The Association of Directors of Public Health
Policy Position: Tobacco

Key Messages

- Smoking is a major killer and the biggest driver of health inequalities, with half the difference in life expectancy between people living in the most and the least deprived areas caused by smoking.
- The economic costs of tobacco use are substantial which include significant treatment cost as well as lost human capital. Smokers in England lose approximately £2,000 of their income each year, which adds an extra burden to households during the cost of living crisis.
- The tobacco industry profits from health harming behaviours. All Governments should adhere to Article 5.3 of World Health Organisation (WHO)'s Framework Convention on Tobacco Control which safeguards the integrity of policies from being compromised by the tobacco industry.
- Governments across all nations should consider the recommendations made in the Khan Review.
- The NHS should commit to a radical upgrade in prevention which includes funding and implementing NICE guidance (NG209).

ADPH Recommendations

National

Tobacco Control Plan to achieve smoke free targets: Governments across the four nations should implement a fully funded Tobacco Control plan to achieve their smoke free targets. England should set out a new Tobacco Control plan to tackle tobacco use.

Investment in public health must be increased across the four nations. In England, the Public Health Grant needs £0.9 billion more a year to reverse years of funding cuts.[1] Public health bodies should continue to invest in and prioritise tobacco control.

Tobacco tax: The Government should revise the tobacco tax escalator so that it is 2% above average weekly earnings rather than RPI.

National licensing scheme to reduce illicit tobacco trade: The Government should consider introducing a national licensing scheme with the aim of eliminating the illicit and illegal trade in tobacco, and to end selling of tobacco products to minors. It is vital that investment is made in enforcement of legislation as well as treatment and prevention.

Age of Sale: The age of sale of tobacco should be raised from 18 to 21.

Stronger Enforcement and Regulations should be imposed to limit the sale of e-cigarettes to underaged children.

Smoke free environments: The Government should ensure all social housing in communal buildings is smoke-free, making stop-smoking a norm and protecting non-smoker populations from the harms of second-hand smoke.

Building wellbeing into policy decision making: At both national and local levels, Governments across the four nations should tackle the social determinants of health – building wellbeing into policy decision making and funding allocation should be a cross-government priority.

Media campaigns: National public health authorities[1] should plan mass media campaigns in partnership with Directors of Public Health (DsPH) to promote stop smoking messages.[2] [3]

Local

Public health authorities should take a whole system approach to tobacco control. Evidence shows that smoking cessation services alone cannot reduce smoking prevalence. Public health authorities should support wider schemes, including interrupting counterfeit supplies and targeted messaging.

Regional cooperation in England and working with Office for Health Improvement and Disparities (OHID) are crucial to maximise impact and prevent duplication of resources. Regions in England should learn from the regional tobacco control programme in North East which is now funded by all 12 local authorities (LA)'s and match funded by the Integrated Care Board (ICB).

The NHS should continue to provide treatment for tobacco dependency as a core part of their services. ADPH welcomes the NHS's £42 million investment to support new treatment services in acute, mental health and maternity services and to help NHS staff to quit.[4]

NHS providers should take action to ensure that hospitals are smoke-free by effectively implementing NICE guidance PH48 (Smoking: acute, maternity and mental health services).

GPs should continue to prescribe nicotine replacement therapy or stop-smoking medicines to patients in need, supported by adequate resources and funding.

Pharmacies: Access to pharmacotherapy should be widened to help smokers stop smoking.

Background

Smoking has killed nearly eight million people in the UK over the last 50 years with an estimated two million more expected to die in the next 20 years without radical changes to smoking rates.[5] Smoking is the leading cause of premature and preventable death in the UK, killing 74,600 people in England in 2019 alone.[6] For every person killed by smoking, at least another 30 are estimated to be living with serious smoking-related disease and disability.[3] Smoking tobacco products is a significant driver of health inequalities, with half the difference in life expectancy between people living in the most and the least deprived areas caused by smoking.[7]

What are the financial benefits associated with reducing tobacco use?

The economic costs of tobacco use are substantial and include significant health care costs for treating the diseases caused by tobacco use as well as the lost human capital that results from tobacco-attributable morbidity and mortality.[8] Smoking costs society £17 billion, as a result of healthcare, productivity and

[1] By national public health authorities we mean bodies with statutory national responsibility for public health functions (eg UKHSA and DHSC in England, Public Health Scotland in Scotland, Public Health Wales in Wales, Public Health Agency in Northern Ireland). These differ across the UK, Crown Dependencies, and associated territories. We have published a separate headline explainer on public health in each of these systems.

social care costs, amongst others.[9] Smokers themselves lose a large part of their income to tobacco, an estimated £12 billion in England each year, or approximately £2,000 per smoker.[6] These figures represent profound losses to individuals and their families, by reducing tobacco use in the UK there would be clear financial benefits to both individuals and society.[6]

Are we on track to achieve smoke free targets in all four nations?

Although smoking prevalence has fallen in all four countries of the UK since 2011, the current trends in smoking show that the UK will miss the Government's Smokefree target (defined as smoking rates being 5% or less) by nine years, and by more than twice that for the most deprived smokers. In addition, in 2021/2022 9% of pregnant women in England were known to be smokers at the time of delivery. This is above the current national ambition to achieve a level of 6% or less by 2022.[10]

What are the current trends in e-cigarette usage?

The proportion of current daily and occasional vapers in 2020 remains statistically significantly higher than in 2014.[7] In 2020, 3.8% of adults were currently daily users of an e-cigarette, while a further 2.6% used an e-cigarette occasionally.[7] This equates to almost 3.3 million vapers in the population of Great Britain.[7] In young people (aged 11-18) current e-cigarette use has more than doubled, from 4% in 2021 to 8.6%.[9]

Policy Context

What are the smoke free targets in all four nations?

The English Government established a 2030 Smokefree target to reduce the prevalence of smoking to 5% or less in order 'to extend healthy life expectancy by five years by 2035'. In 2022, Dr Javed Khan published an independent review into the Government's progress and highlighted key steps for the Government to reach the Smokefree target by 2030. In Wales, the Government published 'A smoke-free Wales: Our long-term tobacco control strategy' to achieve smoke-free Wales by 2030. Scotland also published a Charter for a Tobacco-free Generation by 2034.

What are the plans to reduce smoking prevalence?

In England, the Tobacco Control Delivery Plan was set out in 2017. The plan provided LAs with funding through the public health grant to enable them to commission local tobacco control interventions. The plan was initially set to last from 2017 to 2022. In Scotland, a Tobacco Control Plan was set out in 2018 to achieve Smokefree 2034.[11] The Welsh Government published two-year delivery plans to make Wales smoke free by 2030. Towards a Smoke Free Wales: Tobacco Control Delivery 2022-2024 is the first in the series of two-year delivery plans.[12] Northern Ireland also released Ten year tobacco control strategy for Northern Ireland.[13]

What taxation measures have been implemented on tobacco?

In October 2021, new Tobacco Duty rates were introduced with the rate increasing by 2% above inflation. In addition, tax levied on hand-rolled tobacco (HRT) rose by 6% above inflation and the absolute lowest excise tax rate rose by 3% above inflation.

ADPH Position

A whole system approach for effective tobacco control

A whole system approach to prevention is crucial to decrease the prevalence of smoking and will require collaborative work between local partners such as the NHS, local public health authorities[2], schools and the police.[17] In England, smoking cessation in the NHS excludes a large group of smokers who do not require NHS care and inpatient smokers who are discharged prior to completing treatment. This means community interventions remain critical, and collaboration is needed to encourage smoking cessation.[14]

In 2014, ADPH supported Action on Smoking and Health (ASH)'s development of Clear Tobacco Control – a system-led systemwide framework for improving local delivery of comprehensive tobacco control through self-assessment, peer assessment and targeted deep dives.[14] The framework has been endorsed by OHID. ADPH continue to champion the values that underpin 'CLeaR' which encourages self-critical assessment and cross system leadership.

More public health funding needed to reduce smoking

ADPH welcome the Khan Review's recommendation to increase funding for smoke free policies. More public health investment is needed in all four nations to reduce smoking. In England, the budget for Tobacco Control has been cut by a third in real terms since 2015.[15] Spending over this period for Stop Smoking Services and tobacco control dropped by 45% in real terms.[16] Furthermore, reductions in overall LA budgets are also adversely impacting health and wellbeing locally. 86% of local councils across the UK have a predicted budget deficit and a collective funding gap of over £3 billion.[17] There is a dire need for a combination of additional investment and tougher regulation.

Smoking is clearly a financial burden on the public sector, it is single-handedly responsible for costing the NHS £2.4 billion; £1.2 billion to social care; and a further £13 billion in lost productivity.[18] If the Government were successful in tackling smoking it is estimated that this would create 500,000 more jobs in the UK and the net benefit to public finances would be around £600 million for England alone.[19]

Having a smoke free vision is vital to reduce health inequalities across the UK

Delivering smoke free targets across the four nations would play a major role in increasing healthy life expectancy, while reducing inequalities and levelling up the nation. There is also a strong economic case for achieving smoke free as it reduces NHS and social care spending in managing smoking related illness. However, if current trends continue, we will miss the target by nine years, and by more than twice that for the most deprived smokers.[20]

Turning the Khan Review's recommendations into a cohesive Tobacco Control plan, supported by investment, would provide a strong blueprint for action at national, regional and local level and chart a route to create a smoke free society. ADPH urge the Government to heed the Khan Review's call for immediate investment of £125 million in tobacco control to deliver its Smokefree 2030 ambition. Governments in Wales, Scotland and Northern Ireland should also consider the recommendations of the

[2] By local public health authorities we mean bodies with statutory local responsibility for public health functions (eg upper tier local authorities in England, Health Boards in Scotland and Wales, Public Health Service in Northern Ireland). These differ across the UK, Crown Dependencies, and associated territories. We have published a separate headline explainer on public health in each of these systems.

Khan Review.

Exposing the impacts of commercial tactics

The tobacco industry profits from health harming behaviours and utilise different tactics such as denial, distortion and distraction to shed doubt on public understanding of risk. They influence the policy process and slow the progress of key policy developments like smoke free places, tobacco control and display bans. These tactics need to be called out if we are to counter the strong commercial factors at play as they continue to undermine the aspirations of achieving the smoke free vision in all four nations.

The WHO's Framework Convention on Tobacco Control (FCTC) was the first international treaty in the global health space and was developed to help nations tackle the negative impact of tobacco on the health of their populations.[21] Governments should adhere to Article 5.3 of the treaty and safeguard the integrity of policies from being compromised by the tobacco industry.[22]

Reducing smoking prevalence through taxation

ADPH welcome the introduction of a Minimum Excise Tax (MET) on cigarettes.[23] Increasing tobacco taxes is the most effective intervention to reduce smoking.[24] The Government should revise the tobacco tax escalator so that it is indexed to average weekly earnings rather than RPI. RPI is not a good measure of affordability as wages are not keeping pace with inflation. Weekly earnings should instead be adopted as a better measure of affordability to reduce smoking prevalence.

To reduce smoking prevalence, ADPH recommend that the Government:

- Revise the tobacco tax escalator so that it is 2% above average weekly earnings rather than RPI.
- Enhance the HRT tax escalator on factory made (FM) cigarettes and HRT by 10 percentage points in every budget until the tax on the average HRT cigarette is equivalent to that of FM cigarettes.
- Increase MET for FM cigarettes annually by 4% above the average weekly earnings.[25]
- Update HMRC tobacco elasticity estimates which have not been updated since 2015.
- Eliminate duty-free allowances for tobacco, or at a minimum reduce the HRT allowance from 250g to 100g to be consistent with the allowance for FM cigarettes.
- Introduce an excise tax on disposable (single use) e-cigarettes to disincentivise their use, so lessening their environmental impact and reducing their use as an entry product into vaping by children under 18.

Polluter Pay Principle

In our Policy Survey 2019 to understand the views of our members, 73% of respondents said they supported the implementation of a tax or levy on tobacco manufacturers to help cover the cost of reducing smoking. The polluter pays principle was also recommended in the Khan Review as a solution that the Government can take if it is unable to find the necessary funding. This recommendation was also made by the APPG on Smoking and Health, which urged the Government to reduce net profit margins from around 50% to no more than 10%, which could release £700 million excess profits annually to fund tobacco control and other Levelling Up measures.[26] However, some members are concerned that a levy gives permission to continue harm and could create dependency on the industry that is causing the harm. A statutory levy is also unlikely to change the behaviour of the industry or reduce harm. Ultimately, substantial policy change and sustainable funding is needed to reduce smoking and prevent harm. The Polluter Pays Principle,

as a means of raising funds, should therefore be considered with the wider policy framework with the ultimate aim to stop harm and to achieve smoke free targets in all four nations.

E-cigarettes and other nicotine delivery products

An estimated 4.3 million adults in Great Britain currently use e-cigarettes which equates to 8.3% of the population.[27] ADPH support NICE guidance on tobacco harm reduction (PH45) and have signed the Public Health Consensus statement on e-cigarettes. In our 2019 survey of UK DsPH, 70% of the DsPH who responded supported the use of e-cigarettes in smoking cessation services. A critical recommendation from the Khan Review is to promote vaping as an effective tool to help people to quit smoking tobacco, outlining the role that vaping can play in an effective tobacco control strategy.[17] At the same time, we recognise that vaping is not risk-free and therefore vaping must be presented as an alternative to or replacement for smoking, not an activity which is appealing to the wider non-smoking population.

There is also a need to reduce the use of e-cigarettes among children and young people. Vaping is not for children and whilst it can help people quit smoking, those who don't smoke should not vape. According to a recent study, the use of e-cigarettes among children has increased from 6% in 2018 to 9% in 2021.[13] It is imperative that vaping is not normalised, and that stronger enforcement and regulations are used to limit the sale of e-cigarettes to underaged children, ensuring the right balance is taken around protecting young people and supporting smokers to quit. E-cigarettes could be sold in plain packaging and removed from the forefront of counters to reduce the accessibility of these products to children.[28]

ADPH do not advocate the use of nicotine vapourisers in enclosed public places as there is no consensus among the membership on this issue. We believe more research is needed in relation to the impact of advertising and marketing of nicotine vapourisers, including whether this has any impact on the re-normalisation of smoking behaviour and what the impact is on young people. More industry-independent research is also needed to assess the levels of risk associated with vaping, heat not burn products and other new products.

Further action needed to prevent children and young people from smoking

Most people begin smoking when they are young, while adult smokers who started smoking at the youngest ages are more likely to smoke heavily and find it harder to give up.[29] Hence, even though smoking rates in young people are declining, further action is needed to prevent the take-up of smoking.[30]

Effective action to reduce rates of smoking in young people can be at a population level, such as reducing the public acceptability and visibility of smoking through smoke free places and ensuring effective implementation of regulations on the sale and marketing of tobacco products.[31] ADPH also support raising the age of sale for tobacco from 18 to 21 as studies found that this measure could reduce the number of smokers aged between 18 and 20 by nearly a third.[32]

Planning and delivering smoking cessation services

Specialist Stop Smoking Services are both more effective clinically and cost-wise than integrated lifestyle services. Recent evidence indicated that smoking should be targeted in isolation.[33] In England, specialist smoking cessation services are currently provided by 74% of local authorities with only 1% of local authorities having no form of smoking cessation services.[34] However, Stop Smoking services mostly target people identified with higher levels of need – more support should be provided to the general

population.[26]

ADPH support the NHS's Long Term Plan in England which set out a commitment that by 2023/2024, 'all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services'. ADPH also welcome the NHS's plan to deliver NHS funded tobacco dependence treatment services across inpatient, maternity and outpatient/community settings.[35] [36]

Creating smoke free environments

Evidence shows that smoke-free environments can reduce smoking prevalence.[37] Creating smoke free environments is also important for normalisation and cultural change. The results from our 2019 Policy survey showed that 88% of respondents thought the ban on smoking should be extended to include the immediate vicinity of schools and colleges.[38] 80% thought the ban should cover parks and playgrounds, and 88% thought the ban should include sports and leisure facilities.[39] A consensus has been developing amongst DsPH that nicotine vapourisers can be used in some settings to enable them to become smoke-free. Smoke free places are not the responsibility of Enforcement Officers alone. Housing, fire, social services and the NHS must all play a part in protecting our communities from second-hand smoke.

Tackling illicit trade

Illicit trade covers smuggling, counterfeiting, bootlegging and illegal manufacturing of tobacco. Illicit trade has a role in funding organised crime, and illegal tobacco is a particular danger to children and young people as it can be sold at much lower 'pocket money' prices. As well as being cheaper, illegal tobacco is less likely to comply with health warnings and standards which in turn promotes uptake by children and reduces quitting among adult smokers. HMRC estimates that in 2019/20, illicit tobacco and HRT made up 17% of the market.[40] ADPH welcome the ratification of the WHO Framework Convention on Tobacco Control Protocol and look forward to working with Government to ensure it is fully implemented. There must be effective regulation of tobacco products. In addition, local action on illegal tobacco is essential in protecting our most marginalised communities.

About ADPH

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DsPH) in the UK. It represents the professional views of all DsPH as the local leaders for the nation's health.

The Association has a heritage dating back over 160 years and is a collaborative organisation, working in partnership with others to strengthen the voice for public health. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

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