A MULTI-DISCIPLINARY STUDY INTO THE DRIVERS OF SMOKING CESSATION IN AUSTRALIA

ALBERTO AZIANI | CARLOTTA CARBONE | SERENA FAVARIN | SAMUELE CORRADINI

BOTEC ANALYSIS

UNIVERSITÀ CATTOLICA del Sacro Cuore

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Editors and authors: Alberto Aziani, Carlotta Carbone, Serena Favarin, Samuele Corradini

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A multi-disciplinary study into the drivers of smoking cessation in Australia was prepared under contract with BOTEC Analysis within the framework project *A multi-disciplinary investigation into the drivers for smoking cessation in five countries with ANDS markets funded* by the Foundation for a Smoke Free World. Grant principals: James E. Prieger, Professor at Pepperdine School of Public Policy and senior researcher at BOTEC Analysis and Samuel C. Hampsher, Managing Director at BOTEC Analysis.

Credits: R. Davis (picture p.30), World Health Organization (pictures p.50, 53, 55, 58)

Preface

Smoking is one of the main risk factors for health. Tobacco consumption contributes to a variety of non-communicable diseases, including cancer, heart disease, stroke, chronic respiratory diseases, and diabetes. The WHO (2019) estimates that tobacco consumption is the leading cause of death for smokers; about one in every two smokers dies from smoking-related causes every year. Approximately eight million people a year die from diseases associated with smoking. In response to this, over the past four decades, numerous countries have introduced successful tobacco control policies, which have resulted in longer and healthier lives for their population. Since 2000, Australia, United Kingdom, Sweden and Canada have reduced their smoking prevalence by more than 40%, while Colombia, Norway, and Iceland have done so by more than 50%. Despite this, smoking persists, even in those countries where policies have been implemented, and especially among more disadvantaged social groups. Moreover, smoking reduction policies in other countries have hitherto not been as successful. Indeed, smoking rates in Egypt, Oman, Morocco, and Croatia have steadily increased from 2000 onwards.

The relatively long history of smoking cessation policies allows for a better understanding of what works, what does not, why, and how. Today, policy-makers seeking to further reduce the morbidity and mortality associated with tobacco smoking can learn from the experiences of countries that have succeeded in reducing smoking. However, the social, cultural, and regulatory complexity of smoking habits prevents any straightforward replication of successful policies within a different context, a different country, and a different period. Simply put, no law exists in a vacuum; rather, manifold factors simultaneously determine the success or otherwise of any policy. Yet, sound scientific research and reasoning do allow for the construction and verification of hypotheses and theories about how to replicate cessation elsewhere. Above all, the development of this knowledge will be of particular value for those nations that do not have successful histories of tobacco control; these are very often developing nations in which the vast majority of the world's smokers currently reside (World Health Organization, 2019).

Australia constitutes an ideal case-study through which to achieve this aim. This is because Australia is recognized as a leading country in tobacco control worldwide, due to its long history of tobacco control policies having lowered smoking prevalence over the years. This success was achieved via the combination of strict anti-tobacco regulations and strong social sensitization through enduring anti-smoking campaigns. At the same time, Australia represents a paradoxical situation, insofar as people have easier access to nicotine through traditional tobacco products than they do via the use of Electronic Nicotine Delivery Systems (ENDS), despite the latter being significantly less harmful to health than the former. These features, combined with the abundance of empirical studies on the country, allow for a sound and comprehensive policy analysis.

Adopting a rational approach to the analysis of policy experiences is critical for providing concrete guidance on how to reduce smoking. In this respect, policy-makers have to walk a delicate line that involves carrying out careful study prior to the enactment of new laws, alongside displaying evidence-based regulatory flexibility in implementing and enforcing these laws. The potential consequences from cutting funding to anti-smoking media campaigns, banning certain products, or increasing taxes, should be weighed

carefully to best serve the public interest for both current citizens and future generations. In the field of smoking policy, too often positions become polarized along ideological lines instead of being based on empirical evidence. Ordinarily, there is the argument between, on the one hand, the abstinence approach—from those who want nicotine to be completely banned because of the damage smoking poses to health—and, on the other, the harm reduction approach—from those who recognize the fact that some people still smoke despite all the adopted measures. The need to move beyond ideological positions and adopt a more pragmatic approach is particularly pertinent with respect to ENDS, which lie at the core of the present study.

IV. National Profile

An overview of the markets for tobacco products and ANDS

Carlotta Carbone, Serena Favarin, Alberto Aziani and Samuele Corradini

The present chapter provides a broad overview of both the Australian tobacco control framework and the national strategy for reducing smoking rates and improving population health. It is divided into five main sections. Section IV.A briefly delineates the history of tobacco in Australia, from its introduction in the early 1700s up to the present day. Specifically, it considers general trends in consumption, the role played by tobacco among the Indigenous population, gender differences in smoking, changes in the perception and social acceptability of smoking, along with the development of tobacco control policies. Section IV.B outlines emerging trends in the consumption of tobacco and ANDS, which in Australia primarily pertains to e-cigarettes. Section IV.C explains the role of the main regulatory authorities within the Australian tobacco control framework. Section IV.D presents an overview of tobacco control and related policy drivers in Australia. Specifically, it discusses current and upcoming regulations in the field, the evolution of anti-smoking media campaigns, and the scientific literature that inspired and endorsed tobacco control policies. Section IV.E concludes by elucidating the role of health services and professionals in smoking cessation.

A. History of tobacco in Australia

Aboriginal communities in Queensland, Western Australia and New South Wales (NSW) already had experience with nicotine prior to the arrival of the British colonists in 1770 in Australia. More specifically, they chewed *pituri*, a high-valued substance extracted from the leaves of the autochthonous plant *Duboisia Hopwoodi*, which is closely associated with tobacco and contains nicotine (Figure 2) (Hicks, 1963; Low, 1987; Walker, 1980). The first evidence of this habit for Westerners was when Joseph Bank, in August 1770, wrote in his diary of a mysterious plant whose leaves were constantly being chewed by Aborigines (Beaglehole, 1963). *Pituri* served an integral social function in everyday life, as well as taking on symbolic meaning. For example, according to the prevailing belief at that time, *pituri* had magical properties that enabled chewers to predict the future (Vogan, 2019). Moreover, *pituri* was frequently offered and shared in ceremonies, which, in turn, facilitated social bonding (Brady, 2002; Watson et al., 1983). Historical records show that Aborigines used this substance to endure walking long distances without water or food (Curl, 1878), or fighting in conflicts (Von Mueller, 1877). The smoke plumes from *pituri* was also used to narcotize kangaroos and emus, who subsequently then fell prey to Aborigines (T. H. Johnston & Cleland, 1934).

Figure 2. *Pituri* plant

Note: image free from copyright.

Credits: R. Davis.

Actual tobacco was only introduced to Northern Australian Aboriginal communities in the early 1700s by *Macassans*, who were trepang fishermen from Indonesia (Brady, 2002).[12] The latter exchanged tobacco and pipes with the former in order to secure access to fish in the Australian coasts between Kimberley and the Gulf of Carpentaria. While it remains unknown who introduced tobacco to the Torres Strait Islands communities, records from the period of Western colonization testify to the presence of cultivated groves of tobacco in the Torres Strait Islands (north of Australia), which was typically smoked in bamboo pipes (McNiven, 2008). Aborigines thus rapidly became addicted to tobacco chewing (Roth, 1901). However, not all Indigenous people consumed tobacco prior to colonization; for example, it is likely that southeastern Aboriginal communities began to use tobacco around the time the British settled in Australia (Briggs, 2003).

After the arrival of British settlers in Australia in 1770 and the advent of the process of colonization in 1788, the use of tobacco increased and spread widely across the continent. The Governor Lachlan Macquarie established tobacco plantations in NSW (in both the suburb of Emu Plains and the Hunter Valley) between 1818 and 1820, and then subsequently in Victoria and Queensland in the 1850s (Freeman,

[12] Aborigines, together with Torres Strait Islanders, are the Indigenous population of Australia. In this report, the term "Indigenous" will be used to refer to both these groups, while Aborigines and Torres Strait Islanders will be used separately to indicate the specific population.

2016).[13] By the early 1800s, tobacco use was already widespread among Indigenous people in different areas of the country. During the period of colonization, the use of tobacco and its symbolic value was profoundly different to what it had been previously. Indigenous traditions and rituals associated with the consumption of *pituri* progressively disappeared, as a result of the proliferation of tobacco (Brady & Long, 2003; Low, 1987).

At the very beginning of the colonization period, colonizers used tobacco to pacify the local population. Indeed, they visited Indigenous communities and offered them tobacco as a means through which to curry favor, and initiate the subtle process of civilization and cultural integration (Brady, 2002). Indigenous people were highly appreciative of the colonizers' gifts and fast became addicted to tobacco. During this initial phase, British colonizers and Indigenous people established a relationship predicated on mutual exchange: the former provided the latter with tobacco in exchange for goods, services and labor (Brady & Long, 2003). In this way, colonizers could control tobacco supplies, while the Indigenous people were able to easily obtain the desired product, which they could then also trade with the rest of the island (Brady & Long, 2003). Over the years, such trading practices began to completely favor the colonizers, who demanded ever increasing effort from their Indigenous workforce in exchange for increasingly smaller amounts of tobacco (Walker, 1980). During the 1800s and the beginning of the 1900s, the Indigenous people moved to white settlements to obtain tobacco in exchange for their labor (Brady, 2002; Brady & Long, 2003; Read & Japaljarri, 1978; Rowse, 1998). There, they toiled under horrible conditions in cattle stations, sugar plantations and trading enterprises (e.g., of fish), while being remunerated partially or fully in tobacco (Brady & Long, 2003; Read & Japaljarri, 1978).[14] Ultimately, Indigenous people's addiction to tobacco made them more vulnerable to their colonizers' manipulation (Brady, 2002).

During the 19th century, after a short period of restrictions imposed by the settlers, the consumption of tobacco increased in the colonies. As part of the control policy, home-grown tobacco crops were forbidden, while all the fields that could be plowed were allotted to the production of food for the colony (Walker, 1980). Despite this, illegal tobacco plantations flourished across the territory. Initially, illegal growers were sanctioned, but as wild tobacco crops began to appear in Sydney and Hawkesbury (in NSW) in 1803, the ban was subsequently overturned (Walker, 1980).

For most of the 19th century, pipe smoking was the most common method of tobacco consumption, while the local production of tobacco was supplemented by importing leaves, first from Brazil and then from North America (Walker, 1980). While some people also used snuff, its consumption in the Australian colonies remained relatively low over the years. Between 1850 and the 1880s, both machine- and hand-made cigarettes began to be produced in England and subsequently imported within Australia. At first, the population was reluctant to use this new product, as it was considered to be effeminate or dandyish (Scollo & Winstanley, 2019a). Over time, manufactured cigarettes became common: the affordability of manufactured cigarettes in comparison to smoking a pipe or other tobacco products contributed to an

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[13] Lachlan Macquarie was a British Army officer and colonial administrator from Scotland. Macquarie served as the fifth and last autocratic Governor of NSW from 1810 to 1821. He played a leading role in the social, economic and architectural development of the colony.
[14] In 1901, Australian colonies (i.e., Victoria, South Australia, Western Australia, Tasmania NSW, and the Northern Territory) federated into one country, under the dominion of the British Commonwealth.

increase in consumption among Australians, which, in turn, normalized such smoking behaviors (Walker, 1984; M. H. Winstanley & Woodward, 1992).

In the 19th century, smoking was especially common among disadvantaged sectors of the population and male workers. According to historical records, in 1819, between 80% and 90% of male workers used tobacco (Walker, 1980). Conversely, smoking was less common among women, mainly due to the prevailing gender norms at that time. Smoking was considered to be a male habit, and wholly improper for upper and middle-class women (Walker, 1980). Of those females who were smokers, the majority either belonged to indigenous communities, were convicts, or belonged to the workforce (Walker, 1980).

In the second half of the 1800s, the first anti-tobacco movements began to emerge in Australia (Brady, 2002).[15] For example, in 1857 the youth temperance organization Band of Hope launched educational campaigns in NSW to both prevent students from smoking and raise awareness about the addictive effects of tobacco (Tyrrell, 1999). Between 1880 and the World War I, the first laws regulating tobacco consumption and production were passed. In 1882, a private member's bill banned smoking among juveniles in Australian colonies (Tyrrell, 1999). At the beginning of 1900, the first smoke-free laws were adopted by some Australian states to reduce the consumption of tobacco on public transport. At the same time, the Australian Government imposed, for the first time, an excise on the manufacture of tobacco.[16] Indeed, the commitment of the government and local organizations towards tobacco control remained high until the outbreak of World War I.

During World War I, smoking helped soldiers to cope with the stress and anxiety of the trenches (Walker, 1984). Rations of cigarettes were offered by the Allies to troops, which resulted in a notable increase in consumption among soldiers during that period (Walker, 1984). After World War I, smoking attitudes among women also changed. This derived, in part, from the greater involvement of women in the workforce, which served to soften perceived gender differences in Australia. Female smoking became socially acceptable, despite staunch opposition from more socio-economically advantaged and educated women (Walker, 1980). The anti-smoking campaigns that sought to reduce the consumption of tobacco among the female population never achieved the same level of attention as anti-alcohol campaigns. After World War II, the prevalence of smoking among women increased yet again, in part, as a result of the social and financial emancipation that women gained from being substantially involved in paid labor (Walker,

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[15] Look at Table 1 in Appendix 1 – Timeline for an overview of key events in the history of tobacco and anti-tobacco in Australia.

[16] Excise Act No. 9, 1901, Federal Register of Legislation, https://www.legislation.gov.au/Details/C2018C00378 (Accessed 2 March 2020). Schedule VIII of the Act reports the scale of fees that a manufacturer had to pay for every licence granted to him considering the following factors: "For every factory wherein tobacco, cigars, cigarettes, and snuff may be manufactured in quantities the weight of which, in the whole, manufactured in one year, shall:

a) Not exceed 5,000 lbs., £5 per annum.
b) Exceed 5,000 lbs., but not 10,000 lbs., £10 per annum.
c) Exceed 10,000 lbs., but not 20,000 lbs., £20 per annum.
d) Exceed 20,000 lbs., but not 50,000 lbs., £50 per annum.
e) Exceed 50,000 lbs., but not 100,000 lbs., £100 per annum.
f) Exceed 100,000 lbs., but not 200,000 lbs., £150 per annum.
g) Exceed 200,000 lbs., but not 350,000 lbs., £200 per annum.
h) Exceed 350,000 lbs., £250 per annum."

1984). By the end of World War II, in 1945, it was estimated that 72% of men and 26% of women smoked in Australia (Woodward, 1984).[17]

In the 1930s, the Australian government began to assist the tobacco industry by sustaining the domestic production of tobacco. The Commonwealth enacted the Local Leaf Content Scheme (1936) that imposed a preferential tariff on imported tobacco leaves to manufacturers who used a pre-fixed percentage of local leaves in their products (Freeman, 2016). The percentage of local leaves required was initially 2.5% for cigarettes and 13% for loose tobacco (Industry Commission, 1994). However, in the proceeding decades it gradually increased: by 1965, it had reached 50% for both cigarettes and loose tobacco, while by 1977, with the introduction of the Tobacco Industry Stabilization Plan (TISP), it had rose up to 57% (Industry Commission, 1994). In 1965, the Commonwealth established the Australian Tobacco Board, whose express task was to monitor the national and international market of Australian tobacco leaf, in conjunction with providing recommendations to federal and state ministers on the marketing of tobacco products and the management of the TISP.[18] The Local Scheme and the TISP supported the domestic production of tobacco and guaranteed that local manufacturers could buy Australian leaves at pre-arranged prices (Industry Commission, 1994).

In 1975, the tobacco industry launched large cigarette pack sizes to boost its sales (Scollo & Bayly, 2019a). While, prior to this, cigarettes were commonly sold in packets of 20 sticks, larger packets containing up to 30 and even 50 lighter sticks began to be sold on the market. This constituted a relatively peculiar Australian phenomenon (Scollo & Bayly, 2019a). Large packs were subjected to a lower duty compared to traditional ones, due to the calculation of tobacco duties based on weight and fees on final retail price. Hence, larger cigarette packets were cheaper than traditional packs, with the result of this marked price differential being the wide diffusion of large cigarette packets on the market, which began to exceed the sales of smaller packets (Scollo, 1996).

Between the late 1960s and 1980s, anti-tobacco initiatives spread throughout Australia. As evidence of the damaging health effects of smoking grew (e.g., Bailey, 1970; Preston, 1970; Shapiro et al., 1970), the government strengthened its commitment to tobacco control. In 1969, a new law introduced the first generation of health warnings: 'Smoking is a Health Hazard' appeared for the first time on all cigarette packs. Later, in the 1970s, radio and television advertisements for tobacco products were banned. Scientific research in the 1980s on the health effects of secondhand and passive smoking (e.g., Hirayama, 1981; National Health and Medical Research Council, 1986) encouraged the Commonwealth to adopt smoke-free policies in workplaces and public spaces (Borland et al., 1997; M. H. Winstanley & Woodward, 1992). The government also made progress in terms of health services devoted to smokers. In 1985, the first quitlines (telephone counselling services) were established in Victoria to assist Australians in stopping smoking (Anderson & Zhu, 2007; Pierce et al., 1986). Two years later, the first health promotion body in the world (Victorian Health Promotion Foundation) was established via funds from tobacco taxes. All these policy measures are likely to have contributed to reducing smoking prevalence in Australia. In 1969, 45% of males

[17] Measurements of the prevalence of smoking in Australia are available beginning from 1945 onwards (Greenhalgh, Bayly, et al., 2019).
[18] Tobacco Marketing Act 1965. No.85 of 1965. https://www.legislation.gov.au/Series/C1965A00085. Accessed April 2020.

and 28% of females were smokers (Woodward, 1984), while the percentages in 1989 were, respectively, 30% (-33% compared to 1969) and 27% (-4% compared to 1969) (D. J. Hill et al., 1991).[19]

Meanwhile, local health organizations launched a series of smoking prevention and cessation campaigns, via a range of social advertising channels (e.g., radio, printed materials, television). Chief among these was the Victorian Anti-Cancer Council, founded in 1936 to prevent cancer, which released the first anti-smoking pamphlet in 1967 (Anti-Cancer Council Victoria, 1968). During the same period, the Council also produced a short anti-smoking advertisement, in which the well-known football player Peter Hudson warned against the health risks associated with smoking, and put pressure on the Government to introduce health warnings on cigarette packages. In 1971, the Council launched television advertisements that ridiculed the habit of smoking cigarettes, thus posing a sharp contrast to the image of self-empowerment put forward by many tobacco companies (Dick, 2001).

The 1990s signaled a further decline in tobacco consumption. Towards the end of the decade, in 1998, the prevalence of regular smoking of any tobacco product was 29% among males, and 24% among females (Australian Institute of Health and Welfare, 2017). As will be explained in greater depth in chapter VII, multiple factors played a role in reducing the consumption of tobacco during the 1990s. One of the potential reasons for the decline was the increase in prices for tobacco products. Over a five year period, from 1990 to 1995, the recommended retail price for a Winfield 25-cigarette packet increased by almost 3 AUD (NSW Retail Traders' Association, 1990, 1995).[20] The decline may also have been facilitated by the government's increasingly robust tobacco control policy that sought to de-normalize smoking. Indeed, tobacco product advertising was prohibited in all newspapers and magazines at the Commonwealth level in 1992.[21] In 1997, the government launched for the first time the National Tobacco Campaign to reduce smoking among Australians (D. J. Hill & Carrol, 2003).

A report by the Industry Commission demonstrated that the protectionist policy instantiated in the Local Leaf Content Scheme and the TISP (Tobacco Industry Stabilization Plan) created inefficiencies and prevented competitiveness in the tobacco growing industry (Industry Commission, 1994). This brought about significant change in the industry. The tariffs on the importation of tobacco leaves were abolished (the regulation of their production and sale fell under the Trade Practices Act 1974).[22] In 1995, the Australian Tobacco Marketing Advisory Committee, the Local Leaf Content Scheme and the TISP were abolished (Freeman, 2016). As a consequence of this, the number of plantations established in Australia dropped from 600 in 1994 to 366 in 1995 (Australian Tobacco Marketing Advisory Committee, 1996; Industry Commission, 1994). In the absence of incentives in the domestic market, at the beginning of the

[19] One should display caution when reading these data because they may not be directly comparable. The data reported by Woodward (1984) include individuals who describe themselves as current smokers of cigarettes, pipes or cigars. The author does not specify the age range. The survey data reported by Hill et al. (1991) comprise regular smokers aged 18 years of age and over.
[20] Data produced by NSW Retail Traders' Association (1990, 1995) were retrieved from Scollo and Bayly (2019a). The price is adjusted for inflation using 2012 as the base year. Winfield is an Australian brand of cigarettes that, between the end of the 1970s and 2015, had the highest market share (Scollo & Bayly, 2019a). Currently, it is owned and manufactured by British American Tobacco Australia.
[21] Tobacco Advertising Prohibition Act 1992 No. 218 of 1992. Register ID C2017C00302 https://www.legislation.gov.au/Details/C2017C00302 Accessed February 2020.
[22] Trade Practices Act 1974. No.51 of 1974. https://www.legislation.gov.au/Details/C2010C00331. Accessed April 2020.

2000s, tobacco manufacturers mostly began to purchase tobacco leaves on the international market. Since 2006, no licensed tobacco growers and manufacturers have been authorized in Australia (Australian Taxation Office, 2019). Since 2008, the tobacco contained in Australian-made cigarettes has been grown in the US, Brazil, Zimbabwe and India (Freeman, 2016).

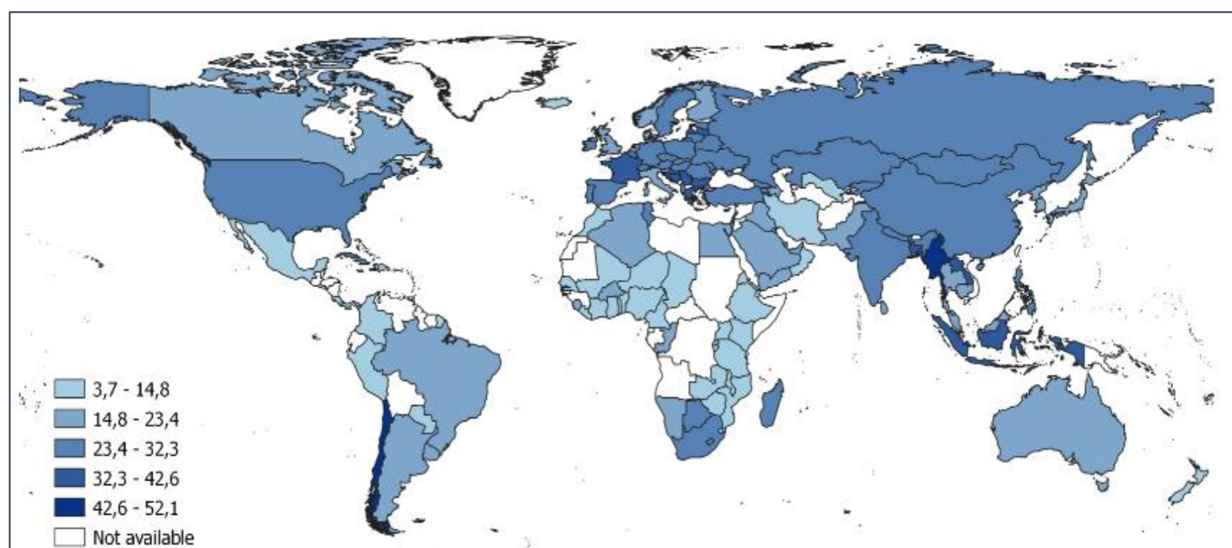
The last two decades have illustrated the progress made by the Australian government in tobacco control. In 2003, the Australian government became a party of the WHO Framework Convention on Tobacco Control (World Health Organization, 2003). The Convention promoted a framework for international cooperation on tobacco control, and outlined common policy guidelines to reduce the harms caused by smoking. In 2012, Australia fully implemented the plain packaging law, that required standardized packages for all tobacco products that were devoid of any distinguishing mark, with the exception of the brand name.[23] In 2012, the government launched the 2012-2018 National Tobacco Strategy (Intergovernmental Committee on Drugs, 2012), aimed at strengthening anti-smoking programs across the whole territory to prevent the manifold health issues associated with smoking. Within this framework, all states and territories received funds to implement local targeted strategies (Intergovernmental Committee on Drugs, 2012).

B. Trends in tobacco consumption in Australia

Australia has a relatively low smoking prevalence in comparison to other countries (Figure 3). Overall, one-in-five (20%) people aged 15 years or older smoke tobacco in the world. At the global level, Kiribati (47%), Montenegro (46%), Greece (43%), Timor (43%) and Nauru (40%) all have a smoking prevalence higher than 40%, according to the most recent available estimates collected by each country and systematized by the Global Health Observatory Data Repository of the WHO (Ritchie & Roser, 2020; World Health Organization, 2020). The percentage of the population aged 15 years or older who smoked any tobacco product in Australia in 2016 was 14.8%. More precisely, the prevalence of current smokers in 2016 was 16.5% for men and 13.0% for women, respectively.[24] The countries where many people smoke are clustered in two main regions: South-East Asia and the Pacific islands and Europe— particularly the Balkan region—as well as France (33%), Germany (31%), and Austria (30%) (Ritchie & Roser, 2020).

[23] Tobacco Plain Packaging Act 2011 No. 148 of 2011. Register ID C2018C00450 https://www.legislation.gov.au/Details/C2018C00450 Accessed February 2020.
[24] The category "current smokers" includes both daily and occasional smokers.

Figure 3. Prevalence of current tobacco smokers aged 15 years or older, 2018



Note: estimates are age-standardized and show percentages.

Source: authors' elaboration of World Health Organization (2020) *data.*

The National Drug Strategy Household Survey (NDSHS), conducted by the Australian Institute of Health and Welfare (AIHW), estimates that in 2016 in Australia 12.2% of people aged 14 years or older smoked daily, while 14.9% were current smokers (Figure 4). Note that these estimates are not wholly comparable with those from the WHO, because WHO sample population is aged 15 years or older and WHO data are aged-standardized. The prevalence of both current smokers and daily smokers has decreased from 1991 to 2016 (by 49% and 50%, respectively). Moreover, the percentage of Australians who have never smoked has increased by 27% over the course of this same period.

Similar, but albeit slightly higher, prevalence rates have been reported by the National Health Survey (NHS) conducted by the Australian Bureau of Statistics (ABS). According to the most recently available estimates, the prevalence of current smokers aged 15 years and older was 15.5% in 2014-2015 and 14.6% in 2017-2018, respectively, whereas the prevalence of daily smokers was 14.0% in 2014-2015 and 13.3% in 2017-2018, respectively (Figure 5). With respect to the adult population, from 1995 onwards the percentage of Australians aged 18 years or older who are daily smokers has decreased by 42.0% (from 23.8% in 1995 to 13.8% in 2017-2018).[25] However, the daily smoking rate has remained relatively similar to the period 2014-2015 (-4.8%) (Figure 6) (Australian Bureau of Statistics, 2018).

Despite differences in both the methodological approaches utilized in these two sources of information (i.e., NHS and NDSHS) and the age groups considered, both surveys have reported a declining trend in smoking prevalence in Australia between 1991 to 2017-2018 (Figure 4, Figure 5 and Figure 6).

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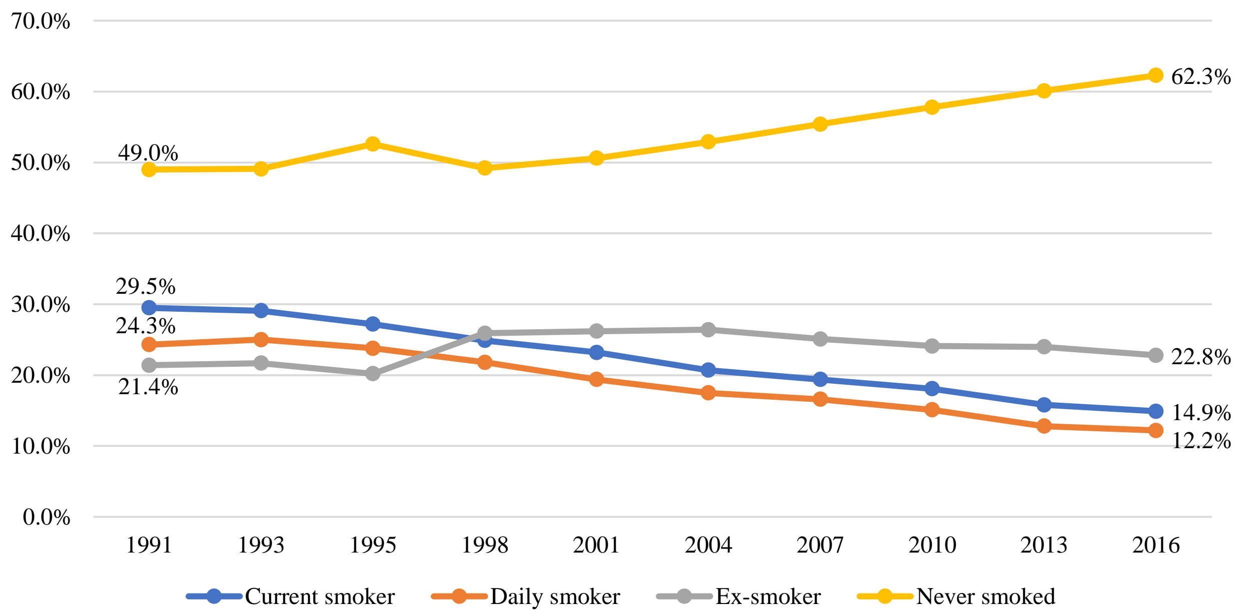
[25] In 2017-18, data from the National Health Survey (NHS) and the Survey of Income and Housing (SIH) were combined to create a much larger sample, which, allows for a more accurate smoker status estimate.

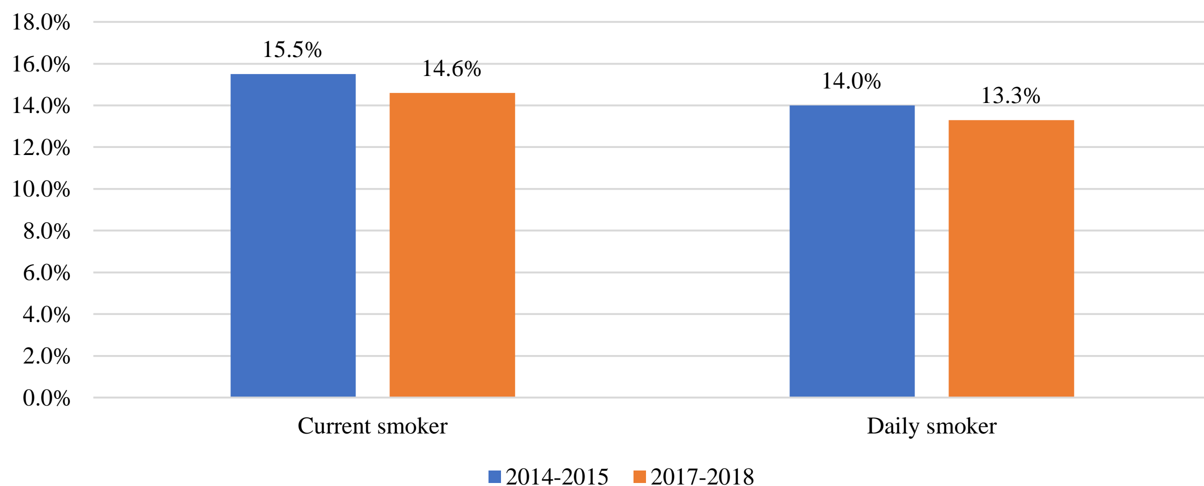
Figure 4. Prevalence of current smokers, daily smokers, ex-smokers and people who have never smoked aged 14 years or older in Australia, 1991-2016 (available years)



Note: values are not age-standardized.

Source: authors' elaboration of Australian Institute of Health and Welfare data (2017).

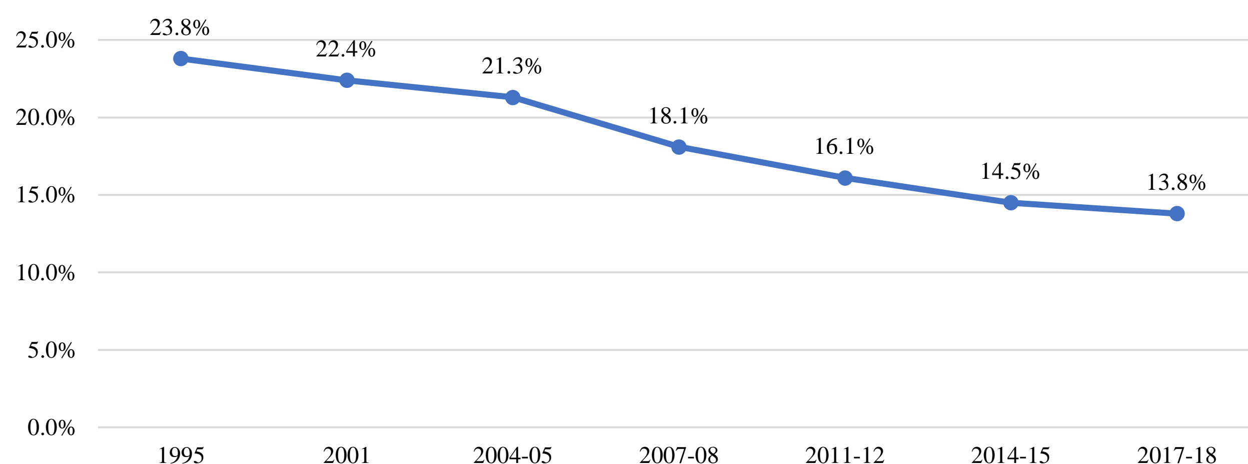
Figure 5. Prevalence of current smokers and daily smokers aged 15 years or older in Australia, 2014-2015 and 2017-2018



Note: values are not age-standardized.

Source: authors' elaboration of Australian Bureau of Statistics data (2015, 2018).

Figure 6. Prevalence of daily smokers aged 18 years or older in Australia, 1995-2018 (available years)

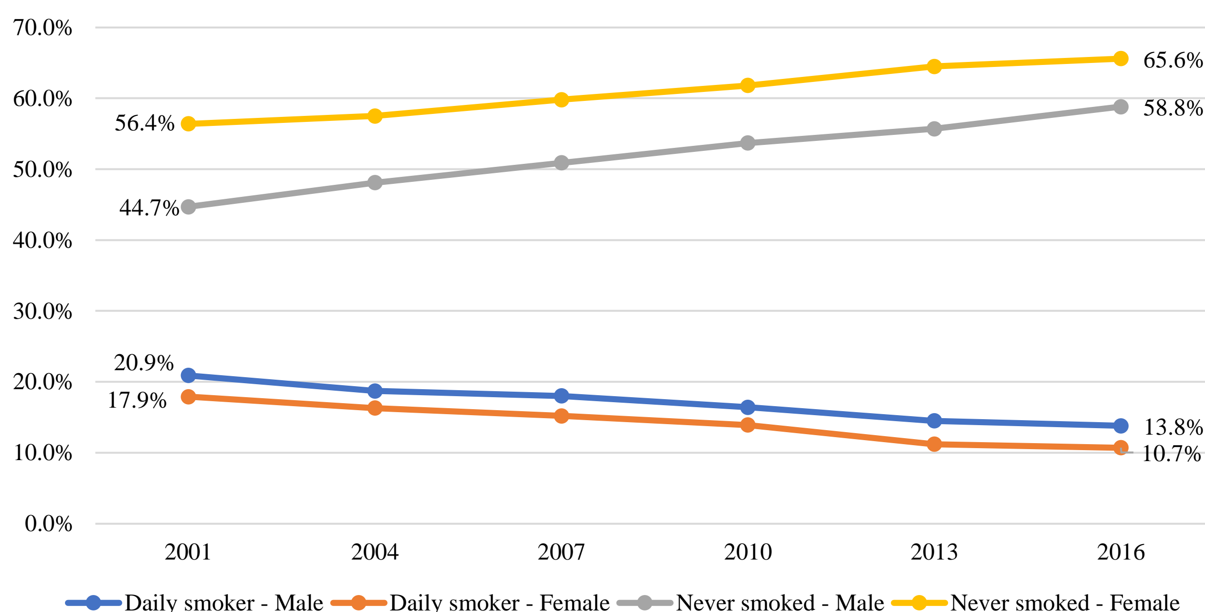


Note: the prevalence of daily smokers is reported for the years 1995, 2001, 2004-2005, 2007-2008, 2011-2012, 2014-2015, and 2017-2018, since the Australian Bureau of Statistics does not run the National Health Survey (NHS) every year. The values reported are not age-standardized. In 2017-18, data from the NHS and SIH were combined to create a much larger sample, which, in turn, allows for a more accurate smoker status estimate.

Source: authors' elaboration of Australian Bureau of Statistics data (1997, 2002, 2006, 2010, 2013, 2015, 2018).

In almost all countries across the globe, men are much more likely to smoke than women. Indeed, more than one-third (35%) of men in the world smoke, compared to just over 6% of women (Ritchie & Roser, 2020). These percentages vary in developed and developing countries. In Australia, while men are also more likely to smoke than women, recent years has seen a downward trend in smoking prevalence among people aged 14 years for both genders. Specifically, between 2001 and 2016, daily smoking prevalence has decreased by 34% for men and by 40% for women, respectively. Moreover, the percentage of people who have never smoked has increased by 32% for men and 16% for women across the same period. This increase in the percentage of Australians who have never smoked is estimated to be higher for men than for women, even though the overall percentage of people who have never smoked is higher for women (65.6% in 2016) than it is for men (58.8% in 2016) (Figure 7).

Figure 7. Prevalence of daily smokers and people who have never smoked aged 14 years or older by gender in Australia, 2001-2016 (available years)



Note: values are not age-standardized.

Source: authors' elaboration of Australian Institute of Health and Welfare data (2017).

Not only has the number of smokers decreased in Australia over the time period considered, but the average number of cigarettes smoked by each smoker has also fallen. The average number of cigarettes smoked per week by Australian smokers aged 14 years or older was 109.5 in 2001 (15.6 cigarettes per day) and 93.6 in 2016 (13.4 cigarettes per day) (Figure 8). This represents a 14.5% decrease in the mean number of cigarettes smoked by each smoker. There was also a slight decrease in the number of cigarettes consumed weekly between 2001 and 2004 (-2.2%), which was proceeded by a constantly rising trend from 2004 to 2010 (+3.7%). Between 2010 and 2013, this tendency registered a sharp decline (-13.7%), which occurred in conjunction with the introduction of the plain packaging legislation in Australia.[26] The downward trend continued between 2013 and 2016, albeit to a notably smaller degree.

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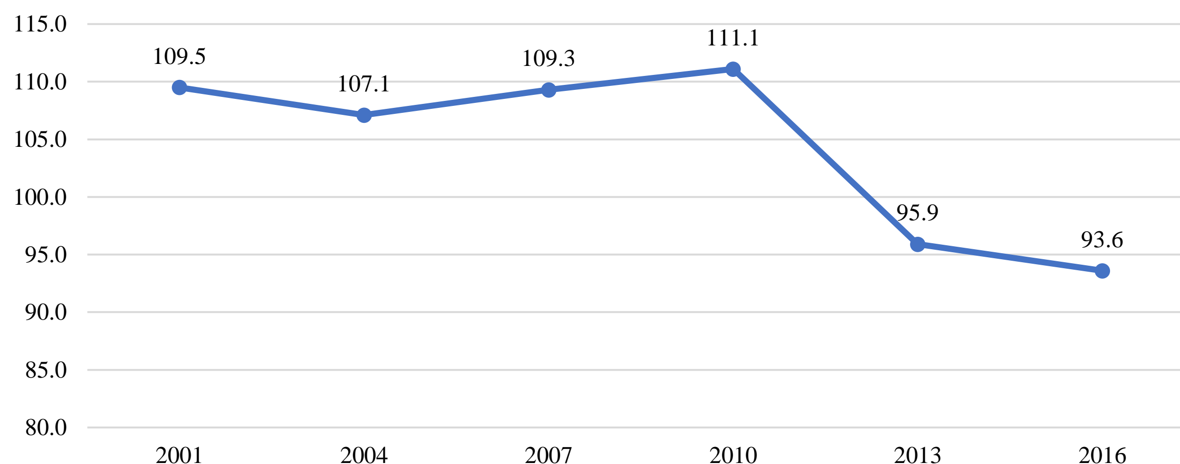
[26] Tobacco Plain Packaging Act 2011. No. 148 of 2011. https://www.legislation.gov.au/Details/C2018C00450. Accessed February 2020.

Figure 8. Average number of cigarettes smoked per week by smokers aged 14 years or older in Australia, 2001-2016 (available years)



Source: authors' elaboration of Australian Institute of Health and Welfare data (2017).

Sales of manufactured cigarettes and tobacco products in general rose from 1947 to 1974 in Australia, before stabilizing between 1974 and 1980.[27] From the 1980s onwards, sales of tobacco products have started to decrease. This decrease was not constant, but, rather, was irregular (Figure 9). Over the last fifteen years, between 2003 and 2017, the quantity of cigarettes sold in Australia have decreased by 40.1% (Figure 10). However, the decrease in this time period was not homogenous; between 2003 and 2009, the retail volume slightly decreased (-6.5%), whereas the volume dropped between 2009 and 2017 (-35.9%). Despite this contraction in retail sales, the retail value of the Australian market increased by 35.4% between 2003 and 2017, as a result of price increases introduced to compensate for the decline in volume.

The downward trend in the retail volume and the concomitant upward trend in retail value are expected to continue to follow these patterns in the next few years, according to forecasts by Euromonitor International (2018). More specifically, the retail volume is expected to decrease by 33.3% between 2017 and 2022, whereas the retail value is expected to increase by 20.7% over the course of this same period. Both the retail volume and value of cigarettes are projected to maintain their opposite inclination. The retail volume is expected to experience a continuous reduction in cigarette consumption, while the parallel incremental increase in the retail value of cigarettes value is likely to be explained by a continual price increase (Figure 10).

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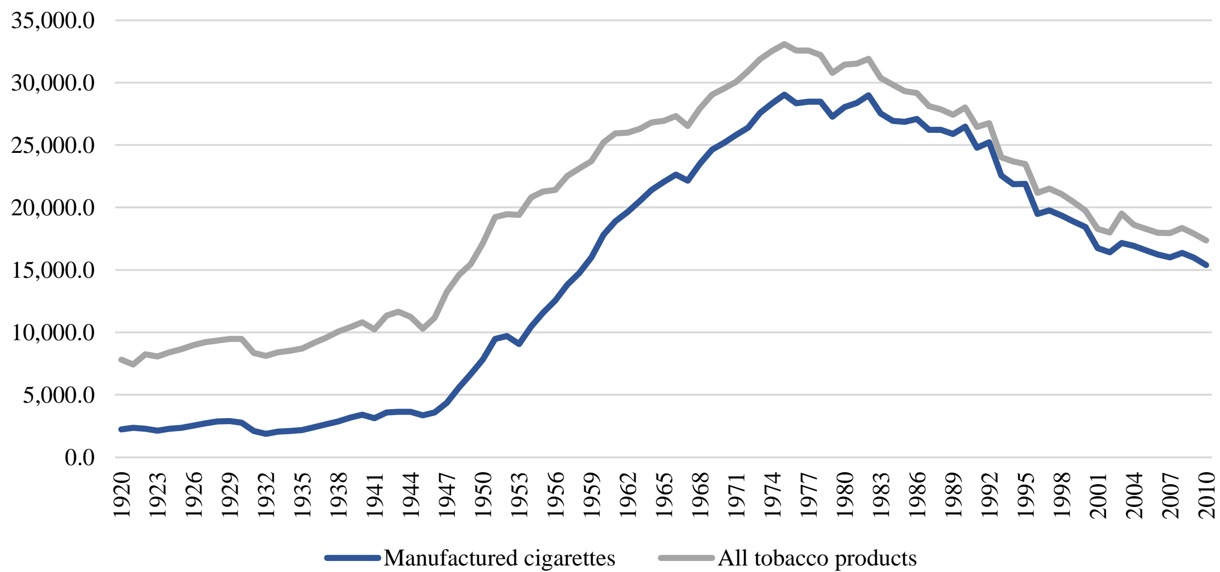
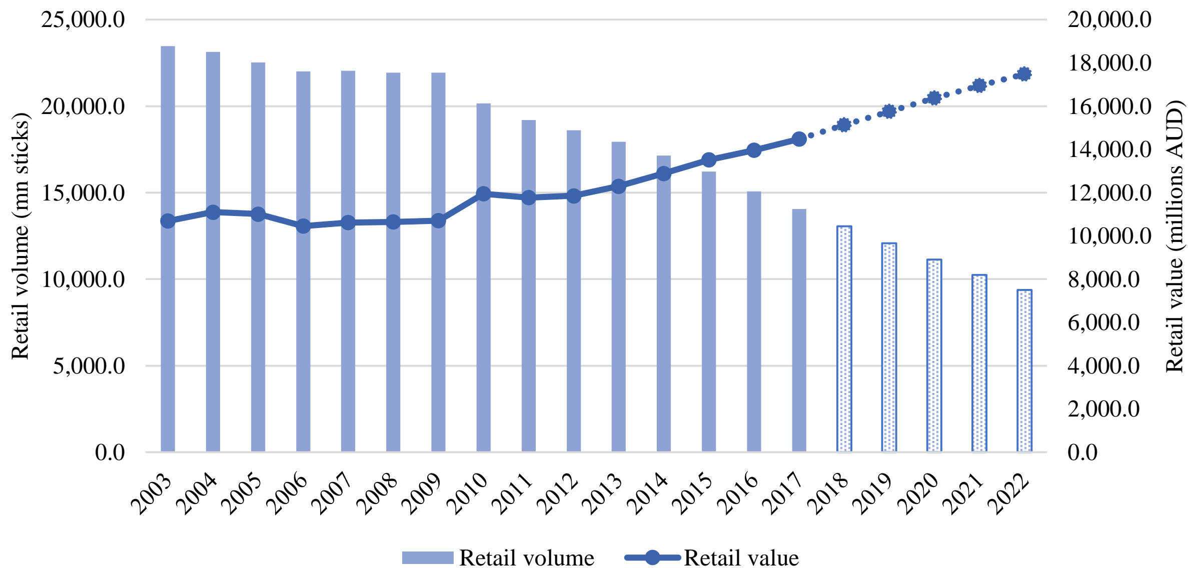
[27] While the sales of manufactured cigarettes and other tobacco products increased during the period between World War II and the 1970s, smoking prevalence consistently decreased after 1945 (see chapter II). One explanation for these opposing trends concerns changes in smoking habits, which during that specific period were characterized by the consumption of industrial products and a higher level of daily consumption.

Figure 9. Sales of manufactured cigarettes and all tobacco products in tons in Australia, 1920-2010 (available years)



Source: authors' elaboration of International Smoking Statistics data (Forey et al., 2012).

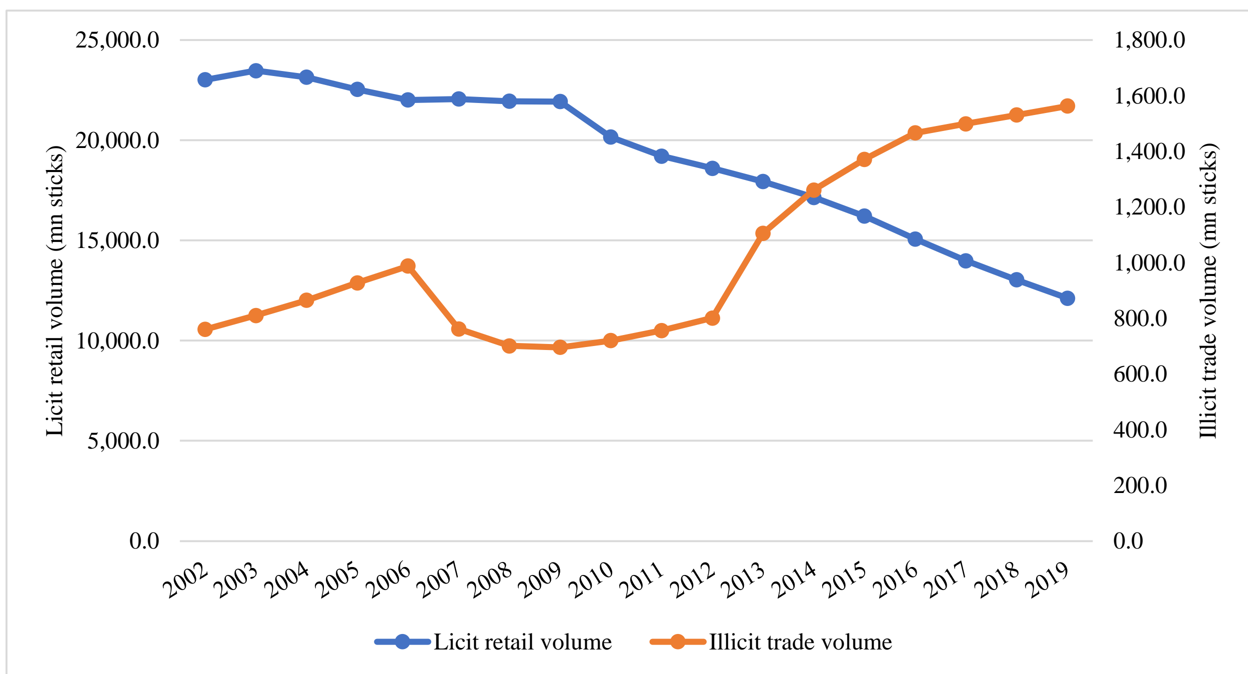
Figure 10. Australian cigarette market: retail volume (million sticks) and value (millions AUD), 2003-2022 (forecasts from 2018 expressed in dots)



Source: authors' elaboration of Euromonitor International (2018) data.

The sales of illicit cigarettes also display a starkly contrasting trend compared to the sales of licit products over the years (Figure 11).[28] As aforementioned, licit retail sales have experienced a period of constant decline from 2003. Instead, illicit retail sales, as estimated by Euromonitor International, have increased over the years, despite both a significant fall of more than 200 million sticks from 2006 to 2007 (-22.9%) and a decline between 2007 and 2008 (-8.0%). From 2012 to 2013, illicit sales experienced a 38.0% increase, which represents the highest yearly growth during the period 2002-2018. It is worth mentioning that, in 2012, the plain packaging policy had already come into effect in Australia, which might have diverted consumers to the illegal market, and, hence, explain the increase in 2013. Similarly, data of KPMG in Figure 12 show an increase in illicit consumption from 2012 to 2013 in Australia (+20.0%). Following this, illicit consumption increased by 8.0% from 2013 to 2014, before decreasing from 2015 onwards.

Figure 11. Australian cigarette market: legal and illegal volume sales (million sticks) in Australia, 2002-2019

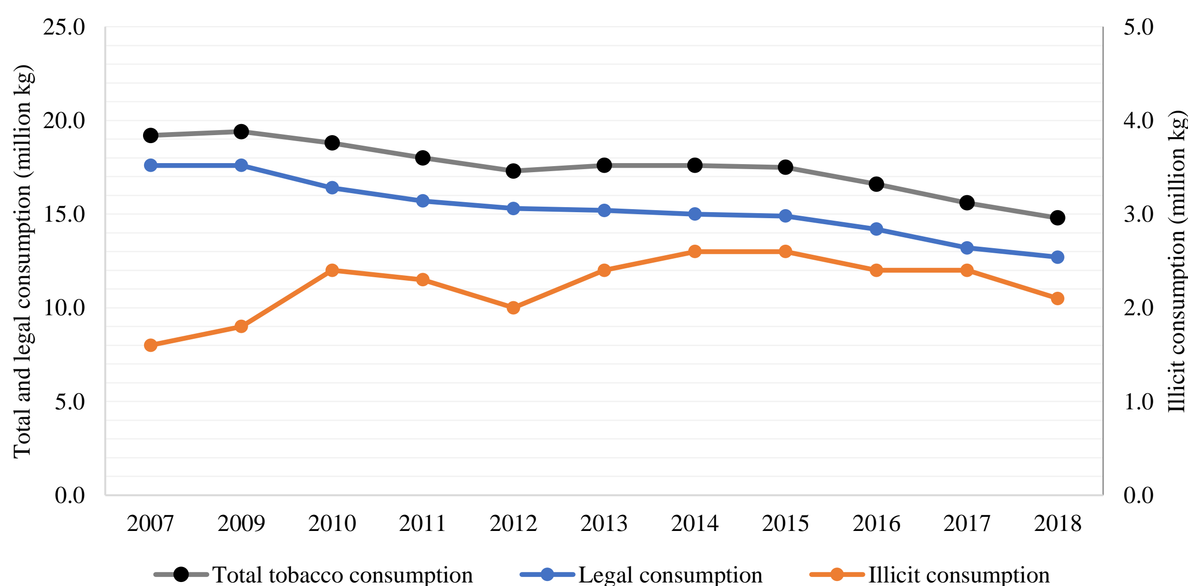


Note: the scales in which the values of the licit retail volume (0 – 25,000 million sticks) and illicit retail volume (0 – 1,800 million sticks) are expressed have a different magnitude. Hence, they cannot be directly compared.

Source: authors' elaboration of Euromonitor International data (2020).

[28] The methodology adopted by Euromonitor International to collect these data is not wholly transparent (Aziani et al., 2020) and, according to some authors (e.g., Blecher, 2010; Gilmore et al., 2014; Lencucha & Callard, 2011), not entirely reliable. Although it has been criticized by some public health experts, Euromonitor International's estimates on illicit cigarette consumption are still the best available time series (Prieger & Kulick, 2018).

Figure 12. Consumption of licit and illicit tobacco products (million kg) in Australia, 2007-2018 (selected years)



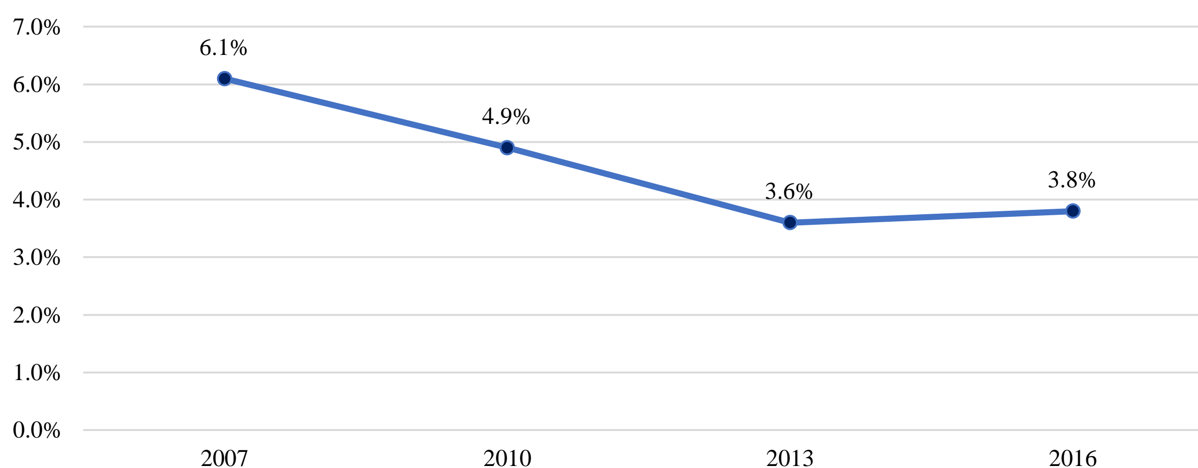
Note: the scales in which the values of total and legal consumption (0 – 25 million kg) and illicit consumption (0 – 5 million kg) are expressed have a different magnitude. Hence, they cannot be directly compared.

Source: authors' elaboration of KPMG (2019) data.

On the other hand, with regards to the prevalence of current smokers of unbranded tobacco aged 14 years or older over the period 2007-2016, the hypothesis according to which the introduction of plain packaging in Australia increased the consumption of illicit tobacco products does not appear to be supported (Clarke & Prentice, 2012; Scollo et al., 2014). According to the AIHW, the prevalence of current smokers of unbranded tobacco decreased from 2010 to 2013 by 26.5% (Figure 13). Moreover, the increase of almost 0.2% percentage points in smokers of unbranded tobacco from 2013 to 2016 is not statistically significant.[29] According to authors such as Scollo et al. (2014), unbranded tobacco is the most common way to supply illicit tobacco products in Australia. According to KPMG estimates, between 2010 and 2016, unbranded tobacco was the most common illicit tobacco product in Australia (KPMG, 2019). From this perspective, then, this decrease appears to suggest that illicit consumption has actually decreased in this period. A further potential explanation is that some of the consumers who were interested in cheap illicit tobacco products switched from buying unbranded loose tobacco to illicit manufactured cigarettes.

[29] Survey questions relating to unbranded loose tobacco were modified in 2010 to only asked respondents about their awareness and use of unbranded loose tobacco, whereas in 2007, 2013 and 2016 respondents were asked about their awareness and use of unbranded loose tobacco and unbranded cigarettes. This should be considered when comparing the 2010 results with the 2007, 2013 and 2016 results. The placement of the questions in the survey (as well as the usual concerns regarding social desirability bias for questions involving illicit activity) may have also impacted how people responded to these questions, and, as such, the results should be interpreted with caution (Australian Institute of Health and Welfare, 2017).

Figure 13. Prevalence of current smokers of unbranded tobacco aged 14 years or older in Australia, 2007-2016 (available years)



Note: the graph shows the trend for the estimated prevalence of current smokers of unbranded tobacco in Australia, as provided by the AIHW via the NDSHS surveys. The percentages are calculated on the population aged 14 years and over.

Source: authors' elaboration of Australian Institute of Health and Welfare (2017) data.

With respect to the types of products being consumed, between 1925 and 1945, the most consumed tobacco product was loose tobacco (on average, accounting for about 70% of sales), whereas from 1955 manufactured cigarettes became the most common tobacco product in Australia (Figure 14). Since 1985, manufactured cigarettes have, on average, accounted for 90% of the sales in the Australian market. More recently, from 2007 to 2016, the use of manufactured cigarettes has begun to decrease (-7%), whereas the use of roll-your-own tobacco has once again increased (+40%) (Figure 15). One explanation for this is the different taxes levied on the two products. Between 2007-2016, the difference in the rate of customs and excise duties on manufactured cigarettes and roll-your-own tobacco increased, namely duties on cigarettes grew faster than those on rolling tobacco (Scollo & Bayly, 2019b). In 2007, the excise on 0.7 grams of roll-your-own tobacco was 0.213 AUD, while the excise on a factory-made cigarette weighing less than 0.8 grams was 0.243 AUD; in 2016, it was 0.534 AUD and 0.611 AUD, respectively.[30]

Regarding ENDS (Electronic Nicotine Delivery System), among the Australian population aged 14 years or older, 0.5% and 4.4% were, respectively, daily and current users of e-cigarettes in 2016.[31] In 2016, 31.5% of men and 30.3% of women aged 14 years or older had used e-cigarettes at some point in their life. However, it is important to note that it is illegal to use, sell or buy nicotine for use in e-cigarettes in Australia (Department of Health, 2020b) and that these data do not differentiate between vapers who use nicotine liquids and vapers who do not. As heated tobacco products cannot be legally sold in Australia, the

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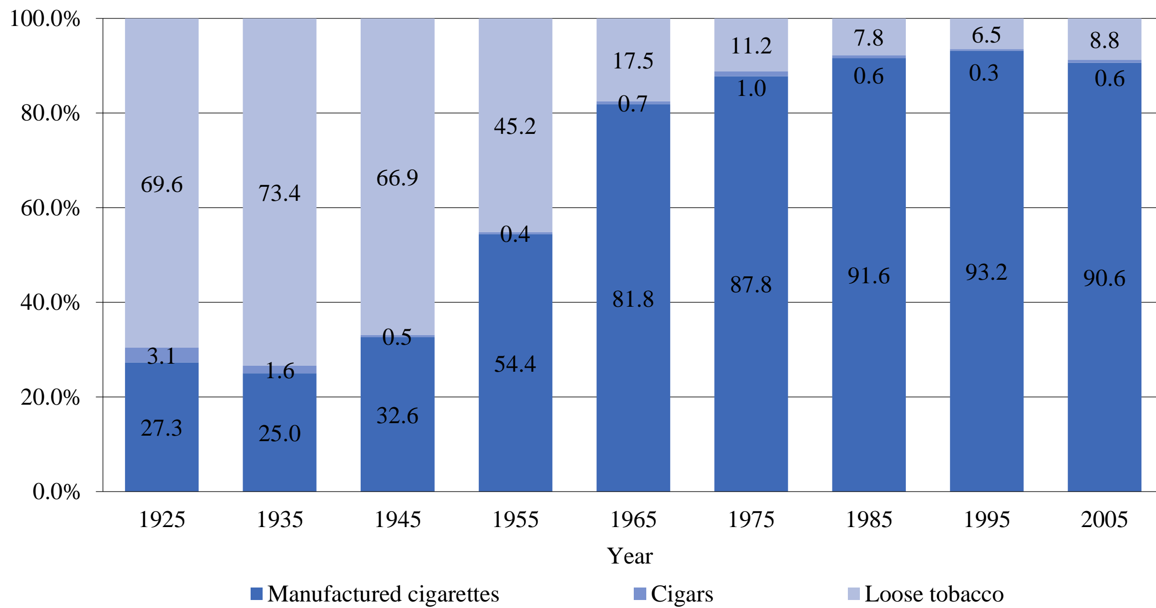
30 Data were retrieved from Scollo and Bayly (2019b), who cited the Australian Taxation Office as the source of the information.

31 ENDS heat a solution to generate an aerosol which usually contains flavorings, and contain nicotine.

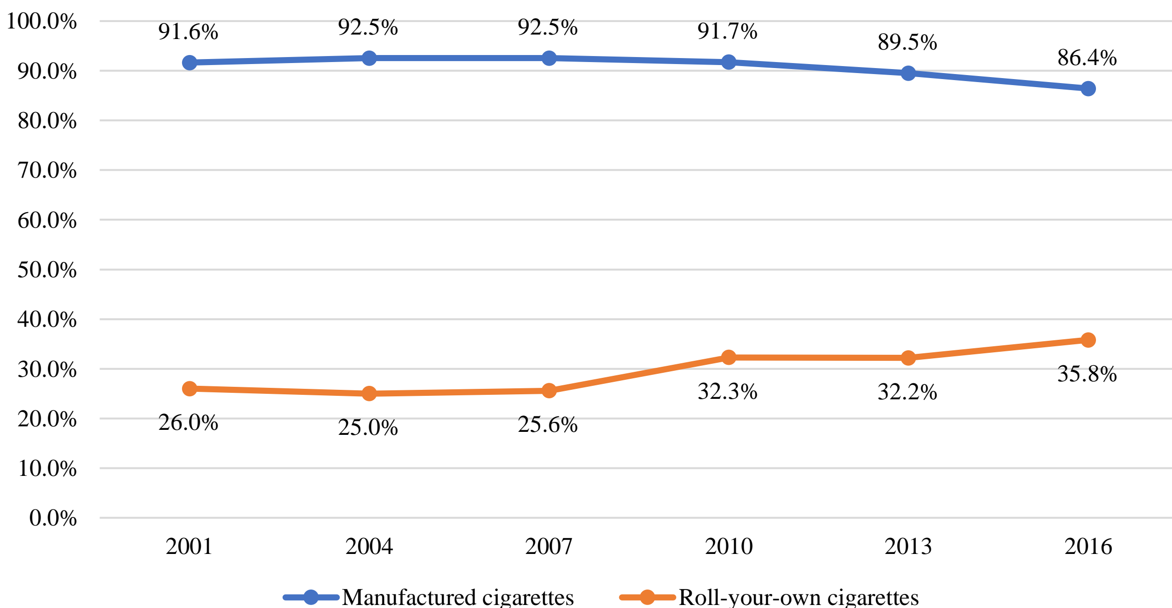
prevalence of use among Australians is likely to be very low. However, there are no current estimates available on the consumption of heated tobacco products in Australia (Greenhalgh, 2019b).

Figure 14. Percentage of sales of tobacco in different forms by weight in Australia, 1925-2005 (available years)



Source: authors' elaboration of International Smoking Statistics data gathered from Forey et al. (2012).

Figure 15. Prevalence of current smokers per type of product smoked in Australia, 2001-2010 (available years)



Source: authors' elaboration of Australian Institute of Health and Welfare (2017) data.

C. Regulatory authorities in Australia

In Australia, five main authorities are in charge of dealing with tobacco control and tobacco-related harm reduction: i) the Department of Health of the Commonwealth, which is in charge of adopting policies to improve the health of Australians; ii) the Ministerial Drug and Alcohol Forum (MDAF), which supports and advises the government on tobacco control strategies; and iii) the Australian Taxation Office (ATO), which enforces tobacco tax legislation; iv) the Australian Border Force (ABF), which enforces the laws regulating the importation of tobacco products; and v) Australian Competition and Consumer Commission (ACCC), which enforces the laws regulating health warnings, smokeless products and safety standards of tobacco products. At the international level, Australia is subject to the regulatory framework and guidelines of the WHO Framework Convention on Tobacco Control, which they signed in 2003. This section provides a description of these aforesaid authorities.

1. The Department of Health of the Commonwealth

The Department of Health of the Commonwealth is the main authority dealing with smoking in Australia as part of the National Tobacco Strategy, which aims to strengthen anti-smoking programs to prevent health harms associated with smoking.[32] Within this framework, the Department of Health fulfils different roles and tasks, including:

- Administering the *Tobacco Advertising Prohibition Act 1992* and the *Tobacco Plain Packaging Act 2011*, and conducting investigations into potential breaches.[33]
- Providing information on tobacco, by, among other things, raising awareness of its harmful health effects, informing people about the existence of safer alternatives to smoking, promoting smoking cessation services (e.g., quitlines), and warning about the penal consequences of infringing tobacco control law.
- Contributing to the design of tobacco control laws, including the introduction of text and graphic health warnings on packets, adoption of plain packaging, the bans on tobacco advertising, restrictions on the sale of smoking products, and taxation.
- Evaluating the effectiveness of tobacco control laws. In accordance with the *Legislation Act 2003*, by 2022, the Department of Health must evaluate if the present policies are working and identify potentially redundant provisions, vulnerabilities, and priority reform

[32] For an overview of the main roles of the Department of Health of the Commonwealth, see: https://www.health.gov.au/health-topics/smoking-and-tobacco/about-smoking-and-tobacco/what-were-doing-about-smoking-and-tobacco.

[33] *Tobacco Advertising Prohibition Act 1992* No. 218 of 1992. Register ID C2017C00302 https://www.legislation.gov.au/Details/C2017C00302 Accessed February 2020; *Tobacco Plain Packaging Amendment Regulation 2012*. No. 29 of 2012. Register ID F2012L00563. https://www.legislation.gov.au/Details/F2012L00563/Amends Accessed February 2020; *Tobacco Plain Packaging Act 2011* No. 148 of 2011. Register ID C2018C00450 https://www.legislation.gov.au/Details/C2018C00450 Accessed February 2020.

areas. Currently, the Department of Health is reviewing the tobacco advertising and plain packaging legislation.[34]

- Promoting anti-smoking campaigns. For example, the Department of Health is currently working on the 'National Tobacco Campaign', 'Tackling Indigenous Smoking', and 'Don't Make Smokes Your Story' anti-smoking campaigns (the last two of which specifically target Indigenous populations). In the past, it has promoted and coordinated many other campaigns, such as, for example, the 'National Warning Against Smoking campaign' (1972-1975).[35]

2. The Ministerial Drug and Alcohol Forum (MDAF)

The MDAF was established by the Council of Australian Governments (COAG) in 2015.[36] Although it is not a regulatory authority, the MDAF has a relevant role in tobacco control in Australia. The MDAF is co-chaired by the Commonwealth Ministers for health and justice and comprises Ministers of health and justice from each state and territory. The main tasks of the MDAF include:

- Implementing the National Drug Strategy 2017-2026—i.e., the broad national framework that aims to reduce and prevent the harmful effects of alcohol, tobacco, and drugs.
- Providing advice and coordinating the decisions of other councils and committees.
- Issuing an annual report on its work over the course of the year to the COAG.

3. Australian Taxation Office (ATO)

The Australian Taxation Office, which was established in 1910 by the *Land Tax Act*, is the principal revenue collection agency for the Australian government.[37] Broadly, the ATO is in charge of administering the tax and superannuation systems.[38] With respect to tobacco products, its principal tasks are:

- Administering the licenses required to grow, produce, and manufacture tobacco, including cases in which it is intended for personal use.

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[34] *Tobacco Advertising Prohibition Act 1992* No. 218 of 1992. Register ID C2017C00302, https://www.legislation.gov.au/Details/C2017C00302 Accessed February 2020; *Tobacco Advertising Prohibition Regulation 1993 No. 129 of 1993*. https://www.legislation.gov.au/Details/F2012C00624 Accessed February 2020; *Tobacco Plain Packaging Act* 2011 No. 148, 2011 https://www.legislation.gov.au/Details/C2018C00450 Accessed February 2020; *Tobacco Plain Packaging Regulations 2011*. No. 263 of 2011. Register ID F2011L02644, https://www.legislation.gov.au/Details/F2011L02644 Accessed February 2020. For an overview on the review process, see: https://www.health.gov.au/health-topics/smoking-and-tobacco/tobacco-control/tobacco-control-legislation-review.

[35] See Table 9 in Annex 1 for an overview of the main anti-smoking mass media campaigns in Australia that were launched between 1972 and 2019.

[36] For an overview of the MDAF's roles and aims, see: https://www.health.gov.au/committees-and-groups/ministerial-drug-and-alcohol-forum-mdaf.

[37] *Land Tax Act 1910*. No. 21 of 1910. https://www.legislation.gov.au/Details/C1910A00021. Accessed on May 2020.

[38] For an overview of the ATO's tasks, see: https://www.ato.gov.au/about-ato/commitments-and-reporting/; https://www.ato.gov.au/Business/Excise-and-excise-equivalent-goods/Tobacco-excise/; and https://www.ato.gov.au/General/The-fight-against-tax-crime/Our-focus/illicit-tobacco/?=redirected.

- Detecting the unlicensed production, manufacture, and importation of tobacco products to prevent tax losses.[39]
- Collecting customs duties on imported tobacco products and fighting tax avoidance, in collaboration with the ABF.

4. Australian Border Force (ABF)

The ABF is a law enforcement agency, established by the Australian Border Force Act in 2015, that is supported by the Department of Home Affairs.[40] Broadly speaking, ABF enforces legislation over the importation of tobacco products into Australia (see section IV.D.8 for an overview of Australian regulation on the importation of tobacco products).[41] With respect to tobacco products, its specific tasks are:

- Avoiding the introduction and circulation of illicit tobacco by monitoring import permits for both commercial and personal use.[42]
- Leading the Illicit Tobacco Taskforce (ITTF). The ITTF, established on 1st July 2018 by the Australian government, aims to disrupt and dismantle organized crime syndicates involved in illicit tobacco trafficking. The taskforce combines the expertise of multiple agencies (e.g., Australian Taxation Office, Department of Home Affairs, Australian Criminal Intelligence, Commonwealth Director of Public Prosecutions) to fight illicit tobacco trade and preserve Commonwealth revenues.
- Collecting tobacco duties and fighting tax avoidance, in collaboration with the ATO (see IV.C.3).

5. Australian Competition and Consumer Commission (ACCC)

The ACCC, established in 1995, is an independent Commonwealth statutory agency that aims to promote competition and fair trading.[43] With respect to tobacco products, its specific task is to enforce:

- The *Competition and Consumer (Tobacco) Information Standard 2011*, which provides mandatory information requirements for health warnings on tobacco products.[44]
- The *Consumer Protection Notice 1991* on smokeless tobacco products.[45]

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[39] See section IV.D.7 for an overview of the regulation on illicit tobacco.
[40] *Australian Border Force Act 2015*. No. 40 of 2015. https://www.legislation.gov.au/Details/C2016C00650 Accessed March 2020.
[41] For an overview of the ABF's tasks, see: https://www.abf.gov.au/about-us/taskforces/illicit-tobacco-taskforce.
[42] See section IV.D.7 for an overview of the regulation on illicit tobacco.
[43] For an overview of the ACCC's tasks, see: https://www.accc.gov.au/about-us/australian-competition-consumer-commission/about-the-accc.
[44] Competition and Consumer (Tobacco) Information Standard 2011, Register ID F2011L02766, https://www.legislation.gov.au/Details/F2011L02766, Accessed May 2020.
[45] Consumer Protection Notice No 10 of 1991, Register ID F2010L03294, https://www.legislation.gov.au/Details/F2010L03294 Accessed May 2020.

- The *Consumer Product Safety Standard on Reduced Fire Risk Cigarettes 2008*.[46]

In 2019, the ACCC was asked to comment on the *Review of Tobacco Control Legislation Consultation* paper regarding current regulations on tobacco, in particular on smokeless tobacco and graphic health warnings (Australian Competition and Consumer Commission, 2019).

6. WHO Framework Convention on Tobacco Control

At the international level, the Australian government signed up to the *WHO Framework Convention on Tobacco Control* in December 2003 (World Health Organization, 2003). This convention is legally binding and requires all signatories to strengthen their respective tobacco control policies and adopt demand reduction strategies. Since joining, the Australian government has improved its tobacco control legislation and promoted anti-smoking mass media campaigns, reporting its progress to the WHO (Slattery et al., 2020a). These improvements mainly concern the adoption of the plain packaging legislation in 2012 (Slattery et al., 2020a), the increase of tobacco taxes in 2010 and 2013 (Slattery et al., 2020b), and the strengthening of smoke-free regulations across all Australian States (Grace, 2019).

D. Tobacco control and related policies in Australia

Originating in the 1970s, the government has progressively strengthened smoking and advertising bans, raised tobacco taxes, promoted anti-smoking campaigns, and imposed severe restrictions on the content, packaging, and importation of tobacco and Alternative Nicotine Delivery Systems (ANDS) (World Health Organization, 2019). This section provides an overview of tobacco control legislation and related policies in Australia.[47] It starts out by presenting the status of current legislation on tobacco and ANDS (paragraphs IV.D.1 to IV.D.8) as well as considering upcoming regulations announced by the government (section IV.D.9); finally, it describes the main anti-smoking media campaigns launched in Australia in recent decades (section IV.D.10). Overall, as discussed in chapter VII, these policies haven proven to be effective in contributing to a decrease in smoking prevalence in Australia over time.

1. Smoke-free environments

Smoke-free policies impose bans that prevent people from smoking in specific places, (e.g., cafes, workplaces, schools, hospitals, etc.). Broadly speaking, they aim to protect people from exposure to secondhand smoke, which, as has been widely established, has harmful health effects for both adults and children (e.g., Feleszko et al., 2014; Jones et al., 2011; Simpson et al., 2007; Z. Wang et al., 2015), including a number of serious lung-related illnesses (e.g., M. A. Campbell et al., 2019; Kim et al., 2014; W. Li et al., 2016; Office on Smoking and Health (US), 2006). These policies also aim to significantly reduce the opportunities to smoke, by making it harder (Callinan et al., 2010). One indirect effect of such bans is that they reduce the perceived popularity, and thereby attractiveness, of smoking (Bayer & Bachynski, 2013), which, in turn, contributes towards its de-normalization (Callinan et al., 2010).

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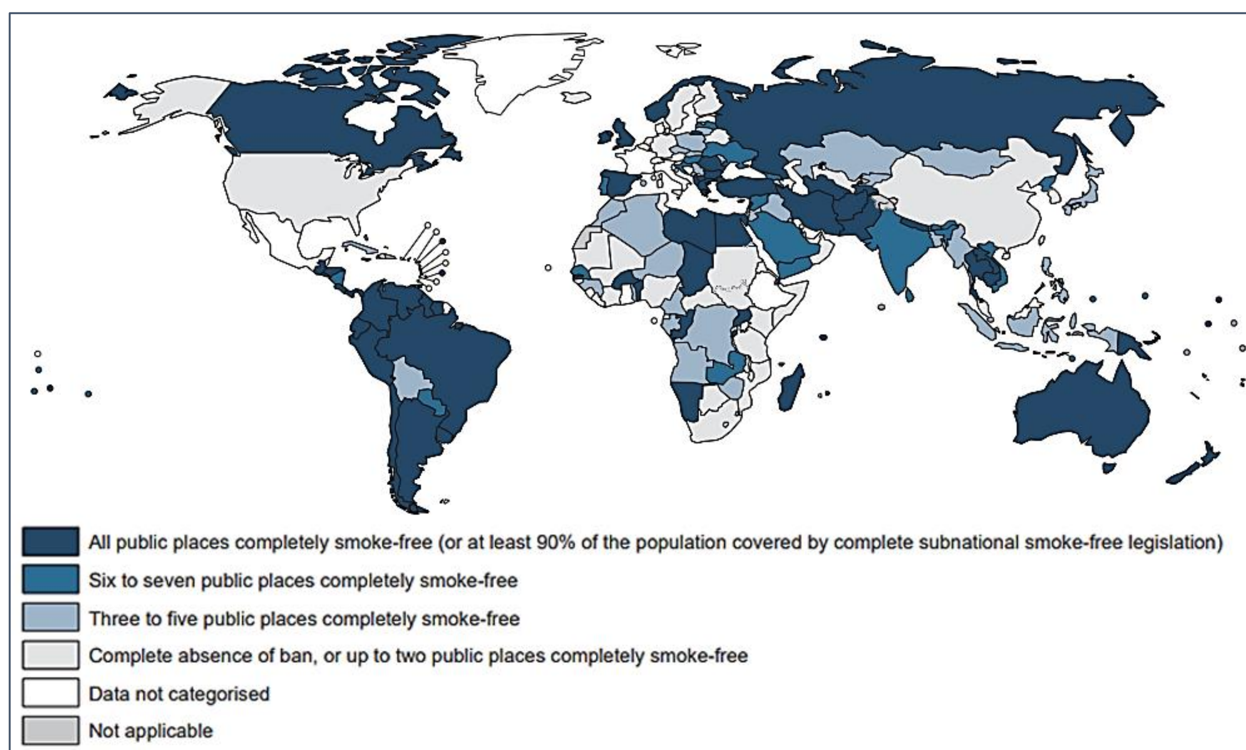
[46] Trade Practices (Consumer Product Safety Standard) (Reduced Fire Risk Cigarettes) Regulations 2008. No. 195 of 2008 https://www.legislation.gov.au/Details/F2009C00252 Accessed February 2020.

[47] See Table 8 in the Annex 1 that shows key dates in the history of tobacco and anti-tobacco in Australia.

At the international level, Australia has some of the strictest regulations on smoke-free environments, along with other countries that are predominantly in the Middle East, South America, North Africa and Northern Europe. These countries, which are the darkest in Figure 16 below, have either banned smoking in all public places across the entire country or guaranteed that at least 90% of the population is covered by subnational smoke-free regulations. The geographical and cultural proximity of Australia and New Zealand may have facilitated a process of mutual influence and learning, which has led to them both becoming leading countries in tobacco control (Studlar, 2005). Indeed, the regulation of tobacco in the two countries is very similar in terms of comprehensiveness, not only regarding smoke-free environments, but also in other fields (see, for example, sections IV.D.3, IV.D.4, IV.D.5).

Figure 16. Smoke-free environment regulation across the world, 2018



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Credits: *World Health Organization (2019).*

During the 1980s, the Australian government took the first steps to implementing smoke-free areas. In that period, there was growing evidence of the health risks caused by secondhand smoke, especially concerning employees and children. In 1986, the government introduced the first set of smoking bans in the workplace and, beginning in the 1990s, adopted stricter smoke-free policies that apply to both public and private sectors (Scollo & Winstanley, 2019b). Since then, the promotion of smoke-free environments has not been uniform across the county; rather, certain states and territories have taken a leading role in developing smoking ban legislation. In 1994, the Australian Capital Territory was the first to approve a

smoking ban inside pubs and clubs.[48] South Australia was the first in 2007 to ban smoking in cars in the presence of minors, imposing a maximum fine of 200 AUD for non-compliance.[49] In both these cases, the measures were soon adopted across all other Australian states and territories (Australian Government Department Health, 2020; Grace, 2019; Riseley, 2003). Research has shown that smoke-free policies have been positively welcomed by the population immediately after their implementation, thus facilitating their adoption and observance (e.g., Walsh & Tzelepis, 2003). Over time, public support for such bans has remained high and even increased (Australian Institute of Health and Welfare, 2002, 2004, 2008).

Currently, legislation at the federal level imposes smoking bans on flights, buses, and in airports.[50] Australian states and territories rule over all other public environments. All States and Territories prohibit people from smoking in enclosed public places, including on public transport (e.g., trains, buses, flights), office buildings, shopping malls, schools and cinemas (Australian Government Department Health, 2020). While smoking in private cars is allowed if minors are not present, smoking in the presence of minors is prohibited across all the States and Territories (the minimum age threshold for defining minors, i.e., 16, 17 or 18, varies depending on the State) (Grace, 2019). Although smoking bans also exist in some outdoor places (e.g., beaches, entrances of buildings), there is tremendous variation across states and territories' legislation in terms of the extent of smoking bans in outdoor places.

2. Plain pack legislation

In April 2010, the Australian Government announced that it would introduce the plain packaging of tobacco products from 1 January 2012, with full implementation due by 1 December 2012. Plain packaging legislation was passed by the House of Representatives in August 2011 and approved by the Australian Senate in November 2011.[51] Plain packs of tobacco products are packets that are sold without any of their usual characteristics, such as colors, images, fonts, textures, finishes, and scents, that is, all the typical elements that enable consumers to remember particular brands (World Health Organization, 2018). In order to make them less appealing, especially among young persons, the design of these packs are standardized, without any involvement from the brand owner, and do not include any advertising, promotion, or sponsorship. Brand names are only permitted in a standardized font on the packaging, which enable the identification of the brand without sponsoring it. The law also requires manufacturers to display on their cigarette packs information about smoking-related harms (Scollo & Greenhalgh, 2018b). Plain packaging laws primarily aim to reduce the appeal of tobacco products and break consumers' brand loyalty. The removal of these aforementioned elements does indeed make it more difficult for smokers to

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[48] Smoke-free Areas (Enclosed Public Places) Act 1994. No. 63 of 1994. Gazette 1994 No S196 https://www.legislation.act.gov.au/a/1994-63/ Accessed February 2020.

[49] Tobacco Products Regulation (Smoking in Cars) Amendment Act 2007. No. 9 of 2007. https://www.legislation.sa.gov.au/LZ/V/A/2007/TOBACCO%20PRODUCTS%20REGULATION%20(SMOKING%20IN%20CARS)%20AMENDMENT%20ACT%202007_9.aspx Accessed February 2020.

[50] Air Navigation Regulation 2016. No. 398 of 2016. https://www.legislation.gov.au/Details/F2016L00398 Accessed February 2020.

[51] Tobacco Plain Packaging Act 2011 No. 148 of 2011. Register ID C2018C00450 https://www.legislation.gov.au/Details/C2018C00450 Accessed February 2020 and Tobacco Plain Packaging Amendment Regulation 2012. No. 29 of 2012. Register ID F2012L00563. https://www.legislation.gov.au/Details/F2012L00563/Amends Accessed February 2020; Tobacco Plain Packaging Act 2011 No. 148 of 2011. Register ID C2018C00450 https://www.legislation.gov.au/Details/C2018C00450 Accessed February 2020.

immediately recognize the brand (Scollo & Greenhalgh, 2018a). In addition to this, these policies also seek to both increase the impact of health warning messages on packs and remove potentially misleading information from them.

The idea of plain packaging on tobacco products was first conceived in Canada during the 1980s (Scollo & Greenhalgh, 2018a), before subsequently being endorsed by health organizations in New Zealand (Carr-Gregg & Gray, 1990). The introduction of plain packaging legislation in Australia was first proposed by the Australian Ministerial Council on Drug Strategy in a report issued in 1992. However, the proposal was rejected by the Australian Senate Community Affairs References Committee, due to a lack of sufficient evidence on its potential effectiveness (Scollo & Greenhalgh, 2018b). It was not until 2008 that the issue resurfaced, when the parties to the WHO Framework Convention on Tobacco Control published a set of Guidelines promoting the use of plain packaging (WHO FCTC Conference of the Parties, 2008). The following year, the National Preventative Health Taskforce of Australia set out to make the nation 'the healthiest country' in the world by 2020 (National Preventative Health Taskforce et al., 2009). The Taskforce issued a report recommending that the government adopt the plain packaging policy to prevent the promotion of tobacco products. In 2012, Australia adopted the plain packaging legislation. Since then, several countries in Europe, Asia, and America have also introduced this form of regulation (Scollo & Greenhalgh, 2019). Currently—together with Australia—New Zealand and Ireland have plain packaging legislation that covers all tobacco products. Other countries (i.e., France, Hungary, Norway, and the UK) have adopted plain packaging for some tobacco products, but not for others. Many other countries have yet to take any steps towards standardizing cigarette packs (World Health Organization, 2018).

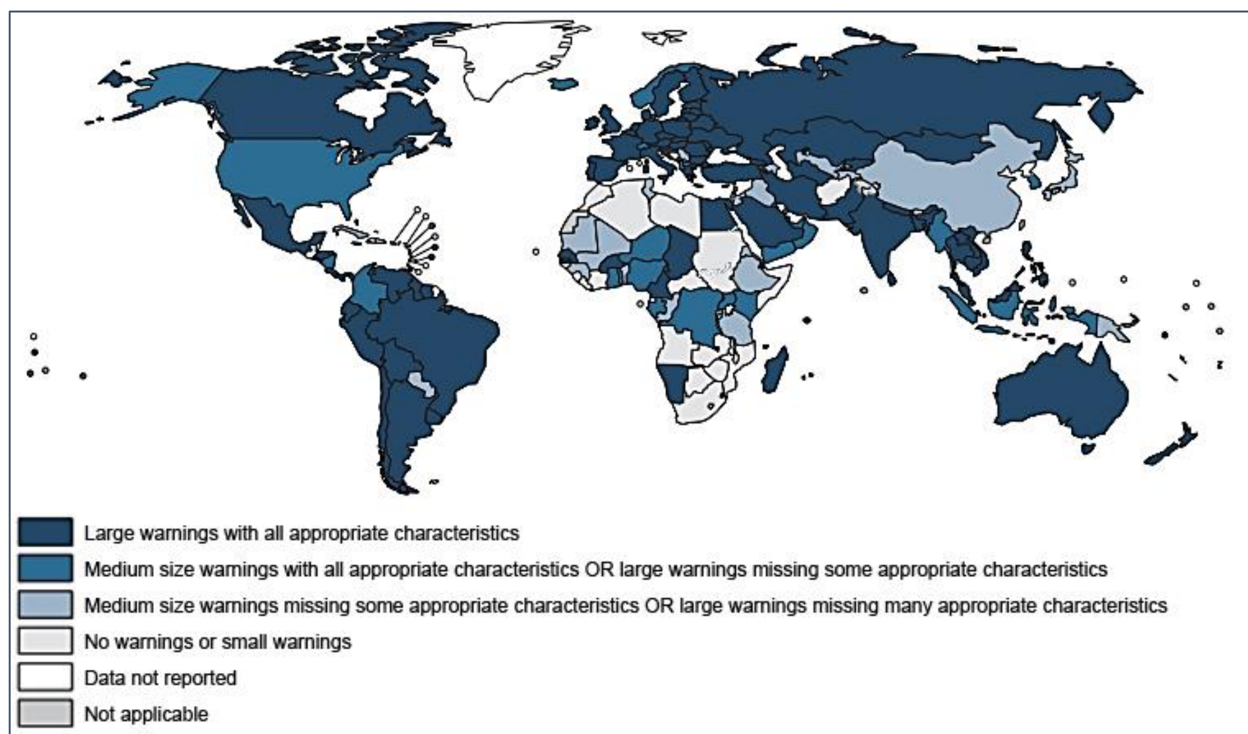
3. Health warnings

Health warnings are labels and images printed on tobacco packs that warn consumers about both the harmful substances contained in the product and their negative impact upon health. Information on smoking cessation services (where to go, who to call) are also frequently included on tobacco packs (Scollo & Hippolyte, 2019). Health warnings are designed in such a way so as to stimulate the so-called fear appeals, via persuasive messages that arouse fear and promote protective behavior (Rogers, 1983; Witte & Allen, 2000). Most of the literature on the impact of health warnings testifies—albeit to different degrees and for different durations—to their effectiveness. For example, many studies have demonstrated that health warnings reduce the allure of tobacco smoking by inducing anxiety in the smoker (e.g., Drovandi et al., 2019; Kees et al., 2006). Other studies have shown that health warnings increase negative emotions towards smoking and stimulate the intention to quit (Bekalu et al., 2019; Cho et al., 2018). However, a smaller proportion of studies have found conflicting results. Indeed, according to Harris and colleagues (2007), health warnings can also lead smokers to develop self-exempting beliefs, such as, for example, rejecting the possibility that they will be afflicted by smoking-related health issues (see Chapter VII for a more in depth discussion of plain packaging effectiveness in inducing smoking reduction).

In contrast to strict smoke-free regulations, health warning policies have been relatively well implemented at the global level, especially in Western countries. Figure 17 shows both the diffusion and the characteristics of health warning labels about the dangers of tobacco across the globe. Countries are colored according to the WHO's (2019) assessment of their health warning policies (with the darkest being the best performers). The best performing countries are those that require tobacco packs to display large warnings with all the appropriate characteristics (e.g., be clear, include pictures, be written in the main

languages of the country, rotatable). Research has demonstrated that these characteristics make warnings more effective (e.g., Evans et al., 2018; D. Hammond, 2011; Strahan et al., 2002). As one can discern, Australia is among one of the best performing countries.

Figure 17. Diffusion and characteristics of health warning labels about the dangers of tobacco across the globe, 2018



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Credits: *World Health Organization (2019).*

Australia has undergone five generations of health warnings: 1973-1986, 1987-1994, 1995-2005, 2006-2012 and 2012-onwards. In 1973, 'Smoking is a Health Hazard' appeared for the first time on all cigarette packs (Chapman, 2003).[52] Since then, health groups have lobbied the government to strengthen health warnings, on the grounds that the existing ones were too mild. In 1987, the Government agreed with this and introduced four types of warning messages (''Smoking kills'', ''Smoking is addictive'', ''Smoking causes lung cancer and heart disease'' and "'Smoking damages your lungs"), which encompassed 20% of the visible packaging (Scollo et al., 2019). Later, in 1994, the government passed a law that standardized health warnings across the county.[53] All health warnings had to include an explanatory message and standardized labels. Warnings were enlarged to occupy at least 25% of the pack, and they were put at the

[52] In fact, Australia already introduced health warning legislation in 1969. However, states and territories delayed the adoption of the law, and it was only in 1973 that the first health warning appeared on tobacco packs (Chapman, 2003).
[53] Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations. No. 83 of 1994 https://www.legislation.gov.au/Details/C2004L00035. Accessed February 2020.

front of the "flip-top" to increase their visibility. The explanatory message had to cover at least 33.3% of the area on which it was printed. Moreover, warning messages had to be displayed on rotation, appearing on the packaging of an equal number of cigarette and tobacco brands each year. In general, these provisions on the labelling of packages anticipated those that would later be approved by the WHO Framework Convention on Tobacco Control (World Health Organization, 2003).[54] In 2004, a new law introduced the fourth generation of warnings, which were applied to almost all tobacco products (i.e., cigarettes, loose, or pipe tobacco, cigars, bidis and nasal snuff) produced in Australia after March 1st 2006.[55] The law specified two rotating sets of seven warnings, which had to occupy at least 30% of the front and 90% of the back of the packaging. The regulation also required manufacturers to integrate both the logo and phone number of quitline (a service which seeks to help smokers quit) into the design of their packages (Scollo et al., 2019).

Currently, health warnings (fifth generation) occupy 75% of the front and 90% of the back of cigarette packs, as specified by an ad-hoc law that came into force in 2012.[56] Two sets of warnings comprising seven each are used with an equal frequency, alternating between odd-numbered and even-numbered years. The quitline logo must be placed on all packages, along with the specific quitline graphic. The required informational message has to be displayed in black text on a yellow background (Scollo et al., 2019).

4. Advertising bans

Advertising of tobacco products convey messages that promote the social acceptability and normalization of smoking (Lee et al., 2012). Such messages may be alluring for both smokers and non-smokers, encouraging them to purchase tobacco products. Advertising bans thus aim to discourage this behavior, with the broader intent of reducing smoking rates and tobacco-related harms (Department of Health, 2020c). According to tobacco companies, smoking advertisements are uniquely intended to prompt established smokers to switch between brands and, as such, do not affect the overall level of consumption (R. Hammond & Rowell, 2001). However, the evidence demonstrates precisely the opposite effect. For example, research conducted at the international level has shown that advertisements do contribute to increased consumption (e.g., U.S. Department of Health and Human Services, 2000), along with encouraging smoking initiation among youths (e.g., DiFranza et al., 2006; Lovato et al., 2011; Wellman et al., 2006). In light of this, especially from the 1970s onwards, many countries began to ban advertisements. This policy proved to be successful, reducing smoking prevalence (e.g., Levy et al., 2004), the intention to smoke (e.g., Brown et al., 2014; DiFranza et al., 2006), and the frequency of consumption (e.g., Blecher, 2008; Yong et al., 2008).

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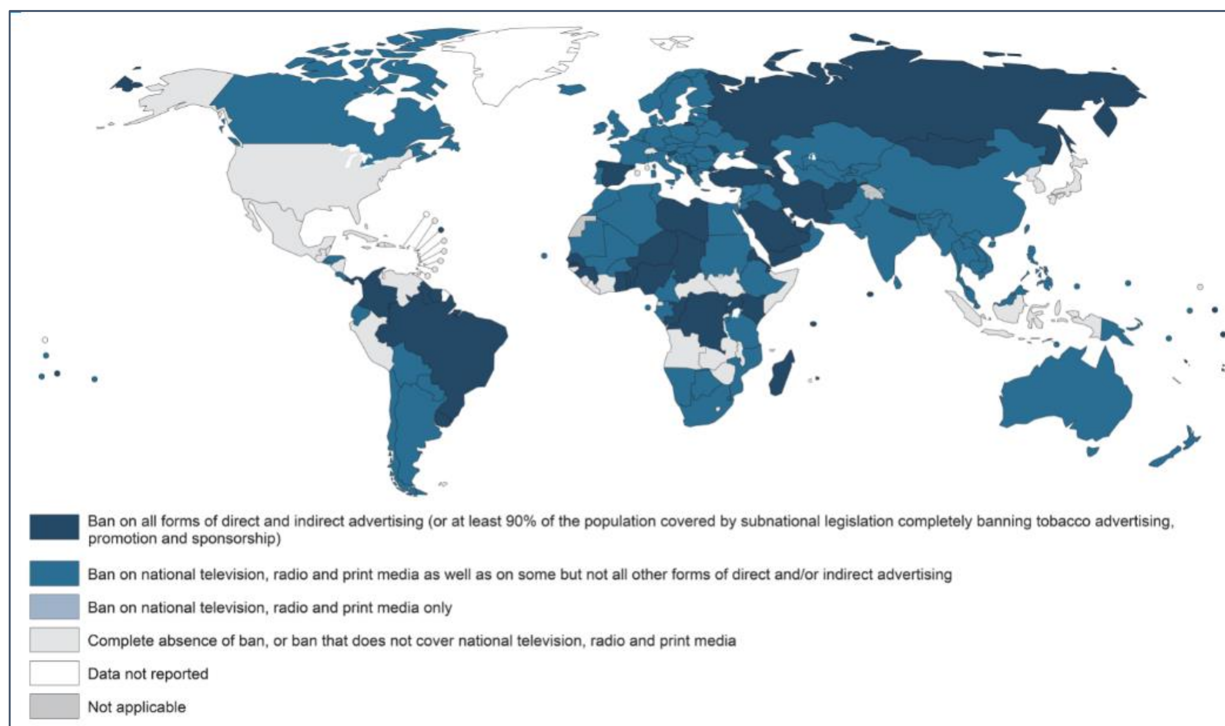
[54] The standards that govern health warnings are designated at the international level. Article 11 of the WHO Framework Convention on Tobacco Control sets out the importance of incorporating health warning labels onto the packaging of tobacco products (World Health Organization, 2003). In 2008, the Conference of the Parties published guidelines to assist parties in the introduction of health warning labels on tobacco products' packs (WHO FCTC Conference of the Parties, 2008). According to the guidelines, the warnings should be clearly displayed to maximize the effectiveness of the labels, take up as much of the packaging as permitted, cover both sides of the pack, include both images and text, and be cyclically modified.

[55] Trade Practices (Consumer Product Information Standards) (Tobacco) Regulations 2004. No. 264 of 2004. https://www.legislation.gov.au/Details/F2007C00131 Accessed February 2020.

[56] Competition and Consumer (Tobacco) Information Standard 2011. Register ID F2011L02766 https://www.legislation.gov.au/Details/F2011L02766 Accessed February 2020.

Currently, almost all countries across the globe ban some forms of advertising of tobacco products. Figure 18 shows the comprehensiveness of the policies that banned tobacco advertising globally. Most countries, including Australia, have imposed bans at least on national television, radio, print media, and in other forms of direct or indirect advertising. There are countries that have implemented a complete ban on all forms of direct and indirect advertising (e.g., Russia, Brazil, Spain, Saudi Arabia, Libya) (World Health Organization, 2019).

Figure 18. Bans on advertising, promotion and sponsorship of tobacco products across the globe, 2018



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Credits*: World Health Organization (2019).*

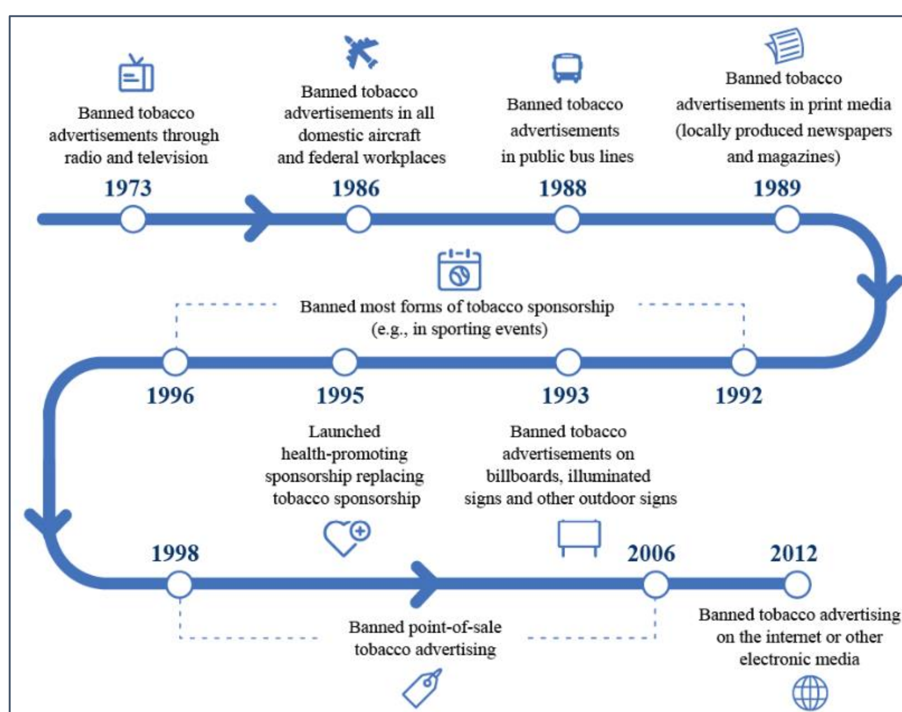
Advertising of tobacco products has been progressively regulated in Australia since the late 1970s (Scollo & Greenhalgh, 2012).[57] However, it was only from the 1980s that the government strengthened its policy. As shown in Figure 19, by the 1990s most forms of tobacco sponsorship were banned. In those

[57] The main Australian laws on tobacco advertising since the 1970s are the following: Broadcasting and Television Act 1942-1973, Register ID: C2004C02564, https://www.legislation.gov.au/Details/C2004C02564 Accessed February 2020; Smoking and Tobacco Products Advertisements (Prohibition) Act 1989. No.181 of 1989. Register ID C2004A03929, https://www.legislation.gov.au/Details/C2004A03929 Accessed February 2020; Tobacco Advertising Prohibition Act 1992 No. 218 of 1992. Register ID C2017C00302, https://www.legislation.gov.au/Details/C2017C00302, Accessed February 2020; Tobacco Advertising Prohibition Amendment Act 2000 No. 135 of 2000. Register ID C2004A00728, https://www.legislation.gov.au/Details/C2004A00728 Accessed February 2020.

years, health organizations strove to replace tobacco sponsorship with messages promoting healthy pursuits and environments. For example, the Victorian Health Promotion Foundation launched a smoking cessation campaign that sought to buy-out tobacco sponsorship from the world of sport. Beginning in 1998, Australian States banned advertising at points-of-sale (POS) which, for many years, were key sites used by the tobacco industry to promote their products (Greenhalgh, 2020).[58] In the last decade, advertisements on the internet and other electronic media came under close scrutiny from the government, before they were ultimately banned in 2012.[59] Currently, at the federal level, tobacco advertisement is allowed if it (Department of Health, 2020c):

- serves political purposes;
- conveys an anti-smoking message;
- is circulated within the tobacco industry;
- is accidentally broadcasted (for example, while filming a television documentary, a tobacco advertisement is involuntarily captured on camera);
- is at the internet POS.

Figure 19 Progress made by Australia in banning tobacco advertising



[58] Both states and territories have the power to regulate the POS advertising. Therefore, restrictions in certain states and territories are more restrictive than those imposed by Commonwealth law.
[59] Tobacco Advertising Prohibition Amendment Act 2012 No. 5 of 2012. Register ID C2012A00005. https://www.legislation.gov.au/Details/C2012A00005 Accessed February 2020.

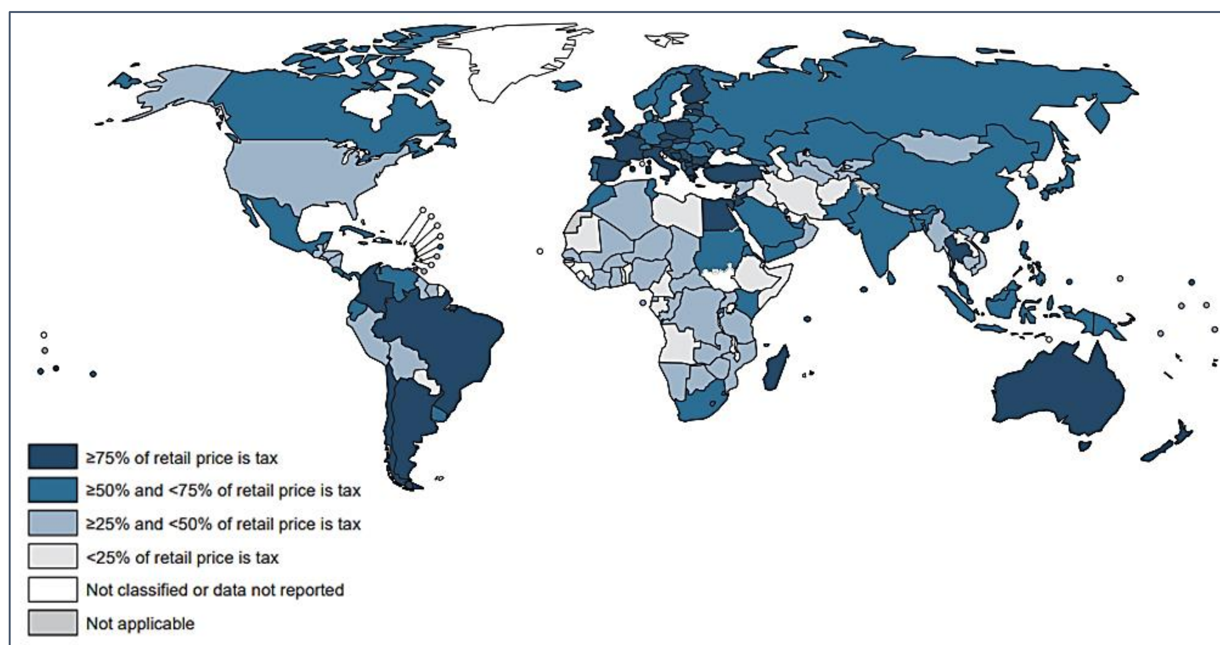
Source: authors*' elaboration on information reported in Grace (2016), and Scollo and Greenhalgh (2012).*

5. Taxation

Taxation is one of the most effective strategies used by governments to reduce smoking rates (National Center for Chronic Disease Prevention and Health Promotion (US), 2014; World Health Organization, 2019). The evidence shows that increases in the price of tobacco products are particularly effective among a) smokers, to stimulate cessation (e.g., Bader et al., 2011; Sharbaugh et al., 2018) or reduce consumption (e.g., Callison & Kaestner, 2014); b) quitters, to avoid any relapse (e.g., Tabuchi et al., 2017); and c) non-smokers, by preventing them from starting smoking (Lynch & Bonnie, 1994). The WHO Framework Convention on Tobacco Control highlighted the importance of this policy, recommending that governments increase the prices of tobacco products to improve the health of their citizens (World Health Organization, 2003).

In most countries across the world, taxes represent between 25% to 50% of the retail price of cigarettes (Figure 20). In relatively few countries they reach 75% of the price or more. In 2018, the tax share of the retail price of the most popular brand of cigarettes in Australia was 77.52% (World Health Organization, 2019). There are only a few countries in the world that levy higher taxes than Australia does, among which are Niue (87.72%), Finland (87.41%), Brazil (82.97%), New Zealand (82.21%), Turkey (81.37%), and the UK (79.39%) (World Health Organization, 2019).[60]

Figure 20. Tobacco tax policy across the globe, 2018



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[60] Niue is a small island nation in the South Pacific Ocean. According to the WHO data, it is the country with the highest tax share of retail price for the most popular brands of cigarettes (World Health Organization, 2019).

Credits: World Health Organization (2019).

In Australia, taxes on tobacco products were introduced at the federal level in 1901; prior to that, each colony had its own tariff (Scollo & Bayly, 2019b). Both the *Excise Act* and the *Customs Act* in 1901 imposed excise and customs duties respectively on tobacco products that were made in Australia and imported.[61] At that time, both these duties were calculated based on the weight of tobacco products.[62] Clearly, over the course of two centuries, the taxation of tobacco products has undergone profound changes. Particularly from the 1980s onwards, which witnessed a more general strengthening of tobacco control, the Australian government began to raise taxes on tobacco products.

In 1983, the government imposed a biannual indexation of both the excise and customs duties on cigarettes and cigars, linking them to the cost of living, as measured by the Australian Consumer Price Index (CPI).[63] This measure was implemented to prevent tobacco products from becoming more affordable over time (Wilkinson, Scollo, Wakefield, et al., 2019). That year, the federal excise duty of cigarettes and cigars was AUD 30.98 per kilo (Australian Tobacco Marketing Advisory Committee, 1994). During the 1990s, partly as a result of the lobbying activity carried out by health organizations, the government further increased tobacco taxes (Dawkins, 1992, 1993, 1994; Willis, 1995). In 1999, the excise rate for all tobacco products was AUD 88.03 per kilo of weight (Australian Tobacco Marketing Advisory Committee, 1994).[64] Federal excise and customs duties levied on tobacco products remained relatively constant until 2010, when the government raised them by 25%. A further annual increase of 12.5% was imposed from 2014 to 2020. Figure 21 shows the value of the excise and customs on cigarettes in Australia, from 2000 to 2019. The graph clearly shows the sharp increase in taxes since 2013.

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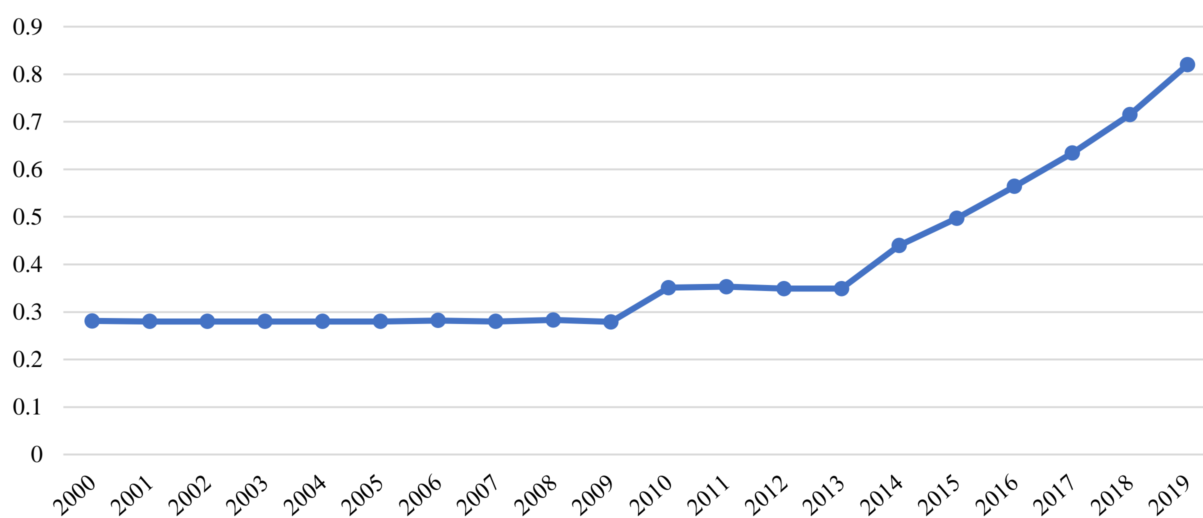
[61] Excise Act 1901. No.9 of 1901. https://www.legislation.gov.au/Details/C2018C00378. Accessed February 2020; Customs Act 1901. No. 6 of 1901 https://www.legislation.gov.au/Details/C2020C00080. Accessed February 2020.

[62] Excise Regulations 1925. Statutory Rules No. 181 of 1925 https://www.legislation.gov.au/Details/F2014C00952. Accessed February 2020.

[63] Excise Tariff Amendment Act. 1983. No. 27 of 1983. https://www.legislation.gov.au/Details/C2004A05276. Accessed February 2020. Consumer Price Index is an indicator of the cost of living, which in Australia is measured by ABS (2019a).

[64] Regarding cigarettes, from 1999 the federal excise and customs duties were calculated based on the number of cigarettes (Scollo & Bayly, 2019b).

Figure 21. Value of excises and custom duties: AUD per cigarettes sticks weighting less than 0.8 grams, 2000-2019



Note: Rate expressed in 2012 AUD and adjusted by the CPI.

Source: author's elaboration on Australian Taxation Office, Australian Department of Immigration and Border Protection and ABS data retrieved from Scollo & Bayly (2019b, fig. Figure 13.2.2).

6. Alternative Nicotine Delivery Systems regulation

This subsection provides an overview of the regulation on Alternative Nicotine Delivery Systems regulation (ANDS). Please note that officially recognized smoking cessation aids (e.g., Nicotine Replacement Therapy) are not addressed here, but rather in section IV.E.

E-cigarettes

E-cigarettes are electronic devices that recreate the sensation of smoking manufactured cigarettes through the vaporization of a liquid solution, which may or may not contain nicotine (Greenhalgh, Grace, et al., 2019). The inhalation of vapor produced by e-cigarettes enables smokers to experience a range of sensorial perceptions similar to those provided by traditional cigarettes, such as olfactory, tactile and gustatory. They may also come in a number of different flavors (UK Royal College of Physicians, 2016).

In Australia, e-cigarettes are highly regulated. Both the government and health organizations are skeptical towards the use of e-cigarettes, due to the paucity of evidence on their health benefits for smokers and potential smokers (Australian Medical Association, 2017; Department of Health, 2020b). According to numerous health organizations, the potential health risks associated with their use outweigh the benefits (Gannon et al., 2018). For example, research conducted at the international level has indicated that e-cigarettes can both serve as facilitators for smoking among young people (e.g., Soneji et al., 2017) and lead to the subsequent uptake of traditional cigarette smoking among non-smokers (e.g., Bell & Keane, 2012; Flouris & Oikonomou, 2010; McKee & Capewell, 2015). However, other studies have argued that the use of e-cigarettes can facilitate smoking cessation (e.g., Beard et al., 2020; Hartmann-Boyce et al., 2016;

Hitchman et al., 2015; Mendelsohn et al., 2020), which points toward the complexity of analyzing the role of e-cigarettes in smoking reduction policies (see Chapter VII).

Currently, both the sale and use of e-cigarettes containing nicotine is banned in all the states and territories in Australia.[65] The Commonwealth Standard for the Uniform Scheduling of Medicines and Poisons classifies nicotine as a 'dangerous poison', unless it is contained in either manufactured tobacco products that are designed for smoking or used for therapeutic purposes.[66] In the case of the latter, nicotine is considered to be a 'prescription-only medicine'. Hence, e-cigarettes that contain nicotine could technically be regarded as 'prescription-only medicine', and thus used for smoking cessation purposes, if they are approved by the Therapeutic Goods Administration (TGA). However, the TGA has thus far not authorized the use of e-cigarettes as official smoking cessation aids (Therapeutic Goods Administration, 2019).

Despite this, individual consumers may legally import e-liquids containing nicotine for personal use through the TGA personal importation procedure scheme. The importation of e-cigarette requires a medical prescription from an Australian doctor, and must be compliant with the state or territory's poison laws (Therapeutic Goods Administration, 2019). Although it is technically possible to do so, it is far for straightforward for Australian vapers to obtain prescriptions for e-cigarettes. According to Mendelsohn (2019), this is because many doctors, as well as health organizations, do not endorse vaping, albeit some of them are aware of the potential benefits of these products for smoking cessation. This mainly stems from a kind of cultural reluctance, insofar as doctors have been trained to use traditional strategies to help smokers to quit and, as such, are skeptical about using new methods (Mendelsohn, 2019). E-cigarettes that do not contain nicotine can be instead possessed (Greenhalgh, Grace, et al., 2019) and sold (The New Daily, 2019) in all states and territories.[67] The importation of these kinds of e-cigarettes does not require a medical prescription.

Heat-not-burn products

Heat-not-burn products are devices that heat tobacco instead of burning it (Abrams et al., 2018). Currently, there are no specific laws in Australia regulating the sale and use of heat-not-burn products (Greenhalgh, 2019a). However, they cannot be legally sold because they contain nicotine and nicotine is considered a 'dangerous poison' in Australia, according to the aforesaid Standard for the Uniform Scheduling of Poisons. While they can be imported, a license is required (Australian Border Force, 2020). Consequently, their use is uncommon, and there is a relative dearth of literature examining them in the context of Australia.

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[65] Queensland was the first jurisdiction in the world to apply the same laws that regulated tobacco cigarettes to e-cigarettes (Whitsunday Times, 2015).

[66] Poisons Standard February 2020, Register ID: F2020L00017, https://www.legislation.gov.au/Series/F2020L00017/Amendments Accessed February 2020.

[67] State and territories have the authority to enact stricter legislation on e-cigarettes.

Other smokeless products

The commercialization of other smokeless tobacco products, such as oral snuff, paste, powder or chewing tobacco is forbidden at both the national level and across all eight states and territories.[68]

7. Illicit tobacco regulation

The illicit tobacco trade is prosecuted under the *Criminal Code Act 1995*, the *Taxation Administration Act 1953* and the *Excise Act 1901*.[69] The main authorities responsible for combating this crime are ABF and ATO (see section IV.C). According to Australian law, illicit tobacco concerns:

- The growing, production and/or manufacture of tobacco—either for commercial or personal use—without the required excise license.
    - Growing tobacco: licenses can only be granted for commercial use, although they are rarely granted (Australian Taxation Office, 2019).
    - Production and manufacturing of tobacco: licenses are required to produce or manufacture cigarettes, cigars, and loose tobacco (excisable goods), as well as tobacco seed, plant and leaf (not excisable goods). However, these are also rarely granted.
- The importation of tobacco within the domestic market without paying the customs duty.[70] International travelers aged 18 years or older do not require a tobacco permit to introduce tobacco products into Australia. However, if they are carrying an amount of tobacco that exceeds the duty-free allowance (one unopened packet of 25 cigarettes, one open packet of cigarettes, or 25 grams of other tobacco products), then they must pay the relevant duty on the whole amount of tobacco, rather than merely the part exceeding the allowance. Failure to declare tobacco products above the duty-free allowance can be prosecuted as an offence or lead to the cancellation of a traveler's visa. Regarding mailed tobacco products, only cigars, chewing tobacco and snuff intended for oral use up to 1.5 kg are allowed to be delivered to Australia (Australian Border Force, 2020).

Sections IV.B respectively provide an overview of the consumption of illicit tobacco, and discuss it in connection with tobacco control policies.

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[68] Trade Practices Act 1974 - Consumer Protection Notice No. 10 of 1991 - Permanent Ban on Goods. https://www.legislation.gov.au/Details/F2010L03294. Accessed March 2020.

[69] Criminal Code Act 1995 No. 12 of 1995 https://www.legislation.gov.au/Details/C2017C00235 Accessed February 2020; Taxation Administration Act 1953 No. 1 of 1953 https://www.legislation.gov.au/details/c2017c00290 Accessed February 2020; Excise Act 1901. No.9 of 1901. https://www.legislation.gov.au/Details/C2018C00378. Accessed February 2020; Customs Act 1901. No. 6 of 1901 https://www.legislation.gov.au/Details/C2020C00080. Accessed February 2020; Treasury Laws Amendment (Illicit Tobacco Offences) Act 2018 No. 82 of 2018 https://www.legislation.gov.au/Details/C2018A00082 Accessed February 2020.

[70] Criminal Code Act 1995 No. 12 of 1995 https://www.legislation.gov.au/Details/C2017C00235 Accessed February 2020; Taxation Administration Act 1953 No. 1 of 1953 https://www.legislation.gov.au/details/c2017c00290 Accessed February 2020; Excise Act 1901. No.9 of 1901. https://www.legislation.gov.au/Details/C2018C00378. Accessed February 2020; Customs Act 1901. No. 6 of 1901 https://www.legislation.gov.au/Details/C2020C00080. Accessed February 2020.

8. Other policies

There are three other main policies of relevance within the Australian tobacco control framework that have not been mentioned in the previous sections. These policies pertain to:

- The content of tobacco products. At the Commonwealth level, there is no existing standard on the proportions or ingredients that tobacco products should contain. States and Territories are free to impose restrictions on flavored cigarettes, which many consider to be more attractive to young people. Currently, fruit and confectionery flavored cigarettes are banned across the country.[71] Menthol cigarettes can be sold and consumed across all the states and territories.[72]
- Age limits. It is illegal to sell or supply tobacco products to young people under 18 years of age in every state and territory.[73]
- Sales restrictions. All Australian states and territories have banned the sale of single cigarettes.[74] Indeed, according to the law, cigarette packs must not contain less than 20 cigarettes (Bayly et al., 2017).

9. Upcoming regulations

The Australian government has recently announced new tobacco regulations. In 2019, the federal health minister Greg Hunt announced the launch of a national strategy that sets out to further reduce the daily smoking rate among the Australian populace (Department of Health, 2019). The defined target of this strategy is to reduce smoking prevalence in the general population to less than 10% by 2025, with a total investment of AUD 20 million. The strategy also comprises targeted interventions and media campaigns to reduce daily smoking among the Indigenous population.

The federal health minister is also planning to reinforce measures on the importation of e-cigarettes and nicotine liquid, which are currently banned across all Australian states and territories. In particular, the TGA, in collaboration with the Department of Home Affairs, have been asked to develop a new law enforcement approach, so as to avoid the undetected importation of e-cigarette liquids containing nicotine, with specific consideration given to the online market (McCauley, 2020). At present, it is only possible to establish that a product does not contain nicotine through laboratory analyzes, which means that this regulation may be difficult for law enforcement to enforce (Greenhalgh et al., 2018).

10. Anti-smoking media campaigns

Anti-smoking campaigns have constituted, and continue to constitute, an important branch of activities within the broader tobacco control framework of the Australian government.[75] The first nationwide smoking cessation campaign was launched between 1973 and 1975, and sought to warn consumers about the potential harm of smoking via the display of posters on public-transport, printed

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[71] https://www.tobaccocontrollaws.org/legislation/country/australia/cd-regulated.
[72] https://www.tobaccocontrollaws.org/legislation/country/australia/cd-regulated.
[73] https://www.tobaccocontrollaws.org/legislation/country/australia/atp-sales-age.
[74] https://www.tobaccocontrollaws.org/legislation/country/australia/atp-sales-restrictions.
[75] Table 9 in the Annex 1 shows the list of the main anti-smoking campaigns in Australia.

advertisements on billboards, and cardboard signs with anti-smoking messages (Carroll et al., 2019). There have been many others since then. The following paragraphs present an overview of the main campaigns from the 1990s to the present day.

In the early 1990s, The National Campaign Against Drug-Abuse began to include anti-tobacco messages, which were directed principally at young women. Messages were issued at the cinema, on television, and in the print media. The campaign sought to discourage people from smoking by changing community attitudes towards smoking (Intergovernmental Committee on Drugs, 2012). This campaign operated as part of a widespread collaboration between the national, state and territory governments, as well as non-governmental organizations. While the campaign was primarily funded by the national government at first, immediately after its conception States and Territories also gradually began to contribute a greater portion of the budget. This national campaign and collaborative efforts have ultimately led to the production of six health-harm advertisement campaigns, and one advertisement campaign supporting the quitline service (Carroll et al., 2019).

The national campaigns also sought to increase both the volume and quality of health and safety information that the tobacco industry was required to issue. The ACCC's campaign in 2006 also aimed to counteract certain labels reported on tobacco products, which may have led consumers to believe that "light" and "mild" cigarettes were less harmful than traditional ones.[76]

The National Tobacco Campaign conducted between 2006 and 2007 focused on young smokers and comprised two stages. The first stage introduced health warning graphics on the packaging of tobacco products, while the second stage, entitled National Tobacco Youth Campaign, aimed—and eventually succeeded—at reducing smoking rates among young people through television, cinema, magazines, radio and outdoor advertising (Carroll et al., 2019).

Subsequent national anti-smoking campaigns between 2010 and 2018 covered a broad range of issues. Anti-smoking campaigns were developed to encourage cessation and prevent relapse among smokers, such as the 'Never Give Up Giving Up' campaign, funded by the Cancer Institute of NSW, which focused on recent quitters. Several campaigns with specific targets were also launched in order to reach vulnerable groups, such as the 'Don't Make Smokes Your Story' campaign for Aboriginal smokers and 'Quit for you, quit for two' campaign for pregnant women.

Over the years, there has also been an increased number of independent campaigns carried out by non-profit organizations or foundations, without any financial assistance from the government. For example, the Minderoo Foundation launched the Tobacco 21 campaign in 2019, for the express purpose of supporting legislation that sought to raise the legal age to purchase tobacco products in Tasmania to 21.

E. Role of Health Services in providing cessation support

Australia has a comprehensive policy framework geared towards reducing the prevalence of smokers, mitigating tobacco health-related harms, and decreasing the social and economic costs associated with smoking (Intergovernmental Committee on Drugs, 2012). The National Tobacco Strategy 2012–18

[76] Australian Competition and Consumer Commission. https://www.accc.gov.au/media-release/accc-resolves-light-and-mild-cigarette-investigation-with-imperial-tobacco Accessed February 2020.

envisaged a series of measures to support smoking cessation. Within the scope of this framework, the Government (both at the Commonwealth and the state and territory levels), NGOs, and quitline service providers were all committed to pursuing the Tobacco Strategy 2012–18. This involved implementing a range of measures, such as increasing the availability of smoking cessation services (e.g., quitlines), setting up quitting programs specifically targeting socially disadvantaged groups (e.g., Indigenous communities, people with mental health issues), launching mass media anti-smoking campaigns, and providing training to health professionals on the most effective anti-smoking treatments based on recent empirical evidence. Quitlines are telephone-delivered services that provide smoking cessation assistance to callers, both at the federal and state and territorial levels, by giving advice and consultative support on how to quit smoking. In some cases, the service may also provide either face-to-face or online training for health professionals on how best to support smoking cessation (this is the case of Quit Victoria quitline for example).

The Australian Government partially covers the costs of smoking cessation services provided in the general practitioners' offices, hospitals, health clinics and other primary care facilities, while the individual users of these services pay the remaining costs (World Health Organization, 2019). The Pharmaceutical Benefits Scheme (PBS), introduced within the National Medicines Policy, provides subsidized pharmacotherapies for smoking cessation, along with prescribing other drugs (Department of Health, 2020a). The main requirement to receive subsidies for smoking cessation medications is that the applicant must participate in smoking cessation counselling. Nicotine patches are the primary pharmacotherapy used in smoking-cessation treatments. Only if a smoker fails to achieve satisfactory results in terms of quitting smoking via the use of nicotine patches, can they then obtain access to other smoking cessation medications. However, participation in smoking counselling is compulsory, and patients must schedule follow-ups with a doctor during the administration of the course. Nicotine patches were only listed on the PBS and made available to all smokers in 2011 (prior to this, only Indigenous smokers could access them under the PBS) (Greenhalgh et al., 2020).The scheme also includes Bupropion and Varenicline, which are two smoking cessation medications that require medical prescriptions and do not contain nicotine, but rather act in response to the presence of the additive substance in the body. Bupropion has been listed in the scheme since 2001, while Varenicline has been listed since 2008 (Greenhalgh et al., 2020). ANDS other than patches are not officially approved tools for smoking-cessation treatments. E-cigarettes, even those without nicotine, are not approved by the TGA for sale as a cessation aid either.

The Australian health service relies on professional healthcare providers to assist people who want to quit smoking, with different medical facilities offering different types of support. General practitioners frequently have the opportunity to establish direct communication with the patient, which enables them to promote smoking cessation practices (Greenhalgh et al., 2016). Doctors focused on this role may also provide practical advice or cessation counselling to smokers seeking to quit (Cunningham, 2014). The Royal Australian College of General Practitioners has developed guidelines for health professionals to assist them in the completion of both these and other related tasks (The Royal Australian College of General Practitioners, 2014). The guidelines present a smoking cessation approach identified as "5A", which is a procedure that begins with being aware of the smoking status of the patient, and then continues by successively assessing their readiness to quit, supporting them with advice and assistance, and, finally, scheduling follow-up meetings to help them maintain their abstinence.

The Australian health system provides standardized guidelines for general practitioners to deal with patients who smoke (The Royal Australian College of General Practitioners, 2014). Smoking cessation

interventions are not planned as a core service by the national health department; however, hospitals may carry out targeted treatments to support quitting attitudes and improve smoking-related healthcare assistance (Mendelsohn, 2015; Weiland et al., 2016). The emergency department in hospitals thus represents an important aspect of the healthcare system's effort to implement smoking cessation measures, as emergency patients are usually motivated to start a quitting process, and post-emergency personal counselling or tailored interventions have proved to be effective (Pelletier et al., 2014; Weiland et al., 2016). The smoking cessation framework is established at the general practice level, with clinical staff and nurses being appointed to provide routine support for smokers in internal care, including personal counselling or NRT medications (Nicotine Replacement Therapy), and its achievements have been found to persist after being discharged from hospital (Mendelsohn, 2015; Rice et al., 2013). In some cases, the clinical service even supports smoking cessation during the post-discharge phase through the provision of NRT medications in an attempt to help achieve long-term abstinence (Williams & Jones, 2012).

There are several other categories of healthcare professionals that contribute to the support of patients who are seeking to quit smoking. Pharmacists supply smoking cessation products or prescribed medications to consumers, as well as being able to provide cessation counselling and recommendations about how the products work (Saba et al., 2014). The association between dental healthcare and smoking also allows dentists to adopt assisting measures to promote smoking cessation attitudes. Dental practitioners are also able to screen for smoking behavior among their patients and provide assistance, such as through referring the patient to the quitline or a general medical practitioner (Ford et al., 2015). Pediatricians, for their part, may recommend cessation interventions to parents and caregivers in order to avoid the exposure of children to passive smoking. Guidelines defined for cardiovascular healthcare highlight the importance of providing advice on smoking cessation measures to smoking patients. Cardiac health professionals are also able to promote quitting attitudes, based on concerns related to the impact that smoking may have on cardiovascular diseases (National Vascular Disease Prevention Alliance, 2012). The relationship between smoking and eye diseases also permits optometrists to discuss smoking behaviors with their patients, in addition to offering counseling for smoking cessation. However, this may not be common practice (Downie & Keller, 2015). Psychologists, psychiatrists and social workers have a crucial role to play in providing smoking cessation support to disadvantaged people with mental or substance abuse disorders, and seeking to integrate nicotine dependence treatments into their ongoing healthcare services (Skelton et al., 2017; Wye et al., 2010).

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