Chapter 5 – The UK: A Case Study[1]

Tobacco policy in the UK demonstrates a period of rapid legislative change following decades of policy continuity. Tobacco advertising was banned in the UK in 2002 and bans on smoking in public places in the UK and devolved territories were introduced from 2005-6. These measures, combined with others already in place, such as smoking cessation services and health education, make the UK the most active tobacco control member state in the EU. It now ranks number one in the *Tobacco Control Scale* discussed in chapter 4. Yet, for most of the post-war period, tobacco policy was marked by a relative lack of regulation. Tobacco control measures were often voluntary rather than legislative, while public health arguments often came second-best to those based on individual choice and the economic benefits of tobacco (Cairney, 2007a). Indeed, it is little over twenty years ago that Baggott's (1988) study of UK and Norwegian policy sought to explain why the former was such a laggard compared to the former. The UK therefore represents one of most fruitful case-studies of tobacco policy change because it seems to have engaged in radical policy change in a relatively short period of time. Our aim is to explain this shift in policy direction. A complementary aim is to consider the issues in relative depth (compared to the broader comparative chapters), identifying the substance and nature of policy (considering, for example, the nature of voluntary agreements), and considering the forces for change, in greater detail.

The first section explores what we mean by 'rapid change'. As we suggest in Chapter 1, tobacco policy can be subdivided into at least 16 different policy instruments. While legislation is most likely to be publicised, the UK had already initiated a range of measures to reduce smoking prevalence and was second on the *Tobacco Control Scale* in the year before it banned smoking in public places (table 4.3). UK tobacco policy is marked by continuity and change, prompting us to consider more than one interpretation of events. Recent tobacco regulation may suggest radical change, as ineffective voluntary agreements are replaced by statutory measures, or incremental change, as new legislation builds on and accelerates existing policy. It also informs our other key narratives of tobacco policy. For example, the extent to which recent UK legislation was enforced or prompted from elsewhere, such as the EU and the UK's devolved governments, depends on how we characterise its policy trajectory (was change incremental or radical?).

The second section seeks to explain tobacco policy change in terms of the five factors outlined in Chapter 2. It outlines who has responsibility for the main tobacco policy instruments and charts the extent to which changes in that responsibility have been associated with policy change. This can relate to domestic changes, such as a change in the institutional responsibility from treasury, trade, and agriculture to the health department. It can also relate to a rise in multi-level governance and the new opportunities, provided by Europeanisation and devolution, for public health interests to pursue tobacco control. The MLG effect can be divided into two related processes. First,

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it increases the scope for venue shopping (Baumgartner and Jones, 1993); pressure participants seek new audiences if they are dissatisfied with progress in their initial focus of pressure. Second, the introduction of new venues influences the policy image of tobacco as policy is made by new participants with a different understanding of the problem and/or their involvement puts pressure on existing participants to emulate their behaviour. The chapter charts the extent to which the dominant policy image of tobacco has changed within government over the post-war period and also considers the extent to which this change is reflected in media and public opinion.

Multi-level governance also refers to the blurry boundaries between formal and informal action, related to the regular consultations between those who make policy and those with whom they communicate; policy is the 'joint product of their interaction' (Rose, 1987: 267-8). This process has been apparent in tobacco policy long before the identification of MLG. In particular, the post-war period was marked by a very close relationship between tobacco companies and key members of the UK Government. It has been replaced by a more open policy network influenced most strongly by public health interests, with tobacco companies increasingly marginalised in the policy process. This shift of influence within government over five decades has gone hand in hand with changes in socio-economic conditions as smoking prevalence, public opposition to tobacco control, and the economic value of tobacco to government have all fallen. It also reflects the importance of the role of ideas, such as the promotion of new scientific evidence and its acceptance within government, and the influence of the experience of other governments which has encouraged policy learning and transfer. These five factors – policy responsibility, agenda setting, group-government relations, socio-economic conditions, and the role and transfer of ideas – can be separated analytically, but they all combine to explain UK tobacco policy change.

What is UK Tobacco Policy?

We can assess the trajectory of UK policy with reference to the 14 policy instruments outlined in chapter 1 (although not all instruments are relevant to the UK) and a table (5.1) of major events in chronological order (see Cairney, 2007a: 49-50; ASH 2005; Read, 1996; Baggott, 1988; Taylor, 1984; Berridge and Loughlin, 2005; Cancer Research UK, 2010; ASH, 2010c).

I. Regulation

1. *Tobacco advertising and promotion*. Cigarette advertising on TV was banned in 1965. The first voluntary agreement with the tobacco industry on advertising (adverts contained the words 'Every pack carries a Government health warning') and health warnings on cigarette packs ('Warning by HM Government: Smoking can damage your health') was introduced in 1971. It was amended in 1972 (including health warnings on brand advertisements and providing further health advice on packs), 1977 (banning the advertising of high tar cigarettes), 1980 (a commitment to increase the health warning and reduce advertising spending), March 1982 (regarding an increase in prize money for sporting events but with related advertising carrying a health warning), October 1982 (adding health warnings to point-of-sale advertising plus a ban on advertising on video

cassettes), 1986 (banning advertising in cinemas and introducing more health warnings, reducing advertising spending and banning advertising in women's magazines aimed at a 16-24 audience), 1987 (banning sports sponsorship), 1991 (reducing the amount of point of sale advertising), and 1994 (increasing the size of health warning on adverts and stipulating that advertising billboards should be at least 200m from schools). Westminster passed legislation to ban tobacco advertising in 2002.

2. *The sale of tobacco*. Bans on the sale of tobacco to children under 16 were introduced in 1908 (one of the earliest in the world) but have always been dogged by ineffective implementation. In 1933 a new bill banned the sale of cigarettes to children under 16 and in 1986 this prohibition was extended to all tobacco products. The British legal minimum age to buy tobacco rose to 18 in 2007. Cigarettes may not be sold in packs smaller than 10, on the assumption that children are more likely to buy singles. Bills passed by Westminster in 2009 (covering, England, Wales and Northern Ireland) and the Scottish Parliament in 2010 banned cigarette vending machines and advertising at point of sale.

3. *Smoking in public places*. Smoking on public transport and in cinemas began to be phased out from the 1970s. A voluntary code of practice on smoking in public places was introduced by the UK government in 1991, suggesting that non-smoking should be the norm if a member of the public was in a building (e.g. post office) through necessity. A government-backed code of practice by the hospitality industry to reduce exposure to ETS was introduced in 1999. Westminster passed legislation to ban smoking comprehensively in public places in 2006 (for England and Wales; the Scottish Parliament legislated in 2005 and a separate decision was made for Northern Ireland in 2005). The Department of Health provided £29.5m (US$47.2m) for English local authorities to implement the ban (ASH, 2010c: 7).[i] Many NHS hospitals have introduced bans on smoking in NHS property and many local authorities have introduced restrictions on the ability of smokers to foster children (due to concerns about passive smoking in the home).

4. *Ingredients, such as the levels of tar in cigarettes*. The EU Tobacco Products Directive limits the amount of tar, nicotine and carbon monoxide in cigarettes (table 4.1). The UK had previously relied on voluntary agreements.

5. *Customs enforcement on smuggling and counterfeit cigarettes*. The UK government announced in 2000 a £200m ($320m) project to reduce smuggling, reducing the illicit market share from 21% in 2000-1 to 15% in 2003-4.[ii] It then announced in 2006 a plan to reduce this market by 1200 tonnes by 2007/8. It estimates that it employs 2150 staff at a cost of £96.5m (US$154.4m) per year and has spent £1.5m (US$2.4m) over 5 years (2003-8) on advertising its new initiative (ASH, 2010c: 3).

II. Finance

6. *Taxation and other levies*. Tax increases on tobacco were used extensively from the 1970s and promoted as a way to discourage smoking from the 1980s. By 1990 the tax (including duty and value added tax) was 73% on a packet of 20 cigarettes, rising to 80% in 2001 and falling to 77% by 2010 (TMA, 2010b). The decrease followed an abandoned commitment to increasing tax by 5% per year. Instead, duty has risen slightly above inflation (ASH, 2010c: 3). While this move has been criticised by Action on Smoking and Health (ASH) (Press Association, 2010), the UK government position is that 'levels of tax on tobacco have peaked, given the threat of smuggling' (Cairney, 2007a: 50).

7. *Spending on directed health services*. The first smoking withdrawal clinic was established in 1958. The National Health Service Stop Smoking Service was established in 1999. It treats approximately 250,000 people per six months (CRUK, 2010). Spending in England rose from £21.5m (£27m, or US$47.2m in 2008 prices) in 2000 to £74m in 2008 (ASH, 2010c: 5).

8. *Economic incentives*. The UK contributed indirectly to the subsidisation of tobacco growing (from 1973 to 2010) as subsidies to tobacco farmers in other countries were included in the Common Agricultural Policy. It has also given tax breaks to tobacco companies sponsoring the arts and sports. Both practices have now ceased.

9. *Litigation against tobacco companies*. This is a practice much more apparent in the US than the UK where the courts have played a minimal role in tobacco control (and class action suits have proved unsuccessful). Indeed, one of the most significant court interventions initially granted (in 1999) a tobacco industry injunction to stop UK government regulations to ban tobacco advertising.

III. Capacity building

10. *Funding for community development programs and organisations to combat tobacco use*. The most relevant group is ASH, set up by the Royal College of Physicians in 1971 to campaign on smoking issues. The UK government has traditionally been ASH's largest contributor. In 1988 it provided £170,000 (£351,900, or US$ 563,040 at 2008 prices) per annum – almost all of ASH's income (Baggott, 1988: 10; Taylor, 1984: 43). In 2009 it provided £142,000 (US$227,000) in project funding (19% of total income), but ASH's core funding is now met by Cancer Research UK and the British Heart Foundation (ASH, 2009).

IV. Education

11. *Health warning labels on cigarette and tobacco packs*. Packs of cigarettes in the UK now contain health warnings with pictures, under EU authorisation rules (chapter 4). The UK Government began a consultation on plain packaging in 2010.

12. *Health education campaigns combating tobacco usage*. The nature of health education shifted from 'stating the facts' and letting individuals decide in the 1950s, to harm reduction (promoting 'low tar' cigarettes) in the 1960s, and to

'absolutism' (there is no safe level of tobacco smoking) in the 1970s. Spending on health education concerning tobacco increased from £414,000 in 1973 (£4 million or US$6.4m in 2008) to £24m (US$38.4m) in 2008 (ASH, 2010c: 8). The rise is reinforced by the cessation of tobacco advertising since 2002 (it was £17m (£53m, US$84.8m) in 1981 – Taylor, 1984: 49).

V. Learning and information tools

13. *Legislative hearings and executive reports*. This element is more important in the US, where Congressional hearings and reports are often used to challenge legislative stalemates and set the policy agenda. However, there have been some notable reports in the UK, from the Chief Medical Officer's annual reports calling for stricter tobacco control (Cairney, 2007a: 62), to the UK Government's White Paper (Cm 4177, 1998) setting out a new tobacco control strategy.

14. *Funding scientific research*. The UK Government-funded Medical Research Council has a long history of tobacco research, including support for the work of Richard Doll and Bradford Hill (who produced one of the earliest studies on tobacco and health - MRC, 2007a; 2007b).

The UK Government has also set targets to reduce smoking prevalence. The significance of such measures is unclear. While the enforcement of some UK government targets (on, for example, waiting times in hospitals) have a strong effect on organisational behaviour, population targets may be meaningless unless linked to particular policy instruments. That said, there is a reasonable link between smoking prevalence and broad targets. The Conservative government aim to reduce smoking prevalence from 30% to 20% from 2000 to 2010 (see Townsend, 1996: 135) was unsuccessful, but the Labour aim to reduce prevalence to 21% by 2010 was met by 2007 (ASH, 2010b: 1; note that the Scottish Government has separate targets). The 2020 target for England is 10% (Department of Health, 2010).

Table 5.1 Major Tobacco Control Events and Decisions in the UK, 1908-2010

1908	Ban on the sale of tobacco to under 16
1950	Publication of Richard Doll and Bradford Hill's initial research
1950s	Limited health education campaigns begin
1958	Introduction of the first smoking cessation clinic
1962	First Royal College of Physicians report *Smoking and Health*
1960s	Health education focus on harm reduction
1965	Ban on cigarette advertising on TV
1970s	Beginning of new health education strategy
1971	Royal College of Physicians report *Smoking and Health Now*
1971	Phase-out of smoking in cinemas and on public transport begins
1971	First voluntary agreement on advertising cigarettes
1971	Action on Smoking and Health established
1977	Royal College of Physicians report *Smoking or Health*
1980s	Taxes on cigarettes begin to be used to discourage smoking
1983	Launch of 'National No Smoking Day'

1984	Ban on smoking in London Underground following fire
1986	Launch of European Commission's 'Europe Against Cancer'
1990	London Regional Transport bans smoking on all of its buses
1991	Voluntary code on smoking in public places
1991	UK Government Green Paper sets targets on smoking prevalence
1991	New health warnings on tobacco packaging (based on EU directive, size of warning opposed by tobacco companies)
1992	Nicotine patches available on prescription
1993	EU Workplace Directive requires smoke-free rest areas
1993	UK Government commitment to increase tobacco taxation by 3% per year
1997	Labour government elected
1998	Scientific Committee on Tobacco and Health report on passive smoking
1998	White Paper on tobacco control includes new targets on prevalence, the NHS smoking cessation programme and proposed voluntary agreement on smoking in the workplace
1999	Voluntary code on smoking in public places, hospitality sector
1999	National Health Service *Stop Smoking Service* established
1999	Class action against tobacco companies by lung cancer sufferers fails
2000	European Court of Justice rejects Tobacco Advertising Directive 1
2000	UK Government initiates major project on cigarette smuggling
2002	Ban on tobacco advertising
2003	Framework Convention on Tobacco Control adopted by 171 countries
2004	Ban on smoking in public places – Ireland
2005	Ban on smoking in public places – Scotland
2006	Ban on smoking in public places – rest of the UK
2007	Legal age to purchase cigarettes rises to 18
2009	Legislation banning cigarette vending machines and advertising at point of sale (2010 in Scotland).

Narratives of UK Tobacco Policy Change

A comparison of the immediate post-World War II period to the present day demonstrates that policy has changed radically, with government support for tobacco as an economic product replaced by a comprehensive set of tobacco control policies designed to minimise smoking prevalence. Most tobacco control measures were absent before the 1970s. Until then, statutory measures focused on the sale of tobacco to children and a ban on televised advertising, the main role for taxation was to raise revenue, and public education focussed on a reduction in smoking or a shift to safer methods (the so called 'harm reduction' or 'harm regulation approach' more likely to be found in drugs treatment and not used in relation to tobacco in many countries - see Berridge, 2004). The 1970s were notable for the rise in tobacco control based on voluntary agreements with the tobacco industry (health warnings on cigarettes) and a shift in health education towards abstention over harm reduction, coupled with the first funding for ASH. This approach continued into the 1980s, with voluntary agreements on

tobacco advertising supplemented by an increase in health education funding and the use of taxation to discourage smoking. The late 1990s were marked by the beginnings of much stronger tobacco control, with a sharp rise in tobacco taxation, coupled with measures to reduce the unintended consequences related to illegal tobacco, an increase in smoking cessation provision, a rise in health education messages through the media and cigarette packets and, in the 2000s, legislation to ban, comprehensively, tobacco advertising and smoking in public places.

Incremental versus sudden or radical change? This chronology informs our characterisation of change. It demonstrates that, although there has been a broad move in the direction of tobacco control in the post-war era, most change appears to have taken place in a concentrated period of time, accelerating from the mid-1980s (under a Conservative party often considered to be pro-tobacco) and again from 1997 (when the New Labour government was first elected). However, our focus on a wide range of policy instruments suggests that flagship legislation to ban tobacco advertising and smoking in public places may have marked a sea change in those particular dimensions but not for tobacco control altogether. Rather, it reflects a much wider or 'comprehensive' package of measures that now marks the UK's tobacco regime out as the most restrictive in the EU and one of the most restrictive in the world.

A key unresolved issue relates to the status of voluntary agreements, since this determines how rapid policy change has been in key areas. A public-health-oriented narrative suggests that these agreements were ineffective and that they were often produced to maintain a close negotiating relationship between tobacco companies and the government, to provide the appearance of tobacco control, and bolster a positive image for the industry (for a similar argument in the US, see Pollay, 1994). For example, the ban on advertising high tar cigarettes only occurred when their share of the market was dwindling; a limit on advertising expenditure favoured the companies with the most established market shares; the health warnings on packs were traded for the ability to name brands when advertising; and, most recently, the voluntary agreement on smoking in public places only required pubs to put up stickers declaring that they were not smoke free (Cairney, 2007a: 52). This perspective indicates that legislation on these topics marks a sea-change in policy in a relatively short period of time. The alternative is to view the agreements as tools adopted regularly by the UK government in many policy areas outside tobacco (Berridge, 2004: 136; Baggott, 1988). They represent statements of intent, to be followed by stronger measures if they are not as effective as hoped. It suggests that policy change took place over a much longer period, with a degree of initial success followed by stronger statutory measures (Cairney 2007a: 50-1).

Voluntary versus enforced change? The status of voluntary agreements also affects our view about the role of the EU. If we treat them as ineffective, then we can trace many significant developments in tobacco policy change, including regulating tar, introducing health warnings on cigarette packs, and banning tobacco advertising (as well as raising taxes), to developments in the EU. Yet, the idea of EU-led coercion does not correspond to the UK's position at the top of the tobacco control league tables. Nor does it explain why the UK has introduced most tobacco control policies before it has been obliged to by the EU.

Leaders or laggards? Finally, the status of the agreements affects the evaluation of UK policy overall. If we view them as ineffective, then we argue that the UK has been a policy laggard for a significant part of the post-war period – at least when compared to countries such as Norway (Baggott, 1988). We may also say that the UK only became a leader when it replaced voluntary with statutory measures. The overall point is that policy as a whole is difficult to characterise. As Berridge (2004: 136) asks, how do we compare the UK's high taxation and voluntary regime with countries that introduced more formal measures in some areas but did not emulate the wider adoption of policy instruments that we find in the UK?

A combination of narratives presents us with a very mixed picture of change. On the one hand, we can point to evidence from the post-war period to suggest that the UK government was a policy laggard that relied on voluntary agreements favoured by a powerful domestic tobacco companies before being obliged to legislate to ban tobacco advertising and smoking in public places following direct coercion from the EU and indirect coercion from the devolved governments. On the other hand, we can identify a tendency to lead the rest of Europe on most other measures of tobacco control, a decision to control advertising beyond the minimum requirements of the EU, and a decision within the UK's Department of Health to support devolved legislation as a means of pursuing a smoking ban in England. Thus, it is possible to defend two competing views of UK policy development – as a laggard forced by others to catch up and change policy dramatically, or as a leader introducing legislative controls as a logical consequence of its overall incremental strategy (Cairney, 2007a; 2009). This argument is crucial to the remainder of the chapter (and to the broader discussions of change throughout the book) because we need to be clear about what we are trying to explain – is it incremental change over a long period of time or a concentrated period of change? We explain the broad shift towards tobacco control in the post-war era in the following section before returning to this issue of explanation in the conclusion (and chapter 10).

Institutions: Who has responsibility for UK tobacco policy?

The Department of Health

In the early post-war period tobacco-related issues were addressed primarily by the Treasury, which, as the hub for tax raising and spending, has always been the key department within government, as well as the Department for Trade and Industry, which was the key actor responsible for promoting tobacco as an exported good and for lobbying the World Bank and IMF on tobacco (Mamudu, 2008b; although see Berridge, 2004: 119 on exceptional anti-tobacco ministers such as Dell at the DTI). The Department of Employment was also involved. As a whole, central government activity was related primarily to the economic advantages of tobacco – as a source of tax revenue, a contributor to the balance of payments (between imports and exports), and a significant provider of jobs (Cairney, 2007a: 47; Taylor, 1984: 69).

The only department with a strong incentive to treat tobacco consumption as a problem to be solved was the Department of Health, but it was often a relatively low status department marginalised from the centre of tobacco policy discussions. Unlike in

Norway, there was no coordinating body to give the Department of Health regular access to other policymaking departments (Baggott, 1988: 14 argues that the Norwegian National Council for Smoking and Health was set up following, and represented a focal point for, anti-smoking pressure). The closest equivalent was an advisory body, the Independent Scientific Committee on Smoking (ISCS, and later the ISCSH then SCOTH). Instead, major policy decisions were taken by cabinet committees led by other departments such as the Home Office and dominated by departments such as the Treasury (Baggott, 1988: 38). The Department of Health was part of the larger Department of Health and Social Security (DHSS) from 1968-88, a situation that reduced the status of health ministers and often presented it with contradictory incentives (e.g. healthier people would live longer and collect more social security benefits) (1988: 39). It was also staffed by ministers who were reluctant to innovate or short of time or political support when they tried (Cairney, 2007a: 52). Indeed, as recently as the mid-1980s, a junior Conservative health minister was removed from his post for pursuing a ban on advertising and sports sponsorship (Taylor, 1984: 94). In other words, although we identify the significance of this shift of responsibility towards the Department of Health, we also show that the change was relatively recent and by no means inevitable.

To some extent the new emphasis was furthered by a change of party in government; the Labour party elected in 1997 expressed a stronger commitment to tobacco control than its Conservative predecessor (and previous Labour governments). Policy change was also encouraged by shifting priorities within the Treasury. When a Treasury report identified smoking as 'the single most significant causal factor for the socio-economic differences in the incidence of cancer and heart disease' (HM Treasury and Department of Health, 2002: 5), it signalled a reduced willingness to support the tobacco industry as a source of tax revenue. Finally, the change was augmented by John Reid's appointment as Health Secretary in 2003. Reid was a strong Secretary, supported by Prime Minister Tony Blair, who ensured that any decision on issues such as the smoking ban would be made by the Department of Health. This also gave greater prominence to its Chief Medical Officer, who in the past had been marginalised in tobacco discussions (Cairney, 2007a: 62).

The EU

The EU has become a key player in tobacco policy (chapter 4), but tracking its effect on UK policy is difficult for two reasons: (1) the strength of EU policy varies from compulsory regulation to the promotion of best practice; and (2) the UK has adopted some policies before the EU made them compulsory for member states. Key EU requirements include: cigarette packs to carry a health warning of 4% (1989) and then 30% at the front and 40% on the back (2001) of cigarette packs; a ban on TV advertising (1989), replaced by an advertising ban on cross border print media, the internet, and sponsorship (2003); attempts to harmonise taxes (from 1972 and 1992); and, recommendations about bans on smoking in public places (table 4.1; Asare et al, 2009: 86). In most cases UK policy on these issues occurred earlier and/ or went further than required by the EU: taxation on tobacco aimed at reducing smoking dates back to the 1980s; the UK committed itself to health warnings on cigarette packs (via voluntary agreements) before the first EU directive; and, it banned smoking in public places well in advance of any EU requirement (Asare et al, 2009: 91). Tobacco advertising presents a

mixed picture because the UK government opposed both Tobacco Advertising Directives before introducing legislation to ban tobacco advertising in a way that went beyond EU requirements before the latest EU ban went into force (Duina and Kurzer, 2004: 58; Cairney, 2007a: 55).

Devolved Governments

Devolution in 1999 to Scotland, Wales and Northern Ireland included health and education policy and therefore some tobacco policy instruments such as smoking cessation services, health education and the ability to fund or commission services from organisations such as ASH. Issues of taxation, customs enforcement, health warnings on cigarette packs and regulations on the product itself remain reserved to the UK government (or Europeanised), while the funding of scientific research is largely a UK responsibility (via the Medical Research Council), with scope for additional devolved funds. In most cases the new devolved responsibilities have not prompted significant policy innovation or divergence because each devolved health department has similar ideas to the Department of Health. The exceptions come from tobacco advertising and the ban on smoking in public places. When it became clear that the bill, introduced in 2000, to ban tobacco advertising in the UK would be delayed (following the dissolution of Parliament in 2001), a separate bill covering Scotland was introduced in 2002 by an opposition MSP (Nicola Sturgeon, who became Scottish Health Secretary from 2007 to the present day), largely to set the agenda and put pressure on the UK government to reintroduce UK-wide legislation (Cairney, 2007a: 55; 2007c).

The issue of smoking bans initially followed a similar path, with the first bill introduced by an opposition MSP in 2003 subject to the same uncertainty about the legislative competence of the Scottish Parliament. The difference in this case is that the bill received significant parliamentary support. It also became clear that prominent public health advocates, such as ASH Scotland and the British Medical Association (BMA) Scotland were prepared to back this bill and criticise the lack of Scottish Executive action (the BMA is the main trade union of the medical profession and has a significant campaigning role in health policy; the BMA Scotland is a devolved branch of the UK body; ASH Scotland is a separate organisation from ASH UK, reflecting separate Royal Colleges in Scotland). This prompted the Scottish Executive, which had previously relied on a voluntary agreement with the Scottish hospitality industry, to introduce its own comprehensive bill in 2005.

As with the EU, the influence of devolved policy activity is often difficult to gauge. While the advertising bill was significant to the Scottish Parliament, it had much less of an impact on the debate in Westminster (2007a: 55). While the decision of the Scottish Executive to ban smoking in public places (combined with similar commitments in Wales and Northern Ireland) raised the issue on the UK agenda, the UK's health secretary John Reid remained committed to a partial smoking ban which exempted bars (pubs) and private clubs.

The UK Parliament (Westminster)

The history of the role of Parliament in tobacco is one of constant post-war involvement but limited influence - until it played a key role in the smoking ban. Its limited influence on tobacco control reflects not only the peripheral role of Parliament to the policy process (Richardson and Jordan, 1979) but also the role of pro-tobacco Members of Parliament (MPs), who ensured that a succession of private members' bills introduced in Parliament to control tobacco were defeated. Parliamentary influence was used in the 1970s as a resource by ministers when negotiating voluntary agreements with the tobacco industry (Berridge, 2004: 123; Baggott, 1988: 30), but the effect of pro and anti control advocates ensured that the issue 'tended to float on and off the agenda' (Baggott, 1988: 32). This position changed dramatically in 2006 when Westminster voted for legislation to ban smoking comprehensively in public places despite attempts by ministers in the Department of Health for more limited bans (see Cairney, 2007a: 63).

Overall, the evidence points to policy change caused partly by a combination of institutional changes. The significance of influence from the EU and devolved territories is marked when we consider its combined effect with UK institutional change. As Cairney (2009: 477) argues, there is a "long tradition of campaigning 'clientelism' in the UK's Department of Health". In the past, the marginalisation of the Department of Health and health ministers prompted them to seek new ways to influence tobacco policy. Its main route was to fund groups such as ASH to raise issues and criticize policy on its behalf. Now, this influence extends to the EU and devolved territories. EU regulations can be used as a benchmark or minimum point from which to build, and devolved policy can be used to put pressure on the UK government as a whole.

Agendas: how important is tobacco control as a policy issue? How is tobacco framed?

There was a time in the UK when tobacco enjoyed a glamorous image, smoking was a normal part of life and media attention was minimal and largely positive. Much early post-war policy centred on supporting tobacco as an industry. This economic image became increasingly challenged by public health groups promoting new scientific evidence on the links between smoking and serious illness. It was also challenged increasingly within the media. In particular, the position of the print media changed when newspapers and magazines no longer relied on significant tobacco advertising revenue (following restrictions and then the ban on advertising). However, the effect of this new image was not uniform within government. The case for tobacco control was increasingly accepted within the Department of Health but not in other departments more likely to focus on employment, export and taxation.

For most of the post-war period the economic image of tobacco was reinforced by an image related to the importance of civil liberties and public opinion. Governments were reluctant to restrict the advertising of a product that was not illegal to sell and people were free to consume. The Labour government rejected calls in 1968 to legislate to ban tobacco advertising and sponsorship primarily because it would be unpopular among Labour's working class base (Taylor, 1984: Cairney, 2007a: 52; note that the successful ban on TV advertising was ensured without recourse to further legislation). This attitude was reinforced from 1979 by a Conservative government ideology stressing a minimal role for the state in regulating behaviour, and therefore placing unusual emphasis on the

role of civil liberties compared to most other countries addressing tobacco (see Studlar 2002). The proposal by a junior minister to legislate to ban tobacco advertising was decried by many Conservative MPs and ministers (including the Prime Minister) as "an attack on 'freedom not cigarettes'" (Cairney, 2007a: 52: Taylor, 1984: 145). Instead, governments sought voluntary agreements with the tobacco industry.

The election of Labour in 1997 marked a significant shift in the willingness of government to accept public health as the dominant tobacco policy image (suggesting, considering Labour's past attitudes, a highly-qualified party effect). This reinforced the rising status of the scientific evidence on the significance of links between exposure to ETS and illness. A developing policy image linked to passive smoking not only reinforced attention to tobacco as a health issue, but also undermined an image based on civil liberties, with the right to smoke now competing with the right to enjoy clean air and attention to the voluntary act of smoking competing with 'involuntary smoking' (Berridge, 2004: 124). The argument that tobacco taxation had a disproportionate effect on poor and older smokers gave way, first, to the argument that taxation would reduce tobacco consumption among those groups and, second, that smoking was a 'waste of working class life' (Berridge, 2004: 131). The argument that a reduction in smoking would allow people to live longer and therefore increase the government's social security bill gave way to health economist arguments highlighting an overall economic cost of tobacco consumption.[iii]

The Labour government was more willing to legislate to ban tobacco advertising and accelerate measures to reduce smoking prevalence, such as higher taxation combined with an expansion of cessation services (Asare et al, 2009: 93). Yet the images related to popularity and civil liberties remained an important reference point. Legislation to ban smoking in public places was passed eventually, 10 years after Labour's election. In the meantime, it promoted voluntary codes of practice with employers and the hospitality industry. Therefore, the idea of a changing policy image or a new dominant image related to tobacco is important, but we should not assume that this reframing alone led inevitably to policy change.

Networks: has there been a shift in power between pressure participants?

The balance of power between tobacco and public health interests within government has shifted profoundly since the early post-war period. As Read (1992; see also Taylor, 1984: 69-71) argues, earlier tobacco policy represented one of the clearest examples of a producer-dominated 'policy community' (or 'cozy network'). Representatives of tobacco companies commanded privileged access to senior ministers and civil servants and their relationship was insulated from most other actors. The relationship was institutionalised during World War II when the Tobacco Advisory Council (TAC, effectively replaced as the political arm of tobacco by the Tobacco Manufacturers' Association, TMA), consisting of representatives of tobacco companies and the UK government, was established to ensure the supply of cigarettes to civilians and members of the armed forces. Its importance as a venue for group-government relations continued because the tobacco industry provided clear economic benefits (taxation, employment, exports). Links with senior government actors in the DTI were maintained to monitor and promote tobacco exports, while other factors such as tobacco sponsorship in arts and sports and

the role of tobacco employment in marginal constituencies influenced the support of several ministers and MPs (Baggott, 1988: 20). Notably, the reliance by government on voluntary agreements with the industry gave the latter a legitimate reason to maintain close contacts and negotiate with the Department for Health and Social Security on a basis that no other organisation rivalled (Baggott 1988: 16). Indeed, Baggott (1988: 40) argues that the tobacco industry 'enjoyed almost a veto power over policy'.

Read (1992; 1996) suggests that this closed policy community was surrounded by a wider 'issue network' of participants who sought to influence government but had more limited scope for access and influence. This includes affiliates of the tobacco industry who could be called on for support, including representatives of tobacco workers, retailers and consumers (such as Freedom Organisation for the Right to Enjoy Smoking Tobacco, FOREST), and organisations such as the Advertising Association, which opposed any tobacco advertising ban that would cause a reduction in revenue (Baggott, 1988: 21).

The issue network also included their opponents within public health. Advocates of stronger tobacco control were not well funded or organised in the early post-war period. The Royal College of Physicians was the main voice in the 1950s and 1960s, but its role was restricted primarily to the dissemination of new scientific information. It established ASH in 1971 (ASH Scotland was established by the Royal College of Physicians Edinburgh in 1973), and ASH anti-tobacco advocacy was joined increasingly by the British Medical Association (BMA). However, a concerted anti-smoking campaign was still in its infancy (Cairney, 2007a: 48). The BMA was not nearly as active or organised on this issue compared to the present day (Baggott, 1988: 11). ASH received almost all of its money from government and so had to be careful about the tone of its criticism (Baggott, 1988: 10). There was also minimal lobbying activity by cancer charities (Baggott 1988: 15). Further, each group was most likely to form its most effective links with the Department of Health, which, at the time, operated at the margins of the tobacco policy community. Therefore, public health groups were effectively obliged to pursue a long-term strategy: building up organisational capacity, gathering and disseminating scientific evidence (the RCP was a key actor in this regard), promoting measures (such as smoking cessation and health education) more readily controlled by the Department of Health, lobbying Parliament, and forming domestic and international networks to share best practice and coordinate their efforts.

The effect of this strategy was long-term success, in terms of the policy effect and the status of public health advocates within government, although change took decades and public health advocates may have not felt successful at the time. The early post-war period contrasts starkly with the 21st century. The influence of tobacco companies has diminished, not only because the economic benefit of tobacco has diminished, but also because the changing policy image of tobacco has resulted in its main avenues of influence being either less receptive (the Treasury) or less central to tobacco policy (the DTI). In contrast, public health groups have close links to the Department of Health as the central government department responsible for policy innovation. The BMA is more organised and has a better developed campaigning role. Although ASH still receives income from government, the proportion has fallen (perhaps making it more independent, even though the Department of Health generally supports its aims). There are more actors

involved on a regular basis, including Cancer Research UK which, as a large and independent charity funding scientific work on a large scale, has always had close links to the Department of Health (and, unusually, it used them to promote tobacco control).

The effect of this shift within policy networks is not inevitable policy change. In this section we have identified privileged access to ministers and civil servants, not dominance of policymaking itself. Rather, this new institutional arrangement represents a new locus of information and the main source of feedback during consultation. It reinforces the newly dominant policy image (health, not economy) that determines the context within which policy decisions are made.

Socioeconomic Factors

Economic Benefits of Tobacco

Most indicators suggest that the importance of tobacco to the economy fell at a time when attention to the economic ill-effects of smoking rose. However, exact figures are elusive partly because the competition between public health groups and tobacco companies to set the agenda on tobacco extends to basic measurements such as the number of jobs that the tobacco industry provides. The TAC estimated that tobacco provided 300,000 jobs (many of which were in economically depressed and/or marginal constituencies) in 1979 (Cairney, 2007a: 47; Taylor, 1984: 69), based on the argument that 'suppliers and in wholesale, distribution and retailing were dependent on the UK tobacco industry' (Tobacco Manufacturer's Association, 2010). This fell to 5000 direct and 80,000 indirect jobs by 2004. ASH suggests a figure of 40,000 in 1979 which fell to 11,000 by 2003 (Cairney, 2007a: 47; Taylor, 1984: 69). The tax raised on tobacco products has also declined because an increase in the tax price per cigarette[iv] has been offset by a reduction in smoking. In 1950, tobacco taxation accounted for a staggering 16% of government revenue, prompting Minister of Health Ian MacLeod to state in 1954 that, 'We all know that the Welfare State and much else is based on tobacco smoking' (Berridge, 2004: 117). It fell to 8% in the 1960s and 3.6% by 1996, remaining at about 4% (Townsend, 1996: 140; Aspect, 2004: 86).

The UK does not grow tobacco, but it is the home country for some of the largest tobacco companies in the world. In 1988 the top four British tobacco companies made £1.89 billion (£3.91 billion, or approximately US$6.3 billion, at 2010 prices) in pre-tax profits and the UK was home for three of the top seven tobacco multinationals (excluding the state owned Chinese tobacco company which dominates the Chinese market) - British American Tobacco, Imperial Tobacco, and Gallahar (Baggott, 1988: 17). These companies dominated the UK market, which meant that any tobacco control policies would primarily affect the domestic industry (1988: 24). This position has changed somewhat following alterations in the market and the rise of cheap imported cigarettes and illegal smuggling. The UK still is home for the second (British American Tobacco) and fourth (Imperial Tobacco) largest companies, but Gallahar (commanding 38.7% of the UK market share) has been owned by Japan Tobacco International (JTI) since 2007 (ASH, 2007). In 1988 cheap imports accounted for 10% of the UK market share (Baggott, 1988: 25). While this has not risen significantly, the UK government estimates that £2.4-4bn (US$3.84-6.4bn) of tobacco taxation was lost from smuggling and cross-

border shopping, compared to £10bn (US$16b) raised in excise and VAT (sales) taxes in 2007/8, suggesting that 19-28% of the market is not taxed (TMA, 2010c).[v]

Smoking prevalence and behaviour

ASH (2010b: 1) states that the highest recorded level of smoking among men (including pipes, cigars and cigarettes) was a staggering 82% in 1948 (the highest smoking rate in the world at that time, no doubt influenced by wartime tension), while prevalence among women was 41% in 1948, rising to 45% in the mid-1960s. By 2008 the figures had fallen to 22% and 21% (table 5.2). In 2008, the 22% who smoked compared to 32% who had quit smoking and 46% who had never tried (Office for National Statistics, 2009: 8). The proportion of people who say they want to give up, primarily for health reasons, has remained constant, at approximately 70%, since the late 1990s (2009: 17; 20), while the daily consumption of cigarettes has fallen from 21.6 in men and 16.6 in women in 1979 to 14 and 13 by 2008 (ASH, 2010b: 3). The proportion of people who say they would not smoke in the presence of children rose from 54% in 1997 to 78% in 2008 (ONS, 2009: 70).

Table 5.2 Smoking Prevalence in the UK, 1948-2008

Year	1948	1974	1986	1998	2008
Men	82%	51%	35%	30%	22%
Women	41%	41%	31%	26%	21%

Source: ASH (2010b)

The long-term trend is therefore clear, and it suggests that a smaller proportion of the population will oppose increased tobacco control. There are also trends within the overall figures that may influence government policy in more detail. For example, the identification of a strong relationship between class and smoking prevalence prompted the Department of Health (2002: 61) to target a specific reduction in prevalence among manual workers, with a particular emphasis on smoking cessation services and tailored education in prisons, hospitals and factories (Department of Health, 2008: 9).

Social attitudes

There is a broad trend in the UK towards a permissive consensus on tobacco control (chapter 3). Berridge (2004: 119) suggests that Richard Crossman's (Secretary of State, DHSS) opposition to legislation banning advertising in 1967 was based primarily on 'electoral considerations, rather than industry influence', while Baggott (1988: 32) reports that only a small majority of the public favoured an advertising ban in the 1970s. However, the ONS (2009: 90) suggests that, since 1996, approximately one-third of the population has supported an increase in tobacco tax representing 'A lot more than inflation', while approximately half have supported 'A lot more than inflation' or 'Just above inflation'.

We suggest in Chapter 3 that it is relatively difficult to present a precise picture of social attitudes to tobacco control because comprehensive polls on the subject have not been taken until recently and the results vary according to the measures employed. Fortunately, there is a wealth of data on the UK that can be used to inform the wider comparative picture. Cairney (2009a: 478) identifies three relevant factors to analyse attitudes to the smoking ban:

1. The use of different opinion polls or the selective use of the same data.

2. The use of consultation documents rather than opinion polls to demonstrate support.

3. The less precise feeling among decision-makers about changing levels of public opinion and the scope for change.

Few policymakers would find a clear message from opinion polls because the results are subject to manipulation regarding the way the question is asked and the results are publicised: while ASH Scotland used the ONS Omnibus Survey to show over 80% support for restrictions in most public places and growing support for restrictions in bars (to 54% by 2002), the TMA suggested that, according to a Scottish Executive commissioned poll, Scottish opinion was 50:50 on the same issue, with 77% against a total ban; in Northern Ireland, the Health Promotion Agency stated that 61% of respondents supported a law to make all workplaces smokefree but not that only 34% wanted a complete ban in pubs; while Alun Pugh AM (Assembly Member) argued that 80% supported controls, the Welsh Assembly's Committee on Smoking in Public Places reported that attitudes varied, with 91% in favour of restrictions in schools but 50% in bars (Cairney, 2009a: 478-9).

The solution in Scotland and Northern Ireland was to use consultation documents to supplement opinion polls, perhaps partly because those in favour of a smoking ban were more likely to respond (2009a: 479). In Scotland, the 80% support in consultations for a smoking ban and the 56% support for a comprehensive ban was used by the Scottish Executive to justify change, while the figure of 91% support was promoted by pressure participants via the media and used by the (UK Government's) Northern Ireland minister to justify action. There is also evidence in Scotland that a comprehensive ban was pursued only when the initial media opposition in 1999 dissipated and the Scottish Executive sensed a shifting public mood from the early 2000s (2009a: 480).

The process was significantly different and rather more convoluted in England (and therefore in Wales which depended on Westminster legislation). A key difference is that the John Reid-led Department of Health was less likely to use consultations and opinion to justify a complete ban. Rather, it downplayed the importance of its consultation results (2009a: 480) and instead sought to follow public opinion to the letter:

> Surveys . . . show 86% of people in favour of workplace restrictions, and a similarly substantial majority of people supporting restrictions in restaurants. But when people are asked whether smoking should be restricted in pubs the figures fall substantially – to around 56% – and when people are asked which sort of restrictions they would

> prefer in pubs only 20% of people choose 'no smoking allowed anywhere' and the majority tend to be opposed to a complete ban. (Cm 6374, 2004: 98)

This was the government position when its legislation was introduced in Westminster. Yet, Labour MPs were influenced by the argument that attitudes to smoking bans were changing rapidly and that the ban itself would increase support (based on the experience in Ireland and Scotland) (Cairney, 2009a: 480). This proved to be the case in England, with (qualified) support for a smoking ban in pubs rising from 48% in 1998 to 56% in 2003, 65% in 2004 and 75% in 2007 and 2008 (2009a: 480; ONS, 2009: 84). Support for the comprehensive smoking ban itself was also high at 80% in 2007 and 81% in 2008 (2009: 88).

The Role of Ideas: Scientific Knowledge

For our purposes the role of ideas has two key aspects: the development of scientific evidence used to reframe the tobacco problem, and the extent to which the UK government has imported ideas from other governments. At first glance it appears that the acceptance within government of the scientific evidence, and therefore a reframing of the tobacco problem, was almost inevitable. Policymakers no longer question whether or not smoking causes ill health, while few question the connection between exposure to ETS and illness. Instead, the policy agenda is concerned with how far to go with tobacco control as a result of the problem.

Yet, the strong connection between ideas and policy only seems inevitable in retrospect. The public health-driven anti-smoking agenda did not begin in the 1950s. Although the association between smoking and lung carcinoma was highlighted by Doll and Hill in 1950, there was considerable uncertainty within the Ministry of Health about how to assess this evidence (Berridge, 2004: 118). It also took time for adjustments within the public health field to take place, which involved movement from a focus on coal pollution and epidemics associated with infectious diseases (Berridge 2004: 118). Notably, the Royal College of Physicians' *Smoking and Health* report in 1962 was undertaken to educate *doctors* (Berridge 2004: 118), suggesting that the smoking-illness link was by no means taken for granted and therefore that its effect on some policymakers from the 1960s was impressive. It is also significant that the 1962 and 1971 reports recommended a form of harm reduction (from cigarettes to cigars or pipes) rather than the contemporary all-or-nothing push to smoking cessation (Berridge 2004: 121). In other words, the evidence itself did not cause any policy change, particularly since considerable resources were devoted by tobacco companies to challenge the smoking-illness association. Rather, this was prompted by a different approach to its dissemination and a reinterpretation of the policy consequences. Berridge (2004: 123) suggests that the new focus, which involved encouraging abstention through health education, tobacco taxation, and a ban on advertising, only developed from the 1970s, while the acceptance of this approach within government took much longer to establish.

The same can be said about the scientific evidence on exposure to ETS, with studies linking ETS to serious illness published in medical journals from the early 1980s but only causing legislative action to ban smoking in enclosed public places from the mid 2000s. While the ISCSH accepted a degree of increased risk to health from passive smoking in

1988, the link did not become a 'scientific fact' within government until its successor, the Scientific Committee on Tobacco and Health (SCOTH), highlighted the risks to lung cancer, heart disease and other illnesses and called for smoking in public places to be restricted (2004: 125). This accords with the Department of Health argument (in interviews in 2006, recounted in Cairney 2007a: 50-1) that the connection was not 'set in stone' until the SCOTH report (compare with Aspect Consortium, 2004: 34). Even then, the acceptance of evidence within government does not cause an inevitable comprehensive ban on smoking in public places. Many other options to accommodate the wishes of smokers and non-smokers could have been found (Berridge 2004: 125) and were tried initially, including the UK government's initial agreement with employers and the hospitality industry to restrict smoking to particular areas or discourage non-smokers from entering certain premises, and the tobacco company plan to introduce air filtration systems.

The Transfer of Ideas

There are similar issues regarding the transfer of ideas from other governments. The post-war debate on the scientific evidence appears to have been won in developed countries, prompting them to share ideas on further tobacco control and produce an impressive degree of international policy diffusion (see chapters 8 and 9). The UK is very much part of this picture. However, we identify two key phases which qualify the role of transfer to some extent. First, when the UK was a post-war laggard it was resistant to the importation of measures such as a ban on tobacco advertising (Baggott, 1988). Second, when the Labour government was elected in 1997 it had already committed itself to a degree of tobacco control that went beyond the international agenda (although this was based on advice from members of key epistemic communities).

The main exception to this picture relates to the smoking ban introduced by the Scottish and UK Governments. In this case there were at least two important sources of learning. The first was the accepted international model (developed from the experiences of California and New York) of incremental change in which smoking restrictions were steadily increased to denormalise smoking in public places, influence public opinion and isolate bars and clubs before a complete ban (Cairney, 2009a: 481-2). The second, based on more recent experience in Ireland (which is closest in size to the devolved territories and shares a border with Northern Ireland), was an immediate and comprehensive ban. The UK as a whole adopted the Irish model and there is clear evidence of learning (Asare and Studlar, 2009), albeit at different times and in different ways (see Cairney, 2009 on four separate 'windows of opportunity' for policy change).

Conclusion

The clearest outcome from this study of the UK is that tobacco policy is radically different when compared to the early post-war regime. It has also changed markedly since the mid-1980s, with tobacco control accelerating particularly since 1997. This general post-war conclusion holds regardless of one's view on the status of voluntary agreements. These agreements have demonstrated at best a partial degree of success in each case (health warnings, advertising, smoking in public places). Yet, while a shift from voluntary to statutory action may have produced a lurch in policy in certain areas, in

each case they represent incremental changes when viewed alongside the wider range of policy instruments pursued by the UK government. We return to this issue, of incremental changes leading to radical change over the long term, in chapter 10.

We explain this shift in policy by focussing on the five core processes identified in chapter 2. Institutional change has been important, with the Treasury and DTI replaced by the Department of Health as the central actor and the EU and devolved territories (and, occasionally, Westminster) providing new sources of policy impetus. The policy image of tobacco has been reframed, from a focus on its economic benefits and the right to sell and smoke tobacco replaced by a focus on health, the tobacco epidemic, and the right to clean air. The fortunes of pressure participants has shifted dramatically, with the tobacco companies that were once at the heart of policymaking now increasingly marginalised in favour of medical and public health interests. The economic benefits of tobacco, public attitudes against tobacco control, and smoking prevalence have all fallen significantly. The status of scientific knowledge demonstrating the connections between smoking, exposure to ETS, and ill health have been 'set in stone' within the UK government now seeking, often with the help of international experience, to know which restrictive measures are the most effective rather than if tobacco control is necessary.

The five factors combined and reinforced each other to produce significant change over a long period. For example, the increased promotion of tobacco control by the EU and devolved governments (and, latterly, Westminster) helped change policy, but perhaps more importantly provided the Department of Health with more avenues for influence. The rise in the evidence regarding exposure to ETS and the receptivity in multiple levels of government to scientific argument, promoted by public health groups, helped transform the policy image of tobacco - from an economic image bolstered with reference to civil liberties and the voluntary nature of smoking (and a tendency towards voluntary agreements with the industry) to an image based on ill health and the involuntary inhalation of ETS. The funding of ASH by the Department of Health, combined with the rise in lobbying activities by the BMA (and, more recently, cancer charities), helped disseminate the evidence on smoking (domestically and internationally – see chapter 9), influence smoking prevalence, and provide a platform for further tobacco control. The reduction in the economic benefits of tobacco undermined the policy influence of the industry. The reduction in smoking prevalence influenced public attitudes to tobacco, which in turn furthered a 'permissive consensus' to tobacco control which was exploited in different ways by different governments. The experience of the Irish and devolved governments put pressure on the UK government to emulate its comprehensive ban and, when this pressure was resisted, helped public health groups put pressure on MPs to vote against the government line. The key point is that no single factor explains this change. Rather, they are all necessary but insufficient conditions for major policy change.

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[i] At the time of writing, £1 equals US$1.6.
[ii] Note the effect of the EU common market which allows for the mobility of people and goods across the UK and makes the enforcement of policy on tobacco smuggling more difficult.
[iii] Townsend (1996) suggests that tobacco cost £610m to the national health service, £20m to the fire service, a net of £190m in social security payments and 50 million working days lost per annum in 1996. ASH (2010a: 2) puts the NHS cost at £2.7bn (as does the Department of Health, 2010: 5), attributes 1600 deaths in 10 years to cigarette-related fires highlights similar working days lost and estimates that making workplaces smoke-free would save £2.3-2.7bn. See also ASH (2010a: 2) on the debate regarding the net economic cost of tobacco in the Czech Republic.
[iv] The UK has the highest tobacco taxation in the EU (ASH, 2010: 3). According to the TMA (2010b), the amount of tax on the RRP of a pack of 20 cigarettes was 73% in 1990, rising to 80% in 2001 and falling to 77% by 2010. For a comparison of prices in the EU, see Aspect Consortium (2004: 79).
[v] ASH 2010: 3 has an estimate of 22%; the Department of Health, 2010 suggests a figure of £3bn in 2006. This is a rather contentious area because tobacco companies have often been blamed (most notably by the WHO) for much of the untaxed, smuggled market – see the Tobacco Control Atlas http://www.who.int/tobacco/en/atlas20.pdf