ADCA is reviewing its policy positions which were first published in 2003. While the principles behind ADCA's policy positions remain extant, the supporting statistics and references now need to be updated. For information on the policy updates, please contact Brian Flanagan, ADCA's Strategic Communications and Policy Officer, on 02 6281 0686 brian.flanagan@adca.org.au

1.1 Tobacco

Summary

The smoking of tobacco products is the single largest cause of premature death and disease in Australia. More than 19 000 Australians are killed by smoking each year. There has been a marked reduction in smoking prevalence since the 1940s and Australia now boasts one of the lowest smoking rates in the world. Despite this, there are a number of areas of major concern including the increasing rates of tobacco use among teenage girls.

Numerous strategies have been adopted in Australia to both prevent the uptake of smoking and encourage people to quit. They include:

- mass media campaigns
- taxation and pricing
- banning tobacco advertising, promotion and event sponsorship
- prominent health warnings on packaging
- limiting age of purchase
- tobacco cessation programs
- bans or limits on tobacco smoking in certain spaces.

Of particular note is the National Tobacco Campaign which resulted in a significant reduction in adult smoking levels, saved many lives and prevented considerable costs from being incurred.

The health consequences of exposure to environmental tobacco smoke – which is also referred to as passive smoking – are of increasing concern. As such, there is strong community support for bans on smoking in public areas, particularly workplaces, shopping centres and restaurants. Despite this, many jurisdictions have been slow to implement legislation restricting smoking in public areas, resulting in a significant number of employees in Australian workplaces still being exposed to tobacco smoke.

There is also concern that the level of funding committed towards reducing tobacco smoking is insufficient when considered in the context of the harms and costs tobacco smoking causes to the community. There is significant disparity between the amount of money collected by governments from tobacco tax compared to the amount allocated towards tobacco prevention.

ADCA supports Australia's National Tobacco Strategy and calls on all governments to adequately fund tobacco prevention and treatment programs and extend legislation to reduce exposure to environmental tobacco smoke.

Effects and levels of harm

Tobacco use was the major cause of drug related death in Australia in 1998

with 19 019 deaths attributable to smoking tobacco. Smoking was also the leading cause of drug related hospital episodes with 142 525 episodes in 1997-98 (Miller & Draper 2001). In 1995 smoking was estimated to have caused 15.3% of all deaths in Australia resulting in 88 266 years of life lost before the age of 70, an average of 4.7 years lost per death (English & Holman 1995).

The economic consequences of tobacco use in Australia have been examined with total costs in 1998-99 estimated at more than $21 billion including net health care costs of over $1 billion. These figures do not include costs associated with pain and suffering due to illness and death resulting from tobacco use (Collins & Lapsley 2003).

There are more than 4000 chemicals in tobacco smoke including carbon monoxide, nicotine, formaldehyde, ammonia and 43 chemicals known to be human carcinogens, that is, cancer-causing substances (International Agency for Research on Cancer 1985).

Smoking one cigarette immediately raises a person's blood pressure and heart rate and decreases the blood flow to body extremities such as the fingers and toes. Brain and nervous system activity is stimulated. Smokers may also experience dizziness, nausea, watery eyes, persistent coughs, shortness of breath and weakened appetite, taste and smell (Australian Drug Foundation 2000).

Smokers also have an increased risk of developing:

- respiratory infections such as pneumonia and chronic bronchitis
- emphysema – a progressive and potentially fatal lung disease
- heart attack and coronary disease
- cancer of the lungs, throat, mouth, bladder, kidneys, pancreas, cervix, and stomach
- stomach ulcers
- peripheral vascular disease due to decreased blood flow to the legs.

Nicotine is highly addictive and many smokers suffer withdrawal symptoms when they cut down or stop smoking cigarettes. These can include increased nervousness and tension, agitation, loss of concentration, changes to sleep patterns, headaches, coughs and cravings (Australian Drug Foundation 2000).

Smokers of illicit tobacco (‘chop chop’) are at risk of additional harms associated with the lack of quality control over this form of the drug. These harms include acute worsening of chronic obstructive pulmonary disease (COPD); acute asthma; pneumonia and pneumonitis from inhaled mildew spores; and inflammation of the alveoli (tiny air sacs in the lungs) causing irreversible damage. Samples of chop chop have been found to be fumigated with bleach and have also been bulked up to add weight with additives such as wheat, hay and other grasses (Action on Smoking and Health Australia 2002;

Bittoun 2002). Although most people smoke chop chop because it is cheap, many also believe that it is better for you than other forms of tobacco (Bittoun 2002). Clearly the evidence does not support this notion.

The health consequences of both short and long-term exposure to environmental tobacco smoke are of increasing concern. There is a wealth of scientific evidence that passive smoking is positively associated with asthma in children, lower respiratory tract illness, lung cancer, major coronary event and a number of other illnesses (Cancer Council New South Wales 2001).

Maternal smoking during pregnancy has a detrimental effect on the developing child. Smoking during pregnancy increases the risk of sudden infant death syndrome, low birth weight and perinatal pregnancy. Babies born to mothers who smoke are on average 200 grams lighter than those who do not smoke (Commonwealth Department of Health and Aged Care 1999).

Smoking in adolescence has been found to produce immediate and long-term changes in the brain. The earlier that young people start smoking and the more they smoke, the more likely they are to suffer from smoking related diseases (VicHealth Centre for Tobacco Control 2001). There is growing evidence that young people, particularly females, are more easily addicted to nicotine than adults (Action on Smoking and Health Australia 2002b, VicHealth Centre for Tobacco Control 2001).

Patterns of use and other trends

Adults

Between 1945 and 1998 there was little change is the prevalence of current tobacco smoking among women in Australia, with 26% smoking in 1945 compared to 24% in 1998. However there was a marked decrease in the prevalence of smoking among men, declining from 72% in 1945 to 29% in 1998 (Commonwealth Department of Health and Aged Care 2000).

The 2001 National Drug Strategy Household Survey results indicate that 49.4% of Australians aged 14 years and older have used tobacco at some time in their lives and 23.2% have used it recently, that is daily, less than weekly or weekly. One in five (19.5%) of Australians aged 14 years and older smoked daily in 2001, a slight decrease from the 1998 rate of 21.8%. Between 1998 and 2001, rates of daily smoking for those aged 20-29 years declined significantly from 31.4% to 26.1%. (Australian Institute of Health and Welfare 2002).

As noted above, the smoking of chop chop is associated with a number of harms additional to those usually linked to smoking. It is therefore concerning that in 2001 almost one in five Australians aged 14 years and over had come across unbranded loose tobacco and the majority of smokers and ex-smokers in this group had smoked it on at least one occasion (Australian Institute of Health and Welfare 2002b).

Aboriginal and Torres Strait Islanders

Smoking is one of the major causes of premature death and illness among Indigenous people in Australia and is responsible for between 1.5 and 8 times more deaths in the Indigenous community than in the non-Indigenous community (Commonwealth Department of Health and Aged Care 2000b).

In 1995, about 51% of Indigenous adults smoked (56% of males and 46% of females) compared to 23% of non-Indigenous people (27% of males and 20% of females) (Australian Bureau of Statistics 1999).

Young people

One in five teenagers (14–19 years) smoked tobacco in 2001 with 15.1% smoking daily. Smoking by young women is an area of growing concern. Female teenagers (16.2%) are more likely than teenage males (14.1%) to be daily smokers. 128 000 women aged 14-19 smoke on a daily basis, compared to 117 000 teenage males (Australian Institute of Health and Welfare 2002).

More than 90% of Australians who currently smoke took up the habit as teenagers and more than 70 000 Australian schoolchildren each year continue to take up smoking (VicHealth Centre for Tobacco Control 2001).

Non English speaking background (NESB) communities

Surveys conducted by the Drug and Alcohol Multicultural Education Centre (DAMEC) between 1992 and 1997 found that smoking levels amongst males of Arabic, Chinese (those born in mainland China), Greek and Vietnamese speaking backgrounds were significantly higher than the general community. An average of 43% of males from non English speaking backgrounds in the studies reported being daily smokers (Drug and Alcohol Multicultural Education Centre 2001). While current levels for males in the general population have declined, community workers and health professionals report ongoing concern about smoking rates amongst some non English speaking background communities (Central Sydney Area Health Service 2002).

Good practice strategies for harm reduction

There is strong international and Australian evidence that comprehensive long-term tobacco control programs are very effective in reducing tobacco consumption among adult and teenage smokers. It has been estimated that 300 000 Americans who died prematurely from tobacco smoking would be alive today had all states followed the comprehensive Californian Tobacco Program (VicHealth Centre for Tobacco Control 2001).

A range of anti-tobacco strategies has been implemented in Australia. Individual strategies include:

- mass media campaigns to educate people about the dangers of smoking and the benefits of cessation and to discourage people from taking up smoking

- banning tobacco advertising, promotion and event sponsorship
- increasing excise taxes on cigarettes to increase the price of tobacco products
- prominent health warnings on tobacco product packaging
- limiting age of purchase of tobacco products to reduce access to tobacco products by young people
- tobacco cessation programs including counselling, education and pharmacotherapies
- implementing bans or limits on tobacco smoking in workplaces and public areas to reduce people's exposure to environmental tobacco smoke.

The precise impact of any one of these strategies has been difficult to assess as many strategies have been implemented simultaneously with one or more other measures. The World Bank, however, has concluded that there is good evidence that each of the following non-price measures reduce cigarette consumption:

- publicised findings of research on the health effects of smoking
- mass media counter advertising
- warning labels on products and advertising
- bans on tobacco advertising and promotion
- restrictions on smoking in workplaces and public places
- cessation initiatives including nicotine replacement therapy (World Bank 1999).

The United States Independent Task Force on Community Prevention Services conducted a systematic review of studies evaluating tobacco control interventions. They strongly recommended taxation; mass media campaigns; multi-component cessation interventions; education of health care providers; and bans or limits on tobacco smoking in workplaces and public areas as effective tobacco control strategies (VicHealth Centre for Tobacco Control 2001).

Mass media campaigns

The implementation of mass media anti-smoking campaigns has been found to be an extremely cost effective and successful strategy to reduce tobacco related harms.

The Australian National Tobacco Campaign is an excellent example of the potential benefits of mass media campaigns. Launched in 1997, it has been seen as the first collaborative tobacco campaign to be organised in Australia, with $7 million allocated by the federal government and additional funding from both state/territory governments and non government organisations. Total funding to date has been estimated at $22 million (Commonwealth Department of Health and Aged Care 2000c).

An evaluation of the National Tobacco Campaign claimed that there has been a significant reduction in adult smoking levels since its inception. It has been estimated that the first six months of the campaign resulted in the potential prevention of 922 premature deaths and an additional 3338 years of life up to the age of 75. The National Tobacco Campaign has been estimated to have averted $24 million in health expenditure in its first six months of operation (Commonwealth Department of Health and Aged Care 2000c).

Banning tobacco advertising, promotion and event sponsorship

Direct advertising of tobacco products in print, television, radio and cinemas was phased out by federal legislation between 1973 and 1976 at which time tobacco companies turned to sponsorship of major sporting events. This shift was of particular concern as evidence emerged that a relationship existed between tobacco sponsorship of sport and brand choice among Australian children (Winstanley, Woodward & Walker 1995).

The federal *Tobacco Advertising Prohibition Act* was passed in 1992. Implementation of the legislation saw the phasing out of tobacco sponsorship of sport with a few exemptions including the televising of international tobacco sponsored events.

Point-of-sale advertising of tobacco products is still permitted nationally provided it is in compliance with any relevant state or territory requirements. However, point of sale advertising has in fact been either banned or restricted in most jurisdictions.

While many gains have been made in reducing tobacco promotion over the past decade, concerns remain about some point-of-sale advertising and value-added promotions. Also of concern is the level and extent of tobacco promotion in film and television programs particularly in light of recent strong evidence that viewing smoking in movies promotes the initiation of smoking among adolescents (Dalton et al. 2003). Researchers found that those adolescents who had seen the most smoking in movies were almost three times as likely to have started smoking themselves, even after correcting for most of the factors which may have made them prone to smoking (Swan 2003). Interestingly, the study also found that the effect of exposure to movie smoking was stronger in adolescents with non-smoking parents (Dalton et al. 2003).

Increasing cigarette prices

Studies into the effects of the cost of cigarettes have shown that ‘real’ price increases (where price increases are not matched by greater earning capacity and are therefore less affordable), can depress demand for cigarettes. Higher prices (usually the result of taxation increases) induce some smokers to quit and prevent other individuals from starting. They also reduce the number of ex-smokers who return to cigarettes and reduce consumption among continuing smokers. On average, a price rise of 10% on a pack of cigarettes would be expected to reduce demand by about 4% (World Bank 1999).

A World Bank report on the economics of tobacco control notes that efforts to set an 'economically optimal' tax level have produced a wide range of estimates (World Bank 1999). However, effective taxation policy must ensure that increases are real and occur as often as necessary to maintain their effectiveness. Further, it is important that taxation effects are not insulated or absorbed by manufacturing techniques or tobacco companies' pricing policies.

Health warnings

Currently a warning message must appear on the front of all tobacco packets as well as an explanatory message providing greater detail on the back of the pack and a telephone number for an information service.

As part of Australia's National Tobacco Strategy, the Commonwealth Government is undertaking an evaluation of the current health warnings on tobacco products to inform recommendations regarding any changes to warnings. Consideration has been given to Canadian-style, graphic, full-colour warnings covering the top half of the front and back of tobacco packages. An evaluation of these health warnings found that they increased concern about the health effects of smoking and increased the motivation to quit amongst a significant proportion of smokers (Environics Research Group 2001).

Concerns also exist around the use of misleading words on tobacco packaging such as 'mild', 'light' and 'ultra light'.

Limiting age of purchase

Smoking behaviour is well established before the end of teenage years and, as such, restricting the availability of cigarettes to young people could contribute to a reduction in smoking prevalence. Currently the minimum age of purchase of tobacco products in all Australian jurisdictions is 18 years. However in Australia in 2001, 82.6% of underage smokers had purchased their last cigarette from a shop or retail outlet (Australian Institute of Health and Welfare 2002b).

ADCA supports initiatives outlined in the *National Tobacco Strategy 1999 to 2002-03: a framework for action* to restrict young people's access to tobacco products. The strategy recommends the prohibition of self-service vending machines; the introduction of consistent licensing and/or registration schemes of outlets where tobacco products are sold; and the development of a national model of best practice in sales to minors programs (Commonwealth Department of Health and Aged Care 1999).

Smoking cessation programs

Smoking cessation programs which are tailored to the target population and which consist of multiple interventions including nicotine replacement therapy (NRT) and techniques to reduce relapse (such as counselling or behavioural therapies) appear to be the most cost effective (Mattick & Baillie 1992). Interventions from a health care professional ranging from advice regarding

quitting through to more comprehensive interventions, when coupled with nicotine chewing gum, are also cost effective (Mattick & Baillie 1992).

Pharmacotherapy treatments for tobacco dependence include NRT and bupropion (registered as Zyban®) the latter of which is currently the only smoking cessation pharmacotherapy subsidised under the Pharmaceutical Benefits Scheme. Both bupropion and all forms of NRT available in Australia (gum, patches, lozenges and inhalers) have been shown to be safe and effective medications which significantly improve the outcomes for smokers who wish to overcome their dependence (Peters & Morgan 2002).

Reducing exposure to environmental tobacco smoke

Introduction of smoking restrictions has been found to protect non-smokers from tobacco related problems, reduce tobacco consumption, reduce uptake of smoking by young people and increase the rate at which smokers attempt to quit (VicHealth Centre for Tobacco Control 2001b).

There is strong community support for smoking restrictions. In 2001, support for smoking bans in the workplace, shopping centres, restaurants and pubs/clubs was 81%, 85%, 84% and 61% of respectively of the population aged 14 years and over (Australian Institute of Health and Welfare 2002b). More than 30 published independent studies show smoking bans do no harm to hospitality establishments and can actually improve their business (Action on Smoking and Health Australia 2002c).

In Australia smoking is prohibited in all federally owned and operated buildings and on all forms of public transport. There has also been significant formal and informal industry self-regulation of smoking in enclosed public places and workplaces. Legislation has been implemented in some jurisdictions for smoke-free indoor areas in workplaces, restaurants, cafes, shops, theatres and sports stadiums, most notably the Melbourne Cricket Ground.

However, despite much progress in the last decade to reduce exposure to environmental tobacco smoke, 25-30% of employees nationally are still exposed to tobacco smoke at work (VicHealth Centre for Tobacco Control 2001b). It is clear that legislation is the most effective strategy to address this issue as opposed to the implementation of voluntary codes. As such, state and territory governments must extend their current legislation restricting smoking in all workplaces and indoor public spaces.

National Tobacco Strategy

In 1999 the Ministerial Council on Drug Strategy endorsed the *National Tobacco Strategy 1999 to 2002-03: a framework for action*. The goal of the strategy is 'to improve the health of all Australians by eliminating or reducing their exposure to tobacco in all its forms' (Commonwealth Department of Health and Aged Care 1999). Its objectives are to:

- prevent the uptake of tobacco use in non-smokers, especially children

- reduce the number of users of tobacco products
- reduce the exposure of users to the harmful health consequences of tobacco products
- reduce exposure to tobacco smoke.

The strategy aspires to reduce tobacco related morbidity, mortality and economic costs in the long term. Short-term measures such as population rates of smoking (overall and among specific target groups), numbers of cigarettes smoked and levels of exposure to environmental tobacco smoke provide an indication of changes to the longer-term outcomes.

Recommended actions accompany specific objectives in each of the following six key strategy areas:

- strengthening community action for tobacco control
- promoting cessation of tobacco use
- reducing availability and supply of tobacco
- reducing tobacco promotion
- regulating tobacco
- reducing exposure to environmental tobacco smoke.

ADCA supports the National Tobacco Strategy and urges all governments to adequately resource strategies to prevent and treat tobacco use. That said, consistent with its view on all aspects of the National Drug Strategic Framework, ADCA believes that there is a need for more specific objectives, strategies and targets for government and community action. ADCA also points to the fact that there have been insufficient resources allocated to the strategy.

Expenditure on anti-smoking programs

In 1997-98, Australian governments collected over $4.5 billion from taxes on tobacco products. Of the $1.56 billion retained by the federal government, less than $4.25 million – a quarter of one per cent of this revenue – was directed to anti-smoking education. It has been estimated that governments receive more than $64 million in taxes from smoking by Australian school children alone (Scollo 1998).

The discrepancy between revenue from tobacco taxes and expenditure by the federal government on anti-smoking programs is demonstrated in the table on the following page.

Table 1 Federal tobacco excise revenue from smokers compared with budget commitments on recent and planned anti-smoking campaigns and strategies

Year	Actual & expected federal excise revenue on cigarettes ($m)	Actual & committed expenditure on anti-smoking ($m)	Factor by which federal revenue from cigarettes exceeds commitment to anti-smoking education
1996-97	1 625	4.25	380 x more
1997-98	1 655	4.25	390 x more
1998-99	1 615	2.99	540 x more
1999-00	1 740	5.21	359 x more
2000-01	4 610	4.16	1 108 x more
2001-02	4 605	2.40	1 919 x more
		62.40 [a]	74 x more [a]

[a] commitment and factor including estimated subsidies for Zyban®
Source: VicHealth Centre for Tobacco Control 2001

Despite increases in recent years, the resources allocated to tobacco control in Australia do not compare well with international levels. Per capita expenditure in the UK, Canada, Ireland and New Zealand are considerably higher than in Australia. When considering the scale of the problems caused by tobacco, government contributions are minimal.

In 2001 bupropion, marketed as Zyban®, was listed on the Pharmaceutical Benefits Scheme (PBS) as a short-term treatment to assist people to quit smoking by reducing withdrawal symptoms and the urge to smoke. The PBS listing resulted in sales of Zyban® increasing dramatically at a cost to the federal government of over $62 million dollars in 2001-02. It has been estimated that the costs for subsidizing Zyban® could end up being over five times the expenditure on anti-smoking education nationally (VicHealth Centre for Tobacco Control 2001).

While ADCA supports pharmacotherapies for tobacco dependence treatment being easily available to smokers, it is important that the investment in treatment for drug dependence does not undermine or reduce efforts in prevention, particularly as many prevention initiatives have been found to be very cost effective. Evidence suggests mass media education may be as much as ten times more cost effective than tobacco dependence treatment (VicHealth Centre for Tobacco Control 2001).

The VicHealth Centre for Tobacco Control published *Tobacco control: a blue chip investment in public health* in 2001. This document outlines a practical agenda for action that would markedly reduce the social costs of tobacco use in Australia. ADCA supports the policy proposal outlined in the document and urges Australian governments to invest considerably greater resources in tobacco control.

ADCA policy recommendations

ADCA recommends that:

- governments adequately resource the actions outlined in Australia's National Tobacco Strategy
- governments develop strategies for increasing awareness among young women of the effects of tobacco products through well designed and delivered mass media anti-tobacco campaigns
- all state/territory governments extend their current legislation to restrict smoking in all workplaces and indoor public spaces.

See also

Treatment	2.4
Taxation and pricing	2.6

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