Queensland
Government

Department of Health

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Mr Trevor Ruthenberg MP
Chair
Health and Community Services Committee
Parliament House
George Street
BRISBANE QLD 4000

Dear Mr Ruthenberg

Thank you for your letter dated 24 October 2014, regarding issues raised in submissions to the Health and Community Services Committee (the Committee) regarding the Health Legislation Amendment Bill 2014. Mr Ian Maynard, Director-General, Department of Health, has asked that I respond on his behalf.

I am pleased to enclose a response to the issues raised by stakeholders in their submissions to the Committee. I trust this information will assist the Committee in its examination of the Bill. Further, I look forward to receiving confirmation from the Committee about questions taken on notice at the recent public hearing 29 October 2014, to enable the Department to respond.

Should you require any further information in relation to this matter, the Department of Health contact is Ms Amanda Hammer, Director, Regulatory Policy Unit, on telephone [redacted]

Yours sincerely

[redacted]

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3 / 11 / 2014

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Health and Community Services Committee

Health Legislation Amendment Bill 2014

Issues raised in submissions

Amendments	Issue	Departmental Response
***Public Health Act 2005* – Asbestos and civil liability**	**Reasonable compliance with indemnity conditions:** Unclear how 'reasonable compliance' is to be satisfied and measured (Sub.7).	• The matters prescribed in new sections 454F to 454I explicitly state the conditions that must be met by a local government for the State to indemnify the local government against any civil liability arising from official conduct of a prescribed person that gives rise to asbestos-related harm. • It is not unusual for legislation to apply a "reasonable test" to determine – for example, in a situation where a requirement or condition has not been met or an action was not taken – what a reasonable person would or should have known, assumed, understood or done in that situation. • Including 'reasonable compliance' provides a form of protection for a local government that has failed to comply with a prescribed condition due to circumstances beyond its control. Where the State is not satisfied that the local government has reasonably complied with an indemnity condition, a court may consider and determine reasonable compliance.
	Significant workplace health and safety risks to Local Government officers investigating asbestos issues, amendments do nothing to mitigate risks (Sub.7). Also concerned that the Bill excludes civil liability under the *Workers' Compensation and Rehabilitation Act 2003* (Sub.8).	• The Bill forms one part of a package of assistance that the Government is providing to local governments. It addresses the most critical issue of statutory indemnity to local governments for protection against asbestos claims during the enforcement of asbestos laws under the Public Health Act. • The role of local government officers does not involve any asbestos removal work. • Local government officers' exposure to asbestos fibres as part of administering the asbestos laws in the domestic setting would be extremely low to negligible. This is because their role is limited to providing advice to homeowners about DIY activities involving asbestos and enforcing asbestos provisions such as: – prohibiting the use of high pressure water cleaners on asbestos material, – responding to complaints relating to the disturbance of asbestos by residents at domestic premises, and – referring large scale and complex asbestos complaints to either the Department of Justice and Attorney-General or Queensland Health for assistance. • If a local government employee suffers any work-related injury or illness (asbestos related or not) this would already be covered by mandatory workers' compensation insurance provided by WorkCover Queensland or otherwise under self-insurance arrangements. Any insurance arrangements outside of WorkCover Queensland must still provide the same level of cover; thus all local government workers are already covered for this outcome.

Amendments	Issue	Departmental Response
	Extra workload for Local Government, funding not addressed in the Bill (Sub.7).	• The scope of the amendments is to indemnify a local government against any civil liability arising from official conduct of a prescribed person that gives rise to asbestos-related harm to a person (other than the prescribed person). • The Local Government Association of Queensland's submissions to the government to date have not requested funding for the additional workload to local governments. • Department of Health complaint data indicate that approximately 110 complaints were responded to by the Department in a one-year period, and 95% of those complaints were classified as minor in nature. When shared across 77 local governments, this does not amount to a large number of complaints per local government. Although it is acknowledged that there would likely be more complaints to the larger councils in the south east corner of the State.
	Assisting State defend claims: Accepts Local Government should assist State to defend claims, however, believes assistance should be limited to providing briefs of evidence and expert testimony in court, and not extend to Local Government paying, or sharing, legal costs incurred by State (Sub.8).	• It is considered reasonable that local governments assist the State with defending a claim, including incurring costs attached with that assistance. • The indemnity conditions have been developed to minimise the impact on local governments with respect to providing sufficient information for the State to defend a claim. • Given the low number of asbestos complaints each year that are not minor in nature (i.e. estimated at 5% of around 110 complaints), it is not anticipated that there will be large numbers of civil liability cases, so the impact is expected to be minimal. • It should also be recognised that, in addition to bearing the cost of compensation for a successful claim, the State must also bear the cost of annual insurance premiums for the indemnity.
	Guidelines: Seeks assurances Local Government will be consulted on guidelines with appropriate deadlines to comment (Sub.8).	• It is the intent that local governments, through the Local Government Association of Queensland, will be consulted during development of any guidelines made under new section 454H. Further, a proposed guideline would be subject to impact assessment under the Government's Regulatory Impact Statement System.
	70 years for preservation of records: significant period of time and will impose considerable costs on councils (Sub. 20) and retention of training and complaint records for 70 years is unreasonable and impractical (Sub.7).	• The requirement to retain records for a period of 70 years recognises the potentially long latency period for asbestos related diseases. The most likely disease outcome for asbestos exposure in domestic situations is mesothelioma which has an average latency period of 20 to 50 years after exposure; however, in some cases disease may develop up to 60 years after initial exposure. • The record keeping requirement must take account of this latency period and must also include a period to take account of possible anomalies or delays associated with the bringing of a claim. This is necessary to ensure the State can adequately defend a claim.

Amendments	Issue	Departmental Response
		• The current general retention and disposal schedule relating to public sector records requires some records (work health and safety and related incidents) to be retained for up to 100 years and other records to be retained permanently. The requirement of the indemnity is not incompatible with these requirements. • It is submitted that the need to ensure adequate documentation exists for the State to defend a claim on the local government's behalf will outweigh the costs incurred by local governments to retain that documentation for 70 years, again noting that the number of complaints per annum are currently small and minor in nature. • A priority under the *Statewide Strategic Plan for the Safe Management of Asbestos in Queensland 2014-2019* is to provide a greater investment in public awareness and education of the risks arising from asbestos. It is anticipated this will also help reduce the risk of exposure of workers and home renovators. In the longer term, the incidence of asbestos related disease is expected to diminish as community awareness increases, compliance with asbestos management and removal standards improves and ACM is removed from workplaces and homes.
	Annual compliance with indemnity conditions certificate: Imposition on councils to varying degrees, depending on the size of council. Consideration should be given to imposing positive obligation on administering agency to maintain portal that can be used by Local Government to update their registers online (Sub.20).	• Providing an annual compliance certificate is not mandatory. However, if provided, it is deemed to be evidence of the matters stated in the certificate, unless there is evidence to the contrary. • The annual compliance certificate provides assurance and certainty to local government administrators that they will be indemnified under the *Public Health Act 2005* for asbestos-related events that are covered under the certificate, rather than being required to verify that they have complied with the indemnity conditions during the assessment of a claim (which may be 40 or 50 years later). • Taking into account the purpose of the annual compliance certificate, and the reliance on it specifying that indemnity conditions were complied with, the requirements for the annual certificate prescribed in new section 454J were deemed appropriate in a legal context. • A portal may be developed to assist local governments maintain online register of records. This will require consideration of record keeping requirements.
	Training of Local Government officers: • understands training of Local Government officers will take place in October 2014, but unclear how ongoing training and support will be managed (Sub.7);	• Training is mandatory for local government officers under the indemnity provisions. • The Government has given a commitment to an ongoing mechanism for the provision of training, and a sustainable mechanism to train local government officers such eLearning program is being explored.

Amendments	Issue	Departmental Response
	• welcomes training on asbestos management, seeks assurance that current scheduled training will be recognised as prescribed training by regulation (s.454G) and that more training will be provided on a regular basis (Sub.8); • seeks Minster for Health and Attorney-General's commitment to clarify council's ability to obtain further training after current training finishes in March 2015 (Sub.20).	
	Cost recovery: • Cost recovery provisions in PH Act considered inadequate, particularly for asbestos clean-up when the responsible party cannot be found, has no assets, or is not the owner of the land (Sub.7, 8 and 20) - prefers cost recovery provisions under *Local Government Act 2009* (Sub.8). • Standalone cost recovery fund should be established for cost recovery when responsible party cannot be found or is unable to pay for site decontamination (Sub.8 and 20) – suggested example of Orphan Spill fund (Sub.20).	• The issue of cost recovery for asbestos clean-up where costs cannot be recouped by councils will be considered by Government in 2015, as part of further work around asbestos which is being led by the Department of Justice and Attorney-General.
Tobacco and Other Smoking Products Act 1998 **– extension of smoke-free areas**	**Authorised person in a school setting:** seeks clarification about who will be an authorised person to enforce the smoking ban on and around school land (Sub.3)	• Authorised persons under the *Tobacco and Other Smoking Products Act 1998* have authority to enforce offences, including the issuing of 'on-the-spot fines' and using other regulatory powers. • Authorised persons for enforcement of smoking bans at schools are proposed to include: environmental health officers and police officers, who can enforce the ban on school land and in the buffer area beyond the boundary; and authorised local government officers of councils that elect to take up the option to enforce, who can ban in the buffer.

Amendments	Issue	Departmental Response
		• Adding an enforcement responsibility to the workload of principals and teachers is not supported and is not an appropriate function for these positions. However, principals and teachers will be able to encourage compliance with the bans by asking people to stop smoking and move on. This is in line with current policy and does not impose additional regulatory burden on school principals.
	Laws need to go further: • Recommends introduction of uniform designated smoke-free spaces in Queensland (including, bus stops, ferry terminals, taxi ranks, train stations, pedestrian malls, grounds of TAFEs and Universities, outdoor market areas, outdoor dining venues and the footpath, within 10m of council buildings, playgrounds, sports stadia) (Sub.2, 5, 13, 15, 23).	• The current legislative reforms are for smoke-free hospitals and schools, as well as personal vaporisers and electronic cigarettes. Government may consider further reform in the future. • Smoking is banned at railway stations throughout Queensland under the *Transport Infrastructure (Railway) Regulation 2006*, and at busway stations in Brisbane under the *Transport Infrastructure (Busway) Regulation 2002*. • Local governments are empowered to regulate smoking at public transport waiting points and malls. Ipswich City is a leader in this area and has smoke-free malls and bus stops. The Queen Street Mall in Brisbane is also non-smoking. • Although the *Tobacco and Other Smoking Products Act 1998* is the primary vehicle for regulating smoke-free areas in Queensland, the extension of smoke-free areas can also be achieved via policy or local laws (noting that if any inconsistency were to arise, the *Tobacco and Other Smoking Products Act 1998* would prevail). • For example, QUT has publicly committed to moving towards a smoke-free environment. The current QUT smoking policy prohibits smoking (which includes using an electronic cigarette) across a broad range of areas at QUT campuses, including: buildings; outdoor areas of a food outlet or area where food and drink is provided; QUT vehicles; within 10 metres of any entrance to buildings, air conditioning intakes, ventilation louvres or opened windows; and in all semi-enclosed thoroughfares such as verandahs.
	• States that Local Governments have failed to use their powers to ban smoking under (s.26ZPB) (Sub.2 and 5).	• The intent of the power to enable local governments to make local laws to ban smoking at pedestrian malls and public transport waiting points is for local governments to assess the needs of their community and the extent to which smoking in those places is problematic, and choose to make a local law to address those issues if the public benefit outweighs the costs of enforcement. • To date, there has been minimal use of this specific authority with four councils introducing local laws including Ipswich, Brisbane, Redland and Fraser Coast councils. Cairns Regional Council is currently considering introduction of local laws. • The Department is aware of local laws being made to regulate smoking in five of the 12 pedestrian malls in Queensland including those located in Ipswich and Brisbane.

Amendments	Issue	Departmental Response
		• The only council to introduce smoking bans at pedestrian malls and public transport waiting points is Ipswich City Council. Brisbane City Council has banned smoking in the Queen Street Mall and has not banned smoking at public transport waiting points. Redlands City Council has banned smoking at specific public transport waiting areas such as ferry terminals only, and Fraser Coast Council has banned smoking at bus and taxi stops, zones, seats, shelters or waiting points.
	• Recommends removal of exemptions for designated outdoor smoking areas in licensed premises and premium gaming rooms (Sub.13).	• The current legislative reforms are for smoke-free hospitals and schools, as well as electronic cigarettes. Government may consider further reform in the future.
	Review of smoking ban in prisons: received reports that ban caused unintended and needless disruption in secure facilities. Recommends ban be reconsidered or provision of support to smokers in prisons (e.g. nicotine replacement therapy) (Sub.26).	• A prohibition on smoking at all public and private correctional facilities in Queensland took effect from 5 May 2014, following amendments to the *Corrective Services Regulation 2006* to prescribe smoking products and smokeless tobacco products as prohibited things. The amendments to remove the exemption from smoking in secure correctional facilities from the *Tobacco and Other Smoking Products Act 1998* is to ensure consistency with the smoking bans already implemented under the *Corrective Services Regulation 2006*. • Informed by experience in New Zealand and the Northern Territory, which have both successfully implemented prison smoking bans, the Department of Health and the Department of Justice and Attorney-General undertook formal planning to develop and implement strategies to increase smoking cessation support for prisoners and staff. • Queensland Corrective Services developed a statewide Implementation Plan and collaborative Guidelines, with Department of Health, to support local working groups develop plans for facility-based implementation. Key strategies to support implementation of smoking bans include increased access to nicotine replacement therapy (NRT) for prisoners; staff quit smoking program; education and communication about smoking bans; tailored assistance from correctional facility health and medical staff including responding to individual clinical or other needs of offenders with existing health conditions and related medications. To assist with implementation, an independent external review of QCS facilities 'state-of-readiness' was undertaken by a New Zealand Corrections Manager who was previously involved in New Zealand implementation.
	Concerned about potential confusion caused by exemptions to ban on smoking within 5 metres of school land (new section 26ZGD) and current general exemptions to smoking bans in, for example residential premises (Sub.26).	• Section 26ZGD(3) – which is located in Part 2C, [new] Division 2A of the *Tobacco and Other Smoking Products Act 1998* – provides an exemption for where the non-smoking buffers around a school extends into an enclosed area of a neighbouring workplace or business.

Amendments	Issue	Departmental Response
		• Smoking bans in enclosed areas are captured under Part 2B of the *Tobacco and Other Smoking Products Act 1998*. This conflict between the buffer zones and enclosed places is resolved under clause 59 of the Bill, which clarifies – in new section 26ZGA – that the new Division 2A does not apply to enclosed places. As stated in the explanatory notes for clause 59, the intent is of new section 26ZGA is 'to provide clarity about the provision under which a person commits an offence for smoking in an enclosed place on health facility land or school land'.
	Opposes smoking ban on, and within 5 metres of, all public and private health facilities: • believes current discretion for hospitals to nominate smoking areas provides effective balance between competing priorities of rights and special needs of vulnerable patients who may be smokers (particularly palliative and mental health patients who are unable or prevented from leaving hospital site to smoke); • minimises potential for increased legal and workplace health and safety risks caused by patients and staff smoking off site and acknowledges responsibilities and sensitivities to local residents whose properties adjoin the hospital (issue of smokers congregating outside their properties) (Sub.6).	• The practical challenges of managing smoke-free facilities are acknowledged, including sensitivities and challenges of supporting specific patient groups to manage smoking bans. • Noting that clear and consistent communication with patients, staff and visitors will support compliance, there will be a public education campaign about the new laws, to commence after passage. • Clear policies and guidelines can be developed to support local implementation, including review of occupational health and safety policies in relation of duty of care to staff. Healthcare facilities also have a duty of care to provide assistance for patients to manage symptoms of withdrawal (i.e. through provision of NRT) or quit smoking. • Fears of increased patient aggression and incidents in mental health facilities are often unfounded. Adjustments to medications are made as part of routine assessment and care by the treating psychiatrist. • The Queensland Mental Health Commissioner's new strategy targets improved health and wellbeing, and extending efforts to reduce smoking for people with mental illness. • Queensland's largest public mental health inpatient facility – The Park, Centre for Mental Health – became completely non-smoking on 31 May 2013. Some patients at this facility are in secure areas and cannot leave the grounds to smoke. The Park planned and implemented a number of tailored strategies including increased diversionary activities, use of clinical tools like smokerlysers, education of staff and patients and promotion of Quitline. The Park has recently released a report to share their strategies including implications for ongoing management. Outcomes included staff adapting well and smoking off the grounds during breaks or waiting until end of shifts, and no increase in incidents of patient aggression. • Other examples of strategies used by health facilities to successfully implement smoke-free environments, include: – Queensland Health facilities have offered a staff smoking cessation program, *Quit Smoking for Life*, since 2005. – The Princess Alexandra Hospital has a policy and procedure for pharmacists, in addition to doctors and nurses, to initiate NRT provision in order to reach more patients who smoke.

Amendments	Issue	Departmental Response
		– The Gold Coast Hospital and Health Service is currently trialling staff smoking cessation clinics where staff are provided face-to-face counselling and NRT to assess if this aids in successful smoking cessation. The Statewide Clinical Respiratory Network developed the Smoking Cessation Clinical Pathway and facilitates nicotine addiction and smoking cessation training courses for staff. • Local clinical judgement and decision making is recommended to address smoking bans for palliative care inpatients. It may be that some assistance is provided to patients who can be assisted off the premises, NRT can be used for others, and where patients are immobile or bed-bound then smoking is already not an option.
	HHS will be liable to manage significant number of patients and elderly residents who will need to move off health facility to smoke (significant staff implications and increase risk of falls and further harm) (Sub.18).	• The Townsville Hospital campus has been smoke-free since 2012 and it is noted that the Townsville Hospital and Health Service Strategic Plan 2014-2018 identifies a number of strategies to improve the health of North Queenslanders, including "...role model healthy behaviours to our community". • As with the concerns raised above, local clinical judgement and decision making is recommended to address smoking bans for inpatients. • Clear policies and guidelines can be developed to support local implementation, including review of occupational health and safety policies in relation of duty of care to staff. Healthcare facilities have a duty of care to provide assistance for patients to manage symptoms of withdrawal (i.e. through provision of nicotine NRT) or quit smoking. • Noting that clear and consistent communication with patients, staff and visitors will support compliance, there will be a public education campaign about the new laws, to commence after passage.
	Concerned proposed implementation date of 1 January 2015 is too short: leaves little time to assess potential impact on medication levels of sudden cessation of smoking (Sub. 6).	• The Minister publicly announced the smoking bans – including the proposed commencement date of 1 January 2015 – in May 2014, with the legislation introduced in September 2014. • The Department of Health is aware that some private hospitals are already implementing a number of quit smoking initiatives. The Department has provided information, examples, tools and resources to support implementation planning, and can provide further implementation advice as required.
	Concerned amendments will lead to community expectations that Local Government will enforce smoking bans at schools and health facilities. Should costs arise for Local Government, then funding and resource issues will arise (Sub.20).	• Local government officers are one of many groups of persons authorised to enforce the smoking bans at hospitals and schools. • Local governments can liaise with Hospital and Health Services to identify areas in the community that require targeted enforcement by Public Health Unit enforcement officers in lieu of local governments.

Amendments	Issue	Departmental Response
***Tobacco and Other Smoking Products Act 1998* – regulation of vaporisers**	**Definition of vaporisers:** • Definition of *personal vaporiser* should capture all devices, even non-nicotine devices and liquids (Sub.13). • Suggests definition of *personal vaporiser* be revised, as it may not cover disposable non-nicotine vaporisers, which by design cannot be taken apart to add nicotine, and therefore are not capable of delivering nicotine when used by consumers (Sub.15 and 19).	• The policy intent is to capture all personal vaporisers, regardless of whether they contain nicotine. The drafting process identified the complexity around defining these products. Further consideration and advice will be sought by the Department to ensure the current definition meets the policy intent.
	Use in outdoor smoke-free areas: Ban on use outdoors difficult to justify on public health grounds, as public risk posed by exposure to bystanders outdoors is likely to be trivial or non-existent compared to cigarettes and substantially less than traffic pollution. Acknowledges challenges of enforcing different restrictions for public use of cigarettes and vaporisers, but suggests that an alternative approach be considered (Sub.11).	• Electronic cigarettes contain a number of chemical substances, typically propylene glycol, glycerol and chemical flavouring agents not intended to be inhaled deeply into the lungs repeatedly on a daily basis. These substances come in different forms and are also found in cosmetics, polyesters and plastics. • More broadly, widespread and visible use of electronic cigarettes in public places poses a risk in increasing their popularity amongst young people. This may encourage them to take up the smoking habit. • Restricting use in existing smoke-free public places aligns with community expectation.
	Oppose amendments: • Unreasonable and disproportionate to impose legislative scheme designed to control tobacco products to non-nicotine vaporisers. • *Health (Drug and Poisons) Regulation 1996* (the Regulation) which prohibits sale, possession etc. of liquid nicotine, without statutory approval, already provide an adequate regulatory framework for managing nicotine products, including vaporisers containing liquid	• Electronic cigarettes contain a number of chemical substances, commonly propylene glycol, glycerol and chemical flavouring agents not intended to be inhaled deeply into the lungs repeatedly on a daily basis. • Ingredients vary and as they are not listed on product labels, it is impossible to know what, and what level, is contained in each product. These substances come in different forms and are also found in cosmetics, polyesters and plastics. • Most electronic cigarettes contain liquid nicotine (listed as a poison in Queensland) and although not itself shown to cause cancer, it may function as a 'tumour promoter'. • World Health Organization has found there is sufficient evidence to caution children, adolescents, pregnant women and women of reproductive age about use and exposure because of the potential for long-term consequences for brain development.

Amendments	Issue	Departmental Response
	nicotine. The issue is a failure to enforce the Regulation which has led to widespread illegal trade in retail outlets and on internet.	
	• No legitimate epidemiological, medical, health or legal basis on which to impose strict legislative regime on sale, supply and promotion of non-nicotine vaporisers. Act already imposes restrictions on the sale and supply of such products, if they seek to resemble or mimic tobacco products/ • Supports views of 53 world health authorities who argue vaporisers should be considered as part of a harm reduction strategy.	• There is also evidence of harm, including death, from children ingesting the contents of electronic cigarettes and malfunction of the device. • Nicotine is a regulated poison under the *Health (Drugs and Poisons) Regulation 1996*. Under that regulation it is illegal to manufacture, obtain, possess, sell or use nicotine unless it is under an approval. It is also illegal to advertise regulated poisons in Queensland. • Within the last 12 months over 1500 products have been seized by, or surrendered to, Queensland Health. The majority of those products have come from home-based internet businesses that purchased the products via the internet from overseas suppliers and were then on-selling to the public. • In July 2014, a successful prosecution was undertaken by the Cairns Pubic Health Unit relating to the advertising and possession of products containing nicotine. The defendant was representing an overseas business and placed flyers in the broader community advertising products containing nicotine. The defendant pleaded guilty and was issued with a fine of $2500. • The challenges facing regulators is that most sales occur via the internet with the transaction occurring outside the state jurisdiction. Additionally, many of the claims made by overseas suppliers are false, as products that claim to not contain nicotine have been found to contain nicotine, while others are silent i.e. do not contain ingredients list indicating presence of nicotine which is misleading to the purchaser.
	• Bill fails to adequately address issue of absence of product standards to regulate quality of products: ingredients; quality or grade of ingredients; standardised labelling and health or other warning labels	• These issues fall outside the objectives of the *Tobacco and Other Smoking Products Act 1998* and are matters to be addressed under other State or Commonwealth legislation. • The issue of product standards is complex and requires consideration of the purpose of the product. If the product is being promoted as a smoking cessation device or is making health based claims, it is required to be registered by the Therapeutics Goods Association (TGA) and listed under the Australian Therapeutic Goods Register of the TGA. The TGA assesses the product standards, claims, ingredients, concentrations etc. and if approved, the products will be required to meet the national requirements for medicines and poisons as per the National Standard for Uniform Scheduling of Medicines and Poisons.

Amendments	Issue	Departmental Response
		• If the product is promoted solely as an alternative to smoking cigarettes, and not as a smoking cessation product, then the product is a consumer product, which is regulated by the Queensland Office of Fair Trading.
	• definition of *personal vaporiser* is too vague and difficult to enforce – 'capable of being used to deliver nicotine' could cover devices that are modified by user for nicotine use, against original intent of manufacturer (Sub.4).	• The policy intent is to capture all personal vaporisers, regardless of whether they contain nicotine. The drafting process identified the complexity around defining these products. Further consideration and advice will be sought by the Department to ensure the current definition meets the policy intent.
	• Electronic cigarettes should be able to be used on all parts of a clubs premise at the discretion of club management, not restricted to use only in designated outdoor smoking areas: • amendments will inadvertently cause more harm than good, as they will force people seeking to reduce or quit smoking by using vaporisers to 'vape' in areas designed for traditional smokes and will be exposed to second hand smoke • Queensland clubs will be out of line with other jurisdictions – will cause problems especially on NSW border • matter should be dealt with at national level, ensuring standardised legislative framework (Sub.12).	• There are already a number of areas where there are differences between New South Wales and Queensland laws. Clubs can manage and communicate these issues to staff and patrons as required. Simple changes to signage may help patrons and visitors understand where and what they can and can't smoke. It is a decision ofthe club patron to utilise a DOSA if they wish to use a personal vaporiser at a club. • A consistent and national legislative approach would be ideal. However, Queensland does not intend to delay action on electronic cigarettes. Other jurisdictions may follow Queensland's lead.

Amendments	Issue	Departmental Response
***Transplantation and Anatomy Act 1979* – advertising regulation**	**Section 41 (restrictions on advertisements relating to buying of tissue) should be repealed rather than amended**: No evidence that advertising donor gametes needs regulating; most advertising web and electronic based making it impossible to police and control; significant number of advertisements generated by community and patients, not corporate; advertising not defined; majority of other jurisdictions do not regulate advertising; and provision of donor gametes essential tool for patients with significant and serious infertility (Sub.9).	• The Bill does not change the current regulation regarding restrictions on advertisements relating to buying of tissue; rather, rather it enables delegation of the approval function. The amendments make this process less burdensome by enabling an authorised departmental officer to be a decision maker instead of the Minister. • Four jurisdictions (Queensland, South Australia, Victoria and Western Australia) regulate advertising of human tissue. • The *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* prohibits commercial trade in tissue, as does Part 7 of *Transplantation and Anatomy Act 1979*, so there is duplication across both Acts. The *Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act 2003* regulates the practice of Assisted Reproductive Technology (ART) but not the activities prior to the ART process, including advertising for egg and sperm donors. • Until recently, when the Department wrote to ART providers, many may have been advertising as they indicated they were not aware of the requirement for Ministerial approval. The Department is not aware of any problems with previous advertising. • As the Queensland Fertility Group indicates, it is difficult to monitor advertising on the internet. To reduce the difficulty in monitoring internet advertising, letters will be sent to ART providers to seek their assistance in advising clients of the need for advertising approval. To make the process as easy as possible, the Department of Health has developed criteria which is used to assess advertising. This is provided to any person wanting to advertise.
	Section 41 does not give the Minister the power to regulate advertising of sperm donors, imposes unnecessary bureaucratic approval process that increases costs, and has little public benefit. Restrictions on advertising are detrimental, there is a shortage of egg and sperm donors in Australia and everything must be done to enable people to donate (Sub.22).	• Sperm is captured by the meaning of 'tissue', as it is a part of the body or extracted from the body. Therefore, the advertising approval requirement relates to advertising for sperm donors. • As noted above, four jurisdictions (Queensland, South Australia, Victoria and Western Australia) regulate advertising of human tissue, and the Bill does not change the current regulation regarding restrictions on advertisements relating to buying of tissue; rather it enables delegation ofthe approval function.

Sub #	Name	Sub #	Name
002	Cancer Council Queensland	012	Clubs Queensland
003	Queensland Catholic Education Commission	013	National Heart Foundation of Australia
004	Peregrine Corporation	015	Quit Victoria
005	Mr Phil Browne	018	Townsville Hospital and Health Service
006	Private Hospitals Association of Queensland	019	National Stroke Foundation Queensland
007	Brisbane City Council	020	Local Government Association of Queensland
008	Logan City Council	022	Mr Stephen Page
009	The Queensland Fertility Group	023	Lung Foundation Australia
010	Torres and Cape Hospital and Health Service	026	Queensland Law Society
011	Professor Coral Gartner		