EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE TOBACCO PRODUCTS CONTROL AMENDMENT BILL 2008

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
TUESDAY, 10 FEBRUARY 2009

SESSION FIVE

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz
Mr I.C. Blayney
Mr J.A. McGinty
Mr P.B. Watson

Hearing commenced at 3.53 pm

CARTER, DR OWEN BRANDON JOHN
Senior Research Fellow, Curtin University,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I thank you for your interest in appearing before us today. The purpose of this hearing is to assist the committee gather evidence for its inquiry into the Tobacco Products Control Amendment Bill 2008. You have been provided with a copy of the committee's specific terms of reference. At this stage, I will introduce myself and the other members of the committee who are present here today. I am the Chairman, Janet Woollard, and the other members are Mr Peter Abetz, Mr Ian Blayney, Mr Peter Watson and Hon Jim McGinty. The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important to understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard reporters will be taking a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist the Hansard reporters if you could provide the full title of it, for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

Dr Carter: I have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Dr Carter: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Dr Carter: Yes.

The CHAIRMAN: Do you have any questions about being a witness at today's hearing?

Dr Carter: No.

The CHAIRMAN: In what capacity do you appear before the committee?

Dr Carter: I am a senior research fellow at the Centre for Behavioural Research in Cancer Control at Curtin University.

The CHAIRMAN: Dr Carter, we very much appreciate that you will give us a PowerPoint presentation and then answer questions following the presentation. Would you be happy for members to interject during the presentation?

Dr Carter: Certainly. Good afternoon. The first photo was taken at a local IGA supermarket and illustrates the current regulations for point-of-sale displays of tobacco. Since 2006, no cigarette advertising whatsoever has been allowed. Only one example of each cigarette packet can be displayed at the point-of-sale display and retailers are allowed a maximum area of one square metre. A series of health warnings must be attached to the display. However, as members can see, it is still quite a dominating feature behind the counter, and it is called a "power wall".

The next slide is of the systematic review that has been pre-released on the internet by the *Nicotine and Tobacco Research* journal. It is literally hot off the press. The ink has not even dried on it yet because it has not been published. This is a systematic review of all the good scientific research to date of the effect that point-of-sale tobacco displays have on smoking. The research identified more than 550 articles, 12 of which were found to have sufficient scientific robustness to be classified as good evidence. The articles were from Australia, the US, UK, Norway and Canada, and constituted a sample of more than 50 000 people. It is quite a good database to draw from. Ten of the 12 studies investigated the effect that point-of-sale tobacco displays have on youth. One fascinating study was from Western Australia. It studied 10 to 12-year-old schoolchildren from Western Australia who were born after tobacco advertising was banned from TV, radio, billboards and newspapers. The study shows that although they were exposed only to the limited point-of-sale displays, 88 per cent of them could identify the Winfield tobacco brand. The lowest brand recognition they could identify with was the budget Holiday brand. With no advertising whatsoever, except at the point-of-sale, 10 to 12-year-old Western Australian children could identify most cigarette brands.

Mr I.C. BLAYNEY: Would they have seen cigarette advertising on racing cars?

Dr Carter: Possibly for international sports sponsorship, but tobacco advertising was banned from national sports sponsorship in Australia during the mid-1990s.

Mr I.C. BLAYNEY: Formula One?

Dr Carter: The most identifiable product in Formula One was Marlboro. It is fascinating research to realise that without any advertising other than point-of-sale displays, brand recognition is high.

Mr J.A. McGINTY: I think the question was: where do the kids get the information from?

Dr Carter: The point-of-sale display is the big one in Western Australia because the only other avenue is international sports sponsorship.

Mr I.C. BLAYNEY: Children see people carrying around their packets of cigarettes.

Dr Carter: Absolutely. The packet is another form of advertising.

Mr P. ABETZ: They are more informed than me. I did not even know that there was a brand of cigarettes called Holiday! I recognised the first three.

Dr Carter: The 10 to 12-year-old children are a bit more savvy.

Mr P.B. WATSON: I thought you were talking about holidays!

Dr Carter: The systematic review suggests that there is robust evidence that youth exposure to point-of-sale tobacco displays increases the children's brand awareness and the perception of smoking prevalence in society. In most of the surveys we have done with Western Australian children, a standard question asked was: what do you think is the smoking prevalence among adults in Western Australia? The average response is 50 per cent, even though the prevalence of smoking among adults in Western Australia is just 16 per cent. Interestingly, 50 per cent of Hollywood stars in blockbuster movies smoke.

Mr J.A. McGINTY: Fifty per cent?

Dr Carter: Yes. The figure today is actually higher than it was in the 1950s. There was a consistent downward trend until the early 1980s and then there was some rather well-documented sponsorship of product placement in movies by tobacco companies and the figure has shot up higher today than it was in the 1950s when the smoking prevalence was 70 per cent.

The CHAIRMAN: We need another Yul Brynner.

Dr Carter: That is right. Robust evidence also shows that exposure to point-of-sale tobacco displays increases children's perception that tobacco is easy to get and, finally, that it also increases the amount of smoking initiation.

The systematic review identified only two studies on the effects on adults of point-of-sale tobacco displays. The first was an experimental study that exposed smokers to point-of-sale tobacco displays and monitored their nicotine cravings. As members might have guessed, the cravings went up when they were exposed to point-of-sale tobacco displays.

[4.00 pm]

The second study was from Victoria. This was part of an omnibus survey, which covered a whole lot of different health issues. It is cheaper to ask about a whole lot of different things at once. The sample was made up of 3 000 people from Victoria, 526 of whom were smokers. They were asked a series of questions about the effect of point-of-sale tobacco displays on their impulse purchases and their desire to purchase cigarettes and how difficult it was for them to go past big tobacco displays when they were trying to quit. One-quarter of the sample said that sometimes they purchase cigarettes on sheer impulse after seeing a point-of-sale display. Just under one-third said that if point-of-sale tobacco displays were removed, they would find it easier to quit. You may not realise this but at any one time, almost 50 per cent of smokers intend to quit within the next 12 months. Most smokers hate smoking. It is love/hate thing. Most smokers would love to quit. It is one of the most difficult addictions to kick. They are the only two pieces of evidence from around the world.

Last year we collected some data in Western Australia. We thought we could improve the Victorian methodology. We had a modest sample because we had no budget. We sampled people who had purchased from point-of-sale displays in supermarkets in Karrinyup Shopping Centre and the Galleria in Morley. Supermarkets account for more tobacco sales than all other types of retailers combined. Woolworths and Coles have the lion's share.

The CHAIRMAN: What percentage?

Dr Carter: Fifty-one per cent.

The CHAIRMAN: So Woolworths and Coles have 51 per cent?

Dr Carter: That also includes the smaller grocers. I do not have those figures. The reason they sell the most is because they are the cheapest. They mark up cigarettes 8 per cent compared to a petrol station or a pub, which mark them up 20 per cent. Most smokers buy cigarettes from them. We sampled equal numbers of people from Karrinyup Shopping Centre and Galleria. We observed people purchasing cigarettes at the supermarkets. As soon as they walked away, we approached them and asked if they minded participating in a health survey. Of the 344 we approached, 206 agreed. Most of the people who disagreed said that they did not have time. It was not as though the sample was biased because people were suspicious of us or anything like that. We still had a 60 per cent response rate, which was quite respectable. We got pretty even numbers from Karrinyup and Galleria. The average age of the sample was 37 years, slightly more females than males but roughly equal, and they were all daily smokers. The very first question we asked was: did you plan to purchase cigarettes before entering this store? Just over one-fifth said no. We then asked: why did you decide to purchase them? There were two standard answers. About two-thirds of the respondents said, "I was in the store at the time and I remembered that I was running out of smokes. I saw the point-of-sale display, which reminded me, so I bought some to stock up." Just under a third said they purchased them out of sheer impulse, on a whim. Interestingly, the young smokers in our sample were twice as prone to making an impulse purchase as the older smokers. There was a significant difference. Then we asked: what, if anything, did you see in the store that prompted you to purchase those cigarettes? These are called unprompted responses. We had not yet told them that we were interested in point-of-sale displays. Spontaneously, eight per cent of our sample said they were prompted by the point-of-sale display. They saw it and it prompted them to buy cigarettes. When we prompted them and asked whether the point-of-sale display influenced them, almost one-fifth said, "Yes, absolutely." Then we looked at the people who planned to purchase cigarettes versus those who did not. Four times as many people who did not plan to purchase cigarettes said

they were prompted by the point-of-sale display. This is clear evidence that point-of-sale displays increase purchases of cigarettes. It does not get any clearer than that.

In terms of the proportion of total sales that we witnessed, 10 per cent of our sample said that they had purchased on an impulse and were prompted by the point-of-sale display. That was around half of unplanned purchases. Around one in two unplanned purchases in supermarkets in Western Australia is prompted by point-of-sale displays. Based on our sample size, we can be 95 per cent confident that the real figure is anywhere between six and 14 per cent of sites. If we assume that our sample is representative of the general population, point-of-sale displays can account for that proportion of impulse purchases. This is consistent with other data that is available in the world. It is from the US and is from two sources of information. One is from the point of sale research academy in the US, which really has a biased interest to suggest that point-of-sale displays increase sales. The other is another US retailer that has a vested interest in inflating its figures as well. The important thing to remember is that the US still has point-of-sale advertising whereas we have no cigarette advertising in Western Australia at all. We would expect the figure to be inflated and for advertising to reflect people's impulse purchases. We have some very restrictive legislation here already. That six to 14 per cent is quite consistent with the international data.

Mr P. ABETZ: Is general advertising of cigarettes banned in the United States?

Dr Carter: It depends on the state. It is banned on all television and radio. Billboards are still allowed in certain states. Magazines and newspapers are allowed to advertise cigarettes in certain states. It is very mismatched. The problem is that a lot of people argue that advertising bans do not work. There have been bans on cigarette advertising on TV in the US for 30 years and it has not really had an effect whereas places such as Australia have comprehensive advertising bans. We have virtually banned cigarette advertising everywhere, except at the point of sale.

[4.10 pm]

We have what is known as a comprehensive advertising ban and it has worked really well. If you have a partial ban, you get partial results obviously, and that is what they have found in the US.

The tobacco industry will often argue that point-of-sale advertising or point-of-sale displays of tobacco do not persuade people to become smokers; all they do is they try to get current smokers to change brands, so the brand switches. The best literature we have suggests smokers are extremely brand loyal; they very rarely change their brand, perhaps 10 per cent a year. In our sample five per cent said, "Yes, this is not my usual brand I purchased." So we asked that five per cent, "What prompted you to try this brand?" Three per cent said, "The point-of-sale tobacco display." So it is actually the largest proportion. The only other response was "Friends' recommendations", which is what you would expect, "Friends who smoke said, 'Try these, they're really good'." So, almost equal numbers suggested them, either their friends or the point-of-sale display. The thing to note here is that people who looked at the point-of-sale displays clearly looked at them, assessed the packets, looked at the ones that they liked the look of, chose them based purely on the look of the pack or what was displayed in front of them. So, to my mind, that is a clear case of advertising. Point-of-sale displays are functioning just like an advertisement.

Then we asked them, "Do you agree or disagree that removing cigarette packs from view in stores would make it personally easier for you to quit smoking?" Twenty-eight per cent agreed; almost the majority disagreed, if that makes intuitive sense. It is not by itself ever going to make people quit, but in combination with a whole raft of other measures it certainly helps. Of the 28 per cent who said they agreed, again that is really consistent with the Victorian data of 31 per cent that I showed you at the beginning. So just around a quarter to a third of people—of Australian smokers anyway—would agree that if you got rid of cigarette packets from line of sight, it would be easier for them to quit; and most smokers do not like being smokers and anything we can do to help them quit I think we really should be doing.

Again if you look at the unplanned impulse purchases, almost half of people who had impulse purchases agreed that getting rid of the point-of-sale display from line of sight would help them quit. It is actually those vulnerable types that are prone to impulses anyway, which we know from the previous data are the younger adults and the kids.

Then finally we asked them: "Would you be supportive or unsupportive of legislation requiring shops to remove cigarette packets from open display?" Almost half the smokers said, "Yes, I would be fully supportive of that." Only 12 per cent said they would be opposed to it.

Mr J.A. McGINTY: This is just smokers?

Dr Carter: Yes, just smokers. We asked the people who were unsupportive: "What's your beef; why would you be unsupportive?" There are two reasons. They felt they had a right to choose from a selection of legal products and they wanted to see them all in front of them to assist their selection. The other cohort just said, "It just wouldn't make any difference, you know, I'd still smoke anyway." So that is their major beef, but effectively you are looking at almost half of smokers that we sampled saying, "Yeah, whatever helps. If people quit it's worthwhile; absolutely." Again there is the tacit acknowledgement that by itself it is not going to make people quit, but it is certainly going to help, amongst other things, and effectively 88 per cent of our sample either are ambivalent or supportive of bans on point-of-sale tobacco displays. These are only smokers; there are no non-smokers in the sample.

So what can we conclude from this? Clearly point-of-sale tobacco displays are a form of advertising, from this data. It does not get any clearer, and if we are trying to ban advertising of tobacco, then point-of-sale displays have to go just like everything else. It is the last bastion of the tobacco industry for advertising. It clearly plays an important role in brand selection and attempts by at least some smokers to try to quit. So there are few smokers in WA who are actually opposed to legislation and there are actually some who would appreciate that being introduced. Any questions?

Mr P. ABETZ: Very helpful.

Mr J.A. McGINTY: Can I ask an unrelated question?

Dr Carter: Certainly.

Mr J.A. McGINTY: Was there any equivalent research done that you are aware of on the actual effect of the ban on smoking in pubs and clubs when it was introduced?

Dr Carter: I am sure you have heard the expression trying to unravel Gladwrap with boxing gloves on.

Mr J.A. McGINTY: Yes.

Dr Carter: It is the analogy of trying to find any one particular effective intervention; it is never going to happen when you have already got other health intervention for smoking. So, yes, there have been attempts but the best research we have has not actually detected any difference. But I talk to smokers all the time and they are quite appreciative of it, to be honest. They do not mind at all. They think it is quite acceptable not to be smoking inside in front of others. They are still kind of a bit guarded about alfresco areas because they still think they have that right, but it is because they really associate cigarette smoke, kind of, with a beer in one hand and a cigarette in the other, and they feel balanced. If they do not have that cigarette in their hand and they have got a beer, they kind of feel like they are tipping over. They seriously do. They just associate it with beer. It is like coffee and beer. It is the same thing—I am sorry, coffee and cigarettes.

Mr J.A. McGINTY: No, coffee and beer!

Dr Carter: Yes. So, to answer your question, there has not been any good research to suggest that it has made a difference, but there is anecdotal evidence that it is quite popular even with smokers.

The CHAIRMAN: Where does your statement that 50 per cent of smokers want to quit come from?

Dr Carter: It is from research from Victoria in about 2000. I can dig it up for you, if you like. It is just under; it is about 45 per cent at any one time in the next six months.

The CHAIRMAN: This must be the Prochaska model. Jim, you had reference to that in your bill a few years ago.

Mr J.A. McGINTY: Indeed.

The CHAIRMAN: Precontemplation, contemplation, preparation, action, maintenance—it must have come from the work in that area.

Dr Carter: Yes, pretty much. The survey was classifying people into those contemplation stages.

Mr P. ABETZ: What percentage actually quit is a different story though.

Dr Carter: It is actually quite predictive. Our research suggests that of the people who say they are going to make a good attempt in the next six months probably about 80 per cent actually do make an attempt. Whether that attempt lasts an hour or two weeks or a year is different, but it is really important to get smokers to make that quit attempt. The more quit attempts you get them to do, the better they get at it. It really takes seven or maybe eight tries these days for people to quit. It is really tough for them.

Mr J.A. McGINTY: Just going back to your earlier observation, I have not seen anything yet that has shown there has been a decline in the proportion of people smoking consequent upon the ban on smoking in pubs and clubs.

Dr Carter: No. There is a great study done by Melanie Wakefield in Victoria that is looking at the introduction of all sorts of different interventions and looking at the Quit line kits and actual subsequent quit rates; and it has concluded so far that there are only two things that make a statistically significant impact: price increases and consistent advertising of quit materials on TV. They are the only two things that we know definitely work.

The CHAIRMAN: I am sorry, was it the price?

Dr Carter: Yes, tax excise.

Mr P. ABETZ: For trying to give it up?

Dr Carter: Yes. If you make consistent increases that are higher than the cost of living, it definitely has an impact; every 10 per cent increase you have in tobacco projects to a four per cent drop in consumption.

Mr P. ABETZ: If we doubled it, it would really achieve something, would it not?

Dr Carter: Yes, but you have to keep doubling it and doubling it. Certainly today's smoker smokes a lot less than a smoker 20 years ago.

Mr P.B. WATSON: Is that because of the cost?

Dr Carter: Absolutely. The average smoker now in Western Australia, from my data, smokes probably 15 to 20 cigarettes; it is less than a packet a day.

Mr P. ABETZ: There used to be plenty of 40-plus a day.

Dr Carter: Absolutely.

Mr P. ABETZ: Which in itself has health benefits; they are smoking less anyway.

Dr Carter: It does. We would still prefer them not to smoke at all, obviously.

Mr P. ABETZ: Yes, sure.

Dr Carter: Smoking four cigarettes a day still has an appreciable effect on your health.

Mr I.C. BLAYNEY: Would they be spending approximately the same proportion of their income; because if the price of cigarettes has doubled, they are only smoking half as many?

Mr P.B. WATSON: Wages have probably gone up too.

Mr I.C. BLAYNEY: As a proportion of their income would it be about the same?

[4.20 pm]

Dr Carter: That is generally what people try and achieve. They will cut down on their tobacco though, that is why you have to have real price increases compared to inflation and wage increases.

Mr J. A. McGINTY: We have not had that since the early '90s.

Dr Carter: No, unfortunately.

Mr J. A. McGINTY: That was the last significant jacking up, as a political policy initiative, the price of cigarettes. It has been CPI basically since —

Dr Carter: Yes, 1996 was a big spike.

The CHAIRMAN: I would assume that the centre works with other centres in other states.

Dr Carter: Yes.

The CHAIRMAN: Whilst the legislation in Tasmania is due to come into effect in 2011, some of the big stores, like Coles in Tasmania, have already removed tobacco advertising from point of sale. Is there research going on there in terms of smoking cessation levels?

Dr Carter: Smoking cessation levels in anticipation of the —

The CHAIRMAN: No, since—because I believe that they have removed it already. Although they do not have to, Coles—I think Coles is —

Mr P. ABETZ: Coles in Tasmania they have really crunched the sale display in so that it is hidden.

Dr Carter: As I was saying before, the comment about unravelling Gladwrap with boxing gloves, it is very hard to ever detect a single difference like that. When you talk to smokers at the moment, there has been 30 years of social engineering to make smoking unacceptable in Western Australia. The smokers really feel besieged. They describe themselves as pariahs, they are the last of a dying breed, they say to themselves. They really do feel like outcasts. So the more legislation we have banning it in alfrescos, banning it in pubs, banning it within playgrounds, makes them feel more and more socially reprehensible, effectively. Lots of smokers, when you ask them, "What's your main motivation to quit?" they might say something like, "So I can rejoin society." They honestly feel that, but at the same —

Mr J. A. McGINTY: I can understand that, but what you are saying—I think it is the Wakefield research—is that there are only two things that actually show that people give up —

Dr Carter: Yes, the comprehensive approach to tobacco control, the grand sum, the whole Gestalt theory, that the sum is greater than the parts. If you create that whole social environment where smoking is unacceptable, it is all these little things that add up, it is not any one little intervention. So, yes, the big things. If you just do a price increase and you do constant advertising, the research we have suggests that that will make an impact. All these other things we do will have little, little impacts but we will never be able to detect them in a scientific manner.

The CHAIRMAN: So then going back to those figures, if this legislation was introduced that banned advertising at point of sale, what percentage do you think of smokers it may help to quit smoking? What percentage —

Dr Carter: Of our sample, 28 per cent suggested that it would help. It is still incredibly difficult to quit, but more importantly for me is that it would reduce impulse purchases, especially amongst the

young smokers. From our figures here, there would be a six to 14 per cent reduction in purchases. So unfortunately that would impact on tobacco sales for tobacco retailers.

The CHAIRMAN: You said the impulse purchasers were the younger people —

Dr Carter: It was more likely to be younger, but there are certainly older people who did impulse purchases as well. You have to distinguish there between people who make an impulse purchase that is just spur of the moment, when they did not actually need the cigarettes, are as opposed to the people who are just reminded that they are running low and they see it and they say, "Oh yes, I'd better buy some while I am here." The tobacco companies will pick up on that. I think I have noticed that in a couple of their submissions as well.

The CHAIRMAN: That they?

Dr Carter: That there is a distinction. Melanie Wakefield's data actually just talks about impulse buying and chucks everything in. The tobacco companies' argument is that some of that is just unplanned purchases, but they were going to purchase them anyway.

Mr P. ABETZ: If they did not purchase it then, they would have bought it at the corner store later that day, or whatever, because they are running out anyway, so it does not really make an effect on the total consumption rate, is what they are trying to argue; yes?

Dr Carter: Yes. But that's why this data is better, because it actually differentiates between impulse and the unplanned purchase.

The CHAIRMAN: Just summarise those figures for me then again, because you went through very quickly. So impulse purchases were 10 per cent to 12 per cent—so it is 50 per cent that you are saying would like to give up at any one point in time?

Dr Carter: Yes, yes.

The CHAIRMAN: Of smokers. The people going in at point of sale, it was roughly 30 per cent that said they would be quite happy to get rid of it completely?

Dr Carter: Actually 88 per cent said they would be quite happy, but 30 per cent said that it would certainly help them when they were trying —

The CHAIRMAN: So 88 per cent said they are quite happy for that advertising at point of sale to go?

Dr Carter: Yes.

The CHAIRMAN: And then 30 per cent said that it may help them actually stop smoking?

Dr Carter: Yes. It certainly would not help that whole 30 per cent—like, it would not translate into quit attempts—but it would help that 30 per cent, amongst other things.

The CHAIRMAN: This legislation is addressing point of sale. It is also addressing alfresco and smoking in cars with children. From your research, would you like to comment on the other areas of the bill, or —

Dr Carter: Yes, absolutely. I conduct constant focus groups with smokers and non-smokers about the topic of smoking. Some interesting research I undertook last year was to see how far is too far. Where is the line in the sand where the nanny state is just too overpowering? Where is that line that you cannot cross, as a government, to impose restrictions on people's personal freedoms? The really interesting results suggested that any behaviour at all that the impacts on other people is fair game for the government. So you have got passive smoking in cars; totally fair game. There is not a smoker I could find that was opposed to that. Any behaviour that impacts on young kids; fair game. What the groups were suggesting is that a government could quite happily legislate until the cows come home on behaviours that impact on others. When it comes to behaviours that only impact on yourself as a smoker, that is where the personal choice comes in and that is where the government

has a clear duty of care to educate. So that is the distinction they make. Impact on other people; legislate, restrict. Impact only on yourself; then educate.

The CHAIRMAN: In relation to cars, they are basically supportive. You sat through Professor Sly's, presentation, and I certainly was learnt a lot from his presentation in terms of the effects of the nicotine and the other compounds. Is there anything that possibly you think you would like to add to his comments in those other areas?

Dr Carter: I am only an industrial psychologist, so I cannot really comment on the health impact stuff, but certainly just from a public perspective there are actually very few smokers who smoke in cars with kids—or admit to it anyway—at the moment. The best research we can find is that it is five per cent, if that. There are very, very few smokers that would object to this kind of legislation. Amongst non-smokers, it is near universal support.

Mr P. ABETZ: Did I hear that correctly, that only five per cent of smokers admit to smoking with kids in the cars; is that right?

Dr Carter: Yes, that is a rule of thumb. It was not a huge sample, but, yes, if that. It is not a large proportion at all.

The CHAIRMAN: The figures that Professor Sly gave was 10 to 15 per cent, but his was a group in a range study of children and parents who had been filling in questionnaires every two years. He actually felt that made it an underestimation. But those people who are involved in that study tend to see one and another's, so I think —

Mr J. A. McGINTY: Professor Sly's figures corresponded with the proportion of the public who smoked, in round figures. They were significantly higher than what you were just saying.

Dr Carter: Yes, the longitudinal studies, like the study—you actually find that people are more honest as well because they have been investing so much time in it already, and they are quite open and frank about their behaviours. As I said, possibly five per cent of people will admit to smoking in cars with children.

Mr J. A. McGINTY: On your point about where the line is drawn, I understand your distinction between impact on other versus impact on self. It also seems to me that in respect of smoking, the line is constantly moving out towards the horizon.

Dr Carter: This is exactly what I was testing in the groups. It is interesting because there was a grey area, like, of women who smoked while pregnant. I threw that one out as a devil's advocate and said, "Well shall we stop women from smoking when they're pregnant because it is harming someone else if that is the case.

[4.30 pm]

Everyone thought that, morally, absolutely, that would be crossing the line. That was one of the difficult ones. There is also the concept that the more self-harm you cause, the more the government has a right to intervene. By that rationale, you could keep going for quite some time. We do not have many restrictions left, unfortunately, other than making it a controlled substance or banning it outright, but that is not such a great idea when you consider the contraband.

Mr J.A. McGINTY: I think that is where the public is ultimately heading to.

Dr Carter: I think so, yes. It is becoming a more acceptable concept. Most smokers think that they are the last generation of smokers. They think that by about 2020 there will not be many kids left who take it up.

Mr P. ABETZ: We hope.

Dr Carter: The data is quite encouraging. The amount of kids who smoke in Western Australia has actually halved between every three-year survey.

Mr J.A. McGINTY: Kids are smarter than their parents!

Dr Carter: It is actually working quite encouragingly well.

Mr J.A. McGINTY: The other interesting thing is a bit of a digression. Cannabis consumption has fallen at the same time. No doubt there is a very strong correlation there. Kids do not want to smoke. To ingest cannabis, you smoke. I think that is having quite a depressing effect on cannabis consumption. It might be a substitution effect as well.

Dr Carter: It is the actual act of smoking cannabis that kids are finding unacceptable. Popping a pill is much more acceptable. If they have a tablet form of marijuana, perhaps it will go up again.

Mr I.C. BLAYNEY: Have you done any survey work on the prevalence of smoking in the Indigenous community?

Dr Carter: The data is not great, but it is fairly consistently suggesting that about 50 per cent of the Indigenous population has smoked since the late 1980s, and that has not changed since the late 1980s. Today it is still the same as it was in the late 1980s, whereas for the general population over the same time, smoking has pretty much halved. Smoking is certainly a massive problem in the Indigenous population.

Mr I.C. BLAYNEY: I find that quite interesting. Obviously, the messages that you are getting through to the rest of the community are not getting through to them.

Dr Carter: This is the interesting thing. It is not just your knowledge about the harmful effects of smoking that cause you to quit. It accounts for about one-third of your decision to smoke. Another third is your culture, so if everyone around you smokes, you are much more likely to smoke. Unfortunately, what we find in Indigenous communities is that it is quite acceptable to smoke.

Mr J.A. McGINTY: That is the significance of those three main groups—mental health patients, Indigenous people and prisoners. They all come together in prisons and that is why there is such a horrendously high rate of smoking in prison.

Dr Carter: Yes; it is about 90 per cent of prisoners.

Mr J.A. McGINTY: You get all those populations together in the one place.

The CHAIRMAN: In relation to the two areas and the two shopping centres that you selected, I live south of the river so I do not know those shopping centres.

Dr Carter: The reason we chose Karrinyup and Galleria is that we wanted to get a wide selection of socioeconomic people.

The CHAIRMAN: I have been told by small grocers that in one area the turnover on tobacco sales for a grocer may be two, three or four per cent, whereas in some other areas it could be 15 per cent.

Dr Carter: Absolutely.

The CHAIRMAN: Do the two areas that you selected give us an across-the-board picture?

Dr Carter: We collected postcode data and from that you can see which suburb they come from and then make an assumption about their level of socioeconomic status. We had a nice even spread across the four quartiles.

Mr P. ABETZ: Having lived in exile for three years in the northern suburbs, Karrinyup draws its clientele from quite a range of socioeconomic areas. I do not know about Galleria.

Dr Carter: Galleria's tends to be a bit lower. We were going to go to Mirrabooka, which is another northern area, or we could have gone south if I could have persuaded my research assistants to do the study.

Mr P. ABETZ: Thank you very much. I found it very helpful.

Dr Carter: Jim mentioned before: where to from here? What are the next things —

The CHAIRMAN: Yes, thank you.

Dr Carter: It is fairly clear.

The CHAIRMAN: Do you think the bill goes far enough for now? As Jim has been asking, if you think the bill goes far enough, what do you think will be the next step?

Dr Carter: I am fully supportive of everything in the bill, absolutely. The next steps might not be within the purview of the state government, but there are things such as plain packaging on cigarette packets. You could even start making cigarettes themselves plain. As soon as you make plain packaging for cigarettes compulsory, you lose the last single form of advertising for tobacco companies. We know from the tobacco companies' own documents that their smokers, their loyal clients, cannot actually blind taste test the difference between the cigarettes. It is all based on the image of the cigarette packet. That is certainly something we would very much like to see.

Mr P.B. WATSON: Just put cancer sticks.

Mr I.C. BLAYNEY: Is there anywhere in the world that has done that?

Dr Carter: Not yet. A couple of countries are pushing hard. Australia is one of them and Canada, Ireland and Iceland are others. It could even be Thailand. Thailand is quite progressive. No-one has quite made it yet, but as soon as the first country does, it will be like a deck of cards. That is what always happens with tobacco legislation.

Mr P. ABETZ: We could possibly be at the forefront instead of bringing up the rear.

The CHAIRMAN: That would be nice. If you want to move an amendment to the bill, go ahead!

Mr J.A. McGINTY: Are you saying that there are any other things to do, apart from the plain packaging? I thought you were going to go on to some other initiatives.

Dr Carter: There is some avant-garde stuff that is not really in the literature yet. We assail smokers' eyes essentially. When we show them a gruesome ad on TV, they recoil in horror. However, we have not really assailed their other senses yet. There is texture, smell and even sound. We have graphic warnings on cigarette packets now. We are not assailing all their senses to make them concerned about their smoking.

The CHAIRMAN: You are thinking that if you open a packet, it should say to you —

Dr Carter: It is possible.

The CHAIRMAN: You do that with children's toys now.

Dr Carter: It sounds like pie in the sky stuff now, but we are assailing only their sight at the moment. There are five senses to scare them, effectively.

Mr P. ABETZ: Perhaps we should not go for plain packaging, but have cancer things in full colour on the packaging. That would be more effective.

Dr Carter: Sorry; that is actually a given. The plain packaging would just be restricted to the —

Mr J.A. McGINTY: — health messages.

Dr Carter: Health messages would be full colour and gory and rotated regularly.

Mr J.A. McGINTY: Hydrogen sulfide-flavoured cigarettes?

Dr Carter: Actually, in the registered list of tobacco additives that the US state government forced companies to list, there are about 400-odd additives, including chocolate. But one of them is skatol, which in small amounts gives off a slight perfume. It is found in beets and tar coal and also in mammalian faeces. If you increase skatol, it smells like faeces. We could start assailing the sense of smell as well. As I have said, we are limiting ourselves at the moment just to sight.

Mr I.C. BLAYNEY: In various places they talk about this chop-chop and illegal stuff. To what degree do you think that the harder you get, the more substitution you will have?

[4.40 pm]

Dr Carter: Chop-chop has got no excise on it at all, obviously, so you can get a big bag of chop-chop for a couple of hundred dollars and it would be worth tens of thousands of dollars once government excise is put on top. Obviously, the more control you put on any substance, even tobacco, the more chop-chop you will find appearing. There are health warnings to give out about chop-chop as well, because if it is not dried properly, it gets a fungus on it. If you smoke that, it does you far more immediate damage than you would ever get from the long-term damage associated with it. There is certainly that and having to educate people and warn them that if they are going to smoke chop-chop, they should make sure it is dried properly.

The CHAIRMAN: What is chop-chop?

Dr Carter: Chop-chop is illegal tobacco. It has not had government excise paid on it and it is just loose tobacco that has been grown from the plant and dried in a backyard somewhere. You can buy big bags of it and it is all shredded for you and you smoke it. Obviously, it is so much cheaper because you are not paying any tax on it.

Mr P.B. WATSON: Did you say it is legal or illegal?

Dr Carter: It is illegal.

Mr P. ABETZ: Is it illegal to grow tobacco?

Dr Carter: Yes, it is. There is no tobacco grown in Western Australia fortunately. As of now, there is none grown in Australia.

Mr P. ABETZ: The last was in Victoria. The blue mould was introduced accidentally and that wiped out the industry some years ago. They used to grow lots of tobacco in Tasmania and some of the valleys in Victoria.

The CHAIRMAN: Your presentation was fantastic. I really enjoyed it; I am sure we all enjoyed it. The visual presentation was good because it accompanied the statistics you gave us. There was information on some of the slides, but I am sure members of the committee would like to view it again. Is it possible that we could be left a copy of your presentation? Is it something that you are about to publish or has it been published?

Dr Carter: It is sitting in the editor's in-tray over at the *Tobacco Control Journal* at the moment. It is having a second review at the moment.

The CHAIRMAN: We have put other submissions up on the internet. If we did not put this submission on the internet, would members like to have another look through that presentation if Dr Carter was agreeable? Unlike the other presentations that we have put on the internet, if it was just for the committee's personal use so that we could have another look through with those statistics, would you be agreeable to that?

Dr Carter: Yes, I can supply you with the paper. I just have to check with the editors that we have no infringed on any copyright laws.

Mr J.A. McGINTY: I think what the Chair is saying is that it would not be something we would publish.

Dr Carter: No, obviously. As a final comment, I would just say about the pubs law that if you separate the drinker from the cigarette, you destroy that marriage, so I would like to see legislation where if you are smoking in a designated area outside a pub, you cannot have a drink with you.

The CHAIRMAN: You are suggesting as a fall-back position that there be a separation of the areas?

Dr Carter: Just to make sure it is enforced and that there is no possible way you can be drinking and smoking.

The CHAIRMAN: I know it happens in some countries. I went to Japan a few years ago. At the airport there was a smoking room. As I walked passed I could see all the smokers.

Dr Carter: It is just a goldfish bowl, yes.

Mr J.A. McGINTY: The bill covers that, as I read it.

Dr Carter: Yes, it is just to ensure that is the case.

The CHAIRMAN: This bill at the moment will in fact achieve the results that you are interested in. Thank you for your evidence before the committee today, Dr Carter. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. Should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Once again, thank you very much.

Dr Carter: Thank you.

Hearing concluded at 4.44 pm