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RACP Submission to the National Tobacco Strategy Consultation 2018

August 2018

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide feedback to the Commonwealth Department of Health's consultation (conducted by Siggins Miller) to inform the development of the next iteration of the National Tobacco Strategy (NTS)[1].

The RACP trains, educates and advocates on behalf of over 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. The RACP represents physicians across a diverse range of disciplines, including but not limited to addiction medicine, public health, oncology, thoracic medicine, cardiology, occupational and environmental medicine, internal medicine and paediatrics and child health.

Australia is a world leader in implementing tobacco control policies, ranging from advertising bans, plain packaging, graphic health warnings, smoke free legislations to tobacco excise. Australia's ongoing efforts in and commitments to tobacco control is clearly reflected in its remarkable success in reducing population smoking rates. As of 2016, the national daily smoking rate has nearly halved since 1991, with only 12.2 per cent of people aged 14 or older smoking daily[1]. The RACP believes that the implementation of a range of effective policies, together with expanded partnerships between government and non-government sectors and a well-defined NTS are key drivers to this success.

The RACP continues to be a strong advocate for the introduction of policy and legislative measures that contribute to further reducing the prevalence and uptake of smoking, with the aim of Australia becoming a 'smoke-free' society. We consider the next NTS of paramount importance as it will again serve as a blue print to further gear Australia to towards becoming a tobacco-free country and embodies a set of commitments that Australia aims to achieve. The fact that the tobacco industry will always find new avenues to challenge any measures that might reduce smoking underlines the importance of our commitment and continued action. The RACP is looking forward to the next iteration of NTS and believes that Australia has the capability to further reduce smoking prevalence and the health inequalities it causes.

This submission provides both general comments on the design of the NTS as well as specific comments with respect to the progress of the NTS, suggested improvements, monitoring and e-cigarettes.

General

1. What should be the key priorities for tobacco control in Australia in the coming years? Do you have any comments on the suitability of the objectives in the current NTS for consideration in the next NTS?

As a Member State of the World Health Organisation (WHO), Australia has an obligation to produce a national strategy consistent with the WHO Framework Convention on Tobacco Control (WHO FCTC). The RACP supports the nine priorities set out in the current NTS, which are evidence-based and captures all the pivotal tobacco control measures that are effective in reducing tobacco smoking.

There is evidence that in response to the plain packaging legislation together with large annual tobacco tax increases, the tobacco industry has modified some of its products to include novel pack sizes, brand extensions and new kinds of products, with a strong focus on perceived value for money[2]. There has been an increase in using roll your own cigarettes among the adult smoking population, in particular in young adults. Use jumped to 36% in 2016 from 32% in 2013, with 50% of young adult smokers aged 18-24 most likely using roll your own cigarettes in 2016[3]. The RACP urges the government to monitor the

[1] The RACP notes that Dr Mel Miller, a Director of Siggins Miller, is currently the acting interim CEO at the RACP. There is no conflict of interest in relation to this submission.

tobacco market closely and consider strengthening the existing packaging and product regulation to better deal with emerging tobacco products and roll your own cigarettes.

Presently, Australia does not have access to precise tobacco product sales data, as tobacco companies are not mandated to provide this information[4] [5]. High availability of tobacco products is considered a form of tobacco promotion; it influences the social norm around smoking and fosters an environment that urges people to smoke[6]. To better monitor the tobacco market and measure the effectiveness of tobacco control policies, it is imperative that the information for all tobacco products available for sale on the market and sales data be provided to government.

The smoking prevalence reductions fall short of achieving the 2018 performance yardstick of reducing daily smoking rate to 10 per cent of the general population and to 50 per cent of Aboriginal and Torres Strait Islander smoking population. The RACP recommends that strengthened efforts occur to accelerate actions under priority areas in the coming years. More concrete steps are needed to move Australia closer to a smoke free society in coming years.

With respect to the objectives in the current NTS, the RACP supports their inclusion in the next NTS. However, we recommend that an additional focus should be placed on preventing smoking initiation among children and young adolescents. Additionally, to ensure good coordination, the state and territory tobacco strategies must align with the next NTS, be they the goals, objectives or priority areas, so a more concerted effort can be made to advance tobacco control in Australia.

Progress, Improvements and monitoring

2. How successful do you think Australia's efforts to date has been in making progress against the nine priorities set out in the current NTS? What are the barriers and facilitators to progressing these priorities?

Overall, the RACP notes that Australia has made good progress towards the nine priorities of the current NTS, although the two performance targets set for 2018 are unlikely to be met. Strong progress is seen in a range of key policy areas over the last few years, including smoke-free areas, progressive increases in tobacco tax, tobacco plain packaging, cessation support, and bans on tobacco advertising, promotion and sponsorship.

Reductions in tobacco use at the population level are clearly shown in the 2016 National Drug Strategy Household Survey (NDSHS), where daily smoking rates are found to have continuously trended downward since 1991, though the decline between 2013 and 2016 was relatively small – around 0.6 per cent[7].

In terms of smoking levels in at risk sub groups of the population, there has been an overall marked decline. Only 27 per cent of Aboriginal and Torres Strait Islander people smoked daily in 2016, in contrast to 35% in 2010[8]. This finding is not consistent across all regions. There has not been much of a decline in remote or very remote regions, with little movement in smoking rates since 1994; the proportion of Aboriginal and Torres Strait Islander people who smoke remained at 54-56 per cent in 2014/15[9]. This underscores the need for additional strategies and support to meet local, cultural and contextual needs of those communities.

A parallel decline is also observed in those living in the lowest socioeconomic areas, with daily smoking rates reduced from 19.9 per cent in 2013 to 17.7 per cent in 2016[10]. We acknowledge these great

achievements and commend considerable actions taken by all stakeholders concerned to strive to realise the priority areas of the NTS within the set timeframe.

The RACP notes the findings from the mid-point review of NTS in 2015, where substantial progress was found in 11 of the 14 indicators specified in the Australian Institute of Health and Welfare (AIHW)'s report[11]. We agree on the barriers and facilitators identified in the mid-point review. In our view, the key facilitators for tobacco control advancement include government commitments, a well set out NTS, expanded partnerships and collaboration, and stronger emphasis on at risk groups. Key barriers are lack of funding for tobacco control programs, as well as coordination and real-time communications on tobacco control activities between the government and non-government sectors.

We believe that to further the aims of the NTS and to tackle tobacco related harm to a greater degree, comprehensive strategies are required, together with multi-sectoral collaboration. The RACP supports the recommendations made in the mid-point review and urges the governments to execute them in full. The table below summaries our feedback and recommendations on some of the priority areas of the current NTS.

Priority Areas	Feedback/ Recommendations
1. Protect public health policies from tobacco industry interference	We maintain that tobacco industry must not be involved in setting public health agenda and that the interactions between government officials and the tobacco industry must be limited, on both health and non-health policy fronts. The tobacco industry is not an expert in health policy and there are major conflicts between the vested commercial interests of the tobacco industry and public health. In the case of tobacco control policy implementation, we have seen how the tobacco industry challenged the implementation of tobacco standardised packaging in Australia[12]. Being a party to the WHO Framework Convention on Tobacco, Australia is mandated to prohibit participation of the tobacco industry in tobacco control policy discussions. It is vital that this prohibition extends and is adhered to in the context of e-cigarettes. The emergence of e-cigarettes potentially provides an opportunity for industry to promote e-cigarettes as a healthy option, though the evidence is inconclusive to date[13]. The RACP supports the development of state specific protocol to help limit interactions between government officials and the tobacco industry and ensure transparent communication.
2. Strengthen mass media and public education campaigns on tobacco cessation	The RACP urges governments to continuously invest in high intensity tobacco control mass media campaigns. This activity is embedded in both the WHO FCTC Article 12 and the WHO MPOWER package, it is a critical part of tobacco control strategy to communicate the danger of tobacco smoking to the broader population and to persuade smokers to quit smoking. It was estimated that 190,000 people stopped smoking as a result of the 1997 Australian National Tobacco Campaign. Based on this figure, the model predicted that this equated to around $A740.6 million savings in health care costs as more than 32 000 cases of chronic obstructive pulmonary disease, 11 000 cases of acute myocardial infraction,10 000 cases of lung cancer and 2500 cases of stroke were avoided. This led the authors to conclude that the national tobacco campaign was cost-effective and effective in reducing tobacco smoking prevalence[14]. Moreover, a 2018 study indicates that the life course impact on current smoking population aged 20 to 69 would result in a loss of $A388 billion in productivity,

	together with a loss in 3.1 million years of life and 6 million quality-adjusted life years (QALYs). Further tobacco control advancement in Australia can lead to potential health and economic gains from increasing productivity[15]. Evidence shows that when employed in conjunction with other tobacco control measures, mass media campaigns are particularly effective in preventing smoking initiation and encouraging smoking cessation[16]. The RACP supports funding a population-level mass media campaign, in addition to targeted campaigns. The RACP recommends that in addition to effective messaging and delivery, such mass media campaigns need to be long-running, culturally tailored and evidence-based. This is in addition to targeted strategies aimed at high smoking prevalence population groups such as Aboriginal and Torres Strait Islander people and people with severe mental illness. The design of campaign strategy needs to factor in the evolving nature of mass media, social marketing and social media.
3. Reduce the affordability of tobacco products	The RACP fully supports the Australian Government's initiative to progressively increase tobacco excise at an annual rate of 12.5 per cent up to 2020, as part of an effort to reduce the affordability of tobacco products. The association between raising the price of tobacco products and reducing tobacco smoking is well established in many studies[17] [18] [19]. The 2016 NDSHS also indicates that 52 per cent of smokers attempted to quit or change their smoking behaviour due to the high cost of tobacco products[20]. A concern of the RACP is that higher tobacco prices can potentially increase illicit trade, though available evidence indicates that tax increases are not the sole element responsible for driving illicit trade[21]. It is noteworthy that tobacco industry continues to adjust their product development and price strategies to offer affordable and novel products to consumers[22]. Consequently, it is important that the government keep close tabs on tactics the industry is using to undermine the high-tax tobacco market in Australia.
4. Reduce smoking rates among Aboriginal and Torres Strait Islander people	The RACP supports the launch of the *Tackling Indigenous Smoking* programme and the development of *National Aboriginal and Torres Strait Islander Health Plan (NATSIHP)* to guide efforts towards reducing the daily smoking rate by half among Aboriginal and Torres Strait Islander people by 2018 and closing the gap. As previously mentioned, the disparity in reduction in smoking rates between remote and very remote and urban regions for Aboriginal and Torres Strait Islander people is substantial. Indigenous Australians were more likely to report being a current smoker if they had: high/very high levels of psychological distress (51% compared with 38% for those with low/moderate levels); had fair/poor self-assessed health status (49% compared with 35% with excellent/very good); and had experienced one or more stressors in the previous 12 months (45% compared with 35% for those who did not)[23]. These risk factors are a consequence of structural oppression and institutional racism[2425] . The RACP Indigenous Strategic Framework states the following:

	The health and wellbeing of Aboriginal and Torres Strait Islanders and Māori has been adversely affected by ongoing colonisation through structural oppression, racism, disruption to cultural practices, family structures, traditional lifestyles, and historical trauma. Loss of agency, identity and powerlessness, and the impact of the social determinants of health, has contributed to compromised physical, social, mental and spiritual health for Indigenous peoples. To drive down smoking rates amongst Aboriginal and Torres Strait Islander people, these risk factors need to be addressed. This requires a broader process of engagement by the Government with Aboriginal and Torres Strait Islander leadership that has self-determination at its core. Personal and community agency has previously been subordinated to institutional control over generations. The Government will have to address driving factors notably including loss of country, language and culture, economic marginalisation, and forensic and penal policies. By acknowledging the failure of previous policy and the inherent institutional racism that underlies it, policy makers are able to stop the normalisation of the health inequities that beset Aboriginal and Torres Strait Islander people. Tobacco smoking is influenced by a range of social, cultural and family factors, including normalisation of smoking in peer groups and families, positive attitudes towards smoking, and smoking as a coping mechanism[26] Additional barriers to quitting in remote areas include underlying social disadvantage and access to and uptake of services/treatment to support quitting[27] We therefore recommend that the government develop and implement additional strategies to tackle inequities in social determinants of health for Aboriginal and Torres Strait Islander people together with providing tailored and culturally appropriate support. In addition, more than half of Aboriginal and Torres Strait Islander women reported smoking during pregnancy[28]. The graph below obtained from the Western LHD HealthStats NSW clearly shows the significant difference in smoking rates between Aboriginal and Torres Strait Islander mothers and their non Indigenous counterparts during pregnancy. This significant difference calls for urgent action, as smoking during pregnancy is linked to obstetric, fetal, childhood and adult health implications. There are relationships between smoking in pregnancy and preterm birth, growth restriction and sudden infant death syndrome, as well as obesity, hypertension, decreased lung function and nicotine addiction in the child's later life.

Smoking at all during pregnancy among Aboriginal and non-Aboriginal mothers, Far West LHD, NSW 2001 to 2016

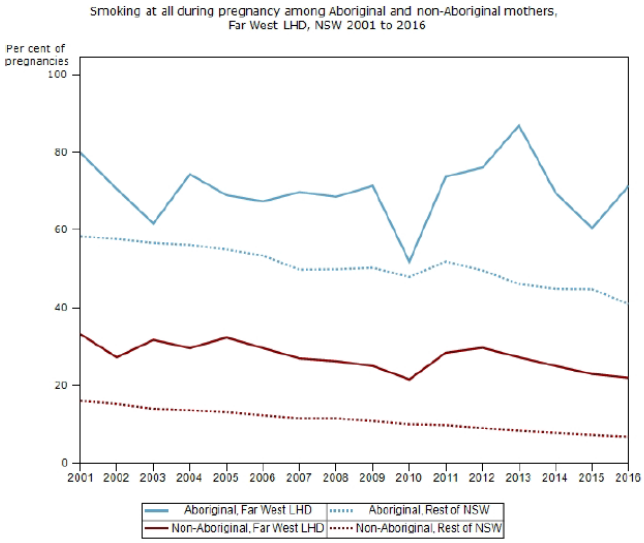

Figure 1: Smoking at all during pregnancy among Aboriginal and non-Aboriginal Far West LHD, NSW 2001 to 2006

A recent paper by Lovett et al, identifies that a discrepancy arises when different methods are used to report trends in smoking inequalities, along with some comments on the associated impacts of this[29]:

- Their analysis emphasises change in the absolute prevalence of smoking within the Aboriginal population (50.0% – 41.4% = 8.6% absolute prevalence decrease), whereas the NTS midpoint report emphasises smoking prevalence in the Aboriginal and Torres Strait Islander population relative to the non-Indigenous population. In relative terms, the ratio of Aboriginal and Torres Strait Islander to total Australian smoking prevalence increased from 2.4 (50.0%:21.3%) in 2004–05 to 2.9 (41.4%:14.5%) in 2014–15.
- This demonstrates that reporting change in absolute versus relative terms can lead to fundamentally different conclusions, which could affect support for programs and policies. This is especially true in light of circumstances such as Productivity Commission reports into expenditure on Aboriginal health.
- Focusing on relative differences in isolation can obscure progress at the population level; that is, the absolute number of Aboriginal and Torres Strait Islander adults quitting or not taking up smoking. Substantial progress has been made in reducing smoking, with an estimated 35,000 fewer Aboriginal and Torres Strait Islander adults smoking every day in 2014–15 compared with if daily smoking remained at 2004–05 prevalence.
- Further, research from other populations demonstrates that communicating information about health inequity using a progress frame rather than a disparity frame (i.e. focusing on the persisting gap) is associated with more positive emotional responses and increased interest in engaging in health-promoting behaviours. Therefore, we consider it

	ethical and more effective to also report absolute progress in smoking prevalence. The RACP believes that a comprehensive approach is needed to reduce the burden of tobacco related harm and improve health equity among Aboriginal and Torres Strait Islander people. Such an approach must include Aboriginal and Torres Strait Islander leadership, partnerships, engagement and cultural tailoring.
6. Eliminate remaining advertising, promotion and sponsorship of tobacco products	The RACP supports extensive restrictions on advertising and promotion of tobacco products. In particular, tobacco plain packaging along with graphic health warnings remove promotional components of tobacco packs and increase knowledge about tobacco related harms. There is a strong body of evidence showing the effectiveness of tobacco plain packaging along with graphic health warnings in reducing the product appeal, sales and tobacco initiation and consumption rates[30]. A systematic review of 32 studies conducted in 20 countries between 1997 and 2014 concluded that strengthened graphic health warnings lead to increases in knowledge of tobacco related harm, Quitline calls and smoking cessation behaviour[31]. The institution of tobacco standardised packaging in Australia was a substantial public health advancement. To maintain the salience and impact of graphic health warnings, the RACP recommends regular review and update. This will maximise the potential of graphic health warnings by further educating smokers and non-smokers about many serious harms of tobacco. Furthermore, a 2017 longitudinal observation study has identified tobacco price boards as an avenue for brand promotion by tobacco retailers, encouraging tobacco consumption. It has been suggested that price information should be given to adult smokers upon request at the point of sale [32].
8. Reduce exceptions to smoke-free workplaces, public places and other settings	The RACP supports comprehensive smoke free legislation, covering all public places and calls on the governments to apply smoking restrictions in all outdoor dining and drinking areas, children's playgrounds, public transport areas, and sporting venues. The comprehensive implementation of smoke-free legislation will not only reduce secondhand smoke exposure and encourage smoking cessation, but also improve adult and child health outcomes[3334]. Additionally, the role of environmental smoking (i.e. parent, sibling and peer smoking) has been identified as a critical element of children and adolescents' susceptibility to smoking[35]. The RACP welcomes the extension of the smoke free legislations to e-cigarettes in most states and territories in recent years, a strong indication of governments' continual effort towards a smoke-free environment.
9. Provide greater access to a range of evidence based cessation services	To assist individual and population level smoking cessation, access to affordable evidence based cessation services is essential. This is particularly the case for high smoking prevalence population groups and low-income individuals. Thus, the RACP recommends that cheaper or free nicotine replacement therapy be available and readily accessible by those population groups.

3. Monitoring

Monitoring progress is crucial to bolstering the progress of the NTS and the associated priority areas. It is one of the evidence-based measures specified in the WHO's MPOWER package. The RACP supports the current approach of specific targets and outcome indicators. However, to better capture detailed smoking patterns and have more accurate estimates of smoking prevalence, we recommend an inclusion of a question on smoking prevalence in the 2021 Australian Census on the ground it targets the whole population[36].

E-cigarettes

1. Are there any particular areas of focus that should be considered in the next NTS when considering e-cigarettes?

Based on the current evidence, the net public health effect of e-cigarettes at this point in time cannot be clarified with any degree of confidence. That is, whether their potential for harm reduction outweighs the risk of counteracting decade long effort in reducing smoking prevalence and renormalising smoking is uncertain.

A range of opinions has been promulgated with regard to their role in helping people quit or reduce smoking, their direct effect on a person's health, and their potential impact on the decades-long move towards a tobacco-free society

The RACP acknowledges that e-cigarettes may have a potential role in tobacco harm reduction and smoking cessation for smokers unable or unwilling to quit. However, due to lack of long-term data and large population studies, e-cigarettes should be treated with caution. Users should be aware when using a nicotine-containing e-liquid that nicotine is highly addictive and a poison.

The National Academies of Sciences, Engineering and Medicine (NASEM) published a comprehensive report on the Public Health Consequences of E-cigarettes in January 2018 after assessing the available evidence on health effects, harm reduction, smoking cessation, and gateway effects related to e-cigarette use. The key conclusions from its report are as follows:

- Overall, there is limited evidence that e-cigarettes may be effective aids to promote smoking cessation
- There is substantial evidence that e-cigarette use is associated with reduced exposure to potentially toxic substances, compared with tobacco cigarettes.
- There is moderate evidence that the use of e-cigarettes is associated with increased chances of smoking cessation, albeit the overall evidence from observational studies is mixed.
- There is substantial evidence that the use of e-cigarettes will increase the likelihood of youth initiating use of tobacco smoking.
- There is conclusive evidence that most e-cigarettes contain and generate potentially hazardous substances

It also concluded that the net public health effect of e-cigarettes will depend on the relative magnitudes of three factors:

- Their impact on youth initiation of combustible products
- Their impact on adult cessation of combustible products and
- Their intrinsic toxicity.

The RACP is of the view that e-cigarettes present no benefits and only potential harms to those who do not smoke, be they people who have never smoked or former smokers. Given that nicotine is a poison and is highly addictive, we are concerned that the use of e-cigarettes may increase the likelihood of tobacco smoking initiation, in particular among adolescents and young people. We recommend the focus be given to the current evidence on:

1) The effectiveness as a smoking cessation aid;
2) Health impacts;
3) Renormalising smoking;
4) Gateway effect; and
5) Product quality and safety in the next NTS when considering e-cigarettes.

The RACP policy on e-cigarettes 2018 presented the best available evidence at the date of publication on these five areas.

It is imperative to improve the evidence base on e-cigarettes and data collection on e-cigarettes sales and use. In concrete terms, the RACP recommends that:

- All levels of government should co-operate to improve data collection on e-cigarette sales and use. This should be accompanied by the collection of the prevalence and characteristics of e-cigarette users by age groups, populations, and tobacco smoking status, to accurately estimate the population and group-specific effects. This can be achieved by adding in a few questions about e-cigarette use – such as experimentation and regular use – in the existing regular population surveys.

- Funding for high quality research on the public health implications of e-cigarettes should be provided, particularly for high-quality randomised clinical trials and population-level studies. Studies should prioritise building evidence on the their short- and long-term health effects, efficacy as a smoking cessation aid, impact on overall smoking rates and smoking initiation rates, as well as extent and impact of dual-use of e-cigarettes and tobacco products

2. What would be suitable evidence based responses to e-cigarettes in the context of the next NTS?

The RACP is of the view that responses to the advent of e-cigarettes should be drawn from our experience with tobacco cigarettes as well as the current evidence base for e-cigarettes.

We recommend that a national e-cigarette policy framework be developed. It will not only allow for a clear set of shared objectives to be set, but also support consistency and coherence in implementing effective policy measures across Australia. When designing such a national framework, it needs to be compatible with tobacco control policies articulated in the WHO mPOWER strategy and in the WHO FCTC. The policy framework should be based on the highest quality evidence available, and strikes an appropriate balance between potential risks and benefits.

Besides a national framework, appropriate regulatory controls on the sale, supply, use and promotion of e-cigarette devices, with a focus on youth protection are required. As such, we recommend the following:

- All states and territories that have not introduced laws specifically governing e-cigarettes should be encouraged to impose some regulation to control their sale, display, advertising and promotion.

- E-cigarettes should not be allowed to be promoted in a way that encourages their uptake or smoking initiation. Their sale and supply to minors must be prohibited in all Australian states and territories.

- E-cigarette product packaging and labelling requirements should be implemented, including:

    - disclosure of all ingredients (in particular nicotine or non-nicotine containing) and their concentrations in e-liquids
    - Child-proof packaging standards to deter children's use and prevent accidental poisonings;
    - Plain (standardised) packaging rules to reduce the appeal of e-cigarettes to youth; and
    - Health warning labels.

- The use of e-cigarettes (vaping), with or without nicotine, should be banned in all areas that are designated to be smoke-free, to protect non-users from potential harms due to exposure to secondhand e-cigarette aerosol.

- E-cigarettes with or without nicotine should be subject to Australia's excise tax, at a lower rate than that of tobacco cigarettes to discourage any e-cigarettes users switching to tobacco cigarettes".

- Effective regulation is needed on the quality control processes used to manufacture these products, and on their labelling requirements, to ensure consumers are appropriately protected.

3. Are there any particular strategies that could be included in the next NTS to minimise the harms associated with the marketing and use of e-cigarettes in Australia?

The RACP is concerned there remains a lack of clear and robust evidence to inform policy makers, clinicians and the public about e-cigarettes. In the absence of conclusive evidence, the sale, supply, promotion and use of e-cigarettes must be effectively regulated and they should not be available to minors. E-cigarettes should be included within smoke-free environment legislation, primarily due to the potential harms from re-normalising smoking and the exposure to second-hand e-cigarette aerosol.

We assert that any therapeutic and toxicity claims made about e-cigarettes must be supported by transparent, high quality studies and have undergone the Therapeutic Goods Administration's or Medsafe's review processes and secured their approval.

The current Australian regulatory approach to e-cigarettes is that nicotine-containing e-cigarettes are illegal under Commonwealth, state and territory legislation. It is important that legislative responses to e-cigarettes are reviewed on a regular basis, in light of emerging evidence.

Given the unknown health impacts of e-cigarettes and their increasing use of, many countries are now implementing measures to regulate their promotion, sale, supply and use.

New Zealand[37]

As of April 2017, the New Zealand Government has in principle made a decision to amend the Smoke-free Environments Act 1990 (SFEA) to legalise the sale and supply of nicotine containing e-cigarettes as consumer products by mid-2018. However, the sale of e-cigarette products with/without nicotine is prohibited to people under 18 years and from the vending machines in R18 settings. In terms of promotion and advertising, only point-of-sale display for all retailers and in store display is permitted. Individual businesses and local authorities are allowed to extend its smoke-free workplace policy to the use of e-cigarettes. E-cigarettes with a therapeutic claim, irrespective of whether they contain nicotine or not, will continue to be classified as medicines; their sale requires authorisation by MedSafe.

Additionally, the NZ Ministry of Health has recently published a report on Health and Independence 2017. Its view on e-cigarettes in the section on 'Getting to Smokefree 2025' is that[38]:

"Although the best thing smokers can do for their health is to quit smoking completely, the Ministry of Health considers that e-cigarettes have the potential to contribute to the Smokefree 2025 goal and could disrupt the significant inequities that are present. How much e-cigarettes can help improve public health depends on the extent to which they are a route out of smoking for New Zealand's 529,000 daily smokers, without providing a route into smoking for youth and non-smokers."

United States[3940]

As of August 2016, the Food and Drug Administration (FDA) extended its oversight to all tobacco products, including all electronic nicotine delivery systems. This means e-cigarettes with nicotine are regulated in the same way as traditional tobacco products, including their manufacture, import, packaging, labelling, advertising, promotion, sale, and supply. All electronic nicotine delivery systems have to undergo the FDA's review and evaluation, including their ingredients, product features, health risks and their attractiveness to minors and non-users. The regulations also prohibit the sale of nicotine containing e-cigarettes to minors in person or online, require health warnings on product packages and in advertisements, and ban their sale in vending machines. Non-nicotine e-cigarette laws vary from state to state. E-cigarettes that are marketed for therapeutic purposes continue to be regulated by the FDA Center for Drug Evaluation and Research.

United Kingdom[41]

Under new 2016 regulations, e-cigarettes are regulated either under the revised European Union (EU) Tobacco Products Directive (TPD) as tobacco products or, if they are making a therapeutic claim, under the United Kingdom (UK)'s Medicines and Healthcare Products Regulatory Agency (MHRA) as medicines. The revised TPD requires that all e-cigarette products sold fully meet the standards stipulated in the Tobacco and Related Products Regulations 2016 to ensure minimum standards for the safety and quality of all e-cigarettes and prevent youth initiation.

Canada[42]

Under the Canadian Food and Drugs Act, nicotine-containing e-cigarettes, with or without a therapeutic claim, are regulated as medicines. Authorisation is required prior to their importation, advertisement or sale in Canada. Non-nicotine e-cigarettes that do not make health claims are unregulated. As of late 2016, the federal government of Canada proposed to amend the Tobacco Act to include e-cigarettes with or without nicotine as a discrete class of products, to render e-cigarettes less accessible to young people.

Thank you for considering the above points of feedback and we look forward to the release of the next iteration of NTS. Should you require any further information regarding this response, please contact Bella Wang, Policy Officer on Bella.Wang@racp.edu.au or on +61 29256 5432.

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