

All Party Parliamentary Group on Smoking and Health



**Delivering a Smokefree
2030: The All Party
Parliamentary Group
on Smoking and Health
recommendations for
the Tobacco Control Plan
2021**

June 2021



About the All Party Parliamentary Group on Smoking and Health

The All Party Parliamentary Group (APPG) on Smoking and Health is a cross-party group of Peers and MPs which was founded in 1976 and is currently chaired by Bob Blackman MP. Its agreed purpose is to monitor and discuss the health and social effects of smoking; to review potential changes in existing legislation to reduce levels of smoking; to assess the latest medical techniques to assist in smoking cessation; and to act as a resource for the group's members on all issues relating to smoking and public health. The secretariat of the group is provided by Action on Smoking and Health.

This report was commissioned by the All-Party Parliamentary Group on Smoking and Health from Action on Smoking and Health (ASH) which provides the Secretariat for the APPG. It was researched and written with support from SPECTRUM, the consortium of academics from ten UK universities funded by the UK Prevention Research Partnership to research the health and economic impacts of policy interventions, including on the wider economy.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either House or its committees. All-Party Parliamentary Groups are informal groups of Members of both Houses with a common interest in particular issues. This report has been endorsed by the Officers of the APPG on Smoking and Health.

Date of publication: 9th June 2021

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Citation: Delivering a Smokefree 2030: The All Party Parliamentary Group on Smoking and Health recommendations for the Tobacco Control Plan 2021. London: APPG on Smoking and Health. 2021.

ISBN 978-1-913448-14-1

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Foreword

The Government's ambition for England to be Smokefree by 2030 is strongly supported by the APPG on Smoking and Health, as it is by the public. Achieving this ambition is a prerequisite for the delivery of manifesto commitments to increase healthy life expectancy by five years by 2035, while reducing inequalities and levelling up the nation.

However, as the Secretary of State himself stated, this will not be delivered by "*business as usual*". The APPG therefore welcomes the Government's commitment, in setting up the Office of Health Promotion within the Department of Health and Social Care, that health will no longer be the business of the DHSC alone, but a core priority for the whole of government. Smokefree 2030 remains, however, an "*extremely challenging*" ambition which will require "*bold action*".

The APPG agrees with the Secretary of State's assessment and we have risen to his challenge. This report sets out our recommendations for the "*bold actions*" we believe must be included in the new Tobacco Control Plan if it is to deliver a Smokefree 2030.

Government action is needed and wanted, because this is an addiction most smokers were trapped into as children. Two thirds of those who try smoking go on to become regular smokers, only a third of whom succeed in quitting during their lifetime. Most smokers want to quit and many more regret ever having started.

However, to end smoking will require funding and the APPG believes, as do the public, that the tobacco manufacturers should be made to pay. This is an industry, which, as the Chief Medical Officer reminded us recently, kills people for profit, and is likely to have killed more people last year than COVID-19.

The UK, home to the tobacco industry, led the way into the tobacco epidemic in the 20th Century. In the 21st Century, we are now showing global leadership in forging the path out. Brexit gives the UK the opportunity for our global leadership in tobacco control to shine on the international stage. While we were part of the EU, the EU spoke for us. Now we can speak for ourselves and we should use this to highlight our ambition to make smoking obsolete and be Smokefree by 2030.

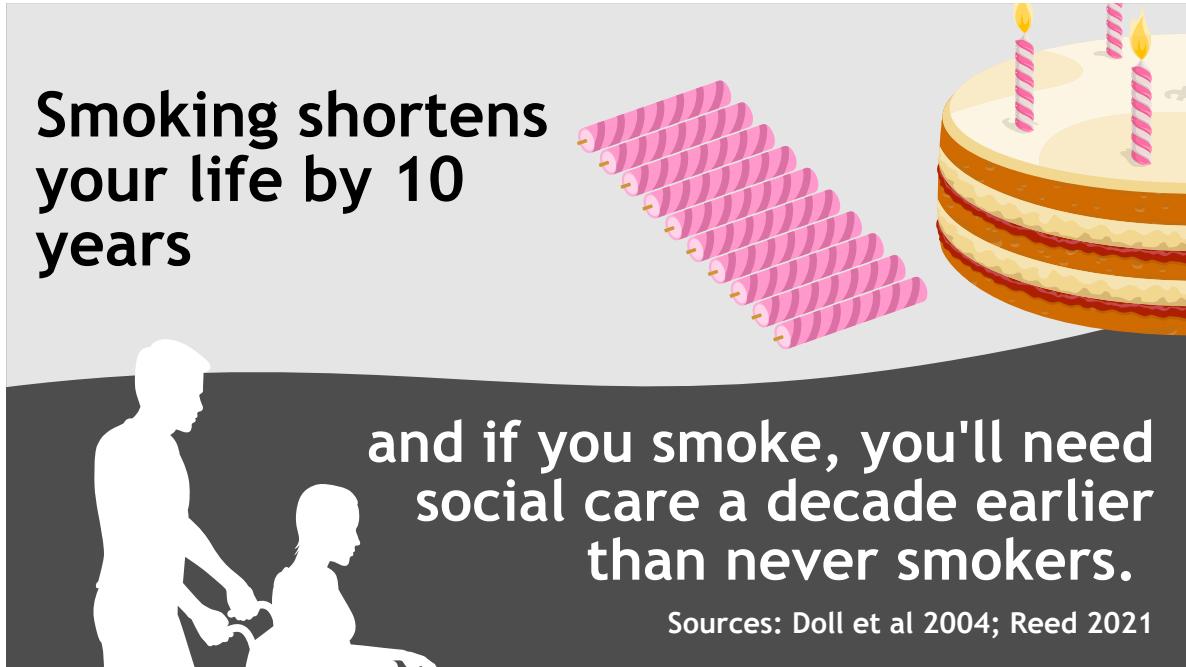


Bob Blackman MP
Chairman of the All Party Parliamentary Group on Smoking and Health

Executive Summary and Conclusions

1. This report sets out the All Party Parliamentary Group on Smoking and Health's recommendations for the Tobacco Control Plan to deliver a Smokefree 2030.¹ Government action to end smoking is both needed and wanted, with three quarters of the public supporting both the ambition and Government action to deliver it. As a world leader in tobacco control and strong supporter of the full implementation of the international tobacco treaty, the WHO Framework Convention on Tobacco Control (FCTC),² our nation quite rightly seeks to be among the first in the world to end the tobacco epidemic.
2. Achieving the Government's Smokefree 2030 ambition,³ of smoking prevalence of less than 5%,⁴ is an essential step towards reducing inequalities and increasing healthy life years,^{5 6} as half the difference in life expectancy between the richest and poorest in society is due to smoking,⁷ and for every smoker who dies another thirty are suffering serious-smoking related diseases.^{8 9} On average, smokers have difficulty carrying out everyday tasks like dressing, eating and walking across a room, seven years earlier than never smokers and need care support ten years earlier than never smokers.^{10 11}
3. And although in 2020 COVID-19 killed around 80,000 people prematurely in the UK,¹² smoking kills on the same scale every year,¹³ and will go on doing so for many years to come unless we make smoking obsolete. We are taking the necessary steps to end the coronavirus pandemic; we must do the same for smoking.
4. The economic, as well as the health benefits, of Smokefree 2030 will be most keenly felt among the most disadvantaged groups and in the most disadvantaged regions. The coronavirus pandemic has thrown a spotlight on the devastating impact of inequalities. Increasing healthy life expectancy by five years by 2035 while reducing inequalities, and levelling up society, in line with the Government manifesto commitments will be a greater challenge post-pandemic than it was before.^{14 15}
5. The APPG therefore welcomes the Government's commitment that its public health reforms "*aim to ensure that the public's health is given the status it deserves - at the very heart of government's priorities for action, policy and investment, nationally and locally, across government and across the NHS.*" Also welcome is the decision to strengthen the role of the Chief Medical Officer (CMO) as the lead independent public health advisor across government.¹⁶
6. The EU's ambition is to be Smokefree by 2040;¹⁷ our Government plans to get there a decade earlier. This is achievable but we must go further and faster than we have ever done before. Smoking rates declined by two thirds over the last half century while smoking-related inequalities grew. To be Smokefree by 2030 we need to reduce smoking by two thirds in only a decade, and by three quarters for smokers in routine and manual occupations.¹³ We are not yet on track.
7. At current rates of decline we will miss the target by seven years, and double that for the poorest in society.¹⁸ There are still nearly 6 million smokers in England, one in seven of the adult population. We will only achieve a Smokefree 2030 by motivating more smokers to make a quit attempt using the most effective quitting aids, while reducing the number of children and young adults who start smoking each year. The evidence about what policy levers work is clear, what is needed is for Government to pull them to their fullest extent.^{19 20}
8. Achieving a Smokefree 2030 cannot be done on the cheap, it will require investment. But the investment required can be counted in millions compared to the billions it costs to treat smoking-related diseases, and in lost productivity caused by smoking-related disability and premature death.

9. The benefits will far outweigh the costs. Smoking does not just damage physical health, but mental health too. One in three smokers show signs of poor mental health, and quitting is linked to improvements in wellbeing at least as great as from anti-depressants.²¹
10. Smoking also drives over a million people into poverty, including over a quarter of a million children, leaching money out of local economies, particularly in disadvantaged communities where household income is lowest.²²
11. Total spending on tobacco based on weighted average prices is estimated to be over £14 billion a year. Only a tiny proportion of the total stays in local communities, with over 90% going up in smoke, in taxes and tobacco manufacturers' profits. Tax revenues nowhere near cover the economic cost of smoking to society. Making smoking obsolete will significantly increase disposable income among poorer smokers and in poorer communities, increasing welfare and jobs.²³
12. The Government's decision that health will no longer only be the business of the DHSC, but a core priority for the whole of government is welcome. Other Government Departments also have a role to play in delivering a Smokefree 2030, for example HM Treasury on taxation, HMRC on the illicit trade in tobacco, and DEFRA on the environmental impact of tobacco.
13. However, the recommendations set out in this report are for DHSC for inclusion in the forthcoming Tobacco Control Plan. They relate to England with respect to health measures and to the UK with respect to reserved matters such as our international role in tobacco control. There is no time to be lost if we are to get on track to be Smokefree by 2030 so these measures need to be put in place by the end of 2021 and sustained until at least 2030.
14. A recommendation that interim targets be set for 2025 is included, so that if we are not on track for a Smokefree 2030 by then, the Tobacco Control Plan can be reviewed and enhanced.



Recommendations

Setting course for a Smokefree 2030

Recommendation 1: Legislate to make tobacco manufacturers pay for a Smokefree 2030 Fund to bring an end to smoking

Recommendation 2: Take our place on the world stage as a global leader in tobacco control.

Recommendation 3: Set interim targets for 2025, and update our strategy if we are not on track to a Smokefree 2030 by then

Behaviour Change Policy and Interventions for a Smokefree 2030

Levelling up through targeted investment

Recommendation 4: Deliver anti-smoking behaviour change campaigns targeted at routine and manual and unemployed smokers (C2DE).

Recommendation 5: Ensure all smokers are advised to quit at least annually and given opt-out referral to Stop Smoking Services.

Recommendation 6: Target support to give additional help to those living in social housing or with mental health conditions, who have high rates of smoking.

Recommendation 7: Ensure all pregnant smokers are given financial incentives to quit in addition to smoking cessation support.

Recommendation 8: Fund regional programmes to reduce the use of illicit tobacco in deprived communities.

Shaping the Consumer Environment

Recommendation 9: Legislate to put health warnings on individual cigarettes, quit messaging on pack inserts and close other loopholes in existing regulations.

Recommendation 10: Reduce the appeal and availability of e-cigarettes and other nicotine products to children.

Recommendation 11: Make the route to medicinal licensing fit for purpose to allow e-cigarettes to be authorised for NHS prescription.

Recommendation 12: Consult on raising the age of sale for tobacco from 18 to 21

Introduction

15. The last Tobacco Control Plan in 2017 set out the vision of a Smokefree generation, defining this as smoking rates of 5% or below.⁴ This vision was to be achieved by shifting emphasis, “*from action at the national level - legislation and mandation of services to focused, local action, supporting smokers, particularly in disadvantaged groups, to quit.*”
16. However, when in 2019 the Government started the clock ticking by setting an end date to achieve this vision of 2030, it also recognised that there was a vital role for national government too.³ That achieving a Smokefree 2030 would be “*extremely challenging*”, that “*bold action*” would be needed, including considering “*a ‘polluter pays’ approach requiring tobacco companies to pay towards the cost of tobacco control*”.
17. The Government committed to set out further proposals for moving towards a Smokefree 2030 at a later date, and last December to a new Tobacco Control Plan designed to deliver the ambition.¹ That Plan is now under development, and it will have to be truly transformative if we are to succeed. With only nine years left to deliver the ambition, smoking rates are not yet declining anywhere near fast enough.
18. In this report the APPG sets out the cutting-edge and proactive measures national government must take, to support action at local level, if we are to achieve a Smokefree 2030.
19. The detailed evidence underpinning the recommendations is in the body of the report set out below. This includes modelling of the impact of the recommendations designed to motivate quitting and increase success rates among smokers who attempt to quit.
20. This work was carried out for the APPG by the Cancer Research UK funded Tobacco and Alcohol Research Group at UCL, part of the SPECTRUM academic consortium. The team at UCL has also estimated the likely impact of raising the age of sale on youth smoking prevalence. They find this is likely to significantly reduce smoking rates among young adults. The illustrative modelling is available for scrutiny on the Open Science Framework.²⁴
21. The impact of each recommendation is modelled separately, and the outcomes cannot be assumed to be additive. However, some measures have the potential to enhance the impact of others. For instance, if in addition to being motivated to quit by behaviour change campaigns, smokers attempting to quit access stop smoking services, their success rates will be improved.
22. The assumption is made that if we also continue to ratchet up the regulations on the marketing of tobacco products, on their packaging and labelling, and the prohibition of flavours for example, we can sustain a 0.5 percentage point annual decline in smoking prevalence. This was the considered view of the modelling team in the light of the available evidence,²⁵ and of what has been achieved in England in recent years.¹³

Public support for Government action

23. The Smokefree 2030 ambition is supported by 76% of the population, including 42% of smokers, backed up by majority support for a wide range of government interventions. Just as there is cross party support in parliament, there is majority support for a range of measures from those who voted for all the main political parties at the last election. For example, three quarters or more of Conservative (76%), Labour (82%) or Liberal Democrat (87%) voters surveyed support making the tobacco manufacturers pay a levy to government to fund measures to help smokers quit and prevent young people from taking up smoking.
24. These results are from the annual ASH funded YouGov survey weighted to be representative of the population.²⁶ This large survey, of over 10,000 adults in England found majority support in 2021 for the following measures (these results are consistent with results for the devolved nations):
- 84% support requiring businesses to have a licence to sell tobacco which they can lose if they sell to underage smokers (4% oppose)
 - 78% support the idea that all smokers staying in hospital should be offered support and medication to help them not to smoke (6% oppose)
 - 77% support making tobacco manufacturers pay a levy to Government for measures to help smokers quit and prevent young people from taking up smoking (6% oppose)
 - 77% support a ban on advertising tobacco accessories such as papers and filters (6% oppose)
 - 72% support increased Government investment in public education campaigns on smoking aimed at adults and children (6% oppose)
 - 71% support requiring cigarette packs to include inserts with Government information about quitting (7% oppose)
 - 70% support health warnings printed on cigarette sticks to encourage smokers to quit (8% oppose)
 - 67% support a ban on smoking in outdoor seating areas of restaurants, pubs and cafes (19% oppose)
 - 66% support tax increases to raise the price of tobacco (15% oppose)
 - 63% support increasing the age of sale from 18 to 21 (15% oppose)
 - 59% support rolling out evidence based scheme to provide financial incentives to help pregnant women stop smoking after being told about a trial in Glasgow (19% oppose)
25. Support grows after measures are implemented, particularly among smokers. In 2015, after the law was passed prohibiting smoking in cars carrying children but before it was implemented, only 40% of smokers supported the legislation. A year later, after it had come into effect, it was supported by 74% of smokers.²⁷
26. Support for a ban on smoking in all cars has also grown significantly, from 59% in 2015 to 67% in 2021. Prohibiting smoking in all cars is now supported by a third of smokers (34%), up from a quarter in 2015.²⁶

Small retailer support for stricter regulation of tobacco

27. There is also support for government interventions to tackle smoking from small independent tobacco retailers. A survey conducted for ASH by specialist research agency NEMS found that most small retailers supported the existing tobacco regulations, as well as increasing the age of sale to 21:²⁸

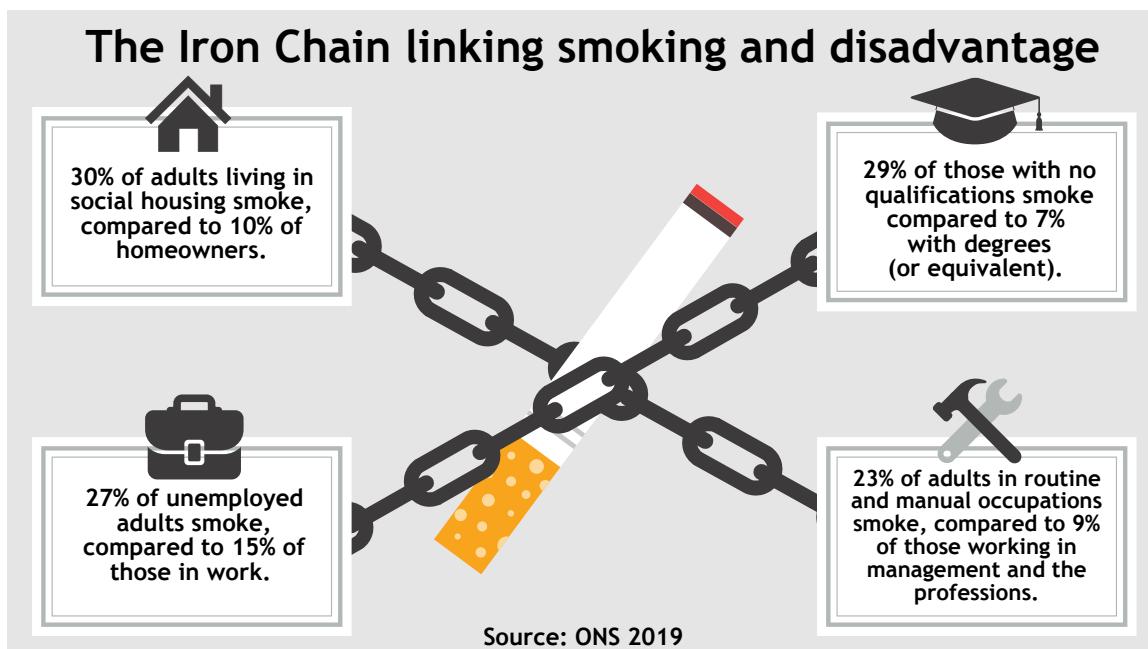
- 64% support minimum pack sizes for cigarettes and rolling tobacco (27% oppose, 8% neither support/oppose or don't know)
- 61% support prohibition of tobacco displays (26% oppose, 13% neither support/oppose or don't know)
- 51% support standardised 'plain' packaging of tobacco packs (36% oppose, 12% neither support/oppose or don't know)
- 52% support increasing the age of sale for cigarettes to 21 (39% oppose, 9% neither support/oppose or don't know)

28. Most small retailers strongly agreed that the following enhanced enforcement measures could help ensure retailers don't sell illicit tobacco or sell to underage smokers:²⁸

- 71% strongly agreed on having a tobacco licence which could be removed if retailers break the law (net agree 84%, net disagree 9%)
- 67% strongly agreed on strengthening of Challenge 21 and Challenge 25 schemes (net agree 78%, net disagree 14%)
- 65% strongly agreed on larger fines for breaking tobacco laws (net agree 77%, net disagree 16%)

The Iron Chain linking smoking and disadvantage

29. There is an ‘Iron Chain’ linking smoking and disadvantage which must be severed if we are to increase healthy life years by 5 years by 2035, reduce inequalities and level up our nation.⁶
30. Smoking is linked to almost every indicator of disadvantage and there is a clear gradient, the more disadvantaged you are the more likely you are to smoke.²⁹ In 2019:¹³
- 30% of adults living in social housing smoked, compared with 22% of those renting privately and 10% of those owning their home with a mortgage.
 - 29% of those with no qualifications smoked compared with 7% of those who have completed a degree or equivalent.
 - 27% of unemployed adults smoked, compared with 15% of those in employment.
 - 23% of adults in routine and manual occupations smoked compared with 9% of those working in management and the professions.
 - 25% of pregnant women in the most deprived decile smoked, compared with 4% in the least deprived.³⁰



31. Building Smokefree communities has a key role to play in reducing smoking initiation in young people, and the transfer of smoking across the generations. Children growing up in communities where smoking is the norm are not only more likely to be exposed to secondhand smoke, and they are also significantly more likely to become smokers themselves.
32. In 2018, children aged 11-15 who were regular smokers were twice as likely to have parents, carers or friends who smoked than never smokers.^{31 32} A recent ASH analysis of UCL’s smoking toolkit study data found that 16 and 17 year olds who smoked were twice as likely to have a family member who smoked. Those who were heavy smokers were four times more likely to have a family member who smokes.³³
33. Smoking rates among children under 16 have fallen to the lowest recorded levels since surveys began in 1982, but still it is estimated that 280 children a day in England start smoking.³⁴ Once started it is difficult to stop, with two thirds of those who try smoking going on to become daily smokers.³⁵ It’s estimated that for every 3 young smokers, only 1 will quit, and 1 of those remaining smokers will die from tobacco-related causes.³⁶
34. Reducing smoking prevalence in young adults is also essential if we are to reduce smoking in pregnancy, which is particularly concentrated in young parents. Among those mothers whose smoking status was recorded, a quarter of pregnant women under 24 at time of booking (first maternity appointment) smoked. This rises to a third for those under 18, compared to an overall average of 12.7% for smoking at booking for all pregnant women. As well as being more likely to smoke in the first place, younger mothers were less likely to quit before pregnancy.³⁰

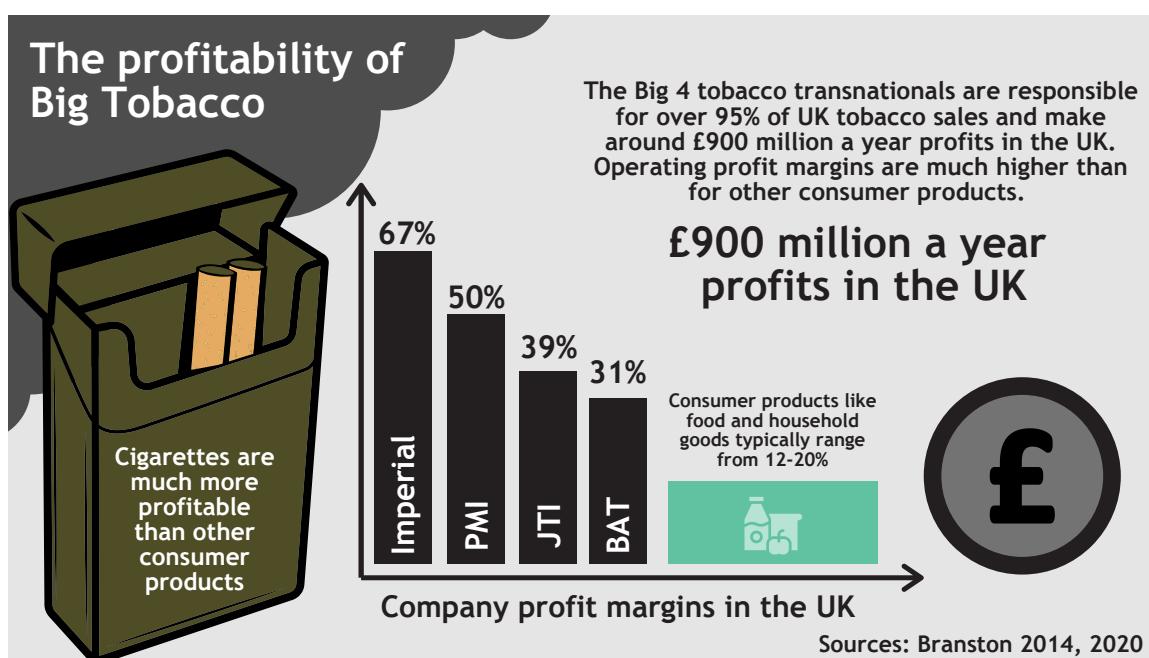
Setting course for a Smokefree 2030

35. Even before the COVID-19 pandemic struck, achieving the Government's goals of a Smokefree 2030 and five years extra healthy life years by 2035, was acknowledged by the Government to be "extremely challenging" and to require "bold action."³ In the wake of the pandemic the scale of the challenge is greater still.
36. The "bold action" needed will require investment, investment which is highly cost-effective. The Government's Green Paper on prevention acknowledged that investment in public health delivers £14 in savings for every £1 spent, both in healthcare savings but also through "longer-term gains in health and to wider society."³
37. Such investment is sorely needed. The Health Foundation estimates that, at a minimum, £1.2bn is needed to restore public health funding to its 2015 levels and a further £2.6bn to level up public health across the country.³⁷ But funding is tight, which is why our lead recommendation is that Government should require the tobacco manufacturers to pay for tobacco control measures to end smoking, through the mechanism set out in summary below. A detailed proposal setting out how the Smokefree 2030 Fund would operate is published as a companion to this report.³⁸

Smokefree 2030 Fund

Recommendation 1: Legislate to make tobacco manufacturers pay for a Smokefree 2030 Fund to bring an end to smoking

38. The Government's ultimatum for industry to make smoked tobacco obsolete by 2030³ will only be delivered if it becomes less profitable to sell combustible tobacco products. A statutory Smokefree 2030 scheme could achieve this by imposing a targeted, tobacco-manufacturer profit cap,^{39 40} utility-style price controls and raise funds from the industry to pay for tobacco control measures through a charge based on sales volumes. The Government should aim to include the Smokefree 2030 Fund in the 2021 Health and Social Care Bill to come into force in 2022.
39. Such a scheme is justified by market failure, which allows an oligopolistic industry, whose products kill consumers when used as intended, to make excess profits.⁴¹ For example, net operating profits for Imperial Brands in the UK were 63% in 2018 and 71% in 2019,⁴² much higher than for most consumer staples such as food, beverages and household goods of 12-20%.⁴³ This compares to profit margins for retailers of around 6%.⁴⁴



40. In 2018 it is estimated that tobacco manufacturers made over £900 million in profits in the UK alone.⁴⁵ Yet despite their enormous profitability, the major tobacco manufacturers pay very little profit tax in the UK.⁴⁶ This likely reflects their global engagement in diverse and elaborate tax avoidance strategies, that allowed Imperial Brands to lower its UK corporate tax bill by an estimated £1.8bn over the last 10 years and BAT to reduce its bill by an estimated £760m.⁴⁷

41. Indeed, the industry is so profitable that Philip Morris International lobbied parliament to support industry funding of £1 billion in return for relaxation of the regulations controlling the marketing of its novel tobacco product, IQOS.⁴⁸
42. The Government quite rightly has put on the record in Parliament that any such funding, unless imposed as a legal requirement by government, would be counter to the UK's obligations as a Party to the WHO FCTC.⁴⁹ We agree and call on the government to legislate to implement a statutory requirement for tobacco manufacturers to pay for a Smokefree 2030 Fund.
43. Internationally, the Smokefree 2030 fund already has a tobacco-specific precedent in the US, for a so-called 'user fee' which raises \$711 million annually from the tobacco industry,⁵⁰ with the amount paid by each manufacturer according to the proportion of total sales by volume. The funds raised are used for tobacco regulation including behaviour change campaigns, retailer compliance work and policy development, implementation, and evaluation.⁵¹
44. The Smokefree 2030 Fund would only apply to tobacco, thereby incentivising the industry to deliver on the Government's ultimatum to make smoking obsolete by 2030, as well as providing the funds needed to deliver the Smokefree 2030 ambition. It has been estimated by ASH that to reinstate the funding needed for a comprehensive tobacco control programme at national, regional and local level to deliver a Smokefree 2030 would cost around £266 million for England and £315 million in total for the UK,⁵² while it is estimated that the Fund could raise £700 million from the tobacco manufacturers.³⁸
45. The UK's withdrawal from the EU opens the door to such a scheme as it gives the Government freedom to control tobacco prices, prohibited by the EU under the Tobacco Tax Directive.⁵³ Regulating tobacco prices is essential to prevent the industry from passing the cost of regulation on to consumers, which would eliminate the incentive to move out of combustible products.
46. The purpose of the scheme is to deliver the Government's ambition to make smoking obsolete and achieve a Smokefree 2030. This would not require a new quango to be set up, as the DHSC has all the expertise needed, both to supervise the scheme and to allocate the funds raised.
47. There is an expert team in place within the DHSC which manages pharmaceutical pricing scheme which has close parallels with the proposed Smokefree 2030 fund. Functions like assessing the Annual Financial Returns of the tobacco manufacturers, in order to monitor compliance, are already carried out for the pharmaceutical industry.³⁸
48. Extending the DHSC remit to the tobacco industry would not be a substantial additional workload, as there are a very small number of manufacturers (two manufacturers alone control over 80% of the market)⁵⁴ making a limited range of products.
49. The DHSC Office of Health Promotion (OHP) under the oversight of the CMO and the Secretary of State would be responsible for the Smokefree 2030 Fund. The OHP would oversee Fund distribution, its evaluation and monitoring, working in collaboration with civil society as required by the WHO Framework Convention on Tobacco Control.²
50. Data collected for the Fund on tobacco sales, marketing, and research, should be published, as is already the case in other countries like Canada, France, and the US.^{55 56 57 58} These data will allow evaluation of the effectiveness of the scheme and are also essential to inform the development of tobacco policies and evaluation of their impact in helping deliver the Government's Smokefree 2030 ambition.
51. Data should be collected for publication in a standard agreed electronic format so as to be easily aggregated, accessible and analysable.

At national and international level on an annual basis:

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

At national level, monthly:

- Brand specific price and sales data for all products;
- Marketing spend by category (consistent with Federal Trade Commission categorisations and also including spending on Corporate Social Responsibility);

- research spend by subject area.

At local authority level, monthly:

- Sales data by product type for all products (including factory made, HRT, heated tobacco products, and e-cigarettes).

52. Effective oversight of the market also requires licensing of the full supply chain. Tobacco manufacturers are already licensed, and the introduction of tracking and tracing has required the entire tobacco supply chain (66 wholesalers and around 55,933 retailers in England)^{59 60} to register for an economic operator identifier (EOID).⁶¹
53. The EOID is in effect a licensing scheme by default as it already requires all the information a licence would include, as well as imposing sanctions and penalties for holding non-compliant stock. A comprehensive tracking and tracing system for cigarette products down to pack level from point of manufacture to point of sale, so non-compliant stock is easy to identify.
54. Turning the existing system into a public health licensing scheme will not therefore require additional work on behalf of retailers or wholesalers, and the administrative costs at national level to oversee the function will be small, estimated at between £1.9 million and £2.5 million a year at current salaries.^{62 63} At the same time it would equip local authorities with the powers to better protect their local communities from those who sell illicit tobacco and tobacco products to children.
55. The Smokefree 2030 Fund would be structured to prevent the industry from making excess profits from sale of combustible products and ensure the market can be regulated effectively by:
 - levying a fixed annual sum from manufacturers of tobacco products to implement the Tobacco Control Plan and provide support to the devolved administrations;
 - making contributions proportionate to manufacturers' market shares of combustible products by sales volume;
 - controlling prices to ensure that the costs cannot be passed on to consumers but must be borne by the manufacturers;
 - publishing data collected for the Fund on tobacco sales, marketing, and research, in aggregate to enable evaluation and revision of policy measures; and
 - implementing a public health licensing scheme building on the track and trace system already in operation.

Global Leadership

Recommendation 2: Take our place on the world stage as a global leader in tobacco control

56. The UK was instrumental in the development and adoption of the WHO FCTC and the protocol to the FCTC on Illicit Trade. Today, the UK plays an extremely active role in supporting the implementation of these important global public health treaties, especially in low and middle-income countries (LMICs). We have shown by example how comprehensive implementation of the full range of measures in the Treaty, including tobacco taxation and illicit trade, as well as health measures like provision of tobacco dependence treatment, can drive down smoking prevalence rates.
57. The UK has also played a leadership role in the development of the evidence-base for tobacco control since the 1950s when UK research identified the link between smoking and lung cancer, to the current day when our world-class research informs global policy development and evaluation.
58. We have been a world leader in tobacco control for well over a decade, and have been instrumental in helping shape the development of EU tobacco policy during that time. However, while we were a member of the European Union, the EU spoke on our behalf in international fora, we could not speak for ourselves. Now we can and should.

59. The UK has a great deal to be proud of, having driven down smoking prevalence in recent years faster than other global leaders such as Australia,⁶⁴ and far faster than other European countries. Since 2007 the UK has rated highest in Europe for its implementation of comprehensive tobacco control programmes in line with World Bank recommendations.⁶⁵ In 2007 our smoking rates were average for Europe, by 2020 they were less than half those of the EU27.^{66 67} If we achieve our ambition of making smoking obsolete by 2030, we will lead the world.
60. Our leadership role is shown not just by implementing the requirements of the FCTC, but also by supporting others to do the same.⁶⁸ The UK invested £15 million over five years to set up the FCTC2030 project,⁶⁹ to support low and middle-income countries (LMICs) to achieve the Sustainable Development Goal (SDG) target to accelerate implementation of the FCTC.⁷⁰ Through the FCTC 2030 project, the UK has been able to directly and meaningfully support over 25 LMICs in their tobacco control efforts, including by making available UK experience and expertise in implementing strong tobacco control.
61. The UK's global leadership is also exemplified by well-established, although to date ad hoc, cross-government collaboration to end the tobacco epidemic in the UK. In particular, HM Treasury has played a key role in reducing affordability through taxation, and HM Revenue and Customs has been highly effective in driving down the illicit trade in tobacco, in both cases to the benefit of government revenues as well as helping drive down smoking prevalence.⁷¹
62. There are other areas where cross-government working is beginning to show promise, for example with DEFRA on the environmental pollution caused by tobacco.⁷² The commitment to establish a new Office of Health Promotion, and for the public's health to be placed "*at the heart of government*" can only strengthen cross-government collaboration going forward. There are opportunities flowing from this for example in the light of the misinformation being spread in online fora on coronavirus, the scope of the proposed regulator for online harms should be broadened to include an explicit duty to act to protect public health.^{73 74}
63. Showing by example how Health Ministries can work across government to implement the FCTC has been central to the success of the FCTC2030 project. The UK was awarded the 2020 United Nations Inter-Agency Task Force Award in recognition of the role the project has played in the global prevention and control of non-communicable diseases. Delivered in partnership with the WHO, UNDP, Australia, and Norway, and involving experts from civil society and academic organizations, the project is truly ground-breaking.
64. However, funding from the UK comes to an end in 2022 before the fruits of the FCTC2030 project can be fully realised. To retain our global leadership role the UK's ODA funding for FCTC2030 should be renewed and enhanced when it runs out at the end of 2021.
65. Furthermore, although in the first Global Tobacco Industry Interference Index, published in 2019, we were rated No. 1 in the world for the work we do to protect public health policy from tobacco companies,⁴⁹ last year we slipped to fourth position.⁷⁵
66. It is a requirement of the WHO FCTC,² that the UK implement stringent regulation of the tobacco industry for the protection of public health, far greater than for any other industry. This includes monitoring and surveillance of industry behaviour and ensuring that public policy is protected from the commercial and vested interests of the tobacco industry in line with Article 5.3 of the WHO FCTC.
67. The DHSC is well aware of its responsibilities under Article 5.3, but that is not always the case for other government departments and local government, or other public authorities including arm's length bodies. The tobacco industry has a track record of trying to interfere in policy development and implementation, and other government departments and public authorities aren't always aware of our obligations.⁷⁶
68. To fulfil this responsibility DHSC should provide all parts of Government (including other Government departments, local authorities, NHS organisations and arm's length bodies) with advice on their

responsibilities to protect public health policies from the commercial and vested interests of the tobacco industry based on the WHO FCTC Article 5.3 guidelines.⁷⁷ There should be a single government portal for all information about the WHO FCTC and its obligations, where minutes of all government meetings with the tobacco industry and linked organisations can be accessed.

69. We can and should take our place on the world stage as a global leader in tobacco control by:

- Extending ODA funding for a further 5 years for the FCTC 2030 programme supporting implementation of the FCTC and the Illicit Trade Protocol for LMICs. (Current funding £3 million p.a. for five years.)
- Bidding to host the next FCTC Conference of the Parties and Illicit Trade Protocol.
- Demonstrating leadership in protecting public policy from the tobacco industry, by ensuring Article 5.3 of the FCTC is adhered to across government and all public authorities.
- Formalising cross-government working to integrate achieving the Smokefree 2030 ambition into broader government programmes to level up society and reduce inequalities.

70. By putting these measures in place by the end of 2021, we can sustain our number one position on tobacco control in Europe, and regain our number one position in the Global Tobacco Industry Interference Index in 2022.

Charting the route

Recommendation 3: Set interim targets for 2025, and update our strategy if we are not on track to a Smokefree 2030 by then.

71. It is essential that interim targets for 2025 and a commitment to review progress at that point are included in the forthcoming Tobacco Control Plan for England. We can't wait until 2030 to assess whether we have achieved our ambition. A mid-term review is essential to determine whether the Plan has put us on track and whether any further interventions are needed. If we are to achieve smoking rates of 5% or below across society by 2030 there is a set of milestones to be reached by 2025 set out in the box overleaf, which bridge the gap between where we are now and where we need to get to.

72. However, in order to be able to measure progress improvements are needed in data collection and analysis:

- Access to, and analysis of, existing datasets needs to be more rapid to allow analysis of key indicators, for example:
 - Full datasets need to be released at the same time as annual Health Survey for England (HSE) and Annual Population Survey (APS) surveys to enable key indicators such as children's exposure to secondhand smoke in homes where carers are smokers to be measured without delay.
 - Data are collected in primary care on smoking status and mental health but are not routinely analysed. Smoking status could also be collected through the Mental Health Services dataset but is not routinely carried out. As a result the data on smoking among people with SMI and others in secondary mental health services is poor. Reliable data is essential to effectively monitor progress in reducing smoking prevalence in people accessing secondary care mental health services and those with serious mental illness.
- The Smoking, Drinking and Drug Use survey among children in England, essential to measuring smoking rates among 11 to 15 year olds, was cancelled in 2020 and needs to be restarted and run annually.

73. These are the gaps that have been identified. However, a consultation should be launched at the same time as the publication of the Tobacco Control Plan to determine what additional data are needed to monitor progress towards a Smokefree 2030.



Milestones



Smoking in adults to fall from 13.9% in 2019 to 9.1% by 2025.¹³



Smoking among routine and manual workers to fall from 23.2% in 2019 to 13.3% by 2025.¹³



Smoking in social housing to fall from 29.8% in 2019 to 16% by 2025.¹³



Smoking in those with a long-term mental health condition to fall from 25.8% in 2020 to 15.4% in 2025.⁷⁸



Reduce smoking in pregnancy:

- From 12.7% in 2020 at time of maternity booking to 8.9% by 2025 to 5% or less by 2030.⁷⁹
- From 10.4% in 2020 at time of delivery to 5% or less by 2025 to be on track to deliver a Smokefree start for every child by 2030.⁸⁰



Reduce smoking among 15-year-olds from 11.4% in 2018 to 7.7% by 2025 on track to be less than 5% by 2030.³¹



Reduce the proportion of children with one or both parents who are smokers from one in four (25.2%) in 2018 to 11.8% by 2025 and 5% or less by 2030.⁸¹



Increase the percentage of households with smoking parents that have no smoking in the home from three quarters (75.9%) in 2018 to 87% by 2025 on track to be 95% or more by 2030.⁸¹

Behaviour change Policy and Interventions to deliver a Smokefree 2030

74. All the recommendations set out below are for measures which are evidence-based and high impact which will:
- Level up and reduce inequalities through targeted investment; and
 - Shape the environment to change behaviour.
75. Measures that help adult smokers quit also help reduce uptake in young people, as those growing up in a smoking household are three times more likely to become smokers themselves.³²

Level up and reduce inequalities through targeted investment

76. The huge gap in smoking prevalence between those in routine and manual occupations and those in other occupations is stubbornly persistent. In 2019 fewer than one in ten professional and managerial workers smoked, well on the way to the Smokefree 2030 target of less than 5%, compared to nearly one in four in routine and manual occupations.¹³
77. Ending smoking for all would lift around 450,000 households out of poverty, including more than a quarter of a million children and 140,000 pensioners,²² concentrated in the poorest most disadvantaged areas of the country. Ending smoking in these communities would not just benefit the health and wellbeing of individuals but also inject money previously going up in smoke into local economies, supporting the levelling up agenda.
78. Smoking is linked to almost every indicator of disadvantage, and these are overlapping communities, so smokers in routine and manual occupations or unemployed, are also more likely to be living in social housing and be more likely to be diagnosed with mental health conditions. We have not been successful in reducing the inequalities gap in smoking and need to redouble our efforts if we are to do so in the next decade to achieve a Smokefree 2030 for all.
79. Targeted investment should be national to reach all disadvantaged smokers wherever they are, but backed up by place-based enhanced support for poorer communities where smokers are concentrated. While smoking remains the norm in such communities not only is it harder for smokers to quit, but smoking will continue to be transmitted from one generation to the next.

Behaviour change campaigns to motivate quit attempts in disadvantaged communities

Recommendation 4: Deliver anti-smoking behaviour change campaigns targeted at routine and manual and unemployed smokers concentrated in the most deprived regions (C2DE).

80. Analysis of government data¹³ shows that in 2019 nearly half all England's 5.7 million smokers are in routine and manual occupations (1.96 million) or long-term unemployed (0.84 million). These are the groups with the highest rates of smoking, (23.2% for those in routine and manual occupations and 26.4% for the unemployed). They are concentrated in the north and midlands, which are also the areas with the lowest average household incomes.⁸²
81. Smokers can only successfully quit if they are motivated to make an attempt and multi-media behaviour change campaigns are the most effective and cost-effective way to motivate them. In 2008 40% of adult smokers in England had tried to quit in the last year, in 2018 this had fallen by a quarter to only 30%. Over the same time period funding for mass media campaigns had fallen by 90% in monetary terms from £23.3 million in 2008/9,⁸³ to around £2.16 million in 2018/19 and £1.78 million for 2019/20; figures for 2020/21 are not yet available.⁸⁴
82. There is evidence that behaviour change mass media campaigns are effective, but that there is a threshold level for mass media campaigns which need to have sufficient intensity and be sustained over time if they are to translate into population reductions in smoking prevalence.⁸⁵ There is also a dose response relationship.^{86 87} This is no surprise; it is why big commercial brands sustain their

advertising campaigns year in year out and continue to advertise on broadcast media to drive awareness. Broadcast media (TV and radio) are also the most trusted media, while trust in the Internet and social media is low.⁸⁸

83. Detailed analysis of campaign impact in the US and Australia demonstrates that population behaviour change can be driven by mass media campaigns delivered with sufficient and sustained intensity.^{89 90} Such campaigns have immediate impact, can be targeted with precision at disadvantaged smokers, which is essential given their higher smoking rates, higher levels of addiction and lower success in quitting.^{91 92 93 94}

84. Behaviour change campaigns like this are both effective and cost-effective. The FDA's *Tips from Former Smokers* campaign,^{95 96} delivering 11 ads a quarter to the target audience from 2012-15, led to over half a million sustained quits during 2012-2015.

85. The campaign, funded by the tobacco manufacturers through the user fee scheme, has been sustained.⁹⁷ The US Centers for Disease Control and Prevention estimates that from 2012-2018 more than 16.4 million people who smoke have attempted to quit, and approximately one million have successfully quit because of the Tips campaign. The campaign was equally effective by subgroups of race/ethnicity, education and mental health and the effects have been durable over time.⁹⁸

86. A comprehensive evaluation of the campaign between 2012 and 2018, which factored in smoking relapse, inflation, and advertising and evaluation, demonstrated that the campaign was associated with healthcare cost savings of \$11,400 per lifetime quit, and \$5,300 per quality-adjusted life year gained.^{99 100}

87. Investment in the US has been high and sustained year in year out, rather than falling year on year as is the case in England, but analysis of specific campaigns supports the US conclusions.¹⁰¹ For example, the annual PHE anti-smoking campaign, Stoptober, was estimated in 2012 to have generated an additional 350,000 quit attempts in England and saved 10,400 discounted life years (DLY) at less than £415 per DLY in the modal age group. A further evaluation of subsequent campaigns indicated a prolonged effect over the first six years of Stoptober campaigns in England with greater impact when campaign budgets were higher.^{102 103}

88. In 2012/13 the national spend on anti-smoking behaviour change campaigns by PHE was over £8 million. When due to funding cuts Stoptober only ran on digital media in 2016, there was a reduction in campaign recognition from 71% the previous year to 48% and the campaign was less effective at reaching older and poorer smokers.¹⁰³ The evidence is clear that exposure to campaigns is needed to drive awareness; digital and social media alone are not effective.

89. There is also a wealth of evidence of what type of campaigns are most effective:^{36 104 105}

- Emotive ads are more effective than factual ads to shape behaviour.
- Health harms messages are most effective at generating increased knowledge, positive beliefs, and quitting behaviour
- Communicating the odds by harnessing emotion is also effective
- Campaigns work for both adults and young people.

90. Inequalities in smoking by socio-economic status are stubbornly persistent and need to be addressed by upweighted behaviour change campaigns among key target groups and communities. National campaigns can be significantly enhanced regionally, when implemented across logical media footprints.

In the north of England which historically has had far higher rates of smoking than the average for England, such campaigns have increased both quit attempts and quit success and have been associated with faster rates of decline in smoking prevalence.

91. In 2005 when Fresh, the tobacco control programme in the North East, was set up, smoking rates were 20% higher than the England average and the disparity was growing. The central plank of Fresh's strategy has been regional health behaviour change campaigns which been associated with the fastest rate of declines in the whole of England. In 2005, smoking rates were 29%;¹⁰⁶ now they are 15.3%, only 10% greater than the England average of 13.9%.¹³
92. The most sustained investment in regional behaviour change campaigns in recent years has been by the Greater Manchester Health & Social Care Partnership (GMHSC Partnership). Since behaviour change campaigns started in Greater Manchester in 2018, the proportion of adult smokers trying to quit in the last year has been sustained at around 40%, despite the lack of national campaigns.¹⁰⁷
93. The Yorkshire and Humber region has utilised the expertise and resources provided by Fresh and GMHSC Partnership programmes to run its own campaigns. This provides a useful model for extending these campaigns to the Midlands too. What is needed is secure funding, which in the US is provided by the tobacco manufacturers.
94. Regional funding for stop smoking behaviour change campaigns in the North and the Midlands would support the levelling up of the poorest regions in England. These are the regions with the highest rates of smoking combined with the lowest Gross Disposable Household Income (these are the only regions with household income below £20,000).⁸² Those in routine and manual occupations are 2.5 times more likely to smoke than those in the professions, with rates of smoking amongst the unemployed 2.8 times as high.¹³
95. A comprehensive evaluation of anti-smoking campaigns funded by the US Food & Drug Administration over the last decade finds that significant reductions can be secured by a campaign running at an average intensity of 12 exposures per quarter, but that a high intensity campaign of 40 exposures per quarter can significantly increase the success rates.* 96 97 98 108 109
96. Tobacco manufacturers are required to fund the FDA for its tobacco control work under legislation set out in the Family Smoking Prevention and Tobacco Control Act,³⁸ which provides sustained and secure funding for its campaigns. This model should be adapted for UK circumstances to ensure delivery of:
 - at least 12 anti-smoking adverts a quarter to routine and manual and unemployed (C2DE) smokers nationally as part of a multi-media behaviour change campaign; plus
 - additional regional funding to ensure total delivery of at least 40 adverts a quarter in the North and Midlands where smoking and economic disadvantage and smoking are more heavily concentrated.
97. Modelling by UCL for the APPG on Smoking and Health estimates that a sustained behaviour change campaign at this level would result in an additional ~1 million quit attempts, ~179 thousand successful quit attempts and ~45 thousand long-term ex-smokers in C2DE occupations in England between 2021 and 2030.²⁴
98. This is equivalent an additional 0.4 percentage point reduction (or 2% relative reduction) in smoking prevalence among those classified as C2DE in 2030 from an estimated 16.6% without the campaign to 16.2%.²⁴
99. The estimated cost of a national multi-media behaviour change campaign at this intensity in year one would be around £18.8 million with an additional £9.2 million for the proposed regional upweighting,

* The standard measure used by the advertising industry is 'gross rating points' which quantify impressions (exposures) as a percentage of the target population, multiplied by frequency. For ease of understanding to a general audience these have been translated into an average number of exposures to an ad for the target audience.

a total of £28 million.¹¹⁰ This would deliver 163,924 extra quit attempts, 27,375 successful quits, and 6,844 long-term ex-smokers. The cost per quit attempt in year one would be around £170; the cost per successful quit attempt £1,023 and the cost per long-term ex-smoker £4,091.

100. These are conservative estimates as they only include the direct impact of the campaign on quit attempts in the target group, the 2.8 million smokers in routine and manual occupations, long-term unemployed and never worked (C2DE).

101. Although they are not the target, some of the remaining 2.9 million smokers in England in other groups would also be exposed to some of the ads and some would be motivated to quit as a result. This will reduce the cost pre quitter and cost per ex-smoker. Behaviour change campaigns have also been shown to impact on young people reducing smoking uptake.¹⁰⁴

102. The reductions in prevalence will also be further increased by the measures to maximise success rates in quitting set out in subsequent sections of this report.

Maximising the proportion of successful quits per quit attempt

Recommendation 5: Ensure all smokers are advised to quit at least annually and given opt-out referral to Stop Smoking Services.

103. Success rates are on average three times as high for smokers using the Stop Smoking Services than quitting unaided,¹⁹ and tobacco dependence treatment including counselling and pharmacotherapy is highly cost-effective, as it increases quality adjusted life years (QALYs) and saves costs.¹¹¹ It is estimated that for every £1 invested in Stop Smoking Services, £2·37 will be saved on treating smoking-related diseases and reduced productivity.¹¹²

104. Stop Smoking Services are atypical in not conforming to the inverse care law. In fact, although throughput has fallen due to lack of promotion of the Services, in 2018/19 only 11% of those setting a quit date came from those in managerial and professional occupations, compared to 27% of those in routine and manual ones. All together more than half (52%) were from disadvantaged groups (27% R&M; 14% unemployed for over a year or never worked; 10% sick/disabled and unable to return to work; 1% prisoners).¹¹³

105. However, funding for these services has been in decline since public health budgets were cut nationally. Since the re-organization of the NHS in 2013 and lower investment, the number attending stop smoking services has dropped by 74%.¹¹⁴ Restoring funding and ensuring universal access, backed up by multi-media behaviour change campaigns, is assumed to reinstate the throughput to those levels seen in 2011/2012.

106. Quitting smoking does more than prevent disease, smokers who quit have better treatment outcomes for everything from cancer to cardiovascular disease, diabetes to dementia, maternity to mental health, stroke to surgery, to the benefit not just of smokers but also the NHS. For example:

- A third of patients are smokers at time of diagnosis with lung cancer, by quitting they can increase their average life expectancy from 1.08 to 1.97 years.¹¹⁵
- Smokers are more than five times as likely as non-smokers to have microbiologically confirmed influenza, and twice as likely to develop pneumonia.¹¹⁶
- Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage, and pre-term birth.¹¹⁷
- Smokers are 36% more likely to be admitted to hospital than non-smokers, and twice as likely to be re-admitted within 30 days.¹¹⁵
- Smokers undergoing surgery require longer hospital stays and higher drug doses; and have higher risks of heart and lung complications, post-operative infection, impaired wound healing, being admitted to intensive care and requiring re-admission to hospital.¹¹⁸

- Quitting smoking is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. Effect sizes are equal to those of antidepressant treatment for mood and anxiety disorders.²¹
107. The NHS Long Term Plan included provision of tobacco dependence treatment to all hospital inpatients, pregnant smokers, and those with long-term mental health conditions.¹¹⁹ However, roll out which was due to start in 2020/21 has been held up by COVID-19, and full roll out is not due until 2023/4 and there are risks it may slip.
108. Furthermore, to date proposals only include tobacco dependence treatment in pregnancy and for inpatients (acute and mental health). It is essential therefore that smokers should have universal access to help to quit through Stop Smoking Services commissioned by local authorities and provided with support to quit when they come into contact with primary and community as well as secondary care.
109. In 2019 over a million patients visited their GP a day,¹²⁰ one in sixty people.¹²¹ GP computer systems typically display the smoking status of patients who consult, which is available in 95% of records, and was updated a median of 2 years before consultation.¹²² However, most GPs are not currently providing the support patients who smoke need to quit. Data from the incentive payments made to GPs for them to engage in brief advice shows that advice to quit is 30 times more common than offering support to quit,¹²³ whereas offering support is more motivating and effective.¹²⁴
110. People typically believe that if a person is motivated to quit, then they will reach out for support, but this is contradicted by evidence. In GP patients wanting to quit, a randomised trial showed that a call *from* the services to the patient increased engagement with support 13-fold compared with asking the patient to initiate contact.¹²⁵ Overall this strategy, known as opt-out as opposed to opt-in, can increase quitting fourfold.¹²⁶
111. Pro-active contacting of smokers with support to quit on an opt-out basis increases quitting more than fourfold and should become standard. This will require ensuring universal access to Stop Smoking Services providing counselling plus pharmacotherapy (including e-cigarettes):
- Provide universal access to Stop Smoking Services for all smokers.
 - Fully roll out the NHS Long Term Plan proposals to fund opt-out tobacco dependence treatment to all hospital inpatients, pregnant smokers, and those with long-term mental health conditions by 2023/4 as planned.
 - Offer very brief advice at every appropriate opportunity when a patient is in contact with health care professionals in primary or secondary care.
 - Use QOF to require GP practices to continue to monitor smoking status annually as well as requiring GPs to provide opt-out referral for smokers to Stop Smoking Services at least once a year.
 - Require all NHS Health Checks to include opt-out referral for smokers to Stop Smoking Services.
 - Add smokers to the Directed Enhanced Service (DES) specification for seasonal influenza and pneumococcal immunisation and giving them an opt-out referral to the Stop Smoking Services when they are called for vaccination.
 - Require all letters inviting patients who smoke to bowel, cervical or lung cancer screening to include evidence of the increased risks for smokers of getting cancer plus an opt-out referral to the Stop Smoking Services.
112. Modelling by UCL for the APPG on Smoking and Health estimates that opt out referrals and universal access to NHS Stop Smoking Services would result in an additional ~488,000 ex-smokers between 2022 and 2030. This would reduce smoking prevalence to 8% in 2030. Without this, it is estimated that smoking prevalence would be 8.6% in 2030. This is 0.6 percentage point reduction (or 7% relative reduction) in smoking prevalence as a consequence of opt out referrals and universal access to NHS Stop Smoking Services.²⁴

Providing additional support to quit for smokers in communities with high rates of smoking

Recommendation 6: Target support to give additional help to those living in social housing or with mental health conditions, who have high rates of smoking.

Reaching communities of smokers through mental health services

113. As many as one in three smokers has a mental health condition, so people with a mental health condition make up a significant proportion of all smokers.¹²⁷ Therefore, strategies to reduce smoking that do not take account of the population with mental health conditions will underdeliver, jeopardising the Government's overall vision for a smokefree country by 2030.
114. When smokers quit, their mental health and wellbeing improves, while the high prevalence of smoking is a key driver in the gap in life expectancy between those with and without a mental health condition. The high rates of smoking among people with a mental health condition remains a major health inequality, with those experiencing more severe and complex conditions having among the highest rates of smoking for any group in the population.
115. It is estimated that around 220,000 people with a severe mental illness (SMI) are currently smoking. A majority of these will access support through secondary mental health services, some through inpatient care but most in the community.^{128 129} These estimates provide a sense of the scale of the challenge in mental health services, but they lack precision due to the poor quality of the data, which needs improving as a priority, as recommended by the APPG.
116. The original NHS Long Term Plan proposals committed that "*a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.*"¹³⁰
117. However, current funding will only support smokers during inpatient stays with insufficient resource to address smoking among the vast majority (~95%) who only receive mental health care in the community. Some resource will be made available to support outpatients in 2023/24 but it is unclear if this will meet the level of need in the community. It is essential the funding is found to deliver the original NHS LTP commitment to provide tobacco dependence treatment to all smokers accessing secondary mental health services and that this is sustained after 2023/24.
118. Modelling by UCL for the APPG on Smoking and Health estimates that delivering targeted support to adults with severe mental health problems receiving treatment in secondary care would result in an additional ~10 thousand ex-smokers between 2022 and 2030. This would reduce smoking prevalence to 33.2% in 2030. Without this intervention it is estimated that smoking prevalence would be 35.0% in 2030. This is a 1.8 percentage point reduction (or 5.5% relative reduction) in smoking prevalence in this group.²⁴
119. Furthermore, the NHS Long-Term Plan proposals will not reach smokers with common mental health conditions. IAPT, the Improving Access to Psychological Therapies programme, has around 1.69 million referrals a year, supporting people with common mental health conditions such as depression and anxiety.¹³¹ Smoking status is not routinely gathered for clients of IAPT services. However, given the high rates of smoking among people with common mental health conditions,⁷⁸ it's likely that around one in four clients smoke, which is equivalent to 504,000 smokers a year.
120. Quitting smoking has been shown to have equal or greater effect than anti-depressants six weeks after quitting, effects which last long term. Ex-smokers also have higher disposable income, greater chances of employment and higher wages, lower risk of poor physical health, all of which contribute to increased wellbeing and reduced cost to the NHS. Improving employment chances, management of physical health conditions and securing better mental health are all existing objectives of IAPT services.^{132 133 134}
121. A feasibility study has already been carried out showing that IAPT counsellors are able and willing to

deliver support to quit, and that clients valued the offer. A pilot programme is underway, and Cancer Research UK is funding development of an online CBT module which longer-term once trialled and tested could form part of the standard online IAPT offer and be integrated into face-to-face treatment.

122. The NHS LTP should be fully implemented so that all smokers in secondary care, not just the one in twenty receiving inpatient care, are offered tobacco dependence treatment by 2023/24 and beyond.

123. In addition, all smokers participating in IAPT programmes for people with common mental health problems like anxiety and depression should be given brief advice to quit and opt-out referral to Stop Smoking Services. The following additional measures should also be implemented to:

- Revise the IAPT minimum dataset to include smoking status on admission.
- Provide training for all IAPT counsellors to make a brief intervention offering support to quit and opt-out referral to the Stop Smoking Services, accompanied by a brief explanation of the benefits of quitting to mental health to all identified smokers.
- Revise the national guidance in line with the evidence to ensure that smoking cessation is included as a mandatory component of IAPT services for all identified smokers.

124. Modelling by UCL for the APPG on Smoking and Health estimates that delivering opt out referral and brief advice to adults with common mental health problems taking part in the IAPT program would result in an additional ~129 thousand ex-smokers between 2022 and 2030. This would reduce smoking prevalence to 22.6% in 2030. Without this intervention it is estimated that smoking prevalence would be 24.3% in 2030. This is 1.7 percentage point reduction (or 7% relative reduction) in smoking prevalence.²⁴

Reaching communities of smokers through social housing

125. Nearly a third of all smokers live in social housing and they are nearly three times more likely than homeowners to smoke. They make more quit attempts than people living in other housing tenures, but are less likely to succeed because they started smoking younger and are more heavily addicted.¹³⁵

126. Targeting social housing is a place-based approach offering enhanced value-for-money because smoking norms and cessation practices spread efficiently through close social networks.¹³⁶ Addressing smoking in social housing is highly targeted towards the most disadvantaged smokers, and carried out at scale could transform environments that currently facilitate smoking to those that promote quitting.

127. Growing up in communities where smoking is the norm leads to significant levels of uptake, transferring higher smoking rates across generations. Children whose parents smoke are nearly three times more likely to become smokers themselves. And a quarter of all children in social housing are exposed to secondhand smoke compared to 1 in 10 children living in owner occupied housing.

128. Targeting smokers in social housing could also help reduce poverty and level up our poorest communities. On average social tenants who smoke spend over £50 on tobacco each week, and tobacco takes up an eighth of their disposable income. Half a million social tenants are living in poverty due to the impact of smoking on their finances, which is one tenant in seven living in social housing.¹³⁷

129. Such a programme would need to include targeted training for professionals working in social housing and other allied professions, such as fire and rescue, to deliver standardised very brief advice (VBA).

130. Providing smokers in social housing with e-cigarette vouchers and advice works has been shown to significantly increase quit attempts and quit success. A pilot programme in Salford with support from Stop Smoking Services provided by community pharmacy increased throughput by 4 times year-on-year, with 5 times as many successful quits for the most deprived quintile. After the pilot finished quitting rates reduced back to previous low levels.

131. Despite the additional cost of the e-cigarette kit, the increased success rate meant that the Swap to Stop pilot was less than half the cost per quit than the standard stop smoking service offer including NRT.¹³⁸ However, it has not been adopted at scale, or even sustained in Salford, due to limited resources for tobacco control. Local authorities and social housing providers need additional funding and encouragement to implement this approach, it will not spread organically, and needs to be a funded component of the Tobacco Control Plan.

132. A third of all smokers live in social housing. Targeting social housing is a place-based approach offering enhanced value-for-money because smoking norms and cessation practices spread efficiently through close social networks.

- Fund social housing providers to run smoking cessation programmes for their tenants in collaboration with community pharmacy, or local Stop Smoking Services as appropriate.
- Train professionals working in social housing in offering very brief advice to quit.
- Include an offer of e-cigarette starter kits in addition to support to quit, to all social housing tenants who smoke to help protect children and adults from exposure to secondhand smoke.

133. Modelling by UCL for the APPG on Smoking and Health estimates that providing support to quit to smokers in social housing with an offer of e-cigarette starter kits would result in an additional ~298 thousand long-term ex-smokers between 2022 and 2030. This would reduce smoking prevalence to 24.4% in 2030. Without the intervention it is estimated that smoking prevalence would be 28.3% in 2030. This is a 3.9 percentage point reduction (or 14% relative reduction) in smoking prevalence.²⁴

Providing additional support to quit to pregnant smokers

Recommendation 7: Ensure all pregnant smokers are given financial incentives to quit in addition to smoking cessation support.

134. Smoking is the single most important modifiable risk factor in pregnancy, which can lead to miscarriage, premature and stillbirth, and cot death.¹¹⁶ The Government's current ambition is to reduce smoking in pregnancy to 6% by 2022, but to date this is nowhere near being delivered. Rates at national level are stubbornly stuck at over 10% and have hardly changed since 2016.¹³⁹

135. The highest rates of smoking are in young pregnant women. Just under a third of pregnant women in England aged under 20 are smoking at their booking appointment and delivery, compared to around one in ten pregnant women overall. As well as being more likely to smoke in the first place, younger mothers were less likely to quit before or during pregnancy.

136. A priority is to ensure that the NHS Long Term Plan is fully implemented so that all pregnant smokers are provided with support to quit. This should be on an opt-out rather than an opt-in basis, as opt-out increases success rates.¹⁴⁰ However, this will not be sufficient.

137. Smoking in pregnancy is concentrated among those who are:

- Living with a smoker
- Living in an area of deprivation or high smoking prevalence
- Smoked throughout a previous pregnancy
- Teenagers

138. Significant declines have only been delivered in localities such as Glasgow, Greater Manchester, and the North East where innovative schemes using financial incentives have been used to motivate pregnant smokers to quit and reward them for doing so.¹⁴¹ Financial incentives are a highly cost-effective intervention with a long-term cost per QALY of £482 and an estimated return on investment of £4 for every £1 invested.¹⁴²

139. A recent randomised controlled trial in Scotland found that women receiving incentives are more than twice as likely to quit compared to those in non-incentivised groups.^{140 143} The average cost of vouchers for each pregnant smoker is around £200. The marginal additional cost to deliver to all pregnant smokers (using as a baseline of 59,000 pregnant smokers in 2020) would be £11.8 million a year. Financial incentives are a highly cost-effective intervention.¹⁴⁴
140. Evaluations of local pilots have found that this approach has been particularly successful in tackling inequalities by achieving good quit rates in the bottom two deprivation deciles. For example, since such a scheme was introduced in South Tyneside in 2017/18, an area of high deprivation, smoking at time of delivery (SATOD) rate has dropped by almost a third, from 19.9% to 13.9% in 2019/20, which is in line with trial results. Greater Manchester has implemented and extended the scheme post-partum, but the results are yet to be evaluated.
141. Smoking is the single most important modifiable risk factor for poor birth outcomes, but smoking rates have stagnated in recent years except where financial incentives have been provided. It is essential that the NHS Long Term Plan proposals to help pregnant smokers quit are fully implemented by 2023/4 and sustained thereafter. In addition, the APPG recommends that the Government provides multi-year funding for a programme to offer all pregnant smokers shopping vouchers to help them quit and remain quit post-partum as part of usual care.
142. Modelling by UCL for the APPG on Smoking and Health estimates that delivering an opt out referral scheme for pregnant smokers along with financial incentives will result in an additional ~7.2 thousand long term abstinent smokers between 2022 and 2030. This would reduce smoking prevalence to 3.2% in 2030. Without the campaign it is estimated that smoking prevalence would be 4.4% in 2030. This is 1.2 percentage point reduction (or 27% relative reduction) in smoking prevalence.²⁴
143. UCL would have preferred to have modelled the impact of financial incentives on reducing the number of women smoking at time of booking, which is the target audience for this intervention. However insufficient data exist at the current time to be able to do this. Therefore, the impact is based on smoking at time of delivery (SATOD) and will be a conservative estimate of the impact of financial incentives in reducing smoking during pregnancy.

Reducing illicit tobacco supply and demand in deprived communities

Recommendation 8: Fund regional programmes to reduce the use of illicit tobacco in deprived communities.

144. Use of illicit tobacco undermines the impact of tax policy in reducing smoking and is concentrated among poorer smokers in disadvantaged communities, contributing to higher rates of smoking. Addressing this disparity requires tackling not just the supply, but also the demand for illicit tobacco in communities where use is endemic as a key element in a comprehensive tobacco control programme.
145. The Illicit Tobacco Partnership has played an important role in helping develop this approach. Coordinated by Fresh the regional tobacco control programme in the North East, in collaboration with academics, local authorities, national government, health and enforcement partners it drives a strategic approach to tackling illicit tobacco at local, regional and national level. The Partnership also provides resources such as insight-led communications tools, and guidance for Trading Standards on WHO FCTC Article 5.3.
146. At regional level in the North East and North West, with varying levels of participation in Yorkshire & Humber, there has also been concerted multi-agency enforcement activity and effective demand reduction measures in place since 2007, delivered as part of a multi-stranded programme with an evidence-based strategic framework:^{145 146 147}
- Developing partnerships

- Engaging frontline workers
- Gathering and developing intelligence
- Delivering enforcement
- Delivering behaviour change campaigns
- Working with retailers and other businesses
- Protecting policies from the vested interests of the tobacco industry
- Assessing progress

147. Activity to tackle illicit tobacco at a local level is ongoing in a number of areas across England. However, delivery of a multi-stranded programme is longest established in the North East where it has been associated with a decline in the illicit market between 2009 and 2019 of a third, from 15% to 10%.

148. The programme has been evaluated,¹⁴⁸ and was described as “*an exemplar of partnership working ... and deserves to be widely disseminated.*” This recommendation was supported by the National Audit Office (NAO).¹⁴⁹ Unfortunately, due to lack of funding, this has not been possible to date, and funding in the regions where it does exist is under threat due to cuts in the public health budget.

149. Sustained funding is needed to support:

- The national Illicit Tobacco Partnership; backed up by support at regional level for
 - Enhanced intelligence and enforcement activity to reduce supply of illicit tobacco;
 - Roll out of the Keep It Out behaviour change campaigns to reduce demand; and
 - Regular tracking of the illicit tobacco market through public surveys to monitor community level market share.

150. Fresh and the GM Health & Social Care Partnership, who run illicit programmes like this in their regions, have estimated that it would cost in the order of £5 million annually to roll it out throughout all the regions in England. This includes co-ordination and management, regional intelligence support, surveillance and enforcement resource, demand reduction (the Keep It Out campaign) and tracking key metrics such as use of and attitudes towards illicit tobacco.

Shaping the environment to change consumer behaviour

151. The most cost-effective ways to change human behaviour are population interventions which shape the environment.¹⁵⁰ When it comes to smoking such interventions are strongly supported by the public. The Government has significant potential to build on environment-shaping measures already in place, and drive more rapid declines in smoking to help achieve a Smokefree 2030.

152. Government action is popular and justified because this is an addiction most smokers were trapped into as children. Two thirds of those who try smoking go on to become regular smokers, only a third of whom succeed in quitting during their lifetime.³⁵

153. Three quarters of smokers regret ever starting smoking, and the majority want to quit. However, only a third plan to try in the next six months, and when they do, on average it takes thirty times before smokers succeed in quitting.¹⁵¹

154. Set out below are a set of low-cost regulatory measures, which will encourage smokers to quit and discourage uptake in young people. The APPG also supports the more detailed recommendations by ASH and SPECTRUM to the Post-Implementation Review of the Tobacco and Related Product Regulations to strengthen the regulations and fix the loopholes being exploited by tobacco manufacturers.¹⁵²

Closing loopholes in existing regulations including by enhancing quit messaging on individual cigarettes and in packs

Recommendation 9: Legislate to put health warnings on individual cigarettes, quit messaging on pack inserts and close other loopholes in existing regulations.

155. The Government should commit to implement our recommendations before the end of 2021. This would not be difficult. Now we have left the EU, the regulations on tobacco advertising (TAPA), Point of Sale, tobacco related products and standardised packaging of tobacco products can easily be amended.

Supplement health warnings on packs with help to quit messaging inside packs

156. Pack inserts with consumer-tested messaging on how to quit are:

- Targeted at existing smokers
- Easy and cheap to implement; and are
- Proven effective in Canada, where they have been a legal requirement since 2000.¹⁵³

157. Research into their impact has shown reading inserts significantly increased over time, unlike reading on-pack health warnings. More frequent reading of inserts is associated with enhanced self-efficacy to quit, increasing both quit attempts and sustained quitting at follow-up.¹⁵⁴ Academic research in the UK supports their use here too.^{155 156 157 158 159 160 161 162} Pack inserts will support and reinforce the impact of other measures which require significant investment, such as behaviour change campaigns and Stop Smoking Services.

Put health warnings on cigarette sticks and rolling papers

158. There is evidence that smokers become inured to some extent to existing warnings and new techniques are needed to refresh their interest. Cigarettes are ‘cancer sticks’ and consumers should be warned on the product not just its packaging. There is a growing body of research evidence supporting the effectiveness of what are known as known as ‘dissuasive cigarettes,’ particularly in making cigarettes less attractive to younger adolescents and never smokers.^{163 164}

159. The lack of health warnings on cigarettes (and cigarette papers) is an obvious loophole in existing regulations. This is already under consideration in Canada, Australia, and Scotland, and could be implemented by a simple amendment to the TRPR regulations which can easily be made now we’ve left the EU.

160. The APPG therefore recommends that anti-smoking messages are refreshed through evidence-based additional measures to introduce:

- ‘Dissuasive’ cigarettes carrying simple warnings ‘Smoking Kills’ or ‘Smoking causes cancer’ on cigarette papers as well as in packs; and
- Government mandated pack inserts encouraging smokers to quit, highlighting the most effective methods.

Replace promotion of smoking by promotion of quitting at point of sale

161. Tobacco gantries are a promotional tool, used by the tobacco manufacturers to advertise the sale of tobacco. The tobacco manufacturers continued to fund the provision of tobacco gantries in shops after product displays were banned, and it is obvious which gantries it funds.

162. Gantry are always sited immediately behind the cash tills, and industry funded gantries carry large signs saying ‘Tobacco on sale here - cigarettes, tobacco, cigars’. They do not advertise

specific brands, but they promote tobacco purchase and therefore smoking when they should be required to carry messaging to encourage smokers to quit, highlighting the most effective methods. Just like pack inserts, this will support and reinforce the impact of other measures which require significant investment, such as behaviour change campaigns and Stop Smoking Services.

163. While brands may not be promoted at point of sale, point of sale can still be used to promote tobacco and this should be prevented by:

- limiting references to the sale of tobacco in shops to the current legal requirement of one A3 sign; and
- replacing promotion of tobacco on display covers with messaging encouraging smokers to quit.

164. The tobacco industry has introduced several innovations that have exploited exemptions in tobacco regulations.^{165 166}

165. For example, smoking accessories, such as filter papers, are exempt from the ban on advertising, despite being products which facilitate the smoking of tobacco, something which has been a concern since the advertising ban was first implemented.¹⁶⁷

Close loopholes in the ban on flavoured tobacco products

166. Smoking accessories are also exempted from legislation prohibiting characterising flavours, and are not required to carry health warnings or to be in standardised packaging.

167. Furthermore, although cigarillos, are subject to the rules prohibiting advertising, but are exempt from regulations for example prohibiting characterising flavours, and requiring standardised packaging and minimum pack sizes. Cigarillos are a close substitutes for cigarettes, and after a long decline sales are now growing again following the ban on flavours in cigarettes.

168. Both routes have been used by tobacco companies to undermine the ban on flavours, by introducing menthol cigarillos and accessories including cards, filter papers and filters, designed to add a menthol flavour both to handrolling tobacco and cigarette sticks.

169. In addition, limiting the prohibition to ‘characterising flavours’ has made it easy to circumvent and complex to oversee (Krüsemann et al 2018). The purpose of flavourings is to make cigarettes more appealing and easier to smoke, whether they are ‘characterising’ or not is irrelevant, as well as setting a standard which is difficult to measure.

170. Data from UCL’s Smoking Toolkit Study, a representative survey of current smokers (18+) in England found that a substantial proportion (just under a fifth) of current smokers in England reported menthol cigarette smoking between July-January 2020/2021. There was no decline in this proportion across the period, suggesting that smokers of menthol cigarettes mitigated the impact of the ban by a variety of means, such as with legal menthol accessories.¹⁶⁸

171. The ban on advertising promotion and sponsorship should be extended to all smoking accessories. The ban on flavours should be extended to all products used in smoking, including cigarillos which are designed to be a cigarette substitute; and smoking accessories such as filters and cards which have been designed to enable smokers to add flavour to their cigarettes.

172. Furthermore, all flavourings should be prohibited as additives, not just ‘characterising’ flavours to prevent the industry from using the lack of precision in this definition to circumvent the flavour ban.

Regulating e-cigarettes and other nicotine products to protect young people while helping adult smokers to quit

Recommendation 10: Reduce the appeal and availability of e-cigarettes and other nicotine products to children.

173. Concerns that use of e-cigarettes among young people would grow rapidly and provide a new pathway into smoking have not materialised in the UK to date. Smoking rates in young people have declined significantly since 2010 when e-cigarette use started to expand rapidly. Vaping among young people aged 11 to 18 years has remained concentrated among existing smokers, with never smokers trying but rarely sustaining e-cigarette use. One in twenty never smokers aged 11 to 18 years have tried vaping and one in a hundred are current users. Young never smokers' reasons for vaping are mainly just to give it a try (67.3%) not because they like the flavours (6.4%) or think it looks cool (4%).¹⁶⁹

174. Rather than e-cigarettes being a 'gateway' into smoking, there appears to be a 'common liability' for risk taking among young people such that adolescents who are most likely to experiment with e-cigarettes are those who are at higher risk of smoking cigarettes (and using other drugs) because of traits such as sensation seeking, risk-taking, and oppositional behaviour.^{170 171} Vaping among young people is stable, but continued vigilance is needed, and e-cigarette regulations should be strengthened to further protect children.

175. There are loopholes in the current legislation which need to be filled. Currently 0% nicotine vaping liquids can be sold legally to children, there are no limits on size as the 10ml restriction only applies to liquids containing nicotine, and they are very often sold in packaging which is particularly attractive to children.¹⁵¹

176. These 0% liquids are frequently sold as 'shortfills' which are larger bottles of liquid in 0mg nicotine strength, including 50ml and 100ml bottles that are only filled to 80% capacity so that a 10ml nicotine shot (or two) can be added to bring the liquid up to the desired nicotine strength.^{172 173} A search online shows, the nicotine shot is frequently given away for free,^{172 174} which means that the products can be sold legally to children and without having to conform to UK product standards.

177. Data from the ASH YouGov surveys on adults,²⁶ and young people,¹⁷⁵ show that standardising the packaging of e-cigarettes and refills (cartridges or e-liquid products) reduces the appeal of vaping to young people, particularly younger children, while having little impact on adult smokers' interest in using the products to quit smoking. Restricting packaging design to prohibit cartoon characters and use of child-friendly descriptors such as sweet names would be a precautionary measure which would not undermine adult product use.

178. Furthermore, existing prohibition of advertising of e-cigarettes is not being fully enforced. Paying for social media influencers through channels such as Instagram and TikTok to promote e-cigarettes is clearly sponsorship, yet tobacco companies are continuing to do this. A review of enforcement processes needs to be carried out to find out what improvements are needed and whether the regulations could be strengthened to make enforcement easier.^{176 177 178}

179. The counterbalance to incentivising and encouraging smokers to switch to vaping must be even greater vigilance in discouraging uptake by young people of e-cigarettes and other alternative nicotine products to ensure that the current low levels of use are sustained, and smoking rates continue to decline among young people.

- Prohibit packaging and labelling of e-cigarettes and e-liquids which have been demonstrated to be appealing to children, for example:
 - product names or descriptors such as sweet names (gummy bears); and
 - attractive colours or cartoon characters on packs.

- Prohibit free distribution of e-cigarettes and e-liquids.
- Review the current warning on e-cigarettes to ensure it is effective at discouraging use by young people while not discouraging use by adult smokers and revise if necessary.
- Regulate all alternative nicotine products, such as pouches, to prohibit sales or free distribution to under 18s, restrict advertising and to restrict promotional packaging.

Recommendation 11: Make the route to medicinal licensing fit for purpose to allow e-cigarettes to be authorised for NHS prescription.

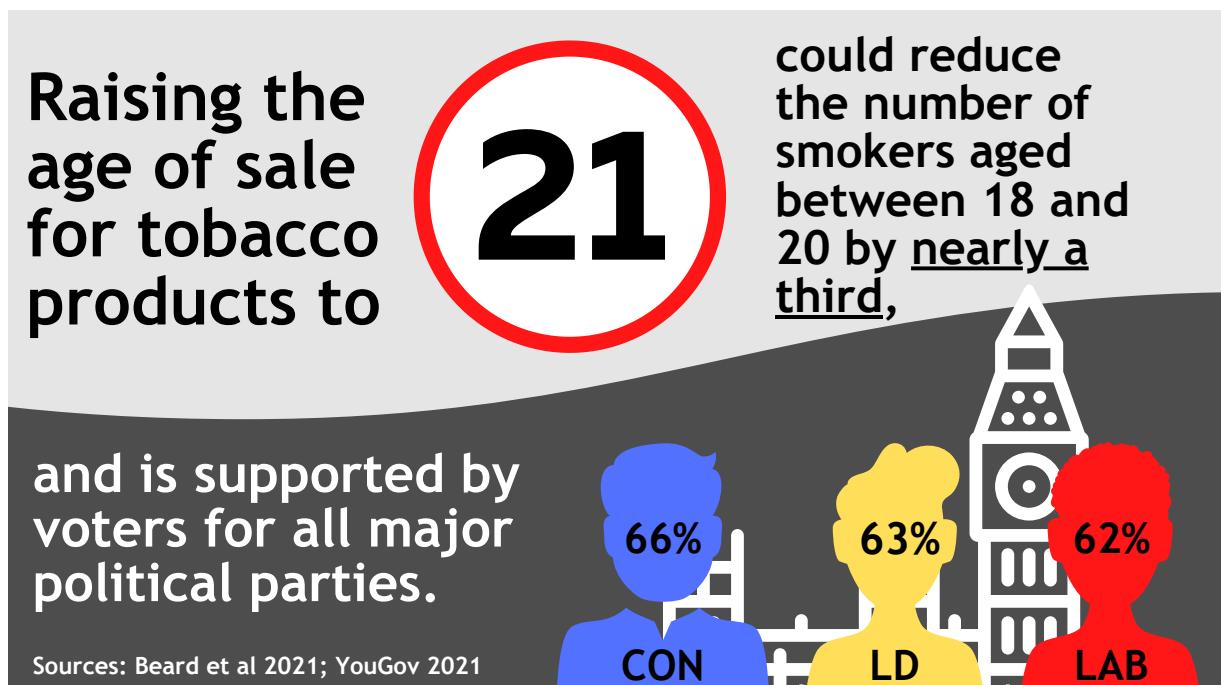
180. The vast majority of e-cigarettes are being used by adult smokers to help them quit smoking, cut down or prevent relapse. This use is supported by evidence that e-cigarettes are an effective quitting aid.^{179 180} In 2017, over 50,000 smokers stopped smoking with a vaping product who would otherwise have carried on smoking.
181. The Tobacco Control Plan 2017³ stated that “*The Medicines and Healthcare products Regulatory Agency (MHRA) will ensure that the route to medicinal regulation for e-cigarette products is fit for purpose so that a range of safe and effective products can potentially be made available for NHS prescription.*” This commitment has not, but can, and must, be delivered.¹⁸¹
182. The aim should be to have licensed e-cigarettes on the market available on prescription to smokers by the end of 2022. This is feasible, but requires the MHRA to provide greater clarity about what is required to make a successful application, both in terms of the evidence needed and the time it will take; and a commitment by government to make a licensed product available on prescription. In other words, a clear and defined market.
183. Both the Government and the MHRA have a key role to play:
- The MHRA should update licensing guidance (as promised in 2019) setting out a clear path to regulation consistent with 2020 COT report recommendations.
 - The MHRA should commit to provide regular support and feedback to e-cig companies preparing applications to ensure submissions will meet MHRA requirements.
 - The Government should commit to make e-cigarettes which gain a medicinal licence a first-line NRT and provide funding to make them available on prescription to smokers being offered help to quit.
184. The e-cigarette market has stagnated in recent years and fell between 2019 and 2020 as misperceptions of the risks of smoking and vaping grew and in 2021 have only now grown back to 2019 levels of use. The proportion of current smokers who have never tried e-cigarettes who believe they are more or equally harmful as cigarettes increased from 27% in 2019 to 42% in 2020.
185. Misperceptions are not limited to the public; they are widespread in the media and among health professionals. It is not surprising therefore that in 2020 just under a third of smokers had never tried e-cigarettes, and for the first time since ASH started monitoring use in 2010 the number of e-cigarette users in Britain went down rather than up year-on-year, falling from 3.6 to 3.2 million, a decline of 12%.¹⁸²
186. Addressing these misperceptions will not be easy but if it were achieved could help more smokers to quit successfully. The proportion of smokers using e-cigarettes in their most recent quit attempt fell from a peak of 40% in 2017, to only 26% in 2020.
187. Changing misperceptions requires imagination and government leadership. The British Medical Association believes that having medicinally licensed e-cigarettes available could be helpful,¹⁸³ as it would increase health professionals’ confidence in the safety and efficacy of such devices. This would enable them to be prescribed to smokers in addition to being available on general sale for smokers to buy.

188. It might also increase their efficacy as a quitting aid. When existing medicinal nicotine products such as patches and gum (NRT) are made available on prescription and through Stop Smoking Services they are a more effective quitting aid than bought over the counter.¹⁸⁴ The same is likely to be true of e-cigarettes, which have been shown through a randomised controlled trial to be significantly more effective than NRT in a stop smoking service setting.¹⁸⁵

Consider raising the age of sale for tobacco products from 18 to 21

Recommendation 12: Consult on raising the age of sale for tobacco from 18 to 21

189. Increasing the age of sale from 18 to 21 has majority support from adults (63% support 15% oppose), including those aged 18-24 who would be most affected by this policy (54% support 24% oppose)²⁶ and 11-18 year olds (59% support 14% oppose).¹⁷⁴ The Government should commit to carry out the consultation and decide whether to proceed by the end of 2021.



190. The majority of children and young people strongly support the Government's Smokefree 2030 ambition (79% support 4% oppose).¹⁷⁴ If England is to be smokefree by 2030 we need to stop people from starting smoking at the most susceptible ages, when they are adolescents and young adults. Two thirds of those who experiment with smoking go on to become daily smokers. Experimentation is rare in adults over 21, so the more we can do to stop young people trying smoking the better.

191. Tobacco manufacturers recognise the importance of this age group, to quote Philip Morris (1986) "*Raising the legal minimum age for cigarette purchaser to 21 could gut our key young adult market (17-20) ...*"¹⁸⁶ Young people who start smoking live to regret it, 69% of adult smokers in England wanting to quit and an even bigger proportion, 75%, regret ever having started smoking.¹⁸⁷

192. As is the case for the current age of sale, this is not about criminalising young people, it is about discouraging them from starting to smoke. However, it is essential that those who are most affected by this policy have their voice heard and taken into account in the decision-making process to ensure the development of evidence-based solutions that have their best interests at heart. Therefore, there should be a consultation on age of sale which specifically engages adolescents and young adults aged 21 and under.

193. The evidence demonstrates that the impact of this policy on youth smoking rates would be significant. In 2019, close to 16% of people aged 18-20 reported that they smoked tobacco, which equates to approximately 364 000 young smokers in England. Smokers aged 18-20 had lower nicotine dependence relative to smokers in other age groups, but were less motivated to quit. This lower motivation suggests they would be less likely than other smokers to attempt to quit in the future without an increase in the age of sale, while their lower dependence suggests they should find quitting less difficult.¹⁸⁸
194. Compared with non-smokers aged 18-20, smokers in this age group are more likely to be from lower socio-economic backgrounds (as measured by housing tenure and social grade).
195. The effect of increasing the age of sale would be cumulative over time by reducing uptake in future generations, particularly in poorer and more disadvantaged communities. Given the lower dependency in those aged 18-20 it could have a significant impact on smoking prevalence as those targeted may be less likely to seek out other illicit sources of tobacco than those in older age groups.
196. The lesson from Smokefree laws implemented in England in 2007 is that a public consultation, which will be essential for a new policy like this, can help raise awareness and make it much easier to enforce legislation.
- 98% of all premises and vehicles inspected between July 2007 and March 2008 were smokefree, complying with the requirements of the law.
 - 87% of all premises and vehicles are displaying the correct no-smoking signage.
 - 81% of business decision makers thought the law was “*a good idea*”.¹⁸⁹
197. Most small tobacco retailers support existing retail regulations of tobacco, including the age of sale, display bans and plain packaging. The current age of sale is already supported by 84% of small tobacco retailers, and over half (52%) support an increase to 21 with only 39% opposing.
198. To make it easier for retailers to secure compliance the legislation should include a mandatory ‘Challenge 25’ component requiring retailers to ask any consumer who looks under 25 to provide proof of identity before selling tobacco to them. (A mandatory ‘Challenge 25’ scheme already exists in Scotland).¹⁹⁰
199. Raising the age of sale from 16 to 18 was associated with a 30% reduction in smokers aged 16 to 17 years old, as was increasing the age of sale to 21 in the US among 18-20 year olds.
200. Modelling by UCL for the APPG on Smoking and Health estimates that increasing the legal age of sale from 18 to 21 would result in an immediate 95 thousand fewer smokers in 2022 and an additional 77 thousand fewer 18-20 year olds taking up smoking long-term up until 2030. This would reduce smoking prevalence in this age group to 2% in 2030. Without this intervention it is estimated that smoking prevalence would be 9.6% in 2030. This is 7.6 percentage point reduction (or 77% relative reduction) in smoking prevalence.
201. Raising the age of sale should also further decrease the numbers of under 18s smoking, by making it harder for children to obtain cigarettes and taking the legal purchase of cigarettes beyond school age.^{191 192} Smoking is a contagious habit, and the age increase will protect younger children from exposure to older pupils in school who smoke and whose behaviour they may want to imitate. The gap will also remove a potential source of supply within schools.^{32 192 193}

202. Increasing the age of sale to 21 also provides an important educational opportunity to communicate the serious risk to young people that if you start smoking you will find it very difficult to stop. Two thirds of those who try smoking go on to become daily smokers and to quote the 2012 Surgeon General's Report, "*Of every 3 young smokers, only 1 will quit, and 1 of those remaining smokers will die from tobacco-related causes.*"³⁶

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ISBN: 978-1-913448-14-1

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ELIZABETH R: M: D: C: M: X: L: V: M: X: L: V: M: X: L: V: M: X: L: V: