Australian Government
Preventative Health Taskforce

AUSTRALIA: THE HEALTHIEST COUNTRY BY 2020

Technical Report 2

Tobacco control in Australia: making smoking history

Including addendum for October 2008 to June 2009

Prepared for the National Preventative Health Taskforce by the Tobacco Working Group

Australia: the healthiest country by 2020.
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Overview and summary of action proposed

Between 1950 – when clear evidence on the dangers of tobacco became available(1, 2) – and 2008, almost 60 years later, more than 900,000 Australians died prematurely because they smoked.(3)

The Australian death toll caused by smoking will pass the million mark within the next decade. The social costs of tobacco exceeded $31 billion in 2005,(4) but it is impossible to put a value on the grief suffered by the hundreds of thousands of families who have lost a child, a spouse or a parent in what should have been the most productive and rewarding years of their life.

Projections based on current patterns of uptake and quitting suggest that on our current course, prevalence of daily smoking will still be over 14% in 2020 and will remain close to 10% well past the year 2070.(5)

Given the scale of death, disease and disability caused, and with an extensive body of evidence now providing clear guidance on effective ways to reduce smoking, both at the population level and in clinical settings, it is simply not acceptable to allow the tobacco epidemic to continue for another 60 years.

Following the adoption of an international Framework Convention on Tobacco Control in 2003,(6) governments around the world are moving quickly to strengthen policies to discourage smoking. Each week, the benchmark changes, with countries and states rapidly copying each other in an accelerating series of 'catch ups'. If we want to reduce smoking to the greatest extent and as soon as possible, we should move to international best practice in all aspects of tobacco control policy.

The Tobacco Working Group of the Preventative Health Taskforce believes that if prevalence of daily smoking were to reduce to 9% or less by 2020, smoking would continue to decline until rates were so low that it would no longer be one of our most important health problems. Achieving this target will require a dramatic reduction in the numbers of children taking up smoking and a doubling of the percentage of smokers who are trying to quit.

Australia's record over the past 30 years has been impressive, but over the past six years we have taken our foot off the accelerator pedal in several areas of tobacco control. Research and international experience indicate the need for sustained effort: there is no cruise control switch. Unless we make tobacco products much less affordable, commit to providing commercially realistic funding for media campaigns not just in some years but every year, ban all remaining forms of promotion and provide greater help for smokers trying to quit, reductions in tobacco use in Australia could easily stall.

This paper presents the latest data on smoking in Australia. Building on extensive information compiled in the National Tobacco Strategy document released in 2004,(7) it provides an update of research available since that time, and describes what has been done over the past four years and where Australia falls short of international best practice.

Crucially, this paper sets out what needs to be done next.

Most importantly, we need to increase taxes on tobacco products, invest more funds in media campaigns and implement other policies that are known to be highly effective, all of which could be done with a net positive increase in government revenue.

The paper also suggests the policies and programs that, in combination, would institutionalise the treatment of tobacco dependence in Australia's healthcare system, recognising that the cost-effectiveness of treating tobacco dependence compares very favourably with other medical interventions.

Finally, we propose something that has not yet been tried anywhere in the world, but which would cost the taxpayer nothing and offers the prospect of shattering the image of cigarettes as an ordinary consumer item. If we act quickly, Australia can overtake the British Government and become the first country in the world to mandate that cigarettes be sold in plain packaging. There is good evidence that this would have a profound effect on young image-conscious teenagers.

If the proposals outlined in this paper are pursued, in addition to dramatically reducing the numbers of people who smoke, we would move to a point where cigarettes are rarely supplied to children, and non-smokers are almost never exposed to second-hand smoke.

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

Action in all seven of the areas described in this document could – even within our lifetimes – make smoking history.

Summary of proposed measures

An overall target of at least one million fewer Australians smoking by the year 2020 (no more than 9% of people aged 14 and over).

Revenue measures that would reduce the affordability of tobacco products

1. Increase excise and customs duty on tobacco to discourage smoking and to provide funding for prevention activities, including those in lower socio-economic status groups.
2. Amend customs and excise legislation to implement measures to prevent erosion of prices through the evasion of duties on tobacco.

Legislative reforms to address current deficiencies in tobacco regulation

3. Mandate plain packaging of cigarettes and increase the required size of graphic health warnings to take up at least 90% of the front and 100% of the back of the pack.
4. Modernise the Tobacco Advertising Prohibition Act 1992 (Cth) to cover new forms of media and to ban internet sales, tobacco displays at point of sale, payments to retailers and proprietors of hospitality venues, and public relations activities including promotion of corporate image and 'corporate responsibility' donations.
5. Establish a national system to more regularly review mandated warnings and to warn smokers of emerging and new evidence about health effects in a more timely and systematic manner.
6. Establish or nominate a regulatory body with the powers to ban, limit or mandate tobacco product constituents, emissions, additives or design features.
7. Strengthen state and territory legislation to ensure that cigarettes are not sold to children.
8. Extend state and territory laws that protect against exposure to second-hand smoke.

Expenditure measures

CAMPAIGNS

9. Provide commercially realistic funding over a period of several years for a continuing social marketing campaign to be developed by an expert group and run in collaboration with state Quit agencies.

   This would include an Indigenous component and research to help maximise impact with lower socio-economic status groups. Funding would need to be sufficient – at least $43 million per annum – to ensure television advertising at levels known to be effective (at least 700 Television Audience Rating Points in every jurisdiction each month) and sufficient to produce creative material for all the major messages (health effects, personal consequences etc) that need to be covered. To complement and enhance the credibility of paid advertising, funding should also cover an advocacy project to alert and assist journalists to report more of the research published each week on the health effects of smoking.

Indigenous tobacco control

10. In addition to the measures included in 9 above and 11 below, fund:
    - advocacy training and mentoring for people working in Indigenous tobacco control
    - Indigenous Tobacco Control Workers in each state and territory affiliate of NACCHO, the National Aboriginal Community Controlled Health Organisation
    - incentives to encourage non-government agencies to employ Indigenous workers to improve Indigenous-specific programs
    - appropriately designed training that is realistic and empowering for health workers
    - a trial of multi-component community-based programs in three sites (urban, rural and remote) to deliver locally managed interventions.

Other initiatives to reduce social disparities in smoking

11. Establish initiatives to tailor services for Indigenous smokers and for other highly disadvantaged groups unable to be reached by mainstream services. These would include:
    - telephone call-back services available to pregnant smokers, to Indigenous and to non-English-speaking smokers in any state or territory, delivered by staff experienced in working with each group
    - resources for professionals to encourage and assist smokers in psychiatric and correctional facilities.
12. Implement programs to subsidise nicotine replacement therapy (NRT) for people who are homeless and other highly disadvantaged people in financial stress, for patients of mental health services, for clients of juvenile justice and correctional services, and for callers to the Quitline.
13. Implement a pilot campaign including outdoor advertising and other initiatives to boost the use of cessation products and services in disadvantaged areas.
14. Trial 'payment for performance for patients' (P4P4P) schemes in highly disadvantaged communities.

Health system interventions

15. Include in healthcare agreements between the Australian Government and states and territories requirements to:
    - provide extended-hours Quitline and call-back services
    - ensure that all government-funded organisations and services are smoke-free
    - ensure that all health and human services (community health centres, maternal and child health services, drug treatment agencies, mental health services and hospitals etc) routinely identify patients who smoke, advise such patients to quit, provide them with NRT and where appropriate refer them to the Quitline.
16. Develop national resources to provide training to professional staff working in private health and medical practices, and in all healthcare services and institutions.

Reinvigoration of the Australian National Tobacco Strategy

17. To reinvigorate Australia's comprehensive National Tobacco Strategy:
    - update (but do not waste time and money redrafting) the Strategy(7) and supporting documents,(8-14) and encourage more effective use of these by the tobacco control field
    - promote the relevance of the Strategy for achieving the Australian Government's broader objectives of reducing the costs of chronic disease, improving workforce productivity, achieving greater social inclusion and contributing to social development, both in Australia and in developing countries.

Overseas development

18. 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 monetary contribution alone.

1. Introduction: the big picture

Smoking continues to be Australia's largest preventable cause of death and disease. Over three million people – just under 18% of Australians aged 14 years and over – still smoke at least weekly.(15) About half of the smokers who continue to smoke for a prolonged period will die early, half of them in middle age(16) when children and grandchildren depend on them, and while they are in the most productive years of their working lives.(17) Tobacco use caused 15,511 deaths in 2003,(18, 19) and cost the Australian community around $31.5 billion in 2004–2005.[1](4) Smoking is responsible for 12% of the total burden of disease and 20% of deaths in Indigenous Australians.(20)

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

Even if the prevalence of smoking were to decline overnight to single-digit figures, the personal and social costs of smoking would continue to be high for many years, not just because the effects are so long term but also because they are so far-reaching. As noted by Collins and Lapsley, their estimates must considerably understate the true costs of tobacco use, given the numerous items for which there was not yet enough research to enable them to plausibly quantify effects. Current estimates of the costs of smoking are based on assessments of the excess risk of premature birth, cardiovascular disease, respiratory disease and cancers of the respiratory, digestive and reproductive organs.(21)

It is indeed hard to think of an organ of the body to which smoking is not harmful, and scientific studies are published literally every day providing new or strengthened evidence of the impact of smoking on dozens of diseases and conditions, including most of the chronic health problems currently driving exponential growth in spending on hospital, medical and pharmaceutical treatments in this country.[2](22)

Beyond the early deaths, the years of debilitating illness and the costs to the public healthcare system, smoking in Australia also contributes significantly to social disadvantage.Spending on tobacco products causes financial stress. (23) It works against the accumulation of wealth, and helps to perpetuate poverty across the generations.(17, 24) Cigarettes increasingly act as a badge(25) and a marker(26) of low educational aspirations, low socio-economic status and unemployment. Smoking by people from disadvantaged backgrounds may be becoming a barrier to acceptance in more advantaged social networks.(27) Doing more to reduce smoking may thus also support the government's central policy goals of educational excellence(28) and social inclusion.(29, 30)

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

After an intial decline in the 1960s, smoking increased again in the early 1970s in response to more agressive marketing by tobacco companies, especially advertising aimed at young women.

1 Including net tangible costs of around $12 billion.

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

In the mid-1990s total spending on media campaigns fell as Quit organisations grappled with budget cuts and simultaneous pressures to develop targeted programs for a growing number of population groups. During this time, cigarettes also became more affordable. After a decade in decline, between 1992 and 1998 the prevalence of smoking among adults flattened. It went into decline again following an increase in media spending and an increase in cigarette taxes in 1999, and the stepping up since 2001 of measures to make public places smoke-free.

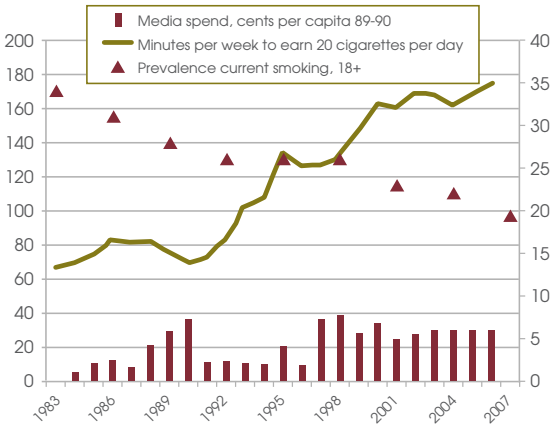


Figure 1: Smoking prevalence in adults aged 18+, spending on media campaigns per person $89–90 and costliness of cigarettes, Australia, 1983–2007

Sources: CBRC analysis of National Drug Strategy Household Survey,(31) Average Weekly Earnings compared with recommended price of tobacco products,(24) reports by government and non-government bodies on spending on tobacco control in Australia(32-34)

These observations of trends over the past 30 years are confirmed by a recently published analysis of changes in smoking behaviour in response to changing policy parameters on a month-by-month basis. Increases in the costliness of cigarettes and large increases in television Target Audience Rating Points have exerted powerful effects in reducing smoking in the largest Australian states. When expenditure is low and prices stay the same, smoking prevalence stops falling.(35)

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

Some jurisdictions in Australia are also doing better than others at reducing smoking.

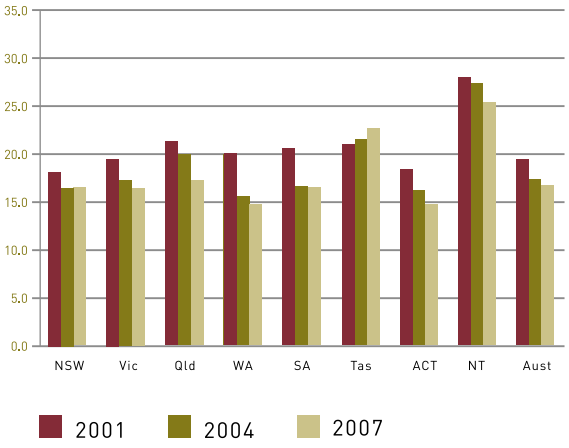


Figure 2: Changes in prevalence of daily smoking, Australians aged 14+, 2001–2007 – each Australian state and territory

Source: National Drug Strategy Household Surveys 1998,(36) 2001,(37) 2004(38) and 2007(39) NB. Rates not age-standardised

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

Meanwhile the World Health Organization has released a policy package (MPOWER) to guide the 168 countries that are signatories to the Framework Convention on Tobacco Control detailing measures on taxation, health warnings and assistance to smokers to quit.(40) It has also drafted official guidance urging far-ranging restrictions on advertising and promotion.(41) Scheduled for discussion at a meeting of the Conference of Parties in November 2008, these guidelines recommend that parties ban every possible form of advertising and promotion including:

- **advertising and promotion on tobacco packaging**, so that only plain packaging would be allowed
- **display of products at point of sale**
- **promotion of tobacco companies themselves** in order to prevent companies influencing the way in which they and their products are perceived
- so-called **'corporate social responsibility'** donations or contributions by the tobacco industry
- other **payments** by the industry such as incentives to retailers, money to venues to fund the building of smoking areas
- **internet sales** of tobacco products.

In New Zealand, the Republic of Ireland, the UK (led by Scotland) and many states and provinces in the US and Canada, governments have recently introduced (or have announced that they will shortly introduce) measures such as bans on retail displays and restrictions on smoking in cars that are still not yet in place in several Australian jurisdictions.

The UK, almost all states in the US and several provinces in Canada subsidise NRT for low-income smokers. The UK Government has announced its intention to mandate plain packaging of tobacco products.(42)

After a decade of at least annual and frequently very large increases in taxes, excise duty on tobacco products has not increased even once in Australia over the past six years. In some states, media spending is lower than it has been for several years. Total spending on tobacco control is well below the levels recommended by expert groups.

If smoking rates in Australia were to decline between 2007 and 2019 at the same rate that they declined between 1998 and 2007, prevalence of smoking[3] would still be around 14% in 2020.(5) In its blueprint for the nation on *Ending the Tobacco Problem*, the US Institute of Medicine has proposed a target for the US of 10% adult smoking prevalence by 2025[4].(43) This paper sets out how Australia could achieve a target of 9% smoking prevalence by 2020, a full five years earlier. In California, which led the way in the US with a well-funded media campaign commencing in 1988 and a strong push towards smoke-free environments, the prevalence of daily smoking is already less than 9%. It should be feasible for Australia to achieve a reduction in smoking similar to that achieved in California.[5]

A target for 2020 *Smoking prevalence of no more than 9% (of Australians 14 years and over, reported smoking daily)[6] equating to around one million fewer Australians smoking.[7]*

3 Percentage of people who smoke every day or some days each week.

4 10% of adults 18+ smoking daily or at least some days each week.

5 The prevalence of daily smoking in California is currently 8.8%. See US Center of Disease Control Behavioural Risk Factor Surveillance system: http://apps.nccd.cdc.gov/brfss/display.asp?cat=TU&yr=2007&qkey=4394&state=CA. To reach prevalence of daily smoking lower than 9% by 2020, smoking rates in Australia would need to reduce over the next 12 years by the same percentage as they have decreased in California over the past 12 years.

6 9% of Australians 14 plus smoking at least weekly. A target such as this should include a sub-target of an absolute reduction in prevalence among Australians in the most disadvantaged 40% of neighbourhoods at least as great as the reduction in neighbourhoods falling between the 41st and 80th percentile in terms of relative disadvantage. The reduction among Indigenous Australians will need to be considerably greater than this if Close the Gap targets are to be achieved.

7 From around three million at present to around two million in 2020.

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

Objectives of the National Tobacco Strategy

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

While the prevalence of smoking in Australia has declined among both teenagers and adults in all social groups, smoking during pregnancy and exposure to tobacco smoke among children remains high, particularly among people living in disadvantaged areas.

2.1 Uptake of smoking

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

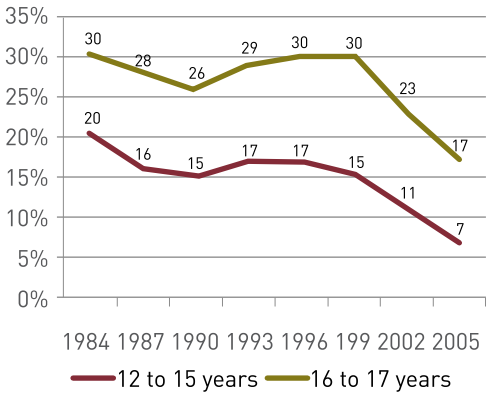


Figure 3: Trends in current smoking (smoked in past week), students aged 12–15 years and 16 & 17 years, Australia, 1984–2005

Source: ASSAD(44)

Current smoking and smoking rates have declined in teenagers of every age. Between 1999 and 2005, rates almost halved among students aged 16–17 years. Among younger students, the rate in 2005 was barely one-third the rate in 1984.(44)

The Australian Survey of Smoking, Alcohol and Drug Use (ASSAD) indicates that in 1987 smoking rates were highest among students living in the most advantaged areas of Australia. Following a sharp reversal of the socio-economic gradient among 12–15-year-olds between 1990 and 1996, between 1996 and 2005 smoking declined equally among students living in areas at all levels of disadvantage.

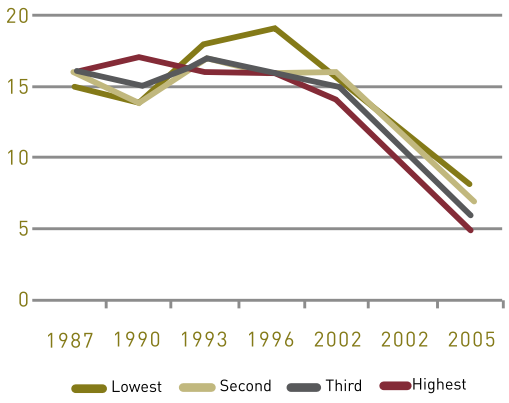


Figure 4: Reported current smoking (smoked in past week), secondary-school students aged 12–15 years, ranked in quartiles by the level of disadvantage of the area in which their school is located, Australia, 1987–2005

Source: White, Hayman and Hill 2008,(45) Table 2

2.2 Smoking rates among adults

The proportion of adult Australians who describe themselves as current smokers was significantly lower in 2007 than in 1980. Smoking rates have fallen in both males and females.(31)

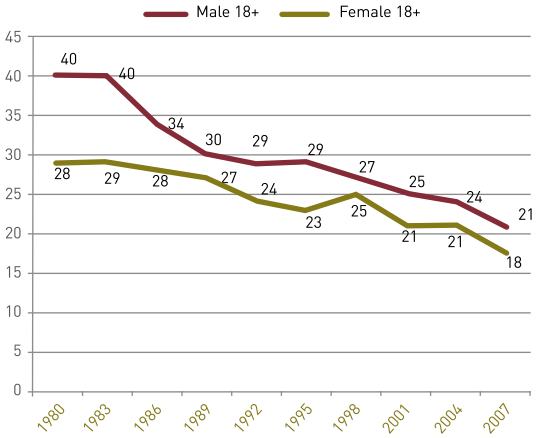


Figure 5: Prevalence of current smokers* aged 18+, Australia, 1980–2007 – males and females

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria(46-52) and National Drug Strategy Household Surveys(15, 53, 54)

In fact, smoking rates have fallen in all age groups.

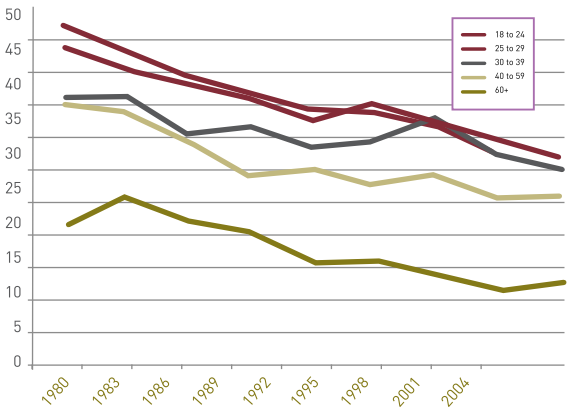


Figure 6: Prevalence of current^ smokers* aged 18+, Australia, 1980–2004 – ages 18–24 to 60+

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria(46-52) and National Drug Strategy Household Surveys(15, 53, 54)

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

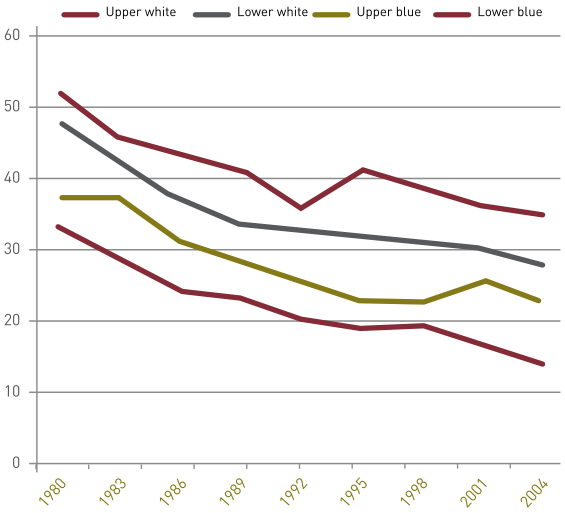


Figure 7: Prevalence of current smokers* aged 18+, Australia, 1980–2007 – by job classification

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria(46-52) and National Drug Strategy Household Surveys(15, 53, 54)[8]

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

While prevalence has fallen among adults and teenagers in all age and occupational groups, progress appears to be halting among people with more limited education and those living in the most disadvantaged areas.(24)

8 *Includes any combination of cigarettes, pipes or cigars.

The AIHW has released data for Australians aged 14+ for 2007, but the figures for Australians aged 18+ have not yet been calculated.

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

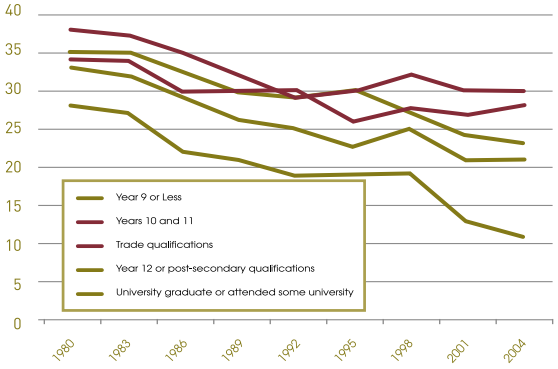


Figure 8: Prevalence of current smokers* aged 18+, Australia, 1980–2004 – by level of education

Source: Centre for Behavioural Research in Cancer analysis of data from Anti-Cancer Council of Victoria(46-52) and National Drug Strategy Household Surveys(15, 53, 54)

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

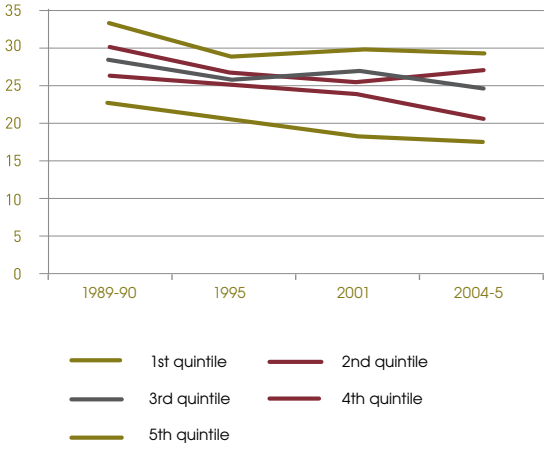
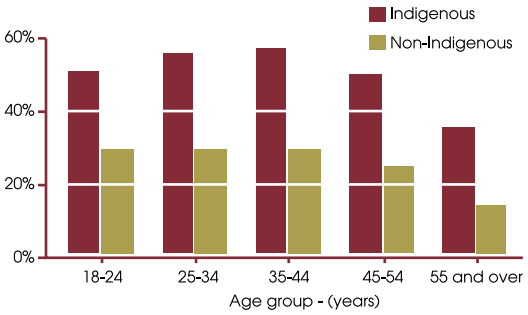


Figure 9: Smoking rates by area of relative disadvantage, Australians aged 18+, 1989 to 2004–2005

Source: ABS National Health Survey(55)

Smoking rates among Indigenous Australians are more than double those in the rest of the community.(56)

Current daily smokers, Males



Current daily smokers, Females

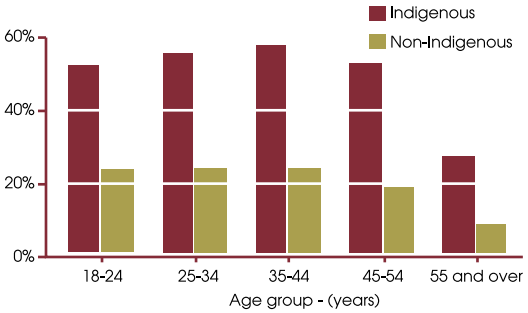


Figure 10: Smoking among Indigenous versus non-Indigenous Australians, 2004–2005 – males and females, various age groups

Source: Reproduced from ABS 2007 Tobacco Smoking – Aboriginal and Torres Strait Islander People: A snapshot (57)

High rates of smoking are also apparent among other marginalised groups, including those with mental illness,(58) drug users,(59) those who are homeless(60) and those in prison.(61) A review of 42 international studies in 20 nations found an average smoking prevalence among people with schizophrenia of 62%.(62) Australian research has reported rates of up to 73% in men and 56% in women suffering from serious psychiatric illnesses.(58, 63, 64)

2.3 Exposure to tobacco smoke among non-smokers

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

Table 1: Women who smoked during pregnancy by Australian state* and territory, 2005

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

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

Source: Laws et al.(65)

Of the 10,857 teenagers who had babies in 2004, 42% smoked during pregnancy.(65) Data from the Australian Institute of Health and Welfare (AIHW) National Perinatal Data Collection Unit indicate that Aboriginal and Torres Strait Islander mothers smoke during pregnancy at about three times the rate of non-Indigenous mothers (52% compared to 16%).(66)[10]

ACTION PROPOSED

Include in healthcare agreements a requirement to collect and report data on smoking during pregnancy.

Smoking during pregnancy may have far-reaching and long-lasting effects on the health and wellbeing of offspring. Recent studies point to long-term impacts including programming for cardiovascular disease(67-70) and fertility problems.(71, 72) Maternal smoking is increasingly being linked[11] with compromised neuro-behavioural(75, 76) and cognitive functioning.(77, 78) Smoking may play a larger role in contributing to the perpetuation of social disadvantage than has previously been appreciated.

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

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

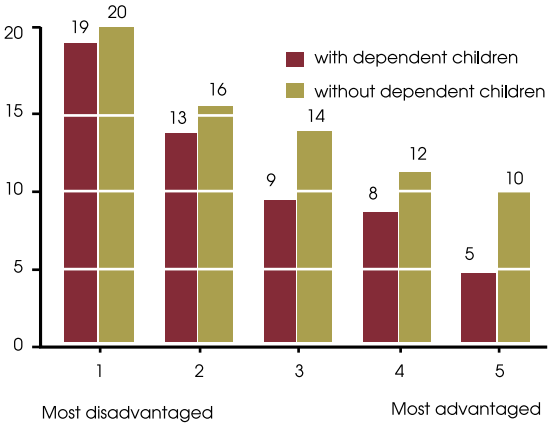


Figure 11: Percentage of households where at least one person smokes inside at least once daily, Australia, 2004

Source: National Drug Strategy Household Survey 2004(79)

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

10 Data on smoking in this population group is currently not collected in Queensland or Victoria.

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

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

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

Among single parents with dependent children, an adult smokes indoors at least once each day in one in three households.(79) Children in households in the most disadvantaged areas are four times more likely to be exposed to tobacco smoke inside than children in households in the most advantaged areas.

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

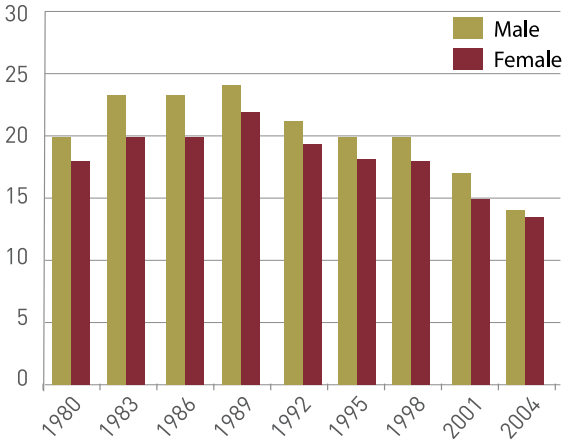


Figure 12: Reported number of cigarettes smoked daily by adults aged 18+, Australia, 1980–2004

Source: NDSHS(80)

The percentage of people who can be classified as heavy smokers has also been declining, with corresponding increases in the percentage of people who self-classify as light smokers.(81)

Small reductions in cigarette consumption have not been demonstrated to reduce the incidence of tobacco-related disease; however, lighter patterns of smoking are associated with both a greater likelihood of attempting to quit and greater success in remaining abstinent.(82-84)

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 agenda[12].(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.

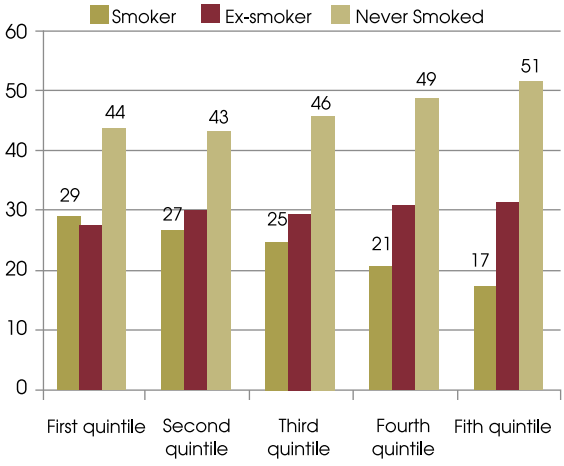


Figure 13: Smoking status – prevalence of current, ever and never smoking by quintile of index of relative disadvantage, Australia, 2004–2005

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 (Philip 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, A$, 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.

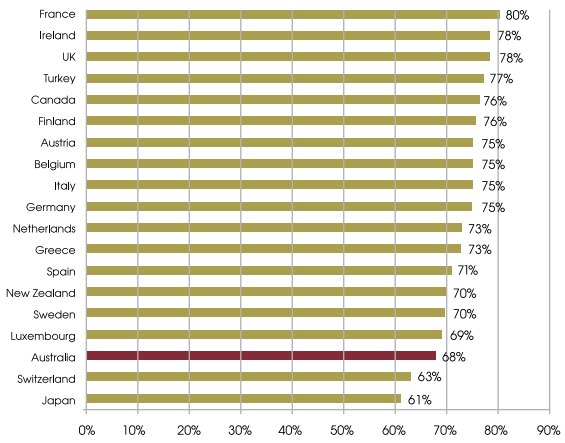


Figure 15: Tax paid as a percentage of final recommended retail price – OECD countries, 2003

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.

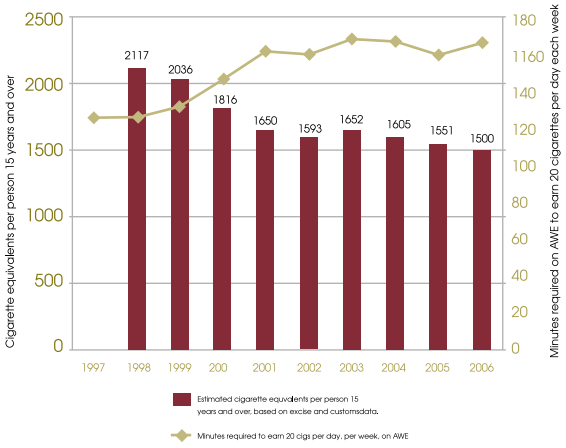


Figure 16: Per capita consumption of cigarettes compared with affordability

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.

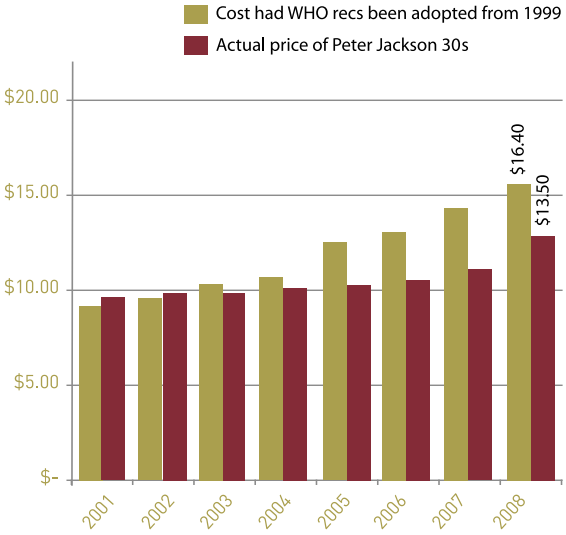


Figure 17: Recommended retail price of Peter Jackson 30s compared with prices if they had increased at 5% per annum

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	Rep't'd price paid	Rec'd retail price	Rep't'd price paid	Rec'd retail price	Rep't'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 classification[21]).

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 I 6. 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 Australia[32], Western Australia[33] 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 I 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.

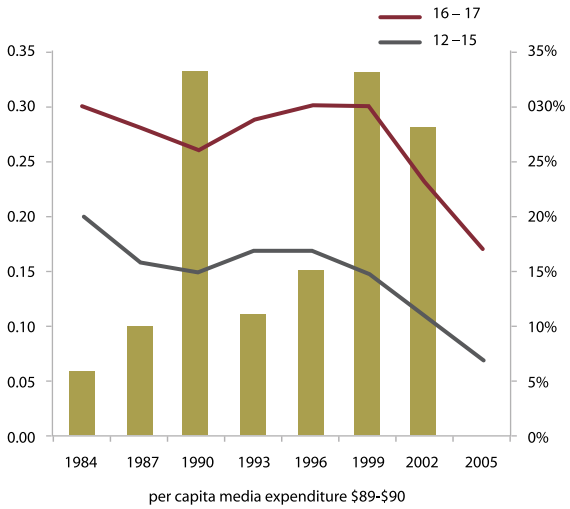


Figure 19: Average expenditure on mass media campaigns ($89–90, average for previous three years) compared with smoking prevalence among students aged 12–15 years, Australia, 1984–2005(44)

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

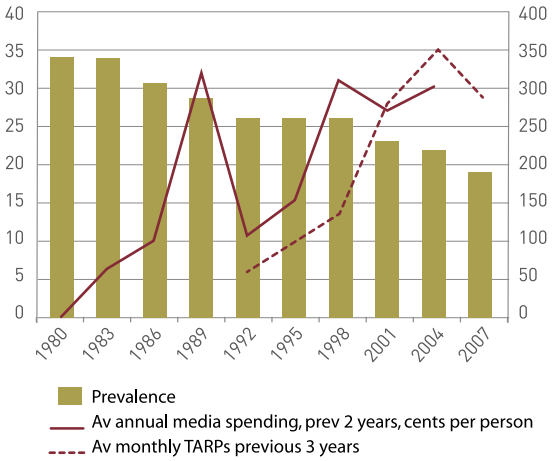


Figure 20: Proportion of adults aged 18+ smoking compared with expenditure on media campaigns and average monthly Television Audience Rating Points, Australia, 1980–2007

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 report[36](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 bupropion[41](379) and worrying reported side-effects for varenicline[42] limit the numbers of people that can be prescribed these medications, whereas NRT can be used by virtually any smoker. Given the unsuitability of these PBS-listed treatments for many groups and the costliness of NRT for very low-income people in general, some commentators have suggested that NRT should be added to the 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.

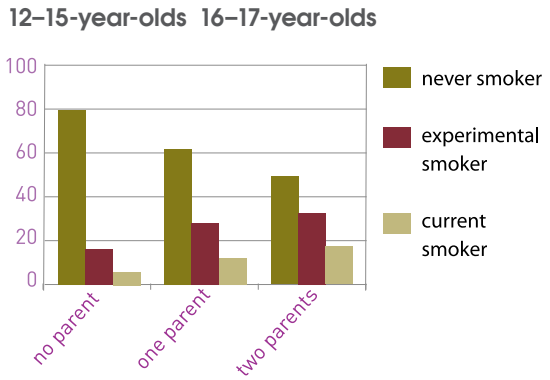


Figure 21: Proportion of students who were never smokers, experimental smokers or current smokers among students with no, one or two parents who smoke, 12–15-year-olds and 16–17-year-olds, Victoria, 2005 – no parent, one parent or two parents smoking

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.

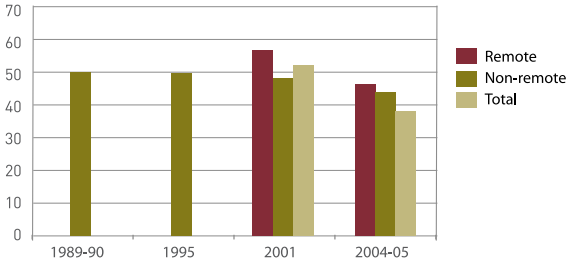


Figure 22: Prevalence of smoking among Indigenous Australians aged 18+, in all areas 2001 and 2004–2005, and in non-remote areas 1989 to 2004–2005

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 (CRCAH), to build the evidence base around what works in helping Indigenous people to quit smoking
- trialling community interventions, including targeted, culturally appropriate communication activities
- 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 show 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.

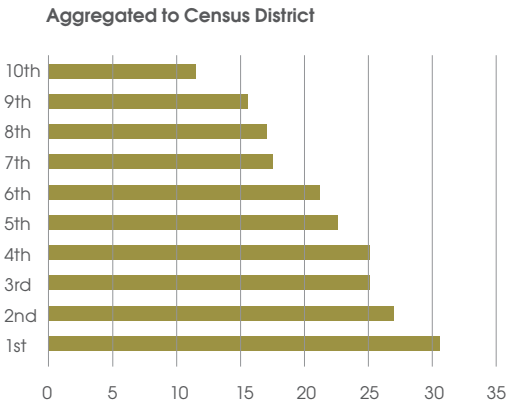


Figure 23: Proportion of persons aged 18+ who smoke regularly, Australia, 2004–2005, by Social and Economic Index of Disadvantage – aggregated to the level of census district rather than merely SLA or local government areas

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)

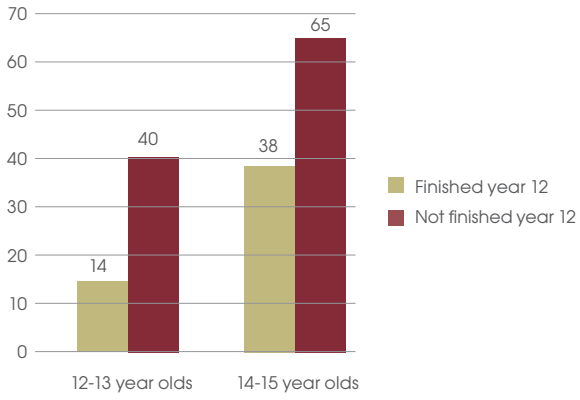


Figure 24: Proportion of secondary school students who have ever tried smoking among those who predict that they will finish Year 12 and among those that don't, Victoria, 2005

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.

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

Much remains to be done in tobacco control in Australia. If we are to meet the target of one million fewer Australians smoking or 9% smoking prevalence by 2020, we will need to implement all the major recommendations, and do so as soon as possible.

A piecemeal approach will be dramatically less effective, will result in more unnecessary deaths, and may perpetuate social inequalities.

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

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

Media campaigns of around 700 TARPs per month on average, together with programs to support smokers to quit, would require a total investment of over $40 million per annum over the next decade. An economic analysis of the impact of the National Tobacco Campaign finds, however, that media campaigns discouraging smoking are highly cost-effective. The sustained 1.4% drop in prevalence observed following the first phase of the campaign will prevent an estimated 55,000 premature deaths, and (in this case for an investment of $9 million over only seven months) will lower healthcare spending by at least $740 million[44] on the four major diseases caused by smoking. (462) California's US$1.8 billion investment in anti-smoking campaigns has saved healthcare costs totalling around US$86 billion to 2004.(463)

Treatments for smoking cessation would be the most costly component of a comprehensive tobacco control program. Based on the pattern observed with Zyban (bupropion) (which cost the PBS $30 million in 2001–2002 but now requires only $2.5 million per annum), we could expect that demand for subsidised NRT would be high for the first year or two but would quickly diminish to a level no higher than most drugs currently on the PBS. A drop of just 5% in prevalence could reduce PBS spending by $4.5 billion on cardiovascular drugs alone over the next 40 years.[45](464)

Most of the benefits from reducing smoking over the coming decade will be realised in the 2030s and 2040s. However, even by 2020 we could expect savings well in excess of our investment. (467-467)

A report to the Australian Department of Health and Ageing assessing the returns on investment in public health to date estimated that the 30% decline of smoking between 1975 and 1995 had prevented over 400,000 premature deaths(468) and saved costs of over $8.4 billion, more than 50 times greater than the amount spent on anti-smoking campaigns over that period.(469) The huge body of research demonstrating the effectiveness of tobacco control interventions suggests that it would be feasible to pick up the pace and slash smoking rates by another 50% over a much shorter period.

A great deal of misery could be avoided and our country would be much more productive and inclusive if we could achieve a target of a million fewer Australians smoking by 2020, as a crucial next step in making smoking history.

44 In current dollars, using a discount rate of 3%.

45 With a Net Present Value of $1.14 billion calculated at a discount rate of 5%.

Major sources used in this document

Documents used in preparing this document include:

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

ii. updates on policies and programs in Australia and internationally gleaned from media reports and discussion on Quit Victoria's Tobacco Control Network

iii. a recent report from the US National Academies' Institute of Medicine setting out a blueprint for ending the tobacco problem in the US(279)

iv. reflections by Professor Simon Chapman, editor of Tobacco Control and long-time activist and commentator, on past successes and future directions in tobacco control in Australia and internationally in his book Advocacy and Tobacco Control: Making Smoking History(85, 470)

v. recently published and soon-to-be-published major reviews of scientific evidence conducted by international scientific agencies such as the International Agency for Research in Cancer,(117) the US National Cancer Institute(471) and the US Surgeon-General(21, 116)

vi. reviews and meta-analyses and studies in scientific journals, in particular the BMJ's Tobacco Control journal, which publishes much of the best international research on population-level interventions(472)

vii. policy recommendations prepared by international health authorities such as the WHO,(473) the World Bank and the US Centers for Disease Control(474)

viii. discussion papers prepared by expert groups such as the international Framework Convention Alliance (of non-government agencies)(475)

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

x. meta-analyses of clinical interventions in the Tobacco Module of the Cochrane Collaboration(340)

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

xii. published and unpublished results of the International Tobacco Control Four Nations (ITC 4 Nations) study, which has been assessing the impact of tobacco control policies in Australia compared with the US, the UK and Canada since 2001(82, 84, 476-488)

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Addendum for October 2008 to June 2009

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Attachment 2: Sample of Studies Pulished January to May 2009 suggested or concluding health effects other thn those already covered in current Consumer Product Information in Australia 149

Since the Preventative Health Taskforce released its discussion paper(1) and an accompanying technical paper on tobacco(2) in October 2008, a major development has been the adoption by Parties to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) of several instruments that will be used by nations to guide implementation of their international obligations under the FCTC to discourage tobacco use. The FCTC is the first treaty negotiated under the auspices of the WHO. As of 13 May 2009 it had 164 Parties, including Australia and all other WHO member states in the Western Pacific Region.

In addition, there have been several developments in Australian states and territories, as well as overseas, relevant to the policies proposed in the Taskforce's reports. These include the release of the Victorian Tobacco Strategy,(3) which sets out implementation dates for a number of key reforms; passage of the NSW *Public Health (Tobacco) Act*; and passage through the Lower House of a bill outlining several reforms with all party support in Western Australia.(4)

Finally, several thousand further studies relevant to the health effects of smoking and the effectiveness of policies to discourage tobacco use have been published over the past six months.

This paper summarises just the major studies and developments since October 2008 considered relevant to consideration of the Taskforce's strategy for tobacco control.

Goals of tobacco control: To reduce the human, social and financial costs of smoking

Smoking and mortality and morbidity

New evidence

Recent studies confirm the importance of smoking alone or in combination with other risk factors as a major contributor to premature death and disease and reduced quality of life.

- Both smoking and adiposity are independent predictors of mortality, but the combination of current or recent smoking with a BMI > or = 35 or a large waist circumference is related to an especially high mortality risk.(5)
- A large prospective cohort study in the US has found that around 55% of premature deaths in middle-aged women can be attributed to the combination of smoking, being overweight, lack of physical activity and a low diet quality. Relative risks for five compared with zero lifestyle risk factors for mortality in middle-aged women were 3.26 (95% confidence interval 2.45 to 4.34) for cancer mortality, 8.17 (4.96 to 13.47) for cardiovascular mortality, and 4.31 (3.51 to 5.31) for all cause mortality. Adherence to lifestyle guidelines is associated with markedly lower mortality in middle-aged women.(6)
- A Finnish study(7) has found that men who had never smoked lived an average of 10 years longer than heavy smokers. The study, published in the *Archives of Internal Medicine*, found non-smokers also had the best scores on all health-related quality-of-life measures, especially for physical functioning.

Attachment 1 provides an overview of research published since 1 October 2008, highlighting the health effects of smoking that are not as well known as those described in consumer product information currently required to be printed on the packaging of tobacco products sold in Australia.

Overseas developments

The 2008 edition of *America's Health Rankings: A Call to Action for Individuals & Their Communities* revealed that the health of Americans has failed to improve for the fourth consecutive year. Key factors contributing to these results included unprecedented levels of obesity, an increasing number of uninsured people, and the persistence of risky health behaviours, particularly tobacco use. The longest running report of its kind, *America's Health Rankings* evaluates a historical and comprehensive set of health, environmental and socio-economic data to determine national health benchmarks, and an annual ranking of the healthiest and least healthy states. During the 1990s, health improved at an average rate of 1.5% per year, but improvements against national health measurements have remained flat for the last four years. Smoking, obesity and the uninsured are the nation's three most critical challenges. *Source: Business Wire, 2008-12-03.*

Smoking and inequality

Overseas research

A UK study assessing the impact of tobacco smoking on the survival of men and women in different social positions found that among both women and men, those who had never smoked had much better survival rates than smokers in all social positions. Smoking itself was a greater source of health inequality than social position and nullified women's survival advantage over men. This suggests the scope for reducing health inequalities related to social position in this and similar populations is limited unless many smokers in lower social positions stop smoking.(8)

A US study has found that living with adult smokers is an independent risk factor for adult and child food insecurity, associated with an approximate doubling of its rate and tripling of the rate of severe food insecurity.(9)

Australian research

A Queensland study has confirmed that smoking remains an important cause of poor health among newborn babies, and that smoking is a major contributor to the poorer health outcomes for Indigenous babies. The adjusted outcomes for babies born to Indigenous non-smokers were similar to those for non-Indigenous non-smokers (preterm, 7.1% v 6.1%; full-term low birthweight, 1.6% v 1.1%). The adjusted percentages for smokers were high regardless of Indigenous status (preterm, Indigenous v non-Indigenous, 8.3% v 7.8%; full-term low birthweight, Indigenous v non-Indigenous, 5.3% v 3.7%). The percentage of Indigenous mothers who smoked (54%) was almost triple that for non-Indigenous mothers (risk ratio, 2.90; 95% CI, 2.81-2.99).(10)

Economic costs

New evidence

A study of medical costs among health plan members in Minnesota, in the United States, found that physical inactivity and smoking were significant predictors of higher medical costs (11) This suggests that investment by health funds in preventative activities would appear to be warranted.

Contrary to claims of those who say that because non-smokers live longer they incur more lifetime healthcare costs, a study from Hong Kong finds that those who have never smoked do not use more acute hospital services in the last years of life.(12)

Objectives of tobacco control: To reduce use of tobacco products and exposure to the toxic elements of tobacco smoke

Prevalence targets

To accurately assess progress we require reliable estimates of tobacco use in the Australian community.

New evidence

A New Zealand study has shown somewhat higher estimates of smoking prevalence based on questions included in the New Zealand Census compared to results for surveys with lower response rates.(13)

Recommended action incorporated into the Strategy (not previously incorporated in the technical paper)

The Strategy proposes that a question on smoking be included in the Australian census (conducted every five years) to allow calibration with the National Health Survey and National Drug Strategy Household Surveys.

To achieve targets for smoking prevalence requires both a reduction in the number of young people taking up smoking and an increase in the percentage of smokers who try and who succeed in quitting.

Cessation

Overseas developments

Results from the US National Health Interview survey(14) indicated that approximately 19.8% of American adults were current smokers in 2007, a decrease of 1.0 percentage point from 2006 (20.8%). Current prevalence in Australia is comparable: 19.2% of Australians 18 years and over reported smoking on at least some days each week in 2007.(15) Cigarette smoking in the US has declined during the past 40 years among all socio-demographic subpopulations of adults; however, the declines during the past decade have been smaller than in previous decades. The proportion of current everyday smokers who made a quit attempt during the preceding year decreased 7.2 percentage points from 1993 (47.0%) to 2007 (39.8%).

As of 2007, only the state of Utah (11.7%) and the US Virgin Islands (8.7%) have so far met the *Healthy People 2010* goal of reducing the percentage of adults who smoke to 12% or less.

California celebrated the 20th anniversary of the launch of the Californian Tobacco Control Program.(14) Between 1988 and 2007, the prevalence of adult current smoking fell by around 40%. In Australia over the same period, prevalence fell by just over 30%.(15)

Survey results released on 6 May 2009 by the City of New York Health Department indicate that the city's adult smoking rate has plummeted since the advent of its tobacco control program, from 21.5% in 2002 to 15.8% in 2008, a decline that Department officials estimate could prevent more than 115,000 premature deaths in future years. Among smokers, the proportion of heavy daily smokers (11 or more cigarettes per day) has fallen from 36.4% to 28.7% since 2002. The New York City tobacco control program has included large increases in excise duty, a hard-hitting media campaign and provision of free nicotine patches to people who call the city's Quitline.(16)

In a discussion of current trends in tobacco use in Canada,(17, 18) McIvor claims that nicotine addiction and unequal access to advice and support from health professionals are the major barriers to smoking cessation in Canada, and key obstacles to reaching the goal of the Canadian Federal Tobacco Control Strategy(19) of reducing smoking prevalence from 19% (in 2005) to 12% or less by 2011.

Uptake

Overseas developments

Since October 2007, several jurisdictions have reported record lows in the prevalence of smoking among teenagers.

In the US, cigarette smoking rates among American teens in 2008 were at the lowest levels since at least as far back as the early 1990s, according to the Monitoring the Future (MTF) study based at the University of Michigan, which has been surveying national samples of 8th-, 10th- and 12th-grade students each year since 1991.(20) The proportions of students indicating any smoking in the prior 30 days (called 'monthly prevalence') stands at 7%, 12% and 20% in grades 8, 10 and 12, respectively. Across the three grades combined, there was a statistically significant decline in monthly smoking prevalence from 13.6% in 2007 to 12.6% in 2008. One important reason that smoking rates have been dropping for over 10 years is that fewer students ever try cigarettes. The proportion of 8th graders who ever smoked a cigarette is down from 49% in 1996 to 21% in 2008 – a decline of nearly six-tenths. In Australia over a slightly shorter period, the proportion of 12–15-year-olds who had ever smoked declined from 47% in 1999 to 29% in 2005.

In Canada, 15% of 15–19-year-olds reported smoking in 2008, compared with around 28% in 1999.(21) This compares with 8.6% of Australians aged 14–19 years reporting smoking in 2007, compared with 25.3% in 1998.(22)

In New Zealand, a University of Auckland study of over 9500 students from over 100 randomly selected secondary schools found that only 8% of students reported smoking cigarettes weekly or more often in 2007, compared to 16% in 2001. Fewer students had ever tried smoking cigarettes – down from 52% in 2001 to 32% in 2007.(23) The ASH Year 10 survey showed daily smoking had fallen from 15.6% in 1999 to 7.3% in 2007.(24) In Australia in 2005, 9% of 12–17-year-olds reported smoking weekly, down from 19% in 1999. The percentage of Year 10s reporting smoking weekly also halved between 1999 and 2005.(15)

Smoking among young people is much higher in the United Kingdom. Health officials in Scotland have reported that the number of young people smoking in Scotland has returned to a level last seen nearly 10 years ago. In 2004 the percentage of young people smoking in Scotland had fallen to just 25% but by 2007 that figure had returned to 31%. *Source: BBC Online, 2008-12-19, http://news.bbc.co.uk/2/hi/uk_news/scotland/7791012.stm.*

Exposure of non-smokers

New evidence

A Canadian panel of experts has issued a report asserting that evidence from new studies strongly suggests that smoking increases the risk of breast cancer.(25) It has warned that girls and young women face special risks from exposure to smoke. For them, even exposure to second-hand smoke during critical periods of breast development (puberty and early stages of pregnancy) may increase the risk of breast cancer later in life. The report found strong evidence that second-hand smoke contributed to premenopausal breast cancer, but did not find enough support to say it increased the risk of postmenopausal breast cancer.

A study presented at the 2009 Annual Meeting of the American Society of Anesthesiologists provides evidence that the carbon monoxide levels of children exposed to second-hand smoke are often similar to those of active adult smokers, and frequently higher than levels in adults exposed to second-hand smoke. Branden E. Yee MD and his research group from the anesthesiology department at Tufts Medical Center studied 200 children between the ages of one and 12 to assess their levels of carboxyhemoglobin, which is formed when carbon monoxide binds to the blood. Carbon monoxide binds to blood 200 times more easily than oxygen, but the resultant carboxyhemoglobin is unable to deliver oxygen to body tissue, including that of the brain, heart and muscle. Children breathe in a greater amount of air per body weight compared to adults. *Source: Medical News Today (UK), 2008-10-20.* A University of Rochester Medical Center study in more than 2000 six- and 18-year-olds in the 2003-2004 National Health and Nutrition Examination Survey (NHANES), presented at the Pediatric Academic Society Meeting in Baltimore, found that second-hand smoke exposure is associated with lower levels of antioxidants in children. *Source: www.eurekalert.org/pub_releases/2009-05/uorm-csm050409.php.*

Research from the University of Western Australia has found that every day at least one child under the age of five goes through a WA emergency department for treatment of an acute respiratory condition linked to second-hand smoke.(26)

Overseas developments

Researchers at University College London and St George's, University of London, measured recent exposure to tobacco smoke in non-smoking middle-aged men taking part in the British Regional Heart Study by measuring the levels of cotinine at two time points 20 years apart. A blood cotinine level above 0.7ng/mL is associated with a 40% increase in the risk of a heart attack, and other studies have suggested that even a level of 0.2ng/mL may increase the risk. The researchers found that while in 1978–80, 73% of men had a cotinine level above 0.7ng/mL, by 1998–2000 that proportion had fallen to 17%.(27)

Comprehensive strategies to reduce smoking

Overseas developments

Britain's oldest and most powerful medical college, the Royal College of Physicians, has issued a new report calling on the UK Government to set a target to eliminate smoking by 2025.(28) The college has campaigned against smoking since its landmark report in 1962 first demanded action to reduce prevalence. It says the tax on tobacco should be increased by 10% every year, and its sale restricted to licensed retailers in premises, such as off-licences, from which children should be banned. Penalties for smugglers should be increased to match those for class-A drugs such as heroin, and also imposed on those who sell cigarettes to children. The college says the approach 'has the potential to end tobacco smoking in the United Kingdom within the next 20 years'.

A major new report has been launched by Action on Smoking and Health(29) to mark the 10th anniversary of the UK Government's first ever tobacco control white paper, *Smoking Kills*. The *Beyond Smoking Kills* report summarises the achievements made to date and sets out a policy agenda to further reduce smoking prevalence. It includes 44 recommendations and has been endorsed by over 100 UK health and welfare organisations. *Beyond Smoking Kills* includes new research, including:

- Revised estimate of the cost of smoking to the NHS
- Public opinion polling showing high levels of support for a wide range of tobacco control policies
- Impact of tobacco branding on young people and implications for plain packaging.

Tobacco control strategies

Regulation

Stephen Sugarman has raised for discussion the idea of 'performance-based regulation' which would impose a legal obligation on manufacturers to reduce their negative social costs. Rather than suing the firms for damages, or telling them how they should run their businesses differently (as typical 'command and control' regimes would do), performance-based regulation allows the firms to determine how best to decrease today's negative public health consequences. Like other public health strategies, performance-based regulation shifts the focus away from individual consumers onto those who are far more likely to achieve real public health gains. Analogous to a tax on causing harm that exceeds a threshold level, performance-based regulation seeks to harness private initiative in pursuit of the public good.(30) In a debate about the proposal published in the BMJ, Sugarman argues that current approaches to some of our most pressing public health problems – voluntary cooperation with business and requiring companies to change how they operate – are not moving us effectively or efficiently in the socially desired direction. Through performance-based regulation, the government informs businesses on the outcomes it wants from them and leaves them to work out the best ways of attaining those regulatory targets.(31)

Price

Increasing taxes on tobacco products

Action 1.1

Ensure that the average price of a packet of 30 cigarettes is at least $20 (in 2008 $ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products.

New evidence

A study of price elasticity of the Canadian tobacco market has found that smokers with lower levels of educational attainment are less price responsive than tertiary educated smokers, but more price responsive than those who had finished high school but had not gone on to university.(32) Illegal and grey market sales of tobacco products are very high in Canada, and the study authors point out that economic theory would suggest that the 'time costs' associated with bypassing high legal prices are less for lower socioeconomic status (SES) groups.

A systematic review of the literature on price sensitivity among different SES groups has found that 14 of 20 studies have found low SES groups to be more price sensitive.(33)

A new study on smokers in the United Kingdom reported significant differences in triggers for quit attempts as a function of socio-demographic factors. Most notably, smokers of higher SES are more likely to report concern about future health, whereas those from lower SES are more likely to cite cost and current health problems.(34)

An Australian study has found that around three-quarters of smokers report that they would try to quit smoking if the price of a packet of cigarettes increased by 50% (74%, 75% and 70% of low-, mid- and high-SES smokers respectively).(35)

Overseas developments

United States

On 4 February 2009, US President Barack Obama signed into law measures that would increase federal excise duty on tobacco by around 62 cents per pack, taking the total federal tax to US$1.This is by far the largest increase ever in the federal tobacco tax in the United States. The measure went into effect on 1 April 2009 and will help to finance the State Children's Health Insurance Program.(36)

Analysts expect the higher prices to drive cigarette consumption down by about 6.25%, leading to an estimated US$20.9 million loss in state tax revenue and tobacco settlement money.

In the United States, up to February 2009, 17 states had proposed legislation to raise taxes on cigarettes. This is in addition to the 12 states that raised taxes in 2007 and 2008. By the end of April, three states – Arkansas, Kentucky and Rhode Island – had passed increases in 2009. (37) The nation's smallest state, Rhode Island, now has the highest tax on cigarettes in the United States, levying US$3.46 in taxes on every pack sold. A US$1-per-pack increase in the state cigarette tax went into effect in April 2009, on top of a hike in the federal tobacco tax from 39 cents per pack to US$1.01 per pack that was implemented on April 1. Combined, the taxes are expected to drive the price of a premium-brand pack of cigarettes up from about US$6.50 to about US$8.35. Despite the tax increase, Rhode Island doesn't necessarily have the country's highest cigarette prices, since some other states impose a minimum price mark-up in addition to taxes. *Source: http://slati.lungusa.org/reports/CigaretteTaxFactSheet_04-09.pdf.*

United Kingdom

A 2% increase in duties on tobacco products was announced in the UK Budget on 22 April 2009.(38) With the Retail Prices Index projected to decline by 3%, this represents an above-inflation increase. *Source: Financial Times, 23 April 2009, http://tinyurl.com/d94p6a.*

This measure will help to offset declines in government revenue resulting from a temporary lowering of the VAT, and will ensure that the price of tobacco products increases despite the lower VAT.(39)

Republic of Ireland

After a 25% increase in cigarette prices last year, the government in Ireland did not further increase taxes on tobacco products in its April 2009 Budget.

Europe

The European Parliament Economic Affairs Committee has recommended a gradual increase in minimum tax rates on cigarettes, making the minimum tax 1.50 euro on a pack of 20 cigarettes from 2014. The aim of the proposed legislation is to avoid distorting the EU single market and to foster tax convergence (tobacco tax rates currently differ from member state to member state). The proposal also aims to bring minimum tax rates for fine-cut rolling tobacco into line with the rate for cigarettes. The European Commission had proposed increasing the minimum rates in two steps, one from 2010 and the other from 2014, but the committee agreed on 2012 and 2014. *Source: press release: Cigarette tax at least €1.50 per pack from 2014 (www.europarl.europa.eu).*

At their meeting on 6 May 2009, however, finance ministers were unable to agree on the proposal and agreed to hold further discussions later in the month. *Source: European Voice, 6 May 2009, www.europeanvoice.com.*

Hong Kong

Excise duty on tobacco products was increased by 50% to HK$24 (US$3.076) per pack in the Hong Kong Budget released on 25 February 2009. *Source: www.smokefree.hk/cosh/ccs/detail.xml?lang=en&fldrid=2....*

Malaysia

Malaysia has fixed a minimum price of 6.00 ringgit (US$1.70) for a pack of 20 cigarettes to discourage smoking. A typical pack costs about 9.00 ringgit but cheaper brands are available for 4.50 ringgit. The minimum

price was implemented at the end of 2008 after the new ruling under the Control of Tobacco Products (Sale of Tobacco Products) Regulations 2008.(40)

Preventing illicit trade

Action 1.2

Develop and implement a coordinated national strategy to prevent the emergence of illicit trade in Australia and to contribute to combating illicit trade internationally.

Action 1.3

Contribute to the development and implementation of international agreements aiming to combat illicit trade.

Action 1.4

Ban the retail sale of tobacco products via the internet.

Action 1.5

End tax and duty-free sales in Australia. Abolish tax and duty concessions for all travellers entering Australia (specified limits for personal use), and participate in negotiations on international agreements concerning the application of limits to international travellers.

New evidence

A study published in the United Kingdom estimates that tobacco smuggling is responsible for about 4000 premature deaths every year – four times the number of deaths that are caused by using all other smuggled illegal drugs combined. About 21% of all tobacco smoked in the United Kingdom enters the country by smuggling, product that accounts for a 12% lower price of legal tobacco.(41) If smuggling was stopped and the price of legal tobacco rose by 12%, the authors predict that 5% to 8% of smokers would decide to quit. This could save about 4000 lives every year. West and colleagues also point out how health inequalities would be alleviated if the government did more to reduce tobacco smuggling. Low-income people are more likely to smoke illegal tobacco and they are more likely to quit when the price of tobacco rises.(41)

In its report 'Tobacco and Terror, How Cigarette Smuggling is Funding our Enemies Abroad',(42) the US House Committee on Homeland Security has reported on the activities of cigarette smugglers, noting that profits are staggering.

Highlights from a review of evidence on the effectiveness of anti-contraband policy measures(43) was presented at the conference of the Society of Research into Nicotine and Tobacco in Dublin in April 2009.The review presents evidence on the effectiveness of licensing, tax markings, tracking and tracing, record-keeping/control measures, enhanced enforcement, export taxation, tax harmonisation, tax agreements, legally binding agreements with the tobacco industry and Memoranda Of Understanding and public awareness campaigns.

Overseas developments

International

Delegates from more than 150 countries met in Geneva in October 2008 to continue negotiation of a protocol to the FCTC on the elimination of illicit trade in tobacco products. A first round of negotiations had been held in February and another is due in June–July 2009. The draft text under discussion underlined the impact of illicit tobacco trade, not only on public health and government revenue, but also on global law and order.(44) The illicit tobacco trade, it says, 'generates huge financial profits funding transnational criminal activity which penetrates, contaminates and corrupts government objectives and legitimate commercial and financial businesses at all levels'.

Officials hope a final text will be ready for adoption in 2010 by the FCTC Parties. The 34-page draft, presented by the INB Chair, sets out principles for the exchange of information and other international

cooperation between governments and their law-enforcement agencies in order to crack down on illicit tobacco trade in all its forms. It would require governments to implement a range of measures to control the supply chain, including licensing of key participants, the imposition of due diligence and record-keeping obligations, and controls to ensure that products are not supplied in amounts that are not commensurate with demand in the purported market of sale. It would also require governments to set up a `tracking and tracing system' for cigarettes and other tobacco products used to make them. It would oblige Parties to criminalise certain activities and institute tough sentences for offenders.

Meanwhile, several governments around the world have continued to introduce measures to reduce illicit trade.

Europe

The US-based International Consortium of Investigative Journalists has reported that Europe is being flooded by smuggled Russian-made cigarettes and that some cigarettes are now being manufactured in the former Soviet Union solely for smuggling.(45) A network of factories and routes has been put together across Europe since 2004, following large-scale smuggling routes previously supplied by major multinational tobacco companies. The new underground smoking trade involves only one brand, Jin Ling, described as `the first ever designed-for-crime brand', which is turning up in more cities and countries across Europe every month. *Source: Kyiv Post, 7 April 2009, http://tinyurl.com/cp26cw.*

On 1 December 2008, an EU Directive(46, 49) came into force that gives the 27 EU countries the option of reducing the duty-free import limit from 200 cigarettes to 40 cigarettes. Duty-free sales to individuals travelling within the EU have been banned since 1999. According to a report from the European Commission, as of May 2009, six EU countries have taken action so far:

- Five countries (Greece, Hungary, Lithuania, Poland, Slovak Republic) have reduced the duty-free import limit to 40 cigarettes for travellers other than air travellers (thus travellers arriving by land or sea)
- One country, Romania, has reduced the duty-free import limit to 40 cigarettes for all travellers, whether arriving by air, land or sea

Bulgaria (2008) has banned duty-free sales at land borders with non-EU countries (Serbia, Macedonia, Turkey), in addition to banning duty-free sales to individuals travelling within the EU. Romania similarly has banned (~2008) duty-free sales at land borders with non-EU countries (Moldova, Ukraine, Serbia), in addition to banning duty-free sales to individuals travelling within the EU.

(Outside Europe, Nepal has banned duty-free sales at its airport in the capital city of Kathmandu (~2008). Barbados (2008), Sri Lanka (~2006) and Singapore (1991) have banned duty-free imports of tobacco products (thus the duty-free import allowance for tobacco products is zero). Bangladesh has been in the process of doing so. India's Health Minister has called for a ban on duty-free sales of tobacco products in India. *Source: Swaraj Thapa, Now, duty-free cigarettes may be stubbed out, Financial Express (47), 20 November 2008, www.financialexpress.com/news/Now--duty-free-cigarettes-may-be-stubbed-out/388063.*)

Canada

The Canada Revenue Agency has contracted the Canadian Bank Note Co. and SICPA Product Security SA to design, produce and distribute the new excise stamp. The stamp contains several security features, much like those found on currency. It will allow authorities to more easily identify legitimate tobacco products and detect counterfeit or contraband products. The agency has also increased audits of tobacco manufacturers and monitoring of tobacco growers. *Source: The Canadian Press, 5 September 2008.*

Singapore

Starting 1 January 2009, every cigarette on sale in Singapore has had to have the letters 'SDPC' stamped near the filter. All unmarked cigarettes will be deemed to be duty-unpaid and illegal. Anyone caught with an unmarked cigarette will be committing an offence and will face a fine of 500 Singapore dollars (US$352) for every packet of cigarettes found in their possession. Branded cigarettes cost an average of more than 11 Singapore dollars a packet, making them among the most expensive in Asia, due mainly to the high duties aimed at discouraging smoking. *Source: AFP, 12 September 2008.*

United States

On 23 March 2009, a Bill was introduced in the House of Representatives by Congressman Anthony D. Weiner of New York, which was referred to the House Committee on the Judiciary. HR 1676 would prevent tobacco smuggling and ensure the collection of all tobacco taxes. With a few exceptions, all cigarettes and smokeless tobacco would be deemed non-mailable and would not be deposited in or carried through the United States Postal Service mails. Currently FedEx, UPS and DHL have voluntarily agreed not to ship cigarettes. Failing to comply with state tax laws by any seller making a sale via telephone, the mail, or the internet would be a federal offence. Age verification, package labelling and inspection authority would be imposed. *Source: www.examiner.com/x-6751-Phoenix-Political-Buzz-Examiner~y2009m3d30-Hike-in-cigarette-tax-prompts-Congressional-PACT-Act.*

The US Court of Appeals for the Second Circuit has reversed several March 2006 lower court orders and reinstated the City of New York's lawsuits against numerous corporations and individuals who own or operate internet websites selling cigarettes. *Source: Kim Mark Jackson, Buffalo (NY) News, 2008-11-14.*

Legislation is pending in New York State to prevent the smuggling of cigarettes by offering the state and municipal governments a cost-effective and real solution to collecting lost cigarette excise and sales tax revenues. The bill (S6506-A/A11733), which is sponsored by Senator Dale Volker, R-Depew, and Assemblyman Dennis Gabryszak, D-Cheektowaga, requires the state to use 'counterfeit-resistant encrypted cigarette tax stamps' that can be read with an electronic scanning device. This provides vital track-and-trace information from manufacture to the point of sale. The bill also provides monies for a Cigarette Tax Criminal Enforcement Fund to consist of 5% of the tobacco receipts for the purposes of adding enforcement agents and conducting the necessary audits to recapture the lost tax dollars that are now in the pockets of smugglers. Moreover, this legislation allows the Tax Department to licence both cigarette manufacturers and importers.

United Kingdom

In the United Kingdom, the government has updated its strategy to prevent smuggling(39) and in April 2009 signed anti-smuggling agreements with two international tobacco manufacturers.(48) The agreements with Philip Morris International (PMI) and Japan Tobacco International (JTI) complement the legislation that the government introduced in 2006, requiring all tobacco manufacturers to help prevent smuggling through careful control of their supply chains. Since the United Kingdom's first Tackling Tobacco Smuggling strategy was published in 2000, HM Revenue & Customs and the Border Agency have:

- Reduced the proportion of illicit cigarettes from 21% in 2000 to 13%
- Seized more than 14 billion cigarettes and more than 1000 tonnes of hand-rolling tobacco in the United Kingdom and abroad
- Broken up 370 criminal gangs involved in large-scale smuggling and prosecuted more than 2000 people and issued more than £35 million worth of confiscation orders

Source: Progress In The Fight To Tackle Tobacco Smuggling, 4NI.co.uk, 22 April 2009.

Ireland

Figures supplied by the Minister for Finance, Brian Lenihan, to the Dail in March 2009 show that the value of cigarettes and tobacco seized by customs officers has more than doubled in the past three years, from €17.5 million in 2006 to €25.6 million in 2007 and to €54.4 million in 2008. Last year, after a 25% increase in cigarette prices, the Irish Tobacco Manufacturers' Advisory Committee called on the government to stamp out the smuggled trade by redeploying public sector workers to support customs officers. *Source: Jim Cusack, 12 April 2009, www.independent.ie/national-news/cigarette-tax--abandoned-over-smuggling-fears-1706538.html.*

Norway

A ban on tobacco display in Norwegian duty-free stores could be in force by October 2009, if, as expected, new tobacco legislation is voted into law by the country's parliament. *Source: Tobacco display ban looms in Norway, The Moodie Report, 2 March 2009, www.moodiereport.com/document.php?c_id=28&doc_id=19966.*

Developments in Australia

Significant drug seizures at the border and a record haul of illegal tobacco were among the key data in the 2007–08 Customs Annual Report tabled in the Australian Parliament on 1 October 2008.(50) The agency also prevented approximately $114 million in duty evasion by seizing a record amount of illegal tobacco at the border – more than 100 million cigarettes (up from 39 million in 2006–07) and 287 tonnes (up from 64 tonnes) of loose tobacco. The number of individual seizures almost tripled, from 21 in 2006–07 to 58 in the past financial year. *Source: Australian Broadcasting Corporation (ABC), 2008-10-02.*

In April 2009 Justice Elizabeth Fullerton in the NSW Supreme Court noted that enforcement of penalties on a person convicted of tobacco smuggling in 2006 were unlikely to act as a deterrent. The Customs Service mounted the prosecution under laws where a jail sentence was not an option, even though it knew the accused had no money, and was on a bond for a previous tobacco smuggling conviction. The issue of the states collecting such Commonwealth debts is being reviewed by Attorneys General. *Source: Nonee Walsh, Tobacco smuggling penalty a 'waste of time', ABC, 8 April 2009.*

Place of use

New evidence

Analysis of data from the Health Survey for England and the 2002 wave of the English Longitudinal Study of Ageing suggest that exposure to second-hand smoke may be associated with increased odds of cognitive impairment.(51) Authors of the study have called for prospective nationally representative studies relating biomarkers of exposure to cognitive decline and risk of dementia.(52)

A new Duke University study using functional MRI scans of the brain has shown that seeing other people smoking can undermine quitting by people attempting to give up smoking.(53) A study of the impact of the national ban on workplace smoking in the Republic of Ireland, which most notably banned smoking in bars, reported a significant decline in smoking prevalence in the general population. The prevalence of smoking also declined among bar workers, among whom there was also a significant drop in consumption of around four cigarettes per day.(54)

Several additional studies of the impact of legislation covering restaurants and bars have found a strong relationship between the introduction of legislation and declines in mortality and hospital admissions.(55, 56)[1] A new study conducted in the United States by the State Department of Public Health and the Harvard School of Public Health shows that a steep decline in heart attack deaths began when Boston and most of its neighbouring cities adopted bans. Nearly 600 fewer Massachusetts residents have died from heart attacks each year since legislators banned smoking in virtually all restaurants, bars and

other workplaces four years ago, according to a recent report that provides some of the strongest evidence yet that such laws save lives. The study found that enforcement of the state-wide law beginning in mid-2004 coincided with a further reduction: from 2003 to 2006, heart attack deaths in Massachusetts plummeted 30%, significantly accelerating what had been a more modest long-term decline.(57)

Researchers have found that the kinds of reductions in Acute Myocardial Infarctions observed in communities that introduce laws banning smoking in hospitality venues are consistent with a five-hour per week reduction in exposure to second-hand smoke.(58)

Overseas developments

An international list of smoking bans has been compiled on Wikipedia. *http://en.wikipedia.org/wiki/List_of_smoking_bans*

Action 4.1

Amend legislation and departmental policies to ensure that smoking is prohibited in any public places where the public, particularly children, are likely to be exposed.

As of 20 April 2009, there are 76 municipalities in the United States in addition to the Cities of Los Angeles and Chicago and the Commonwealth of Puerto Rico which prohibit smoking anywhere on beaches.(59) (Many other municipalities limit smoking on beaches to particular areas.) As of 20 April 2009, 415 municipalities in addition to the City of Los Angeles and the Commonwealth of Puerto Rico had legislation in place banning smoking in parks.(60)

On 29 April 2009, the US state of Maine voted to ban smoking on state park beaches. The legislation also prohibits smoking within 20 feet of playgrounds, snack bars, picnic shelters and public toilets. *Source: WABI-TV CBS 5 (Bangor, ME), 2009-04-29, www.wabi.tv/news/5680/smoking-ban-on-beaches.*

A state Senate committee has proposed a US$250 fine for lighting up at any state beaches and parks in California. *Source: Wyatt Buchanan, San Francisco Chronicle, 2009-03-24.*

As of 20 April 2009, 32 municipalities in the United States in addition to the City of Los Angeles and the State of Oklahoma had laws in place banning smoking in zoos.(61)

Developments in Australia

The Hobart City Council has banned smoking in most public areas within 10 metres of council playgrounds. *Source: Smoking banned near council playgrounds, ABC News, 18 January 2009.*

Surf Coast beaches are the first in Victoria to ban smoking and glass after new laws were approved in October 2008. The law will operate from 15 November to 31 January each year, and anyone who smokes or takes glass onto designated ban areas will be fined $100. *Source: Yasmin Paton, Geelong Advertiser, 2008-10-30.*

Randwick Council in Sydney is considering introducing smoking fines after 11-year-old Adam Fahy-Majeed started a community campaign to ban the habit on Coogee beach last year. Smokers at Bondi, Australia's busiest beach, are ignoring Waverley Council signs that clearly prohibit the habit. They are also lighting up without fear of fines on Waverley's other major beaches, Bronte and Tamarama, although anti-smoking regulations have been in effect since December 2004. *Source: Cigarette beach ban goes up in smoke in Sydney, The Australian, 12 January 2009.*

1 Although one of these studies failed to find a relationship between workplace bans and heart attacks.

Action 4.2

Legislate to ensure that children are not exposed to tobacco smoke when travelling as passengers in cars.

Overseas developments

In April 2009, the Canadian province of British Columbia joined Ontario, Nova Scotia and the Yukon in banning smoking in cars when children are present. *Source: CBC News, 18 March 2009.* Similar legislation is being introduced in Manitoba and New Brunswick, and is being considered in Prince Edward Island. *Source: Jessica Hinds, Canwest News Service (ca), 2009-03-30.*

The Department of Health in the Republic of Ireland is also reviewing a proposal to ban smoking in cars.

Developments in Australia

Laws banning smoking in cars carrying children were introduced into the Queensland Parliament in November 2008.(62) The legislation will also allow councils to regulate smoking at shopping centres and public transport waiting areas. Source: Government to ban smoking in cars with children, ABC News, 14 November 2008. The NSW Government has passed similar legislation(4) and the Victorian(3) Government also announced its intention to introduce similar provisions. The ACT Health Minister has also indicated that she intends to introduce similar legislation this year. *Source: Support for smoke ban in cars containing children, ABC News, 30 March 2009. Legislation is already in force in Tasmania(63) and South Australia.*(64)

MPs in Western Australia have reached agreement on an anti-smoking bill put forward by Independent MP Janet Woollard, ensuring its quick passage through parliament. The legislation will make it illegal for people to smoke in cars carrying passengers aged under 17, with the Health Department, not police, having the discretion to issue $200 fines to repeat offenders. *Source: ABC News, 6 May 2009, http://tinyurl.com/dkw93z.*

Action 4.3

Tighten and enforce legislation to protect against exposure to second-hand smoke in all workplaces (including both indoor and outdoor areas in restaurants and hotels, near the entrances to buildings and air-conditioning intake points and in workplace vehicles).

New evidence

A study on the impact of legislation mandating smoke-free pubs and clubs in Scotland found that exposure to second-hand smoke declined, with no change in the percentage of smokers reporting smoke-free homes, no change in the reported numbers of cigarettes smoked inside at home and no differences between Scotland and the rest of the United Kingdom in self-reported frequency of visiting pubs.(65)

Overseas developments

As of 20 April 2009, 16 US states had laws in place mandating smoke-free restaurants and bars. An additional three states had passed but not yet enacted legislation.(66) Around 340 additional sub-state municipalities had also enacted laws.

As of 20 April 2009, 148 US municipalities in addition to the states of Iowa and Hawaii and the City of Manhattan had legislation in place banning smoking in outdoor dining areas.(67)

A study authored by a Northeastern State University economics professor says the state smoking ban has not had an adverse effect on Oklahoma restaurants.(68) Another study found that no significant harm to charitable gaming revenues was associated with the smoke-free legislation during the 7.5-year study period, despite the fact that Kentucky is a tobacco-producing state with higher-than-average smoking rates.(69)

Developments in Australia

The Cancer Council (Tasmania) has released a report carried out by the University of Tasmania on the economic impact of smoking bans, revealing no lasting economic effects on Tasmanian hotels and clubs.(70)

A case considered in the NSW Supreme Court has clarified the interpretation of open and enclosed spaces in pubs and clubs in NSW. Chief Justice McClennan held that the calculation to be made under the guidelines in clause 6 of the Regulations is only to be made with respect to an area which is covered. An area that is not covered is not relevant to the calculation, regardless of whether the walls and floor continue on into that area. If there are gaps in the ceiling or roof, that place must be assessed for the purposes of clause 6, but the open terrace areas in this case clearly did not amount to 'gaps'.(14)

Action 4.4

Introduce and enforce legislation and encourage the adoption of policies that restrict smoking outdoors where people gather or move in close proximity.

Overseas developments

As of 20 April 2009 in the United States, 130 municipalities in addition to the State of Iowa, the Territory of Guam and the City of San Francisco had legislation in place banning smoking at bus stops and other outdoor transit waiting areas.(71)

Developments in Australia

WA MPs have agreed that smoking will be banned in alfresco areas of restaurants and cafes, and hotels will have to make 50% of their alfresco areas smoke-free. Source: ABC News, 6 May 2009, http://tinyurl.com/dkw93z.

Action 4.5

Protect residents from exposure to smoke-drift in multi-unit developments.

Overseas developments

Jim Bergman, director of the Smoke-free Environments Law Project based in Ann Arbor, Michigan, has reported that as of August 2008, roughly 80 public housing authorities in 15 states from California to Maine have adopted smoke-free policies. The group works with local health departments on smoke-free issues, largely focusing on apartments and condominiums. Any policy change has to be approved by the US Department of Housing and Urban Development and the housing authority's board of commissioners. *Source: Madhu Krishnamurthy, Chicago Daily Herald, 2008-08-31.*

Place of sale

Action 3.3

Amend legislation nationally and in all states to ensure that tobacco is out-of-sight in retail outlets.

An analysis by Paynter and Edwards(72) of peer-reviewed research has found that seven of eight observational studies established statistically significant associations between exposure to tobacco promotion at the place of sale (PoS) and smoking initiation or susceptibility to smoking. Two experimental studies of children found statistically significant associations between exposure to PoS tobacco promotions and beliefs about the ease of obtaining tobacco and smoking prevalence among their peers. An experimental study with adults found that a picture of collected tobacco packs elicited cravings for cigarettes among smokers. A cross-sectional study found that 25% of adult smokers reported impulse purchasing and a third of recent ex-smokers reported urges to start smoking after seeing tobacco displayed.

An intercept study(73) subsequent to Paynter and Edwards has found that unplanned cigarette purchases were made by 22% of participants, with PoS displays influencing nearly four times as many unplanned purchases as planned purchases (47% v 12%, p<.01).

Overseas developments

United Kingdom

In December 2008, the UK Government tabled a bill which included a ban on the open display of tobacco in shops in England and Wales. Source: Ban on tobacco displays announced, BBC News, 10 December 2008; Cigarette sales forced 'under the counter', *www.independent.co.uk/.... See Health Bill 2009, Part 3 – 'Improving public health' http://services.parliament.uk/bills/.* The legislation was considered by the House of Lords on 6 May 2009. Source: onmedica, 27 April 2009, Members of the House spoke strongly against a proposed amendment that would have allowed retailers to keep samples of one pack each above the counter, Clause 19 of the bill was supported 204 to 110, and the bill went to the Lower House for consideration.(74)

Similar legislation was approved in Scotland,(75-77) where larger retailers will have until 2011 and smaller ones to 2013 to comply. The Assembly has approved similar legislation in Northern Ireland, where retailers are also pushing for a 2013 Implementation date. *Source: BBC News.*

Ireland

A ban of displays took effect in the Irish Republic from 1 July 2009, making it the first EU country to introduce such a measure.

New Zealand

The incoming National coalition government in New Zealand has ruled out legislation being considered by the previous Labour government to ban point-of-sale displays of tobacco products. *Source: Retailers Thank National Government, 25 February 2009, www.scoop.co.nz/...*

Europe

A Finnish social policy ministerial group has proposed a range of measures to restrict access to tobacco, including a ban on the display of tobacco products in most shops. *Source: Finland mulls banning display of tobacco, NewsRoom Finland, 27 March 2009.*

Overview

As at the end of November 2008, three countries (Iceland from August 2001, Thailand from September 2005 and Ireland from July 2009), 12 Canadian provinces and territories[2] and the British Virgin Islands (from May 2007) had adopted laws to prohibit the visible display of tobacco products at point of purchase.

Developments in Australia

The state parliament of New South Wales passed legislation(4) that will:

- Put tobacco products out of sight in all supermarkets, petrol stations, newsagencies, general and corner shops by the end of 2009 or very early 2010 (and specialist tobacconists within four years)
- Reduce tobacco sale to a single point of purchase in each retailer, remove it from shopper loyalty programs and partly license its sale
- Limit tobacco sale from vending machines by restricting it to a token system with proof of age required

The out-of-sight retail display requirement in New South Wales will be the first to come into effect in any Australian jurisdiction. The state of Tasmania has previously legislated for it, to come into effect in February 2011. Legislation in the ACT(78) will come into effect on 1 January 2010. Bans have also been announced in Victoria(3) and the Northern Territory.(79)

2 Canada (12 of 13 provinces/territories) 1. Saskatchewan (11 March 2002); 2. Manitoba (1 January 2004)*; 3. Nunavut (1 February 2004); 4. Prince Edward Island (1 June 2006); 5. Northwest Territories (21 January 2007); 6. Nova Scotia (31 March 2007); 7. British Columbia (31 March 2008); 8. Ontario (31 May 2008); 9. Quebec (31 May 2008); 10. Alberta (1 July 2008); 11. New Brunswick (1 January 2009); 12. Yukon Territory (15 May 2009).

MPs in Western Australia have reached agreement on an anti-smoking bill put forward by Independent MP Janet Woollard, ensuring its quick passage through Parliament. Tobacco product displays will soon be banned, but specialist stores will be exempt. *Source: ABC News, 6 May 2009, http://tinyurl.com/dkw93z.*

Action 5.1

Tighten and enforce legislation to eliminate sales to minors and any form of promotion of tobacco at the retail level.

New evidence

A new study(80) has found strong evidence that American adolescents who live in states that comply with tobacco sales laws are less likely to take up a smoking habit than are those who live where the laws are not vigorously enforced. In addition, the study also showed that increasing the price of a pack of cigarettes might have an equal, if not greater, effect. DiFranza and his colleagues analysed data from a 2003 survey of 16,244 adolescents to obtain information on smoking habits. In addition, they looked at state-collected data on merchants' compliance with anti-tobacco laws. They then correlated the data, taking into account such factors as cigarette prices, restaurant smoking policies, anti-smoking campaigns and demographic information that included age, gender, race, ethnicity and parents' education level. The researchers found that as merchants more diligently enforced the ban on tobacco sales to minors and as the price of cigarettes rose, the likelihood of teens smoking dropped. Improved compliance with the laws from 1997 to 2003 was credited with an approximate 21% decline in the likelihood of a teen smoking. Price increases for a pack of cigarettes during that time reduced the odds by about 47%.

Retailers in lower income areas in the United States have been found to be more likely to sell tobacco products to minors. A new study finds that population density is also significantly associated with underage tobacco sales.(81)

A randomised controlled trial evaluating the impact of laws which fine youth for possessing and using tobacco found that the rates of current smoking were not significantly different between the two conditions at baseline, but over time, rates increased significantly less quickly for adolescents in experimental than those in control towns.(82)

An important study in New South Wales examined the impact of enforcement of age-restricted tobacco sales on adolescent tobacco purchasing and smoking, comparing the Central Coast intervention area to the rest of New South Wales and Australia, for students in school years 7 to 12 from triennial health surveys at baseline in 1993 through 2002. Attempts by minors to purchase tobacco in the intervention area declined by 73.6% between 1993 and 2002. Between 1993 and 1996, the prevalence of smoking declined in the Central Coast intervention area, while remaining unchanged in the state as a whole and nationally ($P<0.0001$). Between 1993 and 2002, the prevalence of current smoking in the intervention area was reduced by half. Effective enforcement of an age-restricted tobacco sales law was accompanied by a substantial reduction in attempted purchases of tobacco and of smoking by youth. The long-term follow-up in this study allows us to observe that the impact of the intervention was not only sustained but also increased with time.(83)

Overseas developments

The New York Association of Convenience Stores (NYACS) has fought against an increase of the state's annual registration fee to sell tobacco at retail, from a flat US$100 per store to:

- US$1000 for stores with less than US$1 million in sales, a 900% increase
- US$2500 for stores with sales between US$1 million and US$10 million, a 2400% increase
- US$5000 for stores with more than US$10 million in sales, a 4900% increase

Source: NYACS Fights 'Obscene' Retail Tobacco Fees, Convenience Store News, 4 March 2009.

Promotion

Action 3.1

Legislate to eliminate all remaining forms of promotion, including promotion of price specials, public relations activities, payments to retailers and proprietors of hospitality venues, promotion through packaging and, as far as feasible, through new and emerging forms of media.

New evidence

Documents released in the United States by the Community Rights Counsel, a non-profit Washington law firm, show that corporations including Exxon Mobil, Philip Morris and R.J. Reynolds Tobacco have contributed tens of thousands of dollars towards programs providing free travel for US federal judges. *Source: Eric M. Weiss, Washington Post Staff Writer, www.theusconstitution.org/upload/filelists/224_Washington_Post_5-25-2006.pdf.*

Overseas developments

Nations meeting in Durban, South Africa, in November 2008 at the Conference of Parties to the FCTC unanimously adopted international standards to protect tobacco control public health policies from tobacco industry interests. Additionally, standards were adopted to assist governments to implement their obligations to ban all forms of tobacco advertising, promotion and sponsorship.(84, 85)

Developments in Australia

A *Sunday Mail* investigation has revealed that Imperial Tobacco lavished trendy Adelaide stores with cash incentives and corporate entertainment in return for stocking Peter Stuyvesant brand cigarettes in specially designed cigarette dispensers. The SA Substance Abuse Minister, Jane Lomax-Smith, ordered a report into the laws on the sale of cigarettes through these outlets in the wake of the investigation, which discovered that:

- Cash incentives of up to $2000 a year are offered to stores agreeing to sell cigarettes
- Smoking is promoted as safe and cool in literature given to targeted fashion outlets
- Free cigarettes are handed out to stockists
- Boozy lunches and even a swish cruise have been held for businesses that sell the brand

Source: Sam Kelton, Imperial Tobacco offers cash incentives for fashion outlets to sell Peter Stuyvesant cigarettes, Sunday Mail, 15 December 2008.

From 19 January 2009 the South Australian Government will be restricting the promotion and display of tobacco products at youth events, such as The Big Day Out. Victoria also announced a ban on sales at temporary outlets from 1 January 2010.(3)

Action 9.5

Make smoking a 'classifiable element' in movies and video games.

New evidence

Investigators reported in the BMJ specialist journal *Tobacco Control* that financially lucrative commercial collaborations between tobacco companies and major motion picture studios beginning in the late 1920s are responsible for the smoking imagery so prevalent in 'classic' movies.(86)

A new report released in February 2009, *Smoking Presentation Trends* in US Movies 1991–2008, indicates that tobacco exposure incidents per film have decreased by about half since 2005. However, smoking imagery on film still remains high. While the proportion of all films that are smoke-free has been growing since the late 1990s, it still remains below 50%, even for youth-rated (G/PG/PG13) films, leaving a majority of movies with smoking. In fact, most youth exposure to on-screen smoking occurs in youth-rated films. In 2008, PG13-rated films delivered 65% of on-screen tobacco impressions. The report was conducted by Breathe California of Sacramento-Emigrant Trails and the Center for Tobacco Control Research and Education University of California,

San Francisco. *Source: American Legacy Foundation, 2009-02-25, http://americanlegacy.org/3006.aspx.*

More than one-quarter of adults participating in a New South Wales survey in 2004 thought that movies they had seen recently contained excessive or inappropriate smoking.(87)

Several further studies have found that exposure to movie smoking are strongly associated with trying smoking.(88)

On the other hand, researcher Connie Pechmann from the University of California Irvine has found that television shows that subtly embed second-hand smoke messages in their plots reduce adolescents' intent to smoke, but that epilogues restating the anti-smoking message are counter-productive; they actually make smokers resist the message. *Source: Technology Marketing Corporation, 2009-03-19, www.tmcnet.com/viewette.aspx?u=http%3a%2f%2fwww.tmcnet.com%2fusubmit%2f2009%2f03%2f19%2f4069389.htm&kw=0.*

Overseas developments

Guidelines for implementation of Article 13 of the FCTC concerning Tobacco advertising, promotion and sponsorship adopted in November 2008 state that `Parties should take particular measures concerning the depiction of tobacco in entertainment media products, including requiring certification that no benefits have been received for any tobacco depictions, prohibiting the use of identifiable tobacco brands or imagery, requiring anti-tobacco advertisements and implementing a ratings or classification system that takes tobacco depictions into account'.(89) *Para 31*

In January 2009 the Delhi High court struck down the Indian Government's notification of 2005 banning smoking scenes in films or television. In its order, the court allowed the depiction of smoking scenes in the films as it formed the fundamental right of a film-maker to show his creative abilities. It said banning smoking in films violated a filmmaker's fundamental right of freedom of speech and expression enshrined in Article 19 (1) (a) of the Constitution. *Source: Indian Television Dot Com (in), 2009-01-23.*

Packaging

Action 3.3

Eliminate promotion of tobacco products through design of packaging.

New evidence

Of relevance to promotion through the packaging of tobacco products is the fact that consumer research continues to indicate the power of incidental encounters with other consumers in determining brand choice.(90)

An experimental study of the effects of packaging on the image of smoking and characteristics of tobacco products found that smokers of plain packs were rated as significantly less trendy/stylish, less sociable/outgoing and less mature than smokers of the original pack. Compared with original packs, smokers inferred that cigarettes from these plain packs would be less rich in tobacco, less satisfying and of lower quality tobacco.(91)

A paper presented at the 2009 meeting of the Society for Research into Nicotine and Tobacco(92) found that substantial proportions of UK adult smokers and children reported false beliefs about health risk based on packaging. For instance, around half of adults thought that Marlboros in gold packaging posed less of a risk to health than Marlboros in red packaging. Around one-third thought that Marlboro Golds would be easier to quit than Marlboro Reds. Around half of adults thought that Mayfair Smooth posed less of a risk to health than Mayfair Kingsize. Almost 40% of youth said that they would be more likely to try the Smooth than the Kingsize variant. Around a third of smokers thought it would be easier to quit. The research found that false beliefs were independently associated with descriptors and colour/imagery. The number of people who indicated that there was probably no difference in

health risks between brand variants increased substantially when brands were presented in plain packaging. For instance, the percentages who indicated that there was probably no difference in health risks posed by Lambert & Butler King Size compared with Lambert & Butler Gold increased from 58 to 75%. The percentage indicating that there would be no difference in how hard it would be to quit using the product increased from 68 to 83%. Plain packaging clearly made cigarettes less attractive to both adults and to children.

Overseas developments

At its third session in November 2008, the Conference of the Parties to the FCTC adopted guidelines for implementation of Article 11(93) of the FCTC covering the packaging and labelling of tobacco products. The guidelines state:

> **Plain packaging**
>
> *46. Parties should consider adopting measures to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style (plain packaging). This may increase the noticeability and effectiveness of health warnings and messages, prevent the package from detracting attention from these and address industry package design techniques that may suggest that some products are less harmful than others.*

The Tobacco Technical Paper referred to a discussion paper released by the UK Government including a proposal to introduce plain packaging.(94) After considering submissions commenting on its discussion paper, the government subsequently ruled out implementing such a proposal at that stage. Planned curbs on smoking to be axed, *Source: The Times, 1 December 2008.(95)*

The United Kingdom's largest tobacco company has warned it will take legal action against the government if it introduces a law forcing the firm to package cigarettes in plain white cartons. In a letter from Imperial Tobacco to the Department of Health and members of the Lords, the company states that amendments tabled to the current health bill passing through parliament, outlawing branded packets, will do nothing to make smokers more aware of the health risks or reduce the appeal of smoking. Imperial, which makes Lambert & Butler, Embassy and Regal, says it believes that 'plain packaging for tobacco products is unnecessary, unreasonable and unjustified'. Further, it gives the government notice that it will seek a judicial review of any legislation barring branded packs.

The letter states: 'Imperial Tobacco is also concerned about the continued erosion and potential expropriation of our valuable intellectual property rights ... Regulation that requires plain packaging will expropriate valuable corporate assets in which the company and its shareholders have invested for more than a century and risks placing the UK Government in breach of a range of legal and treaty obligations that relate to intellectual property rights, international trade and EU law'.

Imperial's own research also confirms the importance of branding. In a presentation to investors in 2006, Imperial discussed the introduction of its 'Celebration' range of Lambert & Butler packets. One of the company's executives told the conference: 'They were introduced as a four-month special edition, replacing the original pack until February 2005. The effect was very positive. Already the number 1 brand, our share grew by over 0.4% during this period – worth over £60 million in additional turnover. Often in marketing, it is difficult to isolate the effects of individual parts of the mix. But in this case ... the pack design was the only part of the mix that was changed.' *Source: Jamie Doward, Pledge to stop law on plain cigarette packets, The Observer, 2 March 2009.*

In February 2009 a House of Lords Committee (comprising cross-party backbench peers) considered the government's legislative reforms and proposed several amendments to the UK Health Bill which would mandate

plain packaging.(96) Lord Patel spoke to the amendment reproduced in Attachment 1 during debate of the government's Health Bill on 6 May 2009.(97) Lord Patel withdrew the amendment after the Health Minister undertook to consider the issues of plain packaging in the development of the Government's Tobacco Control Strategy.

Developments in Australia

A case study presented at the World Conference on Tobacco or Health in Mumbai in March 2009(98) demonstrated how the Dunhill brand was able to significantly increase sales and market share in the absence of any allowable media advertising following significant changes in packaging of the product and promotion to retailers encouraging more prominent display at point of sale.

Product

Consumer product information

Action 5.2

Improve consumer information related to tobacco products, including through the mandating of substantially larger front-of-pack health warnings, more regular reviews of health warnings and a more timely system of warning consumers of new and emerging risks.

New evidence

The International Tobacco Control Study has reported on the basis of its program of research comparing the impact of different sizes and forms of health warnings in different countries over the past five years that both size and placement are important in determining the effectiveness of warnings.(99) Front-of-pack warnings are viewed significantly more often than back-of-pack warnings(100) so that larger front-of-pack warnings have significantly more impact than back-of-pack warnings of a comparable size. The Study has also published data indicating that forgoing cigarettes as a result of noticing warnings and quit-related cognitive reactions to warnings are consistent prospective predictors of making quit attempts.(101)

Research conducted for Health Canada has found that graphic health warnings need to cover almost the entire surface of cigarette packages if they are to become more effective in convincing smokers to quit. The department set out to determine whether increasing the warning size from the current level – 50% of the panel's surface – to 75%, 90% or 100% of cigarette packages would have a greater effect on smokers. The research, conducted by Montreal-based polling firm Createc, found that increasing the size of health warning to cover 75% of cigarette packages would only have a 'small impact' and over time would be unlikely to remain more effective than the current coverage of 50%. After interviewing 730 adult smokers, 306 teen smokers and 440 teens who are likely to start smoking, the firm found that warnings need to cover at least 90% of the package for the negative messages about smoking to achieve 'substantial' and 'significant' effects on most indicators. These indicators include perceived communication impact, personal persuasiveness, smoker image, product image, emotional impact and packaging attractiveness.(102)

Overseas developments

At its third session in November 2008, the Conference of the Parties to the FCTC adopted guidelines for implementation of Article 11(93) of the FCTC covering the packaging and labelling of tobacco products. The guidelines state:

> *'12 ... Given the evidence that the effectiveness of health warnings and messages increases with their size, Parties should consider using health warnings and messages that cover more than 50% of the principal display areas and aim to cover as much of the principal display areas as possible.'*

The WHO has selected 'Tobacco Health Warnings' as the theme for the next World No Tobacco Day, which took place on 31 May 2009.(103)

In February 2009, Mauritius announced new regulations to come into force on 1 June 2009, mandating warnings to occupy 65% of the total front/back surfaces of the pack.(104)

The European Commission is planning a new study aimed at developing better graphic images to warn of the damaging effects of tobacco, in a bid to encourage more EU countries to put the pictures on cigarette packets.(105) The Commission has already asked researchers to submit proposals for the new study, which would include developing a new library of colour photographs, images and text warnings about the negative consequences for health of tobacco consumption.

Developments in Australia

The Department of Health and Ageing's evaluation of the Australian graphic health warnings introduced in 2006 was released in April 2009. The evaluation indicated that while smokers strongly approved of the graphic form and the tone and style of warnings, unaided recall of health information declined from 98% in 2000 to 91% in 2008.(106) Smokers interviewed confirmed the importance of the front of the pack for conveying health information, with many smokers commenting that the current warnings were too small and made less prominent by placement on the lid. The evaluation also indicated some wear-out of current warnings and evidence that colours and other design features of cigarette packs were competing with and reducing the impact of warnings.

Tobacco products

Action 5.4

Establish or nominate a body with the power to regulate the design, contents and maximum emissions for all tobacco products (and any alternative nicotine delivery devices that may be allowed onto the market), and with responsibility for specifying required disclosure to government, labelling and any other communication to consumers.

A North American panel of experts has released its findings on principles for reducing tobacco-related harm.(107) Its report describes short- and long-term objectives, and outlines a strategic vision and blueprint for research, policy and communications to reduce the harm from tobacco for the United States. Panel members identified several issues requiring further research before policy changes could be recommended. These issues involve questions, such as whether reducing the nicotine content of cigarettes to non-addicting levels would likely lead to a reduction in smoking prevalence, and what issues might arise from the long-term use of less harmful nicotine-containing products.

New evidence

A University of California Riverside study has shown that smoke from 'light' or 'low-yield' harm-reduction cigarettes retains toxicity that can affect prenatal development.(108) 'Many chemicals found in harm-reduction cigarette smoke have not been tested, and some are listed by manufacturers as safe,' said Prue Talbot, a professor of cell biology who led the study. 'But our tests on mice clearly show that

these chemicals adversely affect reproduction and associated development processes. The effects are likely to be the same in humans, in which case pregnant women would be particularly vulnerable to the effect of smoke from these cigarettes.' The researchers found that both mainstream and sidestream smoke from traditional and harm-reduction cigarettes are toxic to pre-implantation embryos and can retard growth or kill embryonic cells at this stage of development. They were surprised that smoke from harm-reduction cigarettes appeared to be more potent than the corresponding smoke from traditional brands of cigarettes.

A study of the smoking of carbon filter cigarettes (Marlboro Ultra Smooth) produced few differences in smoking topography and exposure compared with conventional low and ultralow-yield cigarettes. Results suggest that the manner in which Marlboro Ultra Smooth cigarettes are smoked by humans is unlikely in the short term to reduce exposure among smokers who switch from a conventional brand.(109)

Variation in ISO/FTC tar yields are predicted by a limited set of cigarette design features, especially filter ventilation, suggesting that governments should consider mandatory disclosure of cigarette design parameters as part of comprehensive tobacco product regulations.(110)

Overseas developments

BAT has updated its website to more clearly state that low-tar cigarettes are unlikely to be any less dangerous; *Source: www.bat.com/group/sites/uk__3mnfen.nsf/vwPagesWebLive/DO52ANCZ?opendocument&SKN=1&TMP=1.*

United States

In November 2008 the United States Federal Trade Commission (FTC) prohibited tobacco companies from claiming that cigarette tar and nicotine ratings are based on an FTC-approved testing method or that they are endorsed or approved by the FTC. The FTC found that the widely used method for testing tar and nicotine, often referred to as the FTC Method, Cambridge Filter Method or ISO Method, is flawed and does not provide consumers with useful information and is likely to mislead consumers. The FTC action rescinds a guidance issued in 1966 that permitted statements concerning tar and nicotine yields based on the FTC Method. Today's FTC puts the tobacco companies on notice that they risk legal action by the FTC if they use the current tar and nicotine ratings in a way that the FTC finds false or misleading. *Source: www.ftc.gov/opa/2008/11/cigarettetesting.shtm.*

On 1 April 2009 the US House of Representatives approved *The Family Smoking Prevention and Tobacco Control Act* by a 298–112 margin, a bill that would give the US government unprecedented powers over the tobacco industry, including new curbs on marketing tactics and cigarette ingredients. The bill was passed by the US Senate on 11 June 2009, and is set to go back to the House of Representatives for approval and signing into law by President Obama.(111) Backed by health groups such as the American Cancer Society, American Heart Association and American Lung Association, apart from controls on advertising and promotion, the bill requires tobacco companies to disclose to the US Food and Drug Administration (FDA) the ingredients in their products, and allows the agency to require changes to protect public health, though not to reduce nicotine content to zero or ban any particular class of tobacco products. *Sources: AFP, 2 April 2009, http://tinyurl.com/cbhnv3; Historic anti-smoking vote to give FDA new power, Washington Post, www.washingtonpost.com/wp-dyn/content/article/2009/06....*

While there is strong support for the legislation, there are also some who remain concerned about the potential downsides, including the unintended consequences, of harm reduction approaches to tobacco control. Some individuals and groups continue to oppose the bill on the grounds that it gives undue influence to tobacco companies, for instance through membership of the Scientific Advisory Committee, and through provisions requiring the FDA to minimise the financial impact of regulations on companies.

Canada

The New Democratic Party has tabled a private member's bill aiming to amend the Canadian Tobacco Act to ban flavours and additives that appeal to children.(112)

Developments in Australia

Late last year, the Federal Department of Health and Ageing engaged the Ipsos-Eureka Social Research Institute to assess the public health value of disclosing cigarette ingredients and emissions data, as proposed by some health groups. The group found the one-off agreement negotiated by former Health Minister Dr Michael Wooldridge was unlikely to have directly promoted or protected the health of Australians. `In research with smokers, non-smokers, and tobacco control stakeholders, the currently disclosed emissions and ingredient information was seen to be incomprehensible, uninteresting, incomplete and difficult to access', the January 2009 report states. `Most members of the public had not and did not intend to access the information (and) providing members of the public with the disclosed information did not seem to discourage them from smoking.'(113)

Non-combustible tobacco products

New evidence

Although associated with lower overall mortality, including a greatly reduced risk of cancer, results of a new study suggest that the use of oral moist snuff, a type of smokeless tobacco widely used in Sweden that is also known as `snus', may increase the risk of fatal stroke.(114)

Ruyan America, Inc., released a report on 29 October 2008 on the results of testing of the safety of its electronic smoking alternatives, specifically the nicotine cartridges that produce the smoke-like vapour that users find satisfies their desire for tobacco. The report summary states that the test results `confirm that the Ruyan(R) E-cigarette is a safe alternative to smoking, very safe relative to cigarettes and safe in absolute terms on all measurements that were applied'. The summary also notes that the report findings refer only and specifically to Ruyan products. The tests were conducted by Dr Murray Laugesen of Health New Zealand, Ltd, who also authored the report, and they were performed by seven leading government, university and commercial laboratories in New Zealand and Canada. Ruyan funded the tests and the report, but had no role in the design of the tests or any input with respect to the findings in the report. No completed tests were withheld from the report, which can be viewed in its entirety at http://healthnz.co.nz/.... *Source: MarketWatch, 29 October 2008.*

A study in *Tobacco Control*(115) has found that non-combustible products are much less effective than combustible products in suppressing abstinence symptoms.

Tobacco control advocates continue to debate the significance of comparative figures on cigarettes and smokeless tobacco in the United States. Only very small numbers of American smokers report shifting to smokeless tobacco products, with greater numbers reporting swapping from smokeless to cigarettes than cigarettes to smokeless.(116) Supporters of the deregulation of smokeless tobacco argue that these figures demonstrate only that people are unaware of the lower risks associated with smokeless tobacco.(117)

Overseas developments

A Florida company that imports and distributes so-called electronic cigarettes has filed suit against the Food and Drug Administration, claiming the agency is illegally blocking imports of its product into the United States. The suit,(118) filed by Smoking Everywhere in the US District Court for the District of Columbia, argues that the FDA has overstepped its regulatory authority by banning shipments of the devices and insisting they need to go through the drug approval process. The company has also recently announced their creation of `vitamin-enhanced' e-cigarette cartridges, including flavours such as grape, pomegranate, bubble-gum, chocolate-chip cookie, fruit

punch, etc. *Source: www.free-press-release.com/news/200904/1240607546.htm....* By contrast, the new Electronic Cigarette Association (www.ecassoc.org) and Ruyan (http://ruyanamerica.com), which is not a member of the ECA, have both opposed the marketing of flavoured e-cigarettes. They are also reported to support bans on the marketing of e-cigarettes to youth, and support reasonable manufacturing and marketing regulations for e-cigarette products.

Health Canada has undertaken a review of e-cigarettes, with the outcome pending. The concern, experts say, is that the exact amount of nicotine released by e-cigarettes is unknown, whereas nicotine levels in approved smoking-cessation aids are clearly indicated and proven to be effective at helping smokers kick the habit.

As mentioned above, the US Congress has recently passed the Family Smoking Prevention and Control Bill, which gives the FDA explicit power to regulate cigarettes and the right to oversee e-cigarettes as well. *Source: http://legaltimes.typepad.com/blt/2009/04/fda-sued-over-electronic-cigarette-embargo-.html.*

Reduced ignition propensity cigarettes

New Federal legislation(119) will require all cigarettes imported and manufactured in Australia to comply with stricter fire safety standards from March 2010. The reduced fire risk (RFR) cigarettes will be designed to self-extinguish before burning to their full length at least 75% of the time, lowering the likelihood of fires caused by discarded butts. Canada and 36 US states have already passed fire-safe cigarette laws, while the EU aims to pass similar legislation by 2011. New York reported a 30% decrease in cigarette-caused fire deaths in the year following the introduction of RFR cigarettes. *Source: Epoch Times.*

Regulations passed in April 2009(120) will bring forward the deadline by which no non-compliant stock may be sold from March 2011 to September 2010.

The Victorian Government has banned the sale and advertising of battery-powered cigarettes (7 syndicated radio). *Source: Victoria bans battery powered cigarettes, The Age, 5 January 2009.*

Queensland researchers Hall and Gartner have called for liberalisation of the sale of smokeless tobacco products in Australia.(121)

Producers

Action 5.5

Investigate the feasibility of legal action by governments and others against tobacco companies.

Overseas developments

The Alberta Government in Canada has introduced legislation that will allow it to join other provinces in suing tobacco companies to recover billions of dollars in smoking-related health costs and for alleged misrepresentation of their products. The legislation would permit the government to retrieve costs resulting from 'wrongful acts or omissions' by tobacco manufacturers, and could see the province try to snare some of the roughly C$500 million in annual health costs associated with tobacco use. Liepert noted that the government hasn't made a final decision on whether it will proceed with a lawsuit and will review its options in the coming months, including whether to join other provinces in one larger case. Alberta is now the eighth province to have laid the groundwork for lawsuits against Big Tobacco. British Columbia and New Brunswick passed legislation and initiated lawsuits to recover healthcare costs, while Ontario, Newfoundland, Nova Scotia, Saskatchewan and Manitoba have also introduced or passed health cost recovery legislation. *Source: Calgary Herald, 12 May 2009, http://tinyurl.com/ozfxf8*

A US appeals court has largely upheld a landmark ruling that cigarette makers lied about the health risks of smoking. Washington's Court of Appeals rejected an appeal by tobacco firms against a 2006 decision that

banned labels such as "low tar" and "light". Companies including Philip Morris USA were found guilty of racketeering and fraud over the issue. Judges upheld the previous ruling, but excluded one firm and two trade groups from their judgement. They ruled that the trade bodies—Council for Tobacco Research-USA and Tobacco Institute—had not made or sold products, so could be excluded. And the firm Liggett was excused because it had co-operated with the authorities and acknowledged health risks. But the judges rejected an argument from the other tobacco firms that they had never claimed that "light" cigarettes were less harmful. The companies are now likely to take their appeal before the US Supreme Court, although commentators say that their chances of success are slim.
Source: BBC News, 22 May 2009
Link: http://tinyurl.com/poqxlo

Promotion of Quit and Smoke-free messages

Action 2.1

Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking

The National Social Marketing Centre in the United Kingdom has launched a database, ShowCase, of fully researched case studies that show how social marketing can achieve and sustain positive changes in people's behaviour to promote healthy lifestyles and reduce health inequalities. The case studies cover more than 30 social marketing campaigns, covering a range of health-related areas, including healthy eating, smoking cessation and cervical screening, which could be replicated elsewhere. *Source: Mashta Campaigns work to change people's lifestyle, BMJ. 2009; 338: b1718, www.bmj.com/cgi/content/full/338/apr27_1/b1718.*

A study on motivation to quit found that worry was a stronger predictor than mere perception of risk, highlighting the need to ensure that smokers are frequently reminded of the personal relevance of health information.(122)

A new study suggests that teenagers who underestimate the risks of smoking – or overestimate the social value – are substantially more likely than their peers to take up the habit. Researchers found that among the 395 high school students they followed for two years, those who thought the health risks of smoking were fairly low, or the social benefits fairly high, were about three times more likely than their peers to start smoking.(123)

A US study has found that adolescents exposed to advertising depicting negative life circumstances resulting from smoking reported lower intentions to smoke than those exposed to control and industry manipulation advertisements. Findings suggest a media campaign focusing on negative life circumstances can be an effective component in reducing smoking in adolescents even if they are not the specific target of such campaigns. The articles provide useful insights into the mechanisms through which the negative life circumstances advertisements influence adolescents' intentions to smoke.(124)

A study of the effect of anti-smoking advertising in different sorts of media programs has found that placing an anti-smoking advertisement within a program in which the viewer is focused on the narrative flow of a story may lead to the reduced immediate cognitive and emotional impact of the advertisement especially among those for whom the advertisement is most relevant, such as those preparing to quit smoking. Placing anti-smoking advertising in light entertainment, sports, documentaries and news programs may make scarce public health dollars go further.(125)

Overseas developments

The New York City Department of Health has run a campaign giving out promotional matchbooks carry various grisly images. The 'Gum Disease' version shows decayed teeth that are yellowed and blackened. Other matchbooks show large, painful tumours and smoke-ravaged lungs. The matchbooks, part of the 'Cigarettes Are Eating You Alive' advertising campaign, are being distributed free at 132 cigarette retailers in the South Bronx, east and central Harlem, and northern and Central Brooklyn – neighbourhoods where smoking has not fallen to the degree it has in other parts of the city. *Source: Sewell Chan, The New York Times, 24 September 2008.*

The American Legacy Foundation® is challenging pet owners to quit smoking for their pets during the month of April, which kicks off Prevention of Cruelty to Animals Month. A growing body of research shows there are no safe levels of exposure to second-hand smoke – for humans or for animals. A new study shows that nearly 30% of pet owners live with at least one smoker – a number far too high given the consequences of exposure to second-hand smoke ('SHS'). *Source: American Legacy Foundation, 2009-04-09*.

Developments in Australia

The NSW Cancer Institute screened graphic television advertisements developed in New York as part of the 'Cigarettes Are Eating You Alive' campaign. They show the effects of cigarettes on a smoker's internal organs using real and computer-generated images. Source: AAP (Australian Associated Press), 2009-02-22.

Quit Victoria launched a new television campaign urging smokers to think about the impact their death would have upon their children. Calls to the South Australian Quitline rose by 68% in January after the introduction of the same advertisement. Source: personal communication, Jacquie Hickling, Manager Tobacco Control Research and Evaluation Program.

Action 2.2

Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups through skewing of television placement to programs most likely to be watched by low SES groups, and by targeting radio, outdoor, transit and other local advertising to low SES neighbourhoods.

New evidence

A study on the effectiveness of anti-smoking advertising on children has shown that they are more effective with younger children at risk than among children not identified as at risk.(126)

Services and treatment

New evidence

Data collected in the International Tobacco Control Policy Evaluation Project confirms that while measures of smokers' motivation to quit do strongly predict quit attempts, they do not predict success in sustained cessation.(127)

Smoke-free healh care

Action 6.1

Ensure all state- or territory-funded healthcare facilities (general, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke, both indoors and on health service grounds.

Overseas developments

As of 20 April 2009 in the United States, the 1658 healthcare facilities operated by the Mayo Clinic and by SSM Health Care were all 100% smoke-free indoors and out.(128)

Clear advice from health professionals

Action 6.2

Ensure all patients, each time they consult a health professional – regardless of whether they are being seen in private or public, in community, general practice or institutional settings – are routinely asked about smoking status and are advised to quit.

Hospital-sponsored stop-smoking programs for inpatients that include follow-up counselling for longer than one month significantly improve patients' ability to stay smoke-free. An update of the Cochrane analysis of clinical trials of programs offered at hospitals around the world finds that efforts featuring long-term support can increase participants' chances of success by 65%.(129)

The results of a simulation on the effects of physician advice and smoking cessation show that offering basic advice and medication could prevent about 13% and 19% of myocardial infarctions and strokes, respectively.(130)

A meta-analysis of the effects of subsidies for pharmacological treatments for tobacco dependence(131) found that there was a statistically significant favourable effect of full financial interventions directed at smokers on continuous abstinence compared to no interventions with a risk ratio (RR) of 4.38 (95% CI 1.94 to 9.87). There was also a significant effect of full financial interventions when compared to no interventions on the number of participants making a quit attempt (RR 1.19; 95% CI 1.07 to 1.32; N = 3). There was a significant effect of financial interventions directed at healthcare providers in increasing the utilisation of behavioural interventions for smoking cessation (RR 1.33; 95% CI 1.01 to 1.77). Comparison of full benefit with partial or no benefit resulted in costs per additional quitter ranging from $US260 to $1453. The authors concluded that full financial interventions directed at smokers when compared to no financial interventions could increase the proportion quitting, quit attempts and utilisation of pharmacotherapy by smokers. Although the absolute differences were small the costs per additional quitter were low.

Overseas developments

The US Preventive Services Task Force has reaffirmed its 2003 recommendation that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. The Task Force also recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counselling for those who smoke.(132) The reaffirmation is based on information found in the updated US Public Health Service Clinical Practice Guideline: Treating Tobacco Use and Dependence: 2008 Update.(133) The US Preventive Services Task Force is the leading independent panel of experts in prevention and primary care. The Task Force, which is supported by the Agency for Healthcare Research and Quality, conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counselling and preventive medications. Its recommendations are considered the gold standard for clinical preventive services.

The New York State Department of Health has released a new round of advertisements urging healthcare providers to make it a priority to urge their patients who smoke to quit. 'Your Patients Are Listening' features images of patients with oversized ears to dramatise smokers' receptiveness to cessation assistance from their doctor. 'Your Patients Are Listening' is the second phase of the award-winning 'Don't Be Silent About Smoking' campaign launched last year by the State Health Department's Tobacco Control Program and its 19 Cessation Centers across the state. The campaign reached nearly four in 10 physicians in New York State. 'Among doctors, nurse practitioners, and physician assistants who saw the campaign, 80% said the advertisements grabbed their attention and 65% reported the advertisements made them think about doing more to help their patients stop using tobacco,' said Jeff Willett, Director of the state Tobacco Control Program. 'Clinicians who saw the campaign were significantly more likely to ask their patients about smoking, advise them to quit, and provide medication to assist them. We expect the new advertisements to have an even greater impact on providers' behavior.' The advertisements for the US$1.2 million campaign have run in medical journals, major daily newspapers, and other publications in New York, as well as on medical websites. The campaign's website, http://talktoyourpatients.org, offers easy-to-access information and resources to help healthcare providers assist their patients who smoke. Source: New Anti-Smoking Ads Tell Doctors Their Patients Are 'All Ears', Yahoo, 4 March 2009.

Developments in Australia

A study assessing the effectiveness of a smoking cessation guideline relevant to the public maternity care settings, with an accompanying implementation program throughout Queensland maternity hospitals, found that where hospitals implemented the guidelines, more women reported being satisfied with advice and the way information on smoking was presented.(134) This smoking program resulted in a decrease of women continuing smoking during pregnancy.

Wolfenden and Wiggers have demonstrated the feasibility(135) and effectiveness(136) of a computer-based intervention to identify smokers and provide smoking cessation advice in a New South Wales (Hunter Valley) pre-operative clinic. The intervention was effective in encouraging patient cessation, and was inexpensive to deliver relative to other surgical costs. Furthermore, the computer-based intervention continues to operate in the preoperative clinic in the absence of ongoing research support.

The Cancer Council WA is conducting a survey of smoking cessation programs offered by Australian universities as part of the undergraduate medical curriculum. Results are pending.

Pharmacotherapies and services

Action 6.3

Improve quality of use of pharmaco-therapies and services demonstrated to assist with smoking cessation.

New evidence

With genotyping costs declining and the cost of conducting conventional trials increasing, researchers from the US National Institutes of Health and Duke University have modelled data suggesting it may save money to genetically stratify patients in clinical trials for smoking cessation.(137) In mid-sized Phase II trials enrolling around 200 patients, 'there was the clearest benefit for genotyping under a wide range of assumptions, (such as) cost per subject for the trial and genotyping cost per subject', according to lead study author George Uhl of the National Institute on Drug Abuse.

Nicotine replacement therapy

Abstinence rates increase among highly dependent smokers when they are given a higher-dose nicotine patch, according to findings presented at the 2009 Joint Conference of the Society for Research on Nicotine and Tobacco (SRNT) and SRNT-Europe (Presentation title: 42 Mg/Day Pre-Cessation Nicotine Patch Treatment for Highly Dependent Smokers. Abstract PA2-3).

Researchers at The Scripps Research Institute in La Jolla, California, report learning, for the first time, that a breakdown product of nicotine, called nornicotine, has the ability to interfere with a broad range of chemical reactions in the body, and that this interaction has the potential to trigger adverse health effects. The study suggests that those who take medications while smoking or using nicotine patches or gum may be at greater risk for potentially adverse drug interactions. Nornicotine could modify these drugs, possibly reducing drug potency and causing side effects, according to the researchers.(138) Source: Bio-Medicine.org, 2002-03-27, http://news.bio-medicine.org/medicine-news-2/Nicotine-patches-and-gum-may-pose-health-hazards-8510-1/. Other research has indicated that endogenous formation of NNN is virtually nonexistent in long-term patch users.(139)

Australian Researcher Raoul Walsh has reviewed previous studies relating to the effectiveness of over-the-counter nicotine replacement therapy (NRT) and concluded that the results of the studies did not convincingly demonstrate that the therapy, when used alone without additional support, was effective in helping smokers to quit.(140)

A study of use of NRT in patients who wished to cut down smoking but who were not yet prepared to quit showed that use of NRT to cut down smoking did in fact prompt many people to quit smoking altogether.(141)

Varenicline

A study of open-label varenicline augmentation found a significant improvement in mood in a small sample of outpatient smokers with persistent depressive symptoms. Larger, double-blind studies are needed to investigate the potential antidepressant effects of varenicline augmentation.(142)

A study of smokers taking varenicline has found that those who had a prior diagnosis of probable lifetime depression did not report qualitatively worse neuropsychiatric symptoms, more new/worsening mood disturbance, or differential abstinence rates compared to smokers who were not prone to depression.(143)

Varenicline also reduces use of alcohol in heavy-drinking smokers.(144)

Overseas developments

In view of the potential, if unproven, risk that varenicline may be associated with serious neuropsychiatric adverse outcomes, Cahill and Stead have recommended in their preliminary benefit-risk assessment that patients attempting to quit smoking with varenicline, and their families and caregivers, should be alerted about the need to monitor for neuropsychiatric symptoms, including changes in behaviour,

agitation, depressed mood, suicidal ideation and suicidal behaviour, and to report such symptoms immediately to the patient's healthcare provider.(145)

A review of the potential for vaccines against nicotine to increase abstinence rates in smoking cessation(146, 147) reports on three anti-nicotine vaccines currently in the advanced stage of clinical evaluation. Results show that the efficiency of the vaccines is directly related to the antibody levels of the probates, a fact that will help to further optimise the vaccine effect. The vaccines are expected to appear on the market between 2009 and 2011.

A Yale psychiatrist, Dr Judson A. Brewer, is bringing together neuroscience and Buddhist practices to help people overcome their addictions. Brewer, Medical Director of the Yale Therapeutic Neuroscience Clinic, has conducted studies with alcoholics and cocaine addicts and is now beginning research to see if teaching people Buddhist practices to increase mindfulness will help them quit smoking. *Source: Ed Stannard, Register Metro Editor New Haven (CT) Register, 2009-02-23, www.newhavenregister.com/articles/2009/02/23/news/new_haven/a1_mon_buddhistsmoking.txt.*

Pfizer India plans to launch 600 smoking cessation clinics across the country in the next two years, in partnership with private sector hospitals and clinics. The government had last year announced to launch the same number of clinics. The government clinics will use NRT such as chewing gum and patches, along with counselling, to help people quit smoking, a method that doctors say has far less success rate than medication which blocks the receptors in the brain absorbing nicotine. *Source: The Economic Times (India), 2009-03-10.*

Developments in Australia

The Therapeutic Goods Administration has issued a warning to doctors regarding the association between varenicline (*Champix®*) and mental problems. By October 2008, the TGA had received 255 adverse reports describing psychiatric symptoms such as depression, abnormal dreams, insomnia, anger and aggression.

Quitline Services

Action 6.4

Increase the availability of Quitline services, expanding the modes of delivery of advice and support, and tailoring services for high-need and highly disadvantaged groups including pregnant women and their partners, people with chronic health conditions, those who do not speak English and people with mental illness. Ensure that funding is provided in line with increased demand generated by advertising, improved health warnings and greater activity by health professionals.

New evidence

Several new reviews(148, 149) and pilot studies(150-155) have indicated the feasibility and usefulness of internet and mobile phone text messaging in encouraging and supporting smokers to quit. A meta-analysis of 22 randomised controlled trials covering a total of 29,549 participants has concluded that there is sufficient evidence to support the use of a Web- or computer-based smoking cessation program for adult smokers.(156)

Telephone-based interventions are also feasible for assisting support persons who want to help smokers to quit.(157)

Overseas developments

In the United Kingdom, health insurance company Bupa has developed a 'QuitClock' to encourage quitters to stay off cigarettes. QuitClock is a Facebook application that not only helps track the time since the last cigarette was smoked but also offers an at-a-glance view of how much money has been saved. By using Facebook, Bupa enables users to also draw on the online support of friends and family to track progress and leave messages of support. Quitclock encourages users with a week-by-week approach, plus the added support and encouragement from family and friends. Quitclock is freely available to install on Facebook profiles at http://apps.facebook.com/quitclock, or search for 'Quitclock' on Facebook. *Source: Eileen Scott, Bupa Corporate Communications, www.bupa.com.*

A consortium headed up by University College London has been chosen by the Department of Health to lead a nationally accredited training system for NHS Stop Smoking practitioners. The United Kingdom is the only country in the world that has a nationwide network of free stop smoking services. As part of the drive to modernise and professionalise the work of these life-saving NHS services, in July 2007 the Minister for Public Health, Dawn Primarolo, announced the government's intention to create a nationally accredited training system for the stop smoking workforce. In October 2008, the Department of Health launched a procurement process to find an organisation to set up an NHS Centre for Smoking Cessation & Training (NCSCT) and develop evidence-based training systems for the stop smoking workforce. National charity Quit and NHS Leeds are both involved in University College London's bid. Subject to contract, the NCSCT is expected to be fully operational by the end of June 2009. The initial contract will be for a period of three years. *Source: The Department of Health, 30 March 2009, http://tinyurl.com/c25ykp.*

Affordable NRT

Action 6.5

Ensure that nicotine replacement therapy is affordable for all those for whom it is clinically appropriate.

New evidence

Another study has indicated the potential usefulness of providing NRT to callers of the Quitline.(158) The study found that offering a free direct mail starter pack of NRT along with telephone counselling is an effective, cost-sharing method for promoting Quitline use, enhancing participant satisfaction, and increasing the reach and effectiveness of Quitlines among Quitline callers with health insurance.

A study of quit rates among NHS patients prescribed various forms of medication suggests that ease of access may be important in determining outcomes in real-world as opposed to research settings.(159)

Overseas developments

A review in the *Millbank Quarterly*(160) has called on the US government to include cessation benefits in all federally funded insurance plans as part of six measures the authors argue are crucial to increasing smoking cessation in the United States.

The Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care, held a public hearing in October 2008 to accept comments on proposed changes to regulations for the Nebraska Medical Assistance Program, also known as Medicaid. The proposed changes will provide for Medicaid coverage of tobacco cessation products and services. The Kaiser Family Foundation noted that Nebraska is one of just seven states where Medicaid does not cover smoking cessation costs. Source: AP, 2008-10-25.

In November 2008 the American Lung Association released a report on Treatments and Services Provided by Each State to Help Smokers Quit, available at www.lungusa.org. The American Lung Association called upon each state to provide all Medicaid recipients and state employees with comprehensive, easily accessible tobacco cessation medications and counselling. The Lung Association recommends states eliminate artificial barriers such as co-pays, limits on the length of treatment and prior authorisation requirements that can make it harder for smokers to get help. Eliminating these barriers is critically important for people with limited incomes, because they create obstacles that greatly discourage these smokers from getting the help they need.

The Lung Association recommends that private insurance plans should also offer comprehensive cessation coverage and encourages states to require all insurance companies to cover these treatments. To date, only eight states (California, Colorado, Maryland, New Jersey, New Mexico, New York, North Dakota and Rhode Island) have enacted legislative or regulatory standards mandating private health insurance companies to provide cessation coverage. Comprehensive coverage requires providing open access to the seven cessation medications and three forms of counselling recommended to treat nicotine addiction by the US Department of Health and Human Services (HHS). These medications include over-the-counter and prescription NRT and two non-nicotine prescription drugs: bupropion and varenicline. According to HHS, counselling should include at least four individual, group or telephone therapy sessions lasting no less than 10 minutes each. *Source: Helping Smokers Quit, State Cessation Coverage, www.lungnet.org/site_files/Helping_Smokers_Quit_State_Cessation_Coverage_11-13-08.pdf.*

Financial Incentives

Action 6.6

Explore whether financial incentives might be effective in helping people to quit or stay non-smokers.

New evidence

Several commentators have called for exploration of whether payments to patients might be effective in helping people to quit smoking.(161-164)

A US study of General Electric workers has found that those who were paid more than US$1140 were three times more likely to quit for at least six months.(164)

An article in the BMJ(165) reports that new websites in the United States are encouraging people to make public commitments to change their behaviour. Over 20,000 people have publicly signed up to change their behaviour at the online commitment store StickK (pronounced 'stick' – the silent second letter 'k' refers to the legal shorthand for contract) since the website launched in January 2008. Of these, about a third have placed a financial stake – promising to hand over a total of US$1.28 million if they fail to meet their goals. A similar initiative in the Philippines resulted in around one-third of people achieving their goals, so this approach may have some benefit for smokers in developed countries such as Australia.

Overseas developments

Pregnant women who smoke may be offered vouchers to encourage them to give up under several health services in the United Kingdom. Telford and Wrekin Primary Care Trust said plans would include women being tested to ensure they had given up. *Source: BBC Online, 2008-10-17.*

Expectant mothers in the North-East Essex NHS will get £20 after a week off cigarettes, followed by £40 after another month, and a further £40 if they manage a whole year. The payments will

be given as Co-op vouchers to buy anything except tobacco and alcohol. The service will pay for the scheme from its £451,000 annual 'smoking cessation budget'. *Source: Andrew Levy, The Daily Mail* and *Mail on Sunday* (uk), 2009-01-23. The Suffolk Stop Smoking Services is offering women free haircuts and beauty treatments under a pilot Health Enhancement Reward Scheme (HERS). *Source: The Daily Mail and Mail on Sunday (uk), 2009-02-05.*

A scheme was launched offering smokers in deprived areas of Dundee Scotland £12.50 a week to quit. Smokers will get the cash in the form of a credit which they can spend on groceries. It follows the success of a similar scheme by NHS Tayside for pregnant mothers. *Source: £12.50 a week offer to quit smoking, Press Association, 25 March 2009.*

In the United States, a new policy at Clark Memorial Hospital gives employees who identify themselves as smokers a month to complete a smoking-cessation and education program provided by the state. Those who fail to do so will have a tobacco-use surcharge deducted from their bi-weekly pay. Feedback from smokers about the tobacco-use surcharge has been mixed. *Source: Matt Koesters, News-Tribune.net (The Online Edition of the New Albany Tribune and Jeffersonville (IN) Evening News), 2009-03-26.*

In Singapore, from 1 May 2009, students who are caught smoking will participate in a mandatory brief online intervention that encourages them to consider quitting smoking. There will also be more concerted efforts to reach upper primary level students. A new initiative called the 'No Butts Project' will provide young smokers with a redemption card when they sign up. The stamps can be redeemed for vouchers and discounts from a book store, hair salon and optician when they attend quit smoking events or counselling sessions. *Source: Online counselling to be mandatory for underaged smokers, Yahoo, 29 April 2009, www.breathe.sg and www.hpb.gov.sg/quit4life.*

Addressing disadvantage and tailoring services

New evidence

The link between smoking and social disadvantage is well known.(166-168) Disadvantage not only increases the risk of smoking; smoking can also contribute to the development of disadvantage.(169, 170)

But can reducing social disadvantage reduce the risk of young people taking up smoking? Several interesting studies published over the last few months suggest that this may be possible.

Researchers have reported that girls with ADHD who took stimulant drugs had half the risk of substance abuse and nearly half the risk of smoking cigarettes as those who were not treated with drugs.(171) Another study has indicated lower rates of uptake of smoking in students in schools which manage to lift educational attainment above levels predicted by SES profiles.(172) A study by Bolton and Rodriguez has suggested that access to unemployment assistance programs helped people to reduce unhealthy behaviour, possibly through the reduction of economic and psychological stress and an increase in the perception of support.(173)

In the United Kingdom, researchers at the University of Nottingham have commenced a research project to find out why residents in the low SES area of Aspley are bucking the national trend and continuing to smoke at high rates. Ann McNeil from the UK Centre for Tobacco Control Studies and Professor in Health Policy and Promotion at the University of Nottingham, who is leading the research, indicated that the researchers will be exploring what can be done in partnership with the community to introduce long-term solutions to reduce their smoking rates. *Source: EurekAlert, 2009-02-17.*

A study of the impact of clean indoor air laws and cigarette prices on various SES groups in the United States found that both policies appeared to benefit all SES and ethnic groups equally in terms of reducing smoking participation and consumption.(174)

Indigenous smoking

Action 7.1

Establish multi-component community-based tobacco control projects that are locally developed and delivered.

Action 7.2

Enhance social marketing campaigns for Indigenous smokers ensuring a 'twin track' approach of using existing effective mainstream campaigns complemented by Indigenous-specific campaign elements.

A study based on interviews with 25 Indigenous community members in two remote communities in the Northern Territory and 13 health staff explored meanings and perceptions of smoking among Indigenous people, and obstacles and drivers of quitting.(175) The results confirm those of earlier reviews(176) which conclude that a complex interplay of historical, social, cultural, psychological and physiological factors influence the smoking behaviours of Indigenous adults. The results signal the importance of the family and kin relations in determining smoking behaviours. While most community participants were influenced by family to initiate and continue to smoke, the health and wellbeing of the family was also cited as a key driver of quit attempts.

The results once again confirm the importance of attending to the social and cultural context when designing tobacco control programs for this population. Specifically, this research supports the development of family-centred tobacco control interventions alongside wider policy initiatives to counter the normalisation of smoking and assist individuals to quit.

Evaluation of a nationwide mass media cessation campaign in New Zealand developed to deliver a cessation message to indigenous people was received positively by Maori smokers and their whānau (extended families), and played a role in prompting quit attempts.(177)

Overseas developments

An anti-smoking campaign using fake cigarette packs labelled 'Maori Killers' was run in New Zealand in November 2008. Te Reo Marama (TRM; the Maori Smokefree Coalition) distributed packs from the 'Maori Killers Tobacco Company', with mock health warnings such as 'Want equality? Smoking is an equal opportunity killer'. The packs contain 20 'Maori killer truths' in the shape of cigarettes, while posters and other material have also been distributed. TRM has been active in recent years in its attempts to reduce Maori smoking rates, and was also at the forefront of a 2006 campaign which successfully got tobacco giant Philip Morris to apologise for using Maori images on cigarette packets in Israel. *Source: NZPA, 'Maori Killers Tobacco Company' campaign launched 31 October 2008.*

In November 2008 a Nunavut woman, Leona Leona Aglukkaq, from Gjoa Haven, was appointed as Canada's Minister for Health. Nunavut, which some have called Canada's first post-treaty Aboriginal government, has been a leader in tobacco control laws, policies and programs among Canada's provinces and territories. *Source: Nunavut-style leadership needed on First Nations tobacco issues, Marketwire, 5 November 2008.*

Developments in Australia

A team of researchers from the Menzies School of Population Health in Darwin has developed a promising new method of monitoring trends in tobacco consumption and potentially the impact of local tobacco control initiatives in Indigenous communities.(178)

Disadvantaged neighbourhoods

Action 8.1

Boost efforts to discourage smoking in highly disadvantaged neighbourhoods.

New research

A review of 48 studies identifying and supporting smokers from disadvantaged groups(179) has found that proactively targeting patients on GP's registers, routine screening or other hospital appointments are potentially effective measures to discourage smoking in highly disadvantaged neighbourhoods. Overall the study found limited evidence on effective strategies to increase access to cessation services for disadvantaged smokers. While many studies collected socioeconomic data, very few analysed effects by SES.

Overseas developments

The National Health Service in the United Kingdom is enlisting 'public health mentors' to offer on-the-spot advice to people they see smoking or drinking in their local neighbourhoods. *Source: Kate Devlin, 'Snoops' to nag their friends to live healthier lives, Telegraph, 23 March 2009.*

People with mental illness

Actions 8.2

Ensure access to information, treatment and services for those with mental health problems.

Actions 8.3

Support cessation among those using mental health services.

Actions 8.4

Encourage cessation in those with mental health problems outside institutional settings.

New evidence

Chapman and Ragg have found that studies reporting very high prevalence of smoking among people with schizophrenia are cited more often than those studies reporting a low prevalence, a result consistent with citation bias. This citation bias probably contributes to the misinformation available on the internet, and may have adverse policy and clinical implications.(180)

Recent US research followed up a sample of stable community-based psychiatric rehabilitation clinic outpatients more than a decade later and found that smoking rates declined by almost a third and the number of 'quitters' had tripled. These results challenge the rather 'pessimistic' view that smokers with schizophrenia are unable to quit smoking and indicate the necessity of examining smoking prevalence over time in order to better understand the quit rates in this special needs population.(181)

A team of Canadian researchers has been trying to find out why individuals with mental health problems start smoking in the first place. They believe that such individuals do not seem to take up smoking to treat their symptoms. They also speculate that some of these people may start smoking because they were exposed to tobacco smoke prenatally.(182)

Although smoking rates are high among those with mental health problems, interest in quitting is also high.(183) A review of 14 studies assessing the readiness to quit of patients living with mental illness(184) concluded that the commonly held false belief that people with mental health disorders are not motivated to cease smoking means that opportunities to encourage smoking cessation among this disenfranchised group are being missed.

Data from the South Australian Omnibus Health survey indicates that while smoking rates are high, people with mental illness are just as likely as other smokers to see anti-smoking advertising on television and on cigarette packets. They are interested in quitting, they try to quit, they talk to their doctor about quitting and they access mainstream Quitline services.(185)

The National Institute of Mental Health has published a report of a meeting held in September 2005 which reviewed tobacco use and dependence and smoking cessation among those with mental disorders, especially individuals with anxiety disorders, depression or schizophrenia. The review concludes that greater collaboration between mental health researchers and nicotine and tobacco researchers is needed to better understand and develop new treatments for co-occurring nicotine dependence and mental illness. Despite an accumulating literature for some specific psychiatric disorders and tobacco use and cessation, many unstudied research questions remain.(186)

Recently published guidelines for smokers with psychiatric comorbidities suggest combination treatment (counselling and pharmaceutical treatment) and prolongation of a therapeutic approach for patients suffering depression.(187)

Evaluation has indicated that the evidence-based *Rx for Change in Psychiatry* curriculum is an effective tobacco treatment curriculum that could be implemented in psychiatry residency training programs and disseminated widely.(188)

Effective smoking cessation for individuals with psychotic disorders is feasible, but most likely requires longer-term treatment, according to results of the largest and longest duration cessation trial in this population, presented at the 2009 Joint Conference of the Society for Research on Nicotine and Tobacco (SRNT) and SRNT-Europe. Results of the study, conducted by Robyn Richmond, PhD, University of New South Wales showed that 79% of the available sample at four years maintained or improved the smoking reduction status they had achieved at year one.(189)

In a small prospective study, varenicline appeared to have some efficacy in patients suffering schizophrenia. None of the 14 patients suffered depression or any worsening of symptoms, and there was some improvement in cognitive symptoms.(190) Similarly, open-label varenicline augmentation was associated with significant improvement in mood in a small trial of outpatient smokers with persistent depressive symptoms.(142)

International developments

A study of the implementation of smoke-free policies introduced in July 2008 in mental health treatment services in the United Kingdom found that sustained policy enforcement was perceived as difficult, but that despite challenges and concerns, the impact of the policy was regarded as beneficial, with some evidence of positive behavioural changes occurring in clients.(191)

Developments in Australia

Kirsten Moeller-Saxone has drawn attention to interest in quitting among consumers at a Psychiatric Rehabilitation and Support Service in Victoria,(192) and has expressed disappointment in the failure to include efforts to reduce smoking among the mentally ill in Victoria's Tobacco Strategy. *Source: Push to slash smoking 'fails mentally ill', The Daily Telegraph, 8 October 2008.*

A study of in-patient units in New South Wales has indicated the inadequate establishment of non-smoking environments and of smoking restriction enforcement, as well as inconsistencies in the provision of smoking care being evident. The findings suggest that failure of psychiatric services to provide smoking care is systemic and not related to particular types of services (for example, acute versus non-acute or regional versus metropolitan).(193)

Mental Health Minister Graham Jacobs is reviewing the ban on smoking in WA mental health hospitals and may allow some patients to continue smoking.(194)

The introduction of smoking bans in mental health facilities in New South Wales has sparked anger among smoker workers. *Source: Adam Cresswell, Tobacco bans spark anger, The Australian, 30 March 2009.*

People from cultural groups where smoking rates are high

A study of patients seen by GPs in Sydney has confirmed higher prevalence of smoking and high levels of nicotine dependence among the Arabic community.(195)

People in prisons and other correctional facilities

Action 8.5

Ensure all state-funded human services agencies and correctional facilities (adult and juvenile) are smoke-free and provide appropriate cessation supports.

New evidence

The rate of bullying decreased following the introduction of the no-smoking policy at the Warren Hill correctional facility. The findings from this study are being used in the development of a new Violence Reduction Policy at HMYOI Warren Hill.(196)

Overseas developments

Officials have reported that the state's year-old indoor smoking ban is working well in Illinois prisons where inmates, who formerly had been allowed to smoke in their cells, have been forced to quit. Starting 1 January 2008, Illinois joined 18 other states and made it illegal to smoke in virtually every public place. That included the state's 28 prisons, meaning 45,000 inmates could not even light up in outdoor prison yards. Prison workers can take smoke breaks in areas created near prison entrances, but inmates must quit smoking. For them, there is help in the form of smoking cessation classes and nicotine patches sold in prison stores. After meals, inmates get three pieces of sugarless candy to ease cravings. Corrections officials believe a smoking ban already in effect in county jails helped with the adjustment. The ban has also curbed complaints from inmates about second-hand smoke. *Source: Smoking ban working well in Illinois prisons, Chicago Tribune, 5 January 2009.*

A smoking ban for Michigan correctional facility employees and inmates was officially enacted on 1 February 2009. Although smoking indoors at the prisons hasn't been allowed for many years, this ban takes things a step further and doesn't allow cigarettes anywhere, at any time. Obtaining tobacco from outside the prison walls also is prohibited. *Source: Jessica Sipperle, Jackson Citizen Patriot, 12 February 2009, 13:38PM MLive blogs, 2009-02-12.*

Correctional facilities are required to be 100% smoke-free indoors in 28 states of the United States. As well as all US Federal Bureau of Prisons institutions which have been 100% smoke-free since July 2004, as of April 2009, seven states and the Commonwealth of Puerto Rico all require all correctional facilities to be smoke-free on their entire grounds (from August 2009 in Louisiana).(197)

Developments in Australia

A focus group study in New South Wales has concluded that smoking cessation programs in prisons should be tailored to the unique stresses of the prison environment. Programs needs to acknowledge the difficulties of quitting smoking in prison arising from the stresses posed by this setting.(198)

Supporting parents and education

Action 9.1

Convey the message that parents can help – by quitting smoking, by making homes smoke-free, by choosing appropriate films, videos and games, and by making it clear that they do not want their children to smoke for the sake of their health.

Nicotine interferes with catecholamine and brainstem autonomic nuclei development during the prenatal period of the rodent (equivalent to first and second trimester of the human); alters the neocortex, hippocampus and cerebellum during the early postnatal period (third trimester of the human); and influences limbic system and late monoamine maturation during adolescence.(199) Research such as this suggests that exposure to tobacco smoke during pregnancy and adolescence when the brain is developing may be more harmful than previously appreciated.

A report published in the US Centers for Disease Control's MMWR journal found that 60.9% of Year 9 to 12 students who ever smoked cigarettes daily had tried to quit smoking cigarettes, but that only 12.2% were successful.(200)

New evidence

Results of the New England Study(201) and analysis of findings of a 28-year longitudinal study of the natural history of cigarette smoking,(202) the longest running of its kind, both confirm the importance of parental smoking behaviours in the uptake of smoking by young people. Another 20-year follow-up study(203) found that children whose parents quit while they were still young (younger than eight years of age) were much less likely to become smokers than children whose parents quit later (after eight years of age).

One possible mechanism for this effect is the impact that having a family member smoking has on perceptions of smoking as a common behaviour. Children whose parents smoke are more likely to overestimate the prevalence of smoking in the community, and such overestimates predict smoking uptake.(204) Young people whose parents smoke also generally perceive it to be easier to get access to cigarettes,(205) a factor highly predictive of uptake.

An Australian study has indicated that low parental attachment score is associated with an increased risk of adolescent smoking, regardless of ethnicity and parental smoking.(206)

Analysis of data on 693 youths from a four-year, three-wave prospective study of a representative sample of Massachusetts adolescents (aged 12–17 years) has indicated that a household smoking ban in the parental home appears to lead youth to prefer smoke-free living quarters once they leave home.(207)

A Swedish study suggests that teenagers in recent times are much more positive than previous generations about parents' attempts to dissuade them from smoking.(208)

Third-hand smoke refers to the tobacco toxins that build up over time – one cigarette will coat the surface of a certain room, a second cigarette will add another coat, and so on. The third-hand smoke is the substance that remains after visible or 'second-hand smoke' has dissipated from the air. A survey of US parents has indicated that beliefs about the health effects of third-hand smoke are independently associated with home smoking bans.(209) Study authors conclude that emphasising that third-hand smoke harms the health of children may be an important element in encouraging home smoking bans.

In a detailed look at nearly 30 years of research on how television, music, movies and other media affect the lives of children and adolescents, a new study has found an array of negative health effects linked to greater use. The report found strong connections between media exposure and problems of childhood obesity and tobacco use. In all, 173 research efforts, going back to 1980, were analysed, rated and brought together in what the researchers said was the first comprehensive view of the topic. About 80% of the studies showed a link between a negative health outcome and media hours or content.(210)

A Norwegian study(211) has found that sports participation in adolescence, and participation in team sports in particular, may increase the growth in alcohol intoxication during late adolescent and early adult years, whereas participation in team sports and endurance sports may reduce later increase in tobacco and cannabis use.

Bedroom televisions are a significant predictor of white teens engaging in smoking and sex, according to a new study by researchers at RTI International, University of North Carolina at Chapel Hill and Middle Tennessee State University.(212) The study, published in the September issue of the *Journal of Broadcasting & Electronic Media*, found that white adolescents who had a television in their bedroom were more likely to regularly view mature-content television programs, have less parental oversight of their media practices, and initiate health risk behaviours, including cigarette smoking and sex. The study was funded by the National Institute for Child Health and Human Development.

School-based initiatives

Action 9.2

Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum and where appropriate in curriculum in tertiary institutions.

Action 9.3

Encourage schools to promote and consistently enforce smoke-free policies (buildings and school grounds) for all members of the school community.

Action 9.4

Encourage universities and other institutes of higher education to adopt smoke-free campuses, including outdoors.

New evidence

A US study using hierarchical linear modelling has found that the enforcement of school tobacco policies, but not the comprehensiveness of those policies, was associated with fewer observations of tobacco use by minors on school grounds as well as lower rates of current smoking among students.(213)

Overseas developments

As of 20 April 2009, 855 colleges in the United States had implemented policies requiring residential halls to be smoke-free indoors. As of the same date, 305 campuses in the United States were totally smoke-free, indoors and out.(214)

Movie classification

Action 9.5

Make smoking a 'classifiable element' in movies and video games.

Overseas developments

The Ontario Film Review Board has agreed to meet with youth representatives to discuss their concerns about smoking in movies. The teenagers want the board to consider each film's depiction of tobacco use when issuing its classified movie ratings. *Source: Ontario teens lobby for stricter ratings of films with smoking, CBC News, 25 February 2009.*

Keeping tobacco control on the agenda

Action 10.3

Ensure greater awareness that profiting from the sale of tobacco products is incompatible with principles of corporate social responsibility.

New evidence

A study just published in the *American Journal of Preventive Medicine* has found that young adults with negative attitudes about the tobacco industry and who supported action against the tobacco industry were one-third as likely to be smokers as those who did not support action against the tobacco industry. Among current smokers, those who had a negative attitude towards the tobacco industry were over four times more likely to plan to quit smoking than smokers who did not support action against the tobacco industry.(215)

Overseas developments

Framework Convention on Tobacco Control

At its third session in November 2008, the Conference of the Parties to the FCTC adopted guidelines for implementation of Article 13(216) of the FCTC which make clear that corporate social responsibility activities by tobacco companies should be regarded as a form of promotion:

Corporate social responsibility

25. It is increasingly common for tobacco companies to seek to portray themselves as good corporate citizens by making contributions to deserving causes or otherwise promoting "socially responsible" elements of their business practices.

26. Some tobacco companies make financial or in-kind contributions to organizations, such as community, health, welfare or environmental organizations, either directly or through other entities. Such contributions fall within the definition of tobacco sponsorship in Article 1(g) and should be prohibited as part of a comprehensive ban, because the aim, effect or likely effect of such a contribution is to promote a tobacco product or tobacco use either directly or indirectly.

27. Tobacco companies may also seek to engage in "socially responsible" business practices (such as good employee-employer relations or environmental stewardship), which do not involve contributions to other parties. Promotion to the public of such otherwise commendable activities should be prohibited, as their aim, effect or likely effect is to promote a tobacco product or tobacco use either directly or indirectly. Public dissemination of such information should be prohibited, except for purposes of required corporate reporting (such as annual reports) or necessary business administration (e.g. for recruitment purposes and communications with suppliers).

The guidelines continue:

> *The Parties should ban contributions from tobacco companies to any other entity for "socially responsible causes", as this is a form of sponsorship. Publicity given to "socially responsible" business practices of the tobacco industry should be banned, as it constitutes advertising and promotion.*

The Conference of Parties also adopted guidelines to assist parties with implementation of Article 5.3 of the Convention on the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry (decision FCTC/COP3(7)).(85) The guidelines for Article 5.3 state:

> *'11. The broad array of strategies and tactics used by the tobacco industry to interfere with the setting and implementing of tobacco control measures, such as those that Parties to the Convention are required to implement, is documented by a vast body of evidence.*
> *The measures recommended in these guidelines aim at protecting against interference not only by the tobacco industry but also, as appropriate, by organizations and individuals that work to further the interests of the tobacco industry.'*

They go on to state:

> *17. The following important activities are recommended for addressing tobacco industry interference in public health policies:*
>
> *(1) Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties' tobacco control policies.*
>
> *(2) Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur.*
>
> *(3) Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry.*
>
> *(4) Avoid conflicts of interest for government officials and employees.*
>
> *(5) Require that information provided by the tobacco industry be transparent and accurate.*
>
> *(6) Denormalize and, to the extent possible, regulate activities described as "socially responsible" by the tobacco industry, including but not limited to activities described as "corporate social responsibility".*
>
> *(7) Do not give preferential treatment to the tobacco industry.*
>
> *(8) Treat State-owned tobacco industry in the same way as any other tobacco industry.*

The guidelines include numerous specific recommendations as to how governments may go about each of the above strategies.

Finland

The Finance Minister of Norway, Kristin Halvorsen, has presented a white paper to parliament on her review of the guidelines for government investments. The government wants to introduce measures such as excluding tobacco-industry investments, watching companies in an ethical grey zone more closely, and studying ways of making climate change a factor in investment decisions. The report outlined the majority government's political intentions, but didn't include specific rules or say when they would be imposed. *Source: Norway aims to ban tobacco from its investment portfolio, The Wall Street Journal, 5 April 2009, http://tinyurl.com/djwpsk.*

Cost effectiveness of tobacco control

A study of the effects of 11 nationally recommended prevention activities on CVD-related morbidity, mortality and costs has recently been conducted in the United States. It found that approximately 78% of adults aged 20 to 80 years alive today are candidates for at least one prevention activity. If everyone received the activities for which they are eligible, myocardial infarctions and strokes would be reduced by approximately 63% and 31%, respectively. If more feasible levels of performance are assumed, myocardial infarctions and strokes would be reduced by approximately 36% and 20%, respectively. Implementation of all prevention activities would add approximately 221 million life-years and 244 million quality-adjusted life-years to the US adult population over the coming 30 years, or an average of 1.3 years of life expectancy for all adults.

Of the specific prevention activities, the greatest benefits to the US population come from providing aspirin to high-risk individuals, controlling pre-diabetes, weight reduction in obese individuals, lowering blood pressure in people with diabetes and lowering LDL cholesterol in people with existing coronary artery disease (CAD). As currently delivered and at current prices, most prevention activities are expensive when considering direct medical costs; smoking cessation is the only prevention strategy that is cost-saving over 30 years.

Aggressive application of nationally recommended prevention activities could prevent a high proportion of the CAD events and strokes that are otherwise expected to occur in adults in the United States today. However, as they are currently delivered, most of the prevention activities will substantially increase costs. If preventive strategies are to achieve their full potential, ways must be found to reduce the costs and deliver prevention activities more efficiently.(217)

When Maciosek et al. recently prioritised 25 preventive interventions, factoring in burden of disease and cost effectiveness, tobacco control was tied for the top priority, and better screening followed by brief intervention yielded a greater benefit in quality-adjusted life-years than the next 10 interventions combined.(218, 219)

Researchers at the Johns Hopkins Bloomberg School of Public Health and the American Legacy Foundation have estimated that truth®, the nations' largest youth smoking prevention campaign, saved $1.9 billion or more in healthcare costs associated with tobacco use.(220) Using standard methods of cost and cost-utility analysis, Holtgrave and colleagues compared the costs of the truth® campaign to the absence of the campaign. The American Legacy Foundation spent $324 million to implement and evaluate the truth® campaign. The authors have compared the cost of the program to its healthcare savings, and found that both base and optimistic case results indicate cost savings over and above the campaign's initial costs. Even the most pessimistic case analysed indicated that the intervention is cost effective to society.

A study analysing data from the Swedish Medical Birth Register has demonstrated that quitting smoking reduces the risk of infant death, particularly deaths among infants four to 15 weeks old.(221)

A study using 30-year follow-up data found that self-reported smoking cessation after coronary artery bypass surgery was associated with a life expectancy gain of three years. Smoking cessation turned out to have a greater effect on reducing the risk of mortality than the effect of any other intervention or treatment.(222)

Potential modest cost savings may accrue with implementation of an institution-based smoking cessation program for patients undergoing total hip and knee arthroplasties through reduced total hospitalisation costs that exceed the cost of the intervention.(223)

Research, evaluation, monitoring and surveillance

A new institute, the Schroeder Institute for Tobacco Research and Policy Studies (SI), has been funded by American Legacy Foundation to play a leadership role in strengthening the national agenda for next generation research in tobacco control. The SI will work collaboratively to stimulate research. It aims to serve a 'think-tank' role in order to speed high-risk innovative new research priorities. The SI will work with the research and practice communities, public, private, government, insurers, policymakers, philanthropy and other stakeholders to support an innovative and forward-thinking research agenda. *Source: American Legacy Foundation, 2008-10-09.*

Although comprehensive tobacco control programs have moved towards logic models that incorporate political and social intermediate objectives such as smoke-free worksites, tobacco control planning and evaluation have been hampered by the lack of timely, comprehensive data about the attitudes and practices of US adults. The Social Climate Survey of Tobacco Control (SCS-TC) was developed as a methodology to objectively measure the fundamental position of tobacco control in society and thereby provide a data collection system to monitor program impacts. The survey includes items to measure progress toward intermediate objectives such as policy changes, changes in social norms, reductions in exposure of individuals to environmental tobacco smoke and rejection of pro-tobacco influences. The results presented on the www.socialclimate.org website are based on annual, cross-sectional assessments of the social climate of tobacco control within the United States from 2000, 2001, 2002, 2003, 2004, 2005, 2006 and 2007.

The Environment Working Group of the National Tobacco Monitoring, Research and Evaluation Workshop has drawn attention to the importance of systematic surveillance and monitoring of key program inputs and outputs and environmental influences as being central to understanding the effectiveness and cost-effectiveness of tobacco control efforts. It has suggested two key priorities for monitoring activities in the United States:

1. Develop and implement a national system for local tobacco control ordinance surveillance.
2. Develop and implement a comprehensive program monitoring system that is used by all states and supported by all funding agencies.(224)

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Attachment 1: Proposed amendment concerning plain packaging, UK Health Bill

LORD PATEL
BARONESS O'CATHAIN
LORD WALTON OF DETCHANT
LORD FAULKNER OF WORCESTER

After Clause 22, insert the following new Clause –

"Plain packaging of tobacco products etc.

(1) The Secretary of State may make regulations imposing such requirements as he considers necessary prohibiting or restricting the sale or supply of tobacco products otherwise than in packages or packaging which comply with the regulations.

(2) The regulations made by the Secretary of State in subsection (1) may impose such requirements the Secretary of State considers necessary or expedient with respect to any one or more of the following particulars –

(a) the colour of the packages or packaging;

(b) the shape and material of the packages or packaging;

(c) distinctive marks displayed on the packages or packaging;

(d) trade marks or registered trade marks displayed on the packages or packaging;

(e) the labelling in any respect of packages, packaging or tobacco products, or associated with packages, packaging or tobacco products;

(f) the contents inside the packages or packaging, in addition to tobacco products; and

(g) any other particulars as may be prescribed by the Secretary of State.

(3) Regulations made under this section may provide that packages or packaging of any such description, or falling within any such class, as may be specified in the regulations shall not, except in such circumstances (if any) as may be so specified, be of any such colour or shape, or display any such mark or trade mark, or any other particulars as may be so specified.

(4) No person shall, in the course of a business carried on by him, sell or supply, or have in his possession for the sale or supply, any tobacco product, package, or packaging in such circumstances as to contravene any requirements imposed by regulations under this section which are applicable to that tobacco product, package, or packaging.

(5) Any regulations made under this section may provide that any person who contravenes the regulations shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding a level on the standard scale specified in regulations made by the Secretary of State.

(6) Before making any regulations under this section, the Secretary of State shall consult such persons as are likely to him to be substantially affected by those regulations.

(7) For the purposes of this Act –

"package" shall mean the packet, container, wrapping or other receptacle which contains or is to contain the tobacco products;

"packaging" shall mean all products made of any material to be used for the containment, protection, handling, transporting, delivery, sale and presentation of the packages;

"tobacco product" shall include cigarettes, cigars and any other product containing tobacco and intended for oral or nasal use and smoking mixtures intended as a substitute for tobacco, and the expression

"cigarettes" includes cut tobacco rolled up in paper, tobacco leaf, or other material in such form as to be capable of immediate use for smoking, and cigarette papers, tubes and filters;

"trade mark" and "registered trade mark" shall have the same meaning as in section 1 of the Trade Marks Act 1994 (c. 26).

(8) Regulations made by the Secretary of State under this section –

(a) may make different provision for different cases; and

(b) may contain such incidental supplemental, consequential and transitional provision as the Secretary of State thinks fit.

(9) The powers of the Secretary of State under this subsection shall be exercisable by statutory instrument which shall be subject to the affirmative resolution procedure."

Attachment Two:
Sample of studies published January to May 2009 suggesting or concluding health effects other than those already covered in current Consumer Product Information in Australia – 140 health effects that smokers arguably should have been warned about but were not over this five-month period

Cardio-vascular disease

Coronary heart disease

Lindsay G, Tolmie E, Martin W, Hutton I & Belcher P. Smoking after coronary artery bypass: high three-year mortality. The Thoracic and Cardiovascular Surgeon. 2009; 57:135–40. Available from: http://www.thieme-connect.com/ejournals/html/thoracic/doi/10.1055/s-2008-1039271

Celebrovascular disease (stroke)

Dochi M, Sakata K, Oishi M, Tanaka K, Kobayashi E & Suwazono Y. Smoking as an independent risk factor for hypertension: 14-year longitudinal study in male Japanese workers. The Tohoku Journal of Experimental Medicine. 2009; 217:37–43. Available from: http://www.jstage.jst.go.jp/article/tjem/217/1/217_37/_article

Woo D, Khoury J, Haverbusch M, Sekar P, Flaherty M, Kleindorfer D, et al. Smoking and family history and risk of aneurysmal subarachnoid hemorrhage. Neurology. 2009; 72(1):69–72.

Atherosclerotic peripheral vascular disease

Csiszar A, Podlutsky A, Wolin M, Losonczy G, Pacher P & Ungvari Z. Oxidative stress and accelerated vascular aging: implications for cigarette smoking. Frontiers in Bioscience. 2009; 14:3128–44.

Knoflach M, Kiechl S, Penz D, Zangerle A, Schmidauer C, Rossmann A, et al. Cardiovascular risk factors and atherosclerosis in young women: atherosclerosis risk factors in female youngsters (ARFY study). Stroke. 2009; 40(4):1063.

Peripheral vascular disease

Agarwal S. The association of active and passive smoking with peripheral arterial disease: results from NHANES 1999–2004. Angiology. 2009; (Epub ahead of print). Available from: http://ang.sagepub.com/cgi/rapidpdf/0003319708330526v1

Aktoz T, Kaplan M, Yalcin O, Atakan I & Inci O. Penile and scrotal involvement in Buerger's disease. Andrologia. 2008;40:401–3. Available from: http://www3.interscience.wiley.com/user/accessdenied?ID=121537834&Act=2138&Code=4719&Page=/cgi-bin/fulltext/121537834/HTMLSTART

Nakamura K, Barzi F, Huxley R, Lam T, Suh I, Woo J, et al. Does cigarette smoking exacerbate the effect of total cholesterol and high-density lipoprotein cholesterol on the risk of cardiovascular diseases? Heart. 2009; (Epub ahead of print).

Micro-vascular injury

Sonnen J, Larson E, Gray S, Wilson A, Kohama S, Crane P, et al. Free radical damage to cerebral cortex in Alzheimer's disease, microvascular brain injury, and smoking. Annals of Neurology. 2009; 65:226–9. Available from: http://www3.interscience.wiley.com/cgi-bin/fulltext/122226848/HTMLSTART

Sudden cardiac death

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Sudden death

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