Joint Select Committee on Tobacco Smoking

# Tobacco smoking in New South Wales

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# Terms of reference

1. That a Joint Select Committee be appointed to inquire into and report on tobacco smoking in New South Wales, and in particular:

    (a) the costs and other impacts of smoking,
    (b) the effectiveness of strategies to reduce tobacco use,
    (c) the effects of smoke-free indoor venues on the initiation and maintenance of the smoking habit,
    (d) factors affecting initiatives for smoke-free indoor areas,
    (e) the effectiveness of media, educative, community and medically-based Quit initiatives,
    (f) the adequacy of the budget for smoking control initiatives, and
    (g) the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005 introduced by Revd Mr Nile in the Legislative Council.

2. That, notwithstanding anything to the contrary in the standing orders of either House, the committee consist of 11 members, as follows:

    (a) four members of the Legislative Council of whom:
        (i) one must be a government member,
        (ii) one must be an opposition member, and
        (iii) Dr Chesterfield-Evans and Revd Mr Nile

    (b) seven members of the Legislative Assembly of whom:
        (i) four must be government members,
        (ii) two must be an opposition member, and
        (iii) one must be an independent or cross bench member.

3. That the members be nominated in writing to the Clerk of the Parliaments and the Clerk of the Legislative Assembly by the relevant party leaders and the independent and cross bench members respectively within seven days of this resolution being agreed to by both Houses.

4. That, notwithstanding anything to the contrary in the standing orders of either House, at any meeting of the committee, any six members of the committee will constitute a quorum, provided that the committee meets as a joint committee at all times.

5. That the committee report by 30 June 2006.

These terms of reference were referred to the Committee by resolution of the Legislative Council, Minutes of Proceedings, Wednesday 8 March 2006, No 139, Item 2, p1882 and the Legislative Assembly, Votes and Proceedings, Wednesday 8 March 2006, No 167, Item 3, p1890.

Following prorogation of the Parliament on 19 May 2006, the Committee was re-established by resolution of the Legislative Council, Minutes of Proceedings, Wednesday 24 May 2006, No 3, Item 7, pp33-34 and Legislative Assembly, Votes and Proceedings, Thursday 25 May 2006, No 4, Item 25, pp67-68. As part of these resolutions, the inquiry reporting date was extended from 30 May 2006 to 30 June 2006.

# Committee membership

| | | |
|---|---|---|
| **Mr Richard Torbay MP** | Independent | *Chair* |
| **The Hon Dr Arthur Chesterfield-Evans MLC** | Australian Democrats | |
| **Ms Angela D'Amore** | Australian Labor Party | |
| **The Hon Greg Donnelly MLC** | Australian Labor Party | |
| **Mr Thomas George MP** | The Nationals | |
| **The Hon Don Harwin MLC** | Liberal Party | |
| **Ms Shelley Hancock MP** | Liberal Party | |
| **Revd the Hon Fred Nile MLC** | Christian Democratic Party | |
| **Ms Virginia Judge MP** | Australian Labor Party | |
| **Mr Paul McLeay MP** | Australian Labor Party | |
| **Mr Matthew Morris MP** | Australian Labor Party | |

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# Chair's foreword

I am pleased to present the report of the Joint Select Committee on Tobacco Smoking, which comprehensively examines the full range of tobacco strategies being implemented in New South Wales. The key message from this inquiry is that more needs to be done to further reduce the prevalence of smoking in this State. The economic costs of smoking for New South Wales are estimated at $6.6 billion per year and tobacco smoking is the single greatest cause of premature death. Further reductions in smoking will save money, enable better use of scarce resources and most importantly, will save many lives.

It is clear that the NSW Government needs to renew its leadership role in tobacco control in Australia by doing more to reduce smoking. The Committee heard, particularly at its public forum in May, that the community is ready for greater action to address smoking rates and save lives.

The Committee has noted that the Commonwealth Government raises over $5 billion per year from tobacco excise, yet has allocated only $24 million over four years for tobacco control. In light of this discrepancy, the Committee has called for greater Commonwealth funding for states and territories. In addition, the NSW Government should also increase its funding for tobacco control, to recommended levels of per capita spending.

A major issue for the inquiry was the smoke-free legislation and the impact of environmental tobacco smoke on workers in licensed venues. Based on the overwhelming evidence from inquiry participants in support of tighter restrictions, the Committee has concluded that among the many considerations in this area, protecting the health of workers is paramount. On this basis we believe that the NSW Government should examine legislation in other jurisdictions intended to protect the health of workers servicing smoking areas in licensed venues. As restrictions on where smoking can occur will help to denormalise smoking, the Committee considers that children's playgrounds should be smoke-free across New South Wales.

The Committee has also recommended tighter restrictions on display of tobacco products, licensing of tobacco retailers and renewed efforts to address sales of tobacco to minors.

The NSW Government can further reduce smoking rates by maintaining tobacco control as a policy priority and increasing measures to ensure people and policy makers do not become complacent about the impact of smoking on the community. It is clear that this will require additional and sustained funding to further implement the *NSW Tobacco Action Plan 2005-2009* and to deliver the required comprehensive and multifaceted approach to tobacco control.

On behalf of the Committee, I thank each of the inquiry participants for their time and expertise. The Committee notes that while tobacco companies made written submissions to the inquiry, they declined our strong encouragement to participate further. I am grateful to my Committee colleagues for the work they have undertaken on this inquiry and their contribution to this report. On their behalf, I would like to acknowledge the Secretariat for their assistance in the conduct of this inquiry, and the production of this report. I commend this report to the Government.

**Richard Torbay**
**Chair**

# Executive summary

### Chapter 1 – Conduct of the inquiry

The inquiry into tobacco smoking in New South Wales emerged out of discussion in the Legislative Council of the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill and the Smoke-free Environment Amendment (Removal of Exemptions) Bill. A resolution to establish the Committee was passed in the Legislative Council on 28 February 2006 and the Legislative Assembly on 8 March 2006. As a joint select committee it is comprised of members of both Houses of the NSW Parliament and was established only for the life of this inquiry.

The Committee received 70 written submissions to the inquiry, conducted four public hearings with 40 witnesses, and held a public forum that provided an opportunity for direct input from members of the community. The Committee also conducted two site visits, to the respiratory unit at Concord Hospital and a licensed venue, the Old Fitzroy Hotel at Woolloomooloo.

### Chapter 2 – The costs and other impacts of smoking

During the course of the inquiry the Committee was presented with substantial evidence on the adverse health effects of smoking and the accompanying costs to the health system and broader society. It is clear to the Committee that smoking carries with it very substantial costs, including economic costs of $6.6 billion annually, these most notably include health costs, as a result of tobacco smoking being the single greatest cause of premature death in New South Wales. The details of these costs, both quantitative and in human terms, are important as they form the context and potential rationale for government policy in relation to tobacco smoking.

The Committee is convinced of the major financial gains associated with tobacco control, again, most notably in terms of the health system. However, more important still than these financial gains are those to be made from improving health, reducing death and disease, freeing up scarce health resources and improving equity as a result of reducing tobacco use. The evidence is very clear that by reducing smoking we can improve the health and lives of individuals, families and communities in New South Wales.

The Committee recognises that the NSW Government, and in particular NSW Health, has a tobacco control plan in place and notes that smoking rates in New South Wales have continued to decline in recent years, from 22.3% in 2003 to 20.1% in 2005. However, the Committee believes that more can and should be done to further reduce the prevalence of smoking and to cut through the barriers to further reducing tobacco use. We note that an estimated 45% of the total costs of tobacco smoking are avoidable, that is, they could be reduced as a result of further government policy and activity.

### Chapter 3 – Tobacco control

The Committee examined tobacco control measures in Australia and specifically New South Wales, as provided for under the *NSW Tobacco Action Plan 2005-2009*. Tobacco control includes such diverse activities as educational initiatives, restrictions on access to tobacco, tobacco advertising bans, the imposition of taxes to raise the price of cigarettes, and health warnings on tobacco packages.

The NSW Government has allocated an estimated $12.1 million for tobacco control in 2005-2006, while the Commonwealth has allocated $24 million over four years. Given that the latter raises $5.237 billion from tobacco excise each year, we consider that it is obligated to allocate much more of this revenue to the states and territories for tobacco control. At the same time, we consider that in light of the estimated impact of tobacco on the community and the high rates of spending in other jurisdictions, the current NSW

Government expenditure of $1.90 per capita per year is not adequate. We recommend that it be increased to between $2.90 and $8.50 per capita per year.

The Committee considers that further reductions in smoking rates can be achieved by the NSW Government maintaining tobacco control as a policy priority and increasing measures to ensure people and policy makers do not become complacent about the impact of smoking on the community. It is clear that this will require additional and sustained funding from the NSW Government and the Commonwealth, to further implement the *NSW Tobacco Action Plan* and other tobacco control measures. Not only will this reduce the costs on the health system and to the community; it will save people's lives.

**Chapter 4 – Strategies to reduce tobacco use**

The NSW and Commonwealth Governments have developed and implemented strategies aimed at reducing tobacco use in the population. As part of the *NSW Tobacco Action Plan*, strategies used in New South Wales to reduce tobacco include media campaigns targeted at the broad population, educational campaigns targeted at school children, community initiatives run by area health services and non-government organisations, and medically-based strategies such as nicotine replacement therapy.

In order to further progress the decline in smoking rates, the Committee recommends the NSW Government continue mass media campaigns and educational campaigns. Due to the extremely high smoking rate in the Aboriginal community, the Committee recommends that this group be a priority, with increased resources for targeted programs.

Another concern of the Committee was the affordability of nicotine replacement therapy (NRT), which has been shown to improve quitting rates, and on this basis the Committee recommends that the NSW Government and the Cancer Institute NSW initiate further discussions with the Commonwealth Government on this issue. The Committee also recommends that there be an enhancement of resources for smoking clinics and/or smoking cessation therapists within area health services in order to better assist chronically dependent smokers.

The evidence presented to the Committee is clear that tobacco control needs to be comprehensive, well funded, multifaceted and long term. Strategies aimed at the broad population must also be appropriate and accessible to high risk groups. At the same time, certain population groups, including Aboriginal people, young people and culturally and linguistically diverse communities, will necessarily require a tailored and targeted approach. The Committee believes that this has been recognised by the NSW Government and that its comprehensive strategies should continue to be developed and implemented. The Committee concludes that the declining smoking rates for New South Wales suggest that tobacco control strategies have generally been effective. However, we recommend that more evaluation of the individual strategies be undertaken by the NSW Government.

**Chapter 5 – The packaging, sales and display of tobacco products**

With tobacco advertising in the traditional sense having been banned for some years, a number of inquiry participants highlighted that the retail environment is now the primary vehicle for the marketing of tobacco products. The Committee considered a range of issues in relation to the sales and display of tobacco.

As part of a multi-faceted approach, the Committee believes that there is a need for an increased focus on the supply side of tobacco control. Currently in New South Wales there is no restriction on point of sale display and the Committee has recommended that there be a restriction of one square meter for retailers, excluding tobacconists. The implementation of a licensing system for wholesalers and retailers of tobacco products and a review of current provisions and activities in relation to sales to minors have also been recommended.

The Committee also examined issues with shopper loyalty programs for customers buying cigarettes and recommends that these be prohibited to discourage purchasing of cigarettes.

**Chapter 6 – Smoke-free venues**

The Committee has documented inquiry participants' comments in relation to the impact of the smoke-free legislation, the *Smoke-free Environment Act 2000* and related regulations, on proprietors of licensed venues, workers and patrons. Building on the personal stories of Mrs Marlene Sharp and Mr Phil Edge, two hospitality workers who developed cancer as a result of exposure to environmental tobacco smoke (ETS) in their workplaces, the overwhelming view expressed to us was that the legislation in New South Wales needs to go further in protecting people from the damaging effects of ETS in licensed venues.

Of the many issues documented in this chapter, the Committee concluded that the need to protect the health of workers is paramount. The Committee has concerns about employees being required to work in any smoking areas including outdoor areas such as beer gardens and other outside areas in and around licensed venues. Because of the importance of maximising the protection of workers' health and in order to ensure optimal compliance with the *Occupational Health and Safety Act 2000*, the Committee considers that legislative provisions relating to this matter in other jurisdictions are worthy of further examination by the NSW Government. The Committee further considers that smoking in children's playgrounds should be restricted on a statewide basis.

**Chapter 7 – Smoking in cars**

As part of its terms of reference the Committee was required to consider the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill, which seeks to ban smoking in cars, introduced to the Legislative Council by Revd the Hon Fred Nile MLC.

The Committee outlines the proposed provisions of the bill and its policy intentions, documenting the research evidence presented in relation to these intentions, and considers the views of a range of inquiry participants both in support of and against the bill. We also note the findings of the educative 'Car and home: smoke free zone' project that ran in New South Wales between 2001 and 2005. We conclude that on balance, an educational approach is more desirable than a legislative one and recommend that a sustained educational campaign drawing on the model and lessons of the 'Car and home: smoke free zone' project be implemented.

**Chapter 8 – Conclusions**

Throughout the inquiry the Committee heard evidence on tobacco control measures in other states and territories and we strongly encourage the NSW Government to take on board the positive steps taken in other jurisdictions to reduce tobacco use. Indeed, we consider that the NSW Government should renew its efforts to become a leader in tobacco control in Australia. The key message from the inquiry for the NSW Government is that the New South Wales community is ready for greater tobacco control to further reduce smoking rates and save lives. The public is looking to the Government to take on this leadership role.

# Summary of recommendations

**Recommendation 1** **30**

That the NSW Government enter into discussions with the Commonwealth Government, via the Council of Australian Governments, to increase the funding allocation for tobacco control to states and territories, in light of the amount of tobacco excise the Commonwealth Government receives.

**Recommendation 2** **35**

That the NSW Government increase funding for tobacco control in line with the recommendations of the *National Tobacco Strategy 2004-2009* from $1.90 per capita to between $2.90-$8.50 per capita per year.

**Recommendation 3** **41**

That the Cancer Institute NSW continue to invest in and develop mass media campaigns aimed at reducing smoking rates.

**Recommendation 4** **43**

That the Cancer Institute NSW evaluate a "cold-calling" approach for the Quitline.

**Recommendation 5** **43**

That the Cancer Institute NSW specifically examine use of the Quitline by rural communities and other disadvantaged groups, and if necessary, develop specific strategies to improve their access to the Quitline.

**Recommendation 6** **46**

That the NSW Government continue to implement tobacco education strategies in schools to help young people understand the risks of smoking.

**Recommendation 7** **50**

That the NSW Government:

- increase resources to develop and implement targeted tobacco smoking health promotion and prevention and cessation program (including nicotine replacement therapy) across Aboriginal communities in New South Wales
- coordinate the formation of collaborative research and evaluation projects to measure the effectiveness of community strategies to allow more evidence to be collected
- provide more funding and resources to provide training for all Aboriginal community controlled health service staff and briefings in interventions regarding tobacco smoking.

**Recommendation 8** **53**

That NSW Health consider adding people in rural and remote areas to the target groups for smoking cessation services identified in the *NSW Tobacco Action Plan 2005-2009*.

**Recommendation 9** **55**

That NSW Health give consideration to ways of ensuring that area health services deliver anti-smoking programs, with specific reference to ensuring access by the full range of disadvantaged groups.

- the potential value of further retailer education initiatives
- further strategies to reduce the prevalence of smoking
- the potential for requiring employers to provide ongoing training to employees in retail outlets.

**Recommendation 20** **79**

That the Minister for Health raise the issue of banning overtly fruit flavoured cigarettes with the Commonwealth Government through the Council of Australian Governments.

**Recommendation 21** **83**

That the NSW Government upgrade its intended nomination scheme for retailers to a licensing system for tobacco wholesalers and retailers which facilitates better compliance with and enforcement of the legislation. In doing so, it should consider the best practice model of licensing set out in the report to the Commonwealth, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements.*

**Recommendation 22** **91**

That the NSW Government amend the *Public Health Act 1991* to restrict point of sale display to one point of sale per venue and one square meter (excluding tobacconists).

**Recommendation 23** **92**

That the NSW Government introduce legislation to prohibit the inclusion of tobacco products in retailer, and specifically supermarket, shopper loyalty programs.

**Recommendation 24** **121**

That the NSW Government examine legislation in other jurisdictions intended to protect the health of workers servicing smoking areas.

**Recommendation 25** **124**

That the NSW Government amend the *Smoke-free Environment Act 2000* to include children's playgrounds as smoke-free areas.

**Recommendation 26** **134**

That NSW Health fund and implement a sustained educational campaign aimed at reducing smoking in cars, based on the 'car and home: smoke free zone' project and drawing on its evaluation findings. The initiative should:

- target the broad community and diverse groups within it
- be supported by strategies delivered through the broad range of health and community services utilised by families and children
- be developed and implemented in partnership with the Roads and Traffic Authority, the NSW Police Service and motoring organisations.

# Chapter 1 Conduct of the inquiry

## Establishment of the inquiry

**1.1** The inquiry into tobacco smoking in New South Wales emerged out of discussions in the Legislative Council concerning two bills, the Smoke-free Environment Amendment (Removal of Exemptions) Bill initiated by the Hon Dr Chesterfield-Evans MLC and the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill introduced by Revd the Hon Fred Nile MLC. The former bill sought to remove exemptions to the ban on tobacco smoking in licensed premises while the latter bill sought to introduce a ban on smoking in cars.

**1.2** During the second reading debate on the smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill on 28 February 2006 Dr Chesterfield-Evans moved that a Joint Select Committee be appointed to inquire into and report on tobacco smoking in New South Wales.

**1.3** Following an amendment by the Minister for Health, the Hon John Hatzistergos MLC, concerning the membership of the Committee, the resolution was passed in the Legislative Council. After the adoption of the same resolution in the Legislative Assembly on 8 March 2006, the inquiry and Committee were established.[1]

**1.4** Following prorogation of the Parliament on 19 May 2006, the Committee was re-established by resolution of the Legislative Council on 24 May 2006 and the Legislative Assembly on 25 May 2006. As part of these resolutions, the inquiry reporting date was extended to 30 June 2006.[2] As a joint select committee it is comprised of members of both Houses of the NSW Parliament and was established only for the life of this inquiry.

**1.5** The terms of reference for the inquiry together with membership of the Committee are located on pages iv and v of the initial section of this report.

## Conduct of the inquiry

### Advertising

**1.6** The Committee widely advertised a call for submissions through Sydney and national newspapers and other media. Letters seeking submissions were sent to a wide-ranging selection of government and non-government bodies, including relevant government agencies, non-government health organisations, retailers, tobacco companies and representatives of the pubs and clubs industries.

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1 Legislative Council, New South Wales, Minutes of Proceedings, Wednesday 8 March 2006, No 139, Item 2, p1882 and Legislative Assembly, Votes and Proceedings, Wednesday 8 March 2006, No 167, Item 3, p1890

2 Legislative Council, New South Wales, Minutes of Proceedings, Wednesday 24 May 2006, No 3, Item 7, pp33-34 and Legislative Assembly, Votes and Proceedings, Thursday 25 May 2006, No 4, Item 25, pp67-68

### Submissions

**1.7** In response to the call for submissions, the Committee received a total of 70 submissions to the inquiry. Submissions were provided by major stakeholders, including the NSW Government, Action on Smoking and Health (ASH), the Cancer Council NSW and tobacco companies. They were also received from a number of individuals. The full list of public submissions and authors appears at Appendix 1.

### Hearings

**1.8** The Committee conducted four days of hearings with a total of 40 witnesses, representing a wide cross-section of organisations and groups. Appendix 2 contains the full list of witnesses. The transcripts of all hearings are available on the Committee's website at www.parliament.nsw.gov.au/tobaccosmokingcommittee.

### Public forum

**1.9** The Committee held a public forum at Parliament House on 1 May 2006 to provide an opportunity for members of the community to speak directly to the Committee about their views on tobacco smoking. There was a positive turn-out with 60 attendees, including 23 speakers. A panel of experts including representatives of ASH, NSW Health, the Cancer Council NSW and the Australian Hotels Association responded to Committee members' questions about the issues raised by forum participants. The transcript of the forum is available on the Committee's website and Appendix 3 contains a list of forum speakers and members of the panel.

### Site visits

**1.10** The Committee undertook two site visits, the first on 22 March 2006 to Concord Hospital's Respiratory Unit. Professor Matthew Peters, respiratory physician, addressed the Committee and hosted an informal tour of the unit.

**1.11** The second site visit took place on 1 May 2006. Members travelled to the Old Fitzroy Hotel, Woolloomooloo, to see first-hand a licensed venue that complied with the smoke-free environment legislation. The Committee was given a tour of the hotel's smoking and non-smoking areas by Mr Garry Pasfield, the licensee and owner, who answered questions about the impact of the legislation on his business.

## The participation of tobacco companies in the inquiry

**1.12** The Committee was eager to include representatives of the tobacco companies in the hearing process and on 27 March 2006 invited Imperial Tobacco Australia Ltd, British American Tobacco Australia and Philip Morris Ltd to appear before the Committee. None of the companies were willing to send representatives to be examined. Further letters were sent on 2 May 2006 requesting their attendance and again all declined. Written submissions were received from each of the companies.

**1.13** The Committee acknowledges the input of these companies through their submissions. However, it also notes its disappointment that tobacco company representatives were unwilling to take part in a hearing or to engage in the inquiry on the same terms as other participants.

## Report structure

**1.14** Chapter 2 addresses term of reference (a), the costs and impacts of smoking, outlines the prevalence of smoking in New South Wales and documents the health impacts and economic costs of tobacco. It then explores the potential economic gains from further tobacco control.

**1.15** Chapter 3 addresses term of reference (f), the issue of tobacco control both nationally and within New South Wales, outlines current legislation, the key players involved in tobacco control and a comparison between New South Wales and other states. It also addresses funding for tobacco control in New South Wales, the barriers to reducing tobacco use and proposals for reducing tobacco use in the future.

**1.16** Chapter 4 addresses the terms of reference (b) and (e), that is, the effectiveness of strategies to reduce tobacco use and the effectiveness of media, educative, community and medically-based Quit initiatives targeting disadvantaged groups such as Indigenous people, culturally and linguistically diverse communities and rural and regional communities. The chapter also addresses the issue of fire safety and reduced fire-risk cigarettes.

**1.17** Chapter 5 examines the sales and display of tobacco products, considering a number of proposals in relation to packaging, sales to minors, licensing of tobacco retailers, display of cigarettes, incentives to purchase and vending machines.

**1.18** Chapter 6 addresses terms of reference (c) and (d), that is, smoke-free venues and factors affecting initiatives for smoke-free indoor areas. The Committee's insights from a site visit to an old hotel which required a building refit to meet the 75:25 requirement are presented. An analysis is made of the impact of the legislation on licensed venues, workers and patrons.

**1.19** Chapter 7 addresses term of reference (g) by considering the ban on smoking in cars envisaged by the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005 introduced by Revd Nile.

**1.20** Chapter 8 draws together major themes of the report and articulates key messages for the NSW Government arising from the inquiry.

# Chapter 2 The costs and other impacts of smoking

> Despite great steps in reducing its prevalence, 1 in 5 people still smoke. Half of all smokers will die early because of their habit – with their average lifespan shortened by up to 12 years.[3]
>
> The evidence clearly demonstrates that governments have an enormous amount to gain from accelerating declines in smoking prevalence including: reduced health care costs; and higher productivity rates from people who would be healthier and living longer, more productive lives.[4]

During the course of the inquiry the Committee was presented with substantial evidence about the adverse health effects of smoking and the accompanying costs to the health system and broader society. The details of these costs, both quantitative and in human terms, are important as they form the context and potential rationale for government policy in relation to tobacco smoking. The chapter begins by reporting on the prevalence of smoking in New South Wales and Australia. It then documents the myriad health impacts of smoking, for example, in relation to cancer, heart disease, respiratory illness and various conditions in children. A number of groups known to have higher rates of smoking are identified, with particular attention given to Aboriginal people, who have around twice the rate of smoking as the broader community. The chapter concludes by reporting the evidence on the economic impact of tobacco, most particularly in terms of costs to the health system, then exploring the potential economic gains from tobacco control.

## The prevalence of smoking

**2.1** Table 2.1 on the following page presents data on the proportion of the population aged 14 and over that use tobacco for each state and territory, as well as nationally. The table shows that in 2004, 19.7% of persons (21.3% of males and 19.7% of females) aged 14 and over in New South Wales were smokers, including those who smoked daily, weekly or less than weekly.

**2.2** This state compares reasonably favourably with the national picture and with other Australian jurisdictions. The equivalent rate for the Australian population was 22.5% (18.8% for males and 20.6% for females), and New South Wales was ranked third lowest, behind Western Australia and South Australia, in its proportion of persons who use tobacco.[5]

**2.3** Slightly different rates were reflected in the New South Wales Adult Health Survey for the same year, which found that 21.0% of persons (22.7% of males and 19.4% of females) aged 16 and over were smokers, including daily and occasional smokers.[6] The same survey found that for both males and females, smoking rates were highest among young adults, with a

3 Submission 19, Australian Medical Association (NSW), p2

4 Submission 40, Royal Australian College of Physicians, p2

5 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: State and territory supplement*, Australian Institute of Health and Welfare, Canberra, June 2005, p2

6 NSW Health, New South Wales Population Health Survey 2004: Report on Adult Health, *NSW Public Health Bulletin: Supplement*, Vol 16, No S-1, November 2005, pp47-8

significantly higher proportion of people aged 16-34 years being current smokers compared to the total adult population.[7]

**Table 2.1: Tobacco smoking status: proportion of the population aged 14 years and over, Australian states and territories, 2004**[8]

| Smoking status | NSW | Vic | Qld | WA | SA | Tas | ACT | NT | Aus |
|---|---|---|---|---|---|---|---|---|---|
| | | | | **(per cent)** | | | | | |
| | | | | **Males** | | | | | |
| Daily | 17.2 | 18.8 | 21.5 | 17.0 | 17.3 | 22.0 | 18.7 | 28.6 | 18.6 |
| Weekly | 2.0 | 2.6 | 1.5 | 1.9 | 1.7 | 1.6 | 3.1 | 1.8 | 2.0 |
| Less than weekly | 2.1 | 2.2 | 1.7 | 1.4 | 1.6 | 1.5 | 1.9 | 2.3 | 1.9 |
| Ex-smoker(a) | 26.8 | 28.0 | 32.6 | 31.7 | 32.9 | 29.8 | 26.2 | 28.3 | 29.2 |
| Never smoked(b) | 52.0 | 48.4 | 42.7 | 48.0 | 46.5 | 45.1 | 50.00 | 39.0 | 48.2 |
| | | | | **Females** | | | | | |
| Daily | 15.8 | 16.1 | 18.1 | 14.0 | 15.7 | 21.0 | 13.7 | 25.9 | 16.3 |
| Weekly | 1.1 | 1.3 | 1.4 | 1.7 | 0.9 | 1.1 | 1.6 | 1.4 | 1.2 |
| Less than weekly | 1.4 | 1.3 | 1.3 | 1.2 | 1.1 | 1.1 | 2.5 | 1.7 | 1.3 |
| Ex-smoker(a) | 22.8 | 23.2 | 23.4 | 26.2 | 24.7 | 26.6 | 25.0 | 22.9 | 23.6 |
| Never smoked(b) | 58.9 | 58.2 | 55.8 | 56.9 | 57.6 | 50.2 | 57.3 | 48.0 | 57.5 |
| | | | | **Persons** | | | | | |
| Daily | 16.5 | 17.4 | 19.8 | 15.5 | 16.5 | 21.5 | 16.1 | 27.3 | 17.4 |
| Weekly | 1.5 | 1.9 | 1.4 | 1.8 | 1.3 | 1.3 | 2.3 | 1.6 | 1.6 |
| Less than weekly | 1.7 | 1.7 | 1.5 | 1.3 | 1.3 | 1.3 | 2.2 | 2.0 | 1.6 |
| Ex-smoker(a) | 24.8 | 25.6 | 27.9 | 28.9 | 28.8 | 28.2 | 25.6 | 25.7 | 26.4 |
| Never smoked(b) | 55.5 | 53.4 | 49.4 | 52.5 | 52.1 | 47.7 | 53.7 | 43.4 | 52.9 |

(a) smoked at least 100 cigarettes (or equivalent amount of tobacco) in lifetime, but no longer smokes.
(b) never smoked more than 100 cigarettes (or equivalent amount of tobacco)

**2.4** The NSW Government submission to the inquiry reports that New South Wales smoking rates have continued to decline in recent years, from 22.3% in 2003 to 20.9% in 2004, to 20.1% in 2005.[9] This accorded with the decline over a much longer period discussed by

7 NSW Health, New South Wales Population Health Survey 2004: Report on Adult Health, *NSW Public Health Bulletin: Supplement*, Vol 16, No S-1, November 2005, pp47

8 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: State and Territory Supplement*, Australian Institute of Health and Welfare, Canberra, June 2005

9 New South Wales Population Health Survey 2003, 2004 and 2005, cited in Submission 48, The Cabinet Office, p4

Professor Simon Chapman when he appeared before the Committee.[10] In 1977 approximately 37% of Australians reported smoking, and in 1989, around 28%.[11]

**2.5** There was some concern among Committee members that the downward trend shown in telephone survey prevalence data in recent years did not match trends in tobacco sales data and that perhaps the true picture of tobacco consumption over time was not sufficiently clear.

**2.6** A number of inquiry participants addressed this issue. Professor Chapman reported that obtaining and analysing sales data was a complex task. He reported that the volume of tobacco being sold was not declining as dramatically as the percentage of reported smokers, explaining that telephone surveys used to determine reported smoking rates have certain biases and may be slightly more optimistic. He emphasised, however, that tobacco sales data was also 'heading in the right direction'.[12] Similarly, Associate Professor Matthew Peters, President, and Ms Anne Jones, Chief Executive Officer, Action on Smoking and Health (ASH), reported that cigarette use per capita has been declining over a long period, but that there was a need for better data on this. They told the Committee that ASH has been seeking from the Commonwealth Government an analysis that integrated data from the Australian Bureau of Statistics and the AIHW that would furnish a more reliable picture of tobacco use.[13]

**2.7** The Cancer Institute gave detailed consideration to this issue in an answer to a question taken on notice during a hearing. It explained the methodological issues associated with telephone surveys that could explain some differences between rates of reported smoking and tobacco sales data. It also reported Customs and Excise data published by the Australian Institute of Health and Welfare (AIHW) that in the Cancer Institute's view 'gives cause for concern'. The data shows that the number of cigarettes cleared through excise from 1999 to 2004 was:

- 25.6 billion sticks in 1999-00
- 22.6 billion sticks in 2001-02
- 23.5 billion sticks in 2002-03
- 23.5 billion sticks in 2003-04.[14]

**2.8** The Cancer Institute also reported that the AIHW commented in relation to this data that 'stability in the number of cigarettes attracting excise in recent years does not correspond to the decline in the estimated number of Australians who smoke, coupled with a decline in the

10 Professor Simon Chapman, School of Public Health, University of Sydney, Slide presentation, 22 May 2006

11 Australian Bureau of Statistics, *Australian Social Trends, 2000*, Australian Bureau of Statistics, Canberra, July 2000, accessed 26 May 2006, <http://abs.gov.au/AUSSTATS/abs@nsf/Previousproducts>

12 Professor Chapman, Evidence, 22 May 2006, p8

13 Professor Matthew Peters, President, and Ms Anne Jones, Chief Executive Officer, Action on Smoking and Health (ASH), Evidence, 5 May 2006, pp64-65

14 Answers to questions on notice taken during evidence 1 March 2006, Professor Jim Bishop, Chief Executive Officer, Cancer Institute NSW, Question 3, p3

amount of cigarettes consumed per smoker between 2001 and 2004.'[15] The Cancer Institute noted that tobacco consumption data is expensive to obtain and concluded, 'Undoubtedly, if governments and quit campaigns collaborated over commissioning surveys on smoking, more reliable trend data would be available at a lower cost.' [16] A recommendation in relation to this issue is made in Chapter 4 (see Recommendation 16).

## Health impacts of tobacco smoke

### Mortality

**2.9** Smoking is a key cause of death in Australia. The NSW Government submission states:

> Tobacco smoking is the greatest single cause of premature death and is a leading cause of morbidity in New South Wales. In New South Wales, cigarette smoking causes around 40% of all deaths in men before the age of 65 years and 20% of all deaths in women before the age of 65 years, which means that an estimated 330,000 males and 165,000 females in New South Wales will die prematurely of smoking related diseases. In 2002, smoking caused 6,608 deaths … in New South Wales.[17]

**2.10** Looking at the international context, Professor Chapman reported that smoking remains the leading cause of death globally. He cited World Health Organisation figures that tobacco caused 4.9 million deaths in 2002 and is projected to cause 10 million deaths in 2020. In Australia, there were 19,000 deaths from tobacco use in 2002.[18]

**2.11** Dr Andrew Penman, Chief Executive Officer of the Cancer Council NSW noted that at least 20% of all cancer deaths are attributable to smoking,[19] while Professor Bishop of the Cancer Institute told the Committee:

> [L]ooking at smokers versus non-smokers, approximately half of the smoking population will die in middle age and, on average, will lose about 10 years of life as a result of smoking.[20]

15 Australian Institute of Health and Welfare, *Statistics on Drug Use in Australia 2004*, cited in answers to questions on notice taken during evidence 1 March 2006, Professor Bishop, Cancer Institute NSW, Question 3, p3

16 Answers to questions on notice taken during evidence 1 March 2006, Professor Jim Bishop, Question 3, p3

17 Submission 48, p4

18 Professor Chapman, Evidence, 22 March 2006, p1

19 Dr Andrew Penman, Chief Executive Officer, The Cancer Council NSW, Evidence, 21 March 2006, p4

20 Professor Jim Bishop, Chief Executive Officer, Cancer Institute NSW, Evidence, 21 March 2006, p27

### Morbidity

**2.12** The Committee was told that smoking affects almost every organ of the body and that smoking-related disease is the most preventable disease in Australia and around the world.[21] We were advised that tobacco smoke contains over 4,000 chemical substances, of which at least 50 are known to be carcinogenic and at least 100 to be toxic.[22]

**2.13** The Cancer Institute's submission contains the following tables documenting the diseases and adverse health effects associated with both active smoking and passive smoking (environmental tobacco smoke).

**Table 2.2: Diseases and adverse health effects of active smoking[23]**

| Cancers | Respiratory diseases & adverse health effects | Cardiovascular diseases & adverse health effects | Other diseases & adverse health effects |
|---|---|---|---|
| • Lung<br>• Oral cavity<br>• Pharynx<br>• Larynx<br>• Oesophagus (squamous cell carcinoma)<br>• Oesophagus (adenocarcinoma)<br>• Pancreas<br>• Urinary bladder<br>• Renal pelvis<br>• Kidney (renal cell carcinoma)<br>• Stomach<br>• Uterine cervix<br>• Granulocytic cells of bone marrow (myeloid leukaemia)<br>• Nasal cavities<br>• Nasal sinuses<br>• Liver | • Chronic obstructive pulmonary disease (COPD)<br>• Acute respiratory illnesses including pneumonia<br>• Premature onset of and an accelerated decline in lung function<br>• All major respiratory symptoms in adults including coughing, phlegm, wheezing & dyspnoea<br>• Poor asthma control<br><br>***In young people & adolescents who smoke:***<br>• Impaired lung growth<br>• Early onset of lung function decline<br>• Respiratory symptoms including coughing, phlegm, wheezing & dyspnoea<br>• Asthma-related symptoms (wheezing) | • Coronary heart disease (CHD)<br>• Cerebrovascular disease<br>• Aortic aneurysm<br>• Peripheral arterial disease<br>• Buerger's Disease | • Gastric ulcer<br>• Cataract<br>• Periodontitis<br>• Duodenal ulcer<br>• Adverse surgical outcomes related to wound healing and respiratory complications<br>• Hip fracture<br>• Reduced fertility in women<br>• Crohn's disease<br>• Age related macular degeneration<br>• Tobacco amblyopia<br>• Osteoporosis<br><br>***Reproductive problems:***<br>• Pregnancy complications<br>• Preterm delivery & shortened gestation<br>• Foetal growth restrictions & low birthweight<br>• Sudden Infant Death Syndrome |

21 Professor Bishop, Evidence, 21 March 2006, p27

22 Associate Professor John Gullotta, President, Australian Medical Association (NSW), Evidence, 21 March 2006, p16

23 Submission 22, Cancer Institute NSW, p5

| Cancers | Respiratory diseases & adverse health effects | Cardiovascular diseases & adverse health effects | Other diseases & adverse health effects |
|---|---|---|---|
| | • Respiratory effects in utero with maternal smoking | | |

**Table 2.3: Diseases and adverse health effects caused by passive smoking**[24]

| In adults | In children | Other adverse health effects for both adults and children |
|---|---|---|
| • Lung cancer<br>• Coronary heart disease<br>• Onset of symptoms of heart disease<br>• Asthma attacks in those already affected<br>• Worsening of symptoms of bronchitis<br>• Stroke<br>• Reduced foetal growth (low-birth-weight baby)<br>• Premature birth | • Cot death (Sudden infant death syndrome)<br>• Middle-ear disease (ear infections)<br>• Respiratory infections<br>• Development of asthma in those previously unaffected<br>• Asthma attacks in those already affected | • Shortness of breath<br>• Nausea<br>• Airway irritation<br>• Headache<br>• Coughing<br>• Eye irritation |

**2.14** The Committee heard from a range of inquiry participants about the major diseases and health effects associated with smoking such as cancer, heart disease, chronic obstructive pulmonary disease, eye disease and asthma.

**2.15** Professor Bishop told the Committee that smoking causes around 20% of all cancers, and that those cancers associated with tobacco smoking tend to have poor prognosis. For example, merely one in eight people with lung cancer, the largest cause of cancer deaths in this state, will be alive five years after diagnosis.[25] The consumer group Cancer Voices, made up of people living with cancer, emphasised the preventability of tobacco-related cancer, in contrast with many other types. [26]

**2.16** The National Heart Foundation, NSW Division, reported that an estimated 13% of all cardiovascular disease is caused by smoking, both active and passive. At present there are more than 1.1 million people in New South Wales with cardiovascular disease, with this figure set to double by 2051 to around 2.3 million.[27]

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24 Submission 22, p5

25 Professor Bishop, Evidence, 21 March 2006, p27

26 Submission 12, CancerVoices Inc, p2

27 Mr Tony Thirlwell, Chief Executive Officer and Ms Jeanie McKenzie, Director, Cardiovascular Health, National Heart Foundation, NSW Division, Evidence, 22 March 2006, p16

**2.17** Associate Professor Peters of ASH, a respiratory physician at Concord Hospital, told the Committee that chronic obstructive pulmonary disease (COPD), which includes both emphysema and chronic bronchitis, is virtually entirely caused by smoking, that '[w]ithout smoking there will be no COPD'.[28] He explained that COPD is caused by lung damage arising from long term smoking; these people experience heavy coughing, spitting and breathlessness, and are very susceptible to respiratory infections such as pneumonia. As a result, they often have difficulty looking after themselves at home and require hospital treatment and nursing care.[29]

**2.18** In its submission, the Optometrists Association detailed the range of eye diseases to which smoking is linked, including age-related macular degeneration, cataracts, glaucoma, Graves ophthalmopathy (thyroid eye disease), toxic amblyopia, retinal vein occlusion and esotropia (an inward turning of the eyes) among babies of mothers who smoke.[30]

**2.19** Asthma NSW noted that the effects of tobacco smoke on people with asthma are well documented and include: an increased likelihood of asthma developing; worsening of existing symptoms such as chest tightening, coughing and wheezing; and increased incidence of asthma attacks.[31] For some individuals, triggers can lead to severe and potentially life-threatening asthma attacks.[32]

**2.20** A large number of inquiry participants noted the negative effects that exposure to ETS has on children and also on infants prior to birth.[33] The Children's Hospital at Westmead listed a range of health conditions in children that exposure to ETS have been shown to be associated with:

- more severe asthma, more frequent exacerbations of asthma, more hospitalisations and more life-threatening attacks
- lower respiratory tract infections such as pneumonia, croup, bronchitis and bronchiolitis
- middle ear disease including acute and chronic otitis media and surgery for middle ear effusions
- impaired lung function
- sudden infant death syndrome
- learning difficulties, behavioural problems and language impairment

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28 Associate Professor Matthew Peters, Respiratory Physician, Concord Hospital, Informal Site Visit, 22 May 2006, p3

29 Associate Professor Peters, Informal Site Visit, 22 March 2006, p1

30 Submission 21, Optometrists Association of Australia (NSW Division), p2

31 Submission 41, Asthma NSW, p3

32 Ms Megan Dephoff, Manager, Programs and Policy, Asthma NSW, Evidence, 22 March 2006, p18

33 See for example Submission 48, p12; Submission 47, Commission for Children and Young People, pp1-2; Ms Dephoff, Evidence, 22 March 2006, p18; Professor Gullotta, Evidence, 21 March 2006, pp16-17

- physiological changes that may increase the risk of cardiovascular disease.[34]

**2.21** A consistent message from many inquiry participants, both medical and lay people, was that exposure to ETS is an important risk factor for the range of health effects, not just direct smoking. The AMA's submission states that there is clear evidence that exposure to ETS substantially increases the risks of a range of diseases, reporting that, for example, people who live with smokers have a 25% greater risk of coronary heart disease, and that exposure to ETS has been shown to lead to a measurable increase in respiratory symptoms.[35]

### Personal stories

**2.22** At its public forum on 1 May the Committee heard directly from members of the community about their views on tobacco smoking. A number of people them told of their experiences of the health effects of tobacco smoking, some of which were severe, and others which were less so, but which were nevertheless significant for the person concerned. These stories highlight the human experience of such health effects, not only for the person directly affected, but also their family.

**2.23** A young man in his twenties, Mr Leslie Marsh, told how having to avoid ETS affects his lifestyle:

> I have very mild asthma. Two times a year I will use a ventalin puffer. However, the smallest exposure to tobacco smoke triggers much larger asthma in me which pretty much means I cannot go to pubs and clubs, things like that, which I will anyway because I am determined to have a social life and I cannot help being sociable, however it means I suffer for a couple of weeks afterwards. Also, I have had to stop playing in bands which I have done since I was at school, because that level of exposure where you are playing every night or at least every weekend is just too much. It is a bit of a first world problem for me that I cannot play in bands but it sucks.[36]

**2.24** Mr Matt Roberts told of the health effects he suffers because of his job as a musician and the extent to which the smoke of other people pervades his daily living:

> I am a freelance musician/entertainer with almost 20 years of experience working in hotels and clubs. I am also a music tutor working in secondary schools and a father of two small children. I have never been a smoker. In my vocation I encounter the hazards of passive smoking on a regular basis. Those hazards for me include headaches the morning after working in a smoky room; bronchial congestion from the effects of smoke inhalation from working with a cold or flu; and stinging, watery eyes, often while my hands are busy playing the guitar, so I cannot wipe them until the end of the song. It makes me look like a very sensitive artist but it is not very comfortable. I even have to check what instruments I use while teaching at schools, as I have often opened a guitar case to find the instruments smelling of tobacco smoke. This gives the opposite impression to the one I seek to make on teenagers about smoking. My

34 Submission 36, The Children's Hospital at Westmead, pp1-2

35 Submission 19, pp3-4

36 Mr Leslie Marsh, Public Forum, 1 May 2006, p6

> clothes, skin, equipment and car smell of stale tobacco smoke, often causing me to leave my clothes outside overnight to avoid bringing the smell into my home.[37]

**2.25** Mr Peter Lavac spoke about the effect that neighbours' smoke is having on his life because of a pre-existing health condition:

> Not long ago I was diagnosed with a very serious life-threatening illness. One of the first things I did was to purchase a small apartment right on the headland on the edge of a cliff overlooking the ocean to take advantage of the fresh clean air coming off the sea. This, I felt, would be conducive to my recovery and treatment, and give me the best possible chance of beating my illness … Much to my horror and dismay, the initial exhilaration was short lived. Lurking below in the apartment directly beneath me were the neighbours from hell, two individuals, the heaviest chain smokers I have ever seen. My current health problems are further aggravated and compensated by the fact that I am asthmatic, and have permanent scarring of my lungs from a bout of pneumonia several years ago. These neighbours smoke incessantly, both inside the flat and on the balcony. Second-hand smoke constantly permeates my apartment and my only relief from the burning sore throat, constant coughing, hoarseness and breathing difficulty occurs when they are out of the building or unconscious. I have tried everything—talking to them, reasoning with them and even remonstrating with them—to no avail. Nothing works. I have been hospitalised twice with severe breathing difficulties resulting from their smoke, and on one occasion it got so bad I even had to call the police … However, nothing could be done … I cannot move to another table, across the road or walk away. I am completely trapped within the walls of my own home. My health and comfort are totally hijacked. I have enough on my plate already trying to focus on beating my disease. I do not need the additional stress of struggling to breathe. I do not need this worry of the real future prospects of lung cancer, heart disease or emphysema, all of which can be caused by passive smoking.[38]

**2.26** Finally, Mr Christopher Ridings told the Committee of the impact tobacco-related disease has had on his family:

> My father died aged 54 in 1966 from a heart attack brought about from an attack of asthma. He had been a smoker most of his adult life. He was in that age group. I represent my mother who died aged 68 in 1984. I am a child of people who died from smoking-related diseases. I endorse so much of what has been said before but I add this only because it is a personal note. When you lose loved ones in your family it leaves a hole. When they die prematurely, it leaves a bigger hole and when they die from something that could have been prevented it leaves a bigger hole still.[39]

### Equity issues: smoking prevalence among disadvantaged groups

**2.27** A number of inquiry participants noted the social distribution of smoking prevalence rates in Australia, and the concomitant equity dimension to the health of people who smoke and those around them.

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37 Mr Matt Roberts, Public Forum, 1 May 2006, p10

38 Mr Peter Lavac, Public Forum, 1 May 2006, p11

39 Mr Christopher Ridings, Public forum, 1 May 2006, p9

**2.28** ASH, the AMA, the Cancer Institute, the NSW Government and NSW Health all noted this issue,[40] as did NCOSS, which reported that a number of key groups are identified in the *NSW Tobacco Action Plan 2005-2009* as having disproportionately high smoking rates, and which are therefore at greater risk of morbidity and mortality. These groups include people of lower socio-economic status, Aboriginal and Torres Strait Islander people, those in contact with the criminal justice system, people who are unemployed, and people with mental illness – with the latter estimated to have a smoking rate of 70-80%.[41] In addition, people in rural areas are more likely to smoke than their metropolitan counterparts.[42]

**2.29** NCOSS pointed out that these groups are the least able to access cessation strategies and to afford products that assist them to quit such nicotine replacement therapy. On this basis it observed that, 'Tobacco control is not just a health issue but an equity issue' and that further reductions in prevalence will benefit the poorest households the most.[43]

### *Aboriginal people*

**2.30** The Committee was concerned to note the particularly high smoking prevalence among people of ATSI descent – around twice the rate of the broader population. Mr Hector Terare, Aboriginal Men's Health Project Officer with the Aboriginal Health and Medical Research Council reported that:

> Data from the 2001 National Health Survey showed that indigenous persons aged 18 years and over were more than twice as likely to be current smokers; that is, 51%, compared to non-indigenous persons at 24%. Various studies have been conducted in recent times of specific individual urban, rural and remote Aboriginal communities in New South Wales. They estimated between 60% and 87% of people in these communities were smokers at the time. In 2004, 56.6% of Aboriginal women in New South Wales reported smoking at some time during pregnancy compared to 55.9% in 2000. This compares with the 13.6% of non-Aboriginal mothers who reported smoking at some time during pregnancy in 2004. Those figures are in the New South Wales Mothers and Babies report of 2004.[44]

**2.31** The Department of Aboriginal Affairs submission to the inquiry cites even higher prevalence figures from the 2004-05 ABS National Aboriginal and Torres Strait Islander Health Survey, which found that 52.9% of Aboriginal people aged over 15, including 51.8% of men and 53.9% of women, were current smokers.[45]

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40 Submission 44, ASH, p2; Submission 19, p3; Submission 48, p4; Submission 22, p6; Dr Denise Robinson, Deputy Director-General and Chief Health Officer, NSW Health, Evidence, 27 March 2006, p67

41 Submission 53, NCOSS, p2

42 Submission 53, p3

43 Submission 53, p3

44 Mr Hector Terare, Aboriginal Men's Health Project Officer, Aboriginal Health and Medical Research Council, Evidence, 5 May 2006, p46

45 Australian Bureau of Statistics, 2004-05 National Aboriginal and Torres Strait Islander Health Survey, cited in Submission 65, Department of Aboriginal Affairs, p7

**2.32** Mr Terare also cited evidence of the resulting higher rates of morbidity and mortality among indigenous people. For example he told us that smoking-related deaths have been estimated as being 2.4 times more common among Aboriginal men and 3.7 times more common among Aboriginal women. Similarly, chronic respiratory disease is suffered more frequently by Aboriginal people, and is reflected in hospitalisation rates which are approximately five times higher among Aboriginal people: in New South Wales in 2002-03, 2,233 indigenous people per 100,000 were hospitalised, compared with the 461 per 100,000 for non-indigenous people. Finally, 12.3% of babies born to Aboriginal mothers in New South Wales were low birth weight compared to 6.2% of babies of non-Aboriginal mothers. [46] The submission of the Department of Aboriginal Affairs also pointed to the important equity implications of the issue.[47]

**2.33** In its submission, ASH noted that there has been very little change in the rates of smoking among indigenous people since 1995,[48] suggesting that initiatives to reduce smoking have had little reach into ATSI communities.

## The economic costs of smoking

**2.34** The Committee heard that the economic costs of smoking are substantial. A study commissioned by NSW Health and undertaken by the economists David Collins and Helen Lapsley in 2005 documented the costs of tobacco on the New South Wales community for the year 1998/99, along with economic benefits to reducing smoking prevalence.

**2.35** The study drew on epidemiological data on the causal relationship between consumption of tobacco and morbidity and mortality, as well as other data on: consumption, output and income; medical, hospital and nursing homes costs and usage; pharmaceuticals usage and costs; workforce, wage rates and earnings; and tax revenues and public expenditure.[49] It estimated both tangible costs (such as hospital funding and business funds which, when reduced, can be freed up to be spent elsewhere) and intangible costs (such as pain, suffering and loss of life, which may be quantified, but which when reduced do not involve a release of resources).[50]

**2.36** The report conservatively estimated that the total social costs of smoking – that is the costs borne by the community as a result of tobacco smoking – in this State were approximately $6.6 billion in 1998-99. Of this, around 27% or $1.78 billion were tangible costs, with the remaining 73%, or around $4.8 billion, being intangible costs largely accounted for by premature death. Of the tangible costs, approximately 58% were borne by individuals, 29% by businesses and 13% by governments. All intangible costs were borne by individuals.[51]

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46 Gracey et al, Indigenous Health Infonet, NSW Health Chief Health Officer's Report and Midwives Data Collection, cited by Mr Terare, Evidence, 5 May 2006, p46

47 Submission 65, pp8-11

48 Submission 44, p2

49 Collins DJ and Lapsley HM, *Counting the costs of tobacco and the benefits of reducing smoking prevalence in NSW*, NSW Health, 2005, pp3-4.

50 Collins and Lapsley, pp4-5

51 Collins and Lapsley, pi

**2.37** The researchers determined that approximately 45% of the total costs were avoidable, that is, they could be reduced as a result of government policy and activity.[52]

### Costs to the health system

**2.38** Collin and Lapsley found that the total direct health care costs associated with tobacco use were $477 million for the State in 1998-99, made up of $115.5 million in medical costs, $147.5 in hospital costs, $146.7 for nursing homes and $67.1 for pharmaceuticals.[53]

**2.39** The study found that around 6800 deaths were caused by tobacco in that year, along with approximately 353,000 hospital bed days, with total hospital costs of $254,500.[54]

**2.40** A number of inquiry participants provided evidence that illuminated some of the costs to the health system.

**2.41** Aside from the issue documented earlier in this chapter that smoking causes illnesses such as cancer and COPD that require hospitalisation, smoking also complicates the experience and treatment of various diseases, necessitating longer hospital stays and thereby increasing health care costs. Both the AMA and Associate Professor Peters pointed out that smoking impedes post-surgery wound healing and increases the risk of infection.[55] The AMA also reported that tobacco interferes with the effectiveness of some medications for asthma and mental illness.[56]

**2.42** When asked about the higher treatment costs associated with patients who are smokers, Professor Bishop of the Cancer Institute explained:

> We are dealing with emphysema, difficult cancers, as I have mentioned, heart attacks and strokes. These are not the short stay problems. These are often the more chronic, more difficult and more resource-intensive diseases.[57]

**2.43** In further information provided to the Committee, Professor Bishop noted that an estimated 54,000 hospital admissions per year are attributed to smoking-caused illnesses and stated:

> [T]here is extensive evidence that smokers are more likely to suffer complications in surgery and have poorer recovery rates than non-smokers. Furthermore, smokers, on average, present for treatment at a much earlier age than do non-smokers. Most expenditure on hospital services occurs in the last two years of life. The likelihood of extensive (and costly) interventions being offered to a 90-year-old is lower than if a 50-year-old presented with the same condition.[58]

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52 Collins and Lapsley, pi

53 Collins and Lapsley, p12

54 Collins and Lapsley, p13

55 Professor Peters, Evidence, 22 March 2006, p1; Submission 19, p3

56 Submission 19, p3

57 Professor Bishop, Evidence, 21 March 2006, p37

58 Answers to questions on notice taken during evidence 1 March 2006, Professor Bishop, Question 3, p3

**2.44** Interestingly, Mr Tony Thirlwell, CEO of the Heart Foundation, NSW Division, noted that technological advancements in the treatment of heart disease have helped to save lives, but at the same time, have led to extra costs to the health system as well as to the individuals involved and their families:

> The better technology gets for saving people from immediate death the more there will be people living with heart disease into the future … So there is actually a greater proportion of people living with heart disease and putting a cost on the health system because of the improved technology. In a way it is an irony that we have our technology working so well to save lives, but the life may not be quite as good as the life they had prior to the event. There are obviously costs to the health system to be incurred as that goes forward.[59]

### Costs to business

**2.45** As noted in the AMA's submission, another important cost area is that incurred by business as a result of smoking-related illnesses.[60] In their report, Collins and Lapsley cite the findings of Bush and Wooden that:

> After controlling for the effects of other variables, smokers were found to be 1.4 times more likely to be absent, and ex-smokers to be 1.3 times more likely to be absent than those who have never smoked … For male smokers the probability climbed to 1.7 times greater than for those who have never smoked …[61]

**2.46** Factoring this information into their calculations, Collins and Lapsley estimated that smoking caused approximately $588.6 million in lost productivity in New South Wales in 1998-99. Of this, an estimated $507.7 million was attributed to reductions in the workforce, and $150.9 million to absenteeism.[62]

### Other costs – fires and litter

**2.47** Greg Mullins, Commissioner of the NSW Fire Brigades spoke to the Committee of the impact that smoking-related fires have on our community:

> I am here today to tell the Committee about one particular impact that perhaps does not have a great deal of recognition or prominence in the community; that is, the number of deaths, injuries, property and environmental damage caused by the fires that are started by cigarettes. Added to this are the many fires caused by children who play with matches and lighters, often in a household where there are smokers, meaning they have access to matches and lighters. Many of these fires have tragic outcomes. As a firefighter for many years I have seen many deaths, severe burn injuries and homes destroyed simply because someone carelessly discarded a cigarette, because they fell asleep with a lighted cigarette in bed or on a lounge, or because they threw what they thought was an extinguished cigarette into a waste bin. I cannot

59 Thirlwell, 22 March 2006, pp17-18

60 Submission 19, p3

61 Bush and Wooden, 1994 and 1995, quoted in Collins and Lapsley, p10

62 Collins and Lapsley, p14

> describe to you the feelings of frustration that this causes to firefighters, ambulance officers, police officers and burns unit doctors and nurses, knowing that such deaths and injuries are preventable.[63]

**2.48** Commissioner Mullins told the Committee that in 2004-05, 4,574 fires in Australia were known to have been caused by cigarettes and smoking materials, equating to more than 12 fires every day, or one fire every two hours.[64]

**2.49** Focusing on New South Wales, Commissioner Mullins reported that in 2004-05, NSW Fire Brigades attended at least 226 structure fires and 783 bush and grass fires that were known to be caused by cigarettes. In addition, some 535 structure fires were caused by matches and lighters. During 2003-04, NSW Fire Brigades attended 488 roadside fires attributed to cigarettes or other smoking materials, and the Rural Fire Service attended many more. He told the Committee that an estimated 7% of all bushfires in Australia are attributed to discarded cigarettes, emphasising that fire services staff consider these known causes to be 'the tip of the iceberg.'[65]

**2.50** According to the National Coroners Information System, 63 people across Australia died in fires directly attributed by the Coroner to cigarettes between 2000 and 2005. Over the same period in New South Wales, 32 out of 233 fire deaths were attributed to cigarettes. Again, this is a conservative estimate. [66]

**2.51** Collins and Lapsley estimated that the total cost of smoking-attributable fires in New South Wales in 1998-99 was $27.3 million. This included approximately $1.4 million in health system costs, $7 million in labour-related costs, $7.2 million in fire services costs and $9.8 million in intangible costs associated with loss of life.[67] Again the authors noted that these costings were conservative as they were not able to include the costs associated with damage to public property such as the loss of wildlife in national parks, nor the loss of amenity during bush regeneration.[68]

**2.52** A number of inquiry participants such as Ms Emily Perry, Senior Policy Advisor with the AMA (NSW), along with the Northern Sydney Central Coast Area Health Service, noted the costs associated with litter arising from discarded cigarette butts and packaging.[69] Clearly, there are both tangible and intangible environmental costs associated with this litter.

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63 Commissioner Greg Mullins, NSW Fire Brigades, Evidence, 5 May 2006, p18

64 Commissioner Greg Mullins, Evidence, 5 May 2006, p18

65 Commissioner Greg Mullins, 5 May 2006, p18

66 Submission 68, NSW Fire Brigades, p3; Commissioner Greg Mullins, Evidence, 5 May 2006, p18

67 Collins and Lapsley, p14

68 Collins and Lapsley, p10

69 Ms Emily Perry, Senior Policy Officer, Australian Medical Association (NSW Division), Evidence, 21 March 2006, p24; Submission 51, Northern Sydney Central Coast Area Health Service, p1

### The cost effectiveness of tobacco control

**2.53** The corollary to the very substantial costs arising from tobacco consumption is the significant gains to be made from tobacco control. Many inquiry participants pointed this out, making the case for further investment to reduce tobacco consumption.[70]

**2.54** In their respective submissions, both ASH and NCOSS refer to the recent report by Access Economics, *Returns on Investment in Public Health: An Epidemiological and Economic Analysis, 2003*, which estimated that the $176 million spent on anti-tobacco public health programs in Australia between 1971 and 2000 had resulted in a savings of $8.6 billion in terms of avoided disease and death. This represented a cost benefit ratio of 1:49.[71]

**2.55** In both the *NSW Tobacco Action Plan 2005-2009* and its submission to the inquiry, the NSW Government has acknowledged the extraordinary magnitude of these gains:

> There are potentially very high social benefits to be gained from effective anti-smoking programs and such programs would yield very high rates of return compared with many other public health programs. Effective tobacco control requires comprehensive and sustained programs and a body of evidence from Australia and overseas shows that they are an extremely cost effective investment. There are few other areas of public health expenditure that would yield such a high rate of return.[72]

**2.56** Looking to the future, Dr Denise Robinson, Deputy Director-General of NSW Health and Chief Health Officer told the Committee:

> The social benefits, according to the study by Collins and Lapsley, are reducing the smoking prevalence over five years by 5% would be approximately $2.3 billion. That has been rounded down to about $9,000 for each person who is prevented from smoking. [73]

**2.57** An important aspect of the substantial economic gains to be made from further reductions in tobacco use concern costs to the health system. Professor Matthew Peters emphasised the significant reductions in demand that would arise from even modest improvements in smoking-related diseases. This, he argued, will free up health care resources for other purposes, thus improving other people's access to health services.

> In whatever the community can allocate to health, if we can reduce the impact of these diseases, COPD, lung cancer, heart disease, if we can reduce the impact of them that is fantastic for the health care system but also fantastic for the people who do not smoke but cannot get in to get a hip replacement. The reason you cannot get in to have a hip replacement is because there is an influenza epidemic and the beds are full because the lung patients are in. It does not matter that you do not smoke.[74]

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70 See for example, Dr Penman, Evidence, 21 May 2006, p6; Submission 40, p2

71 Submission 44, ASH, p3; Submission 53, NCOSS, p2

72 Submission 48, The Cabinet Office, p4

73 Dr Denise Robinson, Evidence, 27 March 2007, p57

74 Associate Professor Peters, Informal Site Visit, 22 March 2006, p9

**2.58** Professor Peters speculated that even a reduction of 5% of the demand within the health system would have a massive impact in freeing up resources to address other health needs.[75]

**2.59** Dr Robinson identified other important gains to be made, for example in terms of child health. She noted that:

> The [Collins and Lapsley] report also found that children are bearing the brunt of passive smoking, indicating that 94% of all of the hospital costs that have been able to be attributed to passive smoking were in that 0 to 14 year age group, and therefore we believe that there are potentially very high social benefits to be gained from effective anti-smoking programs and that these programs would have high yield in particular as far as children are concerned.[76]

**2.60** Aside from these tangible gains for the health system, in its submission, the Cancer Institute cites a number of other potential returns on investment in tobacco control identified in the National Tobacco Strategy. These include:

- stronger families and children – with fewer families, particularly disadvantaged families, affected by early death, disease and disability
- healthy and independent ageing – with older people living longer, more active and more independent lives
- greater profits for Australian businesses outside the tobacco industry – with resources otherwise spent on tobacco to be spent on other goods and services
- a stronger economy – with improved productivity arising from less absenteeism, sickness, disability and death, and accompanying this, much greater demand for goods and services
- stronger communities – with reduced demands on but greater capacity within the informal economy, less litter and fewer bushfires.[77]

**2.61** Looking beyond health to the broader economic issues, in response to suggestions by the tobacco industry that reduced smoking prevalence would have damaging effects on the Australian economy and workforce, the Cancer Council NSW commissioned a study by William Junor, David Collins and Helen Lapsley in 2004. The authors modelled the impact of a reduction in smoking prevalence on output, employment and other macroeconomic variables and concluded that:

> [T]he aggregate effects upon the economy of a decline in New South Wales smoking prevalence would be largely neutral in their effects on output and employment. Normal growth in national output and employment would easily absorb any negative economic impacts …[78]

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75 Associate Professor Matthews, Evidence, 5 May 2006, p59

76 Dr Robinson, Evidence, 27 March 2007, p57

77 National Tobacco Strategy, cited in Submission 22, p6

78 Junor W, Collins D and Lapsley H, *The macroeconomic and distributional effects of smoking prevalence in New South Wales*, the Cancer Council NSW, Sydney, June 2004, p3

## Conclusion

**2.62** The first half of this chapter documented the prevalence of smoking and the many serious health effects of tobacco, both through active smoking and through exposure to tobacco smoke. It is clear to the Committee from both the research evidence and the evidence provided to us during this inquiry, that smoking carries with it very substantial costs, most notably in terms of health costs and productivity costs, but also in terms of the environmental and property damage caused by fires.

**2.63** The Committee is also convinced of the major financial gains associated with tobacco control, most notably in terms of the health system. Just looking at the health budget we recognise strong potential for gains arising from further reductions in tobacco use, through the freeing up of scarce resources that would thereby improve the broader community's access to health care.

**2.64** However, more important still than these financial gains are the gains to be made in terms of improving health, reducing death and disease, and improving equity. The evidence is very clear that by reducing smoking we can improve the health and lives of individuals, families and communities.

**2.65** These findings set the scene for the rest of this report and the following chapter on tobacco control.

# Chapter 3 Tobacco control

The World Health Organisation defines tobacco control as 'a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke'. Tobacco control includes such diverse activities as educational initiatives, restrictions on access to tobacco, tobacco advertising bans, the imposition of taxes to raise the price of cigarettes, and health warnings on tobacco packages.[79] Research indicates that effective tobacco control requires 'comprehensive and sustained programs'[80] while also being 'broadly based, integrated and well resourced'.[81] A review of best practice tobacco control and its applicability to Australia concluded that:

> A comprehensive strategy to reduce tobacco-related harm must include tax and supply policies to reduce the accessibility of products to children; education and treatment programs; and measures to reduce smokers' and non-smokers' exposure to tobacco toxins.[82]

This chapter examines tobacco control measures in place in Australia and specifically New South Wales. It identifies the key players in tobacco control in New South Wales, such as government, non-government and industry stakeholders. Then, addressing the inquiry's terms of reference (f), this chapter examines the funding for tobacco control and the adequacy of this budget. Lastly, it discusses the range of issues that inquiry participants highlighted as the barriers to further reducing tobacco use.

## The national framework for tobacco control

**3.1** The Committee was advised that 'tobacco control is an issue that is subject to several jurisdictions, Federal and State.'[83] The Commonwealth strategy for tobacco control, titled the *National Tobacco Strategy 2004-2009*, is one of a series of strategies that together form the *National Drug Strategy 2004-2009*.[84] The goal of the *National Tobacco Strategy 2004-2009* is to significantly improve health and to reduce the social costs caused by, and the inequity exacerbated by, tobacco in all its forms, such costs and equity issues were outlined in the previous chapter. The objectives of the Strategy, among all social groups, are to:

- prevent uptake of smoking
- encourage and assist as many smokers as possible to quit as soon as possible

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79 Article 1 *WHO Framework Convention on Tobacco Control,* as cited in Drabsch T, *Tobacco Control in NSW*, NSW Parliamentary Library Research Paper 1/05, January 2005, p7

80 Submission 48, The Cabinet Office, p4

81 Submission 49, The Cancer Council, pp 3-4

82 *Tobacco Control: A blue chip investment in public health*, VicHealth Centre for Tobacco Control as cited in Submission 49, pp 3-4

83 Professor Simon Chapman, School of Public Health, University of Sydney, Evidence, 22 March 2006, p1

84 *The National Tobacco Strategy 2004-2009*, p1

- eliminate harmful exposure to tobacco smoke among non-smokers
- where feasible, reduce harm associated with continuing uses of, and dependence on tobacco and nicotine.[85]

**3.2** The *National Tobacco Strategy* sets out the blue print for action plans developed by each state and territory, for example the *NSW Tobacco Action Plan 2005-2009*, which is discussed later in this chapter.[86]

**3.3** The Cancer Institute NSW stated that 'in endorsing the *National Tobacco Strategy 2004-2009* all Australian governments have resolved to work together and in collaboration with non-government agencies on a long term, comprehensive, evidence-based and coordinated national plan to reduce the often hidden but very real misery and wasted human potential caused by tobacco smoking in Australia.'[87]

**3.4** Aside from its leadership and coordination role, the Commonwealth Government is responsible for a number of other national initiatives. It collects and administers the excise, or tax, on tobacco products, such as cigarettes, and controls national anti-smoking campaigns, such as the graphic images on packaging of cigarettes and related media campaigns. The Commonwealth Government also provides funding to states and territories for tobacco control measures. In relation to these areas:

- The publication and broadcasting of tobacco advertisements are prohibited under the *Tobacco Advertising Prohibition Act 1992 (Cth)*. There are also State provisions prohibiting the advertising and promotion of tobacco under the NSW *Public Health Act 1991*.[88]
- The Commonwealth introduced a national system of health warnings in 1994 under the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 1994 (Cth). Clause 7 requires retail packages to be labelled with health warnings. The regulations specify the size, style of text, graphics and positioning of the health warnings on tobacco packages. A review of such warnings was completed in 2004, with the new graphic health warnings approved by the Commonwealth Government in June 2004 coming into effect in March 2006.[89]
- Tobacco manufacturers in Australia are required to pay excise on all locally manufactured cigarette and tobacco products,[90] however the cost of this excise is passed on to customers through the price of cigarettes. The Commonwealth Government received $5.237 billion from this excise in 2004-05.[91] This is in addition

85 *The National Tobacco Strategy 2004-2009*, p9-10

86 Submission 22, The Cancer Institute NSW, p3

87 *The National Tobacco Strategy 2004-2009*, p1

88 Drabsch T, *Tobacco Control in NSW*, NSW Parliamentary Library Research Paper 1/05, January 2005, pp10-11

89 Drabsch T, *Tobacco Control in NSW*, NSW Parliamentary Library Research Paper 1/05, January 2005, p15

90 <www.vctc.org.au/industry/industry.html>(accessed 22 May 2006)

91 <www.budget.gov.au/2004-05/fbo/html/02_part_1-02.htm#P16_1765> (accessed 22 May 2006)

to revenue received through customs duty imposed on the importation of tobacco.[92] Also since 1 July 2000, the 10% goods and services tax (GST) has been applied to tobacco.

**3.5** The Cancer Institute NSW provided the following figures demonstrating the amount of tax including excise on three leading brands of cigarettes as at September 2005. The table indicates that over two thirds of the price of these cigarette brands is collected by the Commonwealth Government.

**Table 3.1: Proportion of tax in price of cigarette as at September 2005**[93]

| Brand | Pack size | RRP | Price per cigarette | Tax% of RRP inc GST | Tax per pack | Tax per cigarette |
|---|---|---|---|---|---|---|
| Winfield | 25s | $10.50 | 42 cents | 66% | $6.93 | 28cents |
| Peter Jackson | 30s | $11.85 | 40 cents | 67% | $7.94 | 26cents |
| Longbeach | 40s | $15.00 | 38 cents | 70% | $10.50 | 26cents |

## Tobacco control in New South Wales

**3.6** The current framework for tobacco control in this State is the *NSW Tobacco Action Plan 2005-2009*. The plan provides the strategic direction for the development and implementation of a range of tobacco control initiatives and sets out the NSW Government's commitment to the prevention and reduction of tobacco-related harm in New South Wales.[94]

**3.7** The goal of the *NSW Tobacco Action Plan 2005-2009* is to improve the health of the people of New South Wales and to eliminate or reduce their exposure to tobacco in all its forms. This goal is being addressed through six focus areas of program activity:

- smoking cessation
- exposure to environmental tobacco smoke (ETS)
- marketing and the promotion of tobacco products
- availability and supply of tobacco products
- capacity building
- research, monitoring and evaluation.[95]

**3.8** The tobacco control measures that form part of the *NSW Tobacco Action Plan 2005-2009* include:

92 Drabsch T, *Tobacco Control in NSW*, NSW Parliamentary Library Research Paper 1/05, January 2005, p16

93 Answers to questions on notice taken during evidence, 21 March 2006, Professor Jim Bishop, CEO, Cancer Institute NSW, p3

94 Submission 48, p1

95 Submission 48, p2

- legislation such as the *Public Health Act 1991* for sales and display (refer to Chapter 5) and the *Smoke-free Environment Act 2000* and the related regulations, that addresses ETS (Chapter 6)
- community and media campaigns, such as the echo campaign 'Quitting smoking is hard – Not quitting is harder', the 'Ladykiller – why risk it' campaign, the 'car and home: smoke-free zone' campaign and advertising of the Quitline (Chapter 4)
- educational campaigns aimed at young people and school children (Chapter 4)
- smoking cessation services such as the Quitline, Quit Kit, local Area Health Service programs (Chapter 4).

**3.9** Dr Denise Robinson, Chief Health Officer, NSW Health, advised the Committee that NSW Health has primary responsibility for implementing the *NSW Tobacco Action Plan*. She identified key activities under the action plan as being:

- enforcement and monitoring of policy and legislative programs to reduce ETS exposure and young people's access to tobacco products
- building the capacity of enforcement officers to monitor and enforce legislation
- provision of evidence-based resources to help people quit smoking
- campaign activity to prevent young people starting to smoke, for example, *Smoking: Don't be a Sucker*
- new programs to specifically focus on populations with higher smoking rates, in particular Aboriginal and Torres Strait Islanders.[96]

## Key players in tobacco control in New South Wales

**3.10** The key players involved in tobacco control in New South Wales include:

- government agencies including NSW Health, Cancer Institute NSW, area health services and other government agencies
- non-government organisations including the Cancer Council NSW, Action on Smoking and Health (ASH), the Australian Medical Association, National Heart Foundation and Asthma NSW
- industry and industry associations including Clubs NSW, Australian Hotels Association, tobacco companies, retail associations and tobacconists.

### *NSW Health*

**3.11** NSW Health is the major driver of tobacco control in New South Wales and works closely with other agencies at the Commonwealth level and with non-government organisations. In

[96] Dr Denise Robinson, Chief Health Officer and Deputy Director General, Population Health, NSW Health, 27 March 2006, p56

particular, NSW Health works in close collaboration with the Cancer Institute NSW and area health services on tobacco control activity.[97] Dr Robinson advised the Committee that:

> Our lead role is in terms of policy development, the provision of cessation services and enforcement of legislation. We are responsible for implementing a large number of the strategies that are inherent in the *NSW Tobacco Action Plan 2005-2009*… We are responsible for overall monitoring of smoking rates in New South Wales and identifying trends and emerging issues and providing advice to our Minister as well as the Minister assisting the Minister for Health and Cancer. [98]

### *Cancer Institute NSW*

**3.12** The Cancer Institute NSW was established in mid-2003 and is Australia's first state-wide, government-supported cancer control agency. According to its website, the Institute promotes the best cancer research, prevention, early-detection, treatment and education initiatives[99] and works with government and non-government agencies at local, state, national and international levels.[100]

**3.13** The Cancer Institute assisted NSW Health in the development of the *NSW Tobacco Action Plan 2005-2009*. The Institute's primary responsibility within the plan is the design, development and delivery of mass media campaigns and since January 2006 it has had responsibility for funding and policy management of the NSW Quitline service.[101]

### *Area health services*

**3.14** The Greater Western Area Health Service advised the Committee that area health services have a significant interest in tobacco control and expend considerable time and resources in policing the legislation and developing strategies to minimise smoking.[102] Enforcement of the legislation, including the sales and display of tobacco products and ETS is undertaken through the public health units, with environmental health officers having responsibility to ensure compliance and investigate any complaints.[103]

**3.15** Area health services throughout New South Wales conduct a range of community-based initiatives to assist smokers to quit. Examples of such initiatives brought to the attention of the Committee include:

- smoking cessation services for clients of the community aged and rehabilitation extended (CARE) network – Hunter New England Area Health Service

97 Submission 48, p1

98 Dr Robinson, Evidence, 27 March 2006, p56

99 <http://www.cancerinstitute.org.au> (accessed 22 May 2006)

100 Submission 22, p3

101 Submission 22, p3

102 Submission 34, Greater Western Area Health Service, p1

103 Dr Robinson, Evidence, 27 March 2006, p61

- Arabic Tobacco Control Project which includes culturally appropriate social marketing targeting males aged 30-50 years of age – Sydney South West Area Health Service
- subsidised nicotine replacement therapy (NRT) – Greater Southern Area Health Service
- tobacco control program advocacy for smoke-free pubs and clubs, supporting the smoke-free workplace policy across the health service and workforce development – Sydney West Area Health Service
- smoking cessation services including smoking cessation interventions for clients through a 12 week program and training of front line workers in effective brief interventions – Greater Western Area Health Service.[104]

### *Other government agencies*

**3.16** Other NSW Government agencies involved in tobacco control measures include the Department of Education and Training (DET), through education programs in schools, and the WorkCover Authority, in terms of responding to passive smoking issues in the workplace. The role of DET will be further explained in the following chapter in the section adressing educational campaigns.

### *Non-government organisations*

**3.17** There are also a number of non-government organisations involved in tobacco control in New South Wales, playing an important advocacy role. These notably include the Cancer Council NSW, Action on Smoking and Health (ASH), Australian Medical Association (AMA), the National Heart Foundation and Asthma NSW. As exposure to ETS in the workplace became a more prominent issue in recent years, unions such as the Liquor Hospitality and Miscellaneous Union have also increasingly been involved in advocacy.

### *Industry and associations*

**3.18** Relevant industry and associations subject to tobacco control through sales, manufacturing and smoking venues include:

- tobacco companies, such as British American Tobacco, Philip Morris and Imperial Tobacco, who all manufacture tobacco products in Australia
- retail associations, such as National Alliance of Tobacco Retailers, and tobacconists, such as FreeChoice Stores
- Clubs NSW and the Australian Hotels Association whose members must comply with the *Smoke-free Environment Act 2000* and its corresponding regulations.

[104] Submission 48, pp8-9

## Comparisons with other jurisdictions

**3.19** Inquiry participants made varying comments on the level of tobacco control in New South Wales compared to other states and territories. NSW Health commented that 'it is certainly recognised that New South Wales has one of the most comprehensive programs in place, addressing all of the major elements identified in the research.'[105]

**3.20** The Cancer Council NSW suggested that this State should aim to meet the best practice that has been demonstrated in other jurisdictions such as:

> … the Queensland approach to smoke-free legislation; the social marketing commitment of Western Australia; and the research infrastructure in Victoria. Overseas jurisdictions with track records in effective tobacco control include California, and the 20 plus jurisdictions that have introduced total smoking bans in all indoor workplaces.[106]

**3.21** The Committee wrote to all states and territories inviting them to provide information on tobacco control measures in their jurisdictions. In general, as all states and territories have endorsed the *National Tobacco Strategy*, the areas of tobacco control are similar, for example restrictions on the sale of tobacco, restrictions on where people can smoke and strategies to help people quit smoking. The main difference between the jurisdictions is how far the restrictions go. For example in Queensland the restrictions on where people can smoke include a ban on smoking outside non-residential buildings, which is a significantly stronger ban than in New South Wales.

**3.22** Appendix 4 provides more detail on the differences between the jurisdictions based on the information received from each state and territory and from NSW Health. More specific comparisons between New South Wales and other jurisdictions will also be made throughout the report as they relate to specific areas of tobacco control.

## Funding for tobacco control

**3.23** The Commonwealth Government has committed $24 million over four years for tobacco control.[107] New South Wales share of this commitment for 2005-2006 is $1.48 million.[108]

**3.24** When he appeared before the Committee, Professor Chapman suggested that the amount that the Commonwealth Government outlays for tobacco control is minuscule in comparison to the tobacco excise revenue:

> But what we have to come is $24 million in Federal money, which is over four years. My view is that it is a pathetic amount of money. The Government takes in $5 billion in tobacco excise and gives, as you can see, about $6 million year. It is almost a

105 Ms Kate Purcell, Acting Director, Centre for Chronic Disease Prevention and Health Advancement, NSW Health, Evidence, 5 May 2006, p5

106 Submission 49, p2

107 Professor Chapman, Evidence, 22 March 2006, p2

108 Submission 48, p3

> derisory amount of money when you see some of the other outlays of money that the Federal Government puts into health.[109]

**3.25** Dr Andrew Penman, CEO of the Cancer Council NSW, advised the Committee that the community considers the Federal Government should spend more on tobacco control:

> The other final benchmark to judge that effort is in terms of public expectation … where we had overwhelming support for the notion that the Government actually spend more money on tobacco control. For instance, 85% say that the Government should spend at least $1 billion nationwide on tobacco control, and 31% say that all money collected from tobacco taxes should be spent on tobacco control.[110]

**3.26** Ms Anne Jones, CEO of Action on Smoking and Health (ASH), also supported the Commonwealth allocating more funds to the states and territories, based on the high level of revenue from tobacco excise, so that each can implement their tobacco action plans more effectively:

> I think there is an opportunity for this Committee to make a recommendation that through COAG [Council of Australian Governments] they make every effort possible to put the evidence that the payments to state and territory governments need to be increased and, if possible, targeted towards preventing tobacco diseases.[111]

**3.27** In response to the evidence received on this matter, the Committee believes that, if the Commonwealth Government raises $5.237 billion in revenue from tobacco excise, it is feasible that the amount it expends on tobacco control, and specifically the allocation for New South Wales, should be substantially increased. Indeed we consider that the Commonwealth is obligated to allocate much more of the revenue raised from excise to tobacco control. The Committee considers that the NSW Government should enter into discussions with the Commonwealth Government to increase the funding allocation for tobacco control to states and territories, in light of the amount of tobacco excise the Commonwealth Government receives. It is appropriate that this occur through COAG.

**Recommendation 1**

That the NSW Government enter into discussions with the Commonwealth Government, via the Council of Australian Governments, to increase the funding allocation for tobacco control to states and territories, in light of the amount of tobacco excise the Commonwealth Government receives.

**3.28** Having received a certain allocation from the Commonwealth, the NSW Government then makes its own allocation for expenditure on tobacco control. Below is a graph setting out each state and territory's allocation for tobacco control in 2003-2004, excluding funding for non-government organisations, based on information provided by The Cabinet Office. The graph

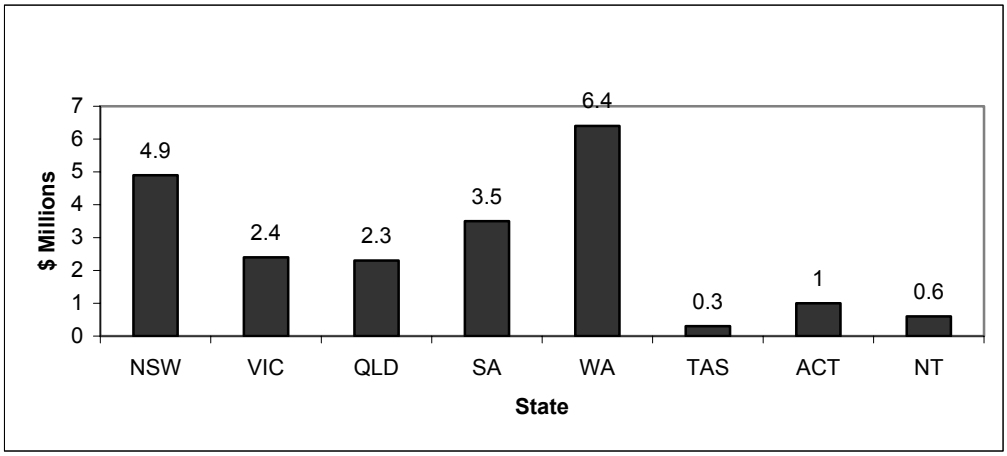
109 Professor Chapman, 22 March 2006, p2

110 Dr Andrew Penman, CEO, Cancer Council NSW, Evidence, 21 March 2006, p6

111 Ms Anne Jones, CEO, Action on Smoking and Health (ASH), Evidence, 1 May 2006, p25

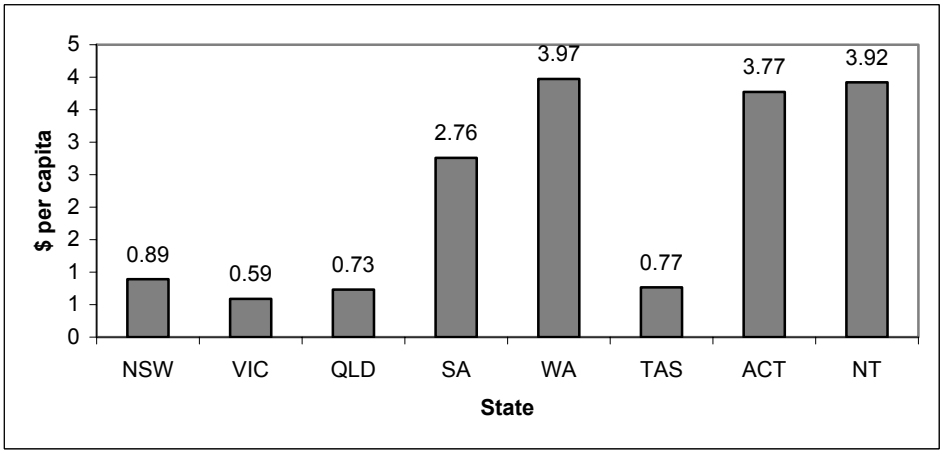
indicates that in 2003-2004 New South Wales expenditure was relatively high in comparison to other states, in aggregate terms.

**Figure 3.1: State and territory government expenditure on tobacco control in 2003-2004**[112]




**3.29** However, when considering the per capita rate based on population statistics from the Australian Institute of Health and Welfare,[113] New South Wales appears less favourably, with only 89 cents allocated per person, compared with $3.97 per person in Western Australia, $3.92 in the Northern Territory and $3.77 in the Australian Capital Territory.

**Figure 3.2: State and territory government per capita expenditure on tobacco control in 2003-2004**[114]



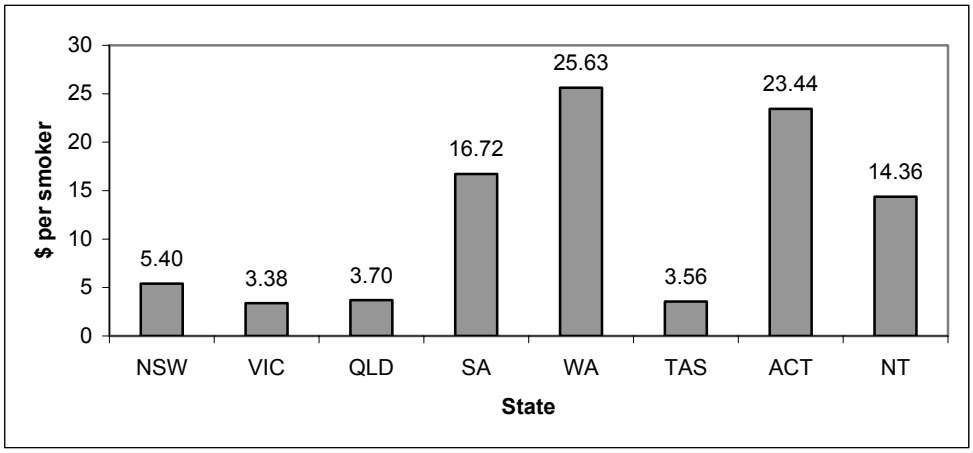

112 Graph based on figures from Submission 48, The Cabinet Office, p2

113 *2004 National Drug Strategy Household Survey*, State and Territory Supplement, Australian Institute of Health and Welfare, June 2005, p12 (figures as at June 2004)

114 Graph based on figures from Submission 48, The Cabinet Office, p2 and the *2004 National Drug Strategy Household Survey, State and Territory Supplement*, Australian Institute of Health and Welfare, June 2005, p12

**3.30** Below is an adaptation of the graph above, taking into account the daily smoking prevalence rate as provided in the *2004 National Drug Strategy Household Survey*.[115] This graph indicates that New South Wales allocated $5.40 for every person that smokes on a daily basis compared with $25.63 per daily smoker in Western Australia, $23.44 in the Australian Capital Territory and $16.72 in South Australia.

**Figure 3.3: State and territory government expenditure on tobacco control in 2003-2004 per daily smoker**[116]




**3.31** The Committee asked NSW Health to comment on funding comparisons between the states. In answering, Dr Robinson pointed to the State's successes in reducing smoking prevalence rates:

> [T]he smoking rates within New South Wales are, indeed, lower than they are in the other states ... So if there are greater commitments that are being put forward by other States, I would suggest to you that in fact we are achieving as well as they are. My understanding is that our occasional smoking, which includes daily smoking plus the occasional cigarette, is now nearing 20.1% and the figure for daily smoking is down to 15.9%.[117]

**3.32** Dr Robison advised the Committee that there has been a significant increase in the funding for tobacco control in New South Wales in recent years. She noted that with the establishment of the Cancer Institute NSW, the expenditure for 2005-2006 is now estimated to be $12.1 million and 'with this increased investment there will be a substantial increase in control activity …[and] a further drop in the level of smoking prevalence.'[118]

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115 *2004 National Drug Strategy Household Survey*, State and Territory Supplement, Australian Institute of Health and Welfare, June 2005, p3 (figures as at June 2004)

116 Graph based on figures from Submission 48, The Cabinet Office, p2 and the 2004 National Drug Strategy Household Survey, State and Territory Supplement, Australian Institute of Health and Welfare, June 2005, p3

117 Dr Robinson, Evidence, 1 May 2006, p25

118 Dr Robinson, Evidence, 27 March 2006, p65

**3.33** The Cabinet Office provided the following breakdown of the estimated total of $12.1 million for tobacco control in 2005-2006, according to the agencies responsible for those funds:[119]

| **Funding** | **Amount (million)** |
|---|---|
| NSW Health | $2.4 |
| NSW Area Health Services | $2.7 |
| Cancer Institute NSW | $7.0 |
| **Total** | **$12.1** |

**3.34** Further to this, The Cabinet Office submission stated that this funding does not constitute the total amount spent on efforts to reduce smoking-related harm in New South Wales as progress in areas such as Aboriginal health, environmental health, and programs run at local area level all make a contribution to preventing and reducing tobacco use. In addition, the Cabinet Office suggested activities of agencies such as WorkCover, NSW Police, the Department of Gaming and Racing and the Department of Education in relation to tobacco fall outside of the allocated funds in the table above.[120]

### Adequacy of the budget for tobacco control in New South Wales

**3.35** There was general agreement amongst the non-government organisations participating in the inquiry that expenditure on tobacco control in New South Wales is inadequate in comparison to the impact of smoking on the community, as outlined in Chapter 2. ASH advised that compared to best practice recommendations for effective tobacco control, 'New South Wales is lagging behind in its per capita funding commitment despite recent funding increases to the Cancer Institute.'[121]

**3.36** The National Heart Foundation (NSW Division) stated in their submission that:

> We strongly suggest that the budget for tobacco control is inadequate. Specifically in terms of the size of the problem, the impact on tobacco related disease, the gap between the known evidence and action, the data on costs (direct and indirect) to the New South Wales community.[122]

**3.37** In their submission to the inquiry, ASH commented that the New South Wales budget for tobacco control of $12.1 million for 2005-2006 is equivalent to less than $1.90 per person in the State. ASH suggested that 'governments must either invest adequately in tobacco control or face increased health care costs and demands' and recommended that, based on best practice and the *National Tobacco Strategy 2004-2009*, the minimum spend on tobacco control in New South Wales should be at least $2.90 per person and up to $8.50 per person.[123]

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119 Submission 48, p2

120 Submission 48, p3

121 Submission 44, Action on Smoking and Health (ASH), p6

122 Submission 17, National Heart Foundation NSW Division, p5

123 Submission 44, p2

**3.38** The Cancer Council NSW also supported an increase in funding for tobacco control from the NSW Government:

> While the budget commitment of the NSW Government has increased in recent years, the current amount spent is between $1.00-$2.00 per capita – far below recognised benchmarks. The Centre for Disease Control recommends spending $US6-17 per capita for a state the size of New South Wales, and the *National Tobacco Strategy* recommends an investment of between $2.90-$8.50 per capita.[124]

**3.39** It was suggested by the Cancer Institute NSW that, if the contributions of Commonwealth-funded programs in New South Wales are taken into account, together with the contributions of agencies such as the Australian Institute of Health and Welfare, the public health departments of universities, the environmental health departments of local government authorities and so on, the current budget will be somewhat higher. However, it also suggested that, even with these contributions, New South Wales' total contributions would be unlikely to reach the minimum expenditure recommended on the basis of the best available evidence.[125]

**3.40** The Cancer Council NSW recommended that the NSW Government commit at least $13.5 million per year for at least 10 years, just for anti-smoking mass media campaigns. It also argued that additional funds are required for activities such as cessation support, research and evaluation, policy and regulatory enforcement.[126]

**3.41** The Cancer Institute NSW highlighted the importance of sustained funding for tobacco control over the coming decades:

> While the level of spending in any one year is clearly important, the *stability* of funding over the years that is absolutely critical. To achieve the goal of the *NSW Tobacco Action Plan* and "improve the health of the people of New South Wales and to eliminate or reduce their exposure to tobacco in all its forms' will take *sustained funding* over at least the next decade or two … Without sustained campaigns to motivate, remind and support smokers to quit and to denormalise smoking, there is every possibility that smoking rates will rise. If they do rise, it will be amongst younger people and the toll of disease and early death from smoking will continue for many more decades to come.[127]

**3.42** The Committee considers that programs to reduce smoking are cost-effective interventions and that the savings to the public purse from even a small reduction in smoking prevalence rates will be substantial. The evidence was clear in the previous chapter that tobacco control programs will pay for themselves many times over.[128]

**3.43** Based on the evidence before the Committee, it is clear that, if the expenditure for tobacco control were increased by both the Commonwealth and NSW Governments and used in effective strategies, there is a strong probability that smoking prevalence will further decrease and that the cost of tobacco smoking on the community will also decrease.

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124 Submission 49, p4

125 Submission 22, p13

126 Submission 49, p4

127 Submission 22, p13

128 Submission 22, p13

**3.44** The Committee believes that, in light of the estimated cost and impact of tobacco smoking on the New South Wales community of $6.6 billion,[129] the current NSW Government expenditure of $12.1 million or $1.90 per capita is not adequate. In addition, New South Wales' expenditure in comparison to other states and territories is low. If the Commonwealth increases funding across the states and territories, in accordance with Recommendation 1, then per capita spending by states and territories will presumably increase. However, the Committee considers that the issue of tobacco control is so important that whether the Commonwealth does or does not do this, New South Wales needs to allocate more to ensure expenditure does reach (Commonwealth) recommended levels.

**3.45** The Committee considers that the NSW Government should increase funding for tobacco control in line with the *National Tobacco Strategy* recommendations of between $2.90 and $8.50 per capita per year.

**Recommendation 2**

That the NSW Government increase funding for tobacco control in line with the recommendations of the *National Tobacco Strategy 2004-2009* from $1.90 per capita to between $2.90-$8.50 per capita per year.

## Barriers to further reducing tobacco use

**3.46** Inquiry participants highlighted to the Committee that there are certain barriers to further reducing tobacco use in the New South Wales community. The Committee heard that the main barriers are complacency, the influence of industry sectors on the political process, inadequate funding levels for tobacco control and the normalising effect of smoking in hotels and clubs.

**3.47** ASH advised that in their view, the main obstacles to further important gains in tobacco control are:

- complacency by government leaders that "enough has been done"
- the political influence of the hotels, clubs and tobacco retailers
- uncritical acceptance by government of industry arguments to weaken regulation.[130]

**3.48** Mr Tony Thirwell, CEO, National Heart Foundation of Australia (NSW Division) also raised the issue of complacency:

> Some people think the issue is largely over and we need not take more action. We disagree with that. There are significant issues to be dealt with with tobacco smoke. Yes, we do not have advertising on the billboards anymore, we do not have advertising on television and we do not have Paul Hogan trying to get us to smoke Winfields, but we do have smoking in pubs and clubs and it looks like we will

129 Professor Bishop, Evidence, 21 March 2006, p37

130 Submission 44, p7

> continue to have smoking in pubs and clubs post 2007. We have issues with retail outlets. We have issues with children's access to tobacco, and those things need to be dealt with.[131]

**3.49** The Cancer Council NSW argued that more needs to be done to ensure we continue to lower smoking prevalence rates in New South Wales, commenting in their submission to the inquiry that:

> Australia has been successful at reducing smoking rates over the last 20 years. But we could do so much more – a more comprehensive approach that addresses environmental cues to smoking, reduces exposure to second-hand smoke, tackles cessation amongst the most socially disadvantaged groups, and eliminates the remaining marketing and promotion tactics to see our smoking rates dive even further.[132]

**3.50** Dr Penman argued that the community is ready and open to more tobacco control to contribute to lowering the smoking rates, suggesting that government policy lags behind community expectations:

> We have a periodic survey of community opinion on several health issues but tobacco is important. It is just amazing how much more advanced the community is in its thinking than we are. I guess you tend to get bound up in the debate and that in turn begins to cloud your view of what is possible. But when you actually survey the community, for instance, the community is prepared to accept restrictions in the retail availability of cigarettes, licensing of retailers and reduction of the number of retail outlets, which would be a very important measure in things like lowering relapse rates and lowering the overall smoking rate. It has hardly been discussed in public policy agenda but the community is there already.[133]

**3.51** The Cancer Council NSW refers to California as a jurisdiction which is setting the global standard for tobacco control:

> Recent news from California that adult smoking rates have dropped to 14%, down from 23% since 1988, demonstrates the benefit of a comprehensive and well-funded anti smoking campaign.[134]

**3.52** The Committee heard that industry bodies, including the Australian Hotels Association, Clubs NSW and tobacco companies may be influencing policy. The issue of political influence will be addressed in more detail in Chapter 6, where it is discussed in relation to smoke-free venues.

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131 Mr Tony Thirwell, CEO, National Heart Foundation of Australia (NSW Division), Evidence, 22 March 2006, p15

132 Submission 49, p4

133 Dr Penman, Evidence, 1 May 2006, p23

134 Submission 49, p4

## Conclusion

**3.53** The Committee recognises that the NSW Government, and in particular NSW Health, has a comprehensive tobacco control plan in place, but believes that more can and should be done to reduce the prevalence of smoking and to cut through the barriers to reducing tobacco use identified by inquiry participants. We consider that this can be achieved by the NSW Government maintaining tobacco control as a policy priority and increasing tobacco control measures to ensure people and policy makers do not become complacent about the impact of tobacco smoking on the community. It is clear that this will require additional and sustained funding from the NSW Government and the Commonwealth, to further implement the *NSW Tobacco Action Plan* and other tobacco control measures. As highlighted in Chapter 2, not only will this reduce the costs on the health system and other costs to the community costs, it will save people's lives.

**3.54** The next few chapters will examine specific areas of tobacco control in New South Wales. The next chapter considers strategies to reduce tobacco use including media campaigns, educational campaigns for school children, medically based strategies such as nicotine replacement therapy, in addition to considering the effectiveness of these strategies. Chapter 5 examines the issues around sales and display of tobacco products and Chapter 6 reviews smoke-free venues including licensed venues, and other public places.

# Chapter 4 Strategies to reduce tobacco use

The previous chapter considered the broad approach taken to tobacco control both nationally and in New South Wales, and highlighted the imperative for the Commonwealth and State Governments to sustain and enhance their commitment to further reduce the prevalence of smoking. This chapter examines the specific strategies used in New South Wales to reduce tobacco consumption, including media campaigns targeted at the broad population, educational campaigns targeted at school children, community initiatives run by area health services and non-government organisations, and medically-based cessation strategies. The chapter also considers the research and monitoring of tobacco control initiatives, along with the issue of reduced fire risk cigarettes. Further strategies to reduce tobacco use such as restrictions on the sale and promotion of tobacco, along with smoke-free venues, will be considered in subsequent chapters.

## Mass media campaigns

**4.1** According to the Cabinet Office, media messages can help create the environment that supports smoking cessation, becoming the stimulus for a new perspective on tobacco use and prompting behavioural change. Marketing vehicles include television, radio, print media (newspaper and magazine), billboards, direct mail, publicity and news coverage. Ideally, such campaigns are complemented by strategies designed to assist smokers to stop. There is strong evidence that people are more likely to be successful in a quit attempt when they receive evidence-based support and advice from easily accessible services. [135]

**4.2** The use of social marketing, such as media campaigns to reinforce the health risks of smoking supported by accessible cessation services is considered best practice in effective tobacco control interventions. The NSW Government agency with primary responsibility in this area is the Cancer Institute NSW's, whose main focus in tobacco control has been the design, development and delivery of public education campaigns, backed up by the offer of support for smokers through the Quitline.[136]

**4.3** The Cancer Institute NSW advised in their submission that they have adapted successful campaigns from other jurisdictions for use in New South Wales and have consistently been on air from May 2004 with the smoking cessation campaigns set out on the following page.

**4.4** Each of the campaigns were run in conjunction with NSW Health, the Quitline and other partners, with the timing planned to take into account other NSW Health campaigns and national campaigns by the Commonwealth Government. According to the Cancer Institute the sustained presence in the media of hard-hitting cessation campaigns has an important influence on reducing smoking prevalence in the community.[137]

135 Submission 48, The Cabinet Office, p5

136 Submission 22, Cancer Institute NSW, p11

137 Submission 22, p11

**Table 4.1: Cancer Institute NSW smoking cessation media campaigns since May 2004[138]**

| Campaign | Period | Key evaluation outcomes |
|---|---|---|
| **Ladykiller** | May to June 2004 | Sustained increase in calls to the Quitline over campaign period (increase of 112%) |
| **New Year** | December 2004 to January 2005 | Calls to Quitline doubled when compared with the previous month |
| **Excuses** | April to June 2005 | 80-90% of smokers had seen the TV ads<br>3 out 4 who saw the ad perceived it to be believable<br>2 out of 3 agreed it reminded them of the dangers of smoking<br>2 out of 3 smokers said they were more likely to stop smoking or to think about quitting |
| **Parents** | September 2005 | 80% of smokers had seen the TV ad<br>Higher recognition among females, younger people and smokers with children<br>59% found the ad attention grabbing; 65% found it believable; and 47% made them think about quitting<br>Smokers with children reacted more strongly<br>72% more likely to stop or think about quitting |
| **Lung disease** | November to December 2005 | 70% of smokers recognised the TV ad; recognition higher among females<br>49% found the ad attention grabbing; 57% found it believable; 46% very relevant and 32% made them think about quitting<br>68% more likely to stop or to think about quitting |

**4.5** Ms Jeanie McKenzie, Director of Cardiovascular Health at the National Heart Foundation (NSW Division), supported this by commenting that 'we are seeing drops in prevalence and I think it is directly due to mass media advertising'.[139] Professor Simon Chapman, Professor of Public Health, Sydney University, also highlighted for the Committee that the best way to reduce tobacco smoking is to continue with mass-reach motivational campaigns, like those of the Cancer Institute NSW.[140]

**4.6** The Committee considers that mass media campaigns such as those undertaken by the Cancer Institute NSW are effective in reducing smoking rates and supports their continuation.

138 Submission 22, p11

139 Ms Jeanie McKenzie, Director, Cardiovascular Health, National Heart Foundation (NSW Division), Evidence, 22 March 2006, p25

140 Professor Simon Chapman, Professor of Public Health, Sydney University, Evidence, 22 March 2006, p4

**Recommendation 3**

That the Cancer Institute NSW continue to invest in and develop mass media campaigns aimed at reducing smoking rates.

## The Quitline

**4.7** Since January 2006 the Cancer Institute NSW has been responsible for funding, oversight of management and the promotion of the Quitline in NSW. The Cancer Institute advised the Committee that:

> The Quitline is an evidence based service that provides telephone counselling support to smokers who want to quit. Smokers call a 13 number (13Quit or 13 7848) to access the service and are offered the opportunity to join a call-back program that can double their chances of quitting successfully.[141]

**4.8** The suggested benefits of telephone counselling services, as highlighted by the Cancer Institute, include:

- providing an important route of access to support smokers in quitting
- playing a symbolic role, telling smokers that smoking cessation is important
- convenience in accessing support services
- the callback service approximately doubles chances of successfully quitting. [142]

**4.9** The Cancer Institute describes the Quitline as 'a media-led Quitline service'. [143] There is a very strong correlation between weight of television advertising, and the number of calls to the Quitline. The Cancer Institute reported that with the increase in media campaign spending in 2004 and 2005, there has been a 58% increase in total calls handled by the Quitline service and a 93% increase in callers participating in the call-back program. [144]

**4.10** Campaign tracking and market research conducted in December 2005 by the Cancer Institute indicates a high level of awareness of the Quitline among smokers but low understanding of its services. In April 2006, the Cancer Institute launched a media campaign to promote the services offered by the Quitline.[145]

**4.11** Further recent evaluation of the Quitline through a follow-up of 788 sample callers has indicated a good (self-reported) quit rate of 48.5% at three months. In the future, the Cancer

141 Submission 22, p12

142 Submission 22, p12

143 Submission 22, p12

144 Submission 48, pp 5-6

145 Submission 48, pp 5-6

Institute has advised that it will be supporting the Quitline to undertake follow-up at six and 12 months in order to establish the long term effectiveness of its services. [146]

**4.12** The Committee supports the efforts of the Cancer Institute and the Quitline phone service and recognises that the Quitline plays an important role in reducing tobacco use by being accessible to the majority of people. However, there have been some concerns raised by witnesses that the Quitline is less accessible and less appropriate for some community groups, including rural residents, Indigenous communities and low-socioeconomic groups, obviously including those without a phone.

**4.13** This issue was raised during the inquiry's public forum, where the Committee heard from members of the community about the issues they felt strongly about in relation to tobacco smoking. Ms Rhonda Wilson of MyHealth Australia, a rural not-for-profit organisation providing drug and alcohol services, raised this particular issue:

> Quitline and phone services are best suited to urban populations. Higher incidence of smoking in rural populations may further indicate that Quitline services have not made sufficient inroads into rural communities.[147]

**4.14** In response to this suggestion Dr Denise Robinson, Chief Health Officer, NSW Health, commented that rural people are a target group for the Quitline:

> People who live in rural areas and certainly they include our target group. We encourage people to make that initial contact. It can be either made by phone call or we have referral mechanisms that exist in community health services and other services throughout the State. Those people who live in rural areas only need to make that one referral. We will then, from the Quitline, undertake follow-up some four to six times in the subsequent year to ensure that there is an adherence to the things that have been agreed to, conformed to, and assistance offered to those who want to quit smoking. Those calls, in return, will be at our expense so we are not in any way wanting to disenfranchise people who live in rural areas. The cost to them is simply the cost of a local call.[148]

**4.15** In addition, Dr John Wiggers, Director of Population Health, Hunter New England Area Health Service, advised the Committee that he has seen no evidence to suggest that the Quitline is not appropriate for rural residents. Dr Wiggers outlined a trial that Hunter New England is involved in, where instead of waiting for smokers to call the Quitline, as only 3-5% of smokers do, the health service makes the initial call to see if smokers would like to partake in the Quitline services:

> What we have been doing with the Quitline in NSW is to try to change their mode of delivery to a proactive approach, to offer a cold-calling approach … cold-calling people in the community; finding smokers and saying, "Do you want care?" We have done a pilot of that and we have published that study. That identified that when we ring up smokers in the community, 50-odd % of smokers will accept an offer of a Quitline counselling program. When we asked those same people will they accept any other form of quit smoking service, in the order of 60 to 70% say that they will accept

146 Submission 22, p12

147 Ms Rhonda Wilson, MyHealth Australia, Public Forum, 1 May 2006, p8

148 Dr Denise Robinson, Chief Health Officer, NSW Health, Evidence, 1 May 2006, p20

> self-help materials that are mailed to them. That demonstrates very strongly a huge, untapped demand amongst smokers for further provision and we are currently testing a model of whether or not a proactive Quitline model would make a difference.
>
> We have identified that 51% of people across the State, rural and urban, will take up the offer of a Quitline service. That suggests to us that there is a demand, both in rural and urban areas, for that sort of service.[149]

**4.16** The Committee was interested to hear about this trial and the very high uptake rate of 51% of those approached compared to 3-5% of smokers who have initiated contact with the Quitline. The Committee suggests that, based on the high uptake of quit services in this trial, NSW Health and the Cancer Institute should consider cold-calling as a new approach for the Quitline across New South Wales. If such an approach can increase the access to the Quitline service then this could help to further reduce smoking prevalence rates. It is appreciated that if such an approach is to be taken significant resources may need to be invested into the Quitline.

**Recommendation 4**

That the Cancer Institute NSW evaluate a "cold-calling" approach for the Quitline.

**4.17** The Committee was not able to ascertain whether the Cancer Institute collects data on use of the Quitline by people in rural areas and other disadvantaged groups, and has taken limited evidence on this issue. Nevertheless, given the central role that the Quitline plays in supporting tobacco cessation, we consider it vital that it be accessible to and accessed by a broad cross-section of the community. It may be the case that the previous recommendation would help to address this issue, for example by targeting people living in certain postcodes. We also suggest that it would be valuable for NSW Health and the Cancer Institute to specifically consider use of the Quitline by rural communities and other disadvantaged groups and if necessary, develop specific strategies to improve their access to the Quitline. The issue of disadvantaged groups' access to a broad range of services is discussed in greater detail in a later section of this chapter.

**Recommendation 5**

That the Cancer Institute NSW specifically examine use of the Quitline by rural communities and other disadvantaged groups, and if necessary, develop specific strategies to improve their access to the Quitline.

### The Quit Kit

**4.18** When people call the Quitline they are offered a Quit Kit, which contains information that aims to support a person to quit smoking. According to the NSW Government submission,

[149] Dr John Wiggers, Director of Population Health, Hunter New England Area Health Service, Evidence, 5 May 2006, p1

the provision and dissemination of self-help cessation materials like the Quit Kit has been a cornerstone of Australian quit campaigns and programs. The Committee was advised that there continues to be strong demand for such resources from health professional groups and from smokers themselves especially via Quitlines. NSW Health has recently developed culturally appropriate self-help materials based on stages of change, to support Aboriginal and Torres Strait Islanders who are quitting smoking. [150]

## Educational campaigns

**4.19** Every three years NSW Health and the Cancer Council NSW conduct a survey on the health of secondary school students as part of the Australian School Students' Alcohol and Drug survey. Findings from the 2002 survey indicated:

- the percentage of NSW students who reported having ever smoked fell from 67% in 1984 to 42% in 2002
- 13% of NSW students were recent smokers (having smoked within the previous week)
- 80% of NSW students identified themselves as non-smokers
- the rate of recent smoking was higher for older students compared to younger students.[151]

**4.20** The 2004 National Drug Strategy Household Survey indicated that 10.9% of 14-19 year olds in New South Wales smoke daily.[152] Considering this smoking prevalence figure and the fact that it is at school age that some children take up and become addicted to tobacco smoking it is important that there are specific campaigns for this target group to educate them about the impacts of smoking. The Hunter New England Area Health Service commented that the formative years of adolescence present both opportunities and risks for the health and well being of young Australians:

> Rapid physical, emotional and social development in these teenage years influences the formation of many lasting behaviours and beliefs. The majority of adults who smoke today, for example, became addicted when they were teenagers. Peer group pressure, inexperience and curiosity could be the determining factors of underage drinking, binge drinking, tobacco smoking and other drug use.[153]

**4.21** The Committee heard that there is 'considerable evidence supporting the potential for school-based interventions to produce positive health outcomes for young people. Increasingly, the agenda of health and education is converging.' [154]

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150 Submission 48, p8

151 Submission 48, p7

152 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: State and territory supplement*, Australian Institute of Health and Welfare, Canberra, June 2005, p3

153 Submission 27, Hunter New England Area Health Service, p3

154 Submission 27, p4

**4.22** The Commission for Children and Young People commented that, based on recent consultations and interviews they have undertaken with children and young people on health issues, quit messages need to be specifically targeted to young people:

> Effective messages to young people need to be designed from a young person's point of view and in terms they understand. They may well need to be different to messages for adults. For example, young people assumed that the current Quit campaign was aimed at adults who were long term smokers. They did not realise they were part of the target audience of the current campaign. Some said that they thought a Quit campaign aimed at young people could work, but it would need to recognise that young people don't see themselves as addicts and that they already intend to quit.[155]

**4.23** The Cabinet Office advised the Committee that the Department of Education and Training (DET) has a range of tobacco education initiatives targeted at young people to help them understand the risks of smoking. Specifically, classroom resources designed to assist teachers to implement tobacco education include:

- *K-6 drug education resource*, 3rd edition
- *Smoke screen a smoking prevention resource* 2001, aimed at students in Years 5-8
- *Healing Time: Stages 2 and 3 drug education resource for Aboriginal students*, 2002
- *Drug education in culturally diverse classrooms: alcohol and tobacco*, 2004, a professional learning package designed to assist teachers to deliver culturally appropriate tobacco and alcohol education
- posters, stickers and bookmarks distributed to primary and secondary schools in 2002 and 2006 to reinforce messages on how smoking can affect fitness as well as the possible negative social consequences of smoking.[156]

**4.24** Further to this, DET continues to support national anti-smoking youth initiatives organised by the Australian Network on Young People and Tobacco along with NSW initiatives, including:

- *National Youth Tobacco Free Day* (NYTFD) has been run since 2001 in all Australian States and Territories. It encourages young people to consider the benefits of not smoking and to be advocates against smoking. NYTFD is celebrated as part of National Youth Week.
- *The Critics' Choice* has been conducted in Australia since 2001, with NSW taking part since 2003. *The Critics' Choice* competition invites primary and secondary students to watch and rate 12 anti-smoking advertisements from around the world, and nominate which one would prevent them from starting to smoke or encourage them to quit. In 2005 more than 20,000 NSW students participated in the competition.
- The NSW Health *'Smoking. Don't be a sucker'* program is aimed at year seven students and designed to promote an active, healthy lifestyle. The program is a joint initiative of the AFL (NSW/ACT), NSW Health and the Sydney Swans with the support of the DET and involves integrating non-smoking messages into a physical activity program.

155 Submission 47, NSW Commission for Children and Young People, p4

156 Submission 48, pp 6-7

The program teaches students the various skills required to play AFL, and encourages them to choose a healthy lifestyle and future without smoking.

**4.25** The Hunter New England Area Health Service described a pilot program called "One Stop Shop Project", which involves a comprehensive approach to health promotion in secondary schools. The health service reported that the pilot results have indicated a reduction in reported tobacco use by students in years 7-10 and further follow up surveys will be conducted later this year.[157]

**4.26** The Committee recognises the importance of getting the message to young people and children that smoking is harmful and that this will potentially reduce the uptake of smoking and reduce prevalence rates among young people. One way to reduce smoking rates for young people is to further address the issue of cigarette sales to minors, which will be examined in detail in Chapter 5. We recognise that there are a number of state-wide strategies and educational campaigns aimed at this target group, such as the initiatives undertaken by the Department of Education and Training. These programs need to continue to ensure that young people are aware of the impacts of tobacco smoking and to reduce smoking rates in this group.

**Recommendation 6**

That the NSW Government continue to implement tobacco education strategies in schools to help young people understand the risks of smoking.

## Initiatives targeting disadvantaged groups

**4.27** In Chapter 2 the Committee outlined the evidence it has received in relation to groups within the community who have high smoking prevalence rates, and/or reduced access to mainstream smoking cessation programs. These groups included:

- low socioeconomic groups in general
- Aboriginal communities
- culturally and linguistically diverse (CALD)communities
- young people and children
- regional and rural communities
- prisoners
- people with mental illness.

**4.28** As advised by the Cancer Council NSW, socially disadvantaged groups in the community have the highest smoking rates and often face complex barriers to quitting smoking, more so than other smokers. People with a mental illness, the very poor, prisoners, people with concurrent

[157] Submission 27, Hunter New England Area Health Service, p4

drug or alcohol addictions, the homeless, and Aboriginal groups have the highest smoking rates in New South Wales.[158]

**4.29** NSW Health has identified groups requiring extra help to quit smoking. As Dr Robinson advised, 'I am particularly anxious that we look at some of the more socioeconomically disadvantaged groups and that we have some measures in place there.'[159] NSW Health has also recognised people with mental illness as requiring further help to quit smoking:

> Another area where we need to focus is on the mental health clients. Again there has been a higher level of smoking in those groups and strategies to implement a smoke-free environment as we have been able to do within other health facilities has not so far been very successful within the mental health arena and that is something we are going to give particular focus to in the future.[160]

### Aboriginal communities

**4.30** As outlined in Chapter 2, the Committee heard evidence of extremely high rates of smoking among Aboriginal people and that the impact of smoking on Aboriginal and Torres Strait Islanders is significant. On this basis, a number of inquiry participants argued the need for targeted cessation strategies in Aboriginal communities.

**4.31** The Department of Aboriginal Affairs (DAA) commented that 'despite overwhelming evidence of the health implications of smoking for Aboriginal people there are very few tobacco cessation programs or resources specifically targeted to Aboriginal people.'[161] The Committee heard that one reason for this was that 'in Aboriginal health programs tobacco is often addressed within broader drug programs, but competing with the more immediate impact of alcohol and illicit drugs therefore tobacco receives a lesser priority.' [162]

**4.32** The DAA advised the Committee that effective smoking cessation and harm minimisation programs for Aboriginal people need to inform smokers and address the range of motivations, perceptions and the cultural context of Aboriginal smoking:

> Aboriginal smokers require specific programs and resources that consider the different historical context and social and economic environments in which Aboriginal people live. Successful strategies need to be culturally appropriate, developed and directed by Aboriginal people and delivered by Aboriginal health workers, through an Aboriginal service provider, to maximise the effectiveness of the program and resources. Effective cessation programs for Aboriginal people require individual and group support that work closely with other organisations in the community. [163]

158 Submission 49, Cancer Council NSW, p12

159 Dr Robinson, Evidence, 27 March 2006, p67

160 Dr Robinson, Evidence, 27 March 2006, p67

161 Submission 65, Department of Aboriginal Affairs, p16

162 Submission 65, p15

163 Submission 65, p16

**4.33** The Committee received evidence that the rate of smoking amongst Aboriginal health workers reflects the overall high rate of smoking in the Aboriginal community and that this needs to be actively addressed before tobacco cessation strategies can be optimally effective.[164] NSW Health indicated that it has recognised this issue and Dr Robinson described an initiative to target the problem:

> Smoking rates are also quite high in the Aboriginal health care workers. Probably no one around this table was around when the push started in NSW Health some 10 or so years ago to actually start to work with the doctors and nurses in the system to make sure that they first gave up smoking so that they were in a legitimate position and able therefore to tell the message to their clients, and that is precisely where we want to go now with respect to the Aboriginal population, so we will be rolling out what we are calling Smoke Check at the present time and we will be working with the Aboriginal health care workers and others to ensure that that message is taken up, that there are strategies in place that will enable them to quit and at the same time encouraging them then to be spreading the message on to their client group, so that is a very strong focus for us.[165]

**4.34** The Committee heard of a number of smoking cessation programs aimed at Aboriginal people that are local or regionally run. For example, the Aboriginal Medical Service in Redfern has run a limited tobacco cessation program for the last five years offering nicotine patches at half the retail price. However, the DAA advised that:

> The program has received no funding, nor does it have the resources to evaluate its effectiveness or to run counselling sessions for tobacco cessation. Anecdotal feedback from participants … [is] that after commencing with nicotine patches, continuing to afford patches is problematic and has contributed to the reverting to smoking. [166]

**4.35** The Committee heard of other local initiatives including the:

- Port Macquarie Aboriginal Medical Service's Partnership for Aboriginal Care Quality Improvement-Smoking Cessation Plan Trial. This trial involves nicotine replacement therapy (NRT) and has been operating for 18 months. So far there has been a success rate of 5% of 380 people abstaining from smoking for six months or more. [167]
- Marri Ma Health Aboriginal Corporation in Broken Hill will receive a Health Promotion Demonstration Grant of $300,000**,** over three years to target smoking in seven surrounding Aboriginal communities. The program involves a health check and follow up for the community to identify potential participants as well as a six week 'quit' plan with counselling and NRT. [168]

164 Submission 65, p17

165 Dr Robinson, Evidence, 27 March 2006, p67

166 Submission 65, p18

167 Submission 65, p21

168 Submission 65, p22

- The Koori Tobacco Cessation Project based in the Illawarra and Shoalhaven regions involved 150 people who received subsidised NRT, information and counselling. The project achieved 6% cessation rates among Aboriginal participants. [169]

**4.36** In terms of a statewide approach, the Committee is aware that a component of the *NSW Tobacco Action Plan 2005-2009* is the NSW Aboriginal and Torres Strait Islander Tobacco Prevention Project. The focus of the project is to train Aboriginal health workers and health workers who predominately work with Aboriginal people to deliver better smoking cessation programs. The administration and implementation of the two-year $495,000 per annum project has gone to tender, and the project will commence in July 2006. [170]

**4.37** The DAA recommended to the Committee that tobacco cessation in Aboriginal communities in New South Wales be made a priority, be adequately funded, maximise community control, long term and holistic, and that such programs be responsive to the social and historical context of smoking in Aboriginal communities. They should also incorporate adequate evaluation and monitoring of effectiveness. However, most importantly the DAA commented that:

> Successful community cessation campaigns need to be designed by and for Aboriginal communities, be locally based with local content and involve elders and significant community members and foster a sense of community ownership and control.[171]

**4.38** In line with evidence from the DAA and other concerned parties Mr Sean Appoo, Research and Service Development Officer with the Aboriginal Health and Medical Research Council (AHMRC), argued the need for:

- an increase in resources to develop and implement a targeted and uniform tobacco smoking health promotion and prevention and cessation program across Aboriginal communities in New South Wales
- specific funding for Aboriginal community controlled health services to deliver nicotine replacement therapy to Aboriginal communities
- the formation of collaborative research and evaluation projects to measure the effectiveness of community strategies to allow more evidence to be collected
- improved funding and resources to provide training for all Aboriginal community controlled health service staff and briefings in interventions regarding tobacco smoking.[172]

**4.39** A report referred to the Committee by the Australian National Council on Drugs, published in December 1995 by the Senate Community Affairs Reference Committee into the Tobacco Industry and the Costs of Tobacco-related Illness made a number of recommendations in

169 Submission 65, p22

170 Submission 65, pp22-23

171 Submission 65, p5

172 Mr Sean Appoo, Research and Service Development, Aboriginal Health and Medical Research Council (AHMRC), Evidence, 5 May 2006, p47

relation to Aboriginal and Torres Strait Islanders echoing those above.[173] The recommendations demonstrate that the issue of high smoking rates in the Aboriginal community was identified over ten years ago, however, the smoking prevalence rates remain significantly high at 52.9%. The Committee considers it unacceptable that these rates remain so high into the future.

**4.40** The Committee notes that both the *National Tobacco Strategy 2004-2009* and the *NSW Tobacco Action Plan 2005-2009* identify the need to tailor initiatives for and target Aboriginal and Torres Strait Islanders, as well as other disadvantaged groups.[174] The Committee recognises that some local Aboriginal Medical Services are conducting smoking cessation programs for the local Aboriginal communities and believes it is important for these programs to continue and to expand.

**4.41** Due to the enormously high smoking prevalence rate in Aboriginal communities and the way this can compound the disadvantage faced by Aboriginal people, the Committee believes this group should be made a priority. In particular, the Committee supports the recommendations put forward by the AHMRC as noted above.

**Recommendation 7**

That the NSW Government:

- increase resources to develop and implement targeted tobacco smoking health promotion and prevention and cessation program (including nicotine replacement therapy) across Aboriginal communities in New South Wales
- coordinate the formation of collaborative research and evaluation projects to measure the effectiveness of community strategies to allow more evidence to be collected
- provide more funding and resources to provide training for all Aboriginal community controlled health service staff and briefings in interventions regarding tobacco smoking.

### Culturally and linguistically diverse communities

**4.42** The *2004 National Drug Strategy Household Survey* conducted by the Australian Institute of Health and Welfare found a smoking prevalence rate of 14.1% in culturally and linguistically diverse (CALD) communities.[175] The Committee is aware that this prevalence rate may not reflect smoking rates in some communities. CALD communities have been identified as a

173 Submission 42, Australian National Council on Drugs, attachment

174 *National Tobacco Strategy 2004-2009*, p37 and the *NSW Tobacco Action Plan 2005-2009*, p15

175 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey,* Australian Institute of Health and Welfare, Canberra, June 2005, p22

target group in the *NSW Tobacco Action Plan 2005-2009* due to their potentially reduced access to mainstream smoking cessation programs.[176]

**4.43** NSW Health advised that there are elements within the Quitline that can cater to CALD clients, whether they are in house or provided via referral to an ethnic counselling service.[177] Dr Robinson also pointed out that:

> There is also a DVD that will be produced in relation to the use of nicotine replacement therapy and that can be accessed through local libraries or the local area health service. It has subtitles which will enable many other groups and individuals to be able to understand the benefits of replacement. [178]

**4.44** As noted earlier, some area health services are focusing on CALD groups in delivering smoking cessation programs. Ms Jeanie McKenzie, Director of Cardiovascular Health, National Heart Foundation, stated that campaigns and efforts targeted at CALD communities are usually delivered at a local level by the area health services:

> They are mostly at a local level, often undertaken by area health services that have paid particular attention to the communities that they consider to be of the highest priority in their geographical area. We have had campaigns for Vietnamese and Chinese groups. I know that Central Sydney has undertaken campaigns aimed at those two groups. I think other area health services have picked on particular groups that they felt were in the most need of education messages. It is not comprehensive probably because it is very labour intensive and expensive. I think we would probably all agree that we would like to see a lot more done in this area.[179]

**4.45** An example of a program run by an area health service targeted at CALD communities is the Arabic Tobacco Control Project run by Sydney South West Area Health Service. This project is focused mainly in the western zone of the health service, in particular the areas of Bankstown, Fairfield, Liverpool, Macarthur and some extension to the Canterbury area. The target group is males aged 30-50 years of age and it includes strategies such as:

- a culturally appropriate social marketing campaign using billboards, newspaper advertisements and radio ads
- funding grants to Arabic organisations
- trialling of subsidised nicotine patches with Arabic-speakers.[180]

**4.46** The Committee understands that CALD communities are a target group under the *NSW Tobacco Action Plan 2005-2009* and that there has been a commitment to develop an appropriate media strategy for CALD groups based on their media consumption patterns, and

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176 *NSW Tobacco Action Plan 2005-2009*, p15

177 Dr John Sanders, Manager, Tobacco and Health Branch, NSW Health, Evidence, 27 March 2006, p66

178 Dr Robinson, Evidence, 27 March 2006, p67

179 Ms Jeanie McKenzie, Director Cardiovascular Health, National Heart Foundation, Evidence, 22 March 2006, p26

180 Submission 48, p8

to undertake this in conjunction with appropriate community specific programs.[181] The Committee endorses this strategy outlined in the Action Plan.

**4.47** The Committee recognises the work undertaken by area health services to cater to specific groups in their areas through culturally appropriate smoking cessation programs.

### Regional and rural communities

**4.48** The smoking prevalence rate for people living in remote and very remote areas is high at 29.2%, as reported in the *2004 National Drug Strategy Household Survey*.[182] The Greater Western Area Health Service advised the Committee that its population 'has the highest smoking prevalence in the State and as a result, the area health service sees an increased burden of tobacco related morbidity and mortality.[183]

**4.49** The Committee heard that smoking cessation services for regional and rural smokers are lacking. MyHealth Australia, a rural not-for-profit organisation dealing with drug and alcohol issues, stated, 'reducing and assisting people to quit cigarettes in rural communities is not well supported by either State or Federal government. Yet, it still contributes as one of the greatest morbidity and mortality burdens for our nation.'[184]

**4.50** Dr Wiggers, Director of Population Health with the Hunter New England Area Health Service, commented that the provision of smoking cessation services to the rural and regional communities is a challenge he faces in his area:

> The critical and obvious issue is how can we ensure that smokers in our communities have access to the services they badly need. The limitations on access relate to distance but they also relate to the physical availability of a variety of different services that smokers can access. What we have been doing in Hunter New England Health to address the issue of access in trying to maximise the accessibility and the reach of our prevention services is to identify those facilities, agencies and settings, if you like, in the community that can maximise the reach of our services to the whole of the population. [185]

**4.51** Earlier in this chapter the Committee recommended that use of the Quitline by rural and other disadvantaged groups be examined. We also noted that our recommendation to introduce cold calling at the Quitline might improve access by rural communities.

**4.52** The Committee believes it remains important that area health services continue the work they are doing in terms of smoking cessation initiatives especially in rural and regional areas where access to mainstream programs may be limited.

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181 *NSW Tobacco Action Plan 2005-2009*, p15

182 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey,* Australian Institute of Health and Welfare, Canberra, June 2005, p22

183 Submission 34, Greater Western Area Health Service, p1

184 Submission 13, MyHealth Australia, p1

185 Dr Wiggers, Evidence, 5 May 2006, p1

**4.53** The Committee notes that the target groups in the *NSW Tobacco Action Plan 2005-2009* does not include rural and remote communities[186], despite them having higher prevalence rates. The Committee considers that NSW Health should include rural and remote communities as target groups under the Action Plan.

**Recommendation 8**

That NSW Health consider adding people in rural and remote areas to the target groups for smoking cessation services identified in the *NSW Tobacco Action Plan 2005-2009*.

### Prisoners

**4.54** The smoking prevalence rates among prisoners is as high as 80%. The Committee was told that tobacco smoking has become a normative activity of prison culture and is considered to be one of the few remaining privileges left to inmates.[187] There are several reasons why it is desirable to reduce smoking among prisoners:

> The 2001 NSW Inmate Health Survey noted: "Given the high rates of tobacco consumption in this population and the use of tobacco as a form of currency, it is essential that effective quit strategies be developed and that attempts to reduce or stop smoking be encouraged … 69% of current women smokers and 76% of men wanted to quit smoking … and said they required assistance to stop smoking". [188]

**4.55** Justice Health[189] indicated in their submission that incarceration represents an opportunity to access a highly disadvantaged group and to make positive population health gains.[190]

**4.56** The Committee was informed that interventions that help inmates to quit smoking, rather than those that merely prevent them from smoking while incarcerated, are likely to make significant contributions to their long-term rehabilitation. Evidence suggests that when prisons ban cigarettes it only serves to create another source of contraband and all of the problems associated with an illegal commodity.[191]

**4.57** Justice Health advised the Committee that it has run free structured smoking cessation programs for inmates since 2001 but considers that the numbers enrolled in these programs 'are inadequate to make a significant impact in reducing smoking prevalence in New South Wales prisons.'[192] Given the current programs high success rate, Justice Health suggests that it

186 *NSW Tobacco Action Plan 2005-2009*, p15

187 Submission 25, Justice Health, p2

188 Submission 25, p2

189 Justice Health's role is to improve the health status of prisoners while also minimising the health consequences of incarceration on individuals, their families and the general community.

190 Submission 25, p2

191 Submission 25, p3

192 Submission 25, p5

is worth expanding the coverage of such programs in order for more inmates to benefit. However, to do this additional resources would be required.[193]

**4.58** The Committee was advised that the National Health and Medical Research Council is funding a large scale trial of nicotine replacement therapy and brief cognitive behavioural therapy intervention within New South Wales and Queensland prisons. This is based on a successful trial at the Lithgow Correctional Centre by Justice Health and the School of Community Medicine University of New South Wales where, after six months, over one quarter of inmates were no longer smoking.[194]

**4.59** The Committee would be interested in the results of this large scale trial and if successful would support the implementation of the program throughout New South Wales prisons as it is recognised that the New South Wales prison population has a significantly high smoking prevalence rates.

### Conclusion

**4.60** It is clear to the Committee from the evidence that strategies to address smoking among disadvantaged groups with high smoking prevalence rates and who have limited access to mainstream smoking cessation programs are vitally important. We note that the *NSW Tobacco Action Plan 2005-2009* identifies the following target groups for smoking cessation services:

- young adults (16-29 years)
- lower socioeconomic groups
- Aboriginal and Torres Strait Islanders
- mental health clients
- CALD groups
- inmates and detainees in correctional settings.[195]

**4.61** The Committee also notes and commends the work undertaken by area health services, Aboriginal health services as well as other non-government organisations to deliver smoking cessation services to these target groups. The Committee believes that it is incumbent on all mainstream services, such as area health services to ensure that they are accessible to the broad range of equity groups. It was suggested to the Committee by Dr Wiggers that incorporating the provision of anti-smoking programs into area health services performance agreements with NSW Health to enhance the capacity of an area health service to impact on smoking rates:

> The department has, as I have indicated, a number of guidelines and resources. One strategy which has been shown in the literature to be effective is to incorporate the provision of cessation care in performance agreements between the Department of Health and each area health service. Performance agreements already include a

193 Submission 25, p5

194 Submission 25, p5

195 *NSW Tobacco Action Plan 2005-2009,* p15

> number of indicators around health service delivery targets, and one way of enhancing the focus on this particular issue is to incorporate a tobacco cessation care element in those performance agreements. [196]

**4.62** The Committee considers that it is very important that area health services deliver anti-smoking programs and that access to services by the full range of disadvantaged groups be ensured. As there may be unforseen disadvantages in including anti-smoking campaigns in performance agreements, we consider that NSW Health should examine the most appropriate means of ensuring service delivery and access across the State.

**Recommendation 9**

That NSW Health give consideration to ways of ensuring that area health services deliver anti-smoking programs, with specific reference to ensuring access by the full range of disadvantaged groups.

## Medically based cessation strategies

**4.63** The Committee received evidence on medically based smoking cessation strategies including interventions by health practitioners, nicotine replacement therapy and specialist-delivered intensive programs like smoking clinics. There are other medically based strategies such as the use of anti-depressants and cognitive behavioral therapy on which the Committee did not receive sufficient evidence to comment.

**4.64** The Cabinet Office advised that smoking cessation treatments ranging from brief clinician advice to specialist delivered intensive programs, including pharmacotherapy, are not only clinically effective, but are also extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments.[197]

### Interventions by health professionals

**4.65** The Cabinet Office advised that it has been demonstrated that even a brief intervention by a health professional increases the probability that a patient will successfully quit smoking. On this basis it agued that, 'embedding quality, evidence based approaches to smoking cessation throughout the health workforce is an essential strategy for reducing the burden of tobacco use in Australia.' [198]

**4.66** The Department of Respiratory Medicine at the Children's Hospital Westmead advised that the hospital setting provides an opportunity to talk to clients about the impact of smoking and to offer cessation options:

196 Dr Wiggers, Evidence, 5 May 2006, p5

197 Submission 48, pp9-10

198 Submission 48, pp9-10

> The hospital setting provides a 'teachable moment', in which the health risks of smoking and the benefits of quitting can be highlighted for parents and young people who smoke, in particular provide an opportunity for cessation counselling. Clinicians can play a powerful role in assisting patients to quit smoking and thereby reduce the high morbidity and mortality associated with tobacco related diseases. Health care professionals working in both the hospital and community setting cannot be excluded from this responsibility ... The hospital should provide guidance to effective interventions for clinicians working in the community setting.[199]

**4.67** NSW Health has published a guide to brief intervention for smoking cessation for all health professionals in the New South Wales health system: *'Let's take a moment: Quit smoking brief intervention – a guide for all health professionals'*. This document outlines clear and practical advice in the provision of smoking cessation interventions for health professionals and includes:

- a simple five-step process (the '5As') for smoking cessation brief intervention
- an evidence-based approach
- practical ways to assess nicotine dependence and stage of change quickly and effectively as part of routine client consultation
- information on the health effects of smoking and the benefits of quitting
- information on pharmacotherapy
- tips for motivational interviewing
- sample questions to use when conducting brief interventions.[200]

**4.68** It was indicated to the Committee that training for health care professionals is important for the delivery of interventions: 'Training of health care professionals in brief intervention methods increases their performance of smoking cessation intervention steps with their patients.'[201]

**4.69** The NSW Government submission advises that NSW Health's Tobacco and Health Branch has written two units in treatment of nicotine dependence for the Vocational Education and Training Population Health Training Package, with the assistance of experts from the field of smoking cessation. NSW Health is currently writing training materials for this package and will deliver training in smoking cessation via videoconferencing and online learning modes from late 2006. A culturally appropriate smoking cessation training program for Aboriginal Health Workers has been developed by NSW Health and will be funded over two years from July 2006.[202]

**4.70** The Department of Respiratory Medicine at the Children's Hospital Westmead also highlighted the importance of training in brief interventions for hospital and community-based clinicians and raised the issue of supporting organisational change within the hospital

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199 Submission 36, Department of Respiratory Medicine at the Children's Hospital Westmead, p4

200 Submission 48, pp9-10

201 Submission 48, pp9-10

202 Submission 48, pp9-10

and community to assist clinicians in delivering such interventions.[203] A recent study at the hospital indicated that:

> [T]raining clinicians in brief intervention for smoking cessation increased clinicians knowledge and confidence in nicotine replacement therapy, motivational interviewing and brief intervention – however further change in practice would be supported by additional changes within the organisation to assist ongoing clinical practice improvement in this area. [204]

**4.71** The Committee recognises the importance of brief interventions by health professionals which may increase the chances of a patient quitting successfully. The Committee supports ongoing training for health professionals to provide effective brief interventions to aid smoking cessation.

### Smoking clinics

**4.72** Smoking clinics are targeted at those smokers who require intensive help, pharmacological interventions and relapse prevention advice. Ms Renee Bittoun, Director, Smoking Clinic, South West Sydney Area Health Service, commented on the target group for such services:

> They are often smokers who have medical repercussions from smoking but persist, and by definition show high dependency. These smokers respond well to frequent counseling. There is strong evidence that interventions and time taken in consultations are closely related to successful permanent quitting. This level of intensity is reported to be at least as cost effective in this group of smokers as any other medical intervention might be for any other illness. [205]

**4.73** The Committee was advised that smokers who are severely dependent 'are a heavy burden on the socio-economic structure of society and their own wellbeing, through medical care and hospitalisations.'[206] Ms Bittoun suggested that free smokers clinics have shown to be cost effective and essential as medical services both in Australia and the United Kingdom in treating these smokers. However, there are only a few in New South Wales. An example highlighted by Ms Bittoun was:

> The Smokers Clinics set up to support patients with Chronic Obstructive Airways Disease at Royal Prince Alfred Hospital, which has shown that smoking cessation in this difficult cohort of smokers has significantly reduced the frequency of their hospital admissions as well as the length of any admissions. There are currently few such clinics in the state of New South Wales. [207]

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203 Submission 36, p3

204 Submission 36, p5

205 Submission 9, Woolcock Institute of Medical Research, pp13-14

206 Submission 9, pp13-14

207 Submission 9, pp13-14

**4.74** Ms Bittoun recommended that there be sustained funding for smokers clinics and/or dedicated smoking cessation professionals in every hospital in New South Wales to meet demand among both in patients and out patients.[208]

**4.75** Professor Matthew Peters, Chair of Action on Smoking and Health (ASH) and a respiratory physician at Concord Hospital, indicated to the Committee that the United Kingdom Government has developed an extensive network of quit smoking clinics:

> It is a model that would be hard to roll out quickly, but the cost of in British pounds of achieving a smoker quitting is UK£160, or A$400 plus some drug costs, to turn someone from a smoker into a non-smoker. We probably do not have the logistics to create quit smoking clinics in the way that they have, but it is a model that could be explored in a small way. At a major teaching hospital, our total resources for specialist smoking cessation is one person for half a day a week. That is the extent of specialist resources.[209]

**4.76** The Committee notes that there are few smokers clinics and professional cessation therapists available in New South Wales. As such services could have a significant impact on those smokers with a chronic dependence, who are likely to make substantial demands on the health system, we consider that NSW Health should significantly enhance resources for smoking clinics and/or professional smoking cessation therapists in every area health service.

**Recommendation 10**

That NSW Health increase resources for smoking clinics and/or professional smoking cessation therapists in every area health service.

### Nicotine replacement therapy

**4.77** Nicotine replacement therapy (NRT) refers to the range of pharmacological nicotine delivery systems, such as patches or gum, which are designed to improve a smoker's chance of quitting by alleviating withdrawal symptoms and the urge to smoke, by replacing part of the nicotine previously obtained from smoking.[210]

**4.78** Three forms of NRT were de-scheduled by the Commonwealth Therapeutic Goods Administration Drugs and Poisons Scheduling Committee in late 2004: patches, gums and lozenges. As a result non-pharmacists (including health workers running cessation programs and retail outlets other than pharmacies) can now legally provide these products. Two other formulations are available over the counter in pharmacies: inhalers and sublingual tablets.[211]

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208 Submission 9, pp13-14

209 Professor Matthew Peters, Chair, Action on Smoking and Health (ASH), Evidence, 5 May 2006, p61

210 Submission 49, p11

211 Submission 48, pp9-10

**4.79** The Committee heard that there is abundant evidence demonstrating that NRT, if correctly used, doubles the chances of a successful quit attempt. Using NRT to quit smoking is not only safe and effective, but is highly cost-effective when compared to other common interventions.[212]

**4.80** The Committee was advised that NSW Health has produced resources on NRT for use by health professionals and their clients: a pamphlet *'Products to help you quit smoking'* and a video *'Health Smart- NRT'*, both of which provide evidence-based information on the correct use of NRT, including appropriate dosage and duration of use. Several thousand copies of the video have been distributed throughout New South Wales to all hospitals, community health centres, tertiary institutions, public libraries, alcohol and other drug services and divisions of general practice. The video is currently being reformatted as a DVD with multiple language subtitles and will be available at no cost from mid 2006 through the NSW Quitline and all area health services.[213]

**4.81** Many inquiry participants, including the Cancer Council NSW, ASH, NCOSS and Professor Chapman raised the issue of affordability of NRT, especially for socially disadvantaged groups, who also have the higher smoking prevalence rates. It was suggested to the Committee that NRT be free for certain groups in the community or subsidised such as through the Pharmaceutical Benefits Scheme (PBS), run by the Commonwealth Government.

**4.82** In its submission the Cancer Council NSW pointed out that there are several policy options for increasing the affordability of NRT for low income groups, including subsidy through the PBS, cash rebates for people on health care cards, and provision of free NRT to eligible quitters as part of cessation services.[214] Dr Andrew Penman, CEO of the Cancer Council NSW commented that:

> Making NRT more available is a good thing to do; it stacks up well against other medical interventions about its similar cost-effectiveness ratios. If you wanted to target that more though I think you could take some of the highly dependent groups in our community—people with mental illness, Aboriginal people, people in the welfare system who have extraordinarily high rates of smoking; somewhere around 50%, 60 % or higher rates of smoking—and you could in fact do something about supplying NRT to those groups in quite a controlled way which would not expose you to the same level of liability as if you were to make it free to everyone. It would certainly be a very good and targeted way to start the job. [215]

**4.83** Professor Chapman advised the Committee of a study of a trial in New York City where 34,900 smokers phoned into a quitline during a promotion and were offered a six-week course of free nicotine patches:

> The authors of this study estimated that 5% of all adults in New York who smoked more than 10 cigarettes a day received nicotine replacement therapy. This is a good illustration of mass-reach type strategies. They followed them up at six months and … of the people who received the nicotine therapy, 33% of them had quit at six months,

212 Submission 48, pp9-10

213 Submission 48, pp9-10

214 Submission 49, pp12-13

215 Dr Andrew Penman, CEO, Cancer Council NSW, Evidence, 1 May 2006, p22

> compared to 6% of smokers who did not receive the nicotine stuff. They extrapolate from that that around about 6,000 people in New York quit smoking as a result of that and the cost was worked out at about $464. That is so rock bottom a price compared to many routine medical procedures that doctors would not hesitate to order for people. I would like to see that sort of stuff.[216]

**4.84** The issue of NRT was also raised at the Committee's public forum. Speakers such as Ms Mary Osborne from the Royal Australian College of Physicians argued that NRT needs to cost less than cigarettes, while Mr Michael Stevens, a pharmacist, recommended that starter packs of NRT be freely available for people wanting to quit smoking. [217]

**4.85** In relation to subsidies through the PBS, Dr Robinson of NSW Health, advised that this approach is limited at present:

> Currently, as far as I am aware, there is no availability under the PBS for people to receive subsidy if they wish to initiate therapy themselves. There is some approval under the PBS for people who are in recognised programs but that would obviously involve a prescription from the local doctor. Availability on the pharmaceutical benefits scheme is obviously a Federal issue rather than a State-based issue. [218]

**4.86** Whilst the Commonwealth Government has already rejected an application to list NRT on the PBS, making it available to the public on prescription at reduced cost, the Cancer Council NSW suggest there are several ways the NSW Government might ensure NRT is accessible to people with the highest smoking rates:

- include provision in the funding for Quitline to cover the cost of free NRT to callers on low incomes (such as health care card holders)
- include specific budget allocations to area health services to include free NRT in all cessation services for low income or socially disadvantaged groups. [219]

**4.87** The Committee considers that the cost of providing free NRT is outweighed by the costs of treating tobacco-related illness and disease. As the Cancer Council NSW indicated, given that the savings from treating tobacco-related illness and disease accrues to the New South Wales budget, it would be appropriate for the NSW Government to help meet the costs of assisting those most at risk to quit smoking.[220] The Committee agrees that free or subsidised NRT would be an effective way to address the barriers for reducing tobacco use, especially in socially disadvantaged groups, who have higher smoking prevalence rates and are less able to afford these evidence-based treatments. The Committee believes that NRT should be affordable and accessible and that the NSW Government and the Cancer Institute NSW should initiate further discussions with the Commonwealth Government on this issue.

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216 Professor Chapman, Evidence, 22 March 2006, p5

217 Ms Mary Osborne, Royal Australasian College of Physicians and Mr Michael Stevens, Public Forum, 1 May 2006, p2 and p6

218 Dr Robinson, Evidence, 1 May 2006, p22

219 Submission 49, pp12-13

220 Submission 49, pp12-13

**Recommendation 11**

That the NSW Government and the Cancer Institute NSW initiate discussions with the Commonwealth Government focussing on the need to make nicotine replacement therapy accessible and affordable for all smokers.

## Cigarette and fire safety

**4.88** The Committee received evidence on strategies to reduce the impact of tobacco on the community by reducing the number of domestic and bush fires caused by cigarettes. Data on the extent of fires caused by cigarettes was presented in Chapter 2. The issue of fires is also briefly addressed in Chapter 7 in the context of the Committee's consideration of smoking in cars.

**4.89** Submissions that briefly raise the issue of a need for action to reduce fires caused by cigarettes included those of the Northern Sydney Central Coast Area Health Service, the Royal Australasian College of Physicians, Mr Joe Alvaro and ASH. [221]

**4.90** The NSW Fire Brigade outlined for the Committee strategies they have pursued to reduce the impact of cigarettes in relation to fires. This included working closely with the NSW Rural Fire Service on a public awareness campaign to draw attention to the incidence of bushfires caused by cigarette butts thrown from vehicles:

> In November 2004 we started a joint campaign after the "Don't be a tosser" campaign for littering. It was known as the "Don't be a firebug" campaign, and there were bumper stickers, et cetera. We had rural fire brigades and urban fire brigades spreading the message to the community that we are working very closely on all these fire safety programs. [222]

**4.91** A further initiative in which the NSW Fire Brigade is taking a lead role at the national level is in relation to reduced fire risk cigarettes, as an attempt to eliminate the ignition source of fires. Commissioner Greg Mullins of the NSW Fire Brigade reported to the Committee that both New York State and Canada have introduced legislation requiring cigarette manufacturers to produce cigarettes that self extinguish when not being actively smoked. The states of Vermont and California have, or will soon, follow suit. [223]

**4.92** Commissioner Mullins stated that results to date from New York have been encouraging:

> Even though it is in the early stages, the experiences in New York State were very encouraging six months after the new standard was introduced. Deaths in that six months dropped from the historical average of 20 to 11. While statisticians of course

221 Submission 51, Northern Sydney Central Coast AHS p3; Submission 40 Royal Australasian College of Physicians, p7; Submission 31, Mr Joe Alvaro, p1; Submission 44 ASH, p7

222 Commissioner Mullins, Evidence, 5 May 2006, p18

223 Commissioner Mullins, Evidence, 5 May 2006, p18

> counsel against drawing any firm conclusions from those early figures, fire officers in New York are quite convinced what the improvement was due to.[224]

**4.93** In 2004, NSW Fire Brigades and the Minister for Emergency Services commenced a campaign to convince all other states and territories to support the introduction of a similar standard in Australia and, 'through bilateral agreements, also in New Zealand. Like all Australian fire services, the New Zealand Fire Service fully supports this initiative.' [225]

**4.94** Commissioner Mullins also indicated that the NSW Fire Brigades initiated work on a new standard for reduced fire risk cigarettes with Standards Australia last year. The committee developing the standard includes various stakeholders, including NSW Health, the tobacco industry and other stakeholders. Commissioner Mullins stated that it is hoped that an Australian standard will be finalised this year and, hopefully, legislation will then follow.[226]

**4.95** British American Tobacco Australia stated in its submission that a Harvard report into the preliminary effects of the New York reduced fire risk cigarettes suggested that the smoke toxicity produced by these cigarettes may be higher than ordinary brands produced in other US states. Further to this, British American Tobacco Australia commented that 'a large number of jurisdictions in the United States (including, without limitation, Arkansas, Maryland, New Jersey, Texas, Colorado, Oregon, New Hampshire, Maine, Rhode Island, Alabama) and also New Zealand have [considered but] rejected such proposals [to introduce lower ignition propensity cigarettes.'[227]

**4.96** The NSW Fire Brigades received further advice from one of the principal authors of the Harvard report and others that refutes British American Tobacco Australia's assertions and provided this in response to questions taken on notice:

> The NSWFB submits that the expert opinion of the principal author of the Harvard paper cited by British American Tobacco Australia in its submission and the advice of Denis Choinere, Director of Regulations and Compliance for Health Canada, and Dr J Hall of the NFPA refute the assertion by British American Tobacco Australia that LIP [low ignition propensity] cigarettes may in practical terms be more toxic than no-LIP cigarettes.
>
> The NSWFB further submits that the information in the British American Tobacco Australia submission in this regard does not provide any grounds whatsoever upon which a move to reduce fire risk cigarettes could, or should, be opposed.[228]

**4.97** Commissioner Mullins reiterated to the Committee the importance of striving for an Australian standard for reduced fire risk cigarettes:

> I hope that the Committee will recognise that fires and the resulting deaths, injuries and property and environmental damage are a consequence of the current design of

224 Commissioner Mullins, Evidence, 5 May 2006, p18

225 Commissioner Mullins, Evidence, 5 May 2006, p18

226 Commissioner Mullins, Evidence, 5 May 2006, p18

227 Submission 46, British American Tobacco Australia, p18

228 Answers to questions on notice taken during evidence 5 May 2006, Commissioner Greg Mullins, NSW Fire Brigade

> cigarettes. I hope that the Committee will support the introduction of an Australian standard, and then national legislation, that allows only reduced fire risk cigarettes to be manufactured, imported or sold in Australia. As a fire chief, I know that those measures will save a lot of lives. [229]

**4.98** The Committee recognises the work undertaken by the NSW Fire Brigades and acknowledges the potential life saving goal of the reduced fire risk cigarettes. We support the development of an Australian standard and development of national legislation to ensure only reduced fire risk cigarettes are sold in Australia.

**Recommendation 12**

That the NSW Fire Brigades continue its work to pursue an Australian standard for reduced fire risk cigarettes.

**Recommendation 13**

That the Commonwealth be requested to introduce legislation to allow only reduced fire risk cigarettes in Australia.

## Effectiveness of the strategies

**4.99** One of the Committee's terms of reference is to examine the effectiveness of strategies to reduce tobacco use. While the Committee did not receive detailed evidence evaluating each of the above mentioned strategies other than that relating to the media campaigns run by the Cancer Institute NSW, general comments can be made on the basis of trends in smoking prevalence rates. As highlighted in Chapter 2, prevalence rates have been decreasing in New South Wales, suggesting that tobacco control strategies have generally been effective.

**4.100** Professor Bishop of the Cancer Institute NSW reported that quit campaigns are effective in terms of dropping the smoking rates and reducing the costs of tobacco smoking related illness on the New South Wales community:

> We think Quit campaigns are very effective. Collins and Lapsley have done an economic review of the effects of smoking which shows that about $6.6 billion a year is spent in New South Wales on smoking-related illness and people dying early—all of the economic effects. We have estimated that as smoking rates drop by 1% a year over a five-year period the economic return to New South Wales would be between $2.3 billion and $5.8 billion. So the money we spend to drop the smoking rate by 1 per cent, which is essentially what we have achieved over the last year, is very effective in terms of health economics …[230]

**4.101** Ms Purcell of NSW Health observed that comprehensive programs are important and that an extensive, multifaceted approach to tobacco control has been effective with all the strategies working together to address tobacco use:

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229 Commissioner Mullins, Evidence, 5 May 2006, p18

230 Professor Bishop, Evidence, 21 March 2006, p35

> I think what the evidence shows us that with regard to tobacco control and our experience over the last 30 years is that the most important thing is having a comprehensive program, and that includes things around pricing, it includes the legislative initiatives around advertising restrictions, it includes sales to minors, it includes the ETS restrictions, and it includes supporting smokers to quit. I think that all those elements actually combine to give you the most effective program. It is quite difficult to identify the impact of one initiative at a given point in time. It is actually the package and having a comprehensive range of initiatives that seems to be the most important thing.[231]

**4.102** The Cancer Institute NSW highlighted that unlike many other areas of public health, there is little debate about the best way to tackle the tobacco problem:

> The seven components of a comprehensive strategy were laid out more than 40 years ago in the landmark 1962 Smoking Health report of the Royal College of Physicians, which made recommendations for government action:
>
> - public education
> - restrict sales to minors
> - restrict tobacco promotion
> - restrict smoking in public places
> - increase tobacco tax/price
> - consumer information and product regulation
> - cessation support services.[232]

**4.103** The Committee heard that all of these interventions are necessary and they act synergistically to reduce smoking rates in a population. However, as the evidence base has grown over the intervening decades, it has become clear that public education, restricting smoking in public places and increasing tobacco tax/price are the most powerful at a population level. [233] The former two measures are focus areas in New South Wales, while the tobacco excise (66% of the price top selling brands) is in place and administered by the Commonwealth Government.

**4.104** While broad smoking prevalence has reduced rates among certain groups, there has been very little change over time for Aboriginal people for example, which indicates to the Committee that more needs to be done to target such groups, as recommended earlier in this chapter.

**4.105** Professor Bishop reminded the Committee that even though smoking rates are decreasing there is more to do and it is imperative to keep the pressure on to ensure rates continue to decrease:

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231 Ms Purcell, Evidence, 5 May 2006, p5

232 Submission 22, p8

233 Submission 22, p8

> While we feel that we are going in the right direction—I think we would all agree that it is not fast enough—we are concerned that the pressure is maintained. There is evidence that if the pressure is taken off in terms of trying to take the message forward about the health effects of smoking then it is possible that smoking rates could level off or go up. After very good effects in the late 1980s or early 1990s there was a levelling off of the prevalence of smoking as some of the campaigns lost some of their steam. I would be concerned that the pressure is maintained. I do not know that there is a stubborn group of smokers; I believe we ought to be able to reduce smoking substantially. Our aim would be to go well below 10%. Just remember, it is the aim of the UK to try to get it down to 28%. They are the sorts of differences that we are dealing with around the world. [234]

**4.106** The evidence presented to the Committee is clear that tobacco control needs to be comprehensive, well funded, multifaceted and long term. As noted earlier in this chapter, strategies aimed at the broad population must also be appropriate and accessible to high risk groups. At the same time, certain population groups, including Aboriginal people, young people and culturally and linguistically diverse communities, will necessarily require a tailored and targeted approach. The Committee believes that this has been recognised by the NSW Government and that comprehensive strategies have been developed and implemented.

**Recommendation 14**

That the NSW Government continue to take a comprehensive, multifaceted approach to further reduce the prevalence of tobacco smoking in New South Wales.

### Research, monitoring and evaluation

**4.107** Research, monitoring and evaluation are identified in the *NSW Tobacco Action Plan 2005-2009* as essential to reducing tobacco use as they provide information to policy makers and enable an assessment of the impact of policy on the community. Research also enables the development of new medical interventions and strategies.[235] The Committee heard some evidence on research, monitoring and evaluation as well as the related issue of data collection, mentioned earlier in Chapter 2.

**4.108** The *NSW Tobacco Action Plan 2005-2009* indicates that evaluation and monitoring programs will be conducted in the areas of smoking cessation, exposure to environmental tobacco smoke, compliance with legislation, and monitoring policy implementation in New South Wales.[236]

**4.109** The Committee was advised that the Cancer Institute NSW takes a prominent role in cancer research in New South Wales and is putting approximately $7 million into trials to improve new cancer therapies. Many of these are focused on lung cancer.[237]

234 Professor Bishop, Evidence, 21 March 2006, p35

235 *NSW Tobacco Action Plan 2005-2009*, p40

236 *NSW Tobacco Action Plan 2005-2009*. p41

237 Professor Bishop, Evidence, 21 March 2006, pp34-35

**4.110** In relation to specific tobacco control research, Ms Anita Tang, Director, Health Strategies, Cancer Council NSW, commented that New South Wales should consider Victoria's approach:

> Victoria leads the way in this; it has an enviable infrastructure and track record in tobacco control research. It is able to develop and use empirical data to guide and develop new tobacco control policies and strategies. It is able to evaluate the impact of campaigns that it runs in a very robust way. It is able to monitor changes in smoking behaviour and attitudes on a regular basis so that they have tracking data. To achieve this, you need a financial investment from several parties. In Victoria between $3.8 million and $5.5 million is spent per annum on tobacco control research with around half of that contributed by the Government.[238]

**4.111** As stated earlier in this chapter, evaluation is undertaken by the Cancer Institute NSW in relation to anti-smoking media campaigns and the Quitline (refer to Table 4.1). The Committee has noted that in the future, the Cancer Institute will also be supporting the Quitline to undertake follow-up with callers at six and 12 months in order to establish the long term effectiveness of this initiative. [239]

**4.112** An issue of concern raised by some members of the Committee and outlined in Chapter 2 is that of the reliance on self-reporting surveys, in which people report on whether or not they have quit smoking and for how long, for measures of the extent of the problem of tobacco smoking. Some people argue that consumption or sales rates of tobacco products may be a better indicator of smoking rates and the effectiveness of strategies in reducing them. Information on sale figures for tobacco products and smoking rates was provided by the Cancer Institute NSW in their response to questions taken on notice, as outlined in Chapter 2.

**4.113** Ms Kate Purcell, Acting Director, Centre for Chronic Disease Prevention and Health Advancement, NSW Health, advised the Committee that NSW Health monitors prevalence data using a consistent methodology, but acknowledged that tobacco sales and prevalence data may differ:

> We look at the trend of prevalence over time to see whether it is in fact rising or falling. The impact of the sales data probably would require some further analysis to actually determine the impact and the difference between prevalence and sales data. [240]

**4.114** On a different issue, the Committee noted that there has been different spending on quit programs in different states, yet the rates of smoking between states have not varied very much. It might be reasonably expected that more money spent on tobacco control strategies would lead to a greater reduction in smoking rates. NSW Health was asked to comment on this and Ms Purcell indicated:

> It is my understanding that all States monitor the elements of their tobacco control programs. Of course, I can only comment on NSW, but we have an ongoing system

238 Ms Anita Tang, Director, Health Strategies, Cancer Council NSW, Evidence, 21 March 2006, p8

239 Ms Kate Purcell, Acting Director, Centre for Chronic Disease Prevention and Health Advancement, NSW Health, Evidence, 5 May 2006, p5

240 Submission 22, p12

> of evaluating and monitoring our investment and our programs in terms of impact on quitting.[241]

**4.115** Based on the limited evidence that the Committee received on the issue of research and monitoring, we note the importance of this work to evaluating and informing tobacco control policy, thereby improving the ability to reduce smoking prevalence rates in the New South Wales community.

**4.116** The Committee notes that evaluation of tobacco control strategies is a focus area for the *NSW Tobacco Action Plan 2005-2009* and that the overall approach of tobacco control in New South Wales appears effective in reducing smoking rates. While there is reasonable data by which to judge the overall approach to tobacco control in New South Wales, it appears that strategies other than the Quitline and media campaigns have not been systematically evaluated. We consider that more evaluation of individual tobacco control strategies is necessary in order to establish how effectively and efficiently specific measures are reducing tobacco use in the New South Wales community.

**Recommendation 15**

That the NSW Government undertake more evaluation of individual tobacco control strategies to establish how effectively and efficiently they are reducing tobacco use in the New South Wales community.

**4.117** In the Committee's view it is important that there be comprehensive national data available to provide a thorough and reliable picture of tobacco consumption in Australia and to contribute to evaluation of tobacco control strategies. It would be appropriate for the Commonwealth Government, with the support of all jurisdictions, to ensure that this is available, integrating data on prevalence, sales and consumption including that currently collected and reported by the AIHW and Australian Bureau of Statistics. We also consider that it maybe valuable for the Commonwealth to invest in a research strategy that investigates and compares the impact of each jurisdiction's policies upon prevalence rates.

**Recommendation 16**

That the NSW Government, through the Council of Australian Governments, request the Commonwealth Government to analyse and publish comprehensive national data on tobacco use over time, including sales and consumption data.

**Recommendation 17**

That the Commonwealth Government invest in a research strategy that investigates and compares the impact of each jurisdiction's policies upon prevalence rates.

241 Ms Purcell, , Evidence, 5 May 2006, p5

# Chapter 5 The packaging, sales and display of tobacco products

With tobacco advertising in the traditional sense having been banned for some years, a number of inquiry participants highlighted that the retail environment is now the primary vehicle for the marketing of tobacco products. This chapter considers a range of issues in relation to the sales and display of tobacco. It starts by documenting the State and Commonwealth responsibilities in this area and exploring the Commonwealth-regulated issue of tobacco packaging. It then documents the evidence before the Committee about the context of retail sales. The chapter then examines and makes recommendations on initiatives in relation to sales to minors, the licensing of tobacco retailers, the display of tobacco products, and cigarette vending machines.

## Commonwealth and state responsibilities

**5.1** As noted in Chapter 3, both the State and Commonwealth Governments have responsibilities in relation to advertising, promotion and display of tobacco products.

**5.2** The publication and broadcasting of tobacco advertisements is prohibited under the *Tobacco Advertising Prohibition Act 1992 (Cth)*. This Commonwealth legislation focuses on advertising in the broad and traditional sense, such on television, radio and the print media, billboards and so on. This is complemented at the State level by provisions in the *Public Health Act 1991 (NSW)* which makes similar provisions prohibiting advertisements in the media, along with the promotion of tobacco through competitions, fee samples and sponsorships. The latter Act also regulates the sales and display of cigarettes through vending machines.

**5.3** The State Government is responsible for regulating point of sale requirements such as the signage, advertising and display of tobacco products. This is provided for in the Public Health (Tobacco) Regulation (1999) (NSW).

**5.4** Regulation of the packaging of tobacco products is a Commonwealth responsibility, via the Australian Competition and Consumer Commission, through the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 1994 (Cth).

## Cigarette packaging

### Graphic health warnings

**5.5** The Committee's inquiry coincided with the commencement of new graphic health warnings on cigarette packages from 1 March 2006, under the Commonwealth's Trade Practices Regulation noted above. The warnings are now compulsory on all cigarette and tobacco packets, and carry full colour images including a gangrenous foot, emphysema, mouth and throat cancer, lung cancer, blocked arteries, and a premature baby. There are 14 images in total, with seven to be rotated in the first year and a further seven in the second. The image and accompanying message take up 30% of the front of a cigarette packet and 90% of the

back. Each warning also carries the Quitline logo and phone number. Manufacturers and retailers have no choice over which packages or images they display.[242]

**5.6** Professor Bishop of the Cancer Institute NSW explained the new warnings were informed by evidence from Canada that smoking prevalence rates reduced as a result of similar images, and were intended to 'make an emotional connection' with smokers, prompting them to think about the health effects of smoking when they pick up their packets.[243] He also informed the Committee that the Cancer Institute launched a television advertising campaign to coincide with the commencement of the graphic health warnings, with the aim of maximising their impact:

> The Cancer Institute is about to launch a campaign which will make the images come alive on television. I am sorry to inflict that on the population of New South Wales, in a way, but we think it will be very effective. Therefore we can build on what's there and again it is part of a comprehensive approach where we pick up something that works well, extend it and see if we can get more value from doing it.[244]

**5.7** A number of inquiry participants commented favourably on the images, anticipating that they will be effective in achieving their aim. The Australian Medical Association (AMA) NSW suggested that the images might be even bigger, taking up half the front of the pack rather than a third.[245]

**5.8** In its submission, British American Tobacco Australia did not refer specifically to the graphic health warnings but did refer to health warnings in broad terms, indicating that it supported:

> … the provision of meaningful and effective information for consumers about the risks of smoking. We believe that governments must play a central role in determining and providing health information to consumers, while tobacco companies should assist governments in implementing messages required by government.[246]

**5.9** Imperial Tobacco Australia's submission was more critical of the graphic warnings, arguing that, rather than a method of enhancing consumer understanding, they are 'an unwarranted attempt to vilify and embarrass smokers.'[247] It suggested that the new images are unlikely to have any more effect in informing consumers of the risks of smoking than the previous ones, citing evidence from Canada to support this,[248] and argued against what it sees as 'the erosion of our intellectual property rights and trademarks through ever increasing and intrusive

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242 Submission 26, Imperial Tobacco Australia Limited,

243 Professor Jim Bishop, Chief Executive Officer, Cancer Institute NSW, Evidence, 21 March 2006, p30

244 Professor Bishop, Evidence, 21 March 2006, p30

245 Professor John Gullotta, President, Australian Medical Association, Evidence, 21 march 2006, p20

246 Submission 46, British American Tobacco Australia, p22

247 Submission 26, Imperial Tobacco Australia, p11

248 Environics, 2001a, *Baseline Surveys: the health effects of tobacco and health warning messages on cigarette packets, Final Report*; Environics, 2001b, *Evaluation of new health warnings on cigarette packa*ges, prepared for Canadian Cancer Society, cited in Submission 26, p11

warnings and pictures, together with the other information we are required to include on our packs'.[249]

**5.10** Having considered the evidence raised during this inquiry, the Committee strongly supports the Commonwealth Government's graphic health warnings initiative, as well as the NSW Government sponsored television campaign to coincide with it.

### Generic packaging

**5.11** Several inquiry participants raised the possibility of generic packaging of tobacco products. According to the Cancer Council NSW:

> The packaging of tobacco products has always been of the utmost importance to the tobacco industry as a marketing tool. This has especially been the case in Australia since most traditional forms of tobacco advertising and sponsorship were banned under the (Commonwealth) Tobacco Advertising Prohibition Act.
>
> Tobacco companies know the importance of pack colour, design and name to communicate the 'personality' of the brand to consumers … The banning of branded tobacco packaging and the requirement that all tobacco products be sold in generic packaging would be an effective way of undermining the impact of tobacco marketing through pack design and brand colours. As Wakefield et al stated "Without brand imagery, packs simply become functional containers for cigarettes, rather than a medium for advertising."[250]

**5.12** Other organisations and individuals who supported the introduction of generic packaging as a means of overcoming packaging as a marketing tool included the AMA NSW, Mr Michael Stevens and Mr Brian Robson, with the latter suggesting that the packaging be coloured 'vomit yellow', a colour shown in research to be least attractive, with the cigarette's brand name in a uniform font type and size.[251] Professor Jim Bishop and Ms Trish Cotter of the Cancer Institute NSW also supported generic packaging as a next step, with Ms Cotter explaining:

> I think that is the next thing to look at. When we see the effect of the new graphic health warnings now, I think that is the next opportunity for governments to look at. The packet is the product and the main advertising vehicle for the product. It is the image that goes with it that people associate it with. So, if you break that connection between the image and the product, hopefully you will have an effect on the product's appeal.[252]

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249 Submission 26, p11

250 Wakefield M, Morley C, Horan JK and Cummings, KM, 'The cigarette pack as image: new evidence from tobacco industry documents, *Tobacco Control*, 2002, No 11, P73-80, quoted in Submission 49, The Cancer Council NSW, pp10-11

251 Submission 19, Australian Medical Association (NSW Division); Submission 3, Mr Michael Stevens, p3; Submission 67, Mr Brian Robson, p26

252 Bishop and Cotter, 21 March 2006, p34

**5.13** Both Imperial Tobacco Australia and British American Tobacco Australia argued against generic packaging. The former stated in its submission:

> A manufacturer's brands are its most valuable business assets, and proposals to further tamper with branding would result in BAT Australia suffering considerable financial loss. Leaving aside for the moment any constitutional implications of such government action, we believe that such punitive measures are inappropriate, and certainly should not be contemplated in the absence of sound empirical evidence that those proposals are likely to meet legitimate objectives.[253]

**5.14** British American Tobacco Australia went on to argue that further increases in warning sizes, let alone generic packaging, would increase demand for illicit tobacco products while also significantly affecting the value of its brands. In turn, it argued that this would place excessive pressure on the tobacco industry, forcing operations offshore and leading to significant job losses.[254]

**5.15** The Committee is more inclined to be persuaded by the behaviour and health benefits of cigarette packaging initiatives than by concerns about the financial impact on tobacco companies. We have already stated our strong support for reducing the rate of smoking and the health effects of tobacco, and previously referred to economic modelling demonstrating that reductions in tobacco use will have marginal net effect on the economy (see paragraph 2.61). However, we consider that we have insufficient research evidence before us to make a firm recommendation on this issue.

**5.16** In addition, as was alluded to in the above quote from British American Tobacco Australia's submission, the issue of cigarette packaging is a Commonwealth rather than a state responsibility. The Committee understands that the possibility of generic packaging has been considered by the Commonwealth Government in the past and we believe that it would be valuable for it to revisit this issue.

**Recommendation 18**

That the Commonwealth Government give further consideration to the effectiveness of generic packaging of tobacco products.

## The context of retail sales

**5.17** The Cancer Council NSW provided detailed written evidence setting the context for a discussion of retail sales of tobacco products. Its submission stated:

> The retail environment is a critical frontier for tobacco control in Australia – with significant restrictions on formal advertising of tobacco in place, the in-store environment is now the dominant outlet for promotion and marketing of tobacco … [I]t provides the principal avenue for promoting tobacco products, maintaining the

253 Submission 46, p22

254 Submission 46, p23

> product brand identity, provides a trigger to purchase, and can provide price or convenience incentives to purchase.[255]

**5.18** In subsequent communication with the Committee, the Cancer Council NSW suggested that, while significant work in tobacco control has aimed to reduce demand for tobacco, less has been done in relation to supply. Noting the harm that tobacco causes in the community, it argued that tobacco should at least be subject to similar controls as other harmful consumer products such as medication, petrol and pesticides in relation to how, when and where such products may be sold.

**5.19** It also outlined emerging research findings from the Cancer Council's behavioural researchers in collaboration with the Macquarie Graduate School of Management, who are examining where and how different smokers purchase cigarettes. The findings suggest that current retail arrangements sustain smoking rates by including the behaviour of 'people in vulnerable stages of change', that is, experimenting starters, intending quitters and recent quitters. The research also suggests that convenience retailing is a significant hazard for these vulnerable groups. The Cancer Council suggested that people who purchase their cigarettes on impulse are of particular interest because:

- those in the vulnerable stages of change, particularly recent quitters, are over-represented among impulse purchasers
- convenience outlets such as petrol stations, corner stores and vending machines are disproportionately the site of impulse purchasing
- regular, committed smokers are significantly less likely to purchase at convenience outlets. [256]

**5.20** The Cancer Council highlighted a number of issues policy suggestions for sales of tobacco products for which there is strong public support:

> In terms of what the community wants the Government to do to restrict tobacco availability in the community, our surveys show that just over 80 per cent of people are saying that tobacco products are too easy to buy, far too readily available. Over four fifths of people are saying that cigarette vending machines should be banned, and 83 per cent say that tobacco retailers should be licensed … Seventy-two per cent strongly agree with the statement that the Government should reduce the number and type of outlets where tobacco products are sold. A similar number—72 per cent—think that it is not acceptable that tobacco is sold in retail outlets where children frequent. Again, I think that points to some areas where community standards and expectations are ahead of where the Government might be at the moment.[257]

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255 Submission 49, NSW Cancer Council, p7

256 Answers to questions on notice taken during evidence, 21 March 2006, Ms Anita Tang, Director, Health Strategies, The Cancer Council NSW

257 Ms Tang, Evidence, 21 March 2006, p4

## Reducing sales to minors

**5.21** In the previous chapter the Committee documented the prevalence rates of smoking among young people of school age, citing for instance one study that showed that 10.9% of 14-19 year olds in New South Wales smoke daily (see paragraph 4.20).[258]

**5.22** The Children's Hospital at Westmead reported research evidence that approximately 42,800 Australian school students make the transition from experimental smoking to established smoker each year, and that over 90% of individuals who have ever smoked and 70% of established smokers began smoking before 18 years of age. In addition, a 2002 study of secondary school students found that 6% of 12 year old students were established smokers, rising to 35% of 17 year old students.[259]

**5.23** Preventing young people from becoming addicted was seen by many inquiry participants as a vitally important outcome for government to pursue.[260] The AMA NSW told the Committee:

> Smokers who take up the habit early in life are more likely to be heavy smokers, have difficulty quitting and are more likely to contract a smoking related illness. A child who starts smoking at 14 years or younger is five times more likely to die of lung cancer than a person who starts aged 24.[261]

**5.24** The NSW Government submission to this inquiry explains that in this State the sale of tobacco to people aged under 18 is prohibited under the *Public Health Act 1991*, with the *Public Health Amendment (Juvenile Smoking) Act 2002* further prohibiting adults from purchasing tobacco on behalf of minors. The submission reports that a comprehensive sales to minors program has been in place in New South Wales since 1996, and that in the same year the *Public Health Act 1991* was strengthened to require retailers to ask for proof of age to ensure that customers purchasing tobacco products are over the age of 18 years. The legislation is supported by regular training programs for health workers and other enforcement officers, and education to increase awareness amongst the general community, tobacco retailers and young people about the *Public Health Act 1991* and proof of age requirements.[262]

**5.25** Within area health services, Environmental Health Officers are responsible for monitoring compliance with the *Public Health Act* and for initiating prosecution proceedings when breaches are repeatedly detected. Area health services are required to monitor the compliance

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258 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: State and territory supplement*, Australian Institute of Health and Welfare, Canberra, June 2005, p3

259 White V and Scollo M, 'How many children take up smoking each year in Australia?' *Australian and New Zealand Journal of Public Health*, 2003, 27(3), pp359-60; White V and Hayman, J, 'Smoking behaviours of Australian secondary students in 2002, Department of Health and Ageing, National Drug Strategy Monograph Series No 54; *Preventing tobacco use among young people: a report of the Surgeon General*, MMSWR Recommendation Report 1994, 43(RR-4), pp1-10; cited in Submission 36, The Children's Hospital Westmead, p2

260 See for example Submission 48, The Cabinet Office, p15; Submission 3, Mr Michael Stevens, p2

261 Queensland Health, cited in Submission 19, p6

262 Submission 48, p15

of at least 10% of retail outlets in their communities, and to report on this annually to the department.[263]

**5.26** The Northern Sydney Central Coast Area Health Service submission cited evidence for the cost effectiveness of preventing tobacco use through initiatives targeting sales to minors. Compared with the cost of creating an ex-smoker through nicotine replacement therapy, creating a 'prevented non-smoker' through that area's work in relation to sales to minors represented a cost-effectiveness ratio of 1:10.[264]

**5.27** The NSW Government reports that:

> An increase in retailer compliance since 1996 has been observed in most Area Health Services of NSW following retailer education, regular compliance monitoring activities and the publicising of successful prosecutions … Since 1991 there have been over 180 prosecutions in NSW, and between 2000 and 2004 there were 61 successful prosecutions of offences under sales to minors legislation. In 2004-05, there was 84 percent compliance of retailers with sales to minors legislation.[265]

**5.28** The Committee is concerned that these figures in relation to prosecutions are low and stand in contrast to the smoking prevalence figures for young people cited above. They also stand in contrast to the vast numbers of retailers across the state and the information reported by the Commission for Children and Young People that few young people believe that their peers have any difficulty in obtaining cigarettes if they want them.[266] While we appreciate that resources are required to achieve successful prosecutions, we are also concerned by the Government's statement above that an increase in retailer compliance has only been observed in 'most' area health services and the implication that prosecutions are pursued only when breaches are 'repeatedly detected'.

**5.29** A position paper prepared by the National Heart Foundation cites evidence published in the *American Journal of Public Health* that legislation in this area needs to be rigorously enforced in order to prevent violations and send a message to the public about the significance of the issue.[267]

**5.30** The Committee has no detailed data on monitoring or prosecutions in relation to sales to minors available to us, but we took the opportunity to ask Professor John Wiggers, Director of Population Health, Hunter New England Area Health Service, about enforcement of sales to minors in his area. While acknowledging the research evidence that threat of enforcement and actual enforcement increases compliance, he indicated that he could not recall any prosecutions in his area in the past two years or so.[268] This, together with the Northern Sydney

263 Submission 48, p15

264 Submission 51, Northern Sydney Central Coast Area Health Service, p1

265 Submission 48, p15

266 Submission 47, Commission for Children and Young People, p3

267 Forster et al, 'the effects of community policies to reduce Youth Access to Tobacco', *American Journal of Public Health*, 88, pp1193-8, cited in National Heart Foundation position paper, *Tobacco and Cardiovascular Disease*, July 2004, p12

268 Professor John Wiggers, Director, Population Health, Hunter New England Area Health Service, Evidence, 5 May 2006, p3

Central Coast Area Health Service's call for 'rigid enforcement of laws on sales to minors'[269] suggests to the Committee that there is a need for greater enforcement of the legislation.

**5.31** In its submission, the Greater Western Area Health Service provides further insights into this issue, pointing to difficulties associated with the courts as well as the legislation:

> Sales of cigarettes to minors are not trivial offences. They represent adults and organisations assisting young people to develop a smoking addiction which will have an impact on their health for the rest of their life. Unfortunately it appears that the legal system does not support this. Penalties for sales to minors are small and do not act enough as a deterrent. The current fine for selling to minors can be $5500 but this level of penalty has never been imposed. There seems to be a belief that being prosecuted for selling cigarettes to minors is just bad luck rather than an example of regular behaviour. Defendants too easily use Section 10 of the Act to avoid conviction. The courts need to support tobacco control initiatives and the process needs to be outside their control (for example issue of on the spot fines).[270]

**5.32** The Committee was advised that the retailer fines in other jurisdictions ranged from $3,500 to $31,500.[271]

**5.33** The Greater Western Area Health Service also suggested that the recent restructure of area health services may have undermined their capacity to monitor tobacco compliance. It reported that in the past the NSW Health Tobacco Branch funded public health units to undertake this role, but that recently the number of these units was reduced, with only one tobacco compliance officer funded for each of the areas. The Area Health Service suggested that this was not practical in rural areas due to geographical distances, and that the budget provided for this role is insufficient. [272]

**5.34** In their submissions, British American Tobacco Australia, Philip Morris and Imperial Tobacco Australia all noted their support for greater measures to eliminate smoking by minors. Imperial Tobacco Australia suggested stricter penalties for retailers,[273] while British American Tobacco Australia called for greater enforcement of the legislation, a greater role for government in retailer education and the development of programs in line with the recommendations of the 2001 National Expert Advisory Committee on Tobacco report to the Commonwealth Government, *A National Approach for Reducing Tobacco in Australia by Young People Aged Under 18 Years*.[274] Philip Morris suggested that licensing of tobacco wholesalers and retailers would help to ensure compliance with the legislation.[275] The issue of licensing is dealt with in detail in the following section.

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269 Submission 51, Northern Sydney Central Coast Area Health Service, p1

270 Submission 34, Greater Western Area Health Service, p1

271 Mr Simon Beynon, Sales and Franchise Manager, FreeChoice Stores, Evidence, 5 May 2006, p35

272 Submission 34, Greater Western Area Health Service, p2

273 Submission 26, p6

274 Submission 46, pp13-4

275 Submission 23, p2

**5.35** When they appeared before the Committee, retailers were also eager to find more effective ways of preventing the sale of tobacco to under-age people.[276] Mr Simon Beynon of the FreeChoice Tobacconist Stores in Queensland told the Committee about legislation recently introduced in that State which enables minors to be fined up to $1500 for purchasing tobacco, not only retailers.[277] He also reported that Queensland had introduced a form to be signed by both the employer and employee of a store. Both are required to verify that the employee has been instructed not to sell to underage people and advised of the penalty should they be caught doing so.[278] In his submission Mr Beynon suggested a 'three strikes and you're out' system whereby retailers caught a third time lose their license to sell tobacco for a period, say one to three months.[279]

**5.36** Mr Ken Henrick, CEO of the National Association of Retail Grocers, was less inclined towards tougher penalties, insisting that most retailers are abiding by the law[280] and that it is family and friends who are supplying cigarettes to young people.[281] Mr David Killeen of the National Alliance of Tobacco Retailers recommended a voluntary system of education and provision of point-of-sale tools to enable retailers to identify people's age, using identification, based on a model under development in the United States. [282]

**5.37** While the Committee does not have before it detailed evidence on the monitoring and prosecution of sales to minors infringements, it does consider that it has sufficient evidence to justify a concern that New South Wales is not performing as well as it should be in relation to sales to minors.

**5.38** The smoking prevalence rates alone suggest a need to invest more in this area, and this is backed up by anecdotal evidence before our committee. The fact that tobacco manufacturers and retailers agree that sales to minors is an important issue, with the former and at least some of the latter suggesting tougher penalties, lends further weight to this conclusion. We are also concerned by the report that there is now only one officer responsible for compliance monitoring in each of the eight area health services.

**5.39** The Committee considers that a review of current provisions and activities in relation to sales to minors should take place, and that this should include systematic consideration of the effectiveness of current levels of retailer monitoring, the number of prosecutions being initiated, of successful prosecutions, and mechanisms to improve both, the potential for higher fines and use of on-the-spot fines, the adequacy of current resources for area health services to properly fulfil their monitoring and compliance role, the potential for further retailer education initiatives and additional strategies to reduce the prevalence of smoking, including retailer licensing.

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276 Mr Ron Bowden, Executive Director, Service Stations Association, Evidence, 5 May 2006, p45

277 Mr Beynon, Evidence, 5 May 2006, p33

278 Mr Beynon, Evidence, 5 May 2006, p43

279 Submission 24, FreeChoice Tobacconist Stores

280 Mr Ken Henrick, Chief Executive Officer, National Association of Retail Grocers, Evidence, 5 May 2006, p43

281 Mr Henrick, Evidence, 5 May 2006, p36

282 Mr David Killeen, President, National Alliance of Tobacco Retailers, Evidence, 5 May 2006, p43

**Recommendation 19**

That NSW Health undertake a formal review of current provisions to address the sales of tobacco products to minors, with a view to significantly reducing smoking rates among young people. This review should encompass both legislative and operational provisions and should include consideration of:

- the efficacy of current levels of monitoring of retailers
- the number of prosecutions being initiated and of successful prosecutions, and mechanisms to improve both
- the potential for higher fines and use of on-the-spot fines
- the adequacy of current resources for area health services to properly fulfil their monitoring and compliance role
- the potential value of further retailer education initiatives
- further strategies to reduce the prevalence of smoking
- the potential for requiring employers to provide ongoing training to employees in retail outlets.

**5.40** On a different matter, during a hearing the Committee heard that some tobacco products are being aimed at young people, for example strawberry and other fruit flavoured cigarettes. Professor Simon Chapman of the School of Public Health at the University of Sydney, brought along a pack of strawberry flavoured cigarettes for the Committee to examine and commented:

> They are making the taste of cigarettes more palatable to young people when they first start off so that they do not cough and splutter and have a negative reaction. They are adding chemicals to make the smell of cigarette smoke in the air more acceptable to others so that people do not complain. Probably one of the most sinister examples that I have seen recently—and this is something that you can do something about in New South Wales—is a brand of cigarettes called DJ Mix or, in other words, disc jockey mix. It is put out by a small company. This pack is strawberry flavour.[283]

**5.41** In its submission, Imperial Tobacco Australia stated that it does not add anything to its products to make them more attractive to children, but explained that use of flavourings is not uncommon:

> Ingredients may be added to tobacco products during manufacture. Ingredients (for example flavourings typically used in food), are sometimes used in some brands to enhance their overall flavour characteristics and aroma, giving each brand its own distinctive style, in line with consumer preferences.[284]

283 Professor Simon Chapman, School of Public Health, University of Sydney, Evidence, 22 March 2006, p6

284 Submission 26, p13

**5.42** The Committee is aware that there have been discussions as to whether the regulation of cigarette flavourings is a Commonwealth or state matter. While a number of states consider this to be a Commonwealth issue as it is responsible for the regulation of the contents of cigarettes, we understand that the Commonwealth does not share this opinion.[285]

**5.43** The Committee believes that fruit flavoured cigarettes are inappropriate as they are obviously intended to make smoking more attractive to children and young people.[286] The Committee considers that this would be a Commonwealth responsibility and encourages the NSW Government to seek to have the matter addressed through the Council of Australian Governments.

**Recommendation 20**

That the Minister for Health raise the issue of banning overtly fruit flavoured cigarettes with the Commonwealth Government through the Council of Australian Governments.

## Licensing of tobacco wholesalers and retailers

**5.44** A range of inquiry participants recommended that a licensing system be introduced for tobacco wholesalers, and particularly retailers. These participants included non-government organisations such as Action on Smoking and Health (ASH), the Cancer Council NSW, the Royal Australian College of Physicians, as well as the two major tobacco companies, Phillip Morris Limited and British American Tobacco Australia.[287]

**5.45** Professor Simon Chapman told the Committee that, in the absence of a licensing system at present:

> You or I could ring up at morning tea and get as many cigarettes as we wanted delivered to our homes and go and sell them at the football on Saturday afternoon, if we wanted to. That seems to me to be an absurd proposition … By introducing licensing we could build into the contingent renewal of their licences the removal of their licences if they were ever found to be supplying cigarettes to children. The penalty would be that they would lose their ability to sell that extremely lucrative product. That would get them in line very quickly.[288]

**5.46** When retailers appeared before the Committee they expressed mixed views on a licensing system. Mr Simon Beynon of FreeChoice Tobacco Stores said that he could see that licensing may have benefits in allowing enforcement of compliance with the law through the revocation

285 Telephone conversation between Ms Susan Leonard, Health Protection Services, ACT Health, 25 May 2006

286 Professor Chapman, Evidence, 22 March 2006, p6

287 Submission 44, ASH, p4; Answers to questions taken on notice during evidence, 21 March 2006, Question 4, p7; Submission 40, Royal Australian College of Physicians, p4; Submission 23, p2; Submission 46, p25

288 Chapman, 22 March 2006, p9

of licenses, but was concerned that it not be a 'revenue-raising exercise for government.'[289] Mr Ron Bowden of the Service Stations Association was unsure about the benefits or what such a system would involve, but indicated that his association would be prepared to consider a detailed proposal.[290] Both Mr David Killeen of the National Alliance of Tobacco Retailers and Mr Ken Henrick of the National Association of Retail Grocers seemed to prefer a voluntary model but neither spoke explicitly against a licensing system.[291]

**5.47** While Imperial Tobacco Australia saw no value in a licensing scheme,[292] both Philip Morris and British American Tobacco Australia spoke in favour of one. The Philip Morris submission stated:

> [Philip Morris Limited] believes that the manufacture and sale of tobacco products should be subject to a licensing system as a means of making certain that tobacco wholesalers and retailers conduct their business in compliance with standards set by regulation. Such a licensing system would also provide a mechanism to revoke the ability to manufacture and sell tobacco products in the event of non-compliance.
>
> Licensing of tobacco wholesalers and retailers could be a means of certifying that only legitimate and qualified businesses are engaged in the manufacture and sale of tobacco products. Under a licensing system, each participant, from manufacturer to the retail outlet, would be required to register with the government, satisfy basic requirements to participate in the tobacco business and comply with regulations applicable to their category of business. Failure to comply could result in fines and/or revocation of the license to operate.
>
> Licensing facilitates the dissemination of information to regulators about tobacco wholesalers and retailers. Licensing could assist the government in enforcing compliance with legislation and regulation, including prevention of sales to minors and the sale of illicit products such as "chop chop". A database of license holders could also enable regulators to communicate directly with the licensees on their obligations under the law.[293]

**5.48** Philip Morris also suggested that such a scheme could be linked to routine compliance monitoring, enabling a retailer's license to be revoked as a penalty for non-compliance with legal requirements. It also argued for evidence of retail staff training to be a condition of a retailer's license.[294]

**5.49** British American Tobacco Limited was perhaps less enthusiastic but said that it would support a licensing system that met certain 'key requirements' including that:

- the scheme be implemented as part of a broader compliance scheme aimed at preventing sales to minors and illicit trade in tobacco products

289 Mr Beynon, Evidence, 5 May 2006, p45

290 Mr Bowden, Evidence, 5 May 2006, p40

291 Mr Killeen, Evidence, 5 May 2006, p40; Mr Henrick, Evidence, 5 May 2006, p40

292 Submission 26, p12

293 Submission 23, pp2-3

294 Submission 23, p3

- the scheme be national and imposed at the Federal level to ensure a level playing field across all jurisdictions, encompassing tobacco retailers, wholesalers and owners of licensed premised with tobacco vending machines
- individual licenses be issued to outlets rather than to chains or franchises
- fees be maintained at the minimum level required to cover administration costs
- the licensor be granted powers to revoke the license based on conviction of a licensee for any serious breach of the license
- granting of a license be conditional upon a government-sponsored training program on responsible retailing
- the licensor be responsible for ongoing training of licensees in legal compliance and for training inspectors to monitor and enforce the conditions of the licence
- licensees be required to display the license clearly at the point of sale
- the scheme be developed in close consultation with tobacco retailers, wholesalers, manufacturers and hospitality owners, and be the subject of a separate and formal review process coordinated by those stakeholders, prior to any articulation in regulations.[295]

**5.50** In its submission, ASH noted a 2002 report commissioned by the Commonwealth Government as part of the National Tobacco Strategy and endorsed by all jurisdictions through the Intergovernmental Committee on Drugs, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements.*[296] The report argues that there is a strong case for licensing on the basis of the magnitude of harm caused by tobacco, and the fact that unlike other products subject to licensing, such as alcohol, gambling and taxis, there is no safe level of tobacco use.[297]

**5.51** Licensing of this nature is a state or territory responsibility. Western Australia, South Australia, Tasmania and the Australian Capital Territory all have licensing systems for tobacco retailers.[298] Like Victoria, Queensland and the Northern Territory, New South Wales does not.

**5.52** In April 2006 the Minister for Health announced that a new system of notification of tobacco retailers would be introduced in New South Wales, via an amendment to the *Public Health Act 1991*. The notification system will require tobacco vendors to provide information on where their products are sold, the nature of their business and the range of other activities they

295 Submission 46, pp25-26

296 The Allen Consulting Group, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements, December 2002,* cited in Submission 44, p4

297 The Allen Consulting Group, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements, December 2002,* pvii

298 Correspondence from Dr John de Campo, Acting Director General, Western Australian Department of Health, to Director, 27 April 2006; correspondence from Mr Keith Evans, Executive Director, Drug and Alcohol Services South Australia, to Director, 27 April 2006; correspondence from Dr Martyn Forrest, Secretary, Tasmanian Department of Health and Human Services, to Director, 28 April 2006; correspondence from Dr Tony Sherbon, Chief Executive, ACT Health, to Director, 30 April 2006

engage in. The system is intended to enable more effective monitoring and enforcement of retailer compliance with legislation, and to facilitate better information provision and education. The legislative changes will also ban sales of tobacco products from mobile venues including cars, caravans, stalls, tents and market stands.[299]

**5.53** According to ASH, the NSW Government has resisted the introduction of a licensing system for retailers for some time.[300]

**5.54** The Committee acknowledges that the notification system to be developed by the government will facilitate communication between health authorities and retailers, thereby supporting the monitoring of compliance with legislation as well as the provision of information and education. We note, however, that a notification system would not furnish the key advantages of a licensing system identified above and articulated in the 2002 report to the Commonwealth on licensing endorsed by each state and territory government. In particular, the nomination system will not facilitate the enforcement of tobacco control measures such as prohibitions on sales to minors, compulsory point of sale regulations and so on. Nor will it provide a mechanism by which authority to sell can be revoked.[301]

**5.55** According to Professor Chapman, the key argument that people have used against a licensing system is one of cost:

> The opposition to it is always one of cost. People say, "It would be costly to set up a licensing scheme." I take the view that a product that causes such serious harm should be licensed. It is not like selling musk sticks or Chupa Chups; it is selling an addictive drug … As to the issue of who would pay for it, the cost of it should be factored into the cost of a licence.[302]

**5.56** Professor Chapman went on to say that this would have the effect of some retailers not seeking a license as it would not be worth their while,[303] while the Cancer Council NSW suggested it could also provide for government to limit the number of licenses issued, 'providing for natural attrition.'[304]

**5.57** Leaving aside this more controversial suggestion, the Committee considers that there would be significantly more value in a licensing scheme than in a notification scheme in terms of the capacity to regulate the trade of what is known to be a harmful product. A licensing system will facilitate better compliance with and enforcement of the law, thereby helping to limit the negative effects of tobacco, while also offering further remedy against illicit products such as 'chop chop'. We note the tobacco industry's support for a licensing system, and the openness of the retail sector to it.

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299 Submission 48, p15; Dr Denise Robinson, Deputy Director-General and Chief Health Officer, NSW Health, Evidence, 27 March 2006, p59

300 Ms Anne Jones, Chief Executive Officer, Action on Smoking and Health (ASH),

301 The Allen Consulting Group, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements, December 2002,* pvii

302 Professor Chapman, Evidence, 22 May 2006, p9

303 Professor Chapman, Evidence, 22 March 2006, p9

304 Answers to questions on notice taken during evidence, 21 March 2006, Ms Anita Tang, Director, Health Strategies, The Cancer Council NSW , Question 4, p7

**5.58** In relation to the issue of cost, which we presume to be a reason why the NSW Government prefers a notification system at this time, the Committee appreciates that there are two aspects to this: costs to the industry and administration costs. In principle, we consider that such a scheme should be run at cost and not be 'revenue-raising'. While costs to licensees should be minimised, we think it reasonable that they be set at a level which offsets the cost to government of administering such a scheme. We also note the statement in the 2002 report to the Commonwealth that industry concerns about cost could be alleviated through a phased introduction of fees.[305] We further note that in the Australian Capital Territory the annual fee to licensees is $200; in Western Australia it is $185; and in Tasmania it is $87.25.[306]

**5.59** The Committee believes that the NSW Government should reconsider its decision to introduce a nomination scheme for retailers, and that it should implement a licensing system for wholesalers and retailers of tobacco products which facilitates better compliance with and enforcement of the law. In responding to this recommendation we ask the NSW Government to give detailed consideration to the best practice model of licensing set out in the 2002 report.

**Recommendation 21**

That the NSW Government upgrade its intended nomination scheme for retailers to a licensing system for tobacco wholesalers and retailers which facilitates better compliance with and enforcement of the legislation. In doing so, it should consider the best practice model of licensing set out in the report to the Commonwealth, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements.*

## Display of cigarette products

**5.60** In 2004 the NSW Government announced that it would permanently remove tobacco products from view in shops and supermarkets but later reversed this plan. In March 2006 it was reported that the Minister Assisting the Minister for Health (Cancer) the Hon Frank Sartor MP, made this decision on the basis that the Commonwealth Government's initiative to put graphic health warnings on cigarette packets had negated the need for bans on display.[307]

**5.61** As noted at the start of this chapter, the *Public Health Act 1991* and Public Health (Tobacco) Regulation 1996 restrict tobacco advertising at the point of sale and require the mandatory

305 The Allen Consulting Group, *Licensing of Tobacco Retailers and Wholesalers - Desirability and Best Practice Arrangements, December 2002,* pvii

306 Correspondence from Dr Tony Sherbon, Chief Executive, ACT Health, to Director, 30 April 2006; telephone conversation between Mr Michael Jackson, Director, Tobacco Control Project, Western Australia Department of Health, and Acting Director, 13 June 2006; correspondence from Dr Martyn Forrest, Secretary, Tasmanian Department of Health and Human Services, to Director, 28 April 2006

307 Clennell A, 'Sartor ignored ad warning', Sydney Morning Herald, 17 March 2006, cited in Submission 19, Australian Medical Association (AMA) NSW, p10; Submission 49, p7

display of health warnings by retailers.[308] At present, retailers may display two packet facings and one carton of any product.[309]

### Views of those in support of a ban on display

**5.62** A number of inquiry participants criticised the Government's reversal and called for reinstatement of a ban on display of cigarette products, citing several reasons.

**5.63** Several participants such as ASH, the AMA NSW and the Royal Australian College of Physicians took the same position as the Cancer Council NSW documented earlier in this chapter, that displays are a form of advertising or product promotion which influences consumer behaviour.[310] Dr Penman of the Cancer Council told the Committee:

> I think point of sale is one of the major residual loopholes for tobacco advertising. The tobacco industry has put an enormous amount of money into designing product displays that are effectively advertisements … My understanding is that there is a very close level of retail management by the tobacco industry and their distributors to ensure that their product gets the best exposure in the retail venue. These are advertising outlets, not just points of sale … We should not have tobacco products on display in retail venues at all; they should be out of sight. The result of that would be that tobacco sales would diminish. That is exactly why the retail industry is opposing it so vigorously.[311]

**5.64** In material provided to the Committee with its answers to questions taken on notice, NSW Health stated:

> There is an extensive body of research showing that point of sale displays serve many of the traditional functions of advertising, such as:
>
> - increasing smokers' daily consumption by cueing smokers to light up or buy cigarettes
> - reducing current smokers' resolve to quit or consider quitting, and
> - encouraging former smokers to resume their habit by reminding them of their preferred brand every time they visit a store.[312]

**5.65** Both Asthma NSW and Professor Simon Chapman argued that removing cigarette products from display would 'de-normalise smoking'.[313] Asthma NSW contended that the everyday presence of cigarette displays in shops, service stations and petrol stations encourages people to believe that they are acceptable and normal products, and that smoking is a normal activity.

308 Submission 48, p16

309 Public Health (Tobacco) Regulation 1996, cl 8

310 Submission 44, p4; Submission 19, p10;

311 Dr Penman, Evidence, 21 March 2006, pp13-14

312 Paper provided with answers to questions taken on notice during evidence by Dr Denise Robinson, Deputy Director General and Chief Health Officer, NSW Health, 27 May 2006, p4

313 Professor Chapman, Evidence, 22 March 2006, p11; Submission 41, Asthma NSW, p10

By contrast, a ban on display would send the message to the public that smoking is no longer the norm.[314]

**5.66** Professor Chapman noted that many legal products are removed from display for the benefit of the community, for example many pharmaceutical products in chemists. Ms Isabel Lukas, a private citizen and participant in the Committee's public forum made a similar point:

> I urge this Committee to take steps so that cigarette displays in newsagencies, supermarkets and any other outlets are not visible to everyone. They should not be displayed like lollies; they should be out of sight. If you want to buy them, you should have to ask for them. They should be brought from under the counter, open the cupboard and get it out that way. It is not a desirable product. We know that supermarkets position products on visible shelves so that their sales are better. Cigarettes should be out of sight—if you want to buy them, ask for them to be taken out of the cupboard to be given to you.[315]

**5.67** ASH emphasised that banning displays on these 'addictive, lethal products' would help to reduce the take-up of smoking by young people, assist recent quitters to remain resolved and avoid relapse and 'send the message that the government takes the dangers of tobacco seriously'.[316] Ms Anne Jones referred to evidence from the United States that adolescents who see retail advertising at least twice weekly are more likely to experiment with smoking. At the same time she argued that bans on display would not greatly influence the market of established smokers. Here she referred to Victorian research that 80% of smokers know their brand and are not influenced by displays.[317] The ASH submission states:

> The analysis is simple. If displays do not encourage smoking they are unnecessary. If they do encourage smoking they represent a risk to public health. Condoning their ongoing presence in retail outlets is an unethical compromise.[318]

**5.68** Other participants in support of a ban on display included private citizens Mr Michael Stevens and Mr Brian Robson, and the consumer advocacy group, Cancer Voices.[319] NSW Health has summarised the main arguments in favour of a ban as including:

- a significant avenue for advertising tobacco products to smokers and young people will be effectively closed off
- inducements to ex-smokers to resume smoking will be substantially reduced
- there will be no need to develop further regulations on point of sale promotion practices to address identified loopholes

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314 Submission 41, p10

315 Ms Isabel Lukas, Private citizen, 1 May 2006, p15

316 Submission 40, pp3-4

317 Ms Anne Jones, Chief Executive Officer, Action on Smoking and Health, Evidence, 5 May 2006, pp63-4

318 Submission 44, p4

319 Submission 3, Mr Michael Stevens, p2; Submission 67, Mr Brian Robson, p26; Submission 12, Cancer Voices, p1

- monitoring retailer compliance with point of sale restrictions will be significantly simplified. [320]

**Retailers' views**

**5.69** Retailers participating in the inquiry argued strongly against a ban on display. Mr Ken Henrick of the National Association of Retail Grocers disputed that display was a form of advertising and argued that there is no evidence that the display of tobacco products causes people to use them.[321]

> Eighty per cent of the population do not smoke. They are all exposed to the displays as well. Most of the people who do smoke, the 17 per cent or whatever that number is now who are regular smokers, do not make their decision to smoke in front of cigarette displays in shops. They are at the football, they are at home watching television, they are driving the car, they are walking the dog, they are playing with the kids. They make the decision somewhere else and come with the decision made.[322]

**5.70** In its submission, the National Alliance of Tobacco Retailers stated:

> In the instance of the proposed ban on display of tobacco products, no causal relationship between ban and policy objective [has been] demonstrated, nor could the achievement of reduced tobacco consumption overall be shown to result from the proposed ban.
>
> Tobacco-control policies seem to us to be ideologically driven and contrary to the personal freedoms of adults and the entitlement of small businesses to use their commercially valuable private property space as they see fit.[323]

**5.71** Mr Henrick indicated that his association had welcomed the Government's decision to reverse the ban on displays, explaining that tobacco sales comprise a major proportion of the sales of independent businesses. He suggested that perhaps half of the income of smaller grocers is derived from tobacco sales and that, as such, they are dependent on this income.[324]

**5.72** Mr Ron Bowden, CEO of the Service Stations Association noted that there is already a distinction in the way that cigarettes versus other products are displayed, arguing that they are not promoted like other products but are held behind a counter for ease of supply. He also argued that the vast majority of people purchasing cigarettes do so with a specific brand in mind, and as such are not influences by displays.[325]

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320 Paper provided with answers to questions taken on notice during evidence by Dr Robinson, 27 May 2006, p4

321 Mr Henrick, Evidence, 5 May 2006, p36

322 Mr Henrick, Evidence, 5 May 2006, p36

323 Submission 62, National Alliance of Tobacco Retailers, p17

324 Mr Henrick, Evidence, 5 May 2006, p37

325 Mr Bowden, Evidence, 5 May 2006, p 37

**5.73** Mr Beynon of FreeChoice Tobacconist Stores conceded that there may be some reasonable compromise concerning the display of cigarette cartons, but argued against a broader ban on the grounds of the disruption that this would cause for business.[326] He argued that tobacconists need to have ease of access to their products:

> We have over 460 brands of different products in our tobacconists. I would like to put them behind a closed door and have you try to find brand X out of 460 in a four-metre area.[327]

**5.74** Aside from convenience, he also noted that having products not on display could have occupational health and safety implications. Finally, Mr Beynon also contended that it would be counterproductive to the graphic health warnings initiative to restrict the display of tobacco products.[328]

### Tobacco companies' views

**5.75** Each of the three tobacco companies strongly advocated against a ban on display of cigarette products. Their primary concern was that such a ban would be anti-competitive, at the expense of consumers and tobacco companies themselves. Each contended that display serves the purpose of assisting adults to choose between brands. Philip Morris defended the rights of adults who have made the choice to smoke to 'easily see, find and select the brands they prefer at point of sale', and of manufacturers to communicate their trademarks to adult consumers. It also pointed to the Competition Agreement Principles between the Commonwealth Government and each state and territory, that regulations should not restrict competition unless first, the benefits to the community as a whole of such a restriction outweigh the costs, and second, the objectives of the relevant legislation can only be achieved by restricting competition.[329] Similarly, British American Tobacco Australia claimed that display restrictions will limit consumer choice and 'impede competition between tobacco companies.'[330] Imperial Tobacco Australia, which has only a minor market share of tobacco production, stated:

> Regulations restricting or banning outright tobacco displays and point of sale advertising simply make it harder for the smaller manufacturers to compete and to communicate with adult consumers.[331]

**5.76** Like the retailer representatives, each of the tobacco companies questioned that there was evidence that a ban on display will reduce consumption on tobacco products.[332] In addition, both Imperial Tobacco Australia and British American Tobacco Australia were concerned that a ban would hurt retailers, particularly smaller ones, by encouraging customers to purchase

326 Mr Beynon, Evidence, 5 May 2006, p39

327 Mr Beynon, Evidence, 5 May 2006, p39

328 Mr Beynon, Evidence, 5 May 2006, pp34-5

329 Submission 23, p2

330 Submission 46, p24

331 Submission 26, p6

332 Submission 23, p2; Submission 46, p24; Submission 27, p7

their cigarettes from supermarkets, which they will assume stock all brands.[333] The latter also foresaw that the business of tobacconists, whose major share of revenue is from tobacco products, would be disproportionately affected.[334]

**5.77** British American Tobacco also expressed the concern that a ban on display could actually contribute to youth smoking rates by making the restricted products more desirable. Finally, it suggested that by putting all legitimate trade 'under the counter' it could risk people equating legal and illegal tobacco, thereby contributing to growth in illicit trade.[335]

### Other jurisdictions

**5.78** The Committee was advised that bans on display have been introduced in Thailand and in Saskatchewan Province in Canada.[336] No Australian jurisdiction has yet introduced a total ban; the tightest restrictions are in Tasmania, where government regulations have mandated the display of large graphic health warnings at the point of sale. Interestingly, this prompted Coles supermarkets to voluntarily adopt an out of sight policy.[337]

**5.79** The Tasmanian legislation prohibits the display of any product within 75 cm of any other displayed product designed or marketed for the use of a child (such as toys or comics), or within 75 cm of confectionary. Tobacco products may only be displayed within a sales unit, only one of which is permitted in each premises. This may not be on a counter accessible to the public, must be within the service area, and may not display more than 150 packets of cigarettes. The area of display may not exceed $4m^2$. Cartons may not be displayed.[338]

**5.80** A discussion paper released in May 2006 by the Tasmanian Government recommended that tobacco retailers be required to move tobacco products out of public sight, for example by placing them under or above the counter, by storing tobacco in closable drawers or cabinets, by installing moveable doors, shutters or curtains over existing display units.[339] The pictures on the following page illustrate Coles' counter arrangements before and after it adopted its out of sight policy.

**5.81** Western Australia recently introduced further restrictions limiting displays of tobacco products to $1m^2$ for the vast majority of tobacco retailers. Larger display areas have been allowed for those retailers who firstly, derive at least 50% of their income from tobacco sales, and secondly, derive at least 80% of their income from such sales. However, in both cases, the number of retailers covered is very small.[340]

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333 Submission 26, p8; Submission 46, p24

334 Submission 46, p24

335 Submission 46, p24

336 Professor Chapman, Evidence, 22 May 2006, pp2-3

337 Submission 40, pp3-4

338 *Public Health Act 1997 (Tas)*

339 Tasmanian Department of Health and Human Services, *Strengthening Measures to Protect Children from Tobacco: Public Health Act 1997 - Discussion Paper*, May 2007

340 Correspondence from Dr John De Campo, Acting Director General, Department of Health, Western Australia, to Director, 27 April 2006; telephone conversation between Mr Michael Jackson,

**5.82** Queensland has also opted for tighter restrictions, including a limit of one tobacco product displayed per retail outlet. In addition, the maximum size of the display must be no more than $1m^2$ for general retail outlets, while tobacconists may display up to $3m^2$, and no cartons may be displayed.[341] Victoria's restrictions are very similar, apart from that the size of display is limited to a maximum of $4m^2$.[342]

**Picture 5.1: Tobacco product display in Coles Tasmania prior to its out of sight policy**[343]


**Picture 5.2: Tobacco product display in Coles Tasmania after its out of sight policy**[344]


Director, Tobacco Control Project, Western Australia Department of Health, and Acting Director, 13 June 2006

341 Correspondence from Ms Ushi Schreiber, Director-General, Queensland Health, to Director, 25 April 2006

342 Correspondence from Mr PM Faulkner, Secretary, Victorian Department of Human Services, to Director, 17 May 2006

343 Submission 44, attachment

344 Tasmanian Department of Health and Human Services, *Strengthening Measures to Protect Children from Tobacco: Public Health Act 1997 - Discussion Paper*, May 2007, p14

### Tighter restrictions

**5.83** The Committee took the opportunity to ask participants about a compromise position of further restrictions on the display in retail outlets along the lines of the Queensland model, instead of a total ban. Few showed a willingness to meet half way.

**5.84** Imperial Tobacco Australia argued that severe display restrictions would mean that only the largest and most popular brands were put on display, thus reducing consumer choice and disadvantaging smaller brands and manufacturers.[345]

**5.85** Similarly, and in keeping with the arguments put forward by both retailers and manufacturers in relation to a total ban, Mr Henrick of the National Association of Retail Grocers pointed to what he saw as unreasonable and unfair encroachment on retailers' commercially valuable space. Like Imperial Tobacco, he also foresaw a disproportionately negative impact on small business operators, caused by consumers moving to purchase items from larger stores which they assumed would carry all brands.[346]

**5.86** On the health advocate side, when asked about further restrictions instead of a ban, Professor John Gullotta of the Australian Medical Association suggested that tightening restrictions further would not be going far enough:

> I think confusing it with size and percentage is similar to the outdoor enclosed definition. I think we really have to be serious about it and just make a decision and say, "Right, we will just get rid of the point of sale displays."[347]

### The Committee's view

**5.87** It is apparent to the Committee that the protagonists both for and against a ban on display of tobacco products, or even further restrictions on display, are firmly divided into two camps with very little common ground.

**5.88** While we are less convinced by some of the more tenuous criticisms put forward by tobacco retailers and manufacturers, such as that a ban may actually increase young people's smoking rates, the Committee does consider that they have raised a reasonable consideration around the issue of competition. We also acknowledge the impact that a ban may have on retailers and especially small ones. Tobacco companies have perhaps been less up front in acknowledging that their own business and profits may be affected.

**5.89** At the same time, as is the case throughout this report, the Committee is mindful of the significant health effects of smoking and suggests that the health benefits to the community of a ban could arguably outweigh the benefits to competition. We also recognise that the major focus of tobacco control has been on demand-side initiatives that seek to address smoking behaviour, with less effort directed towards supply. The Committee further notes that despite the claims of the tobacco and retail industries that there is no evidence that a ban will impact upon consumer behaviour, such evidence has been raised with us.

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345 Submission 26, p8

346 Mr Henrick, Evidence, 5 May 2006, p39

347 A/Professor Gullotta, Evidence, 21 March 2006, p21

**5.90** Having weighed up the opinions of various inquiry participants, the Committee believes that the Government should amend the legislation to tighten restrictions on display area to one square metre (excluding tobacconists), as is the case in Western Australia and Queensland. We also consider that the definition of tobacconists should reflect that adopted in Queensland.

**Recommendation 22**

That the NSW Government amend the *Public Health Act 1991* to restrict point of sale display to one point of sale per venue and one square meter (excluding tobacconists).

## Incentives to purchase tobacco products

**5.91** Health advocacy groups and smaller retailers were in agreement about the desirability of addressing supermarkets' inclusion of tobacco sales in incentives to purchase. The Cancer Council urged government to take action in this area, which it argued is against the principles of responsible retailing and disproportionately impacts on people from lower socio-economic backgrounds.[348]

**5.92** Mr Ron Bowden of the Service Station Association explained that:

> … two supermarket chains offer a petrol discount reward scheme. If you buy more than $30 worth of goods at their stores they will reward you with a 4¢ discount on petrol purchases. We have an issue with that because if you buy three packets of cigarettes you meet that requirement. You might normally buy only one or two. If you gross up your sale there is a reward in the form of a petrol discount. We think that is contrary to the interests of responsible tobacco retailing.[349]

**5.93** Mr Simon Beynon of FreeChoice Tobacco Stores reported that this arrangement is caused by a 'loophole in the legislation' in each state and territory and works against a level playing field for all retailers. He pointed out Queensland had recently moved to address the issue, and recommended that the same occur in New South Wales.[350] Queensland Health advised the Committee that, as of December 2005, shopper loyalty programs such as Fly Buys and fuel discounts are prohibited from including tobacco products.[351]

**5.94** The Committee considers that this is a principled and practical measure that should also be legislated in New South Wales. We assume that the large supermarket chains that offer such incentives would be sufficiently resourced to meet the small administrative costs that might arise from these arrangements.

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348 Dr Andrew Penman, Chief Executive Officer, The Cancer Council NSW, Evidence, 21 March 2006, p14; Submission 49, p8

349 Mr Bowden, Evidence, 5 May 2006, p44

350 Mr Beynon, Evidence, 5 May 2006, pp44-5

351 Correspondence from Ms Ushi Schreiber, Director-General, Queensland Health, to Director, 25 April 2006

**Recommendation 23**

That the NSW Government introduce legislation to prohibit the inclusion of tobacco products in retailer, and specifically supermarket, shopper loyalty programs.

## Vending machines

**5.95** The final issue in respect of retail sales raised by a number of inquiry participants concerned a potential ban on cigarette vending machines. More than ten years ago, in 1995, the Senate Community Affairs Committee recommended that such machines be prohibited in all states and territories .[352]

**5.96** The current legislative requirements in New South Wales under the *Public Health Act 1991* are that cigarette vending may only be placed within certain areas of licensed premises. Machines may not carry advertising of the tobacco products and must have a health warning 'conspicuously displayed'.[353]

**5.97** A number of participants called for the banning of such machines on the grounds of responsible retailing. The Cancer Council pointed out that vending machines make up a small and declining portion of overall cigarette trade, and that they largely cater to people buying on impulse, who are less likely to be 'committed smokers' and more likely to be recent quitters, experimenting smokers or those who are contemplating quitting. He argued that by targeting vending machines and other 'convenience' retail outlets, the government can discourage smoking among these groups and gain greater leverage on smoking rates.[354]

**5.98** Ms Jones of ASH claimed that a ban on vending machines would help address sales to minors, and pointed out that alcohol, pharmaceuticals and many other products are not able to be sold from machines. As a result, she argued that the availability of tobacco in this way 'sends the wrong message' to the community. Ms Jones also advised that the Australian Capital Territory had recently legislated against vending machines, a provision that will come into effect from September 2006.[355] Like ASH, the Royal Australian College of Physicians called for the *Public Health Act 1991* to be amended to end sale of tobacco products from vending machines.[356]

**5.99** In its submission, British American Tobacco Australia defended vending machines. It suggested that as they are restricted to licensed premises, careful verification of patrons' ages ensures that access is restricted to those over 18. It also noted its support for controls 'including signage, location and access control modification.' The company further argued against a ban on vending on the grounds that it would create a burden on business by increasing cash on site and lead to 'problems of stock security, staff management issues and staff pilferage' which smaller venues would be less able to bear. Finally, it claimed that vending

352 Submission 48, p15

353 *Public Health Act 1991*, s 61F

354 Dr Penman, Evidence, 1 March 2006, p14

355 Submission 44, p4

356 Submission 44, p4; Submission 40, p5

machines actually assists regulation in that it is 'better to regulate the relatively few vending machine operators … instead of 12,000 licensed outlets who would instead be supplying tobacco products "over the counter".'[357]

**5.100** During the Committee's site visit to the Old Fitzroy Hotel, we were advised by the licensee and proprietor, Mr Gary Pasfield, that his business takes in very little money from the vending machine, and that removal of it would make no great impact upon the hotel.[358]

**5.101** The Committee believes that, given our Recommendation 22 for one square metre point of sale display, removal of vending machines from hotels and clubs could result in larger point of sale displays in those venues, which would not be desirable.

357 Submission 46, pp24-5

358 Discussion during informal site visit, 1 May 2006

# Chapter 6 Smoke-free venues

> Since the early 1970s medical and environmental health journals have published evidence on the harmful effects of environmental tobacco smoke (ETS) or passive smoking (inhaling other people's tobacco smoke) ... Tobacco smoke contains over 4,000 chemical compounds and over 60 known carcinogens. Exposure to ETS causes many diseases in non-smokers and can increase the risk of lung cancer, cardiovascular disease and other respiratory diseases. Asthma and cardiovascular disease can also be triggered or worsened even by relatively short periods and relatively low levels of exposure.[359]

This chapter examines the development of the smoke-free legislation, particularly for licensed venues and considers the impact of that legislation on workers, patrons and proprietors, addressing terms of reference (c) for the inquiry. In looking at the impact on patrons, this chapter will also address terms of reference (d), the effects of smoke-free indoor venues on the initiation and maintenance of the smoking habit. The chapter also examines the evidence of inquiry participants in relation to smoking in other public places, such as playgrounds, beaches and entrances to buildings. It begins by providing the accounts of two hospitality workers whose health has been seriously affected by exposure to ETS in their workplace.

## Personal stories

**6.1** The Committee invited Mrs Marlene Sharp and Mr Phil Edge to talk to the Committee about their experiences working in venues where smoking occurred. Both are non-smokers who were exposed to ETS at their place of work. The Committee thanks Mrs Sharp and Mr Edge for sharing their stories.

**6.2** Mrs Marlene Sharp was employed as a bar worker from 1972 to 1995. Mrs Sharp told the Committee:

> Well, the environment was smoky, especially on crowded nights when clubs were busy. In those days, it was about four or five nights a week, which I mostly worked night work, so from 4 o'clock in the afternoon until 1 o'clock in the morning in those days. In those days we weren't very educated about passive smoking or smoking in general because I have never ever smoked - the majority of my friends never smoked - but there were some nights that it was so bad that even your breathing was affected. I used to suffer from sore eyes and headaches and cough, if it was very smoky, and the air-conditioning hardly worked at the club, it kept breaking down, there were no windows in the club at all, and that is how it used to affect me.
>
> I was diagnosed with cancer in 1995. I was operated on and it was on the epiglottis. It was devastating because it made a whole difference to my life because I had to learn to eat and drink again, which is not normal, how you eat and drink. Professor O'Brien did the operation and he was amazed. He said, "This is smoking-related cancer. Have you ever smoked?" I said, "No". He said, "Where have you worked?" I said, "I've worked in a hotel and club for 23 years" and he said, "Well, this is definitely smoke

[359] Submission 48, The Cabinet Office, p12

> related", and … I took it to court and … and it was proven that it [the cancer] was caused through passive smoking …
>
> My future looks pretty bleak because in November last year I was diagnosed with the first stage of emphysema and through the radiation it has affected the jaw bone and I had to get what teeth I had out and my plate, they had trouble putting the plate in because the jaw, through the radiation, the bone is starting to deteriorate and because I am numb here, down there, and it is starting to give me a bit of bother, so no, and they keep saying, "Have you smoked" and I say, "No, I've never smoked" and they said, "Well, your lung is now starting to show that through the smoke, the emphysema is in the first stage". [360]

**6.3** Mr Peter Semmler QC, Mrs Sharp's barrister, advised the Committee that Mrs Sharp was awarded compensation of approximately $460,000. He also advised that she was awarded legal costs of approximately $2 million.[361]

**6.4** Mr Phil Edge was employed in a South Australian pub as a gaming and bar worker from 1998 to 2001. He told the Committee:

> I was employed at an Irish pub called Mick O'Shea's Irish Pub in South Australia. I commenced work there in November 1998 and continued working until June of 2001. That is when I was diagnosed with squamous cell carcinoma of the tongue. I was 24 when I was diagnosed with cancer. I went through a partial hemiglossectomy, which is partial removal of the tongue and wall of the mouth, and a radical right neck dissection. I had my salivary glands removed, my jugular vein removed and also three cancerous nodes around the neck removed. I was in hospital for about three weeks. I had six and a half weeks of follow-up radiotherapy. I had immense problems with infection, countless bouts of antibiotic treatment, bone scans, bone density scans, and basically finished up by having hyperbaric treatment. The problem was they couldn't work out whether there was osteoradionecrosis, which is like a dead portion of the bone in the lower part of the mandible, or osteomyelitis, and it ended up being osteoradionecrosis and the hyperbaric treatment basically sorted that out.
>
> It was not until about a year later, because of problems that I was having, that my treating doctor made it clear to me that it was a causative agent of being in the environment at the pub. He was able to explain to me that the specific type of cancer that I was diagnosed with is also found in smokers. Obviously if you have cancer of the lung, there is an amazing amount of information out there in relation to that and not so much about head and neck cancer. Also with the risk factors that I had, I was not a smoker, I occasionally drank, otherwise very fit and healthy and he was able to draw a few other factors into it, being the duration that I was exposed to cigarette smoke was enough over that period - two and a half-plus years - to be equal to a lifetime smoker …
>
> I [took the case to the] Workers Compensation Tribunal and after quite an extensive argument with them I had a confidentiality agreement in the end. I was successful.[362]

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360 Ms Marlene Sharp, Evidence, 27 March 2006, pp1-7

361 Mr Peter Semmler, Barrister, Evidence, 27 March 2006, p14

362 Mr Phil Edge, Evidence, 27 March 2006, pp2-3 – Mr Edge did not sign the confidentially agreement and the amount of damages is still to be settled.

## Smoke-free legislation

**6.5** According to NSW Health, legislative programs form an important and cost effective component of tobacco control programs and complement other tobacco control activities, while also challenging the acceptability of smoking as a social norm.[363] In New South Wales there are several pieces of legislation that relate to ETS, including the *Smoking Regulation Act 1996* moved by Revd Nile MLC that regulated smoking in public places and places of employment.

**6.6** The *Smoke-free Environment Act 2000* commenced in September that year, providing protection from ETS in most enclosed public places including:

- restaurants and cafes
- schools and colleges
- shopping centres
- hospitals and community health centres
- theatres and cinemas
- fitness centres. [364]

**6.7** Bars in restaurants were required to be non-smoking as of 6 September 2001. Licensed premises (pubs, clubs and nightclubs) and the Star City Casino had a limited exemption from the operation of the Act. Those parts of the licensed premises and the Casino to be smoke-free under the Act included:

- dining areas of a licensed hotel where full table services was provided
- dining areas and function areas (where food was served) of a registered club
- dining areas of a nightclub
- the Casino other than those parts that were used exclusively for gaming machines or a bar area. [365]

**6.8** In 2002 a joint working group was convened to consider the practical implications of reducing or eliminating smoking in licensed premises where smoking was allowed. Members of the group agreed to extend non-smoking areas in licensed venues under an agreement called "Share the Air". This was a voluntary agreement for proprietors of licensed premises and contained provision for:

- no smoking at bar or service counters and a designated non-smoking area within at least one bar area from July 2003
- one full non-smoking bar in venues with more than one bar and one non-smoking recreational or gambling area where more than one of the same type exists in a venue, from July 2004. [366]

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363 <www.health.nsw.gov.au/tobacco> (accessed 22 May 2006)

364 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, p1

365 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, p1

**6.9** In October 2003, the Minister for Science and Medical Research and Minister Assisting the Minister for Health (Cancer) the Hon Frank Sartor MP, announced a subsequent joint working group to develop a plan and timetable for banning smoking in indoor licensed areas.[367] This resulted in the *Smoke-free Environmental Amendment Act 2004*, the Smoke-free Environment Amendment Regulation 2005, and the Smoke-free Environment Amendment (Enclosed Places) Regulation 2006, which provide for three incremental phases that lead up to a total ban in enclosed areas of licensed premises by July 2007 and defined what constitutes an enclosed outdoor area.[368] These amendments have been integrated into the *Smoke-free Environment Act 2000* and the Smoke-free Environment Regulation 2000.

**6.10** Below is an outline of the phased in approach brought in under the *Smoke-free Environment Amendment Act 2004*:

- From 3 January 2005 (formalising the Share the Air agreement) smoking is banned in all dining areas and at all counter and bar service areas and if a venue has:
  - more than one bar then one bar should be non-smoking
  - more than one of the same type of gambling area then one of these should be non smoking
  - more than one recreational room that offers the same game or activity as another then one of these should be non-smoking.
- From 4 July 2005 smoking is banned in toilets, foyers, lobbies, thorough fares, dance floors and auditoria in licensed venues and:
  - in a multi-room venue smoking is allowed in a maximum of one room, whether it is a bar, gaming or recreation room. This smoking room must not exceed 50% of the total of the combined area of bar/gaming/recreational rooms
  - in single room venues smoking is permitted in up to 50% of that bar/gaming/recreational room.
- From 3 July 2006:
  - in a multi-room venue smoking is allowed in a maximum of one room, whether it is a bar, gaming or recreation room. This smoking room must not exceed 25% of the total of the combined area of bar/gaming/recreational rooms
  - in single room venues smoking is permitted in up to 25% of that bar/gaming/recreational room.
- From 2 July 2007:
  - all enclosed areas of hotels, clubs and nightclubs that are open to the general public must be completely non-smoking
  - all areas of the Star City Casino with the exception of private gaming rooms must be non-smoking
  - there will be no other exceptions. [369]

366 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, p1

367 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, p1

368 <www.health.nsw.gov.au/tobacco> (accessed 22 May 2006)

369 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, Tab A

**6.11** In terms of penalties and enforcement, NSW Health advised that the maximum penalty for a person smoking in a smoke-free area is $550. The proprietor is also guilty of an offence with penalties between $1100 and $5500. Environmental Health Officers (EHOs) based in area health service public health units are authorised as inspectors to enforce the legislation. There have been no prosecutions under the *Smoke-free Environment Amendment Act 2004* as at March 2006. [370]

**6.12** The Smoke-free Environment Amendment (Enclosed Places) Regulation 2006 provides guidelines in relation to determining what is an enclosed public place, and when a covered outside area is considered to be substantially enclosed for the purposes of the *Smoke-free Environment Act 2000*. Under the regulation:

- a public space is defined as substantially enclosed if the total area of the ceiling and wall surfaces are more than 75% of its total notional ceiling and wall area
- windows and doors may be counted as open space only if they are locked open with a key to the outside for the duration of trading hours
- a minimum of 10% of the total ceiling and wall area must remain open to the elements at all times
- in determining the total notional area of the ceiling and wall surfaces, include any door, window or moveable structure that is a ceiling or wall – regardless of whether the door, window or structure is open. [371]

**6.13** Under this amendment smoking will be permitted in areas with more than 25% of the above described surfaces not enclosed.

**6.14** In Appendix 4 there is a table comparing ETS legislation in each jurisdiction in Australia and in New Zealand. It demonstrates that New South Wales legislation is not especially restrictive but rather, states such as Queensland and Tasmania are leaders in this area. Also, throughout this chapter there are references to overseas jurisdictions that have addressed the issue of ETS in pubs and clubs, such as New York and Ireland. As the Cancer Council NSW commented:

> There are many international jurisdictions that are ahead of New South Wales in relation to dealing with second-hand smoke in pubs and clubs. There is a long list of governments that have already addressed the issue. I will table for the Committee three reports, one each from Ireland, Norway and New Zealand, a one-year report of their smoke-free pubs and clubs.
>
> In addition to those three jurisdictions, in Canada there are seven provinces that have already introduced or addressed the issue of smoke-free pubs and clubs. Other jurisdictions are England, India, Jakarta, Scotland, Sweden and eight states of the United States of America. There is no shortage of jurisdictions that are ahead of us and from which we could learn. [372]

370 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, Tab A

371 NSW Health, Smoke-free legislation briefing for Committee, 21 March 2006, Tab A

372 Ms Anita Tang, Director Health Strategies, Cancer Council NSW, Evidence, 21 March 2006, p4

## Views on the smoke-free legislation

**6.15** The people in the New South Wales community that are primarily impacted upon by the smoke-free legislation include proprietors of licensed venues, those that work in these venues and patrons. A number of inquiry participants raised issues with the smoke-free legislation, primarily with the Smoke-free Environment Amendment (Enclosed Places) Regulation 2006 (hereafter 2006 Regulation), including representatives of the pubs and clubs industries, health non-government organisations and private citizens. Below is an examination of the issues raised with the Committee.

### Implications of the legislation for licensed venues

**6.16** The issues raised by inquiry participants in relation to the impact of the legislation for licensed venues include:

- that the definition of enclosed places has created confusion
- the perceived absence of a level playing field for different pubs, clubs and restaurants
- the phased in approach and period of adjustment
- the potential for "backsliding" by restaurants
- the impact on business.

#### *Definition of enclosed places*

**6.17** As noted earlier in this chapter, the 2006 Regulation defines what is an enclosed and hence an open space, in which people can smoke, as of 2 July 2007. Participants raised issue with the definition in the regulation suggesting that its lack of clarity will make it difficult for proprietors to determine whether or not they comply with the legislation. The Public Interest Advocacy Centre also stated that 'in practical terms it will also be virtually impossible for patrons and employees to determine whether or not there has been non-compliance, and, if so, to challenge such non-compliance.'[373]

**6.18** Mr Wayne Krelle, Deputy CEO of Clubs NSW, commented that the way the legislation has been written makes it very difficult to read and interpret:

> For the layperson and architects, the way that regulation is written is very difficult to read. I think it is poorly drafted. I was reading some of it before I came in, and it reads like gobbledygook. That is my opinion; I am not legally qualified so I am not able to read it well. The average person trying to interpret the regulation would have difficulty.[374]

**6.19** Legal interpretation of the definition was provided to the Committee by Ms Carol Berry, Solicitor at the Public Interest Advocacy Centre (PIAC). Ms Berry advised that the 75% enclosed rule, with its various specifications about doors, permanently locked open windows and notional ceiling areas is problematic and is likely to be tested through litigation:

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373 Submission 45, Public Interest Advocacy Centre, p6

374 Mr Wayne Krelle, Deputy CEO, Clubs NSW, Evidence 5 May 2006, p10

> For example, in some establishments if the windows are locked open in some kind of weather and then locked closed in other kinds of weather then the smoking or non-smoking status of a room will change. PIAC is concerned that this regulation will only confuse rather than empower consumers to challenge proprietors in relation to determining what should be a smoke-free area. PIAC submits that this regulation will, as a direct result of lack of clarity in determining an enclosed place, result in further test case litigation. The fact that patrons and employees still will not be adequately protected from the impacts of passive smoke will invite challenges to the law. In PIAC's view, because this regulation is unclear, and because it will not protect employees and patrons from the impacts of passive smoking, test case litigation will continue to plague the owners of pubs and clubs.[375]

**6.20** It has been suggested that a simple, more commonsense definition of unenclosed would be more appropriate. Mr Tony Thirlwell, CEO, National Heart Foundation suggested that an open area where people can smoke should be an area with no roof. [376] A/Professor John Gullotta, President of the Australian Medical Association NSW, also supported a more simplified definition:

> All the New South Wales laws are doing is making things more complicated for the owners and managers of pubs and clubs. I still think that we should go for the simple way of doing it: If it is an open area it means it has no roof, so the smoke can get away and it is an unenclosed area. By doing this instead, it creates a red tape, bureaucratic nightmare for everybody and makes it very difficult to enforce.[377]

**6.21** Similarly, the Smoke-free Australia Coalition stated that the 2006 Regulation creates 'a complicated, confusing and unenforceable set of exemptions depending on complex calculations of wall and ceiling areas and ratios.'[378] The difficulty in enforcing the existing legislation was demonstrated to the Committee during its site visit to the Old Fitzroy Hotel. Mr Garry Pasfield, the owner and licensee of the hotel, reported that, during a recent visit by NSW Health inspectors, he was advised his hotel's semi-enclosed smoking area (with a louvered roof) did not comply with the legislation. However, on production of advice from the Australian Hotels Association stating how the area did comply, NSW Health subsequently agreed.[379]

**6.22** The Cancer Council NSW also argued that the current definition is not satisfactory and that as a minimum, an outdoor area should be a place that does not have a ceiling or a roof to inhibit the dispersal of smoke. [380] Dr Andrew Penman, CEO, Cancer Council NSW, indicated that

> [W]e have done some sampling in venues that would comply with the new 75% to 25% rule and we have shown that you get levels of exposure in some of those venues

375 Ms Carol Berry, Solicitor, Public Interest Advocacy Centre, Evidence, 5 May 2006, p25

376 Mr Tony Thirlwell, CEO, National Heart Foundation (NSW Division), Evidence, 22 March 2006, p23

377 A/Professor Gullotta, President, Australian Medical Association NSW, Evidence, 21 March 2006, p22

378 Submission 1, Smoke-free Australia Coalition, p2

379 Secretariat notes on the site visit to the Old Fitzroy Hotel, available on the Committee's website: www.parliament.nsw.gov.au/tobaccosmokingcommittee

380 Dr Andrew Penman, CEO, Cancer Council NSW, Evidence, 21 March 2006, p11

> that are higher than the levels of exposure to a non-smoking spouse living in the same house as a smoking partner. We know from studies that this carries a measurable increased risk of lung cancer of about 25%. So this will not eliminate occupational exposure because we have directly measured the levels that are generated in places like that.[381]

**6.23** Other jurisdictions within Australia, such as Victoria, Queensland and Tasmania all define an enclosed place as a place with a roof or ceiling, therefore it is necessary for there to be no roof or ceiling for people to be able to smoke in an outdoor area.[382]

### *The perceived absence of a level playing field*

**6.24** An issue that was brought to the attention of the Committee during its visit to the Old Fitzroy Hotel was the absence of a level playing field for licensed premises in their compliance with the legislation. Mr Pasfield commented that even though the legislation applies to all licensed venues, older hotels, like the Old Fitzroy, are less able to compete with larger, more modern venues such as large clubs in response to the legislation. The different physical structures and limited space of older hotels means that they are less able to adapt their structure to comply. He argued that it would be better to have a ban that would create a level playing field between older and more modern venues. [383]

**6.25** Mr John Thorpe, President of the Australian Hotels Association NSW, also highlighted this issue for the Committee:

> The architecture of this industry, we're just not McDonald operators. We haven't been built to one specification. You can visit country hotels in any one town and find that the architecture at each and every hotel is different. That is something I am sure all of you understand, so we are trying to cater for everybody ...[384]

**6.26** Mr Krelle of Clubs NSW commented similarly, saying 'we have 1,500 venues, pubs have 2,000 venues and no two are the same. So you are trying to fit a set of, I guess, architectural guidelines to fit every environment. That is a really big ask. It is very tough thing to do.' [385]

**6.27** The Committee acknowledges the concerns of smaller and older hotel owners less able to adjust their physical structure and limited space resulting in an uneven playing field for the hotels and clubs and considers a total ban on smoking would have created a more level playing field. As noted earlier, we also appreciate that the legislation has not been easy for hotels and clubs to apply. Changes to the definition of enclosed places may contribute to a more even playing field but primarily the Committee is concerned with ensuring there is a smoke-free environment for workers and patrons.

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381 Dr Penman, Evidence, 21 March 2006, p11

382 Refer to Appendix 4 Summary of Australian and New Zealand tobacco smoking restrictions

383 Notes on the site visit to the Old Fitzroy Hotel (available on the Committee's website: www.parliament.nsw.gov.au/tobaccosmokingcommittee

384 Mr John Thorpe, President, Australian Hotels Association NSW, Evidence, 27 March 2006, p27

385 Mr Krelle, Evidence 5 May 2006, p10

### *Phased in approach*

**6.28** The Cabinet Office stated that the phased in approach to implementing a total ban on smoking in clubs and pubs was introduced to balance the demands of the industry with public health concerns. They suggest it has also enabled broad public acceptance to be established and allowed proprietors adequate time to adapt to the changes in legislation.[386]

**6.29** Clubs NSW stated in their submission that 'the implementation of a phasing in process of smoking restrictions has enabled not only registered clubs but all licensed premises, to more effectively implement the new smoking restrictions and to successfully educate patrons of the changes to achieve what will be major cultural change.'[387] However, in his evidence Mr David Costello, CEO of Clubs NSW, commented that 'the phase in time frame was a very short period of time compared to other jurisdictions.'[388]

**6.30** Further to this, his colleague Mr Krelle commented:

> With the phasing in, there was no agreement … out of the joint working group in relation to timetable. The unions wanted it in January next year. We wanted it later, in July next year. There was a whole range of different views, but we thought that was a fairly tight timetable, to try to get it completely eliminated from within our premises in the time we were given, which is July next year. We were pushing for a longer time frame. That is on the record.[389]

**6.31** The Australian Hotels Association (AHA) stated in their submission that the 'industry needs time in which to make these adjustments. Our operators need to develop, assess and implement far-reaching plans to rescue their businesses and give them a viable footing.'[390]

**6.32** The Committee recognises that the phased in approach has allowed licensed venues time to adjust to the new legislation and acknowledges that this has meant significant change for some venues. However, it is noted that based on timeframes for implementing similar legislation in other jurisdictions in Australia, New South Wales has had one of the longest phase in periods for licensed venues, with a total of 30 months from 3 January 2005 to the final phase in 2 July 2007. By contrast, Tasmania and the Australian Capital Territory had no gradual phase in period, Victoria had a 15 month phase in period and Queensland had 18 months.[391]

### *The potential for backsliding by restaurants*

**6.33** Another concern raised with the Committee was that even though indoor restaurants are smoke-free there may be potential for some restaurants to allow smoking indoors if they use the definition in the 2006 Regulation. For example, if a room is 25% open smoking would be allowed. Participants referred to this slipping of standards as "backsliding".[392]

386 Submission 48, p14

387 Submission 39, Clubs NSW, p1

388 Mr David Costello, CEO, Clubs NSW, Evidence, 5 May 2006, p8

389 Mr Krelle, Evidence, 5 May 2006, p8

390 Submission 4, Australian Hotels Association, p3

391 Refer to Appendix 4 Summary of Australian and New Zealand tobacco smoking restrictions

392 Ms Tang, Evidence, 21 March 2006, p10

**6.34** Mr Robert Goldman, CEO of the Restaurant and Catering Industry Association NSW, acknowledged that this could occur but commented that he does 'not believe that the intention of this legislation is to turn around and say to restaurants if you want to take out that door and open it up that you can now smoke indoors.'[393]

**6.35** The Committee considers that this legislation does not apply to restaurants and that therefore there is no possibility of backsliding by restaurants to the standards set for other licensed venues.

***Impact on business***

**6.36** The Committee heard that the smoke-free legislation, including those parts that have already commenced, has impacted on the business of licensed venues. During its visit to the Old Fitzroy, the Committee was advised by Mr Pasfield that when the smoke-free legislation came into effect it reduced sales by approximately 60% in the upstairs bar. However, he reported that the hotel's sales have came back over a two year period to an acceptable level (although not to the previous level) as patrons adjusted and also through marketing to a different clientele. [394]

**6.37** The AHA advised in their submission that the hotels in New South Wales 'are presently in the throes of adjusting to the enormous changes that have been brought about by the Smoke-free Environment Amendment Act 2004.' The AHA advised that the restrictions that came into effect on 4 July 2005 have resulted in hotels reporting revenue losses of between 10% and 40% and that further losses are expected when the 2006 Regulation comes into effect from July 2007.[395]

**6.38** Mr David Cass, Consultant to the AHA, outlined for the Committee the impact the smoke-free legislation has on the hotel industry in terms of employment:

> [W]e have also talked about employment losses where, at the very minimum, if there is a revenue downturn because of smoking bans and people not going to hotels, we believe that at minimum there will be at least 10% lost employment and that in round figures equates to 4,000 lost jobs in New South Wales alone.[396]

**6.39** Mr Costello provided the Committee with suggested figures for the impact of the smoke-free legislation on Clubs in New South Wales, stating 'the first full year of the total smoking ban will see a reduction in revenue of clubs of between $300 million to $350 million.'[397] Mr Costello referred to other jurisdictions, such as Victoria, to establish the level of impact of the smoke-free legislation on licensed venues:

> It [Victoria] is the best example we have of how New South Wales will be affected. We need to understand that it was a partial smoking ban that was introduced in

393 Mr Robert Goldman, CEO, Restaurant and Catering Industry Association NSW, Evidence, 27 March, 2006, p48

394 Notes on the informal site visit to the Old Fitzroy Hotel (available on the Committee's website)

395 Submission 4, p1

396 Mr David Cass, Consultant, Australian Hotels Association, Evidence, 27 March 2006, p33

397 Mr Costello, Evidence, 5 May 2006, p10

> September of 2002—with no consultation, with no phase-in period, with no chance to change culture. It was almost an overnight decision by the Victorian Government. I publicly concede that revenue is not the only element that needs to be considered but the revenue loss in Victoria settled at around 13.6% in the first year. That equated to about $360 million in forgone revenue for pubs and clubs, the operators and also the Victorian Government in tax, and approximately 3,000 people lost their jobs. In some parts of Victoria the impact was as high as 40%. Four years on Victoria is still 7% down on the 2002 figures and it is estimated that it will take another two to three years to get back to where they were in 2002. So the effect has been fairly substantial.[398]

**6.40** By contrast, some participants suggested that once licensed venues went smoke-free, more non-smokers would frequent the venues and offset any potential losses from smokers leaving these venues.[399] However, the AHA argued in their submission that an increase in clientele from non-smokers, once the total ban of smoking indoors is in place, is unlikely:

> Adherents of a total prohibition policy towards smoking in licensed venues have traditionally pointed to a 'counter-balancing' injection of revenue that might come from people who are non-smokers and who suddenly want to frequent our venues. AHA (NSW) and our members would welcome this but, regrettably, we must rely on the experience of our overseas and now Tasmanian colleagues, who all report that no such change in consumer habits occurs. [400]

**6.41** The Smoke-free Australia Coalition refuted the comments made by the AHA and Clubs NSW that there will be revenue losses from smoke bans and job losses of at least 10% amounting to 4,000 lost jobs, by commenting that similar predictions were made by hospitality industry organisations in relation to bans in both New York and Ireland, yet neither has experienced job losses. The Coalition's submission stated, 'hundreds of studies and reports worldwide, based on objective data, have established that smoking bans do not harm the hospitality trade.'[401]

**6.42** Professor Simon Chapman of the School of Public Health at the University of Sydney, also disputes the claims of AHA and Clubs NSW and provided research from the United States relating to the positive impact of smoking bans in licensed venues in California and New York:

> Studies show that smoke-free workplace laws have a neutral or positive effect on business. More importantly, these laws have overwhelmingly positive effects on the health of workers and customers. California extended smoke-free workplace legislation to all restaurants and stand-alone bars in 1995 and 1998, respectively. As the ever-increasing taxable sales receipts show [in the graph below], eating and drinking establishments that serve alcohol were not adversely affected by the implementation of a smoke-free policy. In fact, in 2000, establishments serving all

398 Mr Costello, Evidence 5 May 2006, pp11-12

399 Submission 45, Public Interest Advocacy Centre, p9

400 Submission 4, p2

401 Submission 1a, p2

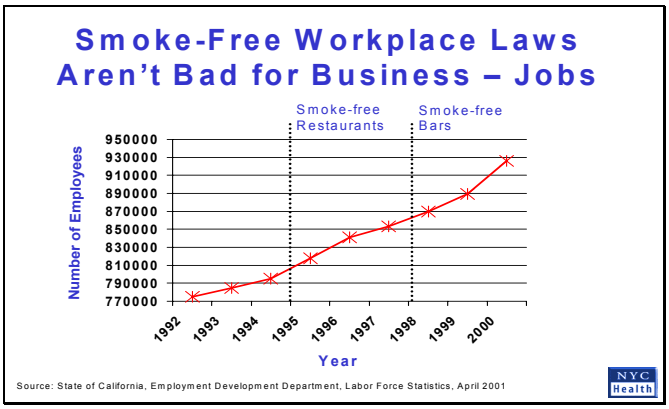
types of alcohol saw an increase of 17% in sales after bars instituted a smoke-free policy in 1998 and a 27% increase since restaurants went smoke-free. [402]

**6.43** Professor Chapman provided the Committee with slides prepared by the New York City Health Department on the impact of smoking bans on the hospitality sector.

**Figure 6.1: Impact of smoke-free bans on businesses in California**[403]


**6.44** Following on from this, Professor Chapman advised the Committee that analyses of economic health measured by growth in the workforce also showed that smoke-free air laws did not hurt California's restaurant and bar industries. California experienced a 19.5% increase in food service workers, compared to a 13.5% increase for all employment statewide over the same period. [404]

**Figure 6.2: Impact of smoke-free bans on jobs in California**[405]




402 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

403 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

404 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

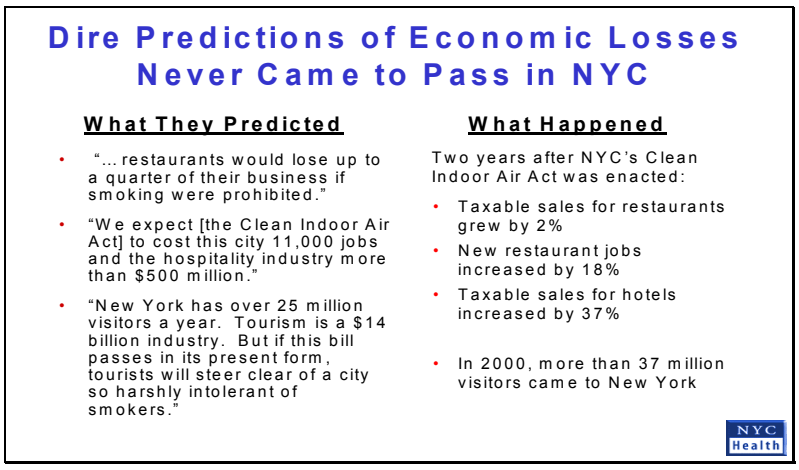
405 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

**6.45** Professor Chapman reported that 26 well-designed studies have found either a neutral or a positive impact of smoke-free workplace legislation on business. He contended that measures have included all objective available data on sales and employment, and have analysed a wide variety of jurisdictions including New York City after most restaurants went smoke-free in 1995. Professor Chapman contended that of the six studies that reported a negative impact on restaurants or bars after they went smoke-free:

- five of these six studies were sponsored by the tobacco industry and all were flawed methodologically
- design flaws included the omission of relevant data, lack of baseline and trends data, inappropriate selection of study periods, and biased selection of comparison time periods
- the decline in sales receipts reported in the single remaining study disappeared when several years of data were analysed. [406]

**6.46** Professor Chapman summarised by suggesting 'the truth is that there is no country or state which experienced negative economic impact after a smoking ban in bars and restaurants.'[407] The slide below suggests that the predictions of economic loss for businesses in New York City did not eventuate.

**Figure 6.3: Predictions of economic loss for businesses in New York City**[408]




**6.47** The Committee took the opportunity to ask Mr Robert Goldman, CEO of the Restaurant and Catering Industry Association NSW, about the impact that bans on smoking in restaurants had on his industry. Mr Goldman commented that after the smoking ban came into place for restaurants in September 2000 the downturn in income for restaurants lasted for about two years, until October 2002, but subsequently improved. Mr Goldman suggested that 'since 2002

406 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

407 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

408 Answers to questions on notice taken during evidence 22 March 2006, Professor Simon Chapman, School of Public Health, University of Sydney, slide presentation

[there has been] enormous increases in disposable income for the population that has enabled them to have greater expenditure of non-discretionary income into restaurants. That has resulted in higher turnover in the industry.' [409]

**6.48** On the basis of his experience, and that of other states, Mr Goldman predicted that while there will be a time of adjustment for licensed venues, patrons will continue going to pubs and clubs:

> Back in, 2003 in Victoria when they initially brought in the no smoking [ban]… there was a drop. The following year, after they adjusted, people changed … The minute you become non-smoking, people are not going to stop going to pubs, it is part of our culture and it should always remain part of our culture.[410]

**6.49** The Committee acknowledges the concerns of the pubs and clubs industry and recognises that there may be some initial downturn in business as a result of the legislation. However, based on the evidence in other jurisdictions it would seem that is not always the case as demonstrated in California and New York City. Further, the experience of restaurants in New South Wales is that after an initial downturn business has improved. In addition, the Committee considers that any loss by the industry can be outweighed by the health and economic benefits to the New South Wales community as a whole. We are also very concerned to protect the health of workers in pubs and clubs, as is explored below.

### Implications of the legislation for workers in licensed venues

**6.50** Many inquiry participants raised the issue of the impact of the smoke-free legislation on workers. They were concerned that the smoke-free legislation has taken too long to be enacted and that it is not a total ban, due to smoking still being permitted in areas that are 25% open which will mean that workers are still exposed to ETS. Specifically, participants argued that the legislation conflicts with occupational health and safety requirements leaving workers subject to serious health risks and employers open to litigation, such as the examples of Mrs Marlene Sharp and Mr Phil Edge.

**6.51** Mr Mark Lennon, Assistant Secretary of Unions NSW, indicated that about 60,000 people work in the hospitality industry and are affected by the legislation:

> Not only do we have members who are directly employed in the hospitality industry … but also people who are in other areas such as service delivery, tradespeople, commercial travellers and those in the entertainment industry all end up at some stage working in pubs and clubs...[411]

**6.52** Mr Lennon commented that the 2006 Regulation will not protect the health and safety of workers in the hospitality industry and that 'we do not believe it matches the promises made by the Government with regard to banning smoking in pubs and clubs.'[412] Mr Lennon emphasised the profound health risks of ETS for workers, stating, 'a redundant worker can be

409 Mr Goldman, Evidence, 27 March, 2006, p48

410 Mr Goldman, Evidence, 27 March, 2006, p48

411 Mr Mark Lennon, Assistant Secretary, Unions NSW, Evidence, 27 March 2006, p34

412 Mr Lennon, Evidence, 27 March 2006, p34

re-employed. A worker who is dead as a consequence of contracting lung cancer cannot.' [413] The unions stressed to the Committee that 'if it is good enough in other workplaces to eliminate smoke from the workplace environment, why is it not good enough to do so in pubs and clubs?'[414]

**6.53** Mr Phil Edge who, as noted above, developed cancer as a result of exposure to ETS at work, stated that there is a need to protect hospitality workers, as young people may not be aware of the dangers of working in an environment with ETS:

> Obviously my perspective is that, being a healthy person as I was before and going to a smoky environment, I was probably being a little naive and not thinking that anything would go wrong and later down the track it has, so my point would be that people who think that they won't be subjected to any harmful effects of passive cigarette smoke, well, they are dreaming, so, yes, definitely a full ban would help.[415]

**6.54** Ms Anita Tang, Director, Health Strategies, Cancer Council NSW, advised the Committee that the occupational exposure to second-hand smoke in pubs and clubs leads to about 75 deaths per year of bar and club workers. [416] Another participant suggested to the Committee that 'for a person working in a bar for eight hours that is equivalent to smoking half a packet of cigarettes, and we cannot ask bar workers to put their health at risk.'[417]

**6.55** Other health non-government organisations such as the Australian Medical Association NSW were similarly concerned about the need to better protect workers health:

> These men and women are forced to be exposed to the harmful effects of ETS, day in and day out, as part of their work. If this is the only issue we look at, I think it is an occupational issue where it is not fair for them to be exposed to this risk—and the risks are well known.[418]

**6.56** The Committee received a number of submissions from entertainers who work in licensed venues, each of whom emphasised the impact of ETS on them.[419] During the public forum a number of people who work in licensed venues were concerned for their health and the likely impact of the legislation. One participant, Mr Bob Daisley, a musician, stated 'it's obvious that our NSW Government is buckling under pressure from the club and hotel owners by allowing smoking in places that are up to 75% enclosed contrary to laws in place to protect those

413 Mr Lennon, Evidence, 27 March 2006, p34

414 Mr Lennon, Evidence, 27 March 2006, p34

415 Mr Edge, Evidence, 27 March 2006, p8

416 Ms Tang, Evidence, 21 March 2006, p10

417 Ms Mimi St John-Austen, Acting Chief Executive Officer, Asthma Foundation NSW, Evidence, 22 March 2006, p21

418 A/Professor Gullotta, Evidence, 21 March 2006, p22

419 Submission 61, Mr Rick Melick; Submission 60, Mr Tony Williams; Submission 56 Mr Ross Hamilton; Submission 55, Ms Jessica Mann; Submission 54 Ms Aviva Sheb'a; Submission 50, Mr Levi Foster

affected. Why are other musicians, hospitality staff and I the exception to being protected in our workplace?'[420] Mr Luke Whitington, previously a hospitality worker, contended:

> New South Wales should adopt the smoke-free laws currently in effect in Queensland, which would ensure that no worker has to come in contact with tobacco smoke. This would also prevent the incongruous situation where the regulations attached to the Smoke-Free Environment Act 2000 allowing smoking in 75% enclosed spaces are in direct contradiction to the Occupational Health and Safety Act 2000, in particular, the Occupational Health and Safety Act 2000, part 1 (3), Objects, (c), "to provide a safe and healthy work environment for people at work that protects them from injury and illness and that is adapted to their physiological and psychological needs".[421]

**6.57** A casino worker, Ms Sharon Eurlings, also spoke at the public forum on the issue of pubs and clubs, along with the exemption to allow smoking in the high rollers section of the Star City Casino:

> Regulations attached to the Smoke-free Environment Act still allow bar staff, musicians, hospitality and promotional staff to be exposed to harmful smoke by allowing pubs and clubs to claim that rooms with one open wall (25% open) are in the open air. This is simply not good enough. Workers in Queensland and Tasmania have the full protection of the law … On behalf of the hospitality workers of New South Wales I ask the NSW Labor Government to legislate to protect equally all New South Wales workers from second-hand tobacco smoke … Furthermore, we call upon the New South Wales Health Minister to work with Health Ministers in all other Australian jurisdictions to bring an end to the high roller rooms exemptions to smoking rooms with a timeline for the end of these exemptions not extending beyond July 2007.[422]

**6.58** The Committee notes that the exemption of high roller rooms also exists in a number of jurisdictions in Australia including Western Australia, Queensland, Victoria and the Northern Territory. On the other hand, Tasmania, South Australia and the Australian Capital Territory all ban smoking in high roller rooms at casinos.[423]

**6.59** The Smoke-free Australia Coalition commented that the legislation:

> [B]etrays the expectations of New South Wales workers who have already made considerable compromises at risk to their health to work with the long deadline (to July 2007) – 12 months later than the total bans in Queensland and Western Australia and 18 months after Tasmania.'[424]

**6.60** Mr Cass of the AHA strongly contested the health assertions of our participants, emphasising 'that the staff who have been working for all these years, in over 200 years of hotel history,

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420 Mr Bob Daisley, Musician, Public Forum, 1May 2006, p13

421 Mr Luke Whitington, Public Forum, 1 May 2006, p17

422 Ms Sharon Eurlings, Public Forum, 1 May 2006, p13

423 Refer to Appendix 4, based on answers to questions on notice taken during evidence 27 March 2006, Dr Denise Robinson, Chief Health Officer, NSW Health

424 Submission 1, p2

there is no indication that there is any higher incidence of smoking-related disease than there is in the wider community.'[425]

**6.61** Mr Cass argued that ETS is not more of a problem in the hospitality industry than it is elsewhere:

> In regard to the employees of our member hoteliers, the approximately 2,000 member hotels in New South Wales, the figures indicate that an average of 60% of hotel employees are smokers and this rises in Sydney CBD hotels to up to about 66% of the staff. In relation to some of the claims that have been made about the effects of environmental tobacco smoke in our workplace, the industry based superannuation scheme, of which all employees are members, has no record of higher mortality rates in our industry, amongst employees in our industry, so it is our view that, despite some claims, ETS has not been and is not more of a problem in our industry than it is elsewhere.[426]

### *Occupational health and safety*

**6.62** The Committee took detailed evidence on the allegations that the ETS legislation is in conflict with legal requirements under the *Occupational Heath and Safety Act 2000*.

**6.63** Mr Semmler QC, Marlene Sharp's legal counsel, advised the Committee that in his opinion employers would be liable for workers developing tobacco smoke related illness:

> [T]he occupational health and safety legislation says every employer shall ensure the health, safety and welfare at work of all his employees. Full stop. That's it. Absolute obligation. Then you allow this compromise to come in in 2007 or whatever it is and you will get some worker out there, day in and day out in the 25% open air area, being exposed to a heck of a lot of smoking because all of the smokers are out there, who one day a few years later will come down with the kind of thing Mrs Sharp came down with because he or she had a susceptible gene and, bang, the employer is liable, and that is the end of it.[427]

**6.64** Dr Andrew Penman, CEO of Cancer Council NSW, also raised the issue of the conflict between the smoke-free legislation and the occupational health and safety requirements and provided the Committee with a Cancer Council publication *When Smoke Gets in Your Eyes*, which reviews 24 cases that have been successfully brought forward in relation to passive smoking cases in Australia. He told the Committee 'I think there are plenty of opportunities for the industry, hoteliers and others, to be sued on the basis of damage at work.'[428]

**6.65** A further legal opinion on this issue was given by Ms Anne Mainsbridge, Senior Solicitor for the Public Interest Advocacy Centre, who advised the Committee:

> It is really clear that employers have an obligation under section 8 (1) of the Occupational Health and Safety Act to ensure the health, safety and welfare at work of all their employees. That duty requires them to ensure that systems of work and the

425 Mr Cass, Evidence, 27 March 2006, p28

426 Mr Cass, Evidence, 27 March 2006, p20

427 Mr Semmler, Evidence, 27 March 2006, p13

428 Dr Penman, Evidence, 21 March 2006, p14

> working environment of employees are safe and without risks to health ... It is clear—I do not think there is any argument—that environmental tobacco smoke is a health risk in the workplace. Current legislation requires employers to take a risk management approach to that risk. In terms of guidance to employers about how they manage that risk, there is a guidance note that was introduced by the National Occupational Health and Safety Commission in 2003, specifically addressing this issue of elimination of environmental tobacco smoke in the workplace. That guidance note says that there is no safe level of environmental tobacco smoke. It also says that the primary objective in controlling employee exposure to environmental tobacco smoke in the workplace must lie in eliminating environmental tobacco smoke. It also says that smoking is to be permitted only in areas where there is full open-air natural ventilation.[429]

**6.66** It was suggested that, in order to be consistent with occupational health and safety requirements, WorkCover should be ordering all bar workers to be provided with protective equipment such as masks and rubber gloves. Professor Bernard Stewart, a medical scientist and expert on environmental carcinogenesis, who is also head of the Public Health Unit at South East Sydney and Illawarra Area Health Service, suggested:

> In theory, full respirators, which is masks and cylinders on the back, it would be rather daunting to be handed your bourbon and coke by someone who was wearing that, but if you want to go for individual protection rather than protecting the whole environment, that is the sort of thing you are looking at.[430]

**6.67** Ms Mainsbridge suggested that Tasmania has smoke-free legislation that better protects workers than New South Wales:

> Under the Tasmanian model, smoking is allowed in outdoor areas of pubs and clubs. Those outdoor areas can have a roof in some circumstances, but they are 50% open. So they are much more open areas than are provided for under the [New South Wales] regulation. The Tasmanian model also provides that those outdoor areas are not serviced, that the people who work in hotels are not required to go into those areas to collect glasses and ashtrays.[431]

**6.68** Another jurisdiction worth noting in relation to the protection of workers from ETS is Queensland, where any smoking areas in licensed venues are non-service, that is staff do not service these areas and in addition to this:

> Under the 2004 amendments, premises holding a hotel, club or casino liquor licence may establish a Designated Outdoor Smoking Area (DOSA) where drinking and smoking can occur. The DOSA is permitted in the outdoor liquor licensed area, however, it must be no more that 50% of the whole outdoor licensed area. There must also be a buffer zone separating the DOSA from other outdoor licensed areas. The licensee must ensure that no food or drink is served, no food is consumed, no

429 Ms Anne Mainsbridge, Senior Solicitor, Public Interest Advocacy Centre, Evidence, 5 May 2006, p26

430 Professor Bernard Stewart, medical scientist, expert on environmental carcinogenesis, Public Health Unit, South East Sydney and Illawarra Area Health Service, Evidence, 27 March 2006, p17

431 Ms Mainsbridge, Evidence, 5 May 2006, p26

> entertainment is offered, and no gaming machines are in the DOSA. The area must also be under the control of a "Smoking Management Plan."[432]

**6.69** In its submission, the Cancer Council NSW stated 'the decision to continue to allow smoking in areas up to 75% enclosed makes a mockery of the public health objective of the Smoke-Free Environment Act and clearly contravenes the National Occupational Health and Safety Commission guidelines on the elimination of exposure to environmental tobacco smoke.' It went on to contend:

> The new regulation institutionalises continued exposure to a known health hazard for pub and club workers for the foreseeable future, providing the industry with a license to kill. It is highly unlikely that the pubs and clubs lobby will willingly accept any further restrictions on smoking once capital investments have been made for renovations to meet the 75/25 definition.[433]

**6.70** The Committee notes that premises that are places of work are bound by the requirements of the *Occupational Health and Safety Act 2000* and Occupational Health and Safety Regulation 2001. There are no exemptions from this legislation, under which employers have a responsibility to assess and control health risks, including those arising from the exposure of staff and other people present in the workplace to environmental tobacco smoke.[434]

### Implications of the legislation for patrons of licensed venues

**6.71** Turning to the implications of the legislation for patrons of the licensed venues, the Committee heard from a number of non-smoking patrons who commented on confusion arising from the definition of enclosed places, the phased in approach and the desirability of completely smoke-free venues. In addition, the Committee's attention was drawn to a potential for conflict with the Commonwealth *Disability Discrimination Act 1992*. The Committee was also interested to examine the effects of smoke-free indoor venues on the initiation and maintenance of smoking habits, as this is part of the terms of reference for the inquiry.

**6.72** The Committee heard from a number of participants that community opinion is ahead of government action in relation to ETS restrictions in licensed venues. Ms Tang of the Cancer Council NSW suggested to the Committee, 'the community is not only ready but in many senses expecting government to take stronger action in relation to tobacco control'. She continued:

> Public opinion polls have consistently shown in excess of 70% of the population in support of smoke-free pubs and clubs. Almost three-quarters of the population say that the Government should take the health of workers and patrons as the primary consideration when deciding whether or not and when to ban smoking in pubs and clubs, and the majority of people—63%—want smoking bans introduced within 12

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432 Correspondence from Ms U Schreiber, Director General, Queensland Health, 25 April 2006, to Director, p2

433 Submission 49, Cancer Council NSW, p5

434 Submission 48, p13

> months. They do not want a long phase in. Indeed, 48% say that they want them immediately. [435]

**6.73** At the public forum a participant, Mr Raymond Graham, commented that, contrary to the claims of the AHA and Clubs NSW, more people will go to licensed premises when smoking is completely banned. He suggested that:

> 'Proof of this can be seen in Ireland and New Zealand where smoking is completely banned. Recently in Kiama, where I come from, we did a little survey amongst the people in the area to find out whether they want smoking in pubs and clubs: 80% said no.'[436]

**6.74** The Public Interest Advocacy Centre presented the Committee with the results of a recent study of community opinions on banning smoking in New South Wales licensed venues, conducted by the Centre for Chronic Disease Prevention and Health Advancement in NSW Health. A series of surveys were conducted in 2003, 2004 and 2005 with the following results:

> The study found that a majority of the New South Wales population supported a total smoking ban in pubs and clubs. The support for smoking bans in clubs increased from 59% in 2003, to 62% in 2004, and 66% in 2005. Similar trends were evident in support for smoking bans in hotels/pubs (54%; 58%; 60%) and bars/nightclubs (54%; 61% and 63%).[437]

**6.75** Further to this, when asked whether a total ban in all areas of licensed venues would make any difference to the number of times they would visit those venues, 'almost 90% of respondents said they would visit those venues more often or as often as currently after July 2007.' [438]

**6.76** Mr Cass of the AHA disputed these figures by reporting that 76% of their patrons are regular smokers and are not pleased with the imposition of smoking bans, further suggesting that the legislation would not achieve its intentions of reducing smoking rates:

> The view of the majority of our patrons - and it is a clear majority - is that there should remain separate areas for smokers and non-smokers in hospitality venues and that both groups should be equally catered for. In our view, removing the ability to smoke in hotels as will occur in July 2007 alienates smokers, but I suppose we can all become accustomed to that, but what we believe it is not doing is it is not reducing the incidence of smoking in the community. Smokers will smoke elsewhere.[439]

**6.77** The Committee considers that based on evidence received during this inquiry, the majority of the New South Wales community is supportive of smoke-free venues. The Committee recognises that in having smoke-free venues smoking becomes denormalised which can potentially lead to more people giving up smoking.

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435 Ms Tang, Evidence, 21 March 2006, pp4-5

436 Mr Raymond Graham, Public Forum, 1 May 2006, p6

437 Submission 45, p8

438 Submission 45, p9

439 Mr Cass, Evidence, 27 March 2006, p20

### *Effects on the maintenance of the smoking habit*

**6.78** The Committee examined the effects of smoke-free indoor venues on the initiation and maintenance of smoking habits, as this is part of the terms of reference for the inquiry. A number of contributors had comments to make on this issue. For example, Ms Tang of the Cancer Council NSW stated that introducing smoke-free legislation whether, in pubs and clubs or other public places, can contribute to prevention of relapse for people trying to quit smoking. Smoke-free venues reduce opportunities and cues to experiment with smoking, increase the success of quit attempts, and change the social norms and culture around smoking and tobacco use. She stated to the Committee 'those things together can help drive a reduction in prevalence rates in the communities and change the social norms of smoking in our community.[440]

**6.79** Professor Chapman explained to the Committee how smoking bans can contribute to denormalising smoking:

> Whenever we remove smoking as a normal activity in a public place, such as a shopping mall, a hotel or pub, people go along to those places and instead of it being the routine to smoke … it is no longer routine. Smoking is relegated to very special occasions, and some of those special occasions are not very pleasant; they are outside in the rain. When someone comes to your place for dinner they slip out to the back garden. Someone asks, "Where's Brian?" "Oh, he's disappeared for a cigarette". It denormalises the whole thing and it works, we know, from accounts of ex-smokers.[441]

**6.80** Associate Professor Matthew Peters, Chair of Action on Smoking and Health (ASH), also raised the issue of denormalising smoking:

> Denormalisation is a very important community strategy to adopt when it wishes to address the problem of smoking ... if I could take you back to the basics of smoking. One is context. We understand that there are certain contexts in which people smoke and certain contexts in which they do not. For instance, churches are places of worship, and places where you just do not smoke because of strong negative connotations; whereas, for many people, morning coffee would be a place strongly associated with their particular smoking habit. So, reducing the sorts of contexts in which people may smoke assists smokers, either not to start smoking or to aid them in attempts at cessation.[442]

**6.81** The Cancer Institute NSW highlighted for the Committee research on the impact of the total smoking ban in Ireland on smokers quitting:

> Research among callers to the Quitline in Ireland, after successful introduction of smoke-free workplaces including all pubs and bars, showed that 39% of those who had quit said that the Smoke-Free at Work legislation had a significant or important bearing on their decision and 55% reported that it was an important aspect in terms of 'staying off'.[443]

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440 Ms Tang Evidence, 21 March 2006, p9

441 Professor Chapman, Evidence, 22 March 2006, p4

442 Dr Matthew Peters, Chair, Action on Smoking and Health (ASH), Evidence, 5 May 2006, pp54-55

443 Submission 22, Cancer Institute NSW, p9

**6.82** The Royal Australasian College of Physicians also cited evidence that comprehensive smoke-free laws can result in a significant increase in calls to Quitlines in the short-term and reduction in smoking rates in the longer-term. It also referred to independent published studies showing that benefits include positive impacts on smoking behaviour and cessation efforts, strong community support and reductions in smoking uptake amongst young people.[444]

**6.83** Dr John Sanders, Manager of the Tobacco Control branch of NSW Health, stated that smoking bans in pubs and clubs are also beneficial for the 4.4% of people in New South Wales that smoke occasionally as it reduces their opportunity to smoke:

> [T]here is a lot of research done overseas… that basically says that if you do stop smoking in public places such as pubs and clubs, that is probably the best you can do in tobacco control. That 4% that is the occasional smoker who have a smoke at the pub every Friday night after work, they will no longer have that opportunity to be occasional smokers. It is peer pressure and I have got a drink so I will light up my only cigarette for the week so I think that you would find that a lot of the occasional smoking rates would drop. [445]

**6.84** The Committee considers that smoke-free pubs and clubs do denormalise smoking and have a positive impact for regular smokers wanting to quit, as well as on occasional smokers.

### *Discrimination*

**6.85** A number of participants suggested that venues where smoking is allowed are actually discriminatory. In its submission the Smoke-free Australia Coalition argued that:

> Smoky workplaces contravene the Federal Disability Act in discriminating in access and employment against a wide range of people, such as those suffering from heart disease, asthma and diabetes. The Human Rights and Equal Opportunity Commission said in the Meeuwissen case that a smoky room is as much of a barrier to an asthmatic as is a flight of steps to a person in a wheelchair. [446]

**6.86** Similarly, the Public Interest Advocacy Centre contended that the 2006 Regulation is inconsistent with the Federal *Disability Discrimination Act 1992*.

> We believe that many people in the community have conditions—and there is evidence to support this belief—that mean they cannot tolerate second-hand smoke, for example, asthma, cystic fibrosis, certain types of diabetes and heart conditions. We say it is impossible, or at least extremely difficult, for these people to work in places where environmental tobacco smoke is present. It is also impossible, or at least extremely difficult, for them to access premises where environmental tobacco smoke is present…We believe it is open to those people to bring complaints of disability discrimination under State legislation, the *Anti-Discrimination Act*, or under federal legislation, the *Disability Discrimination Act*. Those laws make disability discrimination unlawful in a number of areas of public life, including employment, access to

444 Submission 40, Royal Australasian College of Physicians, p4

445 Dr Sanders, Evidence, 27 March 2006, p65

446 Submission 1, p2

> premises, and provision of goods and services. All of those areas are relevant when you are looking at a pub, club or other licensed premises. [447]

**6.87** The Committee received a submission from Ms Suzanne Briscoe-Hough, who has cystic fibrosis (a severe congenital lung disease), who stated that due to her illness she is unable to visit smoking venues, such as pubs and clubs.[448]

**6.88** PIAC advised the Committee that a complaint made under the *Disability Discrimination Act 1992* would be based on a claim of indirect discrimination:

> The requirements for indirect discrimination include, firstly, that there has to be a requirement or a condition that the person has been subjected to. Here, the requirement would be that, in order to work in or to access that place, they are required to be able to tolerate environmental tobacco smoke. The second requirement is that the person cannot comply with that requirement and obviously if they have that type of disability they cannot, or it is extremely difficult for them to, comply. The third requirement is that the substantially higher proportion of people without their disability comply or are able to comply and the fourth requirement is that the condition is not reasonable in the circumstances of the case.[449]

**6.89** The Committee was advised that an example of a successful case was that of *Meeuwissen v Hilton Hotels of Australia* (referred to above by the Smoke-free Australia Coalition), where the complainant established the four requirements above to show that she had been subjected to indirect disability discrimination. She had suffered from cystic fibrosis and had subsequently had a double lung transplant. She had a tendency to develop asthma following that lung transplant and could not tolerate exposure to environmental tobacco smoke. She went into Juliana's nightclub at Sydney's Hilton with friends and had to leave after half an hour because she became seriously affected by the smoke in the nightclub. [450]

**6.90** Ms Meeuwissen's complaint against the Hilton Hotel under the *Disability Discrimination Act*, was upheld by the Human Rights and Equal Opportunity Commission, which found that because the hotel had allowed its patrons to smoke and did not make adequate provision for extraction of the smoke, it had imposed, in effect, a requirement or a condition that anyone attending the nightclub had to be able to tolerate environmental tobacco smoke.[451]

**6.91** In terms of the implications of the case for licensed venues, PIAC advised that these can be costly:

> Discrimination complaints are very costly in terms of compensation payouts and the legal fees that are required to run a discrimination complaint and the time taken to resolve a discrimination complaint. In our experience, based on the cases that we do at PIAC discrimination complaints typically can run for at least two years and, most of

447 Ms Mainsbridge, Evidence, 5 May 2006, pp27-28

448 Submission 58, Ms Suzanne Briscoe-Hough

449 Ms Mainsbridge, Evidence, 5 May 2006, pp27-28

450 Ms Mainsbridge, Evidence, 5 May 2006, pp27-28

451 Ms Mainsbridge, Evidence, 5 May 2006, pp27-28

> all, a discrimination complaint is a very newsworthy issue usually and can result in very bad publicity. [452]

### Other issues

**6.92** Lastly, there was some concern from inquiry participants about the process of developing the smoke-free legislation and the politics behind the final outcome. Certain participants believed that tobacco companies have sought to influence policy for some time, and that compromises were made with the smoke-free legislation due to the political influence of industry associations.[453]

**6.93** The Cancer Institute NSW suggested that the tobacco industry was quick to recognise the threat posed to its business by the designation of smoke-free public places and workplaces:

> Tobacco industry activity has been the most important factor affecting the introduction of smoke-free environments. The rationale for this activity is simple and is illustrated by this quote from a 1978 article in the Financial Times reporting the concerns of a president of a US based tobacco company, on the topic of restrictions on smoking:
>
> *"If they caused every smoker to smoke just one less cigarette a day, our company would stand to lose $92 million in sales annually. I assure you we don't intend to let that happen without a fight."* [454]
>
> The evidence that the industry has engaged in tactics, directly but also covertly through the funding of third party arms length organisations that appear independent of the tobacco industry is extensive. In spite of ample scientific and economic evidence that smoke-free environments are good for health, good for business and popular with the public, the industry and its allies have been successful in influencing scientists and policy makers and subverting normal decision-making processes. [455]

**6.94** Mr Thirlwell stated that the National Heart Foundation was disappointed with the phased in approach but accepted it because it thought at least it would deliver smoke-free pubs and clubs in July 2007. However, he stated that:

> We are not getting smoke-free pubs and clubs in July 2007 now, as we expected. Having accepted it and having said that we were pleased that the Government is moving forward, in some ways we now feel as if we have been kicked in the guts by a compromise that basically will not deliver what we thought we were going to get.[456]

**6.95** Mr Stafford Sanders of the Smoke-free Australia Coalition commented that the major obstacle that they have been faced with in dealing with the issue of smoke-free venues is the

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452 Ms Mainsbridge, Evidence, 5 May 2006, pp27-28

453 Submission 44, ASH, p3 and attachment A2; Mr Stafford Sanders, Smoke-free Australia Coalition, Evidence, 27 March 2006, p40; Submission 45, p5

454 Submission 22, p10

455 Submission 22, p10

456 Mr Thirlwell, Evidence, 22 March 2006, p23

disproportionate influence and the attitude of hospitality industry associations, the Australian Hotels Association and Clubs NSW. He stated:

> These organisations have a history of 10 years of attempting to frustrate this legislation. The AHA and clubs, rather than doing what they I would suggest should have done, and that is to be encouraging their members to fulfil their legal duty of care to their workers and patrons under OH&S law, have instead sought to do everything possible to circumvent that law.[457]

**6.96** Similarly, PIAC suggested that a key factor affecting the definition of enclosed space seemed to be the pressure that has been brought to bear by the pubs and clubs industry, as a result of industry members' concern about the potential impact on business if a total ban is put in place.[458]

**6.97** ASH also believed that industry members have been aggressively lobbying government. In their submission to the inquiry they stated that:

> Sponsored for many years by tobacco companies, the AHA and Clubs NSW have aggressively lobbied government to delay and undermine smoke-free laws – contrary to Occupational Health and Disability Discrimination laws. Despite a long and intense period of consultation that commenced in 1993 between government, health and industry groups, the compromise has resulted in New South Wales ending up with the longest delay and the biggest loophole. Whilst pubs and clubs are smokefree in Tasmania (from January 2006), in Queensland and WA (from July 2006), in the ACT (from end of 2006) the compromise for New South Wales means that smoking will continue indoors until July 2007 and indefinitely in areas up to 75% enclosed. This is unacceptable both ethically and legally. It fails to effectively protect workers and satisfy their reasonable expectation of a safe workplace.[459]

**6.98** The Committee heard from Clubs NSW that the smoke-free legislation for licensed venues was also a compromise for them. Mr Krelle advised the Committee that:

> the way the legislation came out was not entirely the way we would have liked to see it come out. We had a number of areas of difference as did other participants at that [working] group. But the dye has been cast and the legislation has been approved …[460]

**6.99** Mr Krelle stated that the industry would have preferred to trial ventilation systems to remove ETS from licensed venues before imposing bans, but the NSW Government did not support this approach. Also in terms of the definition of enclosed places:

> [O]ur preferred position was a lot simpler to interpret: the volume of air within the space compared to the amount of opening. We were actually after a 5:1 volume model, so that you could easily calculate the volume of air, say within this room, very easily, by some simple mathematical formula and look at the amount of space in this

457 Mr Sanders, Evidence, 27 March 2006, p40

458 Submission, 45, p5

459 Submission 44, ASH, p3

460 Mr Krelle, Evidence, 5 May 2006, p7

> opening, provided that was not greater than 5:1 … [However] our preferred model did not get up. They went for a surface model.[461]

**6.100** Mr John Thorpe, President of the AHA, argued that the representations he has made to government on behalf of his industry are legitimate:

> I don't tell people what to do within Government. I ask people or try to persuade people about the problems that beset an industry that has somewhere around 50,000 employees. I have an obligation to their employment, I have an obligation to the industry and under those circumstances it is not a matter of me telling the Government.[462]

### Conclusion

**6.101** The Committee has documented inquiry participants' comments in relation to the impact of the smoke-free legislation on proprietors of licensed venues, workers and patrons. The overwhelming view expressed to us was that the legislation in New South Wales needs to go further in protecting people from the damaging effects of ETS in licensed venues. Throughout this chapter the Committee has noted a raft of reasons for tighter restrictions on smoking in pubs and clubs, as set out in the points below. Paramount among these is the imperative to protect the health of workers.

- Under the existing legislation approximately 60,000 workers will still be exposed to ETS and its harmful effects, with an estimated 75 deaths each year as a result of working in these environments.
- The 2006 Regulation conflicts with occupational health and safety requirements for employers, leaving them open to litigation from workers, as in the cases of Mrs Marlene Sharp and Mr Phil Edge.
- It is unfair to hospitality workers that other employees are protected from the harmful effects of ETS, given that smoking is banned in all other workplaces.
- Other jurisdictions, and particularly Tasmania and Queensland, have better legislation to protect workers in licensed venues, including that any smoking areas are not serviced by workers.
- There is strong community support for total smoking bans in licensed venues.
- Smoke-free licensed venues denormalise smoking and contribute to increasing quitting rates in regular and occasional smokers, which in turn leads to a reduction in smoking rates and less cost to the community.
- The 2006 Regulation conflicts with the *Disability Discrimination Act 1992*, leaving licensed venues open to litigation from patrons, such as in the case of *Meeuwissen v Hilton Hotels of Australia.*

461 Mr Krelle, Evidence, 5 May 2006, p7

462 Mr Thorpe, Evidence, 27 March 2006, p26

- The 2006 Regulation causes confusion for proprietors, workers and patrons in relation to the definition of an enclosed place and therefore where people can and cannot smoke.
- The legislation, intended for pubs and clubs, has the potential to undermine the standards set for restaurants, and has created an uneven playing field within the hospitality industry.

**6.102** Taking into account the range of evidence provided to the inquiry, the Committee believes that the Smoke-free Environment Amendment (Enclosed Places) Regulation 2006 should be provided with the opportunity to operate and be monitored by the Government to ensure that it applies as intended. Such monitoring should examine whether or not amendments to the regulation are required.

**6.103** The Committee has concerns about employees being required to work in any smoking areas including outdoor areas such as beer gardens and other outside areas in and around licensed venues. Because of the importance of maximising the protection of workers' health, and in order to ensure optimal compliance with the *Occupational Health and Safety Act 2000*, the Committee considers that legislative provisions relating to this matter in other jurisdictions are worthy of further examination by the NSW Government.

**Recommendation 24**

That the NSW Government examine legislation in other jurisdictions intended to protect the health of workers servicing smoking areas.

## Other smoke-free areas

**6.104** Inquiry participants, in particular speakers at the public forum, raised the issue of smoking in public areas other than licensed venues such as playgrounds, sporting stadiums and entrances to buildings, urging that these areas should be smoke-free. Appendix 4 includes the smoking restrictions for these areas in other jurisdictions in Australia. While not being public places, the issue of smoking in cars and people's homes was also raised, primarily because of the impact of ETS on children. Smoking in cars will be discussed in the following chapter.

**6.105** In response to comments made at the public forum Dr Penman, CEO of the Cancer Council NSW, stated it was clear that exposure to ETS has moved beyond the pubs and clubs issue:

> It really highlights how antediluvian our position on pubs and clubs really is when people say we want to have smoke-free apartment buildings and we want to be able to walk down George Street without being exposed to clouds of tobacco smoke. I think the challenge for this Parliament is to really envision a smoke-free world in New South Wales and put in measures to achieve that …[463]

[463] Dr Penman, Evidence, 1 May 2006, p19

### Playgrounds

**6.106** NSW Health advised the Committee that there is a mechanism available to local councils to change the requirements for people utilising playgrounds or beaches, including by restricting smoking.[464] At the public forum, the Committee heard from Ms Kim Curtis, a mother of two young children, who has been successful in her campaign to gain unanimous support from Lismore City councillors to ban smoking in both children's playgrounds and council swimming pools:

> The public have embraced the bans and accepted that it makes sense not to smoke near children. I have received much positive feedback from other parents and even phone calls from strangers to say how good it is that council has made this decision.[465]

**6.107** Since 2003, 19 New South Wales councils have adopted policies regarding smoke-free playgrounds. Others have adopted policies on smoke free sports grounds and swimming pools.[466] However, Ms Curtis suggested that 'we need to standardise these statewide so that no matter which beach you are on, or which playground you are in everyone knows where they stand'. Ms Curtis stated that she attended the forum 'to gain support for a statewide ban on smoking in all these areas enjoyed by our children: these being playgrounds, playing fields, sporting grounds, swimming pools and on patrolled beaches in New South Wales.' She commented that 'if we as responsible adults are serious about adequately protecting our young from all the toxic effects of cigarette smoking it cannot be allowed in the places especially set aside for children to enjoy.'[467]

**6.108** Ms Curtis suggested to the Committee that a statewide ban on smoking in these areas could be achieved by adding definitions to the smoke-free legislation, for example, that smoke-free areas include '10 metres from play equipment and playgrounds.'[468]

**6.109** In response, Dr Denise Robinson, Chief Health Officer of NSW Health told the Committee that she recognised 'the need for a certain core consistency but I would have thought that councils themselves are each different. The issues they are dealing with and the populations they have are different, and therefore I would hesitate to move to a position of saying there should not be flexibility.[469]

**6.110** The Committee was advised that Queensland has introduced a statewide ban on smoking in children's playgrounds.[470]

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464 Dr Denise Robinson, Chief Health Officer, NSW Health, Evidence, 1 May 2006, p23

465 Ms Kim Curtis, Public Forum, 1 May 2006, pp1-2

466 Ms Curtis, Public Forum, 1 May 2006, pp1-2

467 Ms Curtis, Public Forum, 1 May 2006, pp1-2

468 Ms Curtis, Public Forum, 1 May 2006, pp1-2

469 Dr Robinson, Evidence, 1 May 2006, p23

470 Ms Jones, Evidence, 1 May 2006 p23

### Apartment buildings

**6.111** In Chapter 2 the Committee quoted at length from Mr Peter Lavac's vivid description at the public forum of how smokers in the apartment below his are affecting his health.[471]

**6.112** Mr Lavac stated that he has tried many courses of action to remedy the situation with no success and is now considering litigation. Mr Lavac, who is a barrister, commented 'what chance does the little Aussie battler have facing a similar situation?'[472]

**6.113** The Committee was advised by ASH that NSW Health has published a fact sheet that is has available and on its website for advising strata title bodies that all their common areas should be smoke free. ASH suggested that 'there is a provision under the strata title act for a nuisance, like somebody burning things off on their balcony or smoking on their balcony—that those issues can be dealt with through the body corporate and even some legal action taken.'[473]

### Entrances to buildings

**6.114** As outlined in Appendix 4, there are restrictions in other jurisdictions on smoking outside building entrances and air vents. Western Australia, Tasmania, Queensland and the Northern Territory all have varying levels of restrictions for smoking near the entrances of buildings.

**6.115** Ms Anne Jones, CEO of ASH, suggested that:

> New South Wales [should be] doing something similar to what Queensland has done, which in its comprehensive legislation it has banned smoking in outdoor crowded places, including children's playgrounds, and within so many metres from doorways that have public access. So there is a very good example on our door step with what Queensland has achieved through its legislation, and hopefully we can adopt it in New South Wales.[474]

**6.116** Picking up on statements made at the public forum, Dr Penman commented that outside areas should not be assumed to be for smokers:

> One of the people today proposed quite a neat solution that rather than make the assumption that out of doors is for smokers, you make the assumption that out of doors is for non-smokers and you make specific provision for restricted places where smokers can smoke, and those places are chosen to minimise the risk of exposure to non-smokers. [475]

**6.117** The Committee heard from the Sikh Council of Australia who supported strict bans on smoking, including within 20 metres of buildings:

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471 Mr Peter Lavac, Public Forum, 1 May 2006, p11

472 Mr Lavac, Public Forum, 1 May 2006, p11

473 Ms Jones, Evidence, 1 May 2006 pp22-23

474 Ms Jones, Evidence, 1 May 2006 p23

475 Dr Penman, Evidence, 1 May 2006, p24

> Although tobacco smoking is banned in most of the work places but it is often seen that people do smoke outside their offices on the streets and there by put the health of the other people, who happened to be around, at risk because they inhale the puffed out smoke by the smokers … and Sikh Council is of the view that people have the right to protect themselves from smoke inhalation and submits that smoking should be banned in all public places, parks, hotels, bars and restaurants, public transport and at least 20 meters from public or private building.[476]

### Conclusion

**6.118** The Cancer Council NSW reported to the Committee that over half the population support smoke-free beaches. Over three-quarters of people want to see smoking bans in sporting stadiums, and 88% of the community supports smoking bans near children's playgrounds in parks. 'They are all areas where there has been some action at local level, predominantly through local governments, but where community support and standards are probably ahead of where the government might be at the moment.'[477]

**6.119** Ms Tang, Director of Health Strategies at the Cancer Council NSW, advised the Committee that Queensland sets the standard on smoke free areas and second hand smoke for the rest of the country. [478]

**6.120** The Committee considers that smoke-free areas are an important part of tobacco control in New South Wales as they denormalise smoking. This can potentially reduce smoking habits and increase quitting rates, which can contribute to reducing smoking rates and smokers impact on the health system, and which in turn frees up scarce health resources and reduces the costs of smoking on the New South Wales community.

**6.121** The Committee considers that the NSW Government should amend the smoke-free legislation to include children's playgrounds as smoke-free areas.

### Recommendation 25

That the NSW Government amend the *Smoke-free Environment Act 2000* to include children's playgrounds as smoke-free areas.

476 Submission 20, Sikh Council of Australia Inc

477 Ms Tang, Evidence, 21 March 2006, pp4-5

478 Ms Tang Evidence, 21 March 2006, p7

# Chapter 7 Smoking in cars

As part of its terms of reference the Committee was required to consider the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill which seeks to ban smoking in cars and was introduced to the Legislative Council by Revd the Hon Fred Nile MLC. This chapter outlines the proposed provisions of the bill and its policy intentions. It documents the research evidence presented to the Committee in relation to these intentions, before exploring the views of a range of inquiry participants both in support of and against the bill. The chapter also outlines the features and findings of the educative 'Car and home: smoke free zone' project that ran in New South Wales between 2001 and 2005.

## The Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill

**7.1** The Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill was introduced to the Legislative Council by Revd Nile as a private members' bill on 21 June 2005.

**7.2** The bill seeks to add a provision to the Smoke-free Environment Act 2000 by creating an offence of smoking in a motor vehicle at any time. The offence would be punishable with a fine of up to five penalty units.[479]

**7.3** In his second reading speech on the bill, Revd Nile identified the policy intention of the bill as being to:

- reduce the harmful health effects of environmental tobacco smoke (ETS) on motor vehicle passengers, particularly children
- improve road safety by reducing accidents caused by driver distractions arising from cigarettes
- eliminate or reduce the danger of fires caused by cigarettes discarded from moving vehicles.[480]

**7.4** Revd Nile also explained that his intention was that the bill be educative rather than punitive:

> I know some people may be concerned about the practicality of enforcing such a law. However, I do not envisage it being implemented in a draconian fashion. It is another measure I call the schoolteacher legislation, the education-type legislation: The Parliament expresses its view on a health issue, safety issue or road safety issue by passing legislation and then advising the community, through education programs, that this is now the policy of the Government of New South Wales. They will know it is against the law to smoke in a vehicle. I hope it will apply in every other State. The majority of people will obey the law. When we introduced the compulsory wearing of seatbelts many thought that people would break the law, but the observance rate of that law is nearly 99.9% … This legislation will have a similar educative effect on the community.[481]

479 Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill, cl 2

480 Revd the Hon Fred Nile MLC, Legislative Council, New South Wales, *Hansard*, 21 June 2005

481 Revd the Hon Fred Nile MLC, Legislative Council, New South Wales, *Hansard*, 21 June 2005

## Research evidence

**7.5** During his second reading speech and also in moving a motion concerning the bill on 28 February 2006, Revd Nile cited several research studies pertinent to the objectives of the bill. The evidence base for the aim of protecting people and especially children from the health effects of ETS was documented in Chapter 2 of this report, as was some evidence from the NSW Fire Brigades concerning bushfires and roadside fires caused by discarded cigarettes (see paragraphs 2.48 and 2.49).

**7.6** The Committee further notes the evidence from the California Air Resources Board cited in the Action on Smoking and Health (ASH) submission. That study documented the concentration of smoke particles within cars, which was found to be markedly higher than in other settings such as households,[482] presumably as a result of the confined space within a car. Similarly, the Cancer Institute's submission reports that a study conducted at Stanford and Berkeley Universities in the United States demonstrated that after one cigarette is smoked in a room *with open windows*, it takes more than two and a half hours for pollutant levels to diminish to the level of risk considered acceptable by the US Environmental Protection Agency. According to the Cancer Institute, 'It stands to reason that drivers and passengers are at significant risk of exposure to unacceptable levels of carcinogens and toxins if smoking occurred in [a] vehicle.'[483]

**7.7** Within this context, we also note the evidence cited by Hunter New England Area Health Service that young children are especially vulnerable to the health effects of ETS as a result of their small body size, higher breathing rates and underdeveloped immune and pulmonary systems.[484]

**7.8** In relation to driver safety, Revd Nile referred to a 1990 study of the smoking status of people known to have been involved in a car accident and others who had not. According to Revd Nile, the study found that smokers had an increased risk of being involved in a motor accident, and that smoking while driving further increased this risk.[485] In addition, the Cancer Institute NSW cited several studies which have found that smoking whilst driving increased the risk of being involved in a crash, and observed that such risk may be associated with distractions caused by smoking, behavioural differences between smokers and non-smokers, and/or drowsiness caused by high concentrations of carbon monoxide from tobacco smoke.[486] In correspondence to the Committee, the Australian Medical Association (NSW) verified that carbon monoxide, a by-product of burning tobacco, can cause sleepiness.[487]

**7.9** In relation to fires, Commissioner Mullins provided additional data on the cause of fires after his hearing with the Committee. During 2004-05, 7% of bush and grass fires responded to by

482 Submission 44, ASH

483 Submission 22, Cancer Institute NSW, p15

484 Submission 27, Hunter New England Area Health Service, p7

485 Revd the Hon Fred Nile MLC, Legislative Council, New South Wales, *Hansard*, 28 February 2006

486 Brison RJ, 1990, Christie R, 1991 and Violanti JM and Marshall JR, 1996, cited in Submission 22, Cancer Institute NSW, p15

487 Answers to questions taken on notice during evidence, 21 March 2006, Associate Professor John Gullotta, President, Australian Medical Association (NSW), Question 3, p3

the NSW Fire Brigades were reported to have been started by a cigarette. A further 10% were reported to have started as a result of heat from 'smokers materials' including cigarettes. In 39% of bush and grass fires responded to, the cause was undetermined. Very similar figures were also provided for 2003/04. On this basis, Commissioner Mullins concluded, 'Cigarettes have definitely been identified as causing 7% of bushfires in New South Wales, and possibly up to 49%.'[488]

**7.10** In terms of the extent of the occurrence of smoking in cars, the Cancer Council NSW cited evidence that at present 81% of car owners do not allow smoking in their cars and 60% of households with young children where a parent is a smoker do not allow smoking in cars.[489]

## Views on the bill

**7.11** While there was very broad and strong support for reducing smoking in cars for all the reasons documented in the research evidence cited above, the Committee received mixed support for a legislated ban. Some inquiry participants supported a legislated ban, while others were more cautious. These views are detailed below.

### Those in support of a legislated ban

**7.12** A broad range of inquiry participants supported the bill on the basis of protecting health, reducing accidents, reducing bushfires and/or contributing to a cleaner environment. Such participants included Mrs Margaret Hogg of the Non-Smokers Movement of Australia, Mr Peter Mason, Mr Joe Alvaro, the Optometrists Association of Australia (NSW Division), and the Royal Australian College of Physicians.[490] When she appeared before the Committee, Ms Anne Jones of ASH also made a strong statement of support for the bill, particularly on the basis of the health of children, but also for each of these other reasons.[491]

**7.13** Mrs Hogg noted that smoking has already been banned on all public transport, commercial vehicles and in private vehicles used for business purposes, suggesting that a ban in all private vehicles would be a logical next step.[492]

**7.14** A number of participants noted their support for a more limited ban on smoking in cars that only applied where children are present. Professor Simon Chapman of the School of Public Health, University of Sydney, was clear that he did not support a prohibition on smoking in all public places such as parks because he believes this would infringe civil liberties. He also

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488 Answers to questions taken on notice during evidence 5 May 2006, Commissioner Greg Mullins, Commissioner, NSW Fire Brigades, Question 2, p3

489 Ms Anita Tang, Director, Health Strategies, The Cancer Council NSW, Evidence, 21 March 2006, p12

490 Submission 30, Non-Smokers Movement of Australia, p4; Submission 8, Mr Peter Mason, p2; Submission 21, Optometrists Association of Australia (NSW Division), p12; Submission 31, Mr Joe Alvaro, p1; Submission 40, Royal Australian College of Physicians, p4

491 Ms Anne Jones, Chief Executive officer, Action on Smoking and Health (ASH) Evidence, 5 May 2006, p26

492 Submission 30, p4

considers that there should be an evidence base for all public health legislation. However, Professor Chapman argued that there were adequate grounds to justify a ban in relation to children:

> I am for banning smoking in cars when children are on board because children cannot consent to being exposed. Legally, they cannot consent until they are 18 years of age, whereas adults can choose.[493]

**7.15** Professor Chapman argued that there would be a high level of public support for a ban on cars carrying children,[494] as did ASH and the Australian Medical Association (NSW). ASH cited a 2004 survey of over 1300 Australians which found that 73% of participants supported such a ban.[495] The Australian Medical Association (NSW) referred to a poll indicating 90% support for a ban in respect of children.[496]

**7.16** The Australian Medical Association (NSW) expressed the same principle as Professor Chapman that children cannot consent to exposure to tobacco smoke. Its President, Professor John Gullotta, indicated that he stopped short of a total ban on smoking in cars, but did support a ban in relation to children and pregnant women:

> With regard to children and pregnant women in cars, we definitely agree with the ban in cars. A total ban we find perhaps a little difficult to enforce, but it is something we are definitely looking at and discussing at an AMA level. We believe that the best approach is an educational approach, to educate parents and drivers to ensure they know the risks that they are exposing their children to, and to get them to take the responsible upper hand and not smoke in their vehicles. That is the way we are heading, but the debate is still ongoing. But we definitely support it with regard to children and minors.[497]

### Other views

**7.17** Other inquiry participants were more cautious still about a legislative approach. In general they were very supportive of the need to address smoking in cars, but were concerned about the practical issues of how prohibition would be implemented.

**7.18** The NRMA's submission to the inquiry acknowledged the dangers associated with smoking in cars, but did not support a complete ban. Instead, it noted the NRMA's own efforts to educate smokers about these dangers and indicated a willingness to consider involvement in a targeted education campaign.[498]

**7.19** The Hunter New England Area Health Service noted that the introduction of smoke free policies in workplaces, restaurants, public transport and other public places has reduced the

493 Professor Chapman, Evidence, 22 March 2006, p10

494 Professor Chapman, Evidence, 22 march 2006, p4

495 Submission 44, p7

496 Submission 19, AMA, pp6-7

497 A/Professor Gullotta, Evidence, 21 March 2006, p23

498 Submission 43, NRMA, p1

opportunities for exposure of children to ETS. However, it observed that by nature these initiatives are limited in their ability to protect children in private environments such as the home or car, which are also the most common sources of child ETS exposure.[499] At the same time, the Area Health Service stated that as yet there is no evidence available on which to base comment about the potential efficacy of a legislated ban. It recommended that if such a bill were passed it should be implemented in the context of a 'comprehensive intervention program focusing on parents, health services and incorporating social marketing campaigns.'[500]

**7.20** The Cancer Council NSW spoke strongly in support of reducing smoking in cars, but was cautious about a ban. In evidence, Ms Anita Tang, Director of Health Strategies told us:

> We know that the educative approach does work … In terms of whether or not there should be a legislative ban on smoking in cars, I think that the desire to eliminate exposure to second-hand smoke in enclosed places and the known health risk probably needs to be balanced against thinking about how we treat cars when they are essentially a private space. That is why our approach to date has been to encourage smoke free through education. I am not aware of any jurisdiction to date that has legislated to this effect so it is difficult to get a sense of the impact and effectiveness of legislation versus education.[501]

**7.21** Ms Tang also raised the practical issue that while the strongest case for a ban can be made around protecting children and others at risk, it would be much easier in practical terms to enforce a total ban.[502]

**7.22** Both Asthma NSW and the Heart Foundation (NSW Division) were concerned about the enforceability of a ban in cars and argued instead for legislation to be used in respect of other matters. Ms Mimi St-John Austen, Chief Executive Officer of Asthma NSW alluded to the potential for a full ban in pubs and clubs when she stated:

> [O]ur position would be that we believe an education process for car and home is more beneficial, and that we should concentrate on those areas where we can affect directly by legislation.[503]

**7.23** Similarly, the Heart Foundation's submission is explicitly supportive of the bill's principles and rationale, but suggests that the bill 'may be unenforceable, or rather [may] remain unenforced, particularly by the police.'[504] Ms Jeanie McKenzie, the Foundation's Director of Cardiovascular Health, suggested that it would be quite an onerous task for police, as is the case with the legislation banning the use of hand-held mobile phones while driving. Ms McKenzie also concurred that particular social groups may be disproportionately affected by the legislation, given that disadvantaged groups are more likely to smoke.[505]

499 Submission 27, Hunter New England AHS, p7

500 Submission 27, p9-10

501 Ms Tang, Evidence, 21 March 2006, p12

502 Ms Tang, Evidence, 21 March 2006, p12

503 Ms Mimi St John-Austen, A/Chief Executive Officer, Asthma NSW, Evidence, 22 March 2006, p5

504 Submission 17, Heart Foundation (NSW Division), p7

505 Ms Jeanie McKenzie, Director, Cardiovascular Health, National Heart Foundation of Australia (NSW Division), Evidence, 22 March 2006, p20

**7.24** Despite its strong evidence in relation to fires caused by cigarettes, Commissioner Greg Mullins of the NSW Fire Brigades also questioned the enforceability of a ban. He referred the Committee to the *Bushfires Act 1949*, which banned smoking on wharves, pontoons and, during total fire bans, prohibited smoking in the open. The Commissioner told the Committee:

> The experience was that really nobody took much notice of it. It was extremely difficult to enforce, so it was not enforced. I suppose from a fire service point of view my worry would be that people would ignore such a measure. So, again, our tack has been to reduce the possibility that a cigarette can cause a fire in the first place, rather than hoping that cigarettes can be eliminated. If that could actually be enforced, I am sure that it would reduce the number of roadside fires, but, to be honest, I would be a bit sceptical, given the historical experience.[506]

**7.25** The NSW Police Service shares these concerns about enforceability. When he appeared before the Committee, Ron Dorrough, Commander of Traffic Policy for the NSW Police Service, argued that a ban would be extremely difficult to enforce on a number of grounds. He questioned how police would determine which person in the vehicle had been smoking when there were a number of people present and the cigarette had since been extinguished, and if the legislation were to apply to children, how age limits would be applied.[507] Commander Dorrough noted that unlike other legislation dealing with car safety, this ban was directed not just at the driver, but at passengers as well, arguing that the bill would be somewhat anomalous:

> If we were given extra powers under this legislation there are lots of other more serious offences for which we do not have those sorts of powers now which we would like in regards to questioning people in motor vehicles.[508]

**7.26** Commander Dorrough also questioned whether the strong relationship that had been documented between mobile phones and distractions on the road also held true for cigarettes.[509] Instead, he suggested:

> If they have a cigarette in one hand it is still arguable whether they have control of the vehicle. I think it would be an extremely difficult issue for a court of law to prove that a person was out of control just because they had an item in their hand.[510]

**7.27** Finally, Commander Dorrough argued that the bill was principally aimed at addressing a 'health and social matter' and would impose upon police resources that could be better used to meet the core goals of minimising road trauma, promoting safe road use and managing the free flow of traffic. He also noted that when charged, people are entitled to plead not guilty

506 Commissioner Mullins, 5 May 2006, p19

507 Commissioner Ron Dorrough, Commander, Traffic Policy, NSW Police Service, Evidence, 5 May 2006, p50

508 Commissioner Dorrough, Evidence, 5 May 2006, p50

509 Commissioner Dorrough, Evidence, 5 May 2006, p50

510 Commissioner Dorrough, Evidence, 5 May 2006, p51

and take the matter to court, further diverting police resources away from the front line, for the relatively minor matter of smoking.[511]

### An educational approach

**7.28** Like the Cancer Council NSW, the Heart Foundation (NSW Division) and Asthma NSW, the Cancer Institute advocated an educational approach to address smoking in cars:

> We suspect the way forward is by education and by pushing the message of the health effects of reducing the opportunity to smoke in various venues and places by making it unacceptable to smoke in the house or in the car. We think the way to get there is to bring people along with educational programs and peer pressure rather than having a legislative prohibition. It might work; it might not. We know that if we do more of what we are doing more effectively it will work.[512]

**7.29** Each of these organisations, as well as NSW Health, referred to the strong evidence for the effectiveness of educational campaigns such as that of the 'Car and home: smoke free zone' campaign. The Heart Foundation, like other witnesses, suggested that while there was scant evidence available in respect of a legislative ban, this project had provided excellent evidence of the efficacy of education in reducing smoking in cars and in the home.[513] Similarly, Dr Denise Robinson of NSW Health argued that the very strong findings in relation to the campaign showed how amenable people were to changing their behaviour through the provision of education and information.[514] Dr Robinson told the Committee:

> I am sure that parents want to do the best by their children and, once they have the right information, once they understand what the issue is with the right information, they will amend their practices.[515]

#### *The 'Car and home: smoke free zone' project*

**7.30** This initiative, formally titled the Environmental Tobacco Smoke and Children Project, ran from 2000-2004, was funded by NSW Health and managed by the Cancer Council NSW in partnership with Asthma NSW, the National Heart Foundation of Australia (NSW Division) and SIDS and Kids NSW, at a cost of approximately $2.4 million. The catchphrase 'car and home: smoke free zone' was the campaign's slogan and main message.

**7.31** The project sought to change the behaviour of parents and/or carers of children aged 0-6 through the use of best practice, evidence-based health promotion strategies. Its four objectives were to:

- increase awareness among parents/carers of the health effects of ETS on children

511 Commissioner Dorrough. Evidence, 5 May 2006, p52

512 Professor Bishop, Evidence, 21 March 2006, p33

513 Ms McKenzie and Mr Thirlwell, Evidence, 22 March 2006, p20

514 Dr Robinson, Evidence, 27 March 2006, p61

515 Dr Robinson, Evidence, 27 March 2006, p61

- increase knowledge of strategies to reduce exposure of children to ETS in homes and cars
- increase the number of households and cars designated as smoke free zones
- increase the number of health professionals routinely identifying children 0-6 at risk of ETS exposure, and providing information and advice to parents and carers.

**7.32** The project involved three waves of mass media campaigns using paid television, radio and billboard advertisements. This was supplemented by brochures, other printed material, a website and activities such as free education sessions for health and child care professionals. Specific resources and strategies were provided for culturally and linguistically diverse groups, indigenous people and parents with mental illness.[516]

**7.33** The evaluation of the project revealed that almost three-quarters of people (73%) surveyed reported that smoking had not occurred in the home in the previous month, compared with 46.9% prior to the initiative. This represented a 55.7% increase in the number of homes in the target audience that were smoke free.

**7.34** In relation to cars, 60.7% reported that all cars in which children had travelled in the last month were smoke free, compared with a baseline of 42.8%. This represented a 41.8% increase in reports of children travelling only in smoke free cars.[517]

**7.35** Drawing on the lessons from the project's evaluation, the Cancer Institute's submission makes the following suggestions for future strategies based on the 'car and home: smoke free zone' project:

> Media campaigns targeting parents and carers about how best they can protect their children from tobacco smoke should focus on the importance of smoke-free vehicles and should include clear information delivered through maternal and child health, children's hospitals, play groups, child care centres, parent associations and parenting networks.[518]

**7.36** Similarly, the Children's Hospital at Westmead recommended that such campaigns be expanded and sustained over a long period, and that they be augmented with strategies targeting antenatal clinics and delivery units, paediatric services and community-based children's services.[519] The Cancer Institute also suggested:

> Media campaigns aimed at motivating smokers to quit and supporting those who are trying can also make good use of the opportunities to target drivers through radio. Collaborative work with agencies responsible for fire protection and road safety also

516 NSW Health, Asthma Foundation, Heart Foundation, SIDS and Kids, the Cancer Council NSW Cancer Council, *Car and home: smoke free zone – A report on the Environmental Tobacco Smoke and Children Project 2001-2005*, ETS and Children Project, Sydney, October 2005, pp5 and 8

517 NSW Health et al, 2005, p10

518 Submission 22, Cancer Institute NSW, p16

519 Submission 36, The Children's Hospital at Westmead, p3

offer many driving opportunities to communicate the importance of not smoking while driving.[520]

## Other jurisdictions

**7.37** The Committee wrote to the relevant health agency in each state and territory to ascertain their approach to smoking in cars. No jurisdiction has such legislation at this time. [521] Tasmania released a discussion paper on 31 May 2006, *Strengthening Measures to Protect Children from Tobacco,* which focuses on a range of issues aimed at enhancing measures to protect children from ETS. The discussion paper recommends a ban on smoking in cars where children are present and indicates that the advantages of such a ban include that:

- without some form of compulsion some adults will continue to expose children to ETS whilst in a vehicle
- there is a high level of public support indicated
- it denormalises smoking.[522]

**7.38** The main disadvantage indicated is that the ban involves excessive regulation of behaviour in a private vehicle. In lieu of a ban the discussion paper recommends a strong on-going public education campaign to encourage parents and adults to voluntarily not smoke in a vehicle when a child is present. [523] Submissions to the discussion paper close 14 July 2006.

**7.39** The Committee notes that a similar proposal to ban smoking in vehicles carrying children is being made to the Western Australian Government by the local branch of the Australian Medical Association with the support of a local motoring organisation.[524] However, the Western Australia Department of Health indicated in correspondence to the Committee that they support an educative approach, as does Victoria. [525]

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520 Submission 22, p16

521 Correspondence from Mr PM Faulkner, Secretary, Victorian Department of Human Services, to Director, 17 May 2006; correspondence from Mr Keith Evans, Executive Director, Drug and Alcohol Services South Australia, to Director, 27 April 2006; correspondence from Ms Joanne Townsend, Director, Northern Territory Department of Health and Community Services, to Director, 18 April 2006; correspondence from Dr John de Campo, Acting Director General, Western Australian Department of Health, to Director, 27 April 2006; correspondence from Ms Uschi Schrieber, Director-General, Queensland Health, to Director, 25 April 2006; correspondence from Dr Martyn Forrest, Secretary, Tasmanian Department of Health and Human Services, to Director, 28 April 2006; correspondence from Dr Tony Sherbon, Chief Executive, ACT Health, to Director, 30 April 2006

522 *Strengthening Measures to Protect Children from Tobacco,* Department of Health and Human Services, May 2006, pp26-29

523 *Strengthening Measures to Protect Children from Tobacco*, pp26-29

524 *Strengthening Measures to Protect Children from Tobacco,* pp26-29

525 Correspondence from Dr John de Campo, Acting Director General, Western Australian Department of Health, to Director, 27 April 2006; correspondence from Mr PM Faulkner, Secretary, Victorian Department of Human Services, to Director, 17 May 2006

## Conclusions

**7.40** The Committee fully endorses the policy intentions of the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill, that is, to reduce the harmful health effects of ETS on car users, particularly children, to improve road safety by reducing accidents caused by driver distractions arising from cigarettes, and to reduce the danger of fires caused by cigarettes discarded from moving vehicles.

**7.41** It considers that on balance, and particularly because of evidence concerning the remarkable success achieved through the educational 'car and home: smoke free zone' campaign, alongside the absence of research evidence in relation to a legislated ban, that an educational rather than legislative approach is desirable. The Committee is also persuaded by the concerns of police and advocacy-based inquiry participants about the enforceability of the bill's provisions. We acknowledge Revd Nile's argument that the legislation itself would be educative but are concerned that a key test of any legislation is its enforceability.

**7.42** While in the previous chapter we recommended that smoking be banned in children's playgrounds, we note that there is an important difference between these areas and cars. The former are public places, while cars are private. A ban on smoking in cars would thus entail a greater encroachment on individual liberties than one on behaviour in public areas.

**7.43** In light of our strong support for the principles of the bill, the Committee recommends that a further education campaign based on the car and home smoke free zone, and drawing on its evaluation findings, be funded and implemented. As inquiry participants have suggested, such an initiative should target the broad range of health and community services utilised by families and children. It should also be developed and implemented in partnership with agencies responsible for road safety, and with motoring organisations such as the NRMA.

**Recommendation 26**

That NSW Health fund and implement a sustained educational campaign aimed at reducing smoking in cars, based on the 'car and home: smoke free zone' project and drawing on its evaluation findings. The initiative should:

- target the broad community and diverse groups within it
- be supported by strategies delivered through the broad range of health and community services utilised by families and children
- be developed and implemented in partnership with the Roads and Traffic Authority, the NSW Police Service and motoring organisations.

# Chapter 8 Conclusions

This chapter draws together major themes of the report and articulates key messages for the NSW Government arising from the inquiry.

## Major themes of the inquiry

**8.1** It is clear to the Committee that smoking carries with it very substantial costs to the New South Wales community, including economic costs of $6.6 billion,[526] most notably including health costs as a result of tobacco smoking being the single greatest cause of premature death in New South Wales.[527] The Committee is convinced of the major financial gains associated with tobacco control, again, most notably in terms of the health system. However, more important still than these financial gains those gains to be made in improving health, reducing death and disease, and improving equity. The evidence is very clear that by reducing smoking we can decrease smokers impact on the health system and improve the health and lives of individuals, families and communities of New South Wales.

**8.2** The Committee recognises that the NSW Government, and in particular NSW Health, has a tobacco control plan in place and notes that smoking rates in New South Wales have continued to decline in recent years, from 22.3% in 2003 to 20.1% in 2005.[528] However, the Committee believes that more can and should be done to further reduce the prevalence of smoking and to cut through the barriers to further reducing tobacco use. We note that an estimated 45% of the total costs of tobacco smoking are avoidable, that is, they could be reduced as a result of government policy and activity. [529]

**8.3** The Committee considers that a reduction in smoking rates can be achieved by the NSW Government maintaining tobacco control as a policy priority and increasing tobacco control measures to ensure people and policy makers do not become complacent about the impact of tobacco smoking on the community. It is clear that this will require additional and sustained funding from the NSW Government and the Commonwealth, to further implement the *NSW Tobacco Action Plan* and other tobacco control measures. Not only will this reduce the costs to the community and on the health system, freeing up scarce health resources, it will save people's lives.

**8.4** The evidence presented to the Committee is clear that tobacco control needs to be comprehensive, well funded, multifaceted and long term. Strategies aimed at the broad population must also be appropriate and accessible to high risk groups. At the same time, certain population groups, including Aboriginal people, young people and culturally and

526 Collins DJ and Lapsley HM, *Counting the costs of tobacco and the benefits of reducing smoking prevalence in NSW*, NSW Health, 2005, pp3-4.

527 Submission 48, The Cabinet Office, p4

528 New South Wales Population Health Survey 2003, 2004 and 2005, cited in Submission 48, The Cabinet Office, p4

529 Collins DJ and Lapsley HM, *Counting the costs of tobacco and the benefits of reducing smoking prevalence in NSW*, NSW Health, 2005, pp3-4.

linguistically diverse communities, will necessarily require a tailored and targeted approach. The Committee believes that this has been recognised by the NSW Government and that its comprehensive strategies should continue to be developed and implemented.

**8.5** As part of this multi-faceted approach the Committee believes that there is a need for an increased focus on the supply side of tobacco control. In this area the Committee has recommended tighter restrictions for display of tobacco products, implementation of a licensing system for wholesalers and retailers of tobacco products and a review of current provisions and activities in relation to sales to minors.

**8.6** A major issue of the inquiry was the smoke-free legislation and the impact of environmental tobacco smoke on workers in licensed venues. The Committee concludes that among the many considerations in this area, the health of workers is paramount. On this basis, the Committee concludes that greater protections are required in licensed venues and in children's playgrounds. The Committee considers that restrictions on where to smoke will help to denormalise smoking and contribute to the reduction in smoking rates.

**8.7** The Committee heard evidence on tobacco control measures in other jurisdictions and strongly encourages the NSW Government to take on board the positive steps taken in other jurisdictions to reduce tobacco use. Indeed, it should aim to be a leader in tobacco control in Australia. Most importantly, the key message out of the inquiry for the NSW Government is that the New South Wales community is ready for greater tobacco control to further reduce smoking rates and save lives. The public is looking to the Government to take on this leadership role.

# Appendix 1 Submissions

| No | Author |
|---|---|
| **1** | Mr Stafford Sanders – Coordinator, Smoke-Free Australia Coalition<br>1a supplementary submission<br>1b supplementary submission |
| **2** | Mrs Carmel Lamaro |
| **3** | Mr Michael Stevens – Pharmacist, AOD Consultant<br>3a supplementary submission |
| **4** | Mr Brian Ross – Chief Executive, Australian Hotels Association (NSW) |
| **5** | Mr Stephen Brown, Bundabah Wildlife Rescue |
| **6** | Mr JL Tredinnick |
| **7** | Mr Bill Vandenberg |
| **8** | Mr Peter Mason |
| **9** | Ms Renee Bittoun – Director, Smoking Research Unit |
| **10** | Mr Col Shephard |
| **11** | Mr Rod Grieve |
| **12** | Ms Sally Crossing – Chair, Cancer Voices Inc |
| **13** | Ms Rhonda Wilson – Executive Director, myhealth Australia |
| **14** | Mr Colin Sinclair |
| **15** | Ms Lee Burgoyne |
| **16** | Mr Reinhold Meric |
| **17** | Mr Tony Thirlwell – CEO, National Heart Foundation NSW Division |
| **18** | Mrs Dawn Phillips |
| **19** | Associate Prof John Gullotta – President, Australian Medical Association NSW |
| **20** | Mr Bawa Singh Jagdev – Secretary, Sikh Council of Australia Inc |
| **21** | Mr Neil Craddock – President, Optometrists Association Australia |
| **22** | Ms Trish Cotter – Director, Prevention |
| **23** | Mr Bert Van Gossum – Director, Corporate Affairs, Phillip Morris |
| **24** | Mr Simon Beynon – Sales and Franchise Manager, FREECHOICE Stores |
| **25** | Ms Julie Babineau – Deputy Chief Executive, Justice Health |
| **26** | Mr Pardeep Grewal – Legal & Corporate Affairs Director, Imperial Tobacco Australia Limited |
| **27** | Mr Terry Clout – CEO, Hunter/New England Area Health Service |
| **28** | Ms Peta Cauvin |
| **29** | Ms A Mackay |

| No | Author |
|---|---|
| **30** | Ms Margaret Hogge – Secretary, Non-Smokers Movement Australia |
| **31** | Mr Joe Alvaro |
| **32** | Ms Kim Curtis |
| **33** | Mr Colin Coakley – General Manager, Country Women's Association of NSW |
| **34** | Mr Ingo Steppat – Coordinator Environmental Health Services, Greater Western Area Health Service |
| **35** | Confidential |
| **36** | Professor Peter van Asperen – Head, Department of Respiratory Medicine, The Children's Hospital, Westmead |
| **37** | Mr Gary Monks – General Manager, Newsagents Assoc. of NSW and ACT Ltd |
| **38** | Mr Phil Browne |
| **39** | Mr David Costello – CEO, Clubs NSW |
| **40** | Associate Prof Jill Sewell – President, Royal Australasian College of Physicians |
| **41** | Ms Mimi St John-Austen – Acting CEO, Asthma NSW |
| **42** | Dr John Herron – Chairman, Australian National Council on Drugs |
| **43** | Mr Brett Gale – General Manager, Public Affairs, NRMA |
| **44** | Associate Prof Matthew Peters – Chair, Action on Smoking and Health<br>44a supplementary submission |
| **45** | Ms Anne Mainsbridge – Senior Solicitor, Public Interest Advocacy Centre |
| **46** | Mr Brendan Brady – Director Corporate and Regulatory Affairs, British American Tobacco Australia |
| **47** | Ms Gillian Calvert – Commissioner, NSW Commission for Children and Young People |
| **48** | Mr Roger B Wilkins – Director General, The Cabinet Office |
| **49** | Dr Andrew Penman – CEO, Cancer Council NSW |
| **50** | Mr Levi Foster |
| **51** | Dr Stephen Christley – Chief Executive, Northern Sydney Central Coast Area Health Service |
| **52** | Mr Harold Levien |
| **53** | Ms Catherine Mahony – A/Director, Council of Social Service of NSW |
| **54** | Ms Aviva Sheb'a |
| **55** | Ms Jessica Mann |
| **56** | Mr Ross Hamilton |
| **57** | Ms Norma Daisley |
| **58** | Ms Suzanne Briscoe-Hough |
| **59** | Dr Ned Iceton |

| No | Author |
|---|---|
| **60** | Mr Tony Williams |
| **61** | Mr Rick Melick |
| **62** | Mr David Killeen – President, National Alliance of Tobacco Retailers |
| **63** | Ms Kate McGregor – The Cricketers Arms Tavern, Cooks Hill |
| **64** | Mr Brian McBride |
| **65** | Ms Jody Broun – Director General, Department of Aboriginal Affairs |
| **66** | Mr Owen Graham – Vice President, Non-Smokers Movement of Australia |
| **67** | Mr Brian Robson |
| **68** | Commissioner Greg Mullins – Commissioner, NSW Fire Brigade |
| **69** | Ms Dianne DiFrancesco |
| **70** | Mr Paul Dirago |

# Appendix 2 Witnesses

| Date | Name | Position and Organisation |
|---|---|---|
| Tuesday 21 March 2006<br>Parliament House | Dr Andrew Penman | CEO, The Cancer Council NSW |
| | Ms Anita Tang | Director, Health Strategies, The Cancer Council NSW |
| | Associate Professor John Gullotta | GP, President, Australian Medical Association (NSW) and Adjunct Association Professory, Central Clinical School, Faculty of Medicine, The University of Sydney |
| | Ms Emily Perry | Senior Policy Adviser, Australian Medical Association (NSW) |
| | Professor Jim Bishop | Chief Cancer Officer and CEO, Cancer Institute NSW, Professor of Cancer Medicine, University of Sydney |
| | Ms Trish Cotter | Director, Prevention, Cancer Institute NSW |
| Wednesday 22 March 2006<br>Parliament House | Professor Simon Chapman | School of Public Health, Faculty of Medicine, University of Sydney |
| | Mr Tony Thirlwell | CEO, National Heart Foundation, NSW Division |
| | Ms Jeannie McKenzie | National Heart Foundation, NSW Division |
| | Ms Mimi St John-Austen | Acting CEO, Asthma NSW |
| | Ms Megan Dephoff | Manager, Programs and Policy, Asthma NSW |
| Monday 27 March 2006<br>Parliament House | Mrs Marlene Sharp<br>Mr Phil Edge | Former hospitality employees with environmental tobacco smoke-related health conditions |
| | Mr Peter Semmler QC | Barrister for Marlene Sharp |
| | Professor Bernard Stewart | Head, Cancer Control Program, South East Sydney and Illawarra Area Health Service |
| | Mr John Thorpe | President, Australian Hotels Association |
| | Mr David Cass | Consultant, Australian Hotels Association |
| | Mr Mark Lennon | Assistant Secretary, Unions NSW |
| | Mr Tim Ferrari | Industrial Relations Officer, Liquor Hospitality and Miscellaneous Workers Union |

| Date | Name | Position and Organisation |
|---|---|---|
| | Mr Stafford Sanders | Coordinator, SmokeFree Australia Coalition |
| | Mr Robert Goldman | CEO, Restaurant and Catering NSW/ACT |
| | Dr Denise Robinson | Chief Health Officer and Deputy Director General, Population Health, NSW Health |
| | Ms Kate Purcell | A/Director, Centre for Chronic Disease Prevention and Health Advancement, NSW Health |
| | Dr John Sanders | Manager, Tobacco and Health Branch, NSW Health |
| Friday 5 May 2006 | Dr John Wiggers | Director of Population Health, Hunter New England Area Health Service |
| | Ms Kate Purcell | A/Director, Centre for Chronic Disease Prevention and Health Advancement, NSW Health |
| | Mr David Costello | CEO, Clubs NSW |
| | Mr Wayne Krelle | Deputy CEO, Clubs NSW |
| | Commissioner Greg Mullins | Commissioner, NSW Fire Brigade |
| | Ms Anne Mainsbridge | Senior Solicitor, Public Interest Advocacy Centre (PIAC) |
| | Ms Carol Berry | Solicitor – Health Policy and Advocacy, PIAC |
| | Mr David Killeen | Chair, National Alliance of Tobacco Retailers |
| | Mr Ken Henrick | CEO, National Association of Retail Grocers |
| | Mr Ron Bowden | Executive Director, Service Stations Association |
| | Mr Simon Beynon | Sales and Franchise Manager, FreeChoice Stores |
| | Mr Sean Appoo | Research and Service Development Officer, Aboriginal Health and Medical Research Council of NSW |
| | Mr Hector Terare | Men's Health Policy Officer, Aboriginal Health and Medical Research Council of NSW |
| | Commander Ron Dorrough | Commander, Traffic Policy, NSW Police |
| | Associate Professor Matthew Peters | Chair, Action on Smoking and Health (ASH) |
| | Ms Anne Jones | CEO, ASH |

# Appendix 3 Public forum participants

On Monday, 1 May 2006 the Committee held a public forum to hear from members of the community about their views on tobacco smoking. Below is the list of people who spoke at the public forum.

| Name | Organisation |
|---|---|
| Ms Renee Bittoun | Woolcock Institute of Medical Research |
| Mr Cosimo Capoccello | |
| Ms Kim Curtis | |
| Mr Bob Daisley | |
| Ms Sharon Eurlings | |
| Mr Neil Francey | |
| Mr Roy Giles | |
| Mr Raymond Graham | The Cancer Council NSW |
| Ms Julie Heraghty | Macular Degeneration Foundation |
| Ms Margaret Hogge | Non-Smokers Movement of Australia |
| Mr Vince Kelly | |
| Mr Peter Lavac | |
| Ms Isabel Lukas | |
| Mr Leslie Marsh | PNMG |
| Mr Brian McBride | |
| Ms Mary Osborn | Royal Australasian College of Physicians |
| Mr Christopher Ridings | |
| Mr Matt Roberts | |
| Mr Michael Stevens | |
| Mr Paul Sullvon | |
| Mr Luke Whitington | Liquor Hospitality and Miscellaneous Workers Union |
| Ms Rhonda Wilson | Myhealth Australia |
| Ms Barbara Wright | |

In the afternoon, a panel of experts answered the Committee's questions, which were based on issues raised by the speakers at the public forum. The following representatives were on the panel:

| **Name** | **Organisation** |
|---|---|
| Dr Denise Robinson | NSW Health |
| Ms Kate Purcell | NSW Health |
| Ms Pam Wilde | NSW Health |
| Dr Andrew Penman | The Cancer Council NSW |
| Mr David Elliot | Australian Hotels Association (NSW) |
| Ms Anne Jones | Action on Smoking and Health (ASH) |

# Appendix 4 Summary of Australian and New Zealand tobacco smoking restrictions

The Committee wrote to all states and territories inviting them to provide information on tobacco control measures in their jurisdictions. The information in the following table provides detail on the differences between the jurisdictions based on the information received from each state and territory and from NSW Health.

| | WA | TAS | QLD | ACT |
|---|---|---|---|---|
| **Total ban in 'enclosed public places' of Licensed Premises** | Yes (by 31 July 2006). | Yes (at 1 Jan 2006). | Yes (by 1 July 2006). | Yes (by 1 Dec 2006). |
| **Continuing Exemptions for a Casino?** | Yes (Exemption for "high-roller" facilities if adequate ventilation). | No | Yes (Exemption for premium rooms.) | No |
| **Outside building entrances and air vents** | ***From 1 Jan 2005***<br>Non-legislative ban:<br>- Within 5 metres of building entrances.<br>- Within 10 metres of any air intake for ventilation equipment and<br>- Applies to Government buildings only. | ***Currently***<br>Banned:<br>- Within 3 metres of an entrance or exit from any multiple use or non-domestic building.<br>- Within 10 metres of any air intake for ventilation equipment. | ***From 1 Jan 2005***<br>Banned:<br>- Within 4 metres of entrances to non-residential buildings. | Not restricted |
| **Outdoor dining or liquor venues** | Not restricted | ***Currently:***<br>Banned:<br>- 50% of outdoor dining areas (3 metre ban does not apply when food purchased from the occupier is consumed at a table within that area, but 50% overall must be smoke free).<br><br>***From 1 Jan 2006:***<br>Restrictions on outdoor smoking areas at licensed premises:<br>- Must not be serviced; and<br>- If covered by a roof the area must not be more than 50% enclosed by walls or windows. | ***From 1 July 2005***<br>Banned:<br>- Outdoor eating and drinking places (holders of general, club or casino licenses under the Liquor Act can designate an outdoor smoking and drinking area provided specific criteria are met, eg no food or drink service). | Banned:<br>- If the area is covered and it is 75% or more enclosed. |
| **Children's Playgrounds** | Not restricted | Not restricted | ***From 1 Jan 2005***<br>Banned:<br>- Within 10 metres of children's playground equipment. | Not restricted |
| **Beaches** | Not restricted | Not restricted | ***From 1 Jan 2005***<br>Banned:<br>- Patrolled areas of patrolled beaches.<br>- Prescribed swimming areas (i.e. artificial beaches) between sunrise and sunset. | Not restricted |
| **Sporting Facilities** | Not restricted | Banned at any area of an outdoor sporting or cultural venue containing reserved seating. | Banned at major sports facilities, with the exception of roads, carparks, picnic areas, parkland. | Not restricted |
| **Private motor vehicles** | Considered the issue and is not restricted. | A discussion paper is to be released in 2006 which will look at the issue of smoking in cars with children as passengers but there are no current restrictions except in work vehicles. | Restrictions in work vehicles but not restricted in private vehicles | Not restricted |

| | VIC | NSW | SA | NT | NZ |
|---|---|---|---|---|---|
| **Total ban in 'enclosed public places' of Licensed Premises** | Yes (by 1 Jul 2007) | Yes (by 2 Jul 2007) | Yes (by 31 Oct 2007) | No – smoke-free areas must be provided in equal amenity to smoking areas. | Yes |
| **Continuing Exemptions for a Casino?** | Yes (In some bar areas, TAB areas and high roller rooms.)<br><br>***From 1 July 2007*** exemptions only for high roller rooms. | Yes (Private gaming areas of Star City Casino.)<br><br>To be reviewed annually. | No | Yes | No – smoking bans apply to casinos. |
| **Outside building entrances and air vents** | Not restricted | Not restricted | Not restricted | ***Currently:***<br>Banned:<br>- Within 2 metres of entrances (including windows and doors) & within 3 metres of air conditioning inlets. | Not restricted |
| **Outdoor dining or liquor venues** | ***From 1 July 2007:***<br>Banned:<br>- If an area has a roof and the total area of wall surfaces surrounding the area exceeds 75% of the notional wall area. | Not restricted | Not restricted | ***Currently:***<br>Banned:<br>- Within half of fixed seating in outdoor venues. | Not restricted |
| **Children's Playgrounds** | Not restricted | Not under State legislation.<br><br>Banned in some local councils only | Some local council restrictions apply. | Not restricted | Not restricted.<br>Total smoking bans apply to school premises. |
| **Beaches** | Not restricted | Not under State legislation. Banned in some local councils only. | Not restricted | Not restricted | Not restricted |
| **Sporting Facilities** | Not restricted | Not under State legislation. Banned in some local councils only. | Not restricted. | Outdoor public venues may permit smoking such that non-smokers have an area of equal amenity. | |
| **Private motor vehicles** | Not restricted | Not restricted – Rev Fred Nile Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005 | Restrictions in work vehicles but not restricted in private vehicles | Not restricted | |

| | WA | TAS | QLD | ACT |
|---|---|---|---|---|
| **Detailed Phase-in Information** | ***From 1 November 2005***<br>- Smoking permitted in 1 room only in pubs and licensed clubs.<br>- Smoking permitted in a dedicated smoking room in restaurant licensed premises provided certain conditions are met.<br>- Smoking permitted in up to 20% of floorspace of nightclub and Cabaret licensed premises.<br>- Smoking permitted in International Room of Burswood Casino.<br><br>***From 31 July 2006***<br>Banned:<br>In all enclosed public places including enclosed areas of:<br>- Restaurants<br>- Pubs<br>- Clubs<br>(except International Room at Burswood Casino if adequately ventilated) | ***From 1 Jan 2006***<br>Banned:<br>- All indoor public places and workplaces, including all areas of licensed premises and the casino. | ***From 1 Jan 2005***<br>Banned:<br>- 1/3 all indoor licensed premises smoke free including 1/3 of gaming machines.<br>- Within 4 metres of building entrances.<br>- All outdoor sports stadiums managed by the Major Sports Facilities Authority.<br>- Within 10 metres of children's playground equipment.<br>- Patrolled beaches.<br><br>***From 30 Sep 2005***<br>- 2/3 all indoor licensed premises smoke free, including 2/3 of gaming machines.<br><br>***From 1 Jul 2006***<br>Banned:<br>- All enclosed public places.<br>- Outdoor eating and drinking places (holders of general, club or casino licenses under the Liquor Act can designate an outdoor smoking and drinking area provided specific criteria are met.) | ***From 1 Dec 2006***<br>Banned:<br>- In all 'enclosed' public places (includes enclosed areas of restaurants, licensed premises, casino etc). |
| **Retail and promotion** | ***From 31 July 2006***<br>- Licensing of retailers and wholesalers commencing February 2007<br>- Controlled purchase operations for retailers selling to minors<br>- Ban all forms of tobacco advertising and promotion<br>- Limit displays of tobacco products<br>- Investigators and environmental health officers to enforce legislation | - Licensing of retailers and wholesalers<br>- No advertising, marketing to children, price discounts, must have graphic health warnings and display no more than 4m2<br>- Further restrictions are being considered including making tobacco products 'out of sight' | - Limits on displays<br>- Retailers and their employees must be trained in tobacco sales<br>- No loyalty reward points for tobacco products | - Licensing of retailers and wholesalers<br>- Limits on displays and product information – 1m2<br>- Only one point of sale for most retailers<br>- Health warning notice must be displayed |

| | VIC | NSW | SA | NT | NZ |
|---|---|---|---|---|---|
| **Detailed Phase-in Information** | ***From 1 March 2006***<br>Banned:<br>- Smoking in enclosed workplaces (includes shopping centres and restaurants).<br>- Smoking and the promotion or sale of tobacco products at underage 'music/dance' events.<br>- Smoking in covered areas of train station platforms, tram stops and bus stops.<br><br>***From 1 Jul 2007***<br>Banned:<br>- Enclosed licensed premises.<br>- Outdoor dining or drinking areas if a roof is in place and the total area of the wall surface exceeds 75% of the notional wall area. | ***From 4 Jul 2005***<br>Smoking permitted in:<br>- 1 room only in venue with multiple rooms.<br>- 1 area only in single room venues<br>such that the area where smoking is permitted is **not more than 50%** of the total combined bar/ gaming/ recreation areas.<br><br>***From 3 Jul 2006***<br>Smoking is permitted in<br>- 1 room only in venues with multiple rooms.<br>- 1 area only in single room venues<br>such that the area where smoking is permitted is **not more than 25%** of the total combined bar/ gaming/ recreation areas.<br><br>***From 2 Jul 2007***<br>Banned:<br>- Indoors in licensed premises. | ***From 6 Dec 2004***<br>Banned:<br>- In all enclosed workplaces and public areas (exceptions for licensed hospitality venues)<br>- Within 1 metre of all service areas (including front bars and casino gaming tables).<br>- 1 bar in all multi-bar venues or, for single bar venues, at least 50% of the floor area to be non-smoking.<br>- 25% of gaming machines.<br><br>***From 31 Oct 2005***<br>Banned:<br>- 50% of gaming machines.<br><br>***From 31 Oct 2007***<br>Banned:<br>- Pubs<br>- Clubs<br>- Gaming rooms<br>- Casino | | |
| **Retail and promotion** | - Limits on displays and product information – 4m2<br>- Only one point of sale for most retailers<br>- Health warning notice and "no sale to under 18's" sign must be displayed<br>- 1 March 2006 stronger laws for sales to minors including training of employees | - April 2006 notification system for retailers identifying who is a tobacco retailer and where in NSW<br>- No advertising<br>- Limits on displays and product information<br>- Health warning notice and "no sale to under 18's" sign must be displayed<br>- Environmental health officers monitor and enforce legislation | - Licensing of retailers<br>- Only one point of sale for most retailers<br>- All forms of advertising are banned<br>- Currently no restrictions on the size of tobacco displays | - Licensing of retailers<br>- Health warning notice and "no sale to under 18's" sign must be displayed<br>- Limits on displays and product information – 4m2 | ***N/A*** |

# Appendix 5 Minutes

**Minutes No 1, Thursday 9 March 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**At Room 1108, Parliament House, at 1:00 pm**

1. **Clerk of the Parliaments opened meeting**
   The Clerk of the Parliaments declared the meeting open at 1.00pm according to the Resolutions of the Legislative Council on 28 February 2006, Minutes 135, Item 42, page 1846 and Legislative Assembly 8 March 2006, Votes and Proceedings No. 168, Item 3, page 1890.

   The Clerk tabled the Resolutions establishing the Joint Select Committee, and confirmed the membership of the Committee.

   The Clerk advised the Committee that the Legislative Council Standing Orders would apply for the duration of the Committee's existence.

2. **Members present**
   Dr Arthur Chesterfield-Evans
   Mr Greg Donnelly
   Mr Don Harwin
   Revd Fred Nile
   Ms Shelley Hancock
   Ms Virginia Judge
   Mr Paul McLeay
   Mr Matthew Morris
   Mr Richard Torbay

3. **Apologies**
   Ms Angela D'Amore
   Mr Thomas George

4. **Election of Chair**
   The Clerk called for nominations for Chair.

   Dr Chesterfield-Evans nominated Mr Torbay.

   Mr Harwin nominated Ms Judge – nomination declined.

   Mr Harwin nominated Mr Donnelly – nomination declined.

   Mr Harwin nominated Rev Nile.

   The Clerk informed the Committee that there being two nominations, in accordance with the practice of the House a ballot must be held.

   Ballot papers were distributed by the Clerk to Committee members and members lodged their votes.

   The Clerk announced the result of the ballot as follows:

   Mr Torbay – 5 votes
   Revd Nile – 4 votes

Mr Torbay was declared Chair of the Joint Select Committee on tobacco smoking in New South Wales.

Mr Torbay took the Chair.

**5. Procedural Resolutions**

The Committee considered the draft initial motions, previously circulated.

Resolved, on the motion of Ms Judge: that the following initial resolutions be adopted for the life of the Committee:

*1. Sound and television broadcasting*

That in accordance with the resolution of the Legislative Council of 11 October 1994, the Committee authorises the sound and television broadcasting as appropriate, of its public proceedings, unless the Committee decides otherwise.

*2. Arrangements for hearings and site visits*

That the arrangements for the calling of witnesses and for visits of inspection be left in the hands of the Chair and the Secretariat after consultation with the Committee.

*3. Media statements*

That media statements on behalf of the Committee be made only by the Chair, if possible after consultation with the Committee.

*4. Advertising*

That the Secretariat be empowered to advertise and/or write to persons, bodies and organisations inviting written submissions relevant to the terms of reference for the Committee's inquiries.

*5. Publication of transcripts*

That, in accordance with section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 223, the Committee authorise the Director to publish the transcript of evidence taken at public hearings, unless the Committee decides otherwise.

*6. Committee correspondence*

That the Secretariat be empowered to respond to correspondence on behalf of the Committee, where the correspondence concerns routine or administrative matters. In all other cases the Chair must approve replies to correspondence.

*7. Dissenting statements*

That any member who wishes to append a statement of dissent to a report in accordance with Standing Order 228 must advise the Committee of their intention to do so at the last deliberative meeting considering the report.

**6. Call for Submissions**

Resolved, on the motion of Mr Nile, that advertisements calling for submissions be placed in The Daily Telegraph, The Australian, The Australian Financial Review and The Sydney Morning Herald on the day with the greatest circulation, and that a media release be sent to local print and radio media across the State.

Resolved, on the motion of Ms Hancock, that the Chair write to relevant individuals and organisations to invite submissions and that Committee members forward suggested names to the Secretariat by close of business on Monday 13 March 2006.

Resolved, on the motion of Ms Hancock, that the closing date for submissions be 13 April 2006.

**7. Future Committee activity**

Resolved, on the motion of Mr McLeay, that, after consultation with the Chair, the Secretariat circulate a calendar of proposed hearing dates to Committee members and that Committee members forward suggested witnesses to the Committee by close of business Monday 13 March 2006.

**8. Adjournment**

The Committee adjourned at 1:40 pm *sine die*.

**Rachel Simpson**
**Director**

**Minutes No 2, Tuesday 21 March 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**Jubilee Room, Parliament House, at 1:00 pm**

**1. Members present**

Mr Richard Torbay (Chair)
Dr Arthur Chesterfield-Evans
Mr Greg Donnelly
Mr Don Harwin
Revd Fred Nile
Ms Shelley Hancock
Mr Paul McLeay

**2. Apologies**

Ms Angela D'Amore
Mr Thomas George
Ms Virginia Judge
Mr Matthew Morris

**3. Deliberative meeting**

***Confirmation of minutes***

Resolved, on the motion of Ms Hancock, that Minutes No 1 be confirmed.

***Procedural resolutions***

*Supplementary questions*

Resolved, on the motion of Revd Nile, that members provide supplementary questions for witnesses to the secretariat by 5pm on the next business day following the witnesses' appearance.

*Answers to questions on notice*

Resolved, on the motion of Revd Nile, that witnesses be requested to provide answers to questions taken on notice and supplementary questions within 10 working days of the date of the letter sent.

***Call for evidence***

The Committee noted:

- Chair's media release, 14 March 2006
- Letter inviting submissions and list of recipients

***Future Committee activity***

Resolved, on the motion of Revd Nile, that the Committee conduct a half-day public forum on 1 May 2006 and site visit(s) to a pub or club.

**4. Private briefing – NSW Health**

The Committee participated in a private briefing with Dr John Sanders, Manager, Health and Tobacco Branch, NSW Health, Mr Iain Martin, Solicitor, NSW Health, about current smoke free environment legislation.

**5. Public hearing**

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding procedures for the hearing and other matters.

Dr Andrew Penman, Chief Executive Officer and Ms Anita Tang, Director, Health Strategies, The Cancer Council NSW, were sworn and examined.

Mr Penman tabled the document, 'Cancer mortality rates in Australia 1910-1999: The impact of lung cancer', unpublished document prepared by Cancer Council NSW.

Resolved, on the motion of Mr McLeay, that the document be accepted and published.

Ms Tang tabled the documents:

- *The macroeconomic and distributional effects of reduced smoking prevalence in New South Wales,* Cancer Council NSW, June 2004
- *When smoke gets in your eyes …nose, throat and bloodstream: A guide to passive smoking and the law in New South Wales,* Cancer Council NSW*,* February 2001
- 'Smoke-Free Workplaces in Ireland: A One-Year Review', Office of Tobacco Control, Ireland, March 2005
- 'The State of Smoke-Free New York City: A One-Year Review', New York City Departments of Finance, Health and Mental Hygiene, Small Business Services and Economic Development, March 2004
- 'One year of smokefree bars and restaurants in New Zealand: Impacts and responses', *BMC Public Health Journal*, March 2004.

Resolved, on the motion of Ms Hancock, that the documents be accepted and published.

Ms Tang tabled the document, 'Nobody smokes here any more', policy document published by QLD Health, 2004.

Resolved, on the motion of Mr McLeay, that the document be accepted and published.

Ms Tang tabled the documents:

- 'Designated "no smoking" areas provide from partial to no protection from environmental tobacco smoke', Cains et al, Tobacco Control 2004, 13:17-22
- 'Smoke-free laws – international update as at March 2006', unpublished document prepared by Cancer Council NSW
- 'Status of smoking bans in states other than NSW as at March 2006' unpublished document prepared by Cancer Council NSW
- Estimated Morality from Second hand Smoke among Club, Pub, Tavern and Bar Workers in NSW Australia, report commissioned by Cancer Council NSW, 2004
- The Retail Environment in Tobacco Control and accompanying presentation slides, unpublished document prepared by Cancer Council NSW.

Resolved, on the motion of Mr Donnelly, that the documents be accepted and published.

Questioning concluded, the witnesses withdrew.

Associate Professor John Gullotta, General Practitioner, President, Australian Medical Association (NSW) and Adjunct Associate Professor, Central Clinical School, Faculty of Medicine, The University of Sydney and Ms Emily Perry, Senior Policy Adviser, Australian Medical Association (NSW), were sworn and examined.

Ms Perry tabled a document containing images of health warning labels on cigarette packets.

Resolved, on the motion of Ms Hancock, that the document be accepted and published.

Questioning concluded, the witnesses withdrew.

Professor Jim Bishop, Chief Cancer Officer and CEO, Cancer Institute NSW and Professor of Cancer Medicine, University of Sydney and Ms Trish Cotter, Director, Prevention, Cancer Institute NSW, were sworn and examined.

Questioning concluded, the witnesses withdrew.

**6. Deliberative meeting**

Resolved, on the motion of Mr McLeay, that documents tabled by witnesses at the hearing be accepted and published.

Dr Chesterfield-Evans suggested that the Committee consider issuing a summons to the following people:

- Mr John Gallagan, CEO, British American Tobacco
- Mr Gareth Davis, CEO, Imperial Tobacco Australia Ltd
- Ms Nerida White, Managing Director, Philip Morris Ltd

The Committee deliberated.

Resolved, on the motion of Dr Chesterfield-Evans, that the Chair write to Mr Gallagan, Mr Davis and Ms White inviting them to nominate representatives to appear before the Committee at its hearings on 1 or 5 May 2006.

**7. Adjournment**

The Committee adjourned at 5.10 pm until 10.30am, Wednesday 22 March 2006 (public hearing).

**Rachel Simpson**
**Director**

**Minutes No 3, Wednesday 22 March 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**Jubilee Room, Parliament House, at 10:30 am**

**1. Members present**

Mr Richard Torbay (Chair)
Dr Arthur Chesterfield-Evans
Mr Greg Donnelly
Revd Fred Nile
Ms Angela D'Amore
Ms Shelley Hancock
Ms Virginia Judge
Mr Paul McLeay

**2. Apologies**
Mr Don Harwin
Mr Thomas George
Mr Matthew Morris

**3. Public hearing**
The witnesses, the public and the media were admitted.

The Chair made an opening statement regarding procedures for the hearing and other matters.

Professor Simon Chapman, School of Public Health, University of Sydney, was sworn and examined.

Professor Chapman tabled the document, Tobacco Control Journal, December 2003, Vol 12, Supplement III and the overhead slides of his presentation to the Committee.

Resolved, on the motion of Ms Hancock, that the documents be accepted and published.

Questioning concluded, the witness withdrew.

Mr Tony Thirlwell, CEO, National Heart Foundation, NSW Division, Ms Jeannie McKenzie, Director, Cardiovascular Health, National Heart Foundation, Ms Mimi St John-Austen, Acting CEO, Asthma NSW and Ms Megan Dephoff, Manager, Programs and Policy, Asthma NSW, were sworn and examined.

Questioning concluded, the witnesses withdrew.

The Committee adjourned for a site visit to the Respiratory Unit, Concord Hospital.

**4. Site visit and informal briefing– Respiratory Unit, Concord Hospital**
The Committee participated in an informal briefing with A/Professor Matthew Peters, Head, Respiratory Unit, Concord Hospital.

**5. Adjournment**
The Committee adjourned at 4.10 pm until 9.00am, Monday 27 March 2006 (public hearing).

**Merrin Thompson**
**Principal Council Officer**

**Minutes No 4, Monday 27 March 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**Waratah Room, Parliament House, at 9:00 am**

**1. Members present**
Richard Torbay (Chair)
Dr Arthur Chesterfield-Evans
Mr Greg Donnelly
Revd Fred Nile
Mr Don Harwin
Ms Angela D'Amore
Mr Thomas George
Mr Paul McLeay
Ms Virginia Judge

**2. Apologies**

Ms Shelley Hancock
Mr Matthew Morris

**3. Public hearing**

The witnesses, the public and the media were admitted.

Mrs Marlene Sharp and Mr Phil Edge were sworn and examined.

Questioning concluded, the witnesses withdrew.

Professor Bernard Stewart, Cancer Control Program, South East Sydney and Illawarra Area Health Service and Mr Peter Semmler QC were sworn and examined.

Questioning concluded, the witnesses withdrew.

Mr John Thorpe, President, Australian Hotels Association, and Mr David Cass, Consultant, Australian Hotels Association, were sworn and examined.

Questioning concluded, the witnesses and the public withdrew.

**4. Deliberative meeting**

***Member's interest***

Mr George notified the Chair of his financial interest in a hotel.

Resolved, on the motion of Ms Judge, that Mr George's interest be noted.

***Publication of transcript from site visit and informal briefing at Concord Hospital***

Resolved, on the motion of Revd Nile, that the transcript of the informal briefing provided during the site visit to Concord Hospital on 22 March 2006 be published.

***Publication of submission***

Resolved, on the motion of Revd Nile, that submission 1 be published.

***Correspondence***

The Chair noted the following correspondence sent and received:

*Sent*

- Letter from the Chair to Mr Gareth Davis, CEO, Imperial Tobacco Australia, dated 27 March 2006
- Letter from the Chair to Ms Nerida White, Managing Director, Philip Morris Ltd, dated 27 March 2006
- Letter from the Chair to Mr John Gallagan, CEO, British American Tobacco, dated 27 March 2006.

*Received*

- Letter to the Chair from Pardeep Grewal, Legal and Corporate Affairs Director, Imperial Tobacco Australia, dated 21 March 2006.

***Site visit to hospitality venues reflecting requirements of environmental tobacco smoke legislation***

Resolved, on the motion of Revd Nile, that a site visit to hospitality venues take place on 1 or 5 May 2006 and that the Chair write to selected venues indicating the Committee's intention to visit.

***Other business***

Resolved, on the motion of Mr Donnelly, that the Chair forward the transcript of evidence for 27 March 2006 to the following organisations, inviting their written response:

- WorkCover Authority NSW
- Port Kembla RSL
- Mick O'Shea's Irish Pub

Resolved, on the motion of Revd Nile, that the Chair write to health departments in each state and territory seeking information on legislative provisions in respect of environmental tobacco smoke.

**5. Public hearing**

The witnesses, the media and the public were readmitted.

Mr Mark Lennon, Assistant Secretary, Unions NSW, Mr Tim Ferrari, Liquor Hospitality and Miscellaneous Union and Mr Stafford Sanders, Coordinator, SmokeFree Australia Coalition, were sworn and examined.

Mr Ferrari tabled a document from the LHMU National Council, 2001, relating to banning smoking in all public enclosed spaces.

Resolved, on the motion of Mr McLeay, that the document be accepted and published.

Questioning concluded, the witnesses withdrew.

Mr Robert Goldman, CEO, Restaurant and Catering NSW/ACT, was sworn and examined.

Questioning concluded, the witness withdrew.

Dr Denise Robinson, Chief Health Officer and Deputy Director General, Population Health, NSW Health, Ms Kate Purcell, A/Director, Centre for Chronic Disease Prevention and Health Advancement, NSW Health and Dr John Sanders, Manager, Tobacco and Health Branch, NSW Health, were sworn and examined.

Mr Sanders tabled the document, Counting the costs of tobacco and the benefits of reducing smoking prevalence in NSW, Collins & Lapsley, report prepared for NSW Health, 2005.

Resolved, on the motion of Mr Donnelly, that the document be accepted and published.

Mr Sanders tabled the document, Car and home: smoke free zone – a report on the Environmental Tobacco Smoke and Children Project 2001-2005, The ETS Smoke and Children Project, October 2005.

Resolved, on the motion of Ms Judge, that the document be accepted and published.

Mr Sanders tabled the document, The Quit Kit, NSW Health.

Resolved, on the motion of Mr McLeay, that the document be accepted and published.

Questioning concluded, the witnesses and the public withdrew.

**6. Adjournment**

The Committee adjourned at 3:50 pm until Monday 1 May 2006 (public forum).

**Merrin Thompson**
**Principal Council Officer**

**Minutes No 5, Monday 1 May 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**Jubilee Room, Parliament House, at 10:30 am**

**1. Members present**

Richard Torbay (Chair)
Dr Arthur Chesterfield-Evans
Mr Greg Donnelly
Revd Fred Nile
Mr Don Harwin
Ms Angela D'Amore
Ms Shelley Hancock
Mr Thomas George
Mr Paul McLeay
Ms Virginia Judge
Mr Matthew Morris

**2. Public forum on tobacco smoking**

Speakers, the public and the media were admitted.

The Chair made an opening statement welcoming attendees to the forum and outlining the procedures for the day.

The following speakers made statements to the Committee:

- Kim Curtis, private citizen
- Margaret Osborne, Senior Policy Officer, Policy and Programs, Royal Australasian College of Physicians
- Julie Heraghty, Chief Executive Officer, Macular Degeneration Foundation
- Margaret Hogge, President, Non-Smokers Movement of Australia
- Vince Kelly, private citizen
- Michael Stevens, private citizen
- Cosimo Capoccello, private citizen
- Raymond Graham, private citizen
- Rhonda Wilson, Executive Director, MyHealth Australia
- Roy Giles, private citizen
- Leslie Marsh, private citizen
- Christopher Ridings, private citizen
- Matt Roberts, private citizen
- Peter Lavak, private citizen
- Brian McBride, Founder, Non-Smokers Movement of Australia
- Sharon Eurlings, casino employee and member, Liquor, Hospitality and Miscellaneous Union
- Bob Daisley, private citizen
- Neil Francey, private citizen
- Isabel Lukas, private citizen
- Paul Sullivan, private citizen
- Renee Bittoun, Head, Smoking Research Unit, Woolcock Institute of Medical Research, University of Sydney
- Barbara Wright, private citizen
- Luke Whittington, private citizen.

**3. Public Hearing**

The Chair made a statement that the public hearing would proceed in the form of a panel discussion based on issues raised by speakers during the forum.

Dr Denise Robinson, Chief Health Officer and Deputy Director General, NSW Health, Ms Kate Purcell, Acting Director, Chronic Disease Prevention, NSW Health and Dr Andrew Penman, Chief Executive Officer, the Cancer Council NSW, were re-admitted and examined under their previous oaths.

Ms Pamela Wilde, Manager, Legal and Employee Relations, NSW Health, Ms Anne Jones, Chief Executive Officer, Action on Smoking and Health (ASH) and Mr David Elliott, Executive Officer, Australian Hotels Association (NSW), were sworn and examined.

Questioning concluded, the witnesses and the public withdrew.

**4. Deliberative meeting**

***Confirmation of minutes***

Resolved, on the motion of Ms Judge, that Minutes No 2, 3 and 4 be confirmed.

***Proposal to extend the inquiry date***

The Chair indicated that the secretariat liaise with an Indigenous organisation, the Rural Fire Service and the Greater Western Area Health Service about their availability to give evidence at the hearing on 5 May 2006.

Resolved, on the motion of Revd Nile, that the Chair seek to extend the inquiry reporting date to 30 June 2006. Revd Nile indicated he would move a motion in the Legislative Council to seek an extension and that the message be sent to the Legislative Assembly to this effect.

***Invitation to tobacco companies to give evidence***

The Committee noted the correspondence received from tobacco companies:

- Mr Brendan Brady, Director, Corporate and Regulatory Affairs, British American Tobacco, to the Chair, 20 April 2006, declining an invitation to appear before the Committee and give evidence on 1 or 5 May 2006
- Mr Bert Van Gossum, Director Corporate Affairs, Philip Morris Ltd, to the A/Director, 12 April 2006, declining invitation to appear before the Committee and give evidence
- Mr Pardeep Grewal, Legal and Corporate Affairs Director, Imperial Tobacco, to the Chair, 12 April 2006, declining invitation to appear before the Committee and give evidence.

The Committee deliberated.

Resolved, on the motion of Mr Morris, that the Chair write a strongly worded second letter to Mr Brady, Mr Van Gossum and Mr Grewal, re-inviting each to appear at the hearing on 5 May 2006 or on another date convenient to them.

***Correspondence***

The Chair noted the following correspondence sent and received:

*Sent*

- Director to Mr Jon Blackwell, Chief Executive Officer, WorkCover Authority, 31 March 2006, inviting him to respond to comments made during a public hearing on 27 March 2006
- Director to Ms Julie Menzies, Manager, Mick O'Shea's Irish Pub, 31 March 2006, inviting her to respond to comments made during a public hearing on 27 March 2006
- Director to Mr Darcy Martin, Secretary/Manager, Port Kembla Returned Soldiers Club, 31 March 2006, inviting him to respond to comments made during a public hearing on 27 March 2006

- Director to Dr Neale Fong, Director General, Health Department, Government of Western Australia, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions
- Director to Ms Ushi Schreiber, Director General, Queensland Health, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions
- Director to Mr Robert Griew, Chief Executive Officer, Department of Health and Community Services, Northern Territory Government, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions
- Director to Dr Tony Sherbon, Chief Executive, ACT Health, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions
- Director to Ms Patricia Faulkner, Secretary, Department of Human Service – Government of Victoria, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions
- Dr Martyn Forrest, Secretary, Department of Human Services, Government of Tasmania, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions
- Mr Jim Birch, Chief Executive Officer, Department of Health, Government of South Australia, 30 March 2006, seeking information relevant to the inquiry from other jurisdictions.
- Director to the Hon Tony Kelly MLC, Minister for Emergency Services, 27 April 2006, inviting the emergency services agencies to make submissions
- Director to Mr Garry Pasfield, Licensee and Owner, The Old Fitzroy Hotel, 28 April 2006, concerning site visit to take place 1 May 2006

*Received*

- Mr John Gibson, President, Refugee Council of Australia, to the Chair, 10 April 2006, stating they will not be making a submission to the inquiry
- Mr Manual Dovellos, Director, LaserQuit, to the Secretariat, 29 March 2006, emails regarding the service his company provides
- Mr David Collins, Adjunct Professor of Economics, Department of Economics, Macquarie University, to the Chair, 29 March 2006, drawing the Committee's attention to the report, Counting the costs of tobacco and the benefits of reducing smoking prevalence in NSW
- Dr John de Compo, Acting Director General, Department of Health, Government of Western Australia to the Director, 19 April 2006, outlining provisions in that jurisdiction
- Ms Joanne Townsend, Director, Department of Health and Community Services, Northern Territory Government, to the Director, 18 April 2006, outlining provisions in that jurisdiction with the attachments, Welcome to SmokeFree NT, Introducing SmokeFree Public Places and Selling Tobacco, Northern Territory Tobacco Retailers Guide
- Mr Keith Evans, Executive Director, Drug and Alcohol Services, South Australia, to the Director, 13 April 2006, outlining provisions in that jurisdiction.

***Answers to questions on notice***

Resolved, on the motion of Ms Judge, that the Committee publish answers to questions taken on notice received from:

- Dr Denise Robinson, Chief Executive Officer and Deputy Director General, Population Health, NSW Health, 26 April 2006
- Anita Tang, Director, Health Strategies, The Cancer Council NSW, 11 April 2006
- Trish Cotter, Director, Prevention, Cancer Institute NSW, 10 April 2006
- A/Prof John Gullotta, President, Australian Medical Association (NSW) Ltd, 6 April 2006
- Professor Simon Chapman, School of Public Health, University of Sydney, 24 March 2006.

Resolved, on the motion of Dr Chesterfield-Evans, that the secretariat write to A/Prof Gullotta seeking clarification in respect of his answers to questions taken on notice at the hearing on 21 March 2006.

***Publication of submissions***

Resolved, on the motion of Mr Donnelly, that the following submissions be published, with Appendix 2 of Submission 17 and the entire Submission 35 kept confidential, as requested by the authors:

1a. Mr Stafford Sanders, SmokeFree Australia Coalition
2. Mrs Carmel Lamaro
3. Mr Michael Stevens
4. Mr Brian Ross, Australian Hotels Association (AHA)
5. Mr Stephen Brown
6. Mr JL Tredinnick, Bundalah Wildlife Rescue
7. Mr Bill Vandenberg
8. Mr Peter Mason
9. Ms Renee Bittoun, Woolcock Institute of Medical Research
10. Mr Col Shephard
11. Mr Rod Grieve
12. Ms Sally Crossing, Cancer Voices Inc
13. Ms Ronda Wilson, myhealth australia
14. Mr Colin Sinclair
15. Ms Lee Burgoyne
16. Mr Reinhold Meric
17. Mr Tony Thirwell, National Heart Foundation NSW Division (Appendix 2 confidential)
18. Mrs Dawn Phillips
19. A/Prof John Gullotta, Australian Medical Association NSW
20. Mr Bawa Singh Jagdev, Sikh Council of Australia Inc
21. Mr Neil Craddock, Optometrists Association Australia
22. Mr Trish Cotter, Cancer Institute Australia
23. Mr Bert Van Gossum, Phillip Morris
24. Mr Simon Beynon, FREECHOICE Stores
25. Ms Julie Babineau, Justice Health
26. Mr Pardeep Grewal, Imperial Tobacco Australia Limited
27. Mr Terry Clout, Hunter/New England Area Health Service
28. Ms Peta Cauvin
29. Mr/Ms A Mackay
30. Ms Margaret Hogge, Non-Smokers Movement Australia
31. Mr Joe Alvaro
32. Ms Kim Curtis
33. Mr Colin Coakley, Country Women's Association of NSW
34. Mr Ingo Steppat, Greater Western Area Health Service
35. Confidential
36. Prof Peter van Asperen, Department of Respiratory Medicine, The Children's Hospital, Westmead
37. Mr Gary Monks, Newsagents Association of NSW and ACT Ltd
38. Mr Phil Browne
39. Mr David Costello, Clubs NSW
40. A/Prof Jill Sewell, Royal Australasian College of Physicians
41. Ms Mimi St John-Austen, Asthma NSW
42. Dr John Herron, Australian National College on Drugs
43. Mr Brett Gale, NRMA
44. A/Prof Matthew Peters, Action on Smoking and Health
45. Ms Anne Mainsbridge, Public Interest Advocacy Centre
46. Mr Brendan Brady, British American Tobacco Australia
47. Ms Gillian Calvert, NSW Commission for Children and Young People
48. Mr Roger B Wilkins, The Cabinet Office
49. Dr Andrew Penman, The Cancer Council NSW
50. Mr Levi Foster
51. Dr Stephen Christly, Northern Sydney Central Coast Area Health Service

52. Mr Harold Levien
53. Ms Catherine Mahony, NCOSS
54. Ms Aviva Sheb'a
55. Ms Jessica Mann
56. Mr Ross Hamilton
57. Ms Norma Daisley
58. Ms Suzanne Briscoe-Hough
59. Dr Ned Iceton
60. Mr Tony Williams
61. Mr Rick Melick

**5. Site visit to the Old Fitzroy Hotel**

The Committee undertook an informal site visit to the Old Fitzroy Hotel, Woolloomooloo, hosted by the hotel's licensee and owner, Mr Garry Pasfield.

**6. Adjournment**

The Committee adjourned at 4.30 pm until Friday 5 May 2006 (public hearing).

**Merrin Thompson**
**Acting Director**

**Minutes No 6, Friday 5 May 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**Jubilee Room, Parliament House, at 9.00 am**

**1. Members present**

Richard Torbay (Chair)
Dr Arthur Chesterfield-Evans
Mr Greg Donnelly
Revd Fred Nile
Mr Don Harwin
Ms Angela D'Amore
Ms Shelley Hancock
Ms Virginia Judge
Mr Matthew Morris

**2. Apologies**

Mr Thomas George
Mr Paul McLeay

**3. Public hearing**

Witnesses, the public and the media were admitted.

Dr John Wiggers, Director of Population Health, Hunter New England Area Health Service, was sworn and examined.

Ms Kate Purcell, Acting Director, Chronic Disease Prevention and Health Assessment, NSW Health, was readmitted and examined under a previous oath.

Questioning concluded, the witnesses withdrew.

Mr David Costello, Chief Executive Officer, and Mr Wayne Krelle, Deputy Chief Executive Officer, Clubs NSW, were sworn and examined.

Questioning concluded, the witnesses withdrew.

Commissioner Greg Mullins, NSW Fire Brigade, was sworn and examined.

Questioning concluded, the witness withdrew.

Ms Anne Mainsbridge, Acting Senior Solicitor, Public Interest Advocacy Centre, was affirmed and examined.

Ms Carol Berry, Solicitor, Health Policy and Advocacy, Public Interest Advocacy Centre, was sworn and examined.

Questioning concluded, the witnesses withdrew.

Mr David Killeen, Chair, National Alliance of Tobacco Retailers, Mr Ron Bowden, Executive Director, Service Stations Association and Mr Simon Beynon, Sales and Franchise Manager, FreeChoice Stores, were sworn and examined.

Mr Ken Henrick, Chief Executive Officer, National Association of Retail Grocers, was affirmed and examined.

Questioning concluded, the witnesses and the public withdrew.

**4. Deliberative meeting**

***Confirmation of minutes***
Resolved, on the motion of Ms Judge, that Minutes No 5 be confirmed.

***Publication of forum transcript***
Resolved, on the motion of Ms Judge, that the transcript of the public forum on 1 May 2006 be published.

***Publication of notes from site visit***
Resolved, on the motion of Ms Judge, that the notes from the Committee's informal site visit to the Old Fitzroy Hotel on 1 May 2006 prepared by the secretariat be published.

***Invitation to tobacco companies to give evidence***
The Chair reported that a strongly worded second letter to each of the tobacco companies re-inviting each to appear at the hearing on 5 May 2006 or on another date convenient to them was faxed and posted on 2 May 2006, in keeping with the Committee's resolution of 1 May 2006 (see correspondence sent, below).

Mr Torbay also reported that responses declining the Committee's invitation had been received from Imperial Tobacco on 4 May 2006 and Philip Morris on 5 May 2006 (see correspondence received, below), and that no response had yet been received from British American Tobacco.

Mr Chesterfield-Evans moved: That the Chair be requested to determine a date, time and place for a public hearing at which witnesses from Imperial Tobacco, Philip Morris and British American Tobacco will be issued with a summons to appear.

Question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile

Noes: Mr Donnelly, Mr Harwin, Ms D'Amore, Ms Hancock, Ms Judge, Mr Morris, Mr Torbay

Question resolved in the negative.

***Correspondence***

The Chair noted the following correspondence sent and received:

*Sent*

- Chair to Mr Bert Van Gossum, Director, Corporate Affairs, Philip Morris Ltd, 2 May 2006, reissuing the Committee's invitation to appear at a public hearing
- Chair to Mr Pardeep Grewal, Director, Legal and Corporate Affairs, Imperial Tobacco Australia Ltd, 2 May 2006, reissuing the Committee's invitation to appear at a public hearing
- Chair to Mr Brendan Brady, Director, Corporate and R reissuing the Committee's invitation to appear at a public hearing.

*Received*

- Mr Chris Argent, Government and Regulatory Affairs, Philip Morris, email to secretariat, 5 May 2006, declining second invitation to appear at a public hearing on 5 May 2006 and advising that the invitation to attend on another day is being considered
- Mr Pardeep Grewal, Legal and Corporate Affairs, Imperial Tobacco, to Chair, 4 May 2006, declining second invitation to appear at a public hearing.
- Dr Martyn Forrest, Secretary, Department of Health and Human services, Government of Tasmania, to the Director, 28 April 2006, outlining provisions in that jurisdiction
- Dr Denise Roberston, Chief Health Officer and Deputy Director-General, NSW Health, to the Chair, 26 April 2006, advising who will be appearing on the expert panel for the public forum
- Ms Uschi Schreiber, Director General, Queensland Health, to the Chair, 25 April 2006, outlining provisions in that jurisdiction.

***Publication of submissions***

Resolved, on the motion of Ms Hancock, that the following submissions be published:

1b. Mr Stafford Sanders, SmokeFree Australia Coalition
3a. Mr Michael Stevens
62. Mr David Killeen, National Alliance of Tobacco Retailers
63. Ms Kate McGregor, The Cricketers Arms Tavern
64. Mr Brian McBride
65. Ms Jody Broun, Department of Aboriginal Affairs
66. Mr Graham Owen, Non-Smokers' Movement of Australia
67. Mr Brian Robson
68. NSW Fire Brigades

**5. Public hearing**

Witnesses, the public and the media were re-admitted.

Mr Sean Appoo, Research and Service Development Officer, and Mr Hector Terare, Men's Health Policy Officer, Aboriginal Health and Medical Research Council of NSW, were affirmed and examined.

Questioning concluded, the witnesses withdrew.

Commander Ron Dorrough, Traffic Policy, NSW Police, was sworn and examined.

Questioning concluded, the witness withdrew.

Associate Professor Matthew Peters, Chair, Action on Smoking and Health (ASH), was sworn and examined.

Ms Anne Jones, Chief Executive Officer, ASH, was readmitted and examined under a previous oath.

Questioning concluded, the witnesses withdrew.

**6. Adjournment**
The Committee adjourned at 4.10 pm sine die.

**Merrin Thompson**
**Acting Director**

**Minutes No 7, Wednesday 21 June 2006**
**Joint Select Committee on Tobacco Smoking in New South Wales**
**In Room 1108, Parliament House, at 10:00 am**

**1. Clerk of the Parliaments opened meeting**
The Clerk of the Parliaments declared the meeting open at 10.00 am according to the Resolutions of the Legislative Council on 24 May 2006, Minutes No 3, Item 6, pages 33-34 and Legislative Assembly 25 May 2006, Votes and Proceedings No 4, Item 25, pages 67-68.

The Clerk tabled the Resolutions establishing the Joint Select Committee, and confirmed the membership of the Committee.

The Clerk advised the Committee that the Legislative Council Standing Orders would apply for the duration of the Committee's existence.

**2. Members present**
Dr Arthur Chesterfield-Evans
Mr Greg Donnelly
Mr Don Harwin
Revd Fred Nile
Ms Angela D'Amore
Mr Thomas George
Ms Shelley Hancock
Ms Virginia Judge
Mr Paul McLeay
Mr Matthew Morris
Mr Richard Torbay

**3. Election of Chair**
The Clerk called for nominations for Chair.

Dr Chesterfield-Evans nominated Mr Torbay.

There being only one nomination, in accordance with the practice of the House, the Clerk declared Mr Torbay Chair of the Joint Select Committee on Tobacco Smoking.

Mr Torbay took the Chair.

**4. Apologies**
None received.

**5. Minutes**

Resolved, on the motion of Mr Donnelly, that Minutes No 6 be adopted.

**6. Correspondence**

Resolved, on the motion of Mr Nile, that the Committee note the correspondence received.

*Received*

- Mr Stafford Sanders, Communications Officer, ASH Australia, to the Chair, 8 June 2006, attaching ASH media release about osteoarthritis and smoking
- Mr Stafford Sanders, Communications Officer, ASH Australia, to the Chair, 6 June 2006, attaching ASH media release about meningococcal disease and smoking
- Hon Carl Scully MP, Minister for Police, to the Chair, 2 June 2006, concerning the Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005
- Ms Anne Jones, Chief Executive, ASH Australia, to the Chair, 29 May 2006, providing information on NSW's national ranking on effectiveness in tobacco control over the past year
- Ms Anne Jones, Chief Executive, ASH Australia, to the Chair, 18 May 2006, referring to comments made by tobacco retailers in evidence
- Mr Andrew Tink MP, to the A/Director, concerning representations from a constituent regarding smoking in clubs and hotels
- Mr PM Faulkner, Secretary, Victorian Department of Human Services, to the Director, 17 May 2006, providing information on provisions in that jurisdiction
- Dr Tony Sherbon, Chief Executive, ACT Health, to the Director, 30 April 2006, providing information on provisions in that jurisdiction

*Answers to questions on notice*

Resolved, on the motion of Ms Judge, that the Committee publish answers to questions taken on notice received from:

- Ms Anne Mainsbridge, Senior Solicitor, PIAC, to the Chair, 26 May 2006
- Mr Greg Mullins, Commissioner, NSW Fire Brigades, to the Director, 22 May 2006
- A/Prof John Gullotta, President, AMA, to the Director, 10 May 2006
- Ms Kerry Chant, Acting Chief Health Officer and Acting Deputy Director General- Population Health, NSW Health, to the Director, 18 May 2006

**7. Publication of submissions**

Resolved, on the motion of Ms D'Amore, that the Committee publish the following submissions, with certain information kept confidential in Submission 69:

44a. A/Prof Matthew Peters, Action on Smoking and Health
69. Ms Dianne DiFrancesco
70. Mr Paul Dirago

**8. Procedural resolutions**

The Committee considered the draft initial motions, previously circulated.

Resolved, on the motion of Mr George, that the following initial resolutions be adopted for the life of the Committee:

*Media statements*

That media statements on behalf of the Committee be made only by the Chair, if possible after consultation with the Committee.

*Committee correspondence*
That the Secretariat be empowered to respond to correspondence on behalf of the Committee, where the correspondence concerns routine or administrative matters. In all other cases the Chair must approve replies to correspondence.

*Dissenting statements*
That any member who wishes to append a statement of dissent to a report in accordance with Standing Order 228 must advise the Committee of their intention to do so at the last deliberative meeting considering the report.

**9. Consideration of the draft report**
The Chair tabled the draft report, which had been previously circulated.

Chapter 1 read.

Dr Chesterfield-Evans moved: That paragraph 1.13 be amended by inserting at the end of the paragraph: "Despite a motion to subpoena tobacco companies to appear at a hearing the Committee refused to agree to this."

Revd Nile moved: That the motion of Dr Chesterfield Evans be amended by replacing the words "Despite a motion to subpoena tobacco companies to appear at a hearing the Committee refused to agree to this." with ", or to defend their products."

Question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile
Noes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris, Mr Torbay

Question resolved in the negative.

The Chair then read Standing Order 228 concerning dissenting statements.

Original question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile
Noes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris, Mr Torbay

Question resolved in the negative.

Resolved, on the motion of Ms Judge, that Chapter 1 be adopted.

Chapter 2 read.

Resolved, on the motion of Revd Nile, that paragraph 2.19 be amended by omitting the words "while there is little evidence to show that smoking causes asthma".

Resolved, on the motion of Revd Nile, that Chapter 2, as amended, be adopted.

Chapter 3 read.

Resolved, on the motion of Mr McLeay, that the heading for Table 3.1 be amended by inserting at the end "as at September 2005".

Dr Chesterfield-Evans moved: That paragraph 3.19 be amended by inserting at the end of the paragraph: "The Committee was unsure of the truth of this boast in the context of New South Wales' comparatively low spending on tobacco control."

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Resolved, on the motion of Mr McLeay, that the second sentence of paragraph 3.44 be amended by omitting the word "extremely".

Resolved, on the motion of Mr McLeay, that paragraph 3.45 be amended by omitting the word "thus".

Dr Chesterfield-Evans moved: That paragraph 3.45 be amended by inserting "at least" after the words "tobacco control" and inserting at the end of the paragraph: "and that evidence exists that $8.50 is a minimum figure and that at least twice this expenditure can be justified."

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Dr Chesterfield-Evans moved: That Recommendation 2 be amended to read: "That the NSW Government increase funding for tobacco control in line with the recommendations of the National Tobacco Strategy 2004-2009 from $1.90 per capita to at least $8.50 per capita per year."

Question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile
Noes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris, Mr Torbay

Question resolved in the negative.

Resolved, on the motion of Dr Chesterfield-Evans, that paragraph 3.46 be amended by inserting the following words at the end of the paragraph: "and the normalising effect of smoking in hotels and clubs."

Dr Chesterfield-Evans moved: That the second sentence in paragraph 3.53 be amended by replacing the word "maintaining" with "increasing".

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Resolved, on the motion of Revd Nile, that Chapter 3, as amended, be adopted.

Chapter 4 read.

Resolved, on the motion of Mr McLeay, that Recommendation 4 be amended to read: "That the Cancer Institute NSW evaluate a "cold calling" approach for the Quitline."

Resolved, on the motion of Mr McLeay, that Recommendation 5 be amended by omitting "NSW Health and".

Resolved, on the motion of Mr McLeay, that Recommendation 7 be amended by omitting the second dot point and amending the first dot point to read: "increase resources to develop and implement targeted tobacco smoking health promotion and prevention and cessation programs (including nicotine replacement therapy) across Aboriginal communities in New South Wales".

Resolved, on the motion of Mr Harwin, that paragraph 4.62 be amended to read: "The Committee considers that it is very important that area health services deliver anti-smoking programs and that access to services by the full range of disadvantaged groups be ensured. As there may be unforseen disadvantages in including anti-smoking campaigns in performance agreements, we consider that NSW Health should examine the most appropriate means of ensuring service delivery and access across the State."

Resolved, on the motion of Mr McLeay, that Recommendation 9 be amended to read: "That NSW Health give consideration to ways of ensuring that area health services deliver anti-smoking programs, with specific reference to ensuring access by the full range of disadvantaged groups."

Resolved, on the motion of Revd Nile, that Recommendation 10 be amended by replacing the words "significantly enhance" with "increase".

Resolved, on the motion of Mr McLeay, that the last sentence in paragraph 4.87 be amended to read: "The Committee believes that NRT should be affordable and accessible and that the NSW Government and the Cancer Institute NSW should initiate further discussions with the Commonwealth Government on this issue."

Mr McLeay moved: That Recommendation 11 be amended to read: "That the NSW Government and the Cancer Institute NSW initiate discussions with the Commonwealth Government focussing on the need to make nicotine replacement therapy accessible and affordable for all smokers."

Question put and passed.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Noes, asked for his vote to be recorded in the Minutes.

Resolved, on the motion of Revd Nile, that Recommendation 13 be amended by inserting the words "be requested to" before "introduce".

Dr Chesterfield-Evans moved: That throughout Chapter 4 the term "reduced fire risk cigarettes" be replaced with "fire safe cigarettes".

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Resolved, on the motion of Revd Nile, that Chapter 4, as amended, be adopted.

Chapter 5 read.

Resolved, on the motion of Mr Harwin, that Recommendation 18 be amended by inserting the words "effectiveness of" before "generic packaging".

Dr Chesterfield-Evans moved: That a new paragraph be inserted after paragraph 5.39 to read: "The Committee noted that some retailers asked that there be a declaration that as cigarettes were legal, selling them was a legal activity. They were very unhappy during questioning as to why they continued to sell dangerous goods. Some submissions and the Committee believe tobacconists are liable for prosecution for selling unsafe goods and recommends this proposition be tested in court."

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Mr Donnelly moved: That Recommendation 19 be amended by inserting at the end a dot point to read: "the potential for requiring employers to provide ongoing training to employees in retail outlets."

Question put.

The Committee divided.

Ayes: Mr Donnelly, Ms D'Amore, Ms Judge, Mr McLeay, Mr Morris
Noes: Mr Harwin, Mr George, Ms Hancock, Mr Torbay

Question resolved in the affirmative.

Mr Harwin moved: That Recommendation 19, as amended, be amended by replacing the words "the potential for requiring employers to provide ongoing training to employees in retail outlets" with "the adequacy of arrangements for the training of retail employees with respect to the sale of tobacco products".

Question put.

The Committee divided.

Ayes: Mr George, Ms Hancock, Mr Harwin, Mr Torbay
Noes: Mr Donnelly, Ms Judge, Mr Morris, Ms D'Amore, Mr McLeay

Question resolved in the negative.

Resolved, on the motion of Mr McLeay, that Recommendation 20 be amended by inserting the word "overtly" before the words "fruit flavoured".

Dr Chesterfield-Evans moved: That paragraph 5.88 be omitted and the first sentence of paragraph 5.89 be amended to read: "The Committee is mindful of the significant health effects of smoking and suggests that the health benefits to the community of a ban outweigh any possible benefits of competition."

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Dr Chesterfield-Evans moved: That paragraph 5.90 be amended to read: "The Committee believes that the NSW Government should amend the legislation to ban the display of tobacco products."

Question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile
Noes: Mr Donnelly, Mr Harwin, Mr George, Ms Hancock, Ms D'Amore, Ms Judge, Mr McLeay, Mr Morris, Mr Torbay

Question resolved in the negative.

Mr McLeay moved: That paragraph 5.90 be amended to read: "Having weighed up the opinions of various inquiry participants, the Committee believes that the Government should amend the legislation to tighten restrictions on display area to one square metre (excluding tobacconists), as is the case in Western Australia and Queensland. We also consider that the definition of tobacconists should reflect that adopted in Queensland." and that Recommendation 22 be amended to read: "That the NSW Government amend the Public Health Act 1991 to restrict point of sale display to one point of sale per venue and one square meter (excluding tobacconists)."

Question put.

The Committee divided.

Ayes: Mr Donnelly, Mr Harwin, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris, Mr Torbay
Noes: Dr Chesterfield-Evans, Revd Nile

Question resolved in the affirmative.

Dr Chesterfield-Evans moved: That a new paragraph after 5.90 be inserted to read: "The Committee notes the evidence that smokers should be licensed in view of research showing the lack of awareness of risks by smokers, but was not clear how this would be achieved."

Question put and negatived.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Ayes, asked for his vote to be recorded in the Minutes.

Mr McLeay moved: That Recommendation 24 be omitted.

Question put.

The Committee divided.

Ayes: Mr Morris, Mr George, Ms Hancock, Mr Harwin, Mr Donnelly, Mr McLeay, Ms Judge
Noes: Dr Chesterfield-Evans, Revd Nile, Mr Torbay

Question resolved in the affirmative.

Resolved, on the motion of Mr Harwin, that paragraph 5.101 be omitted and replaced with the following paragraph: "The Committee believes that, given our Recommendation 22 for one square metre point of sale display, removal of vending machines from hotels and clubs could result in larger point of sale displays in those venues, which would not be desirable."

Resolved, on the motion of Ms Judge, that Chapter 5, as amended, be adopted.

Chapter 6 read.

Resolved, on the motion of Revd Nile, that paragraph 6.5 be amended by inserting at the end of the paragraph: ", including the Smoking Regulation Act 1996 moved by Revd Nile MLC that regulated smoking in public places and places of employment."

Resolved, on the motion of Revd Nile, that paragraph 6.35 be omitted and that paragraph 6.36 be amended to read: "The Committee considers that this legislation does not apply to restaurants and that therefore there is no possibility of backsliding by restaurants to the standards set for other licensed venues."

Resolved, on the motion of Mr McLeay, that paragraph 6.64 be omitted and inserted after paragraph 6.71, and that the paragraph be amended by inserting at the start: "The Committee notes that".

Resolved, on the motion of Dr Chesterfield-Evans, that paragraph 6.85 be amended by inserting the words "denormalise smoking and" after "do".

Mr McLeay moved: That Recommendation 25 be omitted.

Question put.

The Committee divided.

Ayes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris,
Noes: Dr Chesterfield-Evans, Revd Nile, Mr Torbay

Question resolved in the affirmative.

Mr McLeay moved: That paragraphs 6.103 and 6.104 be omitted.

Question put.

The Committee divided.

Ayes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris
Noes: Revd Nile, Mr Torbay

Question resolved in the affirmative.

Mr McLeay moved: That Recommendation 26 be omitted.

Question put.

The Committee divided.

Ayes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris
Noes: Revd Nile, Mr Torbay

Question resolved in the affirmative.

Mr Donnelly moved: That a new paragraph 6.103 be inserted, to read: "Taking into account the range of evidence provided to the inquiry, the Committee believes that the Smoke-free Environment Amendment

(Enclosed Places) Regulation 2006 should be provided with the opportunity to operate and be monitored by the Government to ensure that it applies as intended. Such monitoring should examine whether or not amendments to the regulation are required."

Question put and passed.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Noes, asked for his vote to be recorded in the Minutes.

Mr Harwin moved: That a new paragraph 6.104 be inserted to read: "The Committee has concerns about employees being required to work in any smoking areas including outdoor areas such as beer gardens and other outside areas in and around licensed venues. Because of the importance of maximising the protection of workers' health, and in order to ensure optimal compliance with the Occupational Health and Safety Act 2000, the Committee considers that legislative provisions relating to this matter in other jurisdictions are worthy of further examination by the NSW Government."

Question put and passed.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Noes, asked for his vote to be recorded in the Minutes.

Ms Judge moved: That a new recommendation be inserted to replace the previous Recommendation 25, to read: "That the NSW Government examine legislation in other jurisdictions intended to protect the health of workers servicing smoking areas."

Question put and passed.

On the question being put, Dr Chesterfield-Evans, being the only member voting for the Noes, asked for his vote to be recorded in the Minutes.

Resolved, on the motion of Mr McLeay, that Recommendation 27 be amended by inserting the word "children's" before "playgrounds", omitting the words, "sporting grounds and entrances to buildings" and inserting at the end of the paragraph "as smoke free areas".

Dr Chesterfield-Evans moved: That Recommendation 27, as amended, be amended by inserting after "children's playgrounds" the words "and sporting grounds and entrances to buildings".

Question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile, Mr George, Ms Hancock, Mr Torbay
Noes: Mr Donnelly, Mr Harwin, Ms D'Amore, Ms Judge, Mr McLeay, Mr Morris

Question resolved in the negative.

Resolved, on the motion of Mr George, that paragraph 6.121 be amended to read: "The Committee considers that the NSW Government should amend the smoke-free legislation to include children's playgrounds as smoke-free areas."

Resolved, on the motion of Revd Nile, that Chapter 6, as amended, be adopted.

Chapter 7 read.

Resolved, on the motion of Revd Nile, that the last sentence in the chapter's introductory paragraph be omitted.

Resolved, on the motion of Mr George, that paragraph 7.42 be amended by omitting the words "sporting grounds and entrances to buildings", and that the words "are public places" be replaced with "is a public place".

Revd Nile moved: That a new recommendation be inserted after Recommendation 28 to read: "That the NSW Government implement a staged health program regarding smoking in cars to reduce road accidents, smoking related diseases, bushfires etc on the following basis, in cooperation with its educational campaign:
First stage: From 1 July 2007, to prohibit smoking in cars with children
Second stage: From 1 July 2008, to prohibit smoking in all motor vehicles – cars, trucks, etc, to be consistent with current prohibition on smoking in buses, ferries, trains and aircraft etc."

Question put.

The Committee divided.

Ayes: Dr Chesterfield-Evans, Revd Nile
Noes: Mr Donnelly, Mr Harwin, Ms D'Amore, Mr George, Ms Hancock, Ms Judge, Mr McLeay, Mr Morris, Mr Torbay

Question resolved in the negative.

Resolved, on the motion of Ms Judge, that Chapter 7, as amended, be adopted.

Chapter 8 read.

Resolved, on the motion of Mr George, that the third sentence in paragraph 8.6 be amended to read: "On this basis, the Committee concludes that greater protections are required in licensed venues and in children's playgrounds."

Resolved on the motion of Revd Nile that Chapter 8, as amended, be adopted.

Executive Summary read.

Resolved, on the motion of Mr McLeay, that in the second paragraph under the Chapter 4 heading the following words be omitted: "and that it consider adding cold calling to the Quitline to increase its capacity and ensure it is accessible to rural and disadvantaged communities."

Resolved, on the motion of Mr McLeay, that the first sentence in the third paragraph under the Chapter 4 heading be amended to read: "Another concern of the Committee was the affordability of nicotine replacement therapy (NRT), which has been shown to improve quitting rates, and on this basis the Committee recommends that the NSW Government and the Cancer Institute NSW initiate further discussion with the Commonwealth Government on this issue."

Dr Chesterfield-Evans moved: That under Chapter heading 4 a new paragraph be inserted to read: "The Committee is unable to conclude that the very modest decline in smoking rates for New South Wales are due to tobacco control strategies as opposed to the general decline in the western world."

Question put and negatived.

Resolved, on the motion of Mr McLeay, that the second and third sentences in the second paragraph under the Chapter 5 heading be amended to read: "Currently in New South Wales there is no restriction on point

of sale display and the Committee has recommended that there be a restriction of one square meter for retailers, excluding tobacconists. The implementation of a licensing system for wholesalers and retailers of tobacco products and a review of current provisions and activities in relation to sales to minors have also been recommended."

Resolved, on the motion of Ms Judge, that the third paragraph under the Chapter 5 heading be amended to read: "The Committee also examined issues with shopper loyalty programs for customers buying cigarettes and recommends that these be prohibited to discourage purchasing of cigarettes."

Resolved, on the motion of Mr Harwin, that the second, third and fourth sentences in the second paragraph under the Chapter 6 heading be replaced with: "The Committee has concerns about employees being required to work in any smoking areas including outdoor areas such as beer gardens and other outside areas in and around licensed venues. Because of the importance of maximising the protection of workers' health and in order to ensure optimal compliance with the Occupational Health and Safety Act 2000, the Committee considers that legislative provisions relating to this matter in other jurisdictions are worthy of further examination by the NSW Government. The Committee further considers that smoking in children's playgrounds should be restricted on a statewide basis."

Resolved, on the motion of Mr Morris, that the Executive Summary, as amended, be adopted.

Resolved, on the motion of Revd Nile, that the report, with amendments, be adopted by the Committee, signed by the Chair and presented to the House.

Resolved, on the motion of Revd Nile, that the Committee Secretariat be authorised to make any typographical or grammatical changes to the report prior to tabling of the report.

Resolved, on the motion of Revd Nile, that, pursuant to section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 223, the Committee publish all non-confidential tabled documents, correspondence, answers to questions taken on notice, minutes, submissions and transcripts.

Dr Chesterfield-Evans and Revd Nile indicated that they would each submit a statement of dissent.

Resolved, on the motion of Ms Hancock, that the statements of dissent be provided to the Committee secretariat no later than 3pm, Friday 23 June 2006.

The Chair indicated that he would endeavour to incorporate comments provided by members into the Chair's Foreword.

**10. Adjournment**

The Committee adjourned at 5:20 pm.

**Merrin Thompson**
**Acting Director**

# Appendix 6 Statements of dissent

## Statement of Dissent on Tobacco Inquiry
## Arthur Chesterfield-Evans

Since cigarettes were shown to cause lung cancer in 1950, many reports have been written. Initially tentative, the medical information has swelled to a huge literature of about 80,000 papers with absolute certainly on one point - tobacco causes a huge number of diseases and kills a lot of people. So medical reports have become more strident as the realisation has dawned that it is the lack of political action that has allowed the killing to continue.

The medical problem is solved - avoid tobacco smoke and the diseases will not do you harm. But the political problem still requires attention - to get the legislative power to be used for the common good.

So political reports are written also. Some are bold from public servants, some risking their promotions to speak the truth about what needs to be done. Others have modest targets and feeble politics, not to upset their venal masters. The paradigm is modest. A drop in smoking prevalence of one percent a year is hailed as a great fall and politicians rush to take credit for every glacial bit of progress.

This report did not begin propitiously. I suggested it in 2005 when I saw the great consensus and progress that a Parliamentary Committee had facilitated in Ireland, which led to huge steps - a ban on smoking everywhere, even in all Irish pubs. But the NSW Government only initiated the inquiry when a ban on smoking in cars was suggested. This after the Government had caved in to the Australian Hotels Association and phased in smoke-free pubs over 3 years and then defined 'outdoors' as anywhere where the total area of the walls and ceiling was 25% open. Then the Government caved in to the retailers and abandoned its suggested ban on point of sale advertising.

When I suggested that the tobacco companies be actually compelled to attend a Committee hearing when they declined the offer, the proposal was voted down, as was recording the fact in the report.

The Committee had wide terms of reference to look at all aspects of tobacco, but sadly only found time for one day in hospital where it saw only one patient. Tobacco costs the State $6 billion a year, not to mention around 4,000 tobacco-caused deaths. Yet there was huge sympathy for publicans who spent some dollars covering their beer gardens to perpetuate smoking areas.

The modest Tobacco Action Plan 2005-2009 suggests spending $2.90 to $8.50 per person per year on Quit programmes. The Centre for Disease Control suggests $US 6-17, and some Californian advice to NSW said $A56 per person per year is cost-effective. This Government spends a lowly $1.90. Yet one public servant boasted 'it is certainly recognised that NSW has one of the most comprehensive programs in place, addressing all of the major elements identified in the research'.

The original draft of this report suggested some significant improvements such as: that outdoors should be defined as not having a roof; that tobacco advertising should be banned at the point of sale; that tobacco vending machines should be banned; that smoking should be banned in sportsgrounds and around the entrance to buildings; that generic packaging should be reconsidered;

and that workers should not be exposed to tobacco smoke in their workplaces. But the Government and Opposition combined to stop all these recommendations. There is a mealy-mouthed bit at the end of chapter 6 about waiting to see if Tasmania and Queensland's bans on service in smoking areas of pubs get away with it.

You will be delighted to know that smoking is to be banned in children's playgrounds, and that fruit flavoured cigarettes and funding nicotine replacement therapy will be discussed with the Commonwealth. And we're educating people about smoking in cars, letting the fire brigade work on reduced fire risk cigarettes, having a multifaceted approach, and asking for just a tad more money. There's a bit in it, but basically tobacco wins more delays - yet again.

**The Hon Dr Chesterfield-Evans MLC**

# STATEMENT OF DISSENT
## The Reverend Hon Fred Nile MLC
## Christian Democratic Party

I strongly dissent from a number of decisions made by the majority of the Committee on Wednesday 21st June, 2006.

The Committee, which was the first major Parliamentary Inquiry into Smoking as a serious health problem, missed an important opportunity to influence Government Policy when it voted to delete excellent Recommendations in the Chairman's Draft Report concerning a number of controversial health issues, such as:

1. THE 25-75 NEW RULE FOR SMOKING AREAS IN HOTELS AND CLUBS. I AGREE WITH THE CHAIRMAN'S RECOMMENDATION THAT SUCH 'OPEN AREAS' MUST NOT INCLUDE A CEILING THAT WILL TRAP THE SMOKE, BUT IT WAS DELETED BY THE COMMITTEE.
2. PROHIBITING SMOKING IN PLAYGROUNDS, SPORTING GROUNDS AND ENTRANCES TO BUILDING

I supported this important Chairman's Recommendation. Unfortunately, the Committee deleted sporting grounds and entrances to buildings but did retain Children's playgrounds. My original Bill, in 1997, that prohibited smoking in public places, forced smokers to congregate at the entrances to office buildings, which have become a smoking hazard.

3. BAN ON THE PUBLIC DISPLAY OF TOBACCO PRODUCTS, CIGARETTES ETC.

I supported the total ban on the public display of cigarettes in retail outlets, but the Committee replaced it with a reduction of display areas to one square metre. It will still put pressure on smokers trying to quit to 'impulse' purchase cigarettes on display.

4. REMOVAL OF CIGARETTE VENDING MACHINES.

I supported the total ban on cigarette vending machines because of their availability and temptation for underage children. Unfortunately, the Committee did not support the removal of cigarette vending machines.

My greatest disappointment was the Committee's rejection of my Bill to prohibit smoking in motor vehicles to protect the health of passengers, especially children from the harmful effects of passive smoke, as well as the dangers of car accidents, by a driver smoking and the impact of bushfires. Possibly 49% of bushfires are caused by cigarette butts thrown from car windows by smokers.

The Committee also rejected my Amendment for a ban in two stages:

FIRST STAGE: To ban smoking in cars with children from 1st July, 2007, in cooperation with the Committee's Recommendation for an Education Campaign concerning smoking in cars and homes, which I supported.

SECOND STAGE: To totally ban smoking in motor vehicles from 1st July, 2008, to allow for a continued education campaign in 2007 and 2008 and time for the smoking drivers to adjust to this new health requirement in the interests of their own health and their passengers and to reduce car accidents and bushfires in NSW.

**The Reverend Hon Fred Nile MLC**