The progress of tobacco control in Western Australia:

achievements, challenges and hopes for the future.

Cancer Council Western Australia

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Foreword

The fight for public health is a long and difficult battle against ignorance, vested interests, and social inequities. Nonetheless, progress in Western Australia in addressing smoking has been one of the great success stories of public health in the latter part of the twentieth century. Smoking and cigarette advertising used to be ubiquitous, but today, most adults do not smoke, fewer children are taking up the habit, and smoking is seen by the community as a serious public health problem. This huge change is testimony to the persistence and drive of many individuals and organisations over the decades. These campaigners have made the public aware of the dangers of smoking for smokers and non-smokers alike, and have publicised the misdeeds of the tobacco industry. Most importantly they have convinced politicians and bureaucrats that action could be taken to curb the use of tobacco.

This publication is timely. It brings together for the first time a comprehensive account of tobacco control in Western Australia, the achievements, challenges, and hopes for the future. In doing so, it also provides a blueprint for other equally intractable public health issues that are only now starting to attract the public and political interest they ought to have.

In reflecting on progress in tobacco control in Western Australia, we can rejoice in the lives it has saved and in the health it has given back to ex-smokers. But much remains to be done. There is still a need for concerted action, regular review of achievements, and the invention of new tactics. We also have to ensure that a proper level of government investment is maintained, so that we can continue to support robust and innovative legislative programs and powerful public education programs. The simple fact is, tobacco is still a major killer despite the gains made over the past four decades.

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- Maurice Swanson, Professor Michael Daube, and Addy Carroll in verifying the historic accuracy of key events in tobacco control in Western Australia.
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- our authors whose contribution to this publication and tobacco control overall have been considerable.

This publication has been a long journey, being conceived in May 2006. For public health advocates of tobacco control, it has been a longer and harder journey with no end in sight – yet. We recognise your efforts and hope that this publication will cause others to ponder on what you have made possible and be inspired to join with you in your important work.

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Contents

Introduction

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Australia has achieved greater falls in daily smoking prevalence than any other nation other than Canada[1] and, with the exception of the Australian Capital Territory, Western Australia has attained a lower adult smoking prevalence than any other state[2] and the lowest level of smoking by youth. There are some Asian and west African nations which have lower smoking levels, but this is mostly explained by their deep cultural proscriptions against female smoking. Asian women do not smoke much, so when you combine them with men, several Asian nations have a lower combined sex smoking prevalence than Australia. By any world standard, Australia has done a lot of things right and much of it has been pioneered in Western Australia.

Since the early 1960s when the early evidence against smoking was first consolidated, Australia has seen four broad eras of contemporary tobacco control:

Era 1 ran from about 1962 to 1973. These were eleven years when newspapers regularly publicised the emerging bad news about smoking, but also when governments failed to introduce any tobacco control measures. It was when Cotter Harvey, the founder of the Australian Council on Smoking and Health (ACOSH) and Nigel Gray, then head of the Anti-Cancer Council of Victoria, laid the foundations of modern tobacco control advocacy. Driven almost entirely by negative news coverage, tobacco use started heading south, to never again head upward.

Era 2, from 1973 to 1982, saw the first health warning peeping from the bottom of cigarette packs and on advertising and thanks to the Whitlam and Fraser governments, the first body blow to tobacco advertising, with the ban on TV and radio advertising that entered into force in September 1976. The downward slide picked up speed. As Daube and Walker document in this report, Western Australia was in the vanguard with early State bills to ban tobacco advertising in other media and did the world a service by providing a stage for the industry to rehearse a pattern of arguments that we all learned to critique in our sleep.

Era 3, from 1982 to 2006, saw the commencement of the first sustained government Quit campaigns and in the early period, the heyday of BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions) – with a local West Australian chapter – which radicalised the advertising debate and made it suddenly more respectable for previously conservative medical associations and colleges to rattle the legislative cage. Era 3 saw the second-hand smoke juggernaut, turbo-charged with accumulating evidence by the mid-1980s, denormalising[3] smoking forever. Reduced smoking opportunities caused by smoke-free policies precipitated an unprecedented fall of about 20% in daily consumption by continuing smokers.[4]

Today, we are in the early days of a fourth era of tobacco control. Nearly all the traditional platforms of comprehensive tobacco control have been checked off:

- our cigarettes are among the most expensive in the world
- tobacco advertising has ceased in all 'above the line' media and retreated into the unregulated Internet and viral marketing
- the battle to have public smoking exiled outdoors is almost over with the end of smoking in bars following restaurants and indoor workplaces. Casino high-roller rooms remain the last bastion of a Dickensian application of occupational health law, with it being apparently acceptable to allow the very rich to ignore the health rights of casino workers

- tobacco packs have been desecrated beyond the imagining of thirty years ago, so instead of smokers passing their friends a designer-crafted box of social promise, smokers pass a photo of an unforgettable gangrenous foot, or a cancerous mouth.

On any global ranking of comprehensive tobacco control, Australia is in the top five nations. BAT calls us 'one of the darkest markets in the world'.[5]

Smoking has become a symbol of an incompatible antithesis of powerful value systems that thousands of times a day evoke environmental concern, the fresh food movement, oral freshness, clean air, concern for others, ethical business conduct, and of course health.

There are several possibilities for the future: tobacco use could go down at about the rate it has over the past decade; it could go down even faster; or it could go down for a few more years and then bottom out to a 'hard core'. A rise in tobacco use seems unimaginable unless governments were to become complacent. So which scenario is more likely?

If the past is our guide, we may see the virtual end of smoking as a significant public health phenomenon in Australia by 2030. But in fact this may be underestimating what might happen. The gradient of the downward slope has increased in recent years from an average annual decline of 7% in the early 1990s to one of over 10% in the past seven years.[6] Youth smoking has fallen to the lowest levels ever recorded[7] so the powerful cohort effect of this will further reduce adult smoking as the years progress.

It therefore seems more likely that things will get even worse for smoking. The Rudd government's commitment to chronic disease prevention has already shown signs of investment in tobacco control. If industry opposition is a guide, the March 2006 pack warnings will be twisting the knife very hard; as will the 2006–2007 indoor area pub smoking bans. Retail displays are starting to disappear and plain, generic packaging is in the early stages of advocacy.[8] All this suggests that the free fall we are seeing will only accelerate. The next round of national prevalence data is highly anticipated.

The 'hard core' scenario (the idea that we may have reached a point where the remaining smokers are deeply addicted and unresponsive to the normal range of interventions) has been examined by Ken Warner and David Burns[9] in the USA. They conclude that while there are certainly sub-populations of hard-to-crack smokers – particularly among those with mental health problems – there is little evidence that the smoking population as a whole is 'hardening': cessation rates have not decreased; daily consumption is falling (something wholly incompatible with the hardening hypothesis of the smoking population) and the prevalence of occasional smokers rising;[10] truly hard-core smokers comprise a small fraction of all smokers; and quitting-susceptible smokers continue to dominate the smoking population.

In Australia today, a large majority of smokers want to quit and the experience of 'regret' at having commenced is nearly universal.[11] This is no different than it has been for decades, and presents the same challenges: to get lots of smokers to the cessation starting line to make quit attempts,[12] supporting them and preventing relapse. The view that we will soon reach a granite rock bottom of (say) 10% of people smoking is pure pessimism and not supported by any good evidence. Western Australia may be the first state to reach 10% and then show what is possible beyond that.

So, how can we make sure we whip all this along harder? I believe we hold three aces that we need to nurture and play hard and often.

Denormalisation

Community attitudes against smoking have never been stronger. The iconography of smoking today has radically changed from the ways Richard Klein saw it in his book documenting the way smoking came to connote a wide range of positive virtues.[13] For decades smoking connoted a ritualistic, seductive, contemplative engagement that worked beautifully for tobacco. Today, the public face of smoking is one of people at the back of every social queue, marginalised, regretful, apologetic, dependent, inconsiderate, resented for demanding work breaks, bravely trying to cover up the smell. While smoking might have once signified rebelliousness and style, today it often connotes a sad, bygone, sickly dependency. Winfield isn't for winners, but for losers; Peter Jackson smokers aren't laughing: they are more likely to be moping outside an office block; and the notion that Alpine is 'fresh', as its advertising used to say, is almost laughable.

Without advertising, this is unlikely to reverse. The widespread and growing antipathy about smoking presents largely unexplored opportunities for encouraging a vast 'reserve army' of tobacco control activists to express themselves more. Harnessing this as a force for advocacy for future policies such as further tobacco tax increases, generic packaging and bans on retail displays should become a priority. Imagine if even one in four doctors became active lobbyists for 'finishing the job' in tobacco control.

While smoking was once normal, it is now increasingly abnormal. With the exception of some Indigenous communities where urgent effort is needed, there is no age group, socioeconomic group or non-English speaking group in Australia where a majority of people smoke. Mohammad Siahpush's work shows 35% of single mothers smoke.[14] In other words, 65% don't. The old refrain that the poor are surrounded by smokers is no longer true. Someone waking from a twenty-year sleep would be amazed how the cultural landscape of smoking has changed. By feeding new information and data into this mix via news and campaigns, we can continue to foment the cultural erosion of smoking.

The tobacco industry's pariah status

A vital part of denormalisation has been the way the tobacco industry has become a pariah industry.[15] People routinely reach for analogies about the tobacco industry when they want to paint a word picture of ethical bottom-feeding.[3] The tobacco industry has been thrown out of nearly every sporting, cultural and academic forum in Australia, and even tossed from its own corporate nest: some corporate social responsibility meetings have excluded its participation.[16] As the American Cancer Society's John Seffrin puts it, no politician wants to stand next to a pariah in the next photo opportunity.

Stan Glantz reminds us that the tobacco industry are like cockroaches: they spread disease and they don't like the light of day to shine on them. Targeting individuals and calling them to account – in the way former NSW Premier Nick Greiner was spotlighted when he later headed BAT[17] – distracts and further tarnishes the industry. It takes a certain sort of ethically anaesthetised person to join the tobacco industry today. It is not where our brightest marketing graduates want to end up. A weak tobacco industry whose political presence is akin to being seen with the Grim Reaper, can only assist tobacco control to grow even stronger.

Population orientation

In Australia, we have always understood that if we were to get on top of smoking, we needed to match the sheer size of the task with the strategies we bring to changing it. We have used mass reach legislation, tax, campaigns and advocacy to get tobacco control messages into the homes and offices of millions of Australians.

There are some who are keen to see Australia go down the UK path and establish a large national network of dedicated smoking cessation clinics. However, a 2005 report[18,19] examining the contribution of this massive program to meeting a target national UK smoking prevalence of 21% by the year 2010, stated:

> *Nationally, stop smoking achieved a reduction in prevalence of 0.51% in 2003-2004. If persisting up to 2010, this success rate would lead to a reduction in prevalence of 3.6% – i.e. from the current level of 26% to 22.4%. For stop smoking service alone to meet the target of 21%, in England the number of successful quitters each year would need to be 50% greater.*

However, in a remarkably understated next paragraph, the report continues:

> *... since successful quitting [in these calculations] is measured by a self-report at 4 weeks and only 25% of smokers remain quit at 12 months ... all the estimates of reduction in prevalence calculated in this report* ***could legitimately be divided by four*** *(my emphasis) – producing an overall reduction of 0.13% per year or around 1% (from 26% to 25%) by 2010 for England.*[18]

The above statement that 'only 25% of smokers remain quit at 12 months' also contrasts with a published evaluation of the program's cessation where, at one year, one in seven (14.6%) of smokers who had attended the English tobacco treatment services were still not smoking.[19] In 2005, Milne[20] examined use of government-supported smoking cessation services in two English regions with the highest numbers of smokers using such services. Comparable with the above caveat, he calculated an annual reduction in smoking prevalence in the region attributable to the cessation services of 0.12%, (a figure corrected later by others as 0.15%[21]) whereas the background quit rate was 1.5%-2%, ten to thirteen times higher.

This is not the way to keep the downward momentum going. Major investment in labour-intensive smoking cessation may threaten the resources dedicated to population-focused campaigns.

Finally, let's consider two potential dangers in the road.

Complacency

All working in tobacco control in Australia have heard others arguing that smoking has been 'done'. But tobacco deaths and disability still have daylight between them and the next contenders. Australia's track record in reducing smoking and the diseases it causes ranks with AIDS control, immunisation and lowering the road toll as modern public health success stories. But it has been a long time since smoking made it to the list of any urgent national health priorities. Obesity, suicide, breast cancer, bird flu, and bioterrorism have all been much more politically fashionable in recent years. The Rudd government's recent announcement of $14.5m for Indigenous tobacco control over four years may be a sign of new thinking.

Keeping the issue alive

In one sense, we are victims of our own success. As we tick off every policy victory, we reduce potential media interest. There are few news stories about tobacco advertising when you don't have tobacco advertising. In the next decade we need to give a lot of careful and creative thought to how to refresh media, political and public interest in tobacco control. 'Finishing the job', 'making smoking history' and giving greater attention to hard-to-reach groups, especially the Indigenous community, will be the organising concepts. Western Australia is well positioned to continue providing leadership in all of these areas.

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Tobacco use and health

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Introduction

Tobacco smoking is a leading risk factor for death and disability in Australia. Tobacco use is associated with the development of many diseases, both life threatening and debilitating, including conditions related to passive/involuntary smoking.

Of the fourteen major risk factors of disease studied, tobacco smoking was responsible for 7.8% of the total burden of disease in Australia in 2003.[1] Among males, tobacco smoking is the leading cause of disease-burden compared with other major risk factors, with 9.6% of the total burden attributed to tobacco smoking.[1]

The tangible social costs of tobacco use in Western Australia were estimated at $430.7 million in 1998-99. The health care component of the tangible costs was $105.5 million of which hospital costs contributed $43.1 million.[2]

A reduction in the prevalence of smoking has the potential to prevent the development of disease, save lives and reduce hospital costs. The prevalence of smoking has been declining in Australia since the early 1970s. The decrease began among males, with the decrease in female smoking prevalence not beginning until the late 1980s.[3,4]

This paper describes the decrease in prevalence among the genders and age-groups over the last two decades in Western Australia. It measures the impact of tobacco use in terms of deaths and hospitalisations on the West Australian population and demonstrates the benefits of the reduction in prevalence over the last twenty years by quantifying the number of deaths, hospitalisations and hospital costs saved by the decrease in prevalence.

To highlight opportunities for further reduction in prevalence by identifying at-risk groups, the paper also describes the influence of regional, Aboriginal and socioeconomic variation in smoking prevalence on tobacco-related deaths.

Method

The study focuses on the change of smoking prevalence and its impact on health in terms of deaths and hospitalisations over the period 1984 to 2004. The reason for selection of the study period is the availability of smoking prevalence and health data.

Prevalence of tobacco use

Smoking prevalence data for Western Australia over the study period were obtained from three surveys, all conducted by the Department of Health. The National Health Survey[5] and the National Drug Strategy Household Survey[6] show overall prevalence figures for Western Australia to be similar to the Department of Health surveys. The Department of Health surveys were selected because the larger sample size allowed estimates for gender, age, region and socioeconomic status. Also, the West Australian surveys were conducted more frequently over a longer period of time.

The prevalence of current smokers was obtained from the Tobacco and Alcohol Consumption Survey for the years 1984, 1985, 1987, 1991, 1994 and 1997. In this series of surveys a current smoker was defined as anyone who smokes daily or at least seven times per week. Smoking prevalence data for 1995 and 2000 were obtained from the Western Australian Health Survey (WAHS). The Western Australian Health and Wellbeing Surveillance System (WAHWSS) measured the prevalence of current smokers in Western Australia during 2002 to 2006. Both the WAHS and the WAHWSS define a current smoker as anyone who currently smokes, either occasionally or daily.

Smoking prevalence data for regional areas and socioeconomic groups were obtained from the WAHWSS for the period 2002 to 2004. Reliable gender and age-specific estimates could be obtained only for regional areas grouped into metropolitan, rural and remote regions. The remote region was defined as the Kimberley, Pilbara and Goldfields regions combined, while the rural region was made up of the South West, Great Southern and Wheatbelt regions. Socioeconomic groups were based on the quintiles of the distribution of values of the Socioeconomic Indexes For Areas (SEIFA) index of disadvantage developed by the Australian Bureau of Statistics from the 2001 Census.[7]

Smoking prevalence in the West Australian Aboriginal population was obtained from the National Aboriginal and Torres Strait Islander Health Survey 2004–2005 in the absence of reliable West Australian data.

The prevalence of smoking during pregnancy was sourced from the Western Australian Midwives Notification System from 1998 to 2004 and the prevalence of household smoking was sourced from the National Drug Strategy Household Surveys in 1995, 1998, 2001 and 2004.

Death and hospitalisation records

Death information for 1984 to 2004 was extracted from the Western Australian Mortality Database on the basis that the underlying cause was known to be associated with tobacco use. Hospitalisation data were obtained for 1984 to 2004 from the Western Australian Hospital Morbidity Data System with a principal diagnosis or external cause related to tobacco smoking. For each cause, the number of deaths and hospitalisations were extracted by five-year age-groups and gender.

Tobacco-related conditions

The tobacco-related conditions included in the analysis were those identified in 1995[8] and updated in 2001.[9] Since the release of these reports a further review was conducted in 2007[1] which identified additional conditions (Table 1). Conditions caused by harm due to both direct and passive tobacco smoking were included in the analysis.

Table 1 **Tobacco-related conditions grouped into four categories used in the study**

Cancer	Cardiovascular	Passive/involuntary	Other
Oropharyngeal	Ischaemic heart disease	Low birthweight	Parkinson's disease[a]
Oesophageal	Pulmonary circulatory disease	SIDS	Chronic obstructive pulmonary disease (COPD)
Stomach	Cardiac dysrhythmias	Asthma (0–14 years)	Crohn's disease
Anal	Stroke	Lower respiratory tract infection (0–4)	Ulcerative colitis
Pancreatic	Peripheral vascular disease	Lung cancer	Ectopic pregnancy
Laryngeal		Ischaemic heart disease	Fire injuries
Lung		Otitis media	Tobacco abuse
Endometrial[a]			Hypertension in pregnancy[a]
Vulva			Antepartum haemorrhage
Penile			
Bladder			
Kidney			

[a] Tobacco provides a protective effect for these conditions

Aetiological fractions

Tobacco-related deaths and hospitalisations for each condition were determined by applying age and sex specific aetiological fractions to the age and sex specific counts for each year for which prevalence data were available.

For cancers and chronic obstructive pulmonary disease (COPD) there is a long time lag between exposure to tobacco smoke and the development of associated disease. Current smoking prevalence is therefore not applicable in calculating the aetiological fraction for these conditions. To determine past exposure for cancers and COPD a synthetic prevalence was derived.[10] For other tobacco-related conditions the time between exposure and disease development is considerably shorter and so the current smoking prevalence was used to calculate condition-specific aetiological fractions by the population-attributable fraction method.[8,9]

To calculate aetiological fractions by the population-attributable fraction method the age and gender-specific smoking prevalence for each year was applied to the relative risks of developing each disease given exposure. The relative risks used in each calculation were those identified by previous studies.[1,9]

For conditions associated with involuntary/passive smoking the prevalence data for household smoking were used to calculate the aetiological fractions for SIDS, lower respiratory tract infection in children younger than 5 years, asthma in children younger than 15 years and otitis media. In adults the fractions for antepartum haemorrhage, low birthweight, hypertension in pregnancy and spontaneous abortion were derived from the prevalence of smoking during pregnancy. Data for these were not available for all years,

so the prevalence of the closest year was applied. This will most likely result in an underestimate of the aetiological fractions for earlier years as the prevalence of maternal smoking (personal communications, Maternal and Child Health Unit, Department of Health, Western Australia) and household smoking[11] have decreased in recent years. Therefore, the deaths and hospitalisations attributed to tobacco for maternal and passive smoking will be underestimates for earlier years.

In the absence of specific West Australian data, aetiological fractions previously derived for fire injuries were applied to data from all years.[9]

Rate of deaths and hospitalisations

Age-specific and age-standardised rates of tobacco-related deaths and hospitalisations were calculated using population figures obtained from the ABS, using the Australian 2001 population to standardise the rates. Rates were calculated for all tobacco-related deaths and hospitalisations and for four disease groups: cancers, cardiovascular disease, conditions associated with passive/involuntary smoking and the remainder (Table 1).

In the analysis of regional, socioeconomic and Aboriginal variation of tobacco-related deaths five years of data (2000 to 2004) were aggregated to increase the precision of the estimations. Standardised mortality ratios (SMR) were calculated to compare the regional, Aboriginal and socioeconomic group rates of tobacco-related deaths with the State rate.

Hospital costs

The average cost per admission for each condition was derived for 2004 hospitalisations. The costs attributed to each condition were calculated by summing the Australian National Diagnostic Related Groups (version 4.2) national public sector cost weights for each hospitalisation of a specific condition. The average cost for each condition was calculated by dividing the total cost for each condition by the number of hospitalisations for that condition.

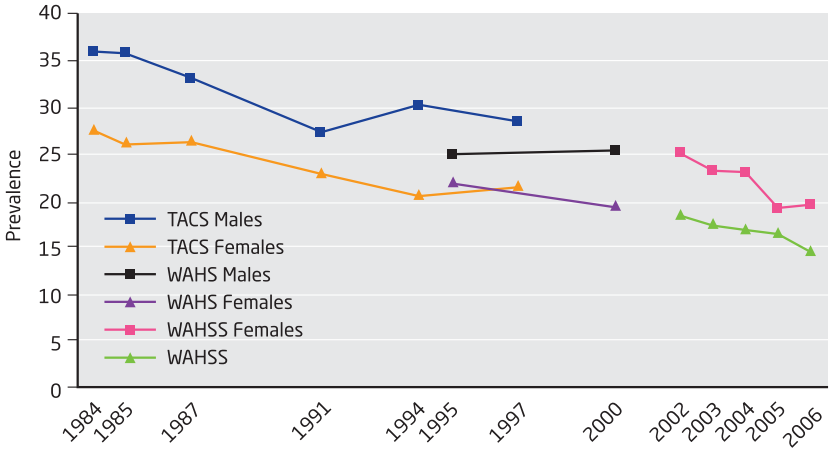
The average cost for each condition in 2004 was then applied to the estimated number of hospitalisations each year by condition. Hospital costs saved annually were calculated by subtracting estimated costs for each year from the costs based on the hospital costs estimated by applying 1984 prevalence data for each year.

Results

Prevalence of tobacco use

Although the prevalence data were sourced from three different surveys with different methods and definitions, the results fit a consistent trend showing a marked decrease in prevalence over the last two decades. During the period 1984 to 2006, the overall prevalence among males decreased from 35.9% to 19.6%, but remained higher than the female overall prevalence. The female overall prevalence decreased by a smaller amount from 27.6% to 14.7% over the same period. During the 1980s the female overall prevalence remained stable and there was no marked decrease until 1991 (Figure 1).

Figure 1 **Overall current smoking prevalence by gender, Western Australia, 1984 to 2006**



The decrease in smoking prevalence over the last two decades was reflected across all age groups. While the smoking prevalence has decreased among all age groups, the largest decrease was among the youngest age group (18 to 24 years) for both genders.

In 1984 the youngest age groups had the highest prevalence of all age groups for both genders (44% for males and 40% for females). By 2006 the prevalence for 18 to 24-year-olds had decreased to 14% for both genders and the highest prevalence was among the 25 to 44-year age-group (Table 2).

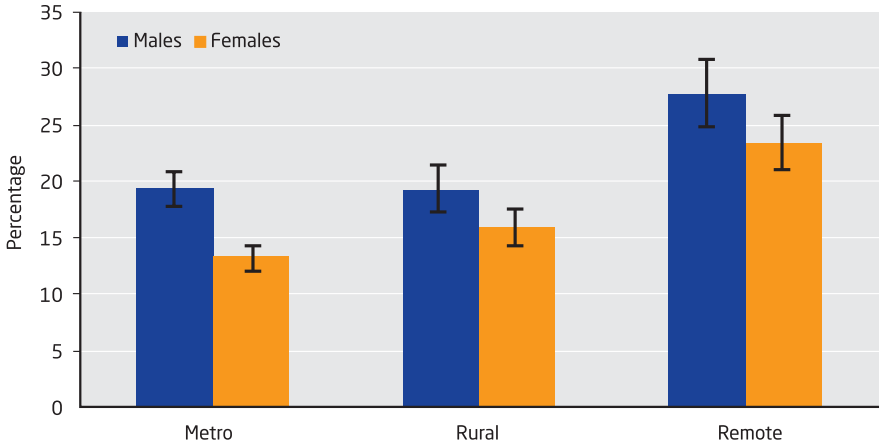
Table 2 **Age-specific prevalence of current smokers in Western Australia, 1984 to 2006**

	Males				Females			
	18-24	25-44	45-64	65+	18-24	25-44	45-64	65+
1984	44	38	33	21	40	28	28	28
1985	40	39	32	24	42	27	24	11
1987	39	34	33	19	38	29	23	12
1991	33	29	26	15	30	25	23	11
1994	39	34	25	16	27	24	17	11
1995	23	30	24	14	29	22	18	13
1997	35	33	25	13	30	27	16	10
2000	32	31	21	10	22	24	19	8
2002	29	29	24	14	23	26	18	6
2003	20	30	25	10	21	22	19	7
2004	19	27	28	7	17	24	17	8
2005	17	27	19	8	13	24	17	8
2006	14	25	21	8	14	19	15	6

Sources: 1. Tobacco and Alcohol Consumption Study, Health Promotions Branch, Department of Health (1984-1994, 1997).
2. WA Health Survey, Epidemiology Branch, Department of Health (1995, 2000).
3. WA Health and Wellbeing Surveillance System (2002-2006).

Data from the WAHWSS were aggregated over three years (2002 to 2004) to derive smoking prevalence figures for regional areas of Western Australia. The only significant difference between the genders was in the metropolitan area, where the male prevalence (19.4%) was significantly higher than the female prevalence (13.4%). While the prevalence in the metropolitan and rural areas for both genders was similar, prevalence in the remote area among males (27.6%) and females (23.3%) was significantly higher than their counterparts in the other regions (Figure 2).

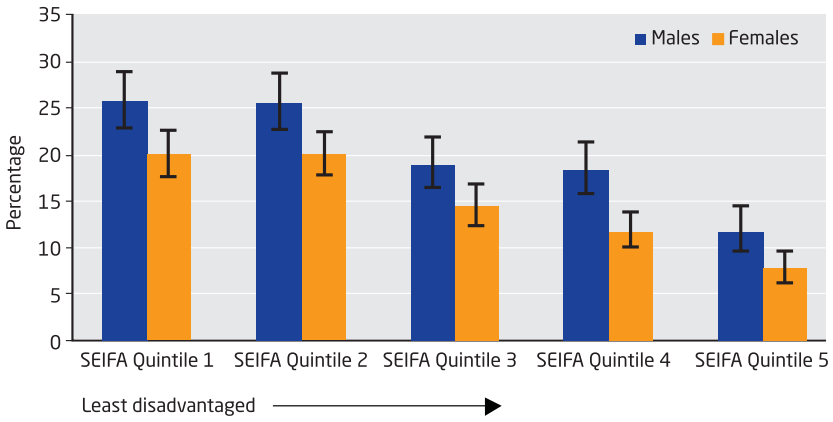
Figure 2 **Current smoking prevalence for metropolitan, rural and remote areas, by gender, 2002 to 2004**



Source: WA Health and Wellbeing Surveillance System, Department of Health, Western Australia.

Prevalence data for the socioeconomic groups indicated a clear gradient of decreasing smoking prevalence with decreasing socioeconomic disadvantage. While the prevalence among the two most disadvantaged groups was similar for both genders, it was significantly higher than both genders in the other groups. The prevalence for both genders of the least disadvantaged group was significantly lower than their counterparts in the other groups (Figure 3).

Figure 3 **Current smoking prevalence by socioeconomic group, Western Australia, 2002 to 2004**



Source: WA Health and Wellbeing Surveillance System, Department of Health, Western Australia.

Results from the National Aboriginal and Torres Strait Islander Health Survey 2004/2005 showed that the prevalence across the age groups among the Aboriginal population in Western Australia was much higher than the prevalence figures for the total West Australian population (Table 3).

Table 3 **Current smoking prevalence, Aboriginal people, Western Australia, 2004–2005**

	Males	Females
18–24	55.4	54.5
25–34	56.2	64.0
35–44	41.2	59.7
45–54	28.2	39.6
55+	28.8	14.3
Total	**44.6**	**50.8**

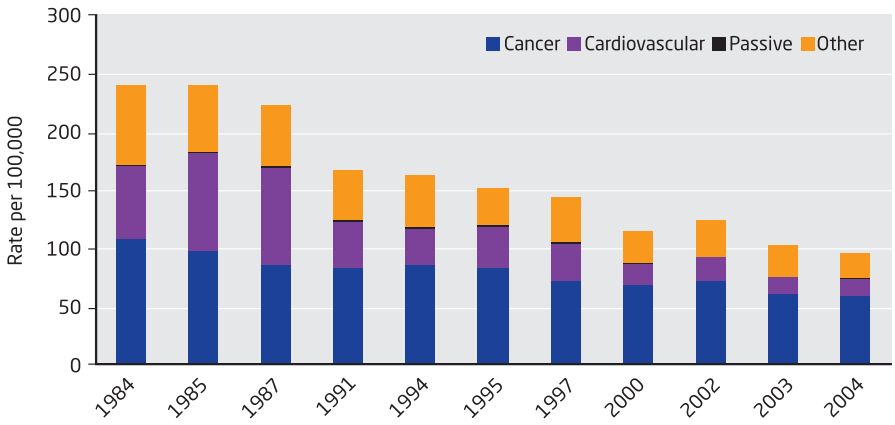
Source: National Aboriginal and Torres Strait Islander Health Survey 2004–2005, ABS.

Data obtained from the Western Australian Midwives Notification System indicated that in 2005, 17.1% of mothers reported smoking during pregnancy. The prevalence of smoking during pregnancy decreased from 22.9% in 1998.

Deaths

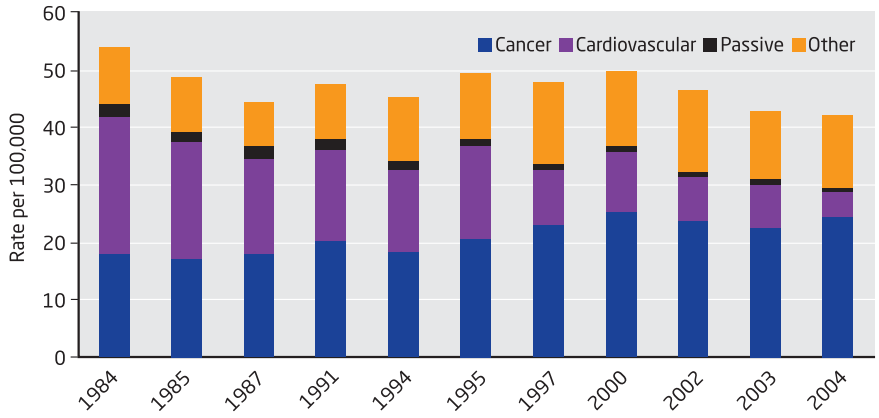
In 2004 there were an estimated 789 male deaths attributed to tobacco in Western Australia at a rate of 95 per 100,000 person-years. Over the period 1984 to 2004 the rate of death due to tobacco-related diseases in males decreased significantly by an average of 3.8% annually (Figure 4). The decrease was explained by a significant decrease in cardiovascular (7.2%), cancer (2.0%), passive (7.0%) and other conditions (3.8%).

Figure 4 **Age-standardised death rate attributable to tobacco among West Australian males, 1984 to 2004**



The rate of tobacco-related deaths was much lower in females than males, reflecting the lower smoking prevalence among females. In 2004, there were an estimated 439 deaths attributable to tobacco at a rate of 42 per 100,000 person-years. Over the period 1984 to 2004 the tobacco-related deaths in females decreased significantly on average by 0.6% annually, although death rates increased in the 1990s (Figure 5). The decrease was due to cardiovascular (5.8%) and passive conditions (6.2%) as rates for cancers (1.7%) and other conditions (2.5%) increased significantly from 1984 to 2004. From 2002 to 2004 there was a stabilisation of the cancer death rate.

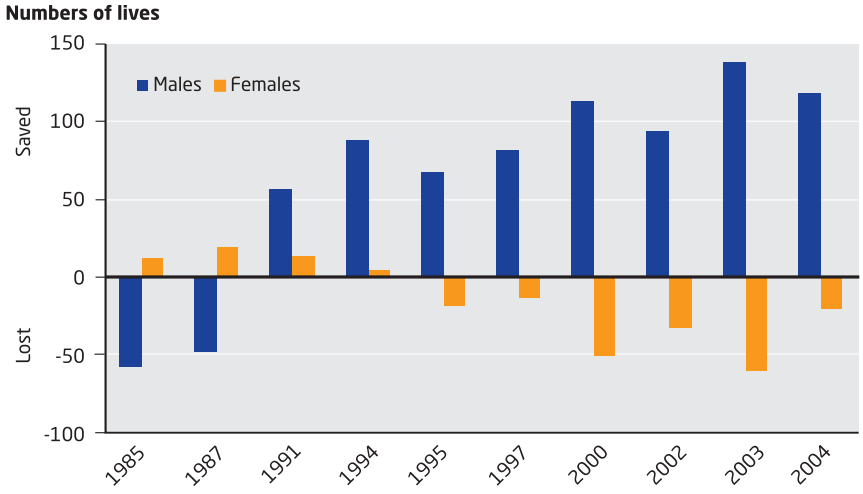
Figure 5 **Age-standardised death rate attributable to tobacco among West Australian females, 1984 to 2004**



However, the trends in death rates attributable to tobacco reflected that of the death rates for the total deaths for each condition. Changes in the prevalence of tobacco use were likely to be responsible for only part of the trends, with many other influences affecting the death rates from these conditions. To calculate the number of lives saved by a decline in smoking prevalence, firstly the number of deaths expected for each year if the prevalence remained constant was determined by applying the population attributable fractions derived for 1984. The expected number of deaths was then compared with the number obtained by applying population attributable fractions derived for each year. The population attributable fractions for 1984, derived from estimation of synthetic prevalence reflecting past exposure, were held constant when calculating the expected number of deaths for cancers and COPD for each year.

By 2004, the number of male lives saved annually, resulting from a decrease in smoking prevalence, had reached 119. The number of lives saved or lost in females was lower due to the lower rate of death attributed to tobacco in females. In females, 195 lives were lost from 1995 to 2004, in comparison with 1984. By 2004 an estimated 20 lives were lost compared with 1984 (Figure 6).

Figure 6 **Number of deaths saved/lost due to changes in smoking prevalence from 1984, by gender**

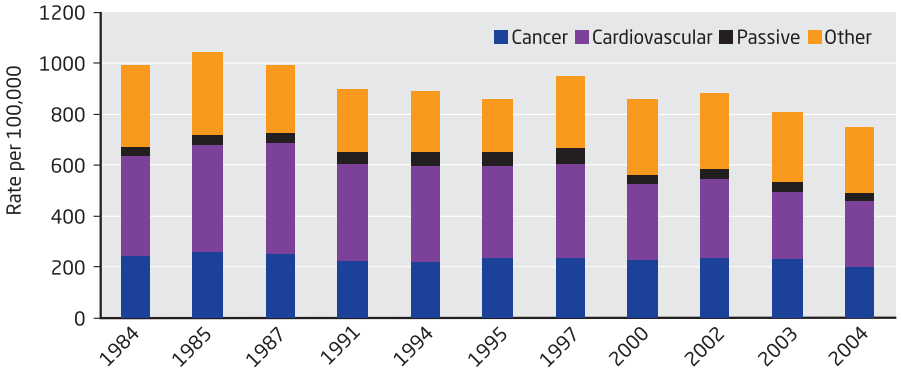


Using linear regression to interpolate the lives saved/lost for years not analysed, an estimated 1071 male lives were saved and 195 female lives lost from 1985 to 2004, due to the change in prevalence since 1984.

Hospitalisations

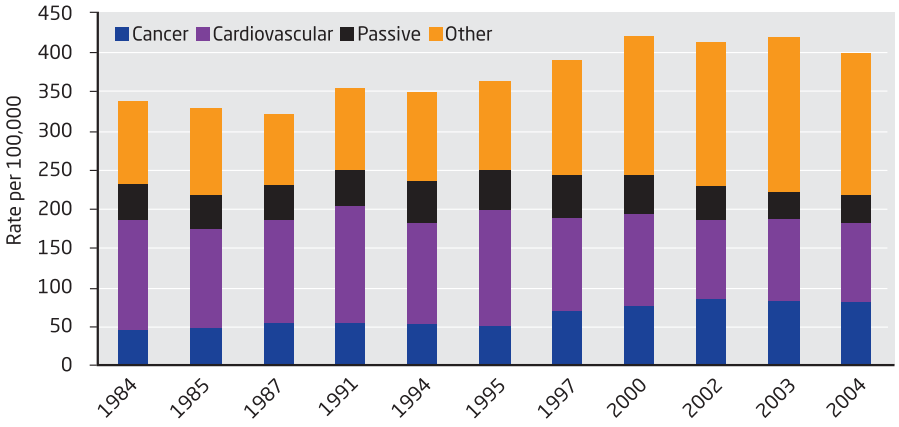
In 2004 there were an estimated 6,742 hospitalisations attributed to tobacco in males in Western Australia at a rate of 751 per 100,000 person-years. Over the period 1984 to 2004 the rate of hospitalisation in males decreased significantly by an average of 0.7% annually. The decrease was due to reductions in the hospitalisation rate for cancer and cardiovascular conditions. The hospitalisation rate for cardiovascular conditions decreased significantly by an average of 1.7% annually, while the rate for treatment of cancer conditions in hospital also decreased by an average of 0.3% annually (Figure 7).

Figure 7 **Age-standardised hospitalisation rate attributable to tobacco among West Australian males, 1984 to 2004**



In 2004 there were an estimated 3,992 hospitalisations attributed to tobacco in females at a rate of 397 per 100,000 person-years. While the hospitalisation rate in females was much lower than in males, reflecting the lower prevalence of smoking among females, the rate significantly increased from 1984 to 2004. Over this period the rate of hospitalisation in females increased by an average of 1.3% annually. Although the rate of hospitalisation for cardiovascular conditions significantly decreased by an average of 1.6% annually, the rate for cancer treatment and other conditions significantly increased by an annual average of 3.1% and 3.9%, respectively (Figure 8).

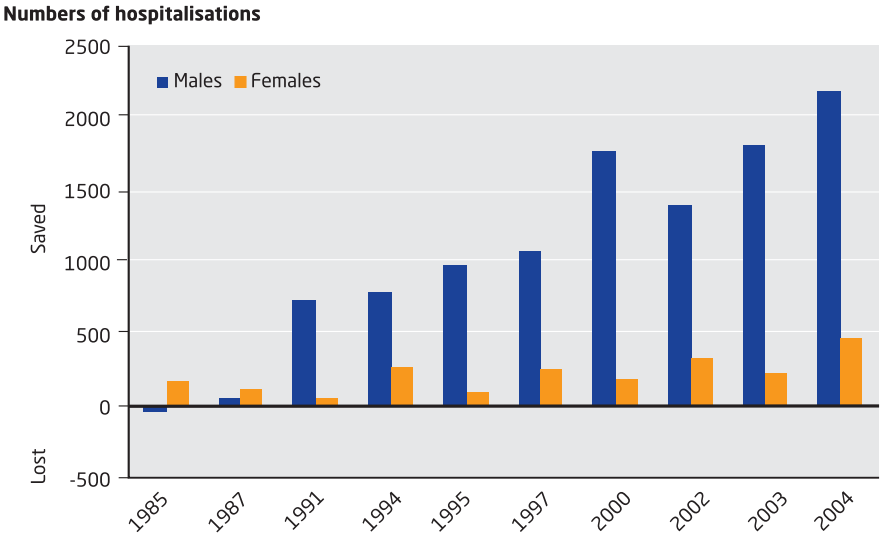
Figure 8 **Age-standardised hospitalisation rate attributable to tobacco among West Australian females, 1984 to 2004**



To measure the number of hospitalisations saved by a decline in smoking prevalence, a similar method was applied to the hospitalisation data as described for the death data, as hospitalisations may be affected by influences other than smoking prevalence alone.

Had the prevalence of smoking remained the same as in 1984, a further 2,184 hospitalisations in males would have been attributed to tobacco in 2004 alone. The savings in terms of hospitalisations were much more modest in females, due to the lower prevalence of smoking and the increasing rate of hospitalisation attributed to tobacco. By 2004, an estimated 469 hospitalisations were saved annually due to a decrease in female smoking prevalence since 1984 (Figure 9). Although the number of hospitalisations for cancer and other conditions increased in females, this was outweighed by the decrease in hospitalisations for cardiovascular disease and conditions related to passive smoking.

Figure 9 **Number of hospitalisations saved/lost due to changes in smoking prevalence from 1984, by gender, 1984 to 2004, Western Australia**

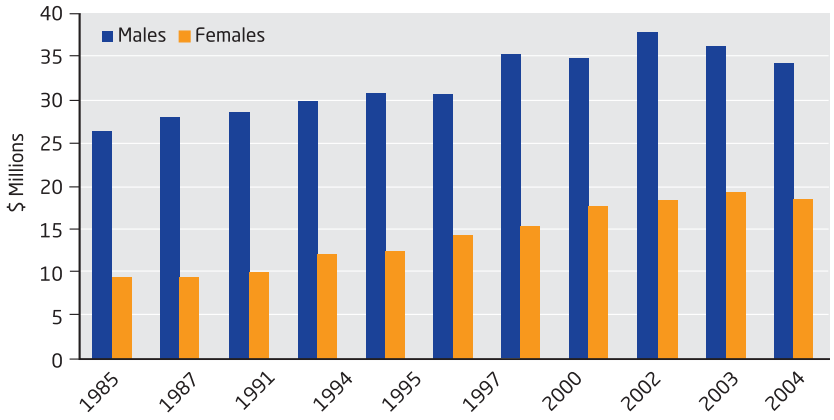


Using linear regression to interpolate the hospitalisations saved for years not analysed, an estimated 18,629 hospitalisations were saved in males and 3,898 in females from 1985 to 2004, due to the change in prevalence since 1984.

Hospital costs

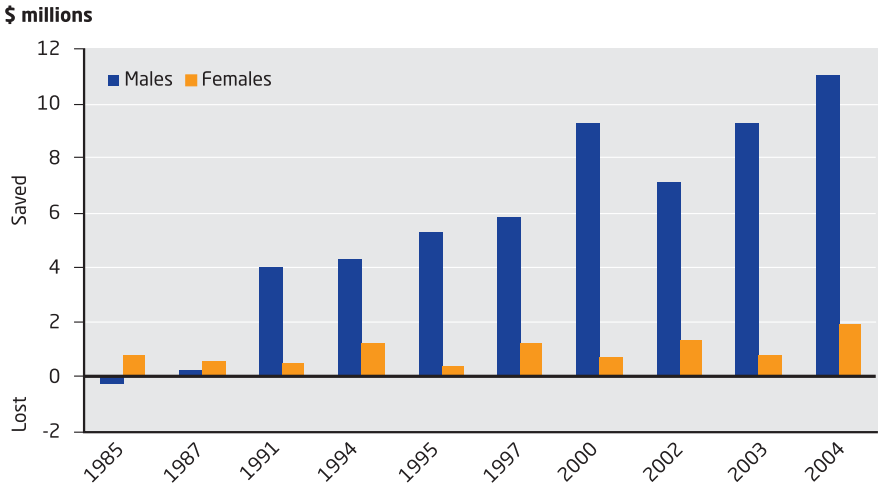
The estimated costs for treatment of tobacco-related diseases in hospital increased from $35.7 million in 1984 to $52.8 million in 2004. The majority of the tobacco-related hospital costs were associated with hospitalisation of males over this period. In 1984 hospital costs of males ($26.3 million) accounted for nearly three times the hospital costs of females ($9.4 million). Over the period 1984 to 2004 the cost of hospitalisation among females increased by 98% while the cost among males increased by 30% (Figure 10). By 2004, the hospital costs among males ($34.2 million) were less than twice that among females ($18.6 million).

Figure 10 **Hospitalisation costs ($ million) for tobacco-related disease by gender, 1984 to 2004, Western Australia**



If the smoking prevalence remained at 1984 levels until 2004, hospitalisations for tobacco-related diseases would have cost an additional $11.0 million among males in 2004. The savings among females were lower than among males due to the increasing hospitalisations for long-term effects of smoking among females, with $1.9 million saved in 2004 (Figure 11).

Figure 11 **Hospitalisation costs savings ($ million) for tobacco-related disease by gender, 1984 to 2004, Western Australia**



Using linear regression to interpolate the hospital costs saved for years not analysed, an estimated $98 million was saved among males and $18 million among females from 1985 to 2004, due to the change in prevalence since 1984.

At-risk populations

The prevalence of smoking varies between sub-groups in the population. The impact of smoking on health is likely to be the greatest in sub-groups with the highest prevalence. The impact on health for population sub-groups was measured by deaths attributed to tobacco.

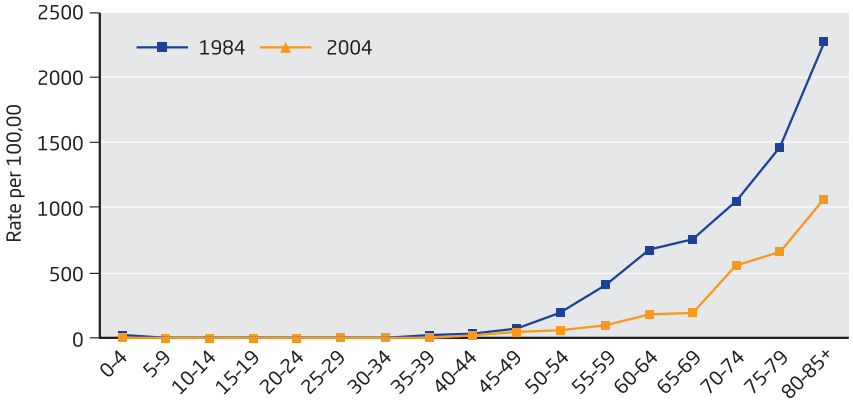
Gender

The results presented previously in this paper demonstrate the difference in impact on mortality between males and females. Although the rate of death in males was higher than females, the male death rate was decreasing at a greater rate than in females. While the death rates for cardiovascular, cancer and other causes were all decreasing in males, the death rates due to cancer and other conditions were increasing in females, reflecting the long-term effects of tobacco smoking and the later decline in smoking prevalence among females (Figures 4 and 5).

Age

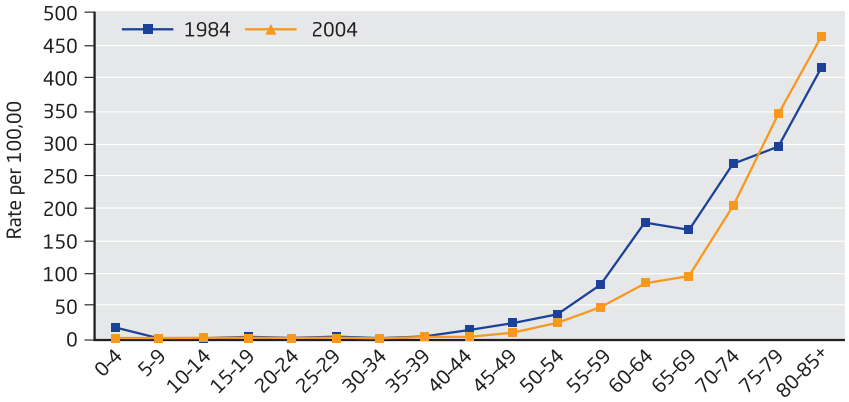
Age-specific death rates indicate that the oldest age groups experienced the highest death rates. After age 44 years the age-specific death rates increased in both genders with the onset of chronic disease. Male age-specific death rates decreased markedly from 1984 to 2004 (Figure 12).

Figure 12 **Age-specific death rate attributable to smoking among males, 1984 and 2004**



In contrast, the death rates for the oldest age groups in females have increased from 1984 to 2004 and the decrease in death rate in the younger age groups was moderate compared with males. This reflected the relatively high prevalence of smoking twenty to thirty years earlier among females aged 75 years and older in 2004 (Figure 13).

Figure 13 **Age-specific death rate attributable to smoking among females, 1984 and 2004**



Regional variation

The rates in males and females resident in the metropolitan and rural areas of the State were similar to the State male and female rates. The death rates in males and females living in remote areas were significantly higher than the State male and female rates as indicated by the Standardised Mortality Ratio. For residents in remote areas there were 36 excess male deaths and 39 excess female deaths during 2000 to 2004 when compared with the State rate (Table 4).

Aboriginal

In comparison with the total State population, the death rate in Aboriginal males was three times higher, while the Aboriginal female rate was more than four times higher. During 2000 to 2004 there were 82 excess Aboriginal male deaths and 54 excess Aboriginal female deaths when compared with the State rate (Table 4).

Socioeconomic status variation

There was a distinct socioeconomic gradient associated with the death rate attributable to tobacco. For the two most disadvantaged groups, the death rates in both genders were more than 40% higher than the State rate, while for the two least disadvantaged groups the death rate was significantly lower than the State rate in both genders (Table 4).

Table 4 **Comparison of death rate attributed to tobacco between population sub-groups and the State, 2000 to 2004**

		Deaths	Expected[a]	SMR[b]	95% CI[c]
Aboriginal					
	Males	126	44	2.89	(2.42-3.45)
	Females	71	17	4.05	(3.18-5.14)
Metropolitan					
	Males	3076	3155	0.98	(0.94-1.01)
	Females	1658	1740	0.95	(0.90-1.01)
Rural					
	Males	752	710	1.06	(0.99-1.14)
	Females	353	337	1.06	(0.94-1.19)
Remote					
	Males	198	162	1.22	(1.06-1.40)
	Females	102	63	1.83	(1.49-2.25)
SEIFA[d]					
Quintile 1	Males	1113	765	1.45	(1.37-1.54)
	Females	578	397	1.46	(1.35-1.58)
Quintile 2	Males	1217	832	1.46	(1.38-1.55)
	Females	629	432	1.46	(1.35-1.58)
Quintile 3	Males	765	777	0.98	(0.92-1.06)
	Females	443	386	1.15	(1.05-1.26)
Quintile 4	Males	554	767	0.72	(0.66-0.79)
	Females	330	421	0.78	(0.70-0.87)
Quintile 5	Males	526	854	0.62	(0.56-0.67)
	Females	332	476	0.70	(0.62-0.78)

a State gender and age-specific rates were applied to the sub-population figures to estimate expected deaths.
b Standardised mortality ratio.
c Confidence interval of the SMR at the 95% level.
d Index of socioeconomic disadvantage. Quintile 1 is the most disadvantaged group and Quintile 5 is the least disadvantaged group.

Discussion

The study quantifies the benefits of a decrease in smoking prevalence over the last twenty years in terms of saving lives, hospitalisations and hospital costs. There are, of course, many more benefits to be gained from a reduction in smoking prevalence such as increased life expectancy, reduced productivity losses and reductions in other health care costs for medical, nursing home and pharmaceutical services.

The increase in life expectancy in the later part of the last century has been attributed to behavioural changes including decreased smoking prevalence, in association with advances in medical technology.[12] Over the last two decades there have been significant decreases in death rates from diseases associated with tobacco use. Lung cancer, COPD and cardiovascular disease death rates have declined in males, while death rates from cardiovascular diseases have declined in females in Western Australia.[13]

The significant declines in cardiovascular death rates found in this study can only be partly attributed to a reduction in smoking prevalence, as a decrease in the prevalence of other risk factors and improvements in treatment of heart disease also contributed to the reduction in cardiovascular deaths.

For those conditions related to cumulative exposure to smoking (cancers and COPD) there is a long lead-time of up to two decades for the development of these diseases. In Australia, smoking prevalence among males has been declining since the early 1970s, while the fall in smoking prevalence among females began in the late 1980s.[3,4]

In males, the reductions in cancer and COPD deaths were related to the decrease in smoking prevalence prior to the 1980s. As the prevalence was still increasing among females in the 1980s, the death rates from cancers and COPD continued to increase due to the time delay from exposure to development of the conditions. In fact, the lag effect of disease development from the peak in smoking prevalence in the 1980s in females caused lives to be lost up to 2004 when compared with data based on the 1984 prevalence figures.

Interpretation of trends in hospitalisation rates is made difficult by factors other than changes in disease incidence or prevalence. Hospitalisations can be affected by changes in admission practices, with cases for specific conditions treated in the community rather than in hospital. In addition, changes in clinical coding practices vary the identification of specific conditions over time. Despite the limitations of the hospital morbidity data, trends in hospitalisation rates were similar to those pertaining to death rates in both genders.

The decrease in the overall hospitalisation rate and rate of hospitalisation due to cancer, cardiovascular disease, conditions associated with passive smoking and other conditions in males reflected the long-term decline in smoking in males. Whereas, among females, the increase in overall hospitalisation rate and the rate of hospitalisation for cancer and other conditions such as COPD, masks the more recent decline in smoking prevalence.

The full benefits of the decrease in smoking prevalence over the last twenty years have yet to be realised, particularly among females, due to the time lag in disease development after exposure to tobacco smoke.

Despite the benefits of the decline in smoking prevalence being only partially apparent there have been significant gains made over the last twenty years. Based on the trends from 1985 to 2004 there was an overall saving of 876 lives, 22,527 hospitalisations and $116 million in costs. Although hospital costs have been averted by a decrease in smoking prevalence (relative to the counterfactual of no fall in smoking prevalence), actual tobacco-related hospitalisation numbers continue to increase. Further reductions in smoking prevalence are needed to decrease the number of future hospitalisations and to help reduce actual hospital costs for treating tobacco-related conditions.

Opportunities also exist to improve the health outcomes of sub-groups in the population by reducing the smoking prevalence among groups with relatively high exposure. The rate of tobacco-related deaths was significantly higher than the general population rate for sub-groups with the highest smoking prevalence. The Aboriginal population, people living in remote areas and those in the lowest socioeconomic groups have the highest smoking prevalence and all could benefit from interventions to reduce smoking prevalence.

The decrease in smoking prevalence among the youngest age group over the last twenty years is encouraging. Data from the National Drug Strategy Household Survey indicate a similar decrease among children aged 14 to 19 years from 19.7% in 2001 to 9.5% in 2004.[6] The future challenge is to ensure the prevalence in this cohort does not increase as the cohort ages.

Over the last twenty years the decrease in smoking prevalence has resulted in significant health gains within the West Australian population. However, considering tobacco-related deaths and hospitalisation rates in males remain much higher than in females and tobacco-related deaths remain high in Aboriginal people, people living in remote areas and low socioeconomic groups, there are opportunities to achieve further substantial health gains through the reduction of smoking prevalence among these groups.

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Changes in the attitudes and beliefs of West Australian smokers, 1984–2007

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Smoking Environment in 1984

In 1984, 36 per cent of West Australian males and 28 per cent of females were daily smokers.[1] By this time the health hazards of smoking had been firmly established for two decades – ever since the publication of the US Surgeon General's report in 1964 definitively linking smoking to increased risk of lung cancer, cardiovascular disease and other serious illnesses.[2] At odds with this knowledge, smoking prevalence had remained stable in Australia for much of the previous decade, despite the introduction of several Commonwealth and State government tobacco control initiatives. These included the message: 'Warning – Smoking is a health hazard' becoming compulsory on cigarette packets nationwide in 1973,[3] trains, buses and ferries in Western Australia becoming smoke-free in 1974,[4] and a ban on direct cigarette advertising on television and radio being introduced in 1976.[3] However, direct tobacco advertising remained ubiquitous on billboards, and regularly featured as full-colour and full-page advertisements in newspapers and magazines. Tobacco companies also circumvented television advertising bans by providing major sponsorship to a variety of sporting and cultural events, including the Benson & Hedges Cup (cricket), and the Winfield Cup and Marlboro Cup (horse racing).[3] Tobacco companies also commonly distributed free samples of cigarettes. No comprehensive tobacco control advertising campaigns to counter tobacco promotions had been conducted within the State. Moreover, smoking remained permissible indoors in all government and private workplaces (including schools and hospitals), inside commercial aircraft, and other enclosed public places such as shopping centres, hotels and nightclubs, and in restaurants. Cessation assistance for smokers was also extremely limited: Nicotine Replacement Therapy (NRT) was only a recent innovation and required a prescription from a medical officer.[3]

Smoking Policy Changes 1984–2007

By 1984 winds of change were stirring. As noted by Swanson and Durston in this report, recognising the societal costs of smoking and that prevalence had remained virtually unchanged for a decade, a newly elected Labor Government in Western Australia imposed a substantial increase in cigarette taxes, raising the State Tobacco Licence Fee from 12.5% to 35% and allocating $2 million of this per year to fund a comprehensive statewide smoking and health education program. The recipient of this money, the Smoking and Health Program of the Public Health Department, appointed a local market research consultancy, RJ Donovan & Associates, to conduct formative research to provide background data for message strategies for an ongoing series of planned smoking and health mass media advertising campaigns. Dr Rob Donovan initially conducted four focus groups with West Australian smokers in January 1984 to provide data on attitudes and beliefs about smoking that could be used to generate appropriate communication and behavioural objectives.[4] The information was used to develop the first Western Australian Quit advertising campaign in 1984, featuring the well-known celebrity Barry Crocker, who provided encouragement and quitting tips to smokers in a sympathetic and humorous manner, in a countdown to 'Quit Week' in May that year. Other campaigns promoting smoking cessation followed in successive years through the mid-1980s.

The new advertising campaigns coincided with the introduction of a raft of new policies. Nationally, smoking became prohibited on domestic aircraft in 1987,[3] and in the same year a new series of stronger health warning labels was compulsorily introduced to cigarette packets.[5] In 1989 the Western Australian Public Service became a smoke-free workplace (Swanson and Durston, this report) and the next year the Western Australian *Tobacco Control Act 1990* was passed in parliament.[6] The new legislation established Healthway in 1991 to allow for the smooth phasing out of tobacco sponsorship of sporting and cultural events. The Act also ensured remaining forms of direct tobacco advertising were banned in the mass media including on billboards, in newspapers and in magazines. The distribution of free samples of cigarettes was also banned, and point-of-sale advertising became highly restricted. In the recognition that Western Australia had become a world leader in tobacco control, Perth hosted the 1990 World Tobacco Control conference. In 1991 the enclosed areas of Western Australian government schools also became smoke-free and in 1994 smoking became prohibited in taxis.[4] However, after the introduction of the *Tobacco Control Act 1990* few legal restrictions on the marketing of tobacco products were introduced until new health warnings appeared on cigarette packets in 1995.[3] Advertising campaigns promoting smoking cessation continued in the early 1990s, although there was no increase in resources for this activity. Consequently, there was a halt in the downward trend in smoking prevalence that had been observed since the mid-1980s.

By 1996 this fact was recognised and the *Occupational Safety and Health Regulations 1996*[7] were introduced to prohibit smoking in all remaining enclosed workplaces, except restaurants, pubs, clubs and casinos. In 1997, the National Tobacco Campaign was launched introducing a new generation of hard-hitting and effective cessation advertisements.[8] Following revised scheduling arrangements allowing over-the-counter sales from 1993 and direct-to-consumer advertising from 1997, NRT use increased significantly.[10] In 2001 a new form of smoking cessation pharmacology, the anti-depressant buproprion (Zyban), became heavily subsidised under the Commonwealth's Pharmaceutical Benefits Scheme making it widely available under prescription from a medical officer for the first time.[9] In 1999 smoking was banned in enclosed public places where food is served,[10] followed eventually in 2006 by a smoking ban indoors in hotels and nightclubs.[11] Provisions for enclosed public places are covered by regulations gazetted under the *Tobacco Products Control Act 2006*.[12] The introduction of this Act in 2006 led to implementation of many controls for which tobacco control practitioners had long advocated. In addition to reducing exposure to second-hand tobacco smoke in public places, the Act introduced a licensing system for tobacco retailers and wholesalers, banned point-of-sale tobacco advertising, limited the size of tobacco product displays in retail outlets and substantially increased penalties for breaching provisions of the Act. Yet another significant achievement in 2006 was the implementation of graphic health warnings on tobacco products nationwide.[13]

The Smoking Environment in 2007

The environment for West Australian smokers in 2007 has changed markedly from that of 1984, including smoking being prohibited in virtually all enclosed public and work places, hotels and clubs and on all forms of public transport, and domestic and international flights. All forms of direct and indirect tobacco advertising (including sponsorship) are banned, except for restricted product displays at point of sale. Adult and youth smokers have been subjected to near-continuous tobacco control advertising campaigns for nearly a quarter of a century. A rotating series of hard-hitting, full-colour, graphic health warnings are mandatory on all tobacco products. NRT is also aggressively advertised by pharmaceutical companies and is available in supermarkets, and buproprion is widely available under prescription. Furthermore, as noted by Somerford in this report, smoking prevalence among West Australian males and females has more than halved, with only 19.6% of males and 14.7% of females being current smokers.

Smoking Study Replication

A series of focus groups was conducted with West Australian smokers in 2007 replicating Donovan's methodology of 1984.[4] The aim of the replication was to assess changes in smokers' beliefs and attitudes towards smoking associated with changes in tobacco control between 1984 and 2007. Four focus groups with samples stratified by age and sex were conducted in February 2007. Participants were recruited from a database of smokers who had previously participated in telephone health surveys for Curtin University of Technology. Each of the four groups comprised six to eight smokers in the following clusters: male smokers aged 18–29 years; female smokers aged 18–29 years; male smokers aged 30–55 years; and female smokers aged 30–55 years. The same themes discussed by participants in 1984 were explored again with participants in 2007. Their responses are contrasted hereafter.

Reasons to Smoke

In 1984 when participants discussed reasons that they smoked, they described the enjoyment derived from smoking, especially in social settings, and the relaxation and stress relief provided. However, participants also described smoking as a compelling habit automatically triggered by a variety of behavioural cues. Some participants also matter-of-factly acknowledged their physiological addiction to cigarettes.

Relaxation and socialisation

In 2007 relaxation and socialisation remained highly salient aspects of smoking enjoyed by participants. The act of sharing cigarettes with friends, and as a natural 'ice-breaker' with strangers, was viewed as a great social facilitator. However, a new dimension to this phenomenon was described by smokers in 2007 that was not mentioned by the 1984 participants: according to some the fact that they are now forced to smoke in isolation in designated places has increased socialisation among smokers, who have become bonded in a self-deprecating kind of way by their shared 'social pariah status'.

Eating, drinking and smoking

Smoking in both 1984 and 2007 was also fondly associated with consumption of food (e.g. 'after a meal') and beverages, especially alcohol (e.g. 'sharing a beer and smoke with friends') and caffeine (e.g. 'with a cup of tea' and 'having coffee with girlfriends'). An interesting aside is that participants in 1984 exclusively coupled smoking and tea, whereas participants in 2007 were far more likely to couple smoking and coffee, reflecting a shift in caffeine consumption towards coffee and away from tea in the intervening years.

Smoking locations and environments

One of Donovan's conclusions in 1984 was that 'smoking control programmes must work to reduce the number of occasions (locations) in which smokers can smoke' (p. 13). To a large extent this has come to pass, with the broad range of environmental tobacco control restrictions introduced since 1984, as previously described, including in restaurants, hotels and clubs. It is perhaps significant that smoking in restaurants was mentioned by participants in 1984 but not in 2007, given that for eight years smoking in enclosed public places where food is served had been prohibited. However, when the focus groups in 2007 were conducted, the indoor restrictions on smoking in hotels and clubs had only been enforced for six months. Thus in 1984 smokers described smoking at hotels with relish and 2007 participants' recent reminiscences were similar: participants described pre-restriction nights at the pub involving endless drinks in one hand and cigarettes in the other (chain-smoking). Having a glass in one hand and a cigarette in the other was described as very natural: 'it feels right'. The new restrictions appear to have forced a change in smoking behaviours: participants suggested that when at pubs and clubs they now went outside, smoked one or more cigarettes in rapid succession, and then returned indoors to rejoin their non-smoking friends.

Many suggested they probably smoked less as a consequence of this. However, others opined that the new restrictions had made little impact on their overall consumption – it had just changed their smoking patterns – although such respondents acknowledged that prior to the new restrictions it had been very difficult for them to monitor the actual number of cigarettes they would smoke in a night.

Other behavioural cues described by participants in 1984 were less social, such as inside private dwellings and vehicles. These remain beyond current smoking restrictions in 2007, and participants' reported automatic behavioural cues in such situations remained similar. It appears that going outside to smoke in 1984 was a near-alien concept, but in 2007 it appeared an accepted part of most smokers' lives. Although participants in 2007 described the private home and car in terms of 'the last bastion for smokers', even here attitudes appear to have changed. For instance, some of the automatic behavioural cues nominated by participants in 1984 that were not mentioned in 2007 included 'doing the washing' and 'talking on the telephone'. After experiencing years of prohibition of smoking indoors in public places, many 2007 participants seemed to accept that smoking indoors was an anti-social and unacceptable behaviour. This acceptance appeared to have extended to even their own private dwellings, with a majority in 2007 suggesting that they did not smoke inside their own homes, particularly if living with others. Suggestions such as smoking while 'doing the washing', or while in bed, were almost alien to participants in 2007. In contrast to homes, most participants in 2007 were still likely to be smoking in their own cars, as they were in 1984. However, one major behavioural shift was noted in terms of when children were passengers. In 1984 smoking in a car with children was widely accepted as 'normal', with only one participant (whose child was asthmatic) not smoking under such circumstances. By 2007, a large majority of participants acknowledged that it was unacceptable to smoke in a vehicle where children were passengers.

Stress relief

On another theme, the stress relief provided by smoking was just as salient for smokers in 2007 as it was in 1984; the therapeutic calming benefit of smoking remains an important justification for continuing the habit. The only apparent change in this regard has been the lexicon used by participants. Participants in 1984 describe smoking in terms of a 'tranquiliser' (e.g. 1984: 'it calms you down', 'when I get upset I just reach for a cigarette'). In 2007 smoking was specifically described in terms of 'stress relief' (e.g. 'I find it a stress relief', 'it decreases stress' and 'when I am stressed it calms me down').

Another interesting difference between participants in 1984 and 2007 is that modern smokers described smoking as a welcome 'break' from work. Smokers in 1984 referred to smoking as a 'treat' or 'a reward after a bit of hard work'. However, in 1984 there was no reason for smokers to leave their workspace in order to smoke a cigarette; they could light up immediately and whenever they wished. This contrasts with participants in 2007 who distinctly described the necessity of going outdoors in order to smoke a cigarette as a 'break', 'time out' or (with heavy irony) 'to get some fresh air'. The physical departure from their workplace was seemingly an important component of the stress relief associated with smoking (e.g. 'time out to go outside for a break', 'get to go outside to have a ciggy break – getting out of the office' and 'excuse to step out of the office'). Thus, while the introduction of smoking restrictions in enclosed workplaces is likely to have significantly reduced the number of opportunities for smokers to consume cigarettes, it may have inadvertently reinforced reliance on smoking as a work-related stress relief strategy.

Addiction

The final theme of why participants smoked in 1984 related to their nicotine addiction. In 2007, this remained unchanged with participants stating that an important reason for smoking is to 'feed my addiction' or 'satisfy the nicotine craving'. Most smokers from both eras had made numerous unsuccessful attempts to quit and suggested consistent failures keenly amplified awareness of their addiction. Smokers from both eras were uncomfortable in this knowledge and described themselves variously as 'hooked', 'trapped'

or 'controlled'. In 2007 a proportion of participants, particularly those in the younger age groups, did not consider themselves an 'addict': (e.g. 'I'm only a social smoker'). Such participants remained unconvinced that quitting would be personally difficult, if and when they decided that they no longer wished to smoke. However, the older smokers in the groups reflected that they too had once believed this of themselves and stated that they were addicted to nicotine long before they realised. 'Social smokers' did not rate a mention in the 1984 study but this does not preclude their existence at that time. Indeed, it seems unlikely that the existence of such attitudes would have changed.

In terms of reasons to smoke, the major themes suggested by West Australian smokers in 1984 were entirely consistent with responses in 2007. It appears that the reasons have changed very little, if at all in the intervening years – most smokers continue to smoke because they are hooked by either nicotine or psychological addiction, or both, with the stress relief and social aspects of smoking remaining powerful reinforcers. Apart from reducing the number of opportunities to smoke, smoking restrictions in public and workplaces appear to have impacted on some of the social reinforcers of smoking. However, the restrictions appear to have made minimal impact on smokers seeking alternative stress-coping strategies and in the workplace may have actually increased reliance on smoking for this.

Reasons to Quit

Donovan also explored the most salient motivations for West Australian smokers to quit. In 1984 the major motivations described by participants included health, expense, personal hygiene and fitness. These motivations remained just as salient to participants in 2007, who bemoaned the expense of smoking (e.g. 'it's expensive', 'a waste of money', 'burning money', 'the price is always going up' and 'the cost!'). Participants in 2007 were also in broad agreement that smoking is 'a filthy habit' with a range of cosmetic drawbacks mentioned, including 'bad breath', 'yellow teeth', 'smelly hair', 'smelly clothes', 'stained fingers', and 'bad skin'. Participants in 2007 also suggested another reason to quit is to 'improve fitness' or 'get fit again'. Cosmetic considerations were most salient among the female participants, compared with male participants who appeared more concerned about the effect of smoking on their fitness.

Health

Among participants in 1984, the single most salient reason to quit was for health. Using a free word association task, the term 'smoking' in 1984 was most commonly associated with 'cancer'. Moreover, when asked ways to improve general health, and ways to reduce the risk of heart disease and cancer, participants immediately responded 'give up cigarettes'. Most previous quit attempts had also been for health reasons. However, Donovan described participants' association between smoking and ill-health as 'superficial, contradictory, and confused' (p. 38), and hypothesised that the automatic association between smoking and cancer was more a conditioned response rather than an internalised belief. For instance, some participants were in outright denial that smoking is harmful to health at all, and many participants were suspicious of the evidence directly linking smoking to major illnesses (e.g. 'Nobody's ever actually proved that smoking causes cancer' and 'not everyone who dies of lung cancer was a smoker'). Participants were far more ready to believe that other underlying factors were the major cause of various smoking-related illnesses and that smoking simply 'irritates' these other factors. Thus, while the participants were obviously uncomfortable with the notion that smoking caused ill-health, they derived great comfort from contrary anecdotal evidence relating to their own experience (e.g. 'I feel fine', 'none of those things have happened to me', 'I know heaps of smokers and they're all fine' and 'my old grandmother is 94 years old and she's a pack and a half a day smoker'). Donovan noted contrary evidence that was confirmed by the participant's own immediate situation or by direct observation of others was very difficult to refute. Moreover, participants in 1984 seemed to believe that *if* they developed health complications from their smoking, then they could simply quit at such time (e.g. 'I can continue to smoke while it doesn't significantly affect my health' and 'I will give it up if a

health problem arises'). Most participants in 1984 also considered themselves to be only 'moderate' smokers and held the view that 'everything in moderation is okay'. This belief served to reinforce their perceived low probability of any major negative effects personally affecting them (e.g. 'it's different if you're a 60 to 80 a day man').

Participants in 2007 appeared much better informed and more ready to accept the detrimental health effects of smoking than their predecessors. Most acknowledged that in all probability they would eventually suffer ill health effects if they continued to smoke, and that it would already be too late to quit once they developed health complications. Participants credited tobacco control advertising as their main source of information about the health effects of smoking, and this appears to have played a major role in constantly reinforcing their belief structure. That is not to say that the smokers liked the advertisements; their usual coping mechanism when confronted with tobacco control advertisements was to 'switch channels' whenever they were exposed to them. Nonetheless, smokers were familiar with most tobacco control advertisements, suggesting that they had paid sufficient attention to take in the messages.

The recent introduction of the graphic health warnings on cigarette packets was also reviled by participants, who described various and many efforts to hide their cigarette packets from view (and polite company) via cardboard sleeves on the outside of packets, or using alternative containers for their cigarettes, such as cigarette cases, tins and wooden boxes. However, again they were quite familiar with the various graphic warnings, suggesting that during a purchase they would ask for a packet with the least worrisome warning (e.g. 'I'll have the one with the statistics' [without gruesome imagery] or 'I'll have the one about pregnancy' [if not pregnant or a male]). Again, this suggests they paid sufficient attention to the warnings to understand the message.

Participants in 2007 were still quite open to the concept of the dose relationship between the amount smoked and relative risk of becoming ill from smoking. Just as in 1984, most participants considered themselves to be only 'moderate' smokers and tried to derive some comfort that they were less at risk than 'others' who were heavier smokers. However, their perceived level of risk for even moderate smokers (such as themselves) was certainly higher than it had been for participants in 1984.

Societal acceptance

Finally, participants in 1984 described smoking as an entrenched behaviour within 'normal' society, with the image of smoking being widely endorsed by smoking in films and advertising (i.e. 'macho', 'super-cool', 'suave and sophisticated' and 'jet-setters'). Certainly, no smokers in 1984 evidenced particular embarrassment at being a smoker; they just had some niggling doubts that it might not be overly good for them. However, smoking, especially in moderation, was considered no worse than other vices, such as drinking alcohol and eating junk food, being physically inactive, and having a 'pot belly'. This contrasts sharply with the comments of participants in 2007 who described feeling 'antisocial' when they smoked and like 'social pariahs' within society. Participants commonly reported receiving 'disdainful looks' when lighting a cigarette in public and receiving rude complaints from strangers, called by one participant as 'social verbal bashing'. Indeed, a commonly mentioned reason participants considered quitting was to 'rejoin society'. This describes a wholly new and powerful motivation for smokers to quit in 2007 that differs significantly from that available to smokers in 1984.

Conclusions

In terms of both reasons to smoke and to quit, the data yielded from the 2007 groups proved consistent with that from the 1984 groups, highlighting the fundamental motivations for smokers that have remained largely unchanged. This should come as no real surprise when the basic human condition has remained the same. However, major shifts in beliefs and attitudes towards smoking were noted, with acceptance of the health hazards associated with smoking becoming nearly universal, and unlike their counterparts in 1984, smokers in 2007 reporting feeling like pariahs within their own society. Over nearly a quarter of a century, sustained education about the detrimental health effects of smoking, and legislation to severely restrict tobacco promotion and smoking in public places, have succeeded spectacularly in transforming smoking from an entrenched cultural phenomenon into a socially unacceptable behaviour.

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Kids and smoking – then, and now

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Of all the things that will confuse historians in the next century, certainly the idea of a lethal product, a product of illness and despair, peddled to youngsters for the profit of the peddler, will be the most confusing.

William Foege, Proceedings of the 8th World Conference on Tobacco or Health (1992)

Introduction

Flashback to the mid-1980s:

> *Bill aged 13, lives at home with his mum and dad and two older brothers. His dad smokes a packet of cigarettes a day. He works in an office where they are allowed to smoke at their desks, and enjoys a smoke with his mates when down at the pub. Bill's mum has a cigarette at parties and when she is stressed. She smoked during all her pregnancies. Visitors to the house often smoke inside and his parents have a cool ashtray collection. His older brothers have bought single cigarettes at the local deli for the same cost as a lollipop. On his way to school, Bill passes billboard advertisements for cigarettes and a Peter Jackson awning spans his local deli. His favourite sport, cricket, is proudly brought to him by Benson & Hedges. Bill and his brothers have only had a few health lessons about smoking at school, and some of their teachers smoke and it isn't that hard to grab a cigarette in the toilets or behind the shed at recess...*
>
> *Some twenty years later and Bill's own son, Ben, is now nearly 13. Ben's dad quit smoking when his workplace went smoke-free. His mum quit smoking when she fell pregnant. No visitors smoke in their house, and very few adults that Ben knows seem to smoke. Those who do often complain about how expensive tobacco is, and keep saying that they are planning to quit. Ben has never seen a tobacco advertising billboard or been to a sporting event with tobacco sponsorship. He has rarely seen anyone smoke in a restaurant and smoking is banned in most places that he and his family visit. His school is entirely smoke-free. A few of Ben's friends have tried cigarettes but most of his peers think it is stupid. One of the older boys at school tried to buy cigarettes at the local deli but the owner got busted for it and had to pay a big fine.*

Through the eyes of two average West Australian children born twenty years apart, the trajectory of smoking over this period reflects dramatic shifts in the social, cultural, policy and legislative environment. For those working in tobacco control, or at the seemingly unending coalface of treating tobacco-related disease, the changes seem sometimes dramatic, sometimes incremental and sometimes, yet to happen.

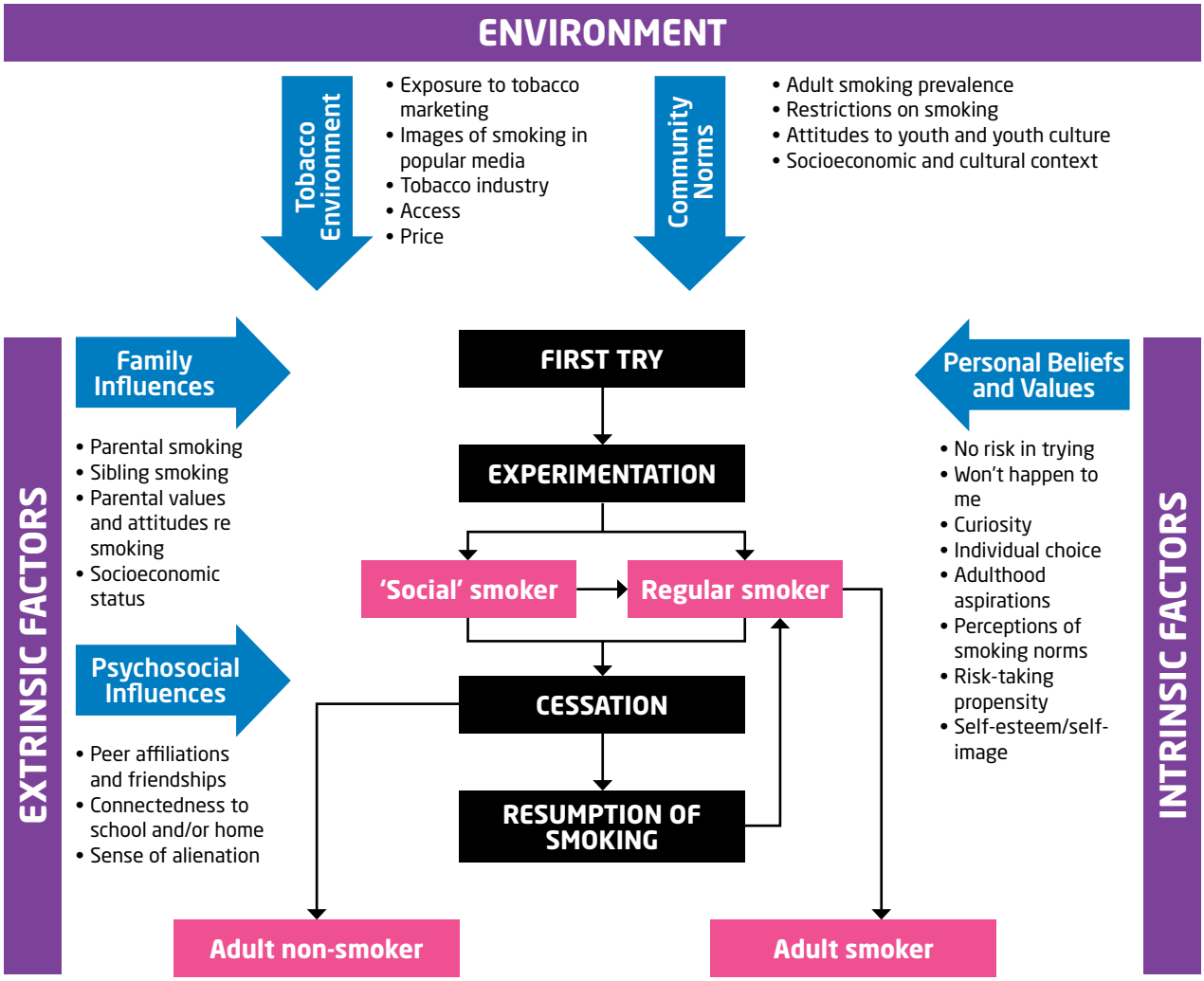
This paper maps the elements and progress of youth smoking prevention in Western Australia over the last twenty years, a story untold until now. It reflects both on achievements and challenges over this period, through the lens of a comprehensive approach to tobacco control.

Why target kids?

Approximately 90% of adult smokers began smoking before the age of 18 years.[1] While there is debate as to the extent to which tobacco control efforts should focus on prevention versus adult cessation, evidence supports the need for effective prevention interventions targeting children and youth as part of a comprehensive approach to tobacco control.[1-3] As well as preventing initial smoking uptake, there is increasing acknowledgement of the need to discourage adolescent experimental smokers from continuing to smoke[3,4] and assist those who already exhibit signs of addiction.[5]

There is a multiplicity of factors that influence youth smoking uptake, as depicted in Figure 1.

Figure 1 **Factors influencing youth smoking**



Effective youth smoking prevention requires a comprehensive multifaceted approach, involving a range of well researched and coordinated strategies that complement and reinforce each other.[6-10] One-off or single focus interventions targeting young people are unlikely to have lasting results.[11]

The West Australian approach to youth smoking prevention

Youth smoking prevention has been an element of tobacco control efforts in Western Australia since the early 1980s yet, until now, its story has never been documented. This paper maps its shape and chronological progress against the key elements of a comprehensive youth smoking prevention framework, and is the outcome of much delving into memories (see acknowledgments) and sleuthing through old reports and resources.

Promotion and visibility of tobacco

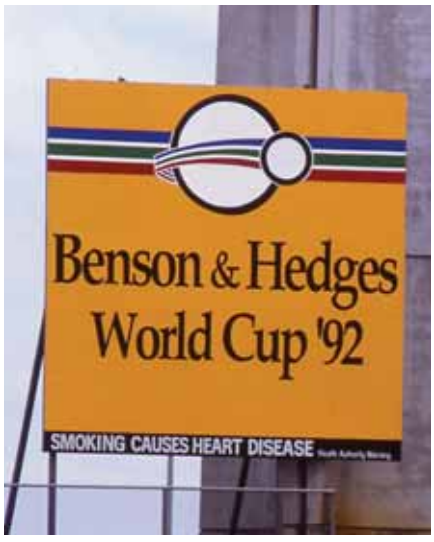
The susceptibility of young people to tobacco advertising and marketing is well documented[12,13] and has underscored much of the global groundswell for legislative bans on tobacco promotion. Reflecting this, 'Give Kids a Chance' was the theme of a campaign implemented in Western Australia in 1983 to support the second attempt in the State to introduce a parliamentary Bill to ban tobacco advertising. While, unfortunately, the 1983 Bill was defeated, health groups continued to advocate for legislative bans on tobacco advertising and the *Tobacco Control Act* (TCA 1990) was successfully passed through Parliament in 1990. Prior to its passage, the urban and retail landscape of Western Australia was cluttered with tobacco advertising and promotions.

A West Australian survey in the early 1990s showed that Peter Jackson and Winfield (the most heavily promoted cigarette brands) were the most commonly smoked brands among children aged 12 to 17 years.[14] While the TCA 1990 restricted tobacco advertising literally to 'point-of-sale' and significantly reduced its visibility, a survey of 186 Perth teenagers (aged 12 to 15) in 2004 found that 46.8% reported seeing advertisements promoting cigarettes all or some of the time when they went to a deli, supermarket or petrol station and 55.4% felt such advertising encourages people to think about smoking.[15]

Young people's perceptions of smoking prevalence and acceptability are potentially influenced by the preponderance of visibly displayed product[16] and point-of-sale promotion,[17] hence the *Tobacco Products Control Act 2006* has further tightened restrictions on point-of-sale advertising and the visibility of stock.

Figure 2 **Retail advertising pre-1990**

Figure 3 **Tobacco sponsorship pre-1990**



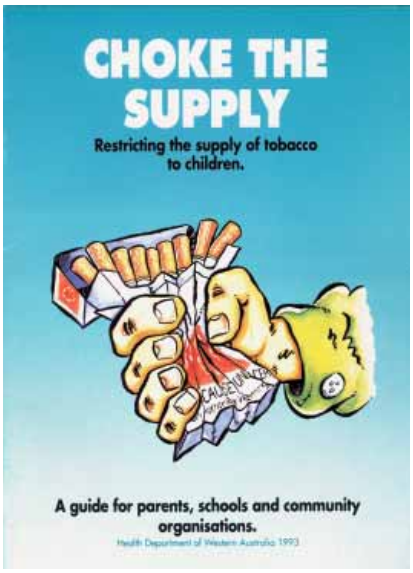
Reducing tobacco access and supply

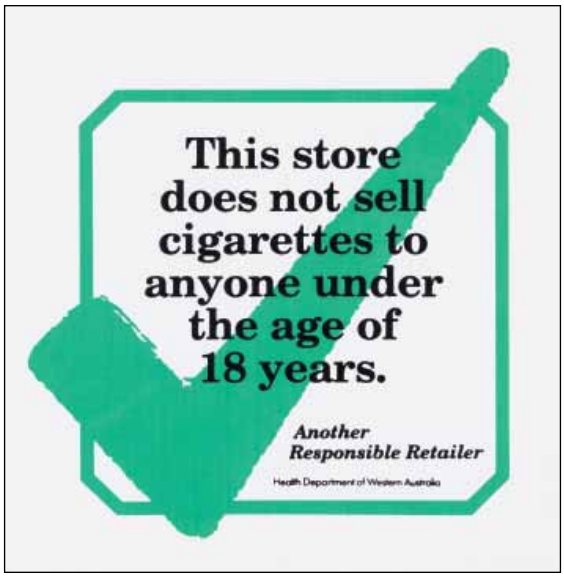
Reducing access to tobacco is an important component of effective programs to reduce smoking among young people.[1,18] While it has been an offence to sell tobacco to anyone under 18 years of age in Western Australia since 1917, prior to the passage of the TCA 1990, sales to minors were commonplace, the penalty very small, and there were no recorded prosecutions. The TCA 1990 increased the penalty from $4 to up to $5000 for an individual and $20,000 for a body corporate for a first offence. As predicated by Deterrence Theory, however, legislative penalties are only effective if the probability of being caught is high and if the punishment is swift, sure and tough.[19] Thus some fourteen months after the new penalties came into effect in Western Australia, 89% of retailers in the vicinity of thirteen Perth high schools were still prepared to sell cigarettes to young looking 16-year-olds, no questions asked.[20]

This compelled the Health Department to explore ways to increase the actual and perceived enforcement of sales-to-minor laws.

Strategies implemented from 1992 included education of retailers and the public; recruitment of support from Liquor and Gaming police officers; enforcement and prosecutions (twenty-four retailers prosecuted by 1994); publicity; rewarding responsible retailers and the dissemination of a community action guide (*Choke the supply*).[19] This combination of measures proved effective, with a 68% drop (from 89% to 28%) in the number of retailers willing to sell cigarettes to minors when the 1992 survey was replicated in 1994.[21]

Figure 4 **Promoting community action** and Figure 5 **Awarding responsible retailers**





However, subsequent replications of sales-to-minors surveys in Western Australia show considerable variability in retailer willingness to sell cigarettes to young people under 18 years (ranging from 20% of purchases by minors being successful in 1996 to 45% in 2002 and 36% in 2004)[22] highlighting the need for vigilant prosecution, publicity and education measures to sustain and further reduce youth access to tobacco. Since 1991, sixty individuals have been prosecuted for selling or supplying cigarettes to children in Western Australia. The *Tobacco Products Control Act 2006*, which replaced the *TCA 1990*, includes a number of new provisions that greatly strengthen the capacity to investigate and enforce sales-to-minors legislation and a range of other offences.

Kid-friendly cigarettes

Cigarettes can have appeal to kids in both real and fake forms. Of the fake variety, 'Fags' were a popular lolly among children growing up in Western Australia in the 1970s and 1980s – for twenty cents or so you could buy a small pack of confectionery cigarettes complete with a red tip to look lit, with children in a schoolyard depicted on the box. The TCA 1990 sought to ban lolly cigarettes, but 'Fags' reinvented themselves as 'Fads' and changed their image sufficiently to evade prohibition, and are still available today. To pre-empt the appealing size and price of aptly named 'kiddie' and 'toddler' packs marketed in other countries, the TCA 1990 prohibited the sale of tobacco in packets of less than twenty in Western Australia.

More recently, tobacco companies have begun to introduce flavoured cigarettes to the market, including a fruity range with flavours such as strawberry and green apple that became available in several Australian states in 2005. It is unlikely that a pink pack of strawberry flavoured and pleasantly smelling cigarettes is designed to appeal to older adults or brand loyal existing smokers. The 'world according to Google' reveals not only press releases from Australian health groups concerned about the appeal of fruity cigarettes to young people, but also an alarming chat room exchange between young people comparing flavours of cigarettes they have tried.[23] In a recent study of US college students, flavoured cigarettes elicited higher positive expectancies and fewer negatives than non-flavoured cigarettes among both smokers and non-smokers.[24]

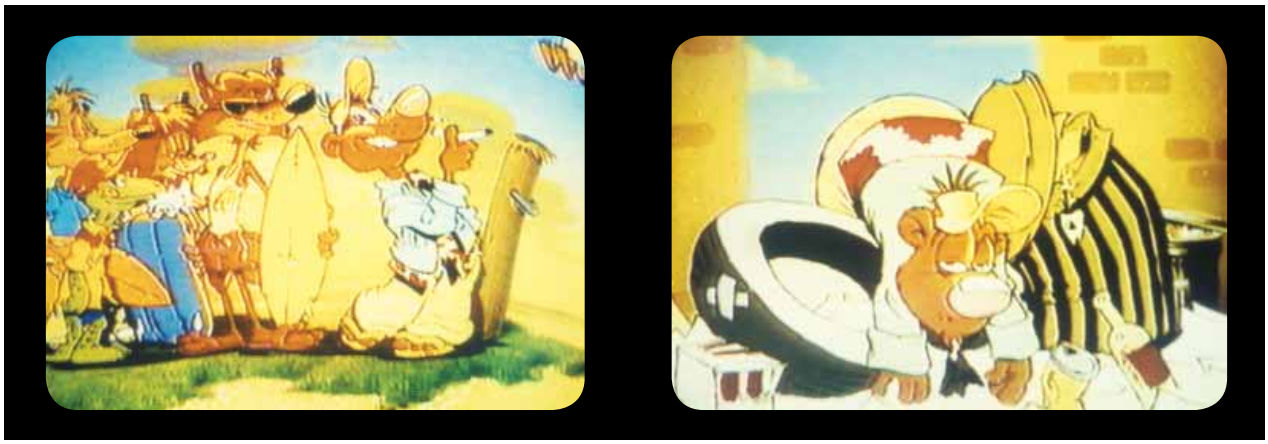
Figure 6 **Lolly fags** and Figure 7 **Strawberry flavoured cigarettes**

Mass media

Evidence from Australia and overseas substantiates the significant role that 'anti-smoking' multimedia campaigns can play in reducing youth smoking prevalence,[25,26] both directly and as a synergistic complement to policy, community and settings-based strategies.

From 1984 to the early 1990s, the Health Department conducted the *Life in the Big Smoke* campaign which targeted 9 to 13-year-olds with a prevention message. A series of animated television advertisements featured cartoon animal characters in various 'real life' teenage situations in which smoking might arise. The advertisement portrayed non-smokers such as 'Scooter' as cool, and smokers like 'Furbag' as uncool and less popular and used the tagline 'only dags need fags'. Television advertisements were complemented by posters, stickers and other merchandise, competitions, puzzles and activities conducted through *The West Australian* and *Sunday Times* newspapers.

Figure 8 **Life in the Big Smoke advertising from the mid-80s**



In 1990 a Smoke Busters Club was developed for primary school-aged children based on and adapted from a similar program in the UK. The Smoke Busters Club promoted non-smoking as a 'cool' choice and sought to affirm and reinforce children's intentions not to smoke. A costumed 'Scooter' from the *Life in the Big Smoke* advertisement series launched Smoke Busters and appeared on club merchandise (see Figure 9). The Smoke Busters Club was promoted through schools and the comic sections of weekend papers. Children who 'signed up' received merchandise, tips on remaining a non-smoker and periodic club member mail outs.

Figure 9 **Smoke Busters Club launch and merchandise**

Following the *Life in the Big Smoke* campaign, there was a relative hiatus in smoking prevention mass media directly targeting children and youth until the establishment of the Smarter than Smoking (STS) Project in 1996,[a] which has run several bursts of media annually complemented by a range of other strategies. Initial television and radio advertisements produced by STS focused on young people experiencing short-term negative consequences of smoking including effects on fitness, skin, finances and attractiveness to the opposite sex. Advertisements developed in 1999 attacked the 'cool' image of cigarettes by ridiculing their use by the fashion industry and in television 'soap opera' programs. In 2002, a new television advertisement

a Funded by Healthway since 1996 and initially managed by a coalition of leading health agencies in Western Australia, including the Heart, Cancer and Asthma Foundations, the Australian Council on Smoking and Health, and the Western Australian Department of Health.

focused on the effects of smoking on relationships, health, sports performance and addictiveness and had the tag line: 'Wouldn't it be easier to quit smoking before you start?' Complementary radio advertisements aired on stations listened to by teenagers highlighted the financial costs of smoking. The most recent STS advertisements were developed in 2005 and focus on the pointlessness of smoking and ways in which teenagers who smoke sometimes 'miss out' on activities enjoyed by others.

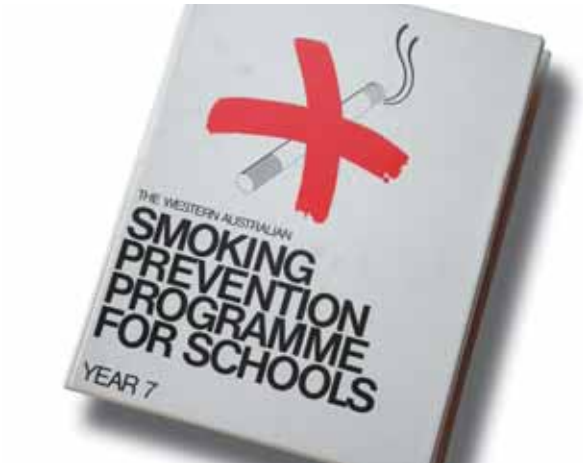
Figure 10 **Smarter than Smoking advertisements Stressing Out** and Figure 11 **Bus Stop**

School-based interventions

Schools have long been a popular setting for smoking prevention, internationally and in Australia. While perhaps difficult for students of the twenty-first century to believe, schools have also traditionally been one of the settings in which youth smoking used to commonly occur, be it behind the shed, on a corner of the oval or in toilet cubicles across the State.

Although the evidence regarding the effectiveness of school-based smoking interventions is somewhat equivocal,[11,27] at a minimum they can delay the onset of smoking[4,28] and provide access to important secondary target groups such as parents, families and the broader community.[29] Key school-based strategies implemented in Western Australia over the last two decades are summarised in Table 1.

Figure 12 **Early school resource** and Figure 13 **Current school resources**



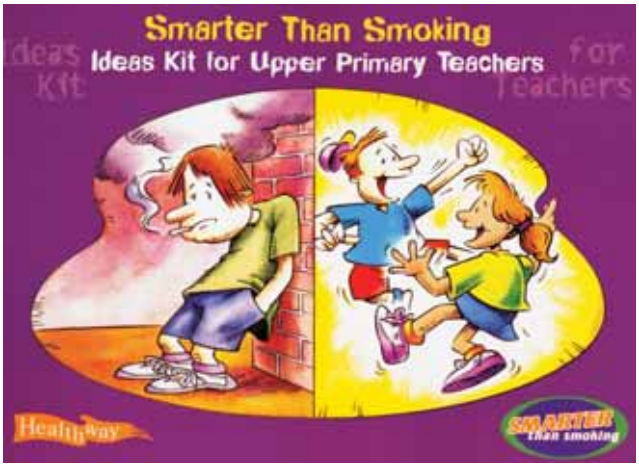


Table 1 **Timeline of school-based smoking interventions in Western Australia**

1984	Smoking prevention program for Year 7 students distributed to all primary schools in Western Australia. Smoking also included in the Heart Foundation's Primary School Heart Health Manual (1984–2005).
1986	Introduction to West Australian schools of comprehensive K-10 health education syllabus which included smoking prevention.
Mid-80s to early 90s	Schools encouraged to get involved in annual Quit Week and provided with activity booklets and merchandise.
1990	Western Australian Education Department implemented policy banning smoking within government school buildings. Smoking was permissible, however, in an outside area out of view of students and public. A 1994 survey found that over 40% of schools still allowed teachers and staff to smoke.[30] During the early to mid-90s, the National Heart Foundation Smoke-free Zones programs provided school administrators with advice on smoke-free policy implementation. From 2005, smoking has been completely banned on school premises, including the land area up to the boundaries.
1991-1994	*Intergalactic smokewatch* developed by the National Heart Foundation as part of its Home Based Health program targeting upper primary students and their parents. It was a comic book with a take-home component to engage parents.
1991 onwards	Sponsorships with non-smoking messages with school-based components including the Rock Eisteddfod series, Quit Football Cup and Eagles player cards.
1993	*Smoke-free billboard competition* encouraging students in Years 1 to 8 to design billboards with non-smoking messages to replace tobacco billboards.
1994	*Smoke-free Generation media awards* involving high school media students in developing billboard, taxi back and radio advertising with no-smoking messages.
1995 onwards	*Smarter than Smoking* (STS) project set up with funding from Healthway. Initial schools resources included a smoking prevention package for use with students in Years 6 and 7, which was later revised and developed into the Ideas Kit for Upper Primary School Teachers (updated in 2000 and 2006).
1996 onwards	Arts and sports sponsorships through Healthway promoting the Smarter than Smoking message (e.g. Barking Gecko Theatre), often with a schools visit or development component.
1997 onwards	*School Drug Education Project* (SDEP) established, funded by the Drug and Alcohol Office. Smoking included as part of a comprehensive approach to drug education in all West Australian schools (government and non-government).
1999	*Ahead of the Pack* resource produced for students aged 12-14 years, comprising videotape, cross-curriculum lesson plans and support materials (updated in 2007, now known as *Keeping Ahead of the Pack*).
2000	Smart Schools grants developed by STS in conjunction with Healthway whereby schools can apply for funding of up to $3,000 to undertake tobacco prevention activities in their local community. On average, 15 schools per year have received Smart Schools grants since 2000.

Table 1 **Timeline of school-based smoking interventions in Western Australia (cont.)**

2001 onwards	The *Critics' Choice* video resource offered to West Australian schools by STS. Students watch, critique and discuss anti-tobacco advertisements from Australia and overseas and vote on the one most likely to prevent them from taking up smoking or encourage them to quit. In its first year *Critics' Choice* was used by 251 schools throughout Western Australia, almost one-third of all schools in the State.
	Keep Left - Youth Smoking Cessation Guide for Nurses was developed as part of a Healthway-funded research study[31] and has been distributed by STS to all schools, along with the offer of training support. The resource aims to increase the role of school nurses in whole-of-school approach to smoking and engage nurses in helping students who smoke cigarettes to quit or cut down.
2002 onwards	*Design an Ad* contest run through the Ed Section of *The West Australian* newspaper which gave students in Years 4 to 12 the opportunity to develop an advertisement based on a brief provided by STS.
2005	*Design an anti-smoking message for you and your community* competition conducted by the STS project, SDEP (now known as *School Drug Education and Road Aware*, SDERA), the Aboriginal Education and Training, Participation and Achievement Standards Directorate of the Department of Education and Training and Tobacco Control Branch (Department of Health). The competition targeted schools with more than 20 Aboriginal students. The designs were developed into resources (e.g. stickers and bookmarks) for use in schools and the community.

Sponsorship

Western Australia has a long history of utilising sponsorship as a social marketing tool to promote health messages. Quit campaign advertisements and posters developed in 1985 featured sports stars of the day such as Tom Carroll (surfer), Pat Cash (tennis player) and Rob de Castella (athlete) promoting the 'Smoking No Way!' message. The Quit Campaign also sponsored a number of high profile teams from the late 1980s with popular appeal to young people, including the Perth Wildcats. A life-size 'Scooter' costume enabled the *Life in the Big Smoke* character to make many public appearances at sponsorship events, giving away merchandise such as team posters, team player cards and stickers to children. Indeed, the author chaperoned Scooter on a number of such occasions, even having to fend off taunting teenagers with rolled up posters at one memorable speedway event, heralding Scooter's diminishing appeal to those who had reached their teens! Sporting role models with appeal to young people also featured on a series of posters in the early days of the Quit Campaign, including world surfing and tennis champions of the era.

Through its close affiliation with Healthway, STS has been able to access and use sports and arts sponsorships as an integral part of its strategy mix. Between 1995 and 2004, Healthway has sponsored approximately sixty organisations annually to promote the STS message, including football, hockey, netball, music events and youth theatre productions. Sponsored youth-related organisations promote the STS message through promotional strategies such as signage and merchandise, message endorsement by role models, competitions, and the implementation of smoke-free policies and banning the sale of tobacco products at sponsored events.

Other communication strategies

The OxyGen website, developed in 1999, is jointly funded by STS, Quit South Australia and Quit Victoria. It provides users with interactive educational activities, tobacco facts and figures, information on industry tactics and updates on tobacco issues and events happening around Australia. Remaining current is one of the challenges for websites targeting technology-savvy teenagers and OxyGen was relaunched in 2004, with current plans to make it even more interactive.

In 2002, STS trialled new media, including an SMS competition and an Internet banner and competition with ninemsn, the *Dolly Magazine* website and Hotmail that targeted West Australian users between 13 and 17 years of age. Evaluation was conducted by The University of Western Australia Health Promotion Evaluation Unit and results suggest both strategies were cost effective and appealing to the target group.

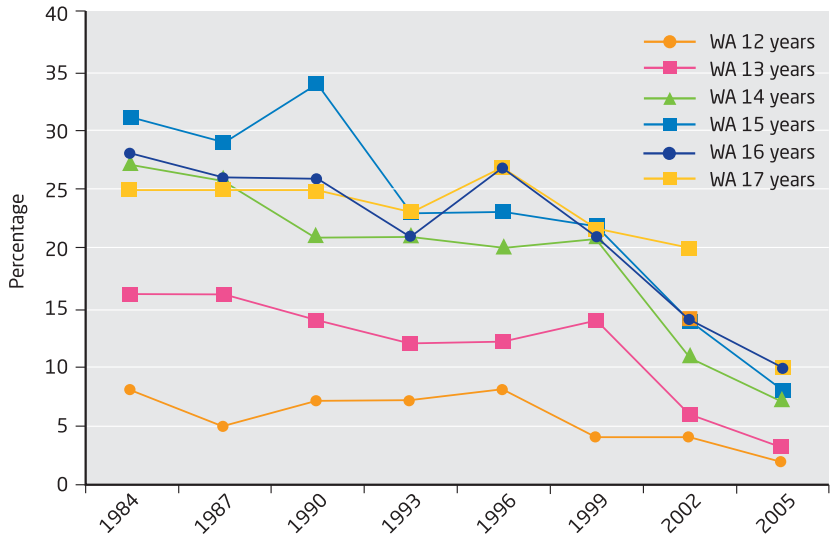
Targeting parents

Parental attitudes and responses to smoking, as well as their own modelling of smoking behaviour are among strong predictors of youth smoking uptake.[32,33] There have been several smoking prevention initiatives targeting parents in Western Australia over the years, most with an emphasis on assisting parents to communicate with their children about smoking, but also touching upon the impact they have as role models of either smoking or non-smoking behaviour. These have included home-based learning materials developed for schools by the National Heart Foundation (Western Australian Division) that had 'take-home' activities for students to do with their parents; the Health Department's development and distribution of a brochure to schools (*You can tip the scales*) in 1993; a series of school-newsletter articles for parents developed in 2002 by STS; and a new STS brochure for parents to assist them in talking to young people about smoking called *'Clearing the air: talking to children and teenagers about smoking'* was developed and distributed to schools in 2003. A survey of Perth parents conducted in 2002 found that the majority of parents felt it important to discuss smoking with their children and had done so, but that smoking rated behind illegal drugs and nutrition in importance as a health issue to discuss with their children.[34]

What has been achieved?

So has all the preceding youth smoking prevention activity made a difference? Smoking prevalence among young people in Western Australia has indeed decreased significantly since 1983 as depicted in Figure 14. STS campaign evaluation also shows an upward trend in the proportion of young people who said they would not take up smoking when older, from 74% in 1996 to 83% in 2005.[35] In addition, young people's attitudes towards smoking have changed over time. Young people are more likely to be turned off by someone who smokes, consider smoking a waste of money and find it easier to say no to a cigarette if offered.[36]

Figure 14 **Trends in youth smoking prevalence in Western Australia, 1984-2005**



The declining prevalence of adult smoking and environmental changes such as tobacco advertising bans, price increases and the normalisation of smoke-free public places have undoubtedly contributed to this and the literature acknowledges the difficulty of disentangling the precise contribution of targeted youth prevention strategies. Nonetheless, the fact that Western Australia has the lowest youth smoking prevalence in Australia, and for the last decade has been the only state or territory with a comprehensive youth smoking campaign, suggests that a smoke-free generation for Western Australia may not be as elusive as it once seemed.

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The contribution of scientists to tobacco control

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In memory of Louisa Alessandri, Debra Blaze-Temple and Aileen Plant, all champions of public health

Introduction

When the tobacco industry starts playing the man rather than the ball, something it is wont to do from time to time, one of the accusations it makes is that scientists and clinicians involved in tobacco control are self-serving careerists who have chosen to become involved in a controversial field because of the notoriety which that involvement brings. A moment's reflection, however, reveals that, were the accusation to be true, effective tobacco control action would be a self-defeating activity because the problem of smoking and the patients it creates would disappear. Moreover, for the great majority of those involved, the contribution to tobacco control is entirely pro bono – very few individuals make their living directly from tobacco control, far fewer than the numbers of scientists who have prostituted themselves to an industry whose products kill prematurely half of those who continue to use them exactly as the manufacturers intend.

Apart from personal example and the advice they provide to patients in clinical settings, the contributions of individuals with a scientific training to tobacco control take three broad forms, all of which may then form the basis for public advocacy. In this chapter, these three forms are denoted as primary research, synthetic research and creative epidemiology. As well as generating evidence on which tobacco control policy and action can be built, the skills of research are increasingly used to evaluate the effectiveness of initiatives to reduce the prevalence and impact of smoking.

Primary research

In attempting to 'get up to speed' on a particular area of medical research, a common starting point is to interrogate the electronic database of published scientific papers maintained by the National Library of Medicine in the United States. Known as Medline or PubMed, in mid-2007 this system returned details of almost three hundred articles in the peer-reviewed literature when searched for authors who declared a West Australian affiliation and whose papers concerned 'smoking', 'tobacco', 'cigarettes' or users of such products (see Table 1). Just under fifty of the papers were themselves reviews of one or more parts of the available evidence on smoking, suggesting that West Australian scientists have made at least 250 original contributions to the international literature on tobacco and health. That figure is inevitably a conservative one because the Medline database does not include every reputable medical journal and because individuals may publish data from Western Australia after they have moved to another institution outside the State. In addition, Medline is 'blind' to much of the 'grey literature' such as official government reports or research commissioned and published by non-government organisations. Thus, the original reports of the regular surveys of smoking among secondary school students in Western Australia are not easily identified via Medline even though they do represent an important local research effort. Finally, a database of scientific papers is only as good as the system of keywords used to classify the papers it contains. In this regard, the earliest paper identified from the search of Medline described above dates only from 1987,[1] but West Australian scientists have been involved in research and advocacy on tobacco for far longer than that.

Table 1 **Results of a Medline search in mid-2007 for papers on aspects of smoking originating in Western Australia**

Type of paper	Number	Percent of total
Descriptive study[a]	105	35.4
Case-control study	11	3.7
Cohort study	73	24.7
Controlled trial	10	3.4
Review	47	15.9
Other	50	16.9
Total	**296**	**100.0**

[a] Includes some evaluation studies.

Notwithstanding these widely understood limitations of Medline and similar databases, it is clear that Western Australia has made an important international contribution to understanding some of the impacts of tobacco on health. With its capacity, unrivalled in the Southern Hemisphere, for population-based electronic linkage of medical records compiled by several different agencies, it should come as little surprise that several strands of this primary research are based on cohort studies, projects in which groups of individuals with known levels of exposure to smoking are followed longitudinally to assess the consequences of that exposure.

The Busselton Study

Conceived by the local general practitioner, Kevin Cullen, the Busselton Study set out to document and follow the health of the whole population of a small rural community located some three hours' drive south of Perth.[2] Starting in 1966, the backbone of the project was a series of six triennial surveys of the health and lifestyle of all adult residents of the Shire of Busselton.[3] There have also been surveys directed specifically at children in Busselton[4] and a follow-up assessment of anyone who had taken part in any of the earlier examinations was conducted in the mid-1990s.[5] With up to thirty years of observation available at that point, the Busselton Study provides a unique picture of the evolution of the patterns and consequences of smoking in a well-defined Australian community. Being based on relatively small numbers of participants, it has taken several decades to accrue sufficient numbers of major health events, even for common conditions such as heart attack, for detailed statistical analyses to become meaningful. Importantly, in contrast to some of the classic cohort studies of smoking conducted overseas,[6,7] which began when unfiltered cigarettes dominated tobacco sales and pipe-smoking by men was still relatively common, the data on smoking from Busselton relate almost exclusively to the modern filtered cigarettes.

The Wittenoom Asbestos Cohort

Established principally to investigate the effects of primary and second-hand exposure to blue asbestos related to a crocidolite mine in the rugged interior of Western Australia, the Wittenoom Study has afforded significant opportunities to examine the clinical and statistical interactions between asbestos and smoking, two major causes of chronic respiratory ill-health and premature death.[8,9]

Studies of the outcome of pregnancy

A third important area of West Australian research supporting tobacco control concerns the impact of maternal smoking during pregnancy. Here there has been a series of internationally significant papers written by respiratory physicians at the Princess Margaret Hospital for Children demonstrating early and lasting adverse effects on lung function of infants born to mothers who smoked during the antenatal period.[10,11] The establishment of the Western Australian Pregnancy Cohort Study, which is following some 2,600 pregnancies through delivery and into childhood, is providing further opportunities to study the long-term outcomes of 'passive smoking' in utero.[12,13]

Surveys of cardiovascular health

Western Australia has been a national leader in studies of the epidemiology of cardiovascular disease, including coronary disease,[14,15] stroke,[16] abdominal aortic aneurysm (AAA),[17] peripheral arterial disease[18] and heart failure.[19] The associated descriptive and case-control studies of risk factors for atherosclerosis, including smoking, have been important, not only in charting trends in cardiovascular health, but also in expanding our understanding of the aetiology of less common and somewhat neglected problems such as subarachnoid haemorrhage – where both active and passive smoking play a role[20] – and AAA[17] and peripheral arterial disease,[18] where, in contrast to coronary disease and stroke, the significant increase in risk associated with smoking appears to be largely irreversible. Furthermore, in combination with data on long-term outcomes obtained from the record linkage system, the information on the smoking habits of participants in successive surveys of cardiovascular risk factors and of men who took part in a large trial of screening for AAA, is now being combined with that from Busselton and elsewhere in systematic studies of the impact of smoking across the whole of the Asia-Pacific Region.[21] At a certain level, the findings from those analyses are not novel; rather, their importance lies in their making clear to national governments across the region that a failure to introduce effective tobacco control strategies now can only result in a huge toll of avoidable premature deaths in the future.

Summary

Western Australia has been an abundant source of important primary research on the adverse consequences of smoking on health. In part, this work has served to demonstrate that modern cigarettes or ways of smoking them are just as harmful as the older, overseas studies of non-filter cigarettes showed. Other parts of this work have been entirely original contributions to scientific knowledge, systematically exploring the contribution of smoking to an ever-lengthening list of disease processes and across the whole of the lifespan. Still other papers have been more synthetic and applied, being concerned with the adverse impacts of smoking at the level of the whole population. But, in terms of their underpinning the West Australian and national tobacco control efforts, what all of these papers have in common is that data form a better foundation for advocacy than does opinion alone, and that data derived from the local community are the most persuasive of all.

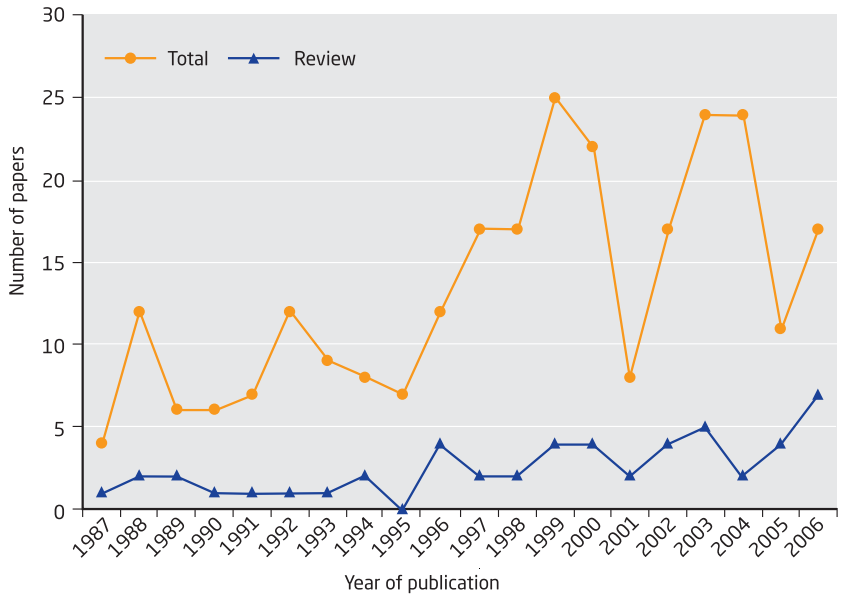
Synthetic research

Until the advent of the Cochrane Collaboration in 1993, 'review papers' that attempted to survey and summarise all of the scientific literature on a particular question tended to arise in two or perhaps three ways. First, postgraduate students often begin their theses by writing a chapter that brings together and synthesises existing knowledge in their chosen field of inquiry, principally in order to identify questions for which no, or only inadequate, answers are available. On occasion, such chapters are converted into manuscripts and successfully submitted for publication in a scientific journal. Second, an editor of a journal might identify an established or emerging authority in a particular field and invite him or her to prepare a review for publication. The third source of reviews also relates to invitations, but of the kind where a

government or other agency commissions a review as the first stage in a process of setting or revising policy. Again, such reviews occasionally are converted into scientific manuscripts and eventually are published in learned journals. Alternatively, they may be published by the agency in their own right.

Given the significant and, at times, pioneering, contributions of West Australian investigators to scientific knowledge on the impact of smoking on health, described above, it should come as little surprise that they are also steadily publishing (invited) review papers on aspects of this knowledge. There has been an average of two to three such papers annually over the last twenty years, but also a rising trend, reflecting the growing stature of West Australian scientists working on aspects of tobacco and health (see Figure 1). Because they usually include a systematic assessment of the strengths and weaknesses of the available evidence, review papers tend to carry even more weight than articles reporting original scientific observations. Comprehensive and apparently balanced reviews are likely to be cited repeatedly by other academic authors, spreading their influence. They also represent very convenient summaries of fields of knowledge for public servants or political aides preparing briefing papers and policy documents for parliamentarians or government ministers. Because it is rather unusual for such documents to include a full list of the sources on which their authors have drawn, it is often more difficult to track the impact of a scientific review paper on policy than it is to demonstrate the regard in which it is held by other academic investigators, as evidenced by their propensity to quote it. However, it seems very likely that learned reviews on tobacco and health prepared by West Australian experts have had important impacts well beyond their specialist professional audiences, and where West Australian scientists have contributed directly to the preparation of such important summary documents as the first and second reports on passive smoking from the National Health and Medical Research Council,[22,23] their influence on public opinion and on government policy is obvious.

Figure 1 **Annual counts of all papers and review papers addressing aspects of tobacco and health, Western Australia, 1987-2006**



The Cochrane Collaboration is an international effort to identify and bring together all randomised controlled trials addressing particular questions in health care. Conceived by Professor Sir Iain Chalmers in Oxford, it takes its name from Archie Cochrane, a noted British epidemiologist, who first suggested that combining the results of equivalent clinical experiments would yield best estimates of the overall effects of a particular treatment, for example, because the large number of observations would reduce the influence of random error. The combined data would therefore form a much better foundation for deciding clinical policy.

The advent of the Collaboration depended not only on Cochrane's idea, first published in 1979,[24] but also on the development, during the 1980s, of mathematical techniques to effect the combination of data he envisaged.[25] That method is now known as 'meta-analysis' and, in the context of tobacco and health, has been used to greatest effect not in combining the results of clinical trials of treatments of smoking-related conditions but in synthesising all of the adequate aetiological studies implicating smoking as a cause of particular diseases. Such an approach becomes a particularly powerful basis for advocacy when combined with the long-established epidemiological technique of 'population attributable fraction', which uses data on patterns of exposure to a hazard in the population and information on the level of risk among those exposed to calculate the proportion or number of cases of a particular condition that would be avoided if that hazard were removed. Thus, the oft-made statement, officially accepted by governments,[26] that smoking causes 19,000 avoidable deaths annually in Australia derives directly from work by English et al. in Western Australia that used meta-analysis to calculate precise estimates of the strength of the relationship between smoking and several dozen different diseases, and then the method of population attributable fraction to determine what this meant at the national level in terms of premature deaths, avoidable admissions to hospital and days spent in hospital.[27] Their project has since been updated by Ridolfo and Stevenson,[28] also in Western Australia, but was a ground-breaking study because its rigorous approach lent such credibility to the results. Indeed, the work of English et al. has served as the starting point for National and State policy on tobacco for over a decade now and has contributed directly to Australia's international pre-eminence as a pioneer in effective tobacco control.

Creative epidemiology

Summarising aspects of the scientific evidence on tobacco and health, either mathematically, using meta-analysis, or via a narrative-style academic review, can be very useful in succinctly communicating to health professionals and specialist journalists the harm done by smoking. However, these forms of communication are not necessarily 'accessible' to politicians, policy-makers and the general public. At worst, such groups may be daunted and doubtful about the mathematics and statistics, and, at best, they may be left asking 'but what does this all mean?' 'Creative epidemiology', a term coined by long-time tobacco control advocate, Michael Daube,[29] is not about manufacturing numbers that support a particular contention; rather, it is the process of rendering carefully compiled epidemiological results into forms that everyone can understand. For example, the estimate that tobacco kills 19,000 Australians annually is given greater immediacy when converted to 'one Australian is killed by tobacco every half an hour'[26] and is put into perspective by the rider, 'more than are killed by alcohol, road crashes, suicides, murders, drowning, snakebites, shark attacks, lightning strikes and HIV/AIDS put together.'[30] As these examples show, one of the aims of 'creative epidemiology' is to find new and newsworthy ways of highlighting aspects of a long-running epidemic, not only to re-engage a public that might think it has heard it all before, but also to catch the attention of newer journalists and politicians whose knowledge of tobacco and health is often embryonic, or at least uneven.

The notion of 'creative epidemiology' highlights an ongoing tension at the intersection between science and advocacy. On the one hand, Professor Sir Richard Doll, grandfather of modern epidemiology and a wellspring of new and detailed information on tobacco and health for over half a century, was always reluctant to use his own data in efforts to influence public policy. For a period, his position appeared to be that science and advocacy were distinct processes that should remain completely separate – a view that might be summarised as, 'I generate the data; it is up to others to decide how to use them.' Later in his long life, however, he seemed to refine this position slightly, but significantly. He became willing to comment on the wider public health significance of particular epidemiological findings published by others, having satisfied himself as to the quality of the science that generated them.[31] Nevertheless, he remained steadfast in his unwillingness to offer equivalent interpretations of his own work because he felt it was up to others to judge its validity, self-assessment, even by a Richard Doll, always being open to error or challenge.

Doug Weed has systematically promulgated a view that diametrically opposes that of Doll. With epidemiology regarded as the basic science of public health, Weed has no problem with the first part of its accepted definition as 'the study of the distribution and determinants of health'[32] but holds that the second part of that definition, 'and the application of this study to control of health problems' confers not a licence but a responsibility on epidemiologists to engage directly in the process of policy-making.[33] Particularly for epidemiologists with a medical background, such engagement represents a huge and dangerous leap into unfamiliar and frightening territory. Because the focus of medical practice is on individual patients, doctors have traditionally stood apart from the rumble-tumble of media and politics, just as, under the Geneva Convention, they seek special and separate status in times of war.

Indeed, creative epidemiology is not without its risks, as three anecdotes will serve to show. First, the near-coincidence of Mother's Day and World No Tobacco Day in Australia prompted Jamrozik and Le to consider how many Australian children have lost a parent to disease caused by smoking.[34] The title of their piece – *Tobacco's uncounted victims* – might be regarded as typifying the efforts of creative epidemiology to find a new 'angle', but their calculations were original while also epidemiologically orthodox. Converting the mathematics into an image of children visiting graveyards on Mother's Day was potentially arresting and 'uncomfortable', but not untrue to the life-and-death reality of smoking.

The discomfort of the audience became overt when, in appearing before a Senate Inquiry in January 1995, Jamrozik likened the epidemic of deaths caused by tobacco in Australia to a 'slow motion Auschwitz'. The analogy was mathematically valid – three million Australians smoking with half to be killed prematurely if they did not give up the habit is a death toll of the same order of magnitude as that at Auschwitz – and its use timely – it was the fiftieth anniversary of the liberation of the camp. Although none was forthcoming, Jamrozik was prepared to counter any criticism in the widespread media coverage that ensued by reminding reporters that most of the victims at Auschwitz shared his Polish heritage. But saddest of all was that the organisation sponsoring his appearance before the Committee leant on Jamrozik to dissuade him from pursuing the argument to its intended conclusion, that there is no place for appeasement in Parliament's dealings with the tobacco industry.

A lack of stomach for the more hard-hitting products of creative epidemiology has also been evident in Western Australia. Beginning with the observations that around one million Australians fought overseas during World War Two, most were men, around three-quarters of them would have been smokers, and tobacco was provided free of charge to military personnel, Jamrozik has suggested undertaking the calculations to compare the lives lost due to active service with the cumulative death toll from tobacco among ex-servicemen and releasing the results on Anzac Day. The consensus among the remainder of the local tobacco control community in Western Australia is that the national day of mourning is too holy and should remain inviolate.

Testing and evaluating interventions

The second part of the definition of epidemiology harkens back to a maxim of TH Huxley – 'the great end of life is not knowledge but action'. In the area of tobacco and health, the ultimate value of science is the extent to which the findings of research are taken up into practice, in terms either of interventions with individuals or changing policies and structures that affect the smoking behaviour of whole populations.

The search of the Medline database described earlier revealed only ten papers reporting aspects of scientific trials of tobacco control interventions, around three per cent of the total apparent output. In terms of content, fourteen papers concerned the epidemiology of smoking behaviour, nine papers examined tobacco control strategies aimed at individuals and sixteen those directed to populations. At first sight, this pattern might be taken as evidence of a gross failure to translate evidence into practice, but Medline and

similar systems are 'blind' to formal citations of that evidence in government documents, for example, or to the number of times secondary and tertiary students quote a scientific paper or visit a reputable website in the course of preparing assignments. Without a significant, ongoing effort, it is impossible to document the number of occasions where a piece of research has been incorporated into, or at least influenced, a health promotion campaign. Nor can one easily enumerate the number of occasions where a research investigator has briefed a policy-maker or parliamentarian, helped in preparation of a media release, or spoken on or off camera or on or off air to a journalist on some aspect of tobacco and health. These are all interventions by scientists or the application of science in tobacco control and education about tobacco. Importantly, the participation by many different members of the West Australian research community in such activities gives the viewer or listener first-hand credence as to the significance the scientific and medical professions attach to the issue of tobacco and health.

Properly designed, implemented and analysed, formal randomised controlled trials yield especially robust evidence about particular strategies for tobacco control, and they also provide an important training ground for new generations of scientific investigators and health promotion practitioners interested in smoking and health. Undertaking such trials, however, poses special challenges. For example, it is far easier to demonstrate that a particular program of classroom sessions results in short-term changes in the knowledge and attitudes of secondary school students around aspects of tobacco than it is to show it has long-term effects on the proportion who become daily smokers. Similarly, the impact of individual and group counselling and of nicotine replacement therapy on the number and success of adult smokers' attempts to quit have been extensively studied, but it remains largely an article of faith, combined with the evidence from longitudinal studies in which many smokers quit spontaneously, that such interventions ultimately translate into greater longevity and reduced morbidity.

In both of the examples just given, in addition to the difficulty of identifying relevant outcomes that might only become evident many years after delivery of an intervention, there is the additional challenge of ascribing patterns of behaviour observed at follow-up to the intervention that was delivered many years before, especially in what has become a very active environment in terms of tobacco control activity. Theoretically, in the setting of a randomised controlled trial, all of the other educational, financial and regulatory interventions designed to reduce the prevalence of smoking in the wider community should 'balance out' across the study groups. However, it requires very large trials to obtain a clear signal about the impact of the experimental intervention when it is delivered in a setting in which there are so many other potentially relevant influences.

But here, too, the skills of research make an important contribution to tobacco control in assisting in the evaluation of various whole-of-community strategies. This can be a frustrating area in which to work because too often too little attention is given to evaluation, the attention that is given, is given too late, the resources set aside for evaluation are too few, and too little of what is learnt is published in order that it can be shared with others and the reinvention of wheels prevented. Where concerted efforts to evaluate innovative strategies are undertaken, the interests of academic investigators in becoming involved may be tempered by the relative scientific weakness of the study designs available for examining whole-of-population initiatives, but examining whether public monies have been applied wisely and effectively and reporting the findings properly are significant responsibilities. In this sphere, science and scientists have made important contributions in Western Australia in pre-testing health promotion materials, selecting evaluation designs, preparing survey instruments, advising on sampling techniques, and in analysis and interpretation of the findings. Again, large portions of this work are not traceable via the usual mechanisms employed in academic life, but some of it has ultimately appeared as peer-reviewed publications.

Conclusion

How one assesses the contribution of science and scientists to tobacco control in Western Australia and elsewhere probably depends on the scientific literacy of the individual charged with undertaking the task. Scientists have strict rules about the quality of evidence and judgments about cause-and-effect that have been crucial to their efforts in generating the evidence that forms the foundation of tobacco control. Non-scientists might venture an assessment based on the apparent public engagement in the tobacco control effort of a limited number of individuals whom they regard as belonging to the scientific community. That assessment would sell very short the breadth and depth of the contribution of science and scientists, not least because the link between smoking and lung cancer, for example, is now a matter of general public knowledge and the huge effort it took to identify, confirm, explain and have that link accepted as one of cause-and-effect is perhaps less important than having a large proportion of the population know of, and believe in, the risk.

But it remains clear that tobacco control in Western Australia is very much a matter of applied science – applying the skills of science in uncovering the risks of smoking; in reviewing, testing and summarising those risks as the evidence accumulates; in devising novel ways by which the nature and magnitude of those risks can be communicated; and in developing and testing interventions designed to reduce, as far and as fast as possible, the proportion of the population running those risks. And it is equally clear many of the contributions to tobacco control of the numerous scientists with an interest in smoking and health in Western Australia are not easy to document because they have not been recorded at all. It is hard to estimate the value of this long tradition of giving of advice and time and energy, and of sharing of wisdom, but thousands of West Australians living today probably owe their lives to it. Furthermore, the altruistic spirit in which almost all of it was done is the best evidence that scientists and doctors do not get involved in tobacco control only to make a name for themselves.

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Advocating for tobacco control in Western Australia, 1971 to the present

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Setting the scene – 1950s and 1960s

The need for tobacco control advocacy and to counter the tobacco industry became increasingly clear during the 1960s, as successive Federal and State governments around Australia ignored or rejected calls to act on scientific evidence and the advice of health experts that included:

1950 the advent of landmark studies in Britain by Doll and Hill[1] that identified smoking as 'an important factor in the cause of carcinoma of the lung' and in the United States by Wynder and Graham[2] that concluded 'the occurrence of carcinoma of the lung in a male non-smoker or minimal smoker is a rare phenomenon'

1957 calls by the National Health and Medical Research Council (NHMRC) on State governments to carry out anti-smoking campaigns and on the Commonwealth government to establish a body to advise on reducing the risk to smokers[3]

1960 recommendation by the NHMRC for restrictions on the advertising of tobacco[3]

1962 publication in Britain of the report by the Royal College of Physicians of London,[4] *Smoking and health*, which drew worldwide attention to the dangers of cigarette smoking

1962 endorsement by the Australian Medical Association, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Royal College of General Practitioners and the Anti-Cancer Council of Victoria of the Report of the Royal College of Physicians and call for restrictions on tobacco advertising and the introduction of a public education campaign[3]

1963 a submission by the NHMRC[3] calling on the Commonwealth government to enforce a total prohibition of tobacco advertising

1964 the release of the first in a series of reports on smoking and health by the United States Surgeon General[5] based on international reviews by distinguished expert advisory committees of the burgeoning body of scientific papers on the hazards of smoking attracting massive media coverage and drawing yet further attention to the dangers of smoking.

In 1963 the Menzies Federal Cabinet's response to the NHMRC submission to ban tobacco advertising was that, 'It did not conceive it to be the function of the Commonwealth Government to take action in these matters', a position revealed when Cabinet papers were released thirty years later.[6]

In contrast to the Australian Government, in Norway the Parliament in 1964 requested 'the government to set up a broadly based committee whose main task should be to plan the campaigns against harmful tobacco smoking'.[7] A report of the committee, chaired by Dr Kjell Bjartveit, was released in 1967 and a condensed English version was published by the International Union Against Cancer (UICC) in 1969.[8] The UICC report recommended a comprehensive program that included educational, restrictive and therapeutic measures noting that the effectiveness of such a program would be diminished if there were a lack of balance between the three components.[8]

The tobacco industry did all it could to decry, deny and undermine the overwhelming scientific evidence. Documents from the American tobacco company Brown and Williamson[9] made public during court cases twenty-five years later reveal tobacco company tactics. These are exemplified in a memorandum in 1969 from JW Burgard to RA Pittman (Brown and Williamson's senior marketing supervisor) about a campaign 'to bring the industry side of the smoking and health controversy to the attention of the general public'. An objective of the campaign was to:

> *... set aside in the minds of millions the false conviction that cigarette smoking causes lung cancer and other diseases; a conviction based on fanatical assumptions, fallacious rumours, unsupported claims and the unscientific statements and conjectures of publicity-seeking opportunists.*[9]

External advocacy - 1971 to 1983

Frustration with the lack of government response to calls for action on tobacco led to the formation of the West Australian branch of the Australian Council on Smoking and Health, ACOSH, in 1971 (ACOSH had been founded in 1967 in New South Wales by Dr Cotter Harvey). In 1978, the Sydney branch of ACOSH ceased to exist, and national direction of the organisation passed to the West Australian branch. ACOSH in the 1970s comprised a group of dedicated volunteers, principally physicians and epidemiologists, focused on raising awareness of the dangers of smoking and getting tobacco control on the political agenda. Norway continued to lead the way in tobacco control and by the time the second report of the Royal College of Physicians of London was released in 1971, a Bill to prohibit tobacco advertising had been drafted for the Norwegian Parliament.[7] 1971 also saw publication of a second report on smoking by the Royal College of Physicians, *Smoking and health now,*[10] and the release of a further major report of the United States Surgeon General on *The health consequences of smoking.*[11]

Legislation was passed by the Australian Federal Parliament in 1969 allowing a warning to appear on cigarette packs, but the state and territory governments each needed to pass their own legislation before warnings could be introduced.[12] Intense lobbying by the tobacco industry resulted in the innocuous and inconspicuous text health warning, 'Warning. Smoking is a health hazard' (see Figure 1). The enactment of legislation by states was protracted and did not occur in Western Australia until 1972.[13]

Figure 1 **Health warning on Australian cigarette packaging, 1973**

In 1972, a ban on direct tobacco advertising on radio and television in Australia was introduced into the Federal Parliament by the Whitlam Labor Government, subsequently passed under the Fraser Coalition Government and implemented in stages from 1973 to 1976.[14] The advertising bans came as no surprise to the tobacco industry which had planned strategies in advance to circumvent the restrictions, illustrated by minutes of a management meeting of an Australian tobacco company, Rothmans, held in 1970. The General Manager is reported as acknowledging that tobacco advertising restrictions were expected 'within the next few years. This is the reason for the existence of the Rothmans National Sports Foundations and our sponsorships which are being developed in anticipation of restrictive advertising action in Australia'.[14]

No further legislative controls on tobacco advertising or promotion were implemented in Australia in the 1970s. A 1976 document of the tobacco company W.D. & H.O. Wills headed *Past strategy and tactics*[15] stated:

> *The fundamental policy of the Industry up until 1974 was to buy time and avoid where possible confrontation with Governments or anti-smoking organisations on strictly medical arguments. The basic strategies were: - To encourage those Governments known to be lukewarm about uniform repressive legislation, which in Australia is essential to the most important aspects of anti-smoking activity, to refrain from agreeing to such legislation ... The Industry has achieved a high degree of access to government on the relevant [issues] and a considerable ability to delay and/or amend proposed restrictive legislation and regulation ... We aim to preserve this situation.*

Landmark legislation was enacted in Norway in 1973 (and implemented from 1975) to prohibit all forms of advertising of tobacco products. Other Scandinavian countries such as Sweden and Finland showed that progressive legislation was possible in areas ranging from rotating health warnings to differential taxation on tobacco products. In Britain, the Royal College of Physicians of London released its third report on smoking and health in 1977.[16] The United States Surgeons General continued with their series of influential reports on the health consequences of smoking,[17] noting in 1979 that in the fifteen years that had elapsed since the first, more than 30,000 scientific papers had provided further irrefutable evidence on the consequences of smoking.[18] In 1977, the UICC published *Guidelines for smoking control*[19] (edited by Dr Nigel Gray of the Anti-Cancer Council of Victoria) followed soon after by a second edition[20] containing a stronger set of recommendations in 1980 (edited by Dr Gray together with Mike Daube, then of the University of Edinburgh in Scotland, previously Director of Action on Smoking and Health in the UK). Arising from this report the UICC's clear policy objectives were promoted to and adopted by other international health agencies, including the World Health Organization.[21]

In Western Australia and other Australian states, a common purpose and consensus on policy priorities in tobacco control helped concentrate efforts as political support for extending restrictions on tobacco advertising at a national level diminished. South Australia was the first state in Australia to introduce a Bill in 1980 to implement further restrictions on tobacco advertising but the legislation was not passed.[14]

In Western Australia, pressure for bans on tobacco promotion was led by ACOSH, working closely with organisations such as the Heart Foundation, the Cancer Foundation (later the Cancer Council) and the Australian Medical Association (AMA), as well as key staff in the Health Department.

ACOSH recognised early the need for active campaigning. Leading medical campaigners in ACOSH included Bruce Armstrong, then head of the NHMRC Epidemiology Unit at The University of Western Australia, respiratory physician Bill Musk and surgeon Kingsley Faulkner. In this early advocacy phase the Director of ACOSH was Steve Woodward, an energetic scientist with great charm and understanding of sporting and related areas as well as the need for an aggressive approach to the tobacco industry. A vascular surgeon, Bill Castleden, took six months unpaid leave to assist in ACOSH's work. ACOSH was strongly supported by the Cancer Foundation and its director, Clive Deverall, who provided office space and other support. Another prominent figure in early campaign activity was Debbie Fisher, initially from the Heart Foundation, where,

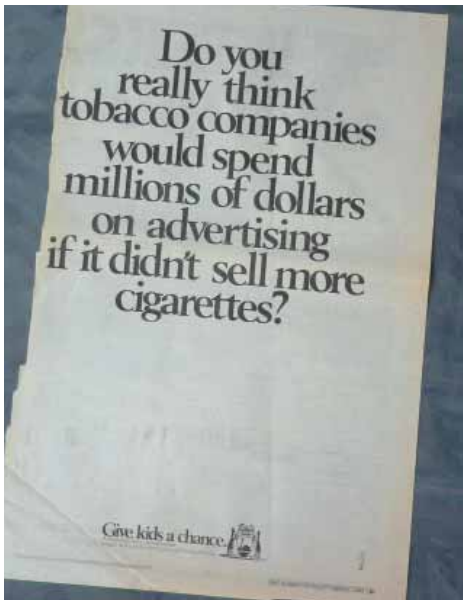
with leading market researcher Rob Donovan (who continued to be a major influence on state and national advertising programs for more than two decades) she developed the first significant advertising campaigns on smoking, then became the first Coordinator of the Health Department's Smoking and Health Project (later to become the Quit Campaign).

ACOSH worked closely with other health and medical organisations as well as the (then) Western Australian Health Department. Dr Charles Watson, Director of Health Promotion, a distinguished neuro-anatomist with a passion for prevention, was supported by campaign-oriented staff including Maurice Swanson and Tahir Turk. Maurice Swanson had played an important role by breaching convention and meeting with the then Opposition health spokesperson Barry Hodge to encourage a stronger approach to prevention generally and tobacco in particular.

The Smoking and Tobacco Products Advertisements Bill, drafted pro bono by a prominent QC, David Malcolm (later to become Western Australia's Chief Justice) was introduced to the Western Australian Parliament in 1982 by the Liberal Member for Subiaco and GP, Dr Tom Dadour, after the Minister for Health had indicated that Cabinet would not support it.[22] There was strong opposition to the Bill from the tobacco industry including full page newspaper advertisements claiming that there would be job losses should a ban on tobacco advertising be introduced.[23] The tobacco industry also exploited its links with the media, particularly with the print media for whom tobacco advertising was a major source of revenue, seeking support for its position – 'legal to sell, legal to advertise'.[23] The *Subiaco Post* newspapers took an early but isolated stand in refusing to accept profitable tobacco advertisements. The Bill was passed in the Lower House but defeated in the Upper House of the Western Australian State Parliament.

In 1983 a Labor Government led by Premier Brian Burke was elected with specific commitments to tobacco control including an advertising ban and a major public education program. The new Health Minister, Barry Hodge, was a strong and committed advocate for health promotion and tobacco control who led key initiatives both in Western Australia and nationally (e.g. for new health warnings). The government supported the introduction of the Tobacco Sale and Promotion Bill 1983 with a media campaign that had a central theme 'Give kids a chance' (see Figure 2).[23] An energetic campaign in support of the Bill was run by ACOSH and health organisations.

Figure 2 **Campaigning FOR the Tobacco Sale and Promotion Bill 1983**



The tobacco industry, through the Tobacco Institute and all the major companies, ran a ferocious and well-funded campaign against the Bill. Opposition also came from media groups such as the Australian Publishers Bureau, sections of the advertising industry, and other groups with allegiances to the industry such as sporting organisations sponsored by tobacco companies (see Figure 3). The industry pressured prominent sportspeople not to support the advertising ban campaign and recruited figures portrayed as 'experts' to raise doubts about the influence of tobacco advertising on children.[23]

Figure 3 **Campaigning AGAINST the Tobacco Sale and Promotion Bill 1983**

Parliamentary debate on the Bill was colourful. One member of Parliament commented that 'The people of Nazi Germany were sheer amateurs compared with the Government in what it is trying to do here,'[24] (to which one of his colleagues added, 'Hitler would have blushed').[25]

The Bill passed in the Lower House but was narrowly defeated in the Upper House by 17 votes to 15.[23] The failure of the 1983 Bill was a major setback that caused leaders in the Government to adopt a cautious approach to further legislation for some years. However, it was an important stepping stone in raising awareness of the dangers of smoking and the impact and power of tobacco companies, paving the way for further efforts in Western Australia later in the 1980s. At a broader level, the unsuccessful attempts to introduce legislation by the Western Australian (1982, 1983) and South Australian Governments (1980, 1983) caused the tobacco industry to regard Australia in 1983 as a bellwether country, setting a pattern for change elsewhere.[23]

Inside-outside advocacy – 1984 to 1990

While the events of 1982 and 1983 were seen as a major setback for tobacco control at the time, they showed that there was strong support for firm action. The Government remained committed to implementing its election commitments, increasing state tobacco taxes and establishing a 'Smoking and Health Project' with a $2 million budget in the Health Department's new Health Promotion Branch.[3] During the rest of the 1980s, the Project (renamed the Quit Campaign) gained a world-leading reputation for innovative approaches to advertising and public relations. The Quit team worked closely with ACOSH and was influential in both informing the public about the harms of smoking and in building community and political support for tobacco control. The approach of the Quit Campaign served as a model for other State

and overseas health departments. Another innovative approach by the Health Department that made a strong contribution to advocacy came through the release of a steady flow of reports from the Epidemiology Branch Director, Dr D'Arcy Holman (later Foundation Professor of Public Health at The University of Western Australia) that provided new and compelling ways of communicating scientific data on the harmful effects of smoking.

A well-recognised feature of tobacco control efforts in Western Australia over many years has been the early and continuing recognition of the need for a strong coalition. Public health advocates in Western Australia and nationally recognised early that *ad hoc* activities were futile, and that success lay in sustained, coordinated efforts working to a clear and agreed plan of action. ACOSH and the Health Department worked closely with tobacco control advocates in other states, notably Dr Nigel Gray and Dr David Hill of the Anti-Cancer Council of Victoria and Action on Smoking and Health Australia (ASH) (whose Director from 1984 to 1993 was Steve Woodward, the previous Director of ACOSH, followed by Anne Jones).

In Western Australia, ACOSH played a crucial role in building consensus as well as a high-level coalition of individuals and organisations willing to campaign for those goals. This approach was further and very effectively developed by Dr Ruth Shean, the Director of ACOSH from 1984 to 1989. During this period ACOSH strengthened its credentials as a medically and scientifically based expert organisation with strong community links and media support, and rekindled the campaign for legislation. During the 1980s, for the most part with the knowledge and support of government, there was a very close working relationship between ACOSH and its member organisations and Western Australian Health Department staff, effectively operating as a coalition with the informal support of Health Ministers. Advocacy activities were coordinated by Ruth Shean, Bill Musk, Kingsley Faulkner in ACOSH, and supported from the Health Department by Mike Daube, Charles Watson, Maurice Swanson and others. A vital member of the coalition was the AMA, which, through high-profile presidents such as Dr Mike Jones and Dr David Watson, supported by the executive director, Paul Boyatzis, played a key role in publicly and privately lobbying Ministers and Members of Parliament from all parties. There was also strong support from prominent individuals, such as Dr Fiona Stanley, and health organisations including the Cancer and Heart Foundations.

The roles played by members of the ACOSH coalition included:[26]

1. **Developing the strategies**
   - all worked together to determine priorities, develop strategies and identify opportunities
2. **Preparing the ammunition**
   - epidemiologists provided statistics on smoking in a highly accessible form
   - ACOSH developed the communications strategies including preparation of media releases, background resources and photographic opportunities
3. **Firing the bullets**
   - select, credible, high-profile experts acted as media spokespeople
   - high level delegations from the AMA and other organisations met with politicians to lobby on issues
   - media consultants helped build relationships with West Australian media as well as maximising coverage of tobacco issues through careful timing of attention-grabbing media releases
   - lateral thinkers among the coalition contributed ideas and identified opportunities for keeping tobacco issues alive in the minds of the public.

ACOSH and the tobacco coalition worked during the 1980s, not only to publicise the dangers of smoking, but also to counter the influence of the tobacco industry with key groups such as politicians, media and sporting leaders. The campaigns run by the West Australian coalition in the 80s placed a major emphasis on demonising tobacco companies and undermining their credibility. Tobacco companies, which continued to advertise and sponsor heavily, provided a ready target but also enabled a David and Goliath approach. A constant flow of new and media-focused ideas from ACOSH, other non-government organisations (NGOs) and the Health Department, sometimes using a light-hearted approach to make a serious point, kept the issues fresh and engaging for the public, the media and opinion leaders. Examples included:

- An 'alternative tobacco company' annual report was written by ACOSH and presented in 1987 by some of the medical royal colleges and other prestigious health groups as 'the type of AGM which the tobacco industry would hold if it was truthful'.[26] The alternative report pioneered the use of market share information to attribute numbers of deaths to specific brands.
- ACOSH bought parcels of shares in tobacco companies, then sold one share each to member organisations and medical supporters so that they could attend AGMs and ask questions as shareholders.
- ACOSH and the AMA held a dramatic press conference to release a report on the number of body parts surgically removed each year as a result of smoking based on work by D'Arcy Holman from the Health Department.
- The AMA worked with ACOSH to develop a 'Death Cards' campaign in which doctors sent postcards to Members of Parliament when patients died because they had smoked.
- ACOSH created an organisation called 'SWATS' – Sports Without Tobacco Sponsorship – which attracted widespread coverage and played an active role in getting across the message that many sports preferred life without funding from tobacco companies.
- To illustrate the magnitude of the problem, ACOSH calculated that 'Smoking kills more people in Australia than the total number killed by drink, drugs, murder, suicide, road accidents, rail accidents, air accidents, poisoning, drowning, fires, falls, lightning, electrocution, snakes, spiders, sharks and crocodiles'.[27,28]

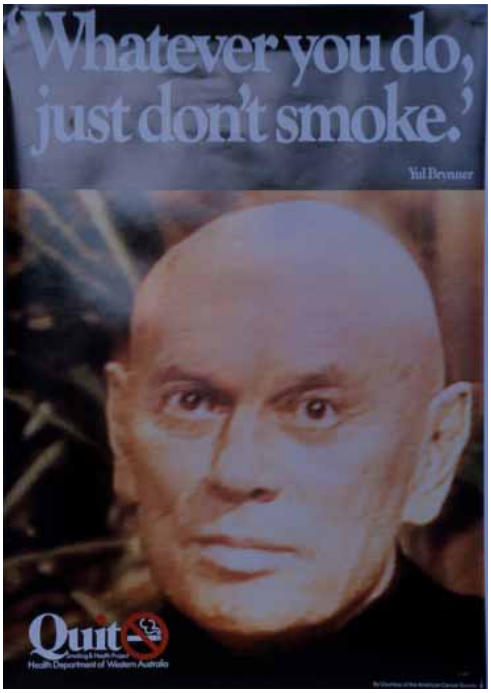
Lobbying by ACOSH, NGOs and the government Quit Campaign developed hand in hand. During the 1980s the Health Department pioneered an approach that combined hard-hitting advertising and promotion with overt advocacy. The Department tested the boundaries of what was acceptable from a government agency in terms of media and other advocacy. By the end of the decade opinion surveys showed high levels of support for this approach among both non-smokers and smokers.

Examples of the Department's activities included:

- Opinion surveys on a range of related issues, one showing that tobacco company executives were less trusted than any other groups in the community – including used car salesmen.
- The Health Department's 'Death Clock' (a digital clock prominently placed as a hoarding in the centre of Perth which ticked over to mark each death caused by smoking) which attracted major publicity when it was launched, further publicity when the tobacco industry attacked it, more publicity when the Department defended it, and continuing publicity for several years.

- An advertisement adapted from an American Cancer Society advertisement featuring the late Yul Brynner (see Figure 4). In this powerful advertisement Brynner spoke about his own lung cancer and said, 'Whatever you do, just don't smoke.' The Department's intent was to show this as a heavily promoted 'one-off' advertisement, preceded by an introduction from the AMA State President Dr David Watson. In a comical series of events, the Australian Broadcasting Tribunal, which had previously approved the advertisement, withdrew its approval at the eleventh hour, on the basis that foreign actors in advertising might deprive Australian actors of jobs. They were unmoved by the knowledge that Yul Brynner had died and was in no position to deprive any actors of work. Health Minister, Ian Taylor held a major press conference that resulted in massive national and state coverage.

Figure 4 **Opportunistic campaigning - Yul Brynner**



The media became increasingly sympathetic to anti-smoking messages. The tobacco industry became less credible but cigarette advertising and promotion continued, although the companies continue to claim that it was never directed to young people.

Legislation to end tobacco advertising remained the focus of advocacy efforts. There were still four major hurdles to overcome: memories of the 1983 defeat, the need for bipartisan support in the Upper House, concerns about possible impacts on State tobacco revenues, and the perceived reliance of sports and arts organisations on tobacco sponsorship.

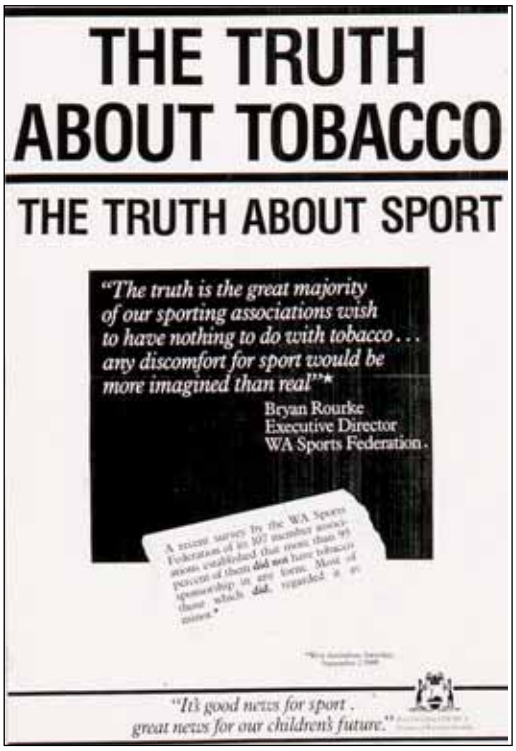
The campaign for legislation was given a crucial boost in 1987 with the passage of the Victorian *Tobacco Act*. The Victorian tobacco coalition, led by Dr Nigel Gray, developed an approach that combined a ban on tobacco advertising with a tobacco tax increase which would fund a Health Promotion Foundation to replace tobacco funding and fund health promotion programs – as well as providing the Government with additional revenue from a 'virtuous' tax. This approach neutralised the tobacco industry's strongest arguments and supporters.

In Western Australia, following passionate lobbying by National Party MP Dr Hilda Turnbull, the leader of the National Party, Hendy Cowan, committed his party to supporting this approach. Premier Peter Dowding then announced that the Labor Government would introduce Victoria-style legislation, which was introduced in the Parliament by Health Minister Keith Wilson.

A frenetic period of lobbying followed the introduction of the Bill. The tobacco industry brought in recipients of tobacco funding, tried to persuade media, sports and arts organisations that they would lose out, and threw mud and money wherever they could. But while the tobacco industry had the big money, its spokespeople gave tobacco control advocates some easy targets. Ron Berryman, head of the Tobacco Institute's Perth office, said in 1989, 'Irrespective of how many children take up smoking in a year, no-one's immortal – everyone dies sooner or later' and '(Cigarettes are harmful, but ...) so are potatoes. Tobacco is in the family. You inhale the fumes of potatoes when you're cooking them.'

Comments in opposition to the Bill included those from Max Trenorden, MLA – 'I do not think I have seen a worse piece of legislation come into this place since I became a member'– and Hon. Bill Hassell MLA[a] 'We have a proposal before us to establish a health promotion foundation. The Orwellian nature of the title is revealed by a moment's thought.'[29]

Figure 5 **Breaking the nexus between sport and tobacco**



The health lobby, coordinated by ACOSH, worked with budgets equivalent to a fraction of the tobacco industry's funding, but it was highly focused and coordinated. Experts were brought in to speak to the benefits of an advertising ban, whether in Victoria or Norway. Sympathetic leaders and organisations in sports, the arts and community organisations were brought into play. Opinion surveys were run, and their results published. Key politicians were visited, phoned and mailed by health organisations and constituents who were mobilised to inundate politicians and media with letters. Ruth Shean at ACOSH creatively developed new letterheads to ensure that every possible organisation was seen to be playing its part by lobbying politicians.

a One of the strongest of the tobacco industry's supporters in the parliament, former Liberal leader Bill Hassell, became a consultant for the Philip Morris company after the end of his parliamentary career.

Nearly eight years after the initial Bills put forward by Tom Dadour and Barry Hodge, the *Tobacco Control Act (1991)* banned most forms of advertising of tobacco (with some exemptions), ended the distribution of free samples of and competitions involving tobacco products, significantly raised the penalties for the sale of tobacco to minors, prohibited sponsorship by tobacco companies (although allowing exemptions for events of national and international significance at the discretion of the State and Federal health ministers), and established the Western Australian Health Promotion Foundation 'Healthway'.

While the focus of West Australian public health advocates was clearly on state-based issues, they also made significant contributions to national and international efforts in tobacco control, from pressure through the Australian Health Ministers' Council to push for stronger, rotating health warnings on tobacco products to hosting the Seventh World Conference on Tobacco and Health in Perth in 1990. There was also significant West Australian involvement in advocacy for the ban on smoking in airlines, introduced nationally in 1987 following an ALP party-room vote led by West Australian Federal MP Ron Edwards (a later Director of ACOSH).

Rethinking advocacy – 1991 to 1999

After the passage of the *Tobacco Control Act* in 1990, and its promulgation in early 1991, the focus of tobacco control advocacy in Western Australia shifted to ensuring effective implementation of the legislation. ACOSH identified its two other major priorities for advocacy as second-hand smoke and tobacco taxation.

ACOSH, where the director was now Noni Walker, worked closely with the Health Department helping to raise awareness of the legislation and its requirements, and supporting the establishment of Healthway (the Western Australian Health Promotion Foundation) with appropriate funding levels. Healthway was not able to play a direct role in advocacy, but under its first Director, Addy Carroll, made some crucial contributions to advocacy organisations and activity through replacing tobacco advertising and promotion, and funding health agencies directly and indirectly involved in advocacy. Healthway also found that the funding actually required to replace tobacco sponsorship of sport and the arts fell far short of the sums claimed during the debates by tobacco companies and their supporters.

A seminal 1981 paper by Japanese epidemiologist Takeshi Hirayama[30] clearly demonstrated the dangers of second-hand smoke, and was followed by a flood of further evidence in this area.[31,32] Second-hand smoke (the inhalation of environmental tobacco smoke) emerged as a strong influence on policy-making by governments, business and decision-making by individuals and became a crucial advocacy battleground.

The tobacco companies continued to deny and undermine the evidence on smoking and disease for both active and passive smoking. In 1986 a series of advertisements in Australian daily newspapers aimed to persuade the public that second-hand smoke was not a health problem. ACOSH, along with others, lodged a formal complaint about the advertisements with the Advertising Standards Council (ASC). The complaint was upheld although no punitive action was available through the ASC.[14]

In the Australian Federal Courts an action coordinated by Steve Woodward of ASH Australia challenged the advertisements under the *Trade Practices Act* (Australian Federation of Consumer Associations (AFCO) vs. the Tobacco Institute of Australia (TIA)).[14] The case continued over many years with contributions from West Australian expert witnesses including Professors Peter Le Souef, Lou Landau and Bill Musk. Justice Morling's 1991 judgement on AFCO vs. the TIA in 1991 found that, in publishing a particular advertisement stating that 'there is little evidence and nothing which proves scientifically that cigarette smoking causes disease in non-smokers', the TIA had engaged in misleading or deceptive conduct in breach of section 52 of the *Trade Practices Act 1974*.[14] Justice Morling concluded that second-hand smoke was a cause of lung

cancer, respiratory disease in children and attacks of asthma.[14] This landmark decision was the impetus for widespread advocacy in Western Australia, and elsewhere, for the expansion of non-smoking policies to worksites, shopping centres, TAB outlets, restaurants, airport terminals, healthcare settings and other indoor public places.

Growing evidence of the effectiveness of increases in the cost of tobacco in reducing demand and consumption of tobacco highlighted the need for increases in federal taxes on tobacco.[14] The Director of Quit Victoria, Michelle Scollo, and ACOSH Director Noni Walker worked together in preparing briefing papers making the case for regular increases in the tax on tobacco, as well as changing the tax on tobacco from a weight to a per stick based system, that could be endorsed by a large range of leading health organisations. This initiative was supported by formal written submissions to the Federal Treasurer and senior Treasury officials outlining the economic and longer term health and social benefits of reform of the tax regime for tobacco.

Following a High Court decision on the respective roles of the Commonwealth and the States, in 1997 taxing powers over tobacco and alcohol became the sole domain of the Commonwealth. This removed an important avenue for local advocacy. Nonetheless, it was a measure of the impact of both tobacco control advocacy and the success of Healthway that the Court Coalition Government immediately announced that Healthway's role and funding would not be adversely affected.

ACOSH worked closely with public health advocates in other states to achieve stronger advertising restrictions at the national level resulting in the Federal *Tobacco Advertising Prohibition Act 1992* banning all remaining forms of tobacco advertising in Australia (with limited exemptions).

In 1995 ACOSH initiated the National Tobacco Scoreboard to recognise achievements in tobacco control by State governments and draw attention to deficits in policy-making and funding commitments. The scoreboard became an annual event coordinated by the AMA and ACOSH to mark World No Tobacco Day (31 May). The state scoring the highest points earned the Best Performance Award while the state with the lowest points was awarded the Dirty Ashtray (an engraved ashtray complete with cigarette butts superglued to the glass). The National Tobacco Scoreboard achieved consistently good media coverage and had a notable impact on ministers in under-performing states.

Ironically, achievements in tobacco control led to a perception in the community and among some public health advocates that:

- The tobacco industry was a less visible and therefore spent force[33] (the Tobacco Institute of Australia closed its Perth office and took a lower profile approach to media in Western Australia).
- Tobacco control measures in place were sufficient.
- Attention and resources could now be directed to other seemingly more pressing public health matters.

There may also have been some complacency following achievement of the hard-won tobacco legislation. For these reasons and because of a natural wish by some to address other issues, it became harder for a while to engage politicians, the media, the community and, even public health policy-makers and practitioners in smoking and health issues. The need for further action, however, was obvious: tobacco remained the largest preventable cause of death and disease, the evidence on the dangers of second-hand smoke was increasing, tobacco companies and their allies, as might have been expected, were adept in finding loopholes in the legislation and developing new forms of promotion, and there were worrying trends in smoking among some sub-populations, particularly schoolchildren.[34]

Recognising shifts in community and political attitudes and with strong leadership by its then President, Professor Konrad Jamrozik, ACOSH took a more proactive role in planning and coordinating strategic directions for tobacco control in Western Australia, facilitating agreement on priorities and roles of the key health organisations in the State. There was a strong emphasis and agreement on the 'best buys', strategies for which there was robust evidence of effectiveness and that represented efficient use of the limited resources available. The Heart Foundation's 'Smarter than Smoking' project, directed towards young people, resulted from collaboration by health organisations to attract funding from Healthway.

The advent of Coalition governments brought more obstacles to advocacy, but also Health Ministers such as Peter Foss and Graham Kierath who, to the surprise of some, pursued tobacco control agendas. Ministers were well briefed and supported by Maurice Swanson in the Health Department. Graham Kierath found a new approach to 'inside advocacy' in his moves to implement a ban on smoking in enclosed workplaces. He had some doubts as to whether his Cabinet colleagues would support this measure, so took the regulations to a meeting of ExCo (the State's Executive Council at which the Governor formally signs regulations into existence) where he had hoped – rightly as it turned out – that the other Cabinet members present would not have bothered to read the papers ahead of the meeting.

Innovative approaches were adopted by ACOSH in order to remind the community and politicians about the dangers of smoking. Examples that gained substantial media coverage included:

- a report for each parliamentary member showing the full impact of smoking in all West Australian electorates (produced by Konrad Jamrozik based on an approach initiated in Scotland) that had a notable impact on West Australian politicians
- a graphic presentation of the risks of smoking in the form of 'bookies' odds' translating scientific data into a form that showed smoking to be a very poor wager.

ACOSH also advocated to reduce exposure of staff, clientele and government regulators to second-hand smoke at the Burswood Casino in Perth. A tactic used by the Casino was to engage consultants who attempted to shift focus away from second-hand smoke as a hazard with the concept of 'sick building' and 'indoor air quality', asserting that other pollutants and inadequate ventilation were at fault.[35] Court action by Occupational Health and Safety authorities saw the now-familiar appearance of experts with a history of research funded by tobacco companies providing evidence denying the effects of second-hand smoke.

Advocacy initiatives in the 1990s were supported by ACOSH Presidents Dr Keith Woollard, a former National and State AMA President with a flair for media advocacy, and Dr David Roberts, also a former AMA State President who took a special interest in pursuing the second-hand smoke agenda. The AMA and the Heart Foundation continued to play an active role in advocacy. The (then) Cancer Foundation established a new Tobacco Program in 1999, having successfully challenged the then Health Minister to match new tobacco funding provided by the Foundation. 'Make Smoking History' combined public education with advocacy, and later also cessation services.

New targets, new approaches – 2000 to 2006

Persistent, concerted action has been the hallmark of tobacco control efforts in Western Australia with a number of key non-government health organisations giving even greater priority to tobacco control in the new millennium, such as the AMA, The Cancer Council and the Heart Foundation (all active both locally and nationally). The Cancer Council Western Australia has significantly increased its investment in tobacco control through the establishment of Make Smoking History, the largest public education campaign undertaken by the Council, and by contributing to national and international efforts in particular through the leadership work of Denise Sullivan, formerly head of the Quit Campaign.

Second-hand smoke continued to be a focus of advocacy campaigns where the battleground moved to pubs and clubs. The main public campaigners against change were not tobacco companies, which took a low profile, but their allies in the Australian Hotels Association, led in Western Australia by its CEO Bradley Woods.[33] In Western Australia, as elsewhere, the alliance between the tobacco industry and the Australian Hotels Association served to intensify what became a David and Goliath battle for smoke-free restaurants, pubs, clubs and international casino. At a national level ASH Australia, led by Anne Jones, explored the potential for legal action against the tobacco companies, employers and business proprietors for harm to employees, patrons and visitors resulting from exposure to second-hand smoke.

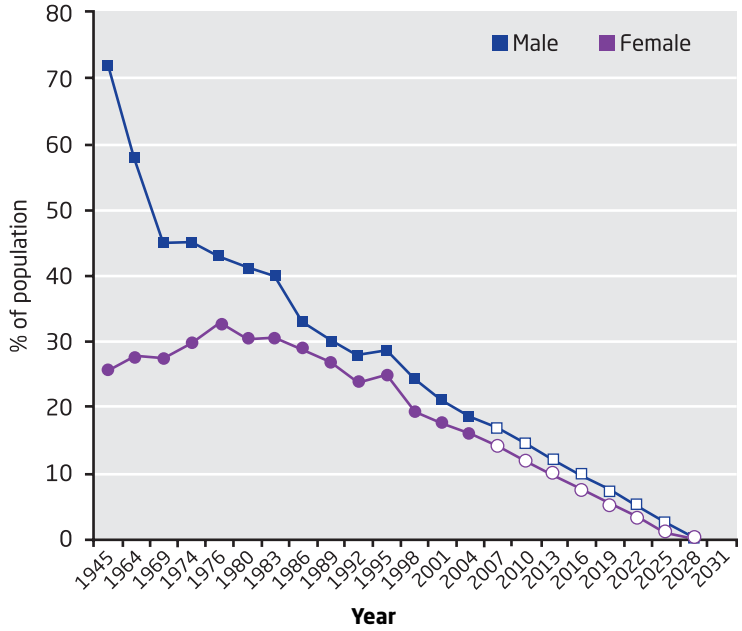
Public and private lobbying of Health Minister Jim McGinty over this phase by the 'big four' – ACOSH, AMA, The Cancer Council and Heart Foundation – emphasised strong public support for tobacco control and helped to bolster political support for an ambitious legislative agenda. The Western Australian Tobacco Products Control Bill 2005 and Tobacco Products Control Regulations 2006, passed in 2006, encountered little opposition in Parliament. The scope of these measures and consequent regulations would have been unthinkable twenty years earlier. Smoking was banned in all enclosed public places including licensed premises (with an exemption for the Burswood Casino's International Room); controls on tobacco promotion were strengthened; point-of-sale displays were limited to one square metre; licensing for tobacco retailers was reintroduced; and the Minister also introduced a ban on smoking in all health premises and their grounds. West Australian health groups also contributed to lobbying nationally, for example for the introduction of graphic health warnings on tobacco packages in 2006.

ACOSH's Director from 2003, Stephen Hall, placed an especial focus on longstanding concerns about smoking among Indigenous people. Advocates continued to draw attention to illicit or barely licit marketing ploys of the tobacco companies, especially initiatives targeting youth, as well as their intrusion into new and less regulated media and settings such as the Internet and fashion and music events.

Advocacy in a climate of success – 2006 to the present

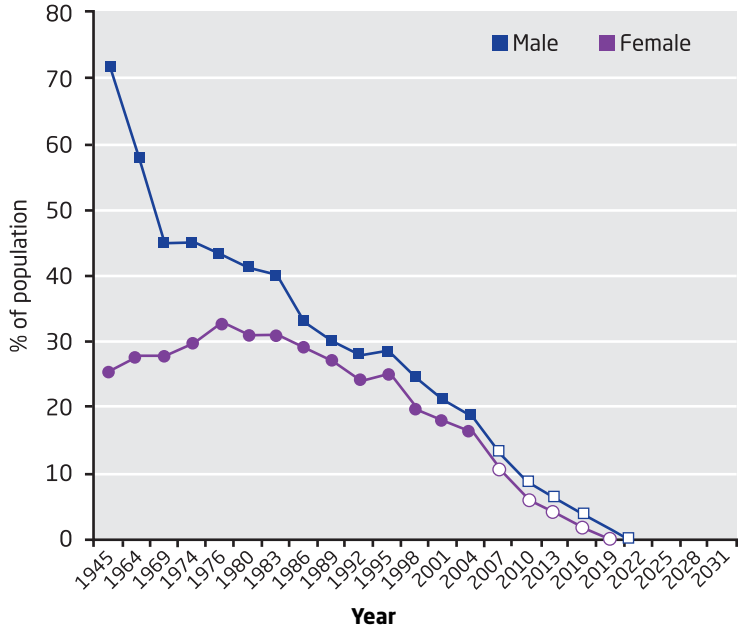
Smoking is no longer commonplace. The 2004 National Drug Strategy Household Survey and the 2005 Australian School Students' Alcohol and Drug (ASSAD) survey found that Western Australia had the lowest smoking rates in the country in both adults and children. 15.5% of West Australian adults were regular smokers, and only 6% of 12–17 year-olds. Non-smoking had become the norm.[36,37] Projections released in 2006 showed that on the basis of trends since 1983, smoking would be virtually non-existent by 2028, but that with a relatively modest improvement in trends this outcome would be achieved by 2022.[37]

Figure 6 **Projection, prevalence of smoking in Australia for persons aged 14 years and over, if present trends continue**



Source: Dhaliwal S, Curtin University of Technology, 2008

Figure 7 **Projection, if 2% annual reduction in prevalence between 2004 and 2007, then rate of decline as before**



Source: Dhaliwal S, Curtin University of Technology, 2008

International attention from these projections contributed further to creating an atmosphere in which non-smoking was seen as the norm. ACOSH's work has complemented that carried out in other States and nationally by longstanding campaigners such as Simon Chapman (Sydney University), Anne Jones (ASH) David Hill (Cancer Council Victoria) and Todd Harper (formerly Quit Victoria). Tobacco control is now widely recognised as one of the great public health success stories. This poses three challenges for public health advocates: combating complacency, maintaining momentum and countering perceptions that enough has been done – for tobacco remains a leading cause of avoidable mortality and morbidity in Australia despite the gains made over almost four decades.

Revelations about the motives and power of the tobacco industry, available from documents disclosed through international court cases, not only show that tobacco companies over the decades have been every bit as ruthless, deceitful and cynical as campaigners had thought, but also emphasise the need for continued vigilance.[38]

Historically government support for tobacco control waxes and wanes and the industry will continue to apply significant resources and ingenuity to promoting smoking. The need for advocacy remains.

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The media and tobacco

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Journalists, like everyone else, have become increasingly aware over the past two decades of the devastating health consequences of smoking. But that journey has raised questions about the role of the media in tobacco control advocacy and whether it is the same as that of the determined health campaigners. Indeed, at times journalists have been accused of anything from consciously ignoring warnings about the perils of smoking – supposedly because of pressure from management worried about losing advertising from the tobacco industry – to turning a blind eye out of cynicism. But what is poorly understood is that the media has never 'owed' anything to the anti-smoking lobby and over time has instead responded to the relative interest and newsworthiness of whatever tobacco control campaigns have offered them.

It is fair to say that twenty-five years ago, journalism and smoking almost went hand in hand, again not reflecting any sinister association, but rather reflecting the times. Journalists who started work at Western Australia's main daily newspaper, *The West Australian*, were given only two things on their first day – an ashtray and a desk blotter. Those who had not yet taken up smoking did so, on the spot, and they joined their colleagues in chain smoking from the moment they walked in the door each morning until when they put their head on the pillow, exhausted at night. Cigarettes, combined with the great amount of paper in the pre-computer newsroom, led to fires regularly breaking out. And at times, angry journalists and subeditors on deadline, with fag in mouth, could be heard swearing in frustration, as their foot got caught in a wastepaper basket while trying to put out the flames.

As former editor of *The West Australian* and radio announcer, Paul Murray, explains, journalists themselves, in movie stereotypes and in real life, had a long love affair with cigarettes, with some suffering from writers block if they were forced to go without them.

> 'I grew up in a family with a father who was a journalist and I used to run over the road and get him his packet of cigarettes almost every day. Dad was like almost all of the journalists of his generation, he smoked. And my brother, when he become a journalist, he smoked and when I became a journalist, I became a smoker,' he explained.
>
> 'No doubt right through my time in journalism and going back to my father's time, from the 40s onwards, there was this huge culture of smoking, so you can sort of read into it from that that the anti-smoking message probably didn't immediately find a receptive home among many journalists.'

But Murray is adamant that, as occurred in his case, their addiction to smoking did not affect their news judgment. He and many other West Australian journalists were cynical enough never to have believed tobacco company claims that the cigarettes they smoked were not damaging their health. Back then, Murray was smoking up to forty cigarettes a day, believing he could make up for his sins later and somehow kickstart his body back to health.

> 'I suppose the first time I really became aware of the anti-smoking lobby was in the early days of the Quit Campaign when Mike Daube and Ruth Shean started to push the message,' he said.
>
> 'I can remember a feature article in *The West* with both of them wearing sort of hippy garb. I think they were both wearing sandals and kaftans, that seems to be my memory of it. And they were almost portrayed as sort of loopy hippies out to ban smoking in Western Australia.'

Figure 1 **Editorial on tobacco, *The West Australian* newspaper, 1989**

The West Australian

PERTH SATURDAY AUGUST 26 1989

Another strike at free choice

THE State Government's proposed phasing out of tobacco advertising and sponsorship of sports and the arts is another bureaucratic intrusion into people's right to make their own choices.

The move has all the odious implications of heavy-handed prohibition by a Government arrogantly scornful of civil liberties. It is seeking to censor the advertising of a product which can be legally produced, sold and consumed.

This newspaper receives an insignificant part of its revenue from cigarette advertising. Governments, by contrast, reap hundreds of millions of dollars in taxes every year from the tobacco industry.

But money is not the central issue here. What is at stake is the liberty of West Australians to make their own judgments about their lives and their lifestyles.

The Government intends to ban tobacco advertising on external hoardings and posters, leaflets and cinema and video promotions, tobacco-related competitions and printed advertisements depicting people. Adding to the farce is the fact that imported magazines with cigarette propaganda won't be touched.

The Government is being hypocritical in trying to exempt sporting events of "national significance", such as cricket and racing which, according to Mr Dowding's odd logic, lack wide appeal to young people. It is obvious that cricket, at least, has a host of avid young fans.

If the Government had the courage of its convictions it would not have made this spurious distinction. If it were dinkum, it would ban cigarette sales.

Why has the Government launched an advertising crackdown now when there was no word about it during the state election campaign or since? There has been no public clamour for such action.

Today tobacco advertising is the target. The question is: what's next?

Some journalists who worked on Perth newspapers in the 1970s and 80s remember a general lack of interest and apathy towards anti-smoking stories, not because of any hidden agenda or widespread addiction to nicotine, but because the message was seen as dull and repetitive. It was to take some health campaigners a long time to realise that what all journalists want is a strong news angle for a story, not something resembling a spiel from a public health newsletter. And the advocates who came up with innovative, quirky angles for anti-smoking stories were soon rewarded with those ideas making their way into print.

Former *Daily News* reporter Joanne Fowler said the Australian Medical Association's West Australian branch took up the cause in the late 1970s, hand-delivering to smoking journalists copies of eastern states media statements warning of the health risks of cigarettes. But they were bland and often failed to quote any local experts.

> 'The general feedback from the news desk was that it wasn't that interesting because everyone knew that smoking was dangerous but they would still do it and nothing would change, so it was a case of "So what?"', she said.

All this was happening against a background of constant, subtle and slick promotion by tobacco companies and the Tobacco Institute of Australia, which had an office in West Perth.

> 'Tobacco companies sponsored sports, arts and racing events, and sports journalists, who were among the heaviest smokers in the building, enjoyed the free cartons of cigarettes they were given when they reported on a tobacco-sponsored event.'

Fowler said the landscape of general acceptance of the tobacco industry's influence did not change until the launch of campaigns such as BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions), when respected local health professionals embarked on what was essentially criminal activity, defacing tobacco advertisements on billboards and anything else they could get their hands (and pens) on. Rather than just preaching to journalists about the evils of smoking, or going on and on about tobacco company plotting and sabotage, they gave them something to write about. These were doctors, running around at midnight with spray cans, who were risking being charged with 'wilful damage' by the police, if arrested. 'The cheekiness of their graffiti and the originality of this approach to anti-smoking made them and their message suddenly news,' according to Fowler.

What followed in the 1980s and 1990s were equally ambitious and provocative anti-smoking campaigns, as campaigners realised there was no free ticket to getting the publicity they so badly wanted. Despite a general belief back in those early days that smoking was an inevitable part of life, many journalists from that time do not recall being 'under the thumb' or failing to understand the health message. They just saw that it was not their job to do the bidding of others, and instead they reported on events depending on their newsworthiness. Preaching to a journalist wins no ground if after thirty minutes on the phone or a three-hour round trip for an interview, they still have no story for their demanding chief of staff. No matter how important a message is for the common good, if there are no new pictures or words, there is no way to fill up the blank space on a newspaper or TV screen. However, Murray still feels that ' ...*The West Australian* played under my editorship, and in general terms since then and before then too, a pretty good role in allowing the anti-smoking message to be broadcast widely to the community.'

Figure 2 **BUGA UP (Billboard Utilising Graffitists Against Unhealthy Promotions), example of a defaced tobacco advertising billboard**

In the early 1990s, a new set of black on white health warnings appeared on cigarette packets, as part of uniform laws introduced across Australia. The win was great for the anti-smoking lobbyists, and brought the anti-smoking message home to the consumer, without relying solely on the media as middle man. But for journalists, it had got to the point where there was a limit to the number of times they could do an article on a message that basically boiled down to 'Smoking Kills'. The anti-smoking campaigners of the time, sensing this, decided to get creative and used pure economics to drive home the message of the cost of smoking, estimating that a habit over twenty-one years meant $145,000 less to spend on holidays and other trappings in life. This was a new approach that the media lapped up, successfully showing there was still much scope for reinventing the anti-smoking message.

Figure 3 **Editorials on tobacco, *The West Australian* newspaper, 1988**

THE WEST AUSTRALIAN MONDAY JUNE 20 1988

The West Australian
PERTH MONDAY JUNE 20 1988

Quit takes aim

IT IS no coincidence that women are the major target group in this year's anti-smoking Quit campaign.

Although men in increasing numbers are being persuaded to give up the habit, women — particularly teenagers — seem impervious to widely publicised warnings about the health dangers that go hand in hand with smoking. In some age groups, female smokers now clearly outnumber their male counterparts. And the trend seems to be growing.

Part of the cause can be traced to cigarette advertising featuring attractive young women in glamorous surroundings and conveying the impression that smoking is a natural pastime in sophisticated lifestyle. The toba... vociferously deny it, but ... to be pitched to ... women.

The West Australian
PERTH FRIDAY JULY 29 1988

Stubbed out

GIVEN growing evidence of the harmful effects of smoking, most West Australians will applaud the State Government's proposals to eliminate the habit from all workplaces.

The guidelines formulated by the Government, major employer groups and trade unions sensibly puts the emphasis on a voluntary approach. Presumably, individual businesses will decide when and on what basis they will move to a smoke-free environment. Even so, there is bound to be resentment from the dwindling number of people who insist on smoking at work.

Where smoking is concerned, however, workplaces have to be viewed differently from public venues. If they are to do their jobs properly, employees have to spend a big part of their day at the workplace. They cannot simply walk out ... colleagues decide ...

Looking back over the past two decades, Fowler, who worked as both a medical journalist and public health media consultant, rates Western Australia's top ten anti-smoking campaigns and stunts as:

- Yul Brynner, Quit advertisement (with him speaking from the grave)
- the Smoking Death Clock (Figure 4)
- Pretty Face, TV advertisement
- Professor Fiona Stanley and the barrel of tar at Welshpool (kindly organised by the Main Roads Department)
- Australian Medical Association's smoking death cards campaign with the Australian Council on Smoking and Health
- Australian Medical Association gatecrashing an Australian Hotels Association media conference and challenging them to go smoke-free (if the hotels lost money by going smoke-free Dr David Roberts, of the Australian Medical Association, would underwrite their losses and if they didn't lose money, the Australian Hotels Association would underwrite the costs to the West Australian economy of treating smoking-caused diseases)
- Australian Medical Association and Australian Council on Smoking and Health display of body parts affected by smoking (including amputated toes and diseased lungs)
- series of media conferences and advertisements and lobbying to abolish tobacco advertisements and sponsorship and create Healthway
- staging of the World Conference on Tobacco and Health in Perth in 1990
- the (then) Western Australian Health Department's 'Emphysema Bill' TV advertisement.

Figure 4 **Death Clock, Perth CBD**

Over the years, the West Australian public watching the progress of tobacco campaigns, both directly and through the media, have become confident they do make a difference. This confidence has led to individuals stepping out of the crowd to help out, such as Perth mother-of-three Zita Roberts who, in 2006, gave up the precious time she had left battling lung cancer to help out The Cancer Council Western Australia's Make Smoking History campaign. Her bravery, regrets and personal pleas worked both on the public – leading to around one-third of West Australian smokers quitting or reducing the amount they smoked, according to the Cancer Council – but also defrosted the media, which had become numb over time to the message 'Smoking Kills'.

With the new millennium, the climate has changed dramatically. At a time when there are fewer smoking-related stories appearing in the media because of a saturated market, there has been a corresponding decrease in the prevalence and tolerance of smoking among new generations of journalists. Young reporters today are far less likely to have the opportunity to report on smoking issues than their peers of ten or twenty years ago. The message that smoking is bad for you is now well understood, so the media's interest is now centred not on whether people can smoke, but where they can legally do so. As smoking venues dry up, so inevitably will the source of new stories. But the job is not yet finished for the anti-smoking lobbyists, as there are still hard-core groups of smokers – from young women to Aboriginal people to mental health patients – and the need for the media remains. And as concerned cancer groups ask the public to rein in their drinking more and more, due to new findings exposing the threat to health from smaller amounts of alcohol, could this possibly lead to a backlash and regression in healthy behaviour that is reflected in smoking rates?

Among the new generation of junior reporters who recently joined *The West Australian* newspaper, most have open contempt for the tobacco industry and repulsion for smoking. They have never even owned an ashtray let alone want to be supplied one by their employer. Cadet journalist and non-smoker, Giovanni Torre, said he could understand why so many journalists had smoked in the past, and why some still maintained the habit, putting it down to the nature of their industry. Journalists tended to push themselves hard, and the work could be unpredictable and stressful, with the traditional coping mechanism being smoking during work and drinking alcohol after it.

> 'I don't smoke because I know that once you're hooked, that rush – that nicotine-induced perkiness is gone, and you find yourself smoking just to feel normal and functional again. Well, I can feel normal and functional without paying for smoking with my cash and my health, so I stay away from it. Both of my grandfathers were smokers and died of lung cancer at age 45 and 65, so I don't need an advert authorised by the Health Department to tell me that it's bad news.'

His sentiment is similar to that of his cohorts, who, like Torre, have no interest in taking up the habit.

But still convincing these journalists, brought up on the anti-smoking message and already converted to the cause, to give newspaper and air space to warnings of the evils of cigarettes will not be any easier if the strategies used in the future fall into the trap of being seen as dull and repetitive. In the end, it will always be news that fills newspapers and TV and radio reports. And as Murray explained, it is in the hands of anti-smoking lobbyists to find new angles for the media.

And looking to the future, this task is likely to take far more of their energy and time as they become caught up in the increasingly fierce fight between media companies for the best news website. And a considerable consequence of the shift to online news is that media requires more news and more often – dramatically shortening the shelf life of any anti-smoking news angle. The public, too, faced with an overload of information can, at the touch of a mouse, filter out any news items they are not interested in. But this is a challenge that health lobbyists must rise to – finding ways to push the boundaries in cyberspace as they did in the past with billboards.

Tobacco control legislation and public policy in Western Australia, 1911–2007

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Serious practitioners of tobacco control appreciate that comprehensive approaches, using a variety of evidence-based strategies, are required to reduce the prevalence of smoking across the population.[1] While there may be some debate about the relative merit of each strategy, most tobacco control practitioners would include the following in their wish list: regular increases in the price of tobacco, usually through increases in tax; sustained, and well-resourced hard-hitting public education campaigns; legislation that prohibits the promotion and marketing of tobacco in all its forms, including sponsorship of sport and the arts; legislation that requires all enclosed workplaces and public places to be smoke-free, protecting people from exposure to second-hand smoke; graphic health warnings on cigarette packages; and the provision of proven treatments for smoking cessation.[2]

This paper chronicles the major changes in public policy and legislation that have driven down the prevalence of smoking in Western Australia.

The State of Western Australia took its first and inadvertent step towards a comprehensive approach to tobacco control when, in an effort to prevent fires, its Parliament prohibited smoking in theatres in 1911.[3]

In 1916, the Parliament passed legislation to prohibit the sale of tobacco products to persons who were not 18 years of age.[4] This piece of legislation was revisited by the Parliament 48 years later when the provisions of this Act affecting the availability of liquor were amended, but they had no consequences for the sale of tobacco products.[5]

The publication of the report from the Royal College of Physicians of London in 1962[6] and the Report of the US Surgeon General's Advisory Committee on Smoking and Health in 1964,[7] led to a greater awareness among health professionals of the health effects of smoking. This awareness also increased in the general community, mainly as a result of coverage of these issues in the mass media.

With a growing number of scientific papers confirming the health effects of smoking, a group of concerned medical and public health specialists led by Dr Cotter Harvey, formed the Australian Council on Smoking and Health (ACOSH) in New South Wales in 1967. The Council's broad objective was to advocate for changes in public policy that would reduce the prevalence of smoking in Australia and the resulting epidemic of smoking-caused disease and death (Musk AW, personal communication, May 2007).* ACOSH also formed a branch in Western Australia in 1971 and, when the NSW branch dissolved in 1978, ACOSH Western Australia assumed responsibility to advocate for smoking and health issues for the nation, particularly for Western Australia.

ACOSH and the Health Education Council of Western Australia lobbied the Minister for Transport[8] to make a change in policy, resulting in a ban on smoking on the (then) Metropolitan Transport Trust buses in 1974. At the time of this prohibition, the same requirement was extended to trains and ferries. The Prospector train service to Kalgoorlie was made smoke-free on 10 October 1991.[9]

* Professor AW Musk, Department of Respiratory Medicine, Sir Charles Gairdner Hospital

In 1975, the State Government passed legislation requiring persons who were involved in the business of selling tobacco to be licensed, enabling the Government to collect revenue into the future from this activity.[10]

In 1978, Western Australia made tentative steps towards making enclosed workplaces smoke-free when the Minister for Health gazetted regulations under the *Hospitals Act 1927*, requiring that enclosed areas of government hospitals be smoke-free.[11] The Minister was assisted in this regard by changes to the *Health Act 1911–79* that required employers to provide workers with a safe environment by eliminating any nuisance-causing agents in the air.[12]

In 1982, public transport was again the focus of tobacco control activity when Regulations were gazetted under the *Metropolitan (Perth) Passenger Transport Trust Regulations 1977*: a person shall not smoke in or upon any portion of a vehicle not set apart for smoking, or upon any part of Trust premises in respect of which a notice is displayed that smoking is prohibited.[13]

In 1972, ACOSH formulated a priority objective to convince the Western Australian Government to pass legislation that would prohibit the advertising and marketing of tobacco products under the control of the state government.[14] In an Australian first, in 1982, Dr Tom Dadour, a general practitioner and Member of the Liberal Government, introduced a private member's bill,[15] with support from ACOSH, which aimed to prohibit advertisements relating to smoking and tobacco products. The Bill passed through the Legislative Assembly, but was defeated by a margin of two votes in the Legislative Council.

In the same year, the National Heart Foundation conducted Western Australia's first Quit smoking campaign, using commercial advertising to encourage smokers to give up smoking for at least one day.[16]

In 1983, a Labor Government was elected and the new Minister for Health, Mr Barry Hodge, introduced a Bill, again with the support of ACOSH, to prevent the advertising and promotion of smoking and products associated with smoking, the sale of such products to young persons, and to repeal the *Sale of Tobacco Act 1916–1964*.[17]

The Bill proposed to make it an offence for any person who published an advertisement, induced or promoted the purchase of a tobacco product, smoking accessory or smoking more generally. The distribution of a free sample of a tobacco product would have become illegal, as would the offer of a prize, gift or benefit in connection with the sale of a tobacco product. Schemes designed to promote the purchase of tobacco products would also have become illegal. The Bill proposed the legal age for purchase of tobacco products be reduced from eighteen to sixteen years, and those under sixteen years of age would not be able to obtain tobacco products from vending machines. If the Bill had become law, tobacco retailers would have been required to display health warnings at the point of sale.

The introduction of this Bill resulted in opposing public relations campaigns: one led by the Government through the Health Department and supported by ACOSH; the other orchestrated by the tobacco industry, supported by tobacco retailers and some sporting and racing organisations that risked losing sponsorship and financial backing from the tobacco industry. Again, this Bill passed through the Legislative Assembly, but was defeated by a margin of two votes in the Legislative Council.[18]

Although the legislation was defeated, the Government determined that there would be an increase in the State Tobacco Licence Fee, from 12.5% to 35%, which generated an additional $20 million in revenue. Of this, $2 million was allocated to the Health Department to conduct a statewide smoking and health education campaign, later to become known as the Quit Campaign (Hodge B, personal communication, May 2007).[†] The Quit Campaign, and other smoking and health campaigns conducted from 1984 onwards, is the

[†] Hon Barry Hodge MLA, Minister for Health, 1983–1986

subject of other chapters in this monograph. Increases in the price of tobacco from 1983 to 2007 played a vital role in reducing the prevalence of smoking. These increases in price resulted from changes to the State Tobacco Licence Fee, and later, to regular increases in the rate of Federal Tobacco Excise.[19]

In 1984, the newly elected Labor Government passed occupational health and safety legislation[20] requiring all employers to promote and secure the health, safety and welfare of persons at work and to protect them against risks to their health and safety. Although this legislation was not developed to address the issue of exposure to second-hand smoke at work, it had the potential to be used for this purpose.

In 1985, the Minister for Health gazetted regulations under the *Health Act 1911*[21] to prohibit persons preparing or displaying food for sale, from smoking tobacco products. While this legislation was not designed to reduce the prevalence of smoking it sent a further message to the community that smoking was not desirable or hygienic.

In the same year, libraries in Western Australia were declared smoke-free under the *Library Board of Western Australia Act 1951*.[22]

Work undertaken during 1985 and 1986 by the then Health Department of Western Australia, to support the West Australian Minister for Health and other ministers for health, contributed to the introduction of new health warnings on cigarette packages in 1987 throughout Australia, which included the warnings: S*moking Causes Lung Cancer*, *Smoking Causes Heart Disease*, *Smoking Damages Your Lungs*, and *Smoking Reduces Your Fitness*.[23] The introduction of these new warnings to replace *Warning – Smoking Is a Health Hazard* was bitterly opposed by the tobacco industry.

In 1987, the Federal Government prohibited smoking on all domestic aircraft effective from 1 December of that year.[24] In 1989, the West Australian Public Service became a smoke-free workplace, following the lead set by the Commonwealth Public Service in 1986.[25]

From 1983 to 1989, health and medical organisations in Western Australia led by ACOSH, together with the leaders of public health programs within the Health Department of Western Australia, maintained their advocacy on the need for legislation to prohibit the advertising and marketing of tobacco products. During these years the Health Department's Quit Campaign conducted a series of hard-hitting advertising campaigns covering the most prevalent diseases caused by smoking, while at the same time encouraging and supporting smokers to quit.[26]

During 1989, the Western Australian Government announced its intention to introduce legislation prohibiting all forms of tobacco advertising and to establish a health promotion foundation to replace the sponsorship of sport, racing and arts activities that were, at the time, receiving tobacco industry sponsorship. Similar legislation had been passed previously in Victoria and South Australia.[27,28]

Unlike the earlier attempts in 1982 and 1983, the *Tobacco Control Act 1990*[29] was passed into law and proclaimed on 1 February 1990.

The major provisions of the Act prohibited most forms of tobacco advertising under State control such as tobacco advertisements published in Western Australia, outdoor billboards and tobacco advertisements that dominated the outside surfaces of retail outlets. Importantly, the Act allowed tobacco advertising inside shops only if the advertising was sited directly adjacent to where the tobacco products were displayed for sale. However, the Act gave the Minister for Health the power to ensure these advertisements complied with certain conditions regarding their size and whether they displayed a prescribed health warning.

Schemes and competitions designed to promote the sale of tobacco products were declared illegal, as was the distribution of free samples of tobacco products. Sponsorship of activities by tobacco companies was made illegal, but the Minister for Health was provided with the power to exempt certain events. All tobacco

sold in Western Australia was required to be labelled in accordance with regulations that described health warning statements and any other information the Minister deemed relevant.

As in 1916, the Act prohibited the sale of tobacco to persons under the age of 18 years, but also specified it was illegal for a proprietor to allow the purchase of a tobacco product from a vending machine by a minor. Vending machines were restricted to licensed premises or staff amenity areas and required to display prominent health warnings. Selling loose cigarettes or in packets containing less than twenty cigarettes was made illegal to limit the tobacco industry's ability to make their products more accessible to young people. The manufacture or sale of smokeless tobacco was made illegal.

The *Tobacco Control Act 1990*[29] established the Western Australian Health Promotion Foundation, later to be known as Healthway. The Foundation's primary objectives included the funding of activities relating to the promotion of good health with particular emphasis on young people; to offer an alternative source of funds for sporting and arts activities previously supported by the tobacco industry and to support sporting and arts activities designed to promote healthy lifestyles. At the time of its establishment the Foundation was funded by 10% of the revenue generated through the collection of State Tobacco Licence Fees.[29] Later governments increased the rate of the licence fee resulting in substantial increases in revenue and decisions to amend the Act to cap the allocation of funds to Healthway.[30]

Healthway proceeded to replace tobacco sponsorship in those sporting, arts and racing events that had previously accepted financial support from the tobacco industry, and funded major health promotion programs and research, while the Health Department managed a successful phasing out of outdoor tobacco advertising that was concluded in 1995.

Following advocacy by ACOSH, in 1991 the enclosed areas of all state government schools were declared smoke-free in response to the requirement under Section 19 of the *Occupational Health, Safety and Welfare Act 1984*[31] for employers to provide for employees and maintain, as far as practicable, a hazard-free working environment. Later in 1997, the Education Department revised its *Smoking in the Workplace Policy* and the new policy prohibited staff, students and visitors from smoking on Education Department premises including Central and District Offices.[32,33]

For similar reasons, the Totalisator Agency Board adopted a policy of making the enclosed areas of their agencies smoke-free.[34] In 1994, pressure from the public and from health organisations resulted in the Taxi Control Board declaring all taxis smoke-free, protecting both passengers and drivers from the effects of second-hand smoke.[35]

This change in policy followed an approach by the Taxi Control Board (Western Australia) to the Hon. Minister for Transport, in February 1991, for smoking to be banned in all taxis from January 1992. It was recorded in the Taxi Control Board Annual Report 1992 that the number of taxis registered with the Board as non-smoking taxis had increased from 17% in 1986 to approximately 58% in 1992.[36]

Following a decision of the Ministerial Council on Drug Strategy, new health warnings for cigarette packages were required from April 1995 and covered 25% of the front of the pack together with an explanation of the warning covering 33% of the back of the pack. The warnings, which appeared in equal frequency, were: *SMOKING CAUSES LUNG CANCER*, *SMOKING IS ADDICTIVE*, *SMOKING KILLS*, *SMOKING CAUSES HEART DISEASE*, *SMOKING WHEN PREGNANT HARMS YOUR BABY* and *YOUR SMOKING CAN HARM OTHERS*.[37] These new warnings added to the growing awareness in the community of the health effects of smoking.

Publication of the National Health and Medical Research Council's (NHMRC) *Report of the working party on the effects of passive smoking*[38] initiated momentum for restrictions on smoking in enclosed public places. Additional reviews on the health effects of passive smoking by the US Surgeon General[39] and the National Research Council Committee (US) on Passive Smoking[40] encouraged ACOSH and other health organisations to advocate for legislation to prohibit smoking in enclosed public places. This advocacy was

given further impetus by reports from the United States Environmental Protection Agency,[41] the Californian Environmental Protection Agency,[42] a report of the Senate Community Affairs Reference Committee[43] and a scientific paper of the NHMRC, *The health effects of passive smoking*.[44]

In response to growing pressure from members of the community for smoke-free public places and workplaces, the Government of Western Australia announced, on 24 August 1996, that it would establish a Task Force on Passive Smoking in Public Places[45] to 'among other things, identify and assess both regulatory and non-regulatory strategies designed to minimise the community's exposure to passive smoking in public places'. In announcing the Task Force, the then Minister for Health said, 'there is now conclusive scientific evidence and substantial public concern about the health risks for non-smokers exposed to tobacco smoke'.[45]

At the same time that the Task Force was deliberating on this issue, in October 1996, one year before the Task Force reported, a coalition of health agencies in Western Australia including the AMA (Western Australia), ACOSH, the (then) Cancer Foundation of Western Australia and the National Heart Foundation of Australia (Western Australia Division) launched a campaign for a Smoke-Free State.[46] The campaign had fifteen objectives, four of which related directly to the following becoming smoke-free: workplaces, public places, educational institutions, cafes, restaurants, hotels and entertainment venues.

In July 1997, also prior to the Task Force on Passive Smoking reporting its recommendations to the then Minister for Health, the Minister for Labour Relations announced the Government had moved to restrict smoking in enclosed workplaces.[47] Specifically, the Minister for Labour Relations gazetted regulations under the *Occupational Health and Safety Act 1984*,[48] which effectively prohibited smoking in all enclosed workplaces, including those within the hospitality industry, from 1 August 1998.

In its report[9] published in October of 1997, the Task Force on Passive Smoking made twenty-two recommendations. Central among these was a recommendation to ' ... ensure uniform protection across the entire community, all enclosed public places (except bars) where children have legal access (whether or not children are present) should become smoke-free from 1 August 1998'. This recommendation applied particularly to restaurants and food service areas. Other recommendations relating to bars, nightclubs and the Burswood Casino recommended incomplete prohibitions, the application of ventilation as a method of reducing the effects of second-hand smoke, and varying timetables for their introduction. These recommendations, as they applied to the hospitality industry, were inconsistent with the new requirements under the *Occupational Health and Safety Act 1984* for enclosed workplaces to be smoke-free. Another inconsistency was an agreement by the Chairman of the Task Force, and all Task Force members other than the Australian Hotels Association, that ventilation was not a solution to the problems created by second-hand smoke.[9]

The Western Australian Government responded to these inconsistencies and to advocacy from health organisations by introducing amendments to the *Health Act 1911* to create Part IXB of this Act entitled 'Smoking in enclosed public places', and enabled the creation of associated regulations.[49] These regulations required all enclosed public places to be smoke-free from 29 March 1999. There were, however, exemptions permitted allowing smoking in specified areas of the hospitality industry provided certain conditions were met. Exemptions were granted for hotels, taverns and other licensed premises including licensed restaurants, nightclubs/cabarets, the Burswood International Casino and the Royal Western Australian Institute for the Blind (Inc.) Bingo Centre that permitted smoking in specified areas in accordance with specific conditions. Smoking was prohibited in all other enclosed workplaces by the Occupational Safety and Health Amendment Regulations.[48]

Part IXB of the *Health Act 1911*, Section 2891[49] required that the Minister for Health carry out a review of the operation and effectiveness of this Part and the regulations, after these changes to the Act and the

regulations had been in operation for three years. The Minister for Health was then required to prepare a report based on this review, recommending further steps to be taken to achieve smoke-free enclosed public places and present it to both houses of Parliament for their consideration.

This report was tabled in the Parliament and made ten recommendations.[50] The first recommendation, and the most important in relation to what further steps could be taken to achieve smoke-free enclosed public places was, 'All exemptions under the current legislation that allow smoking to occur in certain enclosed public places, be removed.'[50]

In response to this report, the Government, in November 2003, proposed further restrictions on smoking in enclosed public places within the hospitality industry including reducing the number of bars in hotels permitting smoking and reducing the floor surface area in nightclubs in which smoking could continue.[51] However, they proposed the exemption for the International Room at the Burswood Casino continue indefinitely.

These proposed changes were not consistent with the primary recommendation of the review report to the Parliament and did not meet the expectation of health and medical organisations that were campaigning for an earlier end-date to any smoking being permitted in the enclosed areas of bars, nightclubs and at the Casino. In May 2004, the health organisations, through ACOSH, communicated their dissatisfaction with the Government's position to the Greens (Western Australia), and the Greens proposed a motion for disallowance of the regulations proposed by the Government.[52] This forced the Government to commit to a review of the proposed regulations, the Health (Smoking in Enclosed Public Places) Regulations 2003,[51] and ensure this review be provided to the Parliament in December 2005. Further, the Government committed to implementing the recommendations from this review and any suggested timeline for implementation.

Later, in 2004, the Minister for Health negotiated with the hospitality industry, mainly the Australian Hotels Association, for an end to smoking in all enclosed areas of hotels on 31 July 2006.

The Government announced changes to the State's health regulations that would see a smoking ban introduced in two stages over nineteen months: smoking would be limited to one room only in licensed premises by 1 November 2005, followed by a total smoking ban in all enclosed public places by 31 July 2006.[53] Unfortunately, the Government decided that the International Room at the Burswood Casino would remain exempt from this prohibition. This announcement was confirmed in regulations gazetted on 30 November 2004.[54] Consequently, a review of the 2003 Regulations was not required.

These changes in public policy made by the Government in relation to prohibitions on smoking in the hospitality industry were second only to the State of Tasmania, which banned smoking in hotels from 1 January 2006,[55] but followed the lead set by several states in the US and by Ireland where smoke-free pubs was achieved in 2004.[56] Nonetheless, these changes would weaken the association between smoking and alcohol consumption, and do much to denormalise smoking in the community and, at the same time, reduce exposure to second-hand smoke for employees and patrons.

In 2000, a review was undertaken by the Commonwealth Department of Health and Ageing of current health warnings and new warnings, possibly with pictures, were considered. In 2006, the Federal Government required that the first set of seven graphic picture warnings should appear on 30% of the front and 90% of the back of cigarette packets and cartons manufactured after 1 March 2006. Later, in 2006, the second set of six warnings started to appear.

This new system of hard-hitting graphic health warnings took full effect from 1 March 2006, through amendments to the Trade Practices Regulations under the *Trade Practices Act 1974*.[57] Subsequent minor amendments were gazetted in October 2005 and February 2007.

Set A of the warnings, required from 1 March in years ending with an even number i.e. 2006, 2008 and are as follows:

1. *Smoking causes peripheral vascular disease*
2. *Smoking causes emphysema*
3. *Smoking causes mouth and throat cancer*
4. *Smoking clogs your arteries*
5. *Don't let children breathe your smoke*
6. *Smoking – a leading cause of death*
7. *Quitting will improve your health*

Set B is required from 1 March in the years ending with an odd number:

8. *Smoking harms unborn babies*
9. *Smoking causes blindness*
10. *Smoking causes heart disease*
11. *Smoking doubles your risk of stroke*
12. *Smoking is addictive*
13. *Tobacco smoke is toxic*

These new graphic warnings complemented the comprehensive approach to tobacco control in Western Australia and provided opportunities for health agencies to increase the awareness of less well-known health effects of smoking.

In June 2005, the Western Australian Government introduced a revised and strengthened Tobacco Control Bill 2005[58] in response to concerted advocacy by the AMA (Western Australia), ACOSH, The Cancer Council Western Australia (previously the Cancer Foundation of Western Australia) and the National Heart Foundation of Australia.[59] This Bill was prepared to address the shortcomings of the *Tobacco Control Act 1990*, in particular to prohibit new marketing and promotional activities by the tobacco industry, and facilitate the collection of evidence to support prosecutions. It replaced the *Tobacco Control Act 1990* and Part IXB of the *Health Act 1911*, and was introduced by the Minister for Health, Hon. Jim McGinty, based on best practice in states of Australia and in other countries.

The key purpose of the Bill was to reduce the incidence of illness and death caused by smoking tobacco through prohibiting the supply of tobacco products to young people and by discouraging the use of tobacco products more generally. This purpose was to be achieved by important provisions that: '... required proof of age to be produced on request at the point of sale or the point of delivery for indirect sales; require anyone who sells tobacco products to be licensed; restrict the sale of cigarette papers, pipes and other smoking implements to persons over 18; require strict supervision of vending machines in licensed premises or in amenity areas of mines; control the sale and promotion of herbal cigarettes similar to tobacco products because credible scientific evidence clearly shows these products pose similar major health risks to tobacco; prohibit the sale of confectionery, toys and other products that are designed to resemble tobacco products; apply controls to Internet sales and other forms of indirect sales of tobacco products; limit sales to one point of sale only in any retail premises; restrict tobacco product displays to one square metre but provide conditional exemptions for some specialist retailers if they are carrying on a business that will meet certain requirements; control information signs about the availability and price of tobacco products; require health warnings and warning signs about offences for selling to minors at point of sale; prohibit hawkers of tobacco products; ban the advertising of price discounting; require distribution of approved guides at retail outlets about the health effects of smoking and how to quit; harmonise labelling requirements for tobacco products with Commonwealth legislation; and provide comprehensive powers of enforcement and investigation consistent with the *Health Act 1911* and tobacco control legislation of other major states.[60]

The *Tobacco Products Control Act 2006*[61] was assented to by Parliament on 12 April 2006, and at the time of writing is the strongest and most comprehensive piece of tobacco control legislation in Australia. For example, Section 104 of the Act – *False information about tobacco products, tobacco control information* – prohibits a tobacco company, or anyone selling tobacco, from providing any person with information about the health effects of smoking that they know to be incorrect. The penalty for this offence is $50,000 for the individual or $250,000 for a body corporate.[62] A similar provision can also be found in the Tasmanian tobacco control legislation.[63]

Since the *Tobacco Products Control Act 2006* was proclaimed, two sets of regulations under the Act have been gazetted. The first, the Tobacco Products Control Regulations 2006,[64] gazetted on 25 July 2006, deals with regulations relating to the sale and supply of tobacco products and smoking in enclosed public places. The most contentious issue in these regulations is the definition of an enclosed public place, as a structure that has a roof, ceiling or walls, and is greater than 50% enclosed by walls, or other vertical structures or coverings. There is evidence that the proprietors of hotels have moved to construct outside semi-enclosed areas to accommodate their smoking patrons, a strategy undermining a primary purpose of the Act.

The second, the Tobacco Products Control Amendment Regulations 2007,[65] gazetted on 28 February 2007, deals with the application for a licence to sell tobacco products, licensing procedures and conditions, and the responsibilities of licensees when selling tobacco. These regulations also cover the requirements for labelling tobacco products, and the limits placed on the surface area of tobacco products that can be displayed. In addition, the regulations set out the requirements for information that must be provided to the purchaser of tobacco products and health warnings that must be displayed at point of sale. These regulations took effect on World No Tobacco Day, 31 May 2007.

This paper has chronicled the progressive development of tobacco control legislation and major changes in public policy from 1916 to May 2007. With the establishment of ACOSH in 1971, the level of advocacy for tobacco control increased substantially. ACOSH gave high priority to the passage of State legislation that would prohibit most forms of tobacco advertising and marketing, and complement the Commonwealth's ban on tobacco advertising through radio and television in 1976.[66] There were two unsuccessful attempts to ban tobacco advertising in 1982 and 1983. From 1983 onwards the Western Australian Health Department's Smoking and Health Program conducted a series of effective mass media-led smoking and health campaigns. Tobacco advertising under state control was prohibited with the passage of the *Tobacco Control Act 1990*[3] and its successor legislation, the *Tobacco Products Control Act 2006*. Regulations promulgated under this legislation have severely restricted the tobacco industry's ability to promote and market its lethal products. Legislation to restrict smoking in enclosed public places, especially in the hospitality industry, has further eroded the social acceptability of smoking. Peter Somerford (this report) describes changes in the prevalence of smoking in Western Australia from 1984 to 2006, which shows a steady and persistent decline. It is difficult, if not impossible, to attribute these changes in the prevalence of smoking to any specific change in public policy or legislation.[67] It is more likely that the changes have acted in concert with each other to create a strong downward pressure on smoking that has also resulted in a decrease in the incidence of death and disease caused by smoking in the late part of the twentieth century and the early part of the twenty-first century in Western Australia.[68]

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Public education campaigns on smoking in Western Australia: their evolution and effects

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Introduction

Western Australia is now well into its third decade of mass media campaigns on smoking; the history and achievements of which, prior to this paper, have only ever been published in part. It is evident the media has fulfilled a number of roles in campaigning on smoking and health issues in Western Australia – being used both to inform and motivate at the individual level and to advocate change at the social and political level.[1] The focus of this paper, however, is on the former, specifically media campaigns targeting the general public and adult population.

Historical overview[a]

Media campaigns on smoking began in Western Australia when the prevalence of smoking was 32%, tobacco advertising and sponsorship were rampant, and smoking was still permissible in many public places, workplaces, trains, planes and automobiles. As well as commencing in a potentially oppositional environment, the advent of the Quit Campaign heralded a new era in the State's use of mass media approaches to public health. Western Australia's Quit Campaign was established in 1983 and first 'went to air' in 1984, and continued to be run annually by Quit Western Australia (formerly known as the Smoking and Health Program within the then Health Department of Western Australia [HDWA[) up until 2005.[b]

The establishment of the Quit Campaign was facilitated by Western Australia's first (Australia's second) Smoke-Free Day Campaign in November 1982.[2] This 'Give it away for a day' Campaign initiated by the National Heart Foundation (NHF) not only brought together a number of stakeholders for the first time for a concerted campaign against smoking, but also placed quitting on the agenda for smokers and the public. Along with the NHF, the Management Committee comprised the Cancer Foundation of Western Australia (now The Cancer Council Western Australia), the Health Education Unit of the then State Public Health Department, the Australian Council on Smoking and Health (ACOSH), a commercial sponsor the Hospital Benefit Fund (HBF), and community representatives such as prominent businesspeople, media personalities and sportspeople. The campaign used paid and unpaid media, promotional events, information kits and quit for the day pledge cards. A Quitline also was established and promoted.

a See Appendix B for a chronology of West Australian anti-smoking television campaigns, 1984-2007.

b The Department of Health continues to make use of media advertising to support legislative aspects of tobacco control (e.g. campaigns promoting changes to laws on smoking in public places and the retail sale of tobacco in 2006 and 2007 respectively).

The campaign achieved an astonishing 97% awareness in the adult general population, no doubt due in large part to the widespread involvement of on-air and print journalists. Furthermore, 47% of non-smokers said they encouraged a smoker to quit for the day, and over a third of smokers attempted to quit for the day, with 23% succeeding. It is not an overstatement to claim that this first 'Give it away for a day' Campaign put Quit and quitting smoking on the map in Western Australia. The 1983 event further paved the way for the absorption of an annual Smoke-free Day into the subsequent Quit campaigns.

Prior to 1995 (the year in which the Smarter than Smoking youth smoking prevention campaign was set up), the HDWA was the only organisation conducting large-scale mass media campaigns on smoking in Western Australia. Some intermittent national campaigns, run by the Commonwealth Department of Health, included a West Australian media component (e.g. the women and smoking advertisement featuring the Helen Reddy 'I am woman' song, aired in 1990). Over time, other organisations began to conduct complementary anti-smoking campaigns, with the 1995 Smarter than Smoking Campaign, and The Cancer Council Western Australia's Make Smoking History Campaign commencing in 2000. Smaller scale campaigns have also been conducted periodically by ACOSH.

The broad aims of smoking and health programs and associated media campaigns in Western Australia have remained relatively constant over time, namely:

- motivating and encouraging adult smokers to quit
- preventing children from becoming regular smokers
- promoting the rights of non-smokers to clean air.

While the themes, target groups, executions and media schedules of West Australian campaigns have varied, they have been characterised by a number of core features; these are summarised in Figure 1 and expanded upon in the discussion of Western Australia's anti-smoking campaign trajectory that follows. It is pertinent to note that these features are congruent with tobacco control best practice as evidenced in the literature.

Figure 1 **Elements of West Australian anti-smoking campaigns**

Key features of tobacco social marketing campaigns	
Underpinned by relevant behaviour change theory	Media as part of a comprehensive approach
Formative research and message testing	Media as an umbrella and reinforcer of other strategies
Target group segmentation	Importance of unpaid media and publicity
Thematic approaches	Comprehensive and coordinated with on-the-ground strategies
Evaluating effectiveness	Adequate and sustained funding
Sharing of what works	

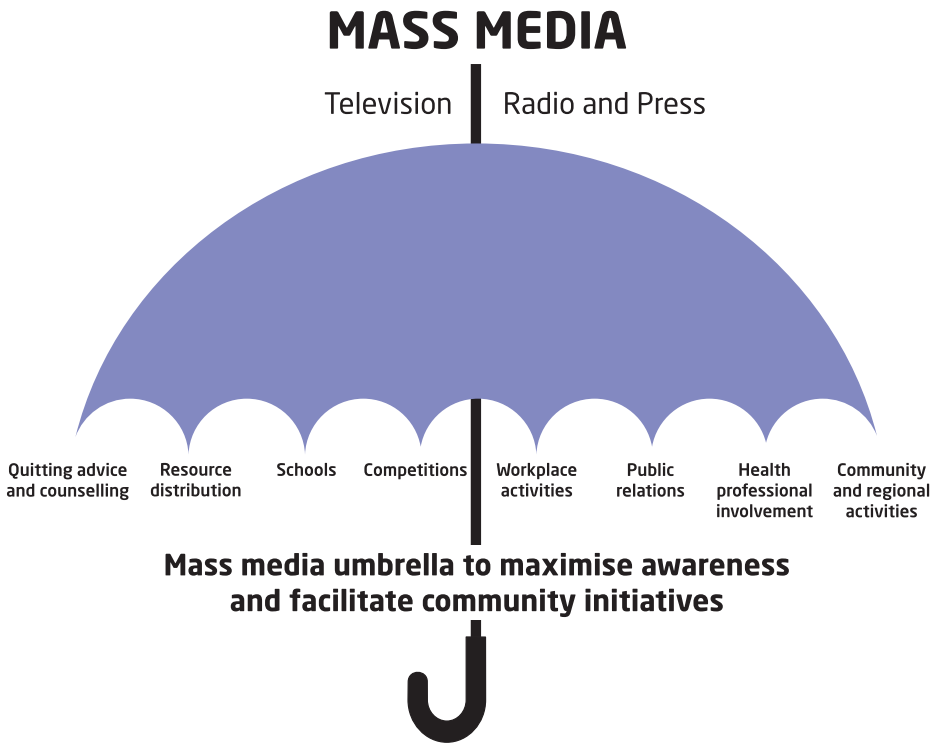
West Australian anti-smoking campaigns – core features and potted history

Media as part of a comprehensive approach

From inception, West Australian anti-smoking media campaigns have been developed in the context of a comprehensive approach to tobacco control, as first articulated in the International Union Against Cancer landmark Guidelines for Smoking Control[3] and reinforced by various subsequent reports and reviews.[4,5] From the outset, media campaigns in this state have been developed within programs that have also been active in relation to education, cessation, policy and legislative aspects of tobacco control. This aligns with international reviews which consistently demonstrate that the most effective approaches to tobacco control are multifaceted and include a range of measures that complement and reinforce each other.[5,6]

In Australia in general during the 1970s and 1980s, health promotion practitioners were increasingly adopting commercial marketing techniques in public health campaigns (i.e. social marketing), and, most notably – but not only – the use of paid advertising. The role of the media as part of a comprehensive campaign is depicted pictorially in Figure 2.

Figure 2 **Mass media as an umbrella for other strategies**



Just as commercial marketers use a variety of strategies in addition to paid advertising, Quit media campaigns have been supported and complemented by activities and the commitment of a number of key agencies, including the Health Department of Western Australia (now the Department of Health), The Cancer Council Western Australia, the NHF, ACOSH, Healthway, the Asthma Foundation of Western Australia, and the Australian Medical Association (Western Australia).

Media as an umbrella and reinforcer of other strategies

While some social marketing campaigns have focused mainly on paid advertising with little regard for other elements of the marketing mix, it would be difficult to make such a criticism of West Australian anti-smoking campaigns. From the outset, West Australian campaigns perceived the media as an umbrella that would bring together the agencies and resources from the public and private sectors too maximise awareness and facilitate the diffusion of community initiatives, and to precipitate or reinforce changes in community attitudes and norms that increase the palatability of policy and legislative restrictions on smoking.

Other tobacco control initiatives that have typically run concurrent with media campaigns include the development and delivery of smoking and health components in school health curricula, special school-based activities, competitions encouraging cessation, university and TAFE events, magazine quizzes, displays and professional development in healthcare settings. The dissemination of Quitkits, information on quitting and referral to the Quitline or cessation programs have been an integral non-media component of campaigns.

Figure 3 **Quitting competition, Quit Campaign 1990**

Figure 4 **Quitting competition, Quit Campaign 1994**

Merchandise developed and distributed in conjunction with Quit campaigns has varied over the years, ranging from the more conventional T-shirts, stickers, hats, posters and key rings to innovative items developed for specific campaigns such as 'Perfect Matchboxes' distributed in workplaces and nightclubs (containing quit tips and sugarless chewing gum), money boxes (for saving money not spent on cigarettes), pens with rotating quit tips and quit tip wallet cards.

Figure 5 **Merchandise and publications produced for the Young Women and Smoking Campaign**

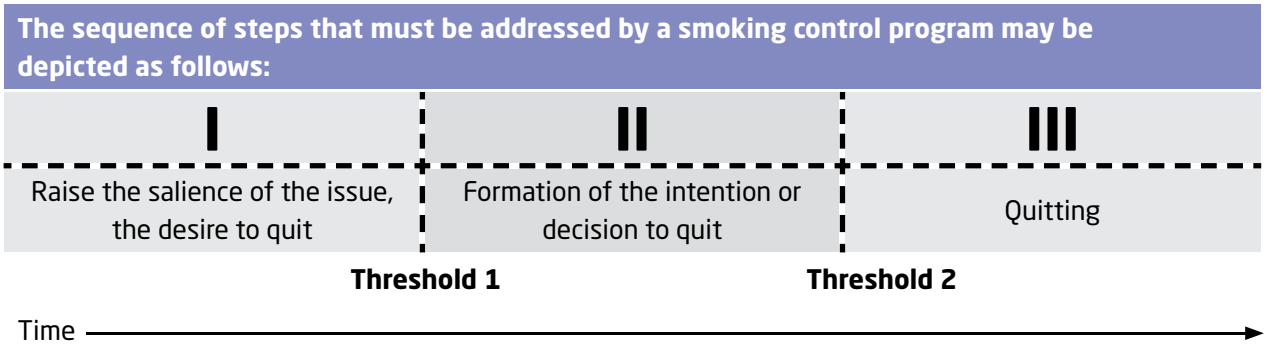
Figure 6 **Money boxes for money saved through quitting, Quit Campaign 1997**

Underpinned by relevant behaviour change theory

The use of an appropriate theoretical framework is recognised as one of the principles of effective communication campaigns.[7] Regardless of the behavioural change theory or model applied, there is generally a progression of stages or range of factors (internal and external) to be influenced, before actual behavioural change occurs.[8] While not always explicit, elements of a number of key health promotion models and behaviour change theories are evident in many of the West Australian anti-smoking campaigns implemented since 1983, although initial conceptual frameworks were grounded in formative research rather than the literature – particularly a stages-of-change approach. As the campaign progressed, the use of theoretical frameworks became more sophisticated.

From the first campaigns, 'calls to action' such as Quit Day, for example, were always preceded by several weeks of media to raise awareness and encourage smokers to think about quitting. This was initially based on the simple model of campaign objectives for the first Quit Campaign: 'Raise their level of wanting to quit; show them how to quit; and help them through the quitting process'.[9] Donovan's grounded theory was based on a staged approach whereby the aim of the Quit campaigns was to take smokers through two thresholds (see Figure 7).

Figure 7 **Early Quit Campaign Stage Model**[9]



In **phase I**, the mass media's task is to use what we term *consciousness raising nigglers* to arouse people.

In **phase II**, the mass media's task is to move people to the action stage by *directing* people to sources of assistance or providing assistance directly through media.

In **phase III**, the mass media's task is to *reinforce* quitting behaviour.

Later campaign planning was based more explicitly on Prochaska and DiClemente's stages of change model in which smoking cessation is usually preceded by stages of pre-contemplation and contemplation.[10] Stages of change also predict relapse as a common occurrence, hence the importance of media and community strategies that reinforce cessation and encourage smokers not to give up if relapse does occur.

The Precede framework[11] for health promotion programs has also been utilised in campaign planning. The 1990 Quit Campaign for example, sought to address predisposing factors (e.g. fear of failure, perceived relative risk of health effects), enabling factors (e.g. incentives to quit, practical tips) and reinforcing factors (e.g. social support) identified using the Precede framework as affecting an individual's ability to quit.[12]

Media scheduling was also underpinned by relevant health promotion and behavioural change models. The communication model employed sometimes used hard-hitting health messages in the first phase of the campaign to heighten awareness of the risks associated with smoking, coupled in the second phase with more positive, supportive and empowering messages to motivate smokers to quit and stay stopped.[13]

Formative research and message testing

Sound formative research is another core feature of effective communication campaigns recognised in the social marketing literature.[7] West Australian anti-smoking campaigns were research-driven from the outset, and this has been an enduring and important feature of all major tobacco control campaigns subsequently conducted in this State. Independent market research agencies were often involved in formative research and pre and post campaign surveys for the first decade of the campaign in particular. New campaign themes or advertising concepts were preceded by formative research investigating smoking-related attitudes, beliefs and behaviours and eliciting specific communication or behavioural objectives and themes for a pending campaign. Such research was typically qualitative and involved focus groups.

In the early years, advertising concepts for campaigns were also tested using quantitative research methods based on those used in the development of commercial advertising.[14] 'Concept-testing' was done to measure the relevance, understanding and credibility of concepts and their effects on smokers' desires or motivation to quit.[12] The testing was generally done prior to production of the advertising to ensure that only those concepts deemed most likely to be effective in communicating a message or encouraging changes in smoking behaviour were considered for production. Occasionally advertisements were tested after they had been broadcast to help explain unanticipated responses, as was the case for the Pretty

Face advertisement that came under fire from the feminist lobby and sparked complaints from the tobacco industry to FACTS (Federation of Australian Commercial Television Stations) that the advertisement was 'misleading', overstating the effects of smoking on a smoker's appearance.[15] Concept testing is done less frequently these days, given knowledge gained over the years as to what is effective, but may be done in cases where there are doubts about the proposed treatment of a subject or likely response of a specific population to the advertising.

Target group segmentation

While many of Western Australia's media campaigns have targeted the 'general community', the media schedule and execution have often been skewed towards particular population segments. The tailoring of messages to different target group segments is congruent with the evidence relating to effective social marketing,[7] and is an area in which tobacco control campaigns have become increasingly sophisticated over time. This has included segmentation based on various factors.

Likelihood of smoking (or epidemiological segmentation)

Campaigns have often been oriented either in their conceptual execution or scheduling to those who are more likely to smoke. The 1990 Quit Campaign for example was particularly aimed at blue-collar workers who had higher smoking prevalence than their white-collar counterparts.[12] As part of the 1994 Quit Campaign, two radio advertisements specifically targeting Indigenous smokers were developed and aired on relevant regional radio stations. Resources for Indigenous health workers were also developed as part of this campaign. More recently, and in response to growing concern over social smoking among young adults, the 2002 to 2005 Quit campaigns focused on 18 to 24-year-olds, challenging their perceptions of their control over their smoking.[16]

Figure 8 **Workplace newsletter**

The Daily News

Quit Day 21 May 1999

Quit Week 16 May – 22 May 1999

Health Department advises 'Quit at Work!'

West Australian workplaces to be involved

Workplaces throughout Western Australia are asking their employees to QUIT smoking. Questions were raised as to why so many workplaces are concerned when the majority of West Australians do not smoke and 80% of current smokers want to quit.

'Every year many smokers choose QUIT WEEK as the time to break the habit,' said one source.

As one employer, close to a workplace said, 'Health is a personal responsibility, however we are supporting people who want to quit smoking. Most employees spend one third of their waking hours here at work and we feel we are ideally suited to help our employees QUIT smoking.'

Workplaces are expected to support the 1999 QUIT CAMPAIGN, citing benefits ranging from less absenteeism, increased productivity as smoke breaks disappear and a healthier, happier workplace.

Large numbers of people plan to participate

Many West Australians are planning to participate. When asked, their reasons varied from improved taste and smell, better skin, fresher breath, whiter teeth, to nicer smelling hair and clothes.

An employer pointed out that while important, these were all short-term benefits. 'As employers we need to look at the big picture when we consider QUITTING.

'Longer term aspects, such as people living longer, the prevention of disease, protecting the health of others, improving fitness, protecting the environment and saving money, all need to be considered to get a true picture of the benefits of QUITTING.'

Marketing executives are reported to be looking carefully at the health benefits of quitting to their target groups of men, women and children. Men are seen to benefit from improved fertility and a reduced risk of impotence, and women benefit even more with fewer contraceptive risks, improved fertility, fewer pregnancy and menstrual problems, healthier childbirth, and less chance of cancer of the cervix, earlier menopause and hysterectomies. Children benefit greatly too with much less damage to their health from smoke.

Reliable Health Department sources state that cigarette smoking is the single largest, preventable cause of death and illness in Western Australia. 'Tobacco accounts for almost 19 000 avoidable deaths in Australia each year and over 1500 deaths in Western Australia.'

Late Breaking News | Weather | Features

Quit Day on Friday 21 May 1999

Quit Week 16 May – 22 May 1999

Smoke-free and clearing.

Quitting smoking rejuvenates workers p 8

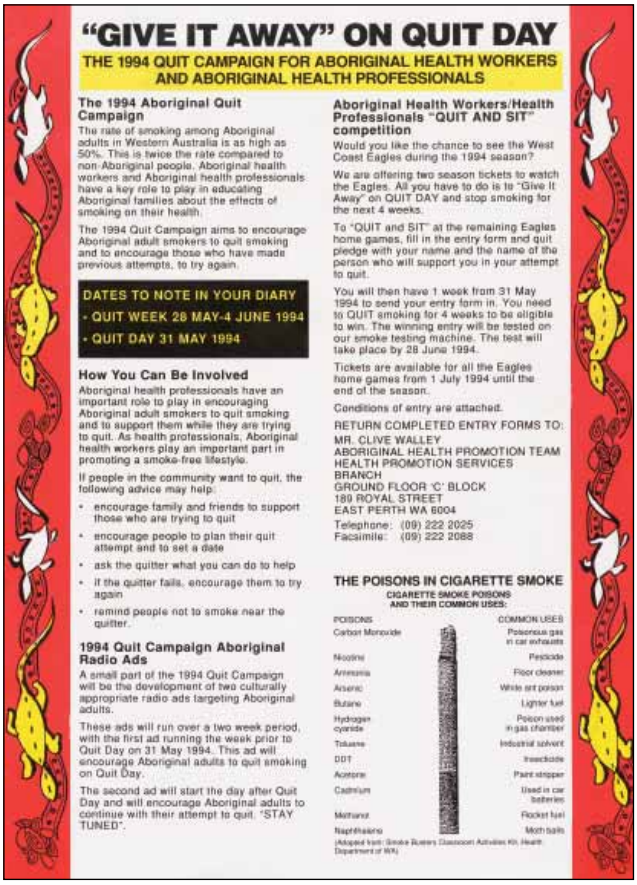
Profits up with smoking down p 10

Figure 9 **Convenience advertising targeting young adults**

Demographic groupings

Other campaigns were specifically developed for population segments such as the Perth Italian community (1989), young women (the Young Women and Smoking Campaign 1991 to 1994), parents (Doctor's surgery, 1995) and children (Life in the Big Smoke, 1985), women (the Jenny series of television commercials, 2003; Zita's story, 2006) and Aboriginal people. For example, in 2004, ACOSH commissioned Indigenous entertainer 'Mary G' to record six radio information spots warning women of the dangers of smoking while pregnant. Both controversial and humorous, Mary G is well known across Australia through her weekly radio show and live performances. The radio spots have subsequently been distributed to 162 Indigenous radio stations across Australia.

Figure 10 **Aboriginal strategies within a Quit Campaign**



"GIVE IT AWAY" ON QUIT DAY

THE 1994 QUIT CAMPAIGN FOR ABORIGINAL HEALTH WORKERS AND ABORIGINAL HEALTH PROFESSIONALS

The 1994 Aboriginal Quit Campaign

The rate of smoking among Aboriginal adults in Western Australia is as high as 50%. This is twice the rate compared to non Aboriginal people. Aboriginal health workers and Aboriginal health professionals have a key role to play in educating Aboriginal families about the effects of smoking on their health.

The 1994 Quit Campaign aims to encourage Aboriginal adult smokers to quit smoking and to encourage those who have made previous attempts, to try again.

DATES TO NOTE IN YOUR DIARY
- QUIT WEEK 28 MAY-4 JUNE 1994
- QUIT DAY 31 MAY 1994

How You Can Be Involved

Aboriginal health professionals have an important role to play in encouraging Aboriginal adult smokers to quit smoking and to support them while they are trying to quit. As health professionals, Aboriginal health workers play an important part in promoting a smoke-free lifestyle.

If people in the community want to quit, the following advice may help:

- encourage family and friends to support those who are trying to quit
- encourage people to plan their quit attempt and to set a date
- ask the quitter what you can do to help
- if the quitter fails, encourage them to try again
- remind people not to smoke near the quitter.

1994 Quit Campaign Aboriginal Radio Ads

A small part of the 1994 Quit Campaign will be the development of two culturally appropriate radio ads targeting Aboriginal adults.

These ads will run over a two week period, with the first ad running the week prior to Quit Day on 31 May 1994. This ad will encourage Aboriginal adults to quit smoking on Quit Day.

The second ad will start the day after Quit Day and will encourage Aboriginal adults to continue with their attempt to quit. "STAY TUNED".

Aboriginal Health Workers/Health Professionals "QUIT AND SIT" competition

Would you like the chance to see the West Coast Eagles during the 1994 season?

We are offering two season tickets to watch the Eagles. All you have to do is to "Give It Away" on QUIT DAY and stop smoking for the next 4 weeks.

To "QUIT and SIT" at the remaining Eagles home games, fill in the entry form and quit pledge with your name and the name of the person who will support you in your attempt to quit.

You will then have 1 week from 31 May 1994 to send your entry form in. You need to QUIT smoking for 4 weeks to be eligible to win. The winning entry will be tested on our smoke testing machine. The test will take place by 28 June 1994.

Tickets are available for all the Eagles home games from 1 July 1994 until the end of the season.

Conditions of entry are attached.

RETURN COMPLETED ENTRY FORMS TO:
MR. CLIVE WALLEY
ABORIGINAL HEALTH PROMOTION TEAM
HEALTH PROMOTION SERVICES BRANCH
GROUND FLOOR 'C' BLOCK
189 ROYAL STREET
EAST PERTH WA 6004
Telephone: (09) 222 2025
Facsimile: (09) 222 2088

THE POISONS IN CIGARETTE SMOKE

CIGARETTE SMOKE POISONS AND THEIR COMMON USES:

POISONS	COMMON USES
Carbon Monoxide	Poisonous gas in car exhausts
Nicotine	Pesticide
Ammonia	Floor cleaner
Arsenic	White ant poison
Butane	Lighter fuel
Hydrogen cyanide	Poison used in gas chamber
Toluene	Industrial solvent
DDT	Insecticide
Acetone	Paint stripper
Cadmium	Used in car batteries
Methanol	Rocket fuel
Naphthalene	Moth balls

(Adapted from: Smoke Busters Classroom Activities Kit, Health Department of WA)

Figure 11 **Campaign targeting young women and smoking**

Stage of behaviour change

Campaign objectives and support strategies were often tailored to smokers at a particular phase in the stages of change model.[10] For instance, the 1994 Quit Campaign focused particularly on smokers who either were contemplating quitting or trying to quit, including those who had previously tried to quit. Pre-testing of the advertisements was conducted to ensure that they were effective with these groups. There was an underlying premise, however, that such campaigns would also have a flow-on effect, helping shift smokers from the pre-contemplative to contemplative stage in relation to quitting.[13] Quitters who were perhaps prone to relapse were also sometimes targeted overtly through advertisements, particularly radio.

Even within a single campaign, media advertising was often strategically scheduled and weighted to guide smokers through the process of quitting, as illustrated by the example from the 1994 Quit Campaign in Table 1.

Table 1 **Media scheduling to guide smokers through the process of quitting: 1994 Quit Campaign**

Timing	Media purpose and emphasis
Several weeks prior to Quit Day	Raising awareness of need for smokers to quit (television phase 1)
Week prior to Quit Day	Preparing smokers to make a quit attempt on Quit Day (countdown in radio and press phase 1 advertising)
Quit Day	Motivating and supporting smokers to quit by providing tips and encouragement (television and radio phase 2)
Post Quit Day	Assisting quitters to stay stopped after Quit Day by reminding them of the health effects of continued smoking (television advertising from phase 1)

Brands and tag lines

As with other commercial and social marketing campaigns, anti-smoking campaigns have undergone 'brand extensions' and have often incorporated a particular tag line or slogan that corresponded to the specific emotional, attitudinal or behavioural change the campaign might be trying to elicit in the target group. Sub-brands introduced in Western Australia and their target groups are shown in Table 2 and have included Smarter than Smoking, Smoke-free WA and Make Smoking History.

Various tag lines – mainly added to the Quit message – are also shown in Table 2. Tag lines represent the 'call to action' or key message that the audience should take from the advertising. Over the years, they have been applied to the end-frame of television advertisements, appeared in press advertisements and as voice-overs on radio advertising, and where appropriate, applied to merchandise items, posters and other resources developed to complement campaigns. Table 2 identifies brands, tag lines or slogans featured in West Australian campaigns from 1984 to 2007.

Table 2 **Campaign brands and tag lines, 1984 to 2007**

Brand and tag lines	Years used	Target group
Brand: Quit[a]		
Take a fresh breath of life.	1984	Adult smokers, general public
What good's a pretty face when you've got an ugly breath.	1984–1985	Young women
Only dags need fags.	1985	School-aged children
Smoking – No way.	1985–1989	Adult smokers, general public
Bring your body back to life.	1990	Adult smokers, general public
Let's clear the air.	1990	Adult smokers, general public
Live and let live.	1991	Adult smokers, general public
Quit because you can.	1991–1994	Young women
Kick the habit.	1993	Adult smokers, general public
Don't get sucked in.	1994	Adult smokers, general public
You can do it.	1994	Adult smokers, general public
Smoking around kids is sickening.	1995	Parents, general public
Feel good – Quit.	1999–2001	Adult smokers, general public
Don't be duped – Quit.	2000	Adult smokers, general public
Have you got a grip on smoking?... Or has smoking got a grip on you?	2002	Young adults
Need a smoke now?... What will you need later?	2003 to 2005	Young adults
What's your Quit plan?	2004–2005 New year	General public
Brand: Make Smoking History[c]		
Nice people, but you don't want to meet them. Keep smoking and you just might.	2001	Adult smokers, general public
How will your smoking affect your life?	2002	Parents who smoke, general public
Don't blow the years ahead.	2004	Older adult smokers, general public
Quitting is hard. Not quitting is harder.	2006	Adult smokers, general public
Make your home and car smoke free now.	2007	Parents who smoke, general public
Brand: Smoke-free WA[a]		
Smoke-free WA	1998–2006	Adult smokers, general public
Brand: National Tobacco Campaign[b]		
Every cigarette is doing you damage.	1997–2006	Adult smokers, general public

[a] Department of Health, Western Australia copyright
[b] Commonwealth Department of Health and Ageing copyright
[c] The Cancer Council Western Australia copyright

While tag lines have often varied from campaign to campaign, smoking related campaigns in Western Australia have been characterised by quite consistent overall branding, with the Quit logo applied to most advertisements and support materials produced in the Department of Health's Quit era, and Make Smoking History applied to all campaigns run by The Cancer Council Western Australia (see Figure 12).

Figure 12 **Examples of logos used in major campaigns**

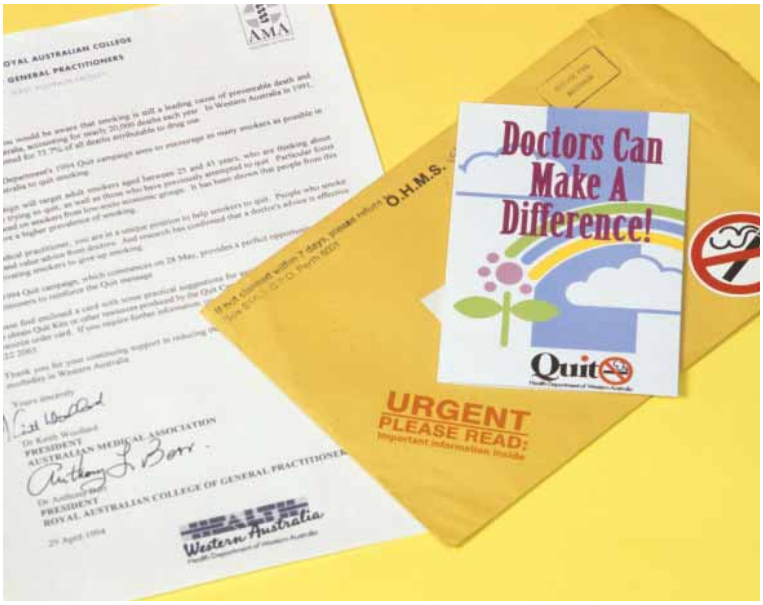
Comprehensive and coordinated with on-the-ground strategies

When applied to public health or community issues, a social marketing approach ideally includes mass media strategies (e.g. television, radio or press), which are complemented and reinforced by 'on the ground' communications products such as the provision of self-help materials, health professional counselling, referral and advice, and educational activities in appropriate settings and local publicity.[17]

Similarly, Quit campaigns and other major media campaigns have sought to involve intermediaries such as health professionals who are in direct contact with smokers and in a position to advise or encourage them to quit. Health professional groups targeted typically included general practitioners, community nurses, pharmacists and specialists working with people affected by smoking related disease. Newsletters and promotion of quitting resources to disseminate to patients were the most common approach. Other health professional groups (e.g. dentists, physiotherapists, hospital nurses, women's health care clinics) have also been targeted in some campaigns through resources or activities.

Figure 13 **Quit Campaign 1994 – Pharmacy display**

Figure 14 **Doctors mail out**



From the inception of the Quit Campaign in Western Australia, Quit Week and Quit Day were key focal points of activity. Heavier scheduling of media during Quit Week would typically be complemented by community-based publicity, quit information and merchandise dissemination and highly visible Quit Week reminders in prominent public places, such as banners in the city and malls. The strategic lighting up of windows of the Dumas House building visible from the freeway to spell QUIT is another example of creative efforts to promote awareness of Quit Week in the late 1980s and early 1990s.

Figure 15 **Dumas House lit up for Quit Week 1989**

Figure 16 **Quit Week banners on St Georges Terrace, 1990**

While the large-scale campaigns have always had a whole of State focus, exposure to mass media advertising and some campaign strategies can be limited in regional and remote areas. Campaigns thus were often given a more localised presence and supported at the regional level by on-the-ground activities instigated by regional health promotion officers, public health units and other supportive groups. Initiatives to support Quit campaigns in regional areas have included local Quit Day promotions at shopping centres, radio interviews, merchandise giveaways, 'brand new non-smoker' bibs given to babies born during Quit Week and school poster competitions.

Figure 17 **Brand new non-smoker bibs distributed to babies born during Quit Week**

Use of unpaid media and publicity

Following the very successful involvement of media and other personalities in Western Australia's first Smoke-Free Day Campaign in 1982, from their inception, Quit campaigns have made deliberate use of creative and imaginative public relations activities to generate media interest and raise the profile of smoking and health issues.

Quit campaign publicity activities and events were often concentrated around an annual Quit Week and Quit Day, which formed an integral component of media campaigns between 1984 and 2005. Some examples of media events and unpaid publicity used to highlight Quit Day or Quit Week are included in Table 3 and Figures 18 and 19 below.

Table 3 **Quit Day publicity events**

1984	1000 primary school children formed the letters of the word QUIT and released helium filled balloons with the slogan 'Quit, take a fresh breath of life'.
1989	Quit Campaign launched by an informed bookmaker, Professor Konrad Jamrozik, at local TAB to draw attention to the relative odds of dying from a smoking-caused illness highlighting, in particular, the relatively lower risk of other causes of death worried about more by the general public (Figure 18).
1990	Quit Day launched in a bank vault, to highlight the financial savings of quitting. A banker provided estimates of the amount of money that could accumulate if a quitter invested money previously spent on cigarettes.
1991	Quit Day launched in a science laboratory at Edith Cowan University's Mount Lawley campus with Dr Kingsley Faulkner, general surgeon and President of ACOSH presiding. Samples of everyday products (e.g. mothballs) and beakers of chemicals, such as naphthalene and formaldehyde were displayed demonstrating the range of poisons found in cigarettes along with a mock-up of a giant cigarette (Figure 19).
1993	New advertisement featuring Dr Fiona Stanley launched by her at the Allen Green Conservatory in Perth.
1994	Testimonial advertisements featuring models who had appeared in cigarette company advertisements, launched at a cinema.
Annual Quit Week	Brand new non-smoker T-shirts distributed through maternity wards to babies born during Quit Week as part of campaigns in the late 80s and early 90s, replaced with 'brand new non-smoker' bibs from the mid-90s.

Figure 18 **Quit Campaign launch 1989**

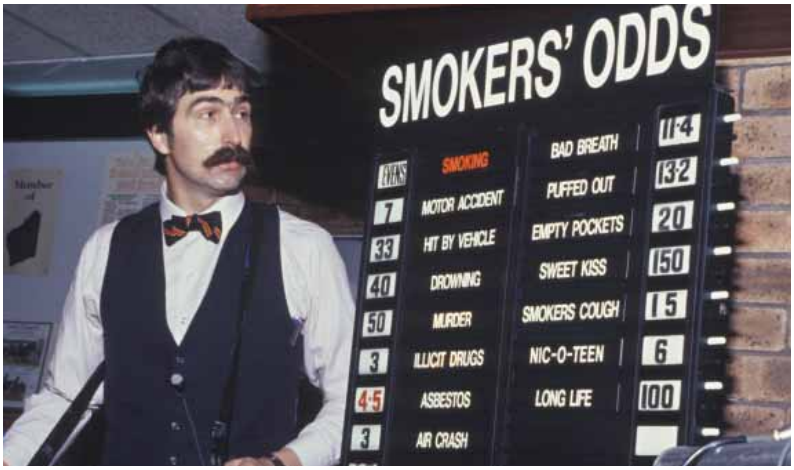


Figure 19 **Quit Campaign 'poisons' launch 1991**

Other low cost community-based publicity strategies used to draw attention to Quit Day included the distribution of carnations, with a Quit sticker affixed to the stem, to people in the city malls; provision of a Quit bow-tie to television weather presenters to wear during that evening's news; promotional breakfast kits delivered to morning radio program hosts that day and carbon monoxide testing of smokers in shopping centres.

Perhaps due to less interest by the media in smoking issues due to saturation over time, the more dramatic high-profile public relations events and launches of earlier Quit campaigns have receded, with the focus in later Quit and Make Smoking History campaigns more on strategic use of public relations opportunities throughout the year to draw attention to smoking and health issues (e.g. media publicity promoting quitting as a new year's resolution or in response to tobacco industry promotions in nightclubs).

Thematic approaches

Each campaign has reflected a particular theme relating to a health effect of smoking, population group or new news angle on smoking (see Table 4 for a sample of themes across the two decades). The need to raise awareness of major health consequences of smoking underpinned the themes and resources developed for many of the earlier campaigns, for example, introducing specific advertisements on smoking's effect on the heart in 1984 in response to research showing low salience of this connection amongst smokers. In later years, campaigns reinforced awareness of well-known health effects or highlighted effects around which evidence had more recently emerged (e.g. the National Tobacco Campaign's 2000 Eye advertisement which focused on smoking as the main preventable cause of macular degeneration). While a few of the television advertisements specifically highlighted the positive and short-term gains of quitting (e.g. Bring Your Body Back to Life, 1990), these were more often addressed through complementary press and radio advertising.

Table 4 **Examples of campaign themes, 1984 to 2007**

Cancer	Second-hand smoke	Benefits/help to quit	Parents who smoke
Sponge (1984) Sam – Smoking gave me throat cancer (1985) Tumour (1997)	Shadow (1990) Doctor's surgery (1995) Tissue (2001)	Fresh breath of life (1984) Let go – Quit because you can (1991) Quitline (1995) Piggy bank (1999)	Cathy (1987) Cat's in the cradle (1989) Should have been there (2002)
Emphysema	**Poisons in tobacco**	**Cigarette models/ Famous people**	**Older smokers**
Bill – Smoking gave me emphysema (1986) Stairs (1988) Lung (1997)	Poisons (1990)	Yul Brynner (1986) Marlboro Man, Winston Man, Lucky Strike (1994)	Don't blow the years ahead (2004)
Heart/vascular disease	**'Big Tobacco'**	**Missed opportunities**	**Young adults**
Heart (1984) Artery (1997)	Recall (2002)	Lifelines (1995) Didn't listen (2001) Echo (2006)	Bum-a-lung (2003) Marshall Menthol (2003)
Stroke	**Everyday people**	**The carers**	**Young women**
Brain (1998)	John's story (2004) Zita's story (2006)	Fiona (1988) Nice people but (2000)	Pretty face (1984) Only women bleed (1994) Jenny's story (2003)

Sharing what works

Internationally and within Australia, tobacco control has generally been characterised by quite a collaborative approach, with sharing of campaign ideas and sometimes resources, transcending geographical boundaries. Such sharing has been a two-way street. Advertisements developed in Western Australia based on international materials included the Yul Brynner ('Whatever you do, just don't smoke') commercial adapted from an American Cancer Society public service announcement released after Brynner's death in October 1985, in which Yul Brynner uttered the words, 'Now that I'm gone, I tell you, don't smoke'. The 1994 Cigarette Model series (Marlboro Man, Winston Man and Janet Sackman – Lucky Strike) was adapted from US documentary footage of interviews with insiders from the cigarette industry.

In fact, the Yul Brynner Quit advertisement was instrumental in changing the Australian Broadcasting Authority's regulations covering the overseas content of television advertising. Prior regulations required that 80% of the content of all television advertisements shown in Australia had to have been shot by an Australian or New Zealand crew. As the advertisement was based on footage of the interview with Yul Brynner, it could not comply with this requirement, but outcry within the media industry led to the regulation being changed such that now there is no requirement within an individual television advertisement for 'local' content, merely a requirement covering the total content of material put to air by stations.

Non-media components of campaigns were also sometimes adapted from elsewhere. For instance, the Quit and Win Competition (run as part of the 1991 Bring Your Body Back to Life campaign) was based on a concept used in Europe, and the Smokebuster Club, instigated for primary students in 1990, was adapted from a UK program.

The Sponge advertisement, adapted from an advertisement developed by New South Wales Health, was used in Western Australia in 1984 and subsequent years. Conversely, a number of Quit and The Cancer Council Western Australia's Make Smoking History advertisements have been used by other states and territories. The series of testimonial commercials known as 'Jenny's story', for example, was picked up by Quit Victoria, Quit South Australia and Quit Tasmania in 2003, and by the New South Wales Cancer Institute in 2004. A similar style campaign, entitled Zita's story, was aired as part of a New South Wales Cancer Institute campaign in October–November 2007 and by Quit Victoria in April 2008.

Furthermore, West Australian anti-smoking campaigns have come to be highly regarded internationally. This is especially noteworthy given the rigorous approach of the agencies involved to selecting materials for use in their campaigns and the well-known reluctance of advertising agencies to use materials developed by others. Other countries that have requested permission to use Quit Western Australia campaign materials include France (Cancer Association), Mongolia (Tobacco Free Youth Project), Japan (Ministry of Health and Welfare), Britain (Heart Foundation) and Singapore (Ministry of Health). The use of Make Smoking History posters in a Czech Republic campaign (2005) and reproduction of the Butt Man poster in Canada (2003), Nigeria (2003) and Uganda (2004) are other recent examples.

Campaign materials developed in Western Australia have also been used or displayed in a number of international resources, including Make Smoking History television advertising on a DVD of *Stop Smoking Advertisements from around the World*, distributed at the World Conference on Tobacco or Health July 2006 and *Didn't Listen*, in The Critics' Choice 2008 DVD resource for use within Australian schools for health education purposes.

Evaluating effectiveness

Evaluation has been an essential element in the success of West Australian anti-smoking campaigns, being used to measure effectiveness, guide future development and demonstrate accountability.

Typically, campaigns would be developed around specific communication and behavioural objectives, which would guide advertisement development and design of support strategies and inform evaluation measures. This is evident in the media briefs for very early campaigns through to recent campaigns developed by The Cancer Council Western Australia. The Smarter than Smoking Campaign was modelled on a similar approach with a strong component of formative research and pre and post campaign surveys of adolescent smokers and non-smokers informing its development.

As well as being a measure of effectiveness, campaign evaluations informed the approach of or treatment of smoking and health issues by future campaigns. For instance, evaluation of early campaigns indicated that personalised health messages are a powerful means of encouraging smokers to consider quitting.[13] Hence advertisements often sought to humanise the consequences of smoking by depicting them as happening 'to everyday people'. In the main, the evaluation of anti-smoking campaigns in Western Australia has been commissioned from independent market research agencies (early) or academic research institutions (later) with expertise in evaluation of social marketing campaigns.

The evaluation of large-scale anti-smoking campaigns, like the Quit and Make Smoking History campaigns, has comprised a combination of process, impact and outcome evaluations. Process evaluation has been used to measure reach and satisfaction with campaign strategies; impact evaluation has measured the immediate effects of campaign advertising on knowledge, attitudes, behavioural intentions and actions; and outcome evaluation has measured the longer-term changes in the prevalence of smoking among the campaigns' target groups. Some examples of process, impact and outcome measures used in the evaluation of West Australian anti-smoking campaigns are shown in Table 5 below.

Table 5 **Examples of process, impact and outcome measures of West Australian anti-smoking campaigns**

Process	Impact	Outcome
Distribution and demand for campaign resource materials	Percentage of smokers who reported that the campaign made them think about quitting	Reductions in the prevalence of smoking
Extent and favour of media coverage of campaign activities	Percentage of smokers who attempted to quit or cut down during the campaign	Reductions in the incidence and deaths from diseases caused by smoking
Calls to the Quitline	Percentage of smokers who quit or cut down over the campaign	
Recall and recognition of the advertising campaign		
Exposure to the campaign advertising		

Quantitative methodologies used in the evaluation of campaigns have consisted of pre-, post- and 3-month follow-up telephone surveys of random samples of adult smokers and recent quitters. The samples have been predominantly drawn from the metropolitan area, with the inclusion of rural samples on occasion. In 2001–2002, Quit Western Australia developed Monthly Tracking Study (MTS) as an alternative and more cost-effective way of routinely monitoring smokers' and recent quitters' knowledge, attitudes and behaviour monthly, and assessed the effectiveness of their campaigns and associated advertising. Each MTS survey had a sample of approximately 200 people (smokers and recent quitters), aged 18 to 50 years, from the Perth metropolitan area. Increasing of the 18 to 24-year-old sample occurred following the Young Adults Campaign, an example of the way in which the evaluation sampling and methodology can be tailored to the objectives and target group of a particular campaign.

Post-campaign evaluations of West Australian anti-smoking campaigns generally have measured the capacity of the advertising to: cut through media clutter and gain awareness of the target group; effectively communicate campaign messages; produce shifts in attitudes among the target group; and impact on the behavioural intent of the target group. Over the last decade, it has become less common for pre- and 3-month follow-up surveys to be conducted largely due to the growing difficulty, and cost, of recruiting and retaining smokers and recent quitters for the research. Ironically, this is a consequence of the decline in prevalence of smoking over the last twenty years or so.

Adequate funding

Effective social marketing campaigns require adequate and sustained funding, yet frequently operate on a shoestring relative to their commercial marketing counterparts, with funding often only allocated one year at a time. There are frequent calls for funding to go beyond 'adequate' to 'ample funding' to further progress tobacco control beyond 'the tipping point'.[18]

The Quit Campaign, which was established in 1984 with a total budget of $2 million per annum, accounted for a large proportion of the Health Department's Smoking and Health program expenditure in the early years. Over the decade that followed there was a steady decline in the annual budget for the program (estimated by experts in the field to have ranged between $1.3 and $1.6 million during the early to mid-

90s). This coincided with expansion of the program's role in the development of State policy and legislation on tobacco as well as steep increases in the costs of media production and placement compromising the duration and intensity of campaigns, and capacity of the program to maintain the freshness of the Quit Campaign through the development of new advertising materials.

Expenditure on media campaigns on smoking was somewhat boosted with the establishment of The Cancer Council Western Australia's Make Smoking History Campaign in 2000 (funded by Healthway), and sporadic advertising by the Commonwealth Department of Health and Ageing as part of the National Tobacco Campaign that was revived in 1997. The Smarter than Smoking youth smoking prevention campaign, discussed in another paper, provided additional media on smoking and health issues albeit targeting school-aged children.

Nonetheless, there is a general perception among public health advocates that investment in population-based health campaigns on smoking is inadequate and has diminished over time. It is estimated that if the annual budget allocation for Department of Health's Smoking and Health Program had kept pace with inflation, it would amount to more than $4.8 million today (according to the Reserve Bank of Australia inflation calculator). Investment in anti-smoking campaigns falls far short of this figure, although smoking continues to be the major cause of ill-health and premature death in this State. Similar under-investment is observed across Australia, despite a number of economic analyses demonstrating the return of investment from expenditure on anti-smoking campaigns.[19,20]

Overall, investment in media campaigning on smoking in Western Australia has been modest throughout much of its history, underscoring the challenge, and resourcefulness and ingenuity required, to enable continued delivery of high quality and effective campaigns that represent value for money. Over time, however, the generally downward trend in the funding available for statewide anti-smoking programs and campaigns has been accompanied by an increase in resourcing requirements for legislative and policy aspects of tobacco control and higher costs of media advertising.

Have campaigns made a difference?

As Somerford confirms in this report, anti-smoking campaigns have made a significant contribution to reductions in the uptake and prevalence of smoking in Western Australia and the incidence and deaths from some diseases caused by smoking such as heart and lung diseases and some cancers. Although it is important to recognise the difficulty in attributing the effects of campaigns given the synergistic environment of tobacco control in Australia, media campaigns have served to consolidate and support other tobacco control initiatives, raise awareness of the hazards of smoking, and build public support and political commitment to other tobacco control measures.[5,6,21]

Measures used to evaluate the effects of campaigns are based on the overarching aims, and the communication and behavioural objectives set for the campaigns, as evidenced in documentation relating to the planning and development of West Australian campaigns. This is exemplified in the table below, which gives the broader communication and behavioural objectives for The Cancer Council Western Australia's Make Smoking History campaigns together with achievement against the objectives for the period 2000 to 2006.

Table 6 **Make Smoking History – achievement against campaign aims and objectives, 2000 to 2006**[a]

Aims	
Contribute to reductions in the proportion of adults who smoke daily	The prevalence of smoking amongst Western Australians aged 18 years and over has declined from 25% in 1997 to 17% in 2006
Communication objectives	
To raise awareness of the serious harms of smoking and highlight the benefits of quitting	85% of respondents who recall the campaign advertising identify at least one correct message from the television advertising *[Baseline post-campaign evaluation MSH waves 1 to 5, and 10 to 15 (2000-2002; 2005-2006)]*
	60% of respondents who recall the campaign advertising report that they believe it is likely they will become ill from smoking if they continue to smoke *[Baseline post-campaign evaluation waves 10 to 16 (2005-2006)]*
	90% of respondents who recall the campaign advertising report that they believe that smoking has already done harm to their body *[Baseline post-campaign evaluations waves 10 to 16 (2005-2006)]*
Behavioural objectives	
To elevate the urgency among smokers to quit smoking	40% of respondents who recall the campaign advertising report that the TV advertisements made them seriously consider quitting
	65% of those respondents who report that the television advertisements made them seriously consider quitting report that they are encouraged to do so in the next month
To encourage smokers to quit by prompting cessation activity	15% of respondents report that as a result of the recent advertising about the effects of smoking, they have sought more information from their GP or health professional
	50% of respondents report that as a result of the recent advertising about the effects of smoking, they have discussed quitting with family, friends or work colleagues
	More than 50% of respondents report that they tried to quit or cut down during the campaign
	Of those who report that they tried to quit or cut down during the campaign, at least 55% report that they had successfully quit or cut down
	About 35% of all respondents report that they successfully quit or cut down during the campaign

a Unpublished data provided by The Cancer Council Western Australia.

The achievements of the Make Smoking History Campaign have built on those of the longstanding Quit Campaign, which over the last two decades has been the catalyst for many West Australians to stop smoking.

Post-campaign evaluations of the Quit Campaign show that successive waves of the campaign have been the trigger for at least one in two West Australians to try to quit smoking. In an analysis of evaluation data from Quit campaigns run by the Department of Health between 1984 and 2005, 56.2% of smokers on average attempted to quit or cut down during respective campaign periods. In all of these campaigns, smokers who indicated that they had attempted to quit or cut down were followed up (3 to 8 weeks post campaign launch, varying with campaign year): on average 7.9% were still quit, and 27.5% still cut down at follow up (see Table 7 below).

Table 7 **Quitting during and post Quit campaigns (1984-2005)**

Action taken in relation to smoking	Average (%)	Median (%)
Attempted to quit or cut down	56.2 %	56 %
Still quit at follow up	7.9 %	8 %
Cut down at follow up	27.5 %	27 %

Calls to the Quitline provide another measure of campaign effectiveness. The availability and promotion of telephone support services for smokers wanting to quit have been integral components of campaigns and tobacco control programs in this State. The Quitline (13 18 48 later changed to 13 78 48) was established in conjunction with the first campaign in 1984, and was run directly by the Department of Health in earlier years and subsequently contracted to the Alcohol and Drug Information Service (ADIS). Both Department of Health and ADIS data indicate significant increases in cessation-related calls during campaign periods. As noted in a recent ADIS report on calls to their service from 1986 to 2006:

> 'variations in the number of licit drug related calls over the period appear to be closely related to public health campaigns, which have at different times targeted prescription drugs, alcohol and tobacco'. [22]

Between 1986 and 2006, ADIS has received a total of 21,993 tobacco-related calls.[22] These represent only a small sub-set of total Quitline calls as ADIS is only involved in responding to calls from smokers who elect to talk to a counsellor about their smoking and issues with quitting. Department of Health data indicate that calls to the Quitline vary, but consistently increase during campaign periods. During campaigns conducted between 2001 and 2005 for example, an average of 377 calls was received by the Quitline each week.

In addition to evaluation results, the recognition that many advertisements have received within the advertising and marketing field is further testament to the calibre of West Australian tobacco campaigns.

Some examples of awards received are presented in Table 8.

Table 8 **Awards won by West Australian anti-smoking advertisements**

Advertisement	Award
Emphysema (Department of Health, 1986)	Commercial of the Year – Golden Key Awards West Australian television advertising
Cat's in the Cradle (Department of Health, 1989)	Finalist award – International Film and Television Festival of New York
1994 West Australian Quit Campaign (Department of Health, 1994)	State Winner, Non-Profit Organisations Marketing, Australian Marketing Institute Awards for Excellence 1994 State Winner, Government/Statutory Bodies Marketing, Australian Marketing Institute Awards for Excellence 1994 State Winner, Marketer of the Year, Australian Marketing Institute Awards for Excellence 1994 National Winner, Government/Statutory Bodies Marketing, Australian Marketing Institute Awards for Excellence 1994
Lifelines (Department of Health, 1996)	Best of Category (television), Campaign Brief Awards, 1996 Best of Year (television), Campaign Brief Awards, 1996 Finalist (television), Perth Advertising & Design Club Awards
Quit radio advertisement (Department of Health, 1996)	Finalist, Radio Writers Award
Doctor's Surgery (Department of Health, 1996)	Finalist – Charity and Community Service (television and radio) Perth Advertising & Design Club Awards Finalist – Charity and Community Service (television), Campaign Brief Awards
Auld Lang Syne (Department of Health, 1997)	Best of Category – Charity and Community Service, Perth Advertising & Design Club Awards, 1997
'Nice People But' (The Cancer Council Western Australia, 2000)	Silver Lion, Cannes International Festival 2001 Silver for Social Marketing/Charity television/Cinema, Annual Perth Advertising & Design Club Awards. 2001 Perth's Best Television Advertisement, Campaign Brief Awards 2001 Bronze, Clio Awards (International), 2002
Tissue (Department of Health, 2001)	Finalist, Clio Awards (International), 2001 Finalist (Television/Cinema Social Marketing), Perth Advertising & Design Club Awards, 2001
'Finger', 'Syringe' and 'Butt Man' advocacy press advertisements (The Cancer Council Western Australia, 2001)	Bronze (Social Marketing/Charity Print), Perth Advertising & Design Club Awards

'Armchair' press advertisement (The Cancer Council Western Australia, 2004)	Finalist in 'Best of Year' Press category, West Australian Campaign Brief awards Silver (Print – Social Marketing & Charity), Perth Advertising & Design Club Awards
Zita's Story (The Cancer Council Western Australia, 2006)	Finalist, Campaign Effectiveness category, Campaign Brief Award, January 2007

Conclusion

Overall, mass media campaigns have made a measurable difference in the lives of West Australians and proven to be a wise investment by State governments and non-government organisations in this State. The early priority given to pre-testing potential advertising concept-executions and the ongoing emphasis on evaluation has set West Australian anti-smoking campaigns apart from others and played a vital role in ensuring the delivery of high quality campaigns that have the desired effects on their target audiences with the efficient use of resources. Undoubtedly, thousands of West Australians owe their health and their lives to the Quit Campaign and others that have followed.

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Healthway's contribution to tobacco control in Western Australia, 1991–2007

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Introduction

The establishment of the Western Australian Health Promotion Foundation (Healthway) in 1991 signalled a new vision and commitment to health promotion in Western Australia. With the support of government, business and the public health community, Healthway has played, and continues to play, a critical role in shaping the health of West Australians.

The beginning

The inclusion of health promotion foundations in proposals for tobacco control laws was a vital turning point in persuading some opponents of the laws to become supporters. Since the 1970s tobacco companies had sponsored sporting and racing organisations as an avenue for cigarette advertising at events (Daube and Walker, this report). Attempts in South Australia in 1980 and Western Australia in 1982 and 1983 to ban tobacco advertising through legislation failed partly because of concerns among parliamentarians over the loss of revenue to sport and racing (Daube and Walker, this report).

In Victoria a proposal, developed by the Anti-Cancer Council, to hypothecate funds from State tobacco taxation revenue to replace tobacco sponsorship with health messages was highly influential in gathering support for legislation in 1987. The Victorian *Tobacco Act* restricted tobacco advertising and marketing and established VicHealth as a health promotion foundation.[1] The concept of health promotion foundations was adopted by South Australia in 1988 and the Australian Capital Territory in 1989.

In Western Australia, partnerships formed between health groups and sportspeople were also important in overturning the allegiance of some sport and racing organisations to tobacco companies and in convincing politicians to support legislation (Daube and Walker, this report). The Western Australian Health Promotion Foundation (Healthway) was established in 1991 under the Western Australian *Tobacco Control Act 1990*.

The Act defined the objectives of Healthway as being to:

- offer an alternative source of funds for sporting and arts activities currently sponsored by manufacturers or wholesalers of tobacco products
- provide funds to replace tobacco advertising with health promotion advertising
- provide grants to organisations engaged in health promotion programs
- fund health promotion research
- sponsor sport, arts and racing activities that encourage healthy lifestyles and advance health promotion programs.

Healthway was initially funded by a business franchise fee on the sale of tobacco.[2] In August 1997, the High Court of Australia ruled that it was unconstitutional for States to charge State-based tobacco taxes. As a result, Healthway is now funded by direct allocation from consolidated revenue. Healthway's budget in its first year of operation amounted to $12.9 million.[3] In 2006/2007, Healthway's budget was $18.6 million, with about one-third allocated to tobacco control.[4]

Making a difference

Replacement of tobacco advertisements (billboards) and sponsorship

Two major avenues for tobacco industry promotion, outdoor advertising and sponsorship, were banned by the *Tobacco Control Act 1990* and an initial focus of Healthway was the replacement of these with health messages.[5]

There was limited use of billboard advertising as a health promotion strategy in Western Australia prior to Healthway. Healthway developed a structured program to phase out tobacco advertising and replace an agreed number of sites with health promotion advertising. This program was complete by mid-1994 with a total Healthway investment of $1.4 million.[6] This included an allocation to health agencies to develop a range of health messages for billboards. The creative use of billboards ensured the success of this program which not only banished tobacco advertising but also gave health agencies the opportunity to promote their health messages.

Tobacco sponsorship replacement for sport, arts and racing organisations was a priority of Healthway in its first five years of operation. Between 1991 and 1994 Healthway replaced sponsorships valued at $3 million for thirty-three organisations.[6] This entailed a major shift in direction and allegiance for tobacco-sponsored organisations: instead of promoting tobacco they were required to promote health as a condition of Healthway funding. *Benson & Hedges* and *Winfield* were replaced with *Be Smoke-free* and *Quit* as well as other health messages. By 1992, except for some exemptions for events of international significance (that ended in October 2006), all tobacco sponsorships in Western Australia were replaced by Healthway.[6]

Figure 1 **'This billboard has given up smoking' was adapted from advertising developed by VicHealth and was used to herald the phasing out of tobacco advertising**

Figure 2 **In motor sports, tobacco sponsorships were replaced by Quit**

As well as replacing tobacco sponsorship, Healthway supports sports, arts and racing organisations that encourage healthy lifestyles and advance health promotion programs. This is a major part of Healthway's work with more than $62 million being allocated between 1991 and 2005 to sports, arts and racing organisations as well as health agencies to promote non-smoking messages.[7]

Health promotion strategies, including signage and personal endorsements, were used to gain similar benefits to those previously given to the tobacco industry. As well as the elimination of tobacco sponsorships the buy-outs provided other benefits including:[8]

- access to venues that attracted large numbers of people with high risk behaviours (the prevalence of smoking among patrons at these venues being 1.8 times higher than for other venues)
- the introduction of smoke-free areas, which helped to create and build support for smoke-free venues
- the creation of social norms where smoking was no longer acceptable at sports, arts and racing venues
- the fostering of new health promotion partners in sports, arts and racing organisations.

Most health sponsorships have communication and behavioural objectives. The former refer to awareness, attitude and intention effects, whereas the latter refer to the adoption of the recommended behaviour (e.g. trying to quit smoking).[3]

The Health Promotion Evaluation Unit, an independent group previously based at The University of Western Australia, conducted a series of community surveys to assess the impact of Healthway sponsorship using a number of measures. Sponsorship was found to be an effective strategy to achieve high prompted awareness, comprehension and acceptance of health messages at sports, arts and racing events. Smoking messages had a high salience among non-smokers and smokers surveyed at Healthway-sponsored events in 2006/2007 with 96% of those surveyed being aware of Quit, 90% aware of Smoke-free Western Australia and 94% of Smarter than Smoking.[9] In 2006/2007, surveys of sponsored events showed that 73% of smokers were aware of these anti-tobacco messages, 64% had positive attitudes to the messages and 43% had formed an intention to act on the message promoted at the event.

These results show sponsorship continues to be an effective communication strategy and also confirms that it can achieve self-reported behaviour change.

Figure 3 **Signage and role models raise awareness and influence attitudes towards smoking**

Funding health promotion research

Towards achieving its legislative objective 'to fund research relevant to health promotion', Healthway makes a significant contribution to health research in Western Australia. In 2006/2007 the health promotion research program supported twenty-two projects (including grant commitments to previously approved multi-year projects and capacity building opportunities) to a total of $2.04 million with additional funding allocated for scholarships, fellowships and a visiting fellow.[4]

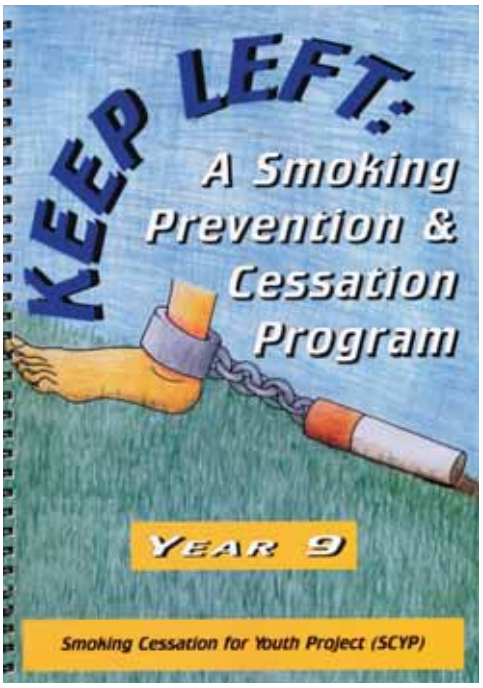
Healthway also made a major contribution to the demise of tobacco industry-funded research by making it a condition of Healthway research funding (from 1992) that universities could not accept grants from tobacco companies. This effectively halted tobacco industry-funded research in Western Australia's four universities.[10]

Although tobacco research has been a stated priority of Healthway since its establishment, by 2004 Healthway had allocated only 5.7% of the available research funding to tobacco control. To address this issue Healthway established the Tobacco Control Research Development Program in 2005, a special five-year initiative to generate more research activity in tobacco control. Three grants of up to $90,000 per year for up to five years each were awarded to trial initiatives in different contexts and settings.

Optimising school nurse involvement in youth-based tobacco control programs – The Child Health Promotion Research Centre, Edith Cowan University

The aim of this program was to build capacity at a number of levels including secondary school nurses, postgraduate students and professionals working in the fields of school health promotion and smoking prevention and cessation. It sought to provide a framework to support school nurses in their role, and to articulate clearly the structure and direction of the secondary school nursing program and ways it can contribute to a reduction in harm from smoking among adolescents, including developing a school strategy. Ultimately, the research aims to decrease the use of, and harm associated with, tobacco among young people.

Figure 4 **Resources developed as part of the tobacco harm reduction research studies**



Family interventions to reduce tobacco smoke exposure of Pilbara Aboriginal children – The Combined Universities Centre for Rural Health

The research team led by The Combined Universities Centre for Rural Health collaborated with the Aboriginal Community Controlled Health Service sector and researchers from the Child Health Promotion Research Unit at Edith Cowan University. The multi-level community intervention used harm minimisation strategies to reduce environmental tobacco smoke exposure among Aboriginal infants and children (0 to 6-year-olds) in South Hedland. Intervention was at three levels: families, the community, and organisations and services addressing health and wellbeing of young Aboriginal children. A key strength of the research project was the potential to build research capacity in tobacco control and health promotion among Indigenous researchers.

Tobacco Control Research Fellowship Training Program – The Centre for Behavioural Research in Cancer Control, Curtin University of Technology

The focus of this program was to foster the development of a West Australian expert to lead a research team conducting studies to inform legislation and policy development, program and campaign design, cessation services and support along with tobacco and related health industry monitoring. The program of research links with the major tobacco campaigns in Western Australia as well as policy-makers.

Funding health promotion projects

The objective of the Healthway Health Promotion Program is to provide grants to health and community organisations to develop new approaches to health promotion that will change community attitudes and behaviour and create environments in which good health is encouraged. From the outset Healthway defined its role as an enabler and catalyst rather than as an implementer of programs. More than $12 million has been allocated directly to tobacco control in both small and large grants for health promotion projects (personal communication with Healthway 2007). Smarter than Smoking is an example of an innovative tobacco control program funded by Healthway from 1995.

Smarter than Smoking – The National Heart Foundation of Australia (Western Australian Division)

The Smarter than Smoking project was a multi-strategy intervention that aimed to reduce smoking prevalence among 10 to 15-year-olds in Western Australia and to educate them to make informed choices about smoking which are beneficial to their health. The project used a comprehensive mix of strategies which included mass media, school-based education programs and resources, promotion of the Smarter than Smoking message through sports, arts and racing sponsorships, the development of youth-orientated publications, website and merchandise, and advocacy to reduce tobacco promotion, availability and affordability for young people.

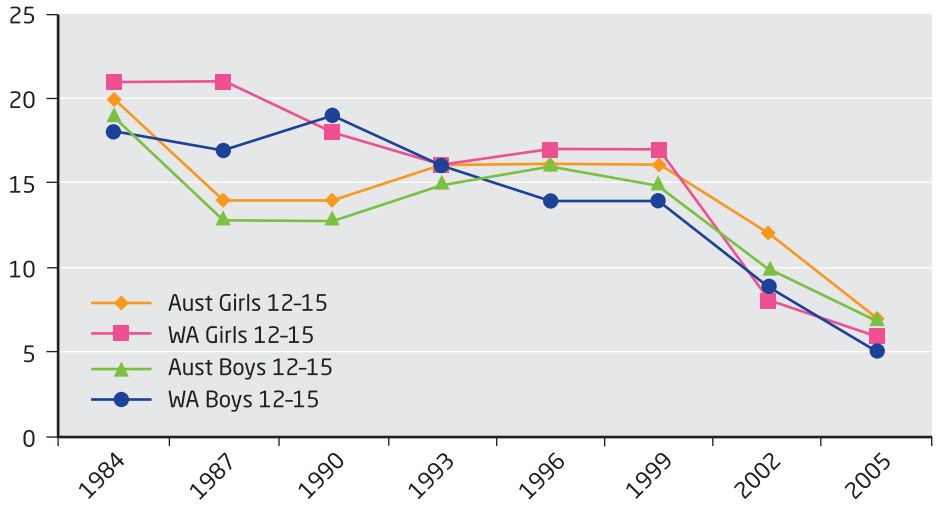
Figure 5 **A member of the youth advisory committee assists with signage at a Smarter than Smoking event**

Smarter than Smoking illustrates the role of Healthway to fund programs that were complementary to, but did not substitute for, core activities of the Western Australian State Government (Quit campaign for adults, legislation to restrict access to tobacco by children and end tobacco advertising). Among other non-government and government activities in Western Australia, Smarter than Smoking contributed to the accelerated decline of smoking among 12 to 15-year-olds in Western Australia from 1999 to 2005.[11-13]

Table 1 **Smoking among Australian and West Australian secondary school children 1984-2005 (percentage of students who smoked in the last seven days)**

Year	Girls 12-15 (%)		Boys 12-15 (%)	
	Australia	Western Australia	Australia	Western Australia
1984	20	21	19	19
1987	14	21	13	17
1990	14	18	13	19
1993	16	16	15	16
1996	16	17	16	14
1999	16	17	15	14
2002	12	8	10	9
2005	7	6	7	5

Figure 6 **Smoking among Australian and West Australian secondary school children 1984-2005 (percentage of students who smoked in the last seven days)**



Health promotion sponsorship and project funding as leverage for smoke-free environments

Healthway has been uncompromising in its pursuit of smoke-free environments through its sponsorship and health promotion programs. Using an incremental approach to increase the number and acceptance of smoke-free policies, Healthway was able to gain support and acceptance of many stakeholders. Table 2 describes some of the steps taken by Healthway towards achieving smoke-free environments.

Figure 7 **This giant billboard proclaimed a smoke-free baseball stadium**

Figure 8 **Cartoons were used to advise patrons that greyhound racing was smoke-free**

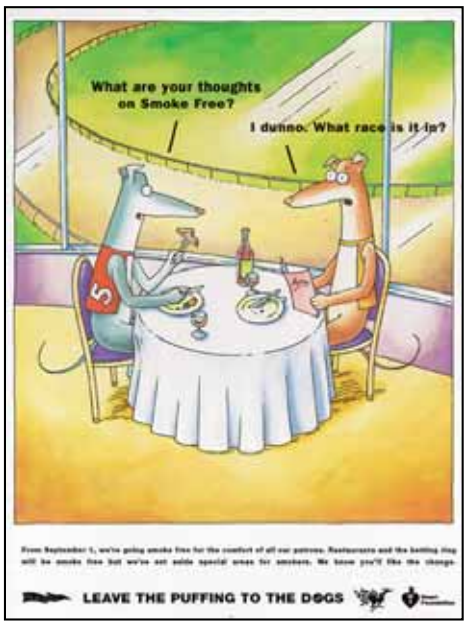


Table 2 **Memorable milestones on the road to smoke-free environments in Western Australia**

1991	Perth Jazz Club Monday night sessions at Hyde Park Hotel go smoke-free in the jazz venue
1992	Fly by Night Musicians' Club goes completely smoke-free
1994	25,000 people applaud when it is announced that Opera in the Park is a smoke-free event
1995	Western Australian Trotting Association makes all indoor areas at Gloucester Park racecourse smoke-free
1995	Grandstands, betting and indoor bar areas at Belmont Park racecourse go smoke-free
1995	Permanent smoke-free areas are introduced at Parry Field, home of baseball
1996	Healthway introduces a sponsorship program to support local musicians to launch CDs of original music in smoke-free licensed premises
1996	Healthway introduces the SmokefreeWA message to promote the concept of a state with clean tobacco-free air and encourage the 76% of adult non-smokers to advocate for fresh air
1997	The Healthway Board decrees that all organisations seeking funding must be prepared to make all indoor areas of their venues smoke-free
1997	Subiaco Oval and the WACA make all indoor and outdoor seated areas smoke-free. Smoking is permitted in designated areas away from the main arenas
1998	The *Financial Review* honours the Western Australian Greyhound Association for bravery in its national sponsorship awards for the implementation of smoke-free policies at Cannington and Mandurah racecourses
1999	44% of Healthway sponsorships now promote the SmokefreeWA message
1999	Healthway introduces the SmokefreeWA Clubs sponsorship program as a means of discouraging recreational clubs with liquor licences seeking an exemption under the Health (Smoking in Enclosed Public Places) Regulations 1999
2000	Healthway publishes its policy on tobacco control
2001	All spectator areas on course, grandstands, the media centre and corporate marquees at the Heineken Classic golf tournament go smoke-free
2001	Subiaco Oval goes completely smoke-free – patrons must leave the ground if they wish to smoke
2000–02	Surveys show 95% community support for Healthway events being smoke-free
2003	The Healthway Board requires all organisations applying for grants over $20,000 to implement comprehensive health policies addressing smoking and other health issues
2004	The Healthway Board clarifies and confirms its policy on smoking on stage as part of live arts performances
2005	A survey of patrons at Opera in the Park finds that 99% support the event being smoke-free
2006	The Healthway Board implements a policy requiring that all outdoor seated areas, viewing areas and other audience areas under the control of a sponsored organisation are 100% smoke-free, and where possible the entire event is smoke-free
2006	Passage of the *Tobacco Products Control Act 2006* strengthens controls on tobacco promotion, provides further protection for non-smokers and updates Healthway's legislative base

There is no doubt that this approach was very successful.[14-17] In 1992, 77% of recreational venues used by sports, arts and racing organisations sponsored by Healthway had designated smoke-free areas (no distinction made between indoor and outdoor). By 2005 the proportion had risen to 93% of venues and over 60% of organisations reported implementing smoke-free outdoor areas by 2005.[18] Support among organisational stakeholders funded by Healthway increased, with surveys indicating a clear trend of increased levels of activity and commitment to smoke-free environments among sports, arts and racing organisations between 1992 and 2005.[19]

Figure 9 **Signage on seats reminds patrons of smoke-free policies**

Research indicates that the introduction of smoke-free policies may change community norms about smoking in public.[20] In Western Australia, early surveys of smoking and non-smoking spectators at football events found little support for smoke-free policies in indoor and outdoor areas. However, after the introduction of these policies in the premier football stadium, support among spectators increased markedly, particularly among non-smokers.[14] By 2006 an overwhelming 93% of people attending Healthway events supported arts, sports and recreational facilities becoming completely smoke-free.[21]

Promoting positive attitudes to tobacco control among the community and particularly among politicians

Healthway works in partnership with many other organisations to advocate for better tobacco control measures. It supports the Australian Council on Smoking and Health which focuses solely on tobacco issues, as well as other organisations that are involved in advocacy on tobacco control issues such as The National Heart Foundation of Australia (Western Australian Division) and The Cancer Council Western Australia. Currently Healthway is one of the thirty active member organisations of the Tobacco Control Coalition established by The Cancer Council Western Australia. This group seeks to broaden support for tobacco control, foster harmonious working relationships among members and provide a mechanism for building skills and knowledge in the community. Healthway was also influential in encouraging organisations to share tobacco campaign messages and work together to promote them, averting the proliferation of messages and providing clear and simple communication with the community.

Many comprehensive campaigns which receive Healthway funding (Make Smoking History, Smarter than Smoking, Say No to Smokes), include media advocacy as a component. Healthway supports advocates in many practical ways, for example, in 2003 two surveys were commissioned by Healthway to gauge community attitudes towards toughening legislation on smoking in public places, which added weight to

the lobbying and advocacy effort.[22] Advocacy campaigns resulted in a number of wins including the passage of the Health (Smoking in Enclosed Public Places) Regulations 1999, the Health (Smoking in Enclosed Public Places) Regulations 2003, the Health (Smoking in Enclosed Public Places) Regulations 2004 and the *Tobacco Products Control Act 2006*.

Healthway was established by the passage of the Western Australian *Tobacco Control Act 1990* by a Labor government and the contribution of the organisation towards positive community attitudes to smoking control has ensured support from successive governments, both Coalition and Labor.

Healthway as a model for health promotion foundations

VicHealth and Healthway were among the founding members of the International Network of Health Promotion Foundations established in 1999. Core activities of the Network are to mentor and support the establishment of new health promotion foundations as well as enhancing the performance of existing Health Promotion Foundations through exchange, mutual learning, and joint action.[23] Membership of the INHPF in 2006 included:

- Austrian Health Promotion Foundation
- British Columbia Coalition for Health Promotion
- Health Promotion Switzerland
- Health 21 Hungarian Foundation
- Korean Health Promotion Foundation
- Malaysian Health Promotion Foundation Initiative
- Polish Health Promotion Foundation
- Thai Health Promotion Foundation (ThaiHealth)
- South African Health Promotion Foundation Initiative
- Victorian Health Promotion Foundation (VicHealth)
- Western Australian Health Promotion Foundation (Healthway).

It has been suggested that impetus for the model of health promotion foundations has been reinforced by the adoption of the World Health Organization Framework Convention on Tobacco Control.[24]

Looking to the future

Tobacco smoking remains the leading preventable cause of death and disease in the community, which together with Healthway's basis in tobacco control legislation, maintains smoking control as a high priority for Healthway in its strategic planning.[25] The decline in smoking among West Australians since the 1980s is encouraging, but Healthway, along with other health organisations, recognises the importance of focusing on the high levels of smoking among Indigenous people and others who are marginalised and disadvantaged. In particular, there is concern for Indigenous people, among whom an estimated 50% smoke daily.

Healthway's commitment to these high priority groups reflects its role in tobacco control research, projects, sponsorships, policy, advocacy, and other initiatives that complement the range of government and non-government organisations involved in a comprehensive approach to tobacco control. Healthway's ability to identify particular target groups and priority areas as well as to fund trials and innovative initiatives places it in a strong position to address 'hard to reach' and high-risk groups in the community.

Through its unique buying power through sponsorship of sports, arts and racing organisations, Healthway can make health promotion a condition of funding by mandating smoke-free environments. Over time, Healthway has extended its requirements for smoke-free indoor areas into outdoor spectator and viewing areas, and aims to continue to push the boundaries so that ultimately all events sponsored by Healthway will be entirely smoke-free.

As well as exerting direct influence with sponsored organisations, Healthway has also worked to form community partnerships, for example, with local government authorities. Areas of influence include assistance to organisations and outdoor venues (beaches, parks and children's playgrounds, outdoor music concerts) where large numbers of people, especially children, are present to implement smoke-free policies and raise awareness, provide role models and reinforce social norms.

There is no doubt that Healthway has played a vital and exceptional role in the West Australian tobacco effort since 1990, not least of which has been the injection of 'new monies' for tobacco control. The track record of Healthway has been that of continuous achievements in the face of changing environments. Healthway's ongoing strategic planning process reflects the broader environment and its flexible approach will ensure that the organisation maintains relevance in a dynamic public health environment.

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Is an end to smoking in sight? Next steps toward making smoking history

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Introduction

In 2005, researchers from Western Australia's Curtin University of Technology made the bold prediction that smoking could be 'a thing of the past in Australia within 25 years if present trends continue'.[1] Interestingly, few challenged the likelihood of such a prospect suggesting that for the wider community at least an end to smoking seems possible and the logical outcome of an enduring battle by public health advocates to curb smoking.

Privately, many public health advocates, while hopeful, are less certain of an end to smoking by 2030. It is clear the tobacco industry remains a formidable force despite past protestations that 'Australia is one of the darkest markets in the world.'[2] It is well resourced, clever, aggressive and uncompromising in its efforts to protect its commercial interests and ward off criticism and regulation.[3] In fact, for the tobacco industry it is largely business as usual despite being mired in controversy, litigation and regulation in Australia and other parts of the world.[4-6] Moreover, it makes no apology for the human carnage its products have caused and may cause in the future,[7] one tobacco company executive even going so far as to rudely declare he was 'on the side of the angels'.[8]

Tobacco Industry Quotes

'Australia is one of the darkest markets in the world ... it probably is the darkest, I mean ourselves and Canada fight every month for who's got the darkest conditions to do tobacco manufacturing and marketing.' David Crowe, Marketing Director, British American Tobacco (BAT) Australia.[2]

'We enter 2007 with considerable momentum. There is no doubt our businesses will continue to face a fiercely competitive environment, but I believe we will have the appropriate plans in place to consistently achieve top-tier performance versus our peers.'
Louis C Camilleri, Chairman of the Board and Chief Executive Officer, Altria Group Inc.[4]

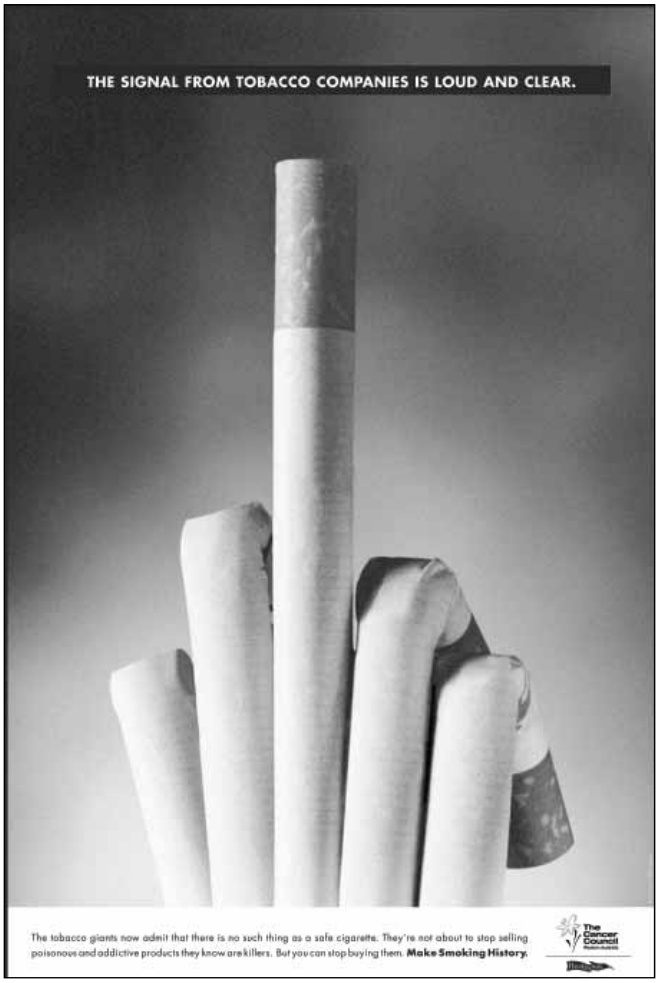
'... despite a changing business environment, we are confident that the tobacco industry has a secure future and that British American Tobacco has the strategy and products to prosper.'
Paul Adams, Chief Executive, British American Tobacco.[5]

'The mature markets of Australia and New Zealand are among the most highly regulated in the world, with pictorial health warnings in Australia and extensive restrictions on display and smoking in public places. However, we have demonstrated our ability to continue to grow our profit.'
Annual Report 2006, Imperial Tobacco Group.[6]

'People are going to criticise us, but that's not going to deter us.'
David Davies, Senior Vice-President Corporate Affairs, Philip Morris International.[7]

'So I think I'm on the side of the angels. I'm running a business which sells risky products and I see myself making a contribution to running that in a responsible way.'
Paul Adams, Chief Executive, British American Tobacco.[8]

Figure 1 **The signal from tobacco companies (Make Smoking History press)**



Earlier papers in this monograph chronicle the tremendous progress that has been made in reducing the use of and harms caused by tobacco in Western Australia. That being the case, how probable is an end to smoking given the might and outward confidence of the tobacco industry? Many public health advocates strongly believe there will come a time when so few people smoke, and community tolerance of smoking is so low, the sale of tobacco will no longer be considered a viable commercial activity. How soon that occurs will depend on the dedication of public health advocates and governments to maintaining Australia's reputation as 'one of the darkest markets in the world.'[2] This paper outlines the next steps toward achieving an end to smoking in Western Australia and indeed nationally (given the goal will not be realised in the absence of national and uniform action on tobacco). In doing so, it takes stock of achievements to date and the challenges ahead.

What we've achieved

Western Australia has a strong record of achievement in tobacco control. The sales, marketing and use of tobacco are strictly controlled with recent changes to laws on tobacco in this State making them among the toughest in the country.[9] As a consequence of concerted campaigning by public health advocates, most people are aware of the risks of smoking and support for measures discouraging the use and promotion of tobacco is strong – even among smokers.[10,11] Help for smokers to quit has improved over the last two decades with the advent of the Quitline and associated self-help resources on smoking and how to stop, the development of pharmacotherapies for treating nicotine dependency and a stronger focus on smoking cessation by health service providers.[12,13] Investment in tobacco control has been boosted and innovation

encouraged since establishment of the Health Promotion Foundation of Western Australia (Healthway) (Carroll and Walker, this report). Most importantly, tobacco control is now embedded in organisational and government policies: making tobacco control the business of many rather than a few.[12-14]

Pleasingly, there have been big returns on investment in tobacco control over the decades. The prevalence of smoking among adults has plummeted from 32% in 1984 to 17% in 2006 (Somerford, this report). Fewer school-aged children are taking up the habit with only 6% current smokers compared with 23% in 1985.[15] Declining use of tobacco has contributed to significant falls in deaths and diseases caused by smoking such as heart and lung diseases and some cancers (Somerford, this report). In addition, the Western Australian Department of Health estimates that tobacco control measures introduced since the mid-1980s over a twenty-year period have helped avert 876 deaths, 22,527 hospitalisations and $116 million in hospital costs (Somerford, this report). The many smokers who quit over that span have benefited through improvements in health, savings and personal pride in their success as well.

What we've achieved

- *strict controls over the use and marketing of tobacco*
- *investment in public education programs*
- *better help for smokers to quit*
- *recognition of tobacco as a serious public health problem*
- *tangible health, social and economic benefits for the individual and community*
- *changes in social norms on tobacco.*

In reflecting on the achievements in tobacco control in Western Australia, and the challenges ahead, it is important we acknowledge the very large and impressive contribution of researchers and public health advocates. Together they have amassed a vast body of evidence on the harms and costs of smoking, good practice in tobacco control and public opinion on topical issues (Jamrozik, this report). Their research and persistent advocacy on smoking and health issues have driven changes to laws and policies on the sale and use of tobacco, and especially justified the increased investment in public health programs on tobacco (Jamrozik, this report). Furthermore, their work has ensured that tobacco control measures and programs delivered in this State are evidence-based, innovative and responsive to emerging issues. Most notably it has helped build a level of political and community support for tobacco control not enjoyed by many other countries.

The challenges ahead

Despite significant gains in tobacco control, there is still need for ongoing action. In Western Australia almost 300,000 adults smoke daily or occasionally,[11] and each year almost 9,000 children start.[15] There has been little change in the high rates of smoking among Aboriginal and Torres Strait Islander peoples, people with mental illnesses and pregnant women (Somerford, this report). Major increases in healthcare costs are predicted in the coming years with tobacco-caused diseases a major contributor;[16] and many smokers hold misconceptions about smoking and quitting.[17,18] The tobacco industry is also changing tack in an attempt to enhance its public profile, promoting itself as socially responsible and ideally placed to develop reduced-harm products.[19] Moreover, there are concerns among public health advocates over the long-term commitment of governments who may be lulled into thinking past actions will serve well into the future. The demise of high-impact media campaigning illustrating the dangers of HIV/AIDS and subsequent rise in new cases of HIV/AIDS,[20] as well as US research showing that where there have been significant reductions in funding for tobacco control programs, positive trends have been reversed, serve as timely warnings.[21] Most worrisome of all, the advocates of tobacco control – while highly effective – are few in number.

The challenges ahead

- *still lots of smokers*
- *help to quit is limited*
- *the industry thrives*
- *government support waxes and wanes*
- *the activists are few*
- *risk of complacency.*

The end game for tobacco

Over the last decade public health advocates have articulated a comprehensive plan of action for achieving the mooted end to smoking. The plan comprises ten core components:

1. Tighter regulation of the product and industry marketing practices

Even with strong controls on the marketing of tobacco products, the tobacco companies continue to apply significant ingenuity to the promotion of tobacco in this State and nationally. As advertising has been banned in one medium, the companies have shifted expenditure to other media not well captured by current legislation.

Globally, the tobacco industry spends billions per annum marketing tobacco. Every medium imaginable is used including buzz or viral marketing techniques, product placement in movies and the Internet.[3] Tobacco industry documents also reveal the companies have painstakingly researched the tastes, habits and aspirations of existing and new target markets – including young people, women and other vulnerable groups – and used this research to develop products and marketing campaigns aimed at them.[3]

Studies show that bans on advertising and promotion are effective in reducing consumption of tobacco and the appeal of tobacco for children, but only if they are comprehensive, covering all media and all uses of brand names and logos.[22] It is vital, therefore, that legislation in Western Australia (and nationally) keeps pace with changes in how the tobacco companies market their products, if it is to succeed in eliminating influences on people to take up or continue smoking.

There is a pressing need for state and national controls over tobacco products too. Paradoxically, tobacco products, though highly toxic, remain unregulated with nothing preventing tobacco manufacturers from adding almost any ingredient they choose.[23] Hundreds of ingredients are used in the manufacture of tobacco products, including sweeteners and flavourings.[24] There is growing concern among public health advocates over the effects of additives on the palatability and addictiveness of tobacco products, as well as additional hazards they may pose, such as increased propensity to cause fires.[24-27] Regulation of the manufacture of tobacco products would end the use of additives that make tobacco smoke milder and easier to inhale, improve taste, and prolong burning and the shelf life of tobacco products ultimately making them less acceptable to consumers.

The tobacco industry continues to obfuscate over the provision of meaningful information for consumers on the constituents of tobacco products, their emissions and biological effects. While in Australia there is a voluntary agreement for disclosure of ingredients between the Commonwealth Government and the three Australian tobacco manufacturers,[28] research suggests that this is likely to be a highly ineffective means of communicating with smokers.[29]

2. Expansion of smoke-free spaces

In Western Australia and elsewhere, the evidence on the adverse health effects of second-hand smoke has resulted in legislation restricting smoking in enclosed public places and most workplaces.[12] The progressive expansion of restrictions on where people may smoke has had added benefits, increasing public awareness of the health harms of second-hand smoke, reducing the exposure of non-smokers to tobacco smoke and encouraging smokers to reduce their consumption of tobacco or quit.[12]

Today most people don't smoke, are well aware of the harms caused by tobacco smoke and are accustomed to smoke-free environments. Not surprisingly, the community is demanding more public spaces be smoke-free recognising that even smoking outdoors can cause annoyance and irritation and sometimes even health problems when people are close together.

Many smokers, however, are still choosing to light up in private spaces such as their home and car, often unaware of the health risks they are imposing on those around them. As a consequence, the attention of public health advocates and policy-makers has turned to children, the mentally ill and other sub-populations within the community who continue to be exposed to second-hand smoke in the home, the car or institutions in which they reside, and are less able to argue their right to breathe clean air.[12]

Local governments and environmental groups have also joined in the push for smoke-free outdoor public spaces arguing cigarette butts left on beaches and in parklands create a danger to small children who may ingest the butts, as may wildlife which frequents the area, and that less smoking outdoors may help reduce one of the most common types of litter found in Australia, as well as exposure to second-hand smoke.[30,31]

3. Intensification of media campaigning

There is a strong body of evidence that clearly demonstrates that long-term, high-intensity counter-advertising campaigns can reduce use of tobacco, save lives and avert health care costs when part of a multi-component program.[12,21,32-34] US and Australian research show that the more money spent, the greater the reduction in smoking – and the longer the investment, the greater and faster the impact.[12,21] The return on investment has also been shown to diminish when funding and efforts have not been maintained.[21]

Media advertising has been an integral component of West Australian tobacco control programs over the last two decades. There is a real need, however, to ensure that these campaigns are sustained and that funding is adequate.[35] Media campaigning on tobacco is essential for addressing public misconceptions about the hazards of smoking, and encouraging personal actions and public policies that prevent harm from tobacco.[18,36]

4. Better support to quit

Five out of six West Australians don't smoke (Somerford, this report), and of those who do smoke, most wish they had never started and want to quit.[37] The majority of smokers will try many times before they quit.[12] With no assistance, however, fewer than 5% will succeed in any single attempt.[12]

While services to smokers in Western Australia have improved markedly over the last two decades, there is considerable scope for improvement. Currently, there is no 'whole of health' approach to the treatment of nicotine dependency with individual health services initiating their own policies and programs on an *ad hoc* basis. National guidelines for general practitioners on smoking cessation were released by the Commonwealth Department of Health and Ageing in 2004, but have not been widely promoted or supported by a comprehensive training program and guidelines mooted for other health professional groups have not followed. Pharmacotherapies remain expensive for many would-be quitters, many of whom have a poor understanding of, or are reluctant to use, such aids.[12] What is more, access to affordable, evidence-based support to quit is not universal.

Continuous improvements in the quality of and access to services and treatments for smokers will aid enormously in advancing health and reducing social costs of smoking in this State by helping thousands more smokers overcome their nicotine dependency.[12,13]

5. Plain packaging of tobacco products

As more conventional forms of tobacco marketing have been restricted in Australia, the tobacco package has become an increasingly important vehicle for promoting the product to consumers, particularly at point of sale.[38] Over the years, the tobacco companies have carefully researched consumer responses to changes in the design of tobacco packaging, especially effects on their impression of tobacco brands and the relative safety of different types of tobacco products (e.g. low tar cigarettes).[38] Plain or generic packaging of tobacco

products has been put forward by public health advocates in Australia, Canada and New Zealand.[38,39] They argue it would significantly decrease the appeal of tobacco products, especially to young people, enhance the impact of health warnings and ensure accuracy of the information provided about the product.[38,39]

Plain packaging is devoid of brand logos, colours and information other than the brand name and government-mandated information.[39] It is a prospect the tobacco industry fears and makes clear it will vigorously oppose:

> *Once POS is banned and products are under the counter, it is only a short step to generic packaging. The antis will gain confidence and seek to eliminate trademarks, the next logical step after lost pack visibility.*
>
> *This issue is on the back burner as far as the antis are concerned until success is achieved at POS.*
>
> *The industry will vigorously fight to retain trademarks but this issue is firmly on the antis' agenda. Given that it is already linked with underage smoking, generic packaging may be achievable in the long term.*[40]

Plain packaging is an integral part of the end game for tobacco. Without it, the industry will continue to get round State and national bans on tobacco advertising and promotion.

6. Storage of tobacco products out of sight

Pack displays have also become a significant form of promotion of tobacco in the retail environment.[12] Tobacco displays in shops normalise smoking and can predispose children to smoke.[41,42] While changes to legislation in Western Australia prohibiting point-of-sale advertising of tobacco have been welcomed by public health advocates, it still allows the display of tobacco products though limits it to one square metre for most retail outlets (Swanson and Durston, this report). Legislation requiring storage of tobacco products out of sight would serve to disrupt use of pack displays as an indirect marketing tool and remove a highly conspicuous inducement to smokers and recent quitters to smoke. Furthermore, it is a move the public would support.[11] The tobacco industry and retail groups expect such a ban will mean a reduction in consumption of tobacco: a desirable public health goal.[41]

7. Fewer retail outlets

In Western Australia, tobacco products are widely available through a broad range of retail outlets, including delicatessens, newsagencies, petrol stations and supermarket chains. Disturbingly, children are able to purchase tobacco with little difficulty despite it being illegal to sell, or supply, tobacco to a minor.[15] The ubiquity and easy access that children have to tobacco is incongruent with the hazardous and addictive nature of tobacco. Steady reductions in the number and types of retail outlets licensed to sell tobacco have potential to reduce the omnipresence of tobacco products in the community and access by children. What is more it sends very clear messages to retailers and consumers about the dangers and social acceptability of smoking.[12]

8. Industry held to account[3]

For decades tobacco companies have misled consumers about the dangers of smoking. They have denied that nicotine is addictive and argued against scientific evidence on diseases caused by smoking. They have commissioned their own research to counter mounting proof that tobacco is addictive and deadly. They have sought to infiltrate and undermine the work of reputable scientific bodies such as the World Health Organization and the International Agency for Research on Cancer. In the marketing of their products, they have deliberately associated smoking with popular sporting and cultural icons, and images of power, success and sex appeal. They have opposed any reasonable legislation that would ensure consumers are well

informed about the dangers of smoking and protected against influences to smoke. Most damning of all, engineering of tobacco products has made it more difficult for smokers to quit.

Nowadays, the tobacco companies concede that smoking is addictive and may harm health though argue against a prohibition on smoking. Instead, they contend they should be allowed to continue to provide a service to those adults who choose to smoke or are unable to stop, and that the scientific community and governments should join with them in developing and promoting products that may be less harmful:

> *According to BAT, the safe cigarette is a myth and any company that claims to have produced one is seriously and dangerously confused.*
>
> *'There's no such thing as a safe cigarette,' said Dr Chris Proctor, head of science and research at BAT. 'I'm pretty sure we will see products coming along in the next year, some of them from us, that are trying to make these first small steps towards less risk but we're still talking about something that is going to be very dangerous.*
>
> *'As a tobacco company, we need to be seen to be putting in as much effort as we can to try to reduce the risks but these first-generation cigarettes are the smallest of steps along the way.*
>
> *'There's a possibility we can reduce the risks a very little bit but even if we do produce a cigarette that contains fewer toxins and tastes the same, there is still no guarantee we will know whether it has any potential for reducing the harm suffered by the smoker.'* [43]

Each of the major international companies is now engaged in a desperate bid to rebuild its public reputation, the object being to thwart regulatory barriers to selling their products and exploiting new markets.

> *The Corporate Affairs Department seeks to sustain a reasonable business environment within which the company can maximise its opportunities to successfully market its products and serve its customers ... We will pursue means of positioning the Company to be able to more effectively forestall continued implementation of hostile regulatory requirements ... We will promote and maintain an identity for Philip Morris as a company responsive to community concerns, and responsible in exercising its right to produce and market tobacco products.*[44]

Many public health advocates are firmly of the view that tobacco companies have not materially altered the way they do business and that they should not be trusted to put public health interests ahead of profits – no matter what they say.[36] It is a responsibility of governments to ensure the industry is not permitted to mislead the public further and that the industry is held accountable for its actions under state and national laws. As Swanson and Durston document in this report, under Western Australian legislation, it is an offence to provide false or misleading information about the health effects of tobacco or legislation on tobacco. Based on Tasmanian legislation, this provision aims, in the words of one tobacco company executive, to 'further [inhibit] corporate communications'.[44] How effective this, and other legislation, is in holding tobacco companies to account will depend on the will and ability of regulatory authorities to take action when required.

9. A stop on donations to political parties

In Australia, the tobacco, alcohol and food industries are among a number of major contributors to political parties.[45] Through generous campaign contributions the tobacco companies have maintained access and opportunity to influence politicians who are supposed to be protecting the public good. While some political parties reject donations from tobacco companies, some do not. It should be unacceptable for any political party to accept donations, either directly or indirectly, from tobacco companies. Over 15,000 Australians die every year because they have smoked.[14] Political parties have a responsibility to all Australians to ensure their public health advocacy is not influenced, or seen to be influenced, by tobacco money.

10. Regular increases in taxes on tobacco

Increases in taxes on tobacco products are one of the most effective measures for reducing consumption of tobacco.[22] The high cost of tobacco products can induce smokers to quit or reduce consumption, deter ex-smokers from relapsing, and discourage young people from taking up the habit.[12,22] Australia has a relatively high tax on tobacco by international standards; nevertheless, there is still ample room to increase prices through taxation as a means of further reducing its affordability.[46]

The end game for tobacco

- *regulation of the product*
- *expansion of smoke-free spaces*
- *intensification of campaigning*
- *better support to quit*
- *plain packaging of tobacco*
- *storage of tobacco out of sight*
- *fewer retail outlets*
- *industry held to account*
- *a stop on donations to political parties*
- *increases in taxes on tobacco.*

Making it happen

The successes of the last twenty years have emboldened public health advocates to think beyond the passage of the next policy or regulatory initiative. An end to smoking is in sight. In fact, one tobacco company executive forecast such a scenario almost a decade ago:

If the antis succeed in their present campaigns and maintain their present momentum, the environment in 2020 could look like the scenario on this slide.

There will be widespread smoking bans in public places and in all areas where children are present.

Plain packaging will have been introduced.

There will be strict regulation of nicotine levels and other ingredients and there will be comprehensive ingredients labelling.

Because nicotine in tobacco products will have been scheduled as a poison, the number of retail outlets licensed to sell tobacco products will be greatly reduced – as only pharmacists will be permitted to sell the product. Tobacco users will have to be licensed. Growers will have to be licensed and there will be regulation regarding the maximum nicotine content of their crop.

There will have been a number of legal payments by the tobacco industry in personal injury suits and class actions, whether through settlements or otherwise. Proprietors of hospitality venues will have compensated patrons for illness deemed to be a result of … exposure to ETS. And negotiated settlements will have been reached by tobacco companies in actions to recover health care costs.[40]

Ending smoking depends on what we do now, just as the long-term sustainability of the tobacco companies depends on what they do now. And they are well prepared.

On the regulatory front, we're very active – making submissions, liaising with governments, assisting the business to comply with legislation in the market place and advocating constructive and responsible practices.

On the litigation front, in a worldwide context we're vigorously defending the company and in Australia, we're working with local counsel to prepare appropriate strategies in readiness for potential lawsuits.

On the public relations front, we are committed to enhancing our corporate positioning strategies through Project Participation and our contributions program.

But we continue to encounter a sceptical and sometimes hostile media and, as we are all well aware, we lack public credibility.

So we need to address our public relations as a matter of priority.[40]

Making smoking history

- *remain vigilant against the industry*
- *persist with efforts*
- *be prepared to seize the moment*
- *bolster political will*
- *keep tobacco issues alive in the minds of individuals and the community.*

Tobacco is still a major cause of death and illness in Western Australia. Public health advocates have outlined a clear plan of action for curbing tobacco use and bringing about an end to smoking. Making it happen demands vigilance over the tobacco industry and its allies, intensification of tobacco control efforts, quick responses to unfolding events and skill in keeping tobacco issues alive in the minds of individuals and the community. We can make it happen. Who are we? We are you, me, everybody.

Here's hoping Western Australia becomes the darkest of markets where the tobacco angels no longer rudely tread.

What is meant by an end to smoking?

Most public health advocates envisage there will come a time when use of tobacco will be so low and the community so intolerant of smoking, the retail sale of tobacco will no longer be seen as a viable commercial activity. Governments may then be receptive to calls by advocates for a ban on the retail sale of tobacco. There is no consensus at this time on how the dependency on tobacco of the few remaining smokers would be managed. Some advocates have suggested restricting the sale of tobacco to specialist pharmacists; others propose that smokers be referred to nicotine dependency clinics. The role of these clinics would be to wean smokers off tobacco and on to pharmaceutical therapies as an aid to quitting use of nicotine products altogether. Some have also suggested various regulatory regimes that would see tighter control over the engineering of tobacco products so as to make them less appealing to consumers in the medium to longer term. An end to smoking does not mean the prohibition of smoking. People may still smoke, but tobacco will be harder to get. It is understood too that the idea of an end to smoking has currency in only a few developed countries. In many parts of the world, the tobacco epidemic is spreading.

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Appendix A: Tobacco control timeline for Western Australia

1911	Smoking prohibited in theatres in Western Australia
1916	Sale of tobacco products to persons under the age of 18 years prohibited
1950	Publication of research by Doll and Bradford Hill in the UK and Wynder in the US that identified smoking as a cause of lung cancer
1962	The Royal College of Physicians of London publishes its report on Smoking and Health
1964	The US Surgeon General releases the first in a series of landmark reports on the hazards of smoking
1971	Australian Council on Smoking and Health (ACOSH) formed a branch in Western Australia
1972	The phase-out of cigarette advertising on radio and television began in Australia
1973	The first health warning on cigarette packets was introduced in Australia: 'Smoking is a health hazard'
1974	Metropolitan trains, buses and ferries in Perth become smoke-free
1975	The West Australian Government passed legislation requiring persons in the business of selling tobacco to be licensed, enabling the government to collect revenue from the activity
1976	Advertising of tobacco was banned on radio and television in Australia
1978	Enclosed areas of government hospitals became smoke-free ACOSH Western Australia assumes responsibility for advocacy on smoking and health issues for the nation, but with a focus on Western Australia
1982	Smoking prohibited in any transport vehicle or Metropolitan Transport Trust (MTT) premises The National Heart Foundation conducted Western Australia's first quit smoking campaign
1983	The Western Australian Government substantially increases taxes on tobacco allocating $2 million per year to community education on smoking
1984	First Quit campaign conducted in Western Australia
1985	Persons preparing or displaying food for sale now prohibited from smoking tobacco products while working Libraries in Western Australia declared smoke-free
1986	Phasing out of smoking in Federal workplaces began
1987	Introduction of new health warnings on cigarette packages throughout Australia The Federal Government banned smoking on domestic airlines
1988	Amendment to the *Australian Broadcasting and Television Act*, extends bans on direct advertising to include all tobacco products The Australian Public Service was converted to a smoke-free workplace
1989	The Western Australian Public Service became a smoke-free workplace

1990	Advertising of cigarettes in magazines and newspapers ceased due to Federal Government legislation under the *Smoking and Tobacco Products Advertisements (Prohibition) Act 1989* Smoking on international flights within Australian airspace was banned from 1 September Cinemas, theatres and concert halls went smoke-free, although smoking was still permitted in the foyers and bars *Tobacco Control Act 1990* was passed in Western Australia on 1 February The Western Australian Health Promotion Foundation (Healthway) formed
1991	Enclosed areas of all State government schools in Western Australia were declared smoke-free TAB agencies in Western Australia introduced smoke-free policies All sleeping cars on the Indian Pacific and Trans Australian line went smoke-free with smoking areas set aside
1992	International airline terminals went smoke-free by July Taxis went smoke-free in January in Perth prohibiting both drivers and passengers from smoking
1993	Cigarette promotion was phased out progressively under the *Tobacco Act 1987* The Federal Government announced an increase in excise duty, to be phased in over the next two years, which would result in an 18% increase in cigarette prices The transdermal nicotine patch became available for sale in Australia
1994	Under the *Tobacco Control Act 1990*, billboard advertising of tobacco products is now banned in Western Australia
1995	New black on white warnings with a description on the back of the pack appeared on tobacco packs Remaining tobacco sponsorships were removed, except for events of international significance
1996	The Smarter than Smoking youth smoking prevention campaign commenced States and territories agree to use the 131 848 telephone number and the national Quitline began Western Australian Government announced that it would establish a Task Force on Passive Smoking in Public Places Smoking banned on all Australian international flights from July, making Qantas and Ansett smoke-free on all flights
1997	The National Tobacco Campaign launched a series of television commercials, Every Cigarette Is Doing You Damage – Lung, Tumour and Artery Staff, students and visitors prohibited from smoking on Education Department premises in Western Australia

1999	The Commonwealth implements tax by stick rather than by weight, increasing the price of large packets in particular In Western Australia, smoking is prohibited in public places where food is served, although exemptions are permitted for specified areas of the hospitality industry
2000	Make Smoking History Campaign (formerly Target 15) at The Cancer Council Western Australia established
2001	The Federal Government announced the phase-out of tobacco sponsorship of internationally significant events by 2006
2004	Australia ratified the global Framework Convention on Tobacco Control The Labor Party announced that it would no longer accept donations from tobacco companies
2005	The Australian Competition and Consumer Commission reaches agreement with the tobacco industry to stop use of misleading product descriptors such as 'light' and 'mild' The Framework Convention on Tobacco Control enters into force
2006	On 31 July pubs and nightclubs go smoke-free in Western Australia Federal government requires graphic health warnings on all cigarette packets and cartons *Tobacco Products Control Act 2006* assented to on 12 April in Western Australia
2007	Licensing for tobacco retailers in Western Australia comes into force with strict limits on display of tobacco products at point of sale

Appendix B: A chronology of Western Australian anti-smoking television campaigns, 1984–2007

Year	Campaign	Agency
1984	Fresh breath of life	Health Department WA
	Pretty face	Health Department WA
	Sponge	Health Department WA
	Vacuum cleaner	Health Department WA
	Heart	Health Department WA
	Barry Crocker – Quit Program	Health Department WA
	Barry Crocker – Stick with it	Health Department WA
1985	Life in the big smoke – Hamburger joint	Health Department WA
	Life in the big smoke – Skateboarding	Health Department WA
	Life in the big smoke – Surfing	Health Department WA
	Life in the big smoke – Drive-ins	Health Department WA
	Sponge	Health Department WA
	Vacuum cleaner	Health Department WA
	Sam – Smoking gave me throat cancer	Health Department WA
	ECG – Smoking, it really is heartbreaking	Health Department WA
	Fresh breath of life	Health Department WA
	I've had enough	Health Department WA
	3 Barrys	Health Department WA
	Saying no	Health Department WA
	Cartoon	Health Department WA
	Rob de Castella – Smoking no way	Health Department WA
	Pat Cash – Smoking no way	Health Department WA
	Tom Carroll – Smoking no way	Health Department WA
1986	Bill – Smoking gave me emphysema	Health Department WA
	Sam – Smoking gave me throat cancer	Health Department WA
	Yul Brynner	Health Department WA
	Sponge	Health Department WA
1987	Cathy	Health Department WA
	Sponge	Health Department WA
	Pat Cash – Smoking no way	Health Department WA
	Health warnings – I don't believe smoking kills you	Health Department WA
1988	Fiona	Health Department WA
	Stairs	Health Department WA

Year	Campaign	Agency
1989	Cat's in the cradle	Health Department WA
	ECG – Smoking, it really is heart breaking	Health Department WA
	Fiona	Health Department WA
	Chemist	Health Department WA
1990	Sponge	Health Department WA
	Fiona	Health Department WA
	Bring your body back to life	Health Department WA
	Poisons	Health Department WA
	Shadow (passive smoking)	Health Department WA
1991	Let go 1 – Quit because you can	Health Department WA
	Let go 2 – Quit because you can	Health Department WA
	Bring your body back to life	Health Department WA
	Poisons	Health Department WA
	Tar baby	Health Department WA
1992	Let go – Quit because you can	Health Department WA
	Remember	Health Department WA
	Dr Roly Bott (AMA)	Health Department WA
	Bring your body back to life	Health Department WA
	Craig Turley – Kick the habit	Health Department WA
1993	Fiona Stanley – It could save your life	Health Department WA
	Sponge	Health Department WA
	Cat's in the cradle	Health Department WA
	Honda Civic – Quit'n'Win Competition	Health Department WA
	Banner	Health Department WA
	Number	Health Department WA
	Hands – Tied	Health Department WA
	Wouldn't be caught dead	Health Department WA
	Craig Turley – Kick the habit	Health Department WA
	Rachel Berger – Smoking sucks us in	Health Department WA
	Rachel Berger – Cost of smoking	Health Department WA
1994	Cigarette models – Marlboro Man	Health Department WA
	Cigarette models – Winston Man	Health Department WA
	Cigarette models – Lucky Strike	Health Department WA
	Cigarette models – Lucky Strike II	Health Department WA
	Boy on bike	Health Department WA
	Delivery room	Health Department WA
	Perfume	Health Department WA
	Only women bleed	Health Department WA

Year	Campaign	Agency
1995	Coroner – Health warnings	Health Department WA
	Lifelines – Male	Health Department WA
	Lifelines – Female	Health Department WA
	Lifeline – Male (Quit Day)	Health Department WA
	Lifeline – Female (Quit Day)	Health Department WA
	John Cleese – Tempted (Before Quit Day)	Health Department WA
	John Cleese – Tempted (Quit Day)	Health Department WA
	John Cleese – Tempted (Post Quit Day)	Health Department WA
	Withdrawal symptoms	Health Department WA
	Quitline	Health Department WA
	Doctor's surgery (passive smoking and children)	Health Department WA
1996	Testimonial – Dale	Health Department WA
	Testimonial – Gary	Health Department WA
	Testimonial – Jackie	Health Department WA
	Testimonial – Stan	Health Department WA
	Testimonial – Shirley	Health Department WA
	Dale II	Health Department WA
	Gary II	Health Department WA
	Jackie II	Health Department WA
	Stan II	Health Department WA
	Stressing Out	Heart Foundation WA
	Stressing Out – Male	Heart Foundation WA
	Stressing Out – Female	Heart Foundation WA
	Quitline	Health Department WA
	Quitline II	Health Department WA
1997	Hannibal Fagster	Heart Foundation WA
	Lung	Cwth Dept Health
	Artery	Cwth Dept Health
	Tumour	Cwth Dept Health

Year	Campaign	Agency
1998	Stressing out	Heart Foundation WA
	Hannibal Fagster	Heart Foundation WA
	Brain (stroke)	Cwth Dept Health
	Lung	Cwth Dept Health
	Artery	Cwth Dept Health
	Tumour	Cwth Dept Health
	Call for help	Cwth Dept Health
	Countdown to Quit Day - 7 days to go	Health Department WA
	Countdown to Quit Day - 6 days to go	Health Department WA
	Countdown to Quit Day - 5 days to go	Health Department WA
	Countdown to Quit Day - 4 days to go	Health Department WA
	Countdown to Quit Day - 3 days to go	Health Department WA
	Countdown to Quit Day - 2 days to go	Health Department WA
	Countdown to Quit Day - 1 day to go	Health Department WA
	Smokefree WA	Health Department WA
1999	Stressing out	Heart Foundation WA
	Stressing out - male	Heart Foundation WA
	Stressing out - female	Heart Foundation WA
	I can	Health Department WA
	I can - Billboard	Health Department WA
	Piggy bank - Just gone up	Health Department WA
	Piggy bank - Generic	Health Department WA
	Fashion	Heart Foundation WA
	Soap opera	Heart Foundation WA
2000	Fashion	Heart Foundation WA
	Soap opera	Heart Foundation WA
	I can II	Health Department WA
	I can II - Billboard	Health Department WA
	Stressing out	Heart Foundation WA
	Nice people but - Compile	Cancer Council WA
	Nice people but - Consultant, surgeon	Cancer Council WA
	Nice people but - Chemo nurse, wig library lady	Cancer Council WA
	Nice people but - Ward nurse, chaplain	Cancer Council WA

Year	Campaign	Agency
2001	Didn't listen	Cancer Council WA
	Didn't listen II	Cancer Council WA
	Nice people but - Compile	Cancer Council WA
	Nice people but – Consultant, surgeon	Cancer Council WA
	Nice people but – Chemo nurse, wig library lady	Cancer Council WA
	Nice people but – Ward nurse, chaplain	Cancer Council WA
	Movie preview	Heart Foundation WA
	Tissue (passive smoking)	Health Department WA
	Tissue – Billboard	Health Department WA
	Sales to minors	Health Department WA
	I can II (revised)	Health Department WA
	Piggy bank (revised)	Health Department WA
	Stressing out (revised)	Heart Foundation WA
	Stressing out (revised) – male	Heart Foundation WA
	Stressing out (revised) – female	Heart Foundation WA
2002	Should have been there	Cancer Council WA
	Should have been there – Billboard	Cancer Council WA
	Bus stop	Heart Foundation WA
	Bus stop – Billboard	Heart Foundation WA
	Testimonial – Dale	Health Department WA
	Dale II	Health Department WA
	Dale III	Health Department WA
	Testimonial – Gary	Health Department WA
	Gary II	Health Department WA
	Testimonial – Shirley	Health Department WA
	Shirley II	Health Department WA
	Marshall Menthol	Health Department WA
	Marshall Menthol – Quitline	Health Department WA
	Marshall Menthol – Billboard	Health Department WA
	Recall – John Clarke	Cancer Council WA
	Recall – John Clarke II	Cancer Council WA
	Recall – John Clarke III	Cancer Council WA
	Get a grip	Health Department WA
	Get a grip – Billboard	Health Department WA

Year	Campaign	Agency
2003	Jenny's story – If I'd quit at 25	Cancer Council WA
	Jenny's story – No warning	Cancer Council WA
	Jenny's story – Staying stopped	Cancer Council WA
	Jenny's story – Billboard	Cancer Council WA
	Bus stop	Heart Foundation WA
	Bus stop – Billboard	Heart Foundation WA
	Sponge	Health Department WA
	Life in the Big Smoke	Health Department WA
	Sam Maher – Smoking gave me throat cancer	Health Department WA
	Yul Brynner	Health Department WA
	Fiona	Health Department WA
	Coroner	Health Department WA
	Lifelines	Health Department WA
	Testimonial – Gary	Health Department WA
	I can II	Health Department WA
	Tissue	Health Department WA
	Bum-a-lung	Health Department WA
	Get a grip	Health Department WA
	Quitline Jack	Health Department WA
	Quitline Jack II	Health Department WA
2004	Bus stop	Heart Foundation WA
	Bus stop – Billboard	Heart Foundation WA
	Don't blow the years ahead	Heart Foundation WA
	Bum-a-lung II	Health Department WA
	John's story (Talkback radio)	Health Department WA
	Bum-a-lung	Health Department WA
2005	Bubblewrap	Cancer Council WA
	Stressing out	Heart Foundation WA
	Bum-a-lung	Health Department WA
	Didn't listen	Cancer Council WA
	Didn't listen II	Cancer Council WA
	Recall – John Clarke II	Cancer Council WA
	Recall – John Clarke III	Cancer Council WA
	Eyes	Heart Foundation WA

Year	Campaign	Agency
2006	Zita's story – Tears apart a family	Cancer Council WA
	Zita's story – I'm not afraid to die	Cancer Council WA
	Zita's story – If I could stop one person	Cancer Council WA
	Zita's story – Quitline	Cancer Council WA
	Zita's story – Billboard	Cancer Council WA
	Eyes	Heart Foundation WA
	Eyes II	Heart Foundation WA
	Echo	Cancer Council WA
	Echo II	Cancer Council WA
	Echo III	Cancer Council WA
2007	Eyes	Heart Foundation WA
	Eyes II	Heart Foundation WA
	Make your home and car smoke-free I	Cancer Council WA
	Make your home and car smoke-free II	Cancer Council WA
	Make your home and car smoke-free – Billboard	Cancer Council WA

In some years, particular campaigns ran in multiple phases.

Every effort has been made to ensure the accuracy of this chronology. However, it may contain some errors due to gaps and inconsistencies in past records.

Inquiries about campaigns should be directed to the agency that ran the campaign, who will refer inquiries on if not the owner of copyright.