

Stephen Gibson

Chair, Regulatory Policy Committee

Regulatory Policy Committee

By email: regulatoryenquiries@rpc.gov.uk

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Dear Mr Gibson

The Tobacco and Vapes Bill Impact Assessment – consumer group comments

We wish to comment on the Impact Assessment for Tobacco and Vapes Bill¹ and the RPC's "green rating" for this analysis.² We believe the fundamentals are flawed and that the assessment does not provide legislators with a reasonable or informative account of the legislation's costs and benefits. Consumers are an often overlooked stakeholder group, and we wish to register our concerns.

The New Nicotine Alliance is a registered charity and consumer association representing current and future consumers of low-risk alternatives to cigarettes, such as vaping products, nicotine pouches, snus and heated tobacco. We confirm no conflicts of interest concerning the tobacco, nicotine, or pharmaceutical industries. Many of us have experienced first-hand the benefits of vaping and other low-risk products to escape smoking. We also count public health experts among our board members, associates, and supporters.

1. Smokefree Generation proposal

In summary, the Smoke-free Generation tobacco proposal – the assessment overstates the benefits. The impact assessment severely overstates the benefits of the Smoke-free Generation measure. It makes unrealistic assumptions about future baseline smoking and related costs and does not compare the proposed policy with the simpler and obvious alternative, which is to raise the age of sale from 18 to 21 for smoking products only. This measure is directed at the "flow" of potential new smokers. That flow is already dwindling to a trickle. The problem is the "stock" of existing ageing smokers who are now facing significant health risks as they pass through their forties or older. This measure does not address that critical at-risk population. In greater detail, the key weaknesses in the analysis of the Smoke-free Generation proposal are as follows:

1. **The most obvious alternative policy is excluded from the analysis.** The options considered for comparative purposes (para 101) fail to consider the most reasonable alternative policy, which would be to limit sales of smoking products to people aged 21 and over instead of banning sales of all tobacco products to people born after 1 January 2009. This alternative measure would secure nearly all the gains attributable to the proposed Smokefree Generation policy without raising new issues of principle about extending the age of majority permanently into adult life or overreaching into non-smoking tobacco products. However, there is good evidence supporting

¹ Department of Health and Social Care, Tobacco and Vapes Bill Impact assessment, 20 March 2024 [\[link\]](#)

² Regulatory Policy Committee, Tobacco and Vapes Bill: RPC Opinion (Green-rated), 8 April 2024. [\[link\]](#)

this policy.³ The option was not modelled as the government says it does not meet its policy objectives (neither will the Smokefree Generation). However, it is an appropriate *comparator* to the Smokefree Generation policy. If done correctly, it would show far lower incremental benefits for the Smokefree Generation proposal than a comparison with “do nothing”. It would be informative for legislators to have such a comparison.

2. **A highly inflated baseline is used for the no-policy (do nothing) option.** Figure 3 shows baseline smoking (age 14-30) would fall from 13.0% in 2023 to a steady state of 9.2% in 2041, then remaining at that level until 2100. Why? The underlying trends in youth and young adult smoking have been sharply downwards over the past twenty years, and this trend is likely to continue as vapes and other non-combustible products displace smoking among young people without any further action from the authorities. It is likely that smoking will largely disappear within this age group within a decade. In 2021, only 3% of 15-year-olds were regular smokers, down from 5% in 2018 and from 30% in 1996.⁴ In 18-21-year-olds, smoking prevalence fell from 34.7% to 17.2% between 2007 and 2024 and remains on a steady downward trend.⁵ Why would this trend not continue as younger adolescents age into the young adult population? This point is important because the proposed measure bears on a problem that is largely already solved through product innovations such as vapes and pouches, yet it does not address the real public health problem and at-risk population – the millions of committed smokers born before 2009.
3. **The implausibility of the modelled impact of the Smokefree Generation proposal on smoking prevalence.** Figure 5 in the impact assessment shows smoking at age 15 stabilising in the base case (a flawed assumption – see 2 & 3 above) but rapidly falling to zero in the policy case. Why would smoking fall to zero if the underlying demand remains? To the extent that young people still wish to smoke, age restrictions have rarely stopped them and are, at best, a frictional impediment rather than an insurmountable barrier. The impact assessment uses naïve assumptions about the efficacy of age restriction policies in reducing smoking, which means that the impact assessment overstates whatever benefits it claims. We already have an age restriction set at age 18, and yet smoking prevalence among 16-17-year-olds was 12.2% in 2023.⁶ Underage users report a variety of ways to access age-restricted products,⁷ and they are ultimately likely to be served by a well-organised illicit market that would sell cigarettes alongside other banned products or by age-stratified secondary trading.
4. **Ignoring the options offered by smoke-free products to smokers later in life.** Paragraph 178 and Figure 9 in the impact assessment show no policy benefits until 2044 and then large benefits accruing to 2100. Given the rate at which vaping is already displacing smoking and the pace of innovation in nicotine products since 2010, it is highly unlikely that many of those smoking as adolescents or young adults in the “no policy” case will still be smoking in 2050 or 2100 and there would be options for them to switch if they wish to. Why would they continue to smoke

³ Pesko, M. F. (2022). Combustible tobacco age-of-sale laws: An opportunity? *Addiction*, 117(3), 514–516. [\[link\]](#)

⁴ NHS England Digital. Smoking, Drinking and Drug Use among Young People in England, 2021 *Part 1: Smoking prevalence and cigarette consumption* (2022). [\[link\]](#)

⁵ Smoking Toolkit Survey. Cigarette Smoking Prevalence in 18-21-year-olds 2007-2024. [\[link\]](#)

⁶ Smoking Toolkit Survey. Cigarette Smoking Prevalence in 16-17-year-olds 2007-2024. [\[link\]](#)

⁷ NHS England Digital. Smoking, Drinking and Drug Use among Young People in England, 2021 *Where pupils get cigarettes* (2022). [\[link\]](#)

until they became ill rather than exercise a harm-reduction option? Without the SFG policy, those born after 1 January 2009 will have grown up with low-risk alternatives to smoking and will have likely tried them. It is quite possible that smoking will be highly unusual in that age group and that anyone beginning to experience negative health or welfare symptoms will exercise their option to switch to a safer product when they need to or wish to. Switching to these options later in life will substantially reduce any benefits from Smokefree Generation.

5. **The stated benefits are exaggerated.** The purported benefits of the policy arise from the difference between the baseline smoking prevalence trajectory for “do nothing” and the Smokefree Generation policy, as shown, for example, in Figure 6 in the impact assessment. These benefits are exaggerated because of the pessimistic assumptions built into the baseline and optimistic assumptions made about the efficacy of the policy.
6. **The claims for productivity and other gains do not reflect the lags and non-linearity in the relationship between smoking prevalence and disease and mortality outcomes.** As discussed, the likely impact on smoking prevalence is exaggerated. However, the benefits that flow from lower smoking prevalence are delayed because ill-health lags smoking behaviour. Those who stop smoking by age 40 avoid nearly all the major disease risks and loss of life-years.⁸ The full mortality penalty does not emerge until much later in life (for example, the famous British doctors’ survey showed the median smoker losing ten years of life from age 73 to 83).⁹ Those affected by the Smokefree Generation measure would not turn 40 until 2049 or later. In a 30-year evaluation, the health effects suffered by those born after 2009 are unlikely to be material, and they cannot be pro-rated from the harms experienced by the existing smoking population and counted in the benefits. The baseline modelling takes no account of people who smoke switching to vapes, pouches or other smoke-free products later in life (i.e. before they turn 40) to avoid serious disease risks. Previous generations did not have this “harm reduction” option and were urged to become abstinent.
7. **The negative impacts of including smoke-free tobacco products in the Smokefree Generation proposal are ignored.** Finally, there is a potential negative impact associated with including *smoke-free tobacco* products in the scope of the generational ban. Such products might include smokeless tobacco, heated tobacco products, tobacco lozenges, or products arising from future innovation. Extensive data suggests that these products can be beneficial as low risk substitutes for smoking, but no rationale has been provided for extending the policy to include these products. We have substantial evidence that snus has reduced smoking and related diseases in countries that allow it.¹⁰ At least one heated tobacco product has been designated “appropriate for the protection of public health” by the US FDA¹¹, and these products have beneficially transformed the market in Japan.¹² The government’s targets are rightly focused on reducing

⁸ Cho, E. R., Brill, I. K., Gram, I. T., Brown, P. E., & Jha, P. (2024). Smoking Cessation and Short- and Longer-Term Mortality. *NEJM Evidence*. [\[link\]](#)

⁹ 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), 1519–1528. [\[link\]](#)

¹⁰ Ramström, L. (2024). Snus Has Saved Many Lives in Sweden – And Can Save Many More. *Qeios*. [\[link\]](#)

¹¹ Food and Drug Administration, Premarket Tobacco Product Marketing Granted Orders, accessed 3 April 2024. [\[link\]](#)

¹² Cummings, K. M., Nahhas, G. J., & Sweanor, D. T. (2020). What Is Accounting for the Rapid Decline in Cigarette Sales in Japan? *International Journal of Environmental Research and Public Health*, 17(10), 3570. [\[link\]](#)

disease and death, but that means the policy focus should be on *smoking*. The “Smokefree Generation” measure should reflect what it says in the name and be confined to *smoking products*. Though the RPC is not mandated to criticise policy, it should try to ensure that impact assessments capture the negative effects of policies. Note that over-extended regulation can have negative effects through needlessly curtailing consumer choice, sending misleading implicit risk communications, and by causing adverse behaviour change, workarounds, or illicit supply for no justifiable reason.

2. The vaping measures

In summary, the restrictive policies on vaping products – the assessment conceals the likely large detriments. The main issue with the impact assessment for vaping policies is that unintended negative consequences are not adequately defined and quantified or compared to intended benefits. The same fundamental problems apply to all the proposed vaping regulations. In this case, poor relative risk estimates and a failure to use quantified estimates have meant the impact assessment conceals rather than reveals the likely scale of harm that would be done by placing significant restrictions on vaping products, given vapes function as low-risk alternatives to smoking. Small increases in smoking arising from vaping restrictions have a high cost using the methods used in this impact assessment. A 0.1 percentage point change (e.g. from 12.9% to 13.0%) in smoking prevalence creates a cost of £3.5 billion using the method adopted in the impact assessment.

1. **The centrality of assessing perverse consequences of vaping policies.** The assessment of vaping policies is largely the assessment of unintended consequences. These are likely because cigarettes and vapes function as *economic substitutes*. It follows that regulatory restrictions or taxes on one may increase the demand for the other. Such plausible negative effects are referred to in the text, for example, in paragraph 38.

38. A possible unintended consequence of the vaping policies is that it could encourage more young people to try smoking. For example, a study from the US found that restricting flavours of vapes led to an additional 15 cigarettes sold for every 0.7mL vape pod not sold.

Also, in paragraph 417, negative impacts on adult smoking cessation are mentioned.

417. The decision aid tool published by Bristol University mentioned above estimated that 4% of smokers quit because of vapes, and 33% of smokers stated that they would not quit and/or smoke more if flavours were not available. For ex-smokers, it was estimated that 13% of ex-smokers vape and 13% of these ex-smokers would relapse if flavours were not available.

The full range of potential unintended consequences is large and broadly comes under three main headings: adverse behaviour change (not quitting smoking, taking up smoking instead of vaping, relapse to smoking); access to illicitly made or imported products (as a buyer or potentially as a seller); and a range of risky workarounds (making and adding DIY flavours, using nicotine concentrates, etc.), some of which may be facilitated by manufacturers. The impact assessment does not address the full range of plausible unintended consequences.

2. **The use of an excessively high relative risk estimate for vaping compared to smoking.** The balance of intended benefits and unintended detriments is directly proportional to the relative

risk comparator used. The impact assessment accepts the view of UK experts that vaping is much safer than smoking.¹³

361. The latest evidence has found that, in the short and medium term, vaping poses a small fraction of the risks of smoking, because vapes do not contain tobacco.

This comparison logically implies that *smoking poses a large multiple of the risks of vaping*, and, therefore, any assessment of costs and benefits would need to carefully reflect unintended increases in smoking arising from regulation. The assessment uses an unpublished 2017 Canadian estimate drawn from an expert elicitation group, which reportedly concluded that vaping has 20% of the risks of smoking (paragraphs 493-494). We have traced the provenance of this 20% figure, and it was not an *estimate* developed from expert elicitation but a conservative *assumption* used to model a measure that would drive switching *from smoking to vaping*. In this case, a high estimate of relative risk (20%) would be conservative and tend to understate the benefits. In the case of UK measures, the anti-vaping measures would tend to drive switching *from vaping to smoking*, and the assumption used would, therefore, be the opposite of conservative, tending to understate the risks.

But later estimates made by the English government's own advisers put the risk at no more than 5% in 2018¹⁴, and the most recent report for the government in 2022 stated the following:13

Based on the reviewed evidence, we believe that the 'at least 95% less harmful' estimate remains broadly accurate, at least over short term and medium term periods. However, it might now be more appropriate and unifying to summarise our findings using our other firm statement: that vaping poses only a small fraction of the risks of smoking. [emphasis added]

The four-fold difference in risk estimate (5% vs 20%) should be recognised in the impact assessment, as the choice of risk comparator substantially affects the balance between intended and unintended consequences. It is unclear why an unpublished Canadian assumption from 2017 was used in preference to the published English government-sponsored estimates from 2018 or 2022 or a similar estimate made by the Royal College of Physicians in 2016.¹⁵ The effect is to understate the likely cost of perverse consequences and overstate the benefits of avoided youth vaping.

- 3. The failure to provide any quantification.** Very small increases in smoking prevalence arising from vaping regulation or partial prohibitions would likely dominate a cost-benefit analysis. For example, each 0.1 percentage point increase in smoking prevalence would represent a cost of £3.5 billion million using the assumption built into the IA.¹⁶ However, the impact

¹³ McNeill, A., et al. (2022). *Nicotine vaping in England: An evidence update including health risks and perceptions. A report commissioned by the Office for Health Improvement and Disparities*. London: (p. 1468). Office for Health Improvement and Disparities. [\[link\]](#)

¹⁴ McNeill A, et al. (2018). *Evidence review of e-cigarettes and heated tobacco products 2018. A report commissioned by Public Health England*. Public Health England. [\[link\]](#)

¹⁵ Royal College of Physicians. (2016). *Nicotine without smoke: Tobacco harm reduction*. RCP London. [\[link\]](#) "the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed **5% of the harm from smoking tobacco.**" (original emphasis)

¹⁶ The IA uses a value per Quality Adjusted Life Year (QALY) of £70,000 and assumes that each smoker who quits (and by implication reverts or does not quit) generates a cost or benefit of 1.0 QALY [see para. 413]. The ONS estimates 6.4 million smokers and a smoking prevalence of 12.9% in the UK [\[source\]](#). A 0.1 percentage point change in prevalence from 12.9% to 13.0% equates to an

assessment does not attempt quantification of these negative effects, even though they would likely swamp any benefits from reduced youth vaping if the risk comparison between smoking and vaping is realistic. This omission is justified with reference to uncertainty:

419. Due to the uncertainty on the size of the impact that restricting vape flavours would have on the number of current smokers not quitting and ex-smokers that relapse, we have not quantified the health impacts of fewer people using vapes to quit smoking.

However, there was no such reticence in quantifying the highly uncertain effects of the smoke-free generation measure. It is more likely that the result of even conservative assumptions for changes in smoking status would show considerable net harm arising from these vaping regulations because of the detrimental effects on adult smoking rates and youth smoking initiation.

4. Ministers might wish to prioritise the risks of youth taking up vaping compared to the risks of adults or adolescents continuing to smoke. In that case, they would need to develop a measure other than QALYs to assess the balance of benefits and detriments to health and well-being.

3. Conclusion

We do not think that the impact assessment provides a useful basis for understanding either the tobacco or vaping policies set out in the Tobacco and Vapes Bill. In essence, the smoking policy misses the critical target population (middle-aged adult smokers), and the vaping policy compromises an important harm reduction option with potentially high costs in net additional smoking. The impact assessment should more accurately reflect the magnitude and distribution of costs and benefits before the Bill is debated in Parliament.

If we may be of further assistance, please do contact us.

Yours sincerely



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additional 49,612 smokers. Multiplying this by £70,000 gives £3,473 million. For each 0.1% change in the number of smokers (not a percentage points change of prevalence), the cost would be £448 million. These calculations are to illustrate the magnitude of costs associated with small changes in population smoking rates that might arise from vaping legislation.