

A Submission to the Standing Committee on Health, Aged Care and Sport Inquiry into the use and marketing of electronic cigarettes (e-cigarettes) and personal vaporisers in Australia

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1. About the author

A graduate from the University of Western Australia, Woodward coordinated the follow-up study of Wittenoom asbestos miners. From there he moved to the Cancer Foundation WA to direct the Australian Council on Smoking and Health (ACOSH) from 1981 to 1984. As Director of ASH Australia from 1984 to 1992, he led campaigns for seven private members' bills and government bills in federal and state parliaments to ban tobacco advertising, to increase tobacco taxes, **ban smokeless tobacco** and to increase recurrent government expenditure on programs to reduce smoking, funded by increases in tobacco taxes. He also organised initiatives that led to bans on smoking on domestic airlines and in federal and state government offices, and provided litigation support to several high-profile cases including a successful prosecution of the Tobacco Institute over its misleading and deceptive conduct. He then became Deputy Director of ASH UK from 1993 to 1994, leading parliamentary campaigns in the House of Commons and House of Lords to ban tobacco advertising, which resulted in a pledge by the incoming government to pass legislation. From 1995 to 1999 he worked as a consultant on various Australian tobacco control projects and, in 2000, the World Health Organisation awarded him its Commemorative Medal in recognition of his contribution to tobacco control. He now runs his own business importing Australian abalone into the UK www.SeafoodAustralia.co.uk and has no financial interest in tobacco as an employee on a salary, grant recipient or consultant.

2. A brief history of Australia's tobacco control record

Like other comparable countries, Australia has a commendable record in reducing tobacco smoking prevalence in some groups and the resultant tobacco related disease rates, as the full health benefits of not inhaling tobacco smoke becomes apparent.

Sadly, the benefits of never smoking tobacco or quitting successfully are not shared evenly across all community groups of Australians.

Tobacco smoking rates and tobacco-caused disease rates remain significantly higher than the national average among Aboriginal people, among the disadvantaged, and among Tasmanians. The Commonwealth Department of Health websites record these data, and the targets to reduce tobacco smoking rates, and death and disease levels that **will not be met** by current strategies. <http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-kff>

3. The position of the Australian medical and health establishment

For the purposes of this section, the “Australian medical and health establishment” is defined as the Commonwealth and state/territory departments of health, and the major non-government medical and health organisations in Australia, including medical societies such as the Thoracic Society, and charities such as the cancer councils, heart and lung foundations.

Australia is a country with a relatively small population on an international scale. The number of people with expertise to be part of Australia’s medical and health establishment is a small subset of Australia’s total population. I was once a member of this small professional community and was able to witness its workings from the inside.

Within the organisations of Australia’s medical and health establishment, the number of health professionals that have any dealings with matters about tobacco is a smaller subset still.

Within the relatively small group of health professionals that have a strong interest in tobacco issues, a very small number exert a very strong leadership position. On occasions, this leadership position can be wrong, as it was with the bans on smokeless tobacco in the 1980s.

The Committee needs to be aware of the influence wielded by a very small group of determined Australian public health professionals on the issue of e-cigarettes.

The views of this determined group are out-of-step with public health colleagues in Australia and elsewhere in the world. The divergence of opinion between so called “Australian tobacco experts”, and international tobacco experts has led to an extraordinarily aggressive, sometimes abusive level of dialogue and correspondence on issues around e-cigarettes. Examples of this can be provided on request. This abusive discourse indicates that the differences of opinion are related to matters other than the scientific evidence, which is usually discussed in more dispassionate terms.

4. Why is the regulatory bar set so high for e-cigarettes?

It is hard to know why the Australian medical establishment has set the regulatory bar so high for e-cigarettes when their benefits are obvious.

As an example, take the position of the Commonwealth Department of Health, published on its website as recently as 1 May 2017.

Below is a screenshot of part of the webpage.

The page begins: “**Reduce the harm from tobacco.** The Department of Health is taking a precautionary approach to e-cigarettes and is continuing to examine the regulatory framework governing e-cigarettes in Australia”.

Reduce the harm from tobacco

📅 Page last updated: 01 May 2017

The Department of Health is taking a precautionary approach to e-cigarettes and is continuing to examine the regulatory framework governing e-cigarettes in Australia.

The Department has advised that there is evidence that e-cigarettes are harmful. On 3 April 2017, the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) issued an updated statement on e-cigarettes, to assist consumers and policymakers in understanding the current evidence about the safety and efficacy of e-cigarettes. The updated statement notes that there is insufficient evidence to support claims that e-cigarettes are safe. The updated statement also recommends that health authorities and policymakers should act to minimise harm to users and bystanders, and to protect vulnerable groups such as young people, until evidence of safety, quality and efficacy can be produced. The updated statement is available on the [NHMRC website](#) [↗](#).

E-cigarette regulation is a shared responsibility between the Commonwealth, state and territory governments. The current regulatory framework draws on existing legislation and regulations that may apply to tobacco products, therapeutic goods, poisons and consumer goods.

The *Therapeutic Goods Act 1989* (TG Act) and associated Regulations establish national regulatory controls that ensure the timely availability of therapeutic goods. To date, the Therapeutic Goods Administration (TGA) has not evaluated or approved any e-cigarettes for this purpose.

a. **Will a precautionary approach reduce the harm from tobacco?**

Yes, the precautionary approach will reduce the harm from tobacco, but not as fast as the harm from tobacco could be reduced if e-cigarettes were treated in Australia as they are in the EU, the UK, the USA, Canada and New Zealand.

The overwhelming burden of harm caused by tobacco is caused by “smoking tobacco”, that is tobacco that is ignited in the form of cigarettes (both manufactured and roll-your-own), cigars and pipes, and the smoke arising from the cigarette, pipe or cigar being inhaled.

Tobacco smoke contains over 7,000 chemicals

<http://www.quit.org.au/downloads/resource/facts-evidence/whats-in-cigarettes-fact-sheet.pdf> .

The disease risk varies by the total toxic load ingested by the smoker and varies by:

- i. What is smoked (cigarettes, cigars or pipes), including tar and nicotine levels;
- ii. How it is smoked, including depth of inhalation, for example puffed or inhaled;
- iii. How much is smoked, for example, numbers of cigarettes smoked per day, or grams of tobacco per day;
- iv. Whether the smoke is filtered or not;
- v. When it was smoked, for example the same number of the same brand of cigarettes smoked in the 1960s were probably more dangerous than cigarettes of the same quantity and brand smoked in the 1990s; and

- vi. Duration of smoking, with the longer a person smoking, the greater the disease risk.

The toxic load from e-cigarettes is much, much smaller than from smoking tobacco. Public Health England has estimated it to be about 5% of the load from smoking tobacco.

This puts e-cigarettes in the same ballpark from a disease risk perspective, as Low Nitrosamine Smokeless Tobacco (LNST) and snus, the idiosyncratic Swedish form of smokeless tobacco.

b. “The Department has advised that e-cigarettes are harmful”.

Yes, but in what dose and relative to what? This statement is misleading, and the question needs to be asked if it is deliberately misleading, in order to serve an unwritten agenda, or it is a mistake?

In my tobacco campaigning days, I remember a Philip Morris Executive proclaiming “even apple sauce is harmful if you have too much of it”

https://archive.org/details/tobacco_doo23e00 and
https://en.wikipedia.org/wiki/Death_in_the_West

Water is harmful, motor vehicles are harmful, any number of products in my kitchen, bathroom and laundry are harmful.

To conflate the possible harm arising from e-cigarettes with the harm caused by smoking tobacco is grossly misleading.

c. The NH&MRC CEO Statement on e-cigarettes

This statement as an objective analysis of the evidence about the health effects and possible harms of e-cigarettes is a pale shadow compared with international reports by similarly accredited health organisations. It begs the question how Australia’s NH&MRC can come up with conclusions that are completely opposite to the conclusions of similarly accredited international organisations on the issue of e-cigarettes.

d. The Therapeutic Goods Administration (TGA)

If e-cigarettes are defined as a therapeutic good, then the only companies that will be able to sell them in Australia are tobacco companies or big pharmaceutical companies, because they will be the only companies that will be able to afford the massive costs associated with getting therapeutic goods registered.

It is disingenuous for the TGA to persist with its furphy about considering an application from e-cigarette manufacturers.

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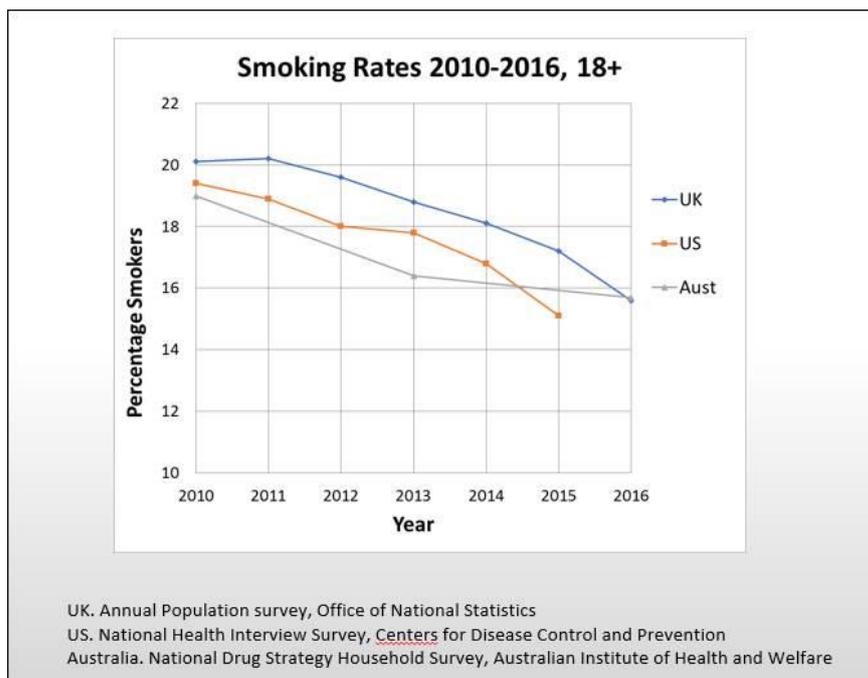
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5. Comparisons with other similarly developed countries

Australia's record in reducing smoking rates is in many ways similar to other developed countries with which we are often compared.



In comparable countries different strategies to reduce smoking were employed at

different times, but the outcomes have been very much the same. For example, in the USA, increases in tobacco taxation and bans on tobacco advertising occurred much later than in Australia and yet smoking rates and tobacco related disease trends are comparatively similar. This suggests, within orthodox bounds (the tobacco reduction strategies first advocated by the Royal College of Physicians of London in 1962), there is no absolute right approach or order in implementing tobacco smoking reduction strategies and no one can claim to know better than another.

However, by way of contradiction, I would like to suggest there is one stand out country, Sweden. Sweden's tobacco smoking rates and its tobacco disease and death rates are much lower than in comparable western countries.

The single distinguishing feature of Sweden's tobacco control policy is the long term use of snus. Snus is a smokeless tobacco product, quite different from the chewing tobaccos common in the USA and elsewhere.

Australia banned all smokeless tobacco products through various steps in the 1980s <http://www.tobaccoinustralia.org.au/chapter-18-harm-reduction/indepth-18a-smokeless-tobacco/18a-1-forms/> ,
<http://www.tobaccoinustralia.org.au/fandi/fandi/c09s4.htm>

I was very active agitator at the time for the state and federal campaigns to ban smokeless tobacco, writing submissions, making representations to members of parliament and government, and to the then Trade Practices Commission. Evidence from Sweden that suggested that the health outcomes for snus users was significantly different to users of other oral smokeless tobacco products was available at the time, but it was ignored, treated as an unexplained anomaly, and no distinction was made between snus and other oral smokeless tobacco products, which are a danger to health.

Among the "evidence" tendered by me, and others, to lobby for the ban on smokeless tobacco, was the "Sean Marsee" story <http://whyquit.com/whyquit/SeanMarsee.html> . Sean, a US citizen, died at 19 years of age from a particularly aggressive form of mouth cancer, which was diagnosed 10 months previously. Sean had chewed smokeless tobacco from the age of 12. This was one case of mouth cancer in a young person who used chewing tobacco – causal or coincidence? There is no good evidence of which I am aware that there are many cases of mouth cancer in teenagers who use smokeless tobacco. Evidence suggests that mouth cancer in younger people may be due to factors other than tobacco or alcohol
<http://www.nhs.uk/Conditions/Cancer-of-the-mouth/Pages/Introduction.aspx> .

However, with his and his family's permission, graphic photos of Sean pre and post surgery were used in the lobbying campaigns, and in Australia, to "good effect", because all smokeless tobacco products were eventually banned.

Today, a disturbingly similar technique of using graphic photos to create a greater

than necessary fear, are being used in the campaign to prohibit e-cigarettes, such as that below:



This person was apparently burned by an exploding lithium battery of a type used to power many mobile devices, such as phones, insulin pumps, and toys. Injuries occur when new technologies are used, particularly when used in a manner not advised or intended by the manufacturer. They are “harmful” products, to use the Department of Health definition, but they are not subject to the same regulatory restriction imposed upon e-cigarettes.

“Tobacco smoking is the leading cause of residential and total fire deaths in at least eight countries, including Australia. Between June 2000 and June 2006, 8% of deaths caused by fire in Australia were cigarette related. Nearly one-quarter of all fire deaths in Australia in 2004–05 occurred in fires started by cigarettes or matches. The total economic impact of these fires is conservatively estimated at \$63 million each year”, reference: <http://www.tobaccoinaustralia.org.au/chapter-12-tobacco-products/attachment-12-2-reduced-fire-risk-rfr-cigarettes/> .

Whatever harm from fires, burns and explosions that could be due to e-cigarettes if legalized in Australia, it would be a tiny fraction of that posed by smoking tobacco which is legal and unregulated by the Therapeutic Goods Administration.

If the use of e-cigarettes led to significant numbers of people smoking fewer cigarettes, as has been observed overseas, then the risk of fire and the resultant injuries from cigarettes would also be expected to be significantly reduced.

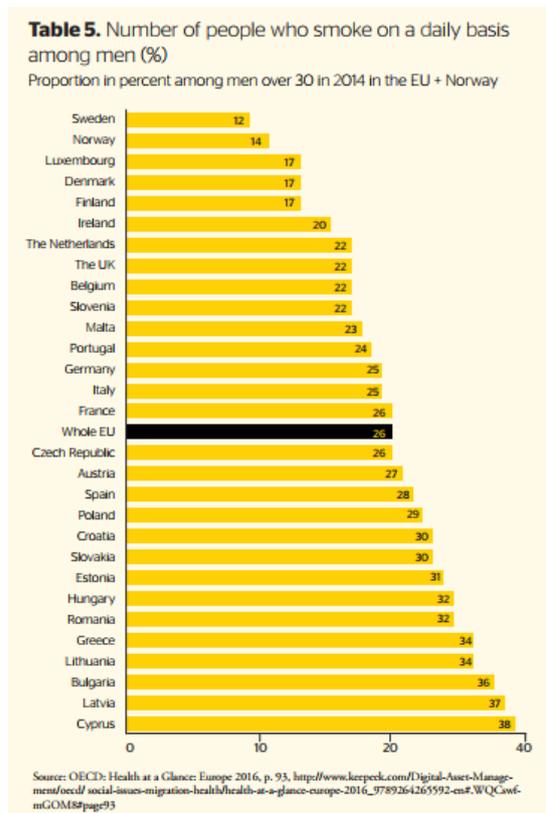
Widespread use of e-cigarettes, as a substitution for smoking tobacco, would be expected to lead to fewer fires, and resultant burn injuries whether caused by conventional cigarettes or e-cigarettes.

Health outcomes for Australia’s hard to reach tobacco smokers may have been very different today, if we had been innovative and followed Sweden’s lead, and encouraged Australian smokers then who would not quit, or could not quit, to use

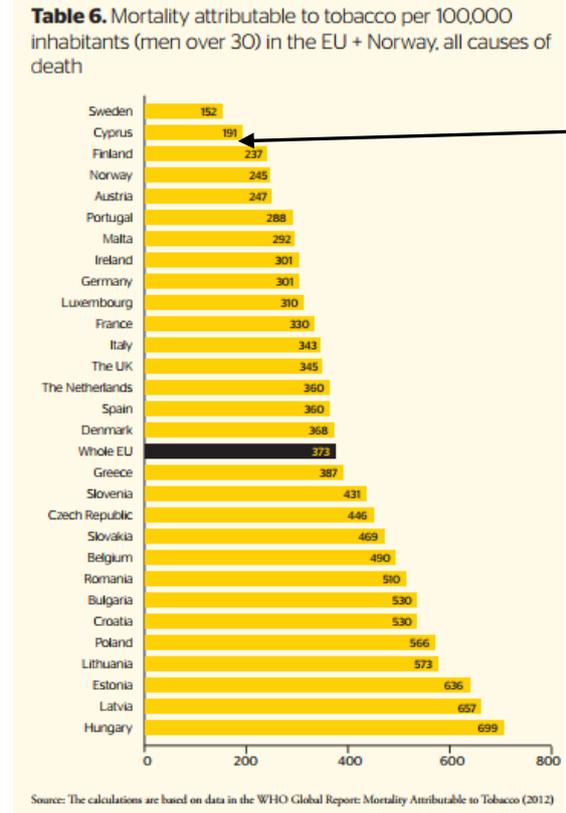
snus instead of smoking tobacco.

The Swedish Snus Commission released a report in June 2017 that estimated that 355,000 deaths from tobacco related diseases could have been prevented if other EU countries had the same tobacco disease rates as Sweden

http://snuskommissionen.se/wp-content/uploads/2017/06/Snuskommissionen_rapport3_eng_PRINT.pdf .



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Several Australian public health experts, individuals and organisations, bathe uncritically in self praise about roles played by them in reducing tobacco smoking levels.

The tobacco attributable mortality rate per 100,000 males aged 30+ years is 32% higher in Australia when compared with Sweden (201/152 per 100,000 persons) http://www.drugsandalcohol.ie/17205/1/WHO_tobacco_mortality.pdf . Most of this excess will be among disadvantaged Australians for whom the differential is far greater.

The number of Australian tobacco-smoking related deaths not prevented, and levels of tobacco-smoking related disease that have not been reduced can be estimated, using the Snus Commission approach but this would make uncomfortable reading for those advocates (including me) who ignored the evidence and did not distinguish snus from other oral tobacco products during the 1980s campaigns on smokeless tobacco.

It needs to be kept in mind that the evidence of the virtues of snus preceded by

several years the introduction of the various nicotine replacement therapies by the pharmaceutical industry, which are broadly supported by Australia's medical and health establishment.

Why the majority of Australia's so called public health experts, both at the individual level and the organisational level (eg NH&MRC), opposed snus and still oppose it today, despite the compelling evidence of its benefits suggests a prejudice or bias. <https://www.mja.com.au/journal/2008/188/1/should-australia-lift-its-ban-low-nitrosamine-smokeless-tobacco-products> ,

There is no room for prejudice, bias, emotional rhetoric or unsubstantiated fears when determining public health policies. Only a sound evidence based approach should be followed.

6. Recent International Reviews on e-cigarettes

There have been a number of recent reviews of the available evidence on the use of e-cigarettes. Several of these reviews have been used to support public policy changes which have led to, or are leading to, the legal use of e-cigarettes in several countries often compared with Australia, for example, the USA, UK and the rest of the EU, Canada and New Zealand.

The list of reports include:

- a. Public Health England <https://www.gov.uk/government/news/e-cigarettes-around-95-less-harmful-than-tobacco-estimates-landmark-review>
- b. Royal College of Physicians of London
<https://www.rcplondon.ac.uk/news/rcp-statement-e-cigarettes>
- c. UK Centre for Tobacco and Alcohol Studies
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf and
- d. University of Victoria Centre for Addictions Research, Canada
<http://www.uvic.ca/research/centres/carbc/assets/docs/report-clearing-the-air-review-exec-summary.pdf>

The tone and conclusions of these international reports is in many parts quite very different to Australia's NH&MRC CEO Statement on e-cigarettes, the publicly expressed opinions of many of Australia's non-government medical and health organisations, and some of Australia's "public health experts".
https://www.nhmrc.gov.au/files_nhmrc/publications/attachments/ds13_nhmrc_ceo_statement_ecigarettes.pdf

Why this is so is not readily apparent when the same body of scientific literature is being examined and reported upon.

Whereas Australia's peak medical and health bodies are in agreement with their international contemporaries on just about every other medical and health issue, they appear to be in vigorous disagreement over e-cigarette policy. Someone is right and someone is wrong. The number of international experts and organisations which who have looked at the issues around e-cigarettes, and the detail to which they have reported, is significantly larger than reports and press releases made by Australian individuals and organisations.

Why should the Australian medical and health establishment be right, and similarly competent international organisations be wrong? Are Australian authorities being led into error, again, in the area of smokeless tobacco policy by a small group of noisy, prejudiced and determined public health advocates?

It would be unusual but not without precedent for parliament and government not to follow the recommendations of the NH&MRC on a matter of health policy.

Indeed throughout the 1950s, 1960s, and 1970s successive federal and state governments appeared untroubled in ignoring recommendations by the NH&MRC on what to do about smoking tobacco, and how to reduce its disease impact.

It is ironic that it appears that the advice of the NH&MRC is to be ignored again if the health benefits of e-cigarettes are to be enjoyed by Australia's tobacco smokers who cannot or will not stop smoking tobacco.

7. Major Findings of the International Reviews

a. Users of e-cigarettes inhale significantly less toxins than smokers of combustible tobacco.

Public Health England has estimated that users of e-cigarettes inhale about 5% of the toxins that smokers of combustible tobacco inhale. It does not appear to be a point of contention that the toxic dose of e-cigarettes is less than conventional smoking tobacco. The contentious point appears to be by how much is e-cigarette vapour less toxic than conventional tobacco smoke – 10% less, 50% less, or 95% less?

Whatever, if fewer toxins are inhaled, less disease and premature death will result. This dose response relationship has been shown conclusively with smoking tobacco.

Sir Richard Doll and Sir Richard Peto conducted the 50 year follow-up study of British doctors

<http://www.bmj.com/content/bmj/328/7455/1519.full.pdf> .

The results were published in 2004. Table 1 from the report shows the health effects of a lower dose of inhaled tobacco toxins. For smokers of 1 to 14 cigarettes a day the mortality rate for lung cancer was 1.31 per

100,000, while for smokers of 15 to 25 cigarettes day, the lung cancer death rate was nearly doubled at 2.33 per 100,000, and for smokers of 25 or more cigarettes a day, the rate is almost doubled again to 4.17.

Table 1 Cause specific mortality by smoking habit, standardised indirectly for age and study year, for all 34 439 men born in 19th or 20th century (1851-1930) and observed 1951-2001

| Cause of death | No of deaths 1951-2001 | Age standardised mortality rate per 1000 men/year | | | | | | | | Standardised tests for trend (χ^2 on 1 df)* | | |
|--|---------------------------|---|--|-----------------|--------------------------|-----------------|-----------------|-----------------|-----------------|--|--------|---------|
| | | Lifelong non-smokers | Cigarette smokers (no other smoking habit previously reported) | | | | | | Other smokers | | N/XXC† | Amount‡ |
| | | | Former | Current | Current (cigarettes/day) | | | Former | Current | | | |
| | | | | | 1-14 | 15-24 | ≥25 | | | | | |
| Cancer of lung | 1052 | 0.17 | 0.68 | 2.49 | 1.31 | 2.33 | 4.17 | 0.71 | 1.30 | 394 | 452 | |
| Cancers of mouth, pharynx, larynx, oesophagus | 340 | 0.09 | 0.26 | 0.60 | 0.36 | 0.47 | 1.06 | 0.30 | 0.47 | 68 | 83 | |
| All other neoplasms | 3893 | 3.34 | 3.72 | 4.69 | 4.21 | 4.67 | 5.38 | 3.66 | 4.22 | 32 | 36 | |
| Chronic obstructive pulmonary disease | 640 | 0.11 | 0.64 | 1.56 | 1.04 | 1.41 | 2.61 | 0.45 | 0.64 | 212 | 258 | |
| Other respiratory disease | 1701 | 1.27 | 1.70 | 2.39 | 1.76 | 2.65 | 3.11 | 1.69 | 1.67 | 44 | 70 | |
| Ischaemic heart disease | 7628 | 6.19 | 7.61 | 10.01 | 9.10 | 10.07 | 11.11 | 7.24 | 7.39 | 138 | 133 | |
| Cerebrovascular disease | 3307 | 2.75 | 3.18 | 4.32 | 3.76 | 4.35 | 5.23 | 3.24 | 3.28 | 48 | 65 | |
| Other vascular (including respiratory heart) disease | 3052 | 2.28 | 2.83 | 4.15 | 3.37 | 4.40 | 5.33 | 2.99 | 3.08 | 77 | 94 | |
| Other medical conditions | 2565 | 2.26 | 2.47 | 3.49 | 2.94 | 3.33 | 4.60 | 2.49 | 2.44 | 34 | 54 | |
| External causes | 891 | 0.71 | 0.75 | 1.13 | 1.08 | 0.79 | 1.76 | 0.89 | 0.92 | 17 | 27 | |
| Cause unknown | 277 | 0.17 | 0.28 | 0.52 | 0.39 | 0.57 | 0.59 | 0.25 | 0.31 | 16 | 24 | |
| All cause (No of deaths) | 25 346 | 19.38 (2917) | 24.15 (5354) | 35.40 (4680) | 29.34 (1450) | 34.79 (1725) | 45.34 (1505) | 23.96 (5713) | 25.70 (6682) | 699 | 869 | |

*Values of χ^2 on one degree of freedom for trend between three or four groups: values ≥ 15 correspond to $P < 0.0001$.

†N/XXC compares three groups: lifelong non-smokers, former cigarette smokers, and current cigarette smokers. Amount compares four groups: never smoked regularly, and current cigarette smokers consuming 1-14, 15-24 or ≥ 25 cigarettes/day when last asked.

For any given number of smokers, it does not matter if the population smoking rate is 5%, 10% or 50%, if they inhale fewer tobacco related toxins, fewer will get sick of tobacco and die from tobacco related diseases. This is shown by the effects of snus in Sweden, the 50 year follow-up study by Doll and Peto, and many, many more studies.

Another British study looked at the health impact of switching from cigarettes to pipes and cigars <http://www.bmj.com/content/314/7098/1860> . The principal author of this study, Professor Nicholas Wald, appeared as an expert witness in the Australian Federal Court case, the Australian Federation of Consumer Organisations v Tobacco Institute of Australia (1991) <http://www.tobaccoinaustralia.org.au/fandi/fandi/c06s3.htm> .

Wald's 1997 study found **“Cigarette smokers who have difficulty in giving up smoking altogether** are better off changing to cigars or pipes than continuing to smoke cigarettes. Much of the effect is due to the reduction in the quantity of tobacco smoked, and some is due to inhaling less. Men who switch do not, however achieve the lower risk of pipe and cigar smokers who have never smoked cigarettes. All pipe and cigar smokers have a greater risk of lung cancer than lifelong non-smokers or former smokers”.

Further the study reported **“This prospective study shows that smokers who switch from cigarettes to pipes or cigars halve their combined risk of dying of lung cancer, ischaemic heart disease, or chronic obstructive lung disease** compared with continuing smokers, but their risk was still about 50% higher than that of lifelong non-smokers”.

“Some of this reduction in risk was due to reduced inhaling, but most of it was due to a reduction in the amount of tobacco smoked”.

“The best option is either not to smoke or to give up altogether, failing that, switching to pipes or cigars is better than continuing to smoke cigarettes”.

It is not a big leap to substitute vaping e-cigarettes for pipes or cigars “for cigarette smokers who have difficulty in giving up smoking altogether”, and expect that vapers who switch from cigarettes will have a significantly improved health outcome, as described by Wald.

The improved health outcome with a lower toxic tobacco smoke dose, as described by Wald in his study of 21,520 men, is entirely consistent with the health outcomes of the nation of Swedish men who have reduced their toxic cigarette smoke exposures by switching to snus.

For organisations and individuals within the Australian medical and health establishment, especially those with special interests in cancer, heart disease and/or chronic obstructive lung disease, that do not draw public attention to these benefits, either by way of public statements or by submission to this inquiry, may suggest a selective treatment of the evidence.

b. e-cigarettes help smokers to quit smoking tobacco.

I am persuaded by the evidence advanced in the major international reports that e-cigarettes help smokers to quit smoking tobacco.

c. The availability of e-cigarettes in environments comparable with Australia is not accompanied by an increase use of tobacco by children and young adults.

I am persuaded by the evidence advanced in the major international reports that e-cigarettes, marketed with reasonable controls, do not pose an unreasonable risk (everything is a risk) in encouraging tobacco use, or e-cigarette use by children and young adults.

d. Secondhand e-cigarette vapour has not be shown to be dangerous to health.

I am persuaded by the evidence advanced in the major international reports that e-cigarette vapour does not pose a significant health risk to bystanders, and whatever risk e-cigarette vapour poses, it will be many

orders of magnitude lower than say the risks posed by motor vehicle exhausts in busy Australian cities.

Conclusions.

I truly believe e-cigarettes should be legalized in Australia because they will bring significant benefits to the health of tobacco smokers who cannot or will not quit. These health benefits will also result in proportional economic benefits.

I am particularly concerned about the “hard-to-reach” groups in the Australian community who continue to smoke at high levels and am less concerned about the mostly white, educated and privileged Australians who continue to show pleasing falls in their tobacco smoking rates.

Current strategies do not seem to be achieving desired falls in smoking rates in “hard-to-reach” groups and an innovative approach is needed.

I do not believe that the introduction of e-cigarettes poses any significant risk to Australian children and young adults who would not otherwise have experimented with smoking tobacco, or become smokers of smoking tobacco.

I regret that my current employment importing Australian seafood to the UK does not permit me to be more exhaustive in examining the evidence on this issue.

I would be happy answer questions or to expand on my evidence to the Committee if requested to do so by the officers serving the committee. My best point of contact is email, [REDACTED].