



## CHAPTER 3: Tobacco: Towards world's best practice in tobacco control

### Contents

<b>The case for prevention</b>	<b>170</b>
<b>Targets</b>	<b>172</b>
<b>Key action areas</b>	<b>173</b>
Key action area 1: Make tobacco products more expensive	175
Key action area 2: Increase the frequency, reach and intensity of social marketing campaigns	178
Key action area 3: End all forms of advertising and promotion of tobacco products	179
Key action area 4: Eliminate exposure to second-hand smoke in public places	182
Key action area 5: Regulate manufacturing and further regulate packaging and supply of tobacco products	184
Key action area 6: Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems	186
Key action area 7: Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians	189
Key action area 8: Boost efforts to discourage smoking among people in other highly disadvantaged groups	192
Key action area 9: Assist parents and educators to discourage use of tobacco and to protect young people from second-hand smoke	194
Key action area 10: Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use	195
Key action area 11: Ensure implementation and measure progress against and towards targets	196
<b>Summary Tables</b>	<b>200</b>
<b>References</b>	<b>221</b>



## CHAPTER 3: Tobacco: Towards world's best practice in tobacco control

### The case for prevention

*'Tobacco has a catastrophic but preventable impact on the health of Australians' (Quote from submission)*

The case for action on tobacco is clear. Since 1950, when the dangers of smoking were recognised, almost one million Australians have died because they smoked.(1)

Trends in recent years have been encouraging,(2) but there is no room for complacency while the death toll from tobacco continues,(3, 4) thousands of young people each year start smoking,(5) non-smokers are exposed to second-hand smoke,(2) disadvantaged groups are disproportionately affected,(6-12) the overall cost of smoking to the economy is more than \$30 billion each year,(13) and tobacco companies maintain efforts to promote sales of their lethal product.(14-16)

Australia has been among the global leaders in tobacco control – nationally, in the states and territories, and through the work of non-government organisations and researchers. At a time when the international commitment to tackling the tobacco problem has never been stronger,<sup>1</sup> we have the opportunity to show the way to the rest of the world in terms of what can be achieved through a comprehensive, coordinated, evidence-based, long-term strategy that is conscious of the needs of the entire community.

We know what needs to be done. The strategies set out in this report are based on the best international evidence and research, together with advice from some of the world's leading experts in tobacco control. We know what works in tobacco control; by contrast, we also know what does not work and should not be further pursued. We have also been assisted by some valuable insights from our consultations and submissions to the Taskforce. When implemented, this strategy will ensure that we have world's best practice in tobacco control.

The target set by the Taskforce is that we should reduce daily smoking to under 10% by 2020. This will require a dramatic reduction in the numbers of children taking up smoking and in the percentage of smokers who try to quit,(17) but on the basis of evidence from Australia and internationally, we are confident that it is achievable. When we reach this target, we believe that smoking will continue to decline until rates are so low that it is no longer one of our most important health problems.

*'The target of further reducing the prevalence of smoking is achievable and can be advanced through collaboration with other key stakeholders' (Quote from submission)*

Achieving the target will require a strong commitment from all who can play a role in getting us there, and a special focus on working with and supporting disadvantaged groups and communities. Australia can also both be a role model for other countries and play a part in helping to implement similar policies, especially in low- and middle-income countries where tobacco promotion is rampant and tobacco control is in its infancy.

1 The international Framework Convention on Tobacco Control (FCTC) is the first treaty negotiated under the auspices of the World Health Organization (WHO). It was adopted by the World Health Assembly on 21 May 2003, and entered into force on 27 February 2005. See [www.who.int/fctc/about/en/index.html](http://www.who.int/fctc/about/en/index.html) for further details.



### INDIVIDUALS CAN:

- Take action to stop smoking. The sooner a person quits, the more benefit they gain, not only from reduction of illness and early death but also in practical ways such as saving money and avoiding frequent breaks away from work. Individuals may need many attempts to quit for good but it is important to keep trying.(1) Those finding it difficult can:
  - Call the Quitline for information and counselling advice
  - Visit their GPs or ask their local pharmacist for help
  - Consider using medications that help lessen the effects of withdrawal from nicotine(18)

### FAMILIES CAN:

- Give up smoking to increase the chances of having a healthy baby and to stop their children from taking up smoking.(19, 20)
- Establish good communication and relationships within the family. This makes it easier to discuss issues such as smoking – and quitting,(21) ensuring that young people know that smoking is addictive and that they should not experiment because of the health risks.

### SCHOOLS CAN:

- Properly enforce smoke-free policies for staff, students and visitors alike.
- Use materials in the curriculum that incidentally increase understanding of the short and longer term effects of smoking.
- Include activities that raise awareness about smoking in drug education.
- Look for any evidence that retailers close to the school are selling cigarettes to students (and, if they are, ask the local council to take appropriate action).
- Be aware that students who are successful with their study and feel connected to their school are much less likely to take up smoking.(22)

### WORKPLACES CAN:

- Discourage people from smoking near the entrances to buildings where they will be seen by (and cause difficulties for) quitters and ex-smokers when they enter and leave.
- Require anyone leaving the premises to smoke to do so in personal rather than company time.
- Not sell cigarettes from canteens or company shops.
- Offer bonuses to long-term employees who have quit and stayed smoke-free. Cash bonuses at one, three, six and 12 months after quitting could help individuals to maintain their resolve. A further bonus at five and 10 years after quitting could help employers retain valued staff.



Work carried out for the Taskforce shows that by simply implementing the two most important strategies recommended in this report (tax increases and extra media spend), we will see approximately one million fewer Australians smoking and will prevent the premature deaths of almost 300,000 Australians now alive just from the four most common diseases caused by smoking. (23)

The history of tobacco control shows the importance of adopting a comprehensive approach, as proposed in this strategy. Within that framework, measures such as removing all avenues for tobacco promotion, supporting disadvantaged groups and protecting non-smokers of all ages are emphasised as especial opportunities for early intervention.

The only significant opposition to this strategy will come from the tobacco industry, which in submissions disagreed with many of the major proposals in our Discussion Paper. We recognise that action designed to reduce smoking dramatically will always be opposed by tobacco companies, but also that the measures they most strongly oppose are those most likely to have the impacts we seek.

Implementing the strategy will require a comprehensive approach, strong leadership and support throughout the community. Surveys at all levels show very strong public support for both overall tobacco control and the specific approaches contained in this strategy.

Tobacco has been one of the great killers of the 20th century. Preventing the premature deaths of at least 300,000 Australians now alive is more than a noble target. This strategy shows how it can be done, ensuring that the Australian program is world's best practice, and offering the opportunity for tobacco control to be one of the great public health success stories of the 21st century.

## Targets

If the comprehensive approach outlined in this strategy is implemented, modelling (23) suggests that we can achieve a reduction in the prevalence of daily smoking among adult Australians (aged 18+) from 17.4% in 2007 (24) to 10% or lower by 2020.<sup>2</sup>

The Council of Australian Governments (COAG) has agreed to a National Partnership Agreement on Preventive Health. (25) This agreement sets an overall target for daily smoking of no more than 10% over the 10 years from 2009, as well as interim targets. Interim targets specify that prevalence of daily smoking among Australian adults aged 18 years plus should decline to 15.4% or lower by 2011, and 14.1% or lower by 2013. In real terms, this equates to a decline of at least 11.5% in adult daily smoking in each state and territory in the four years from 2007 to 2011, and at least a 20% decline in smoking in the six years to 2013.<sup>3</sup>

Meeting these targets at both national and state levels will require a continuation of recent declines (5) in the percentage of young Australians who take up smoking each year, as well as a substantial and sustained increase in the proportion of adult smokers who are seriously trying to quit smoking.

It will also require significant declines in smoking among less educated smokers and those living in disadvantaged areas, which are at least as large as declines among more educated smokers living in more affluent areas.

- 2 And no more than 9% for Australians aged 14 and over, as indicated in reports of the National Drug Strategy Household Survey in 2019.
- 3 The National Partnership Agreement on Preventive Health sets out the agreement of the states, territories and the Australian Government to meet numerous benchmarks including '(jj) reduction in state baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013', Part 4 Clause 15.



'Closing the Gap' in health status between Indigenous and non-Indigenous Australians(26) will not be possible while Indigenous people smoke at a higher rate than other Australians. If prevalence were to halve over the next 10 years, around one in four Indigenous people would still be smoking in 2020. Realistic phased targets can be set for Indigenous smoking after the preliminary impact of the recommended strategies.

A further target for tobacco control in Australia is to eliminate exposure to other people's tobacco smoke, so that by 2020 Australians, especially children, are not being exposed to second-hand smoke in their day-to-day lives and smoking during pregnancy is minimal.

### Key action areas

Experience in Australia and overseas shows that a continuing decline in smoking will require a comprehensive approach, implemented with concerted and sustained effort.(27-30) This includes measures to reduce the affordability of tobacco products and to eliminate all forms of marketing of tobacco products, together with clear information for consumers, vigorous education campaigns and easily accessible support and effective and affordable assistance to smokers to quit.(31, 32) The more comprehensive the approach, the more likely it is that prevalence will decline among all social groups.(33, 34) Significantly reducing the social inequalities associated with tobacco use warrants additional attention for disadvantaged groups.(35) It is also likely that efforts to reduce social disadvantage – such as improving access to pre-school education(36) and improving the quality of teaching and school connectedness in disadvantaged areas(37) – can play a valuable role in reducing high-risk behaviours such as smoking.

To accelerate declines in smoking in Australia it is essential that we step up efforts in:

- Taxation policy
- Public education
- Legislation
- Health system interventions, particularly those aimed at high-need and high-risk groups.



Tobacco control achievements in Australia have been substantial, and efforts will continue as described in state and national(38) tobacco control strategies.<sup>4</sup> To achieve the targets set, however, action is required in the following 11 areas:

- Key action area 1:** Make tobacco products significantly more expensive
- Key action area 2:** Increase the frequency, reach and intensity of social marketing campaigns
- Key action area 3:** End all remaining forms of advertising and promotion of tobacco products
- Key action area 4:** Eliminate exposure to second-hand smoke in public places
- Key action area 5:** Regulate manufacturing and further regulate packaging and supply of tobacco products
- Key action area 6:** Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems
- Key action area 7:** Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians
- Key action area 8:** Boost efforts to discourage smoking among people in other highly disadvantaged groups
- Key action area 9:** Assist parents and educators to discourage tobacco use and protect young people from second-hand smoke
- Key action area 10:** Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use
- Key action area 11:** Ensure Implementation and measure progress against and towards targets

4 It is hoped that this Strategy will also provide the basis for strategies adopted by the Ministerial Council on Drug Strategy.



The case for action in each of the 11 key action areas is set out below, followed by actions measuring progress towards meeting the overall target.

**Key action area 1: Make tobacco products more expensive**

*'A high cigarette price, more than any other cigarette attribute, has the most dramatic impact on the share of the quitting population.'* Memo from Claude Schwab to John Heinenimas (Philip Morris), 5 March 1993 PM doc 2045447810

Increasing prices is one of the most effective measures that government can take to reduce tobacco consumption and prevalence.(27, 39)

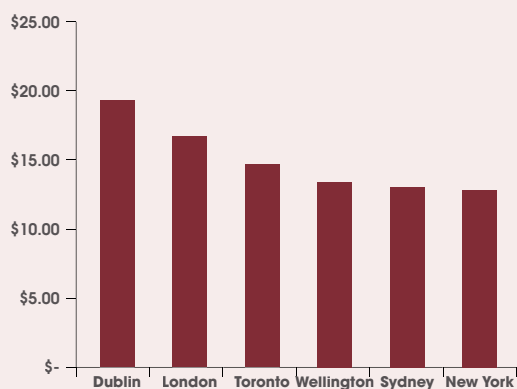
Analysis of changes in smoking prevalence in the largest Australian states in response to changes in various interventions(40) found that the costliness of cigarettes has the most powerful impact of all the policies studied, and that the effect of price was greatest among those on lowest incomes.(41)

While concerns about future health are the main motivator for quit attempts among high socioeconomic status (SES) smokers, cost is a major trigger among smokers of lower SES.(42) International reviews,(27, 43) as well as recent Australian(41, 44) and overseas studies,(45) indicate greater reductions in smoking following tax increases in low compared to high SES groups. A 2008 review of population interventions to reduce tobacco use found that price increase was the only intervention for which there was strong evidence of a greater effect among those on low incomes and in lower-status occupations.(46)

Cigarettes in Australia are less costly than they are in many other comparable countries. In September 2008 a packet of 30 cigarettes cost \$13.50 in Australia, but the equivalent price of 30 cigarettes in other English-speaking countries was around \$20 in Dublin, \$18 in London and \$16 in Toronto; see Figure 3.1.

Figure 3.1:

Price of 30 cigarettes in Australia and other English-speaking countries, A\$, September 2008



Source: Economist Intelligence Unit, September 2008,(47) popular brands from medium-priced stores.

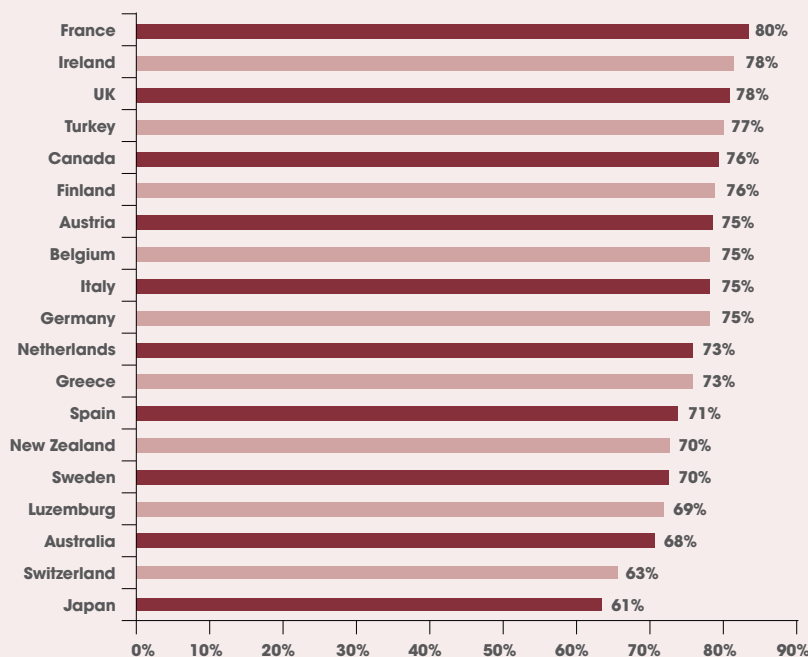
Note: Prices were collected prior to the largest-ever increase in excise duty in the United States in April 2009.

In Australia, taxes presently comprise 68% of the total cost of cigarettes. This percentage is considerably higher in other Organisation for Economic Co-operation and Development (OECD) countries; for example, 80% in France, 78% in the United Kingdom and 76% in Canada.(24)



Figure 3.2:

Tax paid as a percentage of final recommended retail price – OECD countries, 2003



Source: Scollo, M Tobacco in Australia, Facts and Issues.(48)

Modelling of the predicted impact of policy measures on future prevalence of smoking in Australia indicates that increasing the price of tobacco products by at least 50% in real terms within the next three years is vital if we are to achieve the target of 10% adult daily smoking by 2020.(23) Most smokers make several attempts before quitting. Staged increases in price provide opportunities for smokers to think about the costs of smoking and for smokers who have relapsed to try again.

#### Action 1.1

***Ensure that the average price of a packet of 30 cigarettes is at least \$20 (in 2008 \$ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products.***

While increasing the costliness of tobacco products is vital to reducing disparities in tobacco use, it is acknowledged that a large and abrupt increase in prices could trigger financial stress for some smokers who are unable to quit. Financial stress increases the likelihood of a smoker wanting to quit, but is associated with increased likelihood of relapse.(49) There is little direct evidence of food insecurity attributable to tobacco use in Australia, although it is likely that some heavy smokers already spend less than is optimal on food, clothing and other goods and services.

Raising taxes in several stages rather than in a single increase should maximise cessation, triggering many price-sensitive smokers to try to quit each time an increase is introduced or announced. Staged increases will also give remaining smokers time to reduce the number of cigarettes or amount of tobacco they smoke each day and adjust their tobacco and non-tobacco related expenditure.



## RELATED ACTION

This strategy includes numerous measures to provide additional encouragement and assistance for smokers from socially disadvantaged groups. It also includes several measures to ensure that all smokers attempting to quit are able to afford clinically suitable quit-smoking medications including nicotine replacement therapy (NRT). Governments could ensure that smokers in immediate financial stress such as those using emergency housing and relief services and those highly disadvantaged groups who are clients of other state human services are directed to smoking cessation services and able to access available subsidies.

## ILLICIT TRADE

Any availability of illicit tobacco products (that is, products on which taxes have been avoided) undermines the effectiveness of taxation, particularly among low-income groups.(50-52) Increases in excise and customs duty should therefore be complemented by measures to prevent any significant increase in illicit trade.

Since 2004 the Australian Tax Office has vigorously pursued operators who attempt to evade excise duty through the sale of illicit unprocessed tobacco known as chop chop. (53, 54) Locally grown chop chop has become less of an issue in Australia since the phasing out of tobacco growing in 2006; however, some unprocessed tobacco may still be available from overseas. The Australian Customs and Border Protection Service (ACBPS) has measures in place to detect the illegal importation of counterfeit cigarettes and other tobacco products on which customs duty has not been paid, and several offenders have been prosecuted over the last few years. However, so far there appears to have been little progress on measures specified under clauses 15.2, 15.4 and 15.6 of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) to cooperate with other parties on the elimination of illicit trade. No action has yet been taken to require manufacturers

and importers to track and report on sales and distribution (as proposed in a November 2008 Chairperson's text for a Protocol on Illicit Trade in Tobacco Products).(55)

### Action 1.2

***Develop and implement a coordinated national strategy to prevent the emergence of illicit trade in Australia.***

### Action 1.3

***Contribute to the development and implementation of international agreements aiming to combat illicit trade globally.***

### Action 1.4

***Ban the retail sale of tobacco products via the internet.***

## DUTY-FREE SALES

Article 6 of the FCTC states:

*2. Without prejudice to the sovereign right of the Parties to determine and establish their taxation policies, each Party should take account of its national health objectives concerning tobacco control and adopt or maintain, as appropriate, measures which may include: '...*

*(b) prohibiting or restricting, as appropriate, sales to and/or importations by international travellers of tax- and duty-free tobacco products.' WHO FCTC.(56)*

There are no legal barriers preventing the Australian Government from banning the sale of tax- and duty-free tobacco products in Australia. Additionally, obligations under current international agreements would not prevent Australia from introducing laws banning international travellers (both residents and non-residents) from bringing tax- and duty-free tobacco products into the country, provided



that the laws were introduced on public health grounds. Several European countries have recently taken action along these lines.

#### Action 1.5

***End tax- and duty-free sales in Australia. Abolish tax and duty concessions for all travellers entering Australia (specified limits for personal use); and participate in negotiations on international agreements concerning the application of limits to international travellers.***

#### Key action area 2: Increase the frequency, reach and intensity of social marketing campaigns

Well-funded, sustained media campaigns rank second only to price as a key to reducing smoking.

Media campaigns help to personalise the health risks of smoking and increase people's sense of urgency about quitting. To successfully challenge strongly held personal opinions and entrenched self-exempting beliefs, campaigns need to be bold and to take some risks. In order to encourage people to make numerous attempts to quit, to persist through any withdrawal symptoms and to stay a non-smoker, media campaigns need to be on air most of the year. Effective campaigns need to draw on solid behavioural and communications research, and be funded at commercially realistic levels.

#### COMMERCIALY REALISTIC FUNDING

*'Evidence on the value of social marketing (mass media) quitting campaigns is clear: effectively developed and implemented, mass media campaigns can reduce adult smoking prevalence, increase quitting activity and drive calls to cessation services such as Quitlines. As such they form an integral component of any comprehensive tobacco control strategy' (Quote from submission)*


Studies of smoking trends in jurisdictions with and without media campaigns in the early 1980s in Australia(57, 58) and elsewhere(59, 60) indicate that they can be extremely effective in reducing smoking prevalence. As part of a comprehensive scientific review of all available international evidence concerning the impact of the media on smoking attitudes and behaviour,(61) the US National Cancer Institute concluded in its 2008 landmark report that well-funded campaigns can reduce smoking prevalence, with the extent of reductions highly related to levels of media expenditure.(62)

Experience in the United States shows that increases in per capita spending on tobacco control programs are clearly associated with accelerated declines in smoking in both adults(63) and youth.(64) A cohort study in Massachusetts found that, compared to smokers who had the lowest level of tobacco control media campaign exposure, about 280 Target Audience Rating Points (TARPs) per month, those who had the highest (about 838 TARPs per month) were over four times more likely to have quit two years later.

Based on the levels of response to social marketing campaigns observed over the past 15 years in Australia,(40) and taking into account the findings from studies internationally, members of the expert panel overseeing the production of the US National Cancer Institute report on the use of media in tobacco control<sup>5</sup>(62) advise that media spending on Quit campaigns should be high enough to achieve at least 700 TARPs per month. In Australia, achieving an average of 700 TARPs per month would currently cost around \$40 million per year, a figure likely to increase over time with increased media costs and an increasingly fragmented media market.(65)

Media advertising outside New South Wales, Western Australia and Victoria appears to be sporadic. Other than the NSW Cancer Institute (which spent more than \$12 million in 2007),(66) spending on Quit campaigns is considerably

5 Australia's Professor Melanie Wakefield was one of the two senior scientific editors of this report.



lower than the advertising budgets of major commercial retailers in Australia. To maximise the reach and impact of advertising messages, it will be important to capitalise on the remaining years in which free-to-air advertising is still predominant, and also to start moving towards a greater mix of media channels, including free-to-air and subscription television, cinema, print, radio and magazines. To ensure continuing impact over time, funds will also be needed each year for production of new material.

#### **Action 2.1**

*Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking.*

#### **IMPACT OF MEDIA ON DISADVANTAGED GROUPS**

Analysis of smoking prevalence over the first two periods of the *Australian National Tobacco Campaign* shows that changes in smoking rates among blue-collar groups were of a similar magnitude to changes among white-collar groups.(67) This is consistent with the results of earlier research that showed no increase in the disparity between smoking rates among groups with different levels of education after the early Quit campaigns in Sydney and Melbourne.(68,69)

A study of smoking among children in suburbs with varying degrees of socioeconomic disadvantage across Australia between 1987 and 2005(70) found that the level of tobacco-control activity affected the consistency of change in teenage smoking prevalence across different SES groups. Prevalence increased very sharply in low SES teenagers during the period of low tobacco control activity, whereas there was little change among the higher SES teenagers.

A review of the literature published in 2008 has concluded that media campaigns can be equally effective with low and higher SES groups, but that attention must be paid to the placement and style of advertising.

(71) A new cohort study has reported that emotional and narrative advertising messages produced a greater quitting response after two years among lower SES smokers than among higher SES smokers.(72) Emotional narrative communication may be a better method for low SES groups because it enables people to fully and vividly imagine how it would feel to suffer a smoking-related disease.(73-75) Advertising can be placed in television programs more likely to be watched by low SES groups, and additional more localised advertising can be focused on low SES neighbourhoods.

#### **Action 2.2**

*Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups through skewing of placement to television programs most likely to be watched by low SES groups, and by targeting radio, outdoor, transit and other local advertising to low SES neighbourhoods.*

#### **Key action area 3: End all forms of advertising and promotion of tobacco products**

Tobacco kills one in every two long-term users.(76) Many young people show signs of dependency on tobacco products(77-79) (including failure in quitting(80)) before they reach majority age. Anyone trying to introduce cigarettes on the market today would fail. Most Australians believe it would be a good thing if tobacco products were one day no longer sold in retail outlets.(81) There can be no justification for allowing any form of promotion for this lethal product.

The US National Cancer Institute has concluded that there is a causal relationship between the promotion of tobacco and increased tobacco use.(82) Both industry documents and scientific studies show that promotion continues to involve highly sophisticated targeting and segmentation of both existing and potential



users; that the tobacco industry does not effectively self-regulate its marketing practices; and that companies typically respond to partial bans by increasing expenditure in 'permitted' media, such as payments to retailers and proprietors of entertainment venues to display or supply tobacco products, and through new media forms developing as a result of emerging technology. The National Cancer Institute report also points to activities designed to enhance public image and affect attitudes to smoking, such as entertaining influential individuals, sponsorship and donations to 'good causes'. (83)

### **MODERNISING TOBACCO ADVERTISING PROHIBITION ACT**

Australia's *Tobacco Advertising Prohibition Act 1992* and tobacco control legislation in the states and territories effectively prevent most promotion of tobacco through traditional forms of media. However, many newly emerged forms of marketing aimed primarily at young adults (such as viral marketing through internet sites, entertainment venues and events) also influence teenagers. (15) Staggering numbers of people are using social networking sites in which there is considerable discussion of smoking. (84) Submissions from expert health agencies (85) to a review of the Act in 2003 (86) identified numerous loose ends and important loopholes that need to be addressed to ensure that the Act remains effective into the 21st century. The May 2007 meeting of the Ministerial Council on Drug Strategy agreed that all governments would collaborate to ban the sale and advertising of tobacco products over the internet; however, legislative amendments have not yet been drafted, and none of the other recommendations from the 2003 review has been acted on.

Guidelines adopted in November 2008 by the WHO's Conference of the Parties to the FCTC in relation to Article 13 (87) specify that in addition to plain packaging and bans on point-of-sale displays and corporate communication, legislation to restrict promotion by the tobacco industry should also cover modern

communication technologies, including the internet, satellite television and mobile telecommunications.

#### **Action 3.1**

*Legislate to eliminate all remaining forms of promotion including advertising of price specials, public relations activities, payments to retailers and proprietors of hospitality venues, promotion through packaging (see Action 3.4 below) and, as far as feasible, through new and emerging forms of media.*

### **REPORTING ON EXPENDITURE ON ANY RESIDUAL PROMOTION**

In the United States all tobacco companies must supply the Federal Trade Commission annually with detailed information on exactly what they spend on all forms of advertising and promotion of tobacco products. The Australian Government needs to be provided with similar information, not least so it can assess the need for action on any promotional activity that any company believes is not covered by existing Australian legislation.

#### **Action 3.2**

*Regulate to require mandatory reporting of amounts spent on any form of promotion – on payments to public relations companies or any other third parties, as well as details of any other promotional expenditure.*

### **POINT-OF-SALE DISPLAYS**

Displays at point of sale normalise tobacco products in the eyes of children (88) and prompt impulse purchases in smokers and recent ex-smokers. (89) Children and smokers need protection from inducements to buy tobacco products. National consistency has been sought by industry in submissions to the Taskforce. Legislation is being progressively implemented in most jurisdictions, but is absent or not sufficiently robust in others.



### Action 3.3

***Amend legislation to ensure that tobacco is out-of-sight in retail outlets in all jurisdictions.***

#### PROMOTION THROUGH PACKAGING

In Australia and other countries that have already banned traditional forms of tobacco marketing, packaging has become a cornerstone of marketing strategy. Brand names and package design enable the communication of personal characteristics, social identity and aspirations,(90) and are a crucial aspect of marketing tobacco products.(91, 92) Market-testing studies show that package design – through the use of varying colour and other design elements – induces smokers to expect, and then actually experience, their cigarettes to be lower strength, lower in tar and lower in health risk than exactly the same cigarettes presented without this packaging.(93, 94) These misperceptions are part of the constellation of modifiable tobacco marketing factors that make smoking easier to take up and harder to quit.

As noted above, there can be no justification for allowing any form of promotion for this uniquely dangerous and addictive product which it is illegal to sell to children. 'Plain packaging' entails prohibiting brand imagery, colours, corporate logos and trademarks, and permitting manufacturers only to print the brand name in a mandated size, font and place, in addition to required health warnings and other legally mandated product information such as toxic constituents, tax-paid seals or package contents. A standard cardboard texture would be mandatory, and the size and shape of the package and cellophane wrapper would also be prescribed. A detailed analysis of current marketing practices(92) suggests that regulations prescribing plain packaging would also need to encompass pack interiors and the cigarette itself, given the potential for manufacturers to use colours, bandings and markings, and different length and gauges to make cigarettes more 'interesting' and

appealing. Any use of perfuming, incorporation of audio chips or affixing of 'onserts' would also need to be banned.

Consumer research indicates that decreasing the number of design elements on the package reduces its appeal and perceptions about the likely enjoyment and desirability of smoking.(95) Requiring cigarettes to be sold in plain packaging would reinforce the idea that cigarettes are not an ordinary consumer item. It would also reduce the potential for cigarettes to be used to signify status. Plain packaging would increase the salience of health warnings: research subjects show an improved ability to recall health warnings on plain packs.(96-98)

Guidelines for implementation of Article 11 adopted by the WHO's Conference of the Parties to the FCTC state:

*Parties should consider adopting measures to restrict or prohibit the use of logos, colours, brand images or promotional information on packaging other than brand names and product names displayed in a standard colour and font style (plain packaging).(99)*

Shareholder nervousness(100) and industry opposition to restrictions on pack design are a strong indication of the importance of packaging to tobacco sales.(101)

*'In our opinion, (after taxation) the other two regulatory environment changes that concern the industry the most are homogenous packaging and below-the-counter sales. Both would significantly restrict the industry's ability to promote their products.'* Morgan Stanley Research (2007)(102)

Threatened legal challenges from tobacco companies also testify to the importance they attach to packaging as a promotional mechanism. Given that trademark law is aimed at protecting broader public interests and does not provide for absolute private property rights, plain packaging is justifiable, proportionate and not inconsistent with international trade



agreements. International agreements provide flexibilities and exceptions to protect public health.

The industry has argued that plain packaging would make it easier to counterfeit cigarette packets. However, this need not be the case. Strategies proposed in the FCTC's draft protocol to combat illicit trade include the mandating of tax markings that would make cigarette packages extremely difficult to counterfeit.

#### **Action 3.4**

##### ***Eliminate promotion of tobacco products through design of packaging.***

To speed the adoption of plain packaging, the Australian Government could consider a differential rate of excise and customs duty for plain packets introduced to market prior to the required date.

#### **Key action area 4: Eliminate exposure to second-hand smoke in public places**

Significant health risks are posed by exposure to smoke from tobacco products smoked by other people.(103) It is well established that second-hand smoke causes coronary heart disease and lung cancer in non-smoking adults, induces and exacerbates a range of respiratory effects in infants, children and adults, and increases the risk of Sudden Infant Death Syndrome (SIDS) and other serious health outcomes in young children.(104, 105) There is no level of exposure to second-hand smoke that is free of risk.(104, 105) At particular risk are the young, who lack control over their environment,(104) and the socially disadvantaged, who are more likely to be exposed to second-hand smoke at home and elsewhere.(105)

The International Agency for Research Against Cancer (IARC) has recently reported results from its expert scientific review,(106) which determined that evidence is sufficient to conclude that laws restricting smoking in workplaces and other public places reduce population exposure to second-hand smoke, consumption of cigarettes and respiratory symptoms in workers. The IARC found that such policies provide net benefits to business, with no adverse effects on overall sales in the hospitality industry.(107) An international study of adolescents from 32 countries in Europe, Israel and North America published in 2008 confirms a strong relationship between the adoption of national smoke-free laws and declines in adolescent smoking.(108) A review in 2008(109) and several additional studies(110, 111) confirm early suspicions(112) that the introduction of smoke-free policies is followed by a rapid reduction in heart attacks among both smokers and non-smokers.

#### **Action 4.1**

##### ***Amend legislation and departmental policies to ensure that smoking is prohibited in any public places where the public, particularly children, are likely to be exposed.***

#### **SMOKING IN CARS**

Alarming levels of exposure to toxic substances have been documented in children travelling with adults who smoke inside cars,(113-115) with greater concentrations resulting from airflow when windows are open,(116) and exposure more common in lower SES families.(117, 118) Bans on smoking in cars are being adopted by an increasing number of North American jurisdictions and are or shortly will be in force in all but three Australian jurisdictions (Western Australia, the Australian Capital Territory and the Northern Territory), with Western Australia and the Australian Capital Territory also currently considering legislative proposals. Greater national consistency would be desirable to protect Australian children in all jurisdictions.



#### Action 4.2

*Legislate to ensure that children are not exposed to tobacco smoke when travelling as passengers in cars.*

### SMOKING IN WORKPLACES AND PUBLIC PLACES

Over the past four years, all Australian states and territories have extended legislation to reduce public exposure to second-hand smoke. Legislation applies to hotels and nightclubs as well as to restaurants, with exceptions relating to gaming areas in some jurisdictions (New South Wales, Queensland and Victoria) and smoking areas still allowed in hotels in the Northern Territory. Because legislation has been introduced at different times in different places, several loopholes and inadequacies have emerged in some aspects of operation and enforcement. In 2008 a NSW Health Department study of outdoor areas where smoking was still allowed in hotels detected 'poor' air quality well above the WHO-recommended 24-hour exposure limit of 25 micrograms per cubic metre. A third of hotels recorded twice the limit, with some areas exceeding it by 500%.<sup>(119)</sup>

#### Action 4.3

*Tighten and enforce legislation to protect against exposure to second-hand smoke in all workplaces (including both indoor and outdoor areas in restaurants and hotels, near the entrances to buildings and air-conditioning intake points, and in workplace vehicles).*

#### Action 4.4

*Introduce and enforce legislation, and encourage adoption of policies that restrict smoking outdoors where people gather or move in close proximity.*

### SMOKING IN MULTI-UNIT DEVELOPMENTS

In several states in the United States there has been much discussion about the problem of smoke-drift between apartments, some attempts at legal action<sup>(120)</sup> and growing pressure for legislation. In 2006 the NSW Consumer, Trader and Tenancy Tribunal upheld a case brought by occupants of an apartment against their smoking neighbours, requiring them to stop smoking in their adjacent apartment because of smoke drift.<sup>(121)</sup> This precedent could precipitate other such actions and give license to rental managers to advise tenants that smoking is banned in rental apartments. A Canadian survey found that 64% of apartment dwellers would prefer to live in an entirely smoke-free complex and that 46% had experienced smoke from a neighbour seeping into their apartment.<sup>(122)</sup> At least 36 public housing authorities in the United States have banned smoking within private apartments.<sup>(123)</sup>

People would be better able to choose accommodation free of smoke-drift if legislation required that the smoking policy in shared and indoor areas be specified in residential lease agreements in multi-unit apartments, and that all shared areas (lifts, stairwells, walkways, car parks) in multi-storey public housing developments be smoke-free. Currently in Australia, restrictions over smoking in apartment blocks apply in New South Wales and Queensland but not specifically in other jurisdictions.

#### Action 4.5

*Protect residents from exposure to smoke-drift in multi-unit developments.*



### **Key action area 5: Regulate manufacturing and further regulate packaging and supply of tobacco products**

Unlike poisons, firearms and pharmaceutical products, there are relatively few controls in Australia on the ways in which tobacco products are manufactured, packaged and supplied to consumers. Several major deficiencies and loopholes should be addressed.

#### **SUPPLY OF TOBACCO PRODUCTS**

Legislation pertaining to the sale of tobacco products in retail outlets has been introduced at different times in different states and territories. All retailers should be licensed to aid communication of government regulations and as a means of ensuring enforcement of those regulations. The cost of the licence should be sufficient to cover the costs of education, compliance testing and investigation of prosecutions at levels necessary to ensure universal compliance. Any retailer who knowingly sells tobacco products to minors is unfit to hold a licence. Sales to minors could be minimised across the country if states and territories all moved to best practice concerning allowable retail outlets, provisions for checking proof of age, enforcement and penalties.

#### **Action 5.1**

***Tighten and enforce legislation to eliminate sales to minors and any form of promotion of tobacco at the retail level.***

#### **CONSUMER PRODUCT INFORMATION**

The previous four sets of health warnings required on cigarettes in Australia have been introduced only after protracted reviews and with extremely lengthy phase-in periods. During the 14 years it took to upgrade the 1973 warnings, the eight years it took to upgrade the 1987 warnings, and the 10 years it took to upgrade the 1994 warnings, extensive new evidence about the health effects of smoking became available, including much information about which consumers to this day still have not been warned. Consumers need to be warned about all the risks posed by smoking in a clear, systematic and much more timely manner.

The Department of Health and Ageing's evaluation of graphic health warnings introduced in 2006 showed that while smokers strongly approved of the graphic form, and the tone and style of warnings, unaided recall of health information declined from 98% in 2000 to 91% in 2008.<sup>(124)</sup> Smokers interviewed confirmed the importance of the front of the pack for conveying health information, with many smokers commenting that the current warnings were too small and made less prominent by placement on the lid. The evaluation also indicated some wear-out of current warnings, and provided evidence that colours and other design features of cigarette packaging were competing with and reducing the impact of warnings.

Plain packaging increases the prominence of warnings; see 3.4 above. In addition, research by Health Canada indicates that graphic health warnings are most effective if they cover almost the entire surface of cigarette packages. Based on analysis of 38 different indicators, researchers concluded that warnings needed to increase to 90% if they are to 'connect with emotions of various styles of young smokers' and 'make cigarette packs less attractive'.

Australia is now well behind when it comes to the potency of warnings.

Figure 3.3:

Examples of health warnings required on cigarettes in Singapore (neck cancer) and in Thailand (throat cancer)



#### Action 5.2

*Improve consumer information related to tobacco products, including through the mandating of substantially larger front-of-pack health warnings, more regular reviews of health warnings and a more timely system of warning consumers of new and emerging risks.*

### MANUFACTURING OF TOBACCO PRODUCTS - REDUCED FIRE-RISK CIGARETTES

Nearly one-quarter of all fire deaths in Australia in 2004–05 occurred in fires started by cigarettes or matches. The total economic impact of these fires is conservatively estimated at \$81 million each year.<sup>(13)</sup> New regulations requiring cigarettes to be produced to a standard that ensures they are quickly extinguished are due to come into force in March 2010, but the deadline for implementation has recently been brought forward by six months (from March 2011 to September 2010) so that all cigarettes on the market should be reduced fire-risk cigarettes prior to the commencement of the 2010–11 summer fire season.

#### Action 5.3

*Ensure compliance with new regulations regarding reduced fire-risk.*

### DESIGN, CONTENT AND EMISSIONS

Cigarettes can be designed in ways that affect the emission of particular toxins. While it is not clear whether cigarettes can be manufactured to create any less harm to consumers, governments should consider the potential benefits of enforcing requirements for product modifications or reduced emissions with at least some prospect of reducing risk. A crucial element of such regulation would be to prevent any sort of communication with consumers by manufacturers that might provide false reassurance. It would also be essential to ensure that information was collected (in the form of monitoring of biomarkers and disease surveillance) to assess whether in fact any reduction in harm actually did eventuate.

No legislation currently exists enabling the government to mandate requirements regarding the contents or performance of Australian tobacco products; thus the government would currently not be able to mandate any modifications to cigarettes such as those recommended by the WHO's expert advisory group, *TobReg*.<sup>(125)</sup> Further, no



legislation currently mandates the provision of information that would be required to assess the impact on consumers. Detailed requirements for such reporting are likely to be incorporated in guidelines currently being developed by an expert group reporting to the WHO's Conference of the Parties to the FCTC.

#### **Action 5.4**

*Establish or nominate a body with the power to regulate the design, contents and maximum emissions for all tobacco products (and any alternative nicotine delivery devices that may be allowed onto the market), and with responsibility for specifying required disclosure to government, labelling and any other communication to consumers.*

#### **LEGAL ACTION**

Tobacco products cause the premature death of one in every two regular users, resulting in enormous social costs to the entire community, and unquantifiable misery to individuals and families. The continuing sale of such products through tens of thousands of retail outlets across the country raises important legal questions.

#### **Action 5.5**

*Investigate the feasibility of legal action by governments and others against tobacco companies with a view to recovering health and other costs.*

#### **Key action area 6: Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems**

The sheer number of people who once smoked but now do not – around 4.3 million Australians in 2007 – shows that quitting is possible, but it can be a very difficult process nevertheless. (126) Succeeding requires a great deal of determination and the adoption (conscious or not) of strategies to overcome withdrawal and triggers to smoke.

Smoke-free policies not only protect patients and staff from second-hand smoke, they also allow governments and healthcare institutions to reinforce how seriously they regard the health risks of tobacco use. Asking patients about their smoking enables health professionals to personalise those risks, often at highly 'teachable moments' when patients are suffering a serious illness or health incident. Clear advice from a concerned professional can motivate a patient to quit, whether the advice comes from a doctor,(127) dentist,(128) nurse(129) or other health professional, and whether it occurs in practice rooms, in a community health centre or in a hospital.(130)

#### **Action 6.1**

*Ensure all state- or territory-funded healthcare facilities (general, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke, both indoors and on health service grounds.*



## CLEAR ADVICE FROM HEALTH PROFESSIONALS

As demonstrated as long as 30 years ago, because doctors see a large proportion of smokers each year, even small effects can contribute significantly to reducing population prevalence.<sup>(131)</sup> Small effects of treatments are clinically significant because of the very large health gains that accrue from stopping smoking.

### Action 6.2

*Ensure all patients, each time they consult a health professional in private or public, community, general practice or institutional settings, are routinely asked about smoking status and if smokers are advised to quit in line with guidelines developed for relevant professional groups. (132, 133)*

## EFFICACY OF TREATMENT

A very large body of research now confirms that an individual's chances of quitting can be increased by taking medications that lessen withdrawal symptoms<sup>(134, 135)</sup> or reduce the reinforcing effects of tobacco-delivered nicotine.<sup>(136-140)</sup> There is also overwhelming evidence that a structured program of cognitive behavioural advice and coaching can also be helpful, regardless of whether the assistance is provided one to one,<sup>(141)</sup> over the phone<sup>(142)</sup> or in a group<sup>(143)</sup> (in the community or through work).<sup>(144)</sup> Well-designed brochures help some people, but this is not enough for most.<sup>(144)</sup> Success rates are better where advice can be personalised.

This can be achieved through telephone helplines or through computer technologies (such as the QuitCoach<sup>(145)</sup> available through the Australian Government's website), which can be delivered at a much lower cost than printed materials. Programs delivered through peoples' computers or web-enhanced mobile devices using e-mail, text messaging, live calendars and message boards are also likely to be cost-effective.<sup>(146)</sup> Structured programs generally achieve greater success

with increasing contact: four to eight sessions optimises chances at reasonable cost.<sup>6</sup>(148-150) People are also more likely to quit successfully if they use a combination of approaches. Adding medication to counselling (or vice versa) increases success rates.<sup>7</sup>

### Action 6.3

*Improve quality of use of pharmacotherapies and services demonstrated to assist with smoking cessation.*

## AN INTEGRATED, COST-EFFECTIVE SYSTEM OF SERVICES AND AVAILABILITY AND SUBSIDY OF TREATMENTS

We need a combination of services, training, referral arrangements, remuneration and subsidies that will work together in the Australian context to provide evidence-based services and treatments for anyone who wants this assistance or is likely to benefit.

## REFERRALS BY PROFESSIONALS TO QUITLINES

Many health practitioners routinely ask patients about their smoking status and offer prescriptions for anti-smoking medications; however, there is scope to greatly increase follow-up and referrals to Quitlines and other supports where these would be helpful.

Hospitals in New South Wales and Queensland have developed systems to identify all patients who smoke and advise them to quit, as well as offering NRT to help them comply with smoke-free policies. Much could be improved in these systems,<sup>(151)</sup> and much more could be done in other jurisdictions.

6 For further details on the effectiveness of pharmaceutical and behavioural interventions, see the frequently updated meta-analyses published by the Tobacco Addiction section.

147. Lancaster T, Stead LF, Cahill K, R. W, Aveyard PN and R. H.J. Cochrane Tobacco Addiction Group. 2008 (2008 Issue 2): Available from: [www.mrw.interscience.wiley.com/cochrane/clabout/articles/TOBACCO/frame.html](http://www.mrw.interscience.wiley.com/cochrane/clabout/articles/TOBACCO/frame.html).

7 For further detail see the US Department of Health's clinical guidelines: [www.surgeongeneral.gov/tobacco/treating\\_tobacco\\_use08.pdf](http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf).



Quitlines are now advertised on every cigarette pack as part of required consumer information. Mass media advertising also drives calls to the Quitline.(152, 153) However, the Quitline is still an under-utilised service in Australia, partly because of a lack of understanding about what the service offers,(154) and more could be done to promote its use.

For several years, governments in the United Kingdom,(155) the United States,(149, 156) New Zealand(157) and Australia(133, 158) have periodically updated and promoted detailed clinical guidelines for doctors on how best to treat tobacco dependence. An important innovation in the Australian clinical guidelines(133) is the offer of two evidence-based strategies for providing cessation assistance: within the consultation, and/or referral to specialist cessation services. GPs can use fax-referral forms to trigger a phone call to their patients from a trained Quitline adviser. For referrals, the Quitline calls the smoker and discusses options for assistance, which allows callers to be directed to or offered the most appropriate form of support.(159)

GP referral to the Quitline has improved patients' chances of quitting.<sup>8</sup>(161) In a Victorian pilot program, referral to the Quitline has resulted in cessation rates two to three times that which resulted from efforts to encourage GPs to provide in-practice management.(162) The effect was due to the smokers getting extra help to quit from outside the practice, while receiving the same amount of help from within it; the combination of the extra help increased both the number and success of quit attempts. The beneficial effect on quitting in the referral condition was sustained over time. The findings add to the growing body of evidence that

health professional referral of patients who smoke to evidence-based Quit services is effective and acceptable to smokers.(163, 164)

#### Action 6.4

***Increase the availability of Quitline services, expanding the modes of delivery of advice and support, and tailoring services for high-need and highly disadvantaged groups, including pregnant women and their partners, people with chronic health conditions, those who do not speak English and people with mental illness. Ensure that funding is provided in line with increased demand generated by advertising, improved health warnings and greater activity by health professionals.***

#### SUBSIDY OF TREATMENTS

Data from the International Tobacco Control Study suggests that smokers in Australia as well as the United States, United Kingdom and Canada who use quit-smoking medicines are more successful in sustaining cessation than those who do not.(165)

Use of quit-smoking medicines is highly related to price.(166) Providing access to subsidised pharmacotherapy is a powerful method of increasing usage of quit treatments; it also increases the proportion of quit attempts that are successful.(167)

In 2008 a large-scale demonstration project across six states in the United States reported that smokers doubled their success rates when given subsidised NRT and access to a Quitline, with savings in healthcare costs justifying full Medicare coverage of low-cost NRT and referral to Quitline services.(168)

Although available on the PBS, varenicline and bupropion may have some serious side effects, and both are contraindicated for some patients. Good clinical practice for many patients would be to encourage use of NRT; however, NRT products are not affordable for many patients. Patches are already subsidised for Indigenous smokers and veterans, but

8 Referrals from other health professionals, however, have been less successful.

160. Young J, Girgis S, Bruce T, Hobbs M and Ward J. Acceptability and effectiveness of opportunistic referral of smokers to telephone cessation advice from a nurse: a randomised trial in Australian general practice. BMC Family Practice. 2008;9:16. Available from: [www.biomedcentral.com/content/pdf/1471-2296-9-16.pdf](http://www.biomedcentral.com/content/pdf/1471-2296-9-16.pdf).



several other highly disadvantaged groups – in particular people living with mental illness – would benefit from PBS listing or some other form of subsidy for NRT products.

**Action 6.5**

*Ensure that nicotine replacement therapy is affordable for all those for whom it is clinically appropriate.*

**FINANCIAL INCENTIVES**

Financial incentives within healthcare settings have been primarily directed towards providers. With significant potential co-benefits for individuals and governments, and some encouraging results and experiences from such initiatives overseas,(169-171) it may also be appropriate to consider incentives directed towards smokers and potential smokers.

**Action 6.6**

*Explore whether financial incentives might be effective in helping people to quit or stay non-smokers.*

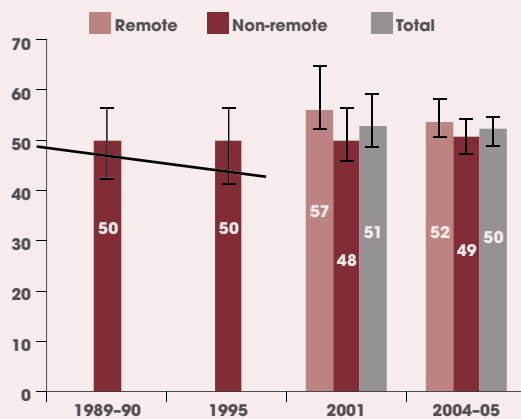
**Key action area 7: Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians**

*'Reducing smoking prevalence among Indigenous Australians must be a high priority if the life expectancy gap is to be successfully closed' (Quote from submission)*

Tobacco use among Aboriginal and Torres Strait Islander peoples causes disturbing levels of ill health and premature death in infants, parents and elders, and is a major contributor to the life expectancy gap.(8) In New Zealand, smoking has declined by more than 20% in Maori men and women over the last four years. (172) In Australia, smoking among Indigenous people appears to have not declined at all over the past 15 years, although rates in remote communities may have improved slightly.

Figure 3.4:

Prevalence of smoking among Indigenous Australians aged 18+, in all areas 2001 and 2004–2005, and in non-remote areas 1989 to 2004–2005



(line = non-Indigenous)

Sources: ABS National Health Surveys 1989, 1995 and 2001, and Aboriginal and Torres Strait Islander National Health Survey 2004–2005

Shortly after its election, the Australian Government pledged \$14.5 million over four years to help tackle smoking in Indigenous communities.(26) This has helped to get the issue on the Indigenous health agenda, and has resulted in a number of projects and initiatives. However, small pilot projects, no matter how well designed and run, will not make the inroads necessary to reduce smoking rates across the Indigenous population as a whole. While there is a place for trials of innovative new approaches, it is now time to scale up efforts, working closely with and through Indigenous organisations. Time and resources should be allowed for training and sharing of insights, and it should be acknowledged that quality of service will improve as staff become more experienced.



## LEARNING THROUGH DOING

*'...there is a need to include both Indigenous-specific activities, as well as measures to ensure access of Indigenous people and communities to mainstream programs and services' (Quote from submission)*

Evidence suggests that multi-component community-based projects developed and implemented by local communities, and involving strong local drivers, are likely to impact on Indigenous smoking. Community control of these projects and the involvement of influential local community members will have greater impact on de-normalising tobacco use and reducing the social acceptability of smoking. A mix of multiple strategies as determined by the local community will reinforce anti-smoking messages and provide a variety of options for families and individuals to address their tobacco use. Projects should be established in a variety of locations, and could be extensions of existing projects. Funding must sustain the projects over a period adequate to evaluate processes and possibly impacts (at least two to three years). Capacity to undertake and evaluate these projects must be built and supported through the other activities suggested below.

### Action 7.1

***Establish multi-component community-based tobacco control projects that are locally developed and delivered.***

## SOCIAL MARKETING FOR INDIGENOUS PEOPLE

Mainstream social marketing campaigns are effective in increasing awareness and understanding of the health effects of smoking among Indigenous people.

Research conducted by the NSW Cancer Institute in 2008 indicates that many mainstream advertisements are considered personally relevant by Indigenous smokers. However, there should be more representation of Indigenous people and relevant themes in campaigns where possible. This may include talent, language, situations and calls to action relevant to Indigenous people. Messages also need to challenge the acceptability of smoking and the inevitability of smoking-related diseases for Indigenous people.

Campaigns that more accurately reflect the life of an Indigenous smoker, in terms of the high prevalence of smoking, experience of smoking-related health effects and cross-generational smoking behaviour, are likely to be powerful in moving Indigenous smokers further along the continuum towards quitting.

Research in New South Wales and experience in Western Australia suggest that the optimum way forward involves a 'twin track' approach of using existing effective mainstream campaigns and adding complementary Indigenous-specific campaign elements. Experience has shown that radio offers a number of opportunities as an inexpensive and complementary medium that can be tailored to local and regional areas.

As with all social marketing, campaigns must be of high quality, based on research, sustained – that is, ongoing for several years rather than one-off efforts – and sufficiently well funded to allow appropriate TARP levels to demonstrate an impact.

### Action 7.2

***Enhance social marketing campaigns for Indigenous smokers, ensuring a 'twin track' approach of using existing effective mainstream campaigns complemented by Indigenous-specific campaign elements.***



## TRAIN INDIGENOUS HEALTH WORKERS

Indigenous health workers should be supported to lead tobacco control activities (and also to be non-smokers). Training is needed to improve knowledge about tobacco use and to build skills in service and program delivery, including:

- Providing brief interventions
- Developing, implementing and evaluating community-based tobacco control programs
- Collection and use of data and evaluating programs

### Action 7.3

*Provide training to Aboriginal and Torres Strait Islander health workers to improve skills in the provision of smoking cessation advice.*

## TRAIN ALL STAFF WORKING IN INDIGENOUS HEALTH SERVICES

Training should include realistic and empowering strategies on how to discuss smoking cessation with patients, and how to develop programs that encourage change in social norms within communities around smoking. Training should be integrated in the multi-component community-based projects (Action 7.1 above).

### Action 7.4

*Improve training in the provision of smoking cessation advice of other health professionals working in Aboriginal and Torres Strait Islander health services.*

## BUILDING CAPACITY OF LOCAL HEALTH SERVICES

Indigenous health workers are already burdened with their daily work, and may have insufficient time and support to undertake tobacco control activities. Specialist workers have been successfully used in other areas, such as drug and alcohol therapy, sexual health and mental health.

Specialist Tobacco Control Workers are needed to assist local Indigenous health services to build their capacities to address tobacco use. The responsibilities of such workers will depend on local requirements but may include:

- Facilitate training and provide support to health service staff in tobacco control
- Support and advise health workers to lead in the development and delivery of community tobacco control programs
- Assist Indigenous organisations to develop and implement policies for smoke-free workplaces
- Advocate for the needs of Indigenous health services in the area of tobacco control (for example, around improved access to NRT)
- Provide support to multi-component community-based tobacco control projects (see Action 7.1)
- Assist Indigenous organisations to develop programs and policies that can support Indigenous health workers to quit smoking
- Collect smoking-related data at the local level
- Support communities and organisations to evaluate tobacco control programs

A clear structure is needed to support these Tobacco Control Workers. The *BREATHE Project* at the Aboriginal Health and Medical Research Council of NSW has a trial in place of Specialist Tobacco Control Workers in four Aboriginal Medical Services. This project could provide a model. A training package developed as part of the project could be enhanced (with further funding) to be used nationally with Specialist Tobacco Control Workers.

### Action 7.5

*Place specialist Tobacco Control Workers in Indigenous community health organisations to build capacity at the local health service level to develop and deliver tobacco control activities.*



## **INCREASE EMPLOYMENT OF INDIGENOUS STAFF IN NGOS**

The work of NGOs in the area of Indigenous tobacco control could be enhanced by the employment of Indigenous workers. Where possible, at least two workers should be employed to maximise the provision of a supportive work environment for Indigenous people.

### **Action 7.6**

*Provide incentives to encourage NGOs to employ Indigenous workers.*

**Key action area 8: Boost efforts to discourage smoking among people in other highly disadvantaged groups, such as people living with mental illness, living in highly disadvantaged neighbourhoods, from cultural backgrounds with high rates of smoking or living in correctional facilities**

*'The decline in smoking prevalence in Australia has not been uniform across states and there are some populations in which the prevalence remains high, including Aboriginal Australians and many of the most disadvantaged groups in society' (Quote from submissions)*

The prevalence of smoking is significantly higher among lower socioeconomic groups, particularly in groups facing multiple personal and social difficulties and challenges. Higher rates of smoking are one of the major factors driving poorer health status in economically disadvantaged areas and groups.

Spending on tobacco products and ill health contribute significantly to financial stress. Over long periods, spending on tobacco works against the accumulation of household savings and assets, and perpetuates intergenerational poverty. Financial stress and poverty create social conditions that may make it more difficult to successfully quit smoking. Smoking by pregnant women may have far-reaching effects on the health of offspring, both as infants and much later in life. Continued high levels of tobacco use by parents and peers powerfully models smoking, thus perpetuating continuing high levels within neighbourhoods and across generations.

## **PEOPLE LIVING IN DISADVANTAGED NEIGHBOURHOODS**

Smoking rates are almost three times higher in census districts (small neighbourhoods within local government areas) that are ranked in the most disadvantaged 10% of districts, compared to those in the least disadvantaged decile. Much of the differential in smoking rates between socioeconomic groups can be explained by higher uptake among young people in low SES areas. Low SES smokers are no less likely to quit, but do seem to be less likely to succeed.(173)

### **Action 8.1**

*Boost efforts to discourage smoking in highly disadvantaged neighbourhoods.*



## PEOPLE LIVING WITH MENTAL ILLNESS

*‘Health and economic harm from smoking and from second-hand smoke impacts disproportionately on the most disadvantaged including people with mental health problems, the homeless, low income smokers and pregnant, disadvantaged women’ (Quote from submission)*

People living with mental illness are more likely to develop, suffer and die from preventable health conditions(174) and are an under-addressed group in tobacco control.(175) They are at least as entitled to benefit from the health consequences of quitting and protection from second-hand smoke as any other members of the community.(176)

Rates of smoking are known to be significantly higher among people with conditions such as anxiety, depression,(2, 10) bi-polar disorder(177) and schizophrenia.(178) Young people at risk of developing mental health problems appear to be more likely to try cigarettes and become regular smokers,(179, 180) and nicotine dependence appears to be closely associated with some aspects of clinical depression.(181) Time spent in psychiatric facilities with cultures that promote smoking can increase people’s tobacco consumption and reduce the likelihood of quitting.(182) It appears that tobacco smoking can increase the risk or worsen certain mental health problems,(183) and that nicotine withdrawal(184) can also temporarily increase symptoms of depression. While failure in quitting can worsen common mental health problems such as depression,(185) such symptoms can generally be managed, and cessation is possible without a deterioration in mental health.(186)

It is important that health professionals encourage people with mental health problems to quit smoking. Treatment for nicotine dependence should be part of the treatment plan for all patients who smoke. People living with mental illness who are not in contact with psychiatric services also need

to be encouraged and supported to quit or, if appropriate, to reduce smoking in preparation for quitting.

### Actions 8.2

**Ensure access to information, treatment and services for those with mental health problems.**

### Actions 8.3

**Support cessation of smoking among those using mental health services.**

### Actions 8.4

**Encourage cessation of smoking in those with mental health problems outside institutional settings.**

## PEOPLE IN CORRECTIONAL FACILITIES

Completely smoke-free correctional facilities have been introduced successfully overseas (for example, the US Federal penitentiary system, at least 10 US states and some Canadian provinces). Such policies protect both prisoners and staff.

Quitting smoking would significantly improve the health prospects of people leaving correctional facilities, and may also improve their prospects for housing and even employment.

Careful planning and implementation, with cessation supports, are crucial; however, strong, well-enforced policies are entirely feasible.

### Action 8.5

**Ensure all state-funded human services agencies and correctional facilities (adult and juvenile) are smoke-free and provide appropriate cessation supports.**



**Key action area 9: Assist parents and educators to discourage use of tobacco and to protect young people from second-hand smoke**

Parents can do much to discourage their children from taking up smoking. Governments can do much to assist parents' endeavours.

**FAMILIES**

Young teenagers with one or more parents who smoke are more than three times more likely to experiment with smoking. Older teenagers are almost three times more likely to smoke regularly than the teenagers of parents who do not smoke.(187)

Analysis of New Zealand data in 2007 compared with 2001 has shown that the decline in smoking prevalence in teenagers has been greatest for students with no parents smoking, and least for students with both parents smoking (Table 7b of the NZ report).(188) An Australian longitudinal study shows that children of non-smokers are also more likely to remain non-smokers in the long term.(20)

Quitting by parents has a very strong effect on subsequent smoking by children, and is probably the single most important thing that a smoker-parent can do to prevent their children from also becoming smokers.(189)

Smoking by children is also highly related to sibling smoking, and older teenagers often state that they hope their younger siblings do not experiment with smoking; siblings may be an untapped resource for tobacco control.(190, 191)

Smoke-free homes increase adults' chances of quitting.(192) and reduce the likelihood of children taking up smoking.(193-195) US studies(196, 197) have found that even after controlling for demographic factors and parents' smoking status, children who lived in homes where smoking was banned were more than 20% less likely to take up smoking than children who lived in homes where smoking was allowed.

Children who spend more time with their families and deal effectively with conflict are less likely to take up smoking: eating dinner together most nights really does seem to be a very good idea!(21) Lack of parental supervision is also strongly associated with smoking experimentation.(187)

**Action 9.1**

*Convey the message that parents can help – by quitting smoking; by making their homes smoke-free; by choosing appropriate films, videos and games; and by making it clear that they do not want their children to smoke for the sake of their health.*

**SCHOOLS, UNIVERSITIES AND OTHER EDUCATIONAL INSTITUTIONS**

Drug education appears to have limited efficacy in reducing uptake of smoking; however, issues surrounding tobacco – tobacco marketing, the medical aspects of tobacco use, and the public health, legal, social and environmental aspects of tobacco marketing and tobacco control – are very topical and important, and it is useful for young citizens to be informed. Thinking about the health and social justice aspects of tobacco is likely to discourage some young people from using the product.

Smoke-free policies in educational institutions provide a clear message that Australia is working towards a smoke-free future. Properly enforced, smoke-free policies in schools have been associated with lower uptake of smoking in children. They send a clear message that smoking is dangerous for everybody, and can also help to reduce peer pressure to experiment with smoking.

**Action 9.2**

*Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum and where appropriate in curriculum in tertiary institutions.*



### Action 9.3

*Encourage schools to promote and consistently enforce smoke-free policies (buildings and school grounds) for all members of the school community.*

### Action 9.4

*Encourage universities and other institutes of higher education to adopt smoke-free campuses, including outdoors.*

## MEDIA

Smoking is portrayed in movies to a much greater extent than it occurs in real life. (198-207) Reviews of the evidence by several scientific bodies (208-210) and several well-designed studies and meta-analyses (211-215) conclude that smoking by popular characters can exert a powerful influence on teenagers, particularly those with temperaments that make them prone to seeking novelty and excitement. (216, 217)

Tobacco-control experts in different countries differ as to the best approach to this problem. (218-220) Bans or automatic ratings for products depicting smoking are strongly opposed by the film and television industries, and would also not be supported by most public health advocates in Australia. One study has shown that the screening of anti-smoking advertisements before films depicting smoking would reduce the impact of such depictions, (221) but advocates fear that such advertisements would quickly become counterproductive unless they had high production values and were frequently replaced. Providing them would be expensive and labour intensive.

Australia should follow the lead of the United States and the United Kingdom, and require the Classification Board to take smoking into account when rating films and video games. Such a move would be consistent with broader government policy on censorship and classification. It may result in fewer damaging depictions of smoking in films seen by younger

teenagers. For this measure to be effective, parents would need to ensure that their children only watch age-appropriate films.

### Action 9.5

*Make smoking a 'classifiable element' in movies and video games.*

**Key action area 10: Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use**

Advocacy is widely recognised as having played a crucial role in tobacco control achievements and in reducing smoking. This in turn has played a significant role in Australia's international leadership to reduce the global burden of tobacco. It is vital that such advocacy is maintained in order to keep smoking and its effects in the news and on the political agenda. In addition to the effect of this in maintaining support for tobacco control among politicians and other decision makers, news coverage about smoking has been demonstrated to have a direct effect on quitting in adults and on smoking by children.

### Action 10.1

*Ensure the public is constantly alerted to information about tobacco and its impact arising from new research findings.*

### Action 10.2

*Ensure that politicians and other opinion leaders are aware of international developments in tobacco control, including guidelines developed to assist countries to meet international obligations under the Framework Convention on Tobacco Control, and research on the efficacy of tobacco control interventions.*



Corporate social responsibility is defined as 'the continuing commitment by business to behave ethically and contribute to economic development while improving the quality of life of the workforce, their families and the local community and society at large'.

Guidelines on the implementation of Article 13 accepted by the Parties to the FCTC (99) state that tobacco companies should be barred from contributing to any other entity for 'social responsibility causes' or from giving publicity to 'socially responsible' business practices, as both constitute advertising and promotion.

Australia should take this a step further and seek to have all companies report the percentage of their revenues generated from tobacco products.

#### **Action 10.3**

*Ensure greater awareness that profiting from the sale of tobacco products is incompatible with principles of corporate social responsibility.*

#### **Key action area 11: Ensure implementation and measure progress against and towards targets**

It will be important to ensure that the Tobacco Strategy is effectively implemented and monitored. Australia has a well-developed surveillance system on tobacco. For most targets, progress can be assessed using existing long-running regular surveys. A few gaps need to be addressed to enable governments to assess whether adequate progress is being made to ensure that targets will be met.

## **ENSURING IMPLEMENTATION**

A National Tobacco Strategy Steering Committee should be established, overseeing and reporting to the Minister for Health and Ageing on implementation of the Strategy at all levels. This is especially appropriate for tobacco, where there is so much evidence on the action that is required and such strong support for its implementation.

## **MEASURING PROGRESS TOWARDS OVERALL TARGET**

To assess whether we are on track in reducing the prevalence of daily smoking among adult Australians (aged 18+) – dropping from 17.4% in 2007 (24) to no higher than 10% by 2020 – we need to monitor the proportion of adult Australians who report current or daily smoking in the Australian Bureau of Statistics (ABS) Health Survey scheduled for 2011 and subsequent surveys to be undertaken prior to 2020. Prevalence of daily and current smoking among Australians aged 14 and over will be reported in the National Drug Strategy Household Surveys scheduled for 2010, 2013, 2016 and 2019. Rates for Australians aged 18 and over could also be reported in these surveys.

A question about smoking has recently been included in the New Zealand census. (222) Because the response rate for the census is virtually universal, this allows calibration with data collected from other surveys (for which response rates are lower).

#### **Action 11.1**

*Establish a National Tobacco Strategy Steering Committee*

#### **Action 11.2**

*Include a question on smoking among Australians aged 18 years and over in the Australian Census scheduled for 2011, 2016 and 2021.*



If it proves impossible to obtain sufficiently reliable regular data on prevalence of smoking among adults, then the Australian Government will need to consider requiring tobacco companies to provide data on sales of tobacco products at a regional level. This could be built in to legislation requiring reports on promotional expenditure, which could also be supplied at a regional level.

### **MEASURING PROGRESS TOWARDS TARGETS FOR EACH STATE AND TERRITORY**

The National Partnership Agreement on Preventive Health sets out the agreement of the states, territories and the Australian Government to meet a benchmark of '(jj) reduction in state baseline for proportion of adults smoking daily commensurate with a 2 percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013', Part 4 Clause 15.

The survey instruments for measurement of these targets has not been specified. Annual population health surveys are held in New South Wales, Victoria, Western Australia and South Australia, but not in the other jurisdictions.

#### **Action 11.3**

***Establish a mechanism to collect reliable data on prevalence in 2011 in Queensland, Tasmania, the Australian Capital Territory and the Northern Territory.***

### **MEASURING TARGETS FOR UPTAKE AND CESSATION**

To achieve substantial reductions in smoking prevalence requires both a reduction in the number of children taking up smoking and an increase in the numbers of smokers quitting.

Reports of the Australian Secondary School Survey of Smoking and the Australian School Students' Alcohol and Drug (ASSAD) Survey regularly include the percentages of secondary school students (aged 12–15 and 16–17 years) reporting smoking at least monthly, weekly and daily. These will continue to be monitored in reports of ASSAD surveys conducted in 2011, 2014, 2017 and 2020.

#### **Action 11.4**

***Include in future reports of ASSAD surveys the proportion (and number) of teenagers who have ever smoked more than 100 cigarettes. Trends over time in this indicator would provide a useful estimate of the incidence and number of children taking up smoking each year.***

In addition to the proportion of adults who currently smoke, trends in attempts to quit (and also the numbers of cigarettes smoked) provide an early warning sign of any likely stalling in quit rates. This information is currently collected each year in the International Tobacco Control (ITC) Policy Evaluation Study (partly funded by the Department of Health and Ageing), which is tracking a cohort of people who were smokers at the commencement of the study in 2002.

#### **Action 11.5**

***Report on trends in the proportion of smokers and recent smokers who have attempted to quit in the previous three and 12 months, and the proportion who intend to quit in the next three months.***



## MEASURING TARGETS FOR SMOKING AND SOCIAL DISADVANTAGE

To achieve substantial reductions in smoking prevalence also requires declines in smoking (preceded by declines in uptake and higher rates of cessation) among less educated smokers and those living in disadvantaged areas to be at least as large as declines among more educated smokers living in more affluent areas. Information on smoking in various SES groups is collected in the National Drug Strategy Household Survey.

### Action 11.6

*Report on trends over time in prevalence of smoking and numbers of cigarettes smoked for persons in all various SES groups, both in Australian Institute of Health and Welfare (AIHW) reports on detailed findings of the National Drug Strategy Household Survey, and in reports of the Australian School Students' Smoking, Alcohol and Drug Survey.*

## MONITORING PROGRESS IN INDIGENOUS SMOKING

The National Aboriginal and Torres Strait Islander (NATSHI) Health and Social Surveys provide a reliable indication over time of the percentage of Indigenous Australians smoking. However, sample sizes are not sufficient in either survey to reliably detect small changes over time in Indigenous smoking at the state level and in the Northern Territory.

### Action 11.7

*Increase sample sizes of the NATSHI Health and Social Surveys to provide reliable indications of changes over time in each state and in the Northern Territory. This should be done in preference to trying to include sufficient Indigenous people in annual state population surveys.*

### Action 11.8

*Use state population surveys to over-sample each year within two or three state health department regions with a high proportion of Indigenous residents, so that reliable estimates of prevalence at a regional level become available on a three-yearly basis.*

### Action 11.9

*Analyse percentage changes in the prevalence of Indigenous smoking compared with percentage changes in previous periods, and compared with absolute and percentage changes in the non-Indigenous population.*

As with the general population, smoking uptake and cessation also needs to be monitored in Indigenous people.

### Action 11.10

*Extend the ASSAD Survey to more remote areas of Australia and to Indigenous schools to ensure the inclusion of greater numbers of Indigenous children.<sup>9</sup> This would enable a reliable indication of changes over time in Indigenous smoking in each state and territory.*

### Action 11.11

*Establish a panel of Indigenous people who are currently smokers to enable the monitoring of intentions and attempts to quit, amounts smoked and the prevalence of smoking indoors and around others. The panel could also be used to monitor the impact of tobacco control policies among Indigenous people.*

<sup>9</sup> Over-sample schools in both urban and rural areas that are listed with Education Departments as having high numbers of Indigenous students.



## **MEASURING TARGETS FOR EXPOSURE TO SECOND-HAND SMOKE**

Data on levels of exposure to second-hand smoke in the community is currently being collected, but is not being reported on (or consequently monitored) in a systematic way.

### **Action 11.12**

*Report on trends over time, by SES, in the proportion of Australians aged 14 years and over exposed to second-hand smoke at work and indoors at home.*

### **Action 11.13**

*Report on long-term trends in the percentage of students (smokers and non-smokers) who have one or more parents who smoke, and who live in homes that are smoke-free.*

### **Action 11.14**

*Report for each state and territory, for women living in areas of varying levels of social disadvantage, and for Indigenous and non-Indigenous women, the proportion of pregnant women who report smoking at early and late stages of pregnancy.*

## Summary Tables

### TOBACCO: IMPLEMENTATION PLAN

Summary of action required and how progress will be measured

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<b>Key action area 1: Make tobacco products significantly more expensive</b>			
1.1 <i>Ensure that the average price of a packet of 30 cigarettes is at least \$20 (in 2008 \$ terms) within three years, with equivalent increases in the price of roll-your-own and other tobacco products.</i>	Australian Government – Treasury; Australian Tax Office (ATO).	Year 1 onwards Continue to increase excise and customs duty each six months in line with CPI. Year 1 Amend Excise and Customs tariffs to add 7.5 cents per stick above CPI in Year 1, with equivalent increases for products dutied by weight. Year 2 Add a further 2.5 cents. Year 3 Add a further 7.5 cents.	Recommended retail price of leading brands. Prices actually paid by consumers. Immediate month-on-month change (pre- and post-increases) in smoking status among various income groups and in sales of tobacco products. Changes in quit attempts and reported number of cigarettes smoked daily.
1.2 <i>Develop and implement a coordinated national strategy to prevent the emergence of illicit trade in tobacco in.</i>	A lead government agency (to be nominated by the Australian Government) with input from the ATO, ACBPS, AQIS, Australian Federal Police, state police, Australian and state Departments of Health.	Year 2 Nominate lead agency. Year 3 Report. Year 4 Legislative reforms if required. Year 5 Review and refinements to Strategy.	Percentage of smokers reporting purchase of tobacco or cigarettes outside licensed outlets.
1.3 <i>Contribute to the development and implementation of international agreements aiming to combat illicit trade in tobacco globally.</i>	Lead agency (as above) and the intergovernmental group established by the Department of Health and Ageing to negotiate the FCTC protocol on illicit trade (the group currently comprising the Department of Health and Ageing, the ATO, Treasury, Attorney-Generals, Prime Minister and Cabinet, Department of Foreign Affairs).	Years 2–4 (and thereafter)	Australia plays a role in developing and implementing international agreements aiming to combat illicit trade in tobacco.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
1.4 Ban the retail sale of tobacco products via the internet.	Australian Government.	Year 2 or 3	Legislation drafted and in force.
1.5 End tax and duty free sales in Australia; abolish tax and duty concessions for all travellers entering Australia (specified limits for personal use); and participate in negotiations on international agreements concerning the application of limits to international travellers.	ATO and ACBPS.	Year 3 Amend <i>Customs Regulations 1926</i> (Cth).	Number of cigarettes sold in Australia not subject to excise and customs duty.
<b>Key action area 2: Increase the frequency, reach and intensity of social marketing campaigns</b>			
2.1 Run effective social marketing campaigns at levels of reach demonstrated to reduce smoking.			Percentage of target audiences (including young and low SES smokers) who: Have seen advertising used in recent campaigns Can name themes covered in advertising (unprompted and prompted) Correctly identify health risks and other disadvantages of smoking See such disadvantages as salient and relevant to themselves Agree that advertising contributed to their decision to quit or assisted with staying stopped Took action in the weeks during or following campaigns Number of Quitline calls in response to different creative material, program placement and advertising weight. Hits to cessation support websites over periods in which advertising is on air.
2.1.1 Fund nationwide screening of most effective television advertisements, including those demonstrated to be most effective in state campaigns.	Department of Health and Ageing and state/territory agencies.	Year 1	
2.1.2 Provide long-term budget allocations at both federal and state levels to ensure commercially realistic funding for media campaigns (at least 700 TARPs per months until smoking prevalence reaches 9%).	Australian Government/ states and territories.	Years 2–5 (and thereafter)	
2.1.3 Fund development of a suite of effective materials covering a range of health issues including dramatic treatments.	Australian Government/ states and territories.	Years 2–5 (and thereafter)	
2.1.4 Place media to ensure maximum reach with smokers including young smokers and smokers from disadvantaged groups.	National Prevention Agency (NPA)* and states and territories working with NGOs. * or appropriate national agency	Years 2–5 (and thereafter)	

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
2.2 Choose messages most likely to reduce prevalence in socially disadvantaged groups and provide extra reach to these groups through the skewing of placement to television programs most likely to be watched by low-SES groups, and by targeting radio, outdoor and other local advertising to low SES neighbourhoods.	Australian Government/states and territories/NGOs.	Years 1–5 (and thereafter)	Percentage of targets who have seen recent advertising. Number of Quilline calls and web-hits from people with disadvantaged postcodes, with and without extra advertising.
<b>Key action area 3: End all forms of advertising and promotion of tobacco products</b>			
3.1 Legislate to eliminate all remaining forms of promotion, including advertising of price specials, public relations activities, payments to retailers and proprietors of hospitality venues, promotion through packaging and as far as feasible through new and emerging forms of media.	Australian Government.	Year 1 Review legislation and policies. Year 2 Amend legislation. Year 3 Introduce restrictions. Year 4 onwards Proactively enforce legislation and prosecute as deterrent to breaches.	Percentage of young people aware of tobacco promotion in media, sport or popular entertainment.
3.2 Regulate to require mandatory reporting of amounts spent on any form of promotion – on payments to public relations companies or any other third parties, as well as details of any other promotional expenditure.	Australian Government.	Year 2	System established or not.
3.3 Amend legislation to ensure that tobacco is out-of-sight in retail outlets in all jurisdictions.	All state and territory governments. All states and territories to implement.	Year 1 Year 2 (by end of 2011)	Percentage of teenagers and adults aware of tobacco advertising at point of sale. Percentage of stores where stock is visible.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
3.4 <i>Eliminate promotion of tobacco products through design of packaging.</i>			
3.4.1 Amend Tobacco Advertising Prohibition Act 1992 to require that no tobacco product may be sold except in packaging of a shape, size, material and colour prescribed by the government, with no additional design features.	Australian Government.	Year 1 or 2	Market weighted percentage of brands that comply with plain packaging regulations.
3.4.2 Undertake research to establish optimal colours, pack sizes and fonts that would be prescribed.	Department of Health and Ageing.	Years 2 and 3 Commission work.	Percentage of teenagers and adults with false beliefs about particular brands (smoother, less tar etc) and extent of positive appraisal of cigarette packaging and brand identities.
3.4.3 Amend Trade Practices CPIS (Tobacco) Regulations 2004 to specify exact requirements for plain packaging.	Australian Government.	Year 3	
3.4.4 Commence new arrangements.	Department of Health and Ageing and Australian Competition & Consumer Commission.	Years 4–5	
<b>Key action area 4: Eliminate exposure to second-hand smoke in public places</b>			
4.1 <i>Amend legislation and departmental policies to ensure that smoking is prohibited in any public places where the public, particularly children, are likely to be exposed.</i>	All state and territory governments.	Year 1 Legislate and introduce policies. Year 3 Restrictions in force in line with best practice in all jurisdictions.	Percentage of Australian population living in jurisdictions not covered by legislation in each area.
4.2 <i>Legislate to ensure that children are not exposed to tobacco smoke when travelling as passengers in cars.</i>	All state and territory governments. Enforcement – state and territory governments.	Year 1 Legislate Year 2 onwards: Enforce	Percentage of smokers with children who report sometimes or often smoking in cars. Percentage of people detected smoking in cars in observational studies.
4.3 <i>Tighten and enforce legislation to protect against exposure to second-hand smoke in workplaces (including outdoor areas in restaurants and hotels, near the entrances to buildings and air-conditioning intake points, and in workplace vehicles).</i>	All state and territory governments and local councils where applicable.	Year 1 Review legislation and policies. Year 2 Amend legislation. Year 4 Restrictions in force in line with best practice in all jurisdictions.	Percentage of adults reporting exposure to second-hand smoke in their place of work. Measures on air-monitoring studies.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
4.4 <i>Introduce and enforce legislation, and encourage adoption of policies that restrict smoking outdoors where people gather or move in close proximity.</i>	All state and territory governments.	Year 1 Review legislation. Year 2 Amend legislation. Year 4 Additional restrictions appropriate to local practice in force in all jurisdictions.	Percentage of adults reporting exposure to second-hand smoke in their day-to-day life.
4.5 <i>Protect residents from exposure to smoke-drift in multi-unit developments.</i>	All state and territory governments.	Year 2 Review policies and explore options. Years 3 and 4 Legislate. By Year 5 Legislation in force all jurisdictions.	Percentage of adults reporting exposure to second-hand smoke in their place of residence.
<b>Key action area 5: Regulate manufacturing and further regulate packaging and supply of tobacco products</b>			
5.1 <i>Tighten and enforce legislation to eliminate sales to minors and any form of promotion of tobacco at retail level.</i>			
5.1.1 <i>Require all tobacco retailers be licensed.</i>	All state and territory governments.	Year 1 Amend legislation. Year 2 All retailers in Australia to be licensed.	Percentage of tobacco retailers in Australia who are subject to licensing regulations.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p>5.1.2 Legislate to preclude sales through vending machines, internet, at hospitality and other social venues.</p>	<p>All state and territory governments.</p>	<p>Year 1 Review legislation. Year 2 Amend legislation. Year 3 Best practice provisions operating in all jurisdictions.</p>	<p>Percentage of young people aware of tobacco products sold through entertainment venues, the internet etc.</p>
<p>5.1.3 Review and if necessary legislate to put the onus of proving age on retailers and to increase the penalties for breaches.</p>			
<p>5.1.4 Ensure licence fees are high enough to provide funds for education on the legislation, compliance monitoring and prosecution.</p>	<p>All state and territory governments.</p>	<p>Year 1 Review budgets for compliance monitoring and enforcement. Year 2 Amend legislation to increase licence fees accordingly. Year 3 Optimal budget for compliance monitoring and enforcement in all jurisdiction.</p>	<p>Percentage of revenues for enforcement programs in jurisdictions from licence fees.</p>
<p>5.2 <i>Improve consumer product information related to tobacco products.</i></p>			
<p>5.2.1 Mandate standard plain packaging of all tobacco products to ensure that design features of the pack in no way reduce the prominence or impact of prescribed government warnings – refer to 3.4.</p>			

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p>5.2.2 Substantially increase the size of required front-of-pack warnings, prohibit misleading labelling, brand names and product characteristics, and ban products such as specially designed covers that would reduce efficacy of warnings.</p> <ul style="list-style-type: none"> <li>■ Research to identify the optimal size for health warnings in the context of plain packaging</li> <li>■ Identify health issues that need to be covered in new warnings</li> <li>■ Specify all changes required to CPI (tobacco) regulations</li> <li>■ Amend regulations</li> </ul>	<p>Department of Health and Ageing.</p> <p>Department of Health and Ageing.</p> <p>Australian Competition and Consumer Commission.</p> <p>Australian Government.</p>	<p>Year 1</p> <p>Year 1</p> <p>Year 2</p> <p>Year 3, Year 6 and every three years</p>	<p>Percentage of smokers able to recall each of the mandated warnings and able to demonstrate understanding of:</p> <p>Magnitude of risk</p> <p>Severity of illnesses and consequences for quality of life</p> <p>Tractability of conditions (curability, survival rates and times)</p> <p>Percentage of smokers endorsing false health information or inaccurate beliefs.</p>
<p>5.2.3 Automatically review and upgrade warnings on tobacco packages at least every three years, with the Chief Medical Officer to have the capacity to require amendments in between.</p>	<p>Australian Health Protection Committee (AHPC) or other appropriate group.</p>	<p>Year 3</p> <p>Amend Trade Practices Act to require such reviews and give the CMO this power.</p>	
<p>5.2.4 Link the process of regularly reviewing mandated consumer product information to a process that would provide more timely warning to Australian consumers of new and emerging health risks through mechanisms such as alerts in the media and notices at point of sale.</p>		<p>Year 1</p> <p>Develop proposal.</p> <p>Year 2</p> <p>Consider proposal and budget requirements.</p> <p>Year 3</p> <p>System operating.</p>	<p>Average time from release of meta-analyses, major studies or major reports to issuing of public statement.</p>
<p>5.3 <i>Ensure compliance with new regulations regarding reduced fire-risk cigarettes.</i></p>			
<p>5.3.1 Introduce reduced fire-risk cigarettes in the market.</p>	<p>Minister for Consumer Affairs.</p>	<p>From March to September 2010</p>	<p>Market-weighted percentage of cigarette brands sold that are compliant with the standard for reduced fire-risk.</p> <p>Number of fires known to be started by discarded cigarettes.</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
5.4 <i>Regulate tobacco design, contents, emissions and labelling.</i>			
5.4.1 Establish or nominate a body with the power to regulate the contents and performance of tobacco products and any alternative nicotine delivery devices that may come onto the market in Australia, and with responsibility for specifying the exact wording of any public disclosures about contents and performance.	Department of Health and Ageing, Australian Government.  Nominated body.	Year 2 Develop proposal. Year 3 Amend necessary legislation to establish body (or give powers to an existing body). Year 4 Commence.	Body established/nominated or not.
5.4.2 Specify the form and content of reporting required for all tobacco products, and the exact wording required for disclosures to consumers.		Year 3	Reporting procedures in place or not.
5.4.3 Consider prohibiting the use of filter ventilation in Australian cigarettes.	Nominated body.	Year 3	Market-weighted percentage of brands using filter ventilation. Market-weighted percentage of brands using targeted additives. Market-weighted averages for targeted emissions.
5.4.4 Consider banning all additives that enhance palatability or addictiveness.	Nominated body.	Year 3	
5.4.5 Specify any further modifications required, restrictions on additives or upper limits for emissions.	Nominated body.	Year 4 onwards	
5.5 <i>Investigate the feasibility of legal action by governments and others against tobacco companies to recover health and other costs.</i>			
5.5.1 Investigate the legal implications of continuing sales of tobacco products and principles that should guide future regulation.	Australian, state and territory governments.	Year 2	Investigations under way or not. If the industry is found to be liable for costs, whether action is in place to recover. Whether or not fines, fees or surcharges are in place to ensure that the costs of addressing harm caused by tobacco have been established.
5.5.2 Investigate possible mechanisms for recovery of costs.			

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<b>Key action area 6: Ensure all smokers in contact with health services are encouraged and supported to quit, with particular efforts to reach pregnant women and those with chronic health problems</b>			
6.1 <i>Ensure all state- or territory-funded healthcare services (General, maternity and psychiatric) are smoke-free, protecting staff, patients and visitors from exposure to second-hand smoke both indoors and on facility grounds.</i>	State and territory ministers and governments.	Depending on current status in jurisdictions. Years 1–2	Absence or presence of state-wide policies.
6.2 <i>Ensure all patients are routinely asked about their smoking status and supported to quit, both while being treated and post-discharge.</i>			
6.2.1 Include requirement in hospital accreditation procedures.	Hospital associations and accrediting organisations.	Year 1 Develop guidelines. Year 2 Implement.	Included or not.
6.2.2 Include a requirement in service funding agreements and performance contracts with senior staff.	State and territory Health Departments.	Year 1 onwards	Percentage of institutions in each jurisdiction that are subject to funding agreements. Percentage of staff for whom action on tobacco is included in performance contracts.
6.2.3 Provide training in institutional or health-service procedures for assessment and referral.	State and territory governments.	Year 2 onwards	Percentage of institutions in each jurisdiction that have established systems and percentage of staff that have undergone training.
6.2.4 Provide training in smoking cessation counselling in pre-service training and continuing professional education for all health workers.	Australian Government. Lead training provider institutions and professional associations in medical, nursing and allied health fields.	Year 2 onwards	Number of health professionals that have undergone training.
6.3 <i>Improve the quality and use of pharmacotherapies and services demonstrated to assist with smoking cessation.</i>	National Prescribers Service, pharmaceutical companies, health professionals, pharmacists and Quitline counsellors.	Year 1 onwards	Percentage of people using pharmacotherapies who receive behavioural information, support or counselling.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
6.4 <i>Increase availability of Quitline service.</i>			
6.4.1 Ensure that Quitlines are resourced to respond to projected demand from media campaigns.	Department of Health and Ageing.	Year 1 Assess the likely increase in demand, additional resources required and optimal arrangements for service provision. Year 2 onwards Upgraded service operating nationwide.	Missed call rates in each state and territories.
6.4.2 Fund the development and delivery of interactive smoking cessation services using approaches such as internet, mobile phone and web-enabled mobile devices.	NPA. Nominated agencies.	Year 2 Preparatory work. Year 3 Web 2.0 Quitline services operating nationwide.	Whether programs are in place.
6.4.3 Establish special Quitline counselling services for pregnant women, including call-back services and feedback to treating obstetricians/GPs/midwives.	NPA. Nominated agencies.	Years 2 and 3 From end of Year 3 Expectant and New Parent Quitline operating nationwide and promoted to all major obstetric care providers.	Number of callers using Expectant and New Parent Quitline, caller satisfaction levels, quit attempts and quit rates in evaluation samples.
6.4.4 Establish a group of counsellors within one or more Quitlines who would deal specifically with people needing to use interpreter services.	NPA. Nominated agencies.	Year 2 Preparatory work. Year 3 Quitline via interpreter operating nationwide and promoted through national non-English language media.	Number of callers using Non-English Quitline, caller satisfaction levels, quit attempts and quit rates in evaluation samples.
6.4.5 Establish a group of counsellors within one or more Quitlines who would deal specifically with people receiving specialist treatment for chronic health conditions (asthma, diabetes, arthritis, CVD etc), mental illness, providing call-back services and feedback to treating health professionals.	NPA. Nominated agencies.	Year 2 Preparatory work. Year 3 Chronic Care, Quitline operating nationally and promoted with all major relevant providers.	Number of callers using Chronic Care Quitline, caller satisfaction levels, quit attempts and quit rates in evaluation samples.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p>6.5 <i>Ensure that NRT is affordable for all those for whom it is clinically appropriate.</i></p> <p>6.5.1 Investigate options for provision including through the Quitline and through the PBS.</p>	<p>Department of Health and Ageing.</p> <p>To be determined.</p> <p>Australian Government.</p>	<p>Year 1 Develop proposal.</p> <p>Year 2 Submit proposal to the Pharmaceutical Benefits Advisory Committee or direct to the Australian Government.</p> <p>Year 3 Consider proposals and implement preferred arrangements.</p>	<p>Number of prescriptions and proportion of prescriptions that are concessional.</p>
<p>6.5.2 Ensure availability of NRT and Quitline services for patients and clients of all state and territory health services.</p>	<p>State and territory governments.</p>	<p>Year 1 onwards NRT available through pharmacies of all public hospitals.</p> <p>Year 2 Voucher scheme operating for clients of all other state-funded human services.</p>	<p>Percentage of public hospitals in each state and territory that routinely provide NRT.</p>
<p>6.6 <i>Explore whether financial incentives might be effective in helping people to quit or stay non-smokers.</i></p> <p>6.6.1 Consider exempting from Fringe Benefits Tax employers who cover the costs of cessation therapies or who provide financial incentives to quit.</p> <p>6.6.2 Trial incentive program for young Indigenous children to stay smoke-free, remain at school etc.</p> <p>6.6.3 Trial projects that use incentive payments to help people to retain their resolve to stay stopped after quitting.</p>	<p>Preventative Health Taskforce. Australian Government. Australian and state governments.</p>	<p>From Year 1 Exploratory research.</p> <p>Year 2 or 3 Implementation to follow if appropriate.</p>	<p>Whether or not pilot projects have been funded and evaluated.</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p><b>Key action area 7: Work in partnership with Indigenous groups to boost efforts to reduce smoking and exposure to passive smoking among Indigenous Australians</b></p> <p>7.1 <i>Establish multi-component community-based tobacco control projects that are locally developed and delivered.</i></p> <p>7.2 <i>Enhance social marketing campaigns for Indigenous smokers ensuring a 'twin track' approach of using existing effective mainstream campaigns complemented by Indigenous-specific campaign elements.</i></p>	<p>Project sites to be determined through a transparent process.</p> <p>Projects to be developed and led by local Indigenous communities. Organisation(s) with main responsibility for the projects depends on the location and nature of the projects, but may include local Indigenous health services, state/territory National Aboriginal Community Controlled Health Organisation (NACCHO) affiliates, or regionally based associations of Indigenous health services.</p> <p>Projects may involve partnerships with Indigenous organisations from other sectors.</p>	<p>Year 1 Project sites chosen. Years 1–4 Projects funded. Year 4 Evaluation.</p>	<p>Percentage of Indigenous people aware of project activities.</p> <p>Changes in knowledge and attitudes in targeted compared to non-targeted communities.</p> <p>Percentage of community events and meetings that are smoke-free.</p> <p>Changes in wholesale orders of tobacco products in targeted communities.</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p>7.2.1 Identify and run existing mainstream tobacco control campaigns that have demonstrated an effect in terms of awareness, impact and relevance to Indigenous people.</p> <p>7.2.2 Identify existing campaign material that could be adapted to include greater representation of Indigenous people and include relevant themes and calls to action.</p> <p>7.2.3 Develop new Indigenous-specific campaign material using radio and complemented by local print and/or outdoor campaigns.</p> <p>7.2.4 Link social marketing campaigns to community projects and activities of health workers.</p> <p>7.2.5 Enhance qualitative research efforts to examine the impact of campaigns and future campaign directions.</p>	<p>Australian, state and territory governments, NPA, NGOs and Quit campaigns, NACCHO and other Indigenous organisations.</p>	<p>Year 1</p> <p>Year 2 onwards</p>	<p>Percentage of Indigenous smokers surveyed who: Have seen advertising used in recent campaigns Can name themes covered in advertising (unprompted and prompted) Correctly identify health risks and other disadvantages of smoking See such disadvantages as salient and relevant to themselves Agree that advertising contributed to their decision to quit or assisted with staying stopped Took action in the weeks during or following campaigns</p>
<p>7.3 Provide training to Aboriginal and Torres Strait Islander health workers to improve skills in the provision of smoking cessation advice and in developing community-based tobacco control programs.</p>	<p>Strengthen delivery of tobacco control information within Aboriginal Health Workers (AHW) training and on-the-job – NACCHO state and territory affiliates, and RTOs providing AHW training.</p> <p>Delivery of brief intervention packages (e.g. Smokecheck, Quit) – state/territory government departments, NGOs (e.g. Quit Victoria).</p>	<p>Year 1 Revision of training packages.</p> <p>Year 1 and ongoing Delivery.</p> <p>Years 1 and 2 Roll out delivery of existing packages (with adaptation where necessary), and evaluation.</p> <p>Years 3 and 4 Revision of packages where necessary. Ongoing delivery and support to AHWs.</p>	<p>Project evaluation.</p>
<p>7.4 Improve training in the provision of smoking cessation advice of other health professionals working in Aboriginal and Torres Strait Islander health services.</p>	<p>Developing and delivering TC programs – (e.g. CEITC 'Talking Up Good Air' kit). Up-to-date information through existing training available to GPs and RNs (e.g. through Divisions of GPs).</p>	<p>Years 1 and 2 Intensively during and ongoing.</p> <p>Years 3 and 4 Less intensive delivery and support activities.</p> <p>Year 1 and ongoing</p>	<p>Project evaluation.</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p>7.5 Place specialist Tobacco Control Workers in Indigenous community health organisations to build capacity at the local health service level to develop and deliver tobacco control activities.</p>	<p>Specialist Tobacco Control Workers should ideally be placed within each Indigenous health service, or within a group of regionally associated Indigenous health services (to be determined with input from the Indigenous community-controlled health sector).</p> <p>State/territory-wide Tobacco Control Workers should also be based at NACCHO state/territory affiliates to support the service-level Tobacco Control Workers.</p>	<p>Year 1 Process to determine placement of these workers.</p> <p>Years 1–4 Workers to be placed.</p> <p>Year 4 Evaluation of impact.</p>	<p>Number of workers in position.</p>
<p>7.6 Provide incentives to encourage NGOs to employ Indigenous workers.</p>	<p>Australian and state and Territory governments to provide incentives to NGOs (e.g. Cancer Councils, Heart Foundation, Quit).</p>	<p>Year 1 and ongoing</p>	<p>Number of Indigenous workers employed in NGOs.</p>
<p><b>Key action area 8: Boost efforts to discourage smoking among people in other highly disadvantaged groups</b></p>			
<p>8.1 Boost efforts to discourage smoking in highly disadvantaged neighbourhoods.</p>			
<p>8.1.1 Target surveillance and enforcement of sales to minors legislation in disadvantaged areas.</p>	<p>State and territory governments and local councils.</p>	<p>Year 1 onwards</p>	<p>Percentage of staff time and funding for education and compliance monitoring spent in low SES areas.</p>
<p>8.1.2 Target promotion aimed at encouraging GPs and other health professionals to refer to Quitlines to practices located in disadvantaged areas.</p>	<p>NPA or appropriate body, divisions of general practice and other local health agencies.</p>	<p>Year 2 onwards</p>	<p>Response and referral rates of health professionals.</p> <p>Number of calls to Quitlines (hits on website) from people giving their address indicating low SES postcodes.</p>
<p>8.1.3 Place the majority of any poster/ outdoor or mobile advertising in highly disadvantaged neighbourhoods.</p>	<p>Quit campaigns.</p>	<p>Year 1 onwards</p>	
<p>8.2 Ensure access to information, treatment and services for those with common mental health problems.</p>			
<p>8.2.1 Intervene more vigorously to prevent smoking uptake in young people at risk of developing mental health problems.</p>	<p>NPA in consultation with mental health agencies, advocacy groups.</p> <p>Other relevant government and non-government organisations.</p>	<p>Year 2 Develop proposals.</p> <p>Year 3 Assess and implement.</p>	<p>Whether discussions have been held and whether initiatives have been commenced.</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
8.2.2 Educate GPs and other health professionals that people with common mental health problems can succeed in quitting and benefit from greater control of withdrawal symptoms.	NPA, National Prescribing Service, agencies involved in GP training.	Year 1 Develop proposals in consultation with mental health agencies and advocacy groups. Year 2 onwards: Assess and implement.	Responses in studies of health professionals.
8.2.3 Ensure that the most clinically suitable pharmacotherapy to aid smoking cessation is affordable for all those with mental health problems.	Department of Health and Ageing.	Year 1 Investigate options for provision including through the Quitline and PBS.	Whether or not any person suffering mental health problems is able to receive or purchase at an affordable price the therapy their psychiatrist believes to be most appropriate.
8.2.4 Train all staff working on Quitlines about common mental health problems and how to support people living with such problems to quit successfully.	Quitlines.	Year 1 Develop plans and programs. Year 2 onwards Run ongoing professional development.	Whether or not training has occurred (and percentage of staff trained) in each state and territory.
8.2.5 Include information on quitting and common mental health problems in Quitbooks, internet and other educational materials.	Quit campaigns.	Ongoing	Whether information is included or not.
<b>8.3 Support cessation among those using mental health services.</b>			
8.3.1 Educate mental health professionals about the importance of quitting and the importance of not discouraging quit attempts in clients.	NPA.	Ongoing	Responses in studies of health professionals.
8.3.2 Include in healthcare agreements requirements that child, adolescent and adult mental health services and drug treatment agencies: <ul style="list-style-type: none"> <li>■ Be smoke-free</li> <li>■ Routinely identify smokers</li> <li>■ Include smoking cessation advice and treatment of nicotine dependence in all patient treatment plans</li> <li>■ Offer support to patients at transition points</li> </ul>	State/territory governments.  Year 2	Requirement included or not.  Percentage of facilities in each jurisdiction subject to and in compliance with agreements.	

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
8.3.3 Support these processes by commissioning the production of national information packages for clinicians and facility managers.	Department of Health and Ageing.	Ongoing	
8.3.4 Run a rolling program to train all staff in such services over a three-year period.	State and territory governments.	Ongoing	Number and percentage of professional staff in each jurisdiction who have undertaken training.
<b>8.4</b> <i>Encourage cessation in those with mental health problems outside institutional settings.</i>			
8.4.1 Encourage GPs, maternal and child health nurses, other health professionals and services such as Kidsline, Mensline and the BeyondBlue information line to ask people about smoking status/extent of tobacco use and to refer smokers to Quitline.	Australian Government /state and territory governments	Year 1 Improve staff training. Year 2 Commence promotion.	Number of referrals from each service.
8.4.2 Fund Quit courses for people with mental illness in non-threatening community settings.	State and territory governments.	Year 1 Evaluate South Australian project. Year 2 onwards Adapt as appropriate in other states and territories.	Number of people attending such courses and quit rates in samples evaluated.
<b>8.5</b> <i>Ensure all state-funded human services agencies and correctional facilities (adult and juvenile) are smoke-free and provide appropriate cessation supports.</i>	State and territory governments.	Years 1 and 2 Planning. Year 3 All facilities completely smoke-free in all states and territories.	Percentage of facilities in each jurisdiction covered by and compliant with policies.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<b>Key action area 9: Assist parents and educators to discourage use of tobacco and protect young people from second-hand smoke</b>			
<p>9.1 Convey the message that parents can help – by quitting smoking; making homes smoke-free; choosing appropriate films, videos and games; and by making it clear that they do not want their children to smoke for the sake of their health.</p>	<p>Quit campaigns and prevention programs (<i>Smarter than Smoking</i> etc).</p> <p>Parents, carers, teachers.</p>	<p>Ongoing</p> <p>Ongoing</p>	<p>Track the percentage of parents of young people under 18 who:</p> <ul style="list-style-type: none"> <li>Ever smoke indoors</li> <li>Have tried to or succeeded in quitting</li> </ul> <p>Track the percentage of young people aged 12–15 and 16–17 years reporting:</p> <ul style="list-style-type: none"> <li>Being aware of the seductive depictions of smoking in films, television, video games etc</li> <li>That parents set clear rules about not smoking at home</li> <li>Know their parents would strongly disapprove of them smoking</li> </ul>
<p>9.2 Cover the medical, social, environmental and economic aspects of tobacco in the school curriculum.</p>	<p>Education systems.</p>	<p>Ongoing</p>	<p>Percentage of young people aged 12–15 and 16–17 years reporting:</p> <ul style="list-style-type: none"> <li>Remembering a lesson at school concerning smoking</li> </ul>
<p>9.3 Encourage schools to enforce smoke-free policies (grounds as well as buildings) for all members of the school community consistently, both indoors and in grounds.</p>	<p>Schools.</p>	<p>Ongoing</p>	<p>Percentage of young people aged 12–15 and 16–17 years reporting schools enforcing smoke-free policies.</p>
<p>9.4 Encourage universities and other institutions of higher education to adopt smoke-free policies, including outdoors on campus.</p>	<p>Universities and other institutions of higher education.</p>	<p>Ongoing</p>	<p>Percentage of administrators reporting enforcement of smoke-free policies in schools and institutions of higher education.</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<p>9.5 <i>Make smoking a 'classifiable element' in movies and video games.</i></p> <hr/> <p>9.5.1 Designate tobacco use as a 'classifiable element', to be taken into account by the Classification Board when rating films.</p> <hr/> <p>9.5.2 Produce guidance notes to the Board and to television licensees based on the literature on the impact of portrayals of smoking on young people.</p> <hr/> <p>9.5.3 Fund a project to raise awareness among people working in the Australian film, television and entertainment industries of the damaging effects of seductive portrayals of smoking in popular entertainment viewed by children.</p> <hr/> <p>9.5.4 Include training to decode depictions of smoking in movies in drug education in schools.</p>	<p>Australian Government.</p>	<p>Year 2</p>	<p>Exposure of Australian teenagers (concentrating on those aged 14–15 years) to portrayals of smoking in movies (both at the cinema and on DVD);</p> <p>Desk-top study of the percentage of films (PG, M and MA) screening in Hoyts and Village cinemas in Australia with positive portrayals of smoking</p> <p>Survey of which films the average 14–15-year-old sees each year</p>

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
<b>Key action area 10: Ensure that the public, media, politicians and other opinion leaders remain aware of the need for sustained and vigorous action to discourage tobacco use</b>			
10.1 <i>Ensure the public is constantly alerted to information about tobacco and its impact arising from new research findings.</i>	NPA, Cancer Councils, Heart Foundation, Diabetes Australia, medical, nursing, pharmacy and other health professional associations and other health-oriented NGOs.	Year 1 onwards	Track volume of media stories about: Health effects of smoking Need for tobacco control measures and percentage that is supportive. Track levels of public support for tobacco control measures.
10.2 <i>Ensure that politicians and other opinion leaders are aware of international developments in tobacco control; including guidelines developed to assist countries comply with international obligations under the FCTC, and research on the efficacy of TC interventions.</i>			
10.3 <i>Ensure greater awareness that selling tobacco products is incompatible with principles of corporate social responsibility.</i>			
10.3.1 <i>Seek to make the percentage of revenue generated from tobacco products an agreed component of CSR award programs (e.g. Australian Business Awards, Telstra Business Awards and Australasian Reporting Awards).</i>	Preventative Health Taskforce.  Prime Minister's Community Business Partnership.	Year 1  Year 3	Number and percentage of business awards programs where guidelines incorporate a requirement to report revenue generated from tobacco and where high levels of revenue preclude high CSR scores.
10.3.2 <i>Seek amendment of ASXCGC Best Practice Recommendations.</i>			
<b>Key action area 11: Measure progress against and towards targets</b>			
11.1 <i>Establish a National Tobacco Strategy Steering Committee.</i>	Australian Government	Year 1	Committee established
11.2 <i>Include a question on smoking among Australians aged 18 years and over in the Australian Census.</i>	Department of Health and Ageing, ABS.	Year 1 Submit question to ABS for consideration of inclusion in 2011 and subsequent census.	Question in 2011, 2016 and 2021 census.
11.3 <i>Establish a mechanism to collect reliable data on prevalence in 2011 in Queensland, Tasmania, the Australian Capital Territory and Northern Territory.</i>	Governments of Queensland, Tasmania, Australian Capital Territory and Northern Territory.	Year 1 onwards	Surveys established or questions included in existing surveys.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
11.4 <i>Include in future reports of ASSAD surveys the proportion (and number) of teenagers who have ever smoked more than 100 cigarettes.</i>	Centre for Behavioural Research in Cancer.	Year 1 Include in report of 2008 survey.	Section included in report.
11.5 <i>Report on trends in the proportion of smokers and recent smokers who have attempted to quit in the previous three and 12 months, and the proportion who intend to quit in the next three months.</i>	Department of Health and Ageing to request co-ordinators of Australian arm of International Tobacco Control study to provide triennial reports.	Year 1 onwards Year 2 onwards	Reports produced and available.
11.6 <i>Report on trends over time in prevalence of smoking and numbers of cigarettes smoked for persons in all various SES groups, both in reports on detailed findings of the National Drug Strategy Household Survey, and in reports of the Australian School Students' Smoking, Alcohol and Drug Survey.</i>	Department of Health and Ageing to request AIHW and Centre for Behavioural Research in Cancer.	Year 1 onwards Year 2 onwards	Inclusion of items in reports of 2010, 2013, 2016 and 2019 National Drug Strategy Household surveys.
11.7 <i>Increase sample sizes of the NATSHI Health and Social Surveys to provide reliable indications of changes over time in each state and in the Northern Territory. This should be done in preference to trying to include sufficient Indigenous people in annual state population surveys.</i>	Department of Health and Ageing to request ABS.	Year 1 onwards	Inclusions in future NATSHI Health and Social surveys.
11.8 <i>Use state population surveys to over-sample each year within two or three state health department regions with a high proportion of Indigenous residents, so that reliable estimates of prevalence of Indigenous smoking at a regional level become available on a three-yearly basis.</i>	State Departments of Health.	Year 1 onwards	
11.9 <i>Analyse percentage changes in the prevalence of Indigenous smoking compared with percentage changes in previous periods, and compared with absolute and percentage changes in the non-Indigenous population.</i>	Department of Health and Ageing to commission a suitable research group.	Year 1	Report commissioned, produced and available.

KEY ACTION AREAS	RESPONSIBILITY	STAGED IMPLEMENTATION	MEASUREMENT
11.10 <i>Extend the ASSAD survey to more remote areas of Australia and to Indigenous schools to ensure the inclusion of greater numbers of Indigenous children.</i>	Department of Health and Ageing and Centre for Behavioural Research in Cancer.	Year 1 onwards	Incorporated in 2011 and future surveys.
11.11 <i>Establish a panel of Indigenous people who are currently smokers to enable the monitoring of intentions and attempts to quit, amounts smoked and the prevalence of smoking indoors and around others. The panel could also be used to monitor the impact of tobacco control policies among Indigenous people.</i>	Department of Health and Ageing to commission a suitable research group.	Year 1 onwards	Panels established and regular surveys undertaken to provide data on the reach and efficacy of programs by monitoring, for instance, the use of NRT and other medications, perceptions of advice from healthcare providers, adoption of smoke-free homes and smoking around children.
11.12 <i>Report on trends over time, by SES, in the proportion of Australians aged 14 years and over exposed to second-hand smoke at work and indoors at home.</i>	Department of Health and Ageing to request research agency and AIHW.	Year 1 onwards	Inclusion of this data in reports on the 2010, 2013, 2016 and 2019 surveys.
11.13 <i>Report on long-term trends in the percentage of students (smokers and non-smokers) who have one or more parents who smoke, and who live in homes that are smoke-free.</i>	Department of Health and Ageing to request research agency and AIHW.	Year 1 onwards	Inclusion of this data in reports on the 2010, 2013, 2016 and 2019 surveys.
11.14 <i>Report for each state and territory, for women living in areas of varying levels of social disadvantage, and for Indigenous and non-Indigenous women, the proportion of pregnant women who report smoking at early and late stages of pregnancy.</i>	Perinatal Statistics Units.	Year 1 onwards	Inclusion of this data in regular reports.



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