Public Health England

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# Standing Committee on Health, Aged Care and Sport: Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia

## A note of errors concerning the UK in previous evidence submissions to the Committee

It has come to Public Health England's attention that there were a series of factual errors in evidence provided to the committee by others. We wish to correct some of those errors which refer to the UK.

a. **"***The rest of Europe is completely different [to the UK] in their approach to the regulation and treatment of e-cigarettes."*
This statement is not correct. E-cigarette (EC) regulation across the European Union (EU) is governed by the European Tobacco Products Directive (2014/40/EU) (TPD), which became applicable in EU countries on 20 May 2016. The Directive is binding on all Member States with relatively minor discretion on national implementation. All products must be notified to a common notification system, with a maximum nicotine concentration, leak proof/tamper proof containers, on-pack health warnings, quality standards for ingredients and the removal of products that do not comply. Print, broadcast and online advertising of EC is prohibited across the UK. Each Member State is required to nominate a "competent authority" to oversee the national notification process. In the UK this is our medicines regulator the Medicines and Healthcare products Regulatory Agency (MHRA).
**It would be more correct to record that "*The rest of Europe operates the same detailed approach to the regulation and treatment of e-cigarettes*".**

b. *"The UK, but especially England, has long taken a dominant, clinical approach toward tobacco control. By that I mean a dominance of dedicated clinics where individual smokers go along and see specialists and are given advice, but particularly pharmacological interventions… Australia and the US – indeed most countries – have tended to take what we call "population focused" approaches to smoking cessation and to tobacco control generally Public policy approaches, mass-reach approaches, big well-funded campaigns, price policy, advertising restrictions, smoke-free areas – that sort of thing. The UK was very slow to catch up with that."*
This statement conflicts with the evidence.

i. Since the Government's 1998 White Paper *Smoking Kills*, the UK has adopted a comprehensive tobacco control policy which includes the "six strands" advocated by the World Bank (similar to the MPOWER approach advocated by the World Health Organization (WHO)). This includes: stopping the promotion of tobacco; making tobacco less affordable; effective regulation of tobacco products; helping smokers to quit; reducing exposure to secondhand smoke; effective communications for tobacco control.
ii. The UK's work on smoking cessation is entirely in line with the WHO Framework Convention on Tobacco Control (FCTC) Article 4 Guidelines, which state that Parties should: "*identify the key, effective measures needed to promote tobacco cessation and incorporate tobacco dependence treatment into national tobacco control programmes and health-care systems*" and "*It is important to implement tobacco dependence treatment measures synergistically with other tobacco control measures*."
iii. A formal system for assessing compliance with comprehensive application of the FCTC exists in the form of the Joossens & Raw Tobacco Control Scale. The Association of European Cancer Leagues regularly produces a "league table" for comprehensive tobacco control, assessing performance on the full range of tobacco control measures and the UK has always been at the top of the table.

So while it is true to say that our policy includes treating tobacco addiction in line with the best clinical evidence, it is not correct to say that this approach is "dominant" in UK policy. It is also untrue to suggest that the UK was "very slow to catch on".

i. In 1962 the UK's Royal College of Physicians advocated the following measures: *"more education of the public; more effective restrictions on the sale of tobacco to children; wider restrictions in smoking in public places; an increase of tax; informing purchasers of the tar and nicotine content of the smoke of cigarettes; investigating the value of anti-smoking clinics to help those who find difficulty in giving up smoking"*. This appeared two years before the US Surgeon General's report.
ii. In 1970 the Health Education Council (HEC) engaged Saatchi and Saatchi to develop its anti-smoking campaigns. In 1973 the HEC's advertising budget was just over £700,000 (or Aus$14,400,000 in today's prices).
iii. Since 1993 smoking reduction has been a stated aim of UK tobacco tax.
iv. Our comprehensive advertising ban was passed in 2002 and our smokefree legislation was passed in 2006. For a short time the UK government was considering standard packaging at a time when the Australian Government had ruled it out.

**It would therefore be more correct to say *"The UK, but especially England, has long taken a lead in comprehensive tobacco control. By that we mean a balance of population and individual level approaches in line with the evidence base and best practice as recommended by WHO and the World Bank. The UK consistently scores highest in Europe on the independent Tobacco Control Scale. Smoking prevalence has fallen steadily over the past two decades and the rate of decline has accelerated in recent years".***

c. *"While it was not considered to be within the competence of the EU to ban electronic cigarettes completely (this being a matter reserved for members states, some of which have or are doing so)"*.
On the contrary, the effect of the TPD was to prohibit Member States from banning e-cigarettes or from requiring medicinal regulation. The effect of the TPD has been to reverse the ban on e-cigarettes in several EU Member States including Finland.

d. *"As a result, they [proponents of e-cigarettes for smoking cessation] have failed to persuade policy makers in any European country, except England. Even there, the arguments supporting these products have failed to convince the UK's Department of Health, which supports the WHO position."*
The Tobacco Control Plan for England published in July 2017 by the Department of Health clearly articulates the government's position on e-cigarettes, supporting their use in smoking cessation and charging Public Health England with a range of actions including repeating our updates on the evidence annually. The governments of Canada, New Zealand and the US have also recently signalled policy moves which will seek to maximise the opportunities from e-cigarettes while managing their risks.

e. "*If you flip that around, you are looking at something like a 95 per cent failure rate [for cessation supported by medicines]. There are not many drugs that doctors would prescribe with a 95 per cent failure rate*."
This relates to use of single nicotine replacement without behavioural support, which is indeed fairly ineffective. In the UK the advice is to provide expert behavioural support and, where necessary, a combination of pharmacotherapies. In England's smoking cessation services the most effective medicine, Varenicline, has a 65% four-week quit rate. Combining pharmacotherapy with behavioural support increases by 3 to 4 times a quitter's chance of success compared to willpower alone.

f. *"Questions are being raised* [about the paper by Nutt et al on the relative risk of e-cigarettes]*. It was a very, very large piece in the British Medical Journal—I think the Guardian also covered it—questioning that process. Basically people were asked to vote as to what they thought the level was, and the 95 per cent figure came out—not 94 per cent, not 90 per cent, not 97 but 95. Where that came from is nobody's guess, other than that process. The problem with that figure, of course, is that there is very little, if any, long-term data that informs that position."*
The BMJ report was not a peer reviewed study, it was a report in the news section. It has been cited as suggesting that either the authors of the paper or indeed PHE were paid by the tobacco industry. Although the BMJ stopped short of making that allegation it was reported as doing so, including by The Observer and the Canadian Broadcasting Company. The claim is false. Correction and/or a retraction have been received where the claim has been made including from The Observer, The Times and CBC.

Specifically the claim "95 per cent figure came out—not 94 per cent, not 90 per cent, not 97 but 95" is incorrect. What the PHE's 2015 independent evidence review actually says is (emphasis added):

i. *"best estimates show e-cigarettes are 95% less harmful to your health"*
ii. *"There has been an overall shift towards the inaccurate perception of EC being as harmful as cigarettes over the last year in contrast to the current expert estimate that using EC is around 95% safer than smoking."*
iii. *"It has been previously estimated that EC are around 95% safer than smoking. This appears to remain a reasonable estimate."*
iv. *"There is a need to publicise the current best estimate that using EC is around 95% safer than smoking."*

The basis for the 95% estimate of relative risk contained in PHE's evidence review is set out in an accompanying Authors' Note. The note makes clear that the estimate is based on the authors' assessment of the international peer-reviewed evidence relating to the safety of e-cigarettes.

g. *"The latest study from the UK on electronic cigarettes showed that they increased cigarette smoking in UK adolescents. This was a 12-month prospective study, the first prospective study to come out of the UK, published last month, into tobacco control. It concluded that every use of cigarettes was robustly associated with initiation, but much more modestly related to escalation of cigarette use".*
This statement would appear to refer to Conner, Mark, et al. *"Do electronic cigarettes increase cigarette smoking in UK adolescents? Evidence from a 12-month prospective study."* Tobacco Control (2017): tobaccocontrol-2016. At the time the evidence was given, "the latest study from the UK on electronic cigarettes" and youth comprising five national surveys and 60,000 subjects in fact found *"prevalence of regular use did not change remaining at 1%. In summary, surveys across the UK show a consistent pattern: most e-cigarette experimentation does not turn into regular use, and levels of regular use in young people who have never smoked remain very low."* Bauld, Linda, et al. *"Young People's Use of E-Cigarettes across the United Kingdom: Findings from Five Surveys 2015–2017." International Journal of Environmental Research and Public Health 14.9 (2017): 973.*

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