Australian Government

Preventative Health Taskforce

Tobacco Control in Australia: *making smoking history*

A Background Paper prepared by Cancer Council Victoria

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Contents

ATTACHMENTS

Executive summary

Twenty-five years after the introduction of the first of a series of policies to discourage smoking, use of tobacco products in Australia is now at an historic low.

The weight of tobacco levied for excise and customs duty has fallen steadily since 1975 (*in total, per person* and *per smoker*) and is currently lower than it has been at any time since records were first collected shortly after Federation.

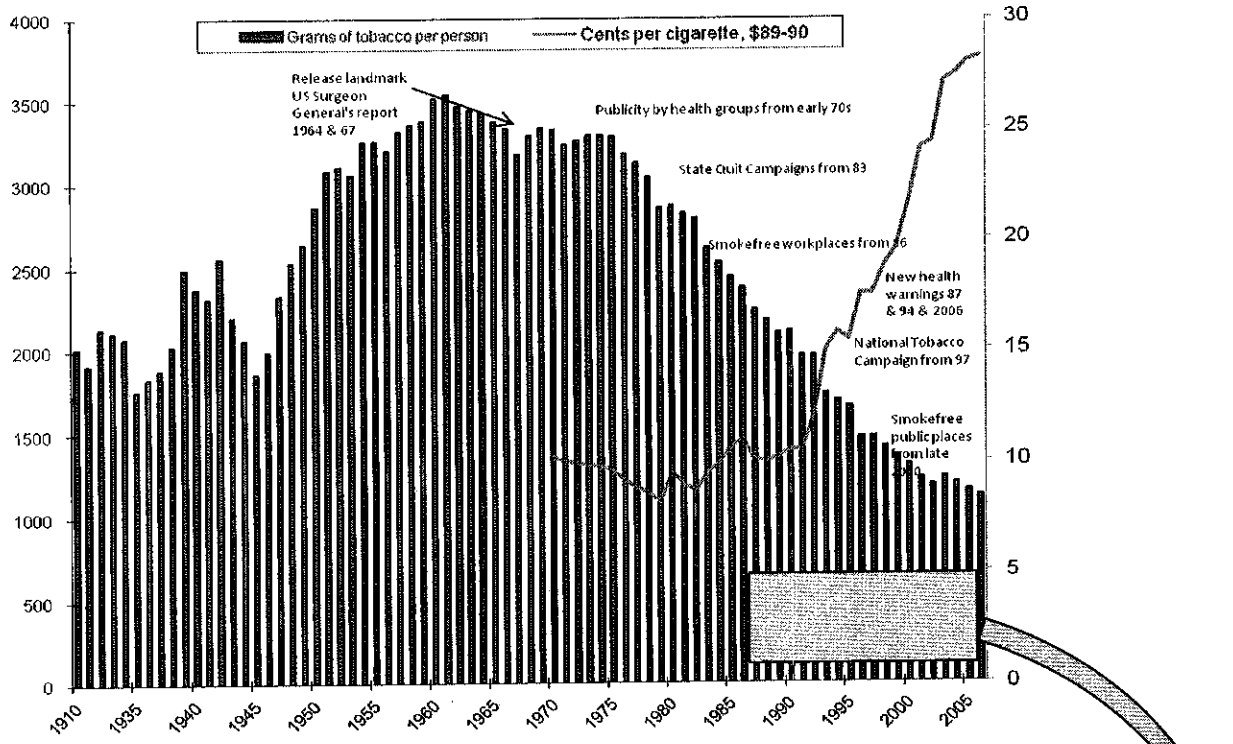


Figure 1 Grams of tobacco dutied per person 15 yrs+ and major tobacco control policies, Australia, 1905 to 2005

Source: Scollo VCTC 2003[1]

However as can be seen zooming in to *per capita* consumption of cigarettes just among Australian teenagers between 1984 and 2005, the downward path of consumption cannot be taken for granted into the future.

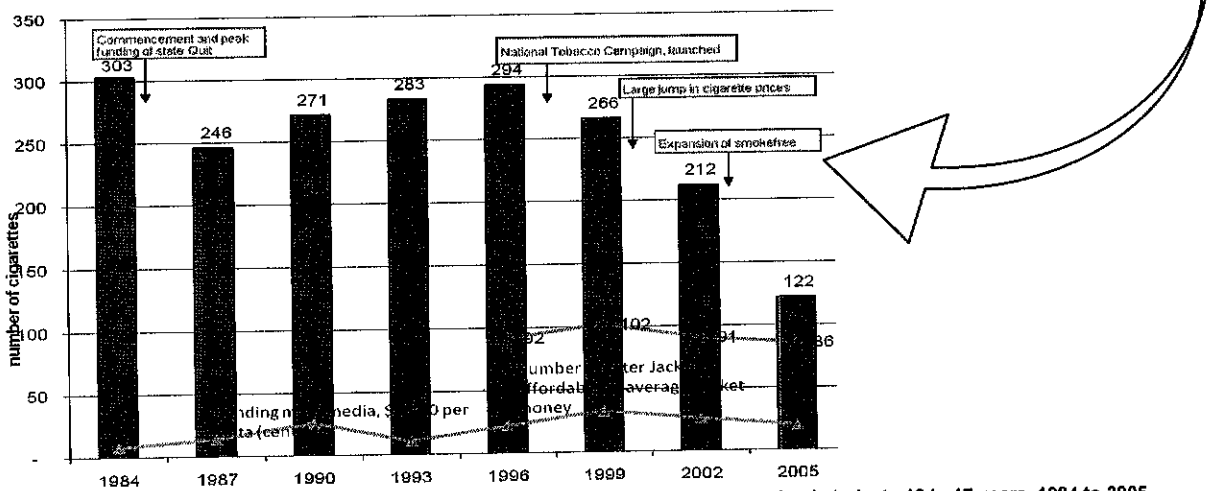


Figure 2 Per capita annual cigarette consumption as reported by Australian secondary-school students 12 to 17 years, 1984 to 2005

Source: Scollo in press[2]

Use of cigarettes by teenagers crept up in Australia between 1990 and 1996 when spending on media campaigns reduced. Many policy goals were achieved between 1997 and 2003 and this was rewarded by a further drop in cigarette consumption apparent in the 2005 survey of teenage smoking.[2]

While much has been achieved, as will be described in this paper, on several aspects of tobacco control over the past six years in Australia we have *taken our foot off the accelerator pedal.* As will also be demonstrated in this

paper, *there is no cruise control switch* in tobacco control. Without serious attention on tobacco taxes, commercially realistic funding for media campaigns and greater help for smokers trying to quit, reductions in tobacco use in Australia could easily stall.

The Rudd Labor government has decided to reorient Australia's approach to public health with a much more vigorous approach to prevention, and greatly increased investment to prevent chronic disease.[3] It has established a Preventative Health Task Force to advise how it can dramatically reduce obesity, alcohol abuse and the use of tobacco in Australia.[4]

Australia is not the only country set to seriously tackle the tobacco problem.

In its blueprint for the nation on *Ending the Tobacco Problem*, the US Institute of Medicine has proposed a target of 10% adult smoking prevalence for the United States by the year 2025[1].[5] Might it be possible, with more vigorous regulatory action than is possible in the US but comparable levels of investment in education and treatment, to beat the Americans and achieve the same 10% target in Australia five years earlier?

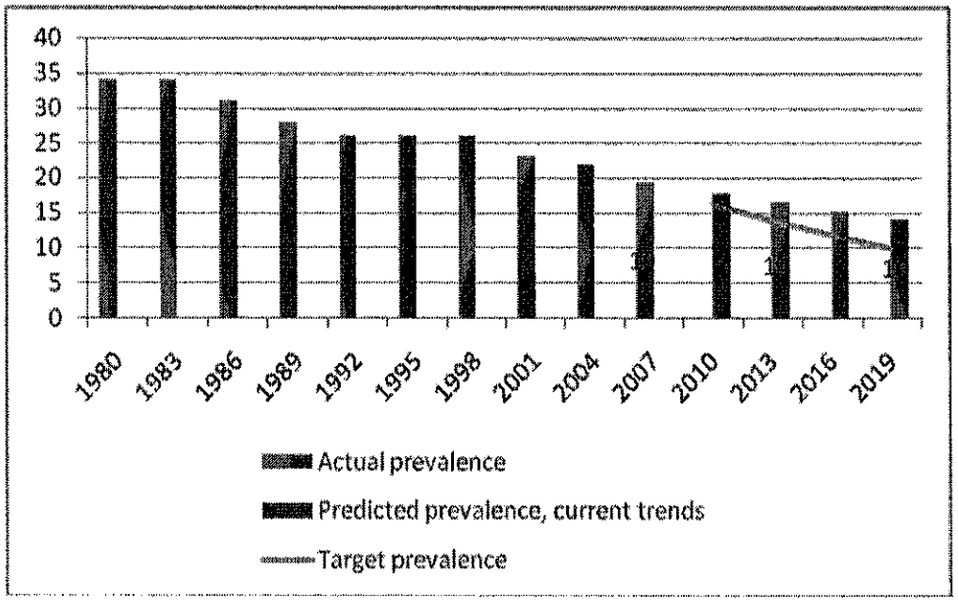


Figure 3 Proportion of people 14 years and over smoking at least weekly, Australia actual 1980 to 2007 and predicted and target prevalence to 2010 to 2019

Source: Scollo, using data from National Drug Strategy Household Survey[6]

This paper presents the latest data on smoking in Australia. Building on extensive information compiled in the National Tobacco Strategy document released in 2004,[7] it provides an update of research available since that time and describes what has been done over the past four years and where Australia falls short of international best practice. It provides a set of ideas for the Taskforce to consider. These include suggestions to the government to implement a number of measures known to be effective and which would help to institutionalise the treatment of tobacco dependence in Australia's health care system. It also proposes a number of measures that have not yet been tried anywhere in the world but which would cost little and offer the prospect of shattering the image of cigarettes as an ordinary consumer item. If we act decisively Australia could for instance overtake the British government in implementing its May 2008 announcement and be the first country in the world to legislate to require cigarettes to be sold in plain packaging. This could well be one of the most powerful measures, of all those suggested, likely to discourage young people from experimenting with cigarettes.

But could we be bolder still, and imagine a day when the level of tobacco use in Australia is so low that it no longer poses a significant threat to public health?

If all the measures outlined in this paper are pursued, then, in addition to dramatically reducing the numbers of people who smoke, we would also quite quickly get to a point where virtually no one ever supplied cigarettes to children, no one ever smoked near a non-smoker or where children could see them, and, over the course of each week, remaining users of tobacco products used significantly fewer, or perhaps *not even any*, products that were combustible.

[1] 10% of adults 18+ smoking daily or at least some days each week

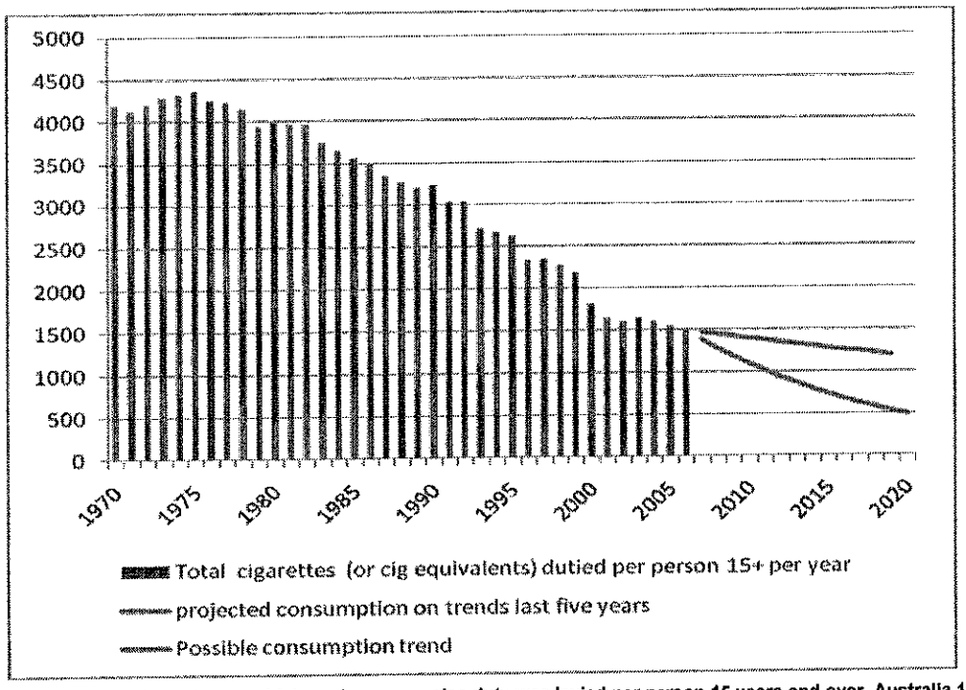


Figure 4 Total cigarettes on which customs or excise duty was levied per person 15 years and over, Australia 1970 to 2005, and projected to 2020

Source: Scollo in press 2008

The paper argues that a piecemeal approach to tobacco control will be much less effective than a comprehensive one, with a higher likelihood of unintended consequences.

Below are set out some of the major gaps in policy, research and data identified throughout this document which the Taskforce might consider in its deliberations and advice to the Government.

Action in all seven of the policy areas described in this document could— perhaps even within our lifetimes if we act soon enough—*make smoking history.*

Summary of ideas for consideration

A possible target

1. an overall target to reduce smoking in Australia by the year 2020 to no higher than **10%**[2]

Legislative reforms that would address gaps in regulation of the tobacco market

2. mandating of plain packaging of cigarettes
3. elimination of all remaining forms of advertising and promotion of tobacco, including through the *banning of internet advertising and promotion* and a *ban on tobacco displays at point of sale*
4. an increase in the required size of graphic health warnings to take up at least 50% of the front and 100% of the back of the pack
5. establishment of a national system to more regularly review mandated warnings and to warn smokers of emerging and new evidence about health effects in a more timely and systematic manner
6. establishment of a regulatory body with powers to ban, limit or mandate tobacco product constituents, emissions, additives, manufacture and design
7. strengthening of state and territory laws that protect against exposure to second-hand smoke.

Detailed provisions of these and a number of additional legislative initiatives mentioned throughout this paper are outlined **in Attachment 19.**

[2] 10% of Australians 14 plus smoking at least weekly. Before adopting this target the Taskforce should consider findings of Coral Gartner's current analysis which replicates the IOM study, projecting long-term trends for each age cohort. A target such as this should include a sub-target of an absolute reduction in prevalence among Australians in the most disadvantaged 40% of neighbourhoods *at least* as great as the reduction in neighbourhoods falling between the 41st and 80th percentile in terms of relative disadvantage. The reduction among Indigenous Australians will need to be considerably greater than this if *Closing the Gap* targets are to be achieved.

Revenue measures that would reduce the affordability of cigarettes

9. increased excise and customs duty on tobacco to discourage smoking and raise revenue for prevention activities, including those for lower SES groups
10. measures incorporated into customs and excise legislation to prevent evasion of duty on tobacco.

Expenditure measures

Inclusion in the 2009–10 Budget expenditure measures for 2009–10 to 2015–16 for

11. a social marketing campaign to be developed by an expert group and implemented in collaboration with state Quit agencies, including a component for research to guide design to maximise impact with lower SES groups and funded sufficiently to ensure reach at levels found to be effective
12. programs to subsidise NRT for highly disadvantaged people in financial stress and for callers to the Quitline
13. internet and telephone services available to any non-English speaking person in any state or territory
14. other initiatives to tailor services for highly disadvantaged groups unable to be reached by mainstream services.

Initiatives that could be included in health care agreements

Inclusion in health care agreements with States and Territories requirements to

15. routinely record smoking status of all patients in every community health centre, maternal and child health service, drug treatment agency and hospital, advise such patients to quit, provide them with NRT and where appropriate refer them to the Quitline
16. provide encouragement and support to quit to clients of juvenile justice programs and correctional facilities
17. provide resources and training to professionals and institutions necessary to provide this routine treatment
18. record and provide data on smoking status, provision of NRT and referral to Quitline to the Australian Institute of Health and Welfare as part of agreed national health data collection arrangements, commencing as soon as possible with collection of data on smoking by women receiving antenatal care
19. provide extended-hours Quitline and call-back services.

Reinvigoration of the Australian National Tobacco Strategy

To reinvigorate Australia's comprehensive National Tobacco Strategy

20. update (but not waste time and money redrafting) the Strategy[7] and supporting documents[8-14] and encourage more effective use of the documents by the tobacco control field
21. use the Strategy to guide the development of further Budget proposals and regulatory reforms
22. promote the relevance of the Strategy for achieving the Government's broader objectives of reducing the costs of chronic disease, improving workforce productivity, achieving greater social inclusion and contributing to social development both in Australia and in developing countries.

Research to improve focus

To guide strategy

23. monitor the findings of studies assessing the impacts of interventions aimed at teenagers outside the classroom, particularly those involving siblings and those focused on disadvantaged groups.

To trial new interventions

24. to work out how best to accelerate social diffusion processes against smoking uptake and towards greater quitting in low-SES groups, assess the impact in several pilot suburbs of outdoor advertising and other initiatives to encourage greater use of cessation treatments and services in disadvantaged areas.

To monitor policy inputs

25. collect data on spending on mass media and other tobacco control activities across Australia
26. update recommendations about required levels of spending in each state on each component of a comprehensive tobacco control program
27. monitor the exposure of Australian teenagers (concentrating on those aged 14 and 15) to portrayals of smoking in movies, videos and computer games.

To monitor objectives

28. request the agencies producing reports on smoking prevalence and behaviour to cover all of the major indicators listed in the National Tobacco Strategy—**see Attachment 20 for details.**

One. Introduction: the Big Picture

Once ubiquitous, smoking around others is generally no longer acceptable in Australia, and markers of the 'spoiled identity' of smoking, smokers and the tobacco industry abound.[15] The prevalence of smoking has more than halved since 1964 shortly before the release of the landmark US Surgeon General's report on the health risks of smoking,[16, 17] and the proportion of teenagers smoking has declined to around one-third the level it was in 1983.[18]

Despite progress over the past 40 years, smoking still poses a major threat to public health. Over three million people—just over 19% of Australians aged 14 years and over—still smoke at least weekly.[19] About half of the smokers who continue to smoke for a prolonged period will die early, half of these in middle age[20] when children and grandchildren depend on them, and while they are in the most productive years of their working lives.[21] Tobacco use caused 15,511 deaths in 2003[22, 23] and cost the Australian community around $31.5b in 2004–05[24]—**see Attachment 1** for more detail. Smoking is responsible for 12% of the total burden of disease and 20% of deaths in Indigenous Australians.[25]

> *Goal of Australia's National Tobacco Strategy: To significantly improve health and to reduce the social costs caused by, and the inequity exacerbated by, tobacco in all its forms[7]*

Even if the prevalence of smoking were to decline overnight to single-digit figures, the personal and social costs of smoking would continue to be high for many years, not just because the effects are so long-term but also because they are so far-reaching. Economists David Collins and Helen Lapsley who prepared the estimates caution that their figures must considerably understate the true costs of tobacco use given the numerous items for which there was not yet enough research to enable them to plausibly quantify effects. Current estimates of the costs of smoking are based on assessments of the excess risk of premature births, cardiovascular disease, respiratory disease and cancers of the respiratory, digestive and reproductive organs.[26] In fact it is hard to think of an organ of the body to which smoking is *not* harmful, and scientific studies are published literally every day providing new or strengthened evidence of the impact of smoking on dozens of diseases and conditions, including most of the chronic health problems currently driving exponential growth in spending on hospital, medical and pharmaceutical treatments in this country.[3][3] See **Attachment 2** for a sample of the research published over the last two years linking smoking to conditions such as diabetes, obesity, arthritis, macular degeneration, hearing loss and periodontal disease.

Beyond the early deaths, the years of debilitating illness and the costs to the public health care system, smoking in Australia is also contributing significantly to social disadvantage. Spending on tobacco products causes significant financial stress.[27] It works against the accumulation of wealth, and helps to perpetuate poverty across the generations.[21, 28] Cigarettes increasingly act as a badge[29] and a marker[30] of low educational aspirations, low socioeconomic status and unemployment. Smoking by people from disadvantaged backgrounds may be becoming a barrier to acceptance in more advantaged social networks.[31] Doing more to reduce smoking may thus also support the Rudd government's central policy goals of educational excellence[32] and social inclusion.[33, 34]

While tobacco use seems likely to continue to cascade downwards in the most educated groups, the history of tobacco control in Australia shows that smoking in the population as a whole will not reduce without vigorous action by governments and health organisations.

Tobacco consumption fell sharply in Australia after the release of the first report of the US Surgeon General, particularly among better-off men, but it increased again in the early 1970s in response to more agressive marketing by tobacco companies, especially advertising aimed at young women—**see** Section Two and **Attachment 3 for futher details.** In the mid-1990s total spending on media campaigns fell as Quit organisations grappled with budget cuts and simultaneous pressures to develop targeted programs for a growing number of population groups. During this time cigarettes also became more affordable. After a decade in decline, between 1992 and 1998 the prevalence of smoking among adults flattened. It went into decline again following an increase in media spending and an increase in cigarette taxes in 1999, and the stepping up since 2001 of measures to make public places smokefree.

[3] The contribution of smoking to the incidence and the costs of treating most of these diseases in Australia has not been documented.

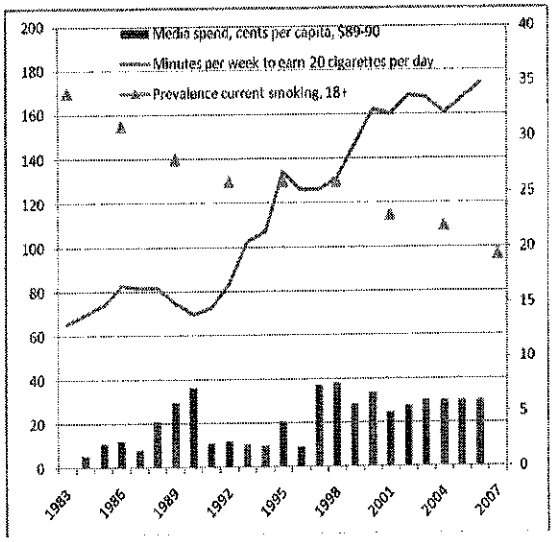


Figure 5 Smoking prevalence adults 18+[4], spending on media campaigns per person, $89-90 and costliness of cigarettes, Australia, 1983 to 2007

Sources: CBRC analysis of National Drug Strategy Household Survey[6], Average Weekly Earnings compared with recommended price of tobacco products[28], reports by government and non-government bodies on spending on tobacco control in Australia[35-37]

Similar flattening-offs in declines were observed in California in the mid-1990s[38] (when funding raised from taxes on tobacco were diverted to other programs and tobacco companies more than tripled spending on outdoor and print advertising so that from 1990 to 1993 the tobacco industry outspent the Proposition 99-funded media campaign by 10 to 1[39]) and again in Florida (when funding on the high-profile *Truth* Campaign was slashed in 1999[40]).

These observations of trends over the past 30 years are confirmed by detailed analysis of changes in smoking behaviour in response to changing policy parameters on a month-by-month basis. A study just published in the *American Journal of Public Health* confirms that increases in the costliness of cigarettes and large increases in television Target Audience Rating Points have exerted powerful effects in reducing smoking in the largest Australian states. It provides a stark warning that smoking prevalence stops falling when expenditure is low and prices stay the same.[41]

Australia is often trumpeted as having one of the lowest rates of smoking in the world. Sampling error and differences in the age range, timing and definitions of current smoking make direct comparisons very difficult, but it would seem that trends in the prevalence of smoking among adults in Australia since 1998 in fact have been similar to those in other English-speaking countries—**see Attachment 4** for further international comparisons.

[4] For a detailed explanation of survey data on smoking prevalence in Australia, **see Attachment 3.**

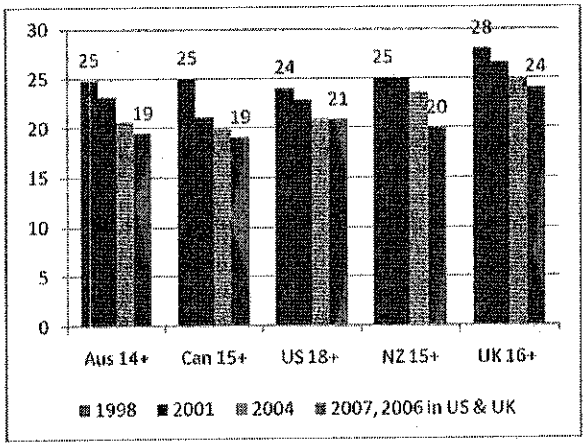


Figure 6 Smoking prevalence (at least monthly) 1998 to 2006-7, Australia, Canada, United States and New Zealand, varying start ages

Sources: Aus: National Drug Strategy Household Survey 2007;[19] Canadian Tobacco Use Monitoring Survey (CTUMS);[42] US Centers for Disease Control MMWR Reports; [43-45] New Zealand Tobacco Use Surveys[46] and A.C. Nielsen NZ data[47] and 2006-07 New Zealand Health Survey[48] and UK General Household Survey[49]

The pattern of reduction of teenagers in Australia also does not seem to differ substantially to those in other English-speaking countries—**see Attachment 5.**

However there are some places in the world doing much better than others in reducing smoking. In California (where a long-running, well-funded comprehensive tobacco control program has emphasised the immorality of marketing a deadly product and the unacceptability of smoking around others) and in New York City (which since 2004 has had a massive blitz on smoking, simultaneously hiking taxes on tobacco, banning smoking in all public places, running a large media campaign and promoting free nicotine replacement therapy), use of tobacco has declined at faster rates than in the rest of the country—**see Attachment 6** for further details.

So, what next for tobacco control in Australia? Long-time tobacco control advocate Professor Simon Chapman has suggested *art-of-the-possible* rates of adult smoking prevalence of 10% (*the current rate of daily smoking in California*), 6.5% (*the current rating of daily smoking in college-educated Californians*) or even 3% (*the current rate of smoking among physicians*) as targets to which developed countries prepared to invest in a reinvigoration of tobacco control efforts could reasonably aspire.[50]

The National Tobacco Strategy released by the government in 2004[7] raised the need for further effort on tobacco regulation, marketing and education, services and treatment for smokers, support for parents and educators, efforts to tackle smoking and disadvantage and more focussed research and education. While there has been some progress in most of these areas since 2005, many of the legislative reforms and programs proposed in the Strategy have not yet been adopted.

In New Zealand, the Republic of Ireland, Scotland and the rest of the UK and many states in the US and provinces in Canada, governments have recently

introduced (or have announced that they *shortly will introduce*) a number of measures that are still not yet in place in Australia and that are likely to further reduce tobacco use in those countries.

Over the past six years in Australia excise duty on tobacco products has not increased even once, and, in some states, media spending is lower than it has been for several years. Total spending on tobacco control is well below the levels recommended by expert groups—**see Attachment 7.** Without serious attention to tobacco taxes and commercially realistic funding for media campaigns not just some years but every year, reductions in tobacco use in Australia could easily stall again.

If smoking rates were to decline between 2007 and 2019 in Australia at the same rate that they declined between 1998 and 2007 then prevalence of smoking[5] would still be *around 14% in 2020*[6], that is, roughly the rate in California in 2006, 14 years earlier. In its blueprint for the nation on *Ending the Tobacco Problem*, the US Institute of Medicine has proposed a target for the US of 10% adult smoking prevalence by 2025[7].[5] This paper sets out how governments in Australia could achieve a target of 10% smoking prevalence by 2020, a full five years earlier.

A possible target for 2020:

Smoking prevalence of no more than 10% (of Australians 14 years and over, reported smoking on one or more days each week)

[5] % of people 14+ who smoke every day or some days each week

[6] Dr Coral Gartner from the University of Queensland is currently preparing a precise prediction taking into account trends over time in each age cohort. Her study will replicate the analysis done by the IOM and should enable assessment of whether 10% is a feasible target. Reaching 10% smoking prevalence would require a four-fold increase in the overall rate of decline observed over the previous six years and a doubling of the high rates of reduction observed in Australia in the mid-1980s and late 1990s.

[7] 10% of adults 18+ smoking daily or at least some days each week

Two. Progress in meeting National Tobacco Strategy objectives: trends and concerns

Objectives of the National Tobacco Strategy

1. *To prevent uptake of smoking*
2. *To encourage and assist as many smokers to quit as soon as possible*
3. *To eliminate harmful exposure of tobacco smoke among non-smokers*
4. *Where feasible to reduce harm associated with continuing use of, and dependence on, tobacco and nicotine*

Prevalence of smoking in Australia has declined among both teenagers and adults in all social groups—see below and **Attachment 3 for further details.** Smoking during pregnancy and exposure to tobacco smoke among children continues to be high among disadvantaged groups.

Uptake of smoking

After an increase in smoking rates between 1990 and 1996, smoking rates among both younger and older teenagers have resumed a downward trend.

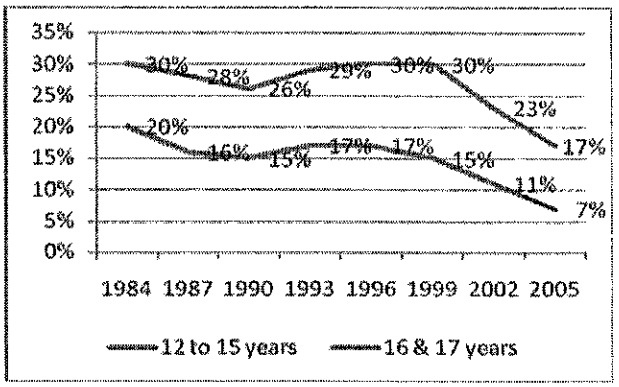


Figure 7 Trends current smoking (smoked in past week), Australia 1984 to 2005, students 12 to 15 years and 16 & 17 years

Source: ASSAD[18]

Since 1984, current smoking has declined significantly in teenagers of every age, and smoking rates are no longer significantly higher among girls than boys in the younger age groups.

Since 1999, rates of current smoking have almost halved among students aged 16 to 17 years. Among younger students, rates in 2005 were barely one-third of what they were in 1984. The percentage of students who report having smoked at least 100 cigarettes has also declined.[18]

The Australian Survey of Smoking, Alcohol and Drug Use (ASSAD) does not collect data on SES status of individual students, however data is available on the level of disadvantage of the

neighbourhood in which each student's school is located. In 1987 smoking rates appeared to be highest among students attending schools in the most advantaged areas of Australia. Following a sharp reversal of the socioeconomic gradient among 12-to-15-year olds between 1990 and 1996, between 1996 and 2005 smoking declined equally among students from schools located in areas at all levels of disadvantage.

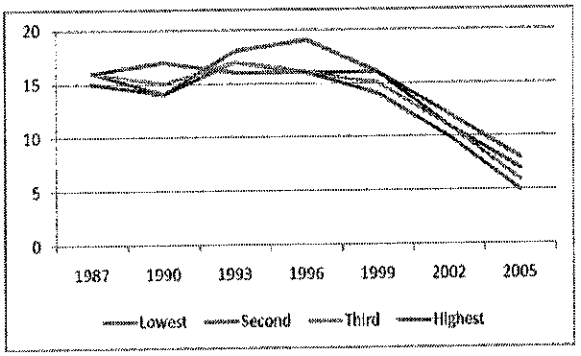


Figure 8 Reported current smoking, (smoking in the last week) secondary-school students aged 12□15 years, ranked in quartiles by the level of disadvantage of the area in which their school is located, Australia —1987 to 2005

Source: White, Hayman and Hill 2008[51], Table 2

Smoking rates among adults

The proportion of adult Australians who describe themselves as current smokers was significantly lower in 2007 than in 1980.

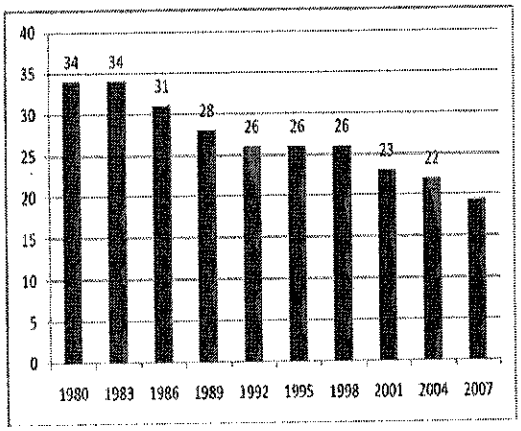


Figure 9 Prevalence of current^ smokers* in Australia aged 18+, 1980 to 2007#

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria[52-58] and National Drug Strategy Household Surveys[19, 59, 60]—**see Attachment 3**

Smoking fell in both males and females.

It seemed at the end of the 1990s that male and female smoking rates might converge,[61] but smoking rates now appear to be falling in parallel in both sexes and in all age groups.

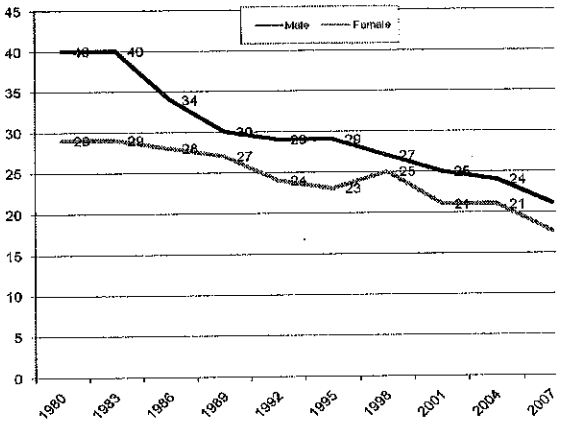


Figure 10 Prevalence of current^ smokers*18+, Australia 1980 to 2007#—males and females

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria[52-58] and National Drug Strategy Household Surveys[19, 59, 60]—**see Attachment 3**

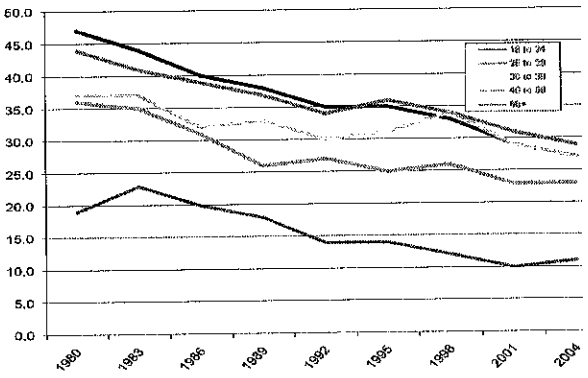


Figure 11 Prevalence of current^ smokers* in Australia aged 18+, 1980 to 2004—ages 18□24 to 60+

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria[52-58] and National Drug Strategy Household Surveys[19, 59, 60]—see Attachment 3

Among people who are employed, prevalence of smoking appears to have fallen almost as much in blue- as in white-collar groups.

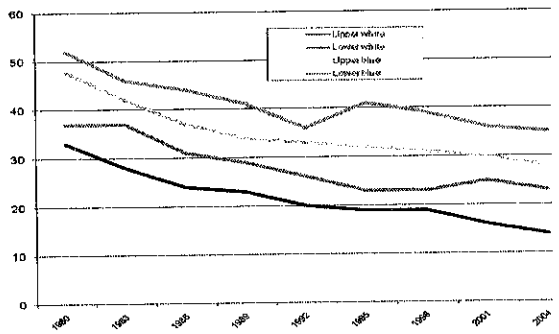


Figure 12 Prevalence of current^ smokers* 18+, Australia 1980 to 2007#—by job classification

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria[52-58] and National Drug Strategy Household Surveys[19, 59, 60]—**see Attachment 3**[8]

[8] ^See Attachment 3 for explanatory notes regarding methodology.

* Includes any combination of cigarettes, pipes or cigars

The AIHW has released data for Australians 14+ for 2007, but the figures for 18+ have not yet been calculated. When the full data set is available we will also provide a breakdown by SES for 2007.

Until 1995, it fell among people of all levels of educational attainment.

While prevalence appears to be going down among adults and teenagers in all age and occupational groups, progress appears to be halting among people with more limited education and those living in the most disadvantaged areas of Australia.[28]

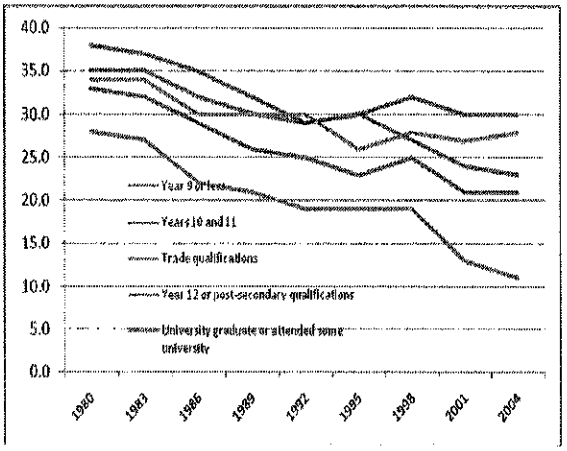


Figure 13 Prevalence of current^ smokers* in Australia aged 18+, 1980 to 2004#—by level of education

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria[52-58] and National Drug Strategy Household Surveys[19, 59, 60]—**see Attachment 3**

Since 1995 smoking prevalence appears to have fallen more sharply among people who have completed school than among people who have not. Rates are plummeting among those with a university education.

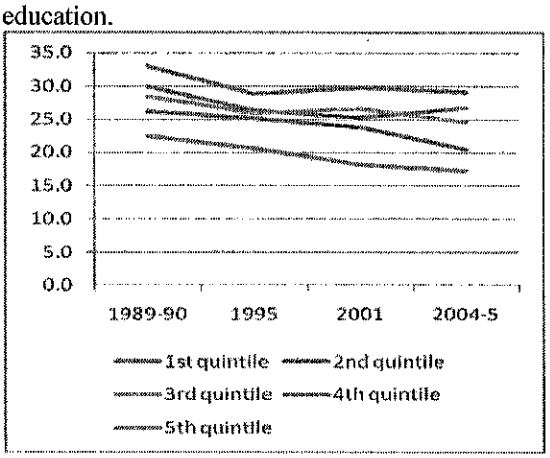


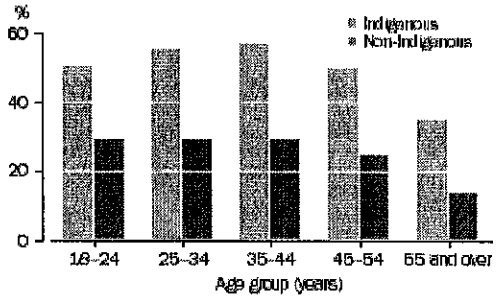
Figure 14 Smoking rates by area of relative disadvantage, Australians 18+ 1989 to 2004□05

Source: ABS National Health Survey[62]

Similarly smoking is declining steadily in those living in the least disadvantaged neighbourhoods but progress is less apparent among those living in the most disadvantaged areas (1st quintile).

Smoking rates among Indigenous Australians are more than double those in the rest of the community.[63].

Current daily smokers, Males



Current daily smokers, Females

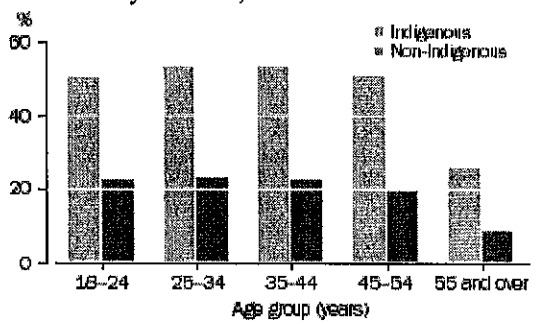


Figure 15 Smoking among Indigenous versus non-Indigenous Australians in 2004□05—males and females various age groups

Reproduced from ABS 2007 Tobacco Smoking—Aboriginal and Torres Strait Islander People: A snapshot [64]

High rates of smoking are also apparent among other marginalised groups including those with mental illness,[65] drug users,[66] those who are homeless[67] and those in prison.[68]

Few data are available at the national level on quitting intentions and behaviour. Data from Victoria indicates a clear increase in quitting intentions over the past ten years.

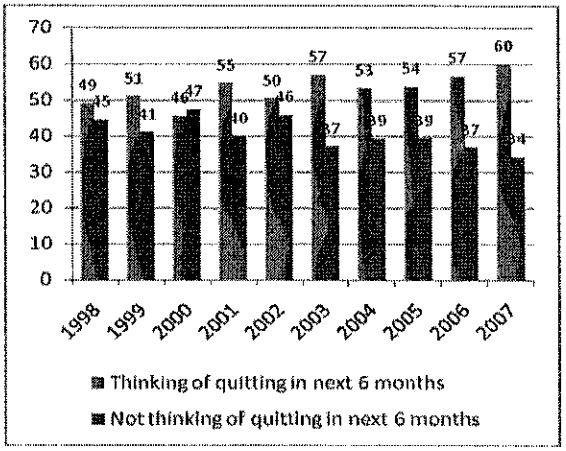


Figure 16 % of smokers intending to quit in next six months and % not thinking of quitting within next six months, Victoria 1998 to 2007

Source: CBRC Smoking and Health population survey 1998 to 2007[69]

Unpublished data from the International Tobacco Control policy evaluation study suggest that over 80% of current smokers Australia-wide have attempted to quit before, with an average of four attempts.[70] People with lower levels of income and education are less likely to have attempted to have quit within the past 12 months, and are less likely to be planning to quit within the next six months.

Table 1 Quitting intentions by Income and Education, % adults 18+ years, Australia 2002

Intention to quit	Income			Education		
	Low	Med	High	Low	Med	High
No plans to quit	28.2	23.9	21.0	27.6	21.3	15.4
Plan to quit in next six months	22.4	24.5	23.8	22.1	21.7	29.7
Have set a date in next month	3.7	3.9	5.7	4.3	3.7	5.6
Have recently attempted to quit	1.4	0.8	1.9	1.0	1.5	2.6

Source: ITCP Four Nations Study, Australia[70]

Idea for consideration

Request the ITC 4 Nations group to publish Australian data on smoking intentions and quit attempts on a triennial basis

Exposure to tobacco smoke among non-smokers

Data have not consistently been collected or published over time,[9] but it appears that smoking among pregnant women remains alarmingly high, particularly among those in disadvantaged groups.

Table 2 Women who smoked during pregnancy by Australian state* and territory, 2005

State or Territory	% of smokers (self-reported)
New South Wales	14.3
Queensland^	20.4
Western Australia	17.1
South Australia**	23.2
Tasmania	27.6
Australian Capital Territory	14.5
Northern Territory§	31.1
Total	17.4

* Excluding Victoria, for which data were not available;^ Smoking status in Qld was reported from 1 July 2005, so information in the table is for July—December 2005; ** Smoking status in South Australia includes women who quit before the first antenatal visit; §Smoking status in Northern Territory was recorded at the first antenatal visit.

Source: Laws et al.[71]

Forty-two percent of the 10,857 teenagers who had babies in 2004 smoked during pregnancy.[71] Data from the AIHW National Perinatal Data Collection Unit indicate that Aboriginal and Torres Strait Islander mothers smoke during pregnancy at about three times the rate of non-Indigenous mothers (52% c.f to 16%).[72][10]

Idea for consideration

Include a requirement to collect data on smoking during pregnancy in health care agreements.

Smoking during pregnancy has significant, far-reaching and long-lasting effects on the health and well-being of offspring. Recent studies point to long-term impacts including programming for cardiovascular disease[73-76] and fertility problems.[77, 78] Maternal smoking is increasingly being linked[11] with compromised neuro-behavioural[81, 82] and cognitive functioning,[83, 84] including infant irritability,[85] hearing problems,[86] attention deficit disorders,[87-91] reduced academic performance,[92] psychological problems,[93] conduct problems[94-96], physical aggression in children,[97] substance abuse [98-100] and psychiatric problems in both teenagers[101, 102] and adults [103, 104] and even arrests in adult offspring.[105, 106] Smoking may be contributing more to the perpetuation of social disadvantage than has previously been appreciated.

In the most disadvantaged areas in Australia, children are exposed to tobacco smoke at least once every day in around one in five households.

In the most advantaged areas of Australia, adults in households without dependent children are half as likely to smoke indoors as adults in households without children. However in the most disadvantaged areas adults with dependent children are equally as likely to smoke indoors as those without.

[9] The AIHW has recently produced guidance about how data should be collected.

[10] Data on smoking is currently not collected in Qld or Vic.

[11] The increased risk must partly be explained by the more stressful environments shared by offspring and mothers who were able unable to quit during pregnancy. Children in less stressful environments are likely to enjoy more protective behavioural styles due both to inherited temperamental qualities and the quality of parenting. However, many of the studies cited above did try to control for social conditions. Further, the dose response found in studies of the impact of quitting compared to *never*, *continued* and *reduced* smoking during pregnancy suggest that increased risk of neuro-behavioural problems must also be partly due to the physiological effects of nicotine

79. Pickett K, Wood C, Adamson J, DeSouza L and Wakshiag L. Meaningful differences in maternal smoking behaviour during pregnancy: implications for infant behavioural vulnerability. J Epidemiol Community Health. 2008;62:318–24. Which has been demonstrated to disrupt fetal brain development in animals.

80. Benowitz N. Nicotine safety and toxicity. New York: Oxford University Press, 1998.

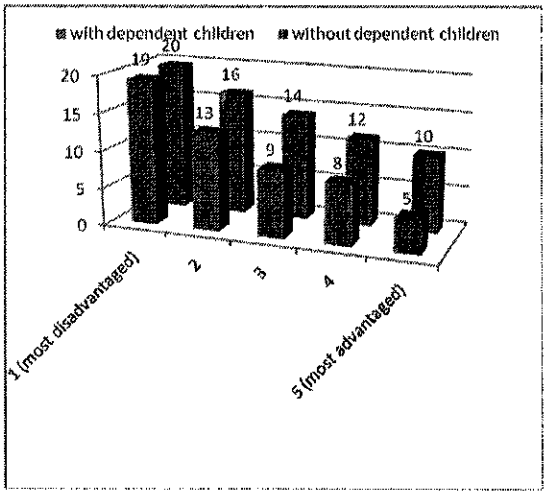


Figure 17 Percentage of households where at least one person smokes inside at least once daily, Australia 2004

Source: National Drug Strategy Household Survey 2004[107]

Among single parents with dependent children, at least one person smokes indoors at least once each day in one in three households.[107]

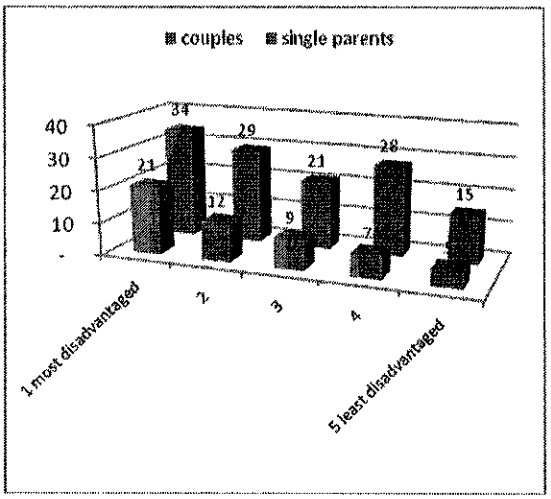


Figure 18 Percentage of households that report at least one person smoking at least one cigarette each day inside the home, Australia 2004—couples with any dependent children compared with single parents with any dependent children, by level of disadvantage

Source: National Drug Strategy Household Survey 2004[107]

Children in households in the most disadvantaged areas of Australia are four times more likely to be exposed to tobacco smoke inside than children in households in the most advantaged areas.

Reduced harm from use of and dependence on tobacco and nicotine

Among people who still smoke, the number of cigarettes smoked each day has been steadily declining since 1989 corresponding with increasing adoption of smoke-free workplaces and increasing price of cigarettes.

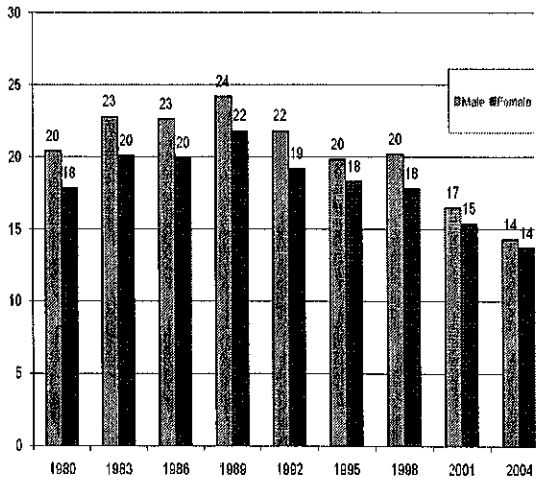


Figure 19 Reported number of cigarettes smoked by adults 18+, Australia 1980 to 2004

Source: NDSHS[2]

The percentage of people who can be classified as heavy smokers has also been declining with corresponding increases in the percentage of people who classify themselves as light smokers.

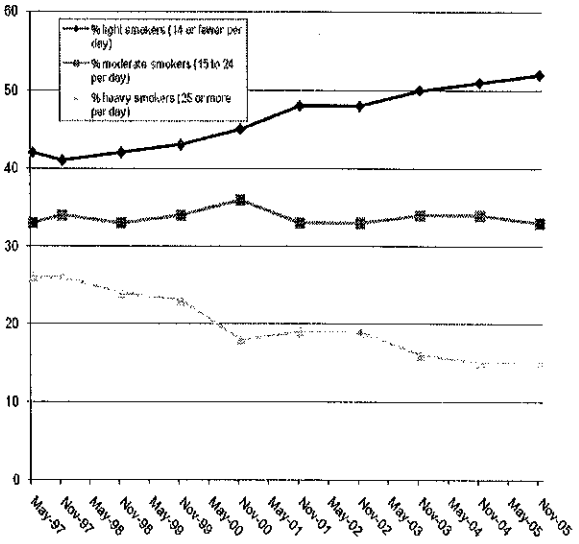


Figure 20 Percentage of smokers classified as light, moderate and heavy smokers, Australia 1997 to 2005

Source: Surveys to assess impact of National Tobacco Campaign[108]

Small reductions in cigarette consumption have not been demonstrated to reduce the incidence of tobacco-related disease, however lighter patterns of smoking are associated with both greater likelihood of attempting to quit and greater success in remaining abstinent.[109-111]

No monitoring systems are in place in Australia to measure emission levels of cigarettes, or performance in terms of preventing compensatory smoking or reduced ignition propensity. Biomarkers of likely harm for users of tobacco and other nicotine products are also not monitored.

Three. Progress in Australia implementing recommended policies and programs

To achieve the objectives of the National Tobacco Strategy, governments around Australia agreed in 2004 to pursue the following seven policies:

1. Regulation of **P**rice through tax, **P**romotion, **P**lace of sale, **P**lace of use, **P**ackaging and **P**roducts (with support expressed also for the idea of regulating **P**roducers)
2. Promotion of Quit and Smokefree messages
3. Cessation services and treatment
4. Community support and education
5. Addressing social, cultural and economic determinants
6. Tailoring for disadvantaged groups and
7. Research, evaluation, monitoring and surveillance

Information about Australian's considerable progress over the past 30 years as well as extensive evidence about the demonstrated or likely potential effectiveness of numerous interventions was set out in Section 6 of the Strategy document[7](pp18-40).

The remainder of this paper describes just ***where Australia's current performance falls short*** in each policy area in relation to

- research about optimal implementation
- the international Framework Convention on Tobacco Control to which Australia became a party in December 2003—**see Attachment 9** for further details and
- international best practice—**see Attachment 8** for a summary across all the policy areas, of progress in Australia compared with other English-speaking countries.

Several thousand additional scientific research papers have been published relevant to tobacco control since the National Tobacco Strategy was published, and thousands of newspaper articles have reported developments in tobacco control in nearly every country in the world.

In its synthesis of international developments and research, this paper has drawn on a wealth of literature from many fields and all over the world, but it has given greatest weight to the findings of the reports of expert groups, meta-analyses, and Australian and international research examining the impact of policy interventions. A list of the broad categories of sources is set out at the end of this document followed by a full list of over 500 references use in preparing this paper.

Particular emphasis is given to evidence on the effect of policies among disadvantaged groups. **Attachment 10** provides a detailed review of evidence from a broad range of disciplines that helps to shed light on underlying drivers of tobacco-related disparities.

It is important to remember that success in tobacco control to date has occurred not through clinical, classroom or workplace interventions but rather through a comprehensive *whole-of-population* approach that has profoundly changed cultural values about smoking.[112, 113] Equally important as regulation, campaigns, programs and treatment, advocates for tobacco control will need to continue to work hard[114] to keep smoking and its effects in the news[115] and on the political agenda[12].[118]

A recent European analysis[119] showed that quit ratios (the proportion of people who have ever smoked who have quit) were highest in those countries with the most developed tobacco control policies (as measured on a Tobacco Control Scale developed by the World Health Organization[120]). High and low-educated smokers benefited roughly equally from nation-wide policies. Another shortly-to-be-published comprehensive review of population-level tobacco control examined the impact of interventions such as smoke-free policies in schools, workplaces and other public places, restrictions on sales to minors, restrictions on advertising, health warnings, increases in prices and multi-faceted interventions. It found no evidence of any policies increasing inequalities and strong evidence of a *reduction* in inequalities resulting from increases in prices.[121]

Most of the disparities in smoking rates between socio-economic groups in Australia result from differences in uptake rather than in cessation. Figure 21 shows that around 30% of people can be classified as 'ex-smokers' regardless of the level of neighbourhood disadvantage. The percentage of people who have never taken up smoking however, is 18% higher in people living in the most advantaged neighbourhoods compared to those living in the least advantaged neighbourhoods.

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[12] In addition to the effect of this in maintaining support for tobacco control among politicians and other decision makers, news coverage about smoking has been demonstrate to have a direct effect on quitting in adults

116. Pierce JP and Gilpin EA. News media coverage of smoking and health is associated with changes in population rates of smoking cessation but not initiation. Tob Control. 2001;10:145-53. Available from: http://tobaccocontrol.bmj.com/cgi/content/abstract/10/2/145

and smoking by children.

117. Smith KC, Wakefield MA, Terry-McElrath Y, Chaloupka FJ, Flay B, Johnston L, et al. Relation between newspaper coverage of tobacco issues and smoking attitudes and behaviour among American teens. Tob Control. 2008;17:17-24. Available from: http://tobaccocontrol.bmj.com/cgi/content/abstract/17/1/17

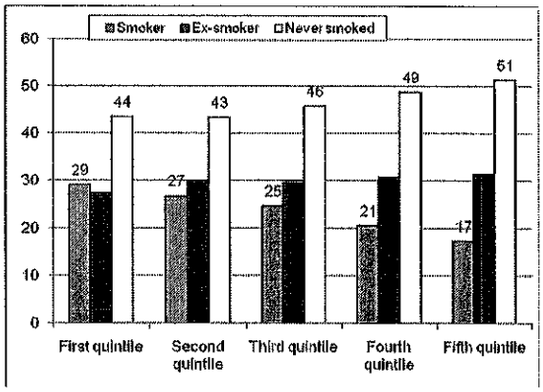


Figure 21 Smoking status, Australia 2004–05—prevalence *of current, ever* and *never* smoking by quintile of index of relative disadvantage

Source: ABS National Health Survey 2004–05

Preventing uptake of smoking is not just about education programs in schools or laws banning sales to minors. In fact, these strategies appear to exert only very weak effects on smoking rates in teenagers.[122-125]

All of the regulatory, educational and policy interventions described below are considered from the point of view of their impact on young people as well as on adults, and their potential impact across social groups.

With concerted efforts over the past 20 years to persuade decision-makers that tobacco is a serious medical, legal, economic, occupational health, mental health, consumer rights, ethical, social and political issue, it is hardly surprising that doctors, nurses, dentists, other health professionals, teachers, academics, business leaders, lawyers, politicians and journalists have been turning away from smoking in record numbers. These groups constitute—they ***are***—the most advantaged 10 to 15% of Australia's population.

A major study just published in the New England Journal of Medicine in May 2008 highlights the social diffusion process that has been at work in the wholesale rejection of smoking among the best educated sections of the population in the United States.[126] Sophisticated network analysis of data from the 12,000 people taking part over a 32-year period in the Framingham study reveals both the shifting position of smokers in society over that period and the dynamics of quitting. In 1971 smokers were indistinguishable from non-smokers in terms of integration in their social networks. Three decades later smokers were at the periphery of these networks aligned mainly only with other smokers.[127] Also interesting is the observation that smokers tended to quit in clusters rather than by gradual attrition.[31]

While over most of the past two decades smoking has been declining pretty much equally among all sections of the community in Australia, this seems recently to have changed. A major challenge, perhaps ***the*** major challenge, for tobacco control for the future is working out how best to accelerate social diffusion against smoking—how to make being a non-smoker and smoking cessation more '*contagious*'—among less well-educated groups and among disadvantaged communities.

I. Regulate

Smoking is so harmful that no company trying to introduce cigarettes into Australia today would succeed in getting them onto the market. Companies that choose to manufacture or sell tobacco products must realise that they do so in an environment where it is simply not acceptable to sell to children or in any way to discourage or undermine adults' efforts to quit. Banning a product that many people are unable to stop using is not a viable option. By regulating the tobacco market as effectively as possible however, the government can seek to eliminate commercial conduct that contributes to ill-informed, non-voluntary and unnecessarily harmful use of and exposure to tobacco.

Effective regulation of tobacco needs to address all four of the traditional '*P*'s of marketing: *Price, Promotion, Place* and *Packaging*. Given the impact of smoking on citizens other than smokers and the dangers of smoking combined with the addictiveness of nicotine, it needs to address '*Place of use*' and '*Product*' and '*Producers*' as well.

I 1. Price through tax

Policy intention: to make tobacco products less affordable

Additional evidence since 2004

Several meta-analyses published since 2004 confirmed the effectiveness of increasing prices to reduce tobacco consumption and prevalence.[119, 121, 128] These and several additional new studies continue to show greater impacts of price increases on quitting in low-income groups.[129, 130]

During the 2nd phase of the National Tobacco Campaign (NTC) (Nov 1999 to Nov 2002) prices of tobacco products increased significantly.[129] Among those people who were still smoking at the end of the 1st phase of the NTC, the prevalence of smoking decreased more among blue- than white-collar groups. Smoking declined by 6% in blue-collar groups but did not fall further in white-collar groups. Analysis of changes in monthly smoking prevalence in the largest Australian states in response to changes in various policy inputs[41] found that costliness of cigarettes has the most significant impact of all the policies studied. Another study in submission reports on the finding that the effect of price was greatest among those on lowest incomes.[131]

Apart from increasing taxes, governments can also influence the costliness of tobacco products by establishing minimum prices and by investing in measures to prevent tax evasion.

Minimum price laws which operate to protect small retailers in about half of US states have been found to result in higher average cigarette prices, but only in states such as New York where price promotions are also prohibited.[132]

The availability of cheap tobacco has been found to undermine the effectiveness of taxation in preventing uptake[133] and promoting quitting, particularly among low-income groups.[134, 135] In the UK one in 20 high-income smokers buys cheap tobacco products on which taxes have been avoided. For low-income smokers the figure is one in five.[136]

Progress against international comparators

The price of tobacco products in Australia rose steadily over the 1980s and 1990s. Each large price increase has been closely followed by declines in consumption.

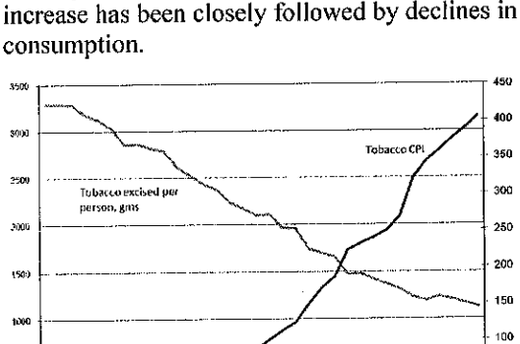


Figure 22 Tobacco products levied for excise and customs duty 1973 to 2006 compared to Tobacco and Cigarettes sub-group of CPI

Source: Facts and Issues in Australia, Ch 13[137]

Level of excise duty on tobacco

A sharp increase in the costliness of cigarettes between November 1999 and February 2001 following government reforms to excise duty was followed by a sharp drop in consumption. Between 2001 and 2006 however, the costliness of cigarettes has barely changed, and per capita consumption has fallen only slightly.

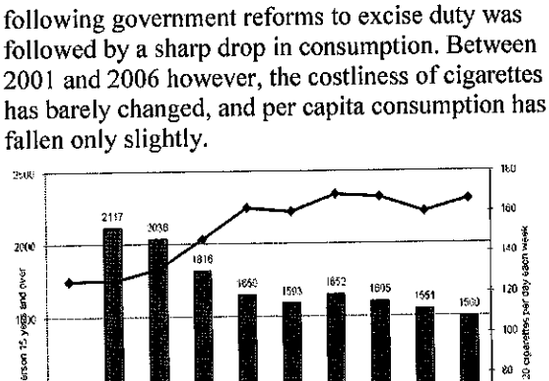


Figure 23 per capita consumption of cigarettes compared with affordability

Source: Facts and Issues in Australia, Ch 13[137]

The World Health Organization has recommended that governments ensure that the price of cigarettes increase in real terms each year by at least 5%. In Australia in 2008, the recommended retail price of *Peter Jackson 30s* is 90 cents lower than it would have been had the previous government adhered to this policy since 2001.

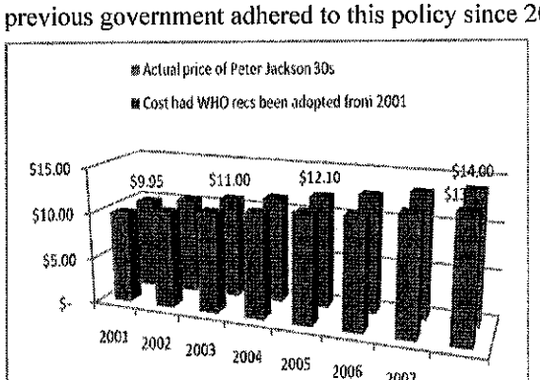


Figure 24 Recommended retail price of Peter Jackson 30s compared with prices if they had increased at 5% per annum

Source: Facts and Issues in Australia, Ch 13[137]

Actual retail prices paid by Australian smokers have been considerably lower than prices recommended by retailers due to the wide availability of discounted packs and cartons from supermarkets as well as from tobacconists.

Table 3 Recommended retail prices per cigarette of leading brands in 2002, 2003 and 2004 vs reported prices paid by consumers, ($ current, cents per stick)

	2002		2003		2004	
Brand	Rec'd retail price	Rept'd price paid	Rec'd retail price	Rept'd price paid	Rec'd retail price	Rept'd price paid
Winfield	37.00	36.02	38.62	36.69	40.00	38.41
Longbeach	33.50	31.09	34.75	31.96	36.25	33.71
Peter Jackson	35.33	34.01	36.67	34.22	38.00	35.33
Horizon	32.67	30.92	34.00	31.49	35.52	32.96
Escort	34.43	32.49	35.71	34.05	37.14	37.36

Sources: Australian Retail Tobacconist Price Lists, August 2002, 2003, 2004;[138] International Tobacco Control Policy Evaluation Study[139]

For more detailed information on taxes and prices in Australia **see Attachment 11.**

While prices are lower than they would have been had the government adopted WHO recommendations and had discounting not been so prominent, they are actually quite a lot higher than might be expected given that there have been no increases in excise and customs duty other than indexation over that time.

Over the past five years the price paid by smokers has increased by considerably more than inflation— in fact prices on tobacco products have increased at a greater rate even than prices of food— see Figure 25.

In the absence of government increases in excise and customs duty on tobacco, it seems that tobacco companies must have increased prices instead. These increases have been applied very gently and gradually so that they would have been unlikely to encourage quitting.

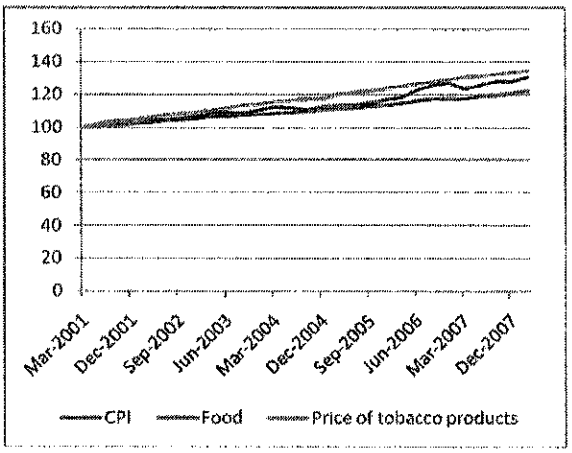


Figure 25 Consumer price index, Food Sub-Index and Tobacco & Cigarettes Sub-group, Australia 2001 to 2007

Source: ABS Consumer Price Index[140]

Because it has been the tobacco companies rather than governments that have increased the unit charge on each pack of cigarettes, it has been *tobacco companies* rather than *governments* which have benefited from the extra revenue resulting from the maintenance in sales.

Revenue protection measures

Since 2004 the Australian Tax Office has continued to aggressively pursue evasion of excise duty through the sale of illicit unprocessed tobacco known as *chop chop*.[141, 142] Over 233 million cigarettes and 472 tonnes of tobacco have been seized since 2002[143] when the first facility to examine containers was established at an Australian port.[13] The Department of Health and Ageing (referred to as DOHA from now on this paper) has convened an Interdepartmental Committee including representatives from the Attorney-General's Department, Treasury, Department of Foreign Affairs and Trade, Australian Customs Service, and the Department of Innovation, Industry, Science and Research. However so far there appears to have been little progress on measures now required under clauses 15.2, 15.4 and 15.6 of the FCTC to 'cooperate with other parties on the elimination of illicit trade'. No action has been taken to introduce tax and related markings on packaging, to require manufacturers and importers to track and report on sales and distribution, to ban the sale of tobacco products to retail customers via the Internet or to abolish duty free sales.

Ideas for consideration

To restore Australian cigarette prices to levels in line with WHO recommendations, increase excise and customs duty by 2.5 cents per stick. Further increases could be considered when other measures are in place to prevent revenue evasion and to improve services for quitters.

Explore barriers to prohibiting manufacturers and retailers from offering short-term discounts on particular tobacco products, or to establishing minimum price levels for cigarettes in Australia.

Develop regulations and administrative systems on tax markings and tracking systems and on abolition of duty free sales and sales through the Internet.

I 2. Place of use

Policy intention: to eliminate exposure to environmental tobacco smoke indoors at work and in public places (and outdoors where exposure cannot be avoided) and to minimise it in residential institutions

Additional evidence since 2004

Evidence about the health risks posed by exposure to second-hand smoke has strengthened with an updated report by the US Surgeon General in 2006.[144] Alarming levels of exposure to toxic substances have been documented in children whose parents smoke inside cars,[145-147] and community support to ban smoking in cars carrying children is now high[148] even though this is not something for which health agencies have particularly pushed.[149] Smoking in cars is more common in lower SES families[150, 151] so legislation restricting smoking in motor vehicles may have a differential effect on exposure to tobacco smoke and attitudes to smoking in more disadvantaged groups.

The International Agency for Research Against Cancer (IARC) will shortly release a report of its findings on the effectiveness of smoke-free policies in reducing population exposure to second-hand smoke.[152] This expert scientific body has concluded that there is sufficient evidence to accept that laws restricting smoking in workplaces and other public places reduce population exposure to second-hand smoke and consumption of cigarettes, and respiratory symptoms in workers. It has also found that such policies provide net benefits to business with no adverse affects on overall sales in the hospitality industry.[153] The extension of smoke-free policies to pubs in New Zealand in December 2004[154] may have been a major factor contributing to a decline of smoking in that country after several years of stalled smoking rates.[48] An international study just released of adolescents from 32 countries in Europe, Israel and North America using multi-level hierarchical regression models has found a strong relationship between the adoption of national smoke-free laws and declines in adolescent smoking.[125]

Although the introduction of smoking bans may more favourably affect smoking *attitudes* in higher occupational groups, a recent review of the impact of policies internationally found that there was no evidence that restrictions in workplaces were more effective in reducing smoking *behaviour*.[121] (Note

[13] About one in 20 shipping containers are currently X-rayed. Although the Customs Service gives priority to containers it judges to be higher risk, some proportion of tobacco products must be being missed.

in Australia however, that prior to the late 1990s voluntary adoption of smoke-free policies was much more common in white- than in blue-collar workplaces so that the impact to date may have been higher among advantaged groups.)

Progress against international comparators

Over the past four years, all Australian states and territories have extended legislation to reduce public exposure to second-hand smoke: progress in Australia has been comparable to that in the United States—**see Attachment 12**. With the exception of the Northern Territory, legislation applies to hotels and nightclubs as well as to restaurants, with some exceptions relating to gaming areas in some jurisdictions. Because legislation has been introduced at different times in different places, several loopholes and inadequacies have emerged in some aspects of operation and enforcement. These could be addressed through amendments.

Bans on smoking in cars are being adopted by an increasing number of North American jurisdictions—**see Attachment 8**. Smoking in vehicles where a person under 16 years of age is also present has been banned in South Australia since May 2007.[14] Bans on smoking in vehicles containing persons less than 18 years of age became effective in Tasmania in January 2008.[15] The Queensland government announced its intention to ban smoking in cars carrying persons less than 16 years of age in May 2008.[16] In April 2008, the NSW government released a discussion paper announcing its proposal to ban smoking in cars containing persons under the age of 18 years.[155] The Victorian Premier has also announced his intention to consider such a proposal.

In several states in the US there has been much discussion about the problem of smoke-drift between apartments, some attempts at legal action[156] and growing pressure for legislation.

Ideas for consideration

Review and if necessary amend state and territory legislation to cover the loose ends and address the loopholes as per the detailed specifications in **Attachment 19.**

Legislate to ban smoking in cars containing children.

Legislate to require leases for multiunit apartment buildings and condominium sales agreements to include the terms governing smoking in common areas and in residential units. Owners could be encouraged to make common areas smoke-free with agreed penalties for breaches, and (given the likelihood of increasing demand)[157] to consider making large sections of apartment complexes completely smoke-free.

[14] *Tobacco Products Regulation Act 1997 (SA) s.48).*

[15] *Public Health Act 2007 (Tas)* s.67H

[16] See Joint statement issued by the QLD Premier, Anna Bligh and Minister for Health, Stephen Robertson, 26 May 2008, http://statements.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=58227.

I 3. Place of sale

Policy intention: To regulate supply so that tobacco products are available to adults who use them, but are not highly visible, and are not sold to children

Additional evidence since 2004

Display of tobacco products in stores contributes to the perception that cigarettes are widely available, and that smoking is the norm. The prominence of such displays may lead young people to over-estimate smoking prevalence among peers and the adult population.[158] The degree of this overestimation has been shown to predict smoking initiation.[159]

Two recent Australians studies demonstrate the powerful impact of retail displays on both children and adult smokers.[160, 161]

The first study used photographs of milk-bar counters with and without cigarettes displayed to assess the effects on children's perceptions. Children who viewed cigarette displays perceived it would be easier to purchase tobacco and tended to recall displayed cigarette brands more often than respondents who saw no cigarettes.[160]

A survey of adults found that when shopping for items other than cigarettes, 25% of smokers purchased cigarettes at least sometimes on impulse as a result of seeing the cigarette display. Thirty-eight per cent of smokers who had tried to quit in the past 12 months and 34% of recent quitters experienced an urge to buy cigarettes as a result of seeing the retail cigarette display. One in five smokers trying to quit and one in eight recent quitters avoided stores where they usually bought cigarettes in case they might be tempted to purchase them. Nearly one-third of smokers thought the removal of cigarette displays from stores would make it easier for them to quit. The study authors conclude that cigarette displays act as cues to smoke, even among those not explicitly intending to buy cigarettes, and those trying to avoid smoking.[161]

Prohibiting the display of tobacco products in supermarkets, convenience stores and other retail outlets would ensure that children and young people would very rarely see tobacco products in daily life, reinforcing the idea that they are not a normal consumer item.[158] It would ensure that smokers who would like to quit are not subject to cues to purchase cigarettes and to continue or to resume smoking as they go about their life doing weekly shopping, buying milk, bread or the newspaper, filling the car with petrol. Given the higher prevalence of smoking and the greater prominence of tobacco in retail outlets in disadvantaged areas,[162] this measure should be at least as effective with children and adults in disadvantaged as in more advantaged neighbourhoods.

Progress against international comparators

Across the world, an increasing number of jurisdictions have taken action to limit or prohibit the display of tobacco products. These include: Iceland (2001), Thailand (2005) British Virgin Islands (2007), Canada (provinces of Saskatchewan, Manitoba, Nunavut, Prince Edward Island, British Columbia, New Brunswick, Northwest Territories, Nova Scotia, Ontario, Quebec, Alberta, Yukon Territory).[163]

In Australia, governments have introduced legislation to ban displays in Tasmania from 2011[17] and have consulted on legislation in the ACT[18] and New South Wales[164]. Victorian and Queensland governments are also understood to be considering such legislation.

The Canadian federal government has consulted on introducing regulations for a national display ban[163, 165] as have governments in New Zealand (which plans to implement restrictions in 2009) Norway (where draft regulations await approval by EU Member States) and Britain (where a consultation paper was released in June 2008)[166].

Idea for consideration

Amend the *Tobacco Advertising Prohibition Act 1992* (Cth)[167] to prohibit display of tobacco products in all states and territories.

I 4. Promotion

Policy intention: To eliminate all remaining forms of tobacco promotion by those in the tobacco trade, and to discourage and address harm caused by other positive portrayals of smoking in the media

4.1 Promotion through new media and events

Additional evidence since 2004

In a comprehensive scientific review to be released in July 2008, the US National Cancer Institute has concluded that the total weight of evidence from multiple types of studies demonstrates a causal relationship between the promotion of tobacco and increased tobacco use.[168] It concludes from both industry documents and scientific studies that promotion of tobacco products continues to involve highly sophisticated targeting and segmentation of both existing and potential users, that the tobacco industry does not effectively self-regulate its marketing practices and that companies typically respond to partial bans by increasing expenditure in 'permitted' media including through new media forms developing as a result of emerging technology.

Progress against international comparators

Australia's *Tobacco Advertising Prohibition Act 1992* (Cth) and tobacco control legislation in the states and territories effectively prevents most promotion of tobacco through traditional forms of media. However many newly emerged forms of marketing aimed primarily at young adults but which also influence many teenagers (such as viral marketing through internet sites, entertainment venues and events)[169] are not so clearly covered.[170] Submissions from expert health agencies[170] to a review of the Act in 2003[171] identified numerous loose ends and a number of important loopholes that needed to be addressed to ensure that the Act remains effective into the 21st Century. None of these recommendations was acted upon prior to the change of government. Ministers agreed at the May 2007 Ministerial Council on Drug Strategy (MCDS) meeting that all Governments collaborate to ban the sale and advertising of tobacco products over the Internet. Recent legal advice the Department has received indicates it is open to the Commonwealth to take the lead and it has engaged a consultant to undertake an economic analysis and develop a Regulatory Impact Statement by July 2008.

Since 2004, sale of tobacco products through the Internet has been banned in several jurisdictions including Brazil, and New York, Connecticut and Alaska. Placement of advertisements onto the Internet is banned in Hong Kong.

Ideas for consideration

In line with recommendations to the 2003 review, amend the TAP Act to expressly prohibit all remaining forms of promotion—see **Attachment 19 for details.**

Require manufacturers to make regular, full and detailed disclosure, with no minimum threshold, of all amounts spent on any kind of promotional activity, including promotion through the pack, through discounts and other assistance to retailers. The disclosures should specify how much is spent on different types of promotional activity.

4.2 Smoking in movies, TV programs, magazines and electronic games

Additional evidence since 2004

There is no doubt that smoking is portrayed in movies to a much greater extent than it occurs in real life.[172-181] Reviews of the evidence by several scientific bodies[5, 182, 183] and several recent very-well designed studies and meta-analyses[184-188] conclude that smoking by popular characters can exert a powerful influence on teenagers, particularly those with temperaments that make them prone to seeking novelty and excitement.[189, 190]

However there is little agreement among tobacco control advocates about what can best be done to address this problem.[191-193] Bans or automatic

[17] *Public Health Amendment Bill 2007* (Tas) cl.9

[18] *Tobacco Amendment Bill 2008* (ACT) cl.20

ratings for products depicting smoking would be opposed by the film and television industries and would also not be supported by most public health advocates. One study has shown that the screening of anti-smoking advertisements before films depicting smoking would reduce the impact of such depictions,[194] but advocates fear that such advertisements would quickly become counter-productive unless they were of high production value and frequently replaced. Providing such advertisements would be expensive and labour intensive.

Progress against international comparators

The Motion Picture Association of America and the government classification authority in the UK have both recently moved to include depiction of tobacco smoking as one of the factors taken into account when they classify new movies. Rating of films in the US in particular has commercial implications in terms of audience numbers, so that this policy may start to result in less depiction of smoking in movies intended for younger audiences being produced in Hollywood studios from now on. So far the effects of this policy have not been dramatic. Several prominent US advocates are pointing to films that they think are rated less restrictively than they should be and are still vigorously pushing for further restrictions.[195]

Attachment 13 sets out several options that could be explored in Australia. One option would be to follow the lead of the US and the UK and simply require the Classification Board to take smoking into account along with all the other things members of the Board are required to take into account when rating films. Such a move would be consistent with broader government policy on censorship and classification, would be supported by parents, may result in a reduction in damaging depictions of smoking in films seen by younger teenagers and ought not to be controversial with the film industry.

Ideas for consideration

Designate tobacco use as a 'classifiable element', to be taken into account by the Classification Board when rating films (with the consequence that films with particularly seductive portrayals of smoking would be likely to be given a more restrictive classification[19]).

Produce a set of guidance notes to the Board based on findings of the literature on the impact of portrayals of smoking on young people.

To assess the effectiveness of this policy, commission a suitable agency to commence ongoing monitoring of the exposure of Australian teenagers (concentrating on those aged 14 and 15) to portrayals of smoking in movies, videos and computer games.

[19] Other classifiable elements are themes of violence, sex, language, drug use and nudity as set out in the *Guidelines for the Classification of Films and Computer Games 2005*.

4.3 Promotion through packaging

[redacted]al evidence since 2004

[redacted]brand names and package design enable th[redacted]unication of personal characteristics, social ident[redacted]d positions in hierarchies of status[196] and are [redacted]crucial aspect of marketing the product.[197] Requiring cigarettes to be sold in plain packaging would reinforce the idea that cigarettes are not an ordinary consumer item. It would also reduce the potential for cigarettes to be used to signify status.

Plain packaging may also increase the salience of health warnings. Students have enhanced ability to recall health warnings on plain packs.[198-200]

Industry resistance to restrictions on pack design is a strong indication of its importance to tobacco sales.[201] UK investors obviously agree that plain packaging would reduce profitability. When the government released its consultation paper flagging its intention to introduce such a policy the price of stocks in Imperial Tobacco Group fell by 3.6%.[202]

Progress against international comparators

Tobacco companies have increasingly used the pack to manipulate the image of new and existing brands[203]—see **Attachment 14** for a detailed description of these activities and for a copy of the UK government's rationale and evidence for **plain packaging**. Draft guidelines for both FCTC Article 11 (Packaging and Labelling) and Article 13 (Tobacco advertising, promotion and sponsorship), encourage parties (governments) to consider the introduction of plain packaging for tobacco products. These draft guidelines will be presented to the third session of the FCTC Conference of the Parties for adoption in November 2008.[20]

Idea for consideration

Require all tobacco products to be sold in plain packaging, the appearance of which could be prescribed in Part 4 of the *Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004* (Cth) ('Regulations') – see **Attachment 19 for further details.**

5. Product information for consumers

Policy intention: to mandate adequate and effective consumer information on tobacco products and at point of sale

5.1 Health warnings

Progress against international comparators

In 2006 after many years of negotiation, testing[204, 205] and assessment,[205] the six black text

[20] The draft guidelines are not currently public documents however staff from the Cancer Council Victoria participated in the official Working Group for both Article 11 and Article 13.

warnings on white background covering 25% of the front and 33% and back of the package that had been required on cigarette packets in Australia since 2004[206] were replaced with fourteen graphic warnings covering 30% of the front and 90% of the back of the pack.[206-208] Long delays were observed in cigarettes with new warnings actually being available in shops.[209] In November 2007, DOHA commissioned Elliot and Shanahan Research to conduct an evaluation of current warnings due for completion in mid-2008.

Cigarettes in a large proportion of the world's countries are now required (or shortly will be required) to carry graphic health warnings. The following countries have now finalized laws requiring picture-based warnings:

> Australia (2006), Belgium (2006), Brazil (2002 improved in 2004 and then again in 2008), Canada (2001), Chile (2006), India (2007), Jordan (2006), New Zealand (2008), Singapore (2004 and then again in 2006), Thailand (2005 and then again in 2007), Uruguay (2006) and Venezuela (2005).

Countries in the 27-member European Community also have the option of requiring picture-based warnings, choosing from among 42 picture messages prepared by the European Commission. The UK will require graphic warnings from October 2008[21]. The Governments of Czech Republic, Hong Kong, Iran, Ireland, Latvia, Malaysia, Mexico, Portugal, Romania and South Africa, have also all now said publicly that picture-based warnings are under consideration.[210]

Several countries have modified size and style several times over the past decade in order to increase effectiveness and most countries requiring graphic warnings specify that these take up around half the pack (50% in Canada, Singapore, Thailand, Uruguay, India, and Chile; 48% in Belgium and Switzerland including borders; 45% including border in Finland and 43% in uni-lingual EU countries, Norway and Iceland). **Attachment 15** provides examples of some of these warnings.[210] The WHO Framework Convention on Tobacco Control[211] specifies that warnings must cover at least 30%, but preferably should cover at least 50% of the principle display areas.

Australia is now well behind when it comes to size and potency of warnings.

Additional evidence since 2004

Previous evidence from the ITC 4 Nations Project surveys indicated greater impact on smokers from Canadian graphic warnings relative to text warnings in the USA, UK and Australia prior to 2006.[212, 213] A further study recently submitted for publication[214] compares the short-term impact of new graphic Australian warnings with the earlier UK move to larger text-based warnings, the continuation of graphic warnings in Canada, and of small text warnings in the US. The study finds that introduction of new graphic warnings in Australia increased salience of warnings, cognitive reactions and behavioural responses. Levels of smokers foregoing cigarettes rose to 17% in response to the 2006 warnings, compared to 14% for the 1995 enhanced text warnings introduced in 1995.[214] The study also indicated the superiority of Canadian warnings despite having been in place since 2001, most likely due to the additional clarity and prominence resulting from their larger size. There was some evidence of increases in avoidance of graphic warnings, however, if anything, such reactions are positively associated with quitting. [215-217] This should assuage concerns among those who feared unintended consequences.

New evidence about the health effects of smoking emerges literally every day—see **Attachment 2**—and yet warnings on cigarette packs in Australia have been reviewed only three times in the past 20 years.[218, 219] Monitoring over four years of the ITC 4 nations study shows clearly that the effects of the warnings decay, suggesting the need for frequent rotation and frequent introduction of new warnings.

All these factors suggest the need for a system by which consumers of tobacco products can much more rapidly be warned of new and emerging risks.

Ideas for consideration

Amend Schedule 2 to the *Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004*,[206] to prescribe that health warnings must cover at least 50% of the front and 100% of the back of the pack—**see Attachment 19** for further details.

Develop and implement a new system for providing consumer product information to smokers, which ensures that package health warnings are reviewed much more regularly and amended where necessary to maintain their effectiveness.

Complement pack warnings with more frequent and rapid warnings through bulletins from a designated authority (perhaps the Chief Medical Officer) to news media and at point of sale.

5.2 Ingredients disclosure

Progress against international comparators

Since 1999 the three tobacco companies currently manufacturing in Australia, Philip Morris Limited (PML), British American Tobacco Australia Limited (BATA) and Imperial Tobacco Australia Limited (ITA) have provided ingredient data to the Department under a *Voluntary Agreement for the Disclosure of the Ingredients of Cigarettes*.[220] The manufacturers provide annual reports which are posted unmodified on the Australian Government Department of Health and Ageing's website.[221] As per the Agreement, the manufacturers provide the following:

[21] *See The Tobacco Products (Manufacture, Presentation and Sale) (Safety) (Amendment) Regulations 2007* http://www.opsi.gov.uk/si/si2007/uksi_20072473_en_1

- composite lists of tobacco ingredients (including flavourings), in alphabetical order, with the functions of each ingredient's (filler, flavour, humectant, preservative, binder etc) also listed
- composite lists of non-tobacco ingredients, in alphabetical order, each product's ingredients being listed separately and processing aids and preservatives combined under each heading
- by-brand variant lists of ingredients, including product weight and tobacco weight, with ingredients listed in descending order by weight.

Ministers attending the May 2007 meeting of the MCDS, agreed that a feasibility study on ingredient disclosure would be commissioned to investigate the legal issues, appropriate powers, costs, suitable locations, timelines, potential risks and other ramifications of formalising these arrangements in law. The study will identify the information needs of consumers, scientists and policy makers. Comments on the Request for Tender were invited and received from an Intergovernmental Committee Project working party in January 2008 and the RFT is likely to be advertised shortly.

See I6 below for ideas for consideration.

5.3 Display of tar, CO & nicotine yields

Current methods for measuring the yields of carbon monoxide and 'tar' from cigarettes using cigarette machines set to standard-puff protocols has now been widely discredited.[222] Such testing does not accurately reflect delivery to humans, and smoking of low-tar cigarettes in the US have not been associated with a reduction in health risks.[223] By placing ventilation holes in the filters, air is mixed with the smoke, and companies have been able to quote low machine-tested levels of tar delivery.[224, 225] However, humans do not smoke like machines. Smokers soon learn to cover the holes in order to get a full dose of nicotine[226] and it seems that they get a full dose of tar in the process.[227]

Progress against international comparators

The Australian Government has ended the legal requirement to display yield information on packs, however the current legislation does not prohibit it.[22] The only constraints on manufacturers displaying yield information and descriptors such as "light" and "mild" arise under the undertakings accepted by the Australian Competition and Consumer Commission (ACCC) in 2005 from Philip Morris, British American Tobacco Australia Limited and Imperial Tobacco Australia Ltd. While the undertakings given by each manufacturer differed slightly, each undertook to cease displaying descriptors and yield information on packs. Tobacco companies that are not subject to these undertakings face no restrictions.

Light and mild descriptors were banned throughout the EU from September 2003.

Additional evidence since 2004

The ITC 4 Nations study found that by 2006 inaccurate beliefs about health benefits of light cigarettes were just as common among smokers in the UK as they had been before the EU ban took effect.[228] The researchers conclude that efforts to correct decades of consumer misperceptions about light cigarettes must extend beyond simply removing 'light and mild' brand descriptors.

Idea for consideration

Prohibit the commercial supply of tobacco products in packs displaying misleading descriptors such as 'light' and 'mild' and similar terms, or any numbers associated with the tar, nicotine and carbon monoxide content of smoke from the cigarettes inside the pack, or any pack that uses colours, brand names, milder taste or any other device to suggest lower yields.

I 6. Product

6.1 Cigarette ingredients and design

Additional evidence since 2004

Cigarettes in Australia have relied heavily on filter ventilation to reduce machine-measured tar levels that bear little resemblance to levels of toxins delivered to typical smokers.[229] Any labelling system based on machine-testing methods that do not mirror human smoking behaviour is likely to mislead consumers.[230] It is difficult to think of a justification for continuing to allow filter ventilation.[231]

Progress against international comparators

Unlike the situation in Canada, New Zealand, the UK, the European Union, Thailand and the US, there are presently no regulatory controls over the reporting of tobacco product constituents, emissions, additives, manufacture or design in Australia.[232]

Ideas for consideration

Establish a regulatory body[23] with powers to ban, specify or mandate any particular tobacco product constituents, emissions, additives, or other aspects of manufacture and design.

One of the first jobs of the regulator could be to investigate the viability of removing additives from cigarettes. Additives should be banned unless manufacturers can demonstrate that these are necessary and that they do not serve to increase palatability, ease of smoking or delivery of nicotine.

Even prior to the establishment of such a regulator, consider banning filter ventilation.

[22] See *Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004 (Cth)*.

[23] The responsible regulator may be an existing agency, such as the Australian Competition and Consumer Commission, or the Therapeutic Goods Administration, or it could be a newly created agency.

6.2 Oral tobacco

Additional evidence since 2004

Several major reviews[233-235] and recent longitudinal studies[236-241] have concluded that low-nitrosamine smokeless tobacco products such as Swedish snus (a form of powdered tobacco sold in tea-bag-like packages which are kept in the mouth and sucked) are significantly less harmful than cigarettes and other tobacco products that are smoked.

Progress against international comparators

Oral tobacco products are sold in the US, Sweden and much of Asia and Africa. In Australia a ban in place since 1989[242] on the retail supply of oral tobacco products (snuff/snus and chewing tobacco) under the *Trade Practices Act 1974* permits individuals to import only small quantities for personal use under the *Customs (Prohibited Imports) Regulations 1956*. Other oral products, where tobacco is not the primary constituent—products such as betel nut, pan masala gutkha, naswar imported from Africa, Asia and the Indian subcontinent— are not captured. In mid-2006, the duty payable on these was aligned with that on loose tobacco. Changes in custom codes over the past few years make it difficult to assess the extent to which imports of these products is increasing.

Some health experts, including some in Australia[243] have called for the wider availability of low-nitrosamine smokeless tobacco.[244-249] Others are more cautious.[249, 250] For the moment most health agencies and advocates[251, 252] support the continuation in Australia of restricted importation of smokeless tobacco products for personal use, ensuring that current users are not denied access, while deterring non-tobacco users (particularly youth) from commencing.

6.3 Alternative nicotine delivery devices

In the last couple of years a proliferation of new devices providing nicotine in products other than those that need to be lit and inhaled are being launched into various markets around the world. Alternative nicotine delivery devices (ANDS) include products such as sweets, hand gel,[253] mouth washes and electronic cigarettes. [253-281] Electronic cigarettes consist of a tubing device resembling a conventional cigarette. This heats a replaceable cartridge filled with liquid nicotine and other chemicals (i.e. does not contain tobacco leaf). The heating process creates a mist that resembles cigarette smoke and is inhaled by the user. The e-cigarette is marketed by some companies as a healthier alternative.

> *It feels like a cigarette/cigar, looks like a cigarette/cigar but has NO tar, NO carbon Monoxide and NO tobacco. This product is a clean, healthy alternative to smoking. ... Egar Cigarette can be used legally indoors, in restaurants – ANYWHERE you wish, where traditional smoking is prohibited!...Beat the smoking ban!* [24]

If e-cigarettes are marketed as an aid in withdrawal from smoking they will be considered a therapeutic good and would have to be listed on the Australian Register of Therapeutic Goods before they could be imported and retailed in Australia. It seems unlikely that they would meet standards for safety and efficacy. If on the other hand e-cigarettes are marketed exclusively as recreational devices, they may not meet the definition of *therapeutic use*. The Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP) currently categorise all nicotine products that are not tobacco products or used for nicotine replacement therapy as falling under Schedule 7, which covers Dangerous Poisons. So, at present such products (not being clearly a tobacco product or a nicotine replacement therapy) would probably not satisfy the stated exceptions meaning that they could not be retailed under State and Territory legislation.

As with smokeless tobacco, health experts are deeply divided about the usefulness of these products. As 'clean' alternatives to cigarette-delivered nicotine some advocates would like to see their use popularised with young people as an alternative to cigarettes. While acknowledging the potential benefits for helping long-time smokers who have been unable to quit to reduce their consumption, other advocates worry about the many possible downsides. The debate about harm reduction has been a divisive one among tobacco control advocates,[282] and the objections raised to harm reduction are sometimes not entirely rational.[283] Concerns are not easily dismissed, however, about the potential of such products to attract young people who would not otherwise have used any form of nicotine and then to act as a gateway to cigarettes. Also worrying is the possibility that adults who might otherwise have given up tobacco completely but, with the availability of such products, remain dependent on nicotine and return to cigarettes which are always likely to be a superior delivery device.[252, 284] Modelling of the potential benefits and harms suggests the need for restricting availability of such products to long-time users unable to quit. However, such an approach would have few public health benefits unless large numbers of such smokers know about such alternative products and were willing to try them. It's a conundrum that continues to be extensively debated.[246, 248, 249, 285-291]

Idea for consideration

Any regulatory body established to regulate the design, labelling and marketing of tobacco products could also be given responsibility for regulating alternative nicotine delivery devices.

[24] See www.egar.com.au, 5 June 2008

6.4 Reduced ignition propensity

Additional evidence since 2004

Research from Canada has confirmed that smokers not uncommonly engage in behaviour (dozing while smoking, leaving cigarettes unattended) that puts their households at risk of cigarette-related fires.[292]

Smoking is the leading cause of residential and total fire deaths in at least eight countries, including Australia.[293] Cigarettes are a significant cause of fire damage resulting in lives lost and economic costs totalling around $81m in 2004-05.[24]

Regular manufactured cigarettes do not self-extinguish, because of the addition to cigarette paper of burn accelerants. Elimination of such chemicals appears to be a simple and effective means of reducing the ignition propensity of cigarettes.[294]

Fire cause investigators and other fire industry leaders unanimously support introduction of regulations to reduce the fire risk of cigarettes.[293, 295]

Progress against international comparators

Since 2004, laws mandating standards for reduced ignition propensity in cigarettes have been enacted in at least 22 US states (ranging from New York in 2004 to North Carolina from 2010) and Philip Morris has stated that it supports the application of a national standard.[296] In October 2007 RJ Reynolds announced that all its cigarettes will be manufactured to the reduced fire risk standard.[297] Canada has had national legislation since 2004 and the EU is also set to impose regulations that would cover the UK, Scotland, the Republic of Ireland and the rest of Europe.[298] Evaluation of the introduction of reduced ignition propensity cigarettes in New York found that cigarettes met the standards, did not significantly increase emissions of tar and carbon monoxide and were acceptable to consumers.[299]

In March 2007, Standards Australia announced the release of a new Australian 'standard for reduced fire risk cigarettes' (a tool by which to measure the self-extinguishing properties of cigarettes), now 'available to State and Federal Governments for inclusion in any future legislation requiring cigarette companies to manufacture reduced fire risk cigarettes'.[300][25] In January 2008 the Australian Competition and Consumer Commission (ACCC) released a draft Regulatory Impact Statement (RIS)[301] recommending the introduction of a mandatory minimum reduced fire risk standard for all cigarettes manufactured in or imported into Australia.[26] The ACCC will shortly release the finalised RIS, but no level of ignition propensity has yet been mandated by any Australian jurisdiction.

Idea for consideration

Prescribe a national mandatory safety standard for reduced ignition propensity cigarettes.

I 7. Producers and purveyors

7.1 Licensing of retailers

Additional research since 2004

Tobacco retail outlets are highly concentrated in lower socio-economic areas.[302] Reductions in the availability of tobacco products are associated with lower levels of smoking.[303]

Progress in Australia compared to internationally

Most states in the US and many provinces in Canada require licensing of tobacco retailers.

A detailed report commissioned by the Australian Government in 2002 (the *Allen report*)[304] concluded that licensing of retailers was the most effective way of informing tobacco retailers and wholesalers of legal obligations and of ensuring that authorities had information necessary to enforce tobacco control laws. Licensing would give 'teeth' to bans on selling tobacco products to under 18s, and other laws relating to tobacco sales, such as those governing point of sale displays and tobacco advertising. Linking a retailer's tobacco licence to compliance with tobacco control measures gives authorities the ability to suspend or withdraw the right to sell tobacco products in the event of a breach. In Tasmania, for example, sales of tobacco products to children are immediately prosecuted, and any second offence is punishable by the imposition of a A$10,000 fine and licence cancellation.[27]

A *best practice* scheme, the Allen report stated, would incorporate the following features:

- Licensing viewed as a health issue, and therefore controlled by health officials (subject to contracting out certain functions).
- Positive licensing approach, where prior approval was required and compliance with minimum conditions demonstrated before sales could commence
- Licences applicable to each particular retail venue rather than each operator
- Applicants required to declare that they have read, understood, and agree to abide by applicable tobacco control laws
- A graduated penalty structure, including warnings, administrative penalties, prosecutions and scope for licence withdrawal
- A consistent approach to licensing among all the States and Territories with the Commonwealth Government issuing and seeking to persuade the

[25] Standards Australia media release, 9 March 2007. Accessible at <http://www.standards.org.au/downloads/070307_Low_fire_risk_cigarettes_Standard_released.pdf>, visited on 1 May 2007.

[26] See Option 3 of draft RIS.

[27] See Tasmanian Health and Human Services Agency website, at <http://www.dhhs.tas.gov.au/agency/pro/tobacco/salestochildren.php> visited on 23 May 2006. See also Division 3, *Public Health Act 1997* (Tas).

States and Territories to adopt best practice licensing principles.[28]

As at 1 June 2008, positive retailer licensing schemes were in place in the ACT,[29] the NT,[30] Qld,[31] SA[32], WA[33] and Tas[34] and a similar scheme has been proposed for NSW[35]

Ideas for consideration

Amend Victorian and NSW legislation in line with that in other states to require all retailers of tobacco products to hold a licence—**see Attachment 19** for further details.

Consider the feasibility of limiting the categories, locations and number of shops to whom the proprietors of which can be issued with licenses to sell tobacco products.

7.2 Licensing of manufacturers

Additional research since 2004

In 2005 tobacco companies would have received revenue from the sales of cigarettes from children exceeding $15m (over $9m would have been received by retailers and $46m by state and federal governments).[137]

Progress in Australia

Tobacco manufacturers in Australia are presently licensed by the Australian Tax Office, under the *Excise Act 1901* (Cth). A decision whether or not to grant a licence, or to suspend a licence, must take account of whether the applicant or licence holder satisfies certain statutory 'fit and proper' criteria. These criteria include whether the company has been convicted of a Commonwealth or State or Territory offence punishable by a fine of 50 penalty units or more. Tobacco control legislation contains many offences in this category,[36] although prosecutions and convictions for breaches of the legislation are very rare and the excise legislation requires only that criminal convictions be taken into account.

Ideas for consideration

When assessing whether a company is "fit and proper' to hold a licence to manufacture tobacco products in Australia, take into account a tobacco manufacturer's complete record of compliance with relevant tobacco control laws (not just criminal offences).

If an agency is created specifically to regulate tobacco products (as per Section 16 above), then the responsibility for licensing of manufacturers could be transferred to that agency.

Such an agency might impose as a condition of license penalties to tobacco companies for failure to achieve specified targets in use of their products by children, as detected in surveys using agreed protocols. The fine could take into account not just the current value of sales to children, but the net present value of lifetime sales to all the children who could be expected to continue to smoke into adulthood.

II. Increase promotion of *Quit* and *Smoke-free* messages

Policy intention: To personalise the health risks of tobacco and to increase people's sense of urgency about quitting and their awareness of effective therapies and services

Additional evidence since 2004

Media campaigns are effective

In July 2008 the National Cancer Institute of the United States will release a 700+-page scientific review of all available international evidence concerning the impact of the media on smoking attitudes and behaviour.

Studies of smoking trends in jurisdictions with and without media campaigns in the early 1980s in Australia[305, 306] and elsewhere [307, 308] indicate that they can be extremely effective in reducing smoking prevalence. In a globalised media environment it is no longer possible to conduct randomised controlled trials given that comparison groups are likely to be exposed to 'treatment' via unpaid coverage in the news media, and given that both groups will be affected by prior and background exposure. In making their assessment the NCI experts however considered the complex and multidimensional effects of media on consumer attitudes and behavior, the effects on norms and opinions, the short- compared with the long-term effects, the direct effects and the diffusional effects through others. They also note the differential effects on different population sub-groups and of different kinds of content and context. Considering all the available evidence the Institute concludes on balance that well-funded campaigns *can* reduce smoking prevalence, with the *extent* of reductions highly related to *levels of media expenditure*.[309]

[28] Precedents include laws governing civil liability claims, and the National Classification Scheme for the classification of films, computer games and certain publications.

[29] *Tobacco Act 1927* (ACT), s. 63.

[30] *Tobacco Control Act* (NT), s. 28.

[31] *Tobacco Products (Licensing) Act 1988* (Qld), s. 15.

[32] *Tobacco Products Regulation Act 1997* (SA), s. 6.

[33] *Tobacco Products Control Act 2006* (WA), s.16

[34] *Public Health Act 1997* (Tas), s. 74A.

[35] *See at pg. 12 of paper at http://www.health.nsw.gov.au/pubs/2008/pdf/protecting_children_from_tobacco.pdf*

[36] Examples include broadcast or publication of a tobacco advertisement under ss.13 and 15, respectively, of the TAP Act 1992 (Cth) (120 penalty units), failure to comply with mandatory product information standards under s. 75AZT of the *Trade Practices Act 1974* (Cth) (10,000 penalty units), and intentional or reckless contravention by a tobacco company of advertising restrictions or other controls on promotions in the *Tobacco Act 1987 (Vic)* (e.g. ss. 6(2D), 7(5), 8(3) and 9(5)) (5000 penalty units).

More broadcast volume, more change

In one of the studies highlighted in the report, Farrelly et al in the US have found that increases in *per capita* spending on tobacco control programs in each state were independently associated with declines in prevalence. They find that if all states had funded their tobacco control programs since 1995 at the minimum or optimal levels recommended by the Centers for Disease Control and Prevention, then by 2003 there would have been up to seven million fewer smokers in the US.[310] Another US study has found a clear relationship between overall state spending on tobacco control and changes in youth rates.[311]

Australian data also suggests a clear relationship between the level of spending on media campaigns and changes in smoking prevalence. [41]

Figures 26 and 27 show smoking prevalence falling among both teenagers and adults when spending on media campaigns and Television Audience Rating Points (TARPs) increased in the late 1980s and following the launch of the National Tobacco Campaign in 1997 in Australia.

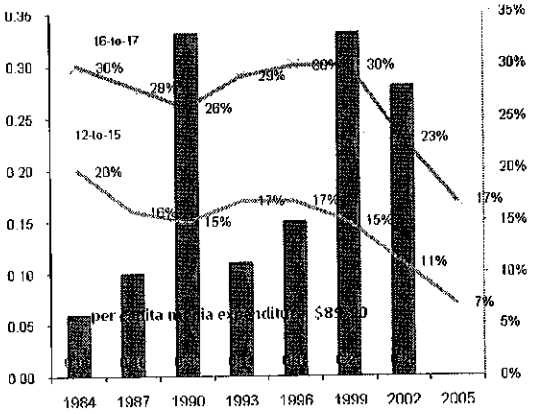


Figure 26 Average expenditure on mass media campaigns ($89□90), (average for previous three years) compared with smoking prevalence among students 12□15 years, Australia 1984 to 2005[18]

Sources: ASSAD 1984 to 2005,[18] reports by government and non-government bodies on spending on tobacco control in Australia[35-37]

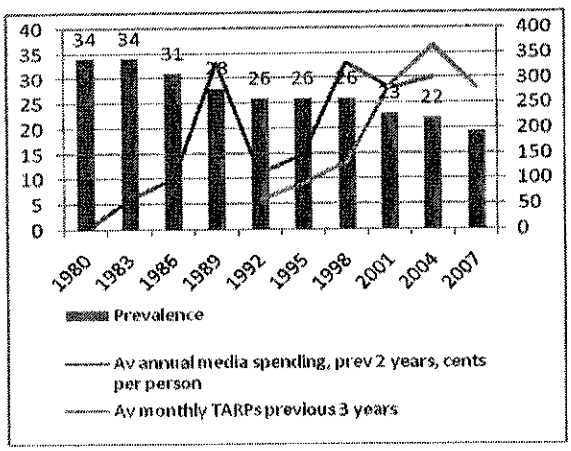


Figure 27 Proportion of adults 18+ smoking compared with expenditure on media campaigns and average monthly Television Audience Rating Points, Australia 1980 to 2007

Source: National Drug Strategy Household Survey,[6] CBRC compilations of media spending[35] and AC Nielsen media TARPS[312]

A study in Massachusetts explored specifically how great media weight needed to be in order to prompt cessation. For every increase of 100 General Rating Points per month during the prior two years, the likelihood of quitting increased by 21%. Compared to smokers who had the lowest level of exposure (about 280 GRPs per month), those who had the highest (about 838 GRPs per month), were more than four times as likely to be an ex-smoker two years later. Based on the levels of response observed over the past 15 years in Australia, and taking into account the findings from studies internationally, the expert panel overseeing the report[37][309] concluded that media spending on Quit campaigns should be high enough to be achieving well over 400 TARPs per month. Audience reach of 700 TARPs, the average monthly in the US state of Massachusetts, would be optimal.

Media campaigns work with blue-collar groups

Some commentators have expressed concern about the relative effectiveness of media-led campaigns among different socioeconomic groups.[313]

Analysis of smoking prevalence over the first two periods of the National Tobacco Campaign in Australia shows that changes in smoking rates among blue-collar groups have been of a similar magnitude to changes among white-collar groups. Between 1997 and 1999, prevalence fell 3.9 percentage points in blue-collar groups, and 3.7 percentage points in white-collar groups.[314] This is consistent with results of earlier research which showed no increase in the disparity between smoking rates among groups with different levels of education after the early Quit Campaigns in Sydney and Melbourne.[315, 316]

Socioeconomic trends in smoking prevalence among Australian children also appear to reflect overall levels of tobacco control funding and taxation policy.

A study of smoking among children in schools located in suburbs with varying degrees of socioeconomic disadvantage in all Australian states and territories between 1987 and 2005 indicates that smoking prevalence decreased in all SES groups.[51] However, the *level* of tobacco-control activity affected the consistency of change across different SES groups, particularly in teenagers aged 12 to 15 years, the period of peak smoking uptake. As indicated in Table 4, in the period of low tobacco-control funding and activity in Australia (1992–1996), smoking prevalence increased among 12- to 15-year-olds, with *the greatest increase among low SES students.* In a period of high tobacco-control activity (1997–2005), by contrast, smoking decreased quite sharply and reductions were consistent across SES groups.

As indicated in the middle columns of Table 4, the prevalence of smoking increased very sharply in low

[37] Australia's Professor Melanie Wakefield was one of the two senior scientific editors on the Monograph.

SES teenagers during the period of low tobacco control activity, whereas there was little change among the higher SES teenagers.

Table 4 Absolute changes in reported smoking prevalence among 12-to-15 year olds in schools in areas of varying SES quintiles during high and low periods of tobacco control activity, Australia—1987–1990, 1990–1996 and 1996–2005

SES quartiles	Absolute change		
	1987–1990 Phase 1 (%)	1990–1996 low activity Phase 2 %	1996–2005 high activity Phase 3 %
Monthly smokers			
Lowest	-1	+6	-12
Second	-2	+3	-10 0.
Third	0	+1	-12
Highest	-1	+1	-13
Current smokers (smoked in past week)			
Lowest	-1	+5	-11
Second	-2	+2	-9
Third	-1	+1	-10
Highest	+1	-1	-11
Committed smokers (smoked on three days in past week)			
Lowest	0	+2	-7
Second	-1	+2	-6
Third	0	0	-7
Highest	-1	0	-7

Source: White, Hayman and Hill, 2008[51]

Some types of ads work better than others

Many different styles of advertising have been used in anti-smoking campaigning over the past 30 years: some focus on the moral turpitude of the tobacco industry, some on the effects of smoking. Some focus on the health effects of smoking, some on the benefits of quitting. Some are essentially informational in their approach either through the presentation of facts and figures or through dramatic visceral presentations of what smoking does to the body. Some hard-hitting advertisements focus on the health effects, and some on the tragedy of the people affected by smoking. Some use actors to create narrative stories, and some use real people.[317]

Increasing interest among researchers about the differential effects of advertising style and content[318-320] and the differential effects of mass media advertising among different socioeconomic groups should provide crucial guidance on advertising content.[315, 321]

While most smokers are aware of the names of most of the major health conditions caused by smoking, many younger and less educated smokers have only a hazy understanding of how young they could be when such diseases strike, the kind of pain or disability that might occur, how their treatment would affect them in daily life or the likely prognosis.

Investigators believe that emotional narrative communication may be a better method for low SES groups because it enables people to fully and vividly imagine how it would feel to have a smoking-related disease. Such advertisements do not rely on explicit arguments or information (which require assessment of the merits of the message, and acceptance of the argument/message).[322-324] Theorists[325] have proposed that narrative messages (messages embedded in the lessons of personal stories) may enhance impact and persuasion through minimising smokers' ability and motivation to counter-argue against a specific argument or message. Emotionally arousing stories are also more likely to be discussed with others,[326, 327] and once shared, are more likely to survive and be rehearsed.[328] Therefore, messages which are personally relevant and emotionally engaging are more likely to increase perceptions of susceptibility to health risks and be passed on to others through interpersonal communication. Narratives are more likely to trigger self-relevant emotional responses, as the viewer is 'transported' or absorbed into the emotional experience of characters with whom they identify.[329, 330] The use of stories in public health communication has previously been found to be very effective through education□entertainment[331] as well as in anti-smoking advertising.[319]

Research being undertaken at the Centre for Behavioural Research in Cancer in conjunction with the University of Melbourne is investigating how best to design messages that appeal to audiences with less formal education.

Recently completed studies have found that graphic emotive advertising about the health effects of smoking is equally effective across different socio-economic groups.[332] For smokers of lowest SES, the path to increased quitting intentions was driven by cognitive and emotional responses to the ads, whereas for those with highest disadvantage, intentions were prompted solely by emotional responses to the ads. Advertisements with a strong narrative focus (personal emotional stories) were equally effective among highly disadvantaged groups as among more advantaged groups in prompting calls to the Quitline.[333]

Youth and young adults are also influenced by advertising that elicits negative emotions.[309] Advertisements with strong emotional appeal are more reliably recalled by young smokers and appear to have a more powerful effect on smoking attitudes and beliefs.[334] Another study comparing the relative effectiveness of different types of advertisements with young adults also confirms the superiority of advertisements on health effects and those making strong negative appeals.[335]

Progress against international comparators

Broadcast volume

Data is no longer collected in Australia on spending by Quit Campaigns and other government and non-government agencies on media campaigns. Factoring out spending by the NSW Cancer Institute which totalled more than $12m in 2007[336] it would be fair to say however, at somewhere around the $10m mark, spending on Quit campaigns would be considerably lower than the budgets of average commercial retailers in Australia.

Table 5 Media advertising budgets for typical consumer & service companies, Australia 2007

Name of advertiser	$spent, 2007
Harvey Norman	87.4
Woolworths Supermarkets	61.3
Coles Supermarkets	58.1
Myer	50.6
McDonald's Family Restaurants	49.7
Bunnings Building Supplies	42.1
David Jones	39.4
Kellogs	38.7
L'Oreal	35.1
Kmart	32.8
Village Roadshow	32.5
KFC	31.3
Virgin Blue airlines	26.9
Ray White Real Estate	25
Flight Centre	23.7

Source: Nielsen Media Research AdEx, Jan to Dec 2007[336]

Only NSW is sustaining average TARPs greater than 400 per month. Media advertising outside of NSW, WA and Victoria appears to be sporadic.

In Australia achieving an average of 400 TARPs per month, an audience reach comparable to the NTC at its peak, would cost $15m per year. A TV campaign reaching a Massachusetts-average level of 700 TARPs per month would cost approximately $26m.[337] Slightly more would be required each year to allow for increasing costs of media and funds would also be needed for production of new material to ensure maximum emotional impact.

Reaching low SES groups

Researchers and managers working on the development of Quit campaigns in Australia have gone to considerable lengths to target media placement (both in terms of timing, program type and particular shows) and to design advertisements for and pre-test them with low SES groups to ensure that they reach and influence people of lower socioeconomic status.[338-343]

While television advertising remains the most cost-effective way of promoting interest among disadvantaged as well as more affluent smokers, the very high concentration of smokers within particularly disadvantaged neighbourhoods provides the opportunity for highly localised advertising of services and treatments. This could be done for public housing estates and areas serviced by particular shopping centres, rather than merely to postcode or local government areas. When smoking rates are presented in deciles of disadvantage calculated according to local government boundaries, rates are generally higher in lower income LGAs. However, when the index of disadvantage is applied to the much smaller areas known as ABS collectors districts, a very clear social gradient emerges.

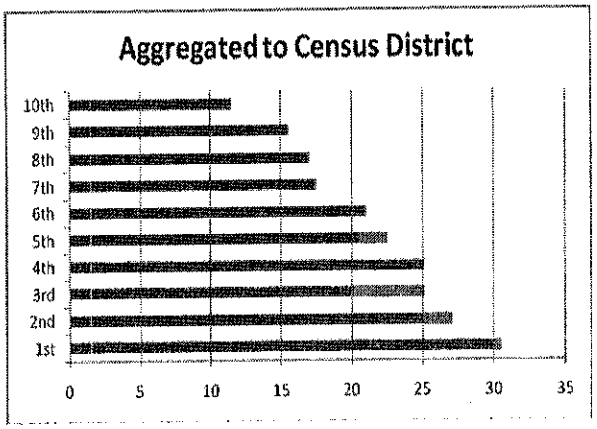


Figure 28 Proportion of persons aged 18 years and over who smoke regularly, Australia 2004-05, by Social and Economic Index of Disadvantage—aggregated at CD, SLA and LGA levels

Source: ABS National Health Survey 2004-05[344]

Quit Victoria is currently exploring billboard, transit, mobile and other outdoor advertising of the Quitline within highly disadvantaged suburbs. This might help to increase usage of the Quitline by people in those areas. It could also be used to promote local courses and other projects that might be established at a local level. Given the lower awareness of stop-smoking treatments among low-income smokers, pharmaceutical companies could also be encouraged to invest in this sort of targeted promotion.

Ideas for consideration

Commission a suitable agency to collect data on spending on mass media and other tobacco control activities across Australia.

Relaunch the National Tobacco Campaign.

Evidence about the impact of campaigns suggests that such a campaign should achieve reach of a minimum of 400 TARPs per month and preferably up to 700 TARPs per month over each of the next six years.

Extra funds for each of the next six years could also be allowed for development of creative material and its pre- and post-testing with low-SES groups.

A further additional amount could be allocated to assess the impact in several pilot areas of outdoor advertising and other initiatives to boost the use of cessation products and services in disadvantaged areas.

III. Improve services and treatment for smokers

Almost everybody who smokes regrets having started and the vast majority would like to stop.[345]

In Australia in 2007 more than 4.3m people classify themselves as "ex-smokers", outnumbering current smokers by more than four to three.[19] Little information is published about these people, however data collected over the 1980s and early 1990s in Victoria suggest that the vast majority would have quit without any form of professional assistance and without using pharmaceuticals.[316] It is difficult to get a clear picture of how long ago ex-smokers stopped smoking, how heavily they smoked before they quit, and how many attempts they made before they finally succeeded, and whether these things have changed over time. With a steady decline in the number of cigarettes smoked each day and thus a decline in the proportion of smokers who smoke heavily,[2] there is little evidence of a "hardening" of the smoking population.[346]

Stories and advertising in the media and graphic warnings on packs all help to personalise the health risks of smoking and trigger quit attempts. Smoke-free workplaces and public places and social pressure not to smoke around others give people other extremely good reasons to quit and stay stopped,[152, 347] and these policies and restrictions on promotion reduce some of the triggers that increase the chance of relapse.[161, 168] Interaction with the health care system provides the opportunity for health professionals to personalise the health risks of smoking to each individual, often at highly "teachable moments" when they are suffering a serious illness or health incident. Whether done by a doctor,[348] a dentist,[349] or a nurse[350] or other health professionals this motivates quit attempts, whether delivered during routine check-ups or while being treated for serious illness or injury in hospital.[351]

However achieving the second goal of the national strategy—*to encourage and assist as many smokers as possible to quit as soon as possible*—requires attention to the problem of most smokers being dependent on tobacco-delivered nicotine.[352, 353] Heaviness of smoking and other indicators of dependence are highly related to failure in quitting,[109] with SES disparities apparent in levels of nicotine dependence, confidence about and intentions to quit,[111] and the average number of years people smoke prior to quitting.[354] The sheer number of people who *once smoked but now don't* shows that it is not impossible, but there is no question that quitting smoking can be a very difficult process.[355] Succeeding requires a great deal of determination and the adoption (conscious or not) of strategies to overcome withdrawal and triggers to smoke.

Therapies that increase success rates

Summary of the current state of evidence

A very large body of research now confirms that an individual's chances of quitting can also be increased by taking medications that lessen withdrawal symptoms[356, 357] or that reduce the reinforcing effects of tobacco-delivered nicotine.[358-362] While success rates outside clinical trials may be a little lower,[363] there is ample evidence that such medications are still effective with more limited or even without any professional supervision.[364, 365] There is also overwhelming evidence that a structured program of cognitive behavioural advice and coaching can increase the number of successful quits. This is so regardless of whether the help is provided one to one,[366] over the phone,[367] or in a group,[368] (in the community or through work).[369] Well-designed brochures help some people, but this isn't enough for most.[369] Success rates are better where advice can be personalised. This can be achieved through computer technologies (such as the QuitCoach[370] available through the government's website) which can be delivered at a much lower cost than printed materials. Programs using text messaging especially when combined with internet resources can also be effective.[371] Structured programs generally achieve greater success with increasing contact: 4–8 sessions optimize chances at reasonable cost.[372-374] Extracts from meta-analyses of results of studies evaluating each of these therapies and interventions are provided in **Attachment 16**. These are drawn from the Tobacco Addiction section[375] of the Cochrane Collaboration at http://www.mrw.interscience.wiley.com/cochrane/clabout/articles/TOBACCO/frame.html

People are also more likely to quit successfully if they use a combination of approaches. Adding medication to counselling (or vice versa) increases success rates—**see Attachment 17** drawn from the US Department of Health's clinical guidelines http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

Doctors and other health professionals sometimes feel disquiet about the relatively low success rates achieved through motivational advice and tobacco dependence medications, however the small but robust effects of treatments are clinically significant because of the very large health gains that accrue from stopping smoking. An effect of as little as 1% on 6-month continuous abstinence rates would result in at least 3 additional years of life for every 100 40-year-old smokers treated.[376] This compares extremely favourably with other life-saving interventions.[377]

Systems for delivering therapies

While a range of effective strategies are available for helping smokers quit (and better ones may become available in time), a far greater challenge is getting

smokers to use them[378, 379] and, preferably, to use the most cost-effective strategies.

In a country where the right to health care is universal, we need a *combination* of services, training, referral arrangements, remuneration and subsidies that will work together in the Australian context to deliver the best possible outcome for the total population.

The Quitline is available to smokers in every state and territory, however whether an individual smoker can receive counselling in another language or access extended counselling (where a counsellor calls them and provides encouragement and advice throughout the quitting process) is dependent on whether they live in one of the states that provide these services. This is particularly inequitable for Australians living in remote Australia where health professionals are in short supply and may be located hours away from where people live.

Quitlines are now advertised on every cigarette pack as part of required consumer information. Mass media advertising also drives calls, so much so that quitline calls are often used as an indicator of the effectiveness of the advertising.[343, 380] However, more could be done. The Quitline is still an underutilized service in Australia, partly because of a lack of understanding about what the service offers.[378]

For several years now governments in the UK[381], in the US [373, 382]), New Zealand[383] and Australia [384, 385] have been periodically updating and promoting detailed clinical guidelines for doctors on how best to go about treating tobacco dependence.

An important innovation in the Australian clinical guidelines[385] is the offer of two evidence-based strategies for providing cessation assistance: within the consultation, and/or referral to specialist cessation services. GPs can use fax-referral forms to trigger a phone-call to their patients from a trained Quitline advisor. For referrals, the Quitline calls the smoker and discusses options for assistance, which allows callers to be directed to or offered the most appropriate form of support.[386]

GP referral to the Quitline results in improved outcomes for patients.[38][388] An Australian study shortly to be published has found that GP referral of smokers to the Quitline resulted in cessation rates two to three times that which resulted from efforts to encourage GPs to provide in-practice management.[389] The effect was due to the smokers getting extra help to quit from outside the practice, while getting the same amount of help from within it and a combination of the extra help increasing both the number and success of quit attempts. The beneficial effect on quitting in the referral condition was sustained over time. The findings add to the growing body of evidence that health professional referral of patients who smoke to evidence-based Quit services is effective and acceptable to smokers.[390, 391]

Providing access to subsidised pharmacotherapy through quitlines is another very powerful method of increasing useage and also increasing the proportion of quit attempts that are successful. Over the past eight years, different countries have taken different approaches to this strategy.

NRT became available in the UK on NHS prescription in 2001 soon after the inception of the NHS Stop Smoking Services in 1999.[392] NRT can also be purchased from pharmacies and, with the classification of some NRT products in the general sale category, from several other outlets[393]. West et al estimate that following listing the proportion of smokers using medicines to aid smoking cessation more than doubled from 8% in 1999 to 17% in 2002.[394]

In New Zealand, vouchers for NRT are provided to people calling the NZ Quitline who redeem them at pharmacies for the heavily subsidized cost of $10. Initially the vouchers were available only from the Quitline or from GPs who had received training in smoking cessation.[383] Since December 2007 they have been available through both the Quitline and all GPs.[395]

In the US, 40 of the 44 states include subsidy for at least one form of NRT in Medicaid arrangements—**see Attachment 8**, and the majority of states subsidize most other forms of NRT—**see Attachment 18**.

In the state of New York which set an ambitious target to reduce the number of smokers in New York by one million over the ten years to 2010[396][39], the NY Quit-line sends free NRT directly to clients at the rate of around 360 shipments per day. In 2007 almost 80,000 clients received NRT starter kits, over 30,000 through on-line ordering. The NRT has been donated by one of the pharmaceutical companies including stock that might otherwise exceed its sell-by date.

Evaluation of programs in New York,[397, 398] Minnesota[399] and New Zealand suggest that provision of vouchers for free or subsidized NRT can significantly increase numbers calling counselling services and numbers making a quit attempt.[400] Such initiatives would appear to be effective with low-income groups.[401]

[38] Referrals from other health professionals however have been less successful.

387. Young J, Girgis S, Bruce T, Hobbs M and Ward J. Acceptability and effectiveness of opportunistic referral of smokers to telephone cessation advice from a nurse: a randomised trial in Australian general practice. BMC Family Practice. 2008;9 16. Available from: http://www.biomedcentral.com/content/pdf/1471-2296-9-16.pdf

[39] Of a total population of just under 20 million people

In Australia until recently and in a very limited way[40], NRT has not been subsidised. By contrast bupropion marketed as Zyban was listed on the PBS in February 2001 and varenicline marketed at Champix in February 2008, but NRT is not included. By the end of June 2008, total PBS subsidies for Zyban will have totalled at least $140m, nearly half of this in the first year.

Table 6 Prescriptions for & spending on Zyban, February 2001 to June 2007

	Services	Expenditure, $s
Feb to June 2001	277,602	66,438,824
2001-02	129,174	29,110,602
2002-03	74,992	16,914,598
2003-04	71,481	12,095,927
2004-05	64,816	4,982,265
2005-06	67,570	4,825,879
2006-07	60,464	3,611,014
Total to June 2007	746,099	137,979,108

Source: PBS data item 8465M[403]

Established contraindications for Zyban[41] [404] and worrying reported side-effects for varenicline[42] limit the numbers of people that can be prescribed these medications, whereas NRT can be used by virtually any smoker. Given the unsuitability of these PBS-listed treatments for many groups and the costliness of NRT for very low income people in general, some commentators have suggested that NRT should be added to the Pharmaceutical Benefits Scheme in Australia.[405] Alternatively (or in addition) Australia could implement a system based on either the New Zealand or the New York systems. Quitlines could distribute NRT if this could be provided free or (with greater administrative complexity) at discount. This model would have the advantage of enabling the Quitline to use free product in promotions to attract additional callers.

Ideas for consideration

Access to all Australians to all Quitline services

Contract an agency to provide telephone call-back services in states not already providing these so as to ensure access to these services for smokers living in rural and remote areas in all parts of the country. Along with this could go a budget to promote such services in rural affairs programs and regional media.

Greater use of Quitline

Quit campaigns should assess whether use of the Quitline by low-SES smokers could be increased through regular appearances of Quit representatives on morning magazine-style TV programs and through local outdoor advertising and direct marketing to health professionals and services located in highly disadvantaged areas with large numbers of smokers.

Increased use of NRT

Commission a study on the pros and cons, feasibility and benefits for various stakeholders of various possible options for the subsidy of NRT in Australia. The aim would be to maximize use of both the Quitline and NRT by low-income smokers. A model incorporating a variety of delivery and subsidy mechanisms could be considered.

In the meantime, fund an initiative to provide vouchers to obtain free NRT for those for whom spending on tobacco products is causing significant financial stress. This could be introduced at the same time as any large increase in excise duty on tobacco. The NRT could be available free through the Quitline, and the vouchers could be provided through duty social workers staffing services for people in distress. This might include: clients of homeless shelters and emergency housing services, emergency relief funds and job search agencies; applicants for supporting parents, sickness benefits, disability pensions, rent assistance or mortgage relief; callers to help-lines for problem gamblers, recently released prisoners; and young people and people with psychiatric illnesses about to move into supported or independent accommodation.

Consider offering to match any donations of NRT by pharmaceutical companies to the Quitline with offers to purchase equivalent quantities of stock. This stock could be used by the Quitline to promote greater use.

Improved quality of use of NRT

Quitlines could explore age- and culturally-appropriate interventions to help people better manage medicines—such as prompts delivered through SMS (text) messages to remind people to take medication at the times they need to and to use it as directed—as a way of increasing quality of use of NRT and other treatments.

[40] Patches went on PBS earlier this year just for Indigenous smokers whom it was accepted by PBAC, more frequently have objections to or problems with oral preparations.

402. Pharmaceutical Benefits Advisory Committee, Sydney: Letter concerning listing of NRT patches for Indigenous smokers. The Cancer Council Australia, 2008.

[41] Zyban is contraindicated in patients with a current seizure disorder or any history of seizures, patients with a known central nervous system (CNS) tumour, patients undergoing abrupt withdrawal from alcohol or benzodiazepines, patients with a current or previous diagnosis of bulimia or anorexia nervosa and patients taking monoamine oxidase inhibitors (MAOIs) a common treatment for depression.

[42] Safety of varenicline (marketed in Australia as Champix and in the US as Chantix) for patients with pre-existing psychiatric conditions has not been established, and physicians have been advised to be cautious after widely reported cases of severe psychiatric episodes in a number of patients, including some with no previously reported history of psychiatric illness.

IV. More usefully support families and educators

Most adults who smoke started as teenagers.[406] Smoking by peers, siblings and parents has consistently been demonstrated to increase the risk of smoking.[406-408] Adolescents who smoke become dependent quite rapidly on tobacco-delivered nicotine.[409-411]

Additional evidence since 2004

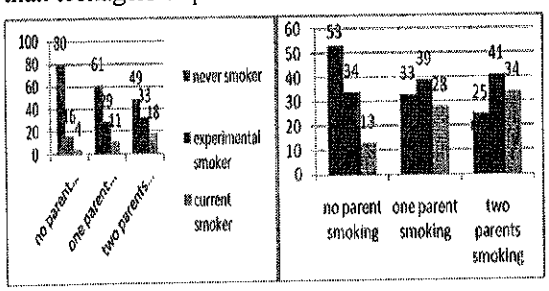
Evidence is accumulating of genetic vulnerability to the development of nicotine addiction,[412] however early and current environmental factors are also very important[413, 414] and it is difficult to imagine how knowledge about inherited proneness to addiction could be used in prevention.[415, 416]

After decades of effort pursuing tobacco education in schools, fewer than half of the published studies of rigorously designed trials show evidence of long-term effects.[417]

A peer-led intervention (ASSIST) which is training opinion-leading teenagers in persuasion techniques—how to talk to their peers about smoking outside the classroom[418]—the evaluation of which was recently published in The Lancet[419], is causing excitement in the field.[420] The study was well designed and the intervention is soundly grounded in social networking theory. The success of such interventions across the population will depend on finding young people with the necessary skills and wide enough social networks. Their sustainability will depend on finding ways to maintain enthusiasm and momentum in the long term. It will be interesting to monitor further developments.

Researchers are increasingly interested in the potential for reaching children through parents and siblings.[421, 422]

Young teenagers with one or more parents who smoke are more than three times more likely to experiment with smoking, and older teenagers are almost three times more likely to smoke regularly than teenagers of parents who do not smoke.



12-to-15-year-olds 16- and 17-year-olds

Figure 29 Proportion of students who were never smokers, experimental smokers or current smokers among students with no, one or two parents who smoke, 12-to-15-year-olds and 16- and 17-year-olds, Victoria 2005 —no parent, one parent or two parents smoking

Source: ASSAD Victoria 2005[423]

Results of a recent Australian longitudinal study show that children of non-smokers are also more likely to remain non-smokers in the long-term.[424]

Analysis of data on smoking among Year 10 students in New Zealand in 2007 compared with 2001 has shown that the relative decline in smoking prevalence has been greatest for students with no parents smoking and least for students with both parents smoking (Table 7b of the NZ report). The relative increases in the proportion of students who had never smoked were greater for students with neither parent smoking. Odds of daily and regular smoking, adjusted for age, gender and ethnicity, are lower in 2007 compared to 2001 in homes with or without smoking, but the decrease was greatest among students living in homes without smoking.[425]

US studies[426, 427] have found that even after controlling for demographic factors and parents' smoking status, children who lived in homes where smoking was banned were more than 20% less likely to take up smoking than children who lived in homes where smoking was allowed. However there is little evidence that educational interventions can encourage the adoption of smoke-free homes.[428] Lack of parental supervision is also strongly associated with smoking experimentation.[423]

Parents who smoke can still socialise their children against smoking,[429] but family-based programs aiming to discourage smoking have been only modestly successful[430] and would be difficult to deliver population-wide. Such programs have rarely involved siblings. Smoking by children is highly related to sibling smoking, and older teenagers often state that they hope their younger siblings don't experiment with smoking: siblings may be an untapped resource for tobacco control.

Quitting by parents has a very strong effect on subsequent smoking by children, and is probably the single-most important thing that a smoker-parent can do to prevent their children from taking up smoking.[431]

Progress in Australia

The websites of state Quit campaigns suggest that they continue to provide information and resources to schools. Little information is available about reach of programs at the school or individual level.

Bans on smoking in shopping centres and the widespread adoption of smoke-free homes must be making it increasingly difficult for children to experiment with smoking undetected by parents. Bans on smoking in cars may reduce smoking around children at home even if parents and other carers don't manage to quit completely.

Evaluation of the 2001 Parents campaign (featuring a young girl recounting a recent event to her dying father '*you should have been there Dad*'), and focus group research on Quit Victoria's 2008 testimonial advertisement depicting a real smoker talking about her fears about what will happen to her children

when she dies[432] suggests that narrative adverts can have a strong impact with low-SES parents.

Ideas for consideration

Continue to monitor and keep abreast of findings of studies assessing the impacts of interventions aimed at teenagers outside the classroom, particularly those involving siblings and those focused on disadvantaged groups.

Given the likely impact on both parents and children, Quit campaigns should invest a high proportion of marketing budgets at parents.

Ask the Centre for Behavioural Research in Cancer to include in future reports of ASSAD, long term trends for teenagers (in each major category of smoking status), of whether parents smoke, and whether their homes are smoke-free.

V. Tailor messages and services for highly disadvantaged groups

A number of groups in Australia have needs unlikely to be adequately met by mainstream initiatives to encourage and support smokers to quit. Several major initiatives targeting the following highly disadvantaged groups are in place in various jurisdictions and sectors in Australia, but these are not uniform across the country.

Indigenous Australians

Progress since 2004

Shortly after it was elected the Rudd government pledged $14.5 million over four years to help tackle smoking in Indigenous communities.[433] This initiative includes:

- supporting research including an initial project to be conducted by the Cooperative Research Centre for Aboriginal Health (CRCAH), to build the evidence base around what works in helping Indigenous people to quit smoking;
- trialling community interventions, including targeted, culturally appropriate communication activities; and
- offering smoking cessation training to staff working in Indigenous health.

A national workshop for key stakeholders was held on 23 May 2008 in partnership with the Cooperative Research Centre for Aboriginal Health to consider and set priorities for the next three years. A report will be available shortly.

The Department has also funded the following Indigenous projects:

- in response to the report *Tobacco: Time for Action*, the establishment in 2003 of the Centre for Excellence in Indigenous Tobacco Control (CEITC) at a cost of $1.21 million over three years, and continuation of funding at a cost of $1.7 million from 2007-2010. CEITC aims to enhance the capacity of Indigenous health workers to reduce tobacco use. This includes resource development, and forums for information sharing between Indigenous health workers.
- a trial to reduce smoking among pregnant Indigenous women in Perth ($205,000) and a tobacco control program in the Katherine West region of the Northern Territory ($256,600).
- funding to the Menzies School of Health Research (MSHR) for smoking cessation programs for communities in the Groote Eylandt area($122,000). Recently, the National Health and Medical Research Council (NHMRC) awarded the MSHR a grant of $1.1 million over five years to conduct a multiple baseline study (since transferred to James Cook University) of four extra communities in the Top End using the Groote Eylandt model.

In June 2008 the Ministry of Health in New Zealand released data showing that smoking among Maori appear to have declined by more than 20% over the past four years, with the reduction of smoking among Maori men greater than that in the overall male population[48]—**see Attachment 6** for further details. Public health experts believe that the decline can be attributed to the effects of smoke-free legislation, vocal advocacy by Maori leaders in tobacco control and social marketing campaigns.

Research since 2004

Public health specialists have recently drawn attention to the absences of research about the effectiveness of interventions to encourage quitting among Indigenous women who are pregnant.[434] The lack of researcher interest in this area may be due to the generally disappointing results of a large number of trials of interventions aimed at disadvantaged smokers generally during the 1980s and early 1990s.[435, 436] Incentives to encourage enrolment and completion of courses are among the few approaches that appear to be promising with disadvantaged groups.

Ideas for consideration

CEITC and CRCAH might consider investigating incentives for smoke-free pregnancy as part of their research program.

Those working in tobacco control in Aboriginal and Torres Strait Islander communities will no doubt continue to work closely and share ideas with those working in Maori tobacco control in New Zealand. Social marketing targeted more specifically to Indigenous people could be explored for Indigenous media, during programs for Indigenous people and perhaps in regional media in the NT, FNQ and the Kimberley.

Pregnant women from Indigenous and other disadvantaged groups

Additional evidence since 2004

Smoking during pregnancy is much more common in women of younger age, with a low social status, a large number of children, without a partner or with a partner who smokes, and among those receiving deficient prenatal care.[437]

Evidence for the effectiveness of interventions to assist pregnant women to quit has strengthened over the past few years,[438] particularly for counselling

and behavioural interventions.[439] Targeted recruitment and modest financial incentives can encourage more people to enroll and complete programs, with consequent increases in quit numbers.[440-442] Among pregnant women in disadvantaged groups pilot programs that provide financial incentives coupled with efforts to encourage support from partners and family members have increased quit rates,[442, 443] and fetal weight.[444]

Progress in Australia since 2004

In the UK changes in licensing since 2005 mean that NRT is no longer contra-indicated for pregnant women.

In Australia DOHA was allocated $4.3 million in the 2005-06 Budget to lead a national program to encourage doctors, midwives and Indigenous health workers to help women – particularly Indigenous women – to stop smoking during and after pregnancy. A National Advisory Group on Smoking and Pregnancy (no longer active) recommended a number of projects that have been funded under this initiative including:

- the development of a **Pregnancy Lifescripts Kit** launched in December 2006
- the development by the AIHW of **national standard data elements** on smoking during pregnancy to provide high quality, nationally consistent data
- the **National Smoke-Free Pregnancy Project** designed to establish an effective, sustainable and realistic tobacco brief intervention for midwives to deliver in public birthing services throughout Australia. (An interview panel established by The Cancer Council South Australia has been appointing project officers in each State and Territory to train the midwives)
- the **SmokeCheck Project** for Aboriginal women in the Katherine West region and
- the **Sax Institute Project** trialling in Perth and Qld a high intensity intervention to reduce smoking among pregnant Indigenous women.

Idea for consideration

Include in health care agreements a requirement that all women receiving care through public maternity hospitals be asked their smoking status, and all women who smoke be referred to courses or to a section of the Quitline staffed by women who are both skilled in quit-counseling and understanding of the pressures facing new mothers.

Non-English speaking people

Quit Victoria has for many years worked with opinion leaders in a culturally and linguistically diverse range of communities to develop greater awareness of, and community participation in, efforts to address the smoking issue. This has included working with ethnic media, and health professionals in areas with high numbers of people from particular cultural backgrounds where smoking rates are high. Since 1989 Quit has run information stalls at most major multicultural events and festivals in Victoria.[445]

Information and telephone counselling is available in most of the major community languages at least in NSW and Victoria.[14] People from non-English speaking backgrounds in regional Australia and in smaller states and territories (where smaller population numbers make it less feasible to run tailored programs) have much more limited access to information and support. The National Expert Advisory Committee on Tobacco has pointed out that a national approach to CALD programs would better serve these groups.[14]

Ideas for consideration

Provide downloadable printed materials for non-English speaking groups.

Promote the Quitline in national multicultural newspapers and on multicultural radio, and extend interpreter services available in some states so as to provide access to the Quitline to non-English speakers anywhere in Australia.

The mentally ill[43]

A recent Australian review of research suggests that a combination of effective drug therapies and counselling were as effective for people with mental illness as for the rest of the population.[446]

Progress in Australia

SANE Australia continues to draw attention to the problems of smoking for those with mental health problems. The Smoking and Mental Health project in South Australia continues to provide useful resources and training. The Quitline has developed and works to a detailed protocol for assisting callers with a mental illness.[447]

DOHA funded three contracts (two with the University of NSW and one with the University of Newcastle) to undertake projects related to smoking and mental health issues, results of which will be posted on its website:

1. a multi-component risk factor intervention for people with severe mental illness: a feasibility study;
2. a three year follow up of a randomised controlled trial of an intervention for tobacco dependence among those with psychotic illness; and
3. a PhD Scholarship Program.

Ideas for consideration

Include in health care agreements with states a requirement that smoking cessation advice be included in patient treatment plans.[446]

Performance agreements with health care facilities could specify that

- psychiatrists treating and other mental health workers caring for people with serious psychotic disorders routinely advise people to quit and provide advice on safe use of nicotine

[43] Those suffering a serious psychotic illness, not just a mental health problem.

replacement therapy to quit without exacerbating symptoms, or to reduce cigarette consumption in preparation for attempts to quit. Intensive assistance should be offered to patients at transition points such as diagnosis and commencement of treatment, discharge after in-patient treatment, being assessed for a disability support pension, and, most critically, moving into supported or independent accommodation.

- child and adolescent mental health services, drug treatment agencies and correctional facilities offer treatment for nicotine addiction as a matter of course in all services and facilities.

Support these processes by commissioning production of (national) information packages for clinicians and for facility managers in each sector.

State and territory governments could support these initiatives through provision of the information package, and a rolling program that would aim over three years to train all staff in such services.

Mental health problems

The pervasiveness of *mental health problems* (as opposed to severe mental illness) among current smokers requires national smoking services such as the Quitline to improve strategies to assist the high percentage of their clients with common problems such as anxiety and depression, especially those whose condition may be exacerbated by their quit attempt.[448] Cessation assistance in the context of common mental health problems should be regarded as a mainstream rather than a special-needs strategy.[44]

Prisoners

Many prison inmates use the opportunity of incarceration to improve their health and fitness. This offers an opportunity for building and capitalizing on interest in quitting.[449] The high rate of substance abuse and mental illness in prison populations suggests the need for prescription pharmaceuticals in addition to nicotine replacement and cognitive behavioural counseling.[450] Professor Robyn Richmond's work in this area using this approach has achieved very promising results in New South Wales prisons.[451, 452] Awefeso's work based on the idea of positive deviance[453] — changing the culture about smoking in prisons by enlisting respected prisoners to talk about their quit efforts—also seems promising.[454]

Ideas for consideration

State governments could require managers of correctional facilities to greatly increase the number of smoke-free cells and units in prisons.

Issue vouchers to purchase nicotine replacement therapy (appropriately priced for the prison economy) to smokers on entry into correctional facilities, and if required, before leaving prison.

Support these processes by commissioning researchers experienced in this sector to produce information packages for health workers and facility managers.

The homeless

Overseas pilot projects suggests that counseling and nicotine replacement therapy have some potential for assisting these most disadvantaged smokers.[455, 456]

For people not yet homeless but in housing crisis or housing stress, quitting smoking could provide extra funds that could make the difference between defaulting on a mortgage or eviction, and keeping a family home.

Idea for consideration

Vouchers to receive free nicotine replacement therapy from the Quitline could be provided to smokers in housing stress and seeking assistance through government rent assistance, direct lending and mortgage relief programs, and to clients of home purchase advisory and counselling services.

VI. Address causes of disadvantage

VI.1 Social inclusion

Adolescents with weak bonds to parents, school and other community institutions are at increased risk of engaging in deviant behavior.[457-459] Students who start to fail at school are much more likely to 'act out' and to engage in high-risk behaviours including smoking.[459-463]

New evidence since 2004

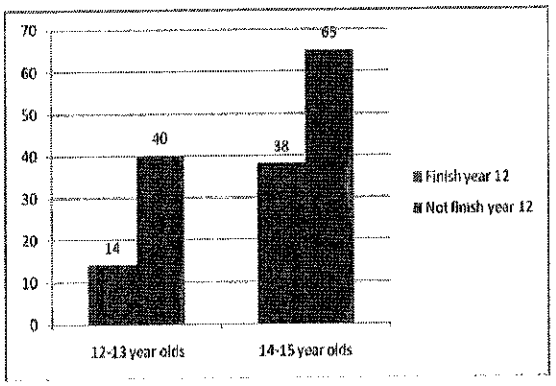
A recent study of the social determinants of smoking found that adjusted for age and gender, Indigenous people who had been removed from their natural family are half as likely to be a non-smoker.[464] Likelihood of being a non-smoker reduces with lower household income and education, and nine other indicators of social disadvantage.

While dozens of social problems can be associated with high rates of smoking, it is evident that many of these problems stem from and could be mitigated by the prevention of educational failure in children.

In Australia, children who predict that they will complete Year 12 are much less likely to have ever tried smoking (or cannabis, inhalants, amphetamines or hallucinogens).[423]

[44] People who disclose that they suffer serious (but currently controlled) psychiatric problems can also be provided with tips for quitting, but should be advised to seek specialist advice regarding any necessary adjustments to anti-psychotic medication.

447. Quit Victoria. Quitline Guidelines: Smoking Cessation and Mental Illness. Melbourne: Tobacco Control Unit, The Cancer Council Victoria, 2003.



Proportion of secondary school students who have ever tried smoking among those who predict that they will finish Year 12 and among those that don't, Victoria 2005

Source: ASSAD, 2005[423]

Among 12-to-13 year olds, those who predict that they are unlikely to finish Year 12 are almost three times as likely to report ever having tried smoking.

Young people who do well at school are more likely to understand information about health risks and are more likely to feel connected to school and to feel hopeful about their future. If they succeed in further education and get a good job, they are much less likely to end up in stressful personal circumstances, or to be part of social groups where lots of people smoke.

As Hilary Graham and her colleagues have demonstrated

> *educational trajectories (as measured by age of leaving education and educational qualifications) are associated with smoking, with uptake in adolescence as well as current smoking, heavy smoking and quitting in adulthood.* ***Education eliminates the effect of childhood circumstances on these dimensions of smoking status****, suggesting that childhood conditions exert their influence through education.* ***Education in turn determines adult socioeconomic position****, with poor adult circumstances adding further to the risk of smoking in adulthood and reducing the odds of quitting.*[465]pii8

Findings of American research on the association between social cohesion and lower smoking rates,[466] and the relationship between social cohesion and self-reported health status[467] suggests that improvements in social capital could also help to reduce smoking uptake. European research suggests that policies to reduce the ugliness and disorder of the most disadvantaged neighbourhoods and provide opportunities for young people to participate in activities that build a sense of community may reduce risk-taking behavior including smoking.[468, 469]

Progress in Australia

The Cancer Council of NSW and the Council of Social Services of New South Wales have jointly released a Tobacco Control and Social Equity Strategy[470] to

- build the capacity of social service agencies to contribute to tobacco control efforts and
- better integrate tobacco control into economic and welfare responses to social disadvantage

The Victorian Quit Campaign is currently developing a detailed response to the state government's call for greater attention to tobacco-related disparities.

Ideas for consideration

Endorse government efforts to ensure universal access to child and maternal health services and early childhood education, a well-resourced public school system that can attract and retain skilled teachers, and use of evidence-based programs to screen for and address early problems with literacy and numeracy.

Endorse government initiatives that improve parenting, prevent family breakdown and promote resilience in children which should not only help to prevent educational failure but also the development of mental health problems and a range of other social problems, all of which are highly correlated with smoking uptake.[471, 472]

Initiatives to encourage training in trades and business skills for young people who are not interested in white collar jobs may also be useful in interrupting smoking trajectories among young men currently at high risk of unemployment. Continuation of education for young women who have babies before they complete school and among women who become single parents could also be helpful.

VI.2 Investing in tobacco control as a component of social development

The World Health Organization recognises the importance of reducing tobacco in the achievement of the United Nations Millennium Declaration 2000[473] in which member nations pledged to work together to eliminate extreme poverty, improve health, and promote human development and sustainable economic progress in the world's poorest nations. It identified tobacco as a major avoidable cause of illness and preventable death in low-income countries, and urged that tobacco control be adopted as a means of improving the economic prospects of the world's poorest billion people.[474] Even in the poorest countries on earth, increasing tobacco taxes can help to decrease average spending on tobacco products, and reduce malnutrition and improve health among children in the poorest households.[475] Other tobacco control policies are also highly cost-effective in achieving development goals. The National Tobacco Strategy specifies that tobacco control should be a component of both welfare and overseas aid.[7]

Progress in Australia

With high smoking rates in many Pacific Island countries in Australia's immediate vicinity,[476], inclusion of countries in the Oceania region to the Australian-New Zealand biannual tobacco conferences is a small but useful contribution to promoting tobacco control in international development.

Australian public health researchers are providing extensive technical assistance in the development of

protocols for the Framework Convention on Tobacco Control.[477]

Idea for consideration

Australia could use its expertise in both the legislative and policy spheres in tobacco control to encourage recipients of overseas aid to adopt strong tobacco control measures as a component of economic and social development. Such a focus would help to amplify Australia's contribution to the achievement of millennium goals to an extent well in excess of what is achievable through its relatively small monetary contribution alone.

VII. Improve focus in research, monitoring and evaluation

VII.1 Better information about effectiveness of interventions

While many studies of cessation interventions report results stratified by socioeconomic group, unfortunately reviews and meta-analyses of such studies (such as those published as part of the Cochrane Collaboration)[478] rarely report on efficacy or effectiveness by socioeconomic status.[479, 480]

Idea for consideration

Researchers in Australia could use their international connections to push for inclusion of the relative effectiveness of interventions on different SES groups in the Cochrane database and in other meta-analyses.

VII.2 Evaluation of initiatives

Several ideas are included in Section Three and set out in full in Attachment 21.

VII.3 Monitoring of progress on objectives

Several ideas are included in Section Two and set out in full in Attachment 21.

VII.4 Surveillance of health and inequality

Idea for consideration

While the evidence is very limited at this stage, and the impacts on smoking are likely to occur largely in future generations, it would be very useful to include in any long-term evaluation of major projects aiming to prevent educational failure and to build social capital, measurements of drug use including smoking in monitoring the impact of such initiatives in target (compared with control) communities.

Four. What next, what first and for what cost?

Many things remain to be done in tobacco control in Australia and if we are to have any prospect of meeting a target of 10% smoking prevalence by 2020, then we will need to do them all and do them as soon as possible.

Accelerating the demise of smoking in young people and across all social groups requires action on many fronts. A piecemeal approach will be dramatically less effective and may perpetuate social inequalities.

Increasing the price of cigarettes will reduce smoking among adults from disadvantaged groups. However among young people such a policy may have a greater impact on children from more advantaged families whose parents do not smoke than on children of smokers who can still obtain cigarettes from their parents.[481] Unless NRT is subsidised, increases in excise duty could cause hardship to those people with severe mental illness who smoke heavily and have not been able to quit.[482] Plain packaging is likely to dramatically reduce the attractiveness of cigarettes to teenagers and young adults, but the effects will be more limited among smokers who are heavily dependent on nicotine. Increasing the availability and affordability of nicotine replacement products should increase quit attempts and successful cessation in heavy smokers, but it may suggest to some young people that it is safe to experiment because an escape route is available.

Only by adopting *all* the measures can downsides be cancelled out and progress across all groups optimised.

Many of the measures required over the next 12 years would be almost cost-free to government.

Restrictions on advertising and smoking in public places are largely self-enforcing. The costs of regulating tobacco products and manufacturers should be covered through the imposition of licence fees. Likewise the cost of regulating retailers should be covered by matching annual fees to the budget required for enforcement.

Media campaigns to reach at least 400 and preferably up to 700 TARPs per month on average would require an investment of several hundred million dollars over the next decade. A recent economic analysis of the impact of the National Tobacco Campaign however finds that returns for such investment are also substantial. The sustained 1.4% drop in prevalence observed following the first phase of the NTC will prevent an estimated 55,000 premature deaths, and (in this case for an investment of $9m over seven months) will lower health care

spending by at least $740m[45] just on the four major diseases caused by smoking.[483]

Based on the pattern observed with Zyban we could expect that demand for subsidized NRT would be quite high for a few years but would gradually diminish to a level no higher than most drugs currently included on the PBS. As demonstrated in Hurley et al's paper, a drop of just 5% in prevalence could reduce PBS spending by $4.5b on cardiovascular drugs alone over the next 40 years[46].[484]

Most of the benefits from reducing smoking will be realised in the 2030s and 2040s. However even by 2020 we could expect to see savings in excess of our investment. Modelling the impact on deaths and costs over just the next ten years, we could expect for every 1,000 smokers who quit, at least 40 will be spared a diagnosis of COPD, heart attack, lung cancer or stroke, with an estimated saving of 75 quality-adjusted-life-years, and health care savings associated just with these four diseases valued in current terms at around A$373,000[47].[485, 486] If impacts on workplace productivity were taken into account, the estimated returns would be higher still.[487]

A report to DOHA assessing the returns on investment in public health to date estimated that the 30% decline of smoking in Australia between 1975 and 1995 had prevented over 400,000 premature deaths,[488] and saved costs of over $8.4b.[489]

Imagine how much more misery could be avoided and how much more productive and inclusive our country could be if, over the next 12 years, we could *pick up the pace*, slash smoking rates by another 50% and achieve our target of 10% smoking prevalence by 2020.

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[45] In current dollars, using a discount rate of 3%.
[46] with a Net Present Value of $1.14b calculated at a discount rate of 5%
[47] Once again using a discount rate of 3%

Major sources used in this document

Documents used in preparing this document include:

i. postings by members of the International Union Against Cancer's GLOBALink network on proposals, legislative and regulatory reforms and implementation details for policies not currently in place in Australia

ii. updates of policy and program implementation in Australia and internationally gleaned from media reports and discussion on Quit Victoria's Tobacco Control Network

iii. a recent report from the US National Academies' Institute of Medicine setting out a blueprint for ending the tobacco problem in the United States[5]

iv. reflections by Professor Simon Chapman, editor *Tobacco Control* and long-time activist and commentator, on past successes and future directions in tobacco control in Australia and internationally in his book *Advocacy and Tobacco Control: Making Smoking History* [112, 490]

v. recently published and soon-to-be published major reviews of scientific evidence conducted by international scientific agencies such as the International Agency for Research in Cancer[152] and the US National Cancer Institute[491] and the US Surgeon-General[26, 144]

vi. reviews and meta-analyses and studies in new areas of tobacco control published in scientific journals in particular in the BMJ's *Tobacco Control* journal which publishes much of best international research on population-level interventions[492]

vii. policy recommendations prepared by international health authorities such as the World Health Organization,[493] the World Bank and the US Centers for Disease Control[494]

viii. discussion papers prepared by expert groups such as the international Framework Convention Alliance (of non-government agencies)[495]

ix. reviews of evidence by government agencies prepared as part of regulatory impact statements required prior to consideration by legislators

x. meta-analyses of clinical interventions in the Tobacco Module of the Cochrane Collaboration[375]

xi. published and unpublished research on tobacco promotion and media education conducted by the Centre for Behavioural Research in Cancer

xii. published and unpublished results of the International Tobacco Control Four Nations (ITC 4 Nations) study which has been assessing the impact of tobacco control policies in Australia compared with the US, the UK and Canada since 2001[70, 109, 111, 212, 345, 496-505]

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Attachments