NATIONAL HEART FOUNDATION WA DIVISION
SUBMISSION TO
THE STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS
ON SUBSTANCE ABUSE IN AUSTRALIAN COMMUNITIES

TOBACCO: AUSTRALIA'S MAJOR SUBSTANCE ABUSE PROBLEM

1. MAGNITUDE OF THE PROBLEM *

Cigarette smoking is the single largest preventable cause of death and illness in the Western world.[1] Consumption of tobacco diminishes quality of life, causes premature death and places a huge financial strain on the community.

Worldwide, smoking kills 3 million people each year and this number is increasing.[2] In developed countries, smoking is responsible for about 2 million deaths per year. If current smoking patterns continue that toll will have risen to 10 million deaths a year by 2025.[3] No responsible Government would allow the sale of tobacco products if there were invented today, since up to half of all regular smokers will die eventually of tobacco-caused diseases. Of those that die of smoking-caused disease, approximately half will die in middle age, that is between 36 and 69 years of age.[4] Disturbingly, the prevalence of smoking is rising rapidly in many developing countries. If these patterns of smoking continue, tobacco will become the largest cause of premature death in the world.

In Australia, tobacco causes over 18,000 avoidable deaths each year, and is responsible for 82% of all deaths caused by drugs.[5] In Western Australia, tobacco kills over 1,400 people a year.[6] Cancer makes up around 35% of all deaths caused by smoking.[4] This includes cancer of the lung, larynx, mouth, oesophagus and pharynx.[7] Of all the deaths caused by lung cancer in Australia, over 80% are attributable to smoking.

The consequences of smoking to health are many and varied. They include not only cancers but cardiovascular disease and respiratory diseases. Smokers have a 70% greater risk of death from coronary heart disease than non-smokers.[8] Tobacco use is accountable for a large proportion of heart attacks among younger cigarette smokers,

[1] Petro R, Boreham J, Lopez A. Mortality from smoking in developed countries 1950 – 2000. Oxford University Press, 1994.
[2] Peto R. Smoking and death: The past 40 years and the next 40. BMJ 1994; 309: 937 – 938.
[3] Davis RM. Slowing the march of the Marlboro Man. BMJ 1994;309; 889-890.
[4] Doll R, Peto R, Wheatley K, Gray R, Sutherland J. Mortality in relation to smoking: Forty years' observations on male British doctors. BMJ 1994; 309: 901 – 911.
[5] English D, Holman CDJ, Milne et al. The quantification of drug-caused morbidity and mortality in Australia. Commonwealth Department of Human Services and Health, Canberra, 1995.
[6] Health Information Centre. The impact of tobacco smoking on health in Western Australia 1984 – 1995. Health Department of Western Australia, June 1997.
[7] US Department of Health and Human Services. The Health Consequences of Smoking – Cancer: A Report of the Surgeon General. Rockville: US Department of Health and Human Services, 1982.
[8] US Department of Health and Human Services. The Health Consequences of Smoking: Cardiovascular Disease. A Report of the Surgeon General. Rockville, Maryland: Public Health Service, Office on Smoking and Health.

both male and female, who would otherwise be at low risk of coronary heart disease.[9] In Australia in 1992, there were 7,265 deaths due to smoking-caused cardiovascular disease.[5] This represented 13% of deaths from cardiovascular disease, 6% of deaths from all causes, and 38% of tobacco-caused deaths in 1992. In the same year, tobacco caused the loss of 88,200 person years of life (before the age of 70 years) and was responsible for 3.4% of total hospital episodes and 4.9% of total hospital bed-days.

2. COSTS OF SMOKING TO THE COMMUNITY *

It was estimated that in 1992, smoking cost the Australian community $12,736 million.[10] Of the tangible costs, 58% are borne by the individual, 35% by business and 7% by Government. This estimate includes direct and indirect health costs, tangible and intangible costs and costs attributed to passive smoking. Proportionally, the cost of smoking in WA for 1992 would have been $1,339 million, equating to an annual cost of $4,097 per smoker in this Sate. Added to these economic costs is the emotional and psychological price paid for smoking. As noted by Australian health economists Collins and Lapsley (1996), pain and suffering cannot be costed in dollar terms but this in no way diminishes the significance of such immeasurable costs.

3. PREVALENCE OF SMOKING IN WA *

Smoking prevalence among Western Australian adults decreased by 20% between 1983 and 1991 (down from 31.8% to 25.1%[11]), but has not changed significantly since 1991. In Western Australia in 1997, 28.5% of adult men and 21.6% of adult women were reported to be smokers. [12]

The prevalence of smoking is higher among specific groups such as people from lower socio-economic backgrounds, young men and Aboriginal people (Table 1). Other groups within the Western Australian population which have a disturbingly high prevalence of smoking include youth and pregnant women. Smoking by pregnant women continues to be a concern because of the health consequences of maternal smoking to the unborn child.

Youth smoking is a priority area as almost all adult smokers begin smoking in adolescence. While the prevalence of smoking among adults has steadily declined in the past decade, there has been relatively little change in the prevalence of smoking among young people. In 1996, 14% of school boys and 17.4% of school girls aged

[9] Parish S, Collins R, Peto R et al for the International Studies of Infarc Survival (ISIS) Collaborators 1995. Cigarette smoking, tar yields, and non-fatal myocardial infarction: 14000 cases and 32000 controls in the United Kingdom. BMJ 1995; 311:471-477

[10] Colins D, Lapsley H. The social costs of drug abuse in Australia in 1998 and 1992. National Drug Strategy Monograph Series No. 30, 1996.

[11] Health Promotion Services Smoking and Health in Western Australia, 1996 Resource Book. Health Promotion Services, Health Department of Western Australia, Perth, 1997.

[12] Health Promotion Services. 1997 Tobacco, alcohol and illicit drug consumption survey. Health Promotion Services, Health Department of Western Australia 1997.

between 12-15 years, and 29.2% of school girls and 24.5% of school boys between 16-17 years reported that they had smoked at least one cigarette in the last week.[13]

Smoking by indigenous Australians is also a major concern. The prevalence of smoking among Australian Aborigines is almost twice the national average.[14] Aboriginal males are admitted to hospital at more than twice the rate of non-Aboriginal males, while Aboriginal females are admitted at 4.7 times the rate of non-Aboriginal females.[15] Also, tobacco caused illnesses occurs at a younger age in Aboriginal people.

Table 1 Prevalence of smoking within the Western Australian population

Target groups	**prevalence**
Adults (over 18 years)	25.1%[9]
Young men (18-29 years)	36%[9]
Young women (18-29)	27.5%[9]
12-17-year-old secondary students	18.1%[10]
Pregnant women (first trimester)	26%[16]
Aboriginal adults (over 18 years)	48%[12]
Adults males (year 10 or less education)	36.5%[9]

4. WHY DO YOUNG PEOPLE START SMOKING ?

> **"**If the last 10 years have taught us anything, it is that the industry is dominated by the companies who respond most effectively to needs of the younger smokers".[17]

Every year in Australia 70,000 teenagers take up smoking.[18] A person who has not started smoking as a teenager is unlikely to become a regular smoker.[19] Children are the tobacco industry's primary source of new customers, replacing adult smokers who have quit or died as a result of their smoking.

[13] Health Promotion Services. Cigarette consumption among Western Australian Secondary School Students in 1996. Centre for Behavioural Research in Cancer and Health Department of Western Australia, 1997.
[14] Aboriginal and Torres Strait Islander Survey, Australian Bureau of Statistics, Perth, 1994.
[15] McLennan W, Madden R. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. Australian Bureau of Statistics and Australian Bureau of Health and Welfare. Australian Government Publishing Service, 1997.
[16] Kurinczuk J, Parsons D E. The Western Australian Pregnancy and Infancy Survey. A short report for the Health Promotion Branch of the Health Department of Western Australia, TVW Telethon Institute of Child Health Research, 1995.
[17] Overall market conditions – F88. 1988 Imperial Tobacco Ltd marketing plan. Vancouver, B.C. Canada: Imperial Tobacco. 1988:6.
[18] Armstrong BK, Daube MD, Shean RE. A Smokefree Australia-Our Bicentenary Resolution?. MJA 1988;149: 1-2.
[19] Department of Health and Human Services. Preventing Tobacco Use Among Young People: A report of the US Surgeon General. Alanta, Georgia: US Department of Health and Human Services, Public Health Service, Centre for Disease Control and Prevention, National Centre for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 1994.

A most recent review by the Royal College of Physicians of London[20] has confirmed that nicotine is as addictive as other "hard" drugs such as heroin. The modern cigarette is nothing more than an efficient nicotine delivery device. The review has provided further evidence on what has been known for some time: smokers start smoking when children, and are addicted to nicotine by the time they are adults. A substantial majority of adults would like to quit smoking, and about one third try each year, but only 1-2% succeeds.

In 1994, The US Surgeon General conducted a comprehensive review of the issues surrounding young people and smoking [19]. The report reached six major conclusions:

- "Nearly all first use of tobacco occurs before high school graduation; this finding suggests that if adolescents can be kept tobacco free, most will never start using tobacco.

- Most adolescent smokers are addicted to nicotine and report that they want to quit but are unable to do so; they experience withdrawal symptoms and relapse rates similar to those reported by adults.

- **Tobacco is often the first drug used by those young people who use alcohol, marijuana and other drugs.**

- Adolescents with lower levels of school achievement, fewer skills to resist persuasive influences to use tobacco, friends who use tobacco, and lower self-images are more likely than their peers to use tobacco.

- Cigarette advertising appears to increase young people's risk of smoking by affecting perceptions of the persuasiveness, image and function of smoking.

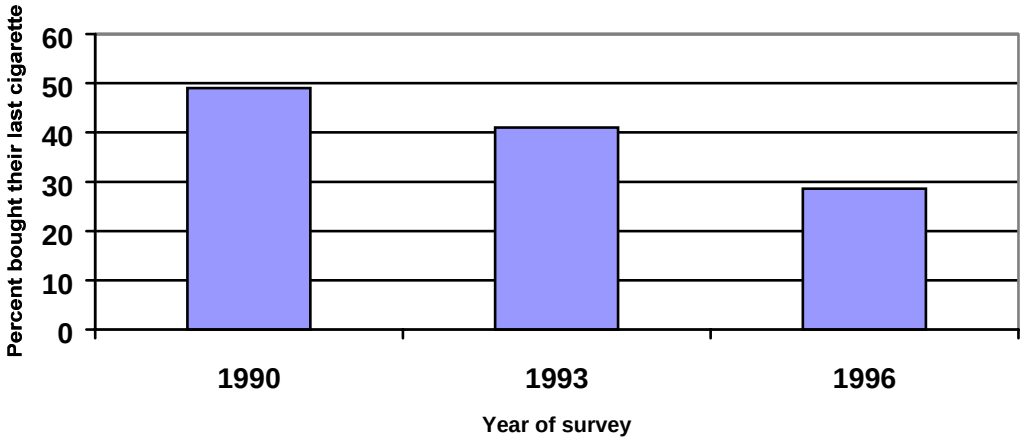
- Community-wide efforts, which include tobacco tax increases, enforcement of minors' access laws, youth-oriented mass media campaigns, and school-based tobacco use prevention programs, are successful in reducing adolescent use of tobacco."

Limiting access by young people to tobacco is an important component of a comprehensive approach to reducing the prevalence of smoking in this important group.

In Western Australia, the Health Department has conducted regular surveys to measure the willingness of retailers to sell cigarettes to young people. In 1992, 1994, and 1996 surveys in the Perth metropolitan area found that the proportion of retailers prepared to sell cigarettes to children dropped from 89% in 1992 to 28% in 1994, and fell to 20% in 1996.[21] However, a similar survey conducted in 1999 by the Australian Council on Smoking and Health revealed that 50% of retailers were willing to sell to two fifteen year olds who looked young for their age.[22]

[20] Moxham J. Nicotine Addiction. BMJ 2000; 320: 391-392.
[21] Health Department of Western Australian. Personal Communication.
[22] The West Australian. 17 July 1999.

The Health Department also conducts regular surveys of smoking prevalence among young people that measures how they obtain cigarettes.[13] In 1996, 28% of students who were current smokers bought their last cigarette. Friends were the single most common source of cigarettes (boys 29.8%, girls 49.6%). This reflects a change from 1993, when overall, 41% student smokers bought their last cigarette and friends accounted for the most common source among 35% of males and 37% of female smokers.



The graph above shows the proportion of students who bought their last cigarette. The graph indicates a drop in the number of children who purchased their last cigarette in 1996 compared with the previous two surveys. During the same period, the supply of cigarettes from friends represented an increasingly important source of cigarettes for young people and indicates that illegal sales had been somewhat restricted. In 1996, the most common retail outlets were milkbars/delis, supermarkets and newsagents. Disturbingly, 14.2% of boys and 6% of girls reported buying single cigarettes from retail outlets despite this being illegal in Western Australia.

Vending machines are also a source of cigarettes for younger people. Among boys who smoked in the last week, 3.1% purchased their last cigarette from a vending machine compared to 0.8% for girls. The Australian Council on Smoking and Health has conducted surveys to determine whether children found it difficult to obtain cigarettes from vending machines located on licensed premises.[23] In both surveys children obtained cigarettes from vending machines on licensed premises with ease.

The number of retail outlets which sell tobacco is also a major concern for those committed to improving public health. It is estimated that in Western Australian there are approximately 5000 retailers who sell cigarettes, but the exact figure is unknown. The availability of cigarettes on almost every street corner throughout the community is inconsistent with a product that kills one half of its consumers when used as the manufacturers intend.

In summary, a significant proportion of children obtains cigarettes through illegal sales from retail outlets. From 1992 to 1996 there was an encouraging reduction in the number of retailers willing to sell cigarettes to children. However, by 1999 this

[23] The West Australian. June 7, 1997 p 44.

positive trend seems to have reversed. And children can easily obtain cigarettes from vending machines located on licensed premises in this State.

5. SHOULD RETAILERS BE LICENSED TO SELL TOBACCO PRODUCTS?

In 1995, the Australian Senate Community Affairs References Committee completed a comprehensive review of the tobacco industry and the costs of tobacco related disease.[24] The Committee made 39 recommendations designed to lessen the impact of tobacco caused disease in the Australian community. Recommendations 25 and 26 related directly to retail outlet's:

"Recommendation 25: That there be a reduction in the number of retail outlets permitted to sell tobacco products and that:

- *As and interim measure, tobacco products be isolated from other products for sale in all outlets currently selling tobacco products; and*
- *In the longer term, those retail outlets permitted to sell tobacco products be restricted to licensed premises and to tobacconists; and that this be phased in to minimise any disruption to small business.*

Recommendation 26: That the licensing systems in all States and Territories provide for the suspension or revocation of a licence where retail outlets sell tobacco products to minors."

Licensing of retailers and wholesalers would achieve compliance with tobacco control legislation, especially as it appears that education and information has failed. Licensing was acknowledged to be the most effective and efficient way to monitor restricted sales. It conveys authority because the right to sell tobacco products can be removed by withdrawal of the licence.

Thus far, the ACT is the first State or Territory government to implement tobacco licensing based on the recommendations of the Senate Community Affairs References Committee. The Tasmanian Cabinet has agreed to introduce legislation that will license tobacco retailers with the aim of reducing sales to minors. It is appropriate to note also that the Draft National Tobacco Strategy has recommended that each jurisdiction in Australia review the feasibility and potential public health benefits of registration schemes for tobacco outlets.[25]

Members of the retail industry have advocated for it to be an offence for children to purchase tobacco products. This proposal was canvassed by legal consultants Minter Ellison Northmore Hale as part of their review of the Western Australian Tobacco Control Act 1990, and rejected.[26] It is the Heart Foundation's strong view that such a proposal would not be appropriate. Such a prohibition would remove the

[24] Report of the Senate Community Affairs References Committee into the Tobacco Industry and the Costs of Tobacco Related Illness. Commonwealth Government Publishing Service. December 1995.
[25] National Expert Advisory Committee on Tobacco. Draft National Tobacco Strategy 1999-2002-03: A Framework for National Action. A paper prepared for the Ministerial Council on Drug Strategy. June 1999.
[26] Minter Ellison Northmore Hale. Final Report: Review of the Operation of the Tobacco Control Act 1990. February 1995

responsibility for not selling tobacco products from retailers and the tobacco industry and place in unfairly on children. It would also inappropriately divert scarce law enforcement resources.

6. THE NEED FOR A COMPREHENSIVE APPROACH

It is widely accepted in the public health community that no single measure is sufficient to produce a dramatic decline in smoking. Twenty years ago the International Union Against Cancer (UICC) recommended that tobacco control programs need to adopt a comprehensive, tri-partite strategy[27]. This strategy must include education for prevention, enforcement of legislation and support for smoking cessation.

While the end goal of any tobacco control program is to reduce death and disease caused by smoking, any comprehensive approach will necessarily include: encouraging smokers to quit, maintaining the non-smoking status of non-smokers, preventing children from taking up smoking and ensuring the rights of non-smokers to breathe clean air.

Specific strategies designed to reduce the access of children to tobacco products will be an important component of a comprehensive approach. However, it is totally unrealistic to expect that strategies to reduce access to tobacco products by minors will, in isolation, reduce the prevalence of smoking by young people.

Consequently, the Heart Foundation's WA Division recommends the adoption of a comprehensive 10 point plan for tobacco control in which retail tobacco outlets would be licensed (see below).[28]

TABLE 1: Ten priorities for tobacco control in Western Australia

	Issue	Initiative	Comment
1.	Public spaces and workplaces	Comprehensive smoke-free policies	Will reduce passive smoking, increase cessation, and remove role models from children's view. Would require a new head of power in the Tobacco Control Act.
2.	Point of sale	Tobacco products made an under-the-counter item with no point-of-sale advertising	Part of a comprehensive smoke-free message; partial control already instituted in Tasmania.
3.	Public education	Adequate funding for general and school education on tobacco	Match the Californian commitment of US$5 per head per annum through a State levy on sales of tobacco products.

[27] Gray N, Daube M. Guidelines for smoking control-2nd edition. Geneva: UICC Technical Report Services, 1980.
[28] Jamrozik K. Priorities for Tobacco Control in Western Australia. Department of Public Health, University of Western Australia, 1999.

4.	Probity in public pronounce-ments	Penalise misleading public statements about tobacco and the tobacco industry	The precedent established in Tasmania needs to be included in local legislation and enforced vigorously.
5.	Price	Regular increases in real price	Will reduce consumption in adolescents particularly, but also in adults.
6.	Promotion	End to exemptions for sporting events and to product placement	Part of a comprehensive smoke-free message; avoids corruption in government.
7.	Prosecution	Increase and publicise efforts to enforce legislation	Law should be of "three strikes and you're out" type; publicity has an important "knock-on effect".
8.	Poisons Act	Remove exemption for nicotine in tobacco	Regulate nicotine content of tobacco and other products for human use under tobacco control legislation.
9.	Packaging	Move to generic packaging	Trademarks are respected but their use is restricted.
10.	Proven treatments	Subsidise aids to cessation that are of proven efficacy	Nicotine patches and other proven treatments should be available to smokers at affordable cost; will require a national effort through AHMC.

Further, Western Australia should adopt a system of licenses for tobacco retailers and a “three strikes and you’re out” provision. In other words, a first offence regarding sales to minors would result in an official warning, a second is prosecuted and a third leads to suspension for at least one year of the licence to sell tobacco.

However, these measures will not be effective without the implementation of a range of other strategies that need to be provided with adequate resources as summarised in the table above.

7. PUBLIC EDUCATION

Major public education campaigns using commercial advertising and media schedules have been implemented in NSW, Western Australia and Victoria since the early 1980s. More recently, the National Tobacco Campaign has successfully implemented a national tobacco and health public education campaign supported by smoking cessation services.

Unfortunately these efforts have been woefully under-resourced. We spend, if we are lucky, just over 50 cents a head around the country trying to reduce the 18,000 deaths a year caused by smoking.

A recent report on the Massachusetts Tobacco Control Program[29] has confirmed that when community-wide tobacco control programs are provided with adequate resources, in this case about $39 million (US) per year for a population of 6 million people, the prevalence of smoking can be reduced in both adults and children[30].

It is appropriate in this context to examine the Federal Government funding for tobacco control in Australia relative to funding for other public health issues. Set out below is a table that does this[31]

1: Recent federal budget commitments to major public health programs (average annual commitments for 1994-95 to 2002-03), compared with deaths from associated causes, 1998

	Average committed per year ($ million)	No. of deaths in 1998[11,12]	Amount ($) committed per death
Black-spot road safety program[5]	38.1	1942	19619
AIDS contro[l6]	49.5	187	264706
Breast cancer[7]	51.6	2558	20172
Cervical cancer program[6]	10.5	302	34603
Illicit drugs			
National Drug Strategy[7]	36.6	630	58095
National Illicit Drug Strategy[8-10]	74.7	630	118571
Asthma management[10]	3.1	685	4525
Preventing falls[10]	1.7	1182	1438
Tobacco (Health Australia) Tobacco Harm Minimisation 1995-1998[6]	6.1	18224	337
National Tobacco Campaign Tobacco Harm Minimisation 1999-2002[9]	2.0	18224	112

It is clear that the funding for tobacco control in this country is appallingly neglected. One may also argue that by comparison, little evidence exists for policy or program effectiveness to support the much larger expenditure allocated to the important area of illicit drug prevention.

* ***These sections of this Submission are largely based on: A Submission to the State Cancer Services Planning Committee (WA), Working Party on the Primary Prevention of Cancer, prepared by Associate Professor Konrad Jamrozik, Department of Public Health, University of Western Australia.***

[29] Bierner L, Harris JE, Hamilton W. Impact of the Massachusetts tobacco control program: population based trend analysis. BMJ 2000;321:351-354.
[30] Media Release. June 28, 2000. Executive Office of Health and Human Services, Department of Public Health, Boston, Massachusetts.
[31] Chapman S. Tough on Drugs—Weak on Tobacco, MJA 2000; 172:612-614