HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr TJ Ruthenberg MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Ms RM Bates MP
Dr AR Douglas MP
Mr JM Krause MP
Mr DE Shuttleworth MP

Staff present:

Mr K Holden (Acting Research Director)
Ms R Stacey (Principal Research Officer)

PUBLIC HEARING—HEALTH LEGISLATION AMENDMENT BILL 2014

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 29 OCTOBER 2014

Brisbane

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Committee met at 11.00 am

CHAIR: Good morning and welcome. I declare open the Health and Community Services Committee public hearing on the Health Legislation Amendment Bill 2014. My name is Trevor Ruthenberg. I am the chair of the committee and member for Kallangur. Other members present today are Mrs Jo-Ann Miller MP, deputy chair and member for Bundamba; Ms Ros Bates MP, member for Mudgeeraba; Dr Alex Douglas MP, member for Gaven; Mr Jon Krause MP, member for Beaudesert; and Mr Dale Shuttleworth MP, member for Ferny Grove. We have an apology from Mr John Hathaway MP, the member for Townsville, who cannot be with us today. We will hear today from seven witnesses who made submissions on the bill. After that evidence, the Department of Health will respond to issues raised by witnesses and any questions from the committee.

The bill was referred to the committee on 9 September 2014 and the committee is required to report to the parliament by 17 November. Submissions accepted by the committee are published on the committee's inquiry webpage. Witnesses are not required to give evidence under oath, but I remind witnesses that intentionally misleading the committee is a serious offence. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Mobile phones or other electronic devices should now be turned off or switched to silent. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript for today's proceedings unless there is good reason not to. The proceedings today are also being broadcast live on the parliamentary website.

GARTNER, Dr Coral, Research Fellow, Centre for Clinical Research, University of Queensland

DURHAM, Ms Alison, Advocacy Manager, Heart Foundation Queensland

FOREMAN, Ms Rachelle, Health Director, Heart Foundation Queensland

LUU-NGUYEN, Ms Thuy, Corporate Lawyer, Peregrine Corporation

FISHER, Ms Lucy, Executive Director, Private Hospitals Association Queensland

CHAIR: I welcome our witnesses and note that Ms Luu-Nguyen is giving evidence via teleconference. I will invite each of you in turn to make an opening statement of about five to 10 minutes, and I will pull you up at about that 10-minute mark. After that the committee will ask questions. We will start proceedings by asking Dr Gartner to make an opening statement.

Dr Gartner: Thank you for inviting me to come and talk to the committee today. Personal vaporisers have attracted much attention in the public health community and also in the general population. These products have the potential to benefit public health if current smokers were to switch to them, and health experts and the current scientific evidence supports that these personal vaporiser products would reduce overall health risks for an individual smoker who switched to personal vaporisers rather than continuing to smoke. However, it is very important in that these products do require regulation to reduce the potential for harmful impacts on the population such as from young nonsmokers potentially taking up these products. So regulation is the key to harnessing their potential benefits and also limiting potential risks.

In my opinion the ideal way to regulate personal vaporisers would be to have separate specific regulations that could then allow for further controls on access to tobacco products while maintaining lesser restrictions on these less harmful options. This could allow personal vaporisers to play a more strategic harm reduction role by potentially becoming a viable alternative product that could eventually replace combustible tobacco cigarettes. However, in the absence of specific regulations for personal vaporisers, I believe the proposed amendment bill represents a very reasonable compromise and introduces some very sensible provisions such as prohibiting sales to under-18s and preventing inappropriate promotion of these products. It will also end the current confusion about what is and what is not legal concerning the sale and use of these products in Queensland.

Restricting public use is likely to have the biggest impact on current users of personal vaporisers. However, banning use in indoor public spaces is a very sensible provision that I would support. With the extension of public outdoor smoking bans it might be better, if possible, if personal vaporisers could be exempted in some circumstances from this because there may be some situations where allowing use in some outdoor areas could be justified. Here I am particularly thinking of people such as residents of supported accommodation facilities for people with serious mental illness who may benefit from being able to use products that are less harmful than cigarettes within a Queensland Health facility. However, I also appreciate that this could present very difficult practical challenges for enforcement and public education of where use is and is not permitted if you were to apply separate rules to personal vaporiser use as to smoking.

With respect to the opinions of personal vaporiser users about regulation—I know this was a topic that was of interest to the committee—we conducted a survey of personal vaporiser users in Australia between January and March this year and 37 per cent of these participants were from Queensland. Applying an age restriction to the sale of personal vaporisers was supported by most of the participants—90 per cent of them agreed with that—and around half of those surveyed opposed applying the same restrictions on the sale of personal vaporisers as on tobacco products. However, compared to other options such as banning domestic sales, there was strong opposition to that and there was also very strong opposition to restricting sales to pharmacies or on prescription. In terms of restrictions on public use of personal vaporisers, 35 per cent of respondents thought that there should be no restrictions on where personal vaporisers could be used. However, I think it is important to note that more than half actually supported having some restrictions on public vaping but they did not want as many restrictions as are currently applied to smoking cigarettes. Only seven per cent of them thought that the same restrictions on public vaping as on smoking should apply. Thanks.

CHAIR: Thank you. We will move to Ms Durham.

Ms Durham: Thank you for the opportunity for the Heart Foundation to speak to you this morning. We have had a long history of advocating for smoking reform, and this is part of that process because of the links with cardiovascular disease. We definitely support the amendments to regulate e-cigarettes in this legislation proposal and we also accept and congratulate the government on the extension of bans to smoking in hospitals, schools and prisons. We are also seeking additional reforms for similar arguments as to why these reforms are happening because of the need for a state-wide consistent approach to smoking bans. Currently, pedestrian malls, public transport waiting points and taxi ranks require local governments to make legislation and that is not really occurring and it is not really happening. We would like to see a state-wide approach to that to protect people in areas where people congregate and they are exposed to smoking. We are also looking for an end to designated outdoor smoking areas in licensed premises because that is where smokers are congregating and they are becoming a bit of a sort of party zone and we would like to see an end to that anomaly. There is another anomaly that is really standing out, and that is that people are still able to smoke indoors and expose workers and patrons to smoking in premium gaming rooms. They are issues we would like the committee to consider.

I just wanted to focus on the e-cigarette regulation. I was hoping we could table the position statement that we reference in our submission because it has about 118 references. You have probably already accessed it, but I was wondering if we could table that.

CHAIR: Is the committee in favour of that being tabled? As there is no objection, we will table that. Thank you.

Ms Durham: I may as well mention the other one we would like to table, if possible, which is the second letter that was sent to the World Health Organisation. Another submission was put in by Peregrine Corporation in which they put the first letter that went to the WHO. We would like to put in the second letter which was from 129 health professionals urging a conservative approach and it is a science evidence based approach to e-cigarettes.

CHAIR: Again, is the committee in favour of that being tabled? As there is no objection, we will table that as well. Thank you. We will table both of those.

Ms Durham: Thank you very much. We thought that the reforms that are recommended looked really good because they are addressing the three recommendations from the Heart Foundation and the Cancer Council Australia in our position paper that I just tabled, and that is to ensure that non-nicotine electronic cigarettes are captured in the description, to ensure that

smoke-free laws include e-cigarettes so that people cannot vape in smoke-free areas and to ensure the prohibition of advertising and promotion of e-cigarettes—basically, that e-cigarettes are treated in the same way as cigarettes because of four key concerns.

One is access to children, which Coral also mentioned. It is a device designed for people to draw substances into their lungs and we do not have evidence to show the health impacts of that. I really do not think we want our children having access to that. We have heard of it being displayed next to lollies in newsagents and petrol stations and that sort of thing and that is like taking us back to where we used to be and we do not want to be there again. So we really think that regulation is a reasonable approach and that that would then mean that they cannot be displayed, sold to children or promoted. They are the key issues on that one. With regard to the issue of our smoke-free laws, which in Queensland are really outstanding and have shown leadership in this area, to allow e-cigarettes to be smoked in our smoke-free areas would really undermine that kind of denormalisation of smoking that we have had, and that is so positive on our young people in particular and uptake rates. So, again, regulation is something that we believe would protect our smoke-free laws.

The other issue is currently unsubstantiated quitting aid claims, so e-cigarettes are not proven as a quitting method. There is some evidence coming out about dual use amongst adolescents—that is, they are using e-cigarettes and smoking at the same time. In fact, that means that they are then getting higher levels of addiction to nicotine. The science is not in either way and so we really feel that it is important to regulate. It will not stop the research being done, and that is important. If e-cigarettes did turn out to be the best thing since sliced bread, we won't not find out about that. Research will still continue even if these regulations occur, and that is a good thing. The last thing is unproven safety and health effects. We do not know the long-term effects and there is exposure to chemicals such as chromium, nickel and toxic metals like that and so we do not know the health effects. Again, our message is regulation is a reasonable approach for public safety. Thank you.

CHAIR: Thank you. I appreciate that. We will now hear from Ms Luu-Nguyen.

Ms Luu-Nguyen: Good morning. Peregrine Corporation is based in Adelaide, but we are a national retailer of tobacco products and we operate 17 stores in Queensland. I want to thank the committee for this opportunity for Peregrine to make a submission to the committee and also want to send the apologies of Ms Audrey Platt, the author of the submissions that you currently have before you.

I do not wish to repeat what is already in the submissions, but in terms of the issues that we would like to highlight for the committee's consideration, firstly, there is an existing framework that regulates products that contain liquid nicotine and then I just want to move on to the very limited concerns that we have regarding the bill.

In relation to the existing framework, we would like it to be noted that insofar as a personal vaporiser product contains liquid nicotine, we think that it falls within the operation of the health, drug and poisons regulations. So from that perspective there is a legislative framework that exists to control products that contain liquid nicotine. It is an issue of whether or not that framework is adequately enforced. Ultimately for us, we do not think that the problem is necessarily addressed by adding an additional layer of regulation to cover what is exactly the same field.

Insofar as a personal vaporiser product does not contain nicotine, from our experience and looking at the labelling that exists on those types of products that we have seen, the main ingredients that we are looking at is water, glycerine and artificial flavours. We do not think that personal vaporiser products that do not contain nicotine have the same risk profile as a product that contains nicotine, obviously. So insofar as the bill seeks to establish a blanket framework for personal vaporisers that contain or do not contain nicotine, we think that products that do not contain nicotine should be treated in a way that is proportionate to their risk profile and we do not necessarily think that they should be subject to the same regulatory framework that imposes the same restrictions that would otherwise apply to a more harmful product that does contain nicotine and the like.

We agree with Dr Gartner's observation that there are very few harm-reduction options available to Australian smokers and personal vaporiser products have a role to play in reducing the health risks for smokers who think that they can be a legitimate replacement for combustible cigarettes. From our perspective, we think that the government should be looking at a way to regulate the products that are already on the market through a mechanism of either introducing

transparent and properly enforceable product standards, which then can control issues regarding ingredients—the quality of ingredients, the quality of components—and potentially health warnings that should attach to the product and the like.

So as an extension of the way in which we see the product should or should not be regulated with personal vaporiser products that contain nicotine and those that do not contain nicotine, the concern that we have with the bill was regarding the definition of 'personal vaporisers', which is contained in clause 53 of the bill. The concern we have is that it says—

A ***personal vaporiser*** is a device that—

(a) is capable of being used to deliver nicotine ...

We have given an example of how we think that definition is a bit vague and potentially could be difficult to enforce in the way that people can swap out certain cartridges from a legitimate product that does not contain nicotine to then replace it with an illicit cartridge that does contain nicotine. The question is then: is it or is it not caught by the act? We have proposed a definition change in clause 20 of our submission and we think that that adequately then address the risk profile that is caused or is imposed by personal vaporisers that contain nicotine and those that do not.

CHAIR: Thank you. That is all at this point?

Ms Luu-Nguyen: Yes, thank you.

CHAIR: Thank you. I will call Ms Fisher from the Private Hospitals Association of Queensland.

Ms Fisher: Good morning, chair, and members of the committee and thank you for the invitation. As noted in our submission, our concern is limited to the specific proposal to remove the existing discretion for private health facilities to provide a designated smoking area on their campus and to extend the boundary to five metres beyond. As healthcare providers, obviously, we strongly support initiatives to reduce smoking rates within the community. However, whilst the intent of the legislation may seem a logical next step along the road to the reduction in smoking rates and measures to minimise exposure to tobacco smoke, we believe that there needs to be some caution that, in introducing this legislation, it does not create some other adverse effects. So our concerns are centred solely on the practical management of the proposal.

Our submission outlines our concerns in relation to potential increased legal liability in respect of admitted patients who leave the premises to smoke; vulnerable patients who are smokers, specifically mental health and palliative patients for whom this extended prohibition may cause additional distress and anxiety at a particularly difficult time in their lives; and some of the problems that the implementation of an entirely smoke free campus had created for some private facilities, particularly those located in residential streets. I just wanted to focus a little more on why we believe that the provision of a designated area is preferable to the current proposal and one that we believe provides a more effective balancing mechanism to manage the competing priorities of accommodating the rights and special needs of particularly vulnerable patients and minimising the potential legal and workplace health and safety risks and, most importantly, sensitivity towards local residents whose properties may be adjacent to many private hospitals.

There are 107 private facilities, of which 53 provide overnight care. They account for about 47 per cent of all hospital separations and over 2.2 million days of care. Whilst some are located in commercial precincts and on busy roads, a large number of them, and particularly among the overnight facilities, are located in residential streets and many of them have bushland adjoining their boundaries.

In 2012, we surveyed our member organisations and, among the overnight facilities, most of them at that time had elected to provide designated outdoor smoking areas rather than operate entirely smoke free. Generally, those decisions had been made after wide consultation with both the Hospital Medical Advisory Committee and the Hospital Workplace Health and Safety Committee, which took into consideration concerns about staff and patient safety, particularly after dark, the particular patient Casemix of the facility and, in some instances, the location of that facility within residential communities' areas of higher fire risk and busy roads.

Significantly, several hospitals commented that they had initially introduced an entirely smoke free campus, but they reverted to providing a designated area due to a range of problems that the entirely smoke free campus had created. They said that, while the majority of people had been compliant in limiting their smoking to the designated area and using the ashtrays provided, once

they had gone smoke free smokers either ignored requests to cease smoking, congregated at or near the entrances to the hospital campus and tossed their butts on the ground or on adjoining neighbours' gardens, obviously creating a fire risk and an unsightly litter problem to manage. But it did generate a significant number of complaints from both visitors to the hospital and the local residents.

Where possible, designated smoking areas tend to be located in a discrete area of a hospital campus. They are generally well away from the entrance and other main thoroughfares and they are often screened from the general public so that that risk of exposure is minimised. Being on the hospital campus, they provide a safe and well-lit area to minimise the potential for an adverse event to occur and one which could give rise to an added legal liability or a potential workplace health and safety issue. They are usually located well away from any areas of fire risk and, wherever possible, from adjoining private residences.

But in contrast, given the physical location of so many private hospitals, we are concerned that extending that prohibition to five metres beyond a hospital boundary will simply relocate that problem to neighbouring private property or local bushland. Exposure to second-hand smoke would obviously be unavoidable for these residents, some of whom may be children or vulnerable adults, and hospitals will be absolutely powerless to prevent such smoking from occurring. So, given that smoking is a behaviour that is not possible in all cases to cease immediately, despite replacement therapies that may be offered, we believe that providing discretion to confine smoking to a designated area is preferable to a total ban as it allows each facility to make an informed decision based on a risk assessment of its own situation, which would include consideration of its location, patient Casemix and other staff and patient safety issues.

In closing, I would stress that we strongly support measures to reduce community smoking rates, but we feel that there is not a lot of point in introducing a legislative requirement that in practice may be extremely difficult to enforce with any great effect and which potentially exposes patients to greater risk of injury or medical mishap whilst off campus and, in some settings, may, in fact, increase rather than decrease the exposure to tobacco smoke for those neighbouring residents and visitors to the hospital, as it may well lead to the reintroduction of congregations of smokers that the provision of a designated area in many cases has been able to either minimise or eliminate. I should add in closing that a large number of our hospitals are smoke free. It is principally the ones in these areas of bushland or residential communities that will have a problem in managing it. Thank you.

CHAIR: Thank you. We are going to go into a period of questioning. We have probably about half an hour or so to do that. We have a broad range of people. So if you want to ask a question, if you would just let me know and then identify who you are asking the question to, please, so that that person is able to respond to your concern or question. Dr Douglas, if you would start?

Dr DOUGLAS: If I could start with Ms Fisher. You were seeking some practical changes because of your experience within the hospital. But there has been a progression over time to eliminate smoking altogether out of hospitals and primarily smoking is a very, very dangerous thing.

Ms Fisher: Of course.

Dr DOUGLAS: As most staff have realised. Do you not see that this is part of just that progression and that, even when you have to implement measures that for practical purposes make it difficult, that people will adapt their behaviour to suit those changes? Do you think that you are at a point that people are incapable of adaptation? Is that what you are saying?

Ms Fisher: I can only speak from the experience of some of our hospitals that did go smoke free and the experience that they had with their neighbours, because people were around the various boundaries of that hospital smoking, hanging over their gardens. They just had a lot of complaints and it was extremely difficult. By finding somewhere discrete within the campus they did pull them back off the streets and kept them in a confined area.

For most of our hospitals, it is really limited to the patients. Certainly, even those that currently still have a designated area, they promote a smoke free environment. It is not advertised as such, but it provides somewhere that stops that congregation around the boundaries and entrances to the hospital.

Dr DOUGLAS: Hospitals are great innovators when there is a problem. Were there some hospitals that were more successful than others because they implemented systems that had incentives or made some suggestion of how they could make that work? Did that come out and was that shared?

Ms Fisher: Certainly, some have been successful. There is a lot of concern among our overnight mental health facilities and particularly with the time frame for the introduction of this. A lot of studies have suggested that you would need a minimum of six months. The challenge is these ones in the residential areas. That is where it is difficult. The ones that have been successful have been the ones that have either been in commercial precincts or on busy roads. The ones that are more in those residential areas, they have found it extremely difficult. I cannot speak for all of them, but certainly the overwhelming majority would still have a designated area.

Dr DOUGLAS: One more just on that point. Of the residential areas, were there any that had successful implementation and what did they do that the others did not?

Ms Fisher: I am not aware of any, but that is not to say that there were not any.

Dr DOUGLAS: Right. So possibly we might find that out. Would it be possible for you to find that out? Your organisation has a wide network. Is it possible?

Ms Fisher: Within our membership, potentially, but not every hospital is a member. So it might be a little challenging for those that are outside our membership.

Dr DOUGLAS: I do not mean to put you to any extra work, but it would be interesting to know. Maybe Alison's organisation might be able to answer.

CHAIR: Can I just ask a follow-up question on that? Right now our schools are substantially inside residential areas and they are smoke free environments. Again, they went through the same process where they have had to adapt, but it is not just an issue at schools anymore. Certainly, in my electorate they all sitting with houses right on their fence lines. I see some correlation between what is trying to be implemented in hospitals and what is already implemented in education. Would you care to comment on that?

Ms Fisher: I think there is a difference in the sense that we have admitted patients so obviously for the duration of time they are in hospital that is their place of residence. They are 24/7 operations, at least the overnight ones are, so you have a constant stream of people 24/7 whereas with schools you have got a more limited pick-up drop-off time, they are visitors by and large to the school and they are not resident in the sense that a patient is. Our concern is principally around those ones who are patients for whom we have a duty of care. We cannot actually stop them leaving the hospital if they wish to, but we still have a duty of care towards them and that does create a challenge to manage.

CHAIR: Before we go on I would like to recognise in the room today a delegation from Pakistan, from both the provincial and national parliaments, who are here observing our parliamentary process. Welcome. We will continue. Mr Shuttleworth?

Mr SHUTTLEWORTH: Thank you, Chair. My question is for Ms Luu-Nguyen. You mentioned during your submission that Peregrine Corporation took issue with clause 53 of the proposed bill and suggested at clause 20 of your submission how that may be overcome. My issue is that with your clause 20 clearly at a point of sale that differentiation is quite easy. Once you leave that point of sale the differentiation is very problematic. How would enforcement subsequently occur? Surely the safest and easiest method to undertake would be to run with the proposed bill as we have it saying that basically all vaporisers are quite easily identified. It is impossible to identify the chemical make-up of what they are vaping once you have left that point of sale. I would like to hear a response in that regard.

Ms Luu-Nguyen: I think the way that we have drafted it is to make it clear to at least retailers what they can and cannot sell. We appreciate that once it does leave the point of sale any product, any vaporising device, can be manipulated and the like, but I guess from an enforcement perspective, I would have thought that the way in which you enforce it is to really go through to look at people who are selling these products and seeing whether nor not they are selling products that are legitimate and that are authorised by the law. The way that we have suggested clause 20, that makes it clear to retailers what they can and cannot sell. That, of course, does not stop the illicit sale of products. People will do that whether or not there is a law in place. As a decent corporate citizen who wants to be given some clear guidance as to what we can and cannot properly sell whilst meeting consumer demand, then we think that, yes, the way that we have drafted it is directed at point of sale and it would at least help us as retailers to work out what can and cannot be sold.

Mr SHUTTLEWORTH: I would suggest that what we are proposing is not necessarily trying to regulate a point of sale retailer, it is trying to regulate better health outcomes for the population and, therefore, beyond that point of sale the enforcement becomes the issue. What we are trying to

do is to cease the habit-forming use of these devices and cease the ongoing public health issue. So whilst the point of sale retailer might not be at fault because they have followed regulation, the issue still remains how we keep the wider public safe and I think that your clause 20 would do very little to overcome that.

Ms Luu-Nguyen: Yes.

Ms BATES: My question is for Ms Fisher. I noticed in your submission mention of increased legal risks for hospitals. Having run hospitals myself in the past I am very well aware that a lot of the private hospitals, as you said before, have areas set aside that are not in the public area, for either staff or patients. We do not see patients and relatives having to run the gamut of the smokers out the front of Royal Brisbane Hospital any more. I have a couple of questions. The first one is a lot of staff smoke and currently if we ban smoking for however many metres from a public hospital setting and then do the same in a private setting I know there are nurses who have to go down the street and go to a bus stop to have a cigarette in the middle of the night if they are on night duty. So the safety issue for staff is one of my concerns. The other issue is the downtime with staff leaving the premises to smoke, particularly if you are in scrub gear for instance and you have to get out of your scrubs and into your civvies and go down the street and come back again it is an awful lot of downtime on your break. They are two issues. The other one is when you said about reducing legal risks for hospitals, who is responsible legally if a patient or a relative or a staff member is assaulted because they had to go off the premises to have a cigarette?

Ms Fisher: That last point we are not sure about. We have had some preliminary advice in respect of an admitted patient that even though you may ask them to sign a waiver you may still have some legal responsibility to that patient because they are an admitted patient and you have got that duty of care towards them. It may be reduced for contributory negligence, but in all probability you would have some liability. In relation to staff, that is another issue. As you pointed out, a lot of nurses unfortunately do still smoke. It is a fact of life. Some hospitals, even those not necessarily on residential streets but on busy roads or in areas that may be considered not quite so safe at night, believe they would have a workplace health and safety obligation to those staff to provide safe break time for them. It is not tested, it is not proven, but it was certainly one of the reasons why some hospitals have decided that somewhere in a nook and cranny of a campus is probably preferable to exposing either their patients or their staff to increased risk.

Mr KRAUSE: I have a couple of questions for Dr Gartner. In your submission you state that vaporisers could have a role to play in harm reduction for smokers. I want you to expand a little bit on what role they could play and also whether the government's proposals will allow this to happen.

Dr Gartner: Many of us in the tobacco control research area are interested in actually eliminating smoking completely. We are interested in whether things that may help in being able to phase out cigarette sales altogether and possibly having a less harmful option that could be sold for those remaining smokers may assist with that. So there is interest that there could be a role to play here. Also there are certain populations of smokers, what we would call maybe hard core, so people with psychiatric conditions or other mental health conditions, who may find it very difficult to completely stop smoking altogether and so having an option that could still reduce their health risks significantly may be quite beneficial for those populations. I am interested in those areas. With the current bill this would actually still allow a role for that. That is why I think it is a very good sensible compromise to regulate these products similar to tobacco products because you eliminate those main concerns that people in the tobacco control area have which is about the inappropriate promotion to young people, advertising and selling to young people that may make smoking and vaping like a very mainstream activity, but it would still allow this product to be used by people who may need it and may benefit from it.

Mr KRAUSE: Following on from that, could you ever foresee a time where there is just a product like vaporisers sold instead of nicotine-containing products?

Dr Gartner: I would hope so, yes. I would hope that that is the future that we move to, that the main product that is sold is a clean nicotine product for those people who need it.

Mr KRAUSE: For those who have the addiction.

Dr Gartner: Yes, and that combustible tobacco is not available or extremely difficult to access.

Mr KRAUSE: Secondly, you also said that we might want to consider whether there is an alternative to banning vaporiser use in all outdoor smoke-free areas. Could you elaborate on that a little bit? Could you give us some suggestions or ideas in that respect.

Dr Gartner: This is a challenging one because I can see from a regulatory point of view and also a public education point of view it is very difficult to have a separate set of rules for vaporisers as for smoking cigarettes, particularly when some of these products look very much like cigarettes and so the public may be confused about what is allowed and what is not allowed. I can see some instances, particularly where you have people with mental health conditions who are in accommodation where they cannot smoke at all, where this would be at least something that they could do on the grounds, if you could exempt it from certain conditions like that. Practically I am not sure the best way to go about doing that, but I guess it is just something to keep in mind about what the potential impacts may be on some populations.

CHAIR: Dr Gartner, right at the start of your presentation you talked about some stats.

Dr Gartner: The users stats?

CHAIR: Yes, the acceptance and non-acceptance. I was a little bit unclear on some of those.

Dr Gartner: This is a survey of people who are currently using these types of products, mostly as a harm reduction measure, so they are not smoking they are using these instead. In terms of applying an age restriction on sale of these products, 90 per cent of the participants supported that. Everyone agrees, basically, that it should not be sold to children. Around half of the people we surveyed opposed applying the same restrictions on sale as on tobacco products.

CHAIR: On the sale of the unit?

Dr Gartner: Of the personal vaporisers. They did not want to see the same restrictions. That also says half of the participants were okay with that. These are current users. When you look at the other options, which were restricting sale to pharmacies only or on prescription, 81 and 93 per cent opposed that. So that whole restricting it to a medical framework is really not what current users want. They obviously see that as restricting the potential of these products to be used for harm reduction. Can I pick up on the lawyer mentioning that it is just glycerine and water and so on. I think the evidence does suggest that there are particulates that are generated from these products and that there are some chemicals that will be emitted. They will be at much, much lower levels than in cigarette smoke but I think to say that it is just water vapour is not correct. I think that needs to be borne in mind, that even without nicotine in them I think we still want to restrict use particularly indoors. Outdoors it is probably less of a risk to people.

CHAIR: Is there any evidence at this point in time in regard to what we call secondary smoking?

Dr Gartner: Secondary vaping, I guess.

CHAIR: Is there any evidence at all, even glimpses at this point in time?

Dr Gartner: I think all we can do is look at what studies have been done, which is just analysing what is in the vapour that is generated, because we certainly do not have any studies on measuring health effects on people exposed to second-hand vaping. I guess the studies that have been done have found some contaminants and I think anything that produces a contaminant indoors, we don't need that. Even if it is very low levels it seems pretty reasonable to me to not allow that indoors. There isn't any evidence of a direct health impact, but I think it will be sensible to say well there are particulates in these matters, particulates are linked to health impacts so it seems reasonable to reduce exposure indoors.

CHAIR: One of my concerns is when I look at some of the activity around e-cigarettes overseas, particularly when I look at Europe where it has actually exploded, there is a humongous use of it over there. Some of the evidence I have read around that indicated that people who have never smoked are actually picking up e-cigarettes as a social activity. I am wondering if you have done any research into the formation of habits and whether that leads into tobacco products or not, or if you have seen any of that research?

Dr Gartner: So whether this is a gateway to tobacco?

CHAIR: Right.

Dr Gartner: The evidence on that is pretty mixed. You can basically interpret it whichever way you like. A lot of the evidence is coming from cross-sectional studies. There is not strong evidence that using an electronic vaporiser will then lead you to smoking. I do not think there is any evidence of that. There is an absence of evidence. I share those concerns about their use by nonsmokers. That is why I think it is really sensible to have strong regulation or promotion and advertising around this. This bill will go a long way to treating them in a similar way to tobacco products. We do not necessarily want to have lots of promotion on these products to the general public.

CHAIR: Thank you. Are there further questions?

Dr DOUGLAS: I have two questions—one to Rachelle and one to Coral. It is the same question. What is the price of not doing this? What does the Heart Foundation think? I know it is a difficult thing to quantify? Have you actually thought about it from the perspective of not doing it?

Ms Foreman: I think our position would be that certainly it is a slippery slope given the evidence we have seen overseas around e-cigarettes, for example. As we have already provided in our evidence, regulating e-cigarettes in this way does not prohibit the research from happening. We really are flying blind in many ways. There is conflicting evidence. We do not know enough about the contaminants. We do not know enough about the long-term health effects. We do not know how this will impact social norms if we just let it go unregulated. We are certainly not supportive of a ban because we believe it will cause black market sales and other things. We are very supportive of regulation as proposed for those very reasons. I cannot put a dollar figure on it. Certainly the social and health costs would be enormous.

Dr DOUGLAS: Coral, could you answer that question?

Dr Gartner: In terms of not doing any regulation on these products at all?

Dr DOUGLAS: What you think in terms of doing this or not doing this. What do you think the impact of not doing it would be?

Dr Gartner: I think it will just contribute to ongoing confusion amongst the public. I think the public are already a bit confused about what you can and cannot do. Can you use these products where smoking is banned and so on? I think the public probably wants some direction on that. In terms of young people taking them up, I am not sure what would happen there. I would imagine that more young people would take it up if we did not put any regulation around it rather than put some regulation around it.

Dr DOUGLAS: Is there any evidence from overseas on this? I have not had a look at Europe as closely, but I have seen a lot from the United States. The impact of not doing anything has been that the take up of people switching to e-cigarettes and using e-cigarettes in public places widely has meant that there has been an escalation in the consumption of these things. I can say that from when I was looking at the sales mechanisms of the shops. Is there any evidence out there that shows that there has been an increase and that it will drive further sales of existing cigarette products and also e-cigarettes?

Dr Gartner: I guess I am more familiar with the UK data. I have some excellent longitudinal data from the UK. It seems to actually be having a positive impact. So smoking is going down in the UK. My understanding is that smoking is also going down in the US as well, even though these products are being taken up. I do not think there is a lot of evidence in those markets that it is leading to an increase in smoking as such. I do not think that we would want to see the same widespread promotion of these products and uptake, particularly amongst nonsmokers, that we see in those markets.

Dr DOUGLAS: I read the medical literature too. There is a small spike in one as opposed to all the others. Am I incorrect that it is young women? Of the whole demographic of smokers there has been a decline in the overall demographic, but there has been a small spike when it comes to women? Am I incorrect? I saw that published in one of the journals. Did I look at that incorrectly?

Dr Gartner: In general?

Dr DOUGLAS: No, it was only a small—

Ms Durham: It is in population age groups. In the age group 25 to 34, 16.7 per cent of females are smoking. For the same age group, 28 per cent of males are smoking. That age group has the highest rates for smoking. You can see that males are actually smoking more.

Dr DOUGLAS: Is it males that has gone up a little bit or females? Proportionally fewer females smoke—

Ms Durham: Both have gone up.

Dr DOUGLAS: When you count the overall amounts, sure it is going down, but there has been this increase. Is there anything to show that this could be related to the sale of e-cigarettes?

Ms Durham: I think the evidence is not there yet. We do not have the evidence.

Dr DOUGLAS: But there is this increase. It was certainly in the medical literature that I read. There was a concern that if we did not extend it there would be problems. That is why I was asking Ms Fisher the questions I was. If we did not keep the progress going these changes would be

reflected in the general demographic. In the lesser demographic you will see that there is an increase. To keep things going we actually need to reduce smoking because smoking kills people. It kills people. That is really what it does; it kills people. There is some evidence here—

Ms Durham: There is building evidence. We have had some come through recently in the *Journal of Adolescent Health* which showed that in Poland 'never cigarette smokers made up a substantial proportion of adolescent e-cigarette users in both age groups.' The evidence is coming through. Way back when low tar cigarettes came in public health organisations embraced them as perhaps a harm minimisation measure. It was found that it was a complete dupe. The tobacco industry knew all this information and knew that it was going to damage people. People embraced it—not me personally, but public health organisations. We do not want to find ourselves in the situation where we have let something bolt through that is actually going to harm people. I do not believe that these regulations are going to stop the research finding out whether it is actually going to help people.

Dr DOUGLAS: Thank you.

Mr SHUTTLEWORTH: My comment was probably more a statement. Anecdotally at least you would expect that tobacco companies are hoping for that same outcome otherwise they would not have bought the manufacturers?

Ms Durham: I absolutely agree. The tobacco industry is buying heavily into e-cigarette promotion. We have evidence of dual use that seems to be coming through in users. Clearly it is something that they can add to their repertoire and will possibly get young people smoking earlier using non-nicotine cigarette

I wanted to comment, if I could, on the Peregrine comment about the retailing of non-nicotine devices. They are actually unregulated now. They are either labelled or not labelled. There is no regulation. You cannot tell at the retail end whether it has nicotine or has no nicotine unless it is tested. Some of the non-nicotine devices may in fact have nicotine. We need the regulation.

CHAIR: Ms Luu-Nguyen, would you like to respond to that?

Ms Luu-Nguyen: Yes. We can only go from what the manufacturers put on the label. We appreciate that there have been studies in the UK and US where products were improperly labelled and there were traces found. From a retailer's perspective, what we are proposing is that one of the issues we think is a gap in this market is proper prescribed standards. If either the TGA or some other regulatory body takes up the challenge in terms of putting out a product standard that would then regulate the type of ingredients that can be put into these devices—the quality and grade of the products that can be used, standard labelling requirements that you see with other products such as food and then any health or other warnings—we think that would cover off what we perceive as a missing link in the structure in terms of the way in which these products are regulated. I do not necessarily think that you can capture all of that in the amendments that are currently being proposed.

CHAIR: Unfortunately, therapeutic goods are not in our area of authority.

Ms Luu-Nguyen: I appreciate that.

CHAIR: We can only deal with those areas of authority that we have authority over. That is not one of those. We appreciate the comment. Dr Gartner, I have another question for you. Some of the product that you can buy to put into the e-cigarette type devices is flavour based. Again, a lot of the research I saw coming out of Europe, particularly England, is that a lot of what is purported to be used in pubs over there now is flavour based—apple, pear, peach or whatever. I did a bit of a recce around some of my service stations and different places. I think Peregrine is right; I could not see from the labelling whether they contained nicotine or not. I am wondering if there is any research around whether people are buying flavour based ones, assuming it has no nicotine or are their eyes wide open and they do not actually know? Are you aware of any?

Dr Gartner: I think people do not know whether it has nicotine in it or not, to be honest. I think people probably assume it does not have nicotine in it. There has been some research done in New South Wales. They did a survey. They found some products did have nicotine in them. There was another survey done by Tasmanian health authorities. Most of the products did not have nicotine in them. There were a few products that had it. It is difficult to say in Queensland. Maybe the people from the health department may have done some testing. They may be able to answer.

CHAIR: I did a quick search online and, by crikey, you do not have to go very far to find the products online and import them without any difficulty whatsoever. Have you got any research on where the primary product is being bought from? Is it being bought online? Do you have any clue?

Dr Gartner: It is mixed. I think a lot of people are buying them online, to be honest, and importing them. People do buy them locally too.

Mr SHUTTLEWORTH: Have any studies been done around the placebo effect of using vaporisers with non-nicotine and what effect that has on someone who is relying on that to break the habit of smoking?

Dr Gartner: There was a clinical trial where they used a non-nicotine e-cigarette as the placebo and it had a pretty much similar result to the nicotine one. It may actually be useful for some people with that behavioural aspect. They could always combine it with something like a patch for an alternate nicotine source. There has not been a lot of research in that area about its usefulness as a behavioural replacement as such. Certainly some of the participants in our study did say that they use non-nicotine and that they find that is good enough.

CHAIR: There being no further questions, I thank you all for your time.

BOHNEN, Mr Stephan, Principal Advisor, Intergovernmental Relations, Local Government Association of Queensland

CHAIR: Welcome, Mr Bohnen. We are going to change gears from smoking and head toward asbestos, is that right?

Mr Bohnen: That is correct.

CHAIR: We have probably got about 25 minutes or so with you. Would you like to make an opening statement and then give us 10 or 15 minutes to throw questions at you, if we need to?

Mr Bohnen: Thank you, Mr Chairman. The Local Government Association of Queensland appreciates the opportunity to appear before the Health and Community Services Committee to assist with the committee's detailed consideration of the Health Legislation Amendment Bill 2014. The bill amends eight Health portfolio acts. Consistent with the submission we have made to the committee, I will limit my remarks to two matters: firstly, the amendments to the Public Health Act 2005 to transfer civil liability for asbestos related matters from local governments to the state; and, secondly, the amendments to the Tobacco and Other Smoking Products Act 1998 to give effect to legislative reforms to extend smoking bans on and around health facilities and school grounds.

Regarding the amendments to the Public Health Act, the LGAQ would like to express its appreciation for the consultation undertaken by the government with regard to the administration and enforcement of routine domestic asbestos matters and for the government's collaborative approach to ensure the seamless delivery of services in partnership. The key issues consistently raised by the LGAQ regarding the devolution of the administration and enforcement of routine domestic asbestos matters have been (1) the need for legal protection via a statutory indemnity for council officers administering the asbestos provisions of the public health legislation; (2) the need for appropriate and ongoing training for council officers; and (3) the need for appropriate cost recovery options including a stand-alone fund in certain circumstances.

The bill focuses on the first of these matters—that is, statutory indemnity. The LGAQ are supportive of these provisions but would like to respectfully request the committee to give consideration to a number of operational and resource issues which have been raised by LGAQ member councils. The prescribed 70-year period for the preservation of records is a significant period of time which will impose considerable cost on councils in maintaining these records. While the LGAQ appreciates the latency periods for asbestos related diseases to be diagnosed, we would urge the committee to recommend that the government give consideration to shortening this period.

Furthermore, the annual compliance certification system, aimed at ensuring a timely response to council record keeping, is likely to be an imposition to varying degrees on councils depending on their size. The solution we propose to minimise the impost on local governments while satisfying the annual compliance certification requirements is one modelled on the registers kept by the chief executive under the Animal Management (Cats and Dogs) Act. Under this model the relevant portfolio department maintains an online portal which councils use to update compliance with their registers. Logging on to this portal and populating the register is deemed to be sufficient to demonstrate compliance. We would urge the committee to recommend that, in the interests of streamlining, reporting for the purpose of annual compliance certification for the statutory indemnity under the Public Health Act be undertaken in a similar fashion.

I now turn to the other two issues consistently raised by the LGAQ in discussions on the administration and enforcement of routine domestic asbestos matters; namely, training and cost recovery options. While the LGAQ appreciates the arrangements put in place for the first tranche of training until March 2015, it is vital that councils be supported by the government through ongoing training beyond March 2015. Councils must be able to obtain further training so that they meet the requirements of the indemnity. The LGAQ urges the committee to recommend that the government commit to the provision of ongoing high-quality training beyond March 2015.

Another important issue and one that requires careful consideration is the recovery of asbestos clean-up costs by contractors that need to be engaged by councils where the owner-occupier is unwilling or unable to comply with their obligations. While the LGAQ acknowledges that cost recovery options under the Public Health Act are adequate in most circumstances, the provisions are simply deficient where owners or occupiers have no assets, where the owner-occupier has absconded and refuses to cover clean-up costs or where the damage is caused by an unknown third party.

In our submission we refer to the recent example of a large regional council which became involved in a domestic asbestos matter and incurred a clean-up bill of $150,000. In addition to the extra costs incurred by local government in absorbing this devolved responsibility, it is simply

impossible for local councils to absorb clean-up costs of this magnitude on either a one-off or a recurring basis. The solution proposed by the LGAQ to deal with these situations is a stand-alone fund initially provided by the state government. The LGAQ has raised this matter with the government for consideration and is more than willing to facilitate negotiation between its members and the government on how a useful and effective model could be developed. It is essential that any model agreed is sustainable in the long term.

Finally, let me conclude with some brief remarks regarding the amendments to the Tobacco and Other Smoking Products Act 1998 to give effect to legislative reforms to extend smoking bans on or around health facilities and school grounds. The LGAQ welcomes the fact that the reforms do not impose a duty on local governments to enforce these bans. However, we are concerned that increased community expectations post the passage of these amendments may lead to a de facto devolution and cost shift to local governments. Should this situation occur, funding and resource issues would inevitably arise. The LGAQ urges the committee to note these concerns. Thank you for your time. I would be happy to answer any questions, Mr Chairman.

Ms BATES: Mr Bohnen, in relation to the training of local government employees on the management of asbestos related events, are you training them at the bonded asbestos level, as in class B, or are you training them at the friable asbestos level, as in class A?

Mr Bohnen: The training is targeted at authorised persons under the legislation. So it is to train authorised persons in local government to undertake their obligations. As to the level, that may be a question to the departmental officers later on. But the training is targeted at authorised persons under the provisions of the public health legislation.

Ms BATES: The reason I am asking is that under the previous government I was the shadow minister for the building industry and public works and one of the issues then was that the majority of people in QBuild were trained at class B level but were not trained at class A level, and that is where we had some asbestos related incidents that the government had to deal with in schools and TAFEs—the TAFE at Mackay was one of them. You are asking us to make sure that we continue training and assisting in that regard, but we really need to know because there is a big difference between class A and class B in terms of people who can actually remove asbestos.

CHAIR: I will ask a follow-up question. Money is being provided for training, as I understand it, through to early 2015—the end of the third quarter of 2014. That is a fairly substantial period of time. Surely local government can pick up the bulk of that training and provide it within that time frame, as in the train the trainer type effort, which means that they are not substantially required to design and develop those courses. There is always substantial cost involved in that. So the training would come at a significantly less cost to local government than if they had to do it themselves. I am not sure where that substantial cost then would come from if, in effect, the training outlines or the course outlines and that sort of thing are being developed and delivered to local government now. Really what we are talking about is an ongoing effort which would involve substantially less cost than having to start afresh.

Mr Bohnen: Yes. The training is already provided in a collaborative effort with involvement of the Local Government Association. I cannot stress enough the importance of continued accessibility for local government officers to ongoing and high-quality training, and we are in discussions as to what that training in the long term could look like. Our estimation is that there is certainly a need initially for an extension of the current training program which includes a three-day training session for up to 20 officers at any one time, and we have training in place for that to occur until March 2015. But that will only provide some initial training. Because local governments have up until now referred complaints to Queensland Health, it is important that they are being properly prepared to take on that responsibility going forward. So we would see an ongoing need for three-day training sessions for new local government officers, for example, or perhaps every two to three years or perhaps a one-day refresher course or perhaps some online training which will save on costs or a combination of these going forward. So these are still issues for discussion. But what precisely that training will look like going forward is up for discussion. But I do need to stress the importance of accessible, high-quality training going forward for these authorised persons in local government.

CHAIR: That is not the premise of my question. I actually support that. I think that is right, especially in an area like this. I was in the Australian Air Force and I dealt with the overhaul of brake units, and I am aware that asbestosis can take 30 or 40 years to appear. So I am not unsympathetic to what you are asking. What I am suggesting though is that the ongoing cost, given the input of capital by the government upfront, is probably not as significant as what is thought or maybe I am missing something here.

Mr Bohnen: The local government officers attending the training—even the training that is being offered between now and March—are already paying for their own attendance to that training session. So it is already a collaborative approach. The trainers are being provided by the government and that is important, and the association has had some involvement in assisting with securing venues et cetera. But the local government attendees at the training are already paying their own way to attend these training sessions and are taking three days out of their schedule.

CHAIR: I appreciate that.

Ms BATES: I have a follow-up question. This is more about what is the Local Government Association doing to give advice to home renovators. I know that there has been a big increase in the number of people renovating their homes with all of those shows on TV and people not knowing the dangers of removing or even being able to recognise asbestos which can lead to an increase in asbestosis and mesothelioma. Is there any program that you are doing to make the general public aware?

Mr Bohnen: In terms of the Local Government Association, no. As an association we are not involved in that work. But that is very much part of the role of local government officers under this devolution of routine domestic asbestos matters. So part of that role is the provision of advice to homeowners for do-it-yourself type activities and the enforcement of provisions under the Public Health Act, for example, in relation to the use of high pressure water cleaners, which are prohibited to be used on asbestos material. So the training to these local government officers very much goes into the provision of advice to homeowners around those issues. That is very much part of that role.

Ms BATES: So if you make an application to a local council to say you are going to renovate your bathroom or your kitchen, does somebody come out on site and have a look to see whether there are asbestos products there before they start the demolition?

Mr Bohnen: My understanding is that, yes, that is part of providing advice and ensuring compliance with the relevant provisions. But the role is limited to domestic matters. So, as soon as we are talking about workplaces, as soon as we are talking about what I understand is called persons conducting a business or undertaking, that is then a matter for Workplace Health and Safety within the Department of Justice and Attorney-General.

The role for local government is limited to domestic matters and it is limited to routine matters. Again, as soon as we are talking about complex, large-scale matters, assistance is provided by state government agencies. The local government role does not extend to those complex cases.

Ms BATES: Thank you.

Mrs MILLER: Stephan, I want to ask you a couple of questions. Firstly, in your submission you talked about the government establishing a fund like an orphan spill fund. Why can't local government set up its own fund?

Mr Bohnen: It is simply not within the capacity of councils to—

Mrs MILLER: But who says so?

Mr Bohnen:—undertake those clean-up costs. Our members tell us so and they have given us examples and I have quoted one.

Mrs MILLER: But they can legally set up a fund. Each individual council, if it liked, could actually set up a fund for this particular purpose. There is nothing lawfully that stops councils from doing that, as I understand it.

Mr Bohnen: The problem is that what seems like a relatively simple matter can quickly extend to a very complex clean-up operation.

Mrs MILLER: So it is all about funding?

Mr Bohnen: It is all about funding.

Mrs MILLER: So you want the government to pay?

Mr Bohnen: Where the owners can be easily identified, there are cost recovery options available. You are absolutely correct there. That is why we are saying in the submission, and I made the point earlier in my remarks as well, that we are looking for that stand-alone fund for situations where there is simply no way to recover the costs for those operations, especially in cases that incur large clean-up bills. While I am not entirely privy to all the details, I understand the example I mentioned involved high-pressure cleaning so neighbouring properties were affected and stormwater drains were affected. Immediately the costs just skyrocketed. If the existing cost

recovery options under legislation are not available to the local government because the owner cannot be identified or has absconded, for those limited circumstances that is where we would see the strong need for a stand-alone fund at least initially contributed by the state government.

Mrs MILLER: My point is, Stephan, that local governments in their budgetary process which every local government in Queensland goes through every year should have some sort of contingency within their budgeting to meet this type of purpose anyway.

Mr Bohnen: It is impossible to predict those sorts of cases—

Mrs MILLER: Yes, I know that. If this sort of case does not come up, that means they do not have to use that contingency funding. This seems to me to be a cash grab by local government for other levels of government, whether it be state or federal, that even though local government can approve the demolition or would approve the demolition if there is a problem with it they go to the higher levels of government and say, 'Well now you pay for it.'

Mr Bohnen: What might be useful in answering your question, Mrs Miller, is to refer to a scheme which we quote in the submission which exists in a related but different area which could serve as a model for what we are talking about and that may clarify our proposal and intentions. It is certainly not a cash grab and we understand that there is a need for this fund to be sustainable over the long term, which is why I indicated that we are happy to undertake negotiations on this.

The model that already exists which we believe could be useful for this stand-alone fund for clean-up costs of asbestos is what we call the orphan spill fund in the submission, but it is now called the reimbursement scheme for orphan incidents. It is run by the Department of Environment and Heritage Protection. With your permission, Mr Chairman, I can table an information sheet that provides the details of how this fund operates. It is specifically set up for local government to have access to—

Mrs MILLER: Which jurisdiction are you talking about? Which state?

Mr Bohnen: Queensland.

Mrs MILLER: That is fine. Are there any other jurisdictions throughout Australia that have the type of fund that you are talking about in relation to asbestos and local government?

Mr Bohnen: I cannot answer that off the top of my head

Mrs MILLER: Can you get back to us on that?

Mr Bohnen: Sure.

CHAIR: Following that line of questioning, how many councils are there in Queensland? Is it seventy—

Mr Bohnen: Seventy-seven now.

CHAIR: If each council tossed 10 grand a year into a fund, that would be $770,000 into a fund that could be used for the same purpose and would cost each council substantially less if they do not use it for that year as it accumulates and very quickly it would be in the millions. I am not sure why that wouldn't work. Could that work?

Mr Bohnen: Potentially, but as I have mentioned earlier the costs potentially are significant. So we see a need initially at least for a state government contribution to this stand-alone fund. Very quickly single incidents could be $150,000, and I gave an example. If we are talking eight or 10 such incidents across the state, that is beyond the capacity of local government to fund entirely. Initially, we see a need for a state government contribution, but how that fund is going to operate sustainably over the long term is a matter for negotiation with the government.

Mrs MILLER: If local government in Queensland cannot afford something like $1½ million per year on the basis of 10 such incidents occurring across the state there is something wrong with the financial sustainability of local government in Queensland, because this is an issue about local government. It is an issue about demolition et cetera and asbestos related disease. Local government is again putting its hand out to other levels of government, whether it be state or federal government, to fund what is in fact its primary purpose. I think you should go back to the Local Government Association and suggest that it put up its own fund and levy each of the individual councils a certain amount of money every year that would go into this type of fund. I would like you to please take that back to the Local Government Association because we see continuously local government putting its hand out all the time for other levels of government to bail them out, particularly in relation to any legislation that means it is going to cost money.

I would like to ask one more thing in relation to the banning of smoking in pedestrian malls and other areas of importance to local government. Has any person been prosecuted in any local government area for breaching these smoking bans and, if not, why not?

Mr Bohnen: I would have to take that on notice. I do not know the answer to that question.

Mrs MILLER: The reason I ask is that right across local government, particularly in South-East Queensland, we are seeing local governments using these cars that go around fining people, for example, for parking on their footpaths which is becoming even more controversial as local government is trying to cash-grab from local ratepayers. They make a lot about having these antismoking laws in malls, but I think it would be interesting for us as a committee to find out whether or not it is lip-service or whether or not they are prosecuting people. If you could take that on notice and get back to us that would be very good.

CHAIR: Can I suggest that he do his best? I am not sure if within the time frame we have left he can, but as best you can we would appreciate that information.

Mr Bohnen: Yes, I am happy to do that.

CHAIR: We are pretty close to our time. If you would like to do a quick wrap-up on the conversation we have had, I will give you a couple of minutes.

Mr Bohnen: The only comment I would make is that it is important for the committee to be aware that this is a devolution—and I am going back to the asbestos matter—from the state government to local government. It is not something that local government has asked for. As is clearly set out in the Partners in Government Agreement, which we have attached to our submission, with any devolution comes the need to consult with local government and provide support. In our view, so far as discussions are concerned this has occurred. I have listed in my remarks and in the submission the issues that are still under negotiation for that package of support to be completed.

CHAIR: Before you leave, I will finish by saying that I hope the cost of the indemnity associated with asbestos is also understood by local government. I think that is a substantial pick-up by the government in regard to potential liability for local government.

Mr Bohnen: I would very much endorse those comments. It was one of the key barriers why until now local governments have been very reluctant to take on that role. That is a key barrier that has now been addressed.

CHAIR: I really appreciate your time, Mr Bohnen. Please take our thanks back to the Local Government Association. If possible, we will need the answers to those questions on notice from you by 5 November. That is also the case for the former witnesses. We will need questions on notice back by 5 November.

MOLLOY, Dr David, Medical Director, Queensland Fertility Group

CHAIR: Welcome, Dr Molloy. We have about 15 minutes with you, so if you would like to make an opening statement and then we will ask a couple of questions.

Dr Molloy: Thank you, Mr Chairman. I am the Medical Director of the Queensland Fertility Group, which is Queensland's first and largest IVF and assisted reproduction unit. We are part of a bigger group called the Virtus Health Group, which is a multistate IVF group which now supplies about 40 per cent of the infertility treatments in Australia. I also wear a hat as chair of the IVF Directors Group. That is the heads of all the IVF units in Australia. That group both sets the standards for IVF treatment for patients and provides regulation for the industry. I have held that position on and off for about 15 years. I first started treating infertility patients in 1986. I have also been president of the AMA in Queensland.

I would like to thank the committee for the opportunity of presenting. I have previously spoken to the minister on this issue and I have sent you individually submissions that we prepared in relation to repeal of section 41 of the Transplantation and Anatomy Act 1979. I would also like to place on record my thanks. I have been treated with great courtesy and assistance by all levels of government—the minister's office, the department and your committee. I have found this episode of trying to mould your opinion an extremely agreeable one.

Basically in 1979 the world's first IVF baby had only been born the year before. Infertility treatment was in its infancy, but that was 35 years ago. Government did face the new technologies with some level of trepidation. As a result, in the 1979 revision of the Transplantation and Anatomy Act section 41 was put in to regulate advertising in relation to the purchase of human tissues, and that included eggs and sperm. Thirty-five years later the management of couples with infertility problems has reached a mature medical service. It is now at the point where one child in every classroom—one in 24—is born from some sort of ART service, mostly IVF. A significant number of those involve the use of donor egg and donor sperm.

I have been involved heavily in the industry since 1986, and in a regulatory, administrative and leadership role since about 1990. I admit that I did not even know that section 41 of the act actually existed and I do not really think many other people did as well because it really has not been administered in Queensland for the best part of 35 years. It suddenly popped up in a well-meaning letter from the department several months ago when I think it was probably brought to their attention.

I would like to argue that the ART industry in Queensland, in terms of the way it has looked after patients, has a good record both of safety and avoidance of controversial ethical issues that can occur in our area. I feel that the regulation of such advertising was probably now a little passe and not really the role of government. I did speak to the minister and felt that, rather than amending the act so that a public servant could carry out the minister's designated role of mentoring and vetting all advertisements, it was probably more appropriate to actually repeal that section of the act. I think the actual role of a health minister looking over an advertisement for donor eggs or donor sperm is probably not quite appropriate for the exalted level of a health minister who is leading a multibillion-dollar department and service. Even in respect of designating it down to the Chief Health Officer, when the Chief Health Officer is managing something like an ebola crisis, to look at an advertisement for donor egg and donor sperm is probably a little over the top to be honest.

In the submissions I presented to you, I felt that there were a number of arguments for repeal of this section of the act rather than simple amendment. I argued that it is not really the role of government to regulate such advertisements, and in fact I have also argued that it is really quite impossible to regulate this advertising. The vast amount of advertising in this area is actually person to person between patients in chat rooms and online. Much of it originates from outside of the state. It is not truly one or two corporate entities so that it is easy to deal with. I would suggest that if we do not repeal this section of the act it would be almost impossible to administer it—simply because of the very nature of modern advertising as such.

Also troubling me in the act is that there is no real definition of what is a good advertisement and what is a bad advertisement. If you are going to regulate advertising, surely you need to provide guidelines of what would be acceptable. The regulation of such advertisements will be very much in the eye of the beholder. Until you tell people what you are going to deem as a just or unjust advertisement, it would be very hard to apply that judgement, particularly as there are a number of penalties associated if you cross the line on that judgement. With those arguments in mind, I did go and see the minister and the minister said, 'The amendments are going to parliament. It is going to be reviewed by this committee, and present your case to this committee for their just consideration.' So I hope that is helpful.

CHAIR: Thank you, Dr Molloy. I would like you to respond to one thing. This subject matter by definition brings with it, in varying degrees, moral and ethical arguments. If ever we are going to regulate anything, surely it is in the moral and ethical fields. How would you respond to that?

Dr Molloy: I have a cautious approach to regulation in any area of medicine. Regulation in medicine rarely works unless it is a very well-defined thing. There are always cases that step outside the areas of regulation and exemptions need to be made. So that is a philosophical thing. In the ethical and moral areas, I also believe that the government is in a position to show leadership—as they have in many areas relating to my function—but in fact to show leadership and advise sometimes, rather than regulate. I suspect that in this particular area of a patient perhaps seeking an egg donor or seeking a sperm donor, or a clinic such as mine—which now has 31 years of reputable history in Queensland in terms of providing medical services to patients—putting a notice on our website saying, 'If you would like to be a sperm donor, please contact this number,' then under the legislation that would be an advertisement. I have many times over the years gone and spoken at functions. We put notices up in the refectory at the university saying, 'Would you like to be a sperm donor? Ring this number please for further counselling and advice.' That constitutes an advertisement. Should we take that advertisement to a senior public servant to have a refectory notice at the university approved?

I do not see in this sort of situation you are regulating an ethical or a moral service. The first donor sperm services were provided in this country in 1950. It has now been an acceptable medical service for over 60 years. Indeed, in all the years that we have been providing these services in Queensland—we were the first to do so—we have not transgressed government. The only time we have ever been in trouble was when we initially followed the dictates of the advisory committee set up in around 1978 or 1979 and we denied donor sperm services to same-sex couples and we ended up in the anti-discrimination court.

CHAIR: I guess I am not advocating that the medical practice is immoral or unethical—I am not advocating that—but I am suggesting that, if an organisation got involved which chose to advertise in a manner other than what would be accepted by the bigger organisations or the groups, surely it is within a government's responsibility, especially in an area where there are moral and ethical implications, to have mechanisms to be able to control that.

Dr Molloy: I suspect that those mechanisms currently exist, and that for such advertisements to be unacceptable they would probably have to be misleading, misrepresentational in some way or offensive. In fact, the government already has the power to regulate those advertisements through consumer affairs and through other mechanisms.

CHAIR: I am not sure I agree with that but that is okay. We appreciate your viewpoint. Does anyone else have some question? We have a few minutes.

Mrs MILLER: Dr Molloy, this particular provision, section 41, has never been used before to your knowledge.

Dr Molloy: Not to my knowledge, ever. I could honestly say with my hand on my heart that senior members of the profession here in Queensland, of which I am one, were gobsmacked when we got the letter from the department. I do not think anyone ever knew it existed. I think what has happened is that I suspect—and I might well be wrong—it has been drawn to the department's attention through some situation and the department quite naturally has probably found that it should have been administering this for the last 35 years. In theory, for the last 35 years, every time we put up one of those notices in the refec, and I have been on radio innumerable times—the ABC, everybody—talking about donor sperm and donor eggs and I have given it a little plug saying, 'If you're interested in being a donor, we'd love to hear from you,' then that is an advertisement. In theory, I should be in jail for the rest of my life, I have done it so many times—I am not sure this is very intelligent to put that on record. So I am sure that this has not been administered and it is really something that has popped up. Quite naturally, whether it is an act you should have administered, I can understand why now there is some action to look at how you sort this out.

We have a really sensible history here in Queensland on both sides of parliament of sorting these sorts of issues out—for example, the stem cell legislation. I came and spoke to the parliamentary committee. I have helped the government on surrogacy. The approach that I have seen consistently in 20 years in this state has been a very, very sensible one from both sides of the House in terms of sorting these issues out. I think this is something that has popped up, and again there is the opportunity to sort it out in a sensible sort of way.

CHAIR: I appreciate that. We have got time for one more question.

Mrs MILLER: Just as a follow-up in relation to this, given this current government's so-called war on red tape reduction, this will be a test to see if the government actually repeals it rather than amends it I suppose. I will follow this up with our representatives from Queensland Health in relation to who would be the person responsible to actually be the arbiter of so-called 'advertisements' if that does not happen.

Mr KRAUSE: Dr Molloy, it is fortunate you made your statements under parliamentary privilege so you cannot be prosecuted for that!

Dr Molloy: That is a big relief!

Dr DOUGLAS: Chair, could I just ask Dr Molloy this question. What will be the impact if we go ahead and pass this law on people being able to access donor eggs and donor sperm? Just a simple answer.

Dr Molloy: Reduction of service.

Dr DOUGLAS: That is it. So we will see less capacity of families to go and have children. That is basically it.

Dr Molloy: That is correct.

Dr DOUGLAS: And it will affect all ranges of people.

Dr Molloy: That is correct.

CHAIR: Sorry, I truly do not understand that. Why would it reduce services?

Dr Molloy: Simply, egg donation in particular is difficult to arrange. It is quite a thing to ask a woman to donate eggs and it is quite a robust process to donate those eggs. Egg donors are scarce on the ground. We have a five-year waiting list for egg donors in our program. Patients go out and recruit their own egg donors in all manner of means but most commonly over the net—advertising and requesting them. Those individual patients would be in contravention of this act.

CHAIR: Because they would need to get approval first? Is that what you mean?

Dr Molloy: If Joan, aged 39, who is sitting out in the suburbs somewhere puts something on a chat site asking someone to be an egg donor, theoretically, at this point in time, she should have in the past and should in the future go to the Minister and request if she can write a four-line blog.

CHAIR: I understand.

Dr DOUGLAS: So really not to repeal this act is against the national interest, isn't it, because we will have fewer taxpayers in the future, won't we?

Dr Molloy: It is an interesting point in that we have actually done the economic studies in terms of looking at the value that an IVF baby brings. With that one in 24 birthrate that we have now from IVF, it costs about $70,000 to produce an assisted reproduction child and the return to the community over their lifetime, after the cost of education et cetera and all of the things that the community pays for, is about 4.1.

Dr DOUGLAS: It speaks for itself. It is a no-brainer.

CHAIR: We do need to move on. Dr Molloy, thank you for your time. We appreciate it.

CARR, Ms Loretta, Manager, Regulatory Policy Unit, Department of Health

CLEARY, Dr Michael, Deputy Director-General, Health Service and Clinical Innovation Division and Chief Operations Officer, Department of Health

DWYER, Ms Sophie, Executive Director, Health Protection Unit, Chief Health Officer Branch, Department of Health

WEST, Mr Mark, Director, Preventative Health Unit, Chief Health Officer Branch, Department of Health

CHAIR: Welcome, Dr Cleary, and your team from the Department of Health. We will need to stop right on 1.15. We are all going to be rushing to get to parliament by two so we will have a hard stop at 1.15. Can we cover a couple of issues early, if that is okay, just so we get them covered, and then I will hand over to you to do a summary of things you have heard and your responses. Can we deal with the issue we just walked away from in regard to the repeal of section 41 and into 42? Are you in a position to deal with that or comment on that?

I am sorry. I have just been informed that the committee will have to finish at one because we have two members who must leave and that will cause us to lose our quorum. So we will be stopping at one. Dr Cleary, if there is anything we do not cover in this time frame, we would appreciate it if you could submit it to us as comments coming out of this.

Mrs MILLER: I have a couple of questions.

CHAIR: Given that we need to stop at one, we will leave that issue and you can respond to that at a later date. Are you okay if we go straight into questions for the health department?

Dr Cleary: Yes. Thank you again for the opportunity to be with the committee. Certainly, if there are matters that have come out of the submissions that you have received in writing or verbally today, and where there are points of clarification, the department will be very pleased to provide some supplementary information for you out of session. Thank you very much for the opportunity to allow the department to do that.

CHAIR: Thank you. We will go straight to questions.

Mrs MILLER: Dr Cleary, thank you for being here today. Just as a follow-up in relation to Dr David Molloy's submission, is it the department's view that there should be an amendment, given that obviously this particular section 41 has not been administered over the last 35 years? Or can you give us some indication of whether or not the department has in fact regulated section 41 and who has in fact made the decision and how many?

Dr Cleary: I will probably need to take the detailed response to that question on notice. However, with all legislation that sits with the department of health, we have a process by which we review that legislation and look at legislative compliance. In many areas the legislative compliance is developed in such a way that, as the provider of the service, you would reasonably expect to be in compliance with the legislation. Where there are specific areas where compliance is measured, then we do that. In relation to the private hospital facilities legislation, for example, we visit the private hospitals annually to look at their compliance with components of the legislation.

In relation to this area, I think it is a very important area for government policy. What the government is proposing is that there would be a delegation of certain powers that currently sit with the minister and that the Minister does not have the ability to delegate to officers within the department. Those powers around advertising could be to, for example, the Chief Health Officer, me or the Director-General to provide some advice on. When we were looking at how that might occur, it would be by an instrument of delegation. The department would consult with the community in terms of the providers before putting in place that delegation. In that regard it would be more around what would be the Minister's expectations around the way the delegated officers would operate and what would be the guidelines for such a delegation?

Mrs MILLER: Would there be, for example, any regulations around this particular section of the act? What I am trying to get at is—I know that, for example, your position or it was mentioned maybe with the Chief Health Officer. Would the department—and I am not talking about expectations and guidelines, which can change overnight. Would you be thinking of something like bringing in more regulations in relation to this?

Dr Cleary: At this stage the way this would be operationalised would be through an administrative instrument. So it would be a formal delegation.

Mrs MILLER: I am aware of that. I am talking about after the formal delegation. I am aware of how the process works, that the Minister has a delegation that says that these functions are to be undertaken by a certain officer. What I am asking about is the point after that. I am not talking about guidelines; I am talking about whether there would be further regulation.

Dr Cleary: At this stage my understanding is that there would not be any need for subordinate legislation to support that process but that the Minister's administrative instrument would provide the guidance on how those types of activities would be undertaken. There is a range of other similar delegations in place within the department that the Minister has oversight of and where they provide not only the administrative instrument of delegation but clarity around how the delegated officers are to manage those delegations. An example—

Mrs MILLER: I have just one further question in relation to section 41. If an officer was to make a decision in relation to section 41, it would then bring in the administrative law requirements which would mean that the officer would have to actually have a statement of reasons, either within that original decision or further on if a statement of reasons was requested under the Judicial Review Act. Has the department gone that far in its thinking?

Dr Cleary: The process that you outlined is the one that we use as a standard process with the delegated decision-making powers that the Minister has provided. With some of the ones I am involved in administering, there is a process by which we look at decisions. If a decision is a positive decision, generally the level of explanation required is less than if there is a negative decision. Certainly that would be a process that would need to be put in place as part of the operationalisation of these arrangements. It does, however, as you know, require parliament's endorsement for the change. So the process that would be put in place would be before the legislation has been proclaimed but after parliament has considered the matter.

Mrs MILLER: So if the officer decides no, this could very well end up in the Supreme Court under the Judicial Review Act. It will.

Dr Cleary: In terms of the way the current operationalisation of this occurs with other acts, the general process is that this is resolved at a local level. In terms of the appeal process, I would need to take advice on that. In other areas of legislation that I am involved with, the appeal has been through to the Ombudsman's office and the Ombudsman has considered it. I think there are probably a number of different avenues for appeal, but that would be something we would work through.

Mrs MILLER: I think you would find that, under the Judicial Review Act, the appeal can go straight through to the Supreme Court. I am sure there would be many potential parents in Queensland who would be horrified at the fact that they might have to fight such an action in the Supreme Court. If you could get back to us on that, that would be very good.

CHAIR: I appreciate that. Are there any other burning subjects? Alex, we have 10 minutes

Dr DOUGLAS: I wish to turn to e-cigarettes, the devices. I have trouble understanding how any device, whether it is called a vaporiser or not, is not captured under the TGA regulations. I say so because, as a general practitioner, all the variety of devices, irrespective of whether they carry anything—and the most recent ones I have seen are those flutter devices for people who have chronic obstructive airways disease, and Michael would be familiar with those—are captured under the TGA. For all intents and purposes it seems bizarre that if it is not captured under that, it would be captured under the legislation that applies to ice pipes and things like that. Ice pipes do not have the ice in them, but ice pipes are banned. I am uncertain why there is this 'in between' classification, because it has already been decided. There have been multiple cases. I think several years ago one of the manufacturers who was putting out placebos for puffers could not get them through because it had to go via the TGA.

Dr Cleary: I might ask Mark West, who is our adviser in this space, to make a comment.

Mr West: Starting with the second part of the statement around ice pipes, most definitely there are already regulations in place at the moment for ice pipes and bongs in the tobacco legislation in Queensland. The definition of those provisions specifically talks about illicit drugs essentially. So drugs that are in the Drugs Misuse Act—the drafting for that at the time was to be very explicit and to remove any confusion about a full range of illicit substances that are regulated under that act. That act is also updated quite often around amphetamine based substances, which unfortunately increase all the time when they change the recipes. That provision is very specific.

I can take on notice the requirements under the TGA for different products. Most definitely, it is the confusion that we are concerned about. It is the confusion between, 'Could it possibly be a bong? Is it really a conventional cigarette? It does not have tobacco in it. Is it non-nicotine versus nicotine versus whatever claims are on these products?' We have worked with the definition to be able to clarify those as much as possible.

Dr Cleary: The only follow-up comment I was going to make is that this is a complex area and I think the complexity lies in the drafting as opposed to the principles that you would apply. The principles were fairly straightforward in terms of the views as to what would be included and captured under the legislation. The complexity has been identified in the drafting of the legislation. We have taken advice from the OQPC about that. They have been very supportive in drafting the legislation to the degree that it will capture those devices that we believe in Queensland need to be captured.

Dr DOUGLAS: Would we not already be captured under the federal legislation and would that not be the overriding legislation, because the Therapeutic Goods Act is very comprehensive and specific? I am happy for an answer.

Ms Dwyer: It is not a therapeutic good; it is a consumer product. So it would not be captured under the Therapeutic Goods Administration law. The only law that currently applies in Queensland is the banning of the nicotine. So we are talking about a consumer product that contains nicotine and the legislation extends from that to control the vaporiser.

Dr DOUGLAS: With respect, we have been through this with a variety of things that are provided to general practitioners for a variety of illnesses which are emerging type illnesses, and they have defined them to be medical products anyway, whether you call them that or not. It is not for the manufacturer to say, 'This is a consumer product. The overriding Commonwealth legislation, from my understanding, is they say it is.

Ms Dwyer: As I understand it—and we can confirm this—it is only if they promote it as a quitting product that it would fall under the legislation. They are not promoting e-cigarettes as a quitting product but a consumer product just to—

Dr DOUGLAS: Defeat.

Ms Dwyer:—inhale. Yes, as such, it does not then fall under therapeutic goods.

Dr DOUGLAS: That will be challenged by the Commonwealth most likely.

CHAIR: We only have a few minutes left. I would like to pick up the subject of smoking in hospitals, specifically with regard to mental health and palliative care patients. If there is a ban placed over the top of hospitals, is there an opinion around how to manage that or to implement that?

Dr Cleary: The implementation of the legislation will obviously follow its consideration by parliament, but a number of our facilities are already smoke free. The important thing there is for alternatives to be offered to patients around options for them during their stay in hospital. That can be a variety of products such as nicotine patches, gum and so on. That deals with the dependency component and is quite an effective mechanism in terms of the management of patients while they are in hospital. Clearly, smoking in hospitals or in the surroundings of hospitals can also be something that can worsen your health. If you are acutely ill, smoking is often associated with a significant worsening of your health during the period that you are ill. In terms of people with chronic lung diseases or with other illnesses who are in hospital, we would generally be encouraging them not to smoke anyway for their own good health.

In terms of some of the specific areas that you mentioned, it is more in terms of providing support for people around the management of any dependency that they may have. There are already good systems in place to do that through the smoking cessation programs that we have. As you would be aware, we have introduced a new arrangement into the Queensland Corrective Services system, and that has been particularly well structured. It has resulted in a significant change in the rates of smoking in the Corrective Services facilities. I think, as I say, it has gone well in terms of acceptance. I do not know whether Mark has any further advice on how that has gone.

Mr West: Only to agree. Earlier on mention was made of stepped change, or making changes over time. Progressively, our healthcare facilities in Queensland—public and private—have most definitely moved to being non-smoking. There has been a policy response first, then supported by legislation backed by very strong community support. This is the next step, and the next step then is to look at the very few designated areas left on campuses and also to address basically the front entrances of these facilities as well—to reinforce and send a strong message that they are non-smoking.

CHAIR: Our time has run out. Could we have your responses back by 5 November, Dr Cleary, to give our staff time to complete the report? If committee members have any further questions that have not been answered, could you please get those back to us by the end of this week so that we can forward them as quickly as we can to the department? If we can have those returned to us by 5 November, that will cover off any extra questions that you may have. With that, I thank Dr Cleary and the staff from the department for their time here. I wish we had more time. I am sure we could go for at least another half an hour. I appreciate your time. We will communicate that to you via a letter and then you will have a chance to respond. We appreciate everyone who turned up today. I declare this hearing closed.

Committee adjourned at 1.00 pm