Submission

No 67

INQUIRY INTO TOBACCO SMOKING IN NEW SOUTH WALES

Organisation:

Name: Mr Brian Robson

Telephone:

Date Received: 5/05/2006

Theme:

Summary

Submission to the NSW Parliamentary Inquiry into Tobacco

Brian Robson

April 2006

Contents:

Submission to NSW Tobacco Inquiry

1. Executive Summary.

This submission gives an activist perspective on tobacco in Australia. The history of tobacco is seen as a political struggle where the medical facts have been largely ignored by successive governments to the immense detriment of public health.

The key point of this submission is that the epidemic of tobacco-caused disease has been immensely prolonged by the actions of the tobacco industry and that it is imperative that the governments take action against them, as a minimum to prevent their marketing strategies, and ideally to charge them with selling a product that they knew to be unhealthy with a view to a settlement similar to that of the James Hardie legislation.

An estimated 800,000 Australians have died *prematurely* of tobacco-caused disease since 1950 when the first major scientific study on smoking was published[1]. The medical forces have been relatively poor lobbyists, the advocacy organisations, which have been running campaigns have been grossly under resourced even by the health groups, and have not even been tax deductible, while the tobacco industry has had all its lobbying subsidised by having tax-deductible status as a business expense.

This submission attempts to give the reader a historical perspective of both the epidemic of tobacco-caused disease and the nature of the inadequate actions against it. Some of the key elements of a proper and well-constructed program of tobacco control are suggested, but there are many groups who have more detail in National Tobacco Strategies, and will submit these. It is the role of the activist to point out the appalling actions of the Tobacco Industry, the ineptitude of the health campaigns, and the indolence and venality of successive governments in the hope that there will be a change of heart and some real action will be initiated.

Naturally the farcical 75:25 indoor smoking regulation is opposed, as this is merely the latest capitulation to the venal Hotel industry, which has inhibited necessary public health reforms for 50 years and is now the effective proxy for the tobacco industry in terms of political and industrial muscle. The ban on smoking is cars is supported, at least for trying to lessen the acceptability of smoking.

What is needed is a real effort by governments, and legislation and resolve similar to that which gave rise to the James Hardie legislation that will make the tobacco industry at last pay for some of the misery that it has created.

It might be noted that James Hardie modelled its corporate behaviour on the tobacco industry that has split itself into different companies years ago, and Altria (previously known as Philip Morris) is currently doing it again, petitions from health organisations notwithstanding.

Recommendations: Suggestions for action are made in Section 10.

The author has been with the BUGA UP group and the Non-Smokers Movement since the early 1980s.

[1] Data extrapolated from Peto et al. Mortality from smoking in developed countries, 1950 to 2000 http://www.ctsu.ox.ac.uk/~tobacco/C5020.pdf

2. Tobacco in a Historical Perspective

2.1 Ritual Small-Volume Consumption

Tobacco started off as a ritual drug, but its hugely increased use this century has created the largest preventable disease epidemic the world has ever seen.

To set tobacco in a historical perspective, it was used by native Americans in small quantities on ceremonial occasions, and brought back to Europe by Sir Walter Raleigh. It was taxed and available in small amounts. Men also made it a social ritual. Gentlemen wore smoking jackets because of the smell and smoked after dinner, retiring to a room for the purpose. Later they emerged, removed their jackets and spent the rest of the evening with the ladies. Cigars and pipes were principally used. Cigarettes were considered lower class. This was ritual use, and the amounts consumed were relatively low.

2.2 Marketing and Consumption Rises in the 20th Century

Two aspects changed this: the invention of the cigarette rolling machine by Duke in the 1880s, and the development of the science of marketing in the 20th century. The First World War was the beginning of a huge rise in world tobacco consumption. The war was so terrible that it was thought good to give the men some pleasure before they went 'over the top', often to their deaths. After the war, smoking was associated with toughness, which was reflected in film actors, and the gradual seduction of women into smoking. Smoking, which had been a private pastime became more widespread and also was allowed in public places, which had been frowned on. Tobacco consumption continued to rise between the wars. After the Second World War the tobacco industry intervened in the Marshall plan to make sure that tobacco as well as food, went to Europe, so that shortage of cash after the war would not interfere with its tobacco addiction.

2.3 An Epidemic Emerges

Though it was believed that smoking was harmful from early days, and King James I of England was well known for his opposition to tobacco saying it was:

A custome lothsome to the eye, hatefull to the Nose, harmefull to the braine, dangerous to the Lungs, and in the blacke stinking fume thereof, neerest resembling the horrible Stigian smoke of the pit that is bottomelesse[2].

Later, this opposition to tobacco became tied up with religious notions, so was discredited as wowserism. However in the 1940s, there was a huge rise in lung cancer, which was not explained, and was attributed to smog from coal fires. Doll and Hill in a landmark study published in November 1950[3] showed that tobacco smoking was the cause of the problem.

The tobacco industry was very concerned by this and Doll himself has said[4] that they tried to remove the harmful ingredients. He has also commented that the type of person in the industry has changed. Before 1950 they were entering a legitimate business. Those who have entered after this time knew that their product was harmful, and have had to make the

[2] King James 1 of England 1604, 'A Counterblaste to Tobacco' http://www.la.utexas.edu/research/poltheory/james/blaste/blaste.html

[3] Doll R . Hill A B. 'The Aetiology of Carcinoma of the Lung' British Medical J. Nov 1950

[4] Doll R. Interview on 2SER-FM 1986

choice as to whether to tell the truth and leave the business, or tough it out fighting politically until some event destroyed their industry.

In the 1950s more medical evidence emerged, but the medical profession did not see its role as political lobbying, and the industry was doubtless the first to be aware that its product could not be made safe. The Report of the Royal College of Physicians in 1962, and the US Surgeon-General in 1964 reflected the puzzlement of the medical establishment that action had not been taken against such a major cause of disease, despite more than a decade of research. These seminal reports were the response of the medical profession at the lack of government action against tobacco despite more than a decade of research and a large number of published papers. It is significant that the US Surgeon-General asked the tobacco industry to vet all scientists used in the production of his 1964 report so that they could not be criticised later[5].

2.4 Slowness to Change

Action against the tobacco problem has been slow, and it is significant that it is still marketed as if it were an innocuous product, being available in almost as many outlets as food and still readily purchasable by minors. It is the most researched subject in the history of medicine by far, presumably because research is proportional to the amount of disease caused, and the cause, which is the sale of cigarettes, has not been acted on sufficiently to make much difference to the diseases it causes. Arguably it is following the gradual rise and fall of any consumer product.

3. Understanding Tobacco-Caused Disease

It is worth having a simple model of tobacco-caused[6] diseases in mind, as there are so many of them that it may cause confusion. Tobacco diseases are best seen as the inhalation of toxic substances, some of which act immediately, and some of which have effects in the longer term.

3.1. The Toxic Ingredients are:

a. Hot gases, which directly irritate and harm mucosa

b. Tar, which contains substances that cause cancer

c. Carbon Monoxide, which inactivates red cell oxygen carrying capacity, and is directly toxic to cells especially those lining both the airways and the blood vessels

d. Nicotine, which resets the nervous system excitability, and the tone (tension) in the blood vessel walls. It is carried in the tar fraction and is responsible for addiction.

e. Particulate matter, which is deposited as soot.

---

[5] Taylor P. 'Smoke Ring, the Politics of Tobacco', Bodley Head 1984

[6] The term tobacco-caused is used in this submission. The tobacco industry is keen to use the term 'tobacco-related', as this emphasised that though statistics showed there was relationship between smoking and diseases it did not 'prove' that smoking caused diseases. The nature of proof was the subject of a significant paper by Sir Richard Doll which defined the criteria for causation, which went beyond statistical associations. Most people now agree that smoking causes diseases, but the terms 'smoking-related' was in such common use that it has persisted in the medical profession, much to the delight of the tobacco industry.

These five ingredients are inhaled actively or passively, and cause a number of diseases, which can be listed in order of the tissues that they come in contact with.

3.2. Input cancers

Cancer of the lips, mouth, pharynx, larynx, bronchi and lung as the tar and hot gases meet the tissues directly.

Cancer of the oesophagus and stomach as the tar-laden saliva is swallowed.

3.3. Lung damage

Emphysema caused by direct damage to lung tissue, deposition of particulates, and airway damage leading to an inability to remove secretions leading to chronic bronchitis.

3.4. Arterial diseases

The tar, nicotine and carbon monoxide cross from the lungs into the bloodstream. The tar and carbon monoxide may directly damage the blood vessel walls, and change the platelets (clotting cells) so that they stick to the blood vessel walls. The smooth muscles in the blood vessel walls are contracted by the nicotine, so the lumen (hole the blood goes through) is smaller. Hence the pressure is higher (due to the same volume having to pass through a smaller pipe), and the flow more turbulent. The arterial effects of smoking are thus caused by reduced blood flow, by complete blockage of arteries or by the weakening of the blood vessel walls so that they dilate or rupture as an aneurysm. This process affects a large number of organs. The organ affected depends on which artery is affected.

Stroke - due to damage to cerebral arteries

Skin ageing - due to reduced skin blood flow

Heart disease - This is worsened by nicotine as the heart has an increased load as the blood vessels contract, but also receives less blood itself through the contracted coronary arteries.

Kidneys - these regulate blood pressure, so damage to these (renal) arteries has a compounding effect, as the kidney produces hormones that increase the body's blood pressure to maintain kidney blood flow.

Uterus - reduced blood flow leads to smaller babies, more prone to all neonatal problems.

Impotence - reduced blood flow to the penis is major cause of impotence

Gangrene - usually of the legs, but also of the fingers in some cases

Fractures - slower healing and an increased incidence of non-union due to reduced blood flow, even in young patients

Peptic Ulcers - due to reduced blood flow and less protective mucous production.

3.5. Direct toxic effects while circulating

Leukaemia- as the tar fraction affects dividing blood cells

Babies - foetal abnormalities are increased

Increased fractures - particularly of the hip and vertebrae in older smokers due to acid/base effects where calcium is mobilised

3.6. Output Cancers - are caused by tars as they leave the body in secretions. The unpleasant smell on the skin of smokers is due to the tars coming out of the sweat glands. All secretions are filtrates of the fluid outside cells, which is concentrated, thus making the cells lining the secretory glands exposed to higher tar concentrations. This results in:

Cancer of the urinary bladder

Cancer of the pancreas

Cancer of the breast

Cancer of the cervix

Cancer of the prostate

3.7. The Addictive Component is nicotine. Thus the trying of it and the temporary adolescent belief of its image-giving properties gives time for a re-setting of nerve outputs. By definition, an addictive substance gives a withdrawal syndrome, as the nicotine level falls. This is be why nicotine supposedly 'relieves stress'. It removes the 'stress' of the withdrawal syndrome. This is important in keeping people smoking.

To illustrate the involvement of the tobacco industry in keeping smoking addictive, Brown and Williamson Tobacco, a division of BAT (British American Tobacco) genetically engineered a high nicotine tobacco plant that did not reproduce. They then patented it in Brazil in the Portuguese language. It was then imported back to the USA. 'Mild' and 'Light' cigarettes then had enough nicotine despite the reduced tar fraction[7]. Dr David Kessler a head of the US Food and Drug Administration showed this, with information from Jeffery Wigand. He then tried to regulate tobacco as a drug, but was not successful.

4. Public Health Significance of Tobacco

While tobacco is not the only cause of many diseases, the fact that there may be other processes also damaging organs does not justify the ingestion of substances that are known to be toxic on their own. The number of deaths are calculated as the difference in deaths between groups of non -smokers and smokers for each disease caused. Death estimates are from 45-60 per day in Australia, about a jumbo jet load per week. Latest research suggests in round figures that about half of smokers die of the habit, and about half of these die in middle age[8].. Because few non-smokers die in the age group 45-60, about half the deaths in this age group are smoking-caused.

Former US Surgeon-General, C. Everett Koop called tobacco,

"The chief preventable cause of death and the greatest public health problem of our time".

---

[7] US PBS Frontline Interview with David Kessler. March 1998, http://www.pbs.org/wgbh/pages/frontline/shows/settlement/interviews/kessler.html

[8] Doll R. Peto R. et al. (2004) Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ Jun 26;328(7455):1519

It is comparable to the great epidemics of nineteenth century, so it is worth drawing historical analogies from these epidemics and responses to them.

4.1. Infectious Disease Epidemics

The nature of infectious diseases was defined by Koch. 'Koch's postulates' are still used to see if a disease is infectious. (They involve proving that a germ can be isolated from a person suffering from a disease and if the germ is introduced into a healthy person, they will be afflicted with a similar disease). Research since then (such as in the early days of AIDS) involves researchers in seeing if the new disease complies with Koch's postulates, and hence is infectious.

A physician, John Snow, understanding the cause of infectious disease, was reputed to have stopped the London cholera epidemic of 1854 by removing the handle of the Broad Street water pump. At a policy level, once the cause of infectious disease was known there was a huge public health effort in engineering. Sewerage systems were produced and great stress was placed on provision of water of good quality. Some opposition to these public works was created by the water carters who made money from selling water by the bucketful. They even managed to get citizens to sign petitions asking the government not to meddle in their affairs by putting water pipes in their houses. They were eventually overcome and piped drinking water became universal (until recent times, when with the use of modern marketing the drink companies have been able to persuade people that the tap water is of poor quality, bringing new profits to the water carters).

4.2. Vaccination

Diseases spread by individuals were often viral and the discovery of vaccination led to the mildly invasive health practice of mass vaccination, which has eliminated small pox, and given the developed world many years free of polio, and much reduced incidence of other infectious diseases.

4.3 A New Disease Paradigm

Tobacco is now the chief preventable disease, and the nature of its definition as a causative agent has been defined by Doll in the same way that Koch defined infectious disease. Doll's work on the causes of cancer speaks of the nature of an association between an exposure to a toxic substance and a disease, a consistency in that association, a relationship in time, and a biological plausibility in terms of experimental evidence. However the tobacco industry is being considerably more successful in obstructing progress in tobacco than the water carters were in stopping fresh water supplies. Doll's work should be used as Koch's is and public health decisions made accordingly.

Tobacco disease is the model for diseases caused by industrial toxins, where an industry gains financially from creating a public health hazard, and endeavours to continue to do so. The difference between tobacco and other industrial toxic diseases (apart from its addictive nature) is that tobacco is unnecessary for the production of any goods.

4.4 Aetiological Fractions are the fraction of a certain disease that can be considered to be caused by tobacco. As a general rule they based on most conservative estimates, and as each new study comes out, they tend to be revised upward. Because the deaths from tobacco are so well known, these revisions are becoming less newsworthy. These conservative figures are also the basis of costing of tobacco-caused disease, so these estimates are also conservative. The other point is that even if a fraction of, for example

heart deaths are due to tobacco, the fraction of premature heart deaths is invariably higher, so if age and human misery is counted, the cost is higher. A good index of the effectiveness of health programs is the number of QALYs (Quality Adjusted Life Years) that can be obtained for a certain investment of dollars. By the same token, the number of QALYs lost by a detrimental influence can be calculated. Tobacco is the leading one of these.

The tobacco companies also try to suggest that it's a 'good deal' for the government as pension costs are saved by the premature death. Quite apart from the abhorrence of a government tacitly agreeing to kill its citizens to save a few dollars, the fact that the companies make this submission suggests that they are well aware of the effect of their products, and culpable accordingly. This is the reason that historically many tobacco industry submissions were 'confidential'.

5. The Tobacco Industry as a Historical Anomaly

5.1. The Legality of Tobacco

There is little doubt that if cigarettes were introduced today, they may be illegal under the Dangerous Goods Act. Their marketing would be illegal under the Trade Practices Act. Clearly they were not illegal when they were introduced, but they could be considered to be so now. At some point in the last 56 years, what the industry has done has become illegal. The Trade Practices Act does not say that it is acceptable to sell a harmful product, merely because it has been sold before. The fact that it is harmful is now known, and arguably the industry commits a crime each time it sells a cigarette. This does not seem to have been noted, much less acted upon, and probably relates both to the activity of the Industry in acting like a respectable business, the inertia of societal thinking, and the pervasiveness and addictiveness of the custom. But there has been more than this.

5.2. Evading Consumer Protection

When the US Federal Trade Commission (FTC) set up its consumer protection legislation, tobacco was specifically excluded. This was not for some high philosophical reason, but because the politicians from the tobacco growing states votes were needed to pass the FTC legislation. The destruction of individuals who tried to act on this, from Mike Pertschuk, who set up the US FTC to a succession of Health Ministers who tried to act on the tobacco industry was well documented in Peter Taylor's classic book, 'The Smoke Ring'[9]. New evidence has emerged recently linking the voting record of US politicians in both the Federal and Californian legislature to their donations[10,11]. In Australia the tobacco industry gave donations to both parties until recently, and continues to give them to the Liberal and National Parties. Prior to the mandated disclosure of political donations, it might be noted that tobacco donations featured in both the 'Age tapes' of the Coombe-Ivanov Affair[12], and the 'WA Inc. Royal Commission'.

---

[9] Taylor P. op cit.

[10] Begay M.E., Glantz S.A., 'Political Expenditures by the Tobacco Industry in California State Politics'. Institute for Health Policy Studies, School of medicine, UCSF, 1388 Sutter St., 11th floor, San Francisco CA 94109, phone (415) 476-4921.

[11] JAMA 19/10/94

[12] Hull Crispin, Canberra Times ?date

5.3. 'Feral Governments'

While the tobacco industry likes to claim it has the same rights as any other citizen, it has immensely more power. Just as an ant and an elephant may be considered philosophically equal as creatures, the tobacco industry has immensely more power than the citizen it claims to be equal to. The income of each of the major tobacco corporations world wide is greater than the gross domestic products of many countries. Thus laws on 'freedom of speech' that were written to allow a small but honest person to tell the truth, are now used to justify the creation of whole realms of lies and disinformation. Smokers, who, the industry alleges are 'knowingly taking the risk', have been shown in a number of studies to have no real idea of the probability of contracting a smoking-caused disease. The Industry adds to this confusion by trumpeting research on minimal problems with statements like 'coffee can kill you' to provide smokers with rationalisations like, 'Since everything kills you, nothing you do can make any difference, so you might as well smoke'.

Given the industry's immense resources, and their ability to carefully create misconceptions conducive to their sales, they should be treated as the equivalent of a government in terms of their market power. But unlike elected government, they are not responsive to the public health interest, and their activities generate immense costs for the national government. They are so powerful that only our legitimate government can oppose them- individuals, or even professions, cannot. It is basic principle of social harmony that with power comes a requirement for responsible action. The tobacco industry has the power, but shows no responsibility. The book 'Brave New World' made Big Brother government the great threat to welfare. It did not consider that the multinational corporation, with the morality of a feral animal but the power of a government, might be a greater threat. The feral companies are effectively at war with our citizens in terms of the number of people they kill, hence the request to governments to act.

At present a health education scheme is disparaged as taxpayer funded propaganda by the 'nanny state', but tax deductible payments to film actors to present cigarettes as exciting and evade the advertising ban is considered 'free enterprise'. Our government needs to take action to defend us. As Edmund Burke famously put it,

'All that is needed for evil to triumph is for good [people] to do nothing'.

6. Tobacco Industry Lobbying

The tobacco industry tries to prevent any action that would make it responsible for the problems it causes. It has consistently acted to increase its sales rather than mitigate its harm. It set up the Rothmans National Sports Foundation in anticipation of the ban on tobacco advertising[13]. The relevant section of the minutes stated, "Discussing smoking and health, Mr Watson advised that we can expect more severe attacks on the industry in the near future. In Canada and the USA, advertising restrictions are pending and in the UK there is no cigarette advertising other than press. We can expect similar restrictions here within the next few years. This is the reason for the existence of the R.N.S.F. and our

[13] Rothmans memo November 1970 was the minutes of a Rothmans management meeting found in a bin and given to the Non-Smokers' Movement of Australia by a cleaner.
It is appended as Appendix 1

sponsorships which are being developed in anticipation of restrictive advertising in Australia'.

A last-minute amendment to the Federal Broadcasting and Television advertising ban allowed sponsorship, which the industry insisted was different to advertising. In that both advertising and sponsorship involve the juxtaposition of the name of a tobacco product and a positive image, many children were unaware that tobacco advertising was banned as they looked at its imagery. The difference between sponsorship and advertising was in who got paid, not in its effect on the viewers. Sponsorship was responsible for the prolongation of tobacco marketing on TV for about 30 years, and product placement in films has ensured that it continues to this day, (less visible to those not targeted).

6.1. Having it Both Ways

The industry, when threatened with advertising restrictions always argued for 'self-regulation', but when self-regulation was achieved, they claimed that what they were doing was not illegal. By this they meant that it was not specifically banned (and they could not reasonably have been expected to actually stop marketing).

Until recently the Industry concerned themselves with the 'benefits' of tobacco in totally economic terms, speaking of value of sales, jobs etc. Any aspect of pain and suffering was ignored. Their literature in the 1990s boosted their costing of the benefits of tobacco by adding a huge amount for 'pleasure'. Presumably this pleasure makes death acceptable, and justifies a change in economic methods. They tend to say as little as possible publicly and nothing that would invite any criticism. Their strategy is to keep tobacco out of the public eye, so that governments will not act on it, and they can continue to make their lethal profits.

6.2. The 'Tightrope' Policy

When it is necessary to make public statements on the health effects of tobacco over the two decades or more the companies have been guided by the so-called 'tightrope policy'. This involves the industry saying that everyone believes that smoking is harmful (hence no one can sue as they assumed the risk), yet we, the industry, do not know if it harmful, or think that the relationship to disease is 'statistical'. Statistics is a science which we know not, (hence we are not liable for knowingly selling a harmful product). Eventually this contrived ignorance will have to be reckoned with.

A spectacular demonstration of the tightrope policy was in the US Congressional hearings in 1994[14]. Here the Industry leaders managed to deny tobacco was addictive [15] by using 'common-sense' (i.e. non-scientific) definitions of addiction. They also managed to admit that smoking was a risk factor, but denied knowing if tobacco caused a number of diseases[16] or if it was harmful, including smokeless tobacco[17]. (Smokeless tobacco

---

[14] Hearing of the House of Representatives Energy and Commerce Committee, Subcommittee on Health and the Environment, Subject: 'Nicotine and Cigarettes, Chaired by Henry Waxman, Californian Democrat. 14/4/94. Transcript available from Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 (202) 225-2927 http://energycommerce.house.gov

[15] Cross examination of all executives by Rep. Wyden, Mr Johnston, RJ Reynolds; Mr Horrigan, Liggett; Mr Sandefur, Brown and Williamson; Mr Tisch, Lorillard; Mr Taddeo, US Tobacco (smokeless), Mr Campbell. Philip Morris. p42-3 of WP5.1 transcript.

[16] See Hearing of the House of Representatives Energy and Commerce Committee 14/4/94. op.cit.

includes snuff, chewing tobacco and tobacco in small pouches like tea bags, which are placed between the lip and gum and cause dental disease and cancers in that situation).

In this world of denial, the chief executives then felt put upon that they were asked to reveal more about their additives than food manufacturers, and generally resented government interference, painting themselves as a highly responsible industry. In that the Australian manufacturers are all branches of multinational corporations, this has huge implications for Australia.

6.3 The 'Rational Smoker' Concept

An extension of the tightrope policy is the 'rational smoker' concept. The concept of the informed smoker, who was aware of all the risks, but still chose to smoke was greatly developed by tobacco interests at the Industry Commission hearings in 1994. The fact that smoking may be harmful was defined as a risk, to be compared with a degree of pleasure. This was then extrapolated to be compared with other risk/pleasure decisions like going hang gliding, and then much work was given to an economic quantification of this pleasure, which was naturally enough measured by what one was willing to pay for the product. A more cynical explanation of the 'rational smoker' is that if enough attention can be given to this, the idea can be fostered that smokers are making their own decisions, (or at least might be making their own decisions). Thus the tobacco companies would not be responsible for the tobacco caused deaths (or might be given the benefit of the well-crafted doubt).

There are two points to be made about this. Firstly that research[18] shows very few smokers are able to accurately estimate their chances of dying in middle age.[19] Most are able to name only a handful of the numerous diseases caused by smoking.[20] Smokers also have little understanding of how tobacco-related illnesses could affect the quality of their lives.[21] And secondly, given the addictive nature of cigarettes, and the deliberate provision of rationalisations by the industry, it is dubious that the best-intentioned smoker can be entirely rational about his/her situation. The so-called 'rational smoker' argument is an attempt by the tobacco industry to avoid product liability litigation.

6.4 Educating and Licensing Smokers

However, a very recent suggestion by some health activists keen to take up this idea has been to 'license' smokers, so that kids reaching the age when they may smoke should have to take a test on the health effects of smoking so that they will be 'rational' smokers and aware of the risks. They would then have to show this license to buy cigarettes. The criminalising effect of this would need to be considered carefully.

Cross examination of Mr James W. Johnson of RJ Reynolds Tobacco Company by Rep. Waxman. Also Andrew H. Tisch of Lorillard Tobacco and William Campbell of Philip Morris

[17] Smokeless tobacco was banned in Australia under the Customs Act as a substance likely to cause injury. US Tobacco challenged this ban in the High Court, spending more than their annual gross sales in Australia to argue along the lines that even if it did cause cancer this was not an injury, but a disease. Because of this Australia was one of the first countries in the world to ban smokeless tobacco.

[18] See Appendix 2

[19] Mullins R, Morand M, and Borland R. Key findings of the 1994 and 1995 Household Survey. Quit Evaluation Studies No. 8, 19941995. 1996, Melbourne: Victorian Smoking and Health Program. 1–23

[20] Tan N, Wakefield M, and Freeman J. Changes associated with the National Tobacco Campaign: results of the second follow-up survey, in Australia's National Tobacco Campaign. Evaluation Report Volume Two, Hassard K, Editor. 2000, Commonwealth Department of Health and Aged Care: Canberra. p. 21– 75

[21] Weinstein N, Slovic P, Waters E, and Gibson G. Public understanding of the illnesses caused by smoking. Nicotine & Tobacco Research. 2004; 6:(2): 349–55

7. International Items of Interest

7.1. The US Congressional Hearings of 1994 were part of the overall challenge to the legitimacy of the tobacco industry in the USA, where Dr David Kessler, of the Food and Drug Administration argued that tobacco should be regulated as a drug and that the industry has been manipulating nicotine levels to keep its addictive properties. It seems that this allegation stands, despite the efforts of the tobacco companies to undermine it.

Representative Henry Waxman, Chairing the US Congressional Committee in his introductory remarks called for a new relationship with tobacco companies, so that they had the same standard of corporate responsibility that the rest of the corporate world accepts. After those hearings, Representative Synar of Oklahoma, one of the driving forces, lost preselection due to negative campaigning by the tobacco and gun lobbies, and the US became more conservative since the following mid-term Congressional elections. In that there were a number of Republicans on the Congressional Committee trying to act as apologists, it cannot be assumed that Australia can wait for US action on tobacco. The US industry is more powerful than the Australian, even relatively, as they are exporting huge amounts, which the Australian offshoots are not.

It might be noted that the recently appointed US Ambassador to Australia, Robert D. McCallum, Jr., of Georgia has an appalling record on tobacco, and indeed as an Attorney-General was responsible for the discontinuation of a number of law suits against tobacco that were on the verge of success.

7.2 Some French Initiatives

One of the problems of tobacco law is that it is not enforced. The French government had given exemptions to exciting Formula 1 racing cars to carry cigarette brand names. When a new team commenced racing it assumed that it would have the same exemption. It raced in Australia (where the laws on car livery were extremely lax), and the French in 1993 prosecuted the company. FISA, the governing body protested, and promised to take the French Grand Prix elsewhere, but did not do so. The prosecution was successful.

A Non-Government Organisation, the Comite National Contre le Tabagisme, was given a seed grant to run prosecutions of areas in breach of tobacco laws. There were plenty of these on TV, in restaurants with no smoke-free sections, and in tobacconists with far more advertising than was allowed. The group ran a large number of prosecutions, most of them funded by out of court settlements from people who breached the laws. Eventually they were too successful and were stopped from doing it. There is no reason why a non-government organisation should not run the prosecutions of unenforced tobacco laws in NSW. Increasingly government services and traditional roles are put out to tender.

8. Political Driving Forces in the War Against Tobacco

8.1 Medical Colleges Marshal Facts

The major problem with the battle against tobacco was that it was not seen as a political battle. Just as infectious disease required a government response and led to fresh water and sewerage systems, so tobacco should reasonably have had the elements of a politically created control system. The response of the medical system was to marshal evidence. When there was a decade worth of research on the harm of tobacco without a significant

government response, the Royal College of Physicians produced a report on tobacco marshalling the evidence for its harmful properties in 1962. The US Surgeon-General did the same in 1964. But they did not really lobby.

The major driving force against tobacco was, ironically enough the non-smokers rights movements that emerged in the 1960s with other 'rights' movements. They were not medical groups, and did not care what smokers did to themselves - they merely wanted none of the smoke in their bodies. The medical groups looked down their noses at these groups, as they were far more concerned about the pathology in the smokers than the minor irritation and inconvenience of the non-smokers, who, in most situations were exposed to less smoke than the smokers. It is significant that the non-smokers rights groups were not even asked to conferences on smoking. In the 1983 World Conference on Smoking and Health in Winnipeg, Canada in May 1983, there was no session for activist groups and Dr Stanton Glantz convened a meeting after hours on the Thursday evening, the last evening of the conference to get money for his campaign for smoke-free air in California. Jeanne Weigum, of the Association for Non-Smokers Rights in Minnesota was the first person to try to set up an information exchange for activists.

8.2 The Non-Smokers' Rights Movement

The non-smokers rights groups were far more politically savvy than the health groups, which gradually and reluctantly embraced their political sophistication as the evidence of the harm that exposure to tobacco smoke emerged. Of considerable importance in this was the paper by Hirayama in the British Medical Journal of 1981[22], which showed that passive smoking considerably increased the incidence of lung cancer. This also led to increased evidence for a dose-response approach to cancer incidence. In other words, if people were exposed to tobacco smoke, their chances of getting a tobacco-caused disease rose with the dose.

Naturally all through this, the tobacco industry scientists tried to maintain that there was probably a 'threshold' and if the dose were below this, there would be no effect. Naturally the lower the dose, the lesser the effect, and the harder it was to demonstrate it, so the tobacco industry bought about 15 years by this strategy, with tame statisticians rubbishing the data.

8.3. BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions)

Australia was unusual in that the activist group BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotion) attacked advertising in a David and Goliath situation. They altered (refaced) advertising to satirise its socially destructive messages. Tobacco was the main item targeted, though there were some attacks on alcohol, sexist advertising and some junk foods. This led to prosecutions when activists were caught, and the ensuing publicity not only undermined tobacco advertising far more than was happening elsewhere in the world, it also took away the tobacco industry's legitimacy as a business in the pubic mind. In this environment, it has taken extraordinary cowardice by successive Australian governments, both Federal and State, to see that Australia has lost its position as a leader in progress towards a smoke-free society.

---

[22] Hirayama T, Non-smoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan. British Med. Journal 282 p 183-.
Reprinted in Ong E, Glantz S Hirayama's work has stood the test of time, Bulletin of the WHO 2000 78 (7), p 938-

In essence the non-smokers rights groups and the right to unpolluted air were the major drivers against tobacco, with Australia helped by the BUGA UP group, which was never really replicated elsewhere in the world. In most cases tort law was extremely important, though in Australia, prosecutions of BUGA UP activists crystallised the moral dimension probably more clearly than elsewhere, as the tobacco companies telling lies were being supported by the law, and the activists telling the truth were the ones prosecuted. In fairness, BUGA UP would not have had such public support if it had not been widely known that tobacco killed many people and that this fact was so noted in the breach rather than the observance.

The tobacco industry recognised the Non-Smokers Rights Movement quite early as the most significant threat to its survival in a famous leaked document, the Roper Report of 1978[23], which was prepared for the [US] Tobacco Institute and concluded that campaigning on the issue of passive smoking by the non-smokers' rights movement is "the most dangerous development to the viability of the tobacco industry that has yet occurred."

The medical establishment took many years to acknowledge this fact, and tensions within the health forces were another major element in their slow progress in reducing the toll of tobacco.

8.4. Litigation as a Substitute for Governmental Action

The courts are very expensive, but litigation is easier to achieve than legislation in the tobacco area, as, even given the huge disparity in resources to fight cases, the courts are at least bound to try to do justice, whereas the political process is not. Australia's progress against tobacco advertising was the best in the world and was driven by activist groups, principally BUGA UP, in the late 1970s and early 1980s.

But smoke-free indoor air progress has principally been driven by litigation in the workers compensation area, spearheaded by the Public Service as employees there have greater job security. Unlike in Australia, in the US civil rights and torts have been the driving force. Sadly, public health legislation has rarely been the pacesetter, and often legislation is only to resolve the 'problem' of the threat of litigation and to make a 'level playing field' for businesses that are reluctant to ban smoking on their premises, but are afraid of litigation. NSW businesses have probably reached this point. It is interesting that some businesses were even scared of litigation in the late 1980s, as seen on the attached sign in document from the Brewarrina RSL, which tried to minimise tobacco liability to patrons. This is included as Appendix 3.

8.5. Personal Smoke-Free Indoor Air Actions

Compensation cases, such as that of Roy Bishop v. Commonwealth of Australia[24] in 1984, and Scholem v. NSW Health Department in 1992[25] which had a common law component have been very important in getting smoke-free indoor air in the workplaces. Interestingly the Federal Public Service went smoke-free in 1987 due to the Roy Bishop case and a relatively progressive head of the Federal Public Service at that time. But the problem is

[23] The Roper Organization, A Study of Public Attitudes Towards Cigarette Smoking and the Tobacco Industry in 1978, Vol. 1, 1978

[24] Administrative Appeals Tribunal A 84/109, 14/10/85

[25] Scholem v. NSW Health Dept, NSW District Court 27/5/92

still not solved for passive smokers, as the Marlene Sharp v. Port Kembla RSL case of 2001[26] shows, or the Phil Edge[27] case of October 2005.

8.6. Advertising and Sponsorship Litigation

The ban on tobacco advertising on TV led to the evolution of sponsorship. Expensive (from the activists' point of view) hearings in the Australian Broadcasting Tribunal in the late 1970s led to prosecutions of both Rothmans and WD & HO Wills in the early 1980s. These did not lead to any political response. A Non-Smokers' Movement initiated prosecution of Channel 10 of 1984 was taken to the High Court by the Director of Public Prosecutions, with a final result in 1991. But despite these committals the loophole was not removed until the Tobacco Advertising Prohibition Act in 1993, and even this did not come into force until 1996. If that were not enough, certain events were exempted and long after European countries, Australia allowed an exemption for the Formula 1 Grand Prix until 2006. This was supposedly because its director Bernie Ecclestone threatened to take the Grand Prix to a more compliant country if they did not. Based on the French experience, this threat was probably hollow, but the Australian government capitulated in any case. The TV cigarette advertising ban took 30 years to actually be implemented!

In the meantime increased use of global satellites may make the laws largely irrelevant. In the early 1990s multinational companies changed the brands that they advertised to facilitate such marketing. Philip Morris switched its advertising to Marlboro, its world brand as opposed to Peter Jackson, its local brand. The obvious reason for this was that with satellite sponsorship advertising, so that the inhibition of promotion would go as slowly as the slowest country.

8.7. Trade Practices Act Litigation

The publicity associated with the protest group BUGA UP, which was particularly active in the period 1978-1983, created a lot of publicity for the view that the advertising industry would never be responsible and so had to have consumer input to the approval process for advertisements. When the Trade Practices Commission re-approved a minimally-changed self regulation system for advertising in 1985, the Australian Consumers Association (ACA) appealed to the Trade Practices' Tribunal[28]. The action nearly bankrupted the ACA. The case received little publicity, and in the end, very little change was achieved to the self-regulatory system, largely because of the lack of an industry-approved alternative. After this defeat for consumers, another Commission hearing into the workings of the Advertising Codes in 1991, which again recommended little change, was not appealed. Clearly the definition of public benefit under the Trade Practices Act for the anti-competitive approval process required only that there be a system of regulation and that it have general industry support. Consumer input or desires were irrelevant.

The issue of misleading industry statements was again handled by the Trade Practices Commission, when the Tobacco Institute debunked the case against passive smoking. The weak 'corrective statement' with which the Commission was satisfied led to the Australian

---

[26] Sharp v. Port Kembla RSL NSW Supreme Court 2001
See also Stewart BW, Semmler PGB: MJA 2002 176:113-116

[27] Phil Edge v. Workcover Corp.SA October 2005.

[28] References for this story include: Sydney Morning Herald 13/8/87, Ad News 6/11/87, ACA submission to the Tribunal

Federation of Consumer Organisations (AFCO) taking the case to the Federal Court[29], where satisfaction was obtained.

The point was that it cost a million dollars and went to the High Court for a single advertisement. Clearly the regulation of advertising is a farce, but it is significant that nothing as been done to improve it since then in terms of ceding power to health or consumer interests. It might be noted that the same argument is now being held for marketing that contributes to obesity.

Since the industry clearly has no intention to do anything but market their product for as long as they are allowed, it is incumbent upon governments to act in the interests of public health.

8.8. Political Response to Plaintiffs' Progress

There have now been a lot of law suits in the USA to get compensation from the tobacco industry. Interestingly, some of them were helped by documents from a lawyer, Jeffery Wigand, who had as his job to destroy documents for the tobacco industry so it could not be sued in tort for its knowledge of the harmful effects of its products. When he saw the documents, he thought that this was so immoral that he took copies of the documents and they were disseminated. A number of States sued the industry and asked for monies. Sadly they did not spend them on tobacco control , but often used them merely to supplement consolidated revenue. Since the return of the conservative Republican administration most of these suits have been discontinued by political interference in the judicial process.

The new US Ambassador to Australia has been one of these Attorneys-General. It might be commented that not only did governments rely on personal injury lawyers to do the job that public health policy should have done decades before, but worse than that they actually interfered in the judicial process, to save the tobacco industry, and allow the people to continue to die. It took years before smokers successfully sued the tobacco industry, as the resources of those terminally ill, both emotionally and financially were not enough to overcome the tobacco industry, which delayed the cases until the plaintiffs died, or called witnesses until the plaintiffs could not afford to continue the cases. In another case in Melbourne, where a librarian with cancer almost sued successfully, the company discovered that she had had an illegitimate child in her youth and threatened to publicise this if she did not discontinue. They were successful in this blackmail. When finally the plaintiff lawyers teamed up so that there was enough money to run the cases, the Industry worked at a political level and got Attorneys-General to drop the public interest cases that were to give redress to large sections of the population, rather than just individuals.

In Australia, the most famous case in this regard was the Rolah McCabe v. BAT (British American Tobacco) Australian Services. Documents which were needed for her to prove what the tobacco industry had known had been destroyed by the company. Rolah McCabe initially won on the grounds that people who destroy evidence should not prosper as a result, but the tobacco company won on appeal. With costs awarded against her, her further cases did not proceed. Rolah McCabe and her husband have both since died.

---

[29] Aust. Federation of Consumer Organisations (AFCO) v. Tobacco Institute of Australia (TIA) No G.253 1987 in NSW Registry of Federal Court

9. Reasons for a General Lack of Action on Tobacco

Given that a jumbo-jet load of people die each week from tobacco-caused illness in Australia, it is worth asking why more has not been done and examining the relatively pathetic record of all parties that may have been involved. The general reasons for this situation are:

9.1. Regular Deaths are Never a Crisis

As people have died at a regular rate and without individual fanfare, it is never a 'crisis' such as if one jumbo jet crashed.

9.2. Tobacco Industry Pretends to be Legitimate

The Industry has acted as if it is a legitimate business, and that its role in continuing to promote cigarettes is legitimate. Its lobby group, which was pretentiously named the 'Tobacco Institute', ran a far more professional campaign than the health groups could even conceive. Eventually when it was more convenient to answer no questions, it was disbanded.

9.3. Government's Tacit Acceptance of the Status Quo

Governments, State and Federal, have always tacitly suggested that it accepted the legitimacy of what was happening. Even as the rhetoric flowed, governments made regulations that acknowledged the situation. It was also perceived the governments did not enforce existing laws. When the advertising TV ban came in 1976, sponsorship was allowed to massively increase. Despite protestation at the Broadcasting Tribunal, and finally successful prosecutions by the Tribunal and then private citizens, the sponsorships will have continued for 30 years, and now satellite TV means that as long as any country in the world allows sponsorship, every country will get it. Similarly the sales to minors laws have always been poorly enforced.

There are two public perceptions that result from this. Firstly that the government is not serious about its laws when big business or money is involved, and secondly that Australia will not enforce its laws, if it might offend groups such as FISA in motor sport, or if there is any possibility (however slight in reality) that tourism income may be lost. The most recent example of this was in the Australian Formula 1 Grand Prix, in 2006 where the livery of cars was of third world standard and years behind the European standard, despite specific submissions on this subject over a long period of time.

9.4. No Civil Rights Lawsuits

There is not the tradition of individual liberty that has seen progress in the US driven by lawsuits from the public on their right to smoke-free air. Australian litigation has been on the right for employees, rather than the public, to have smoke-free air. This was largely because employment in the hotel and club industry tended to be casual, so that plaintiffs had usually not worked in one place for long enough for it to be singly responsible, and the employment in that industry was so tenuous that most potential plaintiffs assumed that they would be successfully sacked, and did not attempt such an action. Health groups looked for plaintiffs for 20 years before they found suitable ones. The Roy Bishop case in the public service happened 20 years before one in a hotel.

9.5. Tobacco is Seen as a Medical Problem, not a Political One

The tobacco problem has been seen as a medical problem, rather than a political one. The cause of all tobacco-caused disease is known, yet there has been a total focus on the smoker rather than the cause. Because there was a medical model, all effort was concentrated on the smoker or potential smoker. Thus, there were 'Quit' campaigns for existing smokers, but the recruitment rate of children was only addressed by education. It was as if an anti-malarial campaign was conducted by treating infected people with drugs and asking uninfected people to wear insect repellent. The swamps were not drained, and only some mosquitoes were sprayed. The tobacco industry was not significantly targeted, and much of their promotion was also allowed.

9.6. The Medical Profession Does not Lobby

The medical profession has not seen its job as political lobbying, hence has given advice to governments, rather than actually lobbied, so the more politically astute industry has been alone in the field. For example it took the health forces a decade to lobby to raise cigarette taxes, which the Industry had quietly lobbied to have linked to the Consumer Price Index, thus avoiding both the rises in real terms and the publicity associated with these rises.

9.7 The Tobacco Industry Only Needs to Maintain the Status Quo

The fact that the Industry only had to retard initiatives, and political parties receiving funding only had to do nothing made it easier for the Industry. The fact that such political party funding was secret must also have helped for a long time. And even when it is made public, the interest in the money was far greater from the recipients than the general public. As one Tandberg cartoon put it, with a politician smirking and saying, 'There is not yet a proven link between me supporting the tobacco companies and the tobacco companies supporting me'.

9.8. Lack of Attention to Politicians

The lack of systematic education of politicians by the health groups has been a serious problem. It is as though politicians are a nurtured enclave facing a disinformation campaign especially tailored for them by industry lobbyists. People die quietly and privately of their tobacco-caused illnesses and the political dimension is just not recognised.

9.9. Lack of Lobbying by Upper Level Bureaucracies

Bureaucrats, including both the health system and the education system, are unable to run a lobbying campaign, as they see themselves in a Westminster tradition of being politically neutral. Politicians are informed and then it is 'their decision'. The tobacco control units in the health dept were always poorly funded and had constantly changing managers at higher levels, who were never fully aware of the significance of tobacco, or were aware enough to know that to insist on action would be fatal for their careers.

9.10. Trade Practices as a Corporate, not Consumer Watchdog

The Trade Practices Commission has seen its role as arbitrating between trading corporations rather than as a defender of the public interest. An illustration of this concept of the Commission's role was that Mr Robert McComas, the former corporate solicitor of AMATIL, a tobacco company, was appointed head of the Trade Practices Commission, and then investigated tobacco advertising in this capacity in 1984-5, before returning to a

directorship of the tobacco company. The investigation was not initiated by the Commission and was only prompted by a request by the Media Council of Australia for re-authorisation of the minimally changed self-regulatory codes. The system that made those codes work in practice was not investigated. Another investigation in 1991 reached much the same conclusion.

9.11. Economics Seen as More Important than Health

The Industry Commission investigated the Tobacco Industry Support Plan as late as 1991. It had its terms of reference carefully defined. Health matters were completely peripheral in 1991, 26 years after the US Surgeon-General's seminal report. The question was still how to help the growers compete with imported tobacco from countries such as Brazil and Zimbabwe where wages were a fraction of Australian ones. Arguably the Industry wanted the growers there as a lobby, and the price of tobacco was not a huge problem, as it was only about 1% of the retail price. In 1994, there were further efforts to scale down the growing industry, or at least stop its subsidies, but the health aspect, which was half of its report, sat uneasily and uncomfortably with its mainly dry economic thrust[30]. Federal subsidies from the Tobacco Industry Support Plan continued to growers until September 1995.

9.12. Health Charities Unwilling to do Advocacy

The health charities have been very conservative in their funding and practice of advocacy. Given that tobacco causes over one third of cancer and one quarter of heart disease, it might be expected that their budgets would have been spent in the most cost-effective ways on this problem. Partly because of the medical model, which treats existent disease, partly the medical tradition of not being political, partly the tradition of being a respectable (i.e. conservative) charity and partly because the people with power in these organisations have a vested interest in research, the budget for political advocacy has been minuscule as a percentage of their budgets.

More recently, NGOs or any group that did any advocacy, even in the field for which it was supposed to be active was frequently defunded by the government. If their funding survived in the short term, they have not won future tenders. This has happened at both a Federal and a State level. It is likely that the Cancer Institute was set up separately from the Cancer Council, as the Minister was unhappy with the degree of tobacco advocacy by the latter.

9.13. Quit Groups - Selling a Non-Behaviour

Quit groups are sometimes thought of as 'anti-tobacco' agencies. But they cannot do political advocacy, and they have never had resources to document industry activities. They are condemned to trying to sell a non-behaviour. They are also minimally resourced even compared to illicit drugs agencies. Private groups such as 'Smokenders', who use ex-smokers to help people through the quitting process by looking at both the addictive and the habitation components have never had much help from the governments, despite copious evidence of the cost-effectiveness of quitting.

9.14. Non-Smokers Rights Groups - Underfunded Lobbyists

[30] Industry Commission , 'The Tobacco Growing and Manufacturing Industry' (Report No. 39, June 1994).

Non-Smokers' rights groups have never had much resources, and have never had tax deductible status, so that effectively the taxpayer funds half of the tobacco industry's advertising and lobbying, but none of the health advocacy. It must be recognised that the evidence these groups are able to give is correspondingly limited, as while they recognise the industry's marketing strategies in a general sense, they do not have the resources to document it all.

9.15. Donations to Political Parties

The major political parties have had generous donations from tobacco companies and these were secret until the recent electoral funding disclosure laws. All the politicians had to do was not initiate action. It's likely that political actions would have made a large difference. Almost certainly, donations are major factor retarding proper action against tobacco.

9.16. The 'Light' Cigarettes Scam

The tobacco industry has made Australian cigarettes the lightest in the world because our excise relates to the weight of the cigarette. This has allowed the per capita amount of tobacco smoke to fall, but half of this fall is due to the tax avoiding cigarette designing rather than any health efforts. The consequence of the lighter cigarettes is that some health people feel that far more progress has been made than is really the case. In fact, because cigarettes have less tar and nicotine in them, more need to be smoked for the same dose of nicotine. The industry has therefore increased the number of cigarettes per pack. Australia now has packets of 50s, whereas most countries rarely have more than 25.

There are another two consequence of these low dose cigarettes. Firstly, that some health groups do not attack them, under the illusion that they are lower tar, therefore assuming that smokers smoked the same number they would have a lower dose, and secondly, the fact that smokers have to light up more often means that the custom is commoner and smoke-free indoor air is correspondingly more difficult to achieve. As was stated in 3.7 above, nicotine levels were adjusted in light cigarettes.

9.17. Using Optimistic Data

Measurement of progress in tobacco control in Australia has usually been by prevalence studies, (i.e. surveys are done in which people are asked if they smoke and how many). These studies are difficult to do, particularly if there have been campaigns against smoking, which make people want to minimise their smoking when answering the questionnaire. This is particularly so in children.

David Sweanor, a Canadian campaigner has pointed out that if the number of people who smoke and the amount they claim to smoke is multiplied, the product falls short of the amount sold. This gap is widening. Thus 'progress' must be evaluated by sticks or weight, the latter having the disadvantages mentioned above.

The net result of all this is that political action has always been behind and less than public opinion would have wanted. This is despite the fact that the parliaments are elected to lead, not follow, public opinion.

Sadly, politicians like to think that a lot of progress has been made, so that they can claim progress without doing anything or offending the industry, so these optimistic figures suit them fine.

10. The Elements of a Good Campaign Against Tobacco

These are:

a. Raising taxes

b. Banning smoking in indoor areas or group situations to de-normalise the self-poisoning behaviour

c. Restricting availability by banning sales to minors

d. Restricting availability by licensing outlets

e. Banning advertising and all other types of promotion

f. Breaking the link between the glamorous images and the pack by mandating generic packaging

g. Running significant public Quit campaigns to the maximum level of their cost-effectiveness

h. Running specific Quit campaigns (secondary prevention) for those with existing disease, respiratory or arterial, as this is highly cost-effective compared with all other interventions.

i. Tort Litigation, for all its faults and expense, since citizens are more equal with the tobacco companies when they are arguing in Court than when they attempt to move the political system.

j. Setting up a Tobacco Industry Funded Trust as was done in the James Hardie legislation to pay for tobacco-caused illness.

10.1 Raising Tobacco Taxes.

William Weis of Seattle showed that tobacco had a price sensitivity of demand of 0.04. Minors, however, had a greater price sensitivity of 0.12 and the effect on minors starting smoking as a habit had a price sensitivity of 0.14. This meant that for every 10% rise in the price of cigarettes, minors smoked 12% less tobacco, and 14% fewer minors became regular smokers. The combination of these two numbers meant that children smoked about 25% less tobacco for every 10% rise in the price of cigarettes. Adults smoked 4% less tobacco, so it was in the financial interest of governments to increase the tobacco tax.

This concept was first used by David Sweanor of the Non-Smokers Rights Association in Canada and came to Australia via the Non-Smokers' Movement of Australia in 1984, being put in the budget submissions of significant health groups, particularly the Australian Council on Smoking and Health in Western Australia, and the Victorian Anti-Cancer Council in 1985. Australian tobacco taxes, which had historically been very low, started to go up significantly from that time.

10.2 Banning Smoking in Indoor areas

This has been very slow and has needed tort law to achieve it. When the Federal Public Service went smoke-free after the Roy Bishop case (see below), it was

demonstrated[31,32,33] that cigarette consumption dropped significantly in smokers in response to the ban. US research work gave a similar conclusion.[34] This is why the tobacco industry has fought indoor bans so hard, and sadly so successfully.

10.3. Banning Sales to Minors

Banning sales of tobacco products to minors has been assumed to reduce smoking as if most children do not take up smoking as part of adolescent rebellion, they do not take it up at all. In the US, where the age of adulthood is raised, it does seem that the Industry is able to persuade older people to start almost as well.

There has traditionally been very poor enforcement of sales to minors legislation. A small group of health inspectors in Gosford showed that it could be done if there were significant prosecutions of tobacco sellers, but they have rarely been emulated. It is generally assumed to be too minor a matter for police action. If there were tobacco licenses it is assumed that the money from these would pay for enforcement and the system would work.

10.4. Tobacco Outlet Licensing

The area of tobacco licensing has been seen as a halfway house between a product being illegal and legal. A great deal more has been done in the area of alcohol licensing, but the model of pharmaceuticals is also cited. Alcohol licensing was historically to reduce availability, and in the case of pharmaceuticals to try to educate the user so that he or she would not harm themselves. In general the objects of licensing are either medical, to reduce sales to minors and make tobacco less available, or financial, to raise revenue.

The concept of 'negative licensing' has also been suggested, which means in essence that anyone may sell tobacco except those who are expressly forbidden to do so, due usually to their past bad record in selling to minors. 'Negative licensing' is a step beyond no licenses as it implicitly states that there is a right to sell tobacco. This is favoured by Philip Morris, and certain small businesses. It would maximise tobacco sales as there would be more sellers and as such, it would create a larger lobby of small businesses that would resist attempts to restrict outlets later.

Extraordinarily, this was introduced by the previous health Minister, Craig Knowles as the Public Health Amendment (Tobacco Control) Bill in 1999. The bill was second read, but never proceeded and lapsed with the prorogation of the Parliament.

The most recent document on licensing is the Allen Consulting Group paper Licensing of Tobacco Wholesalers and Retailers of December 2002[35] for the Federal government. This recommends licensing of tobacco sellers, both wholesalers and retailers. Wholesalers are a

---

[31] Borland R, Chapman S, Owen N, Hill D, Effects of workplace bans on cigarette consumption, Am. J Public Health 1992, 178-80

[32] Indoor smoking bans significantly reduce consumption, and also de-legitimise smoking. Borland R., Chapman S., et al. American Journal of Public Health Vol 80. Feb 1990 p178,

[33] Chapman S. Borland R et al "Why the Tobacco Industry Fears the Passive Smoking Issue', Int. Journal of Health Services Vol 20 No 3 pp 417-27 1990.

[34] Woodruff T, Rosbrook B, Pierce J, Glantz S, Lower Levels of Cigarette Consumption Found in Smoke-Free Workplaces in California, Arch Internal Medicine 1993;153:

[35] http://www.health.gov.au/internet/wcms/publishing.nsf/content/health-pubhlth-strateg-drugs-tobacco-other.htm/$FILE/licensing_tobacco.pdf

cheaper option, but retailers allow more supervision at greater cost. Licensing the manufacturers is also an option. The reasons given for licensing are that there is no safe level of use and the sheer magnitude of the harm done by tobacco. The Tasmanian licensing scheme is probably the best model in Australia, but the ACT model charges license fees on the basis of the amount sold.

The Allen Report comments that Philip Morris was for negative licensing whereas BAT favoured licensing if the licensing were done by revenue authorities but not if it is administered by health authorities. This is merely further evidence that these companies want to sell as much as possible without interference from any public health considerations.

10.5. Advertising and Promotion Bans

Advertising bans are now almost complete, though point of sale should be further restricted. It must be recognised that advertising is different from promotion and other forms of product placement. The incorporation of smoking in movies and getting well known models to smoke in photo shots are still ways of targeting adolescents without adults or non-targeted groups being aware of this. Given that smoking is such an unnatural act, the fact that the group that consistently smokes the most is the 25-34 year olds is amazing, and is a tribute to the continual marketing by the Industry. Initiating smoking requires that the peer groups leaders believe that smoking is 'cool', 'tough', 'adult', 'masculine/feminine' or other desirable quality. The fact that the 16-20s age group do not have the highest rate is probably a spin off from the fact that smokers who can not legally be sold tobacco are less likely to answer as honestly as older smokers. It still means that recruitment is highly significant and merely looking at quit strategies makes it hard to make progress. It is harder to get someone to quit than to stop the initiation. Yet this is almost invariably where the resources are put.

There is still sampling of cigarettes in selected nightclubs.

Media management which has historically included stories about other trivial hazards such as coffee are all designed to cloud the issue of the especially hazardous nature of tobacco. This probably cannot be stopped because of the censorship implications, but one needs to be aware of it to understand where the silly stories come from. It might be noted that at one point the tobacco industry actually persuaded the Australian Skeptics to run articles throwing doubt on the evidence against tobacco.

10.6. Generic Packaging

In the final analysis with satellite TV and the infinite variety of ways tobacco companies have of giving a positive connotation to their product, the box links the imagery and personalises it for the smoker. It is the touchstone. It is therefore necessary to break this link at its only vulnerable point - the pack. Research has shown that a 'vomit yellow' pack is the least attractive colour. All cigarettes should be in this type of generic box with the brand name in a defined font and size.

10.7. Public Media-Based Quit Campaigns

These should be done to the level at which they are likely to be cost-effective. Californian research suggests that this about $56 per person per year, as smoking costs not only the health system (for which governments pay about 68% of the total cost) but also costs the economy through absenteeism, years of working life lost etc. Dileep Bal, who looked the

effectiveness of Quit suggested this level of Quit funding. [36] It is important to use the Californian model of anti-tobacco campaigns which ridiculed the Industry and the smoking habit, as this make tobacco less attractive to those who might otherwise take it up.

It must be remembered that stopping uptake is a battle for the minds of the peer group leaders. It is not trying to stop people following trend setters, nor to encourage personal struggles to quit after they have become addicted.

10.8. Quit Help for People with Known Diseases

Many patients have existing diseases such as hypertension, coronary disease and diabetes. These people are at very high risk of further deterioration. Quitting smoking is immensely cost-effective. Yet hospitals do not have the resources to do this and far less cost-effective treatments are routine, or treatment is less effective after avoidable complications have occurred. The British National Health Service has set up such a system, yet Australia lags behind.

11. What the Committee of Inquiry Should Do

11.1. Request that Classification of Films be by their tobacco content and a warning label be placed on the film, rock clip, video, DVD or computer games and a Quit advertisement be mandated at all showings of films which 'normalise' tobacco smoking by having a significant figure (good or bad) who smokes.

11.2. The Attorney-General Should:

11.2.1. Investigate whether the selling of tobacco is likely to be in breach of the Trade Practices Act, in view of what is known about it.

11.2.2. Sue tobacco companies for the harm that they have caused and to take this action for the whole population on the model of some progressive US States before the Republican administration stopped them doing this.

11.2.3 Prepare laws similar to the James Hardie legislation for asbestos, and set up a scheme in which the tobacco industry and its associated companies which have been spilt off should pay for the harm that they have caused smokers, for their disease and the massive Quit campaigns to reduce future smoking. It might be noted that Altria, the new euphemistic-sounding name for Philip Morris is again splitting into smaller companies, probably to make it more difficult for an action such as is suggested.

11.3. State the Principles of Future Actions.

This should include:

11.3.1 That governments have a duty to end the tobacco epidemic, as the tobacco industry is showing no inclination to do so.

11.3.2. The Government should switch from smoker-based strategies to industry based strategies.

---

[36] Bal D and Lyman What Aren't You Doing and Why Aren't You Doing it? MJA Feb 2004

11.3.3. That the tobacco industry should pay for the harm that its product causes.

11.3.4 That it should be the object of public policy to have smoking totally eliminated as soon as possible.

11.4. State and Advocate a Strategy for Reducing Tobacco Consumption Rapidly by:

11.4.1. Stop tobacco advertising and promotion by following where the tobacco promotion money is spent, rather than by what is observed. This would make a large difference to product placement advertising, currently a large problem in films. If tobacco money is received, the film should, prima face, be considered to be a tobacco advertisement, and be correspondingly in breach of the ban on tobacco advertising. There would need to be a safeguard against the laundering of money to reach tobacco promotions indirectly.

11.4.2. Introduce generic packaging. The colour should be yellow with a specified font for the brand name. Warnings would be as now.

11.4.3. Stop all point of sale displays of tobacco products.

11.4.4 Stop all Tobacco Promotion at Nightclubs

11.5. Strong legislation to ban indoor smoking. This must encourage a behaviour change and must not be side-tracked by air-conditioning or ventilation issues. It must be simply enforced and not rely on air quality standards that are impossible to enforce due to measurement difficulties, or to no objective standards at all. This ban must be for all indoor areas. Indoors should be defined as 'having a roof'.

The notion of the Smoke-Free Environment Amendment (Enclosed Places) Regulation 2006 that having 25% of the total walls and ceiling missing allows a volume to be classified as outdoors is absurd, and should not be allowed unless its proponents come up with some evidence as to the fact that it is safe area to work in such areas. It is not safe, so no such evidence will be forthcoming, and the regulation should be ceased.

11.6. Change Tobacco Access laws, with:

11.6.1. Licensing of tobacco manufacturers, wholesalers and retailers on a regular basis with increases in license fees paying for enforcement.

11.6.2. The withdrawal of licenses as a significant sanction.

11.6.3. A gradual reduction in the number of licenses.

11.7. Allow the Cancer Institute to Do Advocacy and Be Responsible for Enforcement of Tobacco Law. They should be able to advocate strongly for tobacco control policies, yet their tone to date has been decidedly subdued. They need to be empowered to lobby Federal, State, and Local governments, as well as co-ordinating other groups and having input to community initiatives. It would not have its funding cut for doing advocacy - a new concept for Australia's governments.

11.8. Create a Fund for Tobacco-Caused Disease

11.8.1. Initially this would be funded by a levy negotiated for the purpose on the model of the James Hardie legislation. It would need to insist that the tobacco companies paid for tobacco-caused diseases and would use the Dust Diseases Board as the vehicle for the

assessment of the diseases and payment of plaintiffs. Health costs of tobacco-caused diseases would be able to be claimed according to a schedule implemented by hospitals and health practitioners.

It might recover costs from the tobacco industry as the tobacco companies are sued for existing costs on the model of some American States as in 8.8 above, but ideally the legislation would make this unnecessary.

11.8.2 If the Industry were reluctant to pay, it might need some cases to encourage it, and the Attorney-General needs to look at the possibility of these prosecutions. The tobacco industry executives should be personally liable.

11.9. Draft a Strategic Plan for the End of Tobacco Use in Australia

This would involve:

11.9.1. The recognition of tobacco's harmful effect and the fact that many people are addicted, and the steps recommended above must be taken to reduce consumption. (Smokers should be seen as victims of the tobacco industry. Naturally there should be no attempt to ban tobacco per se).

11.9.2. Classify Tobacco as a Drug to put its regulation under the Therapeutic Goods Act. This is clearly applicable given the addictive properties of nicotine. Regulations can then be made quickly and expeditiously based on the latest research to reduce consumption. This would allow progressive measures such as generic packaging and point of sale restrictions to be introduced expeditiously.

11.9.3. Establish an end date for having smoking at negligible levels in the Australian population, say 2012.

11.9.4. Have a comprehensive Quit plan attached to hospitals but with a major public outreach. The Federal government should be requested to add Quit initiatives to Medicare for reputable licensed Quit programmes.

11.9.5. Provide Nicotine Replacement Therapy at reduced cost. This would require Federal/State cooperation, or States could agree to do this for hospital patients and ask the Federal government to do it in the community.

Note: It is not recommended that NSW take the approach being suggested by some in New Zealand that smokeless tobacco be substituted for combustible tobacco[37]. It is true that it is a substitute in terms of nicotine delivery system, but smokeless tobacco (also justifiably called 'spit tobacco') was wisely banned in Australia after a Court case as cited above and it would be foolish to have another epidemic by allowing marketing or even acceptance of a known carcinogen, merely because it kills fewer people than burning tobacco.

11.9.6. Adequately fund the Tobacco Action Plan.

This existing plan is quite good, but has never been adequately funded. Given the extensive literature on the cost-effectiveness of tobacco reduction progress, it is indefensible to underfund such well-researched public initiatives.

[37] http://www.smokeless.org.nz/

11.9.7 The Government should sue the tobacco companies for the cost of tobacco-caused illness.

11.9.8. Establish a Trust. Assuming 11.2.2, part of the settlement might be to establish a trust in which monies from cigarette sales would be used to pay for illness, help people quit and to discourage recruitment. Tobacco executives might be offered immunity from prosecution, in exchange for evidence and provided that they gave a number of years of public service in the hospital system, or in marketing health. Given that the evidence has been deliberately destroyed by the tobacco industry as shown by the Rolah McCabe case.

11.9.9 The asbestos model should be considered and legislation based on the James Hardie Civil Liability Act 2005. The money should go to an expanded Dust Diseases Board, which would administer the monies and decide eligibility, which is likely to be wide, because of the large burden of disease that tobacco has created.

MINUTES OF MANAGEMENT MEETING HELD NOVEMBER, 1970.

Present

Messrs. R. F. W. Watson, P. K. Martin, W. McPherson, J. Blyde, B. L. Cocks, E. G. Tynan, J. A. Stuckey, E. W. H. Cowper, J. H. Harris, L. Smith, W. K. Irish, F. McNulty, T. M. Brien, J. W. Arent, B. P. Weekes, W. J. Garner, S. E. Costigan, A. A. Senders, W. G. Stone, A. E. Stephens, C. J. Foskey, B. Ford, K. E. Kennedy, D. Michod, V. P. Ryan, R. E. Fuller, D. Hourigan, G. Edwards, E. A. Lee, L. K. Clemens, R. B. Glendenning, G. Landy, R. J. King, G. Barnett, R. McDonnell, R. Hilliers, A. Collins, W. H. Garing, J. Scott, G. Jose, A. C. Mitchell, O. O'Brien, D. Hauptfleisch, Miss D. J. Gilmour.

Apologies

Mr. J. R. Witcombe, Mr. U. W. Kelleher - Interstate
Mr. G. Hawkins, Mr. V. A. Brink - Overseas

Mr. Watson advised that the purpose of the meeting was to acquaint those present with recent marketing developments and to discuss other matters of importance.

We knew that the excise increase of 3 cents per pack in August would affect some sections of the cigarette market and the market generally. As expected the market has taken some two to three months to settle down. A recent smoking survey disclosed that Cambridge gained most from the excise increase and Dunhill is the only prestige brand to show a slight increase since excise. As expected, Benson & Hedges has been affected. We believe that we will have dramatic increases over the next six months with Cambridge and further sale gains with Dunhill and a number of new brands.

Discussing the market generally, Mr. Watson pointed out that Lambert & Butler at 46 cents had been introduced to start a new house name. We believe that it is their intention long term to capitalise on the Lambert & Butler name by bringing out other brands from this house lower down the price scale.

Our Company is well represented in the 44 cent price class, however, at 43 cents we have not as yet come up with an answer to Marlboro. However, Liggett and Myers are anxious for us to attack this brand with Chesterfield Filter and L & M. In the 41 cent and 42 cent category Alpine is the only brand selling in an appreciable quantity, and we believe that we offer the smoker a comparable cigarette in Cambridge Menthol for 3 cents less. The 40 cent to 42 cent category represents a monthly sale of over 500 million. There is scope in this area for us to achieve considerable sales increases; for this reason we are testing Rothmans Royals at 40 cents in Brisbane and Newcastle, and in Adelaide at 38 cents. By doing this we propose to stimulate [illegible]

price category represents 200 million cigarettes per month of which we sell 4 million. To correct this situation, we are launching Rothmans No. 7 in Tasmania at 32 cents on Monday, 16th November, 1970.

Flagship K/R has been an overwhelming success. We are now testing Flagship Fine Cut and smokers to date are impressed with the product.

The Australian market is one of the most competitive in the world with more than 150 brands of cigarettes in a multitude of sizes, blends and packagings, selling at a variety of prices.

In the T. P. N. G. we now have more than 50% of the market and are currently selling in excess of 25 million cigarettes per month.

Mr. Watson stressed that executives must accept responsibility and exercise authority.

On the subject of motor vehicles, Mr. Watson stated that the Company is becoming increasingly concerned over the abuse and misuse of its vehicles. Divisional and Departmental Heads must take positive action to correct this situation, particularly in respect of our high accident rate.

Mr. Watson again stressed the importance of executives advising their secretaries of their whereabouts at all times.

Discussing smoking and health, Mr. Watson advised that we can expect more severe attacks on the industry in the near future. In Canada and the U. S. A., advertising restrictions are pending and in the U. K. there is no cigarette advertising other than press. We can expect similar restrictions here within the next few years. This is the reason for the existence of the F. N. S. F. and our sponsorships which are being developed in anticipation of restrictive advertising action in Australia.

All in all, we have not had a bad year. In terms of profit we anticipate a satisfactory result, however, it is imperative that we sell more cigarettes than last year.

Mr. Watson advised that Mr. B. P. Weekes has been appointed General Manager, T. P. N. G.

Appendix 2. Survey of Smokers' Knowledge of the Hazards of Smoking

Subject: Knowledge of Health Effects caused by Smoking: Findings from the 2003 Victorian Population Survey

In 2003, as part of the Victorian Population telephone survey conducted annually by the Centre for Behavioural Research in Cancer, 3001 Victorian adults aged 18 years and older were asked about their knowledge of the health effects of smoking to inform campaign planning and advocacy strategy for the Victorian Smoking and Health Program (Quit).

The standard tobacco use question[1] has been used to determine smoking status. In this memo, smoking status is presented in three categories, *Smokers* (smoke daily, weekly, or less than weekly), *Former smokers* (do not smoke currently but have smoked at least 100 cigarettes in their lifetime, regardless of whether they have ever smoked daily), and *Never smokers* (do not smoke at all and have not smoked 100 or more cigarettes in their lifetime).

Participants were asked two questions regarding knowledge of the health effects caused by smoking. All participants were first asked "In your opinion, are there any illnesses caused by smoking?', where they could any 'yes', 'no' or 'don't know/can't say'. The second question asked only those participants who answered 'yes' to the first question, 'Which illnesses do you think are caused by smoking?', and these respondents were prompted to state as many illnesses as they could and responses were recorded verbatim.

All current smokers (daily, weekly or less than weekly smokers) were also read out loud a list of twelve health problems that included 'some health problems that doctors believe are caused by smoking'. Smokers were asked to respond, 'yes – caused', 'maybe', 'no – not caused' or 'don't know/can't say' to each of these stated health problems. The twelve health problems were presented to respondents in random order. Smokers were categorised as *Daily, Weekly,* or *Less than Weekly Smokers* for the examination of responses to these questions.

As reported in Table 1, 95% of respondents agreed that smoking caused some illnesses, less than 2% of respondents could not say or did not know, and 3.1% disagreed that smoking caused any illnesses. There were more smokers who disagreed (6.6%) that smoking caused illnesses than former (1.9%) and never smokers (2.6%). Similarly, there were more smokers who did not know or could not say whether smoking caused any illnesses (3.4%) compared to former (1.9%) and never smokers (1.4%).

Table 1: Opinion regarding whether any illnesses are caused by smoking, by smoking status

	Total (n=3001)	All Current Smokers (n=523)	Former Smokers (n=886)	Never Smokers (n=1592)
	%	%	%	%
Yes	95.0	89.9	96.2	96.0
No	3.1	6.6	1.9	2.6
Don't Know / Can't Say	1.9	3.4	1.9	1.4

Table 2 reports on the illnesses caused by smoking as recalled spontaneously by respondents. The most frequently reported illness caused by smoking was lung cancer (75.3%), followed by emphysema (40.4%), heart disease or attack (24.2%), and unspecified "cancer" (15.3%). Logistic regression analyses indicated that compared to current smokers, former smokers were one and a half times more likely, and never smokers twice as likely, to report that smoking causes lung cancer. Other illnesses recalled

included asthma (12.2%), respiratory problems (10.3%), throat cancer (11.1%), stroke or vascular disease (7.6%) and circulatory problems (5.4%). Very few recalled low birth weight (1.3%), pregnancy complications (0.5%), SIDS (0.3%), fertility problems (0.1%) and impotence (0.1%) as illnesses that are caused by smoking. Similarly, cancers such as ovarian or gynaecological cancers (1.6%), liver cancer (1.0%) and leukaemia (<1.0%) were rarely reported.

Table 2: Spontaneous recall of illnesses caused by smoking from respondents, by smoking status

	Total (n=2992)[a]	Smokers (n=521)[b]	Former Smokers (n=882)[c]	Never Smokers (n=1590)[d]
	%	%	%	%
Lung Cancer	75.3	66.4	74.4	78.8
Emphysema	40.4	39.6	44.9	38.1
Heart disease/attack	24.2	25.5	26.7	22.3
"Cancer"	15.3	18.6	14.5	14.5
Asthma	12.2	7.3	12.6	13.5
Respiratory problems (bronchitis)	10.3	10.0	10.8	10.0
Throat cancer	11.1	6.0	12.5	12.0
Stroke and vascular disease	7.6	8.7	8.2	6.9
Circulatory problems	5.4	4.7	6.3	5.1
Oral cancer	4.3	3.6	4.4	4.5
Pneumonia	2.5	2.1	3.5	2.2
Eye problems	1.7	3.3	1.3	1.4
Ovarian / Gynaecological cancer	1.6	2.3	2.3	1.1
Diabetes	1.4	0.8	2.1	1.2
Low birth weight	1.3	1.0	1.7	1.2
Liver cancer	1.0	0.8	0.6	1.2
Airway disease (including COAD)	0.7	0.1	0.4	1.0
Pregnancy complications	0.5	0.1	0.5	0.7
Breast cancer	0.5	0.7	0.4	0.4
SIDS	0.3	0.2	0.2	0.3
Kidney cancer	0.2	0.3	0.2	0.2
Fertility problems	0.1	0.0	0.2	0.1
Impotence / sexual ability	0.1	0.5	0.0	0.1
Leukaemia	< 0.1	0.0	0.1	0.0
No illness caused	3.1	6.7	2.0	2.6

Don't know/Can't say	1.9	3.5	1.9	1.4

[a] = 9 missing; [b] = 2 missing; [c] = 4 missing; [d] = 2 missing.

As Table 3 indicates, approximately 93% of smokers specifically asked, agreed that smoking causes lung cancer. Most smokers also agreed that emphysema (88.5%), heart disease/attack (84.5%) and facial skin wrinkling (70.9%) are caused by smoking. Less than half daily smokers (44.8%) reported that smoking causes miscarriage compared to 68.2% of weekly smokers and 76.7% of less than weekly smokers. Around a third of smokers thought smoking causes liver cancer (35.2%), SIDS (32.4%), and cancer of the cervix (30.4%), while over a third disagreed that smoking causes these illnesses (39.7%, 36.3%, 38.6% respectively). Most smokers either didn't know/couldn't say (33.9%)or disagreed (41.2%) that smoking causes early menopause. Similarly, most smokers either didn't know/couldn't say (20.7%)or disagreed (57.4%) that smoking causes leukaemia.

Table 3: Knowledge of Illnesses Caused by Smoking (Current Smokers Only)

	Total Smokers (n=522)	Daily smoker (n=449)	Weekly smoker (n=43)	Less than weekly smoker (n=30)
	%	%	%	%
Lung Cancer	93.3	93.3	93.2	93.3
Emphysema	88.5	90.2	75.0	83.3
Heart disease/attack	84.5	84.2	83.7	90.0
Facial skin wrinkling	70.9	70.2	66.7	86.7
Miscarriage	48.6	44.8	68.2	76.7
Liver cancer	35.2	35.3	41.9	24.1
SIDS	32.4	31.3	38.6	40.0
Cancer of the cervix	30.4	29.8	34.9	33.3
Early menopause	15.1	14.7	22.7	10.3
Leukaemia	14.0	13.8	13.6	17.2
Tuberculosis[a]	24.1	23.6	30.2	23.3
Hepatitis C[a]	4.6	4.2	9.1	3.4

a = illnesses not caused by smoking

Results indicate that the only illness caused by smoking that the majority of Victorians spontaneously recall is lung cancer. Emphysema & heart disease/attack are widely accepted by smokers as illnesses caused by smoking. However, these illnesses are not top of mind for most Victorians. Most other illnesses caused by smoking are only accepted by one third or less of smokers, and recalled spontaneously by less than one tenth of Victorians.

OUR INITIALS & SURNAME	YOUR HOME ADDRESS	YOUR SIGNATURE	CATE-GORY	YOUR HOME CLUB & MEMBERSHIP No. IF APPLICABLE	MEMBERS NAME / NUMBER / SIGNATURE	DATE
PLEASE PRINT YOUR NAME AND ADDRESS CLEARLY ABOVE					INTRODUCED BY	

Brewarrina RSL Club Ltd

A.C.N. 001 050 102

Cnr Sandon and Bourke Streets,
Brewarrina N.S.W. 2839
Telephone: (068) 39 2151

CATEGORIES

A **TEMPORARY MEMBERS**
1. RESIDING FURTHER THAN 80 KMS FROM CLUB.
2. CLUB WITH SIMILAR OBJECTS.
3. ORGANISED SPORT OR COMPETITION.

B **PROVISIONAL MEMBER**
AWAITING DECISION ON APPLICATION FOR MEMBERSHIP

C **GUEST OF MEMBER**
MUST REMAIN IN MEMBERS COMPANY WHILE ON CLUB PREMISES AND DEPART WITH MEMBER. (INCLUDES PROVISIONAL MEMBERS GUEST)

PLEASE READ THIS CAREFULLY BEFORE SIGNING

I UNDERSTAND THAT I WILL NEED TO BE OVER 18 YEARS TO PLAY GAMING MACHINES AND TO BE SERVED ALCOHOLIC BEVERAGES, AND, IF REQUIRED, WILL SHOW IDENTIFICATION, DETAILS OF WHICH WILL BE RECORDED.

- ★ ALL TEMPORARY MEMBERS/VISITORS/GUESTS MUST ADHERE TO THE DIRECTIONS OF THE MANAGEMENT OF THE CLUB.
- ★ I HAVE READ AND FULLY UNDERSTOOD THE RULES FOR TEMPORARY MEMBERSHIP AS PROMINENTLY DISPLAYED AT THE ENTRANCE OF THE CLUB.
- ★ THIS CARD MUST BE PRODUCED WHEN ENTERING THE CLUB AND ON REQUEST OR WHEN CLAIMING POKER MACHINE PAYOUTS.
- ★ THIS MEMBERSHIP IS VALID ONLY FOR THE DAY STAMPED AND FOR THE PERSON TO WHOM IT IS ISSUED.
- ★ ALL TEMPORARY MEMBERS MUST ASSUME THE CONSEQUENCES OF ENTERING INTO CLUB PREMISES WHERE SMOKING IS PERMITTED.