Submission

No 22

INQUIRY INTO TOBACCO SMOKING IN NEW SOUTH WALES

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Summary

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Rachel Simpson
Director
Joint Select Committee on Tobacco Smoking in New South Wales
Parliament of New South Wales
Parliament House
Macquarie Street
Sydney
NSW 2000

10th April 2006

Dear Ms Simpson

Tobacco Smoking in New South Wales

I enclose a submission to the Joint Select Committee on Tobacco Smoking in New South Wales from the Cancer Institute NSW.

I also enclose corrected transcripts from the hearing on 21st March from Professor Jim Bishop, Chief Executive Officer of the Cancer Institute NSW and from myself.

Finally, I enclose our responses to the additional questions posed by Committee members during our meeting with them.

I have also sent the submission and responses to questions by email to tobaccosmokingcommittee@parliament.nsw.gov.au as many of the references we have provided are hyperlinked to the original documents.

Please do not hesitate to contact me if we can provide any further information for the Committee.

Yours sincerely,

Trish Cotter
Director, Prevention

Cancer Institute NSW Submission

to the

Joint Select Committee on Tobacco Smoking in New South Wales

April 2006

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1. Introduction

The Cancer Institute NSW is grateful to the Committee for the opportunity to provide evidence to the Inquiry into Tobacco Smoking in New South Wales.

In so doing, this submission seeks to focus on those areas where the Cancer Institute has a particular responsibility and not to unnecessarily burden the Committee with data already presented by other parties, in particular the detailed evidence presented by NSW Health.

1.2 Role of the Cancer Institute NSW

The Cancer Institute was established in mid-2003 with the following objectives:

- To increase cancer survival rates for cancer patients
- To reduce the incidence of cancer in the community
- To improve the quality of life of cancer patients and their carers
- To operate as a source of expertise on cancer control for the government, health service providers, medical researchers and the general community.

One in five (19.19%) of all cancer deaths is caused by smoking[1] and two in five (39.6%) of all deaths caused by smoking are from cancer.[2] The NSW Cancer Plan 2004-2006[3] places special emphasis on the prevention of cancer with a recognition that reducing smoking prevalence is crucial. Indeed, the second goal of the thirty-three goals laid out in the Cancer Plan commits the Cancer Institute to "Substantially reduce smoking prevalence in NSW".

The Institute works with government and non-government agencies at local, state, national and international levels to achieve its goals. The Institute has a strong commitment to working in partnership with others so as to maximise the effectiveness of the available resources.

1.3 National and NSW frameworks for tobacco control

In endorsing the National Tobacco Strategy 2004-2009, all Australian governments have resolved "to work together and in collaboration with non-government agencies on a long-term, comprehensive, evidence-based and coordinated national plan to reduce the often hidden but nevertheless very real misery and wasted human potential caused by tobacco smoking in Australia."[4]

The strategy has clear objectives and provides compelling evidence of the potential effectiveness of policies and programs. It also provides a blueprint for jurisdictional governments to develop action plans to describe how the challenges in achieving those objectives will be met at a state level.

The NSW Tobacco Action Plan 2005-2009[5] does just that. The Cancer Institute assisted NSW Health in the development of the Plan as a member of the consultation and management committee. The Plan is organised around six 'focus areas'[i]. The Cancer Institute's primary responsibility within the Plan is the design, development and delivery of mass media campaigns and, since January 2006, the funding and policy and management direction of the NSW Quitline service.

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[i] Smoking cessation; exposure to environmental tobacco smoke; marketing and the promotion of tobacco products; availability and supply of tobacco products; capacity building; research, monitoring and evaluation.

2. The costs and other impacts of smoking

It is clear that the highest cost to smokers and their loved ones is the early loss of life. But for most people, death is preceded by weeks, months or years of ill-health. Treatment of the diseases caused by smoking is also a great burden on the health services and the overall impact of tobacco use is a significant drain on the economy.

2.1 The human costs and impacts of smoking

Figure 1 shows the deaths caused by smoking as a proportion of all deaths in NSW in 2002. Smoking caused an estimated 6,608 deaths overall: 18% of all male and 10% of all female deaths respectively.[6] Figure 2 shows the deaths in Australia in 1998 from smoking by disease group.[7]

Half of all long term-smokers will die prematurely, and half of those will dies in middle age.[8] But it is not just a question of length of life. Long-term smokers suffer more disease and disability before they die at younger ages: on average they suffer reduced quality of life for a greater number of years than non-smokers.[9]

Figure 1. Deaths from smoking as a proportion of all deaths in NSW in 2002

Figure 2. Deaths from smoking in Australia in 1998 by disease group

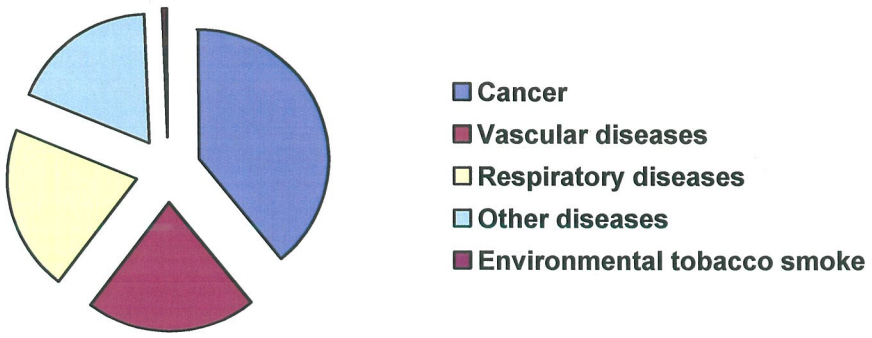


Table 1 lists the diseases and adverse health effects of active smoking and Table 2 does the same for passive smoking[10].

The range of diseases caused by smoking and the sheer scale of the premature death and crippling illness is daunting. In his lecture on Tobacco: a medical history[11] the late Sir Richard Doll commented, "That so many diseases – major and minor – should be related to smoking is one of the most astonishing findings of medical research ... less astonishing, perhaps, than the fact that so many people have ignored it." (See enclosed DVD of the lecture).

Table 1. Diseases and adverse health effects of active smoking

Cancers	Respiratory diseases & adverse health effects	Cardiovascular diseases & adverse health effects	Other diseases & adverse health effects
• Lung • Oral cavity • Pharynx • Larynx • Oesophagus (squamous cell carcinoma) • Oesophagus (adenocarcinoma) • Pancreas • Urinary bladder • Renal pelvis • Kidney (renal cell carcinoma) • Stomach • Uterine cervix • Granulocytic cells of bone marrow (myeloid leukaemia) • Nasal cavities • Nasal sinuses • Liver	• Chronic obstructive pulmonary disease (COPD) • Acute respiratory illnesses including pneumonia • Premature onset of and an accelerated decline in lung function • All major respiratory symptoms in adults including coughing, phlegm, wheezing & dyspnoea • Poor asthma control ***In young people & adolescents who smoke:*** • Impaired lung growth • Early onset of lung function decline • Respiratory symptoms including coughing, phlegm, wheezing & dyspnoea • Asthma-related symptoms (wheezing) • Respiratory effects in utero with maternal smoking	• Coronary heart disease (CHD) • Cerebrovascular disease • Aortic aneurysm • Peripheral arterial disease • Buerger's Disease	• Gastric ulcer • Cataract • Periodontitis • Duodenal ulcer • Adverse surgical outcomes related to wound healing and respiratory complications • Hip fracture • Reduced fertility in women • Crohn's disease • Age related macular degeneration • Tobacco amblyopia • Osteoporosis ***Reproductive problems:*** • Pregnancy complications • Preterm delivery & shortened gestation • Foetal growth restrictions & low birthweight • Sudden Infant Death Syndrome

Table 2. Diseases and adverse health effects caused by passive smoking

In adults	In children	Other adverse health effects for both adults and children
• Lung cancer • Coronary heart disease • Onset of symptoms of heart disease • Asthma attacks in those already affected • Worsening of symptoms of bronchitis • Stroke • Reduced foetal growth (low-birth-weight baby) • Premature birth	• Cot death (Sudden infant death syndrome) • Middle-ear disease (ear infections) • Respiratory infections • Development of asthma in those previously unaffected • Asthma attacks in those already affected	• Shortness of breath • Nausea • Airway irritation • Headache • Coughing • Eye irritation

2.2 The economic costs and impacts of smoking

The greatest burden of illness and costs due to tobacco occurs among households in the lowest quintile of social advantage.[12] Smoking is most devastating for those who can least afford it.

Tobacco use imposes substantial costs on smokers and their families, taxpayers, businesses and the community as a whole.[13]

From mid-1950 to mid-2000, around 697,000 Australians are estimated to have died prematurely due to tobacco use.[14] Smokers who die early or become incapacitated due to tobacco-related disease can no longer contribute to the unpaid economy.

An estimate by leading health economists, Collins and Lapsley, is that tobacco cost the NSW economy at least $6.6b in 1998-99.[15] The authors demonstrate that this estimate is both conservative and incomplete.

Smoking reduces the productivity of the paid workforce through absenteeism and premature loss of highly experienced employers.

Even more significant are the profits forgone on sales of goods and services consumed by smokers involuntarily using tobacco and of people who die early die to tobacco-caused disease.[16]

According to Collins and Lapsley, the direct burden in NSW on taxpayers, businesses and families from tobacco-related disease is $1.78b (including $475m spent on hospitals, nursing homes and pharmaceuticals). The indirect costs are $4.8b due to the high level of premature death.

Looking at the country as a whole, the burden tobacco poses is appalling. The best – again, conservative and incomplete – estimate of the net total costs of tobacco use in Australia in 1998-99 was $21b (tangible and intangible), almost four times the revenue raised by the tax on cigarettes ($5.3b).[17]

2.3 Major social and economic returns by reducing smoking

Based on Collins and Lapsley estimates, a drop in the smoking rate of 5 percentage points over 5 years would deliver the state of NSW a benefit of between $2.3b and $5.8b benefit over 20 years (these figures represent the present value of the benefits accruing over the whole of an assumed twenty year period).

It has been estimated that $2 has been saved on health care for each $1 spent on tobacco control programs to date. The total economic benefits of tobacco control programs are estimated to exceed expenditure by at least fifty to one.[18]

It is difficult to imagine any other public expenditure providing returns of this magnitude.

In addition to the obvious savings that significantly reducing smoking will bring, the National Tobacco Strategy sets out the following important returns on investment in tobacco control:

Stronger families, stronger children

- fewer Australian families, particularly low-income families, devastated by early death or serious disability from smoking-related disease or injuries in house fires

- fewer children from low-income families further disadvantaged by poorer overall health and development, and expenditure on tobacco at the expense of other goods

Healthy and independent ageing

- a greater number of people better able to enjoy their grandchildren or leisure in retirement
- fewer trips to hospital for those managing chronic conditions
- fewer people with serious health problems unable to remain in their own homes
- less need for pensions and benefits with fewer people suffering major disability caused by smoking and more people able to save sufficiently for retirement

Sustainable health care systems

- fewer demands on public hospitals and other health services
- lower demand for pharmaceutical and medical benefits

Greater profits for Australian businesses outside the tobacco industry

- potential increases in expenditure on other goods and services by those who no longer purchase tobacco
- lower insurance costs due to fewer fires and reduced exposure to environmental tobacco smoke

A stronger economy

- a very large expansion in demand for goods and services due to increased spending by many people – people who would otherwise die prematurely – living longer and more active lives
- improved productivity with fewer smoking breaks, less absenteeism and fewer experienced employees dying or retiring ill in middle age

Stronger communities

- fewer demands on and more people contributing to the unpaid economy
- fewer communities and national parks and less bushland devastated by bushfires
- less litter

Improved Indigenous health

- fewer deaths and less disability caused by heart attacks, diabetes, chronic lung disease and cancer, preventable conditions responsible for over 90% of the burden of disease among Aboriginal and Torres Strait Islander peoples

Less harm from illicit drugs

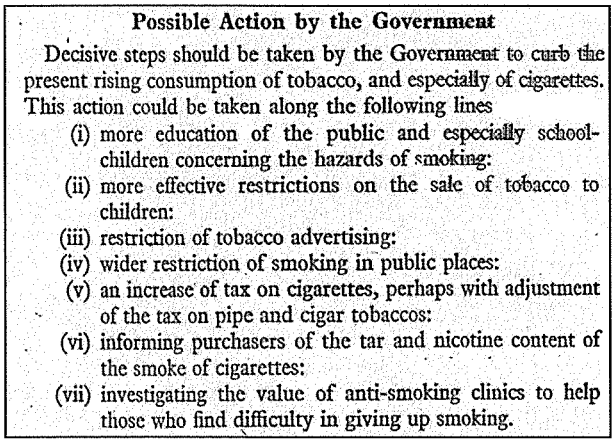
- fewer children taking up illicit drugs as the factors that prevent smoking also protect against many other high-risk behaviours.

3. The effectiveness of strategies to reduce tobacco use

3.1 Comprehensive programs work

Unlike many other areas of public health, there is little debate about the best way to tackle the tobacco problem. The seven components of a comprehensive strategy were laid out more than forty years ago in the landmark 1962 Smoking and Health report of the Royal College of Physicians[19], which made recommendations for government action.

Figure 3. Recommendations of the Royal College of Physicians, 1962



Possible Action by the Government

Decisive steps should be taken by the Government to curb the present rising consumption of tobacco, and especially of cigarettes. This action could be taken along the following lines

(i) more education of the public and especially school-children concerning the hazards of smoking:
(ii) more effective restrictions on the sale of tobacco to children:
(iii) restriction of tobacco advertising:
(iv) wider restriction of smoking in public places:
(v) an increase of tax on cigarettes, perhaps with adjustment of the tax on pipe and cigar tobaccos:
(vi) informing purchasers of the tar and nicotine content of the smoke of cigarettes:
(vii) investigating the value of anti-smoking clinics to help those who find difficulty in giving up smoking.

1. **Public education**
2. Restrict sales to minors
3. Restrict tobacco promotion
4. **Restrict smoking in public places**
5. **Increase tobacco tax/price**
6. Consumer information and product regulation
7. Cessation support services

All of these interventions are necessary and they act synergistically to reduce smoking rates in a population. However, as the evidence base has grown over the intervening decades, it has become clear which of these interventions is the most powerful at a population level and they are highlighted above: public education, smokefree public places and price. (See sections 4 and 6 for further details).

When they are large-scale and sustained, comprehensive programs have been shown to be effective in reducing tobacco use. Table 3 shows the sustained declines in tobacco use in California and Massachusetts where such programs have been in place for more than fifteen years, compared with other US states.

Table 3. Packs purchased per adult per year in California and Massachusetts compared with the other US States, 1990 to 1997

Year	Mass.	% change from 1990	California 1989*	% change from 1990	48 other US states	% change from 1990
1990	125	-	100	-	139	-
1991	120	4	92	8	135	3
1992	117	6	89	11	131	6
1993	102*	18	89	11	125	10
1994	101	19	73	27	126	9
1995	98	22	76	24	124	11
1996	93	26	75	25	124	11
1997	78	38	72	28	124	11

Source: US Tobacco Institute and US Census data, compiled for the Massachusetts Dept of Public Health, May 1997. * indicates year that large-scale campaigning commenced.

4. The effects of smoke-free indoor venues on the initiation and maintenance of the smoking habit

The evidence that smoke-free environments – workplaces, public places and private places including homes – have a profound and positive influence on population smoking rates is beyond doubt.

Smokefree environments not only protect non-smokers from the substantial hazards of breathing in tobacco smoke, they help some smokers to quit for good and others to cut down on their consumption; and they demonstrate to children that smoking is not a normal adult behaviour to which they should aspire.

The NSW Health submission provides substantial evidence on this issue. The Institute would add the following points.

4.1 Effects on smoking of smoke-free workplace policies

Making workplaces smoke-free produces a measurable decrease in the prevalence of smoking among employees, and those who continue to smoke tend to consume fewer cigarettes each day. Prevalence falls on average by 3.8 percentage points according to a meta-analysis of 26 studies performed in three continents. The same study found a reduction in the number of cigarettes consumed by continuing smokers.[20] Furthermore, uptake of smoking by young people starting work is significantly lower if the workplace is totally smoke-free.[21]

4.2 Effects of smoke-free policies in schools

Policies that apply indoors and outdoors, to students, teaching and other staff, and to all visitors to the school help to reduce the uptake of smoking by young people.[22]

4.3 Effects of smoke-free policies at home

Prohibiting smoking in the home has a significant impact on the uptake of smoking by young people.[23]

4.4 Effects of smoke-free policies in hospitality venues

It is difficult to disentangle the impact on prevalence and uptake of smoke-free hospitality venues as distinct from smoke-free workplaces and other public places.

Clearly smoke-free venues augment the impact of smoke-free workplaces for patrons as well as staff. A 2004 Victorian study found that 28% of smokers reported that they were somewhat, or very likely to quit smoking altogether, if smoking is banned altogether in pubs and clubs.[24]

Research among callers to the Quitline in Ireland, after the successful introduction of smoke-free workplaces including all pubs and bars, showed that 39% of those who had quit said that the Smoke-Free at Work legislation had a significant or important bearing on their decision and 55% reported that it was an important aspect in terms of 'staying off'.

Comprehensive smoke-free policies can be implemented successfully in a wide variety of settings, in private as well as public venues. They are popular and achieve high levels of compliance. The precise magnitude of the effects of smoke-free policies on health is difficult to quantify but the evidence suggests that the impact is important at both individual and population levels.

5. Factors affecting initiatives for smoke-free indoor areas

As explained in Section 3 above, the proposal that smoking should be restricted in public places as a means to reduce smoking was articulated by public health experts more than forty years ago. Relatively little was done to promote smokefree environments for a further twenty or more years. This was not only a failure of government, since for many years mainstream health agencies also failed to recognise the importance of environmental tobacco smoke on health.

The tobacco industry was however quick to recognise the threat posed to its business by the designation of smokefree public places and workplaces. Tobacco industry activity has been the most important factor affecting the introduction of smoke-free environments. The rationale for this activity is simple and is illustrated by this quote from a 1978 article in the Financial Times[25] reporting the concerns of a president of a US-based tobacco company, on the topic of restrictions on smoking:

If they caused every smoker to smoke just one less cigarette a day, our company would stand to lose $92 million in sales annually. I assure you we don't intend to let that happen without a fight.

With the emergence of once-secret internal tobacco industry documents, first through whistleblowers[26] and then through litigation in the 1990s, principally in the US, detailed knowledge of the strategies employed to protect and grow the global tobacco business are now in the public domain. Internal documents demonstrate that the industry's strategy on passive smoking is sophisticated and subversive, with the overall goal to maintain sales and profits by preventing, delaying or weakening smokefree legislation.

The industry has established strategic relationships with other industries potentially affected by the introduction of restrictions on smoking such as the hospitality, ventilation and, more recently, the gambling industries. Their combined attempts to obstruct smokefree policies have been consistently applied in Australia and around the world; and consist of these strategic components:

- Dispute the science – argue the problem is one of annoyance not real harm
- Advance 'courtesy' and 'accommodation' – find a social solution to the problem by promoting schemes where smokers and non-smokers can co-exist in the same environment
- Champion ventilation – offer a technical solution to the problem
- Warn of dire economic consequences of smokefree solutions
- Portray champions of smokefree solutions as extremists and smokefree solutions as coercive
- Argue that enforcement of smokefree solutions will be difficult

The evidence that the industry has engaged in these tactics, directly but also covertly through the funding of third party 'arms length' organisations that appear independent of the tobacco industry, is extensive.[27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47]

In spite of ample scientific and economic evidence that smokefree environments are good for health, good for business and popular with the public, the industry and its allies have been successful in influencing scientists and policy makers and subverting normal decision-making processes.[48]

6. The effectiveness of media, educative, community and medically-based Quit initiatives

6.1 The Cancer Institute's media campaigns

The use of social marketing to reinforce the health risks of smoking to adults supported by accessible cessation services is considered best practice in effective tobacco control interventions.

Since its establishment, the Cancer Institute's main focus of tobacco control activity has been the design, development and delivery of public education campaigns backed up by the offer of support for smokers through the Quitline. By adapting successful campaigns from other jurisdictions and from overseas for use in NSW, the Institute has managed to be on air fairly consistently from May 2004 while also investing time and resources in developing new material.

Between 2003 and 2005, there has been a 2.2% decline – from 22.3% to 20.1% - in the adult smoking prevalence in NSW.[49] This most welcome reduction in prevalence will have resulted not only from the recent media campaigns in NSW. Price increases, extensions of smokefree environments will also have played a part in smokers' decisions to quit. Nevertheless, the sustained presence in the media of hard-hitting cessation campaigns will have been an important influence.

Table 4 provides brief details of the media campaigns the Institute has run in conjunction with NSW Health, the Quitline and other partners. The timing of these campaigns has been planned to take into account other NSW Health campaigns and national campaigns by the Commonwealth that run in NSW. Full evaluation reports are available.

Table 4. Cancer Institute media cessation campaigns since May 2004

Campaign	Period	Key evaluation outcomes
Ladykiller	May to June 2004	• Sustained increase in calls to the Quitline over the campaign period (increase of 112%)
New Year	Dec 2004 to Jan 2005	• Calls to Quitline doubled when compared with the previous month
Excuses	April to June 2005	• 80-90% of smokers had seen the TV ad/s • Three out of four who saw the ad perceived it to be believable • Two out of three agreed it reminded them of the dangers of smoking • Two out of three smokers said they were more likely to stop smoking or to think about quitting
Parents	Sept 2005	• 80% of smokers had seen the TV ad • Higher recognition among females, younger people and smokers with children • 59% found the ad attention grabbing; 65% found it believable; and 47% made them think about quitting • Smokers with children reacted more strongly • 72% more likely to stop or to think about quitting
Lung disease	Nov to Dec 2005	• 70% of smokers recognised the TV ad; recognition higher among females • 49% found the ad attention grabbing; 57% found it believable, 46% very relevant and 32% made them think about quitting • 68% more likely to stop or to think about quitting

6.2 A media-led Quitline service

From January 2006, the Cancer Institute has been responsible for the funding, oversight of management and the promotion of the Quitline service in NSW. The Quitline is an evidence based service that provides telephone counselling support to smokers who want to quit. Smokers call a 13 number (13Quit or 13 7848) to access the service and are offered the opportunity to join a call-back program that can double their chances of quitting successfully.

Most current smokers would like to quit and more than half plan to quit in the next six months[50]. Eighty percent of smokers have made a previous attempt to quit.[51]

Telephone counselling services have been operating for more than a decade in Australia and have provided information and advice to hundreds of thousands smokers. Smokers who receive counselling are more likely to quit than those merely posted materials[52,53] and those who receive several calls at key stages in the cessation process have higher long-term success rates.[54,55,56]

Suggested benefits of telephone counselling services include:

- Providing an important route of access to support smokers in quitting[57]
- Playing a symbolic role, telling smokers that smoking cessation is important[58]
- Convenience to access support services[59]
- The callback service approximately doubles chances of successfully quitting[60]

Research undertaken prior to the Cancer Institute's revitalisation of mass media campaigns indicated that less than 4% of Australian adult smokers use the Quitline to help quit[61] with the majority quitting "cold turkey", followed by nicotine replacement therapy.[62] This represents an under-utilisation of a convenient, professional service available to the population of smokers for the cost of a local call.

There is a very strong correlation between weight of television advertising specifically, and the number of calls to the Quitline. With the increase in media campaign spending in 2004 and 2005, there has been a 58% increase in total calls handled by the Quitline service and a 93% increase in callers participating in the call-back program.

Cancer Institute campaign tracking and market research conducted in December 2005, indicates a high awareness of the Quitline among smokers but low understanding of its services. In April 2006, the Cancer Institute will launch a media campaign to promote the services offered by the Quitline.

New data from the Quitline's follow-up of a 788 sample of callers indicates a very good (self-reported) quit rate of 48.5% at three months.[63] In future, the Cancer Institute will be supporting the Quitline to undertake follow-up at six and twelve months in order to establish long-term effectiveness; and will encourage the Quitline to publish their research in a peer-reviewed journal.

6.3 Community and medically-based Quit initiatives

The NSW Health submission includes detailed material on these issues. The Cancer Institute supports the development of cessation services through Area Health Services to offer the intensive support that the minority of smokers need to help them quit for good. The Quitline can act effectively as an entry point to those services.

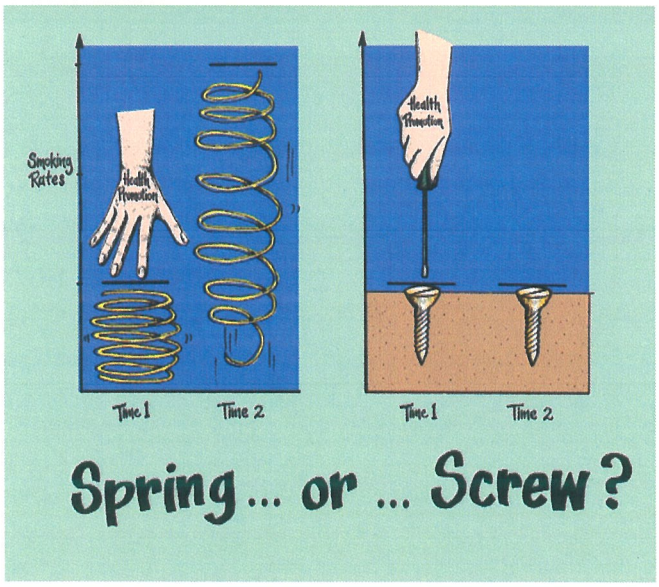
7. The adequacy of the budget for smoking control initiatives

Since the establishment of the Cancer Institute in 2003, the amount of public funds allocated to tobacco control in NSW has increased substantially. The 'budget' stands at about $12.8m in 2005-2006, taking into account the contributions of NSW Health, the Area Health Services, the Cancer Council and other non-government agencies. This is equivalent to about $1.90 per person in NSW.

Based on international best practice[64], the National Tobacco Strategy – endorsed by all Australian governments – proposed a minimum spend of $2.90 per person (at 2004 $ value) and a maximum of $8.50 for tobacco control in NSW.[65]

If the contributions of Commonwealth-funded programs in NSW are taken into account, together with the contributions of agencies such as the Australian Institute of Health and Welfare, the public health departments of our universities, the environmental health departments of our local government authorities and so on, the current 'budget' will be somewhat higher. However, it is unlikely to reach the minimum expenditure recommended on the basis of the best available evidence.

While the level of spending in any one year is clearly important, the *stability* of funding over the years that is absolutely critical. To achieve the goal of the NSW Tobacco Action Plan and "improve the health of the people of NSW and to eliminate or reduce their exposure to tobacco in all its forms", will take *sustained funding* over at least the next decade or two.



There are still more than one million people in NSW who smoke regularly.[6] It is not a stable population: tens of thousands start, quit and relapse every year.

Without sustained campaigns to motivate, remind and support smokers to quit and to denormalise smoking, there is every possibility that smoking rates will rise. If they do rise, it will be amongst younger people and the toll of disease and early death from smoking will continue for many more decades to come.

Three more points should be borne in mind when considering the adequacy of the budget. First, programs to reduce smoking are among the most cost-effective interventions available to any government. The savings to the public purse from even a small reduction in prevalence are enormous (see section 2) and the programs pay for themselves many times over.

Second, NSW smokers contribute nearly $2b to government revenue every year – more than 130 times the current tobacco control budget. Most smokers want to quit and no smokers want their children to smoke. They deserve the very best help available.

Third, a commitment to achieving the maximum efficiency with the available funds, whatever the size of the budget, is essential. Of course, creativity and experimentation should also be encouraged but not at the expense of tried and tested interventions such as mass media campaigns.

Wherever possible, the Cancer Institute has sought to adapt existing material or share the costs of campaign development with other partners in order to make the most of the available funds. The Institute has been instrumental in getting other states and territories to collaborate in a new national campaign to be launched in May 2006. By sharing the development costs, more funds have been preserved for broadcasting to the NSW public.

8. The Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005 introduced by Revd Mr Nile in the Legislative Council

The objective of the *Smoke-free Environment Amendment (Motor Vehicle Prohibition) Bill 2005* is to amend the *Smoke-free Environment Act 2000* by making it an offence for a person to smoke in a motor vehicle "at any time".

The consequences of smoking in vehicles are undoubtedly serious. The Cancer Institute's submission on this issue is provided from a health and safety perspective and we do not seek to offer advice on the practicalities of introducing and implementing this proposed legislation.

8.1 Smoking in vehicles

Tobacco smoke causes 'irritant' effects on the eyes, nose, throat and airways. These effects occur after short-term exposure and are due to irritant chemicals in tobacco smoke, such as acrolein, acetaldehyde, formaldehyde, sulphur and nitrogen oxides, ammonia and other volatile organic compounds.

Given the confined space, drivers and passengers in vehicles where smoking is taking place are exposed to particularly high concentrations of tobacco smoke. Furthermore this exposure does not end when the cigarette is stubbed out. It lasts for several hours after each cigarette is smoked.

A study carried out by Stanford and Berkeley universities in the US[66] demonstrated that after one cigarette is smoked in a *room with the windows open*, it takes more than two and a half hours for the levels of pollutants to fall to the risk level considered 'acceptable' by the US Environmental Protection Agency. It stands to reason that drivers and passengers are at significant risk of exposure to unacceptable levels of carcinogens and toxins if smoking is occurring in the vehicle.

Smoke in cars is especially harmful to children. They are more sensitive to tobacco smoke than adults because they breathe more rapidly and in greater relative volumes. Furthermore, they are rarely in a position to stop an adult driver or passenger from smoking and so can be forced to endure intense and sometimes prolonged exposure to tobacco smoke.

Several studies have found that smoking while driving increases the risk of being involved in a crash.[67,68,69] The association between smoking and increased crash risk could be the result of three factors: distraction caused by smoking, behavioural differences between smokers and non-smokers, and high levels of carbon-monoxide from the tobacco smoke causing drowsiness.

A 1990 review of the literature[45] revealed that smokers have an increased crash risk compared to non-smokers and this greater risk remains when age, gender, education, alcohol consumption and driving experience are accounted for.

Smoking is estimated to be the cause of about 1% of distraction-related vehicle crashes.[70] Conservatively, it is estimated that about 7% of bushfires are caused by discarded cigarettes.[71]

8.2 *Changing behaviour*

After four years of the *Car and Home Smoke-free Zone* campaign (detailed evaluation of this is in the NSW Health submission), some 85% of people in NSW report that their cars are smoke-free.[72] In the 16 to 24 year old age group, this proportion falls to 77% so there is clearly more work to do to persuade the some sections of public not to smoke in vehicles.

Media campaigns targeting parents and carers about how best they can protect their children from tobacco smoke should include a focus on the importance of smoke-free vehicles and should include clear information delivered through maternal and child health, children's hospitals, play groups, child care centres, parent associations and parenting networks.

Media campaigns aimed at motivating smokers to quit and supporting those who are trying can also make good use of the opportunities to target drivers through radio. Collaborative work with agencies responsible for fire protection and road safety also offer many opportunities to communicate the importance of not smoking while driving.

References

[1] NSW Central Cancer Registry, 2006. Unpublished data for 2003.
[2] Ridolfo B, Stevenson C 2001. The quantification of drug-caused mortality and morbidity in Australia, 1998. AIHW cat. no. PHE 29. Canberra: AIHW (Drug Statistics Series no. 7). http://www.aihw.gov.au/publications/index.cfm/title/6461
[3] NSW Cancer Plan 2004-2006. http://www.cancerinstitute.org.au/cancer_inst/campaign/plan_0406.pdf
[4] National Tobacco Strategy, 2004-2009. Ministerial Council on Drug Strategy, November 2004. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-pub-tobacco-tobccstrat2-cnt.htm/$FILE/tobccstrat2.pdf
[5] NSW Tobacco Action Plan 2005-2009: A Vision for the Future. http://www.health.nsw.gov.au/pubs/2005/pdf/tobacco_ap_vision.pdf and Backgrounder http://www.health.nsw.gov.au/pubs/2005/pdf/tobacco_ap_bground.pdf
[6] The health of the people of New South Wales – Report of the Chief Health Officer 2004, NSW Health. http://www.health.nsw.gov.au/public-health/chorep/chorep.html
[7] Ridolfo B, Stevenson C 2001. The quantification of drug-caused mortality and morbidity in Australia, 1998. AIHW cat. no. PHE 29. Canberra: AIHW (Drug Statistics Series no. 7). http://www.aihw.gov.au/publications/index.cfm/title/6461
[8] Peto R, Lopez A et al 1995. Health Effects of Tobacco Use: Global Estimates and Projections, tobacco and Health. 109-120.
[9] Bronnum-Hansen H and Juel K. Abstention from smoking extends life and compresses morbidity: a population based study of health expectancy among smokers and never smokers in Denmark. Tobacco control 2001; 10:(Autumn): 273-78.
[10] Tobacco or Health in the European Union: past, present and future. A report for the Director-General for Health and Consumer Protection, 2004. http://europa.eu.int/comm/health/ph_determinants/life_style/Tobacco/Documents/tobacco_fr_en.pdf
[11] Doll R. Tobacco: a medical history. Journal of Urban Health: Bulletin of the New York Academy of Medicine, Vol 76, Issue 3.
[12] Mathers C Health differentials among adult Australians aged 25-26 years. 1994, Canberra: Australian Institute of Health and Welfare, Australian Government Publishing Service.
[13] National Tobacco Strategy, 2004-2009. Ministerial Council on Drug Strategy, November 2004. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-pub-tobacco-tobccstrat2-cnt.htm/$FILE/tobccstrat2.pdf
[14] Peto R, Lopez, A. Mortality from smoking in developed countries 1950-2000. 2nd Edition. http://www.ctsu.ox.ac.uk/~tobacco/C5020.pdf
[15] Collins DJ and Lapsley HM, Counting the costs of tobacco and the benefits of reducing smoking prevalence in NSW. NSW Department of Health. August 2005. http://www.health.nsw.gov.au/pubs/2005/pdf/costs_of_smoking.pdf
[16] National Tobacco Strategy, 2004-2009. Ministerial Council on Drug Strategy, November 2004. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-pub-tobacco-tobccstrat2-cnt.htm/$FILE/tobccstrat2.pdf
[17] Collins DJ and Lapsley HM. Counting the cost: estimates of the social costs of drug abuse in Australia in 1998-99. National Drug Strategy Monograph Series (No 49). 2002, Canberra, Australia: Commonwealth Department of Health and Ageing. http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pubhlth-publicat-mono.htm/$file/mono49.pdf
[18] Collins DJ and Lapsley HM. Counting the cost: estimates of the social costs of drug abuse in Australia in 1998-99. National Drug Strategy Monograph Series (No 49). 2002, Canberra, Australia: Commonwealth Department of Health and Ageing. http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pubhlth-publicat-mono.htm/$file/mono49.pdf
[19] Royal College of Physicians. Smoking and Health. Pitman Medical Publishing Co Ltd, London, 1962
[20] Fichtenberg CM and Glantz SA (July 2002) Effect of smoke-free workplaces on smoking behaviour: systematic review, *BMJ Vol 325,* 188-194
[21] Farkas et al. Association between household and workplace smoking restrictions and adolescent smoking. JAMA 2000;284:717-22
[22] Wakefield M, Chaloupka F, Kaufman J, Orleands C, Barker D, and Ruel E. Effect of Restriction s on smoking at home, at school, and in public places on teenage smoking: cross sectional study. British Medical Journal. 2000; 321: 333-337
[23] Wakefield M, Chaloupka F, Kaufman J, Orleands C, Barker D, and Ruel E. Effect of Restriction s on smoking at home, at school, and in public places on teenage smoking: cross sectional study. British Medical Journal. 2000; 321: 333-337
[24] Letcher T et al 2004, Would Victorian smokers find it easier to quit if bars and pubs were smoke-free? Centre for Behavioural Research in Cancer, Research Paper Series No 10, Cancer Council of Victoria

http://72.14.203.104/u/CancerCouncilVictoria?q=cache:ipz9QJvroNUJ:www.cancervic.org.au/cbrc-papers/rps10-2004.pdf+Letcher+T&hl=en&ct=clnk&cd=10&ie=UTF-8
[25] Financial Times. 27 September 1978
[26] Glantz SA, Slade J, Bero LA, Hanauer P, Barnes DE. The Cigarette Papers. Berkeley: University of California Press, 1996
[27] Barnes DE, Hanauer P, Slade J, Bero LA, Glantz SA. Environmental tobacco smoke. The Brown and Williamson documents. JAMA. 1995 Jul 19;274(3):248-53
[28] Bero L, Galbraith A, Rennie D. Sponsored symposia on environmental tobacco smoke. JAMA 1994; 271: 612–17
[29] Barnes D, Bero L. Scientific quality of original research articles on environmental tobacco smoke. Tob Control 1997; 6: 19–26
[30] Drope J, Chapman S. Tobacco industry efforts at discrediting scientific knowledge of environmental tobacco smoke: a review of internal industry documents. J Epidemiol Community Health. 2001 Aug;55(8):588-94
[31] Hong MK, Bero LA. How the tobacco industry responded to an influential study of the health effects of secondhand smoke. BMJ. 2002 Dec 14;325(7377):1413-6
[32] Muggli ME, Hurt RD, Blanke DD. Science for hire: a tobacco industry strategy to influence public opinion on secondhand smoke. Nicotine Tob Res. 2003 Jun;5(3):303-14
[33] Barnes DE, Bero LA. Industry-Funded Research and Conflict of Interest: An Analysis of Research Sponsored by the Tobacco Industry through the Center for Indoor Air Research. J Health Polit Policy Law. 1996 Fall;21(3):515-42
[34] Hirschhorn N, Bialous SA, Shatenstein S. Philip Morris' new scientific initiative: an analysis. Tob Control. 2001 Sep;10(3):247-52
[35] Muggli ME, Forster JL, Hurt RD, Repace JL. The smoke you don't see: uncovering tobacco industry scientific strategies aimed against environmental tobacco smoke policies. Am J Public Health. 2001 Sep;91(9):1419-23
[36] Ong EK, Glantz SA. Tobacco industry efforts subverting International Agency for Research on Cancer's second-hand smoke study. Lancet. 2000 Apr 8;355(9211):1253-9
[37] Bero LA, Glantz SA. Tobacco industry response to a risk assessment of environmental tobacco smoke. Tob Control. 1993;2:103-113
[38] Muggli ME, Hurt RD, Becker LB. Turning free speech into corporate speech: Philip Morris' efforts to influence U.S. and European journalists regarding the U.S. EPA report on secondhand smoke. Prev Med. 2004 Sep;39(3):568-80
[39] Muggli ME, Hurt RD, Repace J. The tobacco industry's political efforts to derail the EPA report on ETS. Am J Prev Med. 2004 Feb;26(2):167-77
[40] Trotter L, Chapman S. "Conclusions about exposure to ETS and health that will be unhelpful to us": how the tobacco industry attempted to delay and discredit the 1997 Australian National Health and Medical Research Council report on passive smoking. Tob Control. 2003 Dec;12 Suppl 3:iii102-6
[41] Samet JM, Burke TA. Turning science into junk: the tobacco industry and passive smoking. Am J Public Health. 2001 Nov;91(11):1742-4
[42] Ong EK, Glantz SA. Constructing "sound science" and "good epidemiology": tobacco, lawyers, and public relations firms. Am J Public Health. 2001 Nov;91(11):1749-57
[43] Drope J, Bialous SA, Glantz SA. Tobacco industry efforts to present ventilation as an alternative to smoke-free environments in North America. Tob Control. 2004 Mar;13 Suppl 1:i41-7
[44] Chapman S, Penman A. "Can't stop the boy": Philip Morris' use of Healthy Buildings International to prevent workplace smoking bans in Australia. Tob Control. 2003 Dec;12 Suppl 3:iii107-12
[45] Bialous SA, Glantz SA. ASHRAE Standard 62: tobacco industry's influence over national ventilation Dearlove JV, Bialous SA, Glantz SA. Tobacco industry manipulation of the hospitality industry to maintain smoking in public places. Tob Control. 2002 Jun;11(2):94-104
[46] Ritch WA, Begay ME. Strange bedfellows: the history of collaboration between the Massachusetts Restaurant Association and the tobacco industry. Am J Public Health. 2001 Apr;91(4):598-603
[47] Connolly GN, Wayne GD, Lymperis D, Doherty MC. How cigarette additives are used to mask environmental tobacco smoke. Tob Control. 2000 Sep;9(3):283-91
[48] Going smoke-free. The medical case for clean air in the home, at work and in public places. The Royal College of Physicians, London, 2005.
[49] NSW Health. New South Wales Population Health Survey 2005.
[50] NSW Health 2005, Let's take a moment, quit smoking brief intervention – a guide for all health professionals http://www.health.nsw.gov.au/pubs/2005/letstakeamoment.html
[51] Carter et al 2001, Finding the strength to kill your best friend – Smokers talk about smoking and quitting, Report to Smoking Cessation Forum
[52] Borland R and Hill D. Two-month follow-up on callers to a telephone quit smoking service. Drug and Alcohol Review. 1990:(9): 211-18
[53] Zhu S, Anderson C,M, Johnson CE, Tedeschi G and Roesler A. A centralised telephone service for tobacco cessation: the California experience. Tob Control 2003; 12:(90002): 53ii-58

[54] Zhu S Stretch V, Balabanis M, Rosbrook B Sadler G, and Pierce J. Telephone counselling for smoking cessation: effects of single session and multiple session interventions. J Cons Clin Psycho, 1996;64:202-11
[55] Borland R Blamford J Segan C, Livingstone P, and Owen N. The effectiveness of personalised smoking cessation strategies for callers to a Quitlinie service. Addiction. 2003; 98:(6): 837-46.
[56] Borland R, Segan C, Livingstone P, and Owen N; The effectiveness of call back counselling for smoking cessation: a randomised trial. Addiction. 2001; 98(6): 881-998.
[57] The Cochrane Collaboration, 'Telephone counselling for smoking cessation' (Review).
[58] Borland R, Segan C, Livingstone P, and Owen N; The effectiveness of call back counselling for smoking cessation: a randomised trial. Addiction. 2001; 98(6): 881-998
[59] .Borland R et al Ibid
[60] Borland R, et al. op cit
[61] Miller CL, Wakefield M & Roberts L, 2003, 'Uptake and effectiveness of the Australian telephone Quitline services in the context of a mass media campaign', Tobacco Control, Issue 12, pp.53-58.
[62] NSW Smoking & Health Survey, 2004, Cancer Institute NSW
[63] Unpublished data. NSW Quitline 2006.
[64] US Centers for Disease Control and Prevention. Best practices for comprehensive tobacco control programs. Atlanta: CDC, 1999. www.cdc.gov/tobacco/bestprac.htm
[65] http://www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-pub-tobacco-tobccstrat2-cnt.htm/$FILE/tobacco_planning.pdf
[66] Ott W, Kleipeis N, Switzer P (2001). Measurements and Laplace Transform Models for the Home: A Multi-Compartment Model for Predicting Indoor Environmental Smoke Concentrations. Journal of the Air and Waste Management Association.
[67] Brison, R. J. (1990). Risk of automobile accidents in smokers. Canadian Journal of Public Health, 81, 102-106.
[68] Christie, R. (1991). Smoking and traffic accident involvement: A review of the literature. GR/91-3. VicRoads, Victoria, Australia.
[69] Violanti, J. M., & Marshall, J. R. (1996). Cellular phones and traffic accidents: An epidemiological approach. Accident Analysis and Prevention, 28, 265-270.
[70] Stutts, J. C., Reinfurt, D. W., Staplin, L., & Rodgman, E. A. (2001). The role of driver distraction in traffic crashes. Report prepared for AAA Foundation for Traffic Safety, Washington, DC.
[71] Chapman S, Balmain A. Time to legislate for fire-safe cigarettes in Australia. Med J Aust. 2004 Sep 20;181(6):292-3. http://www.mja.com.au/public/issues/181_06_200904/cha10373_fm.html
[72] The health of the people of New South Wales – Report of the Chief Health Officer 2004, NSW Health. http://www.health.nsw.gov.au/public-health/chorep/chorep.html