Stamping out smoking

Levelling up lung health briefing

19 May 2022

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.[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.

Action on smoking is likely to be the single most effective method of achieving this goal, and 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.[2,3] In addition:

- **Smokers need more social care:** smokers requiring social care do so on average 10 years earlier than non-smokers.[4] Furthermore, smokers are at greater risk of social isolation and loneliness as they age.[5] Quitting smoking is beneficial for their wellbeing, with stopping smoking having been associated with small to moderate improvements in mental health at least as great as those gained from taking anti-depressants.[6]

- **Smokers are less productive than non-smokers in the labour market**. 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.[7]

- **We are falling far short of existing targets:** 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%.

Against this disappointing backdrop, without significant additional resources and action on smoking, the levelling up missions and improvements in healthy life expectancy will not be achieved.

The change we need to see

By 2030, the government must hit its own 'smokefree' target of a 5% smoking rate.

The numbers of smokers making quit attempts, and being supported to quit, have fallen significantly in recent years.[8] This is a direct result of waning government efforts on tobacco control. Action is needed to address this urgently and it is essential that strong, evidence based smoking policies are included within the forthcoming Health Disparities White Paper and the Tobacco Control Plan.

	By the end of 2022	By 2025	By 2027	By 2030
Smoking reduction	A firm commitment to implement a polluter pays levy on the tobacco industry, with funding from this going towards stop smoking services and mass media campaigns. Smoking cessation becomes part of the NHS Core20PLUS5 health inequalities programme, and comprehensive smoking cessation support for everyone attending hospital. A comprehensive Tobacco Control Plan that expands the use of Very Brief Advice for Smoking Cessation across primary care, raises the age of sale from 18 to 21, and outlines clear interim targets working towards a 5% smoking rate by 2030.	At least £266m in funding from the industry levy put towards stop smoking services and mass media smoking cessation campaigns such as Stoptober. The age of sale increased to 21. Screening and offer of stop smoking support for everyone interacting with the NHS. Smoking rates at 9%.	Continued, ringfenced funding for smoking cessation work a local and national level. Smoking rates at 7%.	A national smoking rate of 5%. New targets set to drive down smoking rates amongst those groups with persistently high rates.

Proper funding for stop smoking services and campaigns

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 stop smoking services across the UK, mass media campaigns and other tobacco control measures.

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. Over half those setting a quit date with stop smoking services come from disadvantaged groups, making them an ideal fit for the levelling up agenda.[10] Adequate, ringfenced, long term funding would have a transformational impact, with around £266 million per year needed in England.[11] This could easily be raised from the tobacco industry Polluter Pays Levy.

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.

Increasing the age of sale for tobacco products from 18 to 21

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 of 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% by 2030.[12]

Building smoking cessation into core NHS activities

We want to see smoking cessation incorporated into 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. In addition, Very Brief Advice (VBA) for smoking cessation should be used across primary care. NICE recommended as effective and economical, VBA is a well-established policy to prompt smokers to quit and direct them to support. It needs to be part of a universal offer to people accessing healthcare.

Comprehensive smoking cessation support should also be made available for everyone 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 also 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.

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