

UPDATE:

6.1.1a Tobacco smoking

Introduction

The Australian Burden of Disease Study identified tobacco to be the leading risk factor contributing to the total burden of disease in Australia (9% of the total).^{1,2} It is a key risk factor for cancer (being strongly associated with lung cancer, but also a contributor to many other types including cancers of the mouth, oesophagus, stomach, bladder and cervix)³, heart disease and chronic obstructive pulmonary disease. By the second half of the 1980s it became increasingly clear that there is no level of exposure to secondhand smoke that is free of risk and that children are at particular risk.⁴

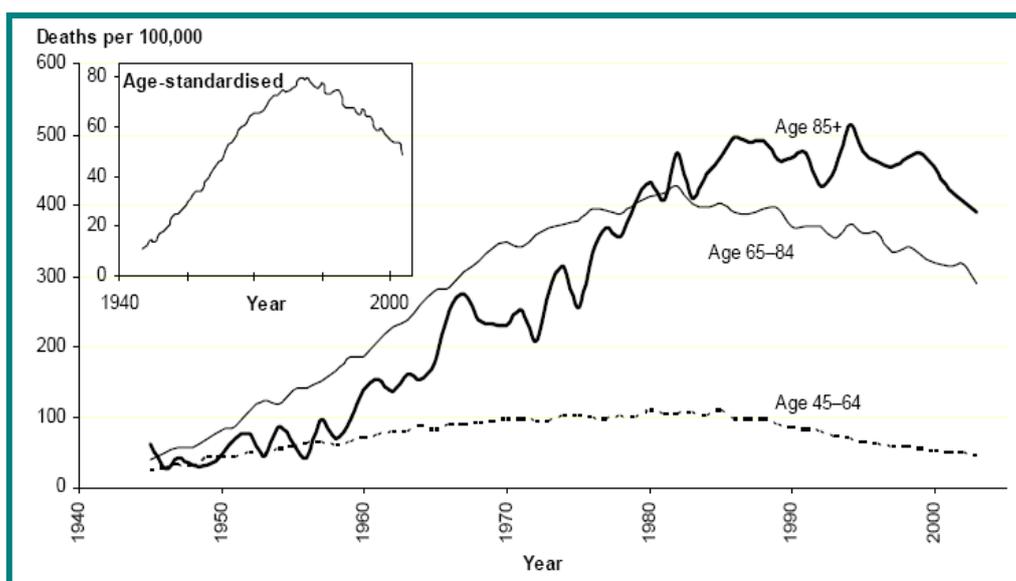
Both smoking tobacco (including using cigarettes, cigars, pipes and shisha/waterpipes) and use of smokeless tobacco (including snuff, snus and dissolvable tobaccos) have harmful effects on health.^{5,6} As smokeless tobacco use in Australia is thought to be low⁷, and data collection on smoking tobacco beyond cigarettes is minimal, this profile will focus on smoking (unless specifically specified).

Australia is often recognised as a world leader in tobacco control, having implemented a number of notable public health activities to discourage tobacco use.⁸ Over the 20th century, and more recently, knowledge from public health research and a raft of tobacco control measures led to significant reductions in tobacco smoking rates and in tobacco-related diseases, contributing to increased longevity, improved quality of life, less disability and fewer deaths.

Smoking related deaths

Smoking is the single biggest cause of lung cancer.⁹ Of five-year survival rates for cancers, those for lung cancer are among the lowest. Between 1983–1987 and 2008–2012, 5-year relative survival from lung cancer improved from 8% to 15%.¹⁰ The age-specific incidence rate of lung cancer increases with age.¹¹

Figure 6.1.1a: Male age-specific and age-standardised death rates for lung cancer, 1945–2003

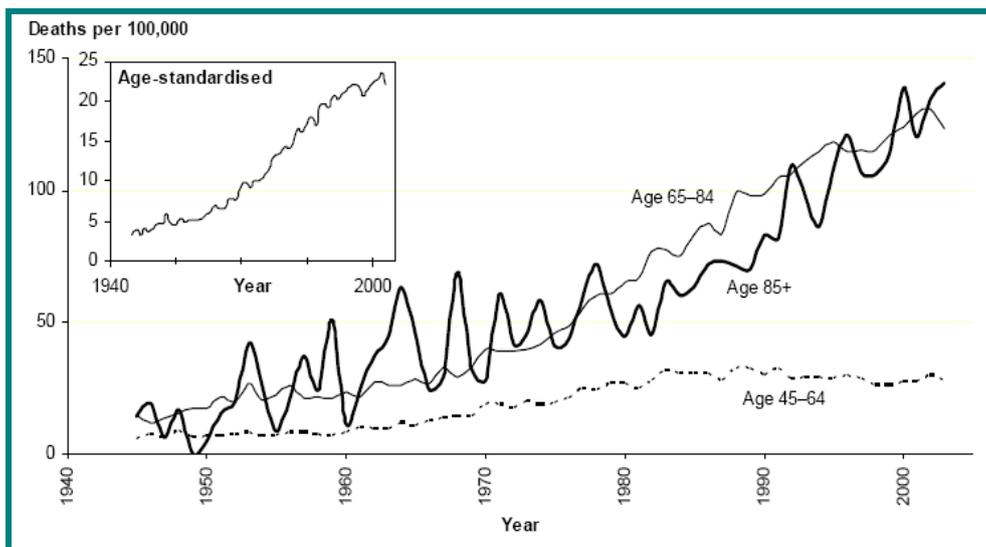


Source: AIHW, *Mortality over the twentieth century in Australia*, 2006, p. 54.

In 1982, the age-standardised male death rate from lung cancer peaked at 80 deaths per 100,000 population (Figure 6.1.1a).¹² By 2000, rates had fallen to 55 deaths per 100,000 and, in 2013, further still, to 41 deaths per 100,000 population¹⁰. For females, the death rate for lung cancer increased

substantially after 1945, though it is still lower than for males, and has shown little evidence of the reduction evident for males (Figure 6.1.1b).¹²

Figure 6.1.1b: Female age-specific and age-standardised death rates for lung cancer, 1945–2003

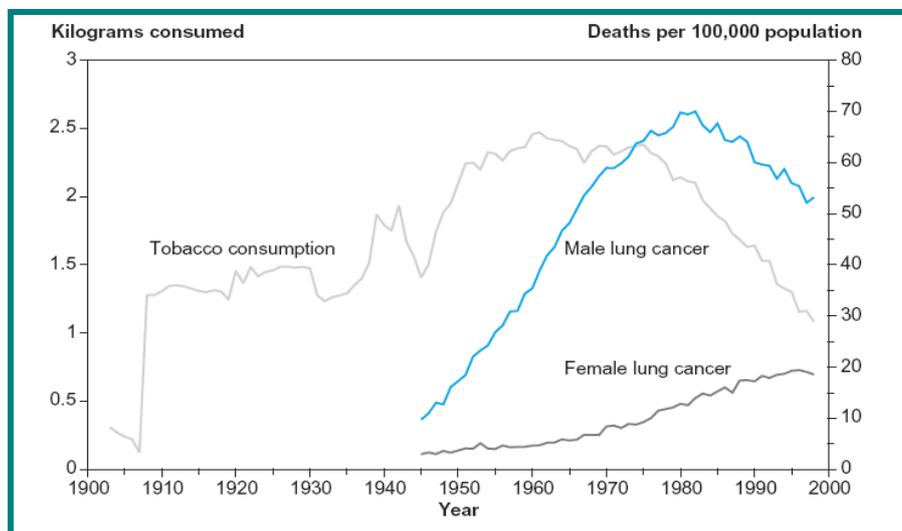


Source: AIHW, *Mortality over the twentieth century in Australia*, 2006, p. 54.

Tobacco consumption

While there was a major decrease in the consumption of tobacco products from the mid-1970s, the death rates reflect the lag time evident in the relationship between tobacco consumption and the development of lung cancer (Figure 6.1.1c).

Figure 6.1.1c: Per person consumption of tobacco products (left hand scale) and death rates from lung cancer, 1903-1998

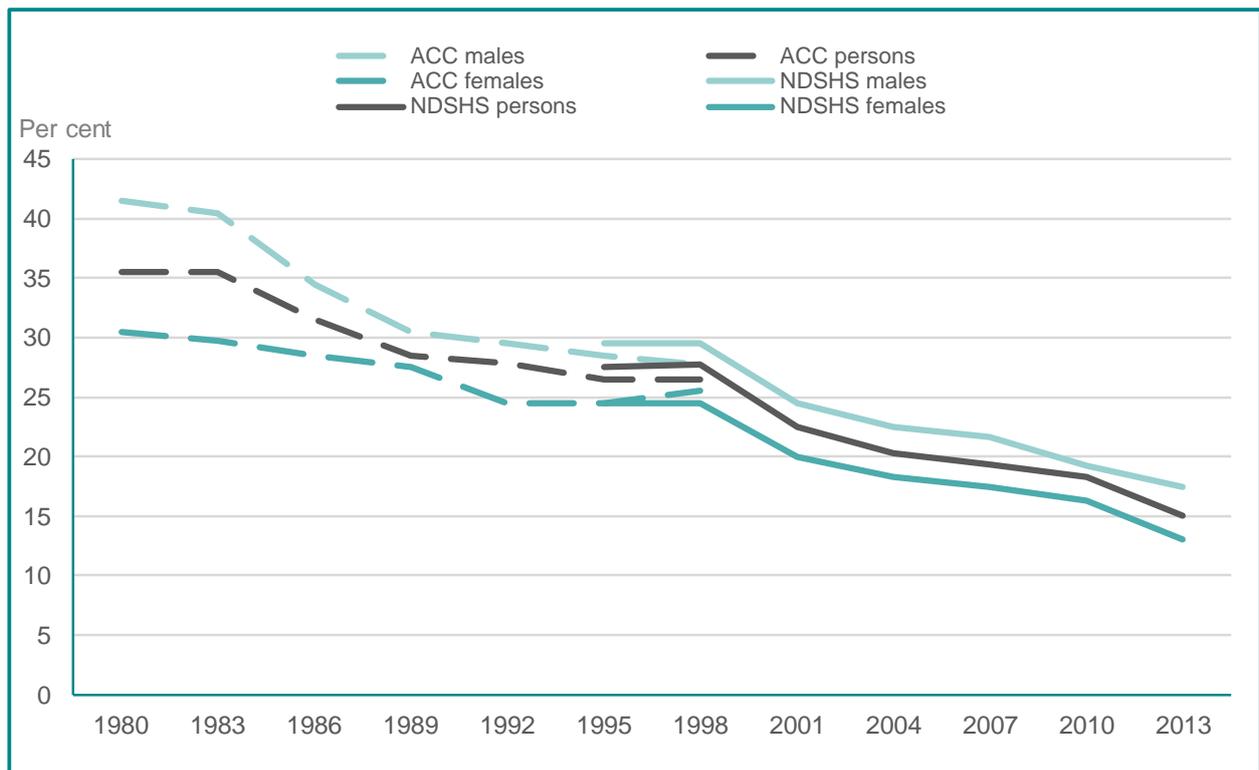


Source: AIHW, *Australia's health 2000*, 2000, p. 354.

Prevalence of smoking

Estimates from survey data showed that regular daily smoking rates for those aged 18 years and over more than halved in approximately thirty years from 35% in 1980 to 15% in 2013 (Figure 6.1.1d).¹³ Rates for males fell by 59% during this time and for females by 57%, giving a daily smoking prevalence in 2013 of 17% and 13% respectively.

Figure 6.1.1d: Prevalence of regular* smokers^ - population aged 18 years and over, 1980 to 2013#



* Anti-Cancer Council data includes those describing themselves as 'current smokers' with no frequency specified; NDSHS data include those reporting that they smoke 'daily' or 'at least weekly'.

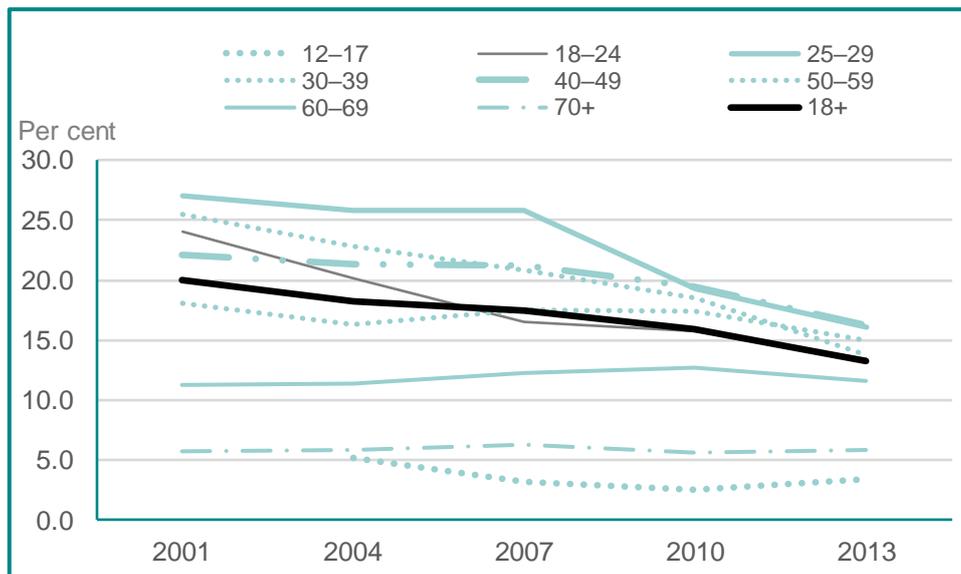
^ Includes persons smoking any combination of cigarettes, pipes or cigars.

Anti-Cancer Council data weighted to 2001 census population data, standardised by age and sex; NDSHS survey data weighted to the Australian population appropriate for each survey year and is not standardised.

Source: Chart by PHIDU; Reproduced from: Greenhalgh, E. M., Bayly, M., & Winstanley, M. H. (2015) 1.3 Prevalence of smoking—adults. In Scollo, M. M. & Winstanley, M. H. [Eds]. *Tobacco in Australia: Facts and issues*. Melbourne, Australian; Cancer Council Victoria.

The prevalence of daily smoking was estimated to be highest from 2001 to 2007 in the 25-29 age group, and then declined to a prevalence similar to that of those aged 40 to 49 years in 2010 to 2013 (Figure 6.1.1e).¹⁴ In 2013, 17.9% of men aged 40 to 49 reported being daily smokers and 15.0% of women aged 25 to 29 years. People aged 70 years and over were the least likely adult age group to be daily smokers, with an overall rate of 5.8% in 2013 (6.6% of males and 5.8% of females).

Figure 6.1.1e: Daily smokers - population aged 14 years and over, by age and sex, 2013



Source: Chart by PHIDU; data: AIHW, National Drug Strategy Household Survey, 2013, Tobacco chapter, Online data tables, November 2014

For Indigenous Australians, the daily smoking prevalence (15 years and over) was estimated to be 39% in 2014-15¹⁵ (almost three times the overall estimated prevalence for daily smoking for all Australians, of 15% in 2013 (aged 18 years and over)). However, daily smoking prevalence for Indigenous Australians had markedly decreased, from 50% in 2004-05.¹⁶ Data from ABS health surveys for years preceding this point until 1995 had recorded little apparent change.

Analysis of data from the *National Aboriginal and Torres Strait Islander Social Survey* in 2012-2013 revealed that the likelihood of risky health behaviours decreased with higher levels of schooling.¹⁷ The proportion of daily smokers in Aboriginal and Torres Strait Islander people who had completed year 12 compared to those who had completed year 10 or below was markedly different (28.0% compared to 50.8%). In addition, 54.4% of Aboriginal and Torres Strait Islander people who were unemployed were estimated to be daily smokers versus 36.0% of those estimated to be employed. These data suggested opportunities to further reduce smoking would be through improving the social determinants of health, in this case, the educational attainment levels of young Aboriginal and Torres Strait Islander peoples, and the employment rate.

Aboriginal and Torres Strait Islander mothers also had much higher rates of smoking during pregnancy than non-Indigenous mothers. For example, in 2014-2015, some 39% of Aboriginal and Torres Strait Islander mothers smoked or chewed tobacco at some time during their pregnancy¹⁸, compared with only 13% of non-Indigenous mothers (2012).¹⁹ This was an improvement from 2005 when 55%, and from 2001 when 59%, of Aboriginal and Torres Strait Islander mothers reported that they had smoked while pregnant.

There are many groups in the Australian population where there is still a high smoking prevalence. Although not a comprehensive list, examples include^{19,20}:

- *People with mental illness:* Australian research has reported smoking rates of up to 35% among patients suffering from common mental disorders and much higher rates in people with serious mental illness¹⁹ (around 66% in people with psychotic disorders²¹).
- *People in prison:* In 2012, 4 out of 5 (84%) prison entrants reported being a smoker.²²
- *People who are homeless:* An Australian research study found that 77% of people experiencing homelessness smoked.
- *People experiencing higher levels of socio-economic disadvantage:* There is a gradient in daily smoking prevalence with the highest prevalence observed in the most disadvantaged. In 2011-2012 the smoking prevalence in the most disadvantaged areas was 2.3 times that in the least disadvantaged areas (23.0% compared to 9.9%).²³ Parental smoking places a significant additional financial burden on large numbers of children living in low-income households.²⁴

Public health practices

In the latter part of the 19th century, strong anti-smoking views were held by colonial politicians, and the first legislative control over tobacco was enacted in 1882 (the SA *Smoking Regulation Bill*) to prevent children from using tobacco, as tobacco smoking was seen as 'the pathway to ruin'.²⁵ All the states enacted legislation to ban the sale of tobacco products to children aged under 16 years and, until the 1970s, these laws were the only restriction on the sale and marketing of tobacco.

By the end of World War II, nearly three quarters of adult males and a quarter of adult females smoked, and there was a substantial tobacco-growing industry in Australia, with some regions economically dependent on the crop.²⁶ By the 1950s, medical evidence was accumulating that tobacco smoking was harmful and was linked to the rising incidence of lung and other cancers. Tobacco smoking was then increasingly recognised as a public health problem. Federal legislation was introduced in the late 1960s to enable a health warning to be applied to cigarette packets, although the legislation was not enacted until 1973, when the message 'Warning - Smoking is a health hazard' first appeared on packets of cigarettes.²⁷ Bans on 'direct' (rather than incidental) radio and television

advertising commenced in 1976 under federal broadcasting legislation, and there were state bans on outdoor advertising from 1987 and, nationally, on advertising from 1992 (although there were some exemptions).

In 1987, as part of a landmark strategy, the Victorian *Tobacco Act 1987* levied a wholesale tax on tobacco products sold in Victoria to fund the Victorian Health Promotion Foundation (VicHealth), with a mandate to promote health and buy out tobacco industry sponsorship of sport and the arts. VicHealth quickly increased funding for QUIT and other health promotion programs, and replaced tobacco company sponsorship of sporting, arts and other events. VicHealth was the world's first health promotion foundation funded by a tax on tobacco, establishing the principle of 'hypothecation', in which tobacco taxes levied by the state are used to support health promoting organisations and activities to reduce smoking. The SA *Tobacco Products Control Act* was amended in 1988 and established Foundation SA²⁸ and Healthway, the WA health promotion foundation, commenced operation as a result of the WA *Tobacco Control Act 1990*.²⁹ In 1997 the High Court of Australia found that state franchise fees on tobacco were unconstitutional.³⁰

The *National Health Policy on Tobacco in Australia* was adopted by the Ministerial Council on Drug Strategy in 1991 as part of the National Campaign Against Drug Abuse. The policy's first premise was the acceptance of the need for a long-term and comprehensive program and it stated that there

*'... had long been recognition... that the resolutions to this problem lie not in a piecemeal approach but in the adoption of a carefully planned, comprehensive, long-term approach encompassing education and information, legislation and restrictive measures and cessation services.'*³¹

A framework for national tobacco control activities by the Australian, state and territory governments was then provided by the *National Tobacco Strategy 1999 to 2002-03*³² and its successors, the *National Tobacco Strategy 2004-2009*³³ and *National Tobacco Strategy 2012-2018*²¹ (Box 1). The strategies outlined long-term plans to improve health and reduce the social costs of tobacco in all its forms, and reduce associated inequalities.

From 1st February 2011, pharmacological support was made available to individuals as an aid to achieving abstinence through inclusion of Nicotine Replacement Therapy (NRT) products on the Pharmaceutical Benefits Scheme (PBS) for eligible individuals.³⁴ Previously, NRT was only available to Aboriginal and Torres Strait Islander people.

Health warnings were progressively strengthened over time with graphic warnings beginning in 2004 and, from 2012, graphic pictures, a warning statement and explanatory message were required to cover 75% of the front and back of every pack.²⁶ On 1st December 2012, Australia became the first country in the world to implement tobacco plain packaging through enacting the *Tobacco Plain Packaging Act 2011* (Box 2).³⁵ There have also been sustained increases in excise rates for tobacco, having increased by 25% in April 2010, 12.5% on four occasions from December 2013 to September 2016 and with the announcement in April 2016 of an additional four 12.5% excise increases from 1 September 2017 to 1 September 2020.³⁶ In addition, Australia is the only country in the world to index tobacco excise to wage inflation (average weekly ordinary time earnings) to ensure that tobacco products do not become relatively more affordable over time.³⁷

Box 6.1.1a National Tobacco Strategy 2012–2018: Guiding principles

"A strategy to improve the health of all Australians by reducing the prevalence of smoking and its associated health, social and economic costs, and the inequalities it causes."

The National Tobacco Strategy 2004-2009 delivered a range of achievements. There was a reduction in daily smoking prevalence (aged 18+) from 18.2% in 2004 to 15.9% in 2010.¹⁴ Notably, in 2008 the first sign of a reduction in smoking prevalence among Aboriginal and Torres Strait Islander groups (aged 15+) was evident from 49% in 2002 to 45% in 2008.³⁸ There was also progress on a number of measures including prohibiting advertising at the point of sale and a number of states and territories passed legislation to require cars to be smoke free when children are in the car.

However, challenges remain for tobacco control. The 2012-2018 Strategy therefore aims to provide a comprehensive approach as part of a sustained effort to tackle this. The strategy recognises the importance of committing to maintaining existing partnerships and building new ones.

The objectives of the 2012-2018 Strategy are to:

- Prevent uptake of smoking
- Encourage and assist as many smokers as possible to quit as soon as possible, and prevent relapse
- Reduce smoking among Aboriginal and Torres Strait Islander people, and other populations at higher risk from, or with a high prevalence of smoking
- Eliminate harmful exposure to tobacco smoke among non-smokers
- Reduce harm associated with continuing use of tobacco and nicotine products
- Ensure that tobacco control in Australia is supported by focused research and evaluation
- Ensure that all of the above contribute to the continued denormalisation of smoking.

Targets to achieve by 2018 are to:

- Reduce the national adult daily smoking rate to 10% of the population
 - From a 19.1%³⁹ (age-standardised) baseline in 2007-08
- Halve the Aboriginal and Torres Strait Islander adult daily smoking rate
 - From a 47.7%⁴⁰ (44.8% (age standardised)) baseline in 2008.

The nine priority areas for action in the 2012-2018 Strategy are to:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference
2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and reshape social norms about smoking
3. Continue to reduce the affordability of tobacco products
4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander people
5. Strengthen efforts to reduce smoking among populations with a high prevalence of smoking
6. Eliminate remaining advertising, promotion and sponsorship of tobacco products
7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems
8. Reduce exceptions to smoke-free workplaces, public places and other settings
9. Provide greater access to a range of evidence-based cessation services to support smokers to quit.

Source: Intergovernmental Committee on Drugs, *National Tobacco Strategy 2012-2018*, 2012, p. 12²¹

The public health activities that contributed to the long-term success in reducing tobacco smoking included:

- identification and promulgation of the risks of active tobacco smoking (which had been known from 1957), and of passive smoking (the first NHMRC report on passive smoking was published in 1986);
- tobacco control legislation including advertising bans and implementation of plain packaging (Box 2);
- reducing affordability of tobacco, through increases in tobacco excise and biannual increases in average weekly ordinary time earnings;
- regulation and policing of sales to minors and point of sale restrictions;
- QUIT programs, health education, social marketing campaigns and increasing availability of NRT through inclusion on the PBS;
- voluntary adoption of, and legislated, smoke-free places: offices, restaurants, clubs and hotels (and increasingly in outdoor dining areas of these venues), entertainment venues, cars and increasingly playgrounds, bus stops and malls;
- monitoring and publicising information on population smoking practices (e.g., tobacco smoking rates, age of uptake, numbers of children in smoke-free homes); and
- successive, comprehensive national strategies for tobacco control;
- funding e.g., Tackling Indigenous Smoking initiative through the COAG Closing the Gap Agreement⁴⁵ and advocacy from non-governmental and other organisations.

Box 6.1.1b Plain Packaging in Australia: A World First

The *Tobacco Plain Packaging Act 2011* came into effect in Australia on 1st December 2012.³⁴

*By the mid-2000s, attractive design of packs was one of the few ways that Australian tobacco companies could continue to promote their products. World-first legislation to standardise the packaging of tobacco was a response to this marketing strategy.*⁴¹

Tobacco advertising has been banned in virtually every form of media – on TV and radio through the 1970s, on billboards and outside shops during the 1980s, in the print media and through sports sponsorship during the 1990s and at point of sale from the early 2000s, with retail display of products banned altogether in most states from about 2010. Plain packaging was considered the next logical step.³⁶

Legal challenges were brought against the plain packaging scheme by the tobacco industry; however, the legislation was upheld by the High Court.⁴²

Post-implementation studies provide early evidence that the tobacco plain packaging measure is having a positive impact on the three specific mechanisms, of reducing the appeal of tobacco products, reducing the potential for tobacco packaging to mislead consumers, and enhancing the effectiveness of graphic health warnings.⁴³

Australia has led the way in implementation of tobacco plain packaging. It has now also been adopted in Ireland, France and the United Kingdom and is under formal consideration in a range of other countries.⁴⁴

Factors critical to success

In its review of one hundred years of mortality, the AIHW identified the reduction of more than 30% in male death rates from lung cancer (from the peak in these rates in the 1980s) as one of the notable successes of public health over the 20th century.⁴⁶ The relationship of tobacco smoking to lung cancer had long been studied, but, as lung cancer became the leading cause of death from cancer (and remained so at the end of the century), public health practitioners worked hard to develop ways to achieve reductions.⁴⁷

Initially, public health interventions were led by a small group of committed, visionary individuals, although Simon Chapman (one of these) disputed this, describing the ‘many, often unsung, people [who] have oxygenated the huge changes achieved in smoking in Australia’.⁴⁸ Jamrozik described how the strategies used to try to control tobacco had to be based on science, rather than on evidence of

‘Public health advocacy often requires pushing governments to act and being critical of inaction.’

–S Chapman, *Medical Journal of Australia*, 2002, p. 662.

Box 6.1.1c The WA QUIT Campaign

‘The WA QUIT Campaign was the first well-funded comprehensive health promotion campaign at a state level. It had a strong outcome in terms of achieving lower smoking rates and lower lung cancer rates than other states.’ – Survey respondent

From 1984 to 2004, the WA QUIT Campaign was conducted year round by QUIT WA (formerly the Smoking and Health Program), in the Population Health Division of the Department of Health, WA. The state-wide campaign encouraged and supported adult smokers to quit smoking.⁵²



‘Only dags need fags’

© State of Western Australia 1984, reproduced with permission.

The WA QUIT Campaign commenced in 1984, using the slogan ‘only dags need fags’ as part of the campaign: a slogan that was still memorable in 1998 among respondents to a survey who were asked what message came to mind after the interviewer said ‘smoking’.⁵³

Strategies implemented by QUIT WA were evidence based and consistent with the best international practice on tobacco control, and included:

- mass media campaigns,
- legislation,
- quitting support,
- school and public education,
- promotion and sponsorship of healthy behaviours,
- support for smoke-free policies,
- collaboration across sectors, and
- research and evaluation.⁵³

persistence in the face of adversity were significant factors behind the success.

Other elements were the use of a multifaceted strategy, a consistent message reinforced by fiscal measures and legislation enacted both federally and by the states and territories to control tobacco. Advertising and promotion of tobacco products by all media was banned in Australia, and campaigns marketed non-smoking behaviour and provided support for those wishing to quit.²⁵ The allocation of taxed funds (formally or otherwise) to attempt to control the consumption of, and remedy the harm done by the taxed product was also critical to the ability of health promotion programs to reduce tobacco consumption.

Public health monitoring of smoking rates and the provision of community information about tobacco (e.g., age of initiation of smoking, smoking cessation rates, smoke-free premises, and ways to quit) were intrinsic to the success of the strategy (Box 3). Detailed evaluations of tobacco control campaigns

their effecti

veness, because no one had attempted population-wide change on such a scale before and, therefore, no evaluative evidence of their likely success or failure was available.⁴⁹

Public health measures to reduce smoking threatened the industries that profited from smoking. These industries had significant resources to fund rear-guard actions to prevent, circumvent (e.g., in relation to advertising) or delay specific actions.⁵⁰ One example was the legal action brought by the Tobacco Institute of Australia Ltd. against the NHMRC in 1996, when it appeared likely that the NHMRC’s second report on passive smoking would lead to more rigorous restrictions on smoking in public places such as restaurants.⁵¹

Public health advocates faced many challenges from the tobacco industry, and, while the metaphors of David and Goliath or ‘being pecked to death by ducks’ lie at two extremes, it was a battle against vested interests, political inertia (in the face of compelling medical evidence) and the maintenance of the status quo.⁴⁸ Public health advocacy, sustained leadership by champions, many hands and

were also important, as they demonstrated the enormous costs of smoking and the potential savings associated with reductions in population smoking rates.

Cost-effectiveness

Cost-effectiveness studies have looked at a variety of aspects of tobacco control and used various study designs from ecological analyses, single or multi-strand evaluations, and modelling studies to clinical interventions.⁵⁴ The majority of these have concluded tobacco control programs to be highly cost-effective.

As with all economic evaluations the breadth of outcomes considered in the study may have a bearing on the conclusion reached. In assessing the cost-effectiveness of tobacco control interventions, it may be difficult for the whole breadth of outcomes to be included (for instance the benefits of reduced passive smoking, increased productivity, or wider social benefits). Therefore, the estimate of cost-effectiveness may be an underestimate of the true effect.

Studies have found substantial healthcare expenditure could be avoided by reductions in smoking prevalence.^{54,55} The VicHealth Centre for Tobacco Control (2003) calculated that if smoking prevalence was reduced from just over 20% to 15% over five years, at least 50,000 fewer Australians would die prematurely over the following 30 years, and reductions in health-care expenditure would total more than \$1 billion. Investment in tobacco control was therefore described as 'a blue chip investment', and it was calculated that

'a \$10 per capita tobacco control program modelled on international best practice would provide social rates of return higher than those of just about any other social policy'.⁵⁵

A study by Hurley calculated the positive impact of even short-term and modest reductions in smoking rates on the numbers of hospitalisations of people aged 35–64 years for heart attack and stroke, and the associated costs of two different scenarios, over a seven-year period.⁵⁴ In scenario 1, smoking prevalence decreased by 1% in the first year, and in scenario 2, smoking prevalence decreased by 1% each year for five consecutive years. Under scenario 1, almost 1,300 hospitalisations would be avoided over seven years, saving about \$20.4 million in health-care costs; and for scenario 2, over 4,000 hospitalisations would be avoided, saving about \$61.6 million (approximately 2.75% of the costs of hospitalisations for these conditions over the period).⁵⁵

Benefits are not limited to stopping smoking. A review of the association between childhood respiratory tract infection (RTI) hospitalisations and the introduction of smoke free legislation in England showed an immediate reduction of 3.5% in RTI admissions (11,000 in England). This equated to estimated annual savings of approximately £17 million (A\$35.4 million) over five years.⁵⁶

These studies showed that there were substantial gains still to be made through further investment in tobacco control. However, of more relevance to inform spending decisions are cost-effectiveness analyses of population level interventions. Evaluations have reported mass media campaigns, especially where sustained and intensive, quitlines, taxation measures and smokefree air laws (among other interventions) to be cost-effective.⁵³

A systematic review (2015) of economic evaluations of worldwide tobacco control mass media campaigns identified ten studies – all of which had found the campaign under study to be cost-effective. However, these campaigns were heterogeneous and it was therefore not possible to establish the necessary components of such campaigns.⁵⁷

The National Tobacco Campaign cost-effectiveness evaluation was the only Australian programme in this review. This campaign included intensive television broadcasting of new anti-smoking advertisements and increased funding for support services for smokers attempting to quit. An evaluation of the first six-month phase of the National Tobacco Campaign in 1997 estimated that a total of \$9 million had been spent (by Commonwealth, state and territory governments), with resultant savings of \$24 million, indicating that the campaign had paid for itself 'more than twice over'.⁵⁸ It was

estimated that the first six months had prevented 922 premature deaths and achieved an additional 3,338 person years of life up to the age of 75 years. This was a conservative estimate as the benefits were only considered over one year. Another analysis assessed the cost-effectiveness of the Campaign over the subsequent lifetime of quitters (censored at age 85 years).⁵⁹ Over the remaining lifetime of the 190,000 quitters, the analysis estimated there would be 55,000 fewer deaths as a consequence of quitting and a gain of over 400,000 quality-adjusted life years. Healthcare cost savings of around \$A740 million (discounted at 3% per year) were predicted. The predicted benefits of the National Tobacco Campaign were 30-fold to 100-fold greater than previously estimated. This analysis did not include broader societal benefits.

Future challenges

Achieving prevalence reductions in harder to reach groups: As described earlier, there are many population groups who have higher daily smoking prevalence than the overall population. Therefore, a key to future progress will be targeted action in these harder to reach groups, alongside continued measures decreasing prevalence in the whole population. These population groups include:

- Indigenous Australians, especially young people and pregnant women;
- People with mental illness, who are in prison, who are homeless, or other high smoking prevalence groups, including people in other socioeconomically disadvantaged groups.

Developing policy measures to appropriately manage the role of new products e.g. vaporised nicotine: Debate over potential harms and benefits of vaporised nicotine products (e-cigarettes) has been polarised with differing policy approaches internationally.⁶⁰ In Australia, the possession or use of nicotine in e-cigarettes without approval is illegal.⁶¹ Concerns over use of these products largely relate to their potential role in renormalising smoking, or in acting as a gateway to tobacco smoking for young people.⁶⁰ However, in other countries their potential contribution as an alternative means to encourage cessation has been endorsed by public health professionals (and others). Policy responses to this and other future challenges must be continually reviewed to minimise harms from tobacco smoking.

Further reducing exposure to secondhand smoke: there is potential to increase the range of smoke-free environments (and reduce exemptions and achieve consistency across Australia) to include prisons, mental health facilities and residential care, al fresco dining areas, as well as the grounds and outdoor areas of hospitals and health services.

Health service responses: Hospitalisation provides a 'powerful teachable moment' for patients when staff are trained to ask about smoking status and provide appropriate assessment, advice, assistance and referrals.⁶²

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