in many countries and in some above 40% or even 50%), may also slow down the rate of decline.³⁷

³² Effect of Tobacco Advertising on Tobacco Consumption: a discussion document reviewing the evidence, DH. 1992.

³³ Partial Regulatory Impact Assessment – smokefree aspects of the Health Bill. September 2006.

http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Regulatoryimpactassessment/DH_4138930

³⁴ California Adult Tobacco Survey, 2004.

³⁵ U.S. Census Bureau, Population Division

³⁶ Prevalence of Cigarette Use Among 14 Racial/Ethnic Populations – United States, 1999-2001. JAMA. 2004;291:814-816

³⁷ Data sources estimate migration from the EU accession countries at around 500,000 in 2006 from countries with smoking rates similar to the UK for women but with male smoking rates at over 30% and in some cases up to 50% or more.

41. Continued and sustained investment in comprehensive tobacco control policies is still, however, proven to be worthwhile. Analysis by the US Centers for Disease Control (CDC) found that the more that states spent on comprehensive tobacco control programmes the greater the reductions in smoking, and the longer that states invested for, the greater and faster the impact. Between 1990 and 2000 cigarette sales dropped more than twice as much in states that invested heavily in comprehensive tobacco control programmes as in the United States as a whole.³⁸ This included not just California but also Arizona, Massachusetts and Oregon.
42. In 1999 CDC recommended optimum tobacco policy expenditure¹³ (see table below), suggesting high and low estimates on the basis of factors such as population and smoking prevalence. CDC recommends a lower spend for larger states, on the basis that spend per capita can be more cost-effective in larger population areas, with a range between \$5 to \$16 dollars per capita a State in larger states (population over 7 million). For California, the largest US State, it recommended a high expenditure of \$442 million and a low of \$165 million (about £9.50 and £3.50 per capita per annum at 2002 prices).³⁹ California's actual tobacco policy spending in 2002, when it peaked, was \$134.54 million.

Optimum spend on tobacco Control		
Annual per capita tobacco control spending	Total amount	Amount per capita in £s (exchange rate at time)
California: CDC 1999 recommendation - high	\$442 m	£9.50
California: CDC 1999 recommendation - low	\$165 m	£3.50
California: actual spending 2002	\$134.54 m	£2.64
England: 2004-5 spend	£124.1 m	£2.48

Source: CDC; American Lung Association of California; and DH.

43. Funding tobacco control at this level is cost-effective because of the long-term benefits of achieving the smoking rates envisaged in the 'fully engaged scenario' in reduced costs to the NHS. For instance such reductions in smoking were calculated in Wanless to lead to a reduction in statin use alone of over £1 billion.¹¹ More work needs to be done on the impact of reductions in smoking prevalence on costs to the health service as statins costs are just a tiny proportion of the total. Other reductions in costs will include reductions in average time spent in hospital following operations¹⁷, fewer premature and low birth weight babies, and fewer heart attacks, strokes¹⁸, cases of respiratory disease and cancer.
44. It is only in the last couple of years that spend in the UK has approached the amount recommended by CDC, or even the amount spent by California when its programme was running effectively. Spend in 2004-5 by the Department of Health was around £2.50 per capita, compared to £2.64 in California in 2002.
45. This level of spend needs to be maintained and increased as there is evidence, not just from California but also from Australia, that levelling off in declines in

³⁸ www.cdc.gov/tobacco/overview/Research_Findings_Effectiveness.htm

³⁹ Action on Smoking and Health. Comments on 'Securing our Future Health'. London, ASH, 2002.

smoking prevalence are associated with lower per capita investment in effective tobacco control policies, such as mass media anti-smoking campaigns.^{7 8 9}

Reducing Demand for Tobacco Products

Smoking Cessation Services

46. As Wanless states, *“Smoking Cessation services are essentially an individual intervention that cannot be expected to deliver significant falls in prevalence.”*⁴¹ It has been estimated that working at the Government’s current target rate of 800,000 4-week quitters over 3 years the Services would deliver absolute prevalence decline of only around 0.1% per annum.⁴⁰
47. However, smoking cessation treatment is highly cost effective. The average cost per life gained for every smoker successfully treated by the services is less than £1,000, well below the NICE guidelines of £20,000 per Quality and excellent value for money.⁴¹ Research also shows the services are reaching smokers from the most disadvantaged areas.⁴²
48. Smoking is a chronic, relapsing, addictive behaviour and a major cause of health inequalities. The Stop Smoking Services should continue to be funded and now that their funding is no longer ring-fenced, mechanisms need to be found to ensure that PCTs continue to support and develop their Stop Smoking Services.
49. ASH has submitted a briefing document to HM Treasury setting out a range of measures which could improve the performance management and effectiveness of the services.⁴³ These include:
- Setting realistic targets for Stop Smoking Services based on numbers of smokers per PCT expected to be treated each year in a range of 5% to 10% of local smokers.
 - Continue to use 4-week quit rates as a success measure but validate by testing CO-levels.
 - Use exception reporting to identify and audit unusually high or low performance outcomes.
 - Introduce telephone counselling as a cost-effective and efficacious alternative to one-to-one counselling.
 - Use GP practices more effectively to give smokers brief advice to quit and refer patients to Stop Smoking services. This could be achieved by rebalancing the Quality Outcomes Framework (QOF) to award most of the points for ensuring that 90% of all smokers are given smoking cessation advice and referred to stop smoking services at least once every fifteen months. This would also be a potentially rich and valuable source of

⁴⁰ West, R. Stop Smoking Service Quality and Delivery Indicators and Targets. A Briefing for the Healthcare Commission. July 2004.

⁴¹ Godfrey, C. Parrott, S. Coleman, T. & Pound, E. The cost-effectiveness of the English smoking treatment services: evidence from practice. *Addiction*, 2005; 100(suppl.2),70-83.

⁴² Chesterman, J. Judge, K. Bauld, L & Ferguson, J. How effective are the English smoking treatment services in reaching disadvantaged smokers? *Addiction*, 2005; 100 (Suppl.2), 36-45.

⁴³ Arnott D. West R. ASH Briefing Document for HM Treasury: Performance Management and Smoking Cessation Targets. November 2006.

information about smokers, providing the limitations of the data are acknowledged.⁴⁴

50. More needs to be done, however, to enable patients to access smoking cessation advice and services from secondary care. For example, smoking cessation is the only intervention that changes the natural history of chronic obstructive pulmonary disease (COPD) or reduces the risk of lung cancer, but only half of all UK chest specialists have direct access to a Stop Smoking counsellor.⁴⁵
51. In addition health professionals in hospitals are not making best use of existing services. A survey in one hospital found that while 20% of inpatients smoked, less than a third were given smoking cessation advice, despite the hospital having a smoking cessation service. Furthermore that while there were high levels of awareness amongst health professionals of the local Stop Smoking Service in a District General hospital, only one in five had referred smokers to the service.

Social Marketing

52. Sustained, high weight, mass media campaigns are a key driver of smokers to the Stop Smoking Services, as can be seen by what happened in the second quarter of 2006 when the campaigns were stopped. Without the impetus of mass media to encourage people to quit, the number of successful quitters through the services fell by 17% from the same quarter in the previous year, from 76,000 in April to June 2005 to only 66,000 in April to June 2006.

Comparison of mass media spend on smoking campaigns in England between 2004-5 and 2005-6 in £ millions					
	Q4 Oct-Dec	Q1 Jan-Mar	Q2 Apr-Jun	Q3 Jul-Sept	Total
2004-5	4.7	6.9	4.9	6.6	23.1
2005-6	3.4	5.5	0.0	3.0	11.9

Source: COI

53. As the table above shows, it was not just that the media spend in that quarter fell to nothing, but also that the media spend in the previous two quarters was more than a third down on the previous year. The level of spend on the services is believed to have remained fairly consistent year on year over this period.⁴⁶
54. It is not surprising that stopping mass media advertising had this impact. A recent US study found that the quit rate among adult smokers increased by about 10 per cent for every 5000 GRPs of state anti-tobacco advertising they were exposed to over two years (gross rating points, a measure of the combination of reach and frequency of the ad exposures – this amounted to about 2 additional ad exposures a month).⁴⁷ The conclusion of numerous studies of mass media campaigns has been that the key to success was

⁴⁴ Notes on 2004/5 Quality and Outcomes Framework data for England

⁴⁵ Campbell, I. A., Lewis, K. E., and Preston, L. A. Surveys and assesment of secondary care smoking cessation services in the uk, 2001-2003. *Thorax* 2003;**53 (Suppl III)**:iii42-iii43(Abstract).

⁴⁶ personal communication from DH

⁴⁷ Hyland et al. Anti-tobacco television advertising and indicators of smoking cessation in adults: a cohort study. *Health Education Research*, 2005.

maintaining a consistent and sustained level of advertising over time.^{48 49 50} This is hardly surprising, since given this is the lesson of commercial advertising, why should it be any different for social marketing?

55. The US Centers for Disease Control has put together recommendations for spend on mass media campaigns, based on the spending levels in the four states which had effective tobacco counter-marketing campaigns that had been successful in changing both attitudes and behaviours. CDC recommended a spend of between \$1-3 a year per capita (based on the whole population). On this basis the absolute minimum spend for England would be \$50 million a year or around £25 million, at current rates of exchange, although CDC recommendations were put together in 1999, nearly a decade ago and when the rate of exchange was nearer \$1.5 to the pound. The amount spent by DH on mass marketing in 2004-5 was £25 million, but it would be more sensible to go for the CDC mid-range recommendation of \$2 per capita which would give an annual spend of £50 million p.a.
56. In terms of cost effectiveness, the NHS Stop Smoking Services cost about £50 million in 2004-5 with drug treatments costing another £45 million. This is a total of £95 million and media costs of £25 million would increase this by about 26%, or £50 million by about 50%. Given that the cost-effectiveness of the services per life year gained is currently estimated at less than £1,000, even if it was doubled by the addition of the mass media costs it would still be more than ten times less than the guideline for NICE used in England of £20,000 per quality life year saved.
57. But the total cost of the advertising should not just be accrued to its role in driving people to the services, as actually mass media advertising also performs a much wider role in stimulating change in attitudes and behaviours around smoking.
58. Social marketing using mass media interventions is expensive but cost-effective on a per capita basis. Sustained high weight media campaigns have been shown to lead to a 1% reduction in smoking prevalence in a randomised controlled trial carried out in England.⁴⁸ Public education campaigns have been proven to provide excellent value for money, costing under £1000 per life year saved.⁴⁷
59. Paid mass media advertising campaigns are an effective means of reducing smoking in all socio-economic groups^{51 52 53}, and can be targeted to be specifically aimed at lower socio-economic groups to tackle health inequalities, but they need to be sustained and have high impact. Such campaigns can also

⁴⁸ McVey D., Stapleton J. Can anti-smoking television advertising affect smoking behaviour? Controlled trial of the Health Education Authority for England's anti-smoking TV campaign. *Tobacco Control* 2000;9:273-282

⁴⁹ Erbas B. et al. Investigating the relation between placement of Quit antismoking advertisements and number of telephone calls to Quitline: a semiparametric modelling approach. *Journal of Epidemiological Community Health* 2006;60:180-182

⁵⁰ Levy D. and Friend K. A Computer Simulation Model of Mass Media Interventions Directed at Tobacco Use. *Preventive Medicine* 32, 284-294 (2001).

⁵¹ Reid DJ, Killoran AJ, McNeill AD, Chambers JS. Choosing the most effective health promotion options for reducing a nation's smoking prevalence. *Tobacco Control* 1992;1:185-97.

⁵² Hill DJ, White VM, Gray NJ. Australian patterns of tobacco smoking in 1989. *Med J Aust.* 1991;154:797-801.

⁵³ Department of Health Economics and Operational Research Division. Effect of tobacco advertising on tobacco consumption: a discussion reviewing the evidence. London: Department of Health, 1992.

reduce incident smoking in young people.⁵⁴

60. Mass media campaigns also need to continue to address smoking in the home and exposure of children; self-enforced restrictions on smoking at home are effective in reducing exposure to children but are currently imposed by less than 20% of households.⁵⁵ Furthermore they are a necessary and very effective driver of smokers to the Stop Smoking Services.

61. To increase the rate of prevalence reduction and achieve the fully engaged scenario we will need to continue to invest in social marketing, particularly mass media, consistently at a high weight, year in year out. This is especially important if we are to reduce prevalence amongst manual workers and pregnant women, both difficult to reach groups that are key to health inequalities targets and which can best be reached by targeted mass media campaigns. It is also vital in providing the engine to feed potential quitters to the Stop Smoking Services.

Advertising, Promotion and Marketing

62. Most tobacco advertising is now banned under the terms of the Tobacco Advertising and Promotion Act 2002, which came fully into force in mid-2005. It is expected to be more effective in reducing uptake than in helping existing smokers quit and so may take some time to have a significant effect.

Point of Sale Advertising

63. Although the ban has largely been complied with⁵⁶ the tobacco industry has not stood still. Limited advertising at the point of sale is still permitted. There is no justification on health grounds for this concession and ASH believes that the remaining point of sale advertising should be banned. Furthermore, research shows that the ability to set out displays in an unregulated way is being exploited by the tobacco industry.^{57 58}

64. Other types of promotion also continues e.g. exclusive sales deals with pubs and bars and music festivals and use of these as a means of promoting their product.⁵⁹ Cross border advertising (e.g via satellite TV, the internet or broadcast of sponsored sports events and incidental advertising in movies) is also still an issue which has to be dealt with at the international level via the development of further controls under the global health treaty the FCTC.²⁷

65. The impact of tobacco branding at the point of sale could be minimised by requiring large graphic warning notices to be displayed where tobacco products

⁵⁴ Siegel M, Biener L. The impact of an antismoking media campaign on progression to established smoking: results of a longitudinal youth study. *Am.J Public Health* 2000;**90**:380-6.

⁵⁵ Blackburn C, Spencer N, Bonas S, Coe C, Dolan A, Moy R. Effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home: cross sectional survey. *Brit.Med.J.* 2003;**327**:257-60.

⁵⁶ F Harris et al. Effects of the 2003 advertising/promotion ban in the UK on awareness of tobacco marketing: findings from the ITC four country survey. *Tobacco Control* 2006; 15 (Supplement III):iii26-iii33.

⁵⁷ Sandford, A. Implementation of the Tobacco Point of Sale Regulations in the United Kingdom. Presentation made at the 13th World Conference on Tobacco or Health, July 2006.

⁵⁸ MacGregor, J. Tobacco Advertising at the Point of Sale: The Trading Standards Experience. MacGregor Consulting Ltd, July, 2006

⁵⁹ Personal communication from former Philip Morris marketing manager. See also ASH. *You've Got to be Kidding*. due to be published on 26 April 2007

are visibly on sale. This has been adopted with great success in other jurisdictions.⁶⁰

66. Under the terms of the Tobacco Advertising and Promotion Act 2002 (Section 8), the Government has the power to prevent tobacco products being displayed in such a manner that they constitute an advertisement. ASH recommends that regulations to ban the display of tobacco products at the point of sale be introduced. This would replicate good practice adopted by provinces of Canada, Thailand and Iceland where laws have been passed to completely remove tobacco products from public view.⁶¹ Ireland is now also going ahead with such a policy since the tobacco industry abandoned its legal challenge at the end of January 2007 and a Scottish Ministerial Working Group on Tobacco Control recently recommended the same to the Scottish Parliament.⁶²

Generic Packaging

67. Now that most forms of tobacco advertising and promotion are prohibited, the tobacco companies are dependent to a large extent on tobacco packaging to convey brand appeal, particularly to children. The inclusion of large pictorial health warnings will go some way towards reducing the impact of tobacco branding. However, to reduce the appeal of tobacco even further, the Government could restrict tobacco companies to plain, generic packaging, as has already been discussed in this country⁶³ and in Canada.⁶⁴

Graphic Health Warnings

68. Evidence from Australia and Canada⁶⁵ suggests that the introduction of picture health warnings on cigarette packs is an effective means of discouraging young people from smoking.
69. The Government should adopt the EU recommendations for inclusion of pictorial health warnings on all cigarette packs as soon as possible. In order to increase the impact of the picture warnings, the Government should seek an amendment to the EU Tobacco Products Directive in order to allow the inclusion of picture warnings on both the front and back of tobacco packaging so that the warnings will be seen on the packs at the point of sale.
70. We would suggest that a new bank of images is in place within three years and renewed every three years thereafter. The renewed image banks should include a greater variety of graphic warnings that have tested well in research so that all the warnings used are picture-based.

⁶⁰ Guidelines for price tickets and other matters (Tobacco Products) 2006. Tasmania Department of Health and Human Services, 2006 <http://www.dhhs.tas.gov.au/agency/publications/index.php> ; presentation given by Dr Martin Bicevskis at the 13th World Conference on Tobacco or Health, July 2006

⁶¹ These laws and their implementation are summarised in a discussion paper: Strengthening measures to protect children from tobacco. Tasmania Department of Health and Human Services, May 2006. <http://www.dhhs.tas.gov.au/healthyliving/smoking/protectchildren.php>

⁶² Towards a Towards a future without tobacco: The Report of The Smoking Prevention Working Group 2006. <http://www.scotland.gov.uk/Publications/2006/11/21155256/0>

⁶³ The tobacco industry and the health risks of smoking. Health Committee. London, The Stationery Office, 2000

⁶⁴ Standing Committee on Health. Towards zero consumption. Generic packaging of tobacco products. House of Commons, Canada, 1994.

⁶⁵ Environics Research Group. Canadian adult and youth opinions on the sizing of health warning messages. October 1999

Protection from secondhand smoke

71. The primary aim of the Government's secondhand smoke legislation is to protect workers from its harmful effects. However, it has a secondary impact of denormalising smoking and helping smokers quit. The initial proposals with exemptions for pubs and bars that did not serve food would have increased health inequalities^{66 67} and would probably have led to fewer smokers quitting from less well off social groups.
72. However, while the comprehensive smoking ban now due to be implemented in summer 2007 will not increase health inequalities it is unlikely to reduce them significantly. (Higher smoking rates in lower socio economic groups are the main contributor to health inequalities and the 1.7% reduction in smoking prevalence estimated in the Regulatory Impact Assessment³³ is likely to be equally spread across the social classes.)
73. The mandated three year review of the legislation should be thorough and where necessary lead to updating the regulations, for example to include exempted premises such as prisons, and problem areas such as external areas or areas less than 50% enclosed with potentially high concentrations of smoke (e.g. sports stadia). For example, Quebec law mandates a 9-metre (almost 30 feet) exclusion zone around many establishments.⁶⁸

Reducing Availability and Supply of Tobacco

Tax and Smuggling

Tax

74. We remain firmly in favour of using price as a means of reducing tobacco consumption, an approach recognised by both the World Bank and World Health Organisation as an economically rational plank of public health policy. We believe that the prices paid by smokers should rise *ahead of the rate of growth in incomes* so as to stop tobacco becoming more 'affordable' (the policy outlined in the 1998 tobacco white paper, *Smoking Kills*¹²¹²). Raising prices also helps to reinforce the introduction of other strategies. An econometric analysis of the decline in consumption in cigarettes in California between 1990 and 1992 estimated that while the media campaign was important, 78% of the decline was attributable to tax increases and 22% to the media campaign.¹⁰
75. Tobacco price elasticity is on average around 0.4, which means that a 10% rise in price leads to a 4% decline in consumption, but it has tended to be higher in developing than developed countries⁶⁹, and also higher among lower-income

⁶⁶ Woodall A, Sandbach E, Woodward C, Aveyard P, Merrington G. The partial smoking ban in licensed establishments and health inequalities in England: modelling study. *BMJ* 2005;331:488-489

⁶⁷ IFF Research Ltd. Survey of Pubs and Bars. Research Report prepared for ASH. September 2005.

⁶⁸ See paragraphs 1, 3, 4 and 6 of section 2 of the Tobacco Act <http://www.canlii.org/qc/laws/sta/t-0.01/20061117/whole.html>

⁶⁹ Jha P, Chaloupka FJ. *Curbing the Epidemic: Governments and the Economics of Tobacco Control*. Washington DC: World Bank, 1999.

smokers⁷⁰, and younger smokers.⁶⁹ In the UK the current long run estimate is that price elasticity is around 0.72, taking into account the smuggled market.⁷¹

76. The 2004 Wanless report concluded that, *“The presence of smuggling places severe constraints on the effectiveness of tobacco taxation as a tool for helping to reduce tobacco consumption. Even following recent successes in reducing the UK smuggled market share, at 18 per cent that share remains substantial and makes a case for further action.”*³ He went on to say, *“The evidence suggests that there are still large gains to be made from further increase in taxation (subject to smuggling).”*
77. There is no reason to assume that this conclusion needs to be revised. In fact, now that the smuggling strategy has led to significant declines in the smuggled market share, and in particular now that a strategy for reducing the illicit market in hand-rolled tobacco has been implemented we believe it is time to reintroduce tax increases above inflation.
78. It was a missed opportunity not to include an increase in tax above inflation in the 2007 Budget. This was shortly before the introduction of smokefree legislation in Wales, and Northern Ireland and England and would have enhanced the impact of the legislation in reducing smoking prevalence, as was found to be the case in Ireland. It would also have reinforced the impact of the smokefree legislation introduced last year in Scotland.
79. We recommended the reintroduction of a real price escalator on top of inflation of 3% in the Budget. Real price tax increases are supported by a majority of public opinion⁷², and an increase of this level is supported by the majority of the population, including a majority of smokers, if the price increases were used to help stop young people take up smoking and help smokers quit.⁷³
80. In 2000 the Government introduced a tobacco smuggling strategy which has been reasonably successful in containing and beginning to reduce the proportion of smuggled cigarettes.
81. Following representations by ASH, the National Audit Office reviewed the strategy in 2005. To quote the National Audit Office in its report of October 2005, *‘If the final fraud figures for 2004-5 were to show an illicit market share for cigarettes of 15 per cent, however, this could suggest that the current approach has reached the limit of its effectiveness in continuing to reduce the level of fraud.’*⁷⁴

Smuggling

82. HM Revenue and Customs have now revised their method of calculating illicit trade market share to give a range rather than a single figure, and have

⁷⁰ Wilson N, Thomson G. Tobacco tax as a health protecting policy: a brief review of the New Zealand evidence. N Z Med J 2005;118(1213):U1403

⁷¹ Cullum P HM Customs & Excise and Pissarides, C LSE. The Demand for Tobacco Products in the UK. Government Economic Service Working Paper No. 150. December 2004. HM Customs & Excise.

⁷² Smoking-related behaviour and attitudes, 2005. Office for National Statistics, London, 2006.

⁷³ West R (2006) Public support for a tobacco levy.

www.smokinginengland.info/Ref/paper5.pdf

⁷⁴ Comptroller and Auditor General's Standard Report on the Accounts of HM Customs and Excise 2004-5. 7 October 2005.

backdated this to 2001-02. It published these figures in the Annual Report for 2005-6 which gave a range for 2004-5 of 10-19%. It is still deciding how to measure whether or not it has met its PSA targets, but the obvious way of doing this is to use the midpoints. On this basis HMRC are well on the way to meeting the PSA target for 2007-8 for cigarettes of 13%. (see table overleaf)

UK market share of smuggled cigarettes				
Year	PSA target	Outturn	Range	Mid-point
2007-2008	13%			
2004-2005	18%		10-19%	14.5%
2003-2004	20%	16%	14-21%	17.5%
2002-2003	21%	15%	12-18%	15%
2001-2002	22%	20%	16-24%	20%
2000-2001	na	21%		
1999-2000	na	18%		
1998-1999	na	10%		
1997-1998	na	5%		
1996-1997	na	3%		

Source: HMRC (Range introduced in 2005-06 Annual report)

83. The 2005 Pre-Budget Report announced a new strategy which was further developed in the 2006 Budget. In March 2006 the Chancellor published the updated tobacco strategy⁷⁵ which included:

- **Working with tobacco manufacturers** – to improve the targeting of counterfeit product, and further restrict supply of both Hand Rolled Tobacco (HRT) and genuine cigarettes. Strengthened Memoranda of Understanding (MOUs) (and in the PBR it had been announced that there would be a consultation on options for introducing covert markings for the UK tobacco retail market) complemented with legislation in the Finance Bill 2006 making it a legal duty for manufacturers not to facilitate smuggling with fines up to £5 million if they didn't;
- **Enhancing HMRC's operational response** – deploying 200 staff specifically to tackle smuggling of hand-rolling tobacco; and a 30 per cent increase in the network of Foreign Liaison Officers;
- **Using technology** – to increase HMRC's ability to detect illicit goods and target resources effectively;

⁷⁵ New Responses to new challenges: Reinforcing the Tackling Tobacco Smuggling Strategy. March 2006. HM Treasury and HM Revenue and Customs.

- **Publicity and communication** – to increase awareness of HMRC enforcement action and to undermine further the appeal of smuggled product to current and potential consumers.
- **A new specific operational target for HRT** (hand-rolled tobacco) of reducing the size of the illicit market by 1,200 tonnes – equivalent to around 20 per cent – by 2007/8.

Working with tobacco manufacturers

84. The Government has subsequently signed updated Memoranda of Understanding (MOUs) with the tobacco industry. However, we remain concerned that the new MOUs retain the same fundamental weaknesses as the previous ones, in that they are not legally enforceable, so rely on the goodwill of the industry and do not contain specific, measurable outcomes.
85. For example, each of the MOUs, with Imperial, Gallaher, and BAT have essentially the same key wording (underlining added):
- **Objective** Imperial/Gallaher/BAT *'is committed to take commercially reasonable steps, as a manufacturer of tobacco products (cigarettes, handrolling and pipe tobacco and cigars) to promote the objective that its tobacco products be sold, distributed and shipped in accordance with all applicable fiscal and legal requirements; sold at retail in accordance with all applicable tax and duty laws in the intended retail market; and at volumes consistent with XXXX's understanding of the domestic consumption in that market and the permissible requirements of the travelling customer '* (Objective 1.3).
 - **Legal Obligations** *'The signing of this MOU is not intended to create binding legal obligation on either party.'* (6.6).
86. While the MOUs are stricter than the previous versions they are still voluntary, with no legal obligations and do not have a full audit and performance review process built into them.
87. For the first time manufacturers are expected to control the sales of Hand-Rolled Tobacco to end markets so that only sufficient product to supply that market will be sold. This is crucial since we know that the majority of smuggled HRT is duty paid from the Benelux countries. Independent verification is crucial given that the industry has been responsible for oversupplying these markets for many years.
88. ASH understands that the European Commission will be issuing a consultation document on the structure and rates of tobacco excise duties shortly, and that it is widely expected to contain a recommendation that tax on HRT be increased to two thirds that of cigarettes with a long-term aim of equalising the rate.⁷⁶ If this were to be agreed it would help reduce the incentive to cross-border shop/smuggle HRT into the UK from other European Member States.

⁷⁶ Currently the minimum excise duty for HRT is 36% of the tax inclusive retail price or 32 €/kilogram compared to 57% and 60/64 €/1000 for cigarettes. In general a cigarette is equivalent of ¾ of a gram.

89. Reducing smuggling needs to remain a priority and it would seem sensible to set new and stronger targets after the current target deadlines are reached in March 2008, for both cigarettes and Hand-Rolled Tobacco.

FCTC Protocol on illicit trade in tobacco

90. The Framework Convention on Tobacco Control is the first health treaty, adopted in May 2003 and brought into force more quickly than any other international treaty.²⁷ It now has 144 Parties, comprising 80% of the world's population. Article 15 covers illicit trade in tobacco products.
91. During the UK's Presidency of the EU in October 2005 the UK held a health summit at which tobacco smuggling was discussed. Following this the UK suggested to the EU Health Council that it could usefully, with the agreement of the relevant EU working groups and the Commission, call for a protocol on illicit trade at the first Conference of the Parties (COP). At the COP in Geneva in February 2006 this idea was put forward and it was agreed by the Parties, that an expert working group would be set up to initiate the development of a Protocol on illicit trade. This expert group is developing a protocol template to go to the second COP which is to be held in Bangkok in June 2007.
92. Work is progressing well and the draft template is currently being finalised. This will then need to be agreed by the Parties and put into negotiation to be developed into a protocol. This includes comprehensive tracking and tracing requirements, but also licensing of the supply chain of both tobacco products and tobacco-specific products such as machinery and filters, with strict compliance and anti-money laundering requirements; enforcement measures and sanctions including confiscation, seizure and financial penalties.
93. The UK Government has played a key role in getting this protocol underway. All these measures will help tackle illicit trade in counterfeit as well as genuine product. HM Treasury and HMRC should therefore support the development of a legally enforceable, comprehensive illicit trade protocol under the FCTC and we would urge HM Revenue and Customs to send representatives to the Conference of the Parties in Bangkok to participate most effectively in discussions about how to take development of the protocol forward.
94. To quote HMRC's new strategy document *'The UK illicit cigarette market is at the end of an international supply chain that stretches to the Far East and Africa as well as closer to home in the Baltic States.'*⁷⁵ We hope with this clearly stated understanding of the global nature of smuggling HMRC is now more willing to collaborate internationally in a global illicit trade protocol.
95. In the 2007 Budget the Chancellor announced that, *"Following a period of consultation, the Government has reached agreement with tobacco manufacturers on the introduction of state-of-the-art pack markings that will enable HMRC and other enforcement agencies to detect counterfeit tobacco products simply and effectively. Manufacturers have agreed to introduce the new pack markings voluntarily during 2007."* Given that covert markings are an essential element of tracking and tracing systems which are central to the illicit trade protocol currently being developed as part of the FCTC, it is important that this is co-ordinated with the development of the protocol. It should be noted as well that the majority of smuggled product is still diverted product manufactured by the major producers, not counterfeit and any such

system needs to be developed to ensure such diversions can quickly be tracked and traced. (Tracking and tracing systems enable product to be tracked and traced through the supply chain so the point of diversion into the smuggled market can be determined and also that they can be properly monitored to ensure all taxes are paid).

Control of sales to underage smokers

96. On 1 January the Government announced that it would be raising the legal minimum age to purchase tobacco from 16 to 18. We supported this move since it will reinforce the dangers of tobacco products, but only on the basis that it was effectively enforced with penalties that are sufficient to dissuade retailers from flouting the law, as there is no evidence that on its own an increase in the age of purchase will have any impact on smoking rates among young people.
97. Laws which are not properly enforced fall into disrepute. In Ireland, for example, the legal age for the purchase of tobacco was raised from 16 to 18 in 2001. However, a recent survey of teenagers under the age of 18 who bought cigarettes from shops found that 92% of them had not been asked for identification. It is already the case that the law in England is not being properly enforced. In 2004 some 70 per cent of underage English smokers bought their cigarettes from small retailers⁷⁷, yet only 50 retailers were fined for selling tobacco to minors in the whole of England and Wales.⁷⁸
98. In 2004 the Government was proposing to introduce a negative licensing system which would provide a strong disincentive to retailers to flout the law as the ultimate sanction would be the removal of their right to sell tobacco.
99. Chapter 3, paragraph 104 of the Public Health White Paper states that: *“We propose that legislation be brought forward to create new powers to ban retailers from selling tobacco products, on a temporary or permanent basis, if they repeatedly flout the law. This complements the work already under way to improve proof of age schemes. We intend to support this measure by looking at higher fines and updated guidance for magistrates, along with education for retailers on better compliance with the underage sales law. Before introducing these measures, we will consult local authorities, the retail industry and other key stakeholders. We will support this with a communications programme for local authority enforcement.”*
100. Unfortunately licensing was not included with the recent announcement of the increase in age of purchase from October 2007. Our understanding is that this is because although the age of sale could be increased through regulations, licensing needed to be brought in through primary legislation and the limited number of Bills announced in the Queen’s speech did not allow space for such legislation. Space must be found, and urgently, as changing the

⁷⁷ The Smoking, Drinking and Drug Use Among Young People in England Survey 2004 showed that nearly 70% of 11 to 15 year old smokers say they buy their cigarettes from small shops such as corner shops and newsagents.

⁷⁸ Data from the Office for Criminal Justice Reform shows that in 2004 only 50 retailers in England and Wales were fined for selling tobacco to minors. Of these 12 received fines between £151-£200 while only one was fined more than £1000.

age of purchase will have no impact whatsoever unless enforcement and penalties for selling to underage smokers are significantly strengthened.

101. Additionally the sale of tobacco from vending machines should be banned . According to the latest survey of smoking among secondary school children in England³⁰ 24% of regular smokers reported buying cigarettes from vending machines at least a few times a week. The survey also found that only 13% of current smokers who bought cigarettes from vending machines found it very or fairly difficult. Whilst the banning of tobacco from vending machines might inconvenience some adult smokers it would be a small price to pay in return for a reduction in cigarette consumption among teenagers.
102. In place of tobacco, ASH recommends that nicotine replacement therapies be made available via vending machines to help increase their availability and accessibility. This would support the policy outlined in the Public Health White Paper which calls for the promotion of stop smoking therapies through a wider choice of outlets. It is absurd that deadly tobacco products are widely available yet products that can help people to stop smoking have limited availability.
103. Penalties and enforcement of underage sales laws should be strengthened significantly at the same time as the age of sale is increased to 18. In particular licensing of retailers should be implemented together with increased fines and potential loss of licence for non-compliance.

Regulatory reform and harm reduction

104. ASH and the Royal College of Physicians recommended to Wanless that the Government develop a harm reduction strategy to give smokers access to nicotine through less harmful means of use than smoked tobacco. It's the tobacco smoke that kills people not the nicotine. It's the nicotine that people are addicted to and not the tobacco smoke. Smokers should be given access to nicotine in a form and at a price that is attractive as an alternative to smoking.
105. We welcome the Chancellor's announcement in the 2007 Budget that VAT on nicotine replacement products would be reduced from 17.5% to 5% from 1 July, as this is a new initiative with great potential and something we have in the past suggested. However, this measure is currently only due to last for one year, which will have a welcome but limited impact in helping reduce smoking prevalence. We would urge the Treasury to sustain this reduction in taxation of such products permanently.
106. Furthermore, regulation of all nicotine products should preferably be given to a stand-alone tobacco and nicotine regulatory authority, with a remit to minimise the proportion of regular nicotine users in society and amongst them, the proportion regularly obtaining nicotine from smoked tobacco.⁷⁹
107. Chapter 8, paragraph 8 of the Public Health White Paper¹⁷ states that the Government does not "*think there is a case for setting up a brand new UK agency to regulate tobacco*", although it gives no reasons for this conclusion.

⁷⁹ Smoking Kills – a critique: Submission to Derek Wanless A Report by ASH and the Royal College of Physicians. 12th January 2004

Paragraph 8 also states that the Government does “*recognise the need for more work to look at how best to regulate tobacco products*” and that it intends to “*develop a strategy for taking this work forward*”.¹⁷

108. So far such a strategy has not been developed. It is nevertheless essential to achievement of the ‘fully engaged’ scenario envisaged by Wanless of 17% smoking prevalence in the short to medium term and 11% by 2022³, without which we cannot minimise future NHS costs.
109. This is because we have now pulled the other known levers to cut smoking prevalence and even with the welcome boost provided by smokefree legislation, and further maintenance and strengthening of existing tobacco control measures, it is likely to take over 15 years just to reach smoking prevalence rates of 17%, although once the price escalator can be reintroduced prevalence rates will come down faster than this.
110. Smoking is the main cause of health inequalities, with smoking rates amongst the most deprived and disadvantaged in society above 70% compared to 25% for the general population.
111. A harm reduction strategy is needed that would give smokers, in particular the most disadvantaged, access to less harmful forms of nicotine in a form and at a price that is attractive as an alternative to smoking. This must be accompanied by effective social marketing so that people understand that it is not the nicotine itself that is harmful but that the harmfulness of delivery varies greatly.
112. A switch of only 1% of the population a year from smoking to less harmful nicotine sources, a conservative target, would save around 60,000 lives in only 10 years.^{16 16}
113. Not only would this save thousands of lives it would also lead to substantial savings for the NHS. (see para 14).
114. Such a harm reduction strategy would be a market-based low-cost public health intervention. But it would require a strong political lead to be taken by Government.
115. It would encourage the development and sale of new, low harm nicotine products as a safe alternative to cigarettes and ensure that all such products were subject to a common regulatory regime including, importantly, their promotion and marketing.
116. HM Treasury could play a crucial role in setting tax differentials between the newly licensed products and cigarettes using price to trigger to behaviour change particularly amongst poorer users. A precedent has already been set in the reduction of VAT on NRT products, but this needs to be sustained permanently and not just be a short-term measure.
117. Not only would this save smokers lives it would also significantly reduce children’s exposure to passive smoke in the home where legislation cannot effectively intervene.
118. This is an issue where an innovative policy response could be developed as part of the 2007 Comprehensive Spending Review. A harm

reduction strategy would enable the PSA targets for the DH to be tightened to match the targets in the 'fully engaged' scenario of 11% smoking prevalence by 2022.

119. The Department of Health should set up a working group including other relevant Government Departments, and related organisations, such as HM Treasury, the Medicines and Healthcare Regulatory Authority, the Health Protection Agency, and public stakeholders such as ASH and the Royal College of Physicians to develop a harm reduction strategy with terms of reference to include:

- Defining a harm reduction strategy for tobacco;
- Determining what bodies are needed to implement such a harm reduction strategy; and
- Developing an implementation strategy.

Appendix A – organisations supporting this submission

ASH

British Heart Foundation

British Lung Foundation

British Thoracic Society

Cancer Research UK

Fresh Smoke Free North East

National Heart Forum

No Smoking Day

QUIT

Roy Castle Lung Cancer Foundation

Royal College of General Practitioners

Royal College of Physicians

Royal Society of Health

Smoke Free Liverpool

UK Public Health Association

World Cancer Research Fund

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