# 6

# Tobacco: prevention and cessation

> … Tobacco smoking is highly addictive: many users are unable to voluntarily cease use, even when aware of the harm tobacco causes.[1]

6.1 The statistics on tobacco availability, its use, public perceptions of the acceptability of its use, and the costs of smoking to the community are frightening.[2]

## Prevalence

6.2 The National Drug Strategy (NDS) Household Survey revealed that in 2001 tobacco was the second most accessible drug to Australians. One in every two people aged 14 years or over had been offered tobacco or had the opportunity to use it in the previous 12 months (57.2 per cent).

6.3 Nearly a quarter of the Australian population aged 14 years or older were smokers in 2001 (23.2 per cent), more than a quarter were ex-smokers (26.2 per cent) and about half (50.6 per cent) had never smoked. Four out of five current smokers smoked on a daily basis. The proportion that smoked daily decreased slightly between 1998 and 2001 (from 21.8 per cent to 19.5 per cent).

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1 VicHealth Centre for Tobacco Control, *Tobacco control: a blue chip investment in public health – overview document*, Anti-Cancer Council of Victoria, Melbourne, June 2001, p 3.

2 The statistics in the next section of this chapter are taken from Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, Drugs statistics series no 9, AIHW, Canberra, May 2002, pp xiii, 3-6, 11-12, 14; Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, Drugs statistics series no 11, AIHW, Canberra, December 2002, pp xx, 20, 22-23, 24-26.

6.4 The 2001 NDS Household Survey reported that the mean age at which Australians reported having first used tobacco was 15.5 years; this figure had remained relatively stable from 1993 to 2001. In 2001 smoking rates peaked in the 20-29 years age group, 33.0 per cent of whom smoked. The lowest proportion of smokers was in the 60+ year age group with 9.7 per cent smoking. One in five teenagers (20.3 per cent) smoked tobacco with females slightly more likely (16.2 per cent) than males (14.1 per cent) to be daily smokers. For all other ages, males had higher smoking rates than females. However, a February 2002 study by McDermott, Russell and Dobson, entitled *Cigarette smoking among women in Australia,* revealed that 'Current figures suggest that within the next decade smoking will be more common among women than men'[3].

6.5 The mean number of cigarettes smoked per week by smokers in 2001 was 109.4 with the number increasing with age until the 50-59 age group (140.3 cigarettes). On average males smoked 111.8 cigarettes per week compared with 106.5 for females. Teenagers smoked on average 71.7 cigarettes per week. Recent smokers spent an average of $41.84 on tobacco weekly; manufactured cigarettes were the most commonly used form of tobacco.

6.6 In 2001 nearly half of all Indigenous Australians smoked (49.9 per cent), a proportion more than twice as great as non-Indigenous Australians smokers (22.8 per cent). The average number of cigarettes they smoked per week was also higher (125.4 compared with 108.3 respectively).

6.7 In the past 12 months a third of smokers (34.2 per cent) had reduced the amount of tobacco smoked per day. For both male and female smokers, cost and effect on health or fitness were the main motivators for change in smoking behaviour.

6.8 The VicHealth Centre for Tobacco Control (VCTC) noted tobacco smoking often goes hand in hand with other addictions.[4]

## Costs

6.9 Canberra ASH Inc pointed out that 'Tobacco is harmful when used as intended …'[5] The Australian Institute of Health and Welfare (AIHW) has

3 McDermott L, Russell A & Dobson A, *Cigarette smoking among women in Australia,* National Tobacco Strategy 1999 to 2002-03 occasional paper, Commonwealth Department of Health and Ageing, Canberra, February 2002, p 11.

4 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 3.

shown of all risk factors for disease, tobacco smoking is responsible for the greatest burden on the health of Australians. It is a major risk factor for various cancers, coronary heart disease, stroke, peripheral vascular disease and a number of other diseases and conditions.[6] McDermott et al pointed out that their projection that within the next decade smoking will become more common among women than men, has implications for women's health for many years to come.[7]

6.10 Collins and Lapsley found that in 1998-99, 19,429 deaths and 965,433 hospital beddays were attributable to tobacco smoking (both active and involuntary[8]). This was more deaths and beddays than were attributed to alcohol and illicit drug use combined. However, in recent years the number of deaths attributed to tobacco smoking has declined slightly, although the number of hospital separations has increased. Total hospital costs attributable to tobacco smoking were estimated to be $718.4 million in 1998-99.[9]

6.11 According to Collins and Lapsley, 224 deaths, 77,950 beddays and $47.6 million in hospital costs were attributable to involuntary smoking, and it was apparent that a high proportion of these costs were imposed on the young. Conditions attributable to involuntary smoking are antepartum haemorrhage, hypertension in pregnancy, low birthweight, premature rupture of membranes, SIDS, childhood asthma and lower respiratory illness (under 18 months). In 1998-99 the under 15s (the young) accounted for 45.7 per cent of deaths, 96.6 per cent of hospital bed days and 94.8 per cent of hospital costs attributable to involuntary tobacco smoking.[10] McDermott et al reported that 'women and their children remain at risk of exposure to ETS [Environmental Tobacco Smoke] at home'[11]. It is clear that smokers inflict great damage on their own and other's children.

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5 Canberra ASH Inc, sub 225, pp 1-2.

6 Australian Institute of Health and Welfare, *Australia's health 2002: The eighth biennial health report of the AIHW*, AIHW, Canberra, May 2002, p 134.

7 McDermott L, Russell A & Dobson A, p 11.

8 Collins and Lapsley disaggregate the costs of smoking into active and involuntary components. They use the term 'involuntary smoking' rather than passive smoking or sidestream smoke or environmental tobacco smoke. Medical conditions attributable to active smoking occur as a result of smokers inflicting adverse health effects on themselves. Conditions attributable to involuntary smoking occur when smokers inflict adverse health effects on others (including the unborn). Collins DJ & Lapsley HM, *Counting the cost: estimates of the social costs of drug abuse in Australia 1998-9,* Monograph series no 49, Commonwealth Department of Health and Ageing, Canberra, December 2002, p 23.

9 Collins DJ & Lapsley HM, pp 11, 50; Australian Institute of Health and Welfare, *Australia's health 2002*, p 134.

10 Collins DJ & Lapsley HM, pp 4, 51.

*11* McDermott L, Russell A & Dobson A, p 12.

6.12 Collins and Lapsley estimated that in 1998-99 the cost of providing health care for diseases attributable to tobacco abuse was $1,094.9 million. This represented some 79 per cent of the total cost of providing health care for the abuse of all drugs examined ($1,389.1 million). It was also estimated that $472.8 million or about 43 per cent of the health care costs attributable to tobacco could have been avoided if effective anti-tobacco policies and programs had been in place.[12]

## Perceptions of the problem and support of policy measures

6.13 The 2001 NDS Household Survey revealed that despite the above health facts, tobacco was primarily associated with a drug 'problem' by only 2.7 per cent of Australians aged 14 years or over (down from 4.2 per cent in 1998). Of the people surveyed, 39.7 per cent accepted the regular use of tobacco by adults. However, tobacco smoking was identified by 44.5 per cent of Australians as the main drug associated with mortality in Australia. It was the second most likely form of drug use to be nominated as a serious concern for the community.[13]

6.14 The 2001 NDS Household Survey also revealed that between 1998 and 2001, public support for measures to reduce the problems associated with tobacco remained strong and had increased. The greatest support (91.2 per cent of Australians aged 14 years or over) was for 'stricter enforcement of laws against supplying tobacco products to minors'. The greatest relative percentage increase in support was for 'banning smoking in clubs/pubs', which increased from 50.0 per cent in 1998 to 60.8 per cent in 2001. The lowest level of support, while still relatively high at 60 per cent, was for 'making it harder to buy tobacco in shops'. There was greater support for all these measures among females than males.[14]

12 Collins DJ & Lapsley HM, pp x, 60.

13 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 7-8; Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, pp 5-7.

14 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, pp 34-35.

## Government and non-government sectors working together

6.15 Given the health costs of tobacco smoking, it is widely recognised that tobacco control is a good investment for government. The National Tobacco Strategy stated 'Tobacco smoking … remains the single largest preventable cause of premature death and disease in Australia'.[15]

6.16 The current framework for national action on tobacco is the *National Tobacco Strategy 1999 to 2002-03*. It operates as part of the NDS and was endorsed by the Ministerial Council on Drug Strategy in June 1999. The National Tobacco Strategy provides a framework for the development and implementation of tobacco control activities at the national and jurisdictional levels. It is a 'national strategy' as opposed to a 'Commonwealth strategy' and aims to provide leadership while maintaining flexibility for each jurisdiction and non-government sector to ensure each group can respond to their needs and priorities. It builds on four decades of state, territory, Commonwealth, national and international experience with tobacco control initiatives.[16] The goals, objectives, key strategy areas and examples of action issues are set out in Box 6.1.

6.17 Under the strategy, state and territory governments have developed tobacco action plans, for example the Northern Territory has developed the 2000-2004 Tobacco Strategic Plan and Tasmania has the Tasmanian Drug Strategic Plan 2001-04.[17] The National Tobacco Strategy also allows for more detailed action plans for specific targeted population groups such as Aboriginal and Torres Strait Islander people, children and young people under 18 years of age, and pregnant women and their partners.[18]

6.18 Built into the strategy is an approach for developing an evaluation plan, an annual reporting system for state, territory and the Commonwealth governments, and performance measures to assess progress and the success of the strategy. A more detailed review by the Commonwealth government of the whole strategy will be undertaken in 2003-04.[19]

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15 *National Tobacco Strategy 1999 to 2002-03: A framework for actio*n, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, June 1999, p 1.

16 *National Tobacco Strategy 1999 to 2002-03: A framework for action*, p 1.

17 Tasmanian Department of Health and Human Services, transcript, 14/6/01, p 1064; Northern Territory Health Services, sub 44, p 8.

18 *National Tobacco Strategy 1999 to 2002-03: A framework for actio*n, pp 2-3.

19 *National Tobacco Strategy 1999 to 2002-03: A framework for action*, pp 3-4.

**Box 6.1 National Tobacco Strategy: Goals, objectives and key strategies**

***Strategy Goal***

To improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms.

***Strategy Objectives***

1. Prevent the uptake of tobacco use in non-smokers, especially children and young people.
2. Reduce the number of users of tobacco products.
3. Reduce the exposure of users to the harmful health consequences of tobacco products.
4. Reduce exposure to tobacco smoke.

***Six Key Strategy Areas*** *(including examples of action issues)*

1. Strengthening community action

(*eg public education campaigns, school education programs, prevention programs, provision of public information on harm effects, health warnings)*

2. Promoting cessation of tobacco use

(*eg professional education to assist health professionals help smokers quit, resources and services to help and provide incentives for smokers to quit, cessation programs)*

3. Reducing availability and supply of tobacco

*(eg reduction in affordability of tobacco products, reduction in illegal sale and supply to minors)*

4. Reducing tobacco promotion

*(eg reduction in advertising through legislation eg in films, TV, video clips, print; reduction of point of sale advertising; reduction in use of tobacco products as marketing tools; removal of tobacco sponsorship of sporting and cultural events)*

5. Regulating tobacco

*(eg disclosure of tobacco ingredients including additives, identification of cigarette yields, reduction of nicotine dependency)*

6. Reducing exposure to environmental tobacco smoke

*(eg establishment of smoke free environments; increasing public awareness and understanding of health risks)*

*Source: National Tobacco Strategy 1999 to 2002-03: A framework for action, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, December 1999, pp 2, 12-15, 18-21, 24-25, 28-31, 34-35, 38-39.*

6.19 The Commonwealth Department of Health and Ageing advised that responsibility for tobacco control is divided between the Commonwealth, state and territory governments.

- The Commonwealth government has direct responsibility under the National Tobacco Strategy for health warnings on tobacco packaging, tobacco taxation, measures against illicit trade, federal advertising and sponsorship restrictions, national social marketing effort, and policy leadership. It also schedules smoking cessation therapies.
- The states and territories are responsible for direct cessation services to smokers, regulation of retailers, passive smoking laws and preventing sales to minors. Some states also run their own social marketing campaigns in addition to their partnership in the National Tobacco Campaign, for example, the Victorian Smoking and Health Program (QUIT). Western Australia is recognised as a leader in public education campaigns that have targeted smoking through QUIT and other programs.[20]

6.20 The Commonwealth Department of Health and Ageing stated that Commonwealth funding for tobacco-related activity (including the National Tobacco Campaign) has been $5.14 million, $4.1 million and $5.1 million, respectively in the financial years 1999-2000, 2000-01 and 2001-02. That figure does not include the subsidy provided for Zyban under the Pharmaceutical Benefits Scheme, which was $29.1 million in 2001-02, according to Health Insurance Commission data. The Department also advised that, while there are no official estimates of the amounts spent by the states and territories, it is believed to be in excess of $10 million per year (not including funding to some non-government organisations such as health promotion foundations).[21]

6.21 The strategies for dealing with tobacco smoking continue to evolve. In June 2002 the Commonwealth Department of Health and Ageing reported the following recent initiatives:

- continued funding of the National Tobacco Campaign – according to the department, an evaluation indicated a decrease in smoking prevalence of 4.2 per cent among smokers aged 18 years and over between the commencement of the campaign in May 1997 and November 2001;
- amendment of the *Tobacco Advertising Prohibition Act 1992* to ban tobacco advertising at international sporting events from 1 October 2006;

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20 Commonwealth Department of Health and Ageing, sub 292, p 5; Victorian government, sub 166, p 3; Western Australian government, sub 115, p 2.

21 Commonwealth Department of Health and Ageing, sub 292, pp 4-5.

- in May 2002 initiation of a review of the Tobacco Advertising Prohibition Act;
- voluntary agreement with the three Australian cigarette manufacturers to disclose ingredients in Australian cigarettes;
- a review of health warnings on cigarette packets with new regulations expected to be in place in mid-late 2003;
- a review leading to the development of Australian smoking cessation guidelines for health professionals;
- from May 2002 establishment of a clearinghouse for information on Indigenous tobacco control, development of strategies aimed at Indigenous health workers and development of culturally appropriate tobacco control resources; and
- continuation of Australia's significant international role in the World Health Organisation's (WHO) Framework Convention on Tobacco Control and its support for the WHO Tobacco Free Initiative.[22] In late May 2003 all members of the WHO unanimously adopted the Framework Convention on Tobacco Control.[23]

## Some future directions for prevention and treatment

6.22 From evidence to the committee it is clear that there is no room for complacency in dealing with this major health problem and that more remains to be done. For example, in June 2000 Alcohol and other Drugs Council of Australia (ADCA) sought an additional objective and strategies for the National Tobacco Strategy. The proposed objective was to improve consumer understanding of the health risks of tobacco smoke; to change individual and societal attitudes to smoking; and to reduce dangers posed by tobacco products through five strategies.[24]

6.23 Further, in June 2001 the VCTC issued a detailed practical agenda on tobacco control for consideration and action by Australian governments and all political parties. The agenda's objective was to markedly reduce the social costs of tobacco use in Australia. The agenda listed several new policies and programs, provided guidance for making some existing

22 Commonwealth Department of Health and Ageing, sub 238, pp 19-21.

23 The Hon T Worth MP, Parliamentary Secretary for Health and Ageing, *Australia welcomes world agreement on tobacco control*, media release, 25/5/03, 2p.

24 Alcohol and other Drugs Council of Australia, *Drug policy 2000: A new agenda for harm reduction*, ADCA, Canberra, June 2000, pp 58-59.

programs more cost effective, and estimated the costs and benefits to the community of the proposals. It suggested that the cost to the Commonwealth government of the proposed programs would be about $97 million per annum for three years, and provided options for financing the package.[25] The agenda was endorsed by 11 peak Australian health non-government organisations.[26]

6.24 In the following sections this committee has considered further actions for dealing with the problems of tobacco smoking under the six key strategy areas identified in the National Tobacco Strategy. As there is a close link between prevention and treatment activities for tobacco smoking, the discussion of these two matters is integrated.

## Strengthening community action

6.25 Despite the success previously outlined of the National Tobacco Campaign, some groups sought further improvement of anti-smoking campaigns. Among their suggestions were that anti-smoking programs should target the whole community from adults through to infants, complemented by sustained efforts by community groups at a local level. These local initiatives should directly involve young people in developing and implementing appropriate strategies. Governments should continue to develop strategies for increasing awareness among young women of the effects of tobacco products.[27] The study by McDermott et al suggested that‘ The benefits to women in particular, of quitting smoking should be emphasised in mass media campaigns and their concern about weight gain taken into account.’[28] The VCTC stated programs should:

> … ensure that smokers and potential smokers from all age and social groups fully understand and appreciate all of the major risks associated with smoking – over 50 different diseases; the personal devastation caused to the families and friends of those who die from smoking-related diseases; the disability that can be caused by smoking related diseases, and the impact this has on quality of life;

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25 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* pp 3-8.

26 The organisations are: Action on Smoking and Health Australia; Alcohol and other Drugs Council of Australia; Australasian Faculty of Public Health Medicine; Australian Council on Smoking and Health; National Asthma Campaign; National Heart Foundation; Public Health Association of Australia; The Cancer Council Australia; Australian Lung Foundation; Thoracic Society of Australia and New Zealand; and VicHealth Centre for Tobacco Control (VicHealth Centre for Tobacco Control, p 2).

27 Alcohol and other Drugs Council of Australia, sub 61, p 20; Hill D, transcript, 15/8/02, pp 1083, 1084.

28 McDermott L, Russell A & Dobson A, p 15.

> the addictiveness of tobacco; the various strategies that can be effective when giving up, and the help that is available.[29]

6.26 The VCTC stressed the need for commercially realistic funding for public education.[30] The National Heart Foundation (WA Division) stated that by comparison with other major public health problems, funding for public education campaigns has been 'woefully under-resourced', involving an expenditure of only 50 cents per head per annum.[31] The Public Health Association of Australia (PHAA) said it was estimated in year 2000 that for effective school tobacco education alone $7.12 per head was needed.[32] According to the Cancer Foundation of Western Australia, governments should devote a minimum of $10 per head of population to public education programs about smoking and governments should set targets for reducing the prevalence of use.[33]

6.27 Tobacco packaging and labelling have the potential to promote cigarette smoking. This potential can be reduced by requiring that the drawbacks of smoking be extensively and graphically listed on packaging. The National Tobacco Strategy background paper pointed out that in Australia there has been labelling of tar and nicotine levels on cigarette packages since 1982 with new and stronger warnings implemented in 1994.[34]

6.28 Currently there are six health warnings prescribed under the Trade Practices Legislation one of which appears on each cigarette packet. The warning is listed in large print on the front of the packet with a more detailed explanation in smaller typeface on the back of the packet and a contact number for more information. For example one warning is 'SMOKING CAUSES HEART DISEASE' and on the back of the pack the following words appear:

> SMOKING CAUSES HEART DISEASE Tobacco smoking is a major cause of heart disease. It can cause blockages in the body's arteries. These blockages can lead to chest pain and heart attacks. Heart attack is the most common cause of death in Australia. Smokers run a far greater risk of having a heart attack than people who don't smoke.

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29 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 5.

30 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 5.

31 National Heart Foundation of Australia (WA Division), sub 177, p 8.

32 Public Health Association of Australia, sub 159, p 10.

33 Cancer Foundation of Western Australia, sub 112, p 3.

34 *Background paper: A companion document to the National Tobacco Strategy 1999 to 2002-03*, endorsed by the Ministerial Council on Drug Strategy, Commonwealth Department of Health and Aged Care, Canberra, June 1999, p 14.

For more information, call 132130.

Government health warning

6.29 In its submission the Commonwealth Department of Health and Ageing advised that a review of the health warnings is being conducted.[35] More recent advice from the Commonwealth Department of Health and Ageing indicated the review is being undertaken jointly by the department and the Commonwealth Department of the Treasury with the assistance of the National Tobacco Strategy Technical Advisory Group.[36]

6.30 The first stage of the review was an evaluation of the existing six health warnings which confirmed the need to update the current warnings and include new consumer information on the health effects of tobacco. Following discussion with community and industry sectors, rigorous marketing testing of up to 16 new Australian health warnings is underway. This includes research into consumer reaction to a range of health warnings covering graphics and associated explanatory messages. When draft regulations and the Regulation Impact Statement are developed public consultation on new health warnings will occur. The department expects new regulations to be in place by mid 2004.

6.31 Several submissions to the committee also suggested that additional written and graphic health warnings be required on cigarette packets. For example, the Young Christian Women's Association of Perth supported the adoption of a pictorial graphic advertisement on cigarette packets (for example, a picture of lungs with cancer etc) as adopted in some other western countries.[37] The Cancer Foundation of Western Australia proposed legislation be introduced mandating all product information other than brand name be the responsibility of the Commonwealth government.[38] Canberra ASH Inc suggested that tobacco products be sold in plain packs with graphic health warnings which should be varied from time to time. It also sought cigars sold singly to carry a health warning and herbal cigarettes to carry a warning.[39]

6.32 A number of submissions to the inquiry also called for controls on the type of packaging allowed. They suggested plain, identical packaging for all

35 Commonwealth Department of Health and Ageing, sub 238, p 20.

36 Commonwealth Department of Health and Ageing, sub 298, p 2.

37 Young Women's Christian Association of Perth, sub 108, p 2.

38 Cancer Foundation of Western Australia, sub 112, p 3.

39 Canberra ASH Inc, sub 192, p 7.

brands of tobacco and cigarettes with only a registered brand number for identification.[40]

## Conclusion

6.33 The committee is supportive of the evaluative work being undertaken on health warnings and of the need for updating the current warnings. The committee is concerned about the evidence that current figures suggest that within the next decade smoking will become more common among women than men and the associated health implications for women. The committee is particularly concerned about the increase in the number of young women taking up smoking.

### Recommendation 43

6.34 **The committee recommends that the Commonwealth, State and Territory governments:**

- **run public education campaigns on the risks of smoking that target the whole community;**
- **continue to develop strategies for increasing awareness among school students, particularly young women, and older women of child bearing age and their partners, of the risks of tobacco smoking for reproduction and their children's health; and**
- **require updated more detailed written and graphic health warnings on cigarette packets.**

## Promoting cessation of tobacco use

6.35 The Australian Medical Association (AMA) recommended that further research be conducted into why people commence smoking, methods to help smokers cease smoking, and the social and economic costs to the community of the ill-effects of smoking on health.[41] The committee notes Collins and Lapsley's contribution to estimating the social and economic costs of smoking, and that research is ongoing on methods of helping smokers come to grips with the problem. It is clear from Chapter 3 on families and earlier in this chapter that parental example is one of the strongest predictive factors in the uptake of smoking.

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40 Canberra ASH Inc, sub 192, p 7; Grantham G, sub 2, p 1; Ollquist R, sub 3, p 2; Public Health Association of Australia, sub 159, p 11; Thomas E, sub 16, p 1.

41 Australian Medical Association, sub 133, p 1.

## Conclusion

6.36 The committee agrees that parental example is one of the strongest predictive factors in the uptake of smoking. While the committee is cautious in recommending further areas for research, it does believe much could be achieved in better understanding why people commence smoking.

### Recommendation 44

6.37 **The committee recommends that the Commonwealth, State and Territory governments contribute funding for further research into why people commence smoking.**

6.38 The VCTC suggested the Commonwealth government force the pace towards greater investment in prevention of tobacco-related diseases by:

- including on the Medicare schedule items that:
  - ⇒ would enable appropriately trained general practitioners (GPs) to provide smoking cessation counselling; and
  - ⇒ would allow GPs to refer smokers to specialist tobacco dependence treatment services as was done in the past for patients with diabetes or mental health problems;
- limiting subsidies for pharmaceutical treatments for non life-threatening conditions, that would be improved by quitting smoking, until after cessation counselling has been attempted;
- requiring pharmacists to confirm that patients are enrolled in cessation programs before they fill prescriptions for subsidised tobacco dependence treatment products;
- making adoption of tobacco control policies and investment in tobacco cessation a condition of health care financing at state, territory and agency levels;
- including tobacco as a priority in all relevant national and state health strategies; and
- making tobacco dependence a national health priority.[42]

42 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 4.

6.39 The Commonwealth Department of Health and Ageing recently advised that the development of best practice guidelines in smoking cessation is a priority task under the National Tobacco Strategy. It said it is based on sound evidence about the potential benefits of even brief intervention by general practitioners in achieving smoking cessation which is summarised in the literature review *Smoking cessation interventions: Review of evidence and implications for best practice in health care settings*[43]. The department further advised that the Australian guidelines are intended to:

- encourage general practitioners to intervene in smoking cessation and to do so in a consistent, evidenced-based manner;
- provide them with the latest evidence with respect to smoking cessation programs and therapies (including effective use of Zyban and other pharmacotherapies ;
- promote the integration of smoking cessation intervention and advice into the general practice setting, including records management; and
- provide a basic set of materials on smoking cessation for general practice that can be easily adapted to the needs of other professions, especially pharmacy, nursing and dentistry.[44]

6.40 The department also stated that General Practice Education Australia was awarded the contract for the development of *Australian best practice guidelines in smoking cessation for general practitioners and supporting resource material.* The department said stakeholder consultations are complete and they are now piloting the guidelines.[45]

6.41 Further, ADCA recommended that free or low cost smoking cessation services be made readily available throughout Australia, and the National Heart Foundation of Australia and the PHAA suggested that aids to cessation that are of proven efficacy, such as nicotine patches, be subsidised.[46] Another suggestion by the Women and Children's Hospital Adelaide was that, given that smoking during pregnancy is a clear risk factor for adverse birth outcomes, subsidies for nicotine replacement therapy is particularly important for pregnant women and their partners.[47]

43 Miller M & Wood L, *Smoking cessation interventions: Review of evidence and implications for best practice in health care settings: Final report*, National Tobacco Strategy 1999 to 2002-03 occasional paper, Commonwealth Department of Health and Ageing, Canberra, August 2001, viii 137p.

44 Commonwealth Department of Health and Ageing, sub 299, p 2.

45 Commonwealth Department of Health and Ageing, sub 299, p 2.

46 Alcohol and other Drugs Council of Australia, sub 61, p 20; National Heart Foundation (WA Division), sub 177, p 8; Public Health Association of Australia, sub 159, p 10.

47 The Women's and Children's Hospital, Adelaide, sub 7, Inquiry into Improving Children's Health and Well Being by the House of Representatives Standing Committee on Family and Community Affairs, p 3.

The work by McDermott et al stressed that 'Smoking cessation programs targeting pregnant women and their partners should become the key component of the national strategy to control tobacco smoke.'[48]

## Conclusion

6.42 The committee agrees that:

- the development of the smoking cessation guidelines for general practitioners is important;
- there is considerable value in subsiding aids such as nicotine patches under the Pharmaceutical Benefits Scheme to better assist cessation of cigarette smoking; and
- in particular, subsidy of replacement therapies is important for pregnant women and their partners.

### Recommendation 45

6.43 **The committee recommends that the Commonwealth, State and Territory governments:**

- **include tobacco as a priority in all relevant national, state and territory health strategies and make tobacco dependence a national health priority;**
- **promote attention to the status of tobacco as a national health priority by requiring the adoption of tobacco control policies and investment as a condition of health care financing at state, territory and agency levels;**
- **make free or low cost tobacco smoking cessation services and aids readily available throughout Australia particularly for pregnant women and their partners; and**
- **investigate the cost benefit analysis of subsidising aids such as nicotine patches under the Pharmaceutical Benefits Scheme to better assist cessation of cigarette smoking.**

6.44 The AMA recommended that life, sickness and disability insurance companies offer reduced premiums to non-smokers.[49] The committee,

48 McDermott L, Russell A & Dobson A, p 13.

49 Australian Medical Association, sub 133, p 1.

recognising the current climate of insurance, however believes that this suggestion should be given further consideration.

6.45 Canberra ASH Inc stressed that 'Treatment for illicit substance abuse and other addictions, to be successful and lasting, should include treatment for the primary drug addiction tobacco'.[50] The committee supports such an approach.

## Reducing availability and supply of tobacco

6.46 The National Tobacco Strategy states that the availability of tobacco relates to two issues – accessibility and affordability.[51]

6.47 According to Collins and Lapsley, 'There is a great deal of persuasive evidence that the demand for tobacco is relatively unresponsive to changes in tobacco prices … the demand for cigarettes is price-inelastic ...'[52] However, Professor Hill told the committee that high prices does have the effect of reducing the amount of tobacco a person consumes.[53] In addition, the 2001 NDS Household Survey revealed that the cost of smoking was the most important motivator in changing people's use of tobacco; it was cited as a reason for change by 54.0 per cent of survey respondents.[54]

6.48 There is considerable support for pricing as a deterrent to smoking, in particular in relation to ensuring that cigarettes do not become affordable for children.[55] The VCTC agenda proposed achieving this by continuing the six-monthly indexation of tobacco excise and customs duty, regularly increasing duty in line with average weekly earnings and estimates of children's average weekly disposable pocket money, and minimising the evasion of customs and excise duty.[56] The AMA suggested that taxes on tobacco products be increased and those products not be allowed into Australia duty free.[57] Increasing taxes to pay for health education, treatment and to discourage smoking was supported by over 60 per cent

50 Canberra ASH Inc, sub 227, p i.

51 *National Tobacco Strategy 1999 to 2002-03: A framework for action*, p 22.

52 Collins DJ & Lapsley HM, pp 24-25.

53 Hill D, transcript, 15/8/02, p 1101.

54 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: Detailed findings*, p 23.

55 Hill D, transcript, 15/8/02, p 1101; Ollquist R, sub 3, p 2; Public Health Association of Australia, sub 159, p 7; Canberra ASH Inc, sub 192, p3.

56 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 3.

57 Australian Medical Association, sub 133, p 1.

of respondents in the NDS Household Survey (64.3 per cent for health education, 67.0 per cent for treatment and 61.1 per cent for prevention).[58]

## Recommendation 46

6.49 **The committee recommends a study of the price elasticity of tobacco and tobacco consumption in Australia be conducted to determine what is the minimum price increase that will stop large numbers of people smoking as a result of price alone.**

6.50 Selling cigarettes to a minor is illegal. However, the 2001 NDS Household Survey revealed that under age smokers most commonly obtained tobacco from a shop or retail outlet (82.6 per cent). The survey also indicated that public support was greater for 'stricter enforcement of laws against supplying tobacco products to minors' than for any of nine other measures to reduce problems associated with tobacco use; 93.3 per cent of respondents were in favour of this.[59] Stricter enforcement was also supported by others in evidence to the committee.[60]

6.51 The National Heart Foundation and the PHAA supported the licensing of tobacco retailers and wholesalers.[61] Given that nicotine is a highly addictive substance, it can be argued that its sale should be tightly regulated. It can also be argued that tighter regulation than occurs at present is urgently needed in the light of the evidence of widespread sale of cigarettes to minors.

6.52 ASH Australia suggested regulation of the sale of tobacco products is best done under a fee-based registration system which would provide:

- information about all those businesses that retail tobacco products; and
- revenue that would finance the monitoring of compliance with the conditions attached to selling tobacco products.[62]

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58 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 34.

59 Australian Institute of Health and Welfare, *National Drug Strategy Household Survey: Detailed findings*, pp 92, 104.

60 National Heart Foundation of Australia (WA Division), sub 177, p 8; VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 4.

61 National Heart Foundation of Australia (WA Division), sub 177, p 6; Public Health Association of Australia, sub 159, pp 9, 11.

62 ASH Australia, informal communication, 6/3/03.

At present only two jurisdictions, the ACT and Tasmania, have fee-based registration systems.[63]

6.53 The Commonwealth Department of Health and Ageing has commissioned a report into the feasibility of introducing a national licensing scheme, which includes:

- identifying and reviewing the public health benefits of registration and/or licensing schemes for tobacco retail outlets and tobacco wholesalers;
- investigating the feasibility and justifiability of introducing registration and/or licensing schemes and the legality of imposing such a scheme/s, including any possible initiatives at the national level; and
- identifying the key elements of a best practice approach to the introduction of registration and/or licensing schemes.[64]

The report has not yet been released but is expected about July/August this year.

## Recommendation 47

6.54 **The committee recommends that the Commonwealth, State and Territory governments work together to develop and legislate for nationally consistent regulations governing the registration and licensing of the wholesalers and retailers of tobacco products, which should include registration fees and an emphasis on heavier penalties for the sale of cigarettes to minors than apply at present.**

6.55 Illegal or chop chop tobacco can be sold more cheaply than legal tobacco, because no excise has been paid on it. The Australian Taxation Office said in 2002 it began an active compliance strategy in Australia's two main tobacco growing areas, Myrtleford in Victoria and Mareeba, Queensland. Over the last two years, work under that strategy has intercepted

63 *Public Health Act 1997*(Tas.), Part 4- Tobacco products, viewed 7/3/03, <http://www.thelaw.tas.gov.au/view/86++1997+GS74B@EN+2003030700>; *Tobacco Act 1927* (ACT), p 40, viewed 7/3/03, <http:www.legislation.act.gov.au/a/1927-14/current/pdf/1927-14.pdf>.

64 Commonwealth Department of Health and Ageing, sub 295, pp 2-3.

215 tonnes of illegal tobacco, preventing evasion of more than $54 million in excise.[65]

6.56 Apart from the evasion of excise, there are concerns about the impact of chop chop tobacco on the health of smokers. Bittoun reported chop chop tobacco may be fumigated with bleach and bulked up with additives.[66]

6.57 The committee believes that there should be more focus on elimination of the chop chop tobacco industry.

## Reducing tobacco promotion

6.58 Tobacco companies still possess a number of avenues through which they can promote their products to the Australian public. Calls continue for legislation and other means of banning such advertising, and for expanding such bans to international broadcasting and the emerging electronic media.[67] The AMA suggested incidental product placement in television programs and movies should be acknowledged at the beginning of each program, and should receive a rating which does not allow the program to be shown when people under 18 years of age are able to view it.[68] The Cancer Foundation of Western Australia recommended legislation requiring tobacco manufacturers to reveal all their expenditures on any forms of promotion, marketing, public relations and incentives to retailers.[69]

6.59 As pointed out earlier in this chapter the Commonwealth Department of Health and Ageing advised that the *Tobacco Advertising Prohibition Act 1992* is being reviewed. More recently the department said that the review is looking to see if the Act is meeting its objectives, consider solutions to difficult provisions and the possibility of extending the objectives of the Act to take better account of new and emerging technologies and modes of advertising and promotion such as the internet. The department foreshadowed the release of a revised issues paper on the Act as soon as possible.[70]

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65 Australian Taxation Office, *Tax Office and Victoria Police to curb illegal tobacco in Melbourne and Sydney*, media release, 20/2/03, pp 1-2.

66 Bittoun R, '"Chop-chop" tobacco smoking', *Medical Journal of Australia*, vol 177(11/12), 2002, p 686.

67 Australian Medical Association, sub 133, p 1; Canberra ASH Inc, sub 192, p 7; Cancer Foundation of Western Australia, sub 112, p 3; Ollquist R, sub 3, p 2; Public Health Association of Australia, sub 159, pp 8-9; VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 4.

68 Australian Medical Association, sub 133, p 1.

69 Cancer Foundation of Western Australia, sub 112, p 3.

70 Commonwealth Department of Health and Ageing, sub 299, pp 2-3.

6.60 Misconduct by tobacco companies should be pursued. The PHAA recommended legislative provisions to penalise those making misleading public statements about tobacco.[71] The VCTC suggested litigation to expose the history of industry misconduct in failing to disclose the true nature of its product and to seek orders to prevent and address continuing and future misconduct.[72]

### Recommendation 48

6.61 **The committee recommends the Commonwealth, State and Territory governments work together to ensure that all remaining forms of promotion of tobacco products be banned, including advertising, incentives to retailers, sponsorships and public relation activities.**

## Regulating tobacco

6.62 According to the National Tobacco Strategy tobacco can also be regulated by disclosure by the tobacco industry of the contents of tobacco products and identification of appropriate interventions to regulate tobacco products.[73]

6.63 The National Tobacco Strategy reported a number of international developments regulating the tobacco industry such as in the Province of British Columbia, Canada's, legislation requiring companies to test and report on all ingredients and additives in their cigarettes, including chemicals used to treat papers and filters, and companies required to report on 44 selected poisons found in tobacco smoke. At the federal level in Canada, there have been proposals to amend the Tobacco Act, including expanding the reporting requirements to obtain data on more than 50 toxic constituents of tobacco and tobacco smoke and the reporting of ingredients used in the manufacturing process. Unlike the USA, there are no regulations in Australia that require the tobacco industry to report to government of the nature and extent of its advertising, promotion and marketing activities.[74]

6.64 In comparison, the National Tobacco Strategy stated, in Australia publicly available information about the contents of cigarettes is still limited.[75] This

71 Public Health Association of Australia, sub 159, p 11.

72 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 3.

73 *National Tobacco Strategy 1999 to 2002-03: A framework for action,* p 32.

74 *National Tobacco Strategy 1999 to 2002-03: A framework for action,* p 32.

75 *National Tobacco Strategy 1999 to 2002-03: A framework for action,* p 32.

is despite the three Australian cigarette manufacturers voluntarily agreeing to disclose ingredients in Australian cigarettes. For example, one brand of cigarettes on the side of the packet stated:

> The smoke from each cigarette contains, on average:
> 1 milligram or less of tar – condensed smoke containing many chemicals, including some that cause cancer;
> 0.2 milligrams or less of nicotine – a poisonous and active drug;
> 2 milligrams or less of carbon monoxide – a deadly gas which reduces the ability of blood to carry oxygen.

6.65 During the course of the current inquiry, there were calls for similar initiatives to those being introduced overseas. Several groups suggested smoking can also be reduced by listing the ingredients of the tobacco products inside.[76] The VCTC recommended the strengthening of product label regulations to require disclosure and effective communication about:

- ingredients, including additives;
- maximum toxic output of products when smoked;
- any information relevant to potential acute and long term biological impact, and
- overall addictive potential and overall health risk.[77]

6.66 Further restrictions on tobacco that were suggested to the committee included:

- PHAA proposing removing nicotine's exemption from classification as a poison under state and territory Poisons Acts;[78] and
- ADCA suggesting a ban on manufacturing processes or additives that make tobacco more palatable to children.[79]

6.67 At present the Commonwealth's Standard for the Uniform Scheduling of Drugs and Poisons, No 18, effective date 1 May 2003[80], lists nicotine as a Dangerous Poison (Schedule 7) except when available as a Pharmacy Medicine (Schedule 2) or as a Pharmacist Only Medicine (Schedule 3), or as a Prescription Only Medicine (Schedule 4), or as a Poison (Schedule 6)

76 Canberra ASH Inc, sub 192, p 7; Cancer Foundation of Western Australia, sub 112, p 3; Young Women's Christian Association of Perth, sub 108, p 2.

77 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 3.

78 Public Health Association of Australia, sub 159, p 10.

79 Alcohol and other Drugs Council of Australia, sub 61, p 20.

80 *Standard for the uniform scheduling of drugs and poisons, no 18, effective date 1 May 2003*, Commonwealth Department of Health and Ageing, Canberra, May 2003, pp 50, 59, 115, 202, 223, 291, 301, 307.

in preparations containing 3 per cent or less of nicotine when labelled and packed for the treatment of animals; or in tobacco prepared and packed for smoking. The Commonwealth's schedule classifies drugs and poisons into Schedules for inclusion in the relevant legislation of the states and territories. There is a high degree of compliance of the states and territories with the Commonwealth's scheduling. The committee understands that the matter of the removal of the nicotine exemption has been looked at in the past but believes it is timely for it to be examined again.

### Recommendation 49

6.68 **The committee recommends that the Commonwealth, State and Territory governments investigate removing nicotine's exemption from classification as a poison under the Commonwealth's Standard for the Uniform Scheduling of Drugs and Poisons and in State and Territory Poisons Acts.**

## Reducing exposure to environmental tobacco

6.69 The dangers of involuntary smoking were outlined earlier in this chapter. The National Tobacco Strategy report, *Environmental tobacco smoke in Australia* prepared by the VCTC in 2001, revealed that:

> … while most Australians are protected from exposure to ETS [environmental tobacco smoke] at work, over one quarter are still not protected in indoor workplaces, and many are inadequately protected in other places. We are still a long way from the point where no Australian is being involuntarily exposed to tobacco smoke toxins … Many smokers and non-smokers (in particular children and some of Australia's more disadvantaged communities) continue to experience very high levels of ETS exposure. Current patterns of ETS exposure are also a contributor to continuing inequality in health status between economically advantaged and disadvantaged groups.
>
> …

> … there is a need for a mix of legislation and public education to encourage smokers to be responsible about their smoking and not smoke around people who might be at risk – that is, anyone.[81]

6.70 Reducing involuntary exposure to toxic tobacco by-products in public places is strongly supported by the community and in evidence presented to the committee. The critical issue here is how public places are defined. Support was expressed in several submissions for a ban on smoking in such places as workplaces, shopping centres, restaurants and some outside areas, where there are doorways, restricted seating and airconditioning intakes. There is also growing support for banning smoking in pubs and clubs.[82] In the 2001 NDS Household Survey over 80 per cent of Australians agreed with smoking bans in workplaces, shopping centres and restaurants and a ban on smoking in pubs and clubs was favoured by three out of five people (60.8 per cent).[83]

6.71 The National Occupational Health and Safety Commission's 2002 position statement on environmental tobacco smoke recommended that exposure to such smoke should be excluded in all Australian workplaces. This exclusion should be implemented as soon as possible.[84] Various state and territory governments have already banned smoking in specified public places. For example since July 2001, smoking has been banned in Victorian restaurants and eateries, and from September 2002 Victorian licensed premises and gaming venues have been required to set aside more smoke free areas.[85]

6.72 The VCTC suggested that the Commonwealth government could provide education to build community support for such policies, and promote best practice regulatory drafting.[86]

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81 VicHealth Centre for Tobacco Control, *Environmental tobacco smoke in Australia,* National Tobacco Strategy 1999 to 2002-03 occasional paper, Commonwealth Department of Health and Ageing, Canberra, May 2001, pp 1-2.

82 Australian Medical Association, sub 133, p 1; Canberra ASH, sub 192, p 7; Grantham G, sub 2, p 1; VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document*, p 4.

83 Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: First results*, p 34.

84 National Occupational Health and Safety Commission, *Position statement adopted by NOHSC concerning environmental tobacco smoke*, media release, p 1, 13/12/02, viewed 25/2/03, <http://www.nohsc.gov.au/NewsAndWhatsNew/MediaReleases/mr-13122002Position-ETS.htm>.

85 Victorian government, sub 255, p 5; Tasmanian government, sub 257, p 3; ACT government, sub 150, p 49.

86 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 4.

6.73 The VCTC's *Environmental tobacco smoke in Australia* report also concluded that education and encouragement, perhaps accompanied by supportive structural change, is the preferred strategy for private environments such as homes for the foreseeable future.[87]

6.74 In addition, the VCTC's report stated that under some circumstances, exposure in unenclosed outdoor environments can be quite severe, for example when downwind of a smoker. Accordingly the report suggested that a comprehensive solution to the problem of involuntary exposure to environmental tobacco smoke will also need to include the widespread adoption of strategies by smokers to ensure non-smokers are not exposed to their smoke.[88]

## Conclusion

6.75 The committee particularly notes that a smoke free workplace plays a valuable role in reducing tobacco consumption. It appears that there is much to gain by extending the smoke free requirements to other public places. The committee also supports efforts for education and encouragement to make private environments, such as homes, smoke free.

### Recommendation 50

6.76 **The committee recommends that the Commonwealth, State and Territory governments:**

- **develop and deliver a program to build community support for a ban on tobacco smoking in public areas where exposure to involuntary smoking is likely; and**
- **develop a similar program to further discourage smoking in private environments, such as homes.**

## Some funding options for future directions

6.77 In its June 2001 agenda for tobacco control the VCTC suggested a range of funding strategies whereby the tobacco industry could pay for existing and additional prevention and treatment activities. Options included:

87 VicHealth Centre for Tobacco Control, *Environmental tobacco smoke in Australia,* p 2.

88 VicHealth Centre for Tobacco Control, *Environmental tobacco smoke in Australia,* p 2.

- increases in tobacco excise and customs;
- the abolition of duty free tobacco sales;
- license fees to be paid by companies that import or sell tobacco products in Australia;
- a surcharge on tobacco company profits;
- a levy to help grow the market for tobacco dependence treatments; and
- a levy on each cigarette sold to finance measures to assist farmers leave the tobacco-growing industry.[89]

6.78 Others have also suggested using tobacco taxes to fund anti-smoking initiatives, more specifically that:

- tobacco taxes be made available to education and health services, to work collaboratively in delivering prevention[90]; and
- the link between tax revenue and expenditure on prevention activities be made.[91]

6.79 As Collins and Lapsley pointed out:

> … tobacco tax revenue does in fact exceed by a considerable margin the tobacco-attributable costs borne by the government sector. This fact is often interpreted to mean that "smokers pay their way".[92]

6.80 In looking at the budgetary impact of drug abuse, not drug consumption, Collins and Lapsley showed that:

> Tobacco tax revenue in 1998-99 exceeded tobacco-attributable costs borne by the public sector by almost $2.8 billion. The beneficiaries of this surplus were State Governments. The Commonwealth's tobacco-attributable outlays exceeded its tobacco revenue by $219m.[93]

6.81 However, how this applies at the present time has not been investigated so the committee is unable to draw conclusions on this matter.

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89 VicHealth Centre for Tobacco Control, *Tobacco control: A blue chip investment in public health – overview document,* p 6.

90 Australian Medical Association, sub 133, p 1; Patton G, transcript, 15/8/02, p 1108.

91 Hill D, transcript, 15/8/02, p 1102.

92 Collins DJ & Lapsley HM, p 24.

93 Collins DJ & Lapsley HM, p 66.

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