

**Levelling up health by
stamping out tobacco**

March 2022



**CLEARING
THE SMOKE**

Contents

Foreword	3
Executive summary	4
Fighting to level up health	4
A significant step change is needed	4
Our recommendations	5
Introduction	6
Chapter 1: 2017 Tobacco Control Plan – Failing to meet current targets	9
Target 1: To reduce adult smoking rates to 12% or less	9
Target 2: To reduce the prevalence of 15 year olds who regularly smoke to 3% or less	10
Target 3: To reduce the prevalence of smoking in pregnancy to 6% or less	10
Target 4: To reduce the gap in smoking between routine and manual occupations and the general population	12
Chapter 2: Smoking and the levelling up missions	14
1. Smoking and economic productivity	14
2. Why smoking shortens healthy life expectancy	15
3. Why smoking is bad news for wellbeing	16
Chapter 3: How tobacco traps disadvantaged communities	19
Chapter 4: Policies that work – How to level up by making smoking obsolete	24
1. Supporting those communities facing the worst health outcomes	24
2. Mass media campaigns, upweighted amongst groups with the highest smoking rates	24
3. Incorporating smoking cessation into NHS work on health inequalities	25
4. Very Brief Advice for smoking cessation	26
5. Regional tobacco control strategies	27
6. Funding for stop smoking services	28
7. Implement a smokefree 2030 fund	29
8. Raise the age of sale for cigarettes and tobacco products from 18 to 21	29
9. Vaping for harm reduction	29
Closing remarks	30
References	31

Foreword

Asthma + Lung UK is the nation's lung charity and we're here for everyone who's living with a lung condition, regardless of what that condition is. We want to drive a transformation in lung health, and a big part of this is preventing people developing lung disease in the first place. Action on smoking is key to this.

We wholeheartedly support the government's commitment to level up the country, and we support the policies outlined by the All Party Parliamentary Group on Smoking and Health in their report **Delivering a Smokefree 2030**. If done properly levelling up could be a golden opportunity for health, but we wait to see if the policies brought forward by the UK government are ambitious enough for the scale of this task.

The COVID-19 pandemic has shone a light on health inequalities. People in poorer communities are more vulnerable to ill health and early death. A range of health risk factors are known to contribute to this, but smoking is possibly the most significant.

As this report makes clear, smoking is an addictive inter-generational cycle, and smoking rates remain stubbornly high within communities that experience the worst health outcomes. While huge progress has been made on smoking rates in the UK over the last 50 years, significant problems remain. Children who grow up around smokers are much more likely to become addicted when they grow up, and when they try to quit themselves, they find it much harder.

We know how to break this cycle. It needs a properly funded, long term, sustainable approach – something that is currently absent. The government must make concerted action on smoking a key pillar of the levelling up agenda. Without this, levelling up health, and the government's ambition to add 5 years healthy life expectancy by 2035, will not be achieved.

Stop smoking services work and are known to be cost effective. However, they've been operating in extremely tight financial circumstances for some time. Many people who could have quit tobacco with their support have not done so because of this.

Funding for stop smoking services is a litmus test for the government's seriousness about making England smokefree by 2030 and achieving the levelling up health missions. Without sufficient, ringfenced funding for stop smoking services we will not see the progress that is so badly needed. We urge the government to implement a 2030 smokefree fund, raising money directly from the tobacco industry to fund these services and help make smoking obsolete.

Other countries recognise the huge problems caused by tobacco and are working to stamp it out entirely. Amongst a comprehensive package of measures, New Zealand are set to ban the sale of tobacco to anyone born after 2008, ensuring a fully smoke free generation. Denmark is also considering a generational ban on the sale of tobacco, while Ireland are looking at this and the possibility of making tobacco companies pay for the huge health costs created by their products. People across the UK deserve the same.

I welcome these innovative policies and hope that politicians in Westminster will show similar ambition and commitment to our smokefree and levelling up plans. This commitment has been missing for too long, and it must change.



Sarah Woolnough
Chief Executive, Asthma + Lung UK



Executive summary

Fighting to level up health

This paper demonstrates that smoking is the single biggest cause of health inequalities and is responsible for half of the difference in life expectancy between the richest and poorest in society. It is directly related to three of the 12 levelling up missions recently announced by the UK government in its Levelling Up White Paper, published February 2022.¹ Significant action on smoking is essential if the Government's ambition to add 5 years healthy life expectancy by 2035 is to be achieved.

Indeed, action on smoking is likely to be the most single effective method of achieving this goal, and smoking is the most important and easily modifiable risk factor related to health inequalities.^{2,3} This is because it is often easier to help people to quit smoking than to address complex risk factors such as poverty and poor housing.

The overall ambition to 'level up' health outcomes is welcome, yet the UK government is currently on track to miss three out of the four targets set out in the 2017 Tobacco Control Plan. It is also on track to miss its own 2030 smokefree ambition for England, which aims to drive smoking rates below 5%.

Smoking is the most important and easily modifiable risk factor related to health inequalities. This is because it is often easier to help people to quit smoking than to address complex risk factors such as poverty and poor housing.

Against this disappointing backdrop, without significant additional resources and action on smoking, these levelling up missions and improvements in healthy life expectancy will not be achieved. We need to be clear about that reality now, so that effective action can be taken.

A significant step change is needed

The numbers of smokers making quit attempts, and being supported to quit, have fallen significantly in recent years.^{4,5} This is a direct result of waning government efforts on tobacco control. Action is needed to address this urgently.

Stop smoking services are known to be effective and cost efficient, but have faced significant funding cuts over recent years. As a result, fewer smokers have been helped to quit. We urge the government to implement a 2030 smokefree fund, raising money directly from the tobacco industry to help make smoking obsolete and properly fund stop smoking services.

In addition, a more strategic and coordinated use of resources is needed. As the NHS moves towards a greater focus on promoting healthy communities and preventing ill health, the case for effective upstream measures such as Very Brief Advice (VBA) for smoking cessation within primary care becomes stronger than ever. The creation of Integrated Care Systems (ICSs) also offers opportunities for enhanced regional coordination for smoking cessation over a larger footprint, with strong evidence that action on this level is effective.⁶

Our recommendations

- **The government must restore comprehensive smoking cessation services.** Stop smoking services are cost effective with a strong track record but have been hit by severe cuts to public health funding. Adequate, ringfenced, long term funding would have a transformational impact, with around £266 million per year needed in England.⁷
- **The government must implement a smokefree 2030 fund to increase funding for stop smoking and related services.** A Polluter Pays Levy on tobacco industry profits in the UK would be simple to implement and easily raise sufficient funds for proper smoking services across the UK, mass media campaigns and other tobacco control measures.
- **‘Levelling up’ must include additional support for those communities and groups facing the worst health outcomes.** While good-quality universal stop smoking services are needed everywhere, the Disparities White Paper must include targeted action to help the most deprived communities break with tobacco.
- **We want to see mass media campaigns such as ‘Stoptober’ receive proper funding, in the region of the £8 million spent in 2012/13, with upweighted work focusing on groups experiencing the highest smoking rates.** Recognised by the World Health Organisation (WHO) as one of the components of best practice tobacco control, media campaigns are effective and cost-efficient, yet continued cuts have reduced their impact.
- **Making smoking cessation core to NHS work on health inequalities, including the Core20PLUS5 programme.** Given the significant effect that smoking has on both overall health inequalities and the clinical areas selected as NHS priorities in this area, its omission from Core20PLUS5 is a big gap.
- **Very Brief Advice (VBA) for smoking cessation should be used across primary care.** NICE (National Institute for Health and Care Excellence) recommended as effective and economical, VBA is a well-established policy to prompt smokers to quit and direct them to support. It needs to part of a universal offer to people accessing healthcare.
- **Comprehensive smoking cessation support for people attending hospital (the Ottawa Model).** Comprehensive programmes of smoking cessation support when people are admitted to hospital produces in-year NHS savings and particularly benefits the most disadvantaged, who are more likely to have long term conditions that require hospital admissions.
- **Local NHS bodies and local authorities must collaborate on regional tobacco control strategies.** The creation of Integrated Care Systems (ICSs) offers opportunities to better coordinate work with local government over a wider footprint. Coordinated effort at this level is already known to be effective in reducing smoking.
- **The government must increase the age of sale for cigarettes and tobacco products from 18 to 21.** Increasing the age of sale from 16 to 18 has significantly cut youth smoking. Evidence from America shows that further increasing the age of sale to 21 reduced smoking rates in this age group by 30% and has a sustainable long-term impact.
- **Stop smoking services should offer vaping to existing smokers, for harm reduction.** Vaping has the potential to help many smokers transition away from tobacco, reducing health harms. People choosing to quit in this way should be supported.

Introduction

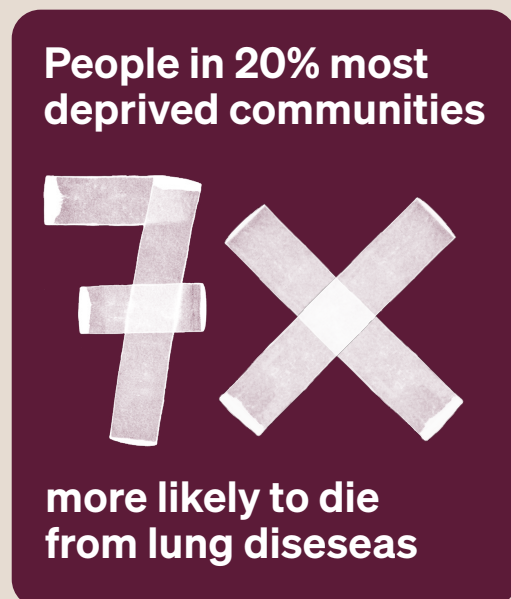
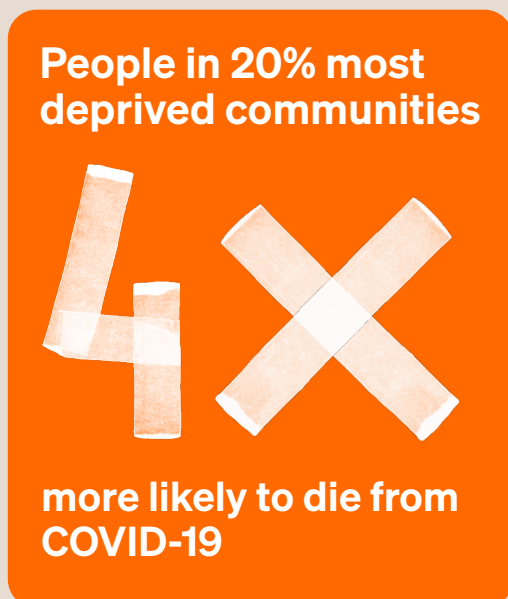
The UK government's Levelling Up White Paper, published at the start of February 2022, set 12 bold ambitions with the aim of 'spreading opportunity and prosperity' to all parts of the UK. Many of these relate to productivity and economic prosperity, while others focus on health and wellbeing. These two issues are inextricably linked.

Concerted efforts to reduce smoking rates will help achieve these ambitious levelling up missions. In fact, these missions cannot be achieved without a strong focus on tackling smoking.

Lung health and disadvantaged communities




Poor lung health is an issue that overwhelmingly affects those from more disadvantaged communities. COVID-19 has brought the UK's unequal health outcomes into plain sight, with those from the 20% most deprived parts of England four times as likely to die from COVID-19 as those in the least deprived areas.⁸

Moreover, the same communities are three times more likely to die of preventable deaths, and seven times more likely to die of a respiratory condition than those from the wealthiest 20% of the population.⁹ Much of this difference is related to smoking.



Levelling up and the challenge posed by smoking

Given this huge disparity it should be no surprise that smoking cessation has a key role to play in three of the 12 Levelling Up missions. These are:

Levelling up Mission		Role of Tobacco
1. By 2030, pay, employment and productivity will have risen in every area of the UK, with each containing a globally competitive city, with the gap between the top performing and other areas closing.		The productivity losses associated with smoking cost the UK just over £14 billion per year – around 0.5% of total UK Gross Domestic Product. Overall smokers earn around 7% less than non-smokers as a result of their dependency on tobacco. ¹⁰
7. By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by 5 years.		Smoking is the single biggest cause of health inequalities and responsible for half of the difference in life expectancy between the richest and poorest in society. ¹¹ Smokers requiring social care do so on average 10 years earlier than non-smokers. ¹²
8. By 2030, well-being will have improved in every area of the UK, with the gap between top performing and other areas closing. ¹³		Stopping smoking is associated with small to moderate improvements in mental health at least as great as those gained from taking anti-depressants. ¹⁴ Smokers are at greater risk of social isolation and loneliness as they age. Stopping smoking is also beneficial for economic wellbeing. ¹⁵

While the Levelling Up White Paper set these ambitions, it made it clear that the detailed policy proposals needed to achieve them will follow within a Disparities White Paper and an updated Tobacco Control Plan. This is welcome progress, but without an urgent and clear roadmap for effective action the poorest communities will continue to be left behind.

Additionally, a roadmap is no use without the tools to do the job. The Institute for Fiscal Studies¹⁶ has pointed out that the levelling up ambition cannot be achieved without bold action and substantial funding. We share these concerns.

“ There is no new money for these missions... We all want to narrow the gap in healthy life expectancy, you can't do it by wishing it away. ”

Professor Sir Michael Marmot

Director of the Institute of Health Equity and Joint President of Asthma + Lung UK

Katy Brown, 64, a retired nursery nurse from Bristol, was diagnosed with chronic obstructive pulmonary disease (COPD) in February 2021, a condition her mother Gina died from last year. Both women smoked for most of their lives, with Katy successfully giving up three years ago.

She says: "Growing up in the 1950s in the steelworks town of Corby, everyone smoked, and it was a normal part of life. Both my parents were heavy smokers, and of their six children, five of us took up smoking too.

"I had my first cigarette when I was eight, and by the time I was 19 and at secretarial college, I was a regular smoker. During my forties, I started to smoke much more heavily, as the usual midlife stresses surfaced. I did stop for three years, but by 2014, I was back on 20 to 30 cigarettes a day.

"Cigarettes were a crutch that I always turned to. Of course, I was aware of the risks of lung cancer, but that didn't put me off, as it always felt like such a remote possibility. I had never heard of COPD, and it was only when my mum was diagnosed with the condition in 2011 that I realised how serious and frightening it could be.

"When I did give up in 2018, it was with the help of a drug called Champix, which was then available on the NHS, and I haven't looked back since. But I regret ever picking up the first cigarette as my life could be completely different now if I hadn't smoked. It worries me that two of my siblings are still heavy smokers, and I hope it doesn't take a health scare to get them to stop.

"People who have never experienced breathlessness, can't imagine how frightening it is. If I'd have known how difficult it is to live with a lung condition like COPD, I'd have stopped smoking years ago."



“ I had my first cigarette when I was eight, and by the time I was 19 I was a regular smoker. ”

Chapter 1: 2017 Tobacco Control Plan – Failing to meet current targets

The last UK Government’s Tobacco Control Plan for England, published in 2017, provides an important backdrop for these levelling up missions. It set the following targets for 2022:

Government target	Progress
1. Reduce adult smoking rates from 15.5% to 12% or less	X
2. Reduce the proportion of 15 year olds who regularly smoke from 8% to 3% or less	?
3. Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less	X
4. Reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population	✓

Data to show whether these targets have been met will not be available until 2023, but it is possible to give a partial assessment of progress based on the latest available data

Target 1: To reduce adult smoking rates to 12% or less

Unfortunately, data collection has been affected by the pandemic, and so it is difficult to be certain as to whether this target can be achieved until the figures for 2022 are released in 2023. However, initial indications suggest we are off track.

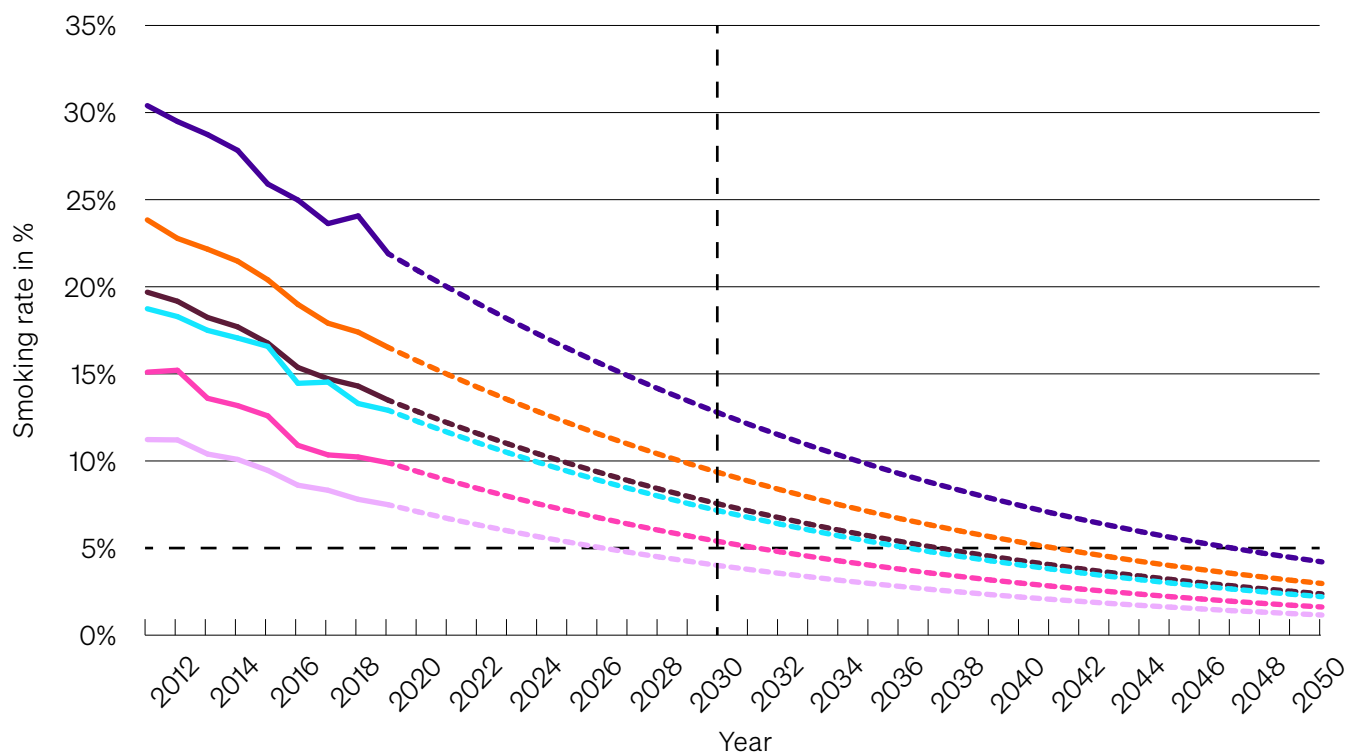
In quarter 1 2020, before COVID hit, 13.8% of those aged 18% and over taking the Annual Population Survey (APS) smoked, a number not statistically significantly different to the annual estimate for 2019 (14.1%). At the time of publication, no summary data for 2020 has been published. There was a drop in smoking rates to 12.3% in quarters 2 and 4 of 2020, but the Office of National Statistics describe this as ‘sudden and implausible’ and stress the need for caution because of methodological changes in the way that data is collected as a result of COVID-19.¹⁸

Figures from the Opinions and Lifestyle Survey (OPN) survey, which did not see methodological changes as a result of the pandemic, show that smoking prevalence for 2020 was 14.5%. Quarterly figures did show significant variations. Research by University College London suggest that the number of young adults aged 19-34 who smoke in England rose by about a quarter in the first lockdown.¹⁹

Research by Cancer Research UK, using data from 2018/19, found that at pre-pandemic rates adult smoking prevalence will reach 5% seven years late in 2037. The situation is worse for the most deprived quintile of the population with this group not set to reach 5% smoking prevalence at the mid-2040s.²⁰ While it is not yet clear whether COVID-19 has changed this, it does highlight the scale of the problem and the amount of work left to do.

Smoking prevalence projections for adults (aged 18+) in England

(with thanks to Cancer Research UK for allowing this data to be reproduced)



In 2019 Cancer Research UK calculated that to reach the smokefree target by 2030, **work on smoking cessation would need to increase by 40%**.²¹ Since then there has been no significant step change in smoking cessation work. While the pandemic may have caused changes in smoking rates and has certainly impacted upon data collection, it will take time for the full picture to emerge. Overall it is likely this target will be missed.

'Our projections indicate that England will not achieve its smokefree ambition of 5% average adult smoking prevalence by 2030 if current smoking prevalence trends continue.'

Cancer Research UK²²

Target 2: To reduce the prevalence of 15 year olds who regularly smoke to 3% or less

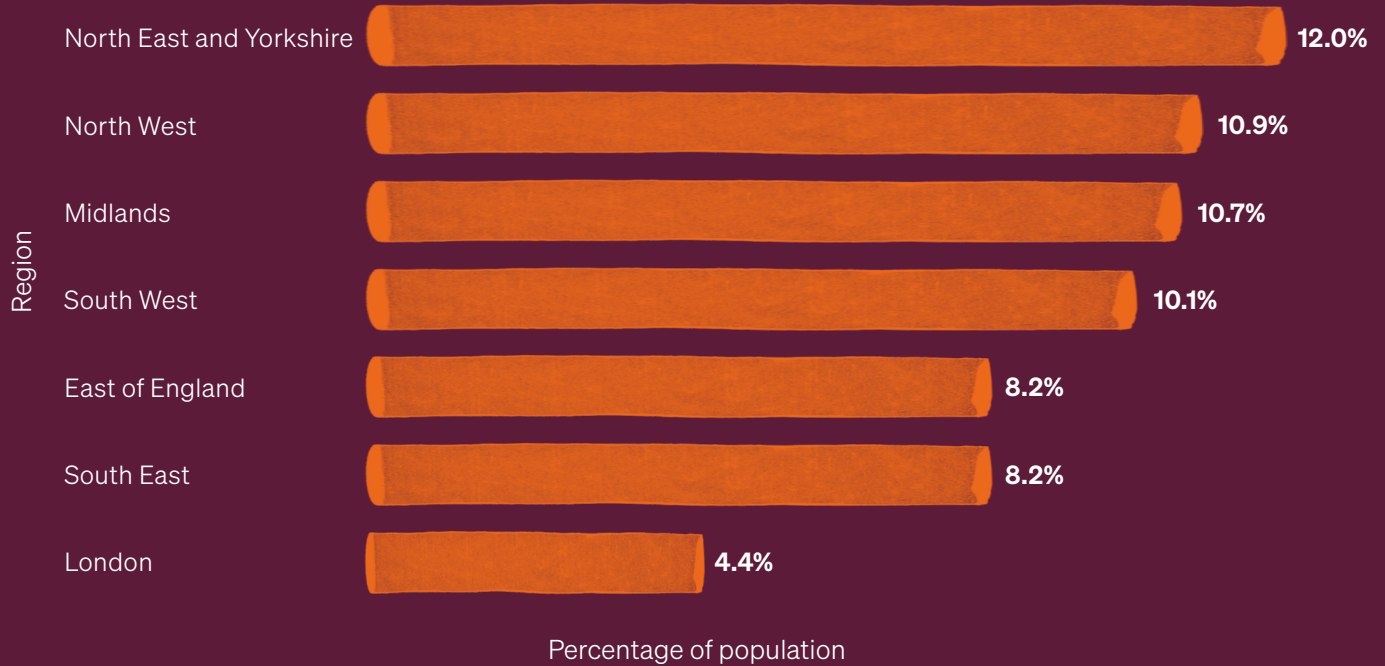
The 2020 Smoking, Drinking and Drug Use among Young People survey was not carried out because of the pandemic, meaning that the last available data is from 2018. This is too old to assess progress. The survey was carried out towards the end of 2021 however, with publication expected summer 2022.

Target 3: To reduce the prevalence of smoking in pregnancy to 6% or less

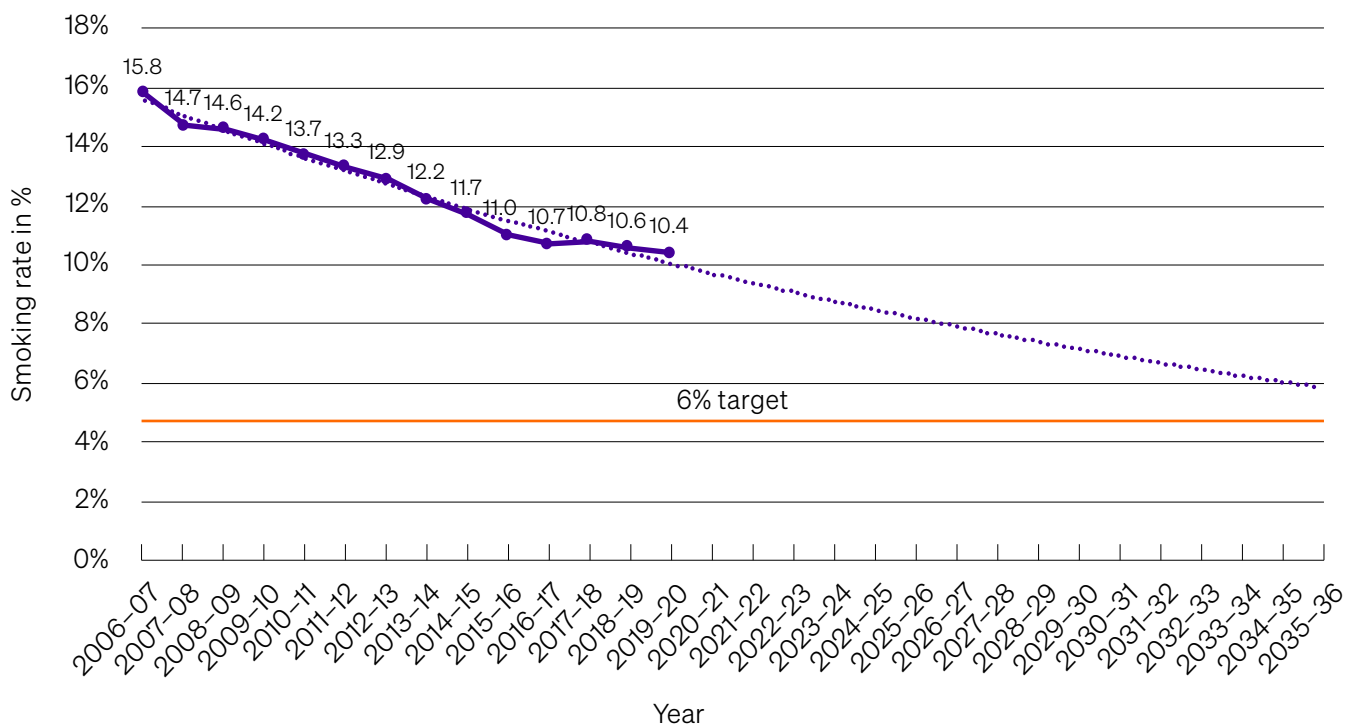
The number of pregnant women smoking at the time of delivery fell steadily in the decade up to 2016 (from 15.8% in 2006) but has largely stalled since then. There has been a small decrease in the number of mothers smoking at delivery in the last few years, from 10.8% in 2017/18 to 10.4% in 2019/20.²³ Figures are considerably off the target of 6%.

The latest data has been impacted by the pandemic, NHS Digital state that it should be interpreted with caution. It still demonstrates significant regional variations (see below) and smoking in pregnancy is five times more common in the most deprived groups compared to the least. **Overall it seems extremely unlikely that this target will be achieved.**

Percentage of mothers smoking at point of delivery by region, England, April 2021 to September 2021²⁴



The percentage of pregnant smokers is falling, but unlikely to hit the government's target of 6% by 2030²⁴



Target 4: To reduce the gap in smoking between routine and manual occupations and the general population

Looking at data between 2017 and 2019, this target seems to have been achieved. A 1.4% reduction is small though, and the difference between routine and manual occupations and the general population is still significant.

	Routine and manual (%)	General population (%)	Difference (%)²⁵
2017	25.7	17	8.7
2018	25.4	16.5	8.9
2019	23.2	15.9	7.3

Summary: Current plans aren't working

While more data are needed, the government appears to be on target to meet just one of the four goals outlined in the 2017 Tobacco Control Plan. This provides a sobering backdrop for the levelling up missions, where action on smoking has a key role to play.

Interventions within the 2017 Tobacco Control Plan were minimal, focusing on information provision and updated national guidance. This approach has not worked, and it is clear that effective, evidenced based interventions are needed to drive change and improve outcomes.

The government was due to publish an updated Tobacco Control Plan in the summer of 2021, but this was delayed, with current information suggesting that this will now be published in autumn 2022. This significant delay is regrettable, and in itself makes the achievement of the above targets, and the 2030 smokefree ambition, less likely.

Danny Patterson, 30, an actor from North Shields, grew up around tobacco and started smoking despite the problems this caused his asthma. His dad's cancer diagnosis prompted him to quit.

"Smoking was everywhere around me where I grew up – so looking back it almost seems inevitable that I would take it up. Both my dad and older brother smoked, and then by the time I was a teenager, my friends had all started too.

"I started off just smoking when I was out with my friends around age 18. They would go outside for cigarettes, and I didn't want to be left out so would join them. I worked as a waiter and everyone there smoked too. I looked up to my older brother and he smoked so the temptation was always there. I thought I was just smoking socially but then one day I woke up and bought a packet of cigarettes and that was it, I was hooked.

"I have asthma and was in hospital with it nine times before my second birthday. It got better as I became a teenager but smoking definitely had an impact on my symptoms. A couple of years of smoking 10-15 cigarettes a day and I ended up having to use my reliever inhaler all the time. I'd wake up in the morning feeling wheezy with a tight chest and I'd have to take my inhaler with me everywhere I went. It was particularly bad after a night out where I'd end up smoking more than usual and I'd wake up sometimes gasping for breath.

"I tried to quit a few times from the age of 25 but I found it really hard and ultimately went back to smoking. Then three years ago, my dad was diagnosed with bladder cancer, which was caused by smoking. Although he hadn't smoked for 10 years, the doctors said the damage to his body had already been done. It was devastating to see him so unwell, and I knew I had to quit.

"It took several more attempts but last year, I turned 30 and quit for good. I've used a combination of nicotine patches, vapes and incredible support from my family and in particular my brother who also quit for good.

"Quitting smoking has been the best thing for my asthma. I've gone from having to use my reliever inhaler every day and taking it with me everywhere to barely needing it at all. I wake up in the morning and I'm able to breathe freely, which is a great feeling."

“ I started off just smoking when I was out with my friends around age 18. They would go outside for cigarettes, and I didn't want to be left out so would join them. ”

Chapter 2: Smoking and the levelling up missions

Concerted effort to reduce smoking rates is directly relevant to three of the 12 Levelling Up missions. This section will demonstrate why action to cut smoking rates will make such a big difference to these ambitions.

1. Smoking and economic productivity

Levelling up ambition: By 2030, pay, employment and productivity will have risen in every area of the UK, with each containing a globally competitive city, with the gap between the top performing and other areas closing.

Economics and health are interrelated. **Ill-health in England's poorest neighbourhoods is estimated to cost the country almost £30bn a year because many people are unable to work, becoming disabled and dying prematurely.**²⁶ Action on Smoking and Health (ASH) have done a significant amount of work in this area, partnering with the University of York. Their research, and that of other academics and economists, makes it clear that smoking is bad for productivity and employment, both for individual smokers and for the government.

There are 252,138 people in England economically inactive because of smoking.²⁷ It is known that smokers are more likely to be absent from work, show higher levels of presenteeism while at work, and have greater levels of work and activity impairment.²⁸ These factors have also been shown to result in lower economic output and lower tax receipts collected by central government.²⁹

Overall ASH calculate that the productivity losses associated with smoking cost the UK just over £14 billion per year – around 0.5% of total UK Gross Domestic Product.³⁰ For the average smoker the cost of smoking in employment terms is equivalent to a 6.8% reduction in annual salary.³¹



**-£14
BILLION**
is the productivity cost
of smoking to the UK
economy each year



6.8%
LESS
is what the average
smoker earns due to
poor health and lower
productivity

Money spent on tobacco disappears from local economies. In addition to reduced productivity, money spent purchasing tobacco would have a far more useful economic impact locally if spent on other goods and services. UK smokers spend around £15.6bn a year on tobacco. If this money was spent on other things, it is estimated that Gross Value Added (GVA), a measure of an economy's health and proxy for Gross Domestic Product at the industry level, would increase between £13bn and £14bn. **Research has shown that the shift in spending from tobacco to other goods and services would stimulate significantly more jobs within those sectors, and result in 345,000 - 375,000 full-time equivalent jobs.**³²

It is clear that action to reduce smoking rates would have a positive impact on productivity and on the levelling up agenda, specifically increasing economic activity in the most deprived areas. This would help to close the gap between the best and worst performing areas.

2. Why smoking shortens healthy life expectancy

Levelling Up ambition: By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by 5 years.

There are very significant differences in health outcomes within the UK population, as shown in the graphics below. **A baby born in one of the UK's most deprived areas can expect to live for almost a decade less³³ than a baby from one of the richest areas.**³⁴

Smoking makes up around half of this difference,³⁵ and research in Scotland found that 'reducing smoking prevalence among the deprived population could have a disproportionately large effect on population health and an important impact on health inequalities.'³⁶



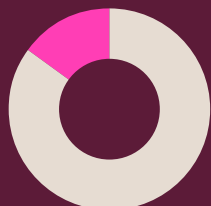
Life expectancy has been increasing steadily for 100 years, but in recent years this has not been shared equally across the population. Those in the richest communities saw a significant increase in life expectancy between 2014–16 and 2017–19, whereas in the poorest communities there was no significant change.³⁷ As a result of the COVID-19 pandemic life expectancy stopped increasing in 2020. For most communities' life expectancy remained static, but for the poorest 10% of women it has gone into reverse.³⁸

Years of life spent in poor health³⁹

~30% of life spent in poor health



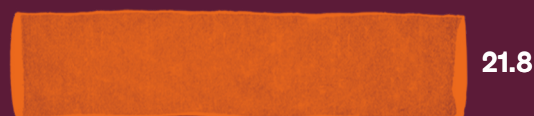
~15% of life spent in poor health



Women:
poorest communities



Men:
poorest communities



Women:
richest communities



Men:
richest communities



The difference in the amount of time that those from the richest and poorest communities can expect to live in good health is even larger than the gap in life expectancy. Those living in the most-deprived areas have the shortest life spans and live more years in poor health.⁴⁰

Those living in the most-deprived communities spend around 30% of their lives in poor health, compared with only about 15% for those in the least-deprived areas,⁴¹ with the Levelling Up White Paper pointing out that females born in Wokingham can expect to live twelve years longer in good health than those born in Southampton.⁴²

As with overall life expectancy, smoking has a huge impact on healthy life expectancy. Research shows that **current smokers are five times more likely to need social care support at home, and that this care is needed on average 10 years earlier than non-smokers**. Clearly this has a very large impact on the lives of those in need of this care, and it also has a large financial cost, making up 8% of local authority spending on adult social care.⁴³ Action on smoking is known to be cost effective, and will save money across the NHS and social care.

Smokers are five times more likely to need social care support at home. This care is needed 10 years earlier than non-smokers and takes up 8% of local authority spending on adult social care.

The huge impact that smoking has on life expectancy makes it clear that the ambition of adding five healthy life years by 2035 can only be achieved with significant work to reduce smoking rates amongst the most deprived communities.

3. Why smoking is bad news for wellbeing

The Levelling Up ambition: By 2030, well-being will have improved in every area of the UK, with the gap between top performing and other areas closing.

Smoking and mental health

Wellbeing is not defined within the Levelling Up White Paper. The Department of Health and Social Care describe it as comprising an individual's experience of their life and a comparison of life circumstances with social norms and values, and state that it is made up of both subjective and objective elements, with positive mental wellbeing a part of this rather than just an absence of mental illness.⁴⁴

The 2019 Opinions and Lifestyle Survey found that smoking was significantly higher amongst those reporting low wellbeing, and it is known that people who smoke are more likely to become socially isolated and lonely as they get older.⁴⁶

In 2021 Taylor et al conducted a systematic review of all the available academic research on smoking cessation and mental health. They found that **smoking cessation was associated with small to moderate improvements in mental health, and that stopping smoking does not cause deteriorations in mental health.**⁴⁷ The incidence of new mixed anxiety and depression was lower in people who stopped smoking compared with those who continued, and reductions in anxiety and depression in those who quit smoking were found to be at least as great as those gained from taking anti-depressants.

While mental health is only one element of wellbeing, these results clearly demonstrate the smokers who have quit experience better mental health in addition to the many physical health and financial benefits.

Smoking and economic wellbeing

Economic well-being is usually defined as having present and future financial security. The section above regarding economic productivity has already detailed that smokers tend to have poorer financial outcomes than non-smokers, and that smoking costs individuals an average of £2,759 per year in lower wages and productivity.⁴⁸

Smokers are five times more likely to need social care support at home. This care is needed 10 years earlier than non-smokers and takes up 8% of local authority spending on adult social care.

16m households fall below the poverty line when smoking expenditure is taken into account, impacting around 2.2 million adults below pension age, 400,000 adults of pension age, and 1 million dependent children.⁴⁹ Helping these families to quit smoking would significantly improve their economic wellbeing, helping to address the additional stressors that this creates. For example, recent research suggests that low-income families have a high awareness of healthy diets but often cannot afford fresh and nutritious food.⁵⁰ Having an additional £37.80 a week (the average spend for someone who smokes 10 cigarettes a day) could make a significant difference to this issue for many.

As with productivity and health life expectancy, it is clear that concerted work to reduce smoking has an important role to play in achieving the levelling up ambition on wellbeing.

Summary: Levelling up health will require bold and urgent action

Using data from 2009–11 and 2017–19, the Health Foundation calculated that at pre-pandemic trends a mean increase of 1.6 years healthy life expectancy is likely to be achieved by 2035. They also estimate that, at that rate, it would take 192 years for men to reach the government's target of 5 additional healthy years life expectancy.⁵¹

Since then the pandemic has put the country through a huge economic and health related shock, and while mortality rates have increased for all groups they have increased fastest for the most disadvantaged.⁵² Jo Bibby, Director of Health at the Health Foundation has pointed out the problems that this causes for levelling up health, along with other consequences of the pandemic such as increased obesity, greater numbers of people drinking at higher-risk levels, and significant levels of inflation.⁵³

It is hard to argue with this analysis, which paints an extremely problematic backdrop for the ambition of adding five years of health life expectancy by 2035. **Evidence suggests that without significant additional spending those missions related to health will not be achieved.** In the absence of sizable funding commitments, large regulatory changes will be needed, all of which adds even more significance to the policy details awaited in the Disparities White Paper and the Tobacco Control Plan.

Liz Moore, age 60, has chronic obstructive pulmonary disease (COPD) and is struggling to give up tobacco.

“Growing up, we used to hang out at ‘the den’. You could say I was influenced to smoke to fit in with my friends. I started smoking at 11 and had a few years off between 17-20. I have addictive tendencies. When I worked it didn’t bother me not to smoke, and I wasn’t allowed to smoke at my parent’s house. I always thought I had control of it when I was young.

“I know I must stop because of my COPD and I know smoking negatively impacts my health but I’m addicted and can’t stop.

“I’m turning 60 this year and I’ve set myself a target to quit for good. I’m on antibiotics at the moment, my chest is wheezy, lots of phlegm and using my Ventolin which I don’t normally use.

“The support is there, but I’m waiting for the switch in my brain to want to start that journey to a smoke-free life. I think of quitting every day so I know I will do it. My doctor said, “We can’t force you to quit, you need to be ready.”

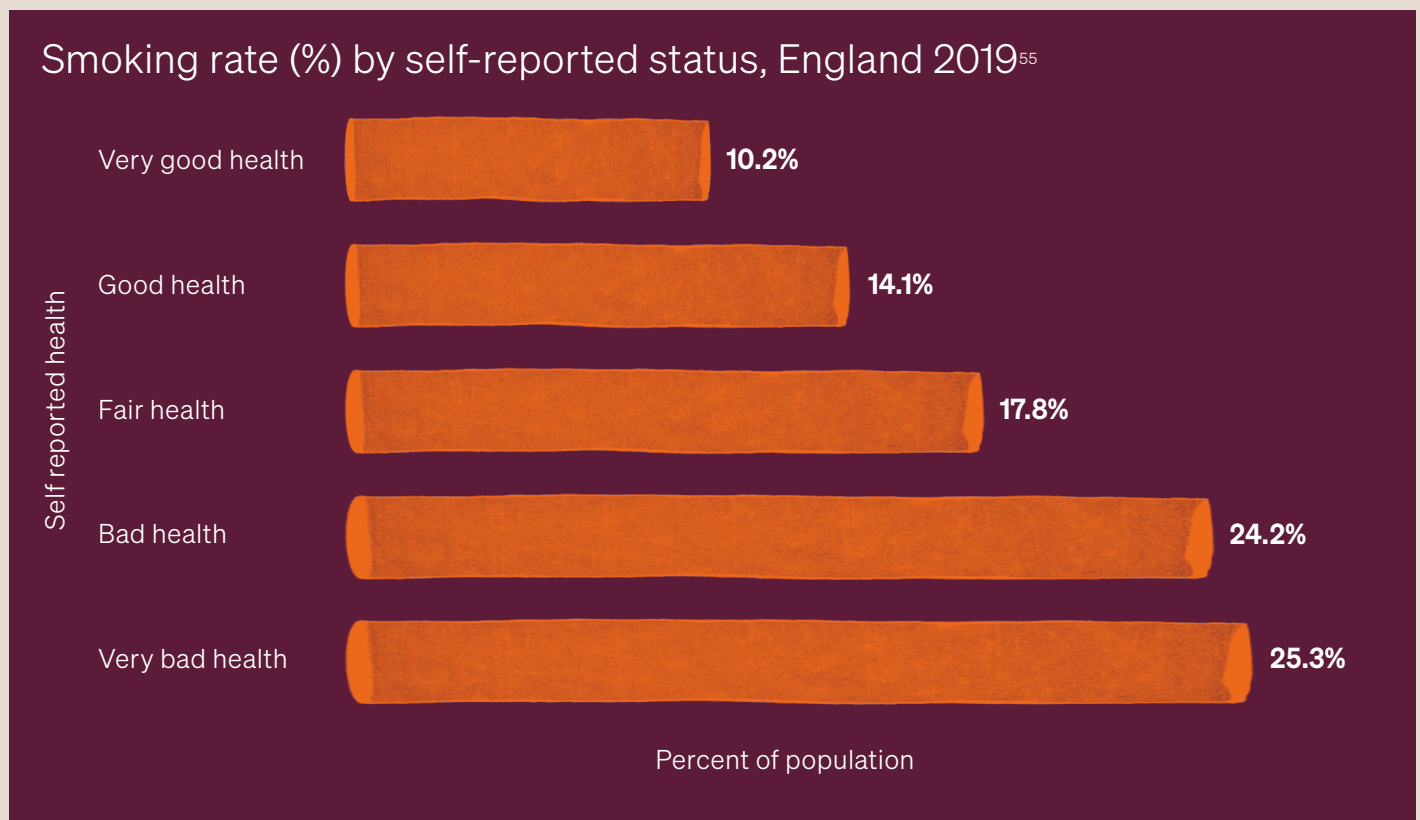
“ Growing up, we used to hang out at ‘the den’. You could say I was influenced to smoke to fit in with my friends. I started smoking at 11 and had a few years off between 17-20. ”



Chapter 3: How tobacco traps disadvantaged communities

There are a number of reasons why smoking is concentrated within groups that experience the worse health outcomes.

Firstly, there is a direct causal link. Smoking is one of the most harmful things anyone can do for their health. The very fact that someone smokes will result in poor health outcomes. Indeed, the Levelling Up White Paper notes that areas with the worst health outcomes tend to have the highest smoking and obesity rates.⁵⁴



Secondly, smoking is a highly addictive habit passed from generation to generation. Children whose parent or caregiver smokes are four times more likely to smoke themselves.⁵⁶ The same research, based on the Millennium Cohort study, shows that smoking uptake occurs within peer groups so that children whose friends smoke are also more likely to smoke themselves.

It is known that the likelihood of a child smoking increases if both parents smoke, with a greater duration of exposure to parental smoking ‘suggesting a dose-response relationship between parental smoking and offspring smoking.’ However, children of parents who had quit smoking were found to be no more likely to smoke than children of parents who had never smoked.⁵⁷

In addition, once addicted to tobacco, smokers who grew up in families who smoked find it harder to quit,⁵⁸ even though they are typically as motivated to quit as other smokers. This may in part be because they tend to be surrounded by social norms which are much more favourable to smoking.⁵⁹

Thirdly, the greater concentration of risk factors faced by those in the most deprived communities makes it harder to respond to health campaigns,⁶⁰ and it is known that people living with social and economic hardship find stopping smoking far more difficult.⁶¹ Research into smoking in a deprived community in England stated that:

“Analysis of the separate components of Townsend deprivation score showed that while independent effects were observed for the association between unemployment, lack of car, and smoking status, the effect of a combination of the variables was much stronger than any one variable on its own.”⁶²

This builds an overall picture where people in the most deprived communities are more likely to be surrounded by weaker anti-smoking norms⁶³ and face multiple problematic risk factors, meaning they are more likely to start smoking, and then to find it significantly harder to quit. This is despite the fact that smokers from deprived communities are typically just as motivated to quit as other smokers.⁶⁴

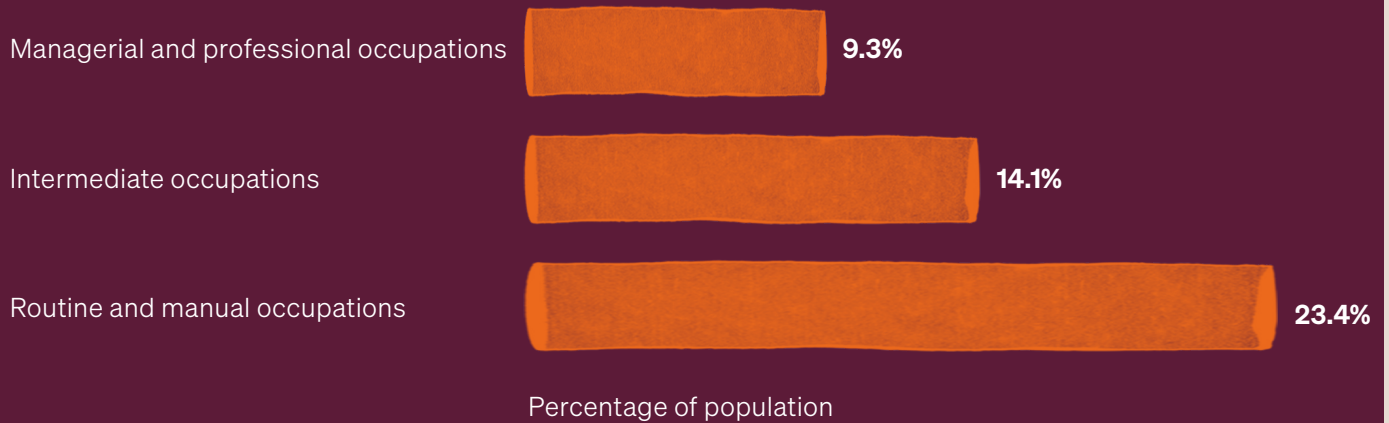
For every three young smokers, it is estimated that one will die prematurely from a smoking related disease.⁶⁵ Preventing the inter-generational cycle, where childhood exposure to smoking increases the likelihood of those children smoking themselves, is key to ending smoking once and for all. This is a systemic, generational problem which needs to be addressed in a long term, systematic manner using both population level approaches and targeted interventions which consider area-based factors such as the social and cultural needs of these communities.⁶⁶

Without such an approach, the negative health consequences of smoking will become more and more concentrated amongst our most disadvantaged communities, sustaining the already stark gap in health outcomes. Levelling Up health will not work without action to address this.

Tobacco and disadvantaged groups

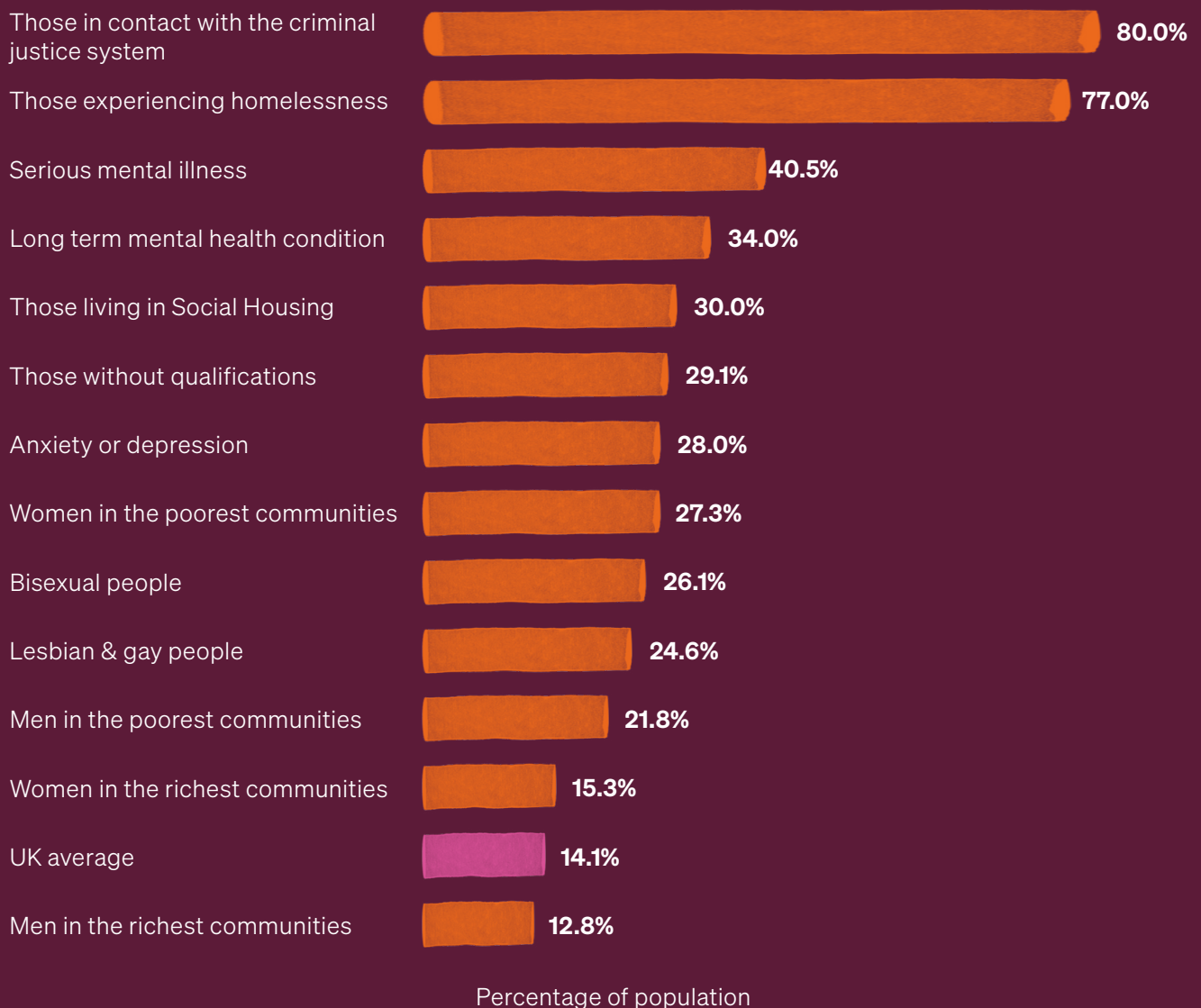
The context outlined above explains why smoking rates remain stubbornly high within the most disadvantaged communities. So while smoking rates in the UK are at an all-time low, they vary enormously between different regions and social groups.

Smoking rates (%) in England 2019, by occupation⁶⁷



Higher smoking rates are associated with almost every indicator of deprivation or marginalisation, with above average smoking rates found amongst some of the most deprived communities.⁶⁸

Smoking rates (%) across different communities⁶⁸



Where groups experience more than one type of disadvantage the negative effects are often multiplied.⁶⁹ Smoking is a negative compounding factor which causes significantly worse health outcomes for all those groups listed above, over and above the adverse experiences they already face.

For example, people with poor mental health die on average 10 to 20 years earlier than the general population, with high smoking rates the biggest cause of this life expectancy gap.⁷⁰ Smoking is the most important and easily modifiable risk factor related to health inequalities.^{71,72} This is because it is often easier to help people to quit smoking than to address complex risk factors such as poverty and poor housing.

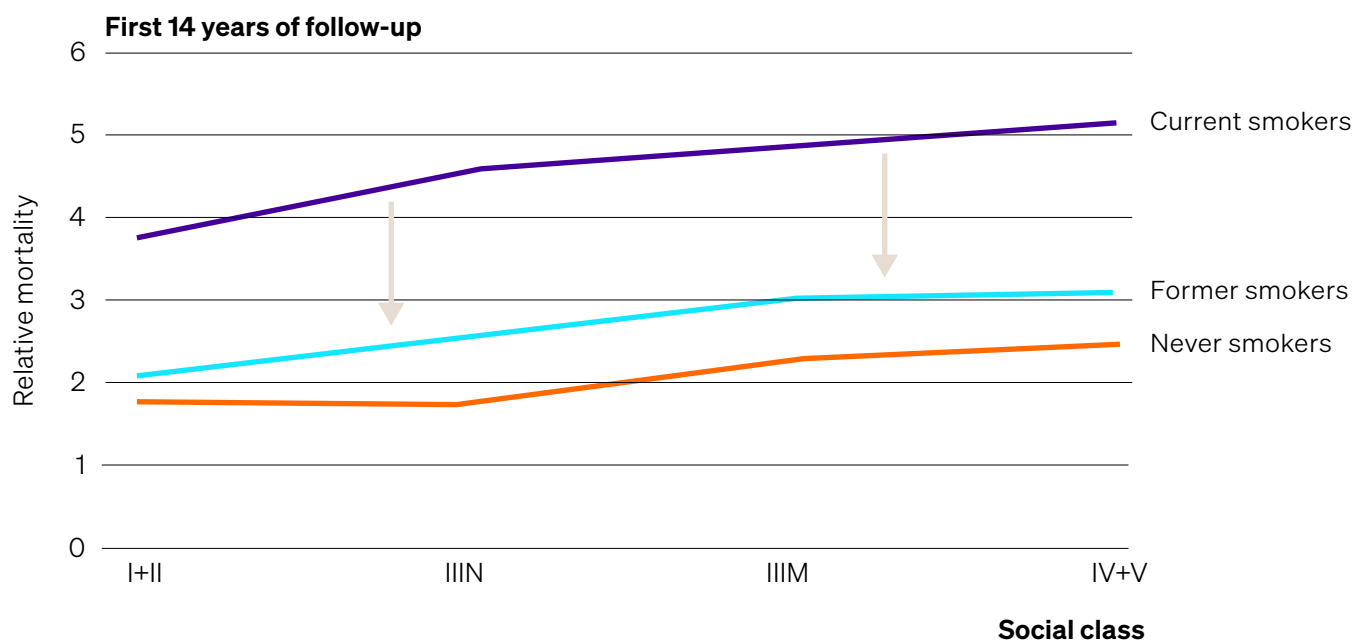
One long term study of over 15,000 Scottish adults aged 45 – 64 found that whether someone smoked or not was a greater source of unequal health outcomes than their social background. It concluded that:

“the scope for reducing health inequalities related to social position in this and similar populations is limited unless many smokers in lower social positions stop smoking.”⁷³

Quitting tobacco has huge positive health benefits

Importantly, the same study found that when they surveyed the same population of smokers 14 years later, relative mortality amongst former smokers has reduced significantly and had reduced to levels similar to that of those who had never smoked. This makes it clear that stopping smoking works to significantly improve health outcomes.

Age adjusted, relative, all cause mortality after 14 years, from Gruer 2009. The blue line shows how much healthier former-smokers have become after giving up



IIIN = III non-manual IIIM = III manual

— Shows how much healthier former-smokers have become after giving up

Ron, 60 from Lincoln, has idiopathic pulmonary fibrosis (IPF). He shares his story of giving up smoking when he was in his fifties, and the support that he received.

“At the age of sixteen I started smoking. I was brought up in a smoking atmosphere. My mum and dad smoked, my brother smoked, my nan smoked, my sister smoked and most of my uncles smoked. Funnily enough, I didn’t want to smoke, but one day I succumbed to peer pressure from a friend when we were going to our school disco. I packed it up at the age of twenty-seven, but I restarted again at the age of thirty and I smoked for the last time when I was fifty. I used to smoke between 15-20 cigarettes a day.

“I’d tried to give up smoking on numerous occasions without success. It’s a habit that is hard to give up. I can always remember when I worked on a shop floor we would go to a tea-room during our breaks for a cup of tea and a cigarette. One day, I lit it and I started smoking and the guy opposite me said, “You didn’t even know you were lighting a cigarette,” he said, “that’s just pure habit.” I think he was right.

“A lot of my friends were doing Iron Man challenges and triathlons and I would train with them, doing lots of training and swimming. For my 50th birthday my best mate paid for me to enter the London Triathlon. I could cycle, and I could swim, but I couldn’t run. When I went for a run my chest was so tight, I was coughing, and I realised just how unfit I was. Because I was cycling and I was swimming and I was doing lots of exercise, I thought smoking had no effect on me, but when I went for that run it made me realise that I needed to stop.

“When I went to the doctor’s and I said to him, “I want to pack up smoking. I can’t do it on my own” he was gobsmacked. He’d been on to me for ages to pack it up. I kept saying, “Yeah, yeah, I will do it” but it wasn’t until I went to him that I was successful.

“He sent me to the local stop smoking service that helps you give up with a nurse as support. At my first appointment I had the carbon monoxide test. My reading was – I’ll always remember - twenty-seven/twenty-eight which is high’, and the nurse said, “You need to pack it up. How do you want to do it?” I didn’t want to use patches because they would come off when I was swimming, so the nurse suggested taking a drug called Champix.

“When I was giving up, I was working full time. The service rang me every week to offer support. They did a very good job and without their help I wouldn’t have been able to do it. If I’m totally honest with myself, I wouldn’t have succeeded in giving up. And then I wouldn’t have married my wife, Maxine, because she doesn’t like smokers.

“To any health care professionals I would say try and offer support. Ask “How can I support you in packing up smoking? Or is there any way I can support you to give up?” I’ve always looked at those images on packs of cigarettes, the damage it does to the lungs and the heart, but when you’re a smoker you don’t take a blind bit of notice. You need support to be offered and for an acknowledgment that it is going to be hard to give up, but that support will help and is there for you. Don’t make a smoker feel guilty, instead be there to support and help. Say, “We understand you started, we know it’s really hard to get off, it’s addictive, and if you feel like quitting is something that you want, we’ll support you to do it.”

Chapter 4: Policies that work – How to level up by making smoking obsolete

While the situation faced by those communities experiencing the worst health outcomes is stark, it can be turned around. If the levelling up agenda is able to deliver a long term, strategic approach to addressing these health inequalities there are huge gains to be made. Asthma + Lung UK support the policies outlined by the All Party Parliamentary Group on Smoking and Health in their report **Delivering a Smokefree 2030** as a blueprint for achieving this.

The number of smokers making quit attempts, and being supported to quit, has fallen significantly in recent years:

- In 2008 40% of adult smokers in England had tried to quit in the last year, but by 2018 this had fallen by a quarter to only 30%.⁷⁴
- The UCL Smoking Toolkit Study also shows a considerable drop in GP triggered quit attempts, decreasing from around 10% of all quit attempts in 2010 to around 3% in 2021.⁷⁵

This trend must be changed. All of the policies below work to either trigger a quit attempt, or help smokers complete their quit attempt successfully.

1. Supporting those communities facing the worst health outcomes

Smoking rates in the UK have fallen significantly, and while a whole population approach is still needed the biggest gains are now to be found amongst the most disadvantaged communities where smoking rates are highest.

Research in this area consistently finds that ‘the scope for reducing health inequalities related to social position... is limited unless many smokers in lower social positions stop smoking,’⁷⁶ and that ‘reducing smoking prevalence among the deprived population could have a disproportionately large effect on population health and an important impact on health inequalities.’⁷⁷

2. Mass media campaigns, upweighted amongst groups with the highest smoking rates

There is strong evidence that mass media campaigns are effective at changing behaviour, and that they are a cost-effective method of stimulating quit attempts.⁷⁸ This includes within more disadvantaged groups, with evidence suggesting work to upweight campaigns for this audience for maximum effectiveness. Fresh, the tobacco control programme in North East England have taken this approach and seen the fastest rates of decline in the whole of England, moving from 29% in 2005 to 15.3% in 2019.⁷⁹

Mass media advertising (TV, radio and social media) is recognised by the World Health Organisation (WHO) as one of the components of best practice tobacco control.⁸⁰ However UK government health bodies currently have limited capacity to run mass media campaigns. Public Health England's advertising budget declined from around £25 million a year in 2010 to £3.8 million a year in 2018. **Public Health England's own evaluation commented that 'as expected, the budget decrease resulted in reduced awareness of Stoptober' (there was a reduction in campaign recognition from 71 per cent in 2015 to 48 per cent in 2016).**⁸¹

We want to see mass media campaigns such as 'Stoptober' receive proper funding, at least the £8 million spent in 2012/13, with upweighted work focusing on groups with the highest smoking rates. Modelling by UCL estimated that a well-funded and sustained behaviour change media campaign would result in an additional 1 million quit attempts, 170,000 successful quit attempts and 45,000 additional long term ex-smokers in 'working class' (C2DE) occupations in England between 2021 and 2030. 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, making this a highly cost-effective intervention.⁸²

3. Incorporating smoking cessation into NHS work on health inequalities

NHS England recently launched Core20PLUS5, its flagship programme focused on addressing health inequalities. The programme will be implemented by ICSs and is intended to provide focus for existing Long Term Plan (LTP) commitments, with additional support from a national team. 'Core20' refers to the 20% most deprived communities in the country. 'PLUS' refers to additional health inclusion group such as ethnic minority communities or the traveller community, who may be missed from the first category, while '5' refers to five key areas of clinical focus. These are:

- **Maternity:** ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups
- **Severe Mental Illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
- **Chronic Respiratory Disease:** a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
- **Early Cancer Diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028
- **Hypertension Case-Finding:** to allow for interventions to optimise BP and minimise the risk of myocardial infarction and stroke⁸³

As already made clear in this report, half the difference in life expectancy between the richest and poorest in society is due to smoking,⁸⁴ and smoking is far more prevalent among the most deprived communities that Core20PLUS5 focuses on. Smoking is also a leading or major risk factor for each of the five key clinical areas:

- **Maternity**, where smoking in pregnancy remains a leading cause of poor outcomes for both mother and child
- **Severe mental illness**, where smoking is the largest contributor to reduced life expectancy and quitting smoking improves mental health
- **COPD**, for which 80% of deaths are caused by smoking
- **Cancer**, for which smoking is the greatest preventable cause
- **Hypertension**, for which smoking is a risk factor. Those with hypertension are at far greater risk of morbidity and mortality if they also smoke.

However, smoking cessation work is not included in this programme at present. We hope that changes will be made to address this. Interventions in these areas have the potential to make a significant impact⁸⁵ and to greatly enhance the effectiveness of Core20PLUS5.

Similarly, the Primary Care Network (PCN) Tackling Neighbourhood Inequalities Service Specification, which aims to address the highest levels of inequalities, does not include any specific work on smoking. A systematic approach to effectively passport smokers to stop smoking services, as below, would be very beneficial.

4. Very Brief Advice for smoking cessation

One effective way of incorporating work on smoking within Core20PLUS5 and the Tackling Neighbourhood Inequalities Service Specification would be the inclusion of Very Brief Advice (VBA) for smoking cessation. This would have even greater impact if rolled out across primary care, so that all smokers were prompted to quit at every interaction with their GP surgery or pharmacist.

VBA is a cost-effective method of triggering a quit attempt in smokers, approved by NICE for use across primary care,⁸⁶ and included within the NHS Health Check best practice guidance.⁸⁷ Following the Ask, Advise, Act process it takes only 30 seconds when delivered correctly, signposting the patient to effective help with a stop smoking service, where they are three times more likely to quit successfully.⁸⁸

However, our own research into this area found that over half of GPs in the UK have never had any training in VBA, just 2% said that the training they had done was comprehensive, and only 8% of GPs use VBA on a daily basis.⁸⁹ The UCL Smoking Toolkit Study shows a considerable drop in GP triggered quit attempts, decreasing from around 10% of all quit attempts in 2010 to around 3% in 2021.⁹⁰ Smokers make one third more GP appointments than non-smokers,⁹¹ and there is clearly a need to address this if the 2030 smokefree target is to be achieved.

Evidence suggests that VBA is effective for use with all those who smoke, but the return on investment is even clearer for those with a respiratory condition – a cohort that the Core20PLUS5 programme will inevitably engage with given that respiratory mortality is seven times higher within the most deprived communities.

VBA is a 30 second structured conversation about smoking cessation



For example, it was found that among those with Chronic Obstructive Pulmonary Disease (COPD), stopping smoking is associated with a 43% decreased risk of hospitalisation.⁹² The British Thoracic Society found that, within a population of 411 COPD patients, spending just £500 helped two patients quit smoking and saved four hospital admissions costing a total of £9,408.⁹³ So, while systematic treatment of smokers is highly cost-effective in almost all settings,⁹⁴ the targeted use of VBA amongst high-risk groups is even more so, and will also produce in-year cost savings in secondary care as set out in the Ottawa Model.⁹⁵

Driving the training and behaviour change within the NHS needed to fully embed VBA across primary care will pose challenges, but could be addressed within the Disparities White Paper, and the NHS Long Term Plan 'refocus' that has been proposed for spring 2022.

Clearly, for VBA to be effective there needs to be a comprehensive, fully funded, stop smoking support system available for smokers to be referred to. As this report details elsewhere, this is not the case in many areas.

5. Regional tobacco control strategies

With the current NHS reforms strongly promoting a shift towards greater integration and helping to prevent people from becoming ill, the case for effective upstream measures, such as primary care VBA and greater work on smoking cessation, is stronger than ever.

At present work on smoking falls within the prevention workstream of the LTP, and while implementation of this work is longer term, other initiatives on smoking are not joined up and frequently work to short timescales. As mentioned, smoking is a significant omission from flagship health inequalities programmes, and a more coordinated approach within the NHS would be hugely impactful.

Evidence for fighting smoking over a larger footprint is strong, with examples such as Fresh in the North East and Greater Manchester seeing local reductions in smoking rates well in advance of national figures.

If community stop smoking support is not available it will weaken the effectiveness of all other efforts to trigger quit attempts in smokers, something which is already a problem in some areas. NHS clinical pathways must be coordinated with local stop smoking services, run by local government, to ensure that smokers are supported as efficiently as possible and to maximise impact. Clear regional strategies at an ICS or combined ICS level should be developed to achieve this, with every ICS and local authority working at this regional level.

In addition to better coordination of services, greater economies of scale enable regional tobacco control teams to run behaviour change campaigns that smaller areas would not be able to afford. They are also better able to coordinate and develop regional smoking policy, and to work with partners to tackle illicit tobacco. Evidence for fighting smoking over a larger footprint is strong, with examples such as Fresh in the North East and Greater Manchester seeing local reductions in smoking rates well in advance of national figures.

ICSs already fund regional tobacco control approaches in Greater Manchester, the North East and Yorkshire and the Humber, with local authorities also providing funding. With their larger footprints, dedicated funding streams for reducing health inequality and links to clinical teams and services, ICSs are perfectly placed to engage in regional tobacco control programmes, and should be encouraged to do so, either individually or with a group of ICSs coming together. In doing this partnership with local government will be essential.

Impact of smoking decline in the UK for areas which had regional tobacco programmes (for some or all of 2012 – 2017)

North East

-5.8%

South West

-5%

North West

-5%

Yorkshire

-4.9%

Impact of smoking decline in the UK for areas which did not have regional tobacco programmes (for some or all of 2012 – 2017)

South West

-4.2%

West Midlands

-4.1%

Anglia

-4.1%

East Midlands

-4%

London

-3.6%

Source: regional analysis of annual population survey 2012 – 2017

6. Funding for stop smoking services

Stop smoking services are known to be both highly effective and cost efficient. Smokers using them to quit are three times more likely to be successful,⁹⁶ and 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.⁹⁷ **The APPG on Smoking and Health also found that in 2018/19, 52% of those setting a quit date with stop smoking services came from disadvantaged groups (routine and manual occupations, unemployed, sick or disabled and prisoners).**⁹⁸

However, despite their effectiveness, stop smoking services have faced regular cuts in recent years, with the number of people supported to quit smoking decreasing in line with this. These cuts must be seen in the context of increased financial pressures on local authorities, many of whom have had to make difficult choices in service delivery due to insufficient government funding allocations.

If funding increased, more people would be helped to quit, making the smokefree ambition more feasible. Analysis by the Taskforce for Lung Health found that had funding been maintained between 2011 and 2019, an additional 104,000 smokers would have used a stop smoking service to quit.⁹⁹

There are also significant disparities in access to stop smoking services around the country: in 2018 just 67% of councils were able to provide a dedicated specialist stop smoking service. Although by 2021 this had improved to 76%, many of these are limited in their offer and while some have adapted well to COVID-19, a third report that the pandemic has compromised their ability to provide support.¹⁰⁰

	Local Authority allocation for smoking cessation for the year (excluding pharmacotherapies)	People supported to quit¹⁰¹
2014/15	£78,941,902.00	229688
2019/20	£38,395,450.50	114153
Change	51.3% decrease	50.3% decrease

The Levelling Up White Paper committed to maintain the Public Health Grant in real terms until 2024/25. However, the Local Government Association has highlighted that the uplift for 2022/23 was 2.8%, whereas inflation is running at 7%, resulting in a real terms cut.¹⁰²

For smoking rates to reach 5% by 2030 there will need to be an additional 1.3 million successful quit attempts over and above the current trend, with CRUK estimating that this will require a 40% increase in activity.¹⁰³ Transformational change in any sector, whether it be education, transport, technology or health, would be unlikely to work if funding was inadequate, allocated on short-term timescales, and with the strong likelihood of future cuts.

We know of stop smoking services who have worked to engage disadvantaged communities, building a local presence in order to grow trust with smokers and demonstrate that they are there to help them in the long term, only for their funding to be cut and these services cancelled. In some instances funding does then reappear, but work to help smokers in these communities then has to start again from square one. This must change.

We view funding for stop smoking services as a litmus test for the government's seriousness about making England smokefree by 2030 and achieving the levelling up health mission. Long term sustainable investment in quality stop smoking services is essential if smokers are to be helped to quit effectively.

We want the UK government to restore comprehensive smoking cessation services. ASH have estimated that the funding needed to achieve the Government's 2030 smokefree ambition would be approximately £266 million per year in England.¹⁰⁴

7. Implement a smokefree 2030 fund

While those working to help smokers quit their addiction must navigate an extremely difficult financial situation, tobacco manufacturers made over £900 million of profit in the UK in 2018. Net operating profits tend to be between 60-70% for tobacco, far higher than for staple consumer products (12-20%), or retailers (6%).¹⁰⁵

We support the introduction of a Polluter Pays Levy on the tobacco industry's excess profits, in line with other organisations including Cancer Research UK, ASH and the APPG on Smoking and Health.^{106,107} This would involve the Government charging tobacco companies per cigarette they sell in the UK to raise additional funding to invest in public health services. The system would be straightforward to introduce as it is based on the already existing Pharmaceutical Pricing Scheme which caps pharma profits to address monopolies.

ASH have estimated that the funding needed to support a comprehensive tobacco control programme at local, regional and national levels in order to achieve the Government's 2030 smokefree ambition would cost approximately £266 million per year in England, and £315 million per year in total for the UK. A levy on tobacco manufacturers would raise an estimated £700 million per year.¹⁰⁸

The Department for Health and Social Care committed to consider a 'polluter pays' approach government's 2019 prevention green paper. However, the government is yet to publish any follow up to this green paper.

8. Raise the age of sale for cigarettes and tobacco products from 18 to 21

In 2019 there were approximately 364,000 young smokers aged 18-20 in England, around 16% of this age group. Compared to non-smokers, these smokers are more likely to be from lower socioeconomic backgrounds.¹⁰⁹ Experimentation with smoking is rare in those over the age of 21 and this policy will help to stop smoking at the ages when people are most susceptible to becoming addicted. Raising age of sale to 21 takes legal tobacco purchase completely out of schools. Older children both supply younger children with cigarettes and serve as role models.

Evidence shows clearly that raising the age of sale to 21 would have a significant and long-term impact on smoking rates. When the age of sale was increased from 16 to 18, it resulted in a 30% reduction in smokers aged 16 and 17. In America, when the age of sale was increased to 21 it also resulted in a 30% reduction in smokers aged 18-20. Modelling by UCL for the APPG on Smoking and Health found that increasing the legal age of sale from 18 to 21 would result in an immediate 95,000 fewer smokers and an additional 77,000 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, an important contribution towards the government's commitment to be smokefree by 2030.¹¹⁰

We are also very supportive of efforts announced in New Zealand to ban the sale of tobacco to future generations in a bid to make smoking obsolete. Under these proposals anyone born after 2008 will not be able to buy cigarettes or tobacco products in their lifetime, something that will also make it less and less financially viable for retailers to sell tobacco over time. In addition, the **Smokefree Aotearoa 2025 Action Plan** includes increased funding for evidence based stop smoking services, efforts to reduce the addictiveness of cigarettes, to reduce the number of outlets selling cigarettes especially in low-income communities, and enhanced penalties and enforcement options.

9. Vaping for harm reduction

E-cigarettes are a relatively new stop smoking tool, but if used correctly represent a big opportunity to reduce the harms caused by smoking, and to help smokers quit their addiction. They are thought to be at least 95% less harmful to health than tobacco^{111,112} and evidence suggests that for many they are an effective means to give up smoking.¹¹³

In 2017 50,000 smokers, who would otherwise have continued to smoke, are estimated to have used vaping to quit tobacco.¹¹⁴ It is clear that with more concerted and systematic work this figure could grow significantly and make a big contribution to meeting the smokefree 2030 ambition.

E-cigarettes are not risk free however, and more research is needed on how long-term vaping can affect the lungs and overall health.¹¹⁵ For example, we know that vaping can have some impact on inflammation in the airways which might cause harm over long periods.¹¹⁶ We don't recommend that anyone start using e-cigarettes unless they are trying to stop smoking. Smokers who successfully switch to vaping should be encouraged to stop eventually, though not at the expense of going back to smoking.

It is encouraging that the Medicines and Healthcare Products Regulatory Agency (MHRA) has issued updated guidance for e-cigarette firms seeking a medicinal licence for their products.¹¹⁷ While e-cigarettes are already regularly used by stop smoking services, this opens the possibility of there being medicinally licenced e-cigarettes which could be prescribed. Updated NICE guidance in 2021 also recognised the benefits of using vaping to help people quit tobacco, while stressing that they are most effective when used in conjunction with behavioural support.¹¹⁸

Nearly a third of smokers have never tried vaping. There is a big opportunity to encourage as many smokers as possible to transition to vaping, and in doing so reduce their health risks.

Behavioural support is best provided by smoking cessation services, which as mentioned have been operating within severe financial constraints for some years and their provision is uneven across the country. The impact of a wider transition to vaping will be undermined if local stop smoking services are not funded to a level which allows them to capitalise on this, making the case for increased funding all the stronger.

Closing remarks

This report makes clear that without concerted action to make tobacco obsolete, progress won't be made towards making the UK a fairer, healthier place to live.

Government work on tobacco has stalled. The 2017 Tobacco Control Plan seems likely to leave a legacy of failure, and the updated Tobacco Control Plan is scheduled to come out over a year late. This must change.

Effective policy options are well known and there is a clear funding stream available. The Department for Health and Social Care committed to consider a 'polluter pays' approach in 2019, and at the start of 2022 have indicated that this is still the case.

We're fighting to see change right now – it's long overdue.

Join the fight

AsthmaAndLunguk.org.uk



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CLEARING THE SMOKE

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