Policy position statement

Tobacco control – smoking and e-cigarettes – January 2019

Introduction

The British Lung Foundation recommends:

- **Comprehensive action plans** in each nation of the UK aimed at reducing smoking rates, with a particular focus on inequalities and at risk groups.
- **Fully-funded, widely available and easily accessible stop smoking services** commissioned in line with national guidelines, and integrated into care pathways across all UK health services
- **Offering e-cigarettes to smokers** as a tool to quit, with training for health care professionals and an evidence-based regulatory framework that supports their adoption
- **Nicotine replacement therapies and pharmacotherapy** to be prescribed across the NHS in an equitable manner to all smokers that need them, with the full range available to suit smokers' needs
- **Delivering regular and varied media campaigns** across the UK to reduce smoking rates
- **Higher taxation and prices** to discourage smoking, while tackling **illicit tobacco** sales
- **Further research on heated tobacco products**, to judge their safety and potential harm

The policy objectives summarised above are our priority campaign areas and apply across the UK. Our teams in England, Scotland and Wales may focus on different areas to reflect the devolved nature of this policy area.

What is smoking and why is it adictive?

Smoking is the act of burning and inhaling a substance for absorption into the bloodstream. Tobacco is the most commonly smoked substance, bought in pre-made or hand-rolled packs.

Tobacco smoke contains over 5,000 chemicals, at least 250 of which are known to be harmful and more than 70 of which are carcinogenic.[1] Nicotine is the most addictive chemical within tobacco products, and is a major factor in tobacco dependency.[2] Nicotine itself is of limited harm, but has been associated with increased heart rate and blood pressure.[3] Certain behaviours, such as hand-to-mouth movements and being in scenarios where people normally smoke, complement chemical dependence and reinforce addiction.[4] Although some smokers associate smoking with feeling less stressed and anxious, smoking only relieves the unpleasant symptoms of nicotine withdrawal.[5]

Around 60% of smokers in the UK want to quit.[6]

How many people smoke in the UK, and what are usage trends?

The Annual Population Survey (APS) is the UK Government's primary data source on UK adult (aged 18+) smoking prevalence. Great Britain wide data is collected from the Opinions and Lifestyle Survey (OPN). National level surveys also operate and provide preferred levels of adult and youth smoking in Wales, Scotland and Northern Ireland.

United Kingdom

Year	Adults (all)	Male (all)	Female (all)
2012	19.6	21.9	17.4
2013	18.8	21.0	16.6
2014	18.1	20.4	16.0
2015	17.2	19.3	15.3
2016	15.8	17.7	14.1
2017	15.1	17.0	13.3

Adult smoking data from the APS[7]

What are the health impacts of smoking?

Smoking is the main cause of preventable death in the UK. It is associated with around 100,000 deaths each year – 79,000 in England,[8] 10,000 in Scotland,[9] 5,500 in Wales,[10] and 2,300 in Northern Ireland.[11] In England, 16% of all deaths are attributable to smoking, and 32% of all deaths were for conditions that can be caused by smoking.[12]

About half of all life-long smokers will die prematurely[13] - on average, cigarette smokers die 10 years younger than non-smokers.[14] Despite common misconceptions, roll-up cigarettes are just as harmful as pre-made ones.[15]

Smoking is a significant causal factor of poor respiratory health, particularly for chronic obstructive pulmonary disease (COPD) and lung cancer – both of which kill more people each year than any other lung disease.[16] Notably:

- In England, 36% of all deaths for respiratory disease are attributable to smoking, as are 54% of deaths for cancers.[17]
- 23% of all admissions for respiratory diseases in England are attributable to smoking, as are 47% of admissions for cancer.[18]
- In Scotland, 41% of respiratory deaths in 2014 were attributable to smoking in males, and 38% in females.[19] Cancer also accounts for the largest number of smoking-attributable deaths in Scotland.[20]

Smokers under 40 are five times more at risk of a heart attack than non-smokers.[21] Smoking is linked with poor health outcomes, including premature menopause, abnormal sperm, osteoporosis, and poor taste and smell.[22] Smoking when pregnant risks premature birth, low birth weight and miscarriage.[23]

Secondhand smoke has also been found to be detrimental to children in particular, placing them at higher risk of respiratory infections, asthma, bacterial meningitis and cot death.[24] In the UK, around 2 million children are estimated to be regularly exposed to secondhand smoke in the home,[25] and secondhand smoke has been linked to around 165,000 new cases of disease among children in the UK each year.[26] However it is likely that children's exposure to secondhand smoke has decreased following smokefree legislation in the UK. In Scotland the target to reduce the percentage of children exposed to smoke at home to 6% by 2020 was achieved in 2015.[27]

What impact does smoking have on the economy and health services?

In order to understand the cost of smoking to society, ASH organisations have totalled the costs of smoking in each nation:

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- Research commissioned by ASH England in 2017 found the total cost of smoking to society in England is around £12.9 billion a year - inclusive of NHS treatment costs, as well as lost productivity due to premature deaths, smoking breaks and absenteeism. [28]
- ASH Scotland conservatively estimated in 2010 that the cost of smoking to society in Scotland is around £1.1 billion each year.[29]
- ASH Wales estimated in 2012 that costs of smoking to society in Wales amounted to £790.66 million annually, whilst noting estimated costs could be over £1 billion.[30]

Smoking has a significant impact on hospital services. In England, there were 485,000 hospital admissions for conditions attributable to smoking in 2016/17– up from 458,000 in 2005/06.[31] In Scotland, there are currently around 128,000 smoking-related admissions per year, which has steadily increased between 2003-2005 and 2011-2013.[32]

Across the UK, a 20-a-day smoker of a premium cigarette brand will spend around £3,600 a year on cigarettes, while an 11-a-day smoker (the average) will spend around £1,800 a year.[33]

What is the link with health inequalities?

Smoking is more common among the most deprived communities. In England, 26% of routine and manual workers smoke, compared to 10% of managerial workers[34]. In Scotland, the proportion of adults who smoke varies from 35% in the most deprived areas, to 11% in the least deprived.[35]

Smoking is more common amongst people with a mental health condition, homeless people and people who have been in prison. Smoking is also shown to be more common amongst people with a chronic illness, health problem or disability (29%) compared with those facing no long-term illnesses (19%).[36]

Certain ethnic groups are more likely to smoke than others. Smoking is comparatively prevalent amongst Black Caribbean (37%) and Bangladeshi (36%) men and white English women (26%).[37] Similarly, smoking rates amongst gay and lesbian people are higher than the general population at 24.2%.[38]

What are e-cigarettes, how has their usage increased and what is their health impact?

E-cigarettes are devices that produce inhalable vapour from nicotine dissolved in water, propylene glycol, vegetable glycerine, and some flavourings.[39] They do not contain tobacco or create any smoke.

In 2017, there were as estimated 3.2 million users in Great Britain.[40] Around half of e-cigarette users use them as a quit aid, and a quarter because they are less harmful than cigarettes.[41]

Current evidence collated by Public Health England estimates that e-cigarettes are 95% less harmful than regular cigarettes.[42] Short-term adverse effects from e-cigarette usage are similar to regular nicotine replacement therapies (NRTs), such as mouth and throat irritation.[43]

E-cigarette vapour contains various harmful compounds, including formaldehyde and other aldehydes, but at a much lower level than cigarette smoke.[44] A recent study funded by the British Lung Foundation found that when heated, e-liquid could reduce the cells' ability to protect the lungs.[45] This type of research is very valuable but we need further long-term studies to best understand the possible effects of usage over a number of years. It remains clear that continuing to use an e-cigarette is significantly less harmful than continuing to smoke cigarettes.

Evidence sourced by Public Health England shows very limited evidence that e-cigarettes act as a route into smoking for children or non-smokers.[46] The proportion of e-cigarette users who have never smoked tobacco is around 2% has not changed since 2012.[47]

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Tobacco control initiatives

England

Year	Adults (all)	Adults (routine and manual occupations)	Young people (regular smokers 11-15)	Pregnant women (at delivery)
2013	18.4	N/A	3	12.2
2014	17.8	29.8	3	11.7
2015	16.9	28.8	N/A	11.0
2016	15.5	24.9	3	10.7
2017	14.9	26.0	N/A	10.8

APS data

Regional variations exist in adult smoking rates. They are higher in Yorkshire and the Humber (17.0%), the North East (16.2%) and the North West (16.1%). They are lower in the South West (13.7%) and South East (13.7%).

Tobacco Control Plan for England

The most recent tobacco control plan for England was published in July 2017. A supplementary delivery plan was published in 2018. Together the documents set out objectives and activities to reduce smoking rates by 2022. There are three key targets in the strategy:

- Reduce adult smoking prevalence rates to 12% or less
- Reduce regular smoking rates among 15 year olds to 3% or less
- Reduce smoking rates throughout pregnancy to 6% or less

Smokefree NHS

The Smokefree NHS campaign, run by Public Health England, has three main objectives:

- Every frontline health care professional should discuss smoking with their patients
- All smokers should be offered on-site stop smoking support or referred to local services
- Completely smokefree buildings and grounds

Wales

Year	Adults (all)	Year	Children (11-16)
2013	21	1986	10
2014	21	1998	13
2015	19	2006	10
2016	19	2014	3
2017	19		

Welsh Health Survey 2013-2015. National Survey for Wales 2016-2017. Data on child smoking rates is sourced from the Health Behaviour in School-aged Children Wales survey.[48]

Welsh Tobacco Control Plan

The most recent tobacco control plan for Wales was published in 2012. The plan set a target of reducing smoking rates in adults to 20% by 2016 and 16% by 2020. The 2016 target was met when the smoking prevalence reduced to 19% in 2015. It identified four areas to focus on to deliver this:

- Leadership in tobacco control
- Reducing the uptake of tobacco use, especially amongst children and young people;
- Reducing smoking prevalence levels
- Reducing exposure to second-hand smoke.

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This was followed by the Tobacco Control Delivery Plan for Wales which was published in 2017. Together, the plans identified the following targets for 2020:

- Adult smoking prevalence to be reduced to 16% by 2020
- Smoking prevalence amongst the highest quintiles of deprivation to be reduced at a faster rate than the lowest quintiles
- Year on year decrease in each health board of the percentage of pregnant women who smoke at 36 weeks

Smokefree public spaces

In May 2018, Wales became the first country in the UK to initiate a ban on smoking in outdoor playgrounds, outdoor school spaces, and hospital grounds. Many hospitals already have smokefree policies, but the new legislation will enable staff to properly regulate and enforce these smokefree areas.

The government plans to implement these new restrictions by summer 2019. The changes will be introduced under the Public Health (Wales) Act 2017.

Scotland

Year	Adults (all)	Pregnant women (at antenatal booking)	Year**	Boys (age 13)	Girls (age 13)
2013	21	18.5	2002	6.0	9.2
2014	22	17.5	2010	2.8	3.2
2015	21	17.3	2013	1.8	1.7
2016	21	15.5	2015	2*	2*

Adult prevalence from Scottish Health Survey. Pregnant women smoke rate data is from the NHS Information Services Division Scotland (ISD Scotland).[49] Child smoking rate data is from the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS).[50]

Tobacco Control Strategy for Scotland

A Tobacco Control Strategy for Scotland: creating a tobacco-free generation covered the 5-year period between 2013-2018. It set out actions to address higher smoking levels in deprived areas, young people's smoking levels, exposure to secondhand smoke, smoking in pregnancy rates, and illicit tobacco trade. It also set 2034 as the year Scotland hopes to become tobacco-free, where the smoking prevalence in the adult population will be 5% or less, being one of the only countries in the world to have done so.

The new action plan for 2018, *Raising Scotland's Tobacco-free Generation*, maintains the central ambition of becoming tobacco-free by 2034. Action include legislating to restrict smoking around hospital buildings, banning tobacco in prisons, establishing a new national stop smoking service brand and running a stop-smoking media campaign. It also outlined the need to meet the following specific targets:

- By 2021 smoking prevalence for SIMD 1 and SIMD 2 (Scottish Index of Multiple Deprivation deciles) combined should be 20% or lower
- By 2022 the proportion of reported regular smokers among 13-15 years old combined should be 3% or less

- By 2023 the smoking prevalence among smokers in the 20-24 yers old age group should be 20% or less

Quit Your Way

As outlined in the Action Plan, all stop smoking services are to exist under the identity Quit Your Way Scotland. This will mean all smokers can access a single, identifiable service which is consistent in provision and outcomes all over the country. The Quit Your Way brand will be developed to provide specialist services for smoking in pregnancy and for smoking and mental health in an inclusive way, to help overcome barriers to access for priority groups.

Northern Ireland

Year	Adults (all)	Year	Young people (11-16)
2012/13	24	2010	7.5
2013/14	22	2013	4.2
2014/15	22	2016	4.1
2015/16	22		
2016/17	20		

From Health Survey (NI). Data on young people smoking rates is from the Young Persons Behaviour and Attitudes Survey, and is the proportion of young people who had smoked in the last week.[xv]

Ten-year tobacco control strategy for Northern Ireland

Department of Health, Social Services and Public Safety in Northern Ireland published the *Ten-year tobacco control strategy for Northern Ireland* in 2012. The strategy outlines a range of measures which if achieved, would meet the long-term aim of a tobacco-free Northern Ireland. This includes working with three priority groups of children and young people, disadvantaged people who smoke, and pregnant women and their partners.

The key objectives for 2020 are:

- Reduce the proportion of 11-16 year old children who smoke to 3%
- Reduce the proportion of adults who smoke to 15%
- Reduce the proportion of pregnant women who smoke to 9%
- Reduce the proportion of smokers in manual groups to 20%
- Ensure that a minimum of 5% of the smoking population in NI access smoking cessation services annually

Policy objectives

Reducing smoking rates

We want to see further reductions in smoking rates across all areas, through preventing further uptake and supporting existing smokers to quit. We support targeted interventions to reduce health inequalities among certain groups, including:

- the most deprived communities
- children and young people
- pregnant women
- homeless people

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- people with mental health problems

Reductions should be delivered through fully funded and innovative stop smoking services, with better referral pathways from other services, equitable provision of treatments, and awareness raising supported by mass media campaigns. We support funding for these services through further tax disincentives for smoking, including a levy on the tobacco industry. We also want to see a regulatory environment which supports the use of e-cigarettes, but recommend further studies on the safety of heated tobacco devices.

Stop smoking services

We want people who smoke to be referred to innovative and cost-effective stop smoking services to support them to quit. These services should also be sustainably funded.

Commissioning, referral, provision

We want stop smoking services to be:

- Commissioned in line with NICE, NHS Health Scotland and National Centre for Smoking Cessation and Training (NCSCT) guidelines
- Personalised and tailored towards the needs of individual smokers, with personalised invitations targeted at groups with high smoking rates
- Evaluated on a regular basis, with examples of innovative and cost-effective services shared widely among commissioners

We also want referrals to stop smoking services fully integrated into clinical pathways across the NHS. This includes ensuring that health care professionals ask all patients admitted into their care about their smoking status, offer very brief advice on quitting, and provide in-house support or refer them to local stop smoking services.

Smokers who get help from their local stop smoking service are up to four times as likely to quit successfully as those who try to quit unaided or with over-the-counter NRT.[51] A Cochrane review found that combined pharmacotherapy and smoking cessation support can increase chances of successfully quitting after at least six months by 70-100%,[52] while other UK based studies found that combined support and medication can increase chances of quitting by 225%.[53]

Fewer people are using smoking cessation services across the country. In England, the number of people who set a quit date via an official service fell from 724,247 in 2012/13 to 450,582 in 2014/15.[54] In Scotland, the estimated annual service uptake rate fell from 10.7% to 6.9% in the same period.[55]

This is in part due to weak referral rates – only one in 13 patients who smoke who were admitted to hospital in England were referred to a hospital or community-based smoking cessation service.[56] This is because formal referral pathways to these services are only available in just over half of hospitals.[57] Only three-quarters of patients were asked if they smoked, and the same proportion were not asked if they would like to quit.[58]

Sustainable funding

We want stop smoking services to be sustainably funded across the UK.

The Scottish Government pledged to maintain its tobacco control budget at the current level within the Tobacco Control Strategy for Scotland, 2013 – 2018. We urge the Government to continue to fund stop smoking services at this level as it looks to refresh the Tobacco Control Strategy in 2018. As the

Tobacco Control Action Plan in Wales is similarly renewed over the coming year, we encourage the Welsh government to incorporate a plan for sustainably funding these services across Wales.

Stop smoking services in England are experiencing severe cuts. Budgets were cut in 59% of local authorities in 2016/17 – up from 39% in 2015/16 and 17% in 2014/15.[59] It is vital that these budgets are not reduced any further if the ambitious targets and commitments to create a smokefree generation are going to be met. We urge that the Government cuts to public health funding are reversed.

We support the introduction of a levy on the tobacco industry, in line with other organisations including Cancer Research UK and ASH.[60] [61] 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.

E-cigarettes

We want smokers to be supported to use e-cigarettes to support their quit attempts. This must involve:

- Ensuring health care professionals are supported to give advice on using e-cigarettes to help quit smoking, as well as on buying and using e-cigarettes, to give smokers the best chance of quiting smoking
- Ensuring that, if further regulation is placed on e-cigarettes in the future, it does not prevent people from having access to different devices that work for them

We also support:

- Further research conducted into the long-term effects of e-cigarette use, especially on people who have already been diagnosed with a lung condition
- The existing restrictions on the promotion of e-cigarettes to children and young people under the age of 18

We don't support a complete change in regulation to allow e-cigarettes to be used in enclosed public spaces, such as on public transport. However, it is not always necessary to ban e-cigarettes in all outdoor areas which are smokefree because they pose much lower risk to bystanders than cigarettes.

Nicotine replacement therapies and pharmacotherapies

We want all smokers to be informed of, and have equal access to, prescribed NRT and pharmacotherapies. These include varenicline (Champix) and bupropion (Zyban). This means that:

- All GPs must be able to prescribe NRT and pharmaoctherapy where appropriate
- Providers of stop smoking services must not restrict which evidence-based NRT and pharmacotherapy is on offer
- Smokers who are prescribed in secondary care are given a discharge bundle to help them stay abstinent
- Hospital formularies include the complete range of NRTs and pharmacotherapies

The number of NRT, varenicline and bupropion items being dispensed in England has plummeted significantly. In England levels of NRT dispensed in primary care is now a quarter of what was dispensed in 2005-06. Varenicline prescriptions are now half of their one million peak in 2010/11. All stop smoking products dispensed in Wales in 2016-17 amounted to just a third of what was dispensed in 2007-08. In Scotland, levels of items dispensed dropped by 40% in just two years.

The BLF's report on stop smoking prescriptions in primary care (2018) found prescriptions have dropped because:

- Public health funding cuts has led to local authorities reducing the level of money they spend on commissioning stop smoking services. This means there are fewer ways smokers can access these prescriptions.
- Stop smoking services have increasingly restrictive prescribing practice, which may include providing prescriptions only for certain priority groups, or only providing a limited type or number of products to smokers
- Some CCGs are discouraging and even banning GPs from prescribing stop smoking products. Since the responsibility to commission stop smoking services was transferred to local authorities, some CCGs have been reluctant to take on the cost of prescribing these products in areas where local authorities are no longer specifically funding prescriptions made by GPs

Health care professionals should feel confident prescribing varenicline, including to people who have a history of anxiety or depression, in line with NICE guidance. Studies have found no link between varenicline and exacerbations of depression or anxiety, or with suicide or cardiac events for people with mental health problems.[62] [63]

Media campaigns

We want UK governments to fund wide-ranging and varied mass media campaigns on both local and national levels. These campaigns should be focused on promoting smoking cessation, preventing smoking uptake, and reducing exposure to second-hand smoke by non-smokers. It is crucial that campaigns are regularly reinforced, as the beneficial effects of being exposed to a campaign on quit rates have been shown to last only for two to three months.[64]

UK government health bodies currently have limited capacity to run mass media campaigns. Public Health England's advertising budget has declined from around £25 million a year in 2010 to £5 million a year in 2017, while the Scottish Government has earmarked funding for only one campaign a year.

Mass media advertising is recognised by the World Health Organisation (WHO) as one of the components of best practice tobacco control.[65] One study on campaigns in England between 2002 and 2009 suggested that each quit effectively cost around £406, less than half the cost per smoker of stop-smoking services.[66]

Taxation, prices and illicit tobacco

Taxation and pricing

We support further taxation on tobacco products to help disincentivise use. To support this, we want the UK government to:

- Increase the annual tobacco tax escalator on cigarettes from 2% to 5% above inflation
- Increase taxes on hand-rolled tobacco above the escalator until they are equivalent to manufactured cigarettes

Raising taxes on tobacco products is one of the most effective ways of reducing tobacco consumption,[67] particularly to reduce tobacco harm among disadvantaged groups, due their responsiveness to price changes.[68] The UK is also required to implement tax policies to reduce tobacco consumption as a signatory of the World Health Organisation Framework Convention on Tobacco Control (WHO FCTC).[69]

Illicit tobacco trade

We support global (WHO FCTC), European (Tobacco Products Directive), national (HMRC) and sub-national (regional and local authority) efforts to tackle illicit tobacco. This includes intelligence gathering, engaging with frontline workers and businesses, enforcement and communication.

We are very clear that the solution to illicit tobacco is not to increase availability of regulated products, as is sometime suggested by the tobacco industry.

All tobacco contains harmful chemicals. Countries where prices are lower generally have a bigger problem with illicit tobacco.[70] Evidence shows the illicit tobacco market share is declining long-term.[71]

Heated tobacco products

We support independent, peer-reviewed clinical research on the risks of harm and health impacts from using heated tobacco products.

It is not yet clear what the short and long term health impacts are of the current generation of these devices. The available independent research suggests that heated tobacco products may be considerably less harmful than cigarettes, and more harmful than e-cigarettes.[72] However, the ERS found research shows that some harmful substances are found in heated tobacco products at only a marginally reduced rate than in cigarettes, whilst others such as the potentially carcinogenic substance acenaphthene is found at almost three times higher than in conventional cigarettes.[73]

We do not advise their usage for non-smokers and advise caution for current cigarette smokers on their usage.

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