Tobacco Control

Policy Position Statement

Key messages:

PHAA will continue to advocate for all levels of government to maintain and build on evidence-based, comprehensive approaches to tobacco control, and work collaboratively with partner organisations to advocate for action that will help to achieve the lowest possible smoking rates in Australia and internationally.

Key policy positions:

1. Although Australia has been a world leader in reducing smoking, 10.7% of adults aged 18 years and over smoked daily in 2020-21.
2. Daily smoking among Aboriginal and Torres Strait Islander adults aged 18 years and over has declined to 40.2% in 2018–19 from 50.0% in 2004-05.
3. Smoking rates remain high among people with mental health conditions and other priority groups. Reducing smoking rates remains a priority to improve health outcomes and eliminate inequities.
4. Smoking continues to decline among children and adolescents.
5. In Australia, smoking is responsible for approximately 21,000 premature deaths each year and is likely to cause the deaths of two in three regular smokers.
6. A comprehensive and sustained evidence-based approach to tobacco control is required.
7. There has been substantial progress in action to reduce smoking nationally and in all jurisdictions, but the case for action remains urgent.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Alcohol, Tobacco and Other Drugs Special Interest Group

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[Note: please refer also to the PHAA Trade Agreements and Health Policy.]

PHAA affirms the following principles:

1. The *WHO Framework Convention on Tobacco Control* (FCTC) was adopted on 21 May 2003 and formally came into force on 27 February 2005. To date, 182 countries (including Australia, in October 2004) have ratified the Convention and are Parties to the FCTC.(17)
2. A comprehensive approach to tobacco control is required and is consistent with the FCTC. A history of authoritative research has confirmed beyond doubt the importance of measures such as taxation; sustained, adequately funded media campaigns; bans on tobacco promotion; and smoke-free measures as crucial components of a broader tobacco control program.(18-21)
3. The *National Preventive Health Strategy 2021–2030*,(30) the *National Drug Strategy 2017 – 2026*,(31) and the Consultation Draft *National Tobacco Strategy 2022–2030*(32) set out a comprehensive approach to tobacco control. This is consistent with the approach recommended by the National Preventative Health Taskforce(33) and the WHO.(34)
4. It will be important to ensure that Federal, State and Territory governments maintain a strong focus on tobacco control, implement consistent approaches, and provide adequate funding for components, such as Aboriginal and Torres Strait Islander specific tobacco control measures, national media campaigns, cessation supports, and special programs for priority populations.

PHAA notes the following evidence:

5. Tobacco remains the leading cause of Australia's largest preventable causes of death and disease.(1) The World Health Organization (WHO) estimates that smoking kills more than 8 million people each year.(3) Increasingly, the burden of mortality and morbidity is moving to low and middle income countries, which are being targeted by multinational tobacco companies.
6. Australia has been a world leader in reducing smoking, with smoking rates continuing to decline in adults, children and adolescents. For example, 10.7% of adults aged 18 years and over smoked daily in 2020-21, a decline from 23.8% in 1995.(4) Despite this reduction, smoking was estimated to be responsible for 21,000 deaths in 2015 alone, and contributes to 8.6% of the total burden of disease in Australia.(1) Smoking is likely to cause the deaths of two thirds of current Australian smokers – or some 1.8 million Australians alive today.(6)
7. There has been a significant reduction in smoking prevalence among Aboriginal and Torres Strait Islander peoples, down to 40.2% in 2018–19 from 50.0% in 2004-05.(7) This is an absolute decrease in prevalence of 9.8% and represents almost 50,000 fewer Aboriginal and Torres Strait Islander smokers compared to if prevalence had remained the same (7). However, patterns of smoking prevalence are

not uniform and there is considerable variation in tobacco use by location, age group and gender.(8, 9) For example, Aboriginal and Torres Strait Islander people in remote areas are more likely than those in non-remote areas to smoke on a daily basis.(8) In addition, while there has been encouraging declines in smoking rates among Aboriginal and Torres Strait Islander populations, inequities between the daily smoking rate among Aboriginal and Torres Strait Islander and non-Indigenous population remains.(10) Despite these improvements in smoking prevalence, tobacco use remains the leading contributor to mortality for Aboriginal and Torres Strait Islander peoples, accounting for 37% of all Aboriginal and Torres Strait Islander deaths, and half of all deaths at age 45 years and over.(11)

8. Individuals with mental health conditions have a higher prevalence of smoking, and those who smoke tend to smoke more heavily than the general population.(36) Illnesses caused by smoking such as cardiovascular disease, respiratory disease and cancer account for a significant proportion of the life expectancy gap between people with and without a mental illness.(37) Smoking prevalence is also significantly higher among LGBTIQ+ peoples.(38)

9. The total cost of smoking in Australia was estimated for 2015/16 at $136.9 billion ($19.2 billion in tangible costs and $117.7 billion in intangible costs).(14)

10. There is no risk-free level of exposure to second-hand smoke.(15) Non-smokers exposed to second-hand smoke at home or work are at increased risk of developing heart disease by 25-30% and lung cancer by 20-30%.(16)

11. Australia's tobacco plain packaging legislation (fully implemented from December 2012) has been hailed internationally as a momentous win for public health despite ferocious opposition from the global tobacco industry.(22) The primary aim of the legislation, as part of a comprehensive approach, was to influence children and young people: post-implementation research studies provide early evidence that plain packaging is achieving its objectives, including by lowering pack appeal, reducing satisfaction of cigarettes and contributing to declines in smoking prevalence.(23, 24) Many countries have followed Australia's lead and adopted this legislation, and others have announced their intention to do so.(25, 26) The tobacco industry has been active in seeking to undermine plain packaging,(26, 27) but all tobacco industry legal actions opposing plain packaging thus far have failed in national and international courts and tribunals.

12. Despite the measures introduced by Australian State/Territory governments, there is clear evidence that tobacco companies are continuing to promote their products,(27-29) including through retail outlets and elsewhere,(28) and to lobby against any action that might reduce their sales.(27) Article 5.3 of the Convention states that "In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law".(17)

13. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3 – Good Health and Wellbeing.

PHAA seeks the following actions:

14. Ensure a strong and continuing focus on tobacco control, adopting and maintaining comprehensive evidence-based approaches, including:

    a. Regular increases in tobacco excise and customs duty on tobacco.

b. Funding for the national tobacco campaign, supported by complementary components at state/territory levels.
c. Continue to grow and mature the Tackling Indigenous Smoking Program nationally and other Aboriginal and Torres Strait Islander specific programs and policies, including supports for Aboriginal Community Controlled Health Service to reduce smoking and nicotine dependence. This includes growing Aboriginal and Torres Strait Islander specific tobacco control evidence, led by Aboriginal and Torres Strait Islander peoples.
d. Ban all forms of tobacco advertising and promotion, including any remaining promotions at point of sale and elsewhere, public relations and lobbying, and political donations.
e. Require tobacco manufacturers to report on any remaining promotional activities, expenditure and on sales volumes.
f. Legislate to enable regulation of the product itself, to require comprehensive and easily understood warnings about the product and to outlaw all features, names and implicit claims likely to falsely reassure smokers or make products more attractive to children.
g. Implement all possible measures to protect non-smokers, especially children, from the dangers of passive smoking.
h. Ensure that public health and evidence based smoking cessation supports are widely available and accessible, particularly for priority groups.
i. Ensure strong support and substantially increased funding to encourage and assist in reducing smoking among people with mental health problems.
j. Phase out smoking from all health care facilities, including psychiatric and drug and alcohol treatment services.
k. Ensure that all inmates and staff in adult and juvenile correctional facilities have smoke-free environments.
l. Strengthen enforcement action to stop imports of nicotine e-cigarette products unless accompanied by a valid medical prescription and/or documentation declaring that they are bound for a registered pharmacy or licensed pharmacy storage facility.
m. Ensure that all sectors of government are aware of and comply with Article 5.3 of the FCTC.

PHAA resolves to:

15. PHAA will work collaboratively with other health organisations to advocate for prevention and intervention programs that will help to achieve the lowest possible smoking rates in Australia and internationally.

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(First adopted 2008, revised 2011, 2014, and 2017)

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