

# **Tobacco Control: A Blue Chip Investment in Public Health**

*The economic case and a detailed proposal for greater investment in  
tobacco control in Australia*

## **SECTION 5**

### **Attachment 1**

**Section 1 – Cover, Contents, Preamble, Executive Summary, Chapter 2**

**Section 2 – Chapters 3, 4 and 5**

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## Attachment 1: Overview of international tobacco control efforts

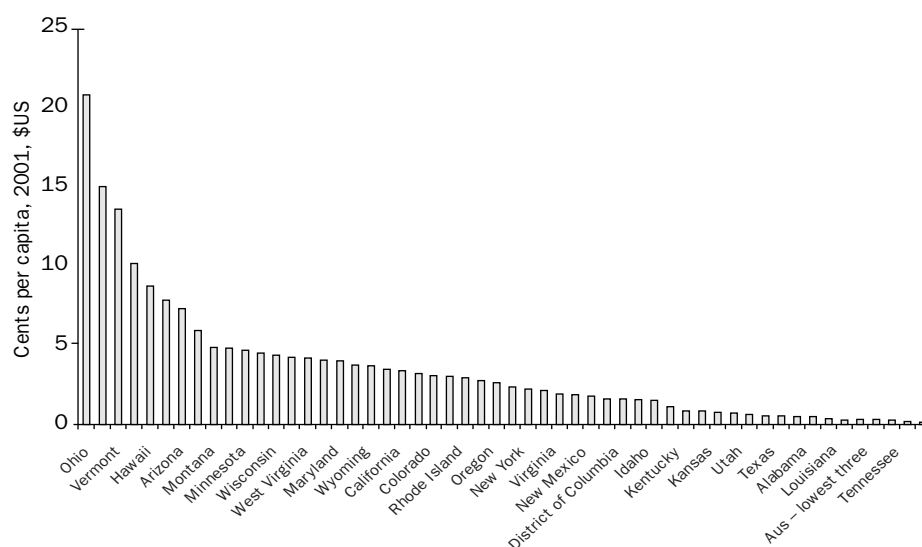
Most English-speaking countries have substantially increased funding of tobacco control over the past few years.

### A1.1 United States

Funded by settlements between US Attorneys General and US tobacco companies, Federal and state governments such as Florida are now spending substantial sums on tobacco counter-advertising campaigns [1]. This is in addition to hypothecated tax revenue in Massachusetts, California, Arizona, Alaska, Maryland, Michigan, Oregon and Utah [1], and extensive programs funded by research grants from government organisations such as the National Cancer Institute as well as commercial organisations such as pharmaceutical companies and philanthropic organisations such as the Robert Wood Johnson Foundation.

Funding for tobacco control on a per capita basis exceeds Australian tobacco control expenditure in almost all US States.

Figure A1.1 Per capita tobacco control expenditure in Australia compared to US States, 1999–2000



Source: US CDC: Investment in Tobacco Control, State Highlights, 2000.

Despite the recent boosts in funding, US public health authorities believe that tobacco control is under-financed in most US jurisdictions. Funding for tobacco control in 1999–2000 exceeded the minimum amount recommended by the US Centers for Disease Control in only seven US states: Arizona, Indiana, Maine, Massachusetts, Mississippi, Ohio and Vermont.



The US Tobacco Use and Dependence Guideline Panel last year recommended that US insurers and purchasers include, as a reimbursed benefit, the counselling and pharmacotherapies it had identified as effective aids to cessation. Coinciding with the launch of the Panel's Clinical Practice, the former US President Bill Clinton announced additional Medicaid funding contingent on US states subsidising nicotine replacement therapies for low-income patients [2].

## **A1.2 United Kingdom**

The UK Labour Government's White Paper, *Smoking Kills*, published in December 1998 [3] introduced a comprehensive strategy that committed the Government to: ban tobacco advertising; to prevent tobacco smuggling<sup>1</sup> (209 million pounds over three years); to launch a major education campaign (50 million pounds over three years); and to undertake policy research (2.5 million pounds).

As reiterated recently by the UK Secretary of State for Health, [6], helping smokers to quit is a key strategy in the UK Labour Government's plans to modernise the National Health Services [7].

The modernisation plan establishes targets for 1.5 million smokers to have given up smoking by 2010, and for the prevalence of women smoking during pregnancy to be reduced from 23% in 1995 to 15% in 2010.

Substantial funds have been devoted to these cessation targets [8], including special allocations to assist disadvantaged groups [9]. Around 60 million pounds is allocated over the three years 1999–2000 to 2001–02 for cessation services. These include a smokers' Quitline, initiatives to promote greater opportunistic interventions by health professionals and funding to regional health authorities to develop a small number of smoking cessation specialist services to assist pregnant women and heavily dependent smokers. In the first year, 10 million pounds was provided to very high need areas, the so-called Health Action Zones. The UK Government has set a target for reduction of smoking rates among manual labourers from 32% in 1998 to 26% by 2010 [10].

The anti-smoking drug, bupropion, was included on the National Health Service in June 2000. In March 2001, all nicotine replacement therapies (NRTs) became available through the National Health Service at subsidised prices. Some forms of NRT will also be available, unsubsidised, for sale in supermarkets and other (lockable) retail outlets. The National Institute of Clinical Excellence will shortly release guidelines providing guidance to GPs on cost-effective prescribing of the two agents.

Action on Smoking and Health (ASH) UK, together with the Cancer Research Fund, the Royal College of Physicians and other major health agencies and learned colleges have supported the Government's overall strategy, noting that smoking cessation in primary care should be regarded as an essential and economically rational component of NHS modernisation. They call for the following measures that would greatly improve the efficiency of the NHS:

1. Inclusion of routine smoking cessation interventions in contracts with primary care agencies, with regular health authority audits to verify compliance.
2. Mandatory inclusion of smoking cessation in the health authorities' Health Improvement Programs.
3. Avoidance of inefficiency in uncapped expenditure for treatment of heart disease risk factors avoidable by greater promotion of cessation.

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1. This undermines tax policies aiming to make tobacco less affordable to children. Between one-quarter and one-third of all cigarettes sold in the UK are sold without duty being paid. Some are sold by small operators selling cigarettes bootlegged from countries with lower tax rates. The vast majority are believed to be cigarettes on which no duty has been paid. Cigarettes are exported from various countries then distributed illegally by criminal organisations [4, 5].

4. Capacity for Specialist Smoking Cessation services to prescribe both bupropion and NRT as “dependent prescribers”.
5. Subsidy of therapies contingent on continuation of quit attempts, along the lines of the so-called abstinence contingent (ACT) model [11, 12].

### **A1.3 Canada**

The Canadian Senate is currently (June 2001) considering a national Bill to hypothecate substantial funding for tobacco control [13]. Senator Colin Kenny’s private member’s bill would impose a 19c tax increase on a package of cigarettes. This would be expected to raise around \$CA360 m annually, half of which would be devoted to mass media education, and half to municipalities. Interestingly, two out of the three major tobacco manufacturers have come out in support of the Bill, promoting in full-page newspaper advertisements the potential of the Bill to greatly reduce youth smoking.

Meanwhile the Canadian Government has announced a package of measures, effective 6 April 2001, to minimise tobacco tax evasion in Canada, and to secure funding for tobacco control. These include:

1. An increase in excise tax rates in Ontario, Quebec, Prince Edward Island, New Brunswick and Nova Scotia in order to equalise taxes between the provinces and increase the price of all products.
2. A reduction in the exemption from tax of exports of tobacco products from 2.5% to 1.5% of a manufacturer’s production of tobacco products in the previous calendar year.
3. A two-tiered tax on exports of tobacco products, so that sales above the 1.5% threshold would be taxed at \$7 per 200 sticks (and \$6 per 200 gms). Tax payments could be refunded where companies provided evidence of payment of import duties in foreign countries.
4. A tax on tobacco products for sale in duty-free shops. The amendments impose excise duty and a new excise tax both on products delivered to duty-free shops in Canada, or exported for delivery to foreign duty-free shops.
5. A tax on tobacco products delivered as ships’ stores.
6. Duty on travellers’ tobacco products.
7. A tobacco manufacturers’ surtax, increasing the tax on tobacco corporations’ profits from 40% to 50%.
8. Miscellaneous amendments concerning management of products in bonding warehouses and new tax stamping requirements.

The Canadian Government has also announced that it will invest over \$480m (including \$58m in existing funding) in Health Canada’s *Tobacco Control Strategy* over the next five years, almost five times the investment that was made in the previous initiative, which is now winding down.

The funding will be allocated to key areas of tobacco control that have been proven effective both in Canada and other jurisdictions. It will bolster existing Health Canada programs, while directing \$210m to mass media campaigns implemented in partnership with health-and- advocacy non-government organisations.

Experience has shown that successful approaches to tobacco control need to be comprehensive, integrated and sustained, and that high-profile, ongoing mass media campaigns are the anchor. The new strategy encompasses all of these elements as well as clear, achievable targets and evaluation methods.



## Ten-Year Measurable Targets

To gauge the success of the strategy, the Canadian Government has set out clear, measurable targets, and will report to the public on the progress being made. These targets are:

- Reduce the number of people who smoke from 25% to 20% of the population.
- Decrease the number of cigarettes sold by 30%.
- Increase retailer compliance with tobacco sales to youth laws from 69% to 80%.

Changes in these areas will be measured through monitoring activities such as the *Canadian Tobacco Use Monitoring Survey* conducted for Health Canada by Statistics Canada to provide continual data on tobacco use in Canada. Retailer compliance surveys and data gathered from the tobacco industry under stringent new federal reporting requirements will also be used. A progress report on activities will be issued in 2002, and a further report will be issued in 2005 based on the evaluation of the strategy.

## Components of the Strategy

Strategies that have worked well in jurisdictions such as California, Massachusetts, and British Columbia, show that a combination of various types of tobacco control efforts, supported by strong and sustained media campaigns, do reduce smoking rates. Successful tobacco control programs target all ages.

## Sustained Mass Media Campaigns

Approximately 40 percent of annual funding will be allotted to mass media campaigns targeted at Canadians of all age groups, with a special emphasis on youth and other high-risk populations. They will be carried out in partnership with stakeholders including national health and tobacco control organisations. The mass media campaigns will strengthen and support all other tobacco control efforts carried out by Health Canada.

## Enhanced Health Canada Tobacco Control Activities

The Tobacco Control Strategy builds upon the activities and directions of recent years through four mutually reinforcing components: protection, prevention, cessation and harm reduction.

### Protection

- Compliance with Health Canada legislation is a priority, particularly to ensure that the 40,000 tobacco retailers in Canada do not sell tobacco to youth.
- As in the past, with initiatives such as the new tobacco health warning messages, research will provide evidence and support for all programs and any new regulations.
- Expertise will be provided to municipalities and others to assist in the adoption of non-smoking rules and by-laws.
- The Canadian Government will continue to defend the Tobacco Act and its position in tobacco-related litigation.

### Prevention

- Prevention very much focuses on youth. Resources and activities will be developed to engage youth in developing effective programs and strategies for their peers.
- Health Canada will provide health policy assistance to the Department of Finance in developing effective tax strategies. Taxation is an important element of tobacco control, as it has clearly been shown to reduce consumption, particularly among youth.

- The Canadian strategy calls for building upon existing web-based and printed resources to inform health care professionals, teachers and others working with youth.
- Partnerships are critical to the implementation of an integrated program. The Canadian Government will work with the provinces, territories and NGOs to build on existing networks, and to enhance the ability of communities to act on this issue.

#### Cessation

- In the area of cessation, steps will be taken to address the need for national standards, including clinical practice guidelines and tools that engage health professionals in the promotion of smoking cessation.
- The strategy aims to enhance public access to programs, resources and information on best practices.

#### Harm Reduction

- Despite the best efforts to reduce smoking among Canadians, there are some who will continue to smoke. Health Canada will continue to exercise its responsibility to regulate products in such a way as to reduce the risk from tobacco use. They will work in collaboration with the United States and other countries to ensure that any changes to the product would have only positive health impacts on the smoker or those exposed to the smoke.

### **First Nations and Inuit**

The Canadian strategy involves a First Nations and Inuit initiative, which is intended to influence behaviors and attitudes related to smoking, help build the capacity of communities to address the health issues around tobacco use, and improve retailer compliance on reserve [through increased education]. Consultations will begin immediately with representatives of First Nations and Inuit associations to determine how best to address the unique challenges tobacco use presents to their communities.

### **Tobacco dependence treatment products**

In Canada provincial government commonly provide insurance for the cost of pharmaceuticals. So far only Quebec is covering the cost of tobacco dependence treatments, including both nicotine replacement products and Zyban.

### ***A1.4 New Zealand***

The New Zealand Government has recently made a substantial investment in tobacco control, increasing expenditure on anti-smoking campaigns to over NZ \$28m, equivalent to more than AUD\$6 per capita per annum. For a population of around four million people, around \$1m per annum is provided to the Quitline to provide a call-back counselling service based on the one developed in Victoria, Australia. An allocation of \$5m has been set aside for Maori cessation, and \$6.18m per annum for a Nicotine Replacement Exchange Card Scheme.<sup>2</sup> Around \$500,000 of this amount has been allocated to Quitline for rental of larger premises and employment of extra counsellors. The Exchange Card allows people who are receiving Quitline call-back counselling to purchase four weeks supply of NRT for \$10, previously costing around \$145 [14]. If people proceed with their quit attempt they are allowed a further four weeks supply. The scheme also allows for pharmacists to be paid a \$6.50 dispensing fee. The scheme is about to be

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2. Full details on the scheme available on request.



extended to doctors and other health care professionals. They will be allowed to provide the Exchange Card if they provide at least three counselling sessions. Some of the Independent Practice Associations (IPAs), which each comprise around 500 GPs, are employing IPA specialist nurse counsellors to counsel on their behalf.

Over 70,000 calls were received in the first six weeks of operation of the scheme, but by early in 2001 calls were averaging 15,000 per month. Around 5,000 people a month are currently proceeding to receive and fill the vouchers. Preliminary evaluation of the program to date indicates that, of those callers to the line offered the exchange card in its first month of operation, around 19% were abstinent at three months. It should be noted that there were many operational problems in the first month, including delays in receipt of follow-up calls.

### **A1.5 Ireland**

Ireland is another country which has recently substantially increased investment in tobacco control, with expenditure on non-pharmacological strategies totalling more than 20 million Irish pounds per annum [15], or approximately AUD\$46m, for a population of under four million people.

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