

SFNW Response to the DH Consultation on the future of tobacco control

Introduction

Smokefree North West (SFNW) is a region-wide initiative in existence since 2002, re-launched this year with new investment from all 24 Primary Care Trusts in the North West. SFNW aims to tackle tobacco related health inequalities across the region, as a campaigning organisation committed to leading the debate for a tobacco free future for everyone in the North West. More information is available at:

www.smokefreenorthwest.org

Vision: A North West free from the harm caused by tobacco

Mission: To work towards a healthier, tobacco free future for the North West's children and young people

The health community in the North West is aligned behind our vision of a tobacco free future for our children as it is only by tackling uptake of smoking in young people that we will break the inter-generation cycle of tobacco-related health inequalities we face in the North West today.

Three North West Tobacco Alliances operate sub-regionally over Cumbria and Lancashire, Greater Manchester, and Cheshire and Merseyside to strengthen the implementation of regional and national tobacco control plans with alliances and organisations at a local level and co-ordinate activities across these three areas. They engage with networks of tobacco leads in each of the 24 Primary Care Trusts and 46 local authorities across the region. Other key partners in SFNW are the sub-regional Public Health Networks.

North West Leaders and the public health community in the North West fully support a comprehensive, cross-governmental and long-term tobacco control strategy for England.

The North West public too supports the development of such a strategy and **64,216** people from across the region submitted postcard responses to this consultation calling for:

*A long-term plan which protects our children and future generations from the harm that tobacco causes

*Measures to remove tobacco out of sight of children

*Measures to protect our children from tobacco marketing

An independent North West public opinion survey (appended) conducted in the first week of June demonstrated overwhelming support by North West residents for further measures to protect children from tobacco. The key findings included:

- 89% agreed with banning retailers from selling tobacco if convicted of selling to under age smokers

- 86% supported licensing retailers to sell tobacco, with licences being revoked if they sold to underage smokers
- 81% agreed with a ban on smoking in cars with passengers aged under 18
- The majority supported the removal of point of sale advertising, a ban on vending machines selling cigarettes, and stopping the sale of packs of 10 cigarettes

There is public support for new legislation to protect children both from exposure to and addiction to tobacco. The level of support alongside the clear evidence based need requires the inclusion of tobacco control measures in a health bill to be included in the next parliamentary session.

Only a cross governmental strategic approach to tobacco control that engages all national Departments and Agencies, as well as local government and its strategic partners and involves civil society, will achieve the bold vision of making smoking history for our children.

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?

Moreover, what else should the government and public services do to deliver these rates?

1.1 We congratulate the Government on its commitment to developing a new national tobacco control strategy. On the basis of a comprehensive new cross-governmental strategy, which is monitored, evaluated and regularly updated and includes for the most highly addicted smokers a harm reduction approach, ambitious new targets should be achievable.

1.2 Recently the rate of decline in smoking prevalence has accelerated in the run up to the introduction of the smokefree legislation and in the twelve months following its implementation. The rate of decline of smoking prevalence in the North West, evidenced by the Smoking Toolkit Study¹, was 3.6% compared with 4.3% for England as a whole, with little variation by socio-economic status, gender or age.

1.3 Internationally substantial and comprehensive tobacco control programmes have significantly accelerated the decline of smoking prevalence in US states such as California, in parts of Australia² and in Canada³.

1.4 Closer to home, here in the North West SmokeFree Liverpool's comprehensive approach has led to a 5% decline in smoking prevalence from 35% to 30% between November 2005 and March 2008.

¹ Smoking Toolkit Study. Robert West. Cancer Research UK Health Behaviour Unit, University College London

² NSW Department of Health Population Health Survey 2006 Report on Adult Health

³ Canada Tobacco Use Monitoring Survey (CTUMS) 2007

http://www.smokefreenorthwest.co.uk/uploads/documents/NewsandMedia/Internal_Regional_Press_Releases/Release%20%20Tobacco%20Control%20Strategy%20launch.doc

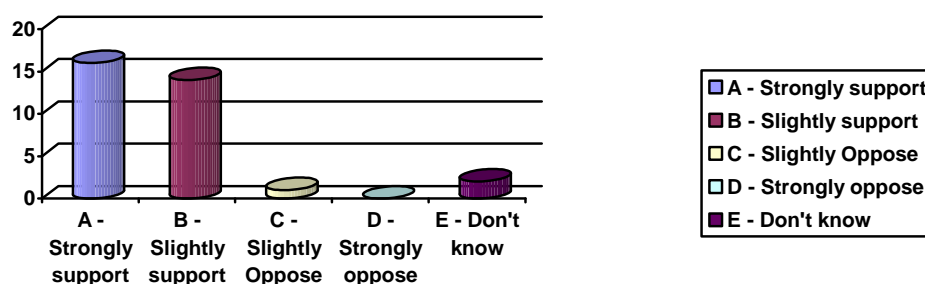
1.5 Based on this the aim should be to reduce smoking prevalence rates for England by 2015 to 11% for the general population and 17% amongst routine and manual workers (compared to 22% and 28% respectively in 2006). In other words the rates necessary to achieve the 'fully engaged scenario'⁴ envisaged by Wanless for 2022 should be achievable by 2015.

1.6 Eroding the differential in smoking between the classes will be slow but achievable in the longer-term. By 2020 it should be possible to reduce smoking prevalence to around 1 in 20 in the general population, and around 1 in 10 in routine and manual groups.

1.7 A consensus has emerged in the North West that an ambitious target of less than 5 per cent smoking prevalence by 2030 should apply right across the classes.

Do you agree that we could achieve a national smoking prevalence level of 5% or less by 2030 – If all partners work together effectively at national, regional and local level?

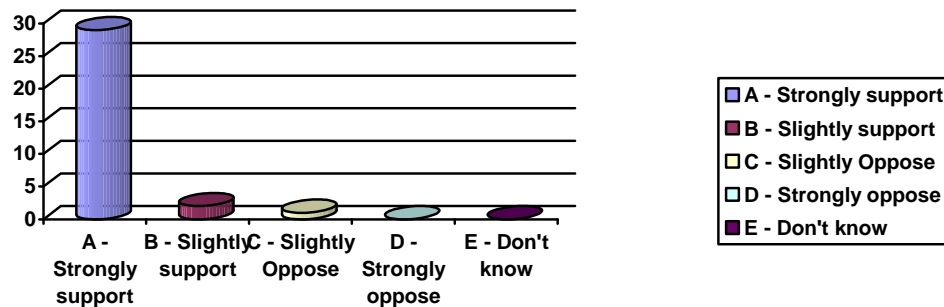
90.9% of respondents at the North West Consultation launch agreed that a national smoking prevalence level of 5% or less could be reached by 2030.



Would you support an integrated partnership approach to cracking down on cheap and illicit tobacco – in line with the North of England cheap and illicit tobacco action plan?

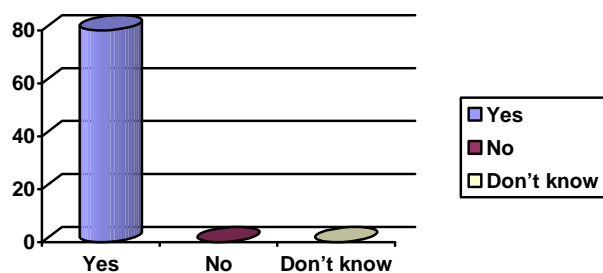
90.6% of respondents strongly supported an integrated partnership to reduce the levels of cheap and illicit tobacco, with 6.3% slightly supporting this.

⁴ Wanless D. Securing our future Health: Taking a long-Term View. Final Report. London. HM Treasury, 2002



Do you pledge to work towards a tobacco free future and to make smoking history for our children in the North West by 2025?

100% of the respondents at the Consultation Event pledged to work towards a tobacco free future.



1.8 In order to achieve these targets it will be essential to set not only national but also regional and local targets for smoking prevalence (and for local targets to be the shared responsibility of PCTs and Local Authorities). Measurement of smoking prevalence at the local level must be undertaken nationally to ensure consistency and validity of data (eg through the Integrated Household Survey). Appropriate performance management and improvement systems will need to be put place eg in LAAs.

Targets for smoking prevalence in young people

1.9 Targets must be set for smoking prevalence in young people and should include 16 and 17 year olds as well as 11-15 year olds following last year's change in age of sale.

1.10 Given that smoking uptake amongst children (11-15 year olds) is concentrated amongst 14 and 15 year olds we would suggest setting targets for these specific age groups for 2015 of 5% for 14 year olds and 10% for 15 year olds (compared to 9% and 15% in 2007 respectively). This would give a smoking prevalence rate amongst 11-15 year olds of 4% by 2015, compared to 6% in 2007.

1.11 Targets set for 16 and 17 year olds will also be crucial but it is difficult to suggest precise targets given a lack of robust data for this age group

1.12 In a survey of 11,724 14-17 year olds conducted on behalf of Trading Standards North West over a fifth (22%) of 14 to 17 year olds surveyed claimed to smoke. Young females were more likely to say that they smoked than young males (26% female vs 17% male). 19% of 14 to 15 year olds surveyed said that they smoked compared with 25% of 16 to 17 year olds.

1.13 Further research is needed in this area and boosting the sample size in the GHS would provide more robust data.

Targets for exposure to secondhand smoke

1.14 Exposure to secondhand smoke remains a significant concern, for adults, children and the unborn.

1.15 Pregnant women significantly under-report smoking rates⁵ and this is likely to increase as smoking becomes increasingly denormalised and exposing others to tobacco smoke less and less acceptable.

1.16 It is suggested that to ensure accurate measurement of smoking rates there should be national unlinked anonymous monitoring of smoking prevalence amongst pregnant smokers through cotinine testing, in the same way as HIV infection rates amongst pregnant women are measured. Appropriate targets for smoking amongst pregnant women for 2015, 2020 and 2030 could then be set once we have an independent measure of smoking prevalence in this population.

1.17 However local PCT level targets should also be set to help PCTs assess their effective contribution to this national target.

1.18 Additional support for pregnant smokers and their families to help them quit is also required (see answers to Q.14).

1.19 Measuring the level of secondhand smoke exposure amongst children and adults remains important, not only to understand the effectiveness of measures to discourage the exposure of non smokers to secondhand smoke primarily in private places, particularly the home and private vehicles but also in residual areas of exposure in the workplace and public places.

1.20 Targets should be set for the proportion of adult smokers who say they don't smoke in the home or in cars. To ensure we also have an independent objective measure of secondhand smoke exposure, given that as smoking becomes increasingly denormalised mis-reporting may rise, cotinine levels should also be monitored and annually reported and targets set for reduction in cotinine levels in both adult non smokers and children.

1.21 There are high levels of public support in the north west for prohibiting smoking in vehicles carrying children under 18 and a legislative approach in this area should be

⁵ Owen L, McNeill. Saliva cotinine as indicator of cigarette smoking in pregnant women. *Addiction* 2001;96:1001-6.

considered. Such legislation is already in place in some jurisdictions eg. legislation was introduced in California in 2008⁶.

Targets for reducing cheap and illicit tobacco

1.22 Access to cheap, illicit tobacco suppresses the effectiveness of the price/tax mechanism as a lever for tobacco control. Illicit tobacco is significantly more likely to be bought by less affluent smokers keeping them addicted and allowing them to smoke more heavily reinforcing that addiction.

1.23 The Trading Standards North West research findings highlighted that more than half of 14 to 17 year olds were regularly purchasing either potentially illegal cigarettes or cigarettes from illegitimate sources.

1.24 New ambitious targets should be set for reducing the market share of illicit tobacco to less than 5% by 2015 including specific targets for the market share of illicit hand rolled tobacco, more commonly used by poorer smokers to less than 33% by 2015.

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

2.1 Only a comprehensive, cross government tobacco control strategy that fully engages civil society will reduce the tobacco related health inequalities we currently face. While smoking may be a disease of the poor, Scottish longitudinal research has shown that even if people's socio-economic circumstances significantly improve, unless they are able to quit smoking their health gain is minimal⁷.

2.2 A high and rising level of tobacco prices remains a key lever to reduce inequalities in tobacco consumption. Tobacco price elasticity is estimated by the World Bank⁸ to be around -0.4 for developed countries, which means a 10% rise in price leads to a 4% decline in consumption and price has an even greater impact amongst the younger and poorer smokers. It is essential that tax rises are used to as part of a comprehensive approach to both reducing prevalence and preventing uptake.

2.3 While high tobacco prices due to sustained increases in taxation are the best way of reducing smoking, this is undermined by cheap and illicit tobacco, particularly in poorer communities. Tougher action is needed to stop smuggling [see answers to Qs 4 & 5 below.]

2.4 However poorer, more disadvantaged smokers also tend to be more heavily addicted⁹ and need greater support to quit successfully. The introduction of a harm reduction strategy providing longer term access to medicinal nicotine would be particularly helpful to

⁶ California Health and Safety Code Sections 118947-118949, California Vehicle Code Section 12814.6. 2006

⁷ Laurence Gruer, Carole Hart, David Gordon, Graham Watt. Smoking and health inequalities: new insights from Renfrew and Paisley 2007

⁸ Jha P, Chaloupka F J. Curbing the Epidemic: Governments and the Economics of Tobacco Control

⁹ Jarvis M and Wardle J. Social patterning of health behaviours; the case of cigarette smoking 2005

poorer and more heavily addicted smokers who are unable to quit. [See answers to questions 13-17]

2.5 In addition there is some evidence that stop smoking services can successfully support more deprived smokers to quit and targeting of appropriate, customer focused services on these groups of smokers may be increase successful quitting in this group.

2.6 Knowsley PCT came first out of England's 152 primary care trusts with more people per head of population who have successfully quit and results that are almost twice the national average. Knowsley is home to some of the most deprived wards in the country with the highest smoking prevalence and over 1,300 Knowsley smokers managed to kick the habit between April and December 2007.

2.7 Knowsley's continued achievement is down to the extensive range of flexible support services smokers can access to help them quit. With GP, hospital, pharmacy and community based services such as Roy Castle Fag Ends available, there is a wide range of services available to suit everyone who wants support to quit smoking.

2.8 Knowsley's stop smoking success has also been attributed to its long term social marketing approach to supporting smokers to quit. Social marketing campaigns targeted more effectively at poorer smokers could also help reduce health inequalities.

2.9 Attention needs to be given to groups with a combination of high levels of smoking and high levels of deprivation. Those with mental health problems are both significantly more likely to smoke and significantly more likely to be deprived relative to the population as a whole. An estimated 40% of people with mental health problems smoke¹⁰. In mental health units 70% of patients smoke and of those around 50% are heavy smokers¹⁰. Smoking also varies according to particular conditions. Research shows that, of those with depression, 56% are smokers and they report more severe withdrawal symptoms than the rest of the population¹⁰.

2.10 Despite the higher rates of prevalence smokers with mental health problems approximately half of smokers would like to quit, however actual quit rates are two to three times lower than the general population¹⁰. Given these inequalities, smokers with mental health problems need targeted and appropriate support to help them quit smoking.

2.11 Fully engaged partnership working is essential for successful local tobacco control action on health inequalities. The Greater Manchester Health Commission provides an excellent example of partnership working across a sub-region to tackle health inequalities. It has been established as part of the emerging City Region Governance Structures in Greater Manchester, led by the Association of Greater Manchester Authorities (AGMA).

2.12 The commission is formed from representative council leaders from the 10 authorities in GM and Chairs from the 10 PCTs in Greater Manchester, as well as other key stakeholders.

¹⁰ Mental Health Foundation, Taking a deep breath, 2007

2.13 In recognition of the urgency and significance of smoking in relation to population health and health inequalities, the GM Health Commission has committed to taking collaborative action with AGMA across a wide range of strategic tobacco control activities across all strands.

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?

3.1 SFNW supports the six strand strategic approach. There is good evidence that each of the six strands of tobacco control is effective in reducing smoking rates. However, more could be achieved by: greater investment in sustained mass media education campaigns that focus not simply on stopping smoking but on reducing uptake of smoking and protecting non-smoking adults and children (including unborn children) from secondhand smoke, as well as investment in social marketing of the stop smoking services; by further reducing tobacco industry promotional opportunities; by greater regulation of tobacco products and by reducing the availability and supply of tobacco products.

3.2 All elements of any strategy should be subject to regular monitoring, evaluation and review.

3.3 In addition, some form of harm reduction strategy would help those smokers who are either reluctant to quit or find it particularly hard to do so, and would help reduce health inequalities. [See answer to Q17.]

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

4.1 An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs, with new tougher targets for a continued reduction in the market share of smuggled cigarettes as well as hand-rolled tobacco.

4.2 The new Borders Agency must work closely with HMRC and the Treasury to develop a new and improved anti-smuggling strategy and ensure that cracking down on smuggling remains a priority for the Government.

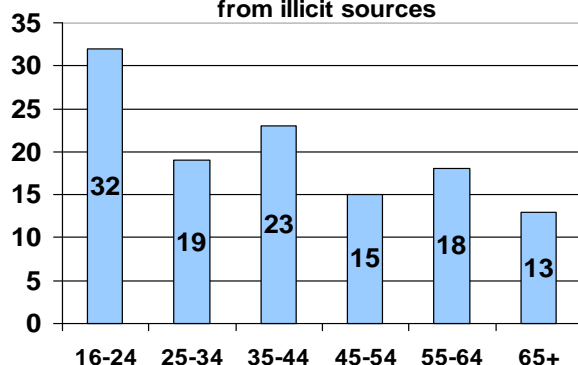
4.3 The UK Government should also lobby for, and sign up to, a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. The UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

4.4 There is extensive evidence of the continuing problem with both counterfeit and smuggled cigarettes and tobacco products. For example, a 2008 BRMB Omnibus Survey¹¹ conducted for ASH showed that:

¹¹ BMRB Omnibus Survey, fieldwork for the first three waves conducted January, March and April 2008, fieldwork is ongoing on the fourth and final wave. 205 smokers were interviewed in January and 732 in March and April.

- 20% of smokers reported buying cigarettes from illicit sources, and 10% reported buying more than three quarters of their tobacco products “cheap”
- A higher proportion of male smokers (26%) than female smokers (16%) reported buying tobacco from illicit sources
- Younger smokers are more likely to report buying from illicit sources

Percentage of smokers who report buying cigarettes from illicit sources



Data from waves 1 & 2 only

4.5 Further research conducted by Smokefree North West and FRESH (Smokefree North East) for the joint North of England Cheap and Illicit Tobacco Health Action Plan also concludes that a significant proportion of tobacco product consumed is not purchased by legitimate means and the relevant taxation paid. In the mind of the average consumer there is little or no distinction between cheap tobacco whether it is a legitimately manufactured product illegally imported and sold, or a counterfeit product. All cheap tobacco is commonly known and sold as “duty frees”. This market is made up of distinct different strands of supply:

- Everyday travellers selling on their “duty free” allowances
- Local people who either travel abroad regularly eg through business, or take a “white van” and import tobacco products.
- Organised crime who import substantial amount of tobacco product ie shipping containers
- Immigrant populations who through contacts in their homeland, where tobacco products are cheaper or counterfeit, import tobacco directly ie from Eastern Europe or China.

4.6 This evidence strongly suggests that integrated action between relevant agencies to combat illegal sales should be a priority for a national tobacco control strategy. This is particularly necessary if, as we recommend, the Government commits itself to a continuing policy of raising tobacco product prices in real terms.

4.7 At national level, effective action to combat illegal sales of course requires co-ordination between Government departments and agencies. For example, the Treasury needs to ensure that HMRC continues to set, publish and monitor targets under its

Departmental Strategic Objectives for reducing the market share both of smuggled cigarettes and hand rolled tobacco in the UK. There also needs to be a strategy for coordinated work on this issue between HMRC and the new Borders Agency.

4.8 The North of England Action Plan on cheap and illicit tobacco is currently out for consultation. It is hoped that this is a model that could be adopted countrywide.

4.9 At a local level effective action requires making partnership working between agencies a key priority for Local Strategic Partnerships, and in particular for CDRPs. Department of Health, Communities and Local Government and Government Offices for the Regions need to co-operate in pressing for this priority to be set out in Local Area Agreements. This would require either including a new National Indicator in the current list, or issuing advice and guidance to ensure that effective inter-agency action is taken under existing indicators (for example NI 115 on substance abuse by children, and NI 123 on smoking prevalence rates among people aged 16 plus).

4.10 Local partnership work that fully engages the police is also important and SmokeFree Liverpool offers an example of a local team that engages trading standards, the police and HMRC officers to tackle this issue at a city level.

4.11 Further consideration should be given to the following suggestions:

- Funding secure email for local authorities. At the moment if Trading Standards Services etc wish to send intelligence, which includes tobacco-related information, to the UK Intellectual Property Office it has to send it double-enveloped by post since current email is not deemed to be as secure by HMRC and the police. Secure email is apparently prohibitively expensive for LAs. If secure email was available to all it would be easier to share intelligence between agencies
- A national database (eg. the UK IPO's Database) could then be utilised or set up and accessed by all agencies who could input and check intelligence
- National protocols for information-sharing between Trading Standards and HMRC
- A national agreement as to what information PCTs could be passing through from intelligence received by Stop Smoking Services, followed by training and guidance for PCT staff on sanitising information to safeguard clients/patients should this be necessary.
- Joint area HMRC/TSS teams could be piloted, using seconded staff to target retail sales and sales from private houses to increase effectiveness and promote better enforcement.

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

5.1 There should be more investment in mass media campaigns to encourage the public to report illegal tobacco sales and to show how the availability of cheap smuggled tobacco undermines other tobacco control measures. There should also be greater transparency of information about the scale of smuggling to allow civil society to monitor the anti-smuggling strategy and lobby for change where necessary.

5.2 At the moment this is seen as a victimless crime, something harmless that most people condone. To change such attitudes funding of hard-hitting national campaigns should be considered targeting geographic areas with a high concentration of smokers, focusing on emotive areas such as health issues, fraudulent tax evasion hitting everyone's pockets and our essential services, underage sales to children, links with organised crime, exploitation of third world workers to produce the counterfeit cigarettes etc might go some way towards changing public perceptions. Further insight research is needed in this area.

5.3 As with high street retailers wanting to protect their alcohol licence, so targeting the financial gain of illicit traders is equally important. Dealing in counterfeit products is a lifestyle offence for the purposes of Proceeds of Crime, and so sellers of counterfeit tobacco face the risk of losing property. While evasion of customs carries significant penalties, the impact of regulation would be enhanced if it also qualified as a lifestyle offence by being listed in Schedule 2 of the Proceeds of Crime Act 2002. The sale of tobacco (and alcohol) on which duty has not been paid should be listed as a lifestyle offence for the purposes of proceeds of crime.

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?

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

6a.1 There is wide support for measures to reduce youth smoking but there is no evidence to show that education interventions targeted specifically at young people are of significant benefit. Indeed, youth smoking prevention campaigns (particularly those initiated by the tobacco industry) can be counter-productive.

6a.2 There is however, good evidence to show that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people. In addition to the 'six strands' identified above, there is widespread and growing support for measures to reduce tobacco marketing such as removing tobacco from view at the point of sale and plain packaging (see answers to questions 7,8,10)

6a.3 There is also a need to consider how the licensing system for films and producer guidelines and watershed rules for television programmes could be amended to ensure that smoking is not glamorised in entertainment aimed at young people. Smoking in films is now a major source of tobacco imagery and international research shows it is linked to uptake amongst young people¹². A recently published monograph by the National Cancer Institute in the US concluded that, "*The total weight of evidence from cross-sectional, longitudinal, and experimental studies indicates a causal relationship between*

¹² Dalton MA, Sargent JD, Beach ML, et al. Effect of viewing smoking in movies on adolescent smoking initiation: a cohort study. *The Lancet*. 2003;362:281–285

*exposure to depictions of smoking in movies and youth smoking initiation*¹³. These conclusions are relevant to the UK as most films viewed by young people are US in origin, although UK-based research evidence, which is currently underway, will be helpful in adding to the evidence base.

6a.4 The tobacco industry recognises the importance of smoking in films and in the past stars have even been paid for smoking on screen. In 1994 US tobacco firm Brown and Williamson was revealed to have spent £1 million over 4 years on product placement, paying stars such as Sean Connery, Sylvester Stallone and Paul Newman cash, cars and gifts to smoke their brands on screen.

6a.5 Although as part of the legal agreement with tobacco companies in the US product placement is now forbidden, smoking in films has not gone down. US analyses have found that smoking in movies is pervasive: three quarters or more of box office hits contained smoking, the majority of which are youth rated films.¹⁴

6a.6 This is currently not an issue taken seriously by film regulators in this country. Although the British Board of Film Classification (BBFC) guidelines for film classification state that *'portrayals of potentially dangerous behaviour which young children are likely to copy, are of particular concern'* and *'Works which promote or glamourise smoking, alcohol abuse or substance misuse may also be a concern, particularly at the junior categories'*, there is little sign that this concern is translated into action when it comes to the classification of films. Most of the films watched by young people in the UK originate from the main US studios, and the US experience of heavy exposure to smoking in films is repeated here.

6a.7 Stronger standards are already set by OFCOM, which is the regulator for the UK communications industry, and we would recommend that such standards are adopted by the BBFC and properly implemented. This would require that smoking *"must not be featured in programmes [films] made primarily for children unless there is strong editorial justification,"* and *"must not be condoned, encouraged or glamorised in other programmes [films] likely to be widely seen or heard by under eighteens unless there is editorial justification".*¹⁵ (Children are defined as under 15). The Guidance notes attached to the code state that: *"Ofcom does not expect it to be a frequent occurrence that a broadcaster would wish to include material that condones, encourages or glamorises the use of or (where relevant) abuse of these substances. However where that occurs e.g. in a movie that pre-dates the understanding that smoking was linked to cancer and other health effects, then the editorial justification for such material must be carefully thought through."* In this example the historical context and the integrity of the film, could be the editorial justification.¹⁶

¹³ National Cancer Institute. US National Institutes of Health. The Role of the Media in promoting and reducing tobacco use. Tobacco Control. Tobacco Control Monograph 19. 2008.<http://cancercontrol.cancer.gov/tcrb/monographs/19/index.html>

¹⁴ Sargent, JD et al. Exposure to movie smoking among US adolescents aged 10 to 14 years: A population estimate. *Pediatrics* 2007; 119 (5): 1167-1176

¹⁵ http://www.ash.org.uk/ash_70d0n794.htm

¹⁶ <http://www.ofcom.org.uk/tv/ifi/guidance/bguidance/guidance1.pdf>

6a.8 Film producers should be required to justify to the licensing authority the inclusion of smoking in films when seeking a certificate less than 18.

6a.9 However, smoking will continue to be condoned and glamourised in many films seen by young people in the near future. We therefore urge that a requirement be immediately imposed that strong anti-smoking ads, produced by the Department of Health or authoritative and respected health organisations, be shown prior to screening of any film with less than an 18 certificate where smoking is condoned, encouraged or glamourised.

6a.10 Research has shown that including anti-tobacco spots before movies does not undermine the audience's willingness to recommend the films to friends, but does neutralise the pro-tobacco influence smoking in the movies has on young audiences. To be effective, anti-tobacco spots cannot be occasional Public Service Announcements shown at the discretion of the cinema owner. They must be distributed, by the studios, on the feature film reel itself (or downloaded to cinemas from satellite, the digital distribution system now emerging). Spots also need to be included in the opening "chapter" on future DVDs, on videos and on-demand viewings and when films are shown on TV. The British Medical Association proposal to target films and programmes which promote smoking, whether deliberately or as a by-product of the programme, by having an anti smoking message preceding/during/end of the film/programme should be fully considered.

6a.11 There is a precedent for such measures as such "innoculation" spots are already being shown in cinemas in Ohio, Vermont, New York, Ontario (Canada) and Washington, DC. In addition, the major movie companies in the US have committed to providing such spots on DVDs sold in California.¹⁷ Action taken in the US is crucial as the vast majority of companies making movies watched by young people in the UK are American.

6b.1 Banning sales of tobacco from vending machines, increasing price through taxation and stronger measures to curb smuggling will reduce the availability of tobacco products to young people.

6b.2 Young people are highly receptive to tobacco promotion and the sophisticated marketing techniques employed previously by the tobacco industry. Young people are also susceptible to attractive pack designs and brand imagery. Therefore in order to deglamorise tobacco products and reduce the attraction to young people there should be a complete ban on tobacco products being displayed at retail level.

6b.3 Licensing of the sale of tobacco should be reintroduced with a penalty for anyone who sells tobacco illegally to have their license removed. This would not just strengthen control of underage sales but would also help retailers by enabling unlicensed sales of tobacco to be tackled more effectively (for example in street markets or car boot sales).

6b.4 There is significant support both from local authorities in the North West and the public for licensing of tobacco retail outlets with 86% of the public supporting such a measure.

¹⁷ http://www.smokefreemovies.ucsf.edu/solution/anti_tobacco_ads.html

6b.5 SFNW does not support the criminalizing of underage smoking as smoking is an addiction to a legal product which is not linked to anti-social behaviour in the same way as alcohol. However, if on further investigation it is found to be effective and practicable to put in place a criminal offence for proxy purchasing, then this would be supported.

6b.6 Schools should be encouraged to de-normalise smoking, and to enforce non-smoking policies within the school day; through smoke free zones around the school and support for smokers. Any incidents of tobacco trading in schools should be reported as a matter of course. (Anecdotal evidence suggests illegal tobacco trading takes place on school grounds)

6b.7 More than half of young smokers in the North West (compared to one third nationally) admit to buying illicit tobacco where no age of sale enforcement exists, so a more effective smuggling strategy is vital to reduce the availability of tobacco products to young people.

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

7.1 Yes. The advertising of tobacco accessories such as cigarette papers or lighters can act as a prompt and reminder about smoking. In recent years there has been a rise in the proportion of smokers using hand-rolled tobacco: from 12% in 1996 to 22% in 2006. It is noteworthy that when the Tobacco Advertising and Promotion Act was implemented Imperial Tobacco chose to place advertisements for Rizla cigarette-rolling papers at the point of sale since they did not require health warnings. Imperial has also used the Rizla brand to sponsor motor racing, thereby maintaining a link between sport and smoking, despite UK and European law which has outlawed tobacco sponsorship of sport.¹⁸

7.2 It is also clear that advertising of cigarette papers, lighters and other products tends to normalise smoking. Advertising for cigarette papers appears on some cigarette gantries and display cases and tobacco companies would not be doing this unless it had promotional and sales benefits. The current exemption of these products allows tobacco manufacturers to continue to advertise them, which could encourage and stimulate young people to smoke. There is also a concern that these products can also be used for the smoking of illicit drugs such as cannabis and cannabis smoking can become a route into nicotine addiction for some young people.

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?

8.1 SFNW supports Option 3, which require retailers to remove tobacco products from display.

8.2 There is strong evidence to show that tobacco advertising and promotion encourages children to smoke and this evidence underpinned the UK law that banned most forms of

¹⁸ Good G. Presentation at UBS Tobacco Conference. Dec 2006

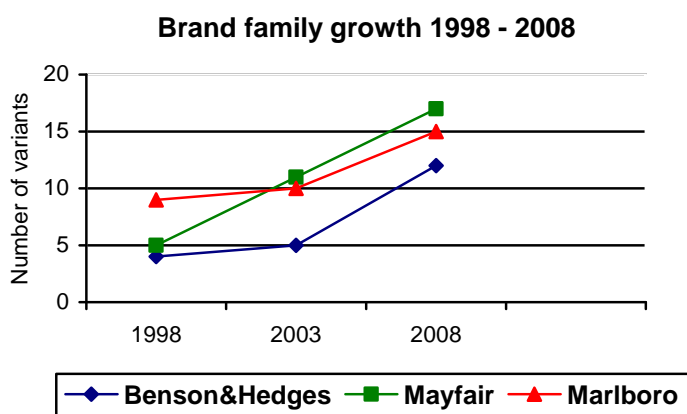
tobacco advertising¹⁹. Tobacco packaging is now the principal means by which tobacco companies promote their brands and point of sale displays are a form of tobacco advertising.

8.3 Removing tobacco products from public view will not affect adult smokers' ability to buy them but it will remove the temptation of children to try to purchase them. It is noteworthy that in Iceland, where point of sale displays were made unlawful in 2001, the proportion of 16 and 17 year olds who reported that they had ever smoked fell from 61% in 1995 to 46% in 2003. Thailand, some Canadian provinces, Tasmania have all introduced restrictions or prohibitions as will Norway, New Zealand and Ireland in 2009.

8.4 SFNW would acknowledge that compliance with the current legislation has been generally good. The legislation to a certain extent has been self policing with tobacco manufacturers representatives ensuring that gantries etc conform generally to the requirements. It must be noted however that there have been cases where retailers have attempted to challenge the spirit of the law by creating, for example a power wall display, in effect stacking multi packs of cigarettes in such a way as to create a virtual advertisement for the brand, and have employed other tactics to circumvent the law.

8.5 Tobacco is usually displayed in smaller retail premises at the counter/till area, sometimes located with other child appealing products such as confectionary. Supermarkets tend to have specialist counters from which tobacco products are retailed but again they tend to be displayed adjacent to confectionary. In a recent survey by TSNW of Tobacco Point of Sale Displays in 68 retail premises across the region, there was confectionary sited very close to the display in 41 premises. This can have the effect of normalising tobacco products and also exposes smokers who are trying to quit, to tobacco products that may cause them to relapse.

8.6 Following the passage of the Tobacco Advertising and Promotions Act 2002, cigarette packaging has become the most prevalent form of advertising for tobacco products. Since 2002, the number of cigarette brands has risen by more than a third.²⁰



¹⁹ Pierce J et al. Does tobacco advertising target young people to start smoking? Evidence from California. JAMA 1991;266(2): 3154-3158

²⁰ Pricechecker 1998, 2003, Safeway and Bookers price list

8.7 The tobacco industry has spent large amounts of money on point of sale displays. Imperial Tobacco has stated that because of advertising restrictions, cigarette packs and their display in retail outlets are now a major marketing tool and that new additions to brand families have increased their share of the market.²¹

8.8 The particular susceptibility of young people to tobacco advertising is well established.²² It is reasonable to conclude that as a key marketing tool, point of sale displays encourage young people to begin smoking and make it more difficult for smokers to quit.

8.9 The most common objection to ending point of sale displays is that this could make smoking more appealing to young people and therefore may not reduce prevalence rates. However there is clear evidence to the contrary from other countries. Evidence compiled through the Canadian Tobacco Use Monitory Survey, for example, showed that in Saskatchewan banning point of sale displays combined with tobacco control measures has coincided with a fall in smoking prevalence rates amongst 15 to 19 year olds - from 29% in 2002 to 21% in 2006.²³

8.10 It is often claimed that removing point of sale displays would place unacceptable costs on small retailers. However, there is evidence from other countries that the cost of adjustment for retailers will in fact be low. This is because the tobacco industry has a vested interest in getting their products sold and in Canada and other jurisdictions where point of sale displays have been restricted or removed the industry has therefore funded the moving of cigarette displays under the counter. Regulations relating to point of sale displays should therefore clearly set out what is required of retailers, on the basis of best practice from other jurisdictions.

8.11 Of course, in the long run, it should be expected that sales of cigarettes in retail outlets will fall: that is the inevitable consequence of the entirely justified Government strategy to reduce smoking prevalence rates. This process will take time – more than sufficient time for retailers to adjust their product mix.

8.12 Recently, Gallaghers have sold cigarettes at £3 for twenty as a promotion. This has been likened to the drug-dealer selling cheap heroin to get someone addicted, who will then have no option but to buy from the dealer. If this practice were to become common place, controls on the minimum price for cigarettes should be implemented.

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?

9.1 SFNW supports Option 3: A total ban on the sale of tobacco products from vending

²¹ Imperial Tobacco, UBS Tobacco Conference, 01 December 2006, London

²² See for example Altman DG et al. (1996). Tobacco promotion and susceptibility to tobacco use among adolescents aged 12 through 17 years in a nationally representative sample. Also Am J Public Health, 86, 1590-1593. Evans N, Farkas A, Gilpin E, Berry C, Pierce J. (1995). Influence of tobacco marketing and exposure to smokers on adult susceptibility to smoking. Journal of the National Cancer Institute, 87, 1538-1545

²³ Canadian Tobacco Use Monitory Survey 2000 - 2007

machines.

9.2 This is evidenced by a recent TSNW Test Purchasing exercise. Accompanied by TSOs, underage volunteers attempted to purchase cigarettes from vending machines in over 120 premises. They were successful in 62% of cases. In a number of premises, the children were not able to purchase tobacco because the machine was broken or empty, but they were not challenged or questioned by bar staff. If they had been able to purchase, the percentage of sales would have been even higher.

9.3 Many machines are incorrectly sited, and where they are sited correctly their use is not being monitored, as staff in those premises are busy attending to their patrons etc. It is clear that young people under the legal age for buying cigarettes (as with alcohol) show considerable ingenuity in getting round age restrictions, and that retailers, pubs and other sales points are not always meeting their legal responsibility to ensure age checks. Clearly the National Association of Cigarette Machine Operators (NACMO) Code of Practice, which the vending machine companies rely on heavily as one of their main methods of restricting underage sales, is not working.

9.4 Cigarette vending machines account for less than one (0.9) per cent of total cigarette sales, but research suggests that around one in six (17 per cent) underage smokers use vending machines to buy cigarettes. The change of the minimum age to 18 could also perpetuate this issue, as 16 to 17 year olds can consume beer, wine or cider if purchased by an adult whilst having a table meal in an appropriate pub. In recent years the number of public houses now selling food has increased, thereby increasing the numbers of children on such premises. This could make it more difficult for staff in those premises to “screen out” underage people using their vending machines, who are legitimately on their premises consuming food and alcohol. There are currently estimated to be around 70,000 vending machines in England and Wales.

9.5 There is also difficulty in determining legally who makes the sale – the member of staff behind the bar serving other customers, the owner of the pub whether an individual or brewing company, the vending machine supplier?

9.6 We strongly support the requirement under the World Health Organisation Framework Convention on Tobacco Control that measures be taken to ensure that vending machines selling cigarettes are not accessible to minors. However, we do not believe that this can effectively be done by any means short of ending cigarettes sales from vending machines altogether. For example, ID or token operated machines would not solve the problem. Unlike a human retailer, a machine cannot verify that the ID is being presented by its proper owner. In a bid to tackle under age purchases from vending machines age verification cards have been issued in Japan. However, these can be easily borrowed from friends and family or indeed copied.

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

10.1 Yes. Although no jurisdiction has yet implemented a law requiring plain packaging, research suggests that it would help deter young people from taking up smoking because smoking would lose its appeal.

10.2 There is evidence from around the world to show that the tobacco industry uses branding in general and pack design in particular to target young people - with BAT stating in internal documents "*One out of every two smokers is not able to distinguish on taste in blind tests. For most smokers and the decisive group of new younger smokers, the consumers choice is dictated by psychological and image factors than minor differences in smoking characteristics.*"²⁴

10.3 A wider array of brand variants also maximises display and therefore advertising space (some members of brand families are virtually indistinguishable on taste alone yet the number of variants has increased dramatically in recent years).

10.4 Packaging can also communicate misleading messages (it would be illegal for manufacturers to claim products were "low tar" "light" or less harmful yet all these can be communicated by the colour of sub-brand packaging)

10.5 Tobacco companies invests considerable resources in making tobacco packaging alluring and eye-catching, as this is now one of the few methods currently available to the industry to market its products to new and existing smokers. Industry analysts Citigroup believe that plain packaging would have a significant negative impact on cigarette sales.

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?

11.1 Currently there is insufficient evidence to show whether a requirement for minimum pack sizes would have a significant impact on youth smoking. ASH has recommended that the policy is kept under review and that further research be conducted. SFNW supports this position but strongly recommends that the Government may wish to consider taking reserve powers to determine permitted pack sizes by Regulation in future.

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.

12.1 SFNW would support further action by both Government and individuals to reduce children's exposure to secondhand smoke. This is particularly important given the strong link between parental smoking and exposure to secondhand smoke and smoking uptake in children. The Government should as a minimum run further mass media campaigns targeted at parents/carers about the health effects of secondhand smoke, particularly in enclosed places such as the home and motor vehicles.

12.2 Further research should be conducted into effective ways of helping parents to stop smoking and to prevent children's exposure to smoke if parents do not stop smoking. (This links to the harm reduction approach outlined in question 17.) The stop smoking services must be adequately funded to continue to target disadvantaged smokers and other groups

²⁴ Freeman B, Chapman S and Rimmer M. The case for plain packaging of tobacco products. University of Sidney 2007

such as parents.

12.3 81% of the North West public would support legislation to ban smoking in vehicles carrying under 18s. SFNW urges the Government to consider extending the smokefree regulations to cover private cars and send a clear message about the dangers of exposing children to secondhand smoke in any enclosed setting.

Part C: Supporting smokers to quit

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

13.1 A monitoring and evaluation strategy is necessary to assess the impacts and outcomes of the new comprehensive cross-governmental tobacco control strategy.

13.2 Other research areas should include: Research to improve the identification, referral and retention of smokers entering into services including pregnant smokers; Research to examine the impact of interventions and policies on different social and ethnic groups; Research to examine the efficacy of different prevention approaches including mass media interventions on young people; Research to support protecting children and adults from secondhand smoke; Research to further our understanding of the supply of and demand for cheap and illicit tobacco; Further research on health inequalities and tobacco; Insight research to inform marketing and communications campaigns as well as service development and redesign.

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

14.1 Stop smoking services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chances of quitting four-fold compared to using willpower alone²⁵. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%. Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

14.2 Acute Trusts should be required to monitor smoking rates of patients and to give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services. Smoking rates of people leaving hospital should also be monitored. In addition, smoking cessation should be included in the Standards for Better Health set by the Healthcare Commission.

14.3 The cost of purchasing stop smoking aids can be a barrier to use, as can the limited

²⁵ Chesterman J, Judge K and Bauld L. How effective are the English smoking treatment services in reaching disadvantaged smokers? *Addiction* 2005; 100 (spl 2), 36-45

availability of these products. Although some versions of NRT are now on general sale, availability is still largely limited to pharmacies and supermarkets. Meanwhile tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs, vending machines in licensed premises, and specialist tobacconists. In order to help smokers who want to quit without NHS support, stop smoking aids should be accessible in all the places where tobacco products are currently sold. There is widespread public support for such as policy in the North West and nationally.

14.4 SFNW has facilitated a Stop Smoking Service User Questionnaire response to the consultation. This survey asked current quitters' views on the consultation questions as well as asking about their opinion on what Stop Smoking Services should offer to quitters in the future (please see Appendix I for the full results).

14.5 Of 290 respondents from across the North West:

- Over 90% of current quitters agree that quitting medicines and products should be available to everyone on the NHS
- 70% of current quitters agree that the Government should promote the development of less expensive and more effective quitting aids
- Overall 90% strongly or somewhat support the removal of cigarettes from vending machines
- Overall 97% of current quitters support a long term plan to prevent children and young people taking up smoking
- Over 70% of current quitters strongly agree that tobacco should be out of sight of children and young people in shops

14.6 Blackpool has the highest known rate of smoking at time of delivery in all of England. In 2007, a key problem was that pregnant women had appeared to receive either wrong or outdated advice on stopping smoking. Women reported that this information was passed to them by either their friends or family or by health professionals.

14.7 The Little Voice Campaign was then developed in Blackpool in 2007 to address the "myths" that local women had heard about stopping smoking while pregnant.

14.8 The most common myths that appeared to be widely believed were that:

- Pregnant women could not access Nicotine Replacement Therapy
- Cutting down or moving to "mild or light" brands was beneficial to health
- Stopping smoking would cause stress for the foetus
- There was no point in smoking if you had smoked in the first 3 months of pregnancy

14.9 Little Voice aimed to eradicate the myths using a combination of high quality training (and toolkits) delivered by the Stop Smoking Service to over 200 health professionals in Blackpool (including social and voluntary groups such as Sure Start, Barnardos and Stonham Housing).

14.10 However, to make a significant difference to the actual number of women who smoke, it appears that much more dramatic action needs to be taken. Such action, which could make a difference nationally, could take the form of:

- A mandatory referral system from every women's unit in the country to their local stop smoking service
- Mandatory training once a year for health professionals with a responsibility for pregnant women
- Funding for the Stop Smoking Services to provide bespoke stop smoking groups for pregnant women who feel they may be judged by other members of the public

14.11 Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the smoking cessation services. Social marketing campaigns targeted at particular social groups should be used to assist those who find it most difficult to quit. Research should also be conducted to determine the efficacy of encouraging smokers to make more quit attempts, more regularly whether or not they seek support.

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

15.1 Clearly much more needs to be done to make the services attractive to people who want to stop smoking. This could be achieved by improving the selection, training, assessment and supervision of specialists; the implementation of treatment protocols, and high quality administrative support for services.

15.2 Mass media health campaigns should be complemented by community-based initiatives to promote local services and national websites and helplines should be better linked into local services with consistent and linked CRM systems.

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

16.1 All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support.

16.2 Smoking cessation should be included as part of the medical training for all healthcare professionals. There should be more outreach with services being set up in places where people are likely to see them, such as in workplaces, shopping centres and schools. Manchester PCT has for example, taken up stalls at local markets which offer a one stop shop for smokers with the option of being referred into group support services if desired.

16.3 Better use could be made of existing social networks including faith groups to reduce smoking prevalence.

16.4 The NHS smoking quitline should appear on all tobacco packaging.

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?

17.1 Yes. People are free to smoke but it is important to find ways of reducing the harm caused by smoking whilst allowing people to use nicotine in a way that will not endanger their health. Nicotine is relatively safe but little has been done to promote longer term use of nicotine replacement therapy as an alternative to smoking for those who are unable to quit. Although the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the accessibility of NRT much more needs to be done.

17.2 The Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking for those smokers who find it most difficult to quit. This should include educational campaigns to raise awareness of the relative safety of nicotine, as currently a significant proportion of smokers and health professionals believe that nicotine can cause smoking-related diseases such as cancer. Nicotine products might also be considered for temporary abstinence to protect children from shs. Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities.

17.3 However, while SFNW would support a harm reduction approach in limited circumstances it would be imperative that educational campaigns maintain that quitting while difficult is perfectly within the reach of the vast majority of smokers.

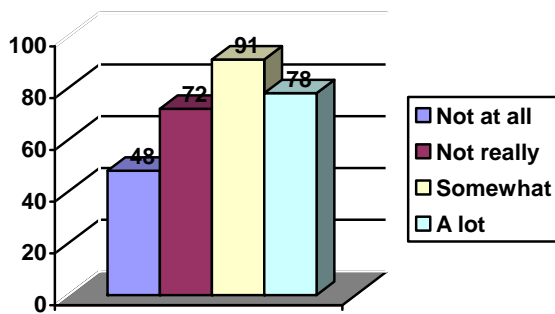
17.4 SFNW also welcomes Government support for reduced ignition propensity cigarettes, which will significantly reduce smoking related house fires and thus inequalities in this area.

**Responding to the government consultation:
Stop Smoking Service User Questionnaire**

Smokefree North West has facilitated a survey of the opinions of clients of Stop Smoking Service users across the region, including questions relating to the current government consultation on the future of tobacco control.

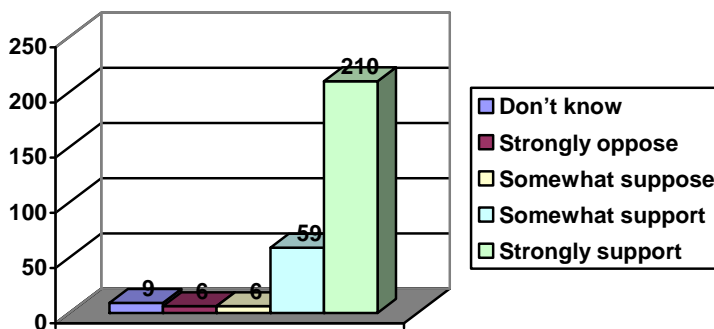
The following responses to these questions have been received to date from North West Stop Smoking Services (n=290).

1. To what extent has the smokefree law made it easier for you to stop smoking?

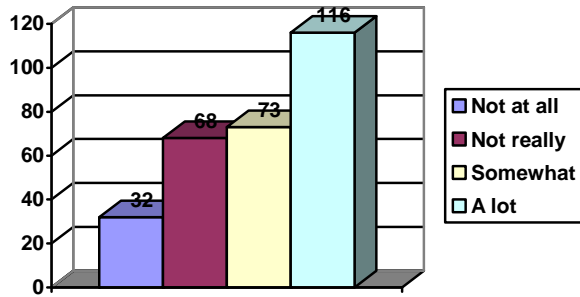


2. Tobacco companies display their products in local shops and supermarkets. Evidence shows that removing the display of tobacco may prevent children and young people from starting to smoke.

a) Would you support removing tobacco out of sight from children and young people within shops?

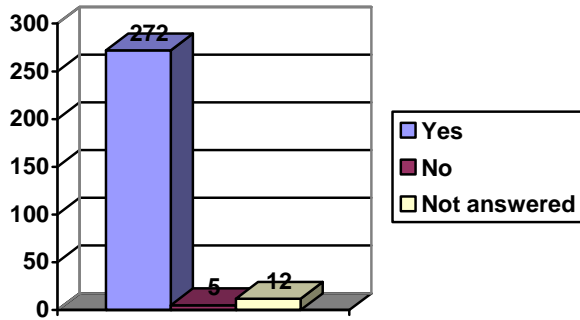


b) To what extent would keeping cigarettes/ tobacco out of sight help your attempts to stop smoking?

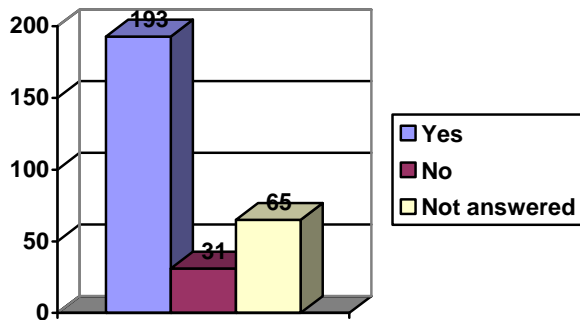


3. There is evidence that quitting medicines and products improve smokers' chances of stopping smoking. Do you agree that:

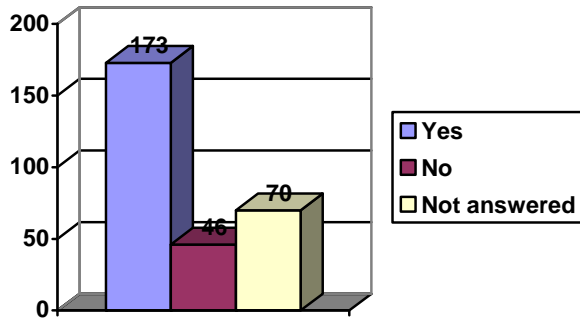
a) These products should be available to all on the NHS?



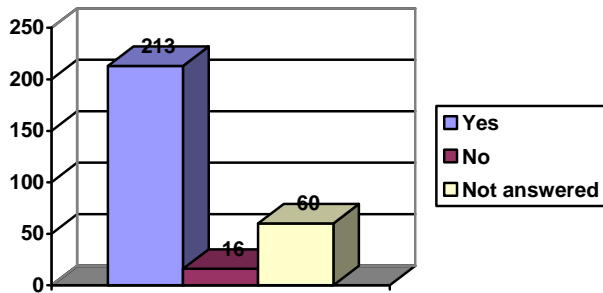
b) Should be more widely available in local shops?



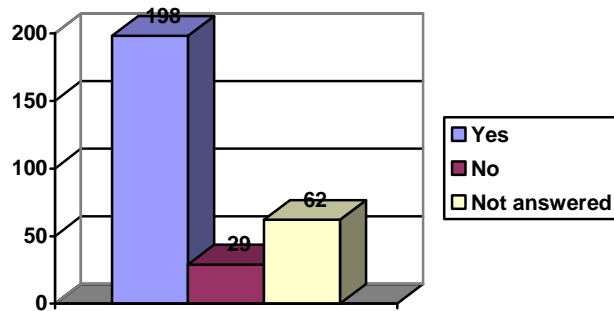
c) Should be sold alongside tobacco products?



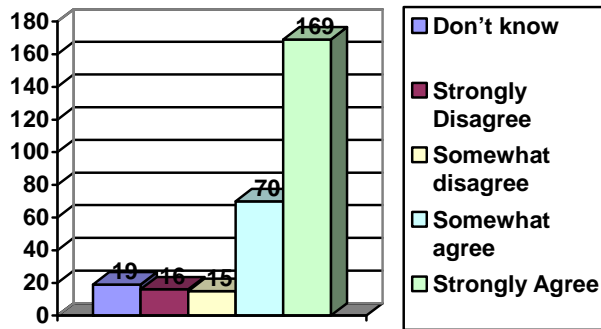
d) Should the Government promote the development of less expensive quitting aids?



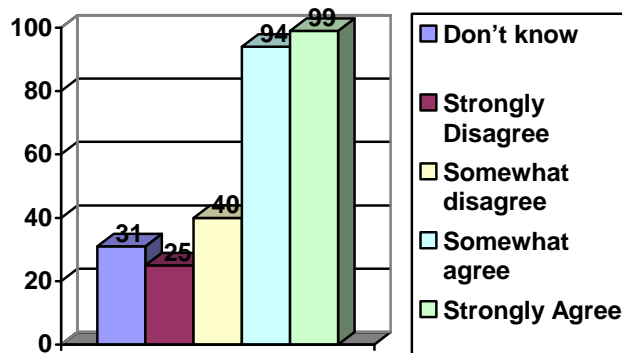
e) Should the Government promote the development of more effective quitting aids?



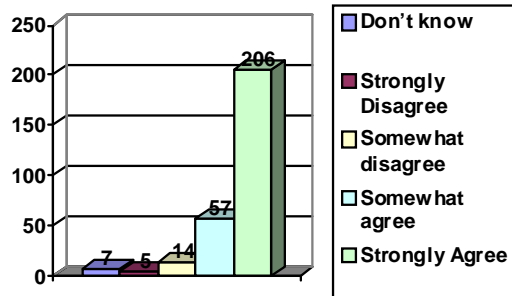
4. To what extent do you agree that the availability of cheap, illegal tobacco products makes smoking more affordable and accessible, particularly to children and young people?



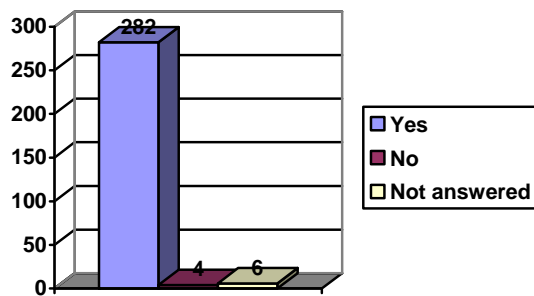
5. It is suggested that children's and young people's decisions to smoke can be influenced by colourful packaging. One study has found that some 49% of teenagers believed that plain packaging would result in fewer teenagers starting to smoke. To what extent would you support the introduction of plain standardised packaging for all cigarettes and tobacco products?



6. 17% of children and young people buy their cigarettes from vending machines. To what extent would you support the removal of cigarettes from vending machines?



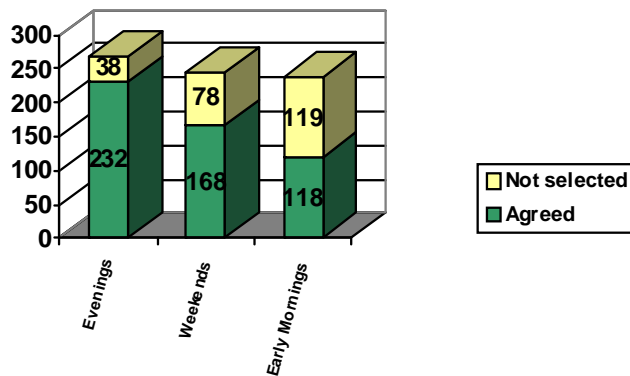
7. Do you support a long term plan to prevent children and young people taking up smoking?



Section 2 – Stop Smoking Services

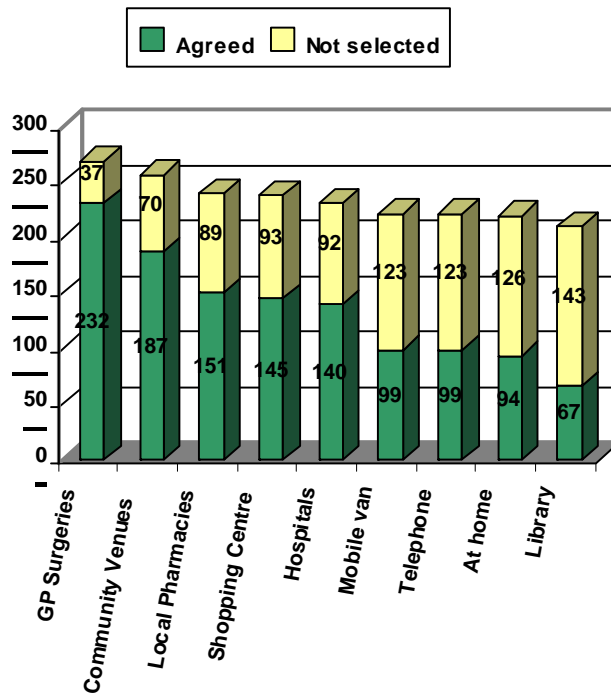
Options for services – sorted by ratings

Availability of Services:



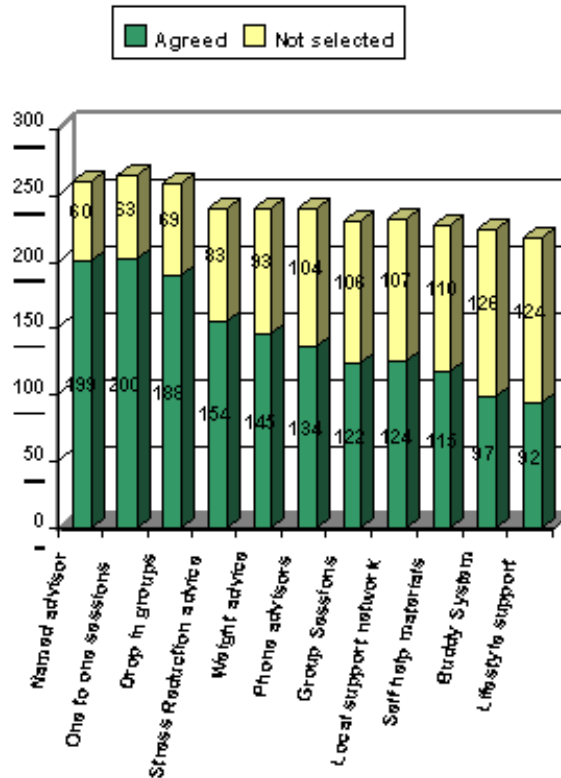
Other Options suggested: 24/7 Service, helpline

Location or types of service:

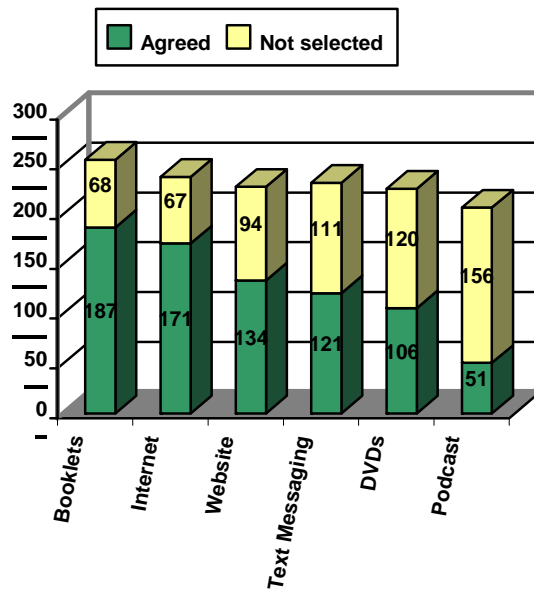


Other options suggested: Schools, Pubs, Workplaces

Ranges of services on offer:

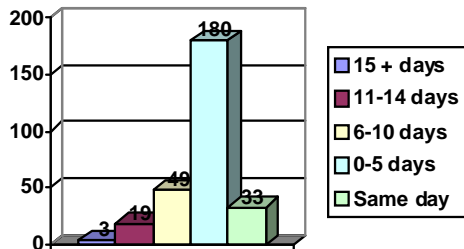


2. What sort of information would you like available to help you stop smoking?

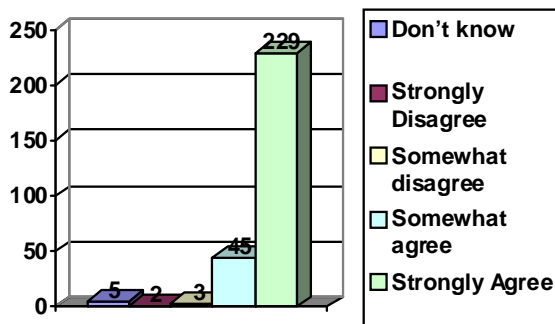


Other suggestions: TV Advertising

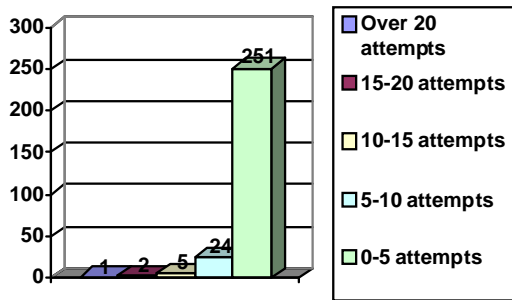
3. Once you have contracted a service for the first time, how soon would you expect to be seen?



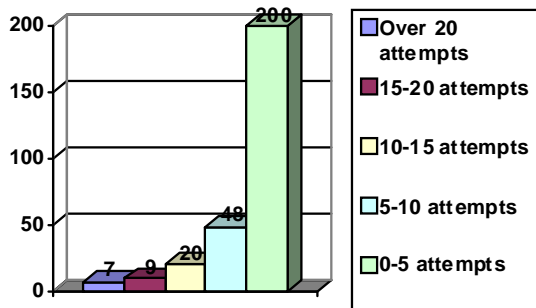
4. To what extent do you support investment in campaigns that motivate smokers to quit and advertise the range of support offered?



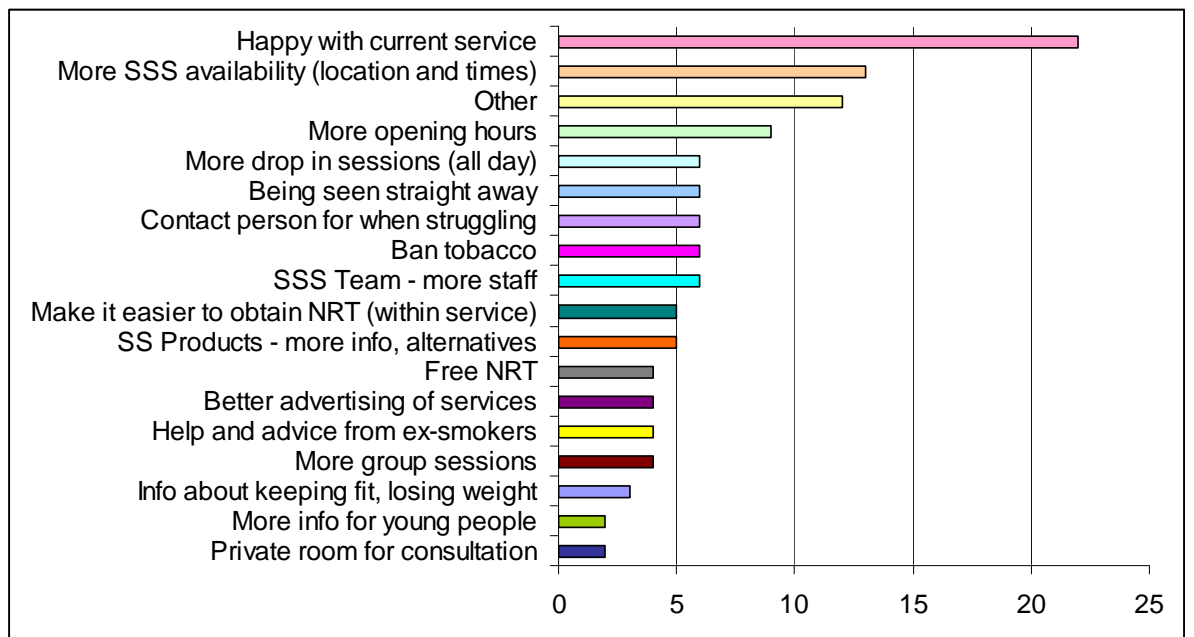
5. How many times have you tried to quit smoking with the service before?



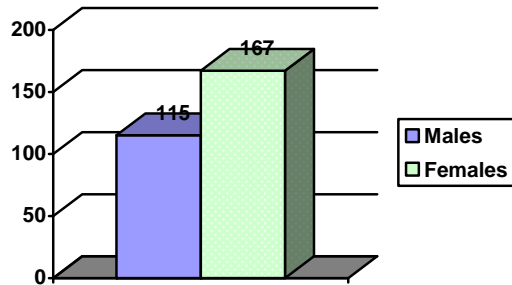
5. How many times have you tried to quit smoking on your own?



Open-ended Questions - Please state one thing that would improve your stop smoking service?



Demographics



5 of the 161 women reported being pregnant at the time of completing the questionnaire.

Age:

