Submission to the Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia

This submission is made on behalf of the Royal College of Physicians of London, UK

The Royal College of Physicians of London represents over 34,000 members and fellows in the UK and across the world. Responsible for standards of postgraduate education and training for physicians, everything that we do at the RCP aims to improve patient care and reduce illness. We are patient centred and clinically led. We drive improvement in the diagnosis of disease, the care of individual patients and the health of the whole population, both in the UK and across the globe.

In 1962 the RCP published a landmark report, *Smoking and Health*, which drew public and professional attention to the health harms of smoking, and advocated a range of population- and individual-level preventive measures [1] which in later years formed the basis of recommendations on national tobacco control policy by the World Bank in 1999 [2], and the 2003 World Health Organisation Framework Convention on Tobacco Control [3].

In 2007 the RCP recommended the adoption of a new strand of tobacco control policy, harm reduction, which aims to provide smokers who prove unable or unwilling otherwise to quit smoking with a less hazardous means of consuming nicotine [4]. Harm reduction approaches are predicated on the principle that smokers smoke primarily because they are addicted to nicotine; that nicotine addiction, of itself, is not a major health hazard and that the harms from smoking arise primarily from the many toxins in tobacco smoke; and hence that in addition to encouraging all smokers to quit if possible, tobacco control policies should encourage those who continue to smoke to switch to a less hazardous source of nicotine. Proof of principle was taken from the Swedish experience of the availability of a form of oral tobacco, known as snus, which has proved to be an affordable, effective and socially acceptable alternative to smoking that is part of the explanation for low smoking rates in Sweden [4,5]. At 7%, adult smoking prevalence in Sweden is now by far the lowest in Europe [6], and indeed probably lower than in any other rich country.

The 2007 RCP report concluded that tobacco control policy should include providing smokers with safer sources of nicotine that are acceptable and effective cigarette substitutes, and this approach has since been incorporated into UK national policy [7,8] and recommended clinical practice [9]. However, since the 2007 report [4] was published the range of available nicotine products has been transformed by the emergence of electronic cigarettes. In 2016 the RCP therefore published an update on harm reduction policy, *Nicotine without smoke* [10], which assessed the potential contribution that electronic cigarettes could make to preventing smoking in the UK. The conclusions of the report are directly relevant to the terms of reference of this inquiry and are therefore reproduced below:

- *Smoking is the biggest avoidable cause of death and disability, and social inequality in health, in the UK.*
- *Most of the harm to society and to individuals caused by smoking in the near-term future will occur in people who are smoking today.*
- *Vigorous pursuit of conventional tobacco control policies encourages more smokers to quit smoking.*

- *Quitting smoking is very difficult and most adults who smoke today will continue to smoke for many years.*
- *People smoke because they are addicted to nicotine, but are harmed by other constituents of tobacco smoke.*
- *Provision of the nicotine that smokers are addicted to without the harmful components of tobacco smoke can prevent most of the harm from smoking.*
- *Until recently, nicotine products have been marketed as medicines to help people to quit.*
- *NRT is most effective in helping people to stop smoking when used together with health professional input and support, but much less so when used on its own.*
- *E-cigarettes are marketed as consumer products and are proving much more popular than NRT as a substitute and competitor for tobacco cigarettes.*
- *E-cigarettes appear to be effective when used by smokers as an aid to quitting smoking.*
- *E-cigarettes are not currently made to medicines standards and are probably more hazardous than NRT.*
- *However, the hazard to health arising from long-term vapour inhalation from the e-cigarettes available today is unlikely to exceed 5% of the harm from smoking tobacco.*
- *Technological developments and improved production standards could reduce the long-term hazard of e-cigarettes.*
- *There are concerns that e-cigarettes will increase tobacco smoking by renormalising the act of smoking, acting as a gateway to smoking in young people, and being used for temporary, not permanent, abstinence from smoking.*
- *To date, there is no evidence that any of these processes is occurring to any significant degree in the UK.*
- *Rather, the available evidence to date indicates that e-cigarettes are being used almost exclusively as safer alternatives to smoked tobacco, by confirmed smokers who are trying to reduce harm to themselves or others from smoking, or to quit smoking completely.*
- *There is a need for regulation to reduce direct and indirect adverse effects of e-cigarette use, but this regulation should not be allowed significantly to inhibit the development and use of harm-reduction products by smokers.*
- *A regulatory strategy should, therefore, take a balanced approach in seeking to ensure product safety, enable and encourage smokers to use the product instead of tobacco, and detect and prevent effects that counter the overall goals of tobacco control policy.*
- *The tobacco industry has become involved in the e-cigarette market and can be expected to try to exploit these products to market tobacco cigarettes, and to undermine wider tobacco control work.*
- *However, in the interests of public health it is important to promote the use of e-cigarettes, NRT and other non-tobacco nicotine products as widely as possible as a substitute for smoking in the UK*

The evidence supporting these conclusions is laid out in full in the report [10]. However, we respond in summary form to the specific questions asked in the inquiry as follows:

1. The use and marketing of E-cigarettes and personal vaporisers to assist people to quit smoking

E-cigarettes are used and marketed in the UK primarily as a consumer alternative to smoking. The great majority of e-cigarette users in the UK use the product as a means to quit, cut down on smoking, or to stay quit [10], independently from medical services or commitment to any formal quit attempt or cessation therapy [10]. Dual use of electronic and tobacco cigarettes is commonplace, but recent data from ASH indicate that in 2017, of nearly 3 million e-cigarette users in the UK, just over half (52%) are ex-smokers. We believe that this increasing use of electronic cigarettes is the major driver of the substantial fall in UK smoking prevalence over the past five years, from 20.2% in 2011 to 15.8% in 2016 [11], vindicating the approach advocated by the RCP

[4,10] and the strong support provided by Public Health England [12] and a wide range of other professional organisations [13].
Although no e-cigarette is licensed as a medicine in the UK, use of e-cigarettes is also recommended for use in formal quit attempts supported by National Health Service Stop Smoking Services [14], and in combination with licensed nicotine products now achieve the highest quit rates [15]. However, despite strong medical assurances that electronic cigarettes are likely to be substantially less harmful than tobacco cigarettes [10,12] a growing proportion of the population believes e-cigarettes to be equally or more harmful than tobacco cigarettes [11]. This is likely to be one part of the levelling off of the upward trend in e-cigarette use over the past two years [11].

In our view therefore, making e-cigarettes easily available to adult smokers is a successful public health strategy which should be supported by strong public health messaging by health professionals and authorities. Commercial marketing of e-cigarettes should be consistent with this strategy, by promoting e-cigarettes as a safer alternative to smoking, and avoiding appeal to children or non-smoking adults.

2. The health impacts of the use of E-cigarettes and personal vaporisers

E-cigarettes and personal vaporisers have been used by millions around the world, and documented cases of suspected acute or short-term adverse health effects are few. Fires arising from battery or charging faults are a recognised problem but described by the US Fire Administration as rare [16].

The long-term health effects of sustained e-cigarette use will not become clear until the products have been in use for several decades. The RCP report concludes that since some of the carcinogens, oxidants and other toxins present in tobacco smoke have also been detected in e-cigarette vapour, long-term use of e-cigarettes may increase the risks of lung cancer, COPD, cardiovascular and other smoking-related diseases. However, the magnitude of such risks is likely to be substantially lower than those of smoking, and extremely low in absolute terms. These potential risks are also amenable to reduction through product technological and purity improvements. There is no evidence that e-cigarette vapour represents a health threat to others.

3. International approaches to legislating and regulating the use of E-cigarettes and personal vaporisers

There is a wide range of regulatory and legislative responses to e-cigarettes, from the relatively liberal approach adopted in the UK, to prohibition. The regulatory options, and potential hazards to public health that both under- and over-regulation could cause, are discussed in detail in Chapter 10 of the RCP report, highlighting the importance of ensuring that on the one hand, regulation protects consumers from harm and ensures that the products they buy are effective; while on the other hand not allowing regulation to stifle product improvement and innovation.

For several years the UK offered two regulatory routes to market for e-cigarettes: as a consumer product, or as a medicine. The consumer product approach, supported by an advertising code of practice [17], was largely successful in preventing irresponsible promotion but provided few incentives, other than consumer preference, for suppliers to aspire to high product standards. The UK Medicines and Healthcare products Regulatory Agency (MHRA) has encouraged uptake of a

relatively light-touch route to medicines regulation for e-cigarettes, but as the regulations remain demanding and compliance expensive, the result is that after more than five years no licensed product has come to market. It is thus evident that requiring all e-cigarettes to comply with medicines regulation is, to date, akin to prohibition.

From May 2017 e-cigarettes are regulated under the EU Tobacco Products Directive (TPD), which requires manufacturers to disclose the content of e-cigarette solutions and emissions, which will (when data are available) enable consumers to identify products with the best emission profiles. The TPD also prohibits most e-cigarette advertising, requires e-cigarette packaging to carry a health warning, and caps the maximum volume and nicotine concentrations of e-liquids. In our view these two latter restrictions are probably counter-productive: the health warning because it probably perpetuates the misconception that e-cigarettes are no less hazardous than tobacco; and the nicotine content restrictions because these are likely to limit effectiveness as a smoking substitute.

4. The appropriate regulatory framework for E-cigarettes and personal vaporisers in Australia

We strongly encourage the use of consumer product regulation, supplemented by restrictions to minimise any appeal to children or non-smokers, and by disclosure requirements (such as those required by the TPD) to facilitate comparison of product efficacy in relation to nicotine delivery, and the relative purity (and hence safety) of the vapour.

5. Any other related matter

We would be pleased to give further evidence to the inquiry if invited to do so.

References

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