



**Public Health Association**  
AUSTRALIA

## **Public Health Association of Australia**

### **Submission to the Senate Standing Committees on Economics**

### ***Inquiry into personal choice and community impacts***

Senate Standing Committees on  
Economics  
PO Box 6100  
Parliament House  
Canberra ACT 2600  
Email: [economics.sen@aph.gov.au](mailto:economics.sen@aph.gov.au)

Contact for PHAA  
Michael Moore – CEO  
PO Box 319  
Curtin ACT 2605

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# Introduction

## The Public Health Association of Australia

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

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

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

## Vision for a healthy population

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

## PHAA's Mission

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

## Priorities for 2015 and beyond

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

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

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### Preamble

PHAA welcomes the opportunity to provide input to the Senate Standing Committee on Economics. The improvement of health and reduction of social and health inequities should be over-arching goals of national policy and recognised as key measures of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards improving health and reducing social and health inequity nationally and, where possible, internationally.

### Health Equity

As outlined in the Public Health Association of Australia's objectives:

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

The PHAA notes that:

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

### Social Determinants of Health

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

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

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### **Terms of Reference**

This submission will address the following terms of reference as set out by the Standing Committee on Economics (the Committee):

- a) The sale and use of tobacco, tobacco products, nicotine products, and E-Cigarettes, including any impact on the health, enjoyment and finances of users and non-users;
- b) The sale and service of alcohol, including any impact on crime and the health, enjoyment and finances of drinkers and non-drinkers;
- c) The sale and use of marijuana and associated products, including any impact on the health, enjoyment and finances of users and non-users;
- d) Bicycle helmet laws, including any impacts on the health, enjoyment and finances of cyclists and non-cyclists;
- e) The classification of publications, films and computer games; and
- f) Any other measures introduced to restrict personal choice 'for the individual's own good'.



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# Key Messages

### Personal responsibility and government stewardship

In a healthy society there is an appropriate balance between personal responsibility and the responsibility of governments. Just as parents, schools, professionals and businesses have a duty of care to the individuals for whom they have responsibility, governments also have a duty of care to ensure that each of the citizens within the community have the full opportunity to reach their potential and to ensure they have the healthiest life. This was well enunciated by the nineteenth century Conservative British Prime Minister, Benjamin Disraeli, who said “The first consideration of a minister should be the health of the people”. The Nuffield Bioethics Board considered this issue in *Public health: ethical issues* and argued for a “stewardship model” with the intention that “the overall aim should be to achieve the desired health outcomes while minimising restrictions on people’s freedom”.

Our report starts from the position that the state has a duty to enable people to lead healthy lives. Everyone should have a fair opportunity to lead a healthy life, and therefore governments should try to remove inequalities that affect disadvantaged groups or individuals. We propose a ‘stewardship model’ that outlines the ethical principles that should be considered by public health policy makers.<sup>1</sup>

The Nuffield stewardship model suggests a balance between ‘acceptable public health goals’ and ‘limitations on coercion and intrusiveness’. The model has the following features:

Acceptable public health goals include:

- reducing the risks of ill health that result from other people’s actions, such as drink-driving and smoking in public places;
- reducing causes of ill health relating to environmental conditions, for instance provision of clean drinking water and setting housing standards;
- protecting and promoting the health of children and other vulnerable people;
- helping people to overcome addictions that are harmful to health or helping them to avoid unhealthy behaviours;
- ensuring that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensuring that people have appropriate access to medical services; and,
- reducing unfair health inequalities.

At the same time, public health programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise the use of measures that are implemented without consulting people (either individually or using democratic procedures); and
- minimise measures that are very intrusive or conflict with important aspects of personal life, such as privacy<sup>2</sup>.

The Nuffield Report is extensive in its discussion of a wide range of issues from water fluoridation to alcohol and tobacco. The key principles, however, are concerned with balancing individual responsibility and enjoyment on the one hand with government responsibility (or stewardship) on the other.



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### **Interference or domination**

Freedom is an important public health issue, which is why the Nuffield approach speaks to the minimisation of coercion and intrusiveness. There is a constant push, especially from certain sectors of industry, to be free from government interference. This fails to recognise a government's responsibilities to protect the health and safety of the community, and to place the interests of public health ahead of those of vested interests.

The need for the public interest to dominate is demonstrated most clearly in the role of the ACCC in preventing either monopolies or the concentration of too much power in the hands of one company allowing it to dominate the market. However, the same applies when a coordinated industry dominates thinking. For example, marketing of alcohol and junk food dominates our airwaves rather than a level playing field that promotes healthy food or illustrates the problems of a close relationship between sport and alcohol marketing.

In a breakthrough philosophical insight presented in *Republicanism: A theory of freedom and government*<sup>3</sup>, ANU and Princeton academic Phillip Pettit argues the issue of domination is the real issue in protection of freedoms, rather than the frequently presented concerns about interference.

There is a fundamental role for personal choice and responsibility for those choices. But it does not sit in isolation from the societal forces around making such choices. Where influence of individuals is so strongly dominated by forces around them, it is much more difficult to make well-informed, responsible choices compared to when there is a balanced view presented on a level playing field.

There would be a different view of the interference arguments put by some in industry if our idea of freedom was based not so much on interference as on domination.

I believe that this republican conception of freedom, this conception of freedom as non-domination, is of the greatest interest in political theory, and that it is important to put it back on the table in current discussions. My aim in this book is to try to identify the main features of freedom as non-domination, to show what it would mean to take the ideal as a political cause, and to indicate the institutional impact of organizing things so that the ideal is advanced.<sup>4</sup>

Domination by industry in marketing of junk food to children, for example, plays a key role in the obesity epidemic. Governments have an option of countering the domination in the market place by junk food companies and delivering a level playing field by investing the same amount of money into marketing fruit, vegetables and good nutrition messages. However, rather than spend huge amounts of taxpayers money in this manner government can achieve the same level playing field, countering the domination, by introducing regulations that restrict the extent of marketing of junk food to children.

Even more aggressive marketing can be seen regarding alcohol. Government regulation of marketing to deliver a much more balanced level playing field would allow a much better understanding of the harms associated with the product rather than the industry favoured nexus with sport and all things fun.

Governments in Australia and around the world have long recognised this principle in relation to tobacco advertising, although the same "freedom" arguments were raised by tobacco companies and those who defended their right to promote use of a lethal product.

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### **The role of government in public health**

There is a long history of governments taking action to protect the community. A healthy community includes public safety, law enforcement, environmental protection, child protection and injury prevention. There is a long history of governments playing a positive and successful role in stewardship of the community. Examples include clean water and sanitation, ensuring the safety of its citizens, dealing with pollution and environmental degradation, mandatory reporting of child abuse and seat belt, car safety and drink-driving laws that have resulted in reducing vehicle related morbidity and mortality to the same levels as in the 1930s despite huge increases in population and in vehicle ownership. Other examples are oversight of health services, food safety, water safety, monitoring of pharmaceutical products, and professional standards for health care workers, engineers, architects, teachers and many other professionals.

Australia is not alone in this success. Other similar governments in developed nations, in particular have a long history of managing their stewardship to protect community health. The reality is that protecting and promoting health is one of government's most fundamental responsibilities. There is a clear reason why countries such as Japan, Iceland and Australia have amongst the healthiest populations on earth (as measured by DALYs and amongst those with longest lifespans. Australia, like these other developed countries, has a long history of public health legislation.

Although these examples go well beyond the specific examples being examined by the Committee, the PHAA considers the context of this inquiry to be critical to a sensible understanding of the issues being considered.

We urge the committee to confirm its strong support for the approach to public health that has been so important to ensuring that Australia is one of the healthiest countries in the world

### **Nanny State**

It is notable that "Nanny State" is a term that was coined in 1965 by a British columnist writing in The Spectator who went under the pseudonym "Quoodle". The whole concept of the "Nanny State" was to point to 'interference' by governments. It is a term usually used in a pejorative way to discourage governments from introducing legislation or regulation that might undermine the power or actions of industry or individuals. It is invariably presented as an interference with the choices of ordinary people. It is rarely if ever used to criticise action by governments to protect the community in areas such as policing and law enforcement, or to opposed public health measures ranging from safe food and water to quarantine. There is an irony in "Quoodle" coining this term. "Quoodle" was the former British Health Minister, Iain McLeod, who in 1954 smoked through a press conference on the dangers of smoking. He died of heart attack at age 57<sup>5</sup>.

The PHAA observes objections to interference by the state are frequently raised by vested interests, including those who seek to sell and promote harmful products.

### **Government's role in social determinants**

The Senate Community Affairs Committee on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"* unanimously agreed (as Recommendation 1) that

the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian context.<sup>6</sup>

In reaching this conclusion, the Committee recognised the following:



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Even in the world's wealthiest countries there are significant discrepancies in life expectancies and health outcomes between groups in society. Research into the correlation between health outcomes and factors such as education and income has led to a growing understanding of the sensitivity of human health to the social environment. Such factors, which include education, gender, power and the conditions of employment, have become known as the social determinants of health.

(Community Affairs 2013 para 2.1)<sup>7</sup>.

The Committee recognised that it is not enough to rely on personal responsibility to ensure best possible outcomes for the healthiness of the people for which governments have a duty of care. As so many of these economic and social factors have such a strong correlation for the satisfying lives people live (their healthiness), and the length of their lives it is important that governments recognise their responsibilities and act on them to ensure all citizens have *an equitable rather than an equal opportunity* to a full and healthy life.

## **PHAA Response to Committee Terms of Reference**

### **a) The sale and use of tobacco, tobacco products, nicotine products, and E-Cigarettes, including any impact on the health, enjoyment and finances of users and non-users**

#### **Tobacco**

Smoking remains Australia's largest preventable cause of death and disease, responsible for some 15,000 deaths annually. The McKinsey Global Institute has identified smoking as the top global social burden generated by human beings, ahead even of armed violence, war and terrorism.

Australian success in reducing the number of people who smoke is seen by governments of all persuasions as an important achievement. It ought to be celebrated. The domination of tobacco companies in the media and marketing space is largely in the past. However, tobacco companies remain vigilant and effective in selling their lethal product through a range of techniques including product placement in movies and series as well as through public relations activities, lobbying and social media.

The reduction of cancer and cardiovascular disease is a key outcome of successive governments not allowing domination of industry – particularly regarding the marketing of tobacco products (including through packaging), increasing prices through taxation the regulation of where people can smoke, and public education.

Tobacco is different from all other products. Recent authoritative Australian research has demonstrated that it is the one product when used as directed by the manufacturer is likely to result in the premature deaths of two thirds of the people who use it<sup>8</sup>. Despite this there are still incredible forces that continue to push the product. According to Margaret Chan, the Director General of the World Health Organization (WHO):

The real slippery slope is this: depriving governments of their sovereign right to use legislation to protect citizens from harm. This is a battle that pitches the power and authority of governments against the power of corporations.<sup>9</sup>

We support the bipartisan approach taken by Australian governments over decades to tobacco control, and further implementation of strategies to reduce smoking as recommended by health authorities including the World Health Organisation and the National Preventative Health Taskforce. We reject any suggestions that

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there should be any diminution of action on smoking. Indeed, there is much scope for further action, particularly to reduce smoking among disadvantaged groups such as people with mental health problems and Aboriginal people.

### **E-Cigarettes**

Margaret Chan, the Director General of the World Health Organization (WHO) in her Keynote address at the World Conference on Tobacco or Health Abu Dhabi, United Arab Emirates on 18 March 2015 stated:

The tobacco industry, too, is always with us, watching for any wavering of resolve that can be exploited, waiting for any opportunity to interfere.<sup>10</sup>

The tobacco companies have been large investors in E-Cigarette expansion.

The PHAA and the World Federation of Public Health Associations (WFPHA) have the following concerns regarding E-Cigarettes:

- The World Health Organization (WHO) noted that both the safety of E-Cigarettes and their alleged superior efficacy in smoking cessation have not been scientifically demonstrated;
- There is a serious potential threat to health arising from the deep inhalation of fine and ultra-fine particles, and nicotine many times a day and over prolonged periods;
- E-Cigarettes may lead minors to try other tobacco products—including conventional tobacco cigarettes;
- Marketing of E-Cigarettes may be used as a ‘trojan horse’ or subversive device by
  - effectively marketing tobacco products, and
  - undermining the huge global achievements in ‘denormalizing’ tobacco use and the smoking “performance”;
- E-Cigarettes may cause many smokers to only reduce smoking, instead of quitting;
- There is a lack of evidence about second hand (or passive) exposure to E-Cigarettes; and,
- There is a lack of quality control standards in the manufacture, distribution and use of E-Cigarettes.<sup>11</sup>

This is why the PHAA and the WFPHA strongly supports the evidence-based position taken by the WHO following publication of its report on the issue of Electronic Nicotine Delivery Systems (ENDS), more commonly known as electronic cigarettes – or E-Cigarettes.

Australia has well established mechanisms for assessment on new products for which therapeutic benefits are claimed. E-Cigarettes, like any other products in this category, should be submitted by manufacturers to the Therapeutic Goods Administration (TGA), with evidence of safety and efficacy; it is then for the TGA to consider this evidence and make determinations as to whether the product may be sold or marketed, and if so where and under what conditions. This process should apply to E-Cigarettes, and should not be circumvented by lobbying or public relations activities.

### **b) The sale and service of alcohol, including any impact on crime and the health, enjoyment and finances of drinkers and non-drinkers;**

Alcohol is now more affordable than it has been in three decades, and is more available and heavily promoted than it ever has been. This is contributing to Australia’s drinking culture and resulting in significant individual, social and economic harms.

The harms associated with alcohol should not be taken lightly by a responsible government. The harmful effects of alcohol consumption include the following:

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- Alcohol plays a role in a range of health problems, including cardiovascular disease, cancers, diabetes, nutrition-related conditions, overweight and obesity as well as the immediate impacts of alcohol for both the drinker and others.
- The harms to others from somebody's drinking are often indiscriminate and far reaching, ranging from random acts of drunken violence to child maltreatment.
- The total cost of alcohol problems in Australia each year exceeds \$36 billion, including the cost to the health system, law enforcement, lost productivity in the workplace, and the pain, suffering and harms to drinkers and those around them.
- Indigenous Australians experience disproportionate rates of alcohol related harm. Mortality rates from alcohol-related diseases are four-times higher among Indigenous than non-Indigenous populations.<sup>12</sup>
- In young people, drinking can adversely affect brain development and lead to alcohol-related problems in later life.
- Alcohol can trigger or worsen pre-existing mental health conditions (e.g. anxiety, depression, schizophrenia).
- Alcohol is a greater factor than speed, fatigue, weather or road conditions in fatal road crashes in Australia and is responsible for more than a third of road deaths.
- Nearly half of all homicides in Australia are preceded by alcohol consumption, either by the victim or the offender.
- Prenatal exposure to alcohol can result in Fetal Alcohol Spectrum Disorders (FASD) leading to learning difficulties, a reduced capacity to remember tasks from day to day, anger management and behavioural issues, impaired speech and muscle coordination, and physical abnormalities in the heart, lung and other organs.

Ordinary people do need to take responsibility for the way they drink. However, there are a range of actions that a government can take to reduce alcohol associated harm as part of the stewardship role that is key to good government. These include: alcohol pricing and taxation; alcohol marketing; and, availability and accessibility of alcohol, supported by well as strong, well-funded and health-based public education

### **Alcohol pricing and taxation**

There is overwhelming consensus among leading Australian and international health authorities that alcohol taxation, when used to increase the price of alcohol, is one of the most effective policy interventions to reduce the level of alcohol consumption and related harms.<sup>13</sup> A review of 112 international studies demonstrated that increasing the price of alcohol reduces the overall consumption of alcohol in the population, including consumption at harmful levels and by young people.<sup>14</sup>

This review found that on average, a ten per cent increase in the price of alcohol reduces consumption by five per cent. Even small increases in the price of alcohol can have a significant impact on consumption and harm, delivering significant economic benefits in terms of improved health and workforce productivity of the community, significant reduction to costs associated with alcohol-related problems (e.g. expenditure on health services and police), and collection of revenue.

In addition to improving health outcomes and reducing social harms, the economic justification for reforming alcohol taxation in Australia is clear and compelling. Particular products, such as alcohol or tobacco, result in externalities, which relate to the costs incurred by others beyond those considered and incurred by individuals in a transaction. Applying taxes is an efficient and effective way to correct these externalities. In the Henry Review of Australia's taxation system, the externalities of alcohol were described

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by Ken Henry as ‘spillover costs’. Henry indicated that “while taxes on alcohol should not be used for general revenue-raising, they may have role in addressing the significant spillover costs on the community associated with alcohol abuse, by changing the price of alcohol faced by consumers”.<sup>15</sup>

The externalities of alcohol far exceed the net revenue acquired through taxation. Since the Henry Review, numerous studies have attempted to quantify the externalities of alcohol. In 2013-14, the government raised \$5.1 billion in alcohol tax revenue. This is the tax on beer, spirits and other excisable beverages and \$826 million in WET revenue (net of producer rebate). In a comprehensive cost-benefit analysis of different alcohol taxation approaches, Marsden and Jacob Associates concluded that the total costs of alcohol harms in Australia would be easily in excess of \$15 billion per year.<sup>16</sup> The tangible social costs of alcohol alone that result from an individual’s alcohol misuse include an estimated \$1.9 billion for healthcare, \$2.2 billion for road traffic accidents, \$1.6 billion for criminal justice and \$3.6 billion in lost productivity, equating to \$9.3 billion. Third party costs, or harm to others that arise from someone else’s drinking, have been estimated to amount to more than \$14 billion in tangible costs. These costs include health care and child protection costs, lost wages and productivity, and out-of-pocket expenses such as property and personal damage, costs of professional counselling to cope with the drinker, and the cost of having to leave home and stay elsewhere to avoid the drinker.

Despite its recognised effectiveness, taxation as a strategy to reduce alcohol-related harm has been under-utilised in Australia. From a public health and economic perspective, the current alcohol taxation regime in Australia is significantly flawed<sup>17</sup>. Taxation of alcohol should be based on the principle that alcohol is no ordinary commodity – it is a product responsible for major harms of both users and non-users in our community. PHAA supports an approach to alcohol taxation that is volumetric, with tax increasing for products with higher alcohol volumes.

### **Alcohol marketing**

Alcohol marketing in Australia is prolific. An unprecedented number of platforms for advertising including through social media and the sponsorship of sporting and cultural events are utilised by the alcohol industry to market their products.

The ubiquity of this marketing has particular impact among young people, with a substantial body of evidence showing that alcohol marketing and promotion contributes to young peoples’ attitudes to drinking, the age at which they commence drinking, and drinking at harmful levels. The National Preventative Health Taskforce recently recommended that in a staged approach, alcohol promotions should be phased out from times and placements which have high exposure to young people aged up to 25 years.

The National Alliance for Action on Alcohol (NAAA), with whom the PHAA has a close relationship, recommends the establishment of a comprehensive framework that will:

- ensure effective regulation of advertising and promotions for alcohol, including a special focus on minimising the exposure of children and young people to alcohol marketing and promotions
- include the phasing out of alcohol sponsorship of music events to which children and young people may be exposed, and the prohibition of alcohol sponsorship of junior sports teams, clubs or programs
- cover all forms of alcohol marketing and promotions, including point-of-sale promotions, print and media advertising, packaging, labelling, sponsorship, viral and internet campaigns
- ensure that standards in relation to advertising, promotion and labelling are stringently applied with penalties for significant breaches

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- ensure that the standards are monitored by an independent panel with membership including expertise in public health and health marketing, and
- require alcohol companies to disclose their annual advertising and sponsorship expenditure.

As a first step, the current exemption permitting alcohol advertising during live sporting broadcasts before 8:30 pm on commercial free-to-air television should be removed as a way of reducing children's exposure to alcohol marketing and promotions.

### **Alcohol availability and accessibility**

Restricting the physical availability of alcohol is a central to efforts to prevent alcohol misuse and harms. The physical availability of alcohol is affected by policies on trading hours, the density of liquor outlets in a given locality (both on premises and off premises), and the type and size of places in which alcohol is sold.

Although liquor licensing is primarily the domain of state and territory governments, it operates within the parameters set by the Commonwealth through National Competition policy. Following the introduction of National Competition Policy in the 1990s, the liberalisation of liquor licensing regimes has resulted in a dramatic expansion of alcohol outlets and venues, resulting in an unprecedented growth in the availability of alcohol.<sup>18</sup> There is a substantial scientific evidence base showing that this deregulation of liquor control correlates with an increase in alcohol-related harms.<sup>19,20,21,22</sup>

The substantial harms arising from alcohol were acknowledged in the Final Report from the Harper Review of National Competition Policy, which was released in March this year. The Final Report noted that the risk of harm to individuals, families and communities from problem drinking provide a clear justification for regulation, and concluded that *"...given the Panel's view that the risk of harm from liquor provides a clear justification for liquor regulation, any review of liquor licensing regulations against competition principles must take proper account of the public interest in minimising this potential harm."*<sup>23</sup>

A government that understands its 'stewardship' role would recognise there is a need for national guidelines on alcohol outlet density and opening hours in addition to a cohesive policy among liquor licensing agencies, planning departments and local governments on this issue, with legislation and action by government authorities placing a primary focus on public health and safety and protecting children and young people.

Accordingly, PHAA urges the Commonwealth to adopt the Harper Review Panel's recommendations that minimising the harms from alcohol should be a central objective of liquor licensing across Australia.

Regulating the availability of alcohol is essential for the following reasons:

- Alcohol is not an ordinary commodity; it is a product that causes significant harms and costs to the community.
- The benefits as a whole from regulating access to alcohol outweigh the costs of reducing competition in the market that supplies alcohol.
- Regulating access to alcohol with the objective of minimising harm can only be achieved by restricting the economic and physical availability of alcohol. This justifies the controls that may otherwise be seen as anti-competitive.

Alcohol should be considered in the same category as other harmful products such as tobacco where restrictions which limit competition are, rightly, justified in the interests of public health.

A government that understands its 'stewardship' role would recognise there is a need for national guidelines on alcohol outlet density and opening hours in addition to a cohesive policy among liquor licensing agencies, planning departments and local governments on this issue, with legislation and action by government authorities placing a primary focus on public health and safety and protecting children and young people.



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### **Alcohol labelling, information and public education**

In December 2011, the Legislative and Governance Forum on Food Regulation (FoFR) declared that the alcohol industry had two years to implement voluntary pregnancy health information labels on alcohol products, before regulating this change. This voluntary period has been extended to 2016.

Alcohol industry organisation, DrinkWise commenced their voluntary scheme in July 2011. Evaluations of this voluntary scheme have found that the messages are weak, with low visibility and limited coverage of alcohol products.<sup>24</sup> International evidence has also shown that without government regulation, industry-led public health initiatives are likely to be contaminated with vested interests, resulting in weak messages that downplay the serious risks associated with harmful products.<sup>25</sup>

Labelling provides a key method of promoting informed choice at both the point of sale and consumption, and should be an essential feature of any product that carries a risk of harm with consumption. To ensure its success, product labelling should be government-regulated rather than industry regulated, and developed by public health experts using the evidence-base of what works.

Public education on alcohol should be the domain of governments and health authorities, not companies whose existence and profitability relies on maintaining and increasing sales of alcohol products.

### **c) The sale and use of marijuana and associated products, including any impact on the health, enjoyment and finances of users and non-users;**

PHAA advocates for legislative and regulatory action to make medicinal cannabis legally available throughout Australia and for a medicinal cannabis regime that, as a short-term interim measure, removes penalties for possession, consumption and supply of personal-level quantities of cannabis when used medicinally as part of a compassionate regime. PHAA supports a national approach to medicinal cannabis that includes establishing a legal supply chain of herbal cannabis, cannabis extracts and, where medically appropriate, synthetic cannabis products.

Widespread public and media interest in medicinal cannabis<sup>26</sup> exists in Australia including in parliaments in a number of jurisdictions (including the Federal Parliament) which are actively considering proposals. The focus is on using cannabis to assist in alleviating unnecessary suffering caused by illness or adverse consequences of treatment. Under international treaties that have been incorporated into Australian domestic law, nations may permit the import, export, supply, use, consumption, etc. of cannabis in all its forms for 'medical and scientific purposes'.<sup>27</sup>

Government regulated medicinal cannabis programs exist in European and North American nations. The approach taken in many of the USA programs where controls are loose, with blurred boundaries between supply for medicinal and recreational purposes, provides a model of how *not* to manage these programs.<sup>28</sup> In contrast, the approach taken in the Netherlands, where a government agency, the Office of Medicinal Cannabis, tightly regulates the service, is an example of how the program can be operated in a safe and effective manner.<sup>29</sup> Medicinal cannabis has been approved for use in more than a dozen countries including the USA, Canada, UK, Denmark, the Czech Republic, Austria, Sweden, Germany, Spain, Canada, Italy, Israel and New Zealand.



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Both scientific research and numerous case reports indicate a range of health conditions for which cannabis has been demonstrated to be beneficial at palliating the symptoms of serious illness or the adverse side-effects of their treatment. These include, but are not limited to, cancer, HIV infection, multiple sclerosis and epilepsy.<sup>30</sup> The most recently published systematic review concludes that ‘There was moderate-quality evidence to support the use of cannabinoids for the treatment of chronic pain and spasticity. There was low-quality evidence suggesting that cannabinoids were associated with improvements in nausea and vomiting due to chemotherapy, weight gain in HIV, sleep disorders, and Tourette syndrome’.<sup>31</sup> Research into medicinal uses of cannabis is limited, with few high-quality trials having been conducted, partly owing to US Government restrictions on making the drug available for medical research purposes.<sup>32</sup> In some jurisdictions, medicinal cannabis is used to treat a host of indications, a few of which have evidence to support treatment with cannabis and many that do not.<sup>33</sup>

The attitudes towards medicinal cannabis expressed by Australian and international professional bodies are mixed. For example, the Cancer Council NSW ‘...supports limited exemptions from criminal prosecution...for cancer patients who have been certified by an approved medical practitioner as having particular conditions, and who have been counselled by such a practitioner about the risks of smoking cannabis’.<sup>34</sup> The Australian Medical Association ‘...acknowledges that cannabis has constituents that have potential therapeutic uses’ and notes that ‘Therapeutic cannabinoids that are deemed safe and effective should be made available to patients for whom existing medications are not as effective’.<sup>35</sup> The AMA also notes that ‘Any promotion of the medical use of cannabinoids will require extensive education of the public and the profession on the risks of the non-medical use of cannabis’.

With regard to medicinal cannabis, the policies and practices of the Commonwealth, State and Territory governments are largely out of step with the attitudes and behaviour of much of the general public, and much professional opinion. Some state governments are now facilitating clinical research into medicinal cannabis, and NSW has adopted a policy not to prosecute terminally ill people using the drug medicinally,<sup>36</sup> an approach supported by PHAA.

It is now timely for Australian governments to give serious consideration to options for a tightly-regulated, compassionate medicinal cannabis regime managed by medical practitioners and the state/territory health departments, ideally underpinned by national legislation and regulation in conformity with Australia’s international treaty obligations. Any medicinal cannabis regime should ideally be supported by provisions for the supply of cannabis to people authorised to use it, and this should not entail obtaining the drug from illicit supply sources. However, this principle should not prevent the removal of penalties for medicinal use as part of a staged approach.

The arguments against permitting terminally ill people to legally access, possess and use cannabis when this is supported by their doctor, represent an ideological stance, not compassionate medical practice. Considerations of facilitating a relatively small number of dying, chronically and acutely sick people to use cannabis as part of a carefully controlled compassionate medical treatment regime need to balance the potential benefits of this for patients and their families (which are relatively high) with the potential negative aspects (which are relatively low).<sup>37</sup> The side effects of using cannabis to provide relief from the symptoms of some chronic illnesses, or in certain age groups, need to be taken into account in assessing these trade-offs.

Current evidence suggests that adverse effects of short-term use for medical indications are generally modest, but further research is needed to evaluate adverse effects of long-term use including risk of dependence, exacerbation of cardiovascular disease and precipitation of psychotic disorder, especially in younger people. Potential adverse side-effects include included asthenia, balance problems, confusion,

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dizziness, disorientation, diarrhoea, drowsiness, dry mouth, fatigue, hallucination, nausea, somnolence and vomiting.<sup>38</sup>

PHAA supports research into both the benefits and side-effects of use of medicinal cannabis and pharmaceutical cannabinoids and that any Australian regime should clearly distinguish between lawful medicinal use and unlawful use for recreational and other purposes.

Legal medicinal cannabis regimes operate in many overseas jurisdictions, reflecting research evidence and clinical experience that some of the contents of the cannabis plant have therapeutic values, for some patients, including but not restricted to the terminally ill. Many people have found the drug helpful for palliating distressing disease symptoms and relieving adverse side-effects or medication in cases where standard medical care is not sufficiently effective. There is good evidence for efficacy for some medical indications but not for others. PHAA supports the current initiatives, at both the Commonwealth and State/Territory levels, to establish legal medicinal cannabis programs and further research on the risks and benefits of medicinal cannabis use.

The PHAA does not support the prohibition of the use of cannabis for recreational purposes. The success of drug policies in Portugal illustrate the effectiveness of regimes that regulate rather than criminalise. Strict regulation of drugs like cannabis would provide government with some of the same levers that have been successful in reducing the use of tobacco. Although there is not consensus within the PHAA membership on this issue, many of our members believe that any regime would have to begin by ensuring restrictions on marketing, distribution and regulation of price – especially through taxation.

### **d) Bicycle helmet laws, including any impact on the health, enjoyment and finances of cyclists and non-cyclists;**

Preventing injuries is cost-effective and can reduce demands on hospitals, general practitioners and other medical services. Injury prevention is vital and needs to be considered integral to the national preventative health program.

Injury risk patterns vary according to a range of factors including: age, gender, geographic location, occupation, culture, and socio-economic status. Injury prevention therefore require a cross-sectional, multi-disciplinary approach. Effective strategies in injury prevention exist with interventions drawing on a mix of: environmental change, behavioral change, policy and legislative development and community involvement.

Over one third of deaths of children less than 14 years of age in Australia are related to injury.<sup>39</sup> Children aged 0-14 account for 14% of all hospitalised injury cases in 2009-10.<sup>40</sup> For very young children (aged 0-4, the leading cause for injury hospitalisation was an unintentional fall (42%).<sup>41</sup>

Research indicates that bicycle helmets greatly reduce the risk of head injuries which are the major cause of death and injury to bike riders.<sup>42</sup> We also strongly support actions that will encourage cycling and other forms of physical activity.

### **e) The classification of publications, films and computer games;**

PHAA has no position on the classification of publications, films and computer games.

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### **f) Any other measures introduced to restrict personal choice ‘for the individual’s own good’.**

PHAA is committed to promoting the health of the public as well as serving as a professional resource for public health personnel. To do so, PHAA has developed seventy evidence based policy and position statements provided freely to the public on a range of public health issues. These policies are provided to the public to help educate Australians about the scientific evidence and policy options public health and include policies and position statements on: (available at: [www.phaa.net.au](http://www.phaa.net.au))

- Aboriginal and Torres Strait Islander Health
- Child Health
- Health Promotion
- Drugs and Alcohol
- Ecology & Environment
- Food and Health
- Health Promotion
- Immunisation
- Infection and Transmissible Disease
- Injury
- International Health and International Trade
- Mental Health
- Obesity
- One Health
- Oral Health
- Political Economy of Health
- Primary Health Care
- Prisoner’s Health
- Women’s Health

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# Recommendations

In response to the terms of reference by the Standing Committee on Economics inquiry into personal choice and community impacts, the Public Health Association of Australia has the following key recommendations. That the Committee:

1. Reinforce the importance of regulation as an important public health intervention
2. Ensure regulations are framed and understood in terms of 'dominance' rather than 'interference'

# Conclusion

PHAA believes that the healthiest society represents a balance between personal responsibility and government responsibility (or stewardship). Governments have an important role to ensure that personal choice is protected by government by limiting coercion (especially as driven by profit) and intrusiveness in line with this submission. We are particularly keen that the following points are highlighted:

- In a healthy society there is an appropriate balance between **personal responsibility and government stewardship**, particularly in respect to the governments duty of care to ensure that each of the citizens within the community have the full opportunity to reach their potential and to ensure they have the healthiest life;
- **Government's role in social determinants** is to recognise their responsibilities and act on them to ensure all citizens have *an equitable rather than equal opportunity* to a full and healthy life;
- **Freedom from dominance rather than interference as a fundamental health issue** which recognises that personal responsibility for choice does not sit in isolation from the societal forces around making such choices. Where an individual is so strongly dominated by forces around them, it is much more difficult to make well-informed, responsible choices and that they are less free than someone who is not dominated.

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to this important discussion.

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

Michael Moore BA, Dip Ed, MPH  
Chief Executive Officer  
Public Health Association of Australia  
24 August 2015

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# References

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- <sup>1</sup> Nuffield Council on Bioethics *Public health: ethical issues* Published: November 2007  
<http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-executive-summary.pdf>
- <sup>2</sup> Nuffield Council on Bioethics *ibid*
- <sup>3</sup> Pettit, Philip (1997), *Republicanism: A theory of freedom and government*. Clarendon Press Oxford.  
<sup>4</sup> *ibid* p51
- <sup>5</sup> Daube, M., Stafford, J., & Bond, L. (2008). No need for nanny. *Tobacco control* 17(6):426-427.  
[http://healthsciences.curtin.edu.au/watdsp/local/docs/no\\_need\\_for\\_nanny\\_2008.pdf](http://healthsciences.curtin.edu.au/watdsp/local/docs/no_need_for_nanny_2008.pdf) (accessed 19 August 2015)
- <sup>6</sup> The Senate Community Affairs Committee, (20 March 2013) on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"*  
[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Community\\_Affairs/Completed\\_inquiries/2010-13/socialdeterminantsofhealth/report/b01](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/2010-13/socialdeterminantsofhealth/report/b01)
- <sup>7</sup> *ibid.*
- <sup>8</sup> Banks E, Joshy G, Weber M, Liu, B, Grenfell R, Egger S, Paige E, Lopez AD, Sitas F, Beral V (2015) Tobacco smoking and all-cause mortality in a large Australian cohort study: findings from a mature epidemic with current low smoking prevalence *BMC Medicine* 2015, **13**:38  
<http://www.biomedcentral.com/1741-7015/13/38> (accessed 19 August 2015)
- <sup>9</sup> Chan M, (2015) Keynote address at the World Conference on Tobacco or Health Abu Dhabi, United Arab Emirates 18 March 2015  
<http://www.who.int/dg/speeches/2015/trends-tobacco-use/en/> (accessed 19 August 2015)
- <sup>10</sup> *ibid*
- <sup>11</sup> Public Health Association of Australia *Statement by the Public Health Associations of Australia on Electronic Cigarettes* Support for WHO evidence-based publication on electronic cigarettes  
<http://www.phaa.net.au/documents/item/704> (accessed 19 August 2015)
- <sup>12</sup> Wilson, M., Stearne, A., Gray, D., & Saggars, S. (2010). *The harmful use of alcohol amongst Indigenous Australians* (Vol. 4). Centre for Indigenous Australian Education and Research Edith Cowan University.
- <sup>13</sup> Anderson, P., Chisholm, D., Fuhr, DC., (2009). Alcohol and Global Health 2: Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* 373:2234-2246.
- <sup>14</sup> Wagenaar, A.C., Salois, M.J., and Komro, K.A., (2009). Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 104:179-190.
- <sup>15</sup> Henry, K., et al, (2009). *Australia's future tax system (Henry Review) — Report to the Treasurer 2009 December*. Canberra: Commonwealth of Australia.
- <sup>16</sup> Marsden Jacob Associates, (2012). *Bingeing, collateral damage and the benefits and costs of taxing alcohol rationally, report to the Foundation for Alcohol Research and Education*.  
[http://bettertax.gov.au/files/2015/06/Foundation\\_for\\_Alcohol\\_Research\\_and\\_Education\\_Submission\\_2.pdf](http://bettertax.gov.au/files/2015/06/Foundation_for_Alcohol_Research_and_Education_Submission_2.pdf)
- <sup>17</sup> National Alliance for Action on Alcohol, (2015). *Alcohol Pricing and Taxation*.  
<http://www.actiononalcohol.org.au/our-work/position-statements/alcohol-pricing-and-taxation>
- <sup>18</sup> Trifonoff, A., Andrew, R., Steenson, T., Nicholas, R. and Roche, A.M. (2011). *Liquor licensing legislation in Australia*. Executive summary. Adelaide: National Centre for Education and Training on Addiction (NCETA).

## PHAA submission on personal choice and community impacts

- <sup>19</sup> Livingston, M., Chikritzhs, T., & Room, R., (2007). Changing the density of alcohol outlets to reduce alcohol-related problems. *Drug and alcohol review*, 26(5), 557-566.
- <sup>20</sup> Livingston, M., (2011). Alcohol outlet density and harm: comparing the impacts on violence and chronic harms. *Drug and Alcohol Review* 30:515-523.
- <sup>21</sup> Morrison, C., & Smith, K., (2015). *Disaggregating relationships between off-premise alcohol outlets and trauma*. Canberra: Foundation for Alcohol Research and Education.
- <sup>22</sup> Allen Consulting Group, (2009). Alcohol-related harm and the operation of licensed premises, Melbourne.
- <sup>23</sup> Harper, I., et al., (2015). *Competition policy review, final report*. Canberra: Commonwealth of Australia.  
<http://competitionpolicyreview.gov.au/final-report/>
- <sup>24</sup> IPSOS Social Research. (2012). *Alcohol Label Audit Prepared for the Foundation for Alcohol Research and Education*. Canberra: Foundation for Alcohol Research and Education. Retrieved from: <http://www.fare.org.au/wp-content/uploads/2011/07/IPSOS-SRI-DRINKWISE-AUDIT-REPORT-1-AUGUST-2012.pdf>
- <sup>25</sup> Eurocare, European Alcohol Policy Alliance (2009). *Labelling initiatives: A brief summary of health warning labels on alcoholic beverages*, pp. 10-12.
- <sup>26</sup> Terminological note: 'cannabis' refers to the plant *Cannabis sativa*. 'Cannabinoids' include cannabis and synthetic and semi-synthetic substances that produce pharmacological effects similar to those produced by cannabis (Mather, LE et al. 2013, '(Re) introducing medicinal cannabis', *Medical Journal of Australia*, vol. 199, no. 11, pp. 759-61). For ease of communication this Position Statement uses the term 'medicinal cannabis' to cover both botanical cannabis and other cannabinoids.
- <sup>27</sup> United Nations Office on Drugs and Crime 2013, *The International Drug Control Conventions*, <<http://www.unodc.org/unodc/en/commissions/CND/conventions.html>>.
- <sup>28</sup> Sabet, K & Grossman, E 2014, 'Why do people use medical marijuana? The medical conditions of users in seven U.S. states', *Journal of Global Drug Policy and Practice*, vol. 8, no. 2. (Note: this is sound research, albeit published in a low-status, advocacy-focussed, online journal.)
- <sup>29</sup> Netherlands Office of Medicinal Cannabis <http://www.cannabisbureau.nl/en/>.
- <sup>30</sup> Grotenhermen, F & Muller-Vahl, K 2012, 'The therapeutic potential of cannabis and cannabinoids', *Dtsch Arztebl Int*, vol. 109, no. 29-30, pp. 495-501; Borgelt, LM et al. 2013, 'The pharmacologic and clinical effects of medical cannabis', *Pharmacotherapy*, vol. 33, no. 2, pp. 195-209, Volkow, ND, Baler, RD, Compton, WM & Weiss, SRB 2014, 'Adverse health effects of marijuana use', *New England Journal of Medicine*, vol. 370, no. 23, pp. 2219-27, Hakkarainen, P et al. 2014, 'Growing medicine: small-scale cannabis cultivation for medical purposes in six different countries', *The International Journal of Drug Policy*, online ahead of print.
- <sup>31</sup> Whiting, PF et al. 2015, 'Cannabinoids for medical use: a systematic review and meta-analysis', *JAMA*, vol. 313, no. 24, pp. 2456-73.
- <sup>32</sup> Bostwick, JM 2012, 'Blurred boundaries: the therapeutics and politics of medical marijuana', *Mayo Clinic Proceedings*, vol. 87, no. 2, pp. 172-86.
- <sup>33</sup> Hill, KP 2015, 'Medical marijuana for treatment of chronic pain and other medical and psychiatric problems: a clinical review', *JAMA*, vol. 313, no. 24, pp. 2474-83.
- <sup>34</sup> <http://www.cancercouncil.com.au/1978/cc-publications/health-strategies-reports-submissions/position-statements/cancer-council-new-south-wales-medical-use-of-marijuana-fact-sheet/>
- <sup>35</sup> See Available from <https://ama.com.au/position-statement/cannabis-use-and-health-2014> .
- <sup>36</sup> Government of NSW 2015, 'Terminal Illness Cannabis Scheme', [http://www.nsw.gov.au/sites/default/files/miscellaneous/sc000197\\_cannabis-scheme-sheet.pdf](http://www.nsw.gov.au/sites/default/files/miscellaneous/sc000197_cannabis-scheme-sheet.pdf).



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<sup>37</sup> This has been the experience of the Netherlands' Office of Medicinal Cannabis which manages a tightly-controlled program, making pharmaceutical-standard herbal cannabis available to authorised patients in that country through pharmacies, and elsewhere in Europe. See <http://www.cannabisbureau.nl/en/>. And see Carter, GT *et al.* 2011, 'Cannabis in palliative medicine: improving care and reducing opioid-related morbidity', *American Journal of Hospice and Palliative Care*, vol. 28, no. 5, pp. 297-303.

<sup>38</sup> Whiting, PF *et al.* 2015, 'Cannabinoids for medical use: a systematic review and meta-analysis', *JAMA*, vol. 313, no. 24, pp. 2456-73.

<sup>39</sup> AIHW: Bradley C 2013. Hospitalisations due to falls by older people, Australia 2009–10. Injury research and statistics series no. 70. Cat. no. INJCAT 146. Canberra: AIHW.

<sup>40</sup> Tovell A, McKenna K, Bradley C & Pointer S 2012. Hospital separations due to injury and poisoning, Australia 2009–10. Injury research and statistics series no. 69. Cat. no. INJCAT 145. Canberra: AIHW.

<sup>41</sup> Tovell A, McKenna K, Bradley C & Pointer S 2012. Hospital separations due to injury and poisoning, Australia 2009–10. Injury research and statistics series no. 69. Cat. no. INJCAT 145. Canberra: AIHW.

<sup>42</sup> [Vicroads.vic.gov.au](http://Vicroads.vic.gov.au), 'Wearing A Bicycle Helmet : Vicroads'. N.p., 2015. Web. 21 Aug. 2015.