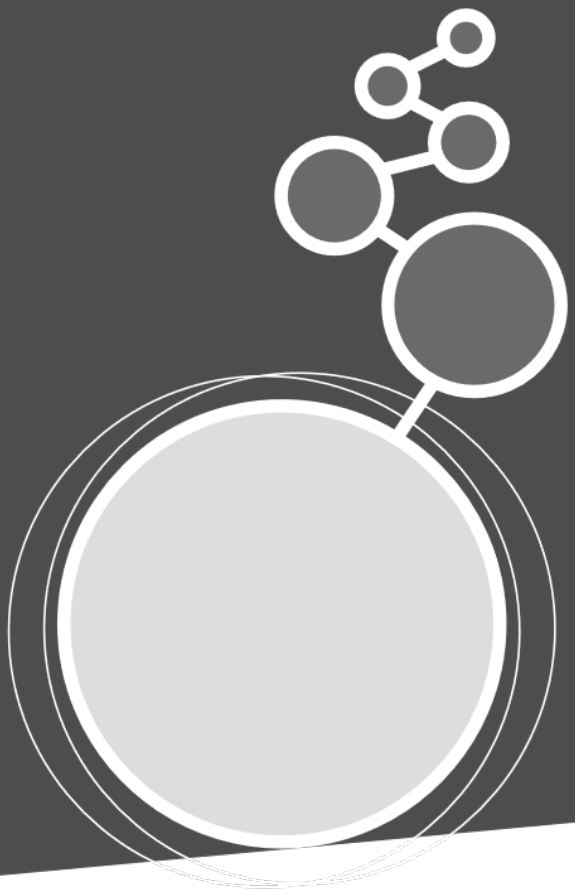
CERI
Collaboration for Enhanced Research Impact

Submission to the National Tobacco Strategy

2022-2030

24 March 2022



The Collaboration for Enhanced Research Impact (CERI) is a joint initiative between The Australian Prevention Partnership Centre and a diverse group of related NHMRC Centres of Research Excellence. We are working together to find alignment in the policy and practice implications of our work and to develop shared communications and early career capacity support across our participating centres.
Please visit our website for a list of participating organisations.

About the author

CERI is a joint initiative between The Australian Prevention Partnership Centre and a diverse group of related NHMRC Centres of Research Excellence. We work together to find alignment in the policy and practice implications of our work and to develop shared advocacy for prevention.

About the publisher

The Australian Prevention Partnership Centre is funded by the NHMRC, Australian Government Department of Health, ACT Health, Cancer Council Australia, NSW Ministry of Health, Wellbeing SA, Tasmanian Department of Health, and VicHealth. The Prevention Centre is administered by the Sax Institute.

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Published March 2022

About the Collaboration for Enhanced Research Impact

The Collaboration for Enhanced Research Impact (CERI) is a joint initiative between The Australian Prevention Partnership Centre and eight NHMRC Centres of Research Excellence. CERI aims to enhance the profile and impact of chronic disease prevention research in Australia.

Established in June 2020, this novel initiative brings together some of Australia's leading prevention researchers to develop shared narratives, work together to translate new knowledge, and support early- to mid-career researchers across all member institutions.

About this submission

The Australian Government Department of Health is refining the draft National Tobacco Strategy (NTS) 2022-2030.

The draft NTS 2022-2030 sets out a national policy framework for all governments to work together and in collaboration with non-government organisations to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and the inequalities it causes.

All Australian governments have overseen the development of the NTS 2022-2030, in consultation with a range of public health and tobacco control experts. The purpose of this consultation was to seek broader stakeholder and community views and feedback on the draft NTS 2022-2030.

This submission was prepared by members of the CERI Coordinating Group on behalf of the CERI member organisations.

Goals and smoking prevalence targets for the draft NTS 2022-2030

The goal of the draft National Tobacco Strategy (NTS) is "…to improve the health of all Australians by reducing the prevalence of tobacco use and its associated health, social, environmental and economic costs, and inequalities it causes." The aim is to achieve national daily prevalence of less than 10% by 2025 and 5% or less by 2030.

We note that even small changes in the prevalence of tobacco use are likely to lead to a significant reduction in the health burden for individuals and the healthcare system, as well as a reduction in economic and societal costs for communities, businesses and governments.[1] We also note that tobacco control has environmental co-benefits, for example, due to reduced air pollution, pesticide use and littering.[2]

The goals and smoking prevalence targets set in the draft Strategy are likely to incur significant economic benefits for Australia. For example, a study concluded that achieving a target of 10% prevalence by 2025 in Victoria would result in a decline in tangible costs of 14.5% ($535 million), and of 15% ($863.4 million) in intangible costs associated with loss of life. Reducing smoking prevalence to 5% in Victoria would lead to a reduction in associated tangible costs of 55.6%, or $2 billion.[3]

The 2030 target set in the draft Strategy could be strengthened by stating that the aim is to achieve as close as possible to 0% smoking prevalence, and that 5% is the upper level of acceptable prevalence by 2030.

We note that data from the ABS National Health Survey show differences in smoking prevalence differs between states and territories and among demographic sub-groups. It is important that the prevalence targets are achieved or bettered in each jurisdiction, and not just according to the national average.

We would like to see greater emphasis on increasing equity between population groups regarding exposure to smoking and development of tobacco-related disease. An overall 5% smoking prevalence goal could still see very high smoking prevalence continue among priority population groups and exacerbate the inequity and relative disadvantage that many of these groups experience.

We suggest including an explicit equity goal in the overall NTS goal. In this regard, we believe a substantially increased investment is urgently needed to develop and implement policies and programs that can accelerate the rate of decline in smoking among populations with high smoking prevalence. This will require both targeted interventions, such as culturally safe smoking cessation programs, but also broader population level measures, such as a mandatory very low nicotine standard for cigarettes, and reduction in the availability of tobacco products.

We recommend that the background and proposed policies concerning Aboriginal and Torres Strait Islander peoples include reference to the origin of the high smoking prevalence among these populations as a consequence of colonisation and that any smoking cessation strategies developed are Aboriginal-led through self-determination.[4]

Objectives for the draft NTS 2022-2030

We support the comprehensive objectives that seek to address tobacco use at both the personal and societal levels, and that recognise the social and commercial determinants of tobacco use.

We are encouraged to note that Objective 2 (*Prevent and reduce nicotine addiction*) and 10 (*Ensure all of the above contribute to the continued denormalisation of the tobacco industry and tobacco use*) go beyond the objectives of the 2012-2018 Strategy.

Preventing and reducing nicotine addiction is appropriate due to the lifelong costs that can be associated with long-term nicotine addiction, particularly when it is in the form of tobacco smoking.

Similarly, we welcome the inclusion of Objective 9 (*Protect tobacco control policy from all commercial and other vested interests*) as an objective rather than just a guiding principle. This reflects the Department's very strong stance on the importance of preventing industry interference. We believe this is an area that could be strengthened in the NTS.

Guiding principles for the draft NTS 2022-2030

The focus on partnership in this draft Strategy is commendable. We applaud that the draft Strategy signals a strong desire to complement existing relationships with new relationships in the healthcare sector.

To achieve the goals and aims of the NTS, it will be necessary for the Australian Government to forge meaningful relationships with state and territory governments. We suggest that The Australian Prevention Partnership Centre's unique coordinating and convening function could play an important role in achieving this goal.

To effectively change health behaviours and address complex public health issues such as chronic disease, a systems approach is required. This enables governments, organisations and individuals to work together to address the problem from many different angles and in dynamic, flexible ways. We suggest that an explicit use of systems thinking and systems approaches should be added as a guiding principle of the NTS to help identify priority actions for implementation, and drive collaboration across government to achieve its goals.

Furthermore, the new policy areas, such as regulating the content of tobacco contents and reducing the supply and availability of tobacco, will require a strong evidence base developed by independent researchers to support implementation. We recommend the inclusion of partnership with academia and acknowledgement of the important role that Australian universities and research institutes can contribute to the NTS. Our Collaboration for Enhanced Research Impact, including the NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame, is an ideal research partner for this work.

We believe treating the tobacco industry as a sunset industry should also be included as a guiding principle, because achieving a permanent reduction in smoking to minimal levels is not consistent with the ongoing commercial viability of the tobacco industry in its current form.

Priority areas for the draft NTS 2022-2030

We broadly support the priority areas contained in the draft Strategy.

We note that the tobacco industry has a history of opposing effective public health policy. It is essential that tobacco control specifically and public policy development more generally be protected from tobacco industry interference. Therefore, this should be included as both a guiding principle and a priority area.

We applaud:

- Priority Area 1 *(Protect public health policy, including tobacco control policies, from tobacco industry interference*), because broader public health policy is included beyond just tobacco control in efforts to protect from public health tobacco industry interference.
- Priority Area 2 (*Develop, implement and fund mass media campaigns and other communication tools to: motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use*), because we support the use of mass media campaigns not just to change behaviour, but also to reshape social norms. For example, there is evidence supporting campaigns that focus on issues such as environmental harm or on misleading and likely deceptive conduct around cigarette design.[5] Modelling work supported by The Australian Prevention Partnership Centre has reinforced the role of media campaigns and tax increases in reducing deaths and disease burden by reducing the use of tobacco products.
- Priority Area 6 (*Eliminate remaining tobacco-related advertising, promotion and sponsorship*) because this makes explicit the desire not just to regulate but to eliminate remaining advertising, as well as all promotion and sponsorship.
- Priority Area 8 (*Strengthen regulation to reduce the supply, availability and accessibility of tobacco products*), because this goes beyond point-of-sale displays to reducing where and to whom tobacco products can be sold.
- Priority Area 11 (*Provide greater access to evidence-based cessation services to support people who use tobacco to quit*), because this supports focus on population-wide cessation service.

We suggest that Priority Area 7 (*Further regulate the contents and product disclosures pertaining to tobacco products*) is strengthened by including a firm commitment to implementing controls on the constituents and emissions of tobacco products, consistent with expectations under Article 9 of the WHO Framework Convention on Tobacco Control (FCTC). While we note that reducing nicotine content in tobacco products is mentioned under Priority 8 (Action 8.10), it fits better under Priority Area 7.

Actions listed under each priority area for the draft NTS 2022-2030

Priority Area 1 (*Protect public health policy, including tobacco control policies, from tobacco industry interference*)

We believe actions under this priority area could be strengthened. For example, consistent with FCTC Article 5.3 of not giving preferential treatment to the tobacco industry, we recommend the NTS include a priority action of reviewing the feasibility of holding tobacco companies criminally responsible for actions that result in avoidable deaths, such as opposing the implementation of public health policies that reduce smoking. This would make their regulation more consistent with other industries that are held responsible for recklessly endangering life and consistent with recent reforms proposed by the Australian Law Reform Commission to strengthen corporate criminal responsibility.

Regarding Action 1.4, we recommend the removal of the phrase "or to require full disclosures of such contributions", as these donations should be outright banned rather than only disclosed. Donations to political parties or other agents with ability to influence tobacco control policymaking is inconsistent with the principle of FCTC Article 5.3.

We note the role of applied research in providing data to better understand and more effectively regulate tobacco industry conduct (Actions 1.5 and 1.8).

Priority Area 2 (*Develop, implement and fund mass media campaigns and other communication tools to: motivate people who use tobacco to quit and recent quitters to continue smoking abstinence; discourage uptake of tobacco use; and reshape social norms about the tobacco industry and tobacco use*)

Despite a high-reach integrated multi-media campaign strategy being a significant contributor to lowering smoking prevalence, Australia has spent nearly a decade without one.

New integrated multi-media campaigns for all smokers are urgently needed because they prompt more people to attempt to quit. Such campaigns discourage young people from taking up smoking, increase the chances that someone who smokes will try to quit, and reduce the likelihood that they will relapse back to smoking. The campaigns increase discussion about quitting between people who smoke and healthcare professionals, and increase the chances of patients who smoke making use of prescribed medicines and recommended support services.[6]

We note the important role of research in monitoring progress, building and sharing the evidence base, and assisting government to adopt best practice.

Enhancing access to nicotine replacement and other therapies can amplify the effectiveness of mass media campaigns. For example, the 10,000 Lives Campaign (Central Queensland Public Health Unit in partnership with the CQ Hospital and Health Service) demonstrated how widespread promotion of free NRT via Quitline services resulted in greater uptake in Quitline assistance.[7]

Priority Area 3 (*Continue to reduce the affordability of tobacco products*)

Increasing the price of tobacco products is the single most effective thing that Government can do to reduce smoking. The Australian Prevention Partnership Centre is undertaking research in this area and we strongly support action to apply the insights and findings of this work.

We note that this topic is a continuing priority for research. According to recent evidence, governments should:

- harmonise the duty on roll your own (RYO) tobacco products so that the tax on a RYO cigarette is equivalent to that on a ready-made manufactured cigarette

- legislate to standardise pack and pouch sizes of all tobacco products
- ensure that the Tobacco Advertising Prohibition Act 1992 is amended to extend to all forms of tobacco promotion (as recommended in the WHO Framework Convention on Tobacco Control) including promotion of pricing strategies such as specialling and volume discounting
- regulate pricing of tobacco products to prevent cushioning of consumers from price increases and cross subsidisation of very low-priced brands with higher prices for premium brands.[8]

Priority Area 4 (*Continue and expand efforts and partnerships to reduce tobacco use among Aboriginal and Torres Strait Islander people*)

We strongly support action in this area. Smoking causes an estimated 37% of all deaths, and 50% of deaths at age 45 years and over, in Aboriginal and Torres Strait Islander peoples. This equates to more than 10,000 preventable premature deaths between 2009 and 2018.[9]

Aboriginal and Torres Strait Islander peoples are disproportionately affected by the economic impacts of smoking. In 2018–19, more than one-third (37%) of Aboriginal and Torres Strait Islander adults were living in households in the lowest income quintile, and in 2014–15 four in five (81%) daily smokers reported spending too much money on cigarettes.[10]

We note that action in this area requires a multisectoral approach that addresses the broader drivers of Indigenous health and wellbeing. Our research shows that Aboriginal adolescents in NSW are significantly less likely to have ever smoked regularly if they also have good mental health, good family relationships, a mother as primary caregiver, stable housing, no history of using alcohol, are not sexually active, and have had no criminal justice interactions.[11]

A review of systematic reviews found benefits to effective tobacco control interventions that are multicomponent or multi-faceted, with Indigenous leadership or collaboration and cultural awareness (e.g. tailored campaigns/programs, although other reviews suggest non-tailored messages can be as effective). Multi-faceted smoking cessation strategies are more effective than single interventions (although they have lower evidence of effectiveness compared to non-Indigenous populations). There are also benefits in terms of self-efficacy and self-esteem for Indigenous school students from tobacco control interventions.[12]

It should also be noted that the above evidence on tobacco control in Aboriginal and Torres Strait Islander populations highlights the benefits and effectiveness of universal, population-level interventions (such as taxation and pricing strategies; bans on tobacco advertising; and restrictions on retail sale of tobacco products) for these populations, as well as more targeted approaches and strategies.

Priority Area 5 (*Strengthen efforts to prevent and reduce tobacco use among populations at a higher risk of harm from tobacco use and populations with a high prevalence of tobacco use*)

We strongly support action in this area.

In 2015 in Australia, the lowest socioeconomic group experienced the greatest amount of disease burden attributable to tobacco use, with 131,954 or 12% of total disability-adjusted life years (DALYs) compared with 47,676 DALY (6.5%) in the highest socioeconomic group. The lowest group experienced a rate of attributable burden that was 2.6 times that of the highest group. In 2015, 191,824 DALYs attributable to tobacco use were considered 'excess' due to socioeconomic position - i.e. these would have been avoided if the rate of burden attributable to tobacco use had been the same as in the group with the lowest rate.[13]

A question about smoking in the Census is warranted given the burden of disease created by tobacco smoking and the overall impact on health and welfare. Smoking levels are a better predictor of future healthcare needs than any

other indicator. Given the increasing costs of surveys and barriers to survey participation, a Census question is the only practical way of determining smoking status among many small population groups, particularly where this needs to be monitored at a sub-national and sub-state level.[14]

We support investment in targeted strategies and approaches for disadvantaged populations, including mental health clients and low SES communities, that must be rolled out in conjunction with sustained investment in universal, population-level approaches and strategies.

Priority Area 6 (*Eliminate remaining tobacco-related advertising, promotion and sponsorship*)

While tobacco products remain regulated as consumer goods that are manufactured and supplied by commercial entities for profit, these entities can be expected to continue to find any remaining loopholes for promoting these products. We strongly support the actions listed under Priority Area 6, particularly Action 6.4 of requiring companies in the supply chain for tobacco products to report details of expenditure AND ACTIONS on any form of advertising and promotion activities. We also support prohibiting such activities.

Priority Area 7 (*Further regulate the contents and product disclosures pertaining to tobacco products*)

Our research about novelty filters strongly suggests the need to standardise the appearance and content of cigarette filters in Australia. Addition of flavour capsules and other novel features that are particularly appealing to youth should be prohibited. Internationally, some jurisdictions are also considering banning cigarette filters completely. Australia should examine the risks and benefits, including impact on palatability, and potential environmental benefits of banning filters, and include this as a possible option under Action 7.3.

Internationally, a number of countries are implementing complete flavour bans for tobacco products. While state and territory governments in Australia have implemented some restrictions in this regard, more comprehensive national standards are desirable.

A voluntary agreement with tobacco companies in Australia has resulted in the lodging of reports listing the major ingredients included. However, this does not extend to RYO tobacco, which many consumers falsely believe to be more "natural". In fact, RYO tobacco contains more additives by weight than do ready-made manufactured cigarettes. Our research supports the need for regulation of equivalent disclosure of such information, and for education to explain the role of such additives in reducing the apparent harshness but not the health harms associated with smoking RYO tobacco.

Our findings underline the need for very careful action in this area, noting that while legislation to require disclosure of additives and emissions is required, companies must not be permitted to engage in any form of promotion that would suggest or imply reduced product harmfulness.[15]

Priority Area 8 (*Strengthen regulation to reduce the supply, availability and accessibility of tobacco products*)

We strongly support all the actions in this priority area. We encourage a commitment to implementing a national minimum licensing scheme for all actors in the tobacco supply chain, without restricting the states and territories or local governments from implementing more restrictive requirements. Reducing the availability of tobacco in the retail environment will support people to quit smoking and to maintain abstinence by removing triggers to purchase tobacco. Our research has also found that there may be important equity impacts from reducing retail availability, as tobacco products are more widely available and at cheaper prices in low-income areas than in high-income areas. Research is needed into the feasibility of transforming the current model of commercial supply of tobacco products by general retailers to one that provides advice and support to quit alongside supply.[16]

Priority Area 9 (*Strengthen regulations for novel and emerging products*)

It is important to pursue an evidence-informed approach to regulation of novel and emerging products. Synthesis of research and learnings from ongoing overseas experience will be crucial. We note the new regulations implemented by the TGA concerning these products. Independent evaluation will also be important to identify

aspects that are working well and areas that could be improved. This could include review of the labelling requirements, and enforcement of diversion from the legal supply to illegal supply (e.g. supply to youth).

Priority Area 10 (*Eliminate exceptions to smoke-free workplaces, public places and other settings*)

We strongly support action by state and territory governments in this priority area. We note the current challenges around enforcement of smoke-free areas in some settings, such as outdoor locations on hospital campuses. Embedding active referral to and delivery of smoking cessation services into such settings should be prioritised. For example, no one should be fined for smoking in these locations without being offered NRT and a referral to smoking cessation assistance.

Priority Area 11 (*Provide greater access to evidence-based cessation services to support people who use tobacco to quit*)

This is perhaps the most challenging area of the draft Strategy. It involves collaboration between states and territories and different parts of the healthcare system, as well as sustained change of practice at both a professional and systems level.

Advising smokers to quit, referring them for Quitline support and prescribing TGA-approved medications are among the most cost-effective healthcare interventions and should be undertaken for every patient who smokes in almost every interaction with Australia's healthcare system.

Treatment for tobacco dependence is not just a preventive health intervention, it is a requirement of good clinical care for almost every disease being treated by Australian healthcare professionals.

Our investigators are ready to assist in any way to provide evidence for institutionalisation of treatment for tobacco dependence in the healthcare system. We have already conducted research on programs that embed proactive smoking cessation treatment into a variety of settings that have demonstrated the reach and uptake of existing services, such as Quitline, can be greatly increased with relatively low-cost promotion. Streamlining delivery of best practice smoking cessation assistance (combination of pharmacotherapy and counselling), such as through free NRT mailed to Quitline clients, will greatly increase the impact of this service. More could be done to increase the reach of these programs, such as through embedding them within a range of NGO services, such as those that provide crisis accommodation or disability support. However, this work needs to be adequately funded, given the existing pressures on many such organisations.

Every person who smokes should be regularly offered advice and assistance to stop smoking. Transforming the supply of tobacco to embed smoking cessation advice and assistance alongside tobacco supply would help to ensure that all people who smoke are offered smoking cessation support whenever they purchase tobacco products. The current model of supply through general retailers does not easily support this model. Hence, transformation of the current model of supply should be reviewed as part of priority areas 1, 2, 5, 6, 8 and 11.

Additional comments

In 2018, tobacco use caused almost 20,500 deaths in Australia, or more than one in every eight deaths (13%). Nine per cent of the disease burden was due to tobacco use, making it the leading single risk factor that contributed to disease burden and deaths. This equated to 430,903 years of healthy life lost from death and illness due to tobacco use in Australia in 2018.[17] It is therefore appropriate for Australian governments to develop and implement a comprehensive strategy to substantially reduce tobacco use over the coming decade.

Our research indicates that preventive health strategies are cost-effective and have numerous economic benefits beyond health benefits. This is particularly the case for multiple strategies for tobacco control.[18] Regulatory strategies, such as those suggested in this draft Strategy, are generally highly effective and cost-effective. Fiscal interventions such as taxation are particularly effective and cost-effective, and tend to have positive impacts for health equity.[19]

The evidence suggests that the most effective approaches are those that combine several interventions across multiple settings, and/or multi-component interventions implemented at different levels of the system or setting.

We note the following:

- **Integration with other national and global frameworks**: The National Tobacco Strategy is designed as a sub-strategy of the 10-year National Drug Strategy (NDS, 2017-2026). However, due to delays in release of the NTS, there is now an overlap of only four years with the NDS. It will therefore be important to drive action early in the life of the NTS in order for any progress on tobacco to be evident by the end of the current NDS.
- **Governance:** While the draft Strategy includes virtually all the necessary priority actions, its chances of success would be improved with more attention to governance issues. For example, who is responsible for reporting progress to Ministers, when and how?
- **Deadlines**: What are the deadlines for each of the priority actions included, and which need to come first? While many items need to be undertaken in tandem, who is responsible for ensuring action? The NTS would be much more likely to be implemented if it included deadlines and a lead agency for every task.
- **Evaluation**: Will there be an assessment of progress part-way through of the Strategy? Perhaps August 2023, 2026 and 2029 would be appropriate reporting points, coinciding with release of the results of the 2022, 2025 and 2028 National Drug Strategy Household Surveys and the release of the results of the ASSAD 2022 survey (baseline, mid-point and final).
- **Evidence**: Our investigators – at The Australian Prevention Partnership Centre and affiliated NHMRC Centres of Research Excellence through the Collaboration for Enhanced Research Impact - can play a major role in monitoring progress, building and sharing the evidence base, and assisting government to adopt best practice. In particular, the NHMRC Centre of Research Excellence on Achieving the Tobacco Endgame is conducting research of high relevance to many of the policy targets outlined within the draft Strategy. This CRE also hosts the International Tobacco Control Policy Evaluation (ITC) Project Survey for Australia, which is the only international cohort study focused exclusively on monitoring the impacts of policy on tobacco and other nicotine product use via longitudinal and cross-country comparisons. Additionally, Tobacco Endgame CRE researchers have conducted modelling of many proposed new and existing policies for the New Zealand government as part of their Smokefree Aotearoa 2025 Action Plan to inform likely impact of these policies. This modelling has included both smoking prevalence, health impacts and economic impacts (including productivity). Similar modelling can be performed for Australia through adapting this model.

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