# SELECT COMMITTEE ON PERSONAL CHOICE AND COMMUNITY SAFETY

**TRANSCRIPT OF EVIDENCE**
**TAKEN AT PERTH**
**FRIDAY, 16 NOVEMBER 2018**

**Members**

**Hon Aaron Stonehouse (Chair)**
**Hon Dr Sally Talbot (Deputy Chair)**
**Hon Dr Steve Thomas**
**Hon Pierre Yang**
**Hon Rick Mazza**

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**Hearing commenced at 9.45 am**

**Mr ASHLEY REID**
**Chief Executive Officer, Cancer Council WA, sworn and examined:**

**The CHAIRMAN**: On behalf of the committee, I would like to welcome you to the meeting. Before we begin, I must ask you that you take either the oath or affirmation.

[Witness took the affirmation.]

**The CHAIRMAN**: You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

**Mr Reid**: Yes.

**The CHAIRMAN**: These proceedings are being recorded by Hansard and broadcast on the internet. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing for the record. Please be aware of the microphone and try to talk into it. Ensure that you do not cover it with papers or make noise near it. I remind you that your transcript will become a matter of public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Would you like to make an opening statement to the committee?

**Mr Reid**: Yes, I would. Thank you. Firstly, thank you for the opportunity to appear today. We greatly appreciate being able to make comment. This year, Cancer Council WA celebrates 60 years of service to the Western Australian community. Our purpose in our constitution is to reduce the incidence and impact of cancer. Great gains have been made in this time. When our organisation was founded, the overall five-year cancer survival rates were around 30 to 40 per cent. They are now nearly 70 per cent and for some of the more common cancers, if found early, five-year survival rates are over 90 per cent. These gains have come through huge investment in research to improve prevention programs, screening, diagnosis and treatment.

Cancer Council WA is predominantly donor funded and we focus on education, prevention, support services and research. Over our history, we have invested $47 million into local world-class research. We pride ourselves on being evidence-based and throughout our history we have maintained this integrity. With tobacco being the leading cause of cancer deaths in this country and being responsible for the greatest disease burden, Cancer Council WA strongly believes that any politician or political party that accepts money from the tobacco industry has a significant conflict of interest with regard to public health. This aligns with the "World Health Organization Framework Convention on Tobacco Control", to which Australia is a signatory.

Smoking causes 16 types of cancer and in WA 1 500 people die from smoking-related causes each year. We understand it takes time to build the evidence through research, and that changing behaviours at a population level also takes time. Our education campaigns have been long term and

highly successful. From SunSmart and the internationally recognised Slip! Slop! Slap! campaign—now in its twentieth year—of SunSmart schools, we have seen melanoma rates for 18 to 39-year-olds halve. Our Make Smoking History campaign has contributed to huge falls in the rate of tobacco smoking. As recently as the year 2000, over 22 per cent of Western Australians smoked. By 2017, this had fallen to 11.6 per cent, mainly through education, government policy and legislation, including excise, advertising restrictions, restrictions on where people can smoke, plain packaging and others. WA is among the world leaders in low rates of tobacco use. A succession of governments should be commended for their stance on tobacco, given the burden that it places on the community.

Why is prevention important? The trajectory of health expenditure in WA over the previous decade is unsustainable. The health budget effectively doubled in 10 years. If we want a healthy, happy and productive community, we must focus on prevention and population health. We all pay for an unhealthy population and the bill will only get bigger. Government absolutely has a role to play in improving the health of its citizens and there are countless successful examples, such as tobacco control and the banning of asbestos products, where the benefits of these measures far outweigh the minor impingement on personal freedoms.

[9.50 am]

With regard to e-cigarettes, I refer to Cancer Council WA's submission and the provided statement on e-cigarettes in Australia. In simple terms, there is growing evidence that e-cigarettes are a precursor to tobacco use in young people; that they cause direct health harms; and that e-cigarette use in non-smokers is associated with future uptake of tobacco. There is an absence of strong evidence that e-cigarettes are an effective quitting aid and the extent to which e-cigarettes may reduce harm over conventional tobacco cigarettes has not yet been determined.

Just last night, the Federal Drug Administration—the FDA—in the US released a report, the "2018 National Youth Tobacco Survey", that highlighted major concerns with a massive rise in teen vaping rates in the US, and it is calling for restrictions and bans on flavours and menthol. The increase in numbers is being described as an epidemic. More than 3.6 million middle and high school students were current—as in the past 30 days—e-cigarette users in 2018. That is a dramatic increase of more than 1.5 million students since the previous year. They note that there has been a 78 per cent increase in use by high school students; a significant increase in frequent use among high school e-cig users; and that the increase in e-cigarette use has driven a 38 per cent increase in the use of any tobacco product among high school students from 19.6 per cent in 2017 to 27.1 per cent in 2018. This reverses a decline in recent years.

Most importantly, the FDA is very clear that youth e-cigarette use leads to smoking. The data shows that kids using e-cigs are going to be more likely to try combustible cigarettes later. This a large pool of future risk. The data make it unmistakably clear that if we are to break the cycle of addiction to nicotine, preventing youth initiation on nicotine is a paramount imperative. In the Australian context these figures are hugely worrying, and argue strongly against any relaxing of current laws. There should be a conclusion very loud and clear that Australia has done well in taking a precautionary approach. This should absolutely continue so we do not introduce the same crisis. Put even more simply, the evidence for harm is increasing and the evidence for benefit is decreasing.

Cancer Council WA trusts the regulatory processes in this country, those such as Therapeutic Goods Administration—the TGA. The onus is on industry to prove safety and benefit, and they have failed to do so. It took many years for the evidence on the harms of tobacco to reach a point where it was inarguable. On this basis we support the precautionary approach and strongly support the position taken by the federal and all state governments that the current laws should not be weakened.

Smoking rates are at record lows, particularly among youth, and we should not put this as risk. Thank you very much.

**The CHAIRMAN**: Thank you very much, Mr Reid. Just to kick things off: we know that the sale of e-cigarettes containing nicotine has been legalised and regulated throughout the EU and the United States, and we know that our peer nations, Canada, New Zealand and England, have all regulated the sale and use of these products to prevent adverse outcomes while allowing supply to those who wish to use them. Why do you think Australia should not follow their lead?

**Mr Reid**: As stated, it takes a long time to build evidence. The precautionary approach—as in first do no harm—should be the way we approach things that could cause huge population health outcomes into the future. If we think of examples such as asbestos, the number of people exposed to that deadly substance ended up causing death. The evidence took many years to build, and once it was known, reversing something is much harder than preventing something in the first place. We have the opportunity, being that we have record low smoking rates in this country, of holding the line against potential future harm; so, the precautionary principle, being that Australia already has record low smoking rates, is something that we would strongly support.

**The CHAIRMAN**: E-cigarettes containing nicotine are available in the aforementioned countries and are available as consumer products, not therapeutic goods. Your submission suggests that e-cigarettes containing nicotine should be assessed by the Therapeutic Goods Administration before being made available. Why do you think these products should be treated as therapeutic goods when they are treated as consumer goods in the other countries?

**Mr Reid**: Nicotine is highly addictive. Companies make a profit from a product that addicts their users. Because nicotine is highly addictive, it is also strongly claimed by many in the industry that it is an effective cessation aid. Because that evidence has not been established, we strongly believe that preventing nicotine—the importation or legalisation of nicotine in e-cigarettes must be maintained.

**The CHAIRMAN**: If products are not making therapeutic claims, should they be treated as therapeutic goods or treated as consumer goods?

**Mr Reid**: I could not comment on the legislation regarding how goods should be treated, other than that we trust the regulatory processes in this country. To purchase any drug, any pharmaceuticals, it must go through a process. For products to be related as safe or to have some benefit, we believe they should also go through that process, particularly for products that may have incredible future harm on the population. So, again, we refer back to the precautionary approach.

**The CHAIRMAN**: In your submission, and you mentioned in it in your opening statement, you say there is growing evidence that e-cigarette use is a precursor to smoking in young people. The sources for those conclusions seem to draw heavily, almost exclusively, from American studies and data. Unlike Australia, the US does not have plain packaging, graphic health warnings, point-of-sale display bans, and comparatively high rates of excise tax. What evidence do you have to suggest that these American studies would repeat themselves here in Australia? For that to happen, would it not suggest that Australia's tobacco control measures are not quite as effective as you think?

**Mr Reid**: Our tobacco control measures have been some of the most effective in the world. Our smoking rates are at record lows. There is a very big difference between an existing addicted population, versus the benefits of not starting. Because we have reduced rates so significantly, we have a whole generation of young people who have not seen smoking as a normal behaviour. If you think of the restrictions, from advertising, in sport, in television, in where you can smoke for example, we have generation of young people who have not seen smoking as normalised behaviour. Our concern is that weakening the laws related to e-cigarettes will re-normalise a behaviour—just

even witnessing the behaviour that is a precursor to smoking—that we have taken decades to reduce, and the harms being that lung cancer is the leading cause of cancer death in this country, with a long latency rate. It can take up to 55 years for the latency of the behaviour to lead to the disease. We would not like to see a future epidemic with something that we could prevent.

**Hon RICK MAZZA**: You mentioned that WA has record low smoking rates, and you went over some of the reasons why you think that might be. What are the key things that you think have taken place over the, say, last 20 years that have reduced those rates?

**Mr Reid**: What we know from the evidence is that the most successful elements to reduce smoking rates have been mass public education; so, investment in educating people as to the dangers of smoking. Price—price is absolutely a signal; so, tax excise and increasing price is a barrier, particularly to young people. Restrictions on where people can smoke—we all remember an era when you could smoke in a restaurant, on a plane, in hospitality venues. The restrictions through government, against fierce opposition, on where you can smoke has been a significant benefit in that space. And then a whole range of measures, including warnings on packets—Australia led the world in graphic warnings as well as in the plain packaging. So there are many, many, elements; it has never been one single element. But all those combined have greatly reduced our smoking rate. As I mentioned, as recently as 2000 it was 22 per cent of Western Australians; it is now just over 11 per cent. Even in that relatively short time we have continued to see significant gains.

[10.00 am]

**Hon RICK MAZZA**: Do you do research on those matters—education, price, restricted places, warnings on packaging—that outlines what the most effective ones are? You see it as a combined holistic approach, but have you actually try to isolate what is the most effective program. Is it education, or is it packaging?

**Mr Reid**: Mass media education is the most successful.

**The CHAIRMAN**: In the answer you have provided just now, Mr Reid, you mentioned the price—the excise tax we have on tobacco. I think a pack of cigarettes is now going to go up to something like $40 a pack. That is the highest it has been. It is probably one of the highest rates in the world, I think. Does that not put the lie to the assumption that young people taking up vaping will then move onto combustible cigarettes when combustible cigarettes, with the excise, are so cost prohibitive? When I speak to people who do vape, one of the main appeals is the reduction in cost when switching from combustible cigarettes to vaping. I am having a hard time imagining a scenario where a young person who does not have much of an income switches from vaping, which is relatively cheap, to combustible cigarettes. Do you have any data or counterarguments to that?

**Mr Reid**: There are growing studies that show that e-cigarettes are a precursor to tobacco. Regardless of price, the fact that e-cigs in other jurisdictions contain nicotine means they are addictive. The fact that the product has an addictive element means that it is more likely that people will move on to other products that have similar addiction. The comment about price—price is absolutely a signal. The price of cigarettes in Australia is expensive. However, the health burden vastly bigger than the excise gained by tobacco. We know that price is a signal. The best thing that you can do for your health and your hip pocket is to quit. A pack-a-day smoker will spend around $15 000 a year. Of course, all of our education campaigns are not just about talking about health, although that is a major concern, but the broader impact on the community of the money that could be spent on better things.

**The CHAIRMAN**: I am not questioning the wisdom of the excise tax on tobacco at this point. I am just sceptical that young people vaping, addicted to nicotine perhaps, would switch to combustible cigarettes when there is such a high excise on combustible tobacco products—on cigarettes. I just

think it seems very unlikely. There may be evidence of that, as you mentioned, in the FDA report that was just released last night. I have not had a chance to read that yet. What is different between the United States and Australia is we have a very high rate of excise. We also have those other measures that you lauded earlier—the graphic warnings, the restrictions on advertising, on retail displays and such.

If I may, a news report appearing in New Zealand's stuff.com.nz titled "Number of Year 10 students vaping doubles, but it's not all bad news" covers a survey by Action on Smoking and Health—ASH New Zealand—where they survey 26 000 year 10 students. ASH is quoted as saying "There is a huge moral panic about young people taking up vaping, and even going on to smoke. These results don't support that at all." Similarly, Public Health England's 2018 evidence review states that "the evidence does not support the concern that e-cigarettes are a route into smoking among young people." The New Zealand Minister of Health says that, "There is no international evidence that vaping products are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it." Could you help me understand why there is such a difference in opinion between yourselves and your international peers?

**Mr Reid**: If I could point to the statement on e-cigarettes and to the large number of co-signatories to that statement, the evidence is growing. We are in an era, much like tobacco way back in the 1940s, 1950s and beyond, where the evidence was not conclusive. It takes many years and many different types of studies in many jurisdictions to build evidence to the point where it is inarguable. We are at a fairly early stage of that. You will see studies, you will see reports, you will see jurisdictional differences around the evidence. It is not yet conclusive. That highlights to us why we should take a precautionary approach, because until the evidence is conclusive, why would we choose to do more harm? Why would we choose to potentially put another generation at risk of vaping being a precursor to tobacco when we already have world leading low rates, and anything that we do that might change that could have a massive future health burden?

**Hon RICK MAZZA**: Just to take a little wind back, price has been a deterrent. Has the Cancer Council done any research on the demographics of smokers? Is it younger people who are a demographic that are reducing smoking? Do low socioeconomic groups reduce their smoking because of price? What are the demographics within that reduction from 22 per cent down to 11 per cent?

**Mr Reid**: Older smokers continue to smoke because they are the ones who are the most addicted. Not starting is a huge benefit in not continuing. We have seen a huge decline in teen smoking rates. We have the lowest teen smoking rates that we have had in history. We do see demographic differences. Not starting is the best preventive measure for an addictive substance. We run a 13 11 20 support line for people who have been diagnosed with cancer. I have never heard of any person saying to the Cancer Council that they wish they had had the freedom to smoke. What they say is that they wish they had never started. If you are dying of lung cancer or someone in your family is dying of the disease, you wish you had never started. When we talk about that demographic difference, anything that we do that puts at risk keeping those rates, particularly of young people, low would be a huge concern to us.

**Hon RICK MAZZA**: The other part of that question was—is the high price reducing smoking in those on low incomes as opposed to those who may be have a higher income and can afford them?

**Mr Reid**: We see higher smoking rates in lower socioeconomic populations. We see higher smoking rates in Aboriginal populations, people with mental health issues, prisoners. There are populations that have higher smoking rates than the average. We work really hard with community organisations to ensure we are educating and informing difficult-to-reach and vulnerable populations. It is absolutely true that we have a lot of work to do in the state to reduce the smoking rates in some of those more vulnerable populations. Particularly if you are on a lower income and

you are spending a significant amount on tobacco, that money could be used for other things—nutritious food, education and that all the other benefits that build a healthy and happy community. We would hate to see that money being spent unnecessarily on a product that is likely to kill you.

**Hon RICK MAZZA**: I agree with that. I suppose the point I am trying to get to is the fact that those who have a low income, even though the price of cigarettes has gone up significantly—I do not know what they are now. I think someone told me recently it was about $30 a pack or something. It is pretty high.

**The CHAIRMAN**: It is going up to $40 soon.

**Hon RICK MAZZA**: Is it? Those that can least afford it seem to be still buying cigarettes, which is, as you say, a major concern because that would deny them other necessities of life.

**Mr Reid**: It is absolutely a concern. It is one of the reasons that we work really hard with different populations to bring those educative messages, to talk about the health benefits, to make sure that some of the reasons that people smoke are assisted through support mechanisms, through cessation aids. We have some very successful and TGA-approved cessation nicotine replacement therapy in this country—from gums to lozenges to patches et cetera. There are proven measures to help people quit. But it is an addictive product. It is very hard to quit. People take multiple attempts. So we need good support services and good nicotine replacement therapy and good cessation programs to really help people to kick it.

**Hon PIERRE YANG**: The Chair mentioned about the amount of year 10 students smoking in New Zealand. What is the legal age for New Zealanders who want to smoke?

**Mr Reid**: I am not sure what the New Zealand age is, but in Australia it is 18. You must be an adult.

**Hon PIERRE YANG**: Are you aware of any underage smokers in Western Australia? Is there a percentage or is there any data about people who are under the age of 18 who smoke?

**Mr Reid**: When we quote the teen smoking rates, it is usually from the younger ages—12 or 13 to 17. We have record low youth smoking rates. It is not an easy thing to study because, of course, it is not a product that you can legally buy until you are 18. But we know that youth smoking is a precursor to adult smoking. If you start young, you are more likely to become addicted and to continue to smoke. The programs that we have focused—even back from our education programs into school-age children—is to both prevent people from starting and also, if young people had started, to try to get them to quit as quickly as possible so that long-term addiction does not take hold.

[10.10 am]

**Hon PIERRE YANG**: You mentioned that your position is that we should take a precautionary approach. What do you mean by that? Can you elaborate a bit more on the stance of the Cancer Council?

**Mr Reid**: Sure. The current laws in Australia prevent the importation of vape products or heat-not-burn products et cetera and the precautionary approach says that we should not introduce the product or weaken the laws until or when the evidence builds to the point that there is either a proven therapeutic benefit or that the risks or harms are proven to not be there. While we have record low smoking rates, particularly in young people, youth, precaution means: let us not bring a product in that might change that, that is a precursor to smoking that will create a future health burden for us.

**Hon PIERRE YANG**: How long will it take for the evidence to build up? What kind of time frame are you looking at?

**Mr Reid**: If you think of the history of tobacco and asbestos, good worldwide evidence can take decades. Whilst other countries might be doing something, I would not suggest that just because others are doing it, we should too. That is not the precautionary approach. This country has taken a world-leading stance on a whole range of tobacco control measures. Our greatest concern is that those measures are weakened by a product that is both addictive, likely to lead to increased smoking rates and cause future population harm. We all pay for that. Our health system pays for, and through taxpayers we pay for, the burden on our health that these companies make profit on. As a country that has worked so well to bring those rates down, the precautionary approach for us is to not weaken the current laws.

**Hon Dr STEVE THOMAS**: Can I just check, your introductory remarks seem to indicate that you referred to a body of evidence linking e-cigarettes with the uptake of standard cigarettes. I guess I am looking for the most reliable study or data that we can cross-reference. Has that been made available for the committee and which particular study would you refer us to in relation to the link of the uptake?

**Mr Reid**: There was a document provided, which was a statement on e-cigarettes, countersigned by a whole range of health organisations that has a significant number of studies linked to that, including studies that have been reviewed or overseen by the NHMRC. There is a list provided to the committee.

**Hon Dr STEVE THOMAS**: But is there a specific study that you think has the greatest value?

**Mr Reid**: I cannot name a specific study, but what we talk about is the growing weight of evidence. The issue sometimes in this field is one study versus another study: this one says this; this one says that. From our point of view, it is the weight of growing evidence. The weight of evidence across a whole range, from epidemiological through to clinical through to laboratory et cetera, has to build a weight of evidence that informs good policy decisions. From our point of view, the weight of evidence is growing that there is more harm than benefit.

**Hon Dr STEVE THOMAS**: I have been reading epidemiological studies now for 30-something years. Back when I first started, we did it on microfiche, not on computers. Is there no study that is effectively a smoking gun at this point that demonstrates a link that you could put down and say, “This one is the study that we base our work on” and that perhaps a lot of other studies are then based on in terms of repeating it?

**Mr Reid**: As the evidence builds, there is no single study. There is a weight of evidence, in our view, and according to all the signatories on that statement of e-cigs, including evident health people, the AMA and the rest, all suggesting taking a precautionary approach. We would back that.

**Hon Dr SALLY TALBOT**: I just wanted to follow up the question about the time frames for the evidence. I am interested that you talk about tobacco and asbestos, because, in fact, there was scientific evidence available about the harmful effects of both those substances many, many years before statutory bans and public health measures were put in place.

**Mr Reid**: Indeed.

**Hon Dr SALLY TALBOT**: My question is: particularly in relation to the dot points that you have listed in your statement, when could we start looking for—I do not know what category, how you want to categorise it, but is there some early evidence? There are obviously people doing research, because you have footnoted several of these dot points. Is the evidence beginning to emerge one way or the other? I am not trying to lead you down one path or the other, but I am just interested that you used those two examples, where, clearly with the benefit of hindsight, we look back and say, “We should’ve acted earlier as policymakers.”

**Mr Reid**: Absolutely, you have highlighted the key point. When we talk about that weight of evidence, our view is the weight of evidence is building that there are harms and that there is growing evidence of harm and decreasing evidence of benefit. Just on that principle, all we are arguing for is that Australia should not weaken its current laws. We are not even talking about introducing necessarily new laws in this space, but we already have federal and all state governments that have laws in place around vaping and e-cig products. We should not weaken those. As for the building evidence, you are absolutely right; there was early evidence around tobacco and asbestos. It took many years to build political will. The evidence had to build to a point where it was inarguable and governments needed to understand that if they did not make decisions—this is where government has an incredibly positive role to play to signal to its citizens that there are things that are dangerous. Evidence is not enough. You have to build political will, you have to build public will, you have to educate people, you have to push back against industry that has a vested interest, and the time period between good evidence and political legislative change can take a long time. That is part of our advocacy role, being an evidence-based organisation, to build that evidence to educate, to bring public will with us and to encourage people in the political world to be brave and to make decisions that protect its citizens.

**Hon Dr SALLY TALBOT**: Can I take you specifically to the second dot point, which is the growing evidence of direct health harms. Can you talk us through a bit of that evidence and tell us the status of that evidence?

**Mr Reid**: The current evidence is building that there is respiratory disease, cardiovascular disease and potential carcinogenesis. A lot of the flavourings that are put into vape products are unregulated. They come from countries without regulation. They contain a whole raft of chemicals, which, again, are unregulated. There is growing evidence that respiratory disease and potential carcinogenesis can come from vaping, but the evidence is not conclusive, and that is one of the reasons why we are also calling for significant investment in research in this space, both in Australia and globally, to build that evidence.

**Hon Dr SALLY TALBOT**: Is some of that research looking at this argument about the difference between smoke and vapour? I noticed several submitters have drawn our attention to the fact that there is an argument about smoke and vapour being two completely different things, not comparable. Is that what that research is looking at?

**Mr Reid**: They are different things. We would try to link—the two different arguments being that vaping may be harmful, and the evidence needs to build for that, but vaping being a precursor to smoking is our key concern. Even if you separate those two things, the fact that young people who vape are more likely to smoke is a huge concern for us. That evidence is strengthening. The issue about safety, of comparing one thing to another: it is not about being safer; it is whether it is safe. That evidence needs to build, and that is why we are calling for increased investment in research.

**Hon Dr SALLY TALBOT**: It is possible to take a precautionary approach, in the sense that it was not possible with tobacco and asbestos?

**Mr Reid**: Correct. Those products needed to be reversed, if you like. We already have laws that are preventing these products. Our simple view is not to change those laws.

**The CHAIRMAN**: You mentioned Australia has world-leading controls on tobacco—I would agree. I think to some extent, we certainly have a very restrictive control on tobacco, the highest excise and such. We were the first people to implement plain packaging and whatnot. But when we look at the smoking rates across Australia, it seems as though they have stalled somewhat. In Western Australia, in fact, there is a slight fluctuation, but we have been at 9.5 per cent, 9.3 per cent, for the last few years. New South Wales, in fact, even increased from 13.5 per cent in

2015 to 15.1 per cent in 2017. This is daily smoking of adults, 16 and over. This is based on data conducted through survey by the health and wellbeing of adults, by each respective state. South Australia's smoking rate increased from 14.9 per cent in 2016 to 16.5 per cent in 2017, whereas Queensland has seen no change from 2016 to 2018.

Still, these are comparatively low rates, historically speaking, but if we look at the trend around the world, Australia has stalled. I think our national smoking rate for 18 years and plus is about 15.6 per cent, whereas the UK and the US have continued to decline in smoking rates and they are now below ours. The UK is 15.1 per cent; the US is 14 per cent. We have these world-leading controls on tobacco. What these other countries have done that we have not done is regulate vaping and e-cigarettes. I will point towards specifically a study called "E-cigarette Usage Is Associated With Increased Past-12-Month Quit Attempts and Successful Smoking Cessation in Two US Population-Based Surveys". That certainly pointed to the idea that vaping was effective as a cessation aid. If you disagree with the assertion that vaping could be used as a cessation aid, to what would you attribute those continuing declining smoking rates in those countries that do not have the world-leading controls that we have, and why is there a disparity between Australia's smoking rates in the UK and the US?

[10.20 am]

**Mr Reid**: There is no strong evidence that vaping is any better as a cessation aid than currently approved nicotine replacement therapy, and for a product that may cause harm—again, back to the precautionary approach—if it is no better than current nicotine replacement therapy products that are approved, then, again, we would strongly argue not to introduce. It is true that the decline in smoking rates has slowed, but they are still declining. It is not unexpected when you have come from such a high base of people smoking that at some point you get to a population that is really difficult to move; it is difficult for the remaining addicted population to keep quitting at those same rates. So we are still seeing an overall decline in smoking rates, but the rate has slowed, and that is also happening globally. To compare jurisdictions is really difficult. I would not argue that there is strong evidence to say that the introduction of vaping is a causation for declining smoking rates in other countries. There are a whole range of factors, all the factors we have mentioned—public education, increased warnings, restrictions on where people can smoke et cetera. So, again, if we have already seen the successes of those measures in Australia that have significantly reduced our smoking rates and will decrease the future burden of cancer and lung cancer specifically, we should not change the current laws.

**Hon RICK MAZZA**: Just with not legalising e-cigarettes or vaping in Western Australia or Australia, often what happens is that black markets arise where people import them anyway. You mentioned earlier flavours and things coming from countries and we do not know what the chemical compound of those are. If we were to legalise e-cigarettes and then regulate what is contained in them, would that not go some way to preventing harm, rather than having a black market where we do not know what chemical compounds are coming in to be used with them?

**Mr Reid**: I would refer to my previous comment that the onus is on industry to demonstrate that they are safe, and they have not done so. It is not up to us to try to argue for industry; they should sell a safe product. We have a whole range of regulation in this country, from safe drinking water to safe food production. The government has a role to play in regulation for product safety—everything from choking hazards on kids toys. The onus is on industry to prove safety and, until they do, we would argue the law should not be changed.

**Hon RICK MAZZA**: That was not quite the answer to the question I had. What I am worried about is a black market arising. You spoke about drinking water, kids toys and things, which the government will have controls over and regulate to make sure that those things are safe, but if we have a black

market arise where it is unregulated, is there not more possible harm in the types of chemicals that are being put in illegally?

**Mr Reid**: I could not comment on the legality argument. I mean, there are a range of things that are illegal, and government makes them illegal for reasons. We as a citizenry accept that some things are illegal—illicit drugs, for example. There are a whole range of products and substances that are illegal. I would not comment on the legality versus illegality, but until industry can demonstrate that a product they want to sell that is addictive is safe, the onus remains on industry.

**The CHAIRMAN**: I suppose on that, then, when we talk about illicit drugs, there is a black market for illicit drugs. There are many out there, and there are some in the health profession—I think the AMA may even have taken this line—who say that a policy of harm minimisation, as opposed to criminalisation, should be adopted. The idea is that adults are going to engage in this activity anyway—in many cases, it is habitual use fuelled by an addiction. Therefore, if they are going to do it anyway, at least some level of decriminalisation or regulation will at least reduce harm in terms of things like shoddy batteries, liquids with unknown ingredients and things like that. Can you just clarify for the committee that the Cancer Council does not take a harm-minimisation approach towards vaping or e-cigarettes?

**Mr Reid**: It is difficult to argue for harm minimisation when you do not know what the harms are, and that is the difficult part about the evidence needing to be conclusive. Our precautionary approach, as I keep mentioning, is the safest way. I could not comment on legality versus illegality; that is not a cancer-control issue.

**The CHAIRMAN**: Sure; I appreciate that. When we talk about the harms, though, we do not know the full extent, I suppose, of the harm of long-term vaping, because it has not been around that long. However, there are several authoritative bodies in the UK, New Zealand, the US and Canada—in fact, two of the largest cancer charities in the world, Cancer Research UK and the American Cancer Society—recognise that vaping, while not completely harmless, is at least less harmful than tobacco. I suppose they have looked at the body of evidence and concluded that while they may not know the long-term effects of vaping, it is at least safer. Tobacco is a legal, albeit controlled, product; therefore, if vaping is less harmful, it should be legalised. What do you say to these other organisations that have endorsed vaping as, if not a cessation aid, at least a less harmful alternative for people who are addicted to nicotine?

**Mr Reid**: They have not endorsed vaping, but my comment would be simply that less harmful does not mean harmless. We already have strong laws in this country that are jurisdictionally different from many other countries, and, back to my earlier point, we should not relax them.

**Hon PIERRE YANG**: Mr Reid, am I correct in saying that the rate of smoking, or the percentages that we have heard, do not include the rate of vaping—that is a different category?

**Mr Reid**: Correct.

**Hon PIERRE YANG**: In the US and UK, we know that there is a continued decreased over there. Do you have the figure for the rate of vaping in those countries?

**Mr Reid**: Some of the data has been provided. I do not have the jurisdictional vaping rates, because, again, there is a report that just came out yesterday from which I quoted some figures about the significant increase in vaping. But all of those jurisdictions would have a whole range of different data on vaping rates, because, again, in some of those countries, they have a greater body of evidence. Because vaping with nicotine is not legal in this country, it is quite a difficult area to study, so comparing the two rates is quite difficult.

**Hon RICK MAZZA**: You spoke earlier about nicotine being a very harmful or addictive product. Of course, gums and patches are used by people attempting to give up smoking. What is the greatest concern with vaping? Is it the simple action of inhaling the vapour that you think might lead people to take up cigarette smoking? To be quite honest with you, I see vaping as being very uncool. It certainly is not the Marlboro man. I have seen people walking down the street with this big cloud of vapour behind them, which looks pretty ridiculous. What is the main concern? Is it the actual action of inhaling?

[10.30 am]

**Mr Reid**: It is a very good point; thank you. The evaluation or the research that is available says that the ritual of smoking is a trigger. The use of a patch or a lozenge is a very different trigger from that ritualised act of smoking, so it is absolutely true that with the concern about increasing vaping—you mentioned you see people—the simple act of re-normalising the behaviour, particularly for people who have been addicted for many years, is a significant trigger.

The benefits of nicotine replacement therapy through gums, lozenges, patches et cetera are also medically supervised. The efficacy is proven. It can take people that are addicted to any substance multiple tries to quit. The average is about five or six attempts for long-term smokers, but the use of nicotine replacement therapy currently approved is proven. The re-normalisation of that act of smoking would be a major concern for us; so it is a good point.

**The CHAIRMAN**: Mr Reid, on that, though, are there currently nicotine replacement therapies that do simulate the action of smoking? Do we have those; I am not familiar with all of them?

**Mr Reid**: Not through the PBS in Australia.

**The CHAIRMAN**: They are available in Australia, are they not? I think I have seen those.

**Mr Reid**: I am not sure they are available through the PBS. The approval for in effect the government to subsidise something that is therapeutic must come through the PBS. Currently, there are a number of products that have been proven on that and they are the gums, lozenges and patches.

**The CHAIRMAN**: The UK Royal College of Physicians and Public Health England both base their position on a study that concluded that long-term use of e-cigarettes is at least 95 per cent less harmful than smoking. I understand that your standard for what quitting aides should be legal is perhaps a lot higher than other organisations, but when we see people that are smoking—who have tried treatments, they have tried these nicotine replacement therapies—is it still your assertion that you would rather have them continue these treatments that are not effective for them than switch to vaping, which would at least be, according to authoritative bodies in the UK, 95 per cent less harmful? Would you still insist that people continue these treatments that are not working for them rather than switch to this less harmful—albeit still harmful—but a 95 per cent less harmful product?

**Mr Reid**: We would simply argue that there are currently approved nicotine replacement therapies that are approved through the TGA that work. Where there are other products that may work but might have harm, we would suggest go with the approved therapies.

**The CHAIRMAN**: We will see if you can answer this question; it is somewhat of a hypothetical I suppose. We do see that a lot of people are engaging in vaping already. You walk around Perth; they are everywhere. There are even vape stores set up to sell accessories—liquids and things like that. People can import this liquid nicotine with some ease in small quantities. Vape devices can be imported with ease. It seems our current approach of prohibition is not working; in fact even with higher excises I would argue that perhaps we are even pushing some people towards these cheaper illegal alternatives with high tobacco excise. But that aside, if we were to legalise and regulate this space, what kind of regulation or what kind of regime would you like to see?

**Mr Reid**: My simple answer is we should not regulate this space. We should not change the current laws. I accept the premise of the hypothetical. When we have 90 per cent of Western Australians who do not smoke, we are talking about a small minority of the population who may seek to use these products. We do not know if they are safe and we do not know if they have any benefit over existing approved, regulated therapies, so our position remains the same. Regardless of the hypothetical, we should not weaken our current laws.

**The CHAIRMAN**: Thank you. I appreciate you answering a somewhat hypothetical question for me. I am not sure if you can answer this. We are able to take answers on notice if need be. To your knowledge, has the Cancer Council received any funding or sponsorship from companies that manufacture or sell smoking quitting aids such as patches—the replacement therapies that you mentioned earlier?

**Mr Reid**: No.

**Hon Dr STEVE THOMAS**: Can I just check with you the position on the use of vaping and e-cigarettes. Again, I am a generation away, so it is not my area of expertise, sadly; or maybe it is a good thing! In the quest for harm minimisation, how does the Cancer Council measure or quantify the argument of the potential theory that using e-cigarettes and vaping reduces harm compared to using normal cigarettes? How do you look at and attempt to quantify whether that is accurate and what do you use as a measure?

**Mr Reid**: I think I refer to your own point in that even if there is a potential theory that they are safer, it has not been proven. Why would an organisation that has spent 60 years trying to reduce the incidence and impact of cancer on a population take a position that might build future harm when we do not have the evidence? It is really that simple.

**Hon Dr STEVE THOMAS**: You are not aware of any quantifiable evidence along those lines? I would imagine that you would do it just to be aware of the research. You are not aware of a single study anywhere that demonstrates that?

**Mr Reid**: I am sure you can find single studies. We talk about the weight of evidence.

**Hon Dr STEVE THOMAS**: If they exist, I guess we can find that elsewhere.

**The CHAIRMAN**: I have one more question. I think in your position document you provided a link to it in your submission. If I am not mistaken, the Cancer Council advocates for banning e-cigarettes and liquids that do not contain nicotine. Given that nicotine is presumably the problem substance here—it is addictive and it may lead people to smoking cigarettes through their addiction to nicotine—what is the rationale behind banning non-nicotine containing vapers and e-cigarettes?

**Mr Reid**: Again, two separate arguments. Nicotine being addictive, if we relax the current laws that allow a product that addicts another generation of people using this product and then we find out down the track this product is unsafe, you have created another massive health burden. Separate to the addictive nature of nicotine, the safety of non-nicotine vape liquid has not been established. Again, from a precautionary principle we would argue that if there is any potential of that product leading to an increase in smoking rates or any potential of that product increasing respiratory harm, carcinogenesis, cardiac disease, then as a community we should not accept it.

**The CHAIRMAN**: I suppose if there is no nicotine involved in these products, though, should they be subjected to the same standards that therapeutic goods or products that make therapeutic claims are subjected to?

**Mr Reid**: While industry makes claims of cessation aid, they should prove it.

**The CHAIRMAN**: I suppose I am thinking of a concentrated oil that has a vanilla flavour which could be used in a vaporiser in an e-cigarette, that makes no therapeutic claim, or the claim on the bottle

is that it is vanilla-scented concentrated flavour. Should that be subjected to Therapeutic Goods Administration approval?

**Mr Reid**: We would argue that you would still need regulatory processes in a country to make sure that the products people use are safe, whether that is food, whether that is any other product that consumers—citizens—use or consume should go through a regulatory process, and that has not.

**The CHAIRMAN**: But you go a little bit further than that, though. Your position, if I am not mistaken, is that it should be subjected to TGA approval, not just merely any food regulatory process or any other consumer process but TGA specifically, as your position—am I right?

**Mr Reid**: Yes.

[10.40 am]

**Hon PIERRE YANG**: What is the basis for your position on that point? Why is that supposed to be getting approval from the TGA?

**Mr Reid**: One of the most common claims made by industry is that e-cigarettes can assist people to quit smoking; therefore, the claims that are being made are therapeutic. We simply say that if the claims are being made by industry as a way of weakening current laws, they should prove that efficacy.

**The CHAIRMAN**: There are local manufacturers that manufacture these flavoured liquids for use in e-cigarettes. They make no therapeutic claims; they merely manufacture a liquid, which may or may not be used in an e-cigarette. When you say "the industry", who are you referring to specifically? Are you referring to everybody involved in this space—people producing batteries, people producing liquids? Are you referring to anyone in particular?

**Mr Reid**: Particularly big tobacco. The large tobacco industry clearly sees vaping as a way to continue selling an addictive product. When we talk about safety, regardless of TGA approval we should know that the products we consume in this country are safe. So whatever regulatory process that might apply to even non-nicotine liquids for the purpose they are being sold to be used for should be shown to be safe—we would hold that line.

**The CHAIRMAN**: So if it is a liquid being manufactured without therapeutic claims, you would say no TGA approval is required then, but whatever regulatory approval process that applies to other consumable goods would apply?

**Mr Reid**: I think, representing the Cancer Council, we should aim for the highest standard.

**The CHAIRMAN**: When you talk about big tobacco in this space, it is certainly true that tobacco companies are interested in entering into vaping—they obviously have their own interests there. But there are a lot of small business owners, local manufacturers and smaller people wanting to get into this space and who operate in this space already, within the law, selling what they can without falling foul of our current tobacco controls. Are you not concerned that if you are setting that bar so high for TGA approval, which is quite an onerous process that requires a lot of money and a lot of time, that you would exclude the possibility of smaller businesses getting into this space and you would almost set up a system where only the big tobacco companies that have the resources to go through that approval would be able to bring their products to market? Does that concern you at all?

**Mr Reid**: What concerns me is that we sometimes talk about people making money over the health of our citizenry. Whether you are big, small or otherwise, if we are potentially introducing a product that is not safe, then we would argue against it.

**The CHAIRMAN**: Okay. Any other questions?

**Hon Dr SALLY TALBOT**: Just one final question from me. This is an issue that is arising in state jurisdictions. Are you aware of campaigns in other states, and is there any sense in which the Cancer Council WA is joining with similar organisations in other states in campaigns around the themes that you have raised with us this morning?

**Mr Reid**: Sure. Cancer councils in all states and territories are part of a federation. Cancer Council Australia acts as kind of the central spokesperson. When you look through the list of health organisations supporting the precautionary approach, it includes all cancer councils as well as Cancer Council Australia and a whole range of other health promotion and public health organisations. There is definitely a collaborative effort to ensure that Australian laws are not weakened.

**Hon Dr SALLY TALBOT**: So this is not Western Australia being groundbreaking or anything in this regard?

**Mr Reid**: No, absolutely not. I would refer you to the second page of that statement on e-cigarettes. There is a list of 20 or 30 organisations, some Australian, some international, all looking at that collaborative effort to make sure we do not weaken those laws.

**The CHAIRMAN**: Just on that, so there is harmonisation, I suppose, in policy across the cancer council federation?

**Mr Reid**: Yes.

**The CHAIRMAN**: Thank you. If there are no other questions, thank you for attending today. A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence. Thank you.

**Mr Reid**: I appreciate the opportunity. Thank you very much.

**The CHAIRMAN**: Thanks Mr Reid; much appreciated.

**Hearing concluded at 10.44 am**

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