



# NATIONAL TOBACCO STRATEGY 2023–2030

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A Strategy to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and the inequalities it causes

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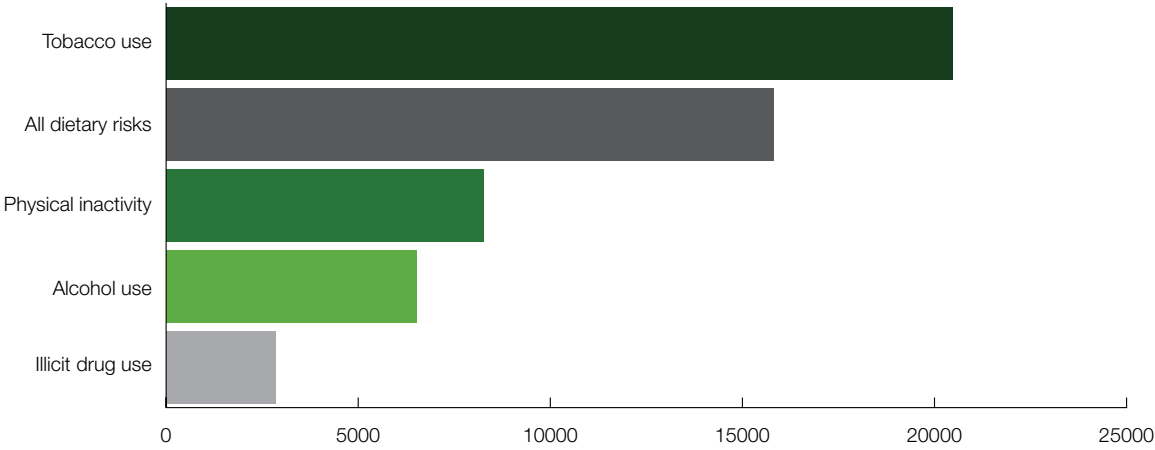
# INTRODUCTION

Tobacco smoking remains the leading cause of preventable death and disability in Australia and is estimated to have killed 1,280,000 Australians between 1960 and 2020.<sup>1</sup> In 2018 alone, tobacco use was estimated to kill almost 20,500 people.<sup>2</sup>

Tobacco use causes more deaths than any other behavioural risk factor (see Figure 1). Up to two-thirds of deaths in tobacco smokers can be attributed to smoking, and long-term smokers die an average of 10 years earlier than non-smokers.<sup>3</sup> Exposure to second-hand smoke is also a cause of preventable death and disability in adults and children.<sup>4</sup>

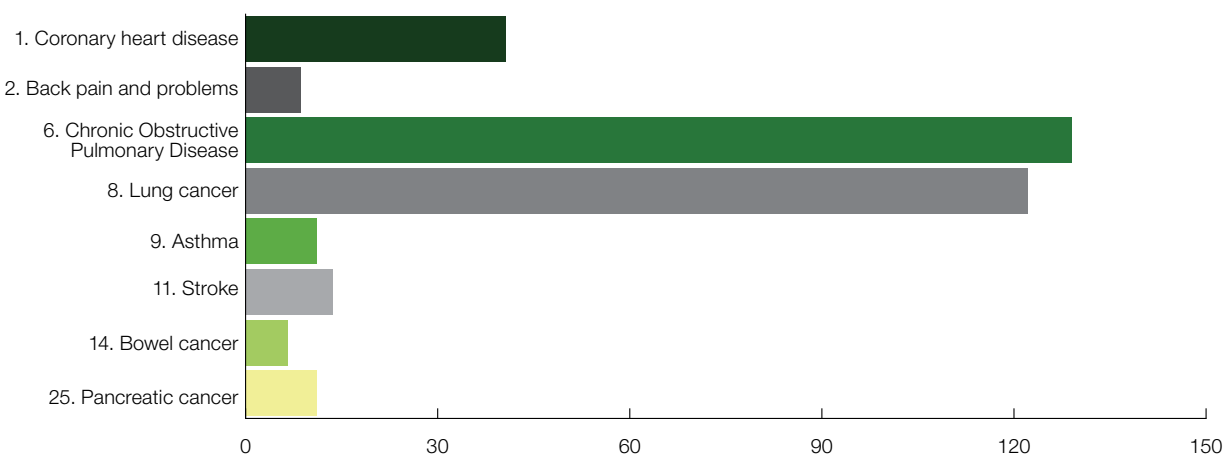
In 2018, tobacco use contributed 8.6% of the total disease burden in Australia, making it the leading risk factor contributing to disease burden and deaths. Tobacco use was causally linked to the burden of 41 individual diseases, including contributing around three-quarters of the total disease burden due to lung cancer and chronic obstructive pulmonary disease (COPD) and over 50% of the burden from oesophageal cancer (see Figure 2).<sup>5</sup>

Figure 1: Number of deaths due to behavioural risk factors, 2018



Source: Australian Institute of Health and Welfare.  
Australian Burden of Disease Study 2018: interactive data on risk factor burden. Canberra: AIHW; 2021.  
Available from: <https://www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-risk-factors>

Figure 2: Contribution of tobacco to diseases ranked in top 25 for highest total burden (DALYs) in Australia, 2018



Source: Australian Institute of Health and Welfare.  
Australian Burden of Disease Study 2018: interactive data on risk factor burden. Canberra: AIHW; 2021.  
Available from: <https://www.aihw.gov.au/reports/burden-of-disease/abds-2018-interactive-data-risk-factors>

In addition to its health impacts, tobacco production, marketing and consumption has serious environmental consequences. The global tobacco supply chain requires significant resource inputs that have detrimental effects on the environment, including the use of harmful chemicals on tobacco farms, deforestation, carbon and other waste emissions, residential and bush fires, and non-biodegradable litter.<sup>6</sup>

Ending the tobacco epidemic is a priority for all Australian governments and there is continued public support for policy measures to reduce tobacco-related harm.<sup>7</sup>

Significantly reducing and eventually eliminating tobacco use in Australia would dramatically reduce illness, increase quality of life, and reduce health, social and economic inequalities for smokers, their families and the wider Australian community. It would prevent hundreds of thousands of premature deaths, reduce the burden of costly tobacco-attributable disease, increase workers' economic productivity and reduce the burden on carers.

All Australian governments have overseen the development of the National Tobacco Strategy 2023–2030 (the Strategy). The Strategy takes into account input from stakeholders including experts, non-government organisations (NGOs) and the public.

The Strategy sets out a new national policy framework for tobacco control in Australia and complements existing policies and legal frameworks at the state and territory, national and international levels. It provides an overview of the effects of tobacco use in Australia, and outlines shared goals, objectives, principles and targets for tobacco control across government and non-government agencies between 2023 and 2030. It also identifies 11 priority areas and associated actions to be implemented, together with mechanisms for monitoring and evaluation.

This Strategy builds on the success of previous national tobacco strategies and strengthens population-wide approaches that have been successful in reducing the prevalence of tobacco use over the past 4 decades. It includes new demand-side and supply-side measures and new measures to protect public health policies from all commercial and other vested interests. It also maintains a strong emphasis on reducing health and social inequalities by complementing population-wide strategies with more targeted approaches to reduce smoking<sup>i</sup> among populations with a high prevalence of tobacco use.

## 1.1 Policy context

### Policy frameworks

This Strategy draws on existing policy and legal frameworks and operates as a sub-strategy of the National Drug Strategy (NDS) 2017–2026. The national framework outlined in the NDS 2017–2026 to minimise and prevent harm relating to tobacco use is supported by the priorities and actions under this Strategy.<sup>8</sup> This Strategy also complements the Australian Government's National Preventive Health Strategy 2021–2030, released on 13 December 2021.

This Strategy builds on the achievements of, and lessons learned from, previous national tobacco strategies which have been in place since 1999. These strategies have outlined a comprehensive and evidence-based approach to tobacco control in Australia. The most recent, the National Tobacco Strategy 2012–2018, emphasised 9 priority areas.<sup>9</sup> Achievements under the 2012–2018 Strategy are summarised in Part 1.2 of this document. Priorities and actions from the 2012–2018 Strategy that remain relevant have been carried over to this Strategy to ensure continued focus, investment and action.

This Strategy recognises Australia's obligations as a party to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). The foreword to the WHO FCTC affirms that the global spread of the tobacco epidemic has occurred due to a variety of factors, including trade liberalisation and direct foreign investment, global marketing, transnational tobacco advertising, promotion and sponsorship, and the international movement of contraband and counterfeit cigarettes. The WHO FCTC and its protocols aim to protect present and future generations from the preventable and devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.<sup>10</sup> Since its implementation in 2005 the WHO FCTC has committed the parties to implement tobacco control measures including policies on tobacco price and tax increases; prohibiting or restricting tobacco advertising, promotion and sponsorship; requiring labelling with more prominent health warnings; preventing and reducing tobacco consumption and nicotine addiction; protecting against exposure to second-hand smoke; promoting tobacco cessation interventions, education and public awareness activities; and combating illicit trade.<sup>11</sup> The WHO FCTC also obliges Australia to take steps to protect its tobacco control policymaking and implementation from interference from the tobacco industry and its interests. The Australian Government reports every 2 years to the Conference of the Parties on Australia's progress in implementing the WHO FCTC.<sup>12</sup>

In keeping with the WHO FCTC, this Strategy emphasises the importance of addressing the upstream drivers of ill-health and inequalities related to tobacco use, including commercial interests, industry engagement in policy development and implementation, marketing, taxation policy, and social and physical environments.<sup>13</sup>

This Strategy also recognises the relationship between tobacco control and Australia's commitment to the United Nations (UN) Sustainable Development Goals (SDGs). The SDGs, adopted by the UN General Assembly on 25 September 2015, comprise 17 goals and 169 targets to be achieved by 2030, with the aim to 'end poverty, protect the planet, and ensure prosperity for all as part of a new sustainable development agenda'.<sup>14</sup> Many of the SDGs have a direct or indirect relation to tobacco control, and further reducing tobacco use will play a major role in global efforts to achieve the SDG target to reduce premature deaths from noncommunicable diseases by one-third by 2030.<sup>15</sup>

<sup>i</sup> As tobacco smoking remains the predominant form of tobacco use in Australia by a wide margin, all prevalence estimates in this document refer to tobacco smoking unless stated otherwise.

In 2020 all Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations signed the National Agreement on Closing the Gap. The objective of the National Agreement on Closing the Gap is to enable First Nations people and governments to work together to overcome the inequality experienced by First Nations people and achieve life outcomes equal to those of all Australians.<sup>16</sup> The guiding principles and actions outlined in this Strategy aim to align with the spirit and the priority reform areas of the National Agreement on Closing the Gap.

## 1.2 Progress and achievements under the National Tobacco Strategy 2012–2018

The National Tobacco Strategy 2012–2018 delivered many achievements. A number of measures were introduced by the Australian Government to reduce the affordability of tobacco products. Most notably, staged 12.5% increases in tobacco excise and excise-equivalent customs duty were implemented annually from December 2013 to September 2020. On 1 March 2014 the basis for the biannual indexation of excise on tobacco products was changed from the Consumer Price Index to a measure based on Average Weekly Ordinary Time Earnings, to ensure tobacco products do not become relatively more affordable over time.

Consistent with Australia's obligations under the WHO FCTC, significant progress in tobacco divestment was made under the 2012–2018 Strategy by government and non-government organisations. The Australian Capital Territory, New South Wales, South Australia and the City of Melbourne have divested their public investment in the tobacco industry. In 2012 First State Super became the first mainstream Australian superannuation fund to implement a tobacco-free investment policy, and in 2013 the Australian Government's Future Fund implemented a tobacco-free policy. Medibank (Australia's largest health insurer), along with many other insurers, superannuation funds, banks and asset managers, have also excluded investment in tobacco.<sup>17</sup>

From December 2012, all tobacco products in Australia were required to be sold, offered for sale or otherwise supplied in plain packaging and feature graphic health warnings, which were expanded and updated under the *Competition and Consumer (Tobacco) Information Standard 2011*. The implementation of tobacco plain packaging was a world first and eliminated a major form of tobacco advertising and promotion in Australia. State and territory governments took additional steps to prohibit and/or further restrict the advertising, display, promotion and sale of tobacco products, particularly in point-of-sale settings.

Australian governments continued to invest in integrated public health campaigns to motivate smokers to quit, motivate recent quitters to continue smoking abstinence, discourage the uptake of smoking and reshape social norms about smoking. Major investments were also made to reduce tobacco use among First Nations people and other populations with a high prevalence of smoking.

Nicotine replacement therapies (NRT) for smoking cessation have become increasingly accessible through the Pharmaceutical Benefits Scheme (PBS) for individuals

attempting to quit smoking, with the additional listing of nicotine gums and lozenges on the PBS in February 2019. Other pharmacotherapies for smoking cessation, such as varenicline and bupropion, are also available on the PBS. In March 2014 an additional course of varenicline was made available through the PBS to patients who have been unsuccessful in achieving smoking abstinence during or after an initial course of PBS-subsidised varenicline.

Smoke-free laws were strengthened in most states and territories to capture e-cigarettes and/or cover a wider range of public places and other settings such as outdoor dining areas, public transport settings, custodial settings, and cars when children are present.

Other key achievements include significant investments by the Australian Government to prevent the trade in illicit tobacco, and the publication of Australian Government guidance regarding the legal obligations of public officials under Article 5.3 of the WHO FCTC (see Part 3, Priority Area 1 for further detail).

### Changes in smoking prevalence

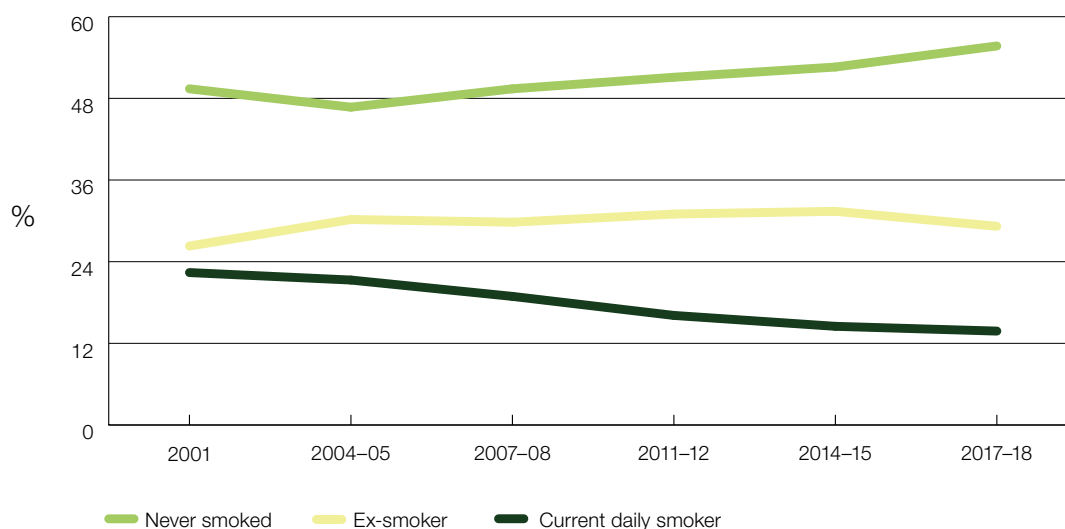
Australia has made significant progress in reducing smoking prevalence over many years. The prevalence of daily smoking among adults (people aged 18 years and over) was 13.8% in 2017–18, a reduction from 16.1% in 2011–12 and 23.8% in 1995.<sup>18</sup> The proportion of 'never smokers' increased from 50.9% in 2011–12 to 55.7% in 2017–18.<sup>19</sup>

Tobacco use among children and young adults fell to unprecedented levels during the period of the 2012–2018 Strategy. The average age at which young people aged 14–24 years smoked their first full cigarette increased significantly from 15.4 years in 2010 to 16.3 years in 2016.<sup>20</sup> Although preventing the uptake of smoking among all young people is preferable, delaying the age when young people first experiment with tobacco products can reduce the risk that they transition to regular or daily smoking and can increase their chances of successfully quitting if they do become regular users. Delaying the use of tobacco may also help reduce the duration and intensity of a person's smoking – factors which are strongly associated with tobacco-attributable disease and premature death.<sup>21</sup>

Substantial progress was also made in reducing exposure to second-hand smoke in homes with children aged 14 years or younger. In 2019, 2.1% of households with dependent children had an adult who smoked daily inside the home, compared with 19.7% in 2001.<sup>22</sup>

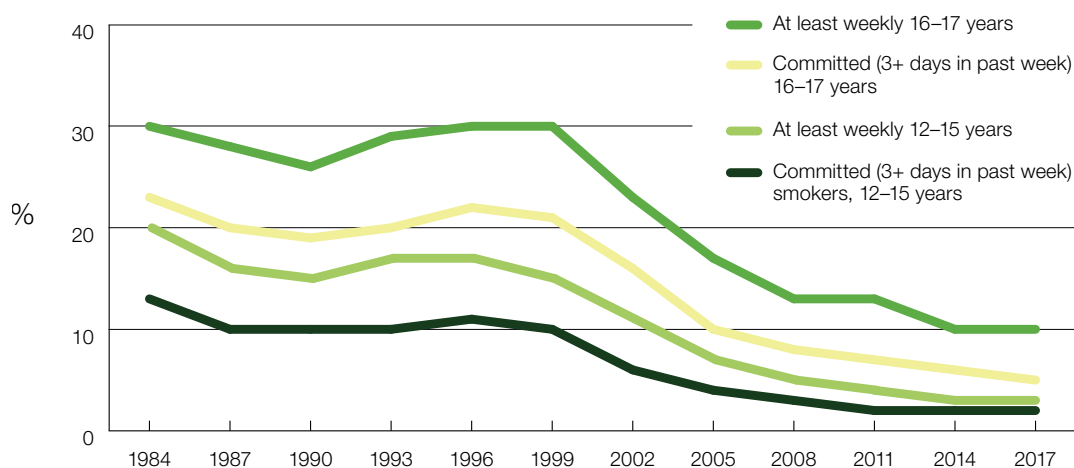
The proportion of secondary school students who have never smoked increased from 77% in 2011 to 82% in 2017,<sup>23</sup> while the proportion of young adults aged 18–24 years who have never smoked increased from 64% in 2007–08 to 75% in 2017–18.<sup>24</sup> Between 1984 and 2017, the proportion of teenagers smoking at least once in the previous week reduced from 30% to 10% among 16–17 year olds, and from 20% to just 3% among 12–15 year olds. In 2017, 1% of people aged 12–15 years had smoked more than 100 cigarettes in their lifetime.<sup>25</sup>

**Figure 3. Persons aged 18 years and over — proportion by current smoker status, 2001 to 2017–18**



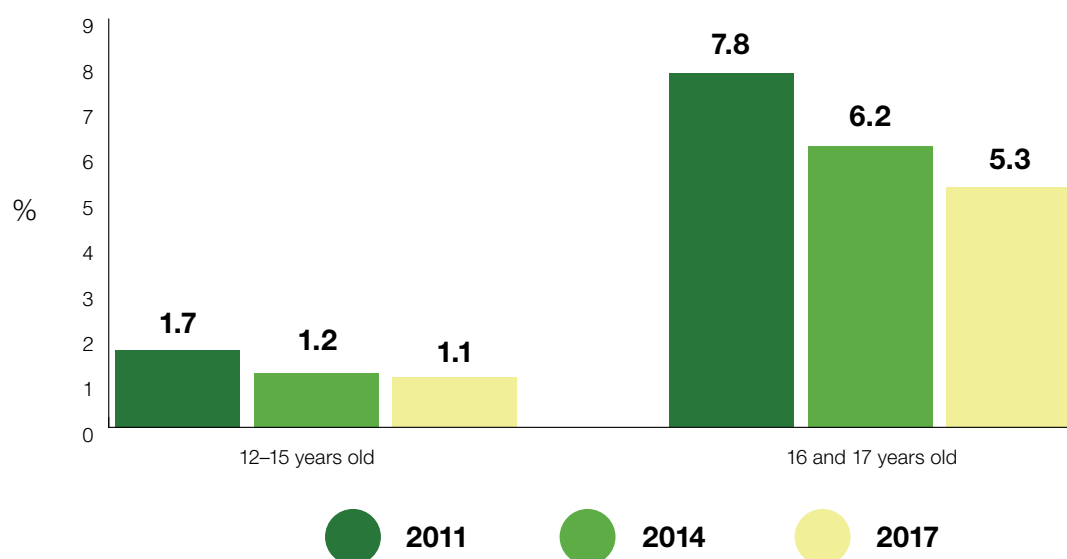
**Source:** Australian Bureau of Statistics. National Health Survey. ABS website; 2018–19.  
Available from: <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/smoking/2017-18>

**Figure 4. Prevalence of Australian secondary school students who report smoking in the last week, at least three days in the last seven**



**Sources:** Guerin N and White V. ASSAD 2017 statistics & trends: Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances. Second edition. Melbourne: Cancer Council Victoria; 2020. Available from: <https://www.health.gov.au/resources/publications/secondary-school-students-use-of-tobacco-alcohol-and-other-drugs-in-2017>

**Figure 5. Percentage of Australian secondary school students (ages 12–15 and 16–17 years) who have smoked at least 100 cigarettes in 2011, 2014, 2017**



**Source:** Guerin N and White V. ASSAD 2017 statistics & trends: Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances. Second edition. Melbourne: Cancer Council Victoria; 2020. Available from: <https://www.health.gov.au/resources/publications/secondary-school-students-use-of-tobacco-alcohol-and-other-drugs-in-2017>

### The hardening hypothesis myth

The 'hardening hypothesis' has been referred to as a justification for increasing the marketing, access and availability of e-cigarettes and novel tobacco products.<sup>26</sup> The hypothesis proposes that tobacco control measures have more readily influenced smokers who found it relatively easy to quit, creating a 'hardening' effect whereby the remaining smokers are increasingly resistant to tobacco control measures. Indicators of hardening may be associated with motivation to quit, nicotine dependence, quit outcomes or a combination of these factors. A recent systematic review of the evidence found that the weight of available evidence does not support the hardening hypothesis.<sup>27</sup> The review found that on average the Australian population of smokers has softened over time. The findings suggest that smokers have instead become more motivated to quit and less dependent on smoking. Findings from the review were consistent with those of other studies which also did not find evidence of hardening.<sup>28</sup>

### Populations with a high prevalence of tobacco use and populations at a higher risk of harm from tobacco use

#### First Nations populations

Findings published by the Australian Bureau of Statistics (ABS) showed that the proportion of First Nations people aged 15 years and over using tobacco decreased from 41% in 2012–13 to 37% in 2018–19.<sup>29</sup>

In 2017 the ABS reported on its analysis of trends in smoking prevalence in the First Nations population over time. The analysis compared the time period 1994 to 2004–05 ('pre-investment in tobacco control') to 2008 to 2014–15 ('post investment in Indigenous tobacco control'). It found:

- reductions in smoking rates in First Nations people aged 18 years and over (2.1 percentage point reduction per year) in the investment period, compared to the 0.7 percentage point per year upward trend in smoking rates in the pre-investment period
- reductions in smoking initiation in the investment period (1.9 percentage points per year), compared to no reduction in the pre-investment period.<sup>30</sup>

The ABS concluded that specific funding for First Nations tobacco control since 2008 has contributed to the reduction in smoking rates among First Nations Australians.

Despite these reductions, the prevalence of tobacco use among First Nations people remains very high, and additional measures need to be taken by all jurisdictions to reduce tobacco use in this population.



### Other populations with a high prevalence of tobacco use or at a higher risk of harm from tobacco use

Progress in reducing smoking prevalence was also seen across all levels of remoteness in Australia. Between 2011–12 and 2017–18, daily smoking prevalence among people aged 18 years and over reduced from 14.7% to 12.7% among those living in major cities, from 18.5% to 15.4% among those living in inner regional Australia, and from 22.4% to 19% in outer regional and remote areas.<sup>31</sup>

Significant reductions in smoking prevalence were also observed in several other population groups during the period of the previous Strategy. In 2020, 9.2% of pregnant people who gave birth smoked at some time in their pregnancy, a reduction from 14.6% in 2009.<sup>32</sup>

### 1.3 What challenges remain?

Despite Australia's success over many years in reducing the prevalence of tobacco use, significant challenges remain. The costs of tobacco use borne by the Australian community in 2015–16 were estimated to be \$137 billion.<sup>33</sup> Tobacco use also remains the biggest contributor to Australia's preventable health burden, contributing 8.6% of the total burden of disease in Australia in 2018<sup>34</sup> and 12% of the total preventable health burden for First Nations people.<sup>35</sup>

Tobacco marketing and use compounds health and social inequalities and is a major contributor to poorer health status in socioeconomically disadvantaged populations. In 2018 the tobacco-attributable burden in Australia was 3.1 times higher in the lowest socioeconomic group compared to the highest socioeconomic group.<sup>36</sup>

In addition to the risks that tobacco use poses to physical health, smoking is associated with an increased risk of a range of mental illnesses including psychosis, schizophrenia, anxiety, depression and bipolar disorder.<sup>37,38,39</sup> Despite a common perception that smoking generally helps people manage their mental health condition, evidence suggests that smoking cessation may help to improve rather than worsen mental health outcomes.<sup>40</sup>

In 2019, people with mental health conditions were twice as likely to smoke daily as people who had not been diagnosed or treated for mental health conditions (20% compared with 9.9%).<sup>41</sup> People who smoke are more likely to experience social isolation and loneliness, and cutting down smoking is associated with a reduction in suicidality and depression. People with mental illness also experience a disproportionate health and financial burden from smoking.<sup>42,43</sup> See Priority Area 5 for further detail on smoking cessation and mental health.

Every encounter with a healthcare setting is an opportunity for promotion of smoking cessation. While a wide range of health professionals are suitably qualified and well placed to support a patient's attempt to quit smoking,<sup>44</sup> there is opportunity to improve access to this support in regional and remote areas, where there are often significantly fewer general practitioners and other health professionals available.<sup>45</sup>

The tobacco industry and other commercial interests continue to pose major challenges to Australia's efforts in tobacco control. As noted by the United States Surgeon General, the tobacco industry is the root cause of the tobacco epidemic and continues to aggressively market and promote lethal and addictive products and to recruit children as new consumers of tobacco products.<sup>46</sup> Alongside efforts to maintain their core business in the marketing of tobacco products and determined opposition to evidence-based measures to reduce tobacco use, the tobacco industry has continued to invest in e-cigarettes<sup>ii</sup> and a range of novel and emerging products.<sup>47</sup>

During the period of the 2012–2018 Strategy, rates of e-cigarette use among children and young people increased markedly in numerous markets globally.<sup>48</sup> Normalisation of e-cigarette marketing and use is undermining population health and has the potential to disrupt the significant achievements Australia has made in tobacco control to date. Reducing the use of tobacco products, e-cigarettes and novel products will necessarily reduce the profits of commercial actors that market them. Industry resistance to evidence-based measures cannot be allowed to undermine government efforts to protect population health and reduce tobacco-attributable death and disease.

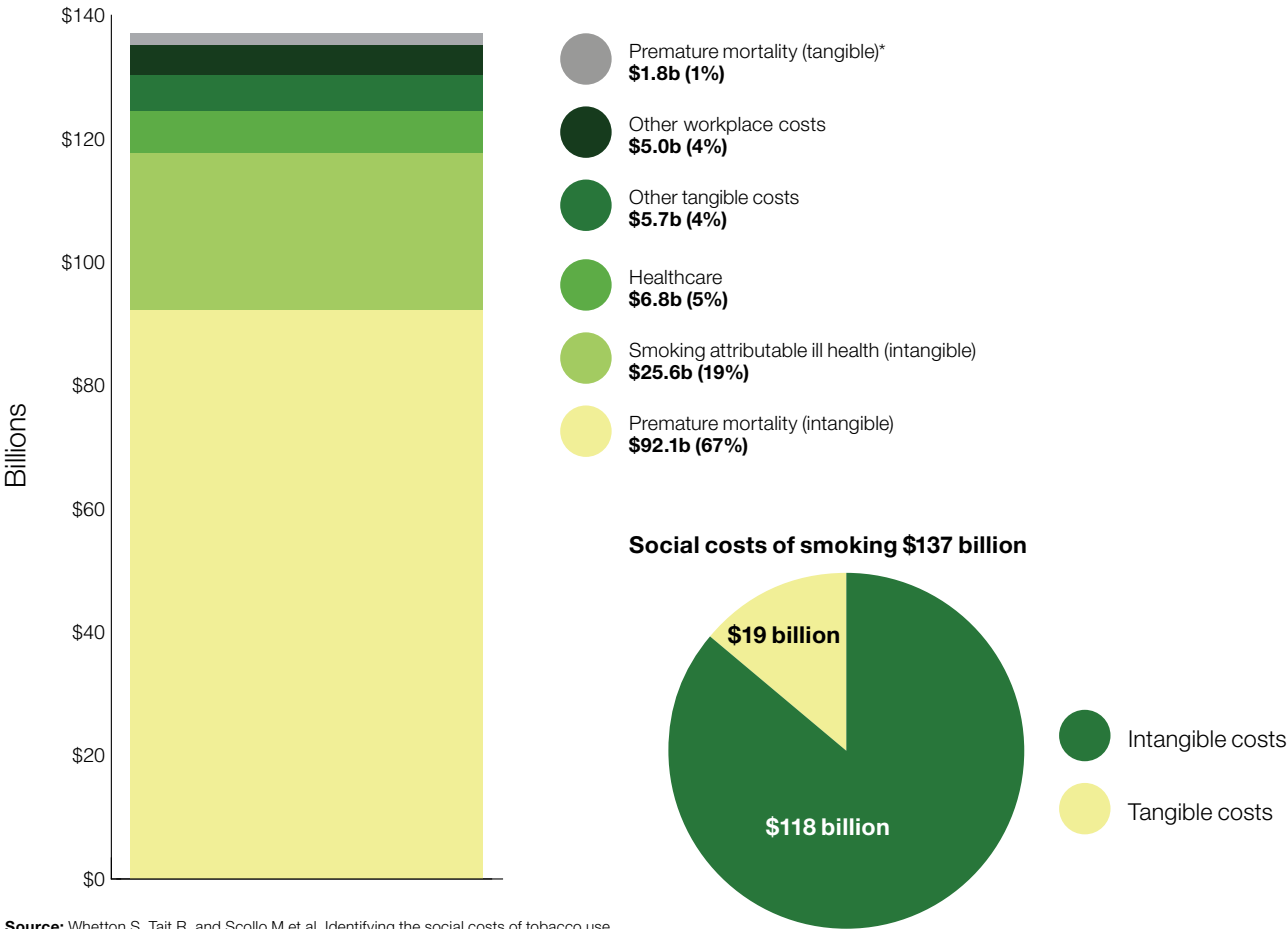
Waste from cigarette butts and e-cigarettes represents an ongoing environmental challenge for Australia. Cigarette butts were identified as the most littered object in Australia in the National Plastics Plan 2021. It is estimated that about one-third of cigarettes sold each year in Australia are littered.<sup>49</sup> Littered cigarette butts contain plastic and chemical residues, including from pesticides, nicotine and heavy metals (leachates), which can contaminate soil and water and can lead to bioaccumulation in the food chain.<sup>50</sup> The cost of tobacco-related litter removal in Australia has been estimated at around \$73 million per year.<sup>51</sup>

ii While there is some variation in the terminology used, 'e-cigarettes' typically refers to battery-powered devices which deliver an aerosol by heating a solution which is breathed in. They are also referred to as vapes, and the act of using an e-cigarette can be referred to as vaping.

Serious and organised crime groups take advantage of the rising cost of legal tobacco products to make more illicit profits. Organised crime groups view the illicit tobacco trade as low risk and high reward and engage in illicit tobacco importations to generate profit.<sup>52</sup> The Illicit Tobacco Taskforce was established in 2018 to investigate, prosecute and dismantle international organised crime groups who use the proceeds of illicit tobacco to fund other criminal activity.<sup>53</sup> The ongoing presence of the illicit tobacco market not only fuels other illicit activities but also undermines public health efforts to reduce demand for tobacco.

The history of tobacco control in Australia and other countries shows that tobacco use can be substantially reduced over time through commitment to, and the implementation of, comprehensive and evidence-based measures. Avoiding complacency and re-emphasising that tobacco use remains the largest preventable cause of death must create a sense of urgency for further actions to be taken to reduce tobacco use in Australia.

Figure 6. Distribution of intangible and tangible costs of smoking in 2015-16



Source: Whetton S, Tait R, and Scollo M et al. Identifying the social costs of tobacco use in Australia in 2015/16. Perth: National Drug Research Institute, Curtin University; May 2019.

# PART TWO: THE FRAMEWORK

## 2.1 The goal

The goal of this Strategy is ‘to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and the inequalities it causes’.

This Strategy aims to achieve a national daily smoking prevalence of less than 10% by 2025 and 5% or less by 2030 in Australia, and reduce the daily smoking rate among First Nations people to 27% or less by 2030. This is consistent with the commitments of the National Preventive Health Strategy and with other countries’ announced plans and targets to eliminate tobacco.<sup>54,55,56</sup>

Other national strategies, such as Australia’s first National Strategic Action Plan for Lung Conditions (published in February 2019), contribute to a new sense of urgency to substantially reduce the national smoking prevalence and to work towards a tobacco-free society.<sup>57</sup>

While these targets are ambitious, substantial progress will be made towards achieving them if the actions in this Strategy are fully implemented.

## 2.2 The objectives

The objectives of the Strategy are:

- Prevent uptake of tobacco use.
- Prevent uptake of e-cigarettes by young people and those who have never smoked.
- Prevent and reduce nicotine addiction.
- Denormalise and limit the marketing and use of e-cigarettes.
- Encourage and assist as many people as possible who use tobacco and e-cigarettes to quit as soon as possible, and prevent relapse.
- Prevent and reduce prevalence of tobacco use among First Nations people.
- Prevent and reduce tobacco use among groups at higher risk from tobacco use, and other populations with a high prevalence of tobacco use.
- Eliminate harmful exposure to second-hand tobacco smoke.
- Prevent and reduce the marketing and harms associated with use of novel and emerging products.
- Ensure tobacco control in Australia is guided by focused research, monitoring and evaluation.
- Protect tobacco control policy from all commercial and other vested interests.
- Ensure all the above contribute to the continued denormalisation of the tobacco industry and tobacco use.

## 2.3 Priority areas

The priority areas build on those identified in previous national tobacco strategies. They are informed by an extensive evidence base and reflect best practice approaches to tobacco control. This Strategy places a strong emphasis on protecting tobacco control from all commercial and other vested interests and reducing the supply, availability and accessibility of tobacco products. It also includes a stronger focus on regulating the contents and product disclosures pertaining to tobacco products and taking concerted action to minimise the risks associated with the marketing and use of novel and emerging products. This Strategy also maintains a strong commitment to reducing the social and health inequalities and environmental impacts associated with tobacco and e-cigarette use. It strongly emphasises working in partnership with First Nations people and other populations with a high prevalence of tobacco use.

This Strategy identifies 11 priority areas for future action:

1. Protect public health policy, including tobacco control policies, from all commercial and other vested interests.
2. Develop, implement and fund evidence-based integrated public health campaigns and other communication tools to motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use.
3. Continue to reduce the affordability of tobacco products.
4. Strengthen and expand efforts and partnerships to prevent and reduce tobacco use among First Nations people.
5. Strengthen efforts to prevent and reduce tobacco use among populations at a higher risk of harm from tobacco use and other populations with a high prevalence of tobacco use.
6. Eliminate all tobacco-related advertising, promotion and sponsorship.
7. Further regulate the contents and product disclosures pertaining to tobacco products.
8. Strengthen regulation to reduce the supply, availability and accessibility of tobacco products.
9. Strengthen regulations on e-cigarettes and novel and emerging products.
10. Eliminate exceptions to smoke-free workplaces, public places and other settings.
11. Provide greater access to evidence-based cessation services to support people to quit the use of tobacco, e-cigarettes and novel and emerging products.

## 2.4. Guiding principles

### Working in partnership

Governments will work collaboratively to achieve national consistency in tobacco control approaches and the goals under the Strategy. Reducing the prevalence of tobacco use cannot be achieved by governments alone. A strength of Australia's approach to tobacco control has been the strong and enduring partnerships developed between governments, NGOs, healthcare professionals, research groups, and community and consumer groups that are free from commercial and other vested interests.

Under this Strategy, governments and NGOs, healthcare professionals, research groups and community groups will:

- strengthen longstanding partnerships
- identify and form new partnerships in order to expand opportunities for tobacco control interventions within and outside health settings and develop an ethos that tobacco control is everybody's business
- build the capacity of organisations and healthcare professionals to implement tobacco control programs.

A priority will be to strengthen existing partnerships between governments, NGOs and First Nations communities and community-controlled organisations. It will also be important to explore partnerships with mainstream services to ensure culturally safe smoking cessation support for First Nations people. These partnerships will underpin the continued development and implementation of policies and programs to tackle tobacco use among First Nations people and contribute to efforts to close the gap in health outcomes as committed to in the National Agreement on Closing the Gap.

New partnerships will be forged between health agencies, social service organisations, mental health care providers and corrections services to reduce smoking prevalence and exposure to second-hand smoke in populations at a higher risk of harm from tobacco use and in other populations with a high prevalence of tobacco use.<sup>58</sup>

Australia will continue to engage in international partnerships to maximise the effectiveness of global tobacco control efforts and to learn and share best practice approaches to reducing tobacco-related harm. Australian government agencies and NGOs will continue to engage with low- and middle-income countries, particularly in the Asia-Pacific region, to provide assistance on tobacco control, including drawing on experiences, learnings and strategies of the Tackling Indigenous Smoking program. Under this Strategy, Australia will also continue to actively engage in global tobacco control forums including the Conference of the Parties of the WHO FCTC.

### The evidence base for tobacco control

Evidence about the harms caused by tobacco marketing and use is overwhelming<sup>59,60</sup> and has identified interventions that are effective in reducing tobacco use. Over the past 50 years, Australian researchers have been important contributors to strengthening this evidence base.

Tobacco control in Australia is underpinned by a commitment to evidence-based policy. Where the evidence does not yet exist on the most effective interventions, Australia will be guided by the best available information and conduct robust evaluation that contributes to the future evidence base. Ensuring that all involved in tobacco control can access the latest evidence and knowledge about tobacco control policies and issues is a priority. Partners will continue to support the free online publication *Tobacco in Australia: Facts and Issues*, a comprehensive review of the major issues in tobacco control, smoking and health in Australia.<sup>61</sup>

### **Protection from all commercial and other vested interests**

This Strategy recognises that commercial actors play a major role in influencing individual behaviours and shaping population health outcomes.<sup>62</sup> The commercial determinants of health are the conditions, actions and omissions by corporate actors that affect health.<sup>63</sup> For example, tobacco companies have employed sophisticated strategies to undermine the development and implementation of the WHO FCTC.<sup>64</sup> Studies have also illustrated tactics employed by the tobacco industry to attempt to counter Australian tobacco control policies.<sup>65</sup>

The WHO has affirmed that the commercial determinants of health affect everyone, that young people are especially at risk, and that unhealthy commodities such as tobacco worsen pre-existing economic, social and racial inequities.<sup>66</sup> For example, First Nations people globally are disproportionately targeted with tobacco and nicotine marketing and are most significantly impacted by commercially driven tobacco-related harms.<sup>67</sup>

Article 5.3 of the WHO FCTC requires that 'in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law'. See Priority Area 1 for further detail.

### **Compliance and enforcement of tobacco control legislation**

Enforcement of tobacco control legislation in Australia has become increasingly important as a result of strategies devised by the tobacco industry, the e-cigarette industry and their associated interests to exploit and evade these regulations.<sup>68,69</sup> A stronger focus on enforcing regulations pertaining to tobacco products, e-cigarettes and novel and emerging products is necessary to protect the health of all Australians.

Effective monitoring of the tobacco supply chain at all stages will help identify the points at which illicit tobacco activity emerge and how the supply chain can be better secured to prevent infiltration. Evidence obtained through monitoring can also inform options to deter participation in illicit tobacco trade, such as severe penalties for those involved and other dissuasive law enforcement measures. Investment in research and evaluation in this area is necessary to help address gaps in enforcement and guide the development of a nationally consistent and evidence-based approach to tobacco control compliance and enforcement. Lessons learned from these activities are also relevant to monitoring and controlling the supply and marketing of e-cigarettes.

Further actions to strengthen compliance and enforcement of tobacco control legislation are included under the priority areas of this Strategy.

# PART THREE: PRIORITY AREAS AND ACTIONS

## **Priority Area 1: Protect public health policy, including tobacco control policies, from all commercial and other vested interests**

### **WHO FCTC and Article 5.3**

In November 2008, parties to the WHO FCTC adopted guidelines for implementation of Article 5.3. The Article 5.3 guidelines were developed in recognition that ‘the tobacco industry has operated for years with the express intention of subverting the role of governments and of WHO in implementing public health policies with respect to the tobacco epidemic’.<sup>70</sup> They recognise the ‘fundamental and irreconcilable conflict between the tobacco industry’s interests and public health policy interests’.<sup>71</sup>

The purpose of the Article 5.3 guidelines is to ensure that efforts to protect tobacco control from commercial and other vested interests of the tobacco industry are comprehensive and effective. The Article 5.3 guidelines also note that relevant measures should be implemented across ‘all branches of government that may have an interest in, or the capacity to, affect public health policies with respect to tobacco control’.<sup>72</sup> In Australia this may include (but is not limited to) government portfolios responsible for health, treasury and finance, environment and climate change, trade, industry, communications, law enforcement, border security, and consumer law. Article 5.3 guideline recommendations include:

- Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties’ tobacco control policies.
- Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur.
- Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry.
- Avoid conflicts of interest for government officials and employees.
- Require that information provided by the tobacco industry be transparent and accurate.
- Denormalise 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’.
- Do not give preferential treatment to the tobacco industry.<sup>73</sup>

Parties to the WHO FCTC continue to report that the tobacco industry remains one of the biggest barriers to implementing the convention.<sup>74</sup> Indeed, the WHO expert group reviewing the impact of the FCTC concluded that ‘the greatest obstacle is the aggressive approach of the tobacco industry, which directly opposes and undermines the FCTC and its recommendations’.<sup>75</sup> Evidence has also highlighted that selective and incomplete approaches to the implementation of Article 5.3 facilitate diverse opportunities for tobacco industry interference in tobacco control policies.<sup>76</sup>

In 2019 the Australian Government published *Guidance for Public Officials on Interacting with the Tobacco Industry* (the Article 5.3 Guide).<sup>77</sup> The Article 5.3 Guide outlines best practice approaches whereby all Australian Government agencies, officials and people acting on their behalf can deliver tobacco control policies in line with Australia’s legal obligations under Article 5.3 of the WHO FCTC. The guidance applies to people acting on behalf of any level or branch of government. The Article 5.3 Guide will be reviewed during the life of this Strategy to ensure the document remains current and comprehensive.

Priority Area 1 refers to a number of measures to further implement Australia’s obligations under Article 5.3 of the WHO FCTC. This does not prevent government organisations and NGOs from implementing additional measures beyond those explicitly recommended in the Article 5.3 guidelines or the Article 5.3 Guide.

### **Protecting tobacco control policy from all other commercial and other vested interests**

This Strategy also recognises the need to protect Australia’s tobacco control settings from other commercial and vested interests. Consistent with this approach, relevant Commonwealth and state and territory ministers have affirmed the importance of protecting public health policy from all commercial and other vested interests related to e-cigarettes.

Evidence from Australia and overseas also reinforces the need to ensure that efforts to protect tobacco control from commercial and other vested interests of the tobacco industry also extend to individuals and organisations whose interests may be aligned with those of the tobacco industry.<sup>78,79,80</sup> This includes the tobacco industry’s practice of using individuals, retail groups, front groups, and affiliated organisations to act, openly or covertly, on their behalf or to take action to further their interests.

### **The importance of independent research and evaluation**

There is strong evidence that sponsorship of studies from manufacturers of drugs and devices leads to more favourable conclusions for the sponsors’ products than sponsorship from other sources.<sup>81</sup> Types of bias associated with industry sponsorship include methodological bias, where there is a systematic error in the design, conduct or analysis of the study such that it deviates from the truth; agenda bias, where study topics align with increased use of industry products; publication and reporting bias, where unfavourable studies or results are suppressed or omitted; and marketing bias, where supportive evidence is preferentially disseminated and sympathetic opinion leaders are given a broad platform.<sup>82</sup> These findings reinforce the importance of ensuring that all tobacco control measures developed and implemented under this Strategy are based on evidence from research and evaluation that is free from commercial and other vested interests.



## **Actions for Priority Area 1**

**1.1** Increase awareness among the public, governments and NGOs about Article 5.3 and tobacco industry practices, including tobacco industry interference in tobacco control policies.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**1.2** Strengthen Australia's implementation of Article 5.3 and the Article 5.3 guidelines through the development of further policy and regulatory approaches.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**1.3** Further develop and implement measures that limit interactions between governments and the tobacco industry to the extent strictly necessary to enable effective regulation of the tobacco industry and tobacco products, and ensure transparency of interactions that do occur.

**Responsibility:** Australian Government, state and territory governments.

**1.4** Develop and implement measures to prohibit contributions from the tobacco industry and those working to further its interests to political parties, candidates or campaigns; or to require full disclosures of such contributions.

**Responsibility:** Australian Government, state and territory governments.

**1.5** Develop regulatory options to require the tobacco industry and those working to further its interests to periodically submit information on tobacco production and manufacture, market share, revenue, marketing expenditure and any related activity, including lobbying, philanthropy, and political contributions.

**Responsibility:** Australian Government, state and territory governments.

**1.6** Review existing legislation and other arrangements and identify best practice policy approaches to prevent and avoid conflicts of interest and perceptions of preferential treatment, partnerships or non-binding agreements between Australian governments and the tobacco industry.

**Responsibility:** Australian Government, state and territory governments.

**1.7** Update relevant policies and guidelines (including the *Guidance for Public Officials on Interacting with the Tobacco Industry*) to ensure that the development and implementation of tobacco control policy in Australia prioritises independent research and evaluation that is free from commercial and other vested interests.

**Responsibility:** Australian Government, state and territory governments.

**1.8** Explore the feasibility of regulating activities described as 'socially responsible' by the tobacco industry and implement such regulatory measures as are appropriate.

**Responsibility:** Australian Government, state and territory governments.

**1.9** Strengthen measures to monitor and evaluate Australia's implementation of Article 5.3 and the Article 5.3 guidelines.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**1.10** Monitor international legal action undertaken against the tobacco industry and explore the feasibility of pursuing similar activities in Australia, including the release of corporate documents as part of settlement agreements.

**Responsibility:** Australian Government, state and territory governments.

**1.11** Develop, implement and evaluate new measures aimed at protecting tobacco control policy development and implementation from all commercial and other vested interests.

**Responsibility:** Australian Government, state and territory governments, NGOs.

## **Priority Area 2:**

### **Develop, implement and fund evidence-based integrated public health campaigns and other communication tools to motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use**

Reviews provide strong evidence that well-funded and sustained public education campaigns increase quitting and reduce smoking prevalence when implemented in the context of a comprehensive tobacco control program.<sup>83,84</sup> Such campaigns are, on average, highly cost-effective.<sup>85,86</sup> Comprehensive tobacco control programs that include mass media campaigns can reduce smoking initiation,<sup>87</sup> increase quitting intentions and behaviours, and reduce smoking prevalence in adults.<sup>88</sup> Campaign reach, intensity and duration and the type of message are determinants of overall effectiveness.<sup>89</sup>

Article 12 of the WHO FCTC requires each party to promote and strengthen public awareness of tobacco control issues, using all available communication tools.<sup>90</sup>

This Strategy also recognises the importance of investing in public education campaigns to raise awareness about the marketing and use of e-cigarettes and their immediate and long-term impacts on individual and population health and the environment. Further detail on this is also provided under Priority Area 9.

#### **Mass media campaigns**

Evidence confirms that mass media public health campaigns that are evidence based in both their creative development and their audience exposure are effective in reducing smoking prevalence across all socioeconomic groups. To maximise effectiveness, messages need to be broadcast widely at a sufficient volume and at regular intervals to people who smoke,<sup>91</sup> and be suitable for all health literacy levels.<sup>92</sup>

With changes in media consumption trends, campaign planners need to develop integrated and responsive media strategies that enable equitable exposure of messaging. While broadcast television audiences are diminishing by around 2% to 3% each year, television remains an effective way to reach mass audiences,<sup>93</sup> particularly among disadvantaged populations, who continue to have much higher smoking rates than the general population.<sup>94</sup> In addition, campaigns now also need greater utilisation of online platforms (e.g., social media, gaming) and channels (e.g., catch-up television, pre-roll videos shown before web news and entertainment videos), as well as more traditional supplementary channels (e.g., radio, out-of-home, print) to expose target audiences to messages. The dispersion of online platforms and channels demands the use of various video and static formats and results in more fragmented,

as well as more targeted and personalised, exposure to messages.<sup>95,96</sup> Campaigns need to use this integrated channel/platform mix to achieve the 75% to 85% exposure levels required for population-level behaviour change.<sup>97</sup> The ongoing reduction in the use of traditional media and increase in the use of digital media during the life of the previous Strategy reinforces the importance of moving quickly and continuing to monitor the appropriateness and effectiveness of campaigns.

To ensure future investments in this area are optimised, coordination and evaluation activities between government and NGOs will be strengthened under this Strategy.

#### **Other forms of public education**

Tobacco packaging and labelling measures are another effective way to help motivate people who use tobacco to quit, and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use.

Since the introduction of graphic health warnings on tobacco packaging in Australia in 2006, epidemiological research has linked many additional conditions and diseases to the use of tobacco. Many consumers are unaware of these health risks and lack understanding of the far-reaching ways in which smoking can affect their health.<sup>98</sup> Evidence is emerging that including information about toxic constituents on prominent health warnings increases awareness of these constituents and smoking-related conditions and may increase the perceived risks of smoking.<sup>99</sup>

An evaluation in 2018 of the graphic health warnings on tobacco packaging showed that the warnings have increased consumer knowledge of the health effects relating to tobacco use and have encouraged the cessation of smoking.<sup>100</sup> The evaluation highlighted a need to reconsider the range of health warnings on tobacco products, including images, warning statements and written information, and that health warnings and messages on tobacco packaging should be rotated frequently to ensure the messages remain impactful.<sup>101</sup> The evaluation also recommended that if new or surprising information is used in graphic health warnings, complementary information through other communication channels can reinforce the messaging and its credibility.

Public relations and innovative marketing strategies can convey information and messages about the harms of tobacco use and the practices of the tobacco industry to very large proportions of the population. For example, a strong content strategy may utilise news media, sponsorships and collaborations to share content such as case studies, tools and resources. Australian governments, tobacco control researchers, the non-government sector, and campaign workers will facilitate this wide sharing of content wherever possible.<sup>102</sup>



## **Actions for Priority Area 2**

**2.1** Deliver integrated public health campaigns that are evidence based in their design and delivery and are at levels of reach and frequency demonstrated to reduce smoking prevalence.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**2.2** Continue complementary evidence-based integrated public health campaigns targeted at and tailored to high-prevalence populations and populations at a high risk of harm from tobacco use.

**Responsibility:** Australian Government, state and territory governments, NGOs, First Nations health organisations such as the National Aboriginal Community Controlled Health Organisation and state/territory affiliates.

**2.3** Continue to monitor and explore the role and effectiveness of campaign media/channels, including consideration of target audience, media consumption trends, equitable exposure of messaging and the need for an integrated, evidence-based and responsive media strategy across traditional, modern and emerging platforms and opportunities.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**2.4** Continue to monitor emerging opportunities to further extend and support campaign messages and support other tobacco control program activities.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**2.5** Continuously improve the effectiveness of evidence-based integrated public health campaigns through rigorous developmental research and campaign evaluation to inform and refine future campaign development.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**2.6** Strengthen communication and collaborative action between the Australian Government, state and territory governments and NGOs to maximise the effectiveness of evidence-based integrated public health campaigns and other tobacco control public education campaigns.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**2.7** Continue to share campaign materials, evaluations and other evidence of effectiveness of public education campaigns with the global tobacco control community.

**Responsibility:** Australian Government, state and territory governments, research organisations, NGOs.

**2.8** Update the range of graphic health warnings on tobacco products to cover additional health effects now established to be caused by smoking, using evidence-based content and presentation; and continue to monitor the need for further updates.

**Responsibility:** Australian Government.

**2.9** Complement the development of new graphic health warnings on tobacco products with other evidence-based messages, such as health promotion inserts, to motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use.

**Responsibility:** Australian Government, state and territory governments.

### Priority Area 3: Continue to reduce the affordability of tobacco products

Reducing the affordability of tobacco products through tobacco tax increases is the single most effective measure that governments can adopt to reduce smoking.<sup>103</sup> Real price increases used in tandem with integrated public health campaigns have had an even stronger, synergistic benefit. Article 6 of the WHO FCTC recognises that price and tax measures are an effective and important means of reducing tobacco consumption, particularly among young people and lower income populations.<sup>104</sup>

Some stakeholders, including the tobacco industry and its allies, have claimed that tobacco taxes are regressive.<sup>105,106,107</sup> In contrast, research in Australia and overseas has found that lower income groups such as young people and low-socioeconomic populations tend to be responsive to price increases.<sup>108,109</sup> The WHO 2015 report on the global tobacco epidemic concludes that raising tobacco taxes and prices reduces consumption and promotes quitting and is especially effective in reducing tobacco use by vulnerable populations. The greatest health and economic benefits from reductions in tobacco use are experienced by the most disadvantaged populations, whose tobacco use reduces more with tax increases.<sup>110</sup> A 2019 report from the World Bank also affirmed that when all relevant costs and benefits are considered, the effects of raising taxes on tobacco are progressive and welfare increasing.<sup>111</sup> Higher tobacco taxes are most effective when part of a comprehensive tobacco control program. Complementing higher taxes with smoking cessation support for those who attempt to quit in response to raising taxes increases the number of people who quit successfully.<sup>112</sup> This research demonstrates the progressive effects of tobacco taxation.

The tobacco industry has used calculated strategies to undermine the public health effects of tobacco excise increases. These include the sale of large packs of manufactured cigarettes and small pouches of roll-your-own tobacco,<sup>113</sup> as well as the sale of odd pack and pouch sizes to create confusing price signals. Other strategies include absorbing tax increases in the cheapest segments of the market, introducing new, cheaper products, selling discounted tobacco through favourable deals with high-volume retailers, and gradually introducing price increases to cushion the effect of excise increases.<sup>114</sup> Governments need to counter these strategies and strengthen monitoring and surveillance in this area. Related issues regarding tobacco advertising, promotion and sponsorship are discussed in Priority Area 6.

Illicit trade in tobacco products also undermines efforts to reduce the affordability of tobacco products. Findings from tobacco tax gap analysis by the Australian Taxation Office show that the size of the illicit tobacco market in Australia in 2020–21 was estimated at \$1.89 billion, approximately 10.4% of the market.<sup>115</sup> Measures to address the illicit tobacco trade are discussed in more detail under Priority Area 8.

### Actions for Priority Area 3

**3.1** Continue to monitor the need for, and benefit of, changes in tobacco excise and excise-equivalent customs duty.

**Responsibility:** Australian Government.

**3.2** Amend the Commonwealth *Tobacco Plain Packaging Act 2011* to standardise pack sizes and stick sizes of manufactured cigarettes, cigarillos and roll-your-own tobacco products.

**Responsibility:** Australian Government.

**3.3** Review tobacco industry strategies and other practices that may be undermining the public health benefits of tobacco excise increases and implement strategies to prevent and minimise these practices.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**3.4** Analyse the effects of tobacco excise increases, including on young people and in low-income populations.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**3.5** Complement tobacco excise increases with additional efforts to motivate and support quit attempts among low-income populations.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**3.6** Complement tobacco excise increases with additional efforts to prevent and minimise the illicit tobacco trade.

**Responsibility:** Australian Government, state and territory governments.

**3.7** Explore the potential impacts and feasibility of, and best practice regulatory approaches to, measures to further reduce affordability of tobacco products, such as introducing a minimum floor price on tobacco products and once-only price changes after each excise increase.

**Responsibility:** Australian Government.

#### Priority Area 4: Strengthen and expand efforts and partnerships to prevent and reduce tobacco use among First Nations people

Tobacco use is the most significant modifiable risk factor contributing to the gap in health status between First Nations people and non-Indigenous Australians and is responsible for 12% of the total preventable health burden for First Nations people.<sup>116</sup> The use of e-cigarettes is also growing among First Nations people. Early interventions to discourage and prevent use of e-cigarettes and to support cessation are critical.

Among First Nations adults (18 years and over), the daily smoking rate steadily decreased from 50% in 2004–05 to 40% in 2018–19. However, the proportion remains higher for people living in remote areas (49%) than in non-remote areas (35%), and the proportion of First Nations adults who smoke living in remote areas has not changed significantly since 2004–05.<sup>117</sup>

Challenges to effective tobacco control, including preventing uptake and supporting smoking cessation in remote areas, are multi-faceted and in many cases location specific. Challenges include the underlying economic and social determinants such as access to education, unemployment, low socioeconomic status and poverty, overcrowding, and difficulty accessing services and treatments to support smoking cessation; the normalisation of smoking behaviours, including among young people, particularly in locations where smoking rates are high; and the lower likelihood of tobacco control (such as media campaigns and cessation supports) and enforcement of tobacco regulations (such as smoke-free areas) compared to non-remote areas.

While smoking prevalence among First Nations people remains high, as detailed above, the vast majority of First Nations people who smoke want to quit (70%) or wish they had never taken up smoking (78%).<sup>118</sup> In 2018–19, 51.4% of First Nations people who smoke aged 15 years and over had tried to quit smoking in the previous 12 months.<sup>119</sup>

In December 2007, all Australian governments agreed to close the gap in life expectancy between First Nations people and the general population within a generation.<sup>120</sup> Reducing smoking prevalence is integral to this goal. Article 4.2 of the WHO FCTC recognises the high levels of smoking and other forms of tobacco consumption by indigenous peoples, as well as the need to take measures to promote the participation of First Nations peoples and communities in the development, implementation and evaluation of tobacco control programs.<sup>121</sup>

The Tackling Indigenous Smoking (TIS) program was established to improve the health of First Nations peoples by preventing smoking uptake and supporting smoking cessation. TIS is a multi-component program that employs evidence-based activities and focuses on tobacco reduction outcomes. Importantly, TIS promotes culturally tailored approaches designed for and by First Nations people, supporting First Nations agency and self-determination to be free from nicotine dependence, while practising continuous quality improvement through regular jurisdictional workshops and field visits. In the context of

Australia's approach to tobacco control, continuation of targeted investments, like the TIS program, to implement culturally safe and locally relevant approaches will continue to be important to accelerate reductions in smoking prevalence among First Nations people. The TIS program will continue to invest in priority groups within the First Nations population, including:

- **Remote areas:** The prevalence of First Nations tobacco use in remote areas has remained stable. The TIS program will increase the intensity and reach of TIS teams in remote areas to help support reductions in smoking among First Nations people living in these areas. Recording client smoking status is increasing in remote areas, especially among health services within TIS service areas compared to those with no TIS presence in the region. This suggests increased awareness among health professionals of the need to address smoking behaviours in TIS-serviced areas and reinforces the need to invest in national TIS program coverage.<sup>122</sup>
- **Pregnant people:** The proportion of First Nations women who smoke during pregnancy has decreased (from 49.3% in 2010 to 42.8% in 2020).<sup>123</sup> The “Which Way?” study found that First Nations women of reproductive age are making quit attempts and 36% have used nicotine replacement therapy and/or stop-smoking medications.<sup>124</sup> Consistent with the Closing the Gap target to improve birthweight, pregnant First Nations people with First Nations babies continue to be a high-priority group for smoking cessation. Governments must provide culturally appropriate tobacco control interventions in clinical, community and online settings. Midwives, nurses, doctors, Aboriginal health workers and other clinical health care providers will continue to play an essential role in delivering holistic, individual and group smoking and nicotine cessation supports in healthcare settings.<sup>125</sup> Regional TIS teams will continue to work in community settings to support pregnant people, their partners and families, new mothers, and women of child-bearing age by delivering a locally tailored mix of preventive population health activities. This includes community education and awareness raising; social media/marketing; advertising; and promotion of smoke-free homes, cars, workplaces and community events. Quitline will continue to be a source of trusted and accessible online resources and telephone-based cessation supports for pregnant First Nations people and their families.
- **Young people:** The proportion of young First Nations people (18–24 years) starting to smoke decreased from 50% in 2004–05 to 36% in 2018–19,<sup>126</sup> which will result in improved health outcomes over time. To further reduce smoking uptake among First Nations young people, it is important to continue addressing broader attitudes, knowledge, and beliefs about tobacco use (e.g., through primary health care brief interventions and increasing the number of smoke-free homes and public places).<sup>127</sup> School-based education and awareness activities, are also essential for smoking cessation and behavioural changes among young people.<sup>128</sup>

- **Prisoners:** First Nations peoples experience disproportionately high prevalence of incarceration, and the prevalence of tobacco use among people entering prison is much higher than in the general community.<sup>129</sup> While prisons in most states and territories are now smoke free, most prisoners recommence smoking on release.<sup>130</sup> Culturally appropriate nicotine cessation support should be provided in prisons, with referrals to local Aboriginal community-controlled health services and supports on release to assist in maintaining smoke-free behaviours.

Priorities in this Strategy that impact the whole population will also benefit First Nations peoples. Measures under these priorities are also expected to support First Nations people who live in areas outside the reach of clinical support providers.

#### **Actions for Priority Area 4**

**4.1** Continue existing Commonwealth investment in multifaceted and culturally safe approaches to reduce tobacco use among First Nations people, and expand state and territory investments to complement and reinforce these approaches.

**Responsibility:** Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

**4.2** Monitor and evaluate the effects of initiatives to improve programs and policies to accelerate reduction in tobacco use among First Nations people.

**Responsibility:** Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

**4.3** Continue to build tobacco control capability and capacity for First Nations communities in Aboriginal community-controlled organisations and mainstream services.

**Responsibility:** Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

**4.4** Support First Nations organisations in their efforts to promote the benefits of being smoke free, as reflected in their organisational policies and community programs.

**Responsibility:** Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream services.

**4.5** Strengthen partnerships and collaboration between First Nations organisations, governments and NGOs.

**Responsibility:** Australian Government, state and territory governments, First Nations organisations, mainstream services, NGOs.

**4.6** Continue to provide training to First Nations health workers, health professionals (such as GPs) and other relevant workers on effective tobacco control interventions.

**Responsibility:** Australian Government, state and territory governments, training providers, Aboriginal community-controlled organisations, mainstream services.

**4.7** Deliver best practice and culturally safe education, intervention, screening, and tobacco and nicotine cessation as part of all routine health service delivery and social and community service provision to First Nations clients.

**Responsibility:** Australian Government, state and territory governments, Aboriginal community-controlled organisations, mainstream health services, government and non-government social service providers.

**4.8** Ensure First Nations people have appropriate access to culturally safe cessation supports and subsidised nicotine replacement therapy, identifying, mitigating and/or addressing barriers to access and uptake of services supporting tobacco and nicotine cessation.

**Responsibility:** Australian Government, state and territory governments, First Nations organisations, mainstream services, NGOs.

**4.9** Encourage and support people from First Nations priority groups (i.e., pregnant people, young people, remote populations and prisoners) and their families to be smoke free or quit smoking. This includes providing messages about tobacco-related harms and the harms associated with second-hand smoke exposure.

**Responsibility:** Australian Government, state and territory governments, First Nations organisations, mainstream services, NGOs.

**4.10** Enhance, implement and evaluate evidence-based integrated public health campaigns for First Nations people by complementing them, where appropriate, with campaign elements tailored to First Nations people and with local community-specific campaigns.

**Responsibility:** Australian Government, state and territory governments, Aboriginal community-controlled organisations, NGOs.

## **Priority Area 5:**

### **Strengthen efforts to prevent and reduce tobacco use among populations at a higher risk of harm from tobacco use and populations with a high prevalence of tobacco use**

This Strategy recognises the importance of promoting health equity, particularly in priority populations, in recognition of the health disparities they experience, and acknowledging that individuals in these communities have unique and often complex health needs.

There are several population groups for whom tobacco control should be considered a particular priority, including populations that are at a higher risk of harm from tobacco use and populations with a higher prevalence of tobacco use compared to the general population.

While some populations are specifically referenced in this priority area, this does not limit governments or other organisations from targeting other populations at a higher risk of harm from tobacco use or with higher rates of tobacco use.

#### **Populations with higher prevalence of tobacco use than the general population**

Tobacco companies have contributed to social inequalities in tobacco use by targeting their marketing activities in disadvantaged areas and social groups, which in turn has increased cues to smoke and manipulated social norms in these communities.<sup>131,132</sup> Tobacco companies have also contributed indirectly to smoking-related inequalities by opposing tobacco control proposals with significant potential to reduce smoking among disadvantaged groups.<sup>133</sup>

There are also a range of other interacting psychological, social, economic and cultural factors which mean that certain populations are more likely to use tobacco and face more barriers to quitting.<sup>134</sup> Populations in Australia with higher rates of tobacco use than the general population include:

- First Nations peoples (see Priority Area 4)
- men<sup>135</sup>
- people living with mental illness
- people with lower levels of education
- people from socioeconomically disadvantaged areas
- people living with a disability
- people residing in regional and remote areas of Australia
- people identifying as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+)<sup>136iii</sup>
- people living with HIV
- people experiencing harmful use of or dependence on drugs and/or alcohol

- people currently in or recently released from prison
- people who are unemployed
- people experiencing homelessness
- people living in lone-parent households with dependent children
- people from culturally and linguistically diverse communities who have come from countries with high rates of tobacco use.<sup>137</sup>

Tobacco use is strongly associated with social disadvantage and contributes significantly to health and financial inequalities in Australia. In 2018, people living in the most disadvantaged socioeconomic areas experienced 3 times the rate of tobacco-attributable death and disease compared to those living in the highest socioeconomic areas.<sup>138</sup> As levels of social disadvantage accumulate, smoking prevalence increases. For example, in 2019, Australians living in the most disadvantaged socioeconomic areas were 3.7 times more likely than those in the most advantaged socioeconomic areas to smoke daily.<sup>139</sup>

People with mental illness have high rates of tobacco use and experience a disproportionate health and financial burden from smoking. Integrating tobacco prevention and cessation interventions into routine mental health treatment, and providing more intensive intervention when required, will contribute to reducing the large health disparities between those with and without mental health conditions.

Australia is a culturally and linguistically diverse population, and there is considerable variation in prevalence of tobacco use among individuals born in different countries who have migrated to Australia.<sup>140</sup> Recent national surveys indicate that overall, people who speak a language other than English at home and people born outside Australia have lower prevalence of smoking than those who primarily speak English at home and those who were born in Australia.<sup>141</sup> However, these summary results mask differences in smoking rates between men and women and may conceal higher smoking rates among smaller population subgroups. For example, targeted studies conducted in Australia have found high smoking rates among men with Chinese or Arabic backgrounds<sup>142,143</sup> and men born in Europe, North Africa and the Middle East.<sup>144</sup> Understanding tobacco use across cultural and linguistically diverse groups in Australia will support the design and development of culturally appropriate tobacco control interventions.

#### **Other populations at a higher risk of harm from tobacco use**

A number of populations are more vulnerable to the health harms of tobacco use regardless of whether they have higher rates of tobacco use than the general population, such as pregnant people, children and young people, and people living with a chronic health condition.

Tobacco use and exposure among pregnant people and their babies is one of the most prevalent preventable causes of infant death and illness and of adverse pregnancy outcomes including preterm birth and still birth.<sup>145</sup>

iii The AIHW National Drug Strategy Household Survey 2019 provides data on smoking rates by sexual orientation, including heterosexual and homosexual/bisexual. Contemporary international evidence substantiates the need for this Strategy to include all people identifying as LGBTIQ+ as a priority population.



Children and young people who are exposed to nicotine can become addicted at lower or more intermittent levels of consumption compared to adults.<sup>146</sup> Evidence also shows that exposure to nicotine during adolescence may result in damaging and long-lasting impacts on brain development.<sup>147</sup>

The harms of tobacco use are also likely to be more significant for people living with chronic health conditions, people admitted into hospital settings and people who are taking medications. For example, evidence has shown higher levels of all-cause mortality for people who continue to use tobacco products after a diagnosis of cancer, as well as reduced effectiveness of chemotherapy, radiotherapy and certain medications.<sup>148</sup>

### **Actions for Priority Area 5**

**5.1** Complement population-level measures with targeted policies, programs and investments to prevent and reduce tobacco use among populations with a high prevalence of tobacco use and populations at a higher risk of harm from tobacco use.

**Responsibility:** Australian Government, state and territory governments, NGOs, social service organisations (both government and non-government).

**5.2** Continue to build the evidence base to identify cost-effective approaches to preventing and reducing tobacco use among populations with a high prevalence of tobacco use and those at a higher risk of harm from tobacco use.

**Responsibility:** Australian Government, state and territory governments, research organisations, NGOs.

**5.3** Increase awareness among populations with a high prevalence of tobacco use and those at higher risk of harm from tobacco use of the availability of evidence-based support to quit smoking.

**Responsibility:** Australian Government, state and territory governments, NGOs, social service organisations.

**5.4** Encourage and support pregnant people and their families to quit, and provide messages about the harm associated with second-hand smoke exposure.

**Responsibility:** Australian Government, state and territory governments, NGOs

**5.5** Implement evidence-based tobacco prevention and cessation programs as part of routine care across all health, social care and custodial settings.

**Responsibility:** Australian Government, state and territory governments, research organisations, NGOs.

**5.6** Embed evidence-based smoking cessation programs across all primary, acute, mental health, drug and alcohol and other healthcare settings and, where applicable, explore the feasibility of mandating these programs as a condition of government funding.

**Responsibility:** NGOs, Australian Government, state and territory governments.

**5.7** Enhance evidence-based tobacco cessation support for prisoners, recently released prisoners, prison staff and their families.

**Responsibility:** State and territory governments, Australian Government.

**5.8** Strengthen collaboration and referral between health services, social services, custodial organisations and tobacco cessation services, such as Quitline services, and identify new partnerships to reduce tobacco use among populations with a high prevalence of tobacco use and those at higher risk of harm from tobacco use.

**Responsibility:** Australian Government, state and territory governments, Quitline services, health services, social service organisations.

**5.9** Enhance Quitline services for populations with a high prevalence of tobacco use and populations at higher risk of harm from tobacco use.

**Responsibility:** State and territory governments, Australian Government.

**5.10** Consider the feasibility of introducing a Census question on tobacco and e-cigarette use and complement this with additional related questions in other government-funded surveys to strengthen monitoring of tobacco prevalence in smaller geographic areas and population subgroups.

**Responsibility:** Australian Government, state and territory governments.

## Priority Area 6:

### Eliminate all tobacco-related advertising, promotion and sponsorship

Tobacco advertising, promotion and sponsorship contribute to an increase in uptake, progression and continuation of smoking (particularly among young people), reduce smoking cessation attempts and encourage former tobacco users to relapse. Article 13 of the WHO FCTC recognises that comprehensive bans on tobacco advertising, promotion and sponsorship are needed to decrease tobacco use.<sup>149</sup> However, the tobacco industry continues to market its products through a range of channels, commercial actors and innovative promotional tactics. It is critical that remaining forms of tobacco-related advertising, promotion and sponsorship and attempts by the tobacco industry to circumvent the current controls are eliminated.

There has been a marked increase in the use of tobacco brand variant names and descriptors. Variant names can enhance the appeal of tobacco products, create misperceptions about relative harmfulness and ease of quitting, and contribute to consumer misperceptions regarding product risk.<sup>150</sup> Other ongoing forms of product promotion include the use of filter innovations, cigarette design features and odd pack sizes.

Evidence from Australia and overseas highlights that commercial suppliers of tobacco products also provide numerous avenues for tobacco advertising and promotion. At present, few regulatory requirements govern payments or other contributions to tobacco retailers or wholesalers, or the provision of financial support to venue operators. Vending machines, price boards and other signage in retail settings are also opportunistic forms of tobacco advertising for tobacco retailers.

Self-promotion of tobacco companies is a marketing strategy, as is publicity for tobacco industry business practices that may be described as socially responsible. With the exception of some restrictions under state and territory legislation, controls governing these activities in Australia are currently limited. Regulatory controls prohibiting or restricting sponsorship agreements involving the tobacco industry in Australia are also limited.

New forms of digital media that emerged during the period of the last strategy have been increasingly used to directly and indirectly promote tobacco products by the tobacco industry and individuals and organisations whose interests align with the tobacco industry. This strategic approach evades legislation and controls that apply to traditional forms of marketing. A new focus will be required to monitor, identify and eliminate these forms of promotion.

The portrayal of smoking in digital content, including films, television and computer games, is managed under the classifiable element of themes through the National Classification Code, the Guidelines for the Classification of Films, and the Guidelines for the Classification of Computer Games.<sup>151</sup> The Australian Government has commenced a

review of Australian classification regulations, which seeks to update the criteria used to classify films, episodic series and computer games, and redesign current classification laws to reflect the current and future digital environment.

The Australian Government Department of Health and Aged Care has commenced a review of Commonwealth tobacco legislation, which covers the *Tobacco Advertising Prohibition Act 1992*, the Tobacco Advertising Prohibition Regulation 1993, the *Tobacco Plain Packaging Act 2011* and the Tobacco Plain Packaging Regulations 2011. The review will ensure that Australia's tobacco control legislative framework supports the objectives of this Strategy.

#### Actions for Priority Area 6

**6.1** Complete the Department of Health and Aged Care review of Commonwealth tobacco control legislation and amend the legislation, where appropriate, to restrict remaining forms of tobacco advertising and promotion.

**Responsibility:** Australian Government.

**6.2** Reduce tobacco product marketing by limiting use of appealing or evocative brand and variant names.

**Responsibility:** Australian Government.

**6.3** Prohibit other forms of tobacco promotion, including price boards, price specials and other displays of tobacco products at point of sale; public relations and lobbying activities; and payments, incentives and rebates by tobacco manufacturers, importers or wholesalers to tobacco retailers and proprietors of hospitality venues.

**Responsibility:** Australian Government, state and territory governments.

**6.4** Continue to monitor and enforce legislation relating to plain packaging of tobacco products, health warnings on tobacco packaging, and advertising of tobacco products.

**Responsibility:** Australian Government.

**6.5** Develop and implement measures to require tobacco companies, importers and wholesalers of tobacco products in Australia to report details and expenditure on any form of tobacco promotion and marketing activity, including contributions to third parties.

**Responsibility:** Australian Government, state and territory governments.

**6.6** Consider the adequacy of the current classification guidelines for television, films and computer games in relation to the portrayal of smoking.

**Responsibility:** Australian Government, state and territory governments, Australian Communications and Media Authority, broadcasters.

**6.7** Monitor, identify and act to prohibit the promotion of tobacco products through current and emerging media platforms and consider pursuing international approaches to such forms of promotion.

**Responsibility:** Australian Government, state and territory governments.

## Priority Area 7:

### Further regulate the contents and product disclosures pertaining to tobacco products

The manufacturing of tobacco products is subject to very few controls, considering the harm caused by its use. Article 9 of the WHO FCTC provides for the Conference of the Parties, in consultation with competent international bodies, to propose guidelines for testing, measuring and regulation of the contents and emissions of tobacco products. This article also provides for each party to adopt and implement measures for such testing, measuring and regulation.<sup>152</sup>

Article 10 of the WHO FCTC requires parties to adopt and implement effective legislative or other measures to require manufacturers and importers of tobacco products to disclose to government authorities information about the contents and emissions of tobacco products, and to require public disclosure of information about toxic constituents and emissions.<sup>153</sup>

Further regulation of the contents and product disclosures of tobacco products is an important area of tobacco control that warrants additional investigation, analysis, and implementation of appropriate policies.<sup>154</sup>

All states and territories have prohibited the sale of fruit and confectionery flavoured cigarettes. Flavours appear to play a particularly important role in influencing smoking.<sup>155,156</sup> Additives such as menthol, sugar, honey, liquorice and cocoa are often used to enhance the taste of tobacco smoke to make the product more palatable and desirable to people who use tobacco, especially those experimenting with tobacco.<sup>157</sup> Such cigarettes can be perceived as having a more positive appeal, better taste and less risk.<sup>158</sup> There is also evidence that tobacco manufacturers have used additives to mask the smell and visibility of side-stream smoke.<sup>159</sup> Some tobacco product additives, such as menthol, may also increase the effects of nicotine, making the tobacco products more addictive.<sup>160</sup>

Variations in filter design and appearance are also common, and further regulation in this area should be considered. For example, filter ventilation (cigarettes with ventilation perforations in the tipping paper) dilutes the smoke inhaled by the smoker, thereby appearing to the user to reduce its harshness and strength of taste. However, such ventilation does not reduce (and may even increase) the health risks and misleads consumers about the harmfulness of products.<sup>161,162,163,164</sup>

The appearance and design of tobacco products can also contribute to perceptions of taste, harm and appeal. Regulating product appearance and design features, such as innovative filters, may be an effective strategy to correct misperceptions and reduce tobacco use.<sup>165</sup>

## Actions for Priority Area 7

**7.1** Develop regulatory options to enhance controls on tobacco product ingredients, emissions and product disclosures in line with agreed guidelines for the implementation of Articles 9 and 10 of the WHO FCTC, and implement them where appropriate.

**Responsibility:** Australian Government.

**7.2** Continue to participate in international cooperation relating to tobacco product regulation and disclosures, including the development of international guidelines for the implementation of Articles 9 and 10 of the WHO FCTC.

**Responsibility:** Australian Government.

**7.3** Develop and implement, where appropriate, regulatory options to standardise the design and appearance of tobacco products and to prohibit the use of novelty features.

**Responsibility:** Australian Government.

**7.4** Require tobacco manufacturers to disclose all additives used in each individual tobacco product, including roll your-own tobacco products, and the purpose for their inclusion.

**Responsibility:** Australian Government.

**7.5** Develop and implement options to prohibit the use of specified additives in tobacco products, including flavourings and menthol.

**Responsibility:** Australian Government, state and territory governments.

**7.6** Monitor international developments and evidence regarding reducing nicotine content in tobacco products and explore the feasibility of pursuing similar measures in Australia.

**Responsibility:** Australian Government, state and territory governments.



## Priority Area 8:

### Strengthen regulation to reduce the supply, availability and accessibility of tobacco products

The widespread availability of tobacco is incongruent with the immense health and social burden associated with its use and is at odds with progress that has been made in other areas of tobacco control in Australia. Reducing retail availability of tobacco is an aspect of a comprehensive approach to tobacco control that requires further strengthening. Reducing the overall supply, availability and accessibility of tobacco products will significantly influence smoking prevalence and Australia's goal to achieve a tobacco-free society.

The retail availability of tobacco products is associated with an increased prevalence of tobacco use and likelihood of relapse among people attempting to quit smoking.<sup>166,167</sup> Tobacco retailer density is higher in areas of low socioeconomic status, and reducing retail availability may be an effective approach to reducing tobacco use in socioeconomically disadvantaged populations.<sup>168</sup> Licensing schemes for tobacco retailers may provide additional benefit through restricting the circumstances in which a licence can be obtained and increasing costs of licences, which may deter retailers from selling tobacco products.<sup>169</sup>

Other strategies that have been implemented internationally to reduce the supply, availability and accessibility of tobacco products include prohibiting the sale of tobacco products to people under 21 years.<sup>170</sup> More broadly, the widespread availability of tobacco perpetuates the normalisation of tobacco products and potentially undermines the effectiveness of other tobacco control measures.

Implementing and enforcing strong measures to control illicit tobacco trade can enhance the effectiveness of high tobacco taxes and other tobacco control policies. Additionally, strong surveillance, enforcement and fines, across all supply chains, are warranted. Other successful strategies undertaken internationally include implementing tracking and tracing systems; controlling the entire supply chain by licensing all parties involved in tobacco product manufacturing and distribution; and international cooperation in investigation and prosecution of participants in illicit trade.<sup>171</sup>

Significant investment has been made to prevent and minimise the illicit tobacco trade. For example, the Australian Government introduced a comprehensive suite of measures to combat illicit tobacco production and trade, including the establishment of the Illicit Tobacco Taskforce on 1 July 2018 and additional funding to detect and destroy domestically grown illicit tobacco crops. A permit regime was also introduced for the importation of most tobacco products, with importers being required to pay all duty and tax liabilities for tobacco products at the border from 1 July 2019.

In September 2019 the Australian Government enacted legislation to support regulation of tobacco products at the border by allowing for the immediate destruction of tobacco seized by the Australian Border Force (ABF). These amendments allow the ABF to target its border operation more efficiently and place a greater focus on detecting and disrupting black economy activity.

## Actions for Priority Area 8

**8.1** Continue to monitor and enforce all tobacco control legislation applicable at the retail level, including legislation prohibiting the sale of tobacco to minors.

**Responsibility:** State and territory governments.

**8.2** Consider regulatory approaches to reduce or prohibit the sale of tobacco products in premises where alcohol consumption occurs, including through vending machines.

**Responsibility:** State and territory governments.

**8.3** Consider banning or further restricting the sale of tobacco products online.

**Responsibility:** Australian Government, state and territory governments.

**8.4** Prohibit alternative and emerging avenues for the sale of tobacco products, such as cigarette delivery services through smartphone applications.

**Responsibility:** Australian Government, state and territory governments.

**8.5** Explore mechanisms to have a consistent licensing scheme in place covering all aspects of the tobacco supply chain in Australia, such as establishing a national framework for licensing schemes.

**Responsibility:** Australian Government, state and territory governments.

**8.6** Explore options to further regulate where tobacco products are retailed, including regulatory approaches to control or restrict the number, type and location of tobacco outlets.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**8.7** Consider requiring tobacco wholesalers to report on the characteristics and prices of all tobacco products purchased and sold.

**Responsibility:** Australian Government.

**8.8** Continue to engage in international cooperation relating to tobacco taxation and addressing illicit trade in tobacco products, including through the WHO FCTC.

**Responsibility:** Australian Government.

**8.9** Continue to monitor the supply and use of illicit tobacco in Australia; continue enforcement efforts to prevent the illegal importation, supply and cultivation of tobacco; and enhance technology and staff capability to identify and respond to illicit trade in tobacco.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**8.10** Identify, mitigate and/or address any barriers to enforcing tobacco legislation at all levels of government.

**Responsibility:** Australian Government, state and territory governments.

**8.11** Consider the feasibility of raising the minimum age of purchase of tobacco products and monitor international developments on this matter.

**Responsibility:** Australian Government, state and territory governments.

## Priority Area 9: Strengthen regulations on e-cigarettes and novel and emerging products

The tobacco industry has a long history of developing and marketing a diverse range of products to support its commercial interests and divert public resources away from evidence-based approaches to reducing tobacco use and nicotine addiction.<sup>172</sup> For example, secret tobacco industry documents indicate that the tobacco industry developed electronic nicotine delivery systems at least as early as 1963.<sup>173</sup>

The tobacco industry also has a history of using reduced exposure claims to mislead consumers into believing that particular products have reduced risk, such as 'light' and 'mild' cigarette claims.<sup>174</sup> In 2005, 3 large tobacco companies were forced to remove these claims from their products in Australia as a result of court enforceable action undertaken by the Australian Competition and Consumer Commission.<sup>175,176,177</sup>

In recent years, tobacco companies have increasingly adopted 'harm reduction' in their corporate messaging to showcase their investments in newer products such as e-cigarettes, to gain access to policymakers and to improve their corporate image. However, the tobacco industry has continued widespread marketing of tobacco and novel nicotine products to non-smokers, contrary to this 'harm reduction' messaging.<sup>178,179</sup>

A wide range of e-cigarettes and novel and emerging products continue to be marketed globally. Broadly, novel and emerging products include heated tobacco products, shisha, nicotine pouches, lozenges and gums.<sup>180</sup> Tobacco products that do not involve heating also continue to be marketed globally, including various types of snuff (tobacco powder inhaled through the nose), snus (small pouches of tobacco absorbed through the gums when placed behind the lip), chewing tobacco and dissolvable tobacco.

Between 2012 and 2022, most state and territory governments amended their tobacco control laws to further restrict the advertising and sale of e-cigarettes in a similar manner to their approach to conventional tobacco products<sup>iv</sup> and prohibited the use of e-cigarettes in legislated smoke-free areas. However, to date, Australia's tobacco control efforts have largely focused on preventing and reducing the use of conventional tobacco products. Accordingly, there is a need to ensure sufficient controls are in place to protect the Australian community from the range of tobacco, nicotine and other drug delivery systems that may be marketed by the tobacco industry, the e-cigarette industry and their associated interests.

## E-cigarettes

E-cigarettes are operated by using a battery to heat liquids containing nicotine and/or other chemicals to generate an aerosol for inhalation. Initially many e-cigarettes resembled conventional tobacco products, but a broader range of devices have now become available on the global market, including those that are disposable, sleek, discreet and/or similar in appearance to a USB flash drive. Many products are also customisable, and some are capable of delivering nicotine to users as efficiently as, and in some cases more efficiently than, cigarettes.

E-cigarette advertising occurs across a range of media channels that have broad reach among young people, including print, websites and social media, and in retail stores. Among adolescents, there is evidence that exposure to e-cigarette marketing via social media is associated with an increase in e-cigarette uptake/initiation.<sup>181</sup>

Although most e-cigarettes marketed globally are likely to contain nicotine, there is also a need to prevent and reduce the risks posed by e-cigarette products that do not contain nicotine, including the use of flavourings, which have been found to be a key factor driving the use of e-cigarettes by adolescents.<sup>182</sup> As part of this, e-cigarettes containing tetrahydrocannabinol (THC – the principal psychoactive constituent of cannabis) and nicotine liquids that have been labelled as nicotine free should also be considered.

To date, Australian governments have taken a precautionary approach to the marketing and use of e-cigarettes in view of the risks these products pose to tobacco control and population health. Broadly, this approach is underpinned by the current state of evidence regarding the direct harms e-cigarettes pose to human health; their impacts on smoking initiation, continuation and cessation; their uptake among young people; and their dual use with conventional tobacco products.<sup>183,184,185,186</sup>

In 2022 the National Health and Medical Research Council published an updated statement on e-cigarettes. The statement advises that all e-cigarette users are exposed to chemicals and toxins that have the potential to cause adverse health effects, and that dual use of e-cigarettes and tobacco products is common. The statement also notes that more evidence is needed to determine the harms and benefits of e-cigarettes when used for smoking cessation and that there are no health benefits of using e-cigarettes for people who currently do not smoke.<sup>187</sup>

Since 1 October 2021, consumers require a valid prescription from an Australian doctor for all purchases of nicotine vaping products, such as nicotine e-cigarettes, nicotine pods and liquid nicotine. This includes purchases overseas as well as in Australia. This framework aims to prevent adolescents and young adults from taking up nicotine e-cigarettes, while allowing current smokers to access these products to use for smoking cessation with appropriate medical advice.<sup>188</sup>

<sup>iv</sup> Conventional tobacco products include manufactured cigarettes, roll-your-own cigarettes, pipes and cigars.

Commonwealth and state and territory ministers have agreed to national guiding principles for e-cigarettes. The principles affirm the need to maintain and, where appropriate, strengthen and make consistent across jurisdictions the current controls that apply to the marketing and use of e-cigarettes in Australia. The principles also affirm that the primary focus and goal of any change to the regulation of e-cigarettes in Australia will be protecting children and young people.<sup>189</sup>

### Other forms of novel and emerging products

The global market for heated tobacco products has continued to grow and poses a major threat to Australia's progress in tobacco control. Heated tobacco products use a battery powered heating system to heat tobacco to produce an aerosol, similarly mimicking the behaviour of smoking conventional cigarettes. However, unlike e-cigarettes, heated tobacco products contain nicotine in the form of tobacco and may include specifically designed cigarettes for heating.<sup>190</sup>

At the eighth session of the Conference of the Parties to the WHO FCTC, in 2018, the parties were invited to prioritise a comprehensive range of measures to prevent and reduce the risks posed by heated tobacco products and other forms of novel and emerging tobacco products. Among other measures, this included restricting or prohibiting the manufacture, importation, distribution, presentation, sale and use of these products.<sup>191</sup> Australia's policy settings for novel and emerging tobacco products will continue to be guided by the WHO FCTC and the decisions of the WHO FCTC Conference of the Parties.

Shisha and other forms of novel products including snuff, chewing tobacco and dissolvable tobacco also have the potential to disrupt Australia's longstanding progress in reducing tobacco use. Accordingly, this Strategy supports the strengthening of existing controls to prohibit or further restrict the marketing and use of these products.

Several tobacco companies are also marketing tobacco-free nicotine products which are sold in a variety of flavours and with different levels of nicotine content.<sup>192</sup> There is a need to closely monitor the marketing and use of these products and their impact on population health, and identify the most appropriate policy response in Australia.

## Actions for Priority Area 9

**9.1** Develop and implement additional measures to further restrict the marketing, availability, use, and end-of-life disposal of all e-cigarette components in Australia, regardless of their nicotine content.

**Responsibility:** Australian Government, state and territory governments.

**9.2.** Develop and implement measures to prohibit the sale of flavoured e-cigarettes, regardless of their nicotine content.

**Responsibility:** Australian Government, state and territory governments.

**9.3** Raise awareness about the marketing and use of e-cigarettes and their immediate and long-term impacts on individual and population health.

**Responsibility:** Australian Government, state and territory governments, NGOs

**9.4** Develop and implement an evidence-based comprehensive regulatory framework for e-cigarettes and all novel and emerging products that pose risks to tobacco control and population health.

**Responsibility:** Australian Government, state and territory governments.

**9.5** Prohibit the use of e-cigarettes and novel and emerging inhaled products such as shisha in areas where smoking is prohibited.

**Responsibility:** State and territory governments, Australian Government.

**9.6** Prohibit advertising, promotion and sponsorship relating to e-cigarettes and other new and emerging products.

**Responsibility:** Australian Government, state and territory governments.

**9.7** Explore the feasibility of having a consistent licensing scheme in place covering all aspects of the e-cigarette supply chain in Australia.

**Responsibility:** Australian Government, state and territory governments.

**9.8** Continue to monitor the supply and use of illicit e-cigarettes and other novel and emerging products in Australia; continue enforcement efforts to prevent illegal importation and supply; and enhance technology and staff capability to identify and respond to illicit trade.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**9.9** Strengthen research, monitoring and surveillance activities pertaining to the marketing and use of e-cigarettes and novel and emerging products.

**Responsibility:** Australian Government, state and territory governments.

## **Priority Area 10:**

### **Eliminate exceptions to smoke-free workplaces, public places and other settings**

Exposure to second-hand smoke causes serious adverse health effects in both adults and children. Under Article 8 of the WHO FCTC, the parties ‘recognize that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability’. Article 8 requires parties to adopt and implement effective measures ‘providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places’.<sup>193</sup>

The WHO FCTC guidelines for implementation of Article 8 affirm that ‘[g]ood planning and adequate resources are essential for successful implementation and enforcement of smoke free legislation’. Strategic approaches to enforcement can improve compliance, simplify the implementation of legislation and minimise the level of enforcement resources needed.<sup>194</sup>

Smoke-free policies are designed not only to protect non-smokers and provide incentives to quit for those who use tobacco but also to prevent uptake and denormalise smoking.<sup>195</sup> For example, young people are influenced by their view of what behaviours are normal and also tend to overestimate the prevalence of smoking in the population, and overestimation of smoking has been shown to be predictive of future smoking initiation among young people.<sup>196</sup> Factors that contribute to young people’s overestimation of smoking prevalence include those related to higher exposure to smoking, such as having peers, parents or other adults in their life who smoke; observing smoking in their community; and their own smoking status.<sup>197,198</sup> Many key strategies in tobacco control, including smoke-free policies, contribute directly and indirectly to denormalisation of smoking.

Evaluation studies of the implementation of smoke-free legislation overwhelmingly report that the legislation is popular.<sup>199</sup> Legislative bans on tobacco use lead to improved health outcomes in the community more generally through reduction in exposure to second-hand smoke. The clearest evidence in this regard relates to reduced incidence of heart attacks and other cardiovascular disease<sup>200,201</sup> and reductions in childhood hospital admissions for asthma and lower respiratory tract infections.<sup>202</sup> Smoke-free policies do not have a negative economic impact on the restaurant and bar industry.<sup>203</sup>

Smoke-free legislation can also influence exposure to second-hand smoke in domestic environments. In addition to protecting children and non-smokers from exposure to second-hand smoke, smoke-free policies at home can increase the chances of smoking cessation among adults and decrease the likelihood of smoking initiation by children in the home.<sup>204</sup> Smoke-free apartment building policies are likely to reduce exposure to second-hand smoke, may improve cessation outcomes among current smokers, and are likely to yield considerable cost savings for landlords and society. Such policies appear to be supported by most residents.<sup>205</sup>

As more Australians than ever are living in apartments and other densely populated settings, there is a need to closely monitor the issue of smoking and smoke drift at residential premises and strengthen policy and regulatory approaches to increase the number of smoke-free homes, including in social housing and multi-unit housing.

As public awareness of the risks of second-hand smoke has increased, smoke-free public spaces have become the norm and the number of smoke-free homes has increased.<sup>206,207</sup> However, among populations with a high prevalence of smoking, exposure to second-hand smoke remains high, particularly for children from low socioeconomic groups and First Nations children. In 2018–19, 72% of First Nations children up to age 14 in remote areas and 54% in non-remote areas were living in households with daily smokers. The proportion of First Nations children living in households where smoking occurs indoors ranged from 8% in non-remote areas to 12% in remote areas.<sup>208</sup>

Non-smokers can be exposed to high levels of second-hand smoke in outdoor settings when close to or downwind of people smoking.<sup>209</sup> As restrictions on smoking in enclosed public places have become more common, people who smoke are increasingly required to smoke outdoors. Problems arise when people who smoke cluster around entrances and exits and near air conditioning intake vents to smoke. People who enter and exit the building are exposed to second-hand smoke, and smoke may drift into indoor smoke-free areas.

Third-hand smoke can also develop when residue from tobacco smoke accumulates on surfaces and in dust, and subsequently reacts with other chemicals in the environment to form additional pollutants. While second-hand smoke exposure involves the inhalation of smoke from a burning tobacco product, third-hand smoke exposure can arise from contact with other compounds that have formed from tobacco smoke residue through inhalation, ingestion and dermal absorption.<sup>210</sup> There is a need to further analyse the health impacts of third-hand smoke exposure and increase awareness among the public about its potential harms.

Comprehensive smoke-free policies that include e-cigarettes also have the potential to reduce the exposure of bystanders to potentially harmful exhaled aerosol toxicants, increase quitting incentives, and support ongoing efforts to denormalise tobacco smoking in the community. These policies may also support a range of other objectives of this Strategy, including efforts to denormalise the marketing and use of e-cigarettes.

## **Actions for Priority Area 10**

**10.1** Continue to monitor and enforce existing smoke-free legislation, and strengthen it where appropriate.

**Responsibility:** State and territory governments, local governments, Australian Government, NGOs.

**10.2** Strengthen partnerships between local governments and NGOs to enhance the promotion, monitoring and enforcement of smoke-free laws and policies.

**Responsibility:** State and territory governments, local governments, NGOs.

**10.3** Ensure all publicly funded services work towards introducing and enforcing comprehensive smoke-free policies.

**Responsibility:** State and territory governments, Australian Government, community and social sectors, drug treatment agencies.

**10.4** Monitor the issue of smoking and smoke-drift at residential premises and strengthen policy and regulatory approaches to increase the number of smoke-free homes, including in social housing and multi-unit housing.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**10.5** Introduce further smoke-free policies in public places, healthcare facilities and outdoor areas where people are in close proximity.

**Responsibility:** Australian Government, state and territory governments, local government.

**10.6** Ensure the provision of smoking cessation support services in smoke-free workplaces to encourage and assist employees and employers who smoke to quit.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**10.7** Improve education about the dangers of second-hand smoke and consider appropriate public messaging options for third-hand smoke exposure.

**Responsibility:** Australian Government, state and territory governments, NGOs.



## Priority Area 11:

### Provide greater access to evidence-based cessation services to support people to quit the use of tobacco, e-cigarettes and novel and emerging products

Smoking cessation results in immediate and long-term health benefits, regardless of age and duration of tobacco use. It reduces the risk of premature death and adverse health events such as cardiovascular diseases, chronic obstructive pulmonary disease, cancer and reproductive health outcomes.<sup>211</sup> Quality of life is improved not just for the person quitting but also for those around them by preventing harms from exposure to second-hand smoke and reducing the likelihood of tobacco use uptake.<sup>212</sup> Quitting smoking can prevent disease progression and recurrence and promote recovery for almost every health condition, illness and medical procedure.<sup>213</sup>

Although quitting can be a difficult process and may take several attempts before complete cessation, millions of Australians have successfully quit smoking. Most smokers want to quit, and more than half make a serious attempt to quit every year.<sup>214</sup> In 2019, 61% of smokers had attempted to undertake activities to quit or cut back in the previous 12 months, with 21% successfully giving up smoking for at least a month.<sup>215</sup>

Population-based strategies play a major role in changing smoking behaviour, promoting smoking cessation and increasing the accessibility of evidence-based cessation services. Population-based strategies (e.g., tobacco excises, evidence-based integrated public health campaigns, smoke-free policies) are broader than those at the clinical or health system level and have an impact on the overall community. They influence tobacco cessation by providing an environment that supports or simplifies efforts for smokers to quit and lowers barriers to quitting that smokers may encounter.<sup>216</sup> Evidence shows that quitting smoking without assistance ('cold turkey') remains the most commonly used method to quit and has been a major contributor to the reduction in smoking prevalence in Australia.<sup>217</sup>

This Strategy recognises that combining clinical and health system based strategies with population-based strategies can have a synergistic effect on improving cessation outcomes. Behavioural counselling and pharmacotherapies can also improve the likelihood that a quit attempt is successful.<sup>218</sup>

Every encounter in a healthcare setting between a patient who uses tobacco and a healthcare professional is an opportunity to encourage and promote quitting, and this should be set as a standard of care. There are a number of specific and non-specific items available on the Medicare Benefits Schedule for GPs and other health professionals to claim when providing nicotine and smoking cessation interventions. GPs, Aboriginal health workers and other health practitioners are well placed to offer brief smoking cessation interventions.<sup>219</sup>

Interventions in a clinical and health system setting can also be improved by embedding comprehensive policies and protocols for tobacco use screening and support for cessation as part of clinical workflow, incorporating reminders in health record systems, providing training for

health professionals, and developing clinical treatment guidelines. In 2021 the Royal Australian College of General Practitioners updated its Supporting smoking cessation guidelines for health professionals on how to encourage and support smoking cessation and individualise smoking cessation therapies for their patients.<sup>220</sup> This resource highlights the range of pharmacological and behavioural therapies available that may be effective for assisting a person to quit smoking.

Other system-wide strategies that have been implemented internationally include establishing minimum standards for the identification and referral of smokers as criteria for health service accreditation, and routine reporting and monitoring of adherence to these standards.<sup>221</sup> In practice, this would mean that every patient in Australia in a hospital, primary care setting, mental health or alcohol and drug treatment service would be asked about their tobacco use; be offered advice on the benefits of quitting and how best to approach quitting; and be referred to Quitline or an accredited face-to-face clinic for evidence-based behavioural support.

Broadening interventions beyond health professionals will reduce the burden on time-constrained health professionals and extend support to all populations, including groups that have a high prevalence of smoking or are severely affected by tobacco use. With appropriate training and guidance, staff in other organisations who are already working with these populations can provide brief interventions and support quit attempts.

Additional efforts can be made to improve access to NRT and other smoking cessation medications, such as increasing their availability through the PBS, accompanied with behavioural support to encourage individuals attempting to quit tobacco to use subsidised and evidence-based cessation therapies. Notably, a condition of access to the PBS subsidy for smoking cessation medications is that the patient participates in cessation counselling, as evidence shows that this combination provides smokers with the greatest chance of achieving long-term cessation.<sup>222</sup> In May 2022 the Pharmaceutical Benefits Advisory Committee recommended allowing an additional 12 weeks of PBS-subsidised NRT in a 12-month period to re-treat patients who had an unsuccessful quit attempt, or to prevent relapse in patients who have ceased smoking during the initial 12 weeks of therapy.<sup>223</sup>

Evidence indicates that Quitline services are an effective means of providing information and advice to people who are interested in or are quitting, and can be used by health systems as an additional aid to clinical interventions as part of follow-up support for patients attempting to quit.<sup>224</sup> There is a need to review and monitor the use of Quitline services across Australia to improve their accessibility and effectiveness, particularly in populations with a high prevalence of tobacco use.

## **Actions for Priority Area 11**

**11.1** Conduct an evaluation of smoking cessation services available in Australia, including Quitline services, and monitor innovative approaches to deliver smoking cessation services.

**Responsibility:** State and territory governments, Australian Government, NGOs.

**11.2** Commission a national situation analysis of treatment of tobacco dependence as outlined in the WHO FCTC Article 14 implementation guidelines.

**Responsibility:** Australian Government.

**11.3** Improve and extend Quitline services, and ensure that there is sufficient capacity to run these services during mass media campaigns.

**Responsibility:** State and territory governments, Australian Government, NGOs.

**11.4** Improve referral pathways to Quitline from other programs across the health system, from primary care services and from other services and NGOs which focus on populations with a high prevalence of tobacco use and those most severely affected by tobacco use (as outlined in Priority Area 5).

**Responsibility:** State and territory governments, Australian Government, NGOs.

**11.5** Improve documentation in medical records of smoking status and cessation interventions offered to tobacco users during admission, care and discharge, across the health system.

**Responsibility:** State and territory governments, Australian Government, NGOs

**11.6** Explore the feasibility of including smoking cessation care in the National Safety and Quality Health Service Standards.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**11.7** Implement IT and accreditation systems to ensure health professionals routinely ask all patients in healthcare facilities about their smoking status and provide smokers with appropriate advice and support to quit.

**Responsibility:** State and territory governments, Australian Government, health professional organisations.

**11.8** Provide policy guidelines and accredited training in smoking cessation (particularly brief interventions) to health professionals, health workers, community and welfare workers and social service organisations, and ensure these are regularly updated to reflect best practice.

**Responsibility:** State and territory governments, NGOs, smoking cessation services, health services, Aboriginal community-controlled organisations, Australian Government.

**11.9** Improve public awareness of services demonstrated to assist with smoking cessation.

**Responsibility:** State and territory governments, Australian Government, NGOs.

**11.10** Monitor and continue to update the evidence base for smoking cessation therapies and tobacco and nicotine dependence treatment.

**Responsibility:** State and territory governments, Australian Government, NGOs, smoking cessation services, health services, Aboriginal community-controlled organisations, social service organisations.

**11.11** Review restrictions on and the accessibility of current smoking cessation pharmacotherapies available on the PBS in the context of the latest evidence, best clinical practice, cost-effectiveness and consumer affordability, and enhance the availability of these medications.

**Responsibility:** Australian Government.

**11.12** Implement measures to ensure that best practice cessation support and tobacco dependence treatment is offered to every tobacco user in every interaction in the health, mental health and alcohol and drug dependence treatment systems, with routine reporting of brief intervention strategies and cessation service outcomes.

**Responsibility:** Australian Government, service providers.

**11.13** Develop and disseminate comprehensive national clinical guidelines and supportive policy strategies to embed the treatment of tobacco and nicotine dependence into health services, primary care, and community and social service organisations.

**Responsibility:** Australian Government, state and territory governments, NGOs.

**11.14** Strengthen tobacco control workforce capability and capacity to deliver evidence-based services to support people to quit the use of tobacco, e-cigarettes and novel and emerging products.

**Responsibility:** Australian Government, state and territory governments, Quit Centre and other NGOs.

## PART 4: GOVERNANCE

Implementation of this Strategy is a shared responsibility between the Commonwealth and state and territory governments, with NGOs also playing a crucial role. Engagement with a wide range of stakeholders has helped to further inform the priorities and objectives outlined in this Strategy.

This Strategy is a sub-strategy to the NDS 2017–2026, and its development has been supported by the Commonwealth and states and territories. All jurisdictions will continue to identify, coordinate and provide advice on tobacco issues in the context of Australia's national alcohol, tobacco and other drug policy frameworks, including this Strategy.

Maintenance of governance and engagement structures over the life of the Strategy will ensure a consistent whole-of-government approach to the implementation of the Strategy and tobacco control in Australia.

Over the life of the Strategy, the Australian Government will also look at opportunities to include consumers, First Nations people, and the tobacco control workforce in decision-making that affects them.



## PART 5: MONITORING AND EVALUATING PROGRESS

Monitoring the implementation of this Strategy will require a coordinated national effort. Progress will be monitored towards the targets in this Strategy to reduce Australia's daily smoking prevalence to below 10% by 2025 and 5% or less by 2030, and reduce the daily smoking rate among First Nations people to 27% or less by 2030.

### Implementation timeframes

An implementation plan will be developed to guide the execution of this Strategy. The implementation plan will outline timeframes for each action.

### Reviews and reporting

A monitoring and evaluation framework will be developed to guide the progress reviews of this Strategy. A mid-point review of progress will be undertaken in 2026–27 to assess whether Australia is on track to achieve the targets for the actions in each priority area. An end-point review will be conducted to assess achievements arising from the Strategy and determine areas of improvement to inform the development and implementation of the next iteration of the Strategy.

Activity reports relating to tobacco control measures will be included in annual reports developed under the NDS 2017–2026.

### Indicators

The Department of Health and Aged Care uses a range of indicators to monitor smoking status, including the ABS National Health Survey, the Australian Institute of Health and Welfare (AIHW) National Drug Strategy Household Survey, and the AIHW National Healthcare Agreement. A range of other indicators will be developed and monitored during the life of this Strategy, in particular to support monitoring of smoking status among priority populations.

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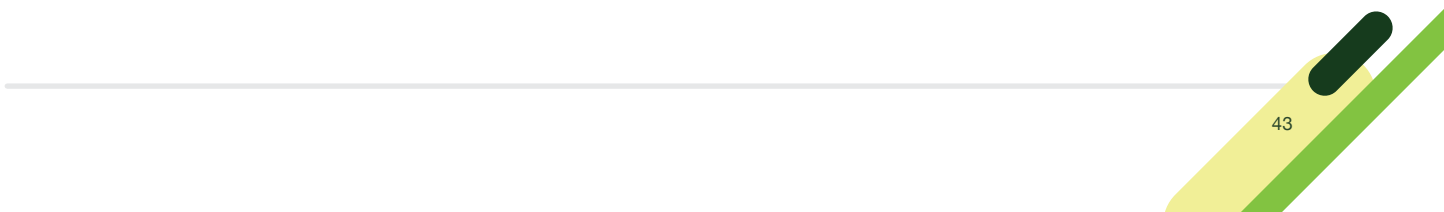


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