Cancer Research UK Briefing: Tobacco Control Policy

Tobacco control is vital to the UK Government's levelling up ambitions. The upcoming Tobacco Control Plan for England and Health Disparities White Paper provide key opportunities to set out a comprehensive plan of action to help address the burden of smoking, reach smokefree targets and ensure the UK cements its position as a world leader in tobacco control. This briefing sets out Cancer Research UK's top priorities.

Cancer Research UK's calls to achieve Smokefree 2030

1. It is vital that smokefree is achieved equitably, that's why **the UK Government must commit to reducing disparities in smoking prevalence, by setting a target of reaching less than 5% smoking prevalence for all socioeconomic groups by 2040 at the latest and putting a clear plan in place to reach this target.**

2. Delivering a robust tobacco control strategy could significantly help reduce smoking prevalence and address a significant contributor of health inequalities – but for this, the strategy must be adequately resourced. **The UK Government should implement a Smokefree Fund, making the tobacco industry pay for the damage caused by smoking but without letting them influence how the fund is spent.**

3. Discouraging uptake is an essential part of tobacco control. A key part of this is continuing to reduce the appeal of smoking. **However, there are currently loopholes in existing regulations on tobacco packaging and flavours which the UK Government should urgently remedy. Government should also explore bold new ways to reduce tobacco uptake – including pack inserts, dissuasive cigarettes, raising the age of sale of tobacco to 21 and maximum pricing.**

4. A key priority for the tobacco control strategy should be to ensure that all people who smoke have access to effective support to help them stop. **Achieving this will require:**
    a. **improving the delivery of smoking cessation support in primary care**
    b. **increasing the number of people accessing Stop Smoking Services**
    c. **introducing the NHS Long Term Plan's tobacco dependence treatment commitments**

Background

Tobacco is the biggest cause of cancer and preventable death in the UK. [1,2] Decades of action have meant adult smoking prevalence in the UK was at a record low at 14.1% in 2019, [3] but this masks significant inequality. **There is no room for complacency when it comes to tackling tobacco.** While some evidence suggests that a large number of people who smoke have attempted to stop during the COVID-19 pandemic,[4,5] CRUK funded research indicated that smoking among young adults increased by 25% in England during the first lockdown – equating to 652,000 more young adults smoking compared to before the pandemic.[6]

Tobacco costs the government, public services, the economy and the taxpayer

The impact of tobacco on the English economy is sizeable. **It is estimated that smoking costs the economy £17 billion per year,** of which:

- £2.4 billion falls to NHS services for treating smoking-related illness.[7]
- £1.19 billion is spent by the social care system on current and former smokers that require care in later life because of smoking related illness. Over 1 million people's care is also being provided informally by friends and family: if this was replaced with formal paid care, it would cost the social care system an additional £14 billion.[7]
- Over £13 billion is lost in productivity costs from tobacco-related lost earnings, unemployment and premature death every year.[7]

People who smoke also spend an average of £1,945 pounds a year on tobacco.[7] When net income and smoking expenditure is taken into account, 1.6 million or **31% of households with someone who smokes fall below the poverty line**.[8] Action to tackle tobacco nationally, regionally and locally is therefore vital to reduce the impact of smoking and tobacco-related disease on public services, the local economy and residents.

Smoking is a leading driver of health inequalities

There are big differences in smoking rates across the population, with **significantly higher smoking rates among the most deprived compared with the least deprived.** These differences make it one of the leading drivers of health inequalities:

- Smoking is responsible for **half the difference in life expectancy** between the lowest and highest income groups in England.[9]
- CRUK estimates show that there are nearly **twice as many smoking-attributable cancer cases in the most deprived group** compared to the least deprived in England. [10]

That's why tackling smoking is essential to both the UK Government's 10-year cancer plan and levelling up ambitions

There are significant gains to be made if we reduce smoking and smoking-related health inequalities. That's why we welcome the UK Government's vision for England to be smokefree by 2030, but according to CRUK analysis based on 2018 data, we are not on track to deliver this ambition until 2037. In fact, **only the least deprived group in England is estimated to be smokefree by 2030, while the most deprived group won't reach this target until the mid-2040s.** [11]

To achieve the 2030 target – and wider cancer and levelling up ambitions – we need to see bolder and more ambitious action on tobacco control. These measures must include regulatory measures that make smoking less appealing as well as effective support and services that help people to quit. But to be effective, this will require adequate and sustainable funding.

CRUK's Recommendations

Priority 1: Achieving smokefree equitably

Tobacco related inequalities must not be allowed to worsen. To ensure that the benefits of a smokefree society are felt equitably by all, it is imperative that existing tobacco-related health inequalities are addressed. We would therefore welcome an explicit commitment to reduce these inequalities – because England will not be smokefree until all groups are smokefree.

The UK Government must commit to reducing disparities in smoking prevalence, by setting a target of reaching less than 5% smoking prevalence for all socioeconomic groups by 2040 at the latest and putting a clear plan in place to reach this target.

Priority 2: Smokefree Fund

Without additional and sustainable funding, it will not be possible to support people who want to stop smoking, or continue to discourage people from taking it up.

Tobacco kills up to half of all users in the long term whilst being highly profitable for its manufacturers: the four largest tobacco manufacturers make around £900 million of profits in the UK each year.[12] In comparison, funding for local, regional and national tobacco control activities in England has been significantly cut in recent years.[13] These funding pressures mean local authorities are not only unable to deliver smoking cessation services as they should,[14] but this also threatens the delivery of local stop smoking campaigns and enforcement activity aimed at preventing underage tobacco sales and tackling illicit tobacco:

- Only 67% of local authorities in England commissioned a specialist service open to all local people who smoke in 2021.[15] Furthermore, between 2013/14 and 2019/20 total local authority spending on stop smoking services and tobacco control in England fell by 43.3% from £148.5 million to £84.2 million.[16]
- National spending in England on public education campaigns has also dropped from a peak of £23.38 million in 2008/9 to just £1.99 million in 2017/18.[17,18]

ASH has estimated that £265.5 million would be needed to pay for national, regional and local tobacco control activity in England, which increases to £315.2 million for UK-wide measures.[19]

That's why the UK Government should introduce **a fixed annual charge on the tobacco industry, making them pay for the damage their products cause, but without letting them influence how the funds are spent.** Funds generated from this charge, which would be administered by the UK Government, should be used to help deliver the necessary **evidence-based tobacco control measures at a national, regional and local level,** such as stop smoking services and mass media campaigns, that are vitally needed to achieve smokefree targets across the UK. The fund should be introduced as an additional source of funding to the restoration of the public health grant to support other vital public health measures and tobacco control measures until the fund is implemented. *See CRUK's recent report, 'Funding the Smokefree Generation', for more information.*

Priority 3: Making smoking less appealing

Over the years, the UK has successfully implemented several regulations aimed at reducing the appeal – and therefore the uptake – of tobacco products. To maximise their impact, DHSC should rectify the loopholes used by the tobacco industry to undermine these measures[20,a]. However, there is also evidence to show that the effectiveness some of these successful measures, like health warnings on cigarette packs, can decrease over time as people who smoke become more used to them. It is therefore important that the UK Government continues to explore new ways of reducing the attractiveness of tobacco products.

The UK Government should explore bold new measures to limit uptake of smoking, including:

- ***Pack inserts:*** Evidence suggests that interventions that make cigarettes less appealing, with displaced cost to the manufacturer, are a prudent policy measure. This evidence is outlined in a recent APPG on Smoking and Health report[21], endorsed by CRUK, that called for mandated pack inserts encouraging people who smoke to stop and advising them on doing so, citing strong public support for the measure.
- ***Dissuasive cigarettes:*** There is some evidence to suggest that dissuasive cigarettes are effective in making cigarettes less appealing to young people.[22,23] This evidence is outlined in a recent APPG on Smoking and Health report,[21] endorsed by CRUK.
- ***Raising the age of sale to 21:*** The age of sale of tobacco is currently 18 in the UK, but recent reports, including the APPG on Smoking and Health report,[21] have been calling for a consultation to increase in the age of sale. Evidence shows that many people who smoke start smoking before the age of 21, with smoking prevalence higher among the 18 to 21 age group than the general population.[24] By restricting the ability of this cohort to buy tobacco products, there may be potential to reduce uptake and thus decrease the adult smoking population.
- ***Maximum unit pricing:*** Historically, tobacco companies have shifted the cost of tax increases on tobacco onto the consumer.[25] They often increased their premium products (overshifting) while minimising the increase in price on their cheaper products (undershifting)[26,27] – likely to avoid the most price sensitive consumers from stopping smoking. Introducing a maximum price on tobacco products would undermine the industry's ability to have very cheap tobacco products, which could be beneficial for health inequalities.[28,29,30 31] Capping the price of tobacco products could also be used as a mechanism to raise funds for public health, through shifting what were industry profits to the government through accompanying tax increases.[32] The UK Government should look into this measure – with a particular focus on how it would affect tobacco-related health inequalities.

Priority 4: Improving access to evidence-based cessation treatment for people who smoke

Everyone who smokes should have access to treatment to help them stop smoking if they want to, but unfortunately this isn't the case.

There are evidence-based cessation treatment available, and promising commitments to expand access in the NHS Long Term Plan. **That's why we are calling for the commitments on smoking within the NHS Long Term Plan to be restated and for progress to be accelerated towards these.[33]**

[a] CRUK would be happy to share our (unpublished) response to the post implementation review of Standardised Packaging of Tobacco Products (SPoT) and Tobacco and Related Products 2016 (TRPR) regulations, which contains further detail on this topic.

Improving the delivery of smoking cessation support in primary care

GPs have a key role to play in encouraging people to stop smoking, given **people who smoke see their GP 35% more than those who don't**. But there is evidence to show **not all GPs are trained in or delivering support to patients – despite our projections showing that this would have a big impact in helping people to quit if improved**. What's more, because stop smoking services aren't available everywhere, some GPs are unable to refer patients to support or unaware of what services are there in the first place.

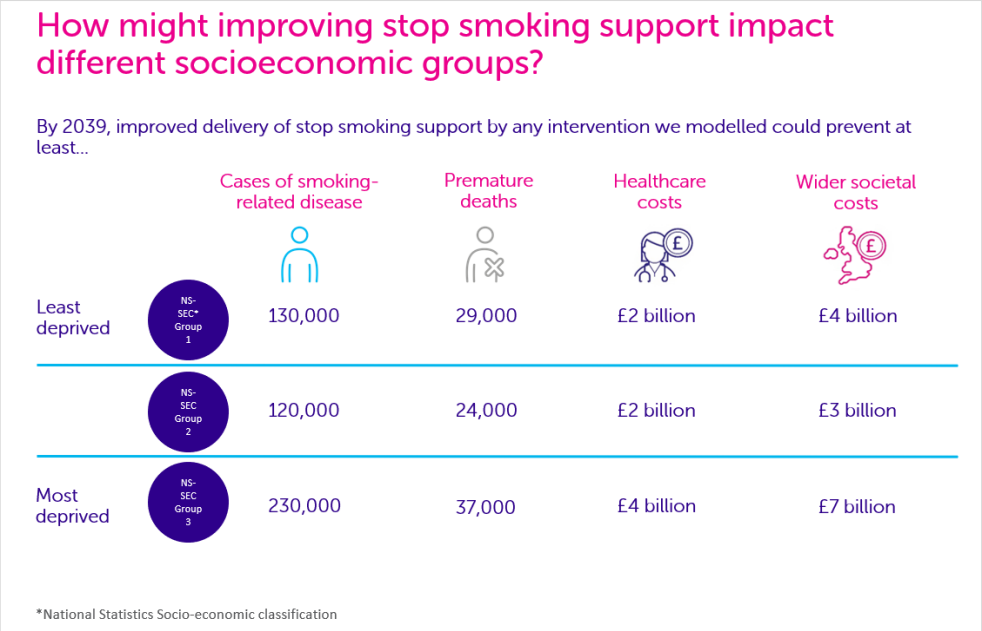

Figure sourced from Making Conversations Count for All. UK-wide analysis.

Steps need to be taken to improve stop smoking support in primary care, this should include:

- **Ensuring all relevant primary care professionals have undertaken training in and are routinely delivering VBA on smoking in consultations with patients who smoke.**
- **Ensuring primary care professionals offer evidence-based interventions to patients to support them to stop smoking, including systematically referring them to a local stop smoking services for ongoing support where available, or prescribing pharmacotherapy for smoking cessation with brief advice.**

Increasing the number of people accessing Stop Smoking Services

Local stop smoking services, which provide a combination of behavioural support and treatment, offer people who smoke **the best chance of stopping successfully**. Yet they are not universally available,[15] mainly due to funding cuts. **It is essential that local authorities have enough resources to fund these services sustainably**, so that they can be available across the country.

CRUK modelling also suggests that **there is more to be gained from increasing the amount of people who access these services rather than improving success rates.** That's why it's crucial that there are **more mass media campaigns that motivate people to stop smoking and signpost them to these services.** These campaigns should especially **target people most at-risk of smoking** for example, pregnant women, those with mental health conditions, and the most deprived.

For any questions on this briefing, please contact Heather.Lafferty@cancer.org.uk

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- *Number & proportion of cancer cases attributable to smoking calculated by combining smoking prevalence in 2003-07, cancer incidence in 2013-17, and relative risk of being diagnosed with cancer in current and ex-smokers versus never-smokers. All calculations split by deprivation quintile (assessed by the income domain of the Index of Multiple Deprivation for cancer incidence and Equivalised Household Income for smoking prevalence), sex & cancer site.*

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