

Feedback on draft National Tobacco Strategy 2022-2030

Dr Colin Mendelsohn MB BS (Hons)

15 March 2022

Table of Contents

Executive summary	2
About me	3
Disclosure	3
PART ONE: SMOKING TARGETS	4
Low smoking target set for 2025	4
PART TWO: TOBACCO HARM REDUCTION	5
Support from Australian medical Colleges	5
THR accelerates the decline in smoking rates	5
Vaping nicotine	5
Heated tobacco products (HTPs)	6
Swedish snus	6
The precautionary principle	7
Framework Convention on Tobacco Control (FCTC)	7
Concerns about vaping are exaggerated	8
1 ‘The direct harms e-cigarettes pose to human health’	8
2 ‘Exposure to nicotine during adolescence may result in damaging and long lasting impacts on brain development’	9
3 ‘Impacts on smoking initiation’	9
4 ‘Impacts on cessation’	11
5 ‘Uptake among youth’	12
6 ‘Dual use with conventional tobacco products’	13
Social justice	13
Regulation	13
The tobacco industry	14
PART THREE. OTHER ISSUES	14
Raising the minimum age of sale	14
Reduce the number of retail outlets selling tobacco	14
PBS listing for combination NRT	15
Mass media campaigns	15
Stop smoking services	15
Affordability	15
References	16

Executive summary

- Australia failed to reach the target of 10% adult daily smoking set for 2018 in the National Tobacco Strategy 2012-2018 by a wide margin
- Based on the slow downward trajectory of smoking prevalence and the strategies proposed in the draft strategy 2022-30, it is highly unlikely that Australia will reach the 'new' target of <10% daily adult smoking by 2025
- Further effective and innovative strategies are urgently needed to achieve targets and reduce inequalities
- The main failing of the draft strategy is the omission of tobacco harm reduction (THR). THR is an important complementary strategy for smokers who are unable or unwilling to quit smoking.
- Vaping nicotine in particular is far safer than smoking and is the most effective quitting aid currently available.
- Other effective safer nicotine alternatives such as heated tobacco, Swedish snus and tobacco free nicotine pouches are of proven effectiveness and should be made available for purchase in Australia by adult smokers.
- THR is leading to accelerated declines in smoking rates in other western countries and modelling indicates it will lead to substantial improvements in public health.
- THR is supported by all other western democracies, is mandated in the FCTC and is endorsed by the RANZCP and RACGP.
- The concerns listed about THR are exaggerated and not evidence-based.
- Under the current regulations, it is far easier to buy deadly cigarettes than risk-reduced alternatives.
- Risk-proportionate regulation should be introduced for safer nicotine products, restricting access to young people and facilitating access to for adult smokers who are unable to quit on their own or with current treatments. Nicotine liquid for vaping should be available as an adult consumer product as it is in all other western democracies
- Another reason for the failure to reach smoking targets was the failure to enact strategies proposed in the National Tobacco Strategy 2012-18 such as mass media campaigns, increased stop smoking services and training of health professionals in smoking cessation.
- Given the high mortality and morbidity of smoking, the other proposals listed in the draft strategy should be introduced as a matter of urgency.
- Further strategies to reduce smoking rates are to raise the minimum age of sale of tobacco products to age 21, substantially reduce the number of retail outlets selling tobacco and PBS listing for combination NRT

Thank you for the opportunity to comment on the draft National Tobacco Strategy 2022-30.

The draft National Tobacco Strategy 2022-30 is an important policy framework which will benefit public health if fully enacted. However, there are three caveats:

Firstly, the smoking target is inadequate. Additional innovative and effective strategies are needed to achieve substantial reductions as soon as possible (see Part 1).

Secondly, it omits a role for tobacco harm reduction (THR), a key, evidence-based strategy for the many smokers who are unable or unwilling to quit on their own or with conventional treatments (see Part 2). THR is essential if Australia is to have any realistic chance of reaching even the low target set.

Thirdly, the draft strategy will only be effective to the extent that the key recommendations are enacted. Many priorities in the National Tobacco Strategy 2012-18 were not funded or implemented and this has resulted in poor outcomes over that period compared to many other western countries (see Part 3).

About me

I am an Australian medical practitioner who has worked in the field of smoking cessation, tobacco control and tobacco harm reduction for over 35 years. I am involved in clinical practice, teaching, research and education.

I am a member of the Smoking Cessation Guideline Expert Advisory Group that develops the [RACGP Australian national smoking cessation guidelines](#).

I was the Founding Chairman of the [Australian Tobacco Harm Reduction Association](#), a registered health promotion charity dedicated to raising awareness of low-risk nicotine products as a substitute for smoking for smokers who can't quit. I have stepped down from the organisation in January 2020.

I was a Conjoint Associate Professor in the School of Public Health and Community Medicine at the University of New South Wales from 2016-20.

I was a past Vice President of the Australian Association of Smoking Cessation Professionals, Australia's peak body for experts in the field of smoking cessation.

I have served on the NSW Health Advisory Committee on Electronic Cigarettes, and I am currently on the Vaping Cessation Expert Panel for the Canadian [Centre for Addiction and Mental Health \(CAMH\)](#), commissioned by Ontario's Ministry of Health. I am also on the Expert Advisory Group for the [Coalition of Asia Pacific Tobacco Harm Reduction Association \(CAPHRA\)](#).

I am currently an investigator on an NHMRC-funded clinical trial on vaping at the National Drug and Alcohol Centre, University of New South Wales, Sydney: [Adding an electronic-cigarette to standard behavioural treatment for low-socioeconomic status smokers: A randomised trial](#)

Disclosure

I have no financial or commercial relationship with any electronic cigarette or tobacco company. I have recently published an independent book on vaping called [Stop Smoking Start Vaping](#).

I was the Founding Chairman of the [Australian Tobacco Harm Reduction Association](#) (ATHRA) charity from 2017-January 2021. The charity accepted unconditional donations from the retail vape sector for the initial legal and website costs of establishing the charity. These donations ceased in March 2020. ATHRA has never accepted donations from tobacco companies or their subsidiaries

PART ONE: SMOKING TARGETS

Progress with smoking cessation in Australia has been slow since 2013. Australia has been outperformed by other comparable western countries such as the UK, US and New Zealand (see pages 5-6).

In 2012, a target of 10% adult (18+) daily smoking was set for 2018 in the National Tobacco Strategy 2012-2018 but was missed by a wide margin. [1] In 2017-18 the adult daily smoking rate was 13.8%. [2]

The target of halving the Indigenous daily smoking rate was also not achieved. In 2018-19, 40% of Indigenous adults were still smoking daily and the gap between Indigenous and non-Indigenous smoking rates had not decreased in spite of the Tackling Indigenous Smoking Program. [3]

More aggressive and innovative strategies are urgently needed to accelerate the decline in smoking and to reduce inequalities.

Low smoking target set for 2025

The draft strategy lacks a sense of urgency. It recognises tobacco smoking as Australia's biggest preventable health problem yet sets a very modest goal of <10% adult daily smoking by 2025.

During the period of the National Tobacco Strategy 2012-2018, daily adult smoking fell from 16.3% to 13.8%, or by 0.4% per year. [2] To achieve the 10% target in 2015, a greater annual decline of 0.54% is needed. Based on the current trajectory and the traditional strategies outlined in the draft document it is highly unlikely that even this modest target will be reached.

In sharp contrast, New Zealand recently set a target of <5% daily adult smoking by 2025. [4] Importantly, this target includes all population groups including Maori and Pacifica groups.

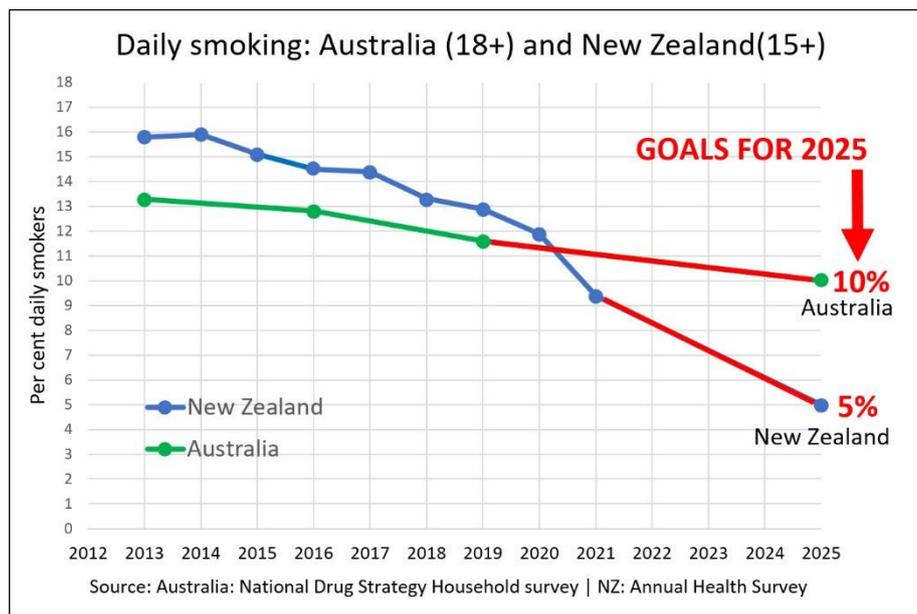


Figure 1. Daily smoking targets for 2025 Australia and New Zealand

Encouraging vaping nicotine is a key component of the New Zealand plan. The Ministry of Health in New Zealand promotes the use of vaping as a quitting aid for smokers and has established websites to support it at www.vapingfacts.health.nz and <https://www.quitstrong.nz/>. It also encourages stop-smoking services and health workers to support smokers in switching to vaping. Nicotine e-liquid is available as an adult consumer product from retail outlets in New Zealand.

New Zealand is also introducing a wide range of innovative strategies, including a special focus on disadvantaged groups, a 'smoke-free generation', increased stop smoking services, a dramatic reduction in retail outlets selling tobacco from 4,000 to 500 and lowering the nicotine content of cigarettes. [4]

PART TWO: TOBACCO HARM REDUCTION

The draft strategy rightly identifies the tobacco epidemic as a priority public health issue and Australia's leading preventable cause of death and illness. However, it dismisses tobacco harm reduction (THR) which is a key component of tobacco control in other western countries.

The document claims to be 'underpinned by a commitment to evidence-based policy' but ignores the substantial evidence supporting tobacco harm reduction. It aims to (p11) 'prevent the increasing uptake in the use of e-cigarettes and other novel and emerging products'. In doing so, it abandons the many Australian adult smokers who are unable or unwilling to quit smoking or nicotine.

The approach to THR is not consistent with Australia's National Drug Strategy, which recognises a legitimate and integral role for drug harm reduction strategies. [5]

Support from Australian medical Colleges

The draft strategy fails to acknowledge that the Royal Australian College of General Practitioners recognises a legitimate role for vaping nicotine as a second-line treatment for smokers who are otherwise unable to quit with other methods.

'For people who have tried to achieve smoking cessation with first-line therapy (combination of behavioural support and TGA-approved pharmacotherapy) but failed and are still motivated to quit smoking, NVPs [Nicotine Vaping Products] may be a reasonable intervention to recommend along with behavioural support.' [6]

The Royal Australian and New Zealand College of Psychiatrists also endorses vaping in its 2018 Position Statement

'The RANZCP acknowledges that e-cigarettes and vaporisers provide a less harmful way to deliver nicotine to people who smoke, thereby minimising the harm associated with smoking tobacco and reducing some of the health disparities experienced by people living with mental illness.' [7]

THR accelerates the decline in smoking rates

Unlike Australia, the decline in smoking rates has accelerated in countries where reduced-risk nicotine products are encouraged.

Vaping nicotine

England has the highest vaping rate of western countries. The adult smoking rate in England has fallen three times faster than in Australia since 2013 when vaping started becoming popular.

The annual rate of decline in smoking since 2013 has been 0.3% in Australia, 0.7% in England and 0.8% in the US. It is highly likely that high rates of vaping in those countries have been a major contributor to this rapid decline. [8, 9] (Figure 2)

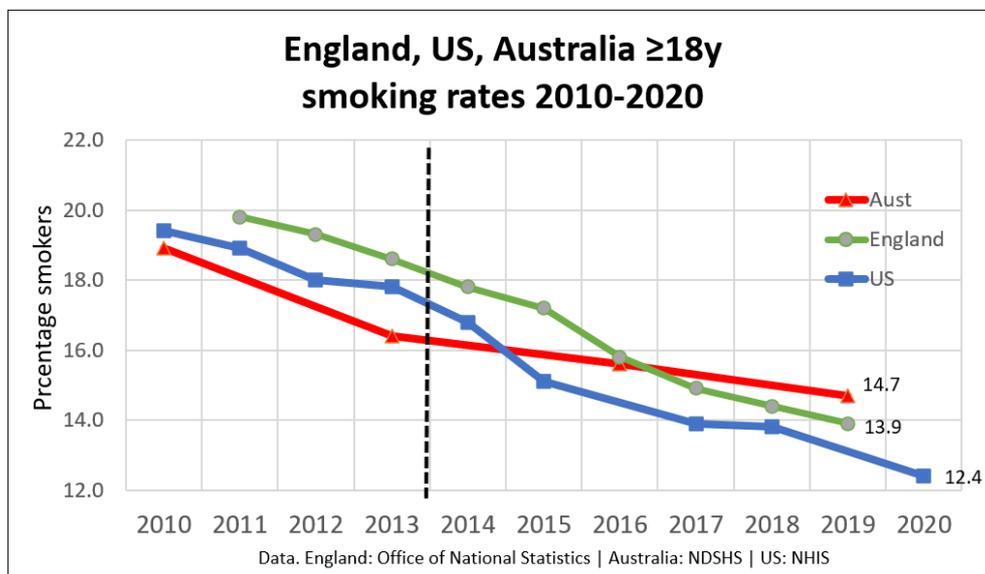


Figure 2. Decline in adult smoking in England, US, Australia

The benefit of vaping has been dramatically demonstrated in the recent New Zealand Health Survey. [10] The New Zealand Parliament passed legislation in August 2020 to regulate nicotine liquid as a consumer product, making vaping more freely available.

Over the last 12 months, there has been an unprecedented 20% decline in adult smoking in New Zealand (13.7 to 10.9%). [10]

This decline is likely to be almost entirely due to vaping as there have been no other significant tobacco policy changes during this time. In comparison, the adult smoking rate in Australia declined by 10% from 2013-2019 according to the National Drug Strategy Household Surveys (16.4% to 14.7%). (Figure 3)

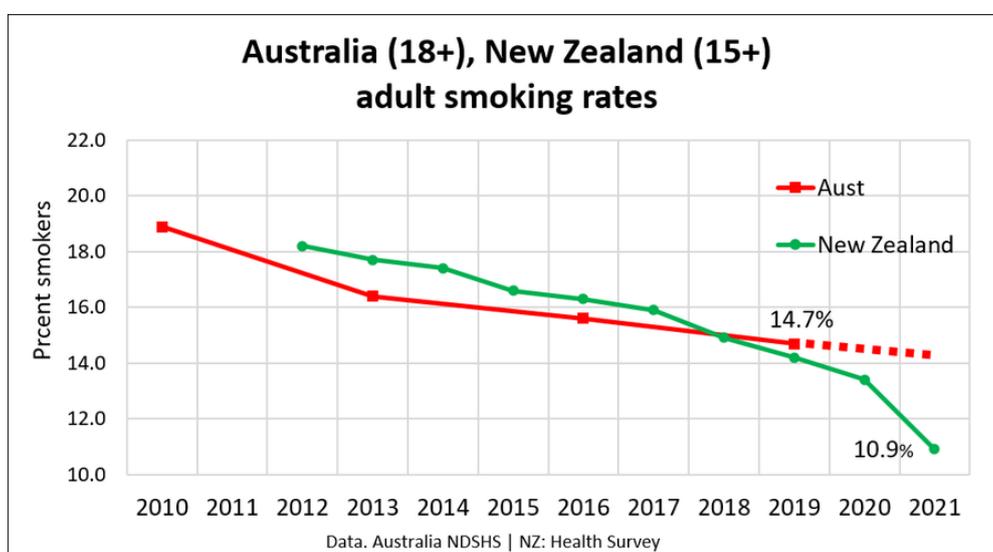


Figure 3. Decline in adult smoking in Australia and New Zealand

Heated tobacco products (HTPs)

Heated tobacco products are replacing combustible tobacco products in many countries and have resulted in substantial declines in smoking rates. In Japan alone, cigarette sales have fallen by an unprecedented 42.4% since 2015 prior to the introduction of HTPs. [11] HTPs are now 31.7% of the overall tobacco market in Japan.

Swedish snus

The widespread use of Swedish snus as a safer alternative to smoking in Sweden and Norway has led to dramatic falls in smoking rates and smoking-related mortality and disease. (Figure 4)

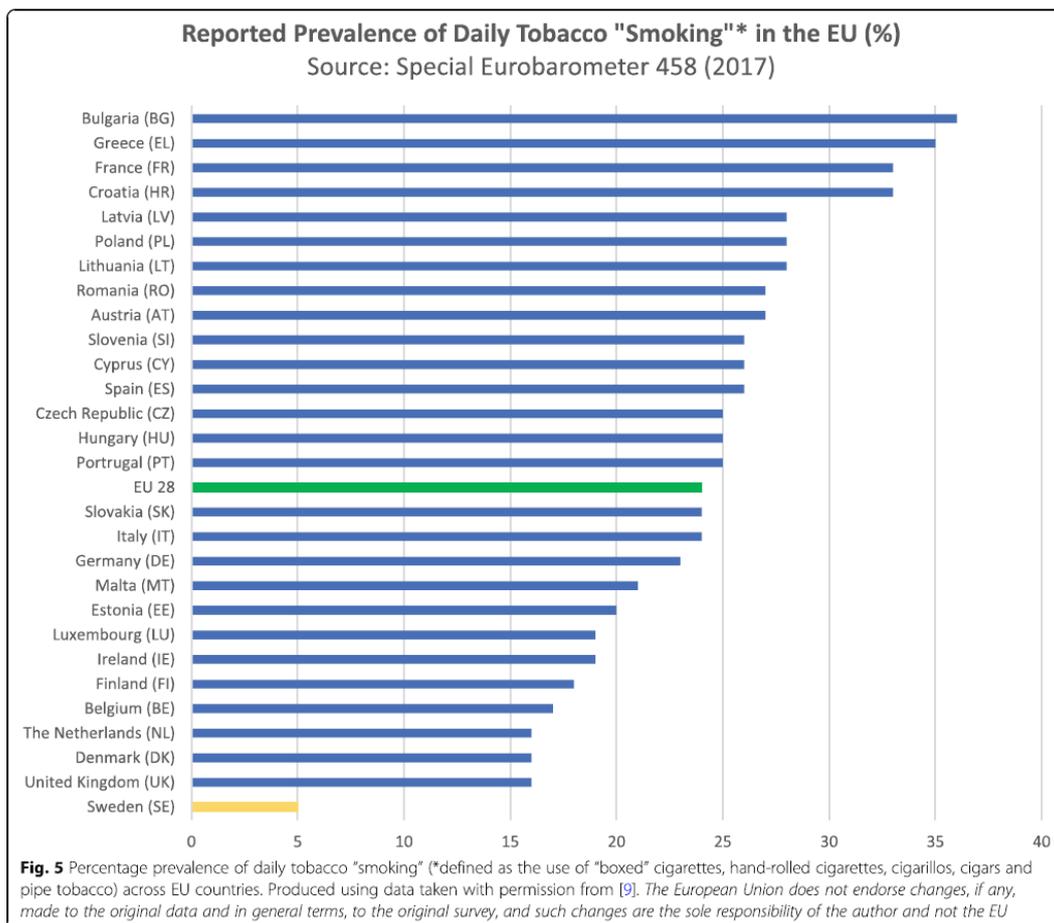


Figure 4. Daily smoking rates in EU countries in 2017

Swedish men have a daily smoking rate of 5%, the lowest in the EU and the lowest rate of tobacco-related mortality in the EU. [12] A review by Public Health England concluded that 'long-term use of nicotine as snus ... has not been found to increase the risk of serious health problems in adults.' [13]

Non-tobacco nicotine pouches are another effective tobacco harm reduction option that could assist some smokers. [14]

The Precautionary Principle

The Precautionary Principle (p25) is misused when applied to vaping.[15] Applying the Precautionary Principle requires weighing the risks of allowing vaping against the risks of not allowing it. Easier access to vaping has small and theoretical risks but the harm from overcautious regulation is much greater, as it denies many smokers the opportunity to quit or switch to a potentially life-saving product. Numerous modelling studies (with one exception) have concluded that the benefits of vaping are considerably greater than the costs. [16, 17]

Framework Convention on Tobacco Control (FCTC)

The draft strategy states (p3) 'This Strategy recognises Australia's obligations as a Party to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC)'.

However, as a signatory to the FCTC Australia is also **obligated** to support tobacco harm reduction. [18] The FCTC requires Australia to not only allow reduced-risk products but actively promote them. In the introduction, article 1(d) of the FCTC defines tobacco control as:

'a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke.'

The draft strategy also states (p12) ‘The Article 5.3 Guidelines recognise the fundamental and irreconcilable conflict between the tobacco industry’s interests and public health policy interests’.

However, this is no longer true. To the extent that the tobacco industry is transitioning to reduced-risk alternatives, its interests align with those of public health. As shown in Figure 5, the major international tobacco companies are steadily switching away from combustibles to lower-risk products and this transition should be encouraged. [19]

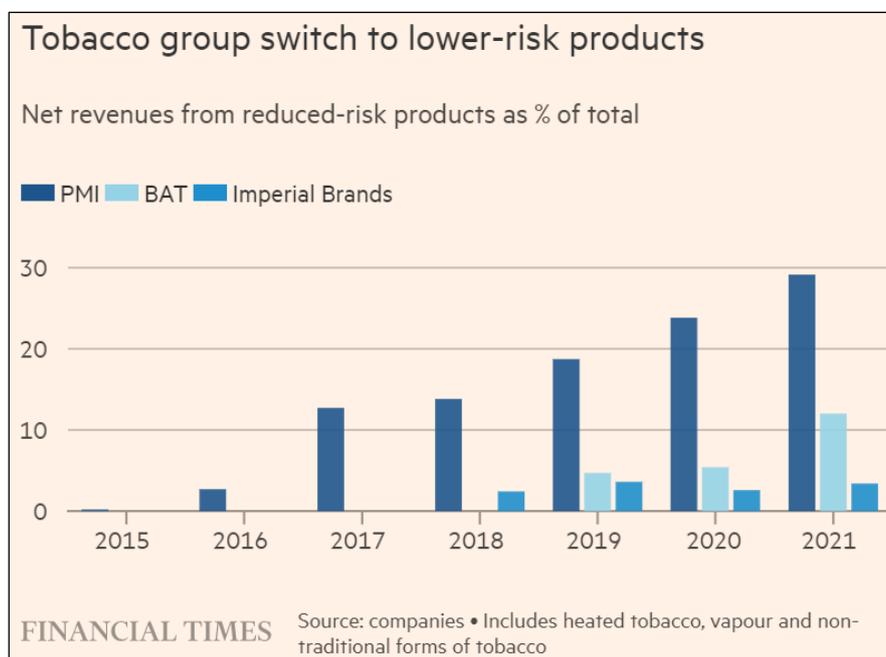


Figure 5. Tobacco companies are switching to lower-risk products

Concerns about vaping are exaggerated

The draft strategy lists the following issues as justification for the precautionary approach taken to vaping (p25). These concerns are exaggerated and do not reflect the latest empirical evidence.

1 ‘The direct harms e-cigarettes pose to human health’

Vaping nicotine is not risk-free but there is overwhelming scientific evidence that it is far less harmful than smoking tobacco. This is based on a substantial reduction in the number and doses of chemicals in vapour, reduced biomarkers of harm and clinical improvements after switching to vaping.

As regular vaping is almost exclusively used by smokers, any risk should be compared to the risk of continuing to smoke which kills prematurely up to 2 in 3 long-term users [20]

Comprehensive reviews by leading, independent health organisations agree that vaping is considerably less harmful than smoking.

Organisation	Statement
Royal College of Physicians, UK [21]	Vaping is at least 95% less risky than smoking
Public Health England [13]	Vaping is at least 95% less risky than smoking
NASEM (US) [22]	Vaping is ‘likely to be far less harmful ’ than smoking
NZ Ministry of Health [23]	Vaping is ‘not harmless, but it is much less harmful than smoking’
Health Canada [24]	‘Vaping is less harmful than smoking’

2 'Exposure to nicotine during adolescence may result in damaging and long lasting impacts on brain development'

There is no evidence so far that nicotine harms the human brain in adolescence. Concerns of harm to brain development from nicotine are based on rat and mouse studies. [26] However, laboratory tests often use unrealistic doses in an artificial setting and animals often respond differently to humans. Rodents are more sensitive to nicotine than humans. As one review concluded, animal tests generally 'fall far short of being able to predict human responses.' [27] However, further research is needed to identify any possible long-term effect.

If nicotine is harmful to adolescent brains, we would expect to see some 'epidemiological' evidence for this in the hundreds of millions of adults who smoked when young compared to never-smokers. However, no evidence has been found.

Nicotine patches and gum are approved in Australia from the age of twelve and can be purchased from supermarkets and petrol stations.

3 'Impacts on smoking initiation'

Adolescents

This 'diversion theory' has been demonstrated in an increasing number of international studies [28-31] and is consistent with the rapid decline in youth smoking rapid in the United States and United Kingdom since vaping became popular (see below).

Also, most teens who try vaping are already smokers. In 2017, two in three twelve-to-seventeen year-olds who had vaped in the last month had smoked first, according to the Australian Secondary Students' Alcohol and Drug Survey. [32] Surveys in other countries have found that over three in four smoking youth had smoked cigarettes before trying vaping. [33-35]

United States

Youth smoking in the US declined at an unprecedented rate, precisely when youth vaping rates escalated as seen in the CDC's annual National Youth Tobacco Survey. [36] The solid blue line in Figure 6 below shows that the fall in smoking in high schoolers (age 15-18y) accelerated after 2013 when vaping (red line) became popular. Only 1.9% of high schoolers smoked once or more in the last 30 days and <0.4% smoked every day. [37] This is consistent with vaping being a gateway **out of** smoking.

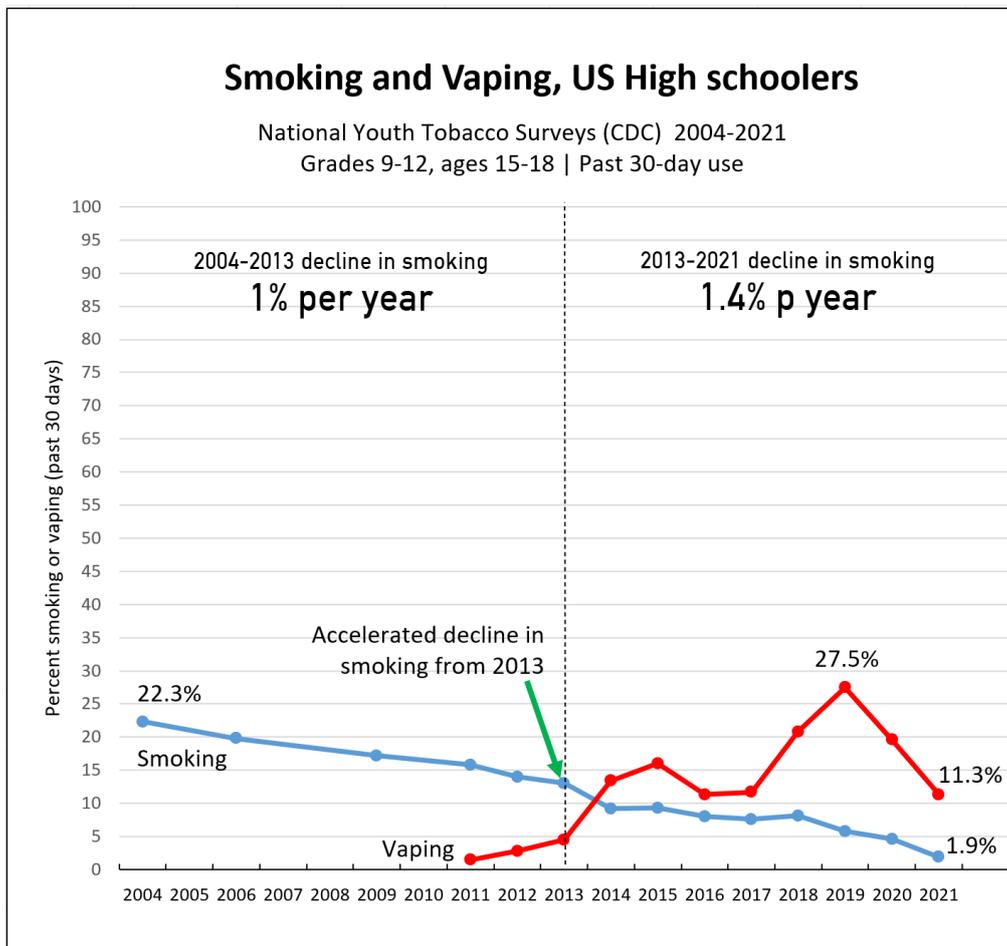


Figure 6. Accelerated decline in US youth smoking after vaping became popular

In 2021, 1.9% of high school students (ages 15-18 years) smoked once or more in the past 30 days. Only 0.3% of all US youth aged 12-15 years smoked (cigarettes and cigars) frequently (20+ days) in 2021. [36]

A study of US high school students found that those who tried vaping first (before smoking) were less likely to be smokers later than those who tried smoking first, suggesting that vaping may have diverted them from becoming smokers. [38]

England

A recent nationally representative study of over 37,000 16-24-year-olds in the UK from 2007-2018 (Smoking Toolkit Study) concluded:

“The increase in prevalence of e-cigarette use in England among the entire sample does not appear to have been associated with an increase in the uptake of smoking among young adults aged 16–24” [39]

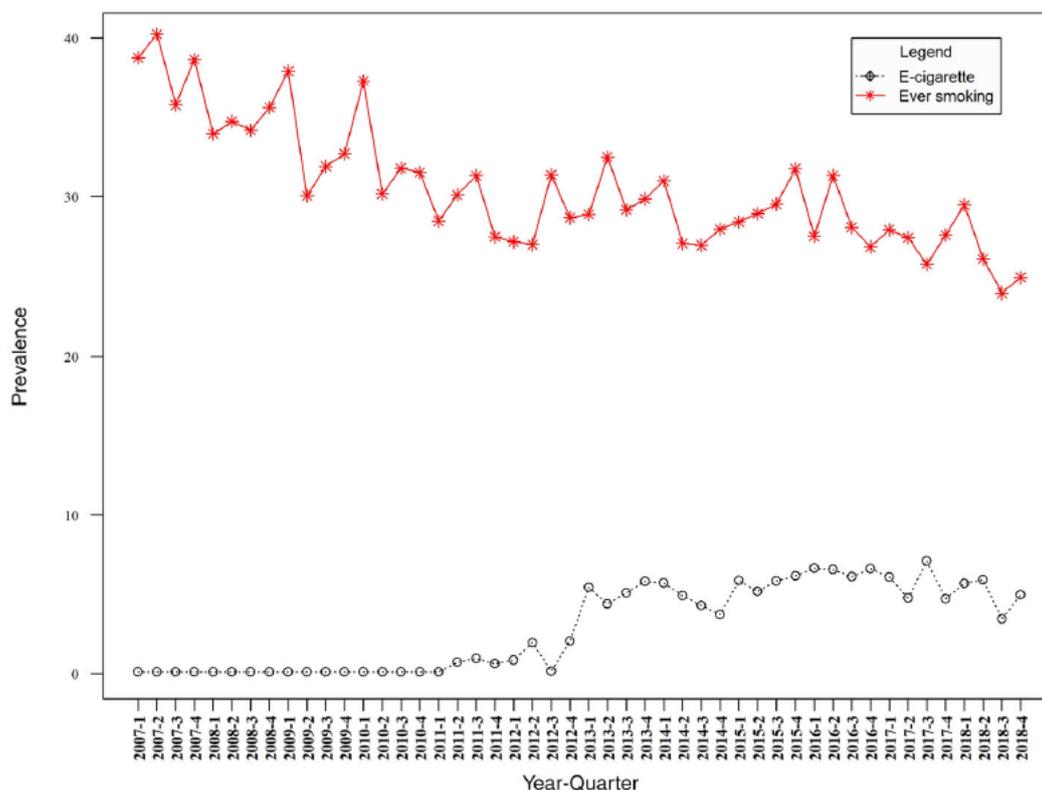


Figure 7. Prevalence of ever-regular smoking and e-cigarette use in 16-24 year-olds from 2007-2018 in England

Adults

Regular vaping is largely confined to smokers and ex-smokers and regular use by adults who have never smoked is rare.

In Australia in 2019, less than one in a hundred adult non-smokers vaped once or more in the previous twelve months. [40] In most cases, vaping by non-smokers is experimental and short-term, often does not involve nicotine and rarely becomes regular use.

According to the New Zealand Ministry of Health in 2020,

‘Despite some experimentation with vaping products among never smokers, vaping products are attracting very few people who have never smoked into regular vaping, including young people.’ [41]

Public Health England reported in 2021 that only 0.2-0.6% of adults in the UK who had never smoked were currently vaping. Never-smokers also vaped less frequently than current or former smokers and most (57%) tried vaping only once or twice. [42]

Other international surveys have found that vaping by adult non-smokers is generally less than half of one percent of the adult population, for example in the United States 0.3%; Germany 0.3%; Iceland 0.4%; and Greece 0.2%. In New Zealand there was no regular use reported by adult non-smokers and current daily vaping by never smokers in the European Union was 0.08%. (references available)

4 ‘Impacts on cessation’

Vaping is not a ‘silver bullet’, but there is growing evidence that it is an effective quitting aid and helps many smokers to quit.

The most recent Cochrane review (September 2021) concluded that vaping with nicotine liquid was 53% more effective than nicotine replacement (nicotine patch, gum, lozenge, spray or inhalator). [43] This means that out of 100 smokers, 6 will quit with NRT and 9-10 will quit with vaping nicotine.

Findings from randomised controlled trials are supported by the results of real-world studies

- Better quality observational studies [44, 45]

- Population studies [9, 38, 46]
- Trends in national smoking rates in countries where vaping nicotine is legal and accessible (see pages 5-6)
- Studies have found that restricting or banning vaping is associated with increased smoking [47-49]

Comparison to stop-smoking medicines

The evidence so far suggests that vaping nicotine is the single most effective quitting aid, more successful than all other smoking medications, including varenicline and bupropion.

A network meta-analysis of 171 RCTs was recently carried out by the prestigious UK National Institute for Health Research, funded by the UK Department of Health and Social Care. [50] It found that vaping nicotine produced the best quit rates of all single agents.

Large population impact

The draft strategy states, ‘novel products such as e-cigarettes have the potential to undermine population health and the significant achievements Australia has made in tobacco control to date.’ (7) **The current evidence suggests the opposite.**

The impact of a quitting aid at a population level depends on both its effectiveness and its reach (the number of people who use it). Vaping nicotine is an effective quitting method and is also the most popular quitting aid in Australia [40] and other western countries. Vaping is an appealing option and smokers want to use it. There are currently an estimated 81.9 million vapers globally. [51]

This combination gives vaping nicotine the potential to reduce smoking rates more than any other currently available option.

For example, Beard et al. estimated that 50,000 – 70,000 smokers quit smoking in 2017 alone as a consequence of using e-cigarettes during a quit attempt. [52]

Modelling / ‘simulation’ studies

Numerous modelling studies of the future risks and benefits of vaping have predicted that vaping will have an overall positive health benefit to the population. [16, 17, 53-55] This is because the benefits of quitting by adult smokers far outweigh any potential harms, such as their use by youth.

After taking the risks of vaping into account, one study projected that replacing most smoking with vaping in the US over a ten-year period would result in averting between 1.6-6.6 million premature deaths and between 20.8 – 86.7 million fewer life-years lost. [56]

As with any new product, it is possible that some harms may emerge over time. Continued monitoring is needed to detect any problems that may arise.

5 ‘Uptake among youth’

Official figures show that underage vaping is rare, and frequent youth vaping is very rare. Less than two per cent of Australian teenagers vaped once or more in 2019 and more than 90% had never tried vaping. [40]

Most teens who try vaping are already smokers. In 2017, two in three twelve to seventeen year-olds who had vaped in the last month had smoked first, according to the Australian Secondary Students’ Alcohol and Drug Survey. [32] Surveys in other countries have found that over three in four smoking youth had smoked cigarettes before trying vaping.

Importantly most use by young non-smokers is short-term and experimental and **frequent** vaping by is very rare. In 2017, only 0.3% of 12-17-year-old Australian non-smokers vaped on three or more days in the last month. [32]

Regular vaping by young non-smokers is also rare in other western countries, for example it is < 0.5% in the UK and the US.

Frequent vaping is mostly by teens who already smoke. [32] In many cases, vaping is used by Australian teens to help them quit smoking (34%), to cut down on smoking (24%), to help prevent relapse (19%) and as a safer alternative to smoking. [40] If young smokers switch to vaping, that can only be a good thing.

6 'Dual use with conventional tobacco products'

Dual use is a normal, temporary transition phase for most vapers and many go on to quitting smoking. [57, 58] Most studies show that dual users are also more likely to quit smoking than exclusive smokers, especially if they vape daily. [59]

Dual use rates decrease over time as smokers adapt to vaping. In Great Britain, the rate of dual use fell from 65% of vapers in 2014 to 30% in 2021 [60] and in the US from 57% in 2015 to 35% in 2019. [61]

Dual use is less harmful than exclusive smoking because most dual users significantly cut back their smoking. [62] Most studies show dual users have lower levels of biomarkers of harm compared to smokers [63] and many studies show improvements in health, such as reduced blood pressure [64] and improved asthma control. [65]

Social justice

Harsh restrictions on vaping nicotine cause the greatest harm to the most vulnerable members of society and increase health and financial inequalities, such as those on low incomes, people struggling with mental illness or alcohol and drug problems, people with disabilities, the LGBTIQ community, homeless people, Indigenous groups and prisoners. These groups have the highest smoking rates and low quit rates.

Smoking is the leading cause of health disparities between the poor and the rich. [66] Traditional tobacco control strategies have had less impact on disadvantaged smokers and health inequalities have increased over time. [67]

There is growing evidence that the uptake of vaping nicotine may be higher in disadvantaged groups. [68-71] The greater use of vaping in these populations could reduce health inequalities. [71] Disadvantaged populations 'have many stressors, few resources and a paucity of other rewards in their lives, thus making the transitory 'pleasures' of smoking and the challenges of nicotine withdrawal more salient. [72] For those for whom the 'loss of smoking' is too great, tobacco harm reduction approaches, such as switching to non-smoked nicotine products, should be considered.' [73]

Regulation

The draft strategy takes the view that 'A stronger focus on enforcing regulations pertaining to ... novel and emerging products is necessary to protect the health of all Australians' (p11). This view is flawed and counterproductive.

Given the large potential public health benefit as outlined earlier, access for adult smokers to high quality regulated reduced-risk products should be readily available with appropriate controls. Australia's regulations so far have focussed primarily on reducing youth vaping and have largely neglected the substantial opportunity to help adult smokers quit. Nicotine liquid should be available as an adult consumer product as it is in all other western democracies.

Access by young people should be restricted as is the case for other adult products, like cigarettes and alcohol. Strategies could include

- Strict age verification at the time of sale
- Sale only from retail outlets where reliable age verification is available
- Third party age verification by online retailers
- Age verification on delivery
- Restricted advertising to prevent appeal to adolescents
- Licensing of retail outlets with penalties and loss of licence for repeated breaches.

Regulation should be proportionate to risk so that more dangerous products (cigarettes) are controlled more strictly than less harmful ones (vaping nicotine)- the Principle of Proportionality. [74] Perversely, much safer nicotine vaping products are currently regulated more strictly than combustible tobacco products.

Strict controls on smoking are appropriate to reduce the substantial risks that cigarettes pose to public health. However, the risks from vaping nicotine are considerably less. Regulations on vaping should be relaxed to reflect the much lower risk to consumers and to improve access for adult smokers.

The tobacco industry

The draft strategy raises concerns that ‘tobacco industry has continued to invest in a range of novel and emerging products, including e-cigarettes’ (p7). It justifies restricting access to reduced-risk products as this will ‘reduce the profits of the industries that market them’. (p7) This is counterproductive and harmful to public health.

In the area of tobacco harm reduction, tobacco companies are mostly focussed on heated tobacco products, an alternative reduced-risk smokeless product, rather than vaping products.

It is unscientific to oppose a safer product just because it is associated with tobacco companies.

Although we can't trust the tobacco industry based on their past behaviour, our overriding priority should be to reduce the death and disease caused by tobacco use as quickly as possible. Safer alternatives to smoking will save lives, regardless of who makes them.

Tobacco companies should be encouraged to continue their transition away from combustible tobacco products as this will benefit public health (page 7).

Eighty percent of vaping products globally are made by non-tobacco companies. Reducing the profits of these companies will threaten an industry which makes a life-saving product and will harm public health.

PART THREE. OTHER ISSUES

Australian tobacco control has become complacent over the last decade and many elements of the National Tobacco Strategy have not been enacted. According to a recent review in Tobacco Control. [75]

‘New tobacco control policies in the last decade have been mainly limited to annual tax increases. To offset political complacency, investment is still needed in tobacco control including national mass media campaigns, whole of government, and targeted approaches to address inequities and bolder policy and legislative reform. Reaching the Draft National Preventive Health Strategy’s proposed target of less than 5% smoking prevalence by 2030 will require a range of measures such as those outlined in the draft strategy and those being considered in New Zealand’

Raising the minimum age of sale

There is now good evidence that raising the minimum legal age of purchasing tobacco products to 21 years significantly reduces smoking rates. This is now federal law in the US and is supported by experts in Australia. [76]

For example, in two studies in the US, ‘On average, exposure to local tobacco-21 laws was associated with a 1.2 percentage point drop in late-adolescent smoking, equivalent to about 10% of the smoking rate in this age group.’ [77]

An alternative approach is the ‘smokefree generation’ strategy being introduced in New Zealand. [4]

The priority in making this decision should be public health, not the commercial interests of tobacco retailers. However, retailers should be supported to find other revenue streams.

Reduce the number of retail outlets selling tobacco

Tobacco control has historically focused on demand-side measures, however further emphasis should be given to the supply of tobacco. [78] Australia has 20,000 retail outlets selling the deadliest consumer product ever invented. It is easy to buy cigarettes at all hours of the day and night in all parts of Australia.

Australia should follow the example set by New Zealand which recently announced a plan to drastically reduce retail tobacco outlets from 4,000 to 500. [4] Liquid nicotine is readily available from hundreds of retail outlets.

Some argue that we should set an end date for tobacco retailing. [78]

In contrast, liquid nicotine for vaping, the most popular and most effective quitting aid is not available for retail sale. This fails the commonsense test and is morally unjustified.

Nicotine vaping products should be at least as accessible as cigarettes, if no more so.

PBS listing for combination NRT

Combination nicotine replacement therapy (nicotine patch + an oral product such as lozenge or gum) is significantly more effective than a single agent. [79] Currently only one product at a time is subsidised by the Pharmaceutical Benefits Scheme.

PBS benefits should be extended to covering the nicotine patch and the gum or lozenge at the same time, so patients can get the optimum benefit from treatment. The additional cost of combination therapy is a barrier to the use of combination therapy and discourages its use, especially by low income and disadvantaged groups who have the highest smoking rates and low quit rates.

Mass media campaigns

Well-funded and sustained social marketing campaigns are evidence-based, cost-effective and increase quit attempts. Although endorsed in the National Tobacco Strategy 2012-18 (Priority Area 6.2), there has been minimal federal funding for these campaigns since 2012.

The draft strategy has again highlighted the importance of mass media campaigns. It is important that funding is allocated to mainstream and social media to deliver this vital strategy during the 2022-2030 campaign period.

Stop smoking services

A lack of smoking cessation services is a major weakness in Australia's stop smoking framework. This is in stark contrast with the network of smoking clinics available in other countries such as the UK and New Zealand. Clinics should be established in major hospitals and community health centres.

Funding should be provided to support and train front-line health professionals. Repeated research has shown a lack of confidence, knowledge and engagement in this area. [80, 81] A recent study of US physicians found very high rates of misinformation about nicotine and it is likely that similar misperceptions apply in Australia. [82]

The important role of health professionals was endorsed in the 2012-2018 NTS (Priority Area 6.9) but very little support and training has been provided. Australia would benefit from a dedicated organisation to coordinate and provide training for health professionals, like the UK National Centre for Smoking Cessation and Training [\[link\]](#).

In 2019, only 1.8% of smokers sought help from Quitline. [40] Better trained and promoted primary care professionals could help fill the gap.

Affordability

Taxes are an effective measure to reduce tobacco consumption. However, Australia has the highest tobacco prices in the world. [83] At the current levels, tobacco taxes no longer appear to be having a positive effect. The most vulnerable and disadvantaged groups who have high smoking rates and difficulty quitting, and high taxes are contributing to financial inequalities and stress. [84] Many addicted smokers are unable to quit no matter how high the taxes.

Excessively high tobacco taxes also have created a flourishing black market with importation of illicit tobacco and chop chop and locally grown tobacco.

Instead of further price rises, other pricing strategies such as wholesale price caps and licensing strategies should be considered. [85] The government also needs to reduce its reliance on tobacco excise tax.[78]

References

1. Intergovernmental Committee on Drugs. National Tobacco Strategy 2012-2018. Publications approval number: D1013 2012. Available at: <https://www.health.gov.au/resources/publications/national-tobacco-strategy-2012-2018>
2. Australian Bureau of Statistics. National Health Survey: First Results, 2017-18. Catalogue no 4364 0.55.001 2018. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Smoking~85>
3. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey, 2018-19 2019. Available at: <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4715.0>
4. New Zealand Government Ministry of Health. Smokefree Aotearoa 2025 Action Plan 2022. Available at: https://www.health.govt.nz/system/files/documents/publications/hp7801_-_smoke_free_action_plan_v15_web.pdf
5. Australian Government Department of Health. National Drug Strategy 2017-2026 2017. Available at: https://www.health.gov.au/sites/default/files/national-drug-strategy-2017-2026_1.pdf
6. Royal Australian College of General Practitioners. Supporting smoking cessation: A guide for health professionals 2021. Available at: <https://www.racgp.org.au/supporting-smoking-cessation>
7. The Royal Australian & New Zealand College of Psychiatrists. E-cigarettes and vaporisers. Position statement 97 2018. Available at: <https://www.ranzcp.org/News-policy/Policy-submissions-reports/Document-library/E-cigarettes-and-vaporisers>
8. Royal College of Physicians TAG. Smoking and health 2021: A coming of age for tobacco control? 2021. Available at: <https://www.rcplondon.ac.uk/projects/outputs/smoking-and-health-2021-coming-age-tobacco-control>
9. Zhu SH, Zhuang YL, Wong S, Cummins SE, Tedeschi GJ. E-cigarette use and associated changes in population smoking cessation: evidence from US current population surveys. *BMJ*. 2017;358:j3262.
10. Ministry of Health New Zealand. New Zealand Health Survey 2020/21 2022. Available at: <https://www.health.govt.nz/publication/annual-update-key-results-2020-21-new-zealand-health-survey>
11. Japan Tobacco International. JT Group 2021 Financial Results and 2022 Forecast 2022. Available at: <https://www.jti.com/jt-group-2021-financial-results-2022-forecast>
12. European Commission. Special Eurobarometer 458. Attitudes of Europeans towards tobacco and electronic cigarettes 2017. Available at: https://data.europa.eu/euodp/en/data/dataset/S2146_87_1_458_ENG
13. McNeill A, Brose LS, Calder R, Bauld L, Robson D. Evidence review of e-cigarettes and heated tobacco products 2018. A report commissioned by Public Health England. London: Public Health England 2018. Available at: <https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review>
14. Patwardhan S, Fagerström K. The New Nicotine Pouch Category: A Tobacco Harm Reduction Tool? *Nicotine Tob Res*. 2022;24(4):623-5.
15. Morphet K, Hall W, Gartner C. The misuse of the precautionary principle in justifying Australia's ban on the sale of nicotine vaping products. *Nicotine Tob Res*. 2020.
16. Mendez D, Warner KE. A magic bullet? The potential impact of e-cigarettes on the toll of cigarette smoking. *Nicotine Tob Res*. 2020.
17. Petrovic-van der Deen FS, Wilson N, Crothers A, Cleghorn CL, Gartner C, Blakely T. Potential Country-level Health and Cost Impacts of Legalizing Domestic Sale of Vaporized Nicotine Products. *Epidemiology*. 2019;30(3):396-404.
18. World Health Organisation. Framework Convention on Tobacco Control (FCTC) 2003. Available at: <http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf?ua=1>
19. Financial Times. Big Tobacco struggles to convince investors it can quit cigarettes 2022. Available at: <https://www.ft.com/content/710c32db-1b23-4a89-b17d-24115a5e69e8>
20. Banks E, Joshy G, Weber MF, Liu B, Grenfell R, Egger S, et al. Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence. *BMC Med*. 2015;13:38.
21. Royal College of Physicians. Nicotine without smoke: Tobacco harm reduction. London: RCP 2016 Available at: <https://www.rcplondon.ac.uk/projects/outputs/nicotine-without-smoke-tobacco-harm-reduction-0>

22. National Academies of Sciences Engineering and Medicine. Public health consequences of e-cigarettes. Washington, DC: The National Academies Press 2018. Available at: <http://nap.edu/24952>
23. New Zealand Ministry of Health. Vaping Facts 2020. Available at: <https://vapingfacts.health.nz>
24. Health Canada. Vaping and quitting smoking 2021. Available at: <https://www.canada.ca/en/health-canada/services/smoking-tobacco/vaping/smokers.html>
25. Committee on Toxicity of Chemicals in Food Consumer products and the Environment (COT). Statement on the potential toxicological risks from electronic nicotine (and non-nicotine) delivery systems (E(N)NDS – e-cigarettes) 2020. Available at: <https://cot.food.gov.uk/sites/default/files/2020-09/COT%20E%28N%29NDS%20statement%202020-04.pdf>
26. Yuan M, Cross SJ, Loughlin SE, Leslie FM. Nicotine and the adolescent brain. *J Physiol.* 2015;593(16):3397-412.
27. Shanks N, Greek R, Greek J. Are animal models predictive for humans? *Philos Ethics Humanit Med.* 2009;4:2.
28. Sun T, Lim CCW, Stjepanović D, Leung J, Connor JP, Gartner C, et al. Has increased youth e-cigarette use in the USA, between 2014 and 2020, changed conventional smoking behaviors, future intentions to smoke and perceived smoking harms? *Addict Behav.* 2021;123:107073.
29. Foxon F, Selya AS. Electronic cigarettes, nicotine use trends and use initiation ages among US adolescents from 1999 to 2018. *Addiction.* 2020.
30. Selya AS, Foxon F. Trends in electronic cigarette use and conventional smoking: quantifying a possible 'diversion' effect among US adolescents. *Addiction.* 2021.
31. Sokol NA, Feldman JM. High school seniors who used e-cigarettes may have otherwise been cigarette smokers: Evidence from Monitoring the Future (United States, 2009-2018). *Nicotine Tob Res.* 2021.
32. Guerin N, White V. ASSAD 2017 Statistics & Trends: Australian Secondary Students' Use of Tobacco, Alcohol, Over-the-counter Drugs, and Illicit Substances. Cancer Council Victoria. 2018. Available at: <https://www.health.gov.au/resources/publications/secondary-school-students-use-of-tobacco-alcohol-and-other-drugs-in-2017>
33. Berry KM, Reynolds LM, Collins JM, Siegel MB, Fetterman JL, Hamburg NM, et al. E-cigarette initiation and associated changes in smoking cessation and reduction: the Population Assessment of Tobacco and Health Study, 2013-2015. *Tob Control.* 2018;28(1):42-9.
34. de Lacy E, Fletcher A, Hewitt G, Murphy S, Moore G. Cross-sectional study examining the prevalence, correlates and sequencing of electronic cigarette and tobacco use among 11-16-year olds in schools in Wales. *BMJ Open.* 2017;7(2):e012784.
35. Jarvis M, Jackson S, West R, Brown J. Epidemic of youth nicotine addiction? What does the National Youth Tobacco Survey 2017-2019 reveal about high school e-cigarette use in the USA? *Qeios* 2020. Available at: <https://www.qeios.com/read/745076.5/pdf>
36. Gentzke AS, Wang TW, Cornelius M, Park-Lee E, Ren C, Sawdey MD, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students - National Youth Tobacco Survey, United States, 2021. *Morbidity and mortality weekly report Surveillance summaries* (Washington, DC : 2002). 2022;71(5):1-29.
37. Wang TW, Gentzke AS, Creamer MR, Cullen KA, Holder-Hayes E, Sawdey MD, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students - ^[SEP]United States, 2019: Centers for Disease Control and Prevention; 2019. 1-22. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6903396/>
38. Shahab L, Beard E, Brown J. Association of initial e-cigarette and other tobacco product use with subsequent cigarette smoking in adolescents: a cross-sectional, matched control study. *Tob Control.* 2020.
39. Beard E, Brown J, Shahab L. Association of quarterly prevalence of e-cigarette use with ever regular smoking among young adults in England: a time-series analysis between 2007 and 2018. *Addiction.* 2022.
40. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW. 2020. Available at: <https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey-2019/contents/summary>
41. New Zealand Ministry of Health. Position Statement on Vaping 2020. Available at: <https://bit.ly/2R5OW8K>
42. McNeill A, Brose LS, Calder R, Simonavicius E, Robson D. Vaping in England: An evidence update including vaping for smoking cessation, February 2021: a report commissioned by Public Health England. London: Public Health England 2021. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/962221/Vaping_in_England_evidence_update_February_2021.pdf

43. Hartmann-Boyce J, McRobbie H, Lindson N, Bullen C, Begh R, Theodoulou A, et al. Electronic cigarettes for smoking cessation. *Cochrane Database Syst Rev.* 2021;4(4):Cd010216.
44. Glasser AM, Collins L, Pearson JL, Abudayyeh H, Niaura RS, Abrams DB, et al. Overview of Electronic Nicotine Delivery Systems: A Systematic Review. *Am J Prev Med.* 2017;52(2):e33-e66.
45. Villanti AC, Feirman SP, Niaura RS, Pearson JL, Glasser AM, Collins LK, et al. How do we determine the impact of e-cigarettes on cigarette smoking cessation or reduction? Review and recommendations for answering the research question with scientific rigor. *Addiction.* 2017;113(3):391-404.
46. Johnson L, Ma Y, Fisher SL, Ramsey AT, Chen LS, Hartz SM, et al. E-cigarette Usage Is Associated With Increased Past-12-Month Quit Attempts and Successful Smoking Cessation in Two US Population-Based Surveys. *Nicotine Tob Res.* 2018.
47. Friedman AS. How does electronic cigarette access affect adolescent smoking? *J Health Econ.* 2015;44:300-8.
48. Pesko MF, Hughes JM, Faisal FS. The influence of electronic cigarette age purchasing restrictions on adolescent tobacco and marijuana use. *Prev Med.* 2016.
49. Xu Y, Jiang L, Prakash S, Chen T. The Impact of Banning Electronic Nicotine Delivery Systems on Combustible Cigarette Sales: Evidence From US State-Level Policies. *Value Health.* 2022.
50. Thomas KH, Dalili MN, López-López JA, Keeney E, Phillipppo D, Munafò MR, et al. Smoking cessation medicines and e-cigarettes: a systematic review, network meta-analysis and cost-effectiveness analysis. *Health Technol Assess.* 2021;25(59):1-224.
51. Global Strategy for Tobacco Harm Reduction. 82 million vapers worldwide in 2021: the GSTHR estimate 2022. Available at: https://gsth.org/documents/119/GSTHR_BP_GNV21_v6_FINAL.pdf
52. Beard E, West R, Michie S, Brown J. Association of prevalence of electronic cigarette use with smoking cessation and cigarette consumption in England: a time series analysis between 2006 and 2017. *Addiction.* 2019.
53. Levy DT, Sánchez-Romero LM, Li Y, Yuan Z, Travis N, Jarvis MJ, et al. England SimSmoke: The Impact of Nicotine Vaping on Smoking Prevalence and Smoking-Attributable Deaths in England. *Addiction.* 2020.
54. Selya AS. Reducing the smoking-related health burden in the USA through diversion to electronic cigarettes: a system dynamics simulation study. *Harm Reduct J.* 2021;18(1):36.
55. Lee PN, Fry JS, Gilliland S, 3rd, Campbell P, Joyce AR. Estimating the reduction in US mortality if cigarettes were largely replaced by e-cigarettes. *Arch Toxicol.* 2022;96(1):167-76.
56. Levy DT, Borland R, Lindblom EN, Goniewicz ML, Meza R, Holford TR, et al. Potential deaths averted in USA by replacing cigarettes with e-cigarettes. *Tob Control.* 2017 DOI: 10.1136/tobaccocontrol-2017-053759.
57. Selya AS, Shiffman S, Greenberg M, Augustson EM. Dual Use of Cigarettes and JUUL: Trajectory and Cigarette Consumption. *Am J Health Behav.* 2021;45(3):464-85.
58. Martinez U, Simmons VN, Sutton SK, Drobos DJ, Meltzer LR, Brandon KO, et al. Targeted smoking cessation for dual users of combustible and electronic cigarettes: a randomised controlled trial. *Lancet Public Health.* 2021;6(7):e500-e9.
59. Piper ME, Baker TB, Benowitz NL, Jorenby DE. Changes in Use Patterns Over 1 Year Among Smokers and Dual Users of Combustible and Electronic Cigarettes. *Nicotine Tob Res.* 2020;22(5):672-80.
60. Action on Smoking and Health UK. Use of e-cigarettes (vapes) among adults in Great Britain 2021. Available at: <https://ash.org.uk/wp-content/uploads/2021/06/Use-of-e-cigarettes-vapes-among-adults-in-Great-Britain-2021.pdf>
61. Mattingly DT, Zavala-Arciniega L, Hirschtick JL, Meza R, Levy DT, Fleischer NL. Trends in Exclusive, Dual and Poly tobacco Use among U.S. Adults, 2014-2019: Results from Two Nationally Representative Surveys. *Int J Environ Res Public Health.* 2021;18(24).
62. Arnold MJ, Nollen NL, Mayo MS, Ahluwalia JS, Leavens EL, Zhang G, et al. Harm reduction associated with dual use of cigarettes and e-cigarettes in Black and Latino smokers: Secondary analyses from a randomized controlled e-cigarette switching trial. *Nicotine Tob Res.* 2021.
63. McRobbie H, Phillips A, Goniewicz ML, Smith KM, Knight-West O, Przulj D, et al. Effects of Switching to Electronic Cigarettes with and without Concurrent Smoking on Exposure to Nicotine, Carbon Monoxide, and Acrolein. *Cancer Prev Res (Phila).* 2015;8(9):873-8.
64. Farsalinos K, Cibella F, Caponnetto P, Campagna D, Morjaria JB, Battaglia E, et al. Effect of continuous smoking reduction and abstinence on blood pressure and heart rate in smokers switching to electronic cigarettes. *Intern Emerg Med.* 2016;11(1):85-94.

65. Polosa R, Morjaria J, Caponnetto P, Caruso M, Strano S, Battaglia E, et al. Effect of smoking abstinence and reduction in asthmatic smokers switching to electronic cigarettes: evidence for harm reversal. *Int J Environ Res Public Health*. 2014;11(5):4965-77.
66. Marmot M, Goldblatt P, Allen JG. Fair Society Healthy Lives 2010. Available at: <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review>
67. Giovenco DP. Different Smokes for Different Folks? E-Cigarettes and Tobacco Disparities. *Am J Public Health*. 2019;109(9):1162-3.
68. Brown J, West R. Quit success rates in England 2007-2017. *Smoking in Britain*. 2017;Vol 5, 1-8.
69. Kock L, Shahab L, West R, Brown J. E-cigarette use in England 2014-17 as a function of socio-economic profile. *Addiction*. 2018.
70. Thirlway F, Bauld L, McNeill A, Notley C. Tobacco smoking and vulnerable groups: Overcoming the barriers to harm reduction. *Addict Behav*. 2019;90:134-5.
71. Twyman L, Bonevski B, Paul C, Bryant J, Gartner C, Guillaumier A. Electronic Cigarettes: Awareness, Recent Use, and Attitudes Within a Sample of Socioeconomically Disadvantaged Australian Smokers. *Nicotine Tob Res*. 2016;18(5):670-7.
72. Gartner C. The potential impact of vaporized nicotine products on vulnerable subpopulations. *Addiction*. 2016.
73. Bonevski B, Thomas DP, Richmond RL. No smoker left behind: it's time to tackle tobacco in Australian priority populations. *Med J Aust*. 2018;208(1):52.
74. Bates C. The principle of proportionality *The Tobacco Reporter* 2019. Available at: <https://tobaccoreporter.com/2018/12/01/the-principle-of-proportionality/>
75. Gifford H, Tautolo E, McCool JP, Gartner C, Edwards R, Maddox R. Getting there together: highlights, challenges and opportunities for tobacco control in the Oceania region. *Tob Control*. 2022.
76. Magnusson RS. Time to raise the minimum purchasing age for tobacco in Australia. *Med J Aust*. 2016;204(6):220-1.
77. Friedman AS. Tobacco-21 Laws: Insights From the US Experience. *Nicotine Tob Res*. 2019.
78. Gartner CE, Wright A, Hefler M, Perusco A, Hoek J. It is time for governments to support retailers in the transition to a smoke-free society. *Med J Aust*. 2021;215(10):446-8.
79. Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. *Cochrane Database Syst Rev*. 2013;5:CD009329.
80. Zwar NA, Richmond RL. Role of the general practitioner in smoking cessation. *Drug Alcohol Rev*. 2006;25(1):21-6.
81. Bernstein SL, Yu S, Post LA, Dziura J, Rigotti NA. Undertreatment of tobacco use relative to other chronic conditions. *Am J Public Health*. 2013;103(8):e59-65.
82. Steinberg MB, Bover Manderski MT, Wackowski OA, Singh B, Strasser AA, Delnevo CD. Nicotine Risk Misperception Among US Physicians. *J Gen Intern Med*. 2020.
83. Numbeo. Price Rankings by Country of Cigarettes 20 Pack (Marlboro) 2020. Available at: https://www.numbeo.com/cost-of-living/country_price_rankings?displayCurrency=AUD&itemId=17
84. Hoek J, Smith K. A qualitative analysis of low income smokers' responses to tobacco excise tax increases. *Int J Drug Policy*. 2016;37:82-9.
85. Scollo M, Branston JR. Where to next for countries with high tobacco taxes? The potential for greater control of tobacco pricing through licensing regulation. *Tob Control*. 2022.