NATIONAL TOBACCO STRATEGY 2012–2018

A strategy to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes

Contents

Executive Summary

Tobacco remains a significant cause of death and disability in Australia. Around 3.3 million Australians still smoke[1] and an estimated 15,000 people die each year of smoking-related illness.[2]

Australia has been successful in reducing smoking prevalence over many years. Yet smoking rates in our community are still too high: 15.1 per cent of people 14 years or over were smoking daily in 2010.[1] The rate of smoking among Aboriginal and Torres Strait Islander people is more than twice that of the general population: 45 per cent of Aboriginal and Torres Strait Islander people aged 15 years and over were smoking daily, in 2008.[3] Smoking rates among the most socioeconomically disadvantaged groups in our community are also high,[1] contributing to and compounding existing health inequalities.

Through the National Healthcare Agreement in 2008, and as updated in 2012, the Council of Australian Governments committed to the following performance benchmark:

'By 2018, reduce the national smoking rate to 10 per cent of the population, and halve the Indigenous smoking rate, over the 2009 baseline'.[4,5]

Progress against this performance benchmark will be measured by reference to the adult daily smoking rate.[6] This performance benchmark forms the basis for the targets adopted in this strategy. While the targets are ambitious, substantial progress will be made towards achieving them if the actions in this strategy are fully implemented.

This strategy has been developed by the Intergovernmental Committee on Drugs (IGCD) Standing Committee on Tobacco, with input from a range of stakeholders, including governments, health groups, community-based organisations, industry organisations and the public. All health ministers endorsed the strategy at the 9 November 2012 meeting of the Standing Council on Health.

This document sets out the national framework to reduce tobacco-related harm in Australia. The goal of the strategy is to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes. It also details objectives and targets for tobacco control until 2018 and sets out nine priority areas for action.

These priority areas have been informed by the extensive national and international evidence base for tobacco control and reflect best practice approaches to reducing tobacco-related harm. The nine priority areas are as follows:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference

2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking

3. Continue to reduce the affordability of tobacco products

4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people

5. Strengthen efforts to reduce smoking among people in populations with a high prevalence of smoking

6. Eliminate remaining advertising, promotion and sponsorship of tobacco products

7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems

8. Reduce exceptions to smoke-free workplaces, public places and other settings

9. Provide greater access to a range of evidence-based cessation services and supports to help smokers to quit.

A strength of the Australian approach to tobacco control has been the strong and enduring partnerships developed between governments, non-government organisations and community groups to reduce the harm caused by smoking. This strategy provides a framework that supports the strengthening and expansion of these partnerships within Australia. The framework also supports Australia's engagement in international partnerships to maximise the effectiveness of global tobacco control efforts and to learn and share best practice approaches to reducing tobacco-related harm.

The strategy also provides a framework for building the evidence base for tobacco control and monitoring progress.

PART ONE: BACKGROUND

1.1   INTRODUCTION

Smoking is a leading cause of preventable death and disease in Australia. It is responsible for more drug-related hospitalisations and deaths than alcohol and illicit drugs combined.[7]

Smoking greatly increases the risk of many cancers, cardiovascular disease, chronic obstructive pulmonary disease and other respiratory diseases, peripheral vascular disease and many other serious medical conditions.[8] Exposure to second-hand smoke also causes disease and premature death in adults and children who do not smoke.[9]

Tragically, half of all long-term smokers will die prematurely because they smoked.[10] Smoking also imposes a heavy financial burden on the Australian community – estimated at $31.5 billion in 2004–05.[11]

Reducing tobacco-related harm in our community is a priority for all governments. The National Tobacco Strategy 2012–2018 has been prepared by the IGCD Standing Committee on Tobacco, with input from a range of stakeholders, including governments, health groups, community-based organisations, industry organisations and the public. All health ministers endorsed the strategy at the 9 November 2012 meeting of the Standing Council on Health.

The strategy sets out the national framework to reduce tobacco-related harm in Australia. It reflects best practice in tobacco control and complements existing policy frameworks at the state and territory, national and international levels.

The strategy provides an overview of the impact of tobacco use in Australia, and outlines shared goals, objectives and targets for tobacco control across government and non-government agencies for the next six years. It also identifies nine priority areas and associated key actions to be implemented to reduce tobacco-related harm.

The approach in this strategy is to build on the success of previous national tobacco strategies and to continue to emphasise population-wide approaches that have been successful in reducing smoking prevalence over the past four decades. Over this time, Australia has progressively implemented a comprehensive range of policies including mass media campaigns, cessation services, health warnings on packaging, prohibitions on tobacco advertising, price increases, and controls on second-hand smoke and access to tobacco. This sustained and comprehensive public health approach has successfully reduced Australian smoking rates to a level among the lowest in the world.[12]

Through the National Healthcare Agreement (NHA) in 2008, and as updated in 2012, the Council of Australian Governments (COAG), committed to the following performance benchmark:

- 'By 2018, reduce the national smoking rate to 10 per cent of the population, and halve the Indigenous smoking rate, over the 2009 baseline.'[4,5]

Consistent with this performance benchmark, the COAG National Partnership Agreement on Preventive Health (NPAPH), signed in 2008 and varied in 2012, contained the following public health outcome:

- 'Reduce the proportion of Australian adults smoking daily to 10 per cent within 10 years.'[13,14]

The targets identified in this strategy are based on the abovementioned performance benchmark and public health outcome (see Part 5.3 for further detail). Achieving these targets requires a renewed focus on proven tobacco control strategies and some new approaches, particularly with populations with a high prevalence of smoking.

This strategy includes important new measures to reduce harm caused by smoking, such as the implementation of the world's first plain packaging laws for tobacco, implementation of new and expanded graphic health warnings in association with plain packaging, restrictions on internet advertising of tobacco products, consideration of further regulation of tobacco products, and strengthening other aspects of tobacco control. There is a strong emphasis on reducing the health inequalities arising from smoking among populations in Australian society with a high prevalence of smoking. Successful population-wide strategies will be complemented by targeted approaches to assist populations with a high prevalence of smoking to quit smoking and to reduce health inequalities.

Finally, this strategy recognises the importance of working in partnership. It will provide a strong platform for continued partnerships between governments and non-government organisations and help drive the establishment of new partnerships to reduce tobacco-related harm. This approach has been a hallmark of tobacco control and has been crucial to its success over many years.

1.2 STRUCTURE

The strategy is divided into seven parts:

- Part One: Background
- Part Two: The Size of the Problem
- Part Three: Policy Context
- Part Four: Progress and Future Challenges
- Part Five: The Framework
- Part Six: Priority Areas and Actions
- Part Seven: Monitoring Progress.

PART TWO: THE SIZE OF THE PROBLEM

2.1 SMOKING PREVALENCE IN THE GENERAL POPULATION

Australia has made significant gains in reducing smoking prevalence over many years. The National Drug Strategy Household Survey (NDSHS)[a] shows that in 2010, 15.1 per cent of people in Australia aged 14 years or older were daily smokers, a reduction from 16.6 per cent in 2007 and from 24.3 per cent in 1991.[1] Around a quarter of the population aged 14 years or older were ex-smokers and more than half had never smoked.[1]

The NDSHS also shows that in 2010, 15.9 per cent of people aged 18 years or older were daily smokers,[1] a reduction from 17.5 per cent in 2007 and from 25 per cent in 1991.[15] In 2010, among adults 18 years or older, 17.4 per cent of the male population and 14.5 per cent of the female population smoked on a daily basis.[1]

The largest declines in daily smoking between 2007 and 2010 were among people in their early 20s to mid-40s, while the proportion of those aged 45 years or older smoking daily remained relatively stable or slightly increased between 2007 and 2010. However, in 2010 almost one in five people in the 20–39-year age group continued to smoke daily.[1]

Figure 1. Tobacco smoking status among people aged 14 years or older, Australia, 1991 to 2010
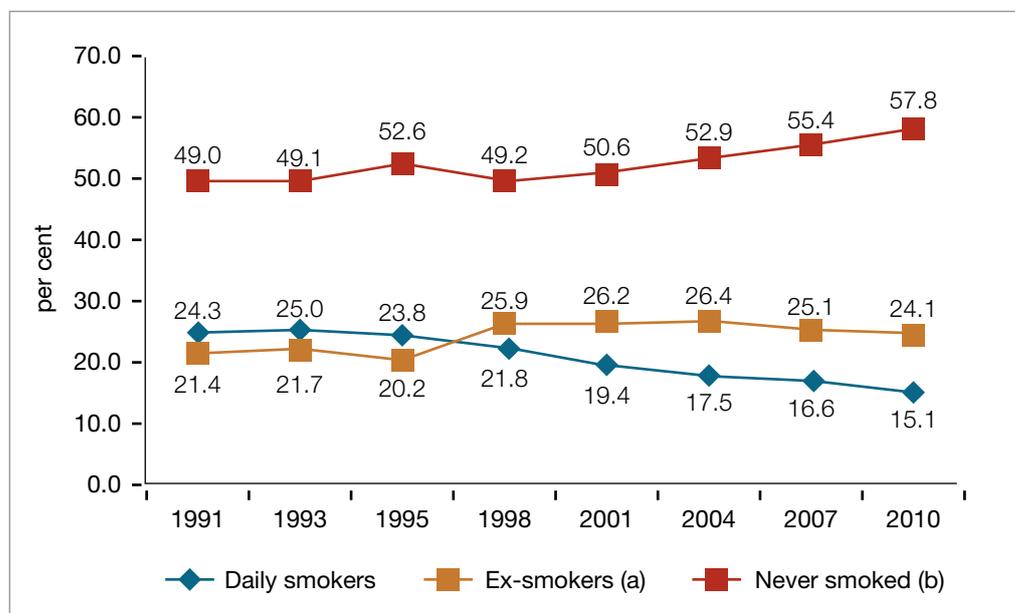
Adapted from Australian Institute of Health and Welfare (AIHW) 2010 National Drug Strategy Household Survey Report.

Notes:

(a) Smoked at least 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco in their life, and report no longer smoking.

(b) Never smoked 100 cigarettes (manufactured and/or roll-your-own) or the equivalent amount of tobacco.

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[a] The 2010 NDSHS is the primary data source referenced in the strategy to demonstrate trend data for smoking prevalence in Australia. The Australian Health Survey: First Results, 2011–12 (released by the Australian Bureau of Statistics on 29 October 2012) has not been referenced in the strategy as it is not directly comparable to the NDSHS. At the time the strategy was prepared, the NDSHS was the most current, comprehensive national data source available.

2.2 POPULATIONS WITH A HIGH PREVALENCE OF SMOKING

Smoking rates among people from low socioeconomic groups, those who are unemployed,[1] homeless[16] or imprisoned,[17] and those with a mental illness[18] or other drug or alcohol dependency[19] are much higher than for the general population.

In 2010, around a quarter of people in low socioeconomic groups (24.6 per cent) reported smoking in the last 12 months.[1] Smoking rates of around 66 per cent have been reported among people with psychotic disorders.[20,21] Daily smoking prevalence among prisoners is estimated at 74 per cent.[17]

In 2010, those living in remote areas were more likely to have reported smoking in the last 12 months (28.9 per cent) compared to those living in outer regional areas (20.7 per cent), inner regional areas (19.9 per cent) and major cities (16.8 per cent).[1]

Smoking Prevalence among Aboriginal and Torres Strait Islander People

Results from the 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) provide the most recent data on tobacco smoking. The daily smoking rates for Aboriginal and Torres Strait Islander Australians were more than double those in the rest of the community: 47.7 per cent of Aboriginal and Torres Strait Islander people aged 18 years and over smoked daily.[3] Forty-five per cent of Aboriginal and Torres Strait Islander people aged 15 years and over were current daily smokers, 20 per cent were ex-smokers, and 33 per cent had never smoked.[3]

Smoking Prevalence among Culturally and Linguistically Diverse Populations

The results of the NDSHS in 2010 show that those who mainly speak English at home are more likely to be current smokers (18.4 per cent) compared to non-English speakers (11.6 per cent) and are also more likely to smoke more cigarettes per week (105 cigarettes) compared to non-English speakers (65 cigarettes). However, the results must be interpreted with caution as the NDSHS was conducted in English and had an underrepresentation of non-English speakers.[1] Additionally, various studies have identified smoking rates as high as 50 per cent in certain culturally and linguistically diverse populations, particularly among men (e.g. men of Arabic,[22] Chinese,[23] and Vietnamese[24] backgrounds).

2.3 SMOKING PREVALENCE IN STATES AND TERRITORIES

Smoking prevalence varies somewhat across Australian states and territories.[1]

In 2010, the Australian Capital Territory (ACT) had the lowest daily smoking prevalence among jurisdictions (11.7 per cent of people aged 18 years and over were daily smokers), while the Northern Territory (NT) had the highest (23.9 per cent).[1]

Figure 2. Changes in daily smoking status of Australians aged 18 years and older by each Australian state and territory, 1998, 2001, 2004, 2007 and 2010
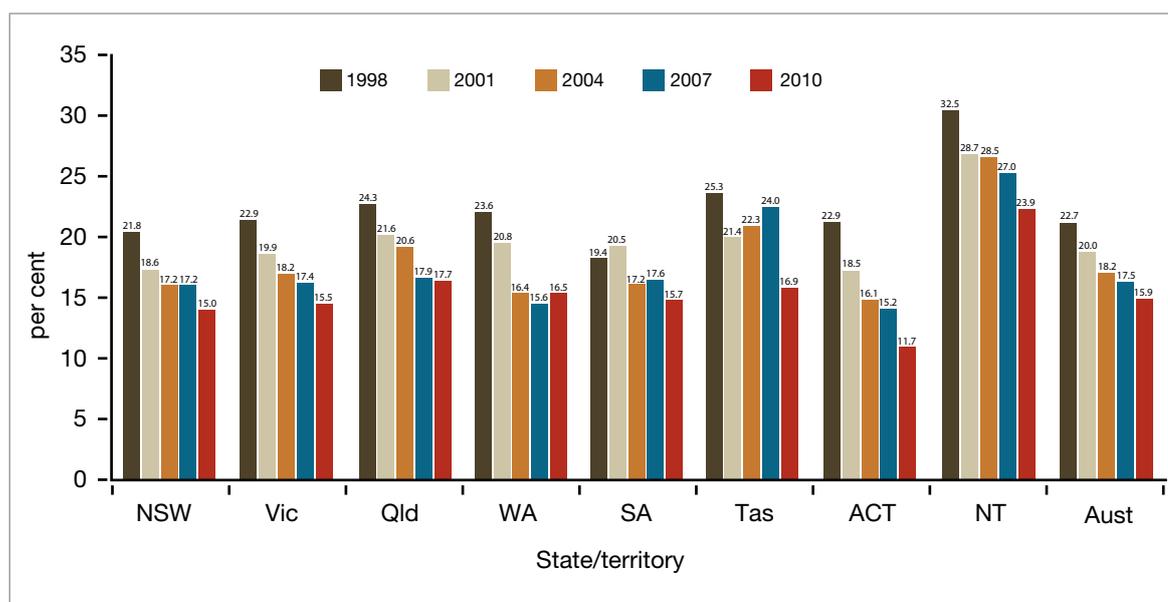
Source: AIHW analysis of National Drug Strategy Household Survey 1998, 2001, 2004, 2007 and 2010.

2.4 SMOKING AMONG SECONDARY SCHOOL STUDENTS

The majority of smokers start smoking as teenagers.[25,26] National surveys of smoking among secondary school students have been conducted since 1984. The latest surveys confirm that smoking prevalence among teenagers fell dramatically in recent years.[27] In 2011, the proportion of students who were current smokers (i.e. smoking in the last week) ranged between 1 per cent among 12-year-olds to 15 per cent among 17-year-olds.[27]

Students who had smoked on three or more days of the preceding week were defined as committed smokers. Only 4 per cent of all students were in this category; the proportion was highest among 17-year-olds, at 9 per cent.[27]

Figure 3. Prevalence of secondary school students who report smoking in the last week, Australia, 1984 to 2011, 12–15 year-olds and 16–17 year-olds
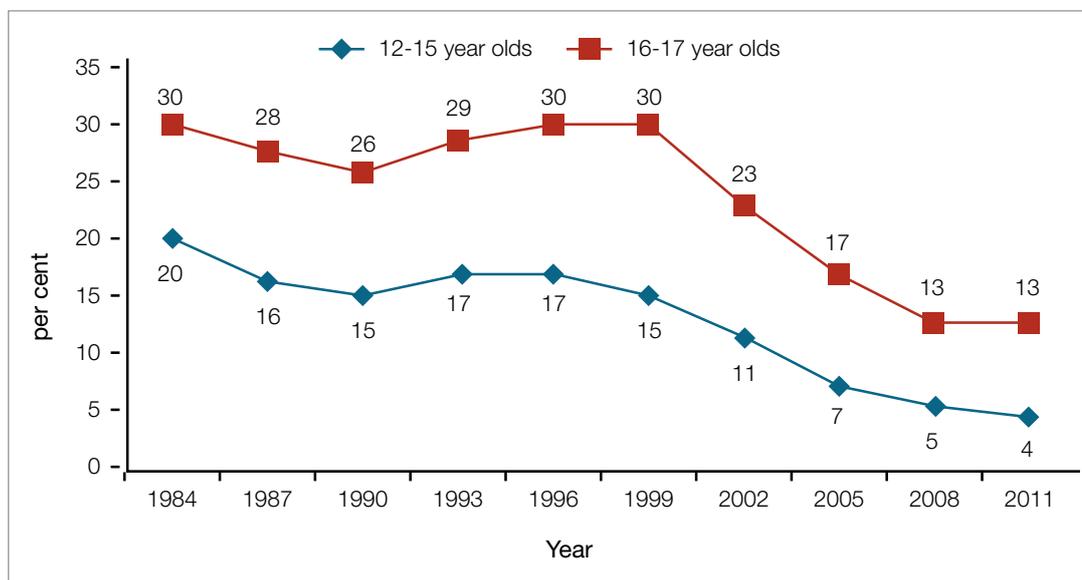
Adapted from:

Germain D, Winstanley M, Zacher M and White V. Trends in smoking prevalence. In Scollo MM and Winstanley MH. *Tobacco in Australia: Facts and Issues*, 4th Edition. 2012, Cancer Council Victoria: Melbourne. (Cites White and Smith 2009 – see below.)

White V and Smith G. *Australian secondary school students' use of tobacco, alcohol, and over-the-counter and illicit substances in 2011*. 2012, Cancer Council Victoria: Melbourne.

PART THREE: POLICY CONTEXT

3.1   POLICY FRAMEWORKS

This strategy draws strongly on existing health and social policy frameworks as well as tobacco control policies at the national and international levels.

It is a sub-strategy of the National Drug Strategy 2010–2015, which provides a framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco and other drugs. Central to this approach are the three pillars of demand reduction, supply reduction and harm reduction, which are applied together to minimise harm.[28]

This strategy recognises the importance of the previous national tobacco strategies that have been in place since 1999, and the substantial progress that has been made under the most recent strategy in 2004–09. These strategies provided a comprehensive, evidence-based partnership for tobacco control for Australia. The National Tobacco Strategy 2004–09 emphasised seven program areas that guided action in tobacco control in Australia.[42] The seven priority areas of the 2004–09 strategy were:

1. Further use of regulation to reduce the use of, exposure to, and harm associated with tobacco

2. Increased promotion of *quit* and *smoke free* messages

3. Improving the quality of, and access to, services and treatment for smokers

4. Providing more useful support to parents, carers and educators, helping children to develop a healthy lifestyle

5. Endorsing 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

6. Tailoring messages and services to ensure access by disadvantaged groups

7. More focused research and evaluation to fine-tune policies and programs.

Achievements under the 2004–09 strategy are summarised in Part 4.1 of this document. Many of the priorities and actions identified in the 2004–09 strategy will continue in this 2012–2018 strategy.

This strategy is informed by the evidence, priorities and approaches outlined in state and territory tobacco control policies.

It also draws on the comprehensive review of evidence and the recommendations of the National Preventative Health Taskforce report[29] released in September 2009 and the Australian Government's response to this report.[30] The National Preventative Health Taskforce completed a significant consultation process across Australia seeking views on the best approaches to address problems associated with tobacco, alcohol and obesity. The report recommended 11 actions to achieve the target of reducing smoking to 10 per cent or less by 2018. Many of these actions have been included in this strategy.

The targets in this strategy are consistent with the performance benchmark agreed by COAG in the 2008 National Healthcare Agreement[4] and its 2012 update[5] and the public health outcome identified in the COAG 2008 National Partnership Agreement on Preventive Health[13] and its 2012 update[14] (for detail, see Part 5.3 of this strategy).

This strategy also takes account of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes. COAG has agreed to six high-level targets for closing the gap between Aboriginal and Torres Strait Islander people and other Australians.[31] The first target, *Close the gap in life expectancy within a generation*, is directly relevant to the National Tobacco Strategy as smoking is the leading risk factor for chronic disease in Aboriginal and Torres Strait Islander people, accounting for 12 per cent of the total burden of disease and one-fifth of deaths,[32] making efforts to reduce smoking in the Aboriginal and Torres Strait Islander population critical.[3]

Finally, this strategy is consistent with Australia's obligations as a party to the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC).[33] The FCTC aims to advance international cooperation to protect present and future generations from the preventable and devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.

The WHO FCTC and its guidelines commit nations to implementing tobacco control measures including policies on tobacco price and tax increases, prohibiting or restricting tobacco advertising, promotion and sponsorship, requiring labelling with more prominent health warnings, protecting against exposure to second-hand smoke, supporting smoking cessation interventions, education and public awareness activities and combating illicit trade.[33] The preamble to the WHO FCTC also recognises the need for the parties to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts.[33]

The Australian Government reports every two years to the Conference of the Parties to the WHO FCTC on progress in implementing the convention.

PART FOUR: PROGRESS AND FUTURE CHALLENGES

4.1 ACHIEVEMENTS UNDER THE NATIONAL TOBACCO STRATEGY 2004–09

The National Tobacco Strategy 2004–09 delivered a range of achievements. Under that strategy, the prevalence of daily smoking fell dramatically among all age and socioeconomic groups. The number of people (14 years or older) who smoked daily decreased by approximately 100,000 (2.9 million in 2007 down to 2.8 million in 2010).[1]

Smoking by teenagers fell to unprecedented levels. In 2011, teenage smoking reached the lowest level in more than 25 years and the majority of secondary school students (77 per cent) had never smoked a cigarette.[27]

Also in 2008, the first signs of progress in reducing smoking prevalence among Aboriginal and Torres Strait Islander people became evident. Smoking prevalence among Aboriginal and Torres Strait Islander people aged 15 years and over declined for the first time in almost 15 years, falling from 49 per cent in 2002 to 45 per cent in 2008.[3] Almost two-thirds of Aboriginal and Torres Strait Islander smokers tried to quit or reduce their smoking in the previous 12 months.[3]

States and territories progressively implemented smoke-free legislation covering many indoor and outdoor public places, thus protecting the health of children, the general public and employees.

Fewer children were exposed to second-hand smoke in their homes. Around 8 per cent of households with dependent children had at least one person who smoked inside the home in 2007 – down from 12.3 per cent in 2004.[34] Several states and territories also passed legislation to require cars to be smoke free when children are in the car.

Mass media campaigns and health warnings on cigarette packets continued to remind smokers of the health risks associated with smoking, encourage and motivate them to quit and prevent relapse behaviour. Mass media campaigns also helped shape broader social norms about smoking and helped reinforce policy and legislative changes. In 2010, almost 40 per cent of smokers had reduced the amount they smoked in a day and almost 20 per cent of smokers had successfully given up smoking for more than a month. A further 29 per cent of smokers made a quit attempt that was not successful.[1]

There was substantial progress by state and territory governments in prohibiting advertising and display of packaging at point of sale and in enforcement of restrictions on the sale of tobacco to minors.

In 2004, the Australian Government introduced graphic health warnings for the first time, requiring almost all Australian-manufactured or imported tobacco product packaging to have graphic health warnings from 1 March 2006. The previous requirement to print yield levels (tar, nicotine and carbon monoxide figures) on packaging was also removed at the time and replaced with qualitative information about harmful smoke constituents.[16,35]

In 2005, following a lengthy investigation, the Australian Competition and Consumer Commission (ACCC) obtained court enforceable undertakings from the then three main Australian cigarette manufacturers, British American Tobacco Australia Limited,[36] Philip Morris Limited[37] and Imperial Tobacco Australia Limited,[38] to remove 'light', 'mild' and related descriptors from packaging; to cease making related health representations; and to contribute $9 million for a campaign to raise consumer awareness that low-yield cigarettes are not a safer/healthier alternative to higher yield (or regular) cigarettes.

The NDSHS[1] provides data that indicates that the availability of illicit tobacco in Australia is low. This supports the view that Australia has successfully prevented the emergence of widespread illicit trade in tobacco as has occurred in some other countries.

4.2 WHAT CHALLENGES REMAIN?

There are many significant challenges for tobacco control in the coming years.

An estimated 15,000 Australians die each year from tobacco-related disease,[2] leaving grieving partners, children, grandchildren and friends behind.

Smoking rates in our community are still too high: in 2010, 15.1 per cent of Australians aged 14 years or over were smoking daily and about three million were smoking at least daily or weekly.[1]

The prevalence of smoking among Aboriginal and Torres Strait Islander adults is more than double that of the general population.[3] Exposure of Aboriginal and Torres Strait Islander children to second-hand smoke in their homes is high[3] and the rate of smoking during pregnancy is also high.[39]

A number of population groups have a much higher prevalence of smoking than the general population. In 2007, children living in households in the most socioeconomically disadvantaged areas in Australia were more than three times more likely to be exposed to tobacco smoke in the home compared to those living in the most socioeconomically advantaged areas.[34]

While smoking rates have declined markedly among secondary school students, in 2008 more than 110,000 secondary school students had smoked at least one cigarette in the week prior to the survey[27] and around 16,500 Australian school children progressed from experimental to established smoking behaviour.[b,40]

There is strong evidence of an association between social determinants – such as unemployment, homelessness, poverty and family breakdown – and drug use. Family influences also have a strong association with drug use.[28] Many of the factors that underlie social disadvantage are also strongly predictive of smoking uptake.[42]

In 2010, daily smoking prevalence among prisoners was estimated at 74 per cent.[17] Smoking prevalence among people with mental illness is also very high:[18] it is estimated that around 66 per cent of people with psychosis are current smokers (73 per cent of men and 56 per cent of women).[20]

Mass media campaigns are highly effective components of tobacco control programs,[43] second only to price increases.[c] The media environment in Australia is changing rapidly and campaigns must adapt to a range of communication challenges and opportunities such as the rapid growth in the number of free-to-air channels and the increasing importance of subscription television, the internet and social media.

There are currently few controls on the manufacturing, distribution and availability of tobacco in Australia. Despite the harm associated with its use, tobacco remains as widely available as commonplace items like bread and milk. Apart from state and territory legislation in some jurisdictions that prohibits fruit- and confectionery-flavoured cigarettes, there are no regulatory controls on the ingredients in tobacco products in Australia.

There is concern that current policy arrangements for product disclosure are inadequate. There is also concern regarding the availability and promotion of alternative nicotine delivery systems such as electronic cigarettes, and whether the current regulatory framework is providing sufficient coverage of these products.

Finally, implementing the actions in this strategy will require a commitment to maintaining existing partnerships and building new ones. Tobacco control, like other public health initiatives, requires sustained effort and comprehensive approaches to be effective. There is no quick fix.

[b] Using the methodology outlined in White and Scollo.

[c] International readers should note this relates to policies in a country where tobacco advertising has already been banned.

PART FIVE: THE FRAMEWORK

5.1 THE GOAL

The goal of this strategy is 'To improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes.'

5.2 THE OBJECTIVES

The objectives of the strategy are to:

- prevent uptake of smoking

- encourage and assist as many smokers as possible to quit as soon as possible, and prevent relapse

- reduce smoking among Aboriginal and Torres Strait Islander people, groups at higher risk from smoking, and other populations with a high prevalence of smoking

- eliminate harmful exposure to tobacco smoke among non smokers

- reduce harm associated with continuing use of tobacco and nicotine products

- ensure that tobacco control in Australia is supported by focused research and evaluation

- ensure that all of the above contribute to the continued denormalisation of smoking.

5.3 TARGETS

By 2018:

- Reduce the national adult daily smoking rate to 10 per cent of the population.

- Halve the Aboriginal and Torres Strait Islander adult daily smoking rate.

The baselines for these targets are set out in the National Agreement Performance Information 2008–09 report for the National Healthcare Agreement.[6] These baselines are a national adult daily smoking rate of 19.1 per cent in 2007–08, and an Aboriginal and Torres Strait Islander adult daily smoking rate of 47.7 per cent in 2008.[6]

5.4 PRIORITY AREAS

This strategy identifies nine priority areas for future action. These priority areas have been informed by the extensive evidence base for tobacco control, and reflect best practice approaches to reduce the harm caused by smoking. They contain demand reduction, supply reduction and harm reduction approaches and build on the progress we have made over the past four decades.

Experience in Australia and internationally shows that reducing smoking rates requires a comprehensive and sustained approach. Reflecting this comprehensive public health approach, the priority areas in this strategy include actions to eliminate the remaining advertising, promotion and sponsorship of tobacco products, reduce the affordability of tobacco products, increase smoke-free areas, strengthen mass media and public education campaigns and cessation services, and support consideration of further regulation of the contents of tobacco products, product disclosure and the supply of tobacco products.

Notably, many of the actions included in this strategy, such as the plain packaging legislation, updated and expanded graphic health warnings, mass media campaigns, tax excise increases, tobacco advertising restrictions and expansion of smoke-free restrictions are likely to further reduce uptake of smoking by young people.

This strategy also has a strong commitment to reducing the social and health inequalities associated with tobacco use. It therefore includes a strong emphasis on working in partnership to reduce smoking rates among Aboriginal and Torres Strait Islander people and other populations with a high prevalence of smoking.

The nine priority areas are:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference

2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking

3. Continue to reduce the affordability of tobacco products

4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people

5. Strengthen efforts to reduce smoking among populations with a high prevalence of smoking

6. Eliminate remaining advertising, promotion and sponsorship of tobacco products

7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems

8. Reduce exceptions to smoke-free workplaces, public places and other settings

9. Provide greater access to a range of evidence-based cessation services to support smokers to quit.

5.5 WORKING IN PARTNERSHIP

Reductions in smoking prevalence cannot be achieved by governments alone. A strength of the Australian approach to tobacco control has been the strong and enduring partnerships developed between governments, non-government organisations and community groups to reduce the harm caused by smoking.

Under this strategy, governments and non-government organisations will:

- Strengthen longstanding partnership relationships

- Identify and form new partnerships in order to expand opportunities for tobacco control interventions within a range of health and community settings

- Build the capacity of a range of organisations and health workers to implement tobacco control programs.

A priority will be to strengthen existing partnerships between governments and Aboriginal and Torres Strait Islander communities and community-controlled organisations. These partnerships will underpin the continued roll-out of policies and programs to tackle smoking among Aboriginal and Torres Strait Islander people and contribute to efforts to 'close the gap' in relation to health outcomes.

New partnerships will also need to be forged between health agencies, social service organisations, mental health care providers and corrections services if people with multiple and complex needs are to be assisted to quit smoking and reduce exposure to second-hand smoke.[28]

Australia will continue to engage in international partnerships to maximise the effectiveness of global tobacco control efforts and to learn and share best practice approaches to reducing tobacco-related harm.[28] Australian government agencies and non-government organisations will also continue to engage with developing countries, particularly in the Asia-Pacific region, to provide assistance on tobacco control as needed. Under this strategy, Australia will also continue to actively engage in global tobacco control forums including the Conference of the Parties to the WHO FCTC.[33]

The Australian Customs and Border Protection Service and the Australian Taxation Office will continue to cooperate with their international counterparts and state and territory governments to reduce the illicit trade in tobacco products.

5.6 BUILDING THE EVIDENCE BASE FOR TOBACCO CONTROL

There is overwhelming evidence about the harms of tobacco. There is also an extensive body of evidence on effective interventions to reduce tobacco-related harm and reduce smoking rates. Over the past 40 years, Australian researchers have been strong contributors to strengthening this evidence base.

The approach to tobacco control is underpinned by our commitment to evidence-based policy. Where the evidence does not yet exist on the most effective interventions, we will be guided by the best available information, and ensure that robust evaluation contributes to the future evidence base.

Comprehensive monitoring and surveillance systems are an essential element of this strategy. They enable us to monitor our progress and determine whether we are achieving our specified targets over time.[29] Ensuring the tobacco control workforce is able to access the latest evidence and knowledge about tobacco control policies and issues is a priority. Australia has a comprehensive and up-to-date resource on tobacco control evidence and policies available online free of charge – Tobacco in Australia: Facts and Issues.[16]

The priority areas and actions in this strategy are underpinned by strong interdisciplinary research and evaluation capacity.[29] Knowledge gaps have been identified by the National Preventative Health Taskforce Report, particularly in relation to evidence-based interventions in Aboriginal and Torres Strait Islander populations and other populations with a high prevalence of smoking.[29] Addressing this gap is a priority.

There is also a need to evaluate the impact of new policies such as the world's first plain packaging laws and disseminate findings to our international partners. Many organisations will be involved in evaluating the effectiveness of these policies at the state and territory and national levels.

5.7 PROTECTION OF TOBACCO CONTROL POLICIES

Transnational tobacco companies employed a range of sophisticated strategies in an attempt to undermine the development of the WHO FCTC.[44] Studies have also shown that the tobacco industry employed a number of tactics to counter Australian tobacco control policies.[45,46]

Article 5.3 of the WHO FCTC requires that:

in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.[33]

The guidelines for implementation of Article 5.3 recognise the fundamental and irreconcilable conflicts between the tobacco industry's interests and public health policy interests, and provide recommendations to protect tobacco control policies from the tobacco industry to the greatest extent possible.[47]

Consistent with these commitments, Australian governments have a long track record of protecting tobacco control policy from tobacco industry interference. The Department of Health and Ageing lists all meetings with the tobacco industry on its website at: *http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-conv-public*.

PART SIX: PRIORITY AREAS AND ACTIONS

6.1 PROTECT PUBLIC HEALTH POLICY, INCLUDING TOBACCO CONTROL POLICIES, FROM TOBACCO INDUSTRY INTERFERENCE

The WHO FCTC has developed guidelines for implementation of Article 5.3, which states that:

in setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law.

The guidelines recognise the 'fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests'[47] and provide recommendations to protect tobacco control policies from the tobacco industry to the greatest extent possible. The recommendations for addressing tobacco industry interference in public health policies include:

- *Raise awareness about the addictive and harmful nature of tobacco products and about tobacco industry interference with Parties' tobacco control policies.*

- *Establish measures to limit interactions with the tobacco industry and ensure the transparency of those interactions that occur.*

- *Reject partnerships and non-binding or non-enforceable agreements with the tobacco industry.*

- *Avoid conflicts of interest for government officials and employees.*

- *Require that information provided by the tobacco industry be transparent and accurate.*

- *Denormalize and, to the extent possible, regulate activities described as 'socially responsible' by the tobacco industry, including but not limited to activities described as 'corporate social responsibility'.*

- *Do not give preferential treatment to the tobacco industry.*[47]

Consistent with these commitments, Australian governments have a long track record of protecting tobacco control policy from tobacco industry interference.

Action

6.1.1 Develop policies and regulatory options to implement Article 5.3 of the WHO FCTC, which relates to tobacco industry interference in public health policies.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.2 STRENGTHEN MASS MEDIA CAMPAIGNS TO: MOTIVATE SMOKERS TO QUIT AND RECENT QUITTERS TO REMAIN QUIT; DISCOURAGE UPTAKE OF SMOKING; AND RESHAPE SOCIAL NORMS ABOUT SMOKING

Mass media campaigns are widely used to expose high proportions of large populations to messages through use of media such as television, radio and newspapers. Far more studies have been conducted to assess the effects of media campaigns on tobacco use than on any other health-related issue, and the evidence for benefit is strong.[48] Recent reviews[49] provide strong evidence that well-funded and sustained mass media campaigns increase quitting and reduce smoking prevalence when implemented within the context of a comprehensive tobacco control program.[50]

Mass media campaigns often also lead to an increase in frequency and depth of discussion about tobacco use within individual social networks and may prompt encouragement to make a quit attempt from family and friends.[48] In addition, public education through mass media channels informs smokers and the community about the harms of smoking, leading to increased quitting intentions and quit attempts.[49]

There is also strong evidence that adult-targeted mass media campaigns can influence uptake of smoking by young people, change young people's attitudes about tobacco use and curb smoking initiation,[49] and thus are likely to be a major factor behind the marked reduction in smoking prevalence among Australian youth over the past 12 years.

Recent evidence confirms the importance of mass media campaigns in preventing relapse among smokers who have recently quit.[51] Mass media campaigns can reduce the very high risk of relapse that occurs in the time window soon after a quit attempt is made. This highlights the need for mass media campaigns to be on air frequently to maximise their benefit to recent quitters.[51] Research suggests that mass media campaigns aired at or near the time of implementation of other tobacco control policies that promote quit attempts could also improve the longer term success of those quit attempts.[50]

Mass media campaigns have traditionally included broadcast media (television and radio) as well as print media (e.g. newspapers and magazines). Reflecting new and emerging communication formats, some mass media campaigns are also utilising digital media, which includes websites and social media tools such as YouTube, Facebook, Twitter, blogging platforms (e.g. Tumblr, Pinterest and Blogger) and mobile apps.

Evidence also confirms the effectiveness of mass media campaigns for low socioeconomic groups. Evaluation of the National Tobacco Campaign reveals that changes in smoking rates among low socioeconomic groups were of a similar magnitude to changes among high socioeconomic groups. Between 1997 and 1999, prevalence fell 3.9 percentage points in blue-collar groups and 3.7 percentage points in white-collar groups.[52] A review of the literature in 2008 concluded that mass media campaigns can be equally effective with low and high socioeconomic groups but that attention must be paid to the placement and style of advertising.[53]

Subsequent studies have demonstrated the kinds of messages that are most likely to benefit lower socioeconomic status (SES) smokers. For example, an Australian study of Quitline calls in response to mass media campaigns found that lower SES smokers were more likely to call when exposed to high negative emotion narrative advertising campaigns.[54] In a cohort study of smokers in Massachusetts who were exposed to varying amounts and types of anti-tobacco campaigns, smokers were more likely to have quit in response to advertisements eliciting negative emotions, including graphic advertisements and personal testimonials, and this applied especially to smokers of lower SES.[55]

There is strong evidence that the effectiveness of mass media is also highly dependent on the level of investment in placing the campaign on air.[43] To maximise effectiveness these messages need to be broadcast at a sufficient volume and at regular intervals to influence smokers' quitting cognition and behaviour, and this is particularly the case for smokers of lower SES.[56]

Article 12 of the WHO FCTC requires each party to the convention to promote and strengthen public awareness of tobacco control issues, using all available communication tools.[33]

From 2009–10 to 2015–16, the Australian Government is investing funds totalling more than $135 million in anti-smoking campaigns. A new phase of the National Tobacco Campaign was launched by the Minister for Health and Ageing on 30 January 2011, and a subsequent phase was launched on 4 November 2012. The Australian National Preventive Health Agency has a leading role in coordinating and implementing a national approach to mass media campaigns.

This enhanced funding for mass media campaigns will deliver benefits in terms of reduced smoking prevalence, particularly when combined with the April 2010 increases in tobacco excise. The National Tobacco Campaign also provides the opportunity to build on existing campaigns implemented by states and territories. It is being further complemented by more targeted campaigns funded by the Australian Government.

Actions

6.2.1 Run effective mass media campaigns (including television radio, print and digital media formats) at levels of reach and frequency demonstrated to reduce smoking and based on current best practice principles.

Responsibility: Australian Government; state and territory governments (as applicable); non-government organisations.

6.2.2 Continue mass media campaigns targeted to Aboriginal and Torres Strait Islander people, including robust evaluation to inform future campaign strategies.

Responsibility: Australian Government; state and territory governments; non-government organisations; Aboriginal and Torres Strait Islander health organisations such as NACCHO and state/territory affiliates.

6.2.3 Continue to monitor the appropriateness and effectiveness of recommended media weights and media types/channels, including exploration of the potential role of digital media such as YouTube, Facebook and Twitter.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.2.4 Continue to implement national tobacco campaigns and state and territory campaigns, including a balance of existing material with proven effectiveness and a suite of new materials.

Responsibility: Australian Government; state and territory governments.

6.2.5 Enhance collaborative action between the Australian Government, state and territory governments and non-government organisations to maximise the effectiveness of mass media campaigns.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.2.6 Complement the implementation of tobacco control policies (e.g. new health warnings on packs and plain packaging) with mass media campaigns to enhance cessation efforts by smokers.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.2.7 Continue to build the evidence base on the effectiveness of mass media to inform and refine future campaign development, including specific analysis of the effectiveness of these campaigns among groups with a high prevalence of smoking.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.2.8 Continue to share campaign materials, evaluations and other evidence of effectiveness of mass media campaigns with the global tobacco control community.

Responsibility: Australian Government; state and territory governments; research organisations; non-government organisations.

6.3 CONTINUE TO REDUCE THE AFFORDABILITY OF TOBACCO PRODUCTS

There is strong evidence of the influence of price on the prevalence of tobacco smoking.[43] Price increases encourage existing smokers to quit and raise the barrier for people considering taking up smoking, especially young people.[30,33,43]

Research examining the impact of tobacco control policies on smoking prevalence identified tobacco price increases as having the greatest effect of all policies examined.[57] Australian research confirms international studies that show that the impact of price rises is most significant in low-income groups. From January 1999 to December 2006, an AUD$1 increase in price was associated with a decline in prevalence of 2.6 per cent among low-income groups compared with a 0.2 per cent decline among high-income groups. The study concluded that increasing the price of cigarettes not only is an effective tobacco control strategy to lower smoking prevalence in the general population but also may provide a means of reducing social disparities in smoking.[58]

Under Article 6 of the WHO FCTC, the parties to the convention recognise that price and tax measures are an effective and important means of reducing tobacco consumption, particularly among young people.[33] Article 6 states that parties should, as appropriate, adopt tax and price policies on tobacco products to reduce tobacco consumption and prohibit or restrict sales or importations of duty-free tobacco products.[33]

In April 2010, the excise on all tobacco products increased by 25 per cent. This policy increased excise by about 7c per stick for cigarettes and nearly $82 per kilo for other tobacco products.

Research conducted after the 2010 tax increase suggests the price increases are having an effect. Recent quitters who quit after the tax increase (versus before) were more likely to report that they were influenced by price.[59,60] Smokers' responses to the recent price increases included smoking-related changes (tried to quit, cut down) and product-related changes (changed to lower priced brands, started using loose tobacco, bought in bulk).[58,61] The authors of this research suggested that regular increases in tobacco tax may further encourage quitting activity.[59] In addition, a Victorian study showed that the 2010 price increase did not appear to have negatively affected continuing smokers' ability to pay for essentials such as food – there was no change in the proportion of smokers who reported this problem between 2009 and 2010.[61,60] There was also a trend towards low-SES smokers being more likely to report that they had tried to quit than high-SES smokers.[61]

The 2012–13 Federal Budget included a measure to change the duty-free concession on tobacco products. Previously, inbound travellers were able to bring in 250 cigarettes or 250 grams of cigars or tobacco products tax free. From 1 September 2012, this was reduced to 50 cigarettes or 50 grams of cigars or tobacco products.

It is important to ensure that increases in the price of tobacco are accompanied by efforts to prevent and minimise the illicit trade in tobacco. To date Australia has been successful in this regard. In 2010, nearly half of smokers aged 14 years or older had seen or heard of unbranded loose tobacco known as 'chop chop'. However, the proportion of smokers using unbranded tobacco half the time or more remained low at 1.5 per cent.[1]

On 31 May 2012, World No Tobacco Day, the Australian Government announced that it would increase penalties for tobacco smuggling. On 6 November 2012, the *Customs Amendment (Smuggled Tobacco) Act 2012* received Royal Assent. The Act creates new offences of smuggling tobacco or tobacco products and conveying or possessing smuggled tobacco products, and will allow a penalty of up to 10 years imprisonment to be imposed, in addition to the existing monetary penalty of up to five times the amount of duty evaded.

Additional efforts may be required to support low-income smokers, such as ensuring access to subsidised nicotine replacement therapy (NRT) or provision of more targeted support to encourage cessation.[29] See Part 6.5 for further detail.

Actions

6.3.1   Analyse the impact of the 2010 tobacco excise increases, including the impact on young people and smokers from low socioeconomic groups.

   Responsibility: Australian Government; research organisations; non-government organisations.

6.3.2   Continue to implement regular staged increases in tobacco excise as appropriate, to reduce demand for tobacco.

   Responsibility: Australian Government.

6.3.3   Complement tobacco excise increases with additional supports for low-income smokers to quit.

   Responsibility: State and territory governments; Australian Government; non-government organisations; social service organisations.

6.3.4   Identify practices that may be undermining the effectiveness of the tobacco excise increases in reducing smoking prevalence (e.g. price discounting) and develop strategies to minimise these practices.

   Responsibility: Australian Government; state and territory governments; non-government organisations.

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

   Responsibility: Australian Government.

6.3.6   Continue enforcement efforts to prevent the illegal importation and illegal supply and cultivation of tobacco and enhance technology and support systems to identify and respond to illicit trade in tobacco.

   Responsibility: Australian Government.

6.3.7   Continue to monitor the supply and use of illicit tobacco in Australia and effective approaches to reduce the illicit trade in tobacco.

   Responsibility: Australian Government; non-government organisations.

6.4 BOLSTER AND BUILD ON EXISTING PROGRAMS AND PARTNERSHIPS TO REDUCE SMOKING RATES AMONG ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Smoking remains one of the main factors influencing the lower life expectancy of Aboriginal and Torres Strait Islander people. Smoking is responsible for one in five of all Aboriginal and Torres Strait Islander people's deaths and is the most preventable cause of poor health and early death among Aboriginal and Torres Strait Islander people.[3]

Current smoking rates among Aboriginal and Torres Strait Islander Australians are more than double those in the rest of the community. In 2008, 45 per cent of Aboriginal and Torres Strait Islander people over the age of 15 years smoked daily.[3]

All governments have agreed to close the gap in life expectancy between Aboriginal and Torres Strait Islander people and the general population within a generation.[62] Reducing smoking among Aboriginal and Torres Strait Islander people is central to this approach.

The health consequences of early smoking initiation are well known and are a particular issue among Aboriginal populations.[63] Smoking is common in many Aboriginal and Torres Strait Islander communities. Strong social norms reinforce early initiation and act as barriers to smoking cessation among Aboriginal people.[63]

However, many Aboriginal and Torres Strait Islander people want to quit smoking. In 2008 nearly two-thirds (62 per cent) of Aboriginal and Torres Strait Islander smokers had tried to quit or reduce their smoking in the last 12 months. The most common reasons for trying to quit/reduce smoking were general health, cost, and encouragement from family and friends.[3]

The National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes identifies the following priority elements of the national program to reduce smoking among Aboriginal and Torres Strait Islander people:

• social marketing activities to reduce smoking-related harms among Aboriginal and Torres Strait Islander people

• Aboriginal and Torres Strait Islander specific smoking cessation and support services

• continued regulatory efforts to encourage reduction/ cessation in smoking

• strategies to improve delivery of smoking cessation services, including NRT

• roll-out of a range of state and territory programs and national programs under the agreement.

The Australian Government committed $100.6 million from 2009–10 to 2012–13 to the Tackling Indigenous Smoking program. Implementation of this program is well under way. It includes the roll-out of regional teams for tackling smoking and healthy lifestyle across 57 regions nationally, enhancements to Quitline, training for health and community workers, and the development of role models and champions to discourage smoking.

In March 2011, the first national anti-smoking campaign targeted specifically to Aboriginal and Torres Strait Islander audiences, Break the Chain, was launched. It included television, radio, print advertising, and posters. Action item 6.2.2 of this strategy commits to the continuation and robust evaluation of mass media campaigns targeted to Aboriginal and Torres Strait Islander people.

States and territories committed $37.84 million from 2009–10 to 2012–13 to tackle smoking among Aboriginal and Torres Strait Islander communities.[64] State and territory programs include initiatives to build the capacity of Aboriginal health workers and other health workers, implementation of community-based projects, the development of partnership and infrastructure programs between governments and Aboriginal community-controlled health organisations, implementation of cessation programs for pregnant women and their families, introduction of targeted social marketing campaigns, and enhanced research and evaluation projects.

Given the high rates of Aboriginal and Torres Strait Islander people in corrections facilities, this is an important setting for tobacco control efforts. Aboriginal and Torres Strait Islander people should be offered support to quit smoking while in prison. This issue is covered under Part 6.5.

To be most effective, initiatives to reduce smoking prevalence among Aboriginal and Torres Strait Islander people need to be culturally sensitive and community led, build partnerships between Aboriginal and Torres Strait Islander organisations and other organisations, and build the capacity of Aboriginal and Torres Strait Islander organisations and workers.[65]

Making non-smoking the norm among Aboriginal and Torres Strait Islander people will require the support and encouragement of local role models, including Aboriginal health workers and community-controlled organisations. Social marketing and cessation programs will need to be tailored to the needs of Aboriginal and Torres Strait Islander people and other communities with a high prevalence of smoking.[65] Strategies should include whole-of-family approaches and a better understanding of protective factors for young people that increase the chances of Aboriginal and Torres Strait Islander people being non smokers.[66] Strengthening data collection and evaluation of existing programs will build the evidence base about effective interventions and inform the roll-out of future programs.[67]

Actions

6.4.1 Continue the investment in, and roll-out of, existing and planned national and state and territory programs to reduce smoking among Aboriginal and Torres Strait Islander people.

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

6.4.2 Monitor and evaluate the impact of these initiatives and use this data to inform and refine future programs to reduce smoking among Aboriginal and Torres Strait Islander people.

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

6.4.3 Continue to build tobacco control capacity for Aboriginal and Torres Strait Islander communities within Aboriginal community-controlled organisations and mainstream services.

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

6.4.4 Support Aboriginal and Torres Strait Islander organisations in their efforts to promote the benefits of being smoke free, as reflected in their organisational policies and community programs.

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

6.4.5 Strengthen partnerships and collaboration between Aboriginal and Torres Strait Islander organisations, governments and non-government organisations.

Responsibility: Australian Government; state and territory governments; Aboriginal and Torres Strait Islander organisations; mainstream services; non-government organisations.

6.4.6 Continue to provide training to Aboriginal and Torres Strait Islander health workers and other relevant workers on effective tobacco control interventions.

Responsibility: Australian Government; state and territory governments; other training providers.

6.4.7 Deliver best practice screening and smoking cessation as part of routine health service delivery and social/community service provision to Aboriginal and Torres Strait Islander clients.

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

6.4.8 Encourage Aboriginal and Torres Strait Islander people to access subsidised nicotine replacement therapy (NRT), identify any barriers to access, and develop strategies to overcome these barriers.

Responsibility: Australian Government; state and territory governments; Aboriginal and Torres Strait Islander organisations; mainstream services; non-government organisations.

6.4.9 Encourage and support Aboriginal and Torres Strait Islander pregnant women and their families to quit and provide messages about the harm associated with second-hand smoke exposure.

Responsibility: Australian Government; state and territory governments; Aboriginal and Torres Strait Islander organisations; mainstream services; non-government organisations.

6.4.10 Enhance mass media campaigns for Aboriginal and Torres Strait Islander people by complementing them, where appropriate, with Aboriginal and Torres Strait Islander specific campaign elements and local community-specific campaigns.

Responsibility: Australian Government; state and territory governments; Aboriginal community-controlled organisations; mainstream services; non-government organisations.

6.4.11 Develop strategies to reduce barriers to successful smoking cessation and uptake of smoking cessation services in Aboriginal and Torres Strait Islander populations.

Responsibility: Australian Government; state and territory governments; Aboriginal community-controlled organisations; mainstream services; non-government organisations.

6.5 STRENGTHEN EFFORTS TO REDUCE SMOKING AMONG POPULATIONS WITH A HIGH PREVALENCE OF SMOKING

Smoking among people from low socioeconomic groups is much higher than among the general population. In 2010, a quarter of those in low socioeconomic groups (24.6 per cent) reported smoking in the last 12 months.[1]

The greatest burden of illness and costs due to tobacco occurs among households in the lowest quintile of social advantage.[28] It is estimated that smoking is responsible for over half of the SES disparity in mortality. However, the deaths are only part of the problem – persistent smokers have more years of disability even though they live 10 years less than non smokers.[10]

Much of the differential in smoking rates between socioeconomic groups can be explained by higher uptake among young people in low socioeconomic areas. Smokers from low socioeconomic groups are no less likely to make a quit attempt but do seem to be less likely to succeed.[29]

Exposure to second-hand smoke in the home is also higher among low SES groups. In 2007, children in households in the most socioeconomically disadvantaged areas in Australia were more than three times as likely to be exposed to tobacco smoke in the home.[34]

In 2010, 28.9 per cent of people living in remote or very remote areas reported smoking in the past 12 months, compared with 16.8 per cent of people in major cities and around 20 per cent of people in inner or outer regional areas.[1] In addition to issues and challenges associated with their geographic isolation, remote and very remote areas also have a higher proportion of Aboriginal or Torres Strait Islander people, and experience lower socioeconomic status.[68]

Prisoners have one of the highest rates of tobacco smoking in the community: approximately 74 per cent report being daily smokers.[17] Continued leadership is required to reduce the prevalence of smoking among prisoners and to reduce exposure to second-hand smoke among prisoners and staff working in correctional settings.

It should be noted that Aboriginal and Torres Strait Islander people are significantly overrepresented in prisons. The Australian Bureau of Statistics estimated that just over a quarter (27 per cent) of the total prisoner population were Aboriginal and Torres Strait Islander people. The proportion of prisoners who identified as Aboriginal or Torres Strait Islander varied across states and territories. The Aboriginal and Torres Strait Islander prisoner population in the Northern Territory comprised 84 per cent of the total prisoner population, while Victoria had the lowest proportion of Aboriginal and Torres Strait Islander prisoners (8 per cent).[69]

Smoking prevalence among people with mental illness is high: around 66 per cent of people with psychosis were current smokers in 2010.[20,21] As one research team notes, 'Given that people with mental illness are a significant percentage of smokers, population-wide approaches need to reach out specifically to this group'.[70] There is evidence that, with support, people with mental illness can quit successfully.[70] There is also evidence that smoking cessation interventions provided for people in substance abuse treatment or recovery are successful in the short term.[71]

There is strong evidence demonstrating the effectiveness of whole-of-population approaches such as tobacco tax increases and mass media campaigns in reducing smoking among low socioeconomic groups[58] (see Part 6.2 and Part 6.3 for further detail). Other measures such as smoke-free legislation and legislation prohibiting tobacco advertising and marketing contribute to the continued denormalisation of smoking. The approach in this strategy is to complement these proven whole-of-population approaches with more targeted approaches for populations with a high prevalence of smoking.

Additional efforts may be required to support low-income smokers to quit smoking, such as ensuring access to subsidised NRT or provision of more targeted support to encourage cessation.[29]

Since February 2011, the Australian Government has provided financial support to help people quit smoking by listing NRT, in the form of transdermal patches, on the Pharmaceutical Benefits Scheme (PBS) for the general population, at a cost of more than $40 million over four years. In addition, there are other medicines available on the PBS to assist patients to quit smoking, including bupropion and varenicline. In 2011, over 217,000 scripts for PBS-subsidised nicotine patches were filled. From 1 January 2012, additional lower strengths of nicotine transdermal patches have been made available through the PBS. GST exemptions have been provided for transdermal or oromucosal NRTs sold in non-pharmacy settings.

The strategy also refers to a range of cessation services available to assist smokers who are seeking additional support to quit, including Quitline services, online services, specialised services and brief interventions by health professionals.

A priority will be placed on establishing new or broader partnerships with organisations that are already working closely with populations with a high prevalence of smoking, and building the capacity of those organisations in tobacco control.

For example, the non-government social and community services sector provides services to populations with a high prevalence of smoking (often low-SES communities) and may have a role in providing information about the availability of quit support and providing ongoing support.[72,73] In addition, a recent study has shown that co-management for smoking cessation of patients with depression by their doctor and Quitline is workable, valued by smokers, and increases the probability of quit attempts.[74,75]

Some populations are specifically in this priority area; however, this does not limit governments or other organisations from targeting other populations with a high prevalence of smoking.

Actions

6.5.1 Identify and form new partnerships between governments, non-government organisations with tobacco control expertise, social service organisations and mental health care providers/organisations to reduce smoking among populations with a high prevalence of smoking.

Responsibility: Non-government organisations; social service organisations (both government and non-government); mental health care organisations; Australian Government; state and territory governments.

6.5.2 Expand effective programs and frameworks to reduce smoking among populations with a high prevalence of smoking.

Responsibility: Non-government organisations; social service organisations; Australian Government; state and territory governments.

6.5.3 Increase awareness among low-income smokers of the availability of subsidised medications to assist them to quit.

Responsibility: Australian Government; state and territory governments; non-government organisations; social service organisations.

6.5.4 Build the capacity of social service organisations and mental health care providers to include tobacco control interventions as part of case management approaches.

Responsibility: Non-government organisations; social service organisations; Australian Government; state and territory governments.

6.5.5 Increase collaboration and referral between mental health care services, social service organisations and smoking cessation services such as Quitline services.

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

6.5.6 Strengthen actions to increase awareness among staff in mental health care services of the benefits of quitting for their clients and develop policies to include smoking cessation advice and management of nicotine dependence as part of routine care.

Responsibility: Australian Government; state and territory governments.

6.5.7 Ensure that mental health services and drug treatment agencies are smoke free.

Responsibility: state and territory governments; Australian Government.

6.5.8 Enhance partnerships and collaboration between state and territory custodial authorities, health agencies and non-government organisations with expertise in tobacco control.

Responsibility: State and territory governments; non-government organisations.

6.5.9 Implement and evaluate policies and programs to reduce exposure to second-hand smoke and encourage smokers to quit in correctional facilities.

Responsibility: State and territory governments.

6.5.10 Provide greater smoking cessation support for prisoners, including access to NRT and other pharmacotherapies.

Responsibility: State and territory governments.

6.5.11 Continue to build the evidence base to identify effective approaches to reducing smoking among populations with a high prevalence of smoking.

Responsibility: state and territory governments; Australian Government; research organisations; non-government organisations.

6.6 ELIMINATE REMAINING ADVERTISING, PROMOTION AND SPONSORSHIP OF TOBACCO PRODUCTS

There is overwhelming evidence documenting the influence of advertising and promotion by the tobacco industry.

Tobacco advertising and marketing efforts by the tobacco industry seek to increase sale and consumption of tobacco by three mechanisms. Firstly, advertising and promotion efforts seek to recruit new smokers by encouraging children or young adults to experiment with tobacco products and progress to regular use. Secondly, they seek to reduce the motivation of current smokers to quit. Thirdly, they seek to encourage relapses and prompt former smokers to resume smoking.[49]

The US Surgeon General's report *Reducing Tobacco Use* noted in 2000 that tobacco companies purposefully marketed to children for many years and that one tobacco company in the US had admitted that the entire tobacco industry conspired to market cigarettes to children.[76] In 2008, the US National Cancer Institute concluded that there is a causal relationship between the promotion of tobacco and increased tobacco use.[49] The US Surgeon General's 2012 report *Preventing Tobacco Use Among Youth and Young Adults* states that:

Advertising and promotional activities by tobacco companies have been shown to cause the onset and continuation of smoking among adolescents and young adults.[77]

The WHO FCTC places a priority on eliminating tobacco advertising, promotion and sponsorship, recognising that this would reduce the consumption of tobacco products.[78] Article 13 requires the parties to the convention to implement a comprehensive ban on tobacco advertising, promotion and sponsorship, subject to constitutional limitations. The guidelines for implementation of Article 13 emphasise the importance of comprehensive bans, as anything less will allow the tobacco industry to continue to exploit loopholes.[78]

Through the Commonwealth *Tobacco Advertising Prohibition Act 1992* and state and territory tobacco control legislation, Australia has successfully prohibited the vast majority of tobacco advertising and promotion.

However, several issues are still to be addressed to eliminate the remaining advertising, promotion and sponsorship of tobacco products in Australia.

Since 1 January 2012, when South Australia's new tobacco regulations came into effect, all jurisdictions in Australia have prohibited the display of tobacco in retail outlets. However, a number of jurisdictions still have exemptions for specialist tobacco retailers or tobacconists to continue to display tobacco and smoking implements.

Article 11 of the WHO FCTC requires the parties to the convention to adopt and implement measures to ensure that tobacco product packaging and labelling do not promote tobacco products in ways that are false, misleading, or deceptive; to require large, rotating health warning messages on tobacco packaging; and to require tobacco packaging to contain information on relevant constituents and emissions of tobacco products.[33]

In countries like Australia where most advertising and promotion is banned, tobacco companies are able to promote their products through branding and package design, thereby creating preferences, differentiation and identification.[79,80]

Research indicates that plain packaging that removes most brand design elements can be successful in decreasing cigarette brand image associations.[80] On 1 December 2011, Australia became the first country in the world to require plain packaging when the *Tobacco Plain Packaging Act 2011* and the *Trade Marks Amendment (Tobacco Plain Packaging) Act 2011* received Royal Assent. The *Tobacco Plain Packaging Regulations 2011* were promulgated on 7 December 2011 and amended on 8 March 2012. The regulations prescribe additional, more specific requirements for the appearance and the retail packaging of tobacco products.

On 17–19 April 2012, the High Court of Australia heard challenges by several tobacco companies to the validity of the *Tobacco Plain Packaging Act 2011*. On 15 August 2012, the High Court found in favour of the Australian Government and rejected the claims made by the tobacco industry, and on 5 October 2012 the court handed down the reasons for the decision.

Under the new plain packaging laws, tobacco industry logos, brand imagery, colours and promotional text are banned. The packaging is a standard drab dark brown colour chosen through market research to have the least appeal to smokers.

Graphic health warnings on tobacco products were updated and expanded in the Competition and Consumer (Tobacco) Information Standard 2011, which commenced on 1 January 2012. Tobacco products are required to display the new warnings by 1 December 2012, to coincide with the full introduction of plain packaging. The size of the graphic health warnings increases to 75 per cent of the front of cigarette packs and cartons, up from 30 per cent, and the current 90 per cent warnings for the back of packs are retained. The size of graphic health warnings for most other smoked tobacco products increases to 75 per cent of both the front and back of packs. Cigars sold singly are also required by the standard to have health warnings.

Graphic health warnings provide a strong and confronting message to smokers about the harmful health consequences of tobacco products and convey the 'quit' message every time a person reaches for a cigarette.[81] An evaluation of the 2006 graphic health warnings on tobacco packaging showed that the warnings have increased consumer knowledge of the health effects relating to smoking, have encouraged the cessation of smoking, and have discouraged smoking uptake or relapse. The evaluation also highlighted the importance of regularly updating the images and messages to maintain smokers' attention.[81]

The *Tobacco Advertising Prohibition Amendment Act 2012* received Royal Assent on 6 March 2012 and commenced on 6 September 2012. The Amendment Act amends the *Tobacco Advertising Prohibition Act 1992* to extend existing restrictions on tobacco advertising to the internet and other electronic media (e.g. mobile phones).

In some jurisdictions, tobacco products continue to be included in retailer shopper loyalty or reward programs. These programs reward customers for smoking, as higher rewards go to those who purchase the most tobacco.[82,83]

Promotion of smoking in movies also remains an important means of glamorising smoking and promoting smoking to mass audiences. The National Preventative Health Taskforce recommended that smoking should be made a 'classifiable element' in movies and video games to be taken into account by the Australian Classification Board.[29]

Actions

6.6.1   Fully implement plain packaging laws by 1 December 2012.

Responsibility: Australian Government.

6.6.2   Fully implement updated and larger health warnings on tobacco packaging by 1 December 2012 and monitor the need for further updating of health warnings.

Responsibility: Australian Government.

6.6.3   Monitor and enforce legislation relating to the plain packaging of tobacco products and health warnings on tobacco packaging.

Responsibility: Australian Government.

6.6.4   Investigate the possible benefits of requiring tobacco companies to report regularly on expenditure on any form of tobacco promotion and marketing activity.

Responsibility: Australian Government.

6.6.5   Explore regulatory options to eliminate any remaining forms of tobacco promotion including advertising of price specials, public relations activities, and payments and incentives to retailers and proprietors of hospitality venues.

Responsibility: Australian Government; state and territory governments.

6.6.6   Consider and develop regulatory options to prohibit the remaining display of tobacco products at point of sale.

Responsibility: State and territory governments.

6.6.7   Restrict the advertising of tobacco products on the internet by enforcing the *Tobacco Advertising Prohibition Amendment Act 2012*.

Responsibility: Australian Government.

6.6.8   Explore the possible benefits of regulatory restrictions on incentive programs between tobacco manufacturers, wholesalers and retailers.

Responsibility: Australian Government.

6.6.9   Consider and develop regulatory options to remove tobacco from retailer shopper and reward schemes.

Responsibility: State and territory governments.

6.6.10   Monitor and explore options to regulate the portrayal of smoking in visual media such as movies, TV programs, music clips, video games and digital media, and the adequacy of the current classification guidelines.

Responsibility: Australian Government; non-government organisations; other relevant bodies.

6.7 CONSIDER FURTHER REGULATION OF THE CONTENTS, PRODUCT DISCLOSURE AND SUPPLY OF TOBACCO PRODUCTS AND ALTERNATIVE NICOTINE DELIVERY SYSTEMS

Regulation of the contents of tobacco products and product disclosure

In comparison to the harm caused by tobacco products, there are relatively few controls on the manufacturing and availability of tobacco.

Article 9 of the WHO FCTC provided for the Conference of the Parties, in consultation with competent international bodies, to propose guidelines for testing, measuring and regulating the contents and emissions of tobacco products. This article also provides for each party to adopt and implement measures for testing, measuring and regulation.[33] Article 10 requires the parties to adopt and implement effective legislative or other measures to require manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products, and to require public disclosure of information about toxic constituents and emissions.[33]

The Australian Government has commissioned several studies in relation to possible regulation of the contents and emissions of tobacco products to build the evidence base in this important area and to inform any future regulatory policies that Australia may implement in line with its obligations under the WHO FCTC.

The further regulation of the *contents* of tobacco products and of tobacco product *disclosures* is an important area of tobacco control that warrants additional investigations and analysis to inform future policies.

There are no regulatory restrictions on the ingredients in tobacco products in Australia,[84] apart from some state and territory government legislation prohibiting fruit- and confectionery-flavoured cigarettes. Additives such as sugar, honey, liquorice and cocoa are used to enhance the 'taste' of tobacco smoke to make the product more desirable to smokers, especially those experimenting with tobacco.[77] Additives such as menthol numb the throat so the smoker cannot feel the smoke's aggravating effects.[77] There is also evidence in the literature that tobacco manufacturers have used additives to mask the smell and visibility of side-stream smoke.[85]

Progress has been made in reducing the fire risk associated with cigarettes. Regulations introduced under the *Trade Practices Act 1974* require all cigarettes sold in Australia after 23 September 2010 to comply with the mandatory standard for reduced fire risk cigarettes: Australian Standard 4830–2007, Determination of the extinction propensity of cigarettes.

There is a voluntary agreement in place between the Australian Government and the three main tobacco companies in Australia that requires the companies to provide annual reports to the government regarding the ingredients of cigarettes. The reports are posted on the website of the Department of Health and Ageing. Research on this system of voluntary disclosure found that the current arrangements were not effective in informing consumers and health experts.[86] The Australian Government has commissioned a study of the feasibility of options for improving product disclosures, which is due to report in early 2013.

Alternative nicotine delivery systems

Alternative nicotine delivery systems are products that have not been classified as safe and effective means of NRT. The main type of alternative nicotine delivery systems on the market at present is electronic cigarettes.

Electronic cigarettes, also called e-cigarettes, are battery-operated devices that generally contain cartridges filled with nicotine, flavour and other chemicals. The electronic cigarette turns nicotine (which is highly addictive) and other chemicals into a vapour that is inhaled by the user. Unlike NRT products, e-cigarettes have not been approved by the Therapeutic Goods Administration for medically supervised use to quit smoking.[87] A number of studies raise considerable doubt about their quality and safety, product consistency and reliability, and about the utility of the labelling and packaging.[88,89,90,91,92,93] There is evidence of e-cigarettes and other alternative nicotine products being advertised on the internet and available in Australia.[94]

Some international jurisdictions (notably the US FDA) have begun to develop responses to e-cigarettes to protect public health. Other jurisdictions (notably the United Kingdom) have announced they are exploring the potential benefits of these devices.

While the sale of nicotine in cartridges is prohibited as a Schedule 7 poison under the Standard for Uniform Scheduling of Medicines and Poisons, these nicotine delivery systems are not currently regulated in Australia. There is a need to better understand the potential risks and/or benefits of these products, determine whether there is a need to increase restrictions on their availability and use, and identify the most appropriate policy approach for Australia.

The Australian Government has commissioned a regulatory impact assessment in relation to electronic nicotine delivery systems and smokeless tobacco products, which is due to report in early 2013.

Availability and supply of tobacco

Tobacco is one of the most widely available consumer products in the community. It is available at almost any type of retail outlet across the country, including petrol stations, milk bars, supermarkets, newsagents, licensed premises and convenience stores. This widespread availability of tobacco contributes to the notion that tobacco products are a normal part of everyday life and are relatively harmless.[95]

Article 16 of the WHO FCTC requires the parties to the convention to prohibit sale of tobacco products to persons under the age set by domestic law or national law or 18 years.[33] All states and territories in Australia have legislation to prevent sale of tobacco to children under 18 years and also have mechanisms in place to monitor and enforce this legislation. There are no restrictions on the age of a person who can sell tobacco.

The majority of jurisdictions have also introduced tobacco licensing schemes. A positive tobacco licensing scheme, which links compliance with tobacco control legislation to the right to sell tobacco products, is generally recognised as best practice. Licensing schemes provide a mechanism to vet potential retailers and ensure they are aware of their responsibilities and are a 'fit and proper' person to sell tobacco.[96]

Actions

6.7.1 Commission research to inform the development of any further regulatory policies on the disclosure of tobacco product ingredients and emissions data to government authorities and to the public.

Responsibility: Australian Government.

6.7.2 Commission research to examine the effects of flavourings and masking agents in increasing palatability of tobacco products and the impact of these substances on smoking behaviours (particularly smoking initiation and uptake) and identify best practice approaches to regulation.

Responsibility: Australian Government.

6.7.3 Explore regulatory options to enhance controls on tobacco product ingredients, emissions and product disclosure in line with agreed guidelines for implementation of Articles 9 and 10 of the WHO FCTC.

Responsibility: Australian Government.

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

Responsibility: Australian Government.

6.7.5 Commission research on alternative nicotine delivery systems such as electronic cigarettes and smokeless tobacco to: examine the risks and/or benefits of these products; determine whether there is a need to increase restrictions on their availability and use; and identify the most appropriate policy approach for Australia.

Responsibility: Australian Government.

6.7.6 Reinvigorate efforts to monitor and enforce legislation prohibiting the sale of tobacco to minors.

Responsibility: State and territory governments.

6.7.7 Consider and explore further regulatory options to implement tobacco licensing schemes for retailers and wholesalers.

Responsibility: State and territory governments.

6.7.8 Commission research to examine the potential benefits, feasibility and best practice regulatory approaches of placing controls on the number and type of tobacco outlets in the community.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.8 REDUCE EXCEPTIONS TO SMOKE-FREE WORKPLACES, PUBLIC PLACES AND OTHER SETTINGS

Exposure to second-hand smoke causes a range of serious adverse health effects in both adults and children.[9]

The International Agency for Research on Cancer (IARC) reported on a scientific review of the effectiveness of smoke-free policies in reducing population exposure to second-hand smoke.[97] It determined that there is sufficient evidence to accept that laws restricting smoking in workplaces and other public places reduce population exposure to second-hand smoke and consumption of cigarettes, and reduce respiratory symptoms in workers. Another study found that such policies provide net benefits to business, with no adverse effects on overall sales in the hospitality industry.[98]

Under Article 8 of the WHO FCTC, the parties recognise that scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability. Article 8 requires the parties to adopt and implement effective measures providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places.[33]

Evaluation studies of the implementation of smoke-free legislation overwhelmingly report that the legislation is popular, compliance is high and the laws are effective in improving air quality and reducing exposure to second-hand smoke. A growing body of evidence suggests that these laws can have a broader impact on smoker behaviour, particularly among young people.[99,100,101,102]

There is increasing evidence that smoke-free legislation has an impact on initiation of smoking among young people and that the strength of smoke-free restrictions in the legislation is a key factor influencing the uptake of smoking.[101,102,103,104,105]

Smoke-free legislation can also influence exposure to second-hand smoke in domestic environments. Following the implementation of smoke-free legislation in Scotland, there was an increase in the proportion of children reporting a complete ban on smoking in their household.[105] A similar pattern was reported in Queensland following implementation of new smoke-free laws in 2006.[103] Smoke-free policies at home can increase adults' chances of quitting.[104]

Smoke-free legislation is largely the responsibility of states and territories. Under the previous National Tobacco Strategy there was significant regulatory reform as state and territory governments progressively introduced legislation to protect workers and the community from exposure to second-hand smoke. Every state and territory bans smoking in enclosed public places including restaurants and cafes and liquor-licensed premises. In addition, all states and territories except Victoria have also introduced or are planning to introduce bans on smoking in outdoor dining areas (although approaches vary between jurisdictions). Indoor environments such as public transit, office buildings, shopping malls, schools and cinemas are also smoke free. There is, however, variability between jurisdictions in terms of exemptions from indoor smoking bans.

Additionally, all states and territories except the Northern Territory have prohibited smoking in cars when children are present.

Non smokers can be exposed to high levels of second-hand smoke in outdoor settings when close to or downwind of smokers.[106] As restrictions on smoking in enclosed public places have become more common, smokers are increasingly required to smoke outdoors. Problems arise when smokers cluster around entrances and exits and near air conditioning intake vents to smoke. People who enter and exit the building are exposed to second-hand smoke and there may be problems with smoke drift into indoor smoke-free areas.

States and territories have different approaches to managing smoking in outdoor areas. Six jurisdictions (Western Australia, Queensland, the Northern Territory, Tasmania, the Australian Capital Territory and New South Wales) have introduced bans on smoking in outdoor dining areas in cafes, restaurants and licensed premises. In Victoria, some local councils have prohibited smoking in outdoor areas. A number of jurisdictions have also prohibited smoking in a range of outdoor spaces such as sporting stadiums, children's playgrounds, patrolled beaches and bus stops.

As public awareness of the risks of second-hand smoke has increased and the introduction of smoke-free public spaces has become the norm, the number of smoke-free homes has increased. However, among populations with a high prevalence of smoking, exposure to second-hand smoke remains high, particularly for children from low socioeconomic groups and Aboriginal and Torres Strait Islander children.[34]

Actions

6.8.1 Continue to monitor and enforce existing smoke-free legislation.

Responsibility: State and territory governments.

6.8.2 Strengthen partnerships between the health sector and local governments to enhance the promotion, monitoring and enforcement of smoke-free laws.

Responsibility: State and territory governments; local governments; non-government organisations.

6.8.3 Ensure all publicly funded health services have comprehensive smoke-free policies in place.

Responsibility: State and territory governments; Australian Government; community and social sector and drug treatment agencies.

6.8.4 Implement policy approaches that reduce children's exposure to second-hand smoke when travelling as passengers in cars.

Responsibility: State and territory governments; Australian Government; non-government organisations.

6.8.5 Enforce existing smoke-free legislation and work towards all workplaces (indoor and outdoor) being smoke free (including outdoor areas in restaurants and hotels, near the entrances to buildings and air conditioning intake points, and in workplace vehicles).

Responsibility: State and territory governments; local governments.

6.8.6 Complement legislative approaches to remaining smoke-free workplaces with efforts to support employees and employers to quit smoking.

Responsibility: Australian Government; state and territory governments; non-government organisations.

6.8.7 Encourage adoption of policies that restrict smoking outdoors where people gather or move in close proximity – commercial outdoor eating areas; public playgrounds; public swimming pools and public recreation centres; sporting stadiums; public sports grounds; enclosed or covered bus stops and taxi ranks; near entrances to public buildings etc.

Responsibility: State and territory governments; local governments; Australian Government.

6.8.8 Monitor the issue of smoking and smoke-drift at residential premises and consider policy approaches to support smoke-free homes, particularly where children are present.

Responsibility: State and territory governments; non-government organisations.

6.9 PROVIDE GREATER ACCESS TO A RANGE OF EVIDENCE-BASED CESSATION SERVICES TO SUPPORT SMOKERS TO QUIT

Quitting smoking at any age results in immediate health benefits, irrespective of how long a person has been smoking. Quitting at age 30 avoids almost all of the mortality hazards associated with smoking.[10]

Article 14 of the WHO FCTC requires the parties to the convention to develop and disseminate comprehensive guidelines based on scientific evidence and best practices, and take effective measures to promote cessation of tobacco use and adequate treatment for tobacco dependence.[33]

A range of cessation services are available to assist smokers who are seeking additional support to quit. These include Quitline services, online services, specialised services and brief interventions by health professionals. These interventions complement whole-of-population approaches such as price increases, mass media campaigns and smoke-free legislation.

While these services are an important part of a comprehensive tobacco control strategy it is important to note that the vast majority of smokers who quit do so unaided – that is, they go 'cold turkey'.[107] Surveys of smokers show that unassisted cessation continues to be the most commonly used method to quit successfully and leads the next most successful method (NRT) by a wide margin.[107]

A 2009 survey of smokers revealed that three-quarters (76 per cent) had gone 'cold turkey' when quitting, two-thirds had reduced the amount they smoked (66 per cent) and only 44 per cent had used NRT.[108]

In 2010, people in Australia who had never smoked (10.6 million) and those who were ex-smokers (4.4 million) far exceeded the number of smokers (3.3 million) aged 14 years or older.[1] The sheer number of ex-smokers in our community shows that it is possible to quit smoking successfully. However, quitting smoking can be a very difficult process and it is necessary to ensure that high-quality evidence-based services are available for those who need them.[29] There is evidence that 'NRTs increase the rate of quitting by 50–70 per cent, regardless of setting'.[109]

The benefits of quitting are felt not just by the smoker but also by the children and other family members around them. For example, the potential harm from exposure to second-hand smoke is prevented when smokers quit, and the chances of their children starting to smoke are reduced. Most smokers quit unaided but it usually takes between three and 14 attempts before a regular smoker finally stops. The success of individual quit attempts can be greatly increased by the use of a variety of smoking cessation aids and services.[110,111]

Brief interventions from health professionals are also an important strategy to motivate and remind smokers of the importance of quitting. Relevant health professionals can include doctors, nurses and Aboriginal health workers. There is evidence of effectiveness in a range of settings, including surgeries, community health centres, outpatient clinics and hospitals.[110,112,113] Even offering brief advice (as little as three minutes) has been shown to have clear benefits, while spending more time (longer than 10 minutes) advising smokers to quit yields higher abstinence rates than minimal advice.[111,114,115]

There are benefits in broadening our approach beyond these traditional health professionals. Providing training, support and encouragement to staff in other organisations who are already working with populations with a high prevalence of smoking will increase their capacity to provide brief interventions and support quit attempts.

From July 2009 to October 2012, there were approximately 286,300 calls to the Quitline throughout Australia, almost all of which were related to smoking cessation. Quitline counselling with active call-back programs can increase quit rates fourfold to sixfold, and referrals to Quitline services from general practice can further enhance effectiveness.

Actions

6.9.1   Increase the availability and range of smoking cessation services such as Quitline, particularly for populations with a high prevalence of smoking and people receiving specialist treatment for chronic health conditions.

Responsibility: State and territory governments; non-government organisations; smoking cessation services such as Quitline services; Australian Government.

6.9.2   Enhance Quitline services for pregnant women (in particular Aboriginal and Torres Strait Islander women), including call-back services and feedback to obstetricians, GPs, midwives and Aboriginal health workers.

Responsibility: State and territory governments; non-government organisations; Quitline and multilingual Quitline services.

6.9.3   Enhance Quitline services for Aboriginal and Torres Strait Islander people, including cultural competency training for tele-counsellors, culturally appropriate quit materials, call-back services and partnerships with Aboriginal community-controlled organisations.

Responsibility: Australian Government; state and territory governments; non-government organisations; Quitline and multilingual Quitline services

6.9.4   Continue to promote Quitline services to smokers and the community through mass media campaigns and other communication channels.

Responsibility: Australian Government; state and territory governments; non-government organisations; Quitline services.

6.9.5   Increase the range of interactive web-based programs provided as part of Quitline services to provide greater opportunities to interact with smokers and encourage them to quit, and ensure the information is regularly updated to reflect best practice.

Responsibility: State and territory governments; non-government organisations; Quitline services.

6.9.6   Improve the integration of Quitline with other programs across the health system, primary care services and relevant non-government organisations, with a priority focus on populations with a high prevalence of smoking (as outlined in Priority Area 6.5).

Responsibility: State and territory governments; Australian Government; non-government organisations; Quitline and multilingual Quitline services; health services.

6.9.7 Develop systems that encourage health professionals to routinely ask patients about their smoking status and provide smokers with appropriate advice and support to quit, including appropriate referral to specialist cessation services.

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

6.9.8 Improve management of smoking cessation for all patients in healthcare facilities, particularly for patients on admission to hospital.

Responsibility: State and territory government health services; non-government organisations.

6.9.9 Provide policy guidelines and accredited training in best practice smoking cessation (particularly brief interventions) to a range of health professionals and health, community and welfare workers, and ensure these are regularly updated to reflect best practice.

Responsibility: State and territory governments; non-government organisations; smoking cessation services such as Quitline and multilingual Quitline services; health services; Aboriginal community-controlled organisations; Australian Government.

6.9.10 Provide policy guidelines and training in brief interventions to social service organisations that are already working with populations with a high prevalence of smoking to build their capacity to support quit attempts in these groups, including by appropriate referral, and ensure these are regularly updated to reflect best practice.

Responsibility: State and territory governments; non-government organisations; social service organisations; smoking cessation services such as Quitline and multilingual Quitline services; Australian Government.

6.9.11 Increase awareness among relevant organisations and populations with a high prevalence of smoking of the availability of subsidised NRTs.

Responsibility: State and territory governments; Australian Government; non-government organisations; smoking cessation services such as Quitline and multilingual Quitline services; health services; Aboriginal community-controlled organisations; social service organisations.

6.9.12 Improve appropriate use of pharmacotherapies and services demonstrated to assist with smoking cessation, especially among populations with a high prevalence of smoking, through increased education and improved referral to smoking cessation services.

Responsibility: Australian Government, state and territory governments; non-government organisations; smoking cessation services such as Quitline and multilingual Quitline services.

PART SEVEN: MONITORING PROGRESS

Monitoring the implementation of this strategy will require a coordinated national effort. Progress in meeting the objectives in this strategy will be measured by the following outcome indicators:

- *Fewer young people smoking regularly*

- *Fewer young people making the transition to established patterns of smoking*

- *Fewer adults smoking regularly*

- *More smokers attempting to quit*

- *Fewer women smoking while pregnant*

- *Fewer children exposed to second-hand smoke at home*

- *Fewer adults exposed to second-hand smoke at home*

- *Fewer adults smoking regularly among*

    o   *Aboriginal and Torres Strait Islander people*

    o   *people of low socioeconomic status*

    o   *other groups with a high prevalence of smoking.*

Progress will be monitored towards the following targets in this strategy, which are consistent with the COAG NHA[4,5] and the COAG NPAPH:[13,14]

By 2018:

- *reduce the national adult daily smoking rate to 10 per cent of the population*

- *halve the Aboriginal and Torres Strait Islander adult daily smoking rate.*

The baselines for these targets are 19.1 per cent for the national adult daily smoking rate (2007–08) and 47.7 per cent for the Aboriginal and Torres Strait Islander adult daily smoking rate (2008).

To assess whether Australia is on track to achieve these targets, a mid-term review of progress will be undertaken in 2015.

All jurisdictions will report regularly to the IGCD on progress in implementing the actions under each priority area set out in this strategy.

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