Promoting a tobacco-free society

A summary paper from the BMA board of science – June 2015

Executive summary

Despite considerable progress on tobacco control, there are still around 10 million adult smokers in the UK (approximately a fifth of the adult population), and 200,000 children and adolescents take up smoking every year. Smoking levels among pregnant woman and vulnerable and disadvantaged groups are particularly concerning. Smoking remains the leading cause of preventable premature death and ill health, accounting for around 100,000 deaths a year in the UK.

Sustained and strengthened action is needed to reduce the levels of tobacco-related harm, with a view to achieving a tobacco-free society by 2035. This should focus on four key tobacco control goals: discouraging and deterring people from starting to smoke (prevention); reducing the harm caused by smoking and helping smokers to cut down and quit; protecting others from second hand smoke; and denormalising tobacco products and the tobacco industry.

A wide range of measures are needed to achieve these goals, which should be embedded in a comprehensive social marketing tobacco control strategy:

Policy and legislative changes – increase taxation on all tobacco products above the rate of inflation; introduce a minimum consumption tax; implement a positive licensing scheme to control and reduce the amount of tobacco legally on sale, and in the longer term, support specific restrictions such as a ban on the sale of tobacco to anyone born after the year 2000; set new targets to reduce trade in illicit tobacco; remove exemptions to smokefree legislation; extend legislation on smokefree vehicles to all private motor vehicles; and introduce stronger measures to limit the impact of smoking in films and television.

Education and information – implement sustained mass media campaigns promoting smoking cessation, highlighting the tactics of the tobacco industry and providing normative messages about smoking and its harms; provide targeted communications for key and hard to reach groups; and establish an independent body to deliver these campaigns that works with local and national stakeholders.

Smoking cessation and harm reduction approaches – provide adequate resources and training to ensure comprehensive access to evidenced-based smoking cessation services and equal access to pharmacotherapies for all smokers; implement targeted interventions for individuals from lower socioeconomic groups and disadvantaged populations; and develop a strong regulatory framework

for electronic cigarettes that maximises their harm reduction potential, ensures their effectiveness, quality and safety, and controls their promotion and sale.

Tobacco industry accountability – ensure the tobacco industry are excluded from public health policy-making at all levels of government; introduce a requirement for tobacco companies to report on sales data, marketing strategies and lobbying activity; strengthen the nicotine regulatory framework to allow greater control over the development of new tobacco products; and introduce an annual levy on tobacco companies to provide funding for future tobacco control, applied proportionately according to a company's market share.

1. Rationale

The aim of this paper is to summarise the BMA's position on the future for tobacco control and to start to consider what measures are needed to move towards a tobacco-free society in the UK.

2. Introduction

The BMA has a long history supporting measures to reduce tobacco-related harm, and has developed wide-ranging policy in this area. Much of this has been successfully implemented, and tobacco control policies in the UK are among the most comprehensive in Europe.[1] The UK has also seen a long-term decline in overall smoking prevalence.[2] Yet nearly one in five adults still smoke,[2] and an estimated 207,000 children and adolescents (aged 11-15) take up smoking every year.[3] This highlights the need for sustained and strengthened action. This is strongly supported by doctors who witness first-hand the devastating effects of tobacco on their patients.

In 2008, the BMA first set a goal for the UK to be tobacco free by 2035,[4] and has reaffirmed this call in its vision for public health published in February 2015.[5] Achieving this goal will require a new, comprehensive approach that builds on the progress made over the last two decades.

For the purposes of this paper, a tobacco-free society is defined as a nominal number of smokers (equating to 5% or less of the total population) and a nominal level of mortality from tobacco-related diseases.

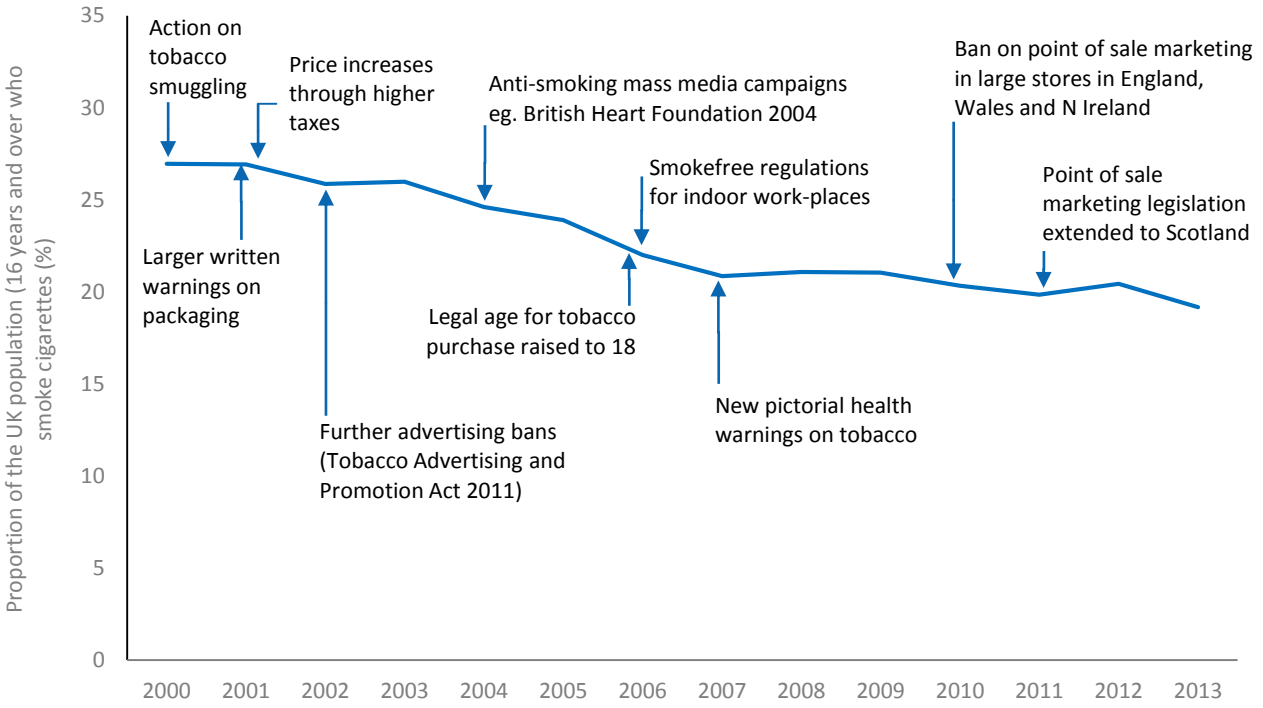
3. The case for action

The number of smokers in the UK is at its lowest level in 40 years, with smoking prevalence of 19 per cent of the adult population (aged 18 and over) in Great Britain in 2013.[3] This decline has been supported by a range of tobacco control measures introduced in recent years (see **Figure 1**). These measures built upon previous tobacco legislation, starting in 1965 with the first ban on cigarette advertising, and the mandatory inclusion of health warnings on all cigarette packaging in 1971. Other notable legislative developments include the 2001 EU Tobacco Products Directive (updated in 2014),[a]

[a] The revised directive made comprehensive advancements in health warnings on tobacco packaging, stating that the warning must cover 65 per cent of the front and back of packets, and that only the traditional cuboid packets are permitted.

the 2002 Tobacco Advertising and Promotion Act,[b] and the 2005 WHO (World Health Organization) Framework Convention on Tobacco Control.[c]

Figure 1. Timeline of tobacco control policies / legislation compared to the proportion of the UK population (16 years and over) who smoke cigarettes, 2000-2013



Source: Action on Smoking and Health (2015) *Key dates in the history of anti-tobacco campaigning*. London: Action on Smoking and Health; Office for National Statistics (2014) *Opinions and lifestyle survey, adult smoking habits in Great Britain, 2013*. Newport: Office for National Statistics.

Despite the welcome introduction of these tobacco control measures, there are still 10 million adult smokers in the UK,[3] and thousands of children and adolescents take up smoking every year.[5,6] Data also show that despite a decrease in the overall rate of smoking, the reductions have been slower among vulnerable and disadvantaged groups, including individuals from lower socioeconomic backgrounds, and those who are unemployed, homeless, imprisoned, or suffering from a mental health condition.[7]

[b] Various restrictions on tobacco advertising were incrementally introduced under this Act, including prohibiting print media and billboard advertising, direct marketing, sponsorship, and tobacco advertising at the point of sale.

[c] A global, legally-binding treaty requiring parties to implement evidence-based measures to reduce tobacco use and exposure to tobacco smoke. The UK has been a party to the treaty since 2004.

Inequalities in smoking rates based on SES (socioeconomic status) have increased in recent years.[8] In 2013, 29 per cent of adults in Great Britain in routine and manual occupations smoked compared to 14 per cent in managerial and professional occupations.[2] Tobacco is responsible for 59 per cent of the health inequalities in Wales and England, with the SES difference in death rates for men aged between 35 and 69 found to be a direct result of smoking.[9]

Smoking prevalence among the one in six adults in the UK with a mental disorder is around 33 per cent, which is 50 per cent higher than the general population[10] (with the strength of this association increasing with the severity of the mental illness). The levels of smoking in prisons are estimated to be in excess of 80 per cent in male and female prisoners,[11] equating to around 68,000 people.[12] There are also key groups for whom it is a priority to reduce levels of smoking, such as expectant mothers and new parents, due to the health risks to their children from SHS (second hand smoke). While smoking prevalence among pregnant women is declining, data from the 2014 HSCIC (Health and Social Care Information Centre) survey found that 12 per cent of mothers in England were smokers at the time of delivery.[13] Smoking prevalence varied significantly depending on region, with NHS Blackpool reporting 27.5 per cent of pregnant women smoking, compared to 1.9 per cent in NHS Central London (Westminster) and NHS Richmond.

Long-term smoking can lead to significant ill health and disease, and smoking is the leading cause of preventable premature death worldwide.[14,15] A 2010 report by the US Surgeon General concluded that "there is no risk-free level of exposure to tobacco smoke, and there is no safe tobacco product."[16] Smoking has been reported to account for approximately 100,000 deaths a year in the UK[17] (79,100 in England,[18] 13,000 in Scotland,[19] 5,600 in Wales,[20] 2,300 in Northern Ireland),[21] and is estimated to cost the NHS in England between £2 billion[22] and £5.2 billion a year.[23]

Exposure to SHS is also a substantial health risk, affecting between 33-43 per cent of adult non-smokers and 40-60 per cent of children globally.[24,25] Second hand smoke contains over fifty known carcinogenic chemicals and has been reported to cause coronary heart disease and lung cancer for people who have never smoked, with SHS exposure increasing the risk of lung cancer by 30 per cent in non-smokers.[26] There are also significant risks to children, with exposure to SHS found to be responsible for 40-60 per cent of the cases of asthma, and increase in the number and severity of episodes among children with established asthma.[25] The infant death rate is 68 per cent higher when the mother is a smoker compared to those who did not smoke,[27] and the risk of sudden infant death syndrome is 2.5 times greater for infants exposed to SHS.[28]

4. Working towards a tobacco-free society

Working towards a tobacco-free society centres on action on the following tobacco control goals:

- discouraging and deterring people from starting to smoke (prevention)
- reducing the harm caused by smoking and helping smokers to cut down and quit
- protecting others from exposure to SHS
- denormalising tobacco products and the tobacco industry.

The first goal has a particular focus on children and young people, as the vast majority of smokers start before they are 18 years old, and virtually all do by the age of 25.[4] A 2012 report from the US found that addiction to smoking has almost always developed by the time young people leave school, with 80 per cent of lifetime smokers addicted before they turn 19.[29]

Younger age groups are also a key focus for denormalisation, as this relates to activities or actions taken to reinforce the fact that tobacco use is not, and should never be, considered a normal activity in society.[30] The aim of these activities is to reduce the appeal of smoking and eliminate the social influences that persuade young people to take it up. As highlighted in the 2008 BMA report, *Forever cool: the influence of smoking imagery on young people*, this reflects how children and young people view smoking as a cool activity, despite the well-documented negative health outcomes.[29] Smoking is seen as a symbolic act of rebellion, and a way of instantly establishing an identity of someone who does not conform to the rules; an image that many young people may wish to portray.[31] The key focus for policy makers should therefore be to deglamourise the use of tobacco products.[32]

Denormalisation is likely to have wider impacts, including encouraging existing smokers to quit through less visible smoking cues and influences. Changing attitudes to what is socially acceptable can encourage people to alter their behaviours, for example, through not wanting to expose others to SHS (eg by not smoking around children in the home). In this context, parallels can be drawn in the way social behaviour has denormalised drink driving.

From a broader perspective, denormalisation activities can help to highlight and mitigate the way the tobacco industry operates. This has the advantage of shifting the focus away from the individual and on to the role of industry.[33] For example, tobacco companies have been found to use a business model focused on increasing new users of their products, even if this means specifically targeting adolescents.[34]

Supporting the tobacco control goals (of prevention, cessation, protection of others and denormalisation) requires a framework for action based around:

- policy and legislative changes
- education and information
- smoking cessation services and harm reduction approaches
- tobacco industry accountability.

This approach recognises that specific interventions can typically address more than one tobacco control goal. Strengthening smokefree legislation, for example, will provide enhanced protection for others from SHS, as well as reducing the normality of smoking in the social environment.

It is also important to embed this approach in a comprehensive social marketing tobacco control strategy. This involves the application of marketing knowledge, concepts, and techniques that will counter tobacco industry tactics and coordinate activities in a way that maximises public health benefits.

While the interventions discussed in this briefing specifically aim to reduce the number of people starting to smoke, and the number of people successfully quitting, broader action is also needed to address the social and economic inequalities that shape the environment in which individuals are born, grow, live, work, and age. These are commonly referred to as the social determinants of health, and are strongly related to lifestyle health risks such as tobacco use. Action to address these inequalities has been comprehensively covered elsewhere, most notably in the 2010 Marmot Review,[35] which sets out a range of universal actions to improve health and wellbeing for all. The BMA has also published its own guidance on ways in which doctors can take action to address the social determinants of health.[36]

4.1. Policy and legislative changes

Policy and legislative changes are an effective mechanism to reduce the accessibility and affordability of tobacco products through a range of approaches, such as taxation increases and regulating the way in which tobacco is sold.

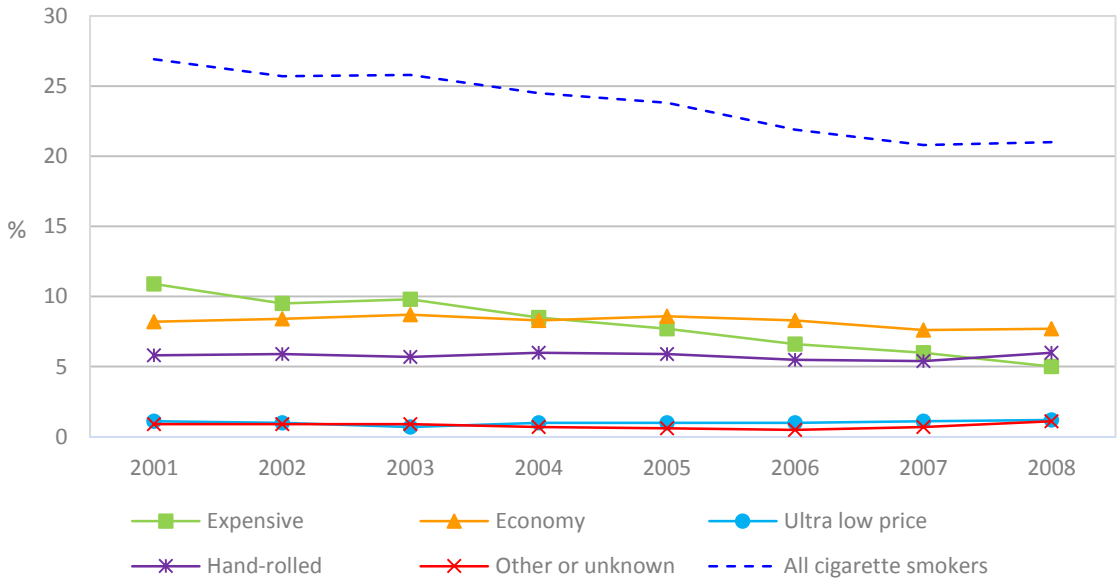
4.1.1. Reducing the affordability of tobacco products

Reducing the affordability of tobacco is one of the most effective ways to decrease smoking uptake and encourage quitting.[37,38] This can be achieved through taxation increases above the rate of inflation, which evidence suggests would reduce levels of smoking.[39,40] It has been estimated that an

increase in the tobacco tax escalator[d] from two to five per cent above inflation would result in 104,000 more smokers quitting, 479 deaths prevented, and an increase in government revenue of £485 million in the first year.[41]

Increasing taxation is particularly effective as those who are most sensitive to price increases (smokers from deprived backgrounds and young people) are disproportionately affected. Reducing the affordability of tobacco has been shown to be one of the only control measures which reduces smoking in these lower SES groups compared to the general population.[42] As this approach would take a proportionally greater amount from those on lower incomes, it is important to ensure measures to increase tobacco taxation are complemented by other measures discussed in this briefing (eg support for smokers to cut down and quit and action on the illegal trading of tobacco).

Figure 2. Smoking trends from 2001 to 2008: overall smoking prevalence and the proportion of Great Britain smoking expensive (premium and mid-price), economy, ultra-low price and roll your own cigarettes



Source: Gilmore A, Tavakoly B, Hiscock R et al (2014) Smoking patterns in Great Britain: the rise of cheap cigarette brands and roll your own (RYO) tobacco. *Journal of Public Health* **37**(1): 78-88.

Action is also needed to reduce growing price differentials between the most expensive and cheapest cigarettes in order to discourage down trading by smokers. The tobacco market has seen significant growth in low-price and discount cigarette brands, in particular among younger age

[d] The tax escalator is a system by which tax is automatically applied to a specific product at a predetermined level above inflation each year.

groups.[29,43,44] As **Figure 2** shows, despite a large decrease in the number of smokers using 'expensive' products, the number of smokers using 'economy', 'ultra low price' and 'roll your own' tobacco did not change significantly between 2001 and 2008.[43,44] This presents a risk to the effectiveness of efforts to reduce smoking rates, and highlights the need to introduce a minimum consumption tax as a way of ensuring that taxation on all cigarettes is at the same level, regardless of quality. This would also ensure that there is no differential between hand-rolled and manufactured cigarettes.

4.1.2. Regulating and limiting the sale of tobacco products

Tobacco products are widely available in the UK, from a range of high street retailers to online websites. There is evidence that reducing access to tobacco and making purchases less convenient can have a significant impact on the number of smokers and delaying smoking onset.[44,45,46] Limiting the sale of tobacco products would also reduce the power of what is already a declining industry, as disinvestment would result in less influence.

An important first step for regulating and limiting the sale of tobacco is the introduction of a positive licensing scheme. This would require all retailers and wholesalers to obtain a licence from their local authority to sell tobacco products. The absence of such a scheme means that there is currently no way to identify the number of places where tobacco can be sold, or to control and reduce the tobacco distribution network. In the short term, a positive licensing scheme would help with enforcing age restrictions for the sale of tobacco products, where retailers found to persistently break the law would have their licence removed.

In the longer term, a positive licensing scheme would support the introduction of limits on the amount of tobacco available for legal sale, enabling a phased reduction over time. This 'sinking lid' on supply would diminish the amount of commercial tobacco released for legal sale.[47] A positive licensing scheme would also support specific restrictions on the sale of tobacco. The BMA would like to see this phased in by prohibiting the sale of tobacco to anyone born after the year 2000, as these are the cohort approaching the age when most people take up smoking. This has the aim of creating a tobacco-free generation that would progressively denormalise smoking and, over time, reduce the number of people who become addicted to nicotine. Data taken from a 2008 survey (of over 8,000 people in England) shows that there is some public support for a total ban on the sale of tobacco in the UK, with nearly 45 per cent of all respondents agreeing the government should work towards a complete ban.[48]

4.1.3. Targeting the illegal tobacco trade

Action to tackle the illicit trade in tobacco is needed to ensure that measures aimed at reducing the demand for and legal supply of tobacco products are not undermined. This is also necessary to protect smokers from the use of unregulated products – for example, illegal cigarettes seized by trading standards in the UK in 2014 were found to contain dangerous contaminants (including asbestos, ground glass and rat and mouse droppings) and to fail fundamental safety tests in relation to fire safety.[49] The latter significantly increases the risk of injury and death resulting from fires caused by illicit cigarettes that do not meet RIP (reduced ignition propensity) standards.

New targets need to be set to reduce the level of illicit trade in the UK. This should be supported by adequate funding and resources for action by HM Revenue and Customs and the UK Border Agency, as well as a framework for national, regional and local partnership working on action to tackle illicit trade. There also needs to be the introduction of key supply chain controls – as required under the Illicit Trade Protocol to the WHO Framework Convention on Tobacco Control[50] – such as effective global tracking and tracing systems for tobacco products. This will help counter the role that tobacco companies are known to play in fuelling illicit trade, specifically countering smuggling, counterfeiting, bootlegging[e] and illegal manufacturing.[51,52,53]

4.1.4. Enhancing and extending smokefree environments

The introduction of smokefree legislation covering all enclosed public places and workplaces has proved very successful, with high levels of compliance[54,55] and positive health outcomes.[56,57,58] It is also an important approach to reducing the normality and visibility of smoking. There are, however, a number of exemptions to the smokefree legislation that need to be addressed, such as removing the exceptions for smoking in prison[59] and on stage during theatrical performances.[f] Doctors also believe the NHS should be an exemplar of best practice in promoting smokefree environments in accordance with NICE (National Institute for Health and Care Excellence) guidance on a smokefree NHS.[60]

Beyond enclosed public places and workplaces, exposure to SHS remains commonplace in private motor vehicles.[61] While the provisions to prohibit smoking in private vehicles carrying children under the age of 18 (due to come into force in England on 1 October 2015) are a welcome development, consideration should be given to extending banning smoking in all private motor vehicles (regardless

[e] Where significant quantities of tobacco products are legally purchased in a country with a low tax rate and are then transported to another with a higher tax rate.

[f] Smoking is allowed on stage when the artistic integrity of a performance make it appropriate for a person to smoke. The theatre exemption applies in England, Wales and Northern Ireland but not in Scotland.

of the age of the driver and passengers). As highlighted in the 2011 BMA report, *Smoking in vehicles* (updated in 2013), this would be easier to enforce; would protect the health of all non-smoking adult passengers (including vulnerable adults); and would reduce the likelihood of driver distraction.[62]

A greater focus is also needed on increasing the protection for children and adult non-smokers in the home setting. As this is not suited to a regulatory or legislative approach, it should be supported by high impact and sustained public health campaigns (see section 4.3). From a broader perspective, action to help smokers quit (see section 4.3) will reduce SHS exposure in homes and private vehicles.

4.1.5. Limiting pro-smoking imagery in entertainment media

Observing a character smoking in entertainment media (ie in films and on television) is known to have a strong influence on smoking onset in young people.[29,63,64,65] Smoking is particularly widespread in films, where it is typically associated with popular characters.[29] This has the impact of making smoking appear 'cool', more acceptable and normal than it really is.

Limiting children and young people's exposure to on screen smoking is an effective way to decrease adolescent smoking onset.[66] Various approaches can support this, including implementing programmes aimed at informing those involved in the production of entertainment media of the potential damage done by the depiction of smoking. This should be complemented by the requirement for pro-smoking content to be taken into consideration for film classification, focused on whether the depiction of smoking is condoned, encouraged or glamourised in the absence of editorial justification. A further requirement should be that any film or television programme with significant pro-smoking content be preceded by an anti-smoking advertisement. This latter approach has been found to diminish the impact of any pro-smoking messages in films.[64,67]

4.2. Education and information

Educational approaches and public health communications are important in raising awareness of the health impacts of smoking and in encouraging smokers to quit.

4.2.1. Mass media campaigns

There is strong evidence that mass media campaigns can encourage quitting and prevent smoking onset.[68,69,70,71,72,73]

The success of these campaigns has been found to depend on the type, reach, intensity, and duration of message.[74] The different approaches that have been used include strong emotive content, scare tactics, information on how-to-quit, anti-industry messages, changing social norms, information

about SHS regulations, increasing awareness of the dangers of smoking through education, medical simulations, testimonials and narratives from other smokers.[75] The most effective types of message have been found to be those highlighting the negative health effects of smoking.[74] Research has shown that targeting of messages is needed for different types of smoker, depending on their attitude towards their smoking habit (eg whether they are looking to quit).[73] Population-wide communication approaches are not always effective at engaging with vulnerable and hard-to-reach groups. Tailored communications may be needed for groups who have particularly high reported levels of smoking, such as individuals with low educational attainment,[8] people from lower SES groups,[8] gay and lesbian people,[76,77] and people with learning disabilities and/or mental health problems.[8,78] Research is needed to determine what type of communications promoting good health, would best reach these groups.

Forever Cool: the influence of smoking imagery on young people also highlights the importance of giving consideration to the source of any pro-health messages. Information directly from a source such as the government is not always well received, especially by young people.[29] A credible and well-respected source is vital for the message to have any effect, which is best provided by an independent body responsible for delivering mass media and social marketing campaigns. Many local groups and stakeholders such as health charities, cessation providers (in the health service and elsewhere) and youth groups have considerable energy and expertise in this field, and should be fully engaged and involved in campaign development and delivery.

4.2.2. Youth programmes

Children and young people are a key target group for health education. Various approaches have been trialled to reach and involve this age group through programmes and activities in a variety of settings, including school-based interventions and youth and community groups. Some of the most effective interventions have been shown to be peer-led. One example is the 'truth' campaign in the United States, which educates young people about tobacco industry tactics through a significant online presence and sponsored events across the country, with success found in reducing numbers of teen smokers.[79] A further example is the Cancer Research UK *#smokethis* campaign which used young, high profile people from the entertainment and sports industries to spread a message denormalising the tobacco industry.

4.3. Smoking cessation and harm reduction approaches

Good quality and comprehensive smoking cessation services are vital in supporting smokers to quit. Where individuals are not able (or do not want) to stop smoking in one step, or they want to reduce

the amount they smoke, harm reduction measures may provide important public health gains. This is particularly important for those who are highly dependent on nicotine.

4.3.1. Comprehensive smoking cessation services and behavioural support

NHS smoking cessation services[g] are a very effective means of supporting people in quitting smoking,[80] yet they are substantially underused by smokers compared to other cessation aids.[81,82] The number of people accessing them is also declining – in England, for example, there was an 11 per cent decline in the use of these services from 2011/12 to 2012/13, and a further 19 per cent from 2012/13 to 2013/14.[83,84] Action is therefore needed to improve the accessibility of NHS smoking cessation services. This can be achieved by running clinics in a variety of settings – including GP practices, pharmacies, work places and easily accessible community centres – and at different times of day.

There are also significant concerns about the basic provision of smoking cessation services at a local level. A 2013 audit found considerable variation across 40 surveyed local authorities in England in the prioritisation of tobacco control, with one in three health and wellbeing boards not making tobacco control a priority in their JHWS (joint health and wellbeing strategy).[85] This is compounded by ongoing cuts to local authority budgets. There is a need for greater prioritisation of evidence-based smoking cessation services, which is best achieved by a mandatory requirement for each local authority to provide them. As well as adequate training and support for all stop smoking practitioners and health professionals working with smokers, this will ensure comprehensive access to good quality cessation services. There is also a need to ensure equal access to pharmacotherapies such as NRT (nicotine replacement therapy),[h] varenicline and bupropion. For some smokers, particularly those on low incomes, the cost of accessing these over-the-counter or on repeat prescription can be an important factor in limiting quit attempts.

4.3.2. Targeting key groups and smoking cessation services in closed settings

In providing accessible and comprehensive smoking cessation services, there is a need to consider a range of hard-to-reach and key groups.

[g] Services that provide a combination of behavioural support and pharmacotherapy to aid smoking cessation.
[h] Nicotine products (such as gums, patches and inhalers) that have been granted a medicines licence by the Medicines and Healthcare products Regulatory Agency. These products have been clinically demonstrated to be more effective in achieving smoking cessation than no support, and can be accessed via prescription or over the counter.

Individuals from lower socioeconomic groups and disadvantaged populations

NHS smoking cessation services can be effective in reducing smoking rates among individuals from lower socioeconomic backgrounds and disadvantaged communities, and in turn help to reduce health inequalities.[86,87] As with access to many prevention and early intervention health services, these individuals typically have poor access to smoking cessation services.[88] This highlights the need for targeted interventions for this group,[89] with service providers (such as general practices and local authorities) commissioning flexible and coordinated services to meet individual's needs.[90] Research is required to understand which interventions are the most effective way of reducing smoking rates within this group.

Pregnant women

Pregnant women who smoke are a key target group for cessation services, and NICE has developed comprehensive guidance in this area for commissioners, managers and practitioners.[91] Adequate resources and training should be provided to ensure universal adherence to NICE guidance, with a key focus on:

- supporting the role of midwives in assessing woman's exposure to tobacco smoking (including through the use of a carbon monoxide test)
- providing information about, and referral to, NHS Stop Smoking Services
- providing initial and ongoing support to help woman who are pregnant to quit smoking (including through cognitive behaviour therapy, motivational interviewing and structured self-help and support from NHS Stop Smoking Services)
- working with partners and others in the household who smoke to quit or avoid smoking around the pregnant woman, mother or baby.

Secondary care settings

While many patients in the secondary care setting receive advice to quit smoking,[92] there should be adequate resources and training to ensure this is a routine part of care for all smokers accessing these services, in particular those with mental health problems and long-term conditions. As set out in NICE guidance, this should apply to the following services: drug and alcohol programmes in secondary care; emergency care; inpatient, residential and long-term care for severe mental illness in hospitals, psychiatric and specialist units and secure hospitals; and planned specialist medical care or surgery.[60]

4.3.3. Harm reduction

Licenced NCPs may be used temporarily or in the longer term to help individuals cut down or reduce the harm caused by smoking. This is particularly important for those who are highly dependent on nicotine and who may not be able (or do not want) to stop smoking in one step. Giving up smoking completely, without the use of NCPs, should remain the ultimate goal, as this removes the reliance on nicotine.

Guidance on tobacco harm reduction approaches has been developed by NICE,[93] and covers the following aspects:

- stopping smoking, but using one or more licensed NCP as long as needed to prevent relapse
- cutting down prior to stopping smoking, either with or without the help of one or more licensed NCP
- smoking reduction, either with or without the help of one or more licensed NCP
- temporary abstinence from smoking, either with or without the help of one or more licensed NCP.

Supporting the wider implementation of NICE guidance is an important aspect in helping to reduce tobacco-related harm. Careful monitoring is needed to ensure that the harm reduction agenda is not subverted by the industry.

E-cigarettes

The use of e-cigarettes for tobacco harm reduction has received considerable attention. While these have become the most popular single type of NCP among current smokers and ex-smokers to help cut down and quit smoking,[94] doctors have expressed concern that any benefits or disadvantages to public health are not yet well established. [95] This is due to there being very limited conclusive evidence of their effectiveness as a cessation aid for long-term smokers; concerns regarding the variability of the components of e-cigarette vapour; and the absence of a significant health benefit associated with dual use of e-cigarettes and tobacco cigarettes.[96]

There is some evidence from other countries that e-cigarettes may be acting as a gateway to smoking.[89,97,98,99,100,101] While data show regular use among non-smoking adults and children in the UK is rare, this needs to be monitored closely, particularly as the availability and promotion of e-cigarettes increases.

There are also a number of additional concerns. The increasing involvement of the tobacco industry in the e-cigarette market has the potential to undermine the progress made on tobacco control in the UK. The visual similarities between e-cigarettes and tobacco products can lead to e-cigarette marketing inadvertently promoting and normalising smoking and create uncertainty around the function of e-cigarettes.[102] Doctors have expressed concerns[70] that through the use of advertising, sporting sponsorships and celebrity endorsements, e-cigarettes are being marketed in a way that targets children, young people and non-smokers.[102] Despite the limited evidence of their effectiveness, the industry has made claims that have been adjudged by the Advertising Standards Agency to go beyond the available evidence.[103] Other concerns relate to their accessibility on the high-street and online, as well as product safety and quality.[70]

In light of these concerns, it is important that e-cigarettes are regulated in a way that maximises their potential for harm reduction; ensures their effectiveness, quality and safety; and provides strong controls on their promotion and sale.

4.4. Tobacco industry accountability

A key aspect in promoting a tobacco-free society is to reduce industry influence on policy development and increase their contribution to managing the burden of tobacco-related harm. This reflects the fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests.

4.4.1. Limiting tobacco industry influence

As the WHO has noted, the tobacco industry has historically employed a multitude of tactics to shape and influence policy.[104] These have included direct and indirect political lobbying and campaign contributions, financing of research, attempting to affect the course of regulatory and policy machinery, and engaging in social responsibility initiatives as part of public relations campaigns.[104] Action is required to minimise this influence in accordance with the WHO Framework Convention on Tobacco Control and its guidelines. This includes a particular focus on ensuring the tobacco industry is excluded from public health policy-making at all levels of government, and prohibiting the use of advertising or corporate social responsibility communications (by tobacco companies and their subsidiaries and agents) to promote their interests and influence public policy.

This should be supported by closer scrutiny of the tobacco industry's operations and working practices. A mandatory requirement to report on sales data, marketing strategies and lobbying activity will inform public health policy, and will allow government and public health organisations to

monitor and respond to how the tobacco industry targets new customers and seeks to influence the development and implementation of tobacco control policy.

As a part of denormalising the tobacco industry, there is also a need to raise awareness about the strategic delaying tactics that they employ to undermine or delay tobacco control measures. Attempts to discredit and contradict unfavourable research have been well documented,[105,106] involving tactics such as submitting overwhelming volumes of evidence, evidential landscaping[i] and misleading quotation of existing evidence scientific critiques.[106] Increasingly tobacco companies have also turned to the courts to challenge changes to legislation, such as the litigation action filed by Phillip Morris International in 2012 and 2014 against the Australian[107] and Uruguayan[108] governments over the introduction of standard packaging and public health warnings. Legal action has also been threatened in the UK in a challenge to legislation to force companies to remove branding from cigarette packaging. Greater public awareness of these tactics is needed to increase scrutiny and move towards an agreement that these are not acceptable practices.

4.4.2. Stronger nicotine regulation

Due to the significant decline in smoking rates over the last 10 years, the tobacco industry has adapted to maintain its market share through the development of new products, such as smokeless tobacco. This has the effect of allowing companies to continue to develop their brand, and increases the accessibility of tobacco. Of particular concern is how tobacco companies are able to introduce smokeless tobacco-based products onto the market with limited regulation. This highlights the need to strengthen the nicotine regulatory framework in order to control and limit the development of new tobacco products. Such a framework would also provide a platform to require a gradual reduction in the nicotine content of existing products.

4.4.3. Funding for tobacco control

Many of the activities outlined in this summary paper require substantial funding and resources, from the provision of comprehensive smoking cessations services to action on illicit tobacco and sustained public health social marketing campaigns. There is a clear case that, in light of the substantial burden on society of smoking, these activities should be funded by the tobacco industry. This approach reflects the increasing and high level of profitability of the UK tobacco market, with conservative estimates that they reached £1.1 billion in 2013.[109] From a practical perspective, the

[i] Promoting a parallel evidence base and deflecting detrimental evidence to divert attention from the issue being discussed.

measures identified in this paper could be funded through an annual levy on tobacco companies, which has political support,[110,111,112] significant public support[113] and could generate £500 million annually.[114,115] This would require a transparent and accountable process for calculating costs, based on accurate values for tobacco control interventions at local, national, and regional levels. It would also need to be applied proportionally according to a company's market share.

5. Call to action

While the UK has made significant progress over the last 30 years on tobacco control, this summary paper highlights the need for further strengthened action, working towards a long-term goal of a tobacco-free society. This represents a considerable challenge to policy makers, and will require a new, comprehensive social marketing approach that includes action in the following areas.

Policy and legislative changes

- Taxation on all tobacco products should be increased above the rate of inflation (increasing the tobacco tax escalator from two to five per cent above inflation).
- A minimum consumption tax for all tobacco products should be introduced to ensure all cigarettes are taxed at the same level and remove the price differential between hand-rolled and manufactured cigarettes.
- A positive licensing scheme for the sale of tobacco products should be implemented. This would tighten limits on the amount of tobacco that is legally on sale and support closer restrictions on who is able to purchase tobacco products. These measures would support the denormalisation of tobacco and a move towards a progressive ban on the sale of tobacco to anyone born after the year 2000.
- New targets to reduce the level of illicit tobacco trade in the UK should be developed, supported by the introduction of key supply chain controls (such as effective global tracking and tracing systems for tobacco products).
- Exemptions to smokefree legislation that permit smoking in prisons and on stage during theatrical performances should be removed.
- The provisions prohibiting smoking in private vehicles carrying children under the age of 18 should be extended to apply to all private motor vehicles.
- Measures should be taken to limit the impact of smoking in films and television on children and young people through:

  - the implementation of programmes aimed at informing those involved in the production of entertainment media of the potential damage done by the depiction of smoking
  - a requirement for pro-smoking content to be taken into consideration for film classification
  - a requirement that any film or television programme with significant pro-smoking content be preceded by an anti-smoking advertisement.

Education and information

- Sustained mass media campaigns should be used to promote smoking cessation, highlight the tactics of the tobacco industry and provide normative messages about smoking and its harms. This should be complemented by targeted communications for key and hard to reach groups.
- An independent body should be established to deliver these campaigns, with formal links with local and national groups and stakeholders (such as health charities, cessation providers and youth groups).

Smoking cessation services and harm reduction approaches

- There should be adequate resources and training to ensure comprehensive access to evidenced-based smoking cessation services and equal access to pharmacotherapies for all smokers. This includes universal adherence to NICE guidance on smoking cessation.
- There should be targeted interventions for individuals from lower socioeconomic groups and disadvantaged populations, including universal adherence to NICE guidance for pregnant women and patients in the secondary care setting.
- The wider implementation of NICE guidance on tobacco harm reduction should be supported.
- Electronic cigarettes should be regulated in a way that maximises their potential for harm reduction; ensures their effectiveness, quality and safety; and provides strong controls on their promotion and sale.

Tobacco industry accountability

- In accordance with the Framework Convention on Tobacco Control, the tobacco industry should be excluded from public health policy-making at all levels of government, and prohibited from using advertising or corporate social responsibility communications to promote their interests and influence public policy.

- Tobacco companies should be required to report on sales data, marketing strategies and lobbying activity.
- The nicotine regulatory framework should be strengthened to allow greater control over the development of new tobacco products.
- An annual levy on tobacco companies should be introduced to provide funding for future tobacco control, applied proportionately according to a company's market share.

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