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Science & Education

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Dear Sirs

Consultation on the future of tobacco control

Thank you for inviting the British Medical Association (BMA) to comment on your consultation on the future of tobacco control. The BMA has a long history supporting comprehensive tobacco control measures and welcomes this consultation and its focus on the need to protect young people and reduce health inequalities.

Smoking is a major cause of preventable morbidity and mortality in the UK, with approximately 114,000 deaths every year from smoking-related illnesses, lung cancer, respiratory illness and heart disease.[1] Smoking disproportionately affects those already disadvantaged by poverty and is a major contributor to health and premature mortality inequalities.[2] The direct cost to the National Health Service (NHS) of treating smoking-related diseases is approximately £1.5 billion annually,[3] while the cost to individuals, families and employers is substantially more.

While tobacco control policies in the UK are among the most comprehensive in Europe,[4, 5] more than one in five adults still smoke,[6] and many people are continuing to take up the habit. The downward trend in smoking prevalence has also slowed in recent years.[7] Experiences in other countries suggests that if we do not sustain and strengthen current tobacco control policies, smoking prevalence will not only stop declining but could even start increasing again.

In building on the achievements over the past decade and to ensure that smoking rates continue to decline, the BMA strongly supports the Government's commitment to develop a new national tobacco control strategy. We believe this is key if we are to effectively tackle health inequalities and reduce the burden of tobacco on individuals and society. There is also strong public support for such an approach. A 2008 YouGov survey of 1,056 adults found there to be strong support for tough measures to protect children from the harm caused by tobacco.[8]

The BMA has published several reports on tobacco control including *Forever cool: the influence of smoking imagery on young people* (2008), *Breaking the cycle of children's exposure to tobacco smoke* (2007), and *Smoking and reproductive life* (2004). Copies are enclosed for your information.

Our responses to the specific questions set out in the consultation document are as follows:

Part A: Reducing smoking rates and health inequalities caused by smoking

Question 1: What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030, and on what basis do you make these suggestions? What else should the Government and public services do to deliver these rates?

The BMA believes that the UK Governments should set ambitious targets for reducing population level smoking prevalence.

In England in 2006, smoking prevalence among the general population was 22 per cent, and among routine and manual workers was 28 per cent. By 2015, the Government should aim to reduce prevalence rates among these groups to 11 per cent and 17 per cent respectively. Smoking prevalence among 11 to 15 year olds in England was 6 per cent in 2007,[9] and the Government should aim to reduce this to 4 per cent by 2015. These targets are based on the long-term trends in smoking prevalence, the significant decline in prevalence in England following implementation of smokefree legislation,[10] and experience from other jurisdictions with comprehensive tobacco control strategies.[11, 12, 13] Progress against these targets should be regularly reviewed. There is also a need to develop a system to collect accurate data on smoking prevalence among pregnant women and their partners before targets for reducing smoking among this group can be set.

In the longer term, as called for in *Forever cool: the influence of smoking imagery on young people* (BMA, 2008), the UK Governments should aim to make the UK tobacco free by 2035. This would follow the example set in Australia where it has been predicted that they will be tobacco free by 2030.[14] These ambitious targets should be achievable with the introduction of a comprehensive adequately funded tobacco control strategy which is monitored, evaluated and regularly updated. This strategy must include the implementation of tough and progressive measures to reduce the demand for, and supply of, tobacco

products. In order to ensure that the smoking prevalence targets are met in the longer-term, adequate resources will be required to sustain and, where appropriate, expand effective tobacco control measures.

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

The BMA believes that the taxation on all tobacco products should be standardised and increased at higher than inflation rates to reduce the affordability and therefore availability of tobacco. This should be complemented by tough action on the illicit trading of tobacco products.

Increasing taxation on tobacco products is a highly cost-effective public health measure,[15] with young people and low income smokers particularly sensitive to increases in price.[16, 17] The World Bank has estimated that, in high income countries like the UK, a 10 per cent increase in price leads to a four per cent reduction in demand.[18] In the UK, recent taxation increases at less than the rate of inflation have meant that tobacco has become steadily more affordable since 2000. The decision to tax hand-rolling tobacco at a lower rate than manufactured cigarettes has also provided an opportunity for smokers to 'trade down' to hand-rolling tobacco and maintain their consumption.

Despite concerns that tobacco taxes may be regressive – as they are disproportionately paid by individuals from low income backgrounds – there are strong public health arguments for retaining high levels of tobacco taxation. The evidence shows that the least affluent smokers are more likely to quit in response to price increases, and will not therefore suffer from the increased cost.[18, 19] A 2004 study from New Zealand found that the health impacts arising from paying higher duty for low income smokers who continued to smoke were several orders of magnitude less than those caused by deprivation or smoking.[20] The authors concluded that the benefits of high tobacco tax outweighed the harms, even for the most deprived communities. It has also been suggested that hypothecating increases in tobacco duty and spending them on smoking cessation services aimed at low income communities makes tobacco tax increases more equitable.[21]

The public health benefits of taxation, however, are undermined by the ready supply of illicit tobacco, which also exacerbates health inequalities as its use is concentrated among poorer smokers. A 2006 study showed that heavy smokers in deprived communities were the most likely to buy smuggled tobacco.[22] In a random sample of smokers in North East England, nearly half (44%) of all smokers reported having bought smuggled tobacco. Research on low income smokers has shown that many perceive smugglers to be doing a service by giving people access to cheaper tobacco.[23] The tobacco industry also argues that the high levels of taxation in the UK create a demand for smuggled tobacco, and lobby for reductions in duty. The evidence shows, however, that high rates of smuggling are often found in economies where prices are relatively low.

Price is not the only – or the most important – driver of trade in illicit tobacco. Rather it should be seen as a criminal activity and enforced as such.[24, 25] Further action is required to reduce levels of bootlegging by reducing the amount of tobacco that people can legally bring into the UK. The indicative level for cigarettes for personal use when travelling between EU countries is currently 3,200, and this should be reduced to 200 cigarettes. Large scale smuggling and counterfeit cigarettes are a major problem in the UK and internationally. In addition to enforcement by domestic governments, multilateral action is also required at an international level. This includes signing up to a robust World Health Organisation (WHO) Framework Convention on Tobacco Control (FCTC) illicit trade protocol, and the existing European Union Agreements.

Efforts to reduce inequalities caused by tobacco use through increased taxation and tough action on illicit trade must also be complemented by further measures to support individuals to quit, as outlined in our response to Part C of this consultation. It is also important to continue monitoring smoking prevalence rates against progress in reducing health inequalities.

Question 3: Do you think the six-strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?

The Department's current six-strand strategy adequately addresses the key areas in relation to comprehensive tobacco control policies. It is essential that this approach is underpinned by effective cross-governmental working. While the UK Governments already work with the WHO and the European Commission, consideration should be given to adopting a formal strategy for international action on tobacco control.

There is also a need to focus on changing the culture in relation to tobacco use. The success of the new national tobacco control strategy will be greatly enhanced if it is embedded in a comprehensive social marketing strategy. Just as the tobacco industry has developed a multifaceted marketing approach to promote tobacco use, so society needs an equally robust and sustained strategy to counter, and ultimately eliminate it. This should start with a thorough market, stakeholder and competitor analysis of the forces influencing tobacco use, and identifying the strengths, weaknesses, opportunities and threats these present. It should also assess strategic direction and the balance that needs to be struck between population level and clinical intervention. Finally, it should include a clear action plan, with realistic and measurable objectives, budget allocation, and timelines. This would incorporate all the policy initiatives in the six-strand strategy, ensuring that they are coordinated in a way that maximises the public health benefits. Strategic planning requires a sustained effort – and this is key in tobacco control.[26, 27, 28, 29, 30, 31] This in turn demands adequate long-term resources.

Question 4: How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

The new UK Borders Agency will have a key role in tackling illicit trade in tobacco. It is essential that it works closely with HM Revenue and Customs (HMRC) and the Treasury to develop a comprehensive anti-smuggling strategy, and to ensure tackling illicit trade remains a key priority area. As outlined in the consultation document, enforcement action at a local level, region-specific research on demand for illicit tobacco, and effective marketing and publicity are key measures that need to be implemented. Further measures could also be introduced to assist enforcement officials in detecting counterfeit products. Jurisdictions including Malaysia and Brazil, for example, require pack markings which allow enforcement officials to detect counterfeit cigarettes easily.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

Most smokers do not identify their cigarettes as counterfeits, and there is little awareness that fake cigarettes may pose additional risks to health. There is a need for mass media educational campaigns aimed at raising awareness of the illicit trade in tobacco, and that encourage the public to report any illegal trading. It is important, however, that such an approach maintains a strong message encouraging people to quit smoking altogether.

Part B: Protecting children and young people from smoking

Question 6: What more do you think the Government could do to:

a) reduce demand for tobacco products among young people?

There is little evidence that policies targeted only at young people are effective tobacco control measures.[32, 33] Reducing demand for tobacco among young people requires a comprehensive tobacco control strategy aimed at reducing smoking prevalence at a population-level (as detailed in the six-strand strategy in Question 3).

Young people in the UK continue to be exposed to a wide range of pro-smoking imagery which encourages the initiation and continuance of tobacco use. As set out in *Forever cool: the influence of smoking imagery on young people* (BMA, 2008) reducing the demand for tobacco products among this age group requires action in three related areas:

1. *limiting pro-smoking imagery in entertainment media* – the entertainment media are full of images that normalise smoking, making it appear both more common and acceptable than it really is. The BMA believes the UK Governments should implement programmes aimed at informing those involved in the production of entertainment media of the potential damage done by the depiction of smoking. Legislation is required to ensure that all films and television programmes which

portray positive images of smoking are preceded by an anti-smoking advertisement. Pro-smoking content should also be taken into consideration for the classification of films, videos and digital material in the UK.

2. *reducing tobacco marketing opportunities* – tobacco marketing is extremely pervasive and encompasses the development, distribution, pricing and promotion of tobacco products. All of these activities focus on the construction and refinement of evocative brands and have the capacity to promulgate pro-smoking imagery and hence encourage tobacco use. In building on the current restrictions on tobacco advertising and promotion, action is required in a number of areas. This includes further restrictions on tobacco advertising and promotion (see Question 7), prohibiting point-of-sale displays (see Question 8), and the introduction of generic packaging of tobacco products (see Questions 10). Price is also a marketing tool used by tobacco companies at a micro level to produce an array of attractive economy and mid-range brands, which make smoking more appealing – especially to young people. Recent data show that the most popular brands among underage smokers are Lambert & Butler, Mayfair and Richmond; all of which are positioned by the industry as cheaper options.[34] These pricing strategies also undermine the effectiveness of broader fiscal measures. The introduction of minimum pricing for tobacco products in the UK would counter this problem. The development of new tobacco products that provide new branding and marketing opportunities which may influence young people also requires careful scrutiny and strict regulation (see Question 17).
3. *increasing pro-health imagery* – the marketing techniques that have been, and continue to be, used to push tobacco can also be used to counter pro-smoking imagery and promote a tobacco-free lifestyle. This includes the implementation of mass media, population-wide communications campaigns promoting antismoking messages and imagery. This would incorporate normative messages about smoking, utilise a range of media formats, and link with international activity and wider initiatives. As the Government is not necessarily the most credible source for young people in relation to public health, consideration should also be given to establishing an independent body to take responsibility for the development and delivery of this communications programme.

b) *reduce the availability of tobacco products to young people?*

Reducing the availability of tobacco products to young people necessitates increased taxation and tough action on illicit trading of tobacco products (see Question 2). Further measures include prohibiting the sale of tobacco from vending machines (see Question 9) and increased restrictions on the sale of tobacco products. Currently, retailers do not need a licence to sell tobacco as is the case for selling alcohol. This makes it difficult to identify and control the number of locations where young people can buy tobacco, and reduces the ability to enforce age of sale restrictions. The resulting widespread availability of tobacco enhances the message that tobacco is commonplace and acceptable. The introduction of a positive licensing scheme – where retailers are required to obtain a licence from their local authority to sell tobacco products – would strengthen regulation of underage sales as anyone who sells tobacco illegally would have their licence removed. It would also help retailers by enabling unlicensed sales of tobacco (eg in street

markets) to be tackled more effectively. The BMA also believes that the sale of tobacco products should be prohibited in supermarkets providing in-house medical services, and in retail outlets in hospitals.

Question 7: Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?

Tobacco marketing in all its forms is a central influence on the initiation and continuance of youth smoking. In particular, evocative tobacco brands are fashioned by using a range of marketing techniques including advertising and promotion of tobacco accessories such as cigarette papers and lighters. It is essential that all forms of tobacco industry advertising and promotion are prohibited.

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option?

The BMA strongly supports comprehensive restrictions that require retailers to remove tobacco products from display in retail environments (option three).

The display of tobacco products at the point-of-sale acts as a form of tobacco advertising that reinforces deceptive notions about the glamour and normalcy of smoking to young people.[35, 36, 37, 38, 39, 40, 41] In the USA, tobacco companies are known to pay retailers in order for their brands to be prominent within the displays.[42] One study has shown that adolescents become more aware of tobacco brands when cigarettes are on display, and that they are more likely to express an interest in trying named brands.[43] School children shown a cigarettes display at point-of-sale were more likely to perceive that it would be easy for them to buy cigarettes than those who were shown a till point with no cigarette display. It is essential that point-of-sale displays are prohibited. Such legislation has already been successfully introduced in New Zealand, Singapore, Iceland and a number of Australian and Canadian states and territories. Point-of-sale display restrictions have now been agreed in the Republic of Ireland and in Scotland.[44] The rest of the UK should follow suit and legislate to ensure that all tobacco products are completely out of sight at point-of-sale. Making tobacco an 'under the counter' product will protect children from tobacco promotion and reinforce the increasing unacceptability of smoking.

Question 9: Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

The BMA strongly supports the introduction of legislation prohibiting the sale of tobacco products from vending machines (option three).

Vending machines are often used by young people to buy cigarettes because there are no effective age verification checks in place. As highlighted in the consultation document, vending machines account for only one per cent of the overall UK market share for tobacco sales; however, a disproportionate number of

young people under the minimum legal age for sale of tobacco continue to be able to purchase cigarettes from this source. For example, in 2006, 17 per cent of 11 to 15 year old regular smokers in England indicated that vending machines were their usual source for purchasing cigarettes.[45] It is clear that the introduction of new technology and the voluntary code on machine siting from the National Association of Cigarette Machine Operators are ineffective. Prohibiting the sale of tobacco products from all vending machines is therefore the only option.

Question 10: Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

The BMA believes the UK Governments should mandate plain packaging for all tobacco products, restricting information on the packet to the name of the cigarette brand, health warnings and any other mandatory consumer information.

Research from Australasia and North America have found that despite the introduction of written health warnings, liveried tobacco product packs continue to communicate strong pro-smoking messages and reinforce evocative brand images.[46, 47, 48, 49, 50, 51, 52, 53] This demonstrates a need to move to generic packaging – plain packaging with only the name of the cigarette brand, health warnings and any other mandatory consumer information – which would eliminate the power of brand liveries as well as incidental marketing opportunities such as product placement. Generic packaging has also been shown to increase and maximise the impact and believability of health warnings.[54, 55, 56]

Question 11: Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

The BMA believes legislation prohibiting the sale of packs of ten cigarettes should be introduced in the UK.

Underage smokers regularly purchase their cigarettes in packs of ten. In England, for example, over half (55%) of underage smokers were found to have last bought a ten pack.[57] Analysis of internal tobacco industry documents confirm that packs of ten are mainly bought by young smokers, including 'new entrants', as a cheaper means of acquiring cigarettes.[17, 58] The Scottish Government recently announced plans to consider prohibiting the sale of cigarettes in packets of less than 20,[59, 60] and legislation has already been introduced in a number of other jurisdictions including Australia, New Zealand, Canada, France, and 14 states in the USA. Prohibiting the sale of 'small packs' of cigarettes is also one of the measures set out in Article 16 of the FCTC.[61]

In addressing concerns that increasing the minimum pack size may drive more smokers to use illicitly traded tobacco products or reduce the chances of individuals who want to cut down and quit, any future changes to the minimum pack size must be supported by complementary measures including tough action on illicit trading of tobacco products and improved smoking cessation services.

Question 12: Do you believe that more should be done by the Government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

The BMA believes that the UK governments should continue with country-wide media campaigns to inform the public about the health effects of exposure to secondhand smoke at home and in vehicles.

Sustained mass media interventions are highly cost-effective on a per capita basis. As highlighted in *Breaking the cycle of children's exposure to tobacco smoke* (BMA, 2007), such campaigns have been introduced in New Zealand and Australia. In New South Wales, Australia, a 'car and home smoke-free zone' project achieved a 56 per cent increase in the number of smoke-free homes (from 47% to 73% of homes surveyed), and a 42 per cent increase in smoke-free cars (from 23% to 61%) between 2002 and 2005.[62] This project used multi-media campaigns to influence parents directly, as well as building capacity within the health professions and communities through targeted resources and grants awarded to support associated projects. New Zealand's 'take the smoke outside' mass media campaign has been running since April 2004 and uses television adverts supported by print and radio advertising and other resources. The first phase concentrated on smoking in the home, and encouraged parents to protect their children by 'taking the smoke outside'. A subsequent commercial publicised the New Zealand 'quit-line' to help parents to stop smoking.

Evaluation of the 2003 DH 'when you smoke, they smoke' campaign found that unprompted awareness that secondhand smoke harmed children's health rose from less than a third (28%) of respondents to half (50%). Three per cent of smokers said that these advertisements had prompted them to quit, while one fifth (19%) said that it had stopped them from smoking around children. It is essential that – in building on the 2003 campaign and more recently the 2008 'I wanna be like you' campaign – there is adequate funding for sustained mass media campaigns highlighting the dangers of secondhand smoke and promoting smokefree homes and vehicles. In developing and implementing these campaigns, it is also important to consider the factors that might prevent individuals from adopting smokefree environments such as inability to leave children unsupervised in order to smoke; lack of appropriate outside space for smoking; lack of comfort or privacy outside home; tobacco addiction; difficulties in requesting visitors not to smoke; and lack of support from friends and family.[63, 64] The BMA does not support the introduction of legislation to prohibit smoking in private dwellings and vehicles. Further research into attitudes towards, and barriers against, implementing smokefree homes and vehicles should also be undertaken and complemented by social marketing targeted at specific groups (eg low income families, single parent families).

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

A number of important research priorities are set out in *Breaking the cycle of children's exposure to tobacco smoke* (BMA, 2007) and *Smoking and reproductive life* (BMA, 2004) including further research to:

- evaluate current cessation services and different models of delivery and support
- develop and evaluate new cessation approaches focussing on disadvantaged, pregnant women (and partners)
- develop and evaluate initiatives at national and local level of increasing smokefree homes and cars, particularly where children are at risk
- continue to monitor trends in children's levels and sources of exposure to secondhand smoke
- ascertain children's and young peoples' views and experiences of secondhand smoke (plus parents', grandparents and other carers)
- evaluate impact of national policy measures (eg increase age of sale, smokefree legislation) on key groups including young people
- further examine the association between the exposure to secondhand smoke with the development of bacterial meningitis in children and the magnitude of the increased risk
- further examine the indication that reduced lung function due to smoking in children and adolescents leads to an elevated risk of developing COPD in later life
- characterise the association between smoking and certain reproductive health outcomes including: menstrual disorders; alterations of sex hormone metabolism; and fetal malformation
- establish the long-term effects of parental smoking on child health – including behavioural problems and childhood and other cancers
- evaluate the burden of smoking on sexual, reproductive and child health in the UK.

Further research is also required to evaluate the barriers to using medicinal nicotine and other pharmacotherapies, and to establish the levels of tobacco use among particular groups, in particular ethnic minority groups.

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:

- ***smokers who try to quit but do not access NHS support?***
- ***routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?***

Support to stop smoking is highly cost effective.[65] The provision of smoking cessation support combined with the use of pharmacotherapies is one of the most effective ways to reduce health inequalities,[66] and by helping parents and carers to stop smoking, will help reduce exposure to secondhand smoke. Stop smoking support will also maximise the effectiveness of population-wide policies to reduce tobacco use. Providing more effective smoking cessation services requires an understanding of the barriers to accessing such services, as well as the factors that encourage uptake.

Smoking cessation interventions and the use of pharmacotherapies have been found to be effective for pregnant women.[67] Various factors have been identified as important for supporting pregnant smokers to quit including:

- training for midwives (who make most of the referrals) on how to refer smokers, rather than how to treat them
- NRT is offered to almost all pregnant smokers, and an efficient prescription system is in place
- flexible home visits
- intensive multi-session treatment by a small number of key staff.[68]

Women who quit smoking while pregnant have very high rates of relapse after giving birth. Between 70 and 85 per cent of women who quit while they are pregnant begin smoking again after their baby is born.[69] There is very little evidence about how to prevent smokers who have quit successfully from beginning to smoke again.[70] A Cochrane review of stop smoking interventions in pregnancy found none that reduced relapse rates. A 2004 review of smoking cessation programmes aimed at pregnant women smokers concluded that the risk of relapse may be reduced if the following considerations are incorporated into interventions:

- smoking habits of partners, others living in the home, and close friends
- support, positive encouragement
- understanding that successful interventions take time and financial commitment
- support from women's social networks
- interventions should take place throughout pregnancy and early childhood care
- differentiation between those who have concrete plans for not relapsing and those who have not thought out possible challenges.

Encouraging young people to quit is a priority. Despite this, evidence about how to promote cessation in this age group is scant. Smoking interventions for young people also need to address the fact that it is common to smoke cannabis as well as tobacco.[71, 72] NRT is now licensed for use in young people over the age of 12 years. It is unclear, however, whether NRT will be effective in helping young smokers to quit.[72, 73,]

[74] A 2006 review of adolescent cessation programmes concluded that more evidence is needed to elucidate effective measures to support young people to stop smoking. Research has found that:

- there is considerable difficulty with recruiting young smokers
- participation and quit rates appear to increase with age
- young people are averse to using stop smoking support services, preferring to quit on their own or with friends' advice
- young people often express a desire to give up, but their views are characterised by ambivalence
- many see quitting as a project for the future, rather than the short term.[71, 73, 75]

In the UK, more than seven out of ten smokers (73%) say they want to quit, and more than half (57%) want to do so within the next year.[76] Nearly four-fifths (79%) of smokers have already made a quit attempt. While the UK is the world leader in offering specialist smoking cessation services, take up of these services is still low. The BMA believes that smoking cessation services should be targeted at high risk groups to include those in the lower socioeconomic groups, pregnant mothers, those with mental health problems and children who are looked after by the state, in foster care or in institutional settings. Consideration should also be given to incorporating smoking cessation services as a part of workplace health via occupational health services. This will require research to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of smoking cessation services. Social marketing campaigns targeted at particular social groups should also be used to assist those who find it most difficult to quit. The UK health departments should ensure that smoking cessation services are adequately funded and resourced. In addition to money already provided, two per cent of the revenues raised from tobacco tax should be ring-fenced for use in providing cessation services especially in areas of deprivation.

The cost and limited availability of smoking cessation aids can be barriers to their use. In comparison to the ubiquitous availability of tobacco products, the availability of NRT is still largely restricted to pharmacies and supermarkets. To support smokers in quitting, smoking cessation products should be available in all the places where tobacco products are currently sold. Encouraging employers to provide access to cessation services will also help to increase their uptake, and, in the longer term, reduce absenteeism resulting from smoking-related ill health.

Question 15: How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

Improving communication and referral between national and local services requires improved selection, training, assessment and supervision of specialists; the implementation of treatment protocols, and high quality administrative support for services. Any national campaigns should also be supported by regional initiatives that promote local services.

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

Healthcare professionals have an important role to play in smoking cessation. Support from a healthcare professional increases quit rates,[17, 77] with evidence showing that around one in five (21-22%) of those who receive medication as well as behavioural support succeed.[78] All healthcare professionals should be trained to offer opportunistic interventions, and support and advice on how to quit; to prescribe appropriate treatment such as NRT, and to refer to specialist smoking cessation services where necessary. This should have a particular focus on groups with a high prevalence and hard-to-reach groups. Engagement with outreach services and existing social networks would provide additional routes for targeting particular social groups.

Part D: Helping those who cannot quit

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

The BMA supports a tobacco-free harm reduction approach to help those who cannot quit. This requires strengthening of nicotine product regulation in the UK.

The current provisions of the medicines regulatory framework inhibit the development of new and innovative nicotine replacement therapies. In contrast, tobacco companies have the freedom to introduce and develop new tobacco-based products into the market with relative ease. Those products that claim to reduce harm are of particular concern because they provide tobacco companies with valuable branding and public relations opportunities. While the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the accessibility of NRT, it is essential that this current regulatory imbalance is redressed. Regulations must be in place to ensure that tobacco companies are prevented from introducing new tobacco products – including those that could be marketed as harm reduction measures. In addition, strengthening the regulatory framework would facilitate the development of pure nicotine products (which like the current medicinal products on the market contain only nicotine and not any other tobacco products). Such regulation should be facilitated through the establishment of a body to regulate nicotine products. To improve the uptake of NRT, there is a need to raise awareness of the relative safety of nicotine, as many smokers believe that nicotine can cause smoking-related diseases such as cancer.[79]

The BMA believes there should be legislation to prohibit the sale of conventional cigarettes and have these replaced with reduced ignition propensity (RIP) cigarettes.

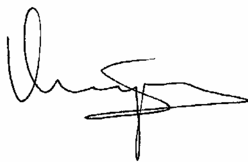
Cigarettes and smoking materials such as lighters and matches are a leading cause of house fires. Most manufactured cigarettes continue to smoulder unless they are extinguished. This means that discarded cigarettes can be a major fire risk. In the UK, fires ignited by tobacco products, matches and lighters are

the biggest cause of fire death and account for over a third of all fatal house fires. In 2006, fires ignited by these materials caused 96 deaths and more than 1,100 injuries.[80] There is also a very strong link between child house fire deaths and socioeconomic deprivation. A 2006 study in England and Wales has shown that children of parents who do not work are nearly 38 times more likely to die in a house fire than those whose parents are employed in professional and managerial jobs.[81]

A study of fire safe cigarettes conducted for the UK government showed that these products reduce, but do not eliminate, the risk of discarded cigarettes igniting upholstery. Up to 78 deaths and 886 injuries could be avoided each year if the safer products were introduced.[82] Both Canada and the State of New York have legislated to ban sales of conventional cigarettes, and replace them with reduced ignition propensity versions. Evaluations of the New York legislation have shown that these products have been accepted by smokers.[83, 84]

I hope you find this information helpful, and look forward to hearing the outcome of your consultation.

Yours sincerely



Professor Vivienne Nathanson
Director of Professional Activities

Enc. *Forever cool: the influence of smoking imagery on young people* (BMA, 2008)
Breaking the cycle of children's exposure to tobacco smoke (BMA, 2007)
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