Public Health Association
AUSTRALIA

Public Health Association of Australia submission on Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015

Health and Ambulance Services Committee
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Contents

Introduction

The Public Health Association of Australia

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Vision for a healthy population

The PHAA has a vision for a healthy region, a healthy nation, healthy people: Living in a healthy society and a sustaining environment, improving and promoting health for all

PHAA's Mission

Is to be the leading public health advocacy group, to drive better health outcomes through health equity and sound, population-based policy and vigorous advocacy

Priorities for 2014 and beyond

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. The aims of the PHAA include a commitment to:

- Advance a caring, generous and equitable Australian society with particular respect for Aboriginal and Torres Strait Islanders as the first peoples of the nation
- Promote and strengthen public health research, knowledge, training and practice
- Promote a healthy and ecologically sustaining human society across Australia, including tackling global warming, environmental change and a sustainable population
- Promote universally accessible people centred and health promoting primary health care and hospital services that are complemented by health and community workforce training and development
- Promote universal health literacy as part of comprehensive health care
- Support health promoting settings, including the home, as the norm
- Assist other countries in our region to protect the health of their populations, and to advocate for trade policies that enable them to do so.
- Promote the PHAA as a vibrant living model of its vision and aims

Preamble

The PHAA (Queensland Branch) welcomes the opportunity to provide input on the Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Health Equity

As outlined in the PHAA's objectives:

> *Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people's health. The health status of all people is impacted by the social, political, and environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease.*

The PHAA notes that:

- Health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups. [(8)]
- Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people [(9)], resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. This is particularly pertinent when considering issues such smoking.

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors.

Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015

The PHAA advocates for all levels of government to maintain and build on comprehensive approaches to tobacco control, and work collaboratively with partner organisations to advocate for prevention and related programs that will help to achieve the lowest possible smoking rates in Australia and internationally.

The Queensland branch of the PHAA writes in support of the proposed amendments contained in the Tobacco and Other Smoking Products (Extension of Smoking Bans) Amendment Bill 2015. Additionally we are writing to suggest that the committee considers the inclusion of further amendments in relation to the licensing of supply (wholesale and retail) of tobacco products.

Unlike other jurisdictions (ACT, NT, SA, TAS, WA), the licensing of the supply (wholesale and retail) of tobacco products is not presently part of the tobacco regulatory framework in Queensland (see Smyth, Freeman, Maag 2015, http://www.phrp.com.au/issues/july-2015-volume-25-issue-3/tobacco-retail-regulation-next-frontier-tobacco-control/). An example of a precedent in this area is the Western Australian 'Tobacco Products Control Act 2006', it for example, contains three separate clauses pertaining to the licensing of 1. Retailers; 2. Wholesalers and; 3. Indirect sellers [http://www.austlii.edu.au/au/legis/wa/consol_act/tpca2006271/s16.html].

Tobacco wholesaler and retailer licensing is considered a best practice tobacco control strategy with a number of potential benefits. It can provide funds for effective enforcement of tobacco control laws and health promotion activities; it can assist enforcement of laws concerning retailing of tobacco products by establishing a database of tobacco retailers; it can provide valuable information on where tobacco is sold and potentially also how much is sold; it can contribute to denormalisation of tobacco smoking. If set at an appropriately high level, tobacco retailer license fees can also provide a disincentive for selling tobacco or reducing the number of points of sale (see recent South Australian research by Bowden, Dono, John & Miller 2014, http://tobaccocontrol.bmj.com/content/23/2/178.short).

We call on the Government to consider introducing mandatory licensing of all retailers selling combustible tobacco products. In the UK, the sale of tobacco products is banned to anyone under the age of 18 years old; however, in spite of this, up to 207,000 children aged 11 – 15 year old begin smoking each year. Introducing a positive licensing scheme would enable local authorities to remove the license of any retailers found not to be acting in accordance with tobacco legislation, such as not enforcing age restrictions or the display ban.

In England and Wales, a negative licensing scheme is currently in operation, in which magistrates can ban retailers from selling tobacco for up to a year if they are found to be acting illegally. This is a time consuming and costly process, which has thus far led to relatively few prosecutions. Introducing a positive licensing system would instead enable local authorities to ensure that retailers are familiar with tobacco regulations and that they are able demonstrate how they intend to comply with these laws before they begin to sell such products.

Research conducted in Australia found that a positive licensing scheme led to a significant increase in awareness of tobacco regulations and in Tasmania led to a 95% compliance rate. In Scotland and Northern Ireland, retailers are currently required to register to sell tobacco. The revenue from a nominal license fee

(the Republic of Ireland currently charges €50 for registration 47) could also be directed into smoking cessation programmes, educational schemes aimed at young people or enforcement initiatives (Royal Society for Public Health 2015 see: https://www.rsph.org.uk/en/policy-and-projects/areas-of-work/smoking-cessation.cfm).

Additionally a tobacco licensing structure would improve data on tobacco supply to the community, for example opening up opportunities for the mapping of outlet density and possibly the volume of sales. Additionally there would be clear advantages in identifying unlicensed supply.

It also provides a mechanism for applying future restrictions on tobacco retailing, such as by banning sales in close proximity to schools. Research from the US and Canada has found a relationship between youth smoking and tobacco retailers located close to schools (see: Report by Freeman and Chapman, 2014 http://www.health.nsw.gov.au/tobacco/Documents/apdix-evidence-tob-retail-policy.pdf).

Amendments to the current legislation regarding a tobacco licensing structure may be most relevant to Part 2, Division 1 of the Queensland Tobacco and Other Smoking Products Act 1998.

Another key consideration is that *'The tobacco industry should legally be required to provide governments with data on the sales of a commodity which is more addictive and harmful to population health, and much less regulated than alcohol.'* This point comes from a 2010 editorial in the Medical Journal of Australia (entitled: Why we need tobacco sales data for good tobacco control written by Gartner, Chapman, Hall and Wakefield).

The Northern Territory 'Tobacco Control Act' (see: http://notes.nt.gov.au/dcm/legislat/legislat.nsf/d989974724db65b1482561cf0017cbd2/ec12260a0ddb372869257dc100021e11?OpenDocument) provides a precedent for the inclusion of tobacco sales information including quantity of sales information in the Queensland legislation, please refer to sections 53 and 53a as copied below:

> ***53 Wholesalers to provide information about retailers***
>
> *(1) The Director-General may require a wholesaler of tobacco products to provide the Director-General with information sufficient to identify the retailers of tobacco products to whom the wholesaler sells or supplies tobacco products and to locate the business premises of those retailers.*
>
> *(2) A wholesaler must comply with a requirement under subsection (1).*
>
> *Maximum penalty: 100 penalty units.*
>
> ***53A Wholesalers to provide information about quantity of tobacco products supplied***
>
> *(1) The Chief Health Officer may request a wholesaler to provide the Chief Health Officer with information about the quantity of tobacco products sold or supplied by the wholesaler to retailers of tobacco products.*
>
> *(2) A wholesaler must comply with a request made under subsection (1).*
>
> *Maximum penalty: 100 penalty units.*

The requirement for the tobacco industry vis-à-vis tobacco 'manufacturer or wholesaler' to supply details of the sales/distribution/supply, including place of sales/distribution/supply and quantity of tobacco and tobacco products, to retailers may be included as amendments in '13A: Power to require details of retail

suppliers' (pages 15-16 of the current act). Changes to this section of the legislation should facilitate the routine provision of data to the 'chief executive' from the 'manufacturer or wholesaler' about the sales/distribution/supply to retailers without the inclusion of any limiting time frame (a time frame limitation of 12 months currently exists in the legislation).

Conclusion

The PHAA appreciates the opportunity to make this submission to influence legislation in this important area.

We hope that you consider these suggestions and amendments as a matter of priority in your current deliberations.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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