HEALTH AND AMBULANCE SERVICES COMMITTEE

Members present:

Ms L Linard MP (Chair)
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP
Dr CAC Rowan MP

Staff present:
Mr B Hastie (Research Director)
Ms K Dalladay (Principal Research Officer)

PUBLIC HEARING—TOBACCO AND OTHER SMOKING PRODUCTS (EXTENSION OF SMOKING BANS) AMENDMENT BILL 2015

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 16 SEPTEMBER 2015

Brisbane

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Committee met at 9.32 am

CHAIR: Good morning and welcome, everyone. Thank you for your attendance today. I now declare open this public hearing of the Health and Ambulance Services Committee. I acknowledge the traditional owners of the land on which we meet and pay my respects to elders past and present. I am Leanne Linard, the member for Nudgee and chair of the committee. The other committee members with me today are: Ms Ros Bates, deputy chair and member for Mudgeeraba; Mr Steve Dickson, member for Buderim; Mr Aaron Harper, member for Thuringowa; Mr Joe Kelly, member for Greenslopes; and Dr Christian Rowan, member for Moggill.

Today we are hearing evidence on the Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015. I would like to welcome Mr Mark McArdle, the member for Caloundra, who introduced the bill into the parliament. The bill aims to decrease the incidence of smoking in Queensland by strengthening smoking bans. It would ban smoking within five metres of all state government buildings, including the parliamentary complex we are meeting in today. Smoking would be banned at all transport waiting areas, pedestrian malls, public swimming pools and skate parks. The sale of cigarettes at pop-up or temporary sales venues would also be banned. Our inquiry into this bill commenced on 14 July and will conclude when we report back to the parliament by 16 October 2015. The committee has received 16 submissions, which are published on the committee web page.

I will advise you of a few procedural matters before we hear from our invited witness. The committee is a statutory committee of the Queensland parliament and, as such, represents the parliament. It is an all-party committee that takes a nonpartisan approach to inquiries. The committee proceedings are subject to the Legislative Assembly's standing rules and orders. People in the room not providing evidence—we do not have an issue with that at the moment—are reminded that they are here to observe proceedings and may not interrupt. Anyone who disrupts proceedings may be removed at the discretion of the chair or by order of the committee. Hansard is making a transcript of proceedings that will become available as soon as practicable and the proceedings are also being broadcast live on the parliament's website. If any media are present who might be recording any of the proceedings, I ask that they adhere to the committee's endorsed media guidelines. Committee staff have a copy of the guidelines available if you require one.

I would now like to welcome the member who introduced the bill into the parliament, Mr McArdle, the member for Caloundra.

McARDLE, Mr Mark, Member for Caloundra, Parliament of Queensland

CHAIR: I invite you to make an opening statement and then we will open up to questions of the committee.

Mr McArdle: Madam Chair, good morning to you and to the committee members. I want to thank you for inviting me here today. I start with a small apology: I am the deputy chair of the Communities, Disability Services and Domestic and Family Violence Prevention Committee, which also meets on this day of each sitting week, so therefore there is a clash. I have limited time here today, so I apologise in advance. That clash in future can raise concerns about my capacity to appear before this committee.

The bill before the House does two things: it provides an incentive for people who are smoking to reduce or cut their smoking to zero; and it provides for a reduction in passive smoking. Both of those are linked undoubtedly to cancer and to other ailments in the body—heart disease and the like—which kill thousands of Queenslanders every year.

The other point I make is that I believe that prevention is much better than repair. If we can prevent people from taking up a habit that can potentially and literally save their lives or give them the full extent of the life that they were going to achieve, that is better than trying to repair somebody at the end of a long process when their body is wracked by a habit that they took up at a younger age. I do not think there is any parent who is a smoker who would not say to their children, 'Don't take up smoking.' There is not a person in this state who would not say to another person, 'Don't take up smoking.'

The implications are quite clear, and the report placed before the committee by the Cancer Council outlines some startling facts. Some 3,700 people die of smoking related illnesses each year, although that data is a bit dated now. If I recall correctly, one in 10 people who pass from a smoking related cancer are in fact passive smokers. There is a significant cost to the Health budget. There is a major cost to productivity across the state and there is an economic loss as well. I believe that we need to put in place, where we can, those laws that provide that assistance. There will be those who will buck the idea, but in the case of smoking there is a proven link between it and many types of cancers. There is no doubt about that. If we as a parliament can move to stop a person from taking up that habit, we should be looking very seriously at it. I will leave it at that and pass back to the committee for questions on the bill.

CHAIR: Thank you very much for your opening statement. I want to ask about the implementation of the proposals in this bill. Have there been discussions with the LGAQ in the drafting of the bill about operationalising the amendments proposed in regard to enforcement?

Mr McArdle: When you say 'enforcement', are you talking about the policing of it or other issues around it?

CHAIR: Yes, in public places, public transport locations.

Mr McArdle: If you are talking about signage, there are a couple of points that I would like to make in that regard. First of all, ignorance of the law is no excuse. We do not have signs for everything we do in this state. We do not have signs everywhere that you cannot relieve yourself, shall we say, in public or you cannot jaywalk or you cannot litter. The education of people in regard to smoking in the past has been run by the Quit campaign, which is an ongoing campaign. In addition to that, it is quite readily picked up by the public who become the enforcers themselves in relation to where people can and cannot smoke.

I am not convinced that we need to have signage in relation to an issue of this nature. First, people know that smoking is bad for you; second, people are quite readily able and do point out to people who are smoking where they should not be to stop smoking; thirdly, people are acutely aware of passive smoking, particularly when they are not a smoker themselves, obviously. I do not believe that there needs to be a major education program. The simple reason is this: if we put in place an education program for every bill that passes through this House the cost would simply be astronomical. There is no doubt that the public is attuned to the issues around smoking. I think the issues in relation to smoking outside public hospitals and schools have been picked up by the public very readily.

CHAIR: You have spoken to signage, but what about enforcement? Say somebody is in a bus shelter waiting for the bus and somebody is smoking. Who will be enforcing the rules around that?

Mr McArdle: This is intriguing, because the state police would be obligated to do so. The advice that I have in relation to the councils is that under the Tobacco Act we cannot force the councils to adopt it. I would like to take that on notice, because I think it is important that I look at that. I understand that the wording of this act means that we cannot force councils to police it. They may opt in. But I would not mind taking that point on notice. I have a nagging doubt in the back of my mind, but my advice is as I stated to the committee just now.

CHAIR: In regard to a definition issue, I would mention that the explanatory notes did not include a lot of detail to be able to further understand the bill, although I appreciate that, obviously, your speech in the House did help. As it goes to definitions, on my reading there is a conflict about the definition of a government building and the perimeter. The bill seems to state five metres of a building, whereas your explanatory notes go to five metres from the entrance. Could you speak to your intention about the perimeter issue?

Mr McArdle: It is five metres of the building, around the building.

CHAIR: So the corner of all building—

Mr McArdle: Correct.

Ms BATES: Thank you, Mr McArdle, for appearing today. We appreciate that. The LGAQ's submissions and also that of the Logan City Council support in principle the approach that is outlined in the amendment to this bill. For the committee's benefit, one of the issues that was raised is that the councils currently have discretionary powers to impose bans and they were concerned about their ability then to designate smoke-free areas as well. Is there any provision in this for councils to actually designate a smoking area somewhere? Obviously the amount of smoking areas around the state is decreasing and this bill will also serve that purpose.

Mr McArdle: Are you asking me whether the bill provides where smoking can occur? The bill provides those areas where it cannot occur. Therefore, by definition, where that does not apply it can occur. Under the bill, of course, you can smoke in a motor vehicle if you are driving past a building that is barred from smoking.

Ms BATES: I have raised this with you before, particularly with smoking around hospital facilities. My concern has always been that a number of hospital staff continue to smoke, regardless of the fact that they know probably better than anybody else that they should not. There are instances, even at the Gold Coast University Hospital, where the staff are a lot further than five metres away from the building. They actually have to be even further away from the hospital, so they are out in a bus stop or down the street or places like that. That has always been one of my overarching concerns, particularly for nurses who smoke on night duty and have to go some distance away from their workplace. It might actually be a safety issue for them. Can you speak to what you think about that?

Mr McArdle: First of all, my point would be that smoking is still legal. Secondly, I do understand the issue of safety. However, my point would be that the overriding principle behind this bill is to prevent smoking in the first place to prevent passive smoking. I do not apologise for the fact that that is the intent of the bill because at the end of the day I am here to try and put into place a bill that is going to save lives. It is not just to save lives; it gives an extended life not just to the individual concerned but also to the family as a whole. I cannot apologise for the issue of people wishing to smoke. I wish they did not smoke, but I am not going to indicate that we are going to make exceptions for that.

Ms BATES: One of the other issues that the LGAQ has raised is that the cost of the proposed penalty per person is 20 penalty units. At the moment I think they provide 10 penalty units. Could you elaborate further on that?

Mr McArdle: If they are looking to me to reconsider the penalty units, I think the penalty units should reflect the seriousness of the matter. If they are keen for me to look again at what that should be I will discuss that with them, but I do not think that should deter the intent of the bill. The intent of the bill is to put in place not prohibitions but certainly incentives not to take up smoking. Smoking is an issue that kills people in this state. It destroys families, it puts people through misery, and I believe passionately that we need to take steps to make certain we do what we can to eradicate a disease such as cancer that stems from smoking.

Mr KELLY: Thank you, member for Caloundra, for turning your mind to this very important topic. As a nurse I have seen firsthand on far too many occasions the damage that smoking does, so certainly you have my support on the objective of reducing smoking rates to as low as possible.

You talk about preventing people from taking up smoking in the first place. From a health economics perspective, the research suggests that increasing the cost to people is one mechanism to reduce smoking. Another is to increase time costs. Why do you think the current time costs that we apply—making people walk out of a building—are not enough and why do we need to go further in relation to the proposed changes that you are putting in this legislation?

Mr McArdle: Smoking is an addiction—there is no question about that—so we have to break the habit of people smoking readily, and we can do that by making them have to walk downstairs and outside. That is an incentive to break it as well. This is all about incentivising, breaking the addiction and getting people to understand that what they are doing is protecting themselves, their families and others. We lose $6 billion per year because of smoking in this state—$6 billion. That is an enormous sum of money. More importantly, we lose 3,700 lives every year. That is more important than the economic outcome, as far as I am concerned. The cost to the Health budget is about $60 million. It is small in comparison to other figures, but these figures are significant when we talk about saving the lives of people and what it means for the benefit of the whole state.

Mr KELLY: There is no doubt about that. Obviously one of the things that you are attempting to do in this bill is prevent clustering near the entrances to buildings. I guess as someone who goes to work and walks past hoards of people smoking outside of the hospital it is quite distressing for me, to be quite frank. In terms of the five-metre rule that you are proposing, are we simply going to be moving the cluster five metres away? My concern would be that if the five metres away from a government building is then outside somebody's house, would we find ourselves in a situation where we have simply moved the problem from the front door of the government building to the front door of the neighbour? I myself live five metres from a state school and regularly have people standing in front of my house smoking which floods into my veranda area, which is quite distressing. Do you have any thoughts on that?

Mr McArdle: You are right. The rule of five metres is to prevent clustering and prevent passive smoking. There will be issues as we go forward but we can address them as we go forward. I think the principle here is: let us start with a premise and then work through that as time goes by. I think when we consider the implications of what we are talking about, we need to be cognisant of issues that may arise but deal with them as they do arise. There are those out there who want to ban smoking entirely. That is simply a nonsense argument. You cannot do that. We have learned in the past that banning a legal item actually creates more problems. So let us deal with what we have and try to reduce the incidence of smoking even further. Yes, every bill has, when it becomes an act, issues to be dealt with. That is what this House is all about. Madam Chair, I have to get moving very quickly. I do apologise for that. My committee starts—

Mr DICKSON: I will be very, very quick. I have to declare an interest: I am an ex-smoker. I gave it up in 2000, which I am very proud of. I think the big issue here is that we have to educate children, and I look at those four components. I think five metres is very reasonable. I think the ban on smoking in transport waiting areas and pedestrian malls is very reasonable. I think you are going to be able to manage banning smoking at public swimming pools. In terms of the skateboard component, I think you are going to find that really difficult, because local authorities are going to be the ones that you want to look after these children who are probably going to start to smoke but the areas are not confined. A swimming pool is a confined area. You can put up signs saying 'It is illegal to smoke in this area'. I think the skate parks are going to be very, very difficult. The banning of cigarettes in pop-up venues, absolutely.

The push I think is a great initiative. I think you will probably get the support of all members of parliament because smoking is not a good thing, but we need to remember that when our generation grew up the Marlboro Man was riding around on a horse. We all thought it was a cool thing to do, and I was one of those people. Smoking was not recognised as something that killed you. It was a thing to do with your friends and peers. Today we know what the harmful effects are. We know that we have to save children's futures, so I think attacking that area is probably the most relevant area we need to go after but at the same time refining where people can and cannot do this. I would like you to take on board the issue relating to the skate parks. I think that would be very, very difficult to police. On the rest of them you have my full support.

Mr McArdle: Thank you for your comment. I think, member for Buderim, we are probably dealing with what may be termed the 'hard core' smokers now and we need to put in place measures that deter them but, more importantly, educate children as well. I grew up in the same era as you. There is no doubt there are absolutely definite links between cancer and smoking. I do not think any bill is going to solve everything, but I think it is part of a puzzle we are trying to put together. This will not solve smoking—there is no question about that—but what we have in place with regard to advertising, plain packaging and cigarettes being hidden in stores is part of getting the message out there about smoking being bad.

I do not think I have ever proclaimed that this will be the panacea, but it will be one more piece of a puzzle that we need to put in place. Again, I think at the end of the day it is about saving lives. It is about understanding implications. It is about looking at a secondary level at the cost, which is important, but I think it is also focusing on preventative medicine as opposed to repair medicine, and I think we need to start doing that more and more. Increasingly our cohort is going to face massive problems medically, if I understand the literature correctly, and I have made the comment before that we need to focus on how we stop it starting as opposed to how we prevent it from ending us.

CHAIR: Given the limited time, the members for Thuringowa and Moggill have indicated that they are happy to not ask their questions. Member for Caloundra, you indicated that you were happy to take on notice questions and clarity requested around enforcement. I also raise a similar question around cost estimates. They are also not included in the explanatory notes and there is no explanation as to why they were not. Would you be willing to take that under consideration for the committee? I thank you very much for appearing before the committee today and for answering our questions.

PULSFORD, Mrs Kaye, Executive Director, Preventive Health, Department of Health

WHITEHEAD, Ms Rebecca, Department of Health

YOUNG, Dr Jeanette, Chief Health Officer and Deputy Director-General, Prevention Division, Department of Health

CHAIR: Thank you very much, Dr Young, for attending today. Would you like to make an opening statement to the committee?

Dr Young: First I apologise, Madam Chair and members of the committee. Unfortunately my colleague Mark West was unable to attend this morning due to illness, so I hope it is okay with you that alternative colleagues are here with me. I have Mrs Kaye Pulsford, who is the executive director of the prevention branch within my area, and Ms Rebecca Whitehead, who is the director in the area responsible for tobacco. They will be here if I am unable to answer questions.

Thank you very much to the committee for the invitation this morning to provide the committee with information on Queensland's tobacco legislation. I know that we all agree that good health is important, and the positive news is that Queenslanders are on the whole healthy. We are living longer and we are smoking less. Some 86 per cent of Queensland adults do not smoke anymore. We are making a difference. Over the last decade in Queensland there has been a 26 per cent reduction in smoking and a significant reduction in the proportion of young people taking up the habit; however, tobacco smoking remains a leading health challenge. Tobacco related deaths and hospitalisations are still too high. Further reducing smoking rates remains a key focus.

Over many years Queensland has implemented a proven multistrategy approach which aims to increase protection from second-hand smoke, support smokers to quit and prevent youth uptake. Our strategies include: creating smoke-free environments by law and policy; implementing quit-smoking campaigns to remind smokers of the dangers of smoking and encourage them to take action; providing tailored quit-smoking advice through the Quitline service—33,000 people call that line each year and we know that we have retention rates for their program of 68 per cent and quit rates of 45 per cent six months after program completion; targeting our quit-smoking programs to reach those with higher rates of smoking; preventing young people from taking up smoking through retail sale and display restrictions; and providing school based education to get healthy messages to children early.

Taken all together, these strategies have been proven to influence healthier behaviours and strengthen community expectations for more smoke-free environments. Indeed, three-quarters of Queenslanders tell us that they actively avoid places where they are exposed to other people's smoke. I would like to provide a bit more detail at this point about Queensland's current tobacco laws, in particular the smoking bans for public places.

I do have a graph that I think shows very clearly how the incremental introduction of tobacco legislation has assisted in reducing daily adult smoking rates in Queensland. I do not know if I can table that. It is a really nice visual way of demonstrating. The red text above the black line and the arrows above refer to key Queensland tobacco legislation, while the blue text and arrows under the line refer to key national legislation. We can see that there has been a considerable decline in smoking rates over the last 2½ decades, from a rate of 24 per cent in 1990 to a rate of 14 per cent last year. The earliest tobacco legislation focused on retail supply and included prohibition of tobacco sales to children under 18, limits on pack size of cigarettes and loose tobacco, prohibition of herbal cigarettes and restriction of vending machine locations so that vending machines must be placed within five metres of a bar or in an adult-only gaming machine area of a liquor licensed venue—and they have to be under staff supervision—and then in 2014 most recently electronic cigarettes, e-cigarettes, were prohibited from sale in vending machines.

The introduction of smoking bans for public places followed soon after that initial tranche of legislation, with smoking bans introduced for many indoor public places in 2001, and Queensland became the nation's leader in 2005 with the phased introduction of smoking bans at outdoor public places including eating and drinking places, entrances to public buildings, patrolled beaches, prescribed outdoor swimming areas, children's playgrounds and sports stadiums. Smoking indoors at liquor licensed venues was also phased out over an 18-month period from early 2005.

Then in 2010 local governments were empowered to play a role in creating smoke-free public places with inclusion in the tobacco act of the option to create local laws banning smoking at public transport waiting points and outdoor pedestrian malls. The introduction of statewide smoke-free public places has progressively expanded, and smoking bans are also in place in cars where children under the age of 16 are present, in business vehicles carrying more than one person, at public and private

prisons, at public and private health facilities including the five-metre buffer, and at state and non-state schools—again, including the five-metre buffer. In 2014 the tobacco act was amended to capture e-cigarettes as smoking products. This means that these devices cannot be used in smoke-free places.

National legislation is focused on reducing tobacco advertising, providing health warnings and implementing pricing measures. This includes tobacco advertising bans for print, television and radio, progressive tobacco excise increases, graphic health warnings on packs, and world-leading plain packaging.

To ensure that these policies and legislation are in place, we need compliance. Supporting compliance is important for ensuring the laws achieve their objective of protecting the health of Queenslanders. It is important that we consider the overall compliance with the regulations including compliance by retailers, licensees, business owners, as well as smokers. Comprehensive action is required to promote and ensure compliance including awareness and education for the community, education advice for industry regarding their obligations, free no-smoking and Quitline signage for retailers, information packages for stakeholders impacted by any new laws, proactive and reactive enforcement, and there is a public telephone service for reporting alleged breaches—13QGOV. There is strong support for smoke-free environments in Queensland. As a result, smoking bans are actually generally very well supported in the community with very high levels of compliance.

Another useful bit of information I thought you should see relates to who is responsible for the different compliance aspects of the different legislation. There are three agencies, as you can see in that table, that undertake enforcement: hospital and health services, local government and Queensland police. Tobacco laws are primarily enforced by environmental health officers employed by hospital and health services. Local governments, however, also are provided with authority under the tobacco act to enforce outdoor smoking bans at some places. These include children's playgrounds, between the flags at beaches and within the buffer areas around hospitals and schools, and local governments retain the revenue from penalties issued by their officers. It should be noted, however, that that authority is optional and there is no duty imposed on local government to undertake enforcement.

Where local governments have introduced local laws for public transport waiting points and malls, enforcement is undertaken by the relevant local government. Smoking bans on hospital and health services' land are enforced by security officers employed by the service. These officers can enforce smoking bans on the land and within the buffers only at the facility for which they are employed. Police enforce the ban on smoking in cars carrying children under 16 years of age and they are also authorised to enforce tobacco sales to minors and prohibited products legislation.

We do a lot of compliance audits. One statewide compliance audit of indoor and outdoor smoking bans at 386 licensed hotels and clubs was undertaken in the financial year 2013-14. Hotel and club licensee and patron compliance with requirements for not smoking in indoor and outdoor areas was extremely high, at 99 per cent, with only three hotels observed to be in breach. Two licensees were issued with improvement notices and one received a notice for failing to direct a patron to stop someone smoking indoors. At that time it was not possible to issue on-the-spot fines for these breaches. That has been addressed since then. For hotels and clubs with designated outdoor smoking areas, DOSAs, compliance was also very high at 93 per cent for outdoor requirements. The vast majority of licensees were compliant with not providing food or entertainment to patrons in DOSAs and 87 per cent of DOSA buffers were compliant. Enforcement responses include improvement notices, official warnings and immediate resolutions.

Another statewide compliance audit for smoking bans was undertaken in 2010 looking at 1,153 outdoor cafes and restaurants, and patron compliance again was extremely high, at 96 per cent. Noncompliance appeared to occur most commonly at smaller premises where no-smoking signage was not visible. During an intensive six-month statewide enforcement period from late 2005 to April 2006, 133,000 site inspections were conducted for indoor and outdoor public places, tobacco retail outlets and liquor licensed premises, with more than 1,100 on-the-spot fines issued. Most breaches were for tobacco retailing laws and smoking bans at building entrances and major sports stadiums. Enforcement of the ban on smoking in cars where children under 16 years are present is undertaken by Queensland police within the scope of their traffic enforcement duties. In 2014-15 they issued 508 infringement notices for that offence. Since the introduction of the offence in January 2010, police have issued around 40 to 50 infringement notices each month.

Another compliance audit was undertaken of 480 retail outlets during February and April this year. Key retail outlet types audited included newsagencies, convenience stores, service stations and supermarkets. The audit included assessment of compliance with restrictions on the location and

storage of smoking products, price ticket requirements and display of mandatory and permitted signage. The audit was based on the tool and methods used in 2012 to allow for comparison over time, with the tool being updated to include electronic cigarettes. Audit results indicated very high compliance again by retailers of between 94 and 100 per cent compliance, and those results indicate an improvement or maintenance of very high compliance with retail restrictions for display and promotion of tobacco products compared with 2012. E-cigarettes were not found to be widely sold at inspected outlets, with less than 15 per cent selling these devices, with tobacconists, convenience stores and service stations most likely to sell them.

A statewide compliance operation was undertaken in late 2014 through to June this year looking at tobacco sales to children. Two hundred and seventy-two covert surveillance operations were conducted at retail outlets assessed as being high or medium risk for sales of smoking products to minors—for example, corner shops close to schools or if there had been previous allegations about a particular outlet. Ninety-nine per cent compliance by retailers was observed, with the one verified account of noncompliance resulting in a formal warning. These results are similar to the previous surveillance conducted in 2013-14 at 551 retail premises which also found retailers to be 99 per cent compliant. A specific project targeting the Gold Coast area during 2013 schoolies period found five verified accounts of noncompliance resulting in a penalty infringement notice for a retailer failing to undertake training of staff and formal warnings to adults for non-retail supply of smoking products to minors.

In terms of the future, a statewide compliance audit of public and private health facilities across the state will be conducted this financial year, and that will focus on compliance with smoking bans on the grounds in the buffer areas of hospitals. We are also going to be shortly launching another quit-smoking advertising campaign on television which will further encourage smokers to quit and call the Quitline. So legislation, coupled with enforcement, quit campaigns and programs need to all continue to work together so that we reduce the impact of smoking on our community.

CHAIR: Dr Young, thank you very much for your opening statement and the very valuable information that you provided to the committee in written form and also your testimony today. I want to ask a question about the nature of smokers. Obviously there has been a significant investment by governments of all shapes and sizes and colours to try to prevent smoking. There are still many people who do still smoke, and I understand from one report I read that there are particular demographics—concerningly young women—who are smoking and sometimes increasing in number. I am not sure if that is correct and I would be interested to hear from you on that. What is the nature of those people who seem to be so resilient to all of those campaigns and continue to smoke? Is it addiction because they are already smoking or is it just that people are becoming immune to the message? What is your opinion on that?

Dr Young: I firmly do not believe that people are becoming immune to the message. I think people hear that message, but the power of tobacco is such that once those people have taken it up and they are addicted it is very, very hard to stop. Tobacco is probably the most addictive substance known. It is more addictive than a lot of the illicit drugs. It is a very difficult product to give up and people need multiple attempts. Not many people give up the first time they try. They try multiple times. That is why we are forever getting people to go back to the Quitline and try again, and we know that eventually with multiple attempts people do give up. There is also some really exciting research—at least I believe it is exciting—that shows that even if you give up for a period and then start again you have helped your health significantly and that will help over your lifetime. So giving up for a period, starting again, giving up again, starting again and then giving up finally for good is the best way to go. There is lots of evidence for that.

In terms of our population, yes, we are seeing delays in the giving up in certain parts of our community. People with low socioeconomic status, people in rural and remote parts and Indigenous people all have higher rates, but they are coming down as well. So we need to keep these strategies that we know have worked to get us from where we were to where we are now. We need to keep them going, and we need to keep them front of mind. So I do believe it is important that we keep on moving ahead with the legislation that we are putting in place for smoke-free places.

CHAIR: You mentioned regional areas and that they have a higher incidence of smoking. I note that there is discretion for councils in regard to how they actively engage in compliance. Do you feel that that discretion means that we are perhaps not doing enough or not enough is being done around enforcement in regional areas by councils to push the message?

Dr Young: Yes. There is actually a program that has been announced by government out there at the moment to support local councils in managing enforcement. So we are working that one through at the moment with local government.

Ms BATES: Hello, Dr Young. It is nice to see you again. Hospitals are the last place that you should smoke, but it is often the most stressful situation that people will ever be in, especially as a smoker, as a relative, a patient or even a staff member having to deal with issues, particularly the issues that those poor nursing staff on the Gold Coast last week had to deal with in the ED department. You mentioned that there has been an overall reduction in smoking of 26 per cent in Queensland. Since the bans outside hospitals—which I thoroughly and absolutely agree with—can you give us a percentage of the reduction in smoking incidence by patients, those with their IV poles who used to be out the front of hospitals, or certainly by staff? I have raised with you before my concern for the safety of staff leaving the hospital to continue smoking.

Dr Young: I do not have that information and I am not sure whether the hospitals and health services would collect it. I will see what either of my colleagues think.

Ms Pulsford: As part of the implementation, the legislation did not stand alone. We also introduced a brief intervention into hospitals. We were encouraging the staff to direct patients to the 13HEALTH line. I cannot give you the exact figure, but I know that there has been a one-third increase in calls to the 13HEALTH line for QUIT information and assistance for inpatients. We did not just put the legislation in place; there was this other supportive initiative at the same time around nicotine replacement patches for inpatients and we continue to provide free nicotine replacement therapy for staff.

Ms BATES: Anecdotally, it looks like it has been reduced because patients are not allowed to be out the front. I am just wondering if they are down the road instead.

Dr Young: I do not know that we would have that data—I do not know that the hospitals would collect it—but the important thing to remember is that the reason people want to smoke is the addiction. If you can remove some of that through nicotine replacement, you can reduce levels of anxiety. We saw that in the prisons. In the prisons we have seen a reduction in the amount of anxiety in the prisoners, because they are not hanging out for their next cigarette. Prisoners were not allowed to ever smoke—not in the recent past—in their rooms or in the facilities; they had to go outside and they were allowed to go outside only at certain times during the day, so they were having to wait for their next cigarette. Giving them nicotine replacement stopped that urge, that need to smoke. Then a lot of them have gone on successfully and quit through that process.

We know that you can help people to deal with that urge to smoke, even if it is temporary, while they are a hospital inpatient and then when they leave they return to smoking, but during that time you can do things to help people. Hopefully, without having the actual data to prove the number of people not smoking on the verge of the hospital, it has had an impact.

Mr KELLY: Just picking up a little bit on what Ros is saying there, I am pretty sure, certainly at the Royal Brisbane, there was a cessation-of-smoking clinical pathway and I feel that that was also at QEII. Is that something that is standard across the state?

Dr Young: It is through all public hospitals.

Mr KELLY: So you would be able to pull data—

Dr Young: Yes.

Mr KELLY: So could you take that on notice to give us some data around take-up and also whether or not that actually is effective?

Dr Young: That was that information that there has been a big increase to calls to the Quitline, but, yes, we can pull that data.

Mr KELLY: Thank you. I just have a few questions. One is firstly just from a technical perspective. As a medical officer, I assume that it is widely accepted that there is absolutely no safe level of smoking; is that correct?

Dr Young: That is correct, yes.

Mr KELLY: In relation to the bill's objectives of reducing clustering and reducing passive smoking, is there any evidence around levels of smoke in the atmosphere that will contribute to damage from passive smoking?

Dr Young: There is evidence for that. Overall, we know that one in 10 people in Queensland who die from a smoking related disease have never actually smoked themselves. More and more of that evidence is coming out as fewer people smoke, because it is easier to untangle. If you have never smoked in your lifetime and you get a smoking related disease, it is easier to say that that is due to passive smoking, whereas if you have had periods where you have smoked and then given up it is harder to work that through. Yes, there is good, solid evidence showing the dangers from different degrees of smoke inhalation.

Mr KELLY: Do we have levels of exposure? If we move the passive smoking from, say, the front of a hospital five metres down the road in front of somebody's house, will that then be moving that exposure to the private property of that particular person or those individuals who live in that house?

Dr Young: The smoke in that situation can escape into the atmosphere. It is most dangerous when it is in an enclosed space, of course. The concern always with schools and hospitals is that we have seen clustering at the entrances. That has been illegal for quite some time—that five-metre rule around entrances—but the idea with the hospitals and schools is that there are a lot of people who wait there. They wait to go into hospitals; they wait to pick up kids from schools. That is why that was brought in, to have that five-metre buffer all the way around.

Mr KELLY: Dr Young, you have already mentioned that there are certain demographic groups that have higher rates of smoking. In the bill there is clearly some work around skate parks targeting younger people. I assume it would be younger men. Is that one of the demographics that has higher rates of smoking?

Dr Young: Younger people have lower rates because they are not taking it up, but we want to get that to as close to zero as possible. Anything we can do to stop people starting smoking is critical, because it is much easier to never start smoking than to give it up once you are an established smoker.

Mr KELLY: One of the groups that I would see has one of the higher rates of smoking—and it is only anecdotally in my personal experience—is people with mental health problems.

Dr Young: Yes.

Mr KELLY: Are there strategies in place for us to assist people who are mentally ill to reduce their rates of smoking?

Dr Young: Yes, we give them the same support and, indeed, additional support as we give to other inpatients in our facilities. There is more understanding now that people who have mental health issues suffer more from physical complaints than people who do not. That is often because we do not focus on those other things that we need to focus, such as the prevention area—so making sure that we assist them to stop smoking. We do not say, 'They are using smoking as a support for their mental illness.' That is wrong. Again, we know that if we help them give up smoking they are less anxious, because nicotine, when people cannot get it, makes people anxious. So we do all of that work with that group. They come under the same requirements as all of our health services in that they cannot smoke in mental health facilities. They are given all the same support that we give in terms of nicotine replacement assistance, the Quitline and we have some enhanced strategies for them as well.

Mr DICKSON: Dr Young, it is always good to see you. I think any bill that we can put forward to minimise smoking is a good thing. I think now we have to really look at putting amendments in this bill to make it even better. I am an ex-smoker. I gave myself up earlier today. I stopped in 2000. This is a really big problem. I went down the path that you spoke about. It took me three times to stop and I am very pleased I did. We have cigarette companies that make a whole lot of money out of this. We have Queensland Health and other providers throughout the country that spend a lot of money on trying to help people who have cancer related diseases because of exposure to smoke. Has anybody done the sums in terms of profit versus cost in trying to rehabilitate or to cure the diseases we have? Also, does the Queensland government subsidise in any way the cure to helping people stop smoking? One of my best friends, who is the worst smoker I have ever met in my life—he was the best man at my wedding—has stopped smoking. BHP subsidised the hypnosis. I thought hypnosis was crazy magic, but he has physically stopped smoking so it must work. What is Queensland Health doing to subsidise people to stop smoking? I see this very clearly. We either stop selling it, we stop people from smoking or we let them smoke. There is one of those three options.

Dr Young: We do a lot. We have the Quitline, which supports people. We have the healthy workplace initiative within workplaces assisting people to stop smoking by providing nicotine replacement therapy, if that works for that person. We have a whole lot of strategies to support people, because everyone gives up smoking differently. Some people just go cold turkey and that suits them. Other people, as you say, go and look for hypnosis. Other people use a whole range of different strategies. It is about working with people and Quitline does that—'What is the best way for them?' There are pharmaceutical interventions. People can go to their GP and work with their GP. There is a whole range of things. It is really important that people have all of those options and are aware of

them. There are websites that help them, that give them information. So it is all of that working together that works with people. Yes, it is subsidised by government—by the Commonwealth and by the state government—in terms of the things that are available.

Mr DICKSON: If you could take on that comment that I made originally relating to the profit margin of cigarette companies versus the cost to government? Has anybody done the sums on that and who comes out on top?

Dr Young: I am sure that has been done and I am sure that it is going to be the tobacco companies, but I will go and get some accurate information for you rather than me thinking it through, thank you.

Mr DICKSON: Thank you for your time today.

Mr HARPER: Thank you very much, Dr Young and your colleagues for coming today. There are some great advances. There is definitely some good data that you have presented in terms of reducing smoking. I think more can be done. I look at the intent of the bill. One the four objectives of the bill is to ban smoking within five metres of all state government buildings. It is always interesting when you come from a region to arrive in Brisbane and see the groups of people at the bottom of buildings. I do not know if that is actually as effective in the regions. You see a clustering certainly down in the city. The other objectives of the bill are to ban smoking at transport waiting areas, swimming pools and skate parks and pop-up venues, which has been discussed. I am wondering if we can do more. I will ask what the alternative measures or strategies could be, particularly—and you did touch on it before—with the Indigenous cohort. Some of the data that I have from the Cancer Council states that they smoke 2.5 times the rate of non-Indigenous people, with no disparity since 2002. I think a lot more has to be done in that area. In terms of education—and I know that you have talked about the Quitline—what can be done specifically targeting those rural, remote and Indigenous areas?

Dr Young: Yes, we have some specific programs that are designed to assist Indigenous people and the different cohorts. Indigenous women who are pregnant is a particular group that is very concerning, because then that harms not only themselves but also the next generation and then we have that ongoing problem. There are programs in place to directly work with Indigenous people, led by Indigenous workers, Aboriginal health workers. I could get you some more specific data and information on those programs if that would be helpful.

Mr HARPER: Sure. The member for Caloundra talked about maybe no more education is required. I was listening to him talk prior to you appearing. I think there is a need for more education in that specific target area just to put the icing on the cake in terms of the bill. Thanks very much.

Dr Young: Yes.

Dr ROWAN: Thank you very much, Dr Young and to your colleagues as well. As a registered medical specialist myself and as a doctor in the area of addiction medicine, I have obviously seen firsthand the harms of cigarette smoking and the consumption of tobacco and nicotine. Can I congratulate the department on the work that it has done to date. Does the department support this bill?

Dr Young: We do. We support anything that increases smoke-free places. There are some technical issues that would be good to get amended just for clarification, but overall, yes, we certainly support the intent.

Dr ROWAN: Can you elaborate a little more on that?

Dr Young: Very minor things. The skateboard park—there is a proposal that smoking be banned within five metres. At the moment we have 10-metre bans for children's playgrounds. I just think for consistency it is an easier message, rather than having five for one thing and 10 for something else. To me, a skateboard park is a children's playground, so that one I think would be a very simple thing.

There are a couple of others. In relation to the swimming one, it could just be the way that I have misread it but the definition states—

Public swimming pool means a pool or other body of water that is open to the public for swimming, whether or not on payment of money.

To me, that includes creeks and rivers—people on the Brisbane River there. Perhaps that is the idea—I have not been able to clarify this—that we do not want anyone smoking within five metres of any river or creek. You can see that there would be a lot of benefit to that. You have rowing regattas, people along rivers and things like. But do you really intend it to be across remote Queensland and things like that? That may or may not be significant.

In terms of the government building one, I assume it is only state government buildings that we are talking about because it is a government building with the state coat of arms, not local government or Commonwealth government, and then we do have the issue that state government departments do not occupy entireties of buildings. It does go through there state owned, leased or occupied, but it just could be a little bit difficult in terms of enforcement for us in that at the moment we do not require signage for us to be able to go and prosecute someone who smokes within five metres of a building entrance whereas this bill is requiring signage to be visible. Then we are going to have—or maybe not, because the public has been so good in complying with all of these bits of legislation over the years—people saying, 'I didn't see that sign. It was around the corner and it wasn't visible.' I just think that is another one. I think sometimes we need to tighten up some of those small issues, but they can sometimes end up being the problem. Rather than selling it as a positive that we are doing this, people often focus on the negatives. So it would be nice to get some of those. As I said, as to the intent of the bill, anything that decreases smoking, that increases the number of smoke-free precincts in the state, I of course absolutely support totally.

Dr ROWAN: Thank you. Just to confirm, the implication of this bill is for vaporisers—e-cigarettes—so this legislation will also cover those devices.

Dr Young: Yes.

Dr ROWAN: In your role and experience, is there any clinical efficacy for e-cigarettes?

Dr Young: The jury is still out on that. There is a lot of research being done world-wide—a lot of good stuff here in Australia that NHMRC is leading and funding and a lot of stuff in the United Kingdom. Really, we do not know yet whether there is any benefit. We have to of course remember that nicotine, per se, is an illegal substance—it is a poison—so people cannot use that in these vaporisers. Despite that, when a number of them were audited nicotine was found. That is a poison. That is dangerous and we have had numerous calls to the poisons hotline of children accidentally drinking that nicotine and causing significant problems. So nicotine is a poison.

In terms of the vaporisers themselves and whether they have any efficacy given that they will not have nicotine in them versus nicotine replacement therapy, the jury is not back yet. We are very concerned that it is potentially going to normalise cigarette smoking again and it produces vapour, and there are associated risks with that vaping. So it is really important that it does not get a foothold, particularly not with children. So the best thing thought at the time was: until we know further if they have harms that we are not aware of we should just treat them the same as cigarettes—exactly the same, so they are purchased the same way, the same age group can purchase them and they can be used in the same places that cigarettes can be used. It just makes it much easier.

The other thing that is very interesting is that people who are enforcing were saying that it was really difficult to work out at times whether someone was—until they got up closer of course—smoking a tobacco cigarette or an e-cigarette and so they did not know whether they should ask people to stop or not. It just was very confusing.

Dr ROWAN: My final question relates to additional strategies that the department would like to see in relation to enhancing the uptake of nicotine replacement therapy and/or other pharmacological treatments for smoking eligible patients. Are there any other additional strategies given that this bill is looking around supply reduction? Again, you have outlined some demand reduction strategies but also access to and availability of treatment. Are there additional things that the department would like to see implemented as a holistic strategy?

Dr Young: I think we have nicotine replacement therapy pretty widely available. People can go to their GP. They can access it in many cases through their workplaces. I probably would like to see the workplace initiative broadened, but that is an issue for businesses and workplaces to take up. In many ways it is best that they take it up because then they engage and they go out and they support it. It is really hard just coming from outside doing things. You are better off with people doing it themselves. So that has been gradually gaining momentum. I would like to see that momentum continue, because I think then you have people in their workplace which is really targeting that group who smoke in all the different workplaces—white collar, blue collar.

Dr ROWAN: Thank you, Dr Young.

Ms BATES: I know that we have pharmacological methods of assisting in ceasing smoking, but one thing that I found out a couple of weeks ago is the difference between Champix and Zyban. I know it is a federal matter as far as the PBS is concerned, but you can be on Champix a lot longer than you can be on Zyban. Champix has had some pretty bad runs with people not being able to take it and Zyban is still the alternative. Can you speak to that, because it is certainly something that I am

going to raise with the federal Minister for Health? If you are really wanting to encourage people to give up smoking and if, for whatever reason, Champix is not the right pharmacological agent for them but they can use Zyban, why is there disparity in the length of time that you can use either product?

Dr Young: I am sorry, but I do not know that answer. I do not know the history behind why they were listed. All I can assume is that is what the pharmaceutical company put to PBS and the evidence they put. That is usually where these things are decided. Sorry.

CHAIR: Dr Young, we are over time. You always bring significant value to our hearings, so thank you so much and thank you to your colleagues for appearing today.

Dr Young: Thank you very much, Madam Chair.

FERGUSON, Mr Robert, Senior Adviser, Environmental and Public Health, Local Government Association of Queensland

HANNAN, Mr Luke, Manager Advocacy—Planning, Development and Natural Environment, Local Government Association of Queensland

MANSFIELD, Mr Shane, City Standards Manager, Logan City Council

CHAIR: Good morning. Welcome and thank you very much for appearing before the committee. I invite you to make an opening statement.

Mr Hannan: The LGAQ welcomes the opportunity to provide feedback to the Health and Ambulance Services Committee on the Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015. The LGAQ has received comments from a number of local governments, including councils that are actively engaged in current compliance activities, in relation to smoke-free areas.

The LGAQ submission maintains that flexibility and discretionary powers for councils to take enforcement action must be retained, providing for a council's consideration of its own local circumstances including their capacity, competing priorities, their own proactive programs and other mitigating factors such as customer driven complaints.

Regardless of local governments' duty to enforce, the proposed bill may raise community expectations for local governments to provide an essentially unfunded new service to the community. In these instances, the proposed bill represents a de facto devolution or cost-shift of state government policy and responsibilities to local government. The LGAQ recommends a detailed implementation and funding strategy accompany the proposed bill that considers fundamental enforcement, education and infrastructure requirements.

The proposed Partners in Government Agreement outlining the relationship between the state government and local government in Queensland states that devolution or delegation of new responsibilities, roles and functions to local government should only occur where there has been prior consultation of the financial implications and other impacts on local government are taken into account and the identification and availability of ongoing revenue sources has been considered. These matters must be closely considered and at the very least outlined in the regulatory impact statement. It is noted that the proposed bill's explanatory notes have no estimation of the cost for government implementation. Thank you.

Mr Mansfield: Again, thank you for the opportunity to speak to the committee. Holistically, Logan City Council supports state strategies to reduce the incidence of smoking in Queensland due to the associated health costs resulting from hospitalisations and premature deaths attributed to smoking related illnesses. The bill notes and highlights that strong tobacco legislation is one element of a multistrategy approach to reducing smoking rates. It is unclear to local government from the position of Logan City Council what the holistic strategy of the state is with respect to reducing the incidence of smoking, and that certainly needs to be clarified. The state also needs to recognise that, with all regulatory legislation, particularly with the extension of no-smoking areas, there are certain needs required—comprehensive education and awareness programs. Also with respect to the state itself in terms of making any legislation, it needs to understand the realistic constraints with enforcement of no smoking in certain areas.

To be clear, quickly in terms of the various elements of the bill, Logan City Council supports 13C, 'Supplier must not sell smoking products from vehicle', and 13D, 'Supplier must not sell smoking products from pop-up store'. With respect to pedestrian malls and public swimming pools, Logan City Council has local laws in place effectively, particularly with respect to malls. We commence on 30 September with a new Beenleigh Town Square. We have been guided by the experience of Ipswich City Council and Brisbane City Council and felt comfortable in making that local law.

In respect of the matters of no smoking at public transport waiting points, council has considered that and is awaiting the outcome of this particular bill. With respect to skate parks, council would also like to send a message in particular with respect to the enforcement constraints and the associated costs. Particularly with respect to enforcement, Logan City Council, for example, in terms of public transport waiting points that are in the open, has approximately 1,500 bus seats, shelters et cetera across the city. It is an element that has been untried from our perspective and research across local governments across Queensland. To our understanding, no local government has a comprehensive approach to that whilst local laws are in various shapes and forms. The net result is that local government enforcement officers do have less powers than, for example, Queensland police. If, for example, somebody chooses to ignore a local government authorised officer, the local government authorised officer has no option but to simply stand by and wait for a positive outcome.

As I said, to be clear, we support the overall holistic objective of reducing smoking incidence. There are issues that need to be considered as part of the evolution of any legislation in this respect. Hopefully I have made that summary quite clear. Thank you.

CHAIR: Thank you very much for your opening remarks. Mr Hannan, can you please advise the committee whether the member for Caloundra consulted with the LGAQ in the drafting of this bill?

Mr Hannan: No.

CHAIR: Do you feel that, given some of the statistics that have been provided here this morning around the rates of smoking in regional versus metro areas of Queensland, enough is being done in the regions to perhaps enforce the powers that are currently of a discretionary nature in our councils?

Mr Hannan: Thank you for the question. As per our submission, we have made the comment that most local governments—77 councils in Queensland, from Brisbane to Boulia to Bundaberg to Bamaga—have very diverse resources available to them. So we have made the comment that most councils do not have the resources or capacity to take on these additional responsibilities.

CHAIR: Do you know if different councils perhaps hold different statistics around enforcement activities? Do you know if there is any consistent kind of record keeping so that we have any data about the number of enforcement activities?

Mr Ferguson: A range of councils across Queensland do keep enforcement and compliance records. I am sure Logan can speak on their own behalf, but I know that the larger councils that do actively get involved in these activities do keep records, yes.

Ms BATES: Thank you very much to you and your colleagues for attending today. Are you always consulted on every piece of legislation that may or may not have an effect on local governments?

Mr Hannan: That is a good question. Generally we are, yes. That is the expectation and that is the expectation outlined in the Partners in Government Agreement that is currently proposed.

Ms BATES: My understanding at the moment is that as a local government association, of course, you are supportive in stopping smoking and having a healthier lifestyle. Of course, the state government has already spent an awful lot of money on the health education of the public. We just heard from Dr Jeanette Young from the Department of Health, who was outlining the current tobacco legislation and how it is enforced by agencies—that local government, whilst it is occupational, can already enforce things, as you mentioned before, about swimming pools, nonresidential building entrances, children's playgrounds et cetera and that any revenue that is generated from the enforcement obviously goes back to local council. If that is the case, why can the revenue that would be generated not cover the cost of the enforcement?

When the previous legislation came through there was a hullabaloo about banning smoking on beaches. I am from the Gold Coast and there was a lot of jumping up and down about who was going to do it, that it was going to cost a lot of money, that 'we will not have any people to do it'. I do not see anybody smoking on the beaches anymore and I do not know what the cost was. I cannot actually tell you what cost it was to the Gold Coast City Council, but I am assuming that if it was an incredibly steep increase in their costs versus the revenue I would have seen it on the front page of the *Gold Coast Bulletin*. Can you talk to the difference between the enforcement and the revenue that could possibly be generated that therefore would cover the costs and any angst that you have over the cost of the bill to council?

Mr Hannan: Revenue sufficiency is the big question and whether or not the revenue generated through compliance enforcement would actually cover the costs. That is something that we would hope would sit alongside the proposed bill as part of the regulatory impact statement in terms of what those cost impacts are. In terms of the current legislation and the coverage of costs, I might ask Shane to outline potentially what the Logan situation is regarding revenue sufficiency.

Mr Mansfield: To be clear, the Logan City Council has existing local laws with respect to all of its facilities: aquatic centres, community centres, libraries et cetera. My understanding is that no penalty infringement notice has been issued for a no-smoking breach. Officers are obviously very skilled in communication and in those types of environments people tend to oblige and do the right thing. To my understanding—and I do not have the parks manager or the aquatic manager with me—generally it is an easy approach.

With respect to the Beenleigh Town Square, the Beenleigh Town Square opens in October, unofficially on 30 September. Our local law was only gazetted on 8 August. Our experience is still unknown in terms of enforcement at a mall situation. In terms of our preparation, we certainly have a

high focus on education and awareness, and officers are obviously blessed with communication skills. Our objective is first to encourage people to do the right thing and highlight the fact that it is no smoking.

With respect to areas like public transport waiting points where you have a large city and a local government area with approximately 1,500 locations to possibly enforce, the issue is how do you get around the 1,500? How do you maintain the intelligence? How do you know which are the primary areas to focus on? All of that is behind-the-scenes costs and, again, from a compliance perspective in terms of new-age compliance, most local governments operate on a voluntary compliance basis. There is no heavy-handed issuing of infringement notices on the spot. Education and awareness, signs—all are additional costs. I am gauging there would not be a profit, if that is what you are talking about in terms of the issuing of infringement notices. I trust I have made myself clear quickly. Do you need any further clarification?

Ms BATES: Obviously your council is already implementing these things, regardless of this legislation. From what you just said, your concern at the moment really is about how you would police, I guess, all the local bus stops. You are already actually doing all those things anyway. The cost implication does not appear to be an issue for your council, because you have done it anyway?

Mr Mansfield: You have to look at each area on its own. As I explained, the Beenleigh Town Square is a new facility. It is the best time to change behaviour, and changing behaviour—from my perspective of 15 years as a compliance manager, with everything from the Building Act and the Environmental Protection Act to parking local laws—is education and awareness. That is a strong need from our perspective. As I said, we are approaching that no differently to everything else. There are hidden costs with that. You just simply do not go out and issue infringements to cover costs.

Mr KELLY: Thank you for your submissions and the work that you do in your communities. My first question is for the LGAQ. Mr Hannan, the submission suggests that you want to maintain flexibility and discretionary powers for councils in relation to enforcement action, giving consideration to local circumstances. Could you elaborate? Other than the resourcing issues that we have already covered, what are those other local circumstances that might lead you to want to maintain those discretionary powers?

Mr Hannan: Apart from the resourcing impacts, not just in terms of enforcement and, probably following on from the previous question, it is also about infrastructure and the infrastructure or subsequent infrastructure costs about, for example, the removal of butt bins at public transport stops. There is that additional impact. Putting resources aside, it comes down to local circumstances regarding complaints received, expectations of the community and what their expectations of the local government are in a particular area. There is a weight of factors. Whether or not they are political or community driven, it does differ from community to community.

Mr KELLY: The complaint issue is interesting. Are you suggesting that if the population of a particular local government area is not happy with the council implementing these sorts of bans we should take that into consideration?

Mr Hannan: That could occur, yes. In terms of a local community's concern of a particular issue.

Mr KELLY: Regardless of the fact that medical research in this area suggests that the evidence is very strong that any level of smoking is damaging for people and, as a government, it has been widely accepted for a long time that we should be doing everything in our power to reduce smoking levels to zero?

Mr Hannan: I agree. Sorry: could you clarify the question?

Mr KELLY: What you are suggesting is if there is a democratic move in a local government area that theses bans should not be applied because people do not want them we should listen to those people. But aren't we, in effect, saying that for a long time as a government we recognise that we have to do everything in our power to override those individual desires? We recognise that we cannot ban smoking, but we really should not be using that as an excuse to not try to enforce things.

Mr Hannan: Yes. Local governments will respond to community concerns and appropriately respond in regard to what their capacity and resources will allow. It is a consideration, yes.

Mr KELLY: I have a question for the Logan City Council. Mr Mansfield, thank you for your submission. Obviously, you are very much on the ground and have been involved for a long time. I am interested in your statements around the lack of or unclear holistic strategy of the state in relation to reducing smoking. Could you just perhaps elaborate a little more on what you see as a holistic strategy?

Mr Mansfield: Certainly. Our understanding is that the legislation is primarily about adding, as per the bill's name, extension of smoking ban areas. Probably what we are talking about there in terms of a holistic strategy is: what are the overall education strategies and awareness strategies? What are the other matters in the portfolio of the state government that are being implemented, other than the extension of no-smoking areas and, therefore, the enforcement associated with that? If that is clear somewhere, we have certainly missed that. We are quite happy to have clarification on that, but that was our understanding. Thank you.

Mr KELLY: Thank you for that. It is a really interesting statement, because from a research perspective the sorts of things that researchers would suggest you should do as a government—and I think all levels of government are involved in this—we are doing in Australia. In fact, I think we are at the cutting edge. It is interesting that you say that. Do you think that is a recent development or do you think that is something that has been the situation for a long time? You said that you have been in compliance for 15 years. Could you comment on that?

Mr Mansfield: I can only comment in terms of the progression of the legislation that I have seen. Over the past 10 years there seems to have been an addition to no-smoking areas and no-smoking bans in certain situations. Gelling that together with a holistic strategy, I am not sure from a local government perspective where that sits in the complete portfolio of action plans, so to speak. It is purely a holistic statement. If there is a document, we are happy to receive that and review that.

CHAIR: Just on that point, I think Dr Young outlined verbally the significant strategy over many years that the government has had in that regard.

Mr DICKSON: LGAQ and our friends from Logan, welcome on board. I have a lot of thoughts about this, but I think generically we all want to do what we can to reduce smoking. I think that is just a given. I come from local government. I understand that you guys have a combined debt of about $8 billion, I think, at the moment across-the-board. It is something like that. That is close to the money?

Mr Hannan: Yes.

Mr DICKSON: That is substantial. I realise that you are not going to want to pay for the implementation of anything. That is human nature and it is not your fault; it is what you are here to do. How do we go about empowering you guys to have the finances? Do you want to get money from the state to be able to do this or should there be an extra tax on smoking to enable you to facilitate these and probably many other programs we should put in place? Do you have any ideas, so that we can actually put a better bill forward?

Mr Mansfield: I do not have an endorsed position from Logan City Council for a request from the state. As manager, I have undertaken preliminary research into the enforcement and the attendance to and, to put to succinctly, the adoption of a local law for no smoking at public transport waiting points. We have figures for approximately 1,200—I apologise: I think I quoted 1,500 before—public transport waiting points. We estimate immediate costs of between $270,000 to $320,000 in no-smoking signage, approximately $130,000 in local education and awareness media campaigns and other awareness events, and for the first 12 months approximately$155,000 in officer resourcing for programed attendance. My understanding is that the research is that a cigarette is lit and out within nine minutes, so obviously it is impossible to have an immediate response. As I explained earlier, it is all about the collection of data, where to focus our resources effectively. That is a very high level statement. As I said, we have not ventured into that field. Only experience will really prove what the actual cost is at the end of the day. Certainly that may highlight that, if that answers your question in a roundabout way?

Mr DICKSON: It goes very close to what I have thrown in front of you, but, as I said in my opening statement, it is a problem we all have to solve. It is just a matter of how we go about that. We want to work with you. I do not think there is anybody on this side of the House who does not want to stop people from smoking, but we need to know where you really sit. We are not going to play games; we need to know the financial input at the end of the day and it gets down to the output we can all achieve together. Thank you.

Mr HARPER: Welcome, gentlemen, and thanks very much for your input. I think you just touched on the costings that I was going to ask about. Do you fundamentally support the bill in its principles and intent to reduce the incidence of smoking, from LGAQ and Logan?

Mr Hannan: Overall the objective of the bill is supported and commendable—there is no doubt about that—however, as I commented in my opening statement, it needs to be accompanied by an implementation and funding strategy that touches on the enforcement role, what needs to be done,

understanding what the cost impacts are, who is best placed to do it and how we are going to actually achieve it on the ground. So yes, I think that answers the question in terms of our overall support for the objectives of the bill. However, it needs that accompanying implementation and funding strategy to sit alongside it.

Mr HARPER: Do you have any alternative strategies from a local government perspective to assist in reducing smoking, or is it entirely left to the state in terms of moving forward?

Mr Hannan: We would welcome a partnership with the state to work out how this should be done. It is a partnership, I agree, and we need to sit down together and work out how best it can be achieved.

Mr HARPER: I can understand the significant costs to the 77 councils right across the state. There is no doubt about it. Yes, together I think we do need to move forward and attempt to reduce the incidence of smoking, but thank you very much.

Dr ROWAN: Thank you to the Local Government Association of Queensland and Logan City Council for your submissions today. My first question is to the Local Government Association of Queensland. Does the LGAQ put submissions to all parliamentary committees or appear before parliamentary committees on every piece of legislation which may have an effect on local government?

Mr Hannan: Generally we do. If it has an impact on local government and we have been involved in the process, of course we will be here to support the bill and point out any issues that need to be addressed. Where local government is involved, one of our key roles is obviously to support local government and the implementation of any new legislation that may or may not affect us.

Dr ROWAN: I want to come back to funding and implementation strategies. In order to do that normally you need good data. I know that we have touched on this before, but is there any benchmarking data of enforcement or infringement occasions that the LGAQ collects or is aware of? I know that we heard earlier from Mr Ferguson that some councils collect that, but is there any benchmarking of why there are differences across councils and why those differences exist?

Mr Hannan: The LGAQ does not have any empirical data on this matter as yet. I am not saying that it could not be achieved; however, it is not something that we collect as a matter of course.

Dr ROWAN: Mr Mansfield, does the Logan City Council have its own workplace based smoking cessation programs for staff, and do councils generally across Queensland have those within their own workplaces?

Mr Mansfield: I can only answer for Logan City Council. Luke may be able to answer for other local governments. Certainly at Logan City Council, as I explained before, all of our facilities are smoke-free under our local laws: our aquatic centres, our community centres, our libraries. We have never had to issue an infringement. Everything is pretty much handled by the great communication skills and the acceptance of people involved if they do happen to smoke. Sorry, I just need to refresh your exact question. Could you just repeat it?

Dr ROWAN: It goes to the point of whether there is a workplace based smoking cessation program for staff. If staff self-identify that they want to give up smoking, can they access that through the Logan City Council or I guess through the LGAQ, or are there any similar programs at other councils across Queensland?

Mr Mansfield: Again speaking for Logan City Council, we have an internal Team Top Health program. Quite often, giving up smoking is part of that program, if that answers your question. Can I also add as part of the evolution of our acceptance for a local law for the Beenleigh Town Square—I know our next speaker is the Queensland Cancer Council. I can only commend them for their support and their information material and their participation at our opening in October, which all committee members are welcome to attend if they wish.

CHAIR: Our time has expired so I thank you, Mr Hannan, Mr Ferguson and Mr Mansfield, for appearing today and for the initiatives that you have outlined about your council taking this public health issue seriously. Mr Hannan, I think you have raised a very valid point that there is not sufficient information with regard to funding and implementation in the bill. You may have heard that was raised and we have asked the member for Caloundra, as it is his private member's bill, to table that information. We appreciate the comments you have made in your submission. Thank you for appearing.

DURHAM, Ms Alison, Advocacy Manager, Heart Foundation

SAVAGE, Ms Anne, Head of Executive Projects and Advocacy, Queensland Cancer Council

CHAIR: Ms Durham and Ms Savage, thank you very much for appearing before the committee on our current deliberations on this bill. Can I invite you both to make a short opening statement and then we will open it up to questions.

Ms Durham: Thank you for the opportunity to come to this hearing and have our input. The Heart Foundation and Cancer Council stand together on this issue and support the proposed recommendations in this bill. We have extra amendments that we have suggested and further reforms that we have also suggested to the parliament. We have been in contact with the AMAQ and the Stroke Foundation, who also support these recommendations and extra reforms. I also wanted to highlight the Cairns and Hinterland HHS submission, which gave some really good detail on how they thought these amendments might work and some technicalities that I thought were really worth looking at.

These tobacco control measures that are proposed will further strengthen our smoke-free laws and provide greater protection for people in public places. We are seeking bipartisan support on this bill. Queensland has a proud record on both sides of the parliament of bringing in really innovative tobacco control measures, starting with leading on the al fresco dining reforms that occurred in 2006 and as the first state to bring in e-cigarette legislation last year. We have a great record and this is an opportunity to take it further.

As a community we know that people want further protection. They do not want to walk through a wall of smoke on their daily tasks like walking down a pedestrian mall or at bus and ferry stops or taxi ranks or outside buildings. We do not want children exposed at skate parks, swimming pools or at local sporting fields, and we do not want young people having easy access to buying cigarettes at pop-up shops at music festivals. I have heard a lot of support in the room and I think nearly every submission supports this piece of legislation.

They are all common sense, and we have provided a lot of evidence in our submission about why we think this is important. They are focused on where people gather in proximity in public places, so that is where people are more likely in outdoor areas to be exposed. The people who are particularly vulnerable are children, the elderly and people with chronic conditions like heart disease, stroke, asthma, lung disease and diabetes. That is why we are all here and that is why the Cancer Council is here too. That is why we recommended the addition of sporting fields.

Because the tobacco industry has a habit of finding ways to get around legislation, we urge the committee to note that e-cigarettes are included in this legislation. Queensland is leading the way on that and we believe they will be captured in this legislation, but I really just wanted to alert you to that and not let it slip by in things like pop-up shops or, if vending machines are banned, not allowing them to slip in. We need a consistent statewide approach to these laws because there are regional differences.

There was a compelling submission No. 1 from some grandparents from Bundaberg who spoke of their concerns for their grandchildren. They are going to local parks and to cafes where there is a lack of signage, monitoring and enforcement compared to Brisbane and what they see interstate. I really felt that was very compelling, and I know that grandparents and parents wherever they live in Queensland do not want to be exposed to smoking when they are out in public.

The further reforms that we have proposed in our submission we have advocated for for many years, and I think they provide a more comprehensive approach than the current bill. That is why we recommended the banning of vending machines, the sale of cigarettes by minors, the ban on premium gaming room indoor smoking—the only indoors anomaly left—the banning of designated outdoor smoking areas and the licensing of retailers to regulate this.

The Heart Foundation has not been able to reference any local Queensland data for our submission. It has not been made available to us, unfortunately. The Chief Health Officer provided some information this morning which we really welcome, and we would really like to see a more transparent process of reporting on this data by Queensland Health, including information on things like the number of retailers and retailer compliance data—the kinds of things that the Chief Health Officer was providing this morning. A licensing scheme which requires retailers to have a licence so we know who they are will give us a much better chance of enforcing that legislation.

The last one was the removal of the outdoor designated smoking areas in licensed premises. It was interesting to see that the Cairns and Hinterland HHS submission No. 9 queried whether state governments need to assess the possibility of liability by keeping those designated outdoor smoking areas. The concern is that the nonsmokers and smokers in those areas are often young people where the highest levels of smoking are, so the concern is that they are becoming popular areas and people could simply be made to leave the venue as they do in cafes and restaurants. Thank you for your time, and I shall hand over to my colleague.

Ms Savage: Thanks, Alison, and thank you all for hearing us this morning. We commend the bill and we commend Mark McArdle for introducing it. This is the culmination of two decades of work by the Cancer Council Queensland, the Heart Foundation and others, and we appreciate you taking the time to read the substantive evidence that we have sent in on this bill.

Obviously we would welcome bipartisan support for this bill and in particular the committee's support. We do know that the tobacco industry is predatory in its marketing. Some of you may not be aware, but at the moment the Australian government is caught up in legal action involving the World Trade Organisation. The tobacco companies are coming after us for Queensland data on the habits of schoolchildren and their smoking patterns, and at the moment we are actively advocating to try and—

CHAIR: Ms Savage, would you mind moving your microphone a bit closer?

Ms Savage: Sorry. My point was about the predatory behaviours of big tobacco and the importance of this legislation as much as possible ending the toll of tobacco in Queensland. We are world leaders and we really could set the benchmark with this bill, so we commend the bill. From our perspective it is quite simple: cigarettes kill people. We have the power to do something about that.

CHAIR: Thank you both very much for your opening statements. Can I just note that in the Heart Foundation submission you mention that we have seen a marked increase in smoking amongst young people aged 25 to 34 over the past 20 years. I just wondered if you would speak to that, given the significant investment that has been made over successive governments to try and combat that.

Ms Durham: Yes, it is an interesting phenomenon. We have seen that rise since 2012. It is particularly in that age group of 25 to 34 where there are the highest rates. In the younger age groups it is better, but it is increasing in those age groups. That is why we need to keep that ongoing pressure of the quit campaigns which are targeted specifically at that group. We have also found incredible success over many years of antismoking campaigns that targeting older adults also has a really good impact on younger people. I think it is trending in the right direction, except in that age group where it is increasing. We need to target them and we need to have supportive legislation as well. That is why I think the designated outdoor smoking areas are a really good area to target.

Ms Savage: I might add to that. When we look at the prevalence among young people, the social pressure to smoke is a factor that needs to be considered, which is why this bill is so important. As much as possible if we can eliminate opportunities for smoking in and around social and peer groups, you will find that the prevalence does start to decrease. That is why this bill is so important. It is pleasing to see a group of school students up there today observing. Our advocacy to you, kids, is do not smoke, support this bill and encourage our members of parliament to do the same.

CHAIR: You talked about the social pressures in that age group, and I am in that age group—just. Would you not say, though, that the social pressures to not smoke have actually increased because it is not seen as being socially attractive or acceptable? I am a mother of young children and do not find it socially acceptable either. Would you not say that that pressure is increasing to become more significant than the pressure to smoke?

Ms Durham: Yes, I think that is true, although what you see in younger children is that they are extremely anti smoking, and then they reach puberty and they completely change and are more open to risk and trying out smoking behaviours. Hence, the young men who tend to be slightly more risk-takers have those slightly higher rates. The more we do in relation to antismoking in terms of making it less accessible in public places and more expensive for them to purchase—and that is a big one; that is why the federal taxes are really important—is an important target for young people.

Ms Savage: It does also depend on peer groups and socio-economic status. We do know that people from disadvantaged areas are disproportionately affected by the burden of tobacco. For example, regionally we know that the prevalence of smoking in North Queensland is one of the highest in Australia. It is 25 per cent against a state average of about 14 or 15 per cent. That is where you tend to see those peer group pressures play out. Again, it does depend. Certainly in Brisbane in more affluent areas the pressure is not to smoke. We are pleased to see that happening, and we would like to see that across demographic groups.

CHAIR: How do you feel Queensland is placed in terms of our initiatives and how effective and strong they are as compared with other states and territories in Australia?

Ms Durham: Queensland is doing very well as far as other states are concerned, but there are spots where we are falling behind. I think that retailer licensing is in the majority of states and territories, whereas Queensland does not have a positive licensing scheme. That is one area where we could improve. What this bill addresses will bring us up to speed with a number of places but also lead. I think we are well placed.

Ms Savage: I agree. This bill gives us an opportunity to be the world leader. That is what we would certainly like to see happen. With the inclusion of a few of our amendments, it would be a world beater. We are extremely pleased with Queensland's progress, but we are poised at an interesting point where we need now to become more consistent across the state in what we do and how we address this, and that speaks to the importance of this bill.

Ms BATES: I am going to play the devil's advocate here. I come from a generation where smoking was the norm and it was cool—a horrible word—to smoke back in that day and age. It is great to see that we have a whole generation of young people who think that smoking is disgusting including my children. From a health perspective we are all very well aware of what tobacco can do. I compliment you on a lot of the amendments that you have proposed. In terms of the legalities of some of your suggestions, though, smoking is not illegal. Designated smoking areas give those hardcore smokers—some people might be trying to give up and others do not want to give up—an area where they can go. In terms of putting them in an area where passive smoking is not going to affect other people, my concern would be if we get rid of designated smoking areas altogether then where do those people go? It is not illegal to smoke at the moment. I would like you to talk me through that.

One of your other recommendations—which is a big thing on the Gold Coast as well because of all the high-rises—is a push to have smoking bans extended to multiunit residential properties such as balconies. How do you tell a home owner that they cannot smoke on their own balcony or that they cannot drink on their own balcony or that they cannot grow tomatoes on their own balcony? Do you know what I mean? That next step is a pretty big one. Can you talk the committee through those issues?

Ms Durham: Thank you for the question. I will speak to the designated outdoor smoking areas. At the moment in cafes and restaurants people cannot smoke indoors and outdoors, and they simply move to the footpath away from that area. We probably need an amendment to make it at least four or five metres from the outdoor eating area. That is happening now and that is working fine. As you have heard from many of the local councils, it is about social enforcement. There are not a lot of breaches occurring. There are not a lot of police needed. So people are enforcing it themselves.

In pubs and clubs, people are still able to go outside and smoke. Despite the barriers that are put in, such as glass partitions and plants, there is still smoke drift. So people are still sitting in eating areas and they are still getting the smoke drift. I do have a real concern about young people who are in those designated outdoor smoking areas, particularly young people, being very close together. Many of them are nonsmokers, and they are just there because they want to be with their peers and hang out in the smoking area. It is great that they cannot bring food there, but as long as you can bring a drink there it is still a social area. I really do not think that it would be a major problem if they had to go out to the outdoor area or onto the footpath and then they would come back in to be with their friends.

Ms Savage: I will respond a little on both points. Firstly, we appreciate that smoking is still legal, and let me be clear that we would prefer that it were illegal. When we get to a prevalence of about five per cent, we may be able to achieve that, and then smoking perhaps will only be available by prescription. We are gradually getting to that point. I agree with you that it is a grey area. Our very strong view is that it can be justified on the basis of what is best for people's health, particularly when you take into consideration the potential harm to others. We take hundreds of calls each year through 131120—our helpline—from people, usually nonsmokers, who are psychologically distressed because of their neighbours' smoke and they cannot escape from that smoke. They have concerns about their children's wellbeing and their family's wellbeing, and they have very little power to do anything about it.

At the moment with the prevalence at 15 per cent you do see an increasing willingness of body corporates to rule on this. I am aware of at least three buildings that have already introduced by-laws even though if they were challenged in court they would probably fail, but the overwhelming majority of people in those buildings feel that it is important enough for the health and wellbeing of them and their families that this needs to be done.

We accept that it is still legal. What we would ask is that for smokers to accept the very obvious health risks and as much as possible not to place others in harm's way if they choose to smoke. There are ways that that can be achieved. I am loath to recommend that anybody should lock themselves in a confined space of their own unit and smoke so as not to expose their neighbours. But, as you have pointed out, we do need to look at it. There does need to be consideration of the fact that they do have the right to smoke in their own home. It is really about the fact that the boundaries are grey as to where their own home ends and their neighbour's home begins. It is tricky. We would like to see much more support for people to quit so we can get to a point where we do not have to have the debate about rights and legalities on this.

Mr KELLY: Happy National Stroke Week.

Ms Savage: Thank you.

Mr KELLY: As a registered nurse myself—my wife is a registered nurse managing an oncology unit and has had over 25 years in oncology work, and I have done oncology myself—you certainly have my support. However, one thing I would note is that I live across the road from a cafe and people regularly stand outside my children's room smoking. That leads me to my question. If we increase the distance away from government buildings—because on the other side of my house I have a school—are we simply going to be moving the clustering of second-hand smokers away from the front entrance of those buildings to other places where they will similarly be impacting on people?

Ms Savage: I am happy to have a go at responding to that. We keep forgetting the intent of this legislation is to help people quit. We recognise that it is difficult but necessary to get to the point where we do not have to deal with the precincts and the boundaries and metres away, because people will actually quit smoking and it will no longer be a problem for us. That is the first point I would make.

The second point I would make is that the introduction of legislation such as this has been demonstrated to exert greater social pressure on people not to smoke when they are conscious that they are impacting on others. Our great hope is that the outcome of this legislation will be to increase and amp up that social pressure even more so that whenever smokers are knowingly smoking in the company of others who are nonsmokers and do not appreciate the second-hand smoke then perhaps they will be discouraged from doing so.

Mr KELLY: Given that the member for Caloundra has said that the bill does not go to education and he does not believe that every bill that comes through parliament can have education as part of it, and given that my children will be second-hand smoking because of the bans in cafes, how is that issue going to be addressed by this bill?

Ms Savage: They can call 131120 and ask to speak to me and I will advocate for them, and I do mean that. There are organisations like the Cancer Council and the Heart Foundation who support the community with this type of thing. Our media team generates about 8,000 news clips every year in regional communities to try to promote this type of campaign or activity. You have our full support on that. We will devote every available resource to making this bill work.

Ms Durham: I think the committee could also recommend that the government properly fund education to support this legislation. Definitely the legislation needs education, campaigns and support to go around it. I think that the Chief Health Officer and the prevention health branch are very dedicated and have shown a lot of leadership in this area of tobacco control with the advances that we have made in Queensland. I think that the committee could make a strong recommendation that this be supported with education and campaigns.

CHAIR: I would certainly support that the bill does not go far enough to provide supportive mechanisms like education.

Mr DICKSON: Alison and Anne, thank you so much for giving us your time and for the comments you have made. Do you think Queensland will be a better place with this bill moving forward or should it be stopped at this point? You can give a direct answer of 'yes' or 'no' and I will be fine.

Ms Durham: Yes. I think Queensland would be a better place with these extra bans.

Mr HARPER: Thank you very much for your contribution today and the work in this important area. You just made a point which you may have picked up on from a previous witnesses here this morning. I am from the region and am surrounded by remote areas. You just said that you have 8,000 media resources going out to remote communities. They are staggering numbers that you have put

together—26 per cent smoking rates on the Darling Downs compared to 66 per cent in Cape York. With those 8,000 media resources, I think more needs to be done. In terms of those comments from the member for Caloundra about education, we do need to educate people. I take your point in terms of funding. What else can be done, particularly in those areas? I will put that question to both of you.

Ms Savage: Absolutely. From our perspective these separate and targeted programs are being delivered, but we would always like to see more funding for them—targeted quit campaigns that focus on the communities at highest risk, which includes Indigenous communities and those with socio-economic disadvantage. The Queensland government does fund campaigns. There have been targeted campaigns for young women. 'Your future is not pretty' is what the campaign was called. Campaigns have very specifically targeted groups that we know from research are at high risk. We need to see much more of that to support those communities with quitting.

The other thing that we need to do and will always need to do if we want to achieve equity in health outcomes is to address social disadvantage. That is a really complex challenge for members of parliament, for the community and for organisations like ours.

Ms Durham: All the more reason, I would say, why we need to have these kinds of reforms, because they are population approaches. They impact on every community, and in so doing they will also impact on disadvantaged communities which of course need extra programs to address disparity, employment issues, housing and all of those issues that we are trying to address to close the gap.

Ms Savage: One other point that I will make is that we do not need to overegg it. There is some evidence emerging that placing signage everywhere can trigger relapses in quit smokers. It is something to be conscious of. You should always consider context and environment.

Our view is that these proposed reforms will generally be accepted by the community who feel that they should have been in place for a while anyway. You consider smoking at bus stops and places where you are among other pedestrians. The level of understanding is pretty good among the general population, but what definitely needs to continue is those very targeted campaigns—not necessarily about this bill—to help people with quitting and to stop the intergenerational trend of their children taking it up. That is where those risks are. My view is that this bill and the legislation that has been proposed will probably be normalised quite quickly. People will very quickly understand that it is not acceptable or legal anymore to smoke at a bus stop. Many of these reforms will be accepted without question and people will fall into line and, hopefully, more people will quit.

I think most of us here in Brisbane have observed the changes that have taken place, even just in Queen Street Mall since they banned smoking in the mall. We used to have groups of young people congregating and smoking in a very public forum where it was almost cool to be seen to be doing so. We have seen the success of that. The retailers and the traders have all been pleased with it. You do not need a lot of signage anymore. It is usually policed by citizens. If people from Brisbane see tourists smoking in our mall, they do not hesitate in letting them know that they are not allowed to. We have really been pleased to see the level of responsiveness and acceptance among the community of these types of changes.

Dr ROWAN: I thank the Heart Foundation and the Cancer Council for their submissions today. As a doctor and a former president of the Australian Medical Association in Queensland, I commend you for the terrific work that you do on behalf of Queenslanders. I am interested in what the data reviewed and seen by the Cancer Council reveals in relation to passive smoking, specifically with respect to childhood cancers. The reason I ask that question is that, given that adults can smoke in private motor vehicles and children can be exposed there, what is the data showing in relation to childhood cancers? My second question is: should smoking be banned in private motor vehicles?

Ms Savage: Absolutely, yes. We have included that in our submission for a range of reasons, not just second-hand smoke but third-hand smoke, which is smoke that sticks to fabrics and materials. If you are a smoker and you are driving your car around with a baby capsule in it and then at some point you happen to have a baby in the car, a baby's young lungs are extremely vulnerable to the types of second-hand and third-hand smoke that can stick to fabrics. As much as possible we try to assist parents who might be smokers with strategies to ensure that they do not expose their young people to smoke. What was the first part of your question?

Dr ROWAN: It was really just around what the data reveals.

Ms Savage: Childhood cancer, yes. It is interesting, because the World Health Organisation estimates that about 10 per cent of those who die from tobacco related illness and disease have never smoked a cigarette in their life, so it is from passive smoking. In Queensland, that is about 370 deaths a year. What you find, though, is that for children it is not the incidence of cancer necessarily

or cancer related deaths but it is things like asthma. It is a risk factor for SIDS, lung conditions and things like that. Because of the long lead time with cancer related behavioural risk factors, there is usually a much longer development time. I am not currently aware of evidence that suggests that smoking is a risk factor for leukaemia. It is not. The health outcomes for children tend to be in different areas that relate to lung health, breathing, circulation and things like that. It is not a clinical answer, but hopefully it answers your question.

Dr ROWAN: Thank you.

CHAIR: Alison and Anne, thank you very much your appearance here this morning. That concludes our hearing today. I would like to thank all witnesses for attending today and assisting us in our examination of the bill. The secretariat will be in touch with those witnesses who have taken any questions on notice. A transcript of the proceedings will be made available on the committee's parliamentary web page as soon as practicable. Our final report will be made available on our web page after it has been tabled in the House on 16 October. I declare the hearing closed.

Committee adjourned at 11.35 am