Pecyn dogfennau cyhoeddus

Is-bwyllgorau ar Reoliadau Mangreoedd etc. Di-fwg (Cymru) (Diwygio) 2012

Lleoliad:
Ystafell Bwyllgora 3 - Senedd

Dyddiad:
Dydd Mawrth, 19 Chwefror 2013

Amser:
09:00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:

Lara Date
Clerc y Pwyllgor
029 2082 1821

Agenda

1. Cyflwyniad, ymddiheuriadau a dirprwyon (09.00)

2. Rheoliadau Mangreoedd etc. Di-fwg (Cymru) (Diwygio) 2012 - Sesiwn dystiolaeth 5 (09.00 - 09.30) (Tudalennau 1 - 12)

Coleg Brenhinol y Ffisigwyr
SFP(4)-03-13 - Papur 1

- Dr Keir Lewis FRCP, Meddyg ymgynghorol ym maes Meddygaeth Anadlu

Cymdeithas Feddygol Prydain
SFP(4)-03-13 - Papur 2

- Dr Tony Calland, Cadeirydd adran foeseg y BMA

3. Rheoliadau Mangreoedd etc. Di-fwg (Cymru) (Diwygio) 2012 - Sesiwn dystiolaeth 6 (09.30 - 10.15) (Tudalennau 13 - 21)

Asiantaeth Ffilm Cymru
SFP(4)-03-13 - Papur 3

- Pauline Burt, Prif Weithredwr

4. Rheoliadau Mangreoedd etc. Di-fwg (Cymru) (Diwygio) 2012 - Sesiwn dystiolaeth 7 (10.15 - 10.45) (Tudalennau 22 - 36)

Cymdeithas Llywodraeth Leol Cymru
SFP(4)-03-13 - Papur 4

- Bethan Jones, Rheolwr Gweithredol, Diogelwch Cyhoeddus & Tai Sector Preifat, Nghyngor Caerdydd

Sefydliad Siartredig Iechyd yr Amgylchedd
SFP(4)-03-13 - Papur 5

- Julie Barratt, Cyfarwyddwr

5. Cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y canlynol: (10.45)
Eitem 6

6. Y prif faterion a'r camau nesaf (10.45 - 11.00)

7. Papurau i'w nodi

SFP(4)-03-13 - Papur 6 - Tystiolaeth ysgrifenedig ychwanegol gan ASH Cymru yn dilyn y cyfarfod ar 22 Ionawr (Tudalen 37)

SFP(4)-03-13 - Papur 7 - Tystiolaeth ysgrifenedig ychwanegol gan Equity yn dilyn cyfarfod a gynhaliwyd ar 29 Ionawr. (Tudalennau 38 - 45)

SFP(4)-03-13 - Papur 8 a 9 - Tystiolaeth ysgrifenedig ychwanegol gan Iechyd Cyhoeddus Cymru yn dilyn cyfarfod a gynhaliwyd ar 29 Ionawr (Tudalennau 46 - 107)

Sub Committees on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

Response from the Royal College of Physicians (RCP)

16 January 2013

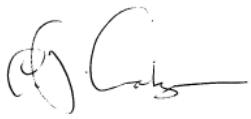
Dear Sir or Madam

Re: The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 27,500 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP is grateful for the opportunity to respond to the above inquiry being conducted by the Enterprise and Business Sub-Committee and the Health and Social Care Sub-Committee. At this stage, we would like to re-submit the comments sent in reply to the earlier consultation on this issue. To that end, please find attached a letter dated 15 March 2012 that sets out the views of both the RCP and the UK Centre for Tobacco Control Studies (UKCTCS).

Yours faithfully



Dr Patrick Cadigan
Registrar

Enclosure: RCP/UKCTCS response to Welsh Government consultation – dated 15 March 2012

15 March 2012

Dear Sir or Madam

Re: Welsh Government - The Smoke-Free Premises etc. (Wales) (Amendment) Regulations 2012

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 26,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

I write on behalf of the RCP and the UK Centre for Tobacco Control Studies (UKCTCS). We are grateful for the opportunity to respond to the above consultation and would like to make the following joint submission.

We understand and sympathise with the desire to support the film and television production industry in Wales, and acknowledge the difficulty that the English exemption must create. However, the concern is that allowing this exemption will result in passive exposure of staff involved in the production to smoke, and may result in actors/actresses who do not smoke being pressured into active smoking for the purposes of the production.

Smoking imagery in film and television is also a widely recognised driver of adolescent experimentation and uptake of smoking, so the impacts of this policy change, if it results in more smoking depictions in the media, are substantially greater than those to the production staff involved.

Furthermore our own analyses of tobacco content in films popular in the UK indicates that use of tobacco remains high, and that branding is particularly common in UK productions (see attached pdf). Equivalent analyses of UK TV programming (in preparation for publication) suggest that content in UK television is much lower than in film, but remains a persistent problem in soaps and reality shows, and rarely with obvious relevance to artistic integrity – as for example in the attached still photo, featuring Marlboro branding, from the Gavin and Stacey Christmas Special.

Our concern is therefore that this amendment will signal a green light for much more widespread use of smoking in productions. We therefore counsel against the amendment. If the government chooses to support it, then we would suggest that the second criterion is amended to require that tobacco content is *strongly justified* rather than simply appropriate.

Yours faithfully

Dr Patrick Cadigan
Registrar

Encl. Lyons Thorax.PDF

Lyons Thorax 2010.pdf

Tobacco and tobacco branding in films most popular in the UK from 1989 to 2008

Ailsa Lyons, Ann McNeill, Yilu Chen, John Britton

See Editorial, p 377

UK Centre for Tobacco Control Studies, Division of Epidemiology and Public Health, School of Community Health Sciences, University of Nottingham, Nottingham, UK

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ABSTRACT

Background Tobacco promotion is now tightly restricted in the UK and many other countries, but tobacco imagery including brand appearances in the media remain potentially powerful drivers of smoking uptake among children and young people. The extent to which tobacco imagery and specific products have appeared in the most popular films viewed in the UK over 20 years has been measured, in relation to year of release, the age certification allocated to the film by the British Board of Film Classification (BBFC), country of origin and other characteristics.

Methods Occurrence of tobacco intervals (tobacco use, implied use or appearance of smoking paraphernalia) and brand appearances were measured by 5 min interval coding in the 15 most commercially successful films in the UK each year from 1989 to 2008.

Results Tobacco intervals occurred in 70% of all films. Over half (56%) of those that contained tobacco intervals were rated by the BBFC as suitable for viewing by children aged <15, and 92% for people aged <18. Tobacco interval appearances fell by ~80% over the study period, but persisted in films in all BBFC categories. Brand appearances were nearly twice as likely to occur in films originating wholly or in part from the UK (UK films). Specific brands, particularly Marlboro and Silk Cut, appeared in 9% of all films, and most brand appearances (39%) were in films with BBFC 15 classification.

Conclusions Tobacco imagery in the most popular films shown in the UK has declined substantially over the past 20 years but continues to occur, particularly in UK films, and predominantly in films categorised as suitable for viewing by children and young people. Specific brand appearances are now rare but occur repeatedly in some films. The BBFC is not currently protecting children and young people from exposure to tobacco imagery in film.

INTRODUCTION

Tobacco use causes nearly 5 million deaths worldwide each year,[1] more than any other avoidable cause, with almost half of all tobacco-related death in the UK being the result of respiratory diseases, predominantly lung cancer and chronic obstructive pulmonary disease (COPD).[2] With 85% of all lung cancer deaths and >80% of all COPD deaths in England attributable to smoking,[2] preventing smoking is therefore a paramount public health priority. Since the majority of smokers become addicted in their teens,[3] measures to prevent exposure of children and young people to tobacco products and positive smoking role models are especially important. Whilst tobacco advertising and sponsorship are now heavily restricted in the UK[4] and many other countries,[5] exposure to tobacco imagery and brand appearances in the media has not been controlled.

It is well established that tobacco companies have used films to promote tobacco products for many years,[6] and since at least 1927.[7] Adolescents who view tobacco use in film and who admire leading actors and actresses whose characters smoke in films are more likely to smoke themselves, and are more likely to view smoking favourably.[8–10] A study from New Zealand reported that adolescents felt that smoking in films was highly prevalent and believed it to be a true representation of reality.[11] These young people perceived smoking prevalence amongst their peers and adults to be higher than it was.[11] Beliefs like these can assist in the social normalisation of smoking, which in turn can promote youth initiation.[12] An exposure–response relationship between smoking imagery in films and subsequent adolescent smoking behaviour has also been demonstrated.[8 13] Given these strong associations and that uptake of smoking has considerable future health implications, exposure to tobacco imagery including branding might be expected to be an important determinant of age classification of films.

This study was therefore carried out to characterise the occurrence of tobacco use and tobacco branding in the most popular films shown in UK cinemas over the past 20 years in relation to year of release, the age certification allocated to the film by the British Board of Film Classification (BBFC), country of origin and other characteristics.

METHODS

We used listings of the most commercially successful films based on gross UK cinema box office takings data provided by the UK Film Council (UKFC)[14] to identify the 15 most popular films viewed in the UK for each year between 1989, the first year that UK-specific figures were collected, and 2008. We obtained DVD copies of the 300 sampled films from rental providers, and viewed and coded them in order of availability. For each film we used DVD package labels, the film credits, the Internet Movie Database (IMDb)[15] and the UKFC[14] to ascertain year of release, run time, age rating of film (as rated by the BBFC,[16] see table 1 for detail) and country of origin. Film genre was determined from the IMDb categories[15]; where more than one category was listed, the most appropriate single genre was determined at the researcher's discretion.

We developed a coding scheme for all appearances of tobacco or tobacco-related products (tobacco intervals) in these films from previously reported methods,[6 18–26] including the following

Table 1 British Board of Film Classification (BBFC)* age-rated restriction categories for films viewed in UK cinemas

Category	Description
Universal (U)	Suitable for all audiences
Parent Guidance (PG)	General viewing, but some scenes may be unsuitable for young children
12/12A†	(12) Suitable for 12 years and older, (12A) under 12s must be accompanied by an adult
15	Suitable for 15 years and over
18	Suitable for 18 years and older

*The BBFC is the independent, non-government body funded through fees from films submitted, which classifies films into age categories based on each film's suitability for viewing by the audience to advise local authorities, who license cinemas under the Licensing Act 2003.[17]
†12- and 12A-rated films have been amalgamated since the 12A film rating replaced the 12 rating for cinema film viewing in 2002.

categories: tobacco use, the consumption of any tobacco product on screen by any character; tobacco paraphernalia, the presence on screen of tobacco or related materials (such as cigarette packets, matches, lighters, ashtrays); and inferred tobacco use, the presence of a verbal or non-verbal inference (such as a comment on smoking, leaving a scene with a packet of cigarettes and lighter, or a smoky atmosphere). Brand appearances were defined as the occurrence of branded tobacco products, or of advertisements, logos or other unambiguous brand appearances. We used 5 min interval coding, which has previously been shown to be a sensitive means of detecting relative changes in behaviour levels[26] and used in studies exploring tobacco use in film.[19–21 23 27] Tobacco use, tobacco paraphernalia and inferred tobacco use were coded as having occurred if observed at least once in any 5 min coding period. Multiple occurrences in the same category in the same 5 min period were counted as a single event; an occurrence that crossed a transition from one 5 min interval to the next was recorded as two events. Brand appearances were coded in the same way, except that when more than one brand appeared in a single 5 min interval, the total number and identity of different brands observed was recorded. Where identical branding of identical products (or advert, merchandise, etc) occurred in the same 5 min interval they were counted once.

ANALYSIS

Data were entered into Microsoft Office Excel[28] as the films were viewed, and analysed using Excel and STATA 10.[29] The total number of film hours coded, and the mean, SD and range of lengths were obtained using summary statistics in STATA. Tobacco use, tobacco paraphernalia and inferred tobacco use occurrences per hour for each film were calculated by dividing the sum of the tobacco episodes in each category in each film by the length of the film. The mean rate of occurrences in all films for each year was calculated by a similar method, as were total and mean figures for all categories of tobacco intervals combined. Trends of the rate of intervals per hour over time, occurrence of tobacco intervals between different BBFC categories, genres, country of origin and other comparisons were made using standard parametric (linear regression) or non-parametric methods (χ^2 test), as appropriate.

RESULTS

The 300 films totalled 582.8 h (34 969 min) of film time, with a mean (SD) of 116.7 (24.7) min, and a range from 78 (*Inspector Gadget*) to 224 (*Dances With Wolves*) minutes. The BBFC U, PG, 12/12A, 15 and 18 categories contained 15, 27, 26, 26 and 6% respectively, of films. Most films (94%) were produced by or in partnership with US producers, and 68% were produced solely from the US. UK producers were involved in 20% of films, and were solely responsible for 3%. Other countries were involved in producing 19% of films, but only one film, *Muriel's Wedding*, had no UK or USA involvement. The 15 most popular films typically accounted for ~50% of each year's gross UK cinema box office takings, based on yearly box office takings.

There were a total of 6994 intervals of 5 min (mean 23 per film, range 16–45) in the films. Tobacco intervals occurred in 1151 intervals (17% of the total) and in 210 (70%) films. The respective proportions of films containing tobacco intervals in each of the BBFC U (15/46), PG (49/80), 12/12A (59/77), 15 (69/78) and 18(16/19) categories were 33, 61, 77, 88 and 84%, respectively. Tobacco intervals occurred in 68% (192/281) of all youth-rated films (BBFC 15 and below). In the most popular films over the past 5 years (2004–8), 44% (33/75) contained at least one interval of tobacco; BBFC U, 19% (3/16); PG, 28% (5/18); 12/12A, 57% (16/28); 15, 73% (8/11); and 18, 50% (1/2). Of those films of 2004–8 containing tobacco intervals, 97% (32/33) were BBFC 15 and lower, and 73% (24/33) were deemed suitable for those aged under 15 years old. Tobacco interval occurrence, in total or any category except branding, was unrelated to country of origin or genre of film. The mean rate of occurrence of all tobacco intervals fell substantially and significantly ($p<0.05$) between 1989 and 2008, from 3.5 to 0.6 per hour; similar trends occurred for all categories of tobacco interval (figure 1) (in each case $p<0.05$, except for branding where $p=0.315$). The occurrence of tobacco intervals in films also fell substantially within all BBFC categories (figure 2).

Tobacco use, predominantly cigarette smoking, occurred in 176 films (59% of all films); 92% (162/176) of the films containing tobacco use were in BBFC 15 and lower categories, and more than half (56%, (98/176)) in BBFC 12/12A and lower categories. Tobacco use did not occur in any U-rated film released after 1999 (figure 2). Tobacco paraphernalia appeared in 180 (60% of all films) films, typically comprising ashtrays (alone or with other paraphernalia in 64% (116/180) of films containing paraphernalia episodes), cigarette or other tobacco packs (62%, 112/180), lighters (49%, 89/180) and matches (26%, 46/180). Inferred tobacco use occurred in 223 episodes in 94 films (31% of all films), typically as non-verbal inferences (74%, 70/94). Brand appearances occurred 48 times in 28 (9% of all films) films, of which 10 (36%, 10/28) had UK production involvement; this proportion was significantly higher than that of all films with US production involvement (20%; χ^2 $p<0.05$). Brand appearances were most common in BBFC category 15 (39% of appearances were in this category), and 82% were certified as suitable for viewing by those under 18. The film with the highest number of branded tobacco intervals was *Pulp Fiction* (BBFC category 18), with brand appearances in 9 out of 31 intervals, though the predominant brand involved was fictional ('Red Apple') and available only from a movie prop supplier.[30] The largest number of different brands to appear in any film was 12, in *Bridget Jones's Diary* (BBFC category 15).

Individual brand intervals occurred a total of 74 times, with Marlboro (21 episodes in 13 films) and Silk Cut (14 episodes in 4 films) being the most frequent (figure 3). Details of appearance by film for these brands are presented in table 2. Marlboro occurred in all BBFC categories except U, and with no relationship to country of origin; six Marlboro appearances were in one film, *Terminator 3: Rise of the Machines*, all within one scene in a US petrol station. Silk Cut appearances all occurred between 2001 and 2004 in films set in the UK and made with UK

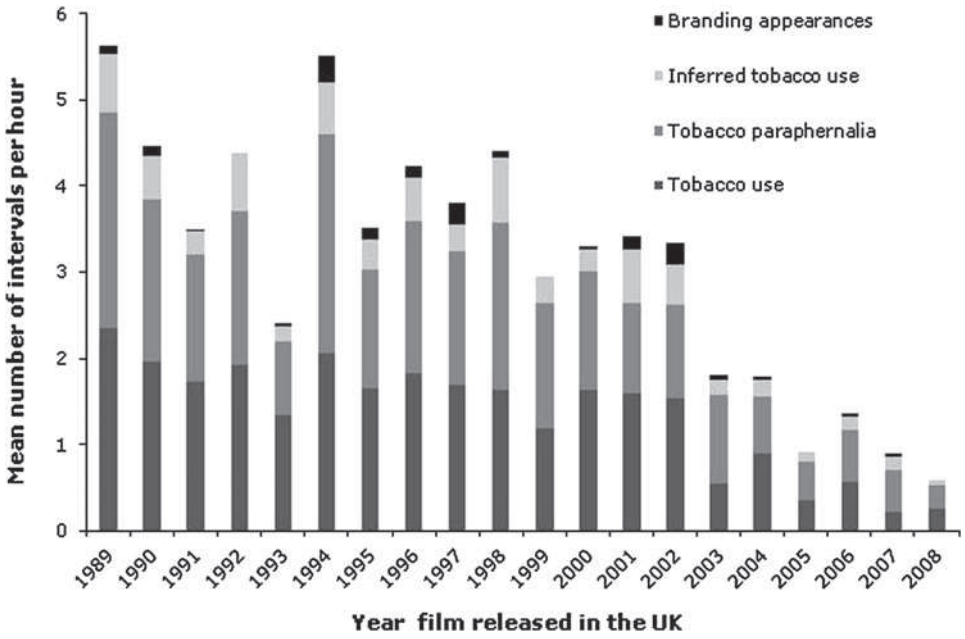

Figure 1 Trends in mean tobacco intervals per hour of film, 1989—2008.

production involvement. The most Silk Cut brand appearances were in *Bridget Jones's Diary* and *About a Boy*, both of which were categorised as suitable for youth viewing (BBFC categories 15 and 12, respectively). The lead character in *Bridget Jones's Diary* (Bridget Jones) smoked Silk Cut regularly throughout the film, as in the novel on which the film was based.[31] In *About a Boy* the main character (Will) also smoked Silk Cut regularly throughout the duration of the film, mostly in the presence of a 12-year-old boy. In the novel on which this film was based,[32] Will smoked infrequently and no brand was identified.

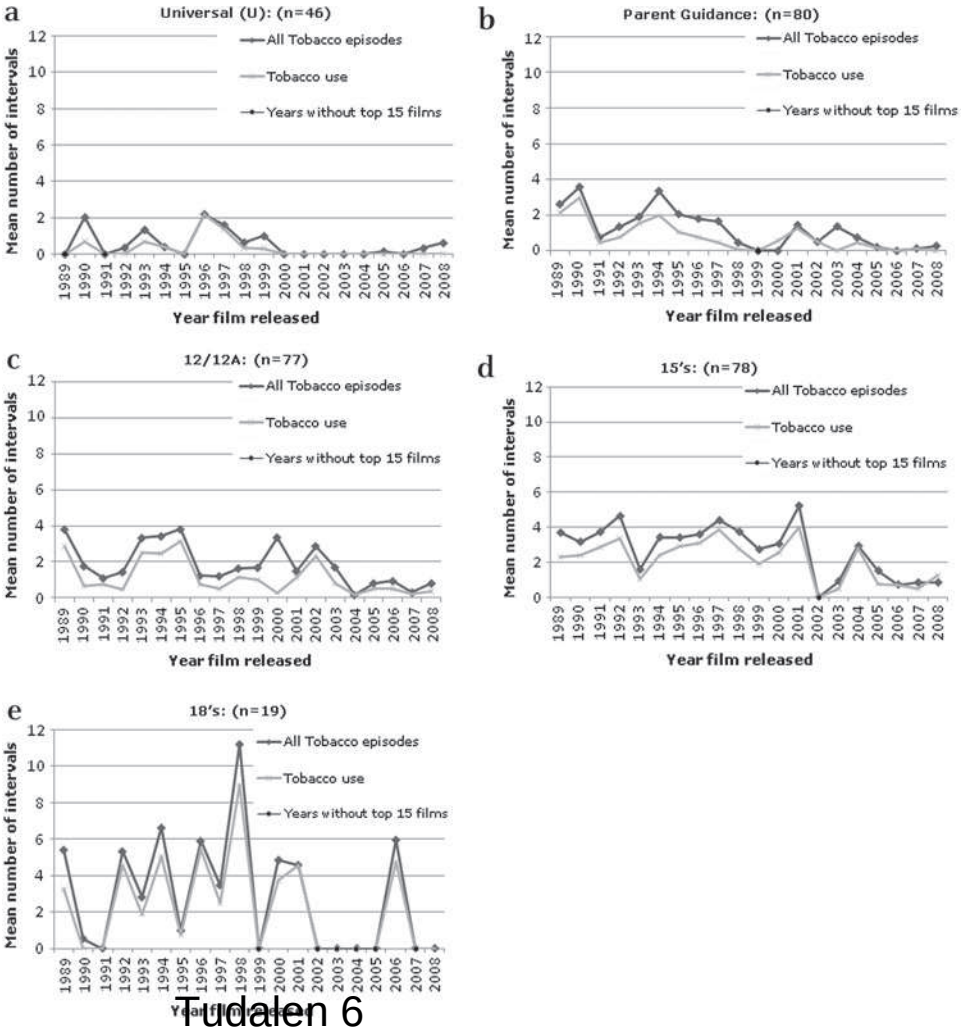

Figure 2 Trends in all tobacco intervals and tobacco use intervals per hour per day by British Board of Film Classification (BBFC) category (all figures expressed as means).

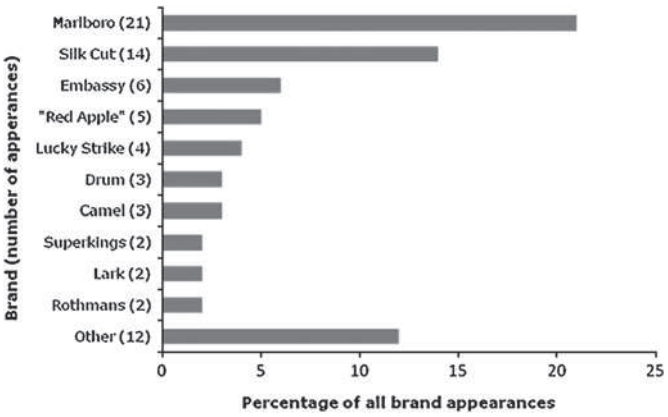

Figure 3 Individual brand intervals in film as percentage of all (74) appearances.

DISCUSSION

Exposure to tobacco smoking and other forms of tobacco imagery in film is a potent driver of youth and adult smoking,[8–10] with major consequences for the subsequent health of the smoker such as lung cancer, COPD and pneumonia.[2] The serious potential hazard represented by tobacco exposure should also be a determinant of film classification, to prevent unnecessary or inappropriate exposure of children and young people to smoking role models. The BBFC guidelines on classification in relation to smoking state only that where '[smoking and tobacco use] feature to a significant extent in works which appeal to children, this will normally be indicated in the Consumer Advice and/or Extended Classification Information.' (p. 12).[33] Tobacco imagery appears not to have any considerable bearing on the BBFC age classification that a film receives. This study shows that appearances of all types of tobacco intervals in films viewed in the UK has declined substantially over the past 20 years, but that appearances remain common in most of the commercially successful films, and persist to some extent in films in all BBFC categories. It also shows that about two-thirds of films including tobacco intervals are currently classified by the BBFC as suitable for viewing by people aged <18, and over half (61%) by people aged <15. Over the past 5 years (2004–8) the proportion of films containing tobacco deemed suitable for those aged under 18 to watch has increased to 97%.

We found that smoking imagery is also more likely to occur in films that originate wholly or partly in the UK. The specific, repeated occurrence of some brands of cigarette in some films raises the possibility that product placement by tobacco companies is still occurring.

Our study was limited, for logistic reasons, to the top 15 most popular films each year, but, as these typically represent ~50% or more of total UK annual box office takings, they are likely to reflect the predominant pattern of tobacco exposure in films seen in UK cinemas each year. Coding the occurrence of any behaviour in films is difficult and there is no standardised method; we used an approach that has been widely used in film analysis,[19 21 23 27] is reliable,[19 23 27] and has been validated as a measure to detect relative changes in levels of behaviour.[34] The 5 min interval method we used was the same as used by several other researchers,[19 23 27 35] though other approaches, such as coding scene changes as separate incidents with a 5 min interval approach,[21] or using 1 min intervals[18] or separate scenes to define intervals[20 26] or methods of continuous measurement,[22 24 25] have been described. Like Everett *et al*[23] we divided the number of 5 min intervals by the length of the film to take into consideration the differences in film lengths. The different approaches have relative strengths and weaknesses, but the main impact of their differences will be in the quantification of occurrence frequency. The presence of tobacco intervals, and their relative frequency, is measured by all approaches.

Our finding that tobacco use, imagery and brand appearances are commonplace in films reflects the findings of several previous studies.[18–24 26 35 36] However, ours is the first study to look at trends over time in appearances, including a wide range of tobacco paraphernalia and inference, and specific brand appearances, in the films most popular with UK audiences. Glantz *et al*[35] limited their definition of 'tobacco usage' to include only smoking or the appearance of ashtrays or advertisements, and Omidvari *et al*[22] only actual smoking. Escamilla *et al*[27] included other paraphernalia (eg, cigarettes), merchandise and advertising in their investigations. Brand appearances[24 25] have previously been defined similarly to the definition employed here. Our finding that 70% of the films viewed contained at least one tobacco interval or brand appearance is consistent with, though slightly lower than, estimates from other studies, most of which explored earlier time periods[18–21] in which our data show occurrence to have been higher. The difference in results is likely to be explained by the differing time periods investigated.

There is little consensus in previous studies as to whether tobacco and related imagery in film has increased,[21] stayed the same[19] or decreased over time.[18] Our study confirms a fall in the frequency of tobacco intervals in the most popular films viewed in the UK, and that exposure to tobacco use (but not to other imagery) in U-rated films has ceased since 2000. This is both important and encouraging from the point of view of public health, and in large part possibly reflects the impact of the 1998 Master Settlement Agreement[37] in the USA in 1998, in which the tobacco industry agreed to curtail or cease certain marketing practices in the USA, and after which appearances of tobacco intervals in a study of US films fell by about half.[24] However, this and the reported decline in brand appearances over a similar period[25] may have affected predominantly adult-restricted films (BBFC 18).[24] Others[36] suggest this may be the result of several factors working together (including a reduction overall in film production, and a producer–distributor shift away from adult-rated films). Although the number of brand appearances in our study was small, our other findings suggest that the decline in appearances in general has affected all films; brand appearances still persist in films rated suitable for viewing by children and young people. Titus *et al*[36] also found brand appearances persisting in films, and suggest that they may actually be increasing.

Previous research from the USA on individual brand appearances has identified Marlboro to be the most common brand,[24 25 36] as in the present study, and this perhaps reflects the fact that Marlboro is the market leader in the USA, accounting for 42.4% of sales.[38] However Silk Cut holds only 5.2% of the UK market[39] and does not have a market share in the USA, so whilst it is not surprising that the brand did not feature in any American film, the strong brand prominence of Silk Cut in two UK films appears disproportionate. Whilst it can be argued that use of Silk Cut was accurate brand translation from book to film in *Bridget Jones's Diary*, that argument does not justify the brand prominence in *About a Boy*.

BBFC classification guidelines do not directly refer to tobacco use under the suitability criteria for certifying ratings of films submitted, but do state in U and PG category guidance that films receiving these certifications will show 'No potentially dangerous behaviour which young children are likely to copy' [33]. No reference to tobacco use, smoking or imitable

Table 2 Films containing the most frequently depicted brands (Marlboro and Silk Cut), by year of UK release, country of origin, British Board of Film Classification (BBFC) certification and number of appearances:

Title	Release year	Country of origin	BBFC rating	Number of appearances*
Marlboro (21 appearances)				
See No Evil Hear No Evil	1989	USA	15	1
The Commitments	1991	Ireland/UK/USA	15	1
Pulp Fiction	1994	USA	18	2
Interview With the Vampire	1995	USA	18	1
Stargate	1995	France/USA	PG	2
Muriel's Wedding	1995	Australia/France	15	1
Men in Black	1997	USA	PG	1
Bean	1997	UK/USA	PG	1
Sleepers	1997	USA	15	1
Sliding Doors	1998	UK/USA	15	1
Men in Black 2	2002	USA	PG	2
Terminator 3: Rise of the Machines	2003	USA/Germany/UK	12A	6
The Simpson's Movie	2007	USA	PG	1
Silk Cut (14 appearances)				
Trainspotting	1996	UK	18	1
Bridget Jones's Diary	2000	UK/France	15	6
About a Boy	2002	USA/UK/France/Germany	12	6
Bridget Jones: The Edge of Reason	2004	UK/France/Germany/Ireland/USA	15	1

*Based on the number of 5 min intervals where branding appears. Where additional forms of the same brand name (cigarettes, advert, billboard, etc) occurred in the same 5 min interval the additional appearances were counted separately.

behaviour is mentioned in either of the other youth-rated age categories (BBFC 12/12A or 15). Given that the BBFC refers specifically to use of drugs, violence, bad language and sex in official guidelines (including strict limitations in youth-rated films), it is surprising, given the extent of the harm caused by smoking and other tobacco use, that these guidelines do not include tobacco.

Most adult smokers first become addicted in their teens[3] and predominantly do so for psychosocial reasons[40] such as perceiving it as a sought-after adult behaviour, or as being rebellious. Direct advertising promotes smoking initiation by young people,[41] and predicts established smoking in young adulthood.[42] Furthermore, research has linked the presence of tobacco on screen to smoking initiation among young people,[8 9 43 44] increased positive attitudes towards smoking[45] and the reinforcement of normative perceptions regarding smoking. On these grounds, some have called for films containing tobacco imagery to be automatically rated for adult viewing only,[36 46–48] or for antitobacco adverts to be screened before films containing tobacco and for brand identification to be prohibited.[49] It has been argued that depiction of smoking in films should continue in the interests of factual accuracy and freedom of expression,[48] yet tobacco depicted in films is rarely factually accurate.[12] However, these considerations are not mutually exclusive from the need to protect children and young people from imagery, which can easily be achieved by more rational application of BBFC classification, such as ensuring that smoking and other tobacco use be excluded from all youth-rated films (BBFC U, PG, 12/12A, and 15), except where an actual historical figure is being represented or where the harms associated with smoking are being shown.[12] Specific brand exposure can also be avoided by the use of fictional brands, as in the case of 'Red Apple'.

Thus, although smoking imagery and branding images in the most popular films have become substantially less common over the past 20 years, it is apparent that children and young people watching films in the UK are still exposed to frequent and at times specifically branded tobacco imagery, particularly in films originating from the UK. More consistent application of BBFC guidance by the BBFC could dramatically reduce this exposure, and hence protect children and young people from damaging imagery and encourage film makers to avoid tobacco imagery in films intended for younger audiences, without compromising artistic freedoms or factual accuracy.

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Competing interests None.

Provenance and peer review Not commissioned; externally peer reviewed.

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Sub Committees on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

Response from the British Medical Association Cymru / Wales

INTRODUCTION

BMA Cymru Wales is pleased to provide evidence to the National Assembly for Wales's Enterprise and Business Committee and Health and Social Care Committee joint sub-committee on the inquiry into the Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012.

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of almost 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, who speak for doctors at home and abroad. It is also an independent trade union. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

Is there a commercial need for this amendment to exempt performers from smoke-free requirements?

No.

We are proud of the success and strength of the various creative industries in Wales, and the role they play in representing Wales to world-wide audiences. We appreciate the large contribution these industries make to the Welsh economy.

However, we feel that an exemption for performers from Wales' flagship smoke free regulations will do nothing to contribute to this already well established industry or to the positive image of Wales as a nation that prides itself it promoting positive public health measures.

Surely the creative industries can replicate the smoking of tobacco products in their productions, to minimal costs, in the same way they do with other scenes – such as drug taking, sex, gunshot wounds or being involved in an accident / explosion - where actors are not required to actually carry out these actions or to put themselves at risk.

Under the amendment, actors and production staff smoking regularly as part of their work run the risk of becoming a regular smoker given the addictiveness of tobacco products, and should be afforded the same public health protection as all other individuals in employment.

There is also the risk that allowing this exemption will increase the incidences of smoking scenes in TV and films in Wales, this has been proven to have a significant impact on children and young people. We recommend reading the BMA 2008 report entitled 'Forever Cool: the influence of smoking imagery on young people'. **Insert reference**

Forever Cool considers the effect of smoking imagery on young people. It begins by examining trends in smoking prevalence and initiation, goes on to review the different forms of pro-smoking imagery and the evidence for how they can affect behaviours and attitudes among young people.

It concludes by exploring effective ways of reducing young people's exposure to positive images of smoking – and increasing their exposure to positive images of health.

Will this amendment achieve its aim of supporting the television and film industry in Wales?

As above, no.

We do not agree that productions / the filming of scenes containing smoking will be forced to move to be filmed in England unless this amendment is implemented. In addition, we are not aware of any evidence to show that the film and television industries will suffer as a result of this exemption not going forward.

There are other ways that the Welsh Government can seek to further support or promote this already attractive and growing industry.

We would think that other industries – such as the pub industry - could equally claim to have a commercial in this way.

Is there sufficient clarity about the circumstances in which the exemption applies?

No.

As we pointed out in our response to the Welsh Governments previous consultation - we are concerned about the interpretation of 'artistic integrity', as surely this would always be a very subjective interpretation. Whether smoking is necessary for the performance is a matter of personal opinion and would be impossible to subject to external checks or balances.

This term leaves itself open to dispute, and also no doubt to legal challenge.

How can this be adequately policed and what is the cost of attempting to do so for local authorities? We also ask what guarantee there is that smoking will only take place in the final take – this seems totally undeliverable as how can anyone predict what take will be the final one?

Do the conditions offer adequate protection to other performers, production staff and members of the public?

No.

The Welsh Governments Tobacco Control Delivery Plan has four Action Areas. A major one of these areas is 'reducing exposure to second hand smoke'. This proposed exemption represents a significant contradiction in the Welsh Governments approach and undermines Wales's reputation as a leader in bringing forward innovative tobacco control measures. On the one hand the Welsh Government seeks to reduce exposure to second hand smoke within an individual's private space, such as in the home and cars carrying children, but is proposing to exempt individuals to be exposed to second hand smoke during their working hours.

Evidence on the health risks of exposure to second hand smoke are well established, as is the BMAs position on this and on smoking more generally. We will not reiterate that here– suffice to say that a key priority for Government is to prevent exposure to second hand smoke and to protect public health and that this amendment represents a huge step backwards from that agenda.

These regulations will only apply during the smoking of the tobacco product, but toxins can be present immediately afterwards and linger in the environment for a long period of time – in the same way they do following smoking in a car.

Might there be any unintended consequences of introducing this exemption?

Yes.

This proposal goes against the Welsh Governments revered and long standing objectives for protecting and promoting the long term health and well-being of the people of Wales.

The ammendment undermines the whole direction of public health promotion and tobacco control in Wales. Fundamentally, it represents a dilution of the Smoke-Fee Premises regulations in Wales, a policy which has received a huge amount of public support.

What health policy considerations are relevant to this amendment?

This amendment contradicts the public health commitments of the Welsh Government and if taken forward will undermine Wales's position as a one-time leader in innovative tobacco control measures.

We see no justification whatsoever for bringing forward this exemption – it is wholly counterproductive.

Film Agency for Wales/Asiantaeth Ffilm Cymru submission to the

Sub Committee on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

1. We would like to thank the sub-committee for this opportunity to provide a submission on the proposed amendment to the Smoke-Free Premises etc regulations, which would create an exemption from the smoke free requirements for performers in connection with the making of a film or television programme where certain specified conditions are met.

2. We have annexed our response to the previous consultation in March 2012 for ease of reference.

3. As already noted in the committee's briefing document, film and television, as with other creative industries, are growth sectors with significant economic impact. To reference an extract from HM Government's BIS publication "Best of British" [1]

   "the UK is an international hub for creativity and commerce, with a sector bigger in terms of percentage of GDP than any other OECD country…. The creative industries contribute 6.2% to the UK economy, with nearly 2 million people in creative employment. NESTA estimates the creative industries will grow on average more than double the rate of the rest of the economy. These companies are competing in a worldwide market… The UK is a world leader in sales of TV formats, and is the second biggest exporter of TV programming hours. In 2008 UK films took 15% of the global box office, up 133% since 2002"

   Similarly, the 2012 BFI Statistical Yearbook notes that the film industry contributed more than £3.3m billion to GDP in 2010; and that the total UK spend in 2011 of the film sector was over £1.2billion[2]

   Wales shares in the growth potential of this sector, complimented by a UK wide commitment by the BFI to film, including developing filmmaking talent across the country, for which the Film Agency for Wales are its national partner.

[1] http://www.bis.gov.uk/assets/biscore/corporate/docs/b/10-845-best-of-british

[2] http://www.bfi.org.uk/statisticalyearbook2012/

4. Film in particular is a high-cost activity, with significant spend on cast, crew, facilities and services, with even lower budget films budgeted around £1m (the average budget of the 27 feature films co-financed by Film Agency for Wales is £926,290 – combined budgets in excess of £25m).

5. Films are typified by being financed through multiple financial partners, often with international partners and often with consideration given to locating some or all of the production in different countries. For example, films may make use of the international co-production treaties or the European Convention on Cinematrographic Co-produciton[3]. The UK currently has treaties with nine other countries[4], and the EU Convention enables the UK to co-produce with other European countries that don't currently have a bi-lateral treaty. By qualifying under the criteria set down by these treaties, the film production can benefit from local financial incentives, including for example the UK tax credit worth the equivalent of 20% of UK qualifying expenditure or Australia's tax credit of up to 40% of qualifying expenditure.

6. What these circumstances illustrate is that the production of feature films involves high levels of international (as well as UK) competition where any given producer – whether considering an inward investment into Wales, or whether a Welsh company considering whether to shoot in Wales or elsewhere – will inevitably be weighing up where it is most advantageous to shoot their film from a financial point of view, as well as taking into consideration local logistics, such as the availability of suitable crew, services and facilities; suitability and accessibility of locations; local rules and permits, etc.

7. If Wales does not implement the amendment to the Smoke-Free Premises etc regulations, this would be an impediment to potential feature productions in what is already a demanding and complex environment. We would contend that that factor would make it more likely that a producer would simply look to the many other alternatives, internationally as well as in the UK, rather than look first at the additional costs and inconvenience of relocating scenes that include smoking.

8. In relation to potential costs in relocating scenes – we would add to the analysis provided in the sub-committee briefing that relocation costs may vary widely and be significantly more than proposed if the scenes concerned require a reschedule of the

[3] http://www.culture.gov.uk/what_we_do/creative_industries/4112.aspx

[4] The UK currently has co-production treaties with Australia, Canada, France, India, Israel, Jamaica, New Zealand, Occupied Palestinian Territories and South Africa.

production to accommodate those scenes; if the scene includes multiple cast and crew; and/or if the scene includes (a) high paid principles, with additional travel and set-up time.

9. In terms of the scale of smoking in film it is worth considering the research conducted by the ESRC-funded UK Centre for Tobacco Control Studies (UKCTCS), which looked at representation of smoking through images of tobacco and related products in the most popular films shown in the UK between 1989 and 2008. They found that while tobacco images have declined substantially over the past 20 years… that in assessing 300 films (20% of which involved UK producers)

   "Occurrence of tobacco use, implied use or appearance of smoking paraphernalia occurred in 70 per cent of all films."[5]

   That's a significant portion of film production and allied economic benefit that Wales would potentially be excluded from should the exemption amendment not be implemented.

9. With regard to on-screen representation smoking and in particular films that are available to young people, it is worth highlighting the British Board of Film Classification is the body tasked with assessing and classifying *all* feature films in relation to their age appropriateness. Additionally of course, when films and televisions are screened by broadcasters, careful thought is given by schedulers as to the age appropriateness of content.

Submitted by Pauline Burt, Chief Executive

On behalf of The Film Agency for Wales

30th January 2013

[5] **http://www.esrc.ac.uk/impacts-andfindings/featurescasestudies/features/15356/Smoking_on_the_silver_screen.aspx**

Annex A – March 2012 submission

Consultation response form

Your name: Suzanne Alizart

Organisation (if applicable): Film Agency for Wales

e-mail/telephone number: 029 2046 7490

Your address: Suite 7, 33-35 West Bute Street, Cardiff
CF10 5LH

Responses should be returned by 16 March 2012 to:

Life Course Branch

Welsh Government

4th Floor

Cathays Park 2

Cardiff

CF10 3NQ

or completed electronically and sent to:

e-mail: TobaccoPolicyBranch@Wales.gsi.gov.uk

Responses to consultations may be made public – on the internet or in a report. If you would prefer your response to be kept confidential, please tick here: ☐

Questions

► ***Question 1: Should the Smoke-Free Premises etc. (Wales) Regulations 2007 be amended to permit smoking by performers where the artistic integrity of the performance makes it appropriate for the performer to smoke? Yes***

Are the proposed Regulations adequate enough to avoid misuse of the exemption?

The proposed Regulations are adequate enough to avoid misuse of the exemption: by making it a personal exemption, linked to the performance and restricting its application to adults, there seems to be little scope for misuse. However, in audiovisual production, there is frequently no clear distinction between rehearsal and performance, both of which often take place in front of the camera. If the Regulation as drafted excludes smoking in rehearsal, this is disproportionate and will hamper the work of artists in preparing their performances without any appreciable health benefits.

► ***Question 2: Are the conditions required by this exemption sufficient to minimise the risk of exposing others to second-hand smoke?***

Given the nature of film and television production, the risk of accumulated smoke affecting co-workers and audiences, is minimal. The conditions proposed are more than adequate.

► ***Question 3: Are the provisions to protect children from exposure to second-hand smoke within the proposed Regulations sufficient?***

The provisions protecting children are more than sufficient: they are stringent, given that a number of period dramas would actually require children to be smoking to reflect common practices of the time.

► ***Question 4: Will the provisions in the proposed Regulations be able to be enforced effectively?***

Provided the responsibility for enforcement is with the production company responsible for the project being filmed, yes.

► ***Question 5: The Welsh Government will provide Guidance to support the implementation of the proposed exemption: will this support be sufficient to assist with the interpretation of the conditions of the exemption (for example, the requirement for 'artistic integrity')?***

It may be helpful to enlist the support of the Film Agency for Wales or other film specialists to review the Guidance when drafted and help tailor it to the film and TV producers charged with implementing the exemption. It may also be helpful to work with Skillset to develop and deliver a series of workshops targeted at floor managers and production managers who will be leading that implementation.

► ***Question 6: Does the draft Regulatory Impact Assessment accurately reflect the costs and benefits of the proposed Regulations? If not, please provide additional information to support your answer.***

The Impact Assessment does provide an overview of the costs and benefits of the proposed Amendment. It does not take into account projects currently being developed by Welsh companies, with the potential for filming in Wales which would have to relocate to London should the amendment not be implemented. In other words, the impact would be on indigenous companies as well as those inward investment projects looking to film in Wales.

► ***Question 7: Do you think there would be any negative impact on individuals or communities within Wales on the grounds of: disability; race; gender or gender reassignment; age; religion and belief and non-belief; sexual orientation; pregnancy and maternity; marriage and civil partnerships; or Human Rights as a result of the proposed Regulations?***

No.

We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here:

Sub Committees on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

Response from Cardiff Council

Scrutiny of the Smoke Free Premises etc. (Wales)(Amendment) Regulations 2012.

Thank you for the opportunity to contribute to the consultation on the above proposed amendment.

Cardiff Council's Public Protection Service welcomes this consultation by the Enterprise and Business Sub Committee and the Health and Social Care Sub Committee on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012.

Public Protection comprises three sections: Food Safety Enforcement, Health and Safety Enforcement and Health Protection (Communicable Disease Control and Health Improvement). The majority of officers working within Public Protection are Environmental Health Officers with a small number of specialist technical officers. Officers are authorised and actively enforce smoke free legislation.

As noted below Public Protection is strongly opposed to the proposed amendment.

We answer the questions asked in the order of raising and thereafter make further comments which we trust will be of assistance to both committees in their consideration of this issue.

Will this amendment achieve its aim of supporting the television and film industry in Wales?

Wales has been the location of choice for film and television programme makers, notwithstanding the fact that smoking in film sets and televisions studios is prohibited.

It is relevant to note that in its report 'The Economic Impact of the UK Film Industry' in September 2012 produced for the British Film Industry Oxford Economics' uses as a case study the developing film industry in Northern Ireland, where the same prohibition on smoking on film sets and television studios exists as is in Wales. The report highlights increased investment, aggressive marketing and government support as being factors that are seeing driving continued growth, with return on investment of £6 for every £1 invested, but does not suggest that the prohibition on smoking is in any way damaging to the success or prospect of continued growth. We suggest that there is no reason to believe that the film and television industry in Wales cannot enjoy the same success in the same circumstances and that the proposed amendment is not necessary to secure it.

PLEASE REPLY TO: Regulatory and Supporting Services, Public Protection, City Hall, Cardiff. CF10 3ND. Tel: (029) 20 871127 Fax: (029) 20877043

Any perceived benefits from the proposed amendment we feel are minimal; neither would it be proportional for Wales to compromise its health ambitions in support of such unproven claims.

This amendment needs to look very carefully at the longer term implications of permitting smoking through this legislative change no only at the industry but the individuals which this amendment will affect. Actors, actresses, film crews and other relevant staff will be subjected to the exposure of carcinogens – no other vocation would actively permit this to occur and be in a situation which in effect positively encourages these individuals to smoke in order to gain 'artistic value' as part of their performance. The health of these individuals need to be taken account and is of course paramount.

Knowing the health effects, Wales should continue to lead the way in protecting the health of those who decide to visit, reside and work in the Country. A more appropriate solution should be to retain the smoking restrictions and invest in seeking and using lifelike alternatives.

It is possible that cancers and other long term illnesses which will be attributed to smoking in this industry will no doubt in years to come, allow individuals to be able to attribute blame to the film and television industry and Wales for their illnesses. WG should not therefore be in the position that would be considered accountable for allowing this to happen.

Allowing this amendment, would in our view directly impact on the health of individuals, their families and our health service. This could even be considered as a means of 'forcing and pressurizing' individuals who work in a highly competitive business to smoke and inhale highly addictive carcinogens as part of their performance.

Is there sufficient clarity about the circumstances in which the exemption applies?

'Artistic integrity', will vary depending on the circumstances and is therefore open to misinterpretation. The question of whether the artistic integrity of the performance requires a person to smoke will be highly subjective and may vary from Director to Director. Would you expect an actor to inject drugs for 'artistic integrity'?

It is proposed that smoking will only be allowed in the final 'take'of any film or television production. However there is no way of determining with any degree of confidence that anyone take is the final version. The Film Director / Producer may only make that decision after viewing a number of takes of the same scene in which case smoking would have to take place in all of the takes.

It is also the case that the same scene has to be shot from a number of different angles, such that a relatively short piece of footage may take a long time to film, and for continuity purposes smoking would have to be consistent throughout the whole of the filming.

In our view

- there is insufficient clarity about the circumstances in which the exemption would apply,
- it would be easy to circumvent the protection that is claimed in the Explanatory Memorandum and that
- The subjective nature of decisions around artistic integrity and the appropriateness or otherwise of smoking in a performance would have the effect of meaning that the exemption would be a virtual carte blanche for smoking during filming.

In these instances, there is no specification as to the purpose of the film or the need to register that filming is taking place. Filming is a more and more regular occurrence, through structured university performances through to the recording of footage for internet use.

If legislation is to be effective in its purpose it has to be clearly understood with limited opportunity for abuse. The success of the current legislation so far is partly because the public fully understand it and themselves enforce it. Adding this complexity will remove this clarity and will make it more difficult to enforce. It will inevitably place an additional burden in time taken to visit and monitor compliance.

Do the conditions offer adequate protection to other performers, production staff and members of the public?

No. For the reasons outlined above we believe that smoking could continue throughout the making of a film or television production. That being the case any other performers, production staff, members of studio audience including children would be exposed to tobacco smoke and are afforded no protection other than in the case of audience members, where they could leave.

Not only is there a concern that smoking would potentially continue throughout filming but the fact that once the smoking scene has ceased both smoke and residual highly toxic particulate contamination from tobacco smoke including carcinogens and heavy metals, such as arsenic, lead, and cyanide will remain in the area for some time.

A study published in February 2010 by the Proceedings of the National Academy of Sciences entitled, ‘Formation of carcinogens indoors by surface-mediated reactions of nicotine with nitrous acid, leading to potential third hand smoke hazards’ found that smoke remaining following smoking has ceased causes the formation of carcinogens. The nicotine in tobacco smoke reacts with nitrous acid - a common component of indoor air - to form the hazardous carcinogens. Nicotine remains on surfaces for days and weeks, so the carcinogens continue to be created over time, which are then inhaled, absorbed or ingested.

All therefore need to be aware of the health risks of exposure to these chemicals once smoking has ceased in the area and recognize that eliminating smoking is the only way to protect against tobacco's smoke contamination and the consequences of exposure to chemical toxins.

Our view is that all employees should be protected under the law.

Might there be any unintended consequences of introducing this exemption?

We believe that there are a number of potential unintended consequences, some of which have considerable financial implications.

Enforcement of the legislation lies with local authorities. Given the highly subjective nature of decisions as to whether smoking is necessary for the artistic integrity of a performance it will be impossible to build up any guidance as to the circumstances in which smoking is permitted. Where there is a dispute between the enforcing authority and the producer of production it will be for the Magistrates' Court to determine whether the smoking was a lawful or unlawful activity.

Film companies will be in a significantly stronger position financially than local authorities which may have the effect of discouraging enforcement and thereby putting the health of performers, production crew and audiences at risk.

It is also the case that Magistrates will have no expertise as to whether a performance is such that smoking is required and will have to rely on expert evidence. We can foresee a circus of 'experts' in theatre and television performances springing up and being used in the courts to argue the question of necessity. This will be expensive and time consuming and given that each production is different and each Producer will have his own ideas will not even contribute to establishing a series of precedents which enforcers and producers could look to for guidance in future productions.

All of the foregoing presupposes that local authorities would have the available resource to police the production of television and films productions for smoking on set, which in the current economic climate we suggest is unlikely. This would mean that the television and film industry would be free to use the exemption in a largely unregulated way, and in doing so would compromise the health of people working in the industry in a way that is not permitted in any other industry.

What health policy considerations are relevant to this amendment?

This amendment is directly contrary to the Welsh Governments' identified key theme in Our Healthy Future to further reduce the number of people who are exposed to second-hand smoke in Wales. It also undermines one of the 4 key areas in the Tobacco Control Action Plan, being to reduce exposure to second hand tobacco smoke.

Other key planks of the Tobacco Control Action Plan for Wales 2012 are to reduce uptake of smoking particularly among young people and children and to reduce the number of people who smoke. We have argued, and continue to argue that depiction of smoking in film and television productions has the effect of normalising smoking and making it socially acceptable, and therefore

object to its depiction onscreen.

We recognize however that this is not an argument against the proposed amendment since it is possible to effectively simulate smoking using props or computer simulation both of which can be done without compromising the health of those surrounding the ‘smoker’.

Finally, some general points, Welsh Government promotes smoke free homes, this presents a conflict of interest and presents a mixed message to the Public. By amending this proposed legislation Wales will be taking a backward step in terms of enforcement and public health protection.

These proposed amendments are strongly opposed. It is unnecessary, and impossible to enforce. We urge both Welsh Government committees to recommend that the amendment be withdrawn or to recommend that it be opposed.

If you require any further information please contact Mrs Bethan Jones, Operational Manager, Public Protection, on 02920 871127. I understand she will be attending Committee on the 19th February to provide oral evidence.

Yours sincerely,

Dave Holland
Head of Regulatory Services

Paper 5

Sub Committees on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

Response from The Chartered Institute of Environmental Health

The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

Response to the Welsh Government Enterprise and Business Sub Committee and the Health and Social Care Sub Committee

Chartered Institute of Environmental Health
Sefydliad Siartredig Iechyd yr Amgylchedd

Sefydliad Siartredig Iechyd yr Amgylchedd

Fel **corff proffesiynol**, rydym yn gosod safonau ac yn achredu cyrsiau a chymwysterau ar gyfer addysg ein haelodau proffesiynol ac ymarferwyr iechyd yr amgylchedd eraill.

Fel **canolfan wybodaeth**, rydym yn darparu gwybodaeth, tystiolaeth a chyngor ar bolisïau i lywodraethau lleol a chenedlaethol, ymarferwyr iechyd yr amgylchedd ac iechyd y cyhoedd, diwydiant a rhanddeiliaid eraill. Rydym yn cyhoeddi llyfrau a chylchgronau, yn cynnal digwyddiadau addysgol ac yn comisiynu ymchwil.

Fel **corff dyfarnu**, rydym yn darparu cymwysterau, digwyddiadau a deunyddiau cefnogol i hyfforddwyr ac ymgeiswyr am bynciau sy'n berthnasol i iechyd, lles a diogelwch er mwyn datblygu arfer gorau a sgiliau yn y gweithle ar gyfer gwirfoddolwyr, gweithwyr, rheolwyr busnesau a pherchnogion busnesau.

Fel **mudiad ymgyrchu**, rydym yn gweithio i wthio iechyd yr amgylchedd yn uwch ar yr agenda cyhoeddus a hyrwyddo gwelliannau mewn polisi iechyd yr amgylchedd ac iechyd y cyhoedd.

Rydym yn **elusen gofrestredig** gyda dros 10,500 o aelodau ledled Cymru, Lloegr a Gogledd Iwerddon.

The Chartered Institute of Environmental Health

As a **professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across England, Wales and Northern Ireland.

The Chartered Institute of Environmental Health (CIEH) welcomes this consultation by the Enterprise and Business Sub Committee and the Health and Social Care Sub Committee on The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012 . We provided a response to the consultation in March 2012 on the same subject, a copy of which is appended as Appendix 1. We very much welcome the fact that Welsh Government is reconsidering this issue and the proposed amendment in detail as, for the reasons we outline we are strongly opposed to the proposed Amendment Regulations.

We answer the questions asked in the order of raising and thereafter make further comments which we trust will be of assistance to both committees in their consideration of this issue.

1. Will this amendment achieve its aim of supporting the television and film industry in Wales?

In the view of the CIEH there is no proven evidence that this amendment will achieve its stated ambition. Where film companies and television companies have given costing purporting to show the cost of transferring production from Wales to England or elsewhere to film scenes depicting smoking all of the costings are speculative, and are not based in fact. Whilst there is no doubt were they to have to transfer production there would be some cost, and that the proposed amendment would assist in them not having to incur the costs and therefore support the industry, there is no evidence that they have done so, nor that they intend to do so.

We argue to the contrary. Wales has been the location of choice for film and television programme makers, notwithstanding the fact that smoking in film sets and televisions studios is prohibited. The BBC has invested a reported £25 million in new studios at Roath Lock, has transferred filming of major series such as Casualty and has made major series such as Upstairs Downstairs and Dr Who in Wales since the ban has been in place. There is no suggestion it was deterred from doing so or that its ambitions will be in anyway curtailed by the ban on smoking on the film and television sets.

It is relevant to note that in its report 'The Economic Impact of the UK Film Industry' in September 2012 produced for the British Film Industry Oxford Economics' uses as a case study the developing film industry in Northern Ireland, where the same prohibition on smoking on film sets and television studios exists as is in Wales. The report highlights increased investment, aggressive marketing and government support as being factors that are seeing driving continued growth, with return on investment of £6 for every £1 invested, but does not suggest that the prohibition on smoking is in any way damaging to the success

or prospect of continued growth. We suggest that there is no reason to believe that the firm and television industry in Wales cannot enjoy the same success in the same circumstances and that the proposed amendment is not necessary to secure it.

There may be speculative and unproven claims that the television and film industries would benefit from the proposed amendment but it is the view of the CIEH that such benefits would be minimal and that there is no necessity, neither would it be proportional for Wales to compromise its health ambitions in support of such unproven claims.

2. Is there sufficient clarity about the circumstances in which the exemption applies?

CIEH believes that the circumstances in which the exemption applies are not at all certain. Whilst the wording of the exception is clear, in that it will apply '*where the artistic integrity of the performance ..... make it appropriate for a person who is taking part in a performance to smoke ...'* those circumstances will vary from production to production , and the question of whether the artistic integrity of the performance requires a person to smoke will be highly subjective and may vary from Director to Director .

It is also the case that the Explanatory Memorandum to the proposed legislation suggests that smoking will only be allowed in the final 'take' of any film or television production, but it is impossible for a director or producer to be able to say with any degree of confidence that anyone take is the final version that will be used, and he or she may only make that decision after viewing a number of takes of the same scene in which case smoking would have to take place in all of the takes. It is also the case that the same scene has to be shot from a number of different angles, such that a relatively short piece of footage may take a long time to film, and for continuity purposes smoking would have to be consistent throughout the whole of the filming.

We believe that there is insufficient clarity about the circumstances in which the exemption would apply, that it would be easy to circumvent the protection that claimed in the Explanatory Memorandum and that the subjective nature of decisions around artistic integrity and the appropriateness or otherwise of smoking in a performance would have the effect of meaning that the exemption would be a virtual carte blanche for smoking during filming.

3. Do the conditions offer adequate protection to other performers, production staff and members of the public?

No. For the reasons outlined in our response to Q2 above we believe that smoking could continue throughout the making of a film or television production. That being the case any other performers, production staff, members of studio audience including children would be exposed to tobacco smoke and are afforded no protection other than in the case of audience members to leave.

4. Might there be any unintended consequences of introducing this exemption?

The CIEH considers that there are a number of potential unintended consequences, some of which have considerable financial implications.

Enforcement of the legislation lies with local authorities. Given the highly subjective nature of decisions as to whether smoking is necessary for the artistic integrity of a performance it will be impossible to build up any guidance as to the circumstances in which smoking is permitted, and where there is a dispute between the enforcing authority and the producer of production it will be for the Magistrates Court to determine whether the smoking was a lawful or unlawful activity. Film companies will be in a significantly stronger position financially than local authorities which may have the effect of discouraging enforcement and thereby putting the health of performers, production crew and audiences at risk.

It is also the case that Magistrates will have no expertise as to whether a performance is such that smoking is required and will have to rely on expert evidence. We can foresee a circus of 'experts' in theatre and television performances springing up and being used in the courts to argue the question of necessity. This will be expensive and time consuming and

given that each production is different and each Producer will have his own ideas will not even contribute to establishing a series of precedents which enforcers and producers could look to for guidance in future productions.

All of the foregoing presupposes that local authorities would have the available resource to police the production of television and films productions for smoking on set, which in the current economic climate we suggest is unlikely. This would mean that the television and film industry would be free to use the exemption in a largely unregulated way, and in doing so would compromise the health of people working in the industry in a way that is not permitted in any other industry.

5. What health policy considerations are relevant to this amendment?

This amendment is directly contrary to the Welsh Governments' identified key theme in Our Healthy Future to further reduce the number of people who are exposed to second-hand smoke in Wales. It also undermines one of the 4 key areas in the Tobacco Control Action Plan, being to reduce exposure to second hand tobacco smoke.

Other key planks of the Tobacco Control Action plan are to reduce uptake of smoking particularly among young people and children and to reduce the number of people who smoke. We have argued, and continue to argue that depiction of smoking in film and television productions had the effect of normalising smoking and making it socially acceptable, and therefore object to its depiction onscreen. We recognise however that this is not an argument against the proposed amendment since it is possible to effectively simulate smoking using props or computer simulation both of which can be done without compromising the health of those surrounding the 'smoker'.

The CIEH strongly opposes the proposed amendment to the legislation as being unnecessary, disproportionate and impossible to enforce. We urge both Welsh Government committees to recommend that the amendment be withdrawn or to recommend that it be opposed.

We would be happy to provide such further evidence or comment as the Committees would consider helpful and would be happy to give oral evidence should that be required.

Julie Barratt
Cyfarwyddwr yng Nghymru
Sefydliad Siartredig Iechyd yr Amgylchedd

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Annex D

Consultation response form

Your name: Julie Barratt

Organisation (if applicable): Chartered Institute of Environmental Health

e-mail/telephone number: j.barratt@cieh.org 01633 865533

Your address: CIEH Wales Directorate, Lakeside House, Lakeside Court, Llantarnam Parkway, Cwmbran, NP44 3GA

Responses should be returned by 16 March 2012 to:

Life Course Branch
Welsh Government
4th Floor
Cathays Park 2
Cardiff
CF10 3NQ

or completed electronically and sent to:

e-mail: TobaccoPolicyBranch@Wales.gsi.gov.uk

Responses to consultations may be made public – on the internet or in a report. If you would prefer your response to be kept confidential, please tick here: ☐

Questions

► ***Question 1: Should the Smoke-Free Premises etc. (Wales) Regulations 2007 be amended to permit smoking by performers where the artistic integrity of the performance makes it appropriate for the performer to smoke? No***

Are the proposed Regulations adequate enough to avoid misuse of the exemption?

No. The regulations state that 'where the artistic integrity of the performance ..... make it appropriate for a person who is taking part in a performance to smoke ...etc

There is no definition of artistic integrity which is a subjective judgement. In the view of CIEH the concept of artistic integrity of the performance is likely to be the cause of disagreement between enforcers and film and television producers which will lead to legal challenge and action.

In the Explanatory Memorandum there is a suggestion that smoking will not be permitted during rehearsals, only during the final performance. We wonder how it will be possible for a director to determine which 'take' will be the final version – very often a considerable number of takes are required from a number of angles before the final version of the scene or part of it is selected. This means that there are potential opportunities for the legislative restriction to be circumvented.

► ***Question 2: Are the conditions required by this exemption sufficient to minimise the risk of exposing others to second-hand smoke?***

No. Following on from our repose to Q1, it will be for the director of programmes to decide whether it is necessary for the 'artistic integrity' of a programme for the characters in it to smoke, therefore the degree to which others on and around the set are exposed will be a matter for him/her, and could, subject to his/ her interpretation of the artistic needs of the production be significant.

► ***Question 3: Are the provisions to protect children from exposure to second-hand smoke within the proposed Regulations sufficient?***

No. There regulations will only apply during the smoking of the tobacco product, but can be present immediately afterwards, where elevated particulate levels may still affect them.

We further take the view that the proposed regulations would be seen as the thin edge of a wedge and that the Welsh Government will be called on to make further amendments to legislation to allow children to be seen around characters who are smoking or even to be seen smoking where the 'artistic integrity of the performance' is deemed to demand it.

► ***Question 4: Will the provisions in the proposed Regulations be able to be enforced effectively?***

No, due to the fact that 'artistic integrity of the performance' is incapable of definition other than in a highly subjective way.

► ***Question 5: The Welsh Government will provide Guidance to support the implementation of the proposed exemption: will this support be sufficient to assist with the interpretation of the conditions of the exemption (for example, the requirement for 'artistic integrity')?***

No. Irrespective of the content of Guidance it is guidance only and whilst all parties may have regard to it the question of when smoking is required will be a decision at first instance for the director of a performance. If this decision is challenged it will be for the local authority to establish in a court of law that smoking was not necessary for the performance and to do so to the necessary criminal standard of proof.

In our view film companies and their financial backers will be in a position to financial such actions, whilst local authorities have not got the financial resources to take on potentially expensive litigation. It is also the case that each case would have to be determined on its own merits and the requirements of 'artistic integrity' would fall to be determined in every case. We can anticipate a very expensive circus of 'expert witnesses' as to what are and what are not the requirements of artistic integrity springing up, which would be undesirable.

► ***Question 6: Does the draft Regulatory Impact Assessment accurately reflect the costs and benefits of the proposed Regulations? If not, please provide additional information to support your answer.***

No. We do not accept that there is a *necessity* to transfer filming of schemes to England as suggested, rather there is a choice to do so and costings are provided based in film producers choosing to do so. We point to our comments made in our response to the last question of this consultation.

► ***Question 7: Do you think there would be any negative impact on individuals or communities within Wales on the grounds of: disability; race; gender or gender reassignment; age; religion and belief and non-belief; sexual orientation; pregnancy and maternity; marriage and civil partnerships; or Human Rights as a result of the proposed Regulations?***

No

We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here:

There is no justification for the *reason* for these regulations. It cannot be argued

that the film and television industry in Wales, which is capable of producing films and television programmes of the highest standard, involving scenes of injuries and disasters is incapable of replicating the smoking of a cigarette or a pipe.

It is not correct to suggest that the only way for a character in a film or television programme to be shown smoking is to allow them to smoke as is suggested in para 1.6 of the Explanatory Memorandum. There is no suggestion that where a character is seen being stabbed or shot that the artistic integrity of the performance requires that they should be stabbed or shot, or that for artistic integrity purposes a character shown taking drugs intravenously should actually be doing so, such activities are capable of being acted using props and special effects. There is no reason why smoking tobacco cannot be replicated in the same way.

We are also concerned that allowing this exemption will encourage a creeping need for further exemptions, for example in live performance. It is not difficult to see an argument being made to the effect that if the artistic integrity of a performance of a play produced for television requires the performers to smoke that same position would appertain if the play was to be performed live in front of an audience.

To suggest as justification for these regulations that if Wales does not go down this route film and television production will transfer to England where the protection afforded by regulations in force is less than currently in Wales is to put us in a position where, irrespective of the initial view of the Welsh government about the needs of Wales, we will fall in with the position in England should sufficient pressure be brought to bear on Welsh Government. The restriction on smoking in performances was introduced on solid health grounds and there is no health evidence to support any amendment to or dilution of the restriction.

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Mark Drakeford AM
The National Assembly for Wales,
Cardiff Bay,
Cardiff,
CF99 1NA

28th January 2013

Dear Mr Drakeford

On behalf of ASH Wales, we would like to thank you for the opportunity to present our argument to the Sub-Committees on the Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012. We welcomed the chance to present the strong evidence in favour of maintaining the existing regulations to protect the workforce in the television and film industries in Wales.

We would like to take this opportunity to briefly expand some of the key points that were raised during our evidence session, in particular with regard to the risks of exposure to second-hand smoke. The dangers of exposure are explicitly referenced in Article 8 of the WHO's Framework Convention on Tobacco Control (FCTC, available at http://whqlibdoc.who.int/publications/2003/9241591013.pdf), to which the UK is signatory. In the associated explanatory guidelines, Principle 1 clearly states that there is **no** safe level of exposure to tobacco smoke, whilst Principle 2 states that **all** people should be protected from exposure to tobacco smoke. The FCTC also pushes strongly for universal coverage to be achieved immediately, with a continuing obligation on signatories to move as quickly as possible to remove any exemptions.

Data has also been collected that demonstrates that even occasional exposure to second-hand smoke can have damaging health implications. In an article published in the British Medical Journal in 2007 on the subject of exposure of non-smoking adults to second-hand smoke following the implementation of Scottish smoke-free legislation, Haw and Gruer note that even occasional exposure is associated with cardiovascular changes (article available at: http://www.bmj.com/content/335/7619/549?grp=1). In the 2006 Report *The Health Consequences of Involuntary Exposure to Tobacco Smoke,* the US Surgeon General confirmed that even a small amount of second-hand smoke can be harmful to health (http://www.surgeongeneral.gov/library/reports/secondhandsmoke/report-index.html).

With regard to the question raised by the committee, we can confirm that we are not aware of any work that has been done specifically on the prevalence of smoking-related diseases amongst cast and crew on TV and film sets in comparison with other sectors of the workforce. However, in addition to the impact of second hand smoke highlighted above, there is clearly a risk of a non-smoking actor becoming addicted to nicotine, which is widely known as a highly addictive substance, with all the attendant harms or the provocation of a relapse amongst members of cast and crew who have successfully quit smoking previously.

Once again, we thank you for your time.

Yours sincerely

E. de Lacy

Elen de Lacy
Chief Executive

Equity
performing for you
yn perfformio trostoch chi

Committee Clerk
Smoke-free Premises etc. (Amendment) Regulations Sub-Committees,
Committee Service
National Assembly for Wales
Cardiff Bay
CF99 1NA

5th February 2013

Dear Sir/Madam,

The Smoke-free Premises etc. (Wales) (Amendment) Regulations 2012

Further to our evidence session on the 29th January 2013 you have asked for further evidence to be provided about the experience of our members in England with the current exemption. In consultation with my regional colleagues in Manchester, Coventry, Sheffield, Glasgow covering all of England, Scotland and Northern Ireland, and also our Recorded Media organisers responsible for all of the major broadcast providers in the UK, we do not have any evidence of any issues connected with the exemption and can find no feedback, negative or otherwise, about the realities of usage on the ground. As stated in my evidence last week, Equity is a member led organisation on policy and if the exemption was an issue our members wanted changed then we would have had representation about it.

We also agreed to provide details of our membership in Wales and please find attached the distribution of our members across the UK. As you will see over the last four years our total membership throughout the UK has gone from 36,525 in 2009 to 37,429 in 2012 and Wales' share has gone from 1,402 to 1,418, with the percentage going from 3.84% to 3.79%. What is also interesting to note is that in 2011, when Roath Lock opened, our membership stood at 1,418, 3.85% percent of our actual membership. The actual number of members living in Wales from 2011 to 2012 did not change at all, and whilst we saw a rise in overall membership across the UK the percentage share in Wales fell to 3.79%. There has not been an increase of members living in Wales, which reflects our experience of talking to members who continue to feel that with the lack of local casting by the broadcasters for the majority of productions being made in Wales they have to live in London in order to work in Wales, which does not make sense commercially for any production.

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Head office Upper St Martin's Lane, London WC2H 9EG
Independent Trade Union
Incorporating the Variety Artistes' Federation

Equity
Ysgrifennydd Cyff Christine Payne
Prif Swyddfa Upper St Martin's Lane, London WC2H 9EG
Undeb Llafur Annibynnol
gan gynnwys Ffederasiwn Artistiaid Adloniant Ysgafn

We wanted also to follow up on one line of questioning from some members of the committee where it would seem that the continuation of smoking on screen would encourage smoking and glamorise it, and we would argue that whilst we would not condone that in any way shape or form, smoking will continue on our screens even if the exemption is not granted in Wales – it will just mean that it will have been made in England, or oversees. The investment will have been made somewhere else and not bought into Wales and therefore not providing work opportunities for our members. This leads us onto a further point we would like to make in addition to our previous evidence.

Much of the questioning last week was about proof of productions not coming to Wales because of the current regulations, and as stated last week we are not in a position to offer any such proof because our members are not involved at the time these decisions are being made. However we think the stronger argument here is what productions could be lost in the future, especially with the proposed new tax incentives introduced in Westminster.

The Chancellor George Osborne announced in his Autumn Statement 2012 plans for tax relief for three of the UK's key creative industries from April 2013. The key areas were animation, video games and high-end TV production sectors, subject to state aid approval. The consultation period has already taken place. It is predicted that this will generate an additional £350 million pounds worth of investment in these areas per year into the U.K. economy, creating thousands of jobs and keeping British skills in demand in a highly competitive industry.

The system aims to enable the U.K. to attract international TV production and put an end to dramas telling a British story going overseas to shoot. The Welsh Assembly Government, through its Creative Sector, is already working hard to attract companies to come to Wales with investment available, however if the playing field is not level on historical drama requiring exemption on smoking then it could be lost and with it the skilled professionals, including our members, who work in the industry as well as the investment back into the Welsh Economy.

Productions such as *Birdsong*, *Strike Back*, *The Tudors*, *Camelot* and the Julian Fellowes' drama *Titanic*, were all made abroad in countries including South Africa, Hungary, the Republic of Ireland and Canada in the last year to take advantage of overseas tax incentives. Anecdotally some of these featured smoking by actors and these could not have been made in Wales under the current legislation. *Sherlock* has been a massive success story for BBC Cymru Wales and, as stated in the evidence given by my colleague from the BBC, it actually features the lead character battling to give up smoking as part of the storyline – however had the production not been this modern adaptation, and had in fact been historically correct, it would more than likely not have filmed here in Wales because of the need to smoke as part of the historical accuracy.

Using the film industry multiplier calculated by Oxford Economics, a world leader in global forecasting and quantitative analysis for business and government, the benefit of this new incentive would be £12 to U.K. GDP for every £1 of tax relief given. Therefore, based on a spend of £350 million per year, a tax incentive of 25 percent of qualifying U.K. spend will mean a total return of £1 billion per year to the U.K. economy and wider benefits to regional economies. Not all of that will be linked to the ability to smoke but if there is a small percentage of that investment which could be lost to Wales because of the lack of an exemption, and with it employment opportunities for our members, then it would seem ludicrous to not lobby to grant an exemption in this case.

The lobbying group TV Coalition compiled the following quotes about the proposed Tax incentive:-

Kudos Film and TV chairman Stephen Garrett, whose company's credits include high end spy drama Spooks, said: "This is welcome news and will ensure that high quality British television drama and documentaries are made where they should be - in the U.K. There will be a real injection into the U.K.'s economy as this new tax relief will generate jobs and growth and encourage tourism while giving the U.K. taxpayer good value for money."

Producers' Alliance for Cinema and Television (PACT) chief executive John McVay said: "High budget productions usually run for a number of series investing significant amounts into the local economy and local businesses, creating jobs and keeping local skills at the cutting edge."

Gareth Neame, managing director, Carnival Films, said: "We are delighted with this new tax incentive which will ensure the best British stories are made into quality television on British shores, instead of being filmed abroad. The U.K. economy benefits, British businesses benefit and the skills of our crew are kept at the highest levels. This is a great boost for skills and growth in our sector."

Left Bank Pictures chief executive Andy Harries said: "Left Bank Pictures shot two productions in South Africa this year – Mad Dogs and Strike Back – because the tax breaks available made it a highly competitive destination. We have many other large scale projects in development and this incentive will allow us to make them in the U.K. whilst supporting the U.K.'s creative community."

And Ivan Dunleavy, chief executive of the studio facilities powerhouse The Pinewood Group described the government move as a "massive shot in the arm to the high-end television production industry which will have positive benefits throughout the economy."

Adrian Wootton, chief executive of the British Film Commission and Film London said: "Up until now we have missed out as we were simply not competitive when compared with other territories. This new tax relief is fantastic news for the sector and the U.K. economy and the British Film Commission is looking forward to working with the industry to repeat the success we've had in bringing international feature film production to the U.K."

Production Guild of Great Britain chief Alison Small said her organization "will be working closely with our membership and others across the U.K. to ensure that access to relevant information and training is available to support the anticipated new levels of production."

The criteria laid out for the exemption is very strict and restrictive, and could remove obstacles to investment into Wales for TV and Film production which can only be a positive thing for our members looking to find work in the creative industries in Wales who already face difficulties if they wish to base themselves here and work here.

As stated in our original evidence we support this narrow exemption where smoking is integral to the performance and where it cannot be replicated by the use of cigarette alternatives.

If you have any further questions, please do not hesitate to contact me.

Yours sincerely

Simon Curtis
National Organiser for Wales
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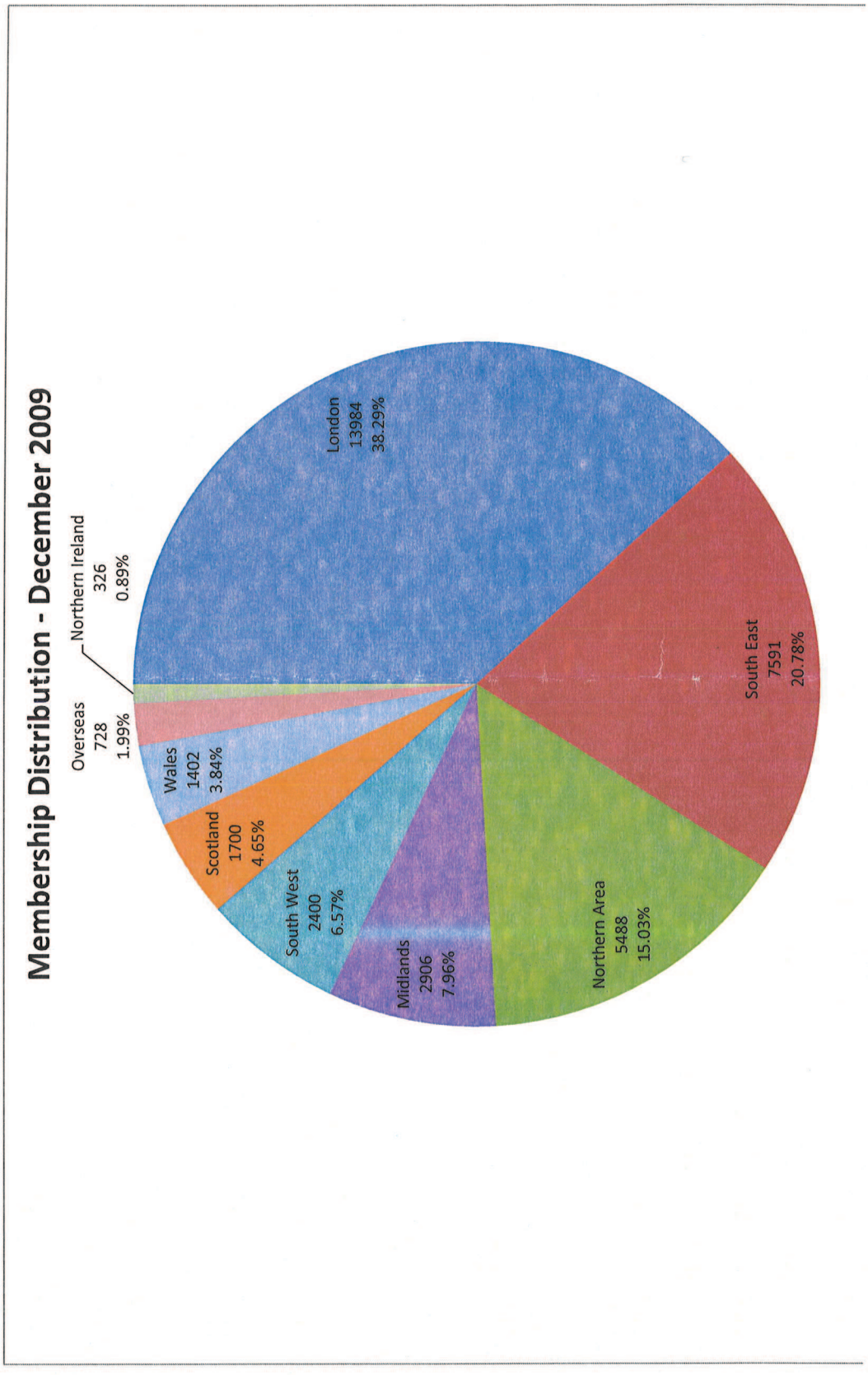
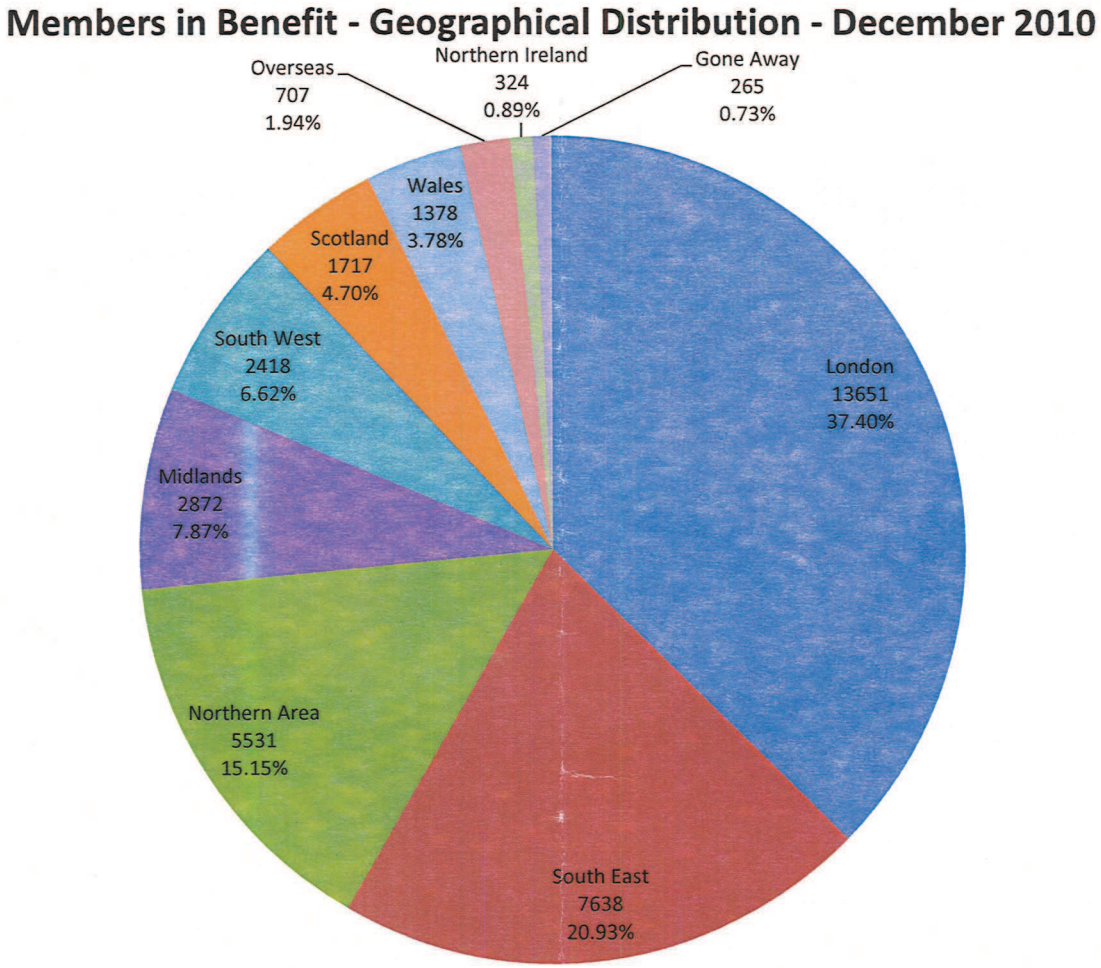

Membership Distribution - December 2009
London
13984
38.29%
South East
7591
20.78%
Northern Area
5488
15.03%
Midlands
2906
7.96%
South West
2400
6.57%
Scotland
1700
4.65%
Wales
1402
3.84%
Overseas
728
1.99%
Northern Ireland
326
0.89%


Members in Benefit - Geographical Distribution - December 2010
Overseas
707
1.94%
Northern Ireland
324
0.89%
Gone Away
265
0.73%
Wales
1378
3.78%
Scotland
1717
4.70%
South West
2418
6.62%
London
13651
37.40%
Midlands
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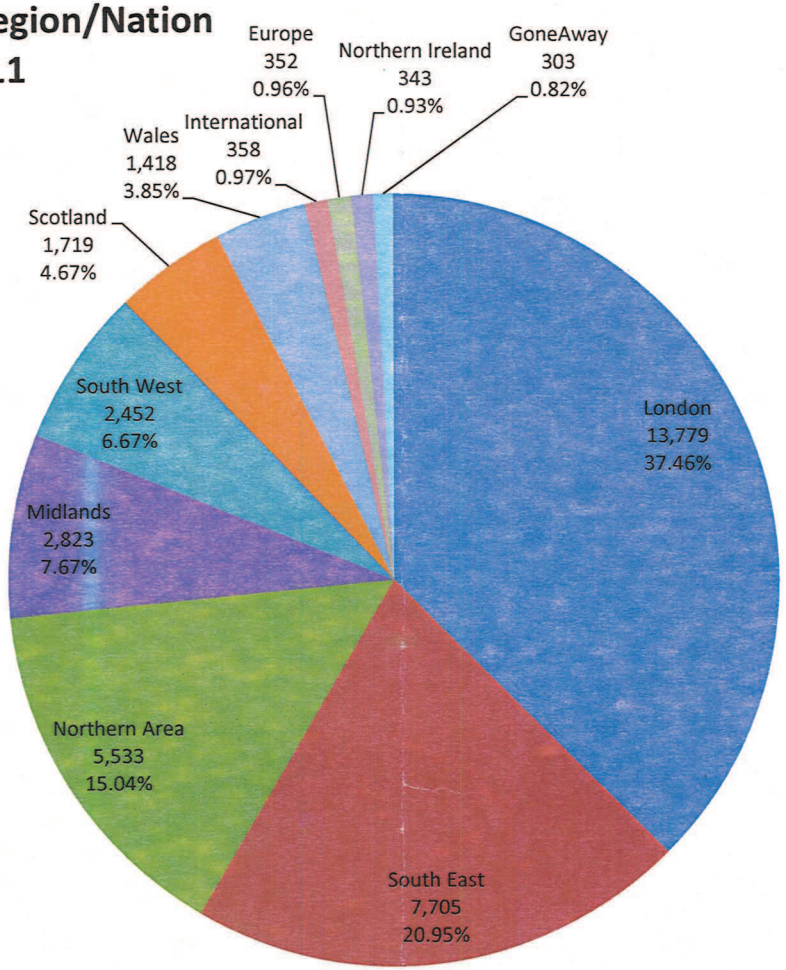
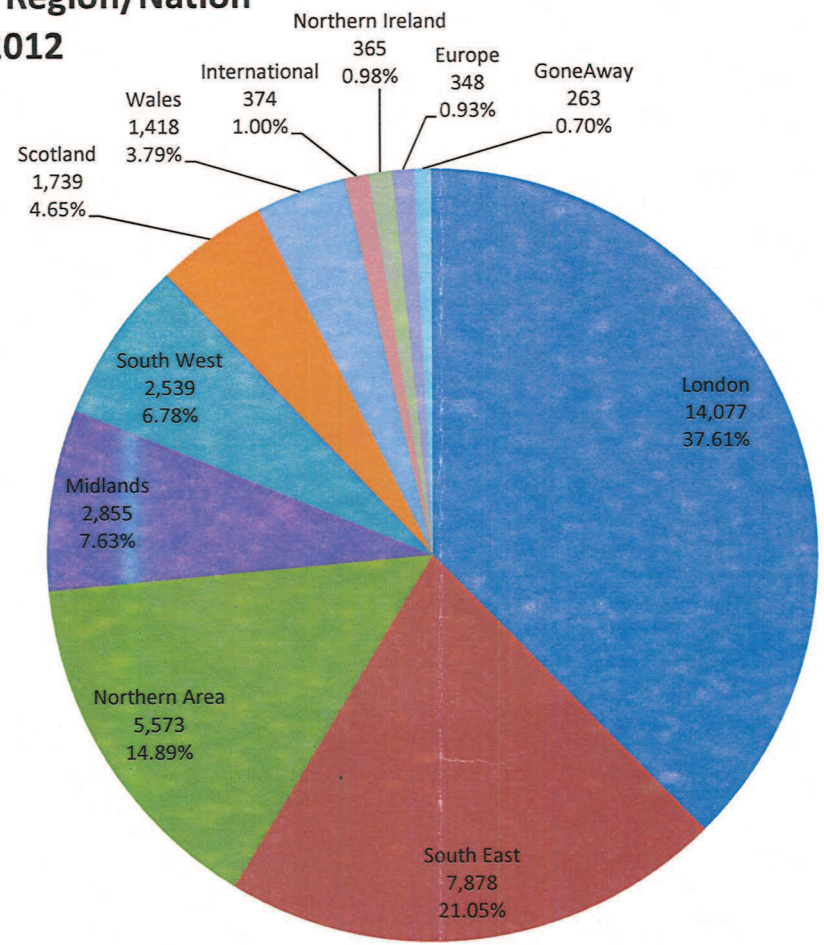
Northern Area
5531
15.15%
South East
7638
20.93%

Members in Benefit by Region/Nation
December 2011



Members in Benefit by Region/Nation
December 2012



Tobacco and health in Wales

June 2012

GIG CYMRU NHS WALES

Arsyllfa Iechyd Cyhoeddus Cymru
Public Health Wales Observatory

Llywodraeth Cymru
Welsh Government

A **technical guide** explaining the data sources and methods used in this report, plus **interactive spreadsheets** containing additional data at health board and local authority level, are available at:
www.publichealthwalesobservatory.wales.nhs.uk/tobaccoandhealth

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ystadegau ar gyfer cymru statistics for wales

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Foreword

This report lays bare the impact of tobacco on health in Wales. Over half a century since Doll and Hill demonstrated the harmful effect of smoking on health, smoking continues to be the single greatest avoidable cause of death causing almost one in five deaths in Wales. Almost one in four adults continue to smoke in 2010 and over 27,500 admissions to hospital were due to smoking. One in five children are regularly exposed to indoor tobacco smoke causing around 500 children to be admitted to hospital each year.

Reducing smoking prevalence and exposure to second-hand smoke is a priority of *Our Healthy Future*, the public health strategic framework for Wales. A *Tobacco Control Action Plan* has now been developed. This has the key aim of reducing the prevalence of smoking in Wales to 16 per cent by 2020. The ban on smoking in enclosed public spaces introduced in 2007 has already begun to pay dividends as demonstrated by the significant reductions in exposure to second-hand smoke shown in this report. However, there are clear challenges. Some sections of society, such as those of lower socio-economic groups have shown little or no reduction in smoking prevalence in recent years.

Recent work by the Public Health Wales Observatory, *Measuring Inequalities: Trends in mortality and life expectancy*, highlighted the widening and unacceptable inequalities in health between the most deprived and least deprived areas of our country. *Fairer Health Outcomes for All* sets out the Welsh Government's strategy for reducing health inequities. This report reveals how smoking is estimated to cause around 30 per cent of the total inequality in death rates between the most and least deprived areas in Wales. To tackle these inequalities we must look beyond smoking itself, to the 'causes of the causes'. Differences in the prevalence of smoking can be attributed to social determinants of health such as education and employment. If we are to be successful in further reducing the prevalence of smoking in Wales we must target those wider social determinants.

Other countries have shown that with bold and sustained action, the prevalence of smoking can be reduced to the levels aspired to in the *Tobacco Control Action Plan*. Government, the health service and wider society must commit to realising this aspiration.

We congratulate our colleagues at Public Health Wales and the Welsh Government for producing the most comprehensive picture of tobacco and health in Wales to date. It shows how far we have come. It demonstrates how much further we need to go.

Dr. Tony Jewell
Chief Medical Officer for Wales

Professor Sir Mansel Aylward CB
Chair, Public Health Wales

Key messages

- Smoking continues to be the greatest single cause of avoidable mortality in Wales. In people aged 35 and over, smoking causes nearly one in five of all deaths and around one third of the inequality in mortality between the most and least deprived areas.
- Twenty-three per cent of adults described themselves as current smokers in 2010. This is considerably lower than in the 1970s, but the fall in rates has slowed down in recent years. Considerable efforts are therefore required to meet the Welsh Government's target of 16 per cent by 2020.
- Overall, smoking is more common in males than in females, although in children and young people the reverse is true. Rates of smoking in males aged 25-34 and 35-44 are particularly high (37 per cent and 31 per cent respectively) and have not reduced appreciably in the last seven years. Latest estimates suggest that around one in six girls aged 15-16 are regular smokers, compared to one in nine boys. Smokers in this age group reported starting at an average of just 12 years of age.
- Smoking rates are highest in the most deprived areas of Wales. More than 40 per cent of people who have never worked or are unemployed are current smokers, with no recent signs of this figure decreasing. Smoking rates in managerial and professional groups continue to fall. These trends are likely to contribute to widening health inequalities in the future.
- Around one in six females living in Wales smoke throughout pregnancy, the highest rate of all UK nations, though this has fallen since 2005. Older mothers and those in managerial and professional groups are most likely to give up smoking during pregnancy.
- The 2007 ban on smoking in enclosed public places has led to considerable falls in people's exposure to second-hand smoke. However, 39 per cent of children live in households where at least one adult is a current smoker, and 20 per cent report recent exposure to second-hand smoke in cars. Exposure is most likely in children of parents who are unemployed or in routine and manual occupations, and children living in more deprived areas are more likely than their less deprived peers to be admitted to hospital for diseases associated with second-hand smoke.
- In 2010, seven out of ten smokers reported that they would like to give up and around six out of ten smokers receiving support from Stop Smoking Wales reported success at the four-week point.
- Overall rates of death from smoking are falling, but socio-economic inequalities are widening due to faster falls in the least deprived parts of Wales than in the most deprived. Lung cancer mortality rates in females have risen in Wales and the UK over the last ten years, whereas in males they have fallen slightly. This is likely a reflection of the differences in the historical patterns of smoking between males and females in the late 20th century.
- Smoking is estimated to cause around 27,700 hospital admissions each year in Wales. This represents a considerable burden on the health service.
- Tobacco is around 30 per cent less affordable than in 1980, but the effectiveness of price as a control measure is diminished by continued access to smuggled products.
- Major reductions in smoking prevalence are achievable, given evidence from California and Singapore.

1 Introduction

The current impact of tobacco use on the health in Wales has its origins in the 20th century, which saw the rise and fall of the smoking epidemic in the UK as a whole. Men were already commonly using tobacco in the 1900s, when manufactured cigarettes were not yet widespread, and as figure 1 shows, consumption rose rapidly and reached a peak around the Second World War. In 1948, an estimated 80 per cent of men were tobacco users[1]. Having been considered socially unacceptable prior to the liberation of women associated with the Suffragette movement in the 1920s[2], tobacco use in women started later than in men, with estimated prevalence reaching 45 per cent in 1966[1].

The realisation in the 1950s and 1960s that smoking causes major harm to health, thanks in part to the long-term study of male British doctors carried out by Richard Doll and colleagues[3], led to falling tobacco consumption in the UK in the latter part of the 20th century.

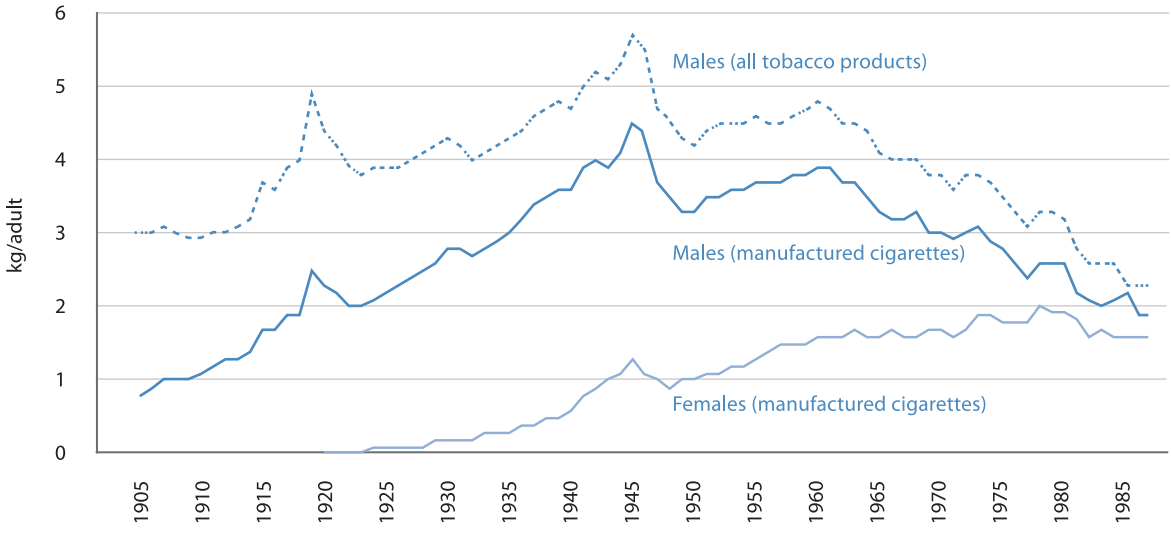
However, the impact of long-term smoking on the young adults of the 1960s and 1970s, when around half the population were tobacco users, continues to be visible in high rates of lung cancer and other smoking-related diseases today.

Furthermore, whilst great strides have been taken in the lowering of smoking prevalence to around one in four adults in Wales, and exposure to second-hand smoke has been reduced by the ban on smoking in enclosed public places in 2007, considerable challenges remain in the drive to stop young people starting to smoke and to help smokers to stop. Dependence on tobacco remains a serious form of drug addiction[2], appearing to offer an escape from the stress of socio-economic deprivation whilst exacerbating it by draining income and harming health[4]. These challenges are recognised by *Our Healthy Future*[5], Wales' current strategy for improving health, which made reducing levels of smoking one of its ten priority outcomes and advocated the development of the recently-published *Tobacco Control Action Plan for Wales*[6].

This report provides a range of information to support the implementation of this action plan, updating *Smoking in Wales: Current Facts* which was published in 2007 by the Welsh Government and Wales Centre for Health. An accompanying technical guide detailing data sources, methods and caveats is available on the Public Health Wales Observatory website, along with interactive spreadsheets containing additional data.

Figure 1

Estimated annual consumption of tobacco products in UK males and females aged 15+, kilograms per adult, 1905-1987



Source: Tobacco Advisory Council[1]

2 The prevalence of tobacco use

Manufactured filter cigarettes remain the most popular form of tobacco product in Great Britain. However, whereas 25 per cent of male smokers and 8 per cent of female smokers in 1998 reported using mainly hand-rolled cigarettes, these figures rose to 39 and 23 per cent respectively in 2010[7]. This may reflect the increased use of smuggled hand-rolling tobacco due to its substantially lower cost (see section 6).

In minority ethnic groups, different tobacco products are used more commonly than in the general population[8]. Smokeless tobacco comes in a variety of forms, including chewing tobacco, which a survey found to be particularly common in Bangladeshi women[9]. The packaging of these alternative forms of tobacco is less likely to have appropriate health warnings and their use is embedded in South Asian culture[8], which presents considerable challenges to cessation services.

The smoking of waterpipes (also known as shisha), which originated in the Middle East and parts of Asia and Africa, is becoming more popular in Europe and can give a misleading impression of being a "safe" alternative to cigarettes since the smoke passes through water first[10]. According to the British Heart Foundation, a single puff of shisha is equivalent to inhaling the smoke from a whole cigarette[11].

2.1 Adults

This section analyses the smoking behaviour of adults (those aged 16 and over) and the prevalence amongst different population sub-groups. The information is taken from surveys where adults may or may not tell the truth about their smoking status. This could lead to bias in the results, for example if certain sub-groups are less likely to admit to smoking than others due to perceptions of social acceptability.

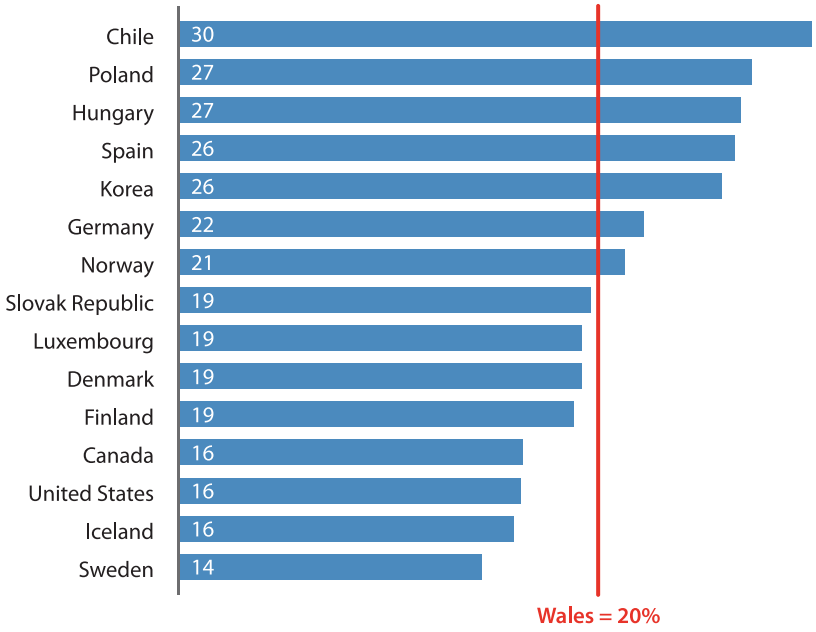
The variation shown between the results of the Welsh Health Survey and the General Lifestyle Survey is likely to be due to differences in their methods, definitions and sample sizes. For example, the Welsh Health Survey has an annual sample size of around 15,000, compared to less than 1,000 in the case of the General Lifestyle Survey. It should also be noted that figures quoted from the General Lifestyle Survey include cigarette smokers only, and may exclude a small number of people who smoke only a pipe or cigar.

International and Great Britain smoking rates

Comparability between international smoking rates is likely to be limited by methodological differences in health surveys across countries. There may be differences in the question wording, the response categories, the age groups covered and the related administrative methods. However, using daily smoking rates of other Organisation for Economic Co-operation and Development (OECD) countries as a guide for comparison, Wales ranks roughly in the middle (figure 2). An outline of tobacco control measures in countries with comparatively low smoking prevalence can be found in section 7.

Figure 2

Percentage of adults who reported smoking daily, OECD countries, 2009



Source: OECD; Welsh Health Survey (Welsh Government)

(a) Note that international comparability is limited due to the lack of standardisation in the measurement of smoking habits in health interview surveys across OECD countries. There is variation in the wording of the question, the response categories, the age groups covered and the related administrative methods.

(b) OECD countries with missing data for 2009 have been omitted from the chart.

Smoking is less common in England than in Wales and Scotland. Around one in four adults in Wales and Scotland reported themselves to be cigarette smokers in 2010, compared to one in five in England (figure 3).

Figure 3

Percentage of adults who reported smoking daily or occasionally, by country, 2010

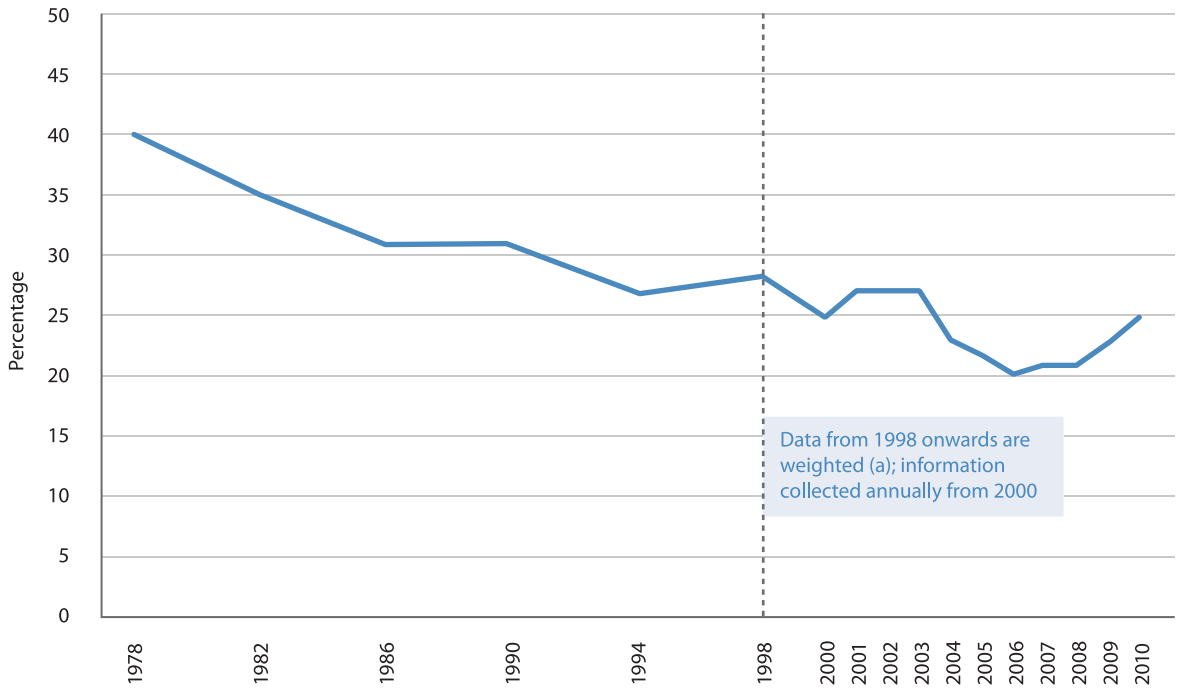
Source: General Lifestyle Survey (Office for National Statistics)

Smoking trends in Wales

Information on smoking behaviour among adults has been reported since the 1970s through the General Lifestyle Survey. Caution is needed in interpreting the results of this survey due to the small sample size for Wales, but the overall percentage of the population who smoke cigarettes has generally decreased over the period shown in figure 4, from 40 per cent in 1978 to between 20 and 25 per cent in recent years.

Figure 4

Percentage of adults who reported smoking daily or occasionally, Wales, 1978-2010

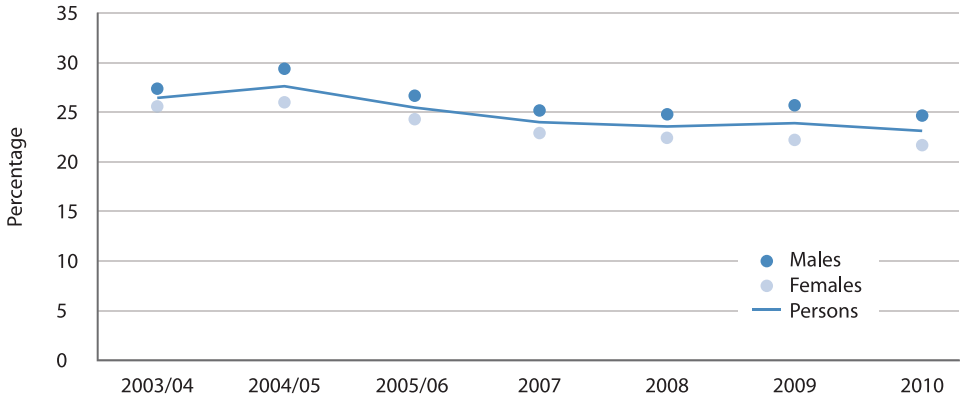


Source: General Lifestyle Survey (Office for National Statistics)

(a) Weighting applied by ONS to compensate for non-response. Technical reports from the survey show that the weighted percentage of smokers has been around one per cent higher than the unweighted percentage from 1998 onwards.

Figure 5

Percentage of adults who reported smoking daily or occasionally, Wales, 2003/04-2010

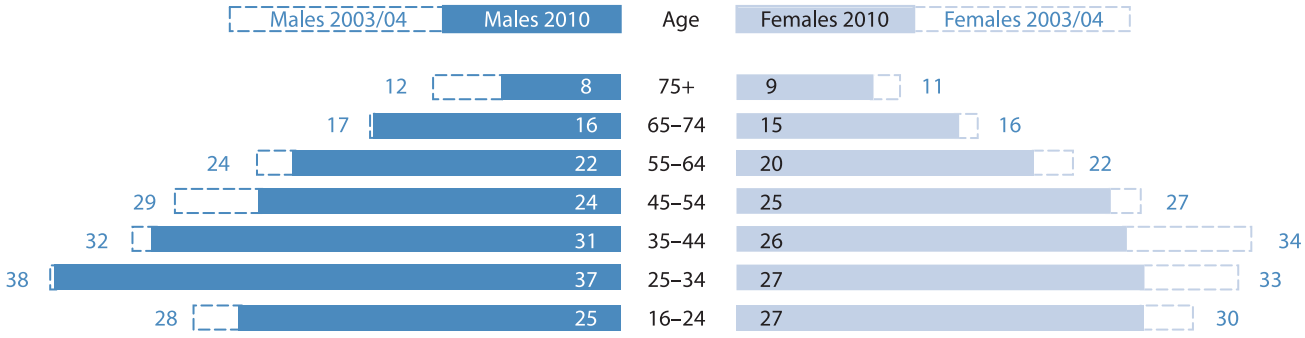


Source: Welsh Health Survey (Welsh Government)

Figure 5 shows trend data for adult smokers from the Welsh Health Survey. This has a much larger sample size than the Welsh sample of the General Lifestyle Survey and the results are therefore less subject to random fluctuation and can be analysed in more detail. The chart shows that smoking remains slightly more common in males than females over this period. The relatively slow pace of decline in smoking rates in recent years, to 23 per cent in 2010, represents a considerable challenge given the target of reaching 16 per cent by 2020 set by the *Tobacco Control Action Plan for Wales*[6].

Figure 6

Percentage of adults who reported smoking daily or occasionally, Wales, by age and sex, 2003/04 and 2010



Source: Welsh Health Survey (Welsh Government)

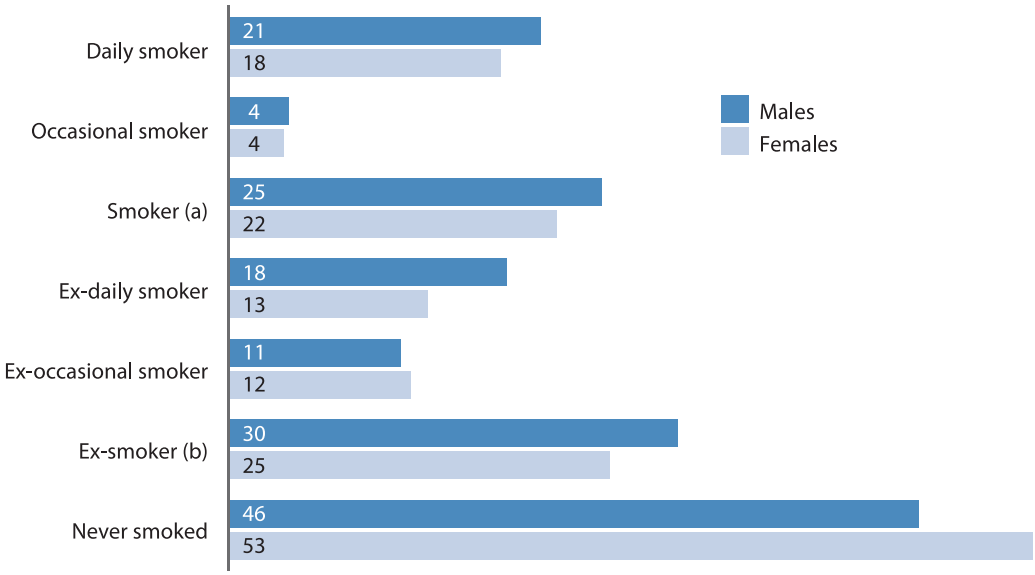
Most age groups have seen a slight decline in smoking rates since 2003/04, although most of the decreases are not statistically significant (figure 6). The rates of male smokers aged 25-34 and 35-44 in 2010 remain at similar levels to 2003/04, however, female smoking rates have decreased for these age groups. The rates of male smokers aged 45-54 and 75+ have decreased since 2003/04, but there has been little change in the 65-74 age group. It can be seen that the prevalence of smoking decreases with age.

Smoking status

In the 2010 Welsh Health Survey, 23 per cent of adults reported that they currently smoke, 27 per cent reported that they used to smoke, and 50 per cent reported that they have never smoked. This suggests that around 570,000 adults in Wales smoke (either daily or occasionally).

Figure 7

Percentage of adults reporting specific smoking status, by sex, 2010



Source: Welsh Health Survey (Welsh Government)
(a) 'Smoker' indicates those who smoke either daily or occasionally.
(b) 'Ex-smoker' indicates those who used to smoke either daily or occasionally.

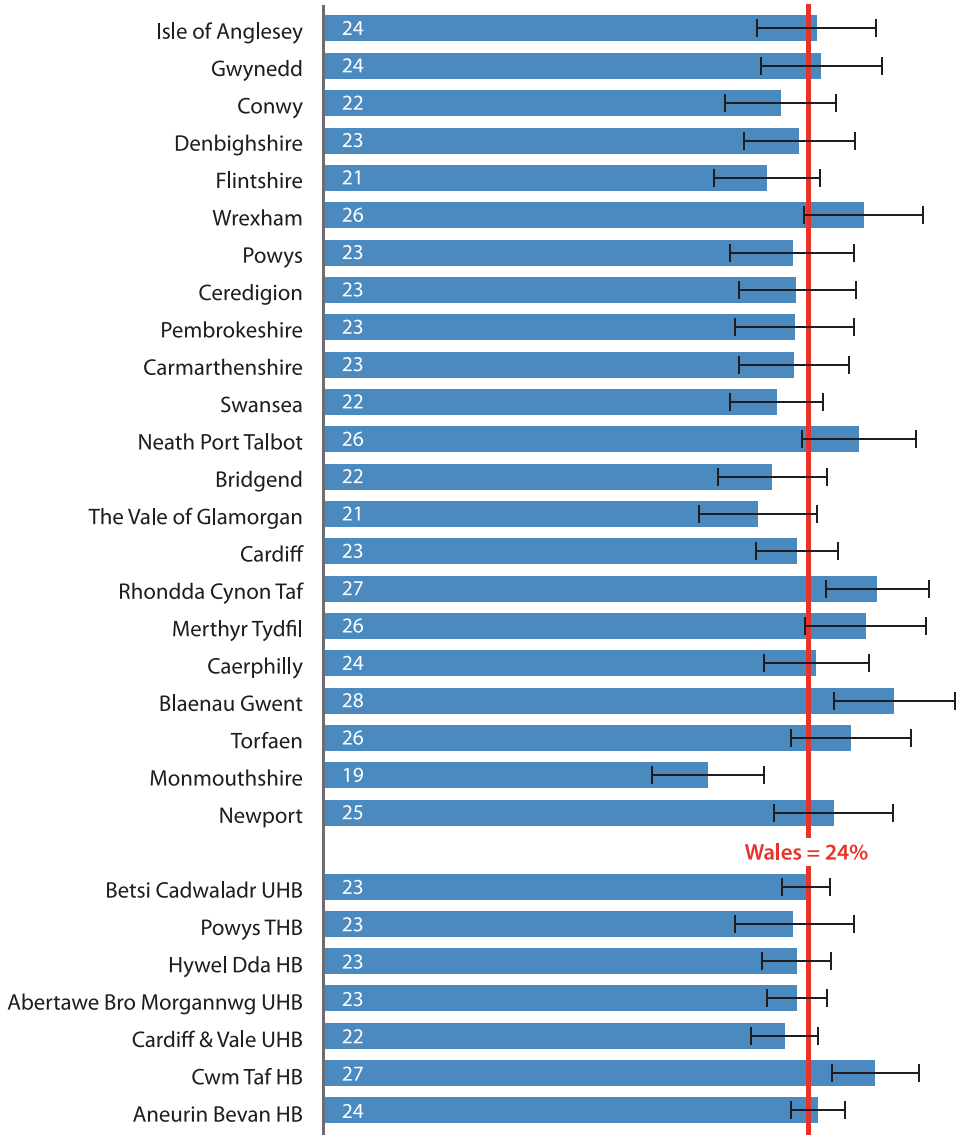
Figure 7 illustrates that a slightly higher proportion of males reported themselves to be smokers (25 per cent) compared with females (22 per cent). The percentage of adults who have never smoked is higher amongst females than males. However, the fact that around half of people surveyed had tried smoking at some point illustrates the challenge of preventing people from taking up this highly addictive habit.

Smoking by geographic area

Combining data from the 2009 and 2010 Welsh Health Surveys, adult smoking rates were highest in the South Wales Valleys areas of Blaenau Gwent and Rhondda Cynon Taf (figure 8). These areas experience high levels of deprivation[12] and as shown in figures 10 and 11, smoking rates in the most deprived areas of Wales rise to around 35 per cent. The variation between levels of smoking across Wales is a key contributor to health inequalities (section 5.2). In 2009-10, nine percentage points separated the smoking rates of Blaenau Gwent and Monmouthshire.

Figure 8

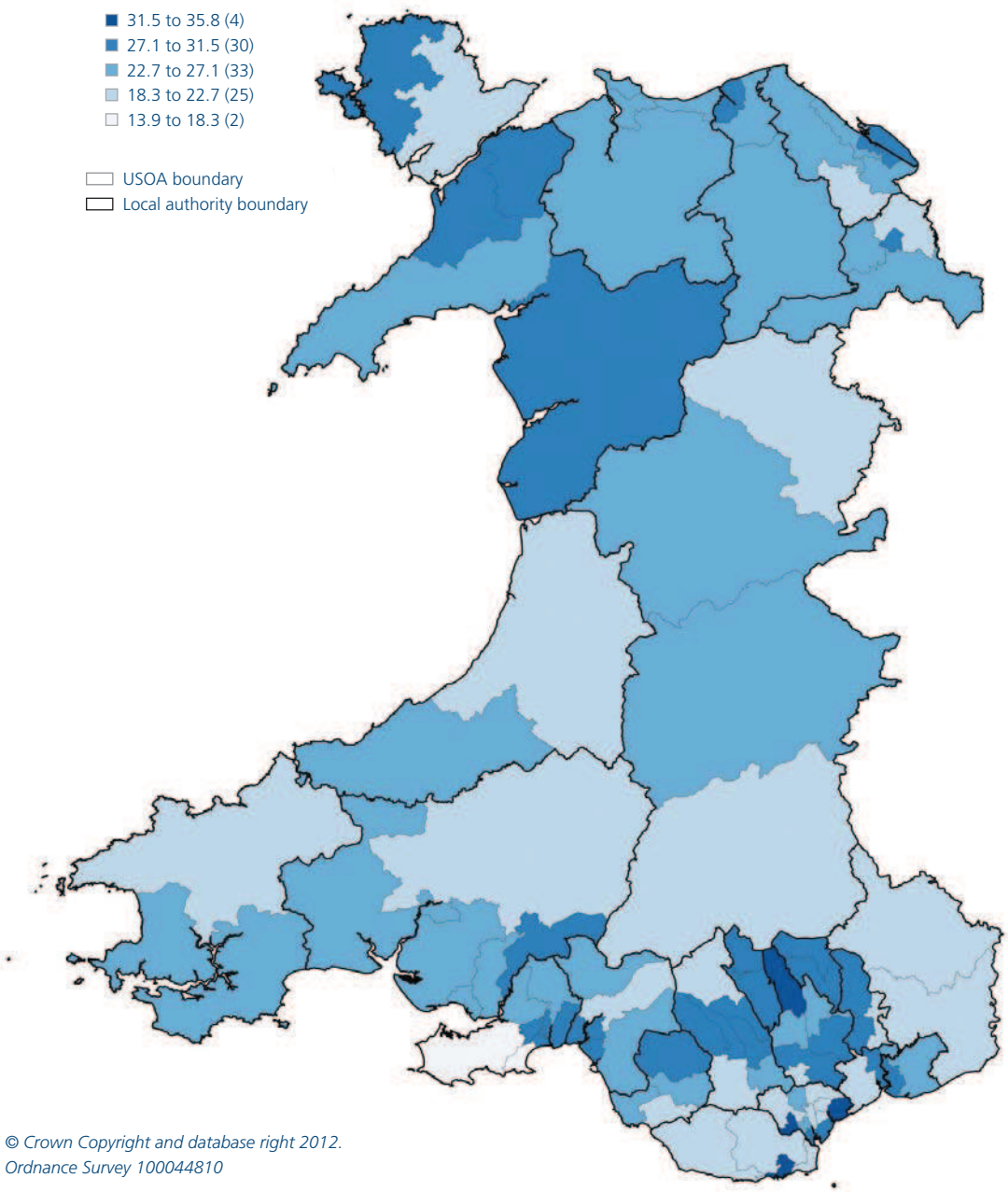
Percentage of adults who reported smoking daily or occasionally, by local authority and health board, age-standardised, 2009-10



Source: Welsh Health Survey (Welsh Government)
Horizontal lines (⊢⊣) show 95 per cent confidence interval

Figure 9

Percentage of adults who reported smoking daily or occasionally, by Upper Super Output Area (USOA), age-standardised, 2003/04-2009



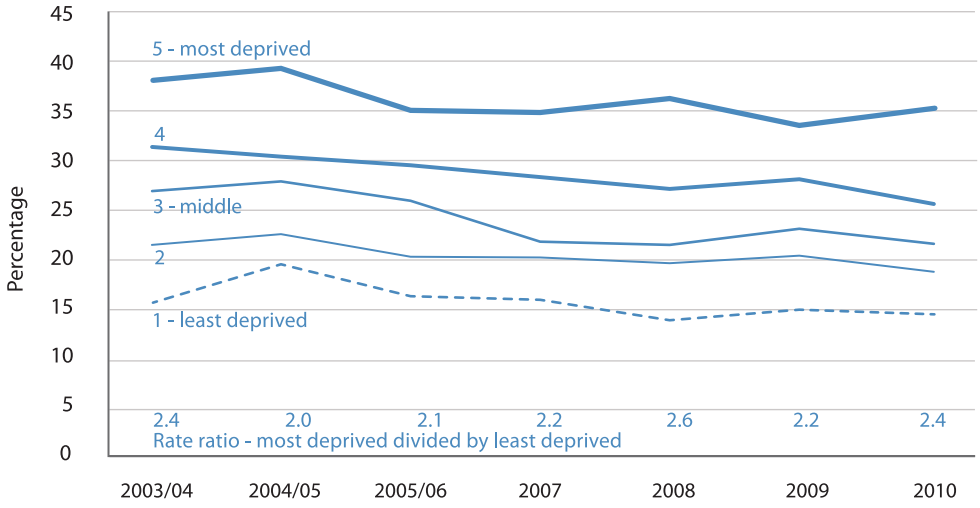
Source: Welsh Health Survey (Welsh Government)

The map in figure 9 shows adult smoking rates using Upper Super Output Areas (USOAs), a statistical geography. Wales has 94 USOAs with a consistent population size of around 30,000. Welsh Health Survey data from 2003/04 to 2009 was combined to increase the sample size for these areas and improve the precision of the estimates. Smoking rates are high across the South Wales Valleys regions, and also in parts of Cardiff, Barry (in The Vale of Glamorgan) and North West Wales. Greater variation can be seen across USOAs in Wales compared to local authority and health board areas (figure 8), with rates ranging from around 14 to 35 per cent.

Smoking by socio-economic factors

Figure 10

Percentage of adults who reported smoking daily or occasionally, by deprivation fifth (Welsh Index of Multiple Deprivation 2008), age-standardised, 2003/04-2010

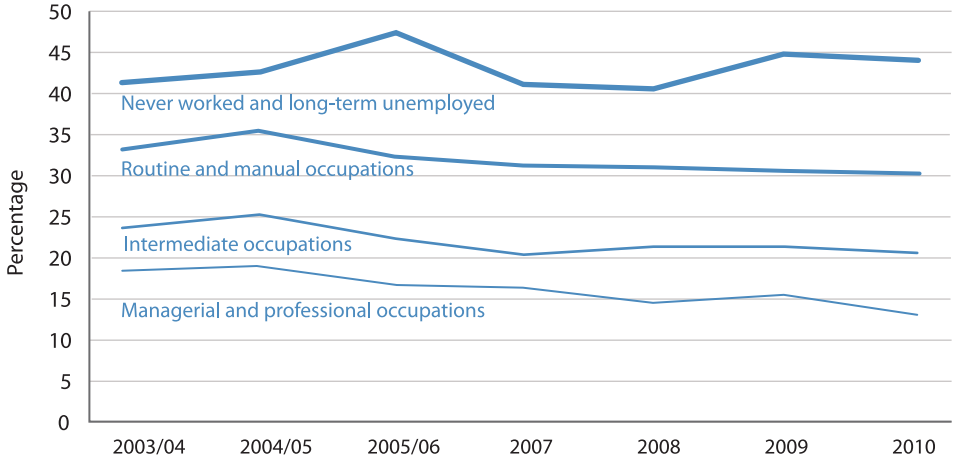


Source: Welsh Health Survey, Welsh Index of Multiple Deprivation (Welsh Government)

As suggested by figures 8 and 9, adult smoking rates are highest in the most deprived parts of Wales (figure 10). This analysis has been carried out by combining small areas across Wales into five groups ('fifths'), based on ranked deprivation scores from the Welsh Index of Multiple Deprivation 2008. All fifths have experienced a slight decline in smoking rates since 2003/04, however, the inequality between the most and least deprived areas (groups 5 and 1) in 2010 remains similar to 2003/04, with rates in the most deprived areas remaining more than twice as high as the least deprived.

Figure 11

Percentage of adults who reported smoking daily or occasionally, by household National Statistics Socio-economic Classification, age-standardised, 2003/04-2010



Source: Welsh Health Survey (Welsh Government)

The magnitude of the challenge to reduce smoking rates to 16 per cent in Wales by 2020 is illustrated by figure 11. In households headed by someone who has never worked or who is long term unemployed, 44 per cent of adults reported to be smoking. This is based on a fairly small number of respondents, showing fluctuation over time, but there is little sign of a downward trend. Smoking rates have dropped slightly among adults in routine/manual households, to around 30 per cent, but not as much as those in managerial/professional households. This has resulted in an increasing inequality between the smoking rates of adults in managerial/professional households and routine/manual and never worked/long term unemployed households between 2003/04 and 2010.

This pattern, if allowed to continue, is likely to contribute to widening health inequalities in the future. For this reason, cessation services such as Stop Smoking Wales aim to target people in more deprived areas[13]. However, if tobacco use begins as an attempt to relieve the stress of socio-economic deprivation[4], then action to improve education, employment and the physical environment is also required to help people stop smoking.

2.1.1 Adults with mental health problems

People with mental health problems are more likely to smoke, and also to smoke more heavily, than the general population[14]. This may be due to tobacco use offering the illusion of reducing stress and anxiety[15]. It may also be that increased socio-economic deprivation acts as a confounding factor, contributing to increased prevalence of both mental illness and smoking; each are considerably more common in the most deprived areas of Wales than in the least deprived[16]. Around 14 per cent of current smokers in Wales report being treated for a mental illness, compared to 8 per cent of people who used to or have never smoked (age-standardised percentages)[17].

Life expectancy in people with schizophrenia is thought to be 20 per cent lower than the general population, a difference which has been partly attributed to high rates of smoking[18]. This places an imperative on the health service to ensure that both patients' physical and mental health are looked after[19].

The prevalence of smoking is thought to be as high as 70 per cent amongst inpatients in mental health units[20]. In Wales, these units are exempted from the 2007 ban on smoking in enclosed public places, whereas in England an initial exemption was withdrawn in July 2008, one year after the implementation of smoke-free legislation.

2.2 Maternity, children and young people

Smoking in pregnancy

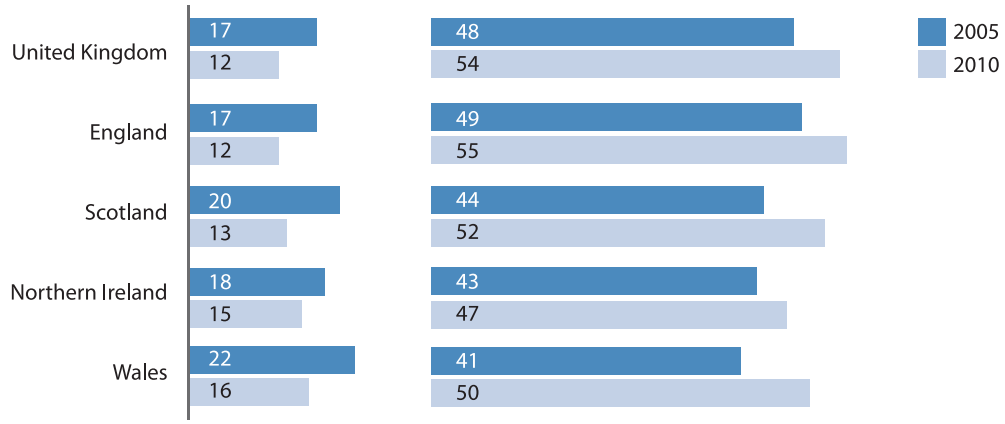
The Infant Feeding Survey is run every five years in the UK, collecting information about the smoking and drinking behaviour of mothers before, during and after pregnancy.

Figure 12

Percentage of mothers, by UK nation, who:

a) smoked throughout pregnancy

b) were smokers but gave up before or during pregnancy



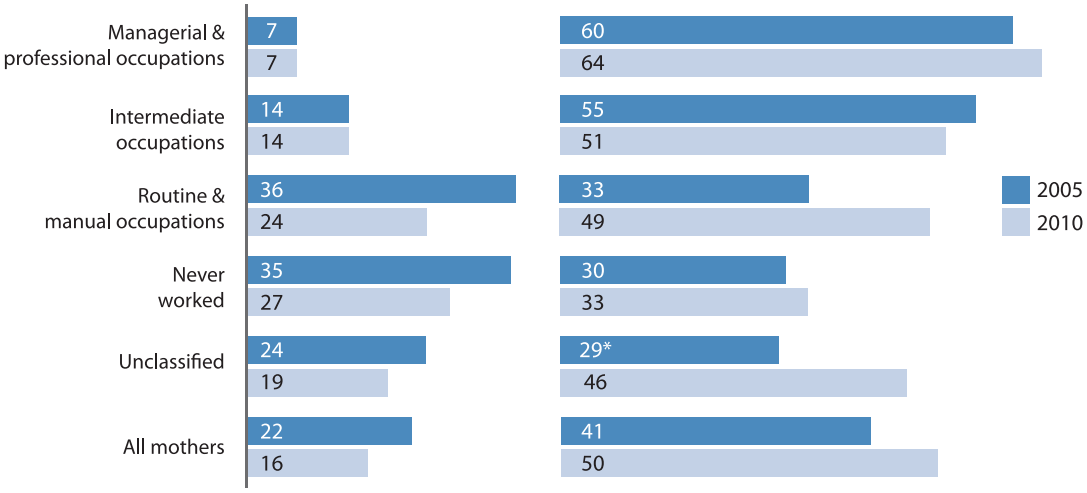
Source: Infant Feeding Survey (NHS Information Centre)

Figure 12 shows that in 2010, the proportion of mothers smoking throughout pregnancy was highest in Wales at 16 per cent, although this is lower than the figure of 22 per cent in 2005. Half of mothers in Wales who were previously smokers had given up before or during pregnancy in 2010, whereas in 2005 the corresponding figure was 41 per cent.

Echoing the pattern shown in figure 11, smoking throughout pregnancy is most common in the routine/manual and never worked groups, whereas the proportion who gave up is highest in the managerial/professional group (figure 13). However, the proportion of mothers in the routine/manual group who stopped smoking has increased from 33 per cent in 2005 to 49 per cent in 2010.

Figure 13

Percentage of mothers in Wales, by individual National Statistics Socio-economic Classification, who:
a) smoked throughout pregnancy b) were smokers but gave up before or during pregnancy

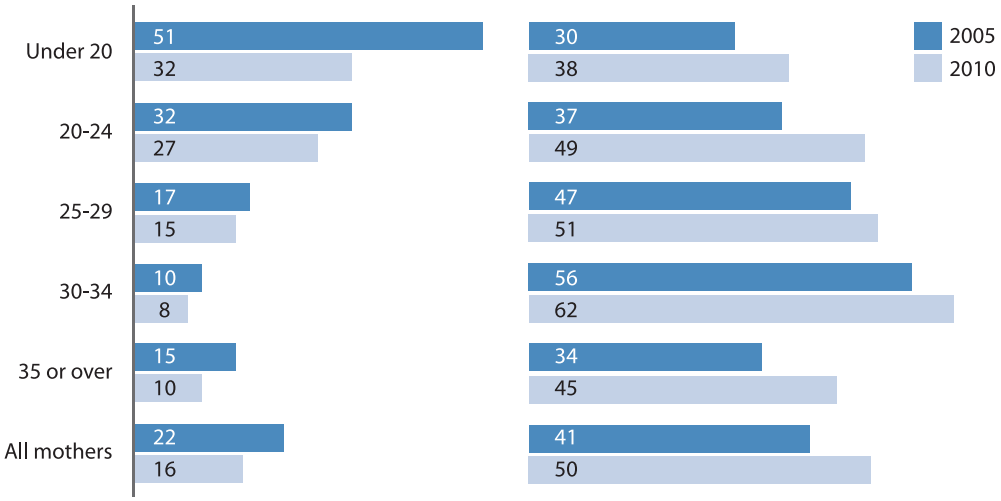


**Data should be treated with caution due to small sample size*
Source: Infant Feeding Survey (NHS Information Centre)

Although the overall proportion of mothers who smoked during pregnancy in Wales is 16 per cent, this is much higher in the lower age groups at 32 per cent and 27 per cent for the under 20 and 20-24 age groups respectively in 2010 (figure 14). However, the former figure has fallen from 51 per cent in 2005, which is a positive sign. Older mothers were generally more likely to stop smoking than younger mothers.

Figure 14

Percentage of mothers in Wales, by age, who:
a) smoked throughout pregnancy b) were smokers but gave up before or during pregnancy



Source: Infant Feeding Survey (NHS Information Centre)

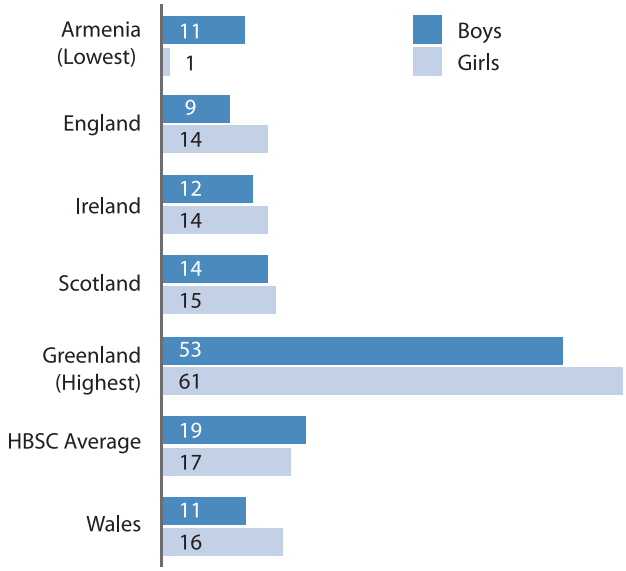
Smoking in children and young people

One of the key priority areas for the Welsh Government is to address smoking among children and young people[6]. Smoking behaviour often starts during adolescence and affects health in later life. The average age at which children aged 15 in Wales start to smoke is just 12 years old[21], with eight out of ten smokers starting before the age of 19[7].

The charts below illustrate results from the Health Behaviour in School-aged Children (HBSC) survey. This is an ongoing international study with a consistent protocol; the latest survey in Wales received 9,194 completed questionnaires from secondary school children between October 2009 and January 2010 (see online technical guide for more information).

Figure 15

Percentage of 15 year-olds who smoke at least once a week by country and sex, 2009/10

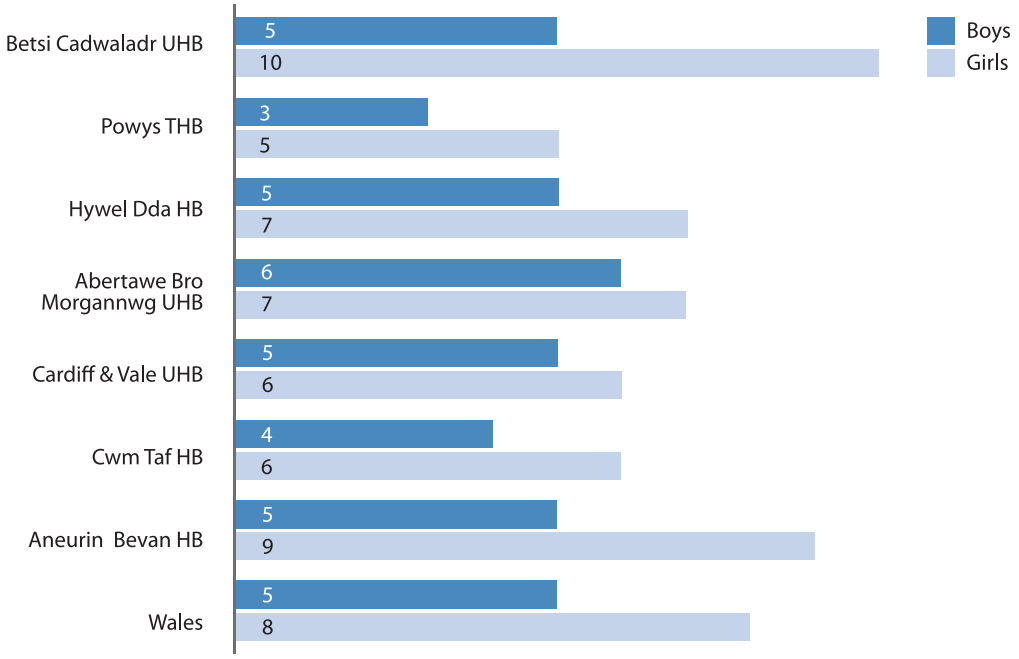


Source: Health Behaviour in School-Aged Children survey (World Health Organisation/Welsh Government)

Girls in Wales are more likely to report smoking weekly than their male counterparts (figure 15). The numbers of boys (11 per cent) and girls (16 per cent) smoking in Wales are similar to their counterparts elsewhere in Great Britain and Ireland.

Figure 16

Percentage of 11-16 year-olds who smoke at least once a week by health board, 2009

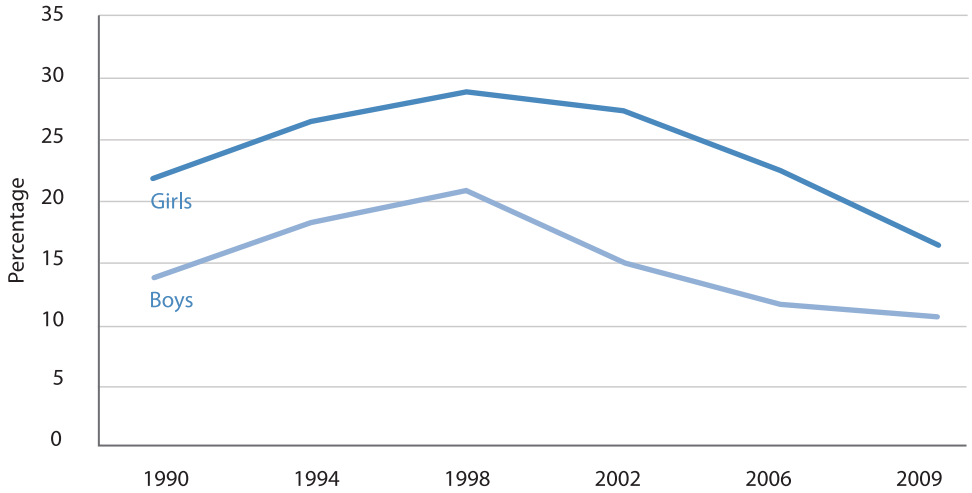


Source: Health Behaviour in School-Aged Children survey (World Health Organisation/Welsh Government)

Figure 16 shows that girls are consistently more likely to smoke than boys across all health board areas in Wales. This is particularly evident in Aneurin Bevan and Betsi Cadwaladr University health boards where girls are approximately twice more likely to smoke than boys. Children and young people living in these areas are also almost twice as likely to smoke regularly than those living in Powys Teaching Health Board. It is noteworthy that whereas adult smoking prevalence is highest in Cwm Taf (figure 8), rates in young people are comparatively low, although this may reflect the relatively small sample size by health board.

Figure 17

Percentage of 15 years-olds in Wales who smoke at least once a week by sex, 1990-2009



Source: Health Behaviour in School-Aged Children survey (World Health Organisation/Welsh Government)

The proportion of regular smokers was consistently higher among girls than boys from 1990 to 2009 (figure 17). In 2009, smoking rates for 15 year-olds in Wales were lower than in 1990 (11 per cent for boys; 16 per cent for girls) following a peak in 1998 (21 per cent for boys; 29 per cent for girls). This overall downward trend is encouraging.

3 Exposure to second-hand smoke

The legislation passed in April 2007 to ban smoking in enclosed public places in Wales was intended to reduce people's exposure to second-hand smoke, which appears to have been successful (section 3.1).

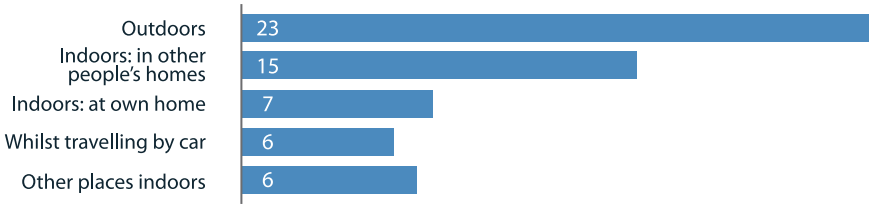
The further reduction of exposure to second-hand smoke is the fourth action area within the Welsh Government's *Tobacco Control Action Plan*. Setting an example for other organisations, health boards in Wales are gradually making their hospital grounds completely smoke-free. National work is also planned by Public Health Wales and ASH Wales to review smoke-free homes initiatives and encourage local promotion of appropriate schemes.

3.1 Adults

In 2010, 21 per cent of adult non-smokers reported being regularly exposed to other people's tobacco smoke indoors, and 33 per cent indoors or outdoors.

Figure 18

Percentage of non-smoking adults who reported being regularly exposed to other people's tobacco smoke, 2010

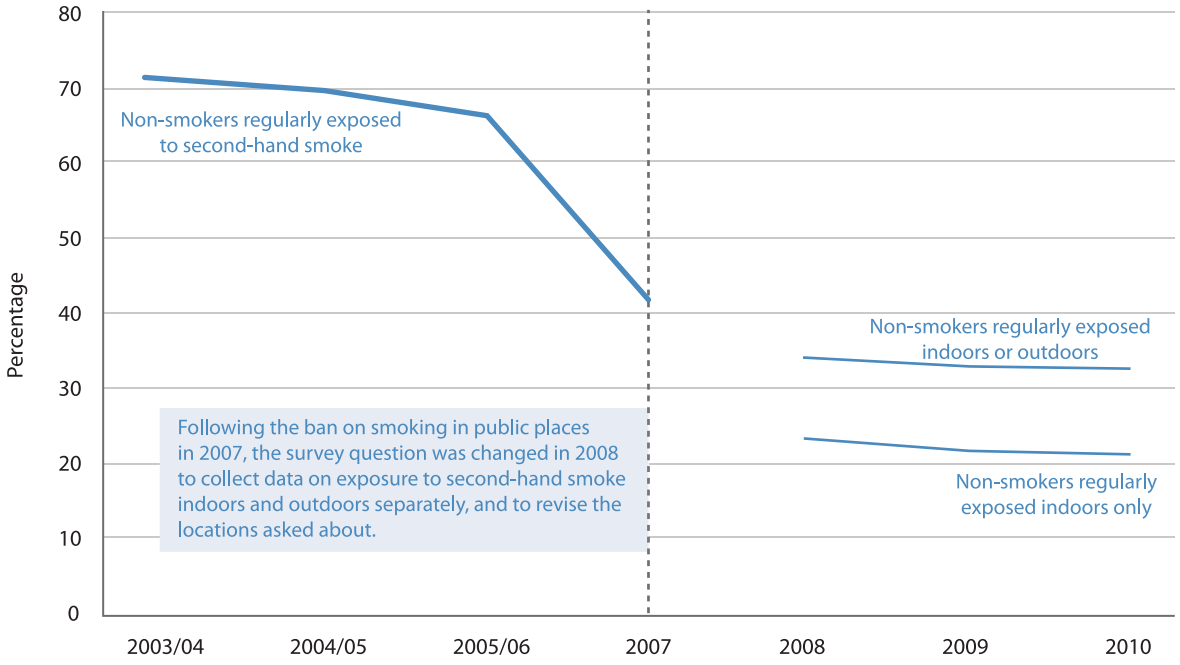


Source: Welsh Health Survey (Welsh Government)

Figure 18 shows that of all adult non-smokers, 15 per cent reported being exposed to other people's smoke in other people's homes, 7 per cent in their own homes, 6 per cent whilst travelling by car, and 6 per cent in other places indoors. Adults' reported exposure to second-hand smoke decreased with age, and this applied for all the places specified.

Figure 19

Percentage of non-smoking adults who reported being regularly exposed to other people's tobacco smoke, 2003/04-2010



Source: Welsh Health Survey (Welsh Government)

The trend in exposure to second-hand smoke (figure 19) reflects a question change on the Welsh Health Survey in 2008. Prior to this, there was no specific guidance to respondents about recording exposure to smoke outdoors. From 2008, the question was revised and asked about exposure indoors and outdoors separately. It also revised the locations asked about in order to reflect the ban on smoking in public places implemented during 2007.

The chart shows that the percentage of non-smokers regularly exposed to second-hand smoke dropped considerably from 66 per cent in 2005/06 to 42 per cent in 2007, coinciding with the implementation of the smoking ban in Wales which came into force on 2nd April 2007, ending smoking in enclosed and substantially enclosed public places. Since 2008, second-hand smoking rates have remained fairly constant, for those exposed indoors or outdoors and indoors only.

3.2 Children

Initial concerns that banning smoking in enclosed public places would lead to increased smoking at home, and therefore increased exposure of children to second-hand smoke, appear to have been unfounded. Studies of primary school children in Wales[22] and Scotland[23] found no increase in exposure, and even suggested a slight decrease, possibly due to parents responding to smoke-free legislation by smoking less at home.

Children living in households where adults smoke

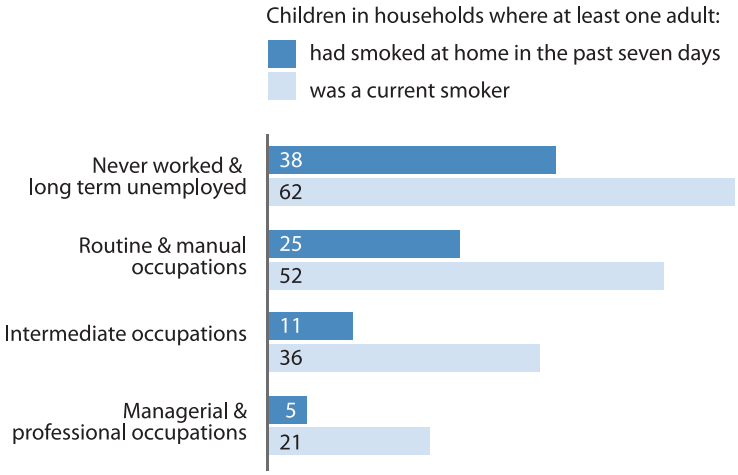
In 2010, results from the Welsh Health Survey showed that 39 per cent of children lived in households where at least one adult was a current smoker, and 17 per cent of children lived in households where at least one adult had smoked in their home in the past seven days.

The percentage of children living in households where at least one adult was a current smoker increases considerably from managerial and professional households through to households headed by someone who had never worked/was long term unemployed (figure 20). Similarly, the percentage of children living in households where an adult had smoked at home in the previous week was five times higher in routine and manual households (25 per cent) compared with managerial and professional households (5 per cent).

Figure 20 also appears to indicate differences in the propensity of adult smokers to smoke in homes where children are present. In managerial and professional households, 21 per cent of children lived with at least one current smoker, yet only 5 per cent of children in these households lived with an adult who had recently smoked in the home. In households headed by someone who had never worked/was long term unemployed, 62 per cent of children lived with a current smoker and 38 per cent with an adult who had recently smoked in the home.

Figure 20

Percentage of children living in households where adults smoke, by household National Statistics Socio-economic Classification, 2009-10



Source: Welsh Health Survey (Welsh Government)

Analysis by area of residence using the Welsh Index of Multiple Deprivation showed similar results, with over twice as many children in the most deprived areas living in households where an adult is a current smoker (55 per cent) compared to the least deprived areas (24 per cent).

Children exposed to smoking in cars

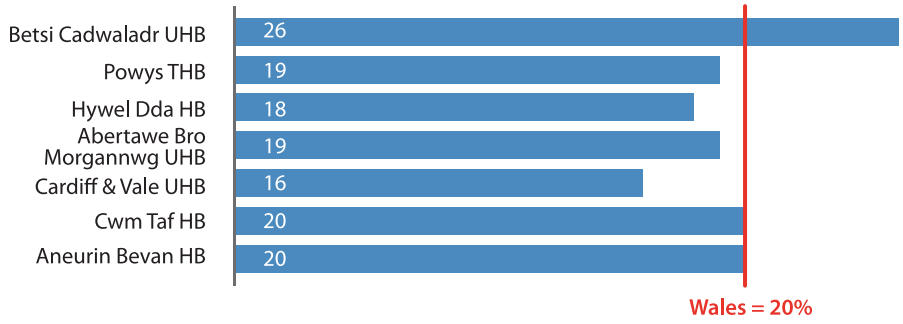
Although the ban on smoking in public places introduced in 2007 protects people from second-hand smoke when travelling on public transport, the same level of protection does not apply when travelling by car. Unlike adults, children are often unable to control whether or not they are exposed to second-hand smoke in cars.

Whilst the smoking ban has had a positive impact in reducing exposure to second-hand smoke in enclosed public places and workplaces, the proportion of children who report being exposed to smoking in cars remains high at 20 per cent (figure 21). The Welsh Government launched a campaign in February 2012 called Fresh Start Wales, calling on adults to keep their cars smoke free to protect children, with a pledge to consider legislation if this does not lead to falls in exposure.

Children living in the Betsi Cadwaladr health board area are more likely to be exposed to second-hand smoke in cars when compared to other health board areas in Wales (figure 21). In fact, nearly one in three girls living in the Betsi Cadwaladr health board area said that they were exposed to smoking the last time they travelled by car. Conversely, one in six boys and girls living in the Cardiff and Vale health board area reported exposure to smoke during their last car journey. Findings for other health board areas are comparable to the Welsh average.

Figure 21

Percentage of 11-16 year-olds exposed to smoke in cars by health board, 2009



Source: Health Behaviour in School-Aged Children survey (World Health Organisation/Welsh Government)

4 Prevention and cessation

Reducing the uptake of smoking and lowering smoking prevalence are two of the key action areas within the Welsh Government's *Tobacco Control Action Plan*. Considerable efforts will be required, both in preventing young people from starting to smoke and helping smokers to quit, in order to meet the target set within the Action Plan of reducing the adult prevalence of smoking in Wales to 16 per cent by 2020.

The health benefits of both these strategies are clear. A major study of cigarette smoking found that quitting at age 60, 50, 40, or 30 years old gained an estimated 3, 6, 9, or 10 years of life expectancy respectively[3].

4.1 National prevention initiatives

The ASSIST programme[24] aims to stop young people starting to smoke by training influential year 8 students as peer supporters. Having been nominated as 'respected' and 'looked up to' by other students, these peer supporters are given initial training and follow-up support to discourage smoking within their year group through informal conversations about the risks of tobacco use.

The programme, which is run by Public Health Wales, trained 1400 peer supporters from 46 schools in 2010/11 (table 1), which represents 21 per cent of the 223 schools in Wales. This is a considerable increase from the 500 peer supporters from 17 schools trained in 2008/09.

Table 1

Number of peer supporters trained by ASSIST programme, 2008/09-2010/11

Year	Number of schools	Number of peer supporters (approx)
2008/09	17	500
2009/10	39	1100
2010/11	46	1400

Source: Public Health Wales

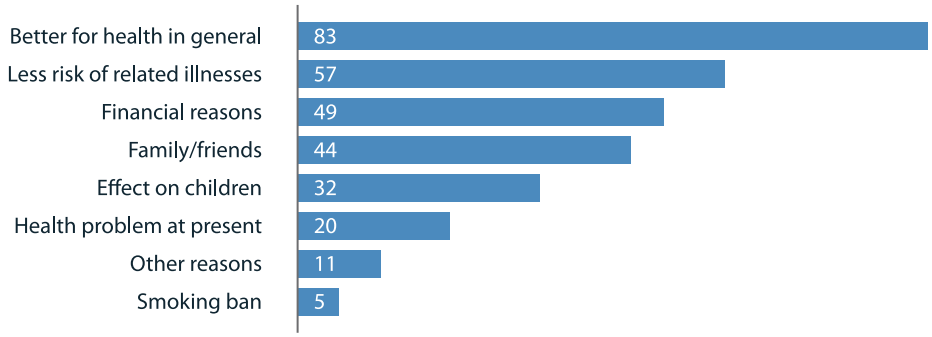
Smokefree Class[25] and Smokebugs! are two further national smoking prevention projects for children and young people. The former is a European initiative run in years 7 and 8, with pupils pledging as a class to remain smoke free. Smokebugs! is a club for younger children (years 4 to 6) which had around 9,400 members in November 2011. Newsletters and activity packs are sent to members, aiming to help them choose not to start smoking, along with discounts for local attractions.

4.2 How many smokers would like to quit, and why?

In Wales in 2010, 70 per cent of adult smokers reported that they would like to give up smoking, while 38 per cent of adult smokers had tried to give up in the last year. Figure 22 shows that the main reason reported by adult smokers for wanting to give up was better health (83 per cent), although nearly half also cited financial reasons.

Figure 22

Percentage of adult smokers citing specific reasons for wanting to give up smoking, 2010



Source: Welsh Health Survey (Welsh Government)

4.3 People using Stop Smoking Wales to help them quit

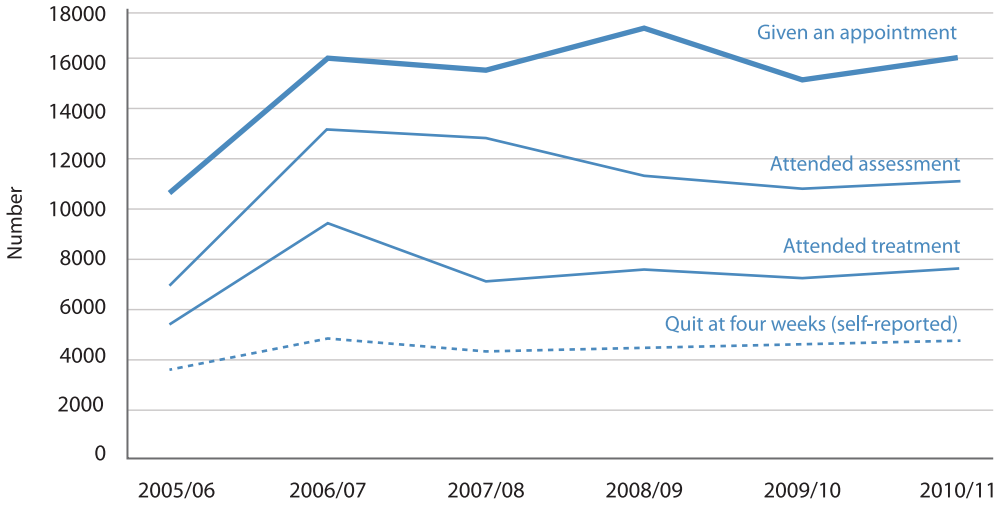
Stop Smoking Wales is a national service provided by Public Health Wales. Trained advisors deliver an evidence-based six-week behavioural support programme to smokers who want to give up, usually in a group setting, across more than 200 sites in Wales. Evidence-based cessation services such as Stop Smoking Wales have been shown to be a cost-effective way of helping smokers to quit[26]. Current priorities for Stop Smoking Wales include preoperative and maternity smoking cessation.

Figure 23 shows that in recent years, an annual average of around 16,000 people contact the service and are given appointments with an advisor. In 2010/11, three-quarters of these appointments were delivered in closed groups, with most of the remainder undertaken on a one-to-one basis to accommodate clients' specific needs. Around 200 people received telephone support. Closed groups have demonstrated a higher rate of successful quitters than one-to-one appointments[27].

The number of smokers going on to attend the initial assessment session fell from around 13,300 in 2006/07 to 11,100 in 2010/11. In 2006/07, when the impending ban on smoking in enclosed public places was perhaps providing smokers with additional motivation to quit, around 60 per cent of people contacting the service went on to attend at least one treatment session. In subsequent years, this figure fell to between 45 and 50 per cent.

Figure 23

Use of Stop Smoking Wales: i) given an appointment, ii) attended assessment, iii) attended treatment, iv) quit at four weeks (self-reported), 2005/06-2010/11



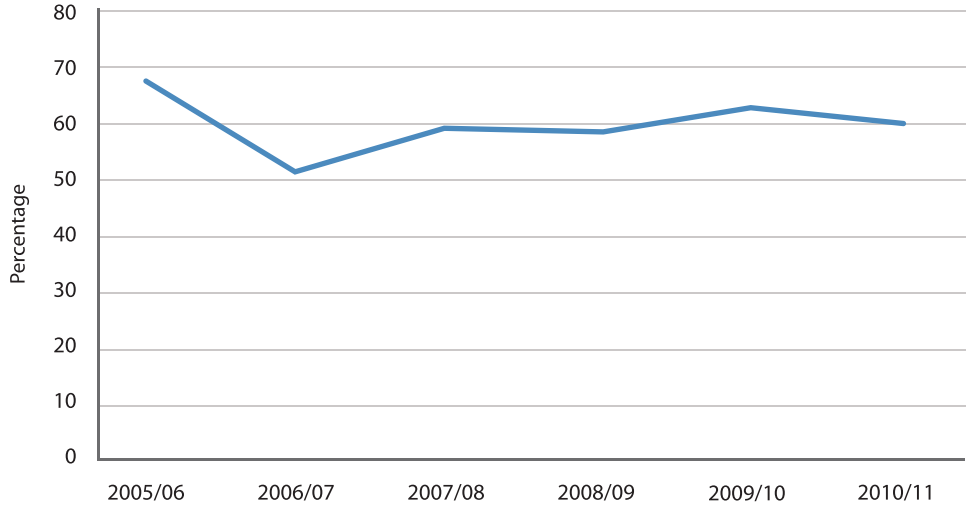
Source: Stop Smoking Wales (Public Health Wales)

The drop in self-reported quit rate in 2006/07 (figure 24) coincides with the higher numbers of smokers attending assessment treatment during this period (figure 23). This may indicate that the 2007 ban on smoking in enclosed public places provided an initial motivation to quit which smokers were then unable to maintain. Since 2007/08, the quit rate has remained fairly steady at around 60 per cent. This compares to a figure of 49 per cent reported in England over the same period[28], although the method of service delivery is slightly different and this may affect the measurement of quit rates.

It should be noted that these trends may be influenced by changes in the reliability of self-reported data. Carbon monoxide (CO) testing provides a more accurate measure of the success of treatment programmes, but not all quitters attend the final treatment session in which this is carried out. Quit status is then confirmed by telephone follow-up.

Figure 24

Quit rate after four weeks (self-reported), percentage of all smokers attending at least one treatment session, 2005/06-2010/11



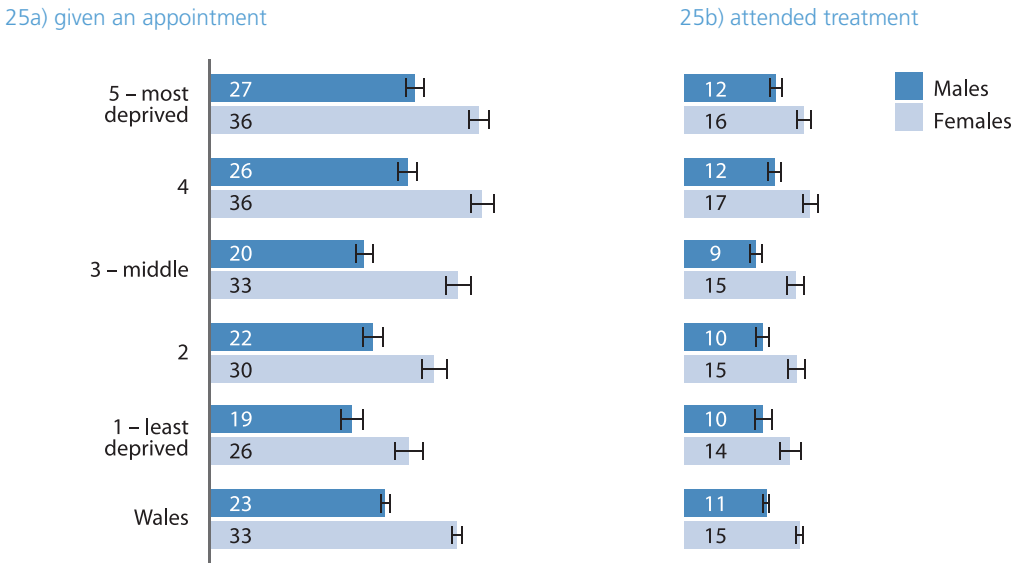
Source: Stop Smoking Wales (Public Health Wales)

The estimated proportion of smokers being given an appointment with Stop Smoking Wales increases with deprivation (figure 25a). This pattern has the potential to start to address inequalities in mortality between the most and least deprived areas (figure 31). However, continuation to treatment appears less likely in the most deprived groups. The rate of treatment is 12 per 1,000 in the most deprived males, compared to 27 per 1,000 who are given an appointment; in the least deprived males, 10 per 1,000 attend treatment compared to 19 per 1,000 given an appointment.

Although women are generally more likely to use the service than men, the proportion of female smokers attending treatment is similar in the least (14 per 1,000) and most deprived areas (16 per 1,000).

Figure 25

Smokers who contacted Stop Smoking Wales in 2011 and a) were given an appointment, and b) attended treatment, age-standardised rate per 1,000 estimated smokers in Wales, by deprivation fifth (Welsh Index of Multiple Deprivation 2011)

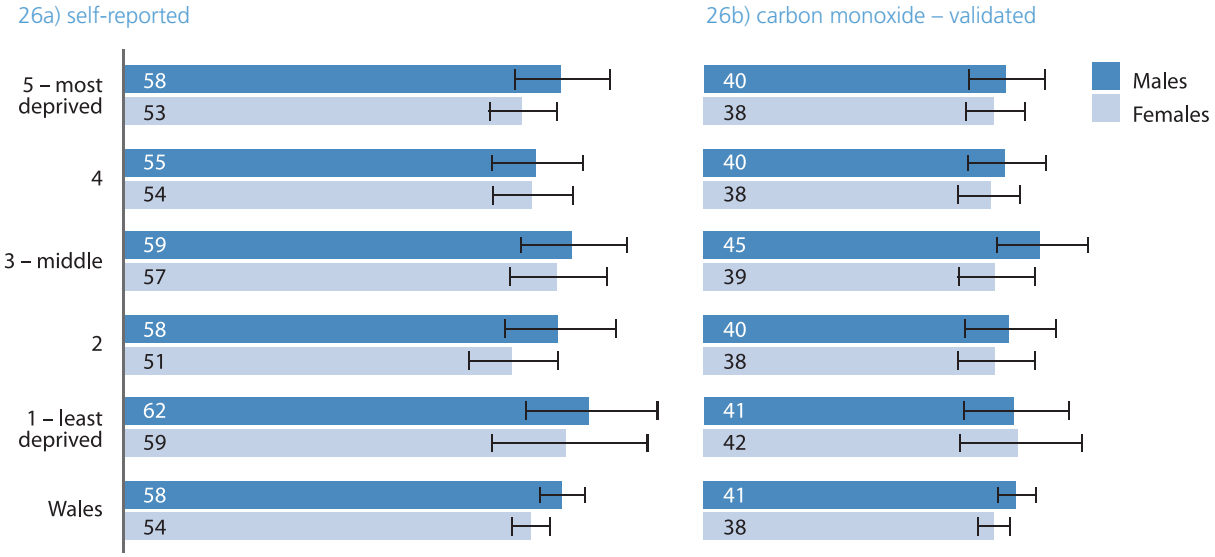


Source: Stop Smoking Wales (Public Health Wales)
Horizontal lines (⊢⊣) show 95 per cent confidence interval

People living in more deprived areas are likely to find it harder to stop smoking than their less deprived peers[29]. Self-reported quit rates in Wales (figure 26a) are slightly lower in the most deprived males than in the least deprived (58 vs 62 per cent), with the gap between females slightly larger (53 vs 59 per cent). However, there is not a great deal of variation across the five groups. The same is true using CO-validated data (figure 26b), where quit rates are only one per cent lower in the most deprived males than in the least deprived.

Figure 26

Quit rate after four weeks, 2011, a) self-reported and b) CO-validated, age-standardised percentage of all smokers attending at least one treatment session, by deprivation fifth (Welsh Index of Multiple Deprivation 2011)



Source: Stop Smoking Wales (Public Health Wales)
Horizontal lines (⊢⊣) show 95 per cent confidence interval

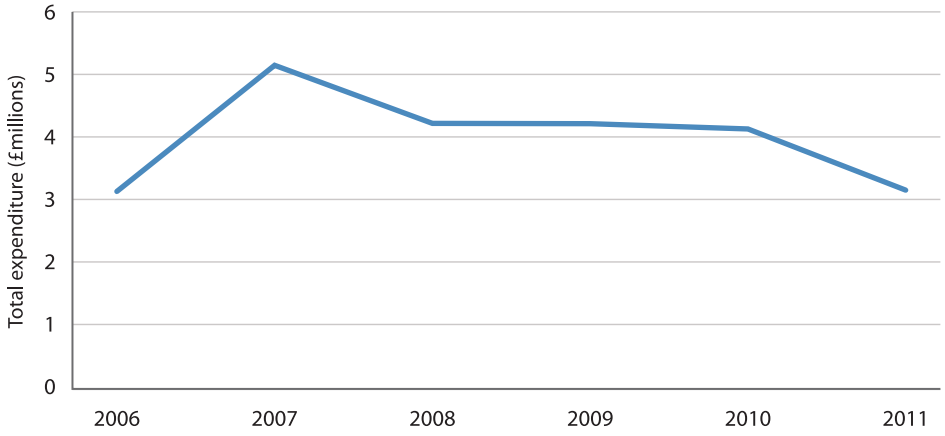
4.4 Use of medicines to help people stop smoking

Research has shown that pharmacotherapy can considerably increase a smoker's chances of quitting[30]. The medicines used to support smoking cessation are: nicotine replacement therapy (NRT) (available in several formulations on prescription, over-the-counter in pharmacies, and on general sale), varenicline and bupropion (both are prescription-only medicines). Varenicline was introduced into the UK in 2006. NRT, varenicline and bupropion have all been approved by National Institute for Health and Clinical Excellence as options for people trying to quit smoking.

In 2007, over £5m was spent on prescriptions of these medicines via primary care, an increase of 62 per cent from 2006. This is consistent with the introduction of the ban on smoking in public places in Wales in April 2007. Overall, the expenditure on these medicines has fallen in the years since 2007 with £3.3m spent in 2011. In this four-year period of time, expenditure on varenicline increased by 41 per cent and on bupropion decreased by 75 per cent.

Figure 27

Annual NHS primary care prescribing expenditure in Wales on pharmacotherapy for smoking cessation, 2006-2011



Source: Comparative Analysis System for Prescribing Audit (NHS Wales Shared Services Partnership)

Community pharmacy NHS smoking cessation services have been developed in Wales, potentially reaching large numbers of smokers in the community who may already visit the pharmacy for other reasons. Figure 27 does not include NHS expenditure on NRT through the pharmacy-based services due to the unavailability of complete data for Wales. Health boards may commission community pharmacy enhanced smoking cessation services at two levels (box 1). NRT can be supplied directly to smoking cessation clients who access either level of service. Table 2 shows the number of community pharmacies commissioned by each health board to provide these services.

Abertawe Bro Morgannwg University Health Board, which has over 100 community pharmacies offering level 2 or 3 smoking cessation services, spent £274,466 on NRT through pharmacy smoking cessation services in financial year 2011, which was considerably more than the £156,534 spent via prescription in 2011. In other areas, prescribing accounts for most of the primary care expenditure on NRT. Hywel Dda Health Board, for example, spent £35,027 on NRT via the pharmacy services and £179,303 via prescriptions in 2011.

Box 1

Levels of enhanced smoking cessation services provided by community pharmacies

Level two:

- Provide NRT and additional support to clients taking part in the Stop Smoking Wales intensive behavioural support programme.
- Ensure clinical suitability of NRT.

Level three:

- Assess client on one-to-one basis, then start supply of appropriate NRT.
- Monitor use of NRT and provide ongoing advice and support.

Table 2

Number of community pharmacies providing smoking cessation services by health board, 2011

	Level 2 only	Level 3 only	Levels 2 and 3	Total community pharmacies
Betsi Cadwaladr UHB	21	84	0	154
Powys THB	0	0	9	23
Hywel Dda HB	66	0	0	100
Abertawe Bro Morgannwg UHB	108	0	1	125
Cardiff and Vale UHB	0	0	0	106
Cwm Taf HB	22	0	8	77
Aneurin Bevan HB	36	0	0	127

Source: All Wales Pharmacy Database (NHS Wales Shared Services Partnership)

5 Impact of tobacco use on health and health services

The health effects of tobacco use are well known and are examined in this section, with a focus on mortality and hospital admissions. Further information regarding the incidence of specific smoking-related cancers is provided online by the Welsh Cancer Intelligence and Surveillance Unit at www.wcisu.wales.nhs.uk.

The full impact of tobacco use on health and health services is hard to quantify in that it is so wide-reaching: fertility can be affected, as well as health in utero; nearly 200 fires in homes in Wales are known to have been caused by smoking materials in 2010/11[31]. Furthermore, the estimates within this section of deaths and hospital admissions due to smoking in adults are likely to be underestimates, given that they do not take into account exposure to second-hand smoke. Lifetime non-smokers have been found to experience approximately 20 per cent higher rates of death from coronary heart disease when exposed to second-hand smoke on a daily basis[32].

It has been estimated that smoking costs NHS Wales around £1 million per day, which is seven per cent of total expenditure on healthcare[33].

5.1 Maternity, children and young people

Smoking in pregnancy increases the risk of miscarriage and complications in pregnancy and labour. The risk of infant mortality is increased by an estimated 40 per cent. More low birth weight babies are born to mothers who smoke, with greater consumption of cigarettes leading to greater reduction in birth weight. Low birth weight has also been associated with ill health in adulthood. Babies born to mothers who smoke are more likely to develop middle ear infections, respiratory infections and asthma. Exposure to second-hand smoke during pregnancy can reduce foetal growth and increase the risk of preterm birth[34]. Under its Institute function, Public Health Wales is currently investigating interventions to improve maternal health through its Reproductive and Early Years Pathfinder Programme.

As well as mortality and health issues, there are also cost implications. Using estimates from a report by the Public Health Research Consortium[35], smoking in pregnancy costs NHS Wales between £352,000 and £2,816,000 per year prior to birth and a further £528,000 to £1,034,000 in the first year of life[36]. Stop Smoking Wales is working with midwifery departments to strengthen referral pathways for pregnant females. It has been reported that spending between £13.60 and £37.00 on smoking cessation interventions per pregnant smoker would yield positive cost savings for the NHS[35].

The patterns shown in figures 15, 16 and 17 are of particular concern as research suggests that habits established early on affect health-related outcomes in later life[37]. Children and young people who smoke regularly before the age of 15 at least double their risk of lung cancer compared to those starting after the age of 25[38].

There are a range of inter-related factors involved when children and young people decide to take up smoking which range from influences such as the individual, family, social, community and society. It is believed that children whose parents or siblings smoke are around 90 per cent more likely to become smokers themselves[6].

With around ten per cent of regular smokers aged 11 to 15 reporting that cigarette vending machines are their usual source of tobacco[39], the Welsh Government introduced a ban in February 2012 on the sale of cigarettes from vending machines to help combat their sale to children and young people.

5.1.1 Hospital admissions in children attributable to second-hand smoke

Exposure to second-hand smoke in childhood is strongly associated with a range of respiratory illnesses and serious diseases, including sudden infant death syndrome and meningitis[40,41]. Given the levels of exposure shown in figures 20 and 21, this represents a major risk to the health of children. Children have little control over their environment and are often unable to remove themselves from the risk of exposure to tobacco smoke. They are also more vulnerable to the effects of second-hand smoking than adults, possibly because they have higher breathing rates[40].

Table 3 shows that around 570 admissions in Wales residents were attributable to second-hand smoke exposure in 2010, with the majority due to lower respiratory infections. Around 10 cases of meningitis, which can seriously endanger health, could also have been caused by second-hand smoke. These figures were calculated using a method published by the Royal College of Physicians[40], in which systematic reviews and meta-analysis were analysed to estimate the fraction of hospital admissions for particular diseases that could be attributed to second-hand smoking. It should be noted that the fractions are based on a range of data which is not directly sourced from the Wales population.

Table 3

Hospital admissions in children aged 0-14 for selected childhood diseases attributable to second-hand smoke exposure, Wales residents, 2010

	Age group	Admissions	Fraction attributable to smoking	Admissions attributable to smoking
Lower respiratory infections[a]	0-2	3,260	10 per cent	326
Middle ear infections[b]	0-14	1,580	7 per cent	111
Wheeze[c]	0-2	530	8 per cent	42
Asthma[d]	3-4	280	4 per cent	11
	5-14	700	10 per cent	70
Meningitis[e]	0-14	50	22 per cent	11
TOTAL				571

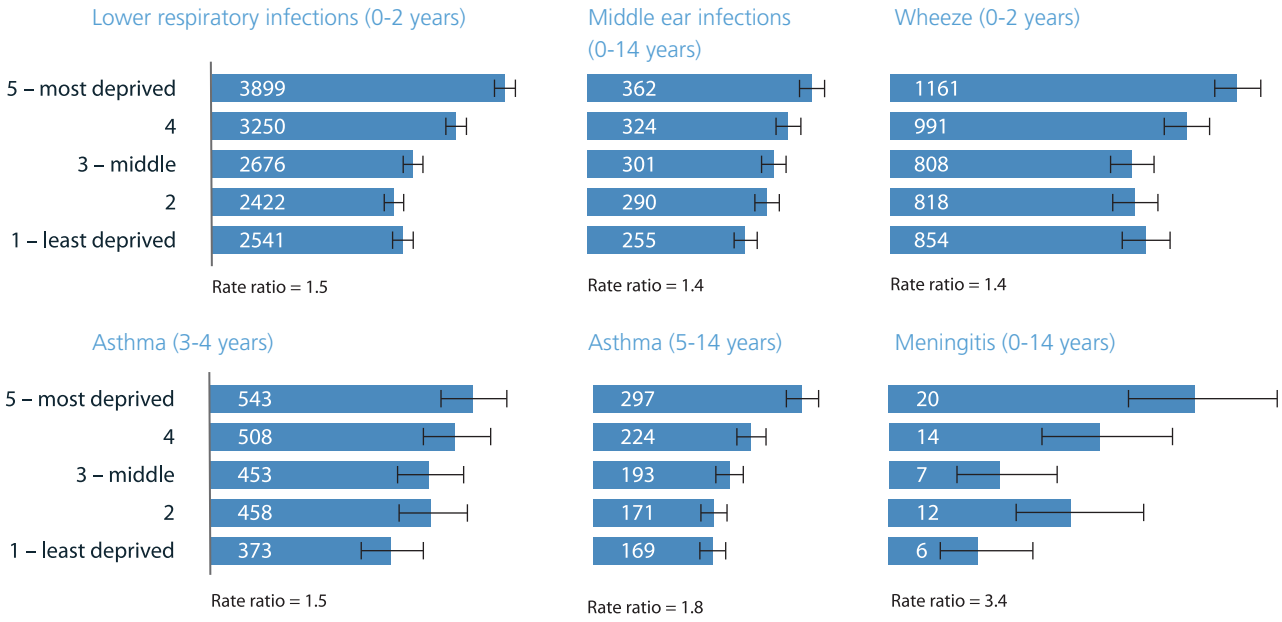
a Acute bronchitis (ICD-10 code J20), acute bronchiolitis (J21), unspecified acute lower respiratory infection (J22); b Non-suppurative (H65) and suppurative and unspecified otitis media (H66); c Code R062; d Asthma (J45) and status asthmaticus (J46); e Meningococcal meningitis (A39.0), and bacterial meningitis (G00)

Source: Patient Episode Database for Wales (NHS Wales Informatics Service); passive smoking-attributable fractions published by Royal College of Physicians[40]

The association between socio-economic group and second-hand smoke exposure in the home (section 5.2) suggests that children living in more deprived areas will have a higher level of exposure than children living in less deprived areas. This could be a contributory factor in the patterns shown in figure 28, where admission rates increase with deprivation for all childhood diseases listed in table 3. These findings are similar to those reported by the Tobacco Advisory Group using data from England[40]. There is a particularly large difference between least and most deprived groups for meningitis, although the numbers of admissions are comparatively low (as indicated by the wide confidence intervals) and interpretation of these rates should therefore be carried out with caution.

Figure 28

Age-specific hospital admission rates per 100,000 for selected childhood diseases attributable to second-hand smoke exposure, Wales residents by deprivation fifth (Welsh Index of Multiple Deprivation 2011), 2008-10



Source: Patient Episode Database for Wales (NHS Wales Informatics Service); mid-year population estimates (Office for National Statistics); Welsh Index of Multiple Deprivation 2011 (Welsh Government); passive smoking-attributable fractions published by Royal College of Physicians[40]
Horizontal lines (⊢⊣) show 95 per cent confidence interval

5.2 Adults

5.2.1 Smoking-attributable mortality

Smoking is the largest single cause of avoidable early death in Wales. In 2010, around 5,450 deaths in people aged 35 and over were caused by smoking, which is 17.8 per cent of all deaths in this age group. A similar proportion of deaths in England (18.1 per cent) were caused by smoking in 2010[42].

A higher proportion of deaths in males than in females can be attributed to smoking (23.0 vs 13.1 per cent, table 4). These figures rise to 25.5 per cent and 16.4 per cent in the most deprived areas of Wales for males and females respectively, reflecting the differences in smoking prevalence shown in figure 10.

Since smoking often leads to premature death, these differences across the genders may be a key reason why women live longer than men. Recent research suggests that smoking causes around 60 per cent of the gender gap in UK mortality rates[43]. Our analysis, using a more detailed measure of smoking-attributable mortality and counting deaths at age 35 and over (rather than at all ages), gives a lower figure of 46 per cent for Wales in 2008-10.

Table 4

Counts and percentages of deaths attributable to smoking, age 35 and over, by cause and deprivation fifth (Welsh Index of Multiple Deprivation (WIMD) 2011), 2010

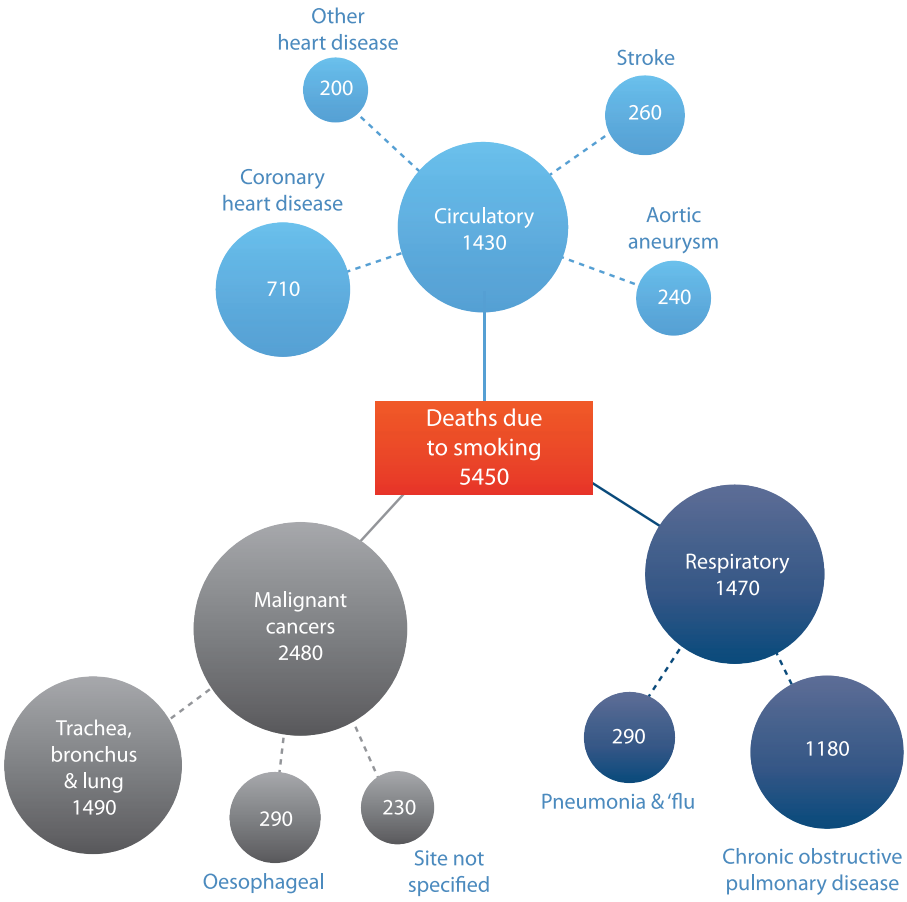
	Males			Females		
	Number of deaths		Attributable to smoking (per cent)	Number of deaths		Attributable to smoking (per cent)
	All	Attributable to smoking		All	Attributable to smoking	
Wales						
All causes	14,520	3,350	23.0	16,030	2,100	13.1
All cancers	4,450	1,600	36.0	4,160	880	21.1
All circulatory disease	4,990	920	18.5	5,310	510	9.6
All respiratory disease	1,990	790	39.9	2,330	680	29.2
All diseases of the digestive system	760	30	4.3	850	30	3.8
By WIMD 2011 fifth (all causes of death)						
5 - most deprived	3,040	780	25.5	3,290	540	16.4
4	3,110	750	24.2	3,330	440	13.1
3 - middle	3,130	710	22.7	3,550	460	12.9
2	2,830	630	22.3	3,160	370	11.8
1- least deprived	2,410	480	19.8	2,700	300	11.1

Source: Annual District Deaths Extract (Office for National Statistics); Welsh Index of Multiple Deprivation 2011 (Welsh Government); smoking-attributable fractions published by NHS Information Centre

Figure 29 shows that just over half of all deaths caused by smoking were due to respiratory and circulatory disease, with cancers accounting for the majority of the rest. Of all deaths from lung cancer and chronic obstructive pulmonary disease (COPD), around 80 per cent were considered attributable to smoking.

Figure 29

Breakdown of deaths attributable to smoking for selected causes, age 35 and over, 2010

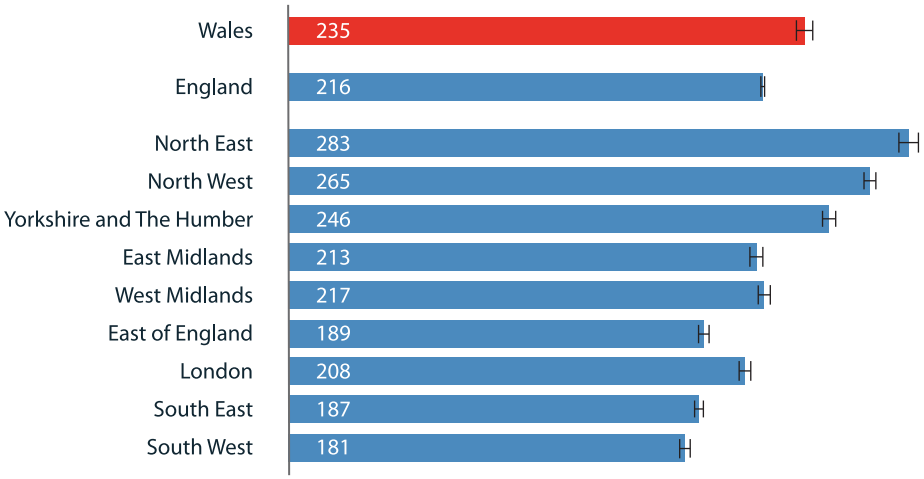


Source: Annual District Deaths Extract (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre

The overall rate of deaths from smoking in England is lower than in Wales, although the North East and North West regions of England have considerably higher rates (figure 30). According to the General Lifestyle Survey[7], the prevalence of smoking in these regions has historically been high, with rates of 30 per cent and over being reported in both males and females over the last decade.

Figure 30

Smoking-attributable mortality, age 35 and over, age-standardised rate per 100,000, all persons, English Regions and Wales, 2007-09



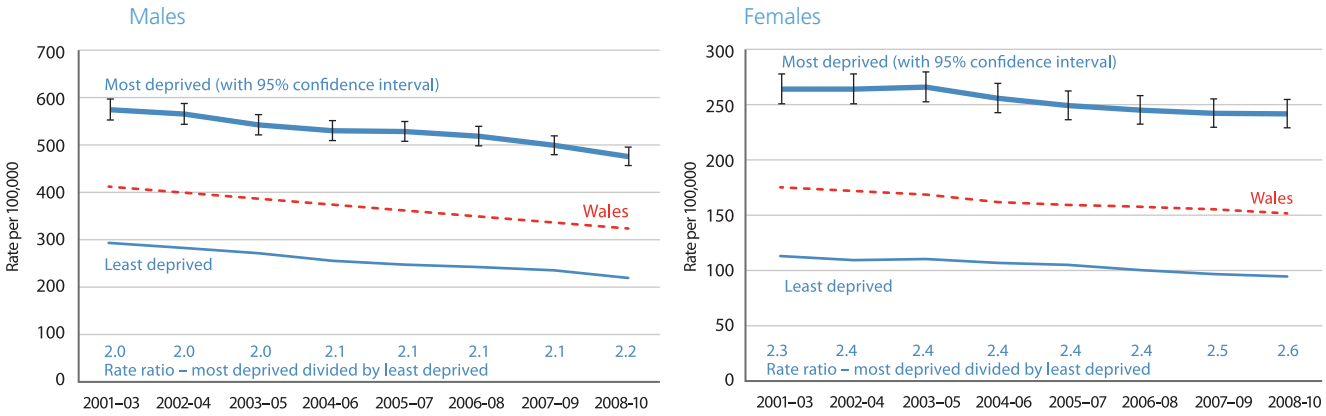
Source: Wales: Annual District Deaths Extract; Mid-year population estimates (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre; England: Local Tobacco Control Profiles for England (Public Health Observatories in England)
Horizontal lines (⊢⊣) show 95 per cent confidence interval

In Wales, where smoking is about two and a half times more common in the most deprived compared to the least deprived areas (figure 10), there is a similar ratio in rates of death from smoking across the deprivation fifths (figure 31). This inequality is slightly larger in females (ratio of 2.6) than in males (2.2) in 2008-10. However, in both sexes, these rate ratios have increased slightly since 2001-03, suggesting a widening inequality. This is due to the mortality rate in the least deprived falling more quickly than the rate in the most deprived. Such trends demonstrate the action required if the Welsh Government's vision from *Fairer Health Outcomes For All*[44] is to be realised: "Improved health and wellbeing for all, with the pace of improvement increasing in proportion to the level of disadvantage."

Rates of death from smoking have also fallen more quickly over the period in males (21 per cent fall) than in females (13 per cent). This difference in trends may partially be explained by historical smoking patterns, with tobacco consumption beginning to fall in males earlier in the 20th century than in females (figure 1).

Figure 31

Smoking-attributable mortality, age 35 and over, Wales and most/least deprived fifth (Welsh Index of Multiple Deprivation 2011), age-standardised rate per 100,000, 2001-03 to 2008-10

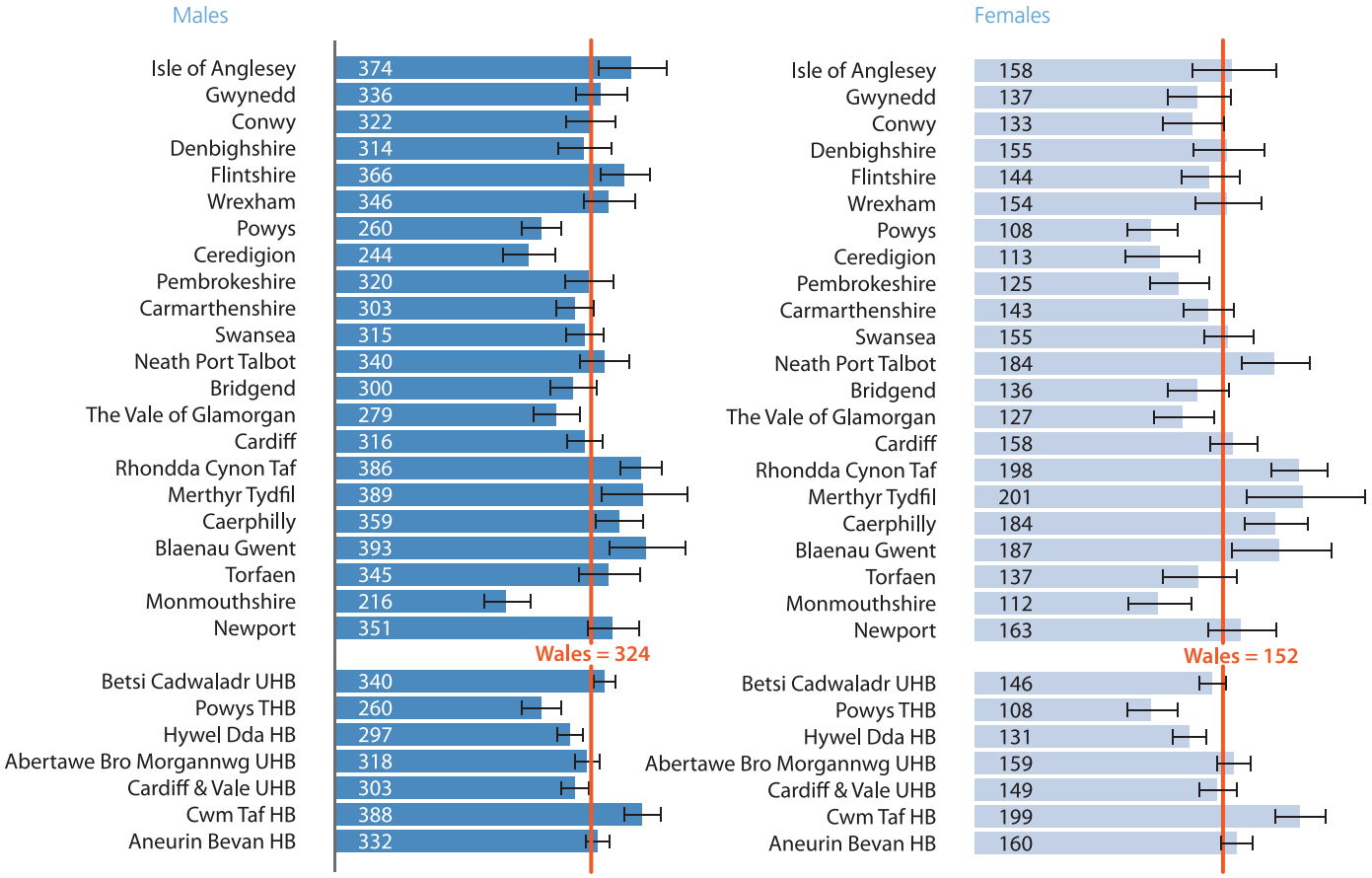


Source: Annual District Deaths Extract & mid-year population estimates (Office for National Statistics); Welsh Index of Multiple Deprivation 2011 (Welsh Government); smoking-attributable fractions published by NHS Information Centre

The pattern of mortality rates from smoking across local authority areas is largely as would be expected given the pattern of smoking prevalence shown in figure 8. The highest rates are found in the South Wales Valleys areas of Rhondda Cynon Taf, Merthyr Tydfil, and Blaenau Gwent (figure 32), where smoking prevalence is highest, and rates are lower in the more rural parts of Wales such as Powys, Ceredigion and Monmouthshire. However, rates in males living in the Isle of Anglesey and Flintshire are higher than might be expected given the prevalence of smoking. In addition, whereas the rate of deaths attributable to smoking in males living in Neath Port Talbot is average, in females the rate is considerably higher than Wales as a whole.

Figure 32

Smoking-attributable mortality, age 35 and over, local authorities and health boards, age-standardised rate per 100,000, 2008-10

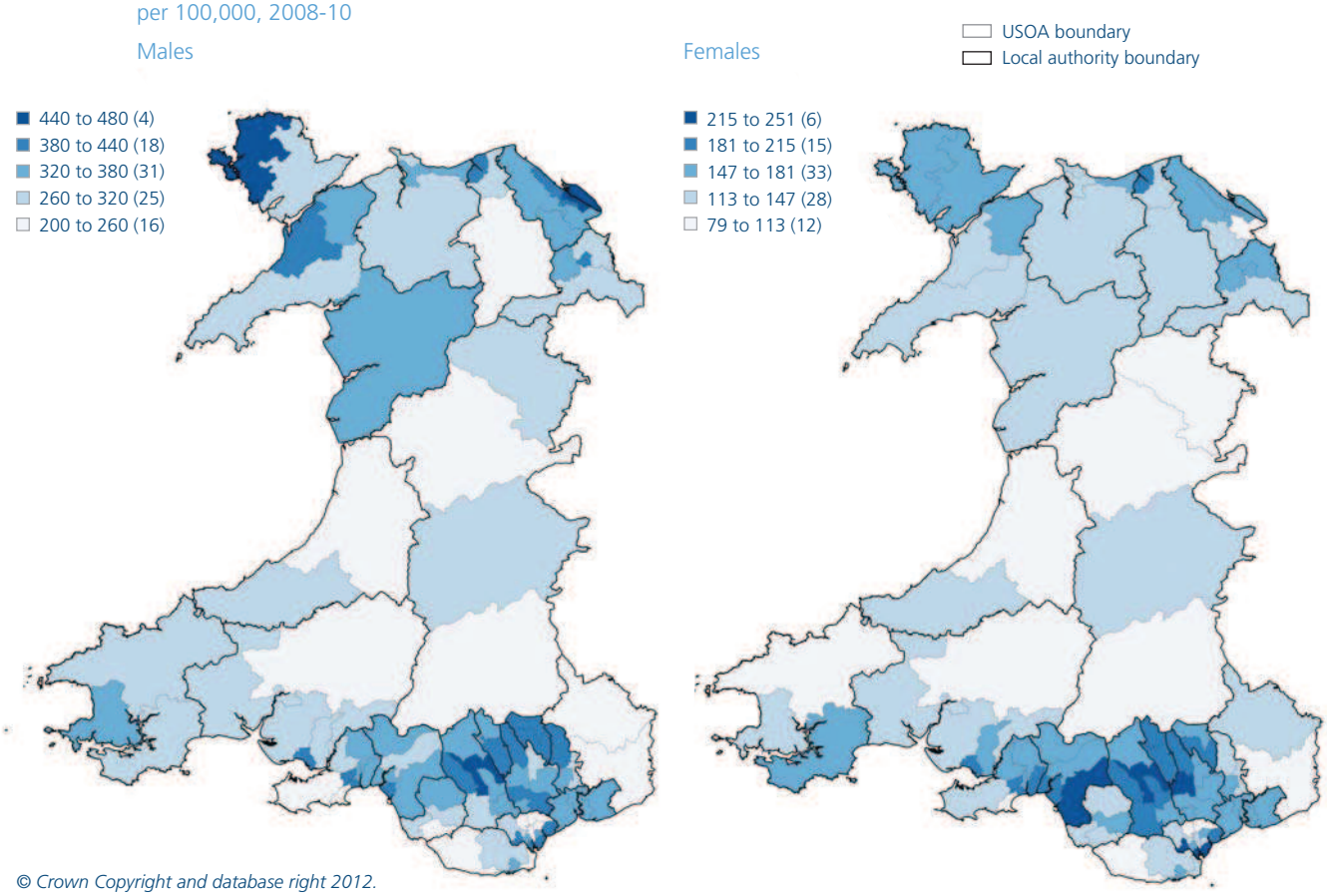


Source: Annual District Deaths Extract & mid-year population estimates (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre
Horizontal lines (⊢⊣) show 95 per cent confidence interval

Maps of death rates from smoking in Upper Super Output Areas (USOAs, figure 33) add further detail to the geographical pattern shown in figure 32. Rates are high in males living in the west of the Isle of Anglesey and the east of Flintshire, and females living in the southeast part of Neath Port Talbot. Local variation is also apparent, with a clear disparity in rates between north and south Cardiff for both males and females. This reflects the USOA map of smoking prevalence (figure 9). Nationally, there is more than a threefold difference between the highest and lowest USOA rates in females, a difference which is slightly smaller in males. This echoes the wider inequalities in females shown in figure 31.

Figure 33

Smoking-attributable mortality, age 35 and over, Upper Super Output Areas (USOAs), age-standardised rate per 100,000, 2008-10



Source: Annual District Deaths Extract & mid-year population estimates (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre

It should be noted that the method of estimating the rate of deaths from smoking is not exact and relies on a single set of population attributable fractions which are not changed over time. To complement these data, the web-based resource accompanying this report includes rates of death from key smoking-related causes such as lung cancer and COPD. It is recommended that these rates be used to aid interpretation of the overall rate in deaths from smoking.

5.2.2 Contribution of smoking to overall inequality in mortality rates

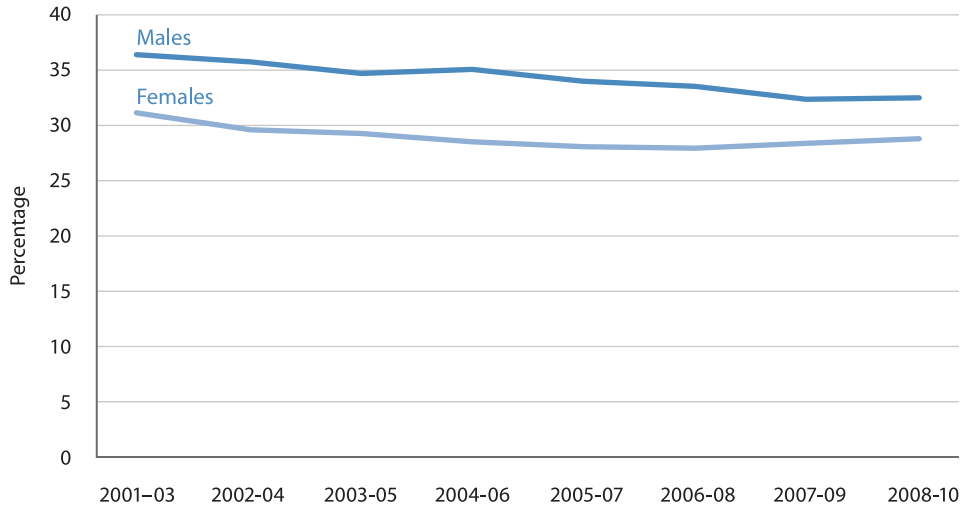
The continuing inequality in all-cause mortality, with substantially higher rates in the most deprived populations than in the least deprived, was documented in the Public Health Wales Observatory's recent profile entitled *Measuring Inequalities: Trends in mortality and life expectancy in Wales*.

Smoking has been referred to as a *proximal* cause of health inequalities[45]. This means that whilst differences in health across socio-economic groups can be attributed to smoking, as explored in this section, differences in smoking prevalence can in turn be attributed to social determinants of health such as education, employment and housing. As a result, whilst helping people to stop smoking is an important aim, long-term reductions in health inequalities are more likely to result from a range of complementary programmes addressing these social determinants.

It has already been shown in this report that smoking prevalence, and consequently smoking-attributable mortality, is higher in the most deprived areas of Wales than in the least deprived (figures 10 and 31). Presented in figure 34 is an estimate of the contribution of smoking-attributable mortality to the inequality in all-cause mortality. In effect, this is an estimate of the reduction in the all-cause mortality inequality that could eventually (given a suitable time lag) be achieved if smoking prevalence, and hence smoking-attributable mortality, in the most deprived populations was reduced to the same level as in the least deprived. See the technical guide online for further methodological information.

Figure 34

Percentage of inequality in mortality attributable to smoking, age 35 and over, 2001-03 to 2008-10



Source: Annual District Deaths Extract & mid-year population estimates (Office for National Statistics); Welsh Index of Multiple Deprivation 2011 (Welsh Government); smoking-attributable fractions published by NHS Information Centre

It is clear that smoking is, and will continue to be, a major contributor to the gap in all-cause mortality. It is estimated that smoking-attributable mortality accounts for around a third of the all-cause mortality inequality in males and only a little less for females.

Over the past decade, the percentage of the all-cause mortality inequality that can be attributed to smoking has fallen slightly for both sexes. This is because whilst the *relative mortality* gap, i.e. the rate in the most deprived divided by the rate in the least deprived, has increased, the *absolute mortality* gap, i.e. the rate in the most deprived minus the rate in the least deprived, has decreased. There may also have been changes in the patterns of other causes of death that have contributed to the relative influence of smoking on inequality in mortality. The rate of decline appears to be greater for males than females. As a result, the difference between the sexes, in terms of the percentage of the all-cause inequality attributable to smoking, is narrowing.

5.2.3 Mortality from specific causes of death related to smoking

This section shows trends in premature mortality for selected causes of death which contribute heavily to smoking-attributable mortality (figure 29). Charts showing local authority and health board rates for these causes of death can be found in the online interactive spreadsheets accompanying this report.

As the following charts show, mortality rates in Wales are generally falling and are either similar to or slightly higher than overall rates for the UK. Inequalities between the least and most deprived areas of Wales are generally slightly larger in females than in males, but in both sexes are remaining consistent or growing.

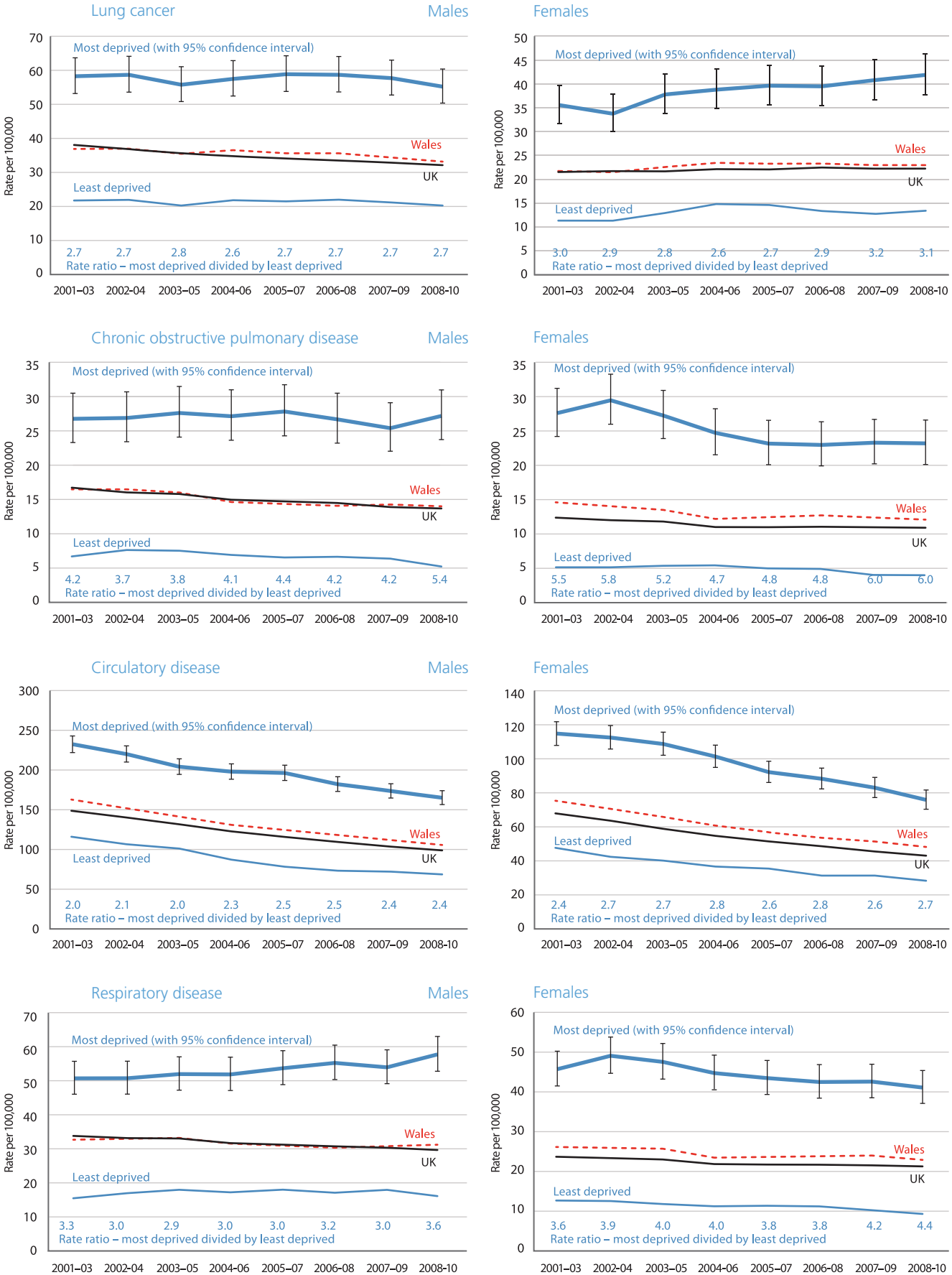
However, rates of respiratory disease mortality in the most deprived males have risen since 2001-03. This may not be linked to diseases attributable to smoking, since the corresponding mortality rate for chronic obstructive pulmonary disease (COPD, which causes the majority of smoking-related deaths due to smoking in males) has remained fairly steady over the period.

Lung cancer mortality rates in females are also noteworthy, in that overall rates in Wales and the UK have remained largely unchanged since 2001-03. Rates in the most deprived females have risen from 36 to 42 per 100,000 over the period, whilst for males these figures have remained stable or fallen slightly. This is likely to be a reflection of the historic differences in smoking prevalence between males and females[46]. Tobacco consumption peaked later in the 20th century in females than in males (figure 1), and given the time lag between changes in prevalence and mortality, this may explain the fact that lung cancer mortality rates have not yet started to fall in females.

The inequality in premature mortality is noticeably larger for COPD than any other cause of death, with rate ratios rising to 5.4 in males and 6.0 in females by the end of the period. Around 80 per cent of deaths from COPD are due to smoking, so this large inequality reflects the difference in smoking prevalence across socio-economic groups shown in figure 10.

Figure 35

Mortality from key causes of death, age under 75, UK, Wales and most/least deprived fifth (Welsh Index of Multiple Deprivation 2011), age-standardised rate per 100,000, 2001-03 to 2008-10



Source: Annual District Deaths Extract & mid-year population estimates (Office for National Statistics); Welsh Index of Multiple Deprivation 2011 (Welsh Government)

5.2.4 Smoking-attributable hospital admissions

Smoking is associated with a wide variety of diseases that can result in admission to hospital. In 2010, around 27,700 admissions in people aged 35 and over are estimated to have been caused by smoking, which represents approximately 5.3 per cent of all admissions in this age group. In England, for financial year 2009/10, this figure was slightly lower at 4.7 per cent. These proportions are considerably lower than for smoking-attributable mortality (table 4), which is likely to reflect the relatively larger numbers of hospital admissions which are not attributable to smoking. Under the method used, individual people could be counted numerous times for repeated admissions to hospital.

Table 5 shows that of all admissions in males in 2010, around seven per cent are estimated to be due to smoking, higher than in females (four per cent). When considering the most deprived areas, the number of attributable admissions increases to eight per cent in males and five per cent in females. This is likely to be a result of the increased prevalence of smoking in more deprived areas (figure 10).

Table 5

Counts and percentages of hospital admissions attributable to smoking, age 35 and over, by cause and deprivation fifth (Welsh Index of Multiple Deprivation (WIMD) 2011), 2010

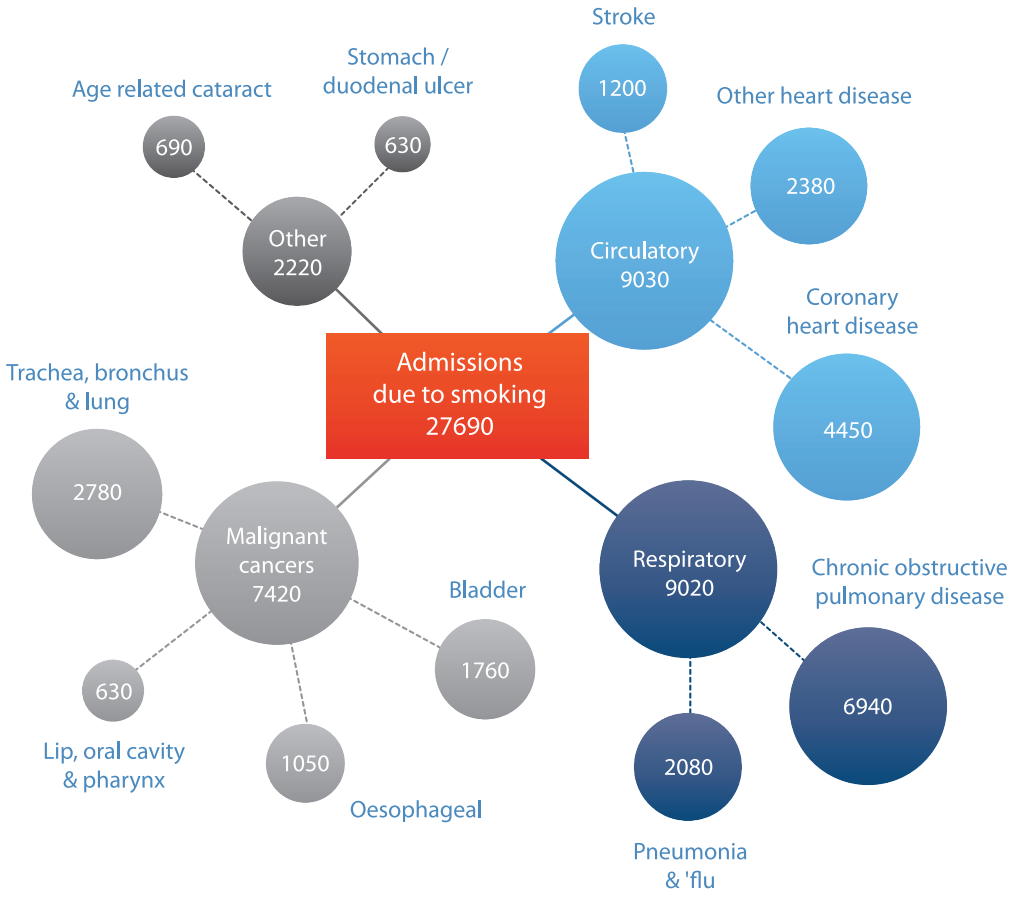
	Males			Females		
	Number of admissions		Attributable to smoking (per cent)	Number of admissions		Attributable to smoking (per cent)
	All	Attributable to smoking		All	Attributable to smoking	
Wales						
All admissions	246,750	17,020	6.9	276,690	10,670	3.9
All cancers	27,180	5,210	19.2	25,060	2,210	8.8
All circulatory disease	31,320	6,240	19.9	24,560	2,800	11.4
All respiratory disease	15,500	4,620	29.8	16,230	4,400	27.1
All diseases of the digestive system	34,680	450	1.3	36,260	440	1.2
By WIMD 2011 fifth (all admissions)						
5 - most deprived	49,680	3,990	8.0	55,910	2,790	5.0
4	51,170	3,710	7.3	57,220	2,390	4.2
3 - middle	52,020	3,550	6.8	58,260	2,160	3.7
2	49,550	3,240	6.5	55,230	1,830	3.3
1- least deprived	44,340	2,530	5.7	50,070	1,500	3.0

Source: Patient Episode Database for Wales (NHS Wales Informatics Service); Welsh Index of Multiple Deprivation (Welsh Government); smoking-attributable fractions published by NHS Information Centre

Two thirds of all admissions caused by smoking in 2010 were the result of circulatory and respiratory diseases (figure 36), with most of the remainder due to cancers. Respiratory disease caused a higher proportion of smoking-attributable admissions in females (41 per cent) than males (27 per cent), with the pattern reversed for circulatory disease (37 per cent in males and 26 per cent in females).

Figure 36

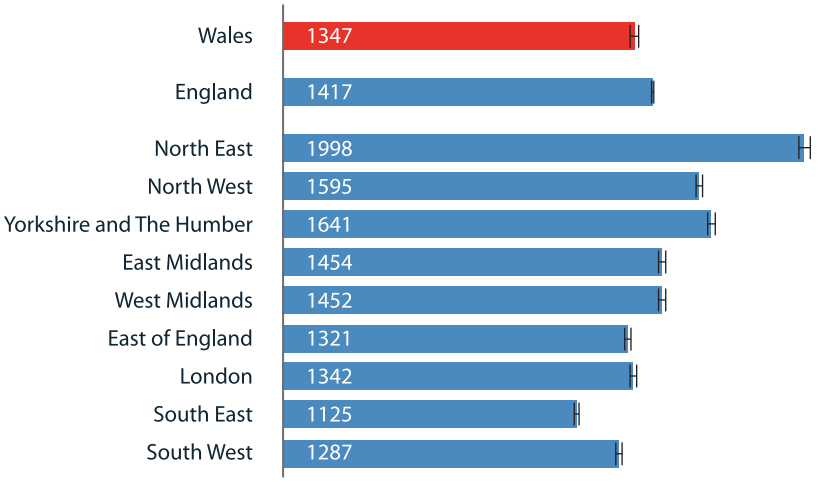
Counts of hospital admissions attributable to smoking for selected causes, age 35 and over, 2010



Source: Patient Episode Database for Wales (NHS Wales Informatics Service); smoking-attributable fractions published by NHS Information Centre

Figure 37

Smoking-attributable hospital admissions, age 35 and over, age-standardised rate per 100,000, English Regions (2009/10), Wales (2009)

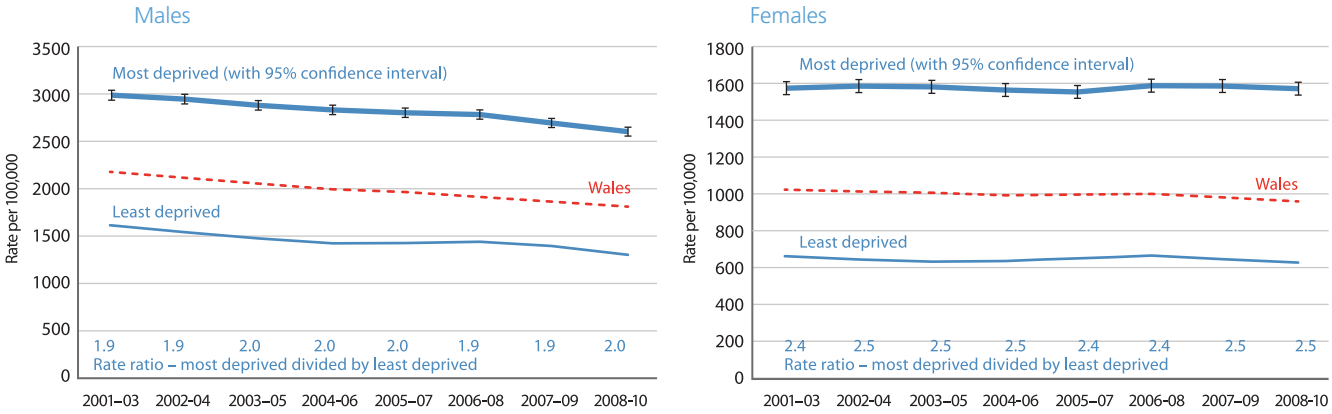


Source: Wales: Patient Episode Database for Wales (NHS Wales Informatics Service); Mid-year population estimates (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre; England: Local Tobacco Control Profiles for England (Public Health Observatories in England)
Horizontal lines (⊢⊣) show 95 per cent confidence interval

The rate of hospital admissions caused by smoking in Wales is lower than in England overall (figure 37), which is surprising given that both smoking-attributable mortality (figure 30) and the percentage of all admissions that are attributable to smoking are higher in Wales (page 42). Using published hospital admissions figures[47,48] the overall crude rate of admissions in Wales residents (260 per 1,000 population) is lower than in England (279 per 1,000). Therefore, lower rates of smoking-attributable admissions in Wales compared to England may reflect wider differences in referral patterns and both the demand for and the supply of hospital services. A cautionary note should also be added: although care has been taken to ensure consistency in methods, there will inevitably be differences in the recording of hospital data between the separate systems in use in England and Wales.

Figure 38

Smoking-attributable hospital admissions, age 35 and over, Wales and most/least deprived fifth (Welsh Index of Multiple Deprivation 2011), age-standardised rate per 100,000, 2001-03 to 2008-10



Source: Patient Episode Database for Wales (NHS Wales Informatics Service); mid-year population estimates (Office for National Statistics); Welsh Index of Multiple Deprivation 2011 (Welsh Government); smoking-attributable fractions published by NHS Information Centre

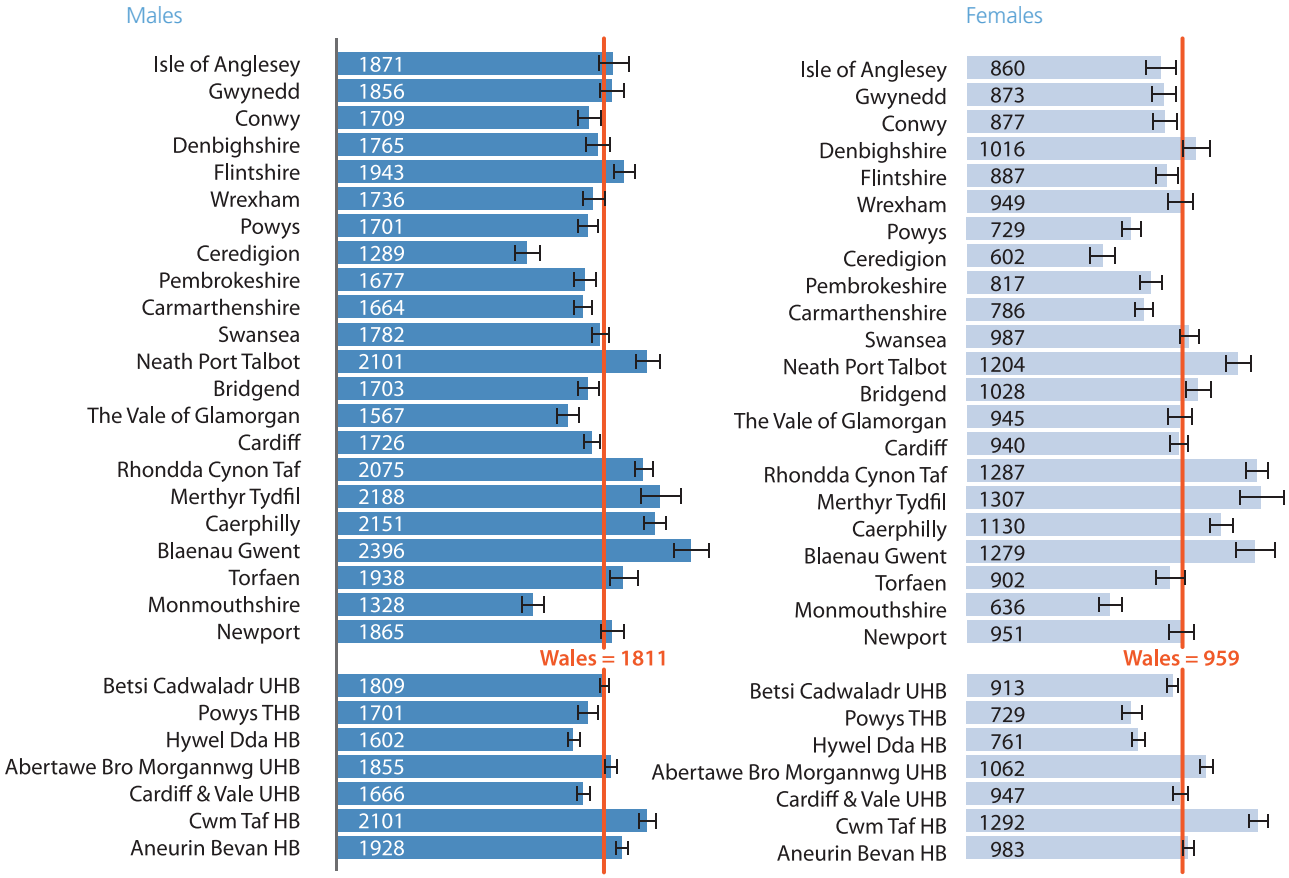
Generally the rate of smoking attributable admissions is falling in males living in Wales; this trend can be seen across the deprivation fifths. However, this is not the case for females, where the admission rate has remained fairly consistent. This is likely to reflect differences in historical smoking patterns between the sexes, as described in relation to the mortality trends in figure 31.

Males in the most deprived fifth are around twice as likely to be admitted to hospital as a result of smoking than males in the least deprived fifth. In females this gap is slightly wider, as in the case of mortality due to smoking (figure 31). In both sexes, the gap has remained fairly stable over the period.

It should be noted that the method of estimating the rate of hospital admissions due to smoking is not exact and relies on a single set of population attributable fractions which are not changed over time.

Figure 39

Smoking-attributable hospital admissions, age 35 and over, local authorities and health boards, age-standardised rate per 100,000, 2008-10



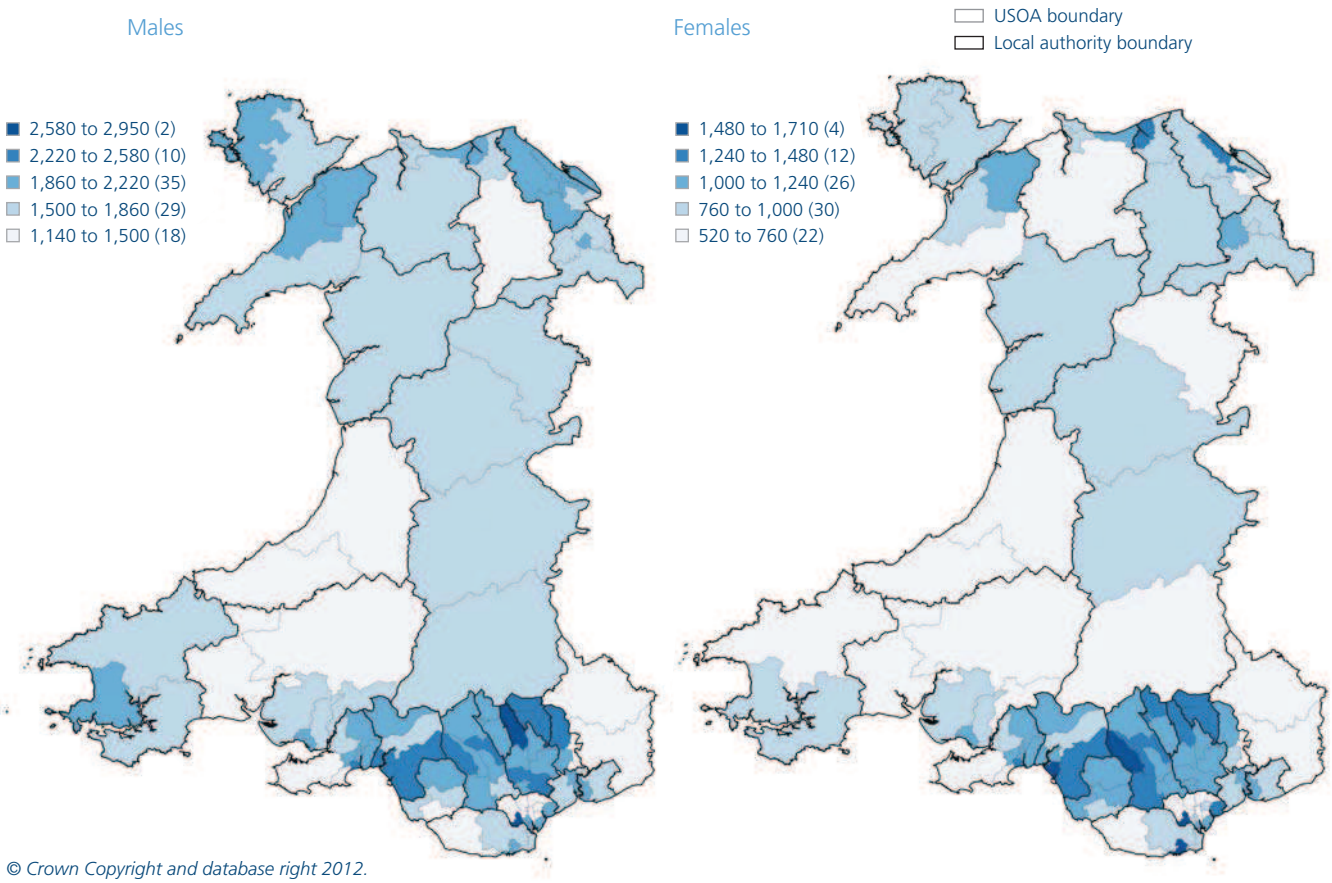
Source: Patient Episode Database for Wales (NHS Wales Informatics Service); mid-year population estimates (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre
Horizontal lines (⊢⊣) show 95 per cent confidence interval

The variation in smoking-attributable hospital admission rates between local authorities is generally consistent with the prevalence of smoking in these areas. However, perhaps reflecting the wider inequalities in females shown in figure 38, there is greater local variation in local authority rates in females than males. For example, the admission rate in males in the Cwm Taf Health Board area is around 16 per cent higher than the Wales rate, whereas in females it is 35 per cent higher.

This pattern is also reflected at Upper Super Output Area level (figure 40), where more than a threefold difference in rates can be found in females (520 to 1,710 per 100,000) compared to a range of 1,140 to 2,950 per 100,000 in males. In both sexes, the areas with high smoking prevalence (figure 9) generally show high rates of admissions, for example in southern Cardiff, the more northerly areas of the South Wales Valleys, and parts of North Wales such as Rhyl.

Figure 40

Smoking-attributable hospital admissions, age 35 and over, Upper Super Output Areas (USOAs), age-standardised rate per 100,000, 2008-10



Source: Patient Episode Database for Wales (NHS Wales Informatics Service); mid-year population estimates (Office for National Statistics); smoking-attributable fractions published by NHS Information Centre

6 Affordability

Increasing the price of tobacco products, for example, by raising levels of taxation, is a key strategy in tobacco control. There is evidence that making tobacco less affordable encourages current users to quit, as well as preventing young people from starting to smoke and lowering consumption in smokers who do not quit[49].

Figure 41 shows that tobacco is 33 per cent less affordable in the UK than in 1980. This is because the relative price of tobacco has increased more than disposable income over the last 30 years. In the South Wales Valleys, tobacco should be comparatively even less affordable, given that disposable income is currently around 20 per cent lower than the UK average[50].

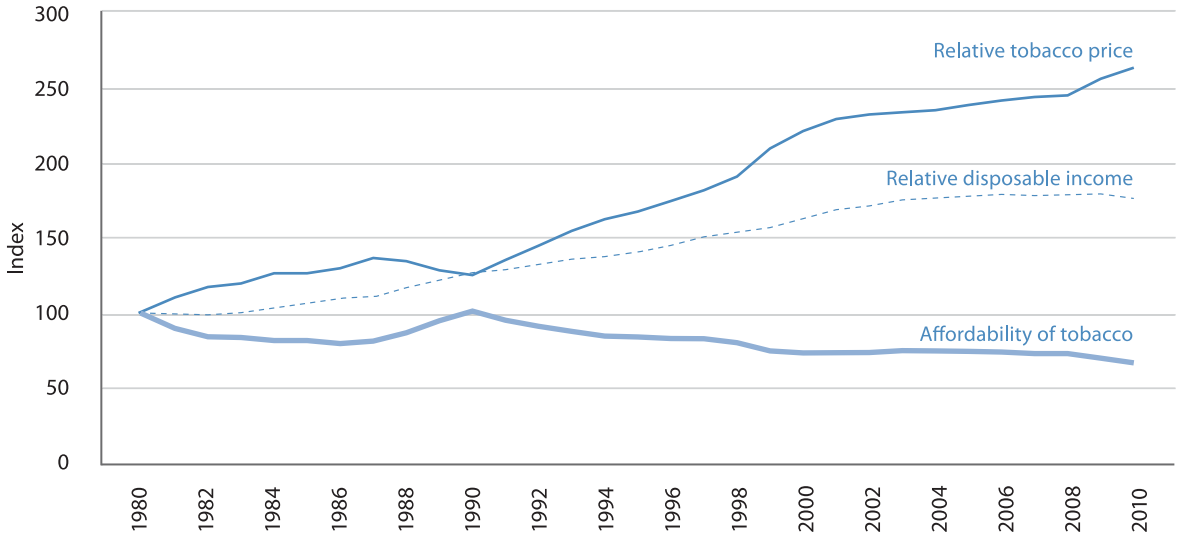
Yet the effectiveness of price in controlling tobacco, perhaps especially in deprived areas such as the South Wales Valleys, is hampered by smuggling. Illicit products provide a cheaper alternative for people living in relative poverty, facilitating continued heavy tobacco use and thus contributing to the perpetuation of health inequalities[51].

Although efforts to limit tobacco smuggling in recent years are considered to have been successful, latest estimates suggest that around one in ten cigarettes and half of all hand-rolling tobacco smoked in the UK are illicit[51]. Of concern recently has been an upward trend in the supply of 'illicit white' cigarettes, which are manufactured solely for smuggling and have been found to contain high levels of toxic heavy metals such as cadmium and lead[52].

In Wales, a survey of around 500 smokers living in the South Wales Valleys found that around one in four had purchased tobacco products brought into the UK by someone who was not a friend or relative[53]. This study also found that younger and heavier smokers were most likely to buy illicit tobacco.

Figure 41

Change in affordability of tobacco over time, UK, 1980-2010



Source: NHS Information Centre; Office for National Statistics

Data supplied by

NHS
The Information Centre
for health and social care

7 Examples of successful tobacco control policy from California and Singapore

The *Tobacco Control Action Plan for Wales* aims to reduce adult smoking prevalence levels to 16 per cent by the year 2020[6]. Such a decrease in smoking rates is a challenging yet attainable aim as it has been achieved elsewhere, including in California and Singapore. The key component of their success has been a sustained multi-faceted approach, including developing and supporting long term multi-tiered policies and programmes, incorporating legislative measures, smoking cessation services, partnerships with key stakeholders, and mass media campaigns[6].

Box 2

The four priority areas within the California Tobacco Control Program

- Countering pro-tobacco influences in the community
- Reducing exposure to second-hand smoke
- Reducing the availability of tobacco
- Promoting services that help smokers quit

California has a long history as an international leader in tobacco control. The landmark 1988 *California Tobacco Tax and Health Protection Act* dedicated 5 cents of the 25-cent tax on cigarettes to fund the California Tobacco Control Program[54] (CTCP) (Box 2), including funding for local health departments and community organisations, a groundbreaking media campaign, and tobacco-related evaluation and surveillance.

This comprehensive approach has changed public attitudes toward tobacco use, creating an environment where tobacco is less desirable, less acceptable, and less accessible. As a result, smoking prevalence among adults has fallen from 26.7 per cent in 1985 to 13.1 per cent in 2009[54]. In Wales, prevalence fell from 31 to 23 per cent over a similar period (figure 4).

Singapore also has one of the strongest tobacco control legislations in the world. Efforts to promote a smoke-free lifestyle in Singapore started in the 1970s when legislations were enacted to ban smoking in public places and prohibit tobacco advertising and promotion. In 1986, the National Tobacco Control Programme, a comprehensive long-term programme for smoking control was launched[55]. The programme uses a comprehensive strategy to promote non-smoking in Singapore and has contributed to reducing smoking levels from 20 per cent in 1984 to 12.6 per cent in 2004[55].

Box 3

Target areas within Singapore's National Tobacco Control Programme

- Raising tobacco taxation
- Tobacco control legislation
- Improving public education
- Increasing partnership working
- Additional provision of smoking cessation services

Central to the successful tobacco control measures introduced by these countries and states is the World Health Organization Framework Convention on Tobacco Control (WHO FCTC). The WHO FCTC is a legally binding global treaty that provides the foundation for countries to implement and manage tobacco control programmes[56]. As of May 2011, the WHO FCTC had 173 Parties covering 87 per cent of the world's population.

To help countries fulfil their WHO FCTC obligations, the WHO in 1998 introduced the MPOWER package of six evidence-based tobacco control measures that are proven to reduce tobacco use. The MPOWER measures provide practical assistance with country-level implementation of effective policies to reduce the demand for tobacco. Together, health warning labels and anti-tobacco mass media campaigns are the most widely embraced MPOWER measures, based on population coverage[56].

Box 4

The six components of MPOWER

- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco

8 Implications for public health

The major implications for public health from this report are presented below. Many of these actions are included in the *Tobacco Control Action Plan for Wales*.

- The rate of decline in smoking prevalence has slowed in Wales in recent years. Sustained and multi-agency partnership working will be required on a national and local level to drive down prevalence to the target of 16 per cent set by the Welsh Government for 2020. International examples demonstrate that such figures are achievable given appropriately bold policy, such as in California, where a proportion of tobacco tax revenue is channelled directly to local interventions to reduce smoking.
- Reducing the high levels of smoking in deprived areas requires innovative implementation of brief interventions and formal cessation services. Proportionate action across the deprivation range, addressing the social determinants of health, is required to level out continuing health inequalities of which smoking is a proximal cause.
- Too many young people in Wales are taking up smoking and carrying on the habit into later life. The removal of cigarette vending machines from public houses is a positive step towards reducing access to tobacco. However, given the addictive nature of smoking and its impact on health, evidence-based interventions need to be implemented from a young age on a Wales-wide basis to reduce uptake. The attractiveness of tobacco products could also be reduced by introducing plain packaging and removing them from view in shops. Supermarkets and large shops in England were banned from displaying tobacco in April 2012.
- The legislation banning smoking in enclosed public places has reduced exposure to second-hand smoke. However, children remain vulnerable to exposure at home and in cars. The existing campaigns to reduce such exposure require national and local backing. Robust monitoring of children's exposure to smoking in cars should remain in place.
- Despite showing signs of falling, the rate of smoking in pregnancy in Wales is still the highest in the UK. Focussed efforts are required to help young mothers and those from routine and manual occupational groups to stop smoking.
- Smuggling is maintaining the affordability of tobacco products. Evidence-based local campaigns are required to educate smokers on the dangers of illicit cigarettes.

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Access to all hyperlinked resources accurate as of 15th May 2012

Smoking Cessation rates in Wales and in England 2007-11

Table 1: Adults' reported smoking behaviour, by age and sex, Welsh Health Survey, 2007 (percent)

	Daily smoker	Occasional smoker	Smoker	Ex-daily smoker	Ex-occasional smoker	Ex-smoker	Never smoked	Non-smoker
Men aged:								
16-24	19	5	23	3	7	10	67	77
25-34	28	6	34	8	9	17	49	66
35-44	25	4	28	14	10	24	47	72
45-54	26	4	30	17	11	27	42	70
55-64	21	4	25	31	13	44	31	75
65-74	13	3	16	37	19	55	29	84
75+	9	1	10	40	22	62	29	90
16-44	24	5	28	9	9	17	54	72
45-64	24	4	28	24	12	36	37	72
65+	11	2	13	38	20	58	29	87
Men aged 16+	21	4	25	19	12	31	44	75
Women aged:								
16-24	20	5	25	5	9	14	61	75
25-34	23	6	29	10	14	23	47	71
35-44	26	3	29	11	10	21	49	71
45-54	24	3	28	15	11	26	46	72
55-64	17	3	20	21	14	35	45	80
65-74	12	3	15	21	15	36	50	85
75+	7	2	9	16	21	37	54	91
16-44	23	5	28	9	11	20	52	72
45-64	21	3	24	18	13	31	46	76
65+	9	3	12	19	18	36	52	88
Women aged 16+	19	4	23	14	13	27	50	77
All aged:								
16-24	19	5	24	4	8	12	64	76
25-34	26	6	32	9	11	20	48	68
35-44	25	4	29	13	10	23	48	71
45-54	25	4	29	16	11	27	44	71
55-64	19	3	22	26	13	39	38	78
65-74	12	3	15	28	16	45	40	85
75+	8	2	9	25	21	47	44	91
16-44	23	5	28	9	10	19	53	72
45-64	22	4	26	21	12	33	41	74
65+	10	2	12	27	19	46	42	88
All aged 16+	20	4	24	17	12	29	47	76

Table 2: Adults' reported smoking behaviour, by age and sex, Welsh Health Survey, 2008 (percent)

	Daily smoker	Occasional smoker	Smoker	Ex-daily smoker	Ex-occasional smoker	Ex-smoker	Never smoked	Non-smoker
Men aged:								
16-24	19	5	25	3	5	7	68	75
25-34	29	7	37	8	10	17	46	63
35-44	26	4	30	15	9	24	46	70
45-54	21	4	25	18	11	29	46	75
55-64	19	3	22	28	15	42	35	78
65-74	12	4	16	35	18	53	31	84
75+	8	2	10	36	22	58	32	90
16-44	25	6	30	8	8	16	53	70
45-64	20	4	23	23	13	36	41	77
65+	11	3	14	35	20	55	31	86
Men aged 16+	20	4	25	18	12	30	45	75
Women aged:								
16-24	21	6	27	4	8	12	61	73
25-34	24	6	30	9	13	23	48	70
35-44	24	4	28	11	10	22	50	72
45-54	20	4	25	12	11	23	52	75
55-64	19	2	21	17	15	33	47	79
65-74	12	1	13	19	15	34	53	87
75+	8	1	9	17	18	35	56	91
16-44	23	5	28	8	11	19	53	72
45-64	20	3	23	15	13	28	49	77
65+	10	1	11	18	17	35	54	89
Women aged 16+	19	4	22	13	13	25	52	78
All aged:								
16-24	20	6	26	3	7	10	65	74
25-34	26	7	33	8	11	20	47	67
35-44	25	4	29	13	10	23	48	71
45-54	21	4	25	15	11	26	49	75
55-64	19	3	22	23	15	37	41	78
65-74	12	2	15	27	17	43	42	85
75+	8	1	9	25	20	44	47	91
16-44	24	5	29	8	9	18	53	71
45-64	20	3	23	19	13	32	45	77
65+	10	2	12	26	18	44	44	88
All aged 16+	20	4	24	15	12	28	49	76

Table 3: Adults' reported smoking behaviour, by age and sex, Welsh Health Survey, 2009 (percent)

	Daily smoker	Occasional smoker	Smoker	Ex-daily smoker	Ex-occasional smoker	Ex-smoker	Never smoked	Non-smoker
Men aged:								
16-24	20	7	27	2	7	9	65	73
25-34	30	7	37	9	9	18	45	63
35-44	27	4	31	12	8	21	48	69
45-54	22	5	27	16	9	25	48	73
55-64	20	3	24	28	13	42	35	76
65-74	13	2	15	37	18	55	30	85
75+	9	1	10	37	23	60	30	90
16-44	25	6	31	8	8	16	53	69
45-64	21	4	25	22	11	33	41	75
65+	11	2	13	37	20	57	30	87
Men aged 16+	21	5	26	18	11	30	45	74
Women aged:								
16-24	22	6	28	4	7	11	61	72
25-34	25	6	31	9	12	21	48	69
35-44	20	4	24	13	11	24	52	76
45-54	22	3	25	13	11	23	52	75
55-64	19	3	21	17	13	30	48	79
65-74	13	2	15	17	16	34	51	85
75+	6	1	8	15	18	33	59	92
16-44	22	5	27	9	10	19	54	73
45-64	20	3	23	15	12	27	50	77
65+	10	2	11	16	17	33	55	89
Women aged 16+	19	4	22	13	12	25	53	78
All aged:								
16-24	21	7	27	3	7	10	63	73
25-34	27	7	34	9	10	20	46	66
35-44	23	4	27	13	9	22	50	73
45-54	22	4	26	14	10	24	50	74
55-64	19	3	23	22	13	36	42	77
65-74	13	2	15	27	17	44	41	85
75+	7	1	9	24	20	44	48	91
16-44	24	6	29	9	9	17	53	71
45-64	21	4	24	18	12	30	46	76
65+	10	2	12	25	18	44	44	88
All aged 16+	20	4	24	15	12	27	49	76

Table 4: Adults' reported smoking behaviour, by age and sex, Welsh Health Survey, 2010 (percent)

	by sex:		by age:			
	Men 16+	Women 16+	16-44	45-64	65+	All 16+
Smoking behaviour:						
Daily smoker	21	18	24	19	10	19
Occasional smoker	4	4	5	3	2	4
Smoker (c)	25	22	29	23	12	23
Ex-daily smoker	18	13	8	19	27	16
Ex-occasional smoker	11	12	9	11	18	12
Ex-smoker (d)	30	25	17	30	44	27
Never smoked	46	53	54	47	43	50
Non-smoker (e)	75	78	71	77	88	77
Location of smoking (smokers):						
Outdoors	93	91	95	91	78	92
Indoors:	78	77	74	82	84	78
At own home	61	64	52	72	82	62
In other people's homes	29	30	37	20	12	30
Whilst travelling by car	53	42	51	49	25	48
Other places indoors	23	18	23	18	11	20
Passive smoking (non-smokers):						
Indoors or outdoors	31	34	42	29	19	33
Outdoors	22	24	31	20	12	23
Indoors	20	23	29	19	12	21
At own home	7	7	8	7	4	7
In other people's homes	13	16	21	12	6	15
Whilst travelling by car	5	6	8	5	2	6
Other places indoors	6	6	9	5	4	6
Give up smoking:						
Would like to give up smoking	69	71	72	70	54	70
Tried giving up smoking in past 12 months	38	38	40	36	34	38

Table 5: Adults' reported smoking behaviour, by age and sex, Welsh Health Survey, 2011 (percent)

	by sex:		by age:			
	Men 16+	Women 16+	16-44	45-64	65+	All 16+
Smoking behaviour:						
Daily smoker	20	18	23	21	9	19
Occasional smoker	4	4	5	3	2	4
Smoker (c)	24	21	28	24	11	23
Ex-daily smoker	18	13	8	18	26	15
Ex-occasional smoker	12	13	10	12	19	12
Ex-smoker (d)	29	26	17	29	45	27
Never smoked	47	53	55	47	44	50
Non-smoker (e)	76	79	72	76	89	77
Location of smoking (smokers):						
Outdoors	94	93	95	93	86	94
Indoors:	77	74	73	78	81	75
At own home	59	59	49	69	76	59
In other people's homes	30	28	37	19	13	29
Whilst travelling by car	52	43	50	49	29	48
Other places indoors	23	14	21	16	15	19
Passive smoking (non-smokers):						
Indoors or outdoors	31	32	40	29	18	31
Outdoors	22	23	29	21	11	22
Indoors	20	21	28	18	10	20
At own home	7	7	9	6	4	7
In other people's homes	13	15	21	11	5	14
Whilst travelling by car	5	6	8	4	2	5
Other places indoors	6	6	7	5	4	6
Give up smoking:						
Would like to give up smoking	68	70	71	70	56	69
Tried giving up smoking in past 12 months	35	40	39	37	33	38

Table 6: Adults' Self-reported cigarette smoking status, by survey year and sex, Health Survey (England), 2011

Cigarette smoking status	Survey year								
	2003[a]	2004	2005	2006	2007	2008	2009	2010	2011
	%	%	%	%	%	%	%	%	%
MEN									
Never regularly smoked cigarettes	45	47	45	49	48	49	49	50	49
Used to smoke cigarettes regularly	28	29	28	27	28	27	27	28	28
Current smoker	27	24	27	24	24	24	24	22	23
Cigarette smokers									
Under 10 cigarettes a day	7	7	8	8	7	7	8	7	9
10 to under 20 cigarettes a day	10	9	11	9	9	10	10	9	9
20 or more cigarettes a day	9	7	8	7	7	7	6	6	5
Number smoked a day not known	0	0	0	0	0	0	0	0	0
Median per current smoker per day	14	13	13	13	13	13	11	11	10
WOMEN									
Never regularly smoked cigarettes	56	56	56	57	58	58	58	59	59
Used to smoke cigarettes regularly	20	22	20	22	21	22	22	23	22
Current smoker	24	23	24	21	21	20	20	18	19
Cigarette smokers									
Under 10 cigarettes a day	7	7	8	8	7	7	7	7	7
10 to under 20 cigarettes a day	10	10	9	9	9	9	9	8	8
20 or more cigarettes a day	7	6	6	5	4	4	5	4	3
Number smoked a day not known	0	0	0	0	0	0	0	-	0
Median per current smoker per day	13	12	11	11	11	11	11	10	10
ALL ADULTS									
Never regularly smoked cigarettes	51	51	51	53	53	54	53	55	54
Used to smoke cigarettes regularly	24	25	24	24	25	25	24	25	25
Current smoker	25	23	25	23	22	22	22	20	21
Cigarette smokers									
Under 10 cigarettes a day	7	7	8	8	7	7	7	7	8
10 to under 20 cigarettes a day	10	10	10	9	9	9	9	8	9
20 or more cigarettes a day	8	7	7	6	6	5	6	5	4
Number smoked a day not known	0	0	0	0	0	0	0	0	0
Median per current smoker per day	13	13	12	12	12	11	11	11	10

Source:
http://www.ic.nhs.uk/searchcatalogue?productid=10152&q=title%3a%22Health+Survey+for+England%22&sort=Relevance&size=10&page=1#top