

t o b a c c o c o n t r o l

a blue chip investment in public health – overview document



A document for the consideration
of Australian governments and
all political parties

VicHealth Centre
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Anti-Cancer Council of Victoria, Melbourne 2003

Endorsed by

Action on Smoking and Health Australia

Alcohol and Other Drugs Council of Australia

Australasian Faculty of Public Health Medicine, Royal Australasian College of Physicians

Australian Council on Smoking and Health

Australian Medical Association*

National Asthma Council Australia

National Heart Foundation of Australia

Pharmaceutical Society of Australia

Royal Australasian College of Physicians

The Cancer Council Australia

The Australian Lung Foundation

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Public Health Association of Australia

Thoracic Society of Australia and New Zealand

VicHealth Centre for Tobacco Control

*With the exception of a couple of options recommended for consideration concerning modifications to Medicare.

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This document was compiled by Ms Michelle Scollo, consultant to the VicHealth Centre for Tobacco Control, with input from staff of the VCTC and members of the Tobacco Control Committee of the Australian Cancer Society.



Tobacco control is one of the best investments governments can make to enhance health and economic well-being.

Tobacco is harmful when used as intended. It kills over 19,000 Australians each year and disables many more. Tobacco smoking is highly addictive: many users are unable to voluntarily cease use, even when aware of the harm tobacco causes.

Tobacco use is so pervasive and so entrenched that governments worldwide have found it difficult to grasp the magnitude of the problem, and equally difficult to contemplate the nature of the solutions required. Most of what has been done to date has merely chipped away at the edges.

Governments have an obligation to do more; an obligation to the smokers who contribute so much to government revenue; an obligation to the families of smokers who suffer so greatly with the early disablement and death of those unable to stop smoking in time; an obligation to the whole community which would benefit so greatly from a reduction in the massive social costs associated with tobacco use.

In 1999 the Ministerial Council on Drug Strategy, a body which includes all state, territory and federal health, justice and police ministers, adopted a national tobacco strategy covering the years 1999 to 2002-03. The National Tobacco Strategy aspires to reduce morbidity and mortality caused by smoking and to lower economic costs in the long term. It sets out numerous approaches to strengthen community action; promote cessation; reduce availability and supply of tobacco products; reduce tobacco promotion; regulate tobacco; and reduce exposure to environmental tobacco smoke. While progress has been made in many areas, insufficient resources have been applied to mass media education and other strategies proven to be effective in reducing smoking prevalence. Progress in many areas is being hampered by structural problems in health sector financing arrangements.

This document outlines a practical agenda for action that would markedly reduce the social costs of tobacco use in Australia. All of the proposals are based on sound thinking and the best available evidence.

The document spells out several new policies and programs. It also provides guidance for making some existing programs more cost-effective. Some of the strategies proposed would immediately reduce spending or actually raise money.

If implemented fully, the proposals would ensure that as many Australians as possible would be able to make an informed choice about whether they wish to attempt to quit. It would result in a reorientation of our health system to provide effective help for tobacco users as part of standard health care. It would make a major contribution to preventing uptake of tobacco by young people.

This document is underpinned by economic analyses and background papers which justify the approaches proposed, cost out the program, and estimate the benefits to the community.

There are seven policy proposals, and proposals for three broad programs of activity. Options for financing the package are also provided.

Policy proposals

Policy 1: Ensure cigarettes do not become affordable to children.

1. Continue six-monthly indexation of tobacco excise and customs duty.
2. Regularly (bi-annually) increase duty in line with AWE and estimates of children's average weekly disposable pocket money.
3. Minimise evasion of customs and excise duty.

As a set, these proposals would increase revenue.

Policy 2: Ensure complete and effective disclosure by tobacco companies to consumers.

1. Through litigation expose history of industry misconduct and seek orders to prevent or address continuing and future misconduct.
2. Strengthen tobacco product labelling regulations to require disclosure and effective communication about: ingredients, including additives; maximum toxic output of products when smoked; any information relevant to potential acute and long term biological impact, overall addictive potential and overall health risk.

These measures impose no significant costs.



3. Ensure disclosure by tobacco companies about marketing activities and sales.

This would be cost-free to government and would reduce the cost of tobacco policy monitoring and evaluation.

Policy 3: Regulate the manufacture and supply of tobacco products to minimise social harm.

Costs to government are not known at this stage.

Policy 4: Reduce involuntary exposure to toxic tobacco by-products.

State governments should mandate smoking bans in all workplaces, indoors in all public places and outdoors in areas such as restricted-seating, near air-conditioning intakes, and near doorways.

The Federal government could provide education to build community support, and promote best practice regulatory drafting and enforcement.

Some education costs and some small compliance monitoring costs for States are anticipated.

Policy 5: Reduce commercial inducements for uptake of smoking by children.

1. Ban remaining forms of tobacco marketing, including through international broadcasting and emerging electronic media.
2. Encourage state governments to ban remaining retail promotion, particularly advertising and purchase inducements at point-of-sale.
3. Encourage States to effectively cut supply of cigarettes to children, with enforcement efforts covered by revenue from retail licence fees.

The first two are essentially no cost, the latter is designed to be self-funding but would add to marginal costs for States if the licence schemes are rejected.

Policy 6: Support broader social policies likely to reduce demand for tobacco.

Uptake of smoking is affected by social modelling and imagery created by years of tobacco company advertising and Hollywood movies. Programs to help adults to quit, restrictions on smoking in public places, and efforts to restrict access to and affordability of tobacco products and to outlaw commercial inducements to smoke have all been demonstrated to reduce smoking in children.

Uptake of smoking is also associated with social

disadvantage and alienation from family, school and community. The federal government can assist through fiscal policies that will ensure that States have adequate funding for educational, family support, recreation and welfare policies, and programs that prevent educational failure and family breakdown and that promote mental health.

This proposal relates to broader Commonwealth-State financing.

Policy 7: Use financial levers to re-orient the health care system towards greater investment in prevention – more rational resource allocation.

The Federal government can shape health care through its power to set conditions for subsidies of pharmaceuticals, and its power to set conditions attached to State financing and agency funding. To force the pace towards greater investment in prevention of tobacco-related diseases the Federal government could consider the following:

- include on the Medicare schedule an item that would allow GPs to refer smokers to specialist tobacco dependence treatment services, as has recently been done for treatment and referral of patients with diabetes or mental health problems; perhaps introduce a further schedule item enabling GPs to provide smoking cessation counselling provided they are appropriately trained
- limit subsidies for pharmaceutical treatments for non life-threatening conditions improved by quitting smoking until after smoking cessation counselling has been attempted
- require pharmacists to confirm that patients are enrolled in cessation programs before they fill prescriptions for subsidised tobacco dependence treatment products
- make adoption of tobacco control policies and investment in tobacco cessation a condition of financing at both the State and agency levels
- include tobacco as a priority in all relevant national and state health strategies; make tobacco dependence itself a national health priority.

These strategies could reduce PBS expenditure, and very significantly reduce it in the longer term.



Program proposals

Program 1: Provide commercially realistic funding for public education.

A key communication objective of the education program would be to ensure that smokers and potential smokers from all age and social groups fully understand and appreciate all of the major risks associated with smoking – over 50 different diseases; the personal devastation caused to the families and friends of those who die from smoking-related diseases; the disability that can be caused by smoking related diseases, and the impact this has on quality of life; the addictiveness of tobacco; the various strategies that can be effective when giving up, and the help that is available.

Jurisdictions internationally which have backed this strategy with adequate funds are seeing real progress, with significant declines in smoking being followed by decreased incidence of disease.

Program 2: Fund a comprehensive, evidence-based tobacco dependence treatment (TDT) program.

This should maximise use of existing public health and health care infrastructure and ensure access to services regardless of which state you live in, whether you live in a rural or urban area, whether you have access to phone or internet services or whether you speak English.

The program would include

1. Support for state Quitlines and national Quit internet-based services to ensure universal access to intensive as well as minimal telephone counselling treatment.
2. Promotion of Quitlines and other cessation services to all health professionals, and funding of initiatives that will ensure as "standard care" for smokers by all health professionals in all health settings at least minimal treatment including: recording of smoking status; brief advice to quit; prescription of bupropion (Zyban) or recommendation of nicotine replacement therapy (NRT) for all suitable patients; referral to Quitlines and treatment outcome follow-up.

3. Improved access to and quality of use of tobacco dependence treatment (TDT) pharmacotherapies through measures to:

- reduce inappropriate prescribing of Zyban and
- increase use of NRT and non-pharmacological treatments.

4. Additional support for people whose smoking poses high immediate risk, *e.g.*

- expectant and new parents
- those who have just had a heart attack
- those suffering chronic diseases such as asthma, emphysema or diabetes.

5. Custom-designed services for young people.

6. National initiatives to promote and provide services to those not proficient in English.

7. Assistance to people whose high smoking rates and extreme social disadvantage warrant special efforts, *e.g.*

- indigenous Australians
- public housing tenants, the unemployed, low-income people in small rural towns
- people with psychiatric disabilities, in institutions or supported accommodation
- people in correctional facilities.

Costs could be minimised by institutionalising tobacco dependence treatment into standard treatment and service protocols, mandated by governments in funding agreements. Measures that helped to "grow" the market for pharmacological treatments could be financed by levies on the sale of TDT products.

Program 3: Ongoing research and evaluation.

Evaluation is critical to assessing the benefits of programs. Strategic research would help to shape tobacco control policies needed in the longer term.



How can we afford this proposal?

The new federal expenditure measures outlined in the proposal total around \$97m for each of the next three years.

Summary of new federal expenditure measures			
	2002-03	2003-04	2004-05
Policy and regulation	\$8m	\$8m	\$8m
Public education	\$42m	\$44m	\$44m
Treatment and support	\$42m	\$40m	\$39m
Research & evaluation	\$5m	\$5m	\$5m
Total	\$97m	\$97m	\$96m

However, the effect of measures to improve access to and quality of TDT use would result in PBS savings of around \$17m per annum.

	\$ 16m	\$ 16m	\$ 17m
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These measures would bring total expenditure on tobacco control, nationwide, to around \$10 per head, still at the lower end of the range recommended by expert bodies in the US, and still only about 4% of the tobacco tax revenue contributed by smokers.

If the government wished, it could completely cover the cost of all the new and even some of the existing programs through one or more of the following measures:

- a further increase in tobacco excise and customs duty, with a percentage of revenue to be devoted to tobacco control programs
- abolition of duty free tobacco sales, and establishment of an export tax on tobacco products
- license fees to be paid by companies that import or sell tobacco products in Australia
- a surcharge on tobacco company profits
- a levy to help grow the market for TDTs
- a levy on each cigarette sold to finance measures to assist farmers leave the tobacco-growing industry.

How can we afford not to adopt this proposal?

I. Benefits to smokers and their families

Early gains

1. Improved access to tobacco dependence treatment therapies and services, particularly in rural areas.
2. Additional money for spending on other goods and services, equivalent to a \$50 per week pay rise, a \$1,450 per annum tax cut or a \$92 per fortnight pension increase.
3. Less asthma, and fewer coughs and colds; fewer school and child care absences; with subsequent improvements in parents' workplace productivity and children's school performance.
4. Improved fitness; greater pleasure from improved sense of taste and smell.
5. Fewer families suffering:
 - the tragedy of still-birth or sudden infant death
 - the shock of a child or parent dying suddenly during an asthma attack
 - the trauma of a child killed in a house-fire
 - the devastation of an infant or adolescent child dying from or severely disabled by meningitis.

Continuing returns

6. Increased household savings, quicker transition to home buying and ownership.
7. Fewer children taking up smoking and thus perpetuating health and material inequality.
8. Lower household spending on medical services.
9. Over the next 15 years, at least 14,000 fewer families grieving middle-aged fathers or mothers dying prematurely from heart attack or stroke.
10. Fewer families losing providers at the peak of their income-earning capacity.



Maturing investments

11. Greater generation of wealth; long term financial support for spouses; greater inheritance for children.
12. Lower spending on medical services.
13. Less incapacitation from: macular degeneration, high-frequency hearing impairment, osteoarthritis and possibly rheumatoid arthritis, and greater enjoyment of activities reliant on sight, hearing or mobility.
14. Fewer men suffering impotence.
15. Over the next 30 years, at least 8,000 fewer middle aged and older parents incapacitated by stroke, and tens of thousands more by emphysema or peripheral vascular disease.
16. At least 10,000 fewer people dying over the next 30 years from cancers of the lung, lip, mouth, pharynx and larynx, oesophagus, stomach, pancreas, vulva, endometrium, penis, bladder and kidney and, possibly the cervix.
17. Possible reductions in young women developing breast cancer in the future.

II. Benefits to Australian businesses

Early gains

1. Reduced property and Workcover insurance premium costs (fewer fires, fewer back injury and passive-smoking related claims).
2. Reduced risk of litigation by employees suffering discrimination or illness due to failure of employers to provide smoke-free workplaces.
3. More goods and services (including many more employment generating services) purchased by those no longer buying tobacco, expenditure on which currently totals around \$7b per annum.
4. A reduction in the estimated \$1.7b absenteeism costs currently attributable to smoking: fewer smoking breaks; less time off work due to serious smoking-related diseases; less sick leave due to fewer respiratory infections in both smokers and non-smoking colleagues; less severe/faster healing back injuries.

Continuing returns

5. Avoidance of lost expertise and performance due to premature death, disease and disability.

Maturing investments

6. More goods and services purchased by people who do not die early having quit smoking – estimated to have totalled \$4.3b in 1998–9.

III. Benefits to Federal government

Early gains

1. Reductions in need for pharmacological treatments for elevated blood fats and other cardio-vascular disease (CVD), and consequent reductions in PBS expenditure.
2. Increased taxes paid on profits by companies selling goods and services consumed by smokers no longer purchasing tobacco products (offsetting reduced tobacco taxes paid by smokers).

Continuing returns

3. Improved management and possible reductions of cost of pharmaceutical subsidies and medical treatment of asthma and diabetes and a range of other chronic diseases made worse by smoking.

Maturing Investments

4. Increased income taxes paid by smokers not dying early, and increased taxes on profits of companies producing products purchased by smokers who do not die early (offsetting pension payments to those who do not die early).

IV. Benefits to State governments

Early gains

1. GST not paid on tobacco products forgone paid instead on purchase of other goods and services.
2. Shorter hospital waiting lists.



III/IV. Benefits to health funders & insurers (federal & state, private & public)

Early gains

1. Immediate or early reductions in costs of:
 - perinatal care, up to 20% per annum
 - treatment for fatal and non-fatal heart attacks, stroke and peripheral vascular disease, starting as early as one year after reductions in smoking prevalence, totalling almost \$100m per annum
 - emergency care for asthma sufferers
 - treatment of meningitis and influenza, both among smokers and, through reduced opportunities for infection, among non-smokers.

Continuing returns

2. Reduced costs due to reductions in the additional complications and slower bone and wound healing suffered by smokers.

Maturing Investments

3. Reduced costs for treatment of CVD, chronic obstructive lung disease and cancers totalling more than \$1.15b over the next 30 years.
4. Reduced lifetime health care spending.

V. Benefits to the community

Early gains

1. Increased public enjoyment of smokefree facilities and of public recreational and natural resources due to reduced litter and bushfires.
2. Reduced tensions between smokers and non-smokers about smoking breaks.

Continuing returns

3. Reduced distress and disruption for individuals and institutions who lose colleagues and mentors who die suddenly in middle age.

Maturing investments

4. Increased years of healthy independent life – shorter lifetime periods of disease and disability;

reduced burdens on family members and other volunteer carers.

5. Contributions of retirees and pensioners who do not die early to child care and many other voluntary activities.

VI. Benefits to regional Australia

Early gains

1. Adjustment assistance to those families currently dependent on sales of tobacco crops.
2. Increased rural tourism spending by people no longer smoking – weekends away, holidays.

Continuing returns

3. Improvements in demand for rural commodities used (raw materials etc) in products purchased by people no longer buying tobacco products.

Maturing investments

4. Reduced pressures on rural health services.
5. Significant reductions in premature deaths and disability among rural Australians among whom rates of smoking and of CVD and cancer incidence and mortality are significantly higher.

This long list of potential returns from investment in tobacco control shows how substantial reductions in smoking could improve the quality of life in our community. Reducing smoking would not only significantly reduce current levels of illness, but would also vastly enhance the future health of children and young people.

This proposal represents one of the most cost-effective public sector expenditure plans ever likely to be presented to Government. No government with a commitment to value for money, no government wishing to see its economy grow, and support private sector development, no government concerned about equity, can afford to avoid providing adequate resources for tobacco control any longer.