Supplementary Submission to the Inquiry into the Use and Marketing of Electronic Cigarettes and Personal Vaporisers in Australia

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We write in response to the publication of submission #336 by Public Health England and separate oral testimony. The submission is dated 16 October 2017. We were unaware when it was published on-line, but it has only last week come to our attention. While not naming Prof Chapman individually, this submission quotes two passages of evidence he gave to the Committee on 8 September 2017, in speaking to our submission (#313). The *Australian* newspaper ran a report about the PHE submission on 24 November titled "Health trio accused of presenting factual errors to ecig enquiry" which named him.

Vaping advocates on social media have been amplifying the PHE submission (see for example this) and challenging Prof Chapman to respond. We thereby make the following submission.

1. PHE comments about the UK's embrace of comprehensive tobacco control policy

in my evidence on 8 September, Prof Chapman said in response to a question from the Chair:

CHAIR: One of the things that is striking in this inquiry is the approach of the health sector in other countries—I particularly refer to the United Kingdom; I am sure it is not universal. There seem to be distinctly different views by the health sectors in the United Kingdom and Australia in relation to this issue. Does anyone have an explanation as to why both government and health advocacy groups in the UK have taken what is seemingly a distinctly different approach to that which we find in Australia?

Prof. Chapman: I can probably have a go at that. I have worked in this field for about 40 years; 17 years of that time was spent as deputy editor and then editor of Tobacco Control, the main journal. From that position, you get a sense of the fashions in different countries for particular approaches to tobacco control. The United Kingdom—but specifically England—has long taken a dominant, clinical approach toward tobacco control. By that I mean a dominance of dedicated clinics where individual smokers go along and see specialists and are given advice, but particularly pharmacological interventions: nicotine replacement therapy, Varenicline, Zyban, things like that.

Australia and the United States—indeed most countries—have tended to take what we call 'population focused' approaches to smoking cessation and to tobacco control generally: public policy approaches, mass-reach approaches, big, well-funded campaigns, price policy, advertising restrictions, smoke-free areas—that sort of thing. THE UNITED KINGDOM WAS VERY SLOW TO CATCH UP WITH THAT. THEY ARE NOW WELL UP WITH THE REST OF THE WORLD IN DOING THAT SORT OF STUFF. (our emphasis) The legacy of it is that many of the people who are in the leading positions of advising government policy over there are interventionists—people whose first thoughts about tobacco control are about what kind of pill, what kind of drug, what kind of chemical intervention can be used. So it was natural to see England go aggressively down the path of embracing e-cigarettes. It is a different approach to most other countries. I do a lot of work still—in retirement—advising people, training and that sort of stuff. You don't find that emphasis anywhere else—maybe in the United States to some extent, but nothing like the extent we see it in the UK.

PHE in their #336 submission stated: “It is also untrue to suggest that the UK was “very slow to catch on”.

They support this statement by referring to (1) the tobacco control policies advocated by the Royal College of Physicians of London Report in 1962 (2) A campaign run in 1970 by the Health Education Council (3) saying that UK tobacco tax has been explicitly aimed at reducing smoking since 1993 (4) naming the dates when the UK banned all tobacco advertising (2002) and smoke free legislation (2006) (5) noting that “For a short time the UK government was considering standard packaging at a time when the Australian Government had ruled it out” and (6) stating that “The UK, but especially England, has long taken a lead in comprehensive tobacco control. … The UK consistently scores highest in Europe on the independent Tobacco Control Scale”.

Our Response

The question put to Prof Chapman by the committee chair was about differences between Australia and UK. After commenting on the long-standing emphasis on individually focussed

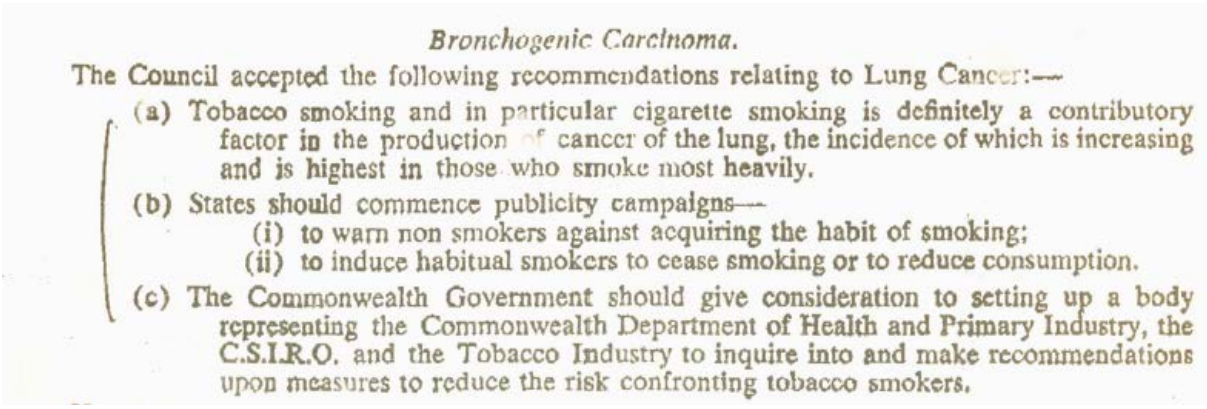
smoking cessation approaches in Britain, it was explicitly stated "they are now well up with the rest of the world" (in tobacco control policy).

However, given the focus of the chair's question on UK v Australia differences, it remains the case that Australia introduced and implemented many (if not most) tobacco control policies well ahead of the UK. Australia's Tobacco Advertising Prohibition Act was passed in 1992. The British equivalent was passed *a whole decade* later. Australia was years ahead of UK in smoke free area legislation (restaurants, bars). We banned smoking in the civil service in 1987. Graphic health warnings, retail display bans, minimum pack sizes, duty-free limits, plain packs, smoke free cars when children are inside, sales to minors (NSW introduced that in 1904!), reduced ignition propensity cigarettes: all of these were implemented in Australia before and sometimes well in advance of when they were implemented in the UK.

A large, comprehensive website Tobacco in Australia, provides information on the history of Australia's efforts.

It is true that the UK has long been the star performer in tobacco control in Europe. But there are many European nations which have been notoriously slow and tepid in their approach to tobacco control. It would not have been difficult to achieve top ranking in Europe with much of the competition there.

The 1962 Royal College of Physicians report was indeed an important early historical document in global tobacco control. However, it is little appreciated that Australia's NHMRC advocated for comprehensive tobacco control five years earlier in 1957 (see report of the 43rd Session of the NHMRC 23 May 1957 – excerpt below). The more important point however, is when the elements of comprehensive tobacco control policy were implemented. With the exception of pack warnings (UK 1971, Australia 1973) as stated above, Australia has implemented all tobacco control legislation and policy ahead of Britain.



Bronchogenic Carcinoma.

The Council accepted the following recommendations relating to Lung Cancer:—

(a) Tobacco smoking and in particular cigarette smoking is definitely a contributory factor in the production of cancer of the lung, the incidence of which is increasing and is highest in those who smoke most heavily.

(b) States should commence publicity campaigns—
(i) to warn non smokers against acquiring the habit of smoking;
(ii) to induce habitual smokers to cease smoking or to reduce consumption.

(c) The Commonwealth Government should give consideration to setting up a body representing the Commonwealth Department of Health and Primary Industry, the C.S.I.R.O. and the Tobacco Industry to inquire into and make recommendations upon measures to reduce the risk confronting tobacco smokers.

Excerpt from 1957 report of NHMRC

And as for PHE's statement "For a short time the UK government was considering standard packaging at a time when the Australian Government had ruled it out." It is difficult to understand how PHE could, in all seriousness, include this claim as an indication of the UK being somehow more advanced than Australia. They seem to be trying to count as something to boast about their government "considering" plain packs "for a short time"

(but doing nothing about it) *after* an earlier Australian government had also ruled it out in the late 1990s but then implemented it in 2012, ahead of the UK. As you would appreciate, governments considering actions without executing these actions are thoughts without effects of consequence.

The two graphs at the end of this submission show clearly that Australian smoking prevalence since 1990 has always been below that in Great Britain. It has only been in the most recent years that they have caught up. Vaping advocates seek to attribute the most recent falls largely to the popularity of electronic cigarettes. Affordability is well understood to be a key determinant of smoking and a separate very important explanation of the more rapid fall in smoking Britain has experienced in recent years. However, the English NHS report Statistics on Smoking in England, 2017 shows that in 2016, tobacco was 27 per cent less affordable than it was in 2006.

Another explanation about why English smoking prevalence has caught up with that in Australia in recent years is that following the implementation of plain packaging in Australia in December 2012, the tobacco industry engaged in major price discounting and sales promotion of (much cheaper) roll your own tobacco. In addition, the hugely successful national mass media quit campaign has been moth-balled since 2013 (see https://theconversation.com/cheaper-cigarettes-roll-your-own-tobacco-slows-smokings-downward-spiral-78745)

For discussion and quotations see: http://www.bbc.com/news/health-39720854

2. "95% safer than tobacco"

PHE argue that the "95% safer" than tobacco claim contained in their and the Royal College of Physicians' reports is a robust estimate of risk.

The provenance of this number lies in the Nutt report, as testified by PHE's Professor John Newton who said under oath to your Committee on 18/10/2017 "There's a lot of nonsense talked about-this 95 per cent figure. It's getting beyond a joke really. We are very clear that this is just one of the figures that we have used, and there are plenty more. *We say what really matters is that evidence underlying this figure came from the Nutt report*." (my emphasis)

So how robust is the evidence that informed the Nutt report estimate?

The Nutt report represented the guesses of 12 people selected by a process that has never been made fully transparent. Two of these are people with publicly declared affiliations with tobacco and/or vaping commercial interests; at least four are people who would never be in anyone's top 500 tobacco control researchers list, having little to no track record. Critically, there was no toxicologist in the group.

Most importantly, the Nutt report itself includes this important qualification

> "A limitation of this study is the lack of hard evidence for the harms of most products on most of the criteria."

Professor Robert West, the editor in chief of Addiction very correctly wrote in 2014

> "Given how long it took to discover the link between smoking and lung cancer when the risks were so great, we have to accept that it will probably be more than 30 years before we would have a chance of being able to use epidemiology to quantify risks from e-cigarette use. In fact we may never be able to do so because we are chasing a moving target in terms of the products and their development."

He then says that toxicological evidence is the only evidence that can be used to make judgements about the relative danger of electronic cigarettes compared with smoking.

Neither West not any of the Nutt group is a toxicologist. This recent (June 2017) review of the pulmonary toxicology of e-cigarettes. I would urge the Committee to read this report very carefully as it points to many important areas of understanding that remain very unclear regarding the toxicology of ecigarettes.

Additional comments regarding oral testimony provided to the Committee by PHE

Smoking cessation rates with e-cigarettes

It was submitted by Prof Newton that smoking cessation rates of up to 67% are achieved with e-cigarettes. This figure is both incorrect and potentially misleading. We fully understand that a 67% figure would seem impressive to the Committee knowing what is generally understood about smoking cessation success rates. This figure is derived from data regularly available from NHS-funded stop smoking clinics. These rates are self-reported quit rates from attendees who nominate a quit date - hence the overall very high quit rates compared to almost all other data on the success of smoking cessation.

The correct data are

2016/17	59% with e-cigarettes vs 51% unassisted; Champix success was 60%
2015/16	58% with e-cigarettes vs 51% unassisted; Champix success was 61%

These are not our figures – they are the published NHS data. Thus it is certainly possible to quit with electronic cigarettes, as it is without them, but quit rates with electronic cigarettes are not so exceptional as to turn public policy on its head.

Data are available at: https://data.gov.uk/dataset/statistics-on-nhs-stop-smoking-services-england

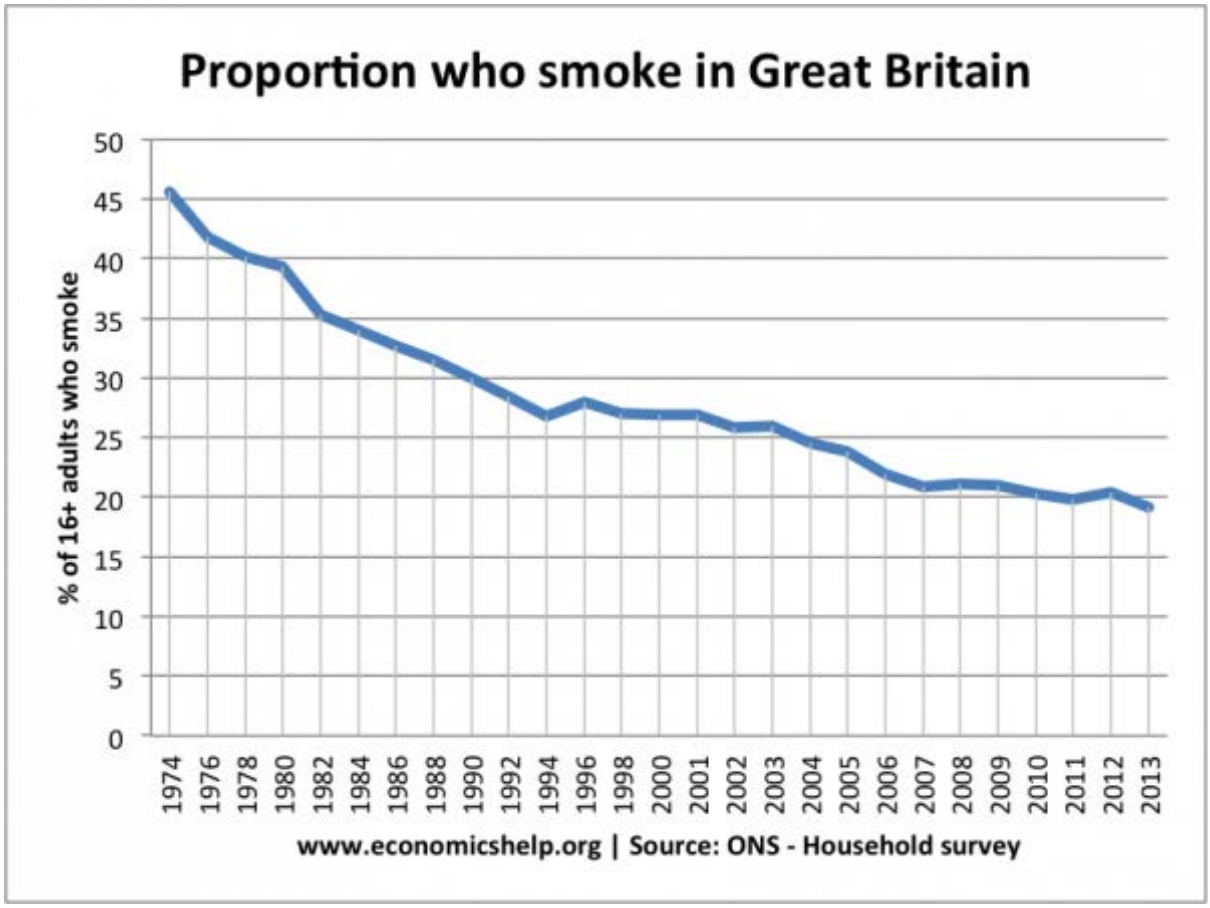
The nature of exhaled e-cigarette vapour

It is again stated by Professor Newton that "The smoke from tobacco smoking is much more dispersed than the vapour from e-cigs — and, of course, the point is that the vapour from e-cigs is a pretty benign substance. It is equivalent to what people use on stage to create a mist. So it is essentially water". We find this a puzzling statement unsupported by any evidence. Water is a small component of e-liquid. The lung does many things but it cannot turn vaping liquid into water. The droplets do absorb some water but paradoxically this property allows them to persist in the environment for long periods leaving their toxic constituents and fine heavy metal particles available for passive inhalation by by-standers.

We also find it unusual that PHE would be so confident that electronic cigarettes are safe, based only on opinion whereas ,with a similarly poor evidence-base, they suggest that heat-not-burn products are unsafe. Professor Newton again – "We would be having a completely different discussion if we were talking here about heat-not-burn tobacco products, but let's leave that one for now."

Summary

We find it most puzzling why PHE has inserted itself so prominently into this contentious debate in Australia. They may feel obliged to defend their stated position where it has been criticised. We have provided for the benefit of the Committee quite a number of examples where submissions and testimony are inaccurate or misleading. It is unfortunate that we have had to do this.



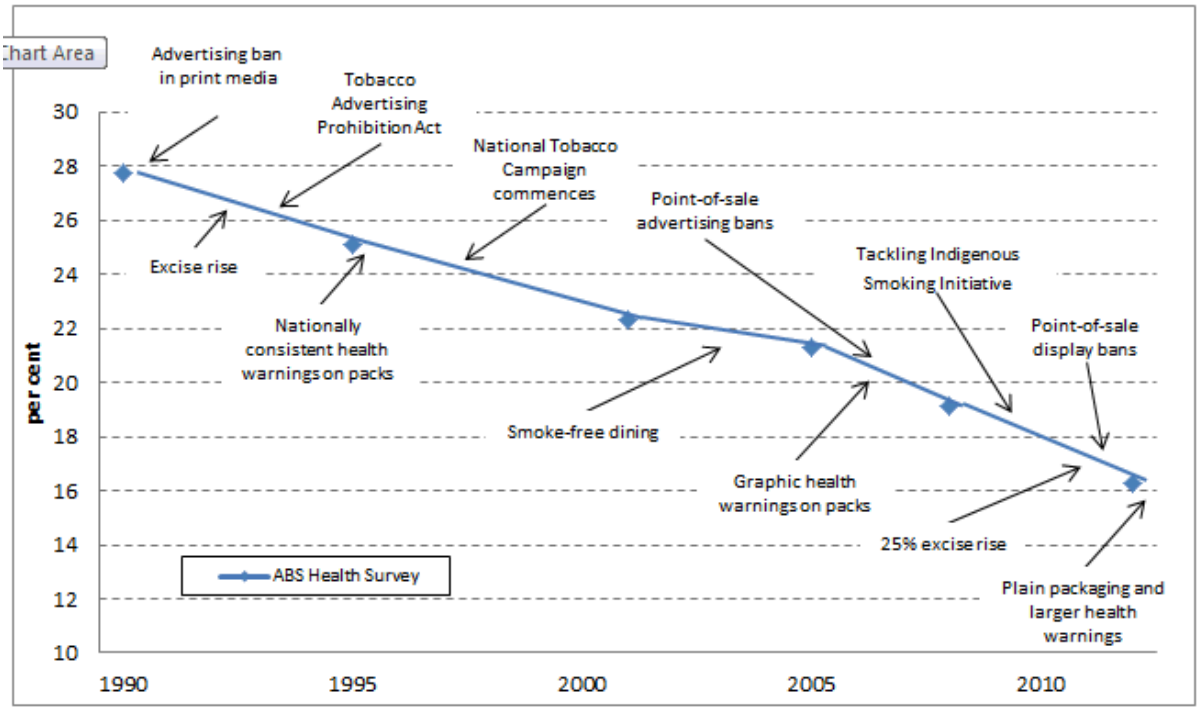


Chart Area
Advertising ban in print media
Tobacco Advertising Prohibition Act
National Tobacco Campaign commences
Point-of-sale advertising bans
Tackling Indigenous Smoking Initiative
Point-of-sale display bans
Excise rise
Nationally consistent health warnings on packs
Smoke-free dining
Graphic health warnings on packs
25% excise rise
Plain packaging and larger health warnings
ABS Health Survey
per cent
30
28
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