ASH briefing on the Smokefree 2030 Fund

30 January 2020

Introduction

1. The Government has announced its ambition for England to be smoke-free by 2030 and said it would consider proposals for revenue raising to pay for this through a 'polluter pays' approach and using health legislation.[1]

2. The 'polluter pays' approach has long been argued for by ASH, supported by the Smokefree Action Coalition of over 300 health organisations. This brief sets out how it should operate, by using health legislation to raise funds from the tobacco industry. A more detailed analysis is included in the consultation submission by ASH and Breathe2025. Throughout this document, we refer to the funds raised by the 'polluter pays' levy as the '*Smokefree 2030 Fund'*.

3. The 'polluter pays' levy would provide, at no cost to the public purse, the funding needed to eradicate the social and geographical inequalities in smoking, and deliver a Smokefree 2030. The *Smokefree 2030 Fund* is also essential if the government is to achieve the ageing society mission to extend healthy life expectancy by five years by 2035, while reducing inequalities (a commitment also included in the Conservative manifesto[2]).

4. As the Green Paper points out "Smokers are disproportionately located in areas of high deprivation. 1 in 4 pregnant women smoke in Blackpool, 1 in 50 in Westminster." The same disparity is true for the adult population as a whole, 21.1% of adults smoke in Blackpool, 11.5% in Westminster. This leads not just to higher costs per head to the NHS from smoking, but also significant economic detriment to the local community.

Summary of the structure of the *Smokefree 2030 Fund*

5. The *Smokefree 2030 Fund* should be:
    - Set up in statute to raise a fixed amount of funding from the tobacco transnationals, based on powers set out in the National Health Service Act 2006 used for the Pharmaceutical Price Regulation Scheme (PPRS)
    - Conform with the Government's WHO FCTC Article 5.3 obligations, such that the tobacco industry plays no role in the setting or implementing of policy, or allocation of the TCF.
    - Incentivise the industry to switch out of combustible products, so they deliver on the Government's *"ultimatum for industry to make smoked tobacco obsolete by 2030, with smokers quitting or moving to reduced risk products like e-cigarettes".*
    - Raise £265.5 million a year until smokefree status has been reached, to pay for tobacco control measures in England at national, regional and local level.
    - Administered by the DHSC and PHE, supported by an advisory council including civil society expertise.
    - The devolved nations should be given the opportunity to opt in, as they do with the PPRS.

Support for a polluter pays approach to revenue raising for tobacco control

6. There is strong support for a *Smokefree 2030 Fund*, from politicians, the health community and the public.
    - The All Party Group on Smoking and Health is calling on the Government to implement a 'polluter pays' levy on the tobacco industry and raise money for a *Smokefree 2030 Fund*.
    - The Smokefree Action Coalition of over 300 health organisations, including medical royal colleges, health charities and professional healthcare organisations, supports such a fund.
    - A large survey of over 10,000 adults in England found that 72% supported making tobacco manufacturers pay a levy or licence fee to Government for measures to help smokers quit and prevent young people from taking up smoking (7% oppose)

Why Big Tobacco should be made to pay

7. The principle that the polluter should pay is well-established within public policy. The tobacco industry is not like other industries in that its product is lethal but nonetheless legal.

8. Smoking is the leading cause of premature death, with half the difference in life expectancy between the richest and poorest in society is directly attributable to smoking. Smoking is also one of the leading modifiable risk factors for years lived with disability.

9. Smoking not only harms our health it also damages the economy and increases pressures on our NHS and social care systems. In 2018 alone, smoking in England cost around £12.5bn. These costs include:[3]
    - £2.4bn to the NHS in treatment costs for health problems caused by smoking
    - £8.9bn of lost productivity caused by early deaths, sickness, absenteeism and smoking breaks at work
    - £880m of social care costs arising from additional social care needs due to disease and disability caused by smoking
    - £325m arising from the cost of fires caused by smoking

10. The damage caused to health and the economy is all due to smoking cigarettes, the vast majority of which are produced by the four tobacco transnationals. Globally the industry is an oligopoly dominated by four main producers, Philip Morris International, British American Tobacco, Japan Tobacco International, and Imperial Brands. In the UK, two of the four are particularly dominant, with Imperial and Japan Tobacco holding a combined market share of over 80% in 2008. Together the four companies had a total market share of 97%.[4]

Powers under the National Health Service Act 2006

11. The National Health Service Act 2006 provides DHSC with powers to raise money directly from industry under primary legislation, currently in relation to the pharmaceutical industry rather than tobacco.[5] [6]

12. The latest aggregate net sales and payment information for the Pharmaceutical Price Regulation Scheme (PPRS) agreement shows that in 2018 the pharmaceutical industry paid £614 million to the Government. Aggregate net sales by the companies covered by

the agreement were £8.9 billion in 2017/18.[7] Proceeds from the PPRS are allocated to the NHS and disbursed by NHS England.

13. The PPRS is designed to deal with the market failure caused by patent protection applied to new chemical or biological entities which gives pharmaceutical companies a temporary monopoly on the supply of individual branded medicines.

14. Market failure exists in the tobacco industry too. Market power, combined with well-intentioned and necessary tobacco control policies, including taxation and marketing restrictions/ad bans, have had the unintended consequence of giving cigarette manufacturers considerable pricing power and high profit margins of up to 67%, compared to 15-20% for most consumer staples.[8] [9] In consequence the transnational tobacco companies that dominate the UK market are immensely profitable, with profits of around £1.5bn per annum.

15. The same powers used to set up the PPRS could also be used to set up a fixed charge or levy on tobacco manufacturers overseen by DHSC, with the money raised accruing to DHSC and Public Health England. It also demonstrates that DHSC already has a team in place overseeing and delivering such a scheme, and so to extend it to tobacco would be a marginal cost with limited risk involved.

How the *Smokefree 2030 Fund* should be structured to raise a fixed amount to support tobacco control

16. The proposed levy would not be an additional tax but a specific charge designed to raise funds to bring the smoking epidemic to an end by 2030, very similar to the US user fee model.[10] [11]

17. The amount to be paid by each manufacturer would be apportioned on the basis of sales volumes of factory-made sticks and hand-rolled tobacco in the UK market with an equivalence calculated for handrolled in line with the evidence of 0.5 grams per stick.[12] This would be measured by the quantities released for consumption over the previous year.

18. The Green Paper states that the ambition for a Smokefree 2030 *"includes an ultimatum for industry to make smoked tobacco obsolete by 2030, with smokers quitting or moving to reduced risk products like e-cigarettes."* The *Smokefree 2030 Fund* would incentivise the industry to deliver on the ultimatum. As the number of cigarettes sold goes down, the charge on each individual cigarette would go up. This would incentivise the industry, and smokers, to switch out of combustible products, and the strength of the incentive would grow over time.

19. The fund would be dedicated in the legislation to pay for the recurring costs of tobacco control measures which have been proven to motivate successful quitting and reduce uptake. The PPRS is administered by DHSC for the devolved administrations, and could be for the *Smokefree 2030 Fund*, if the devolved administrations so wished.

Governance of the *Smokefree 2030 Fund*

20. DHSC should set up a national coordination mechanism in line with the UK's obligations under Article 5 of the FCTC[13] to *"develop, implement periodically update and review our comprehensive multisectoral national tobacco control strategy, to adopt and implement effective legislative, executive, administrative and/or other measures".* This would include oversight of the *Smokefree 2030 Fund*.

21. In line with the guiding principle of the FCTC that *"The participation of civil society is essential in achieving the objective of the Convention and its protocols."* civil society needs to play a full role in the national coordination mechanism. Experts in tobacco control from the academic, clinical, local government and voluntary sector and be administered jointly by DHSC and PHE.

22. Proceeds collected by DHSC from the PPRS are allocated to the NHS and disbursed by NHS England. The *Smokefree 2030 Fund* would, in the same way, be collected by DHSC and allocated with help from an advisory committee including tobacco control experts from the academic, regulatory, voluntary sector and clinical community. However, funding would only be released by the advisory committee for policies and programmes designed to reduce smoking prevalence while helping eliminate inequalities. Funding for regional and local tobacco control would be awarded in line with population weighted by smoking prevalence and inequalities indicators.

23. The committee would also monitor whether strategies to deliver the Government's goal of ending smoking by 2030 are on track and provide evidence-based advice on what further measures are needed. Some of the funds would be used to commission policy evaluation and provision of national support for local and regional interventions. This would ensure that the *Smokefree 2030 Fund* was spent appropriately and transparently in line with the evidence and that outcomes are evaluated.

24. Although the PPRS operates on a largely voluntary basis, companies that choose not to join the PPRS are subject to a statutory scheme, as provided for by the National Health Service Act 2006. A fully statutory scheme would be essential for the *Smokefree 2030 Fund* to comply with the UK's legal obligations as a Party to the WHO FCTC to ensure that public health policies with respect to tobacco control are protected from the commercial and vested interests of the tobacco industry. The guidelines to Article 5.3 of the FCTC, which the UK have adopted, state that, *"Parties should not accept, support or endorse partnerships and non-binding or non-enforceable agreements as well as any voluntary arrangement with the tobacco industry or any entity or person working to further its interests."*

Amount to be raised for the *Smokefree 2030 Fund*

25. In order to increase the rates of decline in smoking prevalence to deliver a smokefree England by 2030 best practice policies and funding will be needed, with particular focus on tackling inequalities. The effectiveness of England's tobacco control strategy to date has been due to the implementation of a comprehensive strategy, involving a range of complementary measures implemented in synergy. It is therefore difficult to estimate a return on investment for any one measure to enable us to build the amount of funding required from the bottom up.

26. In the US the Centers for Disease Control (CDC) recommend a sterling equivalent of a minimum level of £5.26 per capita, with recommended best practice of £7.47. For England, using population levels in 2018, this would equate to a minimum of £310.9 million, for best practice £441.6 million.

27. We compared this to peak funding levels for tobacco control in England for the above functions using publicly available information, uprated to 2018 populations and with inflation to 2019 prices.[14] [15] This includes funding for activity at national, regional and local level.

28. The outcome is lower than both CDC recommendations, but is in the same order of magnitude. In total the *Smokefree 2030 Fund* should be fixed to raise £265.5 million for England annually, increasing by the rate of inflation each year. Uprated to include the populations of the devolved nations the total amount would be £315.2 million.

29. The additional revenue would also relieve pressure on the public health budget. If the *Smokefree 2030 Fund* is not put in place then funding will continue to need to come from the public health budget for tobacco, which is not sufficient at the current time to deliver the government's smokefree 2030 ambition. Funding requirements break down as follows at national, regional and local level. A breakdown is set out below.

Table 3: Summary of total funding needed for Tobacco Control for England and UK

	National functions	Local authority functions	Regional functions	Total
England	£40m	£177.9m	£47.6m	**£265.5m**
UK	£47.5m	£211.2m	£56.5m	**£315.2m**

30. The *Smokefree 2030 Fund* would operate until the smokefree ambition set out in the Green Paper was achieved across society as set out in Section 6 above. If the devolved nations chose to opt in, we assume that it would be on the same basis.

31. In principle, the *Smokefree 2030 Fund* will be a temporary measure, the instrument of its own demise. England and Scotland both have target dates to be smokefree of 2030 and 2034 respectively, but these are ambitious and may not be achieved. In practice, therefore, some tobacco control activity may be needed well beyond 2030.

National oversight, coordination and allocation of funding to programmes

32. At national level funding would be required for the national coordination mechanism, to fund rapid response policy analysis and evaluation, acknowledging that funding exists for more detailed long-term research through NIHR and other mechanisms. The US set this at 5% of the combined funding recommendation, we have set it at £10 million, which is 3.9% (£11.9 million for the UK).

33. Specific funding is needed for national public education campaigns, a key driver in reducing smoking prevalence by discouraging initiation and motivating quit attempts. England used to have a strong track record in this area, but in recent years national spending on such campaigns has been severely cut back.

34. The spend in 2018/19 (£2.5 million) was less than half that of 2015/6 (£5.3 million) and around 90% less than was spent ten years ago (£23.4 million), not accounting for inflation. The Government has refused to confirm the budget allocated for this year saying only that "Audited spend will be available at the end of the financial year".

35. The amount spent in 2018/19 is less than half that of 2015/6 and 10% of the amount spent ten years ago, not accounting for inflation. Over the same time period there has been a significant drop in the proportion of smokers trying to quit. In 2008 40% of smokers in England had tried to quit in the last year, in 2018 this had fallen by a quarter to only 30%. If we are to achieve the necessary rate of decline in smoking prevalence to be smokefree by 2030 we have to increase the number of smokers trying to quit.

36. Public education campaigns are a highly cost-effective means of increasing motivation to quit. To return to peak funding would require a spend of £30 million in 2019 for England (£35.6 million for the UK).

37. Estimated total funding required for national functions in 2019 therefore is £40 million for England, £47.5 million for the UK as a whole.

Regional and local tobacco control functions

38. The Tobacco control Plan for England 2017 focuses on what can be achieved at regional and local level. To quote the then Public Health Minister, in the foreward to the Plan, *"Our vision is nothing less than to create a smokefree generation. To do this we need to shift emphasis from action at the national level - legislation and mandation of services to focused, local action, supporting smokers, particularly in disadvantaged groups, to quit."*

39. The actions for local and regional activity set out in the TC Plan which runs until 2022 are extensive and include not just responsibilities for local authorities but significant NHS engagement. Reaching a smoking prevalence of 5% or less across all population groups by 2030, is even more ambitious and will require a range of local actors working together to deliver consistent advice and support to smokers.

40. The cuts in the public health budget since the handover from the NHS to local government have serious impacts on tobacco control capacity at local and regional level and are increasingly making it difficult if not impossible for local authorities to deliver these activities. In 2019/20 a third of local authorities (31%) no longer provide a specialist stop smoking service, with three quarters (74%) of all local authorities citing pressure on budgets as a threat to their tobacco work.[16]

41. While local authority action and services are at the heart of reducing smoking prevalence, smoking cessation support in the community is not, and has never been, sufficient to reach all smokers. The NHS needs to do more to support the smokers in its care, prompting and supporting their quit attempts and linking into the services provided by local government. The funding included in the NHS Long Term Plan only covers hospital inpatients, smoking in pregnancy and those with long-term mental health conditions, no funding is available until 2020-21 and full roll out is not until 2023-24.

42. There will need to be regional collaboration to support and enable coordination between local government and the NHS, by working between local authorities and Sustainability and Transformation Partnerships, Integrated Care Systems and Clinical Commissioning Groups to ensure implementation of consistent and complementary tobacco control policies and programmes.

Funding for local authority tobacco control functions

43. In the July 2015 Budget statement, the Chancellor announced an in-year reduction of £200 million to the 2015/16 grant of £2.79 billion. Subsequently the Government announced a further cash reduction of 9.7% between 2016/17 and 2021. Although in the 2019 Comprehensive Spending Review the cuts for 2020-21 were reversed, with a 1% increase in real terms in addition, this is not sufficient. The Health Foundation and King's Fund have estimated that £1bn a year is needed to restore funding.

44. Other cuts to local authority Budgets have also had a significant impact. Trading standards staff are crucial to effective enforcement of tobacco laws. The number of local trading standards staff in England decreased by 56% between 2009 and 2016, with 81% of services considering that funding reductions have had a negative impact on their

ability to protect consumers in their area. In 2009 spending on trading standards was £213 million; in 2018-9 it was £108 million.

45. In 2013-14 funding was transferred to local authorities to pay for the transfer of public health functions from the NHS. This required an assessment of the amount being spent by the NHS on stop smoking services and wider tobacco control at that time. This came to £158.5 million in total. This is just under 6% of the total public health budget of £2.7 billion.

46. This is conservative as it does not include trading standards or environmental health funding, for enforcement functions already the responsibility of local authorities before the transfer of public health. Allocation of the fund will need to be weighted according to prevalence and inequalities, for example towards areas with high rates of smoking in pregnancy.

47. Estimated annual funding required for local authority tobacco control functions in 2019 is £177.9 million for England, £211.2 million for the UK as a whole.

Funding for regional tobacco control functions

48. Regional tobacco control programmes have proved effective in helping support localities in delivering reductions in smoking prevalence.21 Between 2012 and 2017 when comprehensive regional tobacco control strategies were in place in the North East, the North West, Yorkshire and Humber and the South West they were associated with significantly higher rates of decline in smoking prevalence in the relevant regions than in regions without such strategies. Reductions in these regions were between 4.9 and 5.8 percentage points, compared to 3.6 to 4.2 percentage points in the regions without such programmes. Furthermore, the highest rates of decline in these regions have been in routine and manual groups, thereby reducing health inequalities.

49. The Government, the National Audit Office, and NICE have all recognised the value of such programmes, but funding has been difficult to find, and even in the northeast has been cut back in recent years. Similar programmes to Fresh in the North West and the South West of England have had their funding completely cut since 2017.

50. Fresh, the regional office of tobacco control in the North East, which has been funded continuously since 2005, although funding has been cut significantly in recent years, provides one model. Greater Manchester has introduced another model in 2017 based on its city region status with unique devolved responsibilities for public health and NHS services. There are different systems in place in different parts of the country and this must to be taken into account when funding is allocated.

51. The principle is clear, however. Funding is needed for a regional tobacco control function funded on a per capita basis but with weighting with respect to smoking prevalence data and inequalities to provide regional support for a comprehensive strategy. Policies associated with greater declines in smoking prevalence include public education campaigns at regional level, coordination of regional enforcement activity on illicit and age of sale and support for delivering of wider tobacco control and smoking cessation by localities.

52. To ensure that regional activity is properly funded, which has only been the case sporadically to date, specific funding will be allocated from the *Smokefree 2030 Fund* for regional policies and programmes in line with populations, weighted to take account of inequalities.

53. At its peak in 2009 funding for Fresh, the longest running regional function with the highest regional rates of decline in smoking prevalence at 5.8 percentage points, was 0.64 pence per capita. Uprating in line with inflation to 2019 would equal to 0.85 pence per capita in 2019.

54. Estimated annual funding required for regional tobacco control functions in 2019 is £47.6 million for England and £56.5 million for the UK as a whole.

References

[1] Cabinet Office and DHSC. Advancing our health: prevention in the 2020s – consultation document. July 2019.
[2] The Conservative and Unionist Party Manifesto 2019
3 ASH. Ready Reckoner. September 2019.
[4] Gilmore AB, Branston JR, Sweanor D. The case for OFSMOKE: how tobacco price regulation is needed to promote the health of markets, government revenue and the public. *Tob Control*. 2010;19(5):423–430
5 DHSC and ABPI. The 2019 Voluntary Scheme for Branded Medicines Pricing and Access. Annex 2: Powers of the Secretary of State Deriving from the National Health Service Act 2006. December 2018.
6 DHSC and ABPI. The 2019 Voluntary Scheme for Branded Medicines Pricing and Access - Chapters and Glossary. December 2018 Annex 2 - Powers of the Secretary of State Deriving from the National Health Service Act 2006
7 PPRS Aggregate Net Sales and Payment Information 2018: Department of Health and Social Care
8 Gilmore AB, Branston JR, Sweanor D. The case for OFSMOKE: how tobacco price regulation is needed to promote the health of markets, government revenue and the public. *Tob Control*. 2010;19(5):423–430. doi:10.1136/tc.2009.034470
9 APPG on Smoking and Health. Delivering the vision of a smokefree generation: The All Party Parliamentary Group on Smoking and Health response to 'Prevention is better than cure'. February 2019.
10 Family Smoking Prevention and Tobacco Control Act 2009. Section 919 User fees.
[11] 11 US Food and Drug Administration. Rules, Regulations & Guidance. User fees. Accessed 20th January 2017.
12 Branston JR et al. Keeping smoking affordable in higher tax environments via smoking thinner roll-your-own cigarettes: Findings from the International Tobacco Control Four Country Survey 2006–15. Volume 193, 1 December 2018, Pages 110-116
13 WHO. Framework Convention on Tobacco Control. 2003.
14 Raw data for these calculations comes from the composite price index published by the UK Office for National Statistics (ONS). http://www.in2013dollars.com/UK-inflation
15 ONS. Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2018. June 2019.
[16] Action on Smoking and Health (ASH) and Cancer Research UK (CRUK). Many Ways Forward: Stop smoking services and tobacco control work in English local authorities. 2020.