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Tobacco Consultation
Department of Health
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2 September 2008

Dear Sir or Madam

Re: DH - Consultation on the future of tobacco control

The Royal College of Physicians is grateful for opportunity to respond to this consultation. The College has a long record of engagement in tobacco control advocacy, training and research since publication of its first report on tobacco, *Smoking and Health*, in 1962 [1]. That report recommended several key policies to reduce the prevalence of and harm caused by smoking, most of which are now established components of modern tobacco control strategy [2]. They were largely ignored by the government of the day [3]. The RCP responded in 1971 by establishing Action on Smoking and Health (ASH) as an independent tobacco control campaigning organisation, and has since published regular reports that have helped to inform public opinion and drive tobacco policy over this period [4-11].

The RCP welcomes this new consultation document [12], and fully endorses the commitment it demonstrates to address this most serious of public health problems. We especially welcome the decision to consult on harm reduction, a strategy that we have repeatedly argued is an overlooked yet potentially highly effective approach to reducing the death and disability, and the social inequalities in health caused by addiction to tobacco smoking [9;11]. We celebrate the success the government has achieved by implementing the measures outlined in the 1998 White Paper, *Smoking Kills* [13], making the UK a world leader in tobacco control policy implementation [14], and support this initiative to move to a higher level of measures for the future.

Our one concern with the proposals in the consultation is however that they are not as bold or imaginative as we would like, or indeed as would be justified by the extent of the problem they address. For too long, tobacco use has been tolerated, even passively condoned by UK governments as a problem that is just too prevalent, ingrained and pervasive to tackle head on. In fact, much more could have been and could still be done to prevent smoking. The public has demonstrated repeatedly, most recently in the widespread compliance with smoke-free legislation, that comprehensive measures to reduce smoking are understood, accepted and even welcomed. The government now needs to lead with even more effective policies to reduce the prevalence of smoking in the UK as quickly as possible. It was an Englishman, Sir Walter Raleigh, who first brought tobacco smoking to Europe and began the global tobacco smoking epidemic. It would be fitting if NHS England could now lead the world in eradicating smoking from society.

We have outlined the measures we think can and should be taken in a publication submitted along with this response [15]. In it we extend the arguments for reform of nicotine regulation articulated in our most recent report [11] by outlining the practical measures that could be taken to realign the controls on the sale, promotion and use of nicotine products to ensure that uptake and use of the most dangerous products are progressively and increasingly discouraged; that cessation of all nicotine use is promoted as the best

individual and societal alternative to tobacco smoking; and that those unable to stop all nicotine use are encouraged as far as possible to switch to less hazardous sources of nicotine. We respond to the consultation with the strong recommendation that the measures contained in the document [15], which are considerably more extensive than those proposed by government [12], are given serious consideration as a more effective and radical approach to the problem of tobacco smoking. Our specific responses to the questions posed in the consultation are as follow:

Part A: Reducing smoking rates and health inequalities caused by smoking

Question 1: What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030, and on what basis do you make these suggestions? What else should the Government and public services do to deliver these rates?

We argue [15] that full implementation of all existing tobacco control strategies available to government, supplemented by effective harm reduction measures, should achieve a reduction in the prevalence of smoking among all adults of at least 1.4 percentage points per year. The RCP welcomes the government's commitment to developing a new national tobacco control strategy but feels that it needs the scope and ambition necessary to tackle the full range of harm caused by tobacco and should be monitored, evaluated and regularly updated. The measures necessary to achieve this are outlined in the attached document [15]. In essence, these comprise much stricter controls on sale, promotion and accessibility designed to 'denormalise' tobacco smoking, and promotion of medicinal nicotine products as a reduced harm alternative. As outlined in the document [15] we would expect measures that denormalise smoking among adults to have a significant impact on smoking in young people by removing exposure to smoking role models, and to be effective across all socioeconomic and other groups, including pregnant women. It will also significantly reduce passive exposure to smoke in the home and other private places.

From a 2006 smoking prevalence among all adults of 22% [12], assuming that prevalence has continued to fall since then with an additional effect from the implementation of smoke-free legislation in 2007, and assuming that the measures we propose can be implemented from 2009, we would expect that prevalence in all adults could reasonably be expected to be reduced to around 11% by 2015, and for smoking to be all but eradicated somewhere between 2020 and 2030. As a result of the denormalisation of smoking that would ensue, we would expect prevalence rates among young people, disadvantaged people, pregnant women and other special groups to fall at broadly similar rates to those in the general adult population.

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

The inequalities caused by tobacco use arise from the higher prevalence of smoking in relatively disadvantaged people, who also tend to take up smoking earlier, smoke more cigarettes, and take in more from each cigarette [8;11].

Conventional tobacco control approaches in the UK have been less effective in manual and unskilled workers [16] and especially so in the most deprived in society [17]. Likely explanations for this are outlined in the consultation document but include the following:

- Price is one of the strongest measures to reduce tobacco smoking, and is especially effective among low income groups [18], but is a measure that is consistently undermined by smuggling and illicit sales in deprived communities
- Smoking is still an established cultural norm in many less affluent communities and cultural groups, making uptake more likely and cessation more difficult
- Accessibility to and uptake of cessation services remains difficult for individuals without access to transport, or who cannot afford to or are not allowed to take time from work to attend

- Early uptake of smoking, during brain growth and development, may lead to more intense levels of dependence that are more difficult to overcome [11] and making cessation interventions less likely to succeed

Our view is that whilst the above and other effects outlined in the consultation document are likely to be overcome by more intense application of conventional measures (price rises, cessation services, health warnings on packs, health promotion media campaigns and others) tailored where possible to appeal particularly to these social groups, these measures alone are unlikely to be enough. That is why we have argued for the application of harm reduction methods, providing smokers who can't quit, or for whom nicotine use is currently too much a part of everyday life to consider quitting soon with an alternative, acceptable source of nicotine that is far less hazardous than smoking [17]. In addition, we support the new measures proposed in the consultation document, such as generic packaging. Together we would expect these approaches to deliver sustained reductions in prevalence across all population groups.

Question 3: Do you think the six-strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?

Harm reduction should be added as a seventh strand.

Question 4: How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

Reducing smuggling and counterfeit sales is crucial to the use of price to encourage smokers to quit smoking, and discourage children and young people from starting smoking. We defer to the specialist inland and international enforcement agencies on the specific response to this topic, but we suggest changes to product labelling to ensure that illicit products can be identified easily, a rescaling of the levels of penalty for tobacco offences to bring them in line with class A drugs, and would seek means of incentivising the enforcement agencies to prioritise tobacco smuggling. Rescaling the penalties applying to tobacco to make them equivalent to those for heroin and other 'hard' drugs may itself be effective in achieving this [15].

An improved strategy to tackle smuggling at national, regional and local level is also needed to stop the flow of tobacco smuggled by criminal gangs. The new Borders Agency must ensure that it works closely with HMRC and the Treasury to share intelligence and effectively implement the Government's anti-tobacco smuggling strategy. The UK Government should also lobby for, and sign up to, a strong illicit trade protocol [19] as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. The UK should also sign the EU anti-smuggling agreements.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

This is a significant challenge as smuggling is widely considered to be a social good rather than ill in more deprived communities. The harms caused by smoking, and the role of smuggling in initiating and perpetuating smoking need to be communicated to the public, and the message reinforced by the prospect of serious penalties for those involved in the illicit trade.

Part B: Protecting children and young people from smoking

Question 6: What more do you think the Government could do to:

a. reduce demand for tobacco products among young people?

Whilst interventions to reduce uptake of smoking, such as the recent ASSIST trial [20] can delay or to a degree prevent incident smoking, the greatest success in reducing smoking among young people has occurred in California and is attributed to the effect of general denormalisation of smoking through effective tobacco control measures in adults [21]. This observation fits with evidence that incident smoking risk is determined by the prevalence of peer smoking [22] and in turn indicates that youth smoking will fall when exposure to smoking role models and other evidence of smoking as a desirable adult behaviour

falls. If the infectious disease analogy [22] is correct then smoking among young people may fall especially rapidly when peer and adult prevalence falls below the equivalent of the herd immunity threshold, though it is not year clear what that threshold is likely to be. Overall however, it is becoming increasingly apparent that the most effective way to prevent uptake of smoking in young people is to drive down the prevalence of smoking among adults.

Among the general tobacco control measures we propose [15], all of which are likely to be effective in young people both directly and indirectly (through denormalisation), the portrayal and placement of smoking in films and TV are particularly important. Smoking in the media remains a substantive marketing ploy and/or passive benefit for the tobacco industry, has increased in frequency in feature films over recent years [23], and has a significant effect on smoking risk [24-26]. We therefore argue that new feature films that appear to condone, endorse, glamourise or encourage smoking should be age certified to prevent screening to children and young people.

b. reduce the availability of tobacco products to young people?

Our response includes a number of recommendations to reduce availability. In particular we propose the introduction of licensing for retailers selling cigarettes and, in addition, that cigarettes should not be sold in retail outlets that admit children. We support the banning of tobacco vending machines [15].

Question 7: Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?

Yes. We propose banning advertising of all such accessories [15].

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option?

Yes. Our preferred options are to prohibit all product display in all premises, and prevent exposure of children to products and purchasing by restricting the sale of tobacco products to licensed premises that do not admit children [15].

Question 9: Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

Yes. We propose banning sale of tobacco from vending machines, but permitting vending machine sale of harm reduction products [15].

Question 10: Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

Yes. Brand image and identity are crucial to marketing and should be blocked. We support plain, generic packaging

Question 11: Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

We are not aware of evidence that this measure will be effective, though we recognise that smaller packs are more affordable and hence potentially more likely to be purchased by younger smokers. However if the restrictions on sale of cigarettes above are implemented, young people under the age of 18 will not be exposed to any cigarette packs in a retail environment. We therefore support the measure, but advocate more radical control on youth access and exposure to tobacco sales.

Question 12: Do you believe that more should be done by the Government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

We are not aware of any specific interventions of proven efficacy in reducing exposure in homes or

vehicles, though exposure of children has fallen substantially in recent years, we think as a result of the general reduction in smoking prevalence and a concomitant reduction in the numbers of adults who smoke in the home [10]. As with youth smoking therefore we see the overall solution to smoking in the home or in vehicles to be the application of the broader tobacco control policies we outline [15], in the expectation that that will reduce the number of family members who smoke at all, and further encourage those who do to smoke outdoors. Health promotion campaigns can continue to be used to encourage smokers not to smoke inside the home or other enclosed private spaces. Harm reduction strategies, involving use of nicotine to substitute for smoking in these contexts, may also be effective. The effectiveness of any such interventions needs to be assessed in relation to objective measures of passive smoke exposure, for example, through monitoring effects on cotinine levels. Cotinine monitoring should also be the method used to assess future trends in typical exposure, and could be the basis for targets to reduce exposure in due course.

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

Priorities should include:

- development of media messages and other social marketing to promote quit attempts and/or harm reduction, promote smoke-free homes and cars, reduce smuggling and other priorities listed above
- pharmacological and behavioural interventions to maximise the effectiveness and reach of cessation interventions
- development and testing of more effective nicotine harm reduction products
- methods of addressing the problems identified in question 14 below

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:

• smokers who try to quit but do not access NHS support?

We believe that research is urgently required (and we are aware of studies in progress) into this problem. Around half of quit attempts are spontaneous (ie unplanned) making use of NHS support less likely; also, many smokers are emphatic that they want to quit through willpower alone. Still more resort to other less clearly effective or else less well proven options, including complementary medicine.
Our view is that the more choice of effective methods available to smokers who want to quit, the more smokers are likely to use one of the available choices. The priorities here are therefore:

- to use social marketing to inform smokers of the choices and effectiveness of different methods of quitting, and how to access them
- try to ensure that NHS services offer as broad a range of choice of evidence-based interventions as possible.

• routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?

Research is also urgently needed for these groups, though again much is in progress. It is still not clear whether conventional approaches using behavioural support and NRT are effective in pregnancy or young people. Smokers from routine and manual groups are likely to be more heavily addicted and research is needed to assess the effects of different approaches to therapy, such as combination high-dose nicotine, in these groups, as well as means of proactively identifying such smokers and alternative means of service delivery, such as rolling groups, different service locations and the role of incentives.

Question 15: How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

By direct electronic referral, followed up by telephone and/or written contact

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

Research is needed into methods of approaching these groups and providing bespoke services for them. However, we believe far more could be done through the commissioning and contracts process to ensure that all smokers who consult their GP or are admitted to hospital (the latter group including a high proportion of smokers) are offered, encouraged to take up, and delivered effective and sustained cessation support. In secondary care in particular, this is a neglected area. Training of health professionals to recognise smoking as an issue they should intervene in, and equipping them to do so effectively, is also a priority which the RCP and other Royal Colleges are working to address.

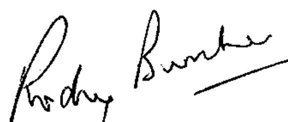
Part D: Helping those who cannot quit

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

Yes, emphatically. We believe that harm reduction could play a vital role in reducing the death and disability caused by tobacco smoking, and in the attached document [15] outline the changes necessary to the current regulations and regulatory systems that apply to nicotine products to make this possible. We argue that a drive to encourage as many smokers as possible to switch to less hazardous sources of nicotine should become a central component of UK tobacco control. The science underpinning this recommendation is summarised in the recent RCP report [11].

We trust these comments will be of use.

Yours faithfully



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Registrar

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