

**Submission to Preventive Task Force, focussing on Tobacco Control
From Ron Borland PhD.**

NB. This is a personal submission from me, it does not represent the views of my employer.

These comments are provided from the perspective of someone who has researched most aspects of tobacco control over the last 20 years.

Overall, the Discussion Paper, at least in so far as it relates to tobacco control, is an important framework for moving forward. I have limited expertise in the other two areas, and have not provided detailed comments on them. That said, I do make some comments on the relationship between the science-base for intervening in the three areas.

The recommendations that are made, if implemented will produce improved outcomes, at least in the area of tobacco control, where my core expertise lies. However, I believe that more could be done at relatively little cost that could, in conjunction with what is recommended, collectively result in faster progress towards reducing tobacco-caused ill health. That said, the worst thing the government could do is to use my criticisms as an excuse for not moving forward on the reforms suggested, I merely urge the government to consider going further, or at the very least encouraging those working in the field to think more ambitiously and bring worked-up versions of additional strategies to the table.

The only major concern I have with the discussion paper is that it implicitly equates the recommendations for the three areas as equivalently evidence-based. This is far from so, the measures recommended for tobacco are much more strongly grounded in evidence. There is still a lot of debate around the causes of obesity apart from, the too general to effectively intervene on, over-nutrition. Alcohol is also more complex than the approach suggests. Some of the proposed solutions are, in my view, overly simplistic and unlikely to achieve their goal. Abuse of alcohol varies considerably across alcohol types and treating all forms of alcoholic beverage as equally risky is likely to result in well-meaning failures of policy instruments premised on this assumption. For example, there is a compelling argument, and some evidence (I have not attempted to systematically review the literature) that alcopops are a far greater risk to young people than products that taste of alcohol. Recent government initiatives targeting these insidious products are well grounded. They are a significant part of the problem, and are part of the social trivialisation of use of psychoactive substances. These products, if used need to be treated with respect, and that can only be done when the products are readily recognised for what they are, not designed to mask their inherent potency.

By contrast with the other two areas, tobacco control is easy in principle. It is notable that the blue-skies proposals in the other sections are missing in tobacco, where the focus is very much on extending the effectiveness of what we know works, rather than also seeking new strategies. Up until now tobacco control has received minimal funding and generally begrudging support from governments, so the tobacco control movement have learned to expect little, and to make only modest requests. That the government are signalling a preparedness to act more strongly is extremely welcome, and this openness deserves putting the strongest possible suite of actions on the table, even is the strongest of these are too big for this government.

The report notes 10 things Australia has the capacity to do. Number 2 eliminate promotion is only theoretically possible if for profit companies were to be removed from the marketing of tobacco products and the promotional aspects of product design were to be eliminated. Yes we can do it, but not with anything proposed in this document. No 5 ensuring no tobacco products are sold to children. There is no strategy presented to achieve this, and I can't think of any that might, short of taking control over sales. All of the rest government can and should do, and in one case, passive smoking, have largely achieved.

I would have liked to see some discussion of the basic principles that underpin the recommendations. Unfortunately, in places the strategies lose sight of the important principle of treating people as responsible beings who will generally try to act in their best interests and thus should be kept well informed, and unless there are good grounds to the contrary, encouraged to make their own choices and supported in doing so. That is they assume human inadequacy, in ways I do not think are always helpful.

The world community have come together to enact the WHO Framework Convention on Tobacco Control (FCTC), the world's first and currently only international law auspiced by WHO. We need to be guided by its aspirations, not its specific obligations, which Australia already essentially complies with. We should be doing all that is possible to address the problem. Currently, this is manifestly not the case, by failing to adequately confront the nature of the corporate tobacco industry, we are trying to address the problem with one arm tied behind our collective backs. For-profit corporations have

been a sacred cow of modern capitalists countries. We are currently in the middle of a financial crisis largely caused by their excesses. Tobacco harm is just another case of the collateral damage that corporations can cause when they operate outside socially valuable domains, or stretch those domains to their breaking points. The government needs to remember that the tobacco industry is a beast of its own creation, through its corporation laws, and while it might be difficult to conceive of other mechanisms for making tobacco available, the role of for profit corporations competing in the market place to sell tobacco products is a large part of the problem, and it would simplify the solution if it could be addressed. The world needs to create models of corporations that are designed to be socially responsible, not just profit maximizing. Now is perhaps the best opportunity governments are likely to have to enact fundamental change. They need to bring together experts in the areas where industry is unable to appropriately constrain its behaviour, representatives of responsible sectors of those industries (unfortunately there are no such tobacco companies) to work out possible solutions. Tobacco, being among the least complex of these so-called 'wicked' problems, it might provide a model situation for developing solutions that could then be adapted for more complex problems like the complex of issues associated with climate change.

Response to the specific 6 points of what is needed to achieve the 9% target.

First, I see no coherent plan to get down to 9% prevalence only vague hopes. Second, I think we should be attempting to do better, but admittedly that will involve recourse to strategies that are not considered in the Discussion Paper.

- Tax increases will help, but some consideration needs to be given on unintended possible adverse effects on the more immediate well-being of the very poor who are unable to quit. These include economic harms to them and possibly increased use of chop-chop. See response to questions for more detailed comment.
- The extent of suggested additional regulation of the tobacco industry fails to mention anything fundamental and is playing at the edges. My substantive comments on this issues are below.
- More and better education campaigns will make a significant contribution, but will need to be well evaluated as we don't know what their limits might be.
- The health care system could do more. The strategy could be strengthened by getting referral to cessation services for all prepared to accept it.
- Access will help disadvantaged people, but unless other things are done to address their disadvantage, they are unlikely to quit in great numbers, but might be more amenable to a substitution strategy.
- I think the idea of tackling social contagion is ill considered. As far as I can tell, it is based on some social linkages between quitters found in one study. I am far from convinced that the effects are anything of great significance, or that if they are, that external agencies could do much to influence them.

Questions

Tax increases

- Increasing the price of cigarettes. This is an obvious strategy. I think even at 67c per stick (\$20 for a pack of 30) cigarettes are still way too cheap. However, to increase the price much more is likely to create other problems, including: increased supply of illegal tobacco, increased real hardship among the poorest smokers who are too addicted to quit, and over-smoking cigarettes. Some of these adverse effects could be ameliorated by using some of the windfall resources from the tax increases to target programs to poorer smokers.
- If prices could be increased further, there might need to be consideration of substituting a minimum price for any purchase of tobacco products for the current rules on minimum pack size, as if cigarettes were \$1 a stick or more, then the outlay for purchasing a single pack might be an incentive to illegal sales.
- The proposal in the Tobacco Technical report to ban internet sales of tobacco would have the unanticipated (by the authors, I assume) consequence of effectively banning personal use of smokeless tobacco as this can only be purchased (from within the country) via mail order and that typically includes internet-based ordering these days. The complex issue of smokeless tobacco is discussed in more detail elsewhere. To maximize the effects on smoking, while minimizing illicit sales (smuggling, increases in chop-chop market), other less expensive and less harmful alternative nicotine delivery devices could be made more readily available.
- Australia should take a leadership role in attempts to stop smuggling. However, the world should accept that allowing tobacco products to be produced by for-profit companies creates a

considerable part of the problem. Stronger control on tobacco production would greatly limit the amount of tobacco available to become part of illicit trade.

Campaigns

- The \$40-50 million for anti-smoking advertising would be money extremely well spent (see work of Wakefield).
- They should also have a strong evaluation component integrated with the message development formative evaluation to maximise future generalizability from pre-testing to implementation. We need a better understanding of how much and what kinds of messages are needed and whether this varies as a function of whether the messages are designed to transmit new knowledge or to act as ongoing reminders.

Other actions:

Controlling tobacco promotion

- We should remove all remaining forms of promotion, which must involve removing the capacity of companies to sell tobacco to consumers for a profit. While that happens or can occur, there will be promotion, be it through product modifications or use of the sales people at point of sale or through buzz marketing techniques, or via public interest news and current affairs stories, or whatever.
- The problem of promotion arises from the kinds of organizations (for-profit corporations) that are currently allowed to dominate the tobacco business. The strategies proposed here are difficult to enforce without accidentally infringing free speech. It would be far preferable to remove the marketing (to consumers) of tobacco products from for-profit corporations (see Borland, 2003, 2006, Callard et al 2005). I personally find it bizarre that there is a proposal (alive in tobacco control and included in the Tobacco Technical Report) to constrain artistic freedom (ie ban depictions of smoking) in a context where governments continue to allow companies to profit from more effectively marketing tobacco products to consumers by being the cleverest at getting around the rules designed to stop tobacco promotion. I accept this might be “politically shrewd” but everybody should be clear, it is deeply irrational. If the marketing of tobacco was effectively controlled, a major motivator to ‘smuggle’ tobacco into entertainment media would be removed. That said, there will still be times that smoking is positively depicted, and gratuitously doing so should, as for other unhealthy and/a anti-social activities, be a criterion for classification.
- Plain packaging is a good idea. However, allowing companies to retain Brand names, which current proposals seem to allow, is deeply problematic (see Borland & Lal, 2004). The brand name is a potent element of marketing. If names are allowed only names that are not currently tobacco products should be allowed. Even here, the companies will do all they can to add value to the new names. The success of these initiatives can be assessed simply. If tobacco companies can still compete for market share, the strategies are at best a partial solution. If the companies pull out of the market, leaving it to government to supply nicotine to addicts, then we can be confident that it has effectively removed the capacity to promote specific brands of tobacco products. It would be far more straightforward to simply legislate to make tobacco ‘controlled substances’ and have government take over whatever marketing to consumers that society is prepared to allow.
- Banning the display of tobacco products at point of sale is sound policy as the current designs of tobacco packs are advertisements for the products they contain. However, if the proposal to increase the size of health warnings on packs is accepted, this need will be reduced. If tobacco is put out of sight, rules will be needed for how the sale of tobacco products can be promoted and what information if any (eg price) should be available and in what form or forms. These rules should mandate health warning of at least half the space of anything promoting or announcing tobacco sales, including signs like “Tobacconist”.

Limiting retail outlets

- Why wait till 2020 to limit outlets? Focus should be on outlets in stores where young people are a major part of the clientele (eg, convenience stores). The other major place to implement restrictions in the short term is in recreational venues.

Product Information For Consumers.

- Health warnings on packs. The proposals here are coherent and likely to increase the impact of health warnings. The proposal to have a proactive system for changing warnings is long overdue and will increase the impact of individual warnings by creating a system to add new knowledge, and will increase the relevance of the warnings and thus their capacity to increase users knowledge. The size increase is beyond anything implemented so far, but all the evidence suggests it will be more effective, assuming the content is well designed. That said, while we now have fairly convincing evidence that strong health warnings stimulate quit attempts, there is no strong evidence that they play any real role in maintenance of cessation, although many smokers report that seeing them on packs helps them resist relapse (Borland et al, in press). Research to date has not found by-country differences in quitting attributable to warnings, suggests their effect are small. The effects found are predictive correlations. Strong warning labels are a cheap and important strategy, but not a major driver of smoking prevalence.
- Ingredients disclosure. This proposal continues to perpetuate a conceptual flaw that nobody seems prepared to confront. Put bluntly, if governments are prepared to allow tobacco companies to market tobacco products that vary in taste, then companies will need to label them and those labels will become associated with the taste differences. Targeting terms is not the real answer.
- The main mechanism for the Lights fraud is filter venting. It corrupts the still official ISO testing regime. It was almost certainly constituted as a strategy for getting around the ISO standard when the industry discovered the low tar, low nicotine cigarettes are not attractive to consumers. Filter venting should be banned. This should be an early part of a comprehensive approach to product regulation (see next sub-section).

Product regulation.

- This is a complex area. In the first instance, as the Tobacco Regulation group of WHO correctly point out (ref), cigarettes are currently on average higher in toxins than they need to be. This is unconscionable. Governments have a moral responsibility to act. Their failure to do so puts their moral culpability for the tobacco epidemic on a par with that of the tobacco industry. Because tobacco companies are ultimately creations of governments, it is possible to argue that governments are even more culpable.
- That said, attempting to clear up smoked tobacco products is, at best, going to produce minor health gains because there are intrinsic limits on what can be achieved given the production of additional toxins in the combustion. If there are to be major gains, then it must involve getting smokers to stop smoking. While the evidence is clear that getting smokers off nicotine altogether will produce greater health gains than getting them onto alternative forms of nicotine, it is plausible (but not proven) that overall it will be easier and, for any given level of effort, more efficient to get smokers onto alternatives than to get them to quit altogether. There is no evidence to show that smokers who can quit will not continue to do so, although it is likely that some will prefer to switch. However, if recent estimates – even the pessimistic ones which suggest that clean smokeless has around 10% or less of the harm of cigarettes, it is hard to conceive of a plausible scenario where a switch strategy would not have net health benefits.
- However, smokeless tobacco or more consumer attractive forms of pure nicotine will not be a panacea either. Smokers will need to be encouraged to try these products and persevere for long enough for them to have the sorts of effects they get from cigarettes (albeit less intense). This brings with it risks of popularizing these products with non-nicotine users, a risk that will need to be managed. The most realistic concerns are around the threats of commercial promotion of smokeless products, and this leading to use by those who would not otherwise use nicotine products. Such potential problems would be minimised if distribution and marketing of such products was in the hands of not-for-profit organizations, because if these products are to rapidly replace cigarettes, there will need to be some active promotion of them to smokers if they are to switch. Even absent such a solution, the risks of smokeless tobacco are grossly overdrawn. Sweden, which has a long tradition of smokeless use, has one of the lowest smoking rates in the world and disease rates which parallel that, even though levels of tobacco use are far higher (especially among men). Men have moved to Snus based primarily on price, the health benefits of snus are still widely unknown by Swedes. In the context of people being aware that smokeless is much less harmful than smoked tobacco, use of smokeless as a

conduit to smoked tobacco use is unlikely. It does not happen much in Sweden, where movement away from smoked is far more common. Further, conjoint daily use of both smoked and smokeless is rare, although occasional use of the non-preferred form is common. There is little risk of creating a dual use problem as high use of both would cross acute toxicity levels and these are experienced as noxious well before they are life threatening.

- I strongly support the proposal for a regulatory agency. As you can see from my other comments, some thoughts will need to be given to its powers. In my opinion, unless the least harmful form of tobacco (smokeless) are reintroduced into the Australian market, the agency will have to try to regulate down the toxins in cigarettes. If much less toxic alternatives were available, its goal could be to phase out smoked tobacco and do so with as much control over the market as the government was prepared to give it (see comments elsewhere).
- The other main area of product regulation where action is urgently required is in prohibiting promotion through making the product more palatable or otherwise masking inherent signs of toxicity. It is completely immoral to take a product that is deadly and dress it up to appear less deadly than it actually is. I strongly suspect it is also illegal, but this has never been tested for tobacco products. However, tobacco companies have been allowed to dress up cigarettes in any engineering modification they can find without any regulatory constraints, short of laws against directly adding more poisons (if the products they add partly pyrolyze to produce more toxins, that is accepted). The industry claims that all the things they add are approved additives for foodstuffs, but this misses the point as most foodstuffs are not largely combusted and the smoke from the combustion ingested. This capacity of the industry to dress up their deadly products as benign must stop. For any product as dangerous as smoked tobacco, any engineering feature designed to improve palatability should be prohibited. This is likely to have a greater public health benefit than removing toxins as it is likely to lead to less uptake.
- Licensing of retailers is an important step to control the market while it is in the hands of the current tobacco companies. However, if tobacco was marketed by a socially responsible body, it would only supply to those it trusted and could act to ensure its retailers met its requirements (ie not to encourage use) rather than the current situation where retailers are one of the key remaining vehicles for promoting tobacco products. Manufacturers do need some form of licensing to ensure that all tobacco produced is distributed legally.

Cessation services

- Quitlines that provide extended services (callback counselling and similar resources should be considered a key primary health care resource. Similarly evidence based web-delivered interventions are extremely cost effective modes of service delivery and supporting them could actually conserve resources, if it led to them displacing more expensive (less cost-effective) modes of providing cessation services. This should mean that these services are funded under the same national mechanisms that supports other essential elements of health care delivery.
- Strategies need to be different for cognitive behavioural therapies/counselling and medications. We know that, at least for more dependent smokers, the two work in synergy. Subsidies of medications should generally be restricted to those prepared to concurrently accept other help (ie accept the support that should maximise their chances of quitting successfully), but exceptions may be needed to encourage high need groups who are resistant to seeking personalized advice. Certainly the very poor should be supported to use NRT regardless of other commitments.
- Evidence-based smoking cessation programs should be treated as part of the primary health care system and funded accordingly. Other health professionals should be provided with incentives (monetary and/or professional recognition) for referral of smokers to such services, which should provide feedback to the referring professional. There is now strong evidence that referral leads to more quitting than in-practice management, essentially because the smokers get more help (Borland et al, 2008).
- Research is now showing quite clearly that the things that influence quit attempts are quite different to those that determine success (ie inhibit relapse) (Borland et al, 1991; West et al, 2001; Hyland et al, 2006). Further, at least some of the policy interventions appear to have

most if not all of their effects by stimulating quit attempts, not in increasing the likelihood of success (Borland et al, in press for health warnings). Further, research we are still to publish will confirm, what appears to be the case from the work published so far, that strength of motivation to quit, while strongly predictive of making quit attempts, does not positively predict success, and under some circumstances, may actually be associated with lower maintenance of cessation. The implications of this is that there is likely to be a greater emphasis on finding ways to help dependent smokers get off cigarettes, and an acceptance, that for many the task is beyond any volitional force. If we accept that nicotine is that addictive, maintenance of highly dependent persons on clean nicotine will become something that will attract greater attention and is likely to have many advocating for it.

Preventing uptake

- Denormalizing smoking as an adult activity is the key to prevention in my opinion. Kids need to know why society is (or at least should be) against tobacco use and to understand the risks of becoming addicted. Most kids appear smart enough to get the message, even though they don't do as we say, they are much more motivated to do as we do, or to do what gets them social rewards. If they smoke, they risk becoming dependent, then they tend to act like all addicts, as agents to attempt to normalise use of their products within their social circles.

Second hand smoke,

- Forget it, apart from some public education to encourage parents to protect their kids, this issue is essentially done. The continued pursuit of miniscule issues is evidence that much of the tobacco control community have lost contact with their long-term goals in pursuit of small and ultimately meaningless victories.

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Fundamental reform

- Fundamental reform of the tobacco industry and serious product regulation is the missing arm of tobacco control. See below for some more thoughts on this. Unless this is taken seriously, the problem will meander on with modest progress and we may even get close to 9%, but with fundamental reform we could get below 2%, however, this might need to involve accepting smokeless tobacco (the cleanest forms), and some in the tobacco control community cannot even contemplate this. Some have labelled them the Quit or die fraternity. As I argue below, substitutes for smoking is not a panacea, but it is the only strategy that is missing that holds the promise of actually effectively getting rid of smoked tobacco as a mass use product.

Disadvantaged groups.

The denormalization of smoking that has progressed over the last 4 decades in mainstream society is not mirrored in some, largely highly disadvantaged, subgroups. Getting progress with these groups will require a range of strategies. In groups like the indigenous community where there is group identification, working with community influentials needs to be a core part of the strategy. Where subgroups are essentially unstructured, eg the mentally ill, other strategies are needed. The strategies suggested really only represent a tip of the iceberg on what needs to be done. Very different strategies will be required for different groups. The main thing will not be so much targeting anti-smoking messages to these groups (although that might be useful for ATSI), but adding supports to assist individuals in these groups and their communities to take effective actions.

- Indigenous Australians. I support all the strategies suggested, but believe there is an additional need to work with community leaders to ensure tobacco is treated as an activity that is not supported implicitly by community leaders and the community become committed to work towards reducing smoking.
- Pregnant women. Demonstrating the viability of the proposed use of Quitlines to manage the encouragement for quitting and support with saying quit for pregnant women and new mothers is important. All the indirect evidence is that it will work, but detail is needed as to how well and of any problematic areas.
- Non-english speaking people. If state Quitlines co-operated they may be able to provide counselling in a range of community languages without need to recourse to translators. In addition if programs like the QuitCoach were translated, they could provide more personalised assistance, at least for those literate in their language.

- The mentally ill. In addition to the suggestions, I recommend that a feasibility trial be undertaken for weaning smokers with mental illness on to long term maintenance NRT if they are unable to quit completely. Something similar could be tried with the homeless.
- Highly disadvantaged neighbourhoods. In addition, I suggest funding programs to ensure health workers in such communities are providing optimal smoking cessation advice and referral. Also in these communities, group cessation programs might be cost-effective and be easy enough to fill, and their viability should be assessed. We know they work, the problem is filling them in a timely way, and high prevalence communities, if focussed on, might provide a critical mass, and the social aspect of groups could provide a framework for community support to stay quit.
- In addition, consideration should be given to providing smoking cessation assistance through unemployment services and through social service agencies.

Supporting prevention

The idea of a National Agency is a good one. However, I suspect the agency would be more useful in the longer term if it had a charter more as a lifestyle enhancement agency, such that it is given a broader remit than just health to consider ways in which we as a society can encourage socially and personally advantageous choices and habits and discourage those that provide net threats to community well-being.

A risk of a Preventative Health focus is that it will be come to be dominated by preventative medications, and area that has a lot of money behind it and a highly inflated view of their potential benefits.

The idea of promoting new monitoring, surveillance and evaluation models is critical. I recommend the recent IARC Handbook on Methods for Evaluating Tobacco Control Policies as a model that could be readily generalised to other areas of health promotion.

Performance indicators

Australia should be looking towards the best possible monitoring and evaluation framework. I recommend that rolling cohorts and young people be established (or continued, the ITC cohort on which I am Australian Principal Investigator, could be institutionalised). Ideally, as in New Zealand (partnership between National Health Survey and ITC project) recruitment into the cohorts could be from participants in cross-sectional surveillance surveys, which should occur every three years at a minimum. The ASSAD survey would be a viable vehicle for recruiting cohorts of youth, and they could be subsequently followed up via the internet or by telephone.

Having cohorts linked to prevalence surveys would enable the characteristics of the cohort to be accurately weighted to the overall population and any differences in responding of participants identified. The use of cohorts enables an understanding of how the interventions that occur affect smokers and capacity to explore any differences by sub-groups. Further, linkage to the ITC survey would enable the situation in Australia to be empirically compared with other countries, strengthening the capacity to make strong inferences about the contribution of specific interventions to tobacco use. These cohorts can also be used as the universal controls for the evaluation of local community interventions where the local group can recruit a parallel cohort from their community.

As noted elsewhere, there is a strong need for more research on tobacco products, something that will be needed for any regulatory agency to be maximally effective.

There are a number of important basic data needs:

1. Assessment of cotinine levels in a representative population survey to better understand actual intakes of nicotine and related toxicants. Such a survey should be repeated regularly.
2. Calibration of national tobacco surveys to better understand the tobacco use – especially in the “non-household” population (eg, homeless, prisoners etc) and those other groups under-represented in surveillance surveys, where smoking rates are believed to be very high based on a range of limited sources.
3. The proposal to collect and report smoking status on pregnant women is a good idea, but it does not go far enough. Smoking status should be a mandatory record on all health care data sets and thus needs to be routinely kept/updated for all client of the health care system, and reported on by major diagnostic categories and by sociodemographics. This could be complemented by parallel surveys with data provided to the census to allow non-response to the surveys to be quantitatively studied.

In addition:

- Consideration should be given to following New Zealand and including a question on smoking status in the national census. If this were done it would provide an ideal opportunity to systematically calibrate the range of sample surveys on which we are dependent for most of our data needs in this area.
- There is a need to use the census or other data collections to enable sufficient calibration between surveys to integrate prevalence surveys of special populations into the overall estimates of smoking prevalence; eg pregnant women, ASTI, people with mental illnesses.

Minor issues with the Discussion Paper.

- The assertion that “Australia’s health care system plays a pivotal role in prevention” (page v111) is contestable. Perhaps it should, but I personally think its role should be auxiliary, and certainly don’t think its current performance is pivotal.
- I question the assertion on page 1x, that successful preventative actions “have required substantial long-term funding”. True some have, but some have not, the bulk of advances in tobacco control have been done with very limited resources. Tax increases to promote health actually make money!
- P21: the 40 out of 1000 is over the next ten years, and from a population around 80% of which are under 50 and thus at low risk for the next 10 years. This seriously underestimates lifetime risk.

In conclusion:

I urge consideration of a more fundamentally coherent approach to tobacco control, one that works towards changing the nature of the tobacco industry, or at least those elements of it that market to consumers. I believe that such an approach would be less costly to implement and result in greater reductions in tobacco-related harms than the current approach could hope to attain (even when augmented in the ways proposed).