

Seeing past the smoke

With an estimated 1,100 million regular smokers in the world today and one related death every 10 seconds, tobacco is one of the world's most used and most dangerous drugs. **Ann McNeill** and **Jamie Bridge** suggest how harm reduction philosophy could replace the usual global 'quit or die' response.

In recent years, there have been many successful interventions and campaigns around the world to reduce or prevent tobacco consumption. In the UK, price increases, marketing bans, sales restrictions, warnings on packaging, nationwide smoking cessation campaigns and services, and education in schools have helped to gradually reduce the prevalence of cigarette consumption. It is anticipated that new smoke free legislation across the UK will have an additional impact.

However, there is still a significant population in every country who are either unable or unwilling to stop smoking, and they are often people from the most deprived areas or groups. In the developing world, where the epidemic is still at an early stage, the toll of tobacco-related mortality and morbidity will be unprecedented for years to come in many countries; if current smoking patterns continue across the world, an estimated 10 million people will die every year as a result of their habit by 2020. Something has to be done to reduce the harms faced by those who continue smoking – we cannot simply disregard and condemn them.

To address this issue, the International Harm Reduction Association (IHRA) took a strategic decision in 2004 to broaden its scope from illicit drugs to all psychoactive substances, including tobacco and alcohol. Harm reduction is an approach widely applied to illicit drug use, which explicitly accepts the continued use of substances, and aims to reduce the associated harms. For illicit drugs, this can involve providing sterile injecting equipment, safe substitute treatments, outreach and peer support, or advice on how to use drugs as safely as possible. For tobacco, however, this approach has received little attention to date.

The premise behind the tobacco

harm reduction approach is that most tobacco use is underpinned by a dependence on nicotine. However, it is not the nicotine that causes most of the harm but rather some of the other 4,000 constituents of cigarette smoke, of which 60 are known carcinogens. Drawing an analogy with illicit drug use, the cigarette is the equivalent of the 'dirty syringe'. Consideration therefore needs to be given to separating the drug from the delivery system.

Cigarettes are the most dominant global tobacco product – highly engineered and sophisticated devices designed to deliver nicotine efficiently to the human body. They are also the most dangerous, and eventually kill about half of those who regularly use them. Although there will never be a truly 'safe' cigarette, it may be theoretically possible to design slightly less harmful cigarettes.

However, very little attention is paid to what goes into the cigarette and what comes out of it – the cigarette is virtually unregulated. One exception to this (highlighted in the IHRA collection – see box) is 'reduced tar' cigarettes, which are deceptively marketed in many countries as 'mild' or 'light'. Cigarette manufacturers often comply with tar reducing legislation by making cosmetic changes to their products, such as adding more ventilation holes to the filters, which provide limited benefits for smokers. Many smokers turn to these brands rather than quitting but then alter the way they smoke in order to compensate for the reductions in nicotine, by taking more puffs, deeper puffs, smoking right down to the butt, or by covering the holes on the filters. While these cigarettes pass the standard machine-operated regulatory tests, they fail to account for the associated behavioural changes, and it is widely accepted that these products have had limited (if any) positive impact on public health.

In the spirit of harm reduction, the tobacco industry and tobacco regulators are negligent if they do not do all within their powers to make cigarettes less harmful for continuing tobacco users. This may include designing cigarettes with a reduced propensity to cause accidental fires, regulating smoke constituents, or changing harmful ingredients that are often added for taste or smoothness.

One alternative to cigarettes is smokeless tobacco, which is currently used around the world in a range of forms – from the high-risk (and largely unregulated) smokeless products used across South Asia, through the fermented and medium-risk products in the USA and Canada, to the much lower-risk (and more highly manufactured and regulated) products used in Sweden. There is a growing recognition that the latter product in particular, which is generally known as 'snus', is significantly less harmful than smoking (but not harmless). There are also products which heat, rather than burn, tobacco – such as 'Eclipse', which is marketed in the USA as a safer alternative to conventional cigarettes. Whether these products could play a role within a tobacco harm reduction strategy has been the cause of much debate within the tobacco control community.

Some tobacco control experts argue that smokers need to be informed about the different options available to them and the associated levels of risk; only then can they make informed consumer choices. However, Sweden is currently the only European country that allows the supply of snus, thanks to special dispensation from the European Union – who have outlawed smokeless tobacco in the rest of the continent. Significantly, Sweden currently has the lowest rates of lung cancer and cigarette mortality in Europe and is the only European nation to achieve the World Health

Organisation's target for reduced *per capita* cigarette use.

On the flipside, some experts argue that the availability of less harmful tobacco products will simply draw attention away from the tried and tested tobacco control strategies, maintaining people's tobacco use when they would otherwise have quit.

There are also harm reducing alternatives to tobacco itself, such as the increasingly diverse range of Nicotine Replacement Therapies (NRTs). These include such products as nicotine gum, patches, nasal spray, inhalators, tablets and lozenges, and are widely available for purchase and prescription. They have no known long-term adverse health effects and are therefore potential substitutes for cigarettes that address the nicotine dependency underlying most tobacco use for people who cannot stop smoking.

In a harm reduction regime, NRTs can have a key role to play in reducing the levels of death and disease attributed to smoking, and can be used alongside existing efforts to help people stop smoking, prevent people from starting, and reduce the harms that non-smokers face through passive smoking. However, NRTs are relatively expensive, largely unavailable to smokers in the developing world, and much more tightly regulated than cigarettes – even after the licences on these products were recently relaxed in the UK. If an NRT was ever developed which could match cigarettes in terms of nicotine dose and speed of delivery, it would probably not be allowed on the market.

Unfortunately, these regulatory barriers are typical in the clouded world of tobacco and nicotine policy –

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a world where a high-risk nicotine-delivery mechanism (the cigarette) can be widely available, relatively inexpensive and largely uncontrolled, but potential harm reducing alternatives are either banned outright across the continent (smokeless tobacco) or restricted to cessation attempts only (NRTs).

Many public health and tobacco policy experts argue that a single, combined regulatory framework is needed for all tobacco and nicotine products. Having such a policy in place would create a level playing field where cleaner nicotine products could replace cigarettes as the dominant form of nicotine delivery.

As with harm reduction interventions for any psychoactive substance, the key factors are information, choice, coverage and accessibility. None of the products or interventions mentioned in this article are designed to stand alone – they should all be seen as part of a collective approach that sits alongside

cessation, prevention and exposure-reduction strategies (in the same way that harm reduction for illicit drug use can sit alongside demand and supply reduction approaches). If smokers cannot be convinced to quit, they could at least be encouraged to reduce the risks that they face (and the risks that other people face) with the help of products such as long-term NRTs (and possibly the availability of regulated smokeless tobacco products) in the UK.

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Researching the case for tobacco harm reduction

This month, IHRA launches an online collection of the '50 Best' key documents on tobacco harm reduction (funded by the Open Society Institute, and part of a series of document collections on the IHRA website). The aim is to provide a free resource centre to highlight the evidence base, reasoning and justification for tobacco harm reduction.

By providing a free online collection of key documents and resources, IHRA hopes to improve international awareness of tobacco harm reduction approaches. The collection is aimed at anybody interested in this field – including policymakers, advocates and smokers themselves. The collection demonstrates how the harm reduction ideology can be applied outside of the traditional illicit drug remit. It also shows how the current tobacco policies and strategies are failing a significant proportion of smokers and condemning them to potentially reducible risks.

The '50 Best' collection on tobacco harm reduction is now available and fully searchable on the IHRA website – www.ihra.net. In addition to this and the existing collection ('HIV prevention and care for injecting drug users'), IHRA also plans to launch further '50 Best' collections in the near future, including 'Alcohol harm reduction' and 'Policing and harm reduction'. For more information, please contact Jamie.Bridge@ihra.net.