THE TOBACCO INDUSTRY AND THE COSTS OF TOBACCO-RELATED ILLNESS

Report of the Senate Community Affairs References Committee

DECEMBER 1995

ISBN 0 642 23594 5

This document was produced from camera-ready copy prepared by the
Senate Community Affairs Committee Secretariat
and printed by the Senate Printing Unit,
Parliament House, Canberra

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Senator Patterson wishes to record that, for personal reasons she was absent from Parliamentary duties and, therefore, was unable to participate neither in the final consideration of the report nor the formulation of its recommendations. Senator Collins wishes to record that, being a recent appointee to the Committee, she was unable to participate in the initial phases of the inquiry. Senator Denman wishes to record that she was a full member of the Committee for most of the inquiry, but was unable to participate neither in the final consideration of the report nor the formulation of its recommendations.

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LIST OF ABBREVIATIONS AND ACRONYMS

ABS	Australian Bureau of Statistics
ACOSH	Australian Council on Smoking and Health
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ASH	Action on Smoking and Health
ATSI	Aboriginal and Torres Strait Islander
BAT	British American Tobacco Company
B&W	Brown and Williamson Tobacco Corporation
CVD	Cardiovascular disease
DHS&H	Department of Human Services and Health
ETS	Environmental tobacco smoke
FAS	Family Allowance Supplement
FDA	US Food and Drug Administration
NESB	Non-English speaking background
NHMRC	National Health and Medical Research Council
PBS	Pharmaceutical Benefits Scheme
PBAC	Pharmaceutical Benefits Advisory Committee

RECOMMENDATIONS

The Committee RECOMMENDS:

Chapter 1

1. That smoking not be permitted in enclosed places, including office, factory, shop or other work sites, shopping centres, restaurants, theatres, hotels and sporting venues.

2. That in respect of offices, shops, restaurants etc., outdoor or separately ventilated indoor spaces be made available for smokers, but that staff not be compelled to work in, or service, these areas.

3. That nicotine transdermal patches (nicotine patches) be listed in the Schedule of Pharmaceutical Benefits; but that they only be prescribed as part of a structured smoking cessation program.

Chapter 2

4. That the provisions of the *Tobacco Advertising Prohibition Act 1992* relating to incidental or accidental broadcast or publication of tobacco advertisements be strictly monitored and enforced by the Department of Human Services and Health.

5. That the *Tobacco Advertising Prohibition Act 1992* be amended to remove the provision for the exemption of publication of tobacco advertisements in association with specified sporting and cultural events of international significance and that this be phased in by the year 2000.

6. That the Commonwealth Government establish a national health promotion foundation or other appropriate national body to provide an alternative source of sponsorship funding to that provided by tobacco companies for major sporting and cultural events.

7. That the current testing procedures for cigarette yields be reviewed by an appropriate independent body to determine whether these procedures accurately reflect the actual levels of tar, nicotine and carbon monoxide inhaled by smokers; and that the printed material contained on cigarette packs on tar, nicotine and carbon monoxide yield levels reflects this information.

8. That, while the Committee favours the listing of nicotine in tobacco prepared and packed for smoking as a Schedule 7 poison by the National Drugs and Poisons Schedule Committee, it believes that further investigation of the implications of this proposal should be undertaken by the Council of Australian Governments and the Australian Health Ministers' Advisory Council.

9. That the National Health and Medical Research Council assess the health effects of tobacco product additives, including determining whether additives potentiate the effects of nicotine.

10. That a list of the ingredients added to tobacco products be provided annually to the Commonwealth Government, on a confidential basis, by those tobacco companies whose products are available for sale in Australia.

11. That a list of the ingredients in tobacco products, and their effects, be distributed (in an appropriate form) with all tobacco products sold in Australia.

12. That the National Health and Medical Research Council appoint a sub-committee to review the current weight-based excise system.

13. That the Commonwealth Government investigate the implications of withdrawing tobacco products from the list of duty-free goods.

Chapter 3

14. That national education programs be developed for primary and secondary school students and that these programs be regularly revised; and that these programs be based on the most recent research and evidence of the socio-economic, environmental, behavioural and personal factors identified as encouraging the take-up of tobacco use by young people, and the continuing use of tobacco by young people. The Committee further recommends that these programs include information on the dangers of passive smoking, particularly for young people.

15. That primary and secondary teachers, who will teach or are teaching health courses that include anti-smoking units, be funded by the Commonwealth Government as part of the National Drug Strategy to attend teacher education and in-service training sessions.

16. That school-based smoking prevention programs be encouraged and expanded; and that they be taught each year from at least Year 4 (about 9 years of age) to the end of secondary schooling.

17. That no smoking be permitted (including smoking by students, staff, parents and visitors) on any school premises; and that students who are found in breach of this be counselled, and supported through drug education and 'Quit' smoking programs.

18. That additional research be undertaken into the efficacy of generic packaging of tobacco products as a means of addressing the problem of juvenile smoking.

19. That comprehensive restrictions on the size, placement and format of point-of-sale advertising of tobacco products, similar to those applying in New South Wales, be applied in all States and Territories.

20. That the distribution of non tobacco-related products associated with the sale of tobacco products be prohibited.

21. That the Commonwealth, State and Territory Governments ensure that there are regular real increases in levels of excise duties and business franchise fees levied on tobacco products; and that the revenue from these taxation increases be directed to tobacco control and health promotion activities.

22. That tobacco products be removed from the basket of goods used in the calculation of the Consumer Price Index.

23. That the minimum age for the purchase of tobacco products be 18 years in all States and Territories; and that the States and Territories investigate the feasibility of making it an offence for persons under the age of 18 years to purchase tobacco products.

24. That an appropriate form of proof-of-age identification be automatically required for young people purchasing cigarettes.

25. That there be a reduction in the number of retail outlets permitted to sell tobacco products and that:

    - as an interim measure, tobacco products be isolated from other products for sale in all outlets currently selling tobacco products; and

    - in the longer term, those retail outlets permitted to sell tobacco products be restricted to licensed premises and to tobacconists; and that this be phased in to minimise any disruption to small business.

26. That the licensing systems in all States and Territories provide for the suspension or revocation of a licence where retail outlets sell tobacco products to minors.

27. That State and Territory Governments, in co-operation with the appropriate retail trade associations, expand their education programs directed at retailers.

28. That, as it is virtually impossible to prevent access by children to cigarette vending machines, these types of vending machines be prohibited in all States and Territories.

29. That State, Territory and Local Governments increase the level of funding and personnel devoted to the enforcement of laws restricting the supply of tobacco products to minors; and that increased resources be devoted to the prosecution of retailers that contravene such laws.

30. That State and Territory Governments institute routine systems of random compliance checks to monitor the sale of tobacco products to minors.

31. That the Commonwealth Government encourage the States and Territories to improve the effectiveness of their enforcement and monitoring programs; and that:

    - as part of their monitoring system the States and Territories provide statistics annually to the Commonwealth on the number of complaints and prosecutions against retailers selling cigarettes to minors; and

    - the States and Territories run a publicity campaign that informs the public of the appropriate bodies to which they can direct complaints regarding the sale of tobacco products to minors.

32. That a system of substantial fines be introduced in all States and Territories to discourage the sale of tobacco products to minors.

Chapter 4

33. That strategies continue to be developed to address the special needs of 'at risk' groups in the community, such as lower socio-economic groups, to reduce the incidence of smoking in those groups.

34. That funding continue to be allocated by the Commonwealth Government for the development of appropriate programs and strategies to address the problem of tobacco use for 'at risk' groups in the community.

35. That strategies, sensitive to Aboriginal and Torres Strait Islander cultural values, be implemented to address the problem of tobacco use in Aboriginal and Islander communities, and that these strategies include:

    - close liaison with Aboriginal and Torres Strait Islander community-based health organisations, especially the Aboriginal Health Services; and

    - the dissemination of culturally appropriate information on tobacco use throughout Aboriginal and Torres Strait Islander communities.

36. That further research be conducted to examine the problem of tobacco use by Aboriginal people in urban areas.

37. That funding be provided by the Commonwealth Government for culturally appropriate programs and strategies to address the problem of tobacco use in Aboriginal and Torres Strait Islander communities, as part of a broader health strategy.

38. That strategies, sensitive to the cultural backgrounds and values of people from non-English speaking backgrounds, be implemented to address the problem of tobacco use in these communities.

39. That funding be provided by the Commonwealth Government for programs to address the problem of tobacco use amongst people from non-English speaking backgrounds, including older people.

INTRODUCTION

Terms of Reference

The matter was referred to the Committee on 8 June 1994 for inquiry and report.

The terms of reference are to inquire into:

The tobacco industry and the costs of tobacco-related illness, with particular reference to:

(a) a review of the current level of regulation of the manufacture, advertising, promotion and sale of tobacco products; and

(b) an exploration of the costs of tobacco-related illness to the Australian community and a review of existing mechanisms for recouping those costs.

The reference was advertised in the national press on 24 September 1994.

The closing date for submissions was originally 11 November 1994; however, given the high level of interest expressed, this deadline was extended. Seventy-one submissions and a large amount of supporting evidence were received. A list of submissions is at Appendix 1.

The Committee held five public hearings, taking evidence from a range of organisations and individuals, including the Commonwealth Department of Human Services and Health, several State and Territory Departments of Health, medical specialists, a range of health groups and representatives of the tobacco industry. A list of hearings is at Appendix 2. A list of witnesses who gave evidence at these public hearings is at Appendix 3.

The inquiry coincided with the publication of major reports on the tobacco industry, and this fact structured the Committee's terms of reference. In June 1994 the Industry Commission issued a comprehensive report on the tobacco growing and manufacturing industries. The report reviewed factors affecting the current and future performance of the industries and their relationship to the efficiency of the economy in general, including trends in local and global markets, the structure and competitiveness of the industry and issues relating to the efficiency of the industries.[1] In September 1994, the Prices Surveillance Authority presented a report on cigarette pricing in Australia.[2] The Committee decided not to examine these issues relating to the tobacco industry.

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1 Industry Commission, *The Tobacco Growing and Manufacturing Industries*, AGPS, Canberra, 1994, p.1.

2 Prices Surveillance Authority, *Inquiry into the Cigarettes Declaration*, Report No. 52, September 1994.

A substantial amount of published information is available on tobacco, its health effects, the history of its use, smoking prevalence, and the operation of the industry. Consequently, the Committee agreed that, while it would address all the terms of reference, it would concentrate on a number of issues of particular concern, namely:

- the health effects of tobacco use and the costs to the community of tobacco-related illness;
- the problem of adolescent smoking, and measures to prevent it, including education, information and access strategies which would limit the uptake of smoking by adolescents;
- advertising and promotion of tobacco products; the regulation of tar and nicotine levels; taxation arrangements; and
- tobacco use amongst specific groups, for example Aboriginal and Torres Strait Islanders, people from non-English speaking backgrounds, and certain socio-economic and occupational groups.

Acknowledgments

The Committee expresses its appreciation to those who made written submissions to the inquiry and who co-operated with the Committee by giving public evidence.

CHAPTER 1

TOBACCO USE – HEALTH EFFECTS AND COST TO THE COMMUNITY

1.1 This chapter discusses the health effects of tobacco use, including the health consequences of both active and passive smoking. The chapter also reviews a number of studies that have attempted to quantify the costs of tobacco-related illness in Australia. Finally, the chapter looks at the various ways the costs of tobacco-related illnesses may be recouped.

Introduction

1.2 Smoking has been identified as the largest single preventable agent of illness and death in developed countries.[1] One study has estimated that smoking already kills 2 million people a year in developed countries, half in middle age and half in old age; this number will increase to 3 million annually by the year 2025.[2] Over the next 30 years the annual number of deaths from tobacco use worldwide will increase from three million in 1995 to more than 10 million.

1.3 In Australia the human cost of tobacco use is also substantial. In 1992, there were an estimated 18 920 deaths from tobacco-related disease. This figure represented 15.3 per cent of all deaths from all causes in all age groups, and 22 per cent of deaths among 35-69 year olds.[3] As the table below indicates, there were an estimated 7 265 deaths due to tobacco-related cardiovascular disease, 6 644 deaths due to smoking- induced cancers and 4 437 deaths from tobacco-related chronic obstructive pulmonary disease. Cigarette smoking is the leading cause of drug-caused deaths and hospital morbidity in Australia.[4]

1.4 The magnitude of the numbers of tobacco-related deaths was starkly put in evidence to the Committee by the Australian Council on Smoking and Health (ACOSH) who stated in their submission that tobacco kills more people in Australia than the 'total number killed by alcohol, drugs, AIDS, murder, suicide, road crashes, rail crashes, air crashes, poisoning, drowning, fires, falls, lightning, electrocutions, snakes, spiders and sharks'.[5]

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1 Submission No.42, p.1 (National Heart Foundation).

2 R.Peto, 'Smoking and Death: the Past 40 Years and the Next 40', *British Medical Journal*, Vol.309, 8 October 1994, p.937.

3 Submission No.71, pp.i, 3 (AIHW).

4 Hospital morbidity refers to morbidity (illness) measured through hospital use.

5 Submission No.29, p.8 (ACOSH).

Table 1
Estimated deaths and hospital episodes for tobacco-related disease in 1992

Tobacco related disease	Estimated number of deaths	Proportion of: Tobacco related deaths (%)	Proportion of: Deaths from all causes (%)	Estimated number of hospital episodes	Proportion of: Tobacco related hospital episodes (%)	Proportion of: Hospital episodes for all causes (%)
Lung cancer	5 063	26.8	4.1	8 879	9.0	0.3
All tobacco related cancer	*6 644*	*35.1*	*5.4*	*16 843*	*17.1*	*0.6*
Coronary heart disease	4 528	23.9	3.7	24 339	24.7	0.8
All tobacco related cardiovascular disease	*7 265*	*38.4*	*5.9*	*44 569*	*45.3*	*1.5*
Chronic obstructive pulmonary disease	4 437	23.5	3.6	20 078	20.4	0.7
All other tobacco related disease	574	3.0	0.5	16 882	17.2	0.6
All tobacco-related disease	**18 920**	**100.0**	**15.3**	**98 372**	**100.0**	**3.4**
All disease	**123 651**			**2 913 538**		

Source: Submission No. 71, p.3 (AIHW).

Active Smoking

1.5 The adverse health effects of active smoking have been extensively documented by respected bodies such as the Royal College of Physicians, the United States Surgeon General and the International Agency for Research on Cancer.[6] Some 57 000 scientific articles have been published that have examined the link between cigarette smoking and disease. Smoking is now identified as a major cause of heart

6 See, for example, Royal College of Physicians, *Smoking and Health Now*, Pitman, London 1971; US Public Health Service, *Smoking and Health: Report of the Advisory Committee to the Surgeon General of the Public Health Service*, Rockville, MD, US Department of Health, Education and Welfare, 1964; US Department of Health, Education and Welfare, *Smoking and Health: A Report to the Surgeon General*, US Department of Health, Education and Welfare, 1979; US Department of Health and Human Services, *Reducing the Health Consequences of Smoking-25 Years of Progress: A Report of the Surgeon General*, Rockville, MD, US Department of Health and Human Services, 1989; International Agency for Research on Cancer, *Evaluation of the Carcinogenic Risk of Chemicals to Humans: Tobacco Smoking*, IARC Monograph Series No. 38, 1986.

disease, stroke, several different forms of cancer, and a wide variety of other health problems.[7] Evidence also indicates that tobacco companies in the United States and the United Kingdom have been aware of the health risks of tobacco use for more than 30 years, yet have publicly denied that such risks existed. [8]

1.6 A recent study, conducted for the Commonwealth Department of Human Services and Health (DHS&H), undertook an extensive review of studies examining the health effects of active cigarette smoking. The study identified 19 medical conditions where there is sufficient evidence of a causal relationship with active cigarette smoking. These conditions include various forms of cancer (including lung, oropharyngeal, oesophageal, pancreatic, laryngeal and renal cancer), ischaemic heart disease, pulmonary circulatory diseases, heart failure, stroke, chronic obstructive pulmonary disease, tobacco abuse, respiratory carcinoma in situ, cardiac dysrhythmias, atherosclerosis, peptic ulcer, low birthweight, and fire injuries.[9]

1.7 Recent research has shown that about half of all regular cigarette smokers will eventually die as a result of smoking. The evidence, based on a 40-year study of British male doctors, found that the risks of smoking had been seriously underestimated. Data from the first 20 years of the study into British doctors (1951-71) indicated that the death rate in middle age (defined as ages 35-69) from all causes was twice as great in smokers as in non-smokers. However, during the second half of the 40-year follow-up (1971-91), the death rate from all causes in middle age smokers was three times that of non-smokers.[10]

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7 US Department of Health and Human Services, *Reducing the Health Consequences of Smoking: 25 Years of Progress : A Report of the Surgeon General*, Rockville, MD, 1989.

8 For instance, internal documents from the Brown and Williamson Tobacco Corporation (B&W) and its parent company, BAT Industries (formerly British American Tobacco Company) of the United Kingdom indicate that in the 1960s, results from tobacco industry laboratories supported the conclusions of the scientific community that determined that smoking was causally related to lung cancer and probably related to heart disease. In the 1970s, B&W and BAT undertook a large research campaign to identify and remove toxic compounds identified in tobacco smoke. However, their research indicated that because of the large number of such compounds in tobacco smoke that it would be difficult to remove them all. Publicly, the industry continued to deny that smoking had been proven harmful to health. See S. Glantz *et al.,* 'Looking Through a Keyhole at the Tobacco Industry: The Brown and Williamson Documents', *Journal of the American Medical Association*, Vol.27(3), 19 July 1995, p.221.

9 D. R. English *et al*., *The Quantification of Drug Caused Morbidity and Mortality in Australia 1995*, AGPS, Canberra, 1995, pp.476-77.

10 R. Doll *et al.,* 'Mortality in Relation to Smoking: 40 Years' Observations on Male British Doctors', *British Medical Journal*, Vol. 309, 8 October 1994.

Tobacco use and cardiovascular disease

1.8 Cigarette smoking is one of the major modifiable risk factors for cardiovascular disease (CVD). Cardiovascular disease is an umbrella term describing a variety of disease processes related to the functioning of the heart and the circulatory system. The Australian Institute of Health and Welfare (AIHW) stated that there is evidence that smoking influences some of the mechanisms responsible for coronary heart disease, peripheral vascular disease and stroke. Experimental data have implicated nicotine and carbon monoxide, which are products of cigarette smoking, as having a role in some of the processes leading to coronary heart disease.[11] A recent Australian study examined the effect of smoking on the incidence of coronary heart disease in the population aged 35-69 years. The study found that male smokers were 2.9 times more likely than non-smoking males of the same age to suffer a first coronary event. The corresponding risk for female smokers was 3.5 times that of non-smoking females. The risk of sudden cardiac death is also two to four times greater for smokers than for non-smokers.[12]

1.9 Studies have demonstrated a clear relationship between smoking and coronary heart disease with up to a five-fold increase in the risk of fatal coronary heart disease among heavy smokers. The risk of coronary heart disease is greatly increased when cigarette smoking is combined with other risk factors, particularly hypertension, family history and high blood cholesterol.

1.10 There is also strong evidence of risk of stroke among smokers. One study indicated that the overall risk of stroke for smokers was 1.5 times that of non-smokers. In addition, the risk for smokers increased with the number of cigarettes smoked per day. Smoking is considered the most important preventable risk factor for atherosclerotic peripheral vascular disease in males and females.[13]

Tobacco use and cancer

1.11 As noted previously, tobacco use has been linked with several forms of cancers. The International Agency for Research on Cancer working group on tobacco smoking has stated that 'there is sufficient evidence that tobacco smoke is carcinogenic to humans'.[14] This increased risk is due to the range of carcinogenic chemicals released on combustion of the tobacco. The working group indicated that cancer of the respiratory tract, upper digestive tract, bladder, renal pelvis and pancreas are causally related to smoking.[15] Table 1 indicates that lung cancer was

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11 Submission No.71, pp.1-2 (AIHW).

12 Cited in *ibid.,* p.2.

13 Herosclerotic peripheral vascular disease occurs when blockages within the blood vessels prevent proper blood circulation. See *ibid.,* p.2.

14 Cited in *ibid.,* p.3.

15 *ibid.*

responsible for 27 per cent of tobacco-related deaths in Australia in 1992, while all tobacco-related cancers were responsible for 35 per cent of tobacco-related deaths in that year.

1.12 A recent study has assessed the risk of cancer for smokers and non-smokers based on Australian and overseas studies. The study found that the risk of cancers for smokers was between 1.6 and 13 times that of non-smokers, depending on the type of cancer. In the case of lung cancer, smokers had a 13 times greater risk of developing the disease than non-smokers. (see Table 2).[16] It was estimated that in 1992 there were 6 644 deaths and 16 843 hospital episodes due to these smoking induced cancers (see Table 1).

Table 2
The excess risk of smokers over non-smokers for selected cancers

Cancer site	Excess risk of smokers
Oropharynx	4.01
Stomach	1.41
Anus	3.18
Pancreas	1.86
Larynx	4.55
Oesophagus	7.48
Lung	13.0
Cervix	1.75
Vulva	3.42
Penis	1.80
Bladder	2.72
Renal parenchymal	1.64
Renal pelvis	3.96

Source: Submission No.71, p.4 (AIHW).

Conclusion

1.13 The Committee considers that on the basis of the scientific and medical studies undertaken both in Australia and overseas active smoking poses a number of health risks. The Committee believes that the link between smoking and a number of diseases and conditions, particularly cardiovascular disease, a number of cancers and lung disease, have been well documented and recognised by numerous health and medical organisations throughout the world.

16 *ibid.,* p.4.

Addictive nature of nicotine

1.14 The Committee received a range of different views on the issue of smoking and addiction and the extent to which nicotine is an addictive drug. The Tobacco Institute of Australia, representing the tobacco industry's view, described addiction as exhibiting four characteristics: intoxication, physical dependence, tolerance and one's life being dominated by the substance in question. The Institute argued that these four factors 'are the traditional criteria for 'addiction', and states that many doctors and lay persons' would agree.[17] The Institute argued that 'none of these criteria are satisfied by cigarette smoking',[18] and the tobacco industry argues that cigarette smoking is more properly characterised as a 'habit', which some people may have difficulty in giving up.[19]

1.15 In elaborating on their reasons for adopting the view that tobacco is not addictive the Institute stated that:

> Smokers do not get 'intoxicated'. Smokers are able to carry out difficult tasks while smoking. Alleged physical dependence is not demonstrated by medically significant withdrawal symptoms as with the truly addictive drugs. Reported withdrawal symptoms or irritability, for example, are similar to the type of psychological symptoms that people may experience when they stop doing any enjoyable activity... With truly addictive drugs, such as heroin and cocaine, we believe that addicts increase their level of drug uptake throughout their drug taking lives. This rarely happens with smokers who typically remain at constant levels throughout their smoking life. Therefore, we believe that there is no 'tolerance' in the scientific sense. Smokers' lives are not dominated by the need to smoke. This is evidenced by the fact that many people in Australia have given up smoking.[20]

1.16 Other evidence strongly suggests, however, that cigarettes and other tobacco products are addictive. A report by the US Surgeon General on nicotine addiction concluded that cigarettes and other forms of tobacco are addicting; nicotine is the drug in tobacco that causes addiction; and the pharmacologic and behavioural processes that determine tobacco addiction are similar to those which determine addiction to drugs such as heroin and cocaine.[21]

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17 Submission No. 43, Appendix 2, p.6 (Tobacco Institute of Australia).

18 See Submission No.43, p.19 (Tobacco Institute of Australia); and Appendix 2 of the submission, p.6. See also Submission No. 44, Appendix 6 (Philip Morris).

19 Submission No.43, Appendix 2, p. 8 (Tobacco Institute of Australia).

20 *ibid.,* Appendix 2, pp. 6-7.

21 US Department of Health and Human Services, *The Health Consequences of Smoking: Nicotine Addiction-A Report of the Surgeon General*, Rockville, MD, 1988, p. 15.

1.17 Nicotine has also been recognised as an addictive substance by such organisations as the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the Medical Research Council in the United Kingdom. [22] In evidence to the Committee, a representative of the National Heart Foundation stated that 'there is an overwhelming consensus in medical circles and scientific circles, outside the tobacco industry - of course - that cigarette smoking is addictive'.[23]

1.18 The Surgeon General's report concluded that tobacco meets the criteria as a pharmacologically addicting substance based on the criteria for drug dependence developed by the World Health Organisation. The primary criteria for drug dependence are that highly controlled or compulsive patterns of drug-taking occur; that a psychoactive or mood-altering drug is ingested by use of the substance and is involved in the resulting patterns of behaviour, and that the drug is capable of functioning as a reinforcer that can directly strengthen behaviour leading to further drug ingestion.[24] Additional criteria for drug abuse include stereotypic patterns of use, use despite harmful effects, relapse following abstinence and recurrent drug cravings. Dependence-producing drugs also often produce tolerance (ie. diminished responsiveness to the effects of the drug), physical dependence and pleasant (euphoriant) effects.[25]

1.19 The primary criteria cited above are sufficient to define drug dependence. Highly controlled or compulsive use indicates that drug-seeking and drug-taking behaviour is driven by strong, often irresistible, urges.[26] It can persist despite a desire to quit or even repeated attempts to quit. Such behaviour is also referred to as 'habitual' behaviour. Drug dependence is also defined by the 'occurrence of drug motivated behaviour; therefore, the psychoactive chemical must be capable of functioning as a reinforcer that can directly strengthen behaviour leading to further drug ingestion'.[27]

1.20 The Surgeon General's report found that, based on a number of studies of nicotine, 'the convergence of findings from several distinct approaches provides

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22 *Transcript of Evidence*, p.711 (NSW Department of Health).

23 *Transcript of Evidence*, p.143 (National Heart Foundation).

24 US Department of Health and Human Services, *op. cit.,* pp.149, 215.

25 *ibid.,* p.7.

26 Highly controlled drug use refers to drug-taking behaviour driven by strong urges. Experimental research and basic observations indicate that smoking is not a random or capricious behaviour that simply occurs at the will or pleasure of those who smoke. Rather, smoking is the result of behavioural and pharmacologic factors that lead to highly controlled or compulsive use of cigarettes. The highly consistent patterns of cigarette smoking illustrate the controlled nature of the behaviour. For example, following initiation of smoking the individual gradually increases cigarette intake over time until he or she achieves a level that remains stable during the smoker's lifetime. See *ibid.,* p.149.

27 *ibid.,* p.8.

compelling evidence that nicotine is a drug that can effectively control behaviour, including behaviour leading to its own ingestion (i.e. dependence or addiction)'.[28]

1.21 With regard to the addictive nature of nicotine, the Surgeon General's report stated that nicotine is psychoactive (mood altering) and can serve as a reinforcer to motivate tobacco-seeking and tobacco-using behaviour. Tolerance develops to actions of nicotine, such that repeated use can be accompanied by increased intake. Nicotine also causes physical dependence characterised by a withdrawal syndrome that usually accompanies nicotine abstinence.[29] Nicotine acts on neurons in the brain's reward system to reinforce dependence. One study explained that 'drugs of abuse such as nicotine, cocaine, and amphetamines target this reward system. By binding to nicotinic receptors, they commandeer neural pathways to prompt the release of dopamine, a neurotransmitter implicated in reinforced behaviour'.[30]

1.22 The controversy over the nature of 'addiction' as reflected in the contrasting views of the medical/scientific community on the one hand and the tobacco industry on the other, reflect to some extent differing interpretations of what constitutes 'addiction'. For example, while the industry holds that intoxication is a core feature of addicting drugs, they tend to downplay the role of compulsion to use the substance (in this case, tobacco) - a role which is emphasised in the medical/scientific definition. In addition, while the industry characterises smoking as a 'habit' it has tended to ignore the fact that:

> The immediate satisfaction smokers report from smoking does largely depend on the sensory cues, the reason those cues are desirable is probably because they have been reinforced or rewarded by nicotine's actions in the brain.[31]

1.23 Recent evidence also suggests that tobacco companies in the US and the UK recognised nicotine's addictiveness more than 30 years ago. A study of numerous documents obtained from several tobacco companies on their internal research into nicotine concluded that the companies 'recognised that nicotine is pharmacologically active, that it is addictive, and that cigarettes are, in essence, nicotine delivery devices'.[32]

1.24 Evidence from the US also indicates that the industry is able to manipulate the level of nicotine to create and sustain smokers' addiction. Evidence suggests that the tobacco companies have achieved this through various means, such as adding

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28 *ibid.,* p.170.

29 *ibid.,* p.215. See also A. Christen and J. Christen, 'Why is Cigarette Smoking so Addicting?', *Health Values*, Vo1.8 (1), January/February 1994, pp.17-24.

30 L. Ember, 'The Nicotine Connection', *Chemical and Engineering News*, 28 November 1994, p.10.

31 *ibid.,* p. 11. See also Submission No. 44, Appendix 6, pp.7-8 (Philip Morris).

32 J. Slade *et al.,* 'Nicotine and Addiction: The Brown and Williamson Documents', *Journal of the American Medical Association*, Vol.27(3), July 19, 1995, p.225.

ammonia-based substances to cigarettes to enhance the delivery of nicotine, adding nicotine to 'low yield' cigarettes by the use of various technologies, and increasing the nicotine content to filters, wrappers and other parts of the cigarette.[33]

Conclusion

1.25 The Committee believes that, on the basis of the evidence received, nicotine is addictive. The Committee accepts the conclusions of the Surgeon General's report, discussed above, that found cigarettes and other forms of tobacco are addictive and that nicotine is the drug in tobacco that causes addiction.

Passive smoking

1.26 While the adverse health effects of active smoking have been well documented over several decades, the health effects of passive smoking have only been systematically investigated since the 1960s.[34] Inhalation of tobacco smoke other than by active smoking is referred to as passive or involuntary smoking; the smoke from this source is also called environmental tobacco smoke (ETS). There are two sources of such smoke – sidestream smoke passing directly into the air from the burning tobacco and the smoke exhaled by smokers. Sidestream smoke is the predominant component of environmental tobacco smoke. The concentration of chemicals in sidestream smoke differs significantly from that of mainstream smoke - for example, it has much higher concentrations of ammonia, benzene, carbon monoxide, nicotine and various highly carcinogenic chemicals.[35]

1.27 Evidence to the Committee suggested that there are serious health effects associated with passive smoking. ACOSH cited several studies that showed a link between passive smoking and respiratory diseases especially in infants and children.[36] The Thoracic Society stated that passive smoke exposure is associated with an increased frequency of asthmatic attacks in children and adults, an increased rate of respiratory infections in children and adults, an increased risk of lung cancer in adults and possible increased risk of death from coronary heart disease in adults.[37]

1.28 Several major studies have also documented the adverse health effects of passive smoking. In Australia, a National Health and Medical Research Council (NHMRC) review of the effects of passive smoking on health concluded that passive smoking had various adverse effects upon child health, adult respiratory health and

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33 D. Kessler, 'Statement on Nicotine-Containing Cigarettes', *Tobacco Control*, Vol. 3, 1994, pp.150-153; See also *Wall Street Journal*, 19 October 1995.

34 *Transcript of Evidence*, p.338 (ACOSH).

35 A. McMichael, 'Passive Smoking: A Review of Research and Public Health Policy', *Cancer Forum,* Vol.7, July 1987, p.49.

36 Submission No.29, pp. 18-19 (ACOSH).

37 Submission No.61, p.2 (Thoracic Society of Australia).

the risks of cancer and cardiovascular disease. The report concluded that there is mounting epidemiological evidence that passive smoking increases the risk of lung cancer, whereas the epidemiological evidence of an increased risk of cancers at sites other than the lung is less strong. In the light of this assessment, the NHMRC recommended that procedures, regulations or laws should be introduced to restrict or prohibit smoking within the workplace.[38]

1.29 In the United States, a report of the US Surgeon General into the health consequences of involuntary smoking concluded that passive smoking is a cause of lung cancer in non-smokers, although the association of passive smoking with cancers other than lung cancers and with cardiovascular disease was not clearly established. The report also found that the children of parents who smoked compared with the children of non-smoking parents had an increased frequency of respiratory infections, increased respiratory symptoms and slightly smaller rates of increase in lung function as the lung matures.[39]

1.30 A more recent study by the US Environmental Protection Agency found that, in children, exposure to passive smoking is causally associated with an increased risk of lower respiratory tract infections such as bronchitis and pneumonia and with additional episodes and increased severity of asthma. The report classified environmental tobacco smoke (ETS) as a Group A (known human) carcinogen. This classification is reserved for those compounds which have been shown to cause cancer in humans.[40] A recent United States study has shown that exposure to ETS during adult life increases the risk of lung cancer of non-smokers. Another study found that married female non-smokers have a 30 per cent greater risk of developing lung cancer than married women whose husbands do not smoke. The study also found that the increased risk for women of developing lung cancer who were exposed to ETS during adult life in the household was 24 per cent, in the workplace (39 per cent) and in social settings (50 per cent).[41]

1.31 Evidence suggests that tobacco companies in the United States and the United Kingdom had known since the mid 1970s of the health effects of passive smoking. Documents obtained through the US Congress indicate that the Brown and Williamson Tobacco Corporation (B&W) and its parent company BAT Industries (formerly British American Tobacco Company) had conducted internal research on ETS, some of which has supported the conclusion that ETS is harmful to health. The

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38 NHMRC, *Report of the Working Party on the Effects of Passive Smoking*, AGPS, Canberra, 1986.

39 US Surgeon General, *The Health Consequences of Involuntary Smoking*, US Department of Health and Human Services, Rockville, MD, 1986.

40 US Environmental Protection Agency, *Respiratory Health Effects of Passive Smoking*, Washington, DC, EPA, 1992.

41 E. Fontham *et al*., 'Environmental Tobacco Smoke and Lung Cancer in Nonsmoking Women', *Journal of the American Medical Association*, Vol.271, No.22, 8 June 1994, p.1752. The study surveyed over 600 women in five cities across the US. The increased risk associated with social settings may reflect a larger number of smokers and smoke exposures in these settings.

reports from BAT's annual research conferences show that BAT had found toxic substances in sidestream smoke. In addition, the reports indicate that sidestream smoke had been found biologically active, and therefore potentially carcinogenic, in BAT's laboratory tests.[42]

1.32 Other research has questioned the association between exposure to ETS and a range of health effects. A recent study commissioned by the Tobacco Institute of Australia concluded that the data did not support a causal relationship between exposure to ETS and lung cancer or heart disease in adults. In relation to the health effects on children, the study concluded that while exposure to ETS is associated with an increased risk of lower respiratory tract infections in infants, there is a weak association between exposure to ETS in infancy and the subsequent likelihood of developing asthma. The study also argued that exposure to ETS was associated with only a small increase in risk for upper respiratory tract infection in children.[43]

1.33 A representative of the AMA, commenting on the study, noted that the publication of the study had not 'changed our attitude' as to the serious health effects of passive smoking. The representative added 'It looks a bit more at the acute effects of passive smoking rather than long term effects. It is another contribution to our understanding of environmental tobacco smoke, but we still feel the majority of opinion is that it is not something that is healthy'.[44]

Conclusion

1.34 The Committee believes that, on the basis of the majority of available studies on passive smoking and health, passive smoking causes a number of adverse health effects for non-smokers, especially in the areas of child health, adult respiratory health and lung cancer.

Recommendations

The Committee RECOMMENDS:

1. That smoking not be permitted in enclosed places, including office, factory, shop or other work sites, shopping centres, restaurants, theatres, hotels and sporting venues.

2. That in respect of offices, shops, restaurants etc., outdoor or separately ventilated indoor spaces be made available for smokers, but that staff not be compelled to work in, or service, these areas.

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42 D. Barnes *et al.,* 'Environmental Tobacco Smoke: The Brown and Williamson Documents', *Journal of the American Medical Association*, Vol.274, No.3, 19 July 1995, p.252.

43 J. Lee *et al., Health Aspects of Environmental Tobacco Smoke*, November 1994, pp.viii-xi.

44 *Transcript of Evidence*, p.393 (AMA).

Listing of nicotine patches on the Pharmaceutical Benefits Scheme

1.35 The Committee received some evidence that nicotine transdermal patches (nicotine patches) should be listed on the Pharmaceutical Benefits Scheme (PBS).[45] Nicotine patches are a recent pharmaceutical development to assist smokers to quit smoking through nicotine replacement therapy. An adhesive patch is applied to the skin which releases a controlled delivery of nicotine into the bloodstream. The patches were approved for use as an aid to smoking cessation in Australia in 1993 and are available on prescription.[46]

1.36 The Pharmaceutical Benefits Advisory Committee (PBAC) in 1994 recommended that nicotine patches be listed under the PBS.[47] The Commonwealth Government, however, rejected the PBAC recommended listing on the PBS in October 1994 on the grounds that nicotine-patch therapy should be provided as part of a structured smoking-cessation program (which it considers is a State government responsibility); and the cost of the measure (the annual cost to the PBS was estimated to be $100 million).[48]

1.37 A number of studies have found that nicotine patches are an effective aid in smoking cessation, especially for motivated, nicotine-dependent smokers.[49] Research suggests that nicotine patches are most successful in cases where the smoker uses 15 cigarettes or more a day, has tried to quit smoking before, is prepared to quit again and where the motivation to quit is strong.[50]

1.38 Research studies that have assessed the success of nicotine patches in smoking cessation have found that the success rates vary, although most report some improvement in cessation rates especially in the short to medium term. One study found that rates of successful cessation at the end of nicotine patch treatment varied widely, from a high of 77 per cent at six weeks after cessation, to a low of 18 per cent at three weeks.[51] Another study assessed the effectiveness of 12-week treatment with a 24 hour nicotine patch treatment in helping heavy smokers to quit smoking; cessation was confirmed in 19 per cent of users.[52] ACOSH, citing several research

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45 Submission No. 18, p.1 (Marion Merrell Dow Australia Pty Ltd); Submission No. 12, p.1 (Dr C. Mendelsohn).

46 ACOSH, *Fact Sheet: Nicotine Patches*, 1993, p.1.

47 The PBAC recommendation was for the provision of a four-week supply of nicotine patches.

48 Submission No.18, Appendix 2 (Marion Merrell Dow).

49 M. A. Russell *et al.,* 'Targeting Heavy Smokers in General Practice', *British Medical Journal*, Vol. 306, 15 May 1993, p.1308; S. Gourlay, 'The Pros and Cons of Transdermal Nicotine Therapy', *Medical Journal of Australia*, Vol.160, 7 February 1994, p.152.

50 ACOSH, *Fact Sheet: Nicotine Patches*, p.1.

51 M. C. Fiore *et al.,* 'Tobacco Dependence and the Nicotine Patch', *Journal of the American Medical Association,* Vol. 266, 18 November 1992.

52 Imperial Cancer Research Fund General Practice Research Group, 'Effectiveness of a Nicotine Patch in Helping People Stop Smoking', *British Medical Journal*, Vol. 306, 15 May 1993, p.1304.

studies on nicotine patches, indicated that after six months abstinence success rates varied from 22 to 42 per cent; a twelve month follow-up study, however, recorded only a 17 per cent success rate.[53] ACOSH noted that the difference in success rates appears to be influenced by the degree and intensity of smoking cessation counselling that accompanies use of the patches.

1.39 Some evidence suggests that the cost to the Commonwealth of listing nicotine patches on the PBS may not be as high as originally estimated. As noted previously, the Commonwealth Government has estimated the annual cost of providing nicotine patches via the PBS at $100 million. Marion Merrell Dow has, however, estimated that the cost to the PBS would be $21.7 million annually.[54] Another submission also suggested that the Commonwealth's cost estimate may have been overstated, due to an overestimate in the predicted demand for nicotine patches should they be listed on the PBS.[55]

1.40 Evidence suggests that nicotine patch therapy may be more cost-effective than many other widely accepted medical practices, eg. treatment for hypertension or screening for cervical cancer. One submission noted that the expenditure associated with extending the life of one woman by one year through cervical cancer screening could extend the lives of nine women, each by one year, if applied to nicotine patch therapy.[56]

1.41 Proponents of the listing of nicotine patches argued that making nicotine patches available via the PBS would address equity and access concerns. Several submissions argued that many smokers, especially pensioners and people from low socio-economic groups, are dissuaded from using nicotine patches because of their cost.[57] One submission from a doctor noted that 'although patches cost about the same as the average day's cigarettes, many financially disadvantaged smokers such as pensioners report that they are unable to afford to outlay the cost of a week's patches at a time (the minimum supply). These smokers buy their cigarettes on a daily basis'.[58]

Recommendation

The Committee RECOMMENDS:

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53 ACOSH, *Fact Sheet: Nicotine Patches*, 1993, p.1.

54 This costing is based on an estimate of 300 000 patients using nicotine patches annually at a price of $72.25 for a 28 day supply of patches. See Submission No.18, p.4 (Marion Merrell Dow).

55 Submission No. 12, p.3 (Dr C. Mendelsohn).

56 Submission No. 18, p.4 (Marion Merrell Dow). See also Gourlay, *op. cit.,* p.157.

57 Submission No. 18, p.7 (Marion Merrell Dow); Submission No. 12, p.3 (Dr C. Mendelsohn).

58 Submission No. 12, p.3 (Dr C. Mendelsohn).

3. That nicotine transdermal patches (nicotine patches) be listed in the Schedule of Pharmaceutical Benefits; but that they only be prescribed as part of a structured smoking cessation program.

The costs of tobacco-related illness

1.42 A number of studies have attempted to quantify the costs and/or benefits of smoking in Australia. The Collins and Lapsley studies and the AIHW study referred to below assess the economic costs generated by tobacco use in Australia while the ACIL study looks at both the economic 'costs' and 'benefits' to the Australian community.

Table 3
Economic costs of tobacco use, 1988

Tangible costs	$m
Production loss	
morbidity	186.5
mortality	1095.4
Total production loss	1281.9
less	
Consumption benefit-mortality	2800.5
Net production loss	(1518.6)
Health care	
medical	114.3
hospital bed-days	317.3
nursing home bed-days	178.0
ambulance services	sna
Total health care	609.6
Consumption	1722.2
Accidents	sna
Law enforcement	-
Abuse campaigns and research	sna
Welfare	sna
Total tangible costs	813.2

Intangible costs	$m
Mortality	
Consumption of deceased	2800.5
Value of loss of life to deceased	3227.8
Suffering of others	snq
Morbidity	
Pain and suffering	
- of sick	snq
- of road accident victims	-
Suffering of others	snq
Total intangible costs	6028.3

TOTAL (tangible and intangible costs)	6841.5

sna indicates significant but not available
snq indicates significant but not quantifiable
- indicates zero or not significant

Source: D. Collins and H. Lapsley, *Estimating the Economic Costs of Drug Abuse in Australia*, AGPS, Canberra, 1991, pp.89-90.

The Collins and Lapsley studies

1.43 In a study commissioned by the then Commonwealth Department of Community Services and Health, Collins and Lapsley provided an estimate of the net cost of tobacco abuse in 1988. The study estimated that the cost associated with tobacco use was $6.84 billion in 1988.[59] This costing comprised tangible costs of $813.2 million, and intangible costs of $6028.5 million. The results are presented in Table 3.

1.44 Tangible costs included in the study, which are defined as costs whose reduction will yield resources which become available to the community for consumption or investment purposes, include costs associated with production losses and health care costs (which include medical, hospital and nursing home costs). Intangible costs are costs such as pain and suffering, which, while real, do not represent a call on the productive resources of the community. As Table 3 shows, the study did not provide estimates for intangible costs associated with pain and suffering. The report noted that while these costs are not easily quantifiable, they represent significant costs. The authors emphasised that these estimates are likely to underestimate the actual costs of tobacco abuse in Australia.

1.45 In a revised study, Collins and Lapsley estimated that the costs of tobacco use in 1992 were $9.2 billion.[60] Unlike the 1988 estimates, the revised figures include cost estimates for passive smoking (totalling $846 million).[61] The total revised costing, based on 1992 mortality and morbidity figures, comprised $692 million of tangible costs, including those associated with loss of workforce productivity, health care costs and resources used in addictive tobacco consumption; and $8.552 billion of intangible costs, including mortality (value of loss of life to the deceased, consumption foregone by deceased, suffering imposed on rest of community) and morbidity (pain and suffering of the sick, and suffering imposed on the rest of the community).[62]

1.46 The authors note that the figures in the revised study are not directly comparable to their earlier study due to 'developments in methodology and an extension in coverage', including the costs of passive smoking (some 10 per cent of the total costs).[63] The authors state that the cost estimates in the current study are

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59 D. Collins and H. Lapsley, *Estimating the Economic Costs of Drug Abuse in Australia*, AGPS, Canberra, 1991, pp.79-90.

60 D. Collins and H. Lapsley, *The Economic Costs Generated by Tobacco Use in Australia*, February 1994, p.16.

61 Passive smoking costs were estimated by using 1990 US estimates of passive smoking deaths as a proportion of deaths attributable to direct smoking and applying this proportion to Australian estimates of direct smoking deaths. See *ibid.,* pp.4, 17.

62 Submission No.27, section 5.1 (DHS&H).

63 Collins and Lapsley (1994), *op. cit.,* p.14.

likely to be an underestimate of the overall cost of tobacco-related illness in Australia.

AIHW study

1.47 A joint project undertaken by the AIHW and the National Centre for Health Program Evaluation has also estimated the costs of tobacco related illness in Australia.[64] As shown in Table 4, the study estimated that in 1989-90 the cost of tobacco related disease was $1 399 million.

1.48 This figure comprised $594 million in direct costs and $805 million in indirect costs. Direct costs comprised health care costs, including the costs of hospital (inpatient costs only), medical, pharmaceutical, nursing home and allied professional care. Indirect costs included foregone earings due to premature deaths and the costs of lost productivity due to ill health.

1.49 In terms of specific diseases, the major contributors to the total cost of tobacco-related disease in 1989-90 were coronary heart disease ($473 million), lung cancer ($235 million), chronic bronchitis ($179 million), peripheral vascular disease ($96 million) and stroke ($80 million). These five diseases together accounted for 76 per cent of the total cost of tobacco related disease in 1989-90.

1.50 The study noted that the cost estimates should be treated as conservative, preliminary estimates only and differ from the cost estimates of other researchers, such as Collins and Lapsley, due to methodological differences.[65]

64 Submission No.71, pp.22-24 (AIHW).

65 For a discussion of the methodology used in the study see *ibid.,* pp.53-56.

Table 4

Costs of major tobacco related diseases by sector of expenditure, Australia, 1989-90

	Health care costs		Indirect costs		Total costs	
Disease	**$ million**	**% of total**	**$ million**	**% of total**	**$ million**	**% of total**
Lung cancer	51	8.6	184	22.9	235	16.8
All tobacco related cancer	**96**	**16.2**	**278**	**34.5**	**374**	**26.7**
Coronary heart disease	118	19.9	355	44.1	473	33.8
Stroke	43	7.2	37	4.6	80	5.7
Peripheral vascular disease	73	12.3	23	2.9	96	6.9
All tobacco related cardiovascular disease	298	50.2	441	54.8	739	52.8
Chronic bronchitis	123	20.7	56	7.0	179	12.8
Peptic ulcer	41	6.9	10	1. 2	51	3.6
All other tobacco related disease	**36**	**6.0**	**20**	**2.5**	**56**	**4.0**
All tobacco related disease	**594**	**100.0**	**805**	**100.0**	**1 399**	**100.0**

Source: Submission No. 71, p.23 (AIHW).

ACIL study

1.51 In a major study commissioned by the Tobacco Institute of Australia, ACIL Economics and Policy Pty Ltd sought to assess 'the costs and benefits to Australians and Australia from smoking'.[66] This study differs from those studies referred to in the previous section in that it attempts to quantify both the economic 'costs' and 'benefits' from tobacco use.

1.52 The study estimated that smoking, and associated activities which supply tobacco products to smokers, provided net benefits to Australia of $12.5 billion in 1992-93. Of this amount, $9.1 billion accrued to smokers in the form of 'consumer surplus', and $3.4 billion constituted the tobacco industry's 'value added' or contribution to Gross Domestic Product.

1.53 'Consumer surplus' is an economic concept that recognises that people are generally willing to pay more for a product than they actually have to pay. It is a way of measuring the utility or value that consumers expect to derive from a product or

66 ACIL Economics and Policy Pty Ltd, *Smoking: Costs and Benefits for Australia*, ACIL, 1994, p.vii.

service.[67] In the ACIL study, consumer surplus is defined as the net benefits from smoking, that is, the total amount smokers are willing to pay for smoking less the costs to them of the activity.[68] One study has noted that 'we know that individuals voluntarily buy tobacco products, which implies that they gain or benefit in exchange for their money. The extra gain that smokers obtain from their purchases is called consumers surplus by economists. This is the amount which consumers gain from their purchases beyond what they actually pay'.[69] In the ACIL study, the calculation of the consumer surplus is based on the demand elasticity of tobacco products (which is calculated at -0.47), the quantity of cigarettes consumed and the purchase price of cigarettes.[70]

1.54 The 'net economic benefits', identified in the ACIL study, combine the benefits to smokers of smoking, added to the incomes and taxes generated (or value added) by the tobacco industry, based on the prices which smokers and the industry face in the market place. The results of the study are summarised in Table 5.

1.55 As noted in the table, the study uses two categories of costs which are characterised as the private costs – the retail price of cigarettes ($5.4 billion) and health-related and other private costs ($3.2 billion). The retail price of cigarettes refers to the purchase price of tobacco (as measured by retail sales), including taxes. Health costs in the study are based on Collins and Lapsley's estimates, adjusted downwards by 50 per cent and indexed to 1992-93 prices.[71] 'Benefits' in the study are measured in relation to the 'consumer surplus' – this concept is a measure of the net benefits to smokers gained from smoking.[72] The study estimates the net benefits to be $9.1 billion. This figure is obtained by subtracting the total benefits ($17.7 billion) from the costs of smoking ($8.6 billion). The GDP figure of $3.4 billion was derived using conventional GDP accounting terms, based on the value added by the tobacco industry, including tobacco product taxes.[73]

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67 Consumer surplus has been defined by the Department of Finance as 'a measure of the benefit to a consumer, net of the sacrifice he or she has to make, from being able to buy a good at a particular price; the difference between the amount a consumer is prepared to pay for a good (rather than go without it) and the amount actually paid'. Cited in *ibid.,* p.10.

68 *ibid.,* pp.24, 52.

69 R. D. Tollison, *Smoking: Costs and Benefits for Australia-Review and Comment*, p.1, cited in Submission No. 65 (ACIL).

70 ACIL report, *op. cit.,* p.52. The demand for tobacco products is inelastic (ie. increasing price does not reduce demand in equal proportion).

71 *ibid.,* pp.21-22.

72 *ibid.,* pp.23-27.

73 *ibid.,* pp.28-30.

Table 5
Costs and benefits of tobacco use, 1992-93

Private Costs and Benefits	
Costs	
Retail price of cigarettes	$5.4 billion
Health related and other private costs	$3.2 billion
Total	$8.6 billion
Benefits	
Purchase price and other effects (a)	$8.6 billion
Consumer surplus	$9.1 billion
Total	$17.7 billion
Industry Value Added (GDP Contribution)	$3.4 billion
Total Net Economic Benefits	$12.5 billion

(a) This includes the purchase cost of tobacco products and other factors (including an estimate of the tangible and intangible costs based on the Collins & Lapsley study (see Table 3)).

Source: ACIL, *Smoking: Costs and Benefits for Australia*, March 1994, pp.xiii, 270.

Costings – Issues

1.56 The studies referred to above provide contrasting views as to the economic and social impact of smoking in the Australian community. Some of the issues raised in these studies are discussed below.

Private versus social costs

1.57 The studies differ in their categorisation of private and social costs. Collins and Lapsley include as social costs all costs which are privately borne by smokers themselves. These include such items as the resources used in producing tobacco products (which is reflected in the price of cigarettes paid by smokers), loss of production and income to smokers, and the value of life foregone by smokers who contract smoking-related disease. In the ACIL report these costs are treated as private costs, rather than social costs. Private costs are costs that are knowingly and freely borne by the consumer.

1.58 Determination of whether costs privately borne by smokers should be classified as private costs or social costs is considered to depend on the extent to

which they are borne intentionally.[74] This in turn depends on the extent to which smokers are aware of the health risks of smoking, whether they are addicted or not, and, if they are, whether they can be said to be rationally addicted. To the extent that smokers are aware, non-addicted and/or rationally addicted, these costs are considered by some as private costs. However, to the extent that smokers are not aware or are irrationally addicted, at least some proportion of these costs will be social costs.

1.59 The Committee received conflicting evidence as to whether the costs borne by smokers should be considered as private or social costs. A representative of ACIL argued that such costs should be considered as private costs as they fulfilled the criteria listed above.[75] In its report, ACIL argues that smokers are well aware of, and fully informed about, the effects of smoking. The report points to the substantial resources spent informing smokers and the public generally of the effects of smoking, and market research polls of Australian consumers that show a high level of awareness across the community of smoking related health risks.[76] On the question of addiction, the representative of ACIL noted that, based on observations of people's smoking behaviour over time, 'what you observe, is that people are giving up smoking regularly…There are now more former smokers than there are present smokers. So that says to me that it is not a matter of total addiction, in the sense of complete inability to give up'.[77]

1.60 An alternative view on these issues was offered by Professor Collins who raised doubts concerning the extent to which smokers are really aware of the effects of smoking.[78] He also questioned whether smokers make rational decisions in deciding to become smokers. He noted that 'there is a great deal of evidence to suggest that almost all smokers start when they are in their very early teens. You really have to ask whether they are capable of looking at the appropriate evidence and evaluating it at that stage. A lot of the evidence is epidemiological evidence which is complex and actually quite inaccessible'.[79] In relation to the question of addiction, Professor Collins argued that about 90 per cent of tobacco consumption 'is at addictive levels. In other words, it is by addicts'.[80]

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74 Industry Commission, *The Tobacco Growing and Manufacturing Industries*, AGPS, Canberra, 1994, pp.226-27.

75 *Transcript of Evidence*, pp.446-48 (ACIL).

76 ACIL report, *op. cit.,* pp.13-14.

77 *Transcript of Evidence*, p.447 (ACIL).

78 See also the discussion of the issue of addiction (paragraphs 1.14 -1.25).

79 *Transcript of Evidence*, p.767 (Professor D. Collins).

80 *ibid*. See also Collins and Lapsley (1994), *op. cit.,* p.7. This estimate was based on the view that consumption of more than 10 cigarettes per day is addictive, based on medical evidence provided to Collins & Lapsley that the addictive threshold for tobacco consumption is likely to be 5-7 cigarettes per day. For a further discussion of the issue of addiction see paragraphs 1.14-1.25.

Treatment of benefits from smoking

1.61 The studies differ in the treatment they accord to the supposed 'benefits' derived from smoking. The ACIL report argues that the Collins and Lapsley study is flawed in that it ignores entirely the 'benefits' that are derived from smoking. The ACIL study, by contrast, calculates substantial net benefits to smokers, based on smokers' willingness to pay for tobacco products.[81] As noted above, it was estimated that some $9.1 billion accrued to smokers in the form of consumer surplus. In Collins and Lapsley's initial study the authors viewed all smoking as drug abuse and consequently assumed that there are no benefits to be derived from this activity. In their more recent study, however, Collins and Lapsley do allow for some level of non-addictive or dependent consumption. Professor Collins noted that 'we do not assume that all smoking yields no benefits. In practice, in our view, a very small proportion of smokers are likely to be both rational and fully informed, and our guess is in the order of 10 per cent [of smokers]'.[82]

1.62 The argument that Collins and Lapsley do not take sufficient account of the benefits of smoking to the economy has been acknowledged in some evidence to the Committee. One submission noted that the benefits to the economy from the tobacco growing and tobacco manufacturing industries as well as taxation receipts might reasonably be offset against the costs of smoking.[83]

1.63 A study has also argued that ACIL's estimate of the net economic benefits to the community have been overstated. This study calculates that the net economic benefits of smoking as $7.7 billion (this compares with ACIL's estimate of $12.5 billion in 1992-93).[84] A comparison of the two estimates is set out in Table 6.

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81 See also paragraphs 1.51-1.55.

82 *Transcript of Evidence*, pp.767-78 (Professor D. Collins).

83 Submission No.2, p.31 (Mr T. Alchin).

84 R. Parish, *Comments on ACIL 'Smoking: Costs and Benefits for Australia'*, Monash University, March 1994, p.8, cited in Submission No.65 (ACIL).

Table 6
Economic costs and benefits of smoking: ACIL and Parish studies

ITEM	ACIL	PARISH
	$ million	$ million
Consumer surplus	9 133	5 721
Government taxes	not included[a]	2 963
Value added	3 425	not included
Publicly-provided health care associated	not included[b]	- 384
Health care provided by private insurers	not included	- 116[c]
Total	12 558	7 714

a: not included as a benefit, but included as a transfer
b: not included as a tax, but included as a transfer
c: estimate

Source: R. Parish, *Comments on ACIL 'Smoking: Costs and Benefits for Australia'*, March 1994, in Submission No. 65, Appendix 1 (ACIL).

1.64 The calculation by ACIL of a perceived 'consumer surplus' of some $9.1 billion has been the subject of some debate. A study by Professor Parish argued that ACIL overestimates the value of the consumer surplus. While, as noted previously, ACIL estimated this item at $9.1 billion, the Parish study argued that the more appropriate figure should be $5.7 billion, some 40 per cent less than ACIL's estimate.[85] Professor Parish noted, however, that 'a rather lower, but not implausible assumption regarding the elasticity of demand would yield an estimate of consumers' surplus similar to ACIL's result'. He also noted that 'any estimate of consumers' surplus is highly conjectural'.[86]

1.65 ACIL, in a submission to the Committee, acknowledged that Professor Parish had drawn attention to 'an analytical error in the equivalence we had assumed for the price elasticity of demand for cigarettes and the price elasticity of demand for smoking'.[87] ACIL noted:

> Thus while correcting for the Parish comment would reduce the consumer surplus estimate, ACIL had already erred on the side of

85 The study noted that, 'ACIL apply the elasticity estimate of -0.47 to the "price" of 0.26 per stick, and assuming a linear demand curve, calculate its intersection with the vertical axis is at a price of $0.82, and that the aggregate consumers' surplus is $9 133 million. The correct procedure is to apply the elasticity estimate to the average retail price of 0.165 per stick: the intersection now occurs at a price of $0.516, and the consumers' surplus turns out to be $5 721.3 million, 40 per cent less than ACIL's estimate'. See Parish, *op. cit.,* p.5.

86 *ibid*., pp.1, 6.

87 Submission No. 65, p.4 (ACIL).

> caution when assuming a price elasticity estimate. A slightly less conservative, but still plausible elasticity estimate would result in a consumer surplus analogous to that in the ACIL report. ACIL therefore continues to adhere to that figure [of $9.1 billion].[88]

1.66 The Industry Commission report raised some concerns with regard to ACIL's estimate of the consumer surplus. The report noted:

> To put ACIL's original $9.1 billion estimate of consumer surplus into perspective, the Commission notes that total private final consumption expenditure on food for 1992-93 was $36.6 billion – and since less than one-quarter of the population are smokers, it implies that smokers were willing to pay an additional amount (over and above the $5.4 billion spent on cigarettes and tobacco in that year) equivalent to their total expenditure on food in order to maintain the same level of cigarette consumption. Despite ACIL's downward revision of the estimate of consumer surplus, [from $9.1 billion to $5.7 billion] the Commission is inclined to question the validity of equating willingness to pay with a net benefit to consumers of tobacco products. Since each consumer has a finite budget, the ability to pay would require a reduction in consumption of other goods and a corresponding reduction in whatever benefit currently accrues from the consumption of those other goods.[89]

1.67 It must be noted that ACIL itself does not seek to draw any policy conclusions from the question of the size of the consumer surplus – as an ACIL representative said to the Committee:

> The ACIL report was careful to explain that the consumer surplus estimates had no implications for policy – that is, there are no actions governments should take based on a knowledge of consumer surplus. The only purpose in undertaking the estimate was because it was ignored by C&L.[90]

Methodological differences

1.68 The studies also make different methodological assumptions which in turn lead to quite different cost estimates. For example, ACIL argues that by employing different assumptions regarding aetiological (or cause of death) data the Collins and Lapsley study would have produced lower estimates of the costs attributed to smoking. ACIL argues that the aetiological fractions used by Collins and Lapsley

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88 *ibid.*

89 Lower socio-economic groups, in particular, may have to reduce their consumption of other goods to pay for the purchase of cigarettes. See Industry Commission, *op. cit.,* p.226. See also Chapter 4.

90 Submission No.65, p.3 (ACIL).

substantially overestimate the mortality effects that can be attributed to smoking.[91] However, ACIL states that 'it is impossible to determine the extent of the overstatement by C&L of premature deaths due to tobacco'.[92] Collins and Lapsley also recognise, however, that caution is needed in interpreting causes of death data, noting in particular the absence of causes of death data for passive smoking and for the abuse of licit drugs.[93]

1.69 The treatment of health costs in the respective studies has also been the subject of debate. As noted above, Collins and Lapsley estimated the health costs of tobacco-related illness at $609.6 million in their original study. ACIL provides an estimate of $384 million for such costs, using Collins and Lapsley's figures, but reducing the estimate by 50 per cent to take account of the alleged over-estimation of such costs by Collins and Lapsley. One study has suggested, however, that ACIL underestimated the health costs in their study and suggested that a more accurate figure would be about $500 million.[94] This estimate is closer to Collins and Lapsley's original figure, which approximates an estimate of the health costs estimated in the AIHW study (totalling $594 million in 1989-90).[95]

Conclusions

1.70 Any attempt to estimate the economic costs and/or benefits of smoking will necessarily involve debate over a range of complex methodological and conceptual issues. An appropriate methodology for measuring 'costs' and/or 'benefits' in this area is unlikely to be easily arrived at, if at all. The various studies reviewed by the Committee approach the problem of measuring the costs and benefits of tobacco use from different perspectives. The Collins and Lapsley studies treat the costs of tobacco-related illness as social costs, while the ACIL study views the costs as private, rather than social costs.[96] Given these fundamental differences in approach it is not surprising that the studies come to different conclusions regarding the economic impact of tobacco use in Australia.

1.71 The Committee recognises that the ACIL study, in offering an analysis of both the 'costs' and 'benefits' of smoking, makes a contribution to debate in this area. The

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91 ACIL argues that there are two methodological criticisms that can be levelled at Collins and Lapsley's use of aetiological fractions -the use of fractions for more than one risk factor, for example, tobacco and alcohol, will result in some of the assessed deaths being counted for both risk factors (double counting); and some confusion between association and causation-causation being concluded as the reason for death, in some instances, when association was as far as could reasonably be claimed. See ACIL report, *op. cit.,* p.19.

92 *ibid.,* pp.16-19.

93 Collins and Lapsley (1991), *op. cit.,* p.63.

94 The figure of $500 million includes an estimate of payments by private health funds. ACIL's original estimate included only publicly provided health care. See Parish, *op. cit.,* p.8.

95 Submission No.71, p.23 (AIHW).

96 See also paragraph 1.59.

Committee, however, believes that the calculation of the 'consumer surplus' may be open to question.

Cost-recovery mechanisms

1.72 Evidence to the Committee suggested several ways in which the costs of tobacco-related illness could be recouped. At present the direct costs of tobacco use in Australia are borne by the contributions of taxpayers to the costs of medical care for smokers and those affected by passive smoking; private individuals, families and friends; the voluntary contributions of individuals and organisations to non-government organisations who conduct smoking prevention/cessation and education programs; and the allocation of a proportion of taxes collected by State and Territory Governments to health promotion bodies.[97]

1.73 In theory, government could attempt to recoup the cost of tobacco-related illness by charging individuals for treatment of tobacco-related illness. However, as DHS&H has noted the possibility of direct cost recovery by, for example, smokers subsidising their own tobacco related medical costs, is precluded under the current Australian health care system which provides access to services on a non-discriminatory basis unrelated to cause of illness. This policy reflects the community attitude that particular groups, such as smokers, should not be singled out or excluded from access to health care services that are universally available.[98]

1.74 Some evidence to the inquiry suggested that tobacco companies should make a direct contribution to the health and other costs imposed on the community by the use of their products. The Thoracic Society of Australia proposed that a Smokers' Compensation Trust be established to provide financial assistance to families where the smoker suffers death or permanent disability as a result of smoking. The tobacco companies would contribute to the fund according to their profits or turnover of tobacco products. The trust would distribute funds to smokers and their families according to lost earnings and damages upon death in a similar manner to workers' compensation payments.

1.75 A representative of the Thoracic Society explained the rationale for establishing the trust in the following terms:

> At the moment, the cost for invalid pensions and widows' pensions and things like that is met by the government if people become disabled from smoking…the government should not bear that cost alone as it does at present. The workers' compensation process works in the same way – the industry contributes to funds from which disabled workers and their families are paid. We feel that we should recognise the

97 *Transcript of Evidence*, p.336 (ACOSH).

98 Submission No.27, section 5.10 (DHS&H).

tobacco industry's contribution to these deaths and disabilities, and that the industry should contribute, in a financial way, to compensation.[99]

1.76 The tobacco industry, by contrast, argues that the industry more than 'pays its way' through the high level of taxation on tobacco products, which counterbalances the health care costs imposed by smokers on the community. ACIL argues that there was a net contribution by smokers of $2.2 billion to consolidated revenue in 1992-93. This figure is derived from taxation receipts levied on tobacco products ($2493 million), plus tariffs on tobacco products ($125 million), minus health care costs ($384 million).[100]

1.77 Another avenue for recovering costs from the tobacco industry canvassed during the inquiry would be to institute litigation proceedings against tobacco companies. Several groups, including ACOSH and ASH Australia, proposed that the Federal Government launch civil legal proceedings against the tobacco companies to recoup the costs associated with the treatment of illnesses and diseases related to tobacco use.[101] ASH Australia argued that the proceeds of such an action would enable, among other things, a fund to be established to provide smoking cessation courses and counselling for smokers.[102]

1.78 The Committee understands that a coalition of anti-smoking groups in Australia proposes to introduce a class action against the industry over evidence that United States tobacco companies concealed research for more than 30 years that showed tobacco was harmful and addictive. The AMA has also proposed that the Commonwealth Government fund a class action in the Federal Court on behalf of smokers. ASH Australia has recently set up a registry of smokers willing to join a class action.[103]

1.79 Litigation against tobacco companies has been more a feature in the United States than in Australia. In 1994 the State of Mississippi became the first US state to file suit against the tobacco industry to seek reimbursement for the costs of treating smoking-related illness incurred by Medicaid and other public health-care programs in the State.[104] The states of Minnesota, West Virginia and Florida have also filed similar suits. It has been reported that several other states may also seek similar

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99 *Transcript of Evidence*, p.366 (Professor A. W. Musk).

100 ACIL report, *op. cit.,* pp.32-33.

101 Submission No.29, p. 16 (ACOSH); *Transcript of Evidence*, p.655 (ASH Australia).

102 ASH Australia, *Press Release*, 30 August 1995, p.1.

103 *The Age*, 24 July, 1995; letter from ASH Australia to the Committee, 11 October 1995.

104 Medicaid is a jointly funded program between the US Federal and State governments to assist States in the provision of medical and health-related services to eligible needy persons. Within broad national guidelines which the Federal government establishes, the States lay down their own eligibility standards; and determine the type, amount and scope of services. The program thus varies considerably from State to State.

compensation from tobacco companies.[105] Numerous lawsuits by individuals have also been instituted against tobacco companies in the United States. In February 1995 a ruling in the US District Court permitted a New Orleans lawsuit filed against US tobacco companies to go forward as a class action. This suit is now the largest class action lawsuit in United States history.[106]

1.80 The Committee received evidence that there may be difficulties in launching litigation proceedings in the Australian context. For example, in regard to the provision of legal aid in Australia in preparing test case compensation claims, a representative of a tobacco company noted that in Australia, unlike the United States, costs follow the event:

> It means that, if any of those claimants are unsuccessful, the government stands to lose an awful lot of money…in America, costs do not follow the event, there are contingency fees. There has never in the history of the industry been a successful claim asserted by any plaintiff to recover damages. I believe that will remain the case. I believe that will be the case in Australia; I believe that will be the case in England. I do not believe that it is appropriate for the government to support claimants who, under like circumstances, have been demonstrated to be wholly unsuccessful claimants in other jurisdictions.[107]

1.81 Another means of recouping the cost of tobacco-related illness in the Australian context would be to increase Commonwealth excise duties and State/Territory business franchise fees on tobacco products. One submission noted that a large increase in this form of taxation would have a significant impact on the demand for tobacco products. Research shows that staged and widely publicised increases in the real price of tobacco products does have an impact on the demand for cigarettes, particularly among adolescents and potential smokers. Directly targeting the revenue earned from the excise and other taxes would significantly reduce the cost to society of tobacco abuse; and such an initiative would clearly signal the Government's further commitment to reducing consumption.[108] As noted in Chapter 3, the Committee believes that there should be regular, real increases in tobacco taxes levied at the Commonwealth and State/Territory levels and that part of the revenue from these taxes should be directed to tobacco control and health promotion activities.[109]

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105 Victorian Smoking and Health Program, *Status Report: What's Happening in the Legislative and Litigation Spheres of Tobacco Control in the USA*, 9 May 1995, pp.22 ,25.

106 *ibid.,* p.25.

107 *Transcript of Evidence*, pp.492-93 (Philip Morris).

108 Submission No.27, section 5.11 (DHS&H).

109 See paragraphs 3.87-3.101.

CHAPTER 2

GOVERNMENT REGULATION OF THE INDUSTRY

2.1 The tobacco industry in Australia is subject to a number of regulatory controls. These regulations are designed primarily to reduce the consumption of tobacco products. This chapter discusses the current regulations which restrict the promotion of tobacco products by way of advertising and promotion, the conditions under which the products are consumed, and taxation arrangements. The chapter also identifies areas where the current regulatory activity of government could be improved or expanded to reduce or modify the consumption of tobacco products for health reasons.

Regulation of tobacco advertising and promotion

2.2 Tobacco advertising has been progressively restricted in Australia since the 1970s. Direct cigarette advertising has been banned on radio and television in Australia since 1976. In 1988, the ban was extended to include all tobacco products. The legislation, however, was framed to allow 'accidental or incidental' advertising. Cinema and billboard advertising remained the responsibility of the States and Territories.[1]

2.3 In 1989 the Commonwealth introduced the *Smoking and Tobacco Products Advertisements (Prohibition) Act 1989*. The Act banned tobacco advertising in all newspapers and magazines from December 1990. Exemptions were allowed for newspapers and journals published overseas and 'not principally intended' for distribution in Australia.

2.4 Prior to the commencement of the *Tobacco Advertising Prohibition Act 1992* the status of tobacco advertising in Australia was as follows:

- direct advertising in the print and broadcast media was prohibited by the Commonwealth by virtue of the *Smoking and Tobacco Products Advertisements (Prohibition) Act 1989* and the *Broadcasting Act 1942* (as amended);
- other forms of advertising (billboards, cinemas, leaflets etc) were prohibited in Victoria, South Australia, Western Australia and the ACT under specific State/Territory legislation; and
- other States/Territories (Queensland, New South Wales, Tasmania and the Northern Territory) continued to rely on voluntary agreements

1 Submission No.27, section 4.14 (DHS&H).

regulating the content and placement of advertisements with the objective of protecting children.[2]

Tobacco Advertising Prohibition Act 1992

2.5 In 1992 the Commonwealth introduced the *Tobacco Advertising Prohibition Act 1992* which introduced further restrictions on all forms of tobacco advertising, including broadcasting and the print media effective from 1 July 1993.[3] The objective of the legislation was to provide a national standard with respect to tobacco advertising prohibition, resulting from the differences in State and Territory legislation and the lack of comprehensive legislation in some States and Territories on certain forms of advertising restrictions.[4]

2.6 The extent of the prohibitions in the Act on the broadcast and publication of tobacco advertisements is extensive, covering almost any conduct which promotes tobacco products. As noted above, the Act prohibited the broadcast or publication of tobacco advertisements, after 1 July 1993. The effect of the legislation is to prohibit print media advertising; advertisements in films, videos, television or radio; advertising on tickets, handbills and other documents; the sale or supply of any item containing a tobacco advertisement; and outdoor advertising on billboards or public transport.[5]

2.7 'Tobacco advertisement' is defined very broadly in the Act, and includes any visual or audible message that publicises or promotes smoking, tobacco products, trademarks, designs or manufacturers' names, or any other words closely associated with tobacco products, whether or not such words are also closely associated with other kinds of products.[6] 'Tobacco product' is also defined widely to include not only tobacco and products containing tobacco, but also cigarette paper, cigarette rollers and pipes.[7]

2.8 There are a number of exemptions and defences in the Act. Tobacco advertising is exempted from the prohibition where:

- it is an accidental or incidental broadcast or publication of tobacco advertisements where the person or body broadcasting does not receive

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2 *ibid.,* section 4.16. Legislation was subsequently enacted in New South Wales in 1991.

3 This Act repealed the *Smoking and Tobacco Products Advertisements (Prohibition) Act 1989.*

4 Submission No.27, sections 4.14-4.19 (DHS&H).

5 Submission No. 45, p.11 (W. D. & H. O. Wills).

6 'Words' include abbreviations, initials and numbers. The display of company colours may or may not be permitted under the Act and is governed by the particular situation and by the provisions of the Act, in particular, whether it is a knowing or reckless broadcast or publication of a tobacco advertisement, whether it is encompassed by the section 9 definition of 'tobacco advertisement' etc. See *Tobacco Advertising Prohibition Act 1992*, s. 9(1).

7 *Tobacco Advertising Prohibition Act 1992*, s. 8.

any benefit for so broadcasting or publishing (clauses 14 and 19 of the Act);

- the advertisement is contained in a publication printed outside Australia and not principally intended for distribution or use in Australia (clause 17);

- it is point-of-sale advertising which is allowed subject to State or Territory laws, or, if there is no such legislation, subject to regulations (clause 16);

- it is an advertisement, in relation to a sporting or cultural event, which the Minister for Human Services and Health has specified in the *Commonwealth Gazette* (clause 18); or

- the advertisement is not published in the course of manufacture, distribution or sale of tobacco products and is published at an individual's own initiative and the individual does not receive any benefit for publishing the advertisement.

2.9 The Act also provides a temporary defence in respect of the publishing prohibition for persons publishing tobacco advertisements arising from a sponsorship contract or other legally enforceable arrangement already entered into before 1 April 1992.[8] Advertisements may not be published after 31 December 1995, or, for those associated with cricket matches, 30 April 1996.

2.10 The *Tobacco Advertising Prohibition Amendment Act 1995* sought to clarify and address some of the unintended consequences of the 1992 parent Act. The Bill amends the *Tobacco Advertising Prohibition Act 1992* to confirm that the 1992 Act is not to apply in a way which would exceed the Commonwealth's power. It also provides for the exemption of various types of tobacco advertisements such as advertisements made in the context of government or political discussion as long as they do not promote tobacco products, and allows advertisements relating to the internal management of the business of a manufacturer or retailer of tobacco products.[9]

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8 Tobacco Advertising Prohibition Bill 1992, *Explanatory Memorandum*. See also Submission No.45, pp.11-12 (W.D. & H.O. Wills).

9 Other exemptions include non-tobacco products which share the same or similar name to a tobacco product, manufacturer, distributor or retailer; the publication of the name of the tobacco manufacturer, distributor or retailer in a telephone directory; and the broadcasting or publication of an advertisement on international air flights. See Tobacco Advertising Prohibition Amendment Bill 1994, *Parliamentary Bills Digest,* p.1.

State/Territory regulations

2.11 State and Territory regulations affecting tobacco product advertising exist in New South Wales, Victoria, South Australia, Western Australia and the ACT. Voluntary codes continue to operate in Tasmania and Queensland. State and Territory legislation continues to be relevant even with the passage of the 1992 Commonwealth legislation.

2.12 While the Commonwealth *Tobacco Advertising Prohibition Act 1992* provides a national baseline of tobacco advertising prohibition, it also provides that those States and Territories with specific legislation can continue to rely on their legislation, except where the Commonwealth prohibition is more stringent. For example, point-of-sale advertising is governed by State laws where such laws exist. In the absence of specific State laws, Commonwealth regulations govern this form of advertising. In addition, some State legislation contains other provisions regulating the promotion and sale of tobacco products.[10]

Incidental and accidental tobacco advertising

2.13 Some evidence to the inquiry, such as the submission from the Health Department of Western Australia, argued that incidental and accidental advertising should be prohibited.[11] As noted before, incidental or accidental broadcast or publication of tobacco advertisements is permitted under the Act. Incidental or accidental advertising is defined in the Act in sections 14 and 19 in the following manner:

> *Section 14*
>
> A person may broadcast a tobacco advertisement if:
>
> (a) the person broadcasts the advertisement as an accidental or incidental accompaniment to the broadcasting of other matter; and
>
> (b) the person does not receive any direct or indirect benefit (whether financial or not) for broadcasting the advertisement (in addition to any direct or indirect benefit that the person receives for broadcasting the other matter).[12]

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10 Submission No.45, p.12 (W.D. & H.O. Wills).

11 Submission No. 51, p.6 (Health Department of Western Australia). Some groups argued that all forms of tobacco advertising should be prohibited. See, for example, Submission No. 53, p.11 (NSW Cancer Council, Australian Consumers' Association and Public Health Association of Australia). This submission is hereafter referred to as the submission of the NSW Cancer Council.

12 Section 51(v) of the Constitution enables the Commonwealth to legislate on postal, telegraphic, telephonic and like services. This provision enables the Commonwealth to legislate covering every person-whether or not the person is a corporation.

Section 19

A person may publish a tobacco advertisement if:

(a) the person publishes the advertisement as an accidental or incidental accompaniment to the publication of other matter; and

(b) the person does not receive any direct or indirect benefit (whether financial or not) for publishing the advertisement (in addition to any direct or indirect benefit that the person receives for publishing the other matter).[13]

2.14 Thus broadcasters are permitted to include incidental material which is technically tobacco advertising – for example, in a report of a sporting event where tobacco advertising is permitted at the venue. If, however, the broadcaster receives some benefit for the tobacco advertising, additional to the benefit arising from broadcasting the sporting event, the tobacco advertisement would not be permitted. Similarly, the Act permits the publication of a tobacco advertisement which is published as an accidental or incidental accompaniment to other matter and for which the publisher does not receive any benefit additional to that which they receive for publishing this other material.[14]

2.15 Some groups argued that, given the progressive restriction on tobacco advertising, it was inconsistent for the government to permit certain forms of advertising to continue. One submission noted that the placement of advertisements in the print media and the broadcast of these advertisements through events on television 'clearly constitutes, in effect, tobacco advertising'.[15] Another submission stated that the display of cigarette brand names on television 'extends well beyond match play, or of anything that could be justified as accidental or incidental'.[16]

2.16 One submission noted that many tobacco sponsored events, such as Benson and Hedges cricket and the Australian Grand Prix generate significant media coverage. The submission said that in an Australian Broadcasting Tribunal inquiry into alleged cigarette advertising during the broadcast of the 1990 Australian Grand Prix, it was estimated that for 17 per cent of the total broadcast time tobacco advertising was visible, which raised doubts as to the 'incidental or accidental' nature of the advertising.[17]

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13 There is no Commonwealth power over publishing. Therefore the Commonwealth must rely on heads of power which are commonly used in the absence of a specific head of power-these powers include the corporations power, the trade and commerce power, the territories power and the incidental power.

14 *Tobacco Advertising Prohibition Act 1992*, sections 14 and 19.

15 Submission No.51, p.5 (Health Department of Western Australia).

16 Submission No.11, p.2 (Canberra ASH). See also Submission No.9, p.1 (Ms L. Scholem).

17 Submission No.51, p.6 (Health Department of Western Australia).

2.17 While concerns were raised during this inquiry in regard to the incidental broadcast of tobacco advertisements in particular, the Committee did not receive any substantial evidence on issues relating to the incidental publication of tobacco advertisements nor to the question of the accidental broadcast or publication of tobacco advertisements.

2.18 With regard to the incidental depiction of cigarettes and smoking in Australian magazines and other publications a recent study found that, following the ban on tobacco advertising in 1992, the incidental depiction of cigarettes and smoking in Australian magazines is 'infrequent by any reasonable standard'.[18] The study noted that 'there appears to be a commendable constraint by many Australian magazine editors in limiting the publication of photographs that show smoking or cigarettes. Some magazines never show smoking, indicating that a goal of total absence of photographs of smoking is achievable'.[19]

2.19 DHS&H advised the Committee that given the broad ranging definition of 'tobacco advertising' in the Act, which includes any writing, still or moving picture, sign, symbol, or other visual image that gives publicity to, or otherwise promotes smoking or the purchase of a tobacco product, the issue of restricting accidental or incidental advertising is a 'complex' issue.[20]

2.20 The Department stated that permitting accidental and incidental advertising is a 'fair compromise' between the health imperative to limit the ability of tobacco companies to place paid advertisements in the various forms of media and the broader need not to restrict or censor the Australian public's access to those media, which may contain non-sponsored portrayals of smoking.[21]

2.21 The Department advised the Committee that it is 'unclear' as to the extent to which accidental and incidental advertising is permitted in overseas countries. However, the Department stated that incidental advertising in the form of unpaid depiction of smoking in films is not prohibited in any country. The Department provided details of the treatment of indirect advertising in New Zealand and Norway both of which have a comprehensive approach to advertising controls similar to that operating in Australia. In New Zealand, incidental and accidental tobacco advertising is permitted in relation to the 'dissemination, broadcasting, or exhibition of any film,

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18 S. Chapman *et al.,* 'Incidental Depiction of Cigarettes and Smoking in Australian Magazines, 1990-1993', *Australian Journal of Public Health* , Vol 19, No.3, 1995, p.314. The study examined the extent of images of smoking or cigarettes in 20 Australian magazines popular among young people or aimed at lower socio-economic groups during three sample periods in 1990 (before the ban), 1991 and 1993 (after the ban).

19 *ibid.,* p.313.

20 Letter from DHS&H to the Committee, dated 23 October 1995, p.4.

21 *ibid.,* p.5.

video recording, or sound recording' and in Norway 'indirect publicity of minor importance' is permitted on radio, television and in films.[22]

Conclusions

2.22 The Committee believes that the incidental or accidental broadcast or publication of tobacco advertisements should still be permitted under the *Tobacco Advertising Prohibition Act 1992*. The Committee considers, however, that the provisions relating to incidental or accidental advertising should be closely monitored and strictly enforced by the Department of Human Services and Health.

Recommendation

The Committee RECOMMENDS:

4. That the provisions of the *Tobacco Advertising Prohibition Act 1992* relating to incidental or accidental broadcast or publication of tobacco advertisements be strictly monitored and enforced by the Department of Human Services and Health.

Sponsorship and advertising

2.23 Although advertisement-related sponsorship of the arts and sporting events by tobacco companies still exists, this type of sponsorship will be prohibited under the *Tobacco Advertising Prohibition Act 1992* after 31 December 1995 (and after 30 April 1996 for sponsorship associated with cricket matches).[23]

2.24 Under the Act, however, there is the capacity to exempt particular sporting or cultural events from the ban on tobacco advertising provided an application for exemption satisfies the Minister for Human Services and Health that the event is of national significance and that failure to grant the exemption might result in the event not being held in Australia. The Act provides that advertising associated with a specified event which has been notified in the *Commonwealth Gazette* cannot explicitly promote tobacco products and must comply with any conditions imposed by the Minister on the tobacco advertising permitted at a specified event.[24]

2.25 The guidelines issued under Section 18 of the Act provide that, in specifying the conditions to be complied with in publishing tobacco advertisements in connection with an event, the Minister may take into account the provisions of any proposed or existing contract and whether the advertisements are necessary to ensure the event takes place in Australia. The Minister may impose conditions, such as

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22 *ibid.,* p.7.

23 *Tobacco Advertising Prohibition Act 1992*, section 21.

24 *Tobacco Advertising Prohibition Act 1992,* section 18.

limiting advertisements to those necessary to ensure that the event is held in Australia; and excluding external advertisements, advertisements in connection with the promotion of an event, and advertisements which appear to be directed at children.[25]

2.26 To date, all 16 applications for exemptions under the Act have been approved by the Minister. These events have included the Whitbread Round the World Yacht Race (WA), Adelaide Grand Prix, Telecom Rally Australia (Perth), Australian Ladies' Masters (Queensland), and the Australian Motor Cycle Grand Prix (NSW).[26]

2.27 On 21 September 1995, the Minister for Human Services and Health announced a review of the provision for exempting sporting events of international significance under Section 18 of the Act. The terms of reference are to review the provision with regard to 'its consistency with the principles and objectives of the legislation; and the relevance to sporting events of international significance in Australia'. The review will assess options for retaining, modifying or removing the provision.[27]

2.28 Several submissions to the inquiry, including submissions from the Australian Medical Association (AMA), National Heart Foundation, ASH Australia, and ACOSH argued that the Act should be amended to remove the exemption provisions permitting tobacco advertising sponsorship of sporting and cultural events.[28] The AMA stated that tobacco sponsorship was 'simply a method of getting around advertising bans'.[29] Another submission noted that tobacco advertising is 'alive and well' in the form of exempted events, such as the Grand Prix.[30]

2.29 In other submissions it was argued that exemptions for tobacco sponsorships should be limited as much as possible and that, where exemptions are granted, the Commonwealth Government should develop stringent conditions.[31] In granting an exemption for tobacco advertising at the 1996 Melbourne Grand Prix the Minister applied the most stringent conditions ever applied by the Commonwealth Government to such an event. Tobacco advertising will only be permitted where it relates to existing international contracts for track signage and sponsorship of teams

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25 Guidelines cited in R. Furlong, 'Tobacco Advertising Legislation and the Sponsorship of Sport', *Australian Business Law Review*, Vol. 22(3), June 1994, p.170.

26 Submission No. 54, p.2 (AMA).

27 Minister for Human Services and Health, *News Release*, 21 September 1995. The review is expected to be completed by 30 April 1996.

28 See Submission No.54, p.2 (AMA); Submission No 42, p.3 (National Heart Foundation); Submission No.41, p.8 (ASH Australia); and Submission No.29, p.13 (ACOSH). The AMA recommended that the legislation providing exemptions should be tightened in the short term and that sponsorships should not be permitted in the longer term.

29 Submission No.54, p.2 (AMA).

30 Submission No.41, p.8 (ASH Australia).

31 Submission No.51, p.5 (Health Department of Western Australia); Submission No.54, p.2 (AMA).

and drivers. Signage other than that associated with the driving teams will be required to carry health warnings, and will be required to occupy at least 25 per cent of the total area of each sign. Advertising away from the track will be prohibited, as will peripheral advertising such as models handing out cigarettes.[32]

2.30 Studies have shown that sponsorship by tobacco manufacturers of televised sport has the same effect on children as more direct cigarette advertising. Children were found to be better able to identify cigarette brands after watching tobacco-sponsored sporting events than they were before. One United Kingdom study found that children were most aware of the cigarette brands which were most frequently associated with sponsored sporting events on television. The study concluded that 'TV sport sponsorship by tobacco manufacturers acts as cigarette advertising to children and therefore circumvents the law banning cigarette advertisements on TV'.[33]

2.31 Another UK study found that over half of the secondary school children in the sample were able to specify a brand name and a sponsored sport or game, such as *Marlboro* and motor car racing. The study argued that:

> Many secondary and older primary school children are aware of the connections between cigarette brand names and sports. Moreover, as the brands and sports most frequently mentioned have often been shown on television, this suggests that children learn about these connections by watching televised sporting events.[34]

Alternative sponsorship

2.32 The Committee recognises that there need to be viable alternatives to tobacco sponsorship of international sporting or cultural events. There are two sources from which such sponsorship may be obtained – private enterprise and the establishment of a national health promotion foundation. It has been noted that non-tobacco private enterprise companies have the opportunity to move into the sponsorship of high exposure sports such as cricket, rugby league and motor racing. There is, however, the possibility that individual companies may be unable or unwilling to completely replace the tobacco sponsorship, given the large sums involved in such sponsorships. It was also pointed out that such companies may have to rationalise their previous

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32 Minister for Human Services and Health, *News Release*, 20 September 1995.

33 F. Ledwith, ' Does Tobacco Sports Sponsorship on Television Act as Advertising to Children?', *Health Education Journal*, Vol. 43, No.4, 1984, p.85.

34 P. Aitken *et al*., 'Children's Awareness of Cigarette Brand Sponsorship of Sports and Games in the UK'*, Health Education Research*, Vol.1, No. 3, 1986, p.209. See also A. Blum, 'The Marlboro Grand Prix', *New England Journal of Medicine*, Vol. 324, No. 13, 1991, pp.913-16; and NZ Toxic Substances Board, *Health or Tobacco*, Wellington, May 1989, pp.48-49.

sponsorships, which may result in other sports, especially the least commercially viable sports, facing the loss of private enterprise financial support of these events.[35]

2.33 Another option would be to establish a national health promotion foundation or other national body to replace the sponsorship funding by tobacco companies. Health promotion foundations have been established in several jurisdictions which, among other objectives, aim to replace tobacco sponsorship in their respective jurisdictions. These foundations currently exist in Victoria, South Australia, Western Australia and the ACT.

2.34 The Victorian Health Promotion Foundation, VicHealth, sponsors over 140 sports and an equivalent number of arts and cultural activities.[36] This funding has enabled a number of sports in Victoria, including tennis, soccer and football, as well as opera, ballet and the visual arts, to be 'completely free of tobacco sponsorship'.[37] VicHealth is funded by a levy of up to 5 per cent on the wholesale sales of tobacco products in Victoria (the levy raises $22 million annually). A national foundation could be supported by a levy on tobacco products at the Commonwealth level, similar to the levy which funds VicHealth.[38] In a document produced by the National Campaign Against Drug Abuse, it was also indicated that it may be necessary to investigate the availability of alternative sources of funding for sponsorship, including other corporate bodies and governments.[39]

Conclusions

2.35 The Committee believes that, on the basis of the evidence received from a wide range of groups and of studies that show sponsorship by tobacco manufacturers acts as cigarette advertising to children, there should be no special exemption permitting tobacco advertising at sporting and cultural events of international significance. The Committee further believes this recommendation should be phased in by the year 2000.

2.36 This Committee also believes that the Commonwealth government should establish a national health promotion foundation or other appropriate national body to provide an alternative source of sponsorship funding. This foundation could be funded by an increase in the tobacco excise.

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35 Furlong, *op. cit.,* p.177.

36 *ibid.,* p.178.

37 Submission No.26, p.4 (Victorian Health Promotion Foundation).

38 Furlong, *op. cit.,* p.182.

39 National Campaign Against Drug Abuse, *National Health Policy on Tobacco in Australia*, March 1991, p.10.

Recommendations

The Committee RECOMMENDS:

5. That the *Tobacco Advertising Prohibition Act 1992* be amended to remove the provision for the exemption of publication of tobacco advertisements in association with specified sporting and cultural events of international significance and that this be phased in by the year 2000.

6. That the Commonwealth Government establish a national health promotion foundation or other appropriate national body to provide an alternative source of sponsorship funding to that provided by tobacco companies for major sporting and cultural events.

Regulation of the level of tar, nicotine and carbon monoxide

2.37 Some evidence received during the inquiry suggested that there should be greater regulation of tar, nicotine and carbon monoxide levels in cigarettes.[40] Australian tobacco manufacturers and importers entered into a voluntary agreement in 1982 to set maximum levels of tar and nicotine allowed in cigarettes. In 1982 the upper limits were 18 mg of corrected particulate matter (CPM or tar) and 1.6 mg of nicotine per cigarette. The agreement was renegotiated in 1986 to cover carbon monoxide content and at the same time maximum yields of tar and nicotine were reduced. In 1988 the permissible levels were reduced further and remain today at 14 mg tar, 1.4 mg nicotine and 18 mg carbon monoxide.

2.38 The Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations, introduced on 29 March 1994, require tobacco products to carry information about their tar, nicotine and carbon monoxide content, specifically the average yields (levels) of these substances and an explanation of their health effects.[41]

2.39 Some evidence to the Committee suggested that the nicotine content of tobacco products should be reduced further because of the addictive properties of nicotine. ACOSH argued that if the nicotine content of cigarettes were reduced the risks of addiction among young people may also be reduced.[42] The organisation suggested that a plan for the systematic reduction in the nicotine content of cigarettes be implemented so that the maximum nicotine content per cigarette would be 0.1 mg of nicotine by the year 2004. Another submission noted that 'reducing nicotine content in cigarettes to non-addictive levels is possible, given the recent admissions

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40 Submission No. 29, p.12 (ACOSH).

41 Submission No.27, section 4.10 (DHS&H).

42 Submission No.29, p.12 (ACOSH).

by the tobacco industry that they have the technology to alter the nicotine content of their product'.[43]

2.40 Other evidence to the Committee, however, questioned whether additional regulation in this area was required. DHS&H stated that the level of nicotine in Australian cigarettes is 'very low compared to cigarettes from other countries, and there is no evidence that the levels are increasing'.[44] A representative of the Department added that 'the smoke yield tables that we have been publishing do not show any evidence of an increase in the level of nicotine in cigarettes sold in Australia. There do not appear to be any across-the-board incremental increases in the level of nicotine in the products being sold in our cigarettes'.[45]

2.41 Some evidence suggests that some benefits may be gained in health terms in smoking low tar/nicotine cigarettes. One United States study reported a 40 per cent reduction in the risk of developing lung cancer in women with the use of low tar/nicotine cigarettes, keeping the number of cigarettes smoked per day constant.[46] One witness stated that while some health benefits may be gained by using low tar yield cigarettes, these benefits may be less than expected. The witness stated that 'the expected benefits in terms of reductions in blood nicotine levels are lower because relatively they [smokers] over-smoke, inhale deeper, harder, longer. So you do not reap all the potential benefit that there is there; but some benefit is gained'.[47]

2.42 DHS&H advised the Committee that further regulation of nicotine, tar and carbon monoxide levels may not be the most effective strategy in that it gives the 'wrong message' – that is, it creates the impression that there is a potentially 'safer cigarette'. The Department noted that its strategy is focused on 'not reducing the nicotine or carbon monoxide, but telling the community what the nicotine and the carbon monoxide do to your body and that it is a poison'.[48] Since January 1995 new labelling regulations have required a fuller explanation of tar, nicotine and carbon monoxide content of cigarettes and their health effects. The information on cigarette packs is now required to state that 'the smoke from each cigarette contains, on average, 12 milligrams or less of tar-condensed smoke containing many chemicals, including some that cause cancer; 1.2 milligrams or less of nicotine – a poisonous and addictive drug; 10 milligrams or less of carbon monoxide – a deadly gas which reduces the ability of blood to carry oxygen'.

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43 Submission No.41, p.6 (ASH Australia). See also *Transcript of Evidence*, p.148 (National Heart Foundation).

44 Submission No. 27, section 4.47 (DHS&H).

45 *Transcript of Evidence*, p.32 (DHS&H). See also *Transcript of Evidence*, p.489 (Philip Morris).

46 US Department of Health, Education and Welfare, *Smoking and Health: A Report of the Surgeon General,* Rockville, MD ,1979, p.25. See also S. Parish *et al.,* 'Cigarette Smoking, Tar Yields, and Non-Fatal Myocardial Infarction', *British Medical Journal*, Vol. 311, 9 August 1995, pp.471-77.

47 *Transcript of Evidence*, pp.148-9 (National Heart Foundation).

48 *Transcript of Evidence,* p.32 (DHS&H).

2.43 DHS&H advised the Committee that the Australian Government Analytical Laboratories (AGAL) has monitored the levels of tar, nicotine and carbon monoxide over the past decade. The results of the testing program have shown that fewer cigarettes contain high levels of tar, nicotine or carbon monoxide and a greater number of cigarettes contain low levels of these substances.[49] The Department stated that 'there is no evidence to suggest that the Commonwealth needs to invoke legislation to control or limit the levels of tar, nicotine and carbon monoxide in cigarettes'.[50] DHS&H also noted that the approach in overseas countries varies. While New Zealand does not regulate tar, nicotine or carbon monoxide levels in cigarettes (although they have the capacity to do so under the *Smoke-Free Environments Act 1990*), the United States Food and Drug Administration has been considering a proposal to regulate nicotine, although it has not been implemented at this stage.

2.44 The Committee believes that the Department's approach to the regulation of tar, nicotine and carbon monoxide levels in tobacco products needs to be re-assessed. While the Department suggests that its strategy is focused more on discouraging tobacco consumption and less on further regulation of tar and nicotine levels in cigarettes it has, nevertheless been involved in negotiations that have resulted in reductions in the tar and nicotine levels of cigarettes through the operation of the voluntary agreement.[51] In addition, given the possible health benefits for smokers of changing to low tar/nicotine cigarettes, an approach that focused on tar/nicotine reduction may be beneficial for many smokers. This would be especially the case as a strategy for encouraging a reduction in overall tobacco use is a long term goal.[52]

2.45 The Committee believes that the regulation of tar, nicotine and carbon monoxide levels in cigarettes needs to be considered in the broader context of the classification of tobacco products as a poison. The Committee discusses this issue further in paragraphs 2.50 to 2.60.

Measuring tar, nicotine and carbon monoxide levels

2.46 An issue of concern raised during the inquiry was the adequacy of the method of testing cigarette yields.[53] The yield information which is on the side of cigarette packs refers to the yields which have been obtained by a standardised protocol agreed to by the government and the tobacco manufacturers. Smoking machines are used to measure yields of nicotine, tar and carbon monoxide by programming them to deliver

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49 Letter from DHS&H to the Committee, dated 23 October 1995, p.9.

50 *ibid*.

51 See paragraph 2.37.

52 See paragraph 2.41.

53 Cigarette yields refer to the tar, nicotine and carbon monoxide levels present in cigarettes. See Submission No.42, p.4 (National Heart Foundation); Submission No.41, p.7 (ASH Australia).

a 35 ml, two-second puff every minute from each cigarette tested, with ventilation holes left unblocked.

2.47 One witness noted, however, that research into what smokers actually do when smoking indicates a process which differs markedly from the process used in the tests. The witness stated that:

> In fact machines do not smoke like people, and we know from clinical and experimental studies that when smokers move to lower nicotine yielding brands...they compensate. They take more puffs, they inhale more deeply, they smoke more cigarettes, they smoke the cigarette down further to the butt and they crush the cigarette, thereby destroying some of the filtration properties of that cigarette. And, more importantly, they also in some cases...put their fingers either partially or wholly over the ventilation holes...and thereby block air coming into the cigarette and thereby increase the volume of nicotine, tar…which they are inhaling.[54]

2.48 One submission cited a study reported in *Choice* magazine in 1993 in which tests were performed on a selection of Australian cigarette brands using the industry testing standard. The results showed that when the ventilation holes were half blocked, tar yields increased by an average of 74 per cent and nicotine yields by an average of 51 per cent. Increases when the holes were fully blocked were even higher. With the doubling of the puff frequency, tar yields increased in the brands tested by an average of 107 per cent and nicotine yields by 73 per cent.[55]

2.49 The doubts expressed in evidence to the Committee concerning aspects of the yield testing procedures and the variable amounts of substances absorbed by smokers has led the Committee to believe that the testing procedures need to accurately reflect differences in smoking behaviours.[56]

Recommendation

The Committee RECOMMENDS:

7. That the current testing procedures for cigarette yields be reviewed by an appropriate independent body to determine whether these procedures accurately reflect the actual levels of tar, nicotine and carbon monoxide inhaled by smokers; and that the printed material contained on cigarette packs on tar, nicotine and carbon monoxide yield levels reflects this information.

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54 *Transcript of Evidence*, pp.268-69 (NSW Cancer Council).

55 Submission No.53, p.5 (NSW Cancer Council).

56 See paragraph 2.41.

Classification of nicotine as a poison

2.50 Some evidence to the Committee suggested that nicotine in tobacco products should be listed as a scheduled poison.[57] One witness stated that 'we still have illogical and inconsistent provisions concerning nicotine ... nicotine is listed ... as a dangerous poison except in tobacco prepared and packed for smoking. This is a major inconsistency in our laws concerning smoking'.[58]

2.51 The Standard for the Uniform Scheduling of Drugs and Poisons is issued by the National Drugs and Poisons Schedule Committee. It classifies drugs and poisons into Schedules for inclusion in the relevant States and Territories legislation.[59] State and Territory poisons inspectors monitor and enforce the legislation. The Standard lists poisons in eight Schedules according to the degree of control recommended to be exercised over their availability to the public. Poisons are classified as follows:

> Schedule 1 – Currently vacant.
>
> Schedule 2 – Poisons for therapeutic use that should be available to the public only from pharmacies; or where there is no pharmacy service available, from persons licensed to sell Schedule 2 poisons.
>
> Schedule 3 – Poisons for therapeutic use that are dangerous or are so liable to abuse as to warrant their availability to the public being restricted to supply by pharmacists or medical, dental or veterinary practitioners.
>
> Schedule 4 – Poisons that should, in the public interest, be restricted to medical, dental or veterinary prescription or supply, together with substances or preparations intended for therapeutic use, the safety or efficacy of which requires further evaluation.
>
> Schedule 5 – Poisons of a hazardous nature that must be readily available to the public but require caution in handling, storage and use.
>
> Schedule 6 – Poisons that must be available to the public but are of a more hazardous or poisonous nature than those classified in Schedule 5.

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57 *Transcript of Evidence*, pp.362-3 (ACOSH).

58 *ibid.*

59 The Committee considers submissions for additions or alterations to the Standard for the Uniform Scheduling of Drugs and Poisons and undertakes policy development, harmonisation of poisons/drugs labelling requirements between Australia and New Zealand and other tasks associated with the public health aspects of the scheduling of drugs and poisons. The Committee comprises expert scientists, government representatives of the States, Territories and New Zealand and Commonwealth registration agencies for drugs and agricultural and veterinary chemicals, and includes industry, pharmacy and consumer representatives. See Australian Health Ministers' Advisory Council, *Standard for the Uniform Scheduling of Drugs and Poisons*, No. 10, AGPS, Canberra, 1995, pp.v, ix-x.

Schedule 7 – Poisons which require special precautions in manufacturing, handling, storage or use, or special individual regulations regarding labelling or availability.

Schedule 8 – Poisons to which the restrictions recommended for drugs of dependence by the 1980 Australian Royal Commission of Inquiry into Drugs should apply.

Schedule 9 – Poisons which are drugs of abuse, the manufacture, possession, sale or use of which should be prohibited by law except for amounts which may be necessary for medical or scientific research conducted with the approval of Commonwealth and/or State or Territory Health Authorities.[60]

2.52 Nicotine is currently listed as a Schedule 7 poison in the Standard for the Uniform Scheduling of Drugs and Poisons [61] 'except in tobacco prepared and packed for smoking'.[62] DHS&H advised the Committee that the exemption of tobacco in the Schedule 'is historical and reflects the prevalence of smoking in the community'.[63] As noted above, Schedule 7 poisons are those which 'require special precautions in manufacturing, handling, storage or use, or special individual regulations regarding labelling or availability'.[64]

2.53 Poisons for therapeutic use (drugs) are scheduled in Schedules 2, 3 and 8 with progression through schedules signifying increasingly strict controls. For agricultural, domestic and industrial poisons Schedules 5, 6 and 7 represent increasingly strict container and labelling requirements with special regulatory controls over the availability of poisons listed in Schedule 7.[65]

2.54 Poisons are not scheduled on the basis of a universal scale of toxicity. Although toxicity is one of the factors considered, and is itself a complex of factors, 'the decision to include a substance in a particular Schedule also takes into account

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60 *ibid.,* pp.vii, 37-39.

61 Nicotine is also exempted from Schedule 7 when included in Schedules 3, 4 or 6. Products containing nicotine for therapeutic (drug) use are categorised as Schedule 3 and 4 poisons. Included in these schedules is nicotine chewing gum, an aid in withdrawal from nicotine addiction. Schedule 3 covers the 2 milligram Nicorette tablets used for smoking cessation which is available without prescription from pharmacists. Schedule 4 covers the 4 milligram Nicorette tablets, along with other products containing nicotine intended as an aid in tobacco withdrawal and available on prescription from a medical practitioner. Schedule 6 refers to nicotine used in animal preparations. See *ibid.*, pp.59, 98, and 152; and *Transcript of Evidence*, p.362 (ACOSH).

62 Australian Health Ministers' Advisory Council, *op. cit.,* p.168.

63 Letter from DHS&H to the Committee, dated 23 October 1995, p.10.

64 Australian Health Ministers' Advisory Council, *op. cit.,* p.vii.

65 *ibid.,* p.ix.

many other criteria such as the purpose of use, potential for abuse, safety in use and the need for the substance'.[66]

2.55 The Standard also includes model provisions about labels and packaging and recommendations about controls on drugs and poisons. The labelling requirements for Schedule 7 poisons require that they state 'Dangerous Poisons' and 'Keep Out of Reach of Children'; the approved name of the poison and the quantity, proportion or strength of the poison; and the name of the manufacturer or distributor or the brand name or trade name by the manufacturer or distributor for the poison.[67]

2.56 The Standard also lists conditions for the availability and use of Schedule 7 poisons. The conditions for availability and use depend on the nature of the poison. Some Schedule 7 poisons are severely restricted, although others are less severely restricted.[68]

2.57 It has been argued that listing nicotine in tobacco products under the poisons schedule would be advantageous. It has been claimed that it 'would give governments full control of the packaging and content of cigarettes' and that 'governments could enforce generic packaging for all brands. Health warnings could be regulated to any required size, as could the delivery of nicotine and carcinogenic tars'.[69]

2.58 Evidence from DHS&H suggested that 'scheduling', as a means of regulatory control of drugs and poisons or as a means of achieving desirable health outcomes is not an automatic, nor necessarily the best, choice for governments.[70] The Department argued that in the case of tobacco, other methods, such as demand reduction in the form of educational campaigns, high taxation of tobacco products, warning labels, and financial support for other anti-smoking initiatives, are more appropriate. DHS&H stated that 'this strategy excludes scheduling as a supply-reduction measure, because the habit is so widespread in the community and restrictive scheduling would be difficult to implement. Prohibitive scheduling of tobacco has the potential to create social problems similar to those experienced when outright prohibition of alcohol was attempted in the USA'.[71]

2.59 The Committee notes that in the United States, the Food and Drug Administration (FDA) has recently ruled that nicotine is an addictive drug, which will enable the agency to regulate tobacco as a drug.[72] Although the FDA has yet to detail

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66 *ibid.*

67 *ibid.,* pp.6, 20.

68 *ibid.,* pp.236-43.

69 *Australian Medicine*, 7 August 1995, p.1.

70 Letter from DHS&H to the Committee, dated 23 October 1995, p.10.

71 *ibid.*

72 'Nicotine is Addictive, Rules FDA', *British Medical Journal*, Vol. 311, 22 July 1995, p.211.

what form the regulation would take, one report noted that the regulatory regime could include measures such as gradually lowering the nicotine levels allowed in cigarettes until they fall below the threshold at which the chemical causes addiction in smokers.[73]

Conclusions

2.60 The Committee believes that nicotine when used in tobacco products should be listed as a Schedule 7 poison under the Standard for the Uniform Scheduling of Drugs and Poisons, but considers that a review into the overall impact the proposal would have on the availability of tobacco products is warranted before the introduction of such a measure.

Recommendation

The Committee RECOMMENDS:

8. That, while the Committee favours the listing of nicotine in tobacco prepared and packed for smoking as a Schedule 7 poison by the National Drugs and Poisons Schedule Committee, it believes that further investigation of the implications of this proposal should be undertaken by the Council of Australian Governments and the Australian Health Ministers' Advisory Council.

Additives in cigarettes

2.61 In addition to concerns raised in relation to the level of tar, nicotine and carbon monoxide in cigarettes, the issue of substances added to tobacco products (additives) was raised during the inquiry. Currently there are no government regulations relating to the use of ingredients (additives) added to tobacco products in Australia, and this lack may have serious consequences.

2.62 One submission from a tobacco company stated that tobacco used in cigarettes commercially manufactured in Australia and in the United States has always contained flavouring ingredients (the most common of which are sugars), as well as processing aids.[74] Another submission from a tobacco company stated that ingredients are primarily used as flavourings, although they also act as casing materials or processing aids. Flavours, such as menthol, are an integral part of tobacco products, and are used to refine and contribute to the taste and distinctiveness of many brands of tobacco products. Casing materials such as sugar or honey are used to smooth the taste. Humectants or moisturisers are used to keep tobacco moist.

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73 'Regulating Tobacco', *Congressional Quarterly Researcher,* Vol.4, No.36, pp.846, 853.

74 Submission No.44, p.8 (Philip Morris).

A small number of processing aids, such as water and carbon dioxide are used for a number of purposes in meeting specific design requirements.[75]

2.63 Evidence to the Committee raised several concerns in relation to additives. These included the nature of the ingredients that are added to cigarettes and their possible health effects, and the related questions of the right of both governments and consumers to have access to appropriate information about such additives.

2.64 One submission noting the possible harmful effects of additives argued that questions arise as to whether, and to what extent, the chemical additives 'that adulterate commercial tobacco products exacerbate the harmful effects of smoking tobacco', given that nicotine itself is harmful to health.[76] It was noted, for example, that the impact of flavourants, such as menthol, which play a role in making cigarettes more 'palatable' to young smokers (especially girls – who often find the harsher taste of regular cigarettes unpleasant) needs to be examined.[77] One submission stated that the role of flavourants in the 'recruitment' of young smokers needs to be examined.[78] One study stated that while additives may be innocuous in themselves they may become toxic when subjected to the heat produced by lighting a cigarette. The study noted that 'a burning cigarette quickly converts from a tobacco store-house to a chemical factory, producing 4 000 compounds. Of these, 400, including nicotine and carbon monoxide, are toxins, and another 40 are carcinogens'.[79]

2.65 The Committee also raised the issue of the possible effect additives may have on the nicotine levels in cigarettes. DHS&H advised the Committee that it was not aware on any conclusive evidence on this issue.[80] The Committee believes that the National Health and Medical Research Council (NHMRC) should investigate the health effects of tobacco products to determine if additives potentiate the effects of nicotine.

2.66 Information supplied by Philip Morris provided details of an evaluation by six scientists of the ingredients added to tobacco in the manufacture of cigarettes in the United States. The authors independently examined extensive published and unpublished toxicologic and other data on the ingredients added to cigarette tobacco and found 'none to be potentially toxic at levels of use'. The evaluation concluded

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75 Submission No.45, p.17 (W. D. & H. O. Wills).

76 Submission No.53, p.6 (NSW Cancer Council).

77 *ibid.*

78 *ibid.*

79 L.Ember, 'The Nicotine Connection', *Chemical and Engineering News*, 28 November 1994, p.9.

80 Letter from DHS&H to the Committee, dated 23 October 1995, p.12.

that the ingredients used by the six major US manufacturers 'are not hazardous under the conditions of use'.[81]

2.67 DHS&H advised the Committee that Commonwealth and State Health Ministers considered the question of additives in 1992 and concluded that the health risks from known additives were not significant and that further action to provide more consumer information on tobacco additives was not justified.[82] This decision was based on the findings of a study by the Centre for Behavioural Research in Cancer on issues relating to additives and pesticides in tobacco. It was decided that the provision of any additional information (to that currently being provided on tar, carbon monoxide and nicotine) would most probably confuse consumers or neutralise the impact of other health information on tobacco packs. The Department noted that this view was endorsed by the NHMRC which indicated that it would not be prepared to set maximum levels for pesticides and additives in tobacco.[83] The position of the NHMRC was that the health consequences of potentially dangerous additives were likely to be insignificant when compared to the harm caused by the naturally occurring toxic contents of tobacco itself.[84]

2.68 The Committee sought information from the tobacco companies on the ingredients added to cigarettes in Australia, and this information was provided on a confidential basis. The list detailed 599 ingredients added to tobacco in products manufactured by the companies in Australia; Wills also advised the Committee that two additional ingredients (not included in the original list provided) are used in the manufacture of that company's cigarettes.[85] While the Committee is not in a position to make a comprehensive assessment of the nature and possible health effects of the list of additives provided, it believes that the ingredients as used (i.e. in combination and in conditions of use) should be subject to an independent review by an appropriate medical/scientific body. The Committee believes that such a course of action would address many of the concerns expressed during the inquiry in relation to the use of additives.

2.69 Evidence to the Committee suggested that governments should have access to information on those ingredients which are added to cigarettes so that they can make informed decisions concerning any possible adverse health effects. One witness stated that 'public authorities need to know what they all are [additives] and to make some independent judgements as to why they are there and their likely effects, if any,

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81 Cited in letter from Philip Morris to the Committee, dated 6 March 1995, p.8.

82 This decision was reaffirmed by the Ministerial Council on Drug Strategy in June 1995. See letter from DHS&H to the Committee, dated 23 October 1995, p.12.

83 ibid., p.11.

84 ibid.

85 Letters from Philip Morris to the Committee, dated 6 March 1995; Rothmans to the Committee, dated 30 March 1995; Wills to the Committee, dated 31 March 1995.

on the public health'.[86] Another witness also noted, 'we do not know what goes into cigarettes and I believe that, like any other consumer product that is taken into the body – pharmaceuticals, beverages, foodstuffs – the government, at the very least, ought to be told what is going into these products'.[87]

2.70 Information on tobacco additives is provided to the United States and New Zealand Governments by tobacco companies on a confidential basis. In New Zealand, the government requires tobacco companies to provide to the Health Department, on an annual basis, a list of all additives that they use in their tobacco products. As noted above, the list is not released to the public and does not specify which additives are selected from the list for use.[88] The Committee believes that the tobacco companies operating in Australia should also be required to provide to the Commonwealth Government annually a list of ingredients used in the manufacture of tobacco products.

2.71 Several submissions also raised the issue of the need for consumers, as well as governments, to be informed about the ingredients added to tobacco products. One witness stated that 'every consumer deserves to know what is in a product, particularly a product that they ingest. I can purchase a jelly off the supermarket shelf and on the side of the packet will be a list of what is in it. I can purchase cigarettes and I do not know what I am going to ingest when I smoke that cigarette'.[89] Witnesses also noted that in addition to a consumer's 'right to know', information on additives was essential in helping consumers make an informed choice as to whether or not to smoke – 'while information is withheld from them, their choice is not fully informed'.[90]

2.72 The tobacco companies argue that to disclose the additives used in the manufacture of cigarettes would be to disclose commercially sensitive material potentially damaging to a particular company.[91] Others, however, have argued that smokers select brands more on the basis of price and brand image, than on the basis of taste. One submission stated that 'there would be little to be gained by any company copying the chemical profile of another brand and thereby hoping to gain market share on the assumption that smokers switch [brands] on the basis of taste' (although taste is presumably one factor involved in brand switching).[92] The Committee believes that consumers have a right to know what ingredients are added

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86 *Transcript of Evidence*, p.148 (National Heart Foundation).

87 *Transcript of Evidence*, p.270 (NSW Cancer Council).

88 Submission No.53, p.6 (NSW Cancer Council).

89 *Transcript of Evidence*, p.664 (ASH Australia).

90 *Transcript of Evidence*, p.147 (National Heart Foundation).

91 *Transcript of Evidence*, p.487 (Philip Morris).

92 Submission No.53, p.7 (NSW Cancer Council).

to cigarettes, and that this right to know outweighs the commercial considerations advanced by the tobacco companies.

2.73 The Committee questioned witnesses on the appropriate form any disclosure of additives might take. Witnesses suggested that, depending on the number of additives used, they could be either listed on the side of the cigarette pack or, if this were not feasible, the additives could be listed on a fold-out piece of paper inserted inside the cigarette pack.[93]

Recommendations

The Committee RECOMMENDS:

9. That the National Health and Medical Research Council assess the health effects of tobacco product additives, including determining whether additives potentiate the effects of nicotine.

10. That a list of the ingredients added to tobacco products be provided annually to the Commonwealth Government, on a confidential basis, by those tobacco companies whose products are available for sale in Australia.

11. That a list of the ingredients in tobacco products, and their effects, be distributed (in an appropriate form) with all tobacco products sold in Australia.

Excise arrangements

2.74 During the inquiry several contributors including ACOSH, ASH Australia, National Heart Foundation and the NSW Cancer Council argued that there should be a change to the basis of calculating excise for cigarettes from the present 'weight' based system to a 'per stick' basis.[94]

2.75 Excise duties may be levied on the basis of the value, volume or weight of a product. Currently, the excise duty levied on tobacco in Australia is determined according to the weight of the manufactured tobacco product. In relation to cigarettes, excise is levied on the total weight of the cigarette (including paper and filter).[95] A sticks-based excise system would levy a tax according to the number of cigarette products sold. A flat rate would apply to each 'stick', whether a large cigar or a light-weight cigarette. As with the current weight-based system, the amount of excise would be independent of the value of the product.

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93 *Transcript of Evidence*, pp.147-8 (National Heart Foundation); *Transcript of Evidence*, pp.275-76 (NSW Cancer Council).

94 Submission No.29, p.14 (ACOSH); Submission No. 41, p.8 (ASH Australia); Submission No. 42, p.4 (National Heart Foundation); Submission No. 53, p.9 (NSW Cancer Council).

95 Industry Commission, *The Tobacco Growing and Manufacturing Industries*, AGPS, Canberra, 1994, p.85.

2.76 Several health groups, proposing a change to the 'per stick' system, have argued that the weight-based system encourages the sale of larger packs, (such as packs of 30s, 35s, 40s and 50s) and that these packs are becoming popular with low income groups and children because they are perceived as offering 'better value' in terms of a cheaper price per stick.[96] One submission noted that 'the concern here is that, with many smokers pacing their purchasing behaviour and daily consumption by the pack, that the extra cigarettes in larger packs, while lighter in tobacco per stick, encourage the smoker to smoke more cigarettes'.[97]

2.77 DHS&H argued, however, that data from the 1993 National Drug Strategy household survey indicated that the availability of larger packs did not necessarily result in smokers consuming more cigarettes.[98] As noted in paragraph 3.22, the evidence also suggests that adolescents use the smaller packs – not the larger packs as suggested by several health groups. For example, among 12-to 17-year olds the most popular cigarette packet size is the 25s, followed by the packs of 30s. The 50 pack size is used by only 5 per cent of 12-to 17-year olds, although younger students use this pack size to a greater extent than older students (9 per cent of 12-year olds use cigarettes from packets of 50s, whereas only 2 per cent of 17- year olds do so).[99]

2.78 One tobacco company – Wills – also proposed a change to a per stick excise system. The company, arguing from a production and economic viewpoint, stated that a per stick system would improve production efficiencies and complement the ongoing efforts to improve productivity and structural efficiency in the industry; encourage product quality improvements; provide a less complicated system to administer; provide a more predictable tax base; and be in line with the tax regimes for tobacco products in other OECD countries.[100] The company also conceded that there would be some financial advantage for the company in a change to a 'per stick' excise arrangement.[101]

2.79 The other two companies (Philip Morris and Rothmans) did not support a change from the current excise arrangements. A representative of Rothmans argued that the company did not consider that a change in the tax regime would result in a 'reduced incidence of smoking through the elimination of cheaper price per cigarette brands and larger packs'.[102] The representative argued that 'we do not agree that the large packs encourage smoking by juveniles as has been suggested. Our market research shows that the 40 to 44 age group is the most attracted to the value for

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96 Submission No.53, p.9 (NSW Cancer Council); Submission No. 41, p.7 (ASH Australia).

97 Submission No.53, p.9 (NSW Cancer Council). See also paragraph 3.20.

98 Letter from DHS&H to the Committee, dated 23 October 1995, Attachment 2, p.7.

99 D. Hill *et al.,* 'Prevalence of Cigarette Smoking Among Australian Secondary School Students in 1993', *Australian Journal of Public Health*, Vol.19, No.4, 1995, p.4.

100 Supplementary Submission No.45, pp.1-2 (W. D. & H.O. Wills).

101 *Transcript of Evidence*, pp.538-39 (W. D. & H.O. Wills).

102 *Transcript of Evidence*, p.589 (Rothmans).

money 50s packs, not the younger age group'.[103] The representative added that the excise paid on the Company's products under the current system is higher per cigarette in some of the 50s packs than for some of the 25s packs.[104]

2.80 The Industry Commission also raised some concerns about the introduction of sticks-based excise system. The Commission argued that such a system would bias production and consumption decisions in favour of longer, and thicker tobacco products.[105] A representative of the Anti-Cancer Council of Victoria responding to these concerns argued that it is 'unlikely' that it would result in 'heavier' cigarettes, 'only one other country in the world…excises by weight and in every country of the world the average weight of cigarettes has come down, I think largely due to consumer preference for low tar brands'.[106] Wills also noted that a longer and thicker type of cigarette was subject to trials in Australia in the 1960s and 1970s, but there was not sufficient consumer demand for the product. It was also noted that provisions similar to those in the European Union could be introduced so that cigarettes beyond a certain length or weight are taxed at a higher rate.[107]

2.81 One submission noted that it is sometimes argued that a per stick excise will result in higher tar and nicotine deliveries. The submission noted that this would not be the case as tar and nicotine deliveries are determined by product design to meet consumer demand. It was noted that consumer demand has resulted in cigarettes delivering 8 mg or less of tar and such cigarettes have increased their market share from 8.6 per cent in 1980 to 51.8 per cent in 1994. It was also noted that tar and nicotine deliveries are not dependent on the amount of tobacco contained in the cigarette.[108]

2.82 DHS&H advised the Committee that a joint review by the Departments of Human Services and Health and the Treasury in 1995 into the manner in which tobacco excise is currently levied, concluded that there was no basis for supporting a change to the excise levy, from a weight-based to a sticks-based system from a health perspective and that such a change would involve considerable disruption to industry.[109]

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103 *ibid.,* p.590.

104 While the excise per cigarette may be higher for some larger packs, the price to consumers per cigarette in the larger packs may be less than the price per cigarette in smaller packs due to price discounting.

105 Industry Commission, *op. cit.,* Appendix N, p.3.

106 *Transcript of Evidence*, p.87 (Anti-Cancer Council of Victoria).

107 Supplementary Submission No.45, pp.2-3 (W. D. & H.O. Wills).

108 *ibid.,* p.3.

109 Letter from DHS&H to the Committee, dated 23 October 1995, pp.12-13.

Conclusion

2.83 On the basis of the evidence received, especially the concerns raised about the impact of the current excise arrangements on consumption patterns, the Committee believes that the current weight-based excise system should be reviewed by the NHMRC.

Recommendation

The Committee RECOMMENDS:

12. That the National Health and Medical Research Council appoint a sub-committee to review the current weight-based excise system.

Duty-free tobacco products

2.84 Currently persons over the age of 18 years entering Australia are permitted to bring into the country 250 grams of tobacco products (or 250 cigarettes) without the payment of duty.[110]

2.85 A recent review of the Australian Customs Service recommended that in the light of the Government's general policy of discouraging the use of tobacco products the Commonwealth Government should consider withdrawing tobacco products from the list of duty-free goods.[111] The review noted that several groups, including the AMA had pointed out 'the anomaly of Government policies discouraging smoking while exempting [these] tobacco products from duty'.[112]

2.86 The Committee believes that the Commonwealth Government should further investigate the implications of withdrawing tobacco products from the list of duty-free items. The Committee understands that Singapore has recently withdrawn the duty-free status of tobacco products.[113]

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110 For Australian Customs purposes, 250 cigarettes are equivalent to 250 grams. Currently, persons may bring with them goods over and above their 'allowance', including tobacco products, as long as these goods are declared and any duty owing is paid. See correspondence to the Committee from the Australian Customs Service, dated 7 November 1995, p.1.

111 F. Conroy (Chairman), *Review of the Australian Customs Service,* December 1993, p.xiii.

112 *ibid.,* p.25.

113 DHS&H, *Estimates Committee Hansard*, 26 May 1995, p.34.

Recommendation

The Committee RECOMMENDS:

13. That the Commonwealth Government investigate the implications of withdrawing tobacco products from the list of duty-free goods.

CHAPTER 3

YOUNG PEOPLE AND THE USE OF TOBACCO

3.1 This chapter discusses issues relating to juveniles and smoking. The Committee, by focusing on young people, recognises that smoking in adolescence sets the pattern for subsequent tobacco use. **Discouraging young people from starting to use tobacco is the key to reducing tobacco-related death and disease in later life**. The first section of the chapter discusses the reasons why young people take up smoking and the incidence of smoking amongst young people. The second section discusses possible approaches in addressing the problem of juvenile smoking, and recommends several options to address this problem.

Why adolescents smoke

3.2 Evidence to the Committee and research, both in Australia and overseas, indicate that young people take up smoking for a variety of reasons. Sociodemographic, environmental, behavioural and personal factors can encourage the onset of tobacco use among adolescents. Among the strongest influences on the decision by a young person to smoke are those created by peer pressure, by the social environment and the family environment in which the young person lives.[1]

3.3 Research in the United States has indicated that the initiation and development of tobacco use among children and adolescents progresses through a number of stages: from forming attitudes and beliefs about smoking, from trying, experimenting with, and regularly using tobacco, to nicotine dependence and addiction. The process from the initial 'try' to the stage of regular use takes on average two to three years, although there is considerable variation among individuals.[2]

3.4 Data from the United States indicate that experimentation with tobacco begins in early adolescence, typically by the age of 16 years. The ages between 11 to 15 have been identified as the peak age groups for trial and experimentation associated with cigarettes.[3] An Australian study conducted in 1989-90 found that the majority (60 per cent) of both current smokers and ex-smokers reported that they began experimenting with smoking between the ages of 15 and 19 years. A further 17 per cent of current smokers and 15 per cent of ex-smokers started experimenting before the age of 15 years.[4]

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1 US Department of Health and Human Services, *Preventing Tobacco Use Among Young People: A Report of the Surgeon General,* US Government Printing Office, Washington D.C., 1994, pp.125-38.

2 *ibid.,* pp.124-25.

3 *ibid.,* pp.104, 138.

4 ABS, *Australian Social Trends 1994*, Cat. No. 4102.0, p.60.

3.5 Research in Australia indicates that where people had reached the age of 20 years and had not smoked, the chance of their taking up smoking was slim. Only 12 per cent of those who had ever smoked began smoking regularly after the age of 21 years. Almost 80 per cent of adults who had ever smoked had taken it up by the age of 20 years.[5] Similar results have been reported in the United States, where research indicates that few adolescents commence smoking after the age of 18 years.[6]

3.6 As noted above, a number of risk factors are associated with the initiation of smoking in young people. Sociodemographic factors are associated with the onset of smoking. Studies have shown that adolescents from families from lower socioeconomic groups; from families where the level of parental educational is low; or where the adolescent is living in a single-parent household, have a higher incidence of smoking than where these factors are not present. One possible explanation of the impact of socioeconomic status and smoking is that youth from lower socioeconomic backgrounds may have to cope more often with stressful situations, such as lacking sufficient resources or living in a one-parent household, and therefore perceive smoking as a quick, easy, coping strategy for stress or loneliness. These youths may also be more susceptible to peer group influences and advertising. Adolescents from low-income families may also have more role models who smoke and less supervision to discourage experimentation than adolescents from higher-income families.[7]

3.7 Environmental risk factors for tobacco use include accessibility and availability of tobacco products (especially through advertising and promotion by tobacco companies); perceptions by adolescents that tobacco use is 'cool'; peers' and siblings' use and approval of tobacco use; and lack of parental support and involvement as adolescents face the challenges of growing up.[8]

3.8 Behavioural risk factors associated with tobacco use include low levels of academic achievement and school involvement, lack of skills required to resist influences to use tobacco and experimentation with tobacco products. These risk factors are also associated with sociodemographic factors.[9] Personal risk factors for tobacco use include a lower self image than peers; the belief that tobacco use is 'functional' (i.e. as a way to act mature, be accepted by a peer group or coping with

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5 Unpublished data from the Anti-Cancer Council of Victoria, dated 8 November 1995. The data are based on a study of the smoking behaviour of adults in Victoria conducted in 1993.

6 US Surgeon General, 'Preventing Tobacco Use Among Young People', *Tobacco Control*, 3, 1994, p.176.

7 US Department of Health and Human Services, *op. cit.,* p.127.

8 *ibid.,* pp.125-32.

9 A US study reports that youth from lower socio-economic status families are limited by fewer opportunities for health enhancing avenues for independence and identity, often lack parental supervision and are at greater risk of beginning smoking than youth from higher socio-economic families. See *ibid.,* p.138.

personal problems); and lack of personal self-confidence in the ability to refuse offers to use cigarettes.[10]

3.9 Adolescent smoking behaviour has been shown to be a risk factor for subsequent smoking.[11] Several US studies have found that 'intentions to smoke' (ie. a clear intent to smoke) have been associated with both the onset and continuation of smoking. Intentions to smoke appear to be a particularly strong predictor of future smoking for those who have already tried smoking. These findings suggest a need for anti-smoking efforts to focus on preventing experimentation with smoking and on discouraging transitions to more regular smoking.

3.10 Research undertaken in Australia by the Open Mind Research Group on behalf of the National Drug Strategy analysed the reasons why young people take up smoking. The study came to similar conclusions as the US studies cited above. The study found that for primary school age children the primary motivation has been identified as 'curiosity', and the excitement of doing something 'forbidden'. For children in this age group the trigger to experiment with cigarettes comes with the availability of cigarettes and the encouragement of older friends, peers or siblings.[12] For early secondary school age children the main motivation to start smoking is associated with peer group pressure – the desire to 'belong'. The study noted that even children who claimed that they disliked smoking when they were younger, had taken up smoking in Year 7 because they considered that this was the 'price of entry' into membership of the social group they desired.[13]

3.11 The Open Mind report found that the core motivation for children in taking up smoking in the late secondary years of schooling was 'the expanding social life young people experience at this age, and the pressures this entails – to feel comfortable, to look comfortable, to look and feel mature...smoking has moved from the 'badge of belonging' within the social network, to a 'badge of maturity', and an assertion of sexuality, and power'.[14] The study found that the sexual cues given by the act of smoking become a key focus at this age – a major preoccupation in discussion about smoking centres on what boys/girls do or don't think of you if you do/don't smoke. Stresses associated with study and with new social situations are also linked with initiation into smoking at these ages.[15]

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10 *ibid.,* pp.133-38.

11 *ibid.,* p.138.

12 Open Mind Research Group, *National Drug Strategy: Adolescent Smoking*, July 1994, p.121. The Open Mind Research report was based on group discussions and interviews with 12-to-24 year-olds, focusing on especially 12-18 year-olds at secondary school and 16-24 year-olds who had left secondary school. The report was based on the observations/conclusions of the researchers.

13 *ibid.,* p.122

14 *ibid.,* p.123.

15 *ibid.,* p.124.

Incidence of juvenile smoking

3.12 Table 7 indicates in that in 1993, the smoking rate for 12- to 15-year-olds was 17.5 per cent (17 per cent of boys and 17.9 per cent of girls), while the smoking rate for 16- to 17-year-olds was 28.8 per cent (27.9 per cent of boys and 29.5 per cent of girls).[16] As the table indicates, the smoking prevalence for both boys and girls in the 12- to 15-year-old age group was similar in 1993, but more girls aged 16 and 17 smoked than boys in the same age group.

Table 7
Smoking rates (percentage), 1990 and 1993

	12 to 15 year-olds		16 to 17 year-olds	
	1990	**1993**	**1990**	**1993**
Male	15.0	17.0	25.6	27.9
Female	16.5	17.9	28.0	29.5
Total	15.7	17.5	27.0	28.8

Source: D. Hill, *et al.,* 'Prevalence of Cigarette Smoking Among Australian Secondary School Students in 1993', *Australian Journal of Public Health*, Vol.19, No.5, 1995, p.5.

3.13 The data indicate that the prevalence of smoking increases with age. Table 8 shows that while 8 per cent of students aged 12 years smoked, for those aged 17 years the prevalence was much higher (a rate of 30 per cent).

3.14 The table also indicates that the proportion of students who had smoked in the 12 months prior to the survey reached a peak of 52 per cent of girls aged 15 years and 48 per cent of boys aged 16 years. The average number of cigarettes smoked per week was similar for both boys and girls up to the age of 14 years. However, for boys aged 15 to 17 years, the weekly consumption of cigarettes was significantly greater than for girls.

16 The data on juvenile smoking are drawn from information collected from four national surveys of school children's smoking habits carried out under the auspices of the Australian Cancer Society and its member organisations in 1984, 1987, 1990 and 1993. See D. Hill *et al.,* 'Prevalence of Cigarette Smoking Among Australian Secondary School Students in 1993', *Australian Journal of Public Health*, Vol 19 (5), 1995.

Table 8
Smoking patterns of secondary students by age and gender (percentage), 1993

	Sex	12	13	14	15	16	17
Current smoker (a)	M	8	13	20	24	27	28
	F	7	14	23	28	28	31
	Total	8	14	22	26	28	30
Smoked in past year	M	21	30	40	44	48	46
	F	19	32	45	52	50	51
Mean number of cigarettes per week	M	8.6	12.3	19.4	28.7	36.9	43.8
	F	7.0	12.9	18.6	23.6	31.3	32.0

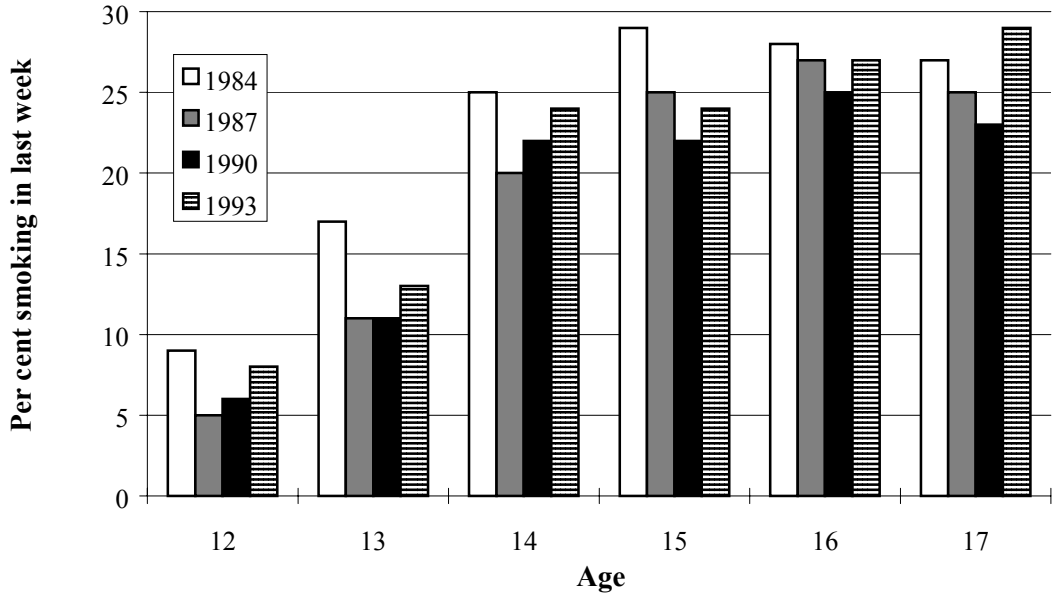
(a) A current smoker is defined as a student who had smoked on at least one of the seven days prior to the survey.

Source: *ibid.*, p.3.

Trends over time

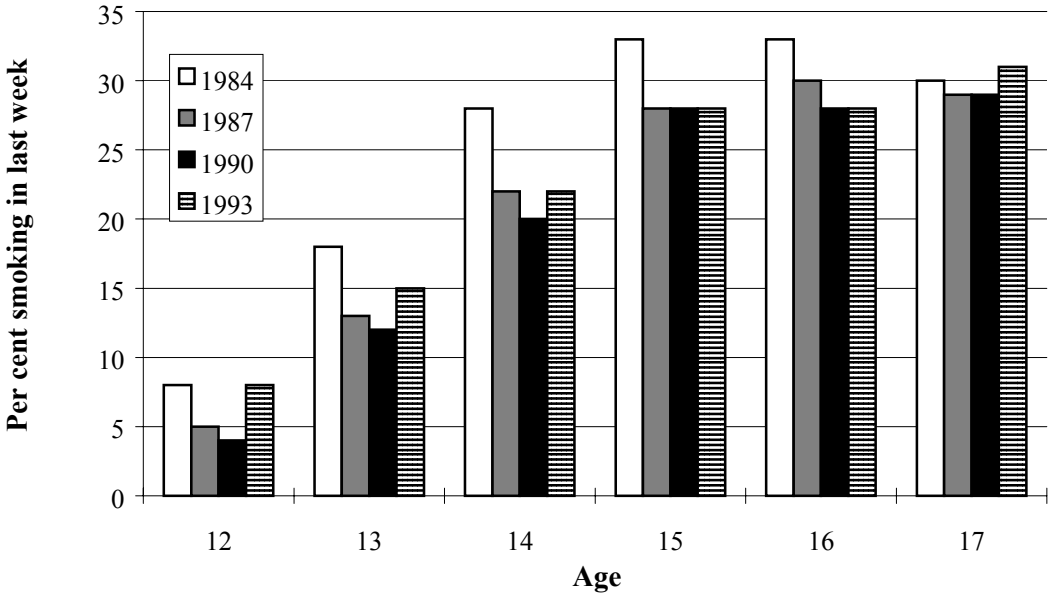
Figures 1 and 2 below show the proportion of students smoking in the last week in the four survey periods from 1984 to 1993.

Figure 1
Proportion of male students smoking in the last week, 1984, 1987, 1990, 1993



Source: *ibid.*, p.4.

Figure 2
Proportion of female students smoking in the last week, 1984, 1987, 1990, 1993



Source: *ibid*.

3.15 The data show that between 1984 and 1990 the prevalence of smoking among 12- to 15-year-olds generally decreased for most ages or remained static. Among students aged 16 to 17 years, the prevalence of smoking decreased or remained static. A number of factors were responsible for this trend including the effects of youth education/information campaigns, restrictions on advertising of tobacco products and cigarette price increases.[17]

3.16 Between 1990 and 1993 the data (as shown in figures 1 and 2) indicate that the proportion of both male and female students smoking in 1993 was higher than in 1990 for most age groups, (except for females aged 15-16 years where the rate remained static). Among 12- to 15-year-olds, the prevalence of smoking in 1993 was significantly higher than in 1990, especially for boys. The proportions of 16- to 17-year-olds smoking between 1990 and 1993 was not significantly different.

3.17 The comparison of the data on smoking rates for 1990 and 1993 suggests that the general trend towards a decline in smoking rates among young people which was evident throughout the 1980s has ended. Slightly more 12- to 15-year-olds were smoking in 1993 than in 1990, mainly due to an increase in smoking rates among boys. The prevalence of smoking among 16- to 17-year-olds remained at similar levels to those of 1990.

17 Advice from the Anti-Cancer Council of Victoria, 31 October 1995.

3.18 It was noted in the study that the increase in smoking rates among young people in the 1990s is due to an increase in 'occasional' smoking rather than in 'committed' smoking (defined as a person smoking on three or more days of the last week). The study found that the proportion of 12-to 15 -year-old 'committed' smokers in 1993 was virtually the same as that in 1990, and not significantly different from that in 1987. For 16- to 17-year-olds, while there was no change in the proportion of committed smokers between 1990 and 1993, the proportion of committed smokers was higher in 1984 than in the three subsequent survey years.[18]

3.19 The reasons for the recently observed trend showing an increase in smoking rates amongst young people in the 1990s have been explained in the following terms:

> Uptake of smoking can be considered to be driven by the belief that it helps project a desired image of oneself. The trend observed in younger students raises the possibility that aspects of popular adolescent culture have changed, in that smoking as a fashion statement has recently gained greater appeal than before. It is possible that the rise in casual smoking might be because of unfavourable behaviour or attitudes of powerful exemplars for youth (such as musicians), characterisation on film and television and reportage in magazines that are influential with young adolescents.[19]

Patterns of tobacco use

3.20 The most popular brand of cigarette reported to be smoked by current smokers in the 1993 survey was *Peter Jackson* (30 per cent of boys and 33 per cent of girls). *Winfield* was the next most popular brand, smoked by 20 per cent of boys and 18 per cent of girls, followed by *Longbeach* (9 per cent of boys and 13 per cent of girls). These three brands captured over 60 per cent of the secondary school smoker market. The most popular packet size was the 25s, with 37 per cent of male and female smokers obtaining their most recent cigarette from packs of this size. The packs of 30 were the next most popular, with 27 per cent of boys and 28 per cent of girls reporting that they obtained cigarettes from these packs. Only 5 per cent of boys and 4 per cent of girls used packs of 50 to obtain cigarettes.[20]

3.21 In all age groups and for both genders, 'friends' were identified as the single most common source of cigarettes, with 34 per cent of males and 35 per cent of female smokers indicating friends as their source of supply.[21] Overall 52 per cent of female and 48 per cent of male smokers purchased the last cigarette they had smoked. Older adolescents were more likely to have purchased their own supply of cigarettes.

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18 Hill, *op. cit.,* p.5.

19 *ibid.,* p.4.

20 *ibid.*

21 Other sources of supply are brothers/sisters, other family members or the purchase of cigarettes.

Some 64 per cent of 17-year-olds bought their last cigarette, compared with 23 per cent of 12-year-olds. Where cigarettes were bought, the most common source of supply was from a milk bar or delicatessen (15 per cent of female and 16 per cent of male smokers). Some 13 per cent of current smokers indicated that in the four weeks prior to the survey, they had bought a cigarette singly. Of this 13 per cent, the majority (59 per cent) had bought the cigarette from a friend or relative, and 20 per cent reported buying a single cigarette from a shop.[22]

Conclusion

3.22 The Committee believes that the increasing incidence of smoking amongst adolescents, especially over recent years, is a matter of grave concern. The Committee considers that a concerted effort needs to be made by governments at all levels, parents, and the broader community to address this problem.

Addressing the problem of juvenile smoking

3.23 The Committee received considerable evidence during the inquiry that a comprehensive and integrated strategy is needed to address the problem of juvenile smoking. One submission, drawing on the experience of the Western Australian Smoking and Health Program stated that 'it is not possible to single out any one strategy as being most likely to be effective. Rather, I would advocate that health authorities do everything that they can, and as much of it at the same time as possible'.[23] A representative of the AMA noted that an 'integrated strategy' is needed combining education, price increases and other initiatives in order to reduce tobacco use.[24] A New Zealand study also emphasised that comprehensive policies to reduce consumption are more effective than any single measure.[25] The study argued that essential features of an effective government policy to reduce tobacco use combines educational programs to inform teenagers about the dangers of tobacco use, the raising of tobacco prices, and a ban on tobacco promotion.

3.24 The Committee believes that a comprehensive approach is needed to address the problem of juvenile smoking. The elements of such an approach are discussed below and include issues relating to education and information, packaging of tobacco products, advertising and promotion, product placement in films and television, and taxation of tobacco products. The specific problems and strategies relating to the access of minors to tobacco products are discussed at paragraphs 3.101 - 3.153.

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22 Hill, *op. cit.,* p.4.

23 Additional information from the Health Department of Western Australia to the Committee, dated 23 March 1995, p.2.

24 *Transcript of Evidence*, p.396 (AMA).

25 NZ Toxic Substances Board, *Health or Tobacco*, Wellington, May 1989, p.103.

Education and information

3.25 Evidence to the Committee suggested that there was a need for a greater emphasis on education and information programs for young people to alert them to the consequences of smoking. Several witness noted that the community generally has a responsibility to educate young people on the dangers of smoking and that more resources needed to be devoted to this task.[26]

3.26 The National Health Policy on Tobacco in Australia recognises that 'education on smoking and health issues is a vital part of any smoking control program. Education, as part of a comprehensive program, can produce a reduction in smoking levels in children and adults and is also effective in preventing the onset of tobacco use...Education should not be seen in a limited context but needs to be considered in terms of both formal and informal education structures'.[27]

Improving mass media education strategies

3.27 During the inquiry the Department of Human Services and Health (DHS&H) informed the Committee that its anti-tobacco advertising campaigns directed at young people to date had not been effective in reducing the incidence of juvenile smoking.[28] A representative of the Department stated that the 'QUIT' program was seen as a 'come-on' to young people (i.e. more of an 'invitation' to smoke, than a discouragement). The Departmental officer further noted that the Department 'had to look very hard at how we were going to develop some messages that were consistent with the values and beliefs of contemporary young people…We have marginalised tobacco smoking in adult social behaviour, but we have made it a more attractive substance to young people.[29]

3.28 Research into the issue of youth smoking by the Open Mind Research Group, on which the Department's new strategy is based, found that a successful strategy had to challenge the positive images and notions that are currently associated with cigarette smoking within contemporary youth culture, including raising the profile and relevance of the health consequences of tobacco use, and focusing on the young smokers' immediate peer group.[30]

3.29 The Open Mind research indicated that it is important to target 'influencers' within the peer group as an effective means of targeting young people generally. The

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26 *Transcript of Evidence*, p.868 (Queensland Cancer Fund); *Transcript of Evidence*, p.369 (ACOSH).

27 National Campaign Against Drug Abuse, *National Health Policy on Tobacco Use in Australia*, March 1991, p.13.

28 *Transcript of Evidence*, p.33 (DHS&H).

29 *ibid.*

30 National Tobacco and Health Public Information Campaign, *Advertising Agency Briefs*, September 1994, pp.5-8.

'influencers' were identified as those young people 'at the cutting edge of youth culture. These are the people who generate the 'trends'. These are also the people who are in a position to challenge the very signals that smoking generates within contemporary Australian youth culture'.[31]

3.30 The research indicated that even non-smokers believed that smokers are 'cool'. At the same time the research found that there are 'positively perceived' non-smokers who project self-confidence in a relaxed and acceptable manner. These teenagers are key models for reinforcing the decision not to smoke amongst current non-smokers. The research concluded that the campaign should be designed to appeal to the 'youth influencers' – both smokers and non-smokers – in mid- to late secondary school (15-17 years) on the basis that 'successfully undermining the positive associations with smoking that currently exist for these young people and influencing their attitudes will in turn influence those within the broader target audience of all young people aged 12-17 years'.[32]

3.31 The research report found that an effective advertising campaign needed to be seen to come from within the 'youth paradigm', not from the adult world, and to recognise that smoking is currently integral to the social fabric of school life; to be sensitive to young people's overall health concerns and self-esteem (that is, motivate young people to adopt appropriate attitudes and behaviour towards smoking, without denigrating their position); and to communicate on a 'youth-to-youth' basis by using persons similar in age to the target audience, or persons seen to be part of their culture.

3.32 The study found that girls are critical of any attempt to 'single them out' in anti-smoking campaigns and that such an approach may inspire them to become further committed to remaining a smoker. The report also found that while school-age smokers can list health slogans, such as 'smoking causes lung cancer', they do not internalise the relevance of these messages for them as young people.[33]

Commonwealth initiatives

3.33 In accordance with the National Health Policy the Commonwealth Government is implementing a Tobacco and Health Public Information Campaign which targets youth. The campaign involves comprehensive mass media activities; and aims to address issues related to the attitudes, incidence and prevalence of smoking amongst young people by undermining the positive associations which cigarette smoking has within the contemporary Australian youth culture; encouraging young smokers to give up smoking; increasing the numbers of young people who are non-smokers; and reducing the motivation to take up smoking.

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31 *ibid.,* p.6.

32 *ibid.,* p.5.

33 *ibid.,* p.8.

3.34 In 1994, The Commonwealth committed $3.1 million to the Tobacco and Health Public Information Campaign targeting young people. The campaign is planned to run in phases for at least three years. The campaign, which is aimed at the 15-17 year age group, is designed to deglamourise and deconstruct the myths surrounding smoking. The campaign message avoids overtly telling young people what to do; the commercials imply, rather than state, that smoking in itself is not glamorous, 'cool' or rebellious.[34]

3.35 The first phase of the youth initiative, the 'Smoking is Really Interesting' campaign, is designed to challenge old attitudes to smoking while aiming to shape and reinforce new ones. The campaign strategy is based on several phases of advertising, involving increasingly more complex messages. The initial phases involve cinema and print media advertising with an expansion to television and other media as the campaign progresses.[35]

Improving teacher education

3.36 Witnesses commented on the need to improve the information available to teachers and the health educators, including the provision of in-service training.[36] One witness noted that, 'there are…repeated requests from health education teachers for more support, for more training about how to teach about tobacco and other health education issues. So it is not being delivered to the children and the people who are charged with the responsibility feel inadequately prepared and supported to fulfil that responsibility'.[37]

3.37 The Committee received some evidence on initiatives in the States in relation to teacher education. For example, in NSW the Department of Health provides funding for the training of drug education consultants who provide information, advice and skills-training for teachers involved in drug and alcohol education in schools.[38] In Western Australia, extensive in-service training is available for teachers in the area of drug education.[39]

Improving education programs in schools

3.38 While the Committee received information from several States/Territories indicating their support for school-based tobacco education programs some evidence argued that more resources should be devoted to these programs in schools providing

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34 Letter from DHS&H to the Committee, dated 23 October 1995, pp.13-14.

35 *ibid.,* p.14.

36 *Transcript of Evidence*, p.140 (Professor K. Jamrozik).

37 *ibid.,* pp.140-41

38 *Transcript of Evidence*, pp.710-11 (NSW Department of Health).

39 *Transcript of Evidence*, p.860 (Queensland Cancer Fund).

information to students on the risks of smoking.[40] One witness noted that, 'not all children are given anti-tobacco education…The amount of time devoted to health education has contracted [in recent years] and tobacco, along with a number of pressing issues, has received less attention in schools'.[41]

3.39 Another witness remarked on the failure of the education system to provide sufficient information to young people on smoking and its effects.[42] A representative of the AMA argued that there should be a formal requirement for education in all schools in Australia about the harmful effects of tobacco use.[43]

3.40 In the United States, the National Cancer Institute identified a number of features considered necessary for effective school-based smoking prevention programs. These factors include that the program be introduced during the transition from primary school to junior high school; that it be incorporated into the existing school curriculum; that it emphasise the social factors that influence smoking onset, the consequences of smoking and refusal skills; and that the program should be socially and culturally relevant to each community. [44] It was also suggested that the delivery of classroom sessions be at least five times per year in the sixth through to the eighth grades; that the involvement of students in the presentation and delivery of the program be encouraged; that parental involvement be encouraged; and that there be adequate training of teachers involved in the program.[45]

3.41 US studies have shown that school-based smoking prevention programs identifying social influences that encourage young people to begin smoking and teaching skills to resist those influences have demonstrated consistent and significant reductions in the prevalence of adolescent smoking. One study examined 90 school-based prevention programs conducted during the period 1974 to 1989 that sought to develop skills to resist social influences. Results from the study indicated that smoking prevalence was on average 4.5 per cent lower among students in the social influence programs than among students in control conditions. In the most successful programs, the smoking prevalence was reduced by about 25 per cent.[46]

3.42 Most of the successful programs in the United States that provide skills for resisting social influences share several major curriculum components. One component is to convey the short-term negative consequences of smoking, including

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40 See Submission No. 56, p.2 (NSW Government); Submission No. 58, p.8 (Queensland Department of Health); Submission No. 38 p.7 (ACT Government). See also *Transcript of Evidence*, p.140 (Professor K. Jamrozik); *Transcript of Evidence*, p.868 (Queensland Cancer Fund).

41 *Transcript of Evidence*, p.140 (Professor K. Jamrozik).

42 *Transcript of Evidence*, p.679 (ASH Australia).

43 *Transcript of Evidence*, p.387 (AMA).

44 US Department of Health and Human Services, *op. cit.,* p.219.

45 *ibid.*

46 *ibid.,* p.225.

social undesirability and physiological impairment. Another component is to have students explore inaccurate normative expectations - students thus learn that smoking is not a 'usual' behaviour for adolescents their age and that the majority of persons in any age group are non-smokers. An additional component is to engage students in training, modeling and reinforcing methods that counter the influences that lead adolescents to smoke, and to coach students to communicate these techniques to others. Some approaches also include personal and social skills training to promote overall competence and reduce the motivations to smoke.[47]

3.43 The effectiveness of school-based smoking prevention programs appears to be enhanced and sustained by comprehensive school health education programs and by community-wide programs that involve parents, mass media, community organisations. In the United States, the positive effects of school-based smoking prevention programs tend to dissipate over time and need to be supplemented by other programs as noted above. One US study noted that 'programs grounded in school-based skills training are indeed important for preventing smoking, although more sustained and comprehensive efforts may be needed for long term success'.[48]

Conclusions

3.44 The Committee believes that there should be a greater emphasis on anti-smoking education programs in schools, including policies promoting a smoke-free environment in schools. The Committee considers that effective national education programs need to be developed for primary and secondary students and that teacher education programs need to be improved.

Recommendations

The Committee RECOMMENDS:

14. That national education programs be developed for primary and secondary school students and that these programs be regularly revised; and that these programs be based on the most recent research and evidence of the socio-economic, environmental, behavioural and personal factors identified as encouraging the take-up of tobacco use by young people, and the continuing use of tobacco by young people. The Committee further recommends that these programs include information on the dangers of passive smoking, particularly for young people.

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47 *ibid.,* pp.218-19.

48 *ibid.,* p.226.

15. That primary and secondary teachers, who will teach or are teaching health courses that include anti-smoking units, be funded by the Commonwealth Government as part of the National Drug Strategy to attend teacher education and in-service training sessions.

16. That school-based smoking prevention programs be encouraged and expanded; and that they be taught each year from at least Year 4 (about 9 years of age) to the end of secondary schooling.

17. That no smoking be permitted (including smoking by students, staff, parents and visitors) on any school premises; and that students who are found in breach of this be counselled, and supported through drug education and 'Quit' smoking programs.

Generic packaging

3.45 A number of contributors to the inquiry, including the AMA, Centre for Adolescent Health and the NSW Cancer Council, argued that cigarette manufacturers should be required to sell their products in neutral or generic packaging.[49] Generic packaging involves the use of simple, plain (black and white) packs containing the brand name, details of contents, a health warning together with the tar and nicotine content and the name of the manufacturer.[50]

3.46 Proponents of generic packaging argue that the current system of 'brand imaging' associated with the design and style of the packs increases the attractiveness of cigarettes for juveniles. One submission noted that brand imaging 'has created a very strong association between the appearance of the packaging and the image portrayed in advertising. This has created what could be called a "store in value" in the package design. The package design is, in itself, a form of advertising.'[51] A witness representing the Centre for Adolescent Health emphasised that the 'image on the pack' is one of the things that young people are buying, 'if you take away that association and make them look unattractive the likelihood of them initiating smoking would be significantly less. You decrease the general social acceptability of the product'.[52]

3.47 Another submission noted that the design of packs is a key component in the tobacco industry's effort to market its products to consumers and that each company

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49 *Transcript of Evidence*, p.385 (AMA); *Transcript of Evidence*, pp.102-4 (Centre for Adolescent Health); Submission No.53, pp.9-10 (NSW Cancer Council).

50 *Transcript of Evidence*, p.103 (Centre for Adolescent Health).

51 *ibid.,* p.102.

52 *ibid.,* p.123.

'will strive to develop and market pack designs that maximise the attractiveness of the pack to each brand's target markets'.[53]

3.48 Contributors to the inquiry cited several studies that showed that children find dull, bland 'generic' packs of cigarettes to be the least attractive and desirable when presented with a range of different packs.[54] The Centre for Behavioural Research in Cancer conducted research, asking children which type of packs they would be most comfortable with and would prefer to be seen with amongst their friends. The research showed that children like to be seen with the more glamorous looking packs rather than the plainer packs.[55] One witness cited a University of Otago study that showed that cigarettes were significantly less attractive to young people when boxed in plain generic packs.[56]

3.49 One submission from a tobacco company argued, however, that plain packaging may have the opposite effect to that intended by advocates of the proposal. It was argued that putting cigarettes in plain packaging may in fact enhance their appeal to juveniles by reinforcing the perception of smoking as an act of rebellion.[57] DHS&H also advised the Committee that Canadian research into generic packaging and research conducted by the Centre for Behavioural Research in Cancer in Australia recognised that, while the intent of generic packaging is to replace positive brand imagery with negative brand imagery, such packaging could in fact have the opposite effect.[58]

3.50 It was also put to the Committee that generic packaging would increase the efficacy of health warnings. One submission noted that neutral packaging would allow government health warnings to be more visible – 'there would be significantly less 'clutter' and less scope for the tobacco industry to disguise the health message by package design and colour schemes'.[59] One tobacco company, disputing these arguments, stated that there was no lack of awareness in Australia of the claimed health risks associated with smoking nor was there evidence to suggest that increasing the visibility of health warnings through plain packaging will influence smoking behaviour.[60]

3.51 Another major reason advanced by the proponents of generic packaging is that the introduction of plain packaging would lead to a reduction in tobacco

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53 Submission No.53, p.9 (NSW Cancer Council).

54 *ibid.*

55 *Transcript of Evidence*, p.272 (NSW Cancer Council).

56 *Transcript of Evidence*, p.123 (Centre for Adolescent Health).

57 Supplementary Submission No.45, p.5 (W.D. & H.O. Wills).

58 Letter from DHS&H to the Committee, dated 23 October 1995, p.14.

59 *Transcript of Evidence*, p.104 (Centre for Adolescent Health).

60 Supplementary Submission No.45, p.7 (W.D. & H.O. Wills).

consumption.[61] This argument is essentially an extension of the other arguments relating to the reduction of the 'glamorous' effect of branded packaging and increasing the prominence of the health warnings on packs and the effect that both would have on consumption.

3.52 Proponents of generic packaging did not provide conclusive evidence that the introduction would lead to a decrease in tobacco consumption amongst young people, and the industry disputed the claim that consumption is determined by the pack design. One submission noted that the relevance of branding and packaging is that it is a means by which smokers can make a choice between different tobacco products.[62]

3.53 The industry pointed out to the Committee that the proposal to require cigarettes to be sold in generic packaging would be a threat to the commercial value of brands to manufacturers. It was stated that brands are a valuable commercial asset owned by tobacco manufacturers because of the consumer goodwill and brand loyalty attached to them. Brands are also the means by which the manufacturers differentiate their products and compete for market share. One tobacco company stated that 'generic packaging would be tantamount to a confiscation of these valuable assets violating the legal and constitutional rights of the manufacturers who own them'.[63] It was also argued by one tobacco company that as the proposal would 'wipe out' the value of the Company's key commercial assets it would have 'little choice but to pursue a substantial claim for compensation'.[64]

Conclusions

3.54 The Committee received a range of often conflicting evidence on the efficacy of generic packaging. While some evidence suggested that generic packaging would reduce the attractiveness of cigarettes for children, other evidence raised some doubts concerning the effectiveness of this approach. The Committee believes that more research needs to be undertaken into the role generic packaging could play in an integrated strategy addressing the problem of adolescent smoking. The Committee considers that, on the basis of the evidence received, there is not sufficient evidence to recommend that tobacco products be sold in generic packaging.

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61 For a discussion of this issue see *ibid.,* p.7.

62 Supplementary Submission No.45, p.7 (W.D. & H.O. Wills).

63 *ibid.,* p.8.

64 *ibid.,* p.4.

Recommendation

The Committee RECOMMENDS:

18. That additional research be undertaken into the efficacy of generic packaging of tobacco products as a means of addressing the problem of juvenile smoking.

Point-of-sale advertising

3.55 Some evidence to the Committee, including submissions from the National Heart Foundation, AMA, ACOSH, and the Centre for Adolescent Health suggested that point-of-sale advertising by tobacco companies should be prohibited.[65]

3.56 As noted in Chapter 2, the *Tobacco Advertising Prohibition Act 1992* has now extended the prohibition of tobacco advertising to almost all forms of direct and indirect advertising and promotion, including sponsorship. Advertising is limited to the right of tobacco companies to place point-of-sale advertising material in retail outlets.

3.57 Point-of-sale material is regulated at both the Commonwealth and State levels. Since 1 October 1993, the Commonwealth has required that point-of-sale material should be within the boundaries of shops, should only be visible from display points within those shops and if placed on windows should face inwards.

3.58 In addition to these minimum requirements imposed by the Commonwealth, a number of States have imposed other restrictions. For example, in New South Wales and Western Australia there are detailed rules governing the location, size, visibility, format and the use of health warnings in relation to this form of advertising.[66] In New South Wales, the area of a tobacco advertisement is limited to 2 000 square centimetres per retail outlet. The maximum width of a tobacco advertisement must be not be less than half and not more than three and a half times the maximum height of the advertisement. In addition, twenty-five per cent of the area of each tobacco advertisement must display one of the four prescribed health warnings, such as 'Smoking Causes Lung Cancer'.[67] It has been argued that New South Wales has the most stringent restrictions on point-of-sale advertising in Australia.[68] Western Australia also has tight controls on this form of advertising, with regulations limiting

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65 Submission No.3, p.3 (National Heart Foundation); *Transcript of Evidence*, p.385 (AMA); Submission No.29, p.14 (ACOSH); *Transcript of Evidence*, p.101 (Centre for Adolescent Health).

66 Supplementary Submission No.45, p.1 (W.D. & H.O. Wills).

67 Letter from NSW Drug and Alcohol Directorate to the Committee, dated 23 November 1995, pp.4-7.

68 Health Department of Western Australia, *Submission to the Review of the Tobacco Control Act 1990*, December 1994, p.13.

the size and position of point-of-sale advertising and a requirement to display a health warning which is 25 per cent of the area of the advertisement.[69]

3.59 The tobacco companies argued that point-of-sale advertising should continue as it offered a means by which manufacturers could provide information to consumers about both existing products and new product lines. Such advertising also enabled companies to compete with each other for brand and market share amongst existing smokers.[70]

3.60 Proponents of a ban on this form of advertising noted that several major medical and consumer groups eg. WHO, World Health Assembly, the International Union Against Cancer and the International Organisation of Consumers' Unions have identified a ban on all forms of tobacco advertising as an essential component of a comprehensive smoking control program.[71]

3.61 It was also argued that it is inconsistent for the Government to have progressively prohibited most forms of advertising while permitting a continuation of point-of-sale advertising. It has also been claimed that allowing the continued promotion of tobacco products in this form undermines the credibility of government health education campaigns against smoking.[72]

3.62 Evidence to the Committee suggested that as children are often in close proximity to convenience stores, milk bars and corner shops where they often purchase cigarettes, they are in direct contact with point-of-sale advertising and can be influenced by the presence of such advertising material. One study, commenting on the influence of point-of-sale advertising, noted that for a 'brand loyal smoker', the reminder value of a point of sale display is low, 'therefore, to the extent that these displays focus on brand image, they may...encourage new smokers to experiment with a particular brand (and with its associated brand image)'. The study concluded that point-of-sale advertising is 'potentially directed at new, youthful smokers'.[73] DHS&H advised the Committee that point-of-sale advertising 'clearly provides a direct association between tobacco products and the images and symbolism associated with smoking in general and specific brands of tobacco'.[74]

3.63 One submission noted that elimination of tobacco promotion has been associated with a decline in tobacco consumption, especially among young people, for example, in New Zealand, Norway and Canada.[75] A study that analysed the

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69 *ibid.*

70 Supplementary Submission No. 45, p.2 (W.D. & H. O. Wills).

71 *Transcript of Evidence*, p.101 (Centre for Adolescent Health).

72 *ibid.,* p.102. See also Submission No.53, p.11 (NSW Cancer Council).

73 US Department of Health and Human Services, *op. cit.,* p.186.

74 Letter from DHS&H to the Committee, dated 23 October 1995, p.15.

75 *Transcript of Evidence*, p.102 (Centre for Adolescent Health).

relationship between tobacco advertising and tobacco consumption in 33 countries found that when the countries were grouped according to the degree of government restriction of tobacco promotion, the greater the degree of restriction, the greater the average annual decline in tobacco consumption by young people. The study found that those countries with total advertising bans (over the period 1970-86) have witnessed a decline in the proportion of youth who smoked by an average 2.7 per cent per year, as against an average decline of 1.6 per cent per year in countries which permitted tobacco advertising in most media.[76]

3.64 However, the relationship between advertising restrictions and decreases in teenage tobacco consumption was disputed by the tobacco companies. One company noted that in Australia, notwithstanding the imposition of advertising restrictions, the rate of juvenile smoking has increased.[77] The submission also noted that in several countries, such as Finland and Sweden, juvenile smoking had increased following the imposition of advertising bans.[78]

3.65 In the United States, over US$300 million was spent by the tobacco companies on point-of-sale advertising in 1990 (this figure represented only 10 per cent less than US$328 million spent on cigarette advertising in magazines that year).[79] It was also claimed that the tobacco companies in Australia have been investing large sums of money in point-of-sale advertising.[80] It was stated that the companies were 'testing the margins' of the various State and Territory provisions as to what is and is not permissible under the legislation.[81] Another submission noted that the tobacco companies operating in Western Australia and New South Wales have been designing new display cases and dispensing units to maintain as large a presence as possible in retail outlets in those states.[82]

Conclusions

3.66 The Committee notes that most forms of direct and indirect advertising have been prohibited in Australia with advertising now largely limited to advertising at point-of-sale. The Committee considers that, on the basis of the evidence received, point-of-sale tobacco advertising should be subject to comprehensive restrictions.

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76 The study noted that some of the decrease in teenage smoking in countries that ban advertising may also be due to health promotion policies, or to price policies in those countries. See NZ Toxic Substances Board, *op. cit.,* pp.64-65.

77 Supplementary Submission No.45, p.5 (W.D. & H.O. Wills).

78 *ibid.* See also Supplementary Submission No. 44, section 5 (Philip Morris).

79 US Department of Health and Human Services, *op. cit.,* p.186.

80 Submission No. 53, p.11 (NSW Cancer Council).

81 *ibid.*

82 Submission No.29, p.14 (ACOSH).

Recommendation

The Committee RECOMMENDS:

19. That comprehensive restrictions on the size, placement and format of point-of-sale advertising of tobacco products, similar to those applying in New South Wales, be applied in all States and Territories.

Other promotional activities

3.67 Some concern was raised during the inquiry by several groups, including the NSW Cancer Council and ASH Australia, at certain promotional activities conducted by tobacco companies, especially the use of 'premiums' or 'premium items'.[83] This involves giveaways of such items as key rings, cigarette lighters, pens or calendars with the purchase of cigarettes.

3.68 The groups concerned with these practices argue that the tobacco companies target children through these promotions. One witness provided an example of 'the cricket calendar that has two packets of *Benson and Hedges* stuck on the front: it pictures Shane Warne, who is every child's hero. I believe that that free gift – which after all you can purchase anywhere, for just two packs of cigarettes – is an inducement to children to smoke'.[84] Other examples were given of promotions that would appeal to young females, such as free diaries and the invitation to send away for *Dolly*-type magazines.[85]

3.69 The Committee also received evidence relating to the promotional activities by companies in certain Aboriginal communities in the Northern Territory.[86] A promotion by Philip Morris involved purchasers receiving a T-shirt (in some instances with the name of the local Aboriginal community) with the purchase of two packs of *Marlboro* cigarettes. One submission commenting on such promotion argued that it was an 'unscrupulous targeting of a community group known to have high levels of tobacco consumption and thus little motivation and knowledge on the health effects of tobacco products to challenge the practise'.[87] It was also noted that such promotions may undermine the health education activities amongst such communities.[88] Philip Morris responded to these concerns by arguing that the Northern Territory promotion was similar to other promotions throughout the country

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83 *Transcript of Evidence*, p.273 (NSW Cancer Council); *Transcript of Evidence*, pp.664-5 (ASH Australia).

84 *Transcript of Evidence*, p.665 (ASH Australia).

85 *ibid.*

86 Submission No.39, p.8 (Northern Territory Department of Health and Community Services); Submission No.20, p.5 (Northern Territory Tobacco Interest Group).

87 Submission No.39, p.8 (Northern Territory Department of Health and Community Services).

88 *ibid.*

and that in the instances where the name of the Aboriginal community was identified on the T-shirt the agreement of the local Aboriginal community was obtained.[89]

3.70 The tobacco companies claim that these types of promotions are not directed to adolescents. One company stated that the items sold with cigarettes 'are carefully chosen to ensure they appeal to persons 18 years of age and above'. The company explained the rationale for the use of premium items in the following terms '[it is] a marketing tool designed to reinforce our consumers' brand loyalty, and to attract smokers of opposition products…it is a method of rewarding our current smokers for choosing to smoke our brand and to illustrate to smokers of competitor products the rewards they can receive if they switch to our brand'.[90]

3.71 Evidence to the Committee suggests that the use of premiums is, at least to some extent, directed at the youth market. Material provided to the Committee by Philip Morris on its marketing activities associated with premiums showed that items such as lighters, caps, T-shirts and videos are provided with the sale of the brands of *Peter Jackson* and *Longbeach.* While the Company claims that their target market associated with these brands is 'adults' smoking their competitors brand cigarettes and/or blue collar smokers, surveys suggest that *Peter Jackson* is the brand most commonly reported to be smoked by teenage smokers (30 per cent of boys and 33 per cent of girls). *Longbeach* was the third most popular brand (smoked by 9 per cent of boys and 13 per cent of girls).[91] The Committee believes that items such as T-shirts, caps and lighters would have appeal to young people.

3.72 A recent United States report into youth smoking has also raised concerns about this type of promotional activity. The report stated that 'the distribution of free samples is one of the most powerful devices available to marketers. It allows a company to put its product into the hands of possible consumers in circumstances where consumers are more likely to try it (e.g, outside of work or school)…Although the cigarette manufacturers argue that samples are not intended for nonusers or minors, there is little evidence of distribution control'.[92] The importance of this form of marketing is reflected in the growth in expenditure on this form of promotion. In the United States, expenditure on the distribution of speciality or premium items increased from US$10 million in 1975 to over US$300 million in 1990.[93]

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89 Supplementary Submission No.44, section 8, p.2 (Philip Morris). For a further discussion of tobacco use amongst Aboriginals see Chapter 4.

90 Supplementary Submission No.44, section 8, p.1 (Philip Morris).

91 Letter from Philip Morris to the Committee, dated 13 April 1995, pp.7-8. See Hill, *op. cit.*, p.4.

92 US Department of Health and Human Services, *op. cit.*, p.186.

93 *ibid*.

Recommendation

The Committee RECOMMENDS:

20. That the distribution of non tobacco-related products associated with the sale of tobacco products be prohibited.

Product placement in films and television

3.73 Evidence to the Committee raised the issue of product placement in films and television and the effect that such practices may have on influencing young people to smoke.[94] Several witnesses noted that tobacco companies, especially in the United States, spend a large proportion of their promotional expenditures on product placement in television and films.[95] One witness stated that a tobacco company in the United States paid US$500 000 to have *Marlboro* cigarettes featured in the film *Superman: the Movie* – a film directed at the children's market.[96]

3.74 Another witness noted that it was 'essential that the insidious practice of product placement in movies and TV production is abolished or at least curtailed…by constant repetition, the use of cigarettes is likely, possibly in a subliminal way, to be accepted as the norm – particularly by those young enough to be more easily influenced, or possibly by lower socio-economic groups lacking objective information'.[97]

3.75 Several options were suggested to the Committee to address the issue of product placement in Australia. Some evidence to the Committee argued that there needs to be greater enforcement of the current laws regarding product placement in films and television. One witness stated that:

> If there is any evidence that money has changed hands from the tobacco industry or its various associated companies to people in films, television programs, plays or whatever, to have products depicted in the scenes, then that is a form of tobacco advertising and is contrary to the Act.[98]

3.76 DHS&H advised the Committee that in the 1995-96 Budget, funds were made available under the *Health Australia* program to enable comprehensive monitoring of

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94 *Transcript of Evidence*, p.636 (Non-Smokers Movement of Australia); p.851 (Queensland Cancer Fund).

95 See Submission No.53, pp.12-13 (NSW Cancer Council).

96 *Transcript of Evidence*, p.851 (Queensland Cancer Fund).

97 *Transcript of Evidence*, p.636 (Non-Smokers Movement of Australia).

98 *Transcript of Evidence*, p.274 (NSW Cancer Council).

compliance with the Act.[99] It was suggested that DHS&H undertake a random audit of recently produced films and television programs to determine whether money from tobacco companies has been used, directly or indirectly, to promote smoking and/or tobacco products and that prosecutions be initiated if breaches of the law have occurred.[100] A representative of the Department noted, however, that securing sufficient evidence to initiate prosecutions regarding product placement in films and television would be difficult. The official stated 'we would dearly love to have evidence that someone is being paid so that we could do something about that. But it is not going to be something that will be easily provided'.[101]

3.77 The *Tobacco Advertising Prohibition Act 1992* provides for the prosecution of any manufacturer who provides financial inducements to include product placement relating to tobacco products in mediums such as television or film.[102] DHS&H advised that the Commonwealth has not initiated any prosecutions of this nature to date.[103] One submission noted that a central consideration 'must be whether or not the appearance of smoking in films has been commissioned' as commissioned product placement is a form of tobacco advertising and as such is in breach of the Act.[104] Imported films with tobacco product placement and magazines imported into Australia that contain tobacco advertising are exempt from the Act.

3.78 Several witnesses noted that there are problems related to artistic freedom and censorship in moves to restrict product placement in films and television. DHS&H noted in its submission that the rationale for the current legislation was to 'avoid infringing freedom of creative expression; to ensure that the Australian film industry is able to compete on an equal footing in an international market; to ensure film, and creative material is unabridged, that is, not subject to censorship of tobacco issues; and to ensure community access to international films [and] television'.[105]

3.79 Anti-smoking groups also acknowledged problems related to this issue. For instance, the Queensland Cancer Fund noted that 'there is a problem in drawing the line between freedom of artistic expression on the one hand and utilisation of these media for exploitation of smoking among children on the other. We do not have a panacea for that problem'.[106]

3.80 Other problems relating to the increasing reach of information technology, such as satellite television, information available on the Internet etc. and the impact

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99 Letter from DHS&H to the Committee, dated 23 October 1995, p.15.

100 Submission No.53, p.14 (NSW Cancer Council).

101 *Transcript of Evidence*, p.36 (DHS&H).

102 *ibid.*

103 Letter from DHS&H to the Committee, dated 23 October 1995, p.15.

104 Submission No.53, p.13 (NSW Cancer Council).

105 Submission No.27, section.4.42 (DHS&H).

106 *Transcript of Evidence*, p.858 (Queensland Cancer Fund).

that this will have on the promotion of tobacco products, especially to young children, was also raised during the inquiry. One witness conceded that it will be 'extremely difficult' to limit the impact of international advertising and information generally on young people who will be exposed to in the future. However, there was a need for Governments to take action to address the problem – 'it may be impractical. It may be impossible to stop all of it… [but] we need, in this country, to start to take a lead in getting other countries to recognise that this is even a problem'.[107]

3.81 It was suggested that Australia should take the lead in encouraging tobacco control charters, international treaties and the like through such institutions as the United Nations. One witness noted that there is now in place an international agreement that all airlines will become smoke-free.[108] One submission argued that tobacco advertising on satellite television could be controlled by amending the Broadcasting Television Act to prohibit tobacco advertising in programs beamed either into Australia or produced in Australia and beamed to other countries. Alternatively, it was argued that separate legislation could be introduced to control tobacco advertising appearing on satellite broadcasted programs.[109]

3.82 Several witnesses suggested that Commonwealth grants to the film industry should only be made under certain conditions related to how such films portrayed smoking and tobacco products generally. One witness suggested that if smoking was portrayed in such films it should be portrayed in a 'realistic' manner.[110] Another witness commented that the 'image' of cigarette smoking in films is being increasingly portrayed as being 'acceptable behaviour'. The witness cited the case of *Muriel's Wedding*, a film supported by Commonwealth funding through the Australian Film Board.[111]

3.83 Other witnesses suggested that greater efforts should be made to raise awareness within the film and television industry of the requirements under the Act in relation to product placement and issues generally relating to the promotion of tobacco products through these mediums, however indirectly.[112] One witness stated that some actors who were required to smoke in films had expressed to him feelings about 'how uncomfortable they felt about it and the moral dilemma about artistic freedom versus the example that they are setting and so forth'.[113]

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107 *Transcript of Evidence*, p.402 (AMA).

108 *Transcript of Evidence*, p.151 (Professor K. Jamrozik).

109 Submission No.51, p.6 (Health Department of Western Australia).

110 *Transcript of Evidence*, p.859 (Queensland Cancer Fund).

111 *Transcript of Evidence*, p.123 (Centre for Adolescent Health).

112 *Transcript of Evidence*, p.89 (Anti-Cancer Council of Victoria); Submission No.53, pp.13-14 (NSW Cancer Council).

113 *Transcript of Evidence*, p.276 (NSW Cancer Council).

3.84 The Committee believes that there needs to be more debate in the community on this issue and that the film and television industry needs to be made more aware of concerns expressed by many within the industry and the community generally. One submission raised the possibility of introducing a film classification system based on whether films portrayed smoking in a positive light or not, similar to the way in which films depicting illicit drug use are now rated M or R.[114]

Conclusions

3.85 The Committee considers that the current legislation providing for the prosecution of manufacturers who provide financial inducements relating to tobacco products should be vigorously enforced. The Committee also believes that increased efforts should be undertaken by the Department of Human Services and Health, especially through the provision of information to the industry, to raise the awareness of the film and television industry of the requirements under the Act regarding product placement and issues relating to the promotion of tobacco products through film and television. The Committee understands that the Department has initiated contact with the relevant industry bodies to ensure compliance with the legislation.[115]

3.86 The Committee recognises that there are issues relating to artistic freedom and censorship in any moves to restrict product placement in films and television and considers that education of the industry and enforcement of the current legislation should be a major priority to ensure a responsible approach.

Taxation

3.87 Several contributors to the inquiry, including the AMA, Australian Cancer Society, National Heart Foundation and ACOSH argued that increases in the level of taxation on tobacco products were needed to discourage young people from smoking.[116] A representative of the AMA stated 'we feel that taxation is an important and responsible mechanism for governments to use in reducing the use of tobacco'.[117]

3.88 Several groups also argued that the Commonwealth and State and Territory Governments should ensure that there are regular real increases in tobacco taxes. For example, the Australian Cancer Society argued that the Commonwealth Government should increase the excise duty on cigarettes by 5 per cent per annum above the CPI-indexed increases that now apply, thus increasing the price of tobacco products in

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114 Submission No.53, p.13 (NSW Cancer Council).

115 Letter from DHS&H to the Committee, dated 23 October 1995, p.15.

116 *Transcript of Evidence*, p.398 (AMA); Submission No.40, p.3 (Australian Cancer Society); Submission No.42, p.5 (National Heart Foundation); Submission No.29, p.14 (ACOSH).

117 *Transcript of Evidence*, p.398 (AMA).

real terms; and that State and Territory Governments should increase the rate of their tobacco franchise fees.[118]

3.89 Tobacco is taxed at the Federal level in the form of excise duties on the weight of tobacco and at the State and Territory level in the form of business franchise fees on wholesale sales.[119]

3.90 Evidence to the Committee suggested that teenagers will reduce their consumption of cigarettes in response to price increases in tobacco products. A representative of the AMA stated that 'it is generally accepted – and much of the work on this comes from the United States – that a ten per cent increase in the price generally results in a four per cent reduction in consumption across the board, and in a fourteen per cent reduction in uptake by children, who are most sensitive to price increases'.[120] Other evidence, cited by the Queensland Cancer Fund, showed that in Canada, where the real price of cigarettes increased by 158 per cent from 1979 to 1991, teenage tobacco use by 15- to 19-year-olds fell by two thirds over the same period.[121] A representative of the Queensland Cancer Fund, commenting on these figures, noted that while pricing policy 'is a blunt instrument...it is also singularly effective. If governments are serious about dropping teenage smoking rates, as the Canadians are, then taxation policy is very, very effective'.[122]

3.91 Studies that have examined the relationship between taxation increases and the demand for tobacco products by teenagers have generally found that teenagers are a very price-sensitive group and particularly more sensitive to price changes than adults. One study reported that adolescents aged 12 to 17 years would reduce their cigarette consumption proportionately to any increase in cigarette price.[123] The Industry Commission report, summarising a number of studies noted that 'there is

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118 Submission No.40, p.7 (Australian Cancer Society).

119 The current rate of Commonwealth excise is $79.02 per kilogram of tobacco. Since February 1984, the excise rate has been indexed to movements in the Consumer Price Index (CPI) on a six monthly basis. However, since 1988 the rate of excise has increased at a faster rate than the CPI. In the 1995-96 Budget the Commonwealth Government announced a 10 per cent increase in the rate of tobacco excise. This increase comprised the bringing forward from 1 August 1995 of a 5 per cent discretionary increase announced in the 1993-94 Budget and an additional 5 per cent increase included in the May 1995 Budget. As noted above, all States and Territory Governments levy taxes on the sale of tobacco products in the form of business franchise fees. The tax is levied as a percentage of the wholesale value of tobacco products. The rate currently applying in all States and Territories is 100 per cent of the value of sales (except Queensland, where the rate is 75 per cent of the value of sales). See Industry Commission, *The Tobacco Growing and Manufacturing Industries*, AGPS, Canberra, 1994, pp.87-88; Tobacco Institute of Australia, *Tobacco Industry Fact Sheet*, 11 October 1995.

120 *Transcript of Evidence,* p.389 (AMA).

121 *Transcript of Evidence*, pp.829-32 (Queensland Cancer Fund).

122 *ibid.,* p.866. See also US Department of Health and Human Services, *op. cit.,* p.273.

123 W. K. Viscusi, *Smoking: Making the Risky Decision*, Oxford University Press, New York, 1992.

some evidence from these studies to suggest that price has a greater effect on the teenage population than on older people, by influencing the decision to smoke'.[124]

3.92 A US Surgeon-General's report into adolescent smoking concluded that 'the large amount of empirical literature on the relationship between cigarette prices and cigarette smoking suggests that increased excise taxes on cigarettes reduce overall cigarette smoking…The price responsiveness of adolescents is at least as high, if not significantly higher, than that of adults – a finding that suggests that an increase in cigarette taxes would result in large reductions in smoking prevalence and cigarette consumption among teenagers'.[125]

3.93 Evidence also suggests that increasing taxation levels is effective in reducing teenage and aggregate smoking levels in the future. One study noted that 'it is quite possible that the cohort of young smokers who never began to smoke as a result of the tax increase would never become regular smokers. As a consequence, over a period of several decades, aggregate smoking and its associated detrimental health effects would decline substantially'.[126] Another study also states that 'an excise tax increase, if maintained in real terms, might continue to discourage smoking participation by successive generations of teenagers and young adults and gradually impact on the smoking levels of older age groups as the smoking-discouraged cohorts move through the age spectrum'.[127]

3.94 Available data suggest that there is some scope for taxation increases as the tax incidence on cigarettes in Australia is relatively low when compared with some overseas countries.

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124 Industry Commission, *op. cit.,* Appendix O, p.6.

125 US Department of Health and Human Services, *op. cit.,* p.272.

126 E. M. Lewit *et al.,* 'The Economics of Government Regulation on Teenage Smoking', *Journal of Law and Economics*, Vol.24, 1981, p.568.

127 E. M. Lewit and D. Coate, 'The Potential for Using Excise Taxes to Reduce Smoking', *Journal of Health Economics*, Vol.1, 1982, p.143.

Table 9
Tax incidence on cigarettes in selected countries (a)
(as of March 1995)

Country	Tax incidence %	Country	Tax incidence %
Denmark	85	Sweden	69
	81	Luxembourg	69
United Kingdom	77	New Zealand	68
Ireland	76	Norway	68
France	75	Canada (average of provinces)	64
Belgium	75	Australia (b)	64
Finland	74	Japan	60
Italy	73	Korea	60
Greece	72	Hong Kong	51
Netherlands	72	Switzerland	50
Germany	72	Taiwan	47
Argentina	70	USA (average of states)	30
Spain	70		

(a) Refers to the tax incidence on a pack of 20 cigarettes.
(b) Data relate to May 1995 and include all States/Territories, except Queensland.

Sources: Anti-Cancer Council of Victoria and Department of the Parliamentary Library.

3.95 As the table shows, the tax incidence, especially in a number of European countries, is considerably higher than in Australia. Denmark imposes the highest taxes on cigarettes, with Australia ranking in the middle range of countries in relation to the taxation of cigarettes.[128]

Consumer Price Index

3.96 Evidence received from several contributors, including Professor Nossal, the Australian Cancer Society and the National Heart Foundation argued that tobacco should be removed from the basket of goods used in the calculation of the Consumer Price Index (CPI).[129] Other evidence, however, did not support this proposal. One submission noted that tobacco products form a significant proportion of household expenditure and are an important item of consumption for a large proportion of

128 See also *Transcript of Evidence*, pp.665-68 (ASH Australia).

129 Submission No.63, p.1 (Professor Nossal); Submission No.40, p.7 (Australian Cancer Society); Submission No.42, p.5 (National Heart Foundation).

Australian households – therefore their exclusion from the CPI would distort the index.[130]

3.97 It was also noted that the index, if it is to accurately measure changes in the prices of goods and services, needs to reflect the actual purchasing patterns of Australian households. One submission stated that 'any adjustment of the CPI, either to the respective weights of the existing basket or to the goods and services in the basket, should continue to be based on an objective assessment of the current expenditure patterns of Australians'.[131]

3.98 The composition of the CPI is based on the 'average' pattern of household expenditure. Expenditure items (eg. tobacco products) are given a 'weighting' or measure of their relative importance as expenditure items. The fact that tobacco is used by less than one-third of the population is taken into account in the calculation of the weighting given to this item. From time to time the CPI basket of goods and services is revised to ensure that it continues to reflect the actual spending patterns of the population.[132] The current 'weighting' given to cigarettes and tobacco (of 2.4 per cent) in the calculation of the CPI is significant, and exceeds the weighting given to several other individual items, including fuel and light charges and holiday travel costs.[133]

3.99 Evidence arguing for the removal of tobacco products from the CPI suggested that its removal would be appropriate given that it is a product currently used by less than a third of the adult population.[134] One study has noted the shift in tobacco use 'towards being a minority discretional expenditure'.[135]

3.100 Professor Nossal also argued that such a move would provide an incentive for governments to raise excise, unlike the current arrangements where an increase in the retail price of cigarettes is reflected in the CPI and, consequently, in the inflation rate. By removing tobacco products from the calculation of the CPI, the impact of any tax increases on these products would not be reflected in the CPI nor in the inflation rate. A representative of the AMA, supporting the change, noted that it would send a signal to smokers by facilitating price increases for tobacco products.[136]

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130 For example, some 38 % of semi- and unskilled workers, and 28% of skilled tradesmen smoke. See Supplementary Submission No.44, section 4, p.1 (Philip Morris).

131 *ibid.,* p.2.

132 ABS, *A Guide to the Consumer Price Index*, AGPS, Canberra, 1993, pp.1-3.

133 *ibid.,* pp.11-14.

134 Submission No.40, p.7 (Australian Cancer Society).

135 A. Herington, 'The Relationship Between Tobacco Prices, Taxation and Consumption in Australia' in B. Durston and K. Jamrozik (eds.), *Tobacco and Health 1990: The Global War,* Health Department of Western Australia, Perth, 1990, p.780.

136 *Transcript of Evidence*, p.400 (AMA).

Recommendations

The Committee RECOMMENDS:

21. That the Commonwealth, State and Territory Governments ensure that there are regular real increases in levels of excise duties and business franchise fees levied on tobacco products; and that the revenue from these taxation increases be directed to tobacco control and health promotion activities.

22. That tobacco products be removed from the basket of goods used in the calculation of the Consumer Price Index.

Restricting the sale of tobacco products to minors

3.101 Reducing the availability of tobacco products to minors is important for a number of reasons. Making cigarettes more difficult to obtain makes it less likely that young people will experiment with smoking at an early age and less likely that they will become regular smokers. Restricting access to tobacco products may also deter those young people unwilling to break laws to obtain tobacco and will add to the perceived social unacceptability of tobacco use. Controlling the sale of tobacco products to minors also emphasises the dangerous nature of tobacco products. These control measures also reinforce the messages about the potentially harmful nature of tobacco that young people receive in school and other settings.

3.102 During the inquiry the Committee received evidence that minors are able to obtain cigarettes relatively easily from a wide variety of sources and that present arrangements for addressing the problem of the purchase of tobacco products by minors is inadequate in most jurisdictions across the country.[137] A number of measures were proposed during the inquiry to address the issue of the sale to minors. These issues, which are discussed below, include the requirement for a minimum age for the purchase of tobacco products, restricting the number of retail outlets, improving retailer education, addressing the problem of vending machines and improving enforcement and compliance.

Minimum legal age for the purchase of tobacco products

3.103 The minimum legal age for the purchase of tobacco products is 18 years in all States and Territories, except in Queensland and Tasmania where the minimum legal age is 16 years. The Committee was advised that in Queensland, legislation to increase the minimum legal age from 16 years to 18 years is planned to be introduced

137 Submission No.53, p.14 (NSW Cancer Council).

in 1996.[138] In Tasmania there are currently no plans to raise the age from 16 to 18 years.[139]

3.104 The Committee believes that a standard minimum age of 18 years for the purchase of tobacco products should be introduced in all States and Territories. The Committee considers that it would be desirable to introduce uniformity across all States and Territories, especially as the age of 18 years has been adopted in most jurisdictions. It would also introduce consistency with the minimum age for the purchase of alcohol, which is 18 years. In the United States, all 50 States and the District of Columbia have adopted a minimum age of 18 years for the sale of tobacco products.[140]

3.105 The Committee also believes that it is important to take action to discourage children and adolescents from smoking until they are more mature and capable of making informed and rational decisions as adults. The Committee notes that the tobacco industry has also advocated establishing a uniform minimum age of 18 years for the purchase of tobacco products by juveniles across all States and Territories.[141]

3.106 The Committee also believes that the State and Territories should investigate the feasibility of making it an offence for persons under the age of 18 years to purchase tobacco products. The Committee considers that in order to encourage compliance with the law there is a need to have some penalty in place in order to deter children and adolescents from attempting to purchase tobacco products. The introduction of such a measure would encourage individual responsibility by children and adolescents and remove the onus on proprietors from accepting full responsibility for the sale of tobacco products to minors, as is the case at present.

Recommendation

The Committee RECOMMENDS:

23. That the minimum age for the purchase of tobacco products be 18 years in all States and Territories; and that the States and Territories investigate the feasibility of making it an offence for persons under the age of 18 years to purchase tobacco products.

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138 Advice from the Queensland Department of Health, 24 October 1995.

139 Advice from the Tasmanian Department of Community and Health Services, 24 October 1995.

140 US Department of Health and Human Services, *op. cit.,* p.249.

141 Submission No.45, p.16 (W.D. & H.O. Wills); *Transcript of Evidence*, p.453 (Tobacco Institute of Australia).

Proof-of-age

3.107 During the inquiry it was argued that one means of discouraging sales to minors would be to require some form of proof-of-age for young people purchasing tobacco products. The proposal to require proof-of-age recognises that it is often difficult for retailers and their staff to accurately determine the age of younger customers. Wills proposed that the ID card system currently used for purchases of alcohol should be extended on a national basis for the purchase of tobacco products.[142] The Committee was advised that this proposal is being considered by the NSW Government.[143]

3.108 The Working Group of State Attorneys General in the United States has recommended that proof-of-age, in the form of a reliable form of photographic identification such as driver's licence, State-issued identification card or passport, be required before cigarettes are sold to persons who appear to be 25 years or younger.[144]

3.109 The Committee believes that a suitable form of identification, such as a driver's licence, 18+ card etc., should be required to be produced by adolescents purchasing tobacco products. The Committee recognises that problems may arise where younger staff, especially those under the age of 18 encounter minors, (who in some cases may be friends or peers), seeking to purchase cigarettes. However, the Committee believes this problem can be overcome by younger staff being instructed by store supervisors to request proof-of-age from those customers who appear under 18 years of age, or to refer these customers to the supervisor.

Recommendation

The Committee RECOMMENDS:

24. That an appropriate form of proof-of-age identification be automatically required for young people purchasing cigarettes.

Restricting the number of retail outlets

3.110 Some evidence to the Committee suggested that the availability of cigarettes to juveniles could be reduced if the numbers of retail outlets selling tobacco products were reduced. Currently tobacco products are sold in a variety of outlets including tobacconists, supermarkets, milk bars, service stations, newsagents and convenience

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142 Submission No.45, pp.16, 20 (W.D. & H.O. Wills).

143 *Transcript of Evidence*, p.538 (W.D. & H.O. Wills).

144 The Working Group proposed that proof-of-age be required for persons aged 25 years or younger because of the difficulty retailers face in accurately determining the age of customers. See Working Group of State Attorneys General, *No Sale: Youth, Tobacco and Responsible Retailing*, December 1994, p.32.

stores. Several submissions proposed that the sale of tobacco products should be restricted to licensed premises and to tobacconists.[145] One submission also suggested that there be a moratorium on the granting of any further tobacco licences.[146]

3.111 Retail organisations were opposed to restrictions on the type or number of outlets permitted to sell tobacco products.[147] The Federation of Australian Retail Tobacco Trade Associations noted that such restrictions would deprive many retail outlets of a significant source of their income. The Federation stated that 'in some cases the loss of the right to sell these products would be catastrophic. In others, it would mean loss of income and possible reductions in staff numbers'.[148]

3.112 Another submission provided data on the importance of tobacco sales to many businesses. For tobacconists, tobacco sales constitute 85 per cent of total dollar turnover. Corresponding percentages for other types of retail outlets are – service stations (40 per cent), convenience stores (30.5 per cent), milk bars (25 per cent), and grocery stores, including supermarkets (8 per cent).[149]

3.113 Some evidence from the retail sector suggested that reducing the number of retail outlets may not lead to a reduction in juvenile tobacco consumption. One submission noted that under-age smokers will still be able to obtain cigarettes through older friends, siblings and often parents who are prepared to purchase on their behalf.[150] The submission also noted that juvenile alcohol use is still a major problem yet all alcohol is sold through licensed outlets.[151] The Federation of Australian Retail Tobacco Trade Associations noted that there has already been a substantial reduction in the number of outlets selling tobacco products – from around 60 000 in 1965 to 40 000 in 1995.[152]

3.114 Those advocating restrictions on the number of tobacco outlets argue that the present arrangements for the 'anywhere, anytime, by anybody' tobacco sales policy is 'antithetical to government policy on reducing smoking in the community'.[153]

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145 Submission No.41, p.9 (ASH Australia); Submission No.53, p.16 (NSW Cancer Council); Submission No.51, p.7 (Health Department of Western Australia).

146 Submission No.53, p.16 (NSW Cancer Council).

147 See Submission No. 66, p.1 (Federation of Australian Retail Tobacco Trade Associations); Submission No. 68, p.4 (WA Tobacco Retailers' Association); Submission No. 67 (Convenience Stores Australasia); Submission No. 70 (Newsagents Association of NSW and ACT).

148 Submission No.66, p.1 (Federation of Australian Retail Tobacco Trade Associations).

149 Supplementary Submission No.44, section 11, p.1 (Philip Morris).

150 Submission No.66, p.1 (Federation of Australian Retail Tobacco Trade Associations).

151 The Committee notes, however, that reducing the number of outlets may reduce juvenile alcohol abuse.

152 The Association noted that this decline is due to a reduction in the number of corner stores with the advent of regional shopping centres, reduction in the number of service stations and increasing volume through major chains. See Submission No. 66, p.1 (Federation of Australian Retail Tobacco Trade Associations) p.1.

153 Submission No.53, p.16 (NSW Cancer Council).

Another submission noted that it is not surprising that recruitment of children as smokers is increasing when 'tobacco products are as ubiquitous as milk and bread'.[154]

3.115 The Committee believes that the widespread availability of tobacco products through the vast number of retail outlets has provided a relatively easy way for minors to obtain cigarettes. One study has shown that the most common outlets for self reported illegal purchase of cigarettes by minors in NSW were small general stores (31 per cent), petrol stations (23 per cent), milk bars (18 per cent), and supermarket chains (14 per cent).[155] This is confirmed by overseas evidence. In the United States, small stores and petrol stations are the major source of cigarettes for underage buyers.[156]

3.116 The Committee believes that minors will be discouraged from purchasing cigarettes if the number of retail outlets is reduced. As a preliminary measure, the Committee believes that tobacco products should be isolated from other products in retail outlets selling tobacco products. In the longer term, the Committee considers that retail outlets permitted to sell tobacco products should be restricted to licensed premises and to tobacconists. To minimise disruption to small business, the Committee believes that this latter proposal should be phased in over time.

Recommendation

The Committee RECOMMENDS:

25. That there be a reduction in the number of retail outlets permitted to sell tobacco products and that:

    - as an interim measure, tobacco products be isolated from other products for sale in all outlets currently selling tobacco products; and
    - in the longer term, those retail outlets permitted to sell tobacco products be restricted to licensed premises and to tobacconists; and that this be phased in to minimise any disruption to small business.

Operation of the licensing system

3.117 Some groups, including the AMA and the Non-Smokers Movement of Australia argued that licensing arrangements for the sale of tobacco products could be improved.[157] All States and Territories, except Queensland, require tobacco

154 Submission No.41, p.9 (ASH Australia).

155 R. Sanson-Fisher et al., 'Availability of Cigarettes to Minors', *Australian Journal of Public Health*, vol. 16, No. 4, 1992, p.356.

156 US Department of Health and Human Services, *op. cit.,* p.248.

157 *Transcript of Evidence*, p.389 (AMA); *Transcript of Evidence*, p.648 (Non-Smokers Movement of Australia).

retailers to be licensed to sell tobacco products; in Queensland wholesalers are required to be licensed.[158] It has been argued that introducing a licensing system creates a 'negative social environment' for tobacco, whereby cigarettes are considered to be a controlled substance rather than a commodity. In addition, the threat of losing a licence would encourage supervisors to inform employees of their responsibilities and insist on compliance with the law.[159] One witness noted that 'you have to register the tobacconists, and you have to make sure that, if they lose their licence, they cannot sell, so that they have a strong financial disincentive to losing their licence'.[160]

3.118 The operation of licensing systems in the States and Territories, however, has shown that they have not been fully effective. It has been found that monitoring of licence holders in several States has been difficult due to the number and type of retail outlets.[161] It was noted in the case of Queensland that the option of introducing a tobacco retail licence was not favoured unless the number and type of retail outlets were substantially reduced.[162]

3.119 The problems of operating a licensing system is illustrated in the case of the ACT. While a licensing system operates in the ACT there is no restriction on the type of outlet that can apply for a licence and the system has largely operated as a revenue-raising function. A representative of the ACT Government stated that 'the licensing system is mainly there to collect franchise fees so that we keep track of who is selling tobacco in the ACT. Historically, providing a licence for tobacco retailers has not been done from a health context; it is just registering a business that wants to sell tobacco products. There has been no concept of restricting outlets from a health perspective'.[163]

3.120 The Committee notes that some problems associated with the operation of licensing systems outlined above, especially monitoring retail outlets for compliance, could be overcome by restricting the number of retail outlets permitted to sell cigarettes (this issue has been addressed in the previous section).

3.121 It has been noted that a flaw in many States' current laws is that they do not clearly impose any sanction on the stores that sell tobacco products to minors. Only in New South Wales, Victoria and South Australia are tobacco licences used for penalty

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158 Advice from the Federation of Australian Retail Tobacco Trade Associations, 27 October 1995.

159 For a discussion of these issues see additional information from the Queensland Department of Health to the Committee, dated 23 March 1995, p.31.

160 *Transcript of Evidence*, p.648 (Non-Smokers Movement of Australia).

161 Additional information from the Queensland Department of Health to the Committee, dated 23 March 1995, p.31.

162 *ibid.*

163 *Transcript of Evidence*, p.313 (ACT Government).

reasons (i.e. licence suspension).[164] In the United States, only 14 States provide for the revocation of a licence as a penalty for non-compliance with laws regarding tobacco sales to minors. The Committee believes that the States' and Territories' legislation should ensure compliance with legislation relating to the sale of cigarettes to minors through suspension or revoking of licences.

Recommendation

The Committee RECOMMENDS:

26. That the licensing systems in all States and Territories provide for the suspension or revocation of a licence where retail outlets sell tobacco products to minors.

Retailer education

3.122 Research indicates that educating retailers about the law reduces illegal sales of tobacco sales to children and adolescents.[165] A number of States have introduced measures specifically directed at retailers. In New South Wales, information is provided to retailers by environmental health officers to ensure their compliance with the Act.[166]

3.123 In Western Australia , the retailer education component of that State's efforts to reduce sales to minors aims to raise retailer awareness of their responsibilities under the law and to provide practical advice and resources to minimise the likelihood of tobacco being sold to a minor. Retailer education is also seen as an essential precursor to enforcement, demonstrating to retailers and the community that a co-operative approach to obtain compliance has been tried before resort to other measures.

3.124 In Western Australia, the Health Department periodically sends all retailers explanatory letters, pamphlets addressing common queries received from retailers, material detailing practical tips for minimising the chance of selling tobacco to under-age persons, and in-store signage. In 1993 store signage was redesigned to include a statement that proof-of-age may be required for tobacco purchases, and a cash register/counter sticker that prompted the sales person was produced. Advertisements about the illegality of selling tobacco to children have also been placed in retail magazines and trade journals.[167] The maximum penalties for the sale of tobacco

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164 Additional information from the Queensland Department of Health to the Committee, dated 23 March 1995, p.5.

165 Additional information from the Health Department of Western Australia to the Committee, dated 23 March 1995, p.9.

166 *Transcript of Evidence*, pp.706-7 (NSW Department of Health).

167 Additional information from the Health Department of Western Australia to the Committee, dated 23 March 1995, pp.9, 49.

products to minors in Western Australia are $5000 for an individual and $20 000 for a body corporate for a first offence and $10 000 for an individual and $40 000 for a body corporate for a second and subsequent offence.[168]

3.125 When the Health Department receives a complaint about a particular store, a letter is sent to the store informing them that a complaint has been received, and reminding them of their legal responsibilities and the penalties involved. The Department noted that these warning letters have 'proved a strong motivator for retailers to reconsider their practices regarding selling tobacco to children. Retailers who have not previously thought about not selling tobacco to children, now think twice, and many more are reminding staff about their policies on demanding proof-of-age for all young people'.[169]

3.126 The Department has also instituted a system of rewarding responsible retailers who conscientiously refuse to sell cigarettes to young people. Retailers receive a 'responsible retailer' sticker and the Department generates positive publicity for the store for not supplying cigarettes to children. The Department encourages schools, parents and regional Health Department personnel to identify local retailers who are eligible for this award.[170]

3.127 The Department also noted that retailers learn by example and that 'their motivation not to sell tobacco to children is reinforced every time they hear through the retailer grapevine or media that another retailer has been prosecuted and fined for selling tobacco to a child'.[171]

3.128 Surveys commissioned by the Western Australian Health Department indicate that between 1992 and 1994 the proportion of retailers prepared to sell cigarettes to young people had dropped significantly from 89 per cent to 28 per cent over that period – a decline of 61 per cent.[172] The Department noted that the significant change in retailers' attitudes and practices to the sale of cigarettes to minors was due to the Department's comprehensive approach of education, enforcement, publicity and positive reinforcement of responsible retailers.

3.129 The Committee believes that more emphasis needs to be placed in the important area of retailer education. The Federation of Australian Retail Tobacco Traders Associations stated in its submission to the Committee that, with the possible exceptions of Western Australia and New South Wales, throughout Australia there is

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168 Health Department of Western Australia, *Submission to the Review of the Tobacco Control Act 1990,* p.48.

169 Additional information from the Health Department of Western Australia to the Committee, dated 23 March 1995, p.49.

170 *ibid.,* p.50.

171 *ibid.,* p.49.

172 *ibid.,* p.50.

a distinct apathy in government toward education of retailers.[173] Another submission noted that retail education programs should be more widely promoted, that retailers should be advised of their responsibilities and be provided with relevant information kits and that a system of warnings and appropriate penalties should be introduced where retailers have knowingly supplied cigarettes to minors.[174]

Recommendation

The Committee RECOMMENDS:

27. That State and Territory Governments, in co-operation with the appropriate retail trade associations, expand their education programs directed at retailers.

Access to vending machines

3.130 Regulations on the placement of vending machines varies throughout Australia. Vending machines are restricted to licensed premises in South Australia and the ACT and to licensed premises and staff amenity areas in New South Wales, Victoria and Western Australia. In Tasmania they are restricted to areas supervised by an adult. In Queensland, vending machines owned or operated by tobacco companies are restricted to areas which are licensed, staff amenity areas, or areas supervised by an adult. The location of independently owned and operated machines in Queensland is not restricted. In the Northern Territory there is no restriction on where vending machines may be located.[175]

3.131 While the location of vending machines is restricted to areas in which children and adolescents are not permitted without adult supervision in all States and Territories except the Northern Territory, they still provide a relatively easy source of access for cigarettes for young children and adolescents. Overseas studies show that whereas children and adolescents may be successful in attempting to purchase cigarettes some of the time in over-the-counter sales, they are successful in purchasing cigarettes from vending machines on most occasions. Studies in Australia confirm these findings. A survey in South Australia found that 12- to 14-year-olds were successful in buying cigarettes on every attempted occasion irrespective of where the vending machines were located. A recent survey in Queensland also showed that adolescents were able to purchase cigarettes from vending machines in 97 per cent of attempted purchases.[176]

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173 Submission No.66, p.2 (Federation of Australian Retail Tobacco Trade Associations).

174 Submission No.67, p.6 (Convenience Stores Australasia). See also recommendation number 25 proposing a reduction in the number of retail outlets.

175 Additional information from the Queensland Department of Health, 23 March 1995, p.13.

176 *ibid.,* pp.13-14.

3.132 A number of options are available for dealing with the issue of access to vending machines by children. These options include the use of some form of locking device or token system which requires the purchase of a token from an adult in order to use the machines; restrictions on access to adult only areas; and the banning of vending machines entirely.

3.133 In relation to the first option, an evaluation of the long-term effectiveness of locking devices in the United States found them to be generally ineffective. The second option, that of restricting vending machines to adult areas only, has also been ineffective. As noted above, a survey in South Australia found that children were successful in buying cigarettes on every attempted occasion, irrespective of whether vending machines were situated in 'adults only' areas.[177]

3.134 A study in New South Wales found that adolescents perceived that vending machines were the easiest of all sources for obtaining cigarettes**.** Vending machines were rated as 'very easy' or 'fairly easy' to purchase cigarettes from by 50 per cent of under-age youth. However, the most common sources for self-reported illegal purchase of cigarettes were small general stores (31 per cent) and petrol stations (23 per cent). Vending machines were a source for 11 per cent of illegal purchases.[178]

3.135 A review of studies in the United States that evaluated the effectiveness of restrictions on the sale of cigarettes through vending machines found that in some instances educational campaigns coupled with licensing and fines resulted in reductions in sales, while in others this approach had no effect. The study concluded that 'results were more significant...when vending machines were entirely banned'.[179]

3.136 Proponents of a total ban on vending machines argue that this needs to be considered as there appears to be no effective means of restricting vending machine sales – interventions which have successfully reduced over-the-counter sales appear to be ineffective in reducing vending machine sales and fines do not appear to be acting as deterrents.[180] In the United States, 21 States have adopted laws restricting tobacco vending machine sales.[181] Some nine US States have banned the sale of cigarettes from vending machines and at least thirty US cities have totally banned cigarette vending machines.[182] In addition, President Clinton has proposed a

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177 See *ibid.,* p.14.

178 Sanson-Fisher, *op. cit.*, p.356.

179 US Department of Health and Human Services, *op. cit.,* p.249.

180 See additional information from Queensland Department of Health to the Committee, dated 23 March 1995, p.15.

181 US Department of Health and Human Services, *op. cit.,* p.41.

182 C. Bartecchi *et al*., 'The Global Tobacco Epidemic', *Scientific American*, May 1995, p.30; US Department of Health and Human Services, *op. cit.,* pp.249-50.

comprehensive ban on vending machines as part of a package of measures to address the problem of youth smoking.[183]

3.137 The Committee recognises that the introduction of a ban on vending machines may lead to a reduction in revenue for many establishments, may cause inconvenience for adult customers who wish to purchase cigarettes and may be seen as a general response to a 'specific' problem of juvenile access to tobacco products. However, the Committee believes that this needs to be balanced against the fact that eliminating this important source of cigarettes for minors will play an important role in addressing the problem of access to cigarettes for minors.

3.138 The Committee believes that, on the basis of evidence in Australia and overseas, attempts to limit the access of minors to vending machines has not been effective. As cigarettes become more difficult to obtain in over-the-counter situations, it is likely that vending machines will become more attractive to children and adolescents attempting to purchase cigarettes. The Committee therefore believes that the sale of cigarettes through the use of vending machines needs to be prohibited.

Recommendation

The Committee RECOMMENDS:

28. That, as it is virtually impossible to prevent access by children to cigarette vending machines, these types of vending machines be prohibited in all States and Territories.

Enforcement and compliance

3.139 Evidence to the Committee suggested that there is a need for improved enforcement of laws relating to restricting access of cigarettes to minors.[184] One witness noted that 'there is not enough compliance monitoring in any of the States in Australia'.[185] Laws prohibiting the sale of cigarettes to children can be effective in restricting the supply of tobacco to young people only if they are actively enforced.

3.140 Evidence suggests that greater emphasis should be placed on the effective monitoring of sales to minors. One submission argued that the current situation with compliance checks was 'piecemeal'.[186] Currently, all States and Territories operate

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183 The other reforms include prohibiting brand name sponsorship of sporting events, limiting tobacco advertisements in magazines with a large teenage readership, requiring proof-of-age for the purchase of cigarettes, and measures to require manufacturers, distributors and retailers to be responsible for underage sales. See 'Clinton Aims to Ban Under Age Smoking', *British Medical Journal*, Vol. 311, 19 August 1995, p.470.

184 *Transcript of Evidence*, p.669 (ASH Australia); *Transcript of Evidence*, p.647 (Non-Smokers Movement of Australia).

185 *Transcript of Evidence*, p.669 (ASH Australia).

186 *Transcript of Evidence,* p.261 (NSW Cancer Council).

community assistance programs whereby members of the public are encouraged to report illegal sales of tobacco products to children. Complaints are directed to the relevant Health Departments in all States and Territories except Tasmania where complaints are directed to the police. In the Northern Territory complaints may be directed to the police or to the Health Department. Evidence suggests, however, that the programs may not be effective in monitoring illegal sales. In Queensland it was reported that the program has had limited success with few complaints being made against retailers despite evidence of considerable under-age smoking. It was noted that members of the public were probably not sufficiently aware that the law relied on them to report breaches.[187] The Committee believes that the States and Territories should do more to inform the public of the appropriate bodies to which they can direct complaints.

3.141 Some evidence suggested that compliance checks using children are the most effective means of monitoring sales. In the United Kingdom, a number of Local Authorities have used children, usually aged between 10 and 13, to make test purchases of cigarettes from retail outlets. Over the period from March 1992 to July 1993, some 43 of the 110 Local Authorities carrying out enforcement programs against illegal tobacco sales made a total of 1 841 test purchases with the help of under-age young people; as a result 38 Local Authorities brought criminal proceedings and 36 of these Authorities gained successful prosecutions in this way. Of the other 59 Authorities, only two had successfully prosecuted retailers without using young people in the monitoring operation.[188] In the United States, the Working Group of State Attorneys General proposed that compliance checks using teenage testers, acting under adult supervision, should be encouraged.[189]

3.142 The problems associated with the operation of the laws in most States and Territories and lack of enforcement of laws in relation to minors was highlighted during the inquiry. In the case of NSW, only seven convictions have been made against retailers illegally selling cigarettes to minors and most convictions have resulted in low fines of approximately $100.[190]

3.143 In Queensland, there have been no prosecutions recorded. A representative of the Department of Health noted that 'the current legislation is very old and it does not have powers associated with it; it was written in 1905 and it has not been amended. It makes it difficult for people to enforce the legislation if they do not have general powers of enforcement: powers to seek information…and powers to take people to court. Current advice would suggest that it is not possible to enforce'.[191]

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187 Additional information from the Queensland Department of Health, dated 23 March 1995, p.18.

188 UK Health Education Authority, *Not for Sale: Stopping Smoking Before it Starts*, n.d., p.5.

189 Working Group of State Attorneys General*, op. cit.*, p.40.

190 *Transcript of Evidence*, p.713 (NSW Department of Health).

191 *Transcript of Evidence*, p.815 (Queensland Department of Health).

3.144 In the ACT two cases have been referred to the courts and one resulted in a successful prosecution. A representative of the ACT Government noted that 'as the legislation stands at the moment, it is very difficult to bring a successful case through the courts unless you observe a demonstrably young person purchasing tobacco from a person who has obviously not taken any notice at all about their age'.[192]

3.145 In Western Australia twenty-four retailers have been prosecuted for the sale of tobacco products to minors and several other cases are pending.[193] In that State there have been more prosecutions of retailers for the sale of cigarettes to minors than all the other States combined.

3.146 As noted above, the State and Territory Governments do not appear to be enforcing the laws relating to the sale of cigarettes to minors, if the level of prosecutions is any indication. One witness stated that 'unfortunately, there is very little enforcement of [the] law in New South Wales and in other States and that is why I believe a significant number of retailers are quite prepared to sell illegally to children because they know that the law is not going to be enforced'.[194] One submission noted that the lack of resources – both human and financial – to dedicate to the enforcement of these laws has been a major obstacle to their effective implementation.[195]

3.147 Penalties for the sale of tobacco products to minors varies between the States and Territories. Fines imposed on proprietors for a first offence range from $200 in the case of Tasmania to $10 000 in the Northern Territory. Most other States impose fines of between $1 000 and $5 000. For second and subsequent offences the fines generally range from $1 000, as in the case of the ACT, to $10 000 in the case of New South Wales, Western Australia and the Northern Territory.[196]

3.148 Western Australia is one State that has made significant progress in the enforcement of laws prohibiting the sale of tobacco to minors.[197] The Health Department now has two employees dedicated to education regarding, and enforcement of, the relevant Act. Enforcement has been strengthened with the support of State police officers responsible for monitoring under-age alcohol sales. Retailers selling tobacco to children are identified through police or Health Department officers incidentally witnessing the sales taking place, and through

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192 *Transcript of Evidence*, p.312 (ACT Government).

193 Additional information from the Health Department of Western Australia, dated 23 March 1995, p.10.

194 *Transcript of Evidence*, p.674 (ASH Australia).

195 Submission No.51, p.6 (Health Department of Western Australia).

196 Additional information from the Queensland Department of Health, dated 23 March 1995, p.42; Tobacco Institute of Australia, *Tobacco Industry Fact Sheet*, 11 October 1995.

197 Additional information from the Health Department of Western Australia, dated 23 March 1995, pp.10-11, 48-49.

investigation resulting from public complaints about individual retailers selling tobacco to minors.

3.149 All cases are forwarded to Public Prosecutors for representation in court. The Department has fostered a positive relationship with legal counsel assigned to tobacco cases, providing them with briefings on the issue of the sale to minors. Counsel now make sentencing submissions stressing the need to prevent young people smoking by restricting their supply and advocating a penalty designed to deter other retailers from selling tobacco to children. As a consequence, fines have increased from $50 in 1992 to $1500 in 1994.

3.150 The Health Department has established a practice of responding to every reported incident of cigarettes being sold to a minor. If insufficient evidence exists to proceed to court, retailers are sent letters informing them of the complaint and warning them that they will be prosecuted if they continue to sell tobacco to children. The Department noted that, as a result, more retailers now contact the Department for assistance in the form of signage and advice generally.

3.151 The Department has also encouraged media coverage of prosecutions by cultivating media contacts, issuing media releases, and targeting and localising stories for relevant newspapers. As a result, virtually every prosecution has received either State, regional or local press coverage. This media coverage has also had the effect of increasing retailers' perceptions of the likelihood of getting caught if they sell tobacco to children.

3.152 As noted above, a novel approach to compliance has been to reward retailers who conscientiously refuse to sell to minors. Retailers, identified as 'responsible' are awarded a sticker to display in their store. The Department uses this strategy to generate positive publicity and increase public awareness that a growing number of retailers are refusing to sell cigarettes to minors. A measure of the success of this strategy is that prior to the passage of the *Tobacco Control Act* in 1990 there were no recorded prosecutions, whereas there have been 24 prosecutions to date since the Act was passed.

Conclusions

3.153 The Committee believes that all States and Territories need to have in place a concerted and active enforcement campaign to complement laws prohibiting the sale of cigarettes to minors. The policies adopted in Western Australia have demonstrated that an active campaign of enforcement can have a marked effect on retailer compliance with the law and is an effective means of reducing young people's access to cigarettes. The Committee supports the Western Australian initiatives and encourages other States and Territories to introduce similar programs.[198]

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198 See also recommendation number 25 proposing a reduction in the number of retail outlets selling tobacco products.

Recommendations

The Committee RECOMMENDS :

29. That State, Territory and Local Governments increase the level of funding and personnel devoted to the enforcement of laws restricting the supply of tobacco products to minors; and that increased resources be devoted to the prosecution of retailers that contravene such laws.

30. That State and Territory Governments institute routine systems of random compliance checks to monitor the sale of tobacco products to minors.

31. That the Commonwealth Government encourage the States and Territories to improve the effectiveness of their enforcement and monitoring programs; and that:

    - as part of their monitoring system the States and Territories provide statistics annually to the Commonwealth on the number of complaints and prosecutions against retailers selling cigarettes to minors; and

    - the States and Territories run a publicity campaign that informs the public of the appropriate bodies to which they can direct complaints regarding the sale of tobacco products to minors.

32. That a system of substantial fines be introduced in all States and Territories to discourage the sale of tobacco products to minors.

CHAPTER 4

TOBACCO USE AMONGST CERTAIN SOCIO-ECONOMIC, OCCUPATIONAL AND OTHER GROUPS

4.1 This chapter considers issues relating to tobacco use which have a particular impact on specific groups within the community. Amongst these are lower-income groups; certain occupational groups where the incidence of tobacco smoking is considered to be higher than the general community; people of Aboriginal and Torres Strait Islander (ATSI) background; and people of non-English speaking backgrounds.

Lower-income groups

4.2 There are a number of underlying social and economic factors which contribute to socio-economic disadvantage. Among these are low income, relatively low educational attainment levels and high unemployment. By comparison with people in higher socio-economic groups, people from lower socio-economic groups have a higher prevalence of poor health and make greater use of doctors, hospitals and outpatient clinics, but make less use of preventive and screening services.[1] Those people with socio-economic disadvantage have a higher prevalence of health risk factors, compared to those with socio-economic advantage. These factors include a higher prevalence of smoking, risk from alcohol, greater likelihood of being overweight and being inactive. The prevalence of smoking, in adults aged between 25 and 64 years, has been shown to be 43 per cent higher in men and 53 per cent higher in women.[2]

4.3 Low levels of education are also associated not only with poor health generally, but with higher use of tobacco which contributes to this situation. Compared with the more highly educated, data show that men (25-64 years) who have received low levels of education (defined as having left school before 15 years of age, with no further qualifications) are 85 per cent more likely to smoke, with the rate for women in this category being 67 per cent.[3] Men and women outside the workforce were also more likely to smoke.[4]

4.4 A clear relationship has been shown to exist between lower occupational status and increasing prevalence of smoking in both men and women.[5] Research has shown

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1 National Health Strategy, *Enough to Make You Sick*, Research Paper No. 1, September 1992, pp.12-13.

2 *ibid.,* p.29.

3 *ibid.,* p.31.

4 *ibid*., p.33.

5 D. Hill, V. White and N. Gray, 'Australian Patterns of Tobacco Smoking in 1989', *Medical Journal of Australia,* Vol.154, June 1991, p.799.

that twice as many male 'lower blue-collar' workers are current smokers compared with 'upper white-collar' workers. On examination of the 'past' and 'never-smoked' categories, the difference was considered to be due mostly to the upper occupational groups (both men and women) never having taken up smoking, rather than having relatively greater success in quitting.[6]

4.5 Although there may not be a direct relationship with socio-economic factors, family composition and marital status also impact on smoking prevalence. For instance, the smoking prevalence for women who head single parent families is 132 per cent higher compared with married women of the same age with dependants. However, for men heading single parent families their smoking prevalence was only 47 per cent higher than their married counterparts.[7] Women living alone were reported to be 74 per cent more likely to smoke than men in this category (22 per cent).[8]

4.6 The results of a study conducted in the United Kingdom suggest that increases in the real cost of cigarettes would help reduce differences between socio-economic groups in the prevalence of smoking and smoking-related diseases, although special support may be needed by families with the greatest economic need.[9] The study assessed the effects of price, income, and health publicity on cigarette smoking by age, sex, and socio-economic group, and concluded that men and women in lower socio-economic groups are more responsive than those in higher socio-economic groups to changes in the price of cigarettes and less to health publicity.[10]

4.7 Analysis of the research suggests that the main effects of increasing the real price of cigarettes (for example, by tax increase) would be to reduce the prevalence of smoking in men and women in lower socio-economic groups and to reduce cigarette consumption by all men and women aged between 25 and 59.[11] It was also suggested that the reasons for high levels of smoking by economically and socially disadvantaged people, most of whom started smoking in their early teens, also need to be addressed, and measures taken to reduce economic hardship and social isolation, especially that experienced by those bringing up children alone.[12]

4.8 However, another UK study argued that low income families in Britain do not give up smoking in response to price rises. The only of effect price rises is to increase

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6 *ibid.*

7 National Health Strategy Research Paper No.1, *op. cit.,* p.34.

8 *ibid.*, p.33.

9 J. Townsend, P. Roderick and J. Cooper, 'Cigarette Smoking by Socioeconomic Group, Sex, and Age: Effects of Price, Income, and Health Publicity', *British Medical Journal*, Vol.309, 8 October 1994, p.926.

10 *ibid.*, p.923.

11 *ibid*., p.926.

12 *ibid*.

the hardship experienced by low income smokers and their children.[13] The intention of the study was to determine the extent to which the greater economic hardship experienced by smokers was caused by their smoking or by their lower socio-economic status compared with non-smokers.[14] The study found that the disadvantages that apparently increase the chances of smoking also, of themselves, increase the chances of hardship. To quite a striking extent, smoking increased hardship independently of marital status, low income, manual work, lack of education, claiming social security benefits, and other factors. It was found that, independent of other factors, smoking was associated with higher levels of financial and material hardship among low income families at each level of income and in each position of relative advantage and disadvantage. 'The greater the extent of disadvantage, and the lower the income, the harsher was the impact of tobacco expenditure on hardship. This impact fell equally on adults and children.'[15] The United Kingdom researchers concluded that if the purpose of tobacco taxation is to stop smoking by those who really cannot afford to smoke, this was not having the required result, and other policies were needed to address the issue.[16]

4.9 By contrast, an evaluation of the Family Allowance Supplement (FAS) program by the Australian Department of Social Security into the impact of additional payments on low-income working families found that the FAS was used primarily to pay for children's basic necessities such as clothing, food and school expenses.[17] The availability of this allowance may have released other income for the purchase of cigarettes but the special funding itself does not appear to have been abused. While this measure may not reduce smoking directly, it may provide some income stability which reduces general economic and other pressures.

4.10 Cigarette pack size is also impacting on the prevalence of smoking, particularly in the lower socio-economic group. Hill and White report that the trend in the cigarette market towards large-pack (heavily discounted) cigarettes has continued unabated. A much higher proportion of both male and female smokers are purchasing their cigarettes in packs of 40 or more.[18] The researchers also found this trend to be strongest among smokers of both sexes from the lower occupational and educational levels. With marketing strategies aimed at this strata of society in which prevalence of smoking is already high it becomes more difficult to further reduce the incidence of smoking in this group.[19] It was suggested that if the method of taxing

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13 A. Marsh and S. McKay, *Poor Smokers*, Policy Studies Institute, London, 1994, p.1.

14 *ibid*., p.80.

15 *ibid*.

16 *ibid*., pp.81-2.

17 Department of Social Security, *Key Findings from the Evaluation of the FAS Program conducted during 1988-89 and 1989-90,* June 1992.

18 D. Hill and V. White, 'Australian Adult Smoking Prevalence in 1992'*, Australian Journal of Public Health*, Vol.19, No.3, 1995, p.308.

19 *ibid.*

tobacco was based on the number of cigarettes per pack, rather than tobacco weight, then the discounting of cigarettes in larger pack sizes could be reduced. Furthermore, the researchers indicated that this change in taxation policy may stop the trend of people from socially-disadvantaged groups buying the larger packs of cigarettes; if a higher price were charged they believed this could help reduce smoking amongst this socio-economic group.[20]

4.11 In an attempt to address the problem of tobacco use amongst lower income groups, the DHS&H advised the Committee that the National Drug Strategic Plan has prioritised certain population groups, such as lower socio-economic groups, to be targeted in drug prevention and treatment activities.[21] The Department also noted that the Tobacco and Health Community Education Grants Program has been developed to further the aims of the *Health Australia* initiative at the community level. While the scope of the Grants Program as a whole is broad, specific projects funded under the Program will aim to meet the needs within each community. These projects may include objectives such as raising the awareness of tobacco and health issues among groups whose needs are not currently being met by mainstream education campaigns. The Grants program is also designed to enable community-based research to be conducted into specific communities or target groups which will provide the Commonwealth with a greater understanding of their smoking prevalence, attitudes to tobacco use, and education needs.[22]

Conclusions

4.12 The evidence indicates that smoking prevalence increases for people on low incomes, those in blue-collar occupations, and the unemployed. Although programs have been successful in reducing smoking overall, it would appear that this impact has been greater on the more educated, middle-class sector of society which has the lowest smoking rates, rather than on other groups in the community. Although some evidence suggests that an increase in tax on cigarettes may have some impact, it would appear that structural changes in areas such as education and training are also needed to improve the overall situation for people in this category. As well, because smoking habits of people who are disadvantaged are often established at a very early age, health promotion programs should attempt to change this pattern and also encourage better attitudes towards health.

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20 *ibid*.

21 The other priority groups are ATSI and people from NESB backgrounds. See letter from DHS&H to the Committee, dated 23 October 1995, p.16.

22 *ibid.,* p.17.

Recommendations

33. That strategies continue to be developed to address the special needs of 'at risk' groups in the community, such as lower socio-economic groups, to reduce the incidence of smoking in those groups.

34. That funding continue to be allocated by the Commonwealth Government for the development of appropriate programs and strategies to address the problem of tobacco use for 'at risk' groups in the community.

Occupational groups

4.13 Little research has been undertaken into patterns of smoking in people in particular occupations, but there are indications that some stressful jobs result in higher percentages of smokers in some occupational groups. Nursing has been reported as being a stressful occupation, and, although nurses could be expected to be aware of the health risks involved in smoking, some evidence suggests that this knowledge has little effect. However, even within this particular occupation smoking rates varied according to the levels of stress experienced in different types of nursing. For instance, data show that, of a group of student nurses who nursed children, 44 per cent smoked cigarettes, as opposed to 33 per cent of those who nursed older patients. In a different student group (home economics) a much lower rate were smoking (15 per cent).[23] The Committee believes that further research should be conducted into the linkages between occupation and smoking, and that strategies should be implemented to reduce the incidence of smoking in high-risk occupations.

People of Aboriginal and Torres Strait Islander (ATSI) Origin

Background

4.14 At the 1991 Census, 1.6 per cent of the Australian population identified as being of Aboriginal or Torres Strait Islander (ATSI) origin. Of this population, 49.5 per cent were male and 50.5 per cent were female.[24]

4.15 People of ATSI background are considered to have the poorest health of all Australians, with Aboriginal women's health being of particular concern.[25] Although the causes of their ill health are complex – involving historical, cultural, social, economic, and structural factors – the diseases which account for most Aboriginal deaths include heart disease, diabetes, hypertension and stroke, injury and poisoning and respiratory disease. Tobacco use is one of the contributory factors in Aboriginal

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23. H. Lea, 'Smoking Trends in Students of Home Economics and Nursing', *Journal of the Home Economics Association of Australia*, XVIII, 1, 1986, p.24.

24. Australian Bureau of Statistics, *Women's Health*, Cat. No. 4365.0, p.125.

25. Australian Institute of Health, *Australia's Health 1994,* AGPS, Canberra, 1994*,* p.27.

people having death rates from respiratory disease seven to eight times greater than for non-Aboriginals.[26]

Incidence of smoking

Australia-wide

4.16 A survey conducted nationally has found that approximately 50 per cent of people of ATSI background smoked cigarettes, with the 25 to 44 year age group showing the highest proportion of smokers (61 per cent). The survey found that males were more likely to smoke (54 per cent) than females (46 per cent).[27]

4.17 Although the majority of Aboriginal people (67 per cent) live in urban areas there has been a lack of comprehensive information available on the use of tobacco and other drugs by Aboriginal people in urban areas.[28] Given the concerns expressed by the Working Party of the National Aboriginal Health Strategy[29] and the current lack of information, a cross-section survey conducted by Perkins *et al.* examined the self-reported use of tobacco (as well as other licit and illicit drugs) in an urban Aboriginal population. Fifty per cent of the Aboriginal people in the study were smokers and, of these, 50 per cent were male and 49 per cent were female. This finding is similar to that reported recently for Aboriginal people in country towns where 64 per cent reported they were smokers.[30] When compared to a non-Aboriginal sample a significantly greater proportion of males and females from the study sample were smokers.[31] Perkins suggests that the anti-smoking messages which have been developed for the wider Australian community are not having an impact on smoking levels among Aboriginal people.[32]

Aboriginal communities in the Northern Territory

4.18 A large percentage (56 per cent) of Aboriginal people living in the Northern Territory smoked cigarettes or tobacco according to a survey conducted in 1986. It was found that more men (71 per cent) than women (43 per cent) were smokers.

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26. B. Bartlett and D. Legge, *Beyond the Maze: Proposals for More Effective Administration of Aboriginal Health Programs,* National Centre for Epidemiology and Population Health, Working Paper No. 34, 1994, p.4.

27. ABS, *National Aboriginal and Torres Strait Islander Survey 1994*, Cat. No. 4190.0, p.13.

28 J. Perkins *et al.,* 'The Prevalence of Drug Use in Urban Aboriginal Communities', *Addiction* (1994) 89, p.1320. DHS&H advised the Committee that the 1994 National Drug Strategy Household Survey investigated tobacco and other drug use amongst urban Aboriginals and that this survey provided some baseline data for this group. See letter from DHS&H to the Committee, dated 23 October 1995, p.18.

29 National Aboriginal Health Strategy Working Party, *A National Aboriginal Health Strategy*, AGPS, Canberra, 1989.

30 Perkins, *op. cit.,* p.1327.

31 *ibid.*

32 *ibid.*

There was little difference in the proportion of smokers across different age groups (ranging from 15 years to beyond 60 years of age), indicating that smoking was a well established practice by the age of 20 years.[33] By contrast, 40 per cent of people living in urban areas of the Northern Territory (including Aboriginal people) smoked.[34] Overall, it was found that a higher percentage of Aboriginal people smoked tobacco compared with other populations surveyed throughout Australia. For example, one-third of the population smoked tobacco in Queensland and New South Wales.[35]

4.19 Geographical location was a significant factor in the prevalence of smoking in the different age groups and in males and females. In the different age groups, 62 per cent to 86 per cent of people living in the Top End of the Territory smoked tobacco, whereas 24 per cent to 48 per cent of people living in the Katherine/Centre regions reported smoking. An alarming factor is that the higher percentage (48 per cent) in the Katherine/Centre regions was from the 15 to 20 year age group. Location also had a striking affect on the prevalence of smoking in women. Of the women who smoked, 73 per cent were from the Top End, and 35 per cent from the Katherine region, which compared with the significantly lower figure of 9 per cent from the Centre.[36] This lower figure is possibly because more Aboriginal people living in this region prefer to chew tobacco (which is discussed further in this chapter).

4.20 Regional differences in the prevalence of smoking could also be related to historical circumstances.[37] Smoking tobacco was introduced to Aboriginal people in Arnhem Land, possibly several hundred years ago. It has since played an important role in social and ceremonial occasions and so the practice of sharing tobacco and individual cigarettes is still widespread. As a result of these practices, and the addictive properties of tobacco (see also Chapter 1), a high proportion of Aboriginals in the Top End are smokers.[38]

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33 C. Watson, J. Fleming and K. Alexander, *A Survey of Drug Use Patterns in Northern Territory Aboriginal Communities: 1986-1987*, Northern Territory Department of Health and Community Services Drug and Alcohol Bureau, 1991, p.69.

34 Australian Bureau of Statistics, 'Alcohol, Tobacco, and Analgesic Consumption, Northern Territory', , in E. Unwin, N. Thomson and M. Gracey, *The Impact of Tobacco Smoking and Alcohol Consumption on Aboriginal Mortality and Hospitalisation in Western Australia: 1983-1991*, Health Department of Western Australia, Perth, August 1994, p.4.

35 ABS, *Smoking Behaviour*: *Queensland*, October 1985; ABS, 'Lifestyle: Health Risk Factors, New South Wales', October 1985, in Watson, *op. cit.,* p.69

36 Watson, *op. cit.,* p.69.

37 Prior to European settlement, Aboriginal people living in Central Australia traditionally chewed *Pituri*, an Aboriginal word for the nicotine-containing plant *Duboisia hopwoodii*. This was an important part of the social ritual of Aborigines in Central Australia, particularly for old men of the tribes, whereas in Arnhem Land smoking tobacco was introduced by Indonesian fishermen possibly several hundred years ago. Since this time tobacco has played an important role in social and ceremonial occasions.

38 Watson, *op. cit.,* pp.69-70.

4.21 In the Top End/Katherine regions, both men and women reported that they smoked because they enjoyed the taste and the feeling that tobacco gives. Men also reported that smoking relieved their boredom. Of the non-smokers, men and women stated that the reasons they did not smoke was because it was bad for their health or they did not like the taste of tobacco. In this region, women expressed concern that smoking caused problems in their community, whereas most men did not acknowledge that tobacco was a community problem. However, those problems which were referred to were mostly health-related.[39]

4.22 The Committee is pleased to note that Aboriginal peoples in Northern Australia have expressed an awareness that smoking is dangerous to health, especially in view of the fact that it has only been in the last few years that this sector of the community has been exposed to anti-smoking messages.[40] However, the Northern Territory Department of Health and Community Services in evidence to the Committee stated that a major area of concern was that there had not been sufficient educational programs to make ATSI people more aware of the dangers of smoking to health.[41] (See also Paragraph 3.69 which discusses the targeting of Aboriginal communities by tobacco companies.)

Chewed tobacco

4.23 Traditionally, Aboriginal people living in Central Australia chewed the nicotine-containing plant *Duboisia hopwoodii* or *pituri*, and in the Katherine and Centre regions another type of nicotine-containing plant *Nicotania* – known as 'bush tobacco' was chewed.[42]

4.24 A study has shown that, of the people interviewed, one-quarter of these chewed tobacco – 38 per cent of whom were women. Chewing tobacco was more prevalent in the older age groups, with almost half of the people being older than 60 years of age.[43] Although more Aboriginal people living in the Centre (41 per cent) than the Top End/Katherine regions chewed tobacco, a much higher percentage of women in the Centre – and across all age groups – (61 per cent) chewed tobacco, compared to 5 per cent of women in the Top End region. Chewing tobacco was also more prevalent in older males living in the Centre.[44]

4.25 It is not clear why chewing is more prevalent among women and older men. Traditionally, it was the older men who chewed *pituri.*[45] However, the increase in

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39 *ibid.,* p.70.

40. ABS, 1989-90 National Health Survey (1993) in Unwin, *op. cit.,* p.5.

41 *Transcript of Evidence,* p.899 (Northern Territory Department of Health and Community Services).

42 Submission No.39, p.2 (Northern Territory Department of Health and Community Services).

43 Watson, *op. cit.,* p.72.

44 *ibid.*, pp.72-3.

45 *ibid*, p.73.

women chewing tobacco could suggest that the availability of smoking tobacco (loose, flake or plug) for chewing has contributed to this situation. Because chewing was generally confined to older men this may be a contributing factor to the high prevalence of smoking among younger men in Central Australia. On the other hand, young girls were taught to chew tobacco and this may be the reason why there is a low prevalence of smoking among women in Central Australia. The Northern Territory is the only State or Territory in which boys' smoking levels are greater than girls.[46]

4.26 At this stage, it is not known what effect the chewing of smoking tobacco has on Aboriginal people's health, and this will probably not be evident for some time. Both the *Duboisia hopwoodii* or *pituri* plant traditionally chewed in Central Australia, and also the *Nicotania* plant known as 'bush tobacco', and chewed in the Katherine/Centre regions both contain nicotine. The raw tobacco of these plants was mixed with saliva or water and ash made from *Eucalyptus.* It has been suggested that the alkali ash may potentiate the nicotine effect.[47] However, when smoking tobacco became available Aboriginals may have switched to this form of tobacco because, traditionally, the only obtainable tobacco was *Nicotania* which was only available at certain times of the year and in particular locations.[48] Thus, the health effects of having constant access to a supply of tobacco for chewing may not become apparent for some years. However, although it is known that chewing tobacco may increase the likelihood of developing carcinomas of the mouth and jaw, these cancers are not prevalent in Aboriginal people at present.[49]

Aboriginal mortality and hospitalisation – Western Australia

4.27 In Western Australia, in the period 1983 to 1991, tobacco smoking was responsible for 13 per cent of all Aboriginal deaths, compared to 10 per cent of Aboriginal deaths being related to excessive alcohol consumption. In 1989-91 the age-standardised death rate[50] for tobacco-caused deaths was twice as high for Aboriginal males, than non-Aboriginal males. For Aboriginal females the age-standardised rate was four times the rate for non-Aboriginal females.[51]

4.28 Hospital admissions for tobacco-related illnesses were also higher for Aboriginals. Aboriginal males were admitted to hospital at three times the rate of non-Aboriginal males, and Aboriginal females at five times the rate.[52] This same

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46 Submission No.39, p.3 (Northern Territory Department of Health and Human Services).

47 Watson, *op. cit.,* p.72.

48 *ibid.*

49 *ibid.,* p.72.

50 A standardised death rate is one which has been standardised for differences in the age distribution.

51 Unwin, *op. cit.,* p.12.

52. *ibid*., p.22.

study shows, in terms of numbers of deaths rather than rates, that tobacco smoking caused deaths among Aboriginals at much younger ages than it did among non-Aboriginals, with 49 per cent of male deaths and 48 per cent of female deaths among Aboriginals occurring before the age of 55 years.[53] For non-Aboriginals only 11 per cent of male and 10 per cent of female deaths due to smoking occurred before that age. The age patterns of deaths caused by alcohol use and tobacco smoking were similar, but in 1989-91 the age-specific death rates were generally higher for tobacco smoking than for alcohol use, with the highest rate differences being in the 75 years and above age group.[54] As well, tobacco-related deaths which occurred in Aboriginal children under 15 years of age were due to fire injuries, low birthweight, and sudden infant death syndrome.[55]

4.29 The Western Australian study has also shown that, although between 1983-1985 and 1989-91 the estimated number of deaths caused by tobacco smoking increased by 7 per cent overall, the age-standardised rate did not increase significantly. This may reflect changes in the size and structure of the population. However, Unwin *et al.* point out that the overall figures conceal some differences in the changes between Aborigines and non-Aborigines and between males and females. For Aboriginal males, there was a slight decrease in the age-standardised rate of deaths between 1983-1985 and 1989-1991 which was not statistically significant. Although there was an increase in the rate for Aboriginal females this was also not statistically significant. In contrast, the age-standardised rates of deaths among non-Aboriginal males and females caused by tobacco smoking changed significantly between 1983-1985 and 1989-1991. The rate for non-Aboriginal males decreased from 136 to 113 deaths per 100 000 person-years, and the rate for non-Aboriginal females increased from 25 to 32 per 100 000 person-years.[56] The overall age-patterns of deaths caused by tobacco smoking remained largely unchanged over the period 1983-1991, with the only generally consistent change being reductions in age-specific death rates for non-Aboriginal males.[57]

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53. *ibid.*, pp.12-14.

54 *ibid.*

55. *ibid*, p.14.

56. *ibid*., p.18.

57 *ibid*.

Table 10:
Estimated number of deaths (and age-standardised death rates*) for the most common causes of death due to tobacco smoking in Western Australia, 1989-1991

	Males		Females	
Aboriginal				
Ischaemic heart disease	37.7	(99)	16.7	(46)
Lung cancer	15.3	(47)	3.8	(11)
Chronic bronchitis	12.7	(40)	4.9	(16)
All tobacco-related causes	99.0	(271)	45.9	(118)
Non-Aboriginal				
Lung cancer	918.4	(34)	298.6	(9.4)
Ischaemic heart disease	824.5	(31)	231.0	(6.8)
Chronic bronchitis	601.5	(20)	183.3	(4.6)
All tobacco-related causes	3147.0	(113)	1111.0	(32)

* per 100,000 person-years.

Source: E. Unwin, M. Gracey and N. Thomson, 'The Impact of Tobacco Smoking and Alcohol Consumption on Aboriginal Mortality in Western Australia, 1989-1991', *Medical Journal of Australia,* Vol.162, May 1995, p.476.

4.30 In an effort to reduce the number of hospital admissions resulting from conditions caused by smoking and to improve the overall health of Aboriginal people, the Western Australian government recently released an educational package to help raise awareness of the health consequences of smoking among Aboriginal health workers and their clients. The new package has been developed by Aboriginal people and, although it has been particularly designed for a Noongar audience to highlight problems which particularly affect people in that community, amendments can be made to cater for regional differences.[58]

Aboriginal women's health

4.31 Smoking is more prevalent among Aboriginal women than it is among non-Aboriginal women. At the time the ABS National Health Survey was conducted in 1989-90, 42 per cent of indigenous women aged 18 years and over were smokers, compared with a figure of 25 per cent for all Australian women. It was also found

58 Marr Mooditj Foundation Incorporated and Health Promotion Services, *Gnummari Wa – You Won't Go Far: Say Goodbye to Smokes*, Health Department of Western Australia, Perth, 1995.

that a higher proportion – 57 per cent – of all Australian women had never smoked, as opposed to 42 per cent of indigenous women, and 79 per cent of indigenous women who smoked had smoked for 10 years or more, which compared with 71 per cent for women generally.[59]

4.32 Although diseases of the circulatory system were the leading cause of death for both female and male indigenous Australians for the combined years 1988 to 1990, this was also the case for the Australian population as a whole.[60] However ATSI women, in particular, have specific health problems and it has been suggested in a number of studies that these health-related problems could be exacerbated by smoking.[61] For instance, in the Northern Territory, female Aboriginal death rates from respiratory conditions are exceedingly high, being 12 times the non-Aboriginal Territorian female death rate, and 15 times the Australian female death rate.[62]

4.33 Tobacco smoking was also found to be a high risk factor for Aboriginal women during pregnancy.[63] A study of Aboriginal women from Arnhem Land found that a total of 72 per cent smoked during their pregnancy. Although there may be other factors, including environmental and nutritional factors, 14 per cent of the infants were born before term and 19 per cent had low birthweights.[64]

4.34 Smoking has also been found to be a risk factor for cervical cancer. The incidence of mortality rates for this type of cancer in Aboriginal women in Australia has been found to be more in accordance with that of developing countries. Although not confined to Aboriginal women, the rate of cervical cancer amongst women smokers was 4.5 times that of non-smokers, and as the number of cigarettes per day increased, so did the rate of cancer.[65]

4.35 In an effort to address the problem of tobacco use in ATSI communities, DHS&H advised the Committee that it is proposed to undertake an Aboriginal and Torres Strait Islander Tobacco and Health Education Strategy.[66] The objective for phase one of the Strategy is to conduct comprehensive qualitative research on issues surrounding tobacco use in Aboriginal and Torres Strait Islander communities throughout Australia. The Strategy consists of a pilot program of research to be

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59 Australian Bureau of Statistics, *Women's Health,* 1994, p.130-31.

60 *ibid.,* p.130.

61 *ibid.,* p.130-31.

62 Submission No.39, p.6 (Northern Territory Department of Health and Community Services).

63 D. Watson, 'Biparietal Diameter in the Australian Aboriginal Fetus', *British Journal of Obstetrics and Gynaecology,* Vol.93, April 1986, p.339.

64 *ibid,* pp.341-2.

65 K. Brock, 'The Epidemiology of Cervical Cancer in Australia', *Cancer Forum*, Vol.15(1), March 1991, pp.18-20.

66 The Strategy is currently awaiting Ministerial approval. See letter from DHS&H to the Committee, dated 23 October 1995, p.17.

conducted in the Northern Territory and Western Australia with a budget of $200 000. It is proposed that research be conducted on a national basis, following evaluation of the results from the pilot study. After implementation of phase one of the Strategy, the results of the research will lead to the development and implementation of culturally specific and targeted education and program materials.[67]

Conclusions

4.36 Although tobacco use is one of the contributory factors in Aboriginal people having poor health, their health problems are also related to structural problems such as unemployment, poor education, inadequate housing, inadequate water supply, access to transport etc. The Committee feels that, as well as culturally appropriate programs to reduce the prevalence of smoking amongst ATSI people living in both rural and urban areas, there is also need to examine the underlying issues which affect health.

Recommendations

35. That strategies, sensitive to Aboriginal and Torres Strait Islander cultural values, be implemented to address the problem of tobacco use in Aboriginal and Islander communities, and that these strategies include:

    - close liaison with Aboriginal and Torres Strait Islander community-based health organisations, especially the Aboriginal Health Services; and
    - the dissemination of culturally appropriate information on tobacco use throughout Aboriginal and Torres Strait Islander communities.

36. That further research be conducted to examine the problem of tobacco use by Aboriginal people in urban areas.

37. That funding be provided by the Commonwealth Government for culturally appropriate programs and strategies to address the problem of tobacco use in Aboriginal and Torres Strait Islander communities, as part of a broader health strategy.

People from non-English speaking backgrounds

4.37 Different health problems related to tobacco use are found in ethnic communities, some of which are related to cultural practices and/or the country of origin. An ABS survey undertaken in 1989-90 showed that the proportion of people who were current smokers at that time was higher among overseas-born men than Australian-born men. Among men, the proportion who had ever smoked (current smokers plus ex-smokers) was highest at the late adult and oldest ages, and again the

67 *ibid.*

proportions were higher for overseas-born males.[68] In contrast, among women there was less difference between Australian-born and overseas-born women, with the proportion of women who have ever smoked being highest at the youngest ages, and declining at each successive age, indicating a relatively recent increased adoption of smoking among women.[69]

4.38 Age-standardised ratios[70] of the proportions of men smoking at the time the 1989-90 National Health Survey was conducted showed that the highest levels were among Poles, Greeks, men from the Middle East, Yugoslavs, Vietnamese and Italians; the lowest proportions were shown to occur among people from Malaysia, India, and China.[71] Age-standardised ratios for women indicated that the highest proportion of people who were current smokers occurred among those from New Zealand, the United Kingdom and Ireland, Germany, Poland, followed by those from the Middle East and North Africa, the Netherlands, and the Australian-born. The lowest proportion of smokers at the time of the survey occurred among women from the United States, India, Italy and Greece.[72]

4.39 For some countries of birth there is a marked contrast between the age-standardised ratios of men and women relative to all men and all women, for example, the relatively high age-standardised ratios of Greek, Yugoslav and Italian men compared with the relatively low age-standardised ratios for women from those countries.[73] However, there is evidence of high age-standardised ratios among both men and women from Poland, the Middle East and North Africa and from New Zealand, relative to all men and women.[74]

4.40 Data from the ABS National Health Survey figures and the National Heart Foundation 1989 Risk Factor Prevalence Survey both indicate high proportions of smokers among men from southern Europe and the Middle East, and moderate levels among those from western Europe. Similarly, both sets of data indicate low levels of smokers among women from southern Europe and from Asia, moderate levels among women from north-east Europe, and slightly higher levels among women from

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68 Australian Institute of Health and Welfare, *Immigrants in Australia: A Health Profile*, Ethnic Health Series, No.1, 1992, pp.139-40. However, these figures would also have included people who, although born overseas, would not have been from NESB backgrounds.

69 *ibid.*

70 Age-adjustment (or age-standardisation) – if comparing two populations where the age structures differ dramatically, crude rates (such as the crude death rate) are unreliable indicators of difference. The statistical technique of age-adjustment (the application of age-specific rates to a standard population structure) is applied to reduce the effect of differing population age structures. See AIHW, *Australian Health Trends 1995,* AGPS, Canberra, 1995, p.109).

71 Australian Institute of Health and Welfare, *op. cit.,* p.140.

72 *ibid.*

73 *ibid*.

74 *ibid.*

western Europe.[75] However, the National Heart Foundation data differ from that of the ABS. They indicate low levels of smoking among men from New Zealand and north-east Europe, high levels of smoking among men from Asia, and lower levels of smoking among women from the United Kingdom and Ireland, New Zealand, the Middle East and North Africa.[76]

4.41 The age-standardised ratios for women indicate that the highest proportion of current smokers in 1989-90 was among women from New Zealand, the United Kingdom and Ireland, Germany, Poland, followed by those from the Middle East and North Africa, the Netherlands, and the Australian-born – the lowest proportion occurring among women from the United States, India, Italy and Greece.[77] Another study found that men born in Scotland, Ireland, Southern Europe and the Middle East were more likely to be smokers; also women from Scotland, Ireland and Western Europe, while those from Greece, Italy, South-East Asia and other parts of Asia were less likely to smoke.[78] Per head of population Australia has more smokers than the United States, Canada and New Zealand.[79]

4.42 The Australian Institute of Health and Welfare has found that there are significant differentials in risk factors by country of birth grouping. Among adult Australians aged 25 to 64 years men, but not women, born in continental Europe were more likely to be smokers (31 per cent higher). Other statistics relating to people born overseas show that women, but not men, born in the United Kingdom and Ireland were more likely to be smokers (18 per cent higher).[80]

4.43 Amongst specific ethnic communities, such as the Vietnamese, Greek, and Spanish-speaking communities, tobacco, alcohol and broader health issues were generally viewed as very low community concerns. Relatively few people identified tobacco as a drug, or were aware that tobacco was a leading cause of death. A high percentage of these communities believed that they did not have enough information about the health risks of tobacco use and other drugs. Amongst these communities it was considered that community-based education programs should be implemented to address the problem and that bi-lingual workers in strategically-located centres were needed to assist people who were experiencing problems.[81] In a study of the

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75 *ibid.*

76 *ibid*.

77 *ibid*.

78 Australian Institute of Health and Welfare, *Australian Health Indicators Bulletin*. No.1, July 1994, p.1.

79 *ibid.*

80 Australian Institute of Health and Welfare, *Health Differentials Among Adult Australians Aged 25-64 years*, AGPS, Canberra, 1994, p.231.

81 S. Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Vietnamese-Speakers in Sydney*, November 1992; S. Everingham, A. Martin and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Greek-Speakers in Sydney*, May 1994; S. Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Spanish-*

Vietnamese-speaking community in Sydney a high use of tobacco was reported by men (42 per cent). This was ten times higher than that of Vietnamese-speaking women (4 per cent).[82] In the Greek community 31 per cent of men reported they were regular users of tobacco, compared with 10 per cent of Greek women.[83] A study of the Spanish community showed that 28 per cent of men and 15 per cent of women smoked regularly.[84] In this community it was reported that the high use of tobacco amongst men was often because of habits already established in their country of birth. However, tobacco use amongst overseas-born Spanish women was thought to be related to age and, in the case of young women, was approaching that of men.[85]

4.44 Indications are that ethnic peoples' cultural backgrounds, particularly if they were born overseas, have a direct impact on their attitudes to tobacco smoking. For instance, high rates of smoking for Greek males reflect the fact that in Greece smoking has always been a status symbol. Combined with the fact that, in terms of per capita consumption, Greece is the second largest consumer of manufactured cigarettes in the world, may help to explain the long-established smoking tradition amongst Greek Australians.[86] It has been reported that smoking was the most serious drug problem facing the Greek community.[87]

4.45 Culture also affects smoking in Vietnam where it is considered to be a status symbol or symbol of manhood and acceptance among other men. Smoking was also considered necessary to conduct business relations. Evidence has indicated that smoking starts during or before the teenage years and there is little attempt to control tobacco use in Vietnam. Barriers to tobacco control included low priority by government and doctors, cultural and social factors and the influence of the tobacco industry.[88] This factor could account for the reason why Vietnamese-speaking people interviewed in a study were much less aware of the harm caused by tobacco than the

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Speakers in Sydney and Wollongong , March 1993, Research Grant Report Series, Drug and Alcohol Directorate, NSW Health Department.

82 S. Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Vietnamese-Speakers in* Sydney, Drug and Alcohol Directorate, NSW Health Department, November 1992, p.viii.

83 S. Everingham, A. Martin and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Greek-Speakers in* Sydney, Drug and Alcohol Directorate, NSW Health Department, May 1994, pp.viii, vi.

84 S Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Spanish-Speakers in Sydney and Wollongong* , Drug and Alcohol Directorate, NSW Health Department, March 1993, p.viii.

85 *ibid.*

86 S. Everingham, A. Martin and B. Flaherty, *Alcohol and Other Drug use, Attitudes and Knowledge Amongst Greek-Speakers in Sydney*, Drug and Alcohol Directorate, NSW Health Department, May 1994, p.11.

87 i*bid.*, p.60.

88 S. Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Vietnamese-Speakers in Sydney*, November 1992, pp.11, 53.

general community.[89] It was found that 59 per cent of Vietnamese-born men were significantly more likely to have ever smoked, compared to only 7 per cent of women. However, males were 37 per cent more likely than females (4 per cent) to report that they smoked tobacco on the day of the survey. But, when compared to the general Australian community, the use of tobacco on a daily basis among Vietnamese-speaking men was 37 per cent compared with 26 per cent, and in the case of Vietnamese-speaking women was much lower – 4 per cent, compared to 22 per cent.[90] The study also found that among Vietnamese-speakers, the unemployed were more likely to report using tobacco on the day of the survey (49 per cent), than other groups (25 per cent). Also, 72 per cent of the people interviewed reported that they first started smoking in Vietnam.[91]

4.46 Amongst the Chinese-speaking community, although there were no differences between smokers and non-smokers in terms of nominated health or social problems associated with tobacco use, the most common social problem associated with tobacco use was identified as passive smoking.[92] These findings suggest that the Chinese community may now be more receptive to the current anti-smoking campaigns that focused on the problems of passive smoking, particularly if instigated at a community level.[93] However, a study conducted amongst the Chinese community in Sydney found that men were far more likely than women to have smoked tobacco. This situation was most marked for the 25-39 year group.[94] Others mentioned that smoking was an important social habit for the elderly, and some evidence suggests that young, unemployed Chinese smoked to relieve boredom.[95]

4.47 Chinese cultural practices have an important influence on smoking trends in the Chinese-speaking community. The main reason the Chinese smoke is for social reasons. The offering of cigarettes is seen as a sign of hospitality and friendship. Smoking represents acceptance of this hospitality. It has therefore been suggested that the social needs of the Chinese need to be addressed in education campaigns which promote role models for refusing cigarettes and creating an environment in which smoking is seen as an anti-social behaviour.[96]

4.48 Ethnic origin has also been found to be a statistically-significant predictor of smoking behaviour in school children aged 9 to 15 years. For example, significantly

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89 *ibid*., p.29.

90 *ibid*., pp.42-3.

91 *ibid.*, pp.43-4.

92 S. Everingham, and B. Flaherty, *Alcohol and other Drug Use, Attitudes and Knowledge Amongst Chinese-Speakers in Sydney*, Drug and Alcohol Directorate, NSW Health Department, June 1995, p.38.

93 *ibid.,* p.81.

94 *ibid*., p.49.

95 *ibid,* p.61.

96 *ibid.* p.80.

fewer children of Asian origin are smokers compared with other non-English speaking children in the same age group.[97] Research by Gliksman *et al.* found that the differences in the prevalence of smoking in children of ethnic origin strongly suggests an important role for cultural as well as familial factors in determining the smoking behaviour of children. Therefore, the smoking behaviour of influential women, particularly mothers, may be of importance in the smoking behaviour of children, and that this may be particularly so for certain ethnic groups.[98]

4.49 The prevalence of coronary heart disease risk factors varies with ethnic origin in adults and children, with persons of Asian ethnic origin generally appearing to have the lowest level of risk factors, with the notable exception of the prevalence of cigarette smoking.[99] However, closer examination of the patterns of cigarette smoking among Asian adults revealed that while this prevalence is very high among men, it is very low among women..[100]

4.50 As has been shown above, and as the Drug & Alcohol Multicultural Education Centre has concluded in a report forming part of their submission to the Committee, the ethnic communities in Australia cannot be treated as a homogeneous group. In some non-English speaking communities tobacco use is much higher than that found in the general Australian population.[101] As a result of studies into the Vietnamese, Greek and Chinese-speaking communities, prevention strategies which were recommended included the provision of effective information via the media to the ethnic communities and, in particular, information on the contribution of tobacco smoking to specific causes of mortality and morbidity.[102]

4.51 The Department of Human Services and Health advised the Committee that a specific NESB tobacco and health education strategy is being developed to ensure that the needs of people from non-English speaking backgrounds are addressed. As an initial step in implementing this strategy a comprehensive research project will be

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97 M. Gliksman *et al.,* 'Cigarette Smoking in Australian Schoolchildren', *Medical Journal of Australia*, Vol.150, 1989, p.83.

98 *ibid.*

99 *ibid.*

100 *ibid.*

101 CEIDA (The Centre for Education and Information on Drugs and Alcohol), The Migrant Health Services Unit, Southern Metropolitan Health Region, The NSW Drug and Alcohol Authority, *The Drug Use Patterns of Four Ethnic Communities: A Summary*, CEIDA, 1987, p.22. See Submission No.69 (NSW Drug and Alcohol Multicultural Education Centre).

102 S. Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Vietnamese-Speakers in Sydney*, November 1992; S. Everingham, A. Martin and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Greek-Speakers in Sydney*, May 1994; S. Bertram and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Spanish-Speakers in Sydney and Wollongong* , March 1993; S. Everingham and B. Flaherty, *Alcohol and Other Drug Use, Attitudes and Knowledge Amongst Chinese-Speakers in Sydney*, June 1995, Research Grant Report Series, Drug and Alcohol Directorate, NSW Health Department.

undertaken into smoking prevalence and attitudes to tobacco use in a range of non-English speaking communities.[103]

Conclusions

4.52 Although young people who were born overseas or are of non-English speaking background are more likely to be aware of tobacco-use risk through the youth strategy campaign which is aimed at reducing smoking in the younger age group, older people in some ethnic groups where the smoking rate is high also need special targeting. The Committee feels this may best be achieved through liaison with ethnic organisations, migrant health services, and the ethnic media. In this way appropriate programs can be developed to address the particular issues of people in most need, taking into account specific cultural situations and language requirements.

Recommendations

The Committee RECOMMENDS:

38. That strategies, sensitive to the cultural backgrounds and values of people from non-English speaking backgrounds, be implemented to address the problem of tobacco use in these communities.

39. That funding be provided by the Commonwealth Government for programs to address the problem of tobacco use amongst people from non-English speaking backgrounds, including older people.

Senator John Herron
Chairman

December 1995

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103 Letter from DHS&H to the Committee, dated 23 October 1995, p.17.

DISSENTING REPORT BY SENATORS NICK MINCHIN AND SUE KNOWLES

The Senate Committee report on the Tobacco Industry and the Costs of Tobacco-related Illness has, in the main, our wide support. The recommendations that seek to encourage people to stop smoking and discourage young people from taking up the habit are to be applauded.

However, in dissenting from the Majority Report we wish to record our opposition to those recommendations in particular which seek to regulate further an industry that we believe is already subject to a high level of regulation. It was emphasised by witnesses during the inquiry that the tobacco industry is already the most highly regulated industry in Australia.[1] We believe that further regulation should only be introduced to address specific and clearly identified problems and should only be adopted if it is clear that legislative intervention will provide an effective solution. We do not believe that the majority has made a convincing case in this regard.

We also oppose those recommendations that seek to intrude into areas that are more properly the responsibility of the States and Territories or that will have an adverse impact on business, especially small business.

We support those recommendations in the majority report that seek to discourage tobacco use amongst adolescents, and we agree that this is best achieved through means such as educational initiatives (recommendations 14-16), introducing a minimum age for the purchase of tobacco products (recommendation 23), and requiring proof-of-age to purchase tobacco products (recommendation 24). We do not consider that restricting the number of retail outlets or other regulatory measures are appropriate, nor are they likely to be effective in reducing access by minors to tobacco products.

We are grateful that the majority report has accepted our recommendation to go further than merely recommending that a minimum age of 18 years for the purchase of tobacco products be introduced (recommendation 23).

We believe that the States and Territories should investigate the feasibility of making it an offence for persons under the age of 18 years to purchase tobacco products. We consider that in order to encourage compliance with the law there is a need to penalise children and adolescents in some manner in order to deter them from attempting to purchase tobacco products. We believe that such a measure would encourage individual responsibility on behalf of adolescents, assist parents in their responsibility to prevent under-age smoking, and lessen the onus on proprietors of

1 See Submission No. 45, p.1 (Wills).

accepting the full responsibility for the sale of tobacco products to minors, as is the case at present.

Senator Minchin wishes to record his dissent from the Committee's statements that it believes cigarettes are addictive (1.25) and that passive smoking causes a number of adverse health effects for non-smokers (1.34).

The Committee's terms of reference did not ask it to reach conclusions on these controversial issues, and nor was sufficient evidence from both sides of the arguments brought to bear.

These are medical conclusions which it is inappropriate for this Senate Committee of inquiry to reach.

Our response to those recommendations in the majority report which we oppose are detailed below.

Recommendation 1:

That smoking not be permitted in enclosed places, including office, factory, shop or other work sites, shopping centres, restaurants, theatres, hotels and sporting venues.

Recommendation 2:

That in respect of offices, shops, restaurants etc., outdoor or separately ventilated indoor spaces be made available for smokers, but that staff not be compelled to work in, or service, these areas.

The adoption of smoke-free policies in the workplace should arise from arrangements entered into between management and employees, as occurs at present. These policies should not be 'directives' imposed by the Commonwealth. With regard to restaurants, an increasing number currently offer patrons the opportunity to select a smoking or non-smoking section. Imposing a total smoke-free policy on restaurants would create economic problems for many in the industry through a loss of restaurant patronage.

We believe that imposing a non-smoking ban on outdoor sporting venues is not practical and would discriminate against smokers who use such venues for legitimate entertainment purposes. We also consider that the economic cost to industry of imposing smoking bans in the workplace, shopping centres, and restaurants, would be considerable, especially for small businesses.

Senator Minchin believes that:

Proponents of bans on smoking in the workplace and other public places base their demands on the premise that tobacco in the air – passive smoking – can harm the health of non-smokers.

These claims are not yet conclusively proved. For example, it has been estimated that in a workplace that permits smoking, it would take between 260 and 1000 hours for a non-smoking worker to be exposed to the nicotine equivalent of a single cigarette. A worker might be exposed to between 2 and 4 cigarette equivalents in a full year of work. It has also been estimated that it would take 300 hours of dining in a restaurant that permits smoking, to be exposed to the nicotine equivalent of one cigarette.[2]

More generally there is insufficient evidence to link passive smoking with a range of adverse health effects. A recent major study commissioned by the Tobacco Institute of Australia concluded that the data did not support a causal relationship between exposure to environmental tobacco smoke (ETS) and lung cancer or heart disease in adults. In relation to the health effects on children, the study concluded that while exposure to ETS is associated with an increased risk of lower respiratory tract infections in infants, there is a weak association between exposure to ETS in infancy and the subsequent likelihood of developing asthma. The study also argues that exposure to ETS was associated with only a small increase in risk for upper respiratory tract infection in children.[3] These findings have also been supported in evidence to the Committee by the Tobacco Institute and Philip Morris.[4]

Recommendation 5:

That the *Tobacco Advertising Prohibition Act 1992* be amended to remove the provision for the exemption of publication of tobacco advertisements in association with specified sporting and cultural events of international significance and that this be phased in by the year 2000.

We do not support this recommendation and believe that the current exemption for tobacco-related sponsorship of sporting and cultural events of national significance that might otherwise be not held in Australia should remain.

Events that are permitted under the current exemption provisions are of considerable importance for State economies, bringing additional revenue into those States and providing many job opportunities. We are concerned that without the exemption, many events, such as the Formula One Grand Prix, Telstra Rally Australia and the

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2 Submission No. 44, Appendix 5, section 1 (Philip Morris).

3 J. Lee *et al., Health Aspects of Environmental Tobacco Smoke*, November 1994, pp.viii-xi.

4 See Submission No. 43, pp. 9-10 (Tobacco Institute of Australia); Submission No. 44, Appendix 5, section 1 (Philip Morris).

Australian motorcycle and Indy Car Grand Prix would not be held in Australia and would thereby deprive the Australian sporting community of the opportunity to view sporting events of international standard. International teams are generally not sponsored by local tobacco companies.

We are also not convinced that sufficient evidence exists to support the claims that advertising sponsorship by tobacco companies of such major sporting events acts as advertising by encouraging children to take up smoking. The tobacco companies admitted that, in general, such advertising around the world encouraged brand changing more than motivating people to start smoking.[5]

The events that are currently permitted are held under very stringent conditions, laid down by the Minister for Human Services and Health, on the type of advertising that is allowed. We note that in granting an exemption for tobacco advertising at the 1996 Melbourne Grand Prix the Minister applied the most stringent conditions ever applied by the Commonwealth Government to such an event. Tobacco advertising at that event will only be permitted where it relates to existing international contracts for track signage and sponsorship of teams and drivers. Signage other than that associated with the driving teams will be required to carry health warnings, and will be required to occupy at least 25 per cent of the total area of each sign. In addition, advertising away from the track will be prohibited.[6]

We believe that these conditions are a 'fair compromise' that allow events of international significance to be seen and enjoyed by the Australian community generally.

Recommendation 6:

That the Commonwealth Government establish a national health promotion foundation or other appropriate national body to provide an alternative source of sponsorship funding to that provided by tobacco companies for major sporting and cultural events.

We question the feasibility of establishing a national foundation when foundations currently exist in several States and the ACT. This surely begs the question of why such a foundation is needed at the national level. It would surely be more cost effective for these foundations to co-ordinate their activities and minimise administrative costs.

Certainly no national foundation should be established before conducting a detailed analysis of the operations of the State Foundations.

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5 Supplementary Submission No.44, section 5 (Phillip Morris).

6 Minister for Human Services and Health, *News Release*, 20 September 1995.

Recommendation 8:

That, while the Committee favours the listing of nicotine in tobacco prepared and packed for smoking as a Schedule 7 poison by the National Drugs and Poisons Schedule Committee, it believes that further investigation of the implications of this proposal should be undertaken by the Council of Australian Governments and the Australian Health Ministers' Advisory Council.

We do not support the first part of the recommendation until assessment of the implications of such a move**,** and especially, the effect listing would have on the availability of tobacco products to Australian consumers, has been made**.**

Given that monitoring and implementation of such a proposal rests with the States and Territories, we are also concerned that insufficient attention has been paid in the Majority Report to questions of how such a measure could be effectively implemented.

In the areas of product labelling and health warnings – two areas that may potentially be affected by Scheduling – the current consumer information provided on tar, nicotine and carbon monoxide levels in cigarettes and the health warnings on packs (that are required to occupy 25 per cent of the pack) is more than sufficient.

The Commonwealth Department of Human Services and Health (DHS&H) advised the Committee that 'scheduling', as a means of regulatory control of drugs and poisons or as a means of achieving desirable health outcomes, is not an automatic, nor necessarily the best, choice for governments.[7] The Department argued that in the case of tobacco, other methods, such as demand reduction in the form of educational campaigns and warning labels, are more appropriate. DHS&H stated that:

> This strategy excludes scheduling as a supply-reduction measure, because the habit is so widespread in the community and restrictive scheduling would be difficult to implement. Prohibitive scheduling of tobacco has the potential to create social problems similar to those experienced when outright prohibition of alcohol was attempted in the USA.[8]

We share these concerns.

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7 Letter from DHS&H to the Committee, dated 23 October 1995, p.10.

8 *ibid.*

Recommendation 11:

That a list of the ingredients in tobacco products, and their effects, be distributed (in an appropriate form) with all tobacco products sold in Australia.

We consider that, if individual consumers wish to know what particular additives are in particular brands of cigarettes, a composite list of additives provided by the tobacco companies could be made available to the public through the Commonwealth Department of Human Services and Health upon application.

We do not support this recommendation as it would not be practical to provide a list of additives with tobacco products sold in Australia. Further, we consider that there is no demonstrated consumer demand that such information be disclosed.

We note that in 1992 Commonwealth and State Health Ministers considered the question of additives and concluded that the health risks from known additives were not significant and that further action to provide more consumer information on tobacco additives was not justified. This decision was reaffirmed by the Ministerial Council on Drug Strategy in June 1995.[9]

We are also concerned that a requirement to disclose additives would compel tobacco companies to disclose commercially sensitive material, and this would be potentially damaging to the individual companies. Evidence to the Committee from one tobacco company noted that:

> There are also some commercial issues. There are trade formulas, much like the Coca-Cola formula, and putting them on the side of our pack would be giving our competitors a distinct commercial advantage. We like to think that our cigarettes are superior to theirs, and I am sure they like to think the same about their own products. But there are commercial issues here about putting formulas and ingredients on the sides of packs. There would need to be commercial protection.[10]

Recommendation 17:

That no smoking be permitted (including smoking by students, staff, parents and visitors) on any school premises; and that students who are found in breach of this be counselled, and supported through drug education and 'Quit' smoking programs.

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9 *ibid.,* pp.11-12.

10 *Transcript of Evidence*, p.487 (Philip Morris).

This issue is more appropriately left to individual school communities. This is yet another attempt by the Commonwealth to 'impose' solutions on the States and Territories. We consider that any moves towards the implementation of non-smoking policies in schools should be done in consultation with the local school communities and the State and Territory governments**.**

Recommendation 21:

That the Commonwealth, State and Territory Governments ensure that there are regular real increases in levels of excise duties and business franchise fees levied on tobacco products; and that the revenue from these taxation increases be directed to tobacco control and health promotion activities.

We do not support the recommendation that there be regular real or excessive increases in the levels of excise duties and business franchise fees levied on tobacco products. We support the current arrangements whereby excise duties are indexed in line with movements in the CPI.

The current levels of tobacco taxation are already excessive. Total tobacco taxation (excise plus State tobacco franchise fees) has escalated substantially during the 1980s and 1990s. The rate of excise on cigarettes has increased by 13 per cent in real terms in the period 1982-94. This, coupled with the enormous increases in State Licence Fees, means that total tobacco taxation receipts have increased in real terms from $1.7 billion in 1981-82 to $3.3 billion in 1993-94, an increase of 96 per cent.[11]

ACIL has estimated that smokers are already taxed an additional $2.2 billion over and above their use of subsidised health care.[12]

Tobacco taxes are also a regressive form of taxation because a higher proportion of smokers are from lower socio-economic groups; thus, a higher proportion of their total expenditure goes on tobacco products. Data from the 1988-89 ABS Household Expenditure Survey show that tobacco product consumption amounts to just over 5 per cent for the lowest income groups compared to only 2 per cent for the highest income groups.[13]

Tobacco taxation is very inequitable. Further tax increases will only hurt lower income groups and the poor. It is unfair and inequitable that the tax burden falls most heavily on those in our society least able to bear it.

In addition, as the demand for tobacco is relatively resilient to price increases, smokers may forego consumption in other areas rather than limit their consumption

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11 Supplementary Submission No.45, p.4 (Wills).

12 ACIL, *Smoking: Costs and Benefits for Australia*, March 1994, p.vii.

13 Supplementary Submission No.45, p.4 (Wills).

of tobacco. This can have undesirable consequences, for example, smokers may divert resources from spending on food, health care or education to fund their spending on purchases of cigarettes.

Senator Minchin wishes to record that he does not support the second part of the recommendation that proposes any revenue from the proposed tobacco taxation increases be directed to tobacco control activities. His stand is based on opposition to the principle of hypothecating, or dedicating, taxes to a particular purpose.

Senator Minchin also wishes to record his dissatisfaction with the Majority Report's apparent reliance on the Collins & Lapsley studies, in preference to the ACIL study, to justify its conclusion that even greater 'cost-recovery' should be extracted from smokers.

Senator Minchin notes that the ACIL study was reviewed by three eminent economists (Professor Tollison, Professor Parish and Dr Albon).

All three concluded that the ACIL approach was superior to Collins and Lapsley, and that the Collins and Lapsley methodology was seriously flawed.[14]

Professor Parish noted in his review that 'the C and L study does not conform to any of the standard canons of cost-benefit methodology and, in my opinion, is largely nonsense'.[15]

Recommendation 22:

That tobacco products be removed from the basket of goods used in the calculation of the Consumer Price Index.

We do not support this recommendation. The Consumer Price Index (CPI) aims to give a guide to the movements of consumer prices generally and the exclusion of one item of the expenditure (eg. tobacco products) of relative importance in terms of household budget for many households, would only distort the index. If tobacco products were excluded from the CPI there would be little reason why other products would not be excluded.

One submission to the Committee stated that 'any adjustment of the CPI, either to the respective weights of the existing CPI basket or to the goods or services included in the basket, should continue to be based on an objective assessment of the current expenditure patterns of Australians'.[16]

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14 See Submission No. 65 (ACIL), Appendices 1-3.

15 R. Parish, *Comments on ACIL 'Smoking: Costs and Benefits for Australia'*, Monash University, March 1994, p.6, cited in Submission No. 65 (ACIL).

16 Supplementary Submission No.44, section 4, p.2 (Philip Morris).

We also consider that the Majority Report recommendation would mask the inflationary effects of tax-driven price increases.

Removing tobacco from the CPI would severely disadvantage Australian workers and social security recipients as the wages of many Australian workers and the payments to social security recipients are indexed to rises in the CPI.[17]

Recommendation 25:

That there be a reduction in the number of retail outlets permitted to sell tobacco products and that:

- **as an interim measure, tobacco products be isolated from other products for sale in all outlets currently selling tobacco products; and**
- **in the longer term, those retail outlets permitted to sell tobacco products be restricted to licensed premises and to tobacconists; and that this be phased in to minimise any disruption to small business.**

In opposing this recommendation, we believe that the economic dislocation to business, and small business in particular, by restricting the number of retail outlets permitted to sell tobacco products would be catastrophic.

Tobacco products represent a significant and profitable product category for many retailers. The marketing and sale of tobacco products is an integral part of the business and income of tens of thousands of retailers.

One submission stated that 'there are adverse consequences to the implementation of availability restrictions. Immense economic dislocation would be caused to the tobacco retail market by such restrictions; businesses would close and jobs would be lost'.[18]

Evidence to the Committee indicated the importance of tobacco sales to many businesses. For tobacconists, tobacco sales constitute 85 per cent of total dollar turnover. Corresponding percentages for other types of retail outlets are – service stations (40 per cent), convenience stores (30.5 per cent), milk bars (25 per cent), and grocery stores, including supermarkets (8 per cent).[19]

Small retail outlets selling tobacco also provide employment for thousands of people, particularly young people and women. The employment opportunities provided are

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17 See *ibid.,* pp.1-2.

18 *ibid.,* section 11, p.1.

19 *ibid.*

extremely important in many communities, particularly country towns and small communities.

At a time of high and increasing unemployment across Australia we deplore the fact that this measure would specifically discourage small business from expanding and providing employment opportunities for Australians.

Recommendation 26:

That the licensing systems in all States and Territories provide for the suspension or revocation of a licence where retail outlets sell tobacco products to minors.

In opposing this recommendation we consider that issues relating to licensing are matters that are more properly the responsibility of the States and Territories. We believe that this recommendation is yet another attempt by the Commonwealth to dictate policy to the States and Territories.

Recommendation 28:

That, as it is virtually impossible to prevent access by children to cigarette vending machines, these types of vending machines be prohibited in all States and Territories.

Such a measure would place many vending machine operators in severe financial difficulties and would put many vending machine operators out of business. This recommendation, if implemented, is yet another attack on small business.

We believe that if it became an offence for persons under the age of 18 years to purchase tobacco products (see recommendation 23), this would send a clear message to minors that the purchase of cigarettes, from any source, should not be contemplated.

The Majority Report itself notes that vending machines are currently restricted in all States to areas in which children and adolescents are not permitted without adult supervision.

The economic impact of this recommendation could mean:

- around 100 small businesses closing almost overnight;
- the write off of vending machinery with a purchase cost of some $73 million;
- loss of jobs for in excess of 500 people involved in installation, service and maintenance activities; and

- no change in the total consumption of tobacco, but arbitrary reduction of some $180 million in retail sales to different sales outlets.

Senator Nick Minchin
(LP, South Australia)

Senator Sue Knowles
(LP, Western Australia)

APPENDIX 1

ORGANISATIONS AND INDIVIDUALS WHO PRESENTED WRITTEN SUBMISSIONS TO THE INQUIRY

Submission No.

1 Mr/Mrs G S Palmer

2 Mr Terry M Alchin

3 Flinders Medical Centre, Respiratory Unit, Department of Medicine

4 Mr David H Lewis

5 International Union Against Cancer

6 Mr J N Reavell

7 Dr Simon Barraclough

8 Dr Ben Ewald

9 Ms Liesel Scholem

10 Ms Kim Skaya

11 Canberra ASH Incorporated

12 Dr Colin Mendelsohn

13 Dr Robert Albon

14 Tobacco Action Group

15 Mr Ian Martin

16 Christian Leaders in Waverley

17 Smokenders (Australia) Pty Ltd

18 Marion Merrell Dow Australia Pty Ltd

19 Mr Kevin Anderson

20 Northern Territory Tobacco Interest Group

21 Department of Industry, Science and Technology

22 Dr Mitchell Smith

23 Public Health Unit for Central and Southern Sydney

24 Quit – South Australian Smoking and Health Project

25 Hunter Centre for Health Advancement

26 Victorian Health Promotion Foundation

27 Commonwealth Department of Human Services and Health

28 Ms T Henderson

29 Australian Council on Smoking and Health

30 Mr W M Castleden, MS FRCS FRACS

31 Allergy and Environmental Sensitivity Support and Research Association

32 Ms Carol Roe

33 Dr W S Egerton, MBMS FRACS

34 Rothmans of Pall Mall (Australia) Limited

35 Hobart District Health Forum

36 The Non-Smokers' Movement of Australia Inc.

37 Mr John A H Booth, MIPM AIMM

38 ACT Government

39 Northern Territory Department of Health and Community Services

40 Australian Cancer Society

41 ASH Australia

42 National Heart Foundation

43 Tobacco Institute of Australia

44 Philip Morris Limited

45 W.D. and H.O. Wills (Australia) Limited

46 Anti-Cancer Council of Victoria

47 Centre for Adolescent Health

48 Dr Steven Gourley, MBBS FRACP

49 The Royal Australasian College of Physicians

50 Tasmanian Cancer Committee

51 The Health Department of Western Australia

52 Queensland Cancer Fund

53 NSW Cancer Council, Australian Consumers' Association & Public Health Association of Australia

54 Australian Medical Association Limited

55 Royal Australasian College of Radiologists

56 The NSW Government

57 Mr Owen Graham

58 Queensland Department of Health

59 Dr H W Lea

60 Australian Council for Health, Physical Education and Recreation (NSW Branch)

61 The Thoracic Society of Australia and New Zealand (WA Branch)

62 Victorian Department of Health and Community Services

63 Professor GJV Nossal

64 Tahir Turn

65 ACIL Economics & Policy Pty Ltd

66 Federation of Australian Retail Tobacco Trade Associations

67 Convenience Stores Australasia

68 WA Tobacco Retailers' Association

69 NSW Drug & Alcohol Multicultural Education Centre

70 Newsagents Association of NSW and ACT

71 Australian Institute of Health & Welfare

APPENDIX 2

DATES OF PUBLIC HEARINGS

Canberra	18 November 1994
Melbourne	24 November 1994
Canberra	3 February 1995
Sydney	10 February 1995
Cairns	22 February 1995

APPENDIX 3

WITNESSES WHO APPEARED AT PUBLIC HEARINGS

Dr S J Benjamin	Public Health Registrar Australian Medical Association Barton ACT
Prof G Bowes	Director Centre for Adolescent Health Parkville VIC
Mrs E Cain	Director Tobacco and Workplace Section Drugs of Dependence Branch Department of Human Services and Health Canberra ACT
Mr R H Carr	Research Fellow Cairns Economic Research Unit James Cook University Cairns QLD
Dr M R Carr-Gregg	Centre for Adolescent Health, Parkville VIC
Mr W G Carter	Acting Assistant Secretary Industrial Crops Branch Department of Primary Industries and Energy Canberra ACT
Mr D Chapman	Chief Executive Officer W.D. and H.O. Wills (Australia) Ltd Pagewood NSW
Assoc Prof S F Chapman	Department of Public Health & Community Medicine University of Sydney Westmead Hospital Westmead NSW
Dr A Chesterfield-Evans	President Non-Smokers Movement of Australia Sydney NSW

Ms B A Clarke	Acting First Assistant Secretary Engineering, Construction and Resource Processing Industries Division Department of Industry, Science and Technology Canberra ACT
Ms E A Clout	Policy Officer Department of Human Services and Health Canberra ACT
Assoc Prof D Collins	Clareville NSW
Mr D R Davies	Vice-President Philip Morris (Australia) Ltd South Melbourne VIC
Mr M W Derkley	Director Alcohol and Drug Service ACT Department of Health Canberra ACT
Ms S Dwyer	Director Health Advancement Branch Queensland Department of Health Brisbane QLD
Mr K Evans	Director Alcohol and Drug Branch Queensland Department of Health Brisbane QLD
Mr P M Feinstein	National Coordinator Smokenders Bondi Junction NSW
Mr H Goldberg	Managing Director Philip Morris (Australia) Ltd Moorabbin VIC
Ms M H Goodin	Senior Tobacco Policy Officer Alcohol and Drug Service ACT Department of Health Canberra ACT
Dr N J Gray	Director Anti-Cancer Council of Victoria Carlton VIC

Mr R J Greenland	Director Public Relations Australian Medical Association Barton ACT
Mr A M Inglis	Public Affairs Manager Queensland Cancer Fund Fortitude Valley QLD
Assoc Prof K Jamrozik	Member Smoking and Heart Attack Committee National Heart Foundation of Australia WODEN ACT
Ms A P Jones	Executive Director ASH Australia Woolloomooloo NSW
Ms J Kerr	Acting Director Industrial Crops Branch Crops Division Department of Primary Industries and Energy Canberra ACT
Mr A C Kingdon	Acting First Assistant Secretary Department of Human Services and Health Canberra ACT
Mr G Krelle	General Manager Rothmans of Pall Mall (Australia) Ltd South Granville NSW
Ms H M Lapsley	Mosman NSW
Ms C J McIver	Member Allergy and Environmental Research Association Ringwood VIC
Dr P Magnus	Medical Director National Heart Foundation of Australia Woden ACT
Mr S N Mallinson	Marketing Director Philip Morris (Australia) Ltd Moorabbin VIC

Mrs G D Markey	Senior Policy Officer Alcohol and Other Drugs Program Northern Territory Department of Health and Community Services Casuarina NT
Mr R Mulla	Chairman Tobacco Leaf Marketing Board (Queensland) Mareeba QLD
Prof A W Musk	President Australian Council on Smoking and Health; and Spokesperson on Smoking and Health Thoracic Society of Australia and New Zealand Subiaco WA
Dr B Nelson	Federal President Australian Medical Association Barton ACT
Ms K Purcell	Senior Policy Analyst Drug and Alcohol Directorate New South Wales Department of Health North Sydney NSW
Ms L Scholem	Committee Member Non-Smokers Movement of Australia Sydney NSW
Mrs M Schultz	Manager Policy Development Section Drug and Alcohol Directorate New South Wales Department of Health North Sydney NSW
Ms M Scollo	Senior Manager Policy Adviser on Tobacco Anti-Cancer Council of Victoria Carlton VIC
Mr J C Scott	Operations Director Philip Morris (Australia) Ltd Moorabbin VIC

Dr H J Stanton	Chairman Tobacco Control Project International Union Against Cancer; and Associate Health Director South Pacific Division Seventh-Day Adventist Church Wahroonga NSW
Ms D Staunton	Chief Executive Tobacco Institute of Australia Sydney NSW
Ms J Stellato-Pledger	President Allergy and Environmental Research Association Ringwood VIC
Mr P J Taylor	Acting Director Health Services Australian Medical Association Barton ACT
Mr D B Trebeck	Director ACIL Economics and Policy Pty Ltd Canberra ACT
Mr P C Wallace	Chief Executive Officer National Heart Foundation of Australia Woden ACT
Mr R D Whiteway	Assistant Director Agri-food Industry Policy Section Department of Industry, Science and Technology Canberra ACT
Mr S D Woodward	Consultant to Prevention and Early Intervention Committee Queensland Cancer Fund Fortitude Valley QLD