CHAPTER 5

Conclusion: Why Did the UK, US and Australia Have Different E-cigarette Policies?

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Abstract We sought to understand why three countries with similar political systems and similar anti-smoking policy histories developed such very different policies towards e-cigarettes. All appealed to a value-free concept of "evidence" in making use of precautionary and harm reduction principles to deal with the remaining uncertainties in the evidence. Yet policy processes were mediated by important contextual factors. These

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included: the nature and role of the state in each country; the political parties in power at the time e-cigarettes were first introduced; the role played by existing regulatory institutions in dealing with e-cigarettes; longer-term changes in ways of thinking about tobacco smoking within public health; the specific pre-history of tobacco control policy, nicotine and smoking cessation services; the organisation of professional and activist networks that were in favour of and against e-cigarettes; the uses of fear to discourage e-cigarette use; and the influence (or lack thereof) of harm reduction ideas from drug or AIDS policy on tobacco control policy. The object of policy also differed between countries from protecting the smoker to protecting children and young people.

Keywords Evidence · Precautionary principle · E-cigarettes · Nicotine · Policy · Activism · Public health · Fear

The UK, Australia and the US are three nations that share a liberal democratic tradition and each of which adopted similar approaches to reducing the public health toll of cigarette smoking after 1962. By the twenty-first century, all had achieved dramatic reductions in smoking prevalence among adults by introducing a range of tobacco control policies that included increased cigarette taxes, restrictions on tobacco promotion,

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smoke-free policies and public education campaigns to encourage smokers to quit and to discourage non-smokers from taking up smoking.

In the early 2000s, all confronted a new common challenge in deciding how to respond to the marketing of e-cigarettes in the first decades of the new century. Each country pursued a different path towards the regulation of these new products; all did so in the name of public health. In this final chapter, we synthesise our accounts as to why our three countries developed very different policies on e-cigarettes over the last decade. Discussion on the subject has often focused on seemingly value-free concept of "the evidence" and the appeal to "the precautionary principle" and tobacco harm reduction. Our analyses emphasise how these concepts are rooted in and mediated by social and policy contexts.

Our conclusions reveal the important role played by country-specific factors. These include: the nature of the state and the "pre-history" of policies towards tobacco and nicotine in each country, as well as the broader political context. Against that backdrop, also key were leading ideas about tobacco control within regulatory institutions and the role of policy and activist networks in each country. Changes within public health, particularly after World War II, also helped to shape differences, as did the impact of ideas from the field of drugs and HIV. The approach to drugs and HIV heavily influenced the political viability of harm reduction approaches, which had implications for tobacco control and e-cigarettes. Also important were differences in the acceptability of fear-based campaigns and what counted as evidence and populations of concern. Who was the object of policy was also important—whether it was the smoker who had to be protected and encouraged to stop smoking or whether it was young people who had to be protected. Let us consider each of these factors in turn.

1 The Nature of the State

England is a highly centralised state in which relatively little power is delegated to local government. The centralisation of policy making in England means that when the central government decided on a policy towards e-cigarettes it became the policy of the whole country. There were initiatives at the local level, but in most cases these were pioneering uses of e-cigarettes in smoking cessation services before this policy was endorsed centrally.

Australia and the US, by contrast, are federal states in which policy making is divided between federal and state governments. States may have their own policies or adopt variations of federal policy. In Australia, federal and state governments agreed to ban the sale of e-cigarettes containing nicotine by using poisons regulations. Some state governments banned the sale of all e-cigarettes, including those that did not contain nicotine. A National Tobacco Strategy has attempted to harmonise state policies.

In the US, most public health policy is a matter of state and sometimes municipal decision making. In the absence of federal policy on e-cigarettes for more than a decade, some cities and states imposed stringent regulation involving limitations on where and to whom e-cigarettes might be sold. San Francisco, for example, was ahead of the federal government striking a precautionary posture when it came to regulating e-cigarettes. Within the federal government, there were disagreements in approach between key bureaucracies with responsibility for the regulating e-cigarettes, the CDC and the FDA. It was only in 2021 that the federal government assumed a leading role shaping policy that would provide a policy framework that would override state and local policies that might have been less restrictive. So the degree of centralisation of state power was a key factor in policy making.

2 The Political Context

Governments from the late 1990s in the UK, both Labour and Conservative/Liberal Democrat, generally welcomed the use of nicotine products and later e-cigarettes. The Labour government expanded stop smoking services to address social inequalities in smoking prevalence, and the use of NRT was a key feature of these services. The Conservative-Liberal Democrat coalition government continued this support. It also expanded the approach to include e-cigarettes in line with its preference for a light, "hands off" approach to regulation.

In the US, there was virtually no political support for making e-cigarettes available as harm reduction devices. Indeed, at a federal level, the Democratic Party and, especially, its most liberal constituents saw e-cigarettes as a threatening ploy by the tobacco industry to undermine tobacco control. In the period marked by federal restraint, restrictive measures were adopted by state and local governments where Democrats were in power. Only marginal libertarian voices with no political sway

expressed an openness to e-cigarettes as part of the more generalised opposition to a "nanny" regulatory state.

In Australia, e-cigarette policy was formulated under a centre-left Labour government that was more sympathetic than its Liberal-National Party predecessor to tough tobacco control policies. Policy was made by a Health Minister who wanted to end tobacco smoking. She was advised by tobacco control advocates who had secured earlier bans on tobacco advertising and the sale of smokeless tobacco products. Smoking was increasingly concentrated in low-income groups, but reducing social inequality in smoking prevalence was much less of a policy focus in Australia apart from public subsidies for NRT and smoking cessation medicines. There was little history of the use of NRT for harm reduction in quit smoking services.

3 The Role of Regulatory Institutions

Regulatory institutions have played a key role in the three countries. In England, the MHRA as the licensing organisation was already heavily involved in the harm reduction agenda. NICE guidelines did not advocate the use of e-cigarettes immediately but later took on board the harm reduction case. Public Health England played a particular important role. As an "arm's length" government body, it was not part of the Department of Health or the "empire" of the Chief Medical Officer. Its tobacco function was free standing and in strong relationship to the drugs and alcohol field, for which the agency was given responsibility when founded in 2013. The new organisation facilitated linkages between policies across tobacco and other substances. In that sense, it mirrored the linkages within the Addiction Research Unit where Michael Russell had carried out his work.

The regional regulatory level was also important. The role of the European Union and Britain's membership was important, as was the consumer response to e-cigarettes in policy processes. This contrasted with the role of WHO's influence on policy. There was a long history of UK/WHO liaison and of policies flowing from national to international levels and vice versa. That did not happen in the case of e-cigarettes in the UK where the EU role was far more influential.

In the US, as noted, there was no unanimity of approach at the federal level. The FDA was more open to tobacco harm reduction than the CDC, which was set against harm reduction in the case of e-cigarettes. This was

illustrated by the CDC's haste in identifying nicotine e-cigarettes as a cause of an outbreak of lung injuries—EVALI that its own investigations later showed were the result of contaminated illicit cannabis vaporisers. Yet there was also a long history of delay in formulating e-cigarette policy at the FDA, which allowed the precautionary position time to take hold and harden.

In Australia, the regulation of nicotine went down the poisons route under the leadership of the federal TGA agency that regulates poisons and medicines. State health departments agreed with this approach and used their own poisons regulations to enforce the policy. Regulators took a hostile stance towards e-cigarettes and used their poisons regulations to effectively ban the sales of e-cigarettes with nicotine unless they had been approved for medical use.

4 Changes Within Public Health Thinking

Our discussion has described changes in public health ideology and focus which have taken place since the nineteenth century. The most notable ones were the post-World War II emphasis on the role of lifestyle and risk in noncommunicable diseases symbolised by the smoking issue. This and the anti-industry/stop smoking "turn" of the 1970s dominated a whole generation of public health researchers and activism. This was the case in all three countries a notable area of similarity between them.

The UK and US pioneered in making anti-tobacco a key public health issue and their approach—restrictions on public smoking, limiting advertising and taxation—had become the standard one across many issues in that field. In the UK, however, by the second decade of the twenty-first century, the anti-tobacco movement, although important as a public health cause, was no longer as dominant as it had been. Those who expressed mistrust of tobacco harm reduction were not specialists known for their tobacco work, but public health generalists, who commented on many public health issues. The nicotine researchers on the other hand were specialists in that field who had spent many years researching the topic. They had moved from the niche of "addiction scientists" into the public health arena. Public health as a practice was also changing in some areas in the UK, with medication and drugs as standard preventive tactics-statins for heart disease, methadone for opioid addiction, nicotine for smoking cessation and harm reduction. It was notable how the mainstream public health approach was still institutionalised in the position

of the Chief Medical Officer (CMO) within government. The CMO, for example, was opposed to the Nudge Unit's encouragement of e-cigarettes uptake under the coalition government. A subsequent CMO, Professor Sally Davies, expressed concerns about e-cigarettes in evidence to the Science and Technology committee of the House of Commons.

In the US, although the public health field had increasingly emphasised "personal responsibility" for health in the 1970s, smoking continued to be framed in terms of industry manipulation. Individuals could not be held accountable for smoking when the tobacco industry lied about the risks of smoking and the power of nicotine addiction. Indeed, the industry had deliberately manipulated nicotine content to better hook smokers. That framing along with the threat to "innocent" bystanders helped to justify strong government action to drive, first, smoking and, later, vaping, into the shadows.

Yet the personal responsibility framing was interpreted as "personal choice" in many parts of the nation, particularly those where Republicans dominated. In these states, there were areas where smoking in public places was not banned and high cigarette taxes had been pre-empted. In both liberal and conservative strongholds, for those who continued to smoke and wanted to quit, it was a clinical model and not a harm reduction approach that came to dominate. Treatment—lifelong, if necessary—was the path to cessation. And complete cessation was the only acceptable outcome.

In Australia, the public health advocate Simon Chapman had been an outsider for most of the 1980s and 1990s as a critic of government inaction and an advocate for tougher tobacco control policies. He became a policy insider by the middle 2000s and along with Michael Daube, shaped policies towards e-cigarettes under the new Federal Health Minister Roxon. Their advocacy of an e-cigarette sales ban was strongly supported by the cancer councils and receptive officials in the federal and state health bureaucracies. There was no countervailing, well-organised professional group that agitated for tobacco harm reduction. Those who were sympathetic to the use of e-cigarettes for cessation (including two of the authors Coral Gartner and Wayne Hall) found themselves with few allies in the tobacco control field. As was also true in the US, attempts were made to silence dissenters in the interests of the field presenting a "united front" to government.

So traditional public health, with its views formed in the 1970s, was strong and institutionalised in all three countries. But its influence in the UK was reduced for various reasons including the position occupied by researchers sympathetic to nicotine harm reduction.

5 The Pre-history of Nicotine Regulation for Cessation and Harm Reduction

There has been much discussion in the public health and anti-smoking fields about the "safer smoking" debacle of the 1970s. The tobacco industry introduced filtered and low-tar cigarettes to reassure smokers that the risks of smoking had been reduced. Initially, this was done with the support of governments, NGOs and public health bodies. The release of internal tobacco industry documents in the 1990s revealed that the companies were aware from their own research that low-tar and filtered cigarettes did not reduce smokers' tar exposure. Even before this in the UK, the issue of compensatory smoking had derailed the safer smoking agenda by the end of the 1970s.

The low-tar cigarette experience engendered strong hostility on the part of the public health field in Australia and the US, provoking scepticism about the feasibility of tobacco harm reduction. In the US, considerable interest in and support for safer cigarettes that dated from the mid-1960s crumbled in the early 1980s when several factors converged: evidence that tobacco companies were targeting children, lawsuits forcing the publication of internal tobacco industry documents that revealed the extent of industry deception, the conceptualisation of nicotine addiction as a disease that required treatment and acceptance and later widespread availability of nicotine replacement therapies.

In Australia, the search for safer cigarette was supported by government in the 1960s and 1970s with the aim of growing domestic tobacco production. Tobacco control advocates such as the Cancer Councils later followed the lead of peers in the UK and US as evidence on compensatory smoking emerged. The failure of safer cigarettes to reduce harm was used as justification for Australia's precautionary ban on the sale of e-cigarettes. The low-tar cigarette experience was also invoked in recent debates about e-cigarettes, with a sales ban often advocated as the best way of avoiding a replication of this earlier history. This was the case to some degree in all three countries.

In the UK, there was a more important harm reduction pre-history. This was the role assigned to nicotine as a therapy and substitute for smoking, long before e-cigarettes came on the scene. Here, there were distinct differences between the three countries. In the UK, there had been support for nicotine as a cessation tactic since the 1970s and this grew in importance during the 1980s and 1990s. Research on nicotine had expanded and, at the policy level, nicotine replacement therapy became embedded within NHS stop smoking services, which had expanded under the Labour government elected in 1997. In the first decade of the twenty-first century, the utility of nicotine therapies had expanded even further with a harm reduction objective. Nicotine was no longer seen as a short-term therapy for smoking cessation but as a potential long-term substance to replace cigarettes and thereby reduce tobacco-related harm. Allied to this was a very different attitude to nicotine addiction. It was seen as acceptable outcome in terms of the balance of risk in relation to tobacco smoking.

The US is a nation that has a long history of hostilities to public health policies perceived to be paternalistic. Youth, however, have always warranted special protections. Concern about the potential danger to youth has dominated US policy conversations about e-cigarettes. In this context, researchers began to suggest that nicotine posed a threat to the adolescent brain. Laboratory studies based on mice proved powerful and politically persuasive. The "brain disease" concept of addiction across the substances also had strong appeal in the US.

In Australia, leading tobacco control figures had long been sceptical of need for NRT, arguing that cold turkey was the most common and successful method of quitting. The policy emphasis was accordingly given to encouraging smokers to make quit attempts and providing behavioural counselling and support via telephone helplines. NRT was available for sale over the counter after the late 1990s, but there was no public subsidy for its use until 2006, when cancer councils persuaded the government to give it a public subsidy to address the social inequalities in smoking prevalence. The fear that NRT would produce an addiction was not a reason given for opposing NRT, but the fear that e-cigarettes would addict non-smoking adolescents become a common justification for a sales ban on e-cigarettes in Australia. This was increasingly reinforced using claims originally made in the US that nicotine exposure damaged adolescents' brains.

So the role of nicotine and attitudes towards addiction showed considerable variation across the three countries even before e-cigarettes arrived. Neither the US nor Australia had the range of stop smoking services nor the health service support for nicotine as a therapy. This meant that the main focus of UK policy was the smoker, not so much the case in the two other countries.

6 Professional Networks in Favour and Against

Professional networks have played a key role in producing a positive response to e-cigarettes in the UK. These have a long history deriving from the network of researchers who first came into the field to work with Michael Russell at the Addiction Research Unit at the Institute of Psychiatry in the 1970s. This group was located in a psychiatric institution and favoured the use of nicotine for what later became called harm reduction. It was not part of the public health mainstream in the 1970s and 1980s. But it remained a cohesive group whose members moved into positions of influence in health institutions from the 1990s onward. Ann McNeill, for example, had worked with Russell and chaired the PHE evidence reviews of e-cigarettes. There were also allied networks, such as the Tobacco Advisory Group of the Royal College of Physicians with John Britton at the helm. This group had moved to support a harm reduction position for nicotine before e-cigarettes came on the scene. The prestige of the RCP and its stop smoking history dating back to the late 1950s gave the Tobacco Advisory Group's views particular weight.

In the US, by contrast, the most prominent networks were anti-e-cigarette and concerned about the adverse impact of nicotine on adolescent brains. At one juncture, the Legacy Foundation—a significant, well-funded organisation—was open to the promise of e-cigarettes, but a change in leadership produced a remarkable about-face. Renamed the Truth Initiative, it took on a leading vocal role in opposing e-cigarettes, which it portrayed as a special threat to adolescents and young adults. Those who took the contrarian pro-harm reduction view comprised a loose network of prominent researchers led by a state attorney general who had played a leadership role in the massive, successful state lawsuit against the tobacco industry. Networks of individuals, research centres and NGOs that opposed e-cigarettes all emerged as powerful evidence brokers. They took the stance that e-cigarettes were dangerous—harmful in and of themselves, even to smokers and especially so to youth.

Other groups in the broader public health community accepted their evidence, partly through trust but partly because there were reputational consequences for dissenters.

The Australian network of tobacco control advocates and state cancer councils was unanimous in supporting Australia's e-cigarette sales ban. Their advocacy had successfully driven smoking prevalence down by persuading governments to adopt public health policies that reduced demand for cigarettes, viz. increased taxes; advertising bans; graphic health warnings; smoke-free policies; and a ban on the sale of smokeless tobacco. Their major policy preference when e-cigarettes appeared was to introduce plain cigarette packaging. They did not see any need for THR policies and were worried that allowing the sale of e-cigarettes would be used to promote smoking and reduce quitting. Given these policy preferences, an e-cigarette sales ban was seen as the best approach to avoid e-cigarettes entering the legal market in Australia.

The minority of Australian health professionals who supported the use of e-cigarettes for cessation and harm reduction were a disparate group of researchers and clinicians. They were not part of the major tobacco policy networks and those with the highest public profile were the subject of personal attacks that alleged they were financed by the e-cigarette and therefore the tobacco industry. Younger tobacco researchers were advised against expressing public support for e-cigarettes or harm reduction to avoid funding at risk, especially that provided by the cancer councils.

So the situation around networks of research has differed sharply between the UK and the other two countries. All have had their e-cigarette supporters, but only the UK had such a well-placed and cohesive network around nicotine with a long history of support for tobacco harm reduction using nicotine. Only in the UK did these researchers have the ear of policy makers.

7 The Use of Fear Campaigns Against E-cigarettes

In both the US and Australia, public health campaigners had used fear campaigns to encourage smoking cessation. This has continued with the use of fear-based campaigns about the risks of e-cigarettes for smokers and young people. In Australia, opposition to e-cigarettes has become something of a moral crusade against youth vaping and smoking. This was demonstrated, first, by the rapidity with which the EVALI outbreak in the

US was used to brand e-cigarettes as dangerous products and, second, by the slowness to acknowledge the evidence that cannabis vaping had played the major role in the outbreak. What distinguished the fear-based campaigns against e-cigarettes from earlier efforts to reduce smoking was a willingness to claim harms—often related to behavioural and personality changes in youth who vaped—that arguably went well beyond the evidence.

Fears were raised in the UK by some tabloid newspapers at the time of EVALI. This led to a significant shift in UK public attitudes towards e-cigarettes after media reports of EVALI. However, public campaigns about e-cigarettes in the UK have not been based on fear. Indeed, public campaigns explicitly promoted e-cigarettes as a safer alternative to smoking and a tool for cessation. This may in part be because of the Science Media Centre, which has called out some of the more dubious research claims about the risks of e-cigarettes that have been promoted by the tabloid media.

8 Activism and Links with Government

The UK has had a long history in tobacco control of nominally outsider organisations working with government while publicly maintaining an "outside/activist" role. ASH was one organisation that had its anti-tobacco origins in the 1970s when it worked closely with the Labour Minister of Health David Owen to introduce tobacco control policies. ASH had changed its policy stance by the early twenty-first century to encompass harm reduction within its tobacco endgame agenda. Nicotine was seen as playing an essential role in ending tobacco smoking in British society. Deborah Arnott, ASH's chief executive, who was adept at coalition building, developed a cohesive group of prestigious institutions to support the concept of nicotine harm reduction well before e-cigarettes came on the scene. This was accomplished in parallel with her advocacy of a smoking ban in public places so that the connection between the two policy objectives was made plain.

Vaper activists were important in Europe where they worked with MEPs to secure the defeat of a move to treat e-cigarettes as medicines. In the UK, they were successful in bringing a "user" dimension to the discussion of policy and research on e-cigarettes. People who smoked had never figured in policy discussion at that level, apart from the emergent discussion of inequality and lone motherhood in the 1980s. But the

policy role of the "user" had become prominent in the illicit drugs field and the smoking field followed suit in the 2000s. There were also links with stop smoking services, which had a strong pro-user ethos. Louise Ross, formerly head of the stop smoking service in Nottingham, became a prominent figure in the New Nicotine Alliance.

In Australia, an ASH organisation had been created to lobby for the public health policies that were introduced in the 1980s and 1990s. It was phased out after all the policies that it advocated for had been implemented. The State Cancer councils took over its advocacy role. Nigel Gray and Ron Borland, two leading anti-smoking advocates, were open to the use of e-cigarettes for tobacco harm reduction, but most of their peers supported the e-cigarette sales ban.

There were no pro-vaping activists in Australia who were as well organised or as effective as those in the UK. Several small groups were established, but they did not prove sustainable with limited funding. This left pro-free market groups with connections to the tobacco industry to make the case for more liberal e-cigarette. This enabled these groups to be easily discredited and public health advocates to unfairly portray all advocates of e-cigarettes as astroturfed tobacco industry fronts.

In Australia, there was no coalition of medical and public health organisations that advocated for e-cigarettes as in the UK. All the Australian organisational equivalents of UK organisations that supported tobacco harm reduction—the state cancer councils, the heart foundation, colleges of physicians and general practitioners, and the Australian Medical Association—were hostile to the use of e-cigarettes for smoking cessation and so strongly supported a sales ban.

Vaper advocates, including some members of the LNP, attempted to allow the sales of e-cigarettes as consumer products, as happened in Canada and New Zealand. These advocates succeeded in forcing two parliamentary inquiries whose majority reports supported Australia's e-cigarette sales ban. The TGA has recently responded to the advocates' pressure for change by reclassifying nicotine in a lower poisons category that allows it to be prescribed by physicians and general practitioners under a special access scheme for unapproved pharmaceuticals. They have also taken steps to facilitate its prescription by general practitioners while still publicly opposing the sale of nicotine as a consumer good. It remains to be seen whether enough doctors will ignore the hostility to e-cigarettes within the organised medical profession and prescribe nicotine to smokers.

In the US, there was activism on the part of vapers and vape-shop owners as well as harm reduction proponents, discussed above. But the more influential NGO activists—Tobacco Free Kids, the Truth Initiative, the American Cancer Society, Bloomberg—all stressed the threat that e-cigarettes pose to youth and children and discounted the potential benefits to smokers who wanted to quit.

9 The Impact of Drugs, HIV and Harm Reduction

The concept of harm reduction had been advocated in the smoking field in all three countries before the advent of e-cigarettes, but only in the UK had harm reduction been linked with nicotine since the 1970s. The impact of harm reduction approaches to reduce HIV transmission in the illicit drugs field varied between the three countries.

In the UK, harm reduction through methadone and needle exchange was a policy response to HIV from the late 1980s and into the 1990s, before the focus shifted towards "recovery" under a Conservative government. The creation of Public Health England brought harm reduction ideas from drugs, alcohol and tobacco into an institutional relationship that influenced policy making. It brought together like-minded staff who had all been through the debates about harm reduction in the illicit drugs field in the 1980s. In most countries, tobacco policy had been a "standalone" public health topic in which policy was made independently of policies on other drugs and alcohol. Those boundaries were weakened within PHE and earlier in the network of nicotine researchers that was forged within the Addiction Research Unit in the 1970s.

In the US, harm reduction for drugs had a more contested policy history. Illicit drug policy had, for most of the past century, been framed by a prohibitionist outlook that criminalised drug use. This remained the case even when, in the 1970s, methadone maintenance became an established element of the therapeutic landscape. The HIV epidemic opened the debate about harm reduction in the drugs field. Activists, drawing upon European experience, became strong advocates for needle exchange, but their efforts met with the fierce resistance at federal and state levels for years. Ultimately, the toll of HIV-related deaths, and the strength of evidence for reducing viral transmission, opened the way for publicly funded needle exchange programmes. Those efforts gained the support of more liberal Democrats, especially. Strikingly, the public voice of proponents of needle exchange and safe injection sites did not make itself much

heard in the controversy over e-cigarettes until very recently. For example, Ethan Nadelman, who for decades had challenged US prohibitionist dug policies, has only recently become a proponent of e-cigarette harm reduction. While harm reduction was important in shaping the outlook of those who moved into the e-cigarettes field, the institutional and policy underpinning seen in the UK was absent.

In Australia, policy influence from the HR movement in the drugs field was largely absent. The illicit drug and tobacco policy arenas were very distinct and had no overlap in their key personnel. An exception was Alex Wodak, who had pioneered NSP and methadone treatment and also worked on tobacco cessation in prisons and general practice. There was support for e-cigarettes among clinicians who worked in the addictions and mental health fields because there was a high prevalence of smoking among their clients. They received no support from key networks in tobacco control. Indeed, some key figures who had supported needle exchanges and heroin prescribing argued that a HR approach to tobacco would increase rather than decrease harm. Similarly, the Australian Greens whose platform supports cannabis legalisation, heroin maintenance treatment and NSP opposes the use of e-cigarettes for THR and supports current Australian policy.

So again, it was mainly in the UK that harm reduction ideas from the drugs field were in a relationship with smoking. Traditionally, those areas were not close and specialists in one area had little to do with experts in the other. But in the UK, there was a history of collaboration dating back to the early alliance at the Addiction Research Unit in the 1970s. This was consolidated by the formation of Public Health England in 2013 which included drugs, alcohol and tobacco within one agency.

10 Who Is Policy For?

Explicit in the discussions round e-cigarettes was a difference in who was seen as the target group for who policy was framed. In the UK, initially it was the chronic smoker, a figure who tied into concerns about inequalities in health which resurfaced at the end of the 1990s. The notable decline in smoking since the 1970s had brought the "poor smoker" to greater prominence. But in Australia and in particular the US, the focus was a traditional one within policy of the "innocent victim" and children.

11 Conclusion

This book represents a first pass at explaining the origins of very different policies towards e-cigarettes in Australia, the UK and the US. We hope that it will encourage more research into policy making in these countries. We also hope that it will encourage similar case studies in additional countries. There would be particular value in similar analyses of the factors influencing e-cigarette policies in Canada and New Zealand, two countries that initially adopted much the same the medical regulation approach as Australia's approach, before allowing the sale of e-cigarettes as consumer goods under tighter regulation. Similarly, there would be value in policy case studies in other high- and middle-income countries that have adopted e-cigarette sales bans, such as Brazil, Malaysia and Singapore.

Expanding the cross-national comparative frame is important because what we can take from this study of three countries who were early leaders in global debates is that interpretation of "the evidence" on the effectiveness and safety of e-cigarette was refracted through pre-existing policy commitments produced by a host of contextual and historical factors highlighted above. British research and evidence focused on the beneficial impacts that e-cigarettes had on smokers who wanted to stop smoking. US research, by contrast, highlighted the threat to the "innocent victim" and children, traditional tropes within the tobacco field. Australian policy makers were very much more influenced by research from the US on the adverse effects on youth than by British research on its benefits for smoking cessation. This was a departure from the previous Australian response to evidence on the harms of cigarette smoking that looked primarily to the UK. The invocation of the precautionary principle to justify an Australian sales ban was strongly mediated by the historical and contextual issues we have outlined.

Some commentators have drawn attention to the inconsistency in the hostility shown to harm reduction using e-cigarettes in the US and Australia, when both countries are in the process of liberalising access to cannabis which is still primarily smoked and vaped. There has also been a debate in the public health field as to whether England's policy is an "outlier" in a world where hostility to e-cigarettes is the norm, or whether it is blazing a pioneering path towards a more rational policy that other countries will eventually follow. Optimists of the latter persuasion

have pointed to policy movements in this direction in the US and more recently in Canada and New Zealand.

What emerges strongly in this comparison of the three countries is the importance of pre-history in relation to nicotine and its usage for cessation and harm reduction. This experience needs to be understood within the context of state decision making and the durable "policy communities" that form around particular issues, such as nicotine and e-cigarettes, and exert considerable influence in concert with powerful interests within government.