



3. Progress in Australia on recommended policies and programs

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

- Regulation of Price through tax, Place of use, Place of sale, Promotion, Packaging and Products (with support expressed also for the idea of regulating Producers)
- Promotion of Quit and smoke-free messages
- Cessation services and treatment
- Community support and education
- Addressing social, cultural and economic determinants
- Tailoring for disadvantaged groups.
- Research, evaluation, monitoring and surveillance.

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

In its synthesis of international developments and research, this paper has drawn on a wealth of literature from many fields and all over the world, but it has given greatest weight to the findings of

the reports of expert groups, meta-analyses, and Australian and international research examining the impact of policy interventions. A list of the broad categories of sources is set out at the end of this document, followed by a full list of over 500 references used.

Particular emphasis has been given to evidence on the effect of policies among disadvantaged groups.

While much has been achieved, for brevity, the remainder of this paper describes areas where Australia's current performance falls short in relation to:

- findings of scientific research
- the international Framework Convention on Tobacco Control, to which Australia became a party in December 2003
- international best practice.

To date, success in tobacco control has occurred not through clinical, classroom or workplace interventions but through a comprehensive whole-of-population approach that has profoundly changed cultural values about smoking.(85, 86) As well as regulation, the various campaigns, programs, treatment and efforts of advocates for tobacco control have played a crucial role(87) in keeping smoking and its effects in the news(88) and on the political agenda¹².(91)

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

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

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



A European analysis(92) showed that quit ratios (the proportion of people who have ever smoked who have quit) were highest in those countries with the most developed tobacco control policies (as measured on a Tobacco Control Scale developed by the WHO(93)). High- and low-educated smokers benefited roughly equally from nationwide policies. A comprehensive review of population-level tobacco control examined the impact of interventions such as smoke-free policies in schools, workplaces and other public places, restrictions on sales to minors, restrictions on advertising, health warnings, increases in prices and multifaceted interventions. It found no evidence of any policies increasing inequalities, and found strong evidence of a *reduction* in inequalities resulting from increases in prices.(94)

Most disparities in smoking rates between socio-economic groups in Australia result from differences in uptake rather than in cessation.

Figure 13 shows that around 30% of people can be classified as 'ex-smokers', regardless of the level of neighbourhood disadvantage. The percentage of people who have never taken up smoking is 18% higher in people living in the most advantaged neighbourhoods compared to those living in the least advantaged neighbourhoods.

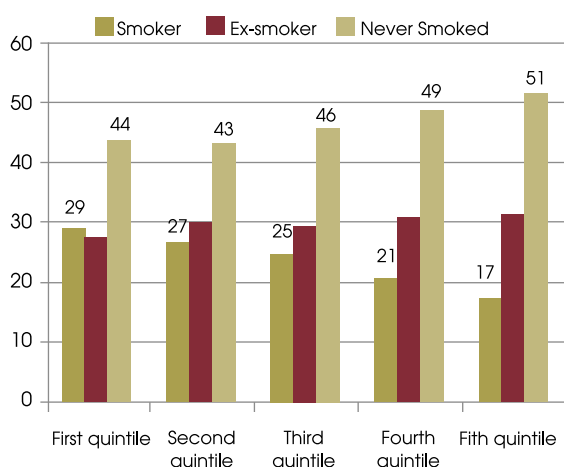


Figure 13: Smoking status – prevalence of current, ever and never smoking by quintile of index of relative disadvantage, Australia, 2004–2005

Source: ABS National Health Survey 2004–2005

Strategies to prevent the uptake of smoking are not just about education programs in schools or laws banning sales to minors.(95-98) All of the regulatory, educational and policy interventions described below are considered from the point of view of their impact on young people as well as on adults, and their potential impact across social groups.

A major challenge for tobacco control is to work out how best to accelerate social diffusion against smoking – how to make being a non-smoker and smoking cessation more 'contagious' – among Indigenous and other disadvantaged communities.

3.1 Regulate

Smoking is so harmful that no company trying to introduce cigarettes into Australia today would succeed in getting the product onto the market.

Banning a product that many people are unable to stop using is not seen as a viable option. By regulating the tobacco market as effectively as possible, governments can seek to eliminate commercial conduct that contributes to ill-informed, non-voluntary and unnecessarily harmful use of and exposure to tobacco.

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



3.1.1 PRICE THROUGH TAX

Policy intention: to make tobacco products less affordable

“A high cigarette price, more than any other cigarette attribute, has the most dramatic impact on the share of the quitting population.”

Memo from Claude Schwab to John Heinenimas (Phillip Morris), 5 March 1993 PM doc 2045447810

Additional evidence since 2004

Several meta-analyses published since 2004 confirm the effectiveness of increasing prices to reduce tobacco consumption and prevalence. (92, 94, 99) These and several additional new studies continue to demonstrate greater impacts of price increases on quitting in low-income groups.(100, 101)

During the second phase of the National Tobacco Campaign (NTC), November 1999 to November 2002, prices of tobacco products increased significantly.(100) Among those people who were still smoking at the end of the first phase of the NTC, smoking declined more among blue- than white-collar groups. Smoking declined by 6% in blue-collar groups but did not fall further in white-collar groups. Analysis of changes in monthly smoking prevalence in the largest Australian states in response to changes in various interventions(35) found that the costliness of cigarettes has the most powerful impact of all the policies studied. Another study awaiting publication reports that the effect of price was greatest among those on lowest incomes.(102)

Apart from increasing taxes, governments internationally have also influenced the costliness of tobacco products by establishing minimum prices and investing in measures to prevent tax evasion. Minimum price laws in some states in the US (which operate to protect small retailers) have resulted in higher average cigarette prices, but these only seem to be effective in states such as New York, where price promotions are also prohibited.(103)

The availability of illicit tobacco products (products on which taxes have been avoided) undermines the effectiveness of taxation in many countries in reducing affordability to prevent uptake(104) and promote quitting, particularly among low-income groups.(105, 106) In the UK one in 20 high-income smokers buy cheap tobacco products on which taxes have been avoided; for low-income smokers the figure is one in five.(107) It is essential that we do not let illicit trade become a problem in Australia.

Progress against international comparators

Cigarettes in Australia are less costly than they are in many other countries. Figure 14 shows what a packet of 30 cigarettes would have cost in Australia in July 2008, had the prices been equivalent to those in other English-speaking countries. This is based on a survey of cigarette prices in several hundred different cities.



Figure 14: Price of a packet of Peter Jackson 30s if cigarette prices in Australia were equivalent to those in other countries, AS, July 2008

Source: Economist Intelligence Unit, August 2008,(108) popular brands from medium-priced stores

The price of cigarettes has not kept pace with the price of many other products and services. If cigarettes in Australia were to cost as much as they do in Ireland, around \$20 for a pack of 30, they would still be cheaper than the price of three hours in a city parking station, a quarter of a tank of petrol in a small car, an outing to a movie with a treat from the snack bar or one music CD download.



Taxes on cigarettes in Australia are also very low as a proportion of total price.

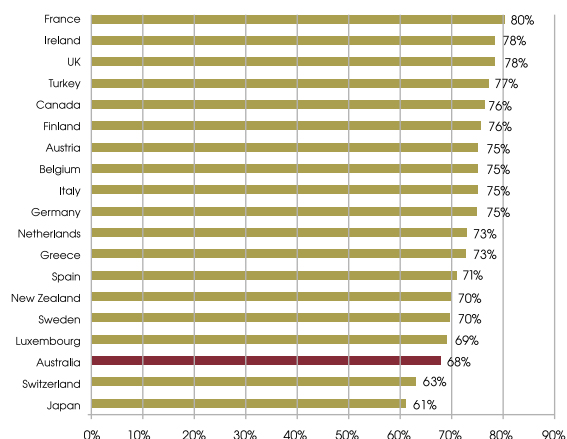


Figure 15: Tax paid as a percentage of final recommended retail price – OECD countries, 2003

Source: Scollo, M Tobacco in Australia, Facts and Issues(109)

A sharp increase in the costliness of cigarettes between November 1999 and February 2001, following government reforms to excise duty, was followed by a sharp drop in consumption. Between 2001 and 2008, however, the costliness of cigarettes has barely changed, and per capita consumption has fallen only slightly.

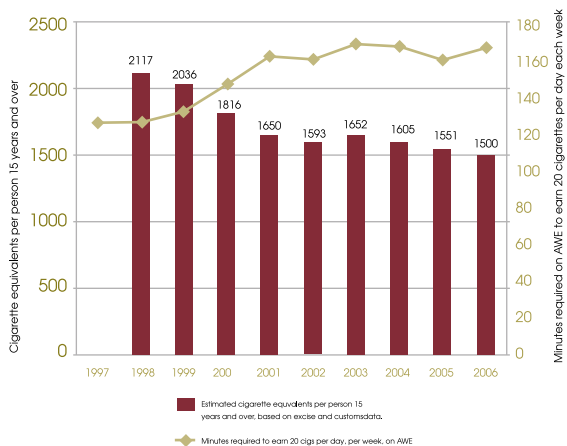


Figure 16: Per capita consumption of cigarettes compared with affordability

Source: Facts and Issues in Australia, Ch 13(109)

The World Health Organization (WHO) recommends that governments ensure that the price of cigarettes increase in real terms each year by at least 5%. In Australia in September 2008, the recommended retail price of a packet of Peter Jackson 30s was \$2.90 lower than it would have been had the previous government adhered to this policy since 1999.

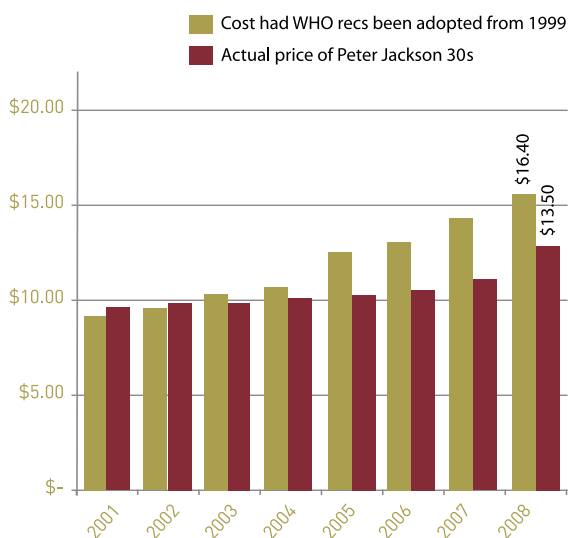


Figure 17: Recommended retail price of Peter Jackson 30s compared with prices if they had increased at 5% per annum

Source: Facts and Issues in Australia, Ch 13(109)

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



Table 2: Recommended retail prices per cigarette of leading brands in 2002, 2003 and 2004 vs reported prices paid by consumers (\$ current, cents per stick)

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

Sources: Australian Retail Tobacconist Price Lists, August 2002, 2003, 2004;(110) International Tobacco Control Policy Evaluation Study(111)

Revenue protection measures

Since 2004 the Australian Tax Office has vigorously pursued operators who attempt to evade excise duty through the sale of illicit unprocessed tobacco known as *chop chop*. (112, 113) Over 233 million illegally imported cigarettes and 472 tonnes of tobacco have been seized since 2002,(114) when the first facility to examine containers was established at an Australian port.¹³ However so far there appears to have been little progress on measures required under clauses 15.2, 15.4 and 15.6 of the Framework Convention on Tobacco Control to cooperate with other parties on the elimination of illicit trade. No action has yet been taken to require manufacturers and importers to track and report on sales and distribution (as proposed in recently drafted Chairperson's text for a Protocol on Illicit Trade in Tobacco Products).(115) An effective policy to prevent the development of illicit trade would also ban sales of tobacco products to retail customers via the Internet and would abolish duty free sales.

ACTION PROPOSED

To restore Australian cigarette prices to levels in line with WHO recommendations, increase excise and customs duty by 7.5 cents per stick.

Once effective measures are in place to prevent revenue evasion (and complemented by better services for quitters), increase excise and customs duty to ensure that the price of an average packet of 30 cigarettes is no lower than \$20.

Prohibit the advertising of price discounts, and assess any barriers to establishing minimum price levels for cigarettes in Australia.

Regulate to require tracking and tracing systems that cover all points in the chain of distribution.

Abolish duty free sales of tobacco products and ban sales to retail consumers through the Internet.

Recognising the cross-border nature of illicit trade, actively participate in the negotiation of an effective protocol to the FCTC.

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



3.1.2 PLACE OF USE

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

Additional evidence since 2004

Evidence about the health risks posed by exposure to second-hand smoke has strengthened with an updated report by the US Surgeon General in 2006.(116)

The International Agency for Research Against Cancer (IARC) has recently reported its expert scientific review of the effectiveness of smoke-free policies in reducing population exposure to second-hand smoke.(117) It determined that there is sufficient evidence to accept that laws restricting smoking in workplaces and other public places reduce population exposure to second-hand smoke and consumption of cigarettes, and respiratory symptoms in workers. It found that such policies provide net benefits to business, with no adverse affects on overall sales in the hospitality industry.(118) Smoke-free policies at home increase adults' chances of quitting.(119) and reduce the likelihood of children taking up smoking.(120-122)

Alarming levels of exposure to toxic substances have been documented in children travelling with adults who smoke inside cars,(123-125) with greater concentrations resulting from airflow when windows are open.(126) Community support to ban smoking in cars carrying children is now high.(127, 128) Smoking in cars is more common in lower SES families,(129, 130) so legislation restricting smoking in motor vehicles may have a differential effect on exposure to tobacco smoke and attitudes to smoking in more disadvantaged groups.

The extension of smoke-free policies to pubs in New Zealand in December 2004(131) may have been a major factor contributing to a decline of smoking in that country after several years of stalled smoking rates.(132) A recent international study of adolescents from 32 countries in Europe, Israel and North America found a strong relationship between the adoption of national smoke-free laws and declines in adolescent smoking.(98)

A review(133) and several very well-designed studies(134, 135) confirm early suspicions(136) that the introduction of smoke-free policies is followed by a rapid reduction in heart attacks among both smokers and non-smokers.

Progress against international comparators

Over the past four years, all Australian states and territories have extended legislation to reduce public exposure to second-hand smoke: progress in Australia has been comparable to that in the US. Legislation applies to hotels (except in the Northern Territory, where limited legislation has been announced but not yet drafted) and nightclubs as well as to restaurants, with exceptions relating to gaming areas in some jurisdictions. Because legislation has been introduced at different times in different places, several loopholes and inadequacies have emerged in some aspects of operation and enforcement . A recent study by the NSW Health Department of outdoor areas where smoking is still allowed in pubs detected 'poor' air quality well above the WHO-recommended 24-hour exposure limit of 25 micrograms per cubic metre. A third of pubs recorded twice the limit, with some areas exceeding it by 500%.(137)

Bans on smoking in cars are being adopted by an increasing number of North American jurisdictions.¹⁴ Smoking in vehicles where a person under 16 years of age is also present has been banned in South Australia since May 2007.¹⁵

¹⁴ Laws prohibiting smoking in vehicles carrying children have been adopted in the Canadian provinces/territories of Nova Scotia, Ontario, British Columbia and the Yukon Territory; the Canadian municipalities of Wolfville (Nova Scotia), Surrey (British Columbia) and Okotoks (Alberta); the US states of California, Maine, Arkansas and Louisiana; the US municipalities of Bangor (Maine), Keyport (New Jersey), West Long Branch Borough (New Jersey) and Rockland County (New York); as well as South Africa and Puerto Rico. Bills have been announced in the provinces of Prince Edward Island and Manitoba.

¹⁵ Tobacco Products Regulation Act 1997 (SA) s.48).



Bans on smoking in vehicles containing persons less than 18 years of age became effective in Tasmania in January 2008.¹⁶ The Queensland government announced its intention to ban smoking in cars carrying persons less than 16 years of age in May 2008.¹⁷ Governments in New South Wales(138, 139) and Victoria(140) have also indicated that they will shortly legislate, and the ACT is also considering such legislation.(141)

In several states in the US there has been much discussion about the problem of smoke-drift between apartments, some attempts at legal action(142) and growing pressure for legislation.

ACTION PROPOSED

Review and if necessary amend state and territory legislation to cover the loose ends and address loopholes.

All governments (that have not already done so) to legislate a ban on smoking in cars carrying children.

All state governments to legislate to require leases for multi-unit apartment buildings and condominium sales agreements to include the terms governing smoking. Owners could be encouraged to make common areas smoke-free with agreed penalties for breaches, and (given the likelihood of increasing demand)(143) to consider making large sections of apartment complexes completely smoke-free.

3.1.3 PLACE OF SALE

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

Additional evidence since 2004

The display of tobacco products in stores contributes to the perception that cigarettes are widely and easily available, and that smoking is the norm. The prominence of such displays may lead young people to overestimate smoking prevalence among peers and the adult population.(144) Perceived availability(145) and overestimation of smoking prevalence(146) have both been shown to predict smoking initiation.

Two recent Australian studies demonstrate the powerful impact of retail displays on both children and adult smokers.(147, 148) The first study shows that children who viewed cigarette displays perceived that it would be easier to purchase tobacco, and tended to recall displayed cigarette brands more often than respondents who saw no cigarettes.(147) A survey of adults found that cigarette displays act as cues to smoke, even among those not explicitly intending to buy cigarettes and among those trying to avoid smoking.(148)

Given the higher prevalence of smoking and the greater prominence of tobacco in retail outlets in disadvantaged areas,(149) this measure may also have a greater effect on children living in more disadvantaged neighbourhoods.

Progress against international comparators

Jurisdictions that have prohibited the display of tobacco products include: Iceland (2001), Thailand (2005), British Virgin Islands (2007), Ireland (2008) and Canada (12 provinces).(150) The Canadian federal government has consulted on introducing regulations for a national display ban,(150, 151) as have governments in New Zealand (which plans to introduce legislation in 2009), Norway and Britain.(42)

16 Public Health Act 2007 (Tas) s.67H.

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



In Australia, governments have introduced legislation to ban displays in Tasmania (2011),¹⁸ the Australian Capital Territory (December 09),¹⁹ the Northern Territory (2010)(152) and New South Wales (2010).(139) The Victorian government is also currently consulting about such legislation.(153)

ACTION PROPOSED

Amend the Tobacco Advertising Prohibition Act 1992 (Cth)(154) to prohibit the display of tobacco products in all states and territories.

3.1.4 PROMOTION

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

PROMOTION THROUGH NEW MEDIA AND EVENTS

Additional evidence since 2004

In a comprehensive scientific review released in August 2008, the US National Cancer Institute (NCI) concluded that the total weight of evidence from multiple types of studies demonstrates a causal relationship between the promotion of tobacco and increased tobacco use.(155) Both industry documents and scientific studies show that promotion continues to involve highly sophisticated targeting and segmentation of both existing and potential users; that the tobacco industry does not effectively self-regulate its marketing practices; and that companies typically respond to partial

bans by increasing expenditure in 'permitted' media, including payments to retailers and proprietors of entertainment venues and through new media forms developing as a result of emerging technology. The NCI report also points to activities designed to enhance public image and affect attitudes to smoking, such as entertaining influential individuals, sponsorship and donations to 'good causes'.(156)

Progress against international comparators

Australia's Tobacco Advertising Prohibition Act 1992 and tobacco control legislation in the states and territories effectively prevents most promotion of tobacco through traditional forms of media. However, many newly emerged forms of marketing aimed primarily at young adults (such as viral marketing through internet sites, entertainment venues and events) also influence teenagers.(157) Staggering numbers of people are using social networking sites. Facebook had over 58 million users at last count and spending by US advertisers on word-of-mouth advertising exceeded \$1 billion in 2007.(158) Submissions from expert health agencies(159) to a review of the Act in 2003(160) identified numerous loose ends and important loopholes that need to be addressed to ensure that the Act remains effective into the 21st century.

The Canadian Government is in the process of modernising its legislation restricting the advertising of tobacco products. In Australia, Ministers agreed at the May 2007 meeting of the Ministerial Council on Drug Strategy that all governments collaborate to ban the sale and advertising of tobacco products over the internet. Legal advice indicated that it is open to the Commonwealth to legislate,²⁰ and the Department of Health and Ageing is currently developing a regulatory impact statement.

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

19 Tobacco Amendment Bill 2008 (ACT) cl.20.

20 Since 2004, sale of tobacco products through the internet has been banned in jurisdictions such as Brazil, New York, Connecticut and Alaska. Placement of advertisements on the internet is banned in Hong Kong.



However, none of the other recommendations from the 2003 review has been acted on.

Draft guidelines shortly to go before the WHO's Conference of Parties specify that in addition to plain packaging and bans on point of sale displays and corporate communication, legislation to restrict promotion by the tobacco industry should also cover modern communication technologies including the internet, satellite television and mobile telecommunications.

ACTION PROPOSED

Modernise the Tobacco Advertising Prohibition Act 1992 (Cth) and ban all remaining forms of promotion in line with the draft Elaboration of guidelines for implementation of Article 13 of the Framework Convention on Tobacco Control.(41)

SMOKING IN MOVIES, TV PROGRAMS, MAGAZINES AND ELECTRONIC GAMES

Additional evidence since 2004

Smoking is portrayed in movies to a much greater extent than it occurs in real life. (161-170) Reviews of the evidence by several scientific bodies(43, 171, 172) and several well-designed studies and meta-analyses(173-177) conclude that smoking by popular characters can exert a powerful influence on teenagers, particularly those with temperaments that make them prone to seeking novelty and excitement.(178, 179)

Tobacco-control experts in different countries differ as to the best approach to this problem. (180-182) Bans or automatic ratings for products depicting smoking are strongly opposed by the film and television industries, and would also not be supported by most public health advocates in Australia.

One study has shown that the screening of anti-smoking advertisements before films depicting smoking would reduce the impact of such depictions,(183) but advocates fear that such advertisements would quickly become counter-productive unless they had high production values and were frequently replaced. Providing them would be expensive and labour intensive.

Progress against international comparators

The Motion Picture Association of America and the government classification authority in the UK both now include the depiction of tobacco smoking as one of the factors taken into account when new movies are classified. As the rating of films in the US in particular has commercial implications – it affects audience numbers – this policy may result in fewer depictions of smoking in movies intended for younger audiences being produced in Hollywood studios. So far the effects of this policy have not been dramatic. Prominent US advocates point to films that they believe are rated less restrictively than they should be, and continue to vigorously push for further restrictions.(184)

Australia could follow the lead of the US and the UK, and require the Classification Board to take smoking into account when rating films. Such a move would be consistent with broader government policy on censorship and classification. It is also likely to be supported by parents, and may result in fewer damaging depictions of smoking in films seen by younger teenagers.



ACTION PROPOSED

Designate tobacco use as a 'classifiable element', to be taken into account by the Classification Board when rating films (with the consequence that films with particularly seductive portrayals of smoking would be likely to be given a more restrictive classification²¹).

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

Fund a project to raise awareness among people working in the Australian film and entertainment industries of the damaging effects of seductive portrayals of smoking in popular entertainment viewed by children.

Include training to decode depictions of smoking in movies in drug education in schools.

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

PROMOTION THROUGH PACKAGING

Additional evidence since 2004

Cigarette brand names and package design enable the communication of personal characteristics, social identity and aspirations,⁽¹⁸⁵⁾ and are a crucial aspect of marketing the product.^(186, 187)


Consumer research indicates that decreasing the number of design elements on the packet reduces its appeal and perceptions about the likely enjoyment and desirability of smoking.⁽¹⁸⁸⁾ Requiring cigarettes to be sold in plain packaging would reinforce the idea that cigarettes are not an ordinary consumer item. It would also reduce the potential for cigarettes to be used to signify status. Plain packaging would increase the salience of health warnings: research subjects show an improved ability to recall health warnings on plain packs.⁽¹⁸⁹⁻¹⁹¹⁾

Plain packaging would prohibit brand imagery, colours, corporate logos and trademarks, permitting manufacturers only to print the brand name in a mandated size, font and place, in addition to required health warnings and other legally mandated product information such as toxic constituents, tax-paid seals or package contents. A standard cardboard texture would be mandatory, and the size and shape of the package and cellophane wrapper would also be prescribed. A detailed analysis of current marketing practices⁽¹⁸⁷⁾ suggests that plain packaging would also need to encompass pack interiors and the cigarette itself, given the potential for manufacturers to use colours, bandings and markings, and different length and gauges to make cigarettes more 'interesting' and appealing. Any use of perfuming, incorporation of audio chips or affixing of 'onserts' would also need to be banned.

Industry opposition to restrictions on pack design is a strong indication of its importance to tobacco sales.⁽¹⁹²⁾

'In our opinion, (after taxation) the other two regulatory environment changes that concern the industry the most are homogenous packaging and below-the-counter sales. Both would significantly restrict the industry's ability to promote their products.' Morgan Stanley Research (2007)⁽¹⁹³⁾

²¹ Other classifiable elements are themes of violence, sex, language, drug use and nudity, as set out in the Guidelines for the Classification of Films and Computer Games 2005.



UK investors obviously agree that plain packaging would reduce profitability. When the UK Government released its consultation paper flagging its intention to introduce such a policy, the price of stocks in Imperial Tobacco fell 3.6%.⁽¹⁹⁴⁾

Nevertheless, the tobacco industry appears surprised that governments have taken so long to move on plain packaging. In its registration filing to the US Securities and Exchange Commission in 2007, US Philip Morris International specified 'restrictions on packaging design, including the use of colors and generic packages' as one of several possible regulatory developments on the horizon.²²

Progress against international comparators

Tobacco companies have increasingly used packaging to manipulate the image of new and existing brands.⁽¹⁹⁵⁾ Proposed guidelines for the Framework Convention on Tobacco Control's Article 11 (Packaging and labelling) and Article 13 (Tobacco advertising, promotion and sponsorship) encourage parties (governments) to consider the introduction of plain packaging for tobacco products.⁽⁴¹⁾

ACTION PROPOSED

Require all tobacco products to be sold in plain packaging, the exact appearance of which (precise colour, paper finish, shape of pack etc) could be prescribed in regulations under the Trade Practices Act 1974.

Commission research to determine exactly how packs should be designed to minimise appeal to young people.

3.1.5 PRODUCT INFORMATION FOR CONSUMERS

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

HEALTH WARNINGS

Progress against international comparators

In 2006, after many years of negotiation, testing^(196, 197) and assessment,⁽¹⁹⁷⁾ the six black text warnings on white background covering 25% of the front and 33% of the back of cigarette packets that had been required in Australia since 1994⁽¹⁹⁸⁾ were replaced with 14 graphic warnings covering 30% of the front and 90% of the back of the pack.⁽¹⁹⁸⁻²⁰⁰⁾ Long delays were observed in cigarettes with new warnings actually being available in shops.⁽²⁰¹⁾ In November 2007 the Department of Health and Ageing commissioned Elliot and Shanahan Research to conduct an evaluation of current warnings, due for completion in October 2008.

Belgium (2006), Brazil (2002, improved in 2004 and again in 2008), Canada (2001), Chile (2006), India (2007), Jordan (2006), New Zealand (2008), Singapore (2004, and again in 2006), Thailand (2005, and again in 2007), Uruguay (2006) and Venezuela (2005) have now all finalised laws requiring picture-based warnings.

Countries in the 27-member European Union (EU) have the option of requiring picture-based warnings, choosing from among 42 picture messages prepared by the European Commission. The UK will require graphic warnings from October 2008.²³ The governments of the Czech Republic, Hong Kong, Iran, Ireland, Latvia, Malaysia, Mexico, Portugal, Romania and South Africa have all stated that picture-based warnings are now under consideration.⁽²⁰²⁾

22 See www.secinfo.com/d14D5a.u6bRr.c.htm#_toc72753_5.

23 See The Tobacco Products (Manufacture, Presentation and Sale) (Safety) (Amendment) Regulations 2007 www.opsi.gov.uk/si/si2007/uksi_20072473_en_1.



Most countries requiring graphic warnings specify that these take up around half the pack (50% in Canada, Singapore, Thailand, Uruguay, India and Chile; 48% in Belgium and Switzerland including borders; 45% including borders in Finland; and 43% in uni-lingual EU countries, Norway and Iceland). Three countries – Brazil, Panama and Venezuela – require a health warning covering 100% of one face of the pack.

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



Figure 18: Examples of health warnings required on cigarettes in Singapore (neck cancer) and in Thailand (throat cancer)

Additional evidence since 2004

A study of Australian teenagers indicated that new graphic health warnings introduced in 2005 resulted in increased cognitive processing of package information, and a greater likelihood of experimental and established smokers thinking about quitting.(203)

If it is accepted that cigarette packages should display product information for consumers, it follows that such information should communicate with consumers as effectively as possible.

Research recently undertaken for the Canadian Government found that health warnings occupying 75% of the pack were more effective than warnings occupying 50% of the pack in conveying information about the health risks of smoking.(204) Based on the analysis of 38 different indicators, researchers concluded, however, that warnings needed to increase to 90% in order to 'connect with emotions of various styles of young smokers' and 'make cigarette packs less attractive'.

New evidence about the health effects of smoking emerges literally every day, yet warnings on cigarette packs in Australia have been reviewed only three times in the past 20 years.(205, 206) Monitoring over four years of the ITC 4 nations study shows clearly that the effects of the warnings decay, suggesting the need for frequent rotation and the regular introduction of new warnings.

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

ACTION PROPOSED

Amend Schedule 2 to the *Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004*,(198) to prescribe that health warnings must cover at least 90% of the front and 100% of the back of the pack.

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

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



INGREDIENTS DISCLOSURE

Progress against international comparators

Since 1999 the three tobacco companies currently manufacturing cigarettes in Australia – Philip Morris Limited (PML), British American Tobacco Australia Limited (BATA) and Imperial Tobacco Australia Limited (ITA) – have provided ingredient data to the Australian Government Department of Health and Ageing under a *Voluntary Agreement for the Disclosure of the Ingredients of Cigarettes*.⁽²⁰⁷⁾ The manufacturers provide annual reports, which are posted unmodified on the Australian Government Department of Health and Ageing's website.⁽²⁰⁸⁾ As per the agreement, the manufacturers provide: composite lists of tobacco ingredients (including flavourings), with the functions of each ingredient (filler, flavour, humectant, preservative, binder etc) also listed; and composite lists of non-tobacco ingredients in alphabetical order, with each product's ingredients listed separately, processing aids and preservatives combined under each heading, and by-brand variant lists of ingredients listed in descending order by weight.

In May 2007 Ministers agreed that a feasibility study on ingredient disclosure would be commissioned to investigate the legal issues, appropriate powers, costs, suitable locations, timelines, potential risks and other ramifications of formalising these arrangements in law. The study, currently in progress, sets out to identify the information needs of consumers, scientists and policy makers.

Meanwhile, the Conference of the Parties to the WHO Framework Convention on Tobacco Control is also developing detailed guidelines about the disclosure of ingredients and emissions.⁽²⁰⁹⁾ See 16. below for further details and action proposed.

DISPLAY OF TAR, CO & NICOTINE YIELDS

The current method for measuring the yields of carbon monoxide and 'tar' from cigarettes using cigarette machines set to standard-puff protocols has now been widely discredited.⁽²¹⁰⁾ Such testing does not accurately reflect delivery to humans, and the smoking of low-tar cigarettes in the US has not been associated with a reduction in health risks.⁽²¹¹⁾ By placing ventilation holes in the filters, air is mixed with the smoke, and companies have been able to quote low machine-tested levels of tar delivery.^(212, 213) However, humans do not smoke like machines. Smokers soon learn to cover the holes in order to get a full dose of nicotine,⁽²¹⁴⁾ and it seems that they get a full dose of tar in the process.⁽²¹⁵⁾

Progress against international comparators

The Australian Government has ended the legal requirement to display yield information on packs; however, the current legislation does not prohibit it.²⁴ The only constraints on manufacturers displaying yield information and descriptors such as 'light' and 'mild' arise under the undertakings accepted by the Australian Competition and Consumer Commission (ACCC) in 2005 from Philip Morris, British American Tobacco Australia Limited and Imperial Tobacco Australia Ltd. While the undertakings given by each manufacturer differed slightly, each agreed to cease displaying descriptors and yield information on packs. Tobacco companies that are not subject to these undertakings face no restrictions. Light and mild descriptors were banned throughout the EU from September 2003, and the US Federal Trade Commission is currently reviewing regulations pertaining to descriptors and labelling.⁽²¹⁶⁾

24 See Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004 (Cth).



Additional evidence since 2004

The ITC 4 nations study found that by 2006, inaccurate beliefs about the health benefits of light cigarettes were just as common among smokers in the UK as they had been before the EU ban took effect.(217) The researchers conclude that efforts to correct decades of consumer misperceptions about light cigarettes must extend beyond simply removing 'light and mild' brand descriptors.

ACTION PROPOSED

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

3.1.6 PRODUCT

CIGARETTE INGREDIENTS, DESIGN AND TOXICITY

Cigarettes sold in different countries vary widely in the delivery of toxic substances.(218) While additives to food products are heavily regulated, there are currently no restrictions in Australia on accepted levels of pesticide residues in tobacco, on substances added to cigarettes during manufacture or, most importantly, on the levels of toxic substances that are delivered to smokers when they inhale.(219) Given that cigarettes in some countries deliver much lower levels of these known toxicants than cigarettes in other countries, and given how much industry scientists know about the toxicology of cigarettes, it ought to be possible for manufacturers to manipulate the tobacco content, additives and design of cigarettes in order to minimise the delivery of specified toxins.(220, 221)

Additional evidence since 2004

Cigarettes in Australia have relied heavily on filter ventilation to reduce machine-measured tar levels that bear little resemblance to levels of toxins delivered to typical smokers.(222) Any labelling system based on machine-testing methods that do not mirror human smoking behaviour is likely to mislead consumers.(223) It is difficult to think of a justification for continuing to allow filter ventilation.(224)

A review of tobacco industry documents showed that more than 100 of 599 documented cigarette additives have pharmacological actions that camouflage the odour of environmental tobacco smoke, enhance or maintain nicotine delivery, or mask symptoms and illnesses associated with smoking behaviours.(225)

Progress against international comparators

An expert scientific committee (TobReg) established by the WHO to advise on cigarette regulation has recommended that governments mandate the progressive lowering of a number of known toxicants in cigarette smoke, in much the same way as the levels of lead in petrol were progressively reduced over the 1980s.(226) Concerns have been raised that attempts to lower the toxicity of cigarettes would be used by tobacco companies to give smokers false reassurance and discourage them from quitting.(227) Such a proposal should not be contemplated without a full ban on all forms of tobacco advertising and promotion, including public relations activities – see I 4. above.

More recently, a working group established by the Conference of the Parties and facilitated by the governments of Canada, the EU and Norway has elaborated guidelines for implementing Articles 9 and 10 of the WHO Framework Convention on Tobacco Control.(209)



It has set out priorities for the testing of contents (nicotine, ammonia and several humectants) and nine different toxic emissions, to be quantified using four different validated methods: one for the two tobacco-specific nitrosamines, one for benzo(a)pyrene, one for the two targeted aldehydes and one for the three targeted volatile organic compounds. With assistance from the WHO Tobacco Laboratory Network, the working group has set out a work plan for the validation of testing methods and has considered mechanisms for financing. The working group considers that the main purpose of regulation at this point is to collect data to enable governments to take appropriate action when there is sufficient evidence to warrant such action. It is working on a proposal to establish a global data repository, and is aiming to develop a set of guidelines for possible adoption by the Conference of Parties at its fourth session, in 2009.

Unlike the situation in Canada, New Zealand, the UK, the EU, Thailand and the US,²⁵ Australia currently lacks legislation that would enable the Commonwealth Government to enforce the necessary restrictions, or indeed to impose any restrictions at all.²⁶(228)

ACTION PROPOSED

Introduce legislation that gives the government powers to ban, specify or mandate any particular tobacco product constituents, emissions, additives or other aspects of manufacture and design. In the process, establish a regulatory body, or give powers to an existing regulatory body, to advise the government on appropriate action.

The regulator would be responsible for authorising the form and content of all communication with consumers about the contents and toxicity of cigarettes, both through information on the packaging and any additional information on government websites or elsewhere.

Legislation to establish regulatory capacity over the content of tobacco products should be preceded by a ban on all forms of tobacco promotion, including public relations activities.

ORAL TOBACCO

Additional evidence since 2004

Several major reviews(229-231) and longitudinal studies(232-237) have concluded that low-nitrosamine smokeless tobacco products, such as Swedish snus (a form of powdered tobacco sold in teabag-like packages that are kept in the mouth and sucked), are less harmful than cigarettes and other tobacco products that are smoked.

25 Legislation giving the US Food and Drug Administration power to regulate tobacco products has passed the House of Representatives and is currently under consideration in the Senate (New York Times, 31 July 2008).

26 In 2007 the government found it was unable to ban fruit-flavoured cigarettes under any current national legislation, despite the product being blatantly attractive to children.



PROGRESS AGAINST INTERNATIONAL COMPARATORS

Oral tobacco products are sold in the US, Sweden and much of Asia and Africa. In Australia, a ban in place since 1989(238) on the retail supply of oral tobacco products (snuff/snus and chewing tobacco) under the *Trade Practices Act 1974* permits individuals to import only small quantities for personal use under the *Customs (Prohibited Imports) Regulations 1956*. Other oral products, where tobacco is not the primary constituent – such as betel nut, pan masala and other products imported from Africa, Asia and the Indian subcontinent – are not captured. In mid-2006 the duty payable on these products was aligned with that on loose tobacco. Changes in custom codes over the past few years make it difficult to assess the extent to which imports of these products is increasing.

Some health experts, including some in Australia,(239) have called for the wider availability of low-nitrosamine smokeless tobacco.(240-245) Others are more cautious, not least on the basis of the risks from these products themselves, as well as the manner in which they might be promoted.(245, 246) For the moment, most health agencies and advocates(247, 248) support the continuation in Australia of the restricted importation of smokeless tobacco products for personal use, ensuring that current users are not denied access, while deterring non-tobacco users (particularly youth) from commencing.

ALTERNATIVE NICOTINE DELIVERY DEVICES

In the last couple of months a proliferation of new devices providing nicotine in products other than those that need to be lit and inhaled have been launched into various markets around the world. Alternative nicotine delivery devices (ANDS) include products such as sweets, hand gel,(249) mouth washes and electronic cigarettes.(249-251)

Electronic cigarettes consist of a tubing device resembling a conventional cigarette. This heats a replaceable cartridge filled with liquid nicotine and other chemicals (i.e. it does not contain tobacco leaf). The heating process creates a mist that resembles cigarette smoke and is inhaled by the user. The e-cigarette is marketed by some companies as a healthier alternative; for example, 'Egar Cigarette can be used legally indoors, in restaurants – ANYWHERE you wish, where traditional smoking is prohibited! ... Beat the smoking ban!' ²⁷

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

As with smokeless tobacco, health experts have differing views about the usefulness of these products.(252, 253) Concerns are not easily dismissed about the potential of such products to attract young people who would not otherwise have used any form of nicotine, and to then act as a gateway to cigarettes.

²⁷ See www.egar.com.au, 5 June 2008.



Also worrying is the possibility that adults who might otherwise have given up tobacco completely could remain dependent on nicotine, helped by the availability of such products, and return to cigarettes, which are always likely to be a superior delivery device. (248, 254) Modelling of the potential benefits and harms suggests the need for restricting the availability of such products to long-time users who are unable to quit. However, such an approach would have few public health benefits unless large numbers of these smokers knew about such alternative products and were willing to try them. This conundrum will continue to be debated. (242, 244, 245, 255-261)

ACTION PROPOSED

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

3.1.7 PRODUCERS AND PURVEYORS

Almost all adult smokers regret that they ever started. (262) Dependence on tobacco-delivered nicotine appears to develop very rapidly in teenagers. (263-267) and exposure of the developing adolescent brain to nicotine may result in long-lasting deficits in cognitive functioning. (268) People who take up smoking as teenagers tend to become heavier smokers and are less likely to give up. (269) and they are more likely to develop diseases caused by smoking. (270, 271) Under these circumstances, it is unacceptable for anyone under any circumstance to sell cigarettes without checking for proof of age.

LICENSING OF RETAILERS

Additional research since 2004

Tobacco retail outlets are highly concentrated in lower socio-economic areas. (272) A Californian study has found a higher prevalence of smoking among students in schools with a higher density of retail outlets, even after adjusting for neighbourhood demographics. (273) Retailers in lower SES areas in the US appear to be more likely to sell cigarettes to minors than retailers in higher SES areas. (274-276) Reductions in the availability of tobacco products are associated with lower levels of smoking. (277)

Progress against international comparators

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

A detailed report commissioned by the Australian Government in 2002 (278) concluded that licensing of retailers was the most effective way of informing tobacco retailers and wholesalers of their legal obligations, and of ensuring that authorities had the information necessary to enforce tobacco control laws. Licensing would give 'teeth' to bans on selling tobacco products to under 18s, and other laws relating to tobacco sales, such as those governing point of sale displays and tobacco advertising. Linking a retailer's tobacco licence to compliance with tobacco control measures gives authorities the ability to suspend or withdraw the right to sell tobacco products in the event of a breach. In Tasmania, for example, sales of tobacco products to children are immediately prosecuted, and any second offence is punishable by the imposition of a \$10,000 fine and licence cancellation.²⁸

²⁸ See Tasmanian Health and Human Services Agency website, www.dhhs.tas.gov.au/agency/pro/tobacco/salestochildren.php, visited on 23 May 2006. See also Division 3, Public Health Act 1997 (Tas).



The report stated that a *best practice* scheme would incorporate features including a positive licensing approach, where prior approval was required and compliance with minimum conditions needed to be demonstrated before sales could commence; licences applicable to each particular retail venue rather than each operation; and a graduated penalty structure, including warnings, administrative penalties, prosecutions and scope for licence withdrawal.²⁹

As at 1 June 2008, positive retailer licensing schemes were in place in the ACT,³⁰ the Northern Territory,³¹ South Australia³², Western Australia³³ and Tasmania,³⁴ and a similar scheme had been proposed for New South Wales.³⁵

ACTION PROPOSED

Governments in Victoria and Queensland to amend legislation in line with that in other states to require all retailers of tobacco products to hold a licence.

LICENSING OF MANUFACTURERS

Additional research since 2004

In 2005 tobacco companies would have received revenue from the sales of cigarettes from children exceeding \$15 million (over \$9 million would have been received by retailers and \$46 million by governments).(109)

Progress in Australia

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

ACTION PROPOSED

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

If an agency is created specifically to regulate tobacco products (as per Section 1.6. above), the responsibility for the licensing of manufacturers could be transferred to that agency.

29 Precedents include laws governing civil liability claims, and the National Classification Scheme for films, computer games and certain publications.

30 Tobacco Act 1927 (ACT), s. 63.

31 Tobacco Control Act (NT), s. 28.

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

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

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

35 See at p12 of paper at www.health.nsw.gov.au/pubs/2008/pdf/protecting_children_from_tobacco.pdf.



3.2 Public education: Increase promotion of Quit and smoke-free messages

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

Additional evidence since 2004

In August 2008 the US National Cancer Institute released a comprehensive scientific review of all available international evidence concerning the impact of the media on smoking attitudes and behaviour.(279) Some of the major research (including some important Australian research) summarised in the review and some of its major conclusions are set out below.

Media campaigns are effective

Studies of smoking trends in jurisdictions with and without media campaigns in the early 1980s in Australia(280, 281) and elsewhere(282, 283) indicate that they can be extremely effective in reducing smoking prevalence. In a globalised media environment it is no longer possible to conduct randomised controlled trials, given that comparison groups are likely to be exposed to 'treatment' via unpaid coverage in the news media, and given that both groups will be affected by prior and background exposure. The NCI experts considered the complex and multidimensional effects of media on consumer attitudes and behaviour, the effects on norms and opinions, the short- compared with the long-term effects, the direct effects and the diffusional effects through others. They also note the differential effects on different population sub-groups and on different kinds of content and context. Considering all the available evidence, the Institute concludes on balance that well-funded campaigns can reduce smoking prevalence, with the extent of reductions highly related to levels of media expenditure.(284)

More broadcast volume, more change

In one of the studies highlighted in the report, Farrelly et al. in the US show that increases in per capita spending on tobacco control programs in each state were independently associated with declines in prevalence. They find that if all states had funded their tobacco control programs since 1995 at the minimum or optimal levels recommended by the Centers for Disease Control and Prevention, by 2003 there would have been up to seven million fewer smokers in the US.(285) Another US study finds a clear relationship between overall state spending on tobacco control and changes in youth rates.(286)

Australian data also suggests that the level of spending on media campaigns determines the extent of changes in smoking prevalence.(287)

Figures 19 and 20 show smoking prevalence falling among both teenagers and adults when spending on media campaigns and Television Audience Rating Points (TARPs) increased in the late 1980s, and following the launch of the National Tobacco Campaign in 1997 in Australia.

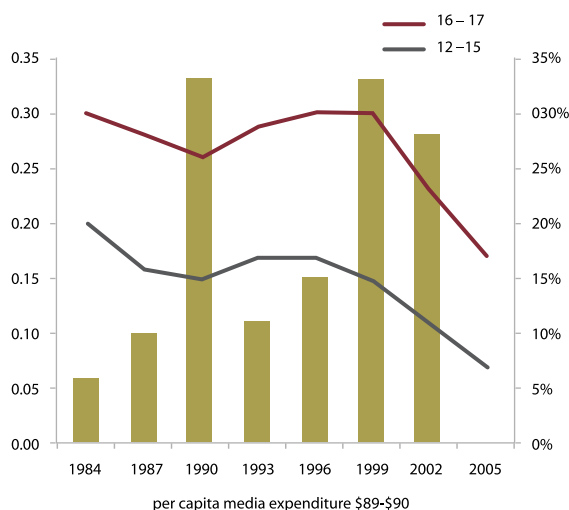


Figure 19: Average expenditure on mass media campaigns (\$89-90, average for previous three years) compared with smoking prevalence among students aged 12-15 years, Australia, 1984-2005(44)

Sources: ASSAD 1984 to 2005,(44) reports by government and non-government bodies on spending on tobacco control in Australia(32-34)

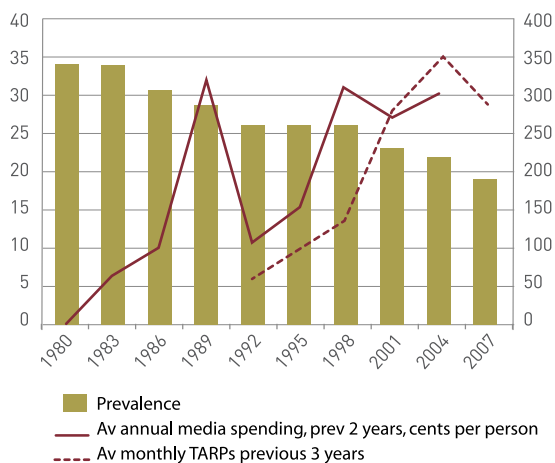


Figure 20: Proportion of adults aged 18+ smoking compared with expenditure on media campaigns and average monthly Television Audience Rating Point, Australia, 1980–2007
 Source: National Drug Strategy Household Survey,(31) CBRC compilations of media spending(32) and AC Nielsen media TARPs(288)

Prevalence flattened in the early 1990s, when spending was reduced. Similar flattening-offs in declines were observed in California in the mid-1990s,(289) when funding raised from taxes on tobacco was diverted to other programs, and tobacco companies more than tripled spending on outdoor and print advertising so that from 1990 to 1993 the tobacco industry outspent the Proposition 99-funded media campaign by 10 to 1.(290)) This trend was also observed in Florida when funding on the high-profile *Truth* campaign was slashed in 1999.(291)

A study in Massachusetts specifically explored the media weight needed in order to prompt cessation. For every increase of 100 General Rating Points per month during the prior two years, the likelihood of quitting increased by 21%. Compared to smokers who had the lowest level of exposure (about 280 GRPs per month), those who had the highest (about 838 GRPs per month) were more than four times more likely to be an ex-smoker two years later.

Based on the levels of response observed over the past 15 years in Australia, and taking into account the findings from studies internationally, members of the expert panel overseeing the report³⁶(284) advise that media spending on Quit campaigns should be high enough to achieve at least 700 TARPs per month.

Media campaigns work with blue-collar groups

Some commentators have questioned the relative effectiveness of media-led campaigns among different socio-economic groups.(292)

Analysis of smoking prevalence over the first two periods of the National Tobacco Campaign in Australia shows that changes in smoking rates among blue-collar groups have been of a similar magnitude to changes among white-collar groups. Between 1997 and 1999, prevalence fell 3.9 percentage points in blue-collar groups and 3.7 percentage points in white-collar groups.(293) This is consistent with the results of earlier research that showed no increase in the disparity between smoking rates among groups with different levels of education after the early Quit campaigns in Sydney and Melbourne.(294, 295)

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

A study of smoking among children in suburbs with varying degrees of socio-economic disadvantage in all Australian states and territories between 1987 and 2005 indicates that smoking prevalence decreased in all SES groups.(45) However, the *level* of tobacco-control activity affected the consistency of change across different SES groups, particularly in teenagers aged 12–15 years, the period of peak smoking uptake. As indicated in Table 3, in the period of low tobacco control funding and activity in Australia (1990–1996), smoking prevalence increased among 12–15-year-olds, with the greatest increase among low SES students. In a period of high tobacco-control activity (1997–2005), in contrast, smoking decreased quite sharply and reductions were consistent across SES groups. The prevalence of smoking increased very sharply in low SES teenagers during the period of low tobacco control activity, whereas there was little change among the higher SES teenagers.

36 Australia’s Professor Melanie Wakefield was one of the two senior scientific editors on the Monograph.



Table 3: Absolute changes in reported smoking prevalence among 12–15-year-olds in schools in areas of varying SES quintiles during high and low periods of tobacco control activity, Australia, 1997–1990, 1990–1996 and 1996–2005

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

Source: White, Hayman and Hill, 2008(45)

Some types of ads work better than others

A recent review of 29 studies has demonstrated that media campaigns can be equally effective with low SES groups, but that attention must be paid to the placement and style of advertising.(296)

Low SES groups have been found, for instance, to watch more daytime and late-night television, and to favour particular radio genres.(297) Emotional narrative communication may be a better method for low SES groups because it enables people to fully and vividly imagine how it would feel to have a smoking-related disease. Such advertisements do not rely on explicit arguments or information (which require an assessment of the merits of the message, and acceptance of the argument/message).(298-300)

Theorists(301) have proposed that narrative messages (embedded in the lessons of personal stories) may enhance impact and persuasion through minimising smokers’ ability and motivation to counter-argue against a specific argument or message. Emotionally arousing stories are also more likely to be discussed with others,(302, 303) and, once shared, are more likely to survive and be rehearsed.(304) Messages that are personally relevant and emotionally engaging are more likely to increase perceptions of susceptibility to health risks, and be passed on to others through interpersonal communication. Narratives are more likely to trigger self-relevant emotional responses, as the viewer is ‘transported’ or absorbed into the emotional experience of characters with whom they identify.(305, 306) The use of stories in public health communication has previously been found to be very effective through education programs and in popular entertainment,(307) as well as in anti-smoking advertising.(308)

PROGRESS IN AUSTRALIA

Reaching low SES groups

Quit campaigns in Australia have gone to considerable lengths to target media placement (both in terms of timing, program type and particular shows), and to design advertisements for and pre-test them with low SES groups to ensure that they reach and influence people of lower socio-economic status.(309-314)

Broadcast volume

Only New South Wales currently sustains average TARPs greater than 700 per month. Media advertising outside New South Wales, Western Australia and Victoria appears to be sporadic.

Other than spending by the NSW Cancer Institute (more than \$12 million in 2007(315)), spending on Quit campaigns is considerably lower than the advertising budgets of major commercial retailers in Australia, at less than \$10–15 million in total around the country.



Table 4: Media advertising budgets for typical consumer and service companies, Australia, 2007

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

Source: Nielsen Media Research AdEx, Jan–Dec 2007(315)
Excludes spending on sponsorship and other forms of promotions

In Australia, achieving an average of 700 TARPs per month would cost around \$40 million per year.(316) In order to maximise the reach and impact of the messages, a mix of media channels would be required, including free-to-air and subscription television, cinema, print, radio and magazines. Funds would also be needed for production of new material to ensure maximum emotional impact.

Greater coverage by the media of scientific research related to smoking would enhance the credibility of campaigns

Studies are published in the medical literature literally every week that illustrate or quantify the hundreds of different ways in which smoking worsens many chronic health conditions, increases the risk of contracting various infectious diseases, reduces fertility, impairs functioning, reduces quality of life and compromises recovery after medical or surgical treatment. While people working in tobacco control frequently see details of such studies, very little of this material reaches the wider community.

Many additional stories on smoking could be generated in Australian newspapers and radio stations, with further work done to cull and summarise newsworthy studies and send information to appropriate journalists and media outlets. Chapman and Dominello trialled such a project in New South Wales in 2001,(317) and were able to demonstrate a 25% increase in media coverage resulting from just six media releases of this nature. One person working on this on a full-time basis could maximise the impact of such materials, working with cancer, heart and other health groups, specialist media, and Indigenous and non-English-speaking groups.

ACTION PROPOSED

Relaunch a long-term National Tobacco Campaign in collaboration with state Quit campaigns.

The campaign should achieve reach of a minimum of 700 Target Audience Rating Points per month, requiring funding of at least \$38 million per year (rising in line with media costs) until smoking has declined to below the 2020 targets.

Extra funds should be allowed for an expert group to develop creative material to be pre- and post-tested with low SES groups. This would require funding of around \$3 million per year.

Funding for this campaign should allow sufficient funds (at least \$1 million per year) for a media component tailored to maximise relevance and reach among Indigenous people.

A health advocacy project should also be funded.

A total of at least \$43 million per annum should be invested in these initiatives.



3.3 Improve services and treatment for smokers

In Australia in 2007, more than 4.3 million people classify themselves as 'ex-smokers', outnumbering current smokers by more than four to three.(15) With a steady decline in both the number of cigarettes smoked each day(15) and a decline in the proportion of smokers who smoke heavily,(80) there is little evidence of a 'hardening' of the smoking population.(318)

Stories and advertising in the media and graphic warnings on packs all help to personalise the health risks of smoking and trigger quit attempts. Smoke-free workplaces and public places, and social pressure not to smoke around others give people other extremely good reasons to quit and remain smoke-free,(117, 319) and these policies and restrictions on promotion reduce some of the triggers that increase the chance of relapse. (148, 155)

While population-level strategies will encourage and assist many people to quit, achieving the second goal of the national strategy – to encourage and assist as many smokers as possible to quit as soon as possible – requires attention to the problem of most smokers being dependent on tobacco-delivered nicotine.(320, 321) Heaviness of smoking and other indicators of dependence are highly related to failure in quitting,(82) with SES disparities apparent in levels of nicotine dependence, confidence about and intentions to quit,(84) and the average number of years people smoke prior to quitting.(322) The sheer number of people who once smoked but now do not shows that it is not impossible, but quitting smoking can be a very difficult process nevertheless.(323) Succeeding requires a great deal of determination and the adoption (conscious or not) of strategies to overcome withdrawal and triggers to smoke.

3.3.1 THERAPIES THAT INCREASE SUCCESS RATES

Medicines and supportive counselling

A very large body of research now confirms that an individual's chances of quitting can be increased by taking medications that lessen withdrawal symptoms(324, 325) or reduce the reinforcing effects of tobacco-delivered nicotine.(326-330) While success rates outside clinical trials may be a little lower,(331) there is ample evidence that such medications are still effective with more limited or even without any professional supervision.(332, 333)

There is also overwhelming evidence that a structured program of cognitive behavioural advice and coaching can also be helpful, regardless of whether the assistance is provided one to one,(334) over the phone(335) or in a group(336) (in the community or through work).(337) Well-designed brochures help some people, but this is not enough for most.(337) Success rates are better where advice can be personalised. This can be achieved through computer technologies (such as the QuitCoach(338) available through the government's website), which can be delivered at a much lower cost than printed materials. Programs using text messaging, especially when combined with internet resources, can also be effective.(339) Structured programs generally achieve greater success with increasing contact: four to eight sessions optimises chances at reasonable cost.³⁷(341-343)

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

37 For further details on the effectiveness of pharmaceutical and behavioural interventions, see the frequently updated meta-analyses published by the Cochrane Tobacco Addiction section.

340 Lancaster T, Stead LF, Cahill K, R. W. Aveyard PN and R. HJ. Cochrane Tobacco Addiction Group. 2008(2008 Issue 2): Available from: <http://www.mrw.interscience.wiley.com/cochrane/clabout/articles/TOBACCO/frame.html>



Health professionals

Interaction with the healthcare system provides the opportunity for health professionals to personalise the health risks of smoking to each individual, often at highly 'teachable moments' when they are suffering a serious illness or health incident. Whether carried out by a doctor,(344) dentist,(345) nurse(346) or other health professional, this interaction can motivate quit attempts.

Doctors and other health professionals sometimes feel disquiet about the high number of smokers who relapse, despite their best efforts to provide firm, motivating advice and medications. But as Russell noted back in 1979, because as a workforce general practitioners see a large proportion of smokers each year, even small effects can contribute significantly to reducing population prevalence.(347) Small effects of treatments are clinically significant because of the very large health gains that accrue from stopping smoking. An effect of as little as 1% on six-month continuous abstinence rates would result in at least three additional years of life for every 100 40-year-old smokers treated.(348) This compares extremely favourably with other clinical interventions.(349)

3.3.2 SYSTEMS FOR DELIVERING THERAPIES

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

Several medications and forms of support are effective in helping smokers quit (and better ones may become available in time), but a far greater challenge is getting smokers to use them(350) and, preferably, to use those that are most cost-effective.

Referrals by professionals to Quitlines

Quitlines are now advertised on every cigarette pack as part of required consumer information. Mass media advertising also drives calls to the Quitline.(314, 351) However, more could be done. The Quitline is still an underutilised service in Australia, partly because of a lack of understanding about what the service offers.(350)

For several years, governments in the UK,(352) the US,(342, 353) New Zealand(354) and Australia(355, 356) have periodically updated and promoted detailed clinical guidelines for doctors on how best to treat tobacco dependence. An important innovation in the Australian clinical guidelines(356) is the offer of two evidence-based strategies for providing cessation assistance: within the consultation, and/or referral to specialist cessation services. GPs can use fax-referral forms to trigger a phone call to their patients from a trained Quitline adviser. For referrals, the Quitline calls the smoker and discusses options for assistance, which allows callers to be directed to or offered the most appropriate form of support.(357)

GP referral to the Quitline has improved patients' chances of quitting.³⁸(359) In a Victorian pilot program, referral to the Quitline has resulted in cessation rates two to three times that which resulted from efforts to encourage GPs to provide in-practice management.(360) The effect was due to the smokers getting extra help to quit from outside the practice, while getting the same amount of help from within it; the combination of the extra help increased both the number and success of quit attempts. The beneficial effect on quitting in the referral condition was sustained over time. The findings add to the growing body of evidence that health professional referral of patients who smoke to evidence-based Quit services is effective and acceptable to smokers.(361, 362)

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

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



A large-scale demonstration project across six states in the US has recently demonstrated that smokers doubled their success rates when given subsidised NRT and access to a Quitline, with savings in healthcare costs justifying full Medicare coverage of low-cost NRT and referral to Quitline services.(363)

Treatment in hospital

As is the case for general practice, advice to quit from treating physicians in hospitals can also motivate many people to quit.(364)

Hospitals in New South Wales and Queensland have developed systems to identify and advise all patients who smoke to quit and to offer NRT to help them comply with smoke-free policies. Much could be improved in these systems.(365) and much less progress in hospitals is evident in other jurisdictions.

Subsidy of treatments

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

NRT became available in the UK on NHS prescription in 2001, soon after the inception of the NHS Stop Smoking Services in 1999.(366) NRT can also be purchased from pharmacies and, with the classification of some NRT products in the general sale category, from several other outlets.(367) West et al. estimate that following the listing of NRT, the proportion of smokers using medicines to aid smoking cessation more than doubled from 8% in 1999 to 17% in 2002.(368)

In New Zealand, vouchers for NRT are provided to people calling the NZ Quitline, and are redeemed at pharmacies for the heavily subsidised cost of \$10. Initially, the vouchers were available only from the Quitline or from GPs who had received training in smoking cessation.(354) Since December 2007 they have been available through both the Quitline and all GPs.(369)

In the US, 40 of the 44 states include a subsidy for at least one form of NRT in Medicaid arrangements.(370)

In the state of New York, which set an ambitious target to reduce the number of smokers by one million over the 10 years to 2010,(371)³⁹ the NY Quitline sends free NRT directly to clients at the rate of around 360 shipments per day. In 2007 almost 80,000 clients received NRT starter kits, over 30,000 through on-line ordering. The NRT has been donated by one of the pharmaceutical companies, including stock that might otherwise exceed its sell-by date.

The evaluation of programs in New York,(372, 373) Minnesota(374) and New Zealand suggests that the provision of vouchers for free or subsidised NRT can significantly increase the numbers of smokers calling counselling services and the numbers making a quit attempt.(375) Such initiatives would appear to be effective with low-income groups.(376)

In Australia NRT has not been subsidised.⁴⁰ In contrast, bupropion marketed as Zyban (and more recently Clorpax and Bupropion-RL) was listed on the Pharmaceutical Benefits Scheme (PBS) in February 2001, and varenicline marketed as Champix in February 2008. By the end of June 2008, total PBS subsidies for bupropion totalled more than \$140 million, nearly half of this figure in the five months to June 2001.

39 Of a total population of just under 20 million people.

40 Patches went on PBS earlier this year solely for Indigenous smokers, as it was accepted by PBAC that they more frequently have objections to or problems with oral preparations.

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



Table 5: Prescriptions for and spending on bupropion, February 2001 to June 2007

	Services	Expenditure, \$s
Feb to June 2001	277,602	66,438,824
2001–02	129,174	29,110,602
2002–03	74,992	16,914,598
2003–04	83,844	12,108,290
2004–05	102,334	5,019,783
2005–06	106,467	4,864,776
2006–07	95,054	3,645,604
2007–08	69,211	2,590,349
Total to June 2007	938,678	140,692,826

Source: PBS data item 8465M and 8710K(378)

Established contraindications for bupropion⁴¹(379) and worrying reported side-effects for varenicline⁴² limit the numbers of people that can be prescribed these medications, whereas NRT can be used by virtually any smoker. Given the unsuitability of these PBS-listed treatments for many groups and the costliness of NRT for very low-income people in general, some commentators have suggested that NRT should be added to the PBS in Australia.(380) Alternatively (or in addition), Australia could establish a system similar to that in New Zealand or New York. Quitlines could distribute NRT, if this could be provided free or (with greater administrative complexity) at a discount. This model would have the advantage of enabling the Quitline to use free product in promotions to attract additional callers.

ACTION PROPOSED

Greater use of Quitline

Quit campaigns should find ways to more effectively promote the Quitline to low SES smokers.

Increased use of NRT

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

In the meantime, fund an initiative to provide vouchers to obtain free NRT to those for whom spending on tobacco products is causing significant financial stress. This could be introduced at the same time as any large increase in excise duty on tobacco. The NRT could be available free through the Quitline, and the vouchers could be provided through duty social workers staffing services for people in distress.

Consider offering to match any donations of NRT by pharmaceutical companies to the Quitline with offers to purchase equivalent quantities of stock.

Improved quality of use of NRT

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

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

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



3.4 Better support families and educators

Most adults who smoke started smoking as teenagers.(269) Smoking by peers, siblings and parents has consistently been demonstrated to increase the risk of smoking.(269, 381, 382)

Additional evidence since 2004

Adolescents who smoke become dependent quite rapidly on tobacco-delivered nicotine.(383-385)

School-based programs

After decades of effort pursuing tobacco education in schools, fewer than half of the published studies of rigorously designed trials show evidence of short-term effects, and almost none have demonstrated long-term effects.(386)

A peer-led intervention (ASSIST), focusing on training opinion-leading teenagers in persuasion techniques for use when talking to their peers about smoking outside the classroom,(387) has recently demonstrated promising results.(388, 389) This approach is worth monitoring.

Family programs

Parents who smoke can socialise their children against smoking,(390) but family-based programs aiming to discourage smoking have been only modestly successful(391) and would be difficult to deliver population-wide. Such programs have rarely involved siblings.

What parents can do

There is much that parents can do to discourage their children from taking up smoking.

Lead by example

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

12-15-year-olds 16-17-year-olds

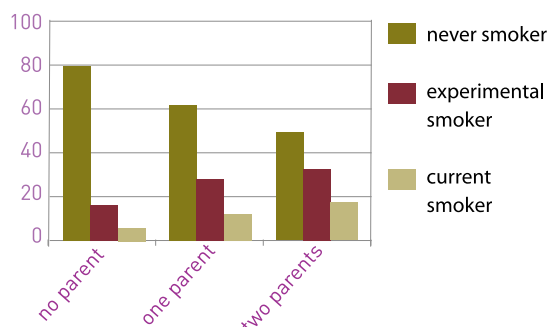


Figure 21: Proportion of students who were never smokers, experimental smokers or current smokers among students with no, one or two parents who smoke, 12-15-year-olds and 16-17-year-olds, Victoria, 2005 – no parent, one parent or two parents smoking

Source: ASSAD Victoria 2005(392)

Analysis of data on smoking among Year 10 students in New Zealand in 2007 compared with 2001 has shown that the decline in smoking prevalence has been greatest for students with no parents smoking and least for students with both parents smoking (Table 7b of the NZ report).(393)

Quitting by parents has a very strong effect on subsequent smoking by children, and is probably the single most important thing that a smoker-parent can do to prevent their children from taking up smoking.(394)

An Australian longitudinal study shows that children of non-smokers are also more likely to remain non-smokers in the long term.(395)

Smoking by children is also highly related to sibling smoking, and older teenagers often state that they hope their younger siblings do not experiment with smoking; siblings may be an untapped resource for tobacco control.(396, 397)

Go smoke-free

US studies(398, 399) find that even after controlling for demographic factors and parents' smoking status, children who lived in homes where smoking was banned were more than 20% less likely to take up smoking than children who lived in homes where smoking was allowed. However, there is little evidence that educational interventions can encourage the adoption of smoke-free homes.(400)



Be a strong family

Children who spend more time with their families and deal effectively with conflict are less likely to take up smoking: eating dinner together most nights really does seem to be a very good idea!(401) Lack of parental supervision is also strongly associated with smoking experimentation.(392)

Progress in Australia

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

Bans on smoking in shopping centres and the widespread adoption of smoke-free homes must make it increasingly difficult for children to experiment with smoking undetected by parents.

Evaluation of the 2001 Parents campaign (featuring a young girl recounting a recent event to her dying father: *'You should have been there, Dad'*), and focus group and tracking research on the WA Cancer Council's testimonial advertisement depicting a real smoker talking about her fears about what will happen to her children when she dies,(402) suggests that narrative adverts can have a strong impact with low SES parents.

ACTION PROPOSED

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

Given the likely impact on both parents and children, Quit campaigns should see parents as an important target group for advertising.

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

3.5 Tailor messages and services for highly disadvantaged groups

Several groups in Australia have needs that are unlikely to be adequately met by mainstream services. Special challenges need to be addressed in tackling smoking in Indigenous communities.

People in institutions such as psychiatric hospitals and correctional facilities lack access to mainstream services, and often smoke at very high rates. Greatly reducing or eliminating spending on tobacco products could well assist with efforts to gain secure housing and employment once they have left institutional care. Several small initiatives targeting highly disadvantaged groups are in place in various jurisdictions and sectors in Australia, but no services are uniformly available across the country.



3.5.1 INDIGENOUS AUSTRALIANS

Progress against international comparators

In June 2008 the Ministry of Health in New Zealand released data showing that smoking among Maori appears to have declined by more than 20% over the past four years, with the reduction of smoking among Maori men greater than that in the overall male population.(132) Public health experts believe that the decline can be attributed to the effects of smoke-free legislation, vocal advocacy by Maori leaders in tobacco control and social marketing campaigns.

In Australia, in contrast, smoking among Indigenous people does not appear to have declined at all over the past 15 years, although rates in remote communities may have improved slightly.

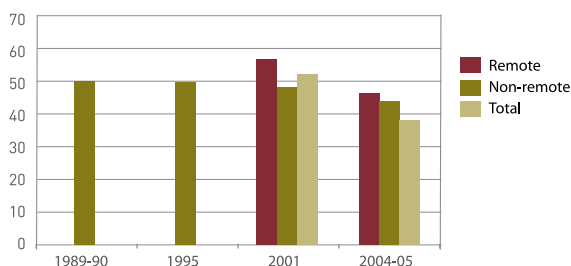


Figure 22: Prevalence of smoking among Indigenous Australians aged 18+, in all areas 2001 and 2004–2005, and in non-remote areas 1989 to 2004–2005

Sources: ABS National Health Surveys 1989, 1995 and 2001, and Aboriginal and Torres Strait Islander National Health Survey 2004–2005

Research since 2004

A comprehensive assessment of evidence on the effectiveness of tobacco control interventions and their applicability to Indigenous populations has identified several strategies that are likely to be effective.

Table 6: Summary of Ivers assessment of effectiveness of interventions for Indigenous groups

	Likely yes	Not known	Unlikely/Limited known no.
Brief advice, hps	✓		
Pharmacotherapies NRT Zyban Varenicline	✓ ✓ ✓		
Antenatal interventions	✓		
Hospital-based	✓		
Media advertising	✓		
Quit courses			●
Sponsorship		●	
Self-help materials (if clear and well illustrated)	✓		
Graphic health warnings	✓		
Tax and price	✓*		
Smoke-free public places		●	

Source: Ivers, 2008(403) * though with possible adverse effects for some.(404)

Progress since 2004

Shortly after its election, the government pledged \$14.5 million over four years to help tackle smoking in Indigenous communities.(405) This initiative includes:

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

The Department has also funded several Indigenous projects.



Where to next?

A national workshop for key stakeholders was held on 23 May 2008, in partnership with the CRCAH, to consider and set priorities for the next three years. The Centre for Excellence in Indigenous Tobacco Control (CEITC) has prepared a review of interventions effective in Indigenous communities, and a further meeting is being organised to advise on plans for action.

The working group notes that several strategies listed elsewhere in this document are likely to exert positive effects on smoking in Indigenous communities. These include increases in the price of tobacco products; greater investment in hard-hitting advertising tailored in content and placement to be as effective as possible with disadvantaged groups; legislation to restrict

smoking in pubs and clubs, cars and other public places; and better enforcement of legislation concerning sales to minors. Broader efforts to reduce socio-economic disparities between Indigenous and non-Indigenous people are also likely to reduce the uptake of smoking.


Small pilot projects, no matter how well designed and run, are not going to make the inroads necessary to reduce smoking rates across the Indigenous population as a whole. While there is a place for trials of innovative new approaches, it is now time to 'get on with the job' and scale-up efforts. Time and resources should be allowed for training and sharing of insights, and it should be acknowledged that quality of service will improve as staff become more experienced – the idea of 'learning by doing'.

ACTION PROPOSED

To help simultaneously build capacity in the Indigenous workforce and change social norms about smoking in Indigenous communities:

- place Indigenous Tobacco Control Workers in each NACCHO state and territory affiliate to support Indigenous communities, in the context of a coordinated national approach, in order to: raise the profile of tobacco control; create smoke-free environments through changes in organisational and community policies; and develop and deliver prevention and cessation activities
- provide incentives to encourage non-government agencies (such as Quit campaigns, state cancer councils etc) to employ Indigenous workers to improve Indigenous-specific programs
- fund appropriately designed training that is realistic and empowering for health workers, and ensure that they are able to provide their patients with pharmacotherapies
- fund a focus-tested, Indigenous-specific social marketing campaign to be delivered at national and local levels that would complement messages in locally delivered programs
- trial multi-component community-based programs in three sites (urban, rural and remote) to deliver locally managed interventions that might include components such as education campaigns, smoke-free areas, regional stores placement, and pricing policies and training for local workers.

The working group acknowledges the isolation and pressures on the small numbers of people currently working in Indigenous tobacco control, and supports the idea of pairing, job-sharing and other arrangements to ensure that workers aren't 'on their own' in stressful work environments. We believe that many people in mainstream tobacco control would be happy to provide much greater support and assistance to Indigenous workers where this is wanted, and would like to explore how such 'supporting partnerships' could be facilitated.



3.5.2 PREGNANT WOMEN FROM INDIGENOUS AND OTHER DISADVANTAGED GROUPS

Additional evidence since 2004

Smoking during pregnancy is much more common in women of a younger age, with a low social status, without a partner or with a partner who smokes, and among those receiving deficient prenatal care.(406)

Public health specialists have drawn attention to the absence of research about the effectiveness of interventions to encourage quitting among Indigenous women who are pregnant.(407) The lack of researcher interest in this area may be due to the generally disappointing results of a large number of trials of interventions aimed at disadvantaged smokers during the 1980s and early 1990s.(408, 409) Evidence for the effectiveness of interventions to assist pregnant women to quit has strengthened over the past few years,(410) however, particularly for counselling and behavioural interventions.(411) Targeted recruitment and modest financial incentives can encourage more people to enrol and complete programs, with consequent increases in quit numbers.(412-414) Among pregnant women in disadvantaged groups, pilot programs that provide financial incentives, coupled with efforts to encourage support from partners and family members, have increased quit rates(414, 415) and fetal weight.(416)

Progress in Australia since 2004

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

In Australia the Australian Government Department of Health and Ageing was allocated \$4.3 million in the 2005–2006 Budget to lead a national program to encourage doctors, midwives and Indigenous health workers to help women – particularly Indigenous women – to stop smoking during and after pregnancy.

On the advice of a National Advisory Group on Smoking and Pregnancy (no longer active), the government funded a Pregnancy Lifescripts Kit. It included the development by the AIHW of national standard data elements on smoking during pregnancy to provide high-quality, nationally consistent data; the National Smoke-Free Pregnancy Project designed to establish an effective, sustainable and realistic tobacco brief intervention for midwives to deliver in public birthing services throughout Australia; the SmokeCheck Project for Aboriginal women in the Katherine West region; and a Sax Institute project in Perth and Queensland trialling a high-intensity intervention to reduce smoking among pregnant Indigenous women.

ACTION PROPOSED

Include in healthcare agreements a requirement that all women receiving care through public maternity hospitals be asked their smoking status, and that all women who smoke be referred for supportive counselling.

Employ a small group of Quitline counsellors experienced in working with pregnant women and new mothers to undertake call-back counselling to pregnant women referred by GPs, midwives and obstetricians Australia-wide.

Investigate the feasibility of voucher schemes to encourage pregnant women to quit and stay smoke-free.



3.5.3 NON-ENGLISH-SPEAKING PEOPLE

Tobacco control groups in several states have for many years worked with opinion leaders in a culturally and linguistically diverse range of communities to develop greater awareness of, and community participation in, efforts to address the smoking issue. This has included working with ethnic media and health professionals in areas with high numbers of people from particular cultural backgrounds where smoking rates are high, and providing stalls at most major multicultural events and festivals.(417)

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

ACTION PROPOSED

Provide downloadable printed materials for non-English-speaking groups.

Promote the Quitline in national multicultural newspapers and on multicultural radio, and fund one or more of the Quitlines to provide telephone-interpreter assisted call-back services to non-English speakers anywhere in Australia.

3.5.4 THE MENTALLY ILL

Smoking rates among those suffering mental illness are considerably higher than among the rest of the population.(418) It is encouraging, however, that declines over the years have been proportional with those in the rest of the population.(419)

Additional evidence since 2004

A recent Australian review of research suggests that a combination of effective drug therapies and counselling were as effective for people with mental illness provided that symptoms are well controlled.(420) Hospitalisation in a smoke-free environment has been shown to increase the tendency for patients to quit.(421)

Progress in Australia since 2004

SANE Australia continues to draw attention to the problems of smoking for those with mental health problems. The Smoking and Mental Health project in South Australia continues to provide useful resources and training. The Quitline has developed and works to a detailed protocol for assisting callers with a mental illness.(422) The Australian Government Department of Health and Ageing funded three contracts to undertake projects related to smoking and mental health issues.



ACTION PROPOSED

Include in healthcare agreements requirements that child, adolescent and adult mental health services and drug treatment agencies:

- be completely smoke-free indoors, with protection from smoke-drift for staff and patients outdoors
- routinely identify smoking status
- include smoking cessation advice and treatment of nicotine dependence in all patient treatment plans⁽⁴²⁰⁾
- offer support to patients at transition points such as diagnosis and commencement of treatment, at discharge after in-patient treatment, when being assessed for a disability support pension and, most critically, when moving into supported or independent accommodation.

The Australian Government could support these processes by commissioning the production of national information packages for clinicians and facility managers. State and territory governments could assist through a rolling program that would aim to train all staff in such services over a three-year period.

MENTAL HEALTH PROBLEMS

The pervasiveness of mental health problems (as opposed to severe mental illness) among current smokers requires national smoking services such as the Quitline to improve strategies to assist the high percentage of their clients with common problems such as anxiety and depression, especially those whose condition may be exacerbated by their quit attempt.⁽⁴²³⁾ Cessation assistance in the context of common mental health problems should be regarded as a mainstream rather than 'special-needs' strategy.⁴³

3.5.5 PRISONERS

Research in New South Wales prisons found that 78% of male and 83% of female inmates were smokers.⁽⁴²⁴⁾ Another recent study has found a 90% smoking prevalence in male prisons.⁽⁴²⁵⁾ Around 50,000 people are clients of correctional facilities in Australia every year,⁽⁴²⁶⁾ and cannot be ignored in a comprehensive strategy.

There has recently been some debate as to whether smoking should be banned in all correctional facilities in Australia, as it is in all US federal penitentiaries and in 10 states including California.

Many prison inmates use the opportunity of incarceration to improve their health and fitness. This offers an opportunity for building and capitalising on an interest in quitting.⁽⁴²⁷⁾ The high rate of substance abuse and mental illness in prison populations suggests the need for prescription pharmaceuticals in addition to NRT and cognitive behavioural counselling.⁽⁴²⁸⁾

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

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



Richmond’s work in this area using this approach has achieved encouraging results in New South Wales prisons.(429, 430) Awefeso’s work based on the idea of ‘positive deviance’(431) – changing the culture about smoking in prisons by enlisting respected prisoners to talk about their quit efforts – also seems promising.(432)

ACTION PROPOSED

Reach a consensus on smoke-free policies for prisons – and implement nationwide.

Ensure that prisoners are provided with appropriate levels of cessation support in and after leaving prison.

3.5.6 THE HOMELESS

For people who are homeless, quitting smoking could make the difference between saving for a bond in rental accommodation or being selected or not selected for a room in shared housing. Overseas pilot projects suggest that counselling and NRT have some potential for assisting these most disadvantaged smokers. (433, 434)

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

IDEA FOR CONSIDERATION

Ensure that all human service agencies are smoke-free.

Provide vouchers to receive free NRT from the Quitline to smokers in housing stress and those seeking emergency housing; to those seeking government rent assistance, direct lending and mortgage relief programs; and to clients of home purchase advisory and counselling services.

3.5.7 HIGHLY DISADVANTAGED NEIGHBOURHOODS

A major study recently published highlights the social diffusion process that has been at work in the wholesale rejection of smoking among the best educated sections of the population in the US.(435) Sophisticated network analysis of data from the 12,000 people taking part over a 32-year period in the Framingham study reveals both the shifting position of smokers in society over that period and the dynamics of quitting. In 1971 smokers were indistinguishable from non-smokers in terms of integration in their social networks. Three decades later, smokers were at the periphery of these networks, mainly aligned only with other smokers.(436) Also interesting is the observation that smokers tended to quit in clusters rather than by gradual attrition.(27)

While television advertising remains the most cost-effective way of promoting interest among disadvantaged as well as more affluent smokers, the very high concentration of smokers within particularly disadvantaged neighbourhoods provides the opportunity for the highly localised advertising of services and treatments. This could be done for public housing estates and areas serviced by particular shopping centres, rather than merely to postcode or local government areas.

Aggregated to Census District

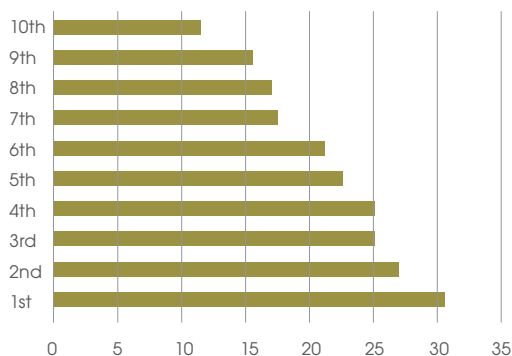


Figure 23: Proportion of persons aged 18+ who smoke regularly, Australia, 2004–2005, by Social and Economic Index of Disadvantage – aggregated to the level of census district rather than merely SLA or local government areas

Source: ABS National Health Survey 2004–2005(437)



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

Quit and Win competitions have not been very successful in the past in encouraging long-term changes in smoking behaviour;(438) however, these competitions have involved relatively small payments, many of which were available only for a 'winner' rather than for all participants. Incentive payments in development projects overseas and in other areas of public administration in Australia (for example, the maternity payments 'baby bonus', favourable tax treatment for certain forms of investment, welfare payments contingent on school attendance, purchase of water tanks) suggest that substantial cash payments might help highly disadvantaged smokers to maintain the necessary resolve to get through the difficulties and discomfort of quitting.

IDEAS FOR CONSIDERATION

Fund a pilot campaign including outdoor advertising and other initiatives to boost the use of cessation products and services in disadvantaged areas.

Trial payment for performance for patients (P4P4P) schemes in highly disadvantaged communities.

3.6 Address causes of disadvantage

3.6.1 SOCIAL INCLUSION

Adolescents with weak bonds to parents, school and other community institutions are at increased risk of engaging in deviant behaviour. (439-441) Students who start to fail at school are much more likely to 'act out' and to engage in high-risk behaviours, including smoking.(441-445)

New evidence since 2004

A study of the social determinants of smoking showed that, adjusted for age and gender, Indigenous people who had been removed from their natural family are half as likely to be a non-smoker.(446) Likelihood of being a non-smoker reduces with lower household income and education, and nine other indicators of social disadvantage.

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

In Australia, children who predict that they will complete Year 12 are much less likely to have ever tried smoking (or cannabis, inhalants, amphetamines or hallucinogens).(392)

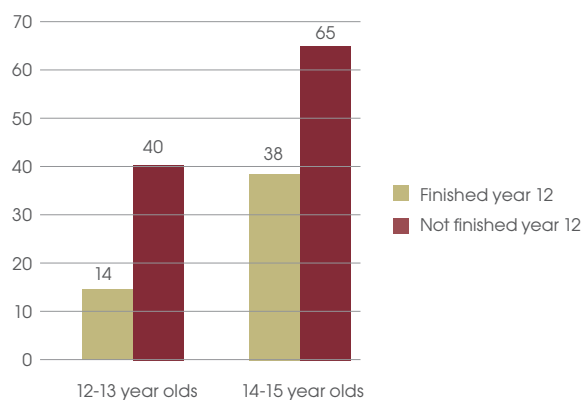


Figure 24: Proportion of secondary school students who have ever tried smoking among those who predict that they will finish Year 12 and among those that don't, Victoria, 2005

Source: ASSAD, 2005(392)



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

As Graham et al. have demonstrated:

“Education eliminates the effect of childhood circumstances on these dimensions of smoking status, suggesting that childhood conditions exert their influence through education. Education in turn determines adult socioeconomic position, with poor adult circumstances adding further to the risk of smoking in adulthood and reducing the odds of quitting.” (447) pii8

Findings of American research on the association between social cohesion and lower smoking rates,(448) and the relationship between social cohesion and self-reported health status,(449) suggest that improvements in social capital could help to reduce smoking uptake. European research suggests that policies to reduce the ugliness and disorder of the most disadvantaged neighbourhoods, and to provide opportunities for young people to participate in activities that build a sense of community, may reduce risk-taking behaviour, including smoking.(450, 451)

Progress in Australia

The Cancer Council of NSW and the Council of Social Services of New South Wales have jointly released a Tobacco Control and Social Equity Strategy(452) to build the capacity of social service agencies to contribute to tobacco control efforts and better integrate tobacco control into economic and welfare responses to social disadvantage.

IDEAS FOR CONSIDERATION

Government efforts to ensure universal access to child and maternal health services and early-childhood education, a well-resourced public school system that can attract and retain skilled teachers, and use of evidence-based programs to screen for and address early problems with literacy and numeracy are all likely to reduce uptake of high-risk behaviours such as smoking.

Initiatives that improve parenting, prevent family breakdown and promote resilience in children should help not only to prevent educational failure but also the development of mental health and other personal and social problems, all of which are highly correlated with smoking uptake. (453, 454)

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



3.6.2 INVESTING IN TOBACCO CONTROL AS A COMPONENT OF SOCIAL DEVELOPMENT

The WHO recognises the importance of reducing tobacco in the achievement of the United Nations Millennium Declaration 2000,(455) in which member nations pledged to work together to eliminate extreme poverty, improve health, and promote human development and sustainable economic progress in the world's poorest nations. It identified tobacco as a major avoidable cause of illness and preventable death in low-income countries, and urged that tobacco control be adopted as a means of improving the economic prospects of the world's poorest billion people.(456) Even in the poorest countries on earth, increasing tobacco taxes can help to decrease average spending on tobacco products, and reduce malnutrition and improve health among children in the poorest households.(457) Other tobacco control policies are also highly cost-effective in achieving development goals. The National Tobacco Strategy specifies that tobacco control should be a component of both welfare and overseas aid.(7)

Progress in Australia

With high smoking rates in many Pacific Island countries in Australia's immediate vicinity,(458) the inclusion of countries in the Oceania region in the biannual Australian–New Zealand tobacco conferences is a small but useful contribution to promoting tobacco control in international development.

Australian public health researchers and government officials are providing extensive technical assistance in the development of protocols for the Framework Convention on Tobacco Control.(6)

IDEA FOR CONSIDERATION

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

3.7 Improve focus in research, monitoring and evaluation

While many studies report results stratified by socio-economic group, it is unfortunate that the reviews and meta-analyses of such studies (such as those published as part of the Cochrane Collaboration)(459) rarely report on efficacy or effectiveness by socio-economic status.(460, 461)

ACTION PROPOSED

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

At present a few of the indicators for assessing progress on the National Tobacco Strategy are not being monitored.

ACTION PROPOSED

Request that the agencies producing reports on smoking prevalence and behaviour cover all of the major indicators listed in the National Tobacco Strategy.