21 January 2016

Ms Sue Cawcutt
Research Director
Education, Tourism and Small Business Committee
Parliament House
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Inquiry on Smoking and tobacco use at universities, technical and further education facilities, and registered training organisations

Cancer Council Queensland Submission

Dear Ms Cawcutt,

Please find attached Cancer Council Queensland's submission in response to the Education, Tourism and Small Business Committee's Inquiry on *Smoking and tobacco use at universities, technical and further education facilities, and registered training organisations*.

We welcome Queensland Government action to improve the health and wellbeing of Queenslanders through the strengthening of tobacco laws and the creation of smoke-free educational facilities.

Smoke free universities, technical and further education facilities, and registered training organisations are in line with world's best practice tobacco control and would support other legislative actions to reduce the prevalence of smoking in Queensland.

Please don't hesitate to contact Cancer Council Queensland's Chief of Staff, Anne Savage, on [redacted] or via [redacted] if you require any further information in support of this submission.

Thank you once again.

Yours sincerely,

Professor Jeff Dunn AO
Chief Executive Officer
Cancer Council Queensland

Smoking and tobacco use at universities, technical and further education facilities, and registered training organisations

Cancer Council Queensland Submission to the Queensland Parliament's Education, Tourism and Small Business Committee

January 2016

Cancer Council Queensland

Cancer Council Queensland (CCQ) is Queensland's leading non-government community organisation in cancer control. CCQ's goal is cancer control through all actions that aim to reduce the burden of cancer on all individuals and the community.

Over many decades CCQ has led anti-tobacco advocacy in Queensland, encouraging the creation of tobacco control laws and social marketing programs that have significantly reduced the prevalence of smoking in Queensland and reduced illness and deaths from tobacco-related disease. The outcomes of CCQ's endeavours include the creation of smoke-free pubs and clubs, bans on smoking in cars carrying children, and most recently a ban on retail display of cigarettes.

CCQ was established in 1961 as the Queensland Cancer Fund, in response to an increasing need for cancer-related services across the state. CCQ employs over 250 staff statewide, and relies on support from more than 1,500 registered volunteers. The organisation has offices in Brisbane, Cairns, Townsville, Mackay, Rockhampton, Bundaberg, Maroochydore, Toowoomba, and the Gold Coast. CCQ is a member of Cancer Council Australia and is affiliated with the Union for International Cancer Control (UICC). Our vision is for a cancer free Queensland.

The facts on smoking in Queensland

Tobacco smoking is a leading cause of preventable death and disease, and health inequality in Queensland. One third of smokers die in middle age losing at least 20 years of life (42% of lung cancer deaths occur in the 45–64 year old age group, and 18% of COPD deaths). Current smokers will die an average of 10 years earlier than non-smokers, with mortality rates increasing substantially with the increased intensity of smoking. Smoking accounts for 1 in 7 deaths in Queensland with 3700 Queenslanders dying annually from tobacco related conditions. About one-third of these were of working age. One in 10 people who die from smoking-related diseases have never smoked themselves.

Prevalence has decreased by 26% over the decade since 2004, but the rate of decrease has slowed over recent years – new measures are now urgently required to continue historical rates of progress.

PREVALENCE IN QUEENSLAND (2014)

- About 17% of Queenslanders are current smokers.
- 14% of Queenslanders smoke daily.
- 3% are non-daily smokers.
- 28% are ex-smokers.
- 55% have never smoked.
- 15.8 years is the age of the first full cigarette for persons aged 14 years and older.
- 15% of women still smoke at some time during their pregnancy.
- 2.6% quit before the second half of pregnancy, and 13% smoke throughout.
- 500,000 Queensland adults are current smokers.

Cancer Council Queensland Position Statement
Smoking and tobacco use at universities, technical and further education facilities, and registered training organisations

Cancer Council Queensland strongly supports a ban on smoking and tobacco use at universities, technical and further education facilities, and registered training organisations. Research shows that the more available tobacco is, the more people smoke, and the more likely it is that young people will start smoking.

Queensland has about 230,000 university students across 10 multi-campus institutions in Queensland, in addition to 180,000 TAFE students at six colleges across 47 sites, and thousands more students enrolled with 3,500 Registered Training Organisations.

In Queensland, smoking rates are elevated among young to middle-aged adults, with a prevalence of about 20 per cent among adults aged 25 to 44 years. In the 18 to 24 year old age group, 23 per cent of males and 17 per cent of females smoke, compared to the population average of just 14 per cent.

Eliminating opportunities for people to smoke by implementing campus-wide smoking bans will help to reduce uptake and continuation of smoking, underpinning the consistency of smoke free laws across Queensland.

It is well established in evidence that most smokers start smoking in their teens and early 20s (Lupton et al, 2015). In a large review of the literature, Hopkins et al. (2001) concluded that reductions in Environmental Tobacco Smoke exposure were greater in settings that had smoking bans than in those with only smoking restrictions. Of particular concern, a recent West Australian study found that a majority of university students reported that they had been exposed to second-hand smoke on campus (80.1%), whereby about one quarter of respondents (23.9%) reported exposure 'at least daily' (Burns, 2013).

Internationally, institutions with 100% smoke-free policies reported having encountered few challenges (Robertson & Marsh, 2015), and universities in the United States are rapidly adopting smoke-free campus policies, with over a quarter of US universities now fully smoke-free (Lupton et al, 2015). One US study examined the efficacy of a campus-wide smoke-free policy through cross-sectional surveys at two matched public universities in the United States in 2008, one implementing a full smoke-free policy and the other an outdoor ban only within a certain distance of doorways, acting as a control. Undergraduate smoking prevalence at the university with the smoke-free campus decreased significantly from baseline whereas the control university's undergraduate smoking prevalence remained the same (Seo et al, 2011).

Smoke free universities, technical and further education facilities, and registered training organisations are in line with world's best practice tobacco control and would support other legislative actions to reduce the prevalence of smoking in Queensland.

General Evidence

Population health impacts
• Cigarette smoking is the single largest preventable cause of death and disease in Australia. • Two in three Australian smokers will die from the habit. • Tobacco smoking is a leading cause of preventable death and disease, and health inequality in Queensland. • One third of smokers die in middle age losing at least 20 years of life (42% of lung cancer deaths occur in the 45–64 year old age group, and 18% of COPD deaths). • Current smokers will die an average of 10 years earlier than non-smokers, with mortality rates increasing substantially with the increased intensity of smoking. • Smoking accounts for 1 in 7 deaths in Queensland with 3700 Queenslanders dying annually from tobacco related conditions. About one-third of these were of working age. • One in 10 people who die from smoking-related diseases have never smoked themselves. • In men, smoking causes 84 per cent of lung cancers, 73 per cent of laryngeal cancers, 43 per cent of bladder cancers and 28 per cent of kidney cancers. • In women, cigarette smoking causes 77 per cent of lung cancers, 66 per cent of laryngeal cancers, 36 per cent of bladder cancers and 21 per cent of kidney cancers.
Impacts of cigarette smoking
• Smoking is known to cause cancers of the lung, mouth, throat, oesophagus, pharynx, larynx, tongue, lips, salivary glands, stomach, cervix, vulva, penis, kidney, liver, pancreas, bladder, and blood (leukaemia and multiple myeloma). • In addition to being a leading cause of cancer, smoking is also linked to an extensive range of serious and life-threatening diseases. Smoking is linked to heart disease, stroke, peptic ulcers, chronic bronchitis, asthma, emphysema, peripheral vascular disease (a cause of gangrene), macular degeneration (a common cause of blindness). • Women who smoke during pregnancy have a greater risk of miscarriage, pregnancy complications and their babies are more likely to have a low birth weight. Parental smoking increases the risk of Sudden Infant Death Syndrome (SIDS) or cot death. • Smoking just one cigarette can have immediate health effects, including: temporary increases in blood pressure and heart rate; constriction of blood vessels, which slows down blood flow around the body; and binding of carbon monoxide to haemoglobin in the bloodstream. This reduces the amount of oxygen delivered to the tissues. • Overall, smokers have a 70% greater risk of death from coronary heart disease than non-smokers. Even smoking one to four cigarettes per day can double or triple the risk of coronary disease. • The risk increases with the number of years of smoking and number of cigarettes smoked. • Smoking cigarettes increase the risk of heart attack two to six times; increase the risk of heart disease among women using the oral contraceptive pill; increase the risk of stroke three-fold; increase the risk of peripheral arterial disease (which can lead to gangrene and limb amputation) by more than five times; and increase the likelihood of an abdominal aortic aneurysm (swelling of the body's main artery in the abdomen which may rupture) by six to seven times (for current smokers).

Passive smoking

- The effects of passive smoking are a focus of concern, particularly for children. The 2013 National Drug Strategy Household Survey found that the proportion of households with dependent children where someone smoked inside the home is about 4%.
- Second-hand smoke is strongly linked to heart disease, lung cancer and respiratory conditions. The WHO has estimated that about 10% of deaths due to smoking are a result of second hand smoke.
- Passive smoking is also associated with a 25% increase in the risk of coronary heart disease among non-smokers; and an increase in the risk of stroke.
- Even brief exposure to passive smoking (e.g. for as little as 30 minutes) can affect the cardiovascular system of non-smokers.
- Non-smokers living with smokers have about a 25% increase in risk of death from heart attack and are also more likely to suffer a stroke.
- The following health problems have been associated with passive smoking: asthma in children; sudden infant death syndrome; lower respiratory tract infections; lung cancer; coronary heart disease.
- Tobacco smoke makes blood 'stickier' and causes blood cells to clump together – this slows the blood flow and makes blockages in the bloodstream more likely; slows the blood flow, making blockages more common; helps to start (and speed up) the artery clogging process; damages the lining of the arteries where clots can form – this starts happening even in healthy young adults.
- Second-hand smoke is especially risky for children and babies. It is associated with low birth weight babies; sudden infant death syndrome (SIDS) – where babies suddenly stop breathing during sleep; bronchitis and pneumonia; middle ear infections; and the onset of asthma or increased frequency and severity of asthma attacks.

Geographic variations in prevalence

- Daily smoking rates in 2011–12 were higher in four HHSs (from 26% in Darling Downs to 66% higher in Cape York) and lower in one HHS (17% lower in Metro North).
- Smoking during pregnancy varied by HHS from over 50% to about 10% in 2009–2011.
- Quitting prior to 20 weeks gestation varied by HHS from 26% to 7%.
- Smoking after 20 weeks gestation varied by HHS from 44% to 9%.
- Disability and hospitalisation:
- About one-quarter of the total disease burden of tobacco smoking is due to disability or loss of good health (23% in 2007), and three-quarters is associated with premature death.
- The disability burden from smoking is primarily associated with the development of chronic respiratory conditions such as COPD, and with cardiovascular diseases such as coronary heart disease and stroke.
- Although tobacco smoking is the dominant cause of lung cancer death, it carries a low disability burden for this disease, in part due to the low five-year survival rate, 14% in 2010. T
- There were about 36,000 hospitalisations per year due to smoking between 2006–07 and 2008–09, where the majority were associated with cardiovascular and respiratory conditions. Smoking related hospitalisations were 2.3% of all hospitalisations.
- Adults in very remote areas are 26% more likely to have ever smoked than those in major cities in 2014.
- Daily smoking rates are about 60% higher in very remote areas of Queensland than in major cities, although non-daily smoking rates are similar.

Impacts on Indigenous Queenslanders

- Adults in disadvantaged areas continue to smoke at about double the rate of advantaged areas.
- Indigenous Australians smoke at 2.5 times the rate of non-Indigenous people, with no change in this disparity since 2002.
- Indigenous Queenslanders, teenagers and women from disadvantaged areas smoke during pregnancy at about 3 to 6 times the rate of others.
- The variation in smoking rates explains a substantial proportion of differences in life expectancy among populations.
- The prevalence of daily smoking in 2012–13 among adult Indigenous Queenslanders (45% non-age standardised) was 2.5 times that of non-Indigenous Queenslanders after adjusting for age differences.
- The prevalence of daily smoking among Indigenous Queenslanders is similar to the national prevalence.
- Indigenous Australians living in remote areas are about 25% more likely to smoke daily than those in non-remote areas. Although daily smoking is decreasing among Indigenous Australians, the gap between Indigenous and non-Indigenous Australians has remained essentially unchanged since 2002.
- In 2012, Indigenous Queenslander women were 3.7 times more likely to smoke at some time during pregnancy than non-Indigenous women (48% compared with 13%). Although Indigenous Queenslander women were more likely to quit before 20 weeks gestation (5.3% compared with 2.4%), the smoking rates after 20 weeks was about 4 times the non-Indigenous rate (43% compared with 11%).
- The rate of smoking during pregnancy among teenage Indigenous Queenslanders was similar to that for other Indigenous Queenslander women (47% compared with 49%), although for non-Indigenous women, rates among teenagers were 2.6 times the rates of women aged 20 years and older (31% compared with 12%).

Impacts on expectant mothers

- The percentage of women smoking at some time during their pregnancy varies from 10% to 50% across Queensland Hospital and Health Services – the state prevalence is 15%.
- On average 13% of Queensland women smoke throughout pregnancy – the rate in disadvantaged areas is six times that of advantaged areas.
- Young women are 2.5 times more likely to smoke at some time during their pregnancy than older women –35% of teenagers in 2012 compared with 14% of older women. Although quit rates are higher in teenagers (6.5% compared with 2.4%), the relative difference in smoking rates during the second half or pregnancy remained (28% of teenagers and 12% of older women). The lowest rate of smoking was among older non-Indigenous women during the last 20 weeks of their pregnancy, 10%.
- Women from remote and very remote areas are 2 to 3 times more likely to smoke during pregnancy than those in cities. In 2011, 13% of women in major cities were smoking before 20 weeks gestation, while 25% of those in remote areas and 42% of those in very remote areas did so.
- Women in remote and very remote areas were less likely to quit before 20 weeks than women in major cities: 1 in 8 did so, while for women in cities, 1 in 6 quit.
- The rate of smoking during pregnancy among teenage Indigenous Queenslanders was similar to that for other Indigenous Queenslander women (47% compared with 49%), although for non-Indigenous women, rates among teenagers were 2.6 times the rates of women aged 20 years and older (31% compared with 12%).

Sex differences
• Daily smoking prevalence is 37% higher in males than females in Queensland, 16% compared with 12% respectively in 2014. • Males are 26% more likely to have ever smoked than females, they are 22% more likely to be ex-smokers, with older males more than three times as likely as older females to be ex-smokers (aged 75 years and older). • Males have a longer duration of daily smoking. They are more likely to have started smoking at a younger age than females (15.3 years compared with 16.4 years for females in 2010), to become daily smokers at a younger age (17.6 years compared to 18.3 years for females) and be older when they quit smoking daily (35.0 years compared with 32.9 years).
Life expectancy, morbidity, and mortality
• Variation in smoking rates explains a substantial proportion of the difference in life expectancy among populations. • Eliminating smoking altogether would enhance life expectancy. The two-year gain in Australia over the past decade (2.3 years for males and 1.6 years for females) would have been almost three years if nobody smoked (3.1 years for males and 2.3 years for females). • If the prevalence of smoking were reduced to 10%, the life expectancy gains would have been 2.6 years for females and 2.0 years for males. Focussing on smoking reduction in those aged under 60 years would have the greatest effect on extending life. • Cigarette smoking killed more than six million people worldwide in 2010. • Smoking causes death, with two-thirds of long-term smokers eventually killed by their addiction. • Cigarette smoking killed more than six million people worldwide in 2010. In 2007, 1 in 4 cancer deaths in Queensland were caused by smoking. • In Australia in 2010, smoking was estimated to cause 20,000 deaths (about 14% of all deaths) where about one-third occurred in people aged 15–69 years. It is estimated that about 3700 of these deaths occurred in Queensland. Almost half (45%) of these deaths were due to lung cancer, 25% to COPD, 15% to cardiovascular diseases and the remainder were due to other cancers and respiratory conditions. • Second-hand smoke is strongly linked to heart disease, lung cancer and respiratory conditions. The World Health Organization estimates that about 10% of deaths due to smoking are a result of second hand smoke. • Globally, tobacco smoking including second-hand smoke was the second largest cause of disease burden in 2010 (largest cause for males and fourth largest cause for females). • In 2010, tobacco smoking was the third largest cause in Australia, accounting for 8.3% of total burden. Data for Queensland for 2010 is not available. Considering the 2007 Queensland study, smoking caused about 50% more burden for Indigenous Queenslanders than for all Queenslanders. Smoking increases the risk of lung cancer, cardiovascular disease, chronic lung disease, and other conditions. About 80% of lung cancer was caused by smoking.

Age differences

- The highest rate of smoking is among young to middle-aged adults (25–44 years), with about 1 in 5 smoking daily in 2014.
- The highest proportion of non-daily smokers is among 18–34 year olds (about 4% compared with about 2% in middle-aged adults). Considering daily and non-daily smoking together, about 1 in 5 persons aged 25 to 44 years is a current smoker. It is therefore imperative to encourage young people to avoid becoming daily smokers, and to stop them from taking up the habit in the first place.
- In 2010, there were about 27,500 teenagers (14–19 years) who smoked daily.
- Middle-aged and older males were more likely to be ex-smokers than any other group. While the prevalence of smoking is based on cigarette smoking, overseas studies show the uptake of non-conventional tobacco products is increasing among young people. These products include electronic cigarettes, hookahs and, in some groups, cigars.
- Socio-economic status and occupation:
- Smoking rates are higher in disadvantaged areas than advantaged areas – 87% higher for daily smoking in 2014.
- In 2010 in Australia, rates of smoking of blue collar workers were about double those of white collar workers. For workers in lower blue collar employment (semi-skilled, unskilled and farm workers) 30% were regular smokers, 25% of upper blue collar workers (skilled workers), 13% of upper white collar workers (professionals, business owners, executives, farm owners, semi-professionals) and 20% of other white collar workers.
- In 2012, about 9,500 women smoked at some time during their pregnancy with a greater proportion from disadvantaged areas. Women from disadvantaged areas were 6 times more likely to smoke during pregnancy than those in advantaged areas – 26% compared with 4%.
- Quit rates in advantaged areas were double those in disadvantaged areas; about 1 in 8 women in disadvantaged areas quit before 20 weeks, while in advantaged areas about 1 in 4 quit.

Toxicity and cancer-causing properties of cigarettes

- Cigarettes contain more than 4000 chemicals. More than 69 of these are known carcinogens, or cancer-causing agents.
- Carbon monoxide, a poisonous gas produced by burning tobacco, decreases the amount of oxygen available to the body, forcing the heart to work harder. Carbon monoxide is also found in car exhaust fumes.
- Nicotine is the addictive drug in tobacco which increases the smoker's blood pressure and heart rate. Concentrated nicotine is a deadly poison and is widely used as an insecticide. Nicotine is more addictive than cocaine or heroin.
- 30 metals have been detected in tobacco smoke including nickel, arsenic, cadmium, chromium and lead. Evidence suggests that many of these compounds may be carcinogenic.
- Other chemicals found in cigarettes include: turpentine – commonly used as paint stripper; butane – a key ingredient of gasoline; ammonia – a component of toilet and floor cleaner; acetone – more commonly used as nail polish remover; formaldehyde – a chemical used by embalmers to preserve dead bodies; methoprene – a flea repellent.

Economic impacts

- Smoking is estimated to cost the Queensland economy more than $6 billion each year, causing more than 3,700 deaths and resulting in over 36,000 hospitalisations. Of serious concern, smoking-related illness and disease is responsible for one in five male deaths and one in 10 female deaths in Queensland each year, and 46% of these are people younger than 75 years of age.
- In 2004–05, tobacco smoking was estimated to cost Australian society $31.49 billion annually.
- Of the total costs:
- 38% related to tangible costs ($12.03 billion).
- These include health system, labour, crime and other quantifiable impacts. The tangible costs of tobacco smoking were 38 times higher outside the health system than within:
- Net labour costs including reduced employment and loss of productivity and the net effect on households due to premature death and illness were estimated to be $11.71 billion.
- Net healthcare costs were $0.32 billion and include hospital, medical, related nursing home, ambulance and pharmaceutical costs.
- 62% related to intangible costs ($19.46 billion), all due to the impact of loss of life.
- Based on Queensland's share of the Australian population alone, in 2004–05, the cost of tobacco smoking to Queensland society was estimated at $6.1 billion, with $0.06 billion spent on healthcare and $1.15 billion on lost production in the workplace.
- Of the tangible costs of smoking, 97% were associated with lost production and impact on household finances, with the remainder associated with health system impacts.

Distribution by payer of the tangible social costs of tobacco abuse in Australia, 2004–05 ($m)

	Households	Business	Government	Total
Workforce labour	0.0	4 517.4	1 231.6	5 749.1
Household labour	9 843.1	0.0	0.0	9 843.1
Health care				
Hospitals	7.3	37.6	178.5	223.4
Medical	17.6	16.1	124.8	158.4
Nursing homes	(37.2)	(0.4)	(139.6)	(177.3)
Pharmaceuticals	12.7	0.0	64.6	77.3
Ambulances	11.4	4.2	21.0	36.6
Total health care	11.8	57.5	249.3	318.4
Fires	16.4	36.5	10.2	63.0
Resources used in abusive consumption (purchase of tobacco)	0.0	3 635.6	0.0	3 635.6
Total	9 871.2	8 247.0	1 491.1	19 609.3
Percentage of total costs	50.3%	42.1%	7.6%	100%

Source: Collins and Lapsley 2008

Tangible social costs of tobacco use in Australia, 2004–05 ($m)

Cost category	$m
Labour	
Labour in the workforce	
Reduced workforce	4 969.5
Absenteeism	779.6
Total	5 749.1
Labour in the household	
Premature death	9 156.4
Sickness	686.7
Total	9 843.1
Total workforce and household labour	15 592.2
Less consumption resources saved	(7 583.1)
Net labour costs	8 009.1
*Health care (net)**	
Medical	158.4
Hospital	223.4
Nursing home	(177.3)
Pharmaceuticals	77.3
Ambulances	36.6
Total net health care costs	318.4
Fires	63.0
Resources used in abusive consumption (purchase of tobacco)	3 635.6
Total tangible costs	12 026.2

Source: Collins and Lapsley 2008

Please note that this submission is supported by a 668 page dossier of medical and scientific evidence, submitted as a separate attachment to the Health and Ambulance Services Committee Inquiry on the *Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015*.