Government of **Western Australia**
Department of **Health**
Public Health Division

ATTACHMENT A

SUBMISSION TO THE SELECT COMMITTEE ON RED TAPE

The effect of red tape on tobacco retail

Background

Tobacco use is conservatively estimated to cause the premature deaths of two out of three of its long-term regular users. In Western Australia (WA) in 2015, 9 per cent of people aged 18 and over were daily smokers, down from 17 per cent in 2002.

Despite this decline in smoking, tobacco use continues to have a major impact on public health and will do so for many years to come due to the time lag between commencement of smoking and onset of tobacco-caused disease. Smoking is a leading cause of burden of disease and disability in WA, responsible for an estimated 1,673 deaths in 2013, and 19,196 hospitalisations in 2015. It is also responsible for significant economic costs, conservatively estimated at $3.0 billion per annum in WA (2009/10 data).

Decades of tobacco control experience in WA, Australia and internationally have demonstrated that a comprehensive approach to tobacco control is required to reduce the prevalence of smoking. This approach includes fiscal policy (price and tax measures to reduce the demand for tobacco) and a range of non-price measures including public information programs, provision of cessation support, restrictions on where smoking may occur, regulation of tobacco products (contents, packaging and labelling), bans on advertising and other forms of promotional activity, and regulations concerning how and where tobacco products may be sold.

The cornerstone of this approach is effective legislation. The promotion, sale and use of tobacco products have been subject to incrementally greater regulation for almost 40 years in Australia, and internationally. However it is well-understood that a continued downward trajectory in smoking prevalence is only observed when there is continued pressure exerted through legislative, educative and other tobacco control measures: if tobacco control ‘stagnates’, so does the prevalence of smoking. Therefore tobacco control measures, once implemented, should remain under review and their settings should be sufficiently responsive to ensure that the public health goal of reducing smoking and its burden of disease in the community is achieved.

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Response to the Terms of Reference

In response to the Terms of Reference a) to g) the DOH submits the following.

The Government of WA adopts a comprehensive approach to tobacco control, consistent with international and national best-practice guidelines Other than adopting fiscal measures and regulating the packaging and labelling of tobacco products (mandated at Commonwealth level), the Government has enacted strong tobacco legislation, funds quit smoking mass media campaigns, and provides smoking cessation services.

The primary piece of tobacco control legislation in WA is the *Tobacco Products Control Act 2006* (consolidated) (the Act). The purposes of this Act are to reduce the incidence of illness and death related to the use of tobacco products –

a) by prohibiting the supply of tobacco products and smoking implements to young persons; and
b) by discouraging the use of tobacco products; and
c) by restricting the promotion of tobacco products and smoking generally; and
d) by reducing the exposure of people to tobacco smoke from tobacco products that are smoked by other people.

The overarching purpose of tobacco control policies at federal, state and local levels is to reduce the harm caused by tobacco products. Most tobacco control policy is formulated at the national and state levels.

State tobacco control policy is articulated in the *Western Australian Health Promotion Strategic Framework 2012–2016* (HPSF). The HPSF states that 'the only way to bring an end to the damaged caused by smoking is to encourage people to stop smoking and discourage children from starting to smoke.' (p. 50). The HPSF identifies legislation and regulation as a fundamental lever for tobacco control (p. 52).

The *National Tobacco Strategy 2012-2018* (NTS was developed by the Intergovernmental Committee on Drugs Standing Committee on Tobacco as a sub-strategy under the *National Drug Strategy 2010–2015*. The NTS was endorsed by the Commonwealth, State and Territory Health Ministers at the November 2012 meeting of the Standing Council on Health. The goal of the NTS is 'to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes.' (p. iii). The role of the Australian Government and State and Territory jurisdictions in enacting, monitoring and enforcing strong tobacco control legislation is explicit (e.g. pp. 29, 30, 34).

The *Framework Convention on Tobacco Control* (FCTC) is an international instrument for tobacco control. Its development commenced in 1999 and it has since become one of the most widely-embraced treaties in the history of the United Nations. Australia was among the earliest parties to endorse the treaty, becoming a signatory in 2003. The treaty entered into force in February 2005.

The FCTC provides an internationally co-ordinated response to combating the tobacco epidemic, and sets out specific steps for governments addressing tobacco use, including a legislative framework for tobacco control.

Other states and territories have adopted their own tobacco control policy frameworks, all of which are consistent with over-arching national and international policy and best practice.

Illicit tobacco in Australia

The Commonwealth Department of Health has primary responsibility for the development and implementation of tobacco product regulatory measures. Issues which relate to excise, customs tariffs, and law enforcement are matters for the Treasury, the Australian Taxation Office (ATO), the Department of Immigration and Border Protection (DIBP) and law enforcement agencies (including the Australian Federal Police and the Australian Criminal Intelligence Commission).

Over the past decade, Australian tobacco companies British American Tobacco Australia Limited, Philip Morris Limited and Imperial Tobacco Australia Limited have released several reports in relation to Illicit Tobacco in Australia, produced by consultancy firms PricewaterhouseCoopers, Deloitte and most recently KPMG LLP.

The Cancer Council Victoria (CCV) has analysed these reports and demonstrated the likely un-representativeness of their information and the discrepancy between the results of their surveys and the results of the Australian Institute of Health and Welfare's National Drug Strategy Household Surveys.

CCV's analysis highlights that seizures of illicit tobacco, levels of consumption reported in government-funded consumer surveys and levels of willingness to sell illicit tobacco in retail audits all suggest that the extent of use of illicit tobacco in Australia is substantially lower than suggested by the tobacco industry commissioned reports.

Economic rationales for the regulation of tobacco sales

The following section is taken directly from from the Allen Consulting Group's report 'Licensing of tobacco retailers and wholesalers: desirability and best practice arrangements' to the Commonwealth Department of Health and Ageing and endorsed by the Intergovernmental Committee on Drugs:

'The Council of Australian Governments (CoAG) has publicly stated that government interventions in markets should generally be restricted to situations of market failure and that each regulatory regime should be targeted on the relevant market failure or failures. This view is not foreign to discussions about the need for regulation of tobacco.

'Economic theory assumes that consumers know best and that privately determined consumption will most efficiently allocate society's scarce resources. Thus, if smokers know their risks and internalise all their costs and benefits, there is no justification, on the grounds of inefficiency (i.e. market failure), for governments to interfere.

'However, these assumptions may not hold for several reasons. In particular, when referring to tobacco, regulation can be said to address the twin market failures of:

- information asymmetries — consumers, particularly minors, may have inadequate information about all the costs and benefits about smoking and hence may make non-maximising (i.e., sub-optimal) decisions about the decision to begin smoking and to continue smoking (i.e., because of its addictive nature); and

- negative externalities — smoking has negative impacts on unrelated third parties directly through passive smoking and indirectly through higher community health costs.

Information asymmetries

'Information asymmetries tend to occur when people are young. As a result, and not surprisingly, people typically start smoking during their teen years. From the standpoint of economics, the early typical age of smoking commencement is relevant because the standard economic concept of consumer sovereignty, which holds that the consumer knows what is best for him or her, may not apply so forcefully to adolescents as to adults.

'The early age of onset of smoking has a direct bearing on individuals' health risks. The risk of lung cancer is far higher in individuals who start smoking at age 15 and smoke one pack a day for 40 years than among those who start at age 35 and smoke two packs a day for 20 years.

'There are two forms of information asymmetries that are considered in the following sections:

- incomplete information about health consequences; and

- inadequate information about addiction.

'Incomplete Information About Health Consequences

'Poorly informed smokers often underestimate the risks of their action. Since people usually react to known risks by reducing risky consumption, incomplete information means more smoking than would otherwise occur.

'There are two principal reasons why smokers tend to be inadequately informed:

- the market participants have hidden or distorted information for consumers — the tobacco industry, like other industries, has no financial incentive to provide health information that would reduce consumption of its products; and

- the significant delay between starting to smoke and the onset of obvious disease obscures the link between the two — consumers tend to derive information on the costs and benefits of smoking primarily from their own experience and what happens to their peers.

'However, the obvious health damage from smoking usually emerges at least 20 to 30 years after exposure. This differs from most other risky behaviours where the costs and benefits are more readily and immediately appreciated.

'The long delay between exposure and effect has also impeded the growth of scientific knowledge. For example, in the US, 1960s evidence suggested that only one in four smokers died from smoking. When risks were re-assessed decades later, the evidence showed that the risks were actually much higher; one in two long-term smokers die from smoking. Anyone who considered starting or continuing smoking 20 or 30 years ago would, therefore, have under-estimated the risks, even if he or she had based the decision on the best available information.

'Furthermore, there are a number of other factors that indicate the existence of information deficiencies regarding the health consequences of smoking:

- consumers may not clearly internalise the risks of smoking, even when they have been informed about them, nor may they accurately judge the risks of smoking relative to other environmental exposures. For example in the US, where young people might be expected to have received more information, almost half of 13-year-olds today think that smoking a pack of cigarettes a day will not cause them great harm; and

- teenagers, even those with good understanding of the risks of smoking, may have a limited capacity to use information wisely. Teenagers behave myopically, or short-sightedly. It is difficult for most teenagers to imagine being 25, let alone 55, and warnings about the damage that smoking will inflict on their health at some distant date are unlikely to reduce their desire to smoke.

Inadequate information about addiction

'The other major information failure in the tobacco market involves inadequate information about nicotine addiction. Smokers acquire:

- psychological addiction to the act of smoking itself — psychological addiction to cigarettes is hardly different from habit formation with respect to other products or practices; and

- physical addiction to nicotine — nicotine addiction is not simply a matter of choice or taste reinforced by repetition, such as choosing to listen to certain music or keeping company with dangerous friends. As with all biologically addictive goods, many people can change their behaviour and quit using tobacco. However, the costs of quitting are significant, and some people find quitting virtually impossible. Most smokers who quit have to make several attempts before they succeed, and former smokers remain vulnerable to resuming smoking (e.g., at times of stress).

'There is clear evidence that young people under-estimate the risk of becoming addicted to nicotine, and, therefore, grossly under-estimate their future costs from smoking. For example:

- among high-school seniors in the US who smoke but believe that they will quit within five years, fewer than two out of five actually do quit, and the rest are still smoking five years later; and

- in high-income countries, about seven out of ten adult smokers say they regret their choice to start smoking and two-thirds make serious attempts to quit during their life.

'Thus, it is the combination of imperfect information about addiction and myopia that results in significant under-estimation of the risks of future health damage. It might be argued that young people are attracted to risky behaviour, (e.g., fast driving or alcohol binge-drinking) and that there is nothing special about smoking.

'However:

- few other risky behaviours carry the high risk of addiction that is seen with smoking, and most others are easier to abandon or modify, and are abandoned or modified in maturity; and

- with smoking, there is no comparable way to behave more prudently, except to quit; even cutting back somewhat on consumption does not reduce the risks proportionally. Also, compared with other risky behaviours, such as alcohol use, new smokers face a very high probability of premature death.

'These factors combined create a probability of addiction and premature death that is higher than for other risk-behaviours. Thus, at best, nicotine addiction greatly weakens the argument that smokers should exercise consumer sovereignty. Given the myopia of young consumers and the likelihood of information failure for all smokers, it is inappropriate to regard an addiction-induced demand as representing genuine welfare gains to the smoker.

Externalities

'Consumers and producers may impose costs or benefits on others, which are known as externalities. The costs imposed by smokers on others are of three principal types:

- the direct physical costs for non-smokers who are exposed to others' smoke;

- the financial externalities that cause monetary loss for non-smokers, whether or not they are exposed to smoke; and

- the 'caring externalities' related to smoking, whereby non-smokers suffer emotionally from the illness and death of smokers unrelated to them personally.

Physical externalities

'Physical externalities from smokers involve both health effects for non-smokers, such as a higher risk of disease or death, and other effects, such as the nuisance of unpleasant smells, physical irritation, and smoke residues on clothes, and the greater risks of fire and property damage. The health effects include:

- for children born to smoking mothers, low birth-weight and an increased risk of various diseases; and

- an increased risk of various diseases in children and adults chronically exposed to environmental tobacco smoke either at home or in the workplace.

Financial externalities

'Financial externalities are costs that are imposed by smokers but at least partly financed by non-smokers. In Australia, where there is a significant proportion of publicly financed healthcare, these smoking-related medical costs might include:

- costs not fully internalised by smokers;

- the costs of treating the newborns of mothers who smoke during pregnancy and others who suffer from the effects of passive smoking; and

- the damage from fires and the higher maintenance costs of workplaces and homes where smokers are present.

Caring externalities

'The third group of externalities — 'caring' externalities — are the most difficult to assess. There is evidence that people are willing to pay for another's well being, even if they do not know the person and even if they do not benefit directly themselves. Public spending on health partly reflects such externalities. Existence value is most readily applied to children, whom society typically protects more than adults. In contrast, caring externalities for adults almost directly contradict the notion of consumer sovereignty.

'Clearly, caring externalities differ across cultures and countries, depending among other things on the importance society assigns to individual sovereignty. Non-smokers may be willing to subsidise efforts to prevent people taking up smoking or efforts to help smokers quit. They may also be prepared to contribute towards the care of sick smokers, even when these represent a financial burden. However, their attitudes may change over time as knowledge about the health effects of smoking becomes more widespread and non-smokers' tolerance for smokers may decline. In any case, there is little solid information of such willingness, so it is difficult to use it to formulate public policies.

Conclusion

'In principle, the regulation of tobacco can be justified on the basis of the twin market failures of information asymmetries (i.e., where people lack adequate information to make optimal decisions) and negative externalities (where the costs of smoking are borne by non-smokers).