EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE TOBACCO PRODUCTS CONTROL AMENDMENT BILL 2008

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 11 FEBRUARY 2009

SESSION TWO

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz
Mr I.C. Blayney
Mr J.A. McGinty
Mr P.B. Watson

Hearing commenced at 10.15 am

HALL, MR STEPHEN LOUIS GEORGE
Executive Director, Australian Council on Smoking and Health,
examined:

MUSK, PROFESSOR ARTHUR WILLIAM
Respiratory Physician, Australian Council on Smoking and Health,
examined:

STICK, PROFESSOR STEPHEN
Physician/Paediatrician, Australian Council on Smoking and Health,
examined:

The Chairman: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the Tobacco Products Control Amendment Bill 2008. You have been provided with a copy of the committee's specific terms of reference. The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. This is a public hearing. Hansard will be making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Have you each completed the "Details of Witness" form?

The Witnesses: Yes.

The Chairman: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The Chairman: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The Chairman: Do you have any questions about being a witness at today's hearings?

The Witnesses: No.

The Chairman: We will ask initially if you would make a presentation, and will then follow up with questions. Professor Stick, I invite you to go first.

Professor Stick: ACOSH unequivocally supports these amendments. There is unequivocal evidence that there is harm to unborn children and children from the effects of environmental tobacco smoke. These amendments will go a long way towards reducing the harm to unborn children and children. I would like to give some medical background. We can estimate from the studies that have been published today, the NHMRC report on passive smoking and the recent

British Medical Association report that each year about 500 children are admitted to hospitals in WA directly as a result of the effects of environmental tobacco smoke. About half of those are due to the effects of children being exposed to tobacco smoke in utero, and the other half to continuing exposure in the home. It is estimated that around 40 per cent of children are still exposed to environmental tobacco smoke either in homes or in cars.

The Chairman: Are you saying that that figure of 250 is a carryover from the damage that was done in utero?

Professor Stick: It is an additive effect. It is an effect on prevalence and severity. There is no question that admissions from lower respiratory illnesses in infants are doubled in those children who have been exposed to cigarette smoke in utero. It is thought that the severity is due to ongoing exposure. Most mothers who smoke during pregnancy continue to smoke afterwards. They also appear to have partners and other family members who smoke in the house. It is a difficult area to disentangle, but research that we have done has shown the direct effects on lung function in children at four days of age. This is from a study we published in *The Lancet* 12 years ago. Those direct effects are well documented. The postnatal effects are still additive to those. As I said, it probably goes to severity.

Another study that we did in the very early days measured cotinine in the urine of children admitted to Princess Margaret Hospital for Children. Cotinine is a by-product of nicotine and a biomarker of exposure. We found that those children admitted to PMH with a respiratory problem were many times more likely to have a mother who smoked and have levels of cotinine detectable in urine. There is now incontrovertible evidence that both in utero and continued exposure postnatally causes increased prevalence and severity. Lots of studies around the world have since demonstrated that.

The other evidence that is very important is that children who are exposed to role models who smoke are more likely to smoke as adolescents and adults. Children who come from families where there is a member who smokes are twice as likely to smoke themselves. The whole idea of smoking being denormalised is quite important so that children can see that the normal acceptable behaviour in the community is not to smoke. That is why some of the legislation relating to public places has been very important to add weight to those arguments.

[10.20 am]

From my perspective, it is clear that it is a very important step for children for smoking to not be allowed in play areas, on beaches and in alfresco dining areas—all areas where children could be exposed—and obviously also in cars, where the amount of irritants, carcinogens and products that are likely to cause problems can be concentrated. These products stay in the upholstery of the car. When people get back into the car, the products are re-aerosolised, so it is not only the person smoking in the car at the time but also the history of smoking in the car and the re-aerosolisation of products when people get into the car.

Mr J.A. McGINTY: Can you explain how that works?

Professor Stick: There are several components to tobacco when it is burning. There are obviously the volatile compounds, but there are also particles that absorb onto the dangerous chemicals. Those particles settle in the car over time. Some are of a size that can be breathed in. When people get back into the car and the car is moving, those particles are re-aerosolised. You can always smell tobacco in a car when you get into one, even if someone is not smoking at the time. From an occupational exposure point of view, a lot of women who are pregnant do not know that they are pregnant until well into the first trimester. If they are working in an environment in which they are exposed to cigarette smoke, their foetus will also be exposed. That is another area in which this amendment is very important. Those aspects of occupational disease lead quite nicely into the comments that Professor Musk wishes to make.

Professor Musk: It goes without saying that I support this amendment. There is no doubt, and it is in the ACOSH submission, about the direct impact of smoking on health. There is also an impact on health from environmental tobacco smoke exposure. It is related to the worsening of asthma, lung cancer and cardiovascular disease, and it is probably also related to premature ageing. A mechanism for determining the relationship between tobacco smoke exposure and ageing has been unravelled recently. Environmental tobacco smoke is really important in the workplace. We were involved in a study at Burswood Casino a few years ago where we monitored lung function and measured cotinine, which, as Steve mentioned, is a metabolite of nicotine. The only source of cotinine in the saliva or urine is from nicotine, so it is specific. We found that the cotinine levels of non-smoking casino workers went up during a work shift. Therefore, they must have been exposed to some tobacco smoke at work, even though some of them were supposed to be in non-smoking areas. The same applies to people in the home. Partners and children are exposed to other people's smoke in the home. If people smoke in cars, it has the same effect. One can extrapolate from the study we did to those studies, which has been done. My main occupation at Sir Charles Gairdner Hospital is looking after people with chronic respiratory disease and lung cancer. We have seen very little progress in the outcome of our efforts to treat lung cancer over the years. We have spent a lot more money on it, we spend a lot more time staging the cancer, and we are much more selective about whom we operate on, but the survival of people with lung cancer has improved very little over the years.

Mr J.A. McGINTY: The survival rate might not have improved, but what about the incidence?

Professor Musk: I am pleased to say that as the incidence of smoking in the community has been going down, there are beginning to be fewer lung cancers. The pattern of lung cancers appears to be changing in that the incidence of adenocarcinoma, which is less of a smoking-related cancer, is increasing proportionally as the overall incidence of lung cancer comes down. Adenocarcinoma is related to smoking, but other things that have not necessarily been recognised may affect it. The pattern of lung cancers is changing but the incidence is also coming down. That is the result of the decline in the prevalence of smoking in the community. We know that about 18 per cent of Australians over the age of 14 are still smoking. That number is a lot less than it used to be, but it is still nearly one in five. That is still unacceptably high. Chronic obstructive lung disease also attracts a lot more treatment these days. The drugs we use to treat it are getting easier to deliver but they are no less expensive. They keep people around for longer and cost the health system a huge amount of money. We have been doing studies in Busselton for more than 40 years and those studies have shown that people who smoke have an accelerated decline in lung function, leading to the level of lung function that we associate with chronic obstructive lung disease. If they stop smoking, the rate of decline stops being excessive, but they do not get significant improvement in their lung function. One of the worries is that if those people also have asthma, the decline in lung function for them is greater than for those who do not have asthma. Unfortunately, about as many asthmatics as non-asthmatics smoke, so we have a real problem with them. Although the number of deaths from smoking is coming down, the costs are still very significant. I am not an economist so I do not want to go any further than that. Chronic obstructive lung disease is also a huge cause of disability in people. People are prematurely invalided. They are unable to contribute to their family's economy or the community's economy. They become respiratory cripples. Their quality of life is pretty terrible.

So anything that reduces the chances of someone taking up smoking or reduces the chances of them being exposed to other people's smoke or reduces their own likelihood of smoking has to be in the interests of their health.

[10.30 am]

The Chairman: I know, Professor, you yourself were involved in the 1980s when they had the posters.

Mr J.A. McGINTY: The BUGA-UP campaign?

The Chairman: That was it.

Mr J.A. McGINTY: Was that you, Professor?

Professor Musk: No-one from ACOSH was ever involved in BUGA-UP. We had to officially dissociate ourselves from it, although we were very sympathetic to it!

The Chairman: I am sorry, it was whilst you were active in the area, not the campaign!

Mr J.A. McGINTY: You never had a spray can in your hands; is that what you are saying?

Professor Musk: That is correct! I brought an article from the *British Medical Journal* that we wrote back in 1994 describing progress on tobacco control in Western Australia, if you are interested, and I would be happy for you to have it.

The Chairman: Yes, thank you very much. Professor Stick, could I ask you about the children whose urinary protein you measured? Is that measure, which I think takes several days, a very expensive test?

Professor Stick: It is becoming cheaper but it is probably around $7 a sample. It is not something, I do not think, that would be undertaken on a sort of mass screening basis, but for studies it is a useful measure and it is a very reliable biomarker of exposure over a period of three or four days.

The Chairman: I have seen lots of people going over to the kits that drinkers have in clubs and checking their blood alcohol level, although they do it as a joke.

Mr P.B. WATSON: Have you spent a lot of time researching?

The Chairman: I have seen them going up and testing. I must admit I have tested as well and I have always been low—I do not drink now, but when I did. I am just wondering whether there is anything like that.

Professor Stick: It is interesting. Anecdotally, during the study the parents knew we were measuring for tobacco exposure. They were very interested to know what levels of exposure the children had and asked subjective questions like, “Is it high or low?” At the time all we could do was relate the levels within the population and say, “Within this population your child was exposed to a fairly high level.” Subsequent to that we did a study of exposure in homes where families claimed to have a smoke-free household. The interesting observation there was that if you look at the levels in the population of families where they claim to have smoke-free homes, there was a huge overlap with those that were smokers who made no effort to smoke outdoors. So I think people who think they have smoke-free homes are kidding themselves to a large extent. So it just shows that this is a very sensitive measure and it is very good at relating exposure. It is one of the most effective measures of relating exposure to an outcome, and the outcomes we have used are things like lung function or admissions to hospital or episodes of asthma.

Mr P.B. WATSON: Professor Stick, could I just ask you a question? I used to work on the counter at the post office in my younger days and there used to be a guy standing next to me who used to say, “I’m just going out for a toilet break.” You could smoke in the post office, but once that stopped he went out for a toilet break and he came back and just stunk of cigarettes. Getting on to your point about the residue staying in the car, if someone like that is smoking in a car and then the person goes into a workplace, can that residue there cause damage to people in that workplace?

Professor Stick: It is very difficult to measure. There is no question that when you breathe out you are breathing out the same things that you breathed in. In fact, there have been some measures done. Peter Dingle, I think, has done some measures looking at the effluent from smoke, showing that it is the same quality as the smoke that we actually take in. Obviously, a lot of it is deposited in the lungs, but a lot of it still comes out, and volatile stuff probably still comes out as well. That is why

you can smell it. If you can smell it, it is there. You know what I mean. That is the bottom line and there is no safe level of exposure.

The Chairman: I think it was Professor Sly who told us yesterday about the respiratory rate of a child in a car and that the child is taking in four times, as an involuntary or passive smoker, even if all the windows are down.

Professor Stick: Yes, absolutely.

The Chairman: We are all obviously very concerned at smoking in cars with children. From what you are saying in terms of the residue that remains in the car, I do not think the community is aware of that fact.

Professor Stick: No. I think the basic thing is that if you can smell cigarette smoke, then the components that do damage are present in the atmosphere, and we know there is no safe level of exposure. We also know that children are more susceptible to exposure to certain carcinogens and other sorts of pollutants within the effluent of the cigarette smoke. I think that in many ways being able to nail this in a scientific way is almost irrelevant because your nose is a very good detector of cigarette smoke.

Mr P.B. WATSON: Is there any evidence of this as an addiction, of breathing it in as an addiction for people later on to want to smoke?

Professor Stick: There is some evidence now coming through. There are two sets of evidence in newborns. The first is that there is a definite withdrawal phase from nicotine in infants who are exposed to cigarettes in utero. It is shown by irritability and various cardiovascular effects, as seen in newborns. The second thing is that there is some evidence that it changes the nicotine receptors in the brain such that it does make those infants more susceptible to addiction when they are older. That is fairly recent evidence but that is clearly coming through in the literature now.

The Chairman: I am not sure whether it was Professor Sly also yesterday who talked about the granny —

Mr P.B. WATSON: The grandmother can pass on the gene to relations.

Professor Stick: Yes.

The Chairman: The genes were affected by the grandmother and that was passed on then.

Professor Stick: Yes.

The Chairman: So the grandchildren were actually suffering because the grandmother was a smoker and it had affected her genes plus the mother's genes and then the child's genes.

Professor Stick: Absolutely; and this is fairly recent evidence that is coming through, and again the ability to measure biomarkers and then to do genetic studies is relatively recent, but certainly what we can measure are changes in the DNA in the grandchildren of grandmothers that smoke.

Mr P.B. WATSON: Professor Musk, your testing for the number of people who smoke was from 14 years of age. Did you ever do tests or surveys for any younger than 14?

Professor Musk: In Busselton we have been involved with schoolchildren, yes, and we have got data but I do not know how much data we have got from those schoolchildren on parents smoking.

Mr P.B. WATSON: No, I was talking about the percentage of 14-year-olds who smoke.

Professor Musk: That data is available but not collected by me particularly.

Professor Stick: There is recent WA data available that I believe will answer that.

Professor Musk: Yes. The other thing you can measure directly is carbon monoxide. You can measure that instantaneously with a thing called a carboliser, which you just blow into like you do a roadside breath test—in fact it is easier than doing a roadside breath test—and that tends to be up in

people who are in a very smoky environment. So if you want to check yourself leaving the smoky bar but it is not as smoky now, you can do it.

The Chairman: Mr Hall, would you like to add to that?

Mr Hall: Clearly ACOSH is here supporting the bill, as our submission said. I would just like to make a few comments on a couple of parts of the bill. Firstly, on the tobacco products displays at point of sale, we support 100 per cent tobacco products going under the counter for three specific reasons. Firstly, it protects children and young people from exposure to tobacco smoke; secondly, smokers have people who are trying to quit and it removes them from the temptation; and, thirdly, this would be consistent with health promotion campaigns about tobacco products being dangerous and addictive. We have got health promotion campaigns out there and yet there is still advertising of tobacco products, so that would give a really consistent message.

I was reading a couple of the submissions online yesterday and I think it is fair to say that the tobacco industry and the retail industry have been on notice for a long time that this is going to happen. It was particularly mentioned in discussion around the 2006 legislation when the Tobacco Products Control Act came in, so it is not as though it is something new that they do not know about. Also one of the retail group submissions mentioned that the tobacco industry paid for the display units, so it is not as though there is going to be a cost to retail, as that is from one of their own submissions to your committee. The third comment I would make is that there was some question of exemptions for specialist tobacco retailers. We do not think there should be any exemptions from all products under the counter for any retailer, particularly people that specialise in selling a lethal product.

[10.40 am]

Mr J.A. McGINTY: What is the policy that underpins that view? If people go into a tobacconist store, they go in there to buy tobacco.

Mr Hall: Yes.

Mr J.A. McGINTY: What is the problem with having tobacco products on display in a tobacconist store? I do not see it as an issue in a tobacconist store.

Mr Hall: We just think it is consistent with health promotion messages and the fact that it is a lethal product. Generally tobacco consumers know what product they want to buy anyway; they go in there and say they want X product. It removes that opportunity to promote new products and things like that.

Mr J.A. McGINTY: I can understand that in a supermarket context or in a general store or a lotto kiosk or something of that nature. However, if we allow a sign on the outside of a store that says tobacco products, tobacconist or whatever, once people go inside it is just a matter of saying here is what is available; it is a Cuban cigar or Peter Stuyvesant, or whatever it is. Why do you support the move from that exemption?

Mr Hall: Ultimately because it is a form of promotion. As demonstrated through the research that is published, point-of-sale displays are used to promote products. Even though you might say it is not visible from outside the store or to passers-by, it is still an opportunity for the industry to promote products. It is clear from industry documents that they see point of sale as an important place for marketing. We just think that in any place where cigarettes are promoted, even if it is an enclosed shop, that opportunity should not be there.

Mr J.A. McGINTY: What is the effect going to be? There would be no effect on the opportunistic purchaser who goes into a store to buy a packet of cigarettes or tobacco products.

The Chairman: No, but there may be a proliferation of those stores as a result of the display going from supermarkets. I mean, you have to think, with this legislation, what step will the tobacco companies take next?

Mr J.A. McGINTY: Yes.

The Chairman: If this legislation does go through Parliament—and we hope it will go through Parliament—we know that the tobacco companies are not going to give up. So we have to think where will they move next, and try to prevent them. I think your suggestion is very relevant.

Mr J.A. McGINTY: Perhaps if I can put it another way, I have in mind a stereotypical old-fashioned tobacconist store. Are there other stores that are less than that, where this restriction might have some practical impact?

Mr Hall: At the moment we are talking about eight stores in Western Australia that are 50 per cent. They can have up to three square metres. I think there is one specialist retailer that goes beyond that and has an unlimited display, because it can demonstrate that more than 85 per cent of its sales are tobacco. So we are not talking about a very large number of businesses. Basically, we would like to drive them into the sea.

Mr J.A. McGINTY: I can understand that.

Professor Stick: What we would like to do is persuade them to diversify their business. Unless you are going to ban children from going into these shops, you have still got the problem that children are going to be exposed to point-of-sale advertising.

Mr J.A. McGINTY: I can understand that argument, yes.

Professor Stick: While it is only a relatively small number, I suppose it is consistent with the policy of avoiding point-of-sale promotion to children.

The Chairman: Stephen, you have suggested one area in which you feel the legislation may be lacking. What other areas would ACOSH recommend in terms of trying to control the —

Mr Hall: Are you talking more broadly or in relation to the bill?

The Chairman: More broadly. The bill focuses on the three areas. From what you have said this morning, you are obviously very supportive, because you have been doing the work yourselves in terms of trying to ban smoking in cars, trying to stop point-of-sale displays, and trying to ban smoking in alfresco areas. We are hoping that Parliament will support these measures, but where do you think the next step is after this?

Mr Hall: Just before I go on to that, I will just make some brief comments on alfresco areas. We think it is very important for a number of reasons. Smoke drift has already been mentioned from smoking areas to smoke-free areas. The second area is obviously that pubs and clubs have a legal responsibility to protect their workers and patrons, under common law, from tobacco smoke. The third area is consistency between local government authorities. A series of local government authorities have introduced smoke-free alfresco areas. Mt Lawley is a classic example, where half of Mt Lawley—the city side of Walcott Street—is a smoke-free, local government area, and the other side of Walcott Street is not. So you have a locality where there are mixed messages; one is in Vincent and one is in Stirling. Certainly having it consistent —

Mr J.A. McGINTY: So Vincent has got the ban and Stirling has not?

Mr Hall: Vincent has been smoke-free from 1 January; Stirling is not. So if you are on the city side of Walcott Street, or if you are at the Flying Scotsman, you cannot smoke, but if you are on the other side of Walcott Street—the Perth College side—you can smoke; all you have to do is walk across Walcott Street. So there is a real inconsistency in one locality. That is a classic example, but the problem is effectively statewide. Once you have consistent legislation and laws right through, obviously you will be able to promote smoke-free alfresco areas effectively, which you cannot really do other than on the basis of local government area by local government area.

Mr J.A. McGINTY: Are there any major entertainment or restaurant precincts—apart from north of Walcott Street—in which the local government authorities have not banned alfresco smoking?

Mr Hall: Any others?

Mr J.A. McGINTY: Are there any major ones? I think of Fremantle, I think of Subiaco, I think of Northbridge, I think of Oxford Street —

Mr Hall: Probably Kalamunda. It is a long way north of the river, I know from discussions yesterday, but there is a growing alfresco kind of trend in Kalamunda —

Mr J.A. McGINTY: But apart from that, all of the major alfresco areas are now smoke-free?

Mr Hall: Not Subiaco.

Mr J.A. McGINTY: Not Subiaco? So that is the major problem, is it?

Professor Stick: Also, from my understanding this only affects the street side of things. If a club or a pub has an alfresco area in the courtyard, it does not affect that.

Mr J.A. McGINTY: It is only the areas within the jurisdiction of the local government authority?

Professor Stick: Yes.

Mr J.A. McGINTY: So Subiaco is the major problem area that remains; is that right?

Mr Hall: And Stirling, which has got Mt Lawley, for example, and Scarborough. I do not know the full layout of each local government area. Some of the country ones have got growing alfresco—places like Bunbury and Broome. Geraldton is moving towards alfresco; they have made a commitment to do that. So we have a real hotchpotch of some that have and some that have not, and some that are sort of on their way.

Mr J.A. McGINTY: It seems to me as though there has been a tremendous take up by local government—by the key local authorities at least —

Mr Hall: Rockingham was the first to implement it, although they announced it after Fremantle, so there are quite a lot.

The Chairman: In those alfresco areas where smoking is banned, can the carbon monoxide measures be checked?

Professor Musk: They can, but it is not as sensitive as cotinine as a measurement of exposure. But if it is a really smoky place, the carbon monoxide level will tend to go up.

Mr Hall: We have been doing some testing of that and we will have some data available fairly soon.

Mr J.A. McGINTY: Can we go back to Subiaco? Have they said they are not interested, or what has been the problem there? It seems to me as though every other key local government authority has either taken action or is onside with action being taken.

Mr Hall: There has been a fairly strong charge towards Subiaco council from some of our members and also from the AMA. Reports to date are that they have not made a decision, but I think they are considering it.

The Chairman: I think some councils are hoping that the changes will come in —

Mr Hall: They certainly have not said they are going to proceed with it as yet. Certainly that was the last I heard.

Mr J.A. McGINTY: They are dragging the chain a bit among their colleagues —

Mr Hall: Yes, a little bit resistant I think it would be fair to say.

On your broader question of where would we like to go from here, we would like to see a comprehensive approach to tobacco control. Obviously there are some issues that are dealt with at a state level and some at a national level. We would certainly like to see plain packaging introduced at a national level, and tax increases and the removal of duty free, which is something that came up

yesterday. That is something we have pushed for, for a while. We were interested yesterday that your member Abetz talked about the whole thing of banning tobacco from being commercially available and being available only to registered nicotine addicts. He used the term "the methadone model". That is certainly something that we are looking at in the longer term. Once we get smoking prevalence rates down to below 10 per cent, those kinds of things can be brought in. We do look forward to the day when tobacco is not available in every milk bar, supermarket, newsagency and petrol station in Western Australia, and when people must go to certain places to buy it, and when they can buy it only if they have got something to say—whatever the system is going to be—that they are a registered nicotine addict. That is certainly something we look forward to.

On the question of prisons, we have been actively involved for some time in campaigning for prisons to be smoke-free. We had some success just over 12 months ago with Greenough Prison, where that has been implemented.

[10.50 am]

Mr J.A. McGINTY: That was driven, though, by the prison officers themselves, as I understand it, rather than any enlightenment from the prison authorities or the government.

Mr Hall: That is right. A petition from the prison officers went to Parliament and it was signed by over 70 per cent of the prison officers from Geraldton. I have spoken with prison officers since then. It has not been without its problems but overall it has been successfully implemented. A number of prisoners have quit smoking and a number of prison officers have quit smoking as well. As I understand it, it has now been expanded to Roebourne Regional Prison and Boronia. They are both 100 per cent smoke free as well in enclosed areas, not in outdoor areas.

Mr J.A. McGINTY: Not in the yards.

Mr Hall: Not in the yards, but the cells are smoke free. We would obviously like to see that expanded right across the state and certainly have concerns, as you have indicated by your questions earlier, about any potential rollback in psychiatric institutions in Western Australia. Other states are very keen to see how it is going here and the fact that it is being implemented.

Mr P.B. WATSON: Is it in the yards in Greenough Regional Prison?

Mr Hall: No, just in enclosed places. They can still smoke in outdoor areas but not indoor areas. One of the problems with Greenough is that it is a transit prison, so people from Kalgoorlie or the Pilbara who are coming to Perth for court or medical reasons are coming from areas where it is permitted, so it is something they have to work through. It probably was not the ideal one to go smoke free first for that reason. We have particular concerns about special population groups—Aboriginal people particularly. We noted the commitment by the commonwealth and by COAG signing off on things in relation to closing the gap in Indigenous life expectancy, and certainly tobacco has been identified as one of the key issues involved in closing the gap. If we can nail Aboriginal tobacco consumption, we are certainly a long way on the way to closing the life expectancy gap. Obviously, all governments have signed off on those COAG agreements. There have been some quite significant dollars committed to it. It will be interesting to see how that rolls out.

Mr J.A. McGINTY: Nothing has worked. You seem to have a bit of optimism about what you are saying now. Is there some initiative that you think has the elements?

Mr Hall Yes, I think it is going to need a range of initiatives. I think we are seeing some interesting things in Aboriginal medical services. For instance, in the Kimberley all Aboriginal medical services are smoke free. If staff smoke, they are not allowed to smoke onsite; in fact, they are not allowed to smoke in their uniforms. They have been told basically that if they are going to smoke, they have got to change their clothes. Those kinds of consistent messages are coming through. Specific health campaigns for Aboriginal people are being developed and piloted. As in the general population where there is no single solution but there has been a range of strategies or a

comprehensive approach, I think it will need to be carefully thought through as well with Aboriginal populations, but it has certainly been talked about by people, not just in the medical profession but also in the wider Aboriginal community.

The Chairman: If there are no further questions, could we just have a summing up from you, Professor Stick?

Professor Stick: I might just put my Smoke Free WA Health hat on for one moment and say that we had a very successful implementation. We had strong leadership to implement it. To all intents and purposes it has been very successful in psychiatric institutions. We would be very concerned about any rollback. I thought we could garner support to continue with the implementation as it was originally planned.

The Chairman: Following on from this hearing, it is your prerogative to also write to the Minister for Mental Health and let him know of your concerns. I am sure I will be speaking with him. I am very concerned to hear there are thoughts of rolling it back.

Professor Stick: It would be understandable if there were some real problems, but the fact is that it has been successful in some of the hardest environments, including the lockdown facilities at Graylands. I think this is something that needs persistence, strong will and good leadership. It is not a matter of shying away at the first sign of a problem.

In summing up, I think the amendment to the bill really does provide additional protection for children that is consistent with all the signs of environmental tobacco smoke exposure in children.

The Chairman: Professor Musk, any comments?

Professor Musk: Only that there is no level of any carcinogen below which there is no risk of cancer, so the risk goes up with the first cigarette smoked or with the first inhalation of environmental tobacco smoke. Other things add to that risk, as with people who have been exposed to asbestos. Luckily, that is on its way out of the equation for the future, because we have banned asbestos in Australia. However, there are still a lot of people around who were exposed in the past. There is no level below which there is no risk, so the more we can protect people from other people's smoke or from taking up smoking themselves the better the health outcomes for the community will be. Therefore, I am in full support of it.

Mr P.B. WATSON: Professor Stick, some people say that they have been smoking and so they are too far gone. They also say that they have been smoking in a car with kids and if they are going to get it, they are going to get it. If they stopped smoking in a car tomorrow, having done it for two years with children, would the rate drop dramatically?

Professor Stick: I think the exposure in utero seems to be set for life, but the other half, if you like, seems to be to current exposure, so the moment you stop exposing the kids to environmental tobacco smoke post natally, their risk of lower respiratory illness is dropped.

The Chairman: It often arises in community suggestions that this health legislation is from a nanny state. What would you say to those people making that comment?

Professor Stick: First, I think there is this civil rights/human rights issue. I do not think it is anyone's right to be addicted to tobacco smoke. I think it is people's right to have clean air, not to have an addiction and not to have cigarettes promoted to them in a way that makes them attractive or for people in an environment where they are more likely to become addicted. I do not think there is any question of this being a nanny state. This is about what is protecting people from a harmful substance that leads to a lifelong and very difficult addiction.

Professor Musk: Surely, that is why we are here—for a Parliament in a democracy to decide what is okay and what is not.

The Chairman: We are hoping that other members of Parliament will look through the comments that you have made today. We hope to persuade them that the evidence is there and that they do have the ability to prevent further ill health of both children and adults.

I thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within that period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Once again, thank you very much.

Hearing concluded at 10.57 am