

# The Politics of Acceptable Addiction



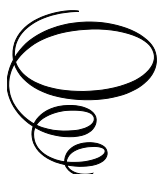
# The Politics of Acceptable Addiction:

*Coffee, Nicotine, and the  
Collapse of Proportional Risk*

By

Roger Bate

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The Politics of Acceptable Addiction: Coffee, Nicotine, and the Collapse  
of Proportional Risk

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## PREFACE

This book began, improbably enough, in a Starbucks.

I was waiting for a coffee when I noticed a young man at the counter. He had the kind of carefully cultivated beard that signals membership in a certain urban tribe. He ordered easily, chatted with the barista, and looked entirely at ease. Then, almost as an afterthought, he slipped a small white pouch into his mouth.

The gesture was subtle. Not furtive exactly, but cautious. He did not scan the room, but he did lower his gaze slightly. Anyone who has lived with a socially ambiguous habit for a long time learns that overt secrecy attracts attention, while quiet normality often passes unnoticed. He was not embarrassed, but neither was he advertising what he was doing.

He was using a nicotine pouch.

What struck me was not the act itself, but the contrast. Here he was, standing in one of the most visible temples of caffeine consumption on the planet, surrounded by people openly dosing themselves with a psychoactive stimulant. Yet his own stimulant use—far less intrusive, far less visible, and probably as benign—required discretion.

Nobody blinked at the coffee.

The nicotine had to be hidden.

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That moment stayed with me because it captured something that had been troubling me for years as I worked in public health, policy, and economics. We live in a culture that is remarkably comfortable with some dependencies and deeply uneasy with others, even when the scientific basis for that unease is weak, outdated, or simply wrong. We tolerate certain risks because they are familiar. We moralise others because they are not—or because they are no longer familiar to those making the rules.

It is worth being clear about my own standpoint.

I am not a smoker. I tried cigarettes briefly as a teenager—perhaps a dozen in total, around the age of sixteen—and never touched them again. This was not an era of ignorance. I knew smoking was dangerous when I tried it. The risks were well established and widely discussed. I smoked anyway, briefly, for reasons that will be familiar: curiosity, social signalling, and the mild lure of the forbidden. Knowledge of risk did not prevent experimentation. It simply limited it.

I did not stop because a warning label frightened me, although it did. I never really began because the habit did not take, because it did not serve me, and because the trade-off was not worth it. The decision was personal, not pedagogical.

Caffeine, by contrast, did take.

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I consume it daily, as do most adults I know. I enjoy the taste of coffee, but more than that, I value what it does. It sharpens attention, structures the day, and makes sustained work possible. When I do not consume caffeine, the effects are immediate and predictable: headaches, dulled concentration, irritability. None of this feels pathological. It feels ordinary.

Public health has no difficulty acknowledging this trade-off. Caffeine dependence is treated as a normal feature of adult life. Its benefits are discussed openly. Its risks are managed through guidance rather than moral instruction. Nobody suggests that coffee drinkers should aspire to abstinence in order to be considered healthy.

In writing this book, I have relied heavily on caffeine. Long stretches of reading, drafting, revising, and thinking are made possible by a stimulant whose risks are treated with calm proportionality.

That contrast frames the puzzle at the heart of this book.

A substance I do not use is treated with far greater moral intensity than one I depend on daily—even though the former, once separated from combustion, appears to pose no greater risk. This book is not written to celebrate nicotine. It is written to ask why public health has been capable of realism about caffeine, alcohol, and other familiar risks, yet has proven so resistant to applying the same logic to nicotine once the true source of harm was identified.

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Over the chapters that follow, I argue that this failure was not primarily scientific. The science has been available for years. The difficulty has been institutional, cultural, and moral. Public health did not simply misunderstand nicotine; it gradually lost the habit of thinking proportionally about risk and replaced it with a framework that rewarded absolutism, precaution and increasingly rigid categories.

Nicotine is the clearest example of this failure, but it is not the only one. The same dynamics appear wherever institutions attempt to govern behaviour rather than exposure, and wherever legitimacy matters more than evidence.

Nor is this a book arguing that people should use nicotine. It is a book about why public health forgot how to learn—and what that forgetting has cost.

The question that animates these pages is not whether nicotine is good or bad. It is whether policy should be based on what we know, or on what we are used to saying.

That question matters far beyond nicotine.

## **A Thought Experiment**

It is sometimes easier to see the structure of a system by applying it somewhere it does not belong.

Imagine that a company such as PepsiCo or Kraft Heinz decides to launch a new coffee product—slightly stronger and designed to deliver caffeine in a more concentrated form. Under the regulatory framework that governs most food and drink, the requirements would be straightforward: disclose ingredients, meet safety standards, avoid marketing to children. Beyond that, the product would enter the market, and consumers would decide whether to use it.

Now imagine that the same product were regulated as nicotine is today.

Before it could be sold, it would need to demonstrate not only that it was safe for users, but that its existence would not produce wider population harms. Would non-users begin consuming caffeine? Would existing users consume more? Could patterns of use shift in ways that are difficult to

predict over decades? The process would be long, uncertain, and heavily contested.

Meanwhile, existing coffee products would remain freely available.

When the product finally appeared, media coverage might look familiar:

“New high-caffeine drink raises fears of youth addiction”

“Experts warn of unknown long-term cardiovascular risks”

“Could concentrated caffeine lead to heart arrhythmias in teenagers?”

The functional reason for the product—helping people stay alert, concentrate, or work—would be acknowledged, if at all, only in passing. The central narrative would be risk, uncertainty, and precaution.

And while this debate unfolded, the product would likely appear anyway—through imports, informal distribution, or less regulated channels—because demand, once established, does not wait for approval.

This sounds absurd.

But as you read this book, I want you to hold that thought.

Because much of what follows can be understood as a system that treats nicotine in precisely this way—judging it not as it exists now, but as it was once embedded in smoking. The question is not whether nicotine carries risk. It does. The question is whether the framework used to manage that risk still reflects reality.

By the end of this book, I want you to decide whether it does.

## AUTHOR'S NOTE ON SOURCES AND EVIDENCE

This book draws on a combination of published research, policy documents, interviews, and personal observation.

Where possible, claims about health risks, pharmacology, and population trends are grounded in peer-reviewed literature and official data sources. The scientific discussion of nicotine, caffeine, and related compounds reflects a broad consensus within toxicology and neuroscience, though interpretation of that evidence varies across institutions and policy settings.

In addition to formal sources, the book incorporates insights from interviews conducted with individuals in the United States and the United Kingdom over the past decade. These include smokers, former smokers, users of nicotine alternatives, clinicians, and policymakers. The interviews were not designed as a representative survey, but as a way of understanding how people experience and interpret risk in practice. Names have been changed or omitted where appropriate.

Some examples are drawn from direct observation, including conversations with retail workers, enforcement officials, and consumers in different regulatory environments. These are used to illustrate broader patterns rather than to establish statistical claims.

The analysis of policy and institutional behaviour reflects the author's interpretation of publicly available information, including reports from international organisations, government agencies, academic institutions, and non-governmental organisations. Where the book discusses funding flows, institutional relationships, or media narratives, it does so based on documented sources and observable patterns, though the conclusions drawn are the author's own.

This is not a technical monograph, nor is it a work of advocacy. It is an attempt to understand how scientific evidence, cultural interpretation, and institutional incentives interact in shaping policy. Where the evidence is clear, it is presented as such. Where it is uncertain, that uncertainty is acknowledged. Where the evidence remains contested, I have tried to present the competing interpretations fairly while explaining why I find some more persuasive than others.

The central argument—that public health has, in some cases, lost the ability to reason proportionally about risk—is offered not as a final conclusion, but as a framework for understanding a set of observable contradictions.



## **PART I:**

# **HOW WE LOST PROPORTIONALITY**

# CHAPTER 1

## THE POLITICS OF ACCEPTABLE ADDICTION

Every society tolerates some addictions while condemning others. The distinction is rarely explained in scientific terms, yet it is enforced with confidence and moral clarity. Coffee is celebrated. Nicotine—even when stripped of smoke, tar, and combustion—is treated as a moral contaminant. One dependence is framed as productivity and wellness; the other as danger and degeneracy.

This book begins with a simple question: why?

It is tempting to treat this as a narrow question about nicotine. It is not. It is a question about how societies decide which risks are tolerable and which are not, and how those decisions become embedded so deeply that they no longer appear to be decisions at all. Every day, we accept behaviours that carry measurable risk—drinking alcohol, driving cars, working long hours under stress—without treating them as moral failings. We manage them, regulate them, and incorporate them into ordinary life.

What is striking about nicotine is not that it carries risk, but that it has been placed outside this category. It is treated not as something to be managed, but as something to be eliminated. That difference is not simply a matter of science. It reflects something deeper about how public health, and the societies it operates within, have come to think about risk itself.

At first glance, the answer appears obvious. Smoking kills. Nicotine is addictive. Public health has spoken. But this explanation collapses under even modest scrutiny. Caffeine and nicotine are pharmacological peers: plant-derived alkaloids, psychoactive stimulants, widely used by adults to regulate alertness, mood, and performance. Both produce dependence. Both produce withdrawal. Neither is carcinogenic in isolation.

And yet their regulatory, cultural, and moral treatment could not be more different.

The argument of this book is that this divergence is not grounded in toxicology or medicine alone. It reflects history, culture, and institutional habit—specifically, the collapse of proportional risk reasoning in modern public health and the tendency to tolerate familiar risks while moralising delegitimised ones.

Nicotine is not unique. It is simply the clearest case.

But precisely because it is clear, it forces uncomfortable questions about how we decide which risks deserve management and which deserve condemnation. In other words, what makes one risk socially acceptable while another becomes morally unacceptable?

## Addiction Without Context

Addiction is among the most moralised concepts in modern policy discourse. It is often treated less as a physiological phenomenon than as a character flaw or social pathology. Yet dependence exists on a spectrum.

Most adults who drink coffee are dependent on caffeine. Like me, many experience headaches, fatigue, irritability, or impaired performance if they abstain. This dependence is widely acknowledged, even joked about. It carries little stigma.

Caffeine dependence is not invisible. Coffee drinkers talk openly about “needing” their morning dose, about withdrawal headaches, about irritability and reduced concentration without it. These effects are accepted as normal features of adult life. Public health messaging does not frame them as pathology. Instead, it offers guidance: avoid excessive intake, be mindful of sleep, take care with vulnerable populations.

Nicotine dependence is treated differently. Even when nicotine is delivered without combustion—through patches, gum, pouches, or vaping—it is framed as failure rather than trade-off. Continued use is treated as evidence of pathology rather than choice.

If addiction alone were the criterion for intervention, caffeine would be regulated aggressively. If health harm alone were the criterion, non-combustible nicotine would be mundane. Neither is the case.

What distinguishes acceptable from unacceptable addiction is not chemistry. It is legitimacy.

Legitimacy is not bestowed by evidence alone. It is conferred by familiarity, social embedding, and political feasibility. Once a behaviour becomes part of ordinary adult life, its risks are managed rather than moralised. Once it becomes associated with marginality, it is more likely to be punished than understood.

Legitimacy is rarely created from scratch. Institutions inherit assumptions from previous generations and embed them in laws, professional norms, bureaucratic routines, and public expectations. Coffee became part of everyday life before modern public health existed. Alcohol survived prohibition and re-entered society as a regulated commodity. Cigarettes followed a different trajectory, becoming first ubiquitous and then increasingly stigmatised. By the time non-combustible nicotine products appeared, they entered a world in which nicotine had already lost its legitimacy. New evidence therefore confronted not an open question, but an inherited institutional judgement.

This book is about how that sorting happens.

It is about how public health moved from managing exposure to managing identity.

The pattern extends well beyond nicotine. Consider alcohol, a substance whose harms are well documented and, in many cases, severe. It contributes to liver disease, cancer, accidents, and social disruption. Yet it is not treated as a problem to be eliminated entirely. It is taxed, regulated, and culturally embedded. Moderate use is accepted. Excessive use is discouraged. The distinction is not always applied consistently, but it exists.

Or consider sugar. Its role in obesity, diabetes, and metabolic disease is widely recognised. Consumption is high, and in many cases habitual. Yet it is not framed as addiction in the same way nicotine is. It is treated as a dietary issue, something to be managed through guidance and personal responsibility rather than moral judgement.

Even behaviours that are not chemical in nature—gambling, for example—are handled in a similar way. They are recognised as potentially harmful, particularly for vulnerable individuals, but they are not removed from society. They are regulated, taxed, and, in many cases, actively promoted.

The question is not why these risks are tolerated.

It is why nicotine is not.

## **Knowing the Risk and Doing It Anyway**

Public health often proceeds as if knowledge of risk should eliminate behaviour. It rarely does.

I am a never smoker. The decision was personal, informed by the known risk but also by the simple fact that I did not enjoy the process of smoking. But several people I grew up with were smokers, one or two still to this day.

Take Cathy. She is 56, a hairdresser and a mother of two. She smoked Marlboro Lights for around twenty years, but at 48 she began to switch to vaping. “I probably still smoked three or four cigarettes a day for a while,” she told me, “but mostly I was vaping—berry flavours. I enjoyed smoking, but as I got older I started worrying about the long-term harm.”

Then there is Tom, a 58-year-old technology manager and father of three. In his twenties he smoked everything—“cigarettes, cigars, marijuana... you name it.” Now he smokes Benson & Hedges. “I know the risks,” he said. “I’ve read it all. But I enjoy it. I tried vaping and occasionally use pouches, but I still smoke—just less than I used to.”

Sean, now 60 and recently retired, smoked Marlboro Reds for a decade and spent years trying to quit in the late 1990s. “I tried patches, gum, lozenges... even snus and more recently pouches,” he said. “None of it worked.” Then he tried a vape. “I loved it straight away.” But the products that worked for him have since disappeared from the legal market. He now relies on a mixture of devices, some sourced informally.

These are not people in denial. They understand risk. But they also make choices within the constraints of habit, preference, and availability. Nicotine influences their decisions, certainly, but so do the products available to them. They use differentiated products that fit their routines, much like coffee drinkers regulate their caffeine intake.

The key point is not that people ignore risk, but that they live with it.

## **The Comfort of Familiar Dependence**

Caffeine exposes how comfortable public health can be with dependence when it is familiar. That experience sharpens the puzzle at the heart of this book. A substance I do not use is treated with far greater moral intensity than one I depend on daily—even when evidence suggests that, once

combustion is removed, the former may carry comparable or lower risks than many accepted dependencies, including coffee.

This asymmetry is not accidental. It is institutional.

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There is also a more subtle dynamic at work, one that operates not at the level of individual choice, but at the level of systems. In many areas of life, people find themselves participating in behaviours that are not individually optimal, but are collectively sustained. Long working hours are a familiar example. Few individuals would choose them in isolation, but once they become the norm, stepping outside them carries a cost. Coffee becomes part of that system—not because it is inherently necessary, but because it allows individuals to function within the expectations imposed on them.

One person drinks coffee to stay alert. Others follow—not necessarily because they prefer to, but because the system rewards those who can maintain pace. Over time, the behaviour becomes normalised. What begins as an individual adjustment becomes a collective equilibrium.

No one sets out to create this system.

But once established, it is difficult to escape.

Nicotine operates in a different version of the same dynamic. It provides moments of pause rather than continuity. It interrupts rather than sustains. It creates breaks in a system that increasingly values uninterrupted performance. In doing so, it becomes visible in a way that coffee does not. What sustains the system is accepted. What interrupts it is questioned.

This is not a conscious decision, it is an equilibrium.

And like many equilibria, it persists even when it is not entirely rational.

## **Harm Reduction When Professionals Are in Charge**

Public health does not reject harm reduction as a principle. It applies harm reduction selectively—most comfortably when it operates within systems of professional control.

The clearest contrast comes from opioid policy.

Methadone and buprenorphine are not risk-free substances. They are opioids. They carry dependency, side effects, and overdose risk. Yet they have become central pillars of opioid harm reduction because they reduce far greater harms associated with illicit opioid use—overdose, infection, instability, and crime.

Health professionals are comfortable with this trade-off.

They acknowledge the risks openly. They accept long-term dependency. They tolerate imperfect outcomes because the alternative is demonstrably worse. Most importantly, they control access, dosing, and framing. Risk is managed within a clinical relationship.

When harm reduction is delivered through medical systems—opioid substitution therapy, supervised consumption, needle exchange—it is framed as pragmatic, evidence-based, and compassionate. When harm reduction is delivered through consumer choice—vaping, nicotine pouches, or other non-combustible nicotine products—it is often framed as permissive, risky, or morally suspect.

The difference is not logic.

It is authority.

## **Medical Gatekeeping and Market Anxiety**

The discomfort with market-based harm reduction extends beyond nicotine.

Insulin is life-saving and dangerous. Its misuse can kill. Yet it is prescribed, regulated, and normalised because it exists within a medical framework. Patients are expected to manage risk—but under supervision.

Opioid substitution therapy follows the same logic. Methadone and buprenorphine are accepted despite dependency and residual harm because they reduce greater harms and remain under professional control.

Caffeine sits at the opposite end of the spectrum. It exists almost entirely outside medicine. Its risks are managed socially rather than clinically. Public health assumes that adults can regulate their intake without supervision, even though caffeine is psychoactive, dependence-forming, and associated with withdrawal.

Nicotine pouches and vaping products fall awkwardly between these models. They are too ordinary to be medicalised, yet too stigmatised to be normalised. They challenge institutional comfort by allowing adults to manage risk without permission.

That autonomy—not the molecule—is what unsettles regulators. Professionals naturally prefer systems they can observe and influence. Prescriptions, supervision and clinical follow-up all fit that model. Consumer markets do not. Individuals choose products, experiment with them, switch brands and respond to prices rather than professional advice. That decentralization is untidy, even when it produces better health outcomes.

Market-based harm reduction removes the visible role of the professional. It substitutes choice for prescription, substitution for supervision, and personal judgement for clinical authority. Even when outcomes improve, the loss of control feels threatening.

Public health understands harm reduction. It is less comfortable when it does not control it.

## **Risk Thermostats and Responsibility**

This pattern becomes clearer when viewed through the lens of John Adams' work on risk.

Adams argued that individuals and societies operate with what he called a “risk thermostat.” People have a preferred level of risk. When risks are reduced in one area, they often compensate by taking more risk elsewhere. When risks are constrained too tightly, they seek alternative outlets. Risk is not eliminated; it is redistributed.

Adams used deliberately provocative examples to illustrate this point. He suggested that if you are a passenger in a car and the driver is behaving recklessly, you may paradoxically be safer undoing your own seatbelt—not because seatbelts are dangerous, but because the driver may respond to visible vulnerability by slowing down.

He even joked that a sharp spike protruding from the centre of the steering wheel might reduce crashes more effectively than an airbag—not as policy advice, but as a way of exposing how mechanical safety devices can alter behaviour. If an airbag makes driving feel safer, the “risk thermostat” may encourage less careful driving.

The key variable is perceived responsibility.

Public health regulators tend to prefer mechanical solutions because they appear predictable and controllable. Behavioural feedback is messier. It undermines the idea that safety can be delivered without negotiation. Yet behaviour is precisely where harm reduction succeeds or fails.

This distinction reflects two different philosophies of public health. One begins with institutions: what regulators, clinicians and policymakers can control. The other begins with people: how individuals actually respond to incentives, products and information.

### **Institutional Risk Aversion and Paternalism**

Physicians and regulators, acting in institutional roles, tend to set policy at very low levels of acceptable risk. They are trained to minimise liability, avoid blame, and adhere to professional norms that reward caution.

Patients and consumers often operate with higher risk tolerance. They value stability, functionality, relief, or routine. Their decisions are shaped by stress, habit, and circumstance rather than abstract optimisation.

When policy ignores this mismatch, paternalism follows.

Paternalism often appears as concern for safety, protection of the vulnerable—especially children—or precaution under uncertainty. But its defining feature is the assumption that professional risk tolerance should be universal.

This assumption is rarely stated explicitly. It does not need to be. It is embedded in guidance, in regulatory thresholds, and in the language used to describe acceptable behaviour. It is reinforced by institutions whose authority depends on appearing cautious rather than proportionate.

When paternalism fails, adult resistance is often misread as irresponsibility rather than legitimate disagreement.

Nicotine policy illustrates this tension more clearly than almost any other area of public health.

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## **Class, Stigma, and Political Feasibility**

Risk does not operate in a social vacuum.

As smoking declined in richer countries, it became increasingly concentrated among poorer populations, those experiencing mental illness, and those living under chronic stress. What was once broadly distributed became stratified. And once it became stratified, it became stigmatised.

Smoking was no longer something “people” did.

It was something “other people” did.

This shift made punitive policy politically easy. Smokers were no longer peers. Their behaviour could be treated as pathology rather than preference. Their voices carried less weight. Their habits could be regulated with fewer political consequences.

Cigarettes’ persistence as currency in prisons is often cited as proof of degeneracy. In reality, it demonstrates reliability under constraint—the same reason cigarettes once functioned as currency in wartime. The function did not change. The social meaning did.

Nicotine inherited that judgment.

Once a substance becomes associated with marginality, evidence struggles to rehabilitate it. Safer substitutes inherit stigma by association, even when they reduce harm dramatically.

Policy follows power more reliably than it follows evidence. This pattern is not unique to tobacco. Throughout history, behaviours practiced by elites tend to be managed, while “others” behaviours are restricted or stigmatized.

## **Professional Opinion Is Just That**

If the decision to write this book began in a Starbucks, the impulse behind it probably began at a public health conference I attended several years ago in London.

Outside the lecture hall, a long table was covered with coffee urns. Delegates refilled their cups repeatedly between sessions. The line formed quickly each morning, and the consumption was enthusiastic.

Inside the hall, several speakers warned about the dangers of nicotine addiction and the need to eliminate nicotine use from society entirely.

Hundreds of professionals were relying on one addictive stimulant to stay alert during the meeting while discussing the moral urgency of eliminating another.

No one considered the coffee table controversial. Dependence on caffeine was simply part of professional life.

Societies do not treat addictions equally. Some become woven into respectable routines; others become symbols of moral failure.

---

### **The Collapse of Proportional Risk**

Public health once reasoned carefully about risk. Dose, delivery and comparative outcomes all mattered.

Over time, this way of thinking eroded.

Risk was flattened into presence. Proportionality gave way to absolutes. Phrases such as “no safe level” migrated from narrow toxicological contexts into lifestyle regulation, where they were poorly suited. As Cass Sunstein argues in *Laws of Fear* and Gerd Gigerenzer demonstrates in *Risk Savvy*, simplifying complex risks into absolute messages can improve communication while simultaneously obscuring important distinctions.

This shift did not occur because the science changed. It occurred because simplification was rewarded and revision was not. What began as an effective response to cigarettes gradually became the default way of thinking about nicotine itself.

Indeed, current nicotine policy exposes the consequences of that shift more clearly than almost any other domain.

Once proportional reasoning collapses, harm reduction becomes conceptually incoherent. Safer alternatives are treated as equally dangerous. Substitution is discouraged. Outcomes stagnate.

## **A Working Hypothesis**

Modern public health appears to embrace harm reduction most readily when three conditions are met.

First, harm reduction reinforces professional authority rather than undermining it.

Second, it occurs within regulated clinical relationships.

Third, it preserves the aspiration to eventual abstinence—even when that aspiration is rarely achieved in practice.

When these conditions are present, harm reduction is described as pragmatic and compassionate. When they are absent—when harm reduction operates through consumer markets and treats long-term use of safer alternatives as an acceptable endpoint—it is framed as permissive or dangerous.

This hypothesis will be tested across the chapters that follow.

If it fails, the argument that follows also fails. If it holds, the implications extend far beyond nicotine.

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## **Why Nicotine Is the Stress Test**

Nicotine is the ideal case through which to examine these dynamics.

Combustion can be removed. Dose can be controlled. Delivery systems can be compared. Population outcomes can be measured. Few policy domains offer such clarity.

If proportional reasoning cannot survive here—where alternatives are obvious and harms dramatically reduced—it is unlikely to survive anywhere.

Nicotine is not just another case study.

It is a stress test for modern risk governance.

---

## The Road Ahead

The chapters that follow trace how these dynamics play out in practice.

They begin with the intellectual shift that displaced dose and comparative risk from public health thinking. They move through the chemistry of nicotine and caffeine, the cultural embedding of some addictions and the stigmatisation of others, and the institutional machinery that amplifies certain narratives while suppressing correction.

They examine how regulators quietly tolerate long-term nicotine use in medical settings while condemning it in consumer markets, how taxation encodes moral judgement rather than harm reduction, and how crises reveal the cost of narrative inertia.

Finally, they ask what it would take for public health to recover its earlier strengths: proportionality, humility, and a willingness to revise.

Nicotine is the case study.

Risk governance is the subject.

The question this book leaves with the reader is not whether nicotine should be liked or disliked, but whether policy should reflect what we know rather than what we are used to saying. That question matters far beyond nicotine.

Before moving on, however, it is worth remembering the scale of the problem. Nothing in this book diminishes the enormous harm caused by smoking. Since smoking is the leading cause of preventable death and lower-risk alternatives can accelerate the decline of smoking, even modest improvements in policy could save millions of lives.

## The Scale of the Issue

Smoking remains one of the largest preventable causes of death worldwide. The scale is often cited, but rarely held together in a way that makes its implications clear.

- Approximately **480,000 deaths per year in the United States** are attributed to smoking.
- Globally, the figure is **roughly 8 million deaths annually**, depending on methodology and attribution.

- Over time, this represents not a static burden but a cumulative one—millions of lives lost each decade.

At the same time, alternatives exist that appear to carry substantially lower risks.

- Estimates commonly place the **relative risk of vaping at around 5% of smoking**, though precise figures remain debated.
- For oral nicotine products such as pouches, estimates are often **lower still, in the range of 1–2%**.

These differences matter not in isolation, but in scale. Even modest substitution from smoking to lower-risk alternatives produces large effects when applied across millions of users.

The structure of the market adds a further dimension.

- Between **10 and 15% of global cigarette consumption** is estimated to occur through illicit channels.
- In some environments, **a large majority of vaping products—often cited at 80–90%—fall outside formal regulatory approval.**

Taken together, these figures describe a system in which risk is concentrated, alternatives exist, and behaviour adapts—sometimes within the formal framework of policy, and often outside it.

The question is not whether smoking remains a major public health problem, but whether the system designed to reduce harm is making the best possible use of the tools available.

## CHAPTER 2

# WHEN PUBLIC HEALTH FORGOT DOSE

Public health did not always think the way it does now.

There was a time when harm was understood as conditional, proportional, and comparative. Exposure mattered. Dose mattered. Route of delivery mattered. Outcomes mattered most of all. Risk was something to be measured, weighed, and managed—not simply declared.

That way of thinking did not disappear because it was disproven. It disappeared because it became increasingly difficult to sustain within the institutional and political environment in which public health now operates.

This chapter is about that shift.

It is about how a discipline that once relied on proportional reasoning—on understanding gradients of risk—came to prefer categorical thinking, and how that preference reshaped the way substances such as nicotine are understood.

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At the centre of this shift lies a distinction that is both fundamental and frequently blurred: the difference between hazard and risk.

A hazard is the intrinsic capacity of a substance or activity to cause harm. Cyanide is hazardous. Ionising radiation is hazardous. So is nicotine. So is caffeine. Even oxygen and water, in sufficient concentration or in the wrong place, become hazardous. Hazard describes potential. It tells us what a substance can do under certain conditions.

Risk, by contrast, describes probability. It tells us how likely harm is to occur under specific conditions of exposure. Risk depends not only on the presence of a hazard, but on dose, duration, route of exposure, and the characteristics of the individual involved. Age, health status, genetics, and environment all matter.

This distinction is not obscure. It is the foundation of toxicology.

For much of its history, public health operated comfortably within this framework. It did not treat substances as simply good or bad. It treated them as more or less harmful under different conditions.

The principle that underpins this approach is often attributed to Paracelsus: the dose makes the poison.

The phrase is simple, but its implications are profound. It denies that substances are intrinsically harmful in isolation. It insists that harm depends on how much is consumed, how often, and in what form. It introduces gradation into what might otherwise appear as binary categories.

This way of thinking is embedded in medicine.

Every drug has a therapeutic window—a range of doses within which it produces benefit without unacceptable harm. Below that range, it does little. Above it, toxicity appears. The molecule itself does not change. The effect does.

Digoxin, for example, is both life-saving and dangerous. At controlled doses, it strengthens heart contractions and treats arrhythmias. At slightly higher levels, it can disrupt cardiac rhythm and cause death. Morphine alleviates severe pain at one dose and suppresses respiration at another. These are not contradictions. They are the predictable consequences of dose-dependent effects.

Medicine does not reject these substances because they carry risk. It manages that risk.

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Public health once applied the same logic more broadly.

Alcohol policy provides a familiar example. Health authorities do not claim that alcohol is safe in all quantities. Instead, they recognise a gradient of risk. Moderate consumption carries much lower risk than heavy consumption. Patterns of use matter. Context matters. Guidance is framed in terms of limits rather than absolutes.

Caffeine is treated similarly. It is recognised as psychoactive and dependence-forming. Withdrawal symptoms are acknowledged. Yet policy assumes that