THE CONVERSATION

Britain’s efforts to reduce smoking are becoming a cash cow for big tobacco

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Roll up! Roll up! Cigarette marketeers playing the long game. Kelly Rowland, CC BY

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It all began so well. A decade ago a heartfelt concern about the addictiveness of nicotine, and the enormous difficulties this presented for would-be quitters, led to an unprecedented investment in intensive smoking cessation services. Beyond Smoking Kills proudly proclaimed year-on-year increases in funding for stop-smoking services and the establishment of centres throughout the country.

Interestingly the argument for doing this was moral rather than epidemiological. The resource-intensity of the services meant there could never be enough people making use of them to noticeably reduce prevalence. The argument instead was that, given the addictiveness of nicotine, helping smokers battle against it was an ethical imperative.

Clinics were established across the land staffed by highly trained cessation workers who took smokers through a tight, evidence-based protocol which choreographed every detail of their quit attempt, right down to setting the date they would stop, and provided a drug regimen to help them cope with nicotine withdrawal.

Initially this comprised various forms of nicotine replacement therapy – patches, gum, inhalers. But such is the grip of nicotine, other pharmaceutical weapons were deemed necessary, including anti-depressant Bupropion and nicotine suppressor Varenicline.

Pharma ploughs the furrow

These developments were inevitably of great interest to the pharmaceutical industry, which, as Ben Goldacre reminds us, “penetrates British academia and medicine to its absolute core”. NRT is big business and smoking cessation services have turned government into a lucrative customer: the funding increase lauded in Beyond Smoking Kills includes massive payments (over £60m in 2012) to pharma companies for prescriptions.

From a commercial perspective though, the cessation market is flawed. Consumers only use the product for a limited period and the whole point is to speed the moment when they stop using it. This flies in the face of three decades of business research which has emphasised the profitability of customer retention and relationship marketing, and spawned countless loyalty schemes – from club-cards to air-miles. For pharmaceuticals this translates into chronic use. Statins – taken by increasing numbers of healthy over fifties for ever60367-5/fulltext) – are the gold standard.

So pharma’s marketers began searching for a business model built around long-term nicotine replacement therapy. The first step had to be a break in the exclusive link between therapy and cessation, but the industry couldn’t promote such an idea with any credibility. Harm reduction, with its respectable scientific justification for chronic nicotine replacement therapy use, solved the problem neatly. The marketing opportunity was pinioned with a Medicines and Healthcare products Regulatory Agency licence extension application for long-term use to reduce harm, and this was granted. Then the pharma cup ran over: the National Institute for Health and Care Excellence explicitly recommended that nictoine replacement therapy was suitable for “lifetime use”. Statin heaven.

Now, inevitably, the tobacco industry has gatecrashed this hitherto select party, thanks to the e-cigarette. This brings us back to the marketers, who long ago recognised the power of consumer choice. Let regulators say what they will, let public health officials pontificate as worthily as they can, a product that does not deliver is still going to lose out to one that does. Unfortunately for pharma, replacement therapy cannot provide the instant nicotine spike which gives tobacco such an advantage.

Light-headed policy

The e-cigarette, though still untried and untested, seems to be both reasonably clean and capable of hitting the nicotine spot. It is certainly promoted as such in campaigns that replicate the heights (or depths) of tobacco advertising – extravagant unproven claims, rich imagery and youthful positioning.

And marketers are neither shy nor retiring: the UK market has exploded in the past year with more than 120 trademark applications, and e-cigarettes have been taken in every conceivable commercial direction. So, as well as the desirable alternative-for-adult-smokers pitch, we also have dangerous beat-the-smoking-ban and dual-use offers, lifestyle accessories such as e-shisha, e-cigarettes with taurine, increased modelling of smoking and blatant targeting of the young.

The tobacco industry, having sniffed out this opportunity, is snapping up e-cigarette companies. The latest example is Lorillard’s acquisition of Skycig, giving the US based conglomerate its first major foothold in the British market.

Undreamed of stakeholder marketing opportunities are emerging. British American Tobacco is even seeking a licence for one of its alternative nicotine delivery devices, and has met the regulator “to discuss the potential budgetary implications of using this type of product”. So smoking cessation services may soon be in the deeply conflicted position of prescribing tobacco industry products, and the tobacco industry’s long-standing “divide-and-conquer strategy against the tobacco control movement” will finally start bearing fruit.

This maelstrom of corporate money-making and manoeuvring seems to have left UK tobacco control lightheaded. What else can explain perverse adjudication that the market

needs regulating, but that the regulator will do nothing for at least three years.

Likewise, only profound dizziness explains the about face on nicotine which a decade ago was villainous enough to launch a thousand clinics but is now being rehabilitated with the NHS drug regulator as its cheerleader. But it takes real blindness to consider perpetual nicotine use, with all the dependence, disempowerment and regressive inequalities this presumes, to be sound public health policy.

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