Association of Directors of Public Health North East

Position Statement on Commercial Determinants of Health

March 2024

Appendix 3 – Tobacco

The scale of the problem	Tobacco is the single most important entirely preventable cause of ill health, disability and death in this country[1], responsible for 64,000 deaths in England a year[2]. No other consumer product kills up to two-thirds of its users[3]. The 2022 independent review on making smoking obsolete[4] found that, if further action on tobacco smoking is not taken, nearly half a million more people will die from smoking by 2030. Smoking causes harm throughout people's lives. It is a major risk factor for poor maternal and infant outcomes[5], significantly increasing the chance of stillbirth and can trigger asthma in children. It leads to people needing care and support on average a decade earlier than they would have otherwise[6], often while still of working age. Smokers lose an average of ten years of life expectancy[7], or around one year for every 4 smoking years. Smoking causes around 1 in 4 of all UK cancer deaths and is responsible for the great majority of lung cancer cases[8]. Smoking is also a major cause of premature heart disease, stroke and heart failure[9] and increases the risk of dementia in the elderly[10]. Tobacco smoking accounts for over 70% of COPD cases in high-income countries[11]. Non-smokers are exposed to second-hand smoke which means that through no choice of their own many come to harm - in particular children, pregnant women, and their babies. The World Health Organisation (2020) has declared the tobacco epidemic as *"one of the biggest public health threats the world has ever faced… All forms of tobacco use are harmful, and there is no safe level of exposure to tobacco."* As a result, smoking puts significant pressure on the NHS. Almost every minute of every day[2] someone is admitted to hospital because of smoking, and up to 75,000 GP appointments could be attributed to smoking each month[12] - equivalent to over 100 appointments every hour. Those who are unemployed, on low incomes or living in areas of deprivation are far more likely to smoke than the general population[2]. Smoking attributable mortality rates are 2.1 times higher in the most deprived local authorities than in the least deprived[2]. Smoking is closely associated with poor mental health[13] and wellbeing. People with mental health conditions die 10 to 20 years earlier with smoking contributing significantly to this[14]. Smokers are also 1.6 times more at risk of dementia[10,] including Alzheimer's and vascular dementia, and 14% of dementia cases can be attributed to smoking internationally[15]. It is estimated that the total costs of smoking in England are over £17 billion[16]. For the North East of England, the overall cost of smoking is £2.5 billion made up of £1.6 billion lost productivity costs, £797.3 million social care costs, £93.7 million in healthcare costs and £12.1 million in fire costs.

Inequalities	Smoking is one of the most important preventable causes of disparities in health and a significant contributor to the gap in life expectancy[17]. For some conditions, such as lung cancer and severe COPD, smoking is the main driver and for others, such as premature CVD, smoking is a major factor. Reducing smoking rates is therefore one of the biggest single health interventions that can be made to level up the nation[18]. Smoking remains a key driver of inequalities and the North East has lost a staggering 113,000 people to smoking since the year 2000 For every death, another 30 people are ill from smoking at any given time. Mortality rates attributed to smoking are 2.1 times higher in the most deprived local authorities than in least deprived local authorities, where more people become addicted when young. Smoking prevalence is much higher in people on lower incomes, unemployed or those experiencing homelessness[19]. The major risks of smoking occur in every ethnic group. Deprived areas are more likely to have lower healthy life expectancy and higher smoking rates. In the least deprived local authority, healthy life expectancy for females is 71 years and smoking prevalence is 2.5%, whereas in the most deprived local authority, healthy life expectancy for females is 17 years lower, at 54 years, and smoking prevalence is over 7 times higher at 19.1%, according to the Public Health Outcomes Framework[20]. NHS pressures from smoking-related diseases are especially high in areas of deprivation. Smoking-related morbidity and NHS activity is concentrated in areas of relative deprivation. The number of smoking attributable hospital admissions per 100,000 is double in the most deprived decile compared to the least deprived. On average, 1 in 11 of all mothers smoked at the time of delivery in 2022 to 2023[21], however this is as high as 1 in 5 in some parts of the country. In 2021 to 2022, 21.1% of pregnant women in the most deprived area smoked at time of delivery, compared to 5.6% in the least deprived area[2]. Pregnant women living in areas where there is high smoking prevalence are also more likely to be exposed to second-hand smoke. This leads to babies having smoking-related adverse birth outcomes. Based on 2022 estimates, the average smoker spends around £47 a week on tobacco, which is around £2,450 a year[22]. On average, stopping smoking would have increased disposable incomes by 9% in 2019, ranging from 6.4% in London to 11.4% in the North East[23].
Examples of tobacco industry tactics	In the 1950s, independent scientific research began to definitively establish the link between smoking and cancer. Since then, the tobacco industry has used a wide range of strategies and tactics designed to keep people using its products and disrupt efforts to protect public health. This can involve attempts to block, weaken or delay proposed regulation, or to undermine or circumvent existing regulation.

	There is general consensus in the global tobacco control community, and among parties to the World Health Organization Framework Convention on Tobacco Control (WHO FCTC), that tobacco industry interference is the greatest barrier to progress in reducing tobacco's deadly toll. Article 5.3 of the FCTC obliges countries to protect their health policies from the "vested interests of the tobacco industry". The Policy Dystopia Model (PDM), developed by the Tobacco Control Research Group and published in 2016, identifies several broad strategies used by the industry to achieve its goals. In addition to lobbying and legal threats, tobacco companies use the following strategies: • **Information management** – to create and disseminate industry-friendly evidence while attacking public health evidence. • **Reputation management** – to rehabilitate the reputation of the industry while attacking public health advocates, researchers and organisations. • **Coalition management** – to build a tobacco industry coalition while fragmenting the public health coalition. Tobacco companies also use the more direct commercial strategies of marketing, sponsorship and other forms of promotion such as Corporate Social Responsibility (CSR). They have complex strategies around taxation and product pricing. They have also been found to be complicit in the illicit tobacco trade. Company strategies overlap and tactics are often combined. Ultimately, all strategies and tactics serve the same goal – to maximise profits. The key tactics are summarised below, with links to further information on Tobacco Tactics. 1. Legal threats and actions 2. Intimidation 3. Lobbying and Influencing Policy 4. Claiming a Public Health Role 5. Support Through Allies 6. Controversial Marketing 7. Corporate Social Responsibility 8. Involvement in Illicit Tobacco
Supporting evidence	The FCTC was the world's first global health treaty, adopted in May 2003 and ratified by the UK in 2004. Article 5.3 of the FCTC requires that "in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law". The guidelines recommend that Parties to the FCTC, including the UK: • Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties' tobacco control policies.

	• Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur. • Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry. • Avoid conflicts of interest for government officials and employees. • Require that information provided by the tobacco industry be transparent and accurate. • Denormalize and, to the extent possible, regulate activities described as "socially responsible" by the tobacco industry, including but not limited to activities described as "corporate social responsibility". • Do not give preferential treatment to the tobacco industry. ASH has a Local Government Declaration on Tobacco Control[24] which the majority of North East councils have signed up to and there is also a Smokefree NHS Pledge which all the North East NHS Trusts have now endorsed. The North East has its own clear declaration for a Smokefree Future[25] which was launched in September 2023 and was led by Fresh along with the Association of Directors of Public Health North East and the North East and North Cumbria NHS Integrated Care Board.
Public perceptions	There is strong public support for a range of policy measures that would reduce smoking further. People who smoke largely do not want their own children or future generations to get addicted to smoking. The annual ASH Smokefree public opinion survey[26] provides a regional breakdown of key metrics to track support. In 2023, North East public support for a range of tobacco control measures were as follows:
What works to reduce tobacco	The evidence base for how to address tobacco goes back to 1962 with the publication of the Royal College of Physicians "Smoking and Health" report. However, it was not until the 1990s that definitive action started to be taken.

	NE
Government target of 5% or fewer people smoking by 2030	78%
Tobacco manufacturers to pay a levy for measures to help smokers quit and prevent young people from starting	79%
Businesses to require a valid licence to sell tobacco which can be removed for under age sales	86%
Raise the age of sale for tobacco from 18-21	69%
All Government health policy should be protected from the influence of the tobacco industry	78%
Increased Government investment in public education campaigns on smoking aimed at adults and children	72%
Cigarette packs to include quitting inserts	69%
Smoking banned in the outdoor seating areas of all restaurants, pubs and cafes	64%

related harm	The WHO offers a useful framework for evidence based activity called MPOWER: The MPOWER package consists a set of six key and most effective strategies for fighting the global tobacco epidemic: 1) Monitoring tobacco consumption and the effectiveness of preventive measures 2) Protect people from tobacco smoke 3) Offer help to quit tobacco use 4) Warn about the dangers of tobacco 5) Enforce bans on tobacco advertising, promotion and sponsorship 6) Raise taxes on tobacco. It is proven that implementation of these strategies effectively decreases tobacco use. As demonstrated by Fresh[27], the North East regional tobacco control programme, evidence is clear that focussing at the level of the individual is not enough but that a comprehensive social norm change approach combined with providing individual information and support is more efficient, effective and cost effective at reducing smoking prevalence. There is recognition that there is no magic solution and multiple strands of activity and policy focus will be required. Fresh believes that the tobacco industries' marketing and promotional practices to recruit and maintain high levels of uptake and addiction and their attacks on effective policy must be exposed and countered. The goal is to change the broad social norms around the use of tobacco and to indirectly influence current and potential future tobacco users on a population level by creating a social environment and legal climate in which tobacco use becomes less desirable, less acceptable, less affordable and less accessible and the possibility of quitting is positioned inside their lives. In the North East, through Fresh working in partnership with localities, a comprehensive eight key strand approach has been implemented: 1. Building infrastructure, skills and capacity for local tobacco control delivery 2. Advocacy for evidence based policies and legislation to achieve a Smokefree 2030 and to minimise influence of tobacco industry 3. Reducing exposure to tobacco smoke and normalising smokefree environments 4. Year round media, communications and education to increase quitting at population level and increase awareness on a broad range of tobacco issues 5. Supporting smokers to stop and stay stopped and also to reduce harm from tobacco 6. Raise price and reduce the illicit trade 7. Tobacco and nicotine regulation including reducing tobacco promotion 8. Data, research and public opinion In 2005 smoking rates in the North East were the highest in England: 29% compared to the 25% average for the nation. Since then, smoking rates have fallen fastest in the northeast and in 2022 smoking rates for smokers

	in routine and manual occupations were lower than the average for England. It is clear though that there is still some way to go to get down to 5% or less, and also noting smoking rates are higher in some other groups. This is why the need for continued international, national, regional and local focus on addressing the key driver of health inequalities is vital.
Tobacco principles	1. The tobacco industry and the organisations it funds should not influence health policy, health services or education/awareness-raising initiatives, particularly those aimed at young people. 2. Children and young people and people from lower socio-economic groups are priority groups to protect from the tactics of the industry. 3. Despite advertising bans, the tobacco industry continues to find ways to promote its uniquely lethal products – local vigilance is needed to tackle evolving forms of promotion 4. Reframing the narrative from personal responsibility to the actions of the tobacco industry is a legitimate intervention

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