Making smoking history – the path to Smokefree 2030.

Dr Nicholas S Hopkinson

Reader in Respiratory Medicine

National Heart and Lung Institute, Imperial College London

Royal Brompton Hospital Campus

Fulham Rd

London

SW3 6NP

[n.hopkinson@ic.ac.uk](mailto:n.hopkinson@ic.ac.uk) Tel: +44 20 73407775 Fax +44 20 73497778

**Competing Interests**

I have read and understood the BMJ Group policy on declaration of interests and declare the following interests: I am Chair of Action on Smoking and Health and Medical Director of The British Lung Foundation

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Smoking is on course to kill around one billion people in the 21st century,1 and leads among preventable causes of morbidity and mortality. The adult smoking rate in England is now 14.4%, down from 19.3% five years ago, but this still represents 6 million smokers2. Smoking is an important driver of health inequality; more than 25% of routine and manual workers smoke, compared to 10% in the professional and managerial group. The UK government, in its Prevention Green Paper3, has set out an ambition for England to be smoke free, defined in its 2017 Tobacco Control Plan as a smoking rate below 5%, by 2030.

The UK has made important progress in addressing the tobacco epidemic4, through the implementation of policies which include reducing the affordability of tobacco products through taxation, the introduction of standardised packaging and display bans5 as well as by advancing effective smoke free legislation, most recently a ban on smoking in cars with children present6. The Health Secretary has acknowledged that the Smokefree 2030 ambition “is extremely challenging” and will require “bold action”,3 so it is important to consider what additional strategies are needed.

The scale and pace of many tobacco control activities depends on the provision of adequate funding. This has been limited by cuts both to public health funding and to local authority budgets more broadly. A key proposal therefore is to hold the tobacco industry, which makes about £1.5 billion/year profits in the UK, responsible for the harm that it causes and introduce a “polluter pays” levy from tobacco transnationals into a SmokeFree 2030 fund. This would be based on powers that are already established in the National Health Service Act 2006 along the lines of the Pharmaceutical Price Regulation Scheme (PPRS). The PPRS addresses market failure in pharmaceutical pricing by raising money from the industry and is administered by the Department of Health and Social Care. The levy would raise a fixed amount of funding, around £300 million/year, the figure being based on restoring the level of funding for tobacco control to the level prior to 2010 and the amount recommended per capita by the US Centers for Disease Control (CDC)7. The Smokefree 2030 fund would support comprehensive media campaigns, local, regional and national tobacco control, trading standards enforcement and the restoration of the universal provision of effective, evidence-based tobacco dependence treatment. Money would be raised from companies in proportion to their contribution to the combustible tobacco market, and the fund administered without any industry input to ensure that the Government’s WHO FCTC Article 5.3 obligations, which require that the tobacco industry plays no role in the setting or implementing of policy, are maintained8 excluding bogus tobacco industry front organisations9. The US Food and Drug Administration (FDA) User Fee Regime10, which raises money from the tobacco industry is a helpful precedent.

Beyond ensuring a secure source of funding for tobacco control measures, what else needs to be done? Preventing child uptake of smoking is essential to deliver a smoke free future and reduce the risk of future ill health.11 12 Increasing the age of sale from 16 to 18 in 2007 was associated with a fall in child smoking13. A further increase from 18 to 21, by taking the legal purchase of tobacco products completely out of schools, should drive additional reductions, particularly as adolescence is a high risk time for the development of addiction and smoking initiation is much less likely once people are in their twenties. In the US, tobacco 21 policies have been shown to be effective14 and since December 2019 are in place nationwide. Requiring a licence to sell tobacco products which could be removed if retailers breach such rules is also a sensible step to reduce children’s access to tobacco products.5

Increasing controls on advertising mean that pack inserts and cigarettes themselves are the last areas in which the tobacco industry can promote its products. Work in Canada supports mandating health promoting pack inserts which include affirmative messages and links to smoking cessation services15. Likewise, a requirement for “dissuasive cigarettes” which are in unappealing colours or which carry health messages on the cigarette paper should be introduced.15

For clinicians, the obligation remains to ensure that our patients are able to access effective treatment for tobacco dependence16 and plans in the NHS Long Term Plan to deliver the Ottawa Model across the NHS need to be accelerated and extended to primary care. The doubling in the rate of quit attempts by smokers in Greater Manchester since the implementation of properly funded media campaigns, while the rate has stood still in the rest of England, is a useful reminder that in tobacco control the more that is done the better the result4-6 8 12-15.

The political promise has been made and a Smokefree 2030 is essential if the Government is to deliver its manifesto commitment to increase healthy life expectancy by five years by 2035. With political will and engagement across the health and social care system it is also achievable.

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