

**Written Comments to the OECD Health Committee**

6 October 2026

Preventing and treating addictions: Best practices in public health

DELSA/HEA(2026)10/ANN1

General Comments

- *Business at OECD* welcomes the opportunity to provide further comments on the forthcoming OECD report on preventing and treating addictions. *Business at OECD* welcomes the paper's coherent public health framing across both substance-related and behavioural addictions. From a self-care perspective, the report is a very strong collection of best practices and includes several evidence-based self-care interventions.
- *Business at OECD* supports a continuum of outcomes whereby smoking cessation and complete switching away from combustible cigarettes represent major public-health gains, while recognising that eventual freedom from nicotine dependence may constitute an additional longer-term health objective for some individuals.
- Nicotine should not be equated with alcohol, opioids, cocaine, or other illicit drugs solely because all may be discussed within the broader topic of substance use disorders. The International Statistical Classification of Diseases and Related Health Problems (ICD) - 11 diagnostic tool developed by the World Health Organization (WHO)¹ uses substance-specific categories because the addiction potential, intoxication, functional impairment, acute toxicity, associated mental disorders, and harm to others differ substantially between substances.
- A further distinction is needed between nicotine, nicotine addiction, and nicotine-containing products. The ICD-11 diagnostic tool recognizes that harm related to the consumption of nicotine may arise through different routes of administration and patterns of use. At the same time, the OECD report correctly acknowledges that medically regulated nicotine replacement therapies (NRT) deliver nicotine without the harmful constituents associated with combustible tobacco products and can support cessation outcomes. This demonstrates that nicotine addiction alone should not be used as a proxy for the overall risk profile of all nicotine-containing products.
- Therefore, product characteristics, route of administration, exposure levels, and user population should remain central considerations in risk assessment. A proportionate and evidence-based guideline specifically for nicotine addiction for best practices in public health should distinguish: (i) nicotine as an addictive molecule; (ii) the acute and chronic

¹ See **ICD-11 for Mortality and Morbidity Statistics** 2025-01 "Disorders due to substance use include disorders that result from a single occasion or repeated use of substances that have psychoactive properties, including certain medications. Disorders related to fourteen classes or groups of psychoactive substances are included. Typically, initial use of these substances produces pleasant or appealing psychoactive effects that are rewarding and reinforcing with repeated use. With continued use, many of the included substances have the capacity to produce dependence. They also have the potential to cause numerous forms of harm, both to mental and physical health. Disorders due to harmful non-medical use of non-psychoactive substances are also included in this grouping."

effects of nicotine exposure; (iii) the toxicants and hazards associated with specific delivery methods; and (iv) population-specific concerns, including youth initiation and use during pregnancy. Such distinctions are consistent with the WHO ICD-11 diagnostic tool and would supplement the accuracy of the report.

- We welcome the additional analytical depth provided by the case studies and the OECD's use of a structured framework addressing effectiveness, efficiency, equity, evidence base and extent of coverage. In relation to tobacco and nicotine, we particularly welcome:
 - the clear focus on supporting adults who smoke through the French Mois Sans Tabac campaign and England's Local Stop Smoking Services;
 - the recognition that vaping is generally considered less harmful than tobacco smoking;
 - the recognition that nicotine vapes are among the three first-choice cessation aids in England's Local Stop Smoking Services, alongside NRT and medicines such as varenicline and cytisinicline;
 - the inclusion of service data relating to the use of nicotine vapes, NRT and combined NRT and vape use;
 - the citation of a randomised trial comparing the cost-effectiveness of e-cigarettes and NRT in stop-smoking services; and
 - the report's attention to health inequalities and the need for cessation services to reach socioeconomically disadvantaged adults who smoke.
- At the same time, the analytical chapters do not apply these findings consistently. The description of English cessation practice recognises nicotine vapes as a first-choice cessation aid, while other parts of the report describe vaping mainly as an emerging threat or prevention challenge. The contextual chapter says that further research is required to determine the "viability" of e-cigarettes for cessation. The Mois Sans Tabac chapter states that vaping is "recognised as a gateway into tobacco consumption." The Real Cost chapter says that e-cigarettes "have been identified as a gateway to tobacco smoking." These categorical formulations sit uneasily both with the more qualified language elsewhere in the report and with the report's recognition of nicotine vapes as a first-choice cessation aid in England.
- We therefore recommend that the tobacco and nicotine chapters be revised around the following principles.

1. Distinguish youth prevention from adult smoking cessation

- *Business at OECD* supports effective measures to prevent access to and use of nicotine products among children and adolescents. The report should nevertheless distinguish consistently between:
 - children, adolescents and adults who do not smoke;
 - adults who currently smoke;
 - adults using a nicotine product in a smoking-cessation attempt;
 - people who use both cigarettes and a non-combustible product;
 - adults who have switched completely away from cigarettes; and
 - former smokers seeking to prevent relapse.
- These populations have different starting points, risk comparators and public-health needs. Evidence concerning associations between youth vaping and subsequent smoking should not be used to determine the advice provided to adults who already

smoke.

- This distinction is particularly important because the report notes both increasing adolescent use of cigarettes or e-cigarettes and a decline in exclusive cigarette smoking among the adolescents covered by the cited survey. It should not characterise these changing patterns without separating exclusive vaping, dual use, prior smoking status and movement between product categories.

2. Update the cessation evidence

- The analytical chapters should incorporate the August 2026 update of the Cochrane living systematic review of electronic cigarettes for smoking cessation.
- According to the published findings supplied with Business at OECD's comments, the review included 80 randomised controlled trials involving 29,861 participants. It concluded that there is:
 - i. high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with nicotine-replacement therapy;
 - ii. moderate-certainty evidence that nicotine e-cigarettes increase cessation compared with non-nicotine e-cigarettes; and
 - iii. moderate-certainty evidence that serious adverse-event rates are similar when nicotine e-cigarettes are compared with NRT.
- The review estimated that approximately 8 to 10 people per 100 using nicotine e-cigarettes might successfully stop smoking, compared with approximately 6 per 100 using NRT. It did not detect evidence of serious short-term harm, while appropriately noting that larger and longer studies remain necessary to evaluate safety. It found the evidence concerning the effects of flavours on cessation outcomes to be inconclusive.
- The need for further research on long-term health effects should therefore not be conflated with uncertainty about whether nicotine e-cigarettes can help adults stop smoking. Those are different evidence questions.

3. Reflect the July 2026 SRNT working-group recommendations

- The report should also acknowledge the Special Communication, "Nicotine E-Cigarettes for Cigarette Smoking Cessation: Recommendations to US-Based Clinicians," published in JAMA on 30 July 2026.
- The paper was developed by a working group within the Treatment Research Network of the international Society for Research on Nicotine and Tobacco. SRNT bars tobacco-industry funding and membership. Its overarching recommendation is that clinicians integrate nicotine e-cigarettes into patient-centred conversations concerning the risks and benefits of evidence-based smoking-cessation treatments.
- The recommendations state that nicotine e-cigarettes are less harmful than cigarettes and have been shown to be more effective for cessation than FDA-approved NRT. They advise clinicians to correct risk misperceptions, explain the predominant role of combustion products in causing smoking-related disease, and provide practical guidance where an adult chooses to use an e-cigarette to stop smoking.
- The existence of these recommendations does not require the OECD to adopt a particular national clinical approach. It does mean, however, that the report should not describe the clinical viability of e-cigarettes for cessation as essentially unresolved.

4. Distinguish nicotine dependence from combustion-related disease

- The report should distinguish systematically among:
 - i. nicotine dependence;
 - ii. the risks associated with different nicotine-delivery products; and
 - iii. the health burden caused predominantly by cigarette smoke and products of combustion.
- The statement in the NRT case study that NRT delivers nicotine without the harmful chemicals found in tobacco products recognises an important underlying principle: the harms associated with different nicotine-delivery mechanisms are not identical. However, that principle is not applied consistently when the report discusses nicotine e-cigarettes or other non-combustible products.
- Regulated non-combustible nicotine products are not risk-free. Nevertheless, the relevant immediate comparison for an adult who would otherwise continue smoking may be between continued cigarette smoking and complete switching to a non-combustible product, rather than solely between nicotine use and complete abstinence.

5. Distinguish complete switching from dual use

- The report refers to dual use in its discussion of adolescent e-cigarette use and recommends further research into the health effects of dual use. However, it does not give equal analytical attention to complete switching away from cigarettes.
- The report should distinguish:
 - i. exclusive smoking;
 - ii. dual use;
 - iii. temporary use during a quit attempt;
 - iv. complete switching away from cigarettes;
 - v. cessation of cigarette smoking while nicotine use continues; and
 - vi. cessation of all tobacco and nicotine use.
- Without this differentiation, an increase in the use of a non-combustible product may be interpreted uniformly as an adverse outcome, even where it accompanies complete cessation of cigarette smoking.

6. Apply harm-reduction principles consistently

- The report expressly recognises harm reduction in other areas of addiction policy. The same analytical principle should at least be considered in relation to cigarette smoking.
- This does not require identical policies for different substances. It requires recognition that public-health outcomes can exist on a continuum. For an adult who would otherwise continue smoking, stopping cigarette smoking completely is a meaningful health outcome even where nicotine use continues.
- The report should therefore evaluate smoking-related interventions against outcomes including:
 - i. cigarette-smoking cessation;
 - ii. complete switching away from combustible cigarettes;
 - iii. reduction in cigarette consumption;
 - iv. avoidance of relapse to smoking; and
 - v. eventual cessation of all nicotine use.

7. Ensure coherence across the three tobacco and nicotine case studies

- The three case studies currently create different narratives:
 - i. Mois Sans Tabac is presented mainly through abstinence, NRT

- affordability and conventional tobacco-control measures.
 - ii. England's Local Stop Smoking Services accurately recognise nicotine vapes as first-choice cessation aids and provide comparative service data.
 - iii. The Real Cost presents e-cigarettes principally through health-risk, dependence and gateway language.
- Each chapter addresses a different population and intervention, so some variation is appropriate. Nevertheless, the chapters should share a common analytical framework that differentiates youth prevention from adult cessation and recognises differences between combustible and non-combustible products.

8. Maintain proportionate claims of causality

- The OECD framework places appropriate emphasis on evidence quality. Causal terminology should therefore correspond to the underlying study design.
- This is particularly relevant to the Real Cost case study. The report describes the principal study as a longitudinal cohort study, rates its overall quality as moderate, and states that campaign exposure was associated with lower odds of initiation. It subsequently says the campaign “prevented” 444,252 initiations and “effectively prevents” initiation. The stronger causal language should be aligned with the actual study design and the report’s own methodological description.
- We also welcome the focus on nicotine-replacement therapy (NRT) and the effectiveness of patches, gums, lozenges, sprays, and inhalers, showing ultimately that NRT increases the likelihood of successful smoking cessation by approximately 50-60%. NRT’s are well-established, evidence-based, non-prescription medicines for smoking cessation that are included on the WHO Model List of Essential Medicines (in patch, gum, lozenge and oral spray formats) since 2009 (WHO, Model List of Essential Medicines, 2025) and are considered a first line pharmacological treatment in the WHO clinical treatment guideline for tobacco cessation in adults (WHO, WHO clinical treatment guideline for tobacco cessation in adults, 2024). Whilst NRT has a core role to play in the delivery of formal smoking cessation treatment services, we encourage the report to also present NRT as an important self-care intervention. For many tobacco users NRT is an accessible, evidence-based cessation medicine to support a self-managed quit attempt out of choice or lack of access to formal cessation services. This is aligned with results from GSCF’s EcoSoc 2.0 study, where NRT was one of the preventative self-care case studies (GSCF, EcoSoc 2.0, 2026).
- We also welcome the recognition of pharmacists as referral/service-access points, and we encourage further consideration of pharmacist-led product selection or support provided outside formal cessation services. NRT is recommended as a first-line pharmacological treatment options for tobacco cessation (WHO, WHO clinical treatment guideline for tobacco cessation in adults, 2024). Many quit attempts occur outside specialist services, and pharmacists, as trained and accessible healthcare professionals, can play a key role in supporting individuals through product selection, behavioural advice, medication counselling and ongoing support for self-managed quit attempts.
- It is referenced in the report that “the rapid evolution of product design, marketing practices, and accessibility, alongside regulatory frameworks lagging” contribute to the emerging patterns of e-cigarette use. We believe that there could be a stronger recommendation in the report for OECD and EU countries to effectively legislate and/or regulate against the uptake of e-cigarettes by non-smokers, particularly young people. It should also be noted that e-cigarettes are not the only recreational nicotine or alternative tobacco products that should be considered, given, for example, the growth in the use of products like nicotine

pouches.

- The report could consider acknowledging that tobacco smoking and the use of regulated non-combustible nicotine products may be associated with different patterns of dependence and usage behaviour. Cigarette smoking is typically characterised by discrete consumption episodes, whereas some non-combustible nicotine products may permit different patterns of use. Recognising these behavioural differences may be relevant when assessing nicotine dependence, cessation pathways, harm-reduction strategies and longer-term treatment outcomes. Such distinctions may help support a more differentiated assessment of prevention, cessation, switching and recovery outcomes across different populations and products.
- The paper discusses many health literacy resources but does not discuss health literacy as an important health outcome in the evaluation of interventions. We suggest emphasizing that health literacy is a key mechanism through which participants gain the knowledge and confidence required to manage smoking cessation independently. Perhaps in future case studies, enhanced health literacy could be evaluated as an outcome.

Specific Comments

- **We recommend adding the following paragraph to the assessment and recommendation chapter:**
 - "Tobacco and nicotine policy should distinguish between preventing initiation among children, adolescents and people who do not currently use nicotine, and supporting adults who smoke to stop smoking. Regulated non-combustible nicotine products are not risk-free, and continued surveillance of their health effects and patterns of use is required. However, nicotine-delivery products differ in their characteristics, toxicant exposure and potential health risks. Recent evidence indicates that nicotine e-cigarettes can increase smoking-cessation rates compared with nicotine-replacement therapy. For adults who would otherwise continue smoking, complete switching away from combustible cigarettes may reduce smoking-related harm. These considerations should be accompanied by appropriate product regulation, accurate risk communication and effective measures to prevent youth access and uptake."
- **Paragraph 23 (Chapter 1): disaggregate products and patterns of use.** The heading "Novel nicotine products are becoming increasingly widespread" groups e-cigarettes, heated tobacco products, snus and nicotine pouches without differentiating their characteristics, routes of administration, patterns of use or risk profiles. The prevalence data presented principally concern e-cigarettes, while the heading and opening sentence refer to the broader category.

Proposed replacement : "Non-combustible nicotine products, including e-cigarettes, heated tobacco products, snus and nicotine pouches, differ in their characteristics, routes of administration, patterns of use and potential health risks. Available prevalence data should therefore be presented separately by product and, where possible, by prior smoking status and use pattern."

Proposed additional sentence: "Monitoring should distinguish initiation among nicotine-naïve people, exclusive use by former smokers, dual use with cigarettes, temporary use during a cessation attempt and complete switching away from combustible cigarettes."

- **Figure 2.3 and accompanying text :** include smoking status :The figure presents trends in regular vaping among people aged 15 and over but does not distinguish current smokers, former smokers and people who have never smoked. That makes it difficult to assess the public-health significance of the trend.

Proposed addition : “Where data permit, future reporting should disaggregate vaping prevalence by age, current and former smoking status, never-smoking status, frequency of use, dual use and complete switching.”

- **Paragraph 24 (Chapter 1): interpret youth trends more cautiously:** The paragraph reports that the proportion of adolescents using cigarettes or e-cigarettes increased, while exclusive cigarette smoking declined. It then characterises the findings primarily as rising e-cigarette uptake. The analysis should distinguish whether the change represents nicotine initiation, substitution away from cigarettes, dual use or movement between categories.
- Proposed addition : “The public-health implications of these trends depend on previous smoking status and subsequent patterns of use. Future monitoring should distinguish nicotine initiation among previous non-users, exclusive cigarette smoking, exclusive vaping, dual use and transitions between these categories.”
- **Paragraph 25 and Box 2.2 (Chapter 1):** We encourage revising the smoking-cessation discussion. The box acknowledges that vaping is generally viewed as less harmful than smoking and is sometimes used as a cessation aid. It then states that further research is needed to determine its “viability” for cessation. This should be updated in light of the August 2026 Cochrane review and July 2026 SRNT working-group recommendations.

Proposed replacement for the opening and closing passages : “Nicotine e-cigarettes are not risk-free, and preventing uptake among children, adolescents and people who do not smoke remains an important public-health objective. They are, however, generally considered less harmful than combustible cigarettes and are used in some jurisdictions to support smoking cessation.

The August 2026 update of the Cochrane living systematic review, covering 80 randomised controlled trials involving 29,861 participants, concluded that there is high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with nicotine-replacement therapy. It also found moderate-certainty evidence of benefit compared with non-nicotine e-cigarettes and moderate-certainty evidence that serious adverse-event rates were similar between nicotine e-cigarettes and NRT.

In July 2026, a working group within the Treatment Research Network of the Society for Research on Nicotine and Tobacco published recommendations in JAMA advising US clinicians to include nicotine e-cigarettes in patient-centred discussions of evidence-based cessation options. SRNT bars tobacco-industry funding and membership.

Further research remains important regarding long-term health effects, product characteristics and patterns of use. This remaining uncertainty should be distinguished from the evidence concerning smoking-cessation efficacy.”

The box 2.2 appropriately says that concerns have emerged that e-cigarettes “may” act as a gateway, but it then reports that users are three times more likely to start smoking without clarifying that an observational association does not itself establish that vaping caused subsequent smoking.

Proposed replacement: "Observational studies have found an association between e-cigarette use and subsequent cigarette smoking among young people. Interpretation of this association should account for potential shared susceptibility, including behavioural, social and environmental factors that may predispose individuals to both behaviours. The evidence should therefore be described as an association unless the cited study design supports a causal conclusion."

- **Paragraph 47 (Chapter 1):** the OECD draft mentions that *"the economic impacts of tobacco, harmful alcohol use, and illicit drug use are substantial, encompassing both healthcare expenditures, productivity losses (e.g. absenteeism, presenteeism, and early retirement), disability and long-term care costs. For illicit drug use, additional costs can arise from criminal justice and law enforcement."* However, the ICD-11 diagnostic tool mentions that *"Disorders due to use of nicotine are characterised by the pattern and consequences of nicotine use."*² Nicotine is an addictive molecule and withdrawal is possible.³ Also, the ICD-11 diagnostic tool expressly notes that harmful behavior arising from nicotine intoxication is unlikely. This differs materially from alcohol-related psychomotor impairment and harm to others, opioid-related respiratory suppression and overdose, cannabis-related cognitive and psychomotor impairment, stimulant-related hyperactivity and psychosis, and hallucinogen- or dissociative-drug-related perceptual and behavioral disturbance.
- **Paragraph 54 (Chapter 1):** the OECD draft states that *"Societal costs extend beyond direct health and economic consequences and affect families, communities, and social institutions. These costs include family disruption, violence, crime associated with illicit drug markets, homelessness, social exclusion, reduced educational attainment, stigma and discrimination, and broader public safety concerns. Harms frequently affect people beyond the individual experiencing the disorder. For example, gambling-related harms can adversely impact partners, children, and other family members through financial strain, relationship breakdown, conflict, and violence."* In this context, a distinction is required between nicotine, nicotine addiction, and the product, method or route through which nicotine is delivered. The ICD-11 diagnostic tool recognizes direct toxic effects and harmful routes of administration as separate mechanisms of harm. It also states that nicotine is used through different forms. However, the OECD draft similarly describes nicotine replacement therapies as medically approved products that deliver controlled nicotine without the harmful chemicals found in tobacco- and nicotine- containing products. It notes that their purpose is to reduce cravings and withdrawal and that evidence supports improved cessation outcomes compared with unaided attempts. This demonstrates that addiction to nicotine should not be used as a proxy for the total risk of every nicotine-containing product. However, despite recognizing these distinctions, the OECD draft does not consistently reflect them in its overall analysis.
- **Paragraph 18 (Chapter 2, Section 2.1):** We suggest including health literacy as another

² See **ICD-11 for Mortality and Morbidity Statistics 2025-016C4A Disorders due to use of nicotine** *"Disorders due to use of nicotine are characterised by the pattern and consequences of nicotine use. Nicotine is the active dependence-producing constituent of the tobacco plant, Nicotiana tabacum. Nicotine is used overwhelmingly through smoking cigarettes. Increasingly, it is also used in electronic cigarettes that vaporize nicotine dissolved in a carrier solvent for inhalation (i.e., "vaping"). Pipe smoking, chewing tobacco and inhaling snuff are minor forms of use. Nicotine is a highly potent addictive compound and is the third most common psychoactive substance used worldwide after caffeine and alcohol. Nicotine Dependence and Nicotine Withdrawal are well described and Nicotine-Induced Mental Disorders are recognized*

³ See **ICD-11 for Mortality and Morbidity Statistics 2025-016C4A Disorders due to use of nicotine** *"Disorders due to use of nicotine are characterised by the pattern and consequences of nicotine use. Nicotine is the active dependence-producing constituent of the tobacco plant, Nicotiana tabacum. Nicotine is used overwhelmingly through smoking cigarettes. Increasingly, it is also used in electronic cigarettes that vaporize nicotine dissolved in a carrier solvent for inhalation (i.e., "vaping"). Pipe smoking, chewing tobacco and inhaling snuff are minor forms of use. Nicotine is a highly potent addictive compound and is the third most common psychoactive substance used worldwide after caffeine and alcohol. Nicotine Dependence and Nicotine Withdrawal are well described and Nicotine-Induced Mental Disorders are recognized*

important social determinant in this section. It is important to note that the capacity to take informed action for health varies considerably across populations. Evidence from the Self-Care Readiness Index shows that across 17 European countries, more than one-third of individuals were estimated to have inadequate or problematic health literacy, approaching two-thirds in some countries. Country-level evidence similarly identifies difficulties understanding written health information among 17% of surveyed respondents in Indonesia and 15% in India, compared with 8% in Australia and 7% in Kenya. Health literacy should therefore be considered an important determinant of individuals' ability to participate effectively in prevention and self-care, including for SUDs (GSCF, Self-Care Readiness Index 2.0, 2022).

- **Case-study overview, paragraph 3, and paragraph 37 (Chapter 3):** We suggest removing categorical gateway claim: The overview says vaping is "recognised as a gateway into tobacco consumption," while paragraph 37 refers to vaping as a "potential gateway." The overview's categorical wording is stronger than the detailed chapter and stronger than Chapter 2, which says e-cigarettes "may" act as a gateway.

Proposed replacement in the overview: "incorporating age-appropriate prevention strategies addressing vaping among children, adolescents and nicotine-naïve young adults"

Proposed replacement for paragraph 37: "Incorporate targeted prevention strategies for children, adolescents and non-users. As vaping has increased among younger age groups, campaigns may include tailored measures to discourage initiation among people who do not smoke. Such measures should be clearly differentiated from cessation communications directed to adults who smoke."

- **Paragraph 37 (Chapter 3):** we suggest to align the recommendation with the target population. Mois Sans Tabac is described as a campaign for adults who smoke. Paragraph 37 moves from adult vaping prevalence to a gateway concern concerning adolescents and young adults, then concludes that the campaign should develop initiatives towards "vapers" generally. The target population and intended outcome are unclear.

Proposed addition : "Initiatives should distinguish adults who smoke and vape, former smokers who vape, adults who have never smoked, and underage users. Messages to adults who smoke should not discourage complete switching away from cigarettes or create the impression that vaping carries

- **Paragraphs 63-65 (Chapter 3):** We suggest broadening the cessation framework. The conclusions focus on information, support services, NRT affordability and cigarette affordability. These are relevant, but the framework does not reflect the broader range of cessation aids that the report itself identifies in the English case study.

Proposed replacement in paragraph 65: "To improve transferability, countries may wish to strengthen smoking-cessation services, improve affordable access to the full range of evidence-based cessation options recognised in national guidance, and provide accurate, population-specific cessation communications."

- **Paragraph 6 (Chapter 4):** Pharmacists indeed play an important role referring people to access services, but they often do much more than that. We suggest acknowledging that pharmacists in particular may play a dual role, serving both as referral points into formal cessation services and as accessible providers of smoking cessation advice and support for individuals undertaking self-managed quit attempts either out of choice or because they cannot easily access formal cessation services.

- **Chapter 4: Coverage of NRT through Local Stop Smoking Services : Case-study title and overview :** The chapter is titled and framed as “Coverage of NRT,” but the service described is a comprehensive cessation service offering behavioural support, NRT, nicotine vapes and prescription medicines. Paragraph 9 expressly states that NRT is one of three first-choice aids alongside nicotine vapes and medicines. The evidence and cost figures also concern different combinations of service support.

Proposed revised title : “Access to evidence-based cessation aids through Local Stop Smoking Services in England”

- **Paragraph 6 (Chapter 4):** We invite to include nicotine vapes in the initial service description. The paragraph lists NRT, prescription medicines, behavioural support and health-literacy resources but omits nicotine vapes, even though paragraph 9 identifies them as first-choice aids.

Proposed replacement : “Support packages include nicotine-replacement therapy, nicotine vapes where provided under applicable national and local arrangements, prescription smoking-cessation medicines, structured behavioural support and health-literacy resources.”

- **Box 4.1, Paragraph 8 (Chapter 4):** The common formats of NRT listed should also include oral spray (one of the NRT formats on the WHO Model List of Essential Medicines along with patch, gum and lozenge) (WHO, Model List of Essential Medicines, 2025).
- **Paragraph 7 (Chapter 4):** We recommend clarifying that due to being widely available on a non-prescription basis, NRT is a highly important self-care tool as it allows people to manage nicotine dependence directly outside traditional clinical settings, either because they choose a self-managed quit attempt or because they are not able to access specialist treatment services. In particular, we recommend stating that NRT is a widely used evidence-based self-care intervention for tobacco nicotine dependence (GSCF, EcoSoc 2.0, 2026).
- **Paragraph 9 (Chapter 4):** We welcome the statement that nicotine vapes are one of three first-choice cessation aids alongside NRT and medicines. This is important evidence of actual national clinical practice and should also be reflected in the chapter overview, policy options, conclusions and cross-country lessons.

Proposed addition: “The inclusion of nicotine vapes among first-choice aids illustrates that cessation services may offer different evidence-based options according to patient preference, previous quit attempts and national guidance.”

- **Paragraph 17 (Chapter 4):** The paragraph relies on the 2018 Cochrane review demonstrating NRT effectiveness against control. It should be supplemented by the August 2026 Cochrane comparison of nicotine e-cigarettes and NRT. The report’s references currently include the older NRT review and a 2019 randomised cost-effectiveness analysis comparing e-cigarettes with NRT, but not the updated living review.

Proposed addition: “The comparative evidence base has continued to develop. The August 2026 update of the Cochrane living systematic review concluded that there is high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with NRT. The review estimated approximately 8 to 10 successful quitters per 100 people using nicotine e-cigarettes, compared with approximately 6 per 100 using NRT.”

- **Paragraph 21 (Chapter 4):** The cited Li et al. study is titled “Cost-effectiveness of e-cigarettes compared with nicotine replacement therapy,” but the paragraph uses it to characterise “NRT-based support” without stating that the trial compared e-cigarettes with NRT.

Proposed replacement: "A randomised controlled trial conducted across three Local Stop Smoking Services assessed the cost-effectiveness of e-cigarettes compared with NRT. The comparative findings should be reported explicitly, rather than presenting the study solely as evidence for NRT-based support."

Additional request: please report the intervention-specific costs, quit outcomes and cost-effectiveness results for both study arms.

- **Paragraph 22 (Chapter 4):** When discussing barriers to accessing smoking cessation interventions, it is important to note that access is multifaceted. Pharmacies can help reduce geographic barriers, waiting times, appointment requirements, service navigation complexity, and stigma associated with specialist addiction services. For some individuals, pharmacy-based support may represent the only professional support they receive during a quit attempt, either because they choose a self-managed quit attempt or because they cannot easily access specialist treatment services. We therefore encourage expanding the concept of access to include accessible, low-threshold support through community pharmacy settings. Regarding financial barriers, it is worthy of note that in the UK the VAT level on NRT was reduced to the minimum permissible level (5%) in 2007 to make it more affordable for smokers wishing to quit.
- **Paragraph 32 (Chapter 4):** The recommendation to fund "the full range of products recommended by national smoking cessation guidelines" is welcome. The chapter should make clear that this includes nicotine vapes where they are recommended.

Proposed replacement: "Increase resources for the full range of cessation aids recommended in national guidance, including NRT, prescription medicines and nicotine vapes where applicable, together with appropriate behavioural support."

- **Conclusions and next steps (Chapter 4):** Proposed additional recommendation: "Ensure that adults who smoke can discuss the full range of evidence-based cessation options through patient-centred shared decision-making. Communications should explain that non-combustible products are not risk-free while avoiding the misperception that their risks are equivalent to continued cigarette smoking."
- **General comment on Chapter 5:** *Business at OECD* supports measures to prevent e-cigarette initiation among children and adolescents. Our comments do not challenge that objective. They seek to ensure that the chapter :
 - Uses causal terms proportionately ;
 - distinguishes youth prevention from adult smoking cessation;
 - accurately describes the limitations of gateway evidence;
 - avoids creating risk misperceptions that may affect adults who smoke; and
 - does not transfer youth-specific findings to other populations.
- **Box 5.1 (Chapter 5):** We suggest to add an adult smoking-cessation context statement. Proposed addition: "This box concerns prevention among children and adolescents. Its conclusions should not be extrapolated to the separate question of nicotine e-cigarette use for smoking cessation among adults. The August 2026 Cochrane living systematic review found high-certainty evidence that nicotine e-cigarettes increase cessation compared with NRT."
- **Box 5.1, paragraph 2 (Chapter 5):** We invite the OECD to update the terminology used. The box says that the aerosol is inhaled by "the smoker." A person using an e-cigarette is not necessarily a smoker.

Proposed replacement: "E-cigarettes are battery-operated devices that heat a liquid to produce an aerosol inhaled by the user."

- **Box 5.1, paragraph 3 (Chapter 5):** We also invite to add the smoking comparator: The description lists potential harmful constituents and risks but does not state that the relevant source studies and risk assessment should distinguish vaping from cigarette smoking. Chapter 2 acknowledges that vaping is generally viewed as less harmful than smoking, but that context is absent here.

Proposed opening: "E-cigarettes are not risk-free and should not be used by children, adolescents or people who do not smoke. For adults who smoke, however, assessment of their potential risks should include comparison with continued cigarette smoking."

Proposed additional sentence : "Most smoking-related disease is caused by inhalation of cigarette smoke and products of combustion rather than nicotine itself."

- **Box 5.1, paragraph 3 (Chapter 5):** We also invite to distinguish EVALI-type injuries from regulated nicotine e-cigarettes : The reference to acute lung injuries should identify the products and substances implicated by the evidence cited. The SRNT working-group recommendations note that the 2019 EVALI outbreak was linked principally to illicit THC products contaminated with vitamin E acetate.

Proposed addition : "Where acute lung injury evidence relates principally to illicit THC-containing products or particular contaminants, this should be stated explicitly rather than attributed without qualification to nicotine e-cigarettes as a category."

- **Box 5.1, paragraph 4 (Chapter 5):** We replace categorical gateway language Comment : The statement that e-cigarettes "have been identified as a gateway" and that evidence suggests vaping "leads to" later tobacco use presents an observational association as causal. Chapter 2 uses the more cautious formulation that e-cigarettes "may act" as a gateway, illustrating an internal inconsistency.

Proposed replacement : "Observational studies have found that adolescents who use e-cigarettes are more likely subsequently to report cigarette smoking than those who do not. This association does not by itself establish that e-cigarette use caused subsequent smoking, as shared behavioural, social and environmental susceptibility may contribute to both behaviours."

- **Paragraphs 11-14 (Chapter 5):** Paragraph 11 appropriately states that campaign exposure was "associated with" reduced likelihood of initiation. Paragraph 13 says the campaign "prevented" more than 440,000 initiations, and paragraph 14 says the findings are "consistent with" a national decline while acknowledging that several measures may have contributed. The consistent formulation should be association or modelled estimate, not established prevention.

Proposed heading for paragraph 13 : "At national level, campaign exposure was estimated to be associated with more than 440,000 fewer adolescent initiations over the study period."

Proposed replacement : "Based on the association between campaign exposure and initiation observed in the longitudinal cohort, the authors modelled the difference between

predicted initiation under observed exposure and a hypothetical no-exposure scenario. The model estimated 444,252 fewer initiations during the study period. As this estimate is derived from an observational exposure study and a counterfactual model, it should not be interpreted as a directly observed number of initiations causally prevented by the campaign.”

- **Paragraphs 21-23 (Chapter 5):** The evidence comes mainly from a longitudinal cohort study. The report rates the study design and confounding domains as moderate and the overall quality as moderate. Consequently, the chapter should avoid categorical statements that the campaign “effectively prevents” initiation.

Proposed conclusion: “The available observational evidence indicates that greater campaign exposure was associated with lower odds of e-cigarette initiation among adolescents. Further evaluation, including stronger causal designs where feasible, would increase confidence in the magnitude of the campaign effect.”

Supporting resources

GSCF. The Global Social and Economic Impact of Self-Care. July 2026. Available from: <https://www.selfcarefederation.org/resources>

WHO. 24th WHO Model List of Essential Medicines, September 2025. Available from: <https://list.essentialmeds.org/>

WHO. WHO clinical treatment guideline for tobacco cessation in adults. July 2024. Available from: <https://www.who.int/publications/i/item/9789240096431>

GSCF. Self-Care Readiness Index 2.0. October 2022. Available from: <https://www.selfcarefederation.org/sites/default/files/2024-10/self-care-readiness-index-report-2022-05122022-v2.pdf>

Cochrane living systematic review : Electronic cigarettes for smoking cessation, updated 26 August 2026. Cochrane living systematic review: Electronic cigarettes for smoking cessation, updated 26 August 2026. Nicola Lindsona, Jonathan Livingstone-Banksa, Ailsa R Butler, Hayden McRobbie, Christopher R Bullen, Peter Hajek, Angela Difeng Wu, Rachna Begh, Annika Theodoulou, Claire MaCaitlin Notley, Nancy A Rigotti, Tari Turner, Thomas Fanshawe, Jamie Hartmann-Boyce <https://doi.org/10.1002/14651858.CD010216.pub11>

Leavens ELS, Pebley K, Smith TT, et al. Nicotine E-Cigarettes for Cigarette Smoking Cessation : Recommendations to US-Based Clinicians. JAMA. Published online July 30, 2026 ;336(9):783-790. doi:10.1001/jama.2026.13087.

General comments for the Recommendations chapter

We understand from the introductory note to the analytical annex that the deadline for comments on the assessment and recommendation chapter, DELSA/HEA(2026)10, was 4 September 2026 and that this chapter is not included in the analytical annex circulated for the present consultation. We are therefore not in a position to assess whether, or how, the comments submitted previously by *Business at OECD* on the assessment and recommendation chapter have been reflected in a subsequent draft.

- For completeness, we respectfully reiterate below our principal earlier comments concerning tobacco and nicotine. We also ask the OECD to take account of two important scientific and clinical-policy developments published since our earlier submission:
 - the August 2026 update of the Cochrane living systematic review of electronic cigarettes for smoking cessation; and
 - the July 2026 recommendations to US-based clinicians developed by a working group within the Treatment Research Network of the international Society for Research on Nicotine and Tobacco and published in JAMA.
- These developments are directly relevant to the report's assessment of effective approaches to treating nicotine dependence and supporting smoking cessation:

1. The report should distinguish prevention, treatment and harm reduction

- a. As noted in our earlier comments, the report should more clearly distinguish among:
 - i. preventing tobacco and nicotine initiation among children, adolescents and people who do not currently use nicotine;
 - ii. supporting adults who smoke to stop smoking;
 - iii. treating nicotine dependence;
 - iv. preventing relapse;
 - v. reducing smoking-related harm among adults who would otherwise continue smoking; and
 - vi. supporting complete switching from combustible cigarettes to regulated non-combustible nicotine products.
- b. These objectives are related, but they are neither identical nor interchangeable. An intervention intended to prevent nicotine initiation among a young person who has never smoked should not automatically determine the advice provided to an adult who smokes and has been unable or unwilling to stop using nicotine.
- c. We support effective measures to prevent youth access and uptake. At the same time, the report should recognise that youth prevention and adult smoking cessation are distinct public-health questions requiring differentiated evidence, communications and policy responses.

2. The assessment should be updated to reflect the August 2026 Cochrane review:

- a. The August 2026 update of the Cochrane living systematic review concluded that there is high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with nicotine-replacement therapy, and moderate-certainty evidence that they increase cessation rates compared with non-nicotine e-cigarettes.⁴
- b. This updated evidence has several implications for the OECD report:
 - i. nicotine e-cigarettes should not be described merely as products that are "sometimes used" for cessation;
 - ii. the current evidence is stronger than a formulation suggesting that their

⁴ According to the published findings, the review covered 80 randomised controlled trials involving 29,861 participants. It estimated that, for every 100 people using nicotine e-cigarettes to stop smoking, approximately 8 to 10 might successfully stop, compared with approximately 6 of every 100 using NRT, approximately 6 using non-nicotine e-cigarettes, and approximately 5 receiving no support or behavioural support alone. The review also reported moderate-certainty evidence that rates of serious adverse events were similar when nicotine e-cigarettes were compared with NRT. It did not detect evidence of serious short-term harm, while appropriately noting that larger and longer studies are required to evaluate safety. Its assessment of the possible effect of flavours on cessation outcomes remained inconclusive.

- basic viability as a cessation intervention remains undetermined;
 - iii. comparative evidence involving nicotine e-cigarettes should be considered alongside evidence for NRT and smoking-cessation medicines;
 - iv. remaining uncertainty about long-term effects should be described without obscuring high-certainty evidence concerning cessation efficacy; and
 - v. evidence concerning youth initiation should be presented separately from randomised controlled trial evidence concerning cessation among adults who smoke.
 - c. The OECD need not recommend a single cessation method or regulatory approach. It should, however, ensure that its assessment of best practice reflects the most current and highest-quality evidence.
3. The **report should take account of the July 2026 SRNT working-group recommendations**⁵. The paper also notes that public-health messages designed to discourage youth e-cigarette use may have unintentionally contributed to confusion among adults who smoke. This reinforces the need for the OECD report to distinguish communications for young people and non-users from communications for adults seeking to stop smoking.

The OECD should not be expected simply to reproduce the SRNT working group's recommendations. It should nevertheless acknowledge them as an important recent development and ensure that its own assessment does not present a less current or less differentiated account of the cessation evidence.

4. Nicotine dependence should be distinguished from combustion-related health risk:

- a. The report should distinguish more consistently between:
 - i. the dependence associated with nicotine;
 - ii. the health risks associated with particular nicotine-delivery products; and
 - iii. the disease burden caused predominantly by inhalation of cigarette smoke and the products of combustion.
- b. Regulated non-combustible nicotine products are not risk-free. Nevertheless, describing cigarettes, nicotine e-cigarettes, heated tobacco products, snus and nicotine pouches principally through a common nicotine-dependence framework may obscure material differences in product characteristics, toxicant exposure and potential health risk.
- c. For an adult who would otherwise continue smoking, the relevant comparison is not always between complete nicotine abstinence and continued nicotine use. The

⁵ In July 2026, a working group within the Treatment Research Network of the international Society for Research on Nicotine and Tobacco published a Special Communication in JAMA entitled "Nicotine E-Cigarettes for Cigarette Smoking Cessation: Recommendations to US-Based Clinicians." The paper's overarching recommendation is that clinicians should integrate nicotine e-cigarettes into patient-centred conversations concerning the risks and benefits of evidence-based treatments for smoking cessation. The institutional provenance of the recommendation is relevant. SRNT is a scientific society that bars tobacco-industry funding and membership. The recommendations therefore provide an important independent clinical perspective on how the developing evidence base should be translated into discussions between clinicians and adult patients who smoke. The paper states that nicotine e-cigarettes are less harmful than cigarettes and have been shown to be more effective for smoking cessation than FDA-approved nicotine-replacement therapies. It recommends that clinicians:

- i. include nicotine e-cigarettes when discussing evidence-based cessation options;
 - ii. use patient-centred shared decision-making;
 - iii. correct misperceptions concerning the relative harms of cigarettes and e-cigarettes;
 - iv. explain that most smoking-related diseases are caused by the by-products of tobacco combustion rather than nicotine itself;
 - v. provide practical guidance to adults who choose to use e-cigarettes in an attempt to stop smoking; and
 - vi. not necessarily require patients first to try or fail an FDA-approved medication before considering a nicotine e-cigarette.
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immediate comparison may be between continued cigarette smoking and complete switching to a regulated non-combustible alternative.

- d. The report should therefore distinguish:
 - i. continued exclusive cigarette smoking;
 - ii. dual use of cigarettes and a non-combustible product;
 - iii. temporary use of a product during a cessation attempt;
 - iv. complete switching away from cigarettes; and
 - v. eventual cessation of all tobacco and nicotine use.
- e. These outcomes should not be combined into a single measure of “nicotine-product use.”

5. The report should recognise harm reduction as part of a continuum of outcomes

- a. Our earlier comments asked the OECD to apply a differentiated framework encompassing prevention, treatment, harm reduction and social reintegration.
- b. The OECD report recognises that addiction policy may pursue a continuum of beneficial outcomes rather than immediate abstinence alone. The same analytical principle should be considered in relation to smoking.
- c. For an adult who would otherwise continue smoking, complete switching from combustible cigarettes to a regulated non-combustible nicotine product may reduce exposure to the toxic products of combustion. Recognising this possibility does not require the OECD to describe any product as safe, endorse a particular commercial product, weaken youth protections or discourage eventual nicotine cessation.
- d. It would instead acknowledge that:
 - i. cessation of cigarette smoking is itself a critical public-health outcome;
 - ii. continued nicotine use is not necessarily equivalent to continued cigarette smoking;
 - iii. complete switching and dual use have different public-health implications; and
 - iv. interventions can be assessed against both abstinence and harm-reduction outcomes.

6. Regulation and communication should reflect differences among products and populations

- a. The report should recommend proportionate, evidence-based approaches that take account of product characteristics, intended populations and patterns of use.
- b. Strong measures should prevent access and uptake among children and adolescents. At the same time, adults who smoke should receive accurate information about the relative risks, benefits and uncertainties of available cessation options.
- c. Risk communication should avoid two opposite errors:
 - i. implying that non-combustible nicotine products are harmless; and
 - ii. creating or reinforcing the incorrect perception that their risks are equivalent to cigarette smoking.
- d. The new Cochrane evidence and the SRNT working-group recommendations make correction of relative-risk misperceptions particularly important.

Specific comments for the Recommendations chapter

Paragraph 9 : distinguish youth uptake from adult cessation

- Comment : The discussion of increasing e-cigarette use among adolescents should be retained but should not be framed in a manner that encompasses all uses or populations. Use by nicotine-naïve adolescents and use by adults attempting to stop smoking are distinct

behaviours requiring different policy responses.

- Proposed addition : “Trends in e-cigarette use among children, adolescents and people who have never smoked should be distinguished from use by adults who smoke as part of a smoking-cessation attempt. Preventing initiation among young people and supporting effective cessation among adults are separate and complementary public-health objectives.”

Paragraph 10 : reflect the possible application of harm reduction to smoking

- Comment : The chapter recognises harm minimisation in other areas of addiction policy. It should acknowledge that some countries also incorporate harm-reduction considerations into policies for adults who smoke.
- Proposed addition : “Harm-reduction approaches vary according to the substance, intervention and national context. In nicotine policy, some jurisdictions seek to reduce smoking-related harm by supporting adults who would otherwise continue smoking to switch completely away from combustible cigarettes, alongside strong measures to prevent youth uptake.”

Paragraph 15 : update the smoking-cessation evidence

- Comment : The description of effective smoking-cessation interventions should be updated to reflect the August 2026 Cochrane review.
- Proposed replacement : “The evidence reviewed demonstrates the value of combining behavioural support with effective smoking-cessation options. These may include nicotine-replacement therapy, prescription smoking-cessation medicines and, in some jurisdictions, regulated nicotine e-cigarettes. The August 2026 update of the Cochrane living systematic review concluded that there is high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with nicotine-replacement therapy.”

Paragraph 20 : disaggregate non-combustible nicotine products and patterns of use

- Comment : The term “novel nicotine products” groups together different products and different patterns of use. Monitoring should distinguish initiation, dual use and complete switching.
- Proposed replacement : “Non-combustible nicotine products differ in their characteristics, routes of administration, patterns of use and risk profiles. Monitoring should distinguish initiation among nicotine-naïve people, dual use with cigarettes, temporary use during a cessation attempt and complete switching away from combustible cigarettes.”
- Proposed additional sentence : “Changes in the prevalence of non-combustible product use should be assessed together with changes in cigarette smoking, because initiation among non-users and complete switching by adults who previously smoked have different public-health implications.”

Paragraph 21 and Box 1.2: revise the conclusion on cessation efficacy

- Comment : Any statement that further research is required to determine whether nicotine e-cigarettes are a viable cessation intervention should be revised. Further research is important for long-term safety, product characteristics and implementation, but the August 2026 Cochrane review reports high-certainty evidence of cessation efficacy compared with NRT.
- Proposed replacement text : “Nicotine e-cigarettes are not risk-free, and preventing uptake among children, adolescents and people who do not smoke remains an important public-health objective. They are, however, generally considered less harmful than combustible

cigarettes and are used in some jurisdictions to support smoking cessation.

- The August 2026 update of the Cochrane living systematic review, covering 80 randomised controlled trials involving 29,861 participants, concluded that there is high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with nicotine-replacement therapy. It also reported moderate-certainty evidence of benefit compared with non-nicotine e-cigarettes and moderate-certainty evidence that serious adverse-event rates were similar between nicotine e-cigarettes and NRT. The authors noted the need for larger and longer studies to evaluate safety.
- In July 2026, a working group within the Treatment Research Network of the Society for Research on Nicotine and Tobacco published recommendations in JAMA advising US clinicians to include nicotine e-cigarettes in patient-centred discussions of evidence-based cessation options with adults who smoke. SRNT bars tobacco-industry funding and membership.
- Evidence concerning smoking cessation among adults should be assessed separately from evidence concerning initiation and use among young people. Remaining uncertainty about long-term effects should also be distinguished from evidence concerning cessation efficacy."

Paragraph 28 : distinguish the harms of combustion from nicotine dependence

- Proposed addition : "The health burden associated with nicotine-delivery products differs according to product characteristics and route of administration. Nicotine dependence should not be treated as equivalent to the health risks caused by inhalation of cigarette smoke and products of combustion."

Paragraph 55 : apply population segmentation expressly to nicotine communications

- Proposed addition : "For tobacco- and nicotine-related communications, segmentation should distinguish children, adolescents and people who do not smoke from adults who currently smoke. Messages designed to prevent youth initiation should not unintentionally reinforce inaccurate perceptions among adults concerning the relative harms or cessation evidence associated with regulated non-combustible products."

Paragraph 58 : update the Cochrane evidence cited

- Comment : The earlier reliance on a 2018 Cochrane review of NRT should be supplemented by the August 2026 Cochrane review comparing nicotine e-cigarettes with NRT.
- Proposed addition : "The evidence base has continued to develop. The August 2026 update of the Cochrane living systematic review concluded that there is high-certainty evidence that nicotine e-cigarettes increase smoking-cessation rates compared with NRT. It estimated that approximately 8 to 10 people per 100 using nicotine e-cigarettes might successfully stop smoking, compared with approximately 6 per 100 using NRT. This evidence should be considered alongside evidence for established pharmacotherapies and behavioural interventions."

Paragraph 63 : revise the principal treatment recommendation

- Proposed replacement : "Countries should ensure wide availability of evidence-based smoking-cessation support. Depending on national clinical and regulatory frameworks, this may include behavioural support, nicotine-replacement therapy, prescription medicines and regulated nicotine e-cigarettes. Adults who smoke should receive accurate information concerning the benefits, risks and uncertainties of the available options through patient-centred decision-making. Communications should make clear that non-combustible

products are not risk-free, while avoiding the misperception that their risks are equivalent to those of combustible cigarettes.”