Australasian College
for Emergency Medicine

Position Statement

Tobacco Smoking and E-Cigarettes

This document is a statement of the Australasian College for Emergency Medicine (ACEM) and relates to the negative health impacts of tobacco and e-cigarettes. The statement has been expanded to include e-cigarettes to reflect the view that e-cigarettes and their related products should be treated the same way as traditional tobacco cigarettes.

January 2022

Document review

Timeframe for review:	every three (3) years, or earlier if required.
Document authorisation:	Council of Advocacy, Practice and Partnerships (CAPP)
Document implementation:	Standards and Endorsement Committee
Document maintenance:	Policy Officer, Policy and Research

Revision history

Version	Date	Revisions
1	Jul 2006	First version
2	Mar 2012	Revised document
3	Jul 2019	New template adopted
4	Dec 2021	Substantial change including inclusion of e-cigarettes

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1. Background

ACEM recognises that tobacco smoking remains the largest single preventable risk factor for death and disease in Australia and New Zealand. Smoking is well recognised as a major preventable cause of respiratory and cardiovascular disease, and of cancer. Within New Zealand smoking is also a contributor to health outcome inequities, with higher rates of smoking among Māori compared to non-Māori, and between low-income and high-income populations. Similarly, in Australia, tobacco smoking has become normalised in Aboriginal and Torres Strait Islander Communities, such that, although declining, persisting high rates of smoking and second-hand smoke continue to contribute to ill health and disease.[1]

Although there have been remarkable decreases in prevalence of tobacco smoking through the implementation of public health policies in Australia and New Zealand over the last twenty years, New Zealand is currently not on track to achieve the goal of Smoke-free Aotearoa by 2025. Currently, 11.6% of adults are daily smokers, and 13.4% smoke at least monthly.[2] Concerningly certain demographic groups have higher rates of smoking, with daily smoking rates of 12.9% in young adults aged 18-24 years, 28.7% of Māori adults and 18.3% of Pacific adults compared to New Zealand European adults 10.1%. Within these groups Māori women have the highest smoking rate at 32% (Māori men 25%).[1]

The College recognises the need for different approaches tailored to priority populations - including but not limited to First Nations peoples, culturally and linguistically diverse (CALD) communities, people with disability, people with mental health illnesses, and people who live with socioeconomic disadvantage.

For all sexes, tobacco use remains the leading risk factor for preventable disease burden in Australia with almost 20,500 attributable deaths (13% of all deaths) in 2018.[3] This burden manifests in the form of preventable ED presentations, from recurrent presentations associated with smoking-related lung diseases, such as chronic obstructive pulmonary disease (COPD) and emphysema, to serious acute illness such as cardiovascular diseases and stroke. Given the substantial impact of tobacco associated health harms on EDs, ACEM has a vested interest in strongly advocating for legislation, policies and programs that support smoking cessation.

In adopting a life-course view to tobacco related harms, ACEM believes there are several key periods in which encouraging smoking cessation is particularly relevant as follows:

- ***Pre-conception, pregnancy and early childhood:*** In the decade between 2009-2019, the percentage of people who smoked during pregnancy was reduced from 14.6% to 10.2% in Australia.[4] In Australia, between 2011-2017, the proportion of mothers smoking during the first 20 weeks of pregnancy fell from 13% to 9.5%.[5] Similarly, in New Zealand, 16% of pregnant women were smokers in 2008, and this fell to 13% in 2021.[6] There are a multitude of negative health effects associated with smoking during pregnancy, including increased risk of perinatal mortality, low birth weight, and prematurity. Passive smoke exposure in early childhood is associated with increased respiratory illness, asthma, and sudden infant death syndrome.[7] Awareness of these potential health impacts can serve as motivation to cease smoking. However, pregnant smokers, especially those who experience social disadvantage are at risk of a range of barriers to smoking cessation, including perceived psychological benefits and expectations and relationships with partners and social supports. Breastfeeding and positive relationships with healthcare providers can conversely support quitting.[8]
- ***Adolescence:*** This is a key age group in which early experimentation with tobacco products can transition to smoking initiation and, consequently, established dependence and addiction. In Australia, daily smoking rates in the 18-24 years age group reduced by more than half from 2001-2019 for both males (24.5% to 10.0%) and females (23.5% to 8.5%). The age of initiation of tobacco increased in the same time period from 14.3 years to 16.6 years and the percentage of young people who had never smoked increased for both the 14-17 year old age group (from 82% in 2001 up to 97% in 2019) and the 18-24 year old age group (from 58% in 2001 to 80% in 2019). However, the chief concern in this age group is the rise in the number of young people who had used e-cigarettes. For people aged 18-24, 26% had used an e-cigarette in their lifetime, the largest proportion for any Australian age group, and 64% of current smokers in this age group had used an e-cigarette. Especially concerning is the rapidity of this increase and among people who were previously a "never-smoker." In 2016, for this 18-24 year old age group only 19.2% of people and 49% of current smokers had ever used an e-cigarette. At the time of first trying an e-cigarette, 65% of 14-17 years and 39% of 18-24 years were a "never-smoker."[9]

- ***Middle age and later years:*** There is significant utility in supporting people to reduce and cease smoking, even when they experience the deleterious health effects of tobacco. Smoking cessation is the best strategy for delaying the progression and reducing mortality of COPD.[10] Similarly, quitting smoking is reduces the risk of all-cause mortality by at least one third for patients with coronary heart disease.[11]

1.1 Methods of consuming tobacco products

Irrespective of the mode of delivery, tobacco products contribute to nicotine addiction and health harms.[12]

Smokeless tobacco refers to a range of products where tobacco is held in the mouth, to allow for oral absorption of nicotine, such as chewing tobacco, snuff and snus. Smokeless tobacco is less dangerous than cigarettes, where tobacco is burnt and nicotine absorbed through inhalation, but still contributes to addiction and can especially increase the risk of oral and dental harms.[13]

The use of e-cigarettes, commonly known as vaping, has been thought less harmful than tobacco smoking, however there is a lack of long-term clinical data to support this sentiment. Concerningly there has been some uptake of the use of e-cigarettes in groups that previously were statistically unlikely to commence smoking, especially young people.[14] Some people use e-cigarettes as a means to quit tobacco smoking, however there is a lack of evidence that supports this as a viable, non-addictive, and less harmful means of long-term cessation of smoking.[15,16] E-cigarettes have also been associated with nicotine-independent specific harms, in the form of e-cigarette or vaping product use-associated lung injury (EVALI). Since first reports in 2019, there have been over 2,600 cases reported to the United States Centre for Disease Control and 57 confirmed deaths, predominantly affecting young people with the median age of EVALI patients 24 years.[17]

2. Position

ACEM supports all jurisdictions moving to ban all smoking, e-cigarette, and smokeless tobacco products. This can be achieved by creating, maintaining, and increasing the number of tobacco and vaping free environments, and introducing measures to reduce the purchase and consumption of these products to normalise a society free of the harms caused by these products for the next generation. This stance benefits the health of current smokers, and the health of those around them, in particular high-risk groups.

ACEM urges all jurisdictions to adopt evidence-based approaches to tobacco cessation, including treating tobacco and e-cigarette addiction from a health perspective. This should incorporate an evidence-based approach to brief interventions, nicotine replacement therapy, and tobacco cessation referrals from EDs.

ACEM supports the following approaches to achieve the complete cessation of smoking and the use of e-cigarettes in Australia and Aotearoa New Zealand, with reference to the WHO Framework Convention on Tobacco Control: [17,18]

- strengthen the tobacco and e-cigarette regulatory system,
- support current smokers and vapers to stop,
- reduce the numbers of young people that start smoking or using e-cigarettes,
- make products less available,
- make products less addictive and less appealing, and
- make products less affordable.
- a lifespan approach for targeted action as described above accompanied by equity focussed interventions that address the social determinants of health for populations at higher risk of tobacco and nicotine use and harms.

3. Recommendations

In order to transition to a society free of smoking and e-cigarettes, jurisdictions will first need to take steps to reduce their consumption before an outright cessation of smoking can be achieved. The key steps to achieve this are to:

a. Ban the sale of tobacco and e-cigarette products to all people born after 2025.

b. Immediate actions must be taken to achieve lower smoking rates in all age groups, in particular preventing and delaying tobacco initiation for youth and other high-risk groups, including smoking and the use of e-cigarettes.

c. Tobacco and e-cigarette promotion, advertisement, and sponsorship should be banned.

d. All tobacco and e-cigarette products and advertising must be produced with accurate health warnings.

e. Current smokers and e-cigarette users should be supported to quit. Health systems must improve access to evidence-based measures that assist with smoking and e-cigarette cessation. All health professionals should receive appropriate training to support patients to quit.[18] ED physicians should be provided with the resources to give their patients who smoke or use e-cigarettes tailored advice on the health risks and to make referrals to quitting services.[19,20] Access to evidence-based nicotine replacement therapies and other pharmacological and non-pharmacological supports should be improved, including removing barriers such as high costs which disproportionately affect those at greatest risk of tobacco addiction. [21]

f. Implement measures to provide protection to non-smokers from passive smoking.

g. Normalise smoke-free environments. This should include the banning and enforcement of tobacco smoking and the use of e-cigarettes in public places, all healthcare facilities, and other designated spaces.

h. All tobacco, nicotine, and e-cigarette products must be produced with plain packaging. This is particularly important for products that target younger people through colourful and enticing packages., such as e-cigarettes and e-liquids.[22] Greater funding is needed for research on the longer-term health impacts of e-cigarettes. Further research is also needed to identify effective strategies to support smoking cessation in high-risk groups.[23,24]

i. Liquid nicotine refills continue to only be available via prescriptions.

j. Tobacco cigarettes and e-cigarettes should not be sold in specialist shops that are within one kilometre of a school.

k. A smoke free generation policy would prohibit the sale, and the supply in public place, of smoking tobacco products and e-cigarettes to new cohorts from a specific date. For example, if legislation commenced on 1 January 2025, then people younger than 18 years at that time or those born after 1 January 2004 would never be able to lawfully be sold tobacco products or e-cigarettes.

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