PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts

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Standing Committee on Health and Wellness

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LOCATION: LEGISLATIVE CHAMBER, HON. GEORGE COLES BUILDING, CHARLOTTETOWN

SUBJECT: BRIEFING FROM THE COUNCIL FOR A SMOKE FREE PEI

COMMITTEE:

Jordan Brown, MLA Charlottetown-Brighton [Chair]
Dr. Peter Bevan-Baker, Leader of the Third Party
Kathleen Casey, MLA Charlottetown-Lewis Point
Darlene Compton, MLA Belfast-Murray River
Bush Dumville, MLA West Royalty-Springvale
Colin LaVie, MLA Souris-Elmira (replaces James Aylward, MLA Stratford-Kinlock)
Chris Palmer, MLA Summerside-Wilmot
Hal Perry, MLA Tignish-Palmer Road

COMMITTEE MEMBERS ABSENT:

James Aylward, MLA Stratford-Kinlock

MEMBERS IN ATTENDANCE:

none

GUESTS:

Canadian Partnership Against Cancer (Dr. Ian Reid); Council for a Smoke Free PEI (Dr. Scott Campbell, Sarah Crozier, Joanne Ings, Marlene Mulligan)

STAFF:

Emily Doiron, Clerk Assistant (Journals, Committees and House Operations)

Edited by Hansard

The Committee met at 10:00 a.m.

Chair (J. Brown): Okay folks, we'll call the meeting to order. We're a couple of minutes after 10:00 a.m. there.

I'm Jordan Brown. I went around and introduced myself, I think, to everybody before we got going. But before we get going, perhaps what we'll do is we'll go around the room here and I'll ask the group to introduce themselves kind of in a horseshoe fashion, and perhaps we'll start with Colin LaVie.

Mr. LaVie: Colin LaVie, MLA for Souris-Elmira.

Dr. Bevan-Baker: Peter Bevan-Baker, MLA for Kelly's Cross-Cumberland.

Ms. Casey: Good morning. I'm Kathleen Casey and I represent Charlottetown-Lewis Point.

Ms. Compton: Good morning. Darlene Compton and I represent Belfast-Murray River, District 4.

Chair: Perhaps, Joanne, if we could just go across the –

Joanne Ings: Do you want me to go this way? Sure. Yes.

Chair: Yeah, sure.

Joanne Ings: Joanne Ings with the PEI Lung Association.

Sarah Crozier: I'm Sarah Crozier with the PEI Heart and Stroke Foundation.

Dr. Ian Reid: I'm Ian Reid and I was with the Tobacco Control Committee of CPAC, which is the Canadian Partnership Against Cancer.

Marlene Mulligan: Marlene Mulligan with the Canadian Cancer Society.

Dr. Scott Campbell: Dr. Scott Campbell. I'm here representing the medical society as the past president and current chair.

Mr. Perry: Hal Perry, MLA for Tignish-Palmer Road.

Mr. Palmer: Chris Palmer, MLA of Summerside-Wilmot.

Mr. Dumville: Bush Dumville, MLA for West Royalty-Springvale.

Clerk Assistant (E. Doiron): Hi. I'm Emily Doiron. I'm the committee clerk for this committee.

Chair: Great, thanks everybody.

First off, I'll call for a motion for adoption of the agenda.

Ms. Casey: So moved.

Chair: Thank you, Kathleen.

Before we get going, I think this is our first committee meeting in the new Chamber, so I guess I'll say to the group that's presenting: Bear with us. I think it's my first time with a presentation happening, which you can see is behind my head literally, so this may be a bit interesting. So you guys know, too, this is available on live stream I guess, Emily?

Clerk Assistant: Facebook and the website.

Chair: Facebook and the Assembly website, and the presentation is concurrently available there, so you can tell people about it later. I think you can find it on the website later, so you'll have a record of kind of a living record of your presentation here today.

That's great in that sense, but it means that we need to maintain some order and when I say that, really what it means is that we can't have more than one person speaking at a time. What I'm going to ask the members to do, and I've already spoken with Dr. Reid about this, it's their preference that we ask questions during the presentation, so basically, what I'll ask is that you get my attention. I'll stop the presentation and we'll go along with questions like that. Hopefully that works all right.

I guess I'll ask if there's anything else the clerk can think of that I need to –

Clerk Assistant: Well I guess just for the microphones, that only one of the microphones on the floor on the members' desks can be on at one time, so the Chair

will be recognizing members before they can speak and that way we'll have our microphones on and that the video camera is on whoever is speaking as well.

Chair: Perfect.

Despite all of the formality, we'll try and make things as easy to go along as possible. If any of you need to leave for a moment or whatever, that's fine. If you wanted to take a minute as a group, that's fine. Just let us know and we can stop the meeting and take a brief recess or whatever is required. There's water, I think, on the table in front of you. There's likely coffee around if you need something to get you going and otherwise, unless there's any questions that you would have of us, we would turn the floor over to you folks for introductions and the presentation.

Dr. Ian Reid: Thank you.

I'm not used to presenting sitting down, but I was told that that would be preferable so I could still be on camera, so I will make the adjustment.

First of all, Mr. Chairman and honoured members, I'm very grateful and on behalf of all of us, I'd like to thank you for the opportunity to present before you this morning. I know from our conversations together that you have a personal interest in some of these issues and the group of five here represent, really, the many dimensions of the issue that tobacco creates for us and for people in PEI. My hope is, today, to give you some up-to-date figures and the reality of what tobacco impact is in our province, and some of the realistic and manageable options that I think this committee could carefully consider and possibly, hopefully, take back for reflection in the Legislature.

Introductions have already been given, so the people that you have in front of you; we have the cancer society, lung association, heart and stroke, the Medical Society of Prince Edward Island and CPAC all represented here this morning.

Smoking is the most preventable cause of the number one, two, and three most common causes of death. That's cancer, heart disease and stroke. Overall, those who are smoking regularly, half of them will die of a smoking-related disease. In fact, an Islander dies every two days from smoking-related disease. A real tragedy is that many of these are well before their elderly years with premature death happening in at least 25% of these smoking-related deaths. These are people in their periods of productivity and that is a substantial group that we are losing to the province.

Forty per cent of smokers will develop cancer sometime in their lifetime; 40%. On top of that, many will develop severe debilitating diseases, whether they're the emphysema or chronic bronchitis or vascular disease. Of course, many people who have a stroke now don't die, but we have many people surviving with serious disabilities as a result of stroke and tobacco is the number one cause of stroke.

Overall, lifelong smokers will lose about 15 to 20 years of their life span. That's actually up from a few years ago. But if you think about it, the average lifespan of a male in Prince Edward Island is about 83 years – 15 years – when you're 60, that 15 years looks pretty important.

Chair: Could I just ask a question?

When you say (Indistinct) do you mean that's improved or it's gotten worse, the 20 and 25 years ago?

Dr. Ian Reid: The estimates now are worse. I think part of it is that although smoking prevalence has dropped some, those who are still profoundly addicted are smoking proportionately a lot, therefore the impact is even proportionately greater.

Another startling figure is that 5% of the tobacco-related deaths are due to second-hand smoke. Nicotine is the most addictive chemical on the planet. It is more addictive than cocaine, more addictive than opiates and all of the addictive potential of all other drugs are all related to nicotine as the standard, and the standard starts at 100. Nicotine is 100 and everything is below that.

As a result, it is the most difficult addiction to overcome. Any of you who are familiar with AA and I am because our church has AA regularly and many of the people who have managed to beat their alcohol addiction

are out at breaks having a smoke usually with a Tims.

Chair: Doctor, Colin LaVie would like to ask a question.

Mr. LaVie: Thanks from the committee for coming in.

I am a smoker that is in the program as we speak. I am a non-drinker, that is, in the addictions program for 15 years now. I see how difficult it is for non-smokers. As a first responder I see a lot of incidents with smokers, whether it be cancer related, stroke related, fire related, where do you stand with the new law on marijuana coming in?

Dr. Ian Reid: I think that's an important issue and I know that with the national meetings at CPAC, it was very much a topic of conversation, because firstly, very few people smoke marijuana who haven't already started by smoking cigarettes. There is no question that there are health risks associated with marijuana that, including malignacies, including precipitation of psychotic breaks in young people. These concerns are very much co-related with smoking in general.

I think that maybe at the end of the presentation, Mr. LaVie, we can even expand a little bit further on that. I imagine members of this group may have their own perspectives on the issue of marijuana, I don't think there's any question; it's here to stay. Now it's a matter of harm reduction, I suspect.

Mr. LaVie: So we will touch on it after?

Dr. Ian Reid: Sure.

Mr. LaVie: Okay, sure.

Dr. Ian Reid: More than half of the people who try to quit, their smoking habit will fail within a week. Withdrawal from nicotine, the symptoms occur within a couple of hours. For some, the withdrawal symptoms are very powerful and demand that they do something about it and it usually means another cigarette.

Nicotine addiction is not a failure of the will of people trying to quit because the majority of people are well aware of the health risks, they're well aware of how important it is to try to quit. They have families are who are constantly trying to remind them of the risks to their loved one. But once addicted, it becomes a very complex condition of both neurological, bio-neurological features with profound addiction and the environment, the psychological aspects, the many different reasons why it's very difficult.

Starting smoking is a choice, but ending smoking is much more difficult and it's not an issue just of someone's willpower.

The other issue with nicotine is, as we mentioned a moment ago, Mr. LaVie, it is considered a gateway drug. Almost all people who have become users of illicit drugs started with tobacco. Conversely, very few people become involved with illicit drugs who have not been smokers to begin with.

Currently, we have about 20,000 smokers in the province; about 15%. Back a generation ago the prevalence of smoking was probably closer to 50%. However, the rate of quitting now has plateaued, so we are not making the same gains now. Now we're dealing much more with the hardcore addicted smokers.

Also, look carefully at the people who are smokers. The majority are low-and middle-income people. The incidence of smoking amongst those with mental illness is about one in four. Amongst our Aboriginal community it's more than half. These are people who can ill-afford to continue their tobacco use, and yet this is where 80% of the smokers are in these low-and middle-income groups.

Approximately 1,000 Islanders quit smoking every year, but half of those are replaced by young smokers who are starting out. Therefore, that is a target group that is vital to address. Because although we are managing to have about 5% of our smokers quit, half of them are replaced that year with young people.

Chair: Dr. Reid, can I ask a question on that?

Dr. Ian Reid: Yes.

Chair: Do you have a sense of at what age – I suspect it's not everybody starts at the

same age – but is there kind of a bell curve at a particular age or over a couple of years where the young folks would start?

Dr. Ian Reid: Do any of you have any thoughts on that issue? To my knowledge, Mr. Chairman, the majority of these are starting before the age of 20.

Marlene Mulligan: I can comment on that. I know we have some counsel members in the gallery as well who are very familiar with the data. What we've seen, I think, is actually, there are cohorts of smokers so you can see in the age groups as you look at the data. We are seeing that early beginning cohort, actually, moving a little bit up in age. So, we're actually seeing more youth uptake in that 20 to 25 range, than we would have a decade ago, I believe. But I believe what Dr. Reid is referring to is likely a youth group that would be from 13 to 25, in the statistic that he's providing there.

Chair: Thank you, Marlene.

Dr. Ian Reid: One of the things I think is important is for all of us to accept is that tobacco is not a private individuals problem alone, it is very much a public health issue. Therefore, is something that requires a comprehensive public health approach.

Chair: Hal Perry.

Mr. Perry: Thank you, Chair.

Just to go back to that last slide; when you talked about 20, 30 years ago, 50% of Islanders did smoke, and now the percentage is around 15. So, there has been positive movement and education to bring that number down to 15%; I think that's a significant decrease, I mean the amount of smokers on the Island, so something is right. But what's wrong where there are 500 young people every year that's starting to smoke? Are we missing something with that demographic or –

Dr. Ian Reid: I think there's much that can be done with that demographic and I think that probably a good analogy of what's happening with the use of alcohol and driving, for example, there's been a paradigm shift that I'm sure you're aware of that in the last decade or so, where the acceptability of heavy drinking followed by driving has become socially completely unacceptable. Once public attitudes fed by their knowledge changes the way these behaviours are seen, and particularly younger people when they have peers who are providing peer support, peer education just like SADD, the Students Against Drunk Driving, are doing in the high schools, similar efforts at that level, particularly involving peers, are likely to make a difference and that's something that probably can be dramatically improved.

Now, the 50% smoking rate was actually from the 1950s. It's not 25 years, it's 50 years ago. As you know, back in the 1950s, it wasn't until the early 1960s that the health risks of tobacco, in spite of the suppression of this by the tobacco industry, they finally became more public and understood.

Chair: Do you know, Dr. Reid, if I might – and maybe this is dealt with later in the presentation, but is there a statistic as to how many of the 500 that are starting each year come from families where one or more parent or a sibling or whatever smokes?

Dr. Ian Reid: I don't have that. Intuitively, I would think that the chances of being a smoker are much greater if you happen to be in a family where smoking is tacitly acceptable. Parents' behaviour as opposed to what they say is often a greater guide for the young person in what they consider acceptable. So, intuitively I would say yes and I think, to expand on that Mr. Brown, I think that if in fact we are capable of reducing the number of adult smokers, therefore reducing the acceptability of tobacco in the family environment, that can only help to being the deterrent for the young people growing up in that environment from smoking. I think that's an insightful thought.

Marlene Mulligan: I can comment on the evidence, if you like. I can comment on the evidence to that.

Chair: Sure.

Marlene Mulligan: So there is evidence and research that indicates that, specifically about teenagers and their likelihood in becoming a smoker in relationship to family in which there is smoking and it's something like 50% or greater. We wouldn't have PEI-

specific data on that, but broadly speaking that's quite well known, to your intuition, yes.

Chair: If you're a teenager in a household that has a smoker, your chances are 50/50 that you'll be one?

Marlene Mulligan: Yes.

Chair: Yes? Okay.

Is that – just if you follow through the data that's there – we heard already, nicotine is the most addictive drug going; second-hand smoke kills 5% - or 5% of the deaths are related to second-hand smoke. I presume that you can become addicted to Nicotine by second-hand smoke as well as smoking it directly?

Dr. Ian Reid: Well, from a pharmacological point of view, if you're exposed to enough of it, I suppose. I am not aware of examples of that – people, who, because they have been exposed to second-hand smoke so often then become smokers just to deal with the withdrawal. It's conceptually possible. I think the main issue with second-hand smoke is the potential impact on innocent people on their health.

Chair: Just a follow-up on that point – the recent changes to laws relating to adults or parents, or whatever, smoking in cars with children in the car, have we started to see the front end of any change related to those changes? Going further back from that, I guess, I should mention no smoking within 15 feet of public spaces and the recent changes that have happened in, say, the last 15 years?

Marlene Mulligan: I can comment on that if you like.

Dr. Ian Reid: Yes, go ahead Marlene.

Marlene Mulligan: Sure.

The Canadian Cancer Society, of course, has been a strong advocate for smoke-free places across the country, but in PEI as well. The data does bare out the changes – when would it be – 15, 20 years ago where it started to be banned in restaurants, right, in common public places – that's certainly those trends are there. In terms of the changes, the kind of tweaking that we've seen, at least in our local data we're not seeing a strong indication.

As Dr. Reid mentioned earlier, there's really been a plateau in our smoking rights since about 2007-2008, so coming onto a decade, which can be related back, actually, to government investment, both federally and provincially, around that. On the smoke free places, there are more in our current legislation that we recommend having that ban because the affect on youth. Again, going back to what Dr. Reid said, there is a normalization. So if you extrapolate that idea that the evidence shows that a teenager in a home with smoking is much more likely to adopt that practice, well you can extrapolate that to public spaces and children that are seeing adults smoking at the sporting field or in the street or whatever, it's still normalizing the behaviour and has an effect on a person's choice as they become older.

Chair: Will you deal with that? Do you have those recommendations in here somewhere?

Dr. Ian Reid: Oh yes.

Chair: Okay, thank you.

Dr. Ian Reid: The other aspect to that question would be looking at the issue of enforcement. It's fine to have it on the books. It would be an interesting question to determine if anyone has ever been fined because they're in contravention of that law that you cannot smoke in a car with someone under 18. My suspicion is that those numbers would be very small, if not zero.
As we were talking about the habit can start quite early.

Chair: Bush has a question for you.

Dr. Ian Reid: Yes.

Chair: Sorry, Bush.

Mr. Dumville: I never realized it at the time, but both my brother and I, we were raised in a house with – my parents were non-smokers and it was the greatest gift they have probably ever given to us because we never even considered smoking and we were

heavily involved in sports, so that took away the need – the next level of peer pressure, the need to belong with our friends in our group. So we were just – we weren't into that.

I can't believe the great gains that we've made in not being able to smoke in public places. Never in my lifetime I'd ever believe we could move that far and I understand there's some slippage around – young females are now taking up smoking more than males are. I'm afraid that with this new marijuana legislation, are we slipping back into like – you're getting smoking cessation going and I'm scared that – is marijuana the same addiction level as nicotine?

Dr. Ian Reid: No, but it is very much – it absolutely is addictive and it does have carcinogenic chemicals within it. I think the difference is, is that the volume of smoking and the majority who are using marijuana is really substantially less than someone who is doing 15-20 cigarettes a day. So it's presumably the health effects may be somewhat mitigated by this usage, but it is a health risk. I mean, this is the legalization of marijuana is harm reduction. That's all it is.

Mr. Dumville: Will marijuana smoking – people switching back and forth, will it set back the cessation, the gains that have been made?

Dr. Ian Reid: Because they are two – they are different chemicals, the most addictive components are different chemicals – I cannot see why they would actually chemically cause more of a chance of an addiction to the other. The main thing is just the normalization of smoking anything.

Mr. Dumville: Yes, because I've seen drastic shift from my times like with my children. They would never, ever think of drinking and driving like our group did and I guess we've all probably been there. But, even now, even noticing my grandchildren, that they are even further on – like the smoking. I was down at Victoria Park with my grandchild to the fireworks and there was somebody smoking up and she said to me, she said: Grampy, he's smoking; you should go and tell him to stop. He was bigger than me, by the way.

So anyway, I think you've got great gains with those two generations. I'm worried about, this marijuana, people being impaired on the highway, I'm worried about: can our police agencies detect it. I think as a society, we're going to be further – it's busy enough out there on the highways with increased traffic and cell phones and people making bad choices. How much trouble are we going to be in here?

Dr. Ian Reid: It remains to be seen.

Mr. Dumville: Thank you, Chair.

Chair: I'd like to just ask one further follow-up and somewhat related question too, the vaping, I think it's called, and I presume there's nicotine in vaping.

Dr. Ian Reid: Some people will vape with tobacco and some people will vape with marijuana. We're starting to get into something I'm not as completely familiar with and maybe some of you have comments about vaping.

Dr. Scott Campbell: The information we had up until a year ago was a presentation from the respiratory therapist at the Queen Elizabeth Hospital and the data isn't out yet on liquid nicotine. It's affect on lung function, addiction or long-term (Indistinct). It just hasn't been around long enough that we know.

What we are starting to see is a pattern where people initiate vaping with the idea of 'I'm going to quit smoking', but they never really stop the nicotine. They still actually have nicotine being consumed. It really is gone from simply just replacing one habit of nicotine replacement with another, in general.

I think you're always going to find people have success, but in my experience in the discussions that I've had with some of the respiratory therapists, is that it's really simply just an exchange of preference for behavior.

Chair: Do we know: Are young people taking up vaping at the same rate they're taking up regular cigarettes? I see Marlene with her hand up there.

Marlene Mulligan: Just to reiterate what Scott is saying, very interesting. Because it is new, there is not a lot of evidence, but did see a presentation from a researcher out of the States that Sarah's group organized that did prove that out as well, that people that are picking up vaping. In terms of looking at it as a cessation device, that it's not really – although it's argued that it should be a cessation device – people are actually ending up taking in more nicotine because they're using both methods and it doesn't actually help them taper, although Dr. Reid will get to our recommendations on that after.

Our key concern here on Prince Edward Island around vaping – because we already do have it included in the smoke-free legislation which his wonderful – is actually the flavoured products and the youth access to the flavoured products. The other thing that we've learned is that with the vaping products, is it's a very clear tactic of the tobacco industry, they're buying up this industry right, left and centre and they are using the same methods to engage youth and new smokers that they did with tobacco products decades ago and they're applying that to vape and vape-like products. It is definitely something that we need our governments, including the federal government, to be acting on.

Chair: Bush Dumville.

Mr. Dumville: Vaping, I came across a gentlemen, he's doing an awful lot of vaping. I know a chain smoker, you used to see 20 cigarettes in the thing, but vaping seems to be worse because this guy has got it hanging out of his mouth all the time, he's playing with it now. It just seems constant; it looks like a worse addiction to me.

Marlene Mulligan: It's very compelling; again, the industry knows how to market products to people and what's going to work. It's compelling, it's a toy, it's technology, it's got a lot of very attractive features, yes.

Dr. Ian Reid: I think the important thing to realize is that, the only thing that vaping – including E-cigarettes in particular really do – it's harm reduction. You're not dealing with the 90-plus chemicals that are burning tobacco that are really the carcinogens. Nicotine is not a carcinogen, but it is the addictive drug. If you're vaping but there's no programmer plan to gradually de-escalate, as been said, you're replacing one source of nicotine with another. That's all that's happening.

Chair: Dr. Campbell had his hand up.

Dr. Scott Campbell: I wanted to build on Marlene's comment about industry strategy targeting young smokers and then segue that into Mr. Perry's comment earlier about: is there any strategy to target those 500 young adults every year.

There's a new initiation looking at some schools where we have health teams going in now, which comprises a social worker, a mental health councillor and two nurses. The fundamental principle of that group of professionals going into school systems is really around mental health and crisis intervention, but part of that is actually having two nurses on that team. Currently, I believe that they're developing a role and one is actually going to be healthy living strategies. Amongst that, I would assume would include also targeting the idea of smoking.

So, around your idea, I think we're starting to see actually going to schools now with a targeted team (Indistinct)

Dr. Ian Reid: So is this a pilot, Scott?

Dr. Scott Campbell: No. This is now completely funded and integrated and I don't think – I think it's – yeah, I don't think it's a pilot, no, because they also have occupational therapy as an (Indistinct) to that and that's being – it was last year in Charlottetown and that's being rolled out now in the west end of the Island and the Montague schools.

Chair: (Indistinct) Dr. Campbell, it's not in all schools across Prince Edward Island right now but it's –

Unidentified Voice: So you're familiar with it?

Chair: It's being rolled out, yeah. I think all the MLAs here likely would be – I had Colin on my list first and then (Indistinct)

Mr. LaVie: Thanks, Chair.

Do we have the same laws for vaping as we do for smoking, like 15 feet away?

Unidentified Voice: (Indistinct)

Mr. LaVie: We do?

Unidentified Voice: I think so.

Marlene Mulligan: Yeah it's all rolled into all the same –

Mr. LaVie: It's all the same? Okay, because I see people vaping just at doorways or inside.

Marlene Mulligan: We are getting – sorry.

Mr. LaVie: So there is the same law?

Marlene Mulligan: There is, and we are getting reports even on school grounds that we've been doing some work on as a council. So, to your observable point, yes there is an issue with enforcement on that.

Mr. LaVie: Are people aware of that? People that smoke kind of abide by the rule more than vapers do. So I'm not sure – is the public aware of the vaping? But it is the same rule? The question is answered.

Chair: (Indistinct) I wonder, too – I was going to ask this question earlier. I'll ask it now since it's related. The flavoured tobacco, and I'm not even sure where that is, to be bluntly honest, but my understanding was it was being phased out in terms of being legal to purchase or at least those little cigar-looking things, but I understand you still can buy the flavoured vape. I'm not sure if I'm saying that right, even, but vape or vapor, whatever it's called. Do you guys know if that's the case?

Marlene Mulligan: Yeah, that's absolutely the case. So on May 1st it became illegal in Prince Edward Island to sell any flavoured tobacco products including menthol, which is leading legislation in the country.

Chair: Is that the vape –

Marlene Mulligan: But that does not include vape, which is to my comment earlier: We need more protections there.

Chair: So we should be looking at making it illegal to buy flavoured vape?

Marlene Mulligan: That's right.

Dr. Ian Reid: And some –

Chair: Is that the right term, too, before I leave that?

Marlene Mulligan: That's what we use, yeah.

Unidentified Voice: Or is it e-juice?

Marlene Mulligan: E-juice, if you like –

Chair: Say that again?

Marlene Mulligan: E-juice.

Chair: E-juice?

Dr. Ian Reid: Mr. Chairman, some of the flavours no one could possibly deny that they're not trying to appeal to younger people when you have things like cotton candy and bubble gum and this kind of thing. Those are clearly not targeted at older adults.

Chair: Thank you.

Darlene had a question.

Ms. Compton: Thank you, Chair.

We talk about smoking in schools and how young children are starting. It's my understanding that between like the ages of 10 and 18 the Island has double the national average of youth smokers. I'm just wondering how that compares to back in 2007 as far as percentage, because we've come a long way, we're saying and it seems to be the case, but if we're still double the national average – can you comment on where we are percentage-wise with other provinces or across Canada as opposed to 10 years ago?

Marlene Mulligan: I can't comment on the youth rate 10 years ago compared to current, sorry.

Sarah Crozier: I know there's SHAPES – it's called SHAPES data that UPEI works on for research around school health and there

are recent numbers in there, but I'm not sure of them off the top of my head.

Ms. Compton: That's actually where I think it came from, the SHAPES data, was in 2016, was that we were still double the national average for that age group so that's a huge concern. We are making great leaps and bounds, but if we're still double the national average, where do we fit into the picture as opposed to 10 years ago? Are we really moving the numbers as much as we – well it's not as much as we want, for sure.

Marlene Mulligan: And not to downplay that because of course it's a concern, but one of the things that we need to do with data like that with regards to the Prince Edward Island population because we're small, it can really skew really easily, that we always look for two other data, like two other surveys and kind of average and we don't necessarily take just one survey to say that that is in fact what's going on.

Again, not to say this is isn't a concern and our rates are definitely higher in the long-term than the national average with youth and we need to work on that, but that definitely was one that stood out, so we need to just see a few more years if that's going to play out or not.

Dr. Ian Reid: If 500 are starting, and people are very unlikely to start if they haven't been smoking before the age of 30, it would suggest just further to what you're saying, is that the majority of these 500 are young people.

Let me tell you a little bit about what PEI is doing. Prince Edward Island actually has amongst the lowest investment in tobacco control per capita of all of the provinces in Canada. What we are doing includes the offer of a $75 per person, per year, assistance to purchase tobacco cessation products and those are nicotine replacement, or NRT, Bupropion earlier known as Zyban. It's now generic and quite cheap, and Varenicline or Champix which is yet to become generic.

On average – and this comes from BC data – the cost of a 12-week treatment overall was about $282 per smoker. In this province, those who are eligible for financial aid may have the cost of these drugs covered. But, the program is not being accessed. In 2016, only 100 smokers used the program last year for a total expenditure of $7,500. So it's not working. If you think about it – if you are relatively poor and it's going to cost $300 to buy these aids, the $75 isn't going to make any difference, and if you have enough money to buy these medications, the $75 is not going to be an incentive. So it would suggest that this current program at $75 per person is useless.

We have –

Chair: Sorry, Peter's got a question there.

Dr. Bevan-Baker: Thank you, Chair.

Thank you so much, Ian and everybody for being here this morning. Also, I want to thank you for circulating your presentation early so we had an opportunity to read through it. Thank you.

I just have a specific question about the nicotine replacement drugs that are part of the program here. You mentioned Bupropion, I believe, is now generic –

Dr. Ian Reid: Yes.

Dr. Bevan-Baker: – whereas Champix is not. Knowing that generic drugs are considerably cheaper than non-generic drugs, does that $282 – is that for the Champix or is that for the generic one?

Dr. Ian Reid: That figure came from BC's program which provides comprehensive pharmacological support. Some of them would have been on Bupropion. Some of them would have been on NRT; some of them would have been on Champix. The average cost, if you took the total cost divided by the number of users, came out to $282 and some people cannot take Zyban or Champix. These do have some side effects and I'm sure Scott can relate well to those. NRT is certainly the most common and 10 weeks of NRT is right on about $282 and that would be the most popular one.

Chair: Go ahead, Peter.

Dr. Bevan-Baker: Thank you, Chair.

Just a follow-up on that, Ian, and I'm aware of the potential problems with Champix and

suicidal tendencies, but the efficacy of the three drugs that you mention there, is there any big difference between their effectiveness?

Dr. Ian Reid: From my understanding is it's – there is no one that stands out that is the drug of choice. Some are very successful with NRTs. Some do very well with Champix. Oftentimes, people will try one. If they can't tolerate it, or it's ineffective they'll move to another.

Maybe Scott has some thoughts on that.

Dr. Scott Campbell: I'm going to step out of the role of the medical society. I'll speak to you just from private practice.

Essentially, the more times a person tries, the greater the potential for success. Usually we'll try simply nicotine replacement therapy early on. Usually that's as a consequence because that person has either been admitted to hospital and was started on a nicotine replacement therapy through the Ottawa model while in hospital, or through the emergency room, or through the COPD clinics. We initiate the Ottawa model, which is based around nicotine replacement therapy, so we use patches and inhalers.

The problem, really, is where it speaks to Ian's point, is that once they leave that particular program, whether it's in hospital or community-based, there is no financial support to continue the efforts. There is a real barrier to that.

We generally start to see that first. If they fail that, generally, will end up coming in and speaking in the office. Most people really aren't excited about Zyban. Zyban, historically speaking, does not have as great the potential for a success as Champix. If you take the normal, let's called it placebo rate, so a person quitting cold turkey, generally the accepted rate is anywhere from 3% to 8% depending on the motivation, how many times they try. If you put them on Zyban, looking at the data you can increase their success rate by 1.5. Whereas you can increase it by three-fold if you put them on Champix.

The problem with Champix is that there is a growing acceptance that people really don't want to take medications anymore. More and more people are coming to the office looking for referral to hypnosis, laser therapy, acupuncture, so we talk about all of the likelihood of those succeeding. Really, irrespective of the success rates, as long as the person is interested in trying to quit, we support them. We also try to support them with the smoking hotline the 1-800 number; regular visits; mental health counselling. Also, we have a social worker that works out of our clinic. If we can put in a referral to the social worker, we'll start building a basket of support and services around that person with the ultimate goal of trying to support their efforts in smoking cessation. If you're strictly looking at what works best, I'd have to put my money on Champix.

Chair: Darlene had a question, first. Ian, you looked like you wanted to say something?

Dr. Ian Reid: No.

Chair: Darlene.

Ms. Compton: Just on that note about affordability. From the outside looking in, I would like to know what a person spends on smoking in a year, and how, you know, does it come down to dollars and cents? Is that the issue? I don't see it as the issue, although we know there is definitely a larger population of low-income people who are smoking. But they seem to find the money for the cigarettes.

Does it come down to – well there's a program and they're going to pay the $282? For me – and maybe just can you speak to that? I don't see that. What's a carton of cigarettes?

Dr. Ian Reid: The –

Ms. Compton: I don't know.

Dr. Ian Reid: The cost per year for a pack-a-day smoker in after-tax money is about $4,500. If you can imagine a low-income family with two smokers, and that's $9,000 a year in after-tax money, that's probably 12 or $13,000 of the total family income every year.

Now, as Scott was saying, the person's motivation is probably the most essential to success, regardless to whatever supports you

provide. That is an essential. But, certainly if you are already spending $4,500 a year and you're desperately trying to get off of it, trying to find another $300 to spend is an added, it's a discretionary added financial burden. You do have a choice if you can't – but don't have a choice to abandon your tobacco addiction because every couple of hours it reminds you. It is a dollar issue. It is a financial issue without any question.

Getting back to what we – oh, is there another question?

Chair: Yeah, there's a couple of more. Darlene had a follow-up, I think and then Colin had a question after that.

Dr. Ian Reid: We may be here a little after 10.

Chair: That's all right. Yeah. Unless – do you guys have to go?

Dr. Ian Reid: No, I don't know, but I can't speak for the rest of them. I'm happy to stay.

Ms. Compton: I realize that. I came from a family of two parents that were pack-a-day smokers. My father died from throat cancer. My sister chose to smoke, and I hated it from day one, and low-income family, so I realize the choice is there.

Because we know that there is a higher percentage of low-income people who smoke, how can we tailor a program to encourage them, I guess? Or how do we make a difference in targeting that particular demographic?

Dr. Ian Reid: The first thing you have to do is eliminate the financial barrier. As I said, if they have a very limited income, and they're got to find, in your family's case $300 times two, that's $600 that they're not going to have for other essentials. That is the first barrier. Because without pharmacological assistance, the success rate is only about one-fifth as good as it would be with a proper pharmacological support.

That has been shown in British Columbia. They went from a 5% success rate to about 27, 28% success rate, by making pharmacological support available.

Ms. Compton: Thank you.

Chair: Colin.

Mr. LaVie: Thank you, Chair.

My question was directed at Dr. Campbell, but Dr. Campbell is stepping out on me.

Dr. Ian Reid: He'll be back.

Chair: (Indistinct) do you want to leave your question until he comes back?

Mr. LaVie: Maybe Dr. Reid can answer it. I'll try to direct it to Dr. Reid.

Dr. Campbell mentioned Champix and as I said earlier, I'm in the program and to date the program is working for me –

[A cellphone rang]

Dr. Ian Reid: Sorry, that should have been shut off, but I'm not technologically advanced. There it is. It's off now.

Mr. LaVie: So, to date, it is working for me. I appreciate it very much what the girls are doing for me.

The Champix, are there side effects from the Champix and what do we do about the side effects?

Dr. Ian Reid: Scott, I have not prescribed Champix.

Dr. Scott Campbell: Sure.

Champix is a routine medication that I use every week. Like any medication, or really anything else we decide to put in our body, everything comes with the potential for side effects. Just because you take something in doesn't mean you're going to get them, but you have the potential for them.

Champix has some serious potential problems with its use. One, is certainly suicidal ideation. It's more common in people with a history of previous suicide attempt or major depression. There are some other ones that generally we talk about. Things like vivid dreams; restless sleep; a little bit of increased anxiety; a sense of inward restlessness; disordered thinking, those kinds of things.

Typically, whenever you sit down and talk

to people and you kind of go through the risk factors and the profiles and you say: look, you know, here is the potential benefit for you. Here are the potential problems we can see. Then, what do you think?

It's about making an informed choice. Really, in primary care we no longer tell people what to do anymore, we simply provide them the options and discuss what may work best for them and try and support them in their choice.

As part of the regular routine, it has been shown that the more you follow-up with people through a smoking cessation program the greater success. Typically, when you would prescribe Champix, you get them to reduce their cigarette consumption over a certain amount up until they start day one of Champix. While you smoke, Champix in the first week, you continue to smoke. When you start the second week of therapy that's your first day of quit. Generally, I see them back that day. I ask them: How's it going? How's it going so far? Are you experiencing any of the side effects? What's your thinking like? What's your sleeping like? Are you getting any other support from any other services?

Then, I generally see them back weekly to keep an eye on them. Then, as they continue to progress through the treatment program, which is originally designed to be 12-weeks, but also has an indication for a second, three-month trial, you follow them a little bit longer out, so usually sometimes every two weeks, or every three weeks, depending on how they're doing through the course.

Chair: Good Colin?

Mr. LaVie: Good.

Chair: Can I just ask: Are there any wait times or anything like that to get into that –

Dr. Scott Campbell: Which program?

Chair: The program you're speaking about, I guess. To see, to look at this?

Dr. Scott Campbell: No. You can go see any family doctor and talk about smoking cessation. Hopefully, each one would be happy to see you at any time.

Chair: Great.

Dr. Ian Reid: I think Scott is understating his interest and commitment to this issue because – and I don't want to be unfair to any family physicians, but it has − there have been surveys of family practice interactions, not on PEI in particular, but it is – tobacco cessation is not always a topic of conversation. Certainly, many are not willing to put in the kind of effort in follow up and support that Scott is.

There is no question that the support of health care professionals, who are skilled and knowledgeable about tobacco cessation, has much more impact than pamphlets and t.v. ads and radio ads and newspaper advertisements. It only takes less than five minutes for a health care professional to introduce the process.

We'll talk about that in a minute, but there are training programs, which are available at a very modest cost, about $150 through CAMH, which is a Canadian – which is out of Toronto. They provide a comprehensive program to teach people how to counsel and how to approach people to introduce the idea of tobacco cessation.

We have one person in the Queen Elizabeth Hospital with that training. The respiratory therapists in the hospitals have that, or equivalent training. We don't really have an opportunity outside of the family practice in the community to access skilled tobacco cessation counselling. Notwithstanding, if you can get into Mount Herbert, that added interaction and ongoing support, as well as pharmacological support, makes a huge difference.

I'm sure that Scott's success rate with his patients would be much – would be impressive compared to some who don't pay a lot of attention to it.

Some of the other things that we have done on PEI, and it has been mentioned, we have the *Smoke-free Places Act,* which has helped reduce exposure to second-hand smoke. There is no longer any smoking on the hospital grounds, or within the hospitals, and at UPEI. We have made some effort by auditing tobacco retailers to make sure they're not selling to people underage. Those are all positive things.

As Marlene was mentioning, the recent elimination of flavoured tobacco has helped. We have had the Smokers' Helpline available for quite some time, and that's part of the province's investment in smoking cessation. Those are some of the things that we are doing.

As Scott was mentioning, really, the shining light in the province in terms of tobacco cessation is what's being done in the hospitals following the Ottawa model. Where, patients are assessed at the moment they enter the hospital as inpatients and respiratory therapists go in and do counselling with them. They will start nicotine replacement therapy immediately. There will be continued follow-up up until they hit the edge of the cliff and walk outside of the hospital.

They may have been in for four or five days or a week or longer. They may have actually been tobacco-free for that time. But then they fall off the wagon as soon as they leave because there is no coordinated effort to pick up the patients once they leave the hospital, which understandably, seems to be an unfortunate, almost waste of resources, as the vast majority of those people without any further support are going to start again.

Chair: Peter, you have a question there.

Dr. Bevan-Baker: Thank you, Chair.

For me this is a really critical element and shines a light on what I think is a glaring problem. It also parallels some of the regular criticisms that we hear of the mental health programs here on Prince Edward Island. Wonderful at dealing with an acute crisis, but you mentioned earlier, Ian, that we need a comprehensive approach here because this is a public health issue.

I'm wondering who, in your opinion, should be providing that coherence from, in this case, inpatients in hospitals and their discharge into the community, who do you think should be responsible for that community follow-up?

Dr. Ian Reid: I don't think there's any question this should be part of our health care resources and health care policy.

The first issue would be to provide enough financial support to have people in the community able to continue with the counselling support. Of course, critical is the pharmacological support. Those two things, there has to be, just like patients when they're discharged there is a home care program and that they need assistance with surgical dressings or medications or whatever. There is nothing equivalent to that to follow-up with the 15% of people who entered the hospital as smokers, or probably higher than that because they're more likely to be sick, and then nothing when they leave.

It's like having the appetizer, but there is no meal and no dessert.

Dr. Scott Campbell: Can I elaborate?

Dr. Ian Reid: Please.

Dr. Scott Campbell: There has been a big push through primary care. There has been a development of a new program called INSPIRED COPD Program, which has come out within the last year. It really is targeting people of recurrent admissions for acute exacerbation of COPD, primarily related to smoking. Most do, not all, but some do.

The idea is that you make a referral to the INSPIRED COPD Program, which is then an outpatient program and links you up to a community-based COPD clinic, which is typically run by nurses. So, it's a collaboration between the primary care doc and these COPD clinics that are housed. In Kings County it's out of the Montague clinic, but they're also out of other provincial clinics around.

The idea is to really target those individuals, who are costing the system more through readmission because of their smoking-related illness. To see if we can actually get them on better medications; target how they take their medications, and to see if we can limit the overall cost and support them better.

To my knowledge, part of the problem that we're missing is where is the nicotine replacement part? We can get them to come in, but if we can't actually help them afford it we're missing that huge – so we're

missing one of the tools at the toolbox for those programs. That's really why we're here.

Dr. Ian Reid: Scott, who pays for those staff and the inspired program, is that provincial?

Dr. Scott Campbell: Yes.

Dr. Ian Reid: Okay.

Chair: Question.

Dr. Bevan-Baker: Chair, can I have a follow-up? Thank you. Thanks for that, Scott.

In other jurisdictions, primary health care centres, I'm really glad you brought up the issue of primary care here, bridge that gap where it's a more collaborative, holistic, individualized approach to health care with an emphasis on prevention, as well.

I'm just wondering whether you feel – and I realize this is a big question and slightly, perhaps, beyond the topic of conversation today, but whether the establishment of primary health care centres on Prince Edward Island might bridge that.

Obviously, it would go beyond smoking cessation, but is that a model that you feel would be a useful path to take for the health care system on PEI?

Dr. Scott Campbell: I think we're already starting to see the emergence of that and the success. If you look at the demands, or probably the better word would be, the needs that people have in communities can no longer be served by just one individual. The basket of talents that are required to look after people, and the amount of knowledge and expertise that is available, supersedes the abilities of any one individual.

Really, comprehensive and collaborative care seems to work best. We can share the responsibility. It tends to be a little bit more of a burden on patients because now you have, rather than seeing one individual for a variety of issues, you kind of have a few multiple appointments. I think the reality is, is that you're being actually supported on a more frequent basis. We know that success in any health care plan, the more you actually touch base with a professional the greater success of that plan and the ultimate outcome.

What we're starting to see, and in Montague, and I'll speak specifically to Montague, is that we are trying to build our basket of services to better support our individuals. We're no longer looking to hire people that do the same thing as us; we're looking to hire people that actually do something a little bit different.

Along those lines we have nurses that have mental health training, COPD training, INR clinic, hypertensive clinics and starting to build that repertoire where we can now support people a little bit better. Is it working? I think it is; people tend to be happier. Not only that, but it seems like we're catching up with those people on a more regular basis and keeping them on track where you don't lose track of them over time.

My answer to your question, I think, would be, yes. I think that's probably part of the way. Is it the answer to every question? No, but it certainly is a positive in our community.

Dr. Bevan-Baker: Thank you.

Dr. Ian Reid: The INSPIRED program is to be applauded. Of course the problem is, is that those who are going to be actually enrolled are those who already have COPD and are frequently getting into the emergency department. These are people way down the line in terms of lung damage and health, quality of health loss.

On the other hand, it would seem to me that if there are resources that have started in their infancy to deal with these people, there may be some opportunity to build those into a place where people who are smokers being discharged from hospital could be directly plugged in if the resources there could be expanded to accommodate that, and then the money spent in the hospital on the Ottawa model wouldn't be essentially wasted.

Prince Edward Island right now receives about $32 million a year in tobacco taxes and spends about $100,000 a year on tobacco cessation and control, or about

0.3%. PEI has the lowest taxes on cigarettes in the Maritimes. Currently, a cigarette tax in PEI is 25 cents, 25.52 in New Brunswick and 27.27 cents in Nova Scotia.

If the taxes on cigarettes were increased to the Nova Scotia norm, there would be approximately $3.3 million in additional revenue. Only a third of that would have to be spent in order to develop and maintain and sustain a comprehensive tobacco cessation and control program comparable to British Columbia, which really leads the country.

Dr. Bevan-Baker: Chair?

Chair: Peter.

Dr. Bevan-Baker: Thank you. Thanks, Chair.

Ian, I'd just like to dig down into those figures a little bit for what you've described in your presentation here as a fully funded tobacco cessation program. It represents – the figure there, 1.1. million – represents a tenfold increase on what we're spending currently. You've mentioned British Columbia a couple of time, and I know that's referenced later on in your presentation, but can you give us an idea of where that 1.1 million would be spent?

Dr. Ian Reid: That is primarily related to – if you took the 20% of smokers that try to quit every year and you calculate the cost of pharmacological support for those people, then you will come up with approximately that number.

In other words, if every smoker who is motivated was given support to get the treatment which is vital to be able to be successful, that's what it would cost approximately. The added cost of counseling is not included in this.

We'll get to this in a moment, but there are a variety of ways to, for lack of a better word, sprinkle – which is a hot word these days – sprinkle that knowledge elsewhere within the health care system broadly with nurses in primary care clinics, nurses who are working for family physicians, dental hygienists, dentists, physiotherapists, occupational therapists. Everyone who encounters a person as a health care provider can have a positive impact.

Those people are already out there right now; and if they're interested, to actually educate them to the point where they should be capable of doing this effectively is a $150 online course. That's it.

Public attitudes: Public surveys in both Alberta and BC have shown overwhelming support for increasing tobacco taxes and then using that revenue for tobacco control and cessation. Over 80% support those measures, and even if you take the subset who are active smokers, 70% of them support that idea even though they'd be paying more for cigarettes.

Most smokers do, if you ask then, want to quit. They understand intellectually what they should be doing. There's no lack of knowledge, so further education on the health risks is probably unnecessary. One out of five will actually try; but currently, without any kind of support, only about one in four or one in five of those who try will actually succeed.

In British Columbia, when they provided good pharmacological support, 27% were successful in eliminating their tobacco use; 70% who participated substantially reduced their tobacco consumption. So even if you can't get them to quit, it can have a very positive impact.

As I mentioned, there are many of us in the health care system who interact regularly with patients – or clients, depending on your preferred word – and it has been shown that it only takes three to five minutes to open the conversation. That one on one opening of the conversation is the most effective catalyst to an interest in quitting.

What is it actually costing, the way we are in the status quo? Federal estimates suggest that it costs us about $30 to $100 annually per smoker per year in direct health costs and indirect costs. That works out to about $65 million of additional costs to the province for the smoking prevalence that we have now.

As we talked about earlier, smoking is a very expensive habit, and it's a cost that many of the people who are smokers can ill

afford. Imagine the improvement in the quality of life of a low income family if they managed to eliminate two parents who smoke and now have $9,000 of after-tax money to be put into their quality of life. Imagine the impact on some of those who are sitting close to the poverty line.

An average pack-a-day smoker loses 15-20 years of life expectancy. One of the things that I've said often in my practice to patients who are, say – one of the commonest times I educate people is when they're having a vasectomy, so you have about 18 minutes where you definitely have their attention. And we talk about it –

Unidentified Voice: (Indistinct)

Some Hon. Members: (Indistinct)

Dr. Ian Reid: We talk about it a little bit. Part of it is a distraction, but part of it is a sincere interest in trying to – because people are then at a point where they're done having their family, they're now about to raise them, they're sort of late middle age and they're looking at the rest of their life and maybe they've gained a little maturity and now they're willing to be open to the idea.

The calculations that I provide them are simple. If you're going to lose 15-20 years of your life – and let's say from now until you retire in 25 years, instead of putting $4,500 of after-tax money into tobacco, you'd put $6,000 of pre-tax money in an RRSP, then you will have well over a quarter of a million dollars, it's probably higher than that, to spend when you're 65 and retired instead of looking at not living until you're 80. Now, how does that look to you? It usually creates a thoughtful conversation.

One of the things that it's only recently we have learned is the effect of ongoing smoking on cancer therapy. These figures, which we heard by presentation from MD Anderson in Texas when we were at CPAC, just blew me away, that the curative initial therapy drops 60% in someone who continues to smoke; and the toxicity of the therapy is 40% more likely to happen.

Just think about it. We have about 300 new cases of cancer a year, and the cost of having to move on to secondary therapies and deal with the toxicities are very difficult to estimate; but if you look – I don't think you can see this, unfortunately, but I'll give you the key thing. For lung and colorectal and head or neck cancers, the cost of the initial assessment and initial treatment is in the range of $28,000 to $30,000 per patient.

If that person develops toxicities, particularly if they have to be managed as an inpatient, the added costs are substantial. If they fail to respond well to initial therapy and have to move on to secondary therapy, the costs of that therapy are substantially proportionately higher because secondary therapies are almost always newer drugs that are restricted and limited in access, and these are, oftentimes, not generic and often can be very expensive.

I don't know what the total cost to the province would be for patients who continue to smoke in spite of having cancer if they smoke throughout their therapy, but it's conceivably very large.

I'm going to present the arguments for and against moving forward with a comprehensive tobacco cessation program. With savings of up to $65 million in direct and indirect costs annually is provocative. Now of course 65 million would be what would happen if every single smoker stopped tomorrow. That's not realistic, but in identifying all of those savings in our four-year mandate and one-year budget formats is not going to be easy. These numbers have come from analysis over many years through Health Canada. I suspect that the savings, if we were successful, would be very substantial.

There would be a reduction in the incidence of new cancers; a reduction in the number of treatment failures and the toxicity of these treatments. There would be an increase in the lifespan economic well-being and the quality of life of those people who were able to stop smoking.

That's profound, particularly, when we're dealing with some of the most vulnerable people in the province.

A reduction in diseases related to exposure to smoke. The number – we have one of the highest incidences of child asthma in the

country. We have children, who are coming into the hospital, being admitted repeatedly with asthma and both parents smoke. This is a target group to try to help deal with it. The people who have – coming in with exacerbations of COPD and cardiovascular disease, and some of these are innocent and have just been exposed to this as second-hand like the child.

As Scott was saying, he sees many emergency room visits and readmissions because of worsening of COPD lung disease and people come in very short of breath. They're getting admitted and they're put on antibiotics and bronchodilators and given a lot of respiratory care. Then they get discharged and many of them will be back again.

We have an opportunity to join British Columbia and the northern territories as leaders in tobacco cessation. That would be something to be proud of. Just as we're proud of Waste Watch, this would be something that we could be very proud of. It would receive wide public support, so there is very little political cost to making this initiative.

It may have an impact on the risk of other addictions. This is like what Mr. Dumville was saying earlier, that if people are not starting tobacco smoking, they may not travel down that road towards other addictions quite as often.

A comprehensive plan could be easily cost-neutral and in fact, it could conceivably be revenue-positive if we decide to increase tobacco taxes to Nova Scotia levels, which would still be within the region.

It has been said by the World Health Organization that the cost-effectiveness of tobacco control rivals that of childhood immunizations – just think of that; the cost of just giving vaccinations to children and what it saves would be comparable to the impact of a comprehensive tobacco control program.

The problem is, is that we've grown up with this. It has been there, and it has become acceptable. We sort of – we just recognize this as an evil that surrounds us, and we don't necessarily take a step back and say: what is this doing to the population?

There are three pillars of effective tobacco control. This is getting to Mr. Chairman, what you're asking: what sort of things could we do?

The three pillars of tobacco control as listed by the World Health Organization are; prevention, cessation and harm reduction. Prevention, particularly preventing the young people and adults from actually starting in the first place, there is no greater disincentive for buying tobacco than high tobacco taxes. It has been shown that an increase in tobacco taxes does stimulate an increased interest in cessation. Simple economics.

(Indistinct) school programs with peer support, this de-normalization of smoking, just like they've been successful in the de-normalization of drinking and driving. It's been well shown that peer programs can be highly effective in a high school setting.

Limiting places where tobacco smoking is allowed. For example, why can't we limit tobacco use in multi-unit dwellings? Why, if you live in an apartment building should you have to be exposed to tobacco within the building? There are some landlords who are making this their policy, but they are in the minority. If you are living in a building where – and let's face it, in many, particularly low-income housing, the prevalence of tobacco smoking is high, so the prevalence of second-hand exposure is high. These people don't have anywhere to go, but the people, who are smoking can at least go outside.

Chair: Dr. Reid, has anybody ever looked at, I guess, to any of your knowledge, the kind of price elasticity of the packaging of cigarettes. In other words, we all know it's illegal to sell one cigarette. I think the last time I knew anything about it, a pack has 20, I think in some cases, and 25 in other cases in it, and I don't even know what that would go for these days and there would be a carton, and so on and so forth.

My guess would be if you were a teenager looking to buy cigarettes, it's going to be harder to come up with money for a carton than it is for a package and so on and so forth.
Have we ever – has anybody ever looked at that?

Dr. Ian Reid: Interesting thought. Does anybody have any comments?

Of course, if you want it badly enough, you'll split the cost with three people, you know. Their innovation is a common feature of adolescence. They'll find a way, right? They'll find a way.

Also reducing access to tobacco sales, if we decided that we would license all retailers who are selling tobacco products, and that we would limit the number of tobacco licences, particularly making sure that retailers anywhere near an educational facility are not selling tobacco, that might have an impact.

Oops, sorry, back up.

Okay, the next pillar with cessation and this is what we really have been focusing upon. If we can establish a program that provides cost-free pharmacological support for cessation we will have four to five times as many people successful in quitting every year.

The support that's necessary, also with trained counselling, as I mentioned before, can be developed by developing a higher concentration of that knowledge within all of the health care professionals. And it's not a particularly expensive thing and it's a one-time cost to provide that education. Ideally, anyone who enters a tobacco cessation program, if they have – it costs them nothing to be able to initiate the pharmacological support and they do have access to counselling somehow.

The Smokers' Helpline, with all due respect, has definite limitations. Face-to-face, just as Scott was describing, his practice is exemplary practice – makes an enormous difference to maintain motivation, to deal with side effects.

This simple training to be a tobacco cessation councillor can be incorporated into some of the medical education, the family medicine residents that are here, the nursing students that are here et cetera. As I mentioned, this can be done in a politically acceptable way and it's cost-neutral.

Finally, for those that we cannot get to quit, trying to avoid the exposure of other innocent people by taking it outside is well worthwhile. There are a number of reasons. First of all, obviously, it avoids exposing family members and loved ones to the tobacco, whether it be in the car or in the house. Secondly, it's a bit of a disincentive if you're going into the garage every time you want to have a cigarette in the wintertime. That actually does act as a bit of a motivator, so it's a side effect.

Look at prenatal clinics and all of the prenatal classes in the province; the impact of smoking on the unborn child is well recognized, the incidents of intrauterine growth retardation is much higher.

As we mentioned, the patients who are coming in with acute exacerbations of asthma, looking carefully at what are the precipitating causes? Do these patients have their tobacco exposure documented? Is there something being done to address that? Unfortunately, in a very busy emergency department, there isn't a lot of time to sit down and do tobacco cessation counseling. Most parents care deeply about their children and are distressed by their addiction, so this is an opportunity to provide some kind of ongoing support once they leave the emergency department, and perhaps our childhood asthma incidents wouldn't lead the country.

I tried to come up with the arguments against a comprehensive tobacco cessation program and I couldn't come up with one. I'd be very interested, if we want to pause, because I don't live in the political world and I am familiar with the issues of budgeting and the limitation of resources, but this is the world that you folks are much more familiar with and I'd be very interested, as I'm sure the rest of the group here would be: When you're thinking about this, and it's about what we're talking about, what ideas come to mind that could be roadblocks to moving this forward? I'd be very interested if any of you would offer your thoughts on why not.

Chair: (Indistinct)

Dr. Bevan-Baker: Thank you.

Well, firstly, let me say that you have my unqualified support for what you're trying to do here –

Dr. Ian Reid: Oh, so you're not going to answer this question?

Dr. Bevan-Baker: Well, no. I mean, the Green philosophy when it comes to health care, many things is to put money in upfront and prevention and being proactive so that – I mean, this fits perfectly with my approach to how we should be dealing with health care issues, smoking or otherwise.

Prior to moving to Prince Edward Island, I lived in a small community in eastern Ontario on the banks of the St. Lawrence River and there was an incredibly vigorous business in black market cigarettes. We lived near a First Nations reserve and also, the other side of the river was the US, so there were opportunities for commerce, shall we say, that were very alluring. That is my only thought here, is that the higher the tax rate on cigarettes, and there's been little discussion this morning around cannabis and I hope we have a chance to come back to that before this is over, but at a certain point you encourage a black market in whatever activity it is that you have taxed to a very high extent.

I'm not suggesting that's what's happening here on Prince Edward Island, but I'm wondering what, if any, statistics we have on the availability of black market cigarettes on PEI?

Dr. Ian Reid: I can't answer that question. Does anybody else know?

Unidentified Voice: No.

Dr. Ian Reid: I know that, as you say, in Ontario and Quebec where there are a high number of Aboriginals on reserve and particular if you're bordering the US border there is, it is a huge problem, but I have no idea about how prevalent that is. I suspect being on an Island does have some benefits in terms of filtering out large quantities of these things, and there's always the risk and this, of course, is the same risk with cannabis.

If the pricing does not make a legitimate purchase of cannabis cheaper, or no less expensive than you can buy it on the street, that whole project will fail. The fact that we are the lowest tax in the Maritimes would suggest that we have some room to maneuver before we bring that incentive to go looking for black market tobacco into the forefront here in PEI.

Marlene Mulligan: I can comment on it, although I don't have anything specific in terms of data to bring to the table, but it's certainly something that the Canadian Cancer Society takes into consideration in terms of its recommendations that it makes and we do talk to our colleagues within the Department of Health and Wellness on a regular basis in terms of enforcement and how's it going, what are the issues?

I can say from that perspective, in general, we're doing very well and that contraband in PEI is not an issue at this point, and then from a policy recommendation perspective from our organization to what Dr. Reid is saying, is that it is about looking within the region and the availability – it becomes economics, right? The markets and all that kind of thing, so the recommendations here, we don't feel, would put us at risk for increasing contraband here.

Dr. Bevan-Baker: Thank you.

Thanks, Chair.

Chair: Anybody else with any questions, comments, thoughts? No?

I don't know what we had told you to expect in terms of –

Dr. Ian Reid: I have one final summary to – seeing that we have – we all seem to have a consensus that there isn't any insurmountable obstacle to keep our government from moving forward on this being probably the most important public health issue that we face in terms of the entire population. If we have achieved that consensus, then this morning's meeting has been worthwhile.

We know that it can be cost neutral. We know that the public will accept it and in fact, will see this as a highly responsible example of good leadership. We also realize that if we in fact can reduce substantially the prevalence of smoking, that there are many savings – some of them are financial. Some of them will be in terms of the savings of lives and the enhancement of quality and quantity of life.

Finally, it is the right thing to do. This is not a partisan or political issue; it is a public health issue. I hope that this committee, after this presentation, will give it some careful thought about how to reflect the committee's viewpoint back to the Legislature.

I can tell you, with substantial disappointment, that this group authored and signed a letter to all members of Treasury Board approximately three or four months ago. We have yet to have an acknowledgement or a reply. It went to everyone in Treasury Board, including the Premier. This opportunity to meet with you is very welcome and we hope that this hearing will actually have some impact.

What you see represented here are representatives of a large number of people with many different diseases, many different perspectives on this, but represent a large portion of the public in front of you.

Now I'm finished.

Chair: Just before we do finish that, do you have a copy of that letter or the date on which it was sent?

Dr. Ian Reid: Yes.

Chair: Can you provide that?

Dr. Ian Reid: We can give it to you.

Chair: Thank you very much.

Peter (Indistinct) question (Indistinct)

Dr. Bevan-Baker: Yeah, standing committees of the Legislature are tasked to make recommendations back to the House on all topics that we hear about, and I've been taking notes as you've been talking this morning, Ian and everybody else present, and it strikes me that there are four separate legislative possibilities that we could make recommendations on and I just want to run through them to make sure that I'm articulating what we heard this morning exactly.

The first one would be you'd like to see an increase in taxes on cigarettes, perhaps one or two cents per cigarette, which would amount to maybe 50 cents per pack?

Dr. Ian Reid: Well, Nova Scotia would be 2.52 cents per cigarette, would be the increase per cigarette, so you'd have to do the math on –

Dr. Bevan-Baker: Yeah.

Dr. Ian Reid: – on a pack.

Dr. Bevan-Baker: Okay.

Dr. Ian Reid: But you're right, it's a little more than 50 cents.

Dr. Bevan-Baker: Yeah.

The second one would be on flavoured vaping products; that you would like to see some restrictions on that or a ban perhaps as we've done with tobacco?

The third would be some sort of legislation regarding smoking in multi-unit dwellings; and the fourth would be, and this I was extrapolating from something you said, but – and by the way, let me say for the first bit that I captured there, that the increased taxes in cigarettes, that it be important that that be specifically directed to cessation programs, not go into general funds – the fourth thing is funding for the 150 online course for health care providers so that they will have the expertise to do it.

Do you think that would be a fair recommendation to make?

Dr. Ian Reid: Yes, with just the addendum to the increase in taxes that that be directed to provide a complete and comprehensive coverage for pharmacological support for tobacco cessation.

Dr. Bevan-Baker: Sure.

Dr. Ian Reid: I didn't think you'd mentioned that, but it's implied.

Dr. Bevan-Baker: Yeah, thanks.

Did I miss any legislative aspects of what you talked about?

Joanne Ings: Just to say that in terms of multi-unit dwellings, one of the largest landlords is the province with seniors housing and lower income housing, and I know over the years that I've been involved

they're moving towards that in some facilities and it makes a huge difference in maintenance costs and refurbishment costs from when a smoker moves out of a unit to get it back on the market.

So there's probably a bit of an appetite for that. I know some of the calls I get at my office are from people in seniors housing, for example, and smoke goes whatever it wants. It shows no favourites or anything like that; and I think, too, the broadening where you can't smoke or there's not the expectation of there being smoke and I know one of our colleagues on the Council for a Smoke Free PEI has done a lot of work in the area of recreational facilities and soccer fields, baseball fields, whatever that might be, and that's really getting much more uptake.

Again, it gets into the point that Marlene made about the normalization of smoking, and I know (Indistinct) gave credit to the 2014 committee who were very clear in their events in 2014 that they weren't smoking events.

So there's some steps there, and I know there's actually more buildings (Indistinct) – you'd be surprised at the number of buildings, particularly a lot of the new buildings, that are completely smoke free totally. Not just in the apartment, but on the deck and even on the grounds. So if someone goes to visit, they have to go, either, across the street, and hopefully it's not a similar kind of building.

But I think there are some of those things, and also as well that smoking on outside patios somehow magically after 10:00 p.m. the smoke doesn't become harmful. I haven't quite figured that one out yet.

Dr. Bevan-Baker: Yeah.

Joanne Ings: But there's (Indistinct) that we've been, is still on our council's legislative agenda that still need to be pushed and parks and some of it's municipal, some of it's even streets. I mean, even the beautiful Victoria Row which is one street up, if you really got out with your chalk and were marking out the 15 meters or feet or whatever it is, it gets pretty blurry out in that area, and what a beautiful place to have a non-smoking area and to accept that challenge, I think, would be really beneficial to us; but there are, Peter, just to get back to your point, some other legislative pieces that the council still has on its list.

Dr. Bevan-Baker: Thank you.

Dr. Ian Reid: Just further, if we could, to what Joanne was saying: In many ways, rather than in the *Smoke-Free Places Act*, trying to enumerate all of the places that you can't smoke, it would be creative to take a look at, well, if you were a smoker, where can you smoke without interfering with other people? And then everywhere else is smoke-free.

I think that that would be a more effective way to give people who are smoking some guidance as to what's acceptable, and would keep us from having to sort of eke our way, nickeling and diming this process: Now we'll do sports fields and now we're going to do outside patios after 10 o'clock.

You can get bogged down in the minutia, but the fundamental thing is this is a toxic, cancer-causing, addictive chemical that we want to protect innocent people from; and with that philosophy, then approaching it from where is it safe for a smoker to be smoking so other people are protected is a novel way to look at that legislation I would suggest.

Chair: Do you know of anywhere else that's done that at this point in time?

Dr. Ian Reid: I don't, but why can't we be the first one?

Chair: (Indistinct) question. Okay, Bush?

Mr. Dumville: Just to back a little bit from just a technical question in regards to quitting either alcoholism or smoking, we hear the story about if you take that one drink after 15 years, if you have a major tragedy in your family or something drives you back to a previous addiction, is it true in either case?

Like if you quit smoking for 15 years and something really happened and you went and started smoking for a week, are you set right back all those years?

Dr. Ian Reid: Some are. Some, and I'm sure Scott can comment on this as well, some people who have smoke – I deal with bladder cancer which is also a tobacco-related disease. I have patients with recurring tumours in their bladders and when they finally quit the bladder tumour recurrences disappear; but some of them will tell you: If you told me I could smoke and it would be okay for my health, I'd have a pack tomorrow.

There's some who actually become almost averse to tobacco smoke, and then there's then some in the middle, but there's no question that some people are primed. Just like opiate addiction, some people are primed and it's like a spark on a powder keg.

Mr. Dumville: Thank you.

The Chair will probably sum up and thank you for being here this morning, but I just wanted to say I enjoyed your presentation. Peter has summed it up very, very well in regards to a legislative approach, and I just hope that this here committee can get through that your sincerity and your passion for this with the Premier and the Cabinet. They'll hear your word today.

Thank you very much for this presentation.

Thank you.

Chair: Anybody else for questions? No?

I may have one more. Do you have a sense of percentage-wise those that do smoke that would like to quit smoking? Would it be 80% or 100?

Dr. Ian Reid: Seventy to 80% of people would actively want to quit if they could possibly do it. It's a highly motivated group, but it's a highly addictive chemical.

Joanne Ings: I'd just like to reiterate on one of Scott's points back a while ago about having the basket of support available. Because yes, smoking has that certainly addictive piece to it, but there's also the psycho-social piece around smoking which can't be ignored either. It's getting past the okay of the nicotine piece, but also the other pieces that some pieces may need to help them in that journey.

As someone who was a pack-a-day smoker, much to my family's chagrin, I did quit; but it took a lot of practice, and there were things that work for some that don't work for others. I think that broad basket of support, Scott, is really, really one of the key pieces to getting this last group of smokers to really pick up that challenge. They want to do it. We just need to have some of those tools in the toolbox to help them.

Dr. Ian Reid: One comment on that: It typically takes at least 20 attempts to quit. That's 19 times when you have failed and look yourself in the mirror and are so disappointed and so is everyone around you. That number can be reduced dramatically if we can support these people in real ways.

Chair: Bush.

Mr. Dumville: Social aspect of it; do you have to get a new group of friends? You know, you're associating with a group who are smokers. How much of a problem is that? How do you get around that?

Dr. Ian Reid: There's a tipping point. It's the same way with alcohol. Once you're with a group of people who are socializing, but the norm within them is you have a designated driver and you have a non-alcoholic beverage available. If that's the norm, that's what happens, and the same thing is – will happen with tobacco. When you hit that tipping point where more of them don't even want to even be exposed to it you'll have a choice; you'll go outside; find other friends or quit.

Mr. Dumville: Because you could actually not belong to that group anymore because your views have changed because you're not into that lifestyle.

Dr. Ian Reid: Peer support for young people, peer rules are more motivating than any external pressures; adults, parents, you name it, it's the peer pressure that makes the biggest difference at that age group.

Mr. Dumville: Thank you.

Chair: Okay, any other questions, comments?

Great, and as I started to say, probably, 20 minutes ago now, I'm not sure what you

were told in terms of your time expectations, but we're certainly thank you very much for your time. I think you can take, from the fact that we were here for an hour and 45 minutes and all the questions that we had, that it was a very, kind of, intriguing subject for this committee to deal with. It looks like something that would be kind of the proverbial low-hanging fruit that we could make a recommendation on.

Along those lines I would say that our general process would be, we do meetings on a number of different subjects. Likely we would meet coming into a legislative sitting to determine what recommendations we might make out of those meetings to the Legislature. That will likely happen in due course. If there is anything else, I'm sure you won't hesitate to be in contact with the clerk or our committee members, and I would certainly encourage you to do that.

We have, in addition to, the legislative changes that Peter summarized already on pages 8 and 9 of your slides, eight and nine of your presentation, seven, eight and nine. Essentially, the recommendations that are there, The Wise Way Forward, I think it's titled. We will certainly be looking at them and we thank you very much for your presentation. It was very informative. I see that Ian's got another comment that he'd –

Dr. Ian Reid: One more comment.

First of all, what would be very helpful, reassuring and encouraging to everyone here would be to have some awareness of where things are going with this committee's deliberations and what presentation would they be making going forward so we know that this, in fact, has legs.

The second – so if there's a way, possibly through the clerk, or possibly through you Mr. Chairman, to keep us abreast of what may be of any substantial developments as they do occur.

The second thing is that you do within the department of health have two people, who are an excellent resource, and I know are absolutely committed to this type of initiate, and I know have the bruises and scars on their foreheads from trying to move it forward. I'm talking about Dr. David Sabapathy and Dr. Heather Morrison. I would heartily encourage this committee to use these people are a resource as you're thinking about how to put meat on the bones of this outline of moving forward, as they know the PEI situation intimately.

Chair: Thank you.

I will tell you and we can discuss this more if you wish later with the clerk. We are somewhat constrained in the way our committee works in terms of we're not at liberty to discuss, you know, draft reports or deliberations or anything like that until they're tabled in the Legislature. I would just mention that to you in terms of your expectations that you might have of the committee going forward.

Dr. Ian Reid: Feel free, I'm sure to contact any of us if we can be of further help in clarifying and perhaps whence the final conclusions are made by this committee about what you're going to present, if we could be aware of when that's happening so we can see it, and we'll be in the gallery and support it.

Chair: Great.

All right, thank you very much, folks. It was a great presentation. Thank you for your time. I know you're all busy individuals, and certainly fulfill a very important role in our community, so I thank you for your time here today.

Unidentified Voice: Thank you.

Chair: We'll just take a two-minute recess while our guests leave.

[Recess]

Chair: Are we missing somebody? Hal? And Peter.

Mr. Dumville: Where did everybody go?

Chair: Well, we still have a quorum, anyway. Let's just wind her down.

We're reconvened and then, I guess, the next question is whether there is any new business to deal with at this meeting.

Peter.

Dr. Bevan-Baker: Chair, I just wanted to know what's on our workplan?

Chair: Perhaps I'll let the clerk address that for now.

Clerk Assistant: The next meeting of the standing committee is next week on the topic of mental health and the minister and the chief mental health and addictions officer are in.

Then, in terms of what's left on the committee's agenda; an invitation has been sent out to Health PEI regarding long-term care facility. It's just a matter of – that'll probably be the next meeting that will be scheduled in that regard.

Just let me check my files here, but I believe that is it in terms of new business that was discussed in the spring.

Ms. Casey: Chair.

In lieu of the fact that the Women's Wellness Centre has opened in Summerside, can we get some sort of an update as to how is that progressing? What programs are happening? I think that would be appropriate.

Chair: Anybody would have any issue or comment on that?

No. Okay, great.

Clerk Assistant: Who exactly would they want − the committee want in?

Chair: I guess would we send something to the minister and ask that they provide somebody to –

Ms. Casey: Sure. Yeah, or just an update, it could be the –

Chair: Do you prefer –

Ms. Casey: – it could be –

Chair: – a written update or –

Ms. Casey: Sure, written update or we could have – yeah, just a written update would be fine, and then if we want to take it further than that, maybe we could proceed after the letter, the response has been received.

Chair: Okay.

Anybody else? Peter.

Dr. Bevan-Baker: Thanks, Chair.

I'm really glad that long-term care, I had forgotten that that was left over from spring, and clearly with some recent events here that's an even more acute issue than it was even then, so I'm glad that's on our workplan.

Can I suggest one further thing? Last year there was a really comprehensive and a very compelling and well-written report by a public health officer, Dr. Heather Morrison, on the social determinants of health. I would love for her to come in here and explain to the committee what the importance of that is, and how government and society can best address those chronic health issues.

It was a report that, like many reports, hasn't seen any action directly related to it. I was just very taken by it, and would appreciate the committee hearing about that.

Chair: You want her to come in and do a –

Dr. Bevan-Baker: I'd like –

Chair: – a presentation?

Dr. Bevan-Baker: – I would yeah. Heather Morrison wrote it.

Chair: She had written a report. Did she do a presentation on that?

Dr. Bevan-Baker: I don't believe so.

Chair: Okay.

Anybody have any issue or whatever?

In terms of, kind of, when we would like to see that what are your thoughts? Are we talking getting her in before the sitting or?

Dr. Bevan-Baker: If that's possible. I mean, in my mind, we have mental health already booked for next week, and the long-term care is a much more acute issue. I mean this report was written a year ago, so if it

doesn't happen before then that's fine. I would put it below, in terms of priority, as far as I'm concerned, long-term care.

Chair: Anybody else have any issue with that?

Dr. Bevan-Baker: Thank you, Chair.

Chair: Kathleen (Indistinct)

Ms. Casey: Go ahead, Chris.

Chair: Chris.

Mr. Palmer: Chair, if we're adding items to our workplan, I would like to have a presentation from whoever it is in charge of doctor recruitment and possibly nurse recruitment and if it's the same thing, just to understand the process; how it works from beginning to end so that we really understand that piece.

Chair: Anybody else have any thoughts or comments. No? Good, okay, we'll ask the clerk to add that to the list.

Clerk Assistant: Sure.

Chair: Kathleen.

Ms. Casey: Mr. Chair, what about – I know that the province has a number of drug programs like Catastrophic Drug Program; Seniors' Drug Program. I know in a setting like this, it's always a, and now that we have people watching online, it might be wise to have somebody come in and explain what drug programs are available to the province. Not only for our benefit, but the benefit of seniors or people who might be able to take the transcript and actually find out what kinds of programs are available through the province.

Chair: Sure.

Any thoughts or issues? Anybody? Comments?

Okay, great. I'll ask the clerk.

Clerk Assistant: Sure.

Chair: In terms of prioritization of those last two, physician – or we'll call it health care recruiting and I don't know what we want –

Ms. Casey: (Indistinct)

Chair: – drug programs, we'll say.

What would we like to see done first, I guess in –

Ms. Casey: (Indistinct) recruitment (Indistinct)

Ms. Compton: Could we possibly do both of them at one meeting?

Chair: Could possibly –

Ms. Compton: In interest of time –

Chair: Okay –

Ms. Compton: – really.

Chair: I'll ask the clerk to reach out and see who we can get and what priority –

Clerk Assistant: So at one meeting, potentially, for those two?

Chair: Yeah.

Clerk Assistant: Okay, great.

Chair: Okay, any other new business?

No.

Can I call for a motion to adjourn?

Mr. LaVie: Motion.

Chair: Great.

The Committee adjourned