National Tobacco Strategy, 2004–2009:
The Strategy

Ministerial Council on Drug Strategy
November 2004

This document was endorsed by the Ministerial Council on Drug Strategy at its meeting in Brisbane on 12 November 2004.

The document was prepared for the Ministerial Council by a consultant with advice from the former National Expert Advisory Committee on Tobacco and supported by the Intergovernmental Committee on Drugs.

The following additional resource documents, produced to assist with development of jurisdictional action plans, can be accessed on the internet at www.nationaldrugstrategy.gov.au

- *National Tobacco Strategy, 2004–2009: Guide to Planning and Investing in Tobacco Control*
- *National Tobacco Strategy, 2004–2009: Definitions and Data Sources for Key Indicators*
- *National Tobacco Strategy, 2004–2009: Meeting the Challenges of the Next Five Years*
  1. *More efficiently regulating tobacco: Ideas and Resources*
  2. *Increasing promotion of Quit and Smokefree messages: Ideas and Resources*
  3. *Improving services and treatment for smokers: Ideas and Resources*
  4. *More usefully supporting parents, carers and educators: Ideas and Resources*
  5. *Addressing social, economic and cultural determinants: Ideas and Resources*
  6. *Tailoring to ensure access for disadvantaged groups: Ideas and Resources*
  7. *Improving information to fine-tune policy: Ideas and Resources*

See also:

- *National Tobacco Strategy, 1999 to 2003–04: Tobacco Bulletin Number 6–Summary of Achievements*
- *Ministerial Council on Drug Strategy. The National Drug Strategy: Australia's Integrated Framework, 2004–2009*

Copies of the Strategy are available on the internet at
http://www.nationaldrugstrategy.gov.au

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Executive Summary

Australia has a strong record of achievement in tobacco control.

Much more, however, remains to be done.

Around 3.5 million Australians still smoke regularly, including around one in five adults and a quarter of young adults (aged 18 to 25 years).

Comprehensive tobacco control strategies that increase the price of tobacco products and change social attitudes to smoking through regulation and hard-hitting campaigns *do* reduce tobacco use.

In a recent study, economists valued the savings associated with avoided deaths and related declines in illness and disability due to reduced tobacco use in Australia over the last 30 years at $8.6b. They estimated that $2 has been saved on health care for each $1 spent on tobacco control programs to date. Total economic benefits are estimated to exceed expenditure by at least 50 to 1. It is difficult to imagine any other public expenditure providing social returns of this magnitude.

The Australian Government has recently reiterated its determination to reduce tobacco use by ratifying the World Health Organization's Framework Convention on Tobacco Control.

The National Tobacco Strategy 2004–2009 is a statement of our resolve as federal, state and territory governments to work *together* and *in collaboration with non-government agencies* on a *long-term, comprehensive, evidence-based* and *coordinated* national plan to reduce the often hidden but nevertheless very real misery and wasted human potential caused by tobacco smoking in Australia.

The **goal** is to **significantly improve health and to reduce the social costs caused by, and the inequity exacerbated by, tobacco in all its forms.**

The objectives of the Strategy 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; and where feasible, to reduce harm associated with continuing use of and dependence on tobacco and nicotine.**

The National Tobacco Strategy is a comprehensive approach to reducing tobacco-related harm. Jurisdictions will:

- further use regulation to reduce the use of, exposure to, and harm associated with tobacco;
- increase promotion of *Quit* and *Smokefree* messages;
- improve the quality of, and access to, services and treatment for smokers;
- provide more useful support to parents, carers and educators helping children to develop a healthy lifestyle;
- endorse policies that prevent social alienation associated with uptake of high risk behaviours such as smoking, and advocate policies that reduce smoking as a means of addressing disadvantage;
- tailor messages and services to ensure access by disadvantaged groups; and
- obtain the information we need to fine-tune our policies and programs.

Further use of regulation

1. Actions to minimise commercial conduct that results in ill-informed, non-voluntary and unnecessarily harmful and costly use of (and exposure to) tobacco products:
   - eliminate remaining forms of tobacco promotion;
   - dramatically reduce the visibility of tobacco products and their accessibility to young people;
   - recommend measures to make tobacco products less affordable;
   - eliminate remaining exposure to environmental tobacco smoke among workers in many blue collar workplaces, including very high rates of exposure in pubs and clubs, and address remaining exposure among clients and staff in publicly-funded (residential) mental health, health care and correctional facilities;
   - develop a system which provides accurate and timely advice to consumers about the health risks of smoking; and
   - develop a regulatory system for tobacco products (and products designed to replace tobacco products) that allows us, if feasible, to reduce overall harm associated with dependence on tobacco-delivered nicotine.

Increased promotion of *Quit* and *Smokefree* messages

2. Conduct evidence-based campaigns to personalise the health risks of smoking, to discourage smoking around children, to encourage smokers to quit sooner rather than later and to make use of available treatments and services.

Improved services and treatment for smokers

3. Improve the quality and acceptability of services to assist smokers to quit, and ensure that effective treatments are available and affordable to all Australian smokers. Jurisdictions will devise and operate a set of interlinking policies and programs to more effectively treat tobacco dependence, especially among: expectant and new parents; people suffering chronic disease; people living in institutions; and other high-need and high-risk groups.

More useful support to parents and educators

4. Support those trying to help children to develop knowledge, attitudes and capacities protective against smoking: run campaigns and programs to encourage parents to quit; assist parents and carers, schools and community organisations to establish clear and consistent rules about smoking; and provide information and resources that will enable tobacco to be covered across the school curriculum.

Endorsement of policies that address causes of disadvantage

5. In addition to the above measures – all of which should help to reduce smoking among disadvantaged groups:
   - endorse policies that may help prevent educational failure and reduce family conflict, both highly predictive of smoking uptake; and
   - advocate that assistance to reduce smoking be included in child development, family support and overseas aid programs.

Tailoring for disadvantaged groups

6. Provide tailored messages and support for people for whom the burden of tobacco use is particularly high and who face barriers in accessing services, that is, among: Aboriginal

and Torres Strait Islander peoples; people with a severe and disabling mental illness; others who are institutionalised, including those in custodial settings; parents and carers in disadvantaged areas; smokers in rural and remote regions; and people from certain cultural backgrounds.

More focused research and evaluation

7. Develop a priority-driven research agenda; get better information about the perceptions and needs of smokers and about public attitudes to tobacco control; trial promising new approaches; address gaps in monitoring and surveillance systems; continue to monitor overall progress in achieving desired impact and outcomes; and adjust program and policy components as required.

Each Australian jurisdiction is able to develop or update an action plan describing efforts to meet each of these challenges.

The National Tobacco Strategy at a glance

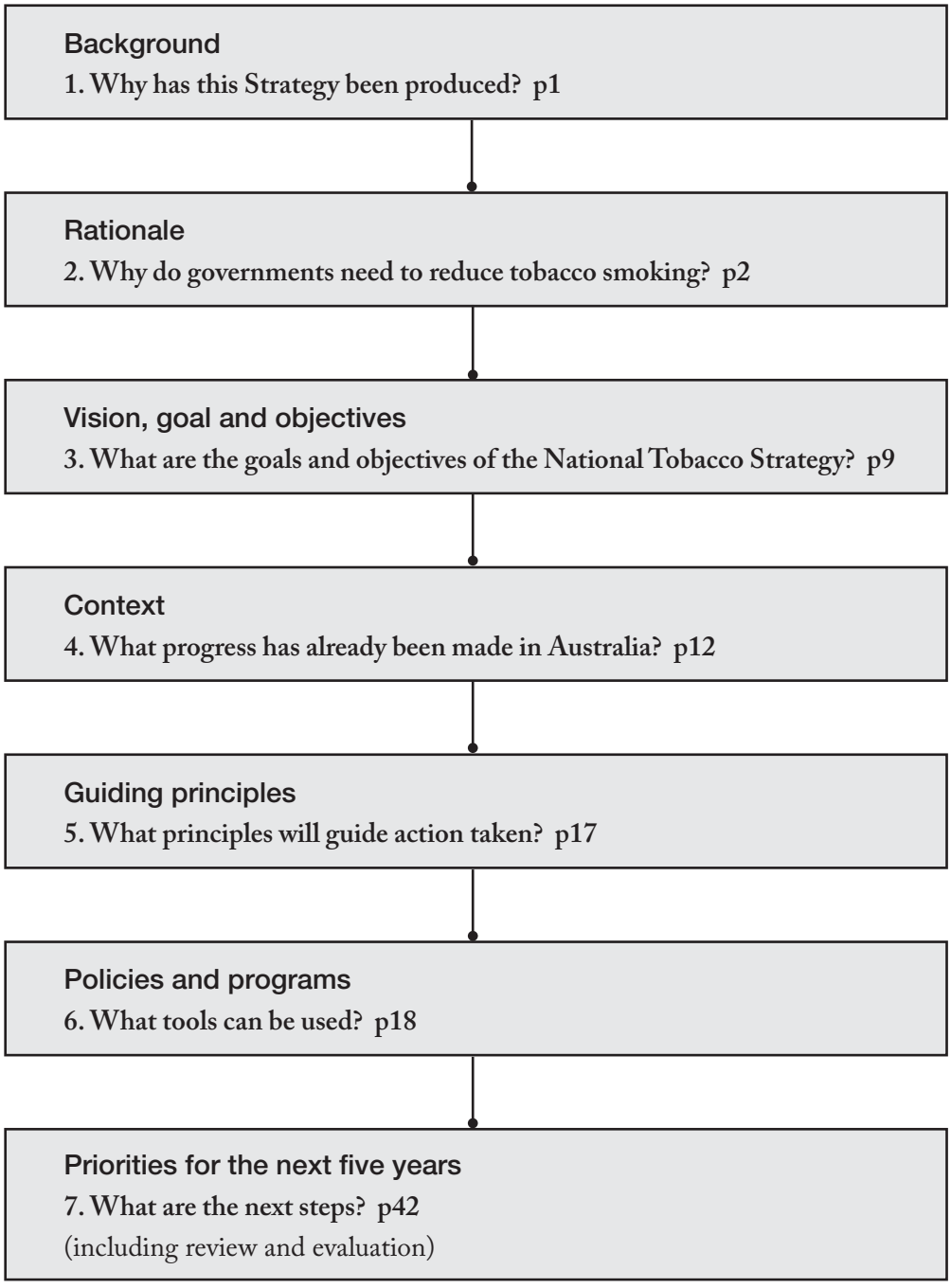


Table of contents

Executive Summary iii

The National Tobacco Strategy at a glance vi

I. Why has this Strategy been produced? 1

2. Why do governments need to reduce tobacco smoking? 2

2.1 Smoking: a free and informed choice? 2

2.1.1 Imbalance in knowledge between consumers and providers 2

2.1.2 Addiction: an anathema to freedom of choice 2

2.1.3 An adult choice, or an error of youth? 3

2.2 Smoking: a tragic waste of human potential 3

2.3 Smoking: a major driver of health system costs 4

2.4 Smoking: a drain on business profits 6

2.5 Smoking: a burden on the entire community 6

2.6 Smoking: an effect of *and* a contributor to social inequality 7

3. What are the goals and objectives of the National Tobacco Strategy? 9

3.1 Goal of the National Tobacco Strategy 9

3.2 Measures of achievement 9

Stronger families, stronger children 9

Healthy and independent ageing 9

Sustainable health care systems 9

Greater profits for Australian businesses outside the tobacco industry 9

A stronger economy 10

Stronger communities 10

Improved Indigenous health 10

Less harm from illicit drugs 10

3.3 Objectives of the National Tobacco Strategy 10

3.4 Objective outcomes 10

Reduced uptake 10

Increased cessation 11

Reduced exposure for non-smokers 11

Reduced harm from use of and dependence on tobacco and nicotine 11

Equity 11

4. What progress has already been made in Australia? 12

4.1 How much has consumption of tobacco reduced? 12

4.2 What problems remain? 14

4.2.1 Smoking uptake 14

4.2.2 Continuing smoking 14

4.2.3 Exposure among non-smokers 15

4.2.4 Harm from continuing use of tobacco 15

4.2.5 Differentials between advantaged and less advantaged groups 15

5. What principles will guide action taken? 17
5.1 Being as effective as possible 17
5.2 Being as efficient as possible 17
5.3 Striving for greater equity 17
6. What tools can be used? 18
6.1 Regulation of tobacco 19
6.1.1 Regulation of Promotion 19
6.1.2 Regulation of Place of sale 20
6.1.3 Regulation of Tobacco Tax 21
6.1.4 Regulation of Place of use 22
6.1.5 Regulation of Packaging 23
6.1.6 Regulation of Products 24
6.2 Promotion of Quit and Smokefree messages 27
6.3 Cessation services and treatment 29
6.4 Community support and education 34
6.5 Addressing social, economic and cultural determinants of health 35
6.6 Tailoring initiatives for disadvantaged groups 37
6.7 Research, evaluation and monitoring & surveillance 39
6.8 Workforce development 40
7. What are the next steps? 42
7.1 What are the most important challenges for the next five years? 42
7.1.1 Further use of regulation 42
7.1.2 Increased promotion of *Quit* and *Smokefree* messages 43
7.1.3 Improved services and treatment for smokers 43
7.1.4 More useful support for parents and educators 43
7.1.5 Endorsement of policies that address causes of disadvantage 43
7.1.6 Tailoring for disadvantaged groups 44
7.1.7 More focused research and evaluation 44
7.2 Who is responsible? 44
7.2.1 Towards a collaborative approach 45
7.2.2 Who will do the work? 45
References 46
Attachment 1. Organisations consulted in the process of development 57

1. Why has this Strategy been produced?

In the hour that you might spend reading this document, two more Australians will have died due to smoking.

For every Australian who dies in a motor vehicle accident more than ten die prematurely due to tobacco[1,2]. Each year more than 4,000 Australians aged between 35 and 64 die due to smoking, robbing them, their families and the community of what ought to have been the most productive and rewarding years of their lives.

More than 19,000 Australians will die over the next year from illnesses caused by tobacco[2]. And the year after that, and for many years to come, unless something is done now.

Tobacco use, more than any other single factor, contributes to the gap in healthy life expectancy between those most advantaged and those most in need.

The National Tobacco Strategy 2004–2009 is one of a series of strategies that together form the National Drug Strategy 2004–2009[3]. It builds on the previous five-year strategy that started in 1999[4].

In line with guidelines for the development of national strategies published by the National Public Health Partnership[5], the Ministerial Council on Drug Strategy (MCDS) devised the Strategy with the help of major government and non-government agencies active in tobacco control in Australia (see Attachment 1 for a list of organisations consulted).

Our approach is informed by what has been done in Australia to date, international research on the effectiveness of tobacco control strategies and the results of several important reviews and evaluations undertaken as part of the National Tobacco Strategy 1999 to 2003–04.

Importantly, however, this Strategy also highlights the need for further work and innovation. The Strategy also emphasises linkages to other policy areas and stakeholders, such as business and welfare, with a view to developing broader partnerships.

The pages that follow summarise what is known about the extent of smoking in Australia, the scale of harm caused, and what works to promote cessation and to reduce tobacco uptake and exposure.

The Strategy includes background information relevant to each policy and program, and a justification for a focus on selected priority groups. It describes what is hoped to be achieved, how the problem will be tackled, the principles which underlie the approach, the way it will be managed and how progress will be assessed.

States and territories can develop their own action plans to ensure that fewer young people take up smoking; to encourage and assist smokers to quit; to reduce exposure to environmental tobacco smoke; and, if possible, to reduce harm among those who continue to use tobacco.

The National Tobacco Strategy 2004–2009 is a statement of our resolve as federal, state and territory governments to work *together* and *in collaboration with non-government agencies on a long-term, comprehensive, evidence-based* and *coordinated* national plan to reduce the often hidden but very real misery and wasted human potential caused by tobacco smoking in Australia.

2. Why do governments need to reduce tobacco smoking?

Two factors justify governments getting involved in discouraging people from smoking. First, the majority of smokers are not making a free and informed choice to smoke. Second, tobacco use imposes substantial costs on smokers and their families, taxpayers, businesses and the community as a whole.

2.1 Smoking: a free and informed choice?

It is often said that smoking is a personal lifestyle choice. This ignores the superficial nature of smokers' understanding of health risks, the reality of addiction, and the fact that the majority of users start and become dependent on tobacco-delivered nicotine before they are adults.

2.1.1 Imbalance in knowledge between consumers and providers

While consumers are generally aware that tobacco smoking is harmful, many still underestimate the extent of the danger relative to other lifestyle risks.

Few smokers are able to accurately estimate their chances of dying in middle age[6]. Most are able to name only a handful of the numerous diseases caused by smoking[7]. Smokers also have little understanding of how tobacco-related illnesses could affect the quality of their lives. Few, for instance, understand that emphysema – one of the most common diseases caused by smoking – is irreversible, life-threatening and incurable[8]. Many young women do not know that smoking reduces fertility[9,10]. Many young parents do not know that smoking around children increases their risk of meningococcal disease[11].

Evidence from internal tobacco company documents released as part of settlements by tobacco companies with US state Attorneys General[1], indicates that, for years, companies were aware of the harmful effects of tobacco and the dependence-producing qualities of tobacco-delivered nicotine, but have failed to adequately warn consumers about the risks.

2.1.2 Addiction: an anathema to freedom of choice

The addictive nature of tobacco products[2] further compromises the consumer's ability to make an informed choice.

Addiction by its very nature distorts thinking processes, giving prominence to thoughts which justify continuing the addictive behaviour, and minimising or excluding consideration of reasons for ceasing it.

1 Over 2.1 million documents from Philip Morris, Lorillard, Council of Tobacco Research and US Tobacco Institute have been placed on company websites as part of a Master Settlement Agreement with US Attorneys General. In addition to the collections from the US-based companies, a huge depository of documents from the British American Tobacco Company and its subsidiaries has been established at Guildford in England. See the extensive Legacy Tobacco Documents Library http://legacy.library.ucsf.edu/ at the Center for Knowledge Management at the University of California, San Francisco.

2 As with other drugs such as cocaine, heroin and alcohol, nicotine can produce psycho-active effects, mood alterations, strong reinforcing effects, physical dependence and tolerance. Based on these criteria for drug dependence developed by the World Health Organization, the US Surgeon General has concluded that nicotine as delivered by tobacco smoking is addictive.

Tobacco-delivered nicotine alters the dopamine and other brain neurotransmitter systems. Some of these changes appear to remain long after use ceases – the so-called "changed-brain syndrome"[12].

Nearly 80% of Australian smokers have tried in the past to quit but have been unsuccessful[7]. On any single attempt to stop smoking, unaided, more than 95% of smokers will fail[13]. Quitting is often described by ex-smokers as the hardest thing they have ever done.

2.1.3 An adult choice, or an error of youth?

More than 90% of Australians who currently smoke began as teenagers[14]: most new users are young people, many as young as 14, 13 and even 12 years of age[15,16].

Nicotine exposure during adolescence produces immediate and long-lasting changes in central noradrenaline and dopamine brain pathways[17]. Scientists now believe that young brains are even more sensitive to nicotine than the brains of older people, and that young people may be more prone to becoming dependent on tobacco-delivered nicotine[18]. The vast majority of teenage smokers show signs of such dependence before they reach the age at which they are regarded as mature enough to be allowed to vote, drive or purchase alcohol[19].

The earlier that young people start smoking, and the more they smoke over their lifetime, the more likely they are to suffer from smoking-related disease. Tobacco affects the body with every puff of smoke, and illness is not so much a matter of *whether* as a matter of *when*. The seeds of emphysema, cancer and heart disease are all sown from the very early stages of use, with recent evidence of circulatory damage to young smokers[20]. Exposure to tobacco smoke during puberty and other critical periods of development of breast tissue may increase the likelihood of breast cancer[21].

Almost 90% of adult Australian smokers now say they wish they had never started using tobacco products[22] but each year around 45,000 Australian teenagers make the transition to regular smoking[16].

2.2 Smoking: a tragic waste of human potential

International studies show that half of all long-term smokers will die prematurely, half in middle age[23,24]. Most people who die in their 40s or 50s due to heart disease are smokers[25] – smokers are four times more likely than non-smokers to suffer a heart attack before the age of 40[26] – and 1,829 Australians between the age of 35 and 64 are estimated to have died in 1998 due to cancer caused by smoking[2]. Smokers are more than three times more likely than non-smokers to die in middle age[24].

But it is not just a question of length of life.

Long-term smokers suffer more disease and disability before they die at younger ages: on average they suffer reduced quality of life for a greater number of years than non-smokers [27]. In addition to the crippling effects of chronic obstructive lung disease and stroke, disabilities exacerbated by smoking include reduced mobility from arthritis[28–30], vision and hearing loss[31–33], loss of fertility [9,10,34], and impotence[35–38].

Not all the health care costs attributable to tobacco are covered by the public purse. In 1998–99, treatment of illness caused by smoking cost smokers and their families more than $145m[3][41].

3 See Table 43 on page 62 of Collins and Lapsley 2002

Addicted smokers who spend their money on tobacco products could be buying other goods and services that would provide much greater benefit to them and to their families. In 2003–04, Australian smokers diverted more than $10b[39] on a product that the vast majority wish they could stop using[22].

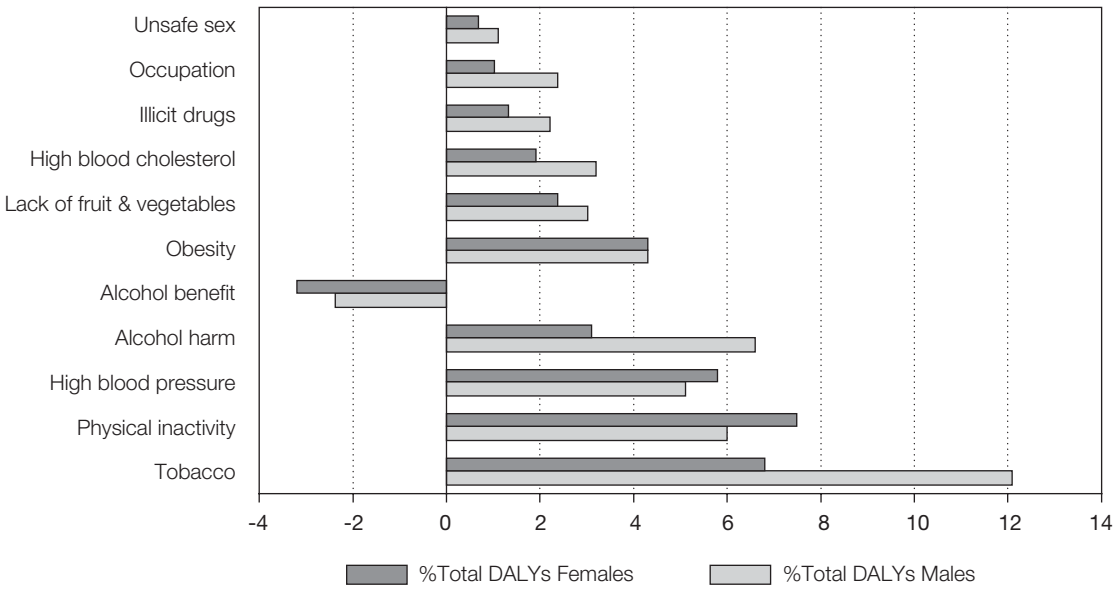
And these are just the tangible costs.

While it is possible to estimate the value of spending foregone, health care costs, lost earnings and even reduced quality of life[4], much more difficult to quantify is the devastating grief of losing a child, a partner, a parent, a friend or a colleague who dies tragically early[2].

2.3 Smoking: a major driver of health system costs

Smoking contributes more to the burden of disease and disability than any other identifiable risk factor (see Figure 1).

Figure 1. The burden of diseases in Australia attributable to 10 major risk factors



Source: AIHW Burden of Disease and Injury in Australia, 1999[40], Chapter 7

Smoking during pregnancy causes up to one quarter of cases of low birthweight[2], a major contributor to costs of antenatal care and a predictor of developmental delays and of ill health in childhood and the rest of life.

4 Collins and Lapsley estimate the total value in 1998–99 of the loss of one year's living at $13.48b, based on an average value of $46,894. They do not attempt to value pain and suffering – both in smokers and those around them – due to illness and deaths caused by tobacco use.

Tobacco smoking contributes to the development of all major chronic diseases and other health conditions nominated as Australian national health priorities (as indicated by the clean sweep of "E"s in Table 1 below). The causes of most conditions are multi-factorial, but no other identified risk factor is as pervasive as tobacco.

Table 1. National Health Priority Areas and common risk factors

		National Health Priority Areas								
			Chronic Diseases					Other		
Risk and protective factors			Heart disease & stroke*	Diabetes*	Cancers*	Asthma*	Arthritis	Mental Health*	Injury*	
		Tobacco*	E	E	E	E	E	E+	(E)[5]	
Additional impact of tobacco		Alcohol misuse*	E		E			E+		
		Hypertension	E							
	E	Dyslipidemia	E							
		Diet*	E	E	E		E			
		Physical activity*	E	E	E		E	E	E	
		Obesity*	E	E	E		E			
		Chronic stress	P	P				E		
		Social support	E	P				E		
	E	Depression*	+	P	+	+		E		
	E E	Early life factors (e.g. low birth-weight, infections abuse/neglect)	E	E	P	P	P	E	P	
		Low socio-economic status through…	E	E	E	P		E	E	
	E	less resources for health care;								
	E	passive smoking;								
	E	peer example, cultural norms on risk factors;								
	E	lack of empowerment								

E = established risk/protective factor; + = association/co-morbidity; P = possible risk factor; * indicates current national population health strategy in existence or close to completion

Source: Last seven columns from National Public Health Partnership. Preventing Chronic Disease: A Strategic Framework Background Paper, NPHP, October 2001, p 23, which adapted Brownson et al, Chronic Disease Epidemiology and Control, APHA, 1998; Wilkinson and Marmot (eds). Determinants of Health: The Solid Facts, WHO, 1998; Australia Health 2000 AIHW, 2000: Global NCD Risk Factor Surveillance WHO 2000.

5 Smoking often causes fires – not one of priority areas for the National Injury Prevention plan, but nevertheless a considerable cost for state governments funding fire services and hospital burns units.

The gross costs in Australia[6] of treating that proportion of major diseases attributable to smoking were estimated in a recent study to have totalled around $2.25b in 1998–99[41]. This is almost equivalent to the entire annual cost of the Pharmaceutical Benefits Scheme in 1997–98, the previous year[7]. The researchers warn that this is almost certainly an underestimate: they were unable to obtain accurate estimates for tobacco-attributable costs of ambulance services, domiciliary care and services by allied health professionals.

Note also that these estimates are based only on those conditions for which scientists have calculated the tobacco-related risk. The study did not attempt to quantify the cost of treating illness and disability for the many other conditions that are known to be adversely affected by smoking – highly prevalent and costly diseases such as diabetes[42] and upper respiratory tract infections[43]. Recent research indicates that treating smokers is likely to cost more, on average, than treating non-smokers. This is due to slower wound healing and the greater incidence of complications among smokers[44,45].

2.4 Smoking: a drain on business profits

Greater even than the costs attributable to tobacco use that are borne by government are those costs borne by business.

Smoking reduces the productivity of the paid workforce through absenteeism – estimated to total $1.07b in 1998–99[41] – and premature loss of highly experienced employees[8]. Even more significant are the profits foregone on sales of goods and services consumed by smokers involuntarily using tobacco ($1.4b net of sales taxes in 1998–99)[9] and of people who die early due to tobacco-caused disease (estimated to have totalled at least $4.3b in 1998–99)[41].

2.5 Smoking: a burden on the entire community

Over the past 50 years, more than 700,000 Australians are estimated to have died prematurely due to tobacco use[46].

Smokers who die early or become incapacitated due to tobacco-related disease can no longer contribute to the unpaid economy. This greatly increases the costs and time spent by other individuals on tasks such as housework, home repairs and caring for children, the elderly and disabled. The value of this labour for the year 1998–99 is estimated at $6.88b[41], the biggest single tangible cost of tobacco use (see Table 2).

The best, though conservative and incomplete, estimate of the net total tangible costs[10] of tobacco use in Australia in 1998–99 is almost $7.59b. The total value in 1998–99 of the intangible cost to smokers of the loss of one year's living is conservatively estimated at $13.48b[11], bringing the total estimated social costs of tobacco use to $21.06b.

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6 Note that estimates of total social costs in Table 2 are based on net costs, taking into account the costs avoided when a proportion of smokers die early.

7 See reports on Health Insurance Commission website.

8 The reduction in the size of the workforce in 1998–99 due to deaths from tobacco-related disease is estimated at > $1.45b.

9 Collins and Lapsley define involuntary use as all use by any person who smokes more than five cigarettes per day, the level of use associated with development of dependence.

10 This takes into account consumption resources saved.

11 Collins and Lapsley did not attempt to value pain and suffering of smokers and their families and friends.

Table 2. Incidence of tangible costs in 1998–99 associated with past and present tobacco abuse (current prices, $m)

	Borne by individuals	Borne by business	Borne by government	Total
Workforce labour		2,063.5	456.0	**2,519.5**
Household labour	6,880.0			**6,880.0**
Health care costs	145.3	69.9	879.6	**1,094.9**
Fire	7.0	13.6	5.7	**26.3**
Resources used in addictive consumption	0	1,402.1		**1,402.1**
Total	**7,032.4**	**3,549.1**	**1,341.3**	**11,922.8**

Source: Collins and Lapsley 2002[41], Table 5.32, p62

Smokers not only involuntarily bear the majority of the costs of tobacco use; they also transfer significant revenue in the form of taxes they pay on tobacco to the rest of society. Revenue from excise duty on tobacco products is expected to total $5.2b in 2004–05 (Budget 2004–05, Budget Paper 1)[47].

2.6 Smoking: an effect of *and* a contributor to social inequality

The greatest burden of illness and costs due to tobacco occurs among households in the lowest quintile of social advantage[48–50]: smoking is most devastating for those who can least afford it[51].

Many of the factors which underlie social disadvantage are also strongly predictive of smoking uptake. The job prospects of young women who leave the education system early to have a baby are severely curtailed. Between 40% and 60% of lone mothers live in poverty compared to only 14% of couples with children[52]. At 37%, their smoking rates are double those of women with partners[53].

Over a lifetime, tobacco use is not just an effect but also a contributor to poverty which in turn undermines health.

As pointed out in a background paper on preventing chronic disease produced by the National Public Health Partnership (NPHP)[54], smoking is the biggest single contributor to the huge disparity in health status between more and less advantaged groups[55].

By way of example, the NPHP sketches out these influences as they relate to the development of cardiovascular disease (see NPHP, 2001, Figure 6[54]).

In addition to increasing the risk of sudden infant death, foetal exposure to tobacco smoke and low birth-weight – a consequence of such exposure and much more common in low-income groups – establishes predispositions to developmental disorders and illnesses in childhood and to several chronic diseases in adulthood[56]. Smoking among adolescents causes the development of symptoms that are precursors to atherosclerosis. Continuing smoking results in a plethora of acute and chronic health problems.

Less obvious, however, and not pointed out in the NPHP background paper, is the ongoing contribution of tobacco use to economic disadvantage itself.

Exposure to environmental tobacco smoke increases the frequency of asthma and many other common childhood illnesses that result in school absences[57]. Absenteeism is strongly associated with, and must contribute to, poor school performance, which in turn reduces educational and training opportunities and long-term job prospects.

Expenditure on tobacco (up to $50 a week for each pack-a-day smoker[12]) impoverishes low-income households, reducing funds available for many other purposes. Long-term expenditure reduces the capacity of families to purchase homes and save for retirement.

Higher levels of smoking among people in disadvantaged circumstances are often attributed to high levels of stress. But there is also emerging evidence that tobacco affects stress-managing neural pathways and therefore may reduce capacity to deal with the challenges of life[58]. Smoking also contributes to the development of depression[59].

Early disablement and death of breadwinners – again much more common in low-income households – further reduces the income and long-term financial security of families, and the grief resulting from loss of a child or premature loss of a partner or parent is also a significant cause of depression[60], in turn a cause of cardiovascular disease[61].

12 Based on average 18 cigarettes per day, and RRP for a pack of Peter Jackson 30s, May 2004

3. What are the goals and objectives of the National Tobacco Strategy?

The Strategy will contribute to **making Australia a healthier, more prosperous and more equitable country.**

3.1 Goal of the National Tobacco Strategy

The goal is to **significantly improve health and to reduce the social costs**[13] **caused by, and the inequity exacerbated by, tobacco in all its forms.**

3.2 Measures of achievement

Investment in tobacco control should reduce smoking, overall population exposure to tobacco toxins and harm caused by smoking, yielding the following major social and economic returns:

Stronger families, stronger children

- fewer Australian families, particularly low-income families, devastated by early death or serious disability from smoking-related disease or injuries in house fires
- fewer children from low-income families further disadvantaged by poorer overall health and development, and expenditure on tobacco at the expense of other goods

Healthy and independent ageing

- a greater number of people better able to enjoy their grandchildren or leisure in retirement
- fewer trips to hospital for those managing chronic conditions
- fewer people with serious health problems unable to remain in their own homes
- less need for pensions and benefits with fewer people suffering major disability caused by smoking and more people able to save sufficiently for retirement

Sustainable health care systems

- fewer demands on public hospitals and other health services
- lower demand for pharmaceutical and medical benefits

Greater profits for Australian businesses outside the tobacco industry

- potential increases in expenditure on other goods and services by those who no longer purchase tobacco
- lower insurance costs due to fewer fires and reduced exposure to environmental tobacco smoke

13 Social costs include both tangible costs – health care costs borne by governments and individuals, lost productivity in households and workplaces, resources used to purchase products by those unable to stop voluntarily – and intangible costs – pain, suffering, grief and lost opportunities for enjoyment suffered by smokers and their families and friends.

A stronger economy

- a very large expansion in demand for goods and services due to increased spending by many people – people who would otherwise die prematurely – living longer and more active lives
- improved productivity with fewer smoking breaks, less absenteeism and fewer experienced employees dying or retiring ill in middle age

Stronger communities

- fewer demands on, and more people contributing to, the unpaid economy
- fewer communities and national parks and less bushland devastated by bushfires
- less litter

Improved Indigenous health

- fewer deaths and less disability caused by heart attacks, diabetes, chronic lung disease and cancer, preventable conditions responsible for over 90% of the burden of disease among Aboriginal and Torres Strait Islander peoples

Less harm from illicit drugs

- fewer children taking up illicit drugs[14].

3.3 Objectives of the National Tobacco Strategy

The **objectives of the Strategy are**, among all social groups:

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

3.4 Objective outcomes

In addition to a large overall reduction in units of tobacco consumed (in total, per capita, and per smoker), by the end of the Strategy it is expected that there will be positive changes in each of the following fourteen *outcome indicators*:

Reduced uptake

1. fewer young people smoking regularly
2. substantially fewer young people making the transition to established patterns of smoking
3. fewer young adults making the transition to dependent patterns of smoking

14 The factors that prevent smoking also protect against many other high-risk behaviours. Children of parents who do not smoke are much less likely to smoke or to use illicit drugs. Encouraging parents to quit and preventing children from smoking is probably an extremely effective way of discouraging use of illicit drugs.

Increased cessation

4. fewer adults smoking regularly
5. substantially more adult smokers attempting to quit
6. substantially fewer quitters relapsing
7. a lower average number of years that users smoke prior to quitting
8. fewer longer term ex-smokers resuming smoking

Reduced exposure for non-smokers

9. substantially fewer infants exposed to tobacco *in utero* and after birth
10. fewer children exposed to smoke indoors, at home, in cars and in places where they play and are cared for
11. fewer people exposed to tobacco smoke at places they work and as they go about everyday life

Reduced harm from use of and dependence on tobacco and nicotine

12. a reduction in the propensity of Australian cigarettes to cause fires
13. a reduction in the exposure of remaining users of tobacco (or tobacco substitutes) to dangerous smoke constituents[15]

Equity

14. reductions in each of the above indicators not just in the total population, but also among disadvantaged Australians, particularly among groups whose health at present is disproportionately affected by tobacco use.

15 Exposure to tobacco might be reduced by replacing some or all tobacco products with medicinal nicotine or other nicotine products. It may also in future be possible to reduce the harmfulness of tobacco products. However, to reduce individual risk, the reduction would have to be significant enough to offset compensatory behaviour such as smoking more or harder. To reduce population risk, the reduction would need to be significant enough to offset any increase in uptake and any resumption of smoking by long-time ex-smokers, as well as any decline in quitting.

4. What progress has already been made in Australia?

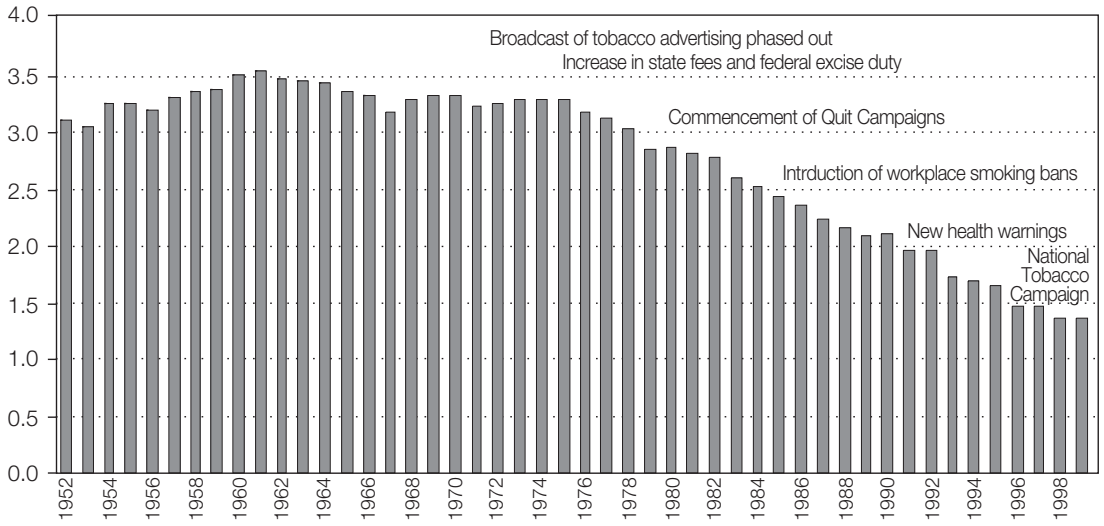
The National Tobacco Strategy 2004–2009 builds on the achievements of the previous Strategy 1999 to 2003–04[3], considerable action by state and territory governments since the early 1980s and more than 30 years of campaigning by non-government agencies.

Much has been achieved, but there is still much scope for further improvement.

4.1 How much has consumption of tobacco reduced?

Records of tobacco excise duty payments suggest that tobacco consumption in Australia has fallen substantially over the past 30 years since the introduction of tobacco control policies (see Figure 2).

Figure 2. Amount (kgs per person 15 years and older) of tobacco products (cigarettes, cigars, RYO) on which excise duty was paid, Australia 1952 to 2000



Source: Scollo, M VCTC[62]

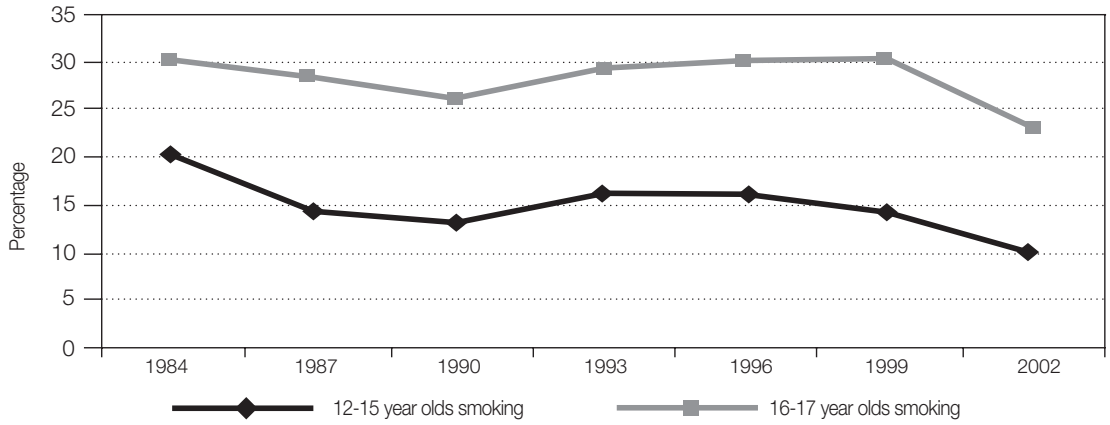
Among adult males, smoking prevalence (the percentage of adult males who report smoking regularly) dropped from 45% in 1974 to around 27% in the late 1990s; among females it fell from 30% to 23%[63].

Smoking among Australian secondary school students declined in the late 1980s, increased in the early to mid-1990s and declined again at the end of the last decade (see Figure 3).

Smoking around non-smokers has also reduced significantly, with increasing numbers[16] reporting smoking bans at work (see Figure 4) and at home (see Figure 5).

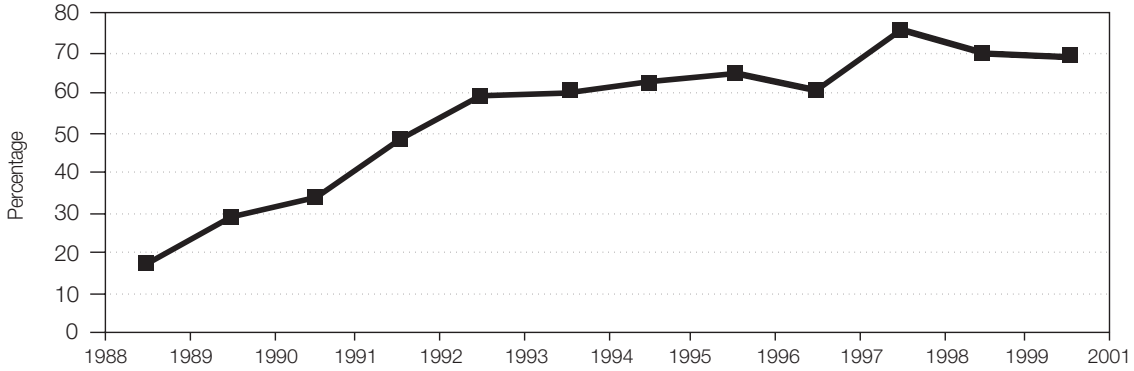
16 This data is collected regularly only in Victoria and South Australia, but data from the 1998 National Drug Household Survey paints a similar picture nationally.

Figure 3. % of 12 to 15-year-olds and 16 and 17-year-olds who have smoked in the last week, Australia 1984 to 2002



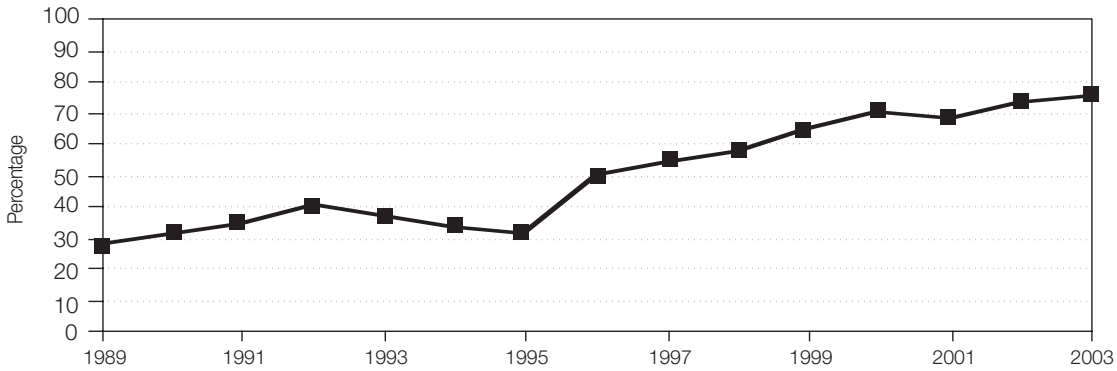
Source: adjusted data from Hill, White & Effendi, 2002[15,64] and White & Hayman, 2004[65]

Figure 4. % of indoor workers who report total smoking bans at work, Victoria 1988 to 2001



Source: Letcher and Borland, 2003[66]

Figure 5. % of adults who discourage visitors from smoking in their home, Victoria 1989 to 2003



Source: Trotter and Mullins, 2003[67]

4.2 What problems remain?

4.2.1 Smoking uptake

Figure 3 shows that in 2002 over 10% of 12 to 15-year-olds and almost a quarter of 16 and 17-year-olds smoked at least weekly.

Very large numbers of Australian school children report factors known to be strongly associated with recent use[68] and uptake[69]. These include, in order of importance:

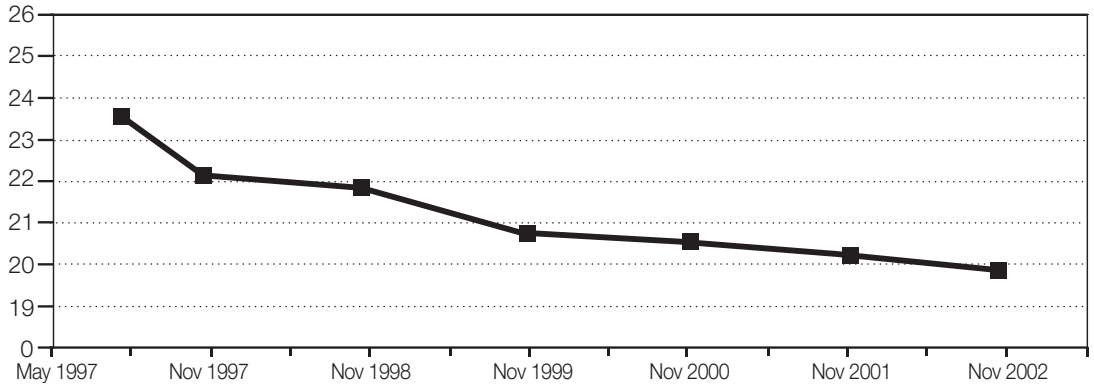
- friends smoking
- having first tried cigarettes at a young age
- favourable attitudes to tobacco
- being easily able to purchase cigarettes
- favourable parental attitudes to tobacco
- poor family discipline
- low commitment to school
- academic failure
- family conflict.

4.2.2 Continuing smoking

In 2001, 22.1% of adults (over three million Australians) smoked on at least a weekly basis[70,71], including around 30% of those in blue collar occupations[50,63].

While smoking rates fell sharply in 1997 following the launch of the National Tobacco Campaign and the start of *direct-to-consumer* advertising of nicotine replacement therapies, declines since that time have been much less significant (see Figure 6).

Figure 6. % of adults (18 years and older) who report smoking at least weekly, Australia 1997 to 2002[17]



Source: Wakefield et al[72]

17 Prevalence reported here is based on telephone surveys and is somewhat lower than the rates reported in surveys conducted by the Australian Bureau of Statistics (face to face) and the National Drug Strategy Household Survey (combination).

Many smokers are unaware of some of the major diseases caused by smoking[73], including many that are difficult to treat and severely compromise quality of life[8,74,75].

Most smokers say they want to give up eventually, however, in periods between advertising campaigns, fewer than a quarter plan to quit within the next month[76].

Without assistance, fewer than 5% of smokers who quit succeed in remaining abstinent for at least one year. Despite clear evidence that using pharmacotherapies and/or behavioural support services increases success rates, many smokers are unaware of[77], have poor understanding of, or are reluctant to use such aids[78,79].

4.2.3 Exposure among non-smokers

In 2001, 34% of people reported exposure to tobacco smoke in places where they worked[66].

In the same year, 38% of children under 12 years lived in homes where at least one adult was a regular smoker[80]. Many children still live in dwellings where smoking is allowed indoors. People with lower levels of education are less likely to report always smoking outside (42%) compared to smokers with higher levels of education (51%)[67].

In 2001, 64% of adults[18] reported being exposed to someone else's tobacco smoke in a public place in the last two weeks[81].

Data are patchy, but a combination of recent studies[82] suggests that at least 20% of younger women smoke regularly during pregnancy. This is significantly lower than the estimated 30% of women who smoked during pregnancy in the mid-1980s[83,84], but is still a major cause for concern.

4.2.4 Harm from continuing use of tobacco

More than 90% of cigarettes used in Australia are marketed as yielding less than 12 mg of "tar"[73,85,86]. Among self-described users of "lights" and "milds", around 55% state that they believe these products to be less harmful[87]. However, despite registering lower on cigarette testing machines, there is no evidence that these products deliver significantly fewer carcinogens and other toxic substances[88–90].

Compilations of available records from each state fire authority suggest that, on average, since 1997 at least 4,574 fires each year in Australia were caused directly by, and up to a further 78,894 fires could also have been associated with, cigarettes and lighters and matches used by smokers[91].

4.2.5 Differentials between advantaged and less advantaged groups

Unlike the situation in many other countries, in Australia since the advent of mass media campaigns, smoking prevalence has reduced in parallel among higher and lower socio-economic status (SES) groups[92]. Nevertheless, there remains a clear relationship between SES and smoking, with people in blue collar occupations, the unemployed and those with less formal education smoking at significantly higher rates than people in white collar jobs and those with tertiary qualifications[92,93] (see Table 3).

18 Data from South Australia only

Table 3. Correlates of tobacco use, Australia, 2001

Characteristics	Proportion >14 yrs who smoke >weekly
Education	
Tertiary qualification	11.7
No tertiary qualifications	23.2
Occupational status	
Professional	16.8
Blue collar	30.4
Marital status	
Married (including de facto)	18.7
Separated or divorced	29.3
Geography	
Urban (capital city)	20
Rural or remote	21.7
Social influences	
< 50% of friends use	16.9
> 50% of friends use	58.8

Source: National Drug Strategy Household Survey, 2001[93]

Smoking prevalence among Aboriginal and Torres Strait Islander peoples varies widely, with rates as high as 80% in some communities[94]. A recent survey of children in Western Australia found that the mothers of around 47% of Aboriginal children smoked during pregnancy[95]. In comparison, 22% of infants in the total Western Australian population are born to mothers who smoked during pregnancy[96].

5. What principles will guide action taken?

Our progress in reducing population exposure to tobacco in all its forms will depend on how well we tackle:

- the most prevalent factors still driving smoking uptake;
- the most significant barriers to smoking cessation;
- the factors driving continuing high levels of smoking in some workplaces and institutions particularly among disadvantaged groups; and
- the technical, communication and regulatory difficulties posed by the development of tobacco products (and alternative nicotine delivery systems) that potentially reduce harm resulting from continuing tobacco use and nicotine dependence.

To address these challenges the National Tobacco Strategy seeks to adopt policies and programs where there is compelling **evidence of potential effectiveness**. The intent is to be as **efficient** as possible and address the significant **inequity** that is caused or exacerbated by tobacco use in this country.

5.1 Being as effective as possible

- Adopt a comprehensive approach that addresses the cultural, pharmacological and behavioural factors that affect smoking uptake, the nature of nicotine dependence, the reinforcement of continued smoking and the process of smoking cessation.
- Build on what has been achieved so far and the lessons learned from experience and from systematic research.
- Focus on approaches most likely to advance the objectives.
- Take into account the global nature of the tobacco industry and the need, therefore, to learn from international experience and to contribute to international initiatives to halt the tobacco pandemic.

5.2 Being as efficient as possible

- Work in partnership to make better use of collective skills and resources.
- Build capacity and maintain energy and enthusiasm within the workforce.
- Assess the impact of all major new initiatives, adjusting our approach as needed.

5.3 Striving for greater equity

- Try to reach people from all sections of the community, over the course of their lives and day to day, in the settings in which they work, shop and socialise.
- Endorse efforts to address disadvantage.
- Put extra effort into initiatives for groups among whom the burden of disease and disadvantage is particularly high.

6. What tools can be used?

Comprehensive tobacco control strategies that increase the price of tobacco products and change social attitudes to smoking through regulation and hard-hitting campaigns do reduce tobacco use[97–103].

The Californian Tobacco Program, in its early phases the most comprehensive in the world, prompted reductions in tobacco consumption in California 50% greater than in the rest of the United States[104]. The American Lung Association has estimated that more than 300,000 Americans who died prematurely due to tobacco would still be alive today had all states followed the example of California and introduced similar programs in 1990[105].

The New York City Department of Health recently announced that the number of adults smoking fell 11% from 2002 to 2003, following significant tax increases, improvement in treatment services for smokers[19] and the introduction of a complete smoking ban in all workplaces including restaurants, pubs and clubs. This is the most significant one-year drop in smoking ever recorded[106]. Smoking rates declined in all ages, ethnicities and boroughs.

People who do not take up smoking are significantly less likely to develop the range of illnesses outlined in Section 2.2. However, many of the major benefits of reduced uptake can take as long as 60 years to be realised[24]. In comparison, strategies that encourage adults to quit can start to reduce deaths, disease and health care costs after just one year[107–109].

In Australia, at least 400,000 premature deaths have been averted over the past 30 years due to reduced tobacco use[110]. A recent study has valued the savings associated with these avoided deaths and related reductions in illness and disability at around $8.6b[111]. Assuming that only 10% of the reduction in tobacco use was due to Quit campaigns and other public health policies, the net benefits of such efforts would total at least $8.4b. Looking just at health care expenditure (and still assuming just 10% of the benefit), it is estimated that $2 has been saved for each $1 spent on tobacco control programs. Total economic benefits must have exceeded expenditure by at least 50 to 1.

As remarked by independent economists evaluating the impact of long-running Quit campaigns in Western Australia and Victoria, it is difficult to imagine any other public expenditure providing social returns of this magnitude[112,113].

The following sections summarise the rationale and evidence for each of eight major policies needed to reduce harm and inequity caused by tobacco: regulation of tobacco marketing (promotion, place of sale, taxation, place of use, packaging and products); promotion of *Quit* and *Smokefree* messages; cessation services and treatment of tobacco dependence; strategies to address social determinants of health; tailoring of programs to disadvantaged groups; community support and education; research, evaluation, monitoring and surveillance; and workforce development. Each section also includes an assessment of how effectively each of these policies is currently being used in Australia.

19 Including a once-off give-away of nicotine patches

6.1 Regulation of tobacco

Overall rationale for regulating tobacco

Tobacco is a unique consumer item: tobacco products cause premature death and disability when used as intended by the manufacturer; and they are addictive. No company trying to introduce cigarettes into Australia today would succeed in getting them onto the market.

One in five adults use tobacco and many are unable to stop despite numerous attempts. Prohibition is clearly an inappropriate choice for governments in these circumstances. Governments cannot solve the problem of addiction, however they can regulate the manufacture, supply, marketing, price, characteristics and use of tobacco products so as to remove barriers to smokers quitting, to protect young people and non-smokers and to ensure that costs are borne by those responsible.

By regulating tobacco we aim: to eliminate commercial conduct that contributes to ill-informed, non-voluntary and unnecessarily harmful use of and exposure to tobacco; and to ensure that the costs of addressing tobacco-related harm are borne by those who manufacture or sell tobacco rather than by other Australian taxpayers.

6.1.1 Regulation of Promotion

Rationale

Promotion of tobacco products normalises and glamourises smoking. It discourages smokers from thinking about quitting, and prompts young people to experiment with smoking, smokers to postpone quitting, quitters to relapse and long-time ex-smokers to resume. No individual or entity producing or selling tobacco should be allowed, in any way, to promote tobacco products or tobacco use. While it is a part of life and will continue to be depicted through the media, producers and directors should be encouraged not to unthinkingly or gratuitously portray smoking in ways likely to promote use.

Policy intention

> To eliminate all promotion of tobacco products by those in the tobacco trade, and to discourage and address harm caused by other positive portrayals of smoking in the media.

Evidence of effectiveness

Exposure to cigarette advertising and positive portrayal of smoking in the media is strongly related to the development of positive attitudes to smoking and smoking initiation among teenagers[114,115].

Econometric studies in high-income countries suggest that comprehensive bans on promotion reduce demand for tobacco by around 7%[98].

Recent research suggests that advertising at point of sale[116] and through the pack[117] increase positive feelings about cigarette brands.

Progress in Australia

Until 15 years ago, promotion of tobacco products was ubiquitous. Young people were bombarded with advertisements associating smoking with fun, sexual attractiveness, glamour

and sophistication. Although the *Tobacco Advertising Prohibition Act 1992* (Cth) has greatly reduced advertising through the mass media, manufacturers continue to promote tobacco products through many avenues and in many venues popular with young people[118,119]. Promotion at night clubs is common[120]. Many top-rating movies released and popular TV programs screened over the last few years depict smoking in a positive way[121]. The cigarette packet itself has become an important promotional item[120,122]. Pack displays in retail outlets have become a significant form of promotion[122], and there have been recent examples of direct-to-consumer advertising on and in the pack[123].

The Act has recently been reviewed[118] and numerous amendments have been proposed to tighten or better enforce restrictions on existing and emerging forms of advertising, and to prevent promotion of tobacco smoking and tobacco products through package design and use of colour[119].

6.1.2 Regulation of Place of sale

Rationale

Tobacco products are so dangerous and so addictive that our aim should be to discourage people from making casual or ill-informed choices to purchase them, and to prohibit people from supplying them at all to children.

The kinds of outlets from which tobacco products are allowed to be sold, how products are displayed and how they are promoted all provide powerful signals to the consumer about the danger and the social acceptability of smoking.

Policy intention

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

Evidence of effectiveness

Community norms, laws and perceived availability of tobacco are among the factors that most affect uptake of smoking[124,125].

Laws banning sales to minors discourage such sales only 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 revenues from illegal sales[126]. The introduction of loss of license as a penalty for selling tobacco products to children, and programs of extensive test purchases (by young people who look underage) have been followed by substantial falls in the willingness of retailers to sell to minors, and the proportion of young people purchasing cigarettes[127]. Falls in consumption by young people, however, have not always followed[128–130].

Progress in Australia

Several jurisdictions have invested heavily in enforcing laws banning sales to minors, and the proportion of 12 to 15-year-olds who reported purchasing their last cigarette has declined quite substantially. However more than 50% of 16 and 17-year-old smokers were still able to purchase cigarettes in 1999, and declines in ability to purchase have been largely offset by increased sourcing of cigarettes from friends[131].

A report endorsed by the Intergovernmental Committee on Drugs on options for licensing has identified substantial economic benefits of licensing tobacco retailers and wholesalers, confirmed that licensing complies with national competition policy and highlighted the benefits of national uniformity[132]. The report has guided the design of licensing schemes in a number of jurisdictions.

Cigarettes in Australia remain more visible and more widely available than any other consumer product, including milk and bread.

6.1.3 Regulation of Tobacco Tax

Rationale

Taxes on tobacco products increase prices which helps to discourage consumption. The Government provides funding for anti-smoking programs from general revenue through the budget process.

Policy intention

To make tobacco products less affordable.

Evidence of effectiveness

The World Bank has concluded that raising tobacco taxes is the single most important step that governments can take to reduce smoking among both adults and young people, particularly in lower socio-economic groups[98]. On average, a 10% increase in the price of cigarettes results in a 4% reduction in smoking by adults and a 16% reduction in children, reducing overall tobacco use but increasing tobacco tax revenue[98]. However, any moves in Australia in this regard will need to be cognisant of the potential for illicit trade and would require further analysis. This would include, but not be limited to, the impact on consumption possibilities (e.g. price elasticities of demand, revenue effects, health effects); and distributional and equity considerations (e.g. would raising excise cause more harm to addicted smokers, who are disproportionately poor, than it would save in terms of preventing young people from smoking?).

Progress in Australia

Since 1983, the excise on tobacco products in Australia has risen in line with the Consumer Price Index (CPI).

The retail price of cigarettes has already increased in the last five years through government action. Examination of *A New Tax System* documentation reveals that after the introduction of per stick excise and the application of GST, premium branded 25s were expected to rise by approximately 6.5%.

Increasing the price of tobacco products will decrease consumption more in low than in high-income groups. Nevertheless, tax increases will cause financial stress for people on low incomes unable to quit: price increases would not be acceptable in the absence of greatly improved quality of, access to and affordability of treatment services and therapies (see Section 6.3).

6.1.4 Regulation of Place of use

Rationale

Exposure to environmental tobacco smoke causes disease in non-smokers[133–137]. Health problems such as asthma and cardiovascular disease can be triggered or worsened even by relatively short periods and relatively low levels of exposure[138–143]. The National Occupational Health and Safety Commission therefore recommends the elimination of smoking in all workplaces (see Guidance Note 3019)[144]. The national response to passive smoking endorsed by the Commonwealth and all states and territories calls for smokefree environments to be the norm[20].

Policy intention

> To eliminate exposure to environmental tobacco smoke indoors at work and in public places (and outdoors where mobility is limited), and to minimise it in residential institutions.

Evidence of effectiveness

No-smoking areas within the same premises as areas where smoking is allowed provide little or no protection from environmental smoke[145]. Smokefree workplace policies (total bans) by contrast virtually eliminate exposure to tobacco smoke during working hours[146]. They also help smokers in those workplaces reduce the amount they smoke each day and increase their chances of successfully quitting[147].

Such policies dramatically affect social norms about smoking. In jurisdictions which introduce smokefree laws, fewer children take up smoking[148] and numbers of smokers and numbers of cigarettes consumed decrease relative to jurisdictions without such laws[149].

A recent study published in the British Medical Journal documented a decline in deaths and hospital admissions for heart attack in an isolated community in the United States, after enactment of a local law to enforce smokefree workplaces and public places[150]. The rate of hospital admission went back up to the previous level when the law was overturned.

Progress in Australia

Smoking restrictions in public transport and offices have increased dramatically in Australia since the mid-1980s, due mainly to the threat of litigation[151].

Legislation in all states and territories now protects patrons and people working in restaurants, cafes and shops from exposure to environmental tobacco smoke but, in most states, many people in factories and small businesses are still likely to come across tobacco smoke[152], mainly in warehouses, confined outdoor areas and stairwells. Levels of exposure among workers in Australian pubs and clubs are believed to be among the highest in the world[153].

Overall, people who are institutionalised, unemployed or working in blue collar occupations are much less likely than white collar employees to benefit from the restrictions on one's own smoking and reduced exposure to other people's smoke that result from working in smokefree offices.

20 National Response see www.NPHP.gov.au

6.1.5 Regulation of Packaging

Rationale

Consumers have a right to know exactly what is in tobacco products, and all the effects of smoking them. They have a right to know about risks associated with smoking as soon as information becomes available.

As with consumers of food products, smokers have a right to information that helps them to judge the absolute and relative harms of various tobacco products.

Policy intention

> To mandate adequate and effective consumer information on tobacco products (and in the media and at point of sale).

Evidence of effectiveness

New pictorial health warnings in Canada, the Netherlands and Brazil have greatly increased awareness of health risks and interest in smoking cessation[154–158]. In Brazil, 67% of smokers reported that they wanted to quit after seeing the new warnings[157].

Progress in Australia

Despite a wealth of new information about risks associated with smoking, tobacco companies have made almost no effort over the past 10 years to inform consumers about risks not covered in the warning labels mandated in the Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations, 1995[159]. For instance, no company took action to alert consumers that smoking by pregnant women could cause Sudden Infant Death Syndrome, despite release of a systematic review published in 1997 finding that maternal smoking doubled the risk[160]. No company directly alerted consumers to findings of a report released in July 2002 by the International Agency for Research in Cancer (IARC), concluding that smoking causes a number of cancers not previously causally linked with smoking – cancers of the liver, stomach, uterine, cervix and urinary tract, and myeloid leukaemia[161]. Many smokers, particularly those who are educationally disadvantaged, are unlikely to have read about such studies in journals or newspapers; fewer still would have remembered and fully appreciated the significance of findings. Clearly a more responsive system is needed.

New Product Information Standards will require colour graphic and text warnings on tobacco products from 1 March 2006. However, once again these will not alert consumers to the extensive new list of risks catalogued in the May 2004 report of the US Surgeon General[162] released some four years after the review of the current warnings was initiated.

More needs to be done to ensure that consumers are not misled. Brand names, descriptors such as “light” and “mild” and yield information on Australian tobacco products indicate delivery as measured by machines rather than as inhaled by smokers[163] who, unlike machines, tend to block ventilation holes in the filter when they hold cigarettes between their fingers. Consumers do not understand this yield information[164]or descriptors[87]. International authorities acknowledge that labelling systems based on flawed testing methods (adopted many years ago by the International Standards Organisation) need to be reviewed[88,165,166]. Approved new consumer product information will no longer require

companies to provide yield information on the pack. Labelling requirements will need to be reviewed if any more adequate testing system is developed internationally.

Tobacco companies have been providing information on tobacco additives by voluntary agreement with the Department of Health and Ageing[167]. Information is provided in raw form on the Department's website, however usefulness to consumers is limited given the absence of interpretation or guidance about the effects and relative harmfulness of ingredients listed[168].

6.1.6 Regulation of Products

Rationale

Cigarettes and ignition propensity

Cigarettes that went out easily after being lit would be annoying to smokers. Modern-day cigarettes stay alight even when they are not drawn on, resulting in unattended or discarded cigarettes starting many fires in beds and other furnishings, and in bushland.

Top-selling cigarette brands in New Zealand recently failed fire-safe tests, with the citrate content in cigarette paper demonstrated to be a critical factor determining ignition propensity[169]. Recent Australian research confirms that cigarette butts (frequently thrown from car windows) can easily ignite bush litter in dry, windy conditions[170].

Harmfulness of tobacco products to users

Tobacco smoke contains over 4,000 chemicals, including dozens of known carcinogens, poisons and irritants[171]. International authorities are expressing growing disquiet that cigarettes on the market today are even more harmful and more addictive than they need to be[166,172]. There is significant variation between brands, and enormous variance in the levels of major known carcinogens delivered by the same brands sold in different countries[173].

With many people unable to quit despite a strong preference and several attempts to do so, it is important to ask whether tobacco smoking can be made any less harmful for continuing smokers[174,175].

While there is as yet no firm epidemiological evidence that further reducing the toxic yields of tobacco products will reduce harm caused by smoking, it would be difficult to justify continuing to allow tobacco products to deliver high levels of known carcinogens, toxins and irritants if these *could* feasibly be removed or greatly reduced[176].

Several tobacco companies in recent years have attempted to produce and market *potentially less hazardous* cigarettes[177–181]. Such developments are fraught with danger, having the potential to undermine efforts to encourage smokers to quit, with no certainty about health benefits to be gained[182–186].

Evidence about the effects of reducing nitrosamines – some of the most toxic carcinogens in cigarette smoke – provides an instructive example. Levels of nitrosamines vary depending on agricultural practices such as fertiliser choice and method of curing[171,187] and several tobacco companies have begun to market products as *low nitrosamine*[188]. However, it seems that not all the different nitrosamines found in cigarette smoke are affected by nitrate content; changes in farming practices may affect some but not others, and cigarettes made with low nitrate tobacco may still produce smoke with a high overall nitrosamine content[189]. It is also possible that cigarettes low in nitrosamines are higher in some other harmful carcinogens.

Given the complexity of the toxicology of tobacco smoke, it is crucial that governments be able to regulate claims about health impact and to require comprehensive testing of products and monitoring of biological effects on consumers[166,184,190–192][21].

Despite the potential pitfalls, scientists experienced in testing cigarette constituents and smoke yields do nevertheless believe that there are several promising means by which the toxicity in cigarette products could genuinely be reduced[178,193,194].

Early attempts to reduce "tar" in Australia and elsewhere probably did result in lower delivery to smokers. Unfortunately, later technological developments such as filter ventilation resulted in low test results on smoking machines, but almost complete compensatory smoking by consumers who were able to block ventilation holes and draw harder[163]. It may, however, be feasible to ban designs that allow such compensation.

Regulation of tobacco products would allow governments to mandate evidence-based, potentially harm-reducing innovations across the whole market. This would be far preferable to allowing tobacco companies to use such features as a selling point in promotional activities – an outcome that would potentially result in an overall increase in use and, as a consequence, an overall increase in harm caused.

Alternative nicotine delivery systems

Interest has been increasing in recent years in the use of nicotine replacement products to help smokers replace or cut down use of tobacco[195–197]. Alternative nicotine delivery systems might include medicinal nicotine or products delivering nicotine for essentially recreational rather than therapeutic purposes[198].

Depending on the way they are formulated, supplied, packaged and promoted, alternative nicotine delivery systems could help reduce overall population harm by enabling smokers to reduce or replace cigarettes. Unregulated, recreational nicotine products could divert smokers from using pharmacotherapies proven to assist with smoking cessation[185,197]. They could also be highly toxic or easily accessible to children and act as a gateway to tobacco smoking[182].

Policy intention

To coordinate regulation of tobacco products and products designed to replace tobacco, in ways that combine to *reduce overall population harm*.

Evidence of effectiveness

The propensity of cigarettes to ignite materials such as soft furnishings or native vegetation could be decreased by reducing the density of tobacco, the circumference of cigarette rods and the burn additives in and the porosity and surface features of cigarette paper[199][22].

Some types of smokeless tobacco (most notably Swedish snus) appear to be less harmful than cigarettes[200–202].

21 Given the long-term nature of smoking-related disease, it will be decades before any reduction in harm becomes obvious. However it is possible to monitor bio-markers of such exposure, including blood levels and excretions of by-products of toxic substances.

22 Legislation recently introduced in the state of New York requires bumps in the cigarette paper that will cause cigarettes to extinguish if not drawn on for some minutes.

Reduction in smoking through use of medicinal nicotine appears to reduce smokers' exposure to carcinogens in tobacco smoke[203], more so than switching to smokeless tobacco or to some of the *potentially reduced exposure* products currently marketed by US tobacco companies[204].

Progress in Australia

Regulation of tobacco products

The Department of Health and Ageing is considering recommendations of a report on options for reducing the ignition propensity of Australian cigarettes[91], however there has been little consideration of broader regulation of tobacco products.

Unlike other jurisdictions such as Canada and New Zealand, no legislative mechanism currently allows Australian governments to regulate the growing or curing of tobacco or the manufacturing of tobacco products. There are no mechanisms to set limits on tobacco product ingredients including those occurring naturally, those remaining as residues from fertilisers or pesticides and those added during manufacture. Nor are there mechanisms to ban or mandate particular design features of cigarettes, or to set limits on delivery of various toxins in tobacco smoke. At present in Australia, there are no market incentives to provide products in a less harmful or addictive form.

The majority of cigarettes sold in Australia could be classified "low tar", however this measurement is achieved mainly through designs (to increase ventilation) that allow compensatory smoking[163]. Many substances are added to tobacco in cigarette manufacture[168]. The effects of these on the palatability or addictiveness of cigarettes – both important to the development of dependence in young smokers – are unknown.

Most types of smokeless tobacco cannot be sold in Australia[23].

Regulation of alternative nicotine delivery systems

Nicotine replacement products are sold in Australia only as an aid for quitting: their indication[24] does not currently extend to smoking reduction or long-term replacement of cigarettes. There is currently no nicotine product available that closely mimics cigarettes in rapidly delivering nicotine to the brain, probably the most promising long-term alternative to smoking[166].

Dozens of products delivering nicotine in food, drink, confectionery and cosmetics are now available for sale in the United States and elsewhere[205]. No policy is currently in place in Australia to guide therapeutic goods and food regulators[25] about how best to regulate such products, and we have no mechanism at all for regulating some classes of products.

Coordinated regulation of tobacco and nicotine products

The absence of measures that reduce harm from continuing smoking results in greatest harm among socially disadvantaged smokers who consume more tobacco and are less likely to fully understand the relative health risks posed by various classes of products.

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23 By Ministerial notice under part V (Consumer protection) Division 1A (Product safety and product information) of the Trade Practices Act 1974 (Cth)

24 Recommended usage as described in product information approved by regulatory authorities

25 Foods Standards Australia and New Zealand has proposed that nicotine be prohibited in food and drink products.

The Ministerial Council on Drug Strategy has commissioned the Department of Human Services, Victoria to undertake a project to investigate regulatory options for the control of tobacco and other nicotine products in Australia.

6.2 Promotion of *Quit* and *Smokefree* messages

Rationale

It is very easy to put off giving up smoking, and people usually need multiple attempts to quit successfully.

Smokers hold many beliefs that help them to justify deferring quitting, for instance scepticism about health information, beliefs that they can overcome risks, misperceptions that smoking affects length but not quality of life and underestimates of the risk of smoking relative to other risks[206]. Many arguments need to be countered and, at different stages of life, different sorts of information can be more or less relevant.

Smokers cycle in and out of "readiness to quit" many times each year, and, without encouragement, can easily lose motivation to persist and remain smokefree.

To effectively communicate with all smokers, many different campaign messages and broadcast advertisements are needed.

As pointed out by Jamrozik (2004)[207], campaigns must "*be bold and take some risks challenging public and personal opinions and feelings so that the issue… remains 'alive'..*" therefore, adequate funds are needed "*not only for production and dissemination of materials but also for associated...market research.*" p760.

Advertising of pharmaceutical products can help to improve the efficacy of Quit campaigns by increasing use of these products and success rates among those quitting. Similarly, Quit campaigns can help to increase understanding of the quitting process and the strategies, treatments and services that might be helpful to smokers. Campaigns can increase numbers attempting to quit and success rates in recent quitters[208], thereby increasing the potential market for, and efficacy of, services and pharmaceutical treatments.

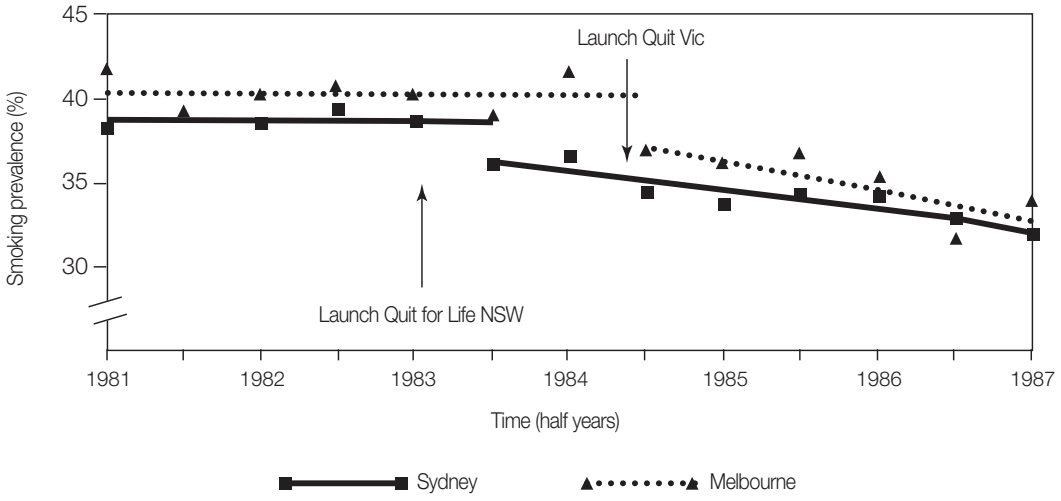
Policy intention

> To personalise the health risks of smoking and to increase people's sense of urgency about quitting and their awareness of effective therapies and contact details for services.

Evidence of effectiveness

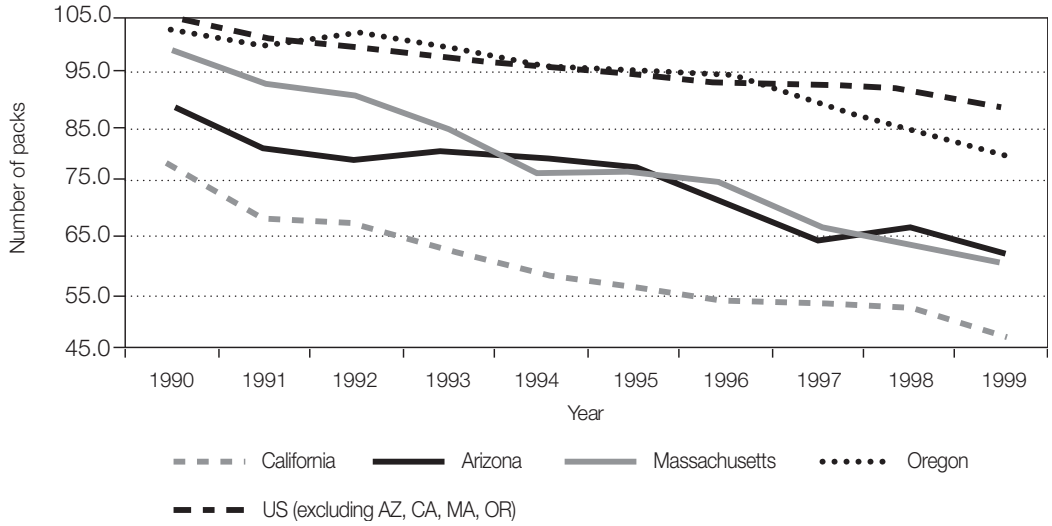
Evaluation of smoking trends in jurisdictions with comprehensive tobacco control strategies shows clear drops in smoking at the commencement of mass media campaigns (see Figures 7 and 8) and evidence of sustained declines with sustained funding (see Californian and Massachusetts data, Figure 8).

Figure 7. % of people (15 years and over) reporting regular smoking in Sydney and Melbourne before and after launch of Quit campaigns in 1983 and 1984



Source: Pierce, Macaskill and Hill 1990[209]

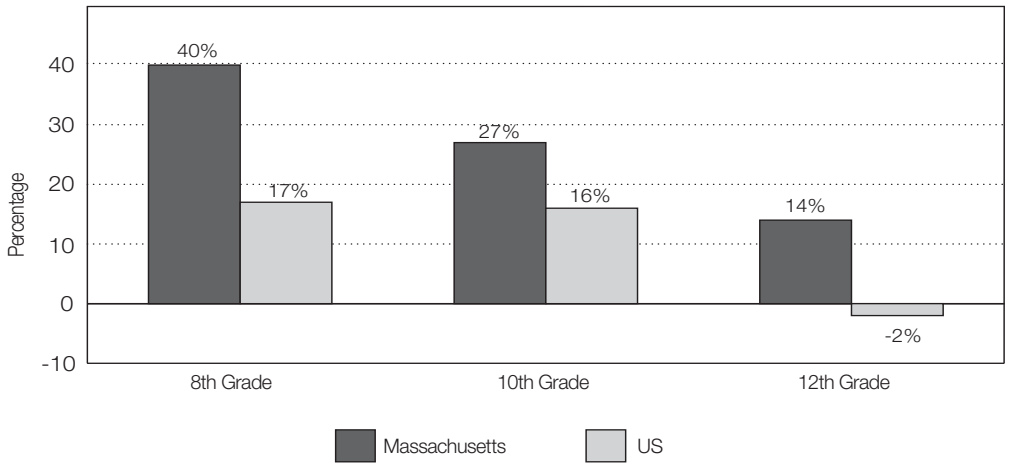
Figure 8. Cigarette sales (number of packs dutied) in states with anti-smoking campaigns vs. US as whole, 1990 to 1999



Source: Farelly, Pechacek and Chaloupka 2003[210]

By resetting community norms about smoking[207] and helping adult role-models to quit, prominent campaigns aimed at the whole community can also greatly reduce smoking by children[211]. For instance, see Figure 9 for changes in students' smoking in Massachusetts compared to the rest of the United States following the launch of the Make Smoking History campaign.

Figure 9. Percentage changes between 1996 to 1999 in reported youth smoking in Massachusetts compared to the rest of the US



Source: Siegel and Biener, 2000[212]

Evidence from New Zealand suggests a decline in attempts to quit by Maori people during periods when mass media advertising is less prominent[213]. Aboriginal and Torres Strait Islander peoples and other disadvantaged groups in Australia may be similarly disadvantaged by declines in Quit advertising.

Progress in Australia

Additional spending on Quit campaigns would encourage more people to quit. It would also increase the efficacy of considerable spending by pharmaceutical companies on encouraging people to use products that improve success rates among those who do try to quit.

6.3 Cessation services and treatment

Rationale

Nicotine is the main drug in tobacco that causes dependence among regular users[214]. Dependence is reinforced by: the rapid delivery of nicotine to the brain provided by inhalation; positive sensations linked to release of the dopamine neuro-transmitter; and relief of withdrawal symptoms by continued smoking[215].

Dependence on tobacco-delivered nicotine can be characterised as a chronic relapsing disorder[216,217]. Without assistance, around 95% of quitters will fail on any single attempt[214]. Most people make multiple attempts before they quit[214], and many people never succeed despite a strong preference not to smoke[216].

At least 70% of Australian smokers are believed to be dependent on tobacco-delivered nicotine[22].

General practitioners have both the opportunity to identify smokers and the credibility to encourage them to quit[218]. Advice from other health professionals is also acceptable to patients[219].

Treating tobacco dependence would help health care services to improve patient outcomes and contain future costs[220].

Policy intention

To ensure that all Australian smokers in contact with the health care system are identified and advised to quit, and that all smokers likely to have difficulty withdrawing from tobacco-delivered nicotine have access to support and appropriate and effective pharmacotherapies.

Evidence of effectiveness

Behavioural support services

Techniques deriving from behavioural science (for example, environmental modification, self-talk and reward strategies) can help smokers remain abstinent and can be successfully taught through self-help materials[221], telephone counselling[222,223] and through face-to-face group or individual counselling[224,225].

Telephone counselling services operating for more than a decade now in Australia[226,227] and California[228] have provided encouragement and advice to hundreds of thousands of smokers. Smokers who received counselling were more likely to quit than those merely posted materials[229,230], and those who received several calls at key stages in the cessation process had higher success rates still[231–233]. Internet and other electronic programs offer potential for tailoring advice and reaching very large numbers of people at very little cost[234–237].

Pharmacotherapies

Pharmacotherapies which affect dopamine release or reduce withdrawal symptoms also improve success rates[238,239].

All commercially available forms of nicotine replacement therapy (NRT) – gum, transdermal patch, inhaler, nasal spray (not sold in Australia) and sublingual tablets/lozenges – are effective. A review of over 100 studies found that NRT increases the odds of quitting 1.5 to two-fold (depending on product type) regardless of how products are prescribed or purchased[238].

Recent reviews of clinical trials, one covering 18 studies[239], the other 4,000 patients[26][240], concluded that bupropion was consistently effective in smoking cessation, doubling abstinence rates at six and 12 months compared to placebo[27]. Bupropion reduces withdrawal symptoms as well as weight gain and is effective for smoking cessation among people with and without a history of depression or alcoholism[240–242]. Good results have been achieved when bupropion and the nicotine patch are combined[243], but more research on combination pharmacotherapy is needed[240].

26 From varying populations

27 There are no significant differences between the anti-depressant drugs, bupropion (listed on the Pharmaceutical Benefits Scheme) and nortriptyline (not listed) when used for smoking cessation, and nortriptyline can be considered as another pharmaceutical for this purpose. The lower cost of nortriptyline compared to bupropion has to be weighed up against the adverse effects and risk profiles, as nortriptyline is related to an increased rate of cardiac events among those with ischemic heart disease. (Roose S, Laghrissi, Thode F et al. Comparison of paroxetine and nortriptyline in depressed patients with ischemic heart disease. JAMA, 1998;279:287–91).

Medicines such as NRT and bupropion increase success rates independent of counselling, but the effects of counselling and pharmacotherapies are additive[244,245]. A recent study demonstrated superior cost-effectiveness of bupropion combined with either minimal or intensive tailored behavioural counselling compared with bupropion alone[245].

Counselling by health professionals

Even brief advice from general practitioners and other health professionals can prompt many smokers to quit[246] – see Miller and Wood (1998) for a full summary of the evidence[247]. More intensive advice by general practitioners increases success rates, but is likely to be adopted by fewer doctors[248,249]. Interventions must be tailored to the practice setting and feasibly incorporated into routine care[250,251]. Practice nurses can also provide useful support[252]. Health professionals who receive training are twice as likely to engage in smoking cessation as those not trained[253].

Encouraging institutions to adopt guideline-based smoking cessation policies requires effective management of organisational change[254]. When health care facilities adopt such policies, more patients do attempt to, and succeed in, quitting smoking[255].

In a recent comprehensive review for the UK Treasury, review Chairman, banker Derek Wanless, identified investment in effective prevention strategies, in particular treatment for tobacco dependence, as a crucial strategy to contain costs and ensure the long-term viability of the British National Health Service[256].

Progress in Australia

While the National Health Service in the United Kingdom and major health agencies in the United States have invested considerably in initiatives to ensure treatment of tobacco dependence for all patients[257,258], Australia currently lacks a national plan for standardised and routine treatment of tobacco dependence[220].

Behavioural support services

The national Quitline (131 848) is funded to operate in each state and territory but will need to be better resourced in the future if it is to cope with increased demand from referrals from GPs and other health professionals, promotion of the Quitline on cigarette packs and increased promotion in the media[220]. Some jurisdictions have developed a fax referral pad to refer those requiring cessation services in hospitals and outpatient facilities to the Quitline. The Quitline provides telephone call-back counselling in Victoria, South Australia and New South Wales, but this service is still not available to smokers in Western Australia, Queensland, Tasmania or the Northern Territory[220].

An internet-based cessation program is available through some but not all Australian Quit campaign websites[259].

While 80,000 people called the Quitline in 2003[260], this represents only a small percentage of Australian smokers[76] and many more people could potentially benefit from the service if it were better promoted[220].

Pharmacotherapies

Use of nicotine replacement therapies (NRT) in Australia has increased greatly since relaxation of scheduling arrangements allowed over-the-counter sales in 1993 and direct-to-consumer advertising of gum and patches in 1997[261]. NRT is now the most common form

of assistance sought by smokers attempting to quit. While the *per day* cost is less than the cost of a packet of cigarettes, the up-front purchase cost of the first packet of NRT does seem to be a barrier for some quitters[78]. The classification of most NRT products has recently shifted from *pharmacy* to *general sales*, however, despite initial concerns, these products will not be subject to Goods and Services Tax[262].

More than 10% of smokers have tried bupropion since it was added to the Pharmaceutical Benefits Scheme in February 2001[263]. Unfortunately many failed to complete treatment or to seek behavioural support counselling offered by either the pharmaceutical companies or Quitlines[264]. Bupropion is contra-indicated for people being treated for diabetes, those with head trauma, those taking systemic steroids and those suffering withdrawal from alcohol or benzodiazepines – refer to Zyban Consumer Medicines Information[265]. Falling into these categories are many Aboriginal and Torres Strait Islander people, many people with serious mental illness and many other disadvantaged smokers who find it difficult to afford NRT.

Counselling and referral by health professionals

At present in the Australian health care system, tobacco dependence is often regarded as a fact of life, rather than as a serious medical condition about which something must be done as a matter of priority.

A recent study found that doctors identify around two thirds of smokers, counsel half of those and refer only 20% to services such as the Quitline[249]. In 2000, only 34% of smokers remembered being advised to quit by a doctor[266].

Several programs over the past 25 years in Australia have attempted to prompt and support GPs to encourage or assist smokers to quit[249,267,268]. The most comprehensive, long-standing and thoroughly evaluated of these is the *Smokescreen* program developed by the School of Public Health and Community Medicine at the University of New South Wales. *Smokescreen* is based on the *stages of change* model[269] and incorporates the *5As* approach (Ask, Assess, Advise, Assist and Arrange follow-up) to smoking cessation counselling[270]. Six separate trials over 22 years have demonstrated the efficacy, effectiveness, dissemination and cost-effectiveness of the program in general practice[271–274], and over the past 20 years, more than 8,000 GPs and other clinicians throughout metropolitan and rural Australia and New Zealand have been trained in its use[275].

Australian universities have also taken the lead in training undergraduate medical students and other health professionals about tobacco use and smoking cessation.

The University of New South Wales' *Smokescreen* tobacco curriculum[276] has been implemented in 57 medical schools globally[277]. Coordinators of Alcohol and Drug Education in Medical Schools (CADEMS) were originally funded by the Federal Government to coordinate teaching on tobacco, alcohol and other drug use and counselling to medical students in each of Australia's 14 medical schools. The *Smokescreen* Education Program has been included in the chapters on tobacco in CADEMS publications to guide design and implementation of curriculum [278,279]. Reinstitution of financial support for CADEMS would allow each medical school to more systematically and comprehensively train medical students to intervene effectively with patients with drug problems including smoking and alcohol abuse.

The Discipline of Health Behaviour Sciences at the University of Newcastle has produced a learning module providing guidelines, case histories and assessment materials for teaching health professionals how to provide smoking cessation counselling[280]. The CADEM

model could usefully be applied in other disciplines to encourage greater involvement and reduce duplication of effort by those covering drug use and counselling in training programs for psychologists, pharmacists, nurses, dentists, physiotherapists and other allied health professionals across the country.

New smoking cessation guidelines for Australian general practice were launched in June 2004[281]. The guidelines aim to assist GPs and other practice staff to deliver effective assistance for smoking cessation in the general practice context. The guidelines are evidence-based and informed by extensive stake-holder consultation and guidelines from other countries (US, UK and New Zealand). The in-practice management approach is based on the *Smokescreen* program which acknowledges that the smoker's own motivation to stop smoking is a key issue, and advice is provided based on the smoker's readiness to quit[275]. The guidelines are also based on the *5As* for brief intervention. In a significant advance on those developed in other countries, the guidelines link general practice advice to stop smoking to Australian state and territory Quitline telephone counselling and educational resources.

With the guidelines successfully developed, published, launched and sent to all general practitioners, it is crucial that their use be widely and actively promoted. An effective implementation strategy would include publicity, integration with medical prescribing software, undergraduate training and continuing medical education, and encouragement of GPs to use mechanisms for referral to cessation services, including Quitlines, in every state and territory.

Several guidelines and other resources for pharmacist involvement have been developed and widely promoted by pharmaceutical companies and the pharmacy profession[282]. Similar guidelines and referral mechanisms need to be developed for other professional groups in line with recommendations in the Department of Health and Ageing's report on evidence and opportunities for brief intervention[247].

Health system interventions

NSW Health has developed guidelines to manage nicotine dependence in patients admitted to NSW health facilities[283], and is aiming for 100% of patients admitted to NSW hospitals to be screened for smoking and 100% of those with a tobacco-related disease to be offered nicotine replacement, and – if they intend to remain smokefree after discharge – referred to the Quitline or their GP for further assistance. The Hunter Population Health Unit is currently trialling an implementation trial in several hospitals. Treatment for nicotine withdrawal is however not yet standard practice for hospital in-patients in any jurisdiction.

Despite several initiatives over the years, advice to quit and referral to, or provision of, quit counselling is far from standard practice for pregnant women and very rare for Aboriginals or Torres Strait Islander peoples, for drug users and for those with psychiatric problems. Treatment protocols need to be adopted by all public maternity hospitals, all Indigenous health services and all drug and alcohol treatment agencies, including those based in correctional facilities.

Towards an integrated strategy

A comprehensive national plan for treating tobacco dependence would enable coordination of policy and spending by programs covering public health, medical and pharmaceutical benefits, medical education, the development of general practice and continuing education of virtually all health professionals.

Ideally, telephone call-back and internet services would be available to smokers from any part of the country and the benefits of Quitlines and other services would be vigorously promoted. Every smoker would be able to afford a clinically appropriate pharmacotherapy, and such treatments would be subsidised where the patient was also undertaking a behavioural support program. All GPs, community pharmacists, practice nurses, dentists and other health professionals would be trained and supported to identify and encourage smokers to quit. GPs and other health professionals in all parts of the country would be able to refer patients to the Quitline. Quitline counsellors would provide feedback to GPs, and pharmacists and practice nurses would support GP advice and counselling. Identification and treatment of smokers would be a national performance indicator for Australian hospitals.

6.4 Community support and education

Rationale

To minimise the number of young people who take up smoking, we must focus on changing factors that are, at once:

- highly predictive of uptake;
- highly prevalent; and
- highly amenable to change.

Research on the predictors of smoking uptake[68,69] would suggest that the most promising approach in Australia would be to:

- help children to develop negative attitudes to smoking;
- teach children how to cope socially while resisting peer offers to smoke;
- get parents to quit while their children are young; and
- prevent children from failing academically and becoming alienated from school.

Policy intention

> To contribute to efforts to prevent uptake by children, and to ensure that the community is well-informed about smoking.

Evidence of effectiveness

School-based health education which includes training in resisting peer offers of cigarettes helps to delay smoking but, without intensive follow-up, has generally failed to prevent uptake altogether[103]. The benefits of school health education programs need to be weighed against the cost of training teachers and the opportunity cost of less curriculum time for core subjects.

Tobacco control is, however, highly topical, and teachers across most curriculum areas are keen to use age-appropriate materials that fit well into learning modules. Learning about the rationale for tobacco control should affect students' attitudes to drug use (highly associated with smoking uptake) and should help to build a more informed citizenry and increase community support for tobacco control in the longer term.

With or without such school-based programs, teenagers are much less likely to take up smoking in communities with strong norms against smoking. Teenagers whose parents have quit are much less likely to take up smoking than teenagers with a parent who still smokes. One major study found that teenagers who had "ever smoked" were twice as likely to quit if their parents quit, with the strongest effects where parents quit prior to their child reaching

nine years of age[284]. Children who live in smokefree homes and live in neighbourhoods where most facilities are smokefree are also less likely to take up smoking[148,285].

Very preliminary evidence from evaluation of initiatives in Victoria shows that improving literacy and enhancing *school effectiveness* might reduce early use of drugs including cigarettes[68,286].

Progress in Australia

Television campaigns encouraging parents to quit have run in all jurisdictions, but advertisements could be screened more extensively.

Smoking is banned in school buildings in all jurisdictions, but not in all cases on school grounds. Many Australian schools continue to treat smoking as a discipline issue for students rather than (as experts recommend) a health issue for the whole school community.

Drug education is compulsory in most jurisdictions, but programs have focused much more on alcohol, illicit drugs and inhalants than on smoking; this is particularly so in schools with a high proportion of Indigenous students.

Several state education departments have recently produced smoking prevention education resources. The Smarter than Smoking project in Western Australia and Quit in South Australia and Victoria have collaborated extensively to produce high quality materials for students. However, across Australia, only 50% of secondary school children can recall a recent lesson about smoking[15].

Most states and territories are investing more resources in literacy and numeracy. Health-promoting schools initiatives are more common in some states than others, and efforts to foster greater resilience and "connectedness" to school are largely restricted to pilot projects.

6.5 Addressing social, economic and cultural determinants of health

Rationale

Uptake of smoking, like many other high-risk behaviours, can be part of a response to various forms of social alienation.

The Intergovernmental Committee on Drugs is developing a Prevention Agenda for the National Drug Strategy 2004 and Beyond[287]. The objective will be to promote factors that protect against drug-related risk and harm.

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

Conversely, as highlighted in Section 2.6, reducing smoking could in itself also help to prevent ill health and financial stress.

As well as increasing financial independence and reducing inequality in Australia, greater investment in tobacco control could help to increase the effectiveness of Australia's assistance

programs in developing countries. As recently remarked by the Economic and Social Council of the United Nations:

> *"Tobacco use has an adverse impact on health, poverty, malnutrition, education and environment. Consequently tobacco control has to be recognised as a key component of efforts to reduce poverty, improve development and progress towards the Millennium Development Goals. Tobacco control needs to be a key component of development assistance programs…" UN, ESC[288].*

Policy intention

To reduce social alienation, which, along with many other negative consequences, is associated with uptake and continuation of high-risk behaviours including smoking, and to invest in tobacco control as a key strategy for preventing and reducing social disadvantage.

Evidence of effectiveness

We need more evidence about the impact on drug use of interventions to address social determinants of health: this is an emerging area of research.

Data on predictors of child health, mental health and educational achievement – such as family conflict, family resources, alienation from school and behavioural problems – are currently systematically measured only in Western Australia[289,290].

Progress in Australia

Child development and family support

Several state governments are investing in initiatives to enhance child development, to prevent family conflict and to build "social capital" in disadvantaged communities[28]. The Australian Government's Communities for Children initiative will provide $110m over four years starting in 2004–05, to expand family support services in 35 disadvantaged localities[291]. Over the same period, the Early Childhood Invest to Grow Initiative will provide about $70m to non-government organisations to run evidence-based intervention programs and will also support a longitudinal study of Australian children[292].

Given the contribution of smoking to poor maternal and child health and ongoing social disadvantage, it is crucial that at least some of the funded national and state projects include initiatives to reduce tobacco use. The impact of reduced smoking on indicators of child health and welfare should be assessed, as well as the impact of such projects (with and without a focus on smoking) on later uptake of drugs including tobacco.

Development aid

Health non-governmental organisations in Australia have over recent years provided advice, research and program materials (for example television commercials and training materials) to public health officials and universities in developing countries.

28 These include: *Head Start for Australia: An Early Years Framework,* an initiative of the NSW Commissioner for Children and Young People, the National Investment for Early Years (NIfTEY) and the Commission for Children and Young People in Queensland; the *ACT Children's Plan*; NSW's *Families First* initiative; Victoria's *Best Start* program, Queensland's *Families – Future Directions strategy:* Western Australia's *Children's First* Strategy; Tasmania's *Our Kid's Action Plan*: and Northern Territories' *Caring for Our Children Reform Agenda.*

At present there is very little appreciation among relevant agencies about the potential for tobacco control to contribute to humanitarian efforts and economic development both in Australia and overseas.

6.6 Tailoring initiatives for disadvantaged groups

Rationale

Several social groups in Australia suffer a particularly high burden of tobacco-related death and disease.

Tobacco use among Aboriginal and Torres Strait Islander peoples is causing appalling levels of ill health and premature death of infants, parents and elders[293]. Dispossession and family dislocation have resulted in profound grief, trauma and social alienation for many Indigenous people, greatly increasing susceptibility to substance abuse. Poor maternal health (to which smoking is a major contributor[96]), unemployment and high rates of incarceration perpetuate disadvantage across the generations. Low self-esteem, perceived and real indifference and prejudice and many other social and cultural factors make it harder for young Aboriginal and Torres Strait Islander people to engage with education and other social systems, and smoking can be symptomatic of that disaffection. Expenditure on tobacco products in some Indigenous households is resulting in reduced family and community resources for nutrition, housing, health care and education[294].

Other groups who smoke at very high rates, whose expenditure on tobacco products is a great financial burden, and who face higher rates of health problems than the rest of the community include:

- people suffering severe and disabling mental illness;
- people who are institutionalised including those in custodial settings[295];
- those parents and carers, and their children, who live in disadvantaged areas; and
- immigrants who left their countries at a time when the dangers of smoking were not well understood.

Children of smokers who are unemployed and staff and residents in institutions who share confined spaces with smokers all suffer high levels of exposure to environmental tobacco smoke. Smoking materials are a common cause of fires in institutions and in houses particularly in disadvantaged areas. In Victorian prisons, fires were the leading cause of death over the 10 years to 2000[296].

Highly disadvantaged groups such as those listed above will benefit greatly from the regulatory and educational measures described in Sections 6.1 to 6.5. People from such groups do, however, face some barriers in accessing Quit and other cessation services.

Prolonged periods of inactivity and boredom contribute to very high levels of tobacco consumption and the development of a very high level of dependence on tobacco-delivered nicotine among people who are unemployed or institutionalised. People who are on pensions, benefits or very low wages are less able to afford smoking cessation treatments. Few people in the groups listed above have internet connection and some do not have the telephone connected. Poor literacy in English is a problem for many Indigenous people and among many Australians who were born overseas. Many Australians living in remote and some rural areas in Australia have quite limited access to medical services and pharmacies and many Indigenous people find it difficult to engage with mainstream health services.

While there are many challenges, additional resources would enable messages to be to tailored to these groups and to reach them through the health services which they commonly use and through community networks in schools and social clubs.

A focus on Indigenous tobacco use could be strengthened with strategies put forward alongside the Aboriginal and Torres Strait Islander Complementary Action Plan 2003–2006[297].

Policy intention

To ensure access to information, treatment and services for people in highly disadvantaged groups who suffer a disproportionate level of tobacco-related harm.

Evidence of effectiveness

While a review of the literature[298] and a major consultation project[299] identified a couple of useful approaches, much more needs to be known about what might "work" to reduce smoking among Aboriginal and Torres Strait Islander communities and other disadvantaged groups. This knowledge is most likely to come by providing community workers with the opportunity to learn from research and from experienced staff, and to systematically reflect on their own practice and feedback from clients.

Progress in Australia

Aboriginal and Torres Strait Islander health

Several tobacco control projects of varying size and duration have been funded over the past 15 years in the larger states. These have focused on quitting to prevent heart disease, quitting during pregnancy and reducing smoking around children. Few projects have lasted long enough to allow staff to develop expertise. Little progress has been made in institutionalising the treatment of tobacco dependence in community-controlled health centres or in making smoking cessation a focus of service for Indigenous people using mainstream health services.

The National Strategic Framework for Aboriginal and Torres Strait Islander Health[300] is a statement of governments' resolve to improve the effectiveness and responsiveness of health services for Indigenous people, and to address the broader economic, social and cultural factors that impact on Indigenous health.

Encouraging and finding ways to support smokers to quit successfully is probably the single most effective thing that could be done to improve child and maternal health, to reduce chronic disease and some communicable diseases and to reduce financial stress, all key aims of the National Strategic Framework for Aboriginal and Torres Strait Islander Health.

The Department of Health and Ageing has funded a Centre of Excellence in Indigenous Tobacco Control to develop leadership in Indigenous tobacco issues and to act as a clearinghouse for research and programs related to tobacco control in Indigenous communities. The Centre's first challenge is to build awareness among Indigenous communities and the health care sector about the necessity of reducing smoking for addressing almost all the major problems that undermine life expectancy and quality of life in Aboriginal and Torres Strait Islander communities.

Queensland has recently developed a state-wide program to provide training and culturally appropriate resources to health workers undertaking brief interventions with Indigenous clients who want to quit smoking.

Other disadvantaged groups

Projects targeting people with mental illness operate in South Australia and Victoria, but activity in other jurisdictions has been limited.

Several jurisdictions are attempting to reduce harm caused by smoking in prisons[301].

The South Australian Quit Campaign runs a program aimed at people in disadvantaged areas.

The Victorian Quit Campaign runs a comprehensive program to encourage and support quitting by people with limited ability to read or speak English, and the NSW and WA state health departments provide translated material and access to telephone interpreter services. Activity in other jurisdictions is quite limited.

6.7 Research, evaluation and monitoring & surveillance

Rationale

Formative research is important for ensuring that programs are evidence-based, relevant to target groups, and feasible to implement in local conditions. Program evaluation is a tool for improving programs' efficiency or effectiveness and for demonstrating accountability[302]. Population monitoring of trends in smoking behaviour will enable the evaluation of the overall National Drug Strategic Framework[303].

Policy intention

> To ensure that research is conducted to assess needs and identify promising approaches and that systems are in place to assess efficacy and cost-effectiveness of programs and policies and the extent to which these are being achieved.

Progress in Australia

Research

Only limited data on the impact of Quit campaigns on children's attitudes to smoking and their knowledge of risks is available. Ongoing qualitative market research to improve how we communicate with potential and existing smokers is required, to more effectively encourage smokers to quit and to build support for tobacco control policies.

Evaluation

The annual evaluation of the National Tobacco Campaign provides data about smoking knowledge, attitudes and intentions[304].

By surveying the same group of people over time in Australia and in three other "like" countries (the UK, the US and Canada), the recently established International Tobacco Control Policy Evaluation Study is providing information on how tobacco control policies affect smoking cessation[305].

Monitoring

Australia's regular, standardised three-yearly surveys of students smoking are an invaluable resource, providing reliable data about changes in children's smoking behaviour since 1984.

The National Drug Strategy Household Survey[71] provides data every three years about smoking rates in various socio-economic groups and for each state. However, sample sizes are not sufficient to easily detect differences over time within jurisdictions, and between groups. Only limited data is currently available on smoking rates among Aboriginal and Torres Strait Islander peoples and among particular cultural groups. The Australian Bureau of Statistics no longer provides data on numbers of cigarettes excised.

The identification of other possible sources for collecting more current information on the prevalence of smoking amongst Aboriginal and Torres Strait Islander groups would be beneficial.

Surveillance

Estimates of deaths and disease attributable to smoking (and consequent social costs) have been calculated for 1989, 1992 and 1998–99[41,306,307]. New estimates need to include calculations for the greatly expanded list of diseases now established to be caused by smoking[162].

6.8 Workforce development

Development of the necessary knowledge and skills among those working in tobacco control at a national, state or local level, requires:

- recruitment and training;
- continuing education; and
- access to information.

Recruitment and training

Given the focus on policy and regulation, there is a need to attract more people from legal, economic, public policy and scientific disciplines to crucial research and policy jobs. Given the importance of the public receiving accurate information about the health risks of smoking and the effectiveness of various treatments, policies and programs there is also a need for more people skilled in media relations.

Continuing education

In addition to 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. The Australian National Training Authority has recently endorsed two units of competency in smoking cessation as part of the national Population Health training package. The advantage of the competency standard system is that the two units can be accessed as electives by anyone studying any Vocational Education and Training Accreditation Board (VETAB) course nationally, such as Occupational Health & Safety, Social Work, Drugs & Alcohol work, Beauty Therapy, etc. Recognition of Prior Learning

assessment provisions enable anyone competent in evidence-based smoking cessation to be assessed and accredited, therefore training can be obtained from any provider.

Access to crucial information

Short term strategies are to:

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

7. What are the next steps?

The Australian Government's recent ratification of the World Health Organization's Framework Convention on Tobacco Control[308] will enable the Australian Government to more pro-actively tackle the regulatory challenges posed by tobacco in this country. States and territories will continue to play a crucial role in regulating the sale of tobacco, in protecting workers and clients from environmental tobacco smoke, in raising community awareness of the dangers of smoking and in treating tobacco dependence in hospitals and in health, mental health and drug treatment services.

7.1 What are the most important challenges for the next five years?

As signatories to the National Tobacco Strategy 2004–2009, jurisdictions will aim to:

- further use regulation;
- increase the promotion of *Quit* and *Smokefree* messages;
- improve the quality of, and access to, services and treatment for smokers;
- provide more useful support for parents, carers and educators helping children to develop a healthy lifestyle;
- endorse policies that prevent social alienation associated with uptake of high risk behaviours such as smoking, and advocate policies that reduce smoking as a means of addressing disadvantage;
- tailor messages and services to ensure access by disadvantaged groups;
- obtain the information needed to fine-tune policies and programs; and
- foster collaboration in program policy and development.

7.1.1 Further use of regulation

To minimise commercial conduct that currently contributes to ill-informed, non-voluntary and unnecessarily harmful and costly use of tobacco products and exposure to tobacco toxins with an aim to:

- **eliminate** remaining forms of tobacco **promotion** (including through the pack itself), and find ways to reduce and offset the impact of **positive portrayals of smoking in films** and other forms of popular entertainment;
- dramatically **reduce the visibility** of tobacco products and their accessibility to young people;
- recommend measures to make tobacco products **less affordable**[29]**;**
- **eliminate** remaining exposure to **environmental tobacco smoke** among workers, clients and patrons in many blue collar workplaces and public places including very high rates of exposure in pubs and clubs; and **minimise exposure** among clients **in** some publicly-funded **(residential) mental health treatment and correctional facilities;**
- devise and find finance for **a system** that **provides accurate and timely advice** that will help consumers more fully understand the risks and consequences associated with smoking;

29 Such measures would be unlikely to have public support until services for smokers are greatly improved.

- develop a **regulatory system** for tobacco and tobacco replacement products that, **if** it is **feasible**, allows us **to reduce** the **overall harm** associated with dependence on tobacco and nicotine; and
- set in place an **overarching legislative framework** that ensures that the costs of addressing tobacco-related harm are borne by those who manufacture or sell tobacco, rather than by other Australian taxpayers.

7.1.2 Increased promotion of *Quit* and *Smokefree* messages

Jurisdictions will develop collaborative approaches to campaigns to personalise the health risks of smoking, to discourage smoking around children, and to encourage smokers to quit sooner rather than later and to use available treatments and services.

7.1.3 Improved services and treatment for smokers

To improve the quality and acceptability of services to assist smokers to quit and to ensure that any new treatments that are significantly more cost-effective than current therapies in treating dependence on tobacco-delivered nicotine are available and affordable to all Australian smokers. Measures will include: interlinking policies and programs to encourage greater involvement by general practitioners and other health professionals in smoking cessation; improving the quality of use of pharmacotherapies; increasing the use of behavioural support services; and ensuring that effective treatment for tobacco dependence is offered wherever possible in people's interactions with the health care system. This would apply especially to pregnant women, people suffering chronic disease, people living in institutions, and among Indigenous people and other high-risk and high-need groups.

7.1.4 More useful support for parents and educators

Provide support to parents, schools and teachers who are helping children to develop knowledge, attitudes and skills protective against high risk behaviours such as smoking by:

- policies which re-set community norms by encouraging adult role models to quit;
- helping parents and schools to give clear and consistent messages and enforce clear and consistent rules about smoking;
- ensuring that smoking is covered in drug education; and
- providing information to developers of curriculum materials and producers of student research materials.

7.1.5 Endorsement of policies that address causes of disadvantage

Each of the above measures will help to discourage smoking across the whole population, but particularly by those from less advantaged backgrounds[30]. They will help to make information about smoking and health available in pictorial as well as written form, through commercial as well as public TV and in higher readership as well as broadsheet newspapers. They will encourage adoption of smokefree policies in blue collar as well as white collar workplaces and entertainment venues. They will also help to make treatment for tobacco dependence more affordable and accessible to low-income groups.

30 Around 40% of the three million people who still smoke regularly in Australia are unemployed or employed in blue collar occupations (ABS, 2003).

In addition to these measures, the Strategy endorses broader government policies and programs that address the underlying causes of disadvantage in our community – for instance, efforts to reduce family conflict and to improve school effectiveness. Such measures are likely to enhance students' connectedness with school, and academic achievement, both highly protective against smoking uptake.

7.1.6 Tailoring for disadvantaged groups

Messages and support for people for whom the burden of tobacco use is particularly high and who face barriers in accessing services, need to be developed, for example among:

- Aboriginal and Torres Strait Islander peoples;
- people with a severe and disabling mental illness;
- people who live in supported or institutional care, including those in custodial settings;
- parents and carers who live in disadvantaged areas;
- people who live in those rural and remote areas of Australia with more limited access to health care services; and
- people who come from certain cultural and linguistic groups where smoking rates are high and ability to read English is limited.

7.1.7 More focused research and evaluation

Development of a priority-driven research agenda for tobacco control will assist in guiding health and medical funding bodies when allocating research grants, and universities when developing course content and research programs. More qualitative research is needed to better understand the perceptions and needs of smokers and community perceptions about tobacco control. Researchers will be encouraged to:

- trial promising new approaches and address gaps in current monitoring and surveillance activities; and
- continue to monitor overall progress in achieving desired impact and outcomes, and to adjust program and policy components as needed.

7.2 Who is responsible?

The Ministerial Council on Drug Strategy (MCDS) is a national ministerial-level forum responsible for developing policies and programs to reduce harm caused by drugs in Australia[3].

Some of the challenges outlined above require autonomous action at the state and territory level. Some can be addressed much more efficiently through national collaboration and coordination. In other cases, action by the Australian Government is required.

The Intergovernmental Committee on Drugs (IGCD) will assist by reporting on activities and developing policy and program proposals for consideration by MCDS. MCDS will rely on IGCD to analyse and tackle administrative and other barriers to action across portfolios and jurisdictions.

Health non-governmental organisations, medical colleges, professional associations, university and research groups and community organisations will offer independent evidence-based

advice on such proposals and on other tobacco matters, where possible as a non-government coalition.

7.2.1 Towards a collaborative approach

As it has been for many years, tobacco control in Australia will continue to be organised through coalitions of government and non-government organisations.

Increasing recognition that reducing smoking is integral to both patient care and containment of future costs should help to strengthen relationships with health care and mental health institutions.

With the increasing importance of pharmacotherapies to treat tobacco dependence, government and non-government agencies should establish transparent guidelines for working with pharmaceutical companies to improve access to and the quality of use of these medicines.

We also need to ensure that information about smoking and treatment of tobacco dependence is institutionalised in education, health care and family support systems as a key strategy for increasing educational opportunity and improving financial security.

In this, the next phase of the National Tobacco Strategy, health groups will also seek to greatly strengthen a whole set of additional partnerships – with the environment movement, and the business, welfare and education sectors – to more effectively address the social determinants of tobacco use.

7.2.2 Who will do the work?

The Australian Department of Health and Ageing and health and other relevant departments in each state and territory are responsible for enforcing tobacco control legislation and administering funding. The Australian Competition and Consumer Commission enforces mandatory consumer information relevant to tobacco products.

Government departments deliver programs in some states and territories; in others, non-government organisations or universities are contracted to run Quit campaigns or organise other projects. Several non-government organisations and universities also devote considerable resources to tobacco control advocacy, education, training, research and evaluation. Pharmaceutical companies contribute substantially to smoking cessation research and training of health professionals.

Effective tobacco control also depends on the day-to-day work of teachers, school administrators, general practitioners, Aboriginal health workers, mental health and health promotion workers, health professionals and many other staff in community organisations across the country.

The IGCD will work with non-government experts to develop a review and evaluation strategy. The evaluation strategy will include a mid-term review in two years time as well as a final evaluation. During the 2008–09 financial year, a process for development of a new strategy will be agreed, taking into account the direction of the National Drug Strategy.

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Attachment 1 Organisations consulted in the process of development

Aboriginal Drug and Alcohol Council (SA)
Aboriginal Health and Medical Research Council (NSW)
Action on Smoking and Health Australia
ACT Health
Alcohol and Other Drugs Council of Australia
Asthma Foundation of WA, Newborns' Asthma and Parental Smoking Project
Australian Council on Smoking and Health, a Western Australia-based organisation representing over 30 medical and health organisations
Australian Health Promotion Association
Australian Lung Foundation
Australian Medical Association
Australian Research Alliance for Children and Youth
Cancer Institute NSW
Central Sydney Area Health Service
Centre for Adolescent Health, University of Melbourne/Royal Children's Hospital, Melbourne
Centre for Behavioural Research in Cancer, The Cancer Council Victoria
Centre for Behavioural Research in Cancer Control, Curtin University, Western Australia
Centre for Health Research and Psycho-oncology, The Cancer Council New South Wales/ University of Newcastle
Centre of Excellence in Indigenous Health
Department of Health, NSW
Department of Health, Western Australia
Department of Health and Community Services, Northern Territory
Department of Health and Ageing, including state offices in WA and Victoria
Department of Health and Community Services, Northern Territory
Department of Health and Human Services, Tasmania
Department of Human Services, SA
Department of Human Services, Victoria
Federation of Ethnic Communities Council of Australia
GlaxoSmithKline Consumer Health Care
GlaxoSmithKline Pharmaceuticals
Healthway, Western Australia
Hunter Area Health Service
Indigenous Tobacco Control Project, Queensland Health
Mental Health Tobacco Control, South Australia
Ministerial Reference Group on Tobacco, South Australia
National Asthma Council, a collaboration of The Thoracic Society of Australia and New Zealand, The Royal Australian College of General Practitioners, the Pharmaceutical Society of Australia, Asthma Foundations of Australia and the Australasian Society of Clinical Immunology and Allergy

National Heart Foundation of Australia
Northern Metropolitan Community Health Services, Adelaide, SA
NSW Quitline, Drug and Alcohol Service, St Vincent's and Mater Health, Sydney
Office of Aboriginal and Torres Strait Islander Health
Pfizer Australia Consumer Healthcare
Pharmacy Guild of Australia
Public Health Association of Australia
Queensland Aboriginal and Islander Health Forum
Queensland Cancer Fund
Queensland Health
Queensland Public Health Forum
Quit SA
Quit Tasmania
Quit Victoria
Quit, Department of Health, Western Australia
Royal Australian College of General Practitioners, National Standing Committee – Quality Care
School of Public Health, University of South Australia
School of Public Health and Community Medicine, University of NSW
Smarter than Smoking Project, *funded by the Western Australian Health Promotion Foundation, managed by a Reference Group and based at the National Heart Foundation (Western Australian Division)*
Smokers Clinics, CSASH, Smoking Cessation Unit, University of Sydney
South Eastern Sydney Area Health Service
South West Sydney Area Health Service
SPARK Resource Centre, South Australia
St Johns Youth Service, SA
Telethon Institute of Child Health Research
The Australian Lung Foundation
The Cancer Council Australia
The Cancer Council ACT
The Cancer Council New South Wales
The Cancer Council Northern Territory
The Cancer Council Tasmania
The Cancer Council Victoria
The Cancer Council Western Australia
The Royal Australasian College of Physicians
Tobacco Control Research and Evaluation Unit, South Australia
Victorian Health Promotion Foundation
VicHealth Centre for Tobacco Control
Wentworth Public Health Unit, NSW