Epworth
Investing with Christian ethics

Position Paper - Tobacco

1. Preamble

1.1. The prevalence of smoking in the UK has declined rapidly over time as a result of comprehensive health education, prevention initiatives and marketing regulation. In 1948, eight in 10 adult males smoked, but with the start of Government health education programmes in the 1970s, this began to reduce steeply, but more recently has tailed off and begun to plateau (Fig 1). [1]

Smoking Prevalence, Adults aged 16 and Over, Great Britain 1948-2012

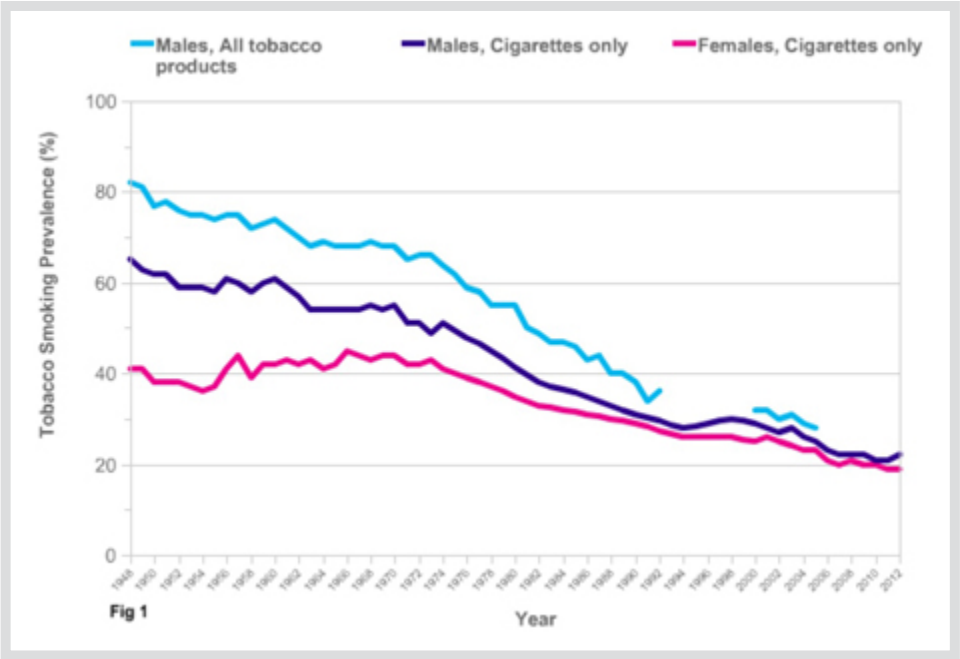
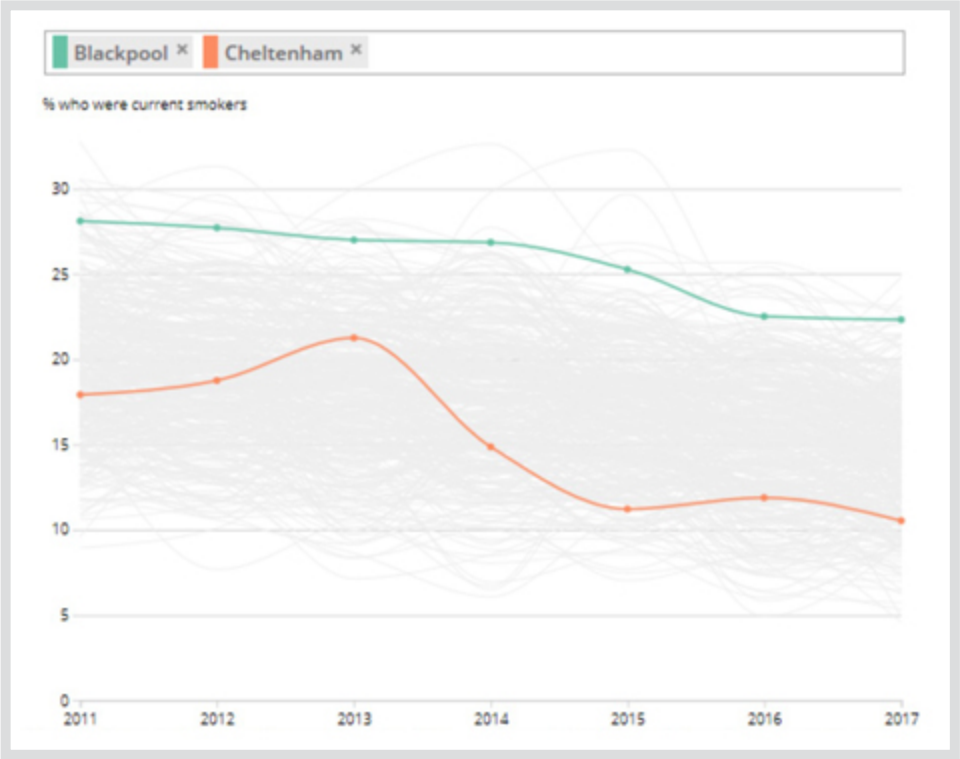


Fig 1

1.2. The disparity in smoking by age and gender has also narrowed over time. According to Government estimates, 15.5% of adults in England over the age of 18 and 15.1% for the entire UK (male and female) were presumed to smoke regularly in 2016 compared to 46% of men in the early 1970s (41% for women). This equates to around 7.4m active smokers. Regional differences remain stubbornly acute, with the prevalence of active smoking remaining higher in Scotland (16.1%) and Northern Ireland (16.3%) than in other parts of the UK.

1.3. The Office For National Statistics paper, 'Adult Smoking Habits in the UK, 2017' notes a 'significant' one-year fall in the prevalence of smoking across all age groups, and in total from 15.8% of the adult population in 2016, to 15.1% in 2017. It is, however, too early to determine if this represents a new longer-term downward trend, although the UK and devolved Governments have all smoking reduction prevalence targets – 12% in England by 2022.

1.4. Active smoking is more prevalent in socio-economically deprived areas, with evidence that it underpins the socio-economic variation in incidence and mortality for a number of cancer types. The prevalence of smoking is also more marked in manual or low-paid occupations (25.9%), compared to professional and managerial occupations (10.2%). Evidence of this can be seen for example, between smoking prevalence in Blackpool – registering one of the highest, and Cheltenham, among the lowest (Fig 2).



1.5. Smoking declines with age. Whereas 17.8% of UK adult males (20% adult females) smoke between the ages of 18-24, the equivalent for the over 65 age group is 8.1%. Smoking appears to peak between the ages of 24-35 (19.7%) and then declines rapidly for both sexes.

1.6. Smoking is the leading cause of preventable mortality, with 81,000 deaths per year from tobacco related illness (see below). This does not include complications arising from passive smoking, nor conditions found in babies, of whom 10% are born to a mother who smokes.

1.7. The socio-economic cost of smoking is stark. Research by Oxford University put the cost to the NHS as exceeding £5.2bn per year, with approximately 485,000 (England) hospital admissions in 2016 linked primarily to tobacco related conditions (by way of comparison, there were 617,000 admissions linked to obesity and over 16m hospital admissions in England in total in 2016-17).

2. Vaping

2.1. Vaping is the inhalation of nicotine vapour produced from an electronic or e-cigarette. The device comprises battery, housing, vapour cartridge and atomizer. By generating heat in the atomizer, vapour liquid is transformed into gas for inhalation. Modern vaping originated in China in 2003; exponential growth in the UK has seen the number of users increase from 700,000 in 2012 to over 6 million by 2015.

2.2. Public Health England has concluded that vaping is 95% safer than smoking. An independent commissioned report (2015) found there to be no evidence that vaping was a route into smoking for children or non-smokers, and that it is a potentially successful route to curing addiction from smoking. E-cigarettes provide users with the nicotine rush gained from smoking, without cancer causing tar and other chemicals.

2.3. The House of Commons Science & Technology Committee published its report 'e-cigarettes' in July 2018, in which Parliamentarians concluded that 'e-cigarettes present an opportunity to significantly (sic.) accelerate already declining smoking rates' and on balance advised that smokers should be 'encouraged to give up, but if that is not possible, they should switch to e-cigarettes as a considerably less harmful alternative'. More controversially, the Committee advised a public debate on whether vaping should be allowed in spaces where smoking is now prohibited on health and safety grounds (offices, public transport etc.) stating there is no 'public health rationale for treating use of the two products (i.e. cigarettes and e-cigarettes) the same'.

2.4. However, as the Committee itself acknowledges, uncertainties remain, and Cancer Research UK (CRUK) maintains that questions linger over the long-term safety of vaping as it has not been in circulation long enough for quantitative and qualitative longer term tests to have been carried out. CRUK states that vaping should be more closely seen as nicotine replacement therapy (NRT), which has long been seen as a safer alternative to smoking. E-cigarettes are also believed to be low risk in respect of conditions such as 'popcorn lung' as the liquid believed to be the cause is banned from use in e-liquids.

2.5. Given the longer-term uncertainties, a precautionary approach has been assumed so that investing in vaping and e-cigarette products are avoided until quantitative and qualitative evidence regarding their safety emerges.

3. Health

3.1. Smoking is the biggest preventable cause of cancer, and is responsible for 25% of all cancer deaths and three in 20 of all cancer cases. There is no statistical difference in risk between cigarette smoking and other forms such as pipe, cigar or shisha.

3.2. Chemicals in cigarette smoke enter the bloodstream and affect the entire body, being held responsible for at least 15 types of cancer as well as heart and lung disease.

3.3. Smoking is primarily linked to lung cancer where it is responsible for around 70% of diagnoses. Lung cancer currently has among the lowest survivability rates of any cancer. Smoking is also linked materially to bowel, bladder, mouth, upper throat and oesophagus cancer.

3.4. Cancer develops as a result of DNA damage caused by the chemicals in cigarette smoke attacking the body, in particular benzene, polonium-210, benzo (a) pyrene and nitrosamines. Each cigarette is a cocktail of around 5,000 chemicals of which 70 are cancer causing e.g. cadmium, arsenic, formaldehyde and chromium.

3.5. Passive smoking increases the risk of contracting cancer by 25% and is particularly dangerous for children and young people. Second hand smoke exposure most often occurs in the home or in private transport. Smoking in a car with a person under 18 was made illegal in 2015, however, infringement is limited to a £50 fine and does not apply to drivers who are 17, or to convertible vehicles where the roof is (fully) down!

3.6. Establishing a causal link between smoking and cancer took sometime, but gathered pace during the 1950s as medical practitioners monitored and observed the prevalence of lung cancer cases. By 1956 evidence had mounted sufficiently for the British Medical Journal to publish, and this was followed by a recommendation in 1962 by the Royal College of Physicians providing incontrovertible evidence of the link between smoking and cancer.

4. Regulation

4.1. Tobacco is now among the most tightly regulated of products that are legitimately offered for sale. Advertising or marketing of tobacco was prohibited in the UK in 2002. The UK became a party to the WHO Framework Convention on Tobacco Control in 2005, which outlawed the practice of smoking in indoor work or public spaces and on public transport. Display of tobacco products in retail outlets was prohibited at the same time, restricting 'display' to behind closed non-viewable cabinets.

4.2. The final piece of highly restrictive legislation arrived in 2016 with the Tobacco and Related Products Regulations 2016, and Standardised Packaging of Tobacco Products Regulations 2015. These mandate standardised, plain packaging for all cigarettes and loose leaf tobacco, and cannot contain any text, trademark, brand or symbols other than health warnings, brand name (in standardised font), quantity and producer. These form among the most constraining sales and marketing restrictions for any legally sold product anywhere.

4.3. The law, however, remains somewhat quaint in its application: The legal age for buying tobacco was raised to 18 in 1987, but this applies only to cigarettes and not to other tobacco products. The legal age for smoking in public remains 16 in England & Wales. Vendors may be fined up to £2,500 for illegally selling cigarettes to minors, but there is no penalty for actually smoking as a minor, apart from confiscation.

4.4. Government, whilst motivated to promote health given the causal link of smoking with a range of diseases, nevertheless continues to benefit financially from the sale of tobacco products. UK excise duty and VAT is among the highest in the world on tobacco products, accounting for around 82% of the recommended retail price (RRP) of a packet of 20 cigarettes (c£9.91). Within the EU, the UK applies the most stringent duty rates followed by Ireland and France (by comparison a packet of 20 cigarettes in France will cost £5.67, and in Bulgaria – the lowest – £2.32).

4.5. The Treasury received c£8.9bn in tobacco excise duty in 2016/17 made up of a standard levy of 16.5% of the retail price plus a specific duty applied per 1,000 cigarettes sold (currently £207.99). Between 2000 and 2016, HM Government received over £146bn in tobacco related duty.

5. Biblical and theological background

5.1. As with so many modern ethical dilemmas, there are few direct Biblical references. Whilst tobacco has been smoked for many centuries by indigenous populations, it was only 'discovered' and developed as a cash crop for recreational purposes in the 16th century.

5.2. Whilst the Bible is silent on tobacco smoking, it is reasonable to draw attention to passages concerned with the body as a temple and 'healthy or pure living'. The key text remains I Corinthians 6: 19-20; "Or do you not know that your body is a temple of the Holy Spirit within you, which you have from God, and that you are not your own? Glorify God in your body".

5.3. These Biblical traditions support the view that practices that pollute or contaminate the body are not God- given and should be avoided.

5.4. John Wesley's views on smoking are obscure. However, given his active interest with the outdoors, exercise, healthy bodies and views expressed in his well-known 'Letter to an Alcoholic', a presumption against the practice of smoking on 'pollution' grounds might be assumed. In his 'Letter' he was concerned at the harm caused by alcohol to the body and the soul that debased self-respect and worth. The intensity of his views on alcohol may not, of course, have extended to tobacco and smoking, given the effects were not so obvious, debilitating or well-known in the 18th century as were the all too obvious effects of alcohol addiction.

5.5. However, in Sermon 50, the 'Use of Money' he says 'but this it is certain we ought not to do; we ought not to gain money at the expense of life, nor (which is in effect the same thing), at the expense of our health'. This would indicate that had the health effects of tobacco been known, he may have taken a not dissimilar view to smoking as he did to alcohol, and would certainly have opposed taking profit from business activities that involved tobacco.

6. Church investors approach

6.1. Tobacco is the most common and widely observed ethical exclusion among faith investors and other secular ethical investors. The Church of England has excluded tobacco since 1962; this was confirmed in 1964, and the position was re-affirmed in 1983 when the Church investment bodies stated; 'the case for retaining this category [of exclusion] is clear cut'.

6.2. The Church Investors Group (CIG) regularly surveys its members on companies excluded from investment. The last survey suggested 96% of its members avoid investment in major stock-exchange listed tobacco companies. Denominations stating they avoid 'tobacco products' include the Baptist Union, Church of Ireland, Church in Wales, Church of Scotland, Roman Catholic Dioceses and the United Reformed Church.

7. Epworth/Central Finance Board of the Methodist Church (CFB) precedents

7.1. The first reference to a policy relating to investment in tobacco dates back to 1963, but there is no record of what this entailed. However, despite later comments that the CFB had always avoided investment in tobacco, there are indications that there was some exposure prior to the establishment of the Investment Unit in 1972.

7.2. From 1972 onwards, tolerance towards exposure to tobacco has been extremely low and has rarely been questioned. Consequently, there is little record of any debate on the subject. However, there has been an untested assumption that if tobacco accounted for 5% or more of profits or sales of any company, it would be excluded from investment on ethical grounds, whilst exposure approaching 5% would be referred to the Joint Advisory Committee on the Ethics of Investment (JACEI) for advice. An early precedent was the sale of a company that manufactured machinery for the tobacco industry.

7.3. There are precedents for decisions taken on companies with exposure to both tobacco and alcohol. The major food retailers sell alcohol and tobacco, but combined sales were not considered sufficiently material to warrant disinvestment on ethical grounds. However, in the 1980's, KwikSave bought an off-licence chain that took its combined alcohol and tobacco sales above 20%, and as a result the holding was sold on ethical grounds.

7.4. In 1999, British Airports Authority (BAA) was considered by JACEI following its purchase of a 'duty free' retailer in 1998. The company's exposure to alcohol and tobacco temporarily rose close to 20%, but had then fallen back to around 15%; JACEI considered, at the time, that this "was not a cause of major concern".

8. Conclusion

8.1. The long serving investment exclusion of tobacco and tobacco related products on grounds of health is clearly accepted and well established and therefore no change to this approach is proposed. Given the longer-term uncertainties, a precautionary approach has been assumed so that investing in vaping and e-cigarette products will be avoided until quantitative and qualitative evidence regarding their safety emerges.

8.2. Epworth has published an accompanying Policy Statement on Tobacco in which its investment approach to tobacco is set out.

9. Notes

1. All sources (except 2) either NHS Digital, ONS 'Adult Smoking Habits in the UK, 2017', National Health England, Cancer Research UK (CRUK),CIG or HM Government.

2. House of Commons Science and Technology Committee Seventh Report of session 2017-19 'e-cigarettes' https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/505/505.pdf