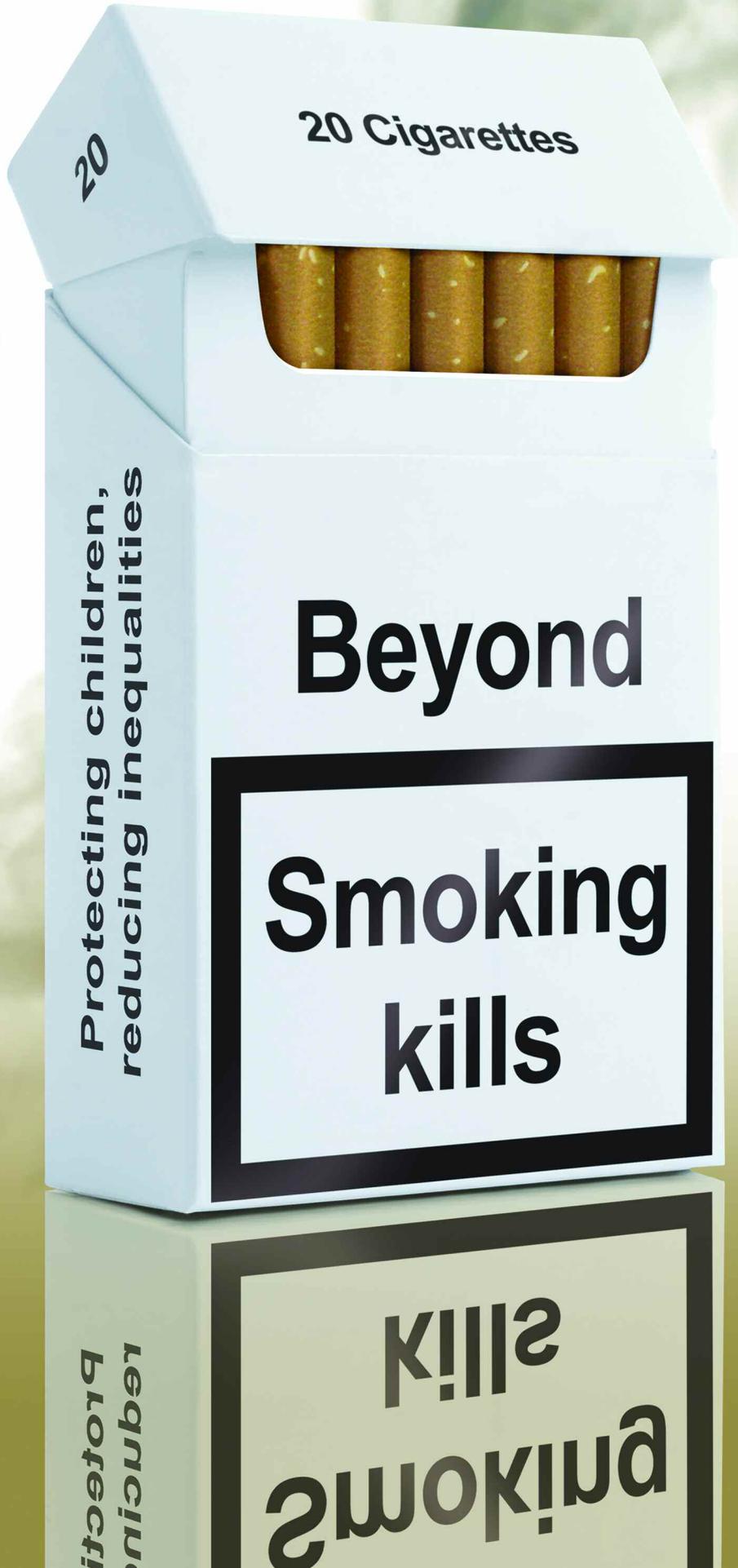


EXECUTIVE SUMMARY



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Introduction

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

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

1. The goal and aims of tobacco control

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

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

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

2. Ten years of progress

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

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

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

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

Recommendations: 1

3. Children and young people

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

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

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

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

4. Health inequalities

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

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

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

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

5. Public opinion

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

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

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

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

6. The regulation and use of tobacco

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

Tobacco advertising and branding encourage children and young people to start smoking.

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

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

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

Recommendations: 11-26.

7. Help to quit

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

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

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

Recommendations: 27-38.

8. Alternatives to smoking

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

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

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

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

Recommendations: 39-44.

9. New commitment, new targets.

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

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

Recommendations: 1-10.

RECOMMENDATIONS

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National strategy

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

Tobacco regulation

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

Mass media

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

Secondhand smoke

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

Stop smoking services and treatment

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

Pure nicotine products

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

ABOUT THIS REPORT

BEYOND *Smoking Kills* is published by Action on Smoking and Health and funded by Cancer Research UK and the British Heart Foundation. This report marks the tenth anniversary of the white paper *Smoking Kills* and sets out an agenda for action for the decade to come. The development of the report was overseen by an editorial board of tobacco control experts and is supported by more than 100 organisations. We would like to acknowledge the contributions made by all our partners.

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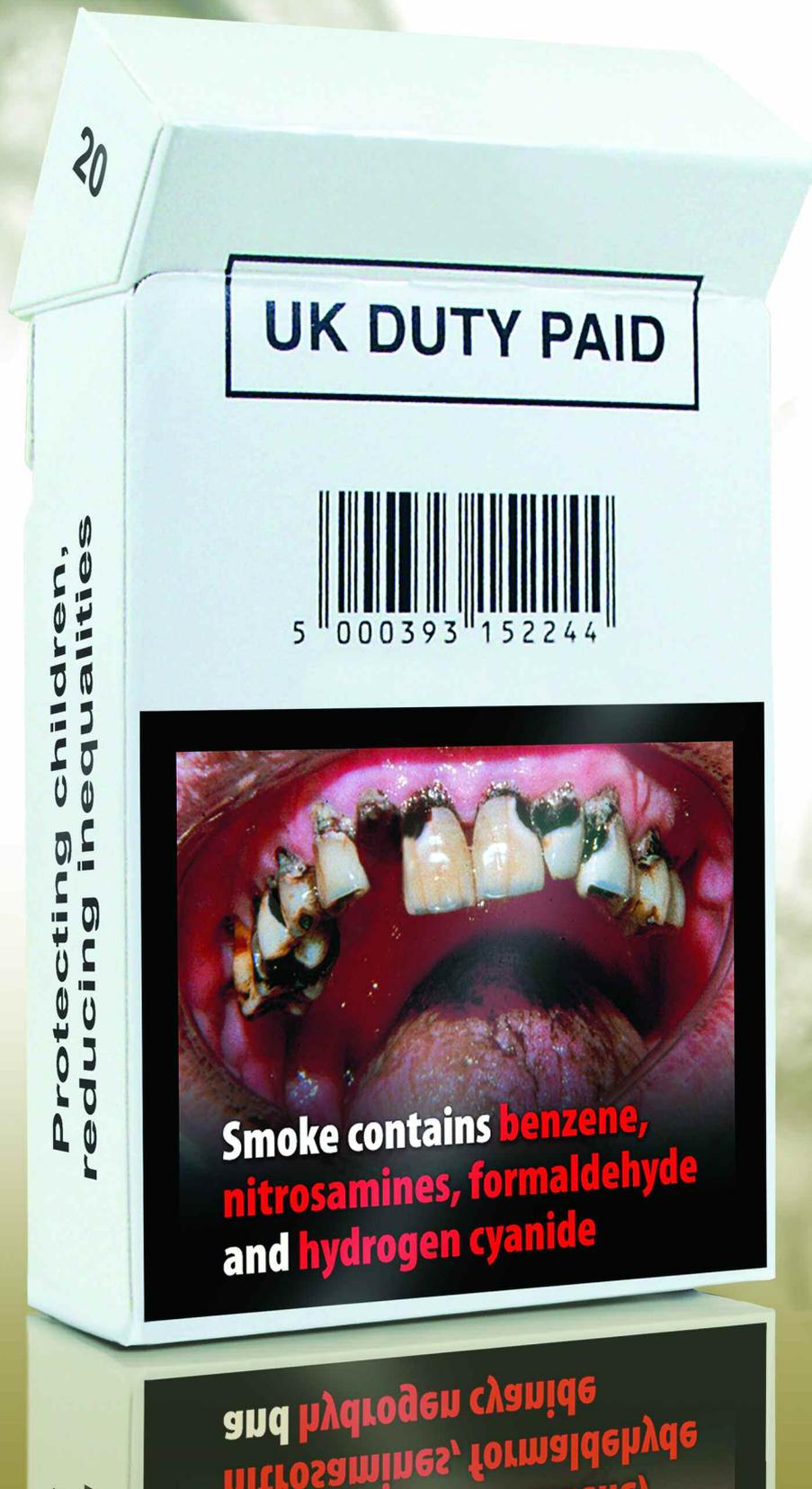
Macmillan Cancer Support
Men's Health Forum
Mental Health Foundation
Mental Health Network
Mouth Cancer Foundation
National Association of Child Contact
Centres
National Children's Bureau
National Heart Forum
NHS Alliance
No Smoking Day
Orchid
Primary Care Cardiovascular Society
QUIT
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and
Gynaecologists
Royal College of Pathologists
Royal College of Psychiatrists
Royal College of Physicians
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Royal College of Radiologists
Royal National Institute of Blind People
Sainsbury Centre for Mental Health
Scottish Public Health Observatory
South Asian Health Foundation
The Roy Castle Lung Foundation
The Stroke Association
Tobacco Control Collaboration Centre
Tommy's (pregnancy related
recommendations)
UK Centre for Tobacco Control Studies
UK Public Health Association
Wales Centre for Health

LOCAL AND REGIONAL

Bolton PCT
Brent Teaching PCT
Bristol PCT
Bury PCT
Dorset PCT
Dudley PCT
East and North Herts PCT
East Midlands Public Health Observatory
Eastern Region Public Health Observatory
Fresh Smokefree North East
Gateshead PCT
Heart of Birmingham PCT
Heart of Mersey
Kent County Council - Children, Families and
Education Directorate
Kingston PCT
Leeds PCT
Liverpool PCT
London Health Observatory
London Teaching Public Health Network
NHS North West SHA
NHS South Central SHA
NHS West Midlands SHA
North East Essex PCT
North East Public Health Observatory
North Lancashire Teaching PCT
North Lincolnshire Council/ North Lincolnshire PCT
North West Public Health Observatory
North Yorkshire and York PCT
Portsmouth City Teaching PCT
Redbridge PCT
Richmond and Twickenham PCT
Sandwell PCT
Sheffield PCT and City Council
Smokefree North West
Solihull NHS Care Trust
South Staffordshire PCT
South East Public Health Observatory
South West Public Health Observatory
South West Thames Institute for Renal Research
South West Thames Kidney Fund
West Herts PCT
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