Tobacco Smoking

2005

Introduction

Tobacco smoking is the largest single preventable cause of death and disease in Australia. Smoking contributes to more deaths and hospitalisations than alcohol and illicit drug use combined. It is a major risk factor for coronary heart disease, stroke, peripheral vascular disease, cancer and a variety of other diseases and conditions.[1]

Smoking rates have been in decline over the past few decades, but it is still responsible for the greatest burden on the health of all Australians, with an estimated 18 000 people dying each year as a result of tobacco smoking. Smoking needs to be universally recognised as one of Australia's major drug problems, as it accounts for 80 per cent of all drug-related deaths.[2]

Tobacco costs the nation in excess of $21 billion in 1998-99 in health care, business and other related costs. A significant under-recognised burden of tobacco smoking is carried by the business sector, with an estimated $2.5 billion loss each year in lost productive labour – this is exclusive of the substantial loss of productivity from ‘smoko’ breaks.[3]

In order to reduce the disease, disability and premature death caused by smoking, the Australian Medical Association is committed to reducing the number of individuals who smoke. To achieve this objective, the following changes are necessary:

- A change in the social climate, so that smoking is no longer viewed by the public as normal, but is regarded as unhealthy and unnecessary;
- A change of the economic and legislative climate, so that cigarettes are less readily available, the influences such as advertising and the media that promote smoking are diminished, and educational programs on the hazards of smoking are supported and reinforced;
- A multifactorial approach to assisting and supporting cigarette smokers in quitting, including individual techniques, use of taxation and encouraging smoke-free environments.

Demographics of those who smoke

When considering which population groups are most affected by cigarette smoking, it is important to recognise that smoking often results from macro-economic forces in which it is virtually impossible for individuals to maintain health-promoting lifestyles. Disempowerment of individuals and overwhelming social influences are recognised as increasing contributors to tobacco smoking. This makes smoking not just a major health and human rights issue, but also matter of health equity.

Cigarette smoking prevalence has declined in the mainstream population. As the more affluent have abandoned cigarette smoking, tobacco control has become more difficult.

There are particular population groups that are at greater risk of taking up and continuing smoking. These are:

- Children and young people;
- Aboriginal peoples and Torres Strait Islanders;
- People with mental illness;
- People serving prison sentences; and
- People from lower socio-economic backgrounds.

<u>Children and young people</u>

There is no safe level of cigarette smoking at any time, including for the foetus during pregnancy. The effects of smoking can start in utero, if the mother is a smoker, with the birth of lower birth weight babies. These babies are then at greater risk of adverse health and social outcomes throughout life.

In this situation, smoking can be seen in the context of contributing to a generational cycle of disadvantage.

Adolescence is characterised by experimentation and risk taking. Parental smoking is a strong indicator of the likelihood of teenage uptake of smoking. Young people are particularly susceptible to peer pressure and a recent National Drug Strategy survey[4] showed around one in nine persons aged 14-17 years smoked daily. Small increases in the number of cigarettes consumed during childhood are associated with higher odds of daily smoking in adolescence[5]. Therefore, targeted anti-smoking campaigns, and strategies to protect children from being illegally supplied cigarettes, should be supported.

It is clear that the best protection against smoking-related illnesses is not to start smoking in the first place. Strategies that reduce the desire of children and adolescents to smoke or reduce the ease of access to tobacco products will have an effect on the likelihood of them becoming regular smokers. Price of cigarettes is the most powerful deterrent against smoking in adolescents.

Another deterrent is controlled purchase operations, whereby trained officers and volunteer teenagers check whether retailers are selling cigarettes to children. Retailers who are selling to children can receive warnings and/or prosecution.

Aboriginal peoples and Torres Strait Islanders

The 2001 National Drug Strategy Household Survey found that the prevalence of current smoking among Aboriginal and Torres Strait Islander people was 50 per cent, more than double that of non-Indigenous Australians (23 per cent) [17]. In some regions of Australia, 83 per cent of Indigenous men and 73 per cent of Indigenous women smoke cigarettes, with cigarette smoking often being a cause and effect of disadvantage. Unfortunately, there is little scientific evidence of useful interventions to cease smoking in these populations. As smoking is such a key factor in the birth of Indigenous low weight babies, research to determine the best methods to assist Indigenous women to stop smoking is a priority.

People from Lower Socio-economic Backgrounds

There is a well-documented link between socio-economic status and health status. In the 1994 NSW Health Promotion Survey, smoking rates in men and women increased with increasing levels of socio-economic disadvantage.

People with mental illness

People with a mental illness, particularly a psychotic illness show significantly elevated rates of cigarette smoking compared with the general population (60 per cent compared with 23 per cent). There is some evidence that in locked psychiatric settings staff use cigarettes to clinically manage patients. In community residential facilities, private living areas have been exempt from legislated bans on smoke-free workplaces.

People with mental illness deserve the same support to cease smoking and to avoid its burden of disease as other members of the community.

Tobacco Smoking Cessation

Quitting smoking is a difficult and challenging process with cigarette smokers having to change many entrenched behaviours if they want to quit. In view of this and the impact of smoking on the individual and the health system, smokers deserve all possible assistance and support in giving up smoking and in staying a non-smoker.

Eight out of every 10 smokers have tried to quit. Tobacco-delivered nicotine addiction is often the main reason people continue to smoke, and nicotine is known to be more addictive than heroin.

There is sufficient evidence for nicotine replacement therapy (NRT) to be made available to people smoking more than 10-15 cigarettes a day. While the use of NRT may not suit everyone, it can be very successful in supporting the behaviour change necessary for quitting smoking. Pharmaceuticals that assist in quitting smoking, such as NRT, should be affordable and not more expensive than cigarettes.

Doctors have a role in delivering public health messages to patients. The benefits of quitting smoking may be the most important of these messages. Therefore, doctors have a responsibility to address, support and encourage patients in ceasing cigarette smoking. Each consultation provides an opportunity to do this, even through a simple question about their smoking practices. There needs to be appropriate remuneration to allow doctors to undertake this work.

It is essential that strategic, targeted research be undertaken regarding the supportive environments required for people to cease smoking, particularly among Aboriginal peoples and Torres Strait Islanders and those from lower socio-economic backgrounds.

Tobacco smoking, medication and medical treatments

Being a smoker is known to impede the healing of wounds post-surgery, and increase the risk of infection. Smoking also interferes with the effectiveness of some medications for asthma and mental illness.

Tobacco promotion and advertising

Australia is considered a 'dark market' by the tobacco industry, as it doesn't allow advertising of their products in any form.[6] Direct cigarette advertising on radio and television was phased out in the mid 1970s and in the print media by the early 1990s. However, since that time, tobacco companies have continued to spend millions of dollars on marketing campaigns in their attempts to attract new smokers and circumvent Australia's legislation prohibiting tobacco advertising. This is often through promotional activities where brand images (such as the 'Alpine' mountain) are displayed or free samples are given out.

In most Australian jurisdictions, legislation has been introduced that bans sporting and other healthy pursuits being sponsored (or being seen to promote smoking directly or indirectly) by tobacco companies. However, there are still some exemptions given to international events such as the Formula 1 Grand Prix. These exemptions should not be renewed and governments, which have not already done so, should enact legislation restricting all forms of tobacco advertising and promotion.

Cigarette Packaging

Cigarette packaging has become a critical marketing tool as the pack design is used to create expectations in the consumer about the product. People who smoke cigarettes demonstrate high brand loyalty so packaging that promotes the purchase and trial of a new brand is a critical tool to increase market share. By using the packet as a billboard, the manufacturers are using one of the last remaining legal avenues open to them to promote their product.

Tobacco Companies' use of the Media

Restrictions on tobacco promotion and advertisement in the media have resulted in the practice of cigarette product placement becoming common in films. There is concern about the depiction of tobacco use on screen because of the potential effect it could have on young people starting and carrying on smoking. Through tobacco use on screen, receptive individuals associate stylised, branded smoking behaviour with other aspirational elements of our culture.[9] Studies show an association between on-screen smoking in an adolescent's favourite movie actor and his or her own smoking behaviour.[10]

A recent study in the American Journal of Public Health [11] shows the incidence of smoking scenes in randomly-selected movies, after falling in the early 1980s, had risen again since the 1990s to levels observed in 1950 – when smoking rates were twice as high. This imbalance is alarming as it is at

odds with current social trends in Australian society. The availability of popular movies and television programs in video and DVD formats ensures that the favourable depiction of smoking can have an influence far beyond an initial broadcast.

There is an international movement to limit the depiction of smoking in the media. The Indian Government has ordered that from mid 2005 no-one on film or television should be depicted smoking, and when old films are shown they will have to carry warnings or they'll have smoking scenes blurred. In Australia, a similar restriction on tobacco appearances in films seems a logical and consistent extension of other advertising restrictions imposed on the tobacco industry.

Tobacco Product Labelling

The tobacco industry has been misleading consumers over so-called 'Light', 'Mild' and 'Low Tar' brands for many years. This behaviour has been nothing less than systematic consumer fraud as labelling cigarettes as 'light' and 'mild' offers smokers a false sense of security based on slick marketing and the misuse of words. Industry documents have revealed that tobacco companies have long recognised that these products were as dangerous as regular cigarettes – but continued to push them as healthy alternatives.[7]

In 2005, the Australian Competition and Consumer Commission (ACCC) obtained court-enforceable undertakings from British American Tobacco Australia Limited and Philip Morris Limited to remove 'light', 'mild' and similar descriptors from their products. The companies will also pay $8 million in total to the ACCC to fund anti-smoking information campaigns and programs.

In the ACCC's view, such '*health claims for low-yield cigarettes were likely to have breached section 52 (misleading and deceptive conduct provision) and other sections of the* Trade Practices Act 1974*, for reasons including the fact that it was generally known that smokers can, and do, compensate for claimed lower yields by smoking cigarettes in ways that obtain higher yields of tar, nicotine and carbon monoxide than indicated on the packets.'*[8]

Smoke-free Environments

Passive (involuntary) smoking involves inhaling cancer-causing substances as well as other toxic components in second-hand tobacco smoke. More than 50 studies of involuntary smoking and lung cancer risk in people who have never smoked, especially spouses of smokers, have been published during the last 25 years.[12] Second-hand smoking was responsible for almost 78,000 bed days and $47.6 million in hospital costs in Australia in 1998–99 [17].

This evidence is sufficient to conclude that involuntary smoking is a cause of lung cancer in people who have never smoked. But it is not just lung cancer. Involuntary smoking is associated with a number of other diseases and adverse effects in non-smokers. Exposure to second-hand tobacco smoke causes:

- Coronary heart disease;
- Increased risk of acute heart disease by 25-35 per cent;
- Adverse effects on the respiratory system with the strongest evidence for a causal relationship being for chest-related illnesses.

People have a right to a clean, safe working environment. This includes a smoke-free environment. While most Australian workplaces are now smoke-free, within the hospitality industry there is still a significant number of workplaces where workers are exposed to passive smoking. It is unacceptable to discriminate against certain groups of workers when determining workplace safety policy. Workers in bars and pubs have just as much right to a safe, smoke-free workplace as anyone else. The only way to protect workers' health is to ban smoking in all workplaces.

An article on the tobacco industry manipulation of the hospitality industry stated "*the tobacco industry works to stay out of the public spotlight during any debates over tobacco control policies because of its low credibility. In recent years, the tobacco industry has effectively turned the hospitality industry into its de facto lobbying arm on clean indoor air*".[13] There is no credible research to support the claims that total smoke bans in licensed venues will harm business and cause loss of jobs.

Other environments that have not always been considered smoke-free workplaces are mental health facilities. While acknowledging the burden and challenges of ill-health already experienced by those with mental illness, those working in these areas are also entitled to a smoke-free workplace.

A smoke-free home environment will reduce the impact of smoking on children and also decrease the likelihood that they will also take up smoking. There have also been recent efforts to have cars legislated as smoke-free environments – especially to protect children from cigarette smoke.

Another aspect of smoking and the environment is the impact of discarded butts on the natural environment. Each year, Australians discard 32 billion cigarette butts, creating 40,000 cubic metres of toxic waste, much of which is flowing into rivers and bays. It takes 15 years for a cigarette butt to break down in the environment [16].

Tobacco taxation

Tax increases are the single most effective intervention to reduce demand for tobacco (tax increases that raise the real price of cigarettes by 10 per cent would reduce smoking by about four per cent in high income countries and by about eight per cent in low income or middle income countries).[14] Therefore, governments (Federal, State and Territory) should be encouraged to make repeated real increases in the rate of tobacco taxation, setting aside the resulting revenue for health promotion activities.

The Federal Government has imposed an excise tax on tobacco products since 1901. Until 1 November 1999, excise duty was levied according to the weight of the manufactured tobacco product: in the case of cigarettes, however, since 1999 a 'per stick' tobacco excise system has been in place.

As at 1 February 2005, the excise paid per stick on a cigarette containing 0.8 grams of tobacco is 22.621 cents per stick. Tobacco products containing more than 0.8 grams of tobacco are charged excise at the weight-based rate of $282.76 per kilogram. These rates are subject to an increase in line with the Consumer Price Index, occurring in August and February each year. [15]

State and Territory Government excise on cigarettes should be rationalised to conform to the same amount in each State and Territory.

The current duty free exemption for tobacco products is an unacceptable tax break for a traveller that also reinforces a positive attitude towards cigarette smoking.

Research

Research supports the making of good policy decisions. Further research should be conducted into the reasons why people commence smoking, into methods to help smokers to cease smoking, and into the social and economic cost to the community of the ill-effects of smoking on health. Research needs to be targeted to assist those population groups that bear the greatest smoking burden, such as Aboriginal peoples and Torres Strait Islanders and those from lower socio-economic groups, to give up smoking.

It is inappropriate for medical research to be directly funded by the tobacco industry. If a researcher undertaking research into smoking-related issues has accepted funding from a tobacco company, it should be mandatory to detail the amount and the precise source of funding in the preamble to any presentation or publication of material developed as a result of that research.

The AMA position

1. The Australian Medical Association believes that medical practitioners have a responsibility, by example and precept, to encourage non-smokers to remain non-smokers, and to encourage smokers to quit smoking. Medical practitioners have a responsibility to advise their patients on the risks of smoking, to assist them to quit smoking, and to co-operate with community education programs to discourage smoking. It is essential that medical

practitioners are financially compensated for the time involved with education and cessation activities.

2. The Australian Medical Association (AMA) acknowledges that the addictive quality of nicotine makes it difficult for smokers to give up the practice. For this reason, smokers should be encouraged and supported to give up smoking at every opportunity. Pharmaceuticals that assist in quitting smoking, such as nicotine replacement therapy, should be affordable and not more expensive than cigarettes.

3. The Australian Medical Association believes it inappropriate for political parties to accept sponsorship from tobacco companies and calls upon all parties to refuse to enter into arrangements, that clearly compromise government health policy.

4. The Australian Medical Association agrees to participate with other medical organisations and anti-smoking organisations in approaching the Federal Government regarding a class action against tobacco companies on smoking-related diseases.

5. The Australian Medical Association contends that the use of words ‘light’ or ‘mild’ or the use of ‘lighter’ colours in the packaging of certain products within a company’s range is deceptive and should also be outlawed.

6. The Australian Medical Association believes that generic tobacco packaging could be an effective way to curb the deceptive practices of the tobacco manufacturers. This would also break the link in consumers' minds between images and specific brands – thus helping to decrease the burden of disease caused by smoking in our community.

7. The Australian Medical Association calls on the Federal Government to counter the impact that celebrity smoking is having on young people, both on and off the screen, by amending the Tobacco Advertising Prohibition Act to ensure that inducements to promote tobacco products and smoking in films and other media are clearly illegal, with substantial penalties for breaches. This needs to include warnings on films for video, DVD and TV audiences. There must also be more funding for mass media campaigns to counter the rising glamorisation of smoking in films.

8. The Australian Medical Association believes that product placement in television programs and movies, should be acknowledged at the beginning of the program and should receive a rating that does not allow the program to be shown when people under 18 years of age are able to view the program.

9. The Australian Medical Association believes that life, sickness and disability insurance companies should offer reduced premiums to non-smokers.

10. The Australian Medical Association believes that smoking by teachers, staff, pupils and visitors on or in the immediate vicinity of school premises should be discouraged because of the influence of such behaviour on the early development of smoking habits in children.

11. The Australian Medical Association believes that medical practitioners and other health professionals should not smoke in public when they are identifiable in their occupational role.

12. The Australian Medical Association believes that all forms of public promotion and marketing of tobacco products should be banned. Tobacco products should be not be promoted at the point of sale. Internal promotion by those in the tobacco trade should be strictly proscribed. Where it is required, it should be limited to the provision of information about price, availability and characteristics.

13. The Australian Medical Association is committed to making it more difficult for minors to obtain cigarettes. Any initiative that helps to increase the age at which people first experiment with tobacco products is likely to have an effect on the overall burden of smoking-related diseases in our community. Evidence shows that the younger a person starts to smoke, the

less likely they are to quit and the more likely they are to become heavy smokers, suffer smoking-related health problems, and die prematurely. Therefore, governments and the police forces have a responsibility to enforce the law regarding the sale of tobacco products to minors.

14. The Australian Medical Association is supportive of the use of Controlled Purchase Operations or 'CPOs'. The public health cost of inaction, the evidence to demonstrate that this initiative is best practice, and the overwhelming need to do something to tackle the issue of underage smoking in our community provide compelling reasons to go ahead with this option.

15. The Australian Medical Association believes passive or environmental tobacco smoke is harmful to health. Smoking should be prohibited in all public areas, including all workplaces, restaurants and public transport, with no exceptions to be made. All workers are entitled to a smoke-free workplace. This includes those working in mental health facilities. The AMA encourages smokers to be responsible for disposing of their butts in a way that does not impact negatively on the environment.

16. The Australian Medical Association calls on State and Territory Governments to standardise their excise taxation on cigarettes to the currently highest taxing State. The AMA calls on all governments to make repeated real increases in the rate of tobacco taxation and to set aside the resulting revenue into health promotion activities.

17. The Australian Medical Association supports more targeted research into methods of smoking cessation. This is a particular priority for population groups who bear a greater burden of smoking and smoking-related disease, such as Aboriginal peoples and Torres Strait Islanders and people from lower socio-economic backgrounds.

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