EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE TOBACCO PRODUCTS CONTROL AMENDMENT BILL 2008

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 11 FEBRUARY 2009

SESSION THREE

Members

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

Hearing commenced at 11.05 am

DAUBE, PROFESSOR MIKE
University Professor, Public Health Advocacy Institute of WA, Curtin University,
examined:

FAULKNER, PROFESSOR KINGSLEY WALTON
Surgeon,
Director of Clinical Teaching (Private Health Sector), University of Notre Dame Australia,
Public Health Advocacy Institute of WA,
examined:

LE SOUEF, PROFESSOR PETER
Professor of Paediatrics, University of WA,
examined:

BOND, MS LAURA
Researcher, Curtin University of Technology,
examined:

The CHAIRMAN: Thank you very much for coming today. On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering 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. 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 the 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 that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing and Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title 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?

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: No.

The CHAIRMAN: We might start with you, Laura, and then let Mike start the ball rolling afterwards. Laura, would you like to go first?

Ms Bond: I am a researcher from the Public Health Advocacy Institute. Basically, I provided some evidence in the submission about tobacco industry documents and put together some possible arguments it might have against the bill. Do I talk about that now?

The CHAIRMAN: No, just general introductions first and then we will ask you each to educate us. We are here to learn from you as the experts.

Professor Le Souef: I am Peter Le Souef. I am the professor of paediatrics at the University of Western Australia and head of the School of Paediatrics and Child Health, but I am also a paediatric respiratory physician, so I look after children with respiratory disorders. I have been working with public health interests in smoking for 25 years and with ACOSH for that period as well.

Professor Faulkner: I am Kingsley Faulkner. I am a surgeon. My current position is the director of clinical teaching in the private hospital sector for the University of Notre Dame Australia. I am a former chairman of the Australian Council on Smoking and Health for several years during the early 1990s when previous legislation went before the house and was successful on that occasion. I was president of the Royal Australasian College of Surgeons from 2001 to 2003 and I served on that council for 10 years leading up to that time. I have been chairman of the Department of General Surgery at Sir Charles Gairdner Hospital, but relinquished that job when I took on the College of Surgeons position. I have had a long interest in tobacco control in this state and in Australia, and I am very interested in this bill. Thank you very much.

Professor Daube: Mike Daube. I am professor of health policy and director of the Public Health Advocacy Institute at Curtin University. I am also president of the Australian Council on Smoking and Health, nationally of the Public Health Association of Australia and also locally of the Health Foundation. If they do not speak for it, I am deputy chair of the national Preventative Health Taskforce. I have been involved in work on tobacco since 1973. I cannot mislead the committee—I was over 10 at the time!

The CHAIRMAN: Mike, would you like to start the ball rolling?

Professor Daube: Thank you. You have our submission, which is consistent with the submissions of various other health organisations. Obviously, we are very supportive of the submission from ACOSH. You have here the current president and the two previous presidents of ACOSH. We are clearly all very much in line with that, as well as the submissions of the other health organisations. We strongly support the proposals in the bill, which are entirely consistent with the best recommendations of health agencies and authorities internationally on tobacco control. They are also consistent with the approach that is proposed in the discussion papers of the national Preventative Health Taskforce. I believe that if it were not for the history of tobacco and the reality that there are vested interests still heavily involved in tobacco, the measures in the bill would all be seen as stock-standard health protection and would have been in place many years ago.

I just want to make three or four points because I suspect that you probably have had a certain amount of overload of people saying that this bill is a good thing. The decline in smoking has been encouraging and has been a public health success in this state and elsewhere, but the history of tobacco control is that it constantly needs reinvigorating.

You cannot be complacent; once you are complacent, things plateau and then, of course, we do not see progress in either declines in smoking or the beneficial consequences in health concerns. There is real concern that there has been a bit of a plateau over the past two or three years. The pace of decline over the past three years has not —
[11.10 am]

The CHAIRMAN: Just in WA, or nationally?

Professor Daube: No, nationally and in WA, but the decline has not been as fast over the past three years as it was over the previous triennium, and I think that what we need to see is that continuing boost to both public perceptions about tobacco, as well as the activity that is in place. The next point I want to make is that the evidence is clearly overwhelming. The evidence has been overwhelming on active smoking for 59 years, and on passive smoking for about 30 years. There is no safe level of exposure to either and there is no case for any form of promotion of tobacco inside stores, outside stores or anywhere else. It is a lethal product; there is simply no case for any promotion, just as there is no case for promotion of other drugs that, indeed, nationally cause less damage than tobacco. Even when I started in this area 36 years ago, there might have been some sympathy for people working in tobacco or selling cigarettes, because the evidence had come in after they had started on their careers and activities. Now, I believe there is no such case of any such sympathy. People who are working in tobacco and selling tobacco have known right from the start that they are profiting from the sale or promotion of a lethal product. We have tried, in our documentation, to give some —

Mr P.B. WATSON: Are you saying an illegal product?

Professor Daube: A lethal product.

We have tried, in our documentation, to give some information about possible counterarguments that are put up. There is one area that I want to mention very briefly, and that is the goldmine of documents that are now available to us following the Master Settlement Agreement of litigation in the US, and as a result of that there are literally tens of millions of tobacco company documents available online. Many of them were once confidential, and Laura has been working with us on the WA tobacco document searching program, and will shortly be publishing a monograph providing as much material as we can find from tobacco industry documents internationally that report on what is happening in WA, developments in WA and so on. Those documents, internationally, show that over the years the tobacco companies have lied and misled, as we suspected they had, and there is now a lot of literature arising from those documents. It is also interesting to see some of the things that they say in their internal documents about the kinds of things that we are talking about here. It is clear from their internal documents that they oppose any measures that will reduce smoking in public places or that will protect people from passive smoking, and they especially oppose any measures that will restrict any form of promotion. I refer to an internal industry document from Philip Morris in the 1990s, which we have attached to our evidence. It talks about their concerns that in the absence of other forms of advertising —

> Retail marketing is therefore no longer the support mechanism, it is the primary communication vehicle.

The documents state that brands require retail activities to reinforce brand image and that the critical issue is to continue to convey the brand image consistently and to create an impact. There is a nice little handwritten note on one of these documents that says that point-of-sale promotion needs to convey image as well as stock and price value messages, and that "we must seek to stay one step ahead", and so on.

What I am really asserting is that from the internal tobacco industry documents there is a mountain of evidence to demonstrate that the measures proposed in this bill are the measures that tobacco companies fear. We have heard, over the years, that every time a measure is proposed that will reduce smoking, somebody says that the sky will fall in, that there is going to be disaster, and that it will not be possible. A good example was when Mr McGinty announced the phasing out of smoking in health services. People said that the sky would fall in, but it all happened, it was very well done and it happened very effectively and so on. We are always being told that the sky will fall in; it never does. What you find after those measures have been introduced is that they are even more popular than they were before, and that they are very well accepted. I think that arguments that the sky will fall in can be discounted. Finally, I would just like to note that in tobacco control

for a long time there has been a phrase the committee will be familiar with, which is called the "scream test". It essentially tells us that if the tobacco industry is screaming and opposing a measure such as this, then we know that it is not in their best interests and that it is, consequently, in the best interests of public health because we are there to see as minimal as possible sales of tobacco, and ultimately an end to the work of the tobacco companies.

These measures have engendered opposition from tobacco companies and I think that that is very encouraging; it shows that you are heading along the right track, and I would certainly like to support the bill very strongly as an important contribution to public health in this state that will bring us into line with a great deal of national and international best practice.

The CHAIRMAN: You mentioned the vested interests of the tobacco companies. Who would you see as having the vested interests on behalf of the tobacco companies in WA and in the other states?

Professor Daube: So far only some submissions are online, so I have only had access to those. There are submissions from the tobacco companies—I note with some amusement that one of them quotes Professor Simon Chapman as though he were supporting their line, whereas, indeed, Professor Chapman has made a specific submission to this committee to say that he totally supports every aspect of the bill—the retail groups, and others that also sell cigarettes or have traditionally been opposed to some measures that will reduce smoking, such as the Australian Retailers Association.

Professor Faulkner: I am marginally older than my colleagues flanking me. In 1945, about 75 per cent of adult males in this country were smokers, including my father, who died prematurely as a consequence of that addiction.

[11.20 am]

Mr P.B. WATSON: Would that be because of the war?

Professor Faulkner: A whole lot of factors; the war was part of it. Returned soldiers, as you know, were —

Mr P.B. WATSON: My father was the same.

Professor Faulkner: — handed out cigarettes and they come from the same area that you now represent.

The CHAIRMAN: When I did my mental health nursing, I was told when I walked into the ward that the best way to communicate with the patients was to sit down and have a cigarette with them.

Professor Faulkner: That is right, and many physicians were still active smokers. But, of course, the initial work was on physicians—doctors—in Britain, studying their smoking habits and following them through over time just to see what happened to them in the long term, and a lot died of their addiction. In 1945, 75 per cent or so of adult males were smokers. It has now dropped to 15 per cent across the country. That has not happened just by chance; it has happened because of evidence that has gone back now 60 years both in the UK and United States, particularly. However, accumulated evidence, as my colleague has mentioned, on passive smoking goes back about 30 years. There is a huge literature now to support measures that will attack this particular scourge, but it is still there and it will not disappear without concerted continuing efforts and, I would agree, without further legislative changes to gradually whittle down the numbers till it drops below 10 per cent, by which time it may well start to whither away altogether. However, it will not happen easily, it will not happen without further legislation, it will not happen without continuing public support, which we believe is there, and it will not happen without continuing scientific evidence to bolster and to explore the ways in which tobacco smoke harms. In my profession as a surgeon, I see not only the lung cancers and the throat cancers but in my area oesophageal cancers, bladder cancers, gastric cancers—probably right across the board malignancies are at a higher rate amongst smokers

than non-smokers in ways, some of which we do not fully understand, but there is a clear association.

The CHAIRMAN: Are they metastases from an initial—

Professor Faulkner: No, primary lesions and probably metastases. One of the theories about cancer formation, of course, is that we have an immunological defence mechanism—all of us are born with it—but the occasional cell misfires, mutates and our immunological defence mechanisms are good enough to recognise the rogue cell to get rid of it. However, in smokers where the whole immunological system is dampened down, depressed, that recognition system is deficient, and it is not only areas where smoke directly attacks or affects the tissues like the lungs, throat and mouth, but also other areas in the body where there is no direct contact, yet the toxins and so on have that effect. The evidence gets stronger and stronger. My colleague to my left will talk about children and their ailments and go on to that area.

I am very concerned that the Parliament of this state continues to look carefully at new legislation, sensible legislation and enacts it when it is in the public interest. I believe the measures that are before the house at the moment are strongly in the public interest. The public backlash to such legislation, I believe, will be minimal and will disappear, as Professor Daube has mentioned. That has been experienced not only in this country, but also in places like Ireland where they thought it would be an absolute catastrophe when they introduced restrictions in the Irish pub, but it did not happen. In California, the United States and a whole lot of areas, legislation has been introduced of a similar nature to what you are proposing in this raft of measures. Therefore, in broad terms, I am very in favour of all the measures in the bill. If there is nudging of the wording, so be it, but the broad thrust of all measures in the bill, I believe, are strongly supported by the evidence, particularly the exposure of children to tobacco at the early stage and also in restaurants and other measures, and at the point of sale—part of the legislation. There is no doubt about it, that children and others are influenced by that. That is why it is put there, why it is put in the most prominent areas and put in the most attractive way possible because it works. The tobacco companies know it works and I believe that we should do something about that aspect and other aspects that need to be looked at that are included in the bill.

Other components of what we should be doing do not fall into the ambit of your bill and therefore I will not address them—things like the way in which the tobacco industry influences through film. There is often smoking in films. People like Sylvester Stallone get half a million dollars just to be seen smoking in the *Rocky* movies, for example. They know it works because it is advertising in the most effective way, as people, and children in particular, view role models.

Mr P.B. WATSON: Do you think in the long term though with so many people cutting down their smoking that it will be seen as abhorrent in the movies and eventually it will cut that out? I know now that I see movies and it turns me off when I see women and guys smoking.

Professor Faulkner: They may regard it as abhorrent, but if you look at a movie like *Titanic*, for example, in an age when young women probably were not smoking very much the lead figures were seen to be smoking. They know it works. They know it works because it is glamorous and it is effective, but that is another issue.

Mr P.B. WATSON: They sunk in the end, didn't they?

Professor Faulkner: Not because of the smoke, I suspect, but they did sink, yes!

The CHAIRMAN: Maybe later we will get some statistics in terms of how much tobacco money goes into film production.

Professor Faulkner: It is huge and there is some data about that, you know, outside the ambit of this legislation. However, there is some data about that as there is some data now accumulating about the way in which the new forms of communication are now being used, such as the videos, Facebook and all the rest of it, that my children are more familiar with than I am. That is why

legislators need to be on their guard to what is happening in the world because there are innovative ways in which the tobacco industry will use advertising of various sorts to get its message across.

My main fundamental reason for being here is that I do not want to see this state lag behind the rest of the country. This state was leading this country in tobacco control legislation and leading the world. There are places in California that are perhaps now leading the world on this issue. We are in danger of slipping behind unless we do more. I commend the former Minister for Health, who sits on your left, for his work on previous matters but it has to continue; there has to be a continuing thrust by legislators in this state. People are in Parliament for only a defined period of time and they must not lose the opportunity to get good legislation through while they are there. That is a huge missed opportunity if they do not.

The CHAIRMAN: Just within Parliament before Christmas, there was, obviously, support from the Labor Party. As you know, the minister has been moving, and introduced legislation that has led to changes. I certainly am very hopeful that the Liberal Party will give its members a conscience vote and will not dictate to its members that they must vote against this bill. Therefore, I hope that various organisations that are active in this area will, in fact, pursue that with the Liberal Party; namely, that it should be a conscience vote because, as you say, this is looking after the community and this is legislation on behalf of the community so members should be able to vote in a way that they believe will protect the community.

Mr P.B. WATSON: Professor, can I just ask you a question: we were talking about 50 to 60 years ago, is smoking—the ingredients—more dangerous now than they were in that period?

Professor Faulkner: As you know, there are more filters and so on. My father used to have "roll my own" type cigarettes and there was no filter; there was nothing at all. However, some of the evidence suggests that if you put all the filters and those sorts of things into the cigarette that people will still want their dose, if you like, of nicotine and they will consume as much as they need to get that dose, to get that kick, because of the addiction. It is a powerful drug of addiction. If you look at quitting rates for heroin and for nicotine and follow them over a 12-month period, there is about a 20 per cent success rate by 12 months. It is powerful. It is not to be sort of sneezed at; a kid trying out the occasional cigarette will be able to quit. However, eventually half of them probably will not be able to quit, and the half that cannot quit will die prematurely because they cannot. That is a huge public health issue and I think all other issues that were maybe put across the board to oppose this legislation—what will it do to the retailers and their financial return and so on—I think they all pale into insignificance compared with that sort of problem.

[11.30 am]

It is a huge killer; 80 per cent of the drug-related deaths in this country are still tobacco-related deaths. As we find out more and more about other drugs, they become more and more dangerous too. But, of course, when tobacco became a social custom we did not understand all of that and as a consequence it became a social custom and therefore so much more difficult to reverse the trend. Nevertheless, that is why public health measures, strongly based on evidence, have to be in place and why we have to get the legislators to do something about it given the opportunity that they have while they are in the Parliament.

Mr P.B. WATSON: Yes, thank you.

The CHAIRMAN: Peter, would you like to address the committee?

Professor Le Souef: I would like to focus on mainly children; that is, the public health and clinical aspects for children because that is the area in which I work.

Firstly, working as a clinician, every day I see children in hospital because their parents smoke. We used to think it was mainly due to the mother but now we know that paternal smoking also increases the risk of disease. Probably, 10 or 15 years ago, we used to admit 300 or 350 children with bronchialitis. That number has come down now because maternal smoking has come down.

However, generally speaking, if the mother smokes it doubles the risk of a child being admitted to hospital. Many children are in hospital simply because of passive smoking—because their mother or father put them there. If they were hospitalised as a result of anything else, you would call it child abuse. In any case, I am sure that you have heard previously —

The CHAIRMAN: I had not heard it described in that way before!

Professor Le Souef: It has been described in that way on several occasions. I first heard the description nearly 20 years ago when an American colleague, writing the Surgeon-General's report, described it as a form of child abuse. I think one can sympathise with that view given that we know smoking puts children in hospital. If you beat them and put them in hospital, you go to gaol; but if you smoke and put them in hospital, you do not. It is, clearly, a view which is, I think, reasonable; albeit one that is a bit too contentious to push in public because, I think, it makes people feel too guilty.

My point is, clinically, we know that it causes disease. I do not think that I need to reinforce that view, again, for the committee. It increases ear disease. It increases chest infections and it also increases the liability to develop asthma and, probably, several other diseases as well. What is the evidence for that? Is it just that passive smoking is bad for children and that a little bit won't hurt them? Twenty years ago, the Australian Consumers' Association—the *Choice* magazine people—took the Tobacco Institute of Australia to court for false and misleading advertising about the effects of passive smoking. Twenty years ago, the Tobacco Institute was saying that there was very little evidence that passive smoking was harmful. I was the first expert witness in the case in Sydney—our side had only two lawyers and the tobacco industry side had about twenty—in which our side wheeled in several trolleys of evidence. The case seemed quite obvious. There were hundreds of papers twenty years ago. That evidence has accumulated further. I want to bring that up because there is overwhelming evidence of a problem. I think we know that that is true. I just want to draw attention to some of the more recent research evidence, some of which we have been involved with. I know that Stephen Stick appeared before the committee earlier. He completed his PhD work in our department. He showed, right from birth, a baby's breathing pattern is different and is adversely affected if the mother smokes. We also know, from the studies that we have done on longitudinal lung growth, that lung growth is impaired in children. We were also surprised when another PhD student of ours looked at the immune system in early life and at two years of age in collaboration with people from the Telethon Institute for Child Health Research and Professor Patrick Holt. We found that even if the father smokes—when the dose is obviously less—the immune system is significantly affected in terms of antibody responses, which are down by somewhere in the vicinity of 50 per cent. That work has been published. I think it underlines the incredibly pernicious strength or danger of tobacco smoke; that is, it can actually damage the —

The CHAIRMAN: Is that with children or in-utero growth?

Professor Le Souef: This is early in life; in the first two years. We are looking at vaccine responses at two years of age. They are impaired right from the start. And that is through passive smoking because it is coming through the father who does not spend as much time around the child. It really underlines that this is not just a small thing that is going to make a few children cough and make the odd child go to hospital. This is something that damages. This is a very powerful drug that not only causes cancer and damage in older people, but also damages the immune system early in life—we do not know if that damage is permanent or transient—badly enough that children are more likely get an infection and go to hospital. Susan Prescott, from the University of Western Australia, has also shown impairment in the immune system in cases where there is parental smoking. We are starting to realise just how dangerous and pernicious smoking is because of this data. I think it underlines the fact that we need to protect children from any form of tobacco smoke exposure because it is such a powerful and dangerous agent. That means that this legislation, which has children at its heart, has to be supported. I do not think we can, in a civilised society, allow children

who have no choice about their environment, to be exposed to something that is obviously—not potentially—clearly harmful.

The final point I will make is that we, as public health advocates and as clinicians, are always trying to get parents to give up smoking. It is difficult, when the public and the government allow people, in full public view, to do something that is harmful to their children—as in smoking in cars or in alfresco or any public place where children are clearly breathing in cigarette smoke. When we allow that to happen it sends a terrible message to the public. It makes our job to get parents to give up smoking much harder when, clearly, there is not enough impetus from society to do something about it. I think this is very important legislation. I think it will have a big effect on the exposure of children and, of course, I strongly support all aspects of it.

The CHAIRMAN: Professor Daube has talked about smoke in terms of it being a lethal product for its carcinogens. You have talked about the damage that it does to the immune system. I know that in the eastern states they have looked at buffer zones in alfresco areas. Is there any research, or is it too soon for such research, that shows the damage that can be done in those alfresco areas?

Professor Le Souef: I think it is an accumulative thing. It is very powerful. Trying to sort out where exposures occur is, obviously, logistically impossible. Clearly, a very low dose is dangerous. Low doses accumulated anywhere, particularly in public, just cannot, I think, be allowed to happen. To ask for specific evidence to show that exposure in buffered zones in alfresco areas damages the immune system—sure you could do it—would cost millions of dollars. It is obviously the case that such exposure in alfresco buffers should not be allowed in the first place because we know that tobacco smoke is dangerous.

The CHAIRMAN: The damage is happening in those alfresco areas.

Professor Le Souef: Yes. I think you can take it as a given that those exposures are going to contribute since we know that very low doses are dangerous.

The CHAIRMAN: They are going to contribute both in terms of the cancers and the damage to the immune system.

Professor Le Souef: As I was riding my bicycle through the heat to this hearing, one of the things I was thinking was that it is likely that carcinogen exposure early in life contributes to later ill health; however, no one has ever been able to do a long enough study. We do know the damage that exposure does in children early on, because we can measure that. We know that it damages the immune system, causes increased rates of infection and all the other things of which, I think, most people are aware—including most of the public. Interestingly, if you ask a mother who smokes whether she smokes around her child or in the car, in the last five or 10 years, I have not had one who said that she did. Yet, if you go out in the street, you know that they do. The reason the parents lie to you is they are so ashamed about what they are doing. They know it is wrong. They know it is harmful, yet they still do it.

Mr P.B. WATSON: It is addictive.

The CHAIRMAN: Laura, would you like to say something?

[11.40 am]

Ms Bond: I would like to say a couple of things in regard to the industry document following Professor Daube's comments. The tobacco industry quoted that point-of-sale displays need to attract impulse purchases and to encourage trial and retrial purchases. The industry maintains that the primary purpose of point-of-sale displays is to impart information to existing smokers about brands. However, we know that cigarettes have the highest brand loyalty of any consumer product, with less than 10 per cent of smokers changing cigarette brands a year.

On second-hand smoke exposure, the industry has obviously denied that nicotine is addictive. It has denied that smoking causes cancer, and now in its documents we can see that it is denying that there

is evidence that second-hand smoke causes harm. The US Surgeon General has stated that there is no risk-free level of exposure to second-hand smoke. Jim Repace has also done some work on outdoor smoking and has found that some levels of outdoor smoking are just as high as those for indoor areas. I am happy to answer any questions about the industry document.

The CHAIRMAN: One of the things that has certainly come up in the Parliament—Professor Daube will recall when it came up a few years ago—was that some members said this is a nanny state. Would you like to comment?

Professor Daube: I wrote a piece in *The West Australian* about the nanny state a while ago. The term "nanny state" is fascinating. It was invented by a British conservative politician called Iain MacLeod. When he was editor of *The Spectator* he wrote a column under the name of Quoodle. Ian McLeod invented the "nanny state" term in that column. As health minister, he was noted in the 1950s for smoking his way through a press conference about the dangers of smoking. He died young from a disease related to smoking. One of the other advocates of the nanny state was an English writer called Auberon Waugh, a heavy smoker, who also died young from a disease related to smoking. The phrase "nanny state" is used by tobacco interests and others as a sort of catch phrase, without any real definition or description. It is invariably used only to abuse either measures or advocates of measures to which those interests are opposed.

I think in any discussion on the nanny state we need to look at the lack of any definition and what a state actually does to control its citizens. We are subject to a raft of measures that protect our health. The first public health measure I am aware of in this state was in 1842, which Professor Faulkner would remember — sorry! It was legislation to protect townships from the slaughtering of food in the limits of the township, so you might call that the nanny goat state! Since then, over and over again, we have been protecting our communities on public health grounds. We have public health protection legislation, road safety legislation and law enforcement legislation. There are a squillion legislative measures that protect us. Very rarely do we hear those condemned as being part of the nanny state. We do not hear condemnation of illicit drug legislation as being part of the nanny state; nor do we hear condemnation of crime legislation as being part of the nanny state. It is used only —

The CHAIRMAN: When it comes to tobacco.

Professor Daube: — in relation to tobacco, and sometimes alcohol, usually by vested interests who are opposed to action in this area. It is a cheap shot used by the industry and sometimes a cheap phrase used by journalists. It has no meaning, and, as I have said in various contexts, it is really time that nanny retired.

The CHAIRMAN: The former minister might be able to answer this. We keep a register in WA for donations to political parties from the tobacco companies. I do not believe the Labor Party accepts them.

Mr J.A. McGINTY: It is a matter of policy to refuse.

The CHAIRMAN: Are there similar registers in other states, and does the Liberal Party still accept donations?

Professor Daube: There are. Probably the best person to advise whether it is happening nationally is Anne Jones from ASH Australia, who I think is appearing later on. My understanding is that across the country the Labor Party does not accept any tobacco company donations, and nor do the Greens. However, the Liberal and National Parties have no such policies. They have accepted tobacco company donations and I think that is one of the examples of tobacco company promotion that should simply be ended. If those parties will not do it voluntarily, it should be by legislation. I am also aware, from the register of lobbyists in this state, that the tobacco companies employ lobbyists directly. They probably employ indirect ones also, but certainly lobbyists are registered for some of the major tobacco companies. Again, it is my view that this might be considered for further legislation. At this stage, any form of tobacco company promotion is utterly inappropriate. It

is a lethal product that kills one in three of its regular users. There is no case for such promotion, and that should apply as much to things such as political donations as to lobbying as it does currently to billboards and so on.

The CHAIRMAN: I think I remember seeing an ex-Labor member's name on that lobbyists register. I need to check that.

Mr J.A. McGINTY: Dr Faulkner spoke about the things that are not covered by the legislation. Perhaps Professor Daube and Mr Faulkner can respond. This legislation deals with smoking in cars and in some public places. What is best practice around the world? Assuming this legislation comes onto the books, where do we look to for the next wave of reforms with respect to smoking?

Professor Faulkner: California has been one state in the United States that has been very proactive in this area through several high-profile public health advocates in that state. Perhaps Professor Daube, in his role, would be in a better position to answer your question than I am. Saskatchewan in Canada, parts of the USA, Iceland, Ireland and other places are starting to get legislation through just ahead of us.

Mr J.A. McGINTY: I think this legislation will bring us up to equal best in every respect around the country. I do not think anything else is happening in any other state that is not either currently being done or will be covered by this legislation.

Professor Faulkner: You may be right. I will ask Michael to respond.

Professor Daube: I make two or three observations in response to that because I have been thinking for a while recently about where next; what are the next stages? The first is to get us at least up to best practice nationally—that is something you raised in earlier discussions—and to focus on some of the disadvantaged groups. The federal government has and will be putting a lot of effort into work on Aboriginal smoking. I think work is needed in disadvantaged areas. It is encouraging that we find that there is always a drip down. Smoking started among the most affluent and they were the first to give up, and the same is happening with various disadvantaged groups. Where do we go next? There are still some areas in which we could do better as a state. One is investment in tobacco control activity and in funding. New South Wales, for instance, is putting $10 million or $15 million into campaigns. We know that measures such as tax increases and strong funding for consistent, sustained and hard-hitting tobacco control campaigns have an impact.

[11.50 am]

So I think we should be looking at some of those measures, and it would probably need national intervention, such as tax, and major national media programs. But the question then is: okay; where next? We are bringing the rate of smoking down, and I think we are getting close to the time—I hope this addresses your question. Sorry, I have a preliminary point: I sent an email to Professor Stanton Glantz, who is really the leader of the activity in California, asking for his view, following some questions that were asked earlier at this committee, as to what had really made a difference in California. His view is strongly that it is the kind of things we are talking about, but especially in California they have also had a major push for many years on protecting non-smokers and on denormalising and—whatever the phrase is—demonising the tobacco industry and pointing to all the immorality and other reproaches of the tobacco industry. So, really strong public advocacy in areas like passive smoking, over time, does get through. What is the next stage, though? Actually, it is a fascinating area. I have always had a view, with no science behind it, that once we get down to below around 10 per cent, there is going to be something different about the dynamic of smoking. It is going to reduce more quickly; it is going to be much more —

Mr P.B. WATSON: Peer pressure.

Professor Daube: Yes, and it will just be much more abnormal or deviant or however you like to describe it. I think we should be looking at the art of what is feasible and maybe raising some of the questions that we would not have dreamed of raising some years ago. In a survey that ACOSH did a

couple of years ago, we just asked the question: "Some people say that there will come a time when smoking is banned. Do you think that is a good thing, a bad thing or whatever?" Sixty-two per cent said that they thought it would be a good thing. I think only about 20 per cent said that they thought it would be a bad thing. So the public out there may be further ahead of us than we think in terms of what will ultimately be acceptable.

In terms of what is feasible, I think we should be starting to say, "Well, when is there going to be a time when this lethal product is no longer commercially sold?" I do not think we should do it by banning use because of all the implications that go with that, and so on. But Australia is an island continent. It is very different from other countries around the world, and I think there is a case for saying that maybe we should set a date 25 years on when we believe that cigarettes should no longer be commercially sold. What should be happening at that time? How would those remaining smokers still get cigarettes and so on, and what do we need to do to work back from that? What are the milestones that we need to achieve to get us there?

In answer to the question, I think we need to change our thinking. What we have done so far is great, and it is incremental. I think we need to change our thinking. In the eighteenth century, snuff was hugely popular, and it came and it went. It was so popular that the queen at the time was known as Snuffy Charlotte. It came and it went. If we are going to see the end of this epidemic, when do we really think that is going to happen? I think it is not unrealistic, on the basis of current trends, with measures such as this happening, to provide a time when cigarettes will no longer be legally sold, when tobacco companies are no longer allowed legally to peddle this known lethal drug, and to look at what people in tobacco control call the end game. I think the public would be strongly with that, and I suspect that when I talk about 25 years, I may even be erring on the side of pessimism, because I think things could move a lot faster than that. So, in answer to the question—I am sorry, it is a long answer to the question—

Mr J.A. McGINTY: Prohibition is what you are saying, ultimately.

Professor Daube : Prohibition on commercial sale, yes.

Professor Faulkner: If this product came on the market now, there is no way it would ever be allowed by government or anybody else, with the toxins, the carcinogens and everything else in it. If a new product came along—let us call it the Daube substance—and it had all those things in it, no government, of course, would allow it. The health authorities of that government—the agencies—would never allow it onto the market; it would not happen. Apropos what Mike has been saying, I think in the future you should not demonise the smoker; you should throw the ball back in the court of those who manufacture this substance and say, "Prove to us, prove to the state and prove to the health authorities that what you manufacture is a safe product. If you can't, it should not be sold, period." But it will take time to get there, because you would have to take the public with you, and to do it out of the blue would cause an uproar and drive it underground, with all the aspects of underground trafficking and so on that go with it. You would have to have the level of smoking in the community down to less than 10 per cent or whatever it might be.

Mr J.A. McGINTY: Yes, I think that is most probably the threshold.

Professor Faulkner: Yes, I think 10 per cent is probably the threshold. After that, you become a bit of a freak if you are doing it. As Mr Watson suggested, it is no longer the norm. You are an antisocial behaviouralist. You are like an arsonist, if you like. You are no longer welcome around the place. But you do not demonise the person who has the addiction; you attack those who are still promoting it.

The CHAIRMAN: And those who have a vested interest in promoting it.

Professor Faulkner: Yes, those who have a vested interest. It is a hugely profitable business. They are still making huge amounts of money. The manufacturing cost of a packet of cigarettes is miniscule compared with the price it is sold for.

Mr J.A. McGINTY: While we are waiting for that day—perhaps to Professor Le Souef—there is the distressing sight outside King Edward Memorial Hospital of pregnant women and women who have just given birth puffing away. What would work in reducing smoking by those people?

Professor Le Souef: I was just thinking about that as my colleagues were talking, and I thoroughly agree with the points they have made, of course. However, society has been a huge mover in stopping smoking in public places. There are very few public places where you can smoke, and this bill will see more of them disappear. I was at the university yesterday—my university—and I am ashamed to say that when we walk outside in the university grounds, outside the buildings, a lot of the staff are smoking.

Mr J.A. McGINTY: Is that still allowed on the university grounds?

Professor Le Souef: It is, and I intend to try to get that to stop, so that university students are no longer allowed to smoke. I think those are the sorts of things that we can do in the meantime that are important. There are 20 000 students at UWA, and UWA is not doing a heck of a lot about smoking. They were also in the news yesterday about drinking, which is clearly a problem as well. So I think we need to complete the work on tobacco use in public places to protect the public, but also, obviously, to protect children.

Then it comes to issues about private places. What do you do about people exposing their children to cigarette smoke in the home? You do not allow them to smack their children, bruise them or injure them. Is it fair to allow parents to knowingly damage their children's lungs in their houses? I think that is an issue that we need to think about next. As a paediatrician, I do not believe we should allow children to be injured in any way either in public places or in private. When it comes to pregnant women, it is a very difficult area. Clearly, the greatest degree of damage at any one time in human life is done to the unborn child, because it is getting the same toxic doses that the mother gets. It is not just the passive airborne levels; it is the active blood-borne levels that the baby is exposed to. We know that damages the baby in many ways, so we have to do something about it. Unless you were to stop the supply of tobacco to women, it is difficult to know whether—if women take illicit drugs, you do not prosecute them necessarily for what they have done to their baby, even though they could. So I think that that is an area that requires a lot of thought, but I do not have a solution for it at this stage. But anything that you do that reduces public smoking will reduce the number of smoking women.

The other point, I think, is Aboriginal health. Exposure of Aboriginal children to tobacco smoke when the mother is pregnant, as well as in childhood, is very much higher, and I think we need to do a lot more as a society to help those members of the community, because the degree of lung disease in Aboriginal children is much higher. So there is a lot to be done, I think. We know how to do it; we just have to go and do it.

[12.00 noon]

Mr J.A. McGINTY: Is the effect of smoking on Aboriginal communities masked by the lower life expectancy?

Professor Le Souef: That is probably part of it.

Professor Daube: That is an important part. Even so, tobacco is responsible for just under one-fifth of the gap. The single simplest thing that can be done to reduce the life expectancy gap is to reduce smoking in Aboriginal communities.

Mr J.A. McGINTY: I had not heard that figure before.

Professor Daube: I can provide material on that. It is the single most-doable activity. There have been three really encouraging developments in that area. It is interesting that although smoking among Aboriginals is still very high around the country and in WA, it is a little lower in WA than in other jurisdictions. That is partly because WA consistently has been ahead of other jurisdictions.

The first of those developments is that not just Aboriginal health organisations, but a range of Aboriginal organisations, are increasingly now seeing tobacco as a major issue for Aboriginal people and Aboriginal health. There has been a quantum shift in the way tobacco is seen by Aboriginal health organisations, ACWA and others, because they are seeing this as a top priority. That is encouraging. Secondly, a range of projects is currently underway. As I mentioned, the Australian Government has recently announced through the Prime Minister that reducing the rate of Aboriginal smoking is a really important priority, and that a raft of activities will be developed in that area. Whether it is slightly imperfect is almost immaterial. There will be a lot of activity in this area in communities as well as nationally that will have some impact. Just like smoking in the rest of the community, we cannot just have a one-off effort; it must be a major thrust. At the moment we are not doing enough. We are condemning Aboriginal people to a life expectancy gap that is outrageous.

Professor Faulkner: In response to that specific question, other than the prematurity issues, SIDS and childhood illnesses and so on, the sorts of illnesses that adults get, by and large, take time to come to the fore. It is probably a 30-year time period before the cardiovascular system starts to pack up to the degree that heart attacks, strokes and gangrene begin to occur, as well as lung cancer et cetera. There is a time lag. That is why, in answer to your question about longevity, it may be that many of those diseases are in train but a person dies of alcoholism, diabetes or kidney failure before the full impact of the tobacco smoking has caught up with him. Having said that, there is a huge morbidity rate that even the mortality rate does not address completely. By the time a 20-a-day smoker reaches 65—a little over Mr Daub's age—he would have about 25 per cent of his lung capacity left. However, a non-smoker would have about 85 per cent of his lung capacity left. That is why people start to stagger at that age. They may not get lung cancer, but they will get emphysema, and it will get worse and worse. It is a cumulative effect that causes damage all the time. Post-mortems were conducted on GIs in their 20s who were killed in the Korean War, and the doctors found more marked atherosclerotic changes in the arteries of the smokers than in the arteries of the non-smokers. The damage is happening all the time. The insidious nature of the damage is that it hits some people quicker than others, but it is happening to them all. That is part of the reason that we must do something about it.

The CHAIRMAN: We would love to hear more from you but unfortunately we have booked other witnesses. It has been very educational. I am sorry that we did not get back to you again, Laura.

Thank you for your evidence before the hearing today. 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. However, 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 all very much.

Hearing concluded at 12.05 pm