

National Tobacco Strategy

A SUMMARY DOCUMENT TO ACCOMPANY THE STRATEGY

The overall reason for producing the National Tobacco Strategy is summed up in the goal...

Goal

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

The objectives are the means to achieve this goal...

Objectives

Prevent the uptake of tobacco use in non-smokers, especially children and young people.

Reduce the number of users of tobacco products.

Reduce the exposure of users to the harmful health consequences of tobacco products.

Reduce exposure to tobacco smoke.

Key strategy areas, created in line with the objectives, are as follows...

Six Key Strategy Areas

Strengthening community action.

Promoting **cessation** of tobacco use.

Reducing **availability** and supply of tobacco.

Reducing tobacco **promotion**.

Regulating tobacco.

Reducing exposure to **environmental tobacco smoke**.

1. Strengthening community action

What will be achieved?

Increase in **public awareness of the harm** associated with any level of tobacco use.

Increase in the strategies, programs and guidelines that educationally support and enhance State and Territory **tobacco education and primary prevention initiatives.**

Increase in the range and number of **community-based programs** that aim to prevent uptake of smoking.

Increase in the **capacity of the community** to actively contribute to tobacco control activity at the local level.

Increase the range, accessibility and appropriateness of **information, education and resources for targeted population.**

How will it be achieved?

- Provide nationally collaborative anti-tobacco education (including mass media, public relations, advocacy campaigns) that reach whole population and targeted population groups including children, young people and their parents.

- Develop and disseminate a range of information for parents, teachers, community groups and youth sector that address the health effects of tobacco.

- Public to contribute to review of the Trade Practices (Consumer Product Information Standards [Tobacco]) Regulations with the outcomes of the review to inform future policy initiatives for health warnings on packages.

- Develop, implement and evaluate the National School Drug Education Strategy.

- Nominate tobacco issues as a priority in school education programs

- Maintain and further develop tobacco related modules in school health curriculum.

- Develop, trial and evaluate a peer education program for young people in and out of school settings.

- Scoping exercise to determine the extent and type of tobacco related prevention programs at State/Territory level for children and young people.

- Develop, implement and regularly review evidence-based national community-based education programs (to cover active and passive smoking) for children and young people.

- Consult with broader community in the development of evidence-based education programs.

- Develop appropriate information and education strategies with the involvement of relevant communities.

- Conduct a national audit of smoking initiatives for Aboriginal and Torres Strait Islander people.

- Conduct a National Aboriginal and Torres Strait Islander People's Tobacco Forum.

- Conduct workshops to equip health professionals and allied workers, community leaders, teachers, parents and community groups with resources to contribute to tobacco control.

- Disseminate nationally a range of short courses, updates and education resources.

- Work with targeted population groups to ascertain the social, cultural and economic factors that influence uptake and continued use of tobacco.

2. Promoting cessation of tobacco use

What will be achieved?

Increase in **public awareness** of the benefits of smoking cessation.

Increase in the range & number of **health professionals and allied workers with skills & resources** to help smokers quit.

Increase in the promotion and accessibility of a range of **resources & services** to assist smokers to quit.

Increase in the **incentives** for smokers to quit.

Increase in the accessibility of appropriate, affordable **smoking cessation interventions for low-income earners and targeted population groups.**

Decrease intra-uterine exposure to **maternal smoking.**

How will it be achieved?

- Assess the need for ongoing cessation based national tobacco campaigns.
- Explore partnerships with the private sector (eg pharmaceutical industry) for the promotion of aids to cessation.

- Develop a national accredited training program to equip health professionals and allied workers to plan and deliver brief interventions and smoking cessation programs.
- Expand the number of modules on tobacco issues and cessation approaches in undergraduate and graduate health related and teacher training courses. Ensure modules include skills development for those working with the targeted population groups identified in the Strategy.
- Develop a national grants scheme to assist in the development and dissemination of best practice cessation programs.
- Disseminate and publicise research and best practice in cessation.

- Provide adequate resourcing of a range of smoking cessation services.
- Continue regular evaluation of the national Quitline service and if appropriate include a national call-back service.
- Based on research, develop separate smoking cessation programs that acknowledge and meet the specific needs of people in the identified targeted population groups.

- Encourage life insurance companies to introduce lower premiums for non-smokers.
- Encourage private health funds to cover smoking cessation services and techniques.
- Ensure access to cessation support in health facilities.

- Research any barriers in accessing nicotine replacement therapy (NRT) by low income earners.
- Research any barriers which may prevent targeted population groups accessing smoking cessation services and products.
- Develop strategies to improve equity of access for targeted population groups.
- Trial NRT for Aboriginal and Torres Strait Islander people in urban, rural and remote settings.
- Implement action research by Aboriginal and Torres Strait Islander communities to inform best practice in smoking cessation programs.

- Develop and disseminate best practice guidelines and training materials regarding smoking and pregnancy for relevant professionals.
- Identify any barriers preventing pregnant smokers and their partners accessing smoking cessation services and products and develop strategies to address these.

3. Reducing availability and supply of tobacco

What will be achieved?

Reduction in **affordability** of tobacco products.

Reduction in **illegal sale and supply of tobacco to minors.**

How will it be achieved?

- Explore mechanisms to maintain regular price increases of cigarettes above the Consumer Pricing Index (CPI).
- Implement the Federal Government's change to a per stick system for levying tobacco excise.
- Consider removal of tobacco products from the list of goods used in the calculation of CPI.
- Commission research to assess the impact of price increases on tobacco products and its relation to the health and wellbeing of low income groups.
- Examine impact of removal of tobacco products from duty-free or excise exemptions.

- Prohibit self service vending machines to prevent access by minors.
- Develop, implement and evaluate a national 'best practice' model in sales to minors programs (including community and retailer education, legislative options, penalties, monitoring, effective compliance checks and enforcement).

4. Reducing tobacco promotion

What will be achieved?

Reduction in the exposure of the public to **messages and images** that may persuade them to start smoking, continue to smoke, or to use, or continue to use, tobacco products.

How will it be achieved?

Accidental & incidental advertising

- Research the level of tobacco accidental and incidental (A&I) advertising in film, television, music and print sources in Australia.
- Consult with film, TV, music and publishing industries to identify mechanisms to prevent and reduce the incidence of A&I advertising, so that smoking is portrayed within the actual Australian experience.
- Explore the application of virtual advertising techniques for television broadcasts of international sporting and cultural events.

Point of sale

- Research the extent of point of sale (POS) advertising in Australia
- Measure the impact of current legislative initiatives, enforcement and monitoring effort on such advertising.
- Consider options to reduce or eliminate POS advertising and implement the decisions.
- Develop a national set of minimum requirements restricting display of tobacco products.

Value-added products and promotions

- Research the extent of value-added products and promotions in Australia and the impact of legislative initiatives, enforcement and monitoring activity for such products and promotions.
- Consider options to eliminate tobacco value-added products and implement the decisions.

Legislation

- Jurisdictions to review current policies and systems that monitor and enforce advertising restrictions. Implement policies, systems and training of relevant personnel to improve monitoring and enforcement.
- Conduct an audit of tobacco advertising legislation, monitoring & enforcement policies in Australia and identify the minimum agreed level of tobacco advertising restrictions to be adopted nationally.
- Review the Commonwealth Tobacco Advertising Prohibition Act 1992 (TAPA) and, for jurisdictions without their own tobacco advertising legislation, any issues about enforcing the Act.

Sponsorship

- Commonwealth Health Minister to continue rigorous assessment of applications for exemption under Section 18 of the TAPA 1992.
- Complete the removal of the tobacco exemption for sporting and cultural events of international significance by the year 2006.

5. Regulating tobacco

What will be achieved?

Tobacco industry to **disclose the ingredients** of, including additives to, tobacco products.

Identification of appropriate interventions to **regulate tobacco products**.

How will it be achieved?

- Publish tables (by brand) indicating ingredients, dosage of ingredients and health effects per stick smoked.
- Disseminate tables in easy-to-read format to inform the general public about their consumption of and exposure to tobacco products.

- NHMRC to review scientific evidence on cigarette yields (including methods of testing and standards) in order to advise the Commonwealth, State and Territory Governments of the best measures of cigarette yields.
- Based on outcomes of NHMRC review, governments to consider ways to inform consumers of the 'actual' amount of tar, nicotine and carbon monoxide they inhale in each cigarette smoked.
- NHMRC to investigate the effects of tobacco additives on the bioavailability of nicotine.
- Government to consider strategies to inform consumers of the health effects of tobacco product additives.
- Explore the relative merits, feasibility and viability of reducing nicotine dependency in comparison with promoting less harmful nicotine delivery systems.

6. Reducing exposure to environmental tobacco smoke

What will be achieved?

Establishment of **smoke free public places** as the norm.

Increase in **public awareness & understanding** of the health risks of exposure to environmental tobacco smoke (ETS).

Increase in accessible and appropriate **strategies for targeted population groups** nominated in the Strategy.

How will it be achieved?

- Explore mechanisms to establish smoke free environments and develop and disseminate a national response to passive smoking identifying best practice and national guidelines.

- Examine effectiveness of policy & legislative initiatives, enforcement & monitoring in Australia & internationally in reducing community and employee exposure to ETS.

- Each jurisdiction to implement strategies to reduce or eliminate exposure to ETS.

- Develop a national ETS education strategy complementing State/Territory activity.

- Develop a national education strategy to reduce exposure to ETS by children.

- Collate research into community attitudes to passive smoking (in workplaces, recreational settings, restaurants, bars, hotels, shops, car, home etc.) and obtain benchmark level of awareness and opinion.

- Collect and collate data on exposure levels in various types of indoor places, lifetime exposures for adults and children, and on the economic impact of the adoption of non-smoking policies by business.

- Through consultation with targeted population groups identify current level of awareness of health risks associated with ETS and social and cultural issues that influence exposure to ETS.

- Promulgate best practice in strategies to improve awareness of ETS in targeted population groups.

National Tobacco Strategy 1999 to 2002-03

A Framework for Action

Endorsed by
the Ministerial Council on Drug Strategy (MCDS)
June 1999

Companion documents

- Background Paper to the National Tobacco Strategy 1999 to 2002-03
- Summary Plan of the National Tobacco Strategy 1999 to 2002-03

© Commonwealth of Australia 1999

ISBN 0642415153

This work is copyright. It may be reproduced in whole or part subject to the inclusion of an acknowledgment of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above, require the written permission of the Commonwealth available through AusInfo. Requests and inquiries should be addressed to the Manager, Legislative Services, AusInfo, GPO Box 1920, Canberra ACT 2601.

Publication approval number: 2596

For further information and other publications produced by the department, visit our website at www.health.gov.au, or call 1800 020 103.

Publications Production Unit (Public Affairs, Parliamentary and Access Branch)
Commonwealth Department of Health and Aged Care
Canberra

Contents

Section 1: National Tobacco Strategy Framework

Introduction	1
Format of Strategy	2
Strategy goal	2
Strategy objectives	2
Key Strategy areas	2
Overall national performance measures	3
Evaluation and monitoring of the National Tobacco Strategy	4
Strategy management	5
Infrastructure support	5
Capacity building	6
Partnerships, networks and links	6

Section 2: National Tobacco Strategy Action Plan

Key Strategy Area 1: Strengthening community action	12
Key Strategy Area 2: Promoting cessation of tobacco use	16
Key Strategy Area 3: Reducing availability and supply of tobacco	22
Key Strategy Area 4: Reducing tobacco promotion	26
Key Strategy Area 5: Regulating tobacco	34
Key Strategy Area 6: Reducing exposure to environmental tobacco smoke (ETS)	36

Section 3: Appendixes

Appendix 1: Abbreviations and a glossary of terms

Appendix 2: Baseline data and explanation of data sources

Section 1: National Tobacco Strategy Framework

Introduction

Australia has been active in implementing tobacco control strategies and first formalised its commitment to a comprehensive approach to tobacco control in the 1991 National Health Policy on Tobacco in Australia. Tobacco smoking, however, remains the single largest preventable cause of premature death and disease in Australia.

In entering the next century, in line with calls from the World Health Assembly for the implementation of comprehensive tobacco control strategies, Australia must reaffirm and formalise its comprehensive approach to tobacco control and ensure a firm commitment to future tobacco control initiatives. The *National Tobacco Strategy 1999 to 2002-03* recognises that future successful action in tobacco control hinges upon coordinated and comprehensive national action. The Strategy is intended to expand on the range of initiatives already implemented by Commonwealth, State and Territory governments and non-government organisations and will link with other relevant national strategic documents to ensure an integrated approach.

The Strategy highlights the need for a comprehensive and multi-variate approach and national collaborative effort to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms. The document, together with the companion background and summary papers aims to provide a detailed, high quality, evidence-based strategy for tobacco control in Australia over the period 1999 to 2002-03 and a system to review and account for progress in tobacco control in Australia. It aims to improve the effectiveness and efficiency of tobacco control in Australia and to continue and expand upon the collaborative partnerships achieved by the 1997 National Tobacco Campaign. The Strategy is identified as a 'national strategy' as opposed to a 'Commonwealth' strategy. It is intended to provide leadership while allowing flexibility for each jurisdiction and the non-government sector to ensure tobacco control action is responsive to the needs and priorities of the jurisdiction and non-government sector.

The development of the Strategy draws on four decades of supported argument regarding tobacco control initiatives and activity that has occurred at a State/Territory, Commonwealth, national and international level. Each of the strategies and actions recommended has some level of evidence. Some have not yet been implemented for sufficient time to have been fully evaluated over the long term, but certainly are well placed in an innovative approach to tobacco control. The strategy advocates moving forward with reasoned and evidence-based initiatives that are rigorously evaluated. Such evaluations should not only include traditional controlled research designs but also time series approaches that are able to accommodate complex factors that contribute to levels of tobacco use in a population.

Thus, the national strategy will both perpetuate current activity in tobacco control and facilitate the further development of a dynamic evidence-based program to reduce the harm associated with the supply and demand for tobacco products in Australia.

Format of the Strategy

An overarching goal and four objectives are identified for the Strategy. In order to meet the goal and overall objectives and expand on the initiatives already undertaken by the Commonwealth, State and Territory governments and non-government agencies, six Key Strategy Areas are identified. Each of these also has its own objectives which, if achieved, will contribute to meeting the Strategy's overall objectives and goal. Actions and strategies to achieve the key strategy area objectives are recommended. The sectors responsible for contribution to the development, implementation and evaluation of these actions and strategies are nominated. The assignment of responsibility for specific action will vary with each of the proposed strategies and subsequent actions.

An important next step will be the development of State and Territory tobacco action plans together with additional targeted national tobacco action plans for the targeted population groups nominated in this Strategy. It is within these plans that specific partnerships, networks and collaborative action at the national level and between sectors can best be nominated against specific actions.

Strategy goal

The overall goal of the National Tobacco Strategy is to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms.

Strategy objectives

In order to achieve the goal of the National Tobacco Strategy, the Strategy aims to:

- prevent the uptake of tobacco use in non-smokers, especially children and young people;
- reduce the number of users of tobacco products;
- reduce the exposure of users to the harmful health consequences of tobacco products; and
- reduce exposure to tobacco smoke.

Key Strategy areas

To address the Strategy objectives, six key strategy areas are identified as:

- strengthening community action for tobacco control;
- promoting cessation of tobacco use;
- reducing availability and supply of tobacco;
- reducing tobacco promotion;
- regulating tobacco; and
- reducing exposure to environmental tobacco smoke.

The consultation process for this Strategy strongly supports the view that the six key strategy areas nominated above represent a comprehensive approach to tobacco control that builds on past effort and strengthens opportunity for a multi-variate approach to tobacco control, encouraging links between the six strategy areas. In particular, the consultation process also highlights the important role played by the general public, identifying communities affected by tobacco products as both

primary targets and primary resources for the achievement of the objectives of the Strategy.

Each key strategy area has identified objectives which, if achieved, will assist in meeting the Strategy's overall objectives. Furthermore, within each key strategy area there are specifically identified action issues to address the key strategy area objectives. Finally, strategies or actions to achieve the objectives are recommended and accompanied by the outputs intended as the result of implementing these strategies and/or taking such action.

Implementation of certain aspects of the *National Tobacco Strategy 1999 to 2002-03* may require more detail than that which can be defined in an overarching national strategy. As such, specific, targeted, national tobacco action plans may evolve from this National Tobacco Strategy. For example, the Strategy consultation process identified the need to develop targeted plans for the following identified population groups:

- Aboriginal and Torres Strait Islander people;
- children and young people under 18 years of age;
- pregnant women and their partners;
- people with a mental health illness;
- people from culturally and linguistically diverse backgrounds; and
- low income earners.

Overlap between groups, particularly in relation to low-income earners is recognised. Specific strategies will need to be developed and implemented at national, State/Territory and local level within the framework of any relevant existing health programs for those specific targeted population groups. The development of such plans takes time. It is important that priority actions for these groups are implemented in tandem with the main Strategy implementation and are not delayed unduly as a result of additional planning processes. For this reason the Strategy includes reference to specific action within the Strategy itself as well as reference to the need to develop detailed plans.

Overall national performance measures

The following overall national performance measures have been identified to measure the progress and success of the Strategy.

Long-term indicators:

- number of deaths and level of disease caused by smoking; and
- economic cost of tobacco-related illness.

Significant changes in the long-term indicators are unlikely to be seen within the short four-year span of the Strategy. It is important, however, for a National Tobacco Strategy to aspire to reduce tobacco-related morbidity, mortality and economic costs. These indicators can certainly be measured during the life of this Strategy although a decline is not expected.

Short-term indicators:

- percentage of the adult population and young people who have never smoked;
- percentage of the adult population, ages 18 and older, who smoke (both regularly and occasionally);
- percentage of the 12-17 year olds who smoke (both regularly and occasionally);
- percentage of Aboriginal and Torres Strait Islander people who smoke;
- percentage of economically disadvantaged people who smoke;
- percentage of women who smoke throughout pregnancy;
- percentage of adults, young people and children (under 12 years) exposed to environmental tobacco smoke (ETS); and
- average number of cigarettes smoked per day for both the adult smoker and the smoker 12-17 years of age;

Some change is expected to be seen in these short-term indicators over the span of the four-year period of the Strategy.

Sources of data collection are identified in the companion background paper and in *Appendix 2* of this Strategy. It is acknowledged that for some indicators (eg percentage of adults, young people and children under 12 years exposed to environmental tobacco smoke) new work may need to be undertaken to establish a baseline measure.

Evaluation and monitoring of the National Tobacco Strategy

The National Expert Advisory Committee on Tobacco will develop an evaluation plan and monitoring system for the National Tobacco Strategy. The evaluation plan will be developed as a priority for action, taking into consideration the evaluation plans for the National Drug Strategic Framework 1998-99 to 2002-03.

The National Tobacco Strategy is intended to act as a framework to assist jurisdictions in the development of State and Territory Tobacco Action Plans. It is essential that outputs be assessed in line with the specific objectives identified against the six key strategy areas nominated in this document. Many of the objectives call for projects to be undertaken and programs developed at jurisdictional level. Development and ownership of such initiatives will be subsequent to endorsement of this document. At that time performance indicators will need to be specified as part of State and Territory Tobacco Action Plans and monitored through an accompanying evaluation process.

It is proposed that each State and Territory government and the Commonwealth Government report annually to the Intergovernmental Committee on Drugs (IGCD) against the National Tobacco Strategy on an agreed set of criteria and performance indicators. States and Territories will provide performance information against their State and Territory Tobacco Action Plans.

The Commonwealth will also be responsible for a review of the National Tobacco Strategy 1999 to 2002-03 in the year 2003 to 2004. This review is expected to inform the development of subsequent National Tobacco Strategies.

Strategy management

The implementation, monitoring and evaluation of the National Tobacco Strategy will be guided by the Intergovernmental Committee on Drugs (IGCD) using the expertise of the National Expert Advisory Committee on Tobacco (NEACT), a committee within the advisory structure of the National Drug Strategic Framework. The NEACT will report directly to the IGCD. The IGCD shall provide annual reports on progress against the National Tobacco Strategy to the Ministerial Council on Drug Strategy (MCDS). The Commonwealth, each State and Territory government and other agencies where relevant, will be responsible for the development of their own tobacco control action plan (incorporating strategies for both active and passive smoking) complementary to the National Tobacco Strategy.

Infrastructure support

The use of multiple strategies applied as continuous action over a period of more than two decades, supported by strong intersectoral collaboration, has ensured tobacco control activity in Australia can be considered a successful case study of achievement in population health. Challenges for sustained action remain. The majority of submissions received through the consultation phase (February to April 1999) for development of the *National Tobacco Strategy 1999 to 2002-03* indicate strong support for the priorities for action nominated in the document but draw attention to the need for strengthened infrastructure support if objectives against these priority areas are to be met.

In line with World Health Organisation (WHO) recommendations that there be nationally identified focal points for tobacco control worldwide, Australia's governance of the National Drug Strategic Framework provides a strong structure within which the National Tobacco Strategy can be developed, implemented and evaluated.

Within this infrastructure, the NEACT, if adequately resourced, will have the capacity to support the MCDS and the IGCD in:

- providing oversight of the implementation and evaluation phases of the *National Tobacco Strategy 1999 to 2002-03*, including national tobacco campaigns;
- identifying priorities for action against the areas nominated in this document such as:
 - research priorities
 - national development of best practice models for prevention, education, training and treatment programs
 - evaluation of best practice models.
- providing advice to the IGCD and MCDS on priorities for funding within the *National Tobacco Strategy 1999 to 2002-03*;
- promoting a “whole of government” approach to Australia's tobacco control effort;
- developing guidelines for effective, sustainable, intersectoral action;
- liaising with national centres of excellence relevant to tobacco control initiatives;

- reviewing current resources for tobacco control initiatives and investigate options for additional sources of funding to support improved effort in prevention, education and treatment programs in the community; and
- developing a monitoring and communication system that ensures coordinated dissemination of information on tobacco control.

Capacity building

Infrastructure support is an important element of capacity building. The *National Tobacco Strategy 1999 to 2002-03* adopts the principle of capacity building (at national, jurisdictional and local community levels) as an important contribution to tobacco control activity. Within the context of the National Tobacco Strategy, capacity building can be considered as one of the foundations on which processes aimed at wellbeing are built. Capacity is represented by the ability to utilise and develop existing resources that would not or have not been identified or utilised for current tobacco control effort. An ongoing level of commitment and investment is required to ensure resources are enhanced not depleted. Rather than identifying gaps and deficiencies in current effort, the use of capacity building principles encourages contributors to recognise current knowledge, skills and productive activity and promotes strengthened collaborative effort and continuous improvement in tobacco control activity.

Important characteristics of capacity for consideration in developing and implementing the National Tobacco Strategy are:

- formation of partnerships;
- transfer of knowledge between partners;
- community problem solving ability; and
- infrastructure support¹

Partnership, networks and strategic links

Within this concept of capacity building, a key contemporary issue for population health strategies is the need to establish mechanisms for strengthened partnerships, networks and links between identified public health policy and strategies. The *National Tobacco Strategy 1999 to 2002-03* is well placed to pursue partnerships at international, national, jurisdictional and local levels.

Internationally, Australia contributes to World Health Organisation initiatives. In line with the 1997 Jakarta Declaration on Health Promotion², the WHO has recently developed a major initiative known as the Tobacco Free Initiative. The long term mission of the project is to decrease the prevalence of global tobacco use. The project goals include:

- stimulating global support for evidence based control policies and actions;
- building new and strengthening existing partnerships for action; and
- accelerating implementation of national, regional and global strategies.

¹Bush, R and Mutch, A 1999. Community Capacity Guidelines. Centre for Primary Health Care, University of Queensland.

²New Players for a New Era – Leading Health Promotion into the 21st Century, Jakarta, 21 – 25 July 1997.

Australia supports fully the objectives of the Tobacco Free Initiative, and the *National Tobacco Strategy 1999 to 2002-03* will complement the directions taken by the WHO.

Australia is well placed to provide leadership on tobacco control strategies in both global and regional settings and to work closely with both WHO Headquarters and the WHO Western Pacific Regional Office to keep them informed of progress on the National Tobacco Strategy.

Nationally, through the National Drug Strategy governance arrangements to the National Public Health Partnership and the Council of Australian Governments (COAG), a number of opportunities exist for cross-reference between key public health initiatives (eg the National Mental Health Strategy, the National Asthma Campaign, the National Diabetes Strategy, Active Australia, the National School Drug Education Strategy).

Collaborative action between Commonwealth and State and Territory governments, local governments, the non-government sector and peak community groups already occurs. For example, the National Tobacco Campaign is a hallmark for collaboration between the Commonwealth, State and Territory governments and non-government sector on tobacco control and can certainly provide a model for future collaborative activity in other areas of tobacco control.

Section 2: National Tobacco Strategy Action Plan

Key Strategy Area 1: Strengthening community action

Objectives:

- Increase in the capacity of the community to actively contribute to tobacco control activity at the local level.
- Increase in public awareness of the harm associated with any level of tobacco use.
- Increase in the range and number of programs that aim to prevent uptake of smoking.
- Increase in the strategies, programs and guidelines in place that support and enhance State and Territory tobacco activities in the community.
- Increase in the range and number of health workers, community leaders and community groups with a high level of awareness and knowledge of tobacco issues and the health effects of tobacco products, equipped with the skills and resources to contribute to community action for tobacco control.
- Increase in the range, accessibility and appropriateness of information and education resources for the targeted population groups nominated in the Strategy regarding the health effects of tobacco use and promoting ways in which such groups can be actively involved in tobacco control activity.

Achieving significant population-wide reductions in tobacco use requires a well informed, involved community able to contribute knowledge and skills and their unique understanding of their own communities to changes in beliefs, attitudes and behaviour related to tobacco and health.

Building the capacity of communities to contribute to tobacco control requires action in four areas³:

- identification and strengthening of partnerships in the community so that reciprocal investments in human, social and economic capital can be made;
- provision of support that encourages knowledge transfer between partners, so that local practice knowledge is integrated with research-based knowledge;
- opportunity for partners to be active in problem solving in relation to tobacco issues in their communities; and
- involvement in establishing and maintaining infrastructure, including contribution to policy initiatives developed at national, jurisdictional and local levels so that sustained investments in social, human and financial capital are maintained.

³Bush, R and Mutch, A 1999. Community Capacity Building. Centre for Primary Health Care, University of Queensland: Brisbane.

⁴Morling, T 1991. Australian Federation of Consumer Organisations Inc vs The Tobacco Institute of Australia Limited, Federal Court of Australia, No. NG 253 of 1987: Sydney.

A well-informed community is one that understands enough about tobacco to make an informed choice about its use. To make this choice, the community must understand the product, the harm associated with any level of use, the difference between use and addiction, the effects of exposure to environmental tobacco smoke (ETS), the need to quit sooner rather than later, that quitting at any age is beneficial, how to get help to quit, and the broader impact of tobacco on society.

There is no shortage of information about tobacco and its impact on health. It is the most widely researched topic in bio-medical history. Indeed the sheer quantity of information in the public arena can be bewildering to the general public. The problem is exacerbated by the efforts of the tobacco industry to promote use of its product and its strategies to discredit and confuse the public health message.³

For communication to be effective it must be credible, consistent and constant. Communicating clear public health messages is complicated by the emerging trend for audiences to fragment across multiple channels and the increasing move to globalisation of communication. This is further complicated by the need to ensure that information is understood by all sections of the community including those who do not read or speak English, for whom English is a second language and for those with low levels of literacy. The prevalence of smoking is significantly higher amongst people of lower educational attainment.

It is well documented in literature that information on its own is unlikely to create behaviour change. If the community is to play a significant role in tobacco control they must also be involved in planning and development of community-based programs for tobacco control. Community leaders, community groups, school communities, the youth sector and parents are all well placed to contribute to action, complementing support already provided through community health professionals such as general practitioners, pharmacists, environmental health officers and health promotion workers.

Strategies for which community support is important include:

- development of collaborative national, state/territory and local anti-tobacco education including mass media, PR, advocacy campaigns reaching whole population and sub-populations including children and young people under 18 years of age;
- development and implementation of the National School Drug Education Strategy;
- development and implementation of school education programs, especially broad school community concepts such as 'Health Promoting Schools';
- development and implementation of evidence-based national tobacco education programs at the community level (to cover active and passive smoking) for children and young people under 18 years;
- contribution to the Review of Trade Practices (Consumer Product Information Standards) Tobacco Regulations including the evaluation of the impact of the current health warnings, generic packaging and the appropriateness of the current Commonwealth National Tobacco Information Line;
- development and provision of short courses and other training and information sessions for relevant community health professionals, community leaders, teachers, parents and community groups;
- development and implementation of strategies sensitive to the cultural backgrounds and values and needs of Aboriginal and Torres Strait Islander people;

- encouraging action research within Aboriginal and Torres Strait Islander communities to determine best practice for tobacco control programs at the local level;
- exploring the cultural and social factors that influence uptake and continued use of tobacco among people from culturally and linguistically diverse backgrounds; and
- involvement of relevant communities in developing information and education strategies that are sensitive to the values, beliefs and culture of the groups involved.

Key Strategy Area 1: Strengthening community action

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Public education:</i> Campaigns	Increase in public awareness of the harm associated with any level of tobacco use.	Collaborative National, State, Territory and local anti-tobacco education, including mass media, PR, advocacy campaigns reaching whole of population and targeted population groups, particularly children, young people and their parents.	Ongoing dissemination of information to whole population and targeted populations regarding the health effects of tobacco.	Commonwealth, State and Territory governments, the non-government and private sectors, community groups.
<i>Public Education:</i> School education	Increase in the strategies, programs and guidelines that educationally support and enhance State and Territory tobacco education and primary prevention initiatives.	Development, implementation and evaluation of the National School Drug Education Strategy.	Strategy adopted and implemented by States and evaluated by the Commonwealth. Professional development of teachers in tobacco education.	Commonwealth with State and Territory governments.
		Tobacco issues nominated as a priority in school education programs (eg. within the concept of 'Health Promoting Schools')	Tobacco education included in school curriculum and broader school community programs (eg within the concept of 'Health Promoting Schools').	Commonwealth, State and Territory governments, School communities.
		Maintenance and further development of tobacco related modules for inclusion in school health curriculum.	Tobacco related modules in school health curriculum.	Commonwealth, State and Territory governments.

Key Strategy Area 1: Strengthening community action

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Public education:</i> School education	Increase in the strategies, programs and guidelines that educationally support and enhance State and Territory tobacco education and primary prevention initiatives.	Develop, trial and evaluate a peer education program for young people in and out of school settings, addressing prevention and early intervention activity relevant to young people.	An evaluated peer education program for young people in and out of school settings.	Commonwealth in consultation with State and Territory governments.
<i>Prevention programs:</i> Children and young people	Increase in the range and number of community-based programs that aim to prevent uptake of smoking.	Scoping exercise to determine extent and type of tobacco related prevention programs for children and young people at State/ Territory level.	A report on the extent and type of tobacco related prevention programs in and outside education settings.	Commonwealth in consultation with State and Territory governments.
		Evidence-based national community-based education programs (to cover active and passive smoking) for children and young people, developed, implemented and regularly reviewed.	A range of best practice programs for children and young people.	Commonwealth in consultation with State and Territory governments.
	Increase in the capacity of the community to actively contribute to tobacco control activity at the local level	Consultation with broader community (eg young people, parents, community leaders) in the development of evidence-based education programs.	A community development approach applied to education programs (active and passive smoking) for children and young people under 18 years.	Commonwealth, State and Territory governments, community groups.

Key Strategy Area 1: Strengthening community action

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Information:</i> General	Increase in public awareness of the harm associated with any level of tobacco use.	Development and dissemination of a range of information for parents, teachers, community groups, youth sector that address the health effects of tobacco.	A collection of targeted information on the health effects of tobacco.	Commonwealth Government.
<i>Information:</i> Targeted population groups nominated in the Strategy.	Increase in the range, accessibility and appropriateness of information, education and resources for targeted population groups.	Work with targeted population groups to ascertain the social, cultural and economic factors that influence uptake and continued use of tobacco.	Targeted population groups better informed about the effects of tobacco and the relevance of those effects to their health and wellbeing.	Commonwealth Government.
<i>Information:</i> Health warnings	Increase in public awareness of the harm associated with any level of tobacco use.	Public contribution to the review of the Trade Practices (Consumer Information Standards) Regulations. The outcomes of the review to inform future policy initiatives for health warnings on packages.	Evaluation of the current health warnings on tobacco products and recommendations regarding any changes to warnings.	Commonwealth Government.
<i>Information:</i> Resources	Increase in the capacity of the community to actively contribute to tobacco control at the local level.	With the involvement of relevant communities, appropriate information and education strategies developed.	Increase in appropriate resources for targeted population groups and for those who support them (eg parents, community leaders, teachers, community health and allied workers).	Commonwealth Government.

Key Strategy Area 1: Strengthening community action

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Information:</i> Resources	Increase in the capacity of the community to actively contribute to tobacco control at the local level.	A national audit of smoking initiatives for Aboriginal and Torres Strait Islander people	A map of existing tobacco control programs for Aboriginal and Torres Strait Islander people	Commonwealth Government together with Aboriginal and Torres Strait Islander peak bodies
		A National Aboriginal and Torres Strait Islander Peoples Tobacco Forum	Forum held and information disseminated to inform Aboriginal and Torres Strait Islander people's Tobacco Action Plan.	Commonwealth Government together with Aboriginal and Torres Strait Islander peak bodies
		Annual State/national workshops held to equip health professionals and allied workers, community leaders, teachers, parents and community groups with resources to contribute to tobacco control.	Enhanced opportunities for education of a range of health workers and key community stakeholders in tobacco control.	Commonwealth, State and Territory governments.
		A range of short courses, updates and education resources disseminated nationally.	An up to date and informed health industry and community workforce.	Commonwealth, State and Territory governments.

Key Strategy Area 2: Promoting cessation of tobacco use

Objectives:

- Increase in public awareness of the benefits of smoking cessation.
- Increase in the range and number of health professionals and allied workers with the skills and resources to help smokers quit.
- Increase in the promotion and accessibility of a range of resources and services to assist smokers to quit.
- Increase in the incentives for smokers to quit.
- Increase in the accessibility and appropriateness of smoking cessation interventions for targeted population groups nominated in the Strategy.
- Decrease in intra-uterine exposure to maternal smoking.

Preventing onset of regular smoking in adolescents is an important component of any comprehensive smoking and health strategy, but it often takes decades before prevention has any measurable effect on morbidity and mortality rates. Smoking cessation is a major means of reducing smoking-related mortality as it prevents the occurrence of disease and reduces the risk of further disease in those who quit.⁴ Therefore promoting smoking cessation to the community is essential.

There are more than three million Australians who currently smoke, more than three quarters of whom want to quit.⁵ The true impact of a lifetime of smoking has now been confirmed with research showing that around half of all lifetime smokers will die as a result of their habit.

Half of these will be killed in middle age (36 to 69 years) losing around 21 years of life.⁶ Many of the diseases associated with smoking are chronic and disabling, placing a large burden on the community.

Age-specific prevalence of smoking declines to ten percentage points less than the overall prevalence by 60 years of age, demonstrating that quitting can, and does, happen with great frequency.

A strategy that is aimed at cessation for all age groups is required for several reasons. First, quitting smoking delivers a health and quality of life outcome to individuals most at risk as well as to their families and workplace associates. Secondly, cessation can affect premature death rates in as little as five years, it delivers rapid and measurable public health outcomes in terms of disease reduction. Finally, it is an effective tool that supports prevention strategies by maximising opportunities for adults to set an example for children and young people.

⁴ World Health Organization 1998. Guidelines for controlling and monitoring the tobacco epidemic, World Health Organisation: Geneva, p 18.

⁵ Borland R & Hill D 1990. 'Two-month follow-up on callers to a telephone quit smoking service' *Drug and Alcohol Review*, no 9 pp 211-218.

⁶ Peto R, Lopez A, Boreham J, Thun M, Heath C 1994 Mortality from smoking in developed countries 1950-2000. Imperial Cancer Research Fund, World Health Organization: Oxford University Press, New York.

Future activity in promoting cessation of tobacco use include:

- assessing the need for an ongoing cessation-based national tobacco campaign;
- exploring mechanisms to more effectively involve health professionals and allied workers in delivery of effective early intervention and smoking cessation programs;
- developing and implementing brief/early intervention programs for a range of health professionals and allied workers;
- resourcing a range of government and non-government funded smoking cessation services;
- undertaking research to identify the barriers in accessing nicotine replacement therapy by low income earners;
- based on this research and the impact on quit rates & net health care costs, developing a strategy to identify and minimise the barriers (cultural, social, economic) which may prevent the targeted population groups nominated in the Strategy from accessing smoking cessation services and products;
- identifying and promulgating best-practice smoking cessation models;
- developing and disseminating best-practice guidelines and training materials regarding smoking and pregnancy for relevant professionals;
- researching effective strategies for delivery of smoking cessation programs and their uptake by people with a mental health illness; and
- identifying the barriers which may prevent pregnant smokers and their partners in accessing smoking cessation services and products, and develop strategies to address these.

Key Strategy Area 2: Promoting cessation of tobacco use

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Public education:</i> Promotion of the benefits of smoking cessation	Increase in public awareness of the benefits of smoking cessation.	Assess the need for an ongoing national tobacco public education campaign that targets cessation based on: <ul style="list-style-type: none"> – evaluation of 1997 campaign – comparative assessment of public education campaigns against other cessation strategies – the need for maintaining quit smoking as ‘top-of-mind’ – priorities for other anti-smoking campaigns. 	Evaluation of the cessation-based 1997 National Tobacco Campaign. Strategies developed and implemented to raise awareness of the benefits of cessation.	Commonwealth with State and Territory governments.
		Explore partnerships with the private sector (eg pharmaceutical industry) for the promotion of aids to cessation.	Private sector smoking cessation campaigns.	Commonwealth Government in association with the private sector.
<i>Professional education:</i> Training and skills development	Increase in the range and number of health professionals and allied workers with the skills and resources to help smokers quit.	Develop a national accredited training program to better equip health professionals and allied workers (including those working with identified targeted population groups) to plan and deliver brief interventions and smoking cessation programs.	A national, accredited brief intervention and smoking cessation training program for front line professionals. Increase in the range of health professionals trained in and promoting smoking cessation.	Commonwealth in consultation with State and Territory governments and relevant bodies.
		Develop national grants scheme to assist in the development and dissemination of best practice cessation programs.	An identified network of best practice cessation programs, supported through a national grants process.	Commonwealth Government, RCGP, AMA, other professional groups

Key Strategy Area 2: Promoting cessation of tobacco use

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Professional education:</i> Training and skills development	Increase in the range and number of health professionals and allied workers with the skills and resources to help smokers quit.	Expand the number of modules on tobacco issues and cessation approaches currently included in further education, undergraduate and graduate health-related and teacher training courses. Ensure modules include skills development for those working with the targeted population groups identified in the Strategy.	Increased number of health related and teacher training courses at university and institutes of technology that include tobacco issues and cessation approaches. Increase in the range of workers trained in and promoting cessation in both general and targeted population groups.	Commonwealth, State and Territory governments in consultation with universities and institutes of technology.
		Disseminate and publicise research and best practice in cessation.	Improved access by health professionals and allied workers to best practice in cessation materials.	
<i>Support services:</i> Programs	Increase in the promotion and accessibility of a range of resources and services to assist smokers to quit. (including the targeted population groups nominated in the Strategy).	Adequate resourcing of a range of smoking cessation services available.	A range of smoking cessation services available.	Commonwealth, State and Territory governments.
		Regular evaluation of the national 'Quitline' service. Based on evaluation, consideration of a national 'Quitline' call-back service (including access to services for the targeted population groups).	An evaluated, cost-effective and efficient national 'Quitline' service with improved access for those quitting smoking, including those in the targeted population groups.	Commonwealth, State and Territory governments.
<i>Support services:</i> Incentives	As above.	Encourage life insurance companies to introduce lower premiums for non-smokers.	Lower premiums for non-smokers.	Commonwealth Government in consultation with Life Insurance Cos.

Key Strategy Area 2: Promoting cessation of tobacco use

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Support services:</i> Incentives	Increase in the incentives for smokers to quit.	Encourage coverage of smoking cessation services/and/or techniques by private health funds.	Cost of smoking cessation services and /or techniques met by private health funds.	Commonwealth Government in consultation with private health funds.
	Increase in incentives for smokers (in health care facilities) to quit.	Ensure access to cessation support in health facilities.	Cessation support (eg NRT) offered as an incentive in health facilities for staff and clients quitting smoking.	Commonwealth, State and Territory governments. in consultation with private health care providers.
<i>Cessation programs:</i> Low income groups/NRT	Increase in the accessibility of affordable smoking cessation interventions for low-income earners.	Commission research to identify barriers to, and recommend solutions for, access to nicotine replacement therapy for low income earners	Policy and strategy in place to enable low income earners to access NRT	Commonwealth Government
<i>Cessation programs:</i> Targeted population groups	Increase in the accessibility of appropriate, affordable smoking cessation programs for the identified target population groups, nominated in the Strategy.	Undertake research to identify the barriers (cultural, social, linguistic, economic, geographic) which may prevent access by targeted population groups to smoking cessation programs. Develop strategies to improve equity of access for targeted population groups.	Barriers to smoking cessation for targeted population groups identified and addressed.	Commonwealth, State and Territory governments.
		Trial NRT for Aboriginal and Torres Strait Islander people in urban, rural and remote settings.	Reported outcomes of trial to inform future cessation programs for Aboriginal and Torres Strait Islander people.	Commonwealth Government in consultation with State and Territory governments

Key Strategy Area 2: Promoting cessation of tobacco use

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Cessation programs:</i> Best practice in cessation for Aboriginal and Torres Strait Islander people.	Increase in the accessibility of appropriate, affordable smoking cessation programs for targeted population groups.	Action research by Aboriginal and Torres Strait Islander communities to develop best practice in smoking cessation programs.	A community action research model for cessation programs for Aboriginal and Torres Strait Islander people.	Commonwealth Government, Aboriginal and Torres Strait Islander communities.
	Increase in the promotion and accessibility of a range of resources and services to assist smokers to quit.	Based on research, development of separate smoking cessation programs that acknowledge and meet the specific needs of people in the identified targeted population groups.	A range of programs that incorporate best practice principles and meet the specific needs of identified targeted population groups.	Commonwealth, State and Territory governments.
<i>Cessation programs:</i> Pregnancy and smoking	Decrease in intra-uterine exposure to maternal smoking.	Develop and disseminate best practice guidelines and training materials regarding smoking and pregnancy for relevant health professionals.	Key health professionals well informed of smoking and pregnancy issues and best practice.	Commonwealth, State and Territory governments, peak health professional groups.
		Identify the barriers that may prevent pregnant women and their partners from accessing smoking cessation services and products; develop strategies to address barriers.	Quitting by pregnant smokers and their partners.	Commonwealth Government.

Cessation programs to address smoking in pregnancy can also address the effects of exposure both during pregnancy and in early childhood to environmental tobacco smoke. This issue is also referred to under Key Strategy Area 6: Reducing Exposure to Tobacco Smoke.

Key Strategy Area 3: Reducing availability and supply of tobacco

Objectives:

- Reduction in illegal sale and supply of tobacco products to minors (children and young people under the age of 18 years).
- Reduction in affordability of tobacco products.

The availability of tobacco products relates to two concepts, accessibility and affordability. Where and how tobacco products are sold along with the cost of purchasing them are factors that determine the overall availability of these products in the community.

Access to tobacco products is an important factor in the uptake of smoking.⁷ In Australia (1996), 46.7% of 12-17 year old smokers had purchased their last cigarette as a result of illegal sales.⁸ This, coupled with the fact that smoking behaviour is well established before the end of teenage years, means that reducing access to tobacco products is likely to contribute to reducing the overall prevalence of smoking. Efforts to reduce children's access to tobacco products in Australia have included increasing the minimum age of purchase to 18 years in all jurisdictions (with penalties imposed on those selling or in some cases, supplying to minors) and restricting the location of vending machines in most jurisdictions.

Approaches to the registration or licensing of tobacco retailers are inconsistent across the country. The consultation process for development of the Strategy raised the issue of registration or licensing of outlets through which tobacco products are sold. Introduction of licensing and/or registration schemes were seen to provide an opportunity to encourage responsible management of tobacco sales, particularly in relation to preventing sales to minors, provision of a venue for information and education for tobacco retailers and a system within which compliance monitoring could be more effectively applied.

Another way of reducing the availability of tobacco products is to increase their cost. Price is a powerful determinant in an individual's decision and choice to smoke. Price sensitive consumers respond to increases in the price of cigarettes by either quitting or lowering their consumption.⁹

Research shows that, in general terms a 10% price increase will, on average, reduce tobacco consumption by between 3-6%.¹⁰ The relationship between price and consumption is even more pronounced for children where a 10% price increase will, on average, reduce demand by 14%.¹¹

⁷ US Department of Health and Human Services 1994. Preventing tobacco use among young people; A report of the Surgeon General: Atlanta, Georgia.

⁸ Hill D, White V, & Letcher T 1997. Tobacco use among Australian secondary students in 1996, Centre for Behavioural Research in Cancer, Anti-Cancer Council of Victoria, p 20. (submitted for publication)

⁹ US Department of Health and Human Services 1994. Preventing tobacco use among young people; A report of the Surgeon General: Atlanta, Georgia.

¹⁰ Australian Cancer Society and the National Heart Foundation 1998. Federal excise on tobacco; tobacco tax solutions May 1998 Budget; a submission to the Australian Parliament, p 10.

¹¹ US Department of Health and Human Services 1989. Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General in Winstanley et al 1995. Tobacco in Australia; facts and issues 1995, Victorian Smoking and Health Program: Carlton South, p 150.

Taxation is a mechanism by which governments can affect the price of tobacco products. The Commonwealth Government raises revenue through excise payments on locally manufactured products and custom duty tariffs on imported products. The Commonwealth Government has increased the real excise level on tobacco products on a number of occasions. While tax increases have increased the price of a packet of cigarettes considerably, youth smoking rates and the slowing of the decline in prevalence of smoking among adults indicate that more needs to be done to reduce the affordability of tobacco products. In reducing the affordability of tobacco products it is recognised that there also exists potential for an undesired outcome for some groups in the community known to have high prevalence rates of smoking combined with low income levels who may still purchase tobacco products at the expense of food or other essential products required to sustain a healthy lifestyle.

The following future strategies are recommended:

Affordability

- maintain regular real increases in the price of cigarettes.
- research the impact of price increases for population groups known to have high prevalence rates of smoking and low income levels.

Accessibility

- review the feasibility and potential public health benefits of registration schemes for tobacco outlets;
- develop a national model identifying best practice in sales to minors programs;
- evaluate the effectiveness of sales to minors strategies in reducing illegal sale; and supply of tobacco to minors;
- prohibit self-service vending machines to prevent access by minors.

Key Strategy Area 3: Reducing availability and supply of tobacco

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Tobacco affordability</i>	Reduction in affordability of tobacco products.	Explore mechanisms to introduce regular increases in the rate of tobacco taxation above the Consumer Price Index.	Price of tobacco products set at a level to discourage smoking.	Commonwealth Government.
		Implement the Federal Government's announcement of change to the per stick system for levying tobacco excise.	Per stick system introduced.	Commonwealth Government.
		Consider removal of tobacco products from the list of goods used in the calculation of CPI.	Price of tobacco products set at a level to discourage smoking.	Commonwealth Government.
		Commission research to assess the impact of price increases on tobacco products and its relation to the health and wellbeing of identified low income groups (including Aboriginal and Torres Strait Islander people; people with a mental health illness and some ethnic communities).	Research studies complete and findings disseminated.	Commonwealth Government.
		Examine the impact of removal of tobacco products from duty-free or excise exemptions.	Reduction in availability of cut-price tobacco products.	Commonwealth Government.

Key Strategy Area 3: Reducing availability and supply of tobacco

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Access to tobacco products:</i> Self-service vending machines	Reduction in illegal sale and supply of tobacco to minors.	Prohibit self-service vending machines in all States and Territories to prevent access to minors.	Consistent approach to self-service vending machines across Australia. Removal of access by minors to self-service cigarette vending machines.	Commonwealth, State and Territory governments.
<i>Access to tobacco products:</i> Sales to minors	As above.	Develop, implement and evaluate a national model identifying best practice in sales to minors programs (including community and retailer education, legislative options, penalty systems, monitoring, using effective compliance checks, and enforcement).	An evaluated model of best practice in sales to minors community based programs, disseminated nationally.	Commonwealth, State and Territory governments; tobacco retail sector, community leaders; local government; parents.

Additional strategies to support prevention of uptake of smoking and management of cessation for minors who wish to quit smoking are identified under Key Strategy Area 1 (Strengthening Community Action), Key Strategy Area 2 (Promoting Cessation of Smoking and Key Strategy Area 4 (Reducing Tobacco Promotion).

Key Strategy Area 4: Reducing tobacco promotion

Objectives

- Reduction in the exposure of the public to messages and images that may persuade them to start smoking, continue to smoke, or to use, or continue to use, tobacco products.

Tobacco promotion encompasses a broad range of activities such as advertising, including point-of-sale and product placement in films, on television, in music and video clips, through sponsorship of events, marketing through product packaging and the distribution of non tobacco-related products associated with the sale of tobacco products.

Research has confirmed that young people are more sensitive to tobacco advertising and promotion than are adults¹² and suggests that children's exposure and receptivity to tobacco advertising and promotion is an important factor in determining future smoking behaviour.¹³ Promotion of tobacco products also undermines public health education programs run by government and non-government organisations.

A range of initiatives has been undertaken to restrict the promotion of tobacco products, with a gradual phasing-in of a complete ban on all forms of tobacco advertising in print, television, radio, and in cinemas, with the exception of point-of-sale advertising. Point-of-sale advertising is prohibited in two States and restrictions are imposed in several other jurisdictions. Tobacco value-added promotions and products and the use of give-aways such as key rings and caps with the sale of tobacco products have been restricted in most jurisdictions, but there continue to be examples of areas where these promotions are undertaken. There have been significant restrictions imposed on tobacco advertising allowed at international sporting events granted exemptions from the general ban on tobacco advertising in Australia. Despite those restrictions, tobacco advertising continues to occur in association with those events and through coverage of international events where tobacco advertising is permitted.

Where health promotion foundations have been established this has been done in part to counter the efforts of the tobacco industry to promote their products, particularly through sponsorship of sport and cultural events. These foundations provide funding to arts and sporting bodies to replace tobacco sponsorship, resources for health promotion and, in some jurisdictions, funding for research. Health promotion foundations have made a significant contribution to the introduction of smoke-free environments in sport, arts and racing organisations. Healthway (the West Australian health

¹² Pollay R, Siddarth S, Segal M, Haddix A, Merrit R, Giovino G & Erikson M 1996. 'The last straw? Cigarette advertising and realised market shares among youths and adults, 1979-1993' *AMA Journal of Marketing*, April 1996.

¹³ Evans N, Farkas A, Gilpin E Berry C & Pierce J 1995. 'Influence of tobacco marketing and exposure to smokers on adolescent susceptibility to smoking', *Journal of the National Cancer Institute*, vol 87, no 20, pp 1538-1545.

¹⁴ Clarkson J, Corti B, Pikora T, Jalleh G & Donovan RJ 1998. Organisational survey 1992-1997 healthy environment policies in sponsored organisations, Health Promotion Evaluation Unit, Department of Public Health and Graduate School of Management, The University of Western Australia: Perth.

¹⁵ World Health Organization 1994. Action plan on tobacco or health for 1995-1999, World Health Organization Regional Office for the Western Pacific, p 2.

promotion foundation) reports that more than 95% of sports, arts and racing organisations in 1997 were implementing smoke-free policies in the majority of their venues and some 60% had introduced such policies at the request of Healthway.¹⁴

In May 1986, the Thirty-ninth World Health Assembly adopted a resolution on tobacco or health which included deploring all promotion of tobacco.¹⁵ Although Australia is internationally renowned for efforts to control the promotion of tobacco products, there are still some avenues available in Australia for tobacco products to be promoted. Some ways of further reducing the promotion of tobacco are:

- to monitor and analyse the level and extent of tobacco promotion in films and on television, accidental and incidental tobacco advertising, point-of-sale advertising and the distribution of value-added products;
- to utilise the above information to make informed decisions on the restriction of provisions allowing these forms of promotion;
- to continue to impose stringent conditions on exempted events under the *Tobacco Prohibition Act 1992* with a phased-in removal of this exemption;
- to develop policies to monitor and enforce advertising restrictions;
- to examine tobacco advertising legislation, monitoring and enforcement policies in Australia and make recommendations on the minimum agreed level of tobacco advertising restrictions to be adopted nationally

Key Strategy Area 4: Reducing tobacco promotion

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Tobacco Advertising Legislation:</i> Tobacco advertising in film, television, music and video clips and print.	Reduction in the exposure of the public to messages and images that may persuade them to start smoking, to continue to smoke, or to use, or to continue to use tobacco products.	Commission research to identify the level of accidental and incidental tobacco advertising in film, television, music and print sources in Australia.	Accurate and realistic portrayal and presentation of the Australian smoking experience in Australian films, TV programs, music and video clips and print materials.	Commonwealth in consultation with State and Territory governments.
		Consult with the film, TV, music and publishing industries, to identify mechanisms already in place (and where relevant develop new mechanisms) that prevent and reduce the incidence of accidental and incidental (A & I) advertising, so that smoking is portrayed within the actual Australian experience.	Improved awareness by industry of the requirements of the Tobacco Advertising Prohibition Act (TAPA)1992; improved monitoring of existing A & I advertising legislation within the Commonwealth and State TAPAs; and, where appropriate, enforcement of breaches.	Commonwealth, State and Territory governments, in partnership with the film, TV and music industries and publishing companies.
		Explore the application of virtual advertising techniques for television broadcasts of international sporting and cultural events.	Virtual advertising replacements for A & I advertising occurring in international sporting and cultural broadcasts.	Commonwealth, State and Territory governments in partnership with TV industry.

Key Strategy Area 4: Reducing tobacco promotion

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Tobacco Advertising Legislation:</i> Point of sale advertising (POS)	Reduction in the exposure of the public to messages and images that may persuade them to start smoking, to continue to smoke, or to use or continue to use, tobacco products.	Commission research to identify the extent of POS advertising in Australia.	A map of POS advertising activity in Australia.	Commonwealth Government.
		Measure the impact of current legislative initiatives, enforcement and monitoring effort in jurisdictions on such advertising.	A national research report on the impact of legislative initiatives, enforcement and monitoring on POS advertising in Australia.	Commonwealth in consultation with State and Territory governments.
		Consider options to reduce or eliminate POS advertising for tobacco products in all jurisdictions.	Evidence-based national and cross-jurisdictional consideration given to prohibiting POS advertising for tobacco products in all jurisdictions.	Commonwealth, State and Territory governments.
		Decisions regarding POS advertising implemented.	Revised conditions for POS advertising applied.	Commonwealth, State and Territory governments.
<i>Tobacco advertising legislation:</i> Tobacco products as marketing tools	As above.	Restrict display of tobacco products as a marketing tool by prescribing the type and size of tobacco products and information displayed regarding product availability.	Reduced and restricted use of tobacco products as marketing tools.	State and Territory governments.
		Develop a national set of minimum requirements restricting display of tobacco products.	A national set of agreed minimum restrictions for display of tobacco products.	Commonwealth, State and Territory governments.

Key Strategy Area 4: Reducing tobacco promotion

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Tobacco advertising legislation:</i> Tobacco value-added products	Reduction in the exposure of the public to messages and images that may persuade them to start smoking, to continue to smoke, or to use or continue the use of tobacco products.	Undertake research into the extent of tobacco value-added products and promotions in Australia and the impact of legislative initiatives, enforcement and monitoring activity for such products and promotions.	National perspective of the extent of value-added products and promotion in Australia. Report on the impact of legislative initiatives, enforcement and monitoring activity on such products and promotions.	Coordinated by Commonwealth Government in consultation with State and Territory governments.
		Consider options for the elimination of tobacco value-added products and promotions in all jurisdictions.	Evidence-based national and cross-jurisdictional consideration given to prohibiting tobacco value-added products and promotions in all jurisdictions.	Commonwealth Government.
		Decisions regarding tobacco value-added products implemented.	Nationally consistent restrictions on promotion of value-added products.	Commonwealth, State and Territory governments.
<i>Tobacco advertising legislation:</i> Monitoring and enforcement	As above.	Where appropriate, jurisdictions review current policies and systems to monitor and enforce advertising restrictions, implement policies, systems and training of relevant personnel to improve monitoring and enforcement.	Improved monitoring and enforcement of legislation prohibiting tobacco advertising.	State and Territory governments.

Key Strategy Area 4: Reducing tobacco promotion

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Tobacco advertising legislation:</i> Tobacco advertising restrictions.	Reduction in the exposure of the public to messages and images that may persuade them to start smoking, to continue to smoke, to use or continue the use of tobacco products.	Conduct an audit of tobacco advertising legislation, monitoring and enforcement policies in Australia and identify the minimum agreed level of tobacco advertising restrictions to be adopted nationally.	An agreement, endorsed by all jurisdictions, to impose, monitor and enforce a level of restriction on advertising that represents the maximum acceptable level of tobacco advertising in Australia.	Commonwealth in partnership with State and Territory governments.
		Review of the Commonwealth Tobacco Advertising Prohibition Act 1992 (TAPA) and within this, consideration of the issues arising in enforcement of the Act in those jurisdictions without their own tobacco advertising legislation.	A completed review of the Commonwealth TAPA with a focus on strengthening enforcement provisions for jurisdictions without their own tobacco advertising legislation.	Commonwealth Government.
		Commonwealth Health Minister to continue to rigorously assess applications for exemption under Section 18 of the TAPA 1992.	Stringent conditions imposed if any events exempted 1999 to 2006.	Minister for Health.
<i>Tobacco advertising legislation:</i> Sponsorship of sporting and cultural events	As above.	Complete removal of the tobacco exemption for cultural and sporting events of international significance by the year 2006.	No exemptions after the year 2006.	Commonwealth Government. ⁴

Key Strategy Area 5: Regulating tobacco

Objectives

- Disclosure by the tobacco industry of the contents of tobacco products.
- Identification of appropriate interventions to regulate tobacco products.

Tobacco control efforts to date have used regulation as a tool for minimising the harm caused by tobacco consumption. The extent of regulation governing the industry is widely accepted given that these products are lethal (even when used as intended) and addictive. The use of tobacco products results in a loss of more than 18,000 lives in Australia each year, while also costing the community more than \$12.7 billion per annum.¹⁶

Restrictions introduced by Australian governments to control the activities of the tobacco industry include:

- legislation banning tobacco advertising;
- regulations requiring all tobacco products to have health warnings;
- minimum age restrictions for which children can be sold cigarettes; and
- legislation prohibiting the sale of individual cigarettes.

There have been a number of recent international developments regulating the tobacco industry. For example in Canada, the Province of British Columbia has recently passed legislation requiring companies to test and report on all ingredients and additives in their cigarettes, including the chemicals used to treat papers and filters. In addition, companies must report on 44 selected poisons found in tobacco smoke. At a federal level in Canada, there are proposals currently being considered to amend the *Tobacco Act*. These include expanding the reporting requirements to obtain data on more than 50 toxic constituents of tobacco and tobacco smoke, and the reporting of ingredients used in the manufacturing process.

Despite the fact that tobacco smoking is the single greatest cause of premature death and disease in Australia, publicly available information about the content of cigarettes is still limited. Recent litigation against the industry in the United States and moves to implement tighter legislative controls on the sale and promotion of tobacco have highlighted the need for stronger regulatory controls on the industry in Australia. In addition, the US tobacco industry has been forced by a series of recent court cases to disclose that it had known for decades of the harmful consequences of smoking their products but had failed to disclose this information to the public. Unlike the USA, there are no regulations in Australia that require the tobacco industry to report to government the nature and extent of its advertising, promotion and marketing activities.

Further steps which governments could consider as part of national collaborative effort on tobacco prior to exploring further regulatory activities include:

- requiring tobacco companies whose products are available for sale in Australia to provide a list of tobacco product ingredients;

¹⁶ Collins D & Lapsley H 1996. National Drug Strategy Monograph Series: The social costs of drug abuse in Australia in 1988 and 1992; No 30, Commonwealth Department of Human Services and Health: Canberra, p 33.

- investigating the effects of tobacco additives on the bio-availability of nicotine;
- exploring the relative merits, feasibility and viability of reducing nicotine dependency versus promoting less harmful nicotine delivery systems; and
- exploring strategies to reduce the addictiveness of tobacco products.

Key Strategy Area 5: Regulating tobacco

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Ingredients:</i> Tobacco constituents	Disclosure by the tobacco industry of the ingredients, including additives to tobacco products.	Publish tables (by brand) indicating ingredients, dosage of ingredients and health effects per stick smoked. Disseminate tables in easy-to-read format to inform the general public about their consumption of and exposure to tobacco products.	Public informed of the content of tobacco products purchased and/or consumed.	Commonwealth Government. Commonwealth, State and Territory governments and other relevant bodies
<i>Ingredients:</i> Cigarette yields	Identification of appropriate interventions to regulate tobacco products.	NHMRC review to advise the Commonwealth on cigarette yields (including methods of testing, standards).	NHMRC review complete.	NHMRC
		Advise the Commonwealth, State and Territory governments of the best measures of cigarette yields based on scientific evidence.	Research findings disseminated to government.	NHMRC in partnership with Commonwealth Government.
		Governments to consider the outcomes of the NHMRC review and develop appropriate strategies that inform consumers of the NHMRC research findings and that identify the 'actual' amount of tar, nicotine and carbon monoxide inhaled per cigarette.	Research findings and their implications disseminated through governments to the public. Consumers informed of the 'actual' amount of nicotine, tar and carbon monoxide they inhale per cigarette.	Commonwealth, State and Territory governments.

Key Strategy Area 5: Regulating tobacco

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Ingredients:</i> Tobacco additives	Identification of appropriate interventions to regulate tobacco products.	NHMRC investigate the effects of tobacco additives on the bio-availability of nicotine.	Health effects of tobacco product additives and effects of nicotine identified.	NHMRC
		Based on research findings, Commonwealth, State and Territory governments develop appropriate strategies to inform consumers of the health effects of tobacco product additives.	Health effects of tobacco products additives and effects on nicotine identified. Consumers aware of the health effects of tobacco additives.	Commonwealth, State and Territory governments.
<i>Ingredients:</i> Nicotine dependency	As above.	Commission and undertake a feasibility study to explore the relative merits and viability of reducing nicotine dependency in comparison with promoting less harmful nicotine delivery systems.	Report for jurisdictional consideration on options for regulating nicotine.	Commonwealth Government.

NB: See KSA 2: “Promoting Cessation of Tobacco Use” for further reference to alternative options to nicotine delivery.

Key Strategy Area 6: Reducing exposure to environmental tobacco smoke (ETS)

Objectives

- Establishment of smoke free environments (both private and public) as the norm.
- Increase in public awareness and understanding of the health risks of exposure to environmental tobacco smoke (ETS).
- Increase in accessible and appropriate strategies for groups nominated as high-risk in the Strategy to improve awareness and understanding of the health risks of exposure to environmental tobacco smoke.

Since the 1970s, evidence on the detrimental effects of exposure to ETS has continued to accumulate. Over 600 medical reports have been published linking exposure to ETS to lung cancer and other respiratory diseases.¹⁷ There have been a number of reviews of the evidence both internationally and in Australia. In Australia, the NHMRC reviewed scientific evidence concerning the possible health effects of exposure to ETS in 1997 concluded, conservatively, that exposure to ETS causes lung cancer in adults, causes lower respiratory illness in children, contributes to the symptoms of asthma in children and may also cause coronary heart disease in adults.¹⁸

In 1998, the Australian Health Ministers Advisory Council (AHMAC) agreed that passive smoking be included in the work program of the Legislation Reform Working Party and that a national response to the issue of passive smoking be prepared. This report is expected to be completed in October 1999. Australia has responded to the mounting evidence of dangers imposed by ETS over the last decade primarily by encouraging formal and informal industry self-regulation of smoking in enclosed public places and workplaces. More formal arrangements include the prohibition on smoking in all federally owned and operated buildings and on all forms of public transport. Legislation exists in some jurisdictions for smoke-free indoor areas in workplaces and other public places such as restaurants, cafes, shops and theatres. Most jurisdictions have also undertaken various forms of education, information and assistance programs, and campaigns with the aim of increasing non-smoking provision in restaurants, cafes and other enclosed public places. The threat of litigation has also been influential in the development of these public health initiatives.

Although progress has been made during the last decade in extending smoke-free facilities, available data informs us that nationally one in five workers have no restrictions on smoking in their place of work¹⁹ and effective non-smoking dining in cafes and restaurants is not currently the norm. It

¹⁷ NSW Health Department 1995. NSW Tobacco and Health Strategy 1995-1999, NSW Health Department, p 10.

¹⁸ National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services, p 3.

¹⁹ Makkai, T & McAllister 1998. Public Opinion towards drug polices in Australia 1985-1995, Commonwealth Department of Health and Family Services: Canberra, p 22.

²⁰ NSW Passive Smoking Taskforce to the NSW Minister for Health 1997. Passive smoking in the hospitality industry – options for control.

²¹ Western Australian Task Force on Passive Smoking 1997. Report of the Western Australian Task Force on Passive Smoking in Public Places.

appears likely that the systematic provision of smoke-free workplaces and enclosed public places will not be achieved by relying on education, information, common courtesy, voluntary codes and other forms of self-regulation. The New South Wales and Western Australian Task Forces on Passive Smoking both conclude that legislation would be the most effective strategy for significantly reducing exposure to environmental tobacco smoke in enclosed public places and workplaces.^{20,21}

Future activity in reducing exposure to environmental tobacco smoke include:

- exploring mechanisms to establish smoke free environments and develop and disseminate a national response to passive smoking identifying best practice and national guidelines.;
- examining the effectiveness of policy and legislative initiatives, enforcement and monitoring in Australia and internationally in reducing community and employee exposure to ETS;
- developing and implementing strategies to reduce and where possible eliminate exposure to ETS;
- identifying the current level of understanding and awareness of the health risks of ETS in groups nominated as high-risk in the Strategy. and social and cultural issues that influence exposure to ETS in private and public places;
- promulgating best practice in strategies to improve awareness of ETS exposure in the targeted population groups nominated in the Strategy;
- collating research into community attitudes to passive smoking in a range of settings (eg workplaces, restaurants, bars, hotels, shops, cars, home) to obtain benchmark levels of awareness and opinion.

Key Strategy Area 6: Reducing exposure to environmental tobacco smoke

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Smoke-free Environments:</i> Public places and workplaces	Establishment of smoke-free public places as the norm in Australia	Explore mechanisms to establish smoke-free environments; develop and disseminate a national response to passive smoking which identifies best practice and provides national guidelines.	Nationally consistent minimum policy approach to enforcement and monitoring re smoking in public places	Commonwealth, State and Territory governments, Industry, key community groups.
		Examine efficacy of policy, legislation, enforcement and monitoring systems both in Australia and internationally that aim to reduce community and employee exposure to ETS.	Best practice legislative provisions prepared as part of national response for consideration by all jurisdictions.	Commonwealth Government.
		Jurisdictions to implement strategies to reduce or eliminate exposure to ETS.	Jurisdictions measure progress on implementation of their ETS strategies.	State and Territory governments.
<i>Smoke free environments:</i> Public awareness	Increase in public awareness and understanding of the health risks of exposure to environmental tobacco smoke (ETS).	Develop a national ETS public education strategy complementing and strengthening State/Territory activity; and an education strategy to reduce exposure to ETS by children.	An informed public in relation to the health risks of exposure to ETS; and an increased proportion of the population supporting access to smoke-free public places and adopting smoke-free private places.	Commonwealth in consultation with State and Territory governments.
<i>Smoke free environments:</i> Targeted population groups	Increase in accessible and appropriate strategies for the targeted population groups nominated in the Strategy.	Consult targeted population groups; identify current level of awareness of the health risks associated with ETS and social and cultural issues that influence exposure to ETS.	Consultation outcomes inform future action related to exposure to ETS for high-risk groups.	Commonwealth, State and Territory governments, community groups.

Key Strategy Area 6: Reducing exposure to environmental tobacco smoke

Action issue	What will be achieved?	How will it be achieved?	Identified outputs	Who will do it?
<i>Smoke free environments:</i> Targeted population groups	Increase in accessible and appropriate strategies for targeted population groups nominated in the Strategy.	Promulgate best practice in strategies to improve awareness of ETS exposure in targeted population groups.	A report for jurisdictional consideration identifying a range of best practice strategies to improve awareness of ETS exposure in targeted population groups.	Commonwealth, State and Territory governments, Community Groups.
<i>Smoke free environments:</i> Research	Increase in public awareness and understanding of the health risks of exposure to ETS.	Collate research into community attitudes to passive smoking (in workplaces, recreational settings, restaurants, bars, hotels, shops, cars, home etc). Obtain benchmark level of awareness and opinion.	Maintenance of current data on community attitudes to ETS.	Commonwealth, State and Territory governments.
		Collect and collate data on exposure levels in various types of indoor places, lifetime exposures for adults and children; and on the economic impact of the adoption of non-smoking policies by business.	Maintenance of current data on exposure levels to ETS.	Commonwealth Government.

Appendix 1: Abbreviations and Glossary of Terms

Abbreviations

AHMAC	Australian Health Ministers Advisory Council
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANCD	Australian National Council on Drugs
COAG	Council of Australian Governments
DETYA	Department of Education, Training and Youth Affairs
IGCD	Intergovernmental Committee on Drugs
MCDS	Ministerial Council on Drug Strategy
MTAG	Ministerial Tobacco Advisory Group
NEACT	National Expert Advisory Committee on Tobacco
NHMRC	National Health and Medical Research Council
NPHP	National Public Health Partnership
OATSIH	Office for Aboriginal and Torres Strait Islander Health
RACGP	Royal Australian College of General Practitioners
WHO	World Health Organization

Glossary of Terms

Abstinence

Refraining from drug use.

Australian National Council on Drugs

One of the advisory bodies supporting the Ministerial Council on Drug Strategy, the Australian National Council on Drugs consists of people with relevant expertise from the government, non-government and community sectors. The Council ensures that the voice of non-government organisations and individuals working in the drug field reaches all levels of government and influences policy development. It has broad representation from volunteer and community organisations and law-enforcement, education, health and social welfare interests.

Best practice

On the evidence available, the best intervention to produce improved outcomes for an identified issue.

Campaign

Social marketing strategies designed for whole of population or targeted population groups. Strategies, underpinned by formative research, may include use of mass media, information dissemination, community development and community action.

Capacity

The ability to utilise and develop existing resources that would not or have not been identified or utilised for current (tobacco control) effort. Characteristics include formation of partnerships, transfer of knowledge between partners, community problem solving ability and infrastructure support.

Consumer Price Index

Six monthly Government measurement of average cost of a range of goods and services in Australia, used to calculate rate of inflation.

Culturally responsive strategies

Strategies that take into account the practices and beliefs of a particular population group, so that the relevant initiatives are acceptable, accessible, persuasive and meaningful.

Demand-reduction strategies

Demand-reduction strategies seek to reduce the desire for and preparedness to obtain and use drugs. These strategies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug-related harm.

Drug

A substance that produces a psychoactive effect. Within the context of the National Drug Strategic Framework, 'drug' is used generically to include tobacco, alcohol, pharmaceutical drugs and illicit drugs. The Framework also takes account of performance- and image-enhancing drugs and substances such as inhalants and kava.

Drug dependence

Drug dependence is characterised by a strong desire to take a drug. Among the indicators of dependence are impaired control over drug use, a higher priority given to drug use than to other activities and obligations, increased tolerance, physical withdrawal symptoms, and repeated drug use to suppress withdrawal.

Drug-related harm

Any adverse social, physical, psychological, legal or other consequence of drug use that is experienced by a person using drugs or by people living with or otherwise affected by the actions of a person using drugs.

Environmental tobacco smoke

A combination of exhaled mainstream tobacco smoke and sidestream smoke from the burning tip of a cigarette.

Evidence-based practice

Evidence-based practice involves integrating the best available evidence with professional expertise to make decisions.

Harm-reduction strategies

Harm-reduction strategies are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use: they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause.

Harm minimisation

Harm minimisation is the primary principle underpinning the National Drug Strategy and refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including abstinence-oriented strategies. Both licit and illicit drugs are the focus of Australia's harm-minimisation strategy. Harm minimisation includes preventing anticipated harm and reducing actual harm. Harm minimisation is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction.

Harmful drug use

A pattern of drug use that has adverse social, physical, psychological, legal or other consequences for a person using drugs or people living with or otherwise affected by the actions of a person using drugs. Hazardous drug use is any drug use that puts the person using drugs, or those living with or otherwise affected by the actions of a person using drugs, at risk of these harmful consequences. Hazardous drug use includes any use of illicit drugs. For tobacco, all use is considered harmful and there is no safe level of consumption.

Intergovernmental Committee on Drugs

One of the advisory bodies supporting the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs is a Commonwealth–State–Territory government forum. It consists of senior officers representing health and law-enforcement agencies in each Australian jurisdiction (appointed by their respective health and law-enforcement Ministers) and other people with expertise in identified priority areas (for example, representatives of the Australian Customs Service and the Department of Education, Training and Youth Affairs).

Licit drug

A drug whose production, sale or possession is not prohibited. 'Legal drug' is an alternative term.

Ministerial Council on Drug Strategy

The peak policy- and decision-making body in relation to licit and illicit drugs in Australia, the Ministerial Council on Drug Strategy brings together Commonwealth, State and Territory Ministers responsible for health and law enforcement to collectively determine national policies and programs to reduce drug-related harm. The Ministerial Council ensures that the Australian approach to harmful drug use is nationally coordinated and integrated. Its collaborative approach is designed to achieve national consistency in policy principles, program development and service delivery.

National Drug Action Plans

The National Drug Strategic Framework will be accompanied by a series of National Drug Action Plans, which will identify priorities for redressing the harm arising from the use of licit and illicit drugs and other substances, strategies for taking action on these priorities, and performance indicators.

National Drug Monitoring and Evaluation Strategy

A comprehensive National Drug Monitoring and Evaluation Strategy will be developed to determine whether the objectives of the National Drug Strategic Framework have been met and priority areas acted upon and whether specific strategies identified in National Drug Action Plans have been effective. An annual monitoring report will be forwarded to the Ministerial Council on Drug Strategy.

National Drug Strategy

The National Drug Strategy, formerly the National Campaign against Drug Abuse, was initiated in 1985, following a Special Premiers' Conference. The Strategy provides a comprehensive, integrated approach to the harmful use of licit and illicit drugs and other substances. The aim is to achieve a balance between harm-reduction, demand-reduction and supply-reduction measures to reduce the harmful effects of drugs in Australian society. The Strategy promotes partnerships between health, law-enforcement and education agencies, drug users, people affected by drug-related harm, community-based organisations and industry, to reduce drug-related harm in Australia.

National Drug Strategy Household Survey

The National Drug Strategy Household Survey series has been the principal data-collection vehicle used to monitor trends and evaluate progress under the National Drug Strategy. The Surveys have been conducted nationally in 1985, 1988, 1991, 1993, 1995 and 1998 and provide data on behaviour, knowledge and attitudes relating to drug use among people aged 14 years and over.

National Expert Advisory Committees

The national expert advisory committees provide a range of advice to the Ministerial Council on Drug Strategy. Committee members are selected on the basis of their expertise in the areas of health, law enforcement, community-based organisations, education, research, government and industry. Committees are established for tobacco, alcohol, illicit drugs and school-based drug education. Additional committees may be established as other priorities are identified. The committees have tasks clearly defined in the National Drug Action Plans.

National Public Health Partnership

The National Public Health Partnership provides a mechanism for the development, implementation and evaluation of national public health programs, promoting and facilitating evidence-based planning and practice. The Partnership Group aims to support national public health interventions and to strengthen public health capacity generally through the development of national frameworks for public health regulation, planning and practice, information and workforce development and through determining national directions for public health research and development. Formal links exist through the National Strategies Coordination Working Group and the meetings of the Chairs of National Public Health Strategies. These are attended by the Chairs of the Australian National Council on Drugs and the Intergovernmental Committee on Drugs.

Partnership approach

In the context of national public policy, a partnership approach for the National Drug Strategy is defined as a close working relationship between the Commonwealth, State and Territory, and local governments, affected communities (including drug users and those affected by drug-related harm), business and industry, community-based organisations, professional workers and research institutions.

Population group

'Population group' can refer to an entire population group, as defined by geographical location, or to sub-groups defined by geographical location, age, risk factor, or possession of a common condition or disease.

Prevention

Within the context of the National Drug Strategic Framework, prevention refers to preventing harmful drug use and preventing drug-related harm. Prevention includes preventing the uptake of illicit drugs.

Supply-reduction strategies

Supply-reduction strategies are designed to disrupt the production and supply of illicit drugs. They may also be used to impose limits on access to and the availability of licit drugs—an example is legislation regulating the sale of alcohol and tobacco to people under the age of 18 years.

Targeted Population Groups

A sub-group in the general population who, in relation to exposure to tobacco products in all forms, are defined by age, risk factors, geographical location or possession of a common condition or disease. Five specific population groups are identified as having population specific issues related to smoking or of exposure to tobacco smoke and with whom specific strategies may need to be developed. The five groups are Aboriginal and Torres Strait Islander people, children and young people under 18 years of age, pregnant women and their partners, people with a mental health illness and people from linguistically and culturally diverse backgrounds. Many of those within these target groups are also noted to be low income earners.

Tobacco control

Refers to a range of supply, demand and harm reduction strategies that aim to improve the health of Australians by eliminating or reducing their exposure to tobacco in all its forms.

Uptake

The commencement of drug use.

Young people and children

Young people refer to young people over 12 years of age and under 18 years of age. Children refer broadly to those under the age of 12 years of age.

Appendix 2: Baseline Data and Explanation of Data Sources

National Tobacco Strategy Short Term Indicators

Indicator

Percentage of the adult population who have never smoked

Male (%)	Female (%)	Total (%)
28.0	39.7	33.9

Source: 1998 National Drug Strategy Household Survey, base population 18+¹

Indicator

Percentage of young people who have never smoked

Sex	Age (years)					
	12	13	14	15	16	17
M	60	50	39	32	29	26
F	68	55	41	31	28	25
Total	64	52	40	31	29	25

Source: Based on data from: Hill, D, White, V, Letcher, T (1999) Tobacco use among Australian secondary students. *Australian and New Zealand Journal of Public Health*, 23, 250-257.²

Percentage of young people who have never smoked

Overall (12-17 years)		
Male (%)	Female (%)	Total (%)
39	41	40

Source: Based on data from: Hill, D, White, V, Letcher, T (1999) Tobacco use among Australian secondary students. *Australian and New Zealand Journal of Public Health*, 23, 250-257.²

Indicator

Percentage of the adult population, ages 18 and older, who smoke (both regularly and occasionally)

	Male (%)	Female (%)	Total (%)
Regular	26.1	20.9	23.4
Occasional	3.9	3.2	3.5

Source: 1998 National Drug Strategy Household Survey, base population 18+¹

Indicator

Percentage of 12-17 year olds who smoke

Chain/heavy smoker* (%)						
Age (years)						
Sex	12	13	14	15	16	17
M	2	2	6	7	8	9
F	1	2	6	6	8	10
Total	1	2	6	7	8	9
Light Smoker* (%)						
M	3	5	7	9	10	10
F	2	5	9	11	12	13
Total	3	5	8	10	11	12
Occasional* (%)						
M	7	9	10	11	12	12
F	6	11	15	18	16	15
Total	6	10	13	14	14	14

*Self-described smoking behaviours

Source: Based on data from: Hill, D, White, V, Letcher, T (1999) Tobacco use among Australian secondary students. *Australian and New Zealand Journal of Public Health*, 23, 250-257.²

Percentage of 12-17 year olds that smoke

Overall (12-17 years)			
	Male (%)	Female (%)	Total (%)
Chain/heavy smoker*	6	5	6
Light smoker*	7	9	
Occasional*	10	14	12

* Self-described smoking behaviours

Source: Based on data from: Hill, D, White, V, Letcher, T (1999) Tobacco use among Australian secondary students. *Australian and New Zealand Journal of Public Health*, 23, 250-257.²

Indicator

Percentage of Aboriginal and Torres Strait Islander people who smoke

Male (%)	Female (%)
53.6	45.8

Source: Australian Bureau of Statistics and Australian Institute of Health and Welfare (1997) *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. ABS Catalogue No. 4704.0. AIHW Catalogue No. IHW2. AGPS: Canberra.³

Indicator

Percentage of economically disadvantaged people who smoke

Occupation Level	Male (%)	Female (%)
Lower blue collar	40.9	31.8
Upper white collar	18.7	16.7

Source: Hill, DJ, White, VM & Scollo, MM (1998) Smoking behaviours of Australian adults in 1995: trends and concerns. *Medical Journal of Australia*, 168, 209-213.⁴

Indicator

Percentage of women who smoke throughout pregnancy

26.8%

Source: 1998 National Drug Strategy Household Survey¹

Indicator

Percentage of adults, young people and children (under 12 years) exposed to environmental tobacco smoke**

Adults (18+) (%)	Young people (12-17) (%)	Children (0-11) (%)
24.1	14.2	8.8

** exposed to smoke in the home

Source: 1998 National Drug Strategy Household Survey¹

Indicator

Average number of cigarettes smoked per day for both the adult smoker and the smoker 12-17 years of age

Adults (18+)
14.9

Source: 1998 National Drug Strategy Household Survey¹

Young People (12-17 years) (number of cigarettes smoked per day)						
Age (years)						
Sex	12	13	14	15	16	17
M	1.6	2.1	3.6	4.7	4.8	5.3
F	0.9	1.8	2.8	3.3	4.4	4.9
Total	1.3	1.9	3.2	3.9	4.6	5.1

Source: Based on data from: Hill, D, White, V, Letcher, T (1999) Tobacco use among Australian secondary students. *Australian and New Zealand Journal of Public Health*, 23, 250-257.²

Young People (12-17 years) (number of cigarettes smoked per day)		
Male	Female	Total
3.2	2.6	2.9

Source: Based on data from: Hill, D, White, V, Letcher, T (1999) Tobacco use among Australian secondary students. *Australian and New Zealand Journal of Public Health*, 23, 250-257.²

Data Sources

1. **Australian Institute of Health and Welfare (1999) 1998 National Drug Strategy Household Survey: First results.** AIHW cat. no. PHE 15. AIHW (Drug Statistics series): Canberra.

The 1998 National Drug Strategy Household Survey (sixth in the series) was conducted during June-September 1998. A representative national sample of 10,030 persons aged 14 years and over was obtained. The interviewing techniques included face to face household interviews and self-completion questionnaires. The data are population weighted.

2. **Hill, D, White, V & Letcher, T (1999) Tobacco use among Australian secondary students.** *Australian and New Zealand Journal of Public Health*, 23, 250-257.

The Centre for Behavioural Research in Cancer, the Anti-Cancer Council of Victoria, conducted a survey of year 7-12 students across the country in 1996. This survey is conducted every three years. Schools were randomly selected among government, Catholic and independent school systems, and 80 students within each school were randomly selected to complete the self-completion questionnaires. In 1996, 31,529 students in years 7-12 were surveyed. The sample consisted of 29,850 12-17 year olds.

3. **Australian Bureau of Statistics and Australian Institute of Health and Welfare (1997) The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples.** ABS Catalogue No. 4704.0. AIHW Catalogue No. IHW2. AGPS: Canberra

4. **Hill, DJ, White, VM & Scollo, MM (1998) Smoking behaviours of Australian adults in 1995: trends and concerns.** *Medical Journal of Australia*, 168, 209-213.

The Centre for Behavioural Research in Cancer, the Anti-Cancer Council of Victoria, conducted the 1995 National Adult Smoking Survey (eighth in a series). Face to face interviews were conducted on 2,819 men and 2,880 women over 16 years of age to estimate the prevalence of smoking in Australian men and women in 1995.

Background paper

A companion document to the
National Tobacco Strategy
1999 to 2002-03

Endorsed by the Ministerial Council on Drug Strategy (MCDS)

JUNE 1999

© Commonwealth of Australia 1999

ISBN 0642415714

This work is copyright. It may be reproduced in whole or part subject to the inclusion of an acknowledgment of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above, require the written permission of the Commonwealth available through AusInfo. Requests and inquiries should be addressed to the Manager, Legislative Services, AusInfo, GPO Box 1920, Canberra ACT 2601.

Publication approval number: 2597

For further information and other publications produced by the department, visit our website at www.health.gov.au, or call 1800 020 103.

Publications Production Unit (Public Affairs, Parliamentary and Access Branch)
Commonwealth Department of Health and Aged Care
Canberra

Contents

Part I. Background	1
1. Introduction	1
2. Smoking prevalence and exposure to environmental tobacco smoke in Australia	3
3. Government involvement in tobacco in the 1990s	4
4. Achievements to date	6
5. The need for a new strategy	7
Part II. National Tobacco Strategy	9
6. Development of a National Tobacco Strategy	9
7. Aims of a National Tobacco Strategy	10
8. Strategy Principles	11
9. Strategy Goal	11
10. Strategy Objectives	11
Part III. Key Strategies	13
11. Key Strategy Areas	13
12. Strengthening Community Action for Tobacco Control	13
13. Promoting cessation of tobacco use	14
14. Reducing the availability of tobacco	15
15. Reducing tobacco promotion	16
16. Regulating tobacco	17
17. Reducing exposure to environmental tobacco smoke	18
18. Summary	20
Appendix A	21
Appendix B	23
Appendix C	25
Appendix D	31

Part I. Background

1. Introduction

- 1.1 Tobacco smoking is the single largest preventable cause of premature death and disease in Australia. Many of the diseases associated with smoking are chronic and disabling, placing a large burden on the community. Active smoking alone caused 141,261 hospital separations during 1994-1995 and is estimated to have killed more than eighteen thousand Australians each year from 1990-1995.¹ Overall in Australia, cigarette smoking was the cause of 15.3% of all deaths and 3.4% of hospital episodes in 1992.² In addition, it has been estimated that in 1992 smoking caused 88,266 person years of life to be lost before the age of 70 years, at an average of 4.7 years lost per death.³
- 1.2 Globally, tobacco is responsible for the deaths of approximately 3.5 million people each year, or one death every nine seconds.⁴ The number of deaths from tobacco are increasing and, unless current trends are reversed, tobacco will kill 10 million people a year by the decade 2020-2030, with 70% of these deaths occurring in developing countries.⁵ Tobacco use is a major threat to health globally; however, it also places a significant burden on families and societies and is a major threat to social and economic development and to environmental sustainability.⁶
- 1.3 The World Health Assembly, the governing body of the World Health Organization (WHO), has adopted since 1970 a number of resolutions concerning tobacco and its health effects. Noteworthy among these resolutions is the call to WHO's member states to implement comprehensive tobacco control strategies.
- 1.4 Australia has been active since the 1970s in promoting and working towards the implementation of comprehensive tobacco control strategies. The Ministerial Council on Drug Strategy (MCDS) is the peak policy and decision making body for licit and illicit drug issues in Australia. MCDS brings together Commonwealth, State and Territory health and law enforcement Ministers to collectively determine national policies and programs to reduce drug-related harm. In 1991, MCDS endorsed a National Health Policy on Tobacco in Australia. Since 1991, other strategic documents such as Better Health Outcomes for Australia, National Health Priority Areas (NHPA) Report: Cancer Control 1997 and the National Drug Strategy have provided excellent overviews of future work in tobacco control, articulating goals and

¹Williams P 1997. Progress of the National Drug Strategy: key national indicators, Commonwealth Department of Health and Family Services: Canberra, pp 22-23.

²English DR, Holman CJD, Milne E, Winter MG, Hulse GK, Codde JP, Bower CI, Corti D, de Klerk N, Knuiman MW, Kurinczuk JJ, Lewin GF & Ryan GA 1995. The quantification of drug caused morbidity and mortality in Australia 1995 Edition, Commonwealth Department of Human Services and Health: Canberra, p 486.

³Ibid p v.

⁴World Health Organization 1998. Guidelines for controlling and monitoring the tobacco epidemic, WHO: Geneva, pp viii.

⁵Ibid p viii.

⁶Ibid p 2.

targets and mechanisms by which these can be achieved. These broad-based documents, however, have not clearly articulated the priorities or the capacities and responsibilities of different jurisdictions and non-government organisations to ensure that targets for tobacco control are achieved. Consequently, in order for Australia to maintain a comprehensive approach to tobacco control into the 21st century, and to ensure a firm commitment to meet Australia's goals and targets for tobacco control, the development and implementation of a National Tobacco Strategy is a necessity and a priority.

- 1.5 The need for action is based on the continuing concern for the welfare of three groups highlighted in the 1991 National Health Policy on Tobacco in Australia:
 - smokers, whose health will be affected by smoking;
 - non-smokers, particularly children, who may take up smoking; and
 - passive smokers, who are likely to be affected by the smoking habits of others.⁷
- 1.6 The deleterious health effects of tobacco, first published in the 1940s-50s, have been well documented in over 57,000 published scientific studies to date. Among the 4,000 chemicals contained in cigarette smoke including carbon monoxide, nicotine, formaldehyde and ammonia are forty three chemicals known to be human carcinogens (cancer causing substances).⁸ English et al (1995) conducted an extensive review of studies examining the health effects of smoking, identifying a causal relationship between active smoking of cigarettes and 32 medical conditions. These conditions include several types of cancer, atherosclerosis, ischaemic heart disease, heart failure, stroke, pneumonia, chronic obstructive pulmonary disease, peptic ulcer, Crohn's disease, spontaneous abortion, low birth weight and sudden infant death syndrome.⁹
- 1.7 English et al (1995) estimated the percentage of cases attributable to smoking for these conditions. They concluded that 84% of male and 77 % of female cases of lung cancer were attributable to active smoking, and among those under 65 years, 44% of strokes in males and 39% of strokes in females were attributable to smoking. In addition, they estimated that the risk of suffering from ischaemic heart disease among smokers under 65 years was three times that of never-smokers and the risk of suffering from atherosclerotic peripheral vascular disease was 2.5 times that of never-smokers.¹⁰
- 1.8 Maternal smoking during pregnancy has a detrimental effect on the developing child. Smoking during pregnancy increases the risk of sudden infant death syndrome¹¹ low birthweight and perinatal mortality.¹² Babies born to mothers who smoke are on average 200 grams lighter.¹³

⁷Commonwealth Department of Human Services and Health 1991. National Health Policy on Tobacco in Australia, Commonwealth Department of Human Services and Health: Canberra, p 1.

⁸US Department of Health and Human Services 1989. Reducing the health consequences of smoking; 25 years of progress. A report of the Surgeon General in Winstanley M, Woodward S & Walker N 1995. Tobacco in Australia; facts and issues 1995, Victorian Smoking and Health Program: Carlton South, p 87.

⁹English DR et al 1995. The quantification of drug caused morbidity and mortality in Australia 1995 Edition, Commonwealth Department of Human Services and Health: Canberra, pp 263-475.

¹⁰Ibid.

¹¹ UK Department of Health 1998. Report of the Scientific Committee on Tobacco and Health, UK Department of Health.

¹²US Department of Health and Human Services 1989. Reducing the health consequences of smoking; 25 years of progress. A report of the Surgeon General-US Department of Health and Human Services, Public Health Service, Centres for Disease Control, Centre for Chronic Disease Prevention and Health Promotion, office on Smoking and Health.

¹³National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services: Canberra, p 25.

Research also indicates that asthmatics have a greater than normal susceptibility to cigarette smoke constricting their airway, when the smoke is actively inhaled.¹⁴

- 1.9 As more information has come to light about the serious health consequences of active smoking and about the toxic nature of environmental tobacco smoke (ETS), increased attention has been paid to the association between ETS exposure and a range of detrimental health effects. These effects include those arising from both short-term and long-term exposures. The National Health and Medical Research Council (NHMRC) reviewed Australian and international scientific evidence concerning the possible health effects of exposure to ETS in 1986 and in 1997. The 1997 review conservatively concluded that exposure to ETS causes lung cancer in adults and lower respiratory illness in children, contributes to the symptoms of asthma in children and may also cause coronary heart disease in adults.¹⁵
- 1.10 The deleterious health effects of tobacco are placing an increasing burden on the Australian health care system. The estimated net health care cost of tobacco use in Australia in 1992 was \$832 million, a 72% increase on 1988 figures.¹⁶ The total tangible and intangible costs of tobacco use, including health care costs, were estimated to be \$12,736 million in 1992.¹⁷ These figures do not include costs associated with exposure to environmental tobacco smoke, welfare, absenteeism or the pain and suffering of the sick and others.

2. Smoking prevalence and exposure to environmental tobacco smoke in Australia

- 2.1 In 1995, 22.7% of all Australians aged 14 years or over (24.3% of males and 21% of females) were smoking on a regular basis (at least daily).¹⁸ The prevalence of smoking is significantly higher among adults from socio-economically disadvantaged groups, Indigenous Australians and some ethnic communities (see paragraph 5.2 p 9).
- 2.2 Eight national studies on the prevalence of smoking in adults have been conducted since 1974. They report that the previous uniform decline in smoking prevalence is not evident in the 1995 survey and that the decline in the prevalence of smoking may have stabilised.¹⁹
- 2.3 National surveys of secondary school children have been conducted in 1984, 1987, 1990, 1993 and most recently in 1996 to determine the prevalence of smoking among 12-17 year olds. A preliminary report of the 1996 survey findings expresses concern that smoking prevalence has stabilised at around 16% for 12-15 year olds and 30% for 16-17 year olds, while the lowest prevalence for smoking in both these age groups was reached in 1990.²⁰

¹⁴ US Department of Health and Human Services 1984. The health consequences of smoking; Chronic obstructive lung disease. A report of the Surgeon General, US Department of Health and Human Services, Public Health Service, Office on Smoking and Health: Rockville, Maryland, DHHS, p 428.¹⁵ National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services: Canberra, p 3.

¹⁷Ibid p 36.

¹⁸ Unpublished figures from the 1995 National Drug Strategy Household Survey, Commonwealth Department of Health and Family Services.

¹⁹Hill DJ, White VM, Scollo MM 1998. Smoking behaviours of Australian adults in 1995: trends and concerns, *Medical Journal of Australia*, vol 168, pp 209-213.

²⁰Hill D, White V, & Letcher T 1997. Tobacco use among Australian secondary students in 1996, Centre for Behavioural Research in Cancer, Anti-Cancer Council of Victoria, p 20. (submitted for publication)

2.4 The level of exposure to ETS has been estimated among children with parents who smoke and among people with spouses who smoke. In Australia in 1995, approximately 1.7 million children aged 0-17 years were potentially exposed to tobacco smoke in the home. The likelihood of exposure decreased with increasing age, with children under five years of age most likely to be exposed.²¹ Research conducted in Victoria has also found that a majority of smokers with children smoke inside the home.²² Despite an overwhelming majority of people who believe that non-smokers can be harmed by breathing other people's smoke, many people continue to experience tobacco smoke exposure in a range of settings.²³

3. Government involvement in tobacco in the 1990s

3.1 One of the most important duties of any government is to protect and improve the general health and well-being of its citizens.²⁴ Tobacco control is clearly identified as a health concern by the Australian government. This concern was clearly articulated and formalised in 1991 when MCDS endorsed a National Health Policy on Tobacco in Australia. In 1994 the National Report Better Health Outcomes for Australians set goals and targets aimed at reducing the prevalence of smoking and exposure to tobacco smoke. The report calls on Commonwealth and State/Territory Governments to continue to implement the strategies which flowed from the National Health Policy on Tobacco in Australia.²⁵

3.2 The National Drug Strategic Plan 1993-1997 proposed goals, objectives, key national indicators and program priorities for focusing national attention and action to reduce the harmful effects of tobacco use within the broader context of reducing the harmful effects of all drug use in Australian society.²⁶ The National Drug Strategic Framework 1998-99 to 2002-03 provides a framework for cooperation and a basis for coordinated action to reduce the harm caused by drugs, including tobacco in Australia. While there is no safe level of tobacco consumption, harm reduction options for those who continue to smoke are receiving more attention.

3.3 In 1994, a Senate Community Affairs Reference Committee inquired into the tobacco industry and the cost of tobacco-related illness. A report entitled 'The Tobacco Industry and the Costs of Tobacco-Related Illness', commonly known as the Herron Report, was presented to Parliament in December 1995.²⁷ The report included a list of 39 recommendations with a view to minimising the deleterious effects of tobacco through a range of Commonwealth, State and Territory Government initiatives. The report furnishes the Government with a list

²¹ Department of Health & Family Services 1997. Progress of the National Drug Strategy: key national indicators; evaluation of the National Drug Strategy 1993-1997 Statistical supplement: Canberra.

²² Ibid chapter 2.

²³ Mullins R & Morand M, 1996. 'Environmental tobacco smoke: public opinion and behaviour' *QUIT Evaluation Studies*, No 8, Centre for Behavioural Research in Cancer, Victorian Smoking and Health Program, pp 27-50.

²⁴ Commonwealth Department of Health and Family Services 1997. Government response to the report of the Senate Community Affairs Reference Committee; The tobacco industry and the costs of tobacco related illness: Canberra, p 11.

²⁵ Commonwealth Department of Human Service and Health 1994. Better health outcomes for Australians; national goals, targets and strategies for better health outcomes into the next century, Commonwealth Department of Human Services and Health: Canberra, p 136.²⁶ National Drug Strategy Committee 1993. National Drug Strategic Plan, 1993-1997, Australian Government Publishing Service: Canberra.

²⁷ Senate Community Affairs References Committee 1995. The tobacco industry and the costs of tobacco-related illness, Senate Printing Unit, Parliament House: Canberra.

of potential mechanisms for recouping and reducing the significant costs of tobacco-related illness and raises for discussion many possible avenues for further regulation of the tobacco industry to reduce the consumption of tobacco products for health reasons. The Commonwealth Government response to the Report of the Senate Community Affairs Reference Committee was tabled in the Senate in September 1997.²⁸ The Government response commits the Commonwealth Government to a range of activities designed to reduce the harmful consequences of smoking.

- 3.4 The Government of Australia holds its international obligations in respect to tobacco control most seriously and has actively worked towards implementing the resolutions of the World Health Assembly concerning tobacco and its health effects. As a member of the Western Pacific Region of the WHO, Australia has been progressing implementation of the relevant components of the WHO Regional Office for the Western Pacific Region Action Plan on Tobacco or Health 1995-1999. The 1995-1999 Action Plan calls on all governments to: develop, implement and strengthen comprehensive national policies and programs on tobacco control; collect data on tobacco use; support health advocacy, education and information; support implementation of appropriate legislation; and to achieve pricing policies that deter tobacco use.²⁹ A summary of the 1995-1999 WHO Action Plan on Tobacco or Health is at Appendix A.
- 3.5 In July 1998 the Director-General of the WHO, Dr Gro Harlem Brundtland, established a Cabinet project, the Tobacco Free Initiative³⁰ to coordinate an improved global strategic response to tobacco as an important public health issue. The long-term mission of global tobacco control, which is expected to take several decades to achieve, is to reduce smoking prevalence and tobacco consumption in all countries and among all groups, thereby reducing the burden of disease caused by tobacco. In support of this mission, the goals of the Tobacco Free Initiative are to:
- galvanise global support for evidence-based tobacco policies and action;
 - build new, and strengthen existing partnerships for action;
 - heighten awareness of the need to address tobacco at all levels of society;
 - accelerate national, regional and global strategy implementation;
 - commission policy research to support rapid, sustained and motivated actions;
 - mobilise resources to support required actions.

Australia fully supports the long-term goals of the WHO Tobacco Free Initiative and expects the National Tobacco Strategy will complement directions taken by the WHO.

- 3.6 Recent government initiatives such as the National Public Health Partnership initiative address the issue of tobacco and provide scope for further activity addressing tobacco issues (see paragraph 7.5 p 12). The National Health Priority Area (NHPA) initiative is an important collaborative mechanism involving Commonwealth, State and Territory Governments, the National Health and Medical Research Council (NHMRC), the Australian Institute of Health and Welfare (AIHW), non-government organisations, appropriate experts, clinicians and consumers. This initiative targets and reports on five priority groups of diseases or conditions (cancer control, cardiovascular health, mental health, diabetes mellitus and injury prevention and control) across the continuum of care (from prevention through to treatment, management,

²⁸ Commonwealth Department of Health and Family Services 1997. Government response to the report of the Senate Community Affairs Reference Committee; The tobacco industry and the costs of tobacco related illness: Canberra, p 11.

²⁹ World Health Organization 1994. Action plan on tobacco or health for 1995-1999, World Health Organization Regional Office for the Western Pacific.

maintenance and research). This provides an integrated approach to tackling health determinants and major risk factors, such as smoking, which are common across several priority areas.

4. Achievements to date

- 4.1 A range of strategies have been implemented by Commonwealth and State/Territory Governments as well as non-government organisations over the years to achieve a substantial reduction in the use of tobacco.
- 4.2 The precise impact of any one of these strategies has been difficult to assess, as many have been implemented simultaneously with other measures. Nonetheless, an undeniable reduction in smoking prevalence has accompanied these measures.³¹ For example, from 1945 to 1992 prevalence of smoking among Australian males fell from 72% to 28%.³² Notwithstanding the addictive properties of nicotine, which is the highly addictive chemical in tobacco,³³ withdrawal from smoking is possible, with and without professional or pharmacological assistance. Between 1974 and 1992 the proportion of ex-smokers in Australia increased steadily.³⁴ By 1995 for those at the age of 45, among people who have ever smoked, more had quit than remained smokers.³⁵
- 4.3 There have also been notable increases in the number of never-smokers among those under the age of 18 years. In Victoria from 1984 to 1996 the number of never-smokers rose from 31% to 42% among 12-15 year olds and 17% to 23% among 16-17 year olds.³⁶
- 4.4 A range of health promotion strategies has been, and continues to be, pursued by all jurisdictions to educate people about the dangers of smoking and the benefits of cessation, to discourage people from taking up smoking, to encourage those people who already smoke to stop and to reduce peoples' exposure to ETS. These strategies include education campaigns; taxation; labelling tobacco products with health warnings; banning most forms of tobacco advertising, promotion and sponsorship; and legislated smoke-free indoor areas.
- 4.5 Considerable work has been undertaken to restrict the promotion of tobacco products, with a gradual phasing-in of an almost complete ban on all forms of tobacco advertising in print, television, radio, and in cinemas³⁷ with the exception of point-of-sale advertising. However,

³⁰ WHO. 1998. Tobacco Free Initiative: Rationale, Update and Progress. WHO. Geneva.

³¹ National Health and Medical Research Council 1995. Health Australia, promoting health in Australia, Discussion paper, p 17.

³² Winstanley M, Woodward S & Walker N 1995. Tobacco in Australia; facts and issues 1995, Victorian Smoking and Health Program: Carlton South, p 11.

³³ US Department of Health and Human Services, Surgeon General 1988. The health consequences of smoking: Nicotine Addiction, Washington D.C. Government Printing Office.

³⁴ Winstanley M, Woodward S & Walker N 1995. Tobacco in Australia; facts and issues 1995, Victorian Smoking and Health Program, Carlton South. p 12.

³⁵ Hill D et al 1998. Smoking behaviours of Australian adults in 1995: trends and concerns, *Medical Journal of Australia*, vol 168, pp 209-213.

³⁶ Hill D et al 1997. Preliminary report; Prevalence of cigarette smoking among Victorian secondary school students in 1996, Centre for Behavioural Research in Cancer, Anti-cancer Council of Victoria, pp 18-20.

³⁷ Commonwealth Department of Human Services and Health 1994. Better health outcomes for Australians; national goals, targets and strategies for better health outcomes into the next century, Commonwealth Department of Human Services and Health: Canberra, p 135.

point-of-sale advertising is prohibited in two States and restrictions on point-of-sale advertising are imposed in most other jurisdictions. Health promotion foundations are in place in one Territory and two States. They provide funding to arts and sporting bodies to replace tobacco sponsorship, resources for health promotion and in some jurisdictions funding for research.

- 4.6 A nationally agreed system of strengthened health warnings on tobacco products has been introduced, resulting in the implementation by the Commonwealth Government in 1994 of some of the strongest and most prominent health warnings in the world.
- 4.7 As part of the strategy to inform all Australians about the health effects of smoking, mass media cessation campaigns have been conducted in a number of jurisdictions. The National Tobacco Campaign launched in June 1997 is the first truly national collaborative anti-smoking campaign. Early indications suggest that the first phase of the campaign has been successful in terms of recognition and recall of salient campaign messages and an increase in smokers' intentions to quit, actual quit attempts and an increase in one-year quit rates.³⁸ The focus of the campaign currently under way is a series of hard-hitting television commercials and public relations activities with the message, 'Every cigarette is doing you damage'. The campaign is supported by a range of cessation services.
- 4.8 To specifically target smoking among youth the minimum purchase age for cigarettes has been increased to 18 years of age in all jurisdictions with retailers found guilty of selling to minors subject to prosecution and financial penalties. There are also restrictions on the location of vending machines in most jurisdictions. In addition, some States have introduced school-based tobacco education programs.
- 4.9 Over the past few years, various regulations have been introduced to tackle the issue of exposure to ETS. Smoking is now prohibited in all federally owned and operated buildings and on all forms of public transport. Legislation exists in some jurisdictions for smoke-free indoor areas in workplaces and other public places such as restaurants, cafes, shops and theatres.
- 4.10 Appendixes B and C summarise tobacco control achievements in more detail.

5. The need for a new strategy

- 5.1 As acknowledged in the National Health Policy on Tobacco in Australia which was adopted by the Ministerial Council on Drug Strategy in March 1991, as a community we are not doing enough to reduce or control an epidemic that on the basis of present trends, will have killed a total of one million Australians by the year 2000.³⁹
- 5.2 Despite a fall in the prevalence of smoking, thousands of unnecessary premature deaths caused by smoking continue to occur. Although the prevalence of smoking among the general population is declining, prevalence remains high among certain population groups. The prevalence of regular smoking (at least daily) among Aboriginal and Torres Strait Islander people in 1994 was 47%, almost twice the 1995 prevalence of regular smoking among the

³⁸ Centre for Behavioural Research in Cancer 1998. Evaluation of the 1997 National Tobacco Campaign; Draft benchmark and follow-up survey results – September 1998, Prepared by the Centre for Behavioural Research in Cancer.

³⁹ Commonwealth Department of Human Services and Health 1991, National Health Policy on Tobacco in Australia, Commonwealth Department of Human Services and Health: Canberra. p 3.

total community (23%).⁴⁰ In 1995, in persons 20 years or over, 42% of male blue collar workers and 40% of female blue collar workers were smoking on a regular or occasional basis compared with only 25.7% of males and 22.2% of females among upper white collar workers.⁴¹ Additionally, in 1995, 46% of adults who were divorced and/or separated were current smokers and 39% of single adults (never married) were current smokers.⁴² Research has also found that the rates of smoking among some ethnic communities, such as among Vietnamese and Greek males, is significantly higher than in the general population.^{43,44}

- 5.3 Recent research also indicates that the prevalence of smoking among 12-17 year olds in Australia has stabilised with the lowest prevalence of smoking in these age groups reached in 1990.⁴⁵ Continued smoking is resulting in increasing levels of lung cancer among Australian women, with a 50% increase in lung cancer mortality from 1960-1989.⁴⁶
- 5.4 Because there is no safe level of tobacco consumption,⁴⁷ reducing the prevalence of smoking will remain a high priority on Australia's public health agenda.

⁴⁰Williams P 1997. Progress of the National Drug Strategy: key national indicators, Commonwealth Department of Health and Family Services: Canberra, p 15.

⁴¹Ibid p 9.

⁴²Makkai T & McAllister 1998. Patterns of drug use in Australia 1985-1995, Commonwealth Department of Health & Family Services: Canberra.

⁴³Rissel C & Russel C 1993. 'Heart disease risk factors in the Vietnamese community of South Western Sydney', *Australian Journal of Public Health*, vol 17, no 1, pp 71-73.

⁴⁴Wilson A, Bekaris J, Gleeson S, Papasavva C, Wise M & Pawe P 1993. 'The Good Heart, Good Life Survey: self-reported cardiovascular disease risk factors, health knowledge and attitudes among Greek-Australians in Sydney', *Australian Journal of Public Health*, vol 17, no 3, pp 215-221.

⁴⁵Hill et al 1997. Tobacco use among Australian secondary students in 1996, Centre for Behavioural Research in Cancer, Anti-Cancer Council of Victoria, p 20. (submitted for publication)

⁴⁶Giles G, Hill DJ & Silver B 1991. 'The lung cancer epidemic in Australia, 1910-1989', *Australian Journal of Public Health*, vol 15, pp 245-247.

⁴⁷The Experts' Statement 1997. Unpublished paper prepared for the Ministerial Tobacco Advisory Group.

Part II. National Tobacco Strategy

6 Development of a National Tobacco Strategy

- 6.1 In September 1994 the Ministerial Council on Drug Strategy (MCDS), the peak Ministerial drug policy and decision making body comprising Commonwealth, State and Territory health and law enforcement Ministers, endorsed the development of a National Tobacco Strategy. In June the following year the MCDS agreed that the development of the National Tobacco Strategy should be incorporated into the Health Australia review of health promotion in Australia and be developed on behalf of the Commonwealth by the then Tobacco Working Group (TWG) tasked with examining and advising on the operation of the Tobacco Harm Minimisation component of Health Australia.
- 6.2 In July 1996, the Minister for Health and Family Services established the Ministerial Tobacco Advisory Group (MTAG). The Group was established to provide expert advice to the Minister on tobacco issues, and was specifically tasked, among other things, with advising the Minister on a national strategy for tobacco control. MTAG's work on a national tobacco strategy commenced in 1998 following its delivery on behalf of the Commonwealth of the successful National Tobacco Campaign, another of the specific tasks set for it by the Minister.
- 6.3 Ongoing work on a national tobacco strategy will be progressed by the Intergovernmental Committee on Drugs (IGCD) using the expertise of the newly formed National Expert Advisory Committee on Tobacco (NEACT). This committee replaces the MTAG. The IGCD comprises senior officers appointed by health and law enforcement Ministers to represent health and law enforcement in each Australian jurisdiction. The NEACT forms one of the National Expert Advisory Committees established to provide high level expert advice to MCDS, the Australian National Council on Drugs (ANCD) and the IGCD on priorities and strategies to address specific drug-related harm, including priorities and strategies for supply reduction, demand reduction and harm reduction. The NEACT will report directly to the IGCD. The ANCD, comprising people with relevant expertise from the government, non-government and the community sectors, provides the Ministers of the MCDS with independent, expert advice on licit and illicit drug issues. The ANCD aims to facilitate an enhanced partnership between governments and the non-government and community sectors in development and implementation of policies and programs to address all drug-related harm. (See diagram of advisory structures at Appendix D.)
- 6.4 The formation of the National Expert Advisory Committees as part of the advisory structures supporting the National Drug Strategic Framework arose from the recommendations of the evaluation of the 1993-1997 phase of the National Drug Strategy. The establishment of the Committees was agreed to by the MCDS in May 1998.
- 6.5 The IGCD has been endorsed by MCDS to prioritise and coordinate activity across the National Expert Advisory Committees to ensure that policies, strategies and directions are consistent with the National Drug Strategic Framework.
- 6.6 In order to complement the period of the National Drug Strategic Framework 1998-99 to 2002-03, a National Tobacco Strategy will span the period 1999 to 2002-03.

7. Aims of a National Tobacco Strategy

- 7.1 The National Tobacco Strategy: reaffirms the goal of the 1991 National Health Policy on Tobacco in Australia, ‘to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms’⁴⁸ and to reflect the considerable work already done by Government and non-government organisations; and provide a framework for future action. Tobacco control frameworks contained in existing international, national, and State and Territory plans as well as more recent research findings and the recommendations of the Herron Report have been integrated to ensure that strategic directions in tobacco control are consistently evolving based on the latest evidence.
- 7.2 The National Tobacco Strategy provides a national framework, reflecting the recommended strategies, priorities, target groups, expected outcomes, time frames and responsibilities of jurisdictions and organisations, ensuring the best utilisation of resources to achieve national goals for tobacco control. It is one component of, and complementary to, the work of the National Drug Strategic Framework.
- 7.3 The implementation of a National Tobacco Strategy is the collaborative effort of all jurisdictions. Such collaboration aims for a high degree of national consistency in approaches to policy and program development while allowing flexibility for individual jurisdictions to pursue jurisdiction-specific priorities.
- 7.4 The recent National Tobacco Campaign has been a hallmark for collaboration between the Commonwealth, State and Territory Governments and non-government sector on tobacco control. It is envisaged that the implementation of a National Tobacco Strategy will strengthen and expand the partnerships developed through the National Tobacco Campaign.
- 7.5 It is recognised that a great deal of activity in tobacco control occurs outside the National Drug Strategic Framework and that there are a number of other national public health strategies which will influence the control of tobacco in Australia. These include, for example, the National School Drug Education Strategy, the National Cancer Control Initiative, the National Mental Health Strategy, the National Environmental Health Strategy, the National Asthma Strategy, the National Diabetes Strategy and the Primary Prevention Strategy. The National Tobacco Strategy establishes links between other national strategies, ensuring tobacco control issues are being addressed in an integrated and consistent manner. Also instrumental is the National Public Health Partnership, established by the Australian Health Ministers’ Conference in October 1996 as a new arrangement between the Commonwealth, State and Territory Governments to enable closer collaboration and coordination across a range of public health functions and infrastructure areas.
- 7.6 Furthermore, it is recognised that in order to achieve substantial gains in tobacco control, a whole-of-government approach to tobacco issues is necessary. Policies and activities of other government sectors such as customs, treasury, education, industrial relations, environment, small business, industry, and in particular, local government, all influence tobacco control efforts.
- 7.7 The National Tobacco Strategy for Australia provides a detailed, high quality evidence-based strategy for tobacco control in Australia over the period 1999 to 2002-03 and establishes a

⁴⁸ National Campaign Against Drug Abuse 1991. National Health Policy on Tobacco in Australia; and examples of strategies for implementation, Canberra, p 5.

system to review and account for progress in tobacco control in Australia. It also improves the effectiveness and efficiency of tobacco control in Australia and continues to expand upon the collaborative partnerships achieved by the National Tobacco Campaign.

7.8 Three companion documents have been produced as final products in the development of a the National Tobacco Strategy:

- (a) this background paper, detailing the context/rationale for a strategy;
- (b) the National Tobacco Strategy; and
- (c) a summary document outlining the key components of the Strategy document.

8. Strategy Principles

8.1 Building on the 1991 National Health Policy on Tobacco, the following principles helped guide the development of a National Tobacco Strategy:

- ‘tobacco use is so injurious to the health of both smokers and non-smokers as to warrant the imposition of appropriate restrictive legislation;
- tobacco use has adverse health effects even with infrequent use and there is no completely safe level or form of tobacco use;
- tobacco use is such a widely accepted practice amongst adults that to ban it completely would be impractical;
- the extent of the health effects of smoking requires strong action to deter people from taking up smoking and to encourage existing smokers to give up smoking’;⁴⁹
- smoking and non-smoking behaviour is shaped by psychological, social, cultural, economic and political factors;
- given the complexity of factors involved in tobacco use, tobacco control efforts require a combination of strategies, both individual and population approaches, to prevent smoking uptake and reduce the prevalence of smoking; and
- tobacco use remains so culturally and economically entrenched and nicotine is a drug of such addictiveness that significant cost will be associated with the array of measures required to make a significant impact on health.

9. Strategy Goal

9.1 The overall goal of the National Tobacco Strategy is to continue to pursue the goal set by the 1991 National Health Policy on Tobacco in Australia: ‘to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms’.⁵⁰

10. Strategy Objectives

10.1 Policy objectives outlined in the 1991 National Health Policy on Tobacco remain current and are applicable to the National Tobacco Strategy. The objectives of the Strategy are:

- to prevent the uptake of tobacco use in non-smokers, especially children and young people;

⁴⁹ National Campaign Against Drug Abuse 1991. National Health Policy on Tobacco in Australia; and examples of strategies for implementation, Canberra, p 5.

⁵⁰Ibid.

- to reduce the number of users of tobacco products;
- to reduce the exposure of users to the harmful health consequences of tobacco products;
and
- to reduce exposure to tobacco smoke.⁵¹

⁵¹ National Campaign Against Drug Abuse 1991. National Health Policy on Tobacco in Australia; and examples of strategies for implementation, Canberra, p 5.

Part III. Key Strategies

11. Key Strategy Areas

11.1 Expanding on initiatives already undertaken by the Commonwealth, State/Territory Governments and non-government agencies the following areas are highlighted for progression under the National Tobacco Strategy:

- strengthening community action for tobacco control;
- promoting cessation of tobacco use;
- reducing availability of tobacco;
- reducing tobacco promotion;
- regulating tobacco;
- reducing exposure to environmental tobacco smoke.

11.2 The identification of these six key strategy areas is consistent with the approach recommended internationally by such bodies as the Royal College of Physicians of London and the International Union Against Cancer (UICC).^{52,53}

11.3 In addition, given the social justice principles which underpin the National Drug Strategic Framework, areas of inequality have been specifically targeted. The strategies consider the needs of particular target groups such as Aboriginal and Torres Strait Islander people, children and young people, pregnant women and their partners, people with a mental health illness, people from culturally and linguistically diverse backgrounds, and those from lower socio-economic groups.

12. Strengthening Community Action for Tobacco Control

12.1 A well-informed community, able to make the fundamental changes in beliefs, attitudes and behaviour is one component in achieving significant population-wide reductions in tobacco use.

12.2 A well-informed community is one that understands enough about tobacco to make an informed choice about its use. To make this choice, the community must understand the product, the harm associated with any level of use, the difference between use and addiction, the effects of exposure to ETS, the need to quit sooner rather than later, that quitting at any age is beneficial, how to get help to quit, and the broader impact of tobacco on society.

12.3 There is no shortage of information about tobacco and its impact on health. It is the most widely researched topic in bio-medical history. Indeed the sheer quantity of information in the public arena can be bewildering to the general public. The problem is exacerbated by the efforts of the tobacco industry to promote use of its product and its strategies to discredit and confuse the public health message.⁵⁴

⁵²Royal College of Physicians of London 1977. Smoking or health: a report of the royal college of physicians. Pitman Medical Publishing Co Ltd: Tunbridge Wells.

⁵³Gray N & Daube M (eds) 1980. Guidelines for smoking control; second edition, International Union Against Cancer: Geneva.

⁵⁴Morling, T 1991. Australian Federation of Consumer Organisations Inc vs The Tobacco Institute of Australia Limited, Federal Court of Australia, No. NG 253 of 1987: Sydney.

- 12.4 For communication to be effective it must be credible, consistent and constant. Communicating clear public health messages is complicated by the emerging trend for audiences to fragment across multiple channels and the increasing move to globalisation of communication. This is further complicated by the need to ensure that information is understood by all sections of the community including those for whom English is a second language and those with low levels of literacy. The prevalence of smoking is significantly higher amongst people of lower educational attainment.
- 12.5 Labelling of tar and nicotine levels on cigarette packages first occurred in 1982. New, stronger health warnings were introduced in 1994. The extent to which further improvements can be made to the public's understanding of the product and its constituents is being investigated.
- 12.6 Public information programs must take account of new developments. Tobacco companies have continued to modify their products to reduce tar and nicotine levels and, at the same time, they have striven to ensure that the nicotine delivered remains at a pharmacologically active level. New products are also being developed eg. "smokeless" cigarettes, nicotine-free tobacco, nitrosamine-(a cancer causing agent) free tobacco. The pharmaceutical industry has further developed alternative nicotine replacement therapies and alternative nicotine delivery devices, e.g. nicotine inhalers.
- 12.7 Internationally, attention has been given to the disclosure of chemicals and additives in tobacco. Other countries are looking at changes to the International Standards for measuring levels of tar, nicotine and carbon monoxide to more accurately reflect the amounts delivered to the smoker. This has led to the consideration of the wording on packages to ensure it does not lead the smoker into believing that the product is safer and delivers less nicotine and other harmful chemicals, e.g. Ultra Light, Extra Mild, Super Light, Micro Mild, Ultimate 1 and so on. Where a regulatory response is introduced, clear, substantial and ongoing public information campaigns will enhance compliance.
- 12.8 While direct public information programs are essential, of equal importance is the contribution of health professionals and allied workers in communicating with specific target audiences, e.g. teachers with school students, doctors with their patients, pharmacists with their customers, employers with their staff and so on. Programs run through schools, health and community settings must be integrated with the wider population approach and be adequately resourced.

13. Promoting cessation of tobacco use

- 13.1 Preventing onset of regular smoking in adolescents is an important component of any comprehensive smoking and health strategy, but it often takes decades before prevention has any measurable effect on morbidity and mortality rates. Smoking cessation is a major means of reducing smoking-related mortality as it prevents the occurrence of disease and reduces the risk of further disease in those who quit.⁵⁵ Therefore promoting smoking cessation to the community is essential.
- 13.2 There are more than three million Australians who currently smoke, more than three quarters of whom want to quit.⁵⁶ The true impact of a lifetime of smoking has now been confirmed with research showing that around half of all lifetime smokers will die as a result of their

⁵⁵ World Health Organization 1998. Guidelines for controlling and monitoring the tobacco epidemic, World Health Organization: Geneva, p 18.

⁵⁶ Borland R & Hill D 1990. 'Two-month follow-up on callers to a telephone quit smoking service' *Drug and Alcohol Review*, no 9 pp 211-218.

habit. Half of these will be killed in middle age (36 to 69 years) losing around 21 years of life.⁵⁷

- 13.3 Age-specific prevalence of smoking declines to ten percentage points less than the overall prevalence by 60 years of age, demonstrating that quitting can, and does, happen with great frequency.
- 13.4 The Strategy is aimed at cessation for all age groups for several reasons. First, quitting smoking delivers a health and quality of life outcome to individuals most at risk as well as to their families and workplace associates. Second because cessation can affect premature death rates in as little as five years, it delivers rapid and measurable public health outcomes in terms of disease reduction. Finally, it is an effective tool which supports prevention strategies by maximising opportunities for adults to set an example for youth.
- 13.5 Smoking cessation is a process rather than an event. At an individual level, smokers are at different stages along the continuum of readiness to quit (from having no intention to quit, having some intention to quit but no timeframe, having an intention to quit in the near future, being in the process of making a quit attempt, having recently made a quit attempt, and either maintaining non-smoking or relapsing back to smoking). Smokers migrate through these stages over time, often taking a decade or more to do so, including relapsing to earlier stages after failed quit attempts. In order to eventually reduce the proportion of people in the population who smoke on a regular basis there must be a net movement of smokers through the stages towards long-term cessation.
- 13.6 For a population strategy to be effective there must be a consistent and sustained presence in the community. Strategies such as mass-media campaigns, medical practitioner interventions, offers of support to smokers and effective Quit line services all play important roles in maintaining the salience of the issue.

14. Reducing the availability of tobacco

- 14.1 The availability of tobacco products relates to two concepts, accessibility and affordability. Where and how tobacco products are sold, along with the cost of purchasing them, are factors that determine the overall availability of these products in the community.
- 14.2 Access to tobacco products is an important factor in the uptake of smoking.⁵⁸ In Australia (1996), 46.7% of 12-17 year old smokers had purchased their last cigarette as a result of illegal sales.⁵⁹ This, coupled with the fact that smoking behaviour is well established before the end of teenage years, means that reducing access to tobacco products is likely to contribute to reducing the overall prevalence of smoking. Efforts to reduce children's access to tobacco products in Australia have included increasing the minimum age of purchase to 18 years in all jurisdictions (with penalties imposed on those selling or in some cases, supplying to minors) and restricting the location of vending machines in most jurisdictions. Approaches to the registration or licensing of tobacco retailers are inconsistent across the country.

⁵⁷ Peto R, Lopez A, Boreham J, Thun M, Heath C 1994 Mortality from smoking in developed countries 1950-2000. Imperial Cancer Research Fund, World Health Organization: Oxford University Press, New York.

⁵⁸ US Department of Health and Human Services 1994. Preventing tobacco use among young people; A report of the Surgeon General: Atlanta, Georgia.

⁵⁹ Hill D, White V, & Letcher T 1997. Tobacco use among Australian secondary students in 1996, Centre for Behavioural Research in Cancer, Anti-Cancer Council of Victoria, p 20. (submitted for publication)

- 14.3 Another way of reducing the availability of tobacco products is to increase their cost. Price is a powerful determinant in an individual's decision and choice to smoke. Price-sensitive consumers respond to increases in the price of cigarettes by either quitting or lowering their consumption.⁶⁰ Research shows that a 10% price increase will, on average, reduce tobacco consumption by between 3-6%.⁶¹ The relationship between price and consumption is even more pronounced for children, where a 10% price increase will, on average, reduce demand by 14%.⁶²
- 14.4 Taxation is a mechanism by which governments can affect the price of tobacco products. The Commonwealth Government raises revenue through excise payments on locally manufactured products and custom duty tariffs on imported products. The Commonwealth Government has increased the real excise level on tobacco products on a number of occasions. While tax increases have increased the price of a packet of cigarettes considerably, youth smoking rates and the slowing of the decline in prevalence of smoking among adults indicate that more needs to be done to reduce the affordability of tobacco products.

15. Reducing tobacco promotion

- 15.1 Tobacco promotion encompasses a broad range of activities such as advertising, including point-of-sale and product placement in films, on television, in music video clips, magazines and journals, through sponsorship of events, marketing through product packaging and the distribution of non-tobacco products associated with the sale of tobacco products.
- 15.2 International research, for instance in Norway which banned tobacco promotion in 1975, indicates that the banning of promotion reduces consumption.⁶³ Unrestricted promotion of tobacco products contributes to the perception that tobacco product use enhances an individual's success and that more people smoke than actually do. Additionally, it provides a way for youth to make the connection between actual and ideal self image by taking up smoking. Research has confirmed that young people are more sensitive to tobacco advertising and promotion than are adults⁶⁴ and suggests that children's exposure and receptivity to tobacco advertising and promotion is an important factor in determining future smoking behaviour.⁶⁵ Promotion of tobacco products also undermines health messages from parents, government and non-government organisations.

⁶⁰ US Department of Health and Human Services 1994. Preventing tobacco use among young people; A report of the Surgeon General: Atlanta, Georgia.

⁶¹ Australian Cancer Society and the National Heart Foundation 1998. Federal excise on tobacco; tobacco tax solutions May 1998 Budget; a submission to the Australian Parliament, p 10.

⁶² US Department of Health and Human Services 1989. Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General in Winstanley et al 1995. Tobacco in Australia; facts and issues 1995, Victorian Smoking and Health Program: Carlton South, p 150.

⁶³ Bjartveit K & Lund K 1998. The Norwegian ban on advertising of tobacco products; has it worked?, Norwegian Cancer Society & Norwegian Health Association: Oslo.

⁶⁴ Pollay R, Siddarth S, Segal M, Haddix A, Merrit R, Giovino G & Erikson M 1996. 'The last straw? Cigarette advertising and realised market shares among youths and adults, 1979-1993' *AMA Journal of Marketing*, April 1996.

⁶⁵ Evans N, Farkas A, Gilpin E Berry C & Pierce J 1995. 'Influence of tobacco marketing and exposure to smokers on adolescent susceptibility to smoking', *Journal of the National Cancer Institute*, vol 87, no 20, pp 1538-1545.

- 15.3 A range of initiatives has been undertaken to restrict the promotion of tobacco products, with a gradual phasing-in of a complete ban on all forms of tobacco advertising in print, television, radio, and in cinemas, with the exception of point-of-sale advertising. Point-of-sale advertising is prohibited in two States and restrictions are imposed in several other jurisdictions. Tobacco value-added promotions and products and the use of giveaways such as key rings and caps with the sale of tobacco products, have been restricted in most jurisdictions but there continue to be examples of areas where these promotions are undertaken. There have been significant restrictions imposed on tobacco advertising allowed at international sporting events granted exemptions from the general ban on tobacco advertising in Australia. Despite those restrictions, tobacco advertising continues to occur in association with those events and through coverage of international events where tobacco advertising is permitted.
- 15.4 Where health promotion foundations have been established this has been done in part to counter the efforts of the tobacco industry to promote their products particularly through sponsorship of sport and cultural events. These foundations provide funding to arts and sporting bodies to replace tobacco sponsorship, resources for health promotion and in some jurisdictions funding for research. Health promotion foundations have made a significant contribution to the introduction of smoke-free environments in sport, arts and racing organisations. Healthway (the West Australian health promotion foundation) reports that more than 95% of sports, arts and racing organisations in 1997 were implementing smoke-free policies in the majority of their venues and some 60% had introduced such policies at the request of Healthway.⁶⁶
- 15.5 In May 1986, the Thirty-ninth World Health Assembly adopted a resolution on tobacco or health which included deploring all promotion of tobacco.⁶⁷ Although Australia is internationally renowned for efforts to control the promotion of tobacco products, there are still some avenues available in Australia for tobacco products to be promoted.

16. Regulating tobacco

- 16.1 There are three tobacco manufacturers currently operating in Australia: British American Tobacco Australasia Ltd, Imperial Tobacco Australia Ltd and Philip Morris (Australia) Ltd.⁶⁸ These companies have been among the most profitable industries in Australia.⁶⁹ In 1996, the Australian manufactured cigarette market generated almost \$6,200 million in sales.⁷⁰
- 16.2 Tobacco leaf is grown in Victoria and Queensland.⁷¹ Unmanufactured and manufactured (cut) leaf is also imported from a number of countries. In addition, a number of international brands and non-cigarette tobacco products are available through specialist importers or Australian manufacturers. The Australian export market of tobacco products is not large and most manufactured cigarettes go to Pacific and South East Asian countries.⁷²

⁶⁶ Clarkson J, Corti B, Pikora T, Jalleh G & Donovan RJ 1998. Organisational survey 1992-1997 healthy environment policies in sponsored organisations, Health Promotion Evaluation Unit, Department of Public Health and Graduate School of Management, The University of Western Australia: Perth.

⁶⁷ World Health Organization 1994. Action plan on tobacco or health for 1995-1999, World Health Organization Regional Office for the Western Pacific, p 2.

⁶⁸ Winstanley M et al 1995. Tobacco in Australia: facts and issues, Second edition, Victorian Smoking and Health Program, Australia, p 221.

⁶⁹ Ibid p 221.

⁷⁰ Tobacco Information Centre 1997. Tobacco Industry Fact Sheet

⁷¹ Ibid.

⁷² Ibid p 221.⁷⁵ National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services, p 3.

16.3 Tobacco control efforts to date have used regulation as a tool for reducing the harm caused by tobacco consumption. The extent of regulation governing the industry is widely accepted given that these products are lethal (even when used as intended), addictive and result in a loss of more than 18,000 lives in Australia each year, while also costing the community more than \$12.7 billion.⁷³

16.4 Restrictions introduced by Australian Governments to control the activities of the tobacco industry include:

- legislation banning tobacco advertising;
- regulations requiring all tobacco products to have health warnings;
- minimum age restrictions for which children can be sold cigarettes;
- legislation prohibiting the sale of individual cigarettes.

16.5 There have been a number of recent international developments regulating the tobacco industry. For example in Canada, the Province of British Columbia has recently passed legislation requiring companies to test and report on all ingredients and additives in their cigarettes, including the chemicals used to treat papers and filters. In addition, companies must report on 44 selected poisons found in tobacco smoke. At a federal level in Canada, there are proposals currently being considered to amend the Tobacco Act. These include expanding the reporting requirements to obtain data on more than 50 toxic constituents of tobacco and tobacco smoke, and the reporting of ingredients used in the manufacturing process.

16.6 Despite the fact that tobacco smoking is the single greatest cause of premature death and disease in Australia, publicly available information about the content of cigarettes is still limited. Recent litigation against the industry in the United States and moves to implement tighter legislative controls on the sale and promotion of tobacco have highlighted the need for stronger regulatory controls on the industry in Australia. In addition, the US tobacco industry has been forced by a series of recent court cases to disclose that it has known for decades of the harmful consequences of smoking their products but has failed to disclose this information to the public. Unlike in the USA, there are no regulations in Australia that require the tobacco industry to report to government the nature and extent of its advertising, promotion and marketing activities.

17. Reducing exposure to environmental tobacco smoke

17.1 Since the 1970s, evidence on the detrimental effects of exposure to ETS has continued to accumulate. Over 600 medical reports have been published linking exposure to ETS to lung cancer and other respiratory diseases.⁷⁴ There have been a number of reviews of the evidence both internationally and in Australia. In Australia, the NHMRC reviewed scientific evidence concerning the possible health effects of exposure to ETS in 1997 and concluded, conservatively, that exposure to ETS causes lung cancer in adults, causes lower respiratory illness in children, contributes to the symptoms of asthma in children and may also cause coronary heart disease in adults.⁷⁵

⁷³Collins D & Lapsley H 1996. National Drug Strategy Monograph Series: The social costs of drug abuse in Australia in 1988 and 1992; No 30, Commonwealth Department of Human Services and Health: Canberra, p 33.

⁷⁴NSW Health Department 1995. NSW Tobacco and Health Strategy 1995-1999, NSW Health Department, p 10.

⁷⁵National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services, p 3.

- 17.2 Internationally, the WHO's updated and revised air quality guidelines conclude that 'there is no evidence for a safe exposure level' of ETS.⁷⁶ WHO findings indicate that, at typical environmental exposure levels, ETS is carcinogenic, increases the risk of fatal and non fatal cardiovascular disease in non-smokers, and causes substantial morbidity and mortality from other serious health effects as a result of acute and chronic exposure.⁷⁷ The California Environmental Protection Agency (1997) found a causal relationship between passive smoking and sudden infant death syndrome, heart disease morbidity and mortality, nasal sinus cancer, as well as serious chronic diseases such as childhood asthma.⁷⁸ In the United Kingdom, the Report of the Scientific Committee on Tobacco and Health concluded that passive smoking is a cause of lung cancer and childhood respiratory disease. Furthermore, the report stated that there is evidence that passive smoking is a cause of ischaemic heart disease, cot death, middle ear disease and asthmatic attacks in children.⁷⁹ Studies amongst babies born to women who are exposed to ETS also indicate a small reduction in birthweight.⁸⁰
- 17.3 Serious effects such as lung cancer and heart disease are in addition to the 'irritant' effects of ETS on the eyes, nose, throat and airways passages.⁸¹ While otherwise healthy adults may experience detrimental effects from ETS exposure, acute effects following short-term exposures pose a special risk for people with pre-existing ailments and conditions, particularly respiratory and cardiovascular diseases. People who suffer from diseases such as asthma, bronchitis and bronchiectasis, or those with inherited tendency to chronic airflow limitation, may experience a critical deterioration in lung function and symptoms as a result of ETS exposure.⁸²
- 17.4 Australia has responded to the mounting evidence of dangers imposed by ETS over the last decade primarily by encouraging formal and informal industry self-regulation of smoking in enclosed public places and workplaces. More formal arrangements include the prohibition on smoking in all federally owned and operated buildings and on all forms of public transport. Legislation exists in some jurisdictions for smoke-free indoor areas in workplaces and other public places such as restaurants, cafes, shops and theatres. Most jurisdictions have also undertaken various forms of education, information and assistance programs, and campaigns with the aim of increasing non-smoking provision in restaurants, cafes and other enclosed public places. The threat of litigation has also been influential in the development of these public health initiatives.
- 17.5 Although progress has been made during the last decade in extending smoke-free facilities, available data informs us that nationally one in five workers have no restrictions on smoking

⁷⁶ World Health Organization 1998 (forthcoming). Air quality guidelines for Europe: Volume 5; indoor, World Health Organization Regional Office for Europe, Copenhagen.

⁷⁷ Ibid

⁷⁸ California Environmental Protection Agency, Office on Environmental Health Hazard Assessment 1997. Health effects of exposure to environmental tobacco smoke, California Environmental Protection Agency: Sacramento.

⁷⁹ UK Department of Health 1998. Report of the Scientific Committee on Tobacco and Health, UK Department of Health.

⁸⁰ National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services, p 27.

⁸¹ Winstanley M, Woodward S & Walker N 1995. Tobacco in Australia; facts and issues 1995, Victorian Smoking and Health Program, Carlton South.

⁸² National Health and Medical Research Council 1997. The health effects of passive smoking; a scientific information paper, Commonwealth Department of Health and Family Services.

in their place of work⁸³ and effective non-smoking dining in cafes and restaurants is not currently the norm. Given that strong and consistent community support over a number of years for smoke-free restaurants and other enclosed places has not been matched by the corresponding provision of smoke-free premises, it appears that reliance on education, information, common courtesy, voluntary codes and other forms of self-regulation will not be successful in achieving the widespread and systematic provision of smoke-free workplaces and enclosed public places.^{84,85} The New South Wales and Western Australian Task Forces on Passive Smoking both conclude that legislation would be the most effective strategy for significantly reducing exposure to environmental tobacco smoke in enclosed public places and workplaces.^{86,87}

17.6 Given the mounting evidence of the health risks posed by exposure to ETS and the ongoing exposure of persons to ETS, it is appropriate that the need for reducing exposure to environmental tobacco smoke is a key strategy area of the National Tobacco Strategy.

18. Summary

18.1 Australia has been active in implementing tobacco control strategies as reflected in the 1991 National Health Policy on Tobacco in Australia and other more recent broad-based strategic documents. Tobacco smoking, however, remains the single largest preventable cause of premature death and disease in Australia.

18.2 In entering the next century, in line with calls from the World Health Assembly for the implementation of comprehensive tobacco control strategies, Australia has formalised and maintained a comprehensive approach and ensuring a firm commitment to future tobacco control activities. The development of the National Tobacco Strategy for Australia recognises that future successful action in tobacco control hinges upon coordinated and comprehensive national action. The Strategy expands on the range of initiatives already implemented by Commonwealth, State and Territory Governments and non-government organisations and links with other relevant strategic documents ensuring an integrated approach.

18.3 This paper provides the context for and the background to the development of the National Tobacco Strategy and is available as a companion document to the National Tobacco Strategy. The Strategy highlights for progression a comprehensive and multi-variate approach for a nationally collaborative effort to achieve the National Tobacco Strategy goal 'to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms'.

⁸³ Makkai T & McAllister 1998. Public Opinion towards drug policies in Australia 1985-1995, Commonwealth Department of Health and Family Services: Canberra, p 22.

⁸⁴ Ibid p 24,27.

⁸⁵ Borland R, Morand M & Mullins R 1997. 'Prevalence of workplace smoking bans in Victoria', Aust NZ Journal of Public Health, vol 21, no 7, pp 694-698.

⁸⁶ NSW Passive Smoking Taskforce to the NSW Minister for Health 1997. Passive smoking in the hospitality industry – options for control.

⁸⁷ Western Australian Task Force on Passive Smoking 1997. Report of the Western Australian Task Force on Passive Smoking in Public Places.

Appendix A

**Taken from the Action Plan on Tobacco or Health for 1995-1999
World Health Organisation
Regional Office for the Western Pacific
1994**

Summary

Background

The tobacco problem in this Region will get much worse before it gets better. The tobacco industry has predicted sales increases in Asia of 33% between 1991 and the year 2000. Tobacco consumption in the Region increased by 15% between 1988 and 1992.

Action Plan on Tobacco or Health for 1990-1994

Countries and areas which had taken significant action prior to the commencement of the 1990-1994 Action Plan have strengthened their activities and implemented further important measures. Many countries and areas which had not taken significant action prior to 1990 have now implemented national action. The majority of countries and areas have now established a national focal point on tobacco or health, and also celebrate World No-Tobacco Day.

Action Plan on Tobacco or Health for 1995-1999

The Action Plan on Tobacco or Health for 1995-1999 calls for all governments to implement comprehensive tobacco control measures by 1999. These include a national policy and a central coordinating agency on tobacco or health, health education, comprehensive tobacco control legislation, and pricing policy. Highlights include:

- a call for a “Tobacco-advertising-free Region by the year 2000” as part of comprehensive legislation on tobacco or health;
- the recommendation that a percentage of tobacco tax should be used to fund sports, arts and health promotion, so that sports and arts organizations do not suffer from the ban on tobacco sponsorship;
- introduction of health information and advocacy on tobacco or health into medical curricula;
- compliance with the International Civil Aviation Organization resolution that all airlines become smoke-free by 1996;
- involvement of religious and other community groups in tobacco-or-health activities;
- the goal, for countries and areas with a long history of tobacco-or-health action, to decrease their tobacco consumption by at least 1%-2% per year;
- the goal, for countries and areas that had not previously taken significant action on tobacco or health, to implement national action (with a view to reducing consumption during the next 2000-2004 Action Plan on Tobacco or Health); and
- the goal, for all countries and areas, to prevent a rise in smoking among women.

Appendix B

Federal developments in tobacco control

- In 1987 a ban on smoking on domestic airline flights and commuter services commenced; this ban was extended in 1990 to include the domestic leg of all international flights;
- In 1988 the ban on the advertising of cigarettes on television and radio, introduced in 1976, was extended to include all tobacco products;
- In 1988 a ban on smoking in buses and coaches registered under the Federal Interstate Registration Scheme was introduced;
- In 1988 a smoke free work environment policy was adopted throughout the Australian Public Service and Commonwealth controlled buildings;
- In 1989 legislation was passed to prohibit the advertising of tobacco products in the print media with effect from December 1990.
- In 1992 legislation was passed imposing a general ban on the broadcasting and publishing of all tobacco advertisements, with certain exemptions.
- In 1994 regulations were enacted to ensure uniform labelling of tobacco products throughout Australia and provision of appropriate product information to consumers including 6 rotating health warnings on tobacco products and information line numbers.
- In 1997 a multi tiered National Tobacco Campaign was launched, combining a series of hard-hitting advertisements on television, radio, newspaper, and bus advertising with the message 'Every cigarette is doing you damage' as well as providing nationally coordinated Quitline services for smokers.

Appendix C

NATIONAL TOBACCO LEGISLATION ANALYSIS Summary of Existing Legislation

Jurisdiction	Commonwealth	NSW	VIC	QLD	SA	TAS	ACT	WA	NT
	<i>Smoking and Tobacco Products Advertisements (Prohibition) Act 1989</i>	<i>Public Health Act 1991</i>	<i>Tobacco Act 1987</i>	<i>Tobacco Products (Prevention of supply to Children) Act 1998</i>	<i>Tobacco Products Regulation Act 1997</i>	<i>Public Health Act 1997 - Part 4 - Tobacco Products</i>	<i>Tobacco Act 1927 & Amendments 1990 & 1993 & Regulations 1991</i>	<i>Tobacco Control Act 1990</i>	<i>Tobacco Act 1992</i>
	<i>Tobacco Advertising Prohibition Act 1992</i>	<i>Public health Amendment (Tobacco) Act 1996</i>	<i>Tobacco (Cigarette Packaging Labels) Regulations 1993 (pursuant to Tobacco Act 1987)</i>		<i>Tobacco Products Regulation Act; Regulations 1997 & 1998</i>	<i>Guidelines under the PHA97</i>	<i>Smoke-free Areas (Enclosed Public Places) Act 1994 & Amends 1997 & Regs 1994</i>	<i>Tobacco Control (General) Regulations 1991</i>	<i>Tobacco Regulations 1992</i>
	<i>Tobacco Advertising Prohibition Regulations 1993</i>	<i>Smoking Regulation Act 1997</i>							<i>Tobacco Amendment Act 1993</i>
	<i>Tobacco Advertising Prohibition Amendment Act 1995</i>					<i>No 4 Guidelines for Tobacco Products</i>		<i>Tobacco Control Amendment Act 1993</i>	<i>Cigarette Containers (Labelling) Ordinance 1972</i>
	<i>Trade Practices Act 1974</i>	<i>Public Health Amendment (Tobacco Advertising) Act 1998</i>	<i>Tobacco Regulations 1997</i>				<i>Cigarette Containers (Labelling) Amend Ordin 1972</i>	<i>Tobacco (Warning Labels) Regulations 1987 - (made under Health Act 1911)</i>	<i>Cigarette Containers (Labelling) Amendment Act 1986</i>
	<i>Trade Practices (Consumer Product Information Standards (Tobacco) Regulations & Amendment 1994</i>		<i>Tobacco (Victorian Health Promotion Foundation) Regulations 1997</i>			<i>No 9 Guidelines for Display of Tobacco Products</i>			
	<i>Air Navigation Act 1920</i>	<i>Public Health Amendment (Tobacco Advertising) Regulations 1998</i>					<i>Tobacco Prods (Health Warnings) Act & Amends 1993 & Regs 1991</i>	<i>Tobacco Control (Package Labels) Regulations 1992 & 1993</i>	
	<i>Air Navigation Regulations (Amendments) 1987, 1990, 1995 & 1996</i>		<i>Tobacco (Amendment) Regulations 1998</i>			<i>No 10 Guidelines for Packaging and Labelling of Tobacco Products</i>	<i>Tobacco Prods (Health Warnings) Ordin Act 1986 & Amends 1987</i>		
	<i>Broadcasting Services Act 1992</i>								
	<i>Interstate Road Transport Act 1985</i>								
	<i>Interstate Road Transport Regulation (Amendment) 1988</i>								
	<i>Federal Airports Corporation Act 1986 & Federal Airports (Amendment) By-Laws Act 1986</i>								

DEMAND REDUCTION STRATEGIES

MARKETING & PROMOTION

Activity:	Commonwealth	NSW	VIC	QLD	SA	TAS	ACT	WA	NT
Published Ads	prohibited by legislation	prohibited by legislation	prohibited by legislation	Commonwealth legislation applies	prohibited by legislation	prohibited by legislation	prohibited by legislation	prohibited by legislation	regulated by voluntary agreement with industry
Broadcast Ads	prohibited by legislation	prohibited by legislation				prohibited			
Sponsorship	acknowledgements restricted by legislation	prohibited by legislation, Minister may grant an exemption	Health Promotion Foundation replaces tobacco sponsorship		Prohibited by legislation; government funded sponsorship program	Nil	prohibited by legislation, Minister may grant an exemption; Health Promotion Foundation replaces tobacco sponsorship	Health Promotion Foundation replaces tobacco sponsorship	
Point-of-sale	restricted by legislation	prohibited by legislation	restricted by legislation		restricted by legislation	prohibited by legislation	restricted by legislation	restricted by legislation	
Value-added Promotions		prohibited by legislation	prohibited by legislation		prohibited by legislation	prohibited by legislation	proposed amendments would prohibit	prohibited by legislation	
Minimum Pack Size		regulated by legislation	regulated by legislation	regulated by legislation (20)	regulated by legislation	regulated by legislation (20)	regulated by legislation (20)	regulated by legislation	

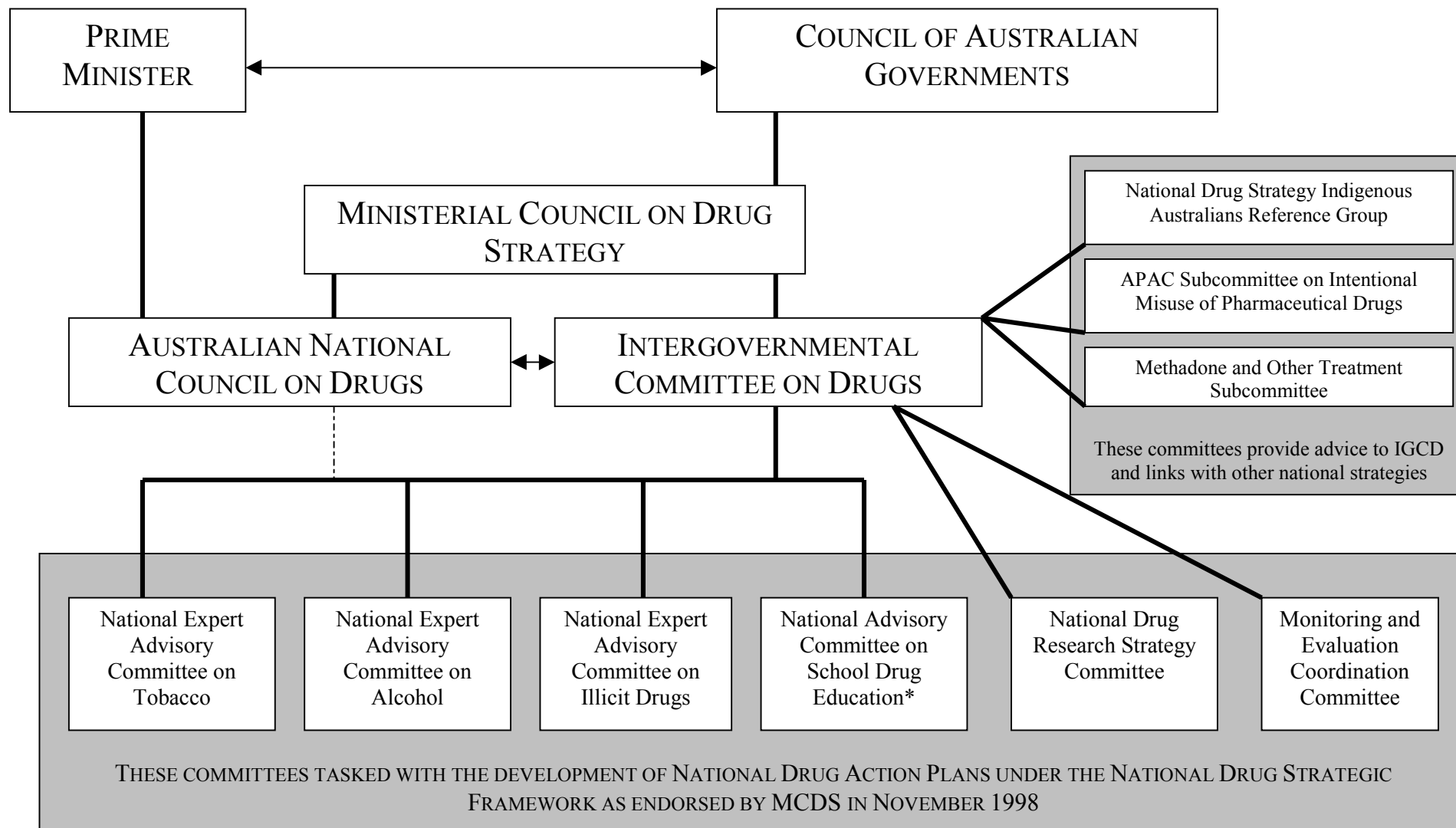
EDUCATION ACTIVITIES									
Activity:	Commonwealth	NSW	VIC	QLD	SA	TAS	ACT	WA	NT
Health Warning Labels	mandatory by legislation on all retail packages of tobacco products								
Telephone services	national information line service	Quit line	Quit line	Quit line	Quit line	Quit line	Quit line	Quit line	Quit line
Media Campaigns	MTAG formulating adult smokers campaign	QUIT campaigns	QUIT campaigns	annual Quit campaign	youth campaign & extension of national campaign via extra funds from Dept Human Services	Quit only		Annual Quit campaign & other media subject to funding. Smokefree WA campaign May 1998	Annual Quit (WNTD & New Years) Campaigns
School-based programs		included in required PDPHP syllabus	Dept of Education Get Real resource	Education Dept resource (new) Life Education	Schools kit produced 1998 - The truth is out there	Education Dept	School based, part of Health & PE; ACT CA Society Peer Support Program	Produce drug education resources	NT Education Dept, Drug & Alcohol Resistance Education (DARE) Program (NT Police)
Grants programs	ad hoc grants administered to national organisations				Grants program from Dept Human Services	Nil		Grants through Health Promotion foundation	Aboriginal Incentives Funds and Quit Week School Grants Program
Cessation Services		Quit campaign, area health services, church & private ADLS	Quit campaign	Quit campaign	Quit campaign	Quit campaign	Quit campaign	Quit campaign ADIS, private organisations, NHF public health units	Quit campaign

SUPPLY REDUCTION STRATEGIES									
Activity:	Commonwealth	NSW	VIC	QLD	SA	TAS	ACT	WA	NT
Vending machines		restricted by legislation	restricted by legislation	restricted by legislation	restricted by legislation	restricted by legislation	restricted by legislation	restricted by legislation	
Passive smoking	smoking prohibited in Federally owned or operated buildings	smoking to be prohibited in public places, with exemptions for those meeting air quality standard (takes effect 5 years after this regulation)	affected by legislation; campaign activity	campaign activity public transport legislation smoking prohibited in government buildings (Cabinet decision)	Smoking in lifts, buses and places of public entertainment is prohibited. With some exceptions smoking will be prohibited in enclosed public dining and cafe areas from Jan 4 1999.	school-based policy in effect	smoking in public places (all shops, cafes, theatres, etc. except licensed premises i.e. Bars) restricted or prohibited by legislation	OHS Regs to prohibit smoking by employees in enclosed workplaces (except designated smoking areas) (Jan 1999) Regulations under Health Act 1911 to take effect 1/1/99 restricting smoking in enclosed public places with exemptions for a limited range of venues which meet adequate ventilation standards	addressed as part of tobacco action project
Retailer compliance campaigns		yes (sales to minors) advertising (planned)	project 1998-99	April-July 1998 education kits advertising	regular random surveillance re correct signage & awareness of the law	being developed	limited compliance testing conducted	biennial compliance testing conducted since 1992	Being developed
Minimum purchase age		18 years	18 years	18 years	18 years	18 years	18 years	18 years	18 years
Penalties for selling to minors		50 penalty units (\$5100)	\$100	\$975 first offence, \$1950 subsequent offence, possible ban	\$5000	\$5000 first offence, \$10000 subsequent offences	\$1000 (proposed license sanctions)	individual \$5000-\$10000, corporate \$10000-\$20000	\$10000

SUPPLY REDUCTION STRATEGIES (Continued)									
Activity:	Commonwealth	NSW	VIC	QLD	SA	TAS	ACT	WA	NT
Penalties for minors purchasing					\$200 if providing false ID or false statement or refuse to produce ID at purchase				
PRICING MECHANISMS									
Activity:	Commonwealth	NSW	VIC	QLD	SA	TAS	ACT	WA	NT
Excise	excise levied per kilogram weight of tobacco; rate gauged to CPI increases								
Business Franchise Fees	State and Territory fees now collected by the Commonwealth and returned to the to each jurisdiction	under review				Retail licensing under review	Retail licensing under review		

Appendix D

ADVISORY STRUCTURES FOR THE NATIONAL DRUG STRATEGIC FRAMEWORK 1998-99 TO 2002-03



** The National Advisory Committee on School Drug Education also reports to the Ministerial Council on Education, Training and Youth Affairs*