Supplementary Submission

No 44a

INQUIRY INTO TOBACCO SMOKING IN NEW SOUTH WALES

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Date Received: 5/05/2006

Theme:

Summary

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Tobacco Control in Australia – Bullseye on the Wrong Target

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It is more than 500 years since Columbus and his crew observed the Native Americans 'drinking smoke'. Tobacco use has slowly permeated through many societies since then. Arguably, there have been four critical and relatively-recent developments that have produced the tobacco-related health problems that we face today.

1. The development of the cigarette-rolling machine in 1880 made large scale manufacture of cigarettes economically viable and turned the American Tobacco Company into a corporate giant.
2. The Great Wars of the 20th Century were times when the smoking of tobacco in pipes was impractical and contributed to a switch to cigarettes as the preferred form of smoking tobacco.
3. The dominance of 'Bright' tobacco that can be processed by flue-curing. This tobacco burns with an acidic smoke that must be deeply inhaled to achieve effective nicotine delivery. This exposes the lower airways and alveolar surfaces to smoke, allowing topical and systemic absorption of toxic organic and other smoke constituents.
4. The considered research-based changes in cigarette product chemistry such that nicotine is very rapidly delivered from smoke and the acute irritant effects of bland tobacco are minimised. This was epitomised by the development of the Marlboro cigarette in the late 1970's.

These technical changes, allied with a generally supportive social and political environment and astute promotion led to a sustained increase in cigarette consumption between 1920 and 1950, one unrivalled by any consumer product in the modern era. It is sobering to reflect that 50 years ago, (Sir) Richard Doll and Bradford Hill's survey of British doctors found that 75% of British doctors were cigarette smokers and that, of the remainder, half smoked a pipe(1). Male smoking rates in the wider community at the time were even higher.

Cigarette smoking rates in British Doctors who were surveyed in 1951 and 1990 fell from 52% to 6%(2). Depending on the precise measure used, smoking prevalence in the young adult Australian population is now around 20%(3). All reasonable estimates suggest that less than 2% of Physicians in Australia and New Zealand are current smokers. The extent of reduction of smoking amongst Physicians has, therefore, been much greater than that in the broader community. We are well aware that our collective health is markedly the better for it.

What is an acceptable or unavoidable level of smoking in a modern, well-educated democracy? Medical and similarly-educated professional groups possess the freedoms and are subject to the influences and constraints of this society. If the smoking rates in these groups are so low, why would we not set a similar target for the wider community? Differences in ethnic background, level of education, socio-economic status and prevalence of mental illness may account for some of this difference but these are obstacles, not barriers.

The apparently unachievable can be achieved in tobacco control with effort. Smoking is now restricted in public places that were, not long ago, considered far too difficult to address. Major sporting venues and restaurants in hotels are now smoke-free. For the benefit of workers, bars should be made smoke-free and this may soon be forced as a consequence of recent litigation(4). Interestingly, these restrictions are well-accepted and do not need to be enforced by 'smoking police' (5). This two-pronged approach - changing smoker behaviour at the same time as wider public attitudes and expectations - should be our model as we address active smoking.

If it is held that 20% prevalence is an appropriate target for adult smoking, then we can be relaxed and comfortable with current anti-smoking efforts. If we were to use 5% as a target, we are clearly underperforming. Where would we begin? We start, firstly, by achieving acceptance that almost all smokers are dependent on nicotine, not enacting a lifestyle choice. Moreover, this

dependence begins in childhood at a time when the concept of future risk is largely irrelevant. Secondly, it should be agreed that achieving lower smoking rates directly benefits current and potential future smokers, both in health and economic terms. If the individuals are better off, so is the collective.

The Federal Government has consistently rejected overtures by the RACP and other organizations to fund tobacco control at a minimum at a level equal to the tax paid by under-age smokers. We should recognise the inadequacy of current levels of investment in tobacco control. Well-funded comprehensive tobacco control programs in California and Massachusetts have seen tobacco consumption fall at twice the rate elsewhere in the US(6). In California, this has been associated with reduced mortality from heart disease(7) and the success in Massachusetts was achieved with the modest annual investment of US$6.50 per head of population(8).

Price rises reduce tobacco use. Cigarette taxes should continue to increase at a rate greater than inflation but, as prices selectively affect poorer sections of this community, all effective forms of pharmacological support to smoking cessation should be subsidised. More effective community education is essential. The Australian National Tobacco Campaign was not planned to target youth, but intensive community-based programs such as that in Florida can dramatically reduce teenage smoking rates(9). All public media campaigns should follow the model of the recent National Tobacco Campaign, with considered planning, review and evaluation but must be better resourced. Each campaign must be changed or terminated in favour of a different one as soon as the effect wanes. Warning messages on cigarette packets, whatever form they take, should be based on evidence of their effect and be changed as often as is necessary.

However, to even approach the more difficult target we must tackle the issue of legitimacy. Used exactly as directed, the carefully designed and refined modern cigarette is responsible for the death of 50% of its users(10). It must be rejected as a legitimate product. The legitimacy of the Tobacco Industry

itself must be challenged. These companies ought not be able to portray themselves as the beleaguered suppliers of a product that a significant section of the population elects to use. Finally, the legitimacy of the financial and other associations that the Tobacco Industry has with governments, political parties and major media organizations must be rejected.

When exposure of non-smokers to environmental tobacco smoke(ETS) is restricted, smokers benefit because they smoke fewer cigarettes(11). In Australia, the maximum benefit from this has probably been achieved and it is time to focus on active smoking. The cigarette and smoking must be denormalised in the way that exposure to ETS has been. Some of these concepts are radical and the targets are challenging but we should be prepared to aim at them.

REFERENCES

1. Doll R, Hill AB. The mortality of doctors in relation to their smoking habits. A preliminary report. BMJ 1954; i:1451-5.
2. Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in Relation to Smoking: 40 Years' Observations on Male British Doctors. BMJ 1994, 309:901-911.
3. Australia's National Tobacco Campaign Evaluation Report Number Two. www.health.gov.au/pubhlth/publicat/document/tobccamp_2.pdf. Accessed October 4th, 2001.
4. Chapman S. Australian bar worker wins payout in passive smoking case. BMJ 2001; 322; 1139.
5. Chapman S, Borland R, Lal A. Has the ban on smoking in New South Wales restaurants worked? A comparison of restaurants in Sydney and Melbourne. Med J Aust 2001; 174: 512-5.
6. Malmstadt JR, Nordstrom DL, Christiansen AL, Rumm PD, Chudy NE, Remington PI. Progress in reducing per capita cigarette sales in Wisconsin 1985-1999. WMJ 2001; 100: 49-53.
7. Fichtenberg CM, Glantz SA. Association of the California Tobacco Control Program with declines in cigarette consumption and mortality from heart disease. N Engl J Med 2000; 343: 1772-7.
8. Biener L, Jarris JE, Hamilton W. Impact of the Massachusetts tobacco control program: population bases trend analysis.BMJ 2000; 321: 351-154.
9. Bauer UE, Johnson TM, Hopkins RS, Brooks RG. Changes in youth tobacco use and intentions following implementation of a tobacco control program: findings from the Florida youth Tobacco Survery, 1998-2000. JAMA 2000; 284: 723-8.
10. Peto R. Smoking and death: the past 40 years and the next 40. BMJ 1994;309:937-9.
11. Chapman S, Borland R, Scollo M, Brownson RC, Dominello A, Woodward S. The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States. Am J Public Health 1999; 89: 1018-1023.