National Cancer Prevention Policy
2007–09

Preventable risk factors

Tobacco

The Cancer Council Australia

www.cancer.org.au

Tobacco

Every day, around 43 Australians die from illnesses caused by smoking, equivalent to over 15,500 deaths every year. Unless action is taken now, Australians will continue to die from illnesses caused by smoking that could have been prevented.

Introduction

In Australia, cigarette smoking became widespread in the 20th century. At that time, tobacco was used by many societies, some of which had used it for many centuries; however, development of the manufactured cigarette in the late 19th century resulted in increased prevalence and consumption (Winstanley, Woodward & Walker 1995). In Australia, by the time of the First World War, tobacco smoking had become popular, particularly the smoking of manufactured cigarettes. By the end of the Second World War, the earliest date for which Australian data are available, 72% of men and 26% of women were smokers (Winstanley, Woodward & Walker 1995).

Since the 1970s, various bodies, including the International Union Against Cancer and more recently the World Health Assembly (the governing body of the World Health Organization), have taken action in recognition of the rising number of deaths caused by tobacco use. The first ever public health treaty on tobacco that outlines comprehensive tobacco control strategies, the Framework Convention on Tobacco Control, was passed by the World Health Assembly in May 2003. By January 2007, 143 member states of the World Health Organization were party to the convention, representing over 90% of the world's population and making it one of the most extensive and rapidly implemented pieces of international law in history (WHO 2006).

Australia was one of the first nations to become active in tobacco control, having used a range of measures, including advertising restrictions, public information, price increases, and controls on smoking in public places, which have contributed to a significant reduction in the prevalence of smoking since the mid-1970s. Tobacco control remains one of the best investments governments can make to enhance the health and economic well-being of all Australians. While progress has been achieved in reducing the prevalence of smoking and protecting people from the harms of second-hand smoke, smoking continues to contribute to one of the highest levels of disease burden attributable to a preventable cause. Tobacco control must remain a high public policy priority, yet tobacco control initiatives are under-funded in the context of their demonstrated human and economic effectiveness. At the same time, efforts to reduce smoking prevalence are undermined by the tobacco industry, which continues to mislead, deceive and conceal the carnage caused by its deadly and addictive product, continues to pursue marketing strategies leading to high youth uptake, and obstructs measures designed to help reduce harm from smoking and exposure to second-hand smoke.

The link between tobacco and cancer

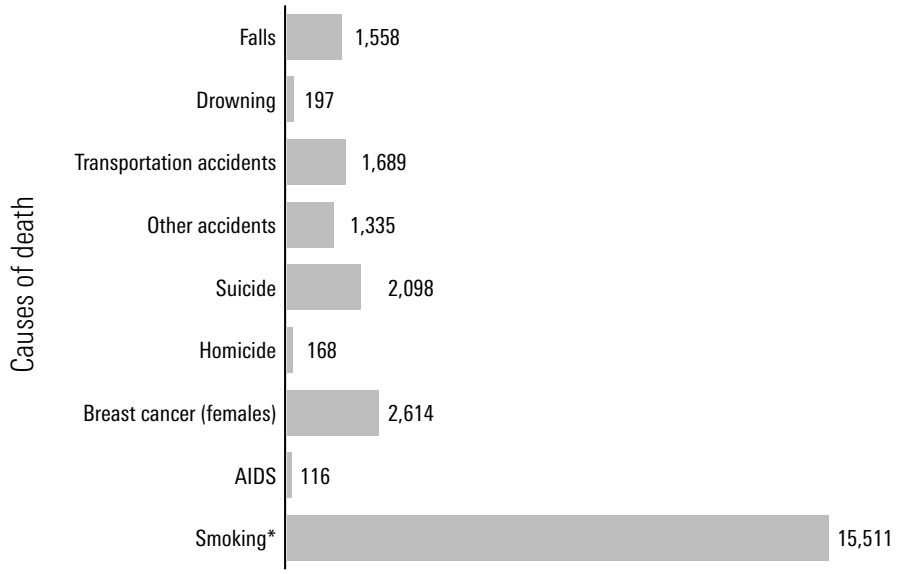
Pathologists and other medical practitioners first observed a rise in the incidence of lung cancer in the 1920s and 1930s. Research published in 1950 confirmed that tobacco smoking was a cause of death and disease, and reports by the Royal College of Physicians in London in 1962 and the US Surgeon General in 1964 resulted in acknowledgment by some governments that smoking was a cause of disease (Winstanley, Woodward & Walker 1995). In a 2004 review the US Surgeon General concluded that there was sufficient evidence to infer a causal relationship between smoking and cancer at the following sites: bladder, cervix, kidney, larynx, lung, oesophagus, oral cavity and pharynx, pancreas and stomach; and between smoking and acute myeloid leukaemia.

There is well-documented evidence of the health effects of exposure to second-hand smoke or 'passive smoking'. In 1986 a major conclusion of a report by the US Surgeon General was that involuntary smoking is a cause of disease, including lung cancer, in healthy non-smokers. This conclusion was supported by reviews published in the same year by the US National Research Council, the International Agency for Research on Cancer, and the Australian National Health and Medical Research Council (USDHHS 2006; Winstanley, Woodward & Walker 1995). In 1992 a US Environmental Protection Agency report classified cigarette smoke as a class A carcinogen and concluded that exposure to second-hand smoke causes lung cancer (USDHHS 2006). The 2006 report of the US Surgeon General on involuntary exposure to tobacco smoke reviews evidence that reaffirms and strengthens the findings of the 1986 report, concluding that exposure to second-hand smoke causes lung cancer and also that there is no risk-free level of exposure to second-hand smoke (see later in this chapter for data on the incidence of cancer and mortality caused by smoking in Australia).

The impact

In Australia, tobacco smoking kills more than 15,500 Australians each year (Begg et al. in press). As shown in the Figure 1.1 each year more Australians are killed by tobacco than by breast cancer, AIDS, traffic and other accidents, murders and suicides combined (AIHW 2006; Begg et al. in press).

Figure 1.1 Number of Australians who died in 2004 because of smoking compared with selected other causes



** Note that the estimate for deaths attributable to smoking is based on data for 2003.*
Sources: AIHW 2006; Begg et al. in press

The Australian Burden of Disease Study quantifies the contribution to health status of mortality, disability, impairment, illness and injury arising from tobacco smoking and other risk factors. The study found that tobacco is one of the leading risk factors for disease, being responsible for 7.8% of the total burden of disease in Australia. Only high body mass creates a greater burden of disease (8.6%) (Begg et al. in press).

Most smokers begin smoking when they are young, and many remain addicted to smoking for life (Winstanley, Woodward & Walker 1995). As a consequence of their addiction, in Australia one in two lifetime smokers will die from diseases caused by tobacco, and more than 22% of these deaths are in people aged under 65 years (AIHW 1998).

Tobacco smoking increases the risk of cardiovascular disease, lung disease and cancer, as well as a number of other conditions (USDHHS 2004). Many of the diseases caused by smoking are chronic and disabling, and it has been estimated that in the US, for every premature death caused by smoking in a given year, there were at least 20 smokers living with a smoking-related disease (USDHHS 2004). Table 1.1 lists the cancers caused by smoking.

Tobacco smoking is a leading cause of cancer, and was estimated to have directly caused 10,592 new cases of cancer (12% of all new cases of cancer) and 7,820 deaths (21.5% of cancer deaths) in Australia in 2001. Between 1991 and 2001, the incidence rate for men of cancers attributable to smoking fell by an average of 1.4% per year, while the rate for women rose by 0.7% per year. These differences are attributable to differences in the prevalence of smoking among Australian men and women over the past 30 years and the time lag between exposure to carcinogens and diagnosis of cancer (AIHW & AACR 2004).

Table 1.1 Cancer site and percentage of new cancers attributable to smoking in Australia in 2001

Site	Males (%)	Females (%)
Lung	89	70
Larynx	69	60
Oral cancers	52	42
Renal (kidney) pelvis	51	43
Oesophagus	50	41
Anus	39	29
Bladder	38	28
Vulva	–	32
Cervix	–	19
Penis	21	–
Pancreas	23	16
Kidney	17	12
Stomach	12	8
Colon/rectum	12	12

Sources AIHW & AACR 2004; Chao et al. 2000; USDHHS 2004

The economic consequences of tobacco use in Australia have been examined, with the total social costs in 1998–99 having been estimated at $21 billion (Collins & Lapsley 2002). It has also been estimated that the health system costs for lung cancer (85% of which is attributable to tobacco smoking) amounted to $107 million in 1993–94 (Mathers et al. 1998). Smoking causes very high levels of ill health and premature death among Aboriginal and Torres Strait Islander peoples, which adds to the social costs among these communities (Briggs, Lindorff & Ivers 2003). In Australia in 2001–02, smoking accounted for more than 291,000 hospital episodes per year, at a cost of $682 million (Hurley 2006).

The challenge

Adults

The prevalence of smoking among Australian adults has been measured by a number of different surveys: the National Drug Strategy Household Survey conducted by the Australian Institute of Health and Welfare (AIHW 2005); Smoking and Health Surveys conducted by The Cancer Council Victoria (White, Hill et al. 2003); National Health Surveys (ABS 2006); and National Aboriginal and Torres Strait Islander Surveys conducted by the Australian Bureau of Statistics (ABS 1994). Consistent trends have been observed, despite minor variations in methods between the surveys, so trends over time rather than specific figures are important foci for policy development (White, Hill et al. 2003).

In 2004 in Australia, 17.4% of people aged 14 years or older were daily smokers, with a further 3.9% of the population reporting weekly or less than weekly smoking (AIHW 2005). The recent decline in the number of daily smokers among men (18.6%) and women

(16.3%) continues the trends observed over the last 25 years (White, Hill et al. 2003; AIHW 2005).

It has been noted that those smokers who regard themselves as 'occasional' or 'social smokers' may make up 29% of all smokers. This segment of smokers holds different attitudes towards smoking and quitting from other smokers, which has implications for campaigns and messages for this group of smokers (Morley et al. 2006).

There are specific populations for which smoking rates remain significantly higher than average, including populations that are socio-economically disadvantaged, Aboriginal and Torres Strait Islander peoples and male Australians born overseas in particular countries.

Socio-economically disadvantaged populations

The prevalence of smoking in Australia in 2001 among lower blue collar workers (36%) remained higher than among upper white collar workers (16%), despite the significant declines in all occupational groups since 1980 observed in surveys of people aged 18 years or older by The Cancer Council Victoria (White, Hill et al. 2003).

Aboriginal and Torres Strait Islander peoples

The prevalence of smoking remains very high among Aboriginal and Torres Strait Islander peoples. The *National Aboriginal and Torres Strait Islander health survey* of 2004–05 indicated that the prevalence of smoking in people aged 18 years and over has remained unchanged at 50% since 1995 (ABS 1994); however, the smoking rates among some remote Aboriginal and Torres Strait Islander communities are much higher (Ivers 2001). After adjusting for age differences, in 2004 Aboriginal and Torres Strait Islander people aged 18 years and over were more than twice as likely as non-Indigenous Australians to be smokers (AIHW 2006). A 2002 survey reported a smoking prevalence of 59% among Aboriginal health workers in New South Wales (Mark et al. 2005).

Potential contributors to the higher prevalence of smoking among Aboriginal and Torres Strait Islander peoples include (Briggs, Lindorff & Ivers 2003; AGDHA 2005):

- the effects of historical colonisation and dispossession (disruption and erosion of language and culture, creation of unhealthy living and social conditions, devaluation of cultural responses to health problems, general subordination due to racism)
- socio-economic disadvantage (the roles of lower levels of education, lower levels of employment and lower weekly income)
- cultural beliefs and strong links to a traditional lifestyle (recognition of homelands, believing in the important role of elders, and English not being a first language have been linked to higher prevalence of tobacco use)
- enjoyment and addiction (similar to their roles in the maintenance of smoking among non-Indigenous people)
- social contexts and pressures (role of smoking in becoming accepted as part of the social group, roles of boredom, stress and anxiety).

A lack of knowledge on the health effects of tobacco does not appear to be a major factor in the higher prevalence of smoking among Aboriginal and Torres Strait Islander peoples (Briggs, Lindorff & Ivers 2003).

Australians born in particular countries

Smoking rates among Australians born in Australia and in other countries were measured in the National Health Survey 2004–05 for people aged 18 years and over (ABS 2006). The overall prevalence among men was 24.2%, but smoking was more prevalent among men born in North Africa and the Middle East (31.9%) and among men born in South East Asia (28.6%). For women born in Oceania (excluding Australia) the prevalence was 26.3%, compared with an overall prevalence among women of 18.4% (ABS 2006).

Teenagers

Among secondary students (Table 1.2), rates of smoking decreased in the late 1980s, and then remained relatively stable in the 1990s (Hill, White & Letcher 1999). Among older students (those aged 16–17 years), the significant decrease among males and females between 1999 and 2002 was the first seen in this age group since 1990 (White & Hayman 2004). Among students aged 12–15 years, the prevalence of smoking also declined between 1996 and 2005.

Table 1.2 Trends in rates of smoking among Australian secondary school children between 1984 and 2005: proportion (%) of students who smoked in the last seven days (age adjusted)

Year	Girls 12–15 years	Boys 12–15 years	Girls 16–17 years	Boys 16–17 years
1984	20	19	32	28
1987	14	13	30	26
1990	14	13	28	24
1993	16	15	29	28
1996	16	16	32	28
1999	16	15	29	30
2002	12	10	25	21
2005	7	7	17	16

Sources: Hill, White & Letcher 1999; White & Hayman 2004; White & Hayman 2006
Note that young people who had left school were not included in the national surveys on which this table is based.

There were an estimated 4.3 million ex-smokers among the 16.4 million Australians aged 14 and over in 2004 (AIHW 2005). However, there were still an estimated 2.9 million Australians who smoked on a daily basis in 2004 (AIHW 2005).

Other challenges

The prevention of more than 17,000 premature deaths in 1998 in Australia can be attributed to a range of successful tobacco control measures that delivered declines in smoking from the early 1970s (DHA 2003). However, with almost one in five Australians continuing to smoke, the nation faces a significant challenge to further reduce smoking rates and avert major social and economic costs to the community.

Compounding the need to further reduce smoking rates is an expected increase in overall cancer incidence rates in Australia of around 30% over the next five to 10 years as a result of population ageing. This trend is likely to continue as the population ages. Reducing smoking prevalence now would lead to significantly fewer overall cancer diagnoses

in the longer-term future, when healthcare services in Australia are likely to be under unprecedented pressure owing to demographic change.

Despite the progress made in Australia to date, significant challenges to achieving continued reductions in tobacco-related harm remain. These challenges include the disproportionate burden of harm among disadvantaged populations, attitudes that undermine effective tobacco control, the influence of the tobacco industry, and a reluctance from governments at all levels to take measures to reduce tobacco use commensurate with the economic and social damage caused by smoking.

Disproportionate tobacco burden

As documented elsewhere in this chapter, socially disadvantaged population groups bear a disproportionately high tobacco burden in Australia. Evidence increasingly shows that, as well as causing a growing inequity in health status, smoking among these groups contributes to a cycle of poverty and disadvantage. Recent research on financial deprivation and smoking has shown that disadvantaged smokers experience financial hardship as a result of tobacco use, and are more likely to want to quit smoking, but less likely to succeed in quitting (Siahpush, Heller & Singh 2005).

Attitudes that undermine effective tobacco control

Resistance to progressive tobacco control can be based on a set of attitudes that are clearly unsupported by evidence or are based on facile excuses for inaction, yet some of which are nonetheless cited by social commentators and policy makers to discourage efforts to reduce the tobacco burden. An important part of 'de-normalising' a habit that causes the extent of preventable death and disease documented in this chapter is to counter, using evidence, the inaccurate framing of tobacco issues cited as a justification for tobacco control complacency. Some of the salient catchphrases used to argue against an increased commitment to tobacco control can be readily debunked in view of the evidence as follows.

> *'We have done everything possible to control tobacco, apart from banning tobacco altogether.'*

This view is contradicted by the evidence, which shows that a comprehensive policy commitment and sustained campaign funding are highly effective in reducing smoking rates. In California, which introduced comprehensive tobacco control measures in 1988, smoking rates have decreased by approximately 38%, from 22.7% to 14% (CDHS 2006). Jurisdictions such as Canada now have daily smoking rates as low as 13.5% (Canadian Tobacco Use Monitoring Survey 2006). There is every reason to believe that, with appropriate measures, smoking rates in Australia could be reduced to less than 5%. None of the required measures would involve banning tobacco products.

> *'Australia is doing OK already' or 'Australia is doing better than anyone else.'*

While Australia should be acknowledged as a world leader in tobacco control policy given its reforms over the past three decades, more than 17% of Australians still smoke every day: which corresponds to almost one in five people incurring a 50% risk of dying as a result of smoking, half of them in middle age. Despite substantial reductions in smoking rates over the past 30 years, tobacco use remains one of the leading preventable causes of disease. Over 15,500 Australians die from smoking-caused diseases each year, and lung cancer rates in women continue to rise.

'It's a legal product.'

Tobacco is a commercial and regulatory anomaly. Smoking causes a higher disease burden than the combined use or misuse of all other 'legal products' that are rigorously regulated for safety reasons, including over-the-counter drugs, prescription medicines, pesticides, alcohol and motor vehicles. On the basis of demonstrated harm, tobacco products are also under-regulated in comparison with government treatment of other environmental carcinogens and hazardous consumer products.

'Smoking provides economic benefits to government and society in general.'

Evidence indicates the opposite: tobacco control is one of the best investments governments can make. Independent economic analyses clearly demonstrate that smoking has a high net social and economic cost to the community. Similar analysis has also shown that a reduction in smoking rates would not harm the economy. There is also objective evidence for a strong return on investment in tobacco control. The most recent Department of Health and Ageing analysis on this issue found that every $1 spent on tobacco control yields $2 in savings, and the consultancy firm Applied Economics concludes that tobacco control yields better gains than any other public health program expenditure, with a benefit to cost ratio of 50:1 (Applied Economics 2003).

'Smoking is an adult choice.'

The vast majority of smokers start smoking while in adolescence, becoming addicted before they are mature enough to make an adult decision and fully understand the consequences of nicotine addiction and the harms of smoking (Schofield et al. 1998; Winstanley, Woodward & Walker 1995). Almost all smokers also say that they regret starting smoking (Fong et al. 2004). Evidence also shows that most adult smokers are not fully aware of the dangers of smoking, with a recent survey finding that while two-thirds identified lung cancer as smoking-related, only one-quarter knew that smoking caused heart disease and fewer than 10% understood the risk of emphysema, stroke and vascular problems (Quit Victoria 2006). Around 90% of smokers report regretting ever having started (Fong et al. 2004).

'Tobacco control is part of a nanny state.'

The argument that government action to reduce smoking rates is restricting personal freedoms with risk-averse, patronising public policy is debunked by the evidence outlined against the five arguments discussed above. In addition, most tobacco control measures are designed to support decisions that people are already making. Every year, 30% to 40% of smokers attempt to quit, but only one in 10 attempts to quit is successful. Tobacco control measures reduce relapse rates and help intending quitters to break their addiction. Measures are mainly about removing inducements to smoke or providing information, support and encouragement to quit.

Governments also have a responsibility to protect non-smokers from the increasingly evident harms of environmental tobacco smoke and to reduce the economic burden, borne by the wider community, imposed by smoking. The restrictions on smokers imposed over recent years have attracted overwhelming community support (VCTC 2002).

Tobacco industry influence

While coordinated efforts to reduce the disease burden of tobacco have made Australia a challenging market for the tobacco industry compared with nations where there are fewer controls, almost one in five Australians continues to smoke, with Australian households spending more than $10 billion on tobacco products per year (ABS 2005).

Tobacco products are among the top 10 best-selling items for a range of retailers, including supermarket chains, grocery stores, petrol stations and newsagents. The tobacco industry in Australia was estimated to be worth $6.2 billion in 2002 (VCTC n.d.), with 52 brands of cigarettes available for sale in June 2003 (Australian Retail Tobacconist 2003). Therefore, tobacco companies are very well-resourced to counter attempts to reduce smoking rates; the industry continues to exploit loopholes in tobacco control regulations and to engage high-powered legal firms when called to account in the courts. The tobacco industry continues to try to court policy-makers and to adopt a stance of legitimacy and good corporate citizenship, despite a proven record of deceptive conduct.

Effective interventions

Comprehensive tobacco control strategies, if sufficiently funded, work to reduce tobacco consumption among both adults and teenage smokers (VCTC 2002). This conclusion is based on studies from the World Health Organization (WHO 1998) and the US Centers for Disease Control and Prevention (CDCP 1999; CDCP 2000; CDCP 2001), and a review carried out for the World Bank (Jha & Chaloupka 1999).

In Australia over the last 30 years an estimated $8.6 billion has been saved through deaths avoided and declines in illness and disability due to reduced tobacco use (DHA 2003). It is estimated that $2 has been saved on health care for each $1 spent on tobacco control programs to date, with total economic benefits exceeding expenditure by at least 50 to 1. Specific strategies include increasing the prices of tobacco products and changing social attitudes to smoking through regulation and hard-hitting media campaigns. The precise impact of any specific strategy has been difficult to assess, as many have been implemented simultaneously or partially, or in an ad hoc way without comprehensive evaluation (Chapman 1993). Moreover, all have been opposed and undermined by tobacco industry activity.

Pivotal to a strategic and coordinated approach to smoking reduction in Australia is the willingness of governments to commit to, and seek to attain, specific smoking prevalence targets. Targets can only be achieved if adequate resources are committed to tobacco control measures in the long term. Evidence shows that it is feasible to achieve a decline of 1% per annum in the prevalence of smoking if tobacco control measures are well-funded and implemented (CDCP 2001). The speed of the decline depends on government action in ensuring adequate spending levels as well as appropriate regulation.

The Cancer Council encourages the Australian Government to set targets for smoking prevalence for Australian adults, children and disadvantaged groups, and to allocate adequate funds for comprehensive tobacco control programs to achieve these targets. In order to further reduce the unacceptable burden of smoking in Australia, governments and other institutions involved in public policy will need to build on the demonstrated success of tobacco control strategies employed in Australia over the past three decades. Priorities for further action are outlined below.

Continual innovation in tobacco control is required to keep pace with changes in the smoking-related environment. For example, a growing evidence base showing the increasing extent of disease linked with smoking demonstrates the need for tobacco control programs that are commensurate with the burden smoking imposes on the community. Accumulated evidence showing which approaches to tobacco control are the most effective should inform government policy. Policy-makers must also be able to react quickly to the tobacco industry's attempts to exploit loopholes in measures designed to reduce smoking rates. There are a number of other examples showing the need for flexible,

progressive solutions, as well as evidence that indicates where public policy for tobacco control in Australia is inadequate.

All jurisdictional governments in Australia have committed, in principle, to the following general approaches to tobacco control, as each priority is to some extent incorporated into the National Tobacco Strategy. However, implementation of the strategy has been gradual, and the funding commitment is not sufficient to convert policy into effective practice. The re-establishment of a multi-jurisdictional advisory body drawing on independent expertise from outside the bureaucracies, such as the former Ministerial Tobacco Advisory Group, would help to guide the implementation of the National Tobacco Strategy.

The Cancer Council Australia outlines the major areas where reform is required below. Rejection of tobacco industry donations by all political parties, while not explored as a specific tobacco control measure below, would also be a significant step in 'de-normalising' smoking and challenging the legitimacy of the tobacco industry.

Recommended funding

Despite the well-documented successes of comprehensive strategies to address tobacco use and the resultant savings in public finances (DHA 2003), government funding of tobacco control in Australia is well below optimal. The US Centers for Disease Control has developed best practice guidelines for the implementation of comprehensive tobacco control programs (CDCP 1999). These guidelines draw on evidence-based analyses of programs implemented in California, Massachusetts and other US states. The guidelines outline nine program components and estimate a range of annual costs. For a state with a population under three million people the cost would be US$7–20 per capita, for populations between three and seven million the cost would be US$6–17 per capita, and for populations over seven million (e.g. Australia-wide) the cost would be US$5–16 (A$7–21). Recommendations from the VicHealth Centre for Tobacco Control on how comprehensive tobacco control programs should be implemented in Australia, based on the Centers for Disease Control best practice guidelines (CDCP 1999), are summarised in Table 1.3 (VCTC 2003).

Table 1.3 Recommended levels of funding for tobacco control programs (Australian dollars, 2003)

Component	A$ million
Community programs	23.25
Chronic disease programs	1.15
School programs	1.65
Enforcement	12.25
Statewide programs	13.07
Counter marketing	64.00
Cessation programs	59.35
Subtotal	**174.69**
Surveillance and evaluation	8.00
Administration and management	11.80
Total	**194.49**

Source: VCTC 2003

In 2007, given estimated costs of $200 million and an Australian population of 20.7 million, the recommended tobacco control measures would cost around A$10 per head. The Better Health for All Australians Initiative from the Council of Australian Governments (federal, state and territory governments) provides an opportunity to meet the recommended levels of investment for tobacco control with its stated intent to: 'promote healthy lifestyles; support early detection of lifestyles risks and chronic disease through a new Well Person's Health Check (available nationally to people around 45 years old with one or more identifiable risks that lead to chronic disease); and support lifestyle and risk modification through referral to services that assist people wanting to make changes to their lifestyle, for example, give up smoking' (COAG 2006). Disappointingly, the initial round of funding in 2006 did not include additional funding for tobacco control initiatives, limiting its impact on cost-effective approaches to health improvement. The Cancer Council and its allies working across all nine jurisdictions in Australia will continue to encourage government to fund evidence-based tobacco control programs on the basis of their potential to deliver optimal social and economic gains to the community.

Social marketing campaigns

The National Tobacco Campaign of the late 1990s ('Every Cigarette Is Doing You Damage') was the first coordinated, multimedia anti-smoking campaign that was run on a national basis and supported by related activities in jurisdictions (e.g. state Quit programs etc.). An independent economic evaluation of the campaign, based on a rigorous analysis, calculated that the $7.1 million invested in the program by the Australian Government in 1997 yielded full cost offsets to the whole economy of $24.2 million, meaning that the campaign paid for itself three times over. Direct savings to the Australian Government alone were calculated to be $10.9 million within the year of its implementation (DHA 2000). Yet the campaign has not been run on a national basis for more than seven years, despite the clear economic benefits and potential for larger long-term returns. Moreover, evidence shows that without recurrent commitment to widely accessible information about the risks of tobacco use, declines in smoking rates can stall or are at risk of reversing.

Based on the success of the National Tobacco Campaign, and adjusting for inflation, there is a clear economic case for committing $11 million on a recurrent basis to a new, evidence-based social marketing campaign. Such a campaign would have a major impact on bringing smoking rates closer to a feasible 5% of the Australian population and add to the success of other tobacco control measures.

Elimination of tobacco promotion

When responding to the Government's review of the *Tobacco Advertising Prohibition Act*, The Cancer Council Australia and allies presented evidence of tobacco industry activity that contradicted the spirit of the Act and, in some cases, represented potential breaches. On the basis of that evidence, the Cancer Council put forward a number of recommendations for amending the Act. However, these were not adopted, and the review committee concluded that no amendments would be made to the Act. An evidence-based case remains, however, for amending the Act to enact and enforce the following additional restrictions on tobacco promotion. Recommended measures include:

- amend the definition of 'tobacco advertisement' to include the use of imagery that associates smoking with a desirable lifestyle, and expand the definition of 'tobacco product' to include cigar and cigarette cases (including the slips introduced to conceal graphic warnings on cigarette packets)
- prohibit all advertising and display at the point of sale

- address smoking in films: for example, classify films with positive depictions of smoking, and run anti-smoking advertisements before cinema screenings of such films
- prohibit the giving of free samples, gifts and other promotional offers aimed at boosting tobacco sales
- prohibit 'mobile retailing': sales of tobacco products should be restricted to places that operate as shops, and shops only, at all times
- prohibit vending machines
- require all tobacco products to be sold only in prescribed generic packaging that does not have any colours or branding or information other than that prescribed by regulation
- regulate Internet advertising and sales, direct mail/sending of catalogues, and mail order
- make it an offence to encourage/employ someone else to run a tobacco advertisement in breach of the Act
- remove exemptions for tobacco advertisements on international flights in and out of Australia
- prohibit marketing outside Australia by Australian companies that would be illegal in Australia
- prohibit false or misleading statements by manufacturers about the addictiveness or health effects of smoking or exposure to smoke
- require tobacco manufacturers to report on all promotional activities and expenditure and on sales volume
- tighten provisions relating to magazines imported from countries with fewer restrictions on tobacco advertising in periodicals.

There are a number of other recommended amendments, indicating both the extent to which the Act is limited in achieving its stated aims and the scope for the tobacco industry to continue to promote its products. The effectiveness of the *Tobacco Advertising Prohibition Act* is also limited by the relatively small penalties associated with breaches, particularly in light of the potential revenues associated with recruiting new smokers through illegal marketing strategies.

While a strengthened *Tobacco Advertising Prohibition Act* would be the appropriate legislative instrument to further restrict tobacco promotion as described, it is unlikely that government would call for another general review of the Act in the near future, thus other approaches to achieve similar results should be considered. For example, direct approaches to supermarket chains to remove tobacco products from sight have the potential to further 'de-normalise' smoking and assist quitters who are at higher risk of relapse when cigarettes are in plain view and more readily accessible. In the meantime, The Cancer Council Australia will continue to make the case for incremental amendments to the Act to phase in the tighter measures described above.

Australia also needs to ensure that the protocols of the World Health Organization Framework Convention on Tobacco Control, which was ratified here in 2004, are observed in the domestic environment, in particular for eliminating loopholes allowing for tobacco industry sponsorship of sporting events.

Product regulation (short-term goals as minuted)

As discussed later in this chapter, tobacco products are a regulatory anomaly in view of the burden that their unregulated availability imposes on the community. All government jurisdictions in Australia have agreed to the principle of reducing smoking rates through

improved regulation, by collectively endorsing the National Tobacco Strategy (see later in this chapter). However, the slow progress of implementation has increased the urgency of tobacco regulation priorities, which include:

- imposing penalties for misleading statements (see recommended amendments to the *Tobacco Advertising Prohibition Act*)
- banning additives that aid palatability and addictiveness
- making reduced ignition propensity cigarettes (shown to significantly reduce fire risk) mandatory
- banning filter venting
- making detailed information on the content of all tobacco products publicly available (possibly on a public domain website)
- imposing a 'polluter pays' requirement/levy on industry.

Real price increases

As articulated in the National Tobacco Strategy (see later in this chapter), imposing price increases on tobacco products through taxation has been shown to directly reduce smoking rates, and is therefore endorsed as evidence-based tobacco control policy. Government revenue derived from increased tobacco tax should fund additional smoking cessation services, to help ensure that people on lower incomes, who already bear a disproportionate tobacco burden, are better supported to quit smoking.

Accountability

Litigation is an increasingly effective way to help make the tobacco industry accountable for the death and disease caused by its products and to obtain funds to support tobacco control measures (Advocacy Institute 2005). The achievements of litigation include (Daynard 2003):

- disclosure of documents that demonstrate the intent of the tobacco industry to target children; deliberately mislead scientists, politicians, and customers about the lethal and addictive nature of their products; and to conspire with smugglers and money launderers around the world
- verdicts against tobacco companies in tobacco cases in the US, made possible by the above-mentioned documents, involving punitive damages of millions or billions of dollars have added to the industry's confusion and loss of legitimacy and, in the US, the increasing possibility of bankruptcy further weakens the industry's position politically and in the financial community
- the first stirrings of responsible behaviour by tobacco companies (Philip Morris now concedes on its website that cigarette smoking is addictive and causes lung cancer and other diseases)
- media coverage and public discussions about tobacco lawsuits, which educate the community about addiction and disease caused by smoking.

In Australia the Australian Competition and Consumer Commission has had some success in enforcing the law against the tobacco industry with respect to its deceptive practices, with the industry agreeing to court-enforceable undertakings to remove 'light' and 'mild' brands from sale and pay for corrective advertising. The industry also promptly withdrew 'split packs' (see elsewhere in this chapter), which represented a breach of packaging regulations, following prompt action from the commission. However, the wealthy tobacco industry is a formidable legal opponent, and the Australian Competition and Consumer

Commission lacks sufficient funds to effectively bring the industry to account. The Australian Government should adequately fund the Australian Competition and Consumer Commission to take on the tobacco industry.

Access to smoking cessation aids

The Cancer Council Australia recommends improved access to smoking cessation aids to an extent commensurate with the damage caused by smoking and the percentage of smokers who would like to quit. Implementation of the other measures articulated in this section would also require an increase in the availability of smoking aids to help ensure an optimal return on investment in initiatives such as social marketing campaigns. A range of products and services needs to be available to support intending quitters, such as counselling, information and education, and nicotine replacement and pharmacological products.

Improved tobacco control policy requires:

- promotion of tobacco-dependence treatment as an integral component of cost-effective health care
- increased government funding of the delivery and promotion of non-drug smoking cessation support services, including Quitlines
- increased funding for programs to educate and prompt healthcare providers to identify and advise patients who smoke to quit, and to refer them to appropriate support services
- implementation of subsidy and access arrangements for pharmacological interventions, to help ensure that treatment is equitable and cost-effective
- tailoring of cessation support services for disadvantaged and high-risk groups, such as Aboriginal and Torres Strait Islander people
- introduction of a Medicare rebate for general practitioners to counsel patients about smoking cessation or for referral to the Quitline or other effective services.

Smoke-free environments

The restrictions on smoking in public places that gained momentum in the mid-to-late 1980s with bans on smoking in Australian workplaces and domestic flights have extended to a number of environments, with evidence showing a significant decrease in the health risks encountered due to second-hand smoke. Smoke-free environments also help to 'de-normalise' smoking and encourage smokers to quit. While all Australian jurisdictions have adopted some bans on smoking in public places, the pace of reform varies, and opportunities for significant improvement remain. In order for restrictions to reach their potential to adequately protect all individuals from the dangers of second-hand smoke, tightening of laws is required in all jurisdictions, with evidence-based recommendations to:

- eliminate the loopholes/exemptions exploited by pubs and clubs
- eliminate 'high-roller' room exemptions (e.g. in casinos, where wealthy patrons are permitted to smoke in enclosed spaces despite the risks to staff)
- ban smoking in outdoor dining areas
- create smoke-free campuses/higher learning institutions.

There is also a clear case for banning smoking in cars carrying children and pregnant women.

Tobacco control strategy for Aboriginal and Torres Strait Islander peoples

The prevalence of smoking among Aborigines and Torres Strait Islanders is around 50%, more than 2½ times the smoking rate of non-Indigenous Australians. Evidence shows that smoking among Aborigines and Torres Strait Islander people is a significant cause of increased cancer mortality and other chronic disease. Indigenous Australians are more than twice as likely to die within five years of a cancer diagnosis as non-Indigenous cancer patients, in large part because of the poor prognosis of cancers caused by smoking (Condon et al. 2005).

The cycle of poverty and disadvantage exacerbated by smoking (discussed elsewhere in this chapter) is particularly acute among Aborigines and Torres Strait Islander people. Despite the importance of smoking in the crisis in Indigenous health, efforts to address the issue have been substantially under-funded. Yet evidence shows that measures to reduce tobacco use, such as information, education and nicotine replacement therapy, can work in Indigenous communities if adequately funded and promoted in a culturally appropriate framework (Briggs, Lindorff & Ivers 2003; Ivers 2004). A tailored approach to tobacco control for Indigenous people, developed in consultation with Indigenous health groups such as the National Aboriginal Community Controlled Health Organisation, is essential to improving the inequity in health outcomes between Indigenous and non-Indigenous Australians and for breaking the cycle of poverty, poor preventive health and disease.

The policy context

Brief history of tobacco control policy in Australia

Australia's tobacco control record over the past three decades has been relatively good. However, governments were initially slow to respond to the evidence demonstrating the dangers of smoking, and evidence-based tobacco control measures continue to be subject to delays and insufficient funding across jurisdictions, despite historical evidence showing the benefits of a strategic approach to reducing smoking rates.

Health authorities in Australia first called for formal government action to reduce tobacco use in the early 1960s, following international research that demonstrated the serious health risks associated with smoking. In 1962, health promotion organisations endorsed a report recommending restrictions on tobacco advertising and the introduction of a public health education campaign. While it took a decade for government to respond to calls for tobacco control measures, male smoking rates fell as the news media informed the public of the dangers of smoking.

The first significant government action, in 1972, was mandatory placement of health warnings on cigarette packages. From 1973 to 1976, broadcast advertising of cigarettes was phased out. These two national measures coincided with a major decline in smoking rates, a trend that has continued, in step with other measures aimed at reducing tobacco use.

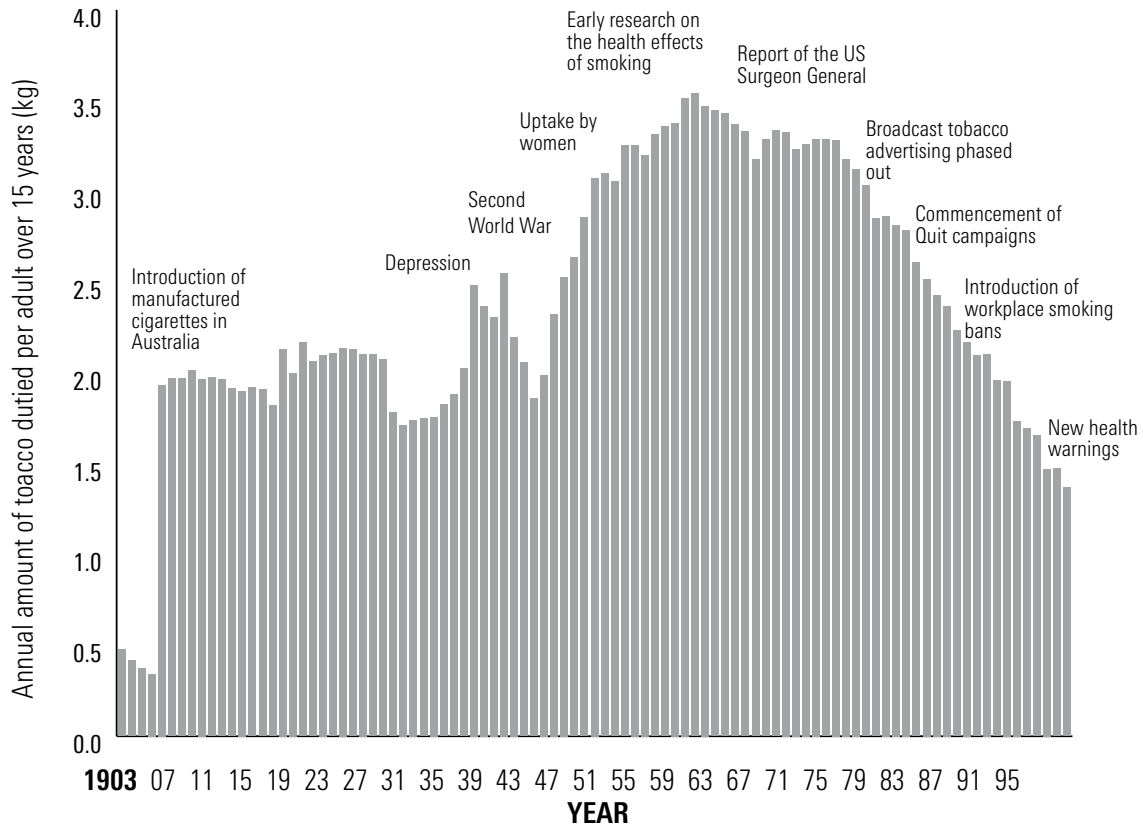
In the 1980s, establishment of preventive health care as a public policy issue, evidence that smoking was the largest cause of preventable death and disease, and a shift in community attitudes to smoking, encouraged governments to do more to reduce the tobacco burden. Passive smoking became a prominent issue in the 1980s because of research demonstrating the dangers of exposure. The Australian Government legislated to eliminate smoking from federal workplaces in 1986 and from domestic aircraft in 1987.

State and territory governments, with varying levels of commitment and delay, have subsequently introduced restrictions on smoking in public places that are subject to jurisdictional legislation, such as public transport, taxis, and enclosed public places (e.g. shopping centres, restaurants and theatres and, in some states, pubs and bars). The Australian Government also banned tobacco advertising in the print media in 1989. In 1992, federal parliament passed the *Tobacco Advertising Prohibition Act*, phasing out most remaining forms of tobacco advertising by 1995.

Other key tobacco control measures have been excises on tobacco products (deterring purchase and providing revenue towards the tobacco disease burden) and social marketing campaigns aimed at raising public awareness of the dangers of smoking.

A milestone social marketing initiative was the Australian Government's National Tobacco Campaign run in 1997 and 1998. A government-commissioned independent evaluation of the campaign found that investment in the first six months of the campaign alone returned more than double in savings via reduced healthcare costs and life-years saved. Despite this success, and recommendations from the evaluation team to re-run the campaign, there has been no coordinated national social marketing campaign aimed at reducing smoking rates on this scale since then. Because of its success, the campaign has been adapted for use in other countries.

Figure 1.2 Adult per capita consumption of tobacco products in Australia



Source: Compiled by Michelle Scollo, VicHealth Centre for Tobacco Control

Australian National Tobacco Strategy 2004–2009

Current national and inter-jurisdictional tobacco control policy is articulated in the Australian National Tobacco Strategy 2004–2009. The strategy sets out the intentions of federal, state and territory governments to work together and collaborate with non-government agencies on a long-term, comprehensive, evidence-based and coordinated national plan 'to significantly improve health and to reduce the social costs caused by, and the inequity exacerbated by, tobacco in all its forms' (MCDS 2004).

The Cancer Council endorses the objectives of the National Tobacco Strategy, which are, across all social groups:

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

The National Tobacco Strategy identifies the following areas for action:

- regulation of tobacco
  - » promotion
  - » place of sale
  - » price (through tobacco tax)
  - » place of use
  - » packaging
  - » products
- promotion of Quit and Smokefree messages
- cessation services and treatment
- community support and education
  - » informing the community
  - » preventing smoking uptake by children
- addressing social and cultural determinants of health
- tailoring initiatives for disadvantaged groups
- research, evaluation, monitoring and surveillance
- workforce development.

Regulation of tobacco promotion

Comprehensive bans on cigarette advertising and promotion were shown to reduce consumption, but more limited partial bans were found have little or no effect in data from 1970 to 1992 from 22 high-income countries (Jha & Chaloupka 1999). Econometric studies in high-income countries suggest that comprehensive bans on promotion reduce demand for tobacco by around 7% (CDCP 1999). When governments ban tobacco advertising in one medium, the tobacco industry will substitute advertising in other media with little or no effect on overall marketing expenditure (Jha & Chaloupka 1999). In Australia, tobacco promotion still occurs at point of sale and on packaging. Research suggests that such advertising increases positive feelings about cigarette brands (MCDS 2004).

Regulation of place of sale

Regulation of the supply of tobacco products should ensure that they are available to adults, but are not highly visible and are not sold to children. Laws banning sales to minors are more effective if the penalties are substantial and the laws are vigorously enforced so that the probability and cost of being caught outweighs the benefit of continuing illegal sales (MCDS 2004). Reductions in cigarette consumption by young people, however, have not always followed increasing sales restrictions. In Australia, the proportion of 12–17-year-olds who report buying their own cigarettes has declined since 1996, but there has been a corresponding increase in reports of obtaining cigarettes by having someone else buy them (White & Hayman 2004).

Regulation of price through tobacco tax

'Real' price increases (where increases are not matched by greater earning capacity, and affordability decreases) can depress demand for cigarettes (Jha & Chaloupka 1999). Higher prices (usually resulting from taxation increases) induce some smokers to quit, prevent other people from starting (CDCP 2000), reduce the number of ex-smokers who relapse, and reduce consumption among continuing smokers. A price rise of 10% on a pack of cigarettes would be expected to reduce demand by about 4%, but efforts to set an 'economically optimal' tax level have produced a wide range of estimates (Jha & Chaloupka 1999). However, effective taxation policy must ensure that increases are real, well publicised, and occur as often as necessary to maintain effective price rises. It is important that taxation effects are not insulated or absorbed by economies in manufacturing or tobacco companies' pricing policies (Winstanley, Woodward & Walker 1995).

Increasing the price of tobacco products will decrease consumption more in low than in high-income groups. However, tax increases can cause financial stress for people on low incomes who continue to smoke. Support for price increases will be more likely if there is increased investment in supporting people on low incomes to quit (MCDS 2004).

Regulation of place of use

Restrictions on smoking in public places and workplaces will obviously benefit non-smokers. Importantly, smokers in workplaces with total bans on smoking are also likely to reduce the amount they smoke and increase their chances of successfully quitting (Fichtenberg & Glantz 2002). There is a high level of public support for restricting smoking in public places in Australia (AIHW 2005).

Regulation of packaging

Tobacco product packaging allows information on the product to be communicated to consumers. Since March 2006 cigarette packages in Australia have been required to carry colour graphic and text warnings on 30% of the front of the pack and 90% of the back of the pack. Information on a national Quit website and Quitline number appears on the back of the pack (DHA 2006). Tobacco products in Australia will no longer carry information about 'yield' of components (e.g. nicotine and tar) following concerns that consumers did not understand this information and acknowledgment that the labelling systems were based on flawed testing (MCDS 2004). Use of descriptors such as 'light' and 'mild' has also ceased after the Australian Competition and Consumer Commission found that the claimed relative health benefits of low yield cigarettes were misleading and likely to breach the Trade Practices Act (ACCC 2005). However, there is still potential for smokers to be misled, with continued use of colours and descriptors implying comparative health benefits, and the mechanism by which deception occurs has not been addressed (King & Borland 2005).

Regulation of products

Possible regulations could be requirements for 'fire safe' or reduced ignition propensity cigarettes (which automatically extinguish when they are not being smoked), and measures to reduce the addictiveness and palatability of products. A policy is needed 'to coordinate regulation of tobacco products and products designed to replace tobacco, in ways that combine to reduce overall population harm' (MCDS 2004).

Promotion of Quit and Smokefree messages

Long-term, high-intensity counter-advertising campaigns can reduce consumption when part of a multi-component program (Jamrozik 2004). Such campaigns also effectively reduce initiation of tobacco use, in combination with other interventions such as price increases and school and community programs (CDCP 2000). The National Tobacco Campaign initiated in 1997 ('Every Cigarette Is Doing You Damage') involved advertisements on television, on radio, in newspapers, and on bus billboards (CDHAC 2004). In a survey conducted to evaluate a 2004 campaign, 48% of smokers reported that the campaign messages provided encouragement to quit (CDHAC 2004).

Cessation services and treatment

Many people are able to overcome their dependence on tobacco and stop smoking, although people commonly have multiple attempts before succeeding (MCDS 2004). In Australia in 2004, 26% of people aged 14 and over described themselves as ex-smokers (AIHW 2005). The Cochrane Collaboration Methods have found the following interventions aimed at improving rates of quitting to be effective: brief advice from doctors; nicotine replacement therapy (via chewing gum, transdermal patch, nasal spray, inhaler, or tablet); the antidepressant drug bupropion (Zyban); tailored self-help materials; telephone counselling; and individual or group counselling (Cochrane Library 2006). However, pharmacotherapies are sometimes not used properly, reducing their efficacy, and clinical trial results are not always replicated when cessation aids are used in the real world.

Resources to encourage and assist doctors to provide cessation advice include the *Guidelines for prevention activities in general practice* (the 'red book') and the SNAP guide on smoking, nutrition, alcohol and physical activity as population health risk factors (RACGP 2005; RACGP 2004). A study on the application of SNAP in general practice noted that while verbal advice on smoking cessation advice is reported as being provided 'very often' by 68% of general practitioners, other studies indicate that only 0.6% of patient encounters involve cessation advice (Amoroso, Hobbs & Harris 2005).

The National Tobacco Strategy recommends an integrated strategy for cessation services that would enable coordination of policy and spending by programs covering public health, medical and pharmaceutical benefits, medical education, development of general practice and continuing education of virtually all health professionals (MCDS 2004).

Informing the community

Counter-advertising or negative messages about smoking from governments and health promotion organisations have been found to reduce consumption consistently according to studies from Australia, North America, Europe and Israel (CDHAC 1999). In general, the impact is greatest and most sustained when there is low general awareness of the health risks of smoking (Jha & Chaloupka 1999). In Australia, there is a high level of public knowledge of illnesses associated with passive smoking, although more could be done to update the community on new research (VCTC 2002a).

Preventing smoking uptake by children

A recent Australian review of youth tobacco prevention (DHA 2005) notes that prevention of tobacco uptake is a critical component of any comprehensive tobacco control strategy. Such efforts have largely focused on young people, given that smoking initiation is most likely to occur before 18 years of age. Theoretically, prevention or 'early intervention' initiatives represent a better long-term solution than cessation initiatives, given the addictive properties of nicotine. However, effective prevention strategies have remained largely elusive (DHA 2005).

High-profile campaigns to reset community norms about smoking and help adult role-models to quit can also greatly reduce smoking by children (MCDS 2004). Focusing efforts on adult smokers is supported by research that demonstrates that mortality can be better reduced by focusing on current smokers and near-term health problems (Levy, Cummings & Hyland 2000; Peto et al. 2000). Parental and sibling smoking is a well-established risk factor for smoking in adolescents (USDHW 1979). When parents who smoke quit before their children begin smoking, the risk of their children taking up smoking is significantly reduced (Farkas et al. 1999).

Adolescents (15–17 years) and people aged 18 to 39 years had similar responses to the Australian National Tobacco Campaign (White, Tan et al. 2003), suggesting that an adult approach is more effective with adolescents than a campaign specifically targeting them (Wakefield, Miller & Roberts 1999). Adolescents showed high campaign awareness regardless of smoking status, and many felt it was relevant to them, including almost 50% of non-smokers. In addition, 85% thought that the campaign made smoking seem less cool and around one-third felt it had discouraged some friends from taking up smoking (White, Tan et al. 2003).

There is little evidence that school-based programs are effective in the long term in preventing uptake of smoking. A review by the Cochrane Collaboration identified 23 high-quality randomised controlled trials of school-based programs to prevent children who had never smoked becoming smokers (Cochrane Library 2006). The interventions included information-giving, social influence approaches (representing the majority of studies), social skills training, and community interventions. There is little evidence that information alone is effective. Although half of the best quality studies in this group found short-term effects, the highest quality and longest trial (the Hutchinson Smoking Prevention Project) found no long-term effects from 65 lessons over eight years (Cochrane Library 2006).

Addressing social and cultural determinants of health

Investing in programs that strengthen community and cultural resources (e.g. programs to reduce the chance of educational failure, family conflict, loss of cultural identity and mental health problems) may well reduce uptake by young people of smoking (MCDS 2004). Such investment is crucial in Aboriginal and Torres Strait Islander and other very disadvantaged communities.

Tailoring initiatives for disadvantaged groups

Several social groups in Australia suffer a particularly high burden of tobacco-related death and disease (MCDS 2004):

- Australian Aboriginal and Torres Strait Islander peoples
- people suffering severe and disabling mental illness
- people who are institutionalised, including those in custodial settings

- parents/carers and children living in disadvantaged areas
- immigrants who left their home countries at a time when the dangers of smoking were not well understood.

Australian Aboriginal and Torres Strait Islander peoples

In 2004, 50% of Aboriginal and Torres Strait Islander people aged 18 years and over were current smokers, the same level reported in 1995. During the same period the prevalence of current smoking (daily, weekly and occasional) among all Australians fell from 27% to 21% (ABS 1994).

An audit by the Centre for Excellence in Indigenous Tobacco Control produced the following recommendations to improve and strengthen Indigenous tobacco control (Adams & Briggs 2005):

- Improve representation of Indigenous people on boards, advisory groups and in partnerships for tobacco control.
- Each state and territory should establish a process to ensure Indigenous tobacco control initiatives are sustainable and consistent.
- Tobacco control training for Aboriginal health workers should be supported through accredited training delivery.
- Professional development training in Indigenous tobacco control should be available.
- Organisations that fund tobacco control research should direct a proportion of their funding to Indigenous tobacco control research.
- Tobacco control research should include Indigenous people.
- Improve accountability of tobacco control organisations to provide services to Indigenous people.
- Develop an Indigenous tobacco control strategy.
- Provide a more consistent approach to tobacco control education for young Indigenous people in schools.
- Improve access to nicotine replacement therapies.

Initiatives for other disadvantaged groups

Projects targeting people with mental illness, people in custodial settings, people in disadvantaged areas, and people with limited English skills operate in some state and territory jurisdictions (MCDS 2004).

Research, evaluation, monitoring and surveillance

The National Drug Strategy Household Survey, which is conducted every three years, provides comparative data for adult smoking prevalence, but only limited data is currently available for Aboriginal and Torres Strait Islander peoples and particular cultural groups (AIHW 2005). Australia's regular, standardised three-yearly surveys of student smoking are a valuable resource, providing reliable data about changes in children's smoking behaviour since 1984 (White & Hayman 2004). Annual evaluation of the National Tobacco Campaign has provided data about smoking knowledge, attitudes and intentions, and Australia is also contributing to the International Tobacco Control Policy Evaluation Study to provide information on how tobacco control policies affect smoking cessation (MCDS 2004).

Workforce development

Recruitment and training

Given the focus on policy and regulation, the National Tobacco Strategy has identified a need to attract more people from legal, economic, public policy and scientific disciplines to crucial research and policy jobs. In addition, the importance of the public receiving accurate information about the health risks of smoking and the effectiveness of various treatments, policies and programs requires more people skilled in media relations.

Continuing education

As well as the behavioural aspects of smoking, people working in tobacco control need to better understand the toxicology and epidemiology of tobacco use and the social, economic and legal aspects of tobacco control. Training for health professionals must also be addressed as part of a comprehensive policy to treat tobacco dependence. To this end, the Australian National Training Authority has endorsed two units of competency in smoking cessation as part of the national population health training package.

Access to crucial information

Short term strategies endorsed in the National Tobacco Strategy are to:

- better synthesise information about developments internationally
- facilitate access to relevant research evidence
- facilitate sharing of ideas and resources between states and territories
- support biennial Australasian tobacco control conferences.

Framework Convention on Tobacco Control

In 2004 the Australian Government ratified the World Health Organization Framework Convention on Tobacco Control. The objective of the convention was to protect present and future generations from the health, social, environmental and economic consequences of smoking and exposure to tobacco smoke. Countries that ratify the convention undertake to implement a range of measures relating to tobacco price and tax increases; tobacco advertising and sponsorship; regulation of tobacco products; tobacco product disclosure; packaging and labelling; education, communication, training and public awareness; cessation measures; illicit trade; sales to minors; support for economically viable alternatives; liability issues; and scientific and technical cooperation and exchange of information (WHO 2004).

Tobacco Advertising Prohibition Act

The *Tobacco Advertising Prohibition Act* was passed in 1992 to, according to section 3 of the Act, 'limit the exposure of the public to messages and images that may persuade them to start smoking, continue smoking, or use, or continue using, tobacco products'; and 'to improve public health'. Evidence shows that the Act has worked effectively as a legislative instrument to limit the exposure of the Australian public to tobacco advertising through traditional mass media forms of marketing. However, a growing evidence base also shows that the Act has been ineffective in limiting exposure through other channels of communication, to which the tobacco industry has increasingly been turning since the Act was introduced.

In August 2003, the Australian Department of Health and Ageing published an issues paper as part of the Government's review of the *Tobacco Advertising Prohibition Act*, inviting submissions to seek 'community views on the relevance of the Act'. The Cancer Council

Australia in partnership with a number of other health promotion organisations, prepared a detailed submission documenting why the Act needed amendment to help eliminate the many 'guerrilla' and 'under the radar' marketing strategies used by the tobacco industry to sustain a lucrative market base in Australia. Evidence was presented, in the submission and at hearings, of strategies that circumvented and contradicted the objectives of the Act, such as event and venue promotions; point-of-sale marketing; direct marketing and the use of databases; premiums and value-added promotions; vending machines; internet marketing; international magazines; 'buzz' marketing; sporting and cultural events; and the promotion of smoking by broadcasters, publishers, film-makers, etc.

Despite the extent of this evidence, supported by separate submissions from health promotion bodies such as the Royal Australian College of General Practitioners, in April 2005 the Australian Government announced that the *Tobacco Advertising Prohibition Act* would not be amended, as the review found it to be working well in its current form and that any gains derived from amendment would be 'insignificant'. The Cancer Council and its allies will continue to collect evidence on the tobacco industry's exploitation of loopholes in the Act. While a general review of the Act is unlikely in the near future, opportunities may exist for one-off amendments.

Trade Practices Act

The *Trade Practices Act (Consumer Product Information Standard) 1974* is the legislative instrument under which graphic warnings on tobacco packaging were approved by federal parliament in 2004 and phased in from March 2006. Further amendments to the Act may facilitate the elimination of tobacco industry innovations such as slips to conceal graphic smoking warnings on tobacco products and 'split packs' enabling people with limited funds, such as children, to pool their money and break cigarette packets in half. In fact, prompt court action from the Australian Competition and Consumer Commission forced the withdrawal of 'split packs' less than three weeks after their appearance in October 2006. While this was an encouraging outcome, the introduction of the packs demonstrates the tobacco industry's capacity to creatively exploit new markets, a capacity that evidence shows would be reduced through tighter packaging regulations under the *Trade Practices Act* and an updated and more rigorous *Tobacco Advertising Prohibition Act*.

Tobacco control: a blue chip investment in public health

Developed by the VicHealth Centre for Tobacco Control and The Cancer Council Victoria, *Tobacco control: a blue chip investment in public health* details a comprehensive framework for tobacco control investment based on analysis of the evidence. It makes recommendations for action by federal, state and territory governments and non-government organisations.

Aims

The Cancer Council endorses the objectives of the National Tobacco Strategy, which are to:

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

What needs to be achieved	How The Cancer Council Australia and its members (the state and territory cancer councils) will do this
Funding for tobacco control activities at a level that is commensurate with the scale of the harms caused, and sufficient to achieve specific declines in the prevalence of smoking	Encourage the Australian Government to set targets for smoking prevalence for Australian adults, children and among disadvantaged groups Encourage the Australian Government to allocate adequate funds for comprehensive tobacco control programs to achieve these targets Continue to develop proposals for funding sources and/or economic assessments to assist in obtaining the required level of tobacco control funding
Informing and reminding smokers about the harms of smoking, and motivating them to quit smoking	Advocate for the development and implementation of a well-funded and evaluated social marketing campaign Participate in national collaboration on the delivery of social marketing campaigns
Eliminating the promotion and marketing of tobacco	Urge the Australian, state and territory governments to eliminate loopholes in the current legislation and address the remaining avenues of promotion and marketing of tobacco, with a particular focus on: • images that portray smoking as desirable, in movies and other popular culture • vending machines and mobile retailing of tobacco • marketing through pack design • Internet advertising and sales display of tobacco products in retail settings • sale of devices designed to conceal health warnings Continue to identify, document and report any examples of promotion and marketing of tobacco and its effect on attitudes, knowledge and behaviour of smokers or those at risk of taking up smoking
Regulating tobacco products to protect the public interest	Urge the Australian, state and territory governments to regulate tobacco products to protect the public and smokers, by: • introducing stronger mechanisms to prevent false or misleading claims by the tobacco industry about its products • banning the use of additives in cigarettes that aid palatability and addictiveness • requiring that all cigarettes in Australia meet standards for reduced fire risk • banning filter venting as part of cigarette design • requiring that tobacco companies publish detailed information about the contents, emissions and design features of all tobacco products Encourage the Australian, state and territory governments to adopt licensing schemes to regulate the retailing of tobacco products Continue to identify, document and report problems that arise from the absence of regulation of tobacco products, and the harms caused to smokers as a result Together with public health groups, examine options and opportunities for improved regulation of tobacco products

What needs to be achieved	How The Cancer Council Australia and its members (the state and territory cancer councils) will do this
Further real increases in the price of tobacco products	Encourage the Australian Government to increase the excise on tobacco products at least in line with increases in average weekly earnings Encourage the Australian Government to ban the sale of duty-free cigarettes in Australia Encourage governments to step up measures to prevent evasion of excise and customs duty on tobacco
Strengthening existing accountability mechanisms to hold tobacco companies to account for the effects of their unlawful conduct	Publicly expose examples of the unlawful conduct of tobacco companies, and demonstrate the ongoing effects of that conduct Encourage litigation against tobacco companies where this is in the public interest Encourage the Australian, state and territory governments to provide resources and powers to bodies charged with enforcing accountability by the tobacco industry, including the Australian Competition and Consumer Commission and state/territory heath authorities
Improvements in access to cessation support	Promote tobacco-dependence treatment as an integral component of cost-effective health care Work with governments and other parties to: • increase funding for Quit services, to meet need • implement subsidy and access arrangements for pharmacological assistance for those most in need • increase the incidence of primary health-care providers referring patients for cessation advice and assistance Facilitate the development and use of effective tailored and targeted support programs for high-risk groups, including Indigenous Australians
Protection of people from involuntary exposure to second-hand smoke and increasing the number of smoke-free public places	Urge state and territory governments to enact strong measures to create smoke-free environments with a particular focus on: • ensuring that legislation in relation to smoke-free pubs and clubs eliminates exposure to second-hand smoke • ending the exemptions to smoke-free legislation currently provided to high-roller rooms and other selected gambling venues • outdoor dining areas • addressing the need for cars carrying children and pregnant women to be smoke-free • health facilities and campuses Collaborate with the higher education sector and individual institutions to encourage smoke-free campuses Continue to conduct research to demonstrate the importance of smoke-free environments in protecting health, assisting smokers to quit, and changing public attitudes towards smoking

What needs to be achieved	How The Cancer Council Australia and its members (the state and territory cancer councils) will do this
Development of targeted tobacco control strategies for Indigenous Australians and others at high risk	Encourage and support the development of a national tailored tobacco control strategy for Indigenous Australians, in collaboration with the National Aboriginal Community Controlled Health Organisation and other Indigenous health groups Encourage governments to provide adequate funding and other resources for the implementation of a tailored tobacco control strategy for Indigenous Australians Continue to identify, document and report on tailored tobacco control interventions for disadvantaged groups
Timely implementation of Australia's obligations under the Framework Convention on Tobacco Control	Monitor, and report on, progress of implementation of Framework Convention on Tobacco Control measures in Australia
Effective implementation and further development of the Framework Convention on Tobacco Control internationally and regionally	Support Framework Convention on Tobacco Control implementation in developing countries in the Western Pacific region Encourage the Australian Government to play a leading role in the further development of the Framework Convention on Tobacco Control, including developing guidelines, protocols and compliance monitoring

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