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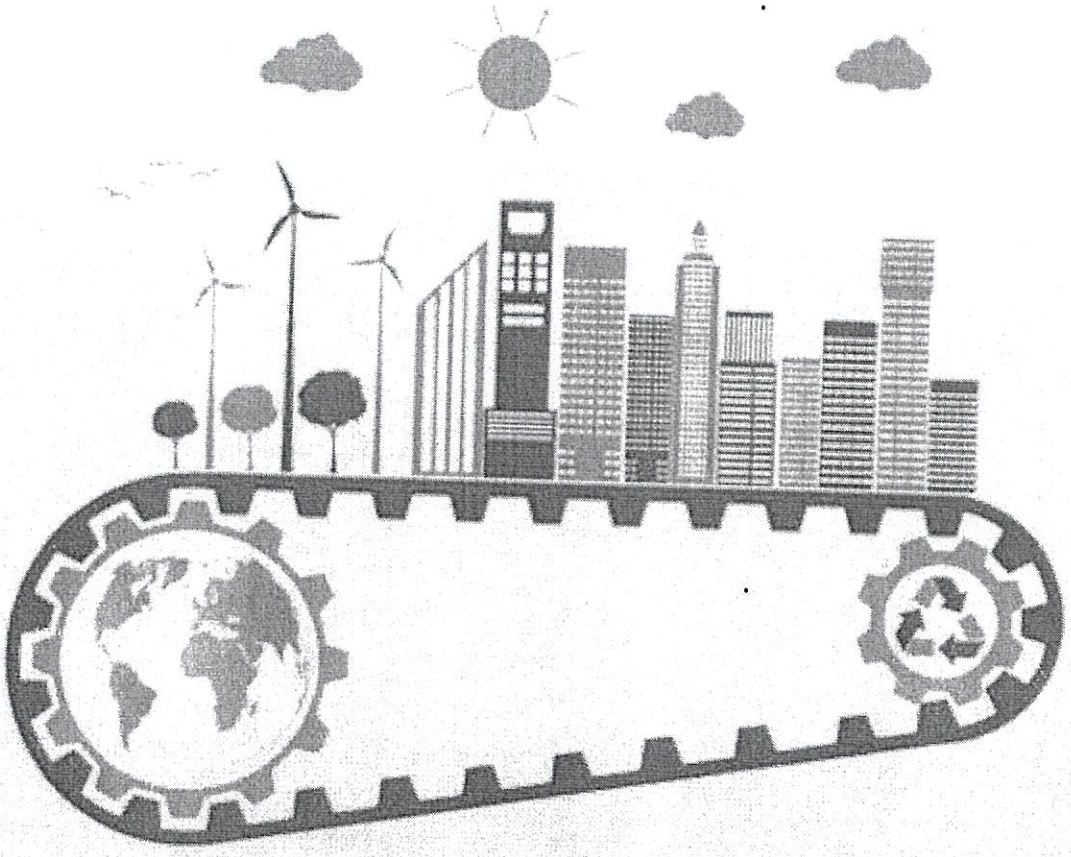

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TRENDS IN TOBACCO CONSUMPTION AND ITS ECONOMIC BURDEN ON THE LOWER INCOME GROUPS IN INDIA

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ABSTRACT

Tobacco use and its pattern are closely linked to age, sex, class , education, income, etc amongst many other factors. Findings from studies within the Member countries of the Region reveal that tobacco use is higher among the agricultural , illiterate and poor population. The utilization of tobacco among rural people in Bangladesh, India and Thailand was above the urban population.

Tobacco use is a major public health problem in India, and its impact is particularly devastating to the poor. Effective tobacco control must be a top priority, both as a health problem and as a way to combat poverty. Tobacco consumption is deeply rooted in cultural practices, and there are countless types of tobacco. We investigated several determinants of tobacco use, including socioeconomic status, marriage, population growth, marketing strategies, and prices. It also took into account tobacco pollution, including economic and social costs, and the adverse health effects of oral cancer in particular. Tobacco consumption in India continues to increase despite tobacco control policies. What is needed is a more visible and proactive tobacco control campaign, including increased public awareness of the harmful effects of tobacco and the active involvement of workplaces and health care workers to promote smoking cessation.

People smoke more tobacco in urban areas than in the rural mind. With age, the prevalence of smoking increases and in India men smoke more tobacco than women. Compared to the urban area, there is more consumption of bidis and hookah in rural areas. Daily smoking is around 6% compared to bidi smoking, which is 10%. In total, 63% of cigarette smokers smoke cigarettes every day, while 81% of bidis smokers smoke bidi every day.

Current study focuses on the consumer spending in India on Tobacco and its impact on the lower income group and the effect of it on the rising household debt burden since 2000. The study has based the analysis on secondary data collected from authentic sources.

Keywords: tobacco, debt burden, poverty

INTRODUCTION

The current and the past decade has witnessed a growing demand for tobacco and alcohol products among the Indian consumers. This has continued even in the current pandemic situation, where the governments had imposed lockdowns, curbing economic activities, which in turn, had an adverse effect on people's income levels. Products like tobacco and alcohol have proven to be addictive, with no decrease in current period consumption. This paper attempts to show the trend of the consumption of these products in comparison to their price levels as also with the different population groups.

Tobacco product prices and consumers' income are the two major economic determinants of tobacco demand. The affordability of tobacco products is dependent on the price of tobacco products relative to consumer income. Tobacco and alcohol products in India have been consumed at high rates by an estimated sixty five per cent of all men and thirty three per cent of all women consuming some form of tobacco and over seventeen per cent of the smokers of the world are from India (Shimkhada and Peabody, 2003).

In countries like India, public health spending is only 1.04% of GDP. Therefore, these financial pressures and the financial burden of combating tobacco related mortality and morbidity can have a significant impact on low and middle-income countries such as India. In 2011, the total economic cost of using tobacco by middle-aged people in India was about $ 22.4 billion. Direct medical costs for hospital care and treatment of tobacco related illnesses were $ 3.6 billion, and associated indirect morbidity costs were $ 3.1 billion.

Tobacco is deadly in any form either be smoking or smokeless; scientific evidences have proved that tobacco leads to disease, disability, and death. According to the International Agency for Research on Cancer (IARC) monograph, there is sufficient evidence in humans that tobacco smoking causes cancer of the lung; oral cavity; naso, oro, and hypopharynx, nasal cavity, and paranasal sinuses; larynx; oesophagus; stomach; pancreas; liver; kidney (body and pelvis); ureter; urinary bladder; uterine cervix; and bone marrow (myeloid leukemia). Colorectal cancer is seen to be associated with cigarette smoking, although there is insufficient evidence for it to be causal. Ninety percent of all lung cancer deaths in men and 80% in women are caused by smoking. Research has clearly indicated causal associations between active smoking and adverse reproductive outcomes, chronic obstructive pulmonary disease, and cardiovascular diseases. Studies on bidi smoking, the most common form of tobacco smoking in India, provide evidence toward causality of it as a carcinogenic substance. Case-control studies demonstrate a strong association of bidi smoking with cancers at various sites, such as oral cavity (including subsites), pharynx, larynx, oesophagus, lung, and stomach. This study showed a significant trend in the duration and amount of Vidis smoking, which causes all types of cancer. Second hand smoke has also been linked to tobacco-related diseases.

Estimates of household expenditure shares from the National Sample Survey (NSS) in India depict that consumption expenditure on addictive substances account for 4.4 per cent of total budget of a household who chooses to consume any of the addictive goods, in both rural and urban India. Households in India have found to be spending a huge amount of their income on tobacco and other addictive substances.

The link between smoking and poverty is well documented; however, tobacco control measures are applied consistently, without due regard for the high-risk target group. In India, nearly 300 million people live in extreme poverty.1 About 28.6% of the population uses tobacco.2Representative national surveys and community studies have shown that tobacco use among the poor is increasing. is continued. The cyclical relationship between tobacco use among the poor and exacerbation of poverty due to tobacco-related illnesses is also well documented. Health care costs involve not only direct medical costs, but also indirect costs of morbidity and mortality. a low and middle income country (LMIC). Public expenditure on health has steadily declined and public expenditure on health represents 1.15% of gross domestic product.4,5 treatment of tobacco-related diseases. In India, socio-economic and health inequalities are endemic. Tobacco-related diseases are a cause and a consequence of poverty. It is not only a social and cultural problem, it is also multifaceted and encompasses biomedical, economic and geopolitical aspects. The use of tobacco in India is expected to have devastating consequences.

Tobacco control policies have the opportunity to break this vicious circle. Tobacco control should be a top priority not only as a health problem, but also as a mechanism for poverty reduction. commitments to achieve the goals - Agenda 2030 for the development of sustainability Goal of poverty reduction and good health. Despite all efforts, smoking is a major health problem in the world and in India a third of the population uses tobacco., and to conduct a targeted intervention, the tobacco epidemic must be assessed and policies government. The purpose of this article is to summarize the scientific knowledge available on smoking in India in order to assess the extent of the problem by examining the tobacco control legislation and its

micro and macro impact on tobacco control in India. The need for this comprehensive assessment is to develop a better understanding of tobacco: the pattern of consumption, the control policies and the gaps that need to be filled will serve as a benchmark for the development of pragmatic tobacco control.

Tobacco Consumption Trends

Around 29 percent of the Indian population, over the age of 18, consume tobacco. This has endangered their health to a great extent, even causing deaths due to the consumption of smoking tobacco or using smokeless tobacco, more for people in the age group of 35 and above.

Costs are estimated under three categories: (1) direct medical and nonmedical expenditures; (2) indirect morbidity costs; and (3) indirect mortality costs of premature deaths. Total economic costs attributable to tobacco use in India in 2017-18.

The total economic costs of tobacco use due to all diseases and deaths in India for persons 35 years and older in 2017–2018 are INR 1773.4 billion (US $27.5 billion), of which 22% is direct cost and 78% is indirect cost. Men bear 91% of the total costs.

Approximately 1.04% of India's GDP is consumed by tobacco use, while excise taxes from tobacco revenue represented only 12.2% of the economic cost. Direct medical expenditures alone represent 5.3% of the total health expenditure.

In the previous year, tobacco-related economic costs accounted for approximately 1.04% of India's GDP, while excise tax revenues from tobacco represented only 12.2% of its economic costs. The direct medical costs alone totalled 5.3% of total health expenditure.

In partnership with the WHO, the Ministry of Health and Family Welfare, Government of India, conducted a comprehensive study for the year 2011 on the economic costs of all tobacco-related diseases combined, as well as four major diseases separately.

For people aged 35–69, the total economic costs associated with tobacco use in 2021 were estimated to be around on the higher side of which a little (about 15%) was direct and 85% was indirect cost. found that economic cost was 1.16% of the GDP and 12% quite the combined state and central government expenditures on health in 2021. A study estimated the economic costs of bidi (hand-rolled tobacco) smoking in India and located that the entire economic costs of diseases and deaths due to bidi smoking among persons 30–69 were INR 805.5 billion or 0.5% of India's GDP in 2017.

Given the big public policy implications of economic burden estimates of tobacco use within the past, it's imperative to supply more up-to-date estimates as and when possible. With the discharge of latest GATS data in 2018 by the Ministry of Health and Family Welfare also because the new nationally representative health expenditure data and periodic labour pool surveys in 2019, by the National Statistical Office, this paper updates the economic cost estimates of tobacco use for the year 2017–2018. A comprehensive study of economic costs from all tobacco-related diseases combined, also as for four major diseases separately, was undertaken for the year 2021 by the Ministry of Health and Family Welfare, Government of India, together with the WHO.15 It estimated the entire economic costs due to tobacco use from all diseases and deaths within the year 2011 for persons aged 35–69 to be INR 1044.8 billion (US $16.18 billion, using 2017–2018 rate of exchange of 1 US $ = 64.56 INR), of which 16% was direct cost and 84% was indirect cost. The study found that economic cost was 1.16% of the GDP and 12% quite the combined state and central government expenditures on health in 2011–2012. A newer study16 estimated the economic costs of bidi (hand-rolled tobacco) smoking in India and located that the entire economic costs of diseases and deaths due

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Direct Costs

Approximately 45.7% and 35.3% of inpatient hospitalization and 32.5% and 26.2% of outpatient visits in rural and concrete areas, respectively, were serviced by public sector providers consistent with the National Sample Survey data. The ailment-specific average expenditure for every of the ailments from private providers was computed and imputed to those receiving treatment from public providers. this is often because the general public health care services are subsidized by the state and, as result, several expenses aren't adequately reflected in expenditures incurred by patients seeking treatment from public service providers. Before such imputation was made, however, the private expenditure data itself was adjusted using the expenditures of only private health care seekers who made payments fully out of pocket. Sampling weights were used while estimating average expenditures. Pregnancy-related expenditures incurred, if any, weren't counted while estimating the typical healthcare expenditures.

Majority of the people in India, in the rural earned a lot less, as less as INR 11000. They do not possess many household luxuries like refrigerator of mixer. But spend about INR 2000 on tobacco. They have also been spending on healthcare.

Direct Medical Costs

Direct medical expenditures from inpatient hospitalization and outpatient visits include expenditures on medicine, doctor's fees, bed charges, attendant charges, medical appliances, diagnostic tests, and patient transportation, which incorporates only the value of ambulance for transporting patients. The other costs of transportation are included under direct nonmedical expenditures.

Direct nonmedical expenditures include (1) expenditures incurred for transportation aside from ambulance and (2) lodging charges of caregivers during inpatient hospitalization and outpatient visits.

Tobacco use-attributable indirect morbidity costs also is responsible for the loss of household income from work that gives rise to inpatient hospitalization or outpatient visits.

The total economic costs causing tobacco use from all diseases in India. per adult annually. Premature mortality alone accounted 75% of the entire economic costs.

As per CMIE data on Household expenditure, Income and Aspirations of the lower income groups (2021), he lower income groups had not much aspirations like buying a house or any other household assets, it was seen that they earning just enough to make their ends meet. Also, health care expenditure cost them a lot, which could significantly be due to their living conditions and their tobacco consumption. Most of them, spent a significant amount of their earnings on the tobacco, which not only cost them directly, but they also had to incur a lot of indirect cost, due to this. This was more prevalent in a male dominated household in India.

REVIEW OF LITERATURE

Estimates of price elasticities and income effects for various tobacco products are hardly available in India. Estimates of National Council of Applied Economic Research (NCAER) the income effect of cigarettes consumption to be −0.56 for the sample period 1981-82 to 1992-93 (Sarma, 2000). Cigarettes smokers alone, in India account for only a fifteen per cent of the total tobacco users. There are no national level studies in India that estimates the price responsiveness, cross price elasticities and income effect of various tobacco products, to the best of our knowledge.

Tobacco consumption among the poor is continuing and questions the penetration of tobacco control policies. Beedis, the cheapest indigenous smoking tobacco, are common among the scheduled caste and uneducated rural adults.

Using NSS data Musgrave and Stern (1988) have estimated the arrack (country liquor) price elasticities in the range of −0.47 and −0.62 in a south Indian state of Karnataka and the income level has not had a significant effect on their alcohol intake. A recent study by Mahal (2000) showed that own price elasticity of demand for alcohol participation is −0.50 for people aged twenty five years and above and −1.00 among those aged between 15 and 25 years. This study used data collected by NCAER, in a survey in the year 1994 among the rural households of fifteen major Indian states. The main reason for the dearth of estimates of income effect and price elasticities for India is the lack of sufficient data on income, prices and quantity consumed for various tobacco products. While the surveys of the National Sample Survey Organization (NSSO) provide cross-sectional information on household's expenditure and quantity consumed of various tobacco products, they don't provide information on prices.

In a study conducted by Lend (2015), in Norway, the proportion when it came to low income level was 12.2% in the study sample and 7.2% in the population sample. One out of every four current smokers talked about having high a high degree of cigarette consumption and having no intention to stop, while one out of three reported being highly dependent on cigarettes. Social inequality in terms of smoking was established. Both the bivariate and the adjusted models show educational differences, with RRR of 5.37, 95% confidence interval [4.26–6.77] for current compared with those who have never smoked/ plan on never smoking in the low educational level. The bivariate model shows a significant association between current smoking and income. In the adjusted model, the RRR for current smoking was 1.53, 95% confidence interval [1.14–2.06] in the lowest compared with the highest income group.

Nargis et al (2019) states that smoking tobacco seems to be more popular in the population encompassing people with lower socioeconomic status(SES) in countries with high income rates which can be fuelled by the disparities in initiation and cessation of smoking. Smoking is a leading benefactor to socio-economic problems in health. Till date, the evidence for any socio-economic disparity in smoking cessation is lacking, notably so in low- and middle-income countries (LMICs). This study examines the association between cessation behaviours and SES of smokers from eight different LMICs.

Corsi and Subramanian in 2014 assessed socioeconomic inequalities in smoking conduct amongst men in India and said that folks who had been wealthier, greater knowledgeable, and having a first rate task had been greater vulnerable to cigarette smoking, and on the alternative side, folks who are much less knowledgeable with terrible socioeconomic popularity had a dependency of bidi smoking. This uncommon variant in socioeconomic gradients in intake of smoking conduct said the various men increase critical difficulty and interest to address this problem. Also, an extra difficulty this is disregarded in lots of research is developing occurrence of twin tobacco intake the various populace and forming a tobacco cease strategy.

RESEARCH METHODOLOGY

The study is a blend of qualitative and quantitative analysis based on time series secondary data culled from authentic published sources.

Period: 2000-2020 (2021—estimated)

Data Source: The study used secondary data gathered from various published sources, like journals, reports, policy briefs and news media.

The data so collected was analysed using statistical software. The tools of analyses used were

For describing the data, various graphical and tabular presentations

For inferring, inferential tools like correlation was used.

OBJECTIVE OF THE STUDY

The study aimed at examining the

1. consumer spending on tobacco and alcohol products since 2000
2. To examine the relation between Price Level Index and Tobacco Consumption

RESULTS AND DISCUSSION

Figure 1: Trend in Number of households and Consumer Price Indices

Source:

The graph (figure1) above shows the trend in number of households in India, Consumer Price Index, Consumer Price Index of Alcohol and tobacco products. From the graph, it can be said that with the increase in the number of households in the last twenty years, there has been an increase in the overall consumer price index and Consumer Price Index of Alcohol and tobacco, though by a lesser extent, while the price level index is almost flat, indicating an increase to a lesser extent.

Table 1: Consumer spending and population growth - correlation analysis

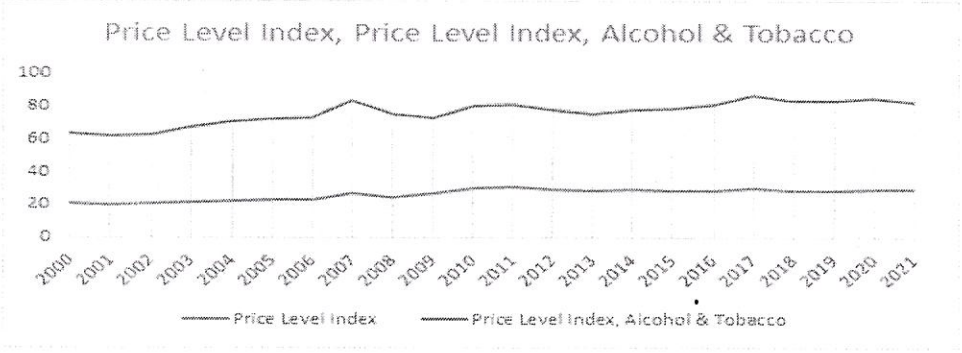
Consumer Spending, (per Capita) in USD (US$)	Total population	Population, 0-14 Years in millions	Population, 15-54 Years in millions	Population, 55+ Years in millions
Alcohol & Tobacco products	.981**	-.985**	.977**	.987**
Total Consumer Spending	.975**	-.978**	.971**	.981**
Consumer Price Index	.996**	-.998**	.995**	.998**

**. Correlation is significant at the 0.01 level (2-tailed).

The above table 1 shows co-efficient of correlation. There is almost a perfect positive correlation between the total consumer spending, consumer spending on alcohol and tobacco products and Consumer Price Index, among total population, population in the age group of 15-54 years and population who are above 55 years of age.

There is a perfect negative between the population in the age group of 0-14 years and the total consumer spending, consumer spending on alcohol and tobacco products and consumer price index. While with respect to the population in the age groups of 15-54 years and those above 55 years, their spending on tobacco and tobacco related products increase.

Figure 2: Price Level Index, Price Level Index for Alcohol & Tobacco



The above graph, shows the price level index movement and price level. A wide gap can be seen between the movement of overall price level index and the price level index of alcohol and tobacco products. According to John (2006) about sixty five per cent of the rural households and forty nine per cent of the urban households have been consuming tobacco or other addictive substances (at least one of them) constantly, while over ninety five per cent consume bidis, cigarettes, or any other in different forms. The rural lot also consumes a lot of locally manufactured liquor, while the urban lot consumes international brands of the same. In all, whatever be the price level index, or price level index of Alcohol, tobacco products, consumption goes up as the population of a certain age group is increasing.

Table 2: Correlation analysis of overall price level index, price level indices of alcohol and tobacco products and alcoholic beverages

Factors	**Total population**	**Population, 0-14 Years in millions**	**Population, 15-54 Years in millions**	**Population, 55+ Years in millions**
Price Level Index	-.401	.404	-.391	-.419
Alcohol & Tobacco	.269	-.243	.285	.231
Alcoholic Beverages	.014	.010	.029	-.023

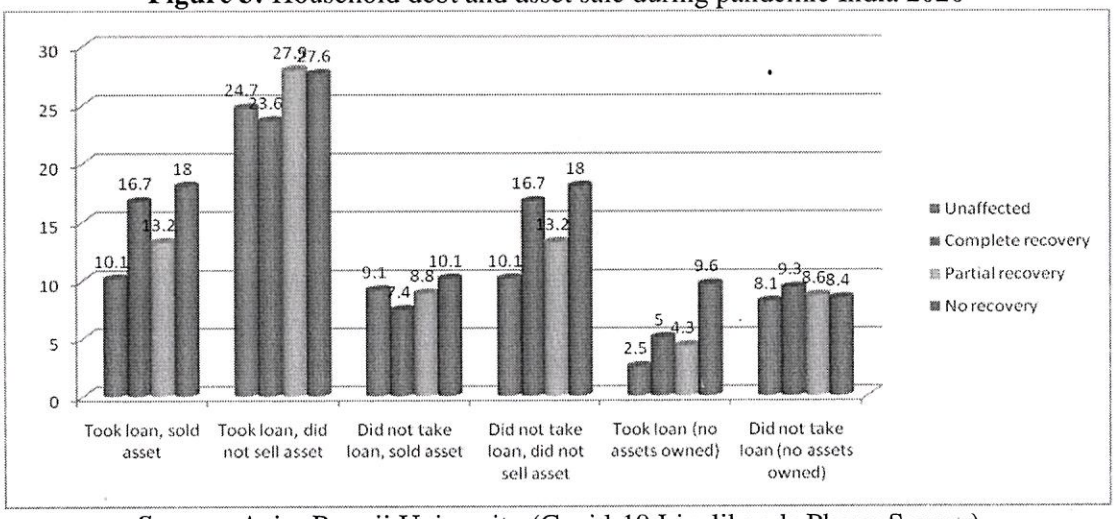
*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

The above table 2 shows the correlation of overall price level index, price level indices of alcohol and tobacco products and alcoholic beverages. The co-efficients of correlation, so established among the variable are not statistically significant both at 5% and 1% level. Hence whatever, be the overall price level index, price level indices of alcohol and tobacco and alcoholic beverages do not show statistical significance as these are addictive products.

The findings of the current study are also in line with Mahal's studies. Further it can be inferred that consumer spending on addictive products like tobacco and alcohol is not responsive to their price levels, in contradiction to the Becker-Murphy(1988) Model which proves the responsiveness of addictive substances to price.

Figure 3: Household debt and asset sale during pandemic India 2020



Source: Azim Premji University (Covid-19 Livelihoods Phone Survey)

Figure 3 According to a 2020 survey in India, 18% of households that did not recover due to reduced food intake during the pandemic had to take out a loan to sell their wealth. Almost 10 percent of households with no wealth and food consumption did not recover and had to take out a loan. Thus, the figures show an inverse relationship between the recovery of food intake and the potential for borrowing or selling among Indian households since the blockade.

Health care costs associated with tobacco use place a heavy burden on the annual health budget, especially in developing countries such as India . The cost of cigarette consumption is related to the cost of consumption itself, personal costs such as adverse health effects and medical costs, and the social cost of cigarettes, such as costs associated with loss of productivity and damage to the environment. . ... In 2002-2003, India received approximately Rs. 300 billion ($6.2 billion) public and private spending on tobacco treatment. Another study found that the direct cost of treating four non-communicable tobacco diseases was Rs. 54 billion (US$1.2 billion) in 2004, or 4.7% of India's national health spending this year. This estimate has been raised to Rs. Rs 104,500 in 2011, of which 16% were related to direct costs and 84% to indirect costs. Direct medical costs related to tobacco disease amounted to Rs. 16,800 rupees, overhead 100,000 won Rs 14,700 and early death Rs. Rs 73,000 Men account for 91% of the total economic burden, while women bear the rest. The percentage of women who used smokeless cigarettes was higher (29%). The cost of treating various diseases related to tobacco use was 1 million won. The cost of treatment for tuberculosis and cancer is 230 billion won for cardiovascular disease (CVD) and 280 billion won for respiratory diseases. Rs 1,400. The overall economic burden varied among the states included in the study. Uttar Pradesh accounted for the highest estimated burden (28%), followed by West Bengal (13%) and Andhra Pradesh (12%). Together, the four states (West Bengal, Maharashtra, Andhra Pradesh and Uttar Pradesh) bear 60% of the burden

of cardiovascular disease. Tamil Nadu, Uttar Pradesh, and West Bengal shared 52% of the cancer burden. Uttar Pradesh and West Bengal accounted for 47% of respiratory diseases. 13% of the burden from tuberculosis occurred in Uttar Pradesh alone. This report compares estimated tobacco costs with several important macroeconomic indicators for India. Expected Rs. The economic cost of cigarettes was 104,500 rupees (US$22.4 billion), accounting for 1.16% of the gross domestic product (GDP). This is 12% more than government and central government health spending combined in 2011-2012. Total revenues from centralized excise taxes on all tobacco products combined in the same year accounted for only 17% of the economic cost of cigarettes. [8] Anti-smoking activities and their economic impacts Established under the National Tobacco Control Program, the National Tobacco Control Team is responsible for overall policy development, planning, monitoring and evaluation, and effective implementation of tobacco control laws. . National Tobacco Control Program Expenditure Government of India provided approximately $8 million (Rs 40 crore) for 2007-2008 tobacco control. Funds have been allocated to state and local programs that include stakeholder education, state and local public awareness campaigns, and monitoring and reporting on tobacco control laws. India's National Tobacco Control Program has invested Rs at the state level. The annual budget is 752,000 rupees. 100,000 as a training budget. Local donations amounted to KRW 10 billion. Annual budget 1348,000 rupees 80,000 as training budget. Taxation system of the tobacco industry The current tax system does not match consumption patterns. Tobacco taxes are already low and bid taxes are close to zero. According to a study on price elasticity in India, it is estimated that a 10% increase in cigarette prices leads to a decrease of 9.1% for Bidis and 2.6% for cigarettes . A 2010 study jointly conducted by the National Institute of Public Finance and Policy found that a 52.8% increase in the price of BDs could have a health impact that prevented premature deaths in 4.6 million smokers and Rs. $36.9 billion ($800 million) to the government. A 158% increase in cigarette prices could prevent an additional 1.8 million premature deaths among current smokers and generate rupees. $146.3 billion (or $3.1 billion). Strict compliance with all tobacco laws in your country may also increase sales. Smoking Cessation Clinic This clinic started operating in 13 centres across India on 31 May 2002, World No Tobacco Day. Since 2002, 34,741 cases have been reported in 18 TCCs in India. 92% were male and 8% were females .

In a study conducted by John (2021), et al; it was found that around 28.6 per cent of Indian adults consume tobacco which costs them their health and, at times, even their health, more specifically, to people who are aged over 35 years.

The tobacco industry contributes enormously to foreign exchange and excise taxes and provides ample employment opportunities, but at the cost of human life. A complete ban on tobacco production in India seems impossible. In this challenging economic environment, the focus should shift to reducing tobacco demand through effective tobacco control measures (law, services, education and primary care) and the rehabilitation of people in the tobacco industry (directly and indirectly). Alternative use of tobacco crops should become the standard for employment retention. Recent research has led to the use of tobacco seeds as a renewable energy source. Both scientists and administrators should evaluate these results to create a scenario in which an agent that symbolizes darkness as a whole can be used. It lights up every household in our country.

SUMMARY AND CONCLUSION

It can be seen that there has been an increase in the overall consumer price index in the last twenty years. It is also seen that the population in the age groups of 15-54 and over 55 years of age have continued to consume tobacco and alcohol products irrespective of the price levels.

Tobacco prevention and management guidelines in India have in large part centred on attention and conduct alternate campaigns, with a whole lot weaker implementation of greater powerful

populace stage interventions, consisting of taxation will increase and the banning of smoking in public places. Recent taxation on cigarettes and bidis turned into 38% and 9%, respectively, while in keeping with WHO, it must be around 70%. Although the brand new authorities in India have expanded tobacco prices, there's nevertheless an enormous distinction among the pricing of top rate and neighbourhood cigarettes, that is encouraging product substitution, and bidis stay subjected to very low taxation. Simulation of tobacco interventions has proven that 1 million myocardial infarctions and 0.6 million stroke deaths in India can be prevented over the subsequent decade, if taxation on cigarettes turned into expanded via way of means of 300%

Tobacco use adds to destitution; redirection of family spending from other essential requirements, for example, food and family needs is subbed by cost of tobacco utilization. Sickness brought about by tobacco prompts expanded cash based spending, and tobacco-related dismalness and mortality are high in the useful age gathering of 24 to 69 years. Mix of tobacco end programs with wellbeing and advancement favourable to grams can be useful in beating the obstructions in tobacco control and diminishing the tobacco-related weight. For pre-venting the overwhelming impact of tobacco, tobacco control policies should be totally carried out, and for better infiltration of approaches, culture-based procedures should be contrived.

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