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AMA submission to Parliamentary Joint Committee on Law Enforcement – Inquiry into illicit tobacco

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The Australian Medical Association (AMA) welcomes the opportunity to make a brief submission to the Parliamentary Joint Committee on Law Enforcement - Inquiry into illicit tobacco.

The AMA supports measures that seek to reduce the trade in, and consumption of, illicit tobacco in Australia. A lack of action around illicit tobacco has the potential to undermine Australia's world leading stance on tobacco control.

Over the past decade there has been a significant decline in the number of Australians who consume tobacco products. However, in 2014, 16 percent of Australians continued to smoke tobacco. The *National Tobacco Strategy 2012-2018* contains a clear goal to further reduce the number of smokers in Australia to just 10 percent by the year 2020. In order to reach this goal it is essential to capitalise on the gains of the last decade and look for new ways to reduce the appeal of smoking.

As an organisation representing medical practitioners, the AMA is acutely aware of the harms of tobacco smoking. The AMA recently updated its policy position and issued a statement *Tobacco Smoking and E-Cigarettes – 2015*, which is attached for reference.

Combatting the trade in illicit tobacco is a key objective of the World Health Organisation's Framework Convention on Tobacco Control. Over the last few decades we have learnt that effective tobacco control is not about any single measure or area of focus. Effective tobacco control requires action on a range of fronts, recognising the dovetailing effect which reduces the likelihood that non-smokers will begin to smoke, and that current smokers will be encouraged to engage in a quit attempt.

The magnitude of the illicit tobacco problem in Australia, as we understand it, is debatable and contentious. Tobacco companies have commissioned a number of reports (from prominent consultancy companies) on illicit tobacco in Australia. Public commentary and critiques of these reports has questioned the large estimates on the size of the illicit tobacco market in Australia, and questioned the credibility of industry sponsored research and analysis.

It is possible that the tobacco industry wishes to amplify the size of the problem, and in turn, use it as a counterargument against tobacco control measures (such as plain packaging and continued

excise increases) that seek to further reduce their market. This is not to suggest that illicit tobacco is not consumed in Australia.

However, the detection of illegal importation should not be used as evidence to weaken Australia's position in relation to tobacco control measures. The tobacco industry argued that the introduction of plain tobacco packaging would result in significant increases in illicit tobacco consumption in Australia. Recent, credible research[1] has found no evidence of this. Further, initial research shows that plain tobacco packaging has had a number of promising impacts including:

- plain tobacco packaging reduces the appeal of cigarette packaging, particularly among young people;
- plain packaging results in smokers noticing and paying more attention to the graphic health warnings; and
- plain tobacco packaging results in more smokers considering a quit attempt or actually engaging in a quit attempt.[2]

More recently there has been some debate about the continuation of increases to tobacco excise. Increasing the price of tobacco products is the most effective measure we currently have available to decrease smoking rates. Evidence shows that for every 10 percent increase in price, there is a four percent reduction in consumption. The tobacco industry has argued that increasing the price of tobacco products will increase the market for cheaper illicit tobacco.

It is possible that an increase in price may initially increase demand for cheaper tobacco products. However, appropriate monitoring and action by government should reduce the amount of illicit tobacco that is available. Increased price, in the absence of cheaper illicit tobacco, will encourage smokers to quit, and deter non-smokers from taking up smoking.

It is vital that the response to illicit tobacco in Australia is informed by independent and credible research into the extent of the problem. At this stage, we do not have access to this information, and therefor would caution the Committee about recommending any responses that undermine tobacco control measures in Australia.

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Tobacco Smoking and E-cigarettes

2015

The AMA position

1. The Australian Medical Association (AMA) recognises that tobacco is unique among consumer products in that it causes disease and premature death when used exactly as intended. There is no safe level of tobacco smoking.

2. The AMA believes that medical practitioners have a responsibility to encourage all smokers to quit smoking. Medical practitioners share a responsibility to advise their patients on the well-established risks associated with smoking, to assist patients in their attempts to quit smoking, and to co-operate with community education programs that aim to discourage smoking.

3. The AMA acknowledges that the highly addictive quality of nicotine makes it difficult for smokers to quit. For this reason, smokers must be encouraged and supported to give up smoking at every opportunity. Workplaces can play an important role in this regard. Pharmaceuticals that assist in quitting smoking, such as medications and nicotine replacement therapy, should be affordable and less expensive than cigarettes.

4. The AMA supports more targeted research into methods of smoking cessation. This is a particular priority for population groups who bear a greater burden of smoking and smoking-related disease, such as Aboriginal and Torres Strait Islander people, people with mental illness and those from lower socio-economic backgrounds.

5. The AMA believes it inappropriate for political parties to accept sponsorship from tobacco companies and calls upon all parties to refuse to enter into arrangements that clearly compromise government health policy.

6. The AMA supports efforts from medical organisations and anti-smoking organisations in approaching the Federal Government regarding a class action against tobacco companies on smoking-related diseases.

7. The AMA calls on all governments to make repeated real increases in the rate of tobacco taxation and to set aside the resulting revenue into health promotion activities.

8. The AMA recognises the risk associated with exposure to second-hand smoke, particularly among infants and young children who may be unable to avoid exposure. For this reason the AMA is supportive of measures that seek to reduce children's exposure to second-hand smoke in confined spaces, including the home and in motor vehicles.

9. The AMA believes that product placement in television programs and movies should be acknowledged at the beginning of the program through a dedicated classification symbol that alerts viewers to the depiction of smoking during the broadcast. A warning message should also be aired to alert viewers to depictions of smoking, in the same way as viewers are alerted to other sensitive content such as drug use, violence and coarse language. The AMA also supports counter advertising to reduce the impact of smoking portrayals, particularly among young people.

10. The AMA believes that smoking by teachers, staff, pupils and visitors on, or in the immediate vicinity of, school premises should be banned because of the influence of such behaviour on the early development of smoking habits in children as well as the risk of second-hand smoke exposure.

11. The AMA believes that medical practitioners and other health professionals should not smoke in public when they are identifiable in their occupational role.

12. The AMA believes that all forms of public promotion and marketing of tobacco products should be banned. Tobacco products should not be promoted at the point of sale. Internal promotion by those in the tobacco trade should be strictly proscribed. Where it is required, it should be limited to the provision of information about price, availability and characteristics.

13. The AMA is committed to precluding minors from obtaining cigarettes. Any initiative that helps to increase the age at which people first experiment with tobacco products is likely to have an effect on the overall burden of smoking-related diseases in our community. Governments and police forces have a responsibility to enforce the law regarding the sale of tobacco products to minors. These efforts are enhanced though measures such as Controlled Purchasing Operations.

14. The AMA asserts that passive or environmental tobacco smoke is harmful to health. Smoking should be prohibited in all public areas without exception, including all workplaces, restaurants, gambling venues and public transport. All workers are entitled to a smoke-free workplace.

15. The AMA has significant concerns about e-cigarettes. E-cigarettes and the related products should only be available to those people aged 18 years and over and the marketing and advertising of e-cigarettes should be subject to the same restrictions as cigarettes. E-cigarettes must not be marketed as cessation aids as such claims are not supported by evidence at this time.

Background

Tobacco is unique among consumer products in that it causes disease and premature death when used exactly as intended. There is no safe level of tobacco smoking. In Australia, tobacco smoking is the largest single preventable cause of death and disease. [1] Smoking contributes to more deaths and hospitalisations than alcohol and illicit drug use combined. It is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, respiratory disease and cancer. Tobacco smoking accounts for 13 percent (or 15,525) of cancers in Australia, including 81 percent (or 8,324) of lung cancers, 59 percent (or 1,973) of oral and pharynx cancers, 60 percent (or 855) of oesophageal cancer and 6 percent (or 951) of colorectal cancers.[2] Tobacco use harms not only the individual smoker, but it can also harm those who are exposed through second-hand tobacco smoke.

Smoking rates in Australia have declined over the past few decades, but 16 percent, or 2.8 million people, in Australia continue to smoke.[3] Tobacco smoking is a contributor to ill health, responsible for 8 percent of the burden of disease in Australia.[4] Each year 15,000 Australians die as a result of tobacco smoking.[5] A large scale Australian study recently found that two in three smokers (1.8 million people) will die as a result of their smoking.[6]

A decade ago, the cost of tobacco smoking in Australia was estimated at $31.5 billion in social (including health) and economic costs.[7] Continued efforts to reduce rates of tobacco smoking are imperative.

In order to reduce the disease, disability and premature death caused by smoking, the AMA (and the medical profession more broadly) is committed to efforts that seek to continually reduce the number of people who smoke tobacco. To achieve this objective, the following changes are necessary:

- continued changes in the social climate, so that smoking is no longer viewed as normal, but is regarded as unhealthy and unnecessary;
- continued changes to the economic and legislative climate, so that cigarettes are less readily available, the influences such as advertising and the media that promote smoking are diminishing, and educational programs on the hazards of smoking are supported and reinforced; and
- multifactorial approaches to assist and support cigarette smokers in quitting, including: strategies targeted at individual smokers, use of taxation and encouraging smoke-free environments.

The National Tobacco Strategy 2012-18 acknowledges the importance of tobacco control measures in Australia, and states a national target to "reduce the national smoking rate to 10 percent of the population, and to halve the Indigenous smoking rate, over the 2009 baseline, by the year 2018". [8]

Demographics of Those Who Smoke

Despite the general decline, rates of smoking remain high among some disadvantaged groups. [9] The relationship between disadvantage and smoking is cumulative, so as the level of disadvantage increases, so do rates of smoking.[10] Higher rates of smoking are also observed in disadvantaged communities.[11] Becoming a smoker in some disadvantaged communities, where smoking is the norm, may be a way of increasing social networks. Disadvantaged smokers may also experience less success with their attempts to quit smoking, possibly because of factors including: lack of support, greater addiction to tobacco, less motivation to quit, lower adherence to cessation treatments, differences in perception and increased exposure to tobacco marketing.[12]

Australia's National Tobacco Strategy notes higher smoking rates among the following groups:

- the unemployed
- the homeless
- those who are in prison
- those with mental illness
- those with alcohol or illicit drug dependency
- Aboriginal and Torres Strait Islander people, and
- some Culturally and Linguistically Diverse groups (particularly among men of Arabic, Chinese and Vietnamese backgrounds).[13]

There is a well-documented link between socio-economic status and health status. Individual indicators, such as educational attainment, income and occupation are also known to be predictors of smoking.[14] Tackling the higher prevalence of smoking in disadvantaged groups will require a combination of tobacco control measures as well as broader efforts to address inequality.[15]

Smoking during Pregnancy

Around one in seven women report smoking during pregnancy.[16] There is no safe level of cigarette smoking at any time, but especially for the fetus during pregnancy. The effects of smoking can start *in utero*. The nicotine in cigarettes may constrict blood vessels in the umbilical cord and uterus, decreasing the oxygen available to the fetus. Research shows that smoking during pregnancy increases the risks of pregnancy complications, premature delivery, low birth weight infants, stillbirth and sudden infant death. It also contributes to reduced lung function in infants. Nicotine is also found in breast milk.[17] These infants are then at greater risk of adverse health and social outcomes throughout life. In this situation, smoking can be seen in the context of contributing to a generational cycle of disadvantage.

Some pregnant women will be reluctant to disclose that they smoke. Health professionals who engage with pregnant women must be mindful of this possibility and provide non-judgemental support and advice on appropriate cessation options. Financial incentives have been shown to increase cessation in pregnant women.[18]

In 2010, it was estimated that 6percent of households with children aged 0–14 had someone who smoked at least one cigarette, cigar or pipe daily inside the home.[19] Second-hand tobacco smoke exposure for infants and young children has been known to cause or exacerbate childhood obesity, behaviour problems, wheezing, asthma, bronchiolitis, pneumonia, middle ear infection, reduced lung function, coughing and cancer. [20] Further the combination of tobacco smoke exposure and low birth weight increases the risk for a range of cardio metabolic diseases and mortality in later life.

Adolescence

Adolescence is a period of increased risk when it comes to smoking. Young people may not consider the long term implications of behaviours such as smoking, and they are also vulnerable to peer pressure. The younger a person takes up smoking, the more entrenched the behaviour is likely to

become, making quitting more difficult. Factors known to influence the uptake of smoking among adolescents include: parental smoking status (role modelling, social norms in the home and access to cigarettes), lower awareness and underestimation of harms associated with smoking, and behavioural and educational problems.

Most smokers take up smoking during adolescence, with very few people taking up smoking after the age of 25 years.[21] This makes it vitally important to invest in interventions that seek to delay the uptake of smoking among young people. Media and education campaigns that seek to reduce the desire to smoke among children and young people are important, as is reducing exposure to advertising and marketing of tobacco products.

Measures that seek to restrict young people's access to tobacco products are also important. Recognising this, in Australia it is an offence to lend, give or sell cigarettes or tobacco to anyone under the age of 18 years. Retailers are encouraged to check the identification to establish that customers are old enough to purchase tobacco products. State Governments oversee the practice of controlled purchase operations, whereby trained officers and volunteer teenagers check whether retailers are selling cigarettes to children. Retailers who are selling cigarettes to children should be prosecuted and should also lose their licence to sell tobacco products.

Aboriginal and Torres Strait Islander peoples

Declines in smoking rates have been observed among Aboriginal and Torres Strait Islander people in recent years. However rates of smoking among Aboriginal and Torres Strait Islander people are still more than twice that of non-Indigenous adults in Australia (43 percent in 2013). [22] Exposure of Aboriginal and Torres Strait Islander children to second-hand smoke in their homes is high[23] and the rate of smoking during pregnancy is also high.[24]

Tobacco control measures that have been successful in the general population are not always successful for Aboriginal and Torres Strait Islander people.[25] For some Aboriginal and Torres Strait Islander communities, where smoking is ingrained, it may play a role in ensuring social cohesion, reinforcing family relationships and affirming cultural identity.[26] Pursuing measures that seek to prevent and/or reduce smoking in key groups, including pregnant women, families and among health workers, is likely to accelerate efforts to reduce smoking rates.

Unfortunately, there is little scientific evidence of useful interventions to cease smoking in these populations. As smoking is such a key factor in the birth of Indigenous low weight babies, research to determine the best methods to assist Indigenous women to stop smoking is a priority.

People with Mental Illness

People with a mental illness, particularly a psychotic illness, show significantly elevated rates of cigarette smoking compared with the general population (32 percent).[27] Unfortunately, cardiovascular disease, which may be attributable to smoking, is a leading cause of illness and death among this group. [28]

People with mental illness deserve the same support to cease smoking and to avoid its burden of disease as other members of the community. Cessation measures may need to be tailored for this group in order to ensure that these efforts do not undermine their overall health and wellbeing.

The AMA acknowledges that for some people with mental illness and those in custodial settings, smoking cessation is more complex and other factors need to be taken into account when encouraging quit attempts, and providing support to cease smoking

Health and Medical Professionals

Health and medical professionals should refrain from smoking when they are identifiable in their professional capacity as there is significant potential to undermine anti-smoking messages. Health institutions should aim to offer programs to support smoking cessation among their patients, as well as among staff. Medical and hospital institutions must enforce smoking bans on their grounds.

Tobacco Smoking Cessation

Nicotine is highly addictive, making quitting smoking a difficult and challenging process. Cigarette smokers have to change many entrenched behaviours if they want to quit, and they may also have to deal with nicotine withdrawal. Smokers therefore require all possible assistance and support in giving up smoking and in staying a non-smoker.

Many smokers want to quit. Estimates indicate that approximately 60 percent of smokers are thinking about, or preparing for a quit attempt.[29] Unfortunately only three to five percent of unaided quit attempts are successful. [30] The rate of successful quit attempts increases to between 25 and 30 percent, if the approach incorporates clinically appropriate cessation tools and counselling and support is provided by a health professional.[31]

There are immediate health benefits for anyone who decides to quit smoking. This includes those people who have already been diagnosed with smoking related disease.

There is sufficient evidence for nicotine replacement therapy (NRT) to be made available to people smoking more than 10-15 cigarettes a day. While the use of NRT may not suit everyone, it can be successful in supporting the behavioural change necessary for quitting smoking. More recently, pharmacological tools have become available to support smoking cessation. All medicines, including NRT and combination therapies that are recognised by the appropriate authorities for their role in smoking cessation should be affordable and less expensive than cigarettes.

It is essential that strategic, targeted research be undertaken regarding the supportive environments required for people to cease smoking, particularly among those groups with higher levels of smoking, including Aboriginal and Torres Strait Islander people and those from lower socio-economic backgrounds.

The Role of the Doctor

Medical practitioners play an important role in encouraging and supporting their patients to quit smoking. Doctors have a responsibility to address, support and encourage patients in ceasing cigarette smoking. Each consultation provides an opportunity to do this, even through a simple question about a patient's smoking practices.

For those patients who indicate an interest in quitting smoking, doctors will assess the level of nicotine dependence and provide advice on suitable cessation options.[32] There is evidence that the provision of brief advice on smoking cessation from a health professional can assist smokers to quit.[33]

Some patients may be reluctant to quit smoking for fear of gaining weight. While it is common for people to gain weight during the quitting process it is not inevitable. Patients can be reassured that activities such as drinking more water, engaging in more physical activity and healthy snacking can reduce the likelihood of weight gain during cessation.

Tobacco Promotion and Advertising

Australia is considered a 'dark market' by the tobacco industry as it does not allow advertising of their products in any form. Direct cigarette advertising on radio and television was phased out in the mid-1970s and in the print media by the early 1990s. Internet based advertising is also outlawed. Nevertheless, tobacco companies continue to invest in activities that aim to attract new smokers.

Australia was one of the first countries to legislate an end to the association between tobacco sponsorship and sporting events. The Tobacco Advertising Prohibition Act 1992 expressly prohibits most forms of tobacco advertising, including the sponsorship of sporting events. Existing sponsorships were allowed to run their course, but no new sponsorships were permitted by the Act.

Tobacco Companies' Use of the Media

While there are restrictions on the overt promotion and advertising of tobacco products in the media, product placement in films and television programs is one avenue that continues to be used to promote tobacco products.

There are legitimate concerns about the depiction of tobacco use on screen because of the potential effect it could have on influencing young people to start, and continue, smoking. Through tobacco use on screen, receptive individuals associate stylised, branded smoking behaviour with other aspirational elements of our culture. The evidence strongly suggests that the depiction of smoking in movies and on television is a contributor to the uptake of smoking among young people.[34]

There is an international movement to limit the depiction of smoking in the media. The Indian Government ordered that from mid-2005 no one on film or television should be depicted smoking, and when old films are shown they have to carry warnings or they will have smoking scenes blurred.

One approach that might be suitable for the Australian context is the addition of a warning at the start of a film or television program that alerts the viewer to depictions of smoking, in the same way viewers are alerted to other sensitive content such as drug use, violence and coarse language. Counter advertising may also reduce the impact of smoking portrayals.

Tobacco Companies and Political Influence

There is no doubt that, like most other industry groups, the tobacco industry lobbies and advocates for conditions that foster and support business growth. Legal and political efforts by the tobacco industry have hampered tobacco control efforts.[35] Given that the cost of using tobacco products is largely carried by smokers, their families and the Government via the health system, it is not appropriate for political parties and other key decision making bodies to accept financial donations from tobacco companies. Governments and research bodies should also be attuned to attempts by the tobacco industry to gain access to sensitive data, particularly information around the preferences and desires of children and young people.

Cigarette Packaging

Cigarette packaging is an important marketing tool for cigarette producers. Attractive and brand recognisable tobacco packaging is intended to sustain smoking and to encourage its uptake in those who do not already smoke. Tobacco packaging has been used to convey social messages around social status, values and character, and there is evidence that it works.[36]

Recognising this, in 2011 the Australian Government legislated for Tobacco Plain Packaging, as part of efforts to reduce the appeal of cigarette smoking. Plain tobacco packaging ensures that all cigarette packages are uniform in appearance, that they are indistinguishable unless closely examined, and that they can no longer be used to reinforce smoking.

This legislation made Australia a world leader in tobacco control. A number of other countries are considering the introduction of similar measures. The measure has not been in place for long enough to establish strong evidence of effectiveness. Preliminary research is very promising though, with some evidence that:

- plain tobacco packaging reduces the appeal of cigarette packaging, particularly among young people;
- plain packaging results in smokers noticing and paying more attention to the graphic health warnings; and
- plain tobacco packaging results in more smokers considering a quit attempt or actually engaging in a quit attempt.[37]

There is no evidence that plain packaging has resulted in an increase in consumption of illicit tobacco products.[38]

In Australia the Government also requires graphic health warnings to be included on the packaging of tobacco products. The warnings aim to increase knowledge about the health impacts of smoking, encourage smokers to quit and to discourage uptake and relapse. An early evaluation of the warnings found that they were successful but also identified opportunities for improvement.[39] These warning should be continually refined in order to maximise their impact.

Tobacco Product Labelling

The tobacco industry has been misleading consumers over so-called 'light', 'mild' and 'low tar' brands for many years. This strategy can be considered to be nothing less than systematic consumer fraud given that labelling cigarettes as 'light' and 'mild' offers smokers a false sense of security based on sophisticated marketing and a misuse of words. Industry documents have revealed that tobacco companies have long recognised that these products are as dangerous as regular cigarettes – but they have continued to push them as healthy alternatives.[40]

In 2005, the Australian Competition and Consumer Commission (ACCC) obtained court-enforceable undertakings from British American Tobacco Australia Limited and Philip Morris Limited to remove 'light', 'mild' and similar descriptors from their products. The companies paid $8 million in total to the ACCC to fund anti-smoking information campaigns and programs.

In the ACCC's view, such '*health claims for low-yield cigarettes were likely to have breached section 52 (misleading and deceptive conduct provision) and other sections of the* Trade Practices Act 1974*, for reasons including the fact that it was generally known that smokers can, and do, compensate for claimed lower yields by smoking cigarettes in ways that obtain higher yields of tar, nicotine and carbon monoxide than indicated on the packets*.'[41]

Smoke-free Environments

Passive (involuntary) smoking involves inhaling cancer-causing substances as well as other toxic components in second-hand tobacco smoke. More than 50 studies of involuntary smoking and lung cancer risk in people who have never smoked, especially spouses of smokers, have been published during the last 25 years.[42]

This evidence is sufficient to conclude that involuntary smoking is a cause of lung cancer in people who have never smoked. In Australia, recent analysis suggests that 136 cases of lung cancer per year are attributable to second-hand smoke exposure.[43] But it is not just lung cancer. Involuntary smoking is associated with a number of other diseases and adverse effects in non-smokers. Exposure to second-hand tobacco smoke causes:

- coronary heart disease;
- A 25-35 percent increased risk of acute heart disease; and
- adverse effects on the respiratory system.

People have a right to a clean, safe working environment. This includes a smoke-free environment. While most Australian workplaces are now smoke-free, within the hospitality industry there are still some workplaces where workers are exposed to passive smoking. It is unacceptable to discriminate against certain groups of workers when determining workplace safety policy. Workers in bars, pubs and gambling venues have just as much right to a safe, smoke-free workplace as any other workers. The only way to protect workers' health is to ban smoking in all workplaces.

Other environments that have not always been considered smoke-free workplaces are mental health facilities. While acknowledging the burden and challenges of ill-health already experienced by those with mental illness, those working in these areas are also entitled to a smoke-free workplace.

A smoke-free home environment will reduce the impact of smoking on children and also decrease the likelihood that they will also take up smoking. There have also been recent efforts to have cars legislated as smoke-free environments – especially to protect children from cigarette smoke.

Tobacco Taxation

Increasing tobacco excise increases the price for tobacco products and results in a decline in tobacco use. It is the single most effective intervention to reduce demand for tobacco products. Evidence showing that for every 10 percent increase in price, there is a four percent reduction in consumption.[44] Therefore, governments should be encouraged to make repeated real increases in the rate of tobacco taxation, setting aside some of the revenue for activities that encourage and support smokers to quit smoking and to delay the uptake of smoking among young people. Taxes must be also be structured to ensure that roll-your-own cigarettes are not a cheaper nicotine alternative.

The AMA supports the reductions to duty free exemptions for tobacco products, but would ultimately like to see the duty free exemption removed entirely removing the opportunity to purchase cheaper tobacco products.

Research

Research supports the making of good policy decisions. Research should be conducted into the reasons why people commence smoking, into methods to help smokers to cease smoking, and into the social and economic cost to the community of the ill-effects of smoking on health. Research needs to be targeted to assist those population groups that bear the greatest smoking burden, such as Aboriginal and Torres Strait Islander people, people with mental health conditions and those from lower socio-economic groups, to give up smoking. Research should also focus on contemporary issues such as internet advertising and on e-cigarettes.

It is inappropriate for medical research to be directly funded by the tobacco industry. If a researcher undertaking research into smoking-related issues has accepted funding from a tobacco company, it should be mandatory to report the amount and the precise source of funding in the preamble to any presentation or publication of material developed as a result of that research.

E-cigarettes

E-cigarettes are battery-powered devices that are designed to mimic smoking by emitting an aerosol (or vapour) to the user, typically containing propylene glycol or glycerol, with or without nicotine. The inhaled aerosol is often flavoured, raising concerns about their intended appeal to young people and their potential to act as a gateway to tobacco smoking. There is considerable concern about the role of the tobacco industry who have invested heavily in the development and promotion of E-cigarettes.

Despite the variation in the legal status of E-cigarettes across the Australian jurisdictions, use of E-cigarettes has increased dramatically. Research with Victorian adults in 2013 found 7.3 percent had used an E-cigarette in the past 12 months, compared with 3.6% in 2012, 1.8 percent in 2011 and 0.7 percent in 2011, with use more likely in younger age groups.[45]

E-cigarettes are being marketed as smoking cessation aids. The evidence supporting the role of E-cigarettes in cessation is mixed and low level[46], and E-cigarettes are not currently recognised as cessation aids by the National Health and Medical Research Council, the Therapeutic Goods Administration or the World Health Organisation. In fact, using an E-cigarette may significantly delay the decision to quit smoking. In addition, there is uncertainty about the longer term health implications of inhaling the vapours produced by the illegally imported (and unregulated) solutions.

There are legitimate concerns that e-cigarettes normalise the act of smoking. This has the potential to undermine the significant efforts that have been dedicated to reducing the appeal of cigarettes to children, young people and the wider population. These concerns are supported by research findings that young people using E-cigarettes progress to tobacco smoking.[47] Currently there is no medical reason to start using an E-cigarette.

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