



# Policy statement

## Tobacco control

### Introduction

The British Heart Foundation (BHF) is actively involved in tobacco control issues because of the strong association between smoked tobacco and ill-health including coronary heart disease (CHD). Smoking is a major risk factor for CHD, and smokers are almost twice as likely to have a fatal heart attack as non-smokers.<sup>i</sup>

Every year in the UK, 114,000 smokers die as a result of smoking, with over 25,000 smoking-related deaths from coronary heart disease.<sup>ii,iii</sup> It is estimated that the cost to the NHS in the UK in treating smoking related illness is between £2.7 billion and £5.2 billion per year.<sup>iv,v</sup>

### Policy statement

The BHF believes that a number of policy changes are needed to further reduce the harm that tobacco inflicts on smokers, on their children and families, and on society as a whole.

These include:

- protecting young people through a comprehensive **ban on cigarette vending machines**, with legislation still required in Wales and Northern Ireland (pages 2-3)
- restricting all forms of marketing of tobacco and tobacco accessories, including a ban on **point of sale** advertising and introduction of **plain packaging** (pages 4-7)
- **reducing exposure to passive smoke**, through improved application of current legislation and by encouraging smokefree homes and vehicles (pages 8-9)
- **helping people to quit** by increasing investment in smoking cessation and by providing Nicotine Replacement Therapy free on prescription (pages 10-11)
- **encouraging harm reduction** for those smokers that are unable or unwilling to quit, coupled with research on the long-term effects of nicotine use (pages 12-14)
- **reducing health inequalities** among smokers from ethnic and lower socioeconomic groups (pages 15-16)
- **raising taxation** on tobacco and reinvesting the money raised in smoking cessation services (pages 17-21)
- **tackling smuggling**, including the introduction of a **positive licensing** scheme for premises selling tobacco, and a tracking and tracing system on all manufactured cigarettes (pages 22-23).



# Policy statement

## Cigarette vending machines

### Introduction

Despite a range of tobacco control measures being implemented, smoking rates amongst children remain consistently high and hundreds of children each day continue to take up smoking.<sup>1</sup> Nearly 40% of adults who are smokers or ex-smokers started smoking before they were 16.<sup>2</sup> The BHF is therefore particularly keen to see further steps taken in preventing young people from becoming addicted to this lethal habit.

### Policy statement

A ban on cigarette vending machines across the UK will cut off one of the major sources of cigarettes for children and create a further barrier to smoking for under-age young people. This is the only effective way to prevent children accessing cigarettes from cigarette vending machines.

The BHF is calling for a comprehensive ban on all cigarette vending machines in Wales and Northern Ireland to mirror the English and Scottish legislation. This must be implemented at the earliest opportunity.

### Background

Young people who smoke are at serious risk of developing life-shortening conditions.<sup>3</sup> People who begin smoking at a young age are more likely to suffer tobacco-related mortality and morbidity, and succumb to tobacco-related diseases earlier.<sup>4</sup> Further, two thirds of adult smokers started smoking when they were underage indicating that young people who take up smoking continue to smoke in later life.

<sup>1</sup> According to figures from cancer Research UK, 450 children taken up smoking every day in the UK, <http://info.cancerresearchuk.org/youthandschools/latestfromthelab/whencellsgowrong/thingswedo/> last accessed 18 August 2009

<sup>2</sup> Statistics on Smoking, England October 2008 (NHS statistics, The Information Centre, DH), Page 8

<sup>3</sup> Doll R, Peto R, Boreham J & Sutherland I (2004) Mortality in relation to smoking: 50 years' observations on male British doctors. *British Medical Journal* 328(7455):1-10

<sup>4</sup> *Ibid*

In 2008, 12% of children and young people who were regular smokers usually bought their cigarettes from vending machines in England.<sup>5</sup> Based on these latest available figures, the BHF estimates that 23,000 11-15 year old regular smokers access their cigarettes through vending machines in England and Wales and that 851 regular smokers accessed cigarettes from vending machines in Northern Ireland.<sup>6</sup> Around one in ten 15 year olds and 13% of 13 year olds who smoke get cigarettes from vending machines.<sup>7</sup> The raising of the age limit for cigarettes from 16 to 18 means there may now be more underage smokers accessing cigarettes from vending machines.

The BHF has been central to ensuring that a ban on all cigarette vending machines was included in the Health Act in Westminster in 2009 and the Tobacco and Primary Medical Services (Scotland) Act in 2010. The ban will be enforced in England and Scotland from October 2011. It is essential that the Welsh Assembly and Northern Ireland Assembly follow suit to ensure inequalities across the UK are not exacerbated – both are expected to legislate for a ban during 2010.

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<sup>5</sup> Smoking, Drinking and Drug Use among Young People in England, Survey 2008, Table 2.23, Page 47

<sup>6</sup> This is a BHF calculation using the latest available data regarding vending machines from Smoking, Drinking and Drug Use among Young People in England 2008 and mid-2007 population estimates by individual year for England and Wales. It is assumed that trends in smoking amongst young people and children are similar in England and Wales.

<sup>7</sup> Black, C. et al. (2009) Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) National Report: Smoking, drinking and drug use among 13 and 15 year olds in Scotland in 2008. ISD Scotland.



# Policy statement

## Tobacco marketing

### Introduction

Tobacco advertising is a major factor in encouraging young people starting to smoke. Since February 2003, virtually all forms of tobacco advertising and promotion have been banned in the UK under the Tobacco Advertising and Promotion Act.

From 2005, cross-border sponsorship by tobacco brands is banned across the European Union under an EU Directive. A total ban on advertising and sponsorship is a core measure advocated within the Framework Convention on Tobacco Control (FCTC), the global treaty that aims to reduce tobacco consumption and smoking-related harm.

### Policy statement

The BHF believes that there should be restrictions on all forms of marketing of tobacco and tobacco paraphernalia aimed at recruiting new smokers. To ensure that young people are protected from tobacco marketing, the BHF believes:

- **sponsorship** or **product placement** at events, in films or through other forms of entertainment should remain restricted
- the advertising of **tobacco accessories** such as cigarette papers should also be prohibited
- the forthcoming ban on tobacco advertising at the **point of sale** across the UK is a key part of effective restrictions on the marketing of tobacco
- **plain packaging** for cigarettes should be introduced across the UK, as it will increase the effectiveness of health warnings and reduce misconceptions about the risks of smoking. Packaging must also include quitting helpline telephone numbers.

## Background

Since the implementation of the Tobacco Advertising and Promotion Act the tobacco industry has invested resources in package design and point of sale displays, which are the only permitted forms of advertising.

For example, Imperial Tobacco has stated that because of advertising restrictions, cigarette packs and their display in retail outlets are now a major marketing tool and that pack redesign alone has increased their share of the market.<sup>8</sup>

### ***Point of sale displays***

Research shows that point of sale displays have a direct impact on young people's smoking behaviour. In 2006, almost half (46%) of UK teenagers were aware of tobacco display at point of sale and those professing an intention to smoke were more likely to recall brands that they had seen at the point of sale.<sup>9</sup> In addition, research in Australia<sup>10</sup> and the USA<sup>11</sup> has shown that point of sale display advertising of cigarettes normalises tobacco use for children and creates a perception that tobacco is easily obtainable.

There is also evidence that retail displays encourage 'impulse buying' so undermining smokers' attempts to quit.<sup>12</sup>

Jurisdictions that have enforced a ban on tobacco advertising at point of sale have reported a decrease in smoking prevalence among young people.<sup>13</sup> The Canadian Tobacco Use Monitoring Survey for example shows that banning point of sale advertising in most Canadian provinces has coincided with a decrease in smoking rates amongst 15 to 19 year olds from 22% in 2002 to 15% in 2007.<sup>14</sup> In Iceland, where point of sale displays were made unlawful in 2001, smoking rates among 16 and 17 years olds fell from 56% in 1999 to 46% in 2003.<sup>15</sup>

A YouGov survey found that 59% of respondents in England said they were in favour of a ban on the display of tobacco products where they are sold. Only 16% were against the measure.<sup>16</sup>

The Health Act in Westminster in 2009 and the Tobacco and Primary Medical Services (Scotland) Act in 2010 both contained measures to ban tobacco advertising at the point of sale, to be implemented by 2013 in England and Scotland. Both the Welsh and Northern Ireland Assembly are expected to pass similar legislation in 2010.

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<sup>8</sup> Imperial Tobacco, UBS Tobacco Conference, 01 December 2006, London

<sup>9</sup> Point of Sale Display of Tobacco Products. The Centre for Tobacco Control Research. University of Stirling, 2008.

<sup>10</sup> Wakefield M, Germain D, Durkin S and Henriksen L: An experimental study of effects on schoolchildren of exposure to point-of-sale cigarette advertising and pack displays. *Health Educ. Res.* 2006; 21: 338-347

<sup>11</sup> Henriksen L et al. Effects on youth of exposure to retail advertising. *JAppl Soc Psychol.* 2002; 32: 1771-89

<sup>12</sup> Wakefield M. The effect of retail cigarette pack displays on impulse purchase. *Addiction.* Nov 2007

<sup>13</sup> According to ASH, Iceland and Thailand, 12 (out of 13) Canadian provinces and territories, the Australian State of Tasmania and the British Virgin Islands have adopted laws to prohibit tobacco advertising at point of sale.

<sup>14</sup> Canadian Tobacco Use Monitoring Survey 2007. Health Canada.

<sup>15</sup> The European School Survey Project on Alcohol and Other Drugs (ESPAD).

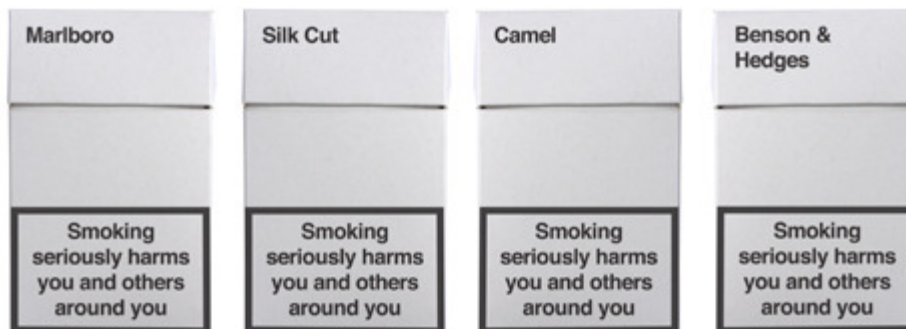
[www.espad.org/sa/node.asp?node=730](http://www.espad.org/sa/node.asp?node=730)

<sup>16</sup> Beyond Smoking Kills. Action on Smoking and Health, London 2008, page 37.

## **Plain packaging**

Package design is part of the branding and marketing process. Tobacco companies have used this as a marketing tool to make products more alluring. Despite the health warnings, packaging remains a 'silent salesman' for tobacco brands.<sup>17</sup>

Plain packaging refers to packaging that has had the promotional aspects removed, meaning that the appearance of all tobacco packs is standardised. Except for the brand name which would be written in a standard typeface, all other trademarks, logos, colour schemes and graphics would be prohibited. The package itself would be plain coloured such as white or brown and display the product content and consumer information as well as the health warnings required by law.



The outcomes of a study commissioned by ASH show that the branding of cigarette packs profoundly affects consumer perceptions of the attractiveness and relative safety of the products.<sup>18</sup> The same research found that adults and young people were significantly more likely to rate packages with the term "smooth", "gold" and "silver" as lower tar, lower health risk, and easier to quit compared to "regular" varieties of the same brands. Removing this branding was found to have an immediate impact, with young people finding cigarettes less attractive and smokers less likely to be misled about the safety of cigarettes.

Similarly, research among adult smokers in Australia found that cigarette packs that displayed progressively fewer branding design elements were perceived increasingly unfavourably by smokers.<sup>19</sup>

Plain packaging has not yet been put into effect in any jurisdiction, but has been under consideration in Canada since the 1990s, and is now under active consideration by Australia, Brazil, and France, as well as the UK. It was recommended by England's Chief Medical Officer in his 2003 annual report.<sup>20</sup> The European Commission is exploring the merits of introducing plain packaging as an amendment to the Tobacco Products Directive 2001/37/EC.<sup>21</sup>

Plain packaging could reduce tobacco consumption by:

- preventing the pack from being used to advertise the product

<sup>17</sup> Underwood, R.L. & Ozanne, J. Is your package an effective communicator? A normative framework for increasing the communicative competence of packaging. *J Market Commun* 1998; 4: 207-20

<sup>18</sup> ASH (2008): *Beyond Smoking Kills: Protecting children, reducing inequalities*. Page 42

<sup>19</sup> Wakefield M, Germain D, and Durkin S. How does increasingly plainer cigarette packaging influence adult smokers' perceptions about brand image? An experimental study. *Tobacco Control*, 2008.

<sup>20</sup> Chief Medical Officer. Annual report of the CMO 2003. Department of Health.

<sup>21</sup> Question in the European Parliament, Androulla Vassiliou, 4 January 2010

- increasing the effectiveness of health warnings
- making it less likely that smokers would be misled about the relative harm of different brands.<sup>22</sup>

The Department of Health in England has stated in its 2010 Tobacco Control Strategy that the evidence base for plain packaging needs to be carefully examined and will encourage further research into the links between tobacco packaging and consumption, particular by the young.<sup>23</sup> In addition, they plan to examine the legal implications of packaging restrictions.

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<sup>22</sup> Plain packaging of tobacco products – Implementation needed. Canadian Cancer Society 2008.

<sup>23</sup> Department of Health (2010). A Smokefree Future: A Comprehensive Tobacco Control Strategy for England. HM Government.



# Policy statement

## Passive smoking

### Introduction

Over 11,000 people are estimated to die each year in the UK as a result of passive smoke.<sup>24</sup> The WHO estimate that 600,000 die each year worldwide due to passive smoke.<sup>25</sup>

### Policy statement

Passive smoking is a recognised cause of significant short and long-term harm to others, particularly to young children. Smokefree legislation has resulted in substantial reductions in exposure to passive smoke in most workplaces and enclosed public places in the UK, but significant exposure still occurs in the home and other private places, such as cars.

The BHF believes that the single most effective way of reducing children's exposure to passive smoke is for parents to quit but, if this isn't achievable, smokefree homes and cars offer the best alternative to help protect children from the harmful effects of passive smoking.

In order to reduce children's exposure to passive smoke, the BHF is calling on UK Governments to:

- promote smokefree homes and cars through national and local campaigns
- ensure that the prohibition on smoking in workplaces is comprehensive, including vehicles that are used for work.

The forthcoming review of the current smokefree legislation in England should evaluate all the measures that could be used to reduce exposure to passive smoke in homes and cars.

<sup>24</sup> Jamrozik, K. (2005), Estimate of deaths attributable to passive smoking among UK adults: database analysis. *BMJ* 2005;330:812-17.

<sup>25</sup> World Health Organisation (2009). Report on the Global Tobacco Epidemic: implementing smoke-free environments.

## Background

There is clear evidence that passive smoking increases the risk of developing CHD.<sup>26</sup> A number of studies have shown an elevated risk of heart disease in people regularly exposed to passive smoke. Non-smokers living with smokers have a 30% increased risk of developing the disease.<sup>27</sup> A study of young adults generated suggestions that non-smokers at risk of CHD should avoid all indoor environments that allow smoking.<sup>28</sup>

Further a study published in the British Medical Journal suggests that previous studies of the effect of passive smoking on the risk of heart disease may have been underestimated. The researchers found that blood cotinine levels among non-smokers exposed to passive smoke were associated with a 50-60% increase risk of heart disease.<sup>29</sup>

The successful implementation of smokefree legislation in Scotland in 2006 and the rest of the UK in 2007 has significantly reduced public exposure to passive smoke. In Scotland, there has been a 75% increase in the number of smokers choosing to make their homes smokefree since the implementation of the Scottish smokefree legislation in 2007.<sup>30</sup> A study has also shown an overall 17% reduction in the number of cases of acute coronary syndrome in Scotland following the legislation, with a 20% reduction in non-smokers.<sup>31</sup> Within Wales, the number of hospital admissions for heart attacks has fallen by 3.7% since the legislation was implemented.<sup>32</sup>

Despite this progress some commercial venues, shisha bars, sports grounds and music festivals, where smoking can occur in covered areas, continue to breach the legislation.<sup>33</sup> Many non-smokers, including children, are also still exposed to passive smoke on a daily basis at home and in cars.

### ***Passive smoking and children***

Passive smoking also increases the risk of a number of health problems in children, including lower respiratory infections, wheezing, asthma, middle ear disease, and bacterial meningitis, and more than doubles the risk of sudden infant death.<sup>34</sup>

Children and young people who live with adult smokers are also much more likely to start smoking than those who live in smokefree homes. At least 23,000 young people in England and Wales each year start smoking by the age of 15 as a result from exposure to smoking in the home.<sup>35</sup>

<sup>26</sup> US Department of Health and Human Services (2006). The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General. Atlanta, USA.

<sup>27</sup> Law, M., Morris, J.K., Wald, N.J. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. *BMJ* 1997; 315: 973-80

<sup>28</sup> Otsuka R, Watanabe H, Hirata K, Tokai K, Muro T, Yoshiyama M, et al, 'Acute effects of passive smoking on the coronary circulation in healthy young adults', quoted in *BMJ* 2004; 328:980-983 (24 April).

<sup>29</sup> Whincup, P et al. Passive smoking and risk of coronary heart disease and stroke: prospective study with cotinine measurement. *BMJ* June 2004

<sup>30</sup> Haw S. Scotland's Smokefree Legislation: Results from a comprehensive evaluation. Paper presented at Towards a Smokefree Society conference, Edinburgh, 10-11 September 2007.

<sup>31</sup> Pell, J.P., Haw, S., Cobbe, S.M. et al (2008). Smokefree legislation and hospitalisations for acute coronary syndrome. *NEJM* 2008;359:482-91.

<sup>32</sup> Welsh Assembly Government (2009): 'Chief Medical Officer for Wales, Annual Report 2008'

<sup>33</sup> Royal College of Physicians. *Passive smoking and children*. A report by the Tobacco Advisory Group. London: RCP, 2010.

<sup>34</sup> Ibid

<sup>35</sup> Ibid



# Policy statement

## Quitting smoking

### Introduction

The healthiest alternative to smoking is to stop smoking. However too few people successfully quit every year and too many people start smoking. Although smoking prevalence is declining slowly, new ways of driving down smoking prevalence are needed especially where smokers find it hard to or are unable to quit.

### Policy statement

The BHF calls on all four UK governments to increase investment in NHS stop smoking services, making them more widely available and easy to access particularly for disadvantaged and pregnant smokers. Nicotine replacement therapy should also be provided free on prescription.

Cessation services must receive continued guaranteed funding from Governments allowing services to be extended to alternative settings such as job centres and mental health units to reach hard to reach groups.

The BHF supports calls for any smokers admitted to hospital to be identified for possible smoking cessation support and for quitting helpline numbers to automatically appear on all tobacco packaging.

### Background

England leads the world in providing free stop smoking services, which are very cost effective and, combined with the use of quitting aids (such as Nicotine Replacement Therapy), can increase a smoker's chances of quitting fourfold compared to willpower alone.<sup>36</sup> Similar services are also provided in Scotland, Wales and Northern Ireland.

On average, each smoker that manages to quit permanently gains 3.6 life years.<sup>37</sup> The average cost per life year gained for every smoker successfully treated by these services is less than £1,000, well below the NICE guidelines of £20,000-30,000 per

<sup>36</sup> ASH (2008): Beyond smoking kills, page 52

<sup>37</sup> Department of Health (2010). A Smokefree Future: A Comprehensive Tobacco Control Strategy for England. HM Government.

QALY (quality-adjusted life year) making smoking cessation the single most cost-effective live-saving intervention provided by the NHS.<sup>38</sup>

However take up of these services by smokers who want to quit is still low with only up to 6% of smokers using them each year. This is largely due to the variation in the content and quality of current cessation services across the country. In 2007, 43% of smokers in England tried to stop yet only 2-3% follow this through with success in the long term.<sup>39</sup>

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<sup>38</sup> Godfrey, C. Parrott, S. Coleman, T. & Pound, E. The cost-effectiveness of the English smoking treatment services: evidence from practice. *Addiction*, 2005; 100 (suppl.2),70-83

<sup>39</sup> West R (2006): Background smoking cessation rates in England



# Policy statement

## Harm reduction

### Introduction

Ideally the BHF would like to see smokers switch to a less harmful alternative as a means of ultimately quitting. However, for many people that are unable or unwilling to completely quit significant health benefits can result through harm reduction that does not lead to quitting completely.

### Policy statement

The BHF supports the principle of harm reduction, based on best available evidence. This approach may be particularly helpful for smokers from lower socioeconomic groups who are heavily addicted to nicotine, so helping to reduce health inequalities.

We believe the UK Government should:

- Increase investment in research into the long-term impacts of nicotine
- Encourage harm reduction based around access to efficient, low-cost pure nicotine products as an alternative to smoking
- Tax new more efficient nicotine products (least harmful products) at the lowest rate of VAT
- Ensure all nicotine containing products are regulated to ensure adequate safety and quality.

### Background

Reducing the harm caused by tobacco smoking by making effective but less hazardous substitute products available to the smoker can lead to variable levels of health benefits, depending on the method used, for smokers unable or unwilling to quit. Techniques include substituting smoked tobacco with:

- the least harmful alternatives, such as Nicotine Replacement Therapy (NRT), e.g. Nicorette or Nicotinell

- moderately harmful alternatives, such as oral snuff or chewing tobacco
- the most harmful alternatives - e.g. low tar cigarettes or reduced smoking.

There is concern that in the UK, the most harmful forms of nicotine delivery (e.g. cigarettes) are the least regulated and easily available, while less harmful alternatives (e.g. NRT) are heavily regulated and other forms (e.g. the Swedish oral tobacco 'snus'), are banned completely.<sup>40</sup>

The argument in favour of a harm reduction strategy is:

- it is the tobacco smoke that kills people, not the nicotine
- it is the nicotine that people are addicted to and not the tobacco
- smokers should be given access to nicotine in a form and at a price that is attractive as an alternative to smoking.

ASH England suggest that a switch of only 1% of the population a year from smoking to less harmful nicotine sources, a conservative target, would save around 60,000 lives in only 10 years.<sup>41</sup> It would also lead to substantial savings for the NHS.

In February 2010 the Department of Health in England signalled their intention to regulate all non-tobacco nicotine-containing products, regardless of whether they are advertised as medicinal products, by the Medicines and Healthcare products Regulatory Agency to ensure that these meet requirements of safety, quality and efficacy. In addition, the strategy aims to provide new routes to quitting for smokers unable to stop abruptly, encouraging them to use a safer alternative to smoking.

At present, there is little industry incentive to research less harmful products, and more research is still required to establish the long-term effects of nicotine.

## **Snus**

Manufactured in Sweden, snus is a moist, sucked form of smokeless tobacco that delivers nicotine at a slower rate than cigarettes, but at a faster rate than many nicotine alternatives. There is some evidence to suggest that the risks associated with snus are lower than those associated with smoking for a number of diseases including cardiovascular disease.<sup>42,43</sup> Within Sweden, sales of snus exceed sales of cigarettes, and it has been credited as contributing to Sweden's low lung cancer rate and to reducing the number of smokers in Sweden.<sup>44</sup> There is current EU policy debate on whether to deregulate types of oral snuff such as snus so that it can be used more frequently to help reduce ill health caused by tobacco smoke.

The sale and marketing of snus is banned under EU law, except in Sweden, though it is being gradually introduced within the United States, Canada and South Africa.<sup>45</sup> The UK will continue to prohibit the availability of snus unless the EU ban is lifted. In

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<sup>40</sup> Bates C, Fagerstrom K, Jarvis MJ, Kunze M, McNeill A, Ramstrom L. European Union policy on smokeless tobacco. A statement in favour of evidence-based regulation for public health. *Tobacco Control* 2003;12:360-7.

<sup>41</sup> Lewis, S., Arnott, D., Godfrey, C. et al (2005). Public health measures to reduce smoking prevalence in the UK: how many lives could be saved? *Tobacco Control* 2005; 14:251-254.

<sup>42</sup> Royal College of Physicians (2007). Harm reduction in nicotine addiction: Helping people who can't quit

<sup>43</sup> Levy DT, Mumford EA, Cummings KM et al. The relative risks of a low-nitrosamine smokeless tobacco product compared with smoking cigarettes: estimates of a panel of experts. *Cancer Epidemiol Biomarkers Prev* 2004;13:2035-42.

<sup>44</sup> The Observer, Jamie Doward, home affairs editor: 'Smokeless tobacco test on the way', 19 February 2006

<sup>45</sup> EU Business: 'Sweden wants EU 'snus' tobacco ban to go up in smoke', 15 September 2009.

contrast, chewing tobacco such as gutka and zarda, largely used by people from south Asia, is legal and unregulated in the UK and has been found to have higher rates of toxins than snus, which remains illegal.<sup>46</sup>

## **Electronic cigarettes**

Electronic cigarettes (e-cigarettes) are a relatively new nicotine innovation, which are designed to look and feel similar to standard cigarettes. They are battery powered devices that simulate standard tobacco cigarettes by vaporising nicotine and other chemicals into an inhalable vapour, which delivers nicotine straight to the blood stream via the lungs.

E-cigarettes have attracted some criticism, most notably from the WHO which stated in 2008 that it does not consider them a legitimate smoking cessation therapy, as some makers have claimed abroad.<sup>47</sup> The Department of Health in England has also advised that consumers 'exercise caution'.<sup>48</sup>

There is conflicting evidence on the effectiveness of e-cigarettes as nicotine delivery devices. One study that measured the effects on heart rate and reducing cigarette cravings compared to standard cigarettes found that e-cigarettes delivered little to no nicotine and suppressed cravings less effectively.<sup>49</sup>

However, other research has suggested that e-cigarettes show promise in relieving craving and reducing withdrawal symptoms compared to some established smoking cessation devices.<sup>50</sup> The same study states that more research is needed to assess their long term effect on cessation.

Knowledge about the acute and long term effects of e-cigarette use is very limited, and the variability in nicotine concentration suggests the quality control processes in place for manufacturers are largely inadequate.<sup>51</sup> However, as e-cigarettes do not contain the harmful toxins found in tobacco smoke, nor produce second-hand tobacco smoke that can affect the health of others, their use is likely to be preferable to smoking in terms of their effect on health.

E-cigarettes are not marketed as smoking cessation devices in the UK, but as "alternative smoking devices". This means they are not subject to the smokefree legislation in the UK, and have been exempt from the regulations imposed on other pure-nicotine products marketed as cessation devices.<sup>52</sup>

The lack of regulation has itself raised questions on safety. The US Food and Drug Administration analysed e-cigarette samples and found that they contained carcinogens and other toxic chemicals such as diethylene glycol, an ingredient used in anti-freeze.<sup>53</sup> This study also found significant variation in the nicotine content compared to what was advertised, including traces of nicotine in some samples identified as containing none.

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<sup>46</sup> McNeill A., Bedi R. et al.: Levels of toxins in oral tobacco in the UK. *Tobacco Control* 2006; 15: 64-67

<sup>47</sup> World Health Organisation: 'Marketers of electronic cigarettes should halt unproved therapy claims', 19 September 2008.

<sup>48</sup> Roberts, M. (2010). 'No proof' e-cigarettes are safe. BBC Online.

<sup>49</sup> Eisenberg, T. (2010). Electronic nicotine delivery devices: ineffective nicotine delivery and craving suppression after acute administration. *Tob Control* 2010;19:87-88

<sup>50</sup> Bullen, C. et al. (2008). Effect of an E-Cigarette on Cravings and Withdrawal, Acceptability and Nicotine Delivery: Randomised Cross-Over Trial.

<sup>51</sup> Flouris, A.D. & Oikonomou, D.N. (2010). Electronic cigarettes: miracle or menace? *BMJ* 2010;340:c311

<sup>52</sup> <http://www.intellicig.com/>

<sup>53</sup> Westenberger, B.J. (2009): US Food and Drug Administration evaluation of e-cigarettes. Center for Drug Evaluation and Research, Division of Pharmaceutical Analysis. Rockville, MD.



# Policy statement

## Smoking and health inequalities

### Introduction

There is a strong association between cigarette smoking and socioeconomic position. Almost every indicator of social deprivation, including income, socioeconomic status, education and housing tenure, independently predicts smoking behaviour.

### Policy statement

The BHF is committed to reducing health inequalities within the UK across the social gradient. For example, our Hearty Lives smoking cessation and prevention project in Newham is targeted at reducing smoking among the young, pregnant eastern European women and their partners, and men from Middle Eastern and South Asian backgrounds.

Smoking cessation services are one way of reducing the levels of smoking prevalence. However they must be adequately funded, prioritised in areas of high tobacco use and tailored to the language and literacy of their users.

### Background

Cigarette smoking is more prevalent among manual social groups than among non-manual, and is lowest among higher managerial and professional classes.<sup>54</sup> In 2006, 29% of men and 27% of women in manual households in England smoked compared to 18% of men and 16% of women in non-manual households.<sup>55</sup>

Between 2001 and 2007, the prevalence of cigarette smoking fell among those in routine and manual households from 33% to 26%.<sup>56</sup> However, overall health inequalities are likely to persist between socioeconomic groups, even if lifestyle factors (such as smoking) are equalized without addressing the fundamental causes of inequality.<sup>57,58,59</sup> The Marmot Review of health inequalities in England, published in

<sup>54</sup> Allender, S. et al (2008): Coronary heart disease statistics 2008. British Heart Foundation, page 83

<sup>55</sup> Ibid

<sup>56</sup> Robinson, S. and Lader, D. (2009) Smoking and drinking among adults, 2007.

<sup>57</sup> Gruer, L, et al (2009): Effect of tobacco smoking on survival of men and women by social position: A 28 year cohort study. *BMJ* 338:b480

<sup>58</sup> Phelan, J.C., Link, B.G. et al (2004) "Fundamental Causes" of social inequalities in mortality: A test of the theory. *Journal of Health and Social Behavior* 45: 265–285

<sup>59</sup> Marmot, M. (2004) *The status syndrome: How social standing affects our health and longevity*. New York: Owl Books.

2010, recommends focusing public health interventions such as smoking cessation programmes on reducing the social gradient.<sup>60</sup>

Smoking rates vary between ethnic groups in the UK with 40% of men smoking in Bangladeshi communities compared to 21% of men smoking in Black African communities for example. Smoking rates in women from ethnic minorities are generally very low with the exception of 24% of Black Caribbean and 26% of Irish women.<sup>61</sup>

These differences in smoking behaviour translate into inequalities in illness and mortality – inequalities which have deepened over the last thirty years. Smokers from lower socioeconomic backgrounds are just as likely to try to quit as smokers from higher socioeconomic backgrounds, but they are less likely to be successful. This is partly due to the fact that smokers from deprived backgrounds have a stronger nicotine addiction, as they seem to take in more nicotine from the same amount of cigarettes as smokers from more affluent backgrounds.<sup>62</sup>

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<sup>60</sup> Marmot, M. (2010). Fair Society, Healthy Lives: a Strategic Review of Health Inequalities in England post-2010. The Marmot Review.

<sup>61</sup> Health Survey for England 2004: The health of minority ethnic groups

<sup>62</sup> ASH (2008): Beyond Smoking Kills, page 29



# Policy statement

## The cost of smoking

### Introduction

Smoking places a significant burden on the UK's health service, with a number of studies estimating the costs to be billions of pounds to the UK taxpayer. Taxation on tobacco provides a significant tool in helping to reduce the attraction of tobacco and reduce the prevalence of smoking.

### Policy statement

Calculations of the cost of smoking are based on analyses of mortality data and the burden of diseases where smoking is a risk factor. These estimates vary, with separate reports indicating the cost to be £2.7bn and £4.4bn a year in England. However, the cost extends far beyond the burden placed on the NHS – the true cost includes the thousands of people whose lives are cut short or ruined through ill-health and disability.

High taxation levels are an important part of the wider tobacco control agenda, acting as a deterrent for young people from taking up smoking and reducing consumption amongst adult smokers. The BHF believes:

- the Westminster Government should ensure that regular data collection is in place to track the burden of smoking related ill health over time, and help to assess the efficacy of relevant public health measures
- the Westminster Government should commit to raise the duty on tobacco by 5% year-on-year in real terms, with any revenue generated from high taxation on tobacco re-invested in cessation services providing all the support necessary for smokers to quit.

### Background

#### *Estimates of NHS costs*

There are a number of studies examining the costs of smoking to the NHS that use different methodologies to calculate the burden and cover different time periods. It is also likely that this picture will continue to shift as the impact of tobacco control measures such as the ban on smoking in public places makes itself felt.

ASH England (2008) *Beyond Smoking Kills*

- Smoking cost the NHS £2.7billion in England in 2006/07. This equates to more than £50million each week spent treating ill health caused by smoking.
- Smoking related hospital admissions costs £1billion in 2006/07, of which £180million was spent on smoking-related coronary heart disease.
- Analysis of smoking related hospital admissions from Hospital Episode Statistics and reported use of outpatient, GP, prescription medicines and practice nurses services from the General Household Survey.
- The breakdown of the total cost of £2.7billion in 2006/07 is £1,020 million for hospital admissions, £900million for prescriptions, £500million for GP consultations, £190million for outpatient visits and £50million for practice nurse consultations.
- This study was undertaken as part of a review of ten years of tobacco control led by ASH and funded by the BHF and others. The final report from this review, *Beyond Smoking Kills*, was published in October 2008. BHF's tobacco control policy statement is in accordance with the *Beyond Smoking Kills* report.
- The Department of Health in England cited these figures in the 2010 tobacco control strategy. smokers should be given access to nicotine in a form and at a price that is attractive as an alternative to smoking.

Allender, S et al (2009) *The burden of smoking-related ill health in the United Kingdom*

- Smoking costs the NHS £5.2billion across the UK in 2005/6, comprising £4.4billion for England, £234million for Wales, £409million for Scotland and £127million for Wales
- This is based on an analysis of WHO burden of disease figures, UK mortality data and data on NHS costs for different diseases. The study analyses NHS costs in 2005/06 according to an allocation of costs developed by the National Health Executive in 1996.
- Estimates that 109,164 deaths can be attributed to smoking (18.6% of all deaths), suggesting that overall numbers of deaths attributable to smoking have not changed significantly in the last 10 years. This equates to 27% of deaths in men and 11% of deaths in women.
- Cardiovascular disease was the largest contributor to the burden of disease attributable to smoking, representing 41% of all smoking related mortality in the WHO EUR-A region in 2002.
- Of the £5.2billion cost of smoking to the NHS, £2.5billion is attributed to cardiovascular disease. This comprises £2.1billion for England, £114million for Wales, £199million for Scotland and £62million for Northern Ireland.

- This study was conducted by the Health Promotion Research Group at Oxford. The group is funded by the BHF but this was not a piece of work commissioned by the BHF.

Phillips, C.J. & Bloodworth, A. (2009) *Cost of Smoking to the NHS in Wales*

- Smoking cost NHS Wales an estimated £386 million in 2007/08; equivalent to £129 per head and 7% of total healthcare expenditure in Wales.
- Secondary care accounts for 67% of the total cost and primary care 33%. £235.6 million is spent on hospital admissions and £21.5 million on outpatient attendances, while £43.1 million is spent on GP consultations, £6.2 million on practice nurse consultations and £79.3 million on prescriptions.
- Smoking accounts overall for an estimated 22% of adult hospital admission costs, 6% of outpatient costs, 13% of GP consultation costs, 12% of practice nurse consultation costs and 14% of prescription costs.

### **European costs**

The Smokefree Partnership estimates that the direct and indirect costs of smoking for European Union/European Free Trade Area countries is €97.7 billion, of which the direct costs of smoking are €49.83 billion, and the indirect costs of smoking are €47.87 billion. Indirect costs include working days lost due to smoking and direct costs include treating ill health and disease caused by smoking. Overall cardiovascular disease (CVD) is estimated to cost the EU economy €192 billion a year. This represents a total annual cost per capita of €391. Exposure to tobacco smoke is calculated to cause 22% of all cases of CVD in industrialised countries.<sup>63</sup>

### **Tobacco taxation**

There is a relationship between demand for tobacco products and their price. The key measure is affordability which is the correlation between increases in the price of cigarettes and increases in household income. Taxation can therefore be an important mechanism to ensure that smoking remains an expensive habit which can, in turn, reduce the prevalence of smoking, and associated ill health.

Tobacco taxation is a fiscal lever to support the Government's policy objective to cut the rates of death and disability attributable to smoking and to discourage young people from taking up smoking.<sup>64</sup> In the 1998 White Paper 'Smoking Kills' the Government announced that it planned to increase tobacco tax by at least 5% a year in real terms. However, since 2001 annual increases have generally been at, or marginally above, inflation rates.<sup>65</sup>

According to the World Bank, high prices due to high taxes on tobacco is the single most effective intervention to prevent smoking.<sup>66</sup> Studies show that a price increase of 10% results in a 2.5% – 5% smoking reduction in the short run and possibly up to 10% in the long run, if prices are increased to keep pace with inflation. There are

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<sup>63</sup> Smokefree Partnership website: 'The cost of tobacco use', April 2010

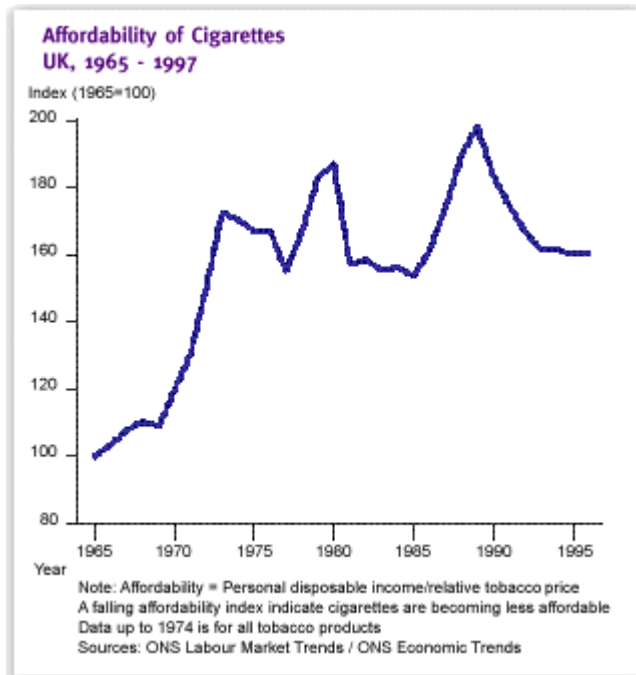
<sup>64</sup> HM Treasury Budget 1999: 'Tobacco and Health'

<sup>65</sup> ASH website: 'UK Tobacco Control Policy and Expenditure – An Overview', March 2010.

<sup>66</sup> Smokefree Partnership (2008) Spotlight on the European Commission proposals to amend EU Directives on the rates and structure of taxes on manufactured tobacco

also some indications that young people are particularly sensitive to increases in price and more likely to reduce consumption at a faster rate than older people.<sup>67</sup>

In 2005 the European Community and 26 EU Member States (including the UK) signed the WHO Framework Convention on Tobacco Control. Article 6 of the FCTC recognises that price and tax measures are an effective and important means of reducing tobacco consumption by various segments of the population, in particular young persons. Countries implementing the FCTC must take account of public health objectives when determining taxation policies.<sup>68</sup>



### **UK tobacco taxation rates**

On 24 March 2010, Chancellor Alistair Darling announced increases in taxation on cigarettes as part of his Budget statement detailed in the table below. Tobacco duty rates increased immediately by 1 per cent above inflation and will increase by 2 per cent above inflation for each of the following four years to 2014-15.<sup>69</sup>

<b>Product</b>	<b>Previous duty</b>	<b>Duty as of 23 March 2010</b>
Cigarettes	24% of the retail price plus £114.31 per thousand cigarettes	24% of the retail price plus £119.03 per thousand cigarettes
Cigars (per kilogram)	£173.13	£180.28
Hand-rolling tobacco (per kilogram)	£124.45	£129.59
Other smoking tobacco and chewing tobacco (per kilogram)	£76.12	£79.26

<sup>67</sup> Ibid

<sup>68</sup> Ibid

<sup>69</sup> HM Treasury, Budget 2010.

The impact of the tobacco duty changes is shown in the table below.<sup>70</sup>

Product	Typical unit	Effect of duty plus VAT on typical item (increase in pence)
Cigarettes	15p	packet of 20
Cigars	6p	packet of 5
Hand-rolling tobacco	15p	25g
Other smoking tobacco and chewing tobacco	9p	25g of pipe tobacco

The Tobacco Manufacturers Association estimate that the total tax revenue from tobacco products was £10billion in 2008-9.<sup>71</sup> This includes excise duty and VAT and covers cigarettes, cigars hand rolled tobacco, chewing tobacco and pipe tobacco.

### ***Effects of increasing tobacco taxation***

In March 2010, ASH England published a report that gave a cost benefit and public finances analysis on tobacco taxation increases.<sup>72</sup> The report shows that raising tobacco prices through taxation by 5% above inflation will:

- lead to 190,000 less smokers
- save the NHS over £20 million a year through reducing the cost of treatment of smoking-related diseases
- reduce smoking-related absenteeism in the work place, saving over £10 million a year
- increase government tax revenues by over £500 million a year, £2.6 in the first five years
- result in wider economic benefits in the first five years of over £270 million per year.

<sup>70</sup> [http://www.direct.gov.uk/en/NI1/Newsroom/Budget/Budget2010/DG\\_186644](http://www.direct.gov.uk/en/NI1/Newsroom/Budget/Budget2010/DG_186644)

<sup>71</sup> Tobacco Manufacturers Association: 'Tax Revenue from Tobacco Products', April 2010.

<sup>72</sup> Reed, H. (2010) The Effects of Increasing Tobacco Taxation: A Cost Benefit and Public Finances Analysis. ASH England.



# Policy statement

## Illicit (smuggled) tobacco

### Introduction

While increasing the price of tobacco is widely recognised as an effective way to prevent young people from starting to smoke and to persuade smokers to quit, efforts can be undermined by illicit (smuggled or counterfeit) tobacco. This is available very cheaply and is mainly bought by poorer smokers, thus negating the use of high tax to reduce smoking.

### Policy statement

Addressing the issue of tobacco smuggling is crucial if we are to reduce health inequalities, and encourage younger people not to smoke. The BHF supports an integrated approach at national, regional and local level to crack down on smuggling. Effective co-operation will be required between all agencies in the UK and Europe. BHF believes:

- new targets should be established on reducing illicit tobacco entering the UK
- the UK Government to introduce a positive licensing scheme to control the number of premises licensed to sell tobacco, providing an effective measure to help clamp down on cheap and illicit tobacco sales
- tobacco companies should introduce tracking and tracing systems on all cigarettes manufactured by them, so that smuggled tobacco can be identified and withdrawn.

### Background

Research for ASH completed in spring 2008 found that in England:

- one in 5 poorer smokers buy smuggled tobacco compared to only one in 20 of the most affluent
- young smokers are most likely to buy smuggled tobacco with one in three smokers from 16 to 24 getting their tobacco from illicit sources.

In Scotland, one in ten 13-15 year olds who smoke buy their cigarettes illegally.<sup>73</sup>

Illicit trade consists of a number of different elements:

- large-scale organised smuggling: the illegal transportation, distribution and sale of large consignments of cigarettes and other tobacco products avoiding all taxes on tobacco products
- small scale smuggling also known as 'bootlegging': the purchase, by individuals or small groups, of tobacco products in low tax jurisdictions in amounts that exceed the limits set by customs regulations, for resale in high tax jurisdictions
- illegal or illicit manufacturing: refers to the production of tobacco products contrary to law (taxation or other laws)
- counterfeiting: a form of illegal manufacturing, in which the manufactured products bear a trademark without the consent of the owner of the trademark.

The illicit trade in tobacco products in the UK primarily consists of large-scale organised smuggling of both authentic manufactured and counterfeit products. In the UK the loss to the Exchequer is currently estimated to be around £2.4 billion a year, largely due to the smuggling of two major products, cigarettes and hand-rolled tobacco.<sup>74</sup>

The issue of smuggling is global, requiring a global solution. The Framework Convention on Tobacco Control (FCTC) is an international public health treaty negotiated under the backing of the World Health Organisation. The Convention entered into force on 27 February 2005, making provisions of the treaty legally binding for the contracting parties. The UK Government is a partner to the treaty. The FCTC is on track to produce a text of a draft illicit trade protocol for adoption by the Conference of the Parties in November 2010.

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<sup>73</sup> Scottish schools adolescent lifestyle and substance use survey (SALSUS) 2006

<sup>74</sup> Measuring Indirect Tax Losses, 2007. October 2007

## Current BHF activity

- The BHF contributes significant funding to anti-smoking organisations, including Action on Smoking and Health (ASH), which campaigns to reduce and eventually eliminate the health problems caused by tobacco.
- The BHF funds QUIT, which helps smokers to give up by offering help and support via a helpline and face-to-face help sessions and Asian QUITLINE, a freephone helpline which provides advice on how to give up smoking in five Asian languages. The BHF also funds National No Smoking Day.
- The BHF is a member of the Smokefree Action coalition, which has long campaigned for effective steps in tobacco control.
- The BHF funded the Beyond Smoking Kills report collated by ASH which set out an agenda for action in tobacco control for the next ten years. In addition, in 2009 the BHF funded an ASH report providing a cost benefit analysis of the FCTC Protocol on the illicit tobacco trade.

## Research

- As well as public education campaigns, the BHF has also funded research into the links between smoking and heart disease. For example, a study by Professor Peter Whincup and his team at St George's Hospital in London showed that the full effects of passive smoking have been underestimated, and that previous studies have not paid enough attention to passive smoking outside the home. The study, which was part-funded by the BHF as part of the British Regional Heart Study, provides an estimate of non-smokers' overall exposure to tobacco smoke (at home, work and in public), shows the increased risk for passive smokers is actually double the earlier estimate of 25%.
- Other BHF-funded research into the effects of smoking on the heart includes a study looking into the association of passive smoking with other risk factors for CHD, and a project examining the influence of genetic factors in smokers, in relation to thrombolysis.

## Hearty Lives Programme

- As part of the BHF's Hearty Lives Programme, up to £150,000 in funding and healthcare professionals resources will be invested in a smokefree Blaenau Gwent programme with the aim of preventing uptake of smoking among adolescents. This will be achieved through a multi-faceted approach concentrating on supportive smokefree environments and socially denormalising smoking.
- Within Newham, the BHF is investing around £70,000 targeted at reducing smoking among the young, pregnant eastern European women and their partners, and men from Middle Eastern and South Asian backgrounds.

<sup>i</sup> Allender S et al (2008): Coronary heart disease statistics 2008. British Heart Foundation, page 81

<sup>ii</sup> Peto, R., et al. (2004), Mortality from smoking in developed countries 1950-2000

<sup>iii</sup> British Heart Foundation (2010): UK coronary heart disease statistics 2009-10

<sup>iv</sup> Callum et al. Beyond Smoking Kills. Action on Smoking and Health. 2008

<sup>v</sup> Allender S, et al. The burden of smoking-related ill health in the UK. Tob Control 2009. 18(4):262-7.